Safe at Home West Virginia

West Virginia's Title IV-E Waiver Initiative

FINAL EVALUATION REPORT

PREPARED FOR
West Virginia Department of Health and Human Resources

BY
Public Consulting Group, Inc.
373 Broadway
South Portland, ME 04106

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WEST VIRGINIA
Department of
Health & Human Resources

Safe at Home West Virginia

Strengthening families & children within their home communities

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Executive Summary

On October 1, 2015, the West Virginia Department of Health and Human Resources (DHHR) implemented the Title IV-E Waiver initiative *Safe at Home* West Virginia. The initiative was designed to address the safety, permanency and well-being of the State's youth with very specific goals.

1. Increase the number of children staying in their home communities
2. Reduce initial foster care entry rates
3. Increase youth safety as demonstrated by decreased rates of maltreatment/repeat maltreatment
4. Improve the well-being of children 12 to 17 years of age as demonstrated through educational achievement and increased numbers graduating high school
5. Improve academic progress of children 12 to 17 years of age by keeping them in the same school
6. Reduce the reliance on congregate care
7. Decrease the length of stay in congregate care for children 12 to 17 years of age
8. Improve family functioning to support reunification
9. Reduce the number of children entering any form of foster care

Public Consulting Group, Inc., via competitive bid, was contracted by DHHR to conduct an evaluation of *Safe at Home* over the multi-year period for which federal funding was received, *i.e.,* from October 1, 2015 through September 30, 2019. Using a mixed methods approach, qualitative and quantitative data were collected and analyzed to answer process, outcome, and cost research questions. The results have further been translated into lessons learned and recommendations for sustained and expanded programming.

Summary of Results

Safe at Home West Virginia was based on the principles of the National Wraparound Initiative. Evaluators examined multiple aspects of implementation to confirm fidelity to the model. Both Local Coordinating Agencies (LCAs) and DHHR generally conformed to the requirements of Wraparound, but there was some fluctuation of fidelity scores and compliance over the course of the demonstration period.

The success of the program in returning youth home or preventing placement in congregate care varied. A higher percentage of youth who were referred early in the demonstration period experienced a reduction in congregate placement and an increase in the likelihood of living at home at six and twelve months after their referral. However, by the middle of the demonstration period, the difference in placement outcomes was

minimal for youth who were referred to the program compared to those in a comparison cohort.

On average, youth referred to *Safe at Home* while they were in congregate care were more likely than youth to be living at home within a year of referral; however, if youth were still living at home when they were referred to the program, they were more likely to be placed in congregate care within a year than those who were not in the program.

Safe at Home youth were more likely to have an initial entry into the foster care system or re-enter the system than comparison group youth. This is potentially due to the lack of mental health data available to produce a comparison group with similar behavioral health needs for these measures; it is possible that the chosen historical comparison group was less likely to have a mental health diagnosis or elevated behavioral health issue. The result may also be potentially due to the increased intensity of the services provided to treatment youth, with Wraparound facilitators working more closely with youth and their families and providing greater opportunity to identify family issues.

Across well-being outcomes, a high percentage of youth showed improvement at six and twelve months after the initial needs assessment. Specifically, education related items showed a large improvement for school attendance, achievement, and behavior. The areas that showed the least amount of growth were family stress and school violence.

It can be said that *Safe at Home* was most successful in helping youth spend fewer nights in congregate care, transition home, prevent return placement, and improve well-being, especially in education. Increased community stakeholder buy-in, including that of juvenile justice staff and judges, which helped the program to gain traction and legitimacy among professionals and families was also a big win for the program. Communication became more routinized as well between LCAs and DHHR, and both parties reported several anecdotal success stories for youth and families.

By contrast, *Safe at Home* was not as successful in preventing placement of youth who had not previously been placed in congregate care or foster care. Overall, *Safe at Home* outcomes followed an interesting pattern where treatment youth performed better than comparison groups for the first six months, but the successes dissipated by twelve months.

In general, *Safe at Home* cost roughly $41,400 per youth per year compared to $14,800 per youth per year for the comparison group, a difference of roughly $26,600 per youth per year. When only room and board and fee-for-services were considered, *Safe at Home* saved nearly $4,065 per youth per year. The program generated a cost savings of $6.8 million in room and board costs and a savings of over $1.6 million for fee-for-services for treatment youth over the course of the program. The most significant portion of these savings can be attributed to the reduced time youth spent in congregate care placements. However, costs to contract with Wraparound service providers averaged $30,682 per youth per year. When the amounts incurred to contract for Wraparound are combined with room and board costs as well as with costs for fee-for-services, overall *Safe at Home* was

roughly $26,600 more per youth per year than the costs of serving youth traditionally. These costs may have been partially mitigated by less DHHR caseworker time spent on these *Safe at Home* cases, but this time was not quantifiable for this evaluation. Success of the program was, therefore, mixed.

Recommendations

The focus of the recommendations offer steps West Virginia can implement to sustain *Safe at Home* from a financial perspective using both traditional Title IV-E dollars and those being made available through the Family First Prevention Services Act.

Funding

A portion of the costs to serve *Safe at Home* youth will be captured using traditional Title IV-E reimbursement. DHHR has placed a fair amount of emphasis on improving its ability to document Title IV-E eligibility for children and youth who come into care, increasing the State's penetration rate by a substantial margin. Those efforts, which are intended to and should continue, will enable DHHR to capture increased federal revenues for maintenance costs and administrative expenditures for children and youth participating in Wraparound when placed out of the home.

However, with greater emphasis placed on serving youth who remain in their home, DHHR needs to take active steps to implement "candidacy" to capture Title IV-E funding for case management services delivered by caseworkers as well as Wraparound facilitators to *Safe at Home* youth. This is especially important given West Virginia's Memorandum of Understanding with the U.S. Department of Justice to remediate the needs of youth known to youth services. In mid stages of the evaluation, DHHR provided Public Consulting Group, Inc. (PCG) with an Excel file that documented, by LCA and youth, the types of services that were being provided to enrolled youth. At least 60 percent of the services provided to participating youth by Wraparound facilitators were case management activities, *e.g.,* conducting an assessment, meeting with youth and/or their families to monitor progress, or assisting with the referral to services.

To maximize federal reimbursement, DHHR needs to take two critical steps:

1. implement candidacy statewide, going beyond defining it in policy and implementing protocols, to document when youth and children are at risk of removal;
2. include Wraparound facilitators in the Department's administrative cost claiming process to capture the proportion of time they spend providing Title IV-E qualifying services and thus receive federal reimbursement for qualifying administrative or case management services provided to youth as well as younger children, if program requirements are expanded.

Documentation

DHHR and its LCAs made concerted efforts to implement the Wraparound model as intended. Wraparound facilitators did a favorable job in documenting when assessments and plans were completed and updated; however, there were shortcomings in documenting when Wraparound facilitators engaged with youth and their caregivers. While interviews with youth and their caregivers documented contact was made to fidelity, case record evidence maintained by Wraparound facilitators failed to document all the contacts with youth and families, making it appear as if contact did not meet the criteria specified by the National Wraparound Initiative model. There were also shortcomings in documenting the extent to which the LCAs developed and linked youth and their families to non-traditional services. The documentation submitted by the LCAs of the services they provided to *Safe at Home* youth largely documented they were providing traditional case management services as opposed to developing services which would best serve the needs of the youth and their caregivers.

Efforts are currently underway to expand the online WV Child and Adolescent Needs and Strengths (CANS) tool to document when Wraparound facilitators have contact with youth and their caregivers and the extent of that contact, *e.g.,* CANS assessment, in-person visit with youth or team meeting; the date of the contact; and how that contact was made, *e.g.,* in person, telephone, or text. Not only will this enhancement enable Wraparound facilitators to better document their contacts with youth and their caregivers and thus document fidelity to the model, it can also be used to generate an invoice received from the LCAs. As caseworkers document their contact with youth and/or their families, they will select a contact level that will be tied to the rate LCAs will be reimbursed for that type of contact.

The WV CANS tool is also being enhanced to capture the types of services to which youth and their families are referred, *e.g.,* traditional services and/or non-traditional services. This will help to not only better identify the extent to which non-traditional services are being developed and provided to support youth and their caregivers but also to link the extent to which the provision of non-traditional services yields better outcomes.

Evaluation

The evaluation of DHHR's implementation of the National Wraparound Initiative approach to case management and service provision under the Waiver demonstration project provides favorable documentation in establishing the Wraparound model for youth, 12 to 17 years of age with or potentially having a behavioral health issue, as a promising evidence-based program. Further evaluation efforts are needed, however, to establish the model as a supported or well-supported practice and, thus, capture federal reimbursement through the Family First Prevention Services Act.

First, a randomized control group needs to be defined which mirrors the characteristics of children or youth referred to *Safe at Home* but for which Wraparound services are not provided. This will be difficult for youth 12 to 17 years of age, given the Memorandum of

Understanding with the U.S. Department of Justice to engage all Youth Services youth in Wraparound, and, thus, the inability to select a randomized control group. However, to the extent West Virginia continues to expand *Safe at Home* to younger children, a quasi-experimental approach could be used to measure the impact of *Safe at Home* between "treatment" and "control" group participants. Here it is recommended that the State consider implementing Wraparound for younger children over time. This provides the opportunity for DHHR to implement Wraparound in specific counties, deeming the children enrolled as the treatment group. A control or comparison group would then be selected of children with similar characteristics, using propensity score matching, from a non-participating county with similar characteristics to that of the participating county, ***e.g.,*** poverty rate, judge, rural vs. suburban.

Second, West Virginia will need to measure outcomes prospectively from the date of discharge from *Safe at Home,* not from point of entry. Outcomes will need to be measured for at least six months from point of discharge to satisfy the Prevention Clearinghouse's criteria for a rating of "supported" and 12 months for a rating of "well-supported." This will also have to involve an adequate number of treatment and comparison youth within the randomized or quasi-experimental samples to document statistical significance.

Transitional Payments

The Administration for Children, Youth and Families, Children's Bureau's issued Program Instruction, ACYF-CB-19-06, that specifies a process for states to follow to capture Title IV-E revenues using Family First dollars before the Prevention Services Clearinghouse has an opportunity to review the literature and studies of evidence-based programs and establish a rating. DHHR is encouraged to identify an evaluator to complete the forms contained within Attachment B of the Program Instruction. The evaluator should use the information from this report as part of its review and as well as conduct a literature review of other studies of Wraparound models employed to serve youth 12 to 17 years of age with a behavioral health issue, incorporating the results from those studies into the forms.

Introduction and Overview

Background and Context

In late 2015, the West Virginia Department of Health and Human Resources (DHHR), Bureau for Children and Families (BCF) received Title IV-E Waiver funding to implement a behavioral health approach to case management, employing the National Wraparound Initiative (NWI) service model. Commonly referred to as *Safe at Home* West Virginia, the program was designed to return youth who were placed outside of the State to West Virginia, facilitate moving youth placed in congregate care to lower levels of foster care, and shorten the length of time youth are in substitute care. The initiative also sought to meet the needs of youth living in the community to enable them to remain in their homes.

As *Safe at Home* West Virginia was being implemented, the State was facing a growing number of children and youth entering its foster care system, with a substantial portion being placed in congregate care. In fiscal year 2012, the entry rate for substitute care in West Virginia was 8.6 per 1,000 children in the population, which was nearly three times the national rate (3.3).[1] Youth ages 12 to 17 were the hardest hit, making up nearly half (46%) of the children who entered care during fiscal year 2013.[2] Of the 1,488 youth between 12 and 17 years old, 71 percent were placed in congregate care.[3]

The Wraparound service model was selected because it demonstrated in the literature to be effective; it builds on the strengths of both the youth and their family members (the latter are often neglected when a youth is placed in congregate care), and it uses a flexible approach of formal and informal supports to target the particular needs of the youth and family members. In addition, West Virginia had a history with this model, having piloted it in its system of care program, Next Step Community Based Treatment, in one region of the State and having positive results.

DHHR contracted with Local Coordinating Agencies (LCAs), which are licensed behavioral health care agencies, to provide services to eligible youth and their families. The LCAs developed Memoranda of Understanding with other community service agencies to provide several of the services needed by youth and their families within their own communities. They were also responsible for hiring and maintaining Wraparound facilitators responsible for leading child and family teams to develop individualized service plans employing the Wraparound process.

To provide a more thorough and consistent assessment of youth, DHHR also implemented the Child and Adolescent Needs and Strengths (CANS) assessment universally across child-serving systems in West Virginia; developed thresholds to guide decision-making about levels of care; and educated system partners about decision-

[1] West Virginia Department of Health and Human Resources, Initial Design and Implementation Report, August 2015, p.5.
[2] *Ibid,* p.3.
[3] *Ibid,* p.3.

making based on needs and strengths of children and families using common assessment language.

Purpose of the Waiver Demonstration

Implemented October 1, 2015, *Safe at Home* West Virginia was designed to address the safety, permanency and well-being of the State's youth by:

1. Increasing the number of children staying in their home communities,
2. Reducing initial foster care entry rates,
3. Increasing youth safety as demonstrated by decreased rates of maltreatment/repeat maltreatment,
4. Improving the well-being of children 12 to 17 years of age as demonstrated through educational achievement and increased numbers graduating high school,
5. Improving academic progress of children 12 to 17 years of age by keeping them in the same school,
6. Reducing the reliance on congregate care,
7. Decreasing the length of stay in congregate care for children 12 to 17 years of age,
8. Improving family functioning to support reunification, and
9. Reducing the number of children re-entering any form of foster care.

Evaluation Framework

Overview

As part of DHHR's agreement with the Administration for Children and Families (ACF) to receive Waiver monies, West Virginia was required to complete an evaluation comprised of three components: a process evaluation, an outcome evaluation, and a cost evaluation. The evaluations were to assess the extent to which the program was implemented as intended, determine if intended outcomes were achieved, identify the population(s) for which the interventions have been most effective, measure the cost effectiveness of the approach, and identify barriers which may have limited the success of the project in achieving the desired outcomes.

To accomplish these goals, in 2015, DHHR engaged Hornby Zeller Associates, Inc. (HZA) to provide objective, third-party evaluation services, doing so through a competitive Request for Proposals process. In March 2018, HZA was acquired by Public Consulting Group, Inc. (PCG), a national expert in child welfare that brings extensive knowledge of program operations and policy to comprehensive evaluations. A seamless transition of HZA staff to PCG provided continuity of the evaluation throughout completion of the project.

Theory of Change/Logic Model

To illustrate the conceptual linkages between the Waiver demonstration and the measurable short-term, intermediate, and long-term outcomes, West Virginia developed the following theory of change model. Using that information in conjunction with knowledge of the Wraparound model West Virginia intended to implement, the evaluation team developed the logic model which follows.

Figure 1. Theory of Change

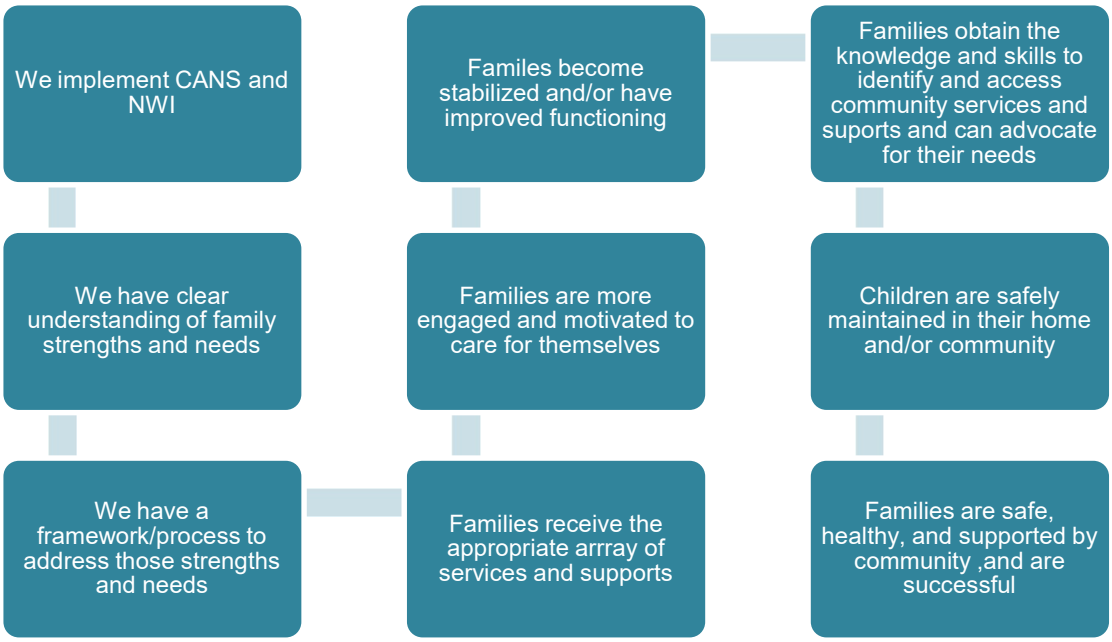
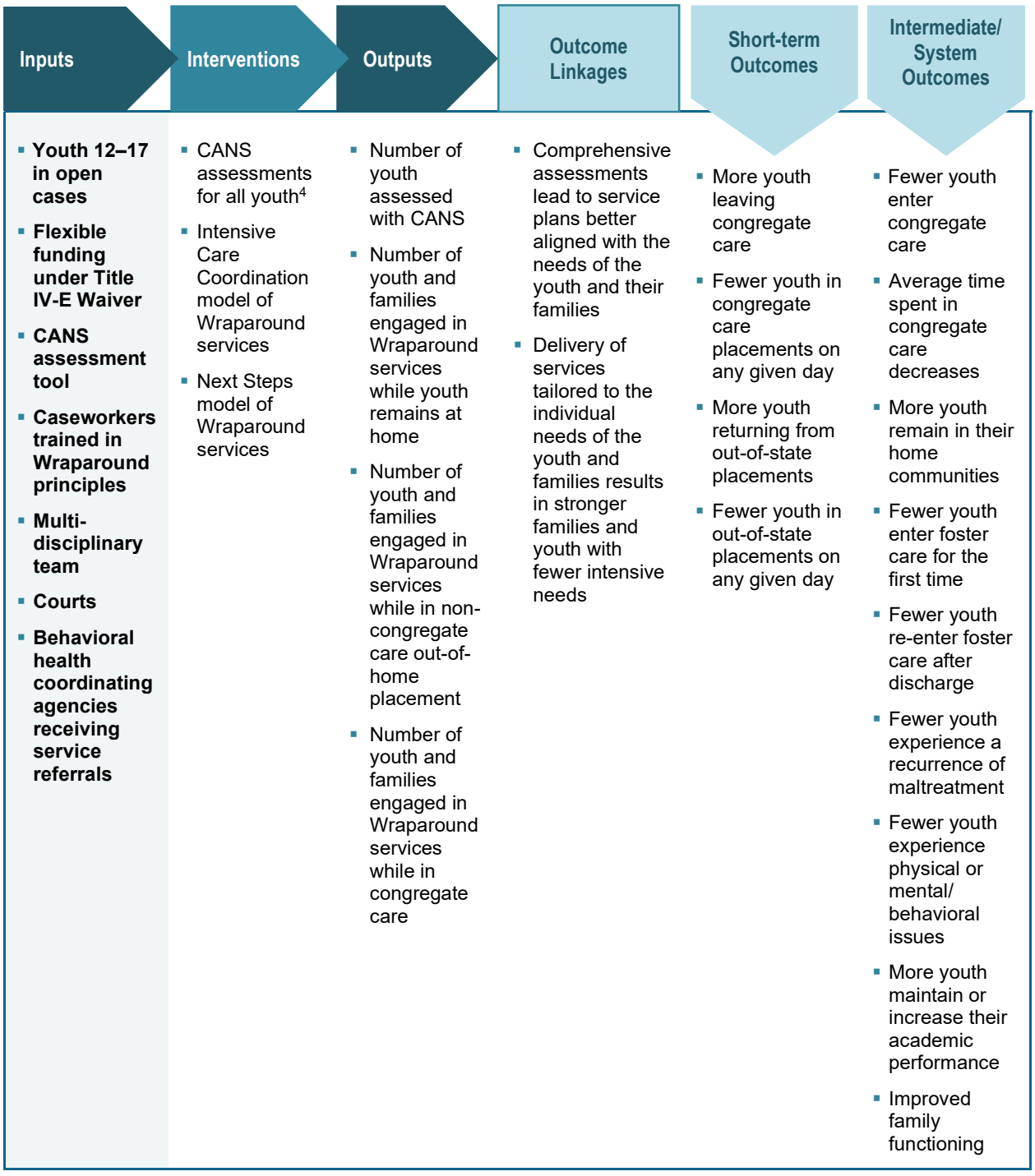


Figure 2. *Safe at Home* West Virginia Logic Model



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

Data Sources and Data Collection Methods

PCG used a mixed-methods approach to answer the process, outcome and cost evaluation questions. Qualitative data collected through interviews and surveys informed results of the quantitative analyses. Quantitative data sources included extracts from West Virginia's statewide automated child welfare information system, FACTS; CANS assessments; a manual review of case records and survey questions.

This section provides a brief summary of the various data collection sources and methods.

Stakeholder Interviews

PCG interviewed DHHR staff, including Central Office administrators, Regional Office staff, community services managers (CSMs),[5] supervisors and caseworkers annually to learn about the successes and challenges of implementing *Safe at Home*. Yearly stakeholder interviews were also conducted with LCA staff, including program directors, Wraparound supervisors and Wraparound facilitators, to gain the perspective of staff who worked directly with youth and their families. Additionally, PCG interviewed judges in 2015, 2017, and 2019 and juvenile justice probation officers and staff in 2015 and 2019 to obtain information about how *Safe at Home* was perceived in the courtroom. In total, more than 540 interviews were conducted over the course of the demonstration project (Appendix B).

Protocols were tailored to each stakeholder group with open-ended questions used to prompt discussion about the implementation process and fidelity of implementation to the Wraparound model and the *Safe at Home* program. While every attempt was made to conduct interviews in person, the evaluation team found that it was sometimes necessary to use telephone interviews to accommodate stakeholder schedules.

Case Record Reviews

Data for the fidelity assessment were gathered, in part, via onsite reviews for a sample of youth served by *Safe at Home* West Virginia. Forty *Safe at Home* cases were selected each year as part of the fidelity assessment, with the number of cases selected for review within each contracted LCA proportional to the number of youth served by that agency. However, the strategy for selecting cases varied between years.

In years one and two, all forty cases were chosen at random. In year three, thirty cases were selected randomly for review across each of the ten LCAs. Each LCA was also asked to choose one case that closed successfully to better understand why the program worked as anticipated. In year four, thirty cases were again selected randomly for review with each of the ten LCAs; but, for the remaining ten cases, each LCA was asked to select

[5] CSMs, who manage single and multi-county DHHR offices, report to regional directors and provide oversight to direct service supervisors and caseworkers.

one case that closed unsuccessfully so that lessons could be gleaned about situations that may not have worked well with this model.

For each case, PCG attempted to interview the youth, his or her caregiver(s), the Wraparound facilitator and DHHR caseworker to determine the extent to which the program was implemented as intended. Wraparound facilitators and caseworkers sometimes had more than one case in the sample, providing an opportunity to consolidate the number of interviews completed while still collecting data for each case.

PCG developed a case record review tool to collect data on the timeliness and completeness of Wraparound model components, like Wraparound and crisis safety plans. The tool assessed specific fidelity requirements. These included the consistency of service provision with a youth or family's needs and culture, youth and family strengths, inclusion of multiple strategies, opportunities for youth to engage in community activities, and maintenance and transition to the least restrictive environment. PCG also examined measurable outcomes connected to the youth's long-term vision and strategies linked to those outcomes to see how well they met the requirements of the Wraparound model.

Further, PCG assessed the crisis safety plan to determine if it included the assignment of roles during a crisis, steps to be taken if a crisis arises, behaviors that signal a crisis may be imminent, methods to de-escalate a crisis, and strategies to prevent crises.

Staff Surveys

PCG developed two survey protocols to assess the process implementation: one to gather data from the perspective of DHHR staff (including community services managers, supervisors and caseworkers) and the other from the perspective of LCA staff (such as LCA program directors, Wraparound supervisors and Wraparound facilitators).

PCG administered DHHR staff surveys online. An email was sent to CSMs with a link to the survey and a request to participate as well as a message to forward the link to their caseworkers and supervisors. The survey asked about staff's involvement in the implementation of *Safe at Home*, the adequacy of the training they received, their engagement with Wraparound service providers and judges, their perceptions of the quality and effectiveness of services, and potential enhancements.

Additionally, the survey asked DHHR staff about the extent to which they align their work with the Wraparound model. PCG initially staggered administration of the DHHR staff survey at the State's request to account for differences in when staff were trained and time/experience working with the program. After *Safe at Home* was fully implemented, the survey was administered annually statewide.

Surveys of LCA staff were also administered online. The survey link was sent directly to email addresses of all applicable LCA staff, using the online CANS database to identify staff participating in the Waiver model. The LCA staff survey was tied to the four phases of the Wraparound model (engagement and team preparation, initial plan development,

plan implementation, and transition) and asked about the quality and effectiveness of services, potential enhancements, frequency of program responsibility completion, adherence to the Wraparound model, and functionality of multi-agency collaboration.

FACTS Extracts

Characteristics of the youth involved in *Safe at Home* were collected from FACTS. PCG received FACTS extracts quarterly from DHHR. Youth characteristics included demographic data, mental health status, youth involvement with juvenile justice, and placement type at time of referral to the program. The five placement types were categorized as out-of-state congregate care and group care, in-state congregate care and group care, emergency shelter, family foster care placement, and youth at home. The data from FACTS were also used to measure outcomes, identifying the characteristics of youth which either contributed to or hindered the achievement of safety, permanency or well-being. Payment data contained within FACTS were also used to measure the cost effectiveness of the Wraparound model, including placement costs and auxiliary service payments.

CANS

At the start of the evaluation, PGC developed an online Child and Adolescent Needs and Strengths assessment for Wraparound facilitators to document the initial and subsequent assessments for each youth. The online assessment tool enabled Wraparound facilitators to inform DHHR caseworkers of the results, doing so for the initial assessment as well as others to show progress over time. It also provided a source of information for the evaluation team to measure improved well-being and fidelity in completing the CANS.

Caseworkers began to refer youth and their families to *Safe at Home* West Virginia on October 1, 2015. The automated CANS database did not become operational until February 12, 2016. During that time, some cases had already transitioned to closure for various reasons, preventing the CANS for some cases to be available for analysis to show change over time as they were not later entered into the system. There was also a learning curve with the Wraparound facilitators navigating the system and remembering to save changes to the document. This accounts for discrepancies regarding the number of youth enrolled and the number of initial CANS completed in the system for the initial phase of the project.

Data Analysis

PCG used both qualitative and quantitative analysis techniques to evaluate the Waiver program. The qualitative or content analyses identified both common and disparate themes as reported by DHHR and LCA staff and other stakeholders. The quantitative analyses included descriptive statistics, outcome measures, and cost calculations. Each of these is discussed in more detail below.

Content Analysis

Content analysis is a method of analyzing qualitative data. Content analysis was used to analyze answers to open-ended questions gathered in interviews and staff surveys. Common threads and differences were identified over time, including those among various stakeholders. This report includes not only emerging themes but also the prevalence and frequency among interview subjects. The content analysis was used in part to assess fidelity and help identify those which were struggling to complete the required practices as intended.

