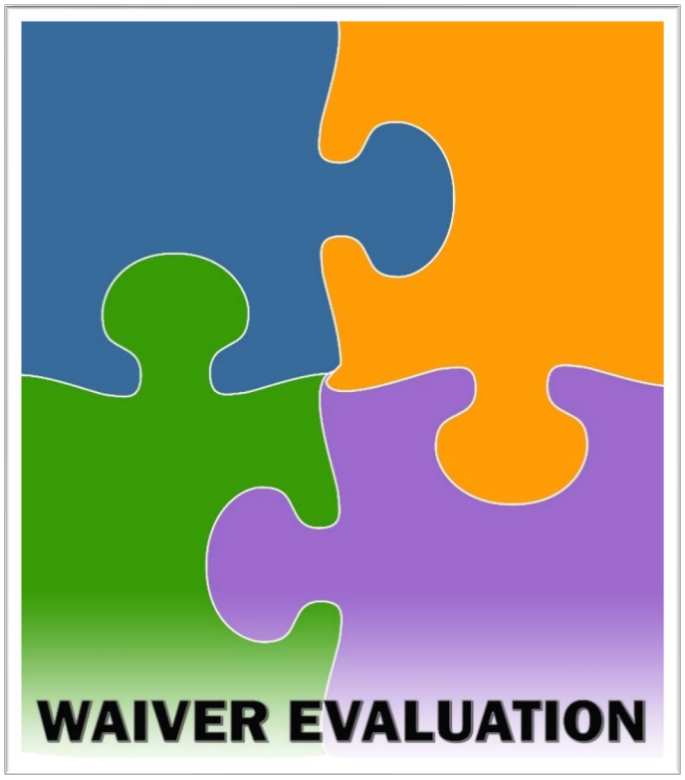

Final Evaluation Report
State of Hawai‘i Title IV-E Waiver Demonstration

FINAL REPORT

March 31, 2020

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EXECUTIVE SUMMARY

The federal Title IV-E Waiver Demonstration gave states the opportunity to waive federal requirements for funding of foster care in order to test and evaluate innovative approaches to meet the particular needs of the child welfare population in that state. By joining the federal Title IV-E Waiver Demonstration, the State of Hawai'i agreed to replace fee-for-service Title IV-E reimbursement for foster care administration and maintenance with a fixed payment, agreed upon in advance for the subsequent five years. Like other Waiver states, Hawai'i traded guaranteed, unlimited, fee-for-service federal contributions to foster care board and maintenance and administrative costs for certain children for a fixed amount of money that could be used for all child welfare services for any child.

Through the flexible funding allowed by the Title IV-E Waiver, the State of Hawai'i implemented four innovative interventions in 2015, aimed at reducing the size of two populations of children in child welfare: (1) Short-Stayers, or those children who enter and exit out-of-home placement within 30 days and (2) Long-Stayers, or those children who have been in care for at least nine months.

A study of the children and youth in foster care in Hawai'i identified these two populations as particularly problematic for the system of care. In FY2012, 54 percent of children placed into foster care in Hawai'i exited within 30 days. Due to workload and other issues, the immediate response to many reports of maltreatment was "remove first and investigate later," resulting in many children going into care for very short stays, often for less than five days. Any removal from home and family is traumatic for children and families, and placement into out-of-home care is an extra workload and financial burden for the system.

On the other end of the system of care, the State of Hawai'i found that 40 percent of children and youth in foster care had been there at least nine months. The likelihood of a return home or other permanent family decreases with the length of stay in care. Only ten to 15 percent of children exit foster care within nine and 18 months of entering care.

After this analysis of the populations most in need of innovative approaches, the State of Hawai'i developed its Title IV-E Waiver Demonstration to consist of four interventions and one new assessment tool, focusing on reducing the populations of Short-Stayers and Long-Stayers in care, and preventing unnecessary entrance into the system.

To address Short-Stayers:

- The Crisis Response Team (CRT) was staffed by social workers who were to respond within two hours to any reports of maltreatment from hospitals, schools, or police with a child in custody, to provide an assessment of the need for placement at the point of first contact.

- Intensive Home-Based Services (IHBS) were provided to families after CRT responds, when out-of-home placement was likely but could be prevented if parents and their children participated in a short-term behavioral, skill-building approach to reducing risk to children, in their own home.

To address Long-Stayers:

- Family Wrap Hawai'i (Wrap) services were a family-centered, family-empowering approach to working with families and their identified supports to develop goals and an individualized plan of action that would lead to a child's reunification with family.
- Safety, Permanency, and Well-Being (SPAW) meetings were designed for children and youth who were considered unlikely to reunify. By bringing together key decision makers from the various youth-serving systems that impact that youth, barrier busting and other systemic strategies and solutions could be designed to help achieve permanency for that youth.
- A new assessment tool, the *Child and Adolescent Needs and Strengths*, was an empirically-supported strengths-based assessment and service planning tool that could help guide the work done in Long-Stayer interventions.

These four interventions and one assessment tool were implemented as planned on two islands; the Waiver Demonstration began on O'ahu on January 1, 2015, and it began on Hawai'i Island on October 1, 2015. The Hawai'i Title IV-E Waiver Demonstration was a five-year Demonstration, and ended on September 30, 2019.

The evaluation of the Hawai'i Title IV-E Waiver Demonstration consisted of three studies:

- The process evaluation gathered qualitative and quantitative data on (1) the implementation of the Demonstration and its interventions and assessments, including the organizational and contextual strengths and barriers to implementation, (2) the provision of services, including the population characteristics, and the scope, duration, frequency, dosage, and intensity of each intervention and (3) parents' and professionals' knowledge, perceptions and experiences from participating in Waiver Demonstration interventions.
- The outcome evaluation gathered quantitative data from a variety of state and provider databases on the safety, permanency, and well-being of children touched by Waiver Demonstration interventions, and tracked these outcomes for each child for most of the duration of the Demonstration, until June 2019.
- The cost study gathered fiscal data on child welfare spending and foster care population data, from three years prior to the Waiver Demonstration and throughout the five years of the Demonstration, to assess what effect the fiscal stimulus of the Waiver and the specific service interventions had on expenditure patterns in participating locations, and the cost of the four interventions vis-à-vis their effectiveness in reducing the population of Short-Stayers and Long-Stayers in Hawai'i and the foster care costs associated with these stays.

These three components of the independent evaluation were a requirement of the federal waiver. The U.S. Administration on Children and Families (ACF), in granting waivers to states, was interested in policy and practice innovations that were rigorously evaluated, to contribute to best practices in the state and the larger body of empirically-supported policy and practice in child welfare nationwide. This *Final Report* presents findings from the data collected for all three forms of evaluation.

Implementation of the Waiver Demonstration

The Waiver Demonstration was implemented from January 2015 through most of 2019, years marked by dramatic trends in Hawai'i child welfare. Over the course of the Demonstration, the child abuse landscape in Hawai'i was changing; there were more children being identified as victims, and the nature of child maltreatment became more complex. Maltreatment reports from hospitals increased and hospital-reported children entered out-of-home care in greater numbers, particularly on Hawai'i Island. Drug abuse and child neglect were common risk factors.

Within this context, DHS, the Child Welfare Services Branch (CWS), and private providers on O'ahu and Hawai'i Island implemented and supported the Waiver Demonstration with a robust infrastructure of planning workgroups, new trainings, community meetings, and a standing monthly meeting of key Demonstration partners from both islands. The Demonstration benefitted from a consistent and experienced Waiver Project Manager solely dedicated to the success of the Demonstration. The Waiver Project Manager, through these monthly meetings and other efforts, facilitated the reporting out of Demonstration intervention processes and outcomes, the telling of success stories, and problem solving and refinement of intervention policies and procedures. Participants in the workgroups and meetings evinced a commitment to the Demonstration and its success.

DHS viewed the Waiver Demonstration as a learning opportunity; a sustained five-year initiative to try new methods of practice and incremental systems change. This opportunity for creative thinking and new ways to approach children and families was emphasized in messaging by DHS administration and the Waiver Demonstration Project Manager. While change in large systems can be difficult, staff, providers, and community partners largely maintained interest in, and commitment to, the Demonstration, as evidenced by multiple activities. In addition to the workgroups and meetings, CWS staff, private providers, and community partners demonstrated support for the Waiver Demonstration and the four new interventions in a variety of ways. Casey Family Programs provided support throughout the Demonstration for activities such as training opportunities, visiting consultants and experts, and sending staff to national meetings and convenings. The Court Improvement Program also provided support for additional meetings and information-sharing venues.

Despite this level of engagement and commitment from many of those involved, as in other Waiver jurisdictions, the implementation of the Demonstration was hampered by a lack of real-

time data that informed participants about how the Demonstration was progressing. There are two separate legacy data systems into which caseworkers are required to enter case-level data; these systems are not actively linked and lack in-depth reporting functionality. The gathering, cleaning, verifying and merging of data from the two DHS databases, as well as that from private providers, was both time consuming and complicated. In fact, it took several years of collecting and re-collecting case data for the evaluators to achieve an acceptable level of data accuracy of the basic set of indicators that comprise the evaluation data set.

The evaluation was able to provide some periodic feedback to Demonstration partners, but these reports were mostly comprised of information about the data itself; partners knew little of Demonstration outcomes until the end of the Demonstration. The lack of real-time feedback and reporting not only affected the ability of CWS leadership to make data-informed decisions about the implementation of the Demonstration, but also impacted efforts to improve data entry practices. Recognizing that the current data systems make data-informed decision making difficult for caseworkers, supervisors, and administrators, the state has committed to building a new Comprehensive Child Welfare Information System (CCWIS) that would house all case-level data and offer more advanced reporting features. The lessons learned through this evaluation about navigating the current data systems and identification of strengths and challenges around data entry, data management, and training about data will be directly applicable to the state's ongoing efforts to modernize and improve its data infrastructure.

Finally, this evaluation reports on a sample of Waiver cases that is not the full set of all children and families served by the Demonstration in Hawai‘i. First, the Demonstration officially ended in September 2019, and the evaluation stopped entering children into the evaluation sample in September 2018, to allow for at least one year to track case outcomes for all children in the sample. Not all case outcomes occur immediately following a service, and the evaluation was interested in longer-term outcomes. Second, there is an unknown number of children who were Waiver participants but not included in the evaluation due to incomplete or missing case data. This large-scale evaluation of child welfare services in Hawai‘i by an independent evaluator was a relatively new phenomenon, and timely data entry by overburdened caseworkers was a continual challenge.

The Short-Stayer Interventions

The Crisis Response Team was welcomed by most in Child Welfare Services and the community as a much-needed addition to the service array, in hopes of finding an alternative response to the "remove first and investigate later" approach that was necessitated when caseworkers were not available as first responders to maltreatment. In the years prior to the Waiver Demonstration, too many children were removed quickly, only to be returned home within a few days. The Waiver Demonstration implemented a Crisis Response, a two-hour response to high-risk reports of maltreatment, that was intended to prevent unnecessary placement by conducting an experienced assessment, and finding relative placements when removal was

necessary. CRT-eligible intakes were those reported by law enforcement, schools, and hospitals who were at imminent risk of removal.

Similarly, Intensive Home-Based Services were implemented as a backstop to prevent placement among those children and families who were responded to by the CRT, and for whom placement was indeed imminent after that response. Intensive Home-Based Services were a short-term intensive service to which CRT caseworkers could refer families for whom removal would otherwise occur.

The Crisis Response Team

Despite fairly concrete criteria for eligibility, this evaluation found that the CRT response was inconsistently applied to eligible intakes on Oʻahu and Hawaiʻi Island, reaching over half of children reported by law enforcement sources, but less than 20 percent of children reported by schools or hospitals. A detailed analysis indicated that the Intake Unit referred children at the greatest risk of removal directly to Child Welfare Services for investigation, rather than attempting a Crisis Response to prevent placement.

Despite implicit disposition decisions by the Intake Unit about when to send a Crisis Response, children seen by the CRT had higher immediate placement rates than children with the same eligibility criteria in the pre-Waiver years of 2012-2014. Because the nature of child maltreatment and the presence of risk factors across all child protection intakes grew more challenging during the Waiver years, it is unknown whether this increase in placement rates is a shortcoming of the CRT, a result of a higher-risk population of children, or other factors affecting placement decisions in general during the Waiver years.

The incidence of children experiencing a short stay in placement was also higher for children seen by the CRT, compared to children with the same eligibility criteria in 2012-2014. Entering and exiting placement within 30 days was particularly likely for those children seen by the CRT who were reported to the hotline by law enforcement sources, at about twice the rate of children reported by schools or hospitals. While the level of risk may be increasing in Hawaiʻi, these short stays suggest that removal was not warranted and many children could have been maintained safely at home.

Intensive Home-Based Services

While many children who received a Crisis Response still experienced an immediate removal, only ten percent of children seen by the Crisis Response Team were referred to Intensive Home-Based Services. This evaluation suggests that there is a good probability that Intensive Home-Based Services could have prevented many of those placements. Of the 198 children served by IHBS in this evaluation, only fourteen children in four families had a subsequent placement.

Such a strong record of success is due in no small part to the selection of HOMEBUILDERS as the IHBS model for the Demonstration. The HOMEBUILDERS model of services to prevent child placement among those families at imminent risk of removal is a highly-structured cognitive-behavioral approach to building skills and acquiring resources with families. Those who implement the HOMEBUILDERS model are required by contract to be supported and monitored by the Institute for Family Development, the creators of the model, and the Institute uses case management software, phone consultation, and in-person site visits to support treatment fidelity. This evaluation analyzed that case data and found high treatment fidelity.

The Intensive Home-Based Services providers experienced difficulty in ramping up to target case levels in the early years of the Demonstration. The HOMEBUILDERS model requires an extensive training schedule before IHBS therapists can serve families, and this contributed to a slow start. There was high turnover of therapists in the first year of the Demonstration, leading to an inability to meet target case numbers. In addition, referring caseworkers saw the eligibility criteria for referring a family to IHBS as restrictive, suppressing referrals. Mid-Waiver, eligibility criteria were broadened, therapist turnover lessened, and case numbers increased.

The Long-Stayer Interventions

The challenge of Long-Stayers, or children and youth who have been in out-of-home care for at least nine months, was a focus of the Waiver Demonstration when it was conceived in 2014. The Wrap and SPAW interventions were chosen to be a part of the Waiver Demonstration to increase the number of reunifications and other forms of permanency for Long-Stayers. The Wraparound, or Wrap, process was provided by EPIC ʻOhana, on both Oʻahu and Hawaiʻi Island, as a family-centered, strengths-based process of working with families toward building skills and supports in the goal of reunification. The Safety, Permanency, and Well-Being (SPAW) meetings gathered professionals and others involved in a child's or youth's case, without the child or family present, to discuss barriers to permanency and brainstorm solutions to move a case out of a stuck situation. Like IHBS, both of these models had set procedures and practices to follow for treatment fidelity.

Both Wrap and SPAW struggled with low referral rates from CWS. While CWS caseworkers were responsible for referring children and families to either Wrap or SPAW, in reality, the Wrap and SPAW programs often reviewed the cases of children, or knew of a family through other means, and called CWS supervisors to query if that child might be an appropriate referral to their service. In focus groups, CWS caseworkers shared that they feared that a referral to Wrap or SPAW, particularly SPAW, would involve the caseworker in additional scrutiny of case decision making and case practice. In addition, many CWS caseworkers noted that the requirement of a completed *Child and Adolescent Needs and Strengths (CANS)* assessment for a referral to Wrap or SPAW was a deterrent.

There were as many as 2,500 Long-Stayers on O‘ahu and Hawai‘i Island during the Waiver years, and fewer than 300 received Wrap and/or SPAW. With the best outcomes possible, these programs would not have substantially affected the number of Long-Stayers in care by reaching a small proportion of the target population.

Family Wrap Hawai‘i

Wrap services were provided to children and families who had the case goal of reunification. In focus groups early in the Demonstration, CWS caseworkers expressed confidence in the service and had positive perceptions of it for their families. Despite this, overall utilization of Wrap largely met projections on Hawai‘i Island, but was lower than projections on O‘ahu. Throughout the Demonstration, caseworkers noted that the lengthy completion of a *CANS* assessment sometimes precluded them from making a referral.

The Wrap provider followed national guidelines for wraparound services, and this evaluation found high treatment fidelity, as shown by quantitative process measures as well as surveys of adult and youth participants. Meetings were monthly, were family-centered, respected family values and culture, and stayed focused on the family’s objectives that would support reunification.

Wrap was successful in helping children reunite with their families for over two-thirds of all the children they served, and reunifications occurred quickly, within five months, on average. Fewer than 20 percent of children served by Wrap and reunified/adopted/or in guardianship subsequently re-entered care. Children who were unlikely to reunify following Wrap were those with a history of sexual abuse and those with higher scores on the Trauma domain of the *CANS*.

Safety, Permanency, and Well-Being Meetings

Safety, Permanency, and Well-Being meetings were provided to find permanent families or settings for children and youth who were considered unlikely to reunify with their families. The children who were served by SPAW had the most challenging histories in care. The SPAW intervention was designed as one meeting of case decision makers, and this conceptualization of the service as one meeting led to target goals for SPAW of serving 200 children per year on O‘ahu and 73 children per year on Hawai‘i Island. In practice, weeks if not months went into preparing a child’s case and the professional participants for a SPAW meeting, and these targets were optimistic. Many fewer children and youth received a SPAW meeting (fewer than 100 on each island over the course of the Demonstration).

Like the other Waiver interventions, SPAW meetings enjoyed active participation and were praised by participants for high treatment fidelity. Participants who were surveyed in the fourth year of the Demonstration were impressed with the skill of SPAW facilitators, the benefit

of “out of the box” thinking in a SPAW meeting, and the importance of including in the meeting those professionals who could make immediate case decisions on behalf of their organization.

SPAW was successful in helping many children and youth exit the foster care system. Even though SPAW was intended for those children unlikely to reunify, a full 22 percent of children served on O‘ahu and six percent of children served on Hawai‘i Island were reunited with their families. Another ten percent of children served on O‘ahu and on Hawai‘i Island exited care to an adoptive family. Of all those children who exited to reunification, adoption, or guardianship, only one child had returned to foster care as of June 2019. These permanency outcomes were more likely for younger children, those with no prior experiences of out-of-home care, and for whom a larger proportion of the SPAW Action Plan had been accomplished.

The Cost Analysis

The federal government provided waivers to state child welfare agencies on the theory that, by waiving the requirement that Title IV-E funds be spent only on foster care, and providing a capped allocation of IV-E funds, states could redirect those funds to services intended to reduce the use of foster care. The resulting savings from a reduced foster care population over the course of the five-year Demonstration would allow the state to invest in services other than foster care.

The cost analysis therefore examined not only expenditures, but also trends in the size of the foster care population. Over the five years of the Demonstration, the foster care population in Hawai‘i increased, rather than decreased, particularly on neighbor islands. These increases were due to an increasing number of entries into, and a decreasing number of exits out of, foster care. The largest proportional increases in foster care entries were on Hawai‘i Island. At the same time, the state enacted increases in the foster care board and maintenance rate in FY2015 and FY2019. These two factors combined to produce an increase in foster care expenditures under the Waiver Demonstration, rather than the expected decrease. The state did increase its investments in services designed to reduce the demand for foster care. However, given these trends in the population and foster care expenses, the revenue needed to support those services had to come from sources other than the capped allocation provided under the Waiver.

Recommendations

The main lesson that runs throughout the evaluation findings is that the Waiver Demonstration in Hawai‘i, like its larger child welfare service system, was implemented and executed by a cadre of experienced and dedicated professionals across child-serving agencies with long-standing and strong relationships with, and in support of, one another. The evaluation finds bountiful evidence of the best of intentions and commitment to implementing the Demonstration and its interventions thoughtfully and with fidelity. As the state transitions to

new federal legislation guiding the provision and funding of services, it will be important to continue to nurture and exploit the wisdom and history of this deeply experienced community.

An important takeaway from the Waiver Demonstration is the benefit of the monthly Waiver meetings. The Waiver Demonstration Project Manager organized and led monthly meetings of roughly 20 to 25 personnel involved in the Waiver Demonstration, including CWS administration, section administrators, workgroup leads, lead purchase of service providers, evaluators, and others. These meetings, described in further detail in this *Report*, saw members come prepared every month to report on the number of children and families served and success stories of families in the Demonstration services, to answer questions from others about referrals and service eligibility, and to raise questions about possible refinements that might improve the service. DHS administrators were consistently affirmative and supportive of the Demonstration and the efforts made by all members. In response, meeting members attended these meetings faithfully throughout the Demonstration; attendance never diminished. This consistent and affirmative communication strategy was fruitful.

Another key lesson from the evaluation of the Demonstration is that current fiscal and data systems hamper rather than support the tasks of management of the Branch as well as data-based decision making. The evaluators received frequent requests from both caseworkers and administrators as to the specifics of how the Demonstration was going, demonstrating an abundant interest in having the ability to know how families and programs are faring overall. Yet few in the agency have the ability to produce reports on case outcomes in a timely manner. The evaluators applaud the state's current efforts to build and transition to a comprehensive CCWIS. The lessons learned from this evaluation (see Chapters Four, Eleven and Twelve) will be useful to the state as they design and launch the new system and train staff. In particular, the evaluation offers significant insight into building buy-in from caseworkers and conveying the importance and benefit of timely and consistent data entry.

It is difficult for a large agency to maintain energy and interest in a five-year endeavor, including one as broad as the Title IV-E Waiver Demonstration. As is common to many initiatives, referrals to all four interventions were highest in the early years of the Demonstration, and waned in the later years. As the state moves forward with other initiatives, it will be important to implement not only the initiatives, but a consistent communication and messaging strategy, to build and maintain interest and commitment to new ways of practice.

Finally, the analysis of outcomes after a Crisis Response suggests that more children are entering care, especially on Hawai'i Island, due to parental substance abuse and child neglect. This trend mirrors that seen in mainland states. It will be important for new DHS policy and practice initiatives to join with other community partners in addressing these two long-standing challenges to family integrity and the safety, permanency, and well-being of children in Hawai'i.

Overview and Purpose of the Waiver Demonstration

Introduction and Overview
Purpose of the Demonstration

INTRODUCTION AND OVERVIEW

Background and Context

The state-administered child welfare system in Hawai‘i is made up of four counties across the seven main islands: Honolulu County (Island of O‘ahu), Maui County (Islands of Maui, Moloka‘i and Lana‘i), Kaua‘i County (Islands of Kaua‘i, Ni‘ihau) and Hawai‘i County (Island of Hawai‘i, hereinafter, Hawai‘i Island[1]). Hawai‘i is a diverse state in both its geography and demographics. Among the more than 1.4 million residents, there is no single majority ethnic group. The four predominant ethnic groups in the state (based on the U.S. Census and based on race alone or in combination) are Caucasians, Filipino, Japanese, and Native Hawaiians, followed by Chinese, Koreans, African Americans and Samoans (Department of Business Economic Development & Tourism (DBEDT), 2015).

O‘ahu is the third largest and most populated of the Hawaiian Islands; approximately 70% of the state population is concentrated on the island of O‘ahu (DBEDT, 2015). The City and County of Honolulu, which is on O‘ahu, is the capitol and largest city in the state of Hawai‘i. The City and County of Honolulu includes the major urban district of Honolulu as well as several rural districts on the leeward coast and north shore. It is also the center of the state government, the major commerce center of the state, and home to a population of 953,207 people according to the 2010 U.S. Census, making it the tenth-largest municipality in the United States. Historically, the island of O‘ahu has had the lowest unemployment rate compared to the other islands and the state; in 2010, the unemployment rate on O‘ahu was 6.0% compared to the state average of 6.9% (The Annie E. Casey Foundation, 2017d).

In contrast, Hawai‘i Island is more than one-and-a-half times the size of all the neighboring islands put together with a total area of 4,028 square miles (DBEDT, 2015). The island is primarily rural with the exception of the county seat in Hilo and the primarily tourist area of Kona. It is the youngest island and only county with a mixed terrain of snowcapped mountaintops, tropical forests, lava desserts, roaming pastures ending at steep cliffs, and uninhabited valleys and mountainsides yet to be developed. The island’s largeness creates isolation and access issues for the county’s children[2] and their families.

The unemployment rate on Hawai‘i Island is very high. As of the most recent 2010 census, the unemployment rate in that year was 9.9%, which exceeded the national unemployment rate of 9.6% for that same year (The Annie E. Casey Foundation, 2017d). With an estimated population of 185,079 in 2010, one in five (23%) of the Hawai‘i Island residents is under age 18 (The Annie E. Casey Foundation, 2017c). In 2010, almost one-quarter (24.5%) of Hawai‘i County’s children

[1] Although it is commonly known as the Big Island, Hawai‘i Island will be used throughout this report.
[2] Throughout this report, “children” will refer to children and youth from infancy through 17 years old.

lived in poverty, by far the highest rate in the state. This number represents an 8.2% increase from 2008 (The Annie E. Casey Foundation, 2017a).

When comparing all four counties of the state of Hawai'i, Hawai'i County was the most severely impacted by the downturn in the state economy with high rates of unemployment, poverty, teen pregnancy, and children in foster care (The Annie E. Casey Foundation, 2017b). Hawai'i County was designated as a medically underserved area and has a population with a high rate of uninsured residents (North Hawai'i Outcomes Project, 2011).

In 2009-10, following the Great Recession, the Child Welfare Branch of Hawai'i DHS suffered devastating losses to its child welfare workforce. Downsizing affected up to 30% of child welfare staff in some counties. These losses resulted in high caseloads (Hawai'i has a statewide average caseload of 26 cases).

In the five years prior to the Waiver Demonstration, the number of victims of maltreatment reported to Hawai'i Child Welfare Intake declined, from 4199 victims in 2010, to 3948 in 2012, to 3681 in 2014 (State of Hawai'i Department of Human Services, 2017; see Figure 1). At the same time, the proportion of those reports that were confirmed as maltreatment rose from 38% to 40%. However, the number of victims reported on Hawai'i Island increased, while the number of victims reported on O'ahu decreased. The confirmation rate on Hawai'i Island in 2014 was 41%, while the confirmation rate on O'ahu was 34% (see Figure 2).

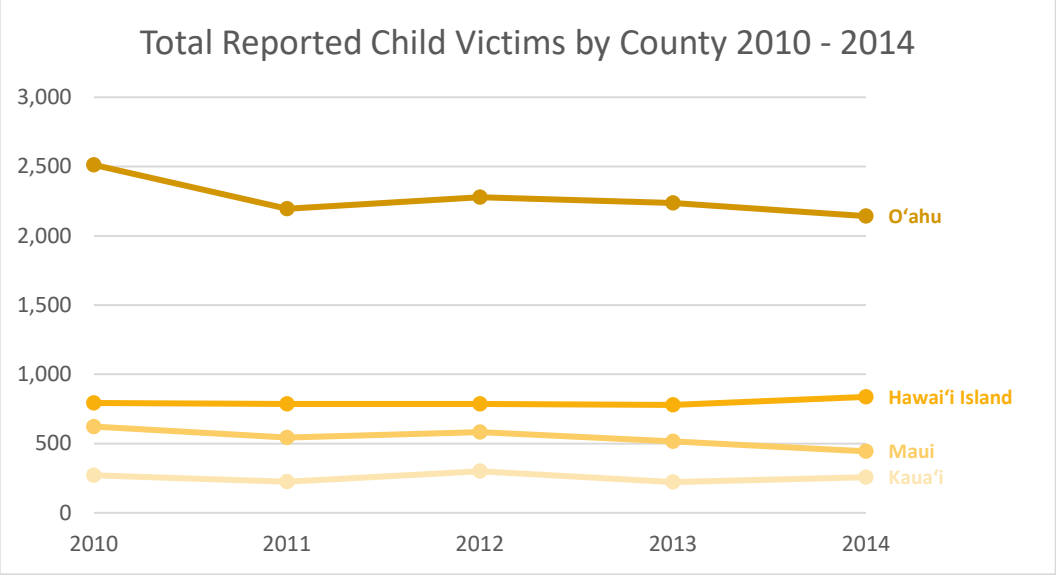


Figure 1. Total Reported Child Victims by County, 2010 – 2014[3]

[3] State of Hawai'i Department of Human Services (2017). *Child Abuse and Neglect in Hawai'i.* Honolulu, Hawai'i: Child Welfare Services Branch.

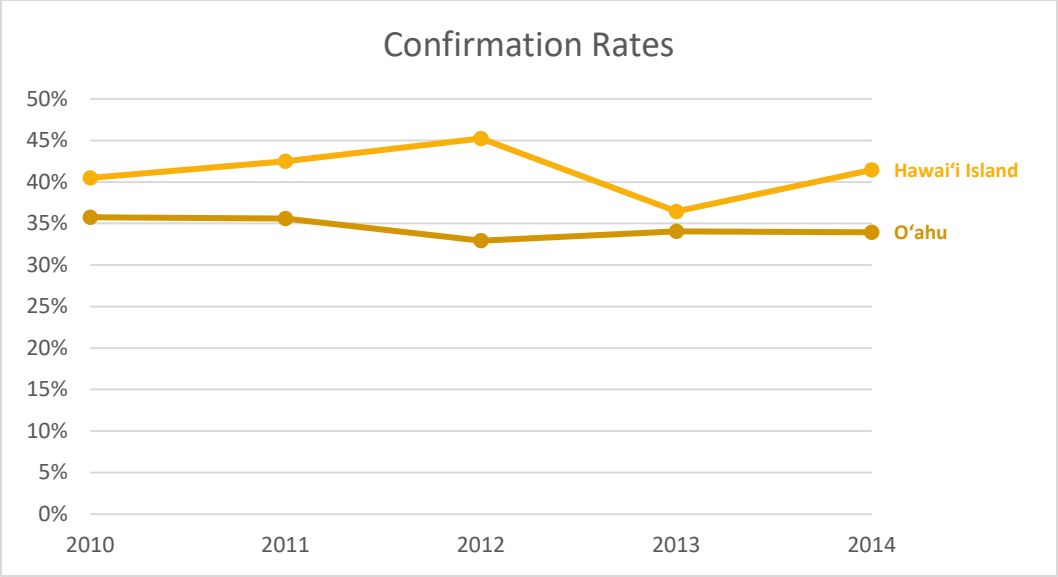


Figure 2. Confirmation Rates[4]

In the five years prior to the Waiver Demonstration, the September 30 foster care population declined and rose again from 2010 to 2014 (AFCARS), mirroring national trends (see Figure 3). The number of children entering care each year slightly increased from 1023 in FY2010 to 1076 in FY2014. The number of children exiting care steadily decreased from 2010 to 2014 (see Figure 4).

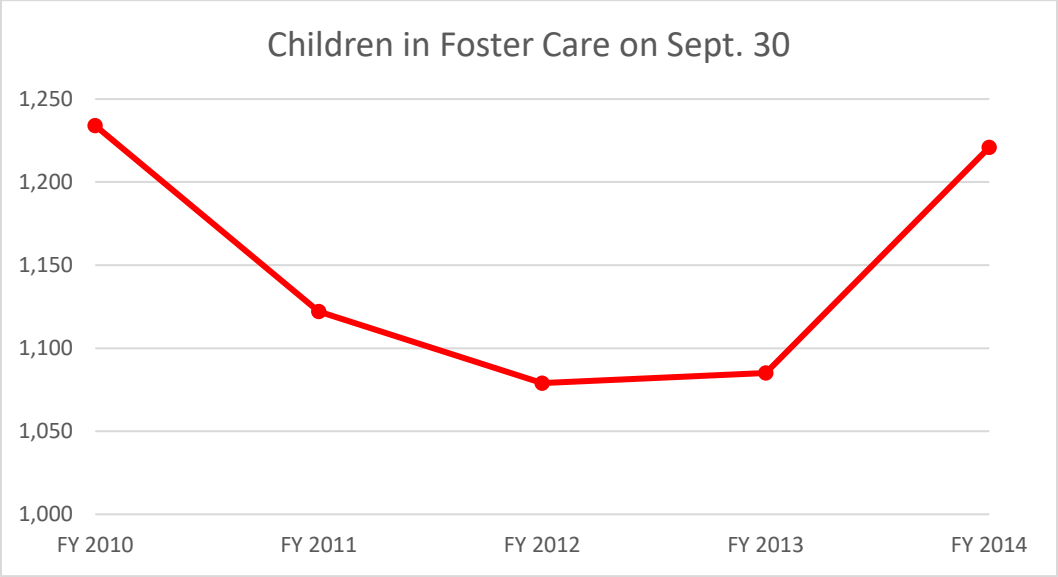


Figure 3. Children in Foster Care on September 30[5]

[4] State of Hawai'i Department of Human Services (2017). *Child Abuse and Neglect in Hawai'i.* Honolulu, Hawai'i: Child Welfare Services Branch.

[5] Children's Bureau (2018). AFCARS State Data Tables 2007 – 2016. [Data files]. Retrieved from https://www.acf.hhs.gov/cb/resource/trends-in-foster-care-and-adoption

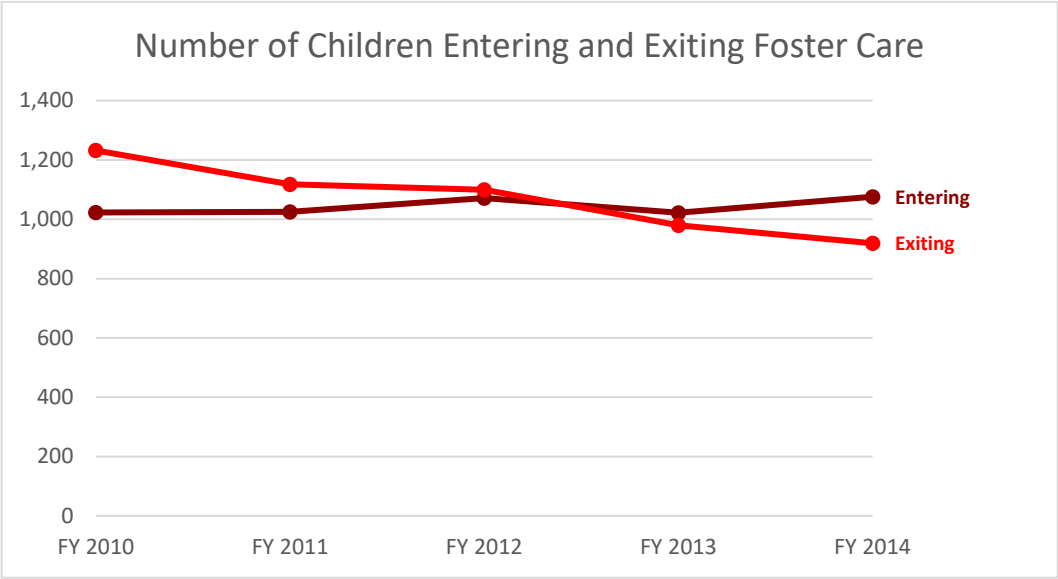


Figure 4. Number of Children Entering and Exiting Foster Care[6]

In 2012, there were 2,196 children in foster care for at least one day in the state of Hawai‘i, of which 1,476 (67%) had been in foster care for nine months or more. On O‘ahu, 1,310 children were in foster care 2012, with 66% of these children being in foster care for nine months or longer (see Figure 5). On Hawai‘i Island there were 470 children in foster care in 2012 with 69% who had been in foster care for nine months or longer. The number of children in foster care who had been in care at least nine consecutive months increased from 2012 to 2014, with 70% of foster children on O‘ahu and 75% of foster children on Hawai‘i Island being in care at least nine months.

[6] Children’s Bureau (2018). AFCARS State Data Tables 2007 – 2016. [Data files]. Retrieved from https://www.acf.hhs.gov/cb/resource/trends-in-foster-care-and-adoption

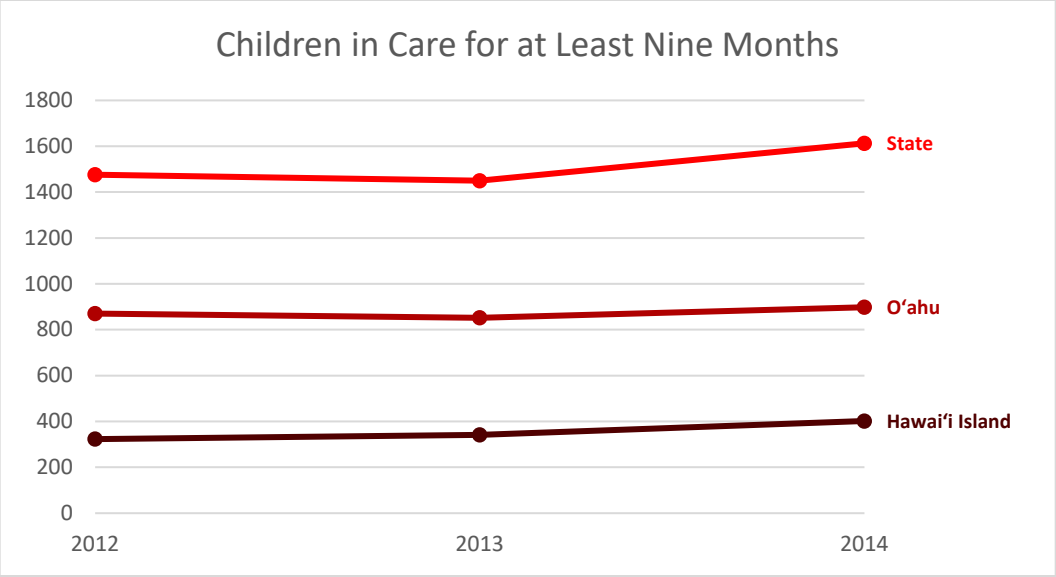


Figure 5. Children in Care for at Least Nine Months[7]

O'ahu and Hawai'i Island were selected for the Title IV-E Waiver Demonstration because these islands have the largest numbers of children and youth in the child welfare system and the Waiver Demonstration interventions could be tested in both rural and urban communities.

Problem Statement

Examination of Hawai'i's statewide child welfare data shows two populations of children and families who might benefit from the type of innovative interventions possible through the Title IV-E Waiver Demonstration. First, statewide data indicate that in FY 2012, far too many children were entering foster care unnecessarily. In that year, 54% of children placed into foster care statewide exited within 30 days. Further analysis showed that 34% of all children placed in foster care were returned to their birth parent(s) within five days of being removed – 47% within ten days. The large number of children entering care unnecessarily was, in part, due to the Child Welfare Services (CWS) response to intake referrals. Hawai'i Revised Statutes (HRS) designate law enforcement as the sole legal authority to remove a child based on its criminal investigation of abuse or neglect allegations. When a child was taken into police protective custody, CWS received a report from law enforcement. CWS staff then responded to provide out-of-home placement. Because assessment workers were unavailable to respond due to workload issues, comprehensive on-site assessment was often not conducted prior to placement. The implication of this "remove first and investigate later" response is that children did not have the opportunity to access alternatives to removal, including in-home services to prevent removal, which may have been possible had comprehensive on-site assessment been conducted.

[7] Children's Bureau (2018). AFCARS State Data Tables 2007 – 2016. [Data files]. Retrieved from https://www.acf.hhs.gov/cb/resource/trends-in-foster-care-and-adoption

In the three years prior to the Waiver Demonstration, reports of maltreatment that were called in by law enforcement, hospitals, and schools had similar dispositions, in that high proportions of reports from those sources were referred directly to Child Welfare Services.

In the three years prior to the Waiver Demonstration, between 84% and 91% of intakes from law enforcement on O'ahu, and 85% to 95% of such intakes on Hawai'i Island, were referred by Intake to Child Welfare Services, rather than diverted or no action taken.

In the three years prior to the Waiver Demonstration, a large majority of intakes from hospitals were also referred to Child Welfare Services, rather than diverted or no action taken. On O'ahu, 69% to 81% of hospital intakes were referred to Child Welfare Services, and 75% to 87% of hospital intakes were referred to Child Welfare Services on Hawai'i Island.

Intakes from schools were also likely to be referred to Child Welfare Services in the years prior to the Waiver Demonstration. From 2012 to 2014, from 52% to 63% of intakes from schools on O'ahu were referred to Child Welfare Services, and from 70% to 72% of school intakes were referred to Child Welfare Services on Hawai'i Island.

Second, The Casey Family Programs' data analysis on the Adoption and Foster Care Analysis and Reporting System (AFCARS) for Hawai'i shows that achieving permanency becomes more difficult when a child has been in foster care for more than nine months. In Hawai'i, pre-Waiver, approximately 60% of all children who entered care exited to permanency within nine months. However, there is a slow down in the permanency rate once a child has been in care for more than nine months. For example, only another 10-15% of children exited foster care within nine and 18 months of entering care (State of Hawai'i Department of Human Services (DHS), 2014).

Target Populations

Based on the problems described above, the populations targeted by the Hawai'i Title IV-E Waiver Demonstration were:

> **Short-Stayers**: Children who come to the attention of CWS through a law enforcement report, hospital report, or school report and are at imminent risk of removal. Data indicates that these children are particularly likely to enter and exit care in a short period of time, within 30 days.
> **Long-Stayers**: Children who have been in foster care for nine months or longer.

PURPOSE OF THE DEMONSTRATION

The Hawai'i Waiver Demonstration focused on these two groups of children in care or likely to enter care. "Short-Stayers" were those likely to enter and exit care within 30 days. "Long-Stayers" were those who had been in care for nine months or longer. These two target populations drove the Demonstration interventions and provided a primary structure to the evaluation.

The primary goal of the Hawai`i Waiver Demonstration was to reduce the size of the Short-Stayer and Long-Stayer populations in Hawai`i, while promoting children's safety, permanency, and well-being.

The Hawai'i Title IV-E Waiver Demonstration implemented four interventions aimed at reducing the number of children entering out-of-home placement, reducing the amount of time children are in out-of-home placement, and increasing the safety and well-being of children served. Specifically, the interventions were: (1) an enhanced Crisis Response Team (CRT) to divert youth from unnecessarily entering the foster care system; (2) Intensive Home-Based Services (IHBS) to prevent children from entering foster care and to provide appropriate support to families; (3) Family Wrap Hawai'i (Wrap) to increase the likelihood of reunification for children and youth who have been in care for at least nine months, and (4) Safety, Permanency and Well-Being (SPAW) meetings to increase the likelihood of exit of children who have been in care for at least nine months to other permanent situations when reunification is unlikely.

Crisis Response Team and Supportive Evidence

For Short-Stayers, the first intervention was an immediate Crisis Response Team, staffed by social workers who were to respond within two hours to reports of maltreatment from hospitals, schools, or police with a child in custody. It was expected that this level of immediate response would prevent the unnecessary placement of children into short-term foster care, which, prior to the Waiver Demonstration, happened when police responders were not immediately joined by child protection social workers to make an assessment at the point of first response. The Crisis Response Team was implemented to provide an immediate assessment by qualified caseworkers using structured decision making, to avoid unnecessary placement.

The provision of a crisis response to those intakes historically known to lead to out-of-home placement (in Hawai'i, intakes from hospitals, schools, and law enforcement) is exemplified in policies in many states that establish the required response time for a child welfare investigator to be on the scene of a report of child maltreatment, based on an assessment of risk or danger to the child. In Hawai'i, child welfare investigators have two possible categories of response to a report accepted by Intake for further response: (1) an immediate response (preferably within

two hours of the receipt of the report but no later than two business days) for reports that fall in the "severe" and "high" range on risk and safety assessment matrices, and (2) a non-immediate response (within five working days of the receipt of the report) for those with lower-risk assessments (*DHS Child Welfare Services Procedures Manual*, "Social Work Investigations," pg. 5).

The basis for assigning differential response times to differing levels of risk to the child is known as Structured Decision Making. Risk and safety assessments, including those used by Hawai'i CWS, are organized around empirically-based indicators of severity of harm and risk of imminent and future harm. At intake, and throughout the life of a case, an assessment of these objective indicators can provide a sound judgment about the intensity of response required by child protective and child welfare services.

The California Evidence-Based Clearinghouse for Child Welfare Practice has found the research evidence for Structured Decision Making to be "promising," as of November 2017.

Intensive Home-Based Services and Supportive Evidence

For Short-Stayers, the second intervention was Intensive Home-Based Services. This intervention was delivered to a subset of the CRT cases, those determined to be at imminent risk of out-of-home placement if intensive services were not provided. The intervention model of service was the HOMEBUILDERS model. It was expected that the addition of an intensive home-based model of service to the child protection response would further reduce out-of-home placement rates.

The Homebuilders model of Intensive Home-Based Services has the following key elements: (1) a caseworker contacts the family within 24 hours of a referral, (2) support is provided in the family's home for four to six weeks, (3) caseworkers are available to the family 24 hours a day, seven days a week, and (4) caseworkers have small caseloads of two or three families to ensure that they can provide intensive and flexible services.

In 2019, researchers at Cardiff University (Bezeczky, *et al*, 2019) conducted a systematic review of 33 studies that met strict criteria of being controlled studies of IHBS. While their review of these studies could not rule out the risk of bias, they did find that children who received IHBS experienced significant reductions in the relative risk of being placed out of home, compared to children in control groups. A child's risk of removal was reduced 43% at three months post-services, and 40% at one year post-services. The researchers also found that program fidelity was related to better outcomes in reducing placement risk.

In September 2018, the California Evidence-Based Clearinghouse for Child Welfare Practice found the research evidence for HOMEBUILDERS to be "supported."

Family Wrap Hawai‘i (Wrap) and Supportive Evidence

For Long-Stayers, the first intervention was Family Wrap Hawai‘i, aimed at children and youth who had been in care for nine months or more, but for whom reunification was thought possible with enhanced services to meet their often multiple and complex needs. It was expected that this intervention would increase the proportion of children and youth in care who were reunified.

Wraparound, or Wrap, is a team-based process of coordinating services and supports around children and families at risk. It operates within a set of values that are family-centered and strengths-based. Wrap coordinators work with families to "wrap" an individualized system of care around the family to support resiliency and prevent the need for more formalized and restrictive means of care.

A systematic review of studies of Wraparound was conducted by Coldiron, Bruns, and Quick in 2017. The review included studies from 1990-2014, and identified seven experimental studies and 15 quasi-experimental studies with some form of comparison group. The findings of the experimental studies were mixed, with two studies finding no differences in outcomes between Wraparound participants and a randomized control group receiving traditional case management. Four experimental studies found better outcomes for Wraparound youth participants in terms of moving to lower levels of restrictiveness of care, running away less frequently, and achieving permanency.

The findings of quasi-experimental studies of Wraparound were also mixed; while many found more positive outcomes for Wraparound, the studies were hampered by questions of fidelity to the Wraparound model, use of unequivalent comparison groups, and other confounding effects (Coldiron, Bruns, & Quick, 2017). This review and others (OJJDP Development Services Group, Inc., 2014) suggest positive benefits of implementing Wraparound, but find that the research findings are not yet at the level of an intervention that is "supported" evidence-based practice.

In July 2018, the California Evidence-Based Clearinghouse for Child Welfare designated the research evidence for Wraparound to be "promising."

Safety, Permanency, and Well-Being (SPAW) Meetings and Supportive Evidence

For Long-Stayers, the second intervention was aimed at children who were thought unlikely to reunify with their families. This intervention was a Safety, Permanency and Well Being (SPAW) meeting, where service providers and other professionals would meet to identify and break down the barriers to permanency. SPAW was intended to move children and youth toward permanent families, such as in adoption.

Casey Family Programs has developed the most well-known SPAW model, called Permanency Roundtables (White, *et al*, 2015). In this model, a structured meeting of a youth's case manager, supervisor, and other professionals is convened, to identify and address barriers to achieving permanency and to "think outside the box" in ways to achieve permanency. The case manager then conducts a follow-up case summary monthly, summarizing the youth's permanency status, and reasons for not achieving permanency.

In 2015, Casey Family Programs evaluated the Permanency Roundtables as conducted in eleven counties in four states, concerning 726 youth, ages 12 and above (White, *et al*, 2015). They found that, twelve months after Roundtables, 62% of youth were still in foster care. Another 27% had aged out of care. Only 9% had achieved permanency (through reunification, guardianship, or adoption). Youth who were most successful in achieving permanency after a Roundtable were those who began the Roundtable with the case goal of reunification.

The SPAW Roundtables have not been systematically reviewed, and, as of 2019, have not received a rating from the California Evidence-Based Clearinghouse for Child Welfare.

Timetable

As planned, the five-year Title IV-E Waiver Demonstration was implemented first on the island of O'ahu, the most urban Hawaiian island, including Honolulu, on January 1, 2015, (with CRT and IHBS) and February 1, 2015 (Wrap and SPAW) and subsequently, on Hawai'i Island, a more rural island with the cities of Hilo and Kona, on October 1, 2015 (all four interventions).

The Demonstration and most interventions continued through September 2019. The SPAW intervention concluded six months early, in concordance with contract terms.

The Evaluation Framework

Overview of the Evaluation
Methodology – Process Evaluation
Methodology – Outcome Evaluation
Methodology – Cost Study
Strengths
Limitations

OVERVIEW OF THE EVALUATION

The evaluation contains three components:

- A **process evaluation** documenting the Demonstration's implementation;
- An **outcome evaluation** comparing measures of safety, permanency and well-being for children who received Waiver-funded services to a group of those who had not received these services; and
- A **cost analysis** examining the costs of the key Demonstration service elements, as well as any savings generated through the provision of the Waiver interventions.

In accordance with the Hawai'i Waiver Terms & Conditions, the evaluation consists of separate sub-studies of each of the four core interventions: CRT, IHBS, Wrap and SPAW, in both process and outcomes. In addition, the process evaluation captures overall organizational and systemic changes and impacts of the Waiver Demonstration. The cost analysis compares spending of Title IV-E and programmatic funds in the three years prior to the Waiver Demonstration to spending under the Waiver Demonstration, and examines the connection of funding to case outcomes.

Theories of Change

The fundamental theory of change to be examined is how the state used waived Title IV-E funding criteria to make changes in service delivery by providing CRT, IHBS, Wrap and SPAW, ultimately to improve safety, permanency, and well-being outcomes for children. The process and outcome evaluations together create the basic narrative of the Waiver Demonstration's impact, explaining how casework practices, new interventions and services help children achieve improved safety, permanency, and well-being. The cost study complements that narrative, describing how a shift in revenue and expenditure patterns enabled practice changes to occur and how to ultimately create better outcomes for children as well as use dollars more efficiently and effectively.

From the *Initial Design and Implementation Report* (2014), the theories of change for each of the four interventions are described, with a detailed enumeration of the core components of each intervention. These theories of change have guided the logic models for the evaluation and are repeated here.

Theory of Change for the Crisis Response Team

Crisis Response Team is implemented

SO THAT

Social Workers have the ability to immediately respond to reports involving school or hospital referral or police protective custody when placement is imminent

SO THAT

Social workers can immediately assess safety and risks
AND
Social workers can make decisions about need for out-of-home placement
AND
Social workers can identify relatives/kin for support or placement options if necessary
AND
Social workers can do safety planning with families if appropriate

SO THAT

Children are supported in their own communities
AND
Social workers make appropriate referrals and service coordination with families
AND
Families have enhanced capacity and support to safely care for their children

SO THAT

Proportion of foster care entries is reduced
AND
Placement with relatives is increased if placement is necessary

Core Components of the CRT Intervention

- 24/7 crisis response to police protective custody and school and hospital referrals;
- Face-to-face contact by a CRT social worker within one to two hours of a CRT assignment by the Intake Unit;
- Immediate family engagement and safety planning by using the State of Hawai‘i Department of Human Services Child Safety Assessment and Analysis for In-Home Services at the time of initial face-to-face contact with the family;

- Decision on case closure, immediate referral to IHBS, referral to one of the two DRS programs when appropriate, family supervision referral/petition filing, or referral to CWS Permanency Unit for placement;
- Monitoring IHBS-referred cases and family supervision cases by the CRT worker as a case manager up to 60 days on the family's progress with weekly face-to-face contact requirement in the first month of services, every two weeks in the second month;
- Completion of Comprehensive Strengths and Risk Assessment within 60 days of intake date or prior to case closing, whichever comes first, to determine overall level of risk to the children in the family when making decisions regarding case disposition, the level and type of intervention and service provision needed by the family;
- Assistance in identifying relatives/kin for placement if placement is necessary; and
- Partnering with law enforcement agencies by executing a Memorandum of Agreement.

Theory of Change for Intensive Home-Based Services

Intensive Home-Based Services are implemented

SO THAT

Families will be connected with a therapist immediately in their time of crisis
AND
The needs of the family can be further assessed

SO THAT

The safety plan can be enhanced to keep children safely in the family home

SO THAT

Family support and community services can be identified

SO THAT

Parents are offered the needed services
AND
Parents can participate in these services

SO THAT

Parents have improved coping, parenting and other necessary skills
AND
Children can remain in their home safely with interventions

SO THAT

Fewer children are placed in foster care
AND
Fewer children are re-referred to CWS
AND
Fewer children have new reports to CWS that are substantiated
AND
Well-being of children and their families is improved

Core Components of the IHBS Intervention

- Visit with the family within 24 hours of referral from CRT to IHBS;
- No more than two cases at a time per IHBS therapist;
- An average of eight-to-ten hours of face-to-face contact with the family per week. Service intensity (hours per week and total hours per intervention) will vary across families based on their level of need. Families typically receive 38-40 hours or more of face-to-face contact during the intervention;
- Use of *North Carolina Family Assessment Scale* by the IHBS provider at the first meeting with the family to assess the needs and develop a service plan and also at the end of the intervention, i.e., the targeted fourth week or at sixth week if the family continues through the maximum time of six weeks;
- Provide skill-based interventions;
- Develop a transition plan for the family with the CRT case manager in Week Two, Three or Four; and
- Determination of IHBS case disposition by CRT case manager by using the Child Safety Assessment and Comprehensive Strengths and Risk Assessment. Case disposition type will include closure, transfer to a permanency unit for foster care placement, family supervision petition or voluntary family supervision agreement, or to differential response services for further prevention/aftercare.

Theory of Change for Family Wrap Hawai‘i

Family Wrap Hawai‘i is implemented

SO THAT

An assessment is done to identify strengths and needs of children and families
AND
A team meeting can be held to include children/youth, their families, and agencies involved with the families

SO THAT

The families are empowered as they engage in developing their service plan
AND
Services offered by different agencies are coordinated

SO THAT

The needs of children and their families can be met more effectively by providing a holistic service plan

SO THAT

Fewer children are placed in institutional settings
AND
Placement stability increases

SO THAT

Children achieve permanency through reunification
AND
Permanency is achieved sooner
AND
Fewer children re-enter foster care
AND
Well-being outcomes of children and youth are improved

Core Components of the Wrap Intervention

- Multi-agency team-based, facilitated monthly meetings of professionals and families to identify and address barriers to reunification;
- Focused engagement of family members for creative case planning and transition for reunification purposes;
- Development of the Family Wrap Plan for Wrap partners to follow up;
- Use of *Child and Adolescent Needs and Strengths* (*CANS*) tool to understand the strengths and needs of the child and family when the case is accepted into Wrap and six months after the first Wrap meeting or at the end of Wrap service participation, whichever comes first;
- Parent Partner and Youth Partner offered to each family and child;
- Follow-up activities by Community Navigator with each participant on progress and supports needed; and
- Availability of Facilitator for post-Wrap consultation if needed.

Theory of Change for Safety, Permanency, And Well-Being Meetings

SPAW is implemented

SO THAT

The contracted provider and the caseworker identify key system decision-makers to be included at the SPAW meeting for the individual child based on that child's needs

SO THAT

Strengths and barriers to achieving permanency can be identified for the child
AND
An action plan is developed and implemented
AND
Roles and responsibilities are determined

SO THAT

Appropriate services are delivered
AND
Informal supports (mentors, coaches, family) are utilized to promote permanency

SO THAT

Placement stability is reviewed and addressed
AND
Tasks assigned to SPAW team members are followed up on
AND
Feedback is provided to the caseworker

SO THAT

Determination is made on whether or not an additional SPAW is needed
AND
Assigned tasks are accomplished

SO THAT

Permanency outcomes are improved
AND

Length of stay in foster care is reduced
AND
Placement stability is improved
AND
Children's well-being outcomes improve

Core Components of the SPAW Intervention

- Case consultation process by professionals and specialists with a focus on safety, permanency, and well-being;
- Development of a Permanency Action Plan for participating members of the SPAW meetings for identified systemic barrier busting;
- Use of *Child and Adolescent Needs and Strengths* (*CANS*) tool to understand the strengths and needs of the child when the case is accepted into SPAW and when a court hearing for adoption or legal guardianship is scheduled or within six months of the SPAW meeting; and
- Follow-up activities by SPAW coordinators on the developed Permanency Action Plans at 30, 60, and 90 days from the SPAW meeting.

Logic Models

Based on these four theories of change, there are four logic models (see Figures 6 - 9). In each logic model, the participant characteristics, service characteristics and outputs are captured in the process evaluation. The outcomes of child safety, permanency, and well-being are captured in the outcome evaluation. In each, the short-term outcomes are those improvements we expected to see by the end of the specific intervention (CRT, IHBS, Wrap or SPAW). The medium-term outcomes are those we expected to see among those in the intervention group within six months of the end of the intervention. The long-term outcomes are those improvements we expected to see statewide over the course of the five-year Demonstration.

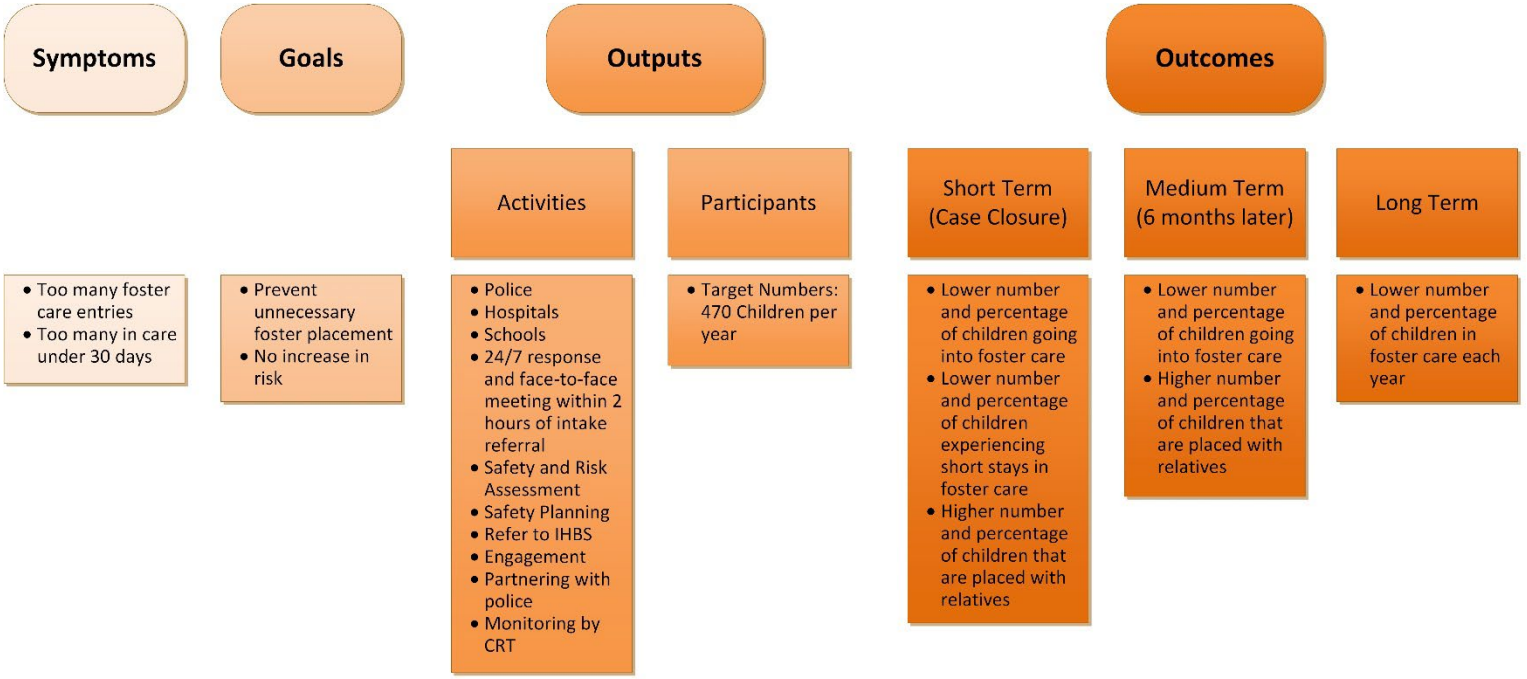
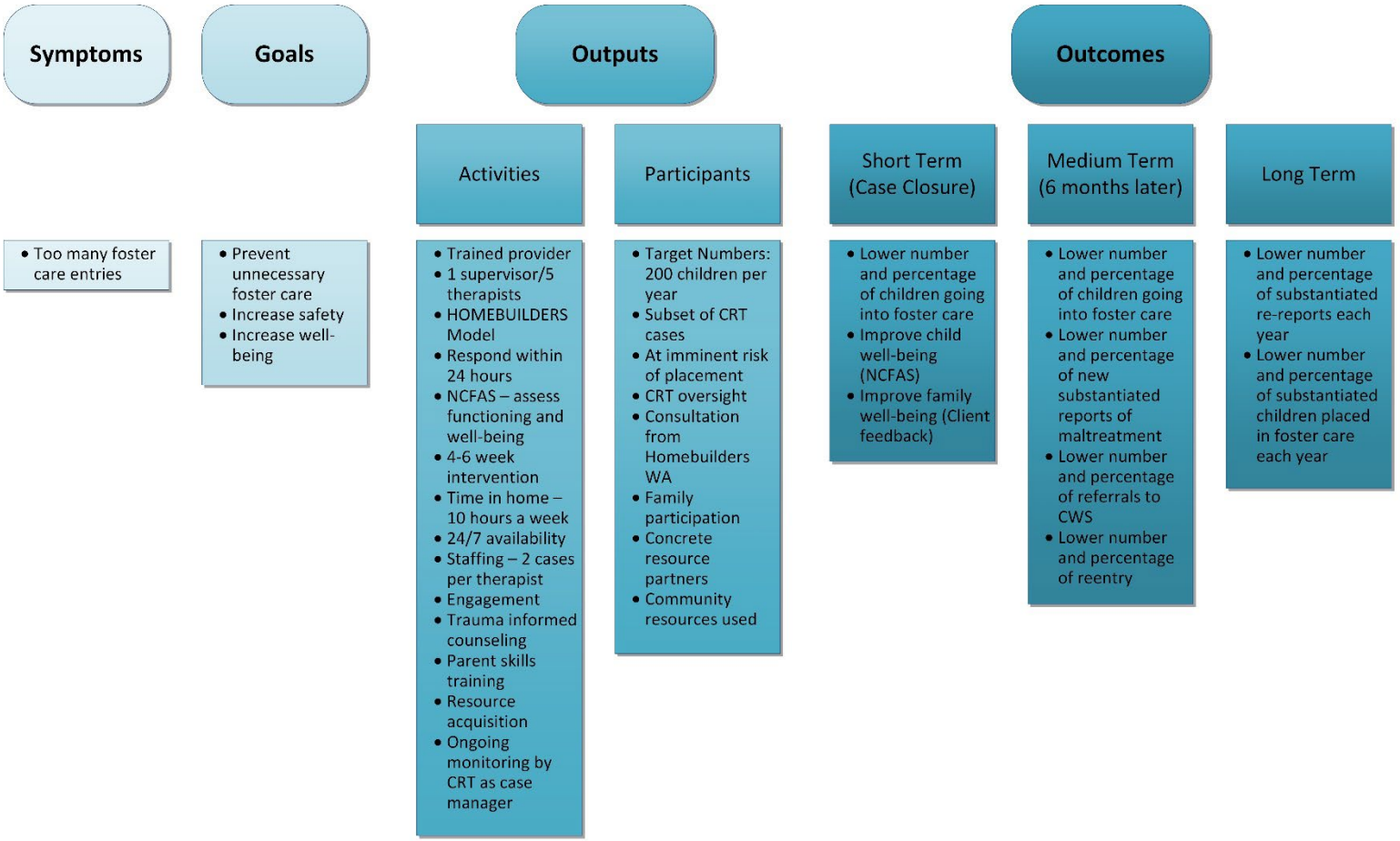


Figure 6. CRT Logic Model



IHBS
Logic Model

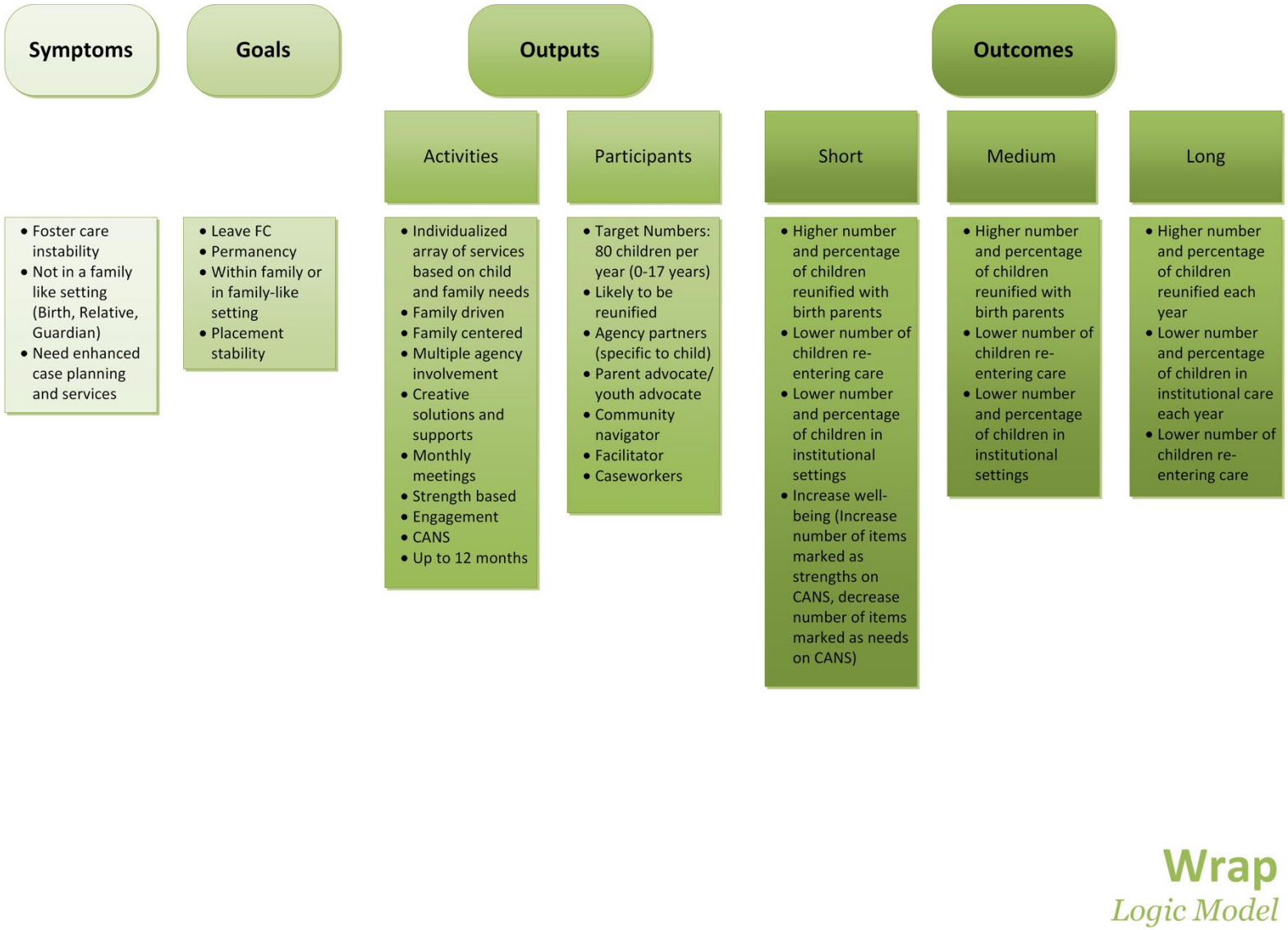


Figure 8. Wrap Logic Model

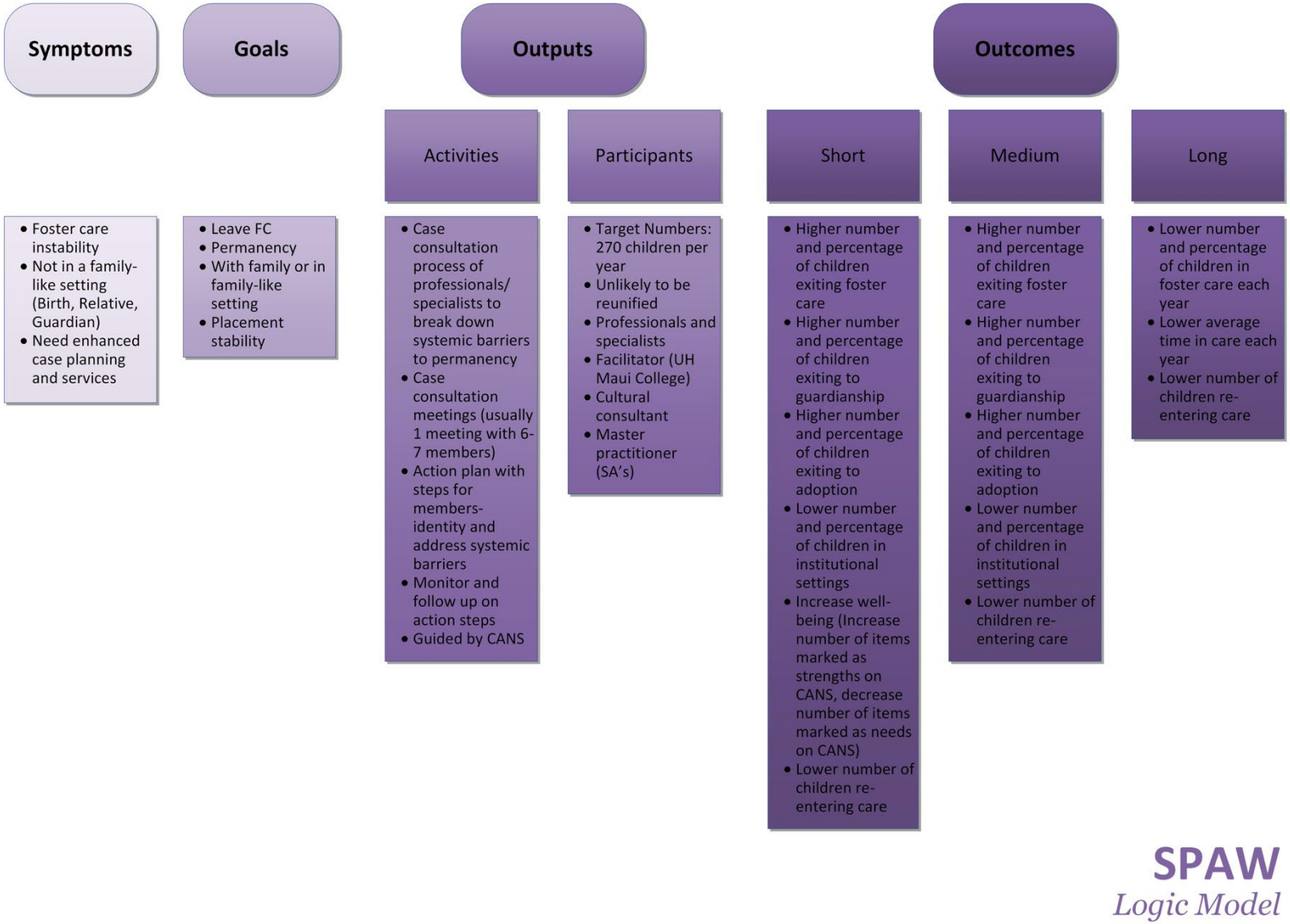


Figure 9. SPAW Logic Model

METHODOLOGY – PROCESS EVALUATION

Key Questions

The key questions to be analyzed by the process evaluation are:

1. Implementation:
    - Was the Waiver Demonstration adequately planned and communicated to staff and community partners?
    - Did key members adequately develop and share knowledge about the Demonstration and the interventions?
    - Did staff have the resources needed to implement the interventions effectively?
    - How well did the staff understand, implement, 'buy-in' and utilize the interventions?
    - Were the community partners adequately involved and engaged in the Waiver Demonstration planning and implementation?
    - What were the organizational and contextual strengths and barriers that hindered or enhanced the implementation or provision of each intervention?
    - Were information systems and communication strategies sufficient to provide data feedback loops about the Demonstration?

