Evaluation of Safe@Home

Final Evaluation Report for the Clark County Department of Family Services Title IV-E Waiver Demonstration Project

Report prepared by:
Nevada Institute for Children's Research and Policy
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Executive Summary

The evaluation for the Clark County Department of Family Services Title IV-E Waiver Demonstration Project was designed to monitor the implementation of the Safe@Home program as well as measure outcome goals set by the program at the start of the demonstration project in 2015. The Safe@Home program is a component of the Safety Intervention and Permanency System (SIPS) that is used to assess families for threats to safety and then determine if those safety threats can be managed by the use of in-home safety services through the Safe@Home program to prevent children from going into out of home placement. The overall goal of the Safe@Home program is to provide in-home safety services that ensure that the children remain safely in their home while the parents work on their case plan with the Department of Family Services (DFS). For the demonstration project, The Nevada Institute for Children's Research and Policy (NICRP) evaluated program progress toward the implementation and outcome goals and provided update reports to DFS regarding program progress toward each of the goals on a quarterly and annual basis. Each of the goals is listed below along with an overview of the project's final progress toward meeting each of them.

Implementation Goals and Progress

Implementation Goals	Findings	Status
Goal 1: By the end of the project, 480 families will have been enrolled in the treatment group and 226 in the comparison group	*Treatment enrollment = 810 families* *Comparison enrollment = 246 families*	*Goal Met*
Goal 2a: Within 45 days of the SPD being approved, a signed a Safety Plan will be completed	*Treatment average = 9.5 days* *Comparison average = 3.5 days*	*Goal Met*
Goal 2b: The Safety Plan will become effective within 1 day of the Safety Plan being completed by DFS	*Treatment average = 1.1 days* *Comparison average = 1 day*	*Goal Met (for comparison families only)*
Goal 3: The number of contracted in-home safety service hours provided to treatment group families will decrease after 12 months of implementation of in-home safety services	*Only nine families were provided with more than 12 months of service but the average number of hours of service provided to them did decrease after the 12th month of service*	*Goal Met*

Outcome Goals and Progress

Outcome Goals	Findings	Status
Goal 1: *Significantly fewer families and children receiving contracted in-home safety services will experience new substantiated investigations of maltreatment compared to those in the comparison group.*	*At the first benchmark, the treatment group experienced statistically significantly* ***more*** *new substantiated investigations as compared to the comparison group. However, at the other benchmarks, there were no statistically significant differences between the two groups with regard to new substantiated investigations.*	*Goal Not Met*
Goal 2*: Significantly fewer children of families receiving contracted in-home safety services will be removed from the home within 12 months of the implementation of the in-home Safety Plan as compared to those in the comparison group.*	*At the first benchmark, the treatment group experienced statistically significantly* ***more*** *new removals as compared to the comparison group. However, at the other benchmarks, there were no statistically significant differences between the two groups with regard to new removals.*	*Goal Not Met*
Goal 3: *The parents of families receiving contracted in-home safety services will have documented significant progress toward increasing their protective capacity as evidenced by scores on the Protective Capacity Progress Assessment (PCPA) 12 months after the implementation of in-home safety services.*	*PCPAs were completed at each measurement interval through 12 months* ***for only 5 families****.*	*Not enough data to measure*
Goal 4: *No impending danger threats will exist in the home 6 and 12 months after contracted in-home safety services are no longer provided to the family.*	*At 6 months (n = 622):* *5.9% experienced a new substantiated investigation of maltreatment and 10.9% experienced a new child removal* *At 12 months (n = 551):* *4.7% experienced a new substantiated investigation of maltreatment and 5.1% experienced a new child removal*	*Goal Not Met*
Goal 5: *Twelve, eighteen, and twenty-four months after case closure, those that received contracted in-home safety services will experience significantly fewer substantiated cases of abuse or neglect in the home as compared to the comparison group.*	*There were no statistically significant differences between the treatment group and comparison group with regard to the number of new substantiated investigations 12, 18, or 24 months after case closure.*	*Goal Not Met*

Fiscal/Cost Study Results

Among families that were reunified at case closure, the average cost of serving comparison group families was slightly higher than the cost of serving treatment group families. However, the difference in cost between the two groups was not statistically significant. This suggests that, even with the added cost of contracted in-home safety services, among those families that were reunified at case closure, the cost to serve treatment group families was not significantly more expensive than the cost to serve comparison group families.

Stakeholder Feedback and Recommendations

Throughout the project, NICRP solicited feedback regarding the Safe@Home program from families enrolled in the program, in-home safety managers, and caseworkers. Below are some key findings regarding the Safe@Home program from the perspective of each of these stakeholder groups.

Families Enrolled in the Program – Based on phone surveys administered to active Safe@Home families:

- Overall, the majority of respondents had positive experiences with the Safe@Home program.
- Respondents valued their in-home safety managers and over the course of the demonstration project, the in-home safety managers improved in their communication with families.
- Respondents indicated that they would benefit from improved communication between the caseworkers and the in-home safety managers.
- The respondents also indicated that they would like the expectations of them to be clearer prior to agreeing to participate in Safe@Home.

In-Home Safety Managers – Based on group interviews conducted with the in-home safety managers:

- Overall, the participants provided favorable feedback with regard to the Safe@Home program.
- Participants suggested that one way to improve the program would be to promote a closer collaborative working relationship between caseworkers and safety managers.
- Participants suggested more flexibility with regard to the review of Safety Plans so that the services provided could be more responsive to the families. For example, services could be ramped up or decreased or the families could be provided different services for which they have exhibited a need.
- A success of the program was that parents began to recognize that they needed to make changes to their behavior for the betterment of their family.

DFS Caseworkers – Based on focus groups held with DFS caseworkers:

- Participants indicated that team decision meetings are an effective method of explaining to safety managers their role in the Safety Plan.
- Characteristics that lead to successful Safe@Home family outcomes include: parents wanting to make positive changes, in-home safety managers that communicate and interact with the entire family, and knowing when impending danger is most likely to occur.
- The caseworkers and supervisors would benefit from more training from the Safe@Home program staff on how to write effective SPDs and Safety Plans.

Below are three recommendations for program improvement based on stakeholder feedback. Details regarding the recommendations are included in the Summary of Results, Limitations, and Lessons Learned section of this report.

Recommendation 1: Assess the plausibility of allowing the in-home safety managers to request Safety Plan reviews.

Recommendation 2: Identify ways to improve the partnership between safety managers and caseworkers.

Recommendation 3: Review, update, and implement caseworker and DFS supervisor training on writing effective SPDs and Safety Plans

Evaluation Plan Revisions

Initially, the evaluation plan included the use of a comparison group of families that would be identified based on a phased roll out of the Safe@Home program. This phased roll out plan would allow for families to be placed in the treatment group when the program was available at their geographic site, while comparison families would be selected from sites where the program had not been rolled out. This strategy allowed the assumption that these families would be very similar in their demographic characteristics and potential eligibility for the program as the only difference between these groups is that the intervention was available at some sites and not others.

Unfortunately, there were several barriers identified in the early months of the evaluation that impacted the evaluation design. The first was a miscommunication regarding the timing of the roll out of the program. The original evaluation plan was based on a slower roll out, but the agency moved faster to make the program available at all sites making the roll out faster than comparison families could be identified. In addition, for families to be included in the comparison group a screening tool called the "Safety Plan Determination" or SPD must be completed correctly to identify which families would have qualified for Safe@Home services had the program been available at their site. Within the first year, several issues were identified with caseworker's accurate completion of this tool, which further delayed enrollment of families into the evaluation. The initial evaluation plan called for 120 families to be enrolled into the comparison group within the first two years, but by the end of the first year only 15 families had been identified. Therefore, a new plan was proposed and approved in 2016, which identified a new comparison group for the evaluation.

The identification of a new comparison group for the current project was proposed to ensure the same level of experimental rigor as the original evaluation plan. The new comparison group includes families that received informal in-home safety services without a paid Safety Manager after CCDFS implementation of the Safety Intervention and Prevention Services model (October, 2014). Therefore, the new research question was, "Do families that receive in-home safety services with a paid Safety Manager have better outcomes than families that receive informal in-home safety services?" Although the research question changed as a result of selecting a new comparison group, the treatment group remained the same.

Under the revised plan, the following criteria was used to identify families eligible to be included in the new comparison group:

1. The family was assigned an in-home caseworker
2. A documented Safety Plan for the family existed
3. The documented Safety Plan identified at least one impending danger threat
4. No formal safety service provider was listed as part of the documented Safety Plan

In keeping with the original evaluation plan, both new and reunified families were eligible for inclusion in the treatment and comparison groups.

The change to the comparison group required a slight change in the measurement of one of the outcomes. In the original evaluation plan, increases in parental protective capacity, as measured by the Protective Capacity Progress Assessment (PCPA), of parents in the treatment group were going to be compared to the increases in parental protective capacity of those parents in the comparison group. However, it was known that PCPAs would not be available for most of the parents in the new proposed comparison group due to existing program policies. Therefore, only within group comparisons of PCPA scores for the treatment group would be analyzed.

Introduction and Overview

On July 1, 2015, Clark County Department of Family Services (DFS) was approved to conduct a Title IV-E Waiver Demonstration Project. Prior to receipt of the Title IV-E Waiver, families served by Clark County Department of Family Services (DFS) that were eligible for in-home safety services could not receive them if they lacked informal supports such as friends, family members, or neighbors to assist in the implementation of an in-home Safety Plan. The children of these families were kept safe through out-of-home care. The Title IV-E Waiver allowed families that lacked informal supports to receive in-home safety services, if eligible, through a paid and specially trained safety manager. The purpose of the Clark County waiver demonstration project was to enhance and increase the capacity of the practice model components concerning in-home safety management services emphasizing community coordination and involvement, thus reducing the historical model of out-of-home placement for children.

There were two specific target populations that received paid in-home safety management services. One population included families and children for whom impending danger was identified via the Nevada Initial Assessment (NIA) and the use of an in-home Safety Plan was justified by the Safety Plan Determination (SPD). The second population included children currently in out-of-home care but whose family had met the Conditions for Return and the Safety Plan Determination justified the use of an in-home Safety Plan.

For the two targeted populations, the evaluation sought to determine if the demonstration project had met its goals of developing and implementing in-home Safety Plans when justified by the SPD, managing impending danger threats, keeping children safe in their homes, and increasing caregiver protective capacity. Further, the evaluation sought to determine if impending danger threats had become non-

existent, and if children were remaining safe from future abuse and neglect and avoiding future out-of-home placements.

The evaluation addressed the following hypotheses presented by the proposed waiver demonstration project:

> H1: After the Safety Plan Determination is complete, a paid in-home safety provider will be identified and agree to provide in-home safety services.
>
> H2: Families and children receiving in-home safety services from a paid safety manager will not experience new substantiated investigations within twelve months of the implementation of the in-home Safety Plan.
>
> H3: The children of families receiving in-home safety services from a paid safety manager will not be removed from the home within twelve months of the implementation of the in-home Safety Plan.
>
> H4: The parents of families receiving in-home safety services from a paid safety manager will have documented progress toward increasing their protective capacity as evidenced by scores on the Protective Capacity Progress Assessment (PCPA) after the implementation of in-home safety services up until twelve months or case closure.
>
> H5: No impending danger threats will exist in the home six and twelve months after in-home safety services are no longer provided to the family by a paid safety manager.
>
> H6: Twelve, eighteen, and twenty-four months after case closure, there will be no further substantiated cases of abuse or neglect in the home.

Evaluation Framework

Overview of the Evaluation - The waiver demonstration project was evaluated using comparison group methodology. The comparison group included families that received informal in-home safety services without a paid safety manager after DFS implementation of the SIPS model (October, 2014). The following criteria were used to identify families eligible to be included in the comparison group:

1. The family was assigned an in-home caseworker
2. A documented Safety Plan for the family existed
3. The documented Safety Plan identified at least one impending danger threat
4. No formal safety service provider was listed as part of the documented Safety Plan

During evaluation planning, DFS identified 158 families that met the criteria listed above and were therefore eligible for the comparison group. An additional 22 families were identified as potential candidates for enrollment into the comparison group.

The treatment group included families receiving in-home safety services provided by a paid safety manager under the Safe@Home program.

The Clark County Department of Family Services serves children and families across five geographic sites and one specialized site. Families from all sites were eligible for enrollment in the demonstration project. Table 1 below indicates the projected evaluation enrollment timeline by project year and by group (comparison and treatment).

Table 1. Projected evaluation enrollment timeline

	Year 1 7/2015-6/2016	Year 2 7/2016-6/2017	Year 3 7/2017-6/2018	Year 4 7/2018-6/2019	Year 5 7/2019-9/2019
Comparison	0*	76	75	75	0
Treatment	60	60	180	180	0
Total	60	136	255	255	0

*After the first year of the project a change was made to the evaluation plan that changed the definition of the comparison group. No families from the comparison group described in the original evaluation plan were eligible for inclusion in the new comparison group. Therefore, 0 families were enrolled during Year 1 of the project.

It was anticipated that by the end of Year 4, data would have been collected for 226 comparison group families and 480 treatment families for a total of 706 families included in the evaluation of the demonstration project. No families were to be enrolled in the demonstration project during Year 5 (7/2019-9/2019). However, scheduled follow-up data on families enrolled in the project would continue to be collected until the end of Year 5. The amount of follow-up data available for families would depend on when they were enrolled into the demonstration project.

DFS was responsible for providing NICRP with a list of the families enrolled in the demonstration project each month. This list identified at which site the family was being served and to which population (new or reunified) and group (treatment or comparison) the family belonged. NICRP reviewed the lists each month to ensure that families were enrolled into the demonstration project only once. During planning of the demonstration project, it was decided that if a comparison group family became eligible for paid in-home safety services, they would not receive them. However, during project implementation, NICRP found several instances in which comparison group cases were later enrolled in the treatment group. Immediately after noticing each dual enrollment, NICRP notified DFS who decided to un-enroll the case in the comparison group and enroll them in the treatment group.

According to the Clark County Department of Family Services and the authors of the in-home safety model, ACTION for Child Protection, the in-home safety model is expected to be equally effective for all families that qualify for in-home safety services as assessed by the NIA and Safety Plan Determination regardless of demographic or other family specific variables. However, data were collected for all families enrolled in the demonstration project to determine if the in-home safety model is more or less effective based on the following family characteristics: 1-Number of children in the family, 2-Type of allegation (neglect, physical, or both), 3-Whether or not there is a child in the home under the age of

five, and 4-Race of the family. The treatment and comparison groups were also compared based on these characteristics to determine their degree of similarity.

Logic Model - The logic model, in Table 2, illustrates the conceptual linkages between the demonstration components and the overall goals of the project.

Table 2. Logic model

Resources	Target Population	Activities	Outcomes			Overall Goals
			Short Term	Intermediate	Long Term	
Title IV-E Funding Families In-Home Safety Manager DFS Staff ACTION for child protection Nevada Institute for Children's Research and Policy	1-Families and children for whom impending danger is identified via the Nevada Initial Assessment (NIA) and the use of an in-home Safety Plan is justified by the Safety Plan Determination (SPD). 2-Children currently in out-of-home care but whose family has met the Conditions for Return and the Safety Plan Determination justifies the use of an in-home Safety Plan.	Conduct Nevada Initial Assessments Develop Safety Plans Implement Safety Plans immediately Provide in-home safety services	Children will be able to remain safely in their home	Families and children receiving in-home safety services from a paid safety manager will not experience new substantiated investigations within twelve months of the implementation of the in-home Safety Plan. The children of families receiving in-home safety services from a paid safety manager will not be removed from the home within twelve months of the implementation of the in-home Safety Plan. The parents of families receiving in-home safety services from a paid safety manager will increase their ability to protect their families. After case closure, families will be able to remain safe and stable independently of services provided by DFS.	No impending danger threats will exist in the home six and twelve months after in-home safety services are no longer provided to the family by a paid safety manager. Twelve, eighteen, and twenty-four months after case closure, there will be no further substantiated cases of abuse or neglect in the home.	Keep children safe from abuse and neglect Increase caregiver capacity

Data Sources and Data Collection Methods – DFS used UNITY, the Nevada SACWIS system, to provide NICRP with baseline data on treatment and comparison group families that met the criteria for inclusion

into the demonstration project. This information was provided to NICRP by the 15th of every month. Based on these data, NICRP provided DFS with follow-up data requests by the end of each month. These data requests related to the different outcome goals. For example, NICRP provided DFS with a list of family IDs and inquired as to whether or not each family had experienced a substantiated investigation or removal 90 days after being enrolled in the program by providing the specific 90-day date window. These follow-up data requests were sent via email in the form of Excel spreadsheets. Upon receipt, DFS entered the requested data into the Excel spreadsheets and sent them back to NICRP via email by the 15th of each month – at the same time they sent the baseline data. The follow-up data request spreadsheets also included information about which PCPAs NICRP needed. These PCPAs were then sent to NICRP via email. DFS also sent NICRP the monthly invoices from the safety service providers that provided in-home safety services to the treatment group. These invoices provided details regarding how many hours and what type of safety services each treatment group family received each month. These invoices were also sent to NICRP by DFS on the 15th of each month.

Sampling Plan - It was anticipated that 706 families would be included in the evaluation of the waiver demonstration project, including two specific target populations. One population included families and children for whom impending danger was identified via the Nevada Initial Assessment (NIA) and the Safety Plan Determination (SPD) justified the use of an in-home Safety Plan. These families did not have an existing open child welfare case, but rather came into the system for new investigations. As seen in Table 3 below, it was anticipated that 144 families in this target population would be included in the treatment condition throughout the demonstration project. The second population included families with children that were in out-of-home care but whose family met the Conditions for Return and the Safety Plan Determination justified the use of an in-home Safety Plan. These families had an open child welfare case and were re-assessed for inclusion in the waiver demonstration project. It was anticipated that 336 families in this target population would be included in the treatment group throughout the demonstration project. It was expected that the comparison group would consist of 226 families and include the same two specific populations described above (158 new families and 68 reunified families). There was an assumption that there would be no discernable differences in the outcomes between the target populations (new families and reunified families). Therefore, the data from the two target populations (new families and reunified families) would not be analyzed separately. In addition, the sample size of new families was likely to be too small to identify differences between the two groups if they did exist.

Table 3. Projected treatment and comparison group enrollment

	Treatment	Comparison	Total
Population 1 (New)	144	158	302
Population 2 (Reunified)	336	68	404
Total	480	226	706
Note: Population 1 refers to families for whom impending danger was identified via the Nevada Initial Assessment (NIA) and the use of an in-home Safety Plan was justified by the Safety Plan Determination (SPD). Population 2 refers to families in which the children were in out-of-home care but the family met the Conditions for Return and the Safety Plan Determination justified the use of an in-home Safety Plan.			

Data Analysis Plan – All quantitative measurement data was entered into IBM Statistical Package for the Social Sciences (SPSS) and checked by the evaluation team on a monthly basis. The data were analyzed quarterly and the results were provided to DFS in the form of quarterly evaluation progress reports.