Descriptive Statistics

The process evaluation included completion of quantitative analyses. Data from FACTS were used to describe the characteristics of youth referred to *Safe at Home*. Additionally, data collected from the online surveys was used to gain the perspective of DHHR and LCA stakeholders. For example, both groups were asked to what degree did training prepare them for their role in the program (Very Well, Somewhat, Not Well, or Unable to Determine).

Outcome Measures

Data from West Virginia's case management system were used to measure the extent to which *Safe at Home* was successful at statistically significant levels in keeping youth safe and helping them to achieve permanency, while data from the CANS were used to measure well-being outcomes. Multivariate analyses of the FACTS data were used to show with which populations the project is most successful.

Cost Calculations

PCG used West Virginia's case management system to measure the fiscal impact of the program. Costs for placing youth outside the home were calculated in addition to the costs of providing auxiliary services, such as transportation, counseling and recreation, among others. The contracts between DHHR and the LCAs provided information on the costs of the Wraparound services themselves.

Target Population

The project served youth with a mental health diagnosis and involvement in two or more systems. The target population included youth who met the following criteria: youth ages 12 to 17 with a severe emotional or behavioral disturbance that impedes his or her daily functioning (DSM-V Axis I) and:

- currently resides in an out-of-state residential placement and cannot return successfully without extra support, linkage and services provided by Wraparound; or

- currently resides in an in-state residential placement and cannot be reunified successfully without extra support, linkage and services provided by Wraparound; or
- is at risk of out-of-state residential placement and utilization of Wraparound can safely prevent the placement, with the operational definition of at risk for *Safe at Home* West Virginia being any youth ages 12 to 17 involved with the child welfare system and has an open case with BCF; or
- is at risk of in-state level one, two, or three or psychiatric residential placement, and can be safely served at home by utilizing Wraparound.

Data Analysis Plan

To measure the impact of *Safe at Home*, a matched historical comparison group was selected to demonstrate the impact of the program on *Safe at Home* youth, drawing comparisons between the two groups. The matched comparison group was selected using Propensity Score Matching, using data from FACTS. The comparison pool was drawn from youth who met the *Safe at Home* referral criteria; *i.e.*, youth ages 12 to 17 in congregate care with a mental health diagnosis (or at risk of entering congregate care with a possible mental health diagnosis) during State Fiscal Years 2011 through 2015.

Propensity scores were calculated using age at referral, gender, race, ethnicity, initial placement setting, report allegation, number of prior placements, evidence of an Axis 1 diagnosis, juvenile justice involvement and placement in a psychiatric hospital or group home. The scores for the treatment group were matched using a nearest neighbor algorithm to select a comparison group that is statistically similar to that of the treatment group (see Appendix A). Significance testing was used to quantify differences in outcomes between the two groups and highlight areas where *Safe at Home* was successful or needed improvement.

Sampling Plan

Table 1 lists each data source, the frequency of collection, and which populations were sampled. Data were collected annually from most sources, except for judges who were interviewed biennially. Data from FACTS were received quarterly. Samples for interviews and case records were selected at random.

Table 1. Data Sampling Plan

Data Type	Source	Frequency	Sample
Document Review	DHHR	Annually	All relevant materials (*e.g.,* policies, federal waiver documentation like Initial Design and Implementation Reports (IDIRs), organizational charts, training manuals)

Data Type	Source	Frequency	Sample
Interviews with Central and Regional Administrative Staff	Central and Regional Office Staff	Annually	Implementation Regions
Interviews with Direct Service Staff	Regional Office Staff	Annually	Implementation Regions
Interviews with Community Members and Providers	Community Members and Providers	Annually	Implementation Regions
Supervisor and Worker Survey	Regional Office Staff	Annually	Implementation Regions, Counties, and Districts
Interviews with Judges	Judiciary	Years one, three, and five	*At least 6 per cycle*
Interviews with Juvenile Justice Probation and Staff	Juvenile Justice	Years one and five	*At least 5 per cycle*
Fidelity Assessment	DHHR and Wraparound Providers, DHHR Caseworkers, Youth and Caregivers	Annually	*Approximately 40 cases per year*
FACTS Analysis	DHHR	Semi-Annually	Treatment and Comparison Groups *All Relevant Cases*
Case Record Reviews	DHHR	Annually	Treatment and Comparison Groups *40 per year*
Cost Analysis	DHHR	Annually	Treatment and Comparison Groups *All relevant cases*
Standardized Assessment Review (CANS)	Wraparound Providers	Annually	Treatment Group Families; Others if Available
Secondary Data Analysis	Children's Bureau Report Data KIDS COUNT American Community Survey	Annually	N/A

Limitations

Each data source was prone to unique forms of uncertainty which are discussed below.

Stakeholder Interviews

While ideally each person involved in *Safe at Home* would have been interviewed to gain every possible perspective, the time involved to collect interview data was limited. A random sample of staff at each position (*e.g.*, administrative staff, caseworkers, judges) from each region was selected to produce an optimal and unbiased sample.

While PCG stressed anonymity, interviewees may still have felt reserved and responded to the questions the way they believe their peers or superiors would have wanted them to respond. Additionally, because interviews were entirely voluntary, it was not always possible to interview every team member (youth, caregiver, Wraparound facilitator, and caseworker) for each case.

Case Record Reviews

Case reviews faced a similar limitation as that of the interviews in that each review was a time-intensive process. Each year 40 cases were selected for the fidelity assessment, with an oversample selected to account for cases where youth and caregivers were not able or willing to participate. Especially for the first case review, there were not enough youth who had completed *Safe at Home* to capture the practices that occurred as cases closed.

An additional limitation to the case reviews was the quality of the case notes. PCG sought specific information from case notes, such as updates to plans and dates of face-to-face meetings; if this information was missing, there was no definitive way to report on data which were lacking, although interviews with youth and their parents were used to supplement missing data where possible.

Staff Surveys

Survey data are also inherently biased towards those who respond since participation in the survey was voluntary. This bias was mitigated as the response rate increased; therefore, PCG reminded staff several times during the survey window to complete the survey. Again, while PCG stressed anonymity, responses could still be biased towards what staff thought their peers or supervisors wanted to hear.

FACTS Extracts

PCG received semi-annual extracts to identify the characteristics of *Safe at Home* youth and measure outcomes. The data housed in the FACTS case management system were entered by DHHR workers and were prone to data entry errors (*e.g.*, incorrect buttons pressed, misspellings, missing data). Additionally, data for a given case could be entered or altered after PCG received extracts; consequently, outcomes were limited to the data included in the data extract received.

While youth who were referred to *Safe at Home* without a documented mental health diagnosis were presumed to have a possible mental health diagnosis, it was not possible to do the same for youth in the comparison group. While there were youth in the comparison group without a documented mental health diagnosis—some of whom may have had a possible diagnosis—this limitation may have influenced the extent to which the comparison group showed better outcomes than the treatment group beyond six months for some measures.

Process Evaluation

Key Questions

The research questions which guided the process evaluation focused on the planning, organization and implementation of *Safe at Home*. They were formulated to examine the efforts employed by the State to plan for the program and the changes which took place over time; the staffing structure, service delivery and capacity of the initiative; and the extent to which the Wraparound model was implemented as intended through the *Safe at Home* program as well as the contribution of stakeholders in achieving the program's success. The research questions explored not only successes but also ongoing challenges to implementation, lessons learned, and application of lessons and changes over time.

Eight questions guided the process evaluation.

Process Research Questions

1. **How was the planning process conducted?**
2. **How was the demonstration organized (including staff structure, funding, administrative oversight, and problem resolution)?**
3. **What number and type of staff were involved in implementation and how long were the implementation periods?**
4. **How was the service delivery system for the Waiver defined?**
5. **What role did the courts play in the demonstration; what is the relationship between DHHR and the court system?**
6. **What contextual factors may impact the Waiver results?**
7. **To what degree are the demonstration programs and services implemented with fidelity to their intended models?**
8. **What barriers were encountered during implementation, the steps taken to address them, and any lessons learned?**

Results

Planning Process

Much of *Safe at Home* planning was completed by workgroups of team members with expertise in areas of service development, practice development, fiscal accounting and reporting, Title IV-E maximization, communications, and data. Community partners participated in the initial planning activities, while judges later reported that they would have liked to have had a role in the initial planning stage. The State used community collaboratives, consisting of DHHR staff and community partners from a variety of fields

(*e.g.*, juvenile justice, behavioral health, education) to help identify the service needs of eligible youth.

DHHR utilized transparency as a key strategy to engage local communities in planning for the Title IV-E Waiver initiative. While *Safe at Home* was integrated into DHHR's ongoing activities, it was frequently presented in larger meetings with community partners (*e.g.*, court improvement meetings) to gain their interest and involvement. DHHR Central and Regional Office staff also provided presentations to organizations that were interested in learning about the program to help engage local stakeholders. The State distributed the semi-annual evaluation reports to legislators to assure they remained informed while *Safe at Home* program leaders continued to conduct outreach with local and state partners, doing so through Facebook and Twitter. Additionally, *Safe at Home* had its own email address where Central Office staff could answer questions about the program directly.

In July 2015, in preparation for Phase I implementation, BCF released a request for applications for LCAs to participate in the program, including a provision to hire Wraparound facilitators. The initial grant awards, announced on August 25, provided startup funds for the hiring of Wraparound facilitators, a daily case rate for facilitating active involvement with youth and their families, and flexible funds for providing necessary Wraparound services. The Local Coordinating Agencies were encouraged to hire their allotted Wraparound facilitators in three cohorts. West Virginia believed this would be the best process to assure their ability to hire and train staff as the number of referrals increased over time.

For Phase II implementation, on February 26, 2016, BCF released a second request for applications for LCAs to participate in the program. The grant awards, announced on March 28, 2016, were adjusted based on lessons learned from Phase I implementation, now requiring the LCAs to hire their allotted positions prior to the implementation date. More time was also allotted 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 III implementation.

West Virginia held an "onboarding" meeting with Phase I Local Coordinating Agencies on September 16, 2015; for Phase II Local Coordinating Agencies on June 7, 2016; and for Phase III Local Coordinating Agencies on March 29, 2017, to assure consistency. They held regular meetings going forward to allow for open discussion and planning regarding processes and outcomes as well for providing peer support and technical assistance among the agencies. Activities of this group included updating the Wraparound plan form, updating the monthly progress summary, developing advanced training specific to the Wraparound facilitation, working with the grants division to update the monthly grant report, and implementing process recommendations stemming from the evaluation.

Leading up to the first *Safe at Home* West Virginia referrals, the State developed a program manual and family guide as well as DHHR/BCF policies, desk guides, and trainings. All staff and providers were afforded Wraparound 101 training, an overview of

the Wraparound process, Family and Youth engagement training that is part of West Virginia's Family Centered Practice Curriculum, and CANS training. DHHR also instituted weekly email blasts to all DHHR staff and external partners which focused on education of the 10 principles of Wraparound, family and youth engagement, and ongoing information regarding *Safe at Home* West Virginia.

LCAs regularly reported on the program at regional summits, meetings, and collaborative efforts across systems. The agencies were required to submit weekly updates to DHHR describing how each youth in the program was progressing. These weekly updates enabled higher-level DHHR staff to provide feedback to both LCAs and county-level workers, help remediate issues and assist with planning. LCAs were an integral part of the planning and development of the program in collaboration with the State.

As noted above, substantial effort was made to educate key stakeholders including the general public on the program. Examples of public and stakeholder outreach included: face-to-face meetings between DHHR staff and judges; weekly email blasts to over 1,000 recipients; quarterly newsletters; press releases; development of a Wraparound expert team; creation of speaking points; a printable flyer; trainings; new policy and policy revision; and, a *Safe at Home* website that was updated regularly. DHHR reduced the intensity of outreach efforts once the program was implemented for more than a year, though all outreach activities continued.

Half of the staff interviewed from Central Office reported that there were minimal changes to their role over the course of the implementation rollout. The other half reported that over time, as the program became fully implemented statewide, their involvement in the planning and development processes for *Safe at Home* diminished. Staff indicated that once policies and practices were fine-tuned during early periods of implementation, like invoicing to provide more explicit information on how youth and families were being served, their involvement decreased. DHHR staff and LCAs also formed more collaborative relationships over time and learned how to communicate more effectively.

During the 2018 interview cycle, Central Office staff indicated that they were beginning to shift from implementation planning to planning for program sustainability as the State began to consider implementation of the Family First Prevention Services Act.

Organization of Waiver Demonstration Initiative

Staff Structure

Safe at Home West Virginia was structured as a collaborative program between DHHR, LCAs, and community partners. DHHR contracted with ten LCAs that were responsible for hiring Wraparound facilitators, a new position created specifically for *Safe at Home*. Wraparound facilitators worked directly with youth and their families to assess their strengths and needs, develop service plans and facilitate access to needed services for both the youth and their caregivers. DHHR caseworkers were also members of Wraparound family teams, monitored LCA performance and provided direct oversight of

the program. Additionally, community partners, including service providers, contributed to meeting the needs of youth. *Safe at Home* staff also made several attempts to meet with judges regularly and offered program information. With judicial buy-in having an influence on the success of *Safe at Home*, some parts of the state were more receptive to the program than others.

LCA staff generally agreed during interviews that their agencies' overarching missions coincided well with that of *Safe at Home*; as a result, agencies did not have to make significant organizational changes to accommodate the program. One change made, however, was the hiring of Wraparound supervisors and facilitators. Wraparound facilitators worked directly with youth and their families, assessed strengths and needs, developed plans to meet those needs, and provided support and guidance. A couple of LCAs also opened additional offices to accommodate the growth in staff.

Funding

As prescribed within the *Safe at Home* funding announcement, LCAs received $70,000 in start-up grants for each Wraparound facilitator and were paid a daily rate of $136 for each youth participating in *Safe at Home*. The daily rate excluded reimbursement for services which were billable to Medicaid, as well as room and board.

Discretionary or "flexible" funds were disbursed by LCAs, according to the *Safe at Home* Program Manual, and were intended for the purchase of a service or commodity needed to meet a specific client need. These funds were only accessed after all other funding sources were explored and exhausted. Flexible funding was always meant to move clients toward the goal of child and family empowerment, helping families and youth to navigate within their communities and enabling Wraparound facilitators to find creative solutions to access services for youth and their families. For instance, one youth with anger management issues was provided a membership to a local boxing club, enabling him to learn how to better channel his behavior appropriately. In other local communities where transportation services were not readily available, LCAs hired staff to provide transportation to youth and their families. And, in another instance, *Safe at Home* helped an older youth successfully move into her own apartment and provided a washer and dryer.

Administrative Oversight

The *Safe at Home* project director worked with LCA staff on an ongoing basis to track cases at a regional level and monitor the amount and quality of referrals received. LCA staff reported that the *Safe at Home* project director held primary responsibility for working directly with DHHR Regional Office staff to address major issues. Wraparound facilitators received guidance, oversight, and support from their supervisors who, in turn, were supervised by program directors. The project director did change in later stages of implementation; however, the new project director who replaced a DHHR retiring staff person had been involved in the project from the start, limiting the need for transfer of knowledge.

DHHR has a well-defined management structure and communication procedure which helped the implementation of *Safe at Home* to be relatively intuitive and straightforward for State staff. Central Office staff did not regularly interact with county level staff beyond sending emails with policy or program updates. Interaction between Regional Office and Central Office staff was largely focused on the weekly tracking logs of *Safe at Home* cases submitted by regional staff. Regional staff received updates about the program through statewide meetings (which were then disseminated to staff within each region's counties). Regional program managers reported that their role in *Safe at Home* was primarily as "the gatekeeper for referrals," where they approved or denied referrals sent by supervisory and/or casework staff from the counties within the regions.[6]

Regional DHHR staff most often interacted with county level staff. They provided guidance, support, and oversight through the supervision of CSMs. Some regional directors indicated that *Safe at Home* was regularly discussed with CSMs in their monthly management meetings and CSMs passed along information to the supervisors and/or caseworkers within their county (or counties). CSMs reported that they provided direct oversight of supervisors and caseworkers and involved Regional Office staff only when problems could not be resolved at the local level. Both Regional Office staff and CSMs agreed that over time, they did not need to be as hands on in their involvement with subordinate staff regarding *Safe at Home*.

The way Central Office staff monitored the work of LCAs did not change throughout the implementation phases. The *Safe at Home* project director, regional directors and regional program managers provided ongoing monitoring and oversight of the LCAs' work. The *Safe at Home* project director provided the most direct oversight, communicating with LCAs on a near-daily basis. Weekly tracking logs were used to examine placement changes and to assure that LCAs had the right support.

Regional Office and county-level staff reported that they had their own processes for holding LCA staff accountable. Examples included monitoring the weekly reports LCAs provided on all *Safe at Home* cases, hosting monthly meetings between themselves and LCAs to staff cases, and providing county staff with additional information whenever requested. A few DHHR staff also reported that judges sometimes held LCA staff accountable by expecting regular updates on the work being conducted and the progress being made on *Safe at Home* cases in their courts.

Additional monitoring was provided by the evaluator, through the fidelity reviews, and the LCAs themselves, which were required to complete their own grant reports. When the State noticed issues with an LCA, it worked directly with the LCA to address concerns. The project director sometimes requested an LCA to submit a Program Improvement Plan (PIP) when corrective action was needed, *e.g.*, such as when required documentation for cases was not being completed on time or not at all. If the issues in the PIP were not resolved in a timely manner, the State reserved the right to terminate the contract with the

[6] Details of the referral process are discussed on pages 20–21.

LCA, although this never occurred. The State also performed additional audits on LCAs whenever necessary.

Problem Resolution

Over the course of the demonstration project, caseworkers and Wraparound facilitators reported that they could speak to their supervisors with ease to receive guidance on their *Safe at Home* cases. Caseworkers and supervisors also reported that they followed the regular chain of command if they were having issues with *Safe at Home* cases and/or partners which they could not resolve independently. Caseworkers started by trying to address issues with their direct supervisors, and then included LCA facilitators and supervisors as necessary. If issues could not be resolved by these parties, then CSMs and LCA program directors became involved. If issues still could not be resolved on a local/county level, then regional program managers and regional directors were engaged. The most severe issues were addressed in conjunction with the *Safe at Home* project director, and all LCA program directors reported that they reached out to the *Safe at Home* project director whenever issues arose. Most interviewees reported that issues were resolved completely and in a timely manner. One caseworker reported that his/her county office had designated a staff person as an informal "*Safe at Home* expert" whom all staff used as a resource for questions.

Implementation Staffing and Duration

Implementation was rolled out in three phases, and youth were chosen from specific West Virginia counties, depending on the project phase.

Table 2. *Safe at Home* West Virginia Phased Rollout

Phase	Counties		Total
I	Region 2:	Boone, Cabell, Kanawha, Lincoln, Logan, Mason, Putnam, Wayne	11
	Region 3:	Berkeley, Jefferson, Morgan	
II	Region 1:	Brooke, Hancock, Harrison, Marion, Monongalia, Ohio	24
	Region 3:	Barbour, Grant, Hampshire, Hardy, Lewis, Mineral, Pendleton, Preston, Randolph, Taylor, Tucker, Upshur	
	Region 4:	Greenbrier, Mercer, Monroe, Nicholas, Pocahontas, Summers	
III	Region 1:	Calhoun, Doddridge, Gilmer, Marshall, Pleasants, Ritchie, Tyler, Wetzel, Wirt, Wood	20
	Region 2:	Jackson, Mingo, Roane	
	Region 4:	Braxton, Clay, Fayette, McDowell, Raleigh, Webster, Wyoming	
		Total Counties in State	**55**

West Virginia officially launched Phase I on October 1, 2015, in 11 counties: Berkeley, Boone, Cabell, Jefferson, Kanawha, Lincoln, Logan, Mason, Morgan, Putnam, and Wayne. Initially, 21 youth were referred for Wraparound Facilitation. West Virginia also began the process of universalizing the CANS across child serving systems at the same time.

Contracted agencies in the Phase I counties were required to have one-third of their Wraparound facilitators hired, trained, and ready to accept referrals by October 1. Six of the thirteen LCA staff interviewed reported there was not enough time between the receipt of their contracts in September and the October 1, 2015 roll-out to hire and train needed Wraparound facilitators. One Central Office staff person reported in later periods that a key difference in the Phase II and III implementations of *Safe at Home* was that the preparation period was less rushed for staff than it was in Phase I, using the lessons learned in the first phase to better role out implementation in later phases.

On August 1, 2016, West Virginia began Phase II of implementation by expanding *Safe at Home* to another 24 counties: 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 BCF region into the demonstration project.

On April 1, 2017, West Virginia began Phase III of implementation by expanding to the remaining 20 counties: Braxton, Clay, Jackson, Roane, Ritchie, Doddridge, Pleasants, Wood, Marshall, Tyler, Wetzel, Calhoun, Gilmer, Wirt, Fayette, Raleigh, McDowell, Wyoming, Mingo, and Webster.

By the end of the demonstration period, 3,086 youth had enrolled in *Safe at Home* West Virginia. West Virginia returned 89 youth from out-of-state residential placement back to West Virginia, 238 youth stepped down from in-state residential placement to their communities, and 45 youth returned home from an emergency shelter placement. West Virginia was able to prevent the residential placement of 1,491 at-risk youth.

As of September 30, 2019, there were 242 Wraparound facilitators and 63 administrators/supervisors from ten LCAs. Each of the LCAs, according to CANS data, had from one to nine administrators/supervisors and from three to 55 facilitators on staff at that time.

Service Delivery System

The *Safe at Home* West Virginia program manual describes the Wraparound process from beginning to end, with specific goals defined for each phase of Wraparound. Table 3 displays the four phases of Wraparound, along with the corresponding goals for each phase. This section outlines the referral process, cross-system communication, eligibility requirements, and staff training for DHHR and LCA staff.

Specific tasks related to each phase are discussed later in this report in terms of model fidelity. Generally, LCAs demonstrated adherence to documentation and fidelity requirements, but there were a few areas where facilitators struggled to document activities thoroughly, as identified via the case record reviews. It is clear, however, that

concerted effort was made to incorporate youth and family voice and choice throughout the planning process.

Table 3. Wraparound Phases and Service Provider Goals

Phase	Corresponding Goals
Engagement and Team Preparation	• Orient to the Wraparound process • Explore strengths, needs, culture and vision • Stabilize crises • Engage additional team members • Arrange meeting logistics
Initial Plan Development	• Develop an initial Wraparound plan • Develop crisis/safety plan
Implementation	• Implement the initial Wraparound plan • Revisit and update the initial plan • Maintain team cohesiveness and trust
Transition	• Plan for cessation of formal Wraparound • Create a "commencement" • Follow up with the family

According to stakeholders, Wraparound services differed from traditional services in a few ways. First, youth and their families were integral participants in forming the plan for services, which was carefully monitored and changed when necessary. In fact, a youth was not eligible to participate in the program if he or she and/or his/her caregiver(s) was not willing to participate in case planning. Facilitators also had much more frequent contact with families, with youth to be visited weekly until they were ready for the Transition phase. The increased contact and involvement in case planning provided the facilitators with a greater understanding of youth and family wants and needs.

Second, facilitators were able to tailor Wraparound services to meet a wide variety of individual and family needs beyond those normally provided. Traditional case management refers youth and their caregivers to a core set of services available within their communities, depending on their identified needs. Wraparound facilitators, on the other hand, worked intimately with families to weave together formal and informal services. The Wraparound team was encouraged to think creatively to link youth and their families to non-traditional services.

Lastly, a goal of Wraparound was to transition youth from reliance on formal supports to natural supports; facilitators helped families through a strategic transition phase to plan for sustainability after formal supports were no longer a part of their lives. All interviewees agreed that when the Wraparound approach was implemented well and families were able to identify informal, natural supports, it had much better success than traditional case management and service delivery for youth and families. However, the one caveat was that implementation did not always go as planned. There were numerous times where

youth and families were unable to identify any informal supports or were unwilling to let others be a part of their team. This undoubtably inhibited long-term outcomes after discharge from the program.

Eligibility Requirements

Initially, eligibility to participate in *Safe at Home* was limited to youth ages 12 to 17 with a behavioral or mental health diagnosis placed (or at risk of being placed) in congregate care. In practice, however, some youth who were referred and participated in the program did not have a diagnosis or were in their own homes or a lower level of placement at the time of referral. When the program manual was updated in July 2017, the eligibility requirements for *Safe at Home* were modified to include youth at risk of placement with a *possible* behavioral or mental health diagnosis, and additional training was provided to DHHR staff to help them identify more at-risk youth for referral. This brought the program manual in line with what was happening on the ground and changed the use of the program to be more preventive in nature.

Referral Process

As displayed in Figure 3, the *Safe at Home* referral process involves multiple steps, a few of which evolved over time. Caseworkers begin by identifying youth who will meet the policy criteria to be eligible for the program. Once a youth has been identified, the caseworker explains the program to the youth and his/her family and obtains their consent to participate, as the program is intended to be voluntary and involve the family as a team. Sometimes caseworkers present the idea of a referral to the Multi-Disciplinary Team (MDT), the court/judge or other involved stakeholders to see if all invested parties are on board.

Figure 3. Referral Process

Once the caseworker identifies an eligible case, it is passed to the supervisor for review, then to the region's program manager who either approves or denies the referral. Initially, if the referral was approved, the program manager sent it to a system of care worker who assigned the case to an LCA (assignment based on a rotation). Then, the system of care worker emailed the assignment back to the program manager, who notified the assigned community provider. This process was streamlined in 2018 to allow regional program managers to assign LCA providers without having to go through the system of care worker. Finally, the LCA assigns the case to a Wraparound facilitator. For this demonstration project, Wraparound facilitators were permitted to have no more than ten *Safe at Home* cases at one time.

Regional Office staff and community providers reported that there was confusion at the beginning of implementation with direct service staff making some inappropriate referrals. Early in the program, facilitators reported receiving cases wherein youth and families had already exhausted all other options and DHHR, expecting the youth not to succeed, seemed to be using *Safe at Home* to prove a need for congregate care. As the intent of *Safe at Home* was to intervene early in a case, additional training for DHHR staff was needed to better prepare them to select youth who were appropriate for referral. Improvement was made by clarifying the target population and referral process with caseworkers and supervisors and by tightening the referral review process with regional program managers. Once everyone was fully trained, caseworkers reported that the referral process took about two weeks.

Cross-System Collaboration and Communication

Many stakeholders believed that the program's success was reliant upon strong cross-system partnerships (*i.e.*, county DHHR staff, Wraparound facilitators, the courts, and other partners when appropriate, including schools and probation officers) to work as a team. Routine communication among and between DHHR and the LCAs, for example, was critical in assuring that all relevant parties had current information of both processes and individual cases. This meant that facilitators would often attend MDT meetings to update and receive updates from caseworkers regularly on case progress. In addition, Central Office management and LCA program managers would provide information about program updates to their respective staff.

Most DHHR supervisors and caseworkers expressed that they were well prepared to work with LCA staff, many due to their prior involvement with the LCAs. Some facilitators also reported previous experience as caseworkers. A few DHHR caseworkers and supervisors reported that working with the LCAs was a "learn as you go" experience as there are no other programs like it in West Virginia.

LCA staff reported that some caseworkers were great to work with, but others were very hard to contact, did not provide necessary information, or did not express an interest in the service they were providing. In these latter instances, there appeared to be a level of dysfunction and confusion about what *Safe at Home* could and could not provide.