2. Provision of Services:
    - How faithfully were the interventions implemented?
    - Were there differences in the implementation of the interventions on Oʻahu and Hawaiʻi Island?

Implementation Science as an Evaluation Framework

The process evaluation is a fundamental element for understanding and interpreting the overall success of a project such as a Title IV-E Waiver Demonstration. The objective of the process evaluation is to assess and demonstrate the project's degree of implementation, fidelity, and simultaneously analyze the broader elements and factors that influence the outcomes and the overall success of the project. These factors can include both external and internal factors. External factors can include policies, funding, and budget requirements at the federal, state, and local-level. Examples of internal factors are organizational capacity, leadership, and

infrastructure. While a high-quality process evaluation requires a rigorous and systematic review of these various elements, there is limited specificity that dictates the direction of the evaluation beyond recommended steps to conduct the evaluation and the data to use. The process evaluation, therefore, allows a large degree of flexibility regarding the organization and structure of the evaluation itself.

The process evaluation of the Hawai'i Title IV-E Waiver Demonstration was conducted through an implementation science (IS) lens, along with the overarching research questions, resulting in a structure that offers more meaningful findings for the agencies and stakeholders involved in the implementation, funding, and evaluation processes. Over the last several years, the field of child welfare has embraced many of the findings and insights from IS, as well as begun to contribute to this growing field. Although IS is predominantly concerned with actual implementation and scaling up of evidence-based practices (EBP), we propose that this same perspective is also appropriate for guiding and organizing the process evaluation.

Implementation science is the scientific study of evidence-informed steps, strategies, and methods used to promote the systematic uptake of research findings and other EBPs into routine practice to improve the quality and effectiveness of services and/or practices in real-world settings (Eccles & Mittman, 2006). The impetus towards adopting EBPs in the field of child welfare has resulted in a simultaneous need to incorporate new structural, organizational and leadership elements, which can be facilitated through understanding and utilizing the findings of IS.

To conduct the process evaluation through an implementation science lens, an IS framework was adapted to create an evaluation framework for benchmarking actual progress. There exist multiple IS frameworks, most of which reflect different stages of implementation and important components or drivers of implementation. There is considerable agreement that the changes associated with the implementation of new practices or an innovation occurs in discernible stages (Aarons, Hurlburt, & Horwitz, 2011; Metz, Naoom, Halle, & Bartley, 2015). Threaded throughout the stages of the implementation process are core components that are the drivers of change. IS research has demonstrated that the core components are dynamic and interact to produce consistent uses of the interventions, and, as a result, the desired outcomes.

There are three objectives to implementation frameworks: (1) describe/guide the process of translating research into practice, (2) understand/explain what influences implementation outcomes, and (3) evaluate implementation (Nilsen, 2015). The National Implementation Research Network (NIRN) framework was utilized and adapted for benchmarking progress for this evaluation. The evaluation incorporated all essential elements of the process evaluation into a broader system-level analysis organized by implementation stage and core components (i.e., implementation drivers).

There are many specific models of implementation science (see James Bell Associates, 2009). The IS framework used for the evaluation of the Hawai'i Waiver Demonstration is most

accurately captured in the graphic below, and is the NIRN framework which is referred to in this document as "the Metz Model" of implementation science. This specific model and graphic were first presented in Metz, *et al*, (2015), were modified by Lee, Freeman, Greeno, *et al*, (2018), and are used here with permission (see Figure 10).

The four stages of implementation are *exploration, installation, initial implementation*, and *final implementation*. They occur over time, and each stage builds on progress and achievements in the prior stage. The *exploration* stage is when stakeholders identify the needs of the population they serve and select an appropriate intervention(s) to address those needs. This occurs before any actual change. The *installation* stage also occurs before the new service or activities are initiated, and involves developing the necessary individual and organizational competencies and infrastructure needed to support the new practices or intervention(s). A project is considered in the *initial implementation* stage once practitioners begin delivering the new services. Finally, once the new practice or intervention has been integrated into all levels of the system and more than half of practitioners are using the new practices with high model fidelity, the project is considered to be in the *final implementation* stage. Although the stages are considered discernible, there are no clear lines of division, and it can be common to encounter much overlap between the stages; activities in one stage might begin before those in a prior stage are successfully achieved, although this is not optimal and can detract from a successful implementation. Additionally, due to logistical factors and imposed funding timelines, it is possible for different components of a project to be in different stages of implementation simultaneously.

According to the Metz model, there are three core components of implementation threaded throughout the four stages of implementation. The core components act as implementation drivers that lead to actual change. The core components are dynamic and interact with each other to produce the necessary changes required for success implementation with high model fidelity. The first core component is *implementation leadership*. Implementation leadership refers to the individuals and groups tasked with overseeing, monitoring, and supporting the implementation process. The second core component is *data and feedback loops*, which largely involves the use of reliable data to inform the decision-making process and establish continuous quality improvement cycles. Finally, the third component is *implementation infrastructure*, which refers to the individual and organizational level capacities needed to support the infrastructure necessary to support the institution and specifically the new practice or innovation.

We propose that applying the Metz Model of implementation science to conduct the process evaluation provides a logical and chronological organization of the data and research findings. Implementation science frameworks are designed to promote the successful implementation of a new innovation or practice. Utilizing the same framework for the process evaluation highlights the obstacles, barriers, strengths and successes while analyzing the services, activities, policies and procedures that were adopted and utilized to support the implementation process over time.

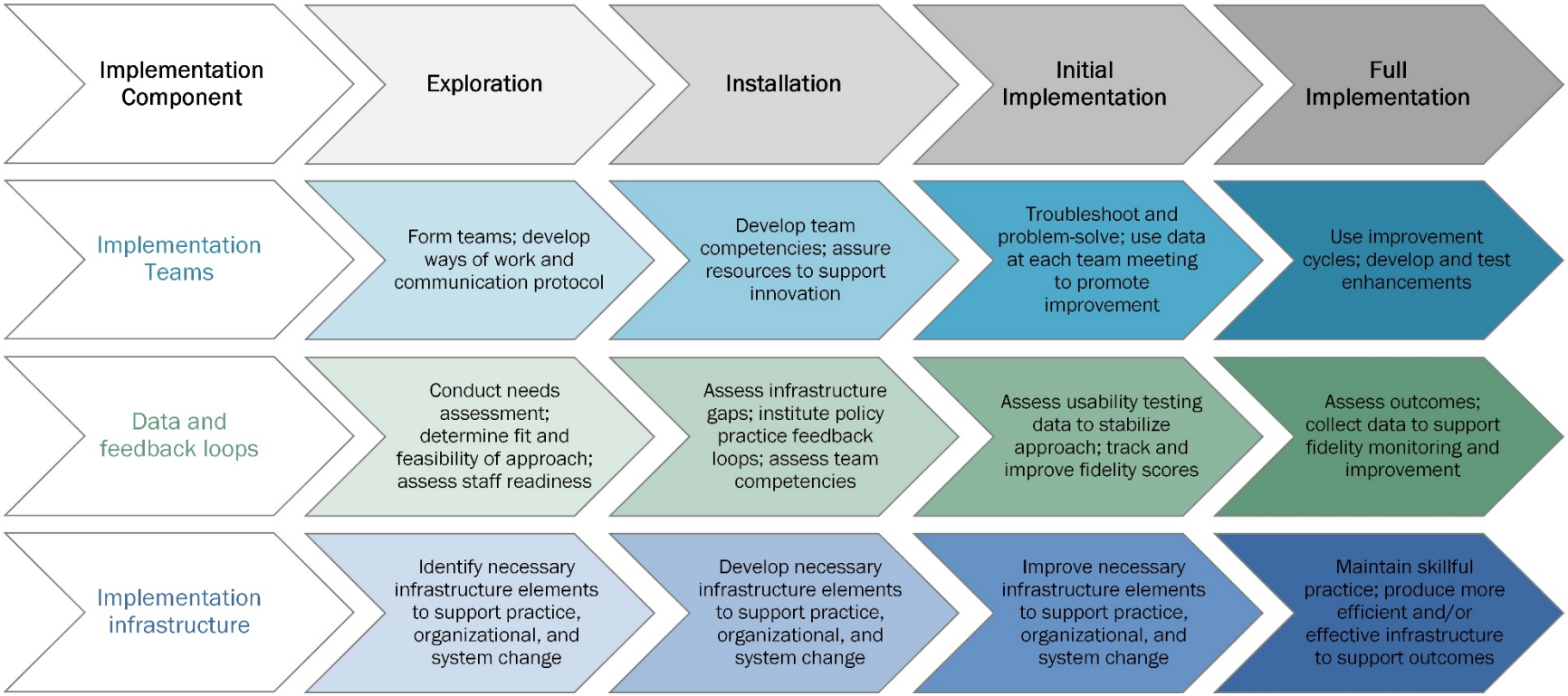


Figure 10. The Metz Model of Implementation Science
Metz, *et al.,* 2015

Design

The process evaluation plan was designed in collaboration with the Title IV-E Waiver Demonstration Executive Committee in the Child Welfare Services Branch, Social Services Division, Department of Human Services, Hawai'i. The Evaluation Team also utilized a variety of techniques and strategies to identify the administrative support for the project and kept up to date on the problem-solving activities of the Waiver Demonstration Executive Committee at various times over the five years of the project.

The process evaluation focused on describing and evaluating the implementation and the service provisions of each of the four interventions, using a mixed methods approach to address these two objectives:

1. A detailed and contextual description of the implementation of the Waiver Demonstration:
    a. Administrative structure and supports
    b. Systematic description of each of the interventions and decision points
    c. Staffing of the interventions
    d. Training of staff
    e. Accuracy of understanding and implementation of interventions by staff
    f. Awareness and understanding of Waiver Demonstration among community partners
2. A thorough and systematic description of the provision of each of the interventions, and their fidelity to original models:
    a. Enrollment of children and families vis-à-vis goals for each intervention
    b. Characteristics of participants
    c. Characteristics of service and fidelity to intervention models
    d. Perceptions of staff and intervention participants regarding fidelity and satisfaction

The process evaluation findings in this report are based on multiple methods to describe and analyze both implementation and service provision.

Document Reviews

A complete document review was conducted in the first year of the Demonstration. This review provided the Evaluation Team with: (1) an in-depth understanding of Title IV-E Waiver Demonstration and its four interventions, (2) an understanding of the broader context in which the Waiver Demonstration operates, and (3) specific information about the various state databases (i.e., CPSS and SHAKA) to inform the quantitative data collection and analysis process. The information gleaned from the review of these informed every stage of the evaluation, from gathering data to interpreting findings.

Additional document reviews occurred throughout the Demonstration. These included the Semi-Annual Reports filed by the Waiver Demonstration Project Manager, the Annual Statistical Reports on Child Abuse and Neglect, minutes from meetings, and official DHS memos pertaining to the Demonstration.

Focus Groups

Members of the Evaluation Team conducted focus groups with groups of CWS administrators, line staff, private providers, and Family Court judges. These focus groups were conducted to gather impressions about the Waiver Demonstration from a large number of administrators, staff, or community partners in a way that would allow a large number of respondents to respond to qualitative, open-ended questions, and provide for anonymity that an individual interview might not.

Site Visits

The Evaluation Team conducted site visits to all units and agencies that were involved in the provision of any of the Demonstration interventions, and visits to the SHAKA database team at Maui College on Maui. At these site visits, members of the Evaluation Team had interactive conversations to (1) introduce themselves to Waiver partners, (2) better understand the interventions and data collection efforts, and (3) answer any questions or address any challenges concerning the evaluation of the Demonstration. Many times, these site visits would center around an evaluation training document or "cheat sheet" (described further later).

Interviews

In addition to focus groups, members of the Evaluation Team conducted interviews with individuals with a key role in the Waiver Demonstration, usually in the first year of the Demonstration. These were primarily Waiver Leadership members, CWS administrators, CWS unit supervisors, and directors and managers of the private provider agencies. These interviews were conducted through semi-structured interviews.

Additional interviews were conducted in the final year of the Demonstration with parents who had participated in Wrap, and professionals who had participated in SPAW. These interviews were either in-person or by telephone, and used structured, open-ended questionnaires.

Participant-Observations

Members of the Evaluation Team attended, observed, and participated in the monthly meetings organized by the Waiver Demonstration Project Manager throughout the Demonstration. At these meetings, key directors and supervisors of the four Demonstration

interventions would report out on the progress of the intervention at their site (number of cases served, and quantitative or anecdotal evidence of progress and challenges for staff, children, and families). The Evaluation Team would also update the group on progress and challenges with the evaluation. A member of the Evaluation Team was also present at most meetings of the intervention Workgroups throughout the first year of the Demonstration, as members refined and elaborated on the practice models described in the IDIR.

Surveys

At intermittent points throughout the Demonstration, the Evaluation Team used surveys to gather information. Surveys were intended to be brief and easy to complete. Surveys took the form of an Excel form to be completed by supervisors (on staffing), online surveys through Survey Monkey emailed to potential respondents, or paper questionnaires (usually distributed to parent participants of interventions).

Participatory Action Research

Finally, the Evaluation Team gathered critical information about the implementation of the Demonstration through a variety of methods of participatory-action research (Kemmis, McTaggart, & Nixon, 2014), where contemporary information that had been learned or developed by the Evaluation Team would be provided to DHS Leadership, CWS supervisors and staff, private providers, or database managers, usually through a document or graphical representation of interventions or data collection strategies. The recipients would be asked for feedback about information, usually in a group or individual conversation, to further inform both the Demonstration and the evaluation of it. These ongoing interactive participation/reflection/learning exercises were critical in building and refining the knowledge base of the evaluation and the Demonstration itself.

Quantitative Process Metrics

For each intervention, quantitative process metrics on service provision and service fidelity were added to, or refined in, CWS or private provider data bases. Care was taken by the Evaluation Team to utilize existing data to the extent possible. Training was provided by the Evaluation Team on any new data fields that were developed for the Demonstration and evaluation.

The Evaluation Team developed procedures and protocols for quantitative administrative data collection as well as developed interview, focus group and survey questions and schedules. The Team received approval from the University of Hawai‘i Institutional Review Board (IRB) for the original protocols and materials as planned at the initiation of the evaluation and received

updated approvals as the evaluation moved forward. Each data collection strategy is described below.

Data Sources and Data Collection

Phases of Data Collection on Implementation

The Evaluation Team employed a variety of Implementation Science strategies in order to address the description of the implementation of the Waiver Demonstration. In order to capture the benchmarking of the implementation of the Waiver Demonstration over time, data on implementation was gathered in roughly four time periods (see Table 1).

Year One: Start-Up

In the first year of the Demonstration, as the interventions began and were refined, the Evaluation Team focused on capturing the initial implementation of interventions and assessments. The Team reviewed documents, conducted focus groups with CWS line staff to assess their understanding of the initial implementation, conducted a survey of initial staffing and training plans, and developed Workflow Charts reflecting the key activities of each intervention.

Year Two: Assessment

In the second year of the Demonstration, after roughly the first year of Demonstration service delivery, the Evaluation Team focused on assessing how well the initial implementation had gone. The Team continued to review newly produced memos and other documents, conducted site visits with CWS line staff, private providers and database managers to understand and refine evaluation tools and supports, interviewed key Demonstration leaders to gather their assessments of the initial implementation, surveyed child welfare line staff about their knowledge and impressions of the four interventions so far, and developed further evaluation supports.

Year Three: Participant Feedback

In the third year of the Demonstration, once there were enough service participants to survey, the Evaluation Team began to solicit feedback from participants about their experiences with the Demonstration, starting with the Wrap intervention, given that it had the highest number of participants served, excluding the Crisis Response Team. Recipients of the CRT response were not queried, given the short-term, immediate nature of the intervention.

Final Year: Administrator, Staff and Participant Feedback

In the final year of Waiver Demonstration service delivery, the Evaluation Team continued to gather impressions from participants in IHBS, Wrap and SPAW through surveys and interviews. A final set of interviews was done with intervention supervisors to gather their assessment of how staffing for the intervention had evolved over time, and a final survey was done of administrators and staff involved in the Demonstration to assess their perceptions of the successes and challenges of the Waiver Demonstration.

All Years

Additional data were collected periodically throughout the Demonstration in an ongoing fashion, particularly in terms of documents and meeting minutes that were produced, participant-observations at all meetings, the delivery of small evaluation analyses to DHS and the resulting feedback and questions that such analyses elicited, and ongoing communication with all providers and line staff about case data for the evaluation.

Table 1

Implementation Science Evaluation Data Collection Activities

Method and Data Source	Island	Year
Document Reviews		
IDIR, manuals, trainings, contracts, tools, data systems	Oʻahu	One
Monthly minutes, memos, Semi-Annual Reports	Oʻahu	All
Focus Groups		
CWS Assistant Program Administrators	Oʻahu	One
CWS line staff	Oʻahu & Hawaiʻi Island	One
Private providers: IHBS, Wrap and SPAW	Oʻahu	One
Family Court judges	Oʻahu & Hawaiʻi Island	Two
Site Visits		
Site visits with CWS line staff	Oʻahu & Hawaiʻi Island	Two
Site visits with private providers	Oʻahu & Hawaiʻi Island	Two
Site visits with database managers	Maui	Two
Interviews		
Demonstration Leaders:		
Title IV-E Waiver Demonstration Project Manager	Oʻahu	Two
CWS Program Development Administrator	Oʻahu	Two
Original process evaluation Principal Investigator	Oʻahu	Two
CWS Section Administrators	Oʻahu & Hawaiʻi Island	Two
CRT Section Administrator, CRT Unit supervisor	Oʻahu	Two
Supervisors, managers, admins in IHBS, Wrap, SPAW	Oʻahu	Two
Wrap participants	Oʻahu & Hawaiʻi Island	Final
SPAW participants	Oʻahu & Hawaiʻi Island	Final
Supervisors: CRT, IHBS, Wrap and SPAW on staffing	Oʻahu & Hawaiʻi Island	Final
Participant-Observations		
Intervention Workgroup meetings	Oʻahu	One
Monthly DHS Waiver meetings	Oʻahu	All
Surveys		
Survey of initial staffing and training	Oʻahu & Hawaiʻi Island	One
Knowledge and Impressions of CWS line staff	Oʻahu & Hawaiʻi Island	Two
Survey of adult and youth participants in Wrap	Oʻahu & Hawaiʻi Island	Three
IHBS parent feedback surveys	Oʻahu & Hawaiʻi Island	Final
Retrospective survey of Demonstration Leaders	Oʻahu & Hawaiʻi Island	Final
Participatory Action Research		
Workflow charts	Oʻahu & Hawaiʻi Island	One
Evaluation cheat sheets and training of staff, providers	Oʻahu & Hawaiʻi Island	Two
Data crosswalk and refinements to data systems	Oʻahu & Hawaiʻi Island	Two
Small evaluation analyses and reports to DHS	Oʻahu & Hawaiʻi Island	All

Document Review

Year One: IDIR, Manuals, Trainings, Contracts, Tools, Data Systems

The Waiver Demonstration Project Manager was a primary resource for accessing essential documents. At the start of the Waiver Demonstration, she compiled a file for all Waiver Demonstration members that contained the following: (1) project directory, (2) acronyms and abbreviations, (3) CWS Internal Communication Form (ICF) memos related to the project, (4) terms and conditions for the Hawai'i Waiver Demonstration, and (5) the *Initial Design and Implementation Report*. From this starting point, the Evaluation Team was able to identify and collect other necessary documents to complete the review. These documents included:

- Initial Design and Implementation Report
- Hawai'i Waiver Demonstration Evaluation Plan
- DHS/CWS Internal Communication Form Memos
- DHS Child Welfare Services Procedures Manual, Part III Casework Services
- Waiver Directory of Working Groups and Key Personnel
- CPSS Quick Reference & Code Table Guide
- HOMEBUILDERS Fidelity Measures: Program Structure Standards (IHBS)
- HOMEBUILDERS Standards (IHBS)
- North Carolina Family Assessment Scale (NCFAS – IHBS)
- Child and Adolescent Needs and Strengths (CANS) – Hawai'i Measure (SPAW/Wrap)
- Child and Adolescent Needs and Strengths (CANS) Manual – Hawai'i (SPAW/Wrap)
- Child Safety Assessment and In-Home Safety Plan Instructions (CRT)
- About Family Wrap Hawai'i Brochure (Wrap)
- SPAW Values Training Materials (SPAW)
- DHS Supplemental Contracts for Intervention Services (IHBS/SPAW/Wrap)
- DHS Request for Proposals (RFP) for Intervention Services (IHBS/SPAW/Wrap)
- Glossary of Terms
- Purchase of Service Agreements
- Waiver Demonstration Terms and Conditions

All Years: Monthly Minutes, Memos, Semi-Annual Reports

- Monthly Waiver Demonstration meeting notes
- Workgroup meeting notes
- DHS Semi-Annual Reports on the Waiver Demonstration
- Additional ICF Memos issued during the Waiver Demonstration
- Annual Hawai'i Child Abuse and Neglect Statistical Reports

Focus Groups

Year One: CWS Assistant Program Administrators, CWS Line Staff, and Private Providers

The Evaluation Team members conducted focus groups at the end of Year One to gauge the overall progress of the Waiver and to identify any implementation challenges. Focus groups were conducted with Child Welfare Services leadership team and line staff, and Purchase of Service providers (for IHBS, WRAP, and SPAW) on O'ahu and Hawai'i Island. A detailed account of participants in the focus groups can be found below under Samples.

In general, the focus groups took between 30-45 minutes to complete. For each focus group, the initial set of questions was developed based on a review of evaluation reports from other Waiver states, information gathered during intervention site visits, participation in Workgroup teleconferences, and the Workflow Charts. The Metz Model was used to benchmark implementation progress. Questions were developed by the entire Evaluation Team and revised accordingly. Draft focus group protocols and questions were shared with the DHS Waiver Project Manager for review and comment prior to each data collection. Although the questions changed slightly based on who was participating (to ensure relevance to their position), they followed the same general format.

Year Two: Family Court Judges

The focus groups with the Family Court judges were coordinated with the assistance of the Senior Family Court judge on O'ahu. The focus groups took between 30-45 minutes to complete and occurred on both O'ahu and Hawai'i Island. The intent was to hear from the Court about their experiences with the Child Welfare Services Waiver Demonstration and to get feedback from the judges, as they were crucial partners in the success of the Waiver. During each focus group, the judges were provided with an overview of the Waiver Demonstration and the four interventions being implemented to address both Short- and Long-Stayer populations. The judges were given copies of the Waiver One-Pagers created by the Evaluation Team as an information graphic providing an overview of each intervention. This was followed by questions about their experience with the Waiver Demonstration.

Site Visits

Year Two: Database Managers

The Evaluation Team traveled to Maui for a one-day meeting with the SHAKA database team at Maui College. This meeting moved the evaluation forward by identifying and refining the data

needed for the evaluation and exploring the kinds of on-line tools and supports the SHAKA system could provide to CWS and other staff, to help support accurate and timely data entry.

Year Two: Site Visits with CWS Line Staff and Private Providers

The Evaluation Team developed on-line support tools and materials for the Waiver Demonstration and the evaluation, with the assistance of the CPSS and SHAKA data base managers. Members of the Team then made on-site visits to all CWS and private provider agencies in Year Two of the Demonstration, to deliver these materials and train staff in the use of the on-line supports.

Interviews

Year Two: Demonstration Leaders on Implementation

The Evaluation Team members conducted interviews to gauge the overall progress of the Waiver after Year One and to identify any implementation challenges. Interviews were conducted with Child Welfare Services leadership team and staff, Purchase of Service providers (for IHBS, WRAP, and SPAW), and major community partners on O'ahu and Hawai'i Island. A detailed account of participants in the interviews can be found below under Sampling Plan.

Interviews generally took between 30-45 minutes to complete. In a process identical to that for focus groups, the initial set of questions was developed based on a review of evaluation reports from other Waiver states, information gathered during intervention site visits, participation in Workgroup teleconferences, and the Workflow Charts. Questions were developed by the entire Evaluation Team. Draft interview protocols and questions were shared with the Waiver Demonstration Project Manager for review and comment prior to each data collection, and revised accordingly. Although the questions changed slightly based on who was interviewed (to ensure relevance to their position), they followed the same general format.

Final Year: Wrap Participants

To gather impressions from family members who participated in Wrap, all clients and participating family members who had completed Family Wrap Hawai'i through the Waiver Demonstration were contacted in the final year of the Demonstration.

The Evaluation Team met with EPIC 'Ohana, Inc., the Wrap provider, to discuss the best way to contact these families. The group agreed that EPIC would make the initial contact with the Wrap participants and explain that the Waiver Evaluation Team wanted to hear their views and experiences with Wrap. The Team designed a script for an EPIC staffer to read as the first contact with a Wrap participant. An additional script for the Evaluation Team member was developed to contact the potential participants and ask for consent to be interviewed.

If the family member agreed to be interviewed after the initial contact was made by EPIC, a member of the Waiver Evaluation Team followed up and contacted the participant. The participant could be the parent(s) or other relative who attended Wrap. The Team adapted the interview questions to distinguish between a biological parent and another relative who attended the Wrap meetings (e.g., aunt, grandparents, etc.). Persons living on Oʻahu or on Hawaiʻi Island were interviewed in person, when possible, but those who had moved to the mainland were all interviewed by telephone. In total, seven participants were interviewed in-person on Oʻahu, two participants were interviewed in-person on Hawaiʻi Island, and three participants by telephone on the mainland U.S. The calls on the mainland were recorded with an ACR phone recorder device and consent was accepted verbally. A digital audio recorder was used to record the in-person interviews when participants consented to have their interviews audio-recorded. The Evaluation Team gave each participant a $50 gift card as a thank you.

The interview instrument consisted of 15 questions. The initial questions were designed to ask the participant about their experiences based on the "Ten Principles of Wraparound" as described in the National Wraparound Initiative (Bruns, Walker, & NWI Advisory Group, 2008). These principles are:

1) Family Voice and Choice;
2) Team Based;
3) Natural Supports;
4) Collaboration;
5) Community Based;
6) Culturally Competent;
7) Individualized;
8) Strengths Based;
9) Unconditional and
10) Outcome Based

Additional questions asked of the participant:

1) What they liked best about the experience with Wrap.
2) What were some of the challenges?
3) Did they have any recommendations for changes?
4) The amount of time spent in Wrap (too little? too much? about right?) and
5) To share a story or memory about the participant's experiences with Wrap.

Final Year: SPAW Participants

Participants whom had been involved in multiple SPAW meetings were contacted for their impressions about the SPAW process in late 2018, first by an e-mail which contained the five survey questions. Participants had the option to respond to the questions via e-mail or participate in a telephone interview. Respondents were called over a three-week period. A lead investigator for the Waiver Demonstration evaluation conducted all the interviews. The interviewer stopped calling respondents after four voice mail messages were left on four separate days with no response.

The questions, developed in cooperation with members of the SPAW team, were as follows:

1. What do you see as the most effective elements of SPAW? Why do you think these were effective?
2. What do you see as the major challenges to SPAW? Can you suggest any areas that need improvements or way to reduce the challenges you noted?
3. Did you see the SPAW experience evolve over time? If yes, what did you see, and how did that improve or detract from the process?
4. If SPAW were to be expanded to the rest of the state, what are the elements that you see that would be most important to its success? What would be the challenges?
5. Please tell me your role, the number of SPAWs you participated in and what year you attended your first SPAW meeting.

Final Year: Supervisors about Staffing

In the final year of the Waiver Demonstration, the Evaluation Team gathered retrospective information on the staffing and staffing challenges experienced by each of the four Demonstration interventions, on each island. In telephone interviews, supervisors and key staff at each unit or provider agency were queried about trends in the sufficiency of staffing over the course of the Demonstration. Respondents were also queried about the content and adequacy of the training received over the course of the Demonstration.

Participant-Observations

Year One: Intervention Workgroup Meetings

At least one member of the Evaluation Team attended the weekly meetings of the four Intervention Workgroups in the first year of the Demonstration. These Workgroups expanded and refined the elements of each program model as they were planned and then implemented on each island.

All Years: Monthly DHS Waiver Meetings

At least one member of the Evaluation Team attended and participated in the monthly DHS Waiver meeting led by the Waiver Demonstration Project Manager. This provided contemporary information from supervisors and key personnel about the implementation of the Demonstration in all four interventions, use of the assessments and other decision-making tools, and possible refinements of the practice models.

Surveys

Year One: Initial Staffing and Training

Staff characteristics were collected via a request for information (RFI) emailed to each of the intervention supervisors or Section Administrators on Oʻahu and Hawaiʻi Island. The RFI included an explanation of the information request along with two tables to be completed by the supervisor on staff characteristics and required training. These characteristics include position, education level, field of study, tenure in position, and training, respecting limitations to information sharing provided by state labor laws. Information on staff workload and capacity was captured in interviews.

Year Two: Knowledge and Impressions of Child Welfare Services Line Staff

The Evaluation Team, building on the focus group and interview themes, developed an on-line, confidential, staff survey for all child welfare staff engaged in the Waiver Demonstration after the second year of implementation. The survey, designed to collect data on the implementation of the Waiver Demonstration, was administered to Child Welfare Services line staff on Oʻahu and Hawaiʻi Island using Survey Monkey software. The intent of the survey was to capture feedback from the line staff who had been on the front lines of implementing the Waiver Demonstration interventions and systemic changes.

Within the IS framework used to guide this evaluation, the intent of the survey was to address several key implementation questions related to the Branch's readiness, capacity, and adaptability in communicating the elements of major systems change to the staff responsible for implementing those changes:

- Were the staff educated and trained on the Waiver interventions?
- Is there evidence that the training was effective so that staff could appropriately (with fidelity) refer children and families to the service that matched their need?
- Do staff have positive perceptions of the system changes in the Waiver Demonstration?
- Do staff feel supported in delivering the new interventions?

These purposes of the survey were consistent with the principles of Implementation Science in that the results were intended to inform the Evaluation Team and Waiver Leadership of the strengths and weaknesses in the current training and supports of staff to faithfully implement a robust system change, and to sustain the effective elements of it after the Demonstration.

The survey questions were multiple choice, on a rating scale, with a few open-ended questions. Items included questions asked about the CWS work environment, knowledge about and perceptions of the Waiver interventions, caseloads, information systems, and demographics. Questions included statements like, "I have received enough information about CRT to understand its overall purpose" and "I have confidence that referring to (one of the waiver interventions) will not compromise the safety of the child." The responses to most of these items used a Likert-scale, generally ranging in values from 1 to 5 corresponding to levels of agreement, a higher number indicating greater agreement.

Other items included organizational climate questions to assess topics such as access to information, workload, supervision, information systems, support, and resources. Organizational context is an important element of implementation, and can provide insight as to why new interventions are being adopted or not.

There were questions specific to each of the four Waiver Demonstration interventions. It should be noted that the survey had a skip pattern structure so that participants only answered questions about the Waiver Demonstration interventions to which they could make referrals. For each intervention, there were questions about knowledge about the intervention, compatibility/culture (meeting the needs of local families), peer buy-in, relative advantage (sense that the intervention is better than the system it replaces), training, time commitments, sense of risk to the children, and utilization. There was one open-ended question which asked: "If there are any barriers to utilization [for each intervention] you think we should consider that were not already addressed, please describe them here."

The Evaluation Team also designed six scenario questions to check the respondent's knowledge of the referral criteria for each Waiver Demonstration intervention. Respondents were asked to select where each case should be referred based on key case details. Respondents also had an opportunity to write in a narrative form more information about their referral choice for each case. The scenarios were developed from the SHAKA information system case information, while making slight changes to protect the confidentiality of the individual child and family.

Year Three: Adult and Youth Participants in Wrap

At the end of the Wrap process for a family, adult and youth participants were invited to complete a questionnaire to measure engagement and satisfaction with the services provided.

Participants were offered a pre-addressed, postage-paid envelope, as well as the option of completing the questionnaire onsite. Participation was anonymous and optional.

The Wrap provider, EPIC 'Ohana, not the Evaluation Team, created two separate questionnaire instruments, one for youth participants and the other for adult participants (i.e., family members, service providers, community supporters, CWS caseworkers, and other relevant participants).

Youth were asked to respond to 11 questions. There were eight closed-ended questions, with answer options on a scale that included, terrible, poor, neutral, good, and great. There were three open ended questions that allowed youth to provide more detailed answers regarding their favorite activities, least favorite activities, and additional comments or concerns.

The adult questionnaire was administered in an ongoing fashion as participants ended Wrap beginning in January 2015, and the youth questionnaire was administered beginning in November 2016.

Final Year: Intensive Home-Based Services Parent Feedback

The providers of the Intensive Home-Based Services are contractually obligated to administer a survey on Family Satisfaction to their clients, at the conclusion of IHBS services. This survey was created by the Family Development Institute, the creator and consulting supervisor of Hawai'i's IHBS model.

IHBS therapists asked clients to complete a feedback questionnaire at the end of their last session to measure clients' level of satisfaction with the program and services received (two questions), as well as fidelity to key program principles and structures (nine questions). Completion was voluntary and anonymous. Respondents could mail the survey at a later date.

Final Year: Retrospective Survey of Demonstration Leaders

In the last year of the Waiver Demonstration, a retrospective survey was sent to CWS administrators, section administrators, the CRT Unit supervisor, and key administrators and staff for the IHBS, Wrap, and SPAW interventions. The survey was administered through email and Survey Monkey, and consisted of ten open-ended and five multiple choice questions. The questions asked for retrospective impressions and opinions about the successes and challenges of the Waiver Demonstration and its implementation. Questions focused on the following:

- Perceived accomplishments of the Demonstration
- Perceived challenges
- Practice changes observed
- Data and information systems

- Training
- Sustainability of Waiver practices
- Waiver Workgroups

Participatory Action Research

Year One: Workflow Charts

During the first year of the Waiver Demonstration, Evaluation Team members attended meetings of each of the intervention workgroups at DHS. While each of the four Waiver interventions was offered soon after the beginning of the Waiver Demonstration, each intervention workgroup spent the first year of the Waiver Demonstration fleshing out the details of each intervention, beyond the basic theory of change, structure, content and purpose outlined in the IDIR. The Evaluation Team captured these more detailed descriptions in intervention Workflow Charts, and shared these with the intervention workgroups for feedback and clarification.

Year Two: Evaluation Cheat Sheets and Training of Staff and Providers

Following a thorough review of data systems in the first year of the Demonstration, the Evaluation Team developed a series of cheat sheets for anyone who was collecting or entering data for the Evaluation. These cheat sheets were originally intended to clarify the critical data elements of the evaluation, but became an important communication tool about the Waiver Demonstration, the four interventions, and their goals and objectives. These cheat sheets and communication strategies are discussed in more detail in a separate chapter on Data Quality and Communications.

Year Two: Data Crosswalk and Refinements to Data Systems

The evaluation of the Waiver Demonstration relied on administrative and practice data collected from four separate data systems across a number of public and private entities. These data systems were not linked; data fields were often redundant or contradictory; the code books and manuals for some of these systems had not been reliably updated over the years. The Evaluation Team, in partnership with the range of data base managers, created a data crosswalk mapping all pertinent data fields and their sources, and made strategic refinements to data systems. These refinements were made in service of both the evaluation and relevance to best practices in child welfare work and the four interventions. These efforts are discussed in more detail in a separate chapter on Data Quality and Communications.

All Years: Small Evaluation Analyses and Reports to DHS

A key element of the participatory action research method was periodic contemporary reports to Waiver Demonstration administrators, line staff, and private providers about one key aspect of Demonstration. These small reports were submitted throughout the Demonstration both to (1) provide real time assessments of the implementation of the Demonstration and (2) solicit reflection and feedback about the findings, perhaps resulting in further refinements to practice models or correction of drift from original models.

In addition, the *Interim Evaluation Report* contained a wealth of information about the children and families involved in each of the interventions, and completion rates for a variety of assessments used in the Waiver Demonstration.

Summary of Sources of Evidence for Evaluation of Implementation

The methods of process evaluation and data collection described above were conducted to evaluate the *implementation* of the Waiver Demonstration, separate and apart from the process evaluation of *service fidelity* for each of the four Demonstration interventions. Using the Metz model of Implementation Science, the three components of implementation (implementation leadership, data and feedback loops, and implementation infrastructure) are presented in the tables below, with the corresponding competencies that show the development of the implementation through the four phases of exploration, installation, initial implementation, and full implementation.

For each component and phase of the implementation of the Waiver Demonstration, the process methods described above are listed, where they have provided evidence by which to assess the degree to which the Demonstration was implemented over the almost five years of the evaluation.

Table 2

Implementation Leadership: Phases, Competencies, and Evidence

Core Component	**IMPLEMENTATION LEADERSHIP**	
Overview:	**Competent teams and leaders are selected and the leaders prepare a plan based on best practices to successfully implement the intervention, and oversee its implementation**	
Phase	**Competency**	**Methods and Evidence for Evaluation**
Exploration	Form leadership teams that have: (1) knowledge of the interventions in order to make informed decisions (e.g., regarding adaptations, fidelity); (2) knowledge of the implementation infrastructure needed to successfully implement this project; (3) knowledge of data-informed decision-making processes, and (4) knowledge of ways to achieve systems change.	• Document Review: IDIR, manuals, trainings, contracts, tools, data systems • Year Two Interviews with Demonstration Leaders • Final Year Retrospective Survey
	Develop work plans and communication plans: (1) create a plan to promote clear, consistent and frequent communication; (2) prepare necessary documents, protocols and plans to achieve success; (3) develop common terms of reference	• Document Review • Year Two Interviews with Demonstration Leaders • Participant-Observation: Waiver meetings and Workgroups
Installation ***(Setting the Stage)***	Develop leadership competencies: (1) identify knowledge and skills necessary for successful implementation, including coaching; (2) develop those competencies, knowledge and skills for all levels of leadership	• Document Review • Participant-Observation: Waiver meetings and Workgroups • Year One Survey of Initial Staffing and Training • Year Two Interviews with Demonstration Leaders • Participatory Action Research: IER Data Analysis
	Assure resources to support innovations: (1) identify resources needed to implement interventions; (2) make action plan to obtain the resources; (3) obtain necessary resources and partnerships to ensure the necessary competencies needed to support and sustain implementation.	• Document Review: contracts • Year Two Interviews with Demonstration Leaders • Final Year Retrospective Survey
Initial Implementation (*Rollout)*	Trouble shoot and problem solve: (1) identify problems, obstacles and barriers after the initial rollout of the intervention; (2) address identified problems with solutions; (3) monitor and conduct follow up to see if problems were resolved; (4) document adaptations related to problem-solving issues	• Participant-Observation: Waiver meetings and Workgroups • Year One Focus groups with line staff and providers • Participatory Action Research: IER Data Analysis • Year Two Interviews with Demonstration Leaders • Year Two Survey of CWS line staff • Year Two Focus Groups with Judges
	Use data to promote improvement: (1) use data and feedback to make necessary changes and adaptations to improve the interventions and the implementation of the interventions; (2) document these adaptations and changes	• Document Review: DHS Semi-Annual Reports • Participatory Action Research: Reports on intervention fidelity
Full Implementation	Use improvement cycles: (1) establish and institutionalize protocols for trouble shooting and problem solving; (2) conduct periodic, continuous quality control to promote desired outcomes and improved success	
	Develop and test enhancements: (1) pilot adaptations and modifications that can enhance the success of the intervention	

Table 3

Data and Feedback Loops: Phases, Competencies, and Evidence

Core Component	**DATA AND FEEDBACK LOOPS**	
Overview:	**Use data and feedback loops to drive decision-making and promote continuous improvement.**	
Phase	**Competency**	**Methods and Evidence for Evaluation**
Exploration	Conduct needs assessment: (1) conduct a data-driven needs assessment to establish prevalence of need for program; (2) select targeted areas to address need(s)	• Document Review: IDIR
	Assess existing data systems, data collection practices and available data: (1) assess the quality and quantity of data available, (2) collect baseline data or develop an immediate plan to obtain baseline data; (3) assess data collection practices; (4) assess the data management system/database to identify problems/barriers/challenges	• Document Review: IDIR, Evaluation Plan • Year Two Site Visits with line staff, providers, managers • Participatory Action Research: Data Crosswalk
	Determine fit and feasibility of intervention(s): (1) conduct a formal assessment of community readiness for the project; (2) review and identify programs, practices and interventions that match target areas and address the identified needs; (3) assess potential barriers to implementing the proposed/selected interventions	• Document Review: IDIR, manuals, contracts, trainings
	Assess staff and stakeholder readiness: (1) assess staff qualifications; (2) assess staff readiness to implement a new project; (3) develop methods to promote buy-in for staff and stakeholders	• Document Review: IDIR • Participant-Observation: Waiver Meetings • Year One Survey of Initial Staffing and Training
Installation ***(Setting the Stage)***	Assess and address data infrastructure gaps related to the new innovations/interventions: (1) evaluate the data administration systems and collection processes and steps; (2) identify obstacles, challenges, barriers to data entry and management; (3) create a plan to overcome these obstacles	• Document Review: Data systems and codebooks, memos • Year One Focus groups with CWS line staff • Year Two Survey of CWS line staff • Year Two Site Visits with line staff, providers, managers • Participatory Action Research: database refinements
	Institute and establish policy-practice feedback loops: (1) create a plan that will help move the interventions/changes in practice forward; (2) develop assessments to understand how the plan and new interventions are working; (3) develop protocols to make changes to the next iteration of the plan	• Participatory Action Research: Workflow Charts, IER Data Analysis, contemporary reports to DHS • Final Year Retrospective Survey
	Assess data system competencies: (1) data systems are up and running; (2) data systems are designed to measure what they need to measure; (3) use data to ensure successful communication within and outside organization	• Participatory Action Research: cheat sheets, data crosswalk, IER Data Analysis • Final Year Retrospective Survey
Initial Implementation (*Rollout)*	Data systems are functioning for measuring and reporting fidelity and outcomes	• Document Review: Homebuilders Standards, databases • Participatory Action Research: database refinements
	Track and improve fidelity - (1) use data to measure intervention and implementation fidelity and track progress in implementation (outcomes); (2) use data to make data-informed decisions to improve fidelity and implementation of intervention/practices	• Document Review: Homebuilders Standards, databases • Participant-Observation: Monthly Waiver Meetings • Participatory Action Research: Contemporary reports
Full Implementation	Conduct data collection and use data to evaluate outcomes	
	Collect data to support fidelity monitoring and improvement: (1) have an established data administration system and collection process that supports ongoing fidelity monitoring; (2) use this data for continual refinement	

Table 4

Implementation Infrastructure: Phases, Competencies, and Evidence

Core Component	**IMPLEMENTATION INFRASTRUCTURE**	
Overview:	**A focus on capacity needed to implement the intervention, since this is for a implementation evaluation. The objective is to evaluate the Demonstration, not CWS in general, but changes to general capacity would hopefully come as a result of the Demonstration.**	
Phase	**Competency**	**Methods and Evidence for Evaluation**
Exploration	Identify and assess necessary **individual-level** infrastructure elements that will be needed to support the PRACTICE of the new intervention (the personnel characteristics, knowledge and skills that are needed for the Demonstration)	• Document Review: IDIR • Year One Survey of Initial Staffing and Training • Year Two Interviews with Demonstration Leaders
	Identify and assess necessary **organizational-level** infrastructure elements to support practice, organizational, and system change required for success implementation (i.e., authority vested in Demonstration Leaders, caseload limits, supervision and coaching, ongoing training schedules, supports of best practice, data-driven decision-making)	• Document Review: IDIR • Year Two Interviews with Demonstration Leaders • Final Year Retrospective Survey
Installation (Setting the Stage)	Install necessary **individual-level** infrastructure elements to support practice, organizational, and system change: (1) select and recruit staff based on necessary skills, knowledge and characteristics; (2) train relevant staff in necessary skills, knowledge and processes; (3) routinize activities to increase buy-in	• Year One Focus Groups with staff and providers • Year Two Interviews with Demonstration Leaders • Year Two Survey of CWS line staff • Final Year Retrospective Survey
	Install necessary **organizational-level** infrastructure elements to support practice, organizational, and system change (caseload limits, supervision and coaching regimens, training schedules, aids and supports of best practice, decision-making)	• Year One Focus Groups with staff and providers • Year Two Interviews with Demonstration Leaders • Year Two Survey of CWS line staff
	Adapt strategic plans to develop necessary individual and organizational infrastructure elements identified: (1) utilize and incorporate data to provide feedback to staff and create other organizational elements to improve practice and organizational fidelity	• Participatory Action Research: cheat sheets • Final Year Retrospective Survey
Initial Implementation (Rollout)	Monitor and Improve necessary **individual-level** infrastructure elements to support practice, organizational, and system change, using data and feedback loops	• Year Two Survey of CWS line staff • Year Three Surveys of Adults and Youth in Wrap • Final Year Surveys of IHBS Parent Feedback • Final Year Interviews with Wrap and SPAW Participants
	Monitor and improve necessary **organizational-level** infrastructure elements to support practice, organizational, and system change using data and feedback loops	• Year One Focus Groups with CWS Staff • Year Two Survey of CWS line staff • Year Three Surveys of Adults and Youth in Wrap • Final Year Surveys of IHBS Parent Feedback • Final Year Interviews with Wrap and SPAW Participants
Full Implementation	Maintain skillful practices: (1) individual and organizational skills, knowledge, and practices are fully functioning and incorporated into daily operations; (2) monitoring and feedback systems are thoroughly integrated into institutional practices	
	Produce more efficient and/or effective infrastructure to support outcomes: (1) data-driven feedback loops, along with monitoring systems are built into infrastructure to produce more effective and efficient processes to improve fidelity.	

Description of Provision of Services and Fidelity

In order to address the description of service provision for each of the four interventions, quantitative indicators of each of the four interventions were identified and tracked (See Table 5). The process indicators were guided by an Implementation Science framework (Fixsen *et al*, 2005; Metz, *et al*, 2015) and gathered all necessary data to measure treatment fidelity (James Bell Associates (JBA), 2009).

Process indicators and the resulting process metrics were focused on capturing the intervention outputs in the logic models, including service description (scope, dosage, frequency, and duration), and model implementation and fidelity (adherence, exposure, quality, responsiveness, and differentiation). Data points were identified in relation to corresponding decision points on the Workflow charts. These data points were revised and streamlined to capture the necessary data on how the interventions were being implemented.

Based on process evaluation best practices, by gathering data on scope, dosage, frequency and duration, the evaluation assessed both whether and how the Demonstration and the four interventions were:

- Enacting eligibility processes and criteria faithfully
- Reaching the intended populations
- Providing the specific services as planned and in the amounts and intensity intended
- Using assessments and other information to support decisions
- Employing case goals and objectives that will logically lead to the desired outcomes

Table 5

Indicators for the Evaluation of Service Fidelity in the CRT, IHBS, Wrap, and SPAW Interventions

CRT Characteristics	CRT Description
Service Description • scope • dosage, frequency, duration	• Case counts • All referrals received from police, hospitals, and schools that meet eligibility criteria via CWS Intake Unit • Immediate (2 hour) in-person response, and 24/7 availability • Complete assessment and refer to IHBS as appropriate, monitor case • Case disposition/case closure
Participant Characteristics	• Children 0-17 years of age • Family assessed to have safety concerns
IHBS Characteristics	**IHBS Description**
Service Description • scope • dosage, frequency, duration	• Case counts • Respond within 24 hours to all referrals from CRT meeting criteria (voluntary, space available) • Screen family, assess & develop service plan • Provide services for 4 to 6 weeks, 24/7, crisis intervention • Provide transition planning & follow up as needed
Participant Characteristics	• Children 0-17 years of age • Family assessed to have safety concerns • At least one parent must voluntarily participate • Use HOMEBUILDERS measures
Wrap Characteristics	**Wrap Description**
Service Description • scope • dosage, frequency, duration	• Case counts • All families referred & screened (appropriate, willing, safety) • Family Wrap meetings with appropriate team members, monthly meetings for 6 months • Use of CANS as guide for Family Wrap Plan • Provide access to support via Community Navigator
Participant Characteristics	• Children 0-17 years of age • Child in foster care 9 months or longer • Child “likely” to reunify • Family assessed to have safety concerns and willing to participate
SPAW Characteristics	**SPAW Description**
Service Description • scope • dosage, frequency, duration	• Case counts • All cases accepted/referred (via SHAKA) by CWS caseworker • Facilitate one SPAW meeting with appropriate professional team members • Follow up at 30, 60, and 90 days
Participant Characteristics	• Children 0-17 years of age • Child in foster care 9 months or longer • Child “unlikely” to reunify

There are two administrative databases used in Hawai‘i Child Welfare. The CPSS (Child Protective Services System) database serves as the fundamental record of the children and families who receive a Waiver intervention, through the entry of a Service Action Code. Caseworkers in the Intake unit and all other units are accustomed to entering a Service Action Code, as well as corresponding initiation dates and termination dates, for any service provided. These “SAC codes” in CPSS are used as the key to identifying any child who enters the Waiver Demonstration, and provide the case counts, or the number of children and families served in a given period of the Demonstration, as well as the duration of service for each intervention.

The SHAKA (State of Hawai‘i Automated Keiki Assistance System) database is used by Centralized Intake to record all reports of child maltreatment and the resulting safety and risk assessments. If a report is then referred on to the Crisis Response Team, Child Welfare Services, or is diverted to Voluntary Case Management, the CPSS database then records the outcome of investigations and subsequent service provision and case dispositions.

Once an official case is opened by Child Welfare Services, the case is given a Case ID Number. The Case ID number is the same for all adults and children involved in that case. Each child receives a unique Client ID Number that remains the same across any cases the child is a part of over their lifetime. Client and Case ID numbers are consistently used between CPSS and SHAKA, for the most part. CPSS also records the Section serving the case, which identifies whether a Waiver Demonstration participant is on O‘ahu or Hawai‘i Island (and in East or West Hawai‘i).

Process Metrics for all Waiver Interventions

Demographics of Children and Families are recorded at Intake in CPSS. These include child sex, number of children in the home, number of adults in the home, and race and ethnicity of each child and adult. Race is recorded at Intake with yes/no responses to the six options of Hawaiian/Pacific Islander, White, Asian, Black, American Indian/Alaskan Native, and Unknown. An individual can be a “yes” on any or all of the above. Ethnicity is also recorded at Intake as only one response to a list of ethnicities (see all ethnicities in the results for each intervention).

Process Metrics Specific to Short-Stayer Interventions

The Evaluation Team gathered data from SHAKA and CPSS on All Intakes (not only Waiver cases), to be able to identify the Pathway to CRT and IHBS: the fidelity of referral to the CRT intervention, given the specific eligibility criteria for CRT, particularly the Source of the Report being law enforcement, schools, or hospitals. CPSS provided information on the source of the report, and SHAKA provided information on whether the report was referred to CRT, Child Welfare Services, diverted to Voluntary Case Management, or closed.

Given that the Short-Stayer interventions are in response to a report of maltreatment, for Waiver cases, the evaluation collected details about the report from CPSS and the Intake Tool

from SHAKA. Notably, CPSS provided information on the Type of Maltreatment (abuse, neglect, sexual abuse, etc.), the Nature of Harm (bruises, malnutrition, etc.), whether the maltreatment was Confirmed, and for confirmed cases, the Severity of Harm. Severity of Harm has six possible responses: Blank, No Injury, No Treatment Necessary, Treatment Required, Serious Injury, and Fatal. For some CRT analyses, this was reduced to a dichotomous variable, where Treatment Required, Serious Injury, and Fatal were categorized as Severe Harm.

In SHAKA, "Question 3" on the Intake Tool asks if the maltreatment meets the state's Legal Definition of Harm.

Also recorded in CPSS are the Primary Perpetrator's relationship to the child, as well as Precipitating Factors to the maltreatment, such as drug abuse, mental health problems, heavy child care responsibilities, etc. Each precipitating factor is recorded as a yes/no, and a child can have multiple such factors.

The IDIR (DHS, 2014) discussed the role of the Waiver Demonstration in preventing placement among those children at risk. There were two indicators of risk available to the Waiver evaluation. "Question 4" on the Intake Tool asks if the child is at Imminent Risk of Harm (yes/no). If the answer is yes, this is followed by 15 yes/no questions called Safety Factors. These are factors found on most state child protection risk assessments, and include such items as death of a sibling, parental substance abuse, hazardous living conditions, and child has special vulnerability or needs.

Crisis Response Team Process Metrics

On Oʻahu, when a report was referred by Intake to the CRT Unit, the CRT caseworker and supervisor made an Initial Disposition for that report. The case could be closed outright, referred to voluntary services (Family Strengthening Services or Voluntary Case Management), or referred to Child Welfare Services for further investigation and perhaps, child placement. If the CRT Unit felt that the case was appropriate for Intensive Home-Based Services (IHBS), it could make that referral to IHBS. In this situation, CRT "kept" the case and IHBS was an additional service provided to a CRT case.

On Hawaiʻi Island, there was no separate CRT Unit. Rather, the same caseworkers provided a Crisis Response or a traditional response, depending on whether the report and the child met the eligibility criteria for a Crisis Response. For this reason, the Initial Disposition of CRT cases on Hawaiʻi Island was entered into SHAKA differently than on Oʻahu, often after the completion of the response to/contact with the family. "Holding" a case was much less likely on Hawaiʻi Island. If a case was "held" by CRT and/or it was referred to IHBS, it received a Final Disposition, which could be any of the above (Closed, Referred to CWS, Referred to FSS or VCM).

A critical service element of the CRT intervention was a Two-Hour Response to the disposition from Intake. Fields were added to the SHAKA interface for entry of date and time of referral from Intake to CRT, and the date and time of the first face-to-face contact between the CRT caseworker and the child. These were manually entered into SHAKA. SHAKA calculated the amount of time between the two events, and this was recorded for each case.

Another core element of the CRT was monitoring IHBS-referred cases and CWS family supervision cases by the CRT worker as a case manager for up to 60 days on the family's progress. In CPSS, CRT caseworkers recorded all family contact on the Contact Log. The total Number of CRT Visits over the service duration was recorded and extracted using data from the contact log.

One responsibility of CRT caseworkers was the completion of Initial Safety Assessments. The State of Hawai'i DHS Child Safety Assessment and Analysis for In-Home Services are used for all families at the time of CRT response to determine the case disposition (case closure, referral to one of the two differential response programs, referral to IHBS, or referral to CWS for placement). These assessments contain the same fifteen Safety Factors as those recorded by Intake on the Intake Tool. For cases requiring CRT monitoring (IHBS-referred cases, CWS family supervision cases, and cases lasting more than 29 days), a Final Safety Assessment was completed in SHAKA.

Intensive Home-Based Services Process Metrics

Families were referred to Intensive Home-Based Services from CRT. Within SHAKA, the CRT caseworker was asked to consider and indicate for each CRT family if they are Eligible for IHBS (yes/no). Once a family was referred to IHBS, Eligibility was assessed again by the IHBS therapist and recorded in ODM. IHBS therapists also recorded the Response Time to a referral to CRT, given the expectation of a face-to-face contact within 24 hours of the referral.

IHBS therapists recorded a variety of data about service provision. Within ODM, the evaluation team accessed for each family, the Number of Face-to-Face Hours, the Total Hours Spent on a Case, the Number of Sessions with the Family, and the Average Number of Sessions per Week. The Duration of Service was also calculated in ODM as the total number of days over the service duration.

Finally, IHBS therapists recorded whether a case had a Premature Closure to IHBS, and why. Reasons could include the family dropping out, the child being placed out of home, or determination of ineligibility.

Process Metrics Specific to Long-Stayer Interventions

The evaluation gathered data from CPSS on the child's history with Hawai'i Child Welfare Services, including the number and type of Confirmed Prior Reports of Maltreatment, Age at

First Removal, Total Number of Removal Episodes, and Total Number of Prior Placements, for all clients involved in the Long-Stayer interventions (Wrap and SPAW). The evaluation did not collect data on the child's case goal (reunification, guardianship, and other outcomes), because this information was considered by CWS leadership to be unreliable.

Data related to the current removal episode (the episode that brought the client into the Waiver) was also collected from CPSS. This included Age at Start of Current Removal, Number of Months Out of Home in this Removal Episode, and Current Type of Placement Setting at the initiation of the Demonstration intervention.

Data for all children with any stay in foster care in Hawai'i from 2009-2018 was extracted from CPSS and sent to analysts at Chapin Hall at the University of Chicago in July 2019 through a data-sharing agreement with the evaluators at the University of Hawai'i. Chapin Hall analysts at the Center for State Child Welfare Data then developed spell files describing the foster care histories and trajectories for all foster children in Hawai'i. Chapin Hall analysts also sent spell files for all participants in Wrap and/or SPAW to the Evaluation Team for use in describing their histories and placement outcomes.

Wrap Process Metrics

EPIC caseworkers recorded a variety of data about Wrap service provision. Within the EPIC database, the caseworker tracked a variety of dates about the service provision for each family, so that the evaluation could calculate Days from Referral to Wrap to Initial Contact, Days from Wrap Referral to Family Consent, Days from Family Consent to Initial Wrap Meeting, Number of Wrap Meetings, and the Duration of Wrap Intervention. The Duration of Service was calculated as the total number of days from Wrap enrollment to case closure to EPIC.

SPAW Process Metrics

Referrals for SPAW services were made through the DHS web-based data system SHAKA. The SPAW contracted provider receiveed an All-In-Care list of eligible cases monthly and worked with CWS and SHAKA staff to set up the necessary access and transfer of information. SPAW Coordinators further assessed and screened the appropriateness of cases on the All-In-Care list for SPAW meetings. SPAW Case Eligibility Status was recorded in the SHAKA system.

Children and youth on the All-In-Care list moved through a variety of statuses as they were being assessed for eligibility for SPAW and served by the intervention. SPAW status changes were documented on the status log in SHAKA. SPAW statuses were noted by the date on which the child or youth achieved that status and included:

- Initial Review is the date that the SPAW caseworker assesses the child's eligibility for the first time.