Limitations - As in all evaluation projects there were limitations to the current study. In the development of the evaluation plan, it was determined that random assignment would not be possible, and a matched case design would not work either because of limited data availability for historical cases. Therefore a comparison group design was identified that would allow for the identification of families that were similar to those in the treatment group because of a phased roll out plan of Safe@Home. Specifically, families receiving services at sites where the Safe@Home intervention had not yet been implemented would be available to be enrolled in the comparison group. The SPD, completed for all families, was to be used to ensure similarities between the treatment and comparison group families. The SPD asks seven questions related to physical and motivational conditions necessary for a family to be appropriate for in-home safety services. The caseworker must answer "Yes" to all seven questions for a family to be eligible for in-home safety services. All families enrolled in the evaluation (both treatment and comparison group) had to be eligible to receive in-home safety services as determined by the seven questions on the SPD. The only difference between the two groups of enrolled families would be whether or not in-home safety services were available to them depending on whether or not the intervention had been rolled out at the site where they were receiving services.

However, during Year 1 of project implementation, it became clear that barriers such as miscommunication of the timing of the intervention roll out and inaccurate completion of the SPD by the caseworkers were impeding the enrollment of families into the comparison group. Therefore, a new comparison group was identified (as described in the current report) and a revised evaluation plan was submitted and approved in 2016. The change in the comparison group also meant that the research question would be altered to account for the difference between these two groups. The current evaluation examined differences in the outcomes of families that received paid in-home safety services through the Safe@Home program and those who had informal supports that allowed their children to remain safely at home. This was a limitation because there might be inherent differences in long-term outcomes for families with informal social networks to help in times of crisis versus those families without informal social supports and therefore relied upon the paid services under the Safe@Home program.

Evaluation Timeframe and Implementation Status

Table 4 below depicts the evaluation timeline from Year 1 to Year 5. The evaluation timeline was not dependent upon program implementation timelines or milestones. However, the ability of the evaluation team to report on program progress was dependent upon the receipt of monthly program data from DFS with which there have been no problems. After the initial evaluation plan change, which was approved in 2016, there were no challenges or changes to the revised evaluation plan.

Table 4. Evaluation timeline

	Year 1 7/2015-6/2016	Year 2 7/2016-6/2017	Year 3 7/2017-6/2018	Year 4 7/2018-6/2019	Year 5 7/2019-9/2019
July	Enrollment begins	7/15/2016: Year 1 Evaluation Report due to DFS;	7/15/2017: Year 2 Evaluation Report due to DFS;	7/15/2018: Year 3 Evaluation Report due to DFS;	7/15/2019: Year 4 Evaluation Report due to DFS;
August					
September					
October	10/15/15: Quarterly Evaluation Report due to DFS;	10/15/16: Quarterly Evaluation Report due to DFS;	10/15/17: Quarterly Evaluation Report due to DFS;	10/15/18: Quarterly Evaluation Report due to DFS;	10/15/19: Quarterly Evaluation Report due to DFS;
November					
December					
January	1/15/16: Quarterly Evaluation Report due to DFS;	1/15/17: Quarterly Evaluation Report due to DFS;	1/15/18: Quarterly Evaluation Report due to DFS;	1/15/19: Quarterly Evaluation Report due to DFS;	
February					
March					3/15/2020: Final Evaluation Report Due
April	4/15/16: Quarterly Evaluation Report due to DFS;	4/15/17: Quarterly Evaluation Report due to DFS;	4/15/18: Quarterly Evaluation Report due to DFS;	4/15/19: Quarterly Evaluation Report due to DFS;	
May	Caseworker focus group; Safety manager interviews; Family feedback solicited;	Caseworker focus group; Safety manager interviews; Family feedback solicited;	Caseworker focus group; Safety manager interviews; Family feedback solicited;	Caseworker focus group; Safety manager interviews; Family feedback solicited;	
June	Chart review of 10% of treatment group enrolled families;	Chart review of 10% of treatment group enrolled families;	Chart review of 10% of treatment group enrolled families;	Chart review of 10% of treatment group enrolled families; Last month to enroll participants;	

The Process Study

The process study includes the measurement of specific program outputs, feedback from program stakeholders regarding program progress, and a chart review designed to assess how caseworkers screened cases for inclusion in the Safe@Home program. The sections that follow describe the key questions, data sources, data collection methods, data analyses, and results for each component of the process study.

Outputs and Output Measures

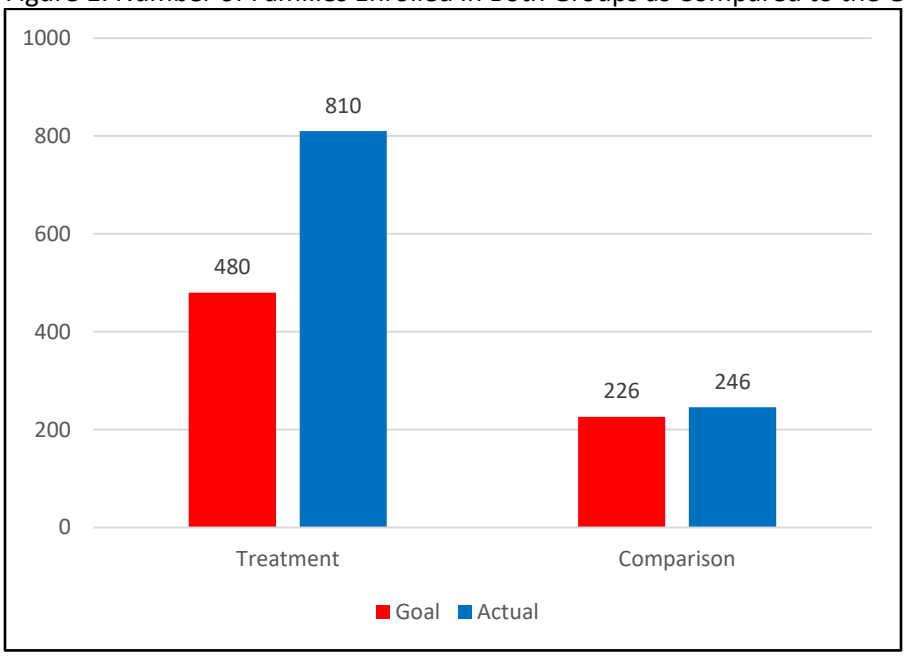
The outputs measured for the process evaluation include the number of children/families enrolled in the demonstration project, how quickly in-home safety services were secured after completion of the SPD, and how the number of safety service hours fluctuated over the course of the case. In the sections that follow, the project goals for each of these outputs is identified along with project progress toward each of these goals. Within each section, the project goal is stated, the methodology used to measure the goal is described, and the progress toward the goal is summarized.

Goal 1: By the end of the project, 480 families will have been enrolled in the treatment group and 226 families will have been enrolled in the comparison group.

In order to determine the effectiveness of the in-home safety services model utilizing contracted safety managers, the outcomes for those receiving in-home safety services provided by a contracted in-home safety manager will be compared to the outcomes of those receiving in-home safety services through informal supports. Families that received contracted in-home safety services were assigned to the "treatment group" and families that received in-home safety services through informal supports were assigned to the "comparison group." Meeting Goal 1 would ensure that there were enough families in both the treatment and comparison groups to identify any meaningful outcome differences between the two groups, if they existed.

Enrollment of families into the demonstration project began July 1, 2015 and ended June 30, 2019. A total of 1056 families were enrolled in the project with 810 of these families being enrolled in the treatment group and 246 being enrolled in the comparison group. As depicted in Figure 1, DFS exceeded both the treatment and comparison group enrollment goals for this project.

Figure 1. Number of Families Enrolled in Both Groups as Compared to the Goal



Goal 2a: Within 45 days of the Safety Plan Determination (SPD) being approved and signed by the DFS supervisor, a Safety Plan will be completed.

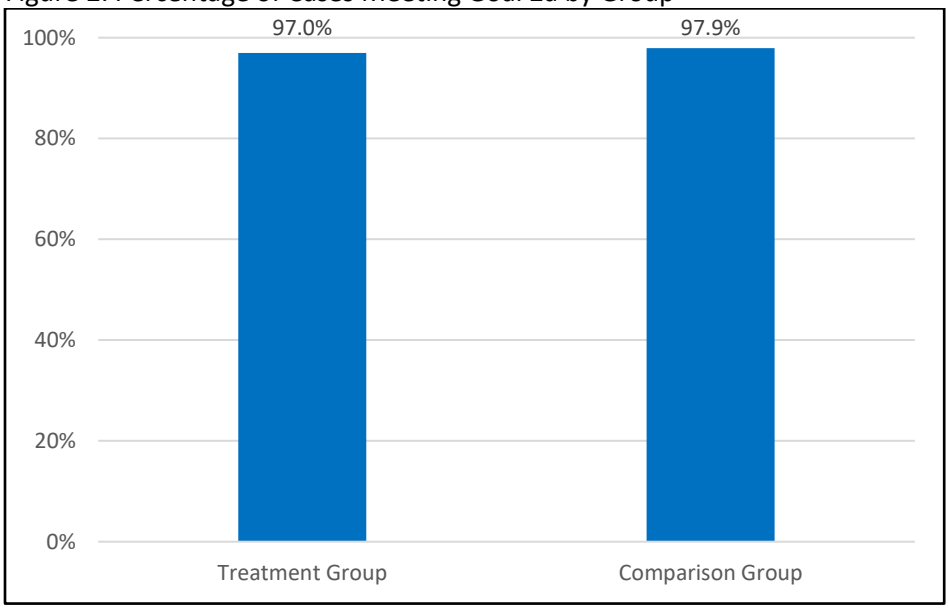
To measure this goal, the average number of days occurring between the date that the SPD was signed by the DFS supervisor and the date the Safety Plan was completed by the caseworker was calculated. Based on monthly reports received from DFS, which indicated these two dates, for treatment group families enrolled in the project, it took an average of 9.5 days for an in-home Safety Plan to be created after the SPD was approved by a DFS supervisor, with a range of 0 to 332 days. For comparison group families enrolled in the project, it took an average of 3.5 days for an in-home Safety Plan to be created after the SPD was approved by a DFS supervisor, with a range of 0 to 190 days.

It is important to note that, for the treatment group families, the average number of days occurring between the date the SPD was approved by a DFS supervisor and the date the in-home Safety Plan was created is based on data for 744 of the 810 enrolled treatment group families. Sixty-six of the treatment group families were not included in the measurement of this goal because the reported date that the Safety Plan was completed preceded the reported date that the SPD was signed by a DFS supervisor. Similarly, the average number of days occurring between the date the SPD was approved by a DFS supervisor and the date the in-home Safety Plan was created was based on only 141 of the 246 enrolled comparison group families. One hundred five of the comparison group families were not included in the measurement of this goal because the reported date that the Safety Plan was completed preceded the reported date that the SPD was signed by a DFS supervisor.

Because the measurement of this goal was based on data for 91.9% of treatment group families and only 57.3% of comparison group families, the treatment group results for this goal are likely a better representation of the process experienced by treatment group families than the comparison group results are a representation of the experiences of comparison group families.

Excluding those cases in which the Safety Plan was completed prior to signature and approval of the SPD by a DFS supervisor (n = 171), DFS met Goal 2a in that, on average, Safety Plans were completed by the caseworkers within 10 days of supervisor approval of the SPD for those families in the treatment group and within 4 days for those families in the comparison group. As seen in Figure 2 below, this goal was met in 97.0% of the treatment group cases and in 97.9% of the comparison group cases.

Figure 2. Percentage of Cases Meeting Goal 2a by Group



Note: Does not include those cases in which the reported date that the Safety Plan was completed preceded the reported date that the SPD was signed by a DFS supervisor.

Goal 2b: The safety plan will become effective within 1 day of the Safety Plan being completed by DFS.

To measure this goal for treatment group families, the average number of days occurring between the date that the Safety Plan was completed and the date that it was signed by the in-home safety manager was calculated. To measure this goal for comparison group families, the average number of days occurring between the date that the Safety Plan was completed and the effective date of the Safety Plan was calculated.

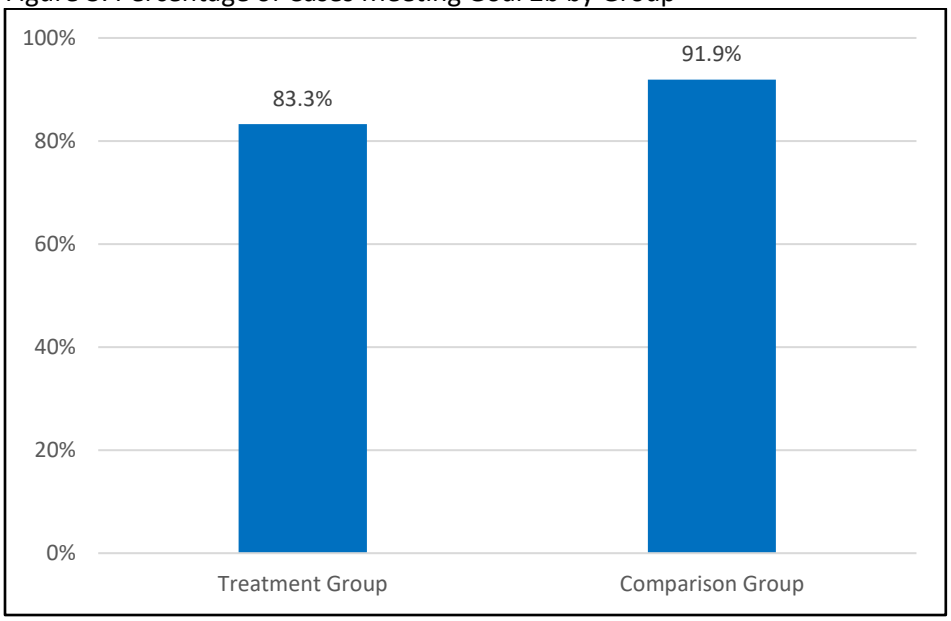
Based on monthly reports received from DFS, which indicate these two dates, for treatment group families enrolled in the project, it took an average of 1.1 days for the safety manager to sign the Safety Plan after it was completed with a range of 0 to 25 days. For comparison group families, it took an average of 1 day for the Safety Plan to become effective after it was completed with a range of 0 to 47 days.

It is important to note that, for the treatment group families, the average number of days occurring between the date that the Safety Plan was completed and the date that it was signed by the in-home safety manager was based on data for 790 of the 810 enrolled treatment group families. Twenty of the

treatment group families were not included in the measurement of this goal because the date the Safety Plan was signed by the in-home safety manager preceded the date that the Safety Plan was completed. Similarly, for the comparison group families, the average number of days occurring between the date the Safety Plan was completed and the date the plan became effective is based on data for 223 of the 246 enrolled comparison group families. Twenty-three of the comparison group families were not included in the measurement of this goal because the effective date of the Safety Plan preceded the date that the Safety Plan was completed.

Excluding those cases in which the Safety Plan was signed by the in-home safety manager (treatment group) or became effective (comparison group) prior to the documented date of its completion (n = 43), DFS met Goal 2b with regard to comparison group families but not treatment group families. For treatment group families, it took an average of 1.1 days for the safety manager to sign the Safety Plan after it had been completed whereas for comparison group families, the Safety Plans, on average, became effective on the same day they were completed. As seen in Figure 3 below, Goal 2b was met in 83.3% of the treatment group cases and in 91.9% of the comparison group cases.

Figure 3. Percentage of Cases Meeting Goal 2b by Group



Note: Does not include those cases in which the reported date that the Safety Plan was signed by the in-home safety manager (treatment group) or the date it became effective (comparison group) precedes the reported date that it was completed.

Based on the available data for Goal 2a and Goal 2b, for treatment group families, it took, on average, 10.6 days after SPD approval for Safety Plans to become effective. For comparison group families, it took, on average, 4.5 days after SPD approval for Safety Plans to become effective.

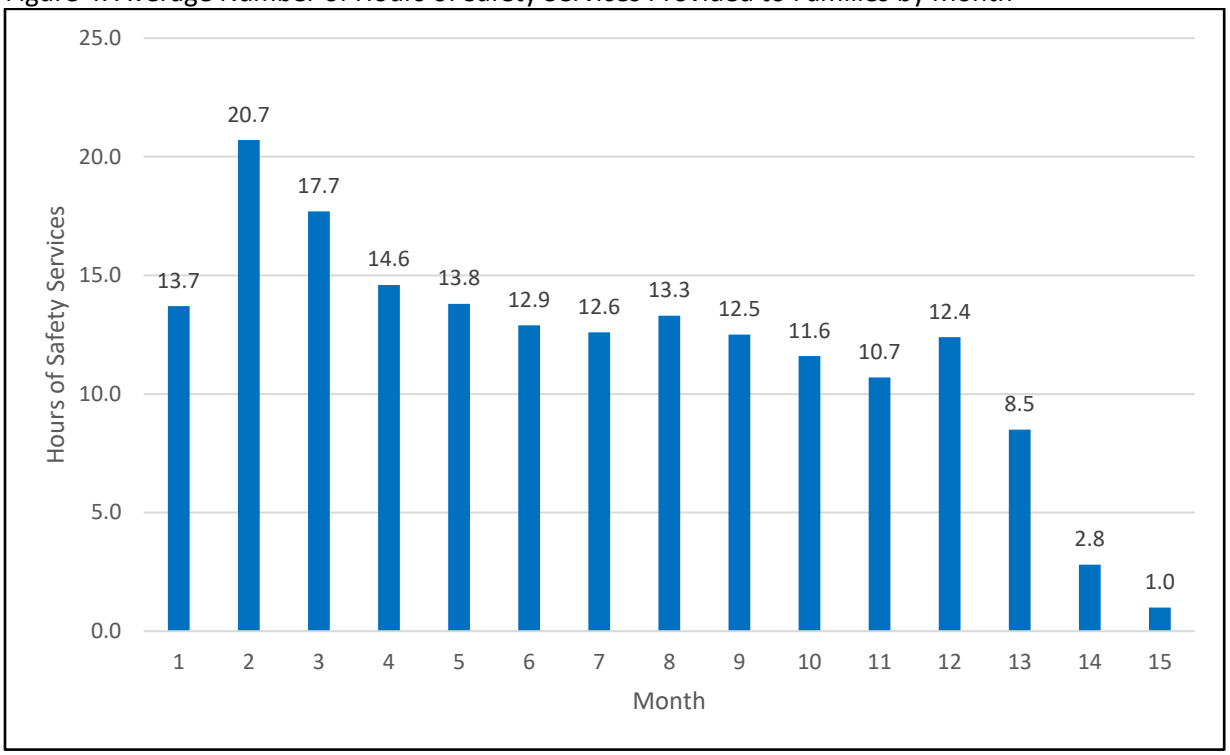
Goal 3: The number of contracted in-home safety service hours provided to treatment group families will decrease after 12 months of implementation of in-home safety services.

To measure this goal, DFS provided NICRP with monthly invoices from the agencies contracted to provide in-home safety services to treatment group families. The invoices indicated the number of hours and types of in-home safety services provided to each treatment group family during the month. In the measurement of this goal it is important to note the following:

- Only those safety service hours invoiced by the safety service agencies that occurred on or after the date that the Safety Plan was signed and before or on the date that safety services ended are included in the measurement of this goal.
- The date that the Safety Plan was signed and the date that safety services ended were provided to NICRP by DFS.
- Based on agency invoices, some families received safety services before the date that the Safety Plan was signed and/or after the reported date that safety services ended. However, as noted above, these safety service hours were not included in the measurement of this goal.
- The safety services contained in this analysis include administrative as well as direct service.
- According to the hours invoiced, some families did not receive in-home safety services every month between the date that their Safety Plan was signed and the safety services end date provided by DFS.