Most staff reported variations in communication between DHHR caseworkers and Wraparound facilitators, where the level was dependent on the needs of each case. In some cases, Wraparound facilitators and caseworkers reported daily contact, in others, a couple of times a week; some reported weekly contact. Regular collaborative and regional summit meetings also offered opportunities for community partners to come together and share ideas on how to meet client needs and address the current service gaps throughout the State. In early 2018, LCA directors and program managers moved from quarterly to monthly meetings to prepare for sustainability and the transition to Family First.

Staff Training

Training was a collaborative effort between DHHR and the LCAs. Approximately half of the DHHR caseworkers/supervisors and most LCA Wraparound facilitators/supervisors report that training sufficiently prepared them for their work with the program. LCA staff were more likely to report satisfaction with the training than were DHHR staff. Of the staff who were dissatisfied, some found the training to be too basic, lacking details of how the program was supposed to work. This sentiment was echoed by a few respondents in the Phase II DHHR staff survey, wherein staff from Phase I reported that the follow-up training they received was beneficial in clarifying their initial confusion, especially since the program's guidance was also made more specific to address the ambiguities between DHHR and LCA responsibilities.

DHHR staff training needs were identified by Central Office staff in a couple of ways, one of which was through feedback received from county-level staff. A survey was administered to all staff following their participation in *Safe at Home* trainings, where they were asked to share their opinion as to what they did not understand or would have liked to have learned more about. For example, staff who participated in the training just prior to implementing Phase I reported confusion about the role between caseworkers and Wraparound facilitators; a half day of training was added to the curriculum to address this specific topic. Another way training enhancements were identified, for both DHHR and LCAs, was by looking at the quality of work being conducted with *Safe at Home* clients through the State's tracking logs and recognizing problems in how *Safe at Home* was being implemented.

While DHHR staff were required to complete Wraparound 101 and CANS training for *Safe at Home*, LCA staff had a much more in-depth and intense level of training. The Applied Wraparound training for LCA staff was adjusted to add more advanced material. Training for LCA staff included the following:

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

In addition to the required training, LCA staff reported during the annual interviews with the evaluator that they also identified individual training needs within their agency and often added more formal and informal trainings, like discussions at team meetings, for

their staff. The amount and type of additional trainings added by LCAs varied by each agency according to their staff needs.

Responses to the evaluation survey administered to LCA staff were largely positive when focused on training. Almost all LCA staff surveyed reported receiving training (97%). Of those who participated in training, close to two-thirds (62%) reported that the training they received prepared them "very well" for their role in the program. On average, the staff who have been with their agency for less time rated the Wraparound training slightly better than staff who have worked with their agency for a longer time (in terms of the degree to which the training prepared them for their role in the program). The difference was slight, however, and not statistically significant. Less than one percent of responding LCA staff felt the training had not prepared them well to engage in the *Safe at Home* initiative.

Interview data were also consistent with survey data regarding DHHR staff's satisfaction with *Safe at Home* training. Of the DHHR staff responding to the third and final survey, 71 percent reported receiving some sort of *Safe at Home* training. While the percentage of staff who said they had received training was lower in 2019 than the previous two years, the vast majority of staff who were trained (97%) reported that the training for *Safe at Home* prepared them very or somewhat well for their role in the program. Though not statistically significant, a larger percentage of the staff who have been with the agency longer reported participating in the *Safe at Home* training when compared to the staff who had worked less time.

Role of the Courts

Courts played an integral role in the success of the program. Providers and DHHR staff agreed that judges hold a powerful position in deciding placement for youth, and many stakeholders reported that judges were, at times, too punitive and used placement as a form of punishment. However, over half of the judges interviewed at baseline wanted the program to provide them with more options beyond out-of-community, residential placement. Judges reported looking to the program for community-based alternatives to keep youth in the home.

Most stakeholders reported that judges were active proponents of the program, but a few judges were highly resistant. One Regional Office staff member stated, "Judges are a tremendously important piece of the pie; they make all the final decisions. Their buy-in is hit and miss; there are judges who will ride the fence until we've sold them on the program, others that look for any opportunity to get the kids to stay in the community, and a few that get stuck on the extreme punitive actions and don't even look at our paperwork because they already think they know what's best for them."

Some stakeholders reported that judges have court-ordered youth into *Safe at Home*, and while this has been done with good intentions, it posed a concern since the program is supposed to be voluntary and based on youth and family voice and choice. Despite attempts to educate judges accordingly, reports of the program being court-ordered continued to be heard throughout interviews conducted into 2019.

One Central Office staff member stated, "I think *Safe at Home* is hard to grasp when you have been telling folks what needs to happen, and now we are shifting to asking folks what needs to happen." Caseworkers reported improved relationships with judiciary as the program's strengths and limitations became better understood.

DHHR and LCA staff further elaborated on the specific role of judges, stating that judges helped to make *Safe at Home* cases successful when they held LCA and DHHR staff accountable for their work and cooperation and follow through on the part of youth and families.

Judges involved with *Safe at Home,* along with LCA and DHHR staff, reported that they valued and often followed provider recommendations. In fact, judges who had direct experience with *Safe at Home* cases in their court reported that they almost always were on board with youth/families trying *Safe at Home* whenever it was recommended. Many Regional Office staff and CSMs reported that judges were helpful when they took on a more active role with *Safe at Home* cases. One CSM shared, "[The judge] helps. [S/he] explains the program well to families and makes sure they understand it. [S/he] monitors the cases closely and is supportive of us and families."

Impact of Contextual Factors

No child welfare system acts in a vacuum, and stakeholders reported several social, political, and economic factors which influenced the program over the course of the demonstration project, including poverty, rurality, workforce recruitment, lack of resources, the opioid epidemic, a high number of kids in out-of-home placement, and other state-supported initiatives.

When *Safe at Home* began in 2015, Wraparound was not new to West Virginia. The State piloted a program called *Next Step Community Based Treatment* (CBT) through a grant in the late 1990s. The program experienced success in Region II but was unsuccessful in its expansion throughout the State. Some stakeholders viewed this prior program as a strength, demonstrating that Wraparound could indeed be successful. However, a couple of stakeholders feared that *Safe at Home* would run into the same issues that led to the demise of CBT.

One of the largest social forces affecting child welfare over the past decade has been the rise of the drug epidemic. According to data from the Centers for Disease Control and Prevention, West Virginia has had the highest rate of death from drug overdoses in the country for several years.[7] Based on preliminary 2018 data, the four counties with the greatest number of overdose death occurrences are Berkeley, Cabell, Kanawha and Raleigh.[8]

[7] http://www.cdc.gov/drugoverdose/data/statedeaths.html
[8] https://governor.wv.gov/News/press-releases/2019/Pages/Gov.-Justice-DHHR-data-suggests-West-Virginia-overdose-deaths-appear-to-be-declining.aspx

Since 2013, when the number of kids in care in West Virginia came to national attention,[9] stakeholders report a resulting change in the general philosophy around addiction. One stakeholder stated, “Our residential facilities are full because of our drug epidemic; our foster homes are full because of it too, but it's a different age group (younger kids) that is more impacted. I think people are starting to realize that with the drug crisis and young vulnerable kids needing placement, we literally cannot take teenagers out of their homes for not going to school.” This inherent change in the residential population has pushed caseworkers to find and maximize the use of alternative programming to try to keep youth with less severe problems, like truancy, safely in their homes.

Several stakeholders also cited the rural culture of West Virginia as a program barrier. *Safe at Home* workers noted that in a culture where receiving help is viewed as a weakness, acceptance of services, even if they are at no cost to the family, can be a hard sell. One stakeholder summarized this by saying, “People keep to themselves, they keep private. It's hard to get the families to open up to the Wraparound approach while respecting that culture.”

Stakeholders further shared concern about the State’s ability to meet the service needs of youth, particularly for teenagers with mental health needs, youth with special needs, and those living in more rural areas. Initially, several juvenile justice probation officers and staff agreed with the goals and concepts of *Safe at Home* but also thought that these goals were unrealistic, citing a lack of community-based service options. Further, stakeholders noted that the State is very poor, which limits their ability, especially in rural communities, to attract and retain needed service providers. The top five services that interviewees reported as lacking were: mentoring, psychological/psychiatric services targeting youth, substance abuse services targeting youth, transportation for youth/families and activities for youth/teenagers such as recreational centers, and after school program options. A few facilitators reported driving over an hour to support youth and their families who live in remote areas.

Central Office staff acknowledged this challenge and stated that the goal was to expand the services already offered by providers and to develop services where needed. To some degree, this was accomplished. Many stakeholders noted that it took a lot of time, effort and money to develop needed services. However, one provider was able to expand service offerings to include a professional family support position to assist clients with various needs, like mentorship, social skill building, community engagement, tutoring and other activities not traditionally available. Other providers pushed facilitators to be creative in developing natural or community supports where paid services were unavailable.

Some LCA providers also stated that poverty created workforce issues, making it a challenge to attract qualified applicants for the Wraparound facilitator position. This led to some inconsistency in the quality of providers, which appeared to be especially true of the recruitment of workers in more rural areas.

[9] *Ibid,* p.3.

The lack of informal, natural support engagement was also problematic. The last phase of the *Safe at Home* program was designed to have facilitators help youth and families identify natural supports who could step in when formal services ended. However, many youth and families had difficulty or simply refused to identify anyone to fill this role. One caseworker said, "Informal supports [outside the family itself] appear to be nonexistent within the area. It appears that the plans thus consist of only the family members who live in the home and formal supports." Interviewees suggested that sometimes families legitimately didn't know or have anyone to fill this role. Other times, the youth or family chose not to involve others as a matter of privacy.

During the demonstration period, West Virginia also ran other demonstrations and projects affecting a comparable target audience to *Safe at Home*. For example, the Home Visitation project funded by the Affordable Care Act selected eight high-risk counties to expand and strengthen home visiting services. Although *Safe at Home* selected a different demographic, *i.e.,* older children, while the home visiting program targets younger children, there may have been an impact from the expansion of community resources, such as an increase in trauma-informed and Wraparound services, to meet the needs of families in both groups. Five of the eight counties initially targeted by *Safe at Home* were also served in the home visiting expansion: Boone, Cabell, Lincoln, Mason and Wayne.

The West Virginia Court Improvement Program (CIP) is another simultaneous run program which may have affected *Safe at Home's* success. Authorized in 1993 under the Omnibus Budget Reconciliation Act, federal funding has been disseminated since 1995 when the West Virginia Supreme Court of Appeals initiated the Court Improvement Program and formed the CIP Oversight Board. The mission of the West Virginia CIP is to create, identify, and promote initiatives that make the Court system more responsible and efficient in achieving safety, permanence, well-being, due process, and timely outcomes for children and families in the State's child welfare system. BCF is an active member of the CIP workgroups, some of which focus on activities parallel to those of *Safe at Home* West Virginia, including Multi-Disciplinary Treatment Teams, Youth Service Interventions, Cross Training, and Data Collection and Management.

Implementation to Fidelity

PCG used an "action research model"[10] to promote program improvement as the project progressed. PCG fed information back to key decision makers in the State at critical junctures and explored with them the implications for adhering to program design and improved implementation. The case reviews of a sample of cases in each LCA, which were conducted annually, provided a basis for comparing results at different points in time, with results indicating whether improvements occurred during the project implementation, as well as which LCAs were struggling to complete required activities on time.

[10] Miles, M.B. and Huberman, A.M. (1994). Qualitative data analysis: an expanded sourcebook. Thousand Oaks, CA: Sage.

According to the staff survey, most Wraparound facilitators met the State's requirements to have a bachelor's degree in social work, sociology, psychology or another human service-related field; 83 percent held a bachelor's degree, while the remaining 17 percent held a master's degree. More than three quarters (79%) stated they had a degree in one of the fields specified as topic relevant. Wraparound facilitators were also required to have at least two years of work experience serving a youth population similar to that of *Safe at Home*'s (*i.e.*, ages 12 to 17 with a possible mental health diagnosis at risk of congregate care entry). Of those surveyed, 86 percent had the minimum two years required experience while 68 percent reported they had a general knowledge of mental illness diagnoses and behavioral disorders in children and more than half (55%) had personal family experience with mental illness, which was considered helpful.

The percentage of Wraparound facilitators with at least two years of experience in the field increased from 60 percent at the time of the first staff survey to 91 percent at the time of the second survey; the percentage reduced slightly to 86 percent in the final survey. The State could make exceptions to one or more of the requirements for the Wraparound facilitators if the applicant had extensive knowledge and/or experience in the field; most facilitators had substantial experience.

The remainder of this section discusses fidelity to the Wraparound model by the phases previously summarized in the "Program Model" section using the data collected from the case record reviews, surveys, and interviews with caseworkers, Wraparound facilitators, youth and their parents.

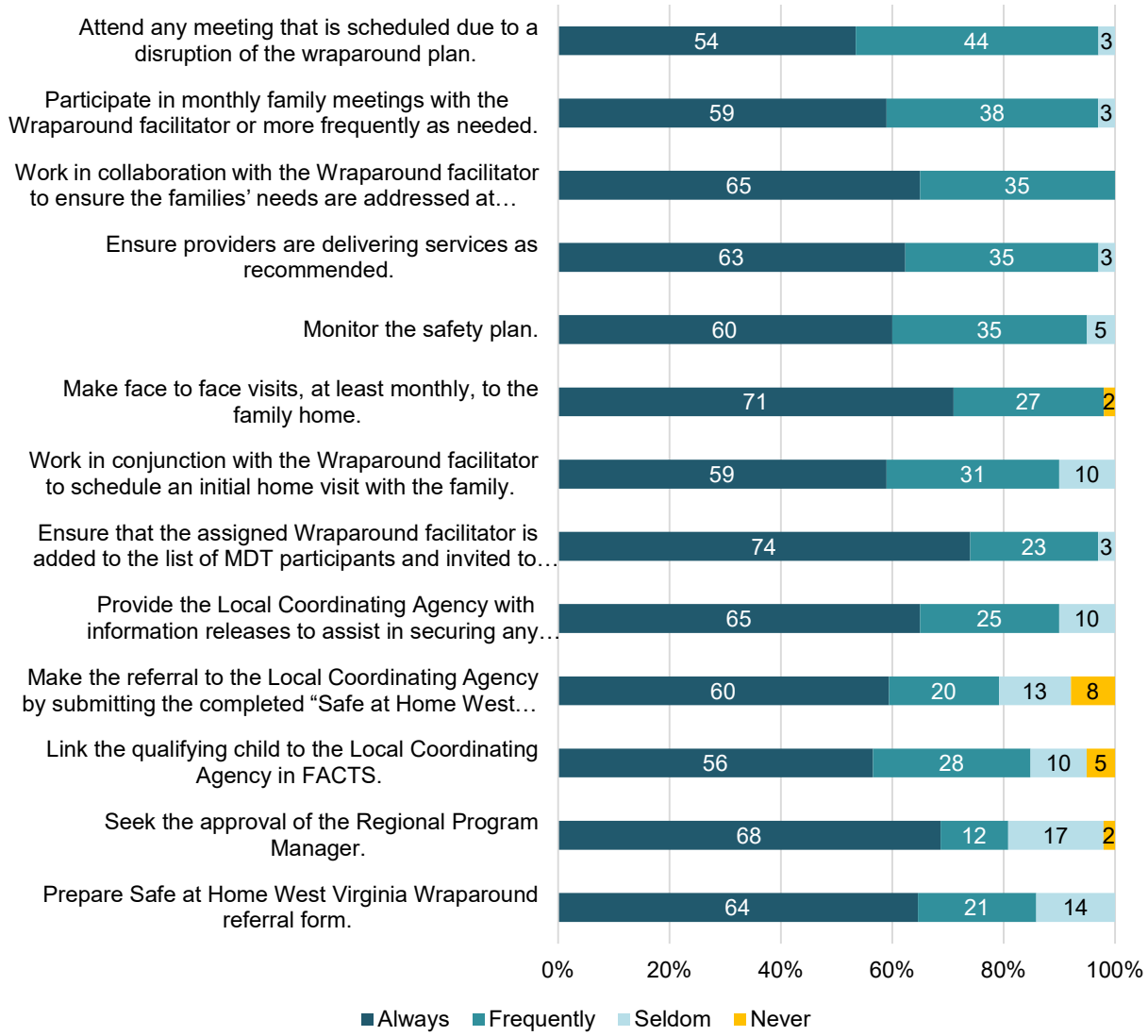
Phase I: Engagement and Team Preparation

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

When asked on the survey how frequently DHHR caseworkers and supervisors adhere to *Safe at Home* policy requirements, most reported they always or frequently complete such tasks. For instance, Figures 4, 5 and 6 show that 80 percent of DHHR staff participating in the staff surveys reported that program tasks "always" or "frequently" are completed. This was true across all years and for all tasks, with the exception of one task in the third year which only 79 percent of staff reported that they provided the LCAs with appropriate release forms either always or frequently.

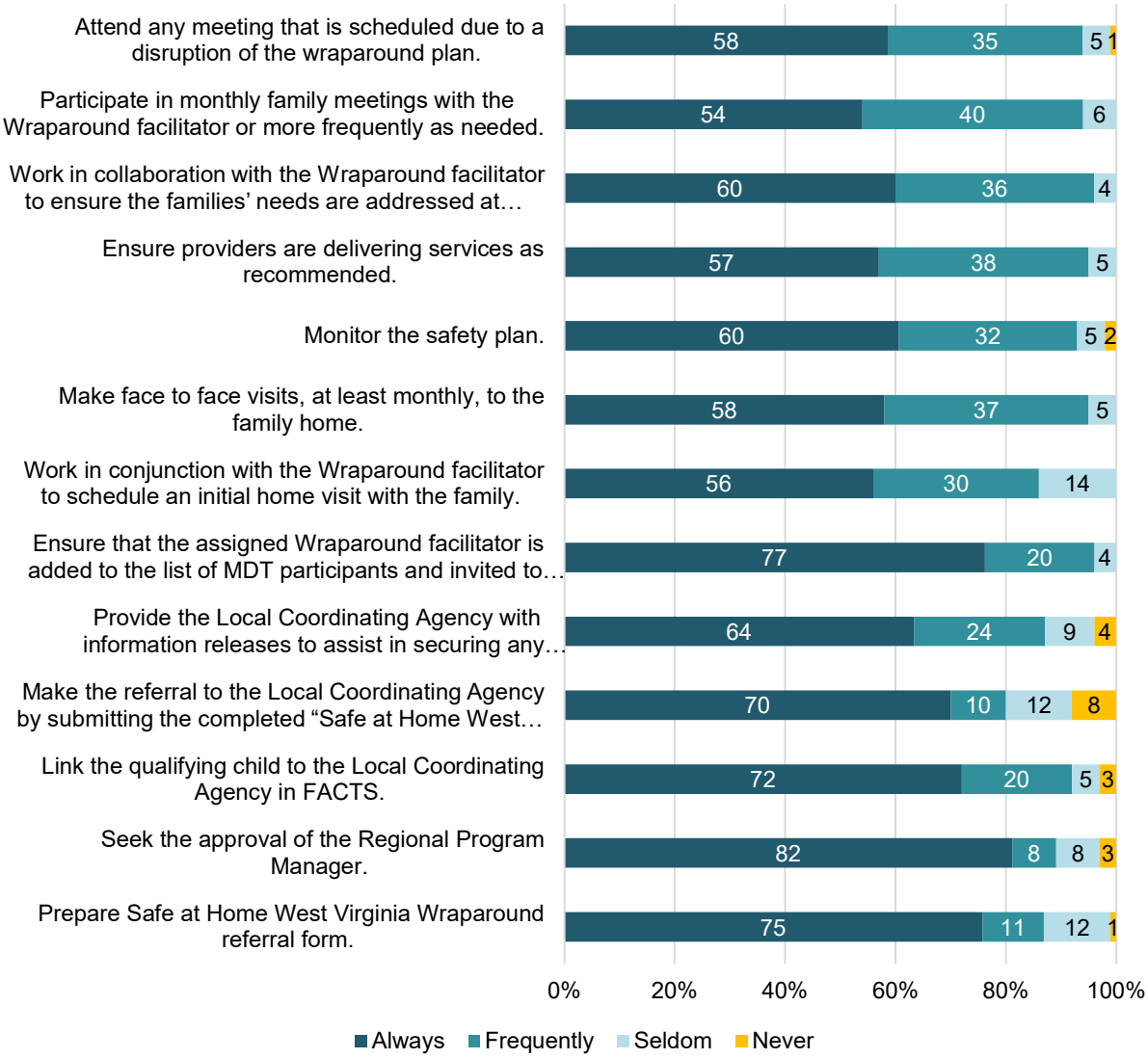
When the frequency in completing the activities is more closely examined, there was a higher rate of compliance in completing case management activities, *e.g.,* monitoring safety plans or having monthly visits in the home, as compared to *Safe at Home* processing activities, *e.g.,* linking child to the LCA in FACTS.

Figure 4. DHHR Staff Frequency of Fidelity Item Performance: Year One



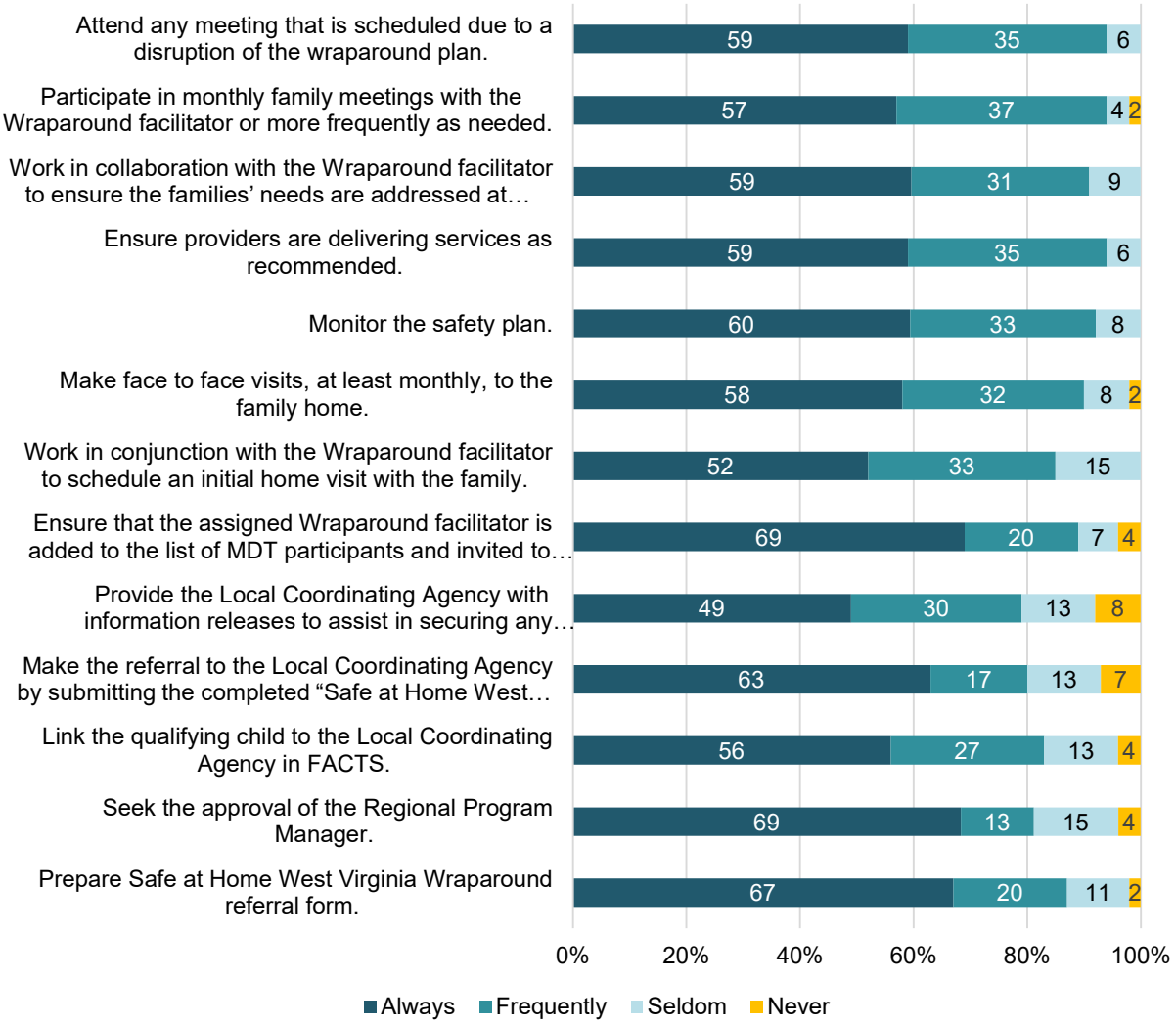
Percentages may not total 100 percent due to rounding.

Figure 5. DHHR Staff Frequency of Fidelity Item Performance: Year Two



Percentages may not total 100 percent due to rounding.

Figure 6. DHHR Staff Frequency of Fidelity Item Performance: Year Three



Percentages may not total 100 percent due to rounding.

LCA staff also reported always or frequently completing *Safe at Home* tasks, although a few agencies fell short of completing the initial CANS assessments and Wraparound and/or crisis safety plans within required timeframes, as observed from the case record reviews. Overall, LCAs did well in conforming to Phase 1 requirements of the Wraparound model.

Interviewees reported that in most cases, youth and families initially learned about *Safe at Home* through their DHHR caseworkers and others through the court. Typically, caseworkers or probation officers provided a brief overview of the program to families and explained how it could help to meet their needs. Following this introduction, Wraparound facilitators provided a more in-depth explanation of what *Safe at Home* entailed.

All youth and families interviewed in 2019 reported that Wraparound facilitators encouraged them to share their strengths, goals, and concerns in the very early stages of the case. Wraparound facilitators consistently reported that in many cases, it took time to build a rapport and get youth and families to fully engage and feel comfortable enough to share their concerns and goals. Several facilitators stated that they tried to find points of common interest, like television shows, to bond with youth, made jokes, and worked to demonstrate dedication, respect and consistency to the youth and family by showing up to appointments on time, doing what they said they would do, and trying to find ways to go beyond a family's expectations to build those relationships.