- Removed is the date the child/youth was screened and does not/will not meet criteria (i.e. due to age, adoption/guardianship was achieved).
- Candidate is the date the child/youth meets some eligibility criteria.
- Excluded is the child/youth was screened and does not currently meet criteria (i.e., reunification is still being pursued, adoption hearing date is within six months). An excluded child can be revisited in a subsequent review of the All-In-Care list.
- Enrolled is the date that the child/youth meets eligibility criteria and is accepted for a SPAW meeting.
- Coordination is the date that the SPAW Coordinator is coordinating/scheduling a SPAW with the stakeholders identified by CWS as valid to the process for a child/youth accepted for a meeting.
- Completed Meeting is the date of the first (and only) SPAW meeting. This is considered the official beginning of the SPAW intervention for the Waiver Demonstration evaluation, given that some children and youth can go through a variety of these prior activities without having ever interacted with SPAW personnel.
- Follow-up. There are three follow-up contacts made, at 30 days, 60 days, and 90 days after the SPAW meeting.
- Closed is the date that the case is closed to SPAW, typically at or after the 90 day follow up contact.

SPAW personnel reviewed the All-In-Care List every month, and could re-review a child or youth who was previously not eligible or was excluded.

SPAW Coordinators were responsible for contacting all SPAW participants and coordinating the SPAW meeting. The Number of Participants Invited and Number of Participants Attending were recorded on the SPAW client dashboard.

In accordance with the SPAW model, the child's SPAW Permanency Rating was assessed pre- and post-intervention. The SPAW Team rated the child's first permanency status at the SPAW meeting by using a Permanency Roundtable tool developed by Casey Family Programs. The second Permanency Rating was made by the SPAW Coordinator at case closure[1]. The SPAW Coordinator also noted the child's Current Permanency Status (current permanency goal, e.g., adoption, reunification, guardianship), and the meeting participants' Recommended Permanency Status (e.g., adoption, reunification, guardianship) at case closure.

A core component of SPAW was the development of a Permanency Action Plan for participating members of the SPAW meetings for identified systemic barrier busting. The SPAW Action Plan, SPAW Goals, and SPAW Goal Completion rate were recorded in SHAKA.

[1] Changes in Permanency Ratings are used in this evaluation as an outcome measure, and will be discussed in more detail in the Outcome Methodology.

Follow Up Contacts by SPAW Coordinators on the developed Permanency Action Plans at 30, 60, and 90 days from the SPAW meeting wre recorded in SHAKA on the status log. The Duration of SPAW Intervention was calculated as the total number of days from SPAW meeting to SPAW case closure. In additions, the evaluation measured the Time from Initial Review to SPAW Meeting and the Time from Initial Review to Case Closure.

Samples

Given the nature of the process evaluation, the sampling plan differed by method. In general, for all focus groups, interviews, or surveys, all relevant CWS or Purchase of Service administrators and staff were invited to take part in any interview or focus group related to the intervention with which they were involved; no representative subsample was selected. The sampling plan for each method is further described below.

Focus Groups

Year One: Focus Groups with Child Welfare Services Assistant Program Administrators

The Evaluation Team conducted a focus group with the assistant program managers responsible for any of the four Waiver interventions at the end of the first year of implementation.

Year One: Focus Groups with Child Welfare Services Line Staff and Private Providers

The Evaluation Team conducted focus groups with the Child Welfare Services line staff and Purchase of Service providers (for IHBS, WRAP, and SPAW) on both Oʻahu and Hawaiʻi Island, at the end of the first year of implementation of Demonstration interventions. This included CWS staff in each of the six sections whose personnel were involved in the Waiver Demonstration. Focus groups were also conducted with the Purchase of Service providers' staff for IHBS, Wrap, and SPAW. Because the invitations were sent out by CWS and not by the Evaluation Team, the Evaluation Team does not know how representative the focus groups were, as well as the response rate. In the first year of implementation, a total of six focus groups were completed.

Year Two: Focus Groups with Family Court Judges

The Evaluation Team conducted interviews/focus groups of community partners in the court system. At the end of the second year of implementation, an initial interview of a court representative was conducted. Based on the information gathered, focus groups were coordinated with the Family Court judges. A total of 11 Family Court judges participated in the focus groups. On Oʻahu, eight judges participated in the focus group. On Hawaiʻi Island, rather than focus groups, one judge was interviewed from West Hawaiʻi and two were interviewed from East Hawaiʻi.

Interviews

Year Two: Interviews with Demonstration Leaders on Implementation

The Evaluation Team conducted individual interviews with the Waiver Demonstration Project Manager, the Child Welfare Services program development administrator, CWS section administrators, the CRT unit supervisor, and managers of IHBS, Wrap, and SPAW in the second year of the Demonstration. A total of eight interviews were conducted.

Final Year: Interviews with Wrap Participants

EPIC successfully contacted 23 people who had completed their Family Wrap Hawai‘i intervention. Although 43 families were included in the potential population for the Family Wrap Hawai‘i intervention, only 23 individuals from 17 families were successfully contacted by EPIC ‘Ohana and accepted the initial solicitation to participate in the study. Of the 23 people who accepted the initial invitation from EPIC, 12 interviews were completed (52% response rate). The Evaluation Team successfully interviewed 14 participants from 12 families; two interviews included a husband/wife pair. Nine participants were on O‘ahu, two on Hawai‘i Island and three on the mainland. The sample was composed of nine mothers or fathers, one aunt, and four grandparents.

There was some drop-off between participants’ agreement to EPIC to be contacted by the Evaluation Team, and ultimately completing an interview. On the mainland, six people were contacted, but only three agreed to the interview. On O‘ahu, 14 candidates from nine families agreed to be interviewed when contacted by an EPIC staff member. The Team decided to contact only one person per family/case, prioritizing the biological mother and/or father. A member of the Evaluation Team contacted nine people from O‘ahu, eight of whom agreed to be interviewed, and seven interviews were completed. One person failed to appear for the scheduled interview; and one person did not respond to texts and calls. On Hawai‘i Island, three people were contacted, but only two agreed to the interview.

Final Year: Interviews with SPAW Participants

The SPAW program was asked to compile a list of “experienced” SPAW participants, defined as someone (a professional) who had participated in multiple SPAW meetings. The SPAW program spent over a month checking their records, and provided a list of names and contact information. They sent the Evaluation Team a list of 27 names: 15 individuals on O‘ahu and 12 individuals on Hawai‘i Island.

The interviewer called all 27 potential participants over a three-week period in November and December, 2018. Two participants on O‘ahu were no longer employed, resulting in a potential pool of 25 respondents. On O‘ahu, there were nine completed interviews (9 out of 13, or 69%). On Hawai‘i Island, there were seven completed interviews (7 out of 12, or 58%).

Participants had a variety of roles within the SPAW program. Five were SPAW managers, facilitators or coordinators. Seven were employees of the Hawai'i State Department of Human Services (DHS) Child Welfare Services (CWS), and four participants were from partner agencies, primarily CAMHD.

Final Year: Interviews with Supervisors on Staffing

In 2019, supervisors of Intake, three supervisors of the CRT intervention, and a key supervisor at each of the Purchase of Service providers of the three contracted interventions on each island, were contacted for an update on staffing and training on the interventions over the course of the Demonstration.

Surveys

Year One: Survey of Initial Staffing and Training

As outlined under Data Collection, staff characteristics were collected via a request for information (RFI) emailed to each of the intervention supervisors or Section Administrators on O'ahu and Hawai'i Island. The RFI was sent to the CRT section administrator, the two CWS section administrators on Hawai'i Island, and the supervisors of the Purchase of Service providers (IHBS, Wrap, and SPAW) on both islands.

Year Two: On-Line Survey of Child Welfare Staff

The Evaluation Team obtained line staff email lists from each of the six CWS section administrators whose personnel were involved in the Waiver Demonstration. Emails with an attached confidential Survey Monkey link were sent to the entire population of all 100 child welfare staff involved in any aspect of the Waiver Demonstration on both islands. The consent to participate was the first page of the survey, thus if a respondent clicked "Agree" and moved past that page, s/he assented to participate in the survey. Two persons declined to participate in the survey and two moved through the survey pages without answering any of the questions. A total of 82 surveys were completed for an 82% valid response rate. See the table below for the number of completed surveys by location. Staff members were given options to either complete the survey by coming to the "survey help desk"; take the survey using one of the Evaluation Team laptops where Team members were available to answer any questions; or they could complete the survey at their desk. On average, it took staff members approximately 15-20 minutes to complete the survey.

Table 6
CWS Line Staff Survey Respondent Location

Location	Count	%
O‘ahu	49	60%
East Hawai‘i	20	24
West Hawai‘i	12	15
Missing Location	1	1
Total Completed Surveys	**82**	**100**

The demographics are reported across all respondents, regardless of geographical location. Seventy-eight percent (78%) of respondents were line staff, 16% were unit supervisors and 6% were section administrators. With respect to education level, 38% had a bachelor's degree, 28% a masters in social work, 32% a masters in a related field and 1% with a higher degree. The mean number of years working at CWS was 11; working in DHS, 11 years, and working in another child service agency, 6 years. The average age of the staff was 45 years old with a range from 25 to 66 years. Seventy-seven percent (77%) were female and 74% carried a caseload. Of the staff who carried a caseload (n=52), the average number of families in their caseload was 15 with an average of 30 children. The range was quite broad: between one family and one child, to 50 families with 62 children.

Year Three: Surveys of Adult and Youth Participants in Wrap

Wrap participants were asked at the final Wrap meeting if they were willing to complete a questionnaire. They could complete it at the meeting, or stamped envelopes were provided if they wished to complete it later or elsewhere. However, sometimes the planned final Wrap meeting did not occur, or not all participants attended the final Wrap meeting. Due to these limitations, distribution rates and response rates of the adult and youth surveys are unknown. Responses were anonymous, as well.

For the adult questionnaire, there were 192 completed questionnaires included for analysis, from 41 participating families. For each family, there were one to ten questionnaires returned from individuals associated with the case, with the average number of responses being 4.7 per case.

Overall, 180 adult respondents indicated their role in the Wrap process (see Table 7). Of those that responded, 59% were service providers, 15% were family members, 13% were parents, and the remaining 7% were a mix of community supporters, guardians, and parent partners.

Table 7

Respondents to Wrap Questionnaire: Adults

Participant Role	(n=180)
Service Provider	59%
Family Member	15
Parent	13
Missing	6
Community Supporter	4
Parent Partner	2
Guardian	1

The Wrap youth survey was administered to 20 respondents from seven separate cases. The number of respondents from each case ranged from 1-5, with an average number of 2.9 respondents for each case.

Final Year: Intensive Home-Based Services Parent Feedback Surveys

The IHBS provider asks adult family members to complete a Client Satisfaction Survey at the completion of their intervention, one questionnaire per family. On O'ahu, 140 surveys were completed, out of 151 families, for a 93% response rate. On Hawai'i Island, six surveys were completed, out of 47 families, for a 13% response rate.

Final Year: Retrospective Survey of Demonstration Leaders

A total of 25 surveys were sent by email and a link to Survey Monkey. These surveys were sent to nine DHS/CWS administrators, eight CWS section administrators, seven private provider managers and supervisors, and one community partner. A total of 14 responses were received, for a 56% response rate. Private providers had a 71% response rate, followed by DHS/CWS administrators (67% response rate), and CWS section administrators (38%). The one community partner did not respond.

Recipients of Service Provision

For the process evaluations of the four interventions (fidelity and service provision), the sample consists of those children (and their families) identified in the CPSS database by the correct Service Action Code (one per Waiver Demonstration intervention) and initiation and termination dates for that intervention. Children are the unit of analysis for these process analyses. The four interventions are analyzed separately, with four separate samples. A child can receive more than one Waiver Demonstration intervention, and is treated as a unique participant in each intervention. The sampling frame for the children and families in these particular analyses is the same as that for the outcome evaluation, and will be described in more detail in the Outcome Methodology.

Data Analysis

The process evaluation used a variety of data collection methods, thus the data analysis differed by method. The data analysis plan for each method is further described below. The Waiver Demonstration interventions were implemented across two islands: Oʻahu and Hawaiʻi Island. Hawaiʻi Island has two quite distinct geographic areas and thus, the island is separated into two child welfare administrative sections: East Hawaiʻi (Hilo) and West Hawaiʻi (Kona). All process evaluation interviews, focus groups, on-line surveys and data analyses on the implementation metrics were conducted in the same manner across both islands.

Paper and On-Line Surveys

The survey data was extracted from the Survey Monkey software and analyzed using the IBM SPSS Statistics software package. The survey data included demographics, intervention-specific data, scenario data to capture knowledge of referral criteria, and organizational context measures. The Evaluation Team primarily used descriptive statistics such as frequencies and cross tabulations to analyze these data. The intervention-specific questions captured data on staff perceptions of knowledge, perceived risk, peer buy-in, time commitment, compatibility, relative advantage, and training. Composite variables were created and analyzed for each construct.

Interviews and Focus Groups

As in all interviews and focus groups, the information elicited from respondents is subjective; the evaluators were seeking the impressions, opinions, knowledge and experiences of the members of the focus group or interview. Because of the nature of subjective responses, for the interviews and focus groups, at least two members of the Evaluation Team conducted each interview or focus group, with each member taking notes. From these notes, evaluators used content analysis techniques to identify themes and to organize content within those themes. The resulting thematic analysis was shared with participants or key members of the group for feedback on accuracy/relevance and subsequent revision.

After each of the interviews or focus groups was conducted, the Evaluation Team used the results to construct theme tables based on content analysis and some potential themes identified prior to the interviews, one theme table per interview or focus group. Once the theme tables were finished, they were used to identify overarching themes, which are discussed at length in the findings section of each intervention chapter. Additionally, interview findings were used to inform the process of refining the process metrics, as there were some questions raised that would be best answered quantitatively.

Process Metrics for Fidelity of Waiver Demonstration Interventions

For the quantitative process measures indicating service delivery and fidelity, data from CPSS, SHAKA, ODM, and EPIC databases were selected or created, and downloaded by the Evaluation Team for statistical analysis every six months. These data were collected for each child served by each intervention. Data cleaning and merging protocols were developed to create the Waiver evaluation database combining relevant case data from the multiple databases to a cohesive dataset (a detailed data management protocol is available from the authors). The database includes data on all Waiver Demonstration cases from January 2015 – September 2018, as identified by the correct Service Action Code in the databases.

The IBM SPSS Statistics software package was used to analyze these data. The Evaluation Team primarily used descriptive statistics such as frequencies and cross tabulations to analyze process metrics used to describe fidelity and provision of services for each of the interventions. When appropriate, correlations and chi-squares were calculated to examine the characteristics of children and service provision that might be related to the outcomes of an intervention.

METHODOLOGY – OUTCOME EVALUATION

Key Questions and Hypotheses

The key questions to be answered by the outcome evaluation are:

1. Among those children reported for maltreatment on O‘ahu and Hawai‘i Island, do the two Short-Stayer interventions (CRT and IHBS) decrease the number and proportion of children who are placed out of home, particularly for under 30 days?
2. Among those children who have been in foster care for at least nine months on O‘ahu and Hawai‘i Island, do the two Long-Stayer interventions (Wrap and SPAW) increase the number and proportion of children who move toward permanency (reunification, adoption, or guardianship)?
3. Do the four Waiver Demonstration interventions maintain or increase the safety and well-being of children and youth receiving those interventions?

Hypotheses for Short-Stayer Interventions:

1a) Providing a Crisis Response will decrease the percentage of reported children who have entries into foster care;
1b) Providing a Crisis Response will decrease the percentage of reported children who have short stays in foster care;
1c) Providing a Crisis Response will increase the percentage of children placed with relatives when placement is necessary.

2a) Providing IHBS will reduce the percentage of reported*[2] children entering into foster care;
2b) Providing IHBS will reduce the percentage of repeat referrals to Child Welfare Services within six months of a report;
2c) Providing IHBS will reduce the percentage of reported* children with new reports within six months of the report;

[2] * Hypotheses have been revised from counting *substantiated* reports to counting *reports*, given the discovery that substantiation is a dynamic field in CPSS and is overwritten over time.

2d) Providing IHBS will improve the well-being and functioning of children and their families.

Hypotheses for Long-Stayer Interventions:

3a) Providing Wrap to those in foster care nine months or longer will reduce the length of stays in foster care;
3b) Providing Wrap will increase the percentage of children achieving permanency through reunification;
3c) Providing Wrap will reduce the number of re-entries into foster care;
3d) Providing Wrap will reduce the percentage of children placed in institutional settings;
3e) Providing Wrap will improve the well-being of children and youth.

4a) Providing SPAW meetings to those in foster care nine months or longer will reduce the length of stays in foster care;
4b) Providing SPAW will increase the likelihood of a permanent placement;
4c) Providing SPAW will reduce the percentage of children placed in institutional settings;
4d) Providing SPAW will improve child and youth well-being.

Design

Crisis Response Team

The outcome evaluation of CRT compared CRT participants to carefully selected comparison groups on placement outcomes. The original analysis plan was to use Propensity Score Matching to create one comparison group of children with reports of maltreatment originating with law enforcement, hospitals and schools from the three years prior to the Waiver Demonstration (2012-2014). However, over the course of the Demonstration, patterns of dispositions from Intake to CRT, and CRT responses to intakes from these three sources, proved to be quite distinct. The distinct disposition pathways are described in the "Service Fidelity of CRT Referrals by Intake" section of this *Report*. Ultimately, the evaluation compared these three samples of children served by CRT to three carefully selected samples of children with intakes from (1) law enforcement, (2) schools, and (3) hospitals from 2012-2014. The resulting selection of comparison groups is described in the "Child Outcomes" section for the CRT.

While not stated in the original hypotheses in the Hawai'i Evaluation Plan, this evaluation also analyzed whether the percentage of Short-Stayers (those entering and exiting care in fewer than 30 days) decreased since pre-Waiver years. For this analysis, only the immediate outcomes of placement are reported; how many children served by CRT on each island were removed the same or next day of the intake, and of those, what proportion were Short-Stayers, defined as children who entered and exited out-of-home placement within 30 days? Again,

proportions of Short-Stayers were compared between the three report groups and three comparison groups. Bivariate analyses were conducted to identify correlates of placement within the Demonstration sample.

Intensive Home-Based Services

A key criterion of Intensive Home-Based Services is that parents agree to fully participate in IHBS services, and remain engaged in services throughout the intervention period. These are voluntary clients, albeit clients who could have their children placed in foster care if they don't volunteer. The evaluation design did not randomly assign voluntary clients to IHBS and non-IHBS treatment groups. Therefore, there is no comparable counterfactual group.

Analysis of child well-being and family functioning from pre- to post-intervention was performed for Demonstration cases only, given that there were no comparable measures of child well-being and family functioning prior to the Demonstration.

Wrap and SPAW

The outcome evaluations of Wrap and SPAW intended to use retrospective matched case comparison designs in which children who received Wrap or SPAW services following implementation of the Demonstration were matched using Propensity Score Matching with Long-Stayer children not participating in these services in the three prior years on the same island. These were to be two separate analyses (Wrap and SPAW). However, challenges arose over the course of the Demonstration. First, the evaluators and child welfare staff were unable to operationalize the definitions of "likely to reunify" (a key eligibility criterion for Wrap) and "unlikely to reunify" (a key eligibility criterion for SPAW), and second, data fields in CPSS indicating case goal were dynamic and unreliable. Given the lack of these criteria in the data on children in care pre-Waiver, selecting comparable groups from 2012-2014 foster care rolls was therefore inappropriate.

The evaluation, instead and where appropriate, developed risk profiles for children referred to Wrap and children referred to SPAW, and used Propensity Score Matching to identify a comparison group from within the 2015-2017 Waiver Demonstration years (the three years for which we have complete data on all Long-Stayer children on Oʻahu or Hawaiʻi Island).

In addition, bivariate analysis was used to identify correlates of outcomes within the Demonstration samples. When more than one child in a family was served by Wrap or SPAW, each child was treated as a separate case, given the focus of the intervention on each child's outcomes separately.

Data Sources and Data Collection Methods

As described earlier in this *Report*, the evaluation utilized data from four separate databases. This section provides an overview of the outcome metrics that were extracted from each database.

Safety Outcomes

New Reports of Maltreatment

All Reports of Child Maltreatment are recorded in the CPSS database, All Intakes file. The report contains the date of the complaint, source of complaint, type(s) of maltreatment, and case disposition. These can be identified for each child by the Client ID. Client ID's for children who received a Short-Stayer intervention were provided to the CPSS database manager, who extracted from CPSS all reports subsequent to the child's referral to CRT or IHBS, respectively.

New Referrals to Child Welfare Services

From the All Intakes file, all new Referrals to Child Welfare Services are noted when the result of a report of maltreatment results in a referral to CWS for further investigation or services. These referrals are identified by Client ID and the date of the referral.

Changes in Safety Assessments

If a child is referred to the Crisis Response Team, s/he receives an Initial Child Safety Assessment by the CRT caseworker. If the case is referred by CRT for Intensive Home-Based Services, the CRT caseworker continues to manage the case, and conducts a second, Final Safety Assessment, when IHBS services are completed.

Permanency Outcomes

Foster Care Entries and Re-Entries

For the CRT Response, this *Report* reports on removals that occurred on the same or next day from the disposition to CRT. These same/next day removals are the outcome of interest given the crisis nature of the Crisis Response Team. The evaluation also reports on length of stay, given the focus on reducing the incidence of short stays in care.

For the IHBS intervention, the evaluation counts NCANDS Placement Outcomes, (placements that occur within 90 days of the intervention), in terms of the dates of removal and the types and lengths of placements in the NCANDS removal episode.

The type of placement was noted in CPSS, and could include:

- Paid: Foster Care
- Paid: Relative Care
- Paid: Emergency Shelter
- Paid: Emergency Foster Care
- Unpaid: Hospitalization
- Unpaid: Detained Minor
- Unpaid: Residential Treatment
- Unpaid: Child with Non-custodial, Legal Parent
- Unpaid: Child Runaway
- Unpaid: Child Elsewhere

Unpaid in this context means that the cost is borne by an entity outside the Department of Human Services (such as the Department of Health).

Placement with Relatives

For the analysis of Short-Stayer interventions, the outcome of Placement with Relatives was applied only when the first paid placement in the episode was with licensed relatives, given the immediate and short-term emphasis of the Short-Stayer interventions.

Placements in Institutional Settings

The evaluation of SPAW tracked whether the number of children Placed in Institutional Settings declined over the course of the Demonstration. This is tracked in CPSS as "Residential Treatment."

Reunifications and Other Dispositions

When a child leaves foster care, the termination date of foster care is recorded in CPSS, as well as a Termination Code, which identifies where the child went upon release from care. Possible Termination Codes include reunification, adoption, guardianship, emancipation, etc. See Legal Status, below.

In Hawai'i, the term "reunification" only applies when the child is returned to his or her biological parents: reunification with extended family is noted as placement with relatives, not as reunification.

Foster Care Exits and Duration of Foster Care

The Crisis Response Team was implemented to reduce the number of children who entered foster care for short stays (of under 30 days). The dates of foster placement and the dates of exits from care are recorded in CPSS, and provided information on the disposition of the exit (return home or other outcomes noted above).

Foster Care Re-Entries

The CPSS database tracks the start and termination dates of placement spells for any child served by Child Welfare Services. These were extracted for each child who participated in either Wrap or SPAW, as to whether any children who exited care following Wrap or SPAW subsequently re-entered care in Hawai'i.

Legal Status

The legal statuses of permanency outcomes in CPSS collected for the Demonstration included:

- Family Supervision: child is in the legal or permanent custody of a family which is willing and able, with the assistance of a service plan, to provide the child with a safe family home.
- Guardianship: duty and authority to make permanent decisions in matters having a permanent effect on the life and development of the minor and to be concerned about the minor's general welfare.
- Legal Custody: court decree imposes on the custodian the responsibility of physical possession of the minor and the duty to protect, train, and discipline the minor and to provide the minor with food, shelter, education, and ordinary medical care.
- No Legal Status: when a child is returned home to parents/legal guardian without family supervision, child is discharged from foster care at age 18, or DHS jurisdiction is terminated as the child has been adopted.
- Other Agency: legal responsibility is assumed by another agency or individual; applies to children receiving board only payment (i.e., requested by QLCC, Casey, Family Court, etc.), permanency assistance or adoption assistance subsidy.
- Permanent Custody: the legal status created by an order of the court divests from each legal custodian and family member who has been summoned…and vests in a permanent custodian, each of the parental and custodial duties and rights of a legal custodian and family member.

Permanency Rating

Using the Casey Family Programs model of Safety, Permanency and Well-Being meetings, the SPAW program recorded a SPAW Initial Permanency Rating in the SHAKA database, which was a rating agreed by the SPAW members, on a six-point scale:

1. Permanency achieved – in adoption, legal guardianship, etc., not emancipation
2. Very good – with family or in a family setting all believe to be lifelong
3. Good – in a family setting all believe to be lifelong; plan for stability is in place; all committed to plan; permanency issues are near resolution
4. Fair – in a family setting all believe could be lifelong; plan for stability is in place; all committed to plan; permanency issues are being addressed
5. Marginal – in a family setting all believe could be lifelong; developing a plan to achieve safety and stability
6. Poor – living a home that is not likely to endure; failure to resolve adoption/guardianship issues

This same Permanency Rating was repeated by the SPAW Coordinator (Final Permanency Rating) when the case was closed to SPAW, at or near 90 days after the SPAW Meeting.

Improvements in Child Well-Being

Beyond those data currently and historically present in the state administrative database (CPSS), the state prepared for the entry of new data on child well-being into existing databases for the Waiver Demonstration evaluation in the following ways:

Family Functioning and Child Well-Being in IHBS

The state contracted the Institute for Family Development in Washington to train the private provider in the HOMEBUILDERS practice model to prevent child placement among families at imminent risk of removal. Personnel from the Institute for Family Development (creators of HOMEBUILDERS) trained the private provider on Oʻahu and on Hawaiʻi Island in 2015. The IHBS private provider uses the HOMEBUILDERS database (ODM) to collect and record all case information, including the *North Carolina Family Assessment Scale* (*NCFAS*). The *NCFAS* was completed at the opening and closing of the case by IHBS therapists. HOMEBUILDERS consultants at the Institute for Family Development provided technical assistance, consultation and coaching, throughout the five years of the Demonstration, and part of that technical assistance consisted of checking the Hawaiʻi ODM database for completion of data collection and practice fidelity. In the third year of the Demonstration, the platform changed from ODM to ECM, but no data fields used in the evaluation were affected.

All families receiving IHBS services were assessed at intake and case closure using the *NCFAS*. The *NCFAS* is scored on a six-point scale from -3 (serious problems) to 0 (adequate) to +2 (clear strength). Each of five domains consist of ratings on several items (termed subscales) used to determine the overall domain score (National Family Preservation Network, 2015; Reed-Ashcraft, Kirk, & Fraser, 2001). The reliability of the *NCFAS* was reported by Kirk, Kim, and Griffith (2005) at both intake and closure with alpha coefficients ranging from .72 to .90 at intake and .79 to .91 at case closure. These results confirm the reliability and results obtained in the original study of the *NCFAS* by Reed-Ashcraft and colleagues (2001).

The findings of Kirk and colleagues (2005) support the validity of the *NCFAS* in relation to placement status at the end of treatment and within one year. The variation found in the strength of the relationships and the range of ratings that predict placement were informative. While closure ratings were significantly related to placement at closure and predictive of placement at one year, intake ratings demonstrated poor validity in this respect. Furthermore, examination of change scores from intake to case closure indicate that positive change across domains was predictive of non-placement at closure, these positive change scores alone were not predictive of placement status at one year. Results suggest that positive change alone is not sufficient to predict placement. However, with the exception of the Overall Parental Capabilities domain, domain scores at or above Baseline/Adequate did predict the absence of future placement. The authors hypothesize that long-term family stability may require evidence of greater change to at least a Baseline/Adequate level of functioning.

Child Well-Being in Wrap and SPAW

The Child and Adolescent Needs and Strengths was used in this evaluation of Long-Stayer interventions. DHS contracted with John Lyons of Chapin Hall at the University of Chicago to modify the *Child and Adolescent Needs and Strengths* (*CANS*; Lyons, 2009; 2015a; 2015b) instrument for Hawai‘i. Dr. Lyons came to Hawai‘i and trained caseworkers on O‘ahu to certification on the *CANS* in 2014. Caseworkers on Hawai‘i Island were trained online in 2015. The *Child and Adolescent Needs and Strengths* is primarily a case planning tool, and is subjective, but was used by Waiver Demonstration states as a proxy measure for child well-being. The Hawai‘i evaluation used the *CANS* as a measure of child well-being by calculating a summary score on each of the five domains of Life Domains, Caregiver Needs, Youth Risk, Behavioral/Emotional Issues, and Trauma Experiences. A higher score on each domain indicated greater need/risk. The *CANS* was completed on SHAKA using the unique child identifier (i.e., CPSS Client ID number).

Target Populations and Samples

DHS estimated that a total of 3,441 families, including 4,885 children, would be offered Waiver-funded services over the course of the five-year Demonstration, from January 2015 through September 2019 [Table 8 is from (DHS, 2014, pg. 21)].

Table 8

Interventions and Projected Number of Children and Families Served

Intervention	# of CHILDREN served per yr.			# of FAMILIES served per year		
	O'ahu	Hilo	Kona	O'ahu	Hilo	Kona
CRT	335	103	39	209	64	24
IHBS	140	45	20	90	28	13
Wrap	70	5	5	50	3	3
SPAW	200	37	36	180	33	33

As stated in the original Evaluation Plan, the intervention samples consist of all children who (1) met the eligibility criteria for the intervention, (2) received the intervention and (3) whose cases were CLOSED to the Waiver intervention by September 30, 2018, to allow a six-month follow-up period (to March 31, 2019) to track case outcomes for all children involved in the Waiver Demonstration. Because outcomes can differ for different children in the same family (one child can be removed while her/his sibling remains at home), this evaluation reports on outcomes for individual children, rather than family outcomes.

Intervention samples were formed for each island, given the social and economic differences described in Chapter One, and the practice differences noted in the specific chapters for each intervention. Evaluation analyses were specific to island and did not combine the two islands into one evaluation of the intervention (see Table 9).

Children could receive multiple interventions over the course of the Waiver Demonstration. For the Crisis Response Team, given the intervention consisted primarily of a two-hour response by a caseworker, children were included in the intervention sample every time that they received a CRT response. The evaluation recorded how many times children were in the sample, and a very few were in the sample twice. None received CRT three times.

In the IHBS, Wrap and SPAW interventions, a child's first experience of each intervention was recorded as the intervention experience. The evaluation recorded any subsequent repeats of the intervention, but did not collect process or outcome information for subsequent experiences.

CRT Intervention Sample

The CRT Intervention was provided 1,745 times on O'ahu during the sampling frame of the evaluation. This was 39% more children than anticipated during the installation phase of the Demonstration.

The Crisis Response was provided 418 times on Hawai'i Island from October 2015 through September 2018, which is very close to the 426 projected CRT responses for the same time period.

IHBS Intervention Sample

The IHBS intervention sample consists of those children who met the eligibility criteria of (1) a referral from CRT, (2) acceptance as an appropriate referral by the IHBS provider, (3) and did not have a premature closure due to child removal, but received the full intervention. There were a total of 151 unique children in the IHBS sample on Oʻahu (29% of projections), and 47 unique children on Hawaiʻi Island (25% of projections).

Wrap Intervention Sample

A total of 109 unique children experienced the Wrap process on Oʻahu (42% of projections), and 26 children experienced Wrap on Hawaiʻi Island (87% of projections).

SPAW Intervention Sample

On Oʻahu, the expected number of children and youth to receive a SPAW process was set at a high number during the development of the IDIR (projections of 750 children on Oʻahu and 219 on Hawaiʻi Island). By the end of September 2018, 74 children and youth had a SPAW meeting on Oʻahu, and 82 on Hawaiʻi Island.

The selection of comparison groups for each of the intervention samples was modified from the original Evaluation Plan (Berry & Helm, 2015) due to challenges in intervention sample sizes, documented here and below, and other challenges, noted in the evaluation findings for each intervention. The specific methodology for the selection of comparison groups is presented in the discussion of outcomes for each intervention, where applicable.

Table 9

Evaluation Sample Projections and Sample Sizes

Island	Intervention	Sampling Frame	Estimated Total Sample 2015-2018	Actual Sample 2015-2018	Percent of Projection
CRT					
O‘ahu	CRT	Jan. 2015 – Sept. 2018	1,256	1,745	139%
Hawai‘i	CRT	Oct. 2015 – Sept. 2018	426	418	98%
IHBS					
O‘ahu	IHBS	Feb. 2015 – Sept. 2018	525	151	29%
Hawai‘i	IHBS	Oct. 2015 – Sept. 2018	195	47	25%
Wrap					
O‘ahu	Wrap	Apr. 2015 – Sept. 2018	262	109	42%
Hawai‘i	Wrap	Jan. 2016 – Sept. 2018	30	26	87%
SPAW					
O‘ahu	SPAW	Jan. 2015 – Sept. 2018	750	74	10%
Hawai‘i	SPAW	Oct. 2015 – Sept. 2018	219	82	37%

Data Analysis Methods

Given the substantial differences between Hawaiian Islands in socioeconomic conditions and the supportive service array, the evaluation did not compare Demonstration outcomes between islands. The outcomes of interventions on O‘ahu were analyzed separately from the outcomes of interventions on Hawai‘i Island. The analysis of Hawai‘i Island combined the Kona and Hilo sites into one sample per intervention, given small sample sizes for each site.

The outcome evaluation relied almost exclusively on quantitative case-level data extracted from administrative databases. Therefore, data analyses used statistical methods to describe the rates of placement and other permanency outcomes for each child served by a Waiver Demonstration intervention. Where appropriate, data analysis used bivariate statistical tests, within intervention samples, to examine correlates of outcomes, such as characteristics of children, their maltreatment histories, precipitating family and risk factors, and service components received. These are described for each analysis.

METHODOLOGY – COST STUDY

In their most basic form, Waiver cost studies address whether spending for child welfare services changed in a manner that is consistent with the Waiver theory of change. Specifically, when given an opportunity to spend federal Title IV-E funds in a flexible manner, as provided by the Waiver agreement, state child welfare agencies will convert what would have been a board and maintenance expenditure into a service expenditure provided to a child who is living at home (i.e., placement prevention), an expenditure that accelerates the timeliness of exits to permanency, and/or an expenditure that reduces the demand for high-end group or congregate care placement. When taken together, successful investments in these services will reduce the demand for foster care and by extension the cost of providing foster care. When that happens, all else being equal, the fraction of total spending dedicated to foster care should drop as the demand for foster care goes down and the use of non-foster care services rises.

With those broad objectives in mind, the aim of the cost study is to document whether observed spending changed in a manner consistent with the underlying theory. In addition, there are secondary questions of interest. Among them, the first one that comes to mind is the cost of the interventions deployed. A straightforward thought experiment highlights the question. If a state spends $10 million per year on interventions designed to reduce entries into care, then over a five-year period those interventions have to reduce demand for foster care by an amount equivalent to $50 million in order to break even. Even greater reductions in foster care generate additional savings beyond the cost of the interventions; smaller reductions imply costs of interventions that exceed the cost of the benefits measured as a reduction in foster care. The answer to this question strikes at the heart of cost neutrality.

In this section of the report, we provide a description of how we gathered the data needed to answer these questions. To summarize, the task at hand has these component parts:

- Establish whether the utilization of foster care has changed over the Waiver-period relative to the pre-Waiver years.
- Establish how spending for foster care has changed.
- Establish how spending for services that reduce the risk of placement and increase rates of permanency has changed.
- Establish the cost of scaling the service investments that Hawai‘i made with the flexible funds.
- Bring the elements together to describe the overarching fiscal impact of the Waiver Demonstration on the child welfare system in Hawai‘i.

Foster Care and Services Spending

As is the case in other states, Hawai‘i has a complex chart of accounts and codes agency officials use to account for revenue by source and expenditures by purpose. In some cases, the funds accounted for are relatively clear-cut vis-á-vis the source and/or the purpose. In other instances, resources/expenditures are pooled, an approach that means it is difficult to track funds with precision.

With that backdrop, we adopted a broad view of data collection. We asked DHS to provide us with as much fiscal detail as possible so that, with that data in hand, we could construct budget categories that would come as close as possible to those needed to understand whether spending changed and in what ways.

To that end, Chapin Hall worked with the Evaluation Team from the University of Hawai‘i and staff at the Hawai‘i Department of Human Services (DHS) to gather the necessary information. The main source of data for the fiscal analysis is the SSD actual expenditure reports. Working closely with DHS, we connected these data to various accounting codes so that different types of spending (e.g., for in-home vs. out-of-home care) could be tracked over time. Specifically, we identified spending in five major areas:

- Spending in out-of-home care *or* in-home services
- Type of expenditure (e.g., direct or Purchase of Service)
- Waiver-specific spending
- Location of spending (e.g., island)
- Revenue source (e.g., state or federal)

Spending for Children In- and Out-of-Home

The SSD expenditures delineate direct spending on foster care (e.g., board and maintenance payments); however this distinction is less clear for purchased services. For example, most services programs serve children in both out-of-home placement and children living with their families. To address this ambiguity, we developed three spending categories: payments for out-of-home placements, spending exclusively for in-home services, and *direct services* that may be provided to children either in or out-of-home.

Regarding spending for children in out-of-home care, we focus primarily on board and maintenance costs because they are the costs most easily identified. The total cost of providing foster care (i.e., board and maintenance) includes administrative costs which include the costs associated with administering foster care such as caseworker time. In general, these costs are not itemized within the chart of accounts. For that reason, we also consider room and board expenditures. These expenditures represent the reimbursement that goes to foster families in the form of per diem rates.

For services while children are at home, we adopted two strategies. To the extent possible, we isolated spending for services delivered while children were in care. We also identified spending for Waiver-supported interventions, with specific emphasis on CRT, IHBS, Wrap, and SPAW services. Again, services spending often includes administrative costs. Where possible we isolated the administrative cost from the cost of services delivered but this was often difficult to do.

Types of Expenditures

SSD has five main *program* areas: adult and community, CPS, CPS payments, general support, and residential support. Based on consultations with DHS fiscal staff, we determined that child welfare services (CWS) spending is contained within the CPS and CPS program areas, with some portion of general support allocated to CWS. CPS includes services provided by DHS and contracted vendors, and CPS payments represent room and board for foster care and adoption/guardianship assistance. Within *general support*, there are designated administrative costs for foster care maintenance, adoption/guardianship assistance, and Medicaid administration. Additionally, DHS confirmed that 79 percent of the general administrative support should be allocated to CWS.

Broadly, spending is categorized by either payroll or operating expenses. In order to characterize major areas of child welfare spending, we further disaggregated these data into branch administration, client payments, purchase of services, program development, and other operating and payroll expenses. These budget categories were used to establish whether an expenditure was directed at a service or regarded as an administrative cost.

Waiver-Specific Spending

Waiver-specific spending comes from two sources—actual expenditures for contracted services, and time estimates of DHS staff for the CRT and referrals to the other Waiver interventions. The contracted Waiver interventions (IHBS, Wrap, and SPAW) can be linked to actual expenditures data using contract and vendor numbers. For Wrap, there is a single contract that can be clearly linked to the expenditures data. However, some of the IHBS contracts bundle non-Waiver services with the Waiver services. As a result, the amount spent for IHBS in contracts that bundle other services is estimated. For example, in a contract that contains IHBS, Comprehensive Counseling and Support Services (CCSS), and Voluntary Case Management (VCM), the amount spent for IHBS is estimated to be 33 percent of the total contract. Additionally, DHS has a contract with University of Hawai‘i Maui Community College (UHMCC) that bundles SPAW with CQI. In this case, UHMCC closely tracked their actual expenditures for SPAW—separate from CQI—and Waiver costs are based on their internal accounting.

Waiver administration, in the form of DHS staff time spent on the CRT and coordinating other inventions, is less clearly defined in the expenditure data. As a result, we conducted a survey of CRT staff on O'ahu and Hawai'i Island that was disseminated in February 2018. The survey asked for staff titles that are closely tied to salary level, the percentage of full time equivalent (FTE) the staff member spends on the CRT, and the amount of time necessary to complete certain CRT tasks (intake, assessment, etc.). Because some CRT staff members—especially on Hawai'i Island—are not 100 percent allocated to CRT, the percentage FTE for each staff member is key. The survey asks about specific tasks associated with screening and serving children, in order to determine the unit costs of CRT services. The time estimates from the survey were then linked with payroll data to estimate the cost associated with the CRT and Waiver administration.

Expenditures by Revenue Source

The foregoing describes the data used to understand how available funds were used, both in total and in reference to Waiver-inspired interventions. The source of those funds – federal or general revenue – is another issue of some interest. In the case of the Waiver, Title IV-E Funds are supposed to support what would have been the federal share of foster care. To the extent those funds are or were not needed to support foster care, then they can be redirected to services. Expenditure tracking by revenue source would make it possible to see the impact of Waiver funds on services expenditures, but this level of detail was not readily available. That being the case, we used an appropriations codebook to determine the revenue source. In most cases, child welfare spending is an admixture of dollars from either general + state sources or special + federal sources. For federal spending, we were able to further break out federal categories such as Title IV-E, Title IV-B, etc.

Data Analysis

The Waiver cost study has two parts. The first addresses whether there was a change in foster care utilization; the second addresses whether the change in expenditures align with what is known about the utilization of foster care. We opted to address the utilization of foster care first because utilization shapes expenditures. The Waiver theory of change contends that investments in services that affect admissions to care, how long children stay in care, and the unit cost of care will lower the utilization of foster care. All things being equal, absent a downward shift in utilization, there is no real need to understand whether foster care expenditures declined on the one hand and services spending increased on the other. More directly, the number of children entering foster care during the Waiver years increased as did the time spent in out-of-home care by the children who were admitted. Under such circumstances, Title IV-E funds designated for foster care could have been diverted to spending on in-home services. However, the cost of foster care would have shifted, then, to other sources of either federal or general revenue. One could argue that the Waiver services slowed the growth of foster care utilization but that narrative does not resolve the underlying dynamic.

The capped allocation agreed to by the state and the federal government had built into it certain assumptions about the use of foster care over the term of the Waiver. Moreover, the capped allocation placed a ceiling on what the state could claim in the way of federal IV-E participation. If the utilization of foster care breached those assumptions, then savings for investment in services sourced from the capped allocation become for the most part a moot point.

Foster Care Utilization

For the analysis of placement, we constructed a longitudinal file that tracks admissions to and exits from foster care. With these data, we were able to count the number of admissions each state fiscal year from 2012 through 2019, a period that includes three pre-Waiver years. We were also able to ascertain how long children spend in care and the types of placement used. Finally, we were able to count the total number of care days provided annually to children in care at the start of the year plus children admitted during the year. From a fiscal perspective, these annual care day counts are especially important because they tell us how much foster care sits behind the annual claim for foster care. These annualized counts describe the draw on the capped allocation for foster care as opposed to other services those dollars might support.

In addition to the broad overview of utilization, we also examined whether services designed to reduce time in care (the Wrap and SPAW services) had their intended impact. To do this, we asked whether children in care past the nine-month mark who received either Wrap or SPAW services left care more quickly than children who did not. Our specific approach incorporated placement data with services data so that we could identify when in their placement history a young person was referred for services. For this analysis, children with a spell start date prior to state fiscal year 2012, and/or predominant placement types other than foster care, kinship care, or some mixture of the three were excluded from the analysis because their numbers are small. For a counterfactual, we track all other children placed post-2012 through 2019 who were not referred for services. To adjust for differences in the population, we control for age at placement, gender, county, race/ethnicity, placement history (e.g., type of care and number of prior placement spells), and elapsed time in care.

Expenditures

The analysis of expenditures (aka costs) focuses on board and maintenance payments and in-home services. We are generally interested in how utilization of foster care connects to board and maintenance spending relative to the spending for in-home services. We expect that on balance spending for out of home care will shrink as a proportion of the total for in-home and board and maintenance. To place those expenditures into context, we consider overall spending. We accomplish this by establishing top line dollar amounts that are then disaggregated into homogenous buckets with regard to purpose. Our main goal is to separate out service dollars from administrative dollars, with out-of-home and in-home care representing the primary service categories of interest. As for the services dollars, there are

two types of expenditures with which to be concerned: services purchased from partner organizations and services delivered to families and children by public agency employees. In the former case (e.g., IHBS), costs are contractual and relatively easy to identify. When in-home services are provided public agency employees, the costs associated with in-home services are more difficult to identify. Using the data culled from the survey described above, we assembled reasonable estimates of those costs.

For the analysis, we focused on the total spending for services, either in-home or foster care board and maintenance. The focus on services spending, as opposed to services plus administrative costs, simplifies the underlying data, at least somewhat. The simplifying assumptions also align more easily with the Waiver theory of change. The Waiver calls for a targeted redirection of board and maintenance expenditures into services expenditures. We assume that administrative costs are a wash. That is, the cost of administering a unit of board and care is roughly the same as the cost of administering a unit of in-home services.

With these data we are interested in discerning whether there was a discernible shift in services spending, as a fraction of total spending, such that Hawai‘i increased its in-home service investments relative to the portion spent on foster care. To the extent there is such a shift, we are also interested in whether the capped allocation was the source of those funds.

STRENGTHS

There are strengths and limitations associated with all evaluation design. There are multiple strengths to this evaluation in terms of methodological and practical design.

In terms of methodological design, the overall design of the evaluation used a mixed methods approach. Both quantitative and qualitative methods were used to collect and analyze data providing a more complete picture of the Waiver Demonstration by combining information from complementary data sources. Quantitative data was helpful in identifying trends in intervention uptake and implementation, while qualitative data helped to explain the trends being observed. It provided contextual data on what is happening with the implementation of the interventions by allowing the Evaluation Team to get inside the program and understand how and why certain components or features were successful or are not. Issues that were identified quantitatively were examined in depth qualitatively providing greater insight into the implementation process.

Second, the evaluation used multiple data sources and data collection methods, which allowed for triangulation of data. Triangulation allowed the Evaluation Team to assess the extent to which all evidence converged, which supported the validity of findings. Also, data was collected from multiple levels within the CWS organization (leadership, supervisors, and line staff) and from service providers and community partners. Input on the Waiver Demonstration and its implementation from the leadership responsible for the policies and planning, from the supervisors responsible for adherence and training, and from the line staff responsible for the implementation of the interventions was collected throughout the Demonstration. This multi-layered and chronological approach to data collection provided the Evaluation Team with a broader, more holistic perspective on the Waiver Demonstration implementation process.

The evaluation linked data from multiple databases to ensure complete and accurate information on children, on services, and on outcomes. In this Waiver Demonstration in Hawai‘i, the Evaluation Team accomplished something that has not been done before with Hawai‘i child welfare data by creating a merged dataset from the various disconnected systems used by the agency (CPSS and SHAKA) and for the Waiver Demonstration (external provider data systems). Data was merged for all children touched by the Waiver Demonstration, and, for Demonstration period and the three years prior to the Demonstration, all child welfare Intakes, which has allowed CWS more comprehensive information about a child and family (demographics, case history, assessment data, event logs, outcomes, etc.) across the multiple systems and throughout the life of a case than ever before. The Evaluation Team worked diligently throughout the Demonstration, in partnership with DHS and database managers, to identify the data fields, learn the databases, and determine how the data fields mapped to variables that were important to understanding interventions and outcomes.

Other methodological strengths included a diverse geography, use of pre-Waiver comparison groups, multi-level analysis, and the use of existing instrumentation. The evaluation design included a rural and an urban site allowing the state to understand the differential influence of geographical and social factors. Establishing comparison groups from pre-Waiver cases was necessary; maintaining the necessary controls on random assignment to concurrent treatment and control groups in a state where counties are separated by miles of water was prohibitive. Along with multi-level data collection, multi-level analyses were conducted. Data on child and family characteristics were collected in order to identify profiles/risks for predictive models for future analysis. The evaluation endeavored to use data fields and instrumentation that was already in place, reducing the lag time for training on data collection that would be required before data collection could begin.

Further strengths in the practical aspects of the study included open communication, established partnerships, and a detailed document review. The Evaluation Team served as an important communication arm of the Waiver Demonstration by providing information and updates on the implementation process to staff throughout CWS and partner agencies through site visits, training, and Demonstration findings. To support capacity building, the Evaluation Team partnered with child welfare administrators, supervisors and providers to identify challenges in all facets of the evaluation and data collection, and worked together to create and deliver solutions to those challenges.

Through these capacity-building efforts the Evaluation Team established vital partnerships. The Team relied on partnerships between child welfare administrators, child welfare practitioners, and child welfare evaluators, all of whom have years of experience and expertise in their areas of responsibility. Because the Evaluation Team created strong relationships and were in constant communication with CWS, data managers and providers, there was a better understanding of the data and greater ability to catch errors or inconsistencies fairly quickly.

The evaluation also included a thorough document review and participation in routine meetings and workgroups. The Evaluation Team remained focused on thoroughly understanding (1) HOW the Waiver was planned and was implemented, (2) WHAT the key variables/data fields were that could capture that, (3) WHO the key players were that had a role in process and outcomes, and (4) HOW the data fit together to tell the COMPLETE "story" of a case. The Team made an active effort to not only understand the Demonstration, but to make sure to capture the data needed to effectively execute the evaluation plan. From the document review, to attending all of the Year One workgroup meetings, to periodic interviews and surveys with partners and participants throughout all years of the Demonstration, the Evaluation Team detailed the procedures and steps taken to facilitate replication of the interventions and the evaluation itself.

LIMITATIONS

Sample Sizes

The Hawai‘i Waiver Demonstration was provided on O‘ahu and Hawai‘i Island, which are substantially different counties, not only geographically, but socially and economically. In the Waiver Demonstration, the Crisis Response Team also took different forms on the two islands. For these reasons, the evaluation analyzed the processes and outcomes of all interventions separately between the two islands. This amplified the sampling challenges when the interventions did not meet projected sample sizes.

The number of children served by the Crisis Response Team met (Hawai‘i Island) and exceeded (O‘ahu) projections, producing evaluation samples of 418 children and 1,745 children, respectively. These substantial samples for the CRT intervention allowed for robust statistical analyses regarding outcomes of safety and permanency.

The remaining three interventions in the Demonstration had varying levels of success in meeting the targeted number of children, with sample sizes ranging from 26 children in the Wrap sample on Hawai‘i Island to 151 children in the IHBS sample on O‘ahu. Most evaluation samples were ultimately less than half of the expected sample size. This affected the ability of the evaluation to (1) form comparable comparison groups and (2) perform robust statistical analyses.

Defining Key Practice Constructs

The eligibility criteria for each of the four Demonstration interventions relied on identifying the presence of a specific condition for a child. For all interventions, these were a key criterion in determining eligibility for that intervention.

CRT: Child is at imminent risk of placement

IHBS: Child is at imminent risk of placement

Wrap: Child is likely to reunify

SPAW: Child is unlikely to reunify

None of these conditions were clearly identified in the assessment tools at the beginning of the Demonstration. The Evaluation Team participated in many discussions with intervention

Workgroups and the Steering Committee over the course of the Demonstration to better define and operationalize each of these criteria, but the definitions were never resolved.

Ultimately, the Evaluation Team utilized the existing assessment item of Imminent Risk of Harm as a proxy for imminent risk of placement, with some additional post hoc analyses identifying correlates of risk of placement (discussed elsewhere in this *Report*). The Evaluation Team found no key correlates in the state data provided to use as proxies for a child or youth being likely or unlikely to reunify.

The absence of clearly specified definitions of these key criteria for disposition to CRT or referral to IHBS, Wrap, or SPAW, made the identification of comparison groups highly challenging.

Low Completion Rates for the *Child and Adolescent Needs and Strengths* (*CANS*)

As is discussed later in this *Report*, the *Child and Adolescent Needs and Strengths* was modified for, and introduced to, the Hawai'i Child Welfare Branch at the beginning of the Waiver Demonstration. Completion of the *CANS* was limited to those children and youth who were referred for either Wrap or SPAW services, and was to be completed for each child or youth at least twice: once, at referral to Wrap or SPAW ("Initial *CANS*"), and again, at the completion of the Wrap or SPAW intervention ("Final *CANS*"). This was the sole measure of child well-being available to the evaluation of the interventions of Long-Stayers in the Demonstration.

Uptake of the *CANS* was low in the first year of the Demonstration, and did not improve over time. Completion rates were low for the Initial *CANS*, and lower still for the Final *CANS*. This constrained the evaluation's ability to measure improvements in child well-being for Long-Stayer children and youth.

Information Technology Challenges

IT challenges were one of the most significant challenges affecting both the implementation and evaluation of the Waiver Demonstration. As noted elsewhere in this *Report*, the Waiver Demonstration was the first extensive process, outcome and cost analysis of Child Welfare Services in Hawai'i. Up until the Waiver Demonstration, a small number of key pieces of information about a child/family/case were required to be entered into the CPSS administrative data system, and periodic reviews of data quality in case records found many errors in data entry and a lack of timely data entry. Similarly, the SHAKA data interface allowed for assessments and case notes to be logged online, rather than on paper, but caseworkers usually had discretion about the format (online versus paper) that they preferred to use.

Upon the implementation of the Waiver Demonstration, child and case level data was routinely gathered by the Evaluation Team, and the first year of the evaluation process identified a great deal of missing information. Given that data entry for many of the data fields used in the evaluation had not been required before the Waiver Demonstration, missing and incorrect data was not unexpected, but the amount of missing and incorrect data was high. The Evaluation Team had set up a schedule to collect data every six months throughout the Demonstration, on the cases served in the prior six months. This quickly evolved into collecting data on the cases served in the prior six months and re-collecting data on all Demonstration cases served before that period, after the Evaluation Team had communicated to CWS the specific cases with missing or incorrect data. Case-level data on all children served by the Waiver Demonstration for the first three years of the Demonstration was therefore extracted and analyzed multiple times, with different outcomes each time. This substantially hampered the ability of the Evaluation Team to provide timely feedback on the successes and challenges of the Demonstration interventions.

Cost Study Limitations

There are several limitations to the cost study. The cost study originally intended to show expenditures by location (i.e. island) for the Waiver interventions and systems level spending. However, the Wrap and SPAW expenditures are under single contracts, and tracking these expenditures by location was not feasible. Additionally, the IHBS expenditures are in contracts bundled with other services and it was not possible to separate IHBS specific spending. As a result, DHS has estimated the amount of the bundled contract associated with IHBS for each year of the Waiver demonstration. The cost study was also not able to identify IV-E administrative expenditures. Accordingly, analysis of spending under the capped allocation is based on the IV-E maintenance expenditures only, not including IV-E administration. Finally, the unit cost analysis of out-of-home care is based on room and board payments that are clearly identifiable in the expenditures data, and does not include difficulty of care payments or the clothing allowance.

Data Quality and Communications

Underlying Principles of the Evaluation Plan
Strategy #1: Explaining the Goals of the Evaluation
Strategy #2: Creating a Visual Map of Problem Areas in Data Entry
Strategy #3: Making Data Entry Meaningful

DATA QUALITY AND COMMUNICATIONS

As a Title IV-E Waiver state, Hawai‘i was required to contract with an external evaluator at the start of the Waiver Demonstration planning process. Due to the complexity of the data systems and the timing of the Initial Design and Implementation Report (IDIR, 2014), the evaluation plan was built around the state's assessment of available data. The Waiver Demonstration was the first substantial effort by the state to use caseworker-recorded administrative data to evaluate in-house and Purchase-of-Service services over multiple years, so there were legitimate concerns about the quantity and quality of the data provided for this evaluation.

Once the Waiver was approved, the Evaluation Team began meeting with state and private provider data managers to learn about the data systems, and associated challenges and opportunities. It became obvious early in this process that the complexity of the state data systems and the sheer volume of missing and incorrect data would necessitate a more proactive and hands-on approach to data collection. The Team began to create and refine a data collection strategy that evolved over the course of the Waiver Demonstration. The design of these strategies was informed by adult learning theory and also by the application of an Implementation Science framework (Metz, Naoom, Halle, & Bartley, 2015).

The main challenge for Hawai‘i is that the Child Welfare Services Branch (CWS) of the Hawai‘i Department of Human Services (DHS) is still in the early stages of CCWIS development and therefore relies on two separate non-SACWIS Administrative Data Bases (ADBs). The task of the Evaluation Team was further complicated due to the necessity of incorporating administrative data from two additional Purchase of Service provider ADBs in order to compile a comprehensive data set for the Demonstration evaluation.

The state keeps administrative data in two databases: the CPSS (Child Protective Services System) database and the SHAKA (State of Hawai‘i Automated Keiki Assistance System) database. The evaluation also utilized two Purchase of Service provider databases: the IHBS HOMEBUILDERS database (called ODM in this document) and the EPIC database (called EPIC in this document).

Many of the challenges discussed in this chapter are specific to ADBs in the state of Hawai‘i and not ones that are likely faced by most states using a SACWIS or CCWIS ADB. However, the most effective solutions we found to address the challenges in Hawai‘i are ones that can be utilized to improve data availability and quality in any jurisdiction regardless of the system in question. The following chapter explores the journey the Evaluation Team underwent to identify and implement these solutions.

Underlying Principles of the Evaluation Plan

The Waiver Demonstration evaluation plan was created with three underlying principles: to (1) communicate clearly, (2) utilize the existing data infrastructure whenever possible, and (3) make data useful. A recent catalog compiled by Casey Family Programs (Roberts, Killos, Maher, O'Brien, & Pecora, 2017) affirms the effectiveness of these principles for promoting research use in child welfare agencies. The application of these three principles in the Hawai'i Waiver Demonstration evaluation are discussed here.

Communicate Clearly

This principle recognized that the Waiver Demonstration evaluators did not just have a responsibility to report on the Waiver Demonstration's progress and effectiveness to the state and the Children's Bureau. The evaluators viewed themselves as partners with the State of Hawai'i to provide feedback and empirical data that the state could use to improve services to children and families. Accomplishing this goal required that the evaluators prioritize clear communication with staff at all levels of CWS.

Utilize the Existing Data Infrastructure Whenever Possible

The second principle recognized that line staff, supervisors, and administrators all have heavy workloads and overwhelming amounts of paperwork. The goal of the Evaluation Team was to utilize existing data points whenever possible to complete the evaluation. When those data points did not exist, the Team's goal was to collect data in a way that added the least amount of paperwork/data entry as possible. By committing to keep additional work to a minimum, the Evaluation Team hoped to create buy-in amongst the staff at CWS.

Make Data Useful

By making data useful to staff, supervisors and administrators, the Evaluation Team sought to provide staff with real-time empirical feedback on the new practices, allowing staff to see the results of these new innovations and to increase buy-in and motivation for the Demonstration. The adoption of this principle also fit within the Implementation Science framework (Metz, *et al*, 2015) that informed the process evaluation. In this framework, data and feedback loops are a core component in the implementation process and are essential for continuous quality control, identifying barriers, and making decisions about changes and modifications throughout the implementation process. This is the lens through which the evaluator's data collection and data quality efforts were approached.

Applying the Guiding Principles

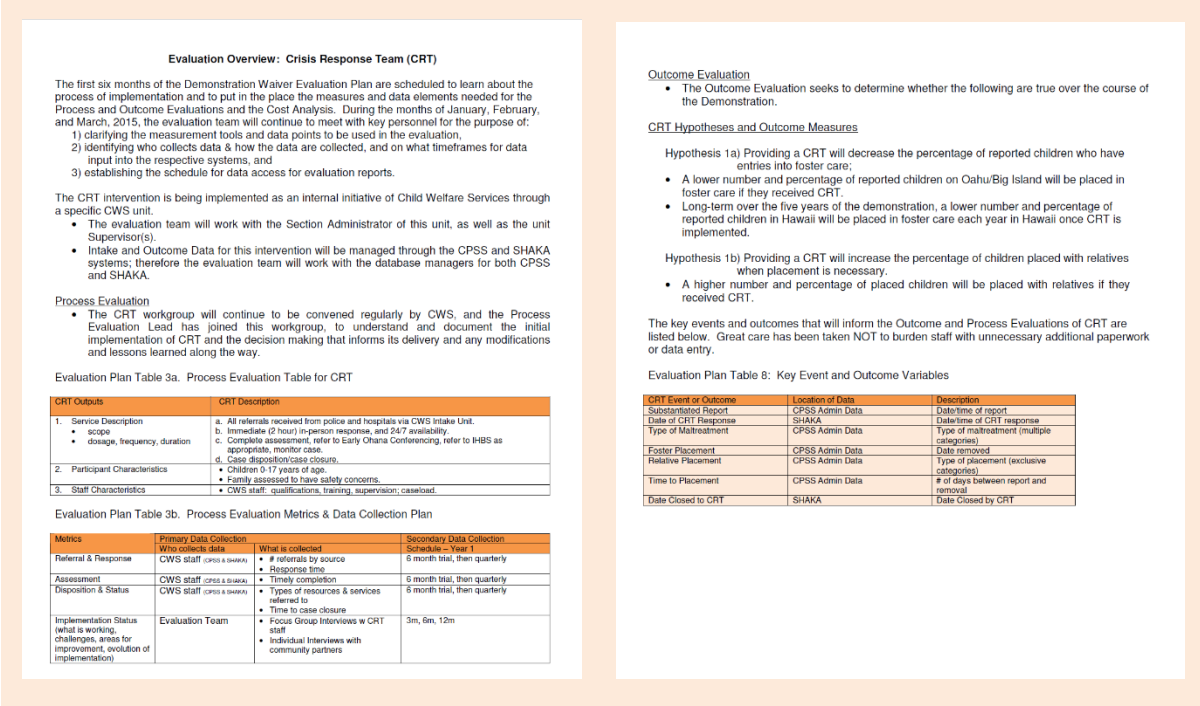
Applying the guiding principles required the evaluators take a proactive role in the Waiver Demonstration. With the state and provider data merged into a single database, Waiver and child welfare leadership could begin to examine the practices and procedures implemented during the Waiver Demonstration in ways not previously available to them. Therefore, the Evaluation Team allocated significant resources, both in personnel and time, towards finding solutions to the data challenges facing the Waiver Demonstration. A series of successive strategies were employed, each built upon the next, resulting in increased success in obtaining the data necessary to conduct the evaluation. These strategies are easily replicated in other child welfare organizations, and are described here.

Since database system challenges were identified in the initial plan for the Waiver Demonstration (IDIR, 2014) and meetings with DHS, the Evaluation Team focused on identifying solutions to mitigate those challenges and create a fully functional evaluation database. To do this, the team developed and implemented two main strategies in the first year of implementation. Both strategies were designed with the underlying principles in mind and were aimed at mitigating the identified data challenges. Despite some success, the strategies failed to fully address the issue of data quality. A shift in thinking about the problem led to the development of a third, more successful strategy. The three strategies and their outcomes are described here.

Strategy #1: Explaining the Goals of the Evaluation

The first strategy was to create a two-page document ("Two-Pager") that provided an overview of the evaluation plan for each of the four Hawai'i Waiver Demonstration interventions. Examples pertaining to the CRT intervention will be utilized throughout this report.

The Two-Pagers were text-based and very detailed; the evaluators hoped to provide readers with a thorough understanding of the evaluation plan (See Figure 11). The goal was to help practitioners and stakeholders understand the data needs of the Evaluation Team, and to improve data entry practices. These Two-Pagers (1) explained the process of the evaluation, (2) outlined the research questions and hypotheses, and (3) summarized the type of outcome metrics that would be needed. These documents were created in February 2015, at the beginning of the Demonstration, and presented to members of the Waiver Demonstration steering committee, who then disseminated them throughout CWS and partner agencies. In conjunction with the Two-Pagers, the Evaluation Team worked extensively with the ADB managers, CWS administrators, supervisors, and workgroup leads to understand each intervention, its workflow, and how that mapped to the data that would be needed for the evaluation.



Evaluation Overview: Crisis Response Team (CRT)

The first six months of the Demonstration Waiver Evaluation Plan are scheduled to learn about the process of implementation and to put in the place the measures and data elements needed for the Process and Outcome Evaluations and the Cost Analysis. During the months of January, February, and March, 2015, the evaluation team will continue to meet with key personnel for the purpose of:

1) clarifying the measurement tools and data points to be used in the evaluation,
2) identifying who collects data & how the data are collected, and on what timeframes for data input into the respective systems, and
3) establishing the schedule for data access for evaluation reports.

The CRT intervention is being implemented as an internal initiative of Child Welfare Services through a specific CWS unit.

- The evaluation team will work with the Section Administrator of this unit, as well as the unit Supervisor(s).
- Intake and Outcome Data for this intervention will be managed through the CPSS and SHAKA systems; therefore the evaluation team will work with the database managers for both CPSS and SHAKA.

Process Evaluation

- The CRT workgroup will continue to be convened regularly by CWS, and the Process Evaluation Lead has joined this workgroup, to understand and document the initial implementation of CRT and the decision making that informs its delivery and any modifications and lessons learned along the way.

Evaluation Plan Table 3a. Process Evaluation Table for CRT

CRT Outputs	CRT Description
1. Service Description • scope • dosage, frequency, duration	a. All referrals received from police and hospitals via CWS Intake Unit. b. Immediate (2 hour) in-person response, and 24/7 availability. c. Complete assessment, refer to Early Ohana Conferencing, refer to IHBS as appropriate, monitor case. d. Case disposition/case closure.
2. Participant Characteristics	• Children 0-17 years of age. • Family assessed to have safety concerns.
3. Staff Characteristics	• CWS staff: qualifications, training, supervision; caseload.