The average number of hours of in-home safety services provided to treatment group families by month of enrollment is shown in Figure 4. On average, families were provided with the most hours of service during their second month of services (M = 20.7) after which the average number of hours of service provided tended to decrease. However, there were slight upticks in the average number of safety service hours provided to families during their eighth and twelfth months of service.

Figure 4. Average Number of Hours of Safety Services Provided to Families by Month

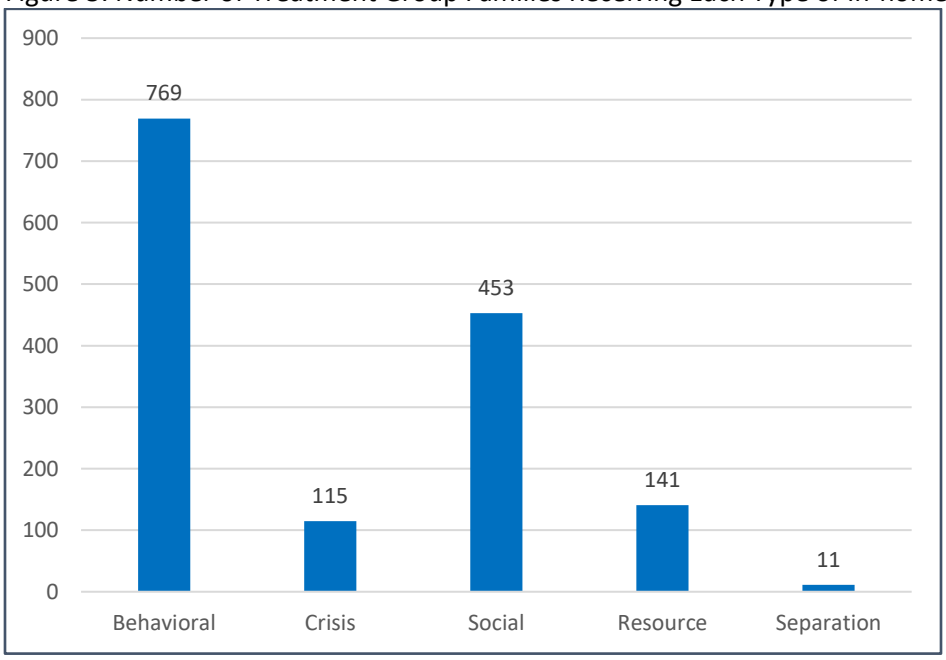


Note: Month 13 includes data for nine families, Month 14 includes data for four families, and Month 15 includes data for one family.

This goal focuses on the number of in-home safety service hours provided to families after 12 months of service and, as depicted in Figure 4, DFS has met this goal in that there was a sizable decrease in the average number of safety service hours provided to families after their twelfth month of enrollment in safety services. However, it is important to note that, only nine families were enrolled to receive services at 13 months, four families were enrolled to receive services at 14 months, and one family was enrolled to receive services at 15 months. Further, one of the four families enrolled to receive services at 14 months received 0 hours of service that month.

There were five categories of direct in-home safety services available to treatment group families: behavioral, crisis, social, resource, and separation. As seen in Figure 6, behavioral and social support are the most common types of in-home safety services provided to treatment group families.

Figure 5. Number of Treatment Group Families Receiving Each Type of In-home Safety Service



Note: These categories are not mutually exclusive in that families can receive more than one type of in-home safety service.

Stakeholder Feedback

In 2016, 2017, and 2018, NICRP solicited feedback regarding the Safe@Home program from families enrolled in the program, in-home safety managers, and caseworkers. Specifically, NICRP administered a phone survey to the primary caregivers of families enrolled in the Safe@Home program, conducted group interviews with the safety managers at each of the agencies contracted to provide safety services to families, and conducted a focus group with DFS caseworkers that provided services to families enrolled in the Safe@Home program. A description of how each of these process evaluation activities was conducted along with a summary of the results are in the sections that follow.

Participant Survey

In 2016, 2017, and 2018, NICRP administered a brief phone survey to Safe@Home participants to assess their experiences and satisfaction with the program. Each year of administration, the participants targeted for the survey included treatment group families that were actively receiving safety services at the time. Prior to NICRP attempting to contact participants, Safe@Home program staff mailed a letter to the primary caregiver of each targeted family to notify them that they might be contacted by NICRP to voluntarily complete the survey. Safe@Home program staff provided NICRP with a list of the names of the primary caregivers for each family and their phone numbers but did not have phone numbers for all of the primary caregivers (See Table 5.) Each year of survey administration, the families on the list were assigned a random number and then sorted in ascending order by their random number. To administer the survey, NICRP staff started calling the primary caregivers at the top of the list and continued down. Once all of the primary caregivers on the list had been called, NICRP started at the top

of the list again and continued in this manner until a minimum 20% response rate was reached. No voicemails were left for the families.

Over the course of the three annual survey administrations, NICRP attempted to contact 254 primary caregivers to complete the phone survey. During each year of survey administration, NICRP attempted to reach the primary caregivers on three (in 2018) or four different days (in 2016 and 2017). Of the 254 primary caregivers that NICRP attempted to contact, 58 (22.8%) did not have working phone numbers in that they were either disconnected or were wrong numbers. (Note that NICRP attempted to contact those participants with disconnected numbers on multiple occasions, however these numbers were not reconnected during administration of the survey.) In total, NICRP was able to complete the survey with 65 primary caregivers for an overall survey response rate of 25.6% (65/254). Five primary caregivers that were reached declined to participate in the survey. Another primary caregiver called upon receiving the letter from DFS explaining the survey and was extremely angry about potentially being contacted for the survey; therefore, NICRP did not contact this family for the survey.

Table 5. Number of treatment group families eligible for the survey, number for whom a phone number was provided, and number that completed the survey by year

	Number actively receiving safety services at the time of administration	Number for whom a phone number was provided	Number completing a survey	Response Rate
2016	112	100	29	29.0%
2017	104	91	21	23.1%
2018	75	63	15	23.8%
Total	**291**	**254**	**65**	**25.6%**

Of the respondents that completed the survey, many indicated that they had multiple in-home safety managers with very different skill levels. Therefore, when asked questions regarding their in-home safety manager, these respondents were asked to consider their overall in-home safety management team. During the 2016 administration of the survey, a large portion of the respondents needed to be reminded of what the program entailed, indicating a possible limitation of the study.

As seen in Table 6 below, each year of survey administration, a high percentage of respondents consistently agreed or strongly agreed that, “The in-home safety manager is easy to work with.” The percentage of respondents that agreed or strongly agreed with this survey item and “The in-home safety manager communicates well.” increased each year of survey administration suggesting program improvement in these areas. In contrast, a smaller percentage of respondents agreed or strongly agreed each year that, “Having an in-home safety manager has helped me work toward completing my case plan.” In 2017 and 2018, the smallest percentage of respondents agreed or strongly agreed with the statement, “I was given the opportunity to provide input into my family's in-home Safety Plan.”

Table 6. Percentage of respondents indicating that they agree or strongly agree with each survey item by year

	2016 (n = 29)	2017 (n = 21)	2018 (n = 15)
I was involved in creating my family's in-home Safety Plan.	69.0%	81.0%	**
I was given the opportunity to provide input into my family's in-home Safety Plan.	67.9%*	76.2%	46.7%
The in-home Safety Plan was clearly explained to me.	69.0%	90.5%	86.7%
I knew what to expect after agreeing to the in-home Safety Plan.	65.5%	85.7%	66.7%
I understand why I have an in-home Safety Plan.	72.4%	95.2%	66.7%
Having an in-home safety manager has helped me work toward completing my case plan.	86.2%	81.0%	66.7%
The in-home safety manager is easy to work with.	86.2%	95.2%	100%
I understand what the in-home safety manager is trying to accomplish by being in my home.	86.2%	90.5%	86.7%
The in-home safety manager communicates well with me.	86.2%	90.5%	100%
My caseworker communicates well with me.	72.4%	85.7%	73.3%

*A response was missing for one respondent for this survey item, therefore for 2016, n = 28 for this item.
**Safe@Home staff requested that this item be removed for the 2018 survey because it was similar to the next item and because the in-home Safety Plan is created in the office before the case is assigned to a provider.

Two additional closed choice survey items were asked of respondents that are not included in Table 6. One survey item assessed how well the caseworker and in-home safety manager communicated with one another. The percentage of respondents that agreed or strongly agreed that they communicated well with one another increased each year of survey administration (48.3% in 2016, 57.3% in 2017, and 60.0% in 2018). During the 2018 administration of the survey, respondents that disagreed or strongly disagreed with this survey item were asked to provide more information and those that did explained that their caseworker did not return their safety manager's emails or phone calls. The other survey item assessed how much time the in-home safety manager spent in each respondent's home as compared to what they expected. As seen in Table 7 below, the percentage of respondents that indicated that the amount of time that the in-home safety manager spends at their home is about what they expected increased every year of survey administration. The percentage of respondents that indicated that the amount of time that the in-home safety manager spends at their home is "more" or "much more" than they expected was highest during 2016 at 27.6% but decreased in 2017 to 19.0% and remained somewhat stable in 2018 at 20.0%. These findings suggest that the program improved somewhat in their communication to respondents about what to expect from the program.

Table 7. Percentage of respondents selecting each option to the survey item, "Would you say that the amount of time that the in-home safety manager spends at your home is..." by year

	2016 (n = 29)	2017 (n = 21)	2018 (n =15)
Much more than you expected	27.6%	19.0%	20.0%
More than you expected	6.9%	14.3%	20.0%
About what you expected	55.2%	57.1%	60.0%
Less than you expected	3.5%	4.8%	0.0%
Much less than you expected	6.9%	4.8%	0.0%

Respondents were asked two open-ended questions on the survey. One question asked the respondents for suggestions to improve the program and the other asked respondents what they like best about the program.

Most of the suggestions for program improvement related to communication, staff training, and Safety Plans. Overall, suggestions related to communication included the following themes:

- The caseworkers should communicate better with in-home safety managers and the clients so that the clients are not surprised by actions of the caseworker
- Let families know how the safety services hours are determined
- Make the expectations of families more clear before they begin safety services, especially with regard to who and how many people will be visiting their home

Suggestions that focused on staff training included the following themes:

- The caseworkers should receive more training so that there is more consistency among them in terms of how they work with families. This will prevent a family from being negatively impacted by the assignment of a new caseworker that does things differently.
- Better training for in-home safety managers so that they all provide the same level of service

Finally, suggestions related specifically to the Safety Plans included the following themes:

- There should be more frequent evaluations of the safety service hours and services to determine reductions or changes
- More value should be placed on the family's input regarding Safety Plans
- The in-home safety managers should not visit in pairs because it feels intrusive
- In-home safety managers should be held accountable for visiting in accordance with the agreed upon schedule

During each year of survey administration, when asked, "What do you like best about the program?" most respondents indicated that what they liked best about the program was their in-home safety manager. Specifically, the in-home safety managers were described as being friendly, personable, knowledgeable, helpful, and understanding. Respondents also indicated that the in-home safety

managers were good listeners, attentive, eager to help, easy to work with, and accessible. Further, the respondents appreciated that the in-home safety managers were hands-on, spoke directly to them, were easy to confide in, and nonjudgmental. Other respondents indicated that what they liked best about the program was learning new skills such as how to communicate with their family members, how to create and maintain a schedule, how to recognize the needs of their children, and how to keep their babies safe. Other things that the respondents liked about the program included how it accommodated their schedule, that they learned about community resources such as food banks and furniture programs because these things made it easier for them to take care of their families, and that it allowed them to keep their children at home.

What families liked best about Safe@Home

- **Their in-home safety manager**
- **Learning new skills**
- **It accommodated their schedule**
- **Learning about community resources**
- **Being able to keep their children at home**

Safety Manager Interviews

In 2016, 2017, and 2018, NICRP conducted face-to-face group interviews with the safety managers from the agencies contracted to provide in-home safety services for the Safe@Home program. All of the agencies contracted to provide in-home safety services participated in the safety manager interviews each year with the exception of 2016. In 2016, London Family and Children's Services Inc. did not participate. A list of the agencies that participated in the interviews each year is included in Table 8 below. For the agencies listed, all of the safety managers that were actively providing safety services to families at the time participated in the group interviews.

Table 8. Agencies that participated in the Safety Manager Interviews each year

2016	2017	2018
• Chicanos Por La Causa Nevada Inc. • Eagle Quest of Nevada • Mojave Mental Health • Shining Star Community Services	• Chicanos Por La Causa Nevada Inc. • Eagle Quest of Nevada • Mojave Mental Health • Shining Star Community Services • Youth Advocate Programs, Inc.	• Chicanos Por La Causa Nevada Inc. • Eagle Quest of Nevada • Specialized Alternatives for Families and Youth • Shining Star Community Services • Southwest Integrated Care Services • Youth Advocate Programs, Inc.

The purpose of the interviews was to learn about the experiences of the safety managers in providing in-home safety services to families through the Safe@Home program and what it was like working with DFS on this initiative. During each of the interviews, NICRP asked each group of safety managers the same set of questions. The questions focused on the Safety Plan, how they are introduced to the families, their experiences in working with the families, and their overall experience with Safe@Home. Below is a summary of the safety manager group interviews.

Safety Plan

Each of the interviews began by asking the safety managers about their level of involvement in the creation of the Safety Plan and the degree to which they are able to recommend adjustments to the plan. Safety managers indicated that they are able to recommend adjustments once they begin working with the family; however, their greatest opportunity to contribute to the in-home Safety Plan is when a Team Decision Meeting (TDM) is held because TDMs facilitate communication amongst all parties involved in the Safety Plan and increase understanding of roles and expectations for both safety managers and families involved. A Team Decision Meeting (TDM) is a meeting in which the family, DFS, a representative from the safety manager's agency, and a third neutral party are convened to decide as a team which services will be provided to the family in addition to the schedule of services that will be provided. In later interviews, safety managers reported that TDMs became less frequent and rarely held.

Additionally, safety managers indicated that, while they have the ability to make recommendations to DFS caseworkers to adjust the Safety Plan once they begin working with the family, the likelihood that their recommendations would be implemented was dependent upon the caseworker, as some caseworkers are more receptive to feedback than other caseworkers. Especially in later interviews, safety managers indicated that because some caseworkers were less receptive than others, it was their sentiment that their recommendations were often ignored or disregarded. Because of this, safety managers indicated, especially in later interviews, that the development of a standard procedure to provide Safety Plan recommendations to the caseworkers would help build trust, partnership, and two-way communication between the safety managers and caseworkers. During the interviews, the safety managers raised additional concerns about the Safety Plans. These concerns included the termination of services, the appropriateness of families that are assigned to the Safe@Home program, and Safety Plans adequately identifying and describing the impending danger threats.

When asked how safety services for families were ended, safety managers reported that while the method of phasing out services had become more common, it is not universal and in fact the method of ending services more abruptly is sometimes also employed. Safety managers indicated that the method of phasing out services is vastly preferred to an abrupt end to services as an abrupt end to services might be harmful to the emotional stability of the children and families in the program.

When asked if they felt that the families they were assigned to work with were appropriate for the program, safety managers overall reported that the majority of the families were appropriate for the program but that there is a subset of families for whom Safe@Home might not be a good fit. This subset of families was described as unwilling to engage in program activities, avoiding visits, lacking a stable home environment, not answering the door for safety manager visits, and not having the children present during scheduled visits. Despite notifying the DFS caseworkers of these repeated behaviors, safety managers stated that these families remained in the program. Several of the safety managers stated that such families are not an appropriate use of resources and do not possess the stability needed to properly implement an in-home Safety Plan.

When asked whether or not the Safety Plans adequately identified the impending danger threats for a family, safety managers reported the impending danger threats for most but not all families were well identified. For some families, safety managers noted that, the impending danger threats were not well identified, changed over the course of the case, or were "hidden" due to the nature of having pre-

scheduled visits. Additionally, the safety managers reported that the times that they were scheduled to be in the home seem ambiguous, as if they are "looking for supposed bad behavior" but do not typically encounter it. Alternatively, some safety managers indicated that although impending danger threats might have been well identified at the onset of a case, they sometimes change over time which results in outdated Safety Plans, causing safety managers to be unsure of their role. Safety managers also reported being unsure as to how they could address the new impending danger and if they could enact different service types that were not specifically mentioned in the Safety Plan. Safety managers also indicated that an increase in unscheduled visits by DFS could help reduce the behavior of families hiding impending danger threats. This could also address the concern of safety managers that visit times are made at the preference of participants and do not necessarily reflect times when impending danger threats are more likely to occur.

Family Introductions

Next, the safety managers were asked about how they are first introduced to the families with whom they work. According to the safety managers, they first meet with families through either TDMs or an initial safety meeting, oftentimes with a DFS worker present. Interviews conducted in 2016 indicate that safety managers were most frequently introduced through participation in a TDM, though in following years, especially 2018, interviews indicate that safety managers were more frequently introduced via an initial safety meeting with a DFS worker present. Despite the decrease in TDMs, safety managers indicate that TDMs are the preferred method of introduction because it promotes collaboration among the family and all involved parties. The safety managers also indicated that TDMs allowed greater opportunity for both families and safety managers to ask questions, understand their roles, be aware of expectations, and suggest any necessary changes.

Working with the Family

When asked about their role in managing in-home safety services for a family, the majority of safety managers indicated that their role was to follow the Safety Plan, build trust, support the family, and to attempt to be as unintrusive as possible. The safety managers at each of the agencies also reported that they work as a team to serve most of the families on their caseloads. The responses from the safety managers were mixed when asked whether DFS's expectations of their work with the families is clear to them before they begin managing in-home safety services. It was reported that some DFS caseworkers more clearly express their expectations than others. The safety managers reported that expectations were the least ambiguous when they were clearly expressed in a written Safety Plan or in an in-person TDM if one was held. Additionally, safety managers reported that some DFS caseworkers have a good understanding of the in-home safety services model and know what role safety managers play, while other caseworkers do not seem to understand the role of safety managers or are uninterested in implementing and adapting to the new model.

Also reported by the safety managers was a lack of clarity in expectations as cases progressed. Safety managers indicated that there is a lack of specific criteria for them to gauge whether a goal has been met and thus where attention should be focused. Safety managers stated that because goal achievement appears to be more subjective than objective, it often seems that cases can remain open despite safety managers seeing a clear lack of impending danger. The safety managers suggested that standardizing the Safety Plan to include Safety Plan expectations and goals using a common language

might alleviate discrepancies such as safety managers being asked about behaviors or information that they were not previously told to be monitoring or documenting.

Safety managers also indicated that it was often unclear as to what was expected of them despite what was included in the Safety Plan, as they could sometimes be expected to perform tasks that were not included in the Safety Plan. Although safety managers indicated that the things they are asked to do on top of the responsibilities listed in the Safety Plan are not burdensome, safety managers suggested that these requests can blur the lines of their role in working with the family. Additionally, safety managers expressed frustration over a general confusion as to what should and should not be included in case notes. Another part of this frustration over case notes was that the majority of the safety managers reported being skeptical as to whether all of the caseworkers read the weekly case notes that they send to them. Several safety managers reported that caseworkers often ask them to resend their notes or provide an overall update on a family. When asked how to improve the communication process between DFS and the safety managers, most of the safety managers acknowledged that the DFS caseworkers are overwhelmed with large caseloads and indicated that the program could be improved by DFS hiring more caseworkers. There was also a suggestion that the DFS caseworkers complete a short questionnaire or form for each family indicating which specific behaviors they want the safety manager to report on so that the caseworker can get the information that they need without confusing the safety manager about what to include in case notes.