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

Phase II: Initial Plan Development

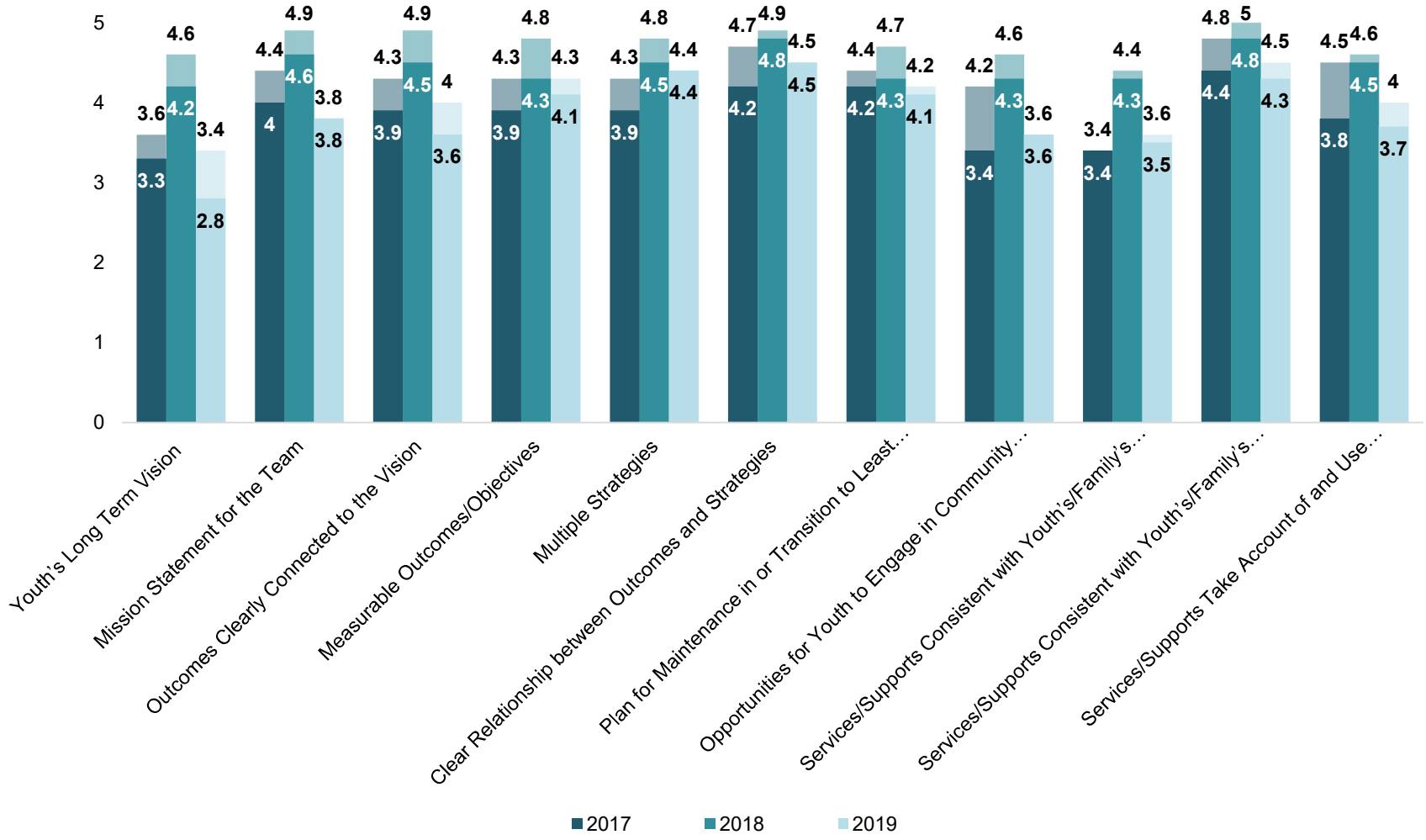
The purpose of the Initial Plan Development phase is to conduct the initial CANS assessment and create the initial Wraparound and crisis safety plans through a collaborative team process. This section of the report discusses who participated in the planning process, what resources were used, and how quickly it happened.

As part of the fidelity case reviews, PCG reviewed the initial and most recent Wraparound plans and rated the content for the extent to which required items were included. Reviewers used a five-point Likert scale to document their findings, with one meaning the item was "not at all" a part of the plan and five meaning the item was "thoroughly" included. Figure 7 displays the change from year-to-year from initial to most recent Wraparound plan documentation fidelity requirements.

Clearly, youth and families played an active, integral role in safety and service planning. Feedback was elicited and incorporated wherever possible. Outcomes, measures, strategies, and plans for maintenance in the least restrictive residential environment were well documented. Scores for all components generally improved from initial to most recent plans. While facilitators struggled the most initially to identify the youth's long-term vision and mission. It should be noted that PCG reviewers found it difficult to identify data on cultural needs of families. Unless culture was specifically identified as part of a service or within the case record itself, attempts to quantify compliance with this measure were limited at best.

Interestingly, average scores of completing items as prescribed by the model were higher in 2018 than in 2017 or 2019. This is likely due to the type of the case records sampled in 2018, when a concerted effort was to select more successfully completed cases than active or discharged without completion as selected in 2019.

Figure 7. Initial and Most Recent Wraparound Plan Fidelity Scores*



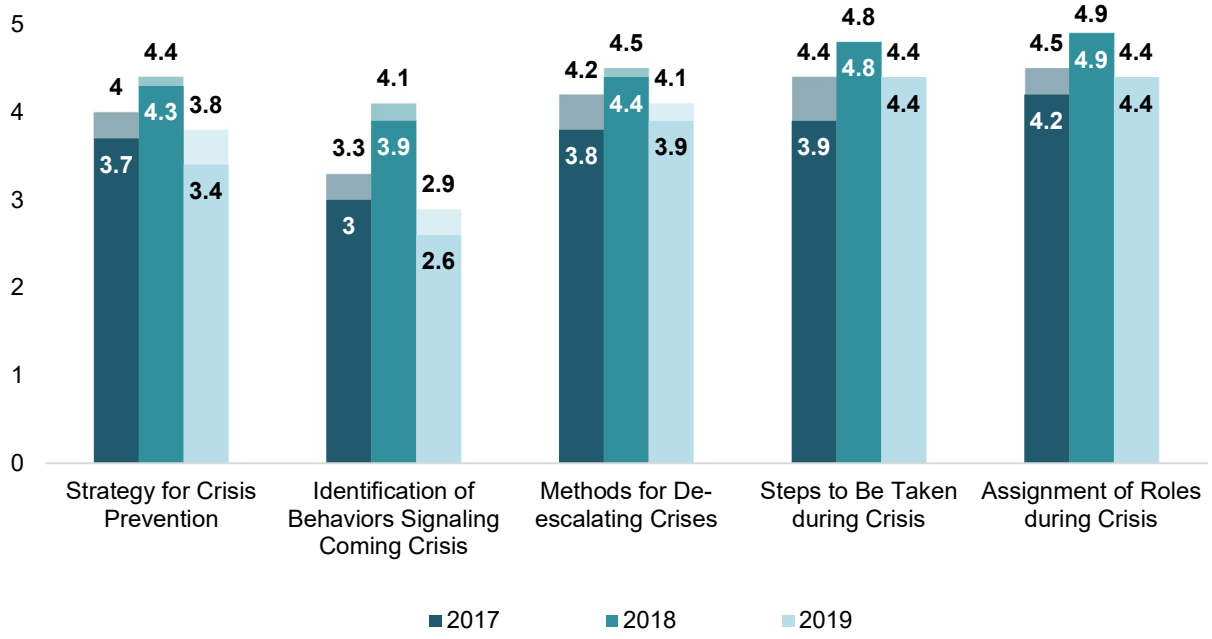
*** Bold columns represent initial Wraparound plan scores for each year, whereas lighter colors represent the most recent scores for the same year. Scores either increased or remained the same in all areas between initial and most recent plans.**

Interviewees reported that facilitators generally took the lead in plan development, while caseworkers reported taking a more supportive role. Caseworkers reported using their legal authority to sign off on service referrals and to follow up with providers to assure that plans were being implemented. They were also able to provide background information to facilitators regarding youth and families and assure that court requirements were being met.

Almost all caseworkers surveyed (97%) who carried *Safe at Home* cases agreed that planning was customized to the strengths and needs of youth. While specific goals varied, the most common included improvement in grades, school attendance, behavior, social skills, family relationships, and completion of high school. Most youth and their parents reported they made progress in achieving their goals through their involvement with the program. One youth stated, “I think I've achieved most everything. I'm at the best place I've ever been at in my life.”

Similar to the review of the Wraparound plans, PCG reviewed the initial and most recent crisis safety plans to assess their thoroughness, again using a five-point Likert scale to assess their completeness. Figure 8 displays the trend in average scores across evaluation years from the initial to the most recent crisis safety plan.

Figure 8. Initial and Most Recent Crisis Safety Plan Fidelity Scores



Again, facilitators generally did well in developing comprehensive safety plans. Nearly every component observed an increase in the average fidelity score from the initial to the most recent. Facilitators struggled most with the identification of behaviors signaling a coming crisis, but this also improved over time. As LCAs learned more about the youth and their families and built a rapport with team members, they were better able to help

youth and caregivers understand what is needed to remediate the behaviors which prompted a referral to *Safe at Home*.

While youth and families were clear about the development and purpose of the Wraparound plan, development of the crisis safety plan was different. Nearly all parents/caregivers remembered having a conversation about a crisis plan, but youth and families were hard pressed to recall details of the plan. Few families reported ever having to use their crisis plan, but most families stated that team members generally knew who to call if things ever got out of hand. Facilitators reported that youth and families were always involved in crisis safety plan development and refinement.

Each component of assessing, referring and monitoring service need and delivery, *i.e.,* CANS, Wraparound plan and crisis safety plan, had specific documentation timeline requirements. CANS assessments were to be completed for all youth within 30 days of referral to *Safe at Home* and every 90 days thereafter. A policy change, which went into effect in June 2017, moved the 14-day initial assessment deadline out to 30 days, with subsequent CANS still to be completed every 90 days thereafter. Initial Wraparound plans were to be completed by Wraparound facilitators within 30 days of program referral and updated as necessary. Initial crisis safety plans were to be completed within 14 days of *Safe at Home* referral with subsequent safety plans updated and refined as necessary.

At three points throughout the demonstration project, PCG collected case review information to track fidelity in terms of CANS assessment, Wraparound plan, and crisis safety plan timeframe compliance. The following table illustrates the average number of days it took Wraparound facilitators to complete the required initial and follow-up assessments and plans.

Table 4. Average Number of Days for Required Initial and Follow Up Assessments and Plans

Requirement	Summer 2017	Summer 2018	Summer 2019
CANS			
Initial (within 30 days of referral)	36	35	43
Follow-up (every 90 days after initial)	90	89	93
Wraparound Plan			
Initial (within 30 days of referral)	45	29	55
Follow-up (as needed)	50	42	41
Crisis Safety Plan			
Initial (within 30 days of referral)	39	22	50
Follow-up (as needed)	53	52	106

It was expected that as the program matured, LCAs and facilitators would become more familiar and comfortable with program implementation and fidelity to completing required assessments and plans on time would improve. However, the data does not necessarily find this to be the case. There was improvement with timeframe compliance between 2017 and 2018 in all areas but timeframe compliance declined between 2018 and 2019. For example, the time to complete the initial CANS assessment went from an average of 36 days in 2017 to an average of 43 days in 2019, after showing improvement (average of 35 days) in 2018. This decrease in the second year, followed by an increase in the third year is true of every required timeframe, except for the follow-up Wraparound plan.

This discrepancy between what was expected and actual average timeframes may be attributable to a few different factors. First, the type of cases selected for review in 2018 and 2019 were different than those selected in 2017. As previously discussed, during the program fidelity review in 2017, forty cases were chosen at random for review. However, this methodology changed for the latter two years. In 2018, thirty cases were randomly selected, and each of the ten LCAs chose one additional case that closed successfully. In 2019, thirty cases were randomly selected, and each LCA was asked to choose one case that closed unsuccessfully.

It could be argued that what made some cases more successful than others was, in part, a family's engagement with services, which could drastically influence the ability of facilitators to adhere to and meet documentation timeframes. In other words, it would be much easier for facilitators to complete assessments and plans if youth and families were cooperative in scheduling and meeting. Therefore, the fact that a quarter of cases selected in 2018 were intentionally chosen to highlight successful youth, could mean that the families were characteristically more compliant and cooperative which aided facilitators in meeting their deadlines. By contrast, it could be argued that the unsuccessful cases chosen in 2019 were more non-compliant or harder to work with and may have depressed average timeframes.

Phase III: Implementation

The third phase of Wraparound, Plan Implementation, focuses on action. Wraparound facilitators were required to have weekly contact with youth and families. Ideally, they will reduce contact as progress is made and youth move toward the final phase, Transition. This frequency and intensity of involvement offered opportunities to revisit and update plans whenever necessary; to assure that the youth, family, and team members remained engaged; to continually monitor progress; to address challenges as they arose; and to celebrate successes. During the fidelity interviews with youth and their caregivers, several reported having frequent contact via phone or text in between weekly meetings. Most youth and families stated that this level of contact was adequate to meet their needs. In fact, there were a couple of instances wherein facilitators had attempted to decrease the frequency of visits and families specifically requested that they not.

To meet the various needs of youth and families, stakeholders reported that a combination of formal and informal services were tailored to meet the needs of youth and their caregivers. The ten most commonly received services included:

1. individual therapy
2. tutoring
3. school advocacy
4. family therapy
5. life skills training
6. youth coaching
7. medication management
8. community outings
9. mentoring
10. parenting classes

Caseworkers, youth, and parents reported that in most cases, Wraparound facilitators were diligent and, for the most part, successful in getting youth to make decisions in ongoing planning activities. In the few cases where youth were not active in service planning, caseworkers reported that facilitators made substantial efforts to engage the youth, but engagement was sometimes a challenge, due to lack of motivation or interest from the youth or his or her mental health issues.

Wraparound facilitators were also responsible for helping youth and families to identify and celebrate milestones and successes. Interviewed youth often reported that facilitators would take them out to dinner, buy them a video game, or take them to get their hair or nails done as a reward for meeting a goal or doing well.

Phase IV: Transition

The purposes of the Transition phase were to plan for the end of Wraparound services when the team's goals and objectives were met, to conduct a commencement or some type of ritual to celebrate success, and to formally discuss where the family could go for help in the future.

While ten cases from the first fidelity review sample had already closed, they had closed before the case moved to the Transition phase, *i.e.*, they were cases that closed unsuccessfully. The second fidelity assessment demonstrated promising practices in terms of transitioning youth out of the program. Of the 14 closed *Safe at Home* cases included in the second fidelity assessment, eight youth had successfully graduated the program, and, thus, completed the Transition Phase. Stakeholders from the eight completed cases reported that the team knew the youth were ready to graduate because

all the goals set forth had been achieved. Very few cases reviewed in 2019 had closed successfully or had entered the transition phase.

Interviewees stated when cases did close successfully, facilitators held some sort of celebration to symbolize graduation for the youth. Often, gifts were given to the youth and, in a couple of cases, scrapbooks with pictures and diplomas/certificates were also provided. For graduation from the program or meeting larger goals, two youth in 2019 reported receiving laptop computers. Youth, parents, and facilitators stated that at the celebration the group discussed the youths' achievements and the progress made throughout the life of the case. Stakeholders also reported that Wraparound facilitators provided the youth/family with information on where to go for help in the future if necessary. In most of the cases, the Wraparound facilitators offered themselves as a resource should any issues arise.

Despite what was observed through the fidelity reviews, the survey administered to facilitators produced fewer positive responses, indicating required activities were not being completed regularly for the Transition Phase, though this has improved from prior cycles. For example, in the 2018 survey, just over half (51%) of the facilitators responded that they "always" or "frequently" create a document that describes lessons learned, what worked well and what did not, and the successes of the process. Results for 2019 show that 56 percent of facilitators reported always creating such documents, while another 25 percent reported creating these documents frequently. More than three quarters (80%) of the facilitators always or frequently created a plan for checking in with the family after services end.

Barriers to Implementation

Barriers to implementation were categorized into five topic areas: training, communication, case involvement, services, and sustainability.

Training

The first phase of *Safe at Home* rolled out in eleven counties on October 1, 2015, as expected. Feedback received by the State from those who participated in the early training indicated a need to clarify the roles of DHHR and LCA staff. The State responded quickly, putting together a workgroup and a 90-day work plan, expanding policy, updating the program manual and retraining staff.

DHHR staff and community providers both reported confusion at the beginning of implementation with caseworkers making some inappropriate referrals. However, both groups have since indicated that these issues were resolved. A couple of LCA staff reported that the quality of information provided by the caseworkers with the referrals has improved over time.

Safe at Home's Wraparound 101 and CANS trainings were later incorporated into DHHR's standardized new worker training, ensuring that all new DHHR staff were trained on *Safe at Home* through the regular employee onboarding processes.

Staff provided feedback during interviews on how training could be improved. The most common suggestions were for the training to include:

1. more "nuts and bolts" level training on specific documentation such as referral forms, Wraparound plans, and general reporting requirements;
2. further hands-on training on Wraparound facilitator and caseworker boundaries and responsibilities, possibly with scenarios and/or roleplay;
3. more time for open-ended discussion in the training; and
4. more ongoing training since both DHHR and the LCAs experience varying degrees of turnover, to assure intent and expectations of the program are not lost.

Suggestions made by LCA staff to improve training included refreshers and/or more training on writing Wraparound plans, meeting documentation requirements and flexible spending expectations, and on engaging youth and family.

Despite the changes made to improve training for caseworkers and facilitators, several continued to comment throughout the demonstration period that there was still some element of learn-by-doing to the *Safe at Home* model. This is not to be unexpected as with all casework practice, caseworkers, supervisors and managers continually learn through experience.

Court Buy-in

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

As part of the early communication efforts for *Safe at Home*, program leaders worked to establish communication with judges and other court staff in order to educate them about the program and obtain their buy-in. However, Central Office staff reported they learned after Phase I that their initial outreach efforts were insufficient. A combined communication plan was created for CSMs and LCA program directors to use when meeting with the judges in their areas. The *Safe at Home* project director sent out preparation materials to CSMs for judges two and a half months prior to roll out of subsequent phases to promote advance education and notice of the program. Meeting with judges was already a regular part of the CSMs' work, and the addition of LCA program directors to some of these meetings offered the opportunity to provide judges with more detail about *Safe at Home*.

In addition to the outreach provided by the CSMs and LCA program directors regarding the program, sometimes the *Safe at Home* project director and Regional Office staff held private meetings with judges. However, there were a few judges who continued to voice concerns about *Safe at Home*. While Central Office staff reached out to these judges several times, they continuously declined invitations to meet.

Central and Regional Office staff and CSMs reported during years two and three of implementation that more judges demonstrated their support for *Safe at Home.* CSMs, supervisors, and caseworkers echoed these sentiments, with 86 percent of survey respondents agreeing or strongly agreeing that "Judges are on board with *Safe at Home*." The input received from interviews with judicial staff demonstrates that judges and other court-involved staff recognized the impact of the services *Safe at Home* youth received was beneficial in youth participants meeting their goals. Central Office staff stated that the increased buy-in of judges was largely attributed to them being able to see the success of *Safe at Home* cases over time.

However, buy-in has not been universal. One Regional Office staff person and a few Central Office staff reported that a few particular judges have created a major hindrance with *Safe at Home* cases. According to caseworkers, supervisors and LCA staff, when non-supportive judges hinder success, it is because they do not recognize court-ordered participation, have unrealistic expectations of youth and families, or expect *Safe at Home* to be a "quick fix" or "magic bullet" as barriers. They also do not recognize small amounts of progress as positive and measurable improvements for youth.

Case Involvement

The time intensive nature of *Safe at Home* influenced caseworker involvement, which diminished to more normal levels as implementation continued. When staff were surveyed at the start of the evaluation, about three-quarters of the caseworkers and supervisors stated that more time was spent on *Safe at Home* cases due to the demand for weekly updates, more paperwork, more case consultation with LCAs, and more meetings to attend. This changed as staff became more familiar with the program and less than one-quarter of DHHR staff were still reporting *Safe at Home* cases taking longer by the end of the demonstration period. About half of the caseworkers and supervisors recently surveyed reported spending about the same amount of time on *Safe at Home* cases as they do on traditional cases, with several also noting the amount of time is about the same they would have spent on these cases anyway since these youth require a more intense level of involvement. Several noted that they felt a deeper understanding of the case and more involvement with the youth involved.

One-third of the LCAs reported struggling with the turnover of Wraparound facilitators in the early stages of implementation. After year two, all but one LCA staff reported that there had not been turnover issues with *Safe at Home* facilitators and supervisors. One Wraparound supervisor stated, "I've seen a lot less turnover with *Safe at Home* than any other job in this field. I think it's because the job is more rewarding. You're working with families on a totally different level."

Services

While stakeholders who participated in the fidelity case reviews reported high levels of inclusion in the service decision-making process, they also noted that not all youth were able to receive all the services which were planned and needed. Caseworkers and facilitators cited three barriers to accessing services. One barrier was the lack of consistency by the youth/families to follow through or be motivated to succeed. In a few cases, placement changes/disruptions resulted in services stopping and starting, which presented an additional challenge. Despite the emphasis of using family voice to establish service need, there were rare instances where disputes between the caseworker and facilitator made it difficult to come to an agreement about what services would be best for the youth.

Youth and family willingness or ability to identify informal supports to engage in family team meetings presented a second barrier. Although the program is based on the principle that informal networks can be utilized to replace formal services overtime, in practice facilitators stated that this was very difficult to achieve.

When interviewed about involvement of natural supports, youth and families often stated that they either had no one to involve or did not want anyone else involved to protect their privacy. This lack of informal supports created barriers in two ways. First, it put the onus of developing an informal support network for the family on the facilitator. In other words, facilitators were pushed to find community resources in which to involve the family and encourage them to participate to build a network. This was more difficult in rural areas where community resources are already thin, and families tend to have privacy concerns. Second, without this natural support network, transition away from formal supports often became more difficult and left families without sufficient resources to sustain progress that was made while participating in *Safe at Home*. For example, one family said that the program had given them a gym pass to work on their health and also created a sense of community, building a social network. However, once the program ended, the family was no longer able to pay for the gym pass.

A third barrier involved a lack of services, especially for those living in rural communities, including placements for teenagers with mental health needs, mentoring programs, medication management, adolescent psychiatry, and services for youth with special needs.

Facilitators provided examples of ways they worked to overcome the challenges caused by barriers to services, including: making numerous calls; physically being there to make sure youth/families followed through; staffing the case with LCA supervisors, DHHR staff and school staff; rewarding youth for participation; working to keep placements stable; identifying informal mentors; and teleconferencing with doctors or getting them to prescribe medications or services for multiple months. LCAs also used their flexible funding to a limited degree to purchase non-traditional services, such as tutoring, gym memberships, computers, phones, housing and car repairs, among others. A stronger focus needs to be given to developing creative solutions to access needed services, either

finding alternative service providers or alternative types of services that would also meet the needs of youth and their caregivers.

Summary of Process Evaluation Results

Safe at Home is based on the principles of the National Wraparound Initiative and fidelity to the model was good overall. Both LCAs and DHHR generally conformed to the requirements for each phase of Wraparound, although fidelity scores in satisfying the time requirements to complete assessments and plans varied from year to year.

Initial planning for *Safe at Home* West Virginia focused on the development of guidance documents for the program, collaborating with LCAs and communicating with community partners, including judges and juvenile justice staff. Outreach and transparency represented continuous efforts throughout the implementation period. The first phase was implemented in October 2015, the second phase in August of the following year and, as of April 2017, the program was fully implemented statewide. Administrative oversight was provided at all levels of DHHR as well as internally by the LCAs. Oversight included holding LCAs accountable for assessing the strengths and needs of youth and their caregivers and providing the services families needed to be successful.

There were a number of program successes. For example, stakeholder buy-in increased, including that of juvenile justice staff and judges. Communication became more well-routinized between LCAs and DHHR, especially as roles and responsibilities were more clearly defined, and both parties reported several anecdotal success stories of individual youth.

There were also a few barriers, including the lack of consistent motivation among youth and their families, their willingness or ability to identify informal supports to engage in family team meetings and available services in some areas. Facilitators were encouraged to be creative in their methods for engagement and problem solving as well as for service delivery; however, success was limited.

Outcome Evaluation

Key Questions

The following questions guided the evaluation to measure the effectiveness of *Safe at Home* in achieving safety, permanency, and well-being for participating youth.

Outcome Research Questions

1. **To what extent has the project reduced the number of youth placed in congregate care?**
2. **To what extent has the project reduced the length of stay in congregate care and what impact did that have on the overall length of time in care for the foster care population?**
3. **To what extent has the project increased the number of youth remaining in their own communities?**
4. **To what extent has the project reduced the rates of initial and repeat foster care entry?**
5. **To what extent has the project improved youth safety/maltreatment recidivism?**
6. **To what extent has the project improved the well-being, educational achievement, and family functioning of youth?**

Sample

As of the completion of the waiver period, a total of 3,038 youth were referred to the program. For the analysis of outcomes, youth were divided into six- and 12-month cohorts based on the date they were referred to *Safe at Home* (Table 5); the cohorts make it possible to identify changes in the impact of the program over time. Outcomes were measured for youth when enough time had passed to allow for six or 12-month measurements; for this reason, data available for youth in the most recent cohort *(i.e.*, Cohort 8) are limited to only descriptive information about the youth population because a full six months in the program has not passed since referral to the program.

PCG employed a quasi-experimental approach to assess the impact of the program, selecting a comparison group that had similar characteristics to the youth who participated in *Safe at Home,* referred to as the treatment group. The matched comparison groups, for each six- and 12-month cohort, 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 and were served by the agency during State Fiscal Years (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 1 diagnosis, juvenile justice involvement and if the youth was ever in a psychiatric hospital or group home. These scores were matched using a nearest neighbor algorithm to select a comparison group that is statistically similar to the treatment group (see Appendix A). For each cohort, there are an equal number of youth in the treatment and comparison groups.

Table 5. Youth Cohorts

Cohort	Group	Referral Period	Number of Youth
1	Treatment	October 1, 2015–March 31, 2016	124
	Comparison	SFY 2010–2015	124
2	Treatment	April 1, 2016–September 30, 2016	221
	Comparison	SFY 2010–2015	221
3	Treatment	October 1, 2016–March 31, 2017	297
	Comparison	SFY 2010–2015	297
4	Treatment	April 1, 2017–September 30, 2017	445
	Comparison	SFY 2010–2015	445
5	Treatment	October 1, 2017–March 31, 2018	512
	Comparison	SFY 2010–2015	512
6	Treatment	April 1, 2018–September 30, 2018	463
	Comparison	SFY 2010–2015	463
7	Treatment	October 1, 2018–March 31, 2019	512
	Comparison	SFY 2010–2015	512
8	Treatment	April 1, 2019–September 30, 2019	512
	Comparison	SFY 2010–2015	-[11]
Total	**Treatment**	**October 1, 2015–March 31, 2019**	**3,086**
	Comparison	**SFY 2010–2015**	**2,526**

While the program targeted youth with behavioral problems, there was some diversity in the characteristics of the *Safe at Home* population. Table 6 displays both the similarities and the differences across the eight six-month cohorts.

Table 6. *Safe at Home* Youth at Referral

Factor	C1 (124)	C2 (221)	C3 (297)	C4 (445)	C5 (512)	C6 (463)	C7 (512)	C8 (512)	Overall
Placement									
Out-of-State Congregate Care	31 (25%)	18 (8%)	12 (4%)	12 (3%)	17 (3%)	12 (3%)	12 (2%)	12 (2%)	126 (4%)
In-State Congregate Care	39 (31%)	73 (33%)	61 (21%)	60 (13%)	52 (10%)	35 (8%)	23 (4%)	30 (6%)	373 (12%)
Emergency Shelter	6 (5%)	18 (8%)	6 (2%)	13 (3%)	22 (4%)	15 (3%)	9 (2%)	6 (1%)	95 (3%)
Family Foster Care	2 (2%)	11 (5%)	13 (4%)	27 (6%)	34 (7%)	34 (7%)	55 (11%)	45 (9%)	221 (7%)
Home	46 (37%)	101 (46%)	205 (69%)	333 (75%)	387 (76%)	367 (79%)	413 (81%)	419 (82%)	2,271 (74%)
Region									
Region 1	0 (0%)	30 (14%)	68 (23%)	95 (21%)	117 (23%)	128 (28%)	164 (32%)	125 (24%)	727 (24%)
Region 2	72 (58%)	110 (50%)	117 (39%)	162 (36%)	196 (38%)	196 (42%)	198 (39%)	237 (46%)	1,288 (42%)

[11] A comparison group was not selected for the last cohort as not enough time has passed to measure outcomes.