Evaluation Plan Table 3b. Process Evaluation Metrics & Data Collection Plan

Metrics	Primary Data Collection		Secondary Data Collection
	Who collects data	What is collected	Schedule – Year 1
Referral & Response	CWS staff (CPSS & SHAKA)	• # referrals by source • Response time	6 month trial, then quarterly
Assessment	CWS staff (CPSS & SHAKA)	• Timely completion	6 month trial, then quarterly
Disposition & Status	CWS staff (CPSS & SHAKA)	• Types of resources & services referred to • Time to case closure	6 month trial, then quarterly
Implementation Status (what is working, challenges, areas for improvement, evolution of implementation)	Evaluation Team	• Focus Group Interviews w CRT staff • Individual Interviews with community partners	3m, 6m, 12m

Outcome Evaluation

- The Outcome Evaluation seeks to determine whether the following are true over the course of the Demonstration.

CRT Hypotheses and Outcome Measures

Hypothesis 1a) Providing a CRT will decrease the percentage of reported children who have entries into foster care;

- A lower number and percentage of reported children on Oahu/Big Island will be placed in foster care if they received CRT.
- Long-term over the five years of the demonstration, a lower number and percentage of reported children in Hawaii will be placed in foster care each year in Hawaii once CRT is implemented.

Hypothesis 1b) Providing a CRT will increase the percentage of children placed with relatives when placement is necessary.

- A higher number and percentage of placed children will be placed with relatives if they received CRT.

The key events and outcomes that will inform the Outcome and Process Evaluations of CRT are listed below. Great care has been taken NOT to burden staff with unnecessary additional paperwork or data entry.

Evaluation Plan Table 8: Key Event and Outcome Variables

CRT Event or Outcome	Location of Data	Description
Substantiated Report	CPSS Admin Data	Date/time of report
Date of CRT Response	SHAKA	Date/time of CRT response
Type of Maltreatment	CPSS Admin Data	Type of maltreatment (multiple categories)
Foster Placement	CPSS Admin Data	Date removed
Relative Placement	CPSS Admin Data	Type of placement (exclusive categories)
Time to Placement	CPSS Admin Data	# of days between report and removal
Date Closed to CRT	SHAKA	Date Closed by CRT

Figure 11. CRT Two Pager

Outcomes

By using the Two-Pagers as a starting point for collaborations with ADB managers, CWS leadership, and Demonstration workgroups, the Evaluation Team was able to design and implement a data protocol to extract, match, and merge data from the DHS and private provider ADBs to create a comprehensive evaluation database. The steps for doing so are detailed here.

Mapping the CWS Data Systems

The following section provides a general overview of the Waiver Demonstration data systems followed by a discussion of specific metrics extracted from those data systems.

As mentioned earlier, CWS keeps case-level administrative data in two non-SACWIS ADBs called CPSS and SHAKA. The two ADBs house different types of data pertaining to each client and serve slightly different purposes, making data entry cumbersome, time-consuming, and sometimes redundant. The more significant challenge is that the while the data eventually coincide, they are not actively linked in such a way that allows for case workers, administrators or evaluators to easily match live data between the two systems to tell the entire "story" of a case. There are limited options for caseworkers to review or explore data about their case load in any meaningful way; without reporting functions, caseworkers must move screen by screen in each ADB to find information about a client. The inability to extract a complete case record

on even a case-by-case basis is compounded and magnified when trying to extract data on multiple cases for purposes such as supervision, quality assurance, and evaluation.

The CPSS database is the official data system for case management and case payments for the state of Hawai'i. CPSS includes data on all children and families served by CWS, with regard to demographic characteristics, maltreatment reports and intake information, legal status and case dispositions, placements and placement changes, and all relevant dates of events. This database has not been modified in any significant way in recent years, and is therefore a consistent source of data on intake characteristics and outcomes for all children in the Waiver Demonstration and in the comparison groups. The CPSS database contains data on each individual (children and adults) served by CWS. New Service Action Codes (SACs) were created in CPSS to identify individuals who received Waiver interventions. Individuals are identified by a Client ID number (unique) and a Case ID number (the same number assigned to each member of a family). Reports of maltreatment are stored in the CPSS Intake subsystem and are assigned an Intake number that is linked to a particular case or client. Therefore, CPSS data is extracted at the child level. Client ID number is the primary key used by the CPSS data system.

The SHAKA database was developed by DHS more recently and is intended to be more user-friendly for caseworkers. This interface allows caseworkers to record and store contact log information as well as safety assessments and other assessments. The SHAKA developers also created an interface for the providers of the SPAW intervention as its primary data collection and storage site. In addition, the SHAKA database developers added a few new fields for the Waiver Demonstration evaluation of all four interventions. The SHAKA database stores data in several different ways. Intake data on reports of maltreatment are identified in SHAKA by the CPSS Intake Number which is a case-level (i.e., the same for all members of a family) identifier. There is an option to also record the CPSS Case ID number in the record, but this field is not consistently utilized. Therefore, data regarding CRT and IHBS cases are identified primarily by Intake number and any data collected in the SHAKA system is at the family-level (i.e., case-level). Alternatively, data related to the SPAW and Wrap interventions are identified by both CPSS Client ID number (child level) and CPSS Case ID number (family-level). CPSS Intake number is the primary key used in the SHAKA system for Short-Stayer intervention participants and Client ID number is the primary key used in the SHAKA system for Long-Stayer intervention participants.

The Institute for Family Development, creator of the IHBS HOMEBUILDERS model, requires that providers use their in-house ADB. At the start of the Demonstration the intervention used the Online Data Management (ODM) database. In early 2018, HOMEBUILDERS transitioned to a new ADB called Exponent Case Management (ECM). As the same data was extracted from each, this report will use the ODM acronym when referring to the IHBS HOMEBUILDERS ADB. This database contains all case information, including assessments, case goals and goal achievement, parent satisfaction, and immediate outcomes, and is used on both O'ahu and Hawai'i Island. The ODM system assigns a unique identification number to each family served by IHBS. In the first year of implementation, the Evaluation Team requested that ODM

managers add a field for CPSS Case ID number to be entered. Data in ODM is collected at the family level and the CPSS Case ID number is the primary key used by the Evaluation Team.

The Wrap intervention is provided by EPIC ʻOhana and uses its own EPIC database (called EPIC in this document) to track characteristics of children, family, assessments and services for the Wrap intervention on both Oʻahu and Hawaiʻi Island. The EPIC system assigns a unique identification number to each child that receives the Wrap Intervention. EPIC also collects the CPSS Client ID number for all clients and has included that field in the evaluation data extraction. Data in EPIC is collected at the child level and the CPSS Case ID number is the primary key used by the Evaluation Team.

Identifying Challenges Related to the State CPSS and SHAKA Databases

A significant step forward in the evaluator's work with the state was the identification of specific challenges to merging data from the multiple ADBs. This knowledge then allowed the Team to work with the Data and Evaluation Workgroup to create efficient and workable solutions. Those challenges are discussed below.

Child-level versus case-level data. The CPSS database contains data on each child served by CWS. Children are identified by a Client ID number (unique) and a Case ID number (the same number assigned to each member of a family/case). Reports of maltreatment are stored in the CPSS Intake subsystem and are assigned an Intake number and linked to a particular case or client. Therefore, CPSS data is extracted at the child level. Client ID number is the primary key used by the CPSS data system. The SHAKA database stores data in several different ways. Data on reports of maltreatment are identified by the CPSS Intake Number. There is an option to also record the CPSS Case ID number in the record, but this field is not always utilized. Therefore, data regarding CRT and IHBS cases are identified primarily by Intake number and any data collected in the SHAKA system is at the family-level (i.e., case-level). Alternatively, data related to the SPAW and Wrap interventions are identified by both CPSS Client ID number and CPSS Case ID number. CPSS Intake number is the primary key used in the SHAKA system for Short-Stayer intervention participants and Client ID number is the primary key used in the SHAKA system for Long-Stayer intervention participants.

Multiple and separate reports of maltreatment may be recorded using the same Intake number. Although separate maltreatment reports for the same child may be received days or even years apart, a unique Intake number is not assigned to these separate reports in CPSS. Instead, the Intake number can be used for a child/case over several Intake events, and separate reports with the same Intake number are thus identified by the date of report in the CPSS Intake Subsystem. This convention created a significant challenge for the Evaluation Team because, as mentioned in the challenge above, Intake number is a primary key used to identify Short-Stayer participant data in the SHAKA database. In order to correctly match records from the CPSS and SHAKA systems, Client ID number, Intake number and Date of Complaint must all be matched correctly in order to create a complete record in the evaluation data set.

Manual entry of primary key data fields (e.g., case or client ID#, dates). As mentioned above, there are several key data fields required to accurately match and merge records between CPSS and SHAKA for Short-Stayer intervention participant data. Another challenge to this process is that these key data fields are entered manually into each database by case workers and social service assistants (SSAs). Anytime data is incorrectly entered (e.g., a typographical error), the Evaluation Team is then unable to complete a match between the two databases. The case must either be excluded from the evaluation data set, or manually investigated by the Evaluation Team to identify a match.

The need to identify Waiver Demonstration cases in the two databases. Although the state had identified the need to identify Waiver Demonstration participants in the two databases, this task had not been completed at the time that implementation began. Through consultation with the evaluators and ADB managers, CWS finalized procedures pertaining to the use of four Service Action Codes (SACs) that would be used in CPSS to identify Waiver Demonstration cases by February, 2016. At that time, it was also decided that because CPSS serves as the main administrative database for CWS, only cases correctly identified with a Waiver SAC would be included in the evaluation. CWS then tasked supervisors to work with staff to enter these SACs for cases served prior to February, 2016 and to ensure that the Waiver SACs were then entered for new cases.

Dynamic database systems and data fields. The final challenge in this area is that both the CPSS and SHAKA databases are dynamic and the data contained in many fields can and does change over time, and overwrites previous entries. For example, at the time of a maltreatment report, a particular child may not be identified as a victim. However, as the case progresses (or if another report of maltreatment is made) the child may be identified as a victim at a later time and the victim status associated with the child's record in CPSS is then changed (i.e., overwritten). All data extracted from the CPSS and SHAKA systems are "point-in-time" data and represent the child or family's status at the particular point in time that the data is extracted (as opposed to the status at the time of the report of maltreatment). This presents a challenge because data extracted at two different points in time may differ significantly depending on the changes in the case between the two data extraction dates.

Identifying Challenges Related to the Use of Private Provider Databases

In general, the private providers have well-designed data systems and make accurate and timely data entry a priority. However, there were some adjustments that had to be made for the Waiver Demonstration to ensure that the Evaluation Team would be able to accurately match provider records to those of the state.

Ensuring that provider data entry included use of CWS client or case identifiers. Each Purchase of Service provider assigns their own case number for a case, has their own definitions for various data fields and/or may identify different children as the target of the intervention for

therapeutic purposes. The Evaluation Team worked with both HOMEBUILDERS and EPIC 'Ohana to modify their databases to include additional identifying information for cases for the evaluation (i.e., CPSS Client or Case ID number) and to crosswalk definitions and terms between databases.

Creating a Protocol for Matching Data between the ADBs

Once the data needs for the evaluation were mapped to the data available in the four ADBs and the challenges associated with the data were identified, the Evaluation Team collaborated with the members of the Data and Evaluation Workgroup to create a comprehensive evaluation data request for each database. Data for each child and family served by each intervention for each child and family served by each intervention were extracted from CPSS, SHAKA, ODM, and EPIC databases by the Evaluation Team for statistical analysis every six months.

A significant challenge for the Evaluation Team was to match case data between the various ADBs. Key data fields in each ADB were identified that would allow the evaluators to most accurately match data from the various systems. An evolving protocol allowed the Evaluation Team to create a single database, which continued to improve in accuracy with each data extract. In the first two years of the Demonstration, the Evaluation Team extracted data on ALL Waiver Demonstration participants every six months (therefore re-pulling data on participants in the first year of the Demonstration several times, as data errors were made known to CWS and corrected).

A detailed Data Management Protocol is available from the authors. Data from each database was extracted every six months throughout the Demonstration, manual verification processes were conducted to identify data errors preventing a correct match/merge of case data on Waiver participants, errors were individually checked with CWS administrators and caseworkers, and case data were re-extracted once corrections were made. If the Evaluation Team had used probability matching instead of this manual process, the resulting evaluation data set would be much smaller and less reliable. The process of verifying and merging the data is complex and a time-consuming endeavor for everyone, but ultimately results in a more comprehensive database.

Remaining Challenges

While the problem of extracting and matching the data was resolved, a new problem arose. The majority of Demonstration cases were not in the evaluation database because key identification variables and other vital case information were either (1) inaccurately entered into the systems or (2) were not being entered at all. Due to these problems, the Evaluation Team was not able to correctly identify Waiver participants in either ADB and had difficulty extracting the necessary data. The specific data entry challenges that were identified by the evaluators were:

Lack of knowledge about new and updated data fields. In order to complete a thorough evaluation of the Waiver Demonstration, both CPSS and SHAKA database managers had to create new codes, update data fields and create new data fields. All CWS staff needed to be informed of and trained to use these new data fields correctly.

Lack of knowledge about the correct usage of data fields that have evolved over time. Some data fields used in the evaluation were originally created for a specific purpose, but the use of these fields has evolved over time. An excellent example is the use of Service Action Codes (SACs). SACs were originally used for billing purposes and entered into CPSS to initiate and authorize payment for services. However, over time, these codes were also used to track any placement, paid or unpaid, in which CWS placed a child. For the Waiver Demonstration, SAC codes were also used to identify Waiver clients. After reviewing the September 2016 data extraction, it came to the attention of both the evaluators and CWS leadership that workers entering data had different understandings about when and why to enter SACs into CPSS and that re-training on the use of these codes was necessary.

Delayed and inaccurate data entry. Perhaps the biggest challenge to the evaluation was delayed and inaccurate data entry by CWS staff. Large caseloads, increased assessment responsibilities, aging hardware, complex and slow data systems and occasional lack of internet accessibility in the field all contributed to the problem.

The lack of adequate case data severely hindered the evaluators' ability to provide actionable data to inform the implementation of the Demonstration interventions and provide caseworkers valuable insights into their own practice. A new strategy was needed to motivate CWS staff to enter the data accurately and in a timely manner.

Strategy #2: Creating a Visual Map of Problem Areas in Data Entry

The next strategy employed was incorporating graphics to supplement the Two-Pagers previously distributed. The goal of this strategy was to inform stakeholders (i.e., administrators, supervisors and caseworkers) of the problem areas in data entry. To do this, the Evaluation Team created "traffic maps" that illustrated data entry problems within the intervention workflow processes (see Figure 12). These visual traffic maps identified the necessary data, and how missing and incorrect data posed challenges to the evaluation. A traffic map was created for each Demonstration intervention; the CRT traffic map is presented here as an example. The traffic maps were presented to Waiver administration and supervisors at a monthly Waiver Demonstration meeting in January 2016.

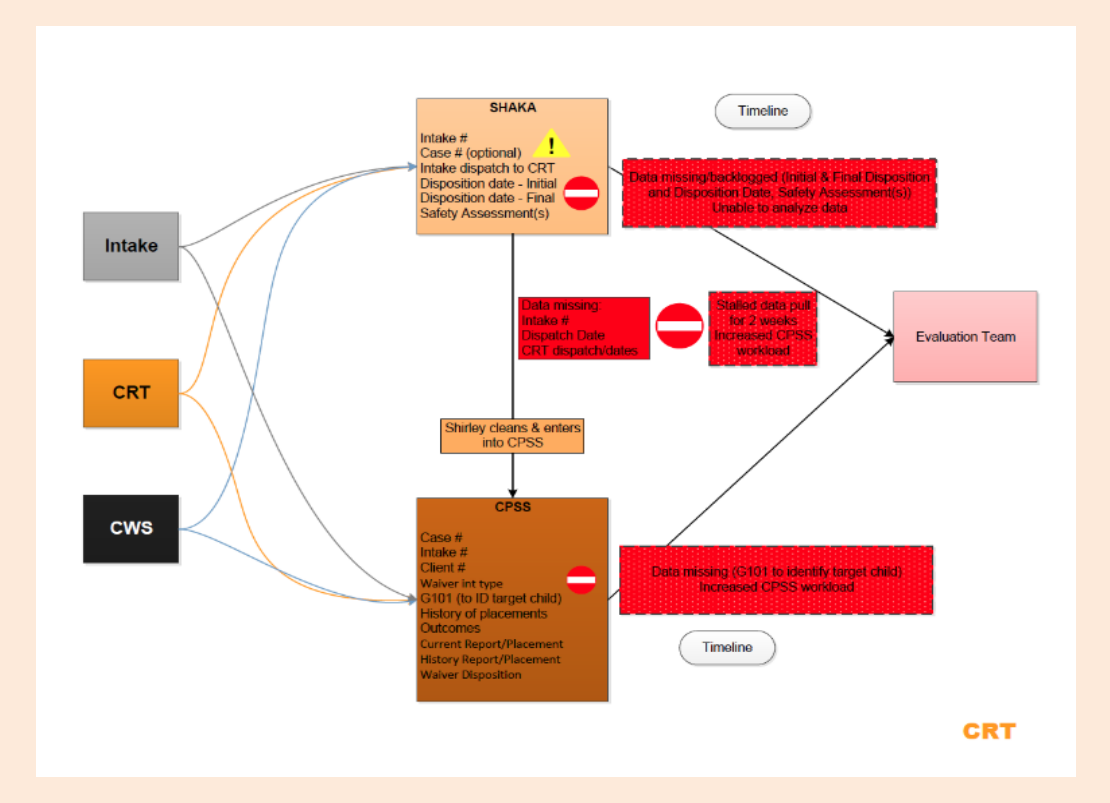


Figure 12. CRT "Traffic Map"

Outcome: Positive Reaction but No Practice Change

Response from CWS and Demonstration Leadership to the graphic portrayal of the challenges was positive. Feedback from the steering committee indicated the traffic maps helped clarify where data entry practices needed to improve (personal communication, 2016). Following the presentation of the traffic map graphics, the steering committee members committed to working with CWS staff to ameliorate the identified problems. Unfortunately, there was no corresponding improvement in data entry.

Despite the lack of improvement, the evaluators continued to create solutions to ensure cases were included in the evaluation sample. As mentioned previously, case data was extracted from the ADBs every six months. The case data for children served in the first three years of the Demonstration was extracted multiple times, at each six-month extraction. After each data extraction, the Evaluation Team would communicate with DHS supervisors and providers about possible missing or incorrect data for individual cases, allowing staff to correct case data prior to the next, redundant, extraction. This process was incredibly detailed and time consuming but without it, the evaluation sample would be much smaller than it ultimately was. This continued challenge led evaluators to rethink the strategies aimed at solving the data challenges.

The true problem was that caseworkers, the people doing the work, did not understand *why* the lack of data entry was such a problem and *how* it related to their work. Caseworkers, of course, were not prioritizing solving the problems of the evaluators. Despite figuring out how to match case data between the two databases, individual barriers (people/knowledge) still prevented the Evaluation Team from being able to obtain the necessary data.

Strategy #3: Making Data Entry Meaningful

After reviewing survey findings, focus group feedback, and personal communications, the Team realized that caseworkers and social service assistants lacked a "big picture" understanding of the Waiver Demonstration and its benefits, as well as an understanding of how their work fit into that picture. The strategies employed to this point, which focused on fixing problems in the data systems, were ineffective at motivating change because they failed to help front line workers understand the importance of data to their work and to the success of the Demonstration and child welfare services in general. The goal of the evaluators became to improve data accuracy and timeliness of entry. The strategies employed to this point were ineffective at motivating change and new strategies would have to be put into place. New strategies would not simply need to communicate what needed to get done, but also needed to address (1) caseworker's roles in the success of each intervention and the Waiver Demonstration as a whole, (2) why data entry is important – to children and families, the organization and to their own professional lives, and (3) specific actions caseworkers could take to help.

To this end, the Evaluation Team formulated a two-part strategy to accomplish this goal. The first part of the communication strategy involved the design and dissemination of four informational documents, one for each Waiver Demonstration intervention, referred to as the "One-Pagers." The second part of the strategy involved the creation of online "Action Plan" tools to help staff quickly identify missing and incorrect data in the CWS ADBs. The evaluators also designed and disseminated training materials on the use of these tools and Waiver Demonstration data entry procedures. The training materials included a PowerPoint presentation and PDF "cheat sheet" to support accurate and timely data entry.

One-Pagers

The first piece of the strategy was infographic "One-Pagers" developed by the Evaluation Team[1] (See Figure 13). These were distributed to all child welfare caseworkers and Purchase-of-Service providers who might encounter a Waiver Demonstration case or a potential case. The purposes of the One-Pagers were four-fold: to (1) explain the goals and objectives of each Waiver Demonstration intervention, (2) explain how the intervention would benefit *both* children/families *and* caseworkers, (3) provide some early outcome feedback about the success

[1] While the One-Pagers appear to cover two pages, they are printed on one double-sided page.

of the intervention, and (4) provide simple, clear and visual instructions about what evaluation data to enter and in which database.

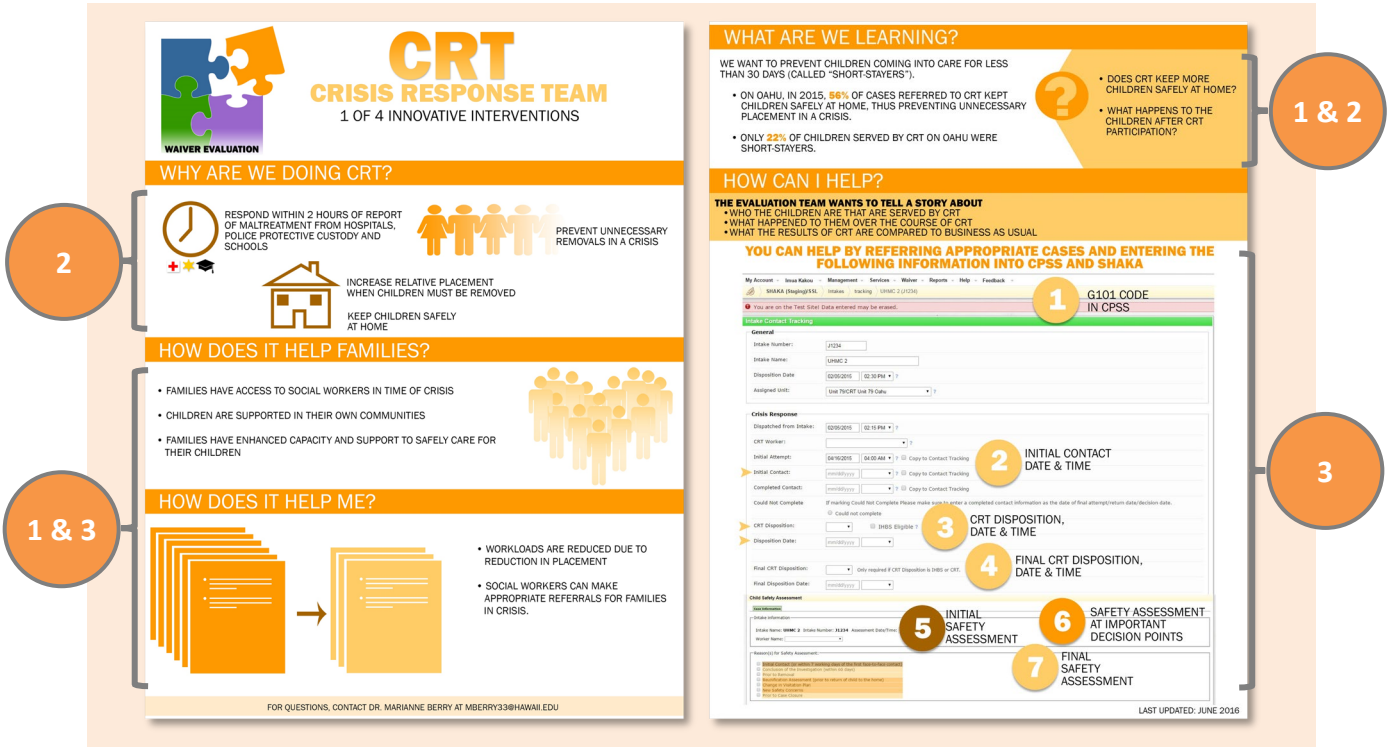


Figure 13. CRT One-Pager

These documents were designed using the principles of adult learning theory to best convey the message. Adult learning theory also aligned with the original guidelines for the evaluation: (1) communicate clearly, (2) utilize the existing data infrastructure whenever possible and (3) make data useful. The decision was made to use infographics as the primary communication tool in the design of the One-Pagers. The graphic aspects of the traffic maps in Strategy #2 were well received, and research demonstrates the effectiveness of infographics as a strategy for improving information retention and comprehension (Bateman et al., 2010; Borkin et al., 2016; Otten, Cheng, & Drewnowski, 2015; Pecora, 2017; Roberts et al., 2017). The design of the One-Pagers also used the feedback from the field to better define the audience for the materials and applied adult learning theory to inform the selection of information included.

Adult learning, as conceptualized in Knowles' (1984) *Theory of Andragogy*, capitalizes on the rich life experiences of adults as a resource and motivating factor in the learning process, and respects adults as self-directed learners. Knowles posited six assumptions of adult learners that should guide the design of adult learning materials and experiences: (1) the learner's need to know, (2) self-concept of the learner, (3) prior experience of the learner, (4) readiness to learn, (5) orientation to learning, and (6) motivation to learn.

Specific aspects of adult learning that informed the design and use of the one-pagers were (Highlighted in Figure 13; Knowles, 1984):

1. Learner's need to know: The materials should convincingly argue the value of data entry to the individual's performance. The One-Pagers specifically addressed this by highlighting how the intervention itself helps families and helps caseworkers.
2. Prior experience of the learner: Respect the variety of experience that participants possess and will utilize these experiences as resources in the learning process. The one-pagers built upon the questions that CWS line staff expressed in data entry training sessions, focus groups, and interviews about how the Demonstration interventions fit with the work and processes they were already familiar with. They provided information that staff felt had not been provided to them in a format that would be accessible given their workload/busy schedules. The one-pagers were designed to be practical and problem-centered to help case workers to connect the new information to their current practice.
3. Readiness to learn: Adults are ready to learn behaviors, ideas, and tasks that will enable them to better cope with the situations they encounter within their daily lives. The back of the one-pager provided a simple "cheat sheet" to remind them what needs to be done to effectively enter data.
4. Orientation to learning: Adults tend to be task-, problem-, and life-centered in their orientation to learning. They are motivated to learn those things that they perceive will help them to increase their performance and competency at important life tasks. The one-pagers provided information to caseworkers about how the intervention will directly benefit them in their current positions.

The One-Pagers were distributed to all child welfare caseworkers involved in the Waiver Demonstration between June and September 2016. The Evaluation Team conducted site visits to CWS units and private providers to distribute and provide training to staff on the interventions and the required data entry, as outlined on the One-Pagers. Section administrators and CWS staff on O'ahu received the Action Plan Training (described next) first. Section administrators and supervisors were asked to distribute and review the One-Pagers at staff meetings or other appropriate venues.

Action Plans

The impact of the infographic One-Pagers was further enhanced by creating a reporting tool that merged information from both ADBs to enable caseworkers, supervisors, and administrators to easily view the key data elements required for the evaluation and identify and correct any missing or incorrect data. As the SHAKA database was more user-friendly, the SHAKA database manager proposed creating a tracking list for all clients involved in the Waiver Demonstration. Because the two ADBs are not actively linked, the evaluators worked closely with SHAKA programmers to ascertain what data from the CPSS database would be necessary to create this list. "Action Plans" were created for each intervention based on the key data fields identified in the One-Pagers. The plans identified clients by CPSS Case or Client ID number (depending on the intervention); displayed key dates; and displayed simple "Yes/No" indicators to identify whether or not key data fields were completed. These reports were called

Action Plans, clearly and visually identifying missing case data. The Action Plans could be filtered by section (region) and unit to allow supervisors and case workers to view only records pertinent to their section/unit. Links to the SHAKA database record allowed caseworkers to quickly access the client record to make corrections or fill in missing data fields. Reports could also be printed and/or downloaded to Microsoft Excel.

The Action Plans went on-line at the same time the One-Pagers were distributed, in June, 2016. Not only did the Action Plans give caseworkers and staff feedback on the data entry procedures outlined in the One-Pagers, but they provided a supervisory tool that created self-directed learning opportunities for staff around data entry and quality.

Training

The Evaluation Team met with each child welfare section on both O‘ahu and Hawai‘i Island to present both the One-Pagers and Action Plans, answer questions, and build relationships with line staff.

Outcomes

Changing the focus from data systems to people better addressed and began to mitigate the underlying challenge of data quality that is inherent in all data systems, including SACWIS and CCWIS. The Administration for Children and Families acknowledged this challenge in its Comprehensive Child Welfare Information System Final Rule (2016) by requiring states who opt to build a CCWIS to (1) develop and maintain a formal data quality plan to be included in the Annual or Operational Advance Planning Document submission and to (2) conduct biennial data quality reviews. Children’s Bureau Technical Bulletin # 6 (2018) identifies completeness, timeliness, and accuracy as the primary characteristics of data quality, noting further that “High-quality data allows the child welfare system to ‘tell the story’ of a child and their family” (Children’s Bureau, 2018). Although not an issue unique to child welfare services, the importance of data quality is frequently mentioned throughout the literature pertaining to the use of administrative data in child welfare research and evaluation.

In a recent study, Allard and colleagues (2018) interviewed over 100 human service agency staff and their data partners to better understand the realities of administrative data use. The authors note that, to this point, most discussion of data quality revolves around discussing the quality and pitfalls of administrative data with only brief discussions of the organizational capacities needed to address these challenges. However, their interview findings demonstrate that many human service agencies face similar challenges to those identified in this *Report*, particularly around data entry and organizational capacity. At the same time, while there is research that explores the assessment of organizational data capacity, there is little guidance on how to improve capacity beyond case studies of success stories that may be far beyond the capacity of most organizations. This lack of guidance or best practices for the improvement of organizational data capacity in the “real world” is demonstrated in the CCWIS Final Rule (2016).

While the Final Rule provides a framework for monitoring and assessing data quality, the guidelines do not provide concrete strategies to address the "human factor" in the data quality equation. The result is that child welfare agencies have little guidance on how to improve the quality of data entered into the system and must continue to address the issue by finding ways to correct for poor data quality after the fact. The Evaluation Team agrees with Allard and colleagues (2018) that the challenge of poor data quality is often only partially solved by changing the system. To truly address the issue, solutions must also attend to engaging Child Welfare Services staff and promoting a shift in attitudes toward data, resulting in behavior changes that improve data quality.

Changes in Attitudes and Knowledge about Data

When the Evaluation Team's strategies shifted from systems to people, there were a number of immediate, positive results. The response of staff and partner organizations to the One-Pagers and accompanying tools was very positive. In particular, staff noted that the One-Pagers gave them the ability to understand how all of the pieces of the Demonstration fit together, and the Action Plans were a convenient way to see their own data entry and make self-corrections (personal communication, August, 2017). Members of the SHAKA data team noted that the One-Pagers were, "one of the most effective handouts" produced to explain a CWS initiative and its data needs. The SHAKA team also indicated that they would use the One-Pagers in their own work to support improved data entry practices. Finally, both Purchase-of-Service contract providers and community partners had positive reactions to the One-Pagers. Feedback from interviews and focus groups was overwhelmingly positive and the most common reaction was that the One-Pagers provided a needed and useful means of understanding what the Waiver Demonstration was about and how all the pieces fit together. Providers particularly appreciated the "cheat sheet" portion of the One-Pagers because it allowed them insight into how their own data would match and supplement the administrative data collected by DHS.

Improvement in Data Quality and Availability

The changes in attitudes and understanding created opportunities for the evaluators to gain a deeper understanding about why the data entry problems were occurring and better information with which to create solutions. In the six-month data extraction immediately following Strategy #3, the Evaluation Team quickly identified missing data and section administrators were able to fix data problems by using the Action Plans. This resulted in faster turnaround on data corrections and a greater number of cases that could be included in the evaluation database. The tools were also used proactively prior to future data extractions to reduce the need to correct and re-extract data.

The Evaluation Team extracted data on Waiver Demonstration children every six months and records that did not meet baseline data quality requirements were excluded. Using CRT as an example, Figure 4.4 shows the differences between the number of children disposed to CRT, and the number of children who were ultimately included in the Waiver evaluation database.

For each reporting period, the green dot is the number of children reported by DHS, and the orange square is the number of children that were ultimately included in the evaluation sample. For a child to be included in the evaluation sample, critical data had to be entered into the appropriate databases, and redundant data had to match between databases. The Evaluation Team extracted data on Waiver children every six months, and did repeated data extractions for previous data periods, after reporting the cases with missing or incomplete data to DHS. In this way, the Evaluation Team was able to pick up children previously missed.

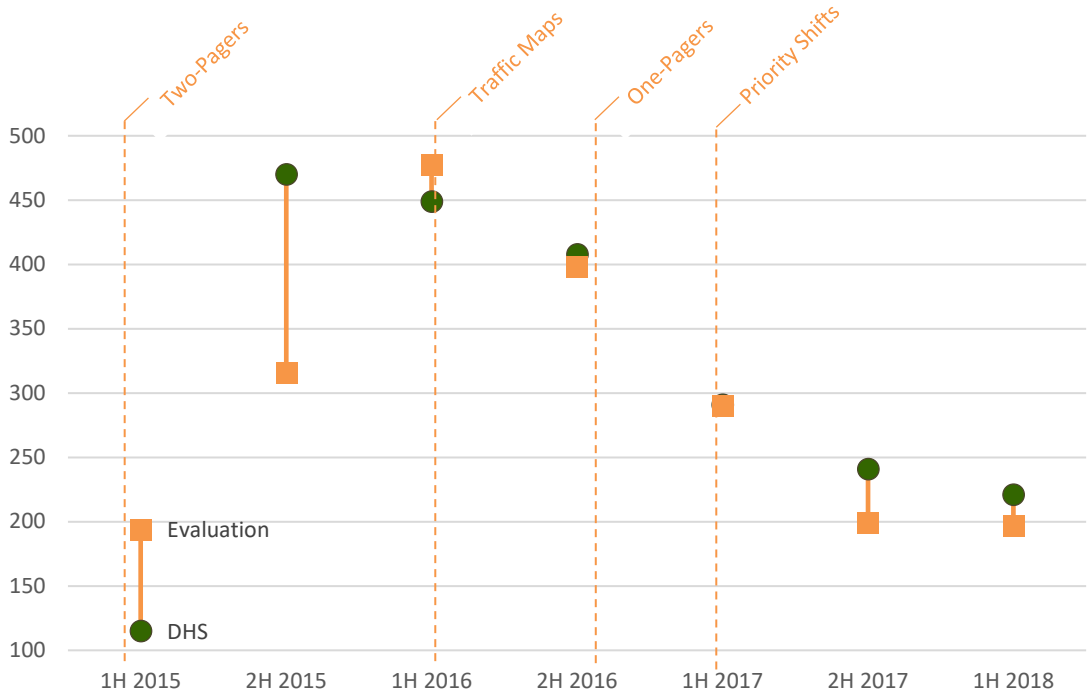


Figure 14. Number of Children Receiving a Crisis Response, DHS Counts versus Evaluation Sample

As seen in Figure 14, the discrepancies between the number of served children reported by DHS, and the number included in the evaluation sample varied greatly for all of 2015, despite the distribution of the Two-Pagers in February 2015. In January, 2016, the "traffic maps" were presented to Waiver Demonstration Leadership, and the identification of children served improved in that six-month period. However, the correct identification of children receiving the Waiver service was at its most accurate in the twelve months following June 2016. The second half of 2016 and the first half of 2017 produced the most accurate data entry in terms of identifying the children receiving the service and providing enough complete case data for the child to be included in the evaluation sample.

Creating a Comprehensive Database

The most significant outcome of this work was the construction of a Waiver Demonstration evaluation database that successfully combined data from the CPSS and SHAKA databases in ways that were not possible prior to the Waiver. Using the evaluation database, the team was able to "tell the story" of the Waiver Demonstration and the children and families it served. The database merges historical information about each child served by the Waiver with intervention data, child assessment data, and case outcome data. In the process, the Evaluation Team gained valuable insights into both data systems and how they coincide that can inform the development of the state CCWIS and hopefully be used to create a more complete system.

Supporting Data-Informed Decision Making

Finally, once a database was established, the evaluators had the ability to analyze the data to provide real-time feedback to CWS leadership on both the implementation of the Waiver interventions and a variety of related practices. Over the course of the Waiver Demonstration, the evaluation produced a series of small reports and supplemental materials that provided the state with valuable insight into both the implementation of the Waiver interventions and CWS practice in general; analyses that were not previously possible due to the lack of a cohesive database that married the information from both CPSS and SHAKA.

The additional feedback and materials provided to the state include[2], but are not limited to:

- Pathways to CRT Analysis: Examination of the referral pathways to the CRT Intervention
- CANS Analysis: Examination of the Completion Rate for CANS tools in the SPAW and Wrap Interventions
- Disparities Analysis: Provision of an "All Intakes" Data Set with data from both SHAKA and CPSS and calculation of disparities ratios to inform state initiatives to address ethnic disproportionality
- Workflow Charts: Detailed workflow charts for each intervention with key data points identified for each step in the workflow
- Data Crosswalk: Detailed analysis of the Waiver-related data fields in each ADB mapped to Waiver Evaluation data needs. This includes how the four ADBs related to one another.
- Data Quality and Verification Reports: Identification of data quality/ data entry issues in various areas including Intake Tool data, Safety Assessment data, and CRT response time

[2] The additional materials are available upon request from the authors of this report.

Remaining Challenges

As noted, the immediate response to the new people-focused strategies was very positive and the evaluators witnessed an increase in staff buy-in for the evaluation goals and improving data quality. However, true behavior change does not happen overnight; continued education and practice are necessary to solidify new habits and ways of work. When discussing data quality in ADBs, numerous authors reflect on the need for a strong culture of data-informed decision making.

Unfortunately, as the Demonstration progressed and departmental priorities shifted, the evaluators' role also shifted. Near the end of the second year of the Demonstration, changes in communications protocols were made and the Evaluation Team had a less active role in communicating with and educating staff as it had in the first two years of the Demonstration. As a result of these changes, the planned follow-up site visits to share results from the *Interim Evaluation Report* to line staff were not able to be scheduled. The evaluators were able to present findings to Waiver and CWS Leadership and Workgroups, but the direct feedback loop from evaluators to line staff was lost. There was a noticeable drop in data entry and quality at this point, as evidenced in Figure 4.4.

Finally, the establishment of the Family First Prevention Services Act which was included in the Bipartisan Budget Act of 2018 (H.R. 1892) signed on Feb. 9, 2018, marked a change to how states may use Title IV-E funding in the future. The discussion about and eventual passage of this Act resulted in a shift in priorities in Hawai'i and across the nation as states began to focus on how this Act would affect the provision of child welfare services going forward. As CWS began to shift priorities, the Waiver Demonstration Project manager was promoted into another position with DHS in early 2019. Another administrator was given responsibility for the management of the Waiver Demonstration, but the Waiver was one of *many* projects this administrator was tasked to manage. The loss of a dedicated and experienced Waiver Project Manager further exacerbated the shift in priorities and the evaluation noted further declines in data entry and quality as well as declines in referral rates to all Waiver interventions.

Discussion

The three strategies discussed here are not distinct from one another; rather they are a single communication strategy that evolved and was refined over time. The initial assumptions that the evaluation plan was built upon were the foundation for creating a data feedback loop which can inform and improve the implementation of the CWS initiatives and allow the evaluators to effectively evaluate the success of those initiatives. As mentioned earlier, the process evaluation was informed by the Implementation Science framework advanced by Metz and colleagues (2015) which posits four implementation stages beginning with the exploration stage where stakeholders identify their community's needs and select an intervention that is appropriate to address those needs. Implementation continues through the installation and

initial implementation phases and will hopefully result in full implementation where the new practice or intervention is integrated into all levels of the system and more than 50% of practitioners are implementing the innovation with high model fidelity. Three core components, implementation teams, data and feedback loops, and implementation infrastructure, function as drivers that advance implementation through the four stages. These components are dynamic and interact to produce consistent uses of the interventions, and, as a result, the desired outcomes.

Initially, the evaluators simply sought to describe the progress of the Waiver Demonstration implementation using this framework. But as the Demonstration progressed, the interdependence of each of the core components became increasingly apparent. In particular, the Evaluation Team noted that a robust data feedback loop is absolutely essential in order for any program to reach the full implementation stage. Not only was reliable and accurate data necessary, but it was also necessary to have infrastructure in place to feed evaluation findings back to the field and then for those insights to be applied.

This realization did not change the goals (quantity and quality of case data) of the Evaluation Team but did result in an evolution of the strategies used to solve the problem as the evaluators better understood the audience and purposes of the strategy. Over time the data feedback loop created by the Evaluation Team shifted its main audience from administrators and supervisors to caseworkers and staff members. The focus of the feedback loop shifted from a systems focus to a people focus; from telling about a problem to collaboration around a challenge. The style of presentation shifted from text-heavy, inaccessible and unconnected to staff member's day-to-day work, to infographic, easy to understand and meaningful to staff.

Applicability Beyond the Hawai‘i Waiver Demonstration

For states with SACWIS/CCWIS, data systems challenges may not be a pressing issue for child welfare systems or evaluators. However, when and if systems issues arise, they may not have quick and easy solutions. Changes to ADBs are costly and take time and resources that may not be available or reasonable. While these issues are not unimportant, and should be addressed, there are often ways to create and implement solutions and/or workarounds as demonstrated in Hawai‘i. The larger challenge for all child welfare agencies, researchers, and evaluators is to ensure that the systems contain "good" data; data that is entered completely, accurately, and in a timely fashion. As the evaluators discovered, staff needed to understand the benefits of good data entry to themselves, their clients, and the agency for this to happen. A clear and effective communication and training plan around good data entry can be an effective strategy to educate staff about the importance of data and to elicit behavior changes in regards to data entry. Understanding how staff interact with the systems provides the insight necessary to formulate and implement these strategies. To construct an effective "people-focused" strategy, the learning theory emphasizes the importance of knowing your audience and their needs as they pertain to the learning goals. To do so requires child welfare leaders and/or external evaluators to actively engage with the front-line staff responsible for entering the data.

The Hawai'i Evaluation Team found the following guidelines to be particularly helpful when engaging with staff:

- Adopt an approach focused on partnership, clarity and limiting additional workload for front line workers. Recognize and respect the workload and responsibilities of staff, add as little work as possible, build rapport and relationships with staff members.
- Maintain continuous communication with staff to understand needs, strengths and challenges. This also helps to avoid misunderstandings and create opportunities to check assumptions. When changes occurred within the management of the Waiver and the evaluators were no longer able to directly communicate in this way, the changes that had begun to occur in data entry behaviors faded.
- Create tools and materials that address the needs of your audience. These tools may be a part of the ADB (i.e., dashboards), but should be built and rolled out in ways that consider the needs of adult learners. The strategies and tools that received the most positive feedback were those that front-line workers found immediately useful and easy to use.

  These strategies:
    - Build on existing knowledge, skills and experience
    - Are easily accessible
    - Are easy to understand
    - Are applicable to the user
    - Have a clear benefit to user

- Find ways to provide timely and relevant feedback to data users that have clear benefits to them and the families and children they serve. Feedback from the field in response to the One-Pagers often included appreciation for clearly presenting how the intervention fit in the "big picture" of CWS services, information about outcomes and progress, and how the evaluation data request would provide tangible benefits to child welfare staff and clientele.
- Recognize the expertise and experience of staff and find ways to build upon existing knowledge and skills to make new learning meaningful.
- Create materials and presentations that convey information in ways that are easy to understand. Child welfare staff often carry heavy caseloads and the responsibility of ensuring at-risk children are safe and cared for. Their time is valuable and providing information in easily accessible formats increases the likelihood that these tools and materials will be used.

Conclusion

Child welfare administrative data offers agency leaders and researchers a wealth of information that can be used to not only inform day-to-day practice in child welfare, but also to answer questions around program implementation and effectiveness and inform policy. However, these data must be of sufficient quality in order to do so effectively. Allard and colleagues (2018) discuss the continuum of data capacity across social service agencies, as well as the common constraints agencies struggle with in attempting to improve the quality of data and to then effectively use that data to achieve their goals. Of particular relevance to this effort is the idea of creating collaborative relationships between agencies and external research partners. Allard notes that, although uncommon, these partnerships do exist and have been beneficial to both parties. Partnership with external researchers can result in improving an agency's insight into data quality and collection and provide agencies with access to expertise in the analysis and interpretation of data in ways that are meaningful to the agency. While the obstacles to such partnerships, such as expense and the difficulty in creating necessary data sharing agreements, are numerous, the benefits to the agency, researchers, and the field can be extensive.

The evaluation of the Title IV-E Waiver Demonstration in Hawai'i provides some initial evidence that such a partnership would be beneficial. The Evaluation Team was able to apply their expertise to create an evaluation database which successfully merged data from four separate systems in ways that had never before been accomplished by the state. This database allowed the evaluators to "tell the story" of the clients served by the Demonstration interventions and to provide the department with insights into the implementation of these services that can be used to improve services and hopefully improve outcomes for children and families in the future. The evaluators also gained and were able to apply critical insights into communicating and collaborating with CWS administrators and staff to begin to create a data-formed decision making culture within the agency. As the agency continues to move forward in its efforts to design and implement a CCWIS and to create a FFPSA plan, these findings will be especially relevant. At the very least, the knowledge gained by the evaluators about how the state data systems work and the identification of the major obstacles to data quality will provide the state with critical insights that can be used in the planning of the state CCWIS system and the construction of the state's data quality plan.

Waiver Demonstration Leadership and Infrastructure

Implementation of the Waiver Demonstration
Service Fidelity in the Demonstration
Knowledge and Impressions of the Demonstration in the Final Year

WAIVER DEMONSTRATION LEADERSHIP AND INFRASTRUCTURE

Implementation of the Waiver Demonstration

Administrative Structure and Support for the Demonstration

The lead agency for the Hawai'i Waiver Demonstration Project was the Hawai'i Department of Human Services (DHS), Social Services Division (SSD), Child Welfare Services Branch (CWS). CWS is responsible for the development, implementation and oversight of the State's Title IV-B and Title IV-E programs. The Child Welfare System in Hawai'i is state-administered and divided into the four counties of Honolulu, Maui, Kaua'i and Hawai'i.

As described in the *Initial Design and Implementation Report* (DHS, 2014), CWS created a core Waiver Demonstration Project administration group consisting of the Social Services Division Administrator, Child Welfare Services Branch Administrator, Child Welfare Services Program Development Administrator and the Waiver Project Manager. This Executive Committee oversaw and was the final problem-solving, decision-making entity for the Waiver Demonstration Project. The Executive Committee provided the guidance to all the Workgroups and the Steering Committee, and reviewed and approved policies and procedures, fiscal issues, and all implementation matters. Members of this group participated in Workgroup and Steering Committee meetings as needed, identified and problem-solved issues, and submitted required Waiver Demonstration reports to the Administration for Children and Families such as the Waiver Demonstration developmental cost plan, IDIR, and semi-annual progress reports.

Once implementation began, the Project Manager assumed responsibility for coordinating the progress of the implementation of the interventions and monitoring the Demonstration's progress in all aspects to ensure service delivery and quality assurance throughout the five years of the Demonstration. The Project Manager was promoted to Director of Policy for the Hawai'i Department of Human Services in the final year of the Demonstration, but remained involved in many activities of the Demonstration. The Program Administrator of Program Development, an experienced administrator in CWS, assumed responsibility for overseeing the Demonstration for the remainder of its final year.

In addition to the Executive Committee, the Waiver Demonstration Project administration group also formed a Steering Committee and a number of other Workgroups to facilitate the administration and implementation of the Demonstration. Those groups are described below:

- **Steering Committee:** This committee was comprised of CWS administrators, the Waiver Project Manager, CWS section administrators, and stakeholders representing the court, community agencies, Department of Health, and the Court Improvement Program Family Advocate. The Steering Committee served as an advisory body that reviewed and guided the Workgroups and oversaw the implementation and continued deliverance of services throughout the Waiver Demonstration.

- **Workgroups:** Eight Workgroups were formed to obtain staff and community input into the design and program development (policies and procedures) of each intervention in the Demonstration and for each major area of responsibility:
    - Crisis Response Team
    - Intensive Home-Based Services
    - Wrap
    - Safety, Permanency, and Well-Being meetings
    - Data and Evaluation
    - Fiscal
    - Communication
    - Rapid Assessment Instruments

The Waiver Project Manager chaired every Workgroup and each Workgroup included a CWS section administrator and Program Development staff member. Private contractors involved in providing intervention services were included in the IHBS, Wrap and SPAW Workgroups. Workgroups met to discuss and make recommendations for that group's specific intervention or function.

Partnering with police, hospitals, schools and other state offices (e.g., Department of Health, Department of Education) was also critical to the success of the four interventions. An important task for the Project Manager and various Workgroups was to develop relationships with these agencies and to facilitate ongoing engagement and dialogue about the Waiver Demonstration goals and activities, through community meetings on O'ahu and Hawai'i Island.

Workflow Charts were created for each Demonstration intervention. These detailed the key actions/processes during the phases of Intake or Case Review, at the initial face-to-face meeting with child/family, over the course of the intervention, and at closure of the Demonstration intervention. They also documented what data was gathered for the evaluation, and at what point in time.

The Workflow Charts were developed in partnership with those most closely involved in implementing and providing each intervention through the Workgroups, and were intended to capture practice elements, as well as the key case information and assessments that inform practice decisions. Workflow Charts were also used to identify process metrics capturing key decision points in each intervention model. The Workflow Charts are presented in the chapters for each of the interventions.

Monthly Waiver Project meetings were held throughout the five years of the Demonstration to address implementation issues, share progress and to update the Waiver Project Steering Committee on the work of the intervention Workgroups. At initial implementation of the interventions, weekly teleconferences were also scheduled with each intervention Workgroup, contracted provider, and assigned assistant program administrators to update each other on the implementation progress to ensure implementation was going as planned or to identify implementation challenges to overcome. After the first year of implementation, the frequency of the Workgroup meetings was reduced based on the judgment of each Workgroup.

Presentations and Informational Meetings

During the first year of the Demonstration, the Waiver Demonstration Project Manager and other members of the Executive Committee attended a variety of meetings and other opportunities in the community on both O'ahu and Hawai'i Island. In these meetings, they explained the Waiver Demonstration and its interventions to child welfare sections, law enforcement entities, hospitals, schools, family court members, and other parties who would be impacted by the Demonstration interventions and the children and families they served (see Table 10).

Table 10
Presentations/Informational Meetings with Community Partners in Year One

	Date
Family Court Symposium	September 2014
East Hawai'i Child Welfare Services and POS Providers	December 2014
Family Court Judges	January 2015
Attorney General's Office	March 2015
Kapi'olani Hospital	March 2015
Queens Hospital	March 2015
Dept of Health/CAMHD	April 2015
Honolulu Police Department	April 2015
Family Court Judges	May 2015
Attorneys' meeting (with GALs)	May 2015
Schofield Barracks Clinic	May 2015
Castle Hospital	May 2015
Attorneys' meeting (w GALs)	June 2015
Honolulu Police Department	June 2015
West Hawai'i Child Welfare Services and POS Providers	July 2015
Child Welfare Law Update Conference	August 2015
Tripler Hospital	September 2015
Honolulu Police Department	October 2015

Training for the New Assessments

The State used the *Child and Adolescent Needs and Strengths* (*CANS*) assessment tool as a criterion for referral to either Wrap or SPAW. The *CANS* was modified for Hawai'i by the creator, Dr. John Lyons, prior to the Demonstration. In the first months of the Demonstration, Child Welfare staff who might refer a child to either Wrap or SPAW (therefore, all staff with a foster case caseload) were provided with training on the Hawai'i *Child and Adolescent Needs and Strengths* (*CANS*) assessment tool. This was an all-day training, and it was provided on both O'ahu and Hawai'i Island. Personnel from the University of Chicago, including Dr. John Lyons, provided on-site training to CWS staff, and continued to provide consultation throughout the Demonstration.

Definitions and Recording of Eligibility Criteria

During the first year of the Demonstration, the Workgroups for each of the four interventions met frequently to discuss, develop, and refine the practice elements of their respective interventions. One member of the Evaluation Team also sat in on most of these meetings. As discussed earlier, each Workgroup developed, with the assistance of the Evaluation Team, a Workflow Chart of the process of the intervention. These Workflow Charts included the identification of the eligibility criteria for each intervention, and the point at time in which the criteria would be identified and assessed.

For the two Short-Stayer interventions (CRT and IHBS), a key criterion was that a child was at imminent risk of placement. At the beginning of the Demonstration, there was no such indicator on any CWS assessments. The Evaluation Team led discussions with each Workgroup and with the Waiver Leadership Team on how imminent risk of placement might be operationalized and assessed, but this discussion was complex and, by the end of the first year of the Waiver Demonstration, was not resolved.

Similarly, the two Long-Stayer interventions (Wrap and SPAW) had the two eligibility criteria of the child being "likely to reunify" (for Wrap) or "unlikely to reunify" (for SPAW). Again, the Evaluation Team led discussions in Workgroups and at monthly Waiver Leadership meetings on how these two constructs might be operationalized and assessed. By the end of the first year of the Waiver Demonstration, this was not resolved.

Training for Data Collection and Data Entry

In the initial months of the Waiver Demonstration, the Data and Evaluation Workgroup worked with the CRT, IHBS, Wrap, SPAW, and *CANS* Workgroups to identify the data fields already existing in current CWS administrative data and assessments that could be utilized in the evaluation of the Demonstration. Members of these workgroups also identified those pre-existing data fields that caseworkers and supervisors had not been consistent in recording to

date. The Evaluation Team worked with data managers and Workgroup members to identify the key data fields that would be used in the evaluation, and these data elements were emphasized as part of the Waiver Demonstration in workforce training, and in system-wide formal DHS communications, or ICFs.

In addition, all members of the Evaluation Team made on-site visits to all CWS units and private providers involved in the Waiver Demonstration. The purposes of these visits were to introduce members of the Evaluation Team, thank administrators, caseworkers and support staff for their participation, conduct training, provide an overview of the Waiver Demonstration and their importance to it, and train participants in the essential data fields for the evaluation and when, where and how to enter that data. These visits were well-received, and are discussed in further detail in this *Report*'s chapter on "Data Quality and Communications."

Knowledge and Impressions of the Demonstration after the First Year

Focus groups were conducted during the first six months of 2016 on both Oʻahu and Hawaiʻi Island with CWS administrators, CWS staff and service providers. As mentioned above, the main areas of interview data centered around personnel in CWS, the Crisis Response Team, Purchase of Service providers, and information systems. From the data collected, overarching themes were identified about perceptions of, and experiences with, the Demonstration in the first year. The themes that arose were:

- Leadership
- Commitment to High Quality Service Delivery, Buy-In, and Purpose
- Staffing and Workload
- The *Child and Adolescent Needs and Strengths* Assessment
- Communication
- Information Systems

For each theme, specific strengths and challenges experienced by administrators, staff and service providers are identified.

Leadership

- The Waiver Leadership Team seemed quite committed to implementation processes, and were trying hard to problem solve when they saw resistance to CWS staff practice change.
- It was not clear to the line or middle management how much support there was from the top of the agency (Director's office) because of lack of follow-up and follow-through for suggestions to improve the interventions.

Commitment to High Quality Service Delivery, Buy-In, and Purpose

- The purposes of the Waiver interventions were understood clearly by most, as were the overall goals of the Waiver.
- Waiver interventions were seen as needed improvements to the existing child welfare system.
- The line staff noted that new attention to documenting their work, information about the workgroup meetings, and the Waiver evaluation was giving them more information and understanding about the youth and the families in their caseloads.
- There seemed to be an awareness of the need for practice change and awareness such as "taking kids too early" and letting them "sit too long in foster care."
- There was support and enthusiasm for the Purchase of Service providers' work.
- New and stronger relationships with community partners, such as the police and Department of Health, were clearly evident.
- It was difficult to balance when changes to the model should be made in response to difficulties versus emphasizing full implementation of current model for adequate evaluation prior to change.

Staffing and Workload

- New initiatives to address sex-trafficking, homelessness, Native Hawaiian disproportionality, and financial assistance were being implemented at the same time as the Waiver, which took time and energy from already over-extended workers.
- There was no adjustment in workload as Waiver programs were implemented, which can lead to capacity and morale issues. These issues bled over into other themes reported by the line staff such as how they can implement new projects when they have so much else on their plate.
- Referring to outside Purchase of Service providers was seen as difficult and time consuming.
- While minimal referrals to Wrap and SPAW could be seen as a lack of "buy-in" from the line staff, it seems more likely that workload was an issue as all line staff reported positive experiences with Wrap and SPAW.
- Prioritizing workload capacity was essential. A process to reduce antiquated or unhelpful paperwork was recommended many times, to streamline line staff responsibilities.

The *Child and Adolescent Needs and Strengths* Assessment

- Completing the *CANS* was seen as difficult and time consuming.
- More reporting functions in SHAKA would have be helpful for line staff and leadership to see (in real time) how the interventions were doing, and what the results were from the *CANS*.

Communication

- Workgroup meetings were consistently mentioned as an effective place for sharing issues and problem-solving.
- Travel funds were utilized to improve communication via monthly meetings, database improvement meetings, and trainings.
- There were many attempts through meetings and intra-agency memos to communicate about the Demonstration and its progress.
- Many of the line staff were not clear about the nuts and bolts of their new responsibilities.
- Section administrators and unit leaders commented that they make suggestions for problem solving, and the Waiver leadership responds, but the ideas did not seem to "be taken up the chain of command" as they did not see the changes they recommended being implemented.
- Outside partners (e.g. Department of Health, police, Family Court, Department of Education) were kept abreast of the Waiver progress and seemed pleased with the new programs.
    - There has been relationship building between agencies
    - There has also been increased collaboration with partners
- Some believed the data and information from the evaluation would help cement the changes in practice that are needed. Many cited excitement about receiving information about how they were doing regarding the new interventions.
- Some also noted the importance of a big picture overview of the Demonstration.
- Many felt it would be helpful to have feedback and training on the overall Waiver and how the different interventions fit together.

Information Systems

Challenges about the information systems were repeatedly brought up by CWS staff in interviews and focus groups. As mentioned previously, CWS currently utilizes two disjointed data systems, CPSS and SHAKA. Both systems house different types of data and there is limited interaction between systems, so staff must alternate between two systems to enter and access data on a case. This is time consuming and often frustrating for workers. Staff stated a single, more efficient system is needed. Also, staff discussed the lack of formal training on the SHAKA system.

- CPSS was antiquated and difficult to use, but was a secure system that CWS staff were familiar with and it has the case history.
- SHAKA was becoming increasingly useful and user-friendly. CRT staff began to see how electronic documentation could streamline their work and make it easier to gather data when taking over a new case. However, changes to SHAKA were noted as slow; inputting data in SHAKA could be slow (e.g. *CANS*); and many CWS staff were not trained to use SHAKA as the Demonstration was rolled out.

- Having multiple databases (CPSS and SHAKA) for CWS staff caused some duplication of work and evaluation challenges.
- Most, if not all, evaluation tools and standardized tools were done on paper and then later, input electronically. This made it hard for CWS workers to complete paperwork in a timely way as it required double effort.
- SACWIS (now CCWIS) had not been released and the timeline for a roll-out was unclear.
- User feedback is not available in the existing system (i.e. reports, summaries based on data entry).

In conclusion, the Evaluation Team heard many common themes related to the implementation processes of the Waiver Demonstration. These themes related to workload and the challenges the line staff have in completing more work associated with the Waiver Demonstration; staffing challenges related to adding a Crisis Response Team; and persistent information system challenges when having to use both an old CPSS information system and the newly developed SHAKA information system. The major problem identified through these interviews was the eligibility and referral pattern of cases being identified as Crisis Response cases. This had both practice and evaluation relevance, since workers were not clear precisely when a CRT case is to be identified and why, and they were requesting clearer protocols for their practice. It also had serious implications for the evaluation, since it was difficult to assess if appropriate cases are being referred to CRT and what was the appropriate disposition of CRT cases.

Knowledge and Impressions of the Demonstration after the Second Year

Knowledge and Impressions of the Interventions by CWS Staff

By early 2017, the Waiver Demonstration had been under way for two years on O‘ahu, and about 1.5 years on Hawai‘i Island. In the first two years of the Demonstration, both DHS and the Evaluation Team had documented low levels of referrals to three of the four Waiver Demonstration interventions, as well as low rates of completion of the *Child and Adolescent Needs and Strengths* assessment, a critical component of the Long-Stayer interventions. These implementation challenges existed despite many efforts by DHS to train, educate, and support staff in their use of the interventions and the assessment tools.

Therefore, in mid-2017, the Evaluation Team conducted a survey of CWS line staff to seek perceptions regarding their use of assessment instruments, their knowledge and perceptions of the four Waiver Demonstration interventions, and their perceptions regarding types of organizational support for their work. Details of the content of the survey and how it was administered can be found in the Process Methodology of this *Report*.

Reported Completion and Perceptions of Assessment Tools

As part of the Waiver Demonstration, Child Welfare Services introduced and implemented the *Child and Adolescent Needs and Strengths (CANS)* tool to support decision-making, including assessing the level of care, planning of services and monitoring the outcomes of the services. Training was provided on both islands. The tool requires that users pass a test to be certified in using the *CANS*, and must be re-certified each year. The intervention model called for the CWS staff to complete an Initial *CANS* before a referral to Wrap and SPAW interventions, and again, periodically throughout the case, or at a minimum, at the closure of the Wrap or SPAW intervention.

Respondents were asked separately if they have completed a *CANS* for Wrap and/or SPAW. Forty-five people responded to the question that they are required to complete the *CANS* for a referral to Wrap. Of those using the *CANS* prior to a referral to Wrap, 49% responded that they always complete the *CANS* before referring to Wrap services (see Table 11). The most frequent reason for not completing the *CANS* was "I don't have time" (36%) while 16% reported "I don't think it is useful." Several respondents noted that they have "started it but didn't finish it." Other reasons, not included as response choices but noted by respondents, included "I'm not certified," "My password is invalid," "The *CANS* does not give me new insight into the family," and "With all the other requirements for a case, it is easy to forget to do an additional assessment."

Forty respondents said that they are required to complete a *CANS* for referrals to SPAW. Of those respondents, 55% responded that they always complete the *CANS* to refer to SPAW. The major reason for not completing the *CANS* was "I don't have time" (30%) and "I don't think it is useful" (20%). Other reasons for not completing the *CANS* included "I didn't renew my certification," "It is easy to forget with all the other case requirements," and "I spent 1.5 hours completing two *CANS* and they were not even discussed during the SPAW meeting."

There did seem to be a challenge in implementing the *CANS* across the Waiver cases, in that self-reported completion rates were from 49% to 55% of respondents. The primary reasons for non-completion of the *CANS* coalesced around not having the time to complete it and not finding it useful. The focus of the *CANS* training on the contributions it can make to case planning and goal setting with the client or family did not appear to be integrated into practice.

Table 11
Completion of CANS Assessments

Completion of Assessments	*CANS* for Wrap	*CANS* for SPAW
	(n=45)	(n=40)
I always complete assessments.	49%	55%
I don't have time.	36	30
I don't think it is useful.	16	20
I started it but didn't finish it.	11	10
I don't have all the information needed.	4	8
Internet isn't available in the field.	4	3
I never think standardized assessments are useful.	4	3
I did it on paper and didn't enter it online.	2	0

Perceptions of Organizational Support

Finally, line staff were asked to respond to a series of questions regarding supports in their work environment. Again, each of these questions had answer choices ranging from Strongly Agree (5) to Strongly Disagree (1). Mean scores are presented in Table 12.

Overall, supervision received the highest levels of positive perceptions, and agreement with positive statements about supervision were generally higher than perceptions about any of the Demonstration interventions. Respondents also felt positive about teamwork in their unit; they agreed that they are close to co-workers, and feel free to share opinions with them.

Perceptions of CWS workload were less than positive, however, not surprisingly. Levels of agreement were high on both Oʻahu and on Hawaiʻi Island that "Even if I work overtime, I cannot finish all of my work," and that "My job responsibilities keep me from getting sufficient rest." Respondents on Hawaiʻi Island indicated significantly less agreement than those on Oʻahu with the statement "My workload has been adjusted as new responsibilities or duties are added," but agreement at both sites was fairly low.

As noted by focus groups, and in conversations with database managers, the Evaluation Team found that caseworkers had frustrations with the DHS information systems, CPSS and SHAKA. While respondents were in high agreement that they can see why entering data into SHAKA is useful, there was substantial agreement that entering data into SHAKA takes too much time. There was a moderate amount of agreement that respondents felt they still need training on how to enter data into SHAKA.

In regard to the CPSS data system, respondents on Hawaiʻi Island were significantly less likely than their counterparts on Oʻahu to agree that they have received enough training on CPSS. Relatively few respondents agreed that they do NOT see why entering data into CPSS is useful, and few agreed that entering data into CPSS doesn't take a long time. The wording of these last

two statements indicates that most respondents do agree that entering data into CPSS is useful, but that it takes a long time.

Line staff had the least positive perceptions/levels of agreement with statements about the organizational resources for their work. The statement with the highest level of agreement was that the lack of connectivity to the internet is a barrier to efficient practice. Levels of agreement were less positive in regard to feelings of confidence in being able to access additional resources when needed, having adequate and up-to-date office equipment, and sufficient staff to meet unit needs.