When discussing their work with families, especially during the interviews that were conducted in 2018, the safety managers at most of the agencies expressed concerns with a DFS policy that limits in-home visits with the families to 30 minutes. Specifically, there was a lot of confusion about whether this was a new policy, whether it was Safe@Home policy, and if it was being applied punitively to some agencies but not others. Safety managers expressed anxiety about the 30 minute time limit as they were concerned about being able to appropriately determine if a child is safe in the home or not. Some safety managers suggested that the families they work with could "hide" a danger for a 30 minute scheduled visit. An additional concern expressed by the safety managers with regard to the 30 minute time limit was that it had essentially cut their pay in half because their agencies only pay them for the amount of time spent in the homes with families.

Safety managers were also asked if they were consulted before a removal takes place for a Safe@Home family with which they work. Very few safety managers reported working with families when they experienced a child removal. Of these safety managers, only one reported being consulted prior to the removal taking place. The other safety managers that had experienced the removal of a child from a family reported that they did not know about the removal until they arrived for a visit and the child was not there, or, in a few cases, the removal was in process when they arrived. Additionally, most safety managers reported that they are never informed why a removal is taking place, if they informed that it is taking place at all.

(Note: Due to the pervasiveness of the confusion amount agencies regarding how long they are expected to stay in a family's home for an in-home safety visit, NICRP followed up with DFS following the safety manager interviews. According to DFS, the safety managers are expected to spend "a minimum of 30 minutes" in a family's home when conducting an in-home safety visit. The safety managers "do not need to stay a full hour if there is no impending danger manifesting." Further, DFS reports that they have communicated this information to the safety manager agencies repeatedly.)

Overall Experience

Throughout the years of interviews conducted, safety managers provided very positive feedback when asked about their overall experience with the Safe@Home program. Safety managers reported that one very positive aspect of the program is that children get to stay at home with their families because some have seen first-hand what a negative impact removing a child from their home can have. Another feature about the program that safety managers appreciated was, unlike therapy, the entire family unit is treated as opposed to just one individual. When asked what successes they have experienced with the program, many of the safety managers provided examples in which the parents came to recognize the need to change their behavior for the betterment of their family. Other examples of successes included parents "increasing their protective capacities" for their children, being receptive to the safety manager's suggestions or re-direction, obtaining employment, securing stable housing, attending therapy sessions, and exhibiting protective behavior.

Of the challenges or barriers faced in carrying out in-home Safety Plans, the majority of safety managers reported facing a lack of communication and support from the DFS caseworkers. This barrier coincided with another reported barrier that caseworkers generally lack knowledge regarding the roles and goals of the safety managers. Another challenge reported by some safety managers was non-compliant parents when implementing in-home Safety Plans.

During the 2018 interviews, when asked about what changes they had noticed with regard to the program, safety managers at some agencies reported that they feel as though DFS has been "micromanaging" them more lately and that "trust has dissipated over time". On the other hand, the safety managers at some agencies reported that their relationship with DFS seems less punitive than it had previously.

Suggestions for Improvement

The safety managers provided several suggestions to improve the Safe@Home program. These suggestions included the following:

- More communication from the DFS caseworkers about the status of the families. This would be so that safety workers could stay updated on the direction of cases. For example, this could include updates about the results of drugs screenings, a court hearing, or a visit the caseworker had with the family.
- Allowing Safety Plan modifications to occur without the DFS caseworker needing to redo the entire Safety Plan.
- Developing a procedure by which a safety manager could request a Safety Plan review. Safety managers indicated that this would be beneficial when they believe that a family is receiving too many or too few safety service hours or if a family might benefit from a different type of safety service.
- Including more informal supports, when possible, so that the safety manager does not need to be in the home so often. It was suggested that if an informal support could be in the home and assist the family then the safety manager could reduce the frequency of in-home visits which could make the family feel more comfortable and less intruded upon.

- Creating a process that would allow a quick and flexible rescheduling of in-home safety visits for families during the holidays or events special to the family.
- Acknowledgement from the DFS caseworkers when they have received the safety managers' emails and voicemails.
- The promotion of a closer collaborative working relationship between caseworkers and safety managers.
- The addition of more information regarding child safety. For example, safety managers would like information on what age is unsupervised outside play for the child appropriate.
- Safety managers having the ability to contact families 30 to 60 days after safety services end so that they can offer them encouragement and determine if they need any support.
- Identification of non-cost prohibitive transportation resources that the families can easily access themselves to attend appointments in the community.

Caseworker Focus Group

In 2016, 2017, and 2018, NICRP held focus groups with DFS caseworkers who had worked with families that received in-home safety services through the Safe@Home program. Safe@Home program staff assisted NICRP in the recruitment of DFS caseworkers for participation in the focus groups and provided space at the Central DFS site for the focus groups to be held. During each of the focus groups, NICRP provided breakfast to the participants. Six caseworkers participated in the 2016 focus group, nine caseworkers participated in the 2017 focus group, and five caseworkers participated in the 2018 focus group. Just prior to each of the focus groups, the participants were asked to complete a short paper and pencil survey indicating how long they had worked in child welfare and for DFS, how long they had been trained on the SIPS model, at which site they worked, and how many families they had worked with that received in-home safety services through the Safe@Home program. Across the three focus groups, the average number of years of experience that the participants had in working in child welfare ranged from seven to seventeen years, the average number of years being trained on the SIPS model ranged from three months to ten years, and the average number of families that they worked with that received Safe@Home services ranged from three to six families. For most of the participants, their only experience working in child welfare was acquired while at Clark County DFS. Participants worked at the South, Central, East, and West sites.

After completing the short survey, focus group participants were asked a set of prepared questions related to Safety Plan Determination (SPD), Safety Plans, safety services, and the Safe@Home program overall. Below is a summary of the responses provided during the focus groups.

<u>Safety Plan Determination (SPD)</u>

To begin each of the focus groups, NICRP asked the participants a few questions about their experiences with the SPD. Overall, the participants reported frustration with the SPD in that they do not always have enough information about families or enough time to complete the SPD accurately but are anxious to get families started with in-home safety services. Therefore, participants reported completing the SPD

despite not having all of the necessary information just to ensure that families could begin receiving services. They reported that they often go back later and update the documentation as needed.

When discussing the process chain for completing SPDs, some participants reported frustration in that there have been instances in which they complete the SPD, "you think it's solid and you submit it, and your supervisor submits it, and you already had your Safety Plan determination meeting with the family and everyone signed off" but then the Safe@Home staff makes them change "just like a word or something because they have to justify the service and they feel it wasn't justified." The participants went on to explain that they then have to re-write it and get everyone to sign off on it again, which delays services getting to families. One participant explained that once all of the needed signatures are obtained, in-home safety services start pretty quickly but that "sometimes it can take me a week to get the signatures and in that time, I'm managing the safety threat in the home." This participant reported that to improve the effectiveness of the program, the process needs to "move faster". When asked what they thought could speed up the process, the participants suggested cutting down the "back and forth" between them and the Safe@Home staff by providing them with more training about what "general verbiage" or "buzz words" they need to use so that Safe@Home can approve them.

The focus group participants reported having some difficulty in completing the SPD but only with regard to the last question, which is, "Are there sufficient resources within the family or community to perform the safety services necessary to manage the identified Impending Danger threats?" The participants indicated that in order for a family to be enrolled in Safe@Home that the answer to this question needs to be marked "Yes." However, when there is a waiting list for Safe@Home services, they indicated that the answer to the question should be "No" but then they struggle with determining whether or not they can maintain the family while they are on the waitlist. The participants also indicated that they are encouraged to mark "Yes" to this question even when they do not believe that Safe@Home is the best fit or adequate for dealing with a families' issues.

When asked how knowledgeable their supervisors are in completing the SPD, the participants reported that they all seem knowledgeable but that there is no consistency between supervisors in how the SPD should be completed. During the discussion they questioned whether or not the supervisors were "blindly approving" the SPDs because the Safe@Home staff often send them back to the caseworkers for more clarification. They described receiving a lot of support from the Safe@Home staff in making the necessary changes to the SPDs that are sent back to them, but they indicated that during that process they are not learning how to independently prepare an SPD that would be accepted by Safe@Home. They reported that this skill would help speed up the documentation process and get in-home safety services to the families quicker. The participants also indicated that it can be difficult to complete the SPD because some families do not "fit the boxes" that need to be checked in order to receive in-home safety services despite their belief that the family could benefit from the services.

During the 2018 focus group, the participants were asked to describe some of the characteristics of families that tend to be successful in the Safe@Home program. Some of the participants indicated that the parents' attitude has a lot to do with their success. Specifically, parents that are compliant just to get their children back are not as successful as those that recognize the need for and desire to make a change in their life. Other participants reported that success has a lot to do with the safety manager. Families with safety managers that go into the home, check on the impending danger and then leave are not as successful as families with safety managers that communicate and interact with the entire family.

Finally, one participant noted that Safe@Home families are typically more successful when it can be determined when the impending danger is most likely to occur so that the in-home safety services are offered when the family needs them.

Overall, the participants reported that with the use of the new model and tools, it seems easier to identify who needs to be served and how. They indicated that it has always been the case that DFS serves some families that do not need to be served, but they feel that this is happening less often since the implementation of the new model. The participants also indicated that as a result of the new model, children are being returned to their homes faster.

Safety Plans

Caseworkers indicated that it has always been the case that DFS serves some families that do not need to be served, but they feel that this is happening less often since the implementation of the new model.

When asked how the Safe@Home program has impacted their ability to create in-home Safety Plans, the participants reported that the plans "have become much more family oriented" and are more focused on the specific needs of each family. Participants also spoke of the value of in-home safety managers in that families feel more comfortable with them and are more willing to disclose information to them than they are with the caseworkers. They explained that the families become more "self-sufficient" because of the knowledge and help that the in-home safety managers provide. Finally, participants reported that Safe@Home has allowed them to send children home faster.

Responses were mixed when asked about how the in-home safety services were being received by the families. Most of the participants indicated that the safety managers have very good rapport with the families and the families are receptive to them. They also reported that the families seem more comfortable with the safety managers than the caseworkers in that the families do not perceive the safety managers as "an authority figure" and therefore disclose more information to them. Some of the participants disagreed with the idea that the families were receptive to the safety managers. These participants reported that many of the families feel overwhelmed because they did not realize that the in-home safety services would be so intense. The participants indicated that the frequency with which some safety managers need to be in the home is intrusive and that the families feel like they are being watched all of the time. However, it was recognized that, in some cases, having a safety manager in the home multiple times a day is the only way a child could safely be returned to the home.

Next, the participants were asked about the level of support they receive in completing Safety Plans. During the 2016 and 2017 focus groups, participants were specifically asked about the support they receive from their supervisors. During the 2016 focus group, it was indicated that some supervisors did not agree that, even with in-home safety services, children could be returned home where a threat still existed. Despite their supervisors not feeling comfortable with the model, the caseworkers reported that if they stood up for their decisions and backed them up based on the model, then the supervisors did not prevent them from implementing in-home Safety Plans. Similar views were expressed in 2017 with participants indicating that some supervisors were more comfortable and supportive in the creation of in-home Safety Plans than others. In 2018, the participants discussed the support that they received directly from the Safe@Home program staff. They reported having worked through mock cases with Safe@Home staff, which they described as being helpful in understanding how to create Safety Plans. Those focus group participants that worked in the same building as the Safe@Home

program staff reported receiving a lot of beneficial support in completing the Safety Plans directly from the Safe@Home staff.

One challenge that was mentioned in completing the Safety Plan was getting the safety managers to understand their role in the plan. The participants indicated that TDMs are an effective method of explaining to the safety managers their role in the plan. Further, they expressed that TDMs are also important when there are several responsible parties included in the Safety Plan. Although they agreed that TDMs are beneficial and ideally should be used for all cases, the focus group participants reported that they are time consuming and that their time could be better spent elsewhere.

Safety Services

Next, the participants were asked whether or not in-home safety services were available during the days and times that they were needed. During the 2016 focus group, the participants reported that the in-home safety service providers only offered services from 7am to 10pm and that most families needed services earlier in the morning when children get ready for school. During the 2017 focus group, the participants indicated that some of the in-home safety providers were "already booked" during the times that they needed them to provide services to families. During this focus group it was suggested that the in-home safety service agencies hire more safety managers or that more agencies be trained to provide services. During the 2018 focus group, none of the participants reported having any problems with the days and times that in-home safety services were available or how quickly the safety service agencies were able to serve families.

During the 2016 focus group, the focus group participants spoke a lot about communication issues when asked what it was like working with the safety managers. It was reported that the safety managers sent them weekly updates on the families that they served but that the format of these updates varied by agency. Some agencies sent extensive case notes that the caseworkers did not consider helpful because there was too much unnecessary information included that they had to "dig through" and other agencies provide very little information (e.g., "Mom is doing well"). Further, some agencies sent the weekly updates as a Word document and some agencies sent them in the body of an email. All of the participants agreed that providing the agencies with a standard template to use for weekly updates would be helpful. During this discussion the participants also indicated that they preferred to communicate directly with the safety manager providing the in-home safety services and not the safety manager supervisor. Weekly staffings that they were having with the safety manager supervisors were not helpful. During the 2017 focus group, some participants reported frustration with in-home safety managers who had deviated from scheduled visits as outlined in the Safety Plan to accommodate the schedules of the families. They also reported being frustrated when safety managers suggested a reduction in the number of safety service hours that a family receives or a change in the type of service delivered. In response, one participant stated, "I'm the captain of the ship!" and indicated that they would be the one to make that decision – not the safety manager. In contrast, during the 2018 focus group, all of the participants reported having great experiences with the in-home safety managers. They were described as "an extension of us" and as being able to identify potential problems within the home and notify the caseworker before problems manifest. Due to the difference in attitude and opinion of previous focus group participants, the 2018 participants were asked if their peers not present felt the same way about the safety managers. One participant explained that "any resource is always welcome" and that they do not see safety managers as negative in any way. One participant noted that the safety

managers had been misused in the past by some caseworkers in that they were treated as "babysitters" but that Safe@Home is now more selective about which cases it accepts so that the safety managers are no longer used in that way.

When asked how they use the information provided to them by the safety managers, the focus group participants explained that the safety managers are very helpful in pointing out potential concerns or impending danger threats and were considered "a second set of eyes". The participants indicated that the information provided to them by the safety managers helps clue them in on things that they should follow-up with when they check-in with families.

When asked about the high frequency of some in-home safety services, the participants reported that sometimes children are court ordered to return home but they question whether or not the children will be safe. Therefore, they create Safety Plans that require in-home safety managers to visit families multiple times a day every day to help mitigate any potential danger.

When discussing the available safety services, some participants indicated the need for more bilingual in-home safety services and unplanned safety manager visits to the families.

Safe@Home Overall

Overall, the focus group participants reported that they like the Safe@Home program. They indicated that because of the program, children spend less time in out of home care, return to their families sooner, and their cases are closed faster. They also noted that the sooner children are returned home, the more responsive families tend to be to the caseworker and working on their case plan. Participants described the in-home safety managers as "an extra set of eyes" on the families, which they have found helpful. They also reported that the safety managers are effective at forming relationships with the families and providing them with the support they need. Participants also indicated that the program is very beneficial for those families that are ready to make changes and that with the help of the safety managers, other families become ready to make changes.

Suggestions for program improvement that were offered by the participants included:

- Having a standardized format for safety manager weekly updates.
- More flexibility in the times and days that in-home safety services can be provided to families.
- Having a Safe@Home staff member at each DFS site to promote program consistency with regard to the development of Safety Plans and to help clarify Safe@Home policies and procedures.
- Making support services available through Safe@Home 24 hours a day 7 days a week so that Safety Plans could be created any time of day, which would prevent children from going to Child Haven.
- Documenting Safe@Home policies with better clarity.

Chart Review

NICRP had planned to conduct a chart review each year of the demonstration project. The chart review was to include a random selection of 10% of the cases of families enrolled in the treatment group to determine fidelity to the model with regard to the design of in-home Safety Plans. The goal of this component of the process study was to gather information about how the family assessments align with

the decision to implement paid in-home safety services as well as how the Safety Plan aligns with the identified safety threats. This information was going to be collected to help monitor the implementation of the project and interpret outcome findings.

The only chart review conducted for the process study occurred in October of 2016. During this review, it was determined that, overall, the documents being reviewed for individual cases (NIA, SPD, and Safety Plan) did not align with one another making it difficult to evaluate the decision making process of the caseworkers. Asked if there would be better documentation to review, DFS reported that the individual case notes would most likely capture the information sought. Due to the anticipated volume of caseworker notes for each case and difficulty accessing the system for review, NICRP did not conduct any other chart reviews. What follows is a description of the methodology and results of the chart review that was conducted.

In October of 2016, NICRP randomly selected 15 (10%) of the treatment condition charts to review. The list of the 15 chart IDs was submitted to the Safe@Home program staff who then printed the NIA, SPD, and Safety Plan for each chart. Two NICRP evaluation team members independently reviewed the documents at DFS to determine whether or not the in-home Safety Plans were based on the NIA and SPD. Specifically, for each chart, NICRP reviewed:

1. Each of the seven SPD questions to determine if the responses were supported by information documented in the NIA.
2. Each of the impending danger threats identified in the SPD to determine if they were addressed in the Safety Plan.
3. Each SPD to determine if the conditions in which the impending danger manifests itself were identified (i.e., times, days, or specific circumstances).
4. Each Safety Plan to determine if it established support for the family during the conditions of impending danger as identified in the SPD.

After reviewing several charts, the two NICRP evaluation team members consulted with one another because, for some of the charts reviewed, the dates and information listed in the NIA and the SPD did not seem to correspond with one another, which made it difficult to review the case documents as planned. Specifically, in some cases the impending danger threats identified in the SPD were not the same impending danger threats identified in the NIA or the family situation described in the SPD was different from the situation described in the NIA. Once this discrepancy was identified, NICRP tracked the following dates for each chart being reviewed:

1. Date the NIA was created and modified
2. Date the SPD was created and modified
3. Date the Safety Plan became effective

After independently reviewing the fifteen charts for the elements described, the two evaluators met to reconcile any discrepancies and summarize the findings.

Results

Of the 15 charts reviewed, the NIA "matched" the SPD in seven of them. Table 9 below indicates the average and range number of days occurring between the date the NIA was created and the date the SPD was created for those cases in which the two documents "matched" and in those cases in which they did not. As can be seen in Table 9, for this review, the NIA and SPD were more likely to "match" one another when there were fewer days occurring between completion of the two documents.