Factor	C1 (124)	C2 (221)	C3 (297)	C4 (445)	C5 (512)	C6 (463)	C7 (512)	C8 (512)	Overall
Region 3	50 (40%)	54 (24%)	72 (24%)	82 (18%)	100 (20%)	68 (15%)	86 (17%)	68 (13%)	580 (19%)
Region 4	2 (2%)	25 (11%)	40 (13%)	103 (23%)	88 (17%)	68 (14%)	58 (11%)	73 (14%)	457 (15%)
Out-of-State	0 (0%)	0 (0%)	0 (0%)	1 (0%)	0 (0%)	0 (0%)	1 (0%)	0 (0%)	2 (0%)
Unknown	0 (0%)	2 (1%)	0 (0%)	2 (0%)	11 (2%)	3 (1%)	5 (1%)	9 (2%)	32 (1%)
Age at Referral									
12	10 (8%)	19 (9%)	25 (8%)	37 (8%)	63 (12%)	41 (9%)	55 (11%)	62 (12%)	312 (10%)
13	20 (16%)	26 (12%)	35 (12%)	64 (14%)	80 (16%)	68 (15%)	82 (16%)	77 (15%)	452 (15%)
14	30 (24%)	48 (22%)	67 (23%)	87 (20%)	98 (19%)	104 (22%)	87 (17%)	91 (18%)	612 (20%)
15	28 (23%)	58 (26%)	65 (22%)	135 (30%)	120 (23%)	119 (26%)	110 (21%)	137 (27%)	772 (25%)
16	32 (26%)	63 (29%)	92 (31%)	103 (23%)	120 (23%)	98 (21%)	143 (28%)	118 (23%)	769 (25%)
17	4 (3%)	7 (3%)	13 (4%)	19 (4%)	31 (6%)	33 (7%)	35 (7%)	27 (5%)	169 (5%)
Gender									
Male	75 (60%)	116 (52%)	186 (63%)	274 (62%)	303 (59%)	259 (56%)	289 (56%)	286 (56%)	1,788 (58%)
Female	49 (40%)	105 (48%)	111 (37%)	171 (38%)	209 (41%)	204 (44%)	223 (44%)	226 (44%)	1,298 (42%)
Race									
White	96 (77%)	181 (82%)	245 (82%)	405 (91%)	435 (85%)	396 (86%)	452 (88%)	436 (85%)	2,646 (86%)
Black	8 (6%)	19 (9%)	15 (5%)	14 (3%)	25 (5%)	27 (6%)	21 (4%)	28 (5%)	157 (5%)
Mixed	16 (13%)	18 (8%)	32 (11%)	20 (4%)	43 (8%)	31 (7%)	24 (5%)	0 (0%)	184 (6%)
Other	4 (3%)	3 (1%)	5 (2%)	6 (1%)	9 (2%)	9 (2%)	15 (3%)	48 (9%)	99 (3%)
Child Protective Services (CPS) or Youth Services (YS) Case									
CPS	12 (10%)	55 (26%)	38 (12%)	85 (20%)	104 (21%)	88 (19%)	125 (24%)	95 (19%)	602 (20%)
YS	112 (90%)	166 (74%)	261 (89%)	365 (81%)	408 (79%)	375 (81%)	389 (76%)	417 (81%)	2,493 (81%)
Length of DHHR Case Prior to *Safe at Home* Referral									
0 up to 6 Months	39 (31%)	68 (31%)	105 (35%)	197 (44%)	266 (52%)	245 (53%)	285 (56%)	328 (64%)	1,533 (50%)
6 up to 12 Months	24 (19%)	34 (15%)	60 (20%)	83 (19%)	84 (16%)	88 (19%)	98 (19%)	66 (13%)	537 (17%)
12 up to 18 Months	20 (16%)	47 (21%)	32 (11%)	55 (12%)	45 (9%)	47 (10%)	36 (7%)	43 (8%)	325 (11%)
18 up to 24 Months	9 (7%)	22 (10%)	30 (10%)	28 (6%)	37 (7%)	23 (5%)	36 (7%)	31 (6%)	216 (7%)
24 Plus Months	32 (26%)	50 (23%)	70 (24%)	82 (18%)	80 (16%)	60 (13%)	57 (11%)	44 (9%)	475 (15%)

Youth age at referral remained consistent across cohorts, with most youth receiving a referral between the ages of 14 and 16. Seventeen-year-olds made up the smallest percentage of *Safe at Home* youth in all eight cohorts. Males also made up more than half of the *Safe at Home* population (58%), which was a consistent trend across cohorts. White youth made up the majority of *Safe at Home*'s population (86% overall) and were also consistently represented across cohorts.

The majority of youth (81%) in *Safe at Home* had a Youth Services case. According to DHHR, "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 remediating child maltreatment.

The median length of time between the DHHR case opening and *Safe at Home* referral decreased significantly from 300 days in the first two reporting periods to 135 days in the three most recent reporting periods. There was also a focus towards prevention, getting youth involved in the program sooner and before crises escalated necessitating their removal from the home.

Data Analysis

In order to identify populations for which *Safe at Home* worked best, a combination of random forest and logistic regression analyses were performed for several of the outcome measures. The population factors which were tested to determine their influence on outcomes include county, gender, race, age, placement at referral, length of time placed out-of-state prior to referral, length of DHHR case activity prior to referral, presence of a mental health diagnosis, juvenile justice involvement, substance use, whether formal services have been received, and number of actionable items in the CANS domains. Each of these factors were applied to the analyses completed for the following outcome measures:

1. initial entry into congregate care;
2. re-entry into congregate care;
3. length of stay in congregate care;
4. county movement (*e.g.,* home county to out-of-county and out-of-county to home county);
5. initial entry into foster care; and
6. re-entry into foster care.

The first step in a population analysis is to run a random forest using the complete list of factors cited above against the various outcome measures. Random forests generate 500 unique population samples equal in size to the original population (*i.e.,* all applicable treatment group members for each outcome). The population samples are made by randomly sampling the original population with replacement. These 500 samples are used to make unique decision trees. Each tree creates a flowchart-type structure of factors that best split the population into those who have a given outcome versus those who do not. Trees stop splitting when there is no benefit to dividing the population. After all 500 trees are created, the importance of each factor is determined by its effectiveness to split the population and isolate those with and without each outcome. Typically, factors that are the most commonly seen in the decision trees are classified as the most important.

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

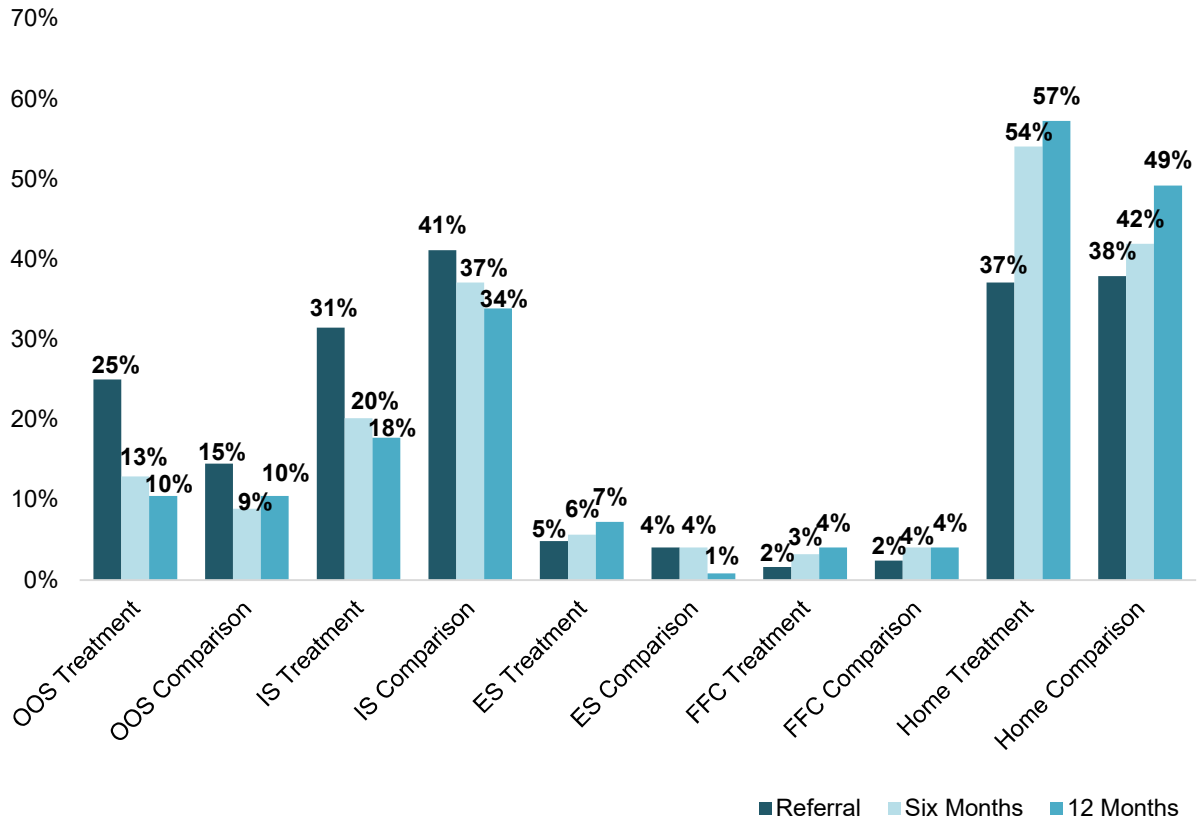
Figures showing the results of this analysis (*e.g.*, Figure 7) can be found after the discussion of each respective outcome measure. The figures are color coded green to show protective (*i.e.*, positive) factors and red to show risk (*i.e.*, negative) factors. If the factor was found to have a significant influence, the bar is boldly shaded while non-significant finds are lightly shaded.

Results

Youth Placement Changes

Contrasting the placement changes of youth in the comparison groups to those in *Safe at Home* (*i.e.*, the treatment groups) provided an opportunity to assess the general impact that *Safe at Home* had on youth placements. The following suite of figures highlights each cohort individually as well as the overall result. Figure 9 compares the placements of *Safe at Home* youth along with their corresponding comparison youth for Cohort 1 at referral and at six- and 12-months following referral, doing so for youth who were referred while in out-of-state congregate care (OOS), in-state congregate care (IS), emergency shelter (ES), family foster care (FFC) or in their own home (Home).

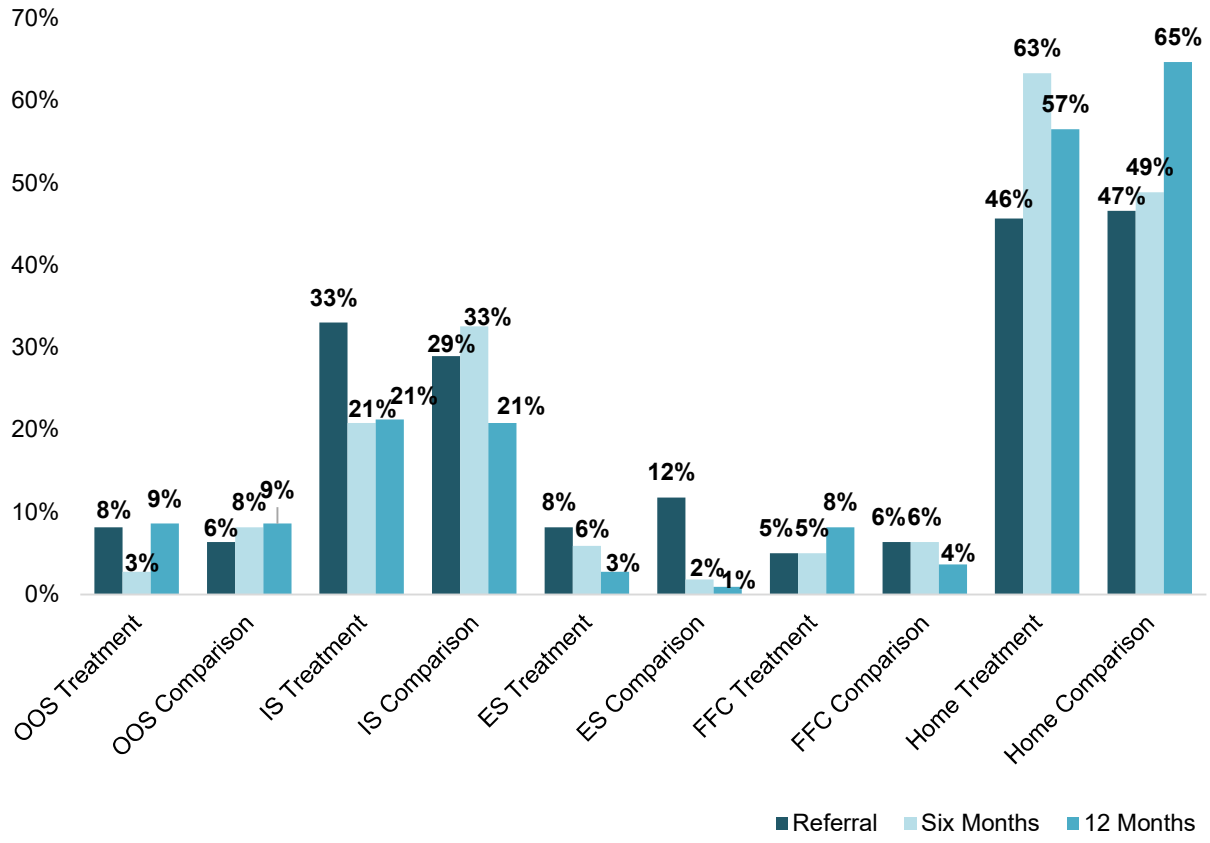
Figure 9. Percentage of Cohort 1 Youth by Placement at Referral, 6 and 12 Months



Overall, placement status was better for *Safe at Home* youth in Cohort 1 than for comparison youth post referral. Both the treatment and comparison groups experienced reductions in congregate care placements six- and 12-months following referral. The reduction of youth who were referred while either in or out-of-state congregate care was more apparent for youth in *Safe at Home* than it was for youth in the comparison group. An increased percentage of youth were living at home at six- and 12-months post-referral for youth in both groups, but again, the positive difference was more pronounced for youth in *Safe at Home*.

Figure 10 replicates the analysis presented in Figure 9 for youth in Cohort 2.

Figure 10. Percentage of Cohort 2 Youth by Placement at Referral, 6 and 12 Months

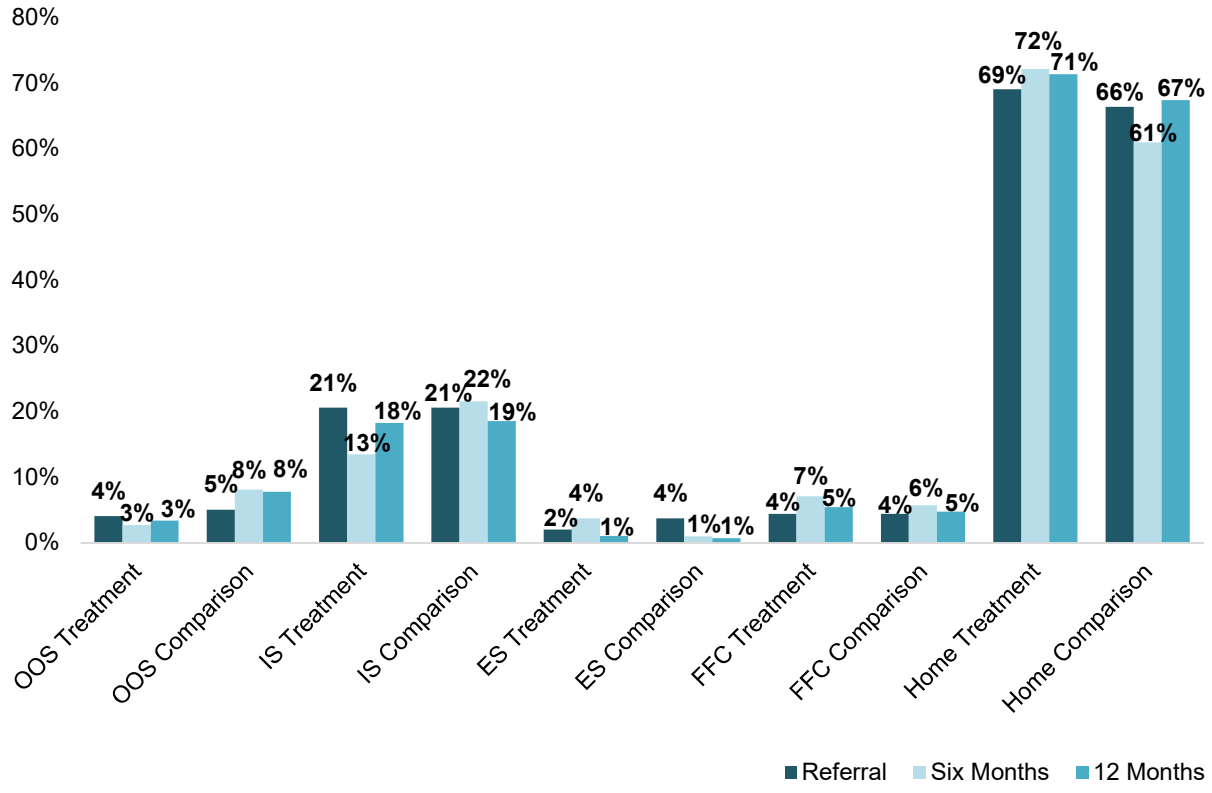


Although a small percentage of Cohort 2's treatment and comparison youth were referred while in an out-of-state congregate care placement, the comparison group experienced a slight increase in youth placed outside of West Virginia at both six- and 12-months post referral. Interestingly, the percentage of *Safe at Home* youth living in out-of-state congregate care decreased by five percentage points six months after referral but increased by nearly the same amount six months later.

Safe at Home youth demonstrated reduced percentages of youth living in in-state congregate care at six and 12 months while the comparison group had increased percentages at six months but decreased percentages at 12 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 12-months. Comparison youth fared slightly better than treatment youth regarding at-home placement 12 months post-referral.

Figure 11 compares the treatment and comparison group placements for Cohort 3 at referral and six and 12 months after referral.

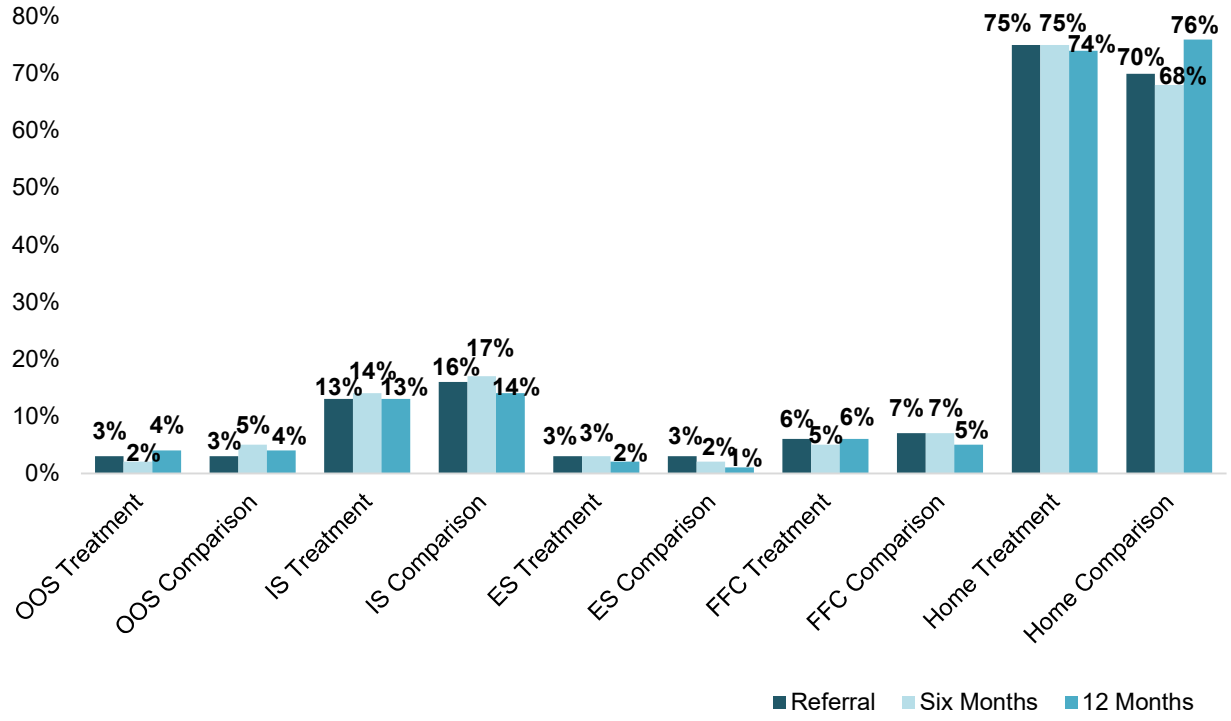
Figure 11. Percentage of Cohort 3 Youth by Placement at Referral, 6 and 12 Months



Overall, *Safe at Home* youth from Cohort 3 demonstrated more positive placement changes at six months than the comparison youth. A smaller proportion of *Safe at Home* youth were in out-of-state or in-state congregate care facilities and more youth were in their homes when compared to youth in the comparison group six months following referral. Each of these results was significant at the $p < 0.05$ level. By 12 months, however, the treatment and comparison groups had similar proportions of youth in the various 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 12 months following referral.

Figure 12 compares the placement status of Cohort 4's *Safe at Home* youth to their corresponding comparison youth at referral and six months and 12 months following referral.

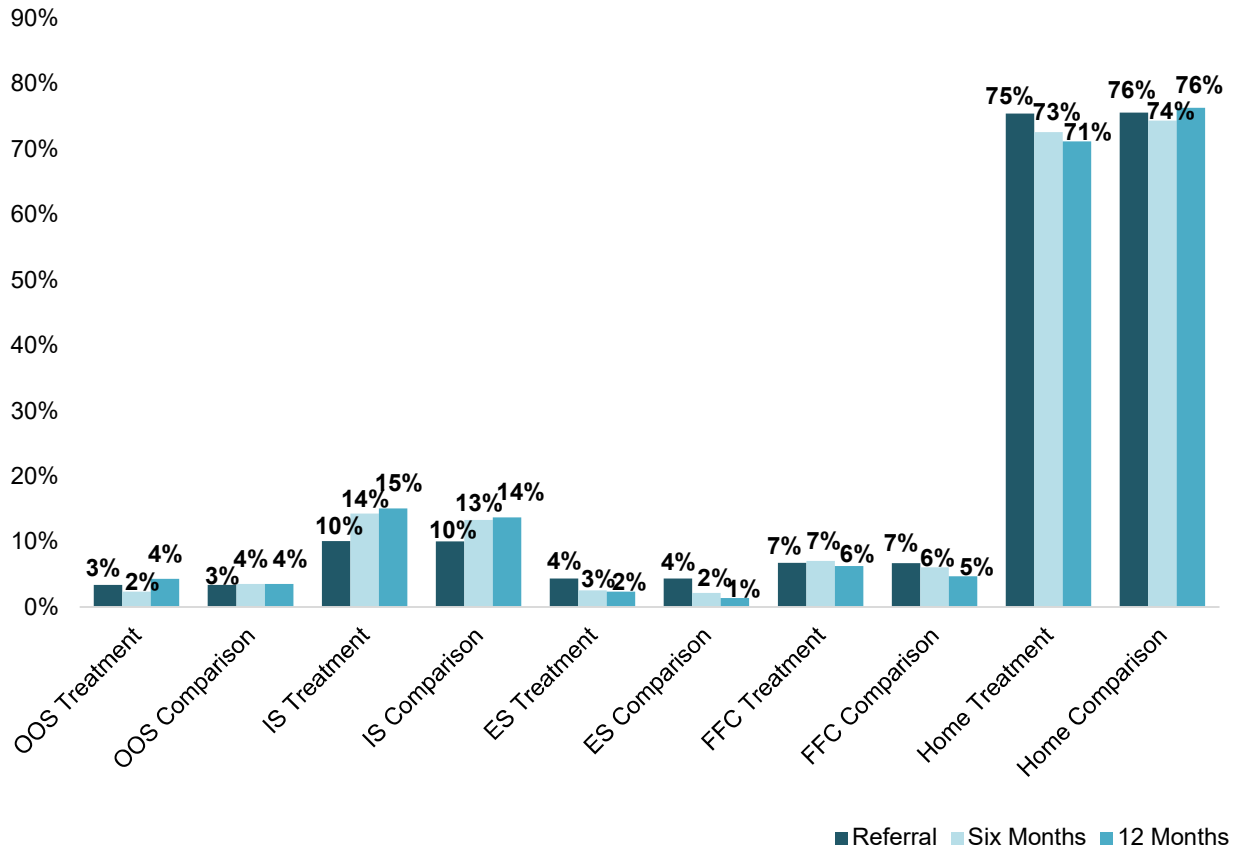
Figure 12. Percentage of Cohort 4 Youth by Placement at Referral, 6 and 12 Months



Overall, the placement differences between *Safe at Home* youth and comparison youth were minimal between six and 12 months. Regarding placement in congregate care, there was a smaller percentage of *Safe at Home* youth in either in- or out-of-state congregate care at six months when compared to the percentage of comparison youth, but by 12 months there were no differences between *Safe at Home* and comparison youth. There was a higher proportion of *Safe at Home* youth living at home at six months, but by 12 months, the difference between the two groups was minimal, with a slightly higher percentage of youth in the comparison group in their homes than those in the treatment group. The results for youth living at home at six months were statistically significant ($p<0.05$).

Figure 13 displays the placements of Cohort 5's *Safe at Home* youth as well as the corresponding comparison youth at referral and six months and 12 months following referral.