Table 12
Perceptions of Organizational Supports

Mean Scores	O'ahu (n=49)	Hawai'i Island (n=32)
Supervision		
My supervisor is knowledgeable about working with children and families.	4.3	4.3
My supervisor listens to my perspective.	4.2	3.9
My supervisor reinforces trainings I receive.	3.9	3.8
I do not have a good relationship with my supervisor.	2.0	2.0
Teamwork		
I feel free to share opinions with people in my unit.	4.0	3.8
I am close to people in my unit.	3.9	3.8
I do not trust advice from people in my unit.	1.9	2.2
Workload		
Even if I work overtime, I cannot finish all of my work.	3.7	3.8
My job responsibilities keep me from getting sufficient rest.	3.7	3.5
My workload has been adjusted as new responsibilities or duties are added.	2.5†	1.9
Information Systems		
I see why entering data into SHAKA is useful.	3.6	3.3
Entering data into SHAKA takes too much time.	3.1	3.3
I still need training on how to enter data into SHAKA.	2.6	2.8
I have received enough training on CPSS.	3.3	2.6††
I do not see why entering data into CPSS is useful.	2.4	1.9
Entering data into CPSS doesn't take a long time.	2.3	2.3
Resources		
Lack of connectivity to internet is a barrier to efficient practice at my work.	2.9	2.6
If I need additional resources to do my job, I feel confident I can get them.	2.7	2.3
The office equipment in our unit are adequate and up-to-date.	2.5	2.5
Our unit has sufficient staff to meet our needs.	1.8	1.8

†† $p < .01$
† $p < .05$

Knowledge of the Waiver Demonstration by Family Court Judges

In February 2017, the lead Family Court Judge on O'ahu invited Evaluation Team members to a meeting with seven of the Family Court judges on O'ahu. Most of the judges had been involved in the child welfare calendar, but a few had not. The purpose of this meeting was to explore what the judges knew and understood about the Demonstration and their perceptions of it after the second year. The Evaluation Team provided an overview of the Waiver Demonstration and distributed one-page descriptions of each intervention to get the discussion started.

Family Court Judges suggested that ALL cases should have such an assessment and hoped that the Waiver evaluation would prove that this is an effective service that could be expanded.

Despite the outreach activities by DHS, the judges said that they were not familiar with the Waiver Demonstration or with the actual interventions being implemented and how they could be accessed. They were extremely interested in the new interventions and frequently asked how they could take advantage of them. For example, they quickly understood and supported the idea of a Crisis Response Team that could professionally assess safety and risks and decide if a child needed to be removed from the family. Family Court Judges suggested that ALL cases should have such an assessment and hoped that the Waiver evaluation would prove that this is an effective service that could be expanded.

Only one judge (other than the lead judge) had heard of IHBS, Wrap or SPAW. Again, they were very positive when the interventions were described, and a few said they had perhaps attended a meeting about these new interventions, but were not aware of how they were being implemented on O'ahu. They were concerned that their cases may have been involved with such interventions without their knowledge. Some suggested that the child welfare workers should be putting such referrals into their Safe Family Home report, so the judges would be aware. One judge suggested that, if a family was using Wrap, that she should know so she could make appropriate scheduling decisions and perhaps alter the direction of the case. Judges were also concerned as to why the guardians ad litem were not better informed about these new programs. The judges wanted to know how well these programs were working; the Evaluation Team members explained that we could not yet report on the outcomes.

The three Family Court judges on Hawai'i Island were also interviewed. Again, one Family Court judge was enthusiastic about the ideas embedded in the Waiver Demonstration, but was only vaguely aware of the actual implementation of these initiatives. He also expressed that he would like to know more about the impact of these practice changes and he would be interested in receiving feedback on the outcomes of the Demonstration. The other two judges on Hawai'i Island were also interviewed. Both were very newly appointed and not aware of the Waiver Demonstration.

Overall, it was clear from these discussions that the judges were enthusiastic about new interventions and services for short- and long-term foster youth and interested in learning more about these services.

Service Fidelity in the Demonstration

Most of the information on service fidelity is in reference to the four Demonstration interventions, and is discussed in the chapters devoted to the interventions. However, the introduction and implementation of using the *Child and Adolescent Needs and Strengths* applied to both of the Long-Stayer interventions, and is discussed here.

CANS Completion for Wrap Referrals

Child Welfare caseworkers were asked to complete an Initial *CANS* assessment when they referred a child to the Wrap intervention. Overall, the completion rates for an Initial *CANS* were fairly low on O'ahu (see Table 5.4). Completion of an Initial *CANS* was very high in the first full year of the Demonstration on Hawai'i Island, but dropped in each following year. The completion rates for the Final *CANS*, to be completed by the child welfare caseworker when the Wrap process is finished for the child, were very low throughout the Demonstration (see Table 13).

Table 13
Initial and Final CANS Completed for Wrap

	Wrap			
	O'ahu		**Hawai'i Island**	
	Initial *CANS*	Final *CANS*	Initial *CANS*	Final *CANS*
2015	57%	19%	-	-
2016	11	6	92%	38%
2017	0	0	45	0
2018	29	0	10	0

Note. Waiver began in October 2015 on Hawai'i Island.

CANS Completion for SPAW Referrals

CWS caseworkers were required to complete a *CANS* assessment prior to the referral of a child or youth to the SPAW intervention. On O'ahu, the completion rate for these initial *CANS* was 93% in the first year of the Demonstration (see Table 5.5), but fell dramatically in the second and third years. Only one child who received SPAW on O'ahu had a Final *CANS* assessment completed.

On Hawai‘i Island, completion rates were high for most of the Demonstration (see Table 14). These completion rates are impressive, given that Hawai‘i Island had referred more children and youth to SPAW than had O‘ahu. Completion rates for Final *CANS*, however, were much lower.

Table 14

Initial and Final CANS Completed for SPAW

	SPAW			
	O‘ahu		**Hawai‘i Island**	
	Initial *CANS*	Final *CANS*	Initial *CANS*	Final *CANS*
2015	93%	0	100%	0
2016	19	0	85	43%
2017	23	5%	22	6
2018	50	0	100	0

Note. Waiver began in October 2015 on Hawai‘i Island.

Knowledge and Impressions of the Demonstration in the Final Year

The Evaluation Team conducted an online survey in the final year of the Demonstration to elicit the reflections of DHS staff and private providers on the successes and challenges of the Waiver Demonstration overall. Their summarized responses to the survey are identified in the word cloud below.

What do you think were the biggest accomplishments of the Waiver Demonstration?

From the responses, four main themes emerged as key accomplishments:

- Successful CRT Implementation,
- IHBS Efficacy,
- The Learning Process, and
- Practice Change

Successful CRT Implementation

In the fifth year of the Demonstration, DHS staff and administrators believed that the implementation of CRT had been successful; the intervention provided immediate responses when families were in crisis and was effective in preventing unnecessary removals. The success of CRT was generally named as one of the biggest accomplishments of the Waiver Demonstration.

IHBS Efficacy

As time with the Waiver Demonstration progressed, staff noticed an increase in efficacy of IHBS. Many noted that IHBS had very positive outcomes in serving families and preventing the removal of high-risk children.

The Learning Process

Through the Waiver Demonstration projects, staff felt it had been a great learning process for CWS as well as the state. The Waiver Demonstration was able to implement and demonstrate learning across the organization. Regardless of outcomes, respondents recognized the efforts taken to test innovations.

> "It allowed CWS to try new initiatives (which would not have been possible otherwise), which assisted us in helping support our children and families."

Practice Change

A majority of respondents expressed a belief that participation in the Waiver Demonstration allowed CWS to step away from "business as usual" to test new initiatives that would not have been possible otherwise. These efforts resulted in significant learning and practice change – ultimately allowing CWS to better serve children and families. Respondents specifically identified CRT as a successful intervention that "broaden[ed] practice."

Respondents also noted that discussions identifying internal barriers to permanency in SPAW Workgroup meetings extended into the Program Improvement Plan (PIP) Workgroup in 2019 and led to the development of a new case staffing model. Not only was the case staffing model included in the PIP as an accountability tool, but the Branch is finalizing a contract to fully implement the model.

What practice changes did you see?

To further explore practice change, the Evaluation Team wanted to know the kinds of practice change respondents saw and experienced. Practice change is a regular part of new practices and the learning process. Participants' thoughts were mainly about better communication with partners, enhanced work with parents, and improved response times.

Different Ways of Thinking

Many respondents noted that the Demonstration brought about new ways of thinking within CWS, and a commitment to innovation and trying new things.

> "I think the practice change that was most beneficial was the support to staff to try something different that had never been tried before, especially with Wrap and SPAW meetings."

Communication with Partners

By bringing CWS staff together with other service partners for facilitated meetings, respondents noted that staff could see the benefits of seeking feedback and input from partners. With these new forms of interaction, communication was seen as improving, along with better collaboration between multiple systems.

Working with Parents

Some survey participants explained that working together with parents was a practice change that they have seen, particularly in Intensive Home-Based Services. This practice change helped to improve engagement with parents. By meeting with families more, both physically and emotionally, to help stabilize families, fewer children were removed, enhancing the achievement of permanency.

Response Time

The response time to reports of maltreatment was another practice change that was noted as an important development for CWS. A shorter response time for families has improved throughout the Waiver Demonstration, through both CRT and IHBS.

> "From my vantage point, the practice change of responding immediately and actually working with families in crisis instead of simply placing children and waiting for the next working day to work with families."

What do you think were the biggest challenges to the Waiver Demonstration?

The participants in the survey expressed the following as the biggest challenges while being a part of the Waiver Demonstration:

- Leadership,
- Practice Changes,
- Challenges of the *CANS*, and
- Buy-In.

And although practice changes were one of the biggest accomplishments, such practice change did not come without challenges as well.

Leadership

Many participants stated that effective leadership was a key barrier to the success of the Waiver Demonstration. Specific areas that respondents felt leadership could have improved were: effective communication, providing a "big picture" view that tied all the pieces together, managing change and encouraging a paradigm shift, engaging staff, maintaining accountability for implementation efforts, and improved training and support.

> "There were not enough champions to drive the changes."
>
> "There was a lack of ownership from Administration to SA's and Sups of the project which made it very difficult to move forward. Staff never embraced the efforts of some Waiver initiatives because the message wasn't shared, and SA's and Sups were reluctant and resistant to change. Practice change was not enforced by leadership, so a lot of it fell to the wayside."

Practice Changes

Some respondents noted that the structure of the Demonstration meant that interventions were constrained to the original parameters of the project. As such, participants expressed difficulties in engaging staff to bring about practice change, because such change sometimes required making further changes to models. The tension between keeping fidelity to original models and changing models to better suit clients sometimes made working with providers difficult.

On the other hand, one respondent noted here, and this was noted in monthly DHS meetings as well, that the SPAW model was not originally implemented with fidelity, given that the Casey

SPAW model utilizes multiple meetings for each child, while the Hawai'i Demonstration model specified the SPAW intervention as consisting of one meeting.

Challenges of the CANS

Many thought that the implementation of the *CANS* was one of the biggest challenges in the Waiver Demonstration. At the beginning of the Demonstration, the *CANS* took time to be fully implemented. Some felt that there was poor buy-in to the *CANS* from supervisors which then translated to the staff. Not only did the *CANS* have a slow start, participants thought it was time consuming to complete as well. This created a great deal of difficulty in embedding it in practice. Although there was and is discussion of combining and streamlining assessments, this was not accomplished during the Demonstration, and some staff viewed the *CANS* as "just one more thing to do."

> "*CANS* was a huge challenge, and I am not sure why. The resistance to *CANS* is a reflection, I think, of a resistance to learning and change in the organizational culture."

Buy-In

Perhaps the most significant challenge faced by the Demonstration was soliciting buy-in at the various levels within CWS. Some respondents noted the slow starts for some of the Waiver interventions.

> "I think the biggest challenge was in the beginning when [IHBS] was introduced and trying to get DHS buy-in. It took a couple of years for the program to get comfortable in taking referrals and for DHS to understand what the criteria was. It was a rough start."

Another representative response was that the most significant barriers were internal and originated with a lack of ownership for the Waiver at administrative levels. Because administrators, SAs and supervisors did not share real-time information about Waiver initiatives with line staff, front-line workers did not fully embrace the new initiatives and were resistant to change. These beliefs were shared by a majority of respondents, and were exemplified by poor implementation of the *CANS* assessment, and low referrals to the interventions.

> "We found out that our biggest barriers are within; they are not systemic nor outside the organization most of the time."

What kind of information or data was helpful to you during the Waiver?

An important element of successful implementation of practices and programs are feedback loops and sharing of information and data. The Evaluation Team was therefore interested in respondents' experiences with Demonstration information and data. From the responses, two main activities were identified as helpful:

- Evaluation Data/Updates/Results and
- The Number of Cases Served/Referred.

Evaluation Data/Updates/Results

Respondents felt that it was beneficial to have updates on the evaluation data as well as the monthly reports provided by evaluators and leadership at monthly meetings. The "One-Pager" reports with brief outcome data were also very helpful in clearly summarizing the impacts of the services.

> "The handouts with the stats and information were very creative and captivating."
>
> "Everything we got was helpful."
>
> "The Evaluation Team put together a 2-page report with valuable information on each project. It summarized a clear message of the impact of services."
>
> "I think the review of data and meetings we had with UH were really helpful in showing that our program was being effective. The data also helped provide evidence to DHS that the program was indeed working at keeping families together."

The Number of Cases Served/Referred

Over the course of the Waiver Demonstration, administration gathered and reported monthly updates on the numbers of cases and referrals to Demonstration interventions. These case counts were useful in helping to resolve some challenges that were faced, by identifying where referrals were low, or where staffing needed to be increased/shared. Staff felt that knowing the number of cases served, and being given intervention updates, was really helpful.

What kind of data or information did you wish you had?

This question was asked to help have a better understanding of how information circulated. The Evaluation Team wanted to know what certain types of information would have been useful at certain parts of the Waiver Demonstration, to have a clear picture of what could have been done better or changed regarding data and information management.

Specific Data

Participants stated wanting to know more of the characteristics of the cases that came through the different Waiver Demonstration programs and the cases that were successful. Others remarked that they wished they had had some information about the evaluation comparison group, and some information about how the Demonstration was doing in terms of fiscal savings. One participant stated in the survey that they had wished that they could pull CPSS and SHAKA data from all referred cases, since they were restricted to being only able to pull for one specific unit.

> "The concept was that money saved could be reinvested. Did that happen? I would like to have seen all of the reports that were submitted."

Clarity about Interventions

Staff questioned why some services were underutilized. There was also confusion about when CRT was supposed to close out a case, and staff noted that they would have liked specific instructions.

Outcomes

Respondents had many responses about information on child and family outcomes that they wish they had had during the Demonstration. Specifically, respondents thought it would have been helpful to know the numbers of children that CRT kept out of foster care, the number and kinds of cases that received IHBS, the numbers of CRT and IHBS children who never entered care, the number and kinds of children who received Wrap and/or SPAW, the number of children reunified, and the number who achieved permanency. There were also some missing pieces such as what specific demographics of families were more successful within each intervention.

Would you change anything about the training on the Waiver?

Table 15
Responses: Would You Change Anything About Training

Response	Count
Yes	8
No	4
No Answer	2

Continuous Trainings

A majority of participants remarked that they had wished to have the trainings continue throughout the Demonstration and be regularly scheduled so that current and new information could be easily circulated between staff, and across interventions. Specific trainings on the *CANS* tool, how to correctly put data into both CPSS and SHAKA, and how to effectively use the data in systems would also have been helpful.

> "There needed to be regular refresher trainings and lots of coaching to reinforce learning in daily practice."
>
> "I would have liked to see annual updates and gatherings to share. I would have liked to see meetings where solutions could have been generated across the work teams and implementation strategies. Instead, each strategy worked as a silo."

How helpful were the Workgroups?

Table 16
Responses: How Helpful Were Workgroups

Response	Count
Very Helpful	6
Somewhat Helpful	6
Not Helpful	1
No Answer	1

Helped with Communication

The improvement of communication between Waiver staff and stakeholders was one of the most commonly noted benefits of having Workgroups. Participants found it important that they were able to share information on what was working and what was not helpful.

Helped to Address Problems

Workgroups were also beneficial when it came to addressing problems and working to solve them. Participants thought that, although they were not successful in addressing all the problems, just being able to discuss data issues, barriers, and improvements within the team was helpful.

> "It's a good vehicle to discuss what's working and the improvements/changes needed. Able to immediately troubleshoot."
>
> "They were helpful in addressing concrete implementation problems. They were not successful in addressing low-usage and motivation problems."

Unhelpful

Although the question asked for what was helpful, participants were not shy to express what about the Workgroups they believed were the least helpful. Respondents expressed their frustration with the participation of the SA's in discussions, noting a lack of feedback from SA's.

> "The discussions with the SAs were at times painfully challenging given the lack of feedback as well as the commitment to regular consistent participation. I surmise this was likely due to their work demands and overwhelm."

Referrals to all interventions declined in 2018. Any thoughts on why?

Lack of Supervisory Motivation

Several participants noted that Section Administrators did not routinely provide reinforcement about the Demonstration interventions. One respondent stated that no reminder or coaching was being made to keep information fresh and new in people's minds.

Expansion of Waiver Interventions to New Target Populations

It is important to note that the IHBS intervention was expanded to serve families with the goal of reunification in late 2017. These families were outside the eligibility criteria specified in the evaluation plan and were excluded from the evaluation.

"I think in 2018 we had the most referrals [to IHBS] as we expanded who we could refer to our program; however, the [evaluation] continued to follow only one of the units that referred to our program [CRT]…. If we were able to compare all of the case referrals from every unit with the past five years, the stats would show more families were served in 2018 and that our program was being used more than ever."

Staffing

Other participants viewed that referrals may have declined due to the increase in workload due to staff vacancies.

Communication

Some noted waning dedication to communications about the Demonstration. Toward the conclusion of the Demonstration, confusion arose about the continuation of services after intervention group was closed.

"We did not do a good job of communicating successes and staying relevant."

"There was some confusion about the continuation of services after the intervention group was closed. There was very little formative feedback, so there was decreased interest in the interventions. There was very little communication to the units and social workers about the Waiver to maintain interest."

Waiver is Ending

Some participants believed the declining of interventions was due to the fact that the Waiver was scheduled to end in September, 2019. Staff expressed feeling overwhelmed due to this. Others noted that the shift to the development of the new PIP shifted the focus and created fatigue.

"I think staff were overwhelmed and there were other initiatives going on (i.e. Wiki Wiki Hire), plus staff knew the Waiver was ending, so if a referral was made, what would "sustain" the support with the family if the Waiver ends this year?"

"There could have been an annual recap, or even a roadshow to maintain interest and energy."

What are your concerns going into the Family First Prevention Services Act?

The Family First Prevention Services Act provides an opportunity to target new federal funding to preventative services. New legislation, while providing opportunities, also brings concerns about transitions. With this question, the Evaluation Team wanted to see what concerns the respondents had regarding the Act.

Staffing

Survey participants expressed concern with a lack of staffing for the development of the current PIP and a transition plan for FFPSA. They felt that the amount of work put onto the current staff is not enough for them to do a good job on data analysis and development of plans. They also felt that some interventions, particularly IHBS, had high staffing requirements that precluded wide-spread use under FFPSA.

"Staffing with the providers. IHBS seems like the most logical way to prevent placement, but with the extensive training and limited slots available, how will that work?"

Financial Issues

Going into the Family First Prevention Services Act, financial issues were also a concern for respondents. Some hope the budget will stay at least the same, going forward. Respondents added that they felt that the federal focus on evidence-based interventions causes problems in trying to implement programs appropriate to the cultures of the local population. Some noted a concern with having to change the criteria of practice models to comply with DHS standards.

Timing and Readiness

Several respondents felt that the state was delayed in preparing for the transition to FFPSA, and had a lack of communication about the plans.

"We need to get started to articulate the evidence-based practices we will use. Other states are being much more active."

"Starting something new takes years to see outcomes and buy-in, as seen in the Waiver."

Anything else you want us to know?

This question was asked to open the floor for further discussion on any positive or negative thoughts about the Waiver Demonstration implementation and interventions. The main theme that was gathered here was the finding that the participants had some worries about the Waiver after its completion.

Pride in Positive Outcomes

Many respondents noted a sense of pride in what Hawai'i accomplished through the Waiver.

"I think that there was a great collaboration between DHS, my program, and UH. I think the Waiver was able to show that it takes a couple years to get a program up and running."

"I am proud of Hawai'i and our efforts to implement and sustain Waiver services. We received fiscal support from the 2019 legislature."

"It was a pleasure to be part of this exciting time and extraordinary team to see what new programs/initiatives can be put into place to help our children either remain in the home or have new solutions/support for youth in need of permanency or families in need of a wide array of supports."

Worries about the Future of the Waiver

Those who were worried questioned which Waiver interventions will continue, and how the interventions will be funded. Many felt that there was a lot of progress that was made through the Waiver, and respondents hoped for that progress to be sustained.

Crisis Response Team (CRT)

Implementation of the Crisis Response Team
Service Fidelity of CRT Referrals by Intake
Service Fidelity of the Crisis Response Team
Child Outcomes After CRT

Crisis Response Team (CRT)

Implementation of the Crisis Response Team

As described earlier, the Crisis Response Team was included in the Waiver Demonstration as a critical early response to reports of maltreatment for a target population identified as children especially likely to be removed at the time of the report and to have a short stay in care (enter and exit in 30 days or less). The two eligibility criteria for a Crisis Response were (1) the report came from law enforcement, schools, or hospitals, and (2) the child was deemed to be at imminent risk of placement. By providing a face-to-face social work response on site within two hours of the report, the Demonstration hoped to prevent unnecessary placements in this population when possible.

As outlined in the Workflow Chart (See Figure 15), when a report of maltreatment came to the Intake Unit, the intake worker collected required information about the details of the allegation, source of the report, and the presence of any of fifteen Safety Factors associated with imminent risk of harm to the child (the "Intake Tool"). Imminent risk of placement is not noted in records. In addition, the Intake worker could check historical files for a record of prior experience with CPS, known criminal history in the family, and current recipience of HAWI (Hawai'i Automated Welfare Information system) benefits (any benefits, including financial and food assistance).

If the above eligibility criteria were met, the report, now called an intake, could be referred to the CRT Unit on O'ahu, or referred for a CRT response on Hawai'i Island. Other dispositions for an intake were referral to Child Welfare Services for an investigation and possible removal, differential response to either Voluntary Case Management or Family Strengthening Services, or to take No Action.

Once an intake was disposed as a CRT case, the CRT caseworker was responsible for meeting with the victim within two hours and conducting a Initial Safety Assessment, assessing the same fifteen Safety Factors available to the Intake worker. If the caseworker determined the child was not safe to return to his or her home, even with efforts to create an in-home safety plan, the caseworker had the authority to dispose the case to CWS for further investigation and/or immediately remove the child, looking for a placement with relatives when possible.

The CRT caseworker could also refer the family to Intensive Home-Based Services, if s/he felt, through consultation with IHBS, that this was an appropriate step, and if the IHBS provider had an opening for the child and family. If the case went to IHBS, the CRT caseworker maintained responsibility for that case until IHBS were concluded. The CRT caseworker was then

responsible for conducting a Final Safety Assessment, and a final disposition, to CWS, VCM, FSS, or case closure.

CRT Workflow Chart

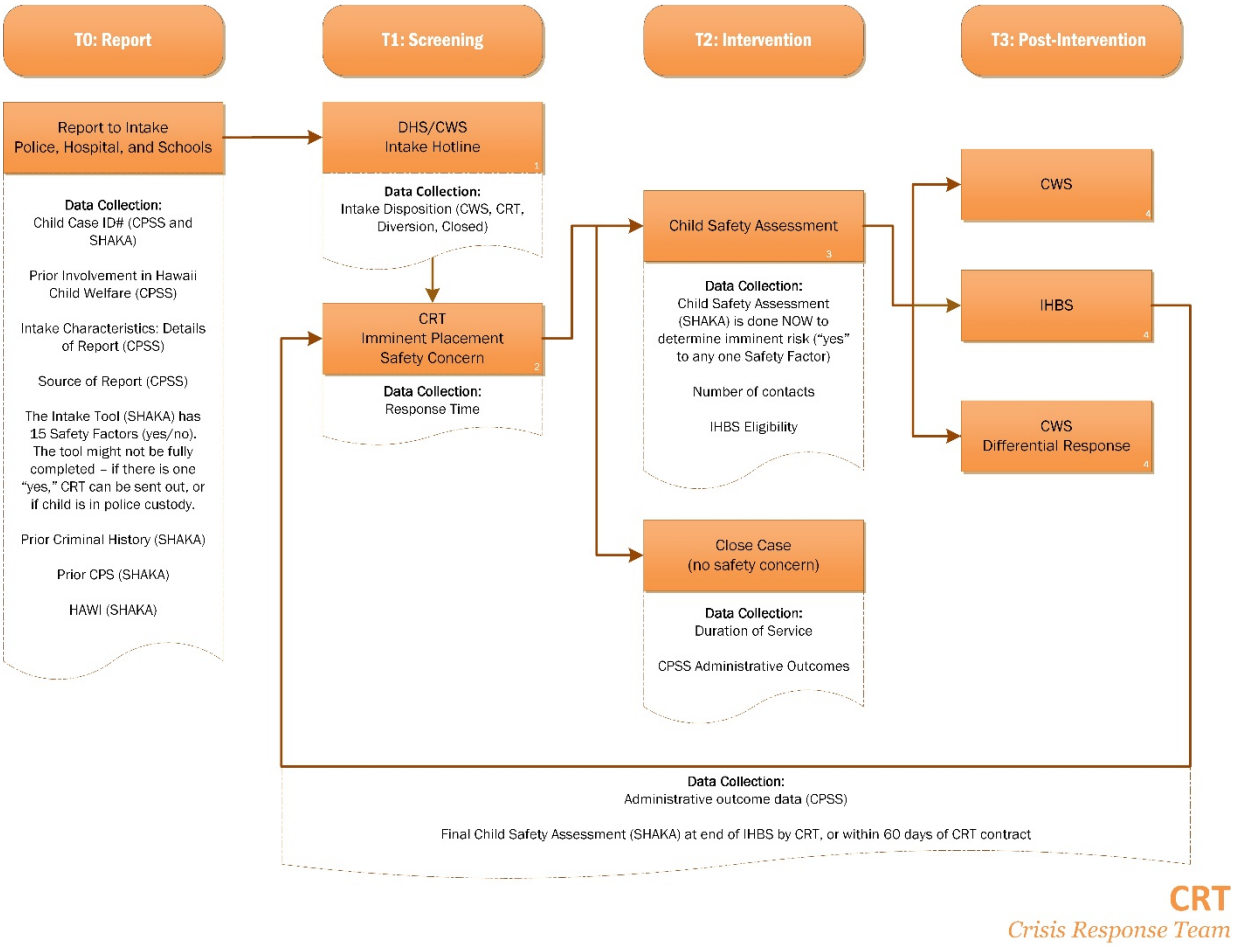


Figure 15. CRT Workflow Chart

Staffing

The design of the Crisis Response Team was different on O‘ahu versus Hawai‘i Island. On O‘ahu, the CRT was a stand-alone specialized unit (a “team”) with a supervisor, caseworkers, and assistants. On Hawai‘i Island, CRT was a “response,” where caseworkers determined if an intake (a report of child maltreatment) met the eligibility criteria for CRT (e.g., the report came from police, hospitals, or school, and a child is at imminent risk of placement) and if so, responded within two hours. If the intake did NOT meet those criteria, the same caseworkers were NOT required to respond within two hours.

Also discussed briefly here are insights on the staffing and training of the CWS Intake Unit, the centralized unit responsible for fielding all intake calls to CWS and for assigning cases to the CRT intervention. The roles and responsibilities of the Intake unit were not discussed in depth in either the IDIR or the Evaluation Plan, but as the Demonstration interventions were implemented in Year One, the unit played a more integral role in the CRT intervention than originally planned (see “Service Fidelity of CRT Referrals by Intake”).

O‘ahu

On O‘ahu, the CRT unit was set up as a stand-alone specialized unit. An existing CWS unit was converted to the CRT unit and all of the staff were internal transfers. The CRT unit was designed to have a total of nine dedicated staff. The dedicated staff for the unit would consist of one supervisor, five social workers, four social service assistants, and one secretary. In addition, twelve standby (nights and weekend/holidays) staff members supported this unit.

In order to accommodate the two-hour response requirement, three eight-hour shifts were identified with the intent to fill after-hour shifts with dedicated staff. At the start of the Waiver Demonstration, the CRT unit was only 27% staffed; staffing consisted of one supervisor, one social worker, and one social service assistant (see Table 17). Thirteen standby staff members (two supervisors, five social workers, and six social service assistants) supported the unit (see Table 18). The swing shift position was filled within the first year of the Demonstration, but the graveyard shift was difficult to fill. This was a persistent difficulty throughout the Demonstration.

Throughout the course of the Demonstration there was turnover in both the CRT unit and standby staff. The CRT unit had a net gain of three social workers and two social service assistants while there were net losses in standby staffing. Standby lost one supervisor, one social worker and all six social service assistants. In the final year of the Demonstration, the CRT unit was 72% staffed, and supported by five standby workers (one supervisor and four social workers).

Table 17
CRT Staffing 2015 - 2018: O'ahu

Position	Positions in IDIR	Positions filled - Waiver start		Positions Filled - Summer 2018		Net Change
	Number	Number	% to Goal	Number	% to Goal	
Secretary	1	0	0%	0	0%	·
Social Service Assistant	4	1	25%	3	75%	↑
Social Worker	5	1	20%	4	80%	↑
Supervisor	1	1	100%	1	100%	↑
Total	**11**	**3**	**27%**	**8**	**73%**	↑

Table 18
Standby Staffing 2015 - 2018: O'ahu

Position	Positions filled - Waiver start	Positions Filled - Summer 2018	Net Change
	Number	Number	
Secretary	0	0	·
Social Service Assistant	6	0	↓
Social Worker	4	4	·
Supervisor	2	1	↓
Total	**12**	**5**	↓

Information regarding staff education level was available for 50% of the CRT staff on O'ahu, the social workers and supervisors. The staff education level of the supervisors and social workers was at the bachelor and master's degree; 67% of supervisors held a master's degree and 42% of social workers held a master's degree. When originally staffed, CRT supervisors and social workers (including standby staff) had an average of 10.7 years of experience working with children and families. At the end of the Demonstration, the average years of experience for CRT supervisors and social workers was 12.4 years.

Hawai'i Island

In East Hawai'i (Hilo), there was no dedicated unit for the CRT. The CWS section in Hilo consisted of three units that all responded to CRT cases (See Table 19). In the initial year of the Demonstration, there was a total of 32 dedicated staff; of those, six staff members also covered standby shifts (nights and weekends/holidays). The CWS staff consisted of one section administrator, three supervisors, three secretaries, 12 social service assistants/aides and 14 line staff. At the end of the Demonstration (September 2018) the CWS staff consisted of one section administrator, three supervisors, three secretaries, 11 social service assistants/aides, and 16 line staff.

Table 19
CRT Staffing 2015 – 2018: East Hawai'i

Position	Positions filled - Waiver start	Positions Filled - Summer 2018	Net Change
	Number	Number	
Secretary	3	3	·
Social Service Assistant	12	11	↓
Social Worker	14	16	↑
Supervisor	3	3	
Section Administrator	1	1	
Total	**33**	**34**	↑

The challenge of having standby staff to cover after-hour shifts was also reported in East Hawai'i mid-way through the Demonstration; standby staff covered all sections.

The staff education level of the supervisors and social workers was at the bachelor and master's degree level with majority of staff holding a master's degree. In the initial year of the Demonstration, the supervisors and social workers had an average of 14.1 years of experience working with children and families. At the end of the Demonstration, that had increased to an average of 15.5 years of experience.

Similar to East Hawai'i, in West Hawai'i (Kona), there was no dedicated unit for the CRT. The CWS West Hawai'i section consisted of two units that respond to all cases, including CRT (See Table 20). There were nine dedicated staff. Of those, two staff members also covered standby shifts (nights and weekends/holidays). The staff consisted of one section administrator, two supervisors, and six line staff. Having staff to cover the stand-by hours was also a challenge in West Hawai'i.

Table 20
CRT Staffing 2015 – 2018: West Hawai'i

Position	Positions filled - Waiver start	Positions Filled - Summer 2018	Net Change
	Number	Number	
Secretary	1	2	↑
Social Service Assistant	6	5	↓
Social Worker	5	6	↑
Supervisor	3	2	↓
Section Administrator	1	1	·
Total	**16**	**16**	·

The staff education level of the supervisors and social workers ranged from bachelor's degree to master's degree with a majority of staff holding a master's degree. The staff had an average of 11.7 years of experience working with children and families.

The staff on Hawai'i Island, from both sites, expressed multiple concerns in a variety of settings that they were often unable to meet the two-hour Crisis Response Team requirement due to the large geographical distances they need to cover on Hawai'i Island.

Intake Unit

In May 2019, the section administrator responsible for overseeing the Intake Unit reflected on the staffing and training of unit staff over the course of the Waiver Demonstration and the use of an answering service to field calls to the Intake hotline. At the start of the Demonstration, the unit was fully staffed and had two experienced supervisors leading the team. At that time, the answering service was used for "after hours" calls to the intake hotline. "After hours" is defined as any time outside of the regular work hours of 7:45 am – 4:30 pm, Monday – Friday and therefore covered night and weekend calls.

Early in the Demonstration period, the unit lost a supervisor and several Intake staff; CWS staffing levels were also reduced in all units during that time period. The reduced staffing, combined with an increase in call volume when CWS took over responsibility for responding to human trafficking,[1] calls led to a change in how the answering service was utilized. In late 2017 – early 2018, the answering service was utilized 24/7 to field calls to support the Intake unit. This is further discussed later in this *Report*.

At the end of 2018, a branch reorganization allowed the Intake unit to add back positions previously lost. Since then, a number of positions have been filled and the Intake unit is approximately 75% staffed. Of those staff, 25% were in training in 2019.

Training for and about the Crisis Response Team

In Year One, staff responsible for providing CRT services received specific training about the CRT Intervention. Staff on O'ahu received CRT core training; support staff received two weeks of in-service training and line staff and supervisors received four weeks of in-service training. Staff on Hawai'i Island received six to eight hours of training provided by the Child Welfare Staff Development staff and Waiver Demonstration Leadership.

[1] The Justice for Victims of Trafficking Act of 2015 required that DHS make a report to law enforcement and track the number of suspected victims statewide. CWS Intake responded to victims of sex trafficking or severe trafficking as a victim of child abuse. Effective December 2017, trafficking reports went to a designated hotline.

The staff serving CRT cases also had responsibility for referring eligible and appropriate families to Intensive Home-Based Services (IHBS). After the initial rollout of the CRT intervention, new staff in East Hawai‘i received training on both CRT and IHBS from their supervisor and section administrator. New staff on O‘ahu received training on the two interventions from CRT team leaders, and from HOMEBUILDERS, the model selected for IHBS. All CRT staff met regularly to discuss the two interventions and were mentored by supervisors. The IHBS supervisor met regularly with the East Hawai‘i section administrator and supervisors to discuss possible referrals, open slots, challenges, progress, etc. The IHBS provider was also invited to monthly section meetings to conduct presentations to ensure that the process, paperwork and expectations were clear. In response to low referral rates to IHBS in West Hawai‘i, the unit section administrator requested a refresher training on the IHBS intervention for all unit staff. This training was conducted by the Waiver Project Manager and the O‘ahu section administrator overseeing the O‘ahu CRT unit.

In addition to these trainings, all CRT staff also received training on the SPAW and Wrap interventions at the start of the Demonstration. Although the O‘ahu CRT unit was not responsible for referrals to SPAW or Wrap, all CWS staff received the SPAW values training and SPAW skills training (conducted by representatives of Casey Family Programs), *CANS* training and certification (conducted by Dr. John Lyons), and Wrap Hawai‘i training (conducted by the staff at EPIC ‘Ohana). The CWS Staff Development Office provided these trainings to all new child welfare hires as well.

Intake Staff Training

At the start of the Demonstration, one of the Intake supervisors worked closely with the CRT Workgroup and Waiver leadership to develop intake procedures for CRT, including determining eligibility and how the disposition of cases to CRT would work. That supervisor was responsible for providing training to all Intake staff. The staff also participated in the CWS rollout activities for the Waiver Demonstration and the SPAW and Wrap training provided to all CWS staff. Answering service staff did not receive training on the Demonstration interventions as their role did not require this knowledge.

Number of Children Served by the Crisis Response Team

Figure 16. Number of Children in CRT Sample on O'ahu and Hawai'i Island

The Crisis Response Team responded to more children than originally anticipated on both O'ahu and Hawai'i Island for most of the Demonstration. Compared to the targets identified in the IDIR (DHS, 2014), the O'ahu CRT responded to 194 children in the first six months of the Waiver Demonstration, 15% above the expected number (see Figure 16). This response rate increased in subsequent periods; during the first half of 2016, the O'ahu CRT responded to more than twice the number of children projected to be served. In the third year of the Demonstration, the number of children served by the CRT declined, but was still above projections.

The Crisis Response Team responded to more children than originally anticipated on O'ahu.

On Hawai'i Island, the number of children met with a Crisis Response also exceeded projections. Implementation of the Waiver interventions was delayed until the fourth quarter of 2015; the number of children with a CRT response in East Hawai'i was 54% above projections in the first half of 2016 (see Figure 16). In West Hawai'i, the number of children receiving a Crisis Response grew from 65% of projections in the initial quarter of the Demonstration to almost double that projected in the second half of 2016. Like trends on O'ahu, the number of children seen on Hawai'i Island was much higher than projected in 2016, but began to decline in 2017 and this continued into 2018.

The majority of reports referred to the CRT were not reports on children in active cases. However, in the early period of implementation on O'ahu, reports that came to Intake on

children in an active CWS case were sometimes referred to the CRT, particularly if the report came in on the weekend (as reported in the *Interim Evaluation Report*, 2017). These cases were categorized as "CRT-A" cases. On O'ahu, 7% of the CRT responses in the first six months of 2015 were on active (CRT-A) cases. This increased to 8% of CRT responses in the second half of 2015, and increased further to 13% of CRT responses on O'ahu in the first half of 2016. In September 2016, DHS Leadership reaffirmed the policy that reports on an active case should be responded to by the unit that holds the case, or by standby in off hours. In the second half of 2016 on O'ahu, the rate of CRT-A cases fell to 8%. This practice ended by 2017.

On Hawai'i Island, the CRT-A rate was 31% of CRT responses in the first quarter of the Waiver Demonstration (October through December 2015). This fell to 10% of CRT responses in the first half of 2016 and 12% of CRT responses in the second half of 2016. This practice ended by 2017.

Knowledge and Impressions of CRT after the First Year

Interviews and focus groups were conducted during the first six months of 2016 on both O'ahu and Hawai'i island with CWS administrators, CWS staff, and service providers. Included in those interviews and focus groups were questions eliciting their knowledge and impressions of the Crisis Response Team.

The Crisis Response Team model was appreciated by staff as a quality service to offer families in the time of a crisis. The CRT focus of placement prevention and the two-hour response did not exist before the Waiver Demonstration and were seen as positive and needed additions to the Child Welfare service array. Staff commented that, in the past, "perhaps we were too quick to remove," that "it's great to be able to offer this to the community," and "this makes a big difference in our response."

There was confusion, however, regarding eligibility and pathways to the CRT. Focus group participants were not clear about the definition of imminent risk of placement. They also expressed a lack of clarity about whether children in reports from sources other than law enforcement, hospitals, and schools could be referred to the CRT.

Another concern that was brought up was the hand-off of a CRT case to Child Welfare Services when a child had been removed from the home. Upon removal of the child and transfer from CRT to CWS, the CWS worker had to appear in court and defend the decision made by a CRT worker to have the child removed.

Staffing was also noted as an issue for the Crisis Response Team. The CRT was designed as an around-the-clock service. However, in the first year, DHS was not able to hire the required personnel to staff the evening and overnight shifts. As a result, standby workers were covering night and weekend shifts in addition to their standard daily shift. This challenge arose in the

first year of the Waiver and proved difficult to solve. In the summer of 2018, nearing the end of the Demonstration period, the unit was still understaffed.

Knowledge and Perceptions of CRT after the Second Year

After the Crisis Response Team had been active for about two years, child welfare staff were asked about their knowledge and perceptions about the Crisis Response Team, in the form of a questionnaire. The questionnaire asked staff to indicate their level of agreement with five statements about their level of knowledge about the Crisis Response Team, their level of agreement with several statements about their positive and negative perceptions of the CRT, and their probable response to two case scenarios in which a referral to the CRT was the appropriate decision, based upon eligibility criteria and CRT training content.

Knowledge About the Crisis Response Team

There were five items measuring how much the staff felt they knew about the CRT. The items were:

- I have received enough information about CRT to understand its overall purpose.
- CRT trainings made the need for the intervention clear to me.
- It is clear how CRT is meant to help children and families.
- The main goal of CRT is not clear to me.
- I am not sure which cases should go to CRT.

The response choices for each item used a Likert scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree). Using the two categories of Strongly Agree and Agree, percentages of agreement were calculated.

A total of 30 CWS staff, who had responsibility for referring cases to CRT or providing CRT, responded to the statements above, regarding their knowledge of the Crisis Response Team. As shown in Table 21, staff felt fairly confident in their knowledge of CRT. The majority of respondents felt that they received enough information about CRT to understand its purpose (86% and 93% on O‘ahu and Hawai‘i Island). There was less agreement with the perception that the trainings made the need for the CRT clear, but higher agreement that respondents clearly understood how the intervention was meant to help children and families.

The majority of child welfare staff felt that they received enough information about CRT to understand its purpose.

The last two statements were reverse-coded, meaning that lower levels of agreement indicate greater knowledge. Very few respondents (7% and 6%) indicated that the goal of CRT was not clear to them or that they were not sure which cases should go to CRT (14% and 6%). There were no significant differences between islands in respondents' perceptions of their knowledge about the Crisis Response Team.

Table 21
Knowledge of the Crisis Response Team

Agreement with Statements	CRT	
	O'ahu (n=14)	**Hawai'i Island** (n=16)
I have received enough information about CRT to understand its overall purpose.	86%	93%
It is clear how CRT is meant to help children and families.	71	87
CRT trainings made the need for the intervention clear to me.	57	63
I am not sure which cases should go to CRT.	14	6
The main goal of CRT is not clear to me.	7	6

Perceptions of the Crisis Response Team

Staff were asked to indicate their level of agreement, on a five-point scale, with a number of items about the Crisis Response Team. These items were averaged into six composite scores related to:

- Knowledge of the intervention
- Perception that the intervention has advantages relative to prior approaches
- Positive peer buy-in about the intervention
- Compatibility with the local context
- Concerns about risk to children with the intervention
- Concerns about the time commitment required for the intervention

Mean scores on these six dimensions are shown in Table 22.

Respondents felt positive about their level of knowledge about the CRT, and that the CRT response had advantages relative to prior approaches. Mean scores were also relatively high in regard to the positive buy-in of peers for the Crisis Response Team. Respondents on Hawai'i Island felt significantly less positive that CRT is compatible with the local context. On a five-point scale, there was substantial concern about the risk involved in a CRT response, and this concern was significantly higher on O'ahu (mean of 3.4) than on Hawai'i Island (mean of 3.0). There was also moderate concern on both O'ahu (mean of 3.1) and Hawai'i Island (mean of 3.1) about the time commitment required for CRT.

Table 22

Perceptions of the Crisis Response Team

Mean Scores	CRT	
	O'ahu (n=14)	**Hawai'i Island** (n=16)
Positive Perceptions of CRT		
Knowledge about CRT	3.9	4.0
CRT has advantages relative to prior approaches	3.9	3.7
Positive peer buy-in about CRT	3.7	3.4
CRT is compatible with local context	3.7†	3.1
Negative Perceptions of CRT		
Negative risk concerns about CRT	3.4†	3.0
Negative concerns re: time commitment for CRT	3.1	3.1

†p<.05

Knowledge of Eligibility Criteria for Referrals to the Crisis Response Team

If a respondent had responsibility for referring reports of maltreatment from Intake to the CRT, s/he was directed to view two scenarios of maltreatment reports, asking what the appropriate referral would be. In both scenarios, the correct response was CRT, based on the stated referral criteria for CRT in training.

> **Scenario 1:** Kaleo is a 9-year-old boy. His teacher saw a bruise on his face and when asked, he said "I was naughty and my dad slapped me." The school called the CWS Hotline. Intake believed the behavior of the primary caregiver put the child at risk for violence. The parent seems to be impulsive, exhibiting physical aggression, and temper outbursts which could likely cause danger to the child.
>
> **Scenario 2:** Queen's Hospital emergency room called CWS. The mother and her son, Jose who is 16 years old came into the ER because he was having a breathing problem. The mother thought it might be asthma. The child had been diagnosed previously with a schizoaffective disorder, and the mother says she does not have the skill or ability to care for child. The child is vulnerable due to lack of self-protection skills or the presence of special needs that his mother is unable to meet, and these are presenting the threat of present or impending danger.

Among the ten respondents who made referrals to the CRT, only 30% would refer a report of a boy with a bruise at school to the CRT and only 40% would refer a young boy at the Queen's Hospital emergency room to the CRT (see Table 23). However, in both scenarios 20% responded "other," and in open-ended narratives of the next steps they would take in these

scenarios, respondents in the "other" category uniformly said they would send the police to the school in the school scenario, and they would wait for the medical evaluation in the hospital scenario.

Based on these results, there continued to be a lack of clarity on eligibility criteria for referrals to the Crisis Response Team in the second year of the Demonstration, with approximately only a third of respondents answering the CRT referral scenarios correctly.

Table 23
CRT Scenarios of Maltreatment Reports

Referral Decision	**CRT**	
	Scenario: Boy with bruise at school (n=10)	**Scenario: Queen's Hospital called** (n=10)
Refer to CRT	30%	40%
Send caseworker out when possible	50	40
Other/no answer	20	20

Service Fidelity of CRT Referrals by Intake

Trends in Maltreatment Reports to Centralized Intake

Hawai'i DHS implemented a Crisis Response Team as an important component of the Waiver Demonstration in response to the high rates of short-stay placement of children after Intake, particularly when the report to Intake came from law enforcement, hospitals and/or schools. Therefore, a key parameter of the original model of the Crisis Response Team was for Intake to send reports that originated with law enforcement, hospitals and schools to the Crisis Response Team, and this was designated as a key CRT eligibility criterion.

The second, and only other, eligibility criterion for a referral to the Crisis Response Team was an indication that the child was at imminent risk of placement. However, at the beginning of the Waiver Demonstration, there was no such question or indicator on the Intake Tool or in Intake records. As indicated in focus groups and surveys discussed earlier, there was confusion about this eligibility criterion, and this was not clarified over the course of the Waiver Demonstration. The evaluation of CRT uses the existing indicator of "imminent risk of harm" as a proxy for this criterion in its analyses, but this was not explicitly agreed upon by CWS as the substitute criterion for a disposition of an intake to the CRT.

As mentioned in the discussion of staffing, at the start of the Waiver Demonstration, an answering service was used for "after hours" calls to the Intake Hotline. "After hours" is defined as any time outside of the regular work hours of 7:45 am – 4:30 pm, Monday – Friday and therefore covered night and weekend calls. However, a simultaneous reduction in staffing and increase in call volume in late-2017 led to the use of the answering service to field all calls 24/7 that came into the Hotline.

When receiving a child abuse Hotline call, the answering service recorded a name and phone number for each call. During business hours, Intake support staff called the answering service every 10 – 15 minutes to collect messages. These messages would then be distributed to Intake staff for response. If a caller declined to leave a name or phone number, the call could be routed directly to an Intake worker for immediate response. After hours calls to the Intake Hotline were handled in the same way throughout the Waiver Demonstration; once an answering service staff recorded the caller's name and phone number, the information would then be passed to CWS staff on duty for response.

Although the answering service handled initial contacts on the Intake Hotline, an Intake worker responded to each call and was responsible for collecting and recording the pertinent details of the complaint and determining the disposition of the call. The Intake Unit gathers information about the child, the family, the maltreatment, and the current risk to the child. Based on the information gathered, Intake can then take No Action, refer the case to Child Welfare Services

for further investigation, refer the case to the Crisis Response Team, or refer the family to the diversionary services of Voluntary Case Management or Family Strengthening Services.

Imminent Risk of Harm

From 2012 through 2014, the three years prior to the Waiver Demonstration, around 90% of all children classified as a victim were noted by Intake to be at imminent risk of harm. This high level continued throughout the Waiver Demonstration.

Trends in Sources of Reports of Child Maltreatment, 2012-2017

Generally, the three most frequent types of reporters of child maltreatment in Hawai'i are schools (the source for 15% of intakes, 2012-2014), hospitals (12%), and law enforcement (12%). Other common reporters are the courts (the source for 11% of intakes), public social agencies (10%), and private social agencies (9%).

Given that the Crisis Response Team was designed to provide an immediate response to maltreatment reports from law enforcement, hospitals, and schools, it is important to examine whether patterns of reports from these three sources remained consistent throughout the Waiver Demonstration[2] (See Figures 17 and 18).

On O'ahu, the number of children with intakes reported by law enforcement sources was lower than that of hospitals or schools, and stayed relatively stable throughout the Demonstration. The number of children with intakes reported by schools was relatively high and also stayed fairly stable throughout the Demonstration. However, the number of children with intakes reported by hospitals increased dramatically, particularly between 2013 and 2015, the time of the transition to the Waiver Demonstration.

[2] 2018 is not included due to incomplete data.

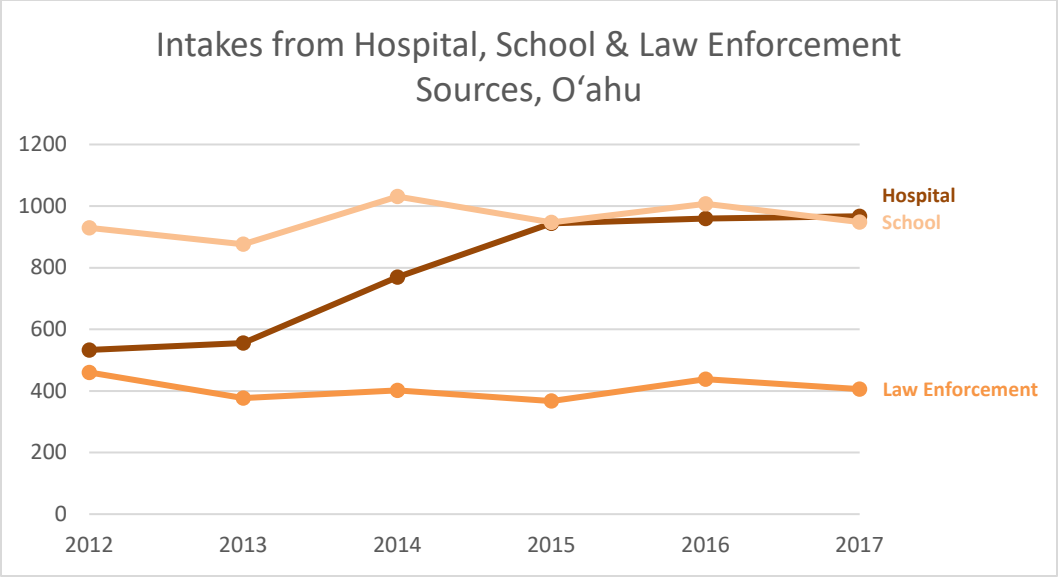


Figure 17. Trends in Source of Report on O‘ahu 2012 – 2017[3]

[3] Detailed numerical tables for all figures are included in Chapter Six Appendix.

In the three years prior to the Waiver Demonstration, on Hawai'i Island, the number of children reported by schools and by law enforcement saw a small decline, while the number of children reported by hospitals increased. This increase in children reported by hospitals continued to increase throughout the Waiver Demonstration. Maltreatment reports from schools also dramatically increased after 2015.

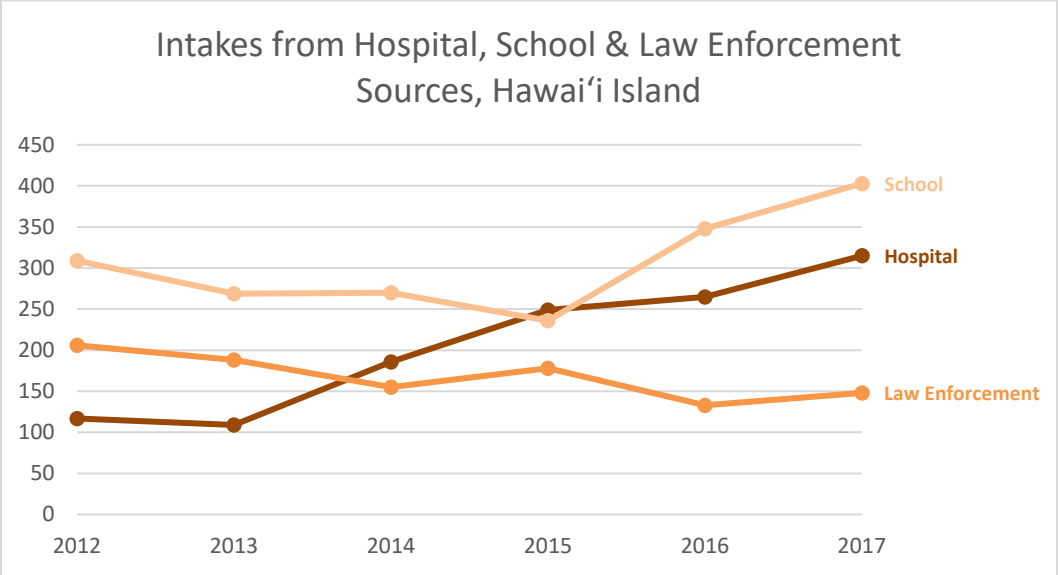


Figure 18. Trends in Source of Report on Hawai'i Island 2012 – 2017

Trends in the Nature of Abuse Intakes in Hawai‘i, 2012-2018

There is another complication in understanding and identifying patterns of referrals to the Crisis Response Team. Looking at information on victims identified in All Intakes on O‘ahu and Hawai‘i Island from 2012-2017, the incidence and nature of child maltreatment of victims reported to Intake has changed over these six years. We do not know if the actual child maltreatment in the state has changed, or if the way the Intake Unit records it has changed, but it has changed.

The Incidence of Victims of Maltreatment

Looking at O‘ahu and Hawai‘i Island, the two sites for the Waiver Demonstration, the number of victims of maltreatment, as noted by Intake, was variable in the three years preceding the Waiver Demonstration (2012-2014), but has steadily increased over the duration of the Waiver Demonstration (See Figure 19; 2018 figures not available).

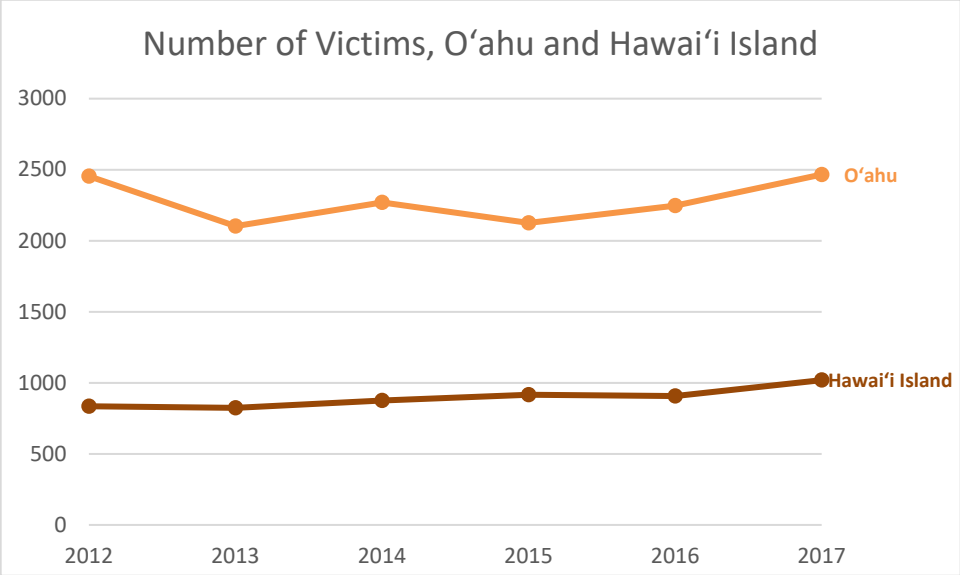


Figure 19. Number of Victims by Year, O‘ahu and Hawai‘i Island

Trends in the Nature of Maltreatment

Recall that the five most frequent types of maltreatment recorded by Intake are:

- Threat of Abuse
- Threatened Neglect
- Physical Abuse
- Physical Neglect
- Sexual Abuse

There are other, less frequent types of maltreatment, like medical neglect, psychological abuse, etc.

How maltreatment of victims was reported/recorded changed from Pre-Waiver years (2012-2014) to Waiver years (2015-2018). We report these changes among victims only, not non-victims. The reader is cautioned that only one Intake Tool (containing information on the victim, maltreatment, and safety factors) is recorded per family/case.

Classifying the nature of the maltreatment as Threat of Abuse or Threatened Neglect increased significantly at the same time as implementation of the Waiver Demonstration (see Figures 20 and 21). The proportion of victims experiencing Physical Abuse and Physical Neglect also declined at the same time. Other types of maltreatment (besides sexual abuse, which was largely disposed to specialized sexual abuse units rather than CRT) were very rare in all years, 2012-2018.

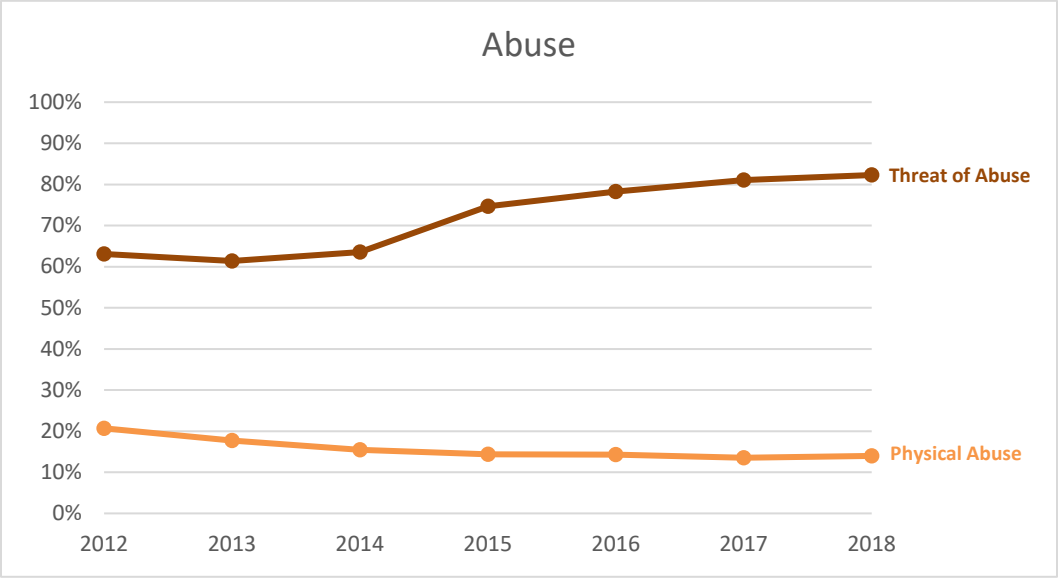


Figure 20. Proportion of Intakes with Types of Abuse, O‘ahu and Hawai‘i Island

Note. All other types of maltreatment at 1% or less

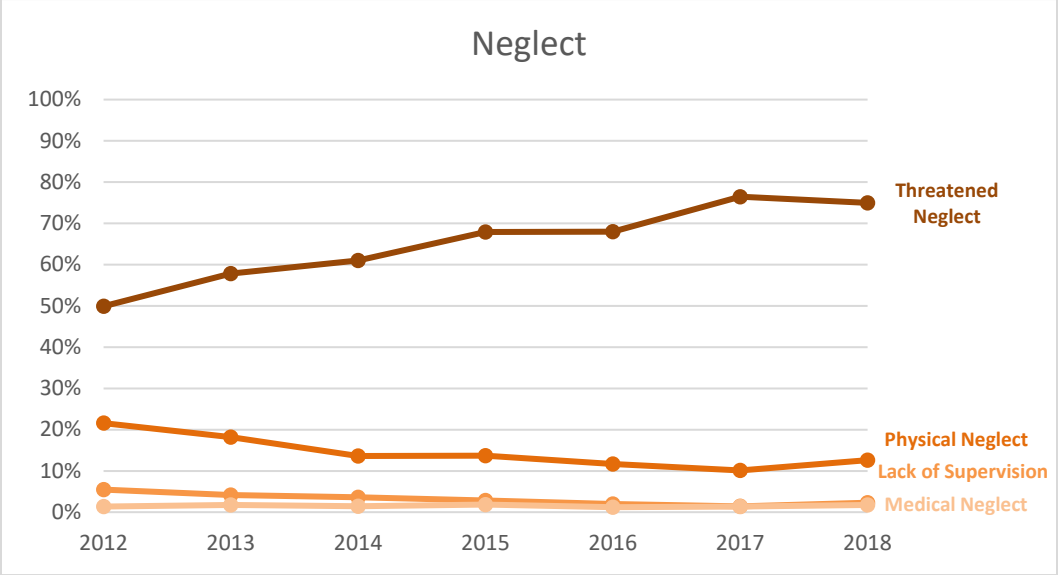


Figure 21. Proportion of Intakes with Types of Neglect, O'ahu and Hawai'i Island

Note. All other types of maltreatment at 1% or less

In addition, in the three years prior to the Waiver Demonstration on O'ahu and Hawai'i Island, about 60% of victims of child maltreatment reports were noted as experiencing more than one type of maltreatment (See Figure 22). As the Waiver Demonstration began, this increased to 70% of victims, and continued to increase over the course of the Demonstration to 78% of victims. Again, these reports were highly likely to include Threat of Abuse and Threatened Neglect.

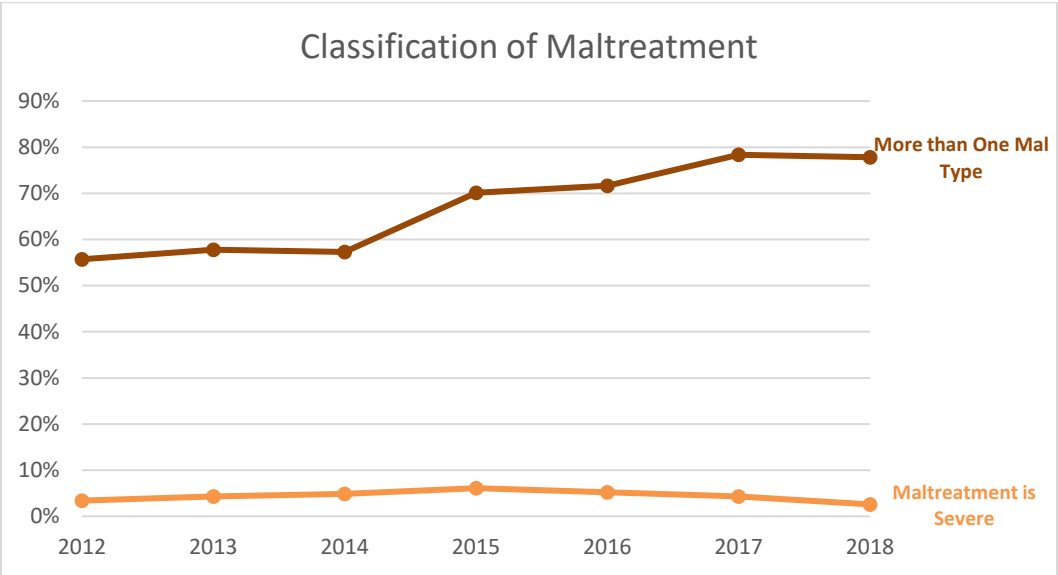


Figure 22. Classification of Maltreatment, O'ahu and Hawai'i Island

While the classification of Threat of Abuse and Threatened Neglect increased over the years of the Demonstration, the proportion of identified victims whose maltreatment met the legal definition of harm decreased, from 42% of victims in 2012, to 31% in 2015, to 29% in 2018. Almost all victims on O'ahu and Hawai'i Island are assessed as being at imminent risk of harm (See Figure 23).