Table 9. Average and range number of days occurring between the NIA and SPD for those cases in which the two documents did and did not "match"

	NIA and SPD did "Match" (n = 7)	NIA and SPD did not "Match" (n = 6)[a]
Average number of days between NIA and SPD	33.28	238.33
Range number of days between NIA and SPD	0 to 92	-90[b] to 640

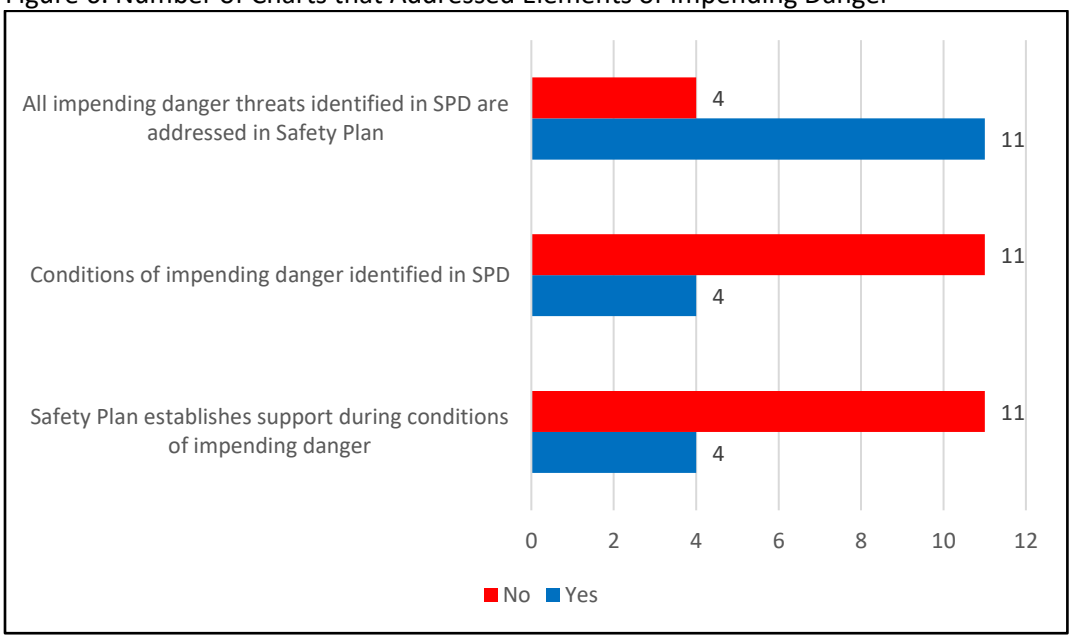
[a] Two cases in which the NIA and SPD did not "match" are not included in these calculations because the two reviewers did not receive the same NIAs to review.
[b] For one case, the SPD was created 90 days prior to the NIA that was provided for review.

Because the NIA and SPD "matched" in fewer than half of the charts reviewed, NICRP inquired about additional documentation that would support the answers to the SPD questions. As a result, NICRP was provided with Nevada Safety Assessments for these charts. After reviewing the Nevada Safety Assessments it was determined that, unlike the NIAs for these cases, the Nevada Safety Assessments did "match" the SPDs in that they both included the same impending danger threats. However, by design, the Nevada Safety Assessments do not provide enough documentation to assess whether or not the information in the assessment supports the answers to the SPD questions.

SPD questions answered based on NIA - Because there were eight charts in which the NIA and SPD did not "match", it was not appropriate to include them in the review of whether or not the answers to the SPD questions were supported by the information in the NIA. Of the seven charts in which the NIA and SPD "matched", the average number of SPD questions that were supported by the information documented in the NIA was six (out of seven questions) with a range of four to seven questions being answered appropriately. In most instances, answers to the SPD questions were not necessarily contradicted by the NIA, rather there was no documentation in the NIA to support the SPD answers.

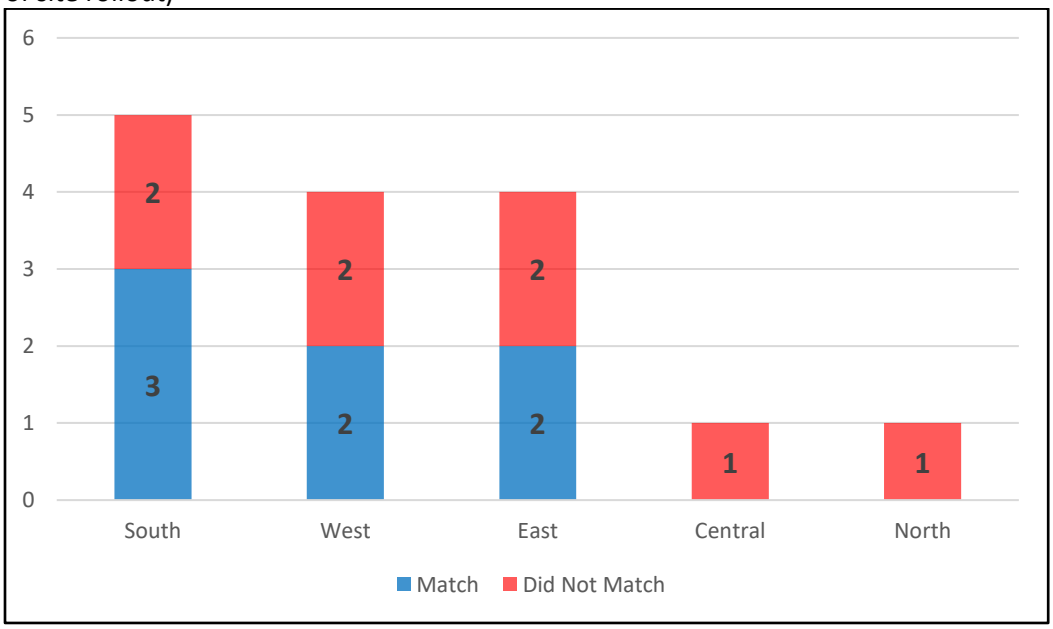
Impending danger threats - As seen in Figure 6 below, in 11 of the 15 charts reviewed, each of the impending danger threats identified in the SPD were addressed in the Safety Plan. However, the details of the conditions of the impending danger (i.e., times, days, or specific circumstances) were only identified in the SPDs of three of these 11 charts. In one additional chart, the details of the conditions of the impending danger were identified in the SPD but not all of the impending danger threats for this case were addressed in the Safety Plan. In all four of the charts in which the details of the impending danger were identified, the in-home Safety Plan established support during the identified conditions of impending danger.

Figure 6. Number of Charts that Addressed Elements of Impending Danger



Differences by site - Given that the degree of caseworker experience with the model and these assessments varies depending on when sites began implementing the model, NICRP analyzed the results of this review by site. As anticipated, more NIAs and SPDs matched at the sites that began implementing the model earlier than those that began implementing it later (see Figure 7).

Figure 7. Number of Charts Reviewed in which the NIA and SPD Did and Did Not Match by Site (in order of site rollout)



As seen in Table 10, there were also site differences with regard to the Safety Plan addressing all of the impending danger threats identified in the SPD. However, with the exception of the South site performing very well and the North site performing poorly, there does not appear to be a trend related to when the site began implementing the model. Also seen in Table 10, with the exception of the single

chart that was reviewed at Central, none of the sites performed well with regard to identifying the conditions of impending danger in the SPD. However, in those cases in which the conditions of impending danger were identified, the Safety Plans clearly established support during those conditions of impending danger.

Table 10. Percentage and proportion of reviewed charts addressing elements of impending danger by site

	All impending danger threats identified in SPD are addressed in Safety Plan	Conditions of impending danger identified in SPD	Safety Plan establishes support during conditions of impending danger*
South	100% (5/5)	20% (1/5)	100% (1/1)
West	50% (2/4)	25% (1/4)	100% (1/1)
East	75% (3/4)	25% (1/4)	100% (1/1)
Central	100% (1/1)	100% (1/1)	100% (1/1)
North	0% (0/1)	0% (0/1)	0% (0/0)
*Only applies if conditions of impending danger were identified in the SPD			

Discussion

The results of the chart review indicate some areas of strength and some areas for improvement with regard to the completion of the NIA, SPD, and Safety Plan.

The review also highlighted the fact that when the SPD is not completed within a few months of the NIA, there is likely a disconnect between the information provided in the NIA and the SPD. Specifically, the impending danger threats identified in the NIA are no longer the same impending danger threats addressed in the SPD due to families' changing circumstances. Therefore, in these cases, the NIA did not provide the documentation necessary to support the answers to the questions on the SPD. Although the Nevada Safety Assessments did somewhat bridge the gap between the NIA and the SPD with regard to understanding the impending danger that was addressed in the SPD, these assessments did not provide enough information to support the answers to the SPD questions. It is not clear if there is a single document that currently exists which would support the responses to the SPD questions in these cases or if the support is contained primarily in case notes. If no single document currently exists, it might be helpful to modify the SPD form to allow a brief statement under each question to support the yes/no answer. Alternatively, the Nevada Safety Assessment could require a more structured narrative to support the answers to the SPD questions. These forms lacked the documentation to support the answers to the SPD questions and made it difficult to ascertain whether or not the questions were answered appropriately which in turn made it difficult to use the tools to determine whether a family was or was not appropriate for receipt of in-home safety services.

A review of the SPDs and Safety Plans indicates that when the SPD details exactly how and when the impending danger manifests itself, the Safety Plan clearly and directly establishes support for the family during these circumstances to mitigate the impending danger. Unfortunately, in 73.3% of the charts reviewed, these details were missing from the SPD. However, in all of the cases in which these details were provided, the Safety Plan provided excellent details of how the in-home safety services would support the family.

In conclusion, the chart review revealed some interesting findings about the process of screening families for the Safe@Home program. First, as expected, those sites that had more experience than others in completing the assessments were better able to document support for findings based on the assessments, ensure that the SPD explicitly outlined the parameters of the danger to the child, and then create a Safety Plan that addressed each of the parameters outlined in the SPD. Second, it seems that there could be some additional documentation included in the assessments so that decisions are more easily evaluated by an outside reviewer on a regular basis. This could include space on the SPD to support a Yes/No answer for each SPD question as well as space on the Nevada Safety Assessment for a narrative that would provide support for decisions made on the SPD. Essentially, this process would allow Safe@Home staff to easily evaluate how caseworkers are making their decisions when cases are enrolled in the program and then provide additional training or assistance to those sites that might need clarification on how best to screen families for the program.

The Outcome Study

The key outcome study questions for the project included:

- Do significantly fewer families and children receiving in-home safety services from a paid safety manager experience new substantiated investigations of maltreatment within twelve months of the implementation of the in-home Safety Plan as compared to the comparison group?

- Do significantly fewer children of families receiving in-home safety services from a paid safety manager experience a removal from the home within twelve months of the implementation of the in-home Safety Plan as compared to the comparison group?

- For the treatment group, is progress toward increasing protective capacity evidenced by scores on the Protective Capacity Progress Assessment (PCPA) after the implementation of in-home safety services up until twelve months or case closure? (This outcome is being measured only within the treatment group. PCPAs were not completed prior to the waiver, therefore this data will not be available for the comparison group families.)

- Do impending danger threats cease to exist in the home six and twelve months after in-home safety services are no longer provided to the family by a paid safety manager?

- Twelve, eighteen, and twenty-four months after case closure, will there will be no further substantiated cases of abuse or neglect in the home for those families that receive in-home safety services by a paid safety manager?

The project outcomes were evaluated using comparison group methodology. The comparison group includes families that received informal in-home safety services without a paid safety manager after DFS implementation of the Safety Intervention and Permanency System (SIPS) model (October, 2014). The

following criteria were used to identify families eligible to be included in the comparison group:

1. The family was assigned an in-home caseworker
2. A documented Safety Plan for the family existed
3. The documented Safety Plan identified at least one impending danger threat
4. No formal safety service provider was listed as part of the documented Safety Plan

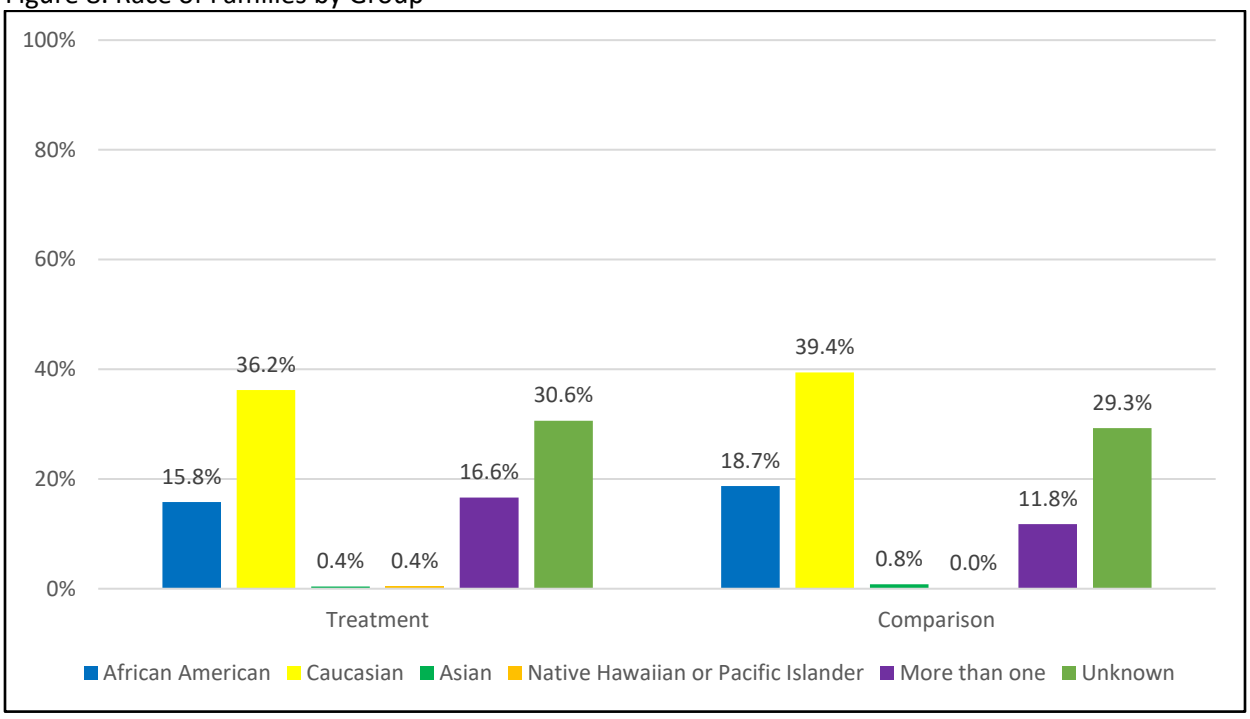
The treatment group includes families that received in-home safety services provided by a paid safety manager.

Sample

A total of 1056 families were enrolled in the Clark County DFS Title IV-E Waiver Demonstration Project. Of the 1056 families enrolled, 810 received in-home safety services through a trained, contracted safety manager with certification in safety management and therefore were enrolled in the treatment group. Of the 1056 families enrolled, 246 received in-home safety services through informal supports such as friends, family members, or neighbors and were enrolled in the comparison group. The following is an overview of the characteristics of the treatment and comparison group families that were enrolled in the demonstration project. For more detailed information, refer to Appendix A.

As seen in Figure 8 below, the families enrolled in the treatment and comparison groups are similar with regard to race. Please note that, for a family to be categorized as African American, Caucasian, Asian, or Native Hawaiian or Pacific Islander, the race for every family member had to be documented as either African American, Caucasian, Asian, or Native Hawaiian or Pacific Islander. If the race of one family member was not reported, then the race of the family was categorized as “unknown”. There are no families for whom the race of every family member was indicated as the same race other than African American, Caucasian, Asian, or Native Hawaiian or Pacific Islander.

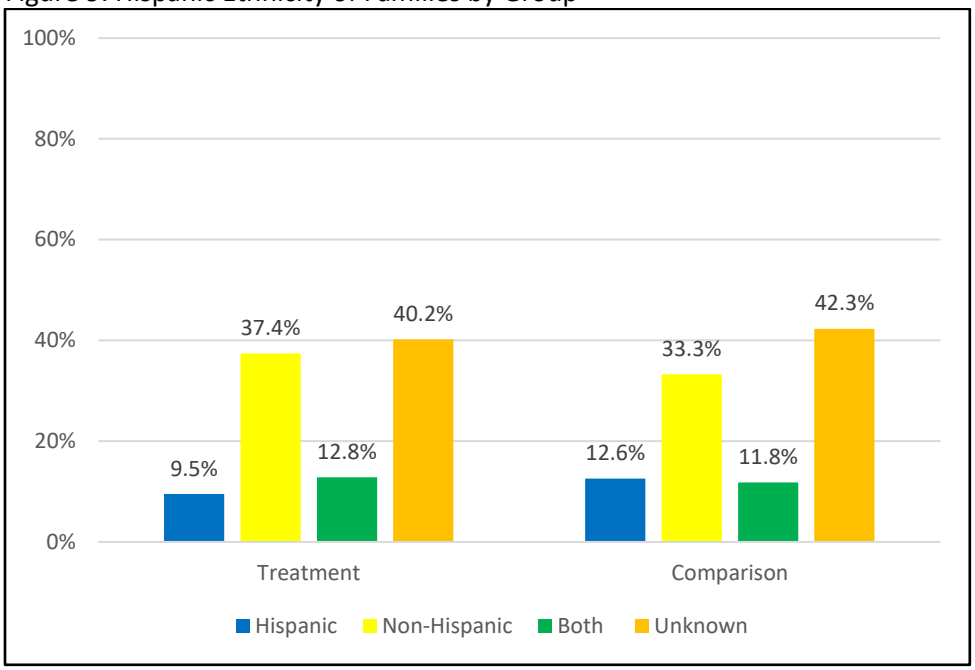
Figure 8. Race of Families by Group



For 320 (30.3%) of the families enrolled in the demonstration project, the race of the family was categorized as "unknown". For 188 of these families, the race of one or more of the parents was unknown. For 62 of these families, the race of one or more of the children was unknown. For 70 of these families, the race of one or more of the parents was unknown and the race of one or more of the children was also unknown.

As seen in Figure 9 below, the families in the comparison and treatment groups are also similar with regard to Hispanic ethnicity. Please note, that for a family to be categorized as Hispanic or Non-Hispanic, the documented ethnicity for every family member had to be either Hispanic or Non-Hispanic. If a family was comprised of both Hispanic and Non-Hispanic members, then the family was categorized as "both". If the ethnicity for any family member was not indicated, then the family was categorized as "unknown".

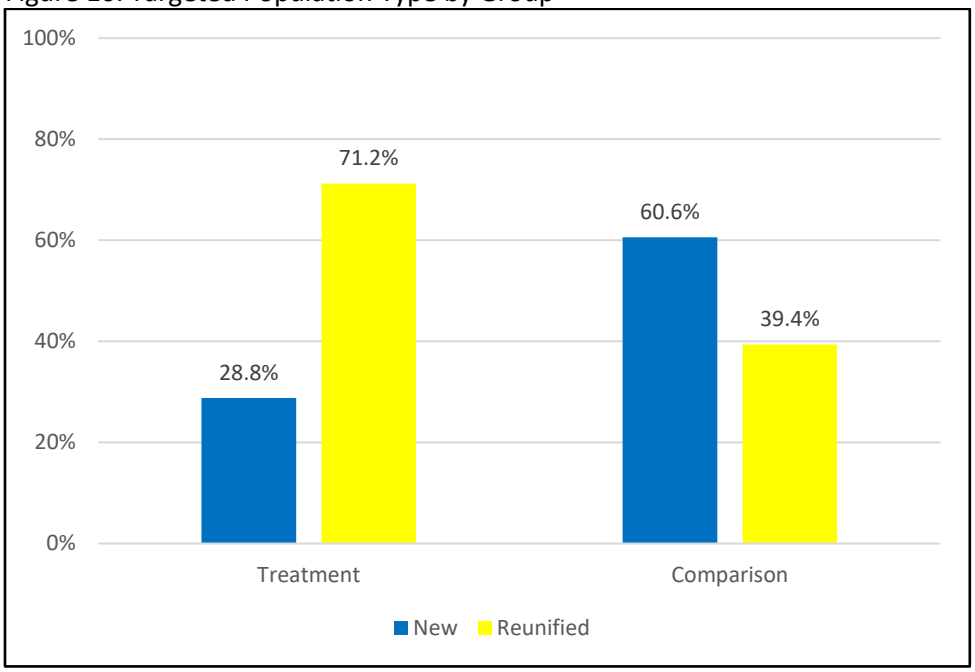
Figure 9. Hispanic Ethnicity of Families by Group



For 430 (40.7%) of the families enrolled in the demonstration project, the ethnicity of the family was categorized as "unknown". For 160 of these families, the ethnicity of one or more of the parents was unknown. For 111 of these families, the ethnicity of one or more of the children was unknown. For 159 of these families, the ethnicity of one or more of the parents was unknown and the ethnicity of one or more of the children was also unknown.