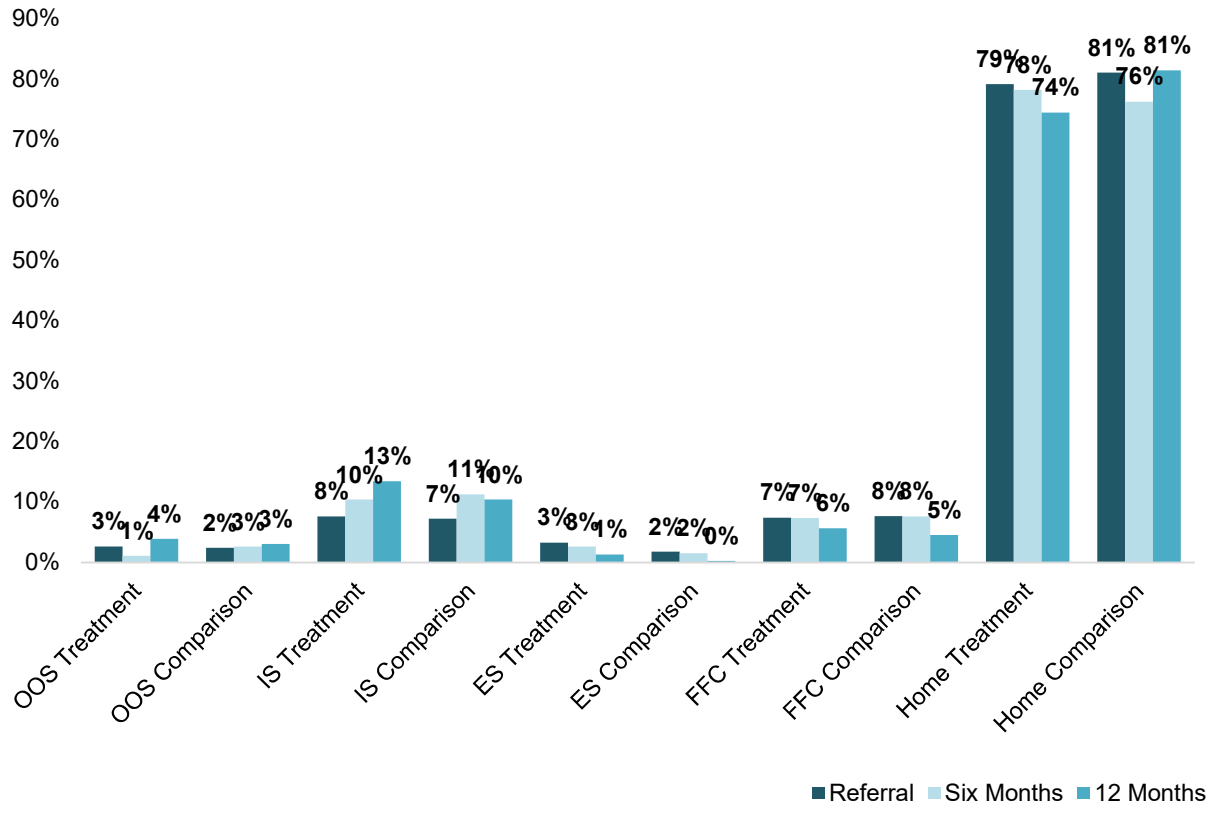
Figure 13. Percentage of Cohort 5 Youth by Placement at Referral, 6 and 12 Months



Safe at Home youth in Cohort 5 had a lower percentage of youth placed in their home at both six and 12 months after referral when compared to the percentage that were in their home when referred. This decline existed for comparison group youth at six months but was not evident at 12 months. Concurrently, there was a rise in the percentage of youth, for both treatment and comparison groups, who were placed in in-state congregate care at six and 12 months after referral.

Finally, Figure 14 displays the placements of Cohort 6's *Safe at Home* youth as well as the corresponding comparison youth at referral and six months and 12 months following referral.

Figure 14. Percentage of Cohort 6 Youth by Placement at Referral, 6 and 12 Months



Cohort 6 youth showed almost an identical trend to youth in Cohort 5 where the percentage of youth placed in the home steadily declines after referral while the percentage of youth placed in congregate care rose, especially for in-state congregate care.

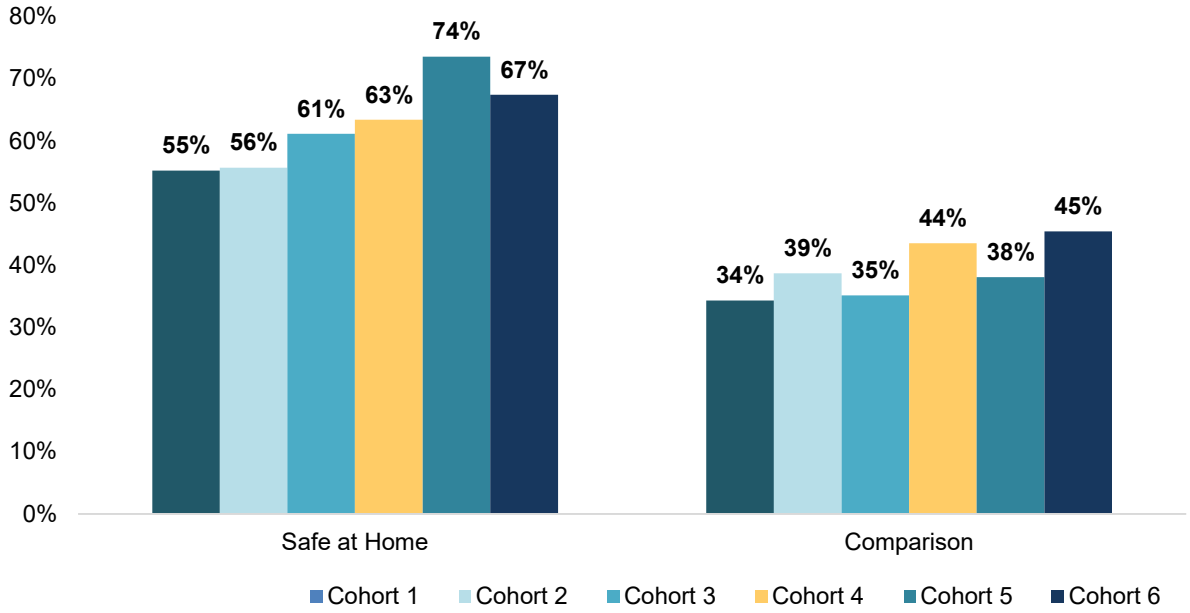
Overall, since the implementation of *Safe at Home*, the percentages of youth placed in their own home 12 months after referral when starting out while in congregate care increased as well as for youth who remained in their home. Treatment group youth showed a similar or decreased percentage of youth in congregate care at six and 12 months than the comparison group. In general, there was a higher percentage of treatment group youth living at home six months after referral than comparison group youth; however, at 12 months, the trend inverted where a higher percentage of comparison group youth were at home.

Congregate Care

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

To investigate the effectiveness of *Safe at Home* at returning youth who were referred in congregate care to their homes, Figure 15 shows the percentage of youth referred while in either in-state or out-of-state congregate care who were placed in their home 12 months after referral. In general, 62 percent of *Safe at Home* youth referred in congregate care were back in their homes at 12 months. Furthermore, each *Safe at Home* cohort had a significantly higher percentage of youth in their home at 12 months than comparison group cohorts ($p < 0.01$).

Figure 15. Percentage of Youth Referred in Congregate Care Placed in Home at 12 Months



Another way to evaluate the impact of preventing placement into congregate care was to compare the results for youth in the treatment cohorts with those in the comparison cohorts who were referred at a lower level of care to see the extent to which they did (or did not) enter congregate care at six and 12 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 12-months following referral (Table 7) to determine the extent to which those youth were later placed in congregate care. In general, a similar percentage of participants (roughly 15 percent) were placed in congregate care six months after referral when comparing treatment and comparison youth; however, at 12 months, there was a significantly ($p < 0.01$) higher percentage of *Safe at Home* youth in congregate care than comparison group youth.

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

Cohort	Group	N Referred at Lower Level	% in CC at 6 Months	% in CC at 12 Months
1	Treatment	54	26%	28%
	Comparison	55	24%	27%
2	Treatment	130	15%	30%
	Comparison	143	28%	17%
3	Treatment	224	16%	18%
	Comparison	221	20%	17%
4	Treatment	373	16%	16%
	Comparison	358	12%	11%
5	Treatment	443	15%	16%
	Comparison	448	14%	12%
6	Treatment	416	11%	17%
	Comparison	418	10%	10%
7	Treatment	477	14%	–
	Comparison	466	10%	–
Overall	**Treatment**	**2,117**	**15%**	**18%**
	Comparison	**2,109**	**14%**	**13%**

Limiting the analysis to youth who participated in *Safe at Home,* within six months of referral, youth who were known to Child Protective Services were more likely to enter congregate care than were youth involved in Youth Services (16% and 14%, respectively). The gap between treatment and comparison group youth became even smaller within 12 months of referral, although the percentage of CPS youth who moved to a congregate care placement was still higher than for those known to Youth Services (19% and 18%, respectively).

The random forest and regression results (described earlier in the Populations Analysis section) are shown in Figure 16. As noted earlier, the colors in the figure are green to highlight protective (*i.e.*, positive) factors and red for risk (*i.e.*, negative) factors. Those factors which are significant are boldly shaded while non-significant factors are lightly shaded. The figure below shows that youth who received clothing assistance, received one or more other services (*e.g.*, counseling, education), or had an Axis 1 diagnosis were significantly more likely to be placed in congregate care at 12 months than youth without those factors.

Interestingly, youth with a larger number of prior placements were significantly less likely to enter congregate care than those with fewer prior placements. Additionally, youth who displayed fewer strengths on the CANS or contained more actionable items in the Risk Behaviors domain on the CANS were slightly more likely to enter congregate care at 12 months.

Figure 16. Random Forest and Regression Analyses for Youth New to Congregate Care

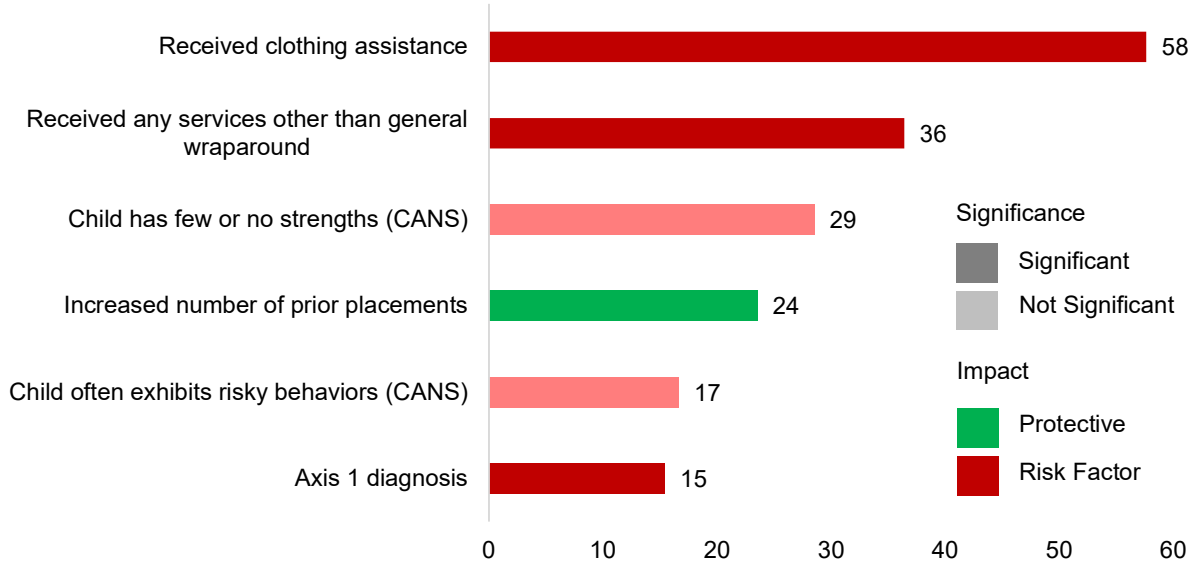


Table 8 displays the results for youth who left congregate care and moved to a lower level of care within 12 months of referral, but ultimately re-entered congregate care at either six or 12 months following their initial congregate care discharge date. Results were only included for youth younger than 17 and where sufficient time had passed to measure outcomes; thus, Cohort 7 was excluded, and only six-month outcomes could be measured for Cohort 6. A larger volume of *Safe at Home* youth was discharged from congregate care to a lower level of care within 12 months than comparison group youth.

The percentage of those youth who returned to congregate care six and 12 months later was slightly lower among treatment group youth than comparison youth. Cohort 1 showed significantly ($p < 0.05$) lower rates of congregate care re-entry at six months for the treatment group than the comparison group while all other cohort and timeframe comparisons did not produce a significant result.

Table 8. Rate of Congregate Care Re-Entry

Cohort	Group	N Discharged from CC within 12 Months	% Re-Entered within 6 Months	% Re-Entered within 12 Months
1	Treatment	60	23%	27%
	Comparison	44	32%	30%
2	Treatment	108	28%	26%
	Comparison	68	29%	26%
3	Treatment	92	16%	24%
	Comparison	64	27%	22%
4	Treatment	127	20%	19%
	Comparison	79	23%	24%
5	Treatment	137	25%	22%
	Comparison	85	21%	25%
6	Treatment	87	15%	–
	Comparison	62	21%	–
Overall	**Treatment**	**610**	**21%**	**23%**
	Comparison	**402**	**25%**	**25%**

While there was little difference in the percentages of youth who re-enter congregate care between CPS and Youth Services, at both six and 12 months, the percentage was lower for youth involved in Youth Services.

Figure 17. Percentages of CPS and Youth Services Youth Who Re-enter Congregate Care

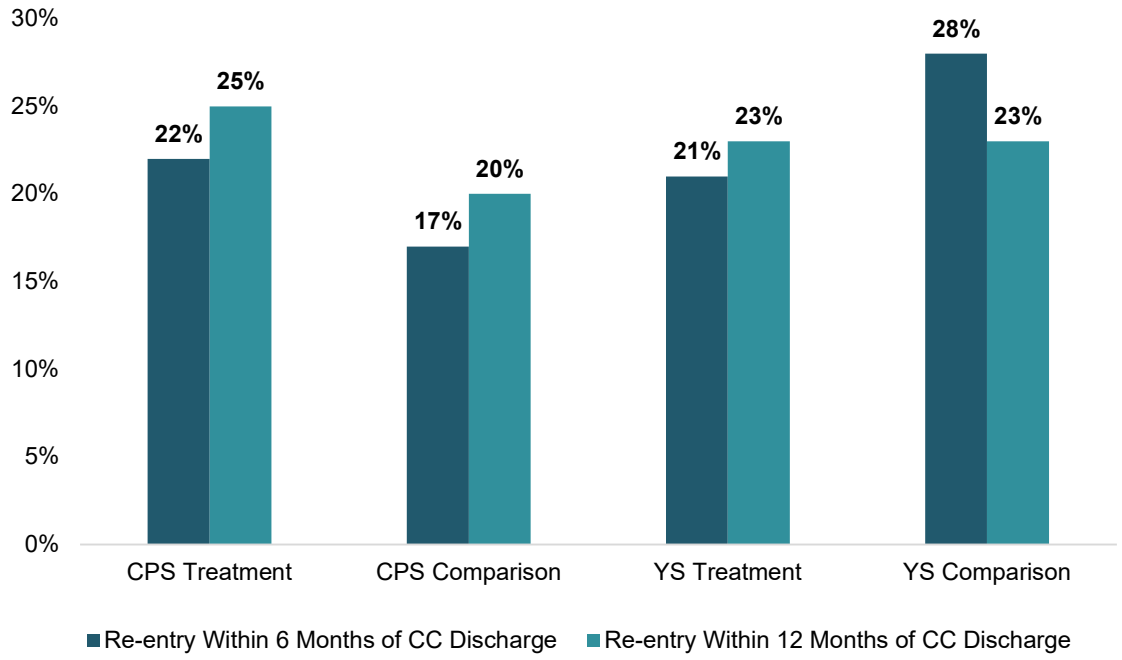
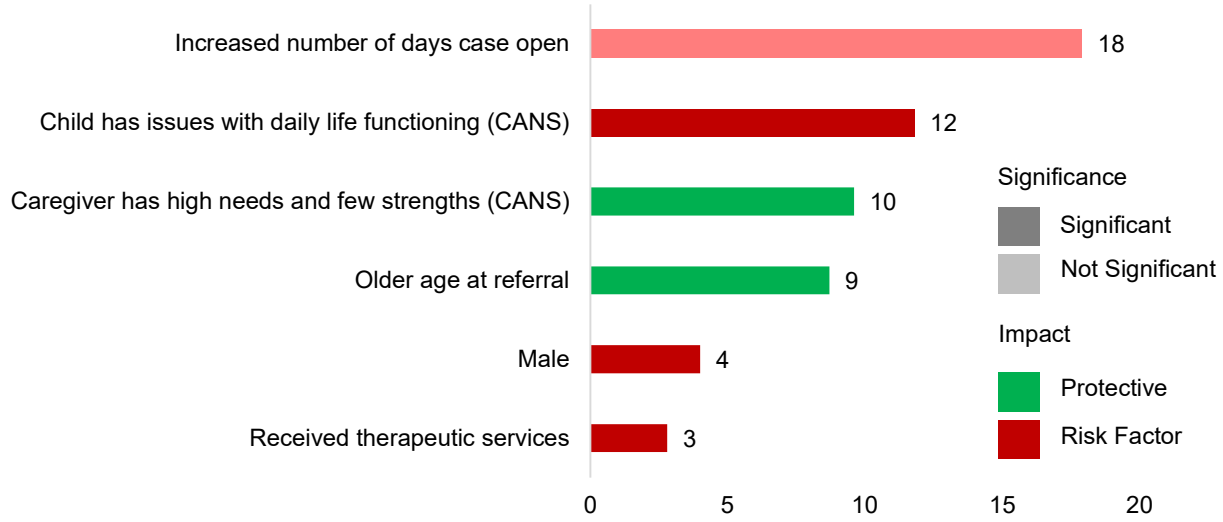


Figure 18, which displays the random forest and regression analyses for re-entry into congregate care, shows that if a youth had more actionable items in the Life Functioning domain, was male, or received therapeutic services, they were more likely to re-enter congregate care within 12 months. Youth with more actionable items in the Caregiver CANS domain or who were older at the time of referral were less likely to re-enter congregate care.

Figure 18. Random Forest and Regression Analyses for Congregate Care Re-Entry



To assess the length of time youth were in congregate care, Table 9 shows the average number of days youth spent in congregate care within six and 12 months of referral. While congregate care initial entry and re-entry rates showed a mix of positive and negative outcomes for *Safe at Home* youth, the average length of stay in congregate care results were clearly positive. *Safe at Home* youth from all cohorts spent substantially less time in congregate care. *Safe at Home* youth spent an average of 51 fewer days in congregate care within six months of referral and 82 fewer days within 12 months than comparison youth. All results were statistically significant at ($p<0.01$).

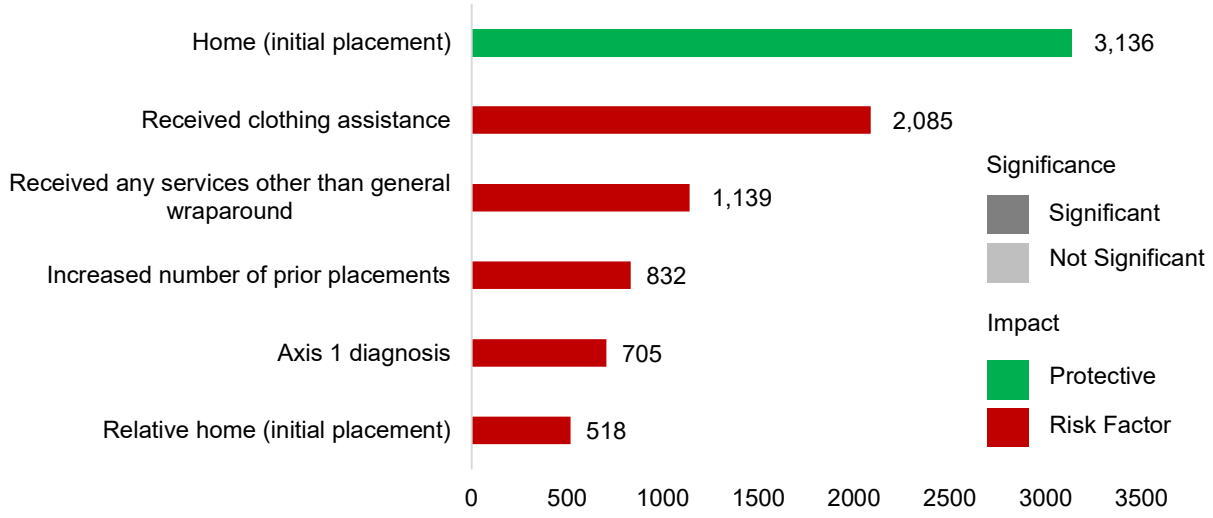
Table 9. Average Length of Stay in Congregate Care

Cohort	Group	Average Days in CC within 6 Months	Average Days in CC within 12 Months
1	Treatment	101	167
	Comparison	137	239
2	Treatment	84	144
	Comparison	131	237
3	Treatment	61	126
	Comparison	122	219
4	Treatment	70	139
	Comparison	127	217
5	Treatment	63	133
	Comparison	115	206
6	Treatment	53	113
	Comparison	113	190
7	Treatment	72	–
	Comparison	111	–
Overall	**Treatment**	**71**	**135**
	Comparison	**122**	**217**

When the results of youth who were known to Youth Services were compared to those who were involved in Child Protective Services, at both six and 12 months from date of referral, Youth Services youth spent less days in congregate care. Within six months of referral, Youth Services youth in the treatment group spent an average of 67 days in congregate care compared to 83 days for those known to CPS. Within 12 months of referral, Youth Services youth who participated in *Safe at Home* spent an average of 130 days in congregate care compared to 150 days for CPS youth.

Not surprisingly, Figure 19 shows youth referred in home were significantly less likely to spend more nights in congregate care than other placements. Those youth who received clothing assistance or other services, had an Axis 1 diagnosis, had a higher number of prior placements or were initially placed with a relative were significantly more likely to spend more days in congregate care.

Figure 19. Random Forest and Regression Analyses for Average Length of Stay in Congregate Care



In general, *Safe at Home* prevented youth from spending more nights in congregate care when compared to youth in the comparison group. Youth in *Safe at Home* were also slightly less likely to re-enter congregate care after leaving the placement than comparison group youth. However, *Safe at Home* youth referred at a level below congregate care were significantly more likely to enter congregate care 12 months after referral than comparison group youth.

Detention

Eighty-one percent of *Safe at Home* youth had a youth services case, meaning that many of the youth in the treatment group likely had, or were at serious risk for, further court and/or juvenile justice involvement. Therefore, initial detention entries and re-entries were examined (Table 10). Per policy, youth could not be referred to *Safe at Home* from a juvenile detention facility so none of the youth started the program while in this placement setting. Conversely, once youth entered a juvenile detention facility, they were no longer eligible to participate in *Safe at Home* and were, thus, discharged from the program upon entry into detention (though they could be re-referred following their exit from detention).

While the overall numbers of youth in detention at six and 12 months were small, six-month results generally appeared to be more positive for *Safe at Home* youth than comparison group youth. This result flipped at 12 months with slightly more treatment youth in detention than comparison group youth. Of those youth who entered detention, five *Safe at Home* youth re-entered a detention facility within 12 months of discharge from placement while one of the comparison group re-entered within the same timeframe.

Table 10. Initial Detention Entries

Cohort	Group	N in Detention at 6 Months	N in Detention at 12 Months
1	Treatment	3	1
	Comparison	4	1
2	Treatment	1	2
	Comparison	4	1
3	Treatment	2	1
	Comparison	7	1
4	Treatment	3	5
	Comparison	6	1
5	Treatment	6	3
	Comparison	3	1
6	Treatment	4	6
	Comparison	3	0
7	Treatment	0	–
	Comparison	3	–
Overall	**Treatment**	**19**	**18**
	Comparison	**30**	**5**

Within six months of referral, only five CPS youth in the treatment group were placed in detention compared to 14 Youth Services involved youth. By the end of 12 months following referral, three CPS youth who participated in *Safe at Home* found themselves in detention as compared to 15 Youth Services youth.

County Movement

A secondary goal of *Safe at Home* was to increase the number of youth living in their home communities. To measure the extent to which this goal was achieved, the movements of youth both leaving and returning to their home counties were examined at six- and 12-months post-referral[12] (Table 11).

For youth who moved from their home county to another county, results were mixed at six months. While a slightly higher percentage of *Safe at Home* youth moved out-of-county at six months in Cohorts 1, 4, 5, 6, and 7, the opposite was true for Cohorts 2 and 3. At 12 months, a larger proportion of *Safe at Home* youth across all cohorts had moved out-of-county as compared to youth in the comparison group. While none of the cohort level results were statistically significant at six months, results at 12 months were statistically significant for Cohort 2 ($p < 0.05$), 4 ($p < 0.01$), 5 ($p < 0.05$), and Cohort 6 ($p < 0.01$). Overall, *Safe at Home* youth were significantly more likely to be moved out of county at both six ($p < 0.05$) and 12 ($p < 0.01$) months than comparison group youth.

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

For youth moving back to their home county, results were overwhelmingly positive for *Safe at Home* youth within six and 12 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 12-month results were significant for all but Cohort 2. Overall, while treatment youth had a greater chance of being placed outside their home county within 12 months of referral, they also had a better chance of returning.

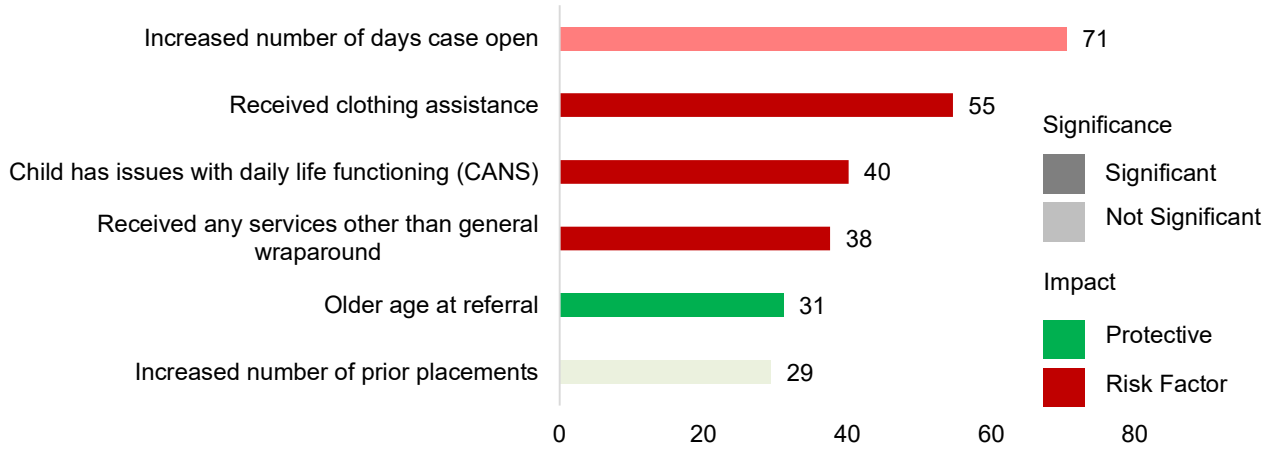
Table 11. Youth County Movements

Cohort	Group	Denominator	% at 6 Months	% 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	364	15%	17%
	Comparison	337	12%	10%
5	Treatment	423	17%	18%
	Comparison	416	14%	12%
6	Treatment	398	13%	19%
	Comparison	394	11%	10%
7	Treatment	450	16%	–
	Comparison	429	11%	–
Overall	**Treatment**	**2,052**	**16%**	**19%**
	Comparison	**1,962**	**14%**	**12%**
From Out-of-County to Home County				
1	Treatment	66	59%	64%
	Comparison	69	28%	39%
2	Treatment	96	61%	59%
	Comparison	103	29%	48%
3	Treatment	74	81%	72%
	Comparison	85	33%	45%
4	Treatment	88	74%	68%
	Comparison	107	28%	50%
5	Treatment	92	65%	75%
	Comparison	97	35%	49%
6	Treatment	70	79%	74%
	Comparison	70	44%	54%
7	Treatment	64	61%	–
	Comparison	85	38%	–
Overall	**Treatment**	**550**	**69%**	**69%**
	Comparison	**616**	**33%**	**48%**

Within six and 12 months of referral, youth who were known to Child Protective Services were more likely to move out-of-county than youth who were involved with Youth Services. *Safe at Home* youth who were known to Youth Services returned to their home county at a much higher rate than Child Protective Services involved youth within six (78% and 50%, respectively) and 12 months (76% and 53%, respectively).