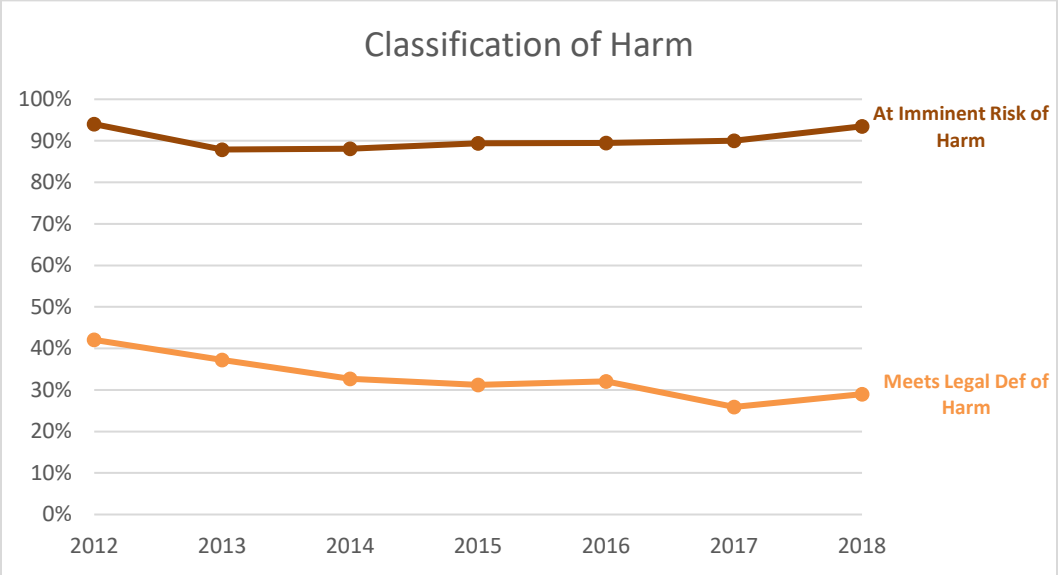


Figure 23. Classification of Harm, O'ahu and Hawai'i Island

Trends in Safety Factors

Finally, there were shifts in the recording of the fifteen safety factors documented on the Intake tool from 2012-2018 (See Figure 24). For victims on O‘ahu and Hawai‘i Island, the most frequently noted safety factor in any year was caregiver violent behavior. After decreasing as a factor from 40% of victims in 2012 to 35% of victims in 2014, caregiver violent behavior increased to 45% of victims in 2018.

A greater increase was seen in the documenting of parental impulsivity, steadily increasing from 24% of victims in 2012 to 37% of victims in 2018. Both of these factors are commonly associated with physical abuse.

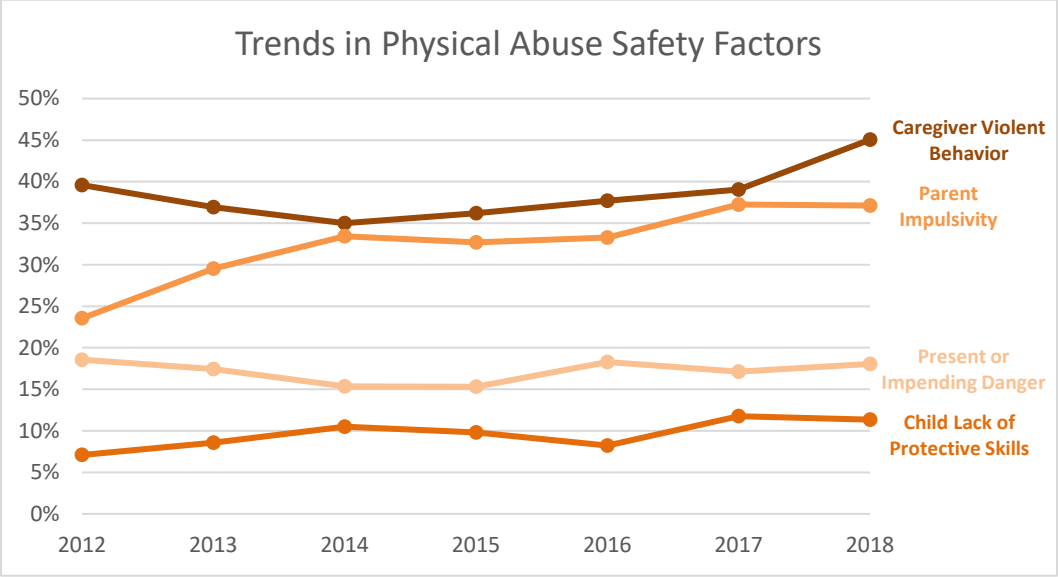


Figure 24. Trends in Physical Abuse Safety Factors, O‘ahu and Hawai‘i Island

There were also changes in safety factors associated with child neglect and threat of neglect (See Figure 25). From 2012 to 2014, documenting that parents cannot meet the child's immediate needs remained at 17% to 18% of victims. This increased to 22% in 2015, and increased dramatically to 27% of victims on O'ahu and Hawai'i Island in 2018.

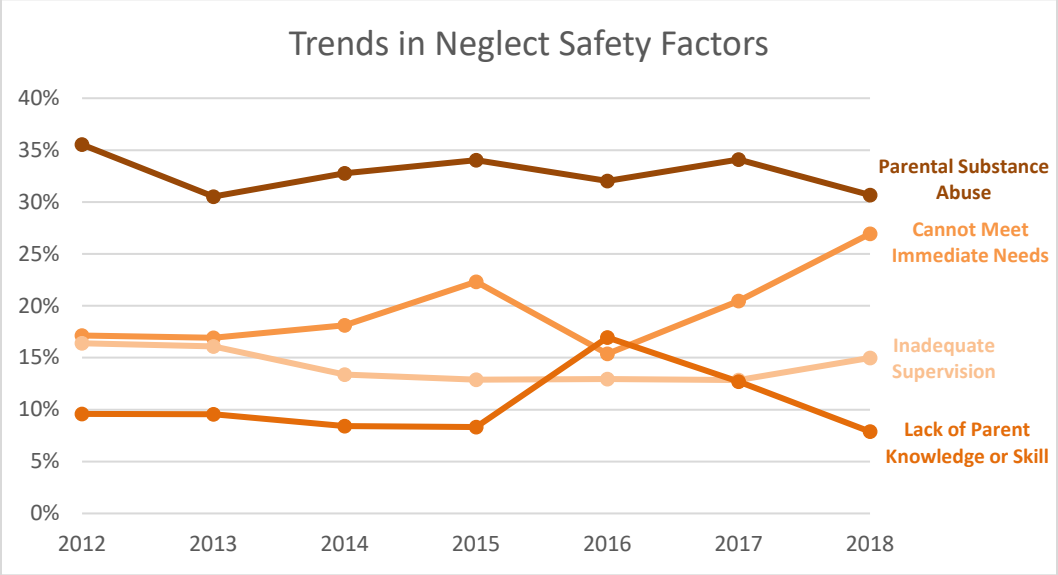


Figure 25. Trends in Neglect Safety Factors, O'ahu and Hawai'i Island

Dispositions of Intakes to the Crisis Response Team

The *IDIR* specified that, once the Waiver Demonstration began, Centralized Intake should refer all intakes from law enforcement, hospital, and school sources and at imminent risk of placement to the CRT. However, there was no designation of imminent risk of placement at intake. Not all intakes from law enforcement, hospitals, and schools were referred to the CRT, and the rates of referral to the CRT differed by the source of the report.

Early in the Waiver Demonstration (2016), the Evaluation Team presented a small report on the referral patterns to CRT described below, showing low and differential rates of disposition to the CRT on both islands. Meetings and discussions with CRT personnel elicited the statement that staffing levels of the CRT on O'ahu and CWS on Hawai'i Island would not support a CRT response for every intake from law enforcement, hospitals, and schools, and that judgments were made about when to send CRT staff in response to a report of maltreatment. In addition, Intake and CRT staff discussed at length whether children identified as maltreated while in a hospital are truly in need of a face-to-face response within two hours, given that they are in the protected setting of a hospital. CWS Leadership reiterated in these meetings and discussions the importance of a crisis response for this group of children, given they might have siblings at risk who are not in the hospital.

Trends in Dispositions of Intakes from Law Enforcement

Once the Waiver Demonstration began in January, 2015, the proportion of children with intakes whose reports came from law enforcement that were referred to Child Welfare Services decreased by more than half, from around 83% to 91% pre-Waiver to between 29% and 39% of intakes during the Waiver on O'ahu (See Figure 26), and to between 29% to 48% of intakes on Hawai'i Island (See Figure 27). Intakes from law enforcement were seldom diverted to voluntary services, before or during the Waiver Demonstration.

During the Waiver Demonstration, over half of all intakes from law enforcement reports were referred to the Crisis Response Team. In the first year of the Demonstration on O'ahu, 54% of Intakes from law enforcement were referred to the Crisis Response Team. This referral rate remained fairly steady throughout the Waiver.

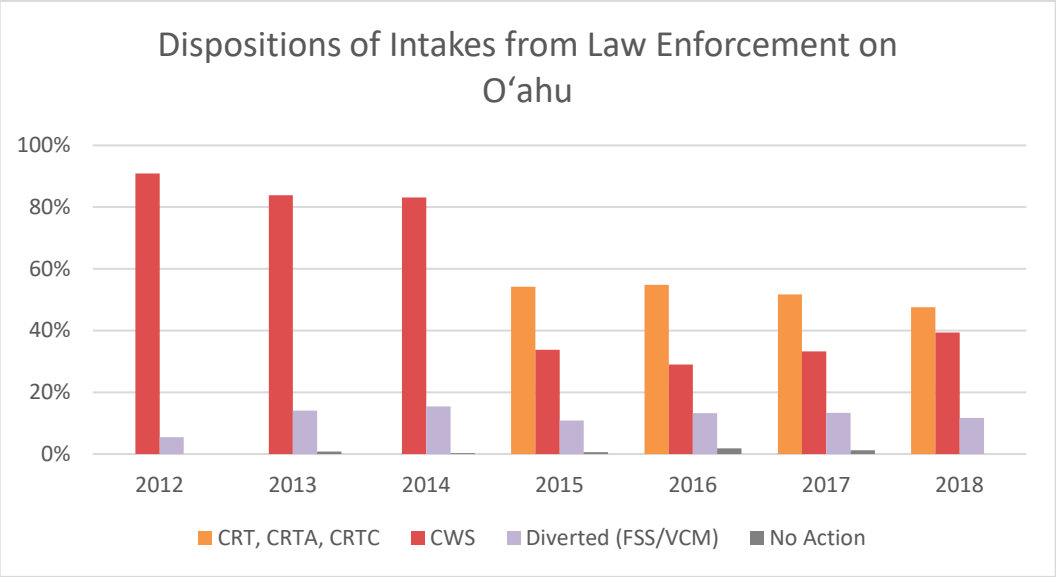


Figure 26. Dispositions as a Percentage of Intakes from Law Enforcement on O'ahu

The Crisis Response was implemented on Hawai‘i Island in October, 2015, so the first full year to examine the referral patterns from Intake was 2016. In 2016, a full 60% of intakes from law enforcement reports received a CRT response. This rose to 65% of such intakes in 2017, but declined to 45% of intakes from law enforcement reports in the first nine months of 2018.

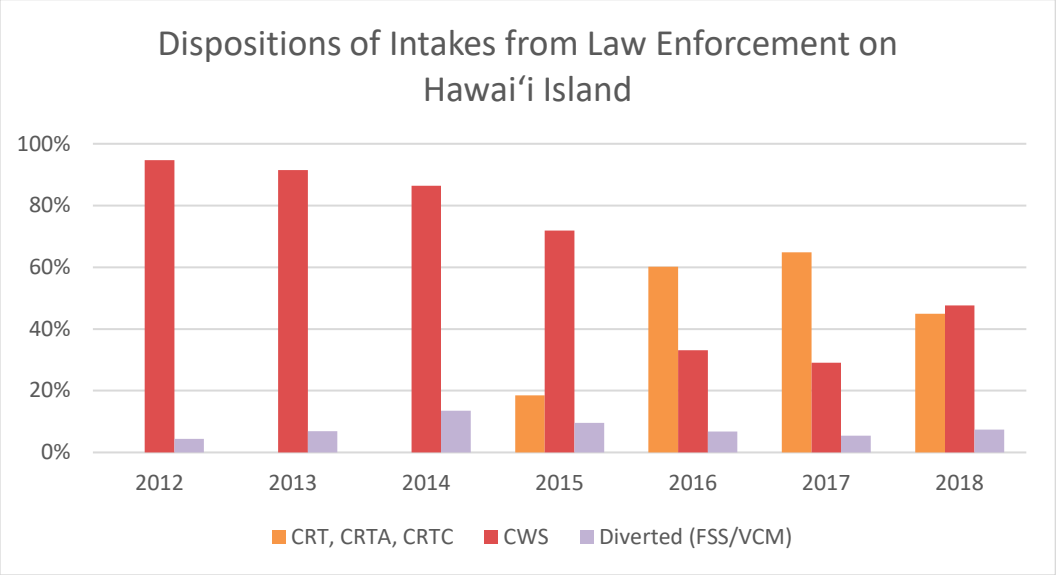


Figure 27. Dispositions as a Percentage of Intakes from Law Enforcement on Hawai‘i Island

Trends in Dispositions of Intakes from Hospitals

During the Demonstration, small proportions of intakes from hospital reports were referred to the CRT (See Figure 28). On O'ahu, only 13% of hospital intakes were referred to the CRT in 2015, the first year of the Demonstration. The CRT referral rate increased to 22% of hospital intakes in 2016, but declined to 15% of intakes in 2017 and 17% of intakes in the first nine months of 2018.

The proportion of referrals of hospital intakes to Child Welfare Services did decrease during the Demonstration years on O'ahu, declining from about 75% pre-Waiver to just above 50% of intakes from hospitals during the Waiver Demonstration. Referrals of intakes from hospital reports to diversionary, voluntary services held steady, at between 25% to 30% of reports.

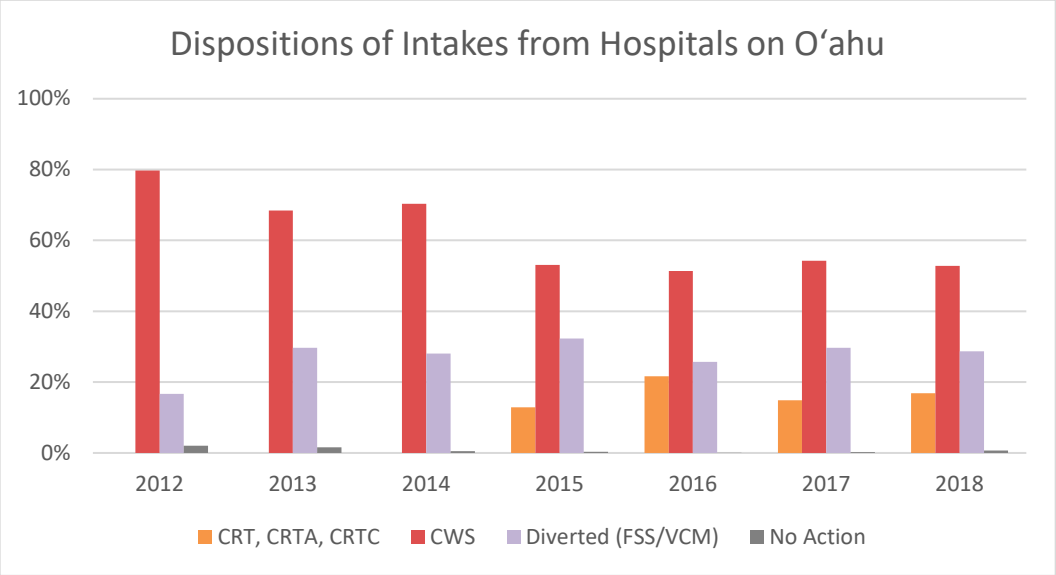


Figure 28. Dispositions as a Percentage of Intakes from Hospitals on O'ahu

Intakes from reports from hospitals on Hawai'i Island were referred from Intake for a CRT response at similar rates to those on O'ahu, with 22% of such intakes being a CRT referral in 2016, 15% being so referred in 2017, and 9% referred to CRT in the first nine months of 2018 (See Figure 29).

On Hawai'i Island, hospital intakes were referred to Child Welfare Services at lower rates once the Demonstration began, decreasing to 58% of intakes in 2016, and holding steady throughout the Demonstration. Referrals of intakes from hospitals to diversionary services saw a large increase, from 20% to 28% of intakes, from 2016 to 2018.

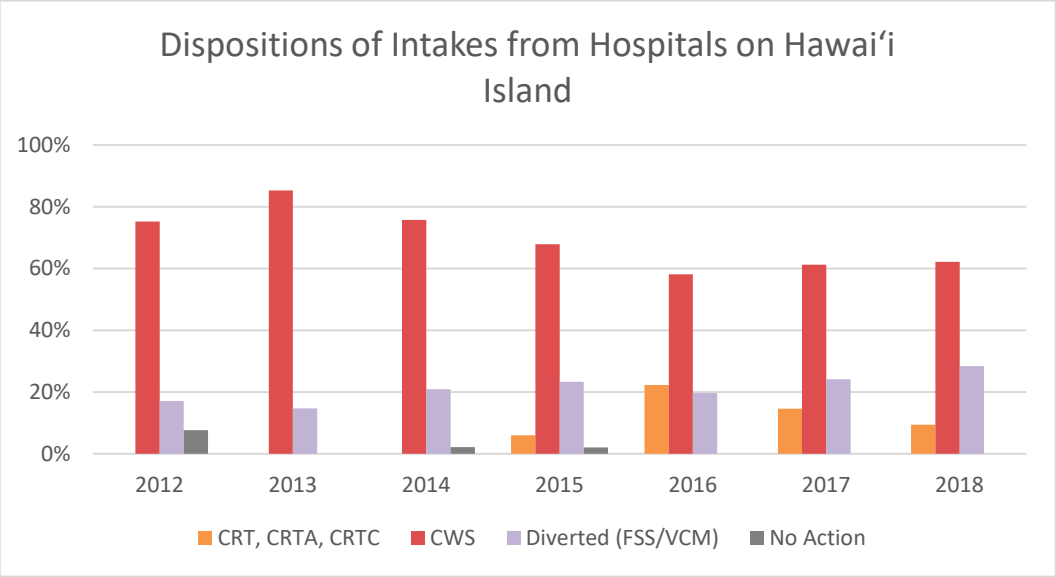


Figure 29. Dispositions as a Percentage of Intakes from Hospitals on Hawai'i Island

Trends in Dispositions of Intakes from Schools

In the first two years after the introduction of the Crisis Response Team, almost one-quarter of intakes from school reports were referred to the CRT. On O'ahu, among intakes that came from school reports, 22% to 25% were referred to the CRT in the first two years of the Demonstration, and this declined to 13% of school intakes in 2017 and 7% of school intakes in the first nine months of 2018 (See Figure 30).

As the Crisis Response Team was introduced, referrals to Child Welfare Services declined in the first two years of the Demonstration on O'ahu, from around 58% of school intakes in the pre-Waiver years, to 32% of intakes in 2015 and 24% of intakes in 2016. However, as referrals to CRT declined in 2017 and 2018, referrals to Child Welfare Services increased.

During the Demonstration years on O'ahu, intakes from school reports were increasingly referred for diversionary, voluntary services, increasing from 47% of school intakes in 2015 to 54% in 2018.

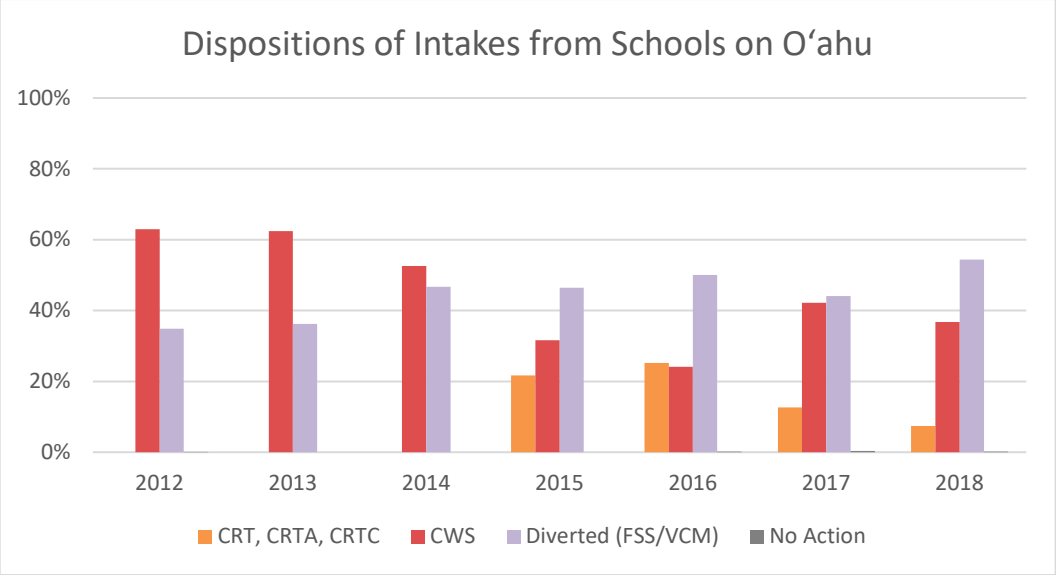


Figure 30. Dispositions as a Percentage of Intakes from Schools on O'ahu

On Hawai‘i Island, around 70% of intakes from school reports were referred to Child Welfare Services in the pre-Waiver years. With the introduction of a Crisis Response in late 2015, one-quarter of intakes from schools were referred for a CRT response in 2016. However, this decreased to 12% of school intakes in 2017 and 8% of school intakes in the first nine months of 2018 (See Figure 31).

Like patterns on O‘ahu, as referrals for a Crisis Response declined, referrals to Child Welfare Services increased during the Waiver years on Hawai‘i Island. Referrals to diversionary services varied between 34% and 45% of school intakes over the course of the Demonstration, higher than in pre-Waiver years.

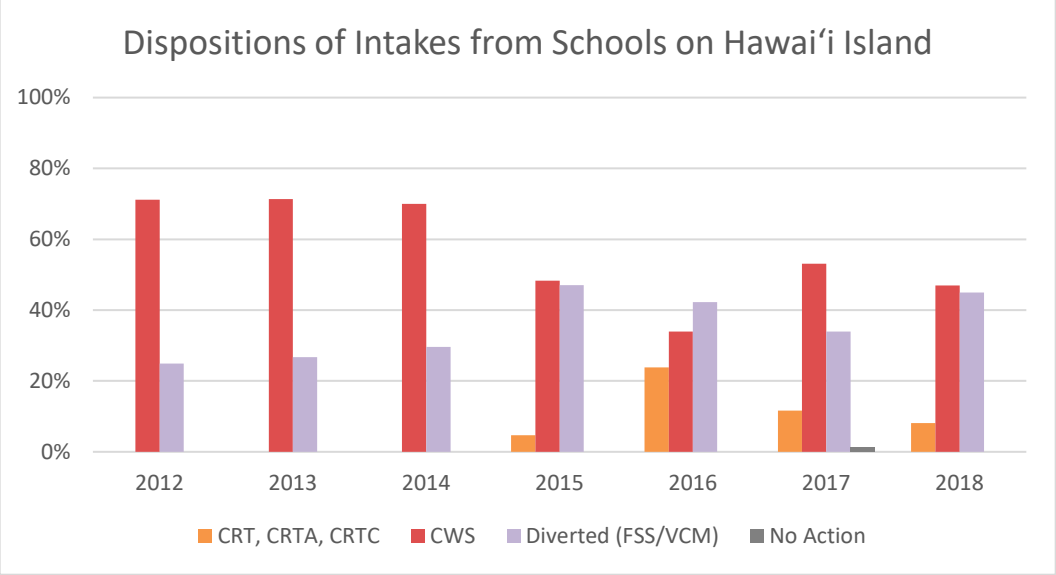


Figure 31. Dispositions as a Percentage of Intakes from Schools on Hawai‘i Island

Differential Risk Profiles for Children by Source of Report

The children who were disposed from Intake for a Crisis Response varied in their risk factors, depending on whether their report of maltreatment came from law enforcement, a hospital, or a school (See Tables 24 and 25).

Oʻahu

Threatened neglect and threat of abuse were common forms of maltreatment for children disposed to the CRT from all three sources, but threatened neglect was particularly likely for intakes from law enforcement and hospitals disposed to the CRT. Threat of abuse was equally likely across the three sources. CRT cases disposed from school reports had the highest proportion of reports concerning physical abuse, and CRT dispositions from law enforcement sources had the highest proportion of reports concerning neglect (threat or actual).

Dispositions to CRT from school reports were the most likely to have maltreatment that met the legal definition of harm, and school intakes were most likely to report safety factors that put the child at imminent risk of harm. Dispositions from law enforcement and hospital reports were more likely than school reports to contain children who had a known history of experience with Child Protective Services, and to have family members with a known criminal history.

Table 24
Risk Factors; Oʻahu

	Source of Report		
	Law Enforcement (n=573)	**Schools** (n=495)	**Hospitals** (n=423)
Threatened Neglect**	49%	30%	42%
Threat of Abuse	47	47	46
Physical Neglect**	14	2	6
Physical Abuse**	11	19	15
Sexual Abuse	6	8	1
At imminent risk of harm**	94	98	94
Meets legal def of harm**	42	61	45
Prior known CPS**	50	37	46
Known criminal history**	45	34	41

** Difference between three report sources is significant at p < .01
* Difference between three report sources is significant at p < .05

Hawai‘i Island

Like O‘ahu, threatened neglect and threat of abuse were common forms of maltreatment for children disposed to a Crisis Response from all three sources, but, on Hawai‘i Island, these types of maltreatment were especially likely for those children reported by hospitals. Among intakes from schools that were disposed for a Crisis Response, the threat of abuse and actual physical abuse were also common. Reports disposed for a Crisis Response from law enforcement sources had the highest proportion of reports involving physical neglect.

Crisis Response children reported by law enforcement personnel were the most likely to have a report where the maltreatment met the legal definition of harm. Safety factors that put a child at imminent risk of harm were highly likely for all children disposed for a Crisis Response, regardless of the source of report. Reports from hospitals were most likely to report children who had a known history of experience with Child Protective Services. Both hospital and school reports disposed to a Crisis Response were most likely to report children who had family members with a known criminal history.

Table 25
Risk Factors; Hawai‘i Island

	Source of Report		
	Law Enforcement (n=176)	**Schools** (n=115)	**Hospitals** (n=70)
Threatened Neglect**	49%	36%	69%
Threat of Abuse**	47	50	79
Physical Neglect	18	9	10
Physical Abuse**	6	28	7
Sexual Abuse	7	4	0
At imminent risk of harm	97	98	96
Meets legal def of harm**	62	48	21
Prior known CPS*	61	69	76
Known criminal history*	60	69	64

** Difference between three report sources is significant at p < .01
* Difference between three report sources is significant at p < .05

Weekday versus Weekend Dispositions to the CRT

As described earlier, the Crisis Response Team was staffed differently on O'ahu and Hawai'i Island. On O'ahu, the Crisis Response Team was a unit, with a supervisor and assigned CRT caseworkers. After-hours and standby workers responded to CRT referrals after hours and on the weekend. On Hawai'i Island, the CRT was conceptualized as a response. The same caseworkers responded to all referrals, and those referrals designated as a CRT case (usually in a discussion between Intake and a CWS supervisor or section administrator) had to be seen by a caseworker within two hours. Similar to O'ahu, after-hours and standby workers responded to CRT referrals after hours and on weekends.

The CRT was developed to respond to intakes from law enforcement reports, hospital reports, and school reports, and these three kinds of reports have very different patterns of reporting over the course of a week. Because schools are not open on weekends, almost all reports from schools come into Intake during a weekday. Law enforcement and hospitals are known to have higher rates of reports on weekends, due to the nature of family stress and family violence and the resulting child maltreatment seen by police officers, hospital emergency rooms, and in hospital labor and delivery units.

Given that two of the types of intakes that were to be referred to the Crisis Response Team had higher than average reporting rates on the weekend, the evaluation analyzed dispositions by the day of the week the report was received by Intake.[4] The evaluation analyzed weekday and weekend patterns of referrals to the Crisis Response Team, given concerns raised in focus groups about occasional heavy CRT referrals on the weekends.

[4] Data on after-hours on weekdays is unavailable to the evaluation.

O‘ahu

Looking at all intakes that occurred on O‘ahu during the Waiver Demonstration years:

- 22% of intakes from law enforcement occurred on Saturday or Sunday.
- 21% of intakes from hospitals occurred on Saturday or Sunday.
- 9% of intakes from all other sources occurred on Saturday or Sunday.
- 0.2% of intakes from schools occurred on Saturday or Sunday.

An examination of the dispositions made by Centralized Intake by day of the week is shown in Figure 32. Combining all reports for which Intake made a referral from 2015-2018, the evaluation examined the dispositions by the day of the week that the report was disposed. Dispositions to the Crisis Response Team, as a proportion of all intakes, were higher on weekends than during the week.

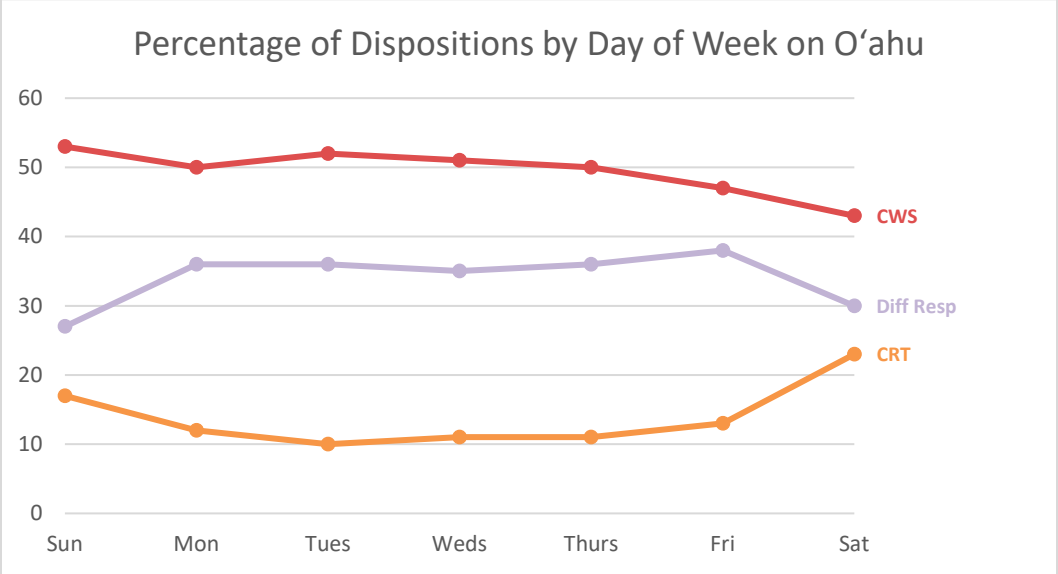


Figure 32. Percentage of Dispositions by Day of Week on O‘ahu

Hawai‘i Island

On Hawai‘i Island, during the Waiver Demonstration years, of all intakes of child maltreatment:

- 15% of intakes from law enforcement occurred on Saturday or Sunday.
- 16% of intakes from hospitals occurred on Saturday or Sunday.
- 9% of intakes from other sources occurred on Saturday or Sunday.
- 2% of intakes from schools occurred on Saturday or Sunday.

An examination of the dispositions made by Centralized Intake by day of the week is shown in Figure 33. On Hawai‘i Island, the percentage of maltreatment intakes that received a Crisis Response rose sharply on Friday and Saturday, while the proportion with dispositions to Child Welfare Services decreased on those same days.

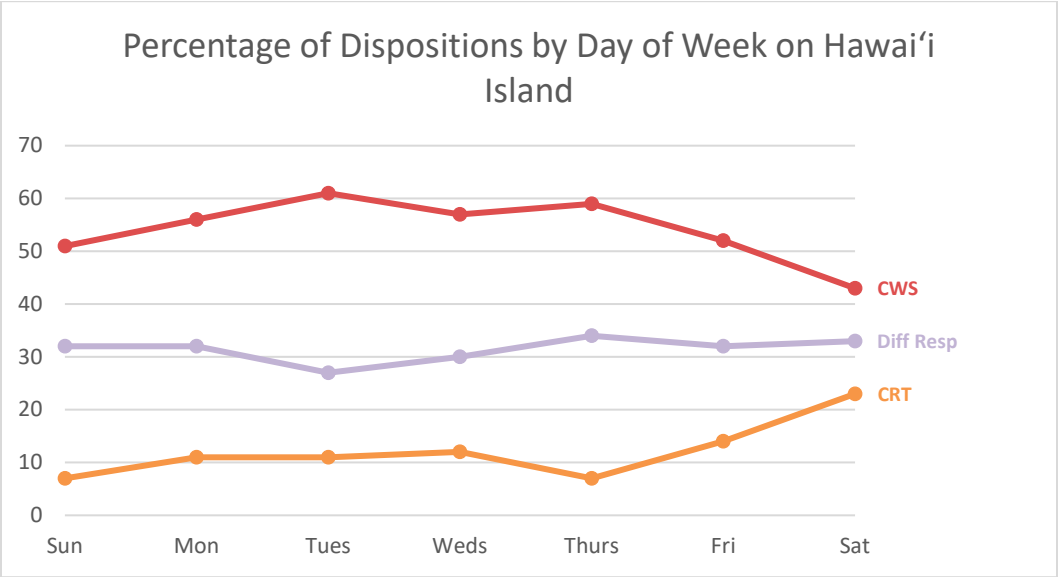


Figure 33. Percentage of Dispositions by Day of Week on Hawai‘i Island

Patterns in Dispositions to the Crisis Response Team versus Child Welfare Services

The number of children referred for a CRT response met (on Hawai'i Island) or exceeded by 40% (on O'ahu) the goals of the Demonstration. On the other hand, fewer than half of all eligible intakes were referred for a Crisis Response.

On O'ahu, over the course of the Demonstration, a CRT response was provided to an average of 52% of intakes from law enforcement, 16% of intakes from hospitals and 16% of intakes from schools. On Hawai'i Island, a Crisis Response was provided to an average of 58% of intakes from law enforcement, 15% of intakes from hospitals, and 16% of intakes from schools. Almost all children disposed to CRT were identified as being at imminent risk of harm, a proxy for imminent risk of placement, the other criterion for eligibility for the CRT.

The evaluators had discussions with DHS leadership and practitioners to try to identify what made the difference between a disposition to CRT and a disposition elsewhere, given that no other eligibility criteria were identified in the Demonstration. Anecdotal evidence from these discussions suggested that children identified as (or considered) at imminent risk of harm were indeed disposed for a CRT response, but that children who were judged to be at a higher risk of placement (not harm), based on a number of risk factors known at Intake, were referred directly to Child Welfare Services. The rationale for this decision was the prediction that a CRT response would ultimately lead to a disposition to Child Welfare Services, so not to waste time on a CRT response.

A detailed analysis of disposition patterns (see Chapter Six Appendix) found that dispositions varied by source of report. Intake did appear to follow the two key eligibility criteria of when to refer a report to the CRT, particularly when the source of the report was law enforcement.

When the source of report was schools, fewer children were referred to the CRT, and many were sent to diversionary programs like Voluntary Case Management. Intake did send school reports with victims to the CRT, but those children were often not at imminent risk of harm (noted on the Intake Tool).

When the source of report was hospitals, Intake did follow the criterion of imminent risk of harm to dispose the intake to the CRT, but the child was likely not to be a victim. The maltreatment was not likely to meet the legal definition of harm. Also, the family having a criminal history was a significant predictor of a referral to the CRT. These findings are confusing, but this set of indicators was the least accurate in predicting a disposition among hospital reports.

Given key differences in the three populations of children (by report source), the evaluation analyzes outcomes for them separately.

Service Fidelity of the Crisis Response Team

Eligibility

Source of Report

Among those children served by the Crisis Response Team on O'ahu, the vast majority of reports came from law enforcement (33%), schools (28%), and hospitals (24%). As noted earlier, the Crisis Response Team also responded to some reports from other sources, but to a limited degree (see Figure 34).

On Hawai'i Island, the vast majority of reports receiving a Crisis Response came from law enforcement (42%), schools (27%), and to a lesser extent, hospitals (17%), following a similar pattern to referrals on O'ahu (see Figure 6.29).

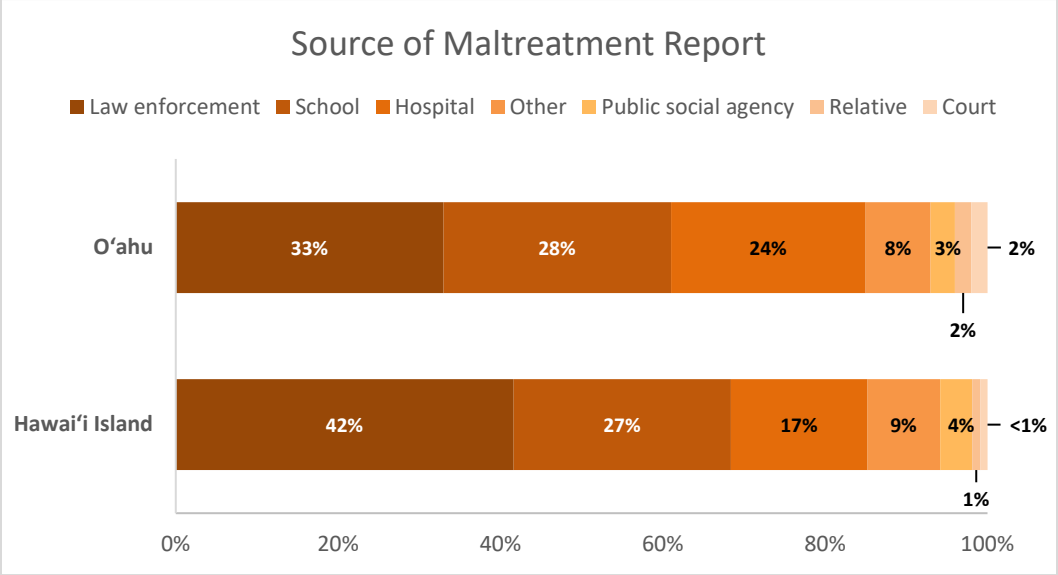


Figure 34. Source of Maltreatment Report

Imminent Risk of Harm

There was no assessment of imminence of risk of placement at intake. Imminent risk of harm was used by the evaluation as a proxy. Almost all children referred to the Crisis Response Team (95% on O'ahu and 96% on Hawai'i Island) were determined at intake to be at imminent risk of harm.

Service Provision

Two-Hour Response Time

One of the defining characteristics of the CRT intervention is that caseworkers will make face-to-face contact with the child within two hours of receiving the referral from the Intake Unit[5]. As described in the Process Methodology, new fields were created in the SHAKA data interface to collect the time stamps of Intake disposition and CRT response.

On Oʻahu, most intake reports referred to the Crisis Response Unit were seen within two hours (see Figure 35). However, on Hawaiʻi Island, only 65% of Intakes were seen within the two-hour response window, confirming the concern that large geographical catchment areas on Hawaiʻi Island make a two-hour response difficult. Only 35% of children were seen within one hour of the referral from Intake.

On Hawaiʻi Island, 65% of children were seen within the two-hour response window, confirming the concern that large geographical catchment areas on Hawaiʻi Island make a two-hour response difficult.

[5] CRT response time represents the time from Intake disposing a case to CRT to the time at which a CRT worker made initial contact with the family. Anecdotal evidence from retrospective staffing interviews conducted in May 2019 indicated that the use of an intake answering service may have resulted in longer response times than indicated in the data collected by the evaluators. The additional time from the initial call to the Intake Hotline to the time the Intake worker was able to contact the complainant was not available for analysis.

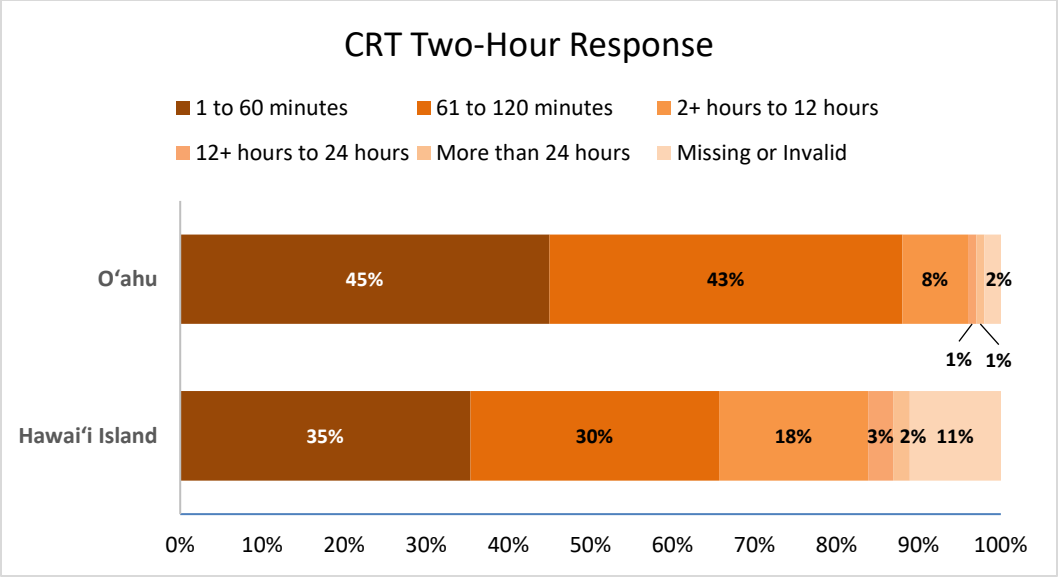


Figure 35. CRT Two-Hour Response

Analysis of Weekday versus Weekend Two Hour Response

There was little variation in response time to CRT referrals on O‘ahu (see Figure 36). Response times averaged between 1.4 and two hours every day of the week. On Hawai‘i Island, there was greater variation in response times for those reports referred as needing a Crisis Response. The average response time on the weekend was around two hours, while responses during the week averaged between 1.5 and 2.7 hours.

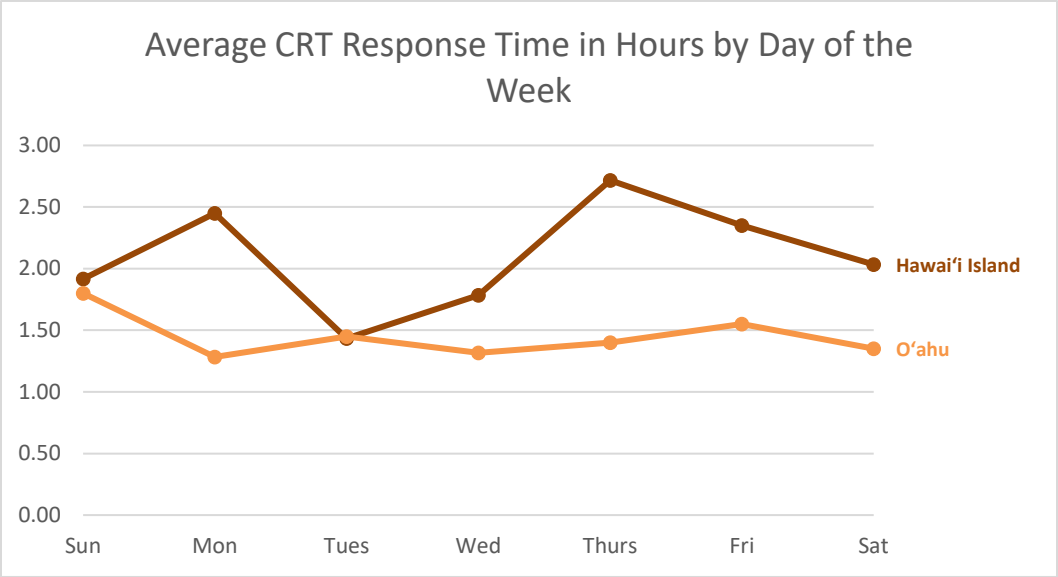


Figure 36. Average CRT Response Time by Day of the Week

Note. This figure is by intake and not by child.

Completion of Initial Safety Assessments

One of the responsibilities of the Crisis Response Team was completing an Initial Safety Assessment. Completion of this tool was required whether a child was seen by the CRT or by CWS, and could be entered in to the SHAKA database, although compliance with recording in SHAKA had not been required or measured prior to the Waiver Demonstration.

Because entering Safety Assessments into the SHAKA database was a new component of the Crisis Response, evaluators assessed whether completion and entry of Initial Safety Assessments for CRT children improved over the course of the Demonstration. On O'ahu, completion of the Initial Safety Assessment in SHAKA did improve over the first two years of the Waiver Demonstration (see Figure 6.32). In the first six months of the Waiver Demonstration, 58% of children had an Initial Safety Assessment entered into SHAKA. This rate increased every six months through 2016; a full 91% of children had an Initial Safety Assessment recorded in SHAKA during the last six months of 2016. Starting in 2017, however, completion rates began to decline.

On Hawai'i Island, completion rates for the Initial Safety Assessment in SHAKA began high (see Figure 37). The completion of Initial Safety Assessments varied a great deal over the course of the Demonstration, ranging from a low of 59% completed, to a high of 100% completed in the last nine months of the Demonstration.

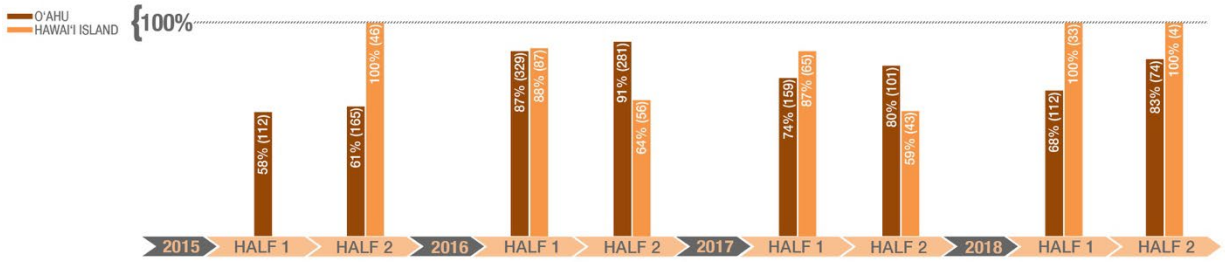


Figure 37. Initial Safety Assessments Completed

Initial Disposition by the Crisis Response Team

On O'ahu, when a report was disposed by Intake to the CRT Unit, the CRT caseworker responded and then the caseworker and supervisor made a disposition for that report. As described earlier, and seen in Figure 6.33, the case could be closed outright, referred to voluntary services, or referred to Child Welfare Services for further investigation and, perhaps, child placement. If the Crisis Response Team felt that the case was appropriate for Intensive Home-Based Services, it could make that referral to IHBS. In this situation, CRT "held" the case and IHBS was an additional service provided to a CRT case.

On O'ahu, 58% of children disposed for a CRT response were then disposed to Child Welfare Services (see Figure 38). Only 9% of children were referred for Intensive Home-Based Services. A large number of children on O'ahu (16%) had their case "held" by CRT rather than closing it after the initial disposition, even though these children were not referred on to IHBS.

On Hawai'i Island, there was no separate CRT unit. Rather, the same caseworkers provided a Crisis Response or a traditional response, depending on whether the report and the child met the eligibility criteria for a Crisis Response. For this reason, the initial disposition of CRT cases on Hawai'i Island shows a different pattern of initial dispositions (see Figure 38), with a disposition immediately after the completion of the response/contact more likely. Almost two-thirds of children were referred on to Child Welfare Services for investigation and perhaps placement. Twelve percent were referred for Intensive Home-Based Services, and 19% were closed after the Crisis Response.

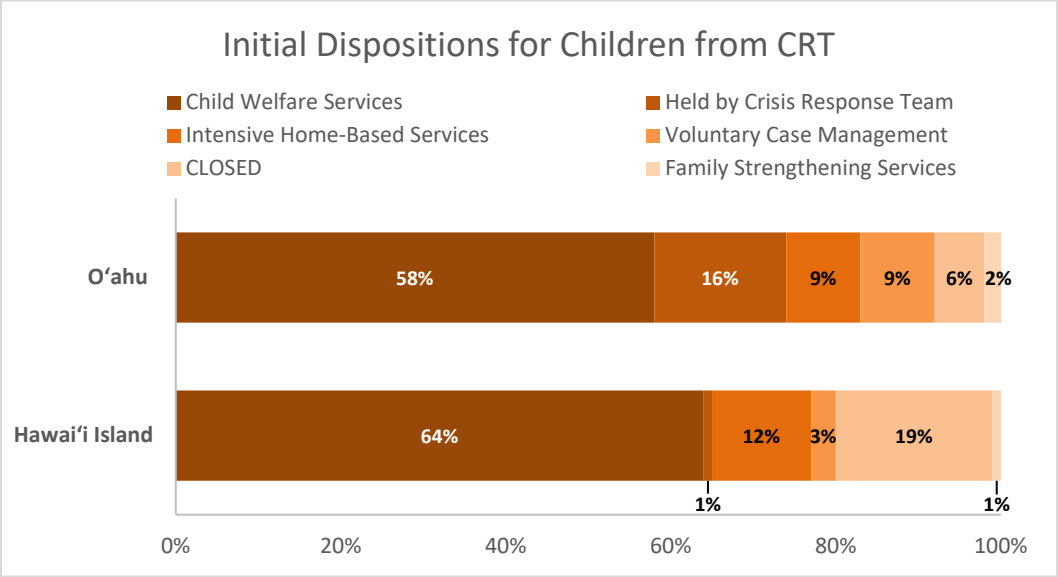


Figure 38. Initial Dispositions for Children from CRT

Service Duration

For those children who received CRT services on O‘ahu, but were not referred on to Intensive Home-Based Services, over two-thirds of children seen by the CRT were closed to CRT (disposed further) on the same day (see Table 26). A full 91% of children saw their cases closed to CRT within 60 days.

For children on Hawai‘i Island who received a CRT response and did NOT receive IHBS, almost three-fourths were closed to CRT (disposed further) on the same day (see Table 6.34). Almost all children not receiving IHBS had their case closed to CRT within 60 days, the prescribed length of service.

Table 26
Length of Service for CRT Only (not including those referred to IHBS)

Number of Days of Service	**CRT**	
	O‘ahu (n=1575)	**Hawai‘i Island** (n=364)
Closed same day	67%	74%
1 to 7 days	16	21
8 to 14 days	2	2
15 to 30 days	3	1
31 to 60 days	3	1
61 days to 90 days	3	0
More than 90 days	6	1
Mean	6 days	2 days
Range	0 to 206 days	0 to 57 days

Note. Calculated using the initiation and termination dates in SHAKA.

Case Monitoring

CRT caseworkers kept track of how many visits they made to each family. If a child was referred by CRT for IHBS services, it was expected that the CRT caseworker would continue to visit the family during IHBS services [these visits will be discussed in regard to IHBS in this *Final Report*]. For those children who received CRT without being referred to IHBS on O‘ahu, half received one more visit by a CRT caseworker (see Table 27). On Hawai‘i Island, half did not receive another visit within CRT, but one-third received a second visit.

Table 27

Number of Visits (after the initial visit) by CRT (among those not referred to IHBS)

In Person Visits	CRT	
	O'ahu (n=1575)	**Hawai'i Island** (n=366)
0	34%	50%
1	50	35
2	12	12
3+	4	3

Profiles of Children and Families Served by the Crisis Response Team

Demographic Characteristics

On O'ahu, the Crisis Response Team responded to reports concerning slightly more girls than boys (see Figure 39). The number of children in the home on O'ahu ranged from one to 11, with a mean of three children in the home. The mode was three, meaning that the most common number of children in the home was three. The number of adults in the home ranged from one to eight, with a mean and mode of two adults in the home. The ages of the children served ranged from infancy to age 17 with a mean age of 7.6 years old at the time of the report.

On Hawai'i Island, over half of the reports referred for a CRT response involved girls (see Figure 39). The number of children in the home on Hawai'i Island ranged from one to ten, with a mean of three children, and a mode of three children. The number of adults in the home ranged from one to seven, with a mean and mode of two adults in the home. The ages of the children served ranged from infancy to age 17, with a mean age of 7.6 years old at the time of the report.

In terms of race, more than half of reports referred to the CRT on O'ahu were said to involve Hawaiian/Pacific Islander children (see Figure 40). Because race is a multiple response item, almost half of all children were noted as White, and 44% were noted as Asian. As seen in Figure 6.37, the O'ahu Crisis Response Team responded to children and families of many different ethnicities, reflecting the multicultural landscape of the state.

In regard to race, over half of the children served on Hawai'i Island were Hawaiian/Pacific Islander, half were White and 35% were Asian (see Figure 40). While only one ethnicity can be recorded (compared to race, which is multiple response), almost half of all reports (45%) that received a CRT response on Hawai'i Island were said to be for children of Hawaiian ethnicity.

Figure 39. Child and Family Demographic Characteristics

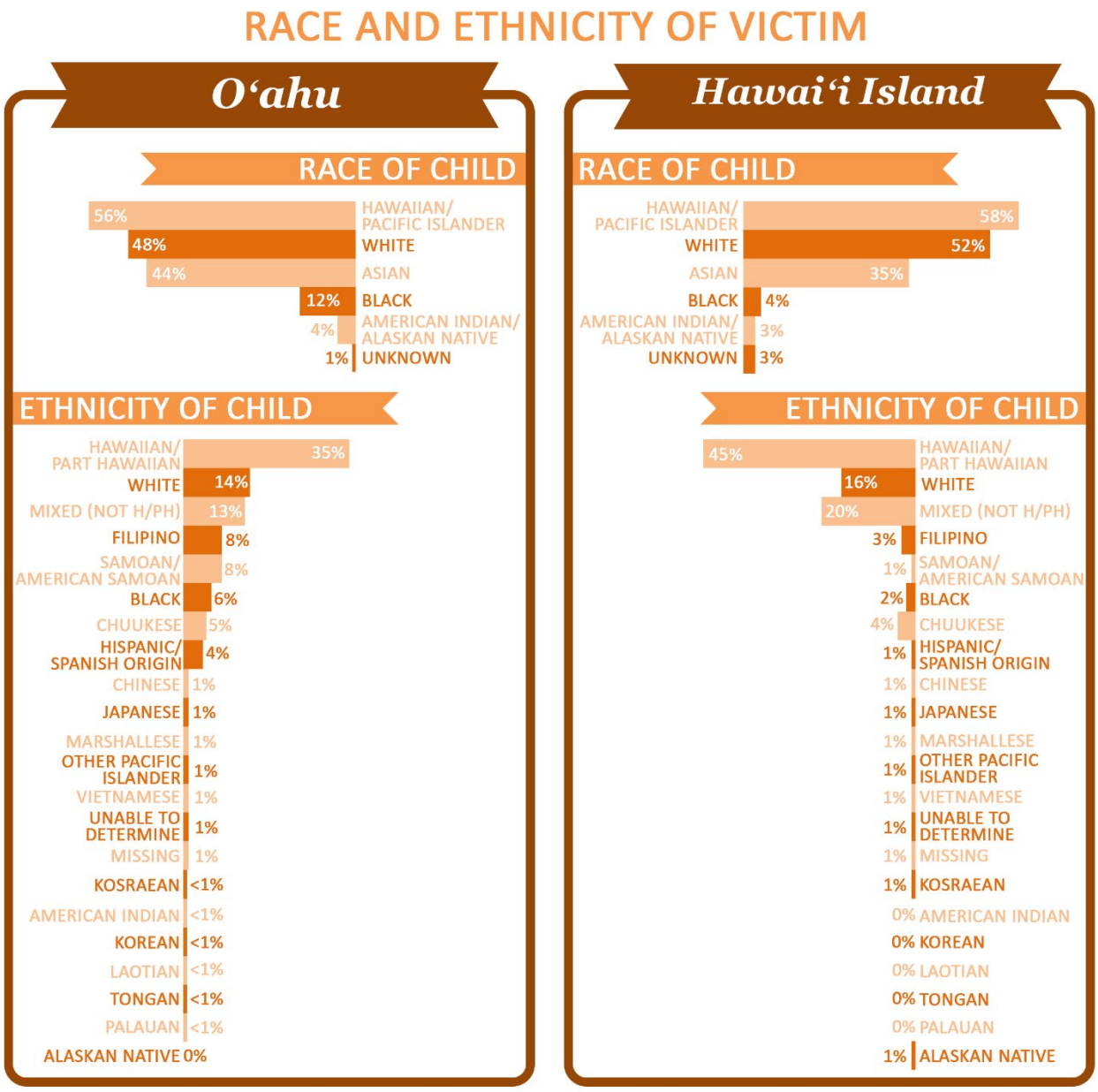


Figure 40. Race and Ethnicity of Victim

Maltreatment

On O‘ahu, the most frequent type of maltreatment reported for children disposed to the CRT was the threat of abuse (49%) followed by threatened neglect (42%; see Table 28). Actual physical abuse (15%) and physical neglect (8%) were much less frequently cited at intake. Few children disposed to the CRT on O‘ahu were reported for sexual abuse (5%).

On Hawai‘i Island, at least half of all children disposed for a Crisis Response were reported for the threat of abuse (53%) and/or threatened neglect (50%; see Table 28). Smaller proportions were reported for physical abuse (14%) or physical neglect (13%). Few children on Hawai‘i Island were reported for sexual abuse.

On O‘ahu and Hawai‘i Island, about half of the reports disposed to the Crisis Response Team were assessed to meet the legal definition of harm (see Table 28).

Of the 1,745 children disposed to the Crisis Response Team on O‘ahu, 1,166 (67%) were identified as victims (see Table 29). Ultimately, 56% of these victims had the maltreatment confirmed. Among those with confirmed maltreatment, 41% had no injury and 43% did not need treatment.

On Hawai‘i Island, there were 337 victims (81% of those disposed for a Crisis Response) (see Table 29). Of these victims, 54% were confirmed, and the majority did not need treatment. One-fifth had a serious injury, however.

For those children identified as a victim on O‘ahu (n=1,166), the most common nature of the harm was the threat of abuse (see Table 30). Other forms of the nature of abuse were seldom identified. For those identified as a victim on Hawai‘i Island (n=337), the threat of abuse was also the most commonly identified.

Table 28

Type of Maltreatment at Intake

Type of Maltreatment[a]	CRT	
	O'ahu (n=1745)	**Hawai'i Island** (n=418)
Threat of abuse	49%	53%
Threatened neglect	42	50
Physical abuse	15	14
Physical neglect	8	13
Sexual abuse	5	4
Lack of supervision	2	4
Abandonment	1	1
Medical neglect	1	2
Psychological abuse	<1	2
Psychological neglect	<1	2
Failure to thrive	0	<1
Classified as a victim	67%	81%
Meets legal definition of harm	48	49

[a]Multiple response.

Table 29

Children Confirmed and Severity of Harm

	CRT	
	O'ahu (n=1166 victims)	**Hawai'i Island** (n=337 victims)
Confirmed		
Confirmed	56%	54%
Not confirmed	35	42
Unsubstantiated/Blank	9	4
Severity of Harm[a]	(n=660 confirmed)	(n=183 confirmed)
No treatment necessary	43%	63%
No Injury/Blank	41	5
Treatment required	12	10
Serious injury	4	21
Fatal	<1	1

[a]Only among those for whom maltreatment is confirmed.

Table 30

Nature of Harm

Nature of Harm[a]	CRT	
	O'ahu (n=1166 victims)	**Hawai'i Island** (n=337 victims)
Threat of abuse	44%	49%
Other	14	27
Physical abuse	13	11
Physical neglect	11	18
Cuts, bruises, welts	10	7
Lack of supervision	6	3
Sexual exploitation	3	2
Abandonment	2	4
Brain damage/skull fracture	2	1
Bone fracture (other than skull)	2	<1
Psychological abuse	1	2
Burns, scalds	1	1
Subdural hemorrhage/hematoma	1	0
Failure to thrive	<1	1
Medical neglect	<1	1
Poisoning/drugging	<1	1
Malnutrition	<1	<1
Internal injuries	<1	0
Concussion	<1	0
Exposure to elements	<1	0
Psychological neglect	<1	0
Unknown	<1	0
Congenital drug addiction	0	1
Dislocation/shaking	0	<1

[a]Multiple response

Risk and Safety Factors

For those children identified at Intake as a victim, the Intake Unit recorded the perpetrator(s) and the precipitating factors contributing to the maltreatment. For the majority of children, the primary perpetrator was a biological parent (85% on O'ahu; 82% on Hawai'i Island) (see Table 31). Other perpetrators were much less common.

On O'ahu (see Table 31), the most common precipitating factors identified at Intake were unacceptable child rearing practices (63%) and an inability to cope with parenting (37%). Precipitating factors for between 10% and 20% of victims were a lack of tolerance of child behavior (19%), a parent's loss of control during discipline (18%), and drug abuse (14%).

On Hawai'i Island, the most common precipitating factors identified at intake were also unacceptable child rearing practices (29%) and the inability to cope with parenting (26%). Precipitating factors for between 10% and 20% of victims were drug abuse (17%) and a lack of tolerance of child behavior (12%). In general, fewer precipitating factors were noted by Intake for victims on Hawai'i Island.

For all children referred to CRT, many had a prior history with Child Protective Services. This was true for 45% of children seen on O'ahu, and 65% of children seen on Hawai'i Island (see Table 32).

At the time of the disposition to CRT, if the child was said to be at risk of harm, the Intake Unit indicated which of 15 safety factors existed for the child, and could indicate more than one. Safety factors for children at risk were similar between O'ahu and Hawai'i Island (see Table 32), and often included severe/present/impending danger, caregiver violent behavior, and parent impulsivity. Intake Unit caseworkers seldom indicated the presence of parental mental illness or hazardous living conditions as a safety factor for children referred to the CRT.

Table 31

Perpetrator/Family Risks

Family Risks	CRT	
	O‘ahu (n=1166 victims)	**Hawai‘i Island** (n=337 victims)
Primary perpetrator		
Bio parent	85%	82%
Stepparent	3	4
Adoptive parent	3	1
Legal guardian	2	2
Other	2	2
Grandparent	2	1
Relative	1	<1
Legal custodian	<1	<1
Unknown	<1	8
Precipitating factors[a]		
Unacceptable child rearing practices	63%	29%
Inability to cope with parenting	37	26
Lack of tolerance of child behavior	19	12
Loss of control during discipline	18	7
Drug abuse	14	17
Spouse abuse/fighting	9	8
Mental health problem	9	8
Alcohol abuse	7	3
Heavy/continuous child care respons.	7	2
Inadequate housing	6	4
Family discord	5	9
Police/court record (not traffic)	3	5
Broken family	2	9
Chronic family violence	2	7
Parental history of abuse	2	4
New baby in home	1	4
Recent relocation	1	2
Incapacity due to handicap/illness	1	1
Insufficient income	1	1
Social isolation	0	1
Mental retardation	0	1
Normal authoritarian discipline	0	1
	(n=1745)	(n=418)
Child has prior CPS	45%	65%

[a]Multiple response

Table 32

15 Safety Factors from Intake Tool

Safety Factors among those at risk of future harm[a]	**CRT**	
	O'ahu (n=1654)	**Hawai'i Island** (n=400)
Caregiver violent behavior	33%	36%
Severe/present/impending danger	33	29
Parent impulsivity	32	32
Inadequate supervision	20	26
Parental substance abuse	18	22
Cannot meet immediate needs	18	17
Child fearful of harm	17	18
Lack of parental knowledge/skills	12	11
Child lacks protective skills	8	15
Child whereabouts unknown/flight risk	7	7
Parental mental illness	6	3
Credible threat to child	4	2
Death of child in household	1	3
Parent negative toward child	1	2
Hazardous living conditions	1	<1

[a]Multiple response

Child Outcomes After CRT

Hypotheses

Providing a Crisis Response will decrease the percentage of reported children who have entries into foster care.

Providing a Crisis Response will decrease the percentage of reported children who have short stays in foster care.

Providing a Crisis Response will increase the percentage of children placed with relatives when placement is necessary.

Entries into Foster Care

The Crisis Response Team was intended to provide an immediate response with the goal of preventing immediate removal of the child. Therefore, for the purposes of analysis of placement outcomes after CRT, this evaluation counts only those placements in which the child was removed the same or next day after the report to Intake. Because some children are recorded in administrative data as removed and returned home on the same day, the evaluation counts only those removals where the child was out-of-home at least overnight.

Same or Next Day Removals

Of the 1,745 children seen by the Crisis Response Team on O'ahu from January 2015 through September 2018, 60% were NOT removed on the same day or next day after a CRT response. Removal rates varied greatly by the source of the report. Among those children reported to Intake by law enforcement, 55% experienced a removal on the same or next day. Of those reported by schools, 27% were removed the same or next day. Of those reported by hospitals, 26% were removed the same or next day (See Figure 41).

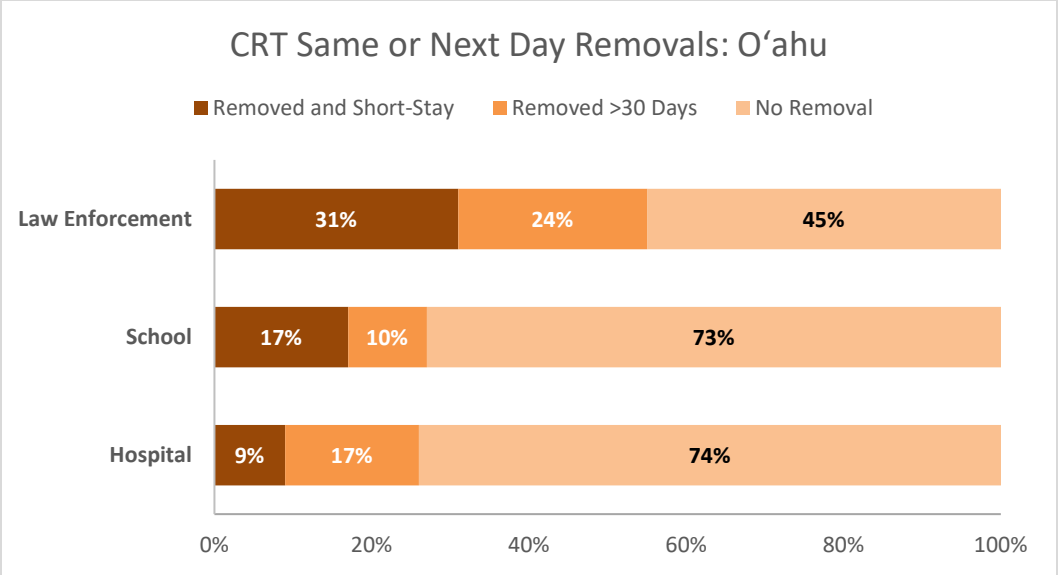


Figure 41. CRT Same or Next Day Removals: O'ahu

Of the 418 children who experienced a Crisis Response on Hawai'i Island, 56% were NOT removed after a Crisis Response. Again, removal rates varied greatly, depending on the source of the report. Those reported by law enforcement were most likely to have a same or next day removal (60%), but only about one-fourth of those reported by schools were removed the same or next day as the report. For those children reported by hospitals, fewer than half (43%) were removed the same or next day (see Figure 42).