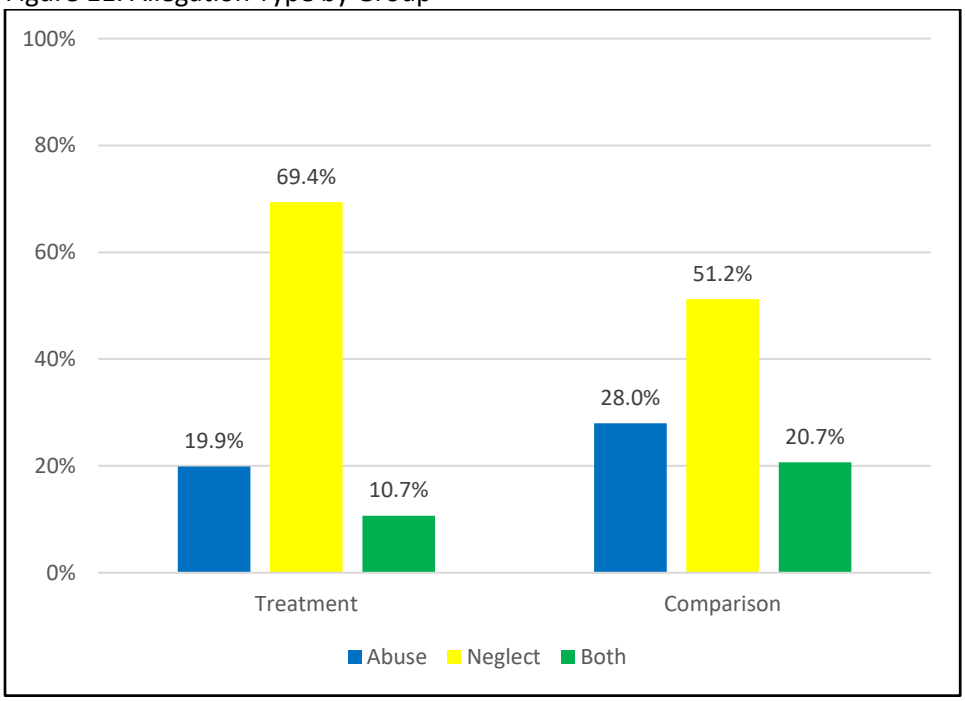
There were two specific target populations included in the demonstration project. One population included families and children for whom impending danger was identified via the Nevada Initial Assessment (NIA) and the use of an in-home Safety Plan was justified by the Safety Plan Determination (SPD). For the purposes of the demonstration project, this population was referred to as "new" families. The second population included children who were in out-of-home care but whose family met the Conditions for Return and the Safety Plan Determination justified the use of an in-home Safety Plan. For purposes of the demonstration project, this population was referred to as "reunified" families. As seen in Figure 10 below, the majority of the treatment group was comprised of reunified families and the majority of the comparison group was comprised of new families.

Figure 10. Targeted Population Type by Group



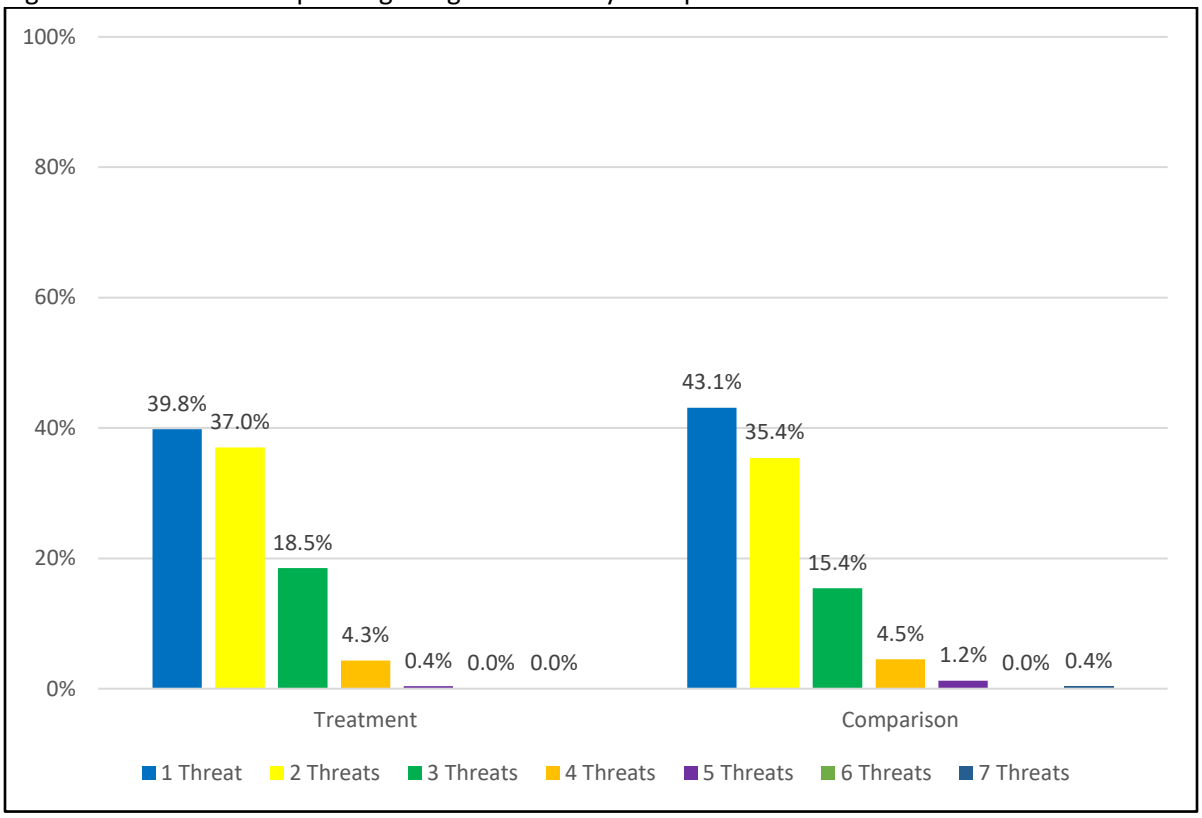
As seen in Figure 11 below, a larger percentage of families in the treatment group received services for allegations of neglect than in the comparison group and a larger percentage of families in the comparison group received services for allegations of abuse and both abuse and neglect as compared to the treatment group.

Figure 11. Allegation Type by Group



The treatment and comparison groups were similar with regard to the proportion of the number of impending danger threats the families were experiencing at the time the Safety Plan was developed. As seen in Figure 12 below, the majority of families in both groups were experiencing one or two impending danger threats. With the exception of one family in the comparison group that was experiencing seven impending danger threats, no families in either group were experiencing more than five impending danger threats at the time the Safety Plan was developed.

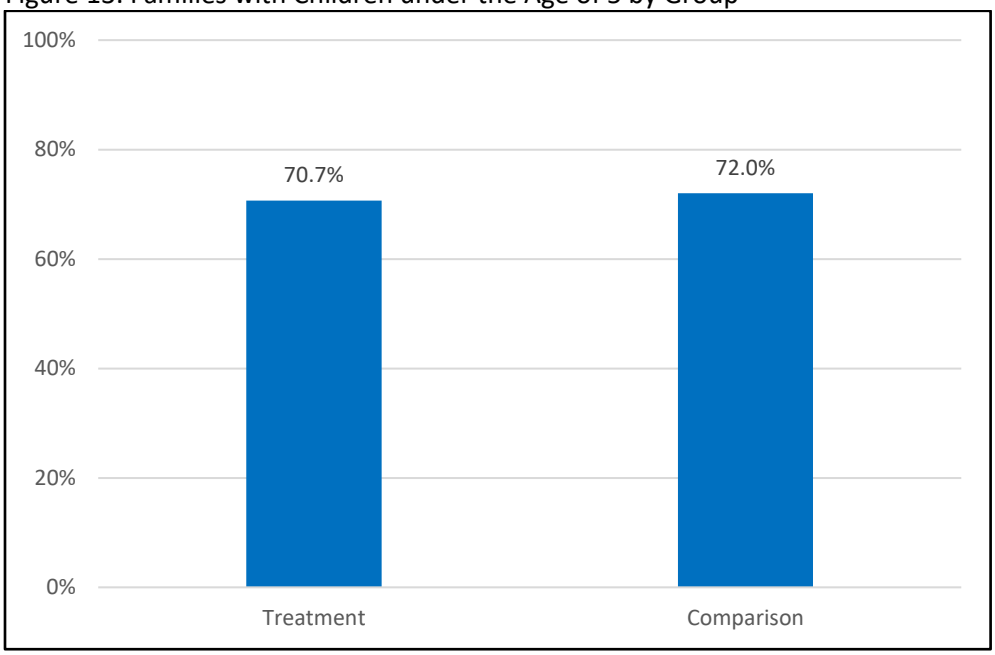
Figure 12. Number of Impending Danger Threats by Group



The most common impending danger threat identified for both the treatment and comparison group families was, “One or both parents/caregivers cannot control their behavior”. The second most common impending danger threat for both the treatment and comparison group families was, “One or both parents/caregivers lack parenting knowledge, skills, and motivation which affect child safety”. For more detailed information, refer to Appendix B.

As seen in Figure 13 below, for both the treatment and comparison groups, approximately 70% of families had at least one child under the age of five years at the time of enrollment.

Figure 13. Families with Children under the Age of 5 by Group



Outcome Study Goals

In the sections that follow, the specific project outcome goals are identified along with project progress toward each of these goals. Within each section, the project goal is stated, the methodology used to measure the goal is described, and the findings for each goal is summarized.

Goal 1: Significantly fewer families and children receiving contracted in-home safety services will experience new substantiated investigations of maltreatment as compared to those in the comparison group.

To measure this goal, DFS project staff reviewed whether or not families enrolled in the demonstration project had experienced new substantiated investigations of maltreatment every 90 days after the implementation of in-home safety services. Specifically, each month, NICRP sent DFS a list of those families that were at the 90 day review benchmark and DFS reported back to NICRP whether or not members of the family experienced any new substantiated investigations of maltreatment during the past 90 days and if so, the type of allegation. The records of families enrolled in the project were reviewed every 90 days until case closure up to 24 months. Substantiated investigations occurring after case closure are captured in Goal 5.

The final request for these data was submitted to DFS by NICRP on August 29, 2019 and included requests for data through August 31, 2019. Due to the timing of this final data request and families' in-homes safety services start date and case closure date, data are not available for all families enrolled in the demonstration project at every 90 day review benchmark. For example, a family might not have reached a specific 90 day review benchmark before their case closed or a family might not have reached a specific 90 day review benchmark before the final data request. It is important to note that this goal is

examining new substantiated investigations of maltreatment while cases are open to DFS. Table 11 below shows the days included in each 90 day review benchmark period.

Table 11. Days included in each 90 day review benchmark period

Benchmark	From	Through
BM1	Date that the Safety Plan was signed by the in-home safety manager (treatment group) or the effective date of the Safety Plan (comparison group)	90 Days
BM2	91 days after the date that the Safety Plan was signed by the in-home safety manager (treatment group) or the effective date of the Safety Plan (comparison group)	180 Days
BM3	181 days after the date that the Safety Plan was signed by the in-home safety manager (treatment group) or the effective date of the Safety Plan (comparison group)	270 Days
BM4	271 days after the date that the Safety Plan was signed by the in-home safety manager (treatment group) or the effective date of the Safety Plan (comparison group)	360 Days
BM5	361 days after the date that the Safety Plan was signed by the in-home safety manager (treatment group) or the effective date of the Safety Plan (comparison group)	450 Days
BM6	451 days after the date that the Safety Plan was signed by the in-home safety manager (treatment group) or the effective date of the Safety Plan (comparison group)	540 Days
BM7	541 days after the date that the Safety Plan was signed by the in-home safety manager (treatment group) or the	630 Days

	effective date of the Safety Plan (comparison group)	
BM8	631 days after the date that the Safety Plan was signed by the in-home safety manager (treatment group) or the effective date of the Safety Plan (comparison group)	720 Days
BM9*	721 days after the date that the Safety Plan was signed by the in-home safety manager (treatment group) or the effective date of the Safety Plan (comparison group)	730 Days
*This benchmark review period only includes 10 days because it allows for the capture of information up to the cut off of 24 months after the Safety Plan was signed by the in-home safety manager (treatment group) or the effective date of the Safety Plan (comparison group)		

As seen in Table 12 below, a larger percentage of treatment group families experienced a new substantiated investigation at BM1, BM2, BM4, BM5, and BM6 as compared to the comparison group families. Conversely, a larger percentage of comparison group families experienced a new substantiated investigation at BM3 as compared to the treatment group families. No families experienced a new substantial investigation at BM7, BM8, or BM9.

Table 12. Number and percent of families that experienced a new substantiated investigation by group at each 90 day review benchmark (BM) while the case was open to DFS

	Treatment			**Comparison**		
	Number of families at benchmark	Number experiencing a new substantiated investigation	Percent experiencing a new substantiated investigation	Number of families at benchmark	Number experiencing a new substantiated investigation	Percent experiencing a new substantiated investigation
BM1	797	29	3.6%	246	1	0.4%
BM2	617	30	4.9%	218	6	2.8%
BM3	337	6	1.8%	128	3	2.3%
BM4	209	8	3.8%	59	2	3.4%
BM5	91	3	3.3%	30	0	0.0%
BM6	61	2	3.3%	14	0	0.0%
BM7	45	0	0.0%	10	0	0.0%
BM8	34	0	0.0%	5	0	0.0%
BM9	20	0	0.0%	4	0	0.0%
Note: It is possible for a family to experience a new substantiated investigation at multiple benchmarks.						

The results of two chi-square tests of independence indicate that the treatment group experienced statistically significantly more new substantiated investigations at BM1 (X^2 (1, N = 1043) = 7.03, p = .008) as compared to the comparison group but not at BM2 (X^2 (1, N = 835) = 1.74, p = .187). There were also no statistically significant differences between the treatment and comparison groups with regard to the number of new substantiated investigations at BM3 (p = .711, Fisher's exact test), BM4 (p = 1.000, Fisher's exact test), BM5 (p = .573, Fisher's exact test), or BM6 (p = 1.000, Fisher's exact test). No families in either the treatment or comparison groups experienced new substantiated investigations at BM7, BM8, or BM9; therefore no statistical comparisons were conducted.

As noted in Table 12 above, it was possible for a family to experience a new substantiated investigation at multiple benchmarks. One treatment group family experienced new substantiated investigations at three 90 day review benchmarks (BM1, BM2, and BM 4). Four treatment group families experienced new substantiated investigations at two 90 day review benchmarks (two families experienced the investigations at BM1 and BM4, one family experienced the investigations at BM2 and BM3, and one family experienced the investigations at BM3 and BM4). Only one comparison group family experienced new substantiated investigations at more than one benchmark (BM2 and BM3).

Of the 78 new substantiated investigations experienced by families in the treatment group, 74.4% were neglect, 12.8% were abuse, and 12.8% were both neglect and abuse. Of the 12 new substantiated investigations experienced by families in the comparison group, 75.0% were neglect, 8.3% were abuse, and 16.6% were both neglect and abuse.

Additional analyses indicate that, of the 78 new substantiated investigations experienced by families in the treatment group, 55.1% were experienced by reunified families and 44.9% were experienced by new families. Of the twelve new substantiated investigations experienced by families in the comparison group, 66.7% were experienced by new families and 33.3% were experienced by reunified families. The number and percent of new and reunified families experiencing a new substantiated investigation at each 90 day benchmark can be seen in Table 13 below.

Table 13. Number and percent of new and reunified families that experienced a new substantiated investigation by group at each 90 day review benchmark (BM) while the case was open to DFS

	Treatment			**Comparison**		
	New	Reunified	Combined	New	Reunified	Combined
BM1	15 (51.7%)	14 (48.3%)	29 (100%)	1 (100%)	0 (0.0%)	1 (100%)
BM2	14 (46.7%)	16 (53.3%)	30 (100%)	3 (50.0%)	3 (50.0%)	6 (100%)
BM3	2 (33.3%)	4 (66.7%)	6 (100%)	3 (100%)	0 (0.0%)	3 (100%)
BM4	3 (37.5%)	5 (62.5%)	8 (100%)	1 (50.0%)	1 (50.0%)	2 (100%)
BM5	0 (0.0%)	3 (100%)	3 (100%)	N/A	N/A	N/A
BM6	1 (50.0%)	1 (50.0%)	2 (100%)	N/A	N/A	N/A
BM7	N/A	N/A	N/A	N/A	N/A	N/A
BM8	N/A	N/A	N/A	N/A	N/A	N/A
BM9	N/A	N/A	N/A	N/A	N/A	N/A
Overall	35 (44.9%)	43 (55.1%)	78 (100%)	8 (66.7%)	4 (33.3%)	12 (100%)

Goal 2: Significantly fewer children of families receiving contracted in-home safety services will be removed from the home within 12 months of the implementation of the in-home Safety Plan as compared to those in the comparison group.

To measure this goal, DFS project staff reviewed whether or not children of families enrolled in the demonstration project had been removed from their homes every 90 days after the implementation of in-home safety services. Specifically, each month, NICRP sent DFS a list of those families that were at the 90 day review benchmark and DFS reported back to NICRP whether or not children had been removed from the home during the past 90 days and if so, how many children were removed. The records of families enrolled in the project were reviewed every 90 days until case closure up to 24 months.

The final request for these data was submitted to DFS by NICRP on August 29, 2019 and included requests for data through August 31, 2019. Due to the timing of this final data request and families' in-homes safety services start date and case closure date, data are not available for all families enrolled in the demonstration project at every 90 day review benchmark. For example, a family might not have reached a specific 90 day review benchmark before their case closed or a family might not have reached a specific 90 day review benchmark before the final data request. It is important to note that this goal is examining new child removals while cases are open to DFS. Table 14 below shows the days included in each 90 day review benchmark period.