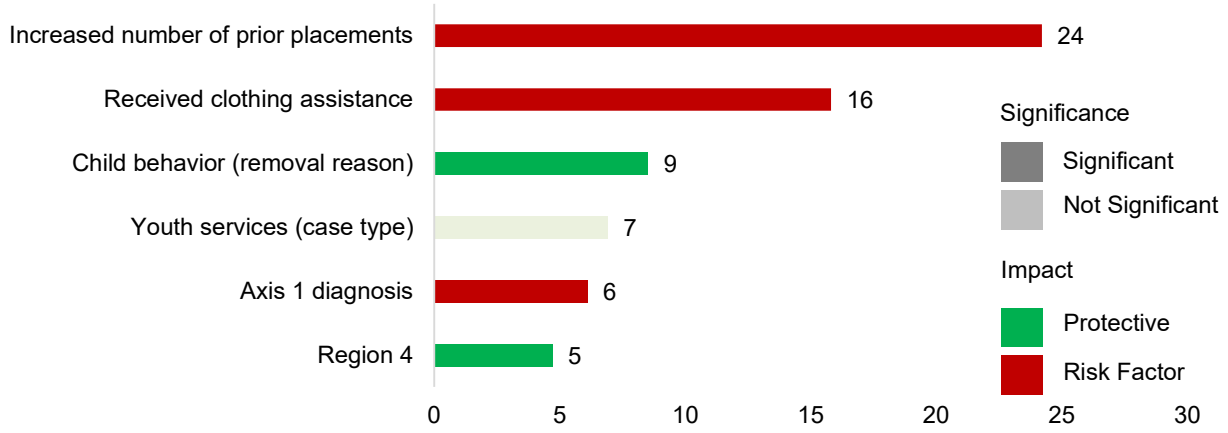
Figure 20 highlights the random forest and regression analyses for youth moving out of county. Youth who were older at the time of referral were less likely to be moved out of county, likely implying that *Safe at Home* was able to find the right mix of supports for those youth. Alternatively, youth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

Figure 20. Random Forest and Regression Analyses for Youth Moving Out of County



When the random forest and regression analyses were run on the youth returning to their home county (Figure 21), it was found that youth removed due to their own behavior problems were significantly more likely to return to their home county, suggesting *Safe at Home* was working for the target population. Youth who were served in Region 4 also had a significantly higher chance of returning to their home county. Youth with a larger number of prior placements, who received clothing assistance, or had an Axis 1 diagnosis were significantly less likely to return to their home county.

Figure 21. Random Forest and Regression Analyses for Youth Returning to Their Home County



Foster Care

Safe at Home aimed to reduce the need for any type of placement outside the home. Table 12 examines initial entry into foster care for those youth who were referred while living in their own homes. Results for youth in the treatment and comparison groups, at both six and 12 months following referral, were similar for Cohorts 1, 3, and 6. Cohorts 4, 5, and 7's *Safe at Home* youth were significantly ($p<0.05$) more likely to enter foster care than comparison youth. In general, youth in the treatment group were significantly ($p < 0.01$) more likely to enter foster care than comparison group youth.

There are two possible explanations for these results; first, it is possible that some of the characteristics of the comparison group population were different from the treatment group population. It is not possible, for instance, to identify youth in the comparison group who *are likely* to have a behavioral health diagnosis or condition. Alternatively, the increased intensity of services and oversight of the *Safe at Home* youth and families may have led to more frequent identification of issues necessitating removal.

Table 12. Initial Foster Care Entries

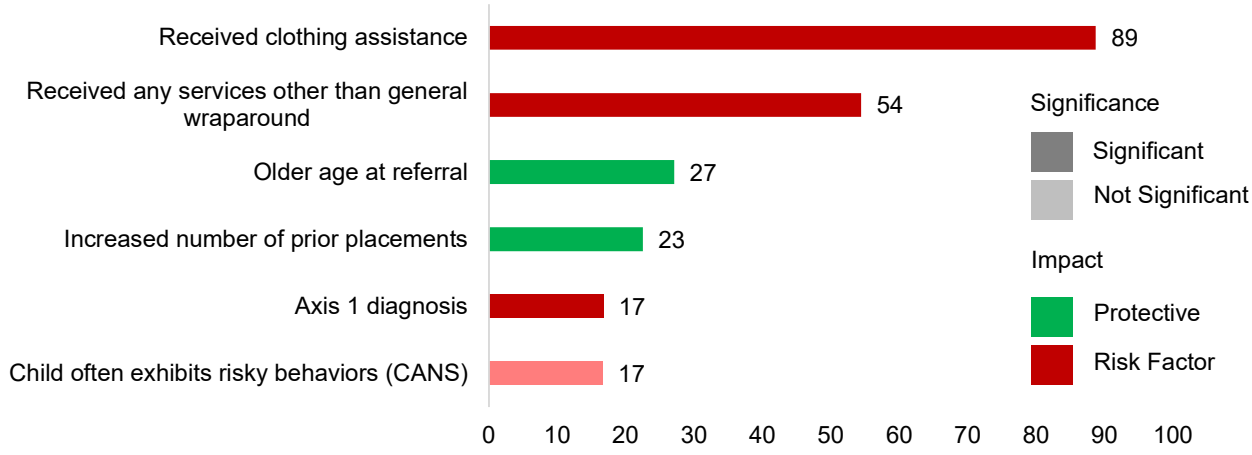
Cohort	Group	Denominator	% Entry at 6 Months	% Entry at 12 Months
1	Treatment	46	28%	33%
	Comparison	47	28%	30%
2	Treatment	101	15%	32%
	Comparison	103	23%	16%
3	Treatment	205	23%	22%
	Comparison	197	22%	20%
4	Treatment	333	20%	22%
	Comparison	312	14%	13%
5	Treatment	387	20%	22%
	Comparison	383	15%	15%
6	Treatment	367	16%	21%
	Comparison	375	14%	12%

Cohort	Group	Denominator	% Entry at 6 Months	% Entry at 12 Months
7	Treatment	413	20%	–
	Comparison	397	13%	–
Overall	**Treatment**	**1,852**	**20%**	**23%**
	Comparison	**1,814**	**16%**	**15%**

Within six and 12 months of referral to *Safe at Home,* CPS youth were more likely to enter foster care than youth involved with Youth Services. A third of the CPS youth entered foster care within 12 months of referral compared to 21 percent of those known to Youth Services.

The random forest and regression analyses show that youth receiving clothing assistance or other services or with an Axis 1 diagnosis, where such data were available, were far more likely to be placed into substitute care when beginning *Safe at Home* in their own home. If youth had a higher number of prior placements (meaning they were removed and returned to the home prior to *Safe at Home* referral) or were older at the time of referral, they were more likely to remain in the home.

Figure 22. Random Forest and Regression Analyses for Initial Foster Care Entry



Foster care re-entry was examined (Table 13) in addition to initial entry into foster care. The denominator for this measure is youth who were discharged from foster care within 12 months of referral to *Safe at Home*. *Safe at Home* youth generally re-entered foster care at a significantly ($p < 0.01$) higher rate than comparison youth across all cohorts at both six and 12 months. Cohort analysis results were statistically significant at six months for Cohort 2 ($p < 0.05$) and the 12-month result for Cohort 4 ($p < 0.01$).

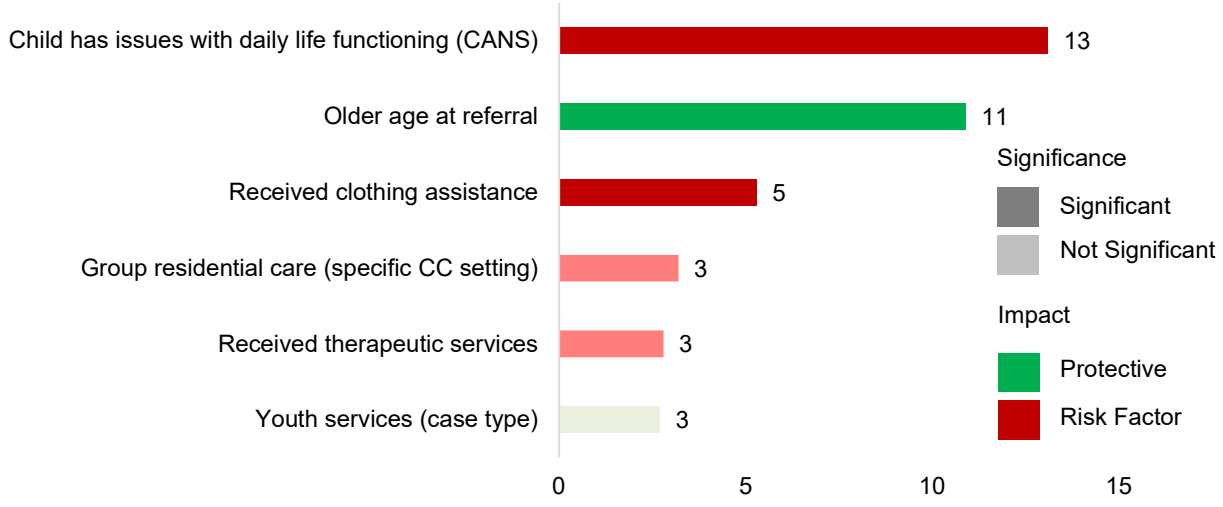
Table 13. Foster Care Re-Entry Rates

Cohort	Group	Denominator	% Re-Entered at 6 Months	% Re-Entered at 12 Months
1	Treatment	43	16%	16%
	Comparison	31	6%	6%
2	Treatment	77	26%	21%
	Comparison	60	10%	10%
3	Treatment	84	19%	23%
	Comparison	62	15%	15%
4	Treatment	122	23%	20%
	Comparison	80	10%	5%
5	Treatment	131	21%	20%
	Comparison	89	7%	15%
6	Treatment	80	11%	–
	Comparison	75	8%	–
Overall	**Treatment**	**537**	**20%**	**20%**
	Comparison	**397**	**9%**	**11%**

Here as well, Youth Services youth fared better than CPS youth. A third of the CPS youth incurred a subsequent removal within 12 months of discharge as compared to 19 percent of youth known to Youth Services.

Figure 23, displaying the random forest and regression analyses, highlights that those youth who were older at the time of referral were significantly less likely to re-enter care. Youth who received clothing assistance or had a larger number of actionable Life Functioning domain CANS items were significantly more likely to re-enter care.

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



When youth did enter foster care, relative placements played a critical role in minimizing trauma for youth. Due to the small sample size, the results displayed in Table 14 are reported for the full population of treatment and comparison youth instead of by cohort. When youth were placed in foster homes, *Safe at Home* youth were significantly more likely to be placed in a relative home at both six and 12 months (both at $p < 0.01$) than were comparison youth.

Table 14. Percentage of Youth Placed in Relative Homes

Group	Denominator	% in Relative Home at 6 Months	% in Relative Home at 12 Months
Treatment	178	66%	68%
Comparison	194	28%	30%

Placement stability was also considered when examining outcomes related to foster care. Table 15 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 12 months of referral was measured. Outcomes were calculated for Cohorts 1 through 6. *Safe at Home* youth in Cohorts 1 and 3 experienced more placement stability than their comparison counterparts. There was no difference in the rate of placement stability between comparison youth and *Safe at Home* youth in Cohort 4, and *Safe at Home* youth in Cohorts 2, 5, and 6 experienced more 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. Overall, a slightly higher percentage of *Safe at Home* youth experienced placement instability than comparison group youth.

Table 15. Foster Care Placement Stability

Cohort	Group	N Youth Referred Out-of-Home	% Youth with 3+ Moves in 12 Months
1	Treatment	81	32%
	Comparison	78	37%
2	Treatment	124	43%
	Comparison	120	31%
3	Treatment	98	23%
	Comparison	105	27%
4	Treatment	130	28%
	Comparison	134	28%
5	Treatment	138	30%
	Comparison	133	24%
6	Treatment	103	30%
	Comparison	93	24%
Overall	**Treatment**	**674**	**31%**
	Comparison	**663**	**28%**

The percentage of CPS youth who had more than three placement moves within 12 months of being referred to *Safe at Home* is more than double the percentage of Youth Services youth who did not satisfy the federal placement stability criteria (47% and 22%, respectively).

Another way in which foster care outcomes were examined was to look at the rates of reunification (Table 16) within six- and 12-months following referral to *Safe at Home*. Overall, youth in the treatment group were significantly more likely to reunify within both six and 12 months than youth in the comparison groups ($p < 0.01$). This was highly significant across all cohorts within six months ($p < 0.01$). Within 12 months all results were significant, but the significance level varied (between $p < 0.05$ for Cohorts 1 and 2 and $p < 0.01$ for Cohorts 3, 4, and 5).

Table 16. Reunification Rates

Cohort	Group	N Out-of-Home	% Reunified within 6 Months	% Reunified within 12 Months
1	Treatment	78	35%	47%
	Comparison	77	14%	29%
2	Treatment	120	40%	49%
	Comparison	118	16%	36%
3	Treatment	92	52%	61%
	Comparison	100	17%	32%
4	Treatment	112	53%	60%
	Comparison	133	17%	35%
5	Treatment	125	50%	58%
	Comparison	129	17%	35%
6	Treatment	96	45%	51%
	Comparison	88	24%	38%
7	Treatment	99	36%	–
	Comparison	115	17%	–
Overall	**Treatment**	**722**	**45%**	**55%**
	Comparison	**760**	**17%**	**34%**

The rate of reunification within 12 months of referral was substantially higher for youth involved in Youth Services. Sixty-two percent of Youth Services youth reunified with their families within 12 months of referral as compared to only 14 percent of CPS youth.

In general, *Safe at Home* youth were more likely to have an initial entry into the foster care system or re-enter the system than comparison group youth. While it is difficult to pinpoint what is driving the differences, it is possible youth in the comparison group were less likely to have a mental health diagnosis or elevated behavioral health issue. The result is also potentially due to the increased intensity of the services provided to treatment youth, with Wraparound facilitators working more closely with youth and their families and providing greater opportunity to identify family issues. Once in foster care, *Safe at Home* youth were significantly more likely to be placed with a relative and be reunified with their biological family or relatives than comparison group youth.

Maltreatment

Safe at Home also strived to increase the safety of youth by reducing the rate of maltreatment/repeat maltreatment. Table 17 displays the number of youth with a maltreatment referral subsequent to their referral to *Safe at Home* and the number for which that referral led to a substantiation of maltreatment.

For Cohorts 1 through 4, *Safe at Home* youth experienced fewer maltreatment referrals within six and 12 months of their referral to the program than comparison youth. Slightly more maltreatment referrals were made for *Safe at Home* youth than comparison youth in Cohorts 5, 6 and 7 within six months of referral to the program. The numbers of substantiated maltreatment referrals were minimal, but when they did occur, it was only *Safe at Home* youth who received a substantiation. In total, eight *Safe at Home* youth received a new substantiation within 12 months. Assuming the eight youth are limited to CPS involved youth, the rate of repeat maltreatment within 12 months was no more than two percent.

Table 17. Youth with New Referrals and/or Substantiations

Cohort	Group	Referral within 6 Months	Substantiation within 6 Months	Referral within 12 Months	Substantiation within 12 Months
1	Treatment	3	0	3	0
	Comparison	15	0	22	0
2	Treatment	24	0	30	0
	Comparison	32	0	42	0
3	Treatment	29	0	46	1
	Comparison	33	0	48	0
4	Treatment	43	1	71	1
	Comparison	49	0	70	0
5	Treatment	63	0	83	2
	Comparison	57	0	80	0
6	Treatment	54	2	74	4
	Comparison	46	0	65	0
7	Treatment	70	2	–	–
	Comparison	51	0	–	–
Overall	**Treatment**	**286**	**5**	**307**	**8**
	Comparison	**283**	**0**	**327**	**0**

Summary of Safety and Permanency Outcome Evaluation Results

The biggest success for *Safe at Home* was in returning many of the youth who had been in congregate care placement to their communities. West Virginia was also able to expand the program and shift to a prevention focus. Eligibility was expanded to include youth ages 12 to 17 with a behavioral or mental health diagnosis placed or at-risk of being placed in congregate care to include at-risk youth who *possibly* had a behavioral or mental health diagnosis.

Overall, *Safe at Home* outcomes followed an interesting pattern where treatment youth performed better than their comparison groups for the first six months, but the successes dissipated by twelve months. As noted in the limitations section, there were no data for youth in the comparison group with *possible* mental health diagnoses which may have influenced the result, limiting the similarities between the treatment and comparison youth for this characteristic. Consequently, it is not possible to know if the severity of mental health issues explains the lack of difference in results a year after service begins.

The stepwise regression analyses highlighted which populations the program did and did not work well. Youth with an Axis 1 diagnosis or who received other supports were at higher risk of not achieving favorable outcomes than youth without a diagnosis. Conversely, *Safe at Home* appeared to work well for older youth. Additionally, *Safe at Home* youth referred while placed in congregate care showed more favorable outcomes than comparison group youth referred while in such a setting. Lastly, the program was more successful for youth involved in Youth Services than CPS youth.

Well-Being

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

Wraparound facilitators from the LCAs administered CANS assessments to youth in *Safe at Home*. Once the assessments were completed, they were entered into the online WV CANS database. Per policy, youth in the program were to have an initial CANS assessment completed within 30 days of referral and subsequent CANS were to be completed every 90 days thereafter. There were no CANS available for youth in the comparison groups; thus, the analysis for the well-being measures are limited to pre/post comparisons of the CANS assessments for *Safe at Home* youth only.

The results of the initial CANS assessments for youth from Cohorts 1 through 6 were compared to those completed at six and 12 months post-initial CANS to measure progress while in the program, with the results limited to six months for youth in Cohort 7. Progress was measured by the extent to which scores improved, meaning the number of needs/actionable items reduced over time. Additionally, a comparison of CANS

improvements, distinguishing the results between CPS and Youth Services youth, is also provided.

As shown in Table 18, the count of CANS assessments available for analysis became more limited as more time elapsed after the youth's entry into *Safe at Home*. This was due to a closure of *Safe at Home* cases prior to six or 12 months.

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

Factors	C1	C2	C3	C4	C5	C6	C7
Number of youth with an initial CANS assessment	107	196	254	387	436	389	382
Number of youth with a 6-month follow-up CANS	69	107	132	223	228	183	69
Number of youth discharged before a 6-month follow-up CANS could be performed	26	57	71	111	134	132	141
Number of youth where not enough time has passed before a 6-month CANS can be performed	0	0	0	0	0	1	38
Number of youth where enough time has passed, and no 6-month CANS was performed	12	32	51	53	74	73	134
Number of youth with a 12-month follow-up CANS	31	52	61	109	106	39	7
Number of youth discharged before a 12-month follow-up CANS could be performed	71	120	157	222	179	265	174
Number of youth where not enough time has passed before a 12-month CANS can be performed	0	0	0	2	4	12	200
Number of youth where enough time has passed, and no 12-month CANS was performed	5	24	36	54	147	73	1

Table 19 provides an overview of the percentage of youth who had at least one need/actionable item selected in the CANS, by domain, during the initial assessment. Life Domain Functioning was consistently the domain with the highest percentage of youth who had a need at the time of the initial assessment, hovering around 90 percent for all cohorts. The other three domains (*i.e.*, Child Behavioral/Emotional Needs, Child Risk Behaviors, and Trauma Stress Symptoms) showed a decreasing percentage of youth with these needs over time, which is likely due to the shift in *Safe at Home*'s focus to prevention.

Table 19. Percentage of Youth with a Need on Initial CANS

CANS Domain	C1 (107)	C2 (196)	C3 (254)	C4 (387)	C5 (436)	C6 (389)	C7 (382)	Overall (2,151)
Child Behavioral/Emotional Needs (13 items)	83%	78%	69%	68%	67%	63%	62%	63%
Child Risk Behaviors (13 items)	47%	42%	35%	37%	32%	28%	25%	31%
Life Domain Functioning (19 items)	93%	92%	91%	90%	90%	89%	91%	86%
Trauma Stress Symptoms (12 items)	50%	41%	32%	28%	34%	29%	28%	31%

Table 20 shows the percentage of youth who had a six or 12-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). Overall, more than half of the youth exhibited improvement in each domain at six and 12 months; in fact, this statement holds true for over two-thirds of youth with a 12-month follow-up.

The only instances where improvement was below 50 percent was at six months for Cohorts 1 and 4 in the Trauma Stress Symptoms domain. However, by 12 months more than 60 percent of the youth in both cohorts showed a reduction in their needs related to the Trauma Stress Symptoms. Interestingly, Youth Services youth showed a significantly higher improvement at six months for this domain than youth involved with CPS (56% to 43%; $p < 0.05$).

Table 20. Percentage of Youth with Improved Scores

CANS Domain	% Improved at 6 Months	% Improved at 12 Months
Cohort 1		
Child Behavioral/Emotional Needs	50%	73%
Child Risk Behaviors	55%	71%
Life Domain Functioning	59%	82%
Trauma Stress Symptoms	40%	57%
Cohort 2		
Child Behavioral/Emotional Needs	58%	72%
Child Risk Behaviors	64%	80%
Life Domain Functioning	66%	77%
Trauma Stress Symptoms	59%	71%
Cohort 3		
Child Behavioral/Emotional Needs	54%	58%
Child Risk Behaviors	64%	67%
Life Domain Functioning	63%	70%
Trauma Stress Symptoms	58%	61%
Cohort 4		
Child Behavioral/Emotional Needs	57%	65%
Child Risk Behaviors	53%	57%
Life Domain Functioning	69%	73%
Trauma Stress Symptoms	49%	69%
Cohort 5		
Child Behavioral/Emotional Needs	65%	73%
Child Risk Behaviors	64%	73%
Life Domain Functioning	67%	77%
Trauma Stress Symptoms	50%	77%
Cohort 6		
Child Behavioral/Emotional Needs	59%	61%
Child Risk Behaviors	64%	89%
Life Domain Functioning	71%	72%

CANS Domain	% Improved at 6 Months	% Improved at 12 Months
Trauma Stress Symptoms	53%	64%
Cohort 7		
Child Behavioral/Emotional Needs	42%	–
Child Risk Behaviors	67%	–
Life Domain Functioning	61%	–
Trauma Stress Symptoms	75%	–
Overall		
Child Behavioral/Emotional Needs	58%	67%
Child Risk Behaviors	61%	68%
Life Domain Functioning	67%	75%
Trauma Stress Symptoms	53%	69%

While the results are similar for Youth Services and CPS youth, a higher proportion of Youth Services involved youth demonstrated improvement in two domains when compared to CPS youth. The first is the Life Functioning Domain with 76 percent of Youth Services youth demonstrating improvement within 12 months of referral compared to 69 percent of CPS youth. The other is Symptoms of Trauma with 71 percent of Youth Services youth having observed improvement within 12 months as compared to 64 percent of CPS youth.

As noted earlier, in addition to the main CANS domains, there were triggered sub-modules which dove deeper for several topics where youth identified needs. Table 21 provides the percentage of youth who triggered a sub-module in the initial CANS assessment. The submodules which were most commonly triggered across cohorts were Delinquent Behavior followed by Substance Use. The Adolescent Suicide sub-module saw the greatest reduction in use over time. When comparing Youth Services and CPS youth, there was little difference in which submodules they triggered with the exception that Youth Services youth had a significantly higher likelihood of triggering the Delinquent Behavior submodule than CPS youth (54% to 37%; $p < 0.05$).

Table 21. Percentage of Youth with Triggered Sub-Modules

Submodule	C1 (107)	C2 (196)	C3 (254)	C4 (387)	C5 (436)	C6 (389)	C7 (382)	Overall (2,151)
Adolescent Suicide	13%	10%	5%	6%	5%	4%	4%	5%
Child Suicide	1%	1%	1%	1%	1%	1%	1%	1%
Commercial Sexual Exploitation	1%	0%	2%	1%	1%	1%	0%	1%
Children's Sexual Behaviors	12%	12%	9%	11%	11%	7%	7%	8%
Delinquent Behavior	50%	44%	54%	52%	52%	51%	47%	42%

Submodule	C1 (107)	C2 (196)	C3 (254)	C4 (387)	C5 (436)	C6 (389)	C7 (382)	Overall (2,151)
Fire-Setting	1%	1%	1%	3%	1%	1%	1%	1%
LGBTQ	4%	2%	4%	5%	3%	5%	5%	3%
Sexually Abusive	18%	13%	13%	14%	11%	9%	9%	10%
Substance Use	26%	27%	28%	29%	31%	26%	24%	23%

Family Functioning

Progress in family functioning was calculated by using the Family Functioning domain of the CANS which was further broken out into the specific items within that domain (Table 22). The most common Family Functioning need on the initial assessment was Family Stress followed by Residential Stability; this finding was consistent across cohorts. Of those with a CANS assessment at six-months, 42 percent showed improved Family Stress scores as well as 52 percent on Residential Stability scores. Though the number of 12-month assessments was limited, when looking at the entire Family Functioning domain, 51 percent of youth showed an improvement from the initial CANS to the 12-month follow-up. A comparison of Youth Services to CPS involved youth shows that youth involved with CPS had a slightly higher percentage of youth with improved family functioning than Youth Services youth.

Table 22. Youth with Improved Family Functioning

CANS Item	N with Need on Initial CANS	N with 6 Month CANS	N Improved at 6 Months	N with 12 Month CANS	N Improved at 12 Months
Cohort 1					
Physical Health	5	1	1	1	1
Mental Health	2	2	0	1	1
Substance Use	1	1	1	1	1
Family Stress	27	23	13	12	8
Residential Stability	8	5	4	3	2
Total	**32**	**24**	**14**	**13**	**9**
Cohort 2					
Physical Health	17	10	2	7	2
Mental Health	5	1	1	1	1
Substance Use	5	4	2	3	1
Family Stress	29	16	5	7	4
Residential Stability	13	5	1	3	2
Total	**49**	**27**	**7**	**14**	**6**
Cohort 3					
Physical Health	7	2	1	2	1
Mental Health	10	4	2	2	1
Substance Use	3	2	0	1	1
Family Stress	35	20	8	13	6

CANS Item	N with Need on Initial CANS	N with 6 Month CANS	N Improved at 6 Months	N with 12 Month CANS	N Improved at 12 Months
Residential Stability	17	10	4	7	5
Total	**46**	**25**	**10**	**16**	**8**
Cohort 4					
Physical Health	10	5	1	3	1
Mental Health	9	5	0	3	0
Substance Use	6	3	2	1	1
Family Stress	57	33	15	17	8
Residential Stability	20	13	7	5	3
Total	**75**	**42**	**21**	**21**	**11**
Cohort 5					
Physical Health	22	14	5	8	4
Mental Health	15	9	4	4	2
Substance Use	13	8	4	1	1
Family Stress	50	31	10	18	5
Residential Stability	19	12	7	4	2
Total	**83**	**51**	**21**	**24**	**12**
Cohort 6					
Physical Health	19	12	2	2	1
Mental Health	5	3	2	1	1
Substance Use	6	4	1	2	1
Family Stress	39	24	8	2	1
Residential Stability	20	6	3	1	0
Total	**72**	**34**	**11**	**6**	**2**
Cohort 7					
Physical Health	13	2	0	–	–
Mental Health	3	0	–	–	–
Substance Use	5	1	1	–	–
Family Stress	34	7	5	–	–
Residential Stability	19	3	2	–	–
Total	**55**	**10**	**6**	**–**	**–**
Overall					
Physical Health	125	50	12	23	10
Mental Health	60	24	9	12	6
Substance Use	50	24	12	9	6
Family Stress	341	164	69	75	35
Residential Stability	143	58	30	28	16
Total	**528**	**230**	**97**	**104**	**53**

Educational Functioning

Similar to the analysis of family functioning, an analysis of educational functioning drew on the use of CANS data to identify the areas of challenge and improvement for youth in *Safe at Home*. Educational functioning items fell within the Life Domain Functioning and

Trauma Stress Symptoms CANS domains and were inclusive of four specific items: School Achievement, School Attendance, School Behavior, and School Violence. Results for educational functioning items are displayed in Table 23.