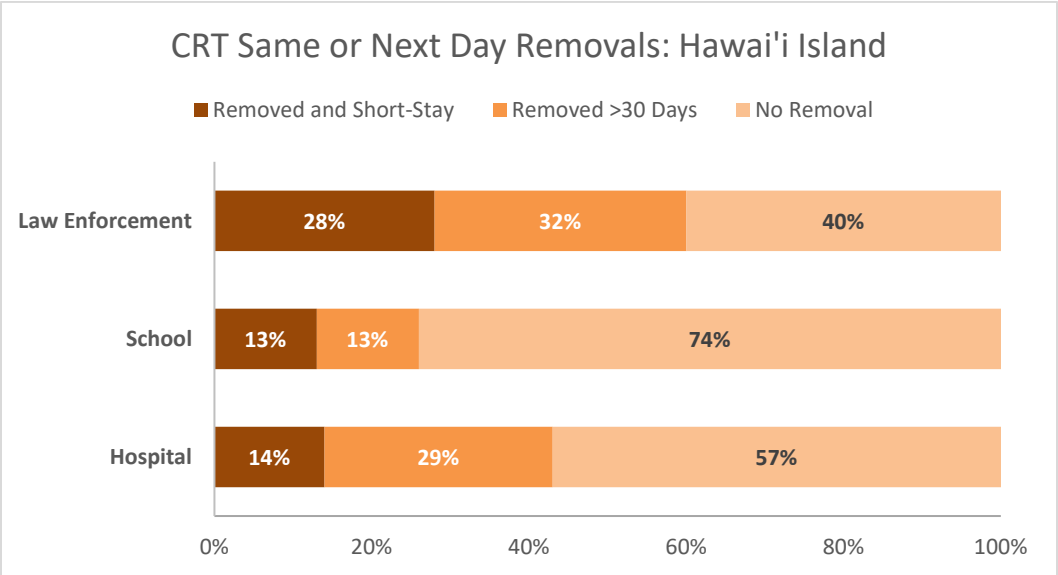


Figure 42. CRT Same or Next Day Removals: Hawai'i Island

As noted earlier, 67% of the children disposed to the CRT on O'ahu, and 81% of the children disposed for a Crisis Response on Hawai'i Island, were classified as a victim. Of course, victims are much more likely than non-victims to be removed from home. When the sample of children seen by CRT is reduced to victims only (1,166 on O'ahu and 337 on Hawai'i Island), the removal rates increase by 12%- 20% on O'ahu (See Figure 43). Removals for victims reported by schools and hospitals are still below 50%.

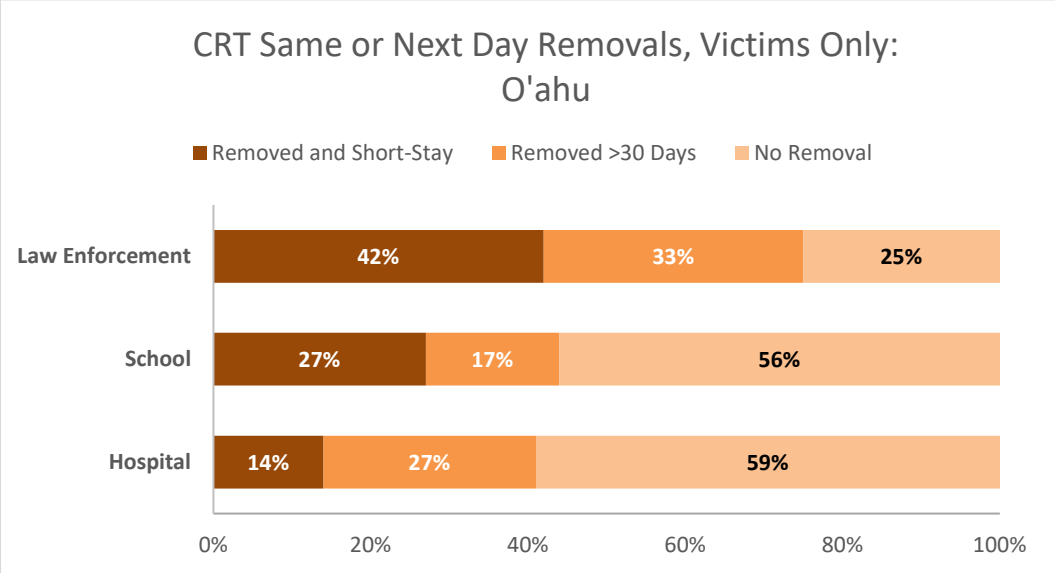


Figure 43. CRT Same or Next Day Removals, Victims Only: O'ahu

On Hawai'i Island, the removal rates increased by 10% for victims reported by law enforcement, but did not increase for children reported by hospitals, and by only 1% for children reported by schools (see Figure 44). Similar to patterns on O'ahu, fewer than half of victims reported by hospitals were removed from home. Fewer than one-third of victims reported by schools were removed.

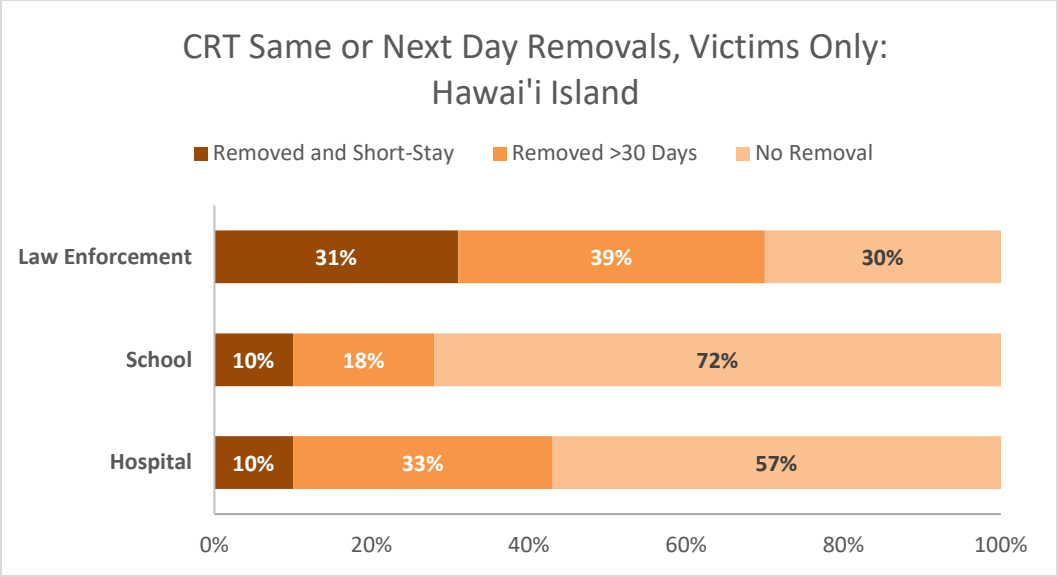


Figure 44. CRT Same or Next Day Removals, Victims Only: Hawai‘i Island

On O‘ahu, when children were seen by the CRT within the two-hour response window, 55% were removed on the same or next day. This was a statistically significant greater number than when the response time was longer. A possible explanation for the higher placement rate for those with quicker CRT responses is that children at lower perceived risk of placement received longer response times; i.e., that the O‘ahu CRT triaged their responses relative to the perceived risk. There was no relationship between child placement and meeting the two-hour response time on Hawai‘i Island.

Changes in Placement Outcomes over Time

The evaluation also considered whether placement rates improved over the four years of the Waiver Demonstration evaluation period.

O‘ahu

Children reported by law enforcement and seen by the CRT had the highest same-or-next-day removal rate overall (55%), but for 2015-2017, the removal rate decreased slightly from 54% to 48% before increasing sharply to 69% in 2018 at the end of the Demonstration (see Figure 45). Children reported by schools had the next highest overall removal rate, at 27%, and this rate increased from 20% in 2015 to 40% in 2017 before dropping to 29% in 2018. Children reported by hospitals had the lowest removal rate, at 26%, and this held fairly steady throughout the Demonstration.

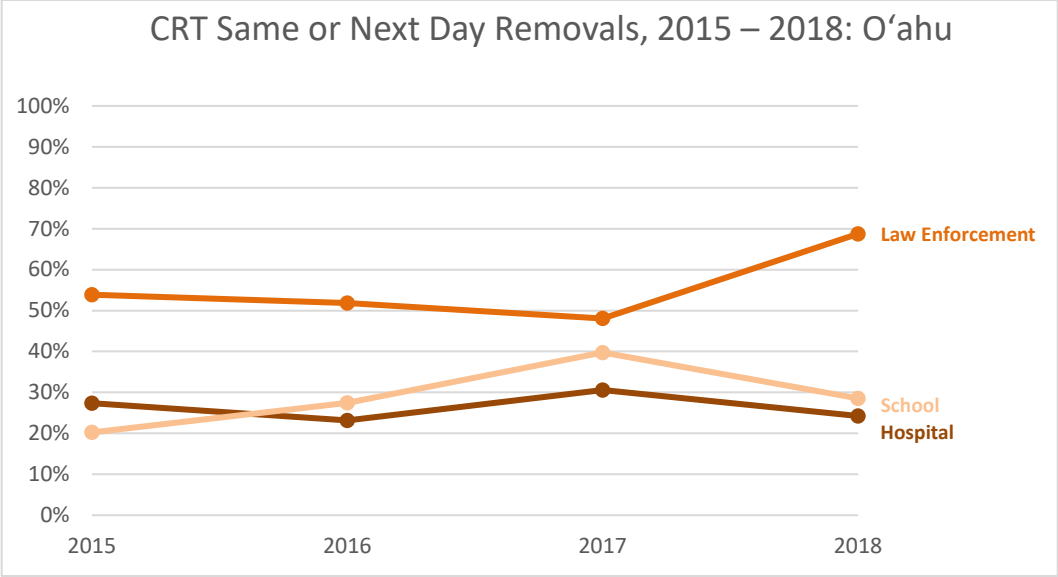


Figure 45. CRT Same or Next Day Removals, 2015 – 2018: O‘ahu

Hawai‘i Island

On Hawai‘i Island, the same-or-next-day removal rate was 44% on average. However, law enforcement reported children had the highest removal rate, at 60%. In the last three months of 2015, the removal rate for law-enforcement-reported children was 91%, but this rate dropped precipitously to the lowest removal rate for all CRT children in 2018 (only 35% of children reported by law enforcement had a same-or-next-day removal) (see Figure 46). Children reported by schools began with a high removal rate (67% in 2015), dropping to only 11% of such children in 2016, and then increasing to 50% in 2018. The same-or-next-day removal of children reported by hospitals increased each year of the Demonstration, from 11% in 2015 to 75% in 2018.

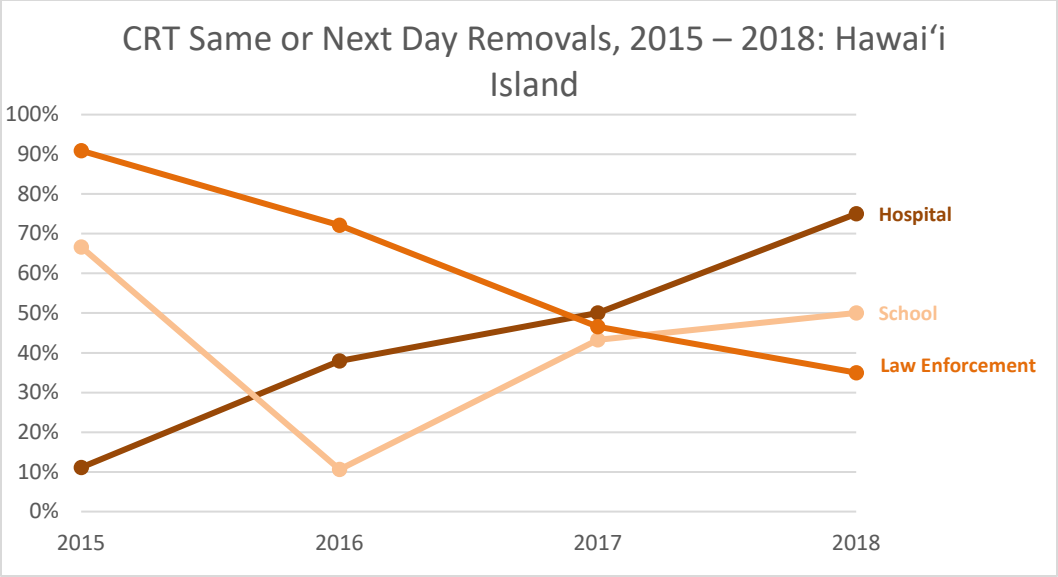


Figure 46. CRT Same or Next Day Removals, 2015 – 2018: Hawai'i Island

Short Stays in Foster Care

The Crisis Response Team was created, in part, to prevent unnecessary placements, often indicated by short stays in placement, defined in the Waiver Demonstration as a foster care episode of 30 days or less. Again, the occurrence of a short stay in placement was highly related to where the report of maltreatment originated. Children reported to Intake from law enforcement sources were the most likely to be a short-stayer (entered and exited care within 30 days). About one-third of the children disposed to the CRT from a law enforcement report on O'ahu, and 28% of the same group of children on Hawai'i Island experienced a removal with a short stay in out-of-home care (See earlier Figures 41 and 42).

Compared to children reported by law enforcement, fewer children reported by schools (17%) went into care overnight and then had a short stay in care. A smaller percentage (13%) of school-reported children with a Crisis Response on Hawai'i Island were removed, stayed out-of-home at least overnight and had a short stay in care.

While those children reported by hospitals had the lowest same or next day removal rate on O'ahu, few (9%) were short-stayers. A small percentage of hospital-reported children on Hawai'i Island (14%) were removed overnight and were short-stayers as well.

When the sample is reduced to victims only (1,166 on O'ahu and 337 on Hawai'i Island), the percentage of children experiencing a short stay on O'ahu increases to 29% overall, especially among those reported by law enforcement (see earlier Figure 41). On Hawai'i Island, however, while the experience of removal increased for victims, the experience of a short stay in care

decreased, especially for those reported by schools and hospitals (see earlier Figures 41 and 42). Hawai‘i Island removals were more likely to result in stays in care longer than 30 days.

Length of Short Stay

For those children who did enter and exit out-of-home care in 30 days or less, their stays were likely to be very short. The vast majority of short-stayers entered and exited care in five days or less (See Figures 47 and 48). Those most likely to enter and exit care in five days or less on O‘ahu were those reported by law enforcement, and those with the shortest short-stays on Hawai‘i Island were those reported by schools.

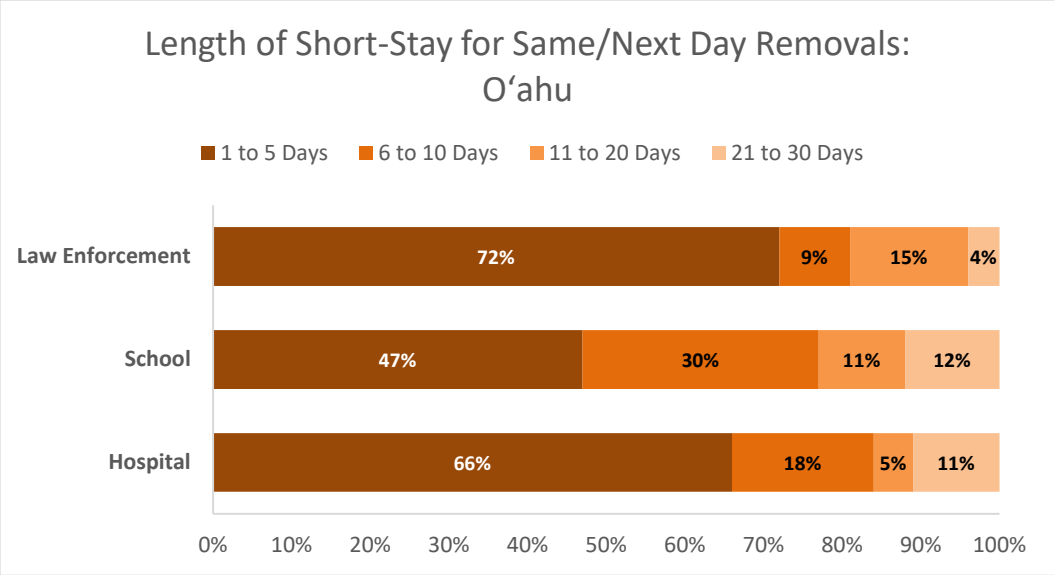


Figure 47. Length of Short-Stay for Same/Next Day Removals, 2015 – 2018: O‘ahu

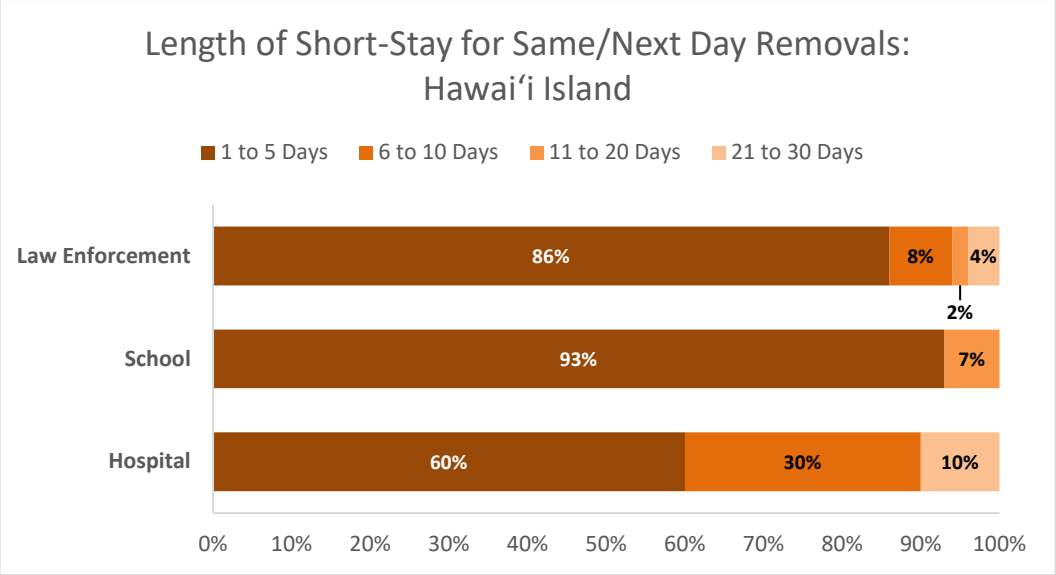


Figure 48. Length of Short-Stay for Same/Next Day Removals, 2015 – 2018: Hawai'i Island

Placements with Relatives

Overall, on O‘ahu, 22% of children removed were placed with relatives (in a paid placement) in their first placement upon removal. On Hawai‘i Island, only 9% of children were placed with relatives (in a paid placement) initially upon removal.

Looking at children removed the same day or next day after the CRT response, there were significant differences between law enforcement-reported children, hospital-reported children, and school-reported children in what type of placement setting the child experienced for the first placement.

On O‘ahu, children reported by hospitals were the most likely to be placed with relatives in a paid placement upon removal, and those reported by law enforcement were the least likely to be initially placed with relatives in a paid placement (see Figure 49). Law enforcement-reported children and those reported by schools were especially likely to be initially placed in an emergency foster home.

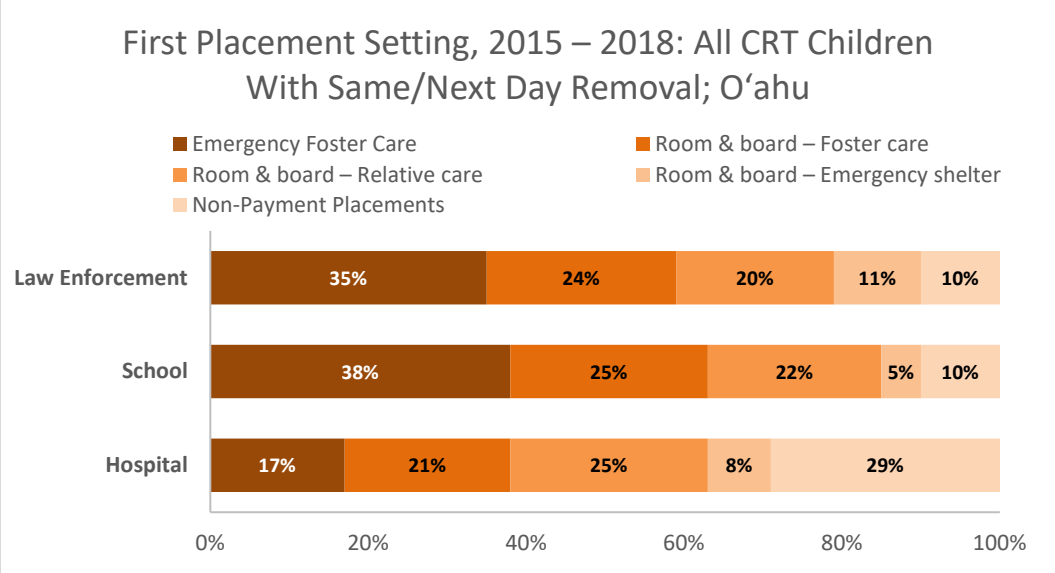


Figure 49. First Placement Setting, 2015 – 2018: All CRT Children With Same/Next Day Removal; O‘ahu

On Hawai‘i Island, only 9% of all children removed on the same day or next day of the CRT response were placed with relatives in a paid placement (see Figure 50). The use of paid, non-relative foster homes in the initial placement was much more common than on O‘ahu.

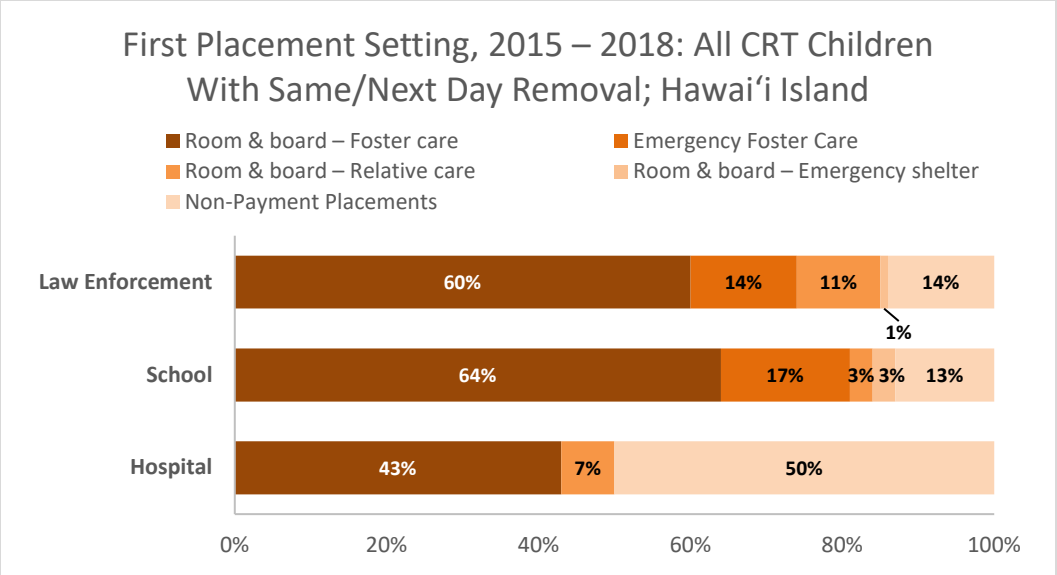


Figure 50. First Placement Setting, 2015 – 2018: All CRT Children With Same/Next Day Removal; Hawai'i Island

Those children on O‘ahu who experienced short stays in their initial out-of-home placement were especially likely to have been placed in an emergency foster home (see Figure 51). Children whose initial placement was with relatives were more likely to stay in care longer than 30 days.

On Hawai‘i Island, the use of regular (non-emergency) foster homes for the initial placement was much more frequent than on O‘ahu. The majority of both short-stayers and others were placed in regular foster homes (see Figure 52).

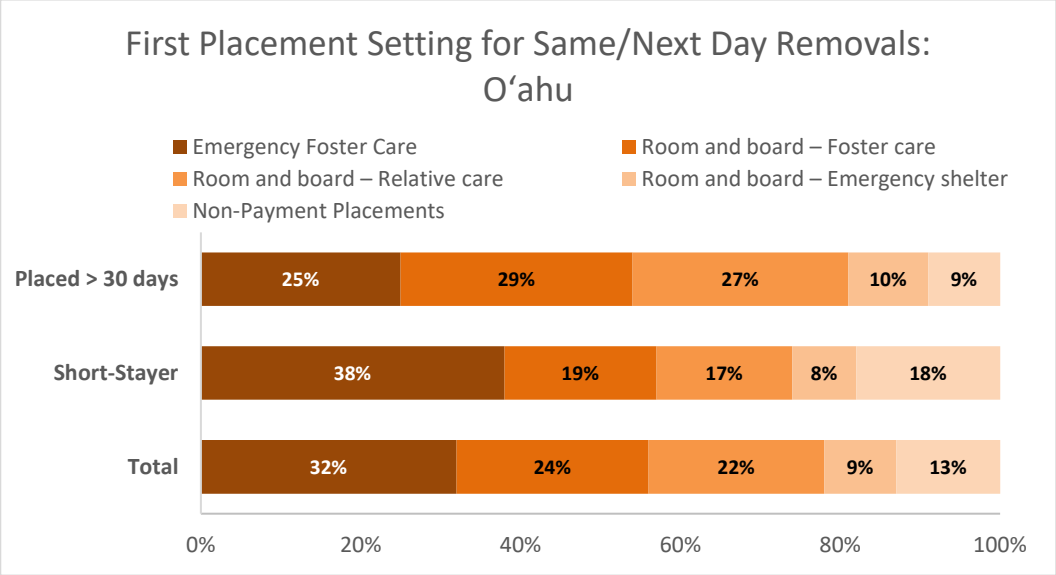


Figure 51. First Placement Setting for Same-Next Day Removals: O‘ahu

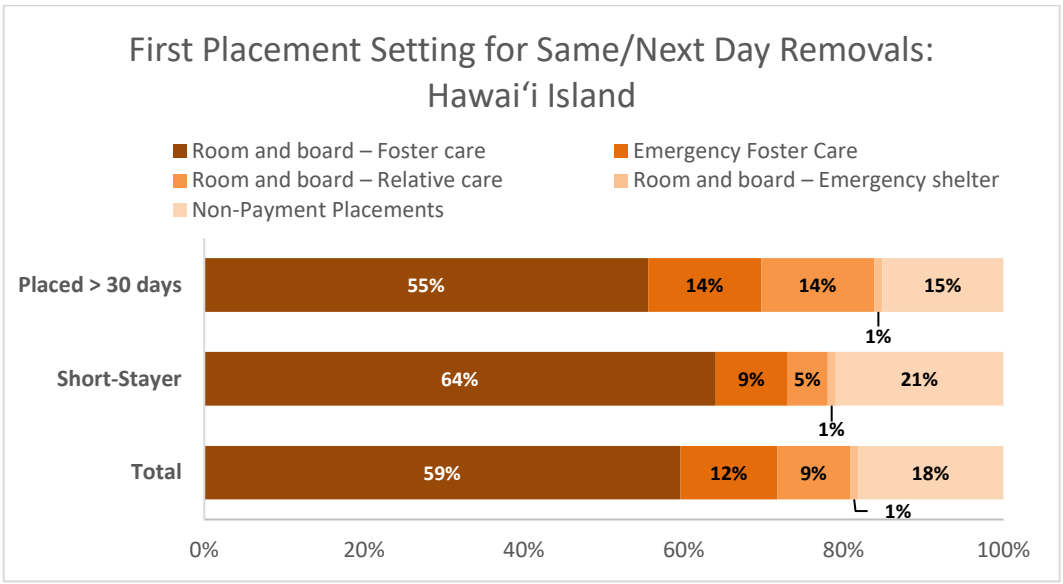


Figure 52. First Placement Setting for Same-Next Day Removals: Hawai‘i Island

Disposition Following CRT

After providing a Crisis Response, the CRT caseworker and supervisor could close the case or dispose the child and family on to other services (See Figure 53). On O‘ahu, two-thirds of children were referred on to Child Welfare Services after the CRT response. On Hawai‘i Island, three-fourths of children with a Crisis Response were referred on to Child Welfare Services.

The next most common disposition after a referral to CWS was for CRT to close the case. This occurred for 16% of children on O‘ahu and 22% of children on Hawai‘i Island.

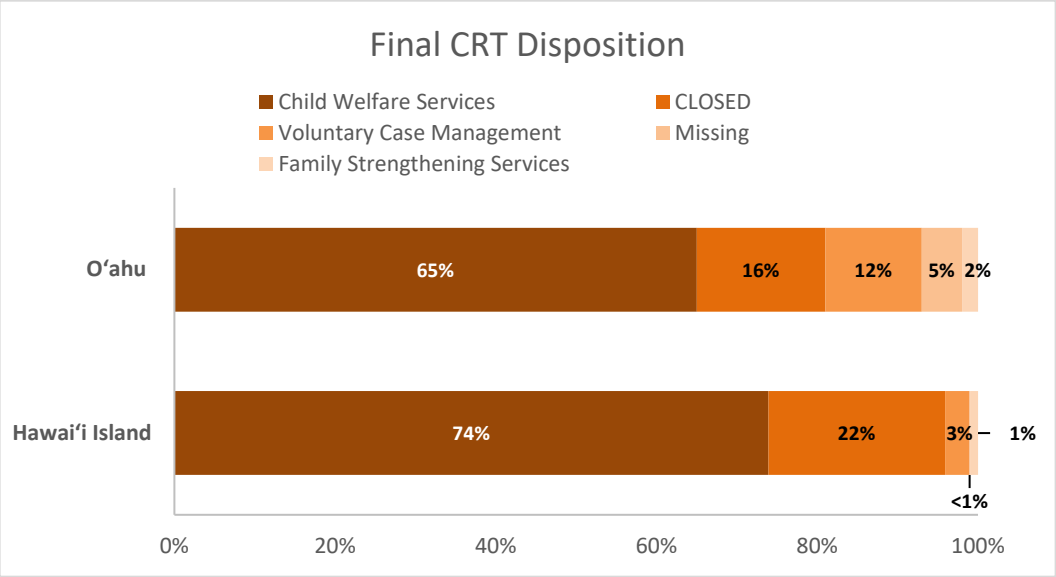


Figure 53. Final Dispositions for Children from CRT who did not receive IHBS

Comparing Outcomes to Pre-Waiver Years

Selection of Comparison Groups

There are a LOT of moving parts to consider in trying to compare outcomes for pre-Waiver child abuse intakes to Waiver child abuse intakes.

1. The categorization of maltreatment (or the actual condition of abused children) has changed.
2. The use of diversionary programs has increased, especially for school-reported children.
3. Intake referred children to CRT differently, depending on the source of the report.

The original plan of analysis was to use Propensity Score Matching to identify a comparison groups from Pre-Waiver years. Propensity Score Matching uses child characteristics, such as demographics, nature of maltreatment, and risk factors, in the treatment group (here, those receiving CRT), to develop a profile of children with a propensity for the placement outcome, and use the "propensity scores" of individual CRT children to identify children in the comparison group with the same propensity for the placement outcome, based on the same demographic, maltreatment, and risk factors.

Propensity Score Matching to identify comparison groups from Pre-Waiver years was not appropriate, given that the nature of child maltreatment and the incidence of risk factors (the items on which the Waiver and pre-Waiver groups would be matched by propensity score) changed over the course of 2012-2018, as documented earlier in this chapter (see "Trends in the Nature of Abuse Reports to Hawai'i Child Welfare Intake").

Instead of using Propensity Score Matching to identify comparison groups, the evaluation selected children with intakes from 2012-2014, who met the same eligibility criteria for a disposition to CRT during the Waiver years: (1) the source of the report was law enforcement, schools, or hospitals, and (2) the child was assessed as being at imminent risk of harm.

The population of All Intakes for calendar years 2012-2014 was the source for the selection of comparison groups. This population was reduced to those children:

- served on O'ahu or Hawai'i Island,
- not in out-of-home care at the time of the Intake report,
- less than 18 years old at the time of the Intake report,
- reported from a source in law enforcement, schools, or hospitals, and
- with an assessment at Intake of being at imminent risk of harm.

This resulted in a population of 5,478 Intakes from the pre-Waiver years of 2012-2014. Given the different risk profiles of children, depending on whether they were reported to Intake by

law enforcement, schools, or hospitals, these were divided into six comparison groups, as shown in Table 33.

Table 33
Comparison Group Sample Sizes

	Law Enforcement	School	Hospital
O‘ahu	1,044	1,641	1,374
Hawai‘i Island	497	581	341

The reader will recall that there are three hypotheses about the impact of CRT on foster care placement under the Waiver:

- Providing a Crisis Response will decrease the percentage of reported children who have entries into foster care.
- Providing a Crisis Response will decrease the percentage of reported children who have short stays in foster care.
- Providing a Crisis Response will increase the percentage of children placed with relatives when placement is necessary.

Entries into Foster Care

Statewide Trends, Pre-Waiver through Waiver Years

The Crisis Response Team responded to a subset of Intakes during the Waiver Demonstration years of 2015-2018. During the pre-Waiver years of 2012-2014, foster care entries began to rise on Hawai‘i Island, while decreasing somewhat on O‘ahu (See Figure 54).

In 2015, foster care entries increased on both O‘ahu and Hawai‘i Island. During the Waiver years, the number of children entering care statewide fluctuated, with a small dip in 2017 and an increase in 2018 (See Figure 54).

It is important to consider the overall context of foster care entries when assessing foster care entries among those children seen by the Crisis Response Team.

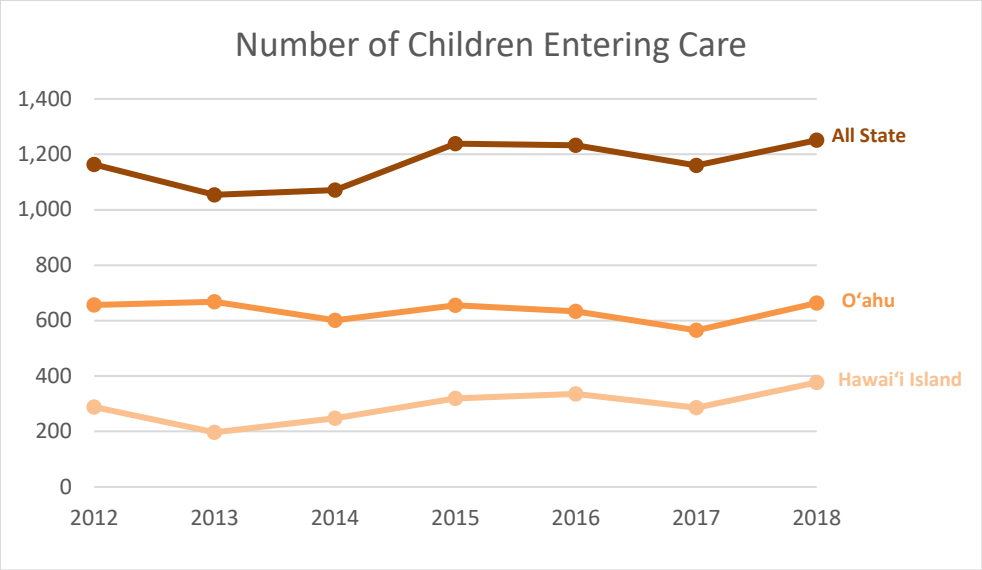
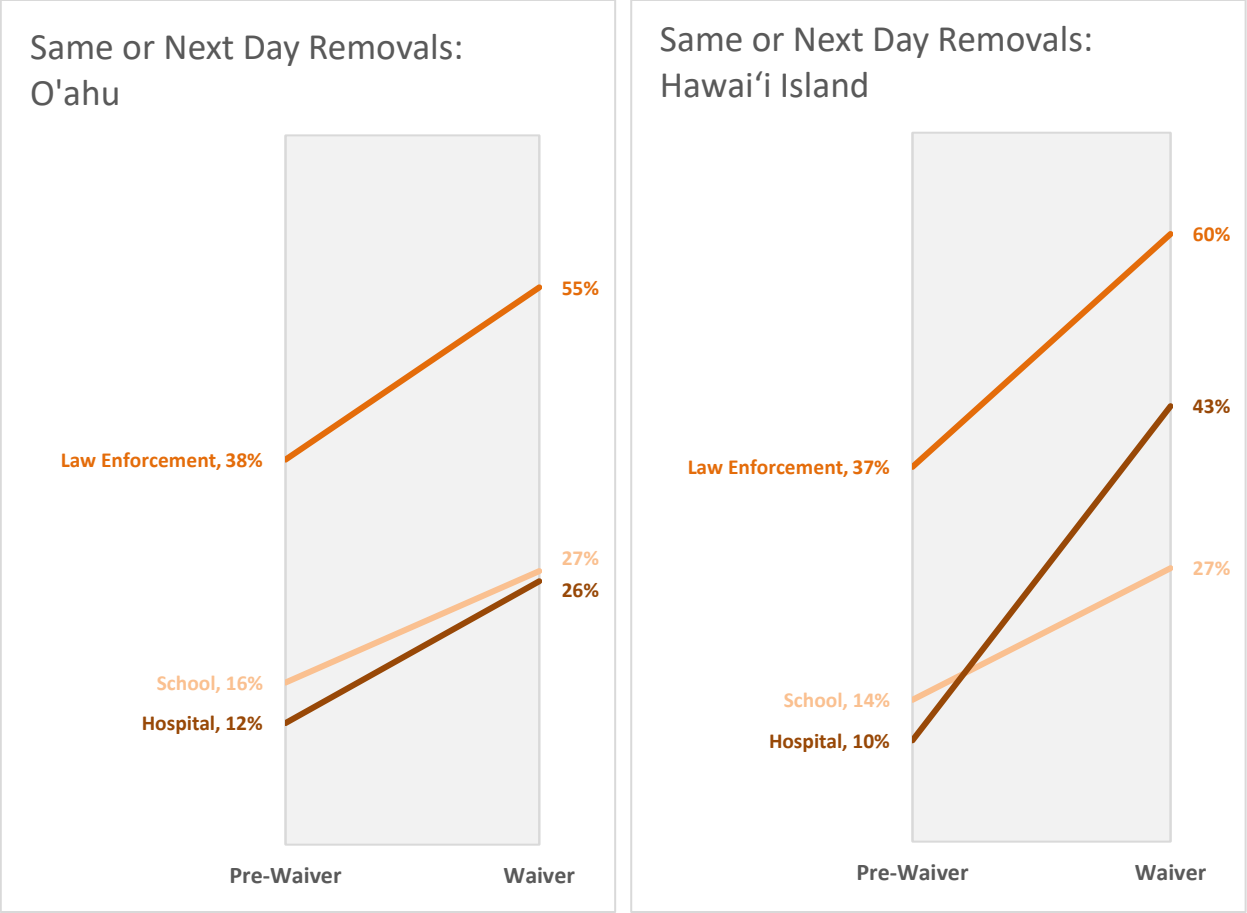


Figure 54. Number of Children Entering Care

The evaluation examined placement rates for Intakes from the three sources of law enforcement, schools, and hospitals, who were said to be at imminent risk of harm, in the pre-Waiver years of 2012-2014. We compared that to placement rates for children with a CRT response from the same three sources during the Waiver years of 2015-2018. Rates are calculated as the percentage of intakes that resulted in placement, to control for differing numbers of intakes in each year and by each source.

On O'ahu, placement rates were higher for children during the Waiver years (see Figure 55). The increase was 17% for intakes from law enforcement, 14% for intakes from hospitals, and 11% for intakes from schools.

On Hawai'i Island, placement rates were also higher during the Waiver years (see Figure 55). The increase was 33% for hospital intakes, 23% for intakes from law enforcement, and 13% for intakes from schools.



Fig*ure 55.* Same or Next Day Removals, O‘ahu and Hawai‘i Island

Short Stays in Foster Care

During the Waiver years, the proportion of children (seen by CRT) experiencing a short stay in out-of-home care was higher than the proportion of similiarly eligible children experiencing short stays in pre-Waiver years (See Figure 56). However, the increase in short stays was smaller than the increase in removal rates.

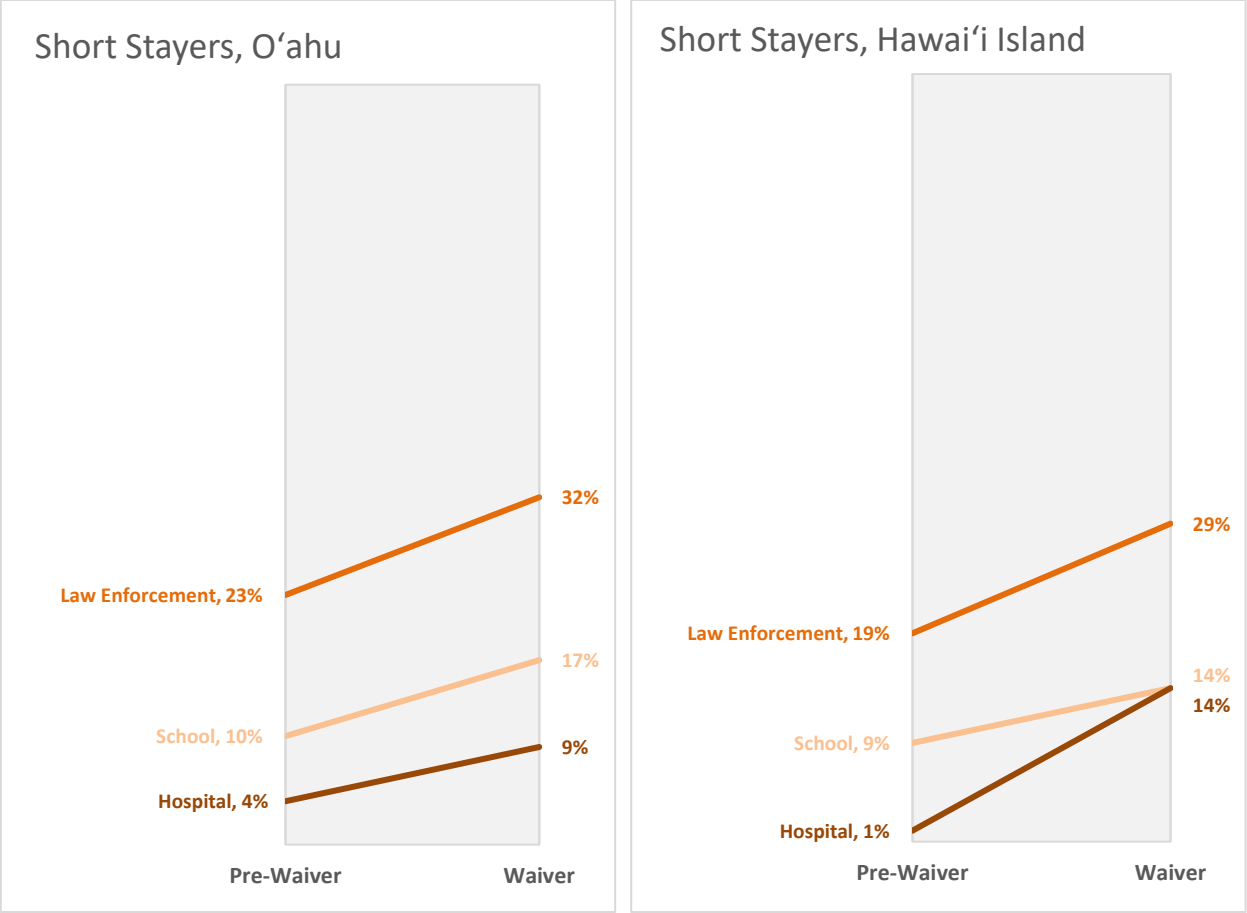


Figure 56. Short Stayers, O‘ahu and Hawai‘i Island

Placements with Relatives

Law Enforcement Intakes

Compared to pre-Waiver years, more children who were removed from home were placed with relatives in their initial placement on O‘ahu (See Figure 57). Smaller proportions were placed in emergency foster homes.

On Hawai‘i Island, relative placements slightly decreased as a proportion of initial placements (See Figure 58).

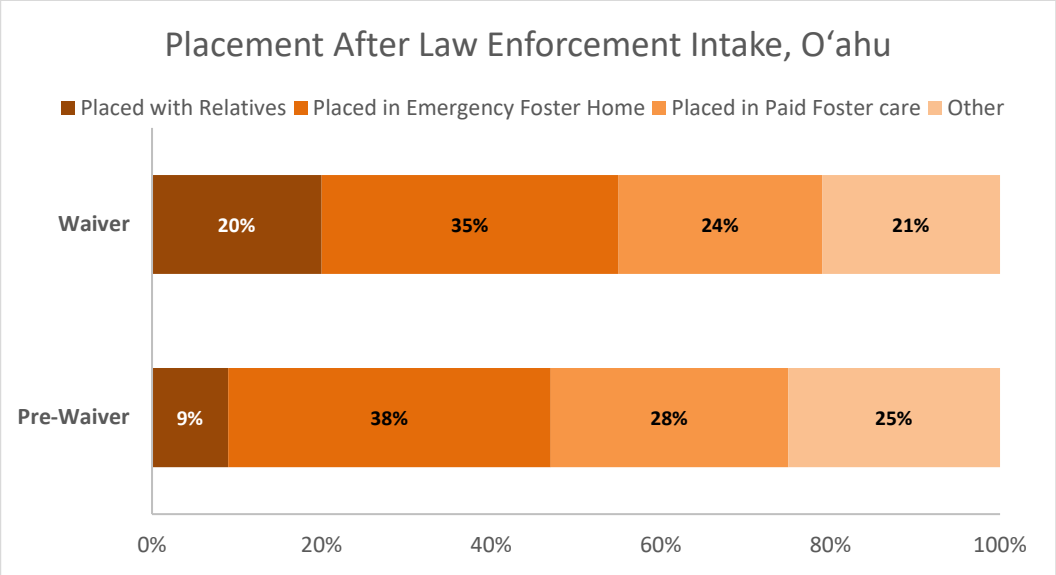


Figure 57. Placement After Law Enforcement Intake, O‘ahu

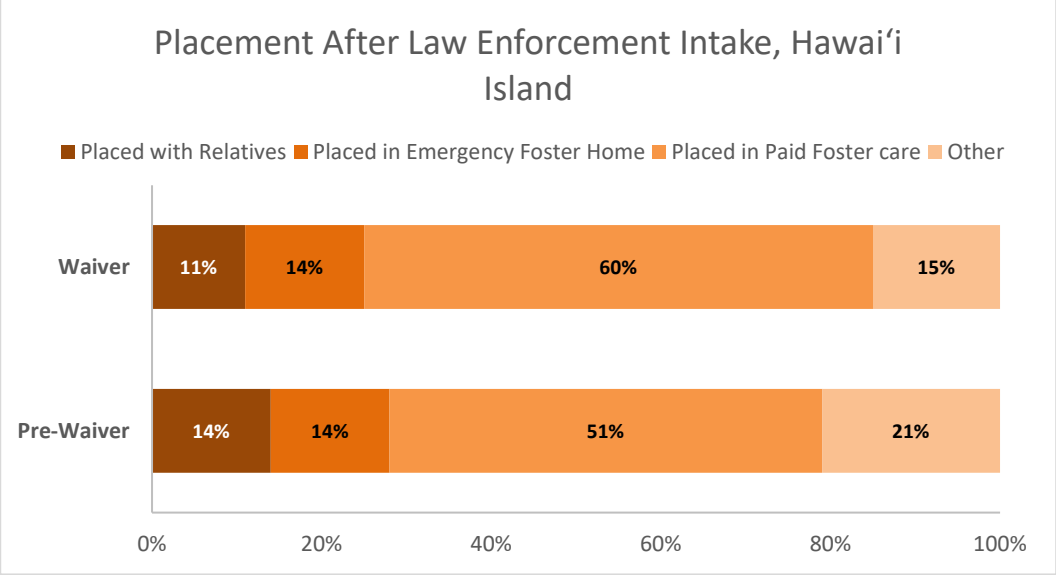


Figure 58. Placement After Law Enforcement Intake, Hawai‘i Island

School Intakes

Compared to pre-Waiver years, a greater proportion of children who were removed after a school intake on O‘ahu were placed with relatives (See Figure 59). The use of emergency foster homes in these circumstances decreased during Waiver years.

There was little change in the use of relatives for the initial placement following a school intake on Hawai‘i Island from pre-Waiver to Waiver years (See Figure 60). The use of paid foster care placements increased, and the use of emergency foster homes decreased.

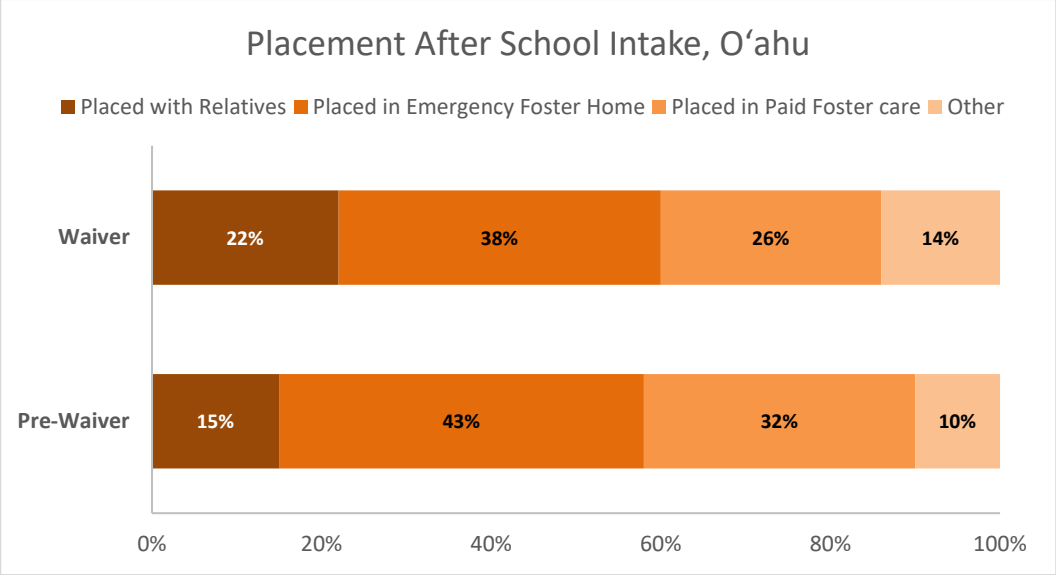


Figure 59. Placement After School Intake, O'ahu

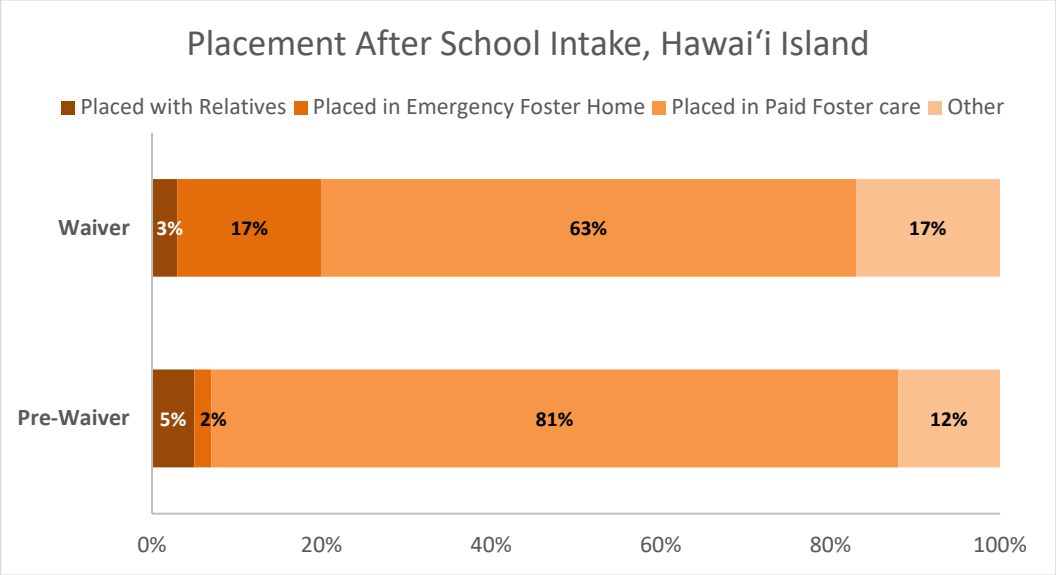


Figure 60. Placement After School Intake, Hawai'i Island

Hospital Intakes

The use of relative placements for children reported to Intake by hospitals increased during the Waiver years on O'ahu (See Figure 61). In addition, the use of emergency foster homes for this population increased during the Waiver years.

On Hawai'i Island, no children with a hospital-reported intake were placed in an emergency foster home, either during the pre-Waiver years or the Waiver years (See Figure 62). There was

a small increase in children being placed with relatives with the introduction of a Crisis Response.

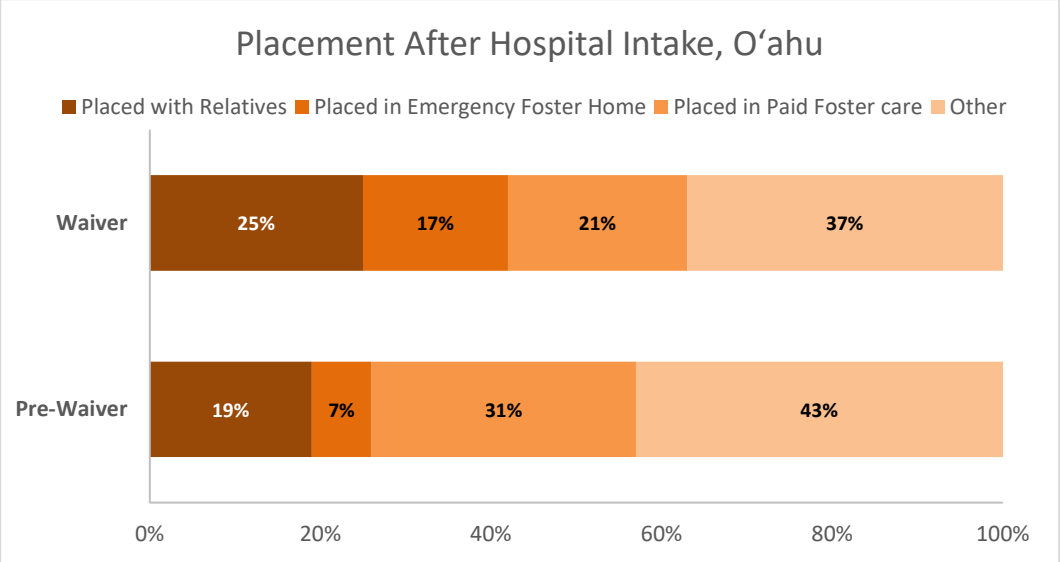


Figure 61. Placement After Hospital Intake, O‘ahu

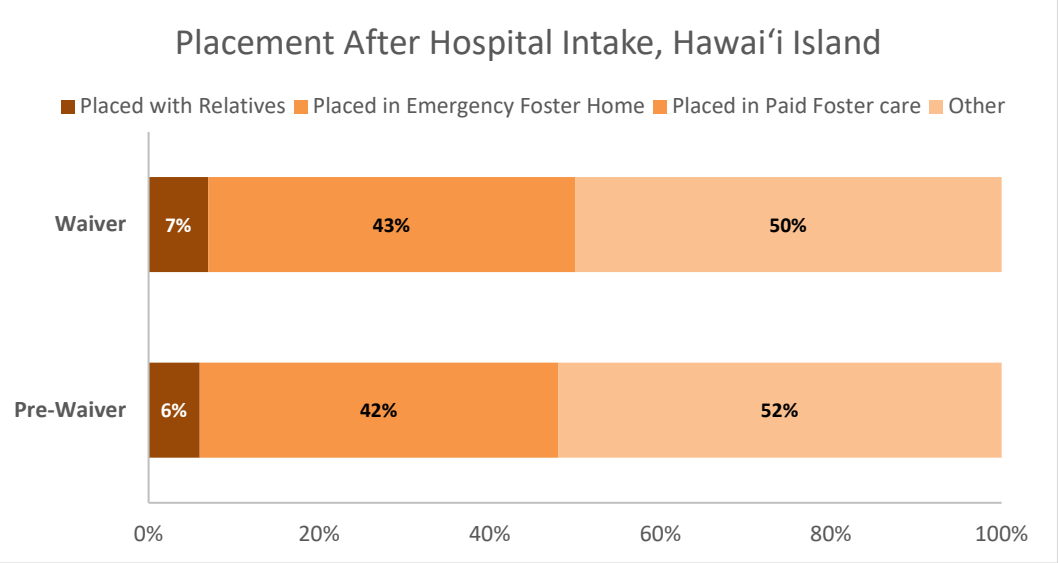


Figure 62. Placement After Hospital Intake, Hawai‘i Island

Correlates of Same/Next Day Removal Following CRT Response

A series of bivariate tests (chi-square and t-test) were performed, using information from the Intake Tool and the Initial Safety Assessment, to identify those characteristics known at the time of a CRT response that were associated with a same/next day removal (with overnight stay) following the CRT response.

The characteristics tested were:

- Sex of child
- Age of child at time of report
- Types of maltreatment
  - Physical abuse
  - Physical neglect
  - Threat of abuse
  - Threatened neglect
- Safety Factors from Initial Safety Assessment
  - Unacceptable child rearing method
  - Inability to cope with parenting
  - Lack of tolerance of child's behavior
  - Loss of control during discipline
  - Drug abuse
- Intake Tool: Child is at imminent risk of harm
- Intake Tool: Maltreatment meets legal definition of harm
- Safety Factors from Intake Tool
  - Caregiver violent behavior
  - Abuse/Neglect presents present or impending danger
  - Parent impulsivity
  - Parent cannot/will not provide adequate supervision
  - Parental substance abuse
  - Cannot meet child's immediate needs
  - Child fearful of harm
  - Lack of parental knowledge or skill
  - Child's lack of self-protective skills

Except for demographics, these items were chosen based on prior analyses of predictors of whether an intake was sent to CRT/CWS or to a differential response service. Except for the child's sex and age at time of report, all items were marked yes/no, or present/not present.

O‘ahu Law Enforcement Reports

Table 34 shows those characteristics that were associated with a same/next day removal. The overall placement rate for children disposed to CRT on O‘ahu after a report from law enforcement (n=573) during the Waiver Demonstration was 55%. That placement rate was higher when one of several key characteristics were present.

Among those children reported by law enforcement sources on O‘ahu, the characteristic most strongly associated with an immediate removal were parental substance abuse (noted on the Intake Tool and on the Initial Safety Assessment). Removal was also much more likely when the parent was assessed by the CRT responder as having a lack of tolerance of child behavior, a loss of control during discipline, an inability to cope with parenting, and showing unacceptable child rearing practices. Threatened neglect, physical neglect, and the threat of abuse were also much more likely to result in an immediate removal.

Table 34

Placement Rate after a Report from Law Enforcement: O‘ahu

O‘ahu	**CRT**	
	Placement Rate when Risk Factor:	
	Present	**Not Present**
Type of maltreatment:		
Threatened neglect	78%	32%
Physical neglect	77	51
Threat of abuse	76	37
Initial Safety Assessment:		
Drug abuse	84	51
Lack of tolerance of child behavior	79	52
Loss of control during discipline	79	52
Inability to cope with parenting	79	45
Unacceptable child rearing practices	79	30
Intake Tool:		
Parental substance abuse	86	49
Parent impulsivity	66	50

$p < .001$

Hawai‘i Island Law Enforcement Reports

Table 35 shows those characteristics that were associated with a same/next day removal. The overall placement rate for children disposed to CRT on Hawai‘i Island after a report from law enforcement (n=176) during the Waiver Demonstration was 60%. That placement rate was higher when one of five key characteristics were present.

Among law enforcement reports on Hawai‘i Island, immediate removal was especially likely when the Initial Safety Assessment indicated drug abuse. Threatened and physical neglect were predictive of immediate removal, as were unacceptable child rearing practices and an inability to cope with parenting.

Table 35

Placement Rate after a Report from Law Enforcement: Hawai‘i Island

Hawai‘i Island	**CRT**	
	Placement Rate when Risk Factor:	
	Present	**Not Present**
Type of maltreatment:		
Physical neglect	87%	53%
Threatened neglect	74	46
Initial Safety Assessment:		
Drug abuse	94	56
Unacceptable child rearing practices	86	49
Inability to cope with parenting	79	53

$p < .01$ (larger confidence interval due to smaller sample size)

O‘ahu School Reports

The overall placement rate for children disposed to CRT on O‘ahu after a report from a school (n=495) during the Waiver Demonstration was 27%. That placement rate was higher when one of several key characteristics were present (See Table 36).

The most significant predictor of child removal after a school report on O‘ahu was drug abuse. Many other items on the Initial Safety Assessment were key predictors of removal, including a lack of tolerance of child behavior, an inability to cope with parenting, unacceptable child rearing practices, and a loss of control during discipline.

When a child was removed by CRT after a report from a school on O‘ahu, the type of maltreatment was mostly likely to be threatened neglect, the threat of abuse, or physical abuse.

The older the child was at the time of the report, the higher the incidence of immediate removal. A full 43% of children aged either 16 or 17 were removed following a CRT response, compared to 32% of those aged 11 to 15, and 26% of those aged six to ten years old. There are smaller placement rates for those aged from infancy to age 5 (these children who are below school age could be siblings of school-aged children reported by a school).

Table 36
Placement Rate after a Report from a School: O'ahu

O'ahu	**CRT**	
	Placement Rate when Risk Factor:	
	Present	**Not Present**
Type of maltreatment:		
Threatened neglect	46%	19%
Threat of abuse	45	12
Physical abuse	44	23
Initial Safety Assessment:		
Drug abuse	68	25
Lack of tolerance of child behavior	54	19
Inability to cope with parenting	51	21
Unacceptable child rearing practices	51	11
Loss of control during discipline	49	21
Intake Tool:		
Parent impulsivity	46	22
Demographics:		
Child age at time of report		
16 years +	43%	
11-15 years	32	
6-10 years	26	
1-5 years	16	
Infant	19	

$p < .001$

Hawai'i Island School Reports

The overall placement rate for children disposed to CRT on Hawai'i Island after a report from a school (n=115) during the Waiver Demonstration was 26%. That placement rate was higher when one of four key characteristics were present (See Table 37).

Drug abuse, noted by Intake or at the Initial Safety Assessment, was the strongest predictor of removal after a report from a school on Hawai'i Island. Other predictors of same or next day removal were a loss of control during discipline and unacceptable child rearing practices, noted on the Initial Safety Assessment.

Table 37
Placement Rate after a Report from a School: Hawai'i Island

Hawai'i Island	**CRT**	
	Placement Rate when Risk Factor:	
	Present	**Not Present**
Initial Safety Assessment:		
Drug abuse	86%	22%
Loss of control during discipline	64	21
Unacceptable child rearing practices	52	19
Intake Tool:		
Parent substance abuse	60	23

$p < .01$ (larger confidence interval due to smaller sample size)

O'ahu Hospital Reports

The overall placement rate for children disposed to CRT on O'ahu after a report from a hospital (n=423) during the Waiver Demonstration was 26%. That placement rate was higher when one of several key characteristics were present (See Table 38).

Immediate removal following a CRT response was most likely when the type of maltreatment was physical neglect or threatened neglect. Those children removed were also likely to have parents who were assessed as having an inability to cope with parenting. Drug abuse and unacceptable child rearing practices also distinguished between those removed and not removed following a CRT response.

Table 38

Placement Rate after a Report from a Hospital: O'ahu

O'ahu	CRT	
	Placement Rate when Risk Factor:	
	Present	Not Present
Type of maltreatment:		
Physical neglect	58%	24%
Threatened neglect	43	14
Threat of abuse	41	13
Initial Safety Assessment:		
Inability to cope with parenting	51	19
Drug abuse	44	23
Unacceptable child rearing practices	44	18

$p < .001$

Hawai'i Island Hospital Reports

The overall placement rate for children disposed to CRT on Hawai'i Island after a report from a hospital (n=70) during the Waiver Demonstration was 43%. That placement rate was higher when one of two key characteristics were present (See Table 39).

On Hawai'i Island, those children who were immediately removed following a CRT response were especially likely to be reported for physical neglect and be assessed as having caretakers who could not provide adequate supervision.

Table 39

Placement Rate after a Report from a Hospital: Hawai'i Island

Hawai'i Island	CRT	
	Placement Rate when Risk Factor:	
	Present	Not Present
Type of maltreatment:		
Physical neglect	86%	38%
Initial Safety Assessment:		
Cannot provide adequate supervision	90	37

$p < .05$ (larger confidence interval due to smaller sample size)

Correlates of a Short Stay in Out-of-Home Care Following CRT Response and Removal

The same list of child characteristics and risk factors applied to the analysis above was applied to an analysis of all children removed following a CRT response. In this analysis, each factor was tested to identify whether it predicted that the child would have a short stay in care (30 days or less), or whether it was associated with a longer stay in care.