Table 14. Days included in each 90 day review benchmark period

Benchmark	From	Through
BM1	Date that the Safety Plan was signed by the in-home safety manager (treatment group) or the effective date of the Safety Plan (comparison group)	90 Days
BM2	91 days after the date that the Safety Plan was signed by the in-home safety manager (treatment group) or the effective date of the Safety Plan (comparison group)	180 Days
BM3	181 days after the date that the Safety Plan was signed by the in-home safety manager (treatment group) or the effective date of the Safety Plan (comparison group)	270 Days
BM4	271 days after the date that the Safety Plan was signed by the in-home safety manager (treatment group) or the	360 Days

	effective date of the Safety Plan (comparison group)	
BM5	361 days after the date that the Safety Plan was signed by the in-home safety manager (treatment group) or the effective date of the Safety Plan (comparison group)	450 Days
BM6	451 days after the date that the Safety Plan was signed by the in-home safety manager (treatment group) or the effective date of the Safety Plan (comparison group)	540 Days
BM7	541 days after the date that the Safety Plan was signed by the in-home safety manager (treatment group) or the effective date of the Safety Plan (comparison group)	630 Days
BM8	631 days after the date that the Safety Plan was signed by the in-home safety manager (treatment group) or the effective date of the Safety Plan (comparison group)	720 Days
BM9*	721 days after the date that the Safety Plan was signed by the in-home safety manager (treatment group) or the effective date of the Safety Plan (comparison group)	730 Days
*This benchmark review period only includes 10 days because it allows for the capture of information up to the cut off of 24 months after the Safety Plan was signed by the in-home safety manager (treatment group) or the effective date of the Safety Plan (comparison group)		

As seen in Table 15 below, a smaller percentage of comparison group families experienced the removal of a child at BM1, BM2, BM3, BM4, and BM5 as compared to the treatment group families. At BM6, a larger percentage of comparison group families experienced the removal of a child as compared to the treatment group families. No families experienced the removal of a child at BM7, BM8, or BM9.

Table 15. Number and percent of families that experienced a new removal of a child by group at each 90 day review benchmark (BM) while the case was open to DFS

	Treatment Group			Comparison Group		
	Number of families at benchmark	Number experiencing a new removal	Percent experiencing a new removal	Number of families at benchmark	Number experiencing a new removal	Percent experiencing a new removal
BM1	797	76	9.5%	246	7	2.8%
BM2	617	39	6.3%	218	11	5.0%
BM3	337	12	3.6%	128	4	3.1%
BM4	209	6	2.9%	59	1	1.7%
BM5	91	1	1.1%	30	0	0.0%
BM6	61	2	3.3%	14	1	7.1%
BM7	45	0	0.0%	10	0	0.0%
BM8	34	0	0.0%	5	0	0.0%
BM9	20	0	0.0%	4	0	0.0%

Note: It is possible for a family to experience a new removal at multiple benchmarks. For example, a child could be removed at one benchmark, return home, and then be removed at a future benchmark. Similarly, families with multiple children could experience the removal of one child at one benchmark and another child at a future benchmark.

The results of two chi-square tests of independence indicate that the treatment group experienced statistically significantly more new removals at BM1 (X^2 (1, N = 1043) = 11.49, p = .001) as compared to the comparison group but not at BM2 (X^2 (1, N = 835) = .47, p = .495). There were also no statistically significant differences between the treatment and comparison groups with regard to the number of new removals at BM3 (p = 1.000, Fisher's exact test), BM4 (p = 1.000, Fisher's exact test), BM5 (p = 1.000, Fisher's exact test), or BM6 (p = .467, Fisher's exact test). No families in either the treatment or comparison groups experienced new removals at BM7, BM8, or BM9; therefore no statistical comparisons were conducted.

As noted in Table 15 above, it is possible for a family to experience a new removal at multiple benchmarks. Nine treatment group families and three comparison group families experienced a new removal at two of the 90 day benchmarks while their cases were open to DFS.

During the demonstration project, 276 children were removed from the homes of families enrolled in the treatment group while their cases were open to DFS and 49 children were removed from the homes of families enrolled in the comparison group while their cases were open to DFS. It is important to note that these numbers represent the cumulative number of children removed at each benchmark but not unique children removed. In other words, each time a child was removed from their home, it was counted as a removal. For example, a child could have been removed from their home at one benchmark, return home, and be removed again at another benchmark.

Of the 136 new removals experienced by families in the treatment group, 65.4% were experienced by reunified families and 34.6 % were experienced by new families. Of the 24 new removals experienced by families in the comparison group, 54.2% were experienced by reunified families and 45.8% were

experienced by new families. The number and percent of new and reunified families experiencing a new removal at each 90 day benchmark can be seen in Table 16 below.

Table 16. Number and percent of new and reunified families that experienced a new removal of a child by group at each 90 day review benchmark (BM) while the case was open to DFS

	Treatment			Comparison		
	New	**Reunified**	**Combined**	**New**	**Reunified**	**Combined**
BM1	29 (38.2%)	47 (61.8%)	76 (100%)	2 (28.6%)	5 (71.4%)	7 (100%)
BM2	11 (28.2%)	28 (71.8%)	39 (100%)	5 (45.5%)	6 (54.5%)	11 (100%)
BM3	5 (41.7%)	7 (58.3%)	12 (100%)	3 (75.0%)	1 (25.0%)	4 (100%)
BM4	1 (16.7%)	5 (83.3%)	6 (100%)	0 (0.0%)	1 (100%)	1 (100%)
BM5	0 (0.0%)	1 (100%)	1 (100%)	N/A	N/A	N/A
BM6	1 (50.0%)	1 (50.0%)	2 (100%)	1 (100%)	0 (0.0%)	1 (100%)
BM7	N/A	N/A	N/A	N/A	N/A	N/A
BM8	N/A	N/A	N/A	N/A	N/A	N/A
BM9	N/A	N/A	N/A	N/A	N/A	N/A
Overall	47 (34.6%)	89 (65.4%)	136 (100%)	11 (45.8%)	13 (54.2%)	24 (100%)

When reviewing the results of Goal 1 and Goal 2, it is important to remember that the removal of a child from a family is not necessarily due to a new substantiated investigation of maltreatment but is more likely due to the family not following the terms of the in-home Safety Plan.

Goal 3: The parents of families receiving contracted in-home safety services will have documented significant progress toward increasing their protective capacity as evidenced by scores on the Protective Capacity Progress Assessment 12 months after the implementation of in-home safety services.

To measure this goal, DFS provided NICRP with the Protective Capacity Progress Assessments (PCPAs) of the parents of those families enrolled in the project every 90 days after the implementation of in-home safety services. Specifically, each month, NICRP sent DFS a list of those families that were at the 90-day review benchmark and DFS provided NICRP with the PCPAs of those families.

In order to quantify the PCPA, NICRP calculated an overall average PCPA score by assigning a score to the progress toward meeting each goal in the PCPA as indicated by the caseworker (No progress = 1, Minimal progress = 2, General progress = 3, Significant progress = 4, and Goal achievement = 5), adding up these scores, and then dividing the sum by the number of goals listed in the PCPA.

PCPAs were not completed for families once their case was closed to DFS therefore, if a case closed prior to a 90 day review benchmark, the PCPA was not considered "due." In addition, if a family was "due" a PCPA but the site at which they were receiving services had not begun using the PCPA, then a PCPA for that family was not expected to be completed. During the first year of the project, because so few PCPAs were being completed at the anticipated 90 day review benchmarks, NICRP decided upon a window of time for which PCPAs could be accepted for each 90 day review benchmark. Specifically, PCPAs completed between 30 and 134 days after the implementation of in-home safety services counted as 90 day PCPAs, PCPAs completed between 135 and 224 days after the implementation of in-

home safety services counted as 180 day PCPAs, PCPAs completed between 225 and 314 days after the implementation of in-home safety services counted as 270 day PCPAs, and PCPAs completed between 315 and 404 counted as 360 day PCPAs.

During the third quarter of Year 3, NICRP began sending DFS a list of all of the enrolled families for whom their DFS case had closed with the dates of any PCPAs that had been received for those families and asked DFS to send any additional PCPAs that had been completed for those families. This was done in effort to ensure that NICRP had received all completed PCPAs for families enrolled in the project.

The final request to DFS from NICRP regarding PCPAs was sent August 29, 2019. Any PCPAs that were due through August 31, 2019 were requested at that time. From July 2015 through August 2019, NICRP received 550 valid treatment group PCPAs. As indicated in Table 17, 87 additional PCPAs were received, however, these PCPAs were considered invalid in that the items measuring progress (Section II) were not completed/included with the PCPA, multiple response options measuring progress were selected, progress toward all of the goals was not indicated, the PCPA received did not align with a 90 day review benchmark, or the PCPA was incomplete.

Table 17. The number of treatment group PCPAs received at each 90 day review benchmark

Days after implementation of in-home safety service	Number of PCPAs received	Number of invalid PCPAs received	Number of valid PCPAs received
30 – 134 (90 Day PCPA)	304	48	256
135 – 224 (180 Day PCPA)	198	19	179
225 – 314 (270 Day PCPA)	87	13	74
315 – 404 (360 Day PCPA)	48	7	41
Total	637	87	550

It is important to note that for 407 (50.2%) of the 810 treatment group families, NICRP received no valid PCPAs. For 41 of these 407 families, at least one PCPA was received but it was invalid. For the remaining 366 families, no PCPAs were received.

Of the 550 valid PCPAs that were received, for 190 families, only 90 day PCPAs were received; for 36 families, 90 and 180 day PCPAs were received; for eight families 90, 180, and 270 day PCPAs were received; and for five families, 90, 180, 270, and 360 day PCPAs were received. For other families, more than one PCPA was received but not in sequential order beginning with the first 90 day review benchmark. As seen in Table 18 below, based on the PCPA scores, protective capacity tended to increase over time.

Table 18. Average PCPA scores for treatment group families with multiple PCPAs

	90 Day PCPA Average Score	180 Day PCPA Average Score	270 Day PCPA Average Score	360 Day PCPA Average Score
36 Families	2.83	3.43	X	X
8 Families	2.63	2.83	3.04	X
5 Families	1.95	2.34	2.45	2.81
Note: PCPA scores range from 1 (No Progress) to 5 (Goal Achievement);				

A paired samples t-test was conducted to determine if there was a statistically significant increase in PCPA scores from 90 to 180 days for all treatment group families for whom a valid 90 and 180 Day PCPA was received (including those that also had 270 and 360 Day PCPAs). The average PCPA score improved by .49 (SD = .97) and the results from the paired samples t-test [t (51) = 3.60, p = .001] show a statistically significant difference between the 90 Day and 180 Day scores indicating that overall, PCPA scores significantly increased from 90 Days (M = 2.64) to 180 Days (M = 3.13). Due to the small sample size of families with 90, 180, and 270 Day PCPAs (n = 13) and 90, 180, 270, and 360 Day PCPAs (n = 5), no additional analyses were conducted.

Goal 4: No impending danger threats will exist in the home 6 and 12 months after contracted in-home safety services are no longer provided to the family.

The six-month review benchmark included the day that contracted in-home safety services ended until six months after contracted in-home safety services ended. The twelve-month review benchmark included six months and one day after contracted in-home safety services ended until twelve months after contracted in-home safety services ended. To measure this goal, each month, NICRP sent DFS a list of those families that were at the six and twelve-month review benchmarks and DFS reported back to NICRP whether or not the families had experienced a new substantiated investigation of maltreatment or the new removal of a child.

The final request for these data was submitted to DFS by NICRP on August 29, 2019 and included requests for data through August 31, 2019. Due to the timing of this final data request and families' in-homes safety services end date, data are not available for all families enrolled in the demonstration project. Additionally, it should be noted that 53 treatment group families received contracted in-home safety services after their safety services end date. None of these families was included in the measurement of this goal.

As seen in Table 19 below, within six months of safety services ending, 5.9% of treatment group families experienced a new substantiated investigation and 10.9% experienced a new removal of a child. At the twelve-month review benchmark, 4.7% of treatment group families experienced a new substantiated investigation and 5.1% experienced a new removal of a child.

Table 19. Percent of treatment group families that experienced new substantiated investigations and new child removals 6 and 12 months after contracted in-home safety services were no longer provided to the family

	6 Months (n = 622)	12 Months (n = 551)
New substantiated investigations	5.9%	4.7%
New child removals	10.9%	5.1%

Goal 5: Twelve, eighteen, and twenty-four months after case closure, those that received contracted in-home safety services will experience significantly fewer substantiated cases of abuse or neglect in the home as compared to the comparison group.

To measure this goal, DFS reviewed the records of families enrolled in the demonstration project 12, 18, and 24 months after case closure. Specifically, each month, NICRP sent DFS a list of those families that were at the 12, 18, and 24-month review benchmarks and DFS reported back to NICRP whether or not the families had experienced a new substantiated investigation of maltreatment. The 12-month review benchmark included the day that the case closed until twelve months after the case closed. The 18-month review benchmark included twelve months and one day after the case closed until eighteen months after the case closed. The 24-month review benchmark included eighteen months and one day after the case closed until twenty-four months after the case closed.

The final request for these data was submitted to DFS by NICRP on August 29, 2019 and included requests for data through August 31, 2019. Due to the timing of this final data request and families' case closure dates, data are not available for all families enrolled in the demonstration project. Additionally, it should be noted that NICRP identified 15 treatment group families for whom cases had been reopened after case closure (as evidenced by new SPD sign dates or Safety Plan completion dates after receipt of a case closure date). None of these families was included in the measurement of this goal. As seen in Table 20 below, a smaller percentage of comparison group families experienced a new substantiated investigation 12 and 24 months after case closure as compared to treatment group families. However, at 18 months after case closure, a smaller percentage of treatment group families experienced a new substantiated investigation as compared to comparison group families.

Table 20. Number and percent of families that experienced a new substantiated investigation after case closure at each review benchmark by group

	Treatment Group			**Comparison Group**		
	Number of families at benchmark	Number experiencing a new substantiated investigation	Percent experiencing a new substantiated investigation	Number of families at benchmark	Number experiencing a new substantiated investigation	Percent experiencing a new substantiated investigation
12 Months	464	41	8.8%	230	13	5.7%
18 Months	350	12	3.4%	201	9	4.5%
24 Months	250	7	2.8%	176	2	1.1%

The results of two chi-square tests of independence indicate that there are no statistically significant differences between the treatment group and comparison group with regard to the number of new substantiated investigations 12 months after case closure (X^2 (1, N = 694) = 2.17, p = .140) or 18 months after cases closure (X^2 (1, N = 551) = 0.38, p = .536). There were also no statistically significant differences between the treatment group and comparison group with regard to the number of new substantiated investigations 24 months after case closure (p = .317, Fisher's exact test).

Of the 60 new substantiated investigations experienced by families in the treatment group, 70.0% were experienced by reunified families and 30.0 % were experienced by new families. Of the 24 new substantiated investigations experienced by families in the comparison group, 29.2% were experienced by reunified families and 70.8% were experienced by new families. The number and percent of new and reunified families experiencing new substantiated investigations at each benchmark following case closure can be seen in Table 21 below.

Table 21. Number and percent of new and reunified families that experienced a new substantiated investigation after case closure at each review benchmark by group

	Treatment			**Comparison**		
	New	Reunified	Combined	New	Reunified	Combined
12 Months	13 (31.7%)	28 (68.3%)	41 (100%)	9 (69.2%)	4 (30.8%)	13 (100%)
18 Months	3 (25.0%)	9 (75.0%)	12 (100%)	6 (66.7%)	3 (33.3%)	9 (100%)
24 Months	2 (28.6%)	5 (71.4%)	7 (100%)	2 (100%)	0 (0.0%)	2 (100%)
Overall	18 (30.0%)	42 (70.0%)	60 (100%)	17 (70.8%)	7 (29.2%)	24 (100%)

The Fiscal/Cost Study

A cost-effectiveness analysis was conducted to determine if case closure based on family reunification (i.e., not adoption, guardianship, etc.) was more cost effective for those families that received in-home safety services from a paid safety manager or for those families that received in-home safety services through informal unpaid supports. Case closure based on family reunification was used as the definition of "success" for the cost analysis because it was achievable for both the treatment and comparison group families. The case level costs included costs incurred from the date of Safety Plan implementation until DFS case closure.

Data Sources and Collection Procedures

Specific case level costs for both the treatment and comparison group families were calculated to determine if there was a cost savings in implementing an in-home Safety Plan with the use of a paid safety manager or implementing an in-home Safety Plan with informal unpaid supports. For those cases in which children were returned home because of the implementation of in-home safety services (reunified families), only those costs associated with services after the child was returned to the home were included in the analysis. DFS was responsible for providing NICRP with the specific case level program costs, referred to as "ingredients". The list of "ingredients" that DFS proposed to provide for the analysis can be seen in Table 22 below. Table 22 includes the "ingredient", a description of the

ingredient, and the source of its cost. The table also includes a column called status, which indicates the "ingredients" that DFS ultimately did and did not provide for the analysis.

Table 22. Originally proposed cost analysis data sources

"Ingredient"	Description	Source	Status
One day of in-home care	Salary and wages Employee benefits Contract Services District Attorney Other services and supplies Travel and training Internal services Overhead Depreciation	Clark County DFS Fiscal Unit (FY15 actual costs divided by the total number of days of in-home care provided per child in FY15 based on UNITY)	Provided
One day of out-of-home care	Salary and wages Employee benefits Contract Services District Attorney Other services and supplies Travel and training Internal services Overhead Depreciation	Clark County DFS Fiscal Unit (FY15 actual costs divided by the total number of days of out-of-home care provided per child in FY15 based on UNITY)	Provided
In-home safety services	Contracted services provided by safety service provider	Invoice from safety service provider	Provided
Room and board (out-of-home placements)	Cost of room and board based on foster care rate paid; Different rates for type and age include: Regular: • Age 0-12 • Age 13 & Up Specialized: • Age 0-12 • Age 13 & Up Sibling: • Age 0-12 • Age 13 & Up Emergency Agency: • All Ages	UNITY payment system	Not provided
Medical Costs*	All costs billed to Medicaid	Quarterly report from Nevada state Medicaid	Not provided
*If the quarterly Nevada state Medicaid reports do not contain medical costs for both the treatment and comparison group families, this ingredient will not be used for the cost analysis.			

Each month when DFS provided NICRP with follow-up and baseline data, they also provided information regarding the status of cases at closure as it was made available to them (i.e., adoption, reunification, guardianship, etc.). At the end of the project, NICRP reached out to DFS to obtain the status of cases for all closed cases for which this information had not been received. Once the case closure status of all closed cases was confirmed, using the data provided for Outcome Goal 2, NICRP determined which families with the case closure status of reunification experienced new child removals between the date that their Safety Plan was implemented and the date that their case was closed. For these families, NICRP requested from DFS information regarding the placement of the children removed. Specifically, NICRP requested the type of placement(s) in which each child was placed and the dates of the placement(s).

Despite the placement type detail provided (e.g., "Family Foster Care 0 - 12 years of age", "Specialized Foster Care 0 - 12 years of age Custody Kids", "Emergency Shelter Sibling Rate 0 - 12 years of age") and numerous discussions with DFS to try to ascertain the costs for these detailed placement types, it was determined that NICRP would only rely on the broader placement categories of out-of-home care, in-home care, and care at Child Haven. Please note that Child Haven was not one of the originally proposed "ingredients". The "ingredients" and associated costs used for the analysis are listed in Appendix C. The only "ingredient" that ultimately reflected the actual cost of care for a family was the in-home safety services hourly rate because NICRP knew the number of hours of safety services provided to each family as a result of measuring Output Goal 3. The other "ingredients", as described in Table 22, reflected averaged costs from 2015 (including the Child Haven per child rate). It is important to note that, at the direction of DFS, placement days with relatives, days spent in detention, and days spent as runaway status were all assigned the cost of $0.00.

Data Analysis

Only cases of families that were reunified at case closure were included in the cost-effectiveness analysis. Overall, 81.1% of families enrolled in the demonstration project experienced family reunification at case closure. However, as seen in Table 23, a larger percentage of families in the comparison group experienced reunification (91.5%) as compared to families in the treatment group (77.9%).