The most common educational functioning need on the initial assessment was School Achievement followed by School Behavior. The most improved item was School Attendance from the time of the initial CANS to that of the six- and 12-months assessments with roughly 70 percent of youth across the cohorts demonstrating improvement. Overall, school-based needs were reduced by 57 percent at six months and by 66 percent at 12 months.

Comparing Youth Services youth to CPS involved youth, those youth who were involved with Youth Services showed a significantly higher percentage of improvement in School Attendance than CPS youth at six months (72% to 58%; $p < 0.05$); however, CPS youth showed a modestly higher improvement on School Behavior than Youth Services youth at six months (60% to 51%) and at 12 months (84% to 59%; $p < 0.05$).

Table 23. Youth with Improved Educational Functioning

CANS Item	N with Need on Initial CANS	N with 6 Month CANS	% Improved at 6 Months	N with 12 Month CANS	% Improved at 12 Months
Cohort 1					
School Achievement	22	12	40%	6	33%
School Attendance	14	6	100%	4	100%
School Behavior	33	24	32%	14	50%
School Violence	11	4	0%	1	0%
Total	**56**	**33**	**41%**	**17**	**59%**
Cohort 2					
School Achievement	45	32	61%	21	71%
School Attendance	31	20	67%	9	67%
School Behavior	50	32	62%	15	80%
School Violence	18	11	27%	5	20%
Total	**93**	**61**	**59%**	**30**	**67%**
Cohort 3					
School Achievement	73	37	51%	22	55%
School Attendance	49	27	71%	17	71%
School Behavior	53	30	68%	16	81%
School Violence	17	7	22%	3	67%
Total	**123**	**61**	**65%**	**35**	**77%**
Cohort 4					
School Achievement	100	60	49%	32	53%
School Attendance	82	51	72%	30	73%
School Behavior	90	55	54%	39	62%
School Violence	21	14	6%	7	14%
Total	**180**	**111**	**58%**	**64**	**66%**

CANS Item	N with Need on Initial CANS	N with 6 Month CANS	% Improved at 6 Months	N with 12 Month CANS	% Improved at 12 Months
Cohort 5					
School Achievement	136	64	60%	41	63%
School Attendance	90	43	68%	32	66%
School Behavior	114	54	54%	39	69%
School Violence	38	20	17%	8	25%
Total	**236**	**121**	**57%**	**72**	**68%**
Cohort 6					
School Achievement	124	38	46%	17	59%
School Attendance	97	34	62%	14	57%
School Behavior	102	28	47%	12	58%
School Violence	26	4	9%	2	0%
Total	**211**	**57**	**51%**	**25**	**56%**
Cohort 7					
School Achievement	134	31	52%	-	-
School Attendance	78	15	67%	-	-
School Behavior	110	23	57%	-	-
School Violence	30	7	43%	-	-
Total	**234**	**49**	**61%**	**-**	**-**
Overall					
School Achievement	1,007	389	53%	153	59%
School Attendance	706	284	70%	116	70%
School Behavior	868	348	54%	147	67%
School Violence	242	103	17%	33	24%
Total	**1,784**	**707**	**57%**	**268**	**66%**

Summary of Well-Being Outcome Evaluation Results

Across the child well-being outcomes, a high percentage of youth showed improvement at six and 12 months after the initial CANS assessment. In particular, education related items showed a large improvement for school attendance, achievement, and behavior. Additionally, youth exhibited fewer actionable items in subsequent CANS assessments across the four domains, as shown in Table 23, from the time of the initial CANS to those completed six and 12 months later. The items that demonstrated the least amount of growth were family stress and school violence.

Cost Evaluation

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

Cost Evaluation Questions

1. **Are the costs of providing the Waiver services to a youth and family less than those provided before the Waiver demonstration?**
2. **How does *Safe at Home* alter the use of federal funding sources as well as state and local funds?**
3. **What is the cost effectiveness of the program?**
4. **Is the project cost neutral?**

Data Sources and Data Collection

The cost analysis uses placement and payment data contained within FACTS to compare the costs of out-of-home care and fee-for-services for those incurred for youth in the treatment group to those in the comparison group. Dates of enrollment in *Safe at Home* are used to measure the contracted costs for services provided by the Wraparound providers. The data sources, however, do not provide enough data to answer the second and fourth questions; there, the cost evaluation is limited to answering the first and third questions.

Data Analysis and Results

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 6. It also provides a glimpse of the contracted costs for services provided by the LCAs.

When the cost evaluation was first completed, a daily rate for room and board expenditures was developed using costs incurred by youth in Cohort 1's comparison group (Table 24). The cost of providing out-of-home care to youth in the comparison cohort was calculated, limiting the cost to the first 365 days of substitute care for those who remained out of the home longer than one year following the date they qualified for inclusion in the comparison group. This limitation was applied to ensure that the same amount of time was applied to the review of costs for the treatment and comparison groups. Those costs were then used to compute an average daily rate which has continued to be used for the cost evaluation. With rates subject to change year to year, it is important that a standard rate be developed and applied to eliminate the impact of rate increases and, thus, avoid the inappropriate appearance of *Safe at Home* costs being higher just because of rate increases.

Table 24. Daily Rates Calculated Using Cohort 1's Comparison Group

Placement Setting	Cost
Out-of-State Residential Care	$239.91
In-State Residential Care	$161.95
Shelter Care	$150.17
Therapeutic/Specialized Foster Care	$57.29
Family Foster or Relative Care	$21.47

The resulting rates are then applied to the number of days youth were in out-of-home placement, applying the rate for each placement setting to the days they were in such a setting. The analysis is limited to the first year following enrollment in *Safe at Home* for comparative purposes. As illustrated in Table 25 and limiting the analysis to the cohorts where 12 months have passed since referral, *Safe at Home* generated a cost savings of over $6.8 million for room and board expenditures for youth in the first six treatment cohorts with respect to the comparison cohorts. The savings were largely the result of reducing the number of days youth spent in residential care, both in-state and out-of-state.

Table 25 also includes the average cost of room and board per youth placed in substitute care for each cohort. The average cost for youth in the comparison group fluctuated from cohort to cohort, with an overall average of rate at roughly $18,400 per youth across the six-month review periods. Conversely, the average cost for youth in the treatment group consistently decreased for each subsequent cohort, with the exception of Cohort 6, resulting in an average rate per youth of roughly $13,600 overall.

Table 25. Cost of Room and Board Payments

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

Placement Setting	Comparison Group	Treatment Group
Average Cost per Youth	**$23,549.17**	**$15,851.48**
Cohort 3		
Out-of-State Residential Care	$1,167,654.73	$499,498.08
In-State Residential Care	$3,254,784.08	$1,969,618.25
Shelter Care	$361,311.11	$463,727.65
Therapeutic/Specialized Foster Care	$76,594.24	$76,365.09
Family Foster or Relative Care	$64,062.38	$73,980.89
Totals	**$4,924,406.55**	**$3,083,252.95**
Average Cost per Youth	**$16,580.49**	**$10,381.32**
Cohort 4		
Out-of-State Residential Care	$1,022,027.77	$758,363.80
In-State Residential Care	$3,914,421.62	$2,925,208.25
Shelter Care	$527,400.09	$716,915.73
Therapeutic/Specialized Foster Care	$192,144.42	$70,177.97
Family Foster or Relative Care	$110,584.90	$81,623.72
Totals	**$5,766,578.80**	**$4,522,289.47**
Average Cost per Youth	**$12,958.60**	**$10,229.86**
Cohort 5		
Out-of-State Residential Care	$1,053,216.41	$640,566.70
In-State Residential Care	$3,628,087.43	$2,978,976.88
Shelter Care	$735,837.26	$765,120.58
Therapeutic/Specialized Foster Care	$180,400.35	$147,860.69
Family Foster or Relative Care	$128,554.14	$162,174.01
Totals	**$5,726,095.59**	**$4,694,698.86**
Average Cost per Youth	**$11,183.78**	**$9,169.33**
Cohort 6		
Out-of-State Residential Care	$551,559.12	$487,502.45
In-State Residential Care	$2,483,236.52	$2,021,992.30
Shelter Care	$395,249.73	$577,256.82
Therapeutic/Specialized Foster Care	$241,183.06	$98,134.58
Family Foster or Relative Care	$125,290.91	$181,195.22
Totals	**$3,796,519.34**	**$3,366,081.37**
Average Cost per Youth	**$22,733.35**	**$17,173.68**
Overall		
Totals	**$28,342,501.53**	**$21,541,989.94**
Average Cost per Youth	**$18,431.72**	**$13,616.12**

Fee-for-services costs *(e.g.*, case management, maintenance, services) were also examined to determine if *Safe at Home* was having a positive impact in reducing expenditures incurred by West Virginia to meet the needs of youth (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 was nearly $1.6 million less than the comparison group. Education expenditures

accounted for the largest proportion of fee-for-service costs followed by Other. Several service categories (*e.g.*, Assessment, Case Management) were not incurred for *Safe at Home* youth since they were Administrative Services Organization (ASO) payments which were included in the contracted Wraparound services with the LCAs.

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
Total	**$184,701.91**	**$89,003.56**
Cohort 2		
Assessment	$27,713.50	$502.75
Case Management	$22,379.00	$0.00
Clothing	$22,263.16	$21,766.79
Education	$46,955.66	$32,210.19
Independent Living	$35,037.13	$11,376.92
Legal	$1,555.91	$851.34
Maintenance	$24,586.75	$0.00
Other	$6,448.34	$34,460.20
Services	$22,486.57	$3,130.60
Supervised Visitation	$6,282.38	$0.00
Transportation	$37,641.24	$0.00
Total	**$253,349.64**	**$104,298.79**
Cohort 3		
Assessment	$37,260.00	$0.00
Case Management	$29,668.00	$0.00
Clothing	$26,999.30	$18,149.27
Education	$50,550.72	$1,360.00
Independent Living	$28,022.63	$1,850.00
Legal	$248.28	$0.00
Maintenance	$25,100.60	$373.60
Other	$22,867.51	$22,383.79
Services	$28,192.58	$3,228.98
Supervised Visitation	$4,290.00	$0.00
Transportation	$41,209.24	$0.00

Service Category	Comparison Group	Treatment Group
Total	**$294,408.86**	**$47,345.64**
Cohort 4		
Assessment	$44,910.00	$0.00
Case Management	$43,610.00	$0.00
Clothing	$38,116.07	$29,384.36
Education	$61,177.92	$41,944.05
Independent Living	$35,429.04	$2,287.84
Legal	$492.86	$1,080.56
Maintenance	$31,683.50	$5,031.11
Other	$21,194.65	$35,611.96
Services	$48,300.28	$651.36
Supervised Visitation	$9,024.00	$0.00
Transportation	$61,990.00	$0.00
Total	**$395,928.32**	**$115,991.24**
Cohort 5		
Assessment	$74,700.00	$0.00
Case Management	$72,716.00	$0.00
Clothing	$45,989.21	$30,265.73
Education	$91,884.44	$54,534.50
Independent Living	$43,357.72	$2,799.57
Legal	$954.16	$618.79
Maintenance	$24,086.76	$673.61
Other	$21,542.39	$43,995.42
Services	$95,585.17	$0.00
Supervised Visitation	$11,238.00	$0.00
Transportation	$78,544.47	$0.00
Total	**$560,598.32**	**$132,887.62**
Cohort 6		
Assessment	$61,470.00	$0.00
Case Management	$62,697.23	$0.00
Clothing	$31,979.51	$26,248.40
Education	$102,062.87	$13,515.66
Independent Living	$21,291.38	$1,907.43
Legal	$185.48	$190.50
Maintenance	$20,028.91	$1,135.85
Other	$18,037.86	$17,927.54
Services	$57,894.08	$2,323.39
Supervised Visitation	$9,322.00	$0.00
Transportation	$61,533.03	$0.00
Total	**$446,502.35**	**$63,248.77**
Overall		
Total	**$2,135,489.40**	**$552,775.62**

Contracted costs to provide Wraparound services were also examined. A daily case rate of $136 was paid to the LCAs to provide assessments, case management, and supervision for treatment youth, as well as to provide services that were traditionally not funded by the agency. Using the number of days youth were enrolled in *Safe at Home*, roughly $30.7 million was incurred to provide services to enrolled youth between October 1, 2015 and September 2018. These costs equate to an average cost of $41,397 per youth in Cohorts 1 through 6.

Close to one million dollars of the $30.7 million would have been incurred by DHHR if *Safe at Home* had not been implemented. That is, costs would have been incurred for assessments, case management, supervised visitation and transportation had the Waiver initiative not been implemented. Interviewed DHHR staff suggested some of the costs of Wraparound services were likely offset by caseworkers who spent less time on *Safe at Home* cases since Wraparound facilitators were providing such intensive services for youth/families.

A summary of the costs is provided in Table 27 which breaks out the cost per youth for both *Safe at Home* and the comparison groups per year. In general, *Safe at Home* costs roughly $41,400 per youth per year compared to $14,800 per youth per year for the comparison group, a difference of roughly $26,600 per youth per year. When only room and board and fee-for-services are considered, *Safe at Home* saved DHHR nearly $4,065 per youth per year.

Table 27. Total Cost Per Youth Per Year

Cohort	Number of Youth	Room and Board Costs	Fee-for-Service Costs	Wraparound Costs	Cost per Youth
Safe at Home					
1	124	$18,891.04	$717.77	$33,271.74	$52,880.56
2	221	$15,851.48	$471.94	$32,997.54	$49,320.96
3	297	$10,381.32	$159.41	$29,995.56	$40,536.29
4	445	$10,229.86	$260.65	$29,860.71	$40,351.23
5	512	$9,169.33	$259.55	$29,999.16	$39,428.04
6	463	$7,270.15	$136.61	$30,867.01	$38,273.77
Total	**2,062**	**$10,447.13**	**$268.08**	**$30,681.78**	**$41,397.00**
Comparison					
1	124	$23,584.95	$1,489.53	$0.00	$25,074.48
2	221	$23,549.17	$1,146.38	$0.00	$24,695.55
3	297	$16,580.49	$991.28	$0.00	$17,571.77
4	445	$12,958.60	$889.73	$0.00	$13,848.33
5	512	$11,183.78	$1,094.92	$0.00	$12,278.70
6	463	$8,199.83	$964.37	$0.00	$9,164.19
Total	**2,062**	**$13,745.15**	**$1,035.64**	**$0.00**	**$14,780.79**

Summary of Cost Evaluation Results

The program generated a cost savings of $6.8 million in room and board costs and a savings of close to $1.6 million for fee-for-services for treatment youth in Cohorts 1 through 6. The most significant portion of the savings can be attributed to the reduced time youth spent in congregate care placements. However, as noted above, costs to contract with Wraparound service providers averaged $30,682 per youth per year.

When the amounts incurred to contract for Wraparound is combined with the savings incurred for room and board as well fee-for-service costs, overall *Safe at Home* costs DHHR roughly $26,600 more per youth per year than the cost of serving youth traditionally. These costs may have been partially mitigated by less DHHR caseworker time spent on *Safe at Home* cases and the costs paid to the LCAs for case management and other services directly provided.

Recommendations

Over the last 12 to 18 months, DHHR has focused its attention on identifying strategies to sustain the Wraparound model post-Waiver and has even considered expanding the National Wraparound Initiative model to serve children under the age of 12. Given a Memorandum of Understanding West Virginia has with the U.S. Department of Justice to continue focused work with youth, it is important for DHHR to identify ways to sustain the Wraparound model at least for those involved with Youth Services.

West Virginia recently received federal grant monies to implement Wraparound to serve individuals with a Serious Emotional Disturbance and the State is supporting a smaller Wraparound initiative focusing on children with a behavioral health issue, helping them to get the services they need before they come to the attention of BCF. The focus of the recommendations, which follow, offer steps West Virginia can implement to sustain *Safe at Home* from a financial perspective using both traditional Title IV-E dollars and those being made available through the Family First Prevention Services Act.

Funding

A portion of the costs to serve *Safe at Home* youth will be captured using traditional Title IV-E reimbursement. DHHR has placed a fair amount of emphasis on improving its ability to document Title IV-E eligibility for children and youth who come into care, increasing the State's penetration rate by a substantial margin. Those efforts, which are intended to and should continue, will enable DHHR to capture increased federal revenues for maintenance costs and administrative expenditures for children and youth participating in Wrapround when placed out of the home.

However, with greater emphasis placed on serving youth who remain in their home, DHHR needs to take active steps to implement "candidacy" to capture Title IV-E funding for case management services delivered by caseworkers as well as Wraparound facilitators to *Safe at Home* youth. This is especially important given West Virginia's Memorandum of Understanding with the U.S. Department of Justice to remediate the needs of youth known to youth services. In mid stages of the evaluation, DHHR provided PCG with an Excel file that documented, by LCA and youth, the types of services that were being provided to enrolled youth. At least 60 percent of the services provided to participating youth by Wraparound facilitators were case management activities, *e.g.,* conducting an assessment, meeting with youth and/or their families to monitor progress, or assisting with the referral to services.

To maximize federal reimbursement, DHHR needs to take two critical steps:

1. implement candidacy statewide, going beyond defining it in policy and implementing protocols, to document when youth and children are at risk of removal;
2. include Wraparound facilitators in the Department's administrative cost claiming process to capture the proportion of time they spend providing Title IV-E qualifying services and, thus, receive federal reimbursement for qualifying administrative or case management services provided to youth as well as younger children, if program requirements are expanded.

Documentation

DHHR and its LCAs made concerted efforts to implement the Wraparound model as intended. Wraparound facilitators did a favorable job in documenting when assessments and plans were completed and updated; however, there were shortcomings in documenting when Wraparound facilitators engaged with youth and their caregivers. While interviews with youth and their caregivers documented contact was made to fidelity, case record evidence maintained by Wraparound facilitators failed to document all the contacts with youth and families, making it appear as if contact did not meet the criteria specified by the National Wraparound Initiative model. There were also shortcomings in documenting the extent to which the LCAs developed and linked youth and their families to non-traditional services. The documentation submitted by the LCAs of the services they provided to *Safe at Home* youth largely documented they were providing traditional case management services as opposed to developing services which would best serve the needs of the youth and their caregivers.

Efforts are currently underway to expand the online WV CANS tool to document when Wraparound facilitators have contact with youth and their caregivers; the extent of that contact, *e.g.,* CANS assessment, in person visit with youth or team meeting; the date of the contact; and how that contact was made, *e.g.,* in person, telephone, or text. Not only will this enhancement enable Wraparound facilitators to better document their contacts with youth and their caregivers and, thus, document fidelity to the model, it can also be used to generate an invoice received from the LCAs. As caseworkers document their contact with youth and/or their families, they will select a contact level that will be tied to the rate LCAs will be reimbursed for that type of contact.

The WV CANS tool is also being enhanced to capture the types of services to which youth and their families are referred, *e.g.,* traditional services and/or non-traditional services. This will help to not only better identify the extent to which non-traditional services are being developed and provided to support youth and their caregivers but also to link the extent to which the provision of non-traditional services yields better outcomes.

Evaluation

The evaluation of DHHR's implementation of the National Wraparound Initiative approach to case management and service provision under the Waiver demonstration project provides favorable documentation in establishing the Wraparound model for youth, 12 to 17 years of age with or potentially having a behavioral health issue, as a promising evidence-based program. Further evaluation efforts are needed, however, to establish the model as a supported or well-supported practice and, thus, capture federal reimbursement through the Family First Prevention Services Act.

First, a randomized control group needs to be defined which mirrors the characteristics of children or youth referred to *Safe at Home* but for which Wraparound services are not provided. This will be difficult for youth 12 to 17 years of age, given the Memorandum of Understanding with the U.S. Department of Justice to engage all Youth Services youth in Wraparound, and, thus, the inability to select a randomized control group. However, to the extent West Virginia continues to expand *Safe at Home* to younger children, a quasi-experimental approach could be used to measure the impact of *Safe at Home* between "treatment" and "control" group participants. It is recommended that the State consider implementing Wraparound for younger children over time. This provides the opportunity for DHHR to implement Wraparound in specific counties, deeming the children enrolled as the treatment group. A control or comparison group would then be selected of children with similar characteristics, using propensity score matching, from a non-participating county with similar characteristics to that of the participating county, *e.g.,* poverty rate, judge, rural vs. suburban.

Second, West Virginia will need to measure outcomes prospectively from the date of discharge from *Safe at Home,* not from point of entry. Outcomes will need to be measured for at least six months from point of discharge to satisfy the Prevention Clearinghouse's criteria for a rating of "supported" and 12 months for a rating of "well-supported." This will also have to involve an adequate number of treatment and comparison youth within the randomized or quasi-experimental samples to document statistical significance.

Transitional Payments

The Administration for Children, Youth and Families, Children's Bureau's issued Program Instruction, ACYF-CB-19-06, that specifies a process for states to follow to capture Title IV-E revenues using Family First dollars before the Prevention Services Clearinghouse has an opportunity to review the literature and studies of evidence-based programs and establish a rating. DHHR is encouraged to identify an evaluator to complete the forms contained within Attachment B of the Program Instruction. The evaluator should use the information from this report as part of its review and as well as conduct a literature review of other studies of Wraparound models employed to serve youth 12 to 17 years of age with a behavioral health issue, incorporating the results from those studies into the forms.

Appendix A. Statistical Similarity of Treatment and Comparison Groups

Table 28. Significance Testing by Cohort

Measure	C1	C2	C3	C4	C5	C6	C7	Test
Gender	0.59	0.78	0.44	0.78	0.75	0.74	0.57	Chi-Squared
Hispanic	0.19	0.65	0.69	0.35	0.79	0.91	0.91	Chi-Squared
Black	0.58	0.71	0.63	0.34	0.16	0.25	0.83	Chi-Squared
UTD	1.00	1.00	1.00	1.00	1.00	1.00	1.00	Chi-Squared
White	0.88	0.77	0.76	0.74	0.29	0.24	0.90	Chi-Squared
Native Hawaiian	0.97	0.16	0.32	0.65	1.00	0.20	0.53	Chi-Squared
Asian	0.96	1.00	0.32	1.00	1.00	1.00	1.00	Chi-Squared
American Indian	1.00	1.00	1.00	0.56	0.56	0.36	1.00	Chi-Squared
Asian Pacific Islander	1.00	1.00	1.00	1.00	1.00	1.00	1.00	Chi-Squared
Unknown Race	0.53	1.00	0.48	1.00	0.16	0.56	1.00	Chi-Squared
Declined	1.00	1.00	1.00	1.00	1.00	1.00	0.32	Chi-Squared
Placement Type	1.00	0.81	0.33	0.70	0.87	0.66	0.67	Chi-Squared
Parent Jail	0.53	0.07	0.56	1.00	0.78	1.00	0.51	Chi-Squared
Abandonment	1.00	1.00	0.08	0.70	1.00	0.56	0.76	Chi-Squared
Child Alcohol	1.00	1.00	0.32	0.76	1.00	0.65	1.00	Chi-Squared
Parent Alcohol	0.59	0.70	1.00	0.32	0.80	0.40	0.65	Chi-Squared
Caretaker Unable to Cope	0.30	1.00	0.32	0.94	0.65	1.00	0.65	Chi-Squared
Child Behavior	0.45	0.93	0.74	0.94	0.70	0.69	0.81	Chi-Squared
Child Disability	0.34	1.00	1.00	1.00	1.00	1.00	1.00	Chi-Squared
Parent Death	1.00	1.00	0.56	1.00	1.00	0.56	0.56	Chi-Squared
Child Drugs	0.52	1.00	0.33	0.44	0.59	0.81	0.44	Chi-Squared
Parent Drugs	0.41	0.38	0.65	0.86	0.53	0.86	0.09	Chi-Squared
Housing	0.34	0.70	0.74	0.78	0.19	1.00	0.61	Chi-Squared
Neglect	0.52	0.56	0.86	0.90	0.60	0.58	0.18	Chi-Squared
Physical Abuse	0.85	0.41	1.00	0.80	0.70	1.00	0.29	Chi-Squared
Relinquishment	0.97	1.00	1.00	1.00	0.70	1.00	1.00	Chi-Squared
Sexual Abuse	0.61	0.59	1.00	0.26	0.61	0.53	0.39	Chi-Squared
Voluntary	0.34	0.15	1.00	0.32	1.00	0.16	1.00	Chi-Squared
Other	1.00	1.00	1.00	1.00	1.00	1.00	1.00	Chi-Squared
Number of Prior Placements	0.22	0.34	0.61	0.70	0.90	0.79	0.95	One Way ANOVA
Axis 1 Diagnosis	0.80	0.85	0.68	0.22	0.27	0.39	0.32	Chi-Squared
Juvenile Justice Involved	0.84	0.86	0.25	0.33	0.27	0.41	0.36	Chi-Squared

Measure	C1	C2	C3	C4	C5	C6	C7	Test
Psychiatric Hospital	0.41	0.57	0.16	0.46	0.56	0.33	0.64	Chi-Squared
Group Home	0.88	0.58	0.93	0.38	0.88		0.87	Chi-Squared
Age at Referral	0.82	0.09	0.53	0.77	0.72	0.74	0.06	One Way ANOVA

Appendix B. Total Stakeholder Interviews for Demonstration Project

Table 29. Completed Stakeholder Interviews

Stakeholder Type	Fall 2015	Summer 2016	Summer 2017	Winter 2017	Summer 2018	Spring 2019	Summer 2019	Total
DHHR Central Office	8			6		7		21
DHHR Regional Office	6			6		7		19
DHHR CSM				8		8		16
DHHR Supervisor				10		10		20
DHHR Caseworker		24	25	16	21	17	27	130
Direct Service Staff (includes Youth Services Workers and Supervisors)	11							11
Community Providers (includes Contracted Service Provider Administrators, Workers, and Supervisors)	13							13
LCA Program Director				5		7		12
LCA Wraparound Supervisor				5		7		12
LCA Wraparound Facilitator		17	24	11	16	13	33	114
Youth		22	14		10		21	67
Parents/Caregivers		24	16		8		22	70
Judges	8			6		8		22
Prosecutors	1							1
Probation Officers	1					16		17
Juvenile Justice Department Staff	2					1		3
Total	**50**	**87**	**79**	**73**	**55**	**101**	**103**	**548**