Table 23. Status of families at case closure by group

	Treatment	Comparison	All
Reunified	77.9% (631)	91.5% (225)	81.1% (856)
Other	4.6% (37)	2.4% (6)	4.1% (43)
Reunified and Other	2.7% (22)	3.3% (8)	2.8% (30)
No Status	14.8% (120)	2.8% (7)	12.0% (127)
Total	100% (810)	100% (246)	100% (1056)

To ensure a clean sample of cases for the cost-effectiveness analysis, some cases were excluded based on details received about cases over the course of the project. Specifically, 45 cases were excluded for the following reasons, which are not mutually exclusive:

- The family received safety services after the reported safety services end date (n = 42)
- The family's case was reopened after case closure (n =14)
- All safety services provided to the family were carried out by the DFS caseworker (n = 1)
- The family received safety services after the case was closed (n = 1)

All 45 of the cases that were excluded from the analysis were treatment group cases. The final number of cases that contributed to the cost-effectiveness analysis (n = 811) included 586 treatment group cases and 225 comparison group cases.

Of the 811 cases of families included in the cost-effectiveness analysis, 786 (217 comparison cases and 569 treatment cases) did not experience any new child removals between the date that their Safety Plan became effective and their case closure date. Therefore, the costs of these cases was based on the number of days that the case was open (Safety Plan effective date through case closure date) and the number of children in the family. Specifically, the cost included the in-home daily rate per child multiplied by the number of days that the case was open multiplied by the number of children in the family. For treatment group families the cost also included the cost of in-home safety services (number of hours received x hourly in-home safety services rate).

Of the 811 cases of families included in the cost-effectiveness analysis, 25 (8 comparison cases and 17 treatment cases) experienced new child removals between the date that their Safety Plan became effective and their case closure date. For each of these cases, NICRP determined how many days each child in the family spent in in-home care, out-of-home care, and at Child Haven. Then NICRP multiplied the number of days for each type of care by the rate provided in Appendix C and summed these totals. For treatment group families the cost also included the cost of in-home safety services (number of hours received x hourly in-home safety services rate).

Results

As seen in Table 24 below, on average, among those families that were reunified at case closure, the average cost of serving comparison group families (M = $112,034.44) was slightly higher than the cost of serving treatment group families (M = $103,069.82). However, the results of an independent samples t-test indicate that there is no statistically significant difference between the treatment group and comparison group with regard to cost [t (809) = 1.08, p = .279]. This suggests that, even with the added cost of in-home safety services, among those families that were reunified at case closure, the cost to serve treatment group families was not significantly more expensive than the cost to serve comparison group families.

Table 24. Minimum, maximum, mean, and standard deviation costs of serving families reunified at case closure by group and population

Group	Population	Minimum	Maximum	Mean	SD
Treatment	Both (n = 586)	$3,470.34	$1,008,632.88	$103,069.82	$108,621.54
	New (n = 173)	$9,220.68	$1,008,632.88	$128,813.13	$138,728.92
	Reunified (n = 413)	$3,470.34	$752,609.97	$92,286.31	$91,232.99
Comparison	Both (n = 225)	$11,707.74	$656,934.30	$112,034.44	$97,149.26
	New (n = 138)	$13,442.22	$656,934.30	$123,925.77	$106,400.20
	Reunified (n = 87)	$11,707.74	$423,863.55	$93,172.32	$77,208.83

As seen in Table 24 above, among families reunified at case closure, on average, families new to DFS cost more to serve than reunified families (M = $126,644.46 and M = $92,440.47 respectively). Although the results of an independent samples t-test indicate that the difference in cost between the two populations is statistically significantly different [t (503.90) = 4.20, p = .000], it is important to note that reunified families are those families that DFS was working with prior to being included in the demonstration project and none of those costs are reflected in this analysis.

Summary of Results, Limitations, and Lessons Learned

Summary of Results

There were four implementation goals set for the evaluation and three of the four goals were met which included the enrollment goal, how quickly Safety Plans were completed after SPD approval, and a reduction in contracted in-home safety services after twelve months. The fourth implementation goal was met with regard to the comparison group families and was very close to being met with regard to the treatment group families. Specifically, the goal was that Safety Plans would become effective within one day of the Safety Plan being completed by DFS. For comparison group families, the Safety Plans became effective within an average of one day. For treatment group families, the Safety Plans became effective within an average of 1.1 days.

There were five outcome goals set for the evaluation. Four of the outcome goals were not met and there was not enough data available to measure progress toward the fifth goal. Specifically, the treatment group families experienced more new substantiated investigations (Goal 1) and more new removals (Goal 2) than the comparison group families within 90 days of the implementation of their Safety Plan. Between 90 days and case closure, there were no differences between the two groups with regard to the number of new substantiated investigations or new removals. There were also no differences between the two groups with regard to the number of new substantiated investigations 12, 18, or 24 months after case closure (Goal 5). The remaining two goals applied only to the treatment group families. Goal 4 of the evaluation was that no impending danger threats would exist in the home 6 and 12 months after contracted in-home safety services were no longer provided to the families. The existence of impending dangers was indicated by new substantiated investigations and new child removals being reported for treatment group families at both follow-up time points. Finally, there were not enough PCPAs completed to measure progress toward Goal 3, which was that there would be documented progress of the treatment group families increasing their protective capacity.

Overall, those families that received in-home safety services from a contracted provider had more new substantiated investigations and more new removals within 90 days of their in-home Safety Plan being implemented than those that received in-home safety services from informal supports. However, there were no differences between the two groups of families in the number of new substantiated investigations or new removals between 90 days and case closure or in the number of new substantiated investigations up to 24 months after case closure. Finally, families receiving in-home safety services from a contracted provider did have impending danger threats in their homes within 6 and 12 months of in-homes safety services ending.

Limitations

Some of the limitations of the current evaluation relate to the evaluation plan, the evaluation protocol, the validity of the data, the fidelity with which the model was implemented, and the outcomes measured. Each of these limitations is described below.

The Evaluation Plan

In the originally proposed evaluation plan, both the treatment and comparison groups would have included families that were eligible to receive in-home safety services from a specially trained paid in-home safety manager. The difference between the two groups would have been that the treatment group families received the in-home safety services and the comparison group families did not. In the revised evaluation that was carried out, both the treatment and comparison group families received in-home safety services but differed in terms of who provided the services. Specifically, the treatment group families received in-home safety services from a specially trained paid in-home safety manager and the comparison group families received in-home safety services from informal supports such as family members, friends, and/or neighbors. It is possible that just by virtue of having access to these types of informal supports, the comparison group families had a greater likelihood of success than the treatment group families. It could be argued that the current evaluation is a comparison of natural versus artificial supports. In this regard, the findings of the current evaluation indicate that overall, artificial supports are not any better or worse than natural supports.

Evaluation Protocol

Throughout the project, there was some deviation from the evaluation protocol, which required the removal of some cases from certain analyses or resulted in an overall less clean sample of cases for comparison. Specifically, as noted earlier in the Fiscal/Cost Study section, several treatment group families continued to receive in-homes safety services after it was reported that their services had ended or they began receiving services again, the cases of some treatment group families closed and then were reopened to the same services, in one case the DFS caseworker and not the in-home safety manager provided all of the in-home services to a treatment group family, and at least one treatment group family received safety services after their case was closed to DFS. There were also several instances throughout the project in which families that were assigned to the comparison group became enrolled in the treatment group. After alerting DFS to the dual enrollment, DFS unenrolled the family in the comparison group and enrolled them in the treatment group.

Validity of the Data

Unfortunately, there is some evidence to suggest that the data provided for the evaluation should be questioned with regard to its validity. Specifically, in several instances, NICRP asked DFS for clarification about data for a specific case which led to the identification of incorrect data previously being reported for the case. For example, when reviewing placement data for families for the fiscal/cost study, it was learned that some families had more or fewer children removed from the home than was reported for the measurement of Outcome Goal 2. Another example of data errors being identified concerns the number of children in families at enrollment. Specifically, at case closure, some children within families were identified as having been adopted and other children within the same families were identified as being reunified. When asked about the conditions in which this would occur, DFS realized that for some cases, the number of children that they had reported as being in the home at enrollment was incorrect because some children had been adopted prior to enrollment. DFS was able to review and resubmit the data for all of the families enrolled in the evaluation regarding the number of children in the home at enrollment. However, the data discrepancies identified due to the first example described were examined only for those families included in the fiscal/cost study. Although it was fortunate to have been able to learn about and correct some of these data errors, it brings into question what other data errors exist for cases for which there was no reason to inquire.

Fidelity

The quantity and quality of the PCPAs completed and the data excluded in the measurement of Output Goal 2 bring into question the degree to which the model was implemented with fidelity. According to the description of the model in Nevada's Title IV-E Waiver Demonstration Project Proposal, the PCPA "is documented every 90 days following implementation of the case plan to measure progress related to what must change as identified in the case plan and evaluate the continuing approach to safety management." Therefore, regardless of the starting date used to determine when the first PCPA was due for families, a PCPA should have been completed every 90 days for each family while the case was open and this did not occur. Further, as a measure of progress, the PCPA should help determine when case closure is appropriate, however some PCPAs were completed after case closure (n = 32). There were also PCPAs that NICRP received that, with the exception of dates and signatures, were blank. When NICRP inquired about these PCPAs, DFS indicated that the judges overseeing the cases instructed that they be closed so the PCPAs were signed and dated for the case files. An audit conducted by NICRP in 2017 identified several areas in need of improvement with regard to the completeness and quality of the PCPAs. Although NICRP received a higher percentage of valid PCPAs that were due in the last two years of the project, anecdotally, the quality of the PCPAs remained the same. Finally, cases were excluded from the measurement of Output Goal 2 because data indicated that (1) Safety Plans were completed prior to supervisor approval of the SPD, which Safety Plans are based on and (2) Safety Plans became effective before they were completed. Neither of these are in keeping with fidelity to the model.

Outcomes Measured

Finally, a limitation of the evaluation is the amount of data collected regarding outcomes after case closure. Specifically, the only information captured after case closure was whether or not there was a new substantiated investigation for cases and what type of allegation was reported within 12 months after case closure, 12 to 18 months after case closure, and 18 to 24 months after case closure. The dates of the investigations were not collected and there was no information collected regarding

removals. This would have been valuable information to collect especially with regard to cases that were reunified at closure. When collecting data to measure Outcome Goal 2 (new child removals occurring between Safety Plan implementation and case closure), some new child removal dates that were received occurred after case closure. (These data were not included in the measurement of Outcome Goal 2.) Based on the limited data available, of the 856 families that were reunified at case closure, 37 experienced a removal after case closure. These removals ranged between 14 and 230 days after case closure with a removal occurring on average 7.67 months after closure. Approximately half of these removals took place within three months of case closure. If the dates of new removals and the dates of new substantiated investigations after case closure had been collected for all cases, it could have potentially allowed for a deeper dive into understanding the circumstances of the removals and allegations following case closure and how to better determine if cases should remain open.

Lessons Learned

Evaluation Lessons Learned

Throughout the evaluation process NICRP and DFS worked together to develop the evaluation plan and continually assess its ability to accurately measure the implementation and expected outcomes for the program. As the project and the evaluation progressed, valuable lessons were learned which are described below.

Communication and Collaboration – Due to changes in leadership at DFS there were different people at the table when the evaluation plan was created than when it was actually implemented. This led to a need for reviews of the evaluation plan and an explanation of why the methodology and specific variables were selected for measurement. As new members of the waiver team came on board it was important for them to understand why specific data were being requested and what would be done with it. This communication structure led to the identification of some issues within the first year that allowed modifications to the overall evaluation plan to be made to ensure that the comparison group would be large enough to make comparisons to the treatment group (details were described in the Executive Summary of this report).

Flexibility and Responsiveness – As the evaluation progressed, NICRP and DFS maintained a continued open dialogue about how each of the goals was measured. These discussions resulted in some changes to the dates that were used to measure time between events to give the most accurate picture of how the program was being implemented. It was crucial to the evaluation that both DFS and NICRP were flexible and willing to look for solutions and adapt when necessary.

Programmatic/Implementation Lessons Learned

Clarifications in Policy and Training – Upon completion of the stakeholder surveys, service provider interviews, and caseworker focus groups NICRP identified three primary recommendations for program improvement; (1) Assess the plausibility of allowing the in-home safety managers to request Safety Plan reviews, (2) Develop a plan for improving the partnership between Safety Managers and Caseworkers, and (3) Review, update, and implement caseworker and DFS supervisor training on writing effective SPDs and Safety Plans. Each of these is discussed in more detail below.

(1) Assess the plausibility of allowing the in-home safety managers to request Safety plan reviews. Over the three administrations of the participant survey, the item with which the fewest number of respondents agreed with each year was, "I was given the opportunity to provide input into my family's in-home Safety Plan." A recurrent theme from the safety manager interviews also related to having input on the Safety Plan. Due to strong relationships that the in-home safety managers build with the families and the amount of time that they spend with them, it is reasonable to believe that they would hold valuable information regarding which additional services a family might need as well if a family needs an increase or decrease in services. Perhaps DFS could create a "Safety Plan Review Proposal Form" that in-home safety managers could complete in which they make their argument for different services for a family or an increase or a decrease in services. These forms could then be reviewed by both the Safe@Home program staff and the caseworker to determine plausibility of the arguments. The results would then be provided to the safety managers and the families.

(2) Develop a plan for improving the partnership between Safety Managers and Caseworkers. The results of the family surveys, safety manager group interviews, and the caseworker focus groups suggest a disconnected relationship between these two groups of individuals. Communication between the two seems heavily one-sided where the caseworkers expect the safety managers to provide information to them while providing little in return. Having little to no feedback from the caseworkers makes it difficult at times for the safety managers to work to support the families. The work of the caseworkers and safety managers could be more effective if they viewed themselves as colleagues working together as a team to support the families enrolled in Safe@Home.

(3) Review, update, and implement caseworker and DFS supervisor training on writing effective SPDs and Safety Plans. Based on the feedback from the in-home safety managers and the caseworkers, it is recommended that DFS review and update their training on writing effective SPDs and Safety Plans. It is strongly encouraged that DFS solicit feedback from the in-home safety managers to learn, from their viewpoint, what makes a good actionable Safety Plan. This information could be incorporated with the needs of the Safe@Home program staff to provide a training to the caseworkers. Due to repeated reports of the inconsistency in the competency of supervisors in completing the SPD and Safety Plans, it is recommended that supervisors attend these trainings and be held accountable for SPDs and Safety Plans that they "rubber stamp" through the process.

Link to Evaluation Reports

Once the final evaluation report is finalized, DFS will provide links to the interim and final evaluation reports.

Appendix A. Family Demographics

	Treatment Group (n = 810)		Comparison Group (n = 246)		Total (n = 1056)	
Variable	**Count (n)**	**Percent (%)**	**Count (n)**	**Percent (%)**	**Count (n)**	**Percent (%)**
Population	**810**	**100%**	**246**	**100%**	**1056**	**100%**
New	233	28.8	149	60.6	382	36.2
Reunified	577	71.2	97	39.4	674	63.8
Number of children in the family	**810**	**100%**	**246**	**100%**	**1056**	**100%**
1	239	29.5	69	28.0	308	29.2
2	223	27.5	71	28.9	294	27.8
3	166	20.5	53	21.5	219	20.7
4	91	11.2	31	12.6	122	11.6
5	48	5.9	9	3.7	57	5.4
6	27	3.3	4	1.6	31	2.9
7	9	1.1	4	1.6	13	1.2
8	7	0.9	1	0.4	8	0.8
9	0	0.0	3	1.2	3	0.3
10	0	0.0	1	0.4	1	0.1
Allegation Type	**810**	**100%**	**246**	**100%**	**1056**	**100%**
Abuse	161	19.9	69	28.0	230	21.8
Neglect	562	69.4	126	51.2	688	65.2
Both	87	10.7	51	20.7	138	13.1
Child under 5yo in the family	**810**	**100%**	**246**	**100%**	**1056**	**100%**
Yes	573	70.7	177	72.0	750	71.0
No	237	29.3	69	28.0	306	29.0
Race of the family	**810**	**100%**	**246**	**100%**	**1056**	**100%**
African American	128	15.8	46	18.7	174	16.5
Asian	3	0.4	2	0.8	5	0.5
Caucasian	293	36.2	97	39.4	390	36.9
Native Hawaiian/Pacific Islander	3	0.4	0	0.0	3	0.3
More than one	135	16.6	29	11.8	164	15.5
Unknown	248	30.6	72	29.3	320	30.3
Ethnicity of the family	**810**	**100%**	**246**	**100%**	**1056**	**100%**
Hispanic	77	9.5	31	12.6	108	10.2
Non-Hispanic	303	37.4	82	33.3	385	36.5
Unknown	326	40.2	104	42.3	430	40.7
Both	104	12.8	29	11.8	133	12.6
Number of impending danger threats on SP	**810**	**100%**	**246**	**100%**	**1056**	**100%**
1	322	39.8	106	43.1	428	40.5
2	300	37.0	87	35.4	387	36.6
3	150	18.5	38	15.4	188	17.8
4	35	4.3	11	4.5	46	4.4
5	3	0.4	3	1.2	6	0.6
6	0	0.0	0	0.0	0	0.0
7	0	0.0	1	0.4	1	0.1

Appendix B. Impending Danger Types

	Treatment Group		Comparison Group		Total	
	Count (n)	Percent (%)	Count (n)	Percent (%)	Count (n)	Percent (%)
Impending Danger Types	**1527**	**100%**	**460**	**100%**	**1987**	**100%**
Living arrangements seriously endanger the physical health of the child(ren)	17	1.1	9	2.0	26	1.3
One or both parents/caregivers intend(ed) to hurt the child and show no remorse	2	0.1	6	1.3	8	0.4
One or both parents/caregivers cannot or do not explain the child's injuries and/or conditions	23	1.5	16	3.5	39	2.0
A child is extremely fearful of the home situation	17	1.1	12	2.6	29	1.5
A parent or caregiver is violent and no adult in the home is protective of the child(ren)	138	9.0	51	11.0	189	9.5
One or both parents'/caregivers' emotional stability, developmental status, or cognitive deficiency seriously impairs their ability to care for the child(ren)	222	14.5	50	10.9	272	13.7
Parents/caregivers unable to control their behavior	450	29.5	143	31.1	593	29.8
Family does not have resources to meet basic needs	92	6.0	21	4.6	113	5.7
No adult in the home will perform parental duties and responsibilities	22	1.4	6	1.3	28	1.4
One or both parents/caregivers have extremely unrealistic expectations	35	2.3	7	1.5	42	2.1
One or both parents/caregivers have extremely negative perceptions of a child	8	0.5	2	0.4	10	0.5
One or both parents/caregivers fear they will maltreat the child and/or request placement	9	0.6	0	0.0	9	0.5
One or both parents/caregivers lack parenting knowledge, skills, and motivation which affect child safety	433	28.4	124	27.0	557	28.0
Child has exceptional needs which the parents/caregivers cannot or will not meet	59	3.9	13	2.8	72	3.6

Appendix C. “Ingredients” and Associated Costs Used for the Cost-Effectiveness Analysis

“Ingredient”	Cost
1 day of in-home care per child	$216.81
1 day of out-of-home care per child	$533.43
1 day at Child Haven per child	$360.00
1 hour of in-home safety services	$60.00
1 day of relative placement per child	$0.00
1 day of detention per child	$0.00
1 day of runaway status per child	$0.00