Oʻahu Law Enforcement Reports

No child characteristic or risk factor was associated with a short stay in care. However, several factors were associated with a longer stay in care (of more than 30 days) at $p < .01$:

- Threatened neglect
- Unacceptable child rearing practices
- An inability to cope with parenting
- Drug abuse/Parental substance abuse
- Abuse/neglect of a present/impending danger

Hawaiʻi Island Law Enforcement Reports

No child characteristic or risk factor was associated with a short stay in care. However, several factors were associated with a longer stay in care (of more than 30 days) at $p < .05$:

- Physical neglect
- Threatened neglect
- Drug abuse/Parental substance abuse
- Abuse meets legal definition of harm
- Parent impulsivity
- Cannot meet child's immediate needs

Oʻahu School Reports

No child characteristic or risk factor was associated with a short stay in care, or a longer stay in care.

Hawai‘i Island School Reports

No child characteristic or risk factor was associated with a short stay in care. However, two factors were associated with a longer stay in care (of more than 30 days) at $p < .05$:

- Physical abuse
- Cannot provide adequate supervision

O‘ahu Hospital Reports

No child characteristic or risk factor was associated with a short stay in care. However, two factors were associated with a longer stay in care (of more than 30 days) at $p < .01$:

- Threatened neglect
- Drug abuse/parental substance abuse

Hawai‘i Island Hospital Reports

No child characteristic or risk factor was associated with a short stay in care. However, several factors were associated with a longer stay in care (of more than 30 days) at $p < .05$:

- Threat of abuse
- Threatened neglect
- Drug abuse/Parental substance abuse
- Parental impulsivity
- Child’s lack of protective skills

Intensive Home-Based Services (IHBS)

Implementation of Intensive Home-Based Services
Service Fidelity of Intensive Home-Based Services
Child Outcomes After IHBS

Intensive Home-Based Services (IHBS)

Implementation of Intensive Home-Based Services

Intensive Home-Based Services (IHBS) were intended as a placement prevention resource for families (1) seen by the Crisis Response Team who were (2) assessed to be at risk of placement into foster care. The IHBS intervention was a Purchase of Service intervention, and was based on the HOMEBUILDERS model of services. As such, it was a cognitive-behavioral program, focusing on skill-building and acquisition of concrete, social, informational, and formal supports. Services were provided by therapists who provided services in the home or other non-office settings and were available by phone at all hours. Services were limited to four to six weeks in duration.

Based on the Child Safety Assessment and In-Home Safety Plan, if the child was not placed out of home but a placement was deemed imminent, a CRT caseworker or supervisor could refer a family to IHBS by contacting the IHBS supervisor. If the family was deemed an appropriate referral and a slot was available to serve the family, an IHBS therapist would visit the family within 24 hours of the referral. If a slot was not available, the family might be "held" for a short time by CRT to wait for an opening, or the case might be disposed to CWS for services. Intensive Home-Based Services were voluntary; a family could opt out once the service was described to them (knowing that the alternative is most likely child placement out of home). All parents in the home had to be available and willing to participate in intensive home-based services for four to six weeks.

In the first seven days of the IHBS intervention, the therapist completed the *North Carolina Family Assessment Scale* (*NCFAS*) with the family and created and recorded the goals of a Service Plan. Over the course of the cognitive-behavioral intervention, the therapist recorded the number and length of contacts/sessions with the family, both face-to-face and otherwise. In the final two weeks of the intervention, the therapist created a Transition Plan with the family, to maintain gains made during the intervention. At the end of the intervention, the therapist recorded whether and how many service goals were met.

The CRT caseworker maintained responsibility for monitoring the family during the IHBS intervention. At the end of IHBS, the IHBS therapist completed a post-service *NCFAS*, and created a Discharge Report on goals completed. This was recorded and given to the CRT caseworker. The therapist asked the family to complete a Client Feedback Survey. The case reverted to CRT and CRT could then close the case or dispose it to other services. The IHBS therapist was available to the family for two booster sessions in the six months following the IHBS intervention.

IHBS Workflow Chart

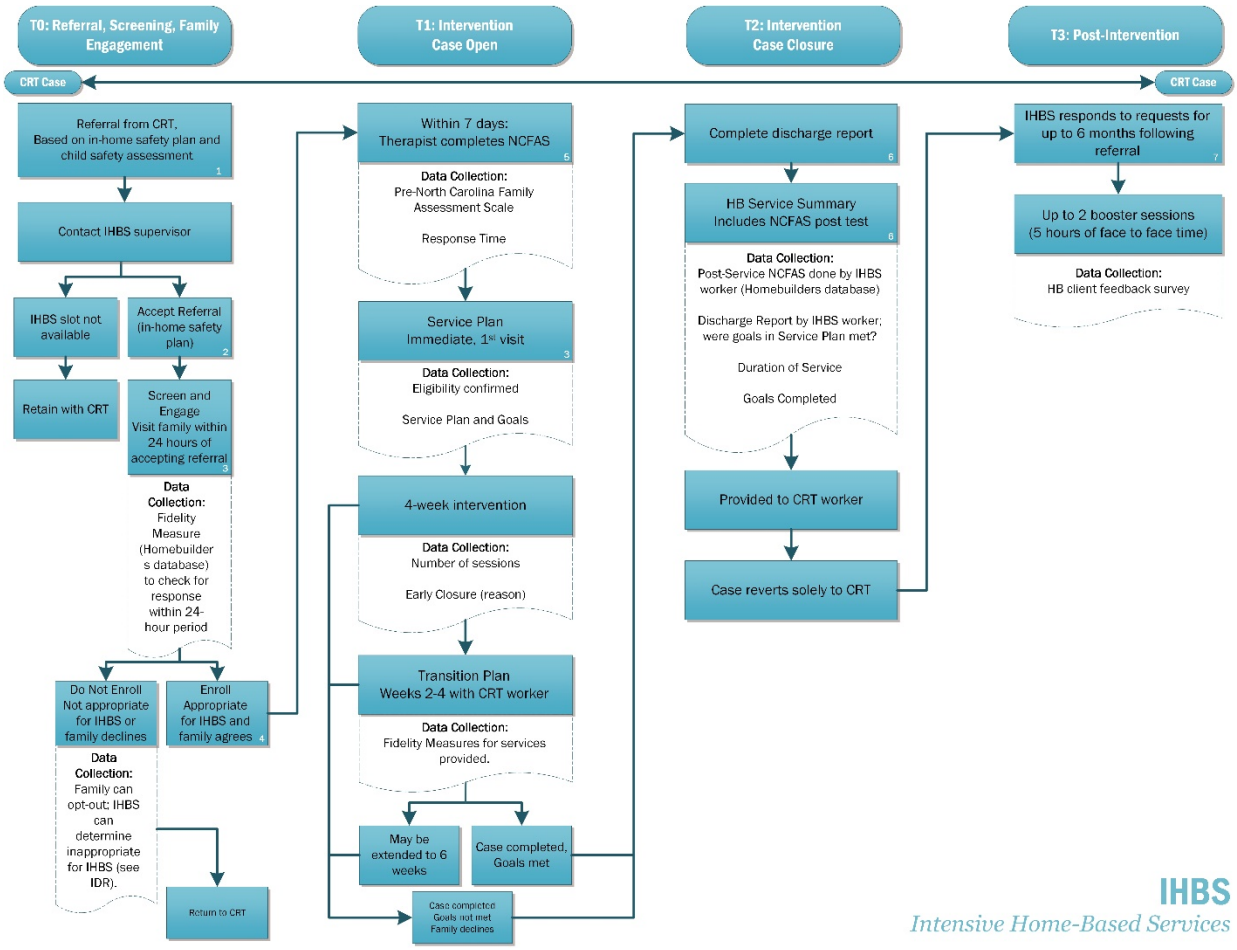


Figure 63. IHBS Workflow Chart

Staffing

O‘ahu

The initial Purchase of Service IHBS staffing plan on O‘ahu consisted of one full-time supervisor and five full-time therapists (see Table 40). There was difficulty staffing up to complete levels in the first year of the Demonstration. The provider faced difficulty with hiring as well as high turnover rates. At the beginning of implementation, there were five therapists on board who went through the extensive HOMEBUILDERS training program. Low referral rates, the demands of the HOMEBUILDERS model and the extensive training process initially affected staffing and led to turnover and a heavy workload for the program director.

At the end of the first year, the IHBS unit on O‘ahu was at its lowest staffing level with one full-time supervisor and two full-time therapists. Because of the continued low referral rates to the IHBS intervention, turnover continued to be a challenge and staffing remained lower than planned, with one program director and three therapists until changes in referral criteria were enacted in late 2017. By mid-2018, the IHBS intervention on O‘ahu was fully staffed with one program director and five therapists.

Table 40
IHBS Staffing 2015 - 2018: O‘ahu

Position	Positions in Contract	Positions filled - Waiver start	Lowest Staffing Count 2016	Positions Filled - Summer 2018
	Number	Number	Number	Number
Supervisor	1	1	1	1
Therapist	5	5	3	5
Total	**6**	**6**	**4**	**6**

Staff education over the course of the Waiver was at the bachelor and master’s degree level with the majority of staff (all but one therapist) holding a master’s degree. The staff had an average of 5.75 years of experience working with children and families.

Hawai‘i Island

The IHBS intervention was provided by two contractors on Hawai‘i Island.

- Parents Inc. (East Hawai‘i/Hilo): There were a total of three dedicated staff that supported IHBS in Hilo (see Table 41). The staff consisted of one program administrator, one supervisor, and one therapist (0.5 FTE). At the time of implementation, Parents, Inc. was fully staffed. All staff held master’s degrees and had an average of 18 years of experience working with children and families. In 2017, a second therapist was hired. There was some

turnover in the supervisor and second therapist positions, but the program continued to be fully staffed through the end of the Demonstration. Over the course of the Demonstration, staff education was primarily at the master's degree level and the staff had an average of 12.5 years of experience working with children and families.

Table 41
IHBS Staffing 2015 - 2018: East Hawai'i

Position	Positions in Contract	Positions filled - Waiver start	Positions Filled - Summer 2018
	Number	Number	Number
Supervisor	1	1	1
Therapist	1.5	1	2
Total	**2.5**	**2**	**3**

- Catholic Charities (West Hawai'i/Kona): There were a total of two dedicated staff that supported IHBS in Kona (see Table 42). The staff consisted of one program director and one therapist. Staffing was stable for the majority of the Demonstration period with turnover in the final year. The staff's education was at the master's degree level.

Table 42
IHBS Staffing 2015 - 2018: West Hawai'i

Position	Positions in Contract	Positions filled - Waiver start	Positions Filled - Summer 2018
	Number	Number	Number
Supervisor	1	1	1
Therapist	1	1	1
Total	**2**	**2**	**2**

Training for and about Intensive Home-Based Services

Intensive Home-Based Service providers received training in the HOMEBUILDERS model core curriculum upon hire. In addition to this training they also received training on information systems, relapse prevention, supervision, leadership, cognitive interventions, and the application of behavioral interventions. In addition to an extensive training program, new IHBS therapists received close supervision from the lead therapist.

CRT staff were responsible for referring eligible families to the IHBS intervention. The training provided to CWS staff regarding the IHBS intervention varied by island. The O'ahu CRT unit participated in the HOMEBUILDERS training at the start of the Waiver. On Hawai'i Island, this training was covered in the previously mentioned 6 – 8 hour in-service training for the CRT intervention. Child Welfare Services supervisors from all three sites had regular interaction with IHBS supervisors regarding referrals and eligibility.

Number of Children and Families Referred to IHBS

Intensive Home-Based Services were consistently under-referred over the course of the Waiver Demonstration. On O'ahu, 167 children were referred to IHBS by September 2018 (see Figure 64). Referrals on O'ahu reached their apex at 97% of the goal in 2015 (the first year of the Waiver Demonstration), and declining thereafter. In 2017, the IHBS intervention began serving families outside the eligibility for the Waiver Demonstration, particularly for those families who had recently experienced child removal and were seeking reunification.[1] These families are not counted or included in the Waiver Demonstration evaluation sample.

On Hawai'i Island, after a slow rate of referral in the first quarter of implementation, referrals grew to 70% of the projected number in 2016, and 76% of the projected number in 2017.

Overall, a total of 66 families on O'ahu were referred from the CRT to IHBS. There were 24 such families in East Hawai'i and two families referred in West Hawai'i.

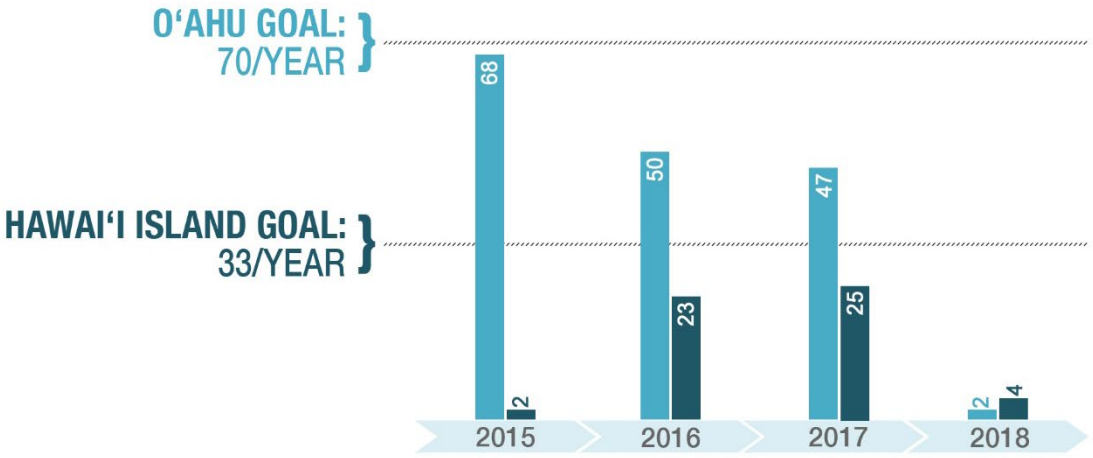


Figure 64. Children Referred from CRT to IHBS[2]

[1] The case counts reported in this section refer to children and families referred and accepted to IHBS. In the early stages of implementation, CRT staff and supervisors reported a "learning curve" in regard to appropriate IHBS referrals. In a "back-and-forth" dialogue with the IHBS supervisor, a number of referrals were not accepted by IHBS because referral criteria were not met, but this type of dialogue has no record in any database. However, as the Demonstration progressed, CRT staff reported increased understanding of referral criteria and as a result fewer inappropriate referrals.

[2] Detailed numerical tables for all figures are included in Chapter Seven Appendix.

Number of Children and Families Served by IHBS

Figure 65. Number of Children in IHBS Sample on O'ahu and Hawai'i Island

The number of children who met eligibility criteria and were served by IHBS was below one-third of projected numbers on both O'ahu and Hawai'i Island, reflecting the staffing difficulties discussed earlier, and an unclear understanding of appropriate referrals, discussed below (see Figure 65). In this section, the number of children "served" refers to those who began services with IHBS, and includes those who might not have completed the intervention (to be discussed later).

On O'ahu, the number of children served by IHBS was highest in the first eighteen months of the Demonstration, declining after that. On Hawai'i Island, the number of children served by IHBS varied from 74% of projections to 10% of projections in any given six-month period.

The 167 children served by IHBS on O'ahu were in 56 families. The 46 children served in East Hawai'i were in 20 families, and one child served in West Hawai'i was in one family.

In the third year of the Waiver Demonstration, as a response partly to low referrals and partly to caseworker interest in IHBS for the other children, the referral criteria for IHBS was modified, on a case-by-case basis, to include the provision of IHBS to children who have been in foster care no longer than 30 days who might return home immediately if parents were willing to participate in IHBS. This was formalized in an Internal Communication Form Memo, dated August 14, 2017. The evaluation did not include these children in the evaluation sample for two reasons. First, the expanded criterion was done on a case-by-case basis at first, and understood to be "outside the Waiver," and caseworkers therefore did not enter into the child's case data that s/he was in the Waiver Demonstration sample. Then, when the expansion criterion was formalized, these children were still not usually designated in the database as participating in the Waiver Demonstration. Therefore, the number of children in the IHBS evaluation sample does not reflect the expansion of the overall population served in 2018 and 2019.

Knowledge and Impressions of IHBS after the First Year

Intensive Home-Based Services struggled with low referral rates during the first year of implementation. In focus groups, low referral rates were said to be due to multiple factors such as confusion with eligibility criteria, eligibility criteria that were considered too stringent, and high employee turnover. Staff consistently discussed the eligibility criteria for IHBS as a barrier and that a gap in service remains for families that do not quite meet the restrictive criteria of HOMEBUILDERS. Staff identified a potential need for an intermediate-level home-based service. Staffing for IHBS was an issue as well with the intensive and lengthy training process required to get a therapist prepared to take on a caseload; high turnover rates plagued the program in the first year.

Knowledge and Impressions of IHBS after the Second Year

Knowledge About IHBS

After IHBS had been active for about two years, child welfare staff were asked about their knowledge regarding the Intensive Home-Based Services. There were five statements measuring how much the staff knew about the intervention.

- I have received enough information about IHBS to understand its overall purpose.
- IHBS trainings made the need for the intervention clear to me.
- It is clear how IHBS is meant to help children and families.
- The main goal of IHBS is not clear to me.
- I am not sure which cases should go to IHBS.

The response choices for each statement used a Likert scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree). Using the two categories of Strongly Agree and Agree, percentages of agreement were calculated.

A total of 30 CWS staff with responsibility for referring families to IHBS responded to the statements above, regarding their knowledge of IHBS. As shown in Table 43, staff felt fairly confident in their knowledge of IHBS. The majority of respondents felt that they received enough information about IHBS to understand its purpose. There was less agreement with the perception that the training made the need for IHBS clear, but higher agreement that respondents clearly understand how the intervention was meant to help children and families.

The majority of child welfare staff felt that they received enough information about IHBS to understand its purpose.

The last two statements were reverse-coded, meaning that lower levels of agreement indicate greater knowledge. Very few respondents indicated that the goal of IHBS was not clear to them or that they were not sure which cases should go to IHBS. This is a substantial difference from the confusion about IHBS eligibility criteria expressed in the first-year focus groups. There were no significant differences between islands in respondents' perceptions of their knowledge about the IHBS intervention.

Table 43
Knowledge of Intensive Home-Based Services

	IHBS	
	Oʻahu (n=14)	**Hawaiʻi Island** (n=16)
I have received enough information about IHBS to understand its overall purpose.	71%	88%
It is clear how IHBS is meant to help children and families.	71	75
IHBS trainings made the need for the intervention clear to me.	57	69
The main goal of IHBS is not clear to me.	7	6
I am not sure which cases should go to IHBS.	6	14

Perceptions of Intensive Home-Based Services

Staff were asked to indicate their level of agreement, on a five-point scale, with a number of statements about the Intensive Home-Based Service intervention. These ratings of agreement with the statements were averaged into six composite scores related to:

- Knowledge of the intervention
- Perception that the intervention has advantages relative to prior approaches
- Positive peer buy-in about the intervention
- Compatibility with the local context
- Concerns about risk to children with the intervention
- Concerns about the time commitment required for the intervention

Mean scores on these six dimensions are shown in Table 44.

For the IHBS intervention, positive perceptions were relatively high on both Oʻahu and Hawaiʻi Island (see Table 44). Respondents had high levels of agreement that IHBS has advantages relative to prior approaches. Mean scores on both Oʻahu and Hawaiʻi Island indicated that respondents perceived positive buy-in by peers about IHBS. Staff on Oʻahu had slightly more favorable perceptions about IHBS as being compatible with the local context, but the difference was not statistically significant.

Table 44

Perceptions of Intensive Home-Based Services

	IHBS	
Positive Perceptions of IHBS		
IHBS has advantages relative to prior approaches	3.9	3.7
Knowledge about IHBS	3.8	4.0
Positive peer buy-in about IHBS	3.6	3.5
IHBS is compatible with local context	3.4	3.2
Negative Perceptions of IHBS		
Negative concerns re: time commitment for IHBS	3.5	3.2
Negative risk concerns about IHBS	3.2	3.2

Knowledge of Eligibility Criteria for Referrals to IHBS

If a respondent had responsibility for referring to IHBS, or if s/he were a CRT caseworker, s/he was directed to view two scenarios of children seen by CRT, asking what the appropriate action would be (see Table 45). Thirty-one (Scenario 1) and thirty (Scenario 2) respondents answered. In both scenarios, the correct choice of action was a referral to IHBS, based on the stated referral criteria for IHBS in training.

Scenario 1: CRT workers went to the house of Shelly and her three children, Antonia (age 10), Raquel (5), and Robert (3) at 3:00 am. CWS was called by the police after they received a call from Shelly's neighbor saying he heard screaming next door. When CRT arrived, they found that Antonia had been hit with a wire brush resulting in approximately 20 to 30 small holes in her scalp. The other two children were crying hysterically and refused to talk with the CRT worker. Shelly admitted hitting the children, stating she "just lost control." As a single parent, she supported the family by part-time employment and public assistance. Raising three children alone was overwhelming and financial problems were never-ending. The house was very dirty, with layers of clothes and trash.

Scenario 2: CRT was sent out after a school counselor called Intake saying that a 6-year-old girl, Tiffany, had come to school with bruises many times. She always had different explanations about the bruises, some of which were hard to believe. When CRT investigated the case, there were suggestions of domestic violence. The mother was very quiet and seemed fearful during interviews when the husband was present. She also made a comment to the CRT worker that he took her phone away whenever she left the house. When asked if she has been hit Tiffany becomes tearful but does not respond. Both parents live in the house, but you are worried about the safety of the mother and child if they stay in the home with the father.

The likelihood of a referral differed by the context of the scenario. In the first scenario, physical abuse was present, and the mother said it was due to a "loss of control." The mother said she was a single parent, had financial problems, and the house was dirty. For 34% of respondents, the course of action was to refer to IHBS. However, another 33% would refer the case to CWS for placement of the child. In this scenario, 20% of respondents answered "other," and the open-ended narrative responses to this scenario indicated the need for further information and conversations with the mother, particularly, and some respondents listed a variety of immediate steps they would take to ensure safety before making a referral decision.

In the second scenario, a six-year old girl often came to school with bruises, CRT responded and suspected domestic violence. The mother seemed fearful, and the father took her phone when he left the house. In this second scenario, 20% of respondents would refer the family to IHBS. Another 26% would refer the family to CWS for placement of the child. Over one-third of respondents checked "other" as their response, and the responses typically recommended asking the mother if she was willing to go to a DV shelter or other safe place. If the mother refused, many recommended calling the police to take protective custody of the child.

Despite the survey responses indicating that few respondents were not sure which cases should go to IHBS, the results of the two scenarios indicate low fidelity in following IHBS referral eligibility criteria, and provide some explanation for the low actual referral rates to IHBS.

Table 45
IHBS Scenarios of Maltreatment Reports

Referral Decision	**IHBS**	
	Scenario: Mother is overwhelmed (n=31)	**Scenario: Possible domestic violence** (n=30)
Refer to IHBS	34%	20%
Refer to CWS for placement	33	26
Continue with CRT only	10	17
Refer to VCM/FSS	3	0
Other	20	37

Service Fidelity of Intensive Home-Based Services

Eligibility

Almost all children referred to IHBS by CRT (96%) had been assessed by Intake to be at imminent risk of harm. There is no assessment of imminence of placement at intake.

At the time of referral to IHBS, the CRT/CWS caseworker had completed an In-Home Safety Plan for 88% of the children referred on Oʻahu, and 98% of the children referred on Hawaiʻi Island.

All IHBS referrals were assessed by CRT caseworkers to be eligible for IHBS services when they were referred, on both Oʻahu and Hawaiʻi Island. However, on each island, 2% of referred cases were deemed ineligible by the IHBS provider once the case was assessed by the IHBS therapist. Reasons included placement not being imminent for the child (on Oʻahu) and serious safety concerns (on Hawaiʻi Island).

Referrals from the Crisis Response Team to IHBS

On both Oʻahu and Hawaiʻi Island, 10% of children seen by the Crisis Response Team were referred to IHBS.

Because children were referred to IHBS from CRT, their pathway to IHBS usually started with a report of maltreatment from law enforcement, schools, or hospitals. On Oʻahu, the majority of cases referred to IHBS by CRT were for children whose report of maltreatment came from a school (see Figure 66). About one-fourth of those children referred to IHBS had come from a hospital report. Less than one-fifth of the cases referred to IHBS on Oʻahu had come from a report from law enforcement.

On Hawaiʻi Island, the proportions of children referred to IHBS services were very similar across reports from law enforcement, schools, and hospitals (see Figure 66).

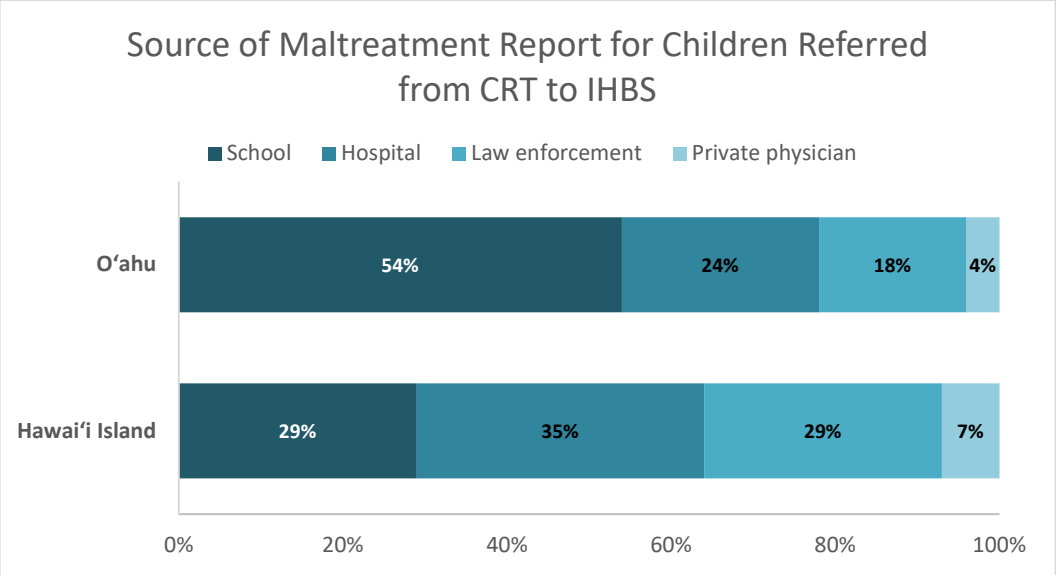


Figure 66. Source of Maltreatment Report for Children Referred to CRT from IHBS

Comparison of Children Referred and Not Referred from CRT to IHBS

The hallmarks of Intensive Home-Based Services are that they are short-term, services are delivered in the home and other non-office settings, interventions are concrete and cognitive-behavioral in nature, and therapists are available to families at all hours. Families have to agree to fully participate. Due to these specific characteristics of the intervention, not all families who received a CRT response would be an ideal candidate for the IHBS intervention.

After the first two years of the Demonstration, the Evaluation Team analyzed whether those children and families referred from CRT to IHBS were significantly different than those not referred. The following differences were noted and are discussed in more detail in the *Interim Evaluation Report* (Berry, *et al*, 2018).

Children who were referred to IHBS services on O'ahu were significantly younger than those not referred, with a mean age of 6.5, compared to 7.8 among those receiving CRT only. Those referred to IHBS were significantly more likely to be White and/or Asian than were those not referred to IHBS.

On O'ahu, children who were referred to IHBS were especially likely to have experienced the threat of abuse (53%), threatened neglect (47%) and/or physical abuse (23%). Threatened neglect and physical abuse were significantly more likely for those referred from CRT to IHBS. No sexual abuse or abandonment cases were referred to IHBS on O'ahu.

The most common precipitating factors for children referred to IHBS on O'ahu were unacceptable child rearing practices (38%), an inability to cope with parenting (31%), a loss of control during discipline (31%), and a lack of tolerance of child behavior (29%). Children referred to IHBS on O'ahu were significantly more likely than those not referred to have a

parent with a loss of control during discipline, a new baby in the home, or a parental history of abuse. They were significantly less likely to have parents with unacceptable child rearing practices, parents with a mental health problem, alcohol abuse in the family, or family discord.

The most common safety factors identified at Intake for those children referred to IHBS on O'ahu were the child experiencing severe/present/impending danger (49%), caregiver violent behavior (40%), or parent impulsivity (26%). Children were significantly more likely to be referred to IHBS when they had experienced caregiver violent behavior or impending danger.

On Hawai'i Island, those families referred to IHBS had significantly fewer children in the home, on average. The majority of IHBS-referred children were said to be of a Hawaiian/Pacific Islander race, similar to CRT-only children. However, with regard to ethnicity, those who were Hawaiian/Part Hawaiian were significantly less likely to be referred to IHBS, while those classified as "mixed; not Hawaiian/Part Hawaiian" were significantly more likely to be referred to IHBS.

On Hawai'i Island, the most common type of maltreatment for those children referred to IHBS was the threat of abuse (52%). Less common were threatened neglect (26%), physical neglect (17%), physical abuse (17%), and lack of supervision (17%). However, those referred to IHBS were significantly more likely than CRT-only children to have experienced lack of supervision or psychological abuse, and were less likely to have experienced threatened neglect. Children who were referred to IHBS on Hawai'i Island were significantly more likely than those not referred to have experienced maltreatment that meets the legal definition of harm.

On Hawai'i Island, the most common precipitating factors for children referred to IHBS were unacceptable child rearing practices (50%), lack of tolerance of child behavior (33%), and drug abuse (22%). Children referred to IHBS were significantly more likely than those not referred to have parents with unacceptable child rearing practices or a lack of tolerance of child behavior.

The most common safety factors identified at Intake for those children referred to IHBS on Hawai'i Island were parental substance abuse (38%), parent impulsivity (29%), or the child experiencing severe/present/impending danger (29%). Children were significantly less likely to be referred to IHBS services if there was caregiver violent behavior, the child was fearful of harm or if the parents could not meet the child's immediate needs.

Early Case Closures

While few children were deemed ineligible for IHBS services once they were referred to IHBS, a few children/families did not complete IHBS services (see Table 46). On O'ahu, 10% of referred children and their families did not complete IHBS services. The non-completion rate on Hawai'i Island was 13%. The primary reasons for not completing IHBS were child placement, or the child being otherwise out of the home for more than seven days.

Table 46
IHBS Premature Closure

Reason for Premature Closure	O'ahu (n=167 referred children)	Hawai'i Island (n=54 referred children)
Child placed	3%	4%
Child out of home more than 7 days	3	3
Ineligible	2	2
Drop-out	1	0
IHBS services not needed	1	0
Referent initiated closure	0	4
Total Prematurely Closed	**10%**	**13%**

Service Provision

Twenty-Four Hour Response Time

On O'ahu, all families referred to IHBS had a face-to-face meeting with an IHBS therapist within 24 hours of referral (see Figure 67). The mean length of time between referral and the in-person meeting was 10 hours.

On Hawai'i Island, 70% of families referred to IHBS had a face-to-face meeting with an IHBS therapist within 24 hours of referral, with a mean length of time between referral and the in-person meeting of 21 hours (see Figure 67).

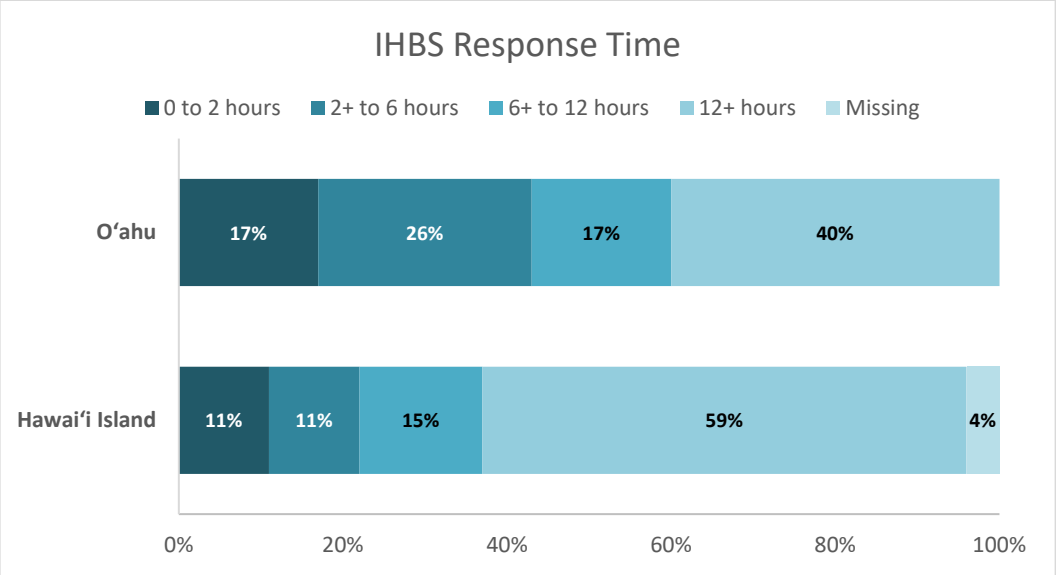


Figure 67. IHBS Response Time

Duration of Service

A total of 151 children on O'ahu and 47 children on Hawai'i Island were eligible for, received, and completed Intensive Home-Based Services, and were eligible to be included in the evaluation sample.

All children served by IHBS on O'ahu completed IHBS within six weeks, the prescribed maximum duration of service (see Table 47). The longest a family was served was 39 days. The average duration of service was 30 days, or one month. Fewer than half of cases were closed by IHBS within four weeks.

On Hawai'i Island, all families served by IHBS were closed to IHBS within six weeks (see Table 47). The longest a family was served was 42 days, or six weeks. The average length of service was 33 days. Very few cases were closed in four weeks or less.

Table 47
IHBS Direct Service

Service Parameters	IHBS	
	O'ahu (n=151 children)	**Hawai'i Island** (n=47 children)
Range of length of service	22 to 39 days	27 to 42 days
Avg. length of service	30 days	33 days
Avg. face-to-face hours	43 hours	41 hours
Avg. total case hours	95 hours	75 hours
Avg. number of sessions	25 sessions	23 sessions
Avg. sessions per week	4.7 per week	4.0 per week
% Families closed within 4 weeks	42%	6%
% Families closed within 6 weeks	100%	100%
No. of children with post services	(n=64)	(n=13)
Avg. face-to-face sessions (post)	1.4	1.0
Avg. face-to-face hours (post)	2.4	2.1

Intensity of Service

On O'ahu, IHBS therapists provided an average of 95 hours to each case served in the Waiver Demonstration (see Table 47). They devoted an average of 25 face-to-face sessions with the families they served, at an average of five sessions per family, per week.

On Hawai'i Island, IHBS therapists provided an average of 75 hours to each family served (see Table 47). They spent an average of 23 face-to-face sessions with the families over the course of service, at an average of four sessions per family, per week.

Case Monitoring by CRT during IHBS

CRT caseworkers have the responsibility of monitoring families while they are receiving Intensive Home-Based Services. On O'ahu, for the 151 children who completed IHBS services, over half had three visits by their CRT worker during this time (see Figure 68).

On Hawai'i Island, of the children who were referred to and completed IHBS services (n=47), about one-third received no further visits from a CRT caseworker (see Figure 68). Again, given that the CRT intervention is understood as more of a type of response than being a separate unit on Hawai'i Island, the lack of ongoing monitoring is not surprising, but not faithful to the original CRT model.

On O'ahu, those children who completed IHBS had their case open to CRT for an average of 76 days, ranging from one day (closed same day as Intake referral) to 326 days (see Table 48). Almost one-third of children had a CRT case open longer than 90 days.

On Hawai‘i Island, the mean length of a CRT case for those who completed IHBS was 39 days (see Table 48). All CRT cases receiving IHBS were closed to CRT within 90 days.

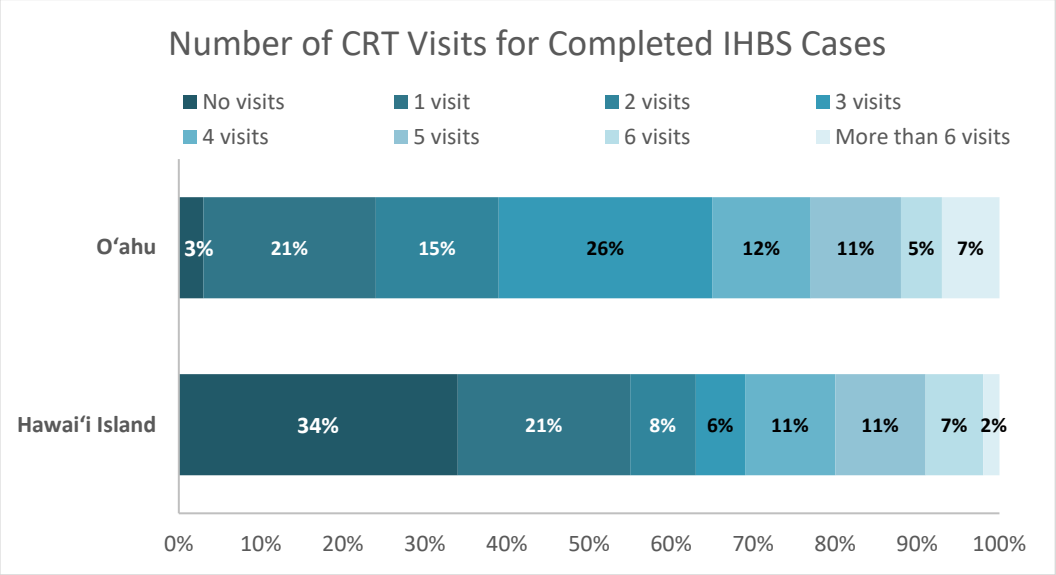


Figure 68. Number of CRT Visits for Completed IHBS Cases

Table 48

Length of CRT for Completed IHBS Completed Cases

Number of Days of Service	**IHBS**	
	O‘ahu (n=151 children)	**Hawai‘i Island** (n=47 children)
Closed within 60 days	52%	90%
1 to 7 days	4	0
8 to 14 days	2	0
15 to 30 days	5	13
31 to 60 days	41	77
61 to 90 days	11	4
More than 90 days	31	0
Missing	8	6
Range	1 to 326 days	29 to 80 days
Mean	76 days	39 days

Completion of Final Safety Assessments by the Crisis Response Team

Once a child had received services from Intensive Home-Based Services and the IHBS service was terminated, the CRT caseworker was responsible for conducting a second/Final Safety Assessment. The evaluation tracked the completion of Final Safety Assessments, given that their completion and entry into SHAKA was a new requirement. On O‘ahu, the completion of Final Safety Assessments did improve over the first three years of the Demonstration to almost

two-thirds of children served (see Figure 69). On Hawai‘i Island, the completion of Final Safety Assessments was very high in the first full year of the Demonstration, but fell sharply after that.

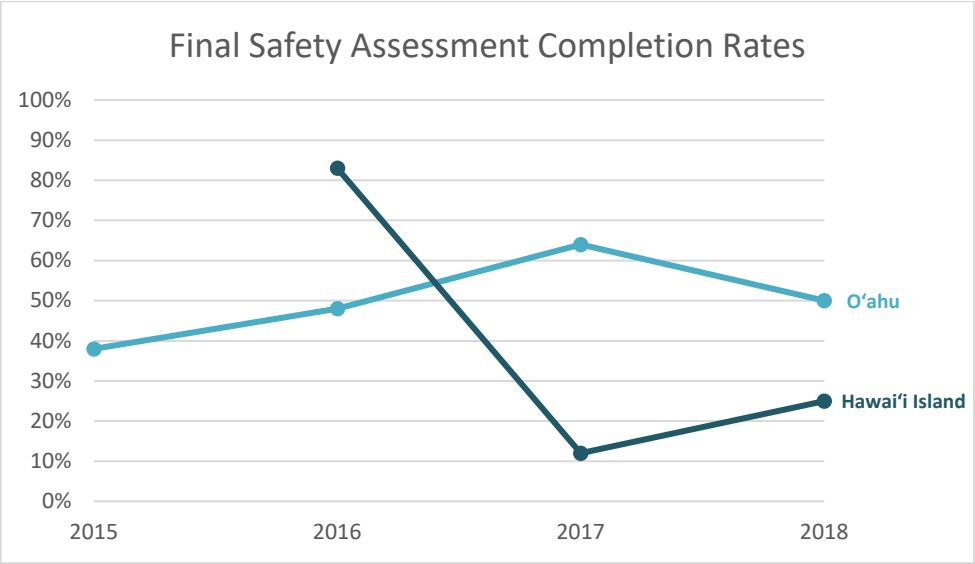


Figure 69. Final Safety Assessment Completion Rates

Profiles of Children and Families Served by IHBS

Demographic Characteristics

On both O‘ahu and Hawai‘i Island, there were similar proportions of male and female children served by IHBS (see Figure 70). The average number of children served in each household was three, and the average number of adults in the household was two. Children served on O‘ahu were most likely to be between the ages of one and six, while children on Hawai‘i Island were most likely to be infants.

Those referred to IHBS on O‘ahu were likely to be White and/or Asian and/or Hawaiian/Part Hawaiian (see Figure 71). The most common races reported served by IHBS on Hawai‘i Island were White and Hawaiian/Part Hawaiian. The most common ethnicity for both islands was Hawaiian/Part Hawaiian.

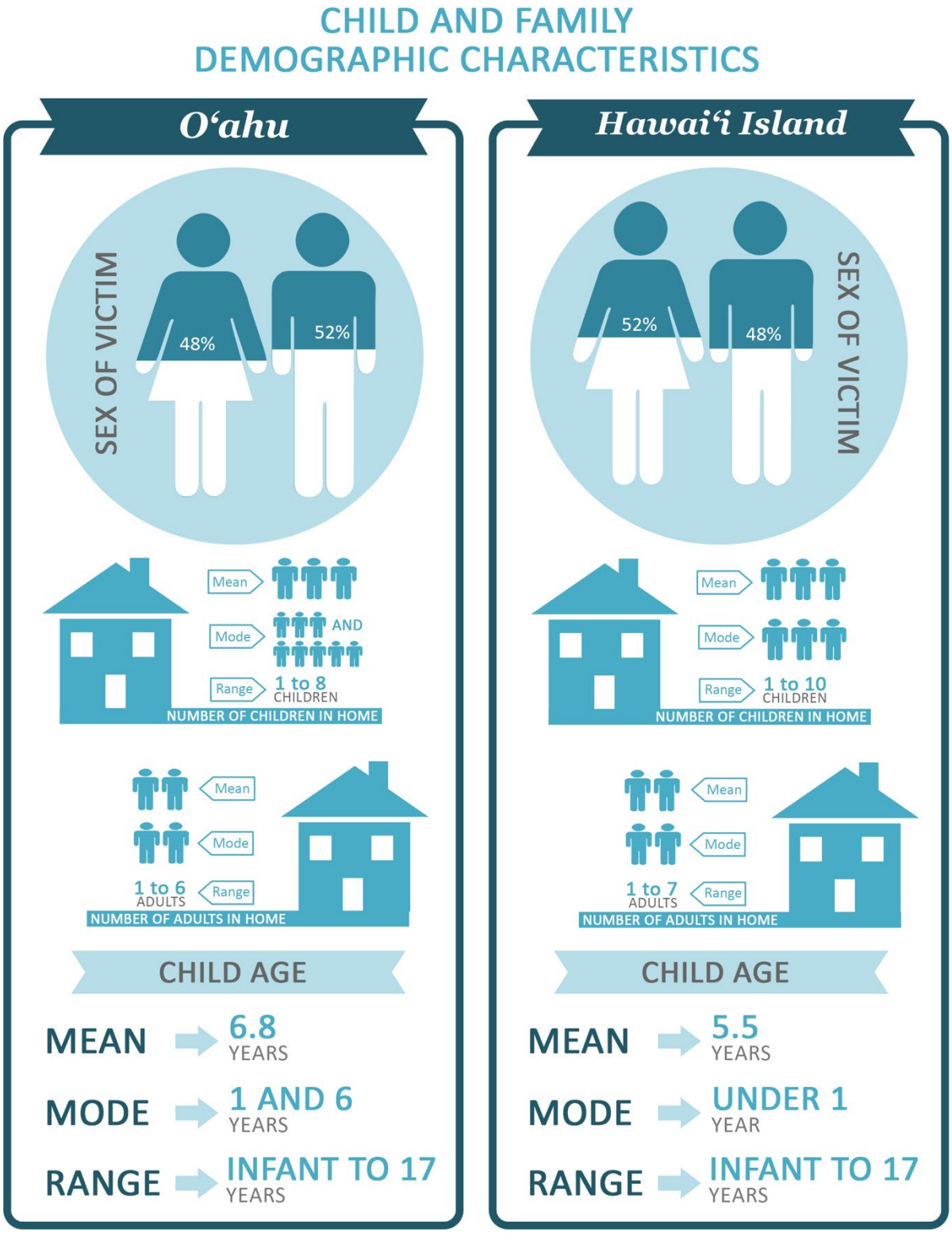


Figure 70. Child and Family Demographic Characteristics

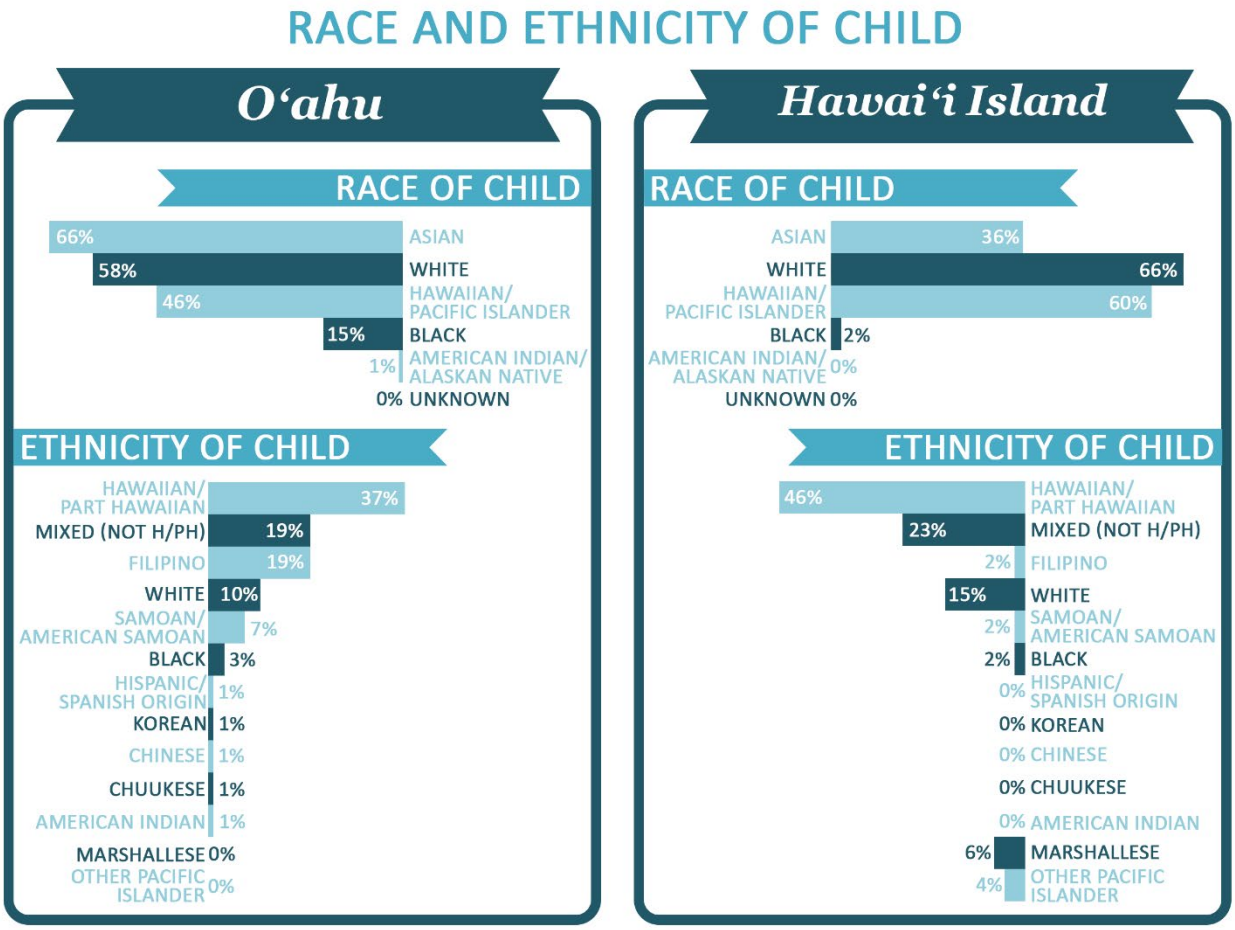


Figure 71. Race and Ethnicity of Child

Maltreatment

The six most common types of maltreatment that were the subject of the Intake report for children on O'ahu are denoted in Table 7.19. Children who were referred to IHBS were especially likely to have experienced the threat of abuse (54%), threatened neglect (42%), and/or physical abuse (25%).

On Hawai'i Island, the most common type of maltreatment for those children referred to IHBS was the threat of abuse (45%) (see Table 7.19). Less common were threatened neglect (32%), physical abuse (11%), physical neglect (6%), and lack of supervision (9%).

On O'ahu, 56% of those children referred to IHBS had their maltreatment confirmed (see Table 49). On Hawai'i Island, 60% of those children referred to IHBS had their maltreatment confirmed.

About half of the children who were referred to IHBS on O'ahu and Hawai'i Island were likely to have experienced maltreatment that meets the legal definition of harm (see Table 50).

Table 49
Type of Maltreatment at Intake

Type of Maltreatment[a]	**O'ahu** (n=151)	**Hawai'i Island** (n=47)
Threat of abuse	54%	45%
Threatened neglect	42	32
Physical abuse	25	11
Physical neglect	5	6
Lack of supervision	2	9
Sexual abuse	0	4

[a]Multiple response

Table 50

Children with Maltreatment Confirmed and Severity of Harm

	O'ahu (n=115 victims)	**Hawai'i Island** (n=30 victims)
Meets legal definition of harm	51%	51%
Confirmation		
Confirmed	56%	60%
Not confirmed	32	40
Unsubstantiated/Blank	12	0
Primary perpetrator		
Bio parent	83%	93%
Stepparent	13	3
Grandparent	1	0
Adoptive parent	1	0
Other	2	4
Severity of Harm[a]	(n=64 confirmed)	(n=18 confirmed)
No treatment necessary	42%	72%
No Injury/Blank	42	6
Treatment required	16	11
Serious injury	0	11

[a]Only among those confirmed.

Risk and Safety Factors

The CRT caseworker completed an Initial Safety Assessment before referring a child and family to Intensive Home-Based Services.

The most common precipitating factors for children referred to IHBS on Oʻahu were unacceptable child rearing practices (33%), a loss of control during discipline (21%), an inability to cope with parenting (17%), and a lack of tolerance of child behavior (17%) (see Table 51).

On Hawaiʻi Island, the most common precipitating factors for children referred to IHBS were unacceptable child rearing practices (21%) and drug abuse (21%) (see Table 51).

About half of children served by IHBS had had prior experience with Child Protective Services in Hawaiʻi (46% on Oʻahu; 60% on Hawaiʻi Island). Almost all children were judged to be at risk of future harm (see Table 51).

The safety factors reported for children differed between Oʻahu and Hawaiʻi Island (see Table 52). The most common safety factors for children served on Oʻahu were severe/present/impending danger to the child (48%), and caregiver violent behavior (44%). On Hawaiʻi Island, the most common safety factors reported were parental substance abuse (43%), and child lacks protective skills (43%).

Table 51

Family Risks

Family Risks[a]	O'ahu (n=151)	Hawai'i Island (n=47)
Precipitating factors[a]		
Unacceptable child rearing practices	33%	21%
Loss of control during discipline	21	4
Lack of tolerance of child behavior	17	11
Inability to cope with parenting	17	6
Drug abuse	7	21
Heavy/continuous child care respons.	7	0
Inadequate housing	6	2
Spouse abuse/fighting	5	0
Child has prior CPS	46%	60%

[a]Multiple response

Table 52

15 Safety Factors from Intake Tool

Safety Factors*	O'ahu (n=151)	Hawai'i Island (n=47)
Severe/present/impending danger	48%	19%
Caregiver violent behavior	44	28
Parent impulsivity	21	13
Child fearful of harm	19	15
Cannot meet immediate needs	15	13
Inadequate supervision	14	19
Parental substance abuse	13	43
Child lacks protective skills	10	43
Lack of parental knowledge/skills	6	15
Credible threat to child	5	0
Child whereabouts unknown/flight risk	3	6
Death of child in household	1	6
Parental mental illness	1	0
Parent negative toward child	0	2
Hazardous living conditions	0	0

[a]Multiple response

Family Functioning and Child Well-Being at Service Onset

The *North Carolina Family Assessment Scale* (Reed-Ashcraft, Kirk, & Fraser, 2001) contains five domains of family functioning and child well-being: Environment, Parental Capabilities, Family Interactions, Family Safety, and Child Well-Being.

For the families receiving IHBS on O'ahu, the domain showing the greatest strength at the onset of IHBS was the physical environment (33% rated as showing strength in this domain). The domains showing the most stress were parental capabilities (95% rated as a problem, including 11% as a serious problem) and family safety (93% rated as a problem, including 9% as a serious problem). No families were rated as having strengths in the areas of parental capabilities or family safety at the onset of services (see Table 53).

On O'ahu, 25% of the families served by IHBS were assessed to be adequate or at community baseline in regard to the well-being of their child(ren) at the onset of services, 16% were assessed to have strengths in this domain, while the remaining 59% of families were assessed as having problems in regard to the well-being of their child(ren) (see Table 53).

On Hawai'i Island, the domain for which the most families were assessed as having strengths was the physical environment (40% rated as showing strength in this domain) (see Table 54). The domains showing the most stress were parental capabilities (98% rated as a problem), and family safety (89% rated as a problem, with 19% as a serious problem). While 40% of families were noted to have strengths in their physical environment, notably, almost one-quarter (23%) of the families served by IHBS on Hawai'i Island were assessed to have "serious problems" in regard to their physical environment, which includes such circumstances as the safety of the neighborhood, physical safety of the home, and adequate space for family members, as well as adequate income.

On Hawai'i Island, 15% of the families served by IHBS were assessed to be adequate or at community baseline in regard to the well-being of their child(ren). An additional 25% of families were assessed to have strengths in this domain. Few families were assessed to have a serious problem in regard to child well-being (see Table 54).

Table 53

Pre-IHBS NCFAS Domain Scores: O'ahu (n=151)

NCFAS Domain	Serious Problem	Moderate Problem	Mild Problem	Baseline/ Adequate	Mild Strength	Clear Strength
	%	%	%	%	%	%
Environment	3	22	13	29	28	5
Parental Capabilities	11	73	11	5	0	0
Family Interactions	0	24	43	19	14	0
Family Safety	9	61	23	7	0	0
Child Well-Being	8	31	20	25	9	7

Table 54

Pre-IHBS NCFAS Domain Scores: Hawai'i Island (n=47)

NCFAS Domain	Serious Problem	Moderate Problem	Mild Problem	Baseline/ Adequate	Mild Strength	Clear Strength
	%	%	%	%	%	%
Environment	23	0	28	9	40	0
Parental Capabilities	6	51	41	0	2	0
Family Interactions	13	23	19	17	9	19
Family Safety	19	40	30	11	0	0
Child Well-Being	6	26	28	15	17	8

Parent Feedback on Service Fidelity

The IHBS therapist administered a Client Satisfaction Survey (here, called the Parent Feedback Questionnaire) to parents at the end of the IHBS intervention, and the questions largely focused on whether clients were satisfied that the therapists were faithful to the principles and practices of the IHBS model. The response rate to this survey was very high on Oʻahu (140 completed surveys among 151 families for a 93% response rate). Only six surveys were completed on Hawaiʻi Island (of 47 families for a 13% response rate). Only the Oʻahu surveys are discussed here, given these response rates.

A key tenet of the IHBS model is the availability of the therapist at all times. Parents largely affirmed that therapists were always available; all (100%) indicated that the therapist told him or her they were available to the client 24 hours a day, 7 days per week, and encouraged him or her to call whenever needed (see Table 55). However, when asked if the therapist response was timely when called for help, only 47% said that they response was always timely.

Convenient and intensive services are another key aspect of the IHBS model. A full 94% of respondents said that the therapist scheduled visits at convenient times for the family. About three-fourths of families responding said that they met with their IHBS therapist four or more times per week.

The IHBS model used in Hawaiʻi is a skills-based intervention. When asked if the therapist helped family members learn new skills, 91% responded that therapists had helped them do so. Among those respondents learning new skills, 95% reported that they were actually using these skills.

Parents were asked if their therapist connected them with community resources, an important part of a short-term intervention. A full 89% of respondents indicated that the therapist helped them connect with resources (the remaining 11% said that community resources were not needed).

The IHBS model is a strengths-based and client-centered model that prioritizes a strong and respectful working relationship with families. A full 88% of respondents were very satisfied that the therapist listened to and understood their situation, and 92% said that the therapist respected their culture and values.

Table 55

IHBS Parent Feedback Questionnaire

Fidelity Question	**O‘ahu** (n=140)
Therapist explained 24/7 availability	100%
Response was timely if I called for help	
Always	47
Most of the time	4
Sometimes	37
Never	3
I did not call for help	9
Therapist scheduled visits at convenient times	94
Frequency of meetings with therapist	
Four or more times per week	73
Two to three times per week	26
One time per week	1
Therapist helped family members learn new skills	91
I am using these skills (among the 126 learners)	95
Therapist helped me get connected with resources	89
Therapist listened to me and understood my situation	
Very satisfied	88
Therapist respected my culture and values	
Very satisfied	92

Child Outcomes After IHBS

Hypotheses

Providing IHBS will reduce the percentage of reported children entering into foster care.

Providing IHBS will reduce the percentage of children with new reports within six months of the report.

Providing IHBS will reduce the percentage of repeat referrals to Child Welfare Services within six months of a report.

Providing IHBS will improve the well-being and functioning of children and their families.

Entries into Foster Care

For the purposes of analysis of placement following IHBS, this analysis counts NCANDS placements (within 90 days of completion of IHBS). Placements are counted only for those children and families who completed IHBS.

Only 14 children were placed into foster care after completing IHBS on O‘ahu.

Only 14 children were placed into foster care after completing IHBS on O‘ahu (see Figure 72). Five of these children (from the same family) were short-stayers following removal. Ten removed children were in paid placement settings (including nine with relatives) and four were in non-paid settings (see Table 56). These 14 children came from four families.

No children on Hawai‘i Island went into placement after completing IHBS.

No children on Hawai‘i Island went into placement after completing IHBS.

Intensive Home-Based Services were provided to 24 children after they had first been placed into care following CRT (five children on O‘ahu and 19 children on Hawai‘i Island). All were short-stayers in that placement episode, and returned home prior to the start of IHBS services.

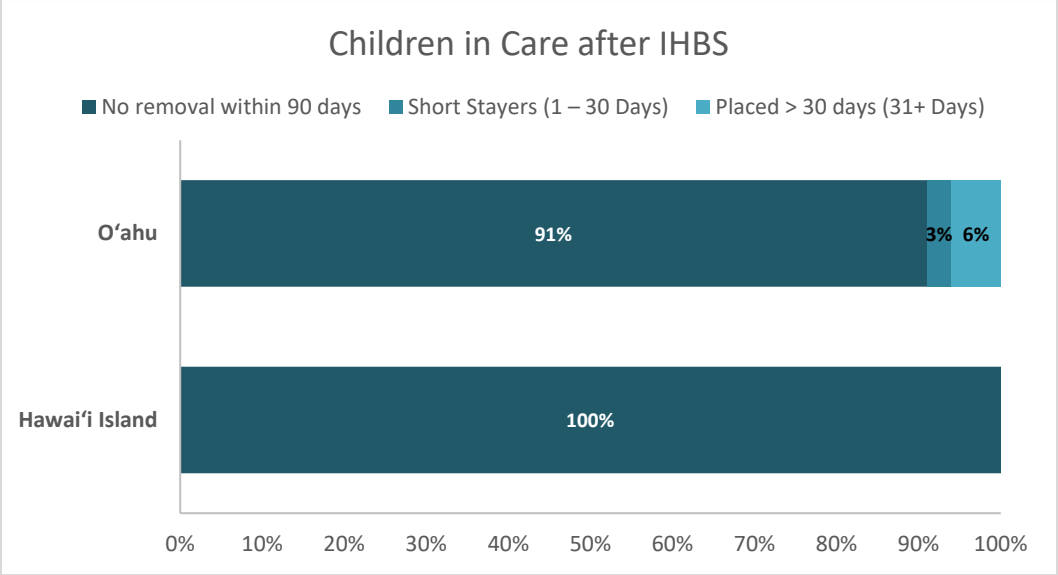


Figure 72. Children in Care after IHBS

Table 56

Type of First Placement Following IHBS

Placement Type	**O'ahu** (n=14)
Paid Placements	
Room and Board – Relative Care	64%
Room and Board - Foster Care	7
Emergency Foster Care	7
Non-Payment Placements	
Child Elsewhere	22

New Reports of Maltreatment Following IHBS

On O'ahu, 15 children (10%) in four families had a new report of maltreatment within six months following the completion of IHBS services. Five children (3%) in one family had a new report of maltreatment while receiving IHBS services.

On Hawai'i Island, no children or families had a new report of maltreatment within six months following the completion of IHBS services. One child (2%) had a new report of maltreatment while receiving IHBS services.

New Case Open to Child Welfare Services

On O'ahu, nine children (6%) in three families had a new referral for investigation (case opening) following IHBS services. On Hawai'i Island there were no children and families who received a new referral for investigation (case opening) following IHBS services.

Improvements in Family Functioning and Child Well-Being

Changes in NCFAS Ratings

Families receiving IHBS were assessed using the *North Carolina Family Assessment Scale* twice; once at onset of services, and again at the end of services. The assessment was completed by the IHBS therapist. Having two administrations of the same assessment tool allows for a measure of improvement over the course of treatment. As described earlier, the creators of the *NCFAS* (Kirk, *et al*, 2005) have found that the best predictor of placement outcomes is NOT the degree of improvement/decline over time. Rather, the best predictor of whether children are maintained in their own homes is whether families achieve a rating of "adequate/baseline" by the end of IHBS.

Family safety and family interactions, the domains showing the greatest stress at the onset of services, showed the greatest improvement in the numbers of families achieving adequate or higher assessments at termination of IHBS.

For those families receiving IHBS on O'ahu, two-thirds or more were assessed at being at or above baseline at the end of IHBS on any of the following: physical environment, parental capabilities, family interactions, family safety, and child well-being (see Table 59). Family safety and family interactions, two domains in which no families were assessed to have strengths at the onset of services, showed the greatest improvement in the numbers of families achieving adequate or higher assessments at termination of IHBS. An impressive 87% of families were assessed at case closure to be at or above adequate in family safety at case closure, compared to only 7% at the onset of services (see Table 57). Similarly, a full 81% of families were assessed as being at or above adequate at case closure in the domain of family interactions, compared to 33% at the onset of services. The domain showing the least improvement was the physical environment, although families were generally assessed to be adequate or above in this domain at the onset of services.

For those families receiving IHBS on Hawai'i Island, family safety was the domain where the most families achieved ratings of adequate or above by case closure (62% were assessed as adequate or above at case closure, compared to 11% at the onset of services) (see Tables 58 and 60). After services, about half of families (55%) were assessed to be adequate or above in their physical environment at case closure, about the same proportion as at service onset.

On Hawai'i Island, family safety was the domain where the most families achieved ratings of adequate or above by case closure.

Table 57

Pre- and Post-IHBS NCFAS Domain Scores: O'ahu (n=151)

NCFAS Domain	Type	Serious Problem	Moderate Problem	Mild Problem	Baseline/ Adequate	Mild Strength	Clear Strength
		%	%	%	%	%	%
Environment	Pre	3	22	13	29	28	5
	Post	0	6	19	18	48	9
Parental Capabilities	Pre	11	73	11	5	0	0
	Post	1	13	12	54	19	1
Family Interactions	Pre	0	24	43	19	14	0
	Post	0	3	16	40	40	1
Family Safety	Pre	9	61	23	7	0	0
	Post	3	1	9	61	25	1
Child Well-Being	Pre	8	31	20	25	9	7
	Post	6	7	13	31	35	8

Table 58

Pre- and Post-IHBS NCFAS Domain Scores: Hawai'i Island (n=47)

NCFAS Domain	Type	Serious Problem	Moderate Problem	Mild Problem	Baseline/ Adequate	Mild Strength	Clear Strength
		%	%	%	%	%	%
Environment	Pre	23	0	28	9	40	0
	Post	11	15	19	13	38	4
Parental Capabilities	Pre	6	51	41	0	2	0
	Post	11	2	49	26	8	4
Family Interactions	Pre	13	23	19	17	9	19
	Post	13	6	26	28	21	6
Family Safety	Pre	19	40	30	11	0	0
	Post	0	25	13	36	15	11
Child Well-Being	Pre	6	26	28	15	17	8
	Post	0	19	30	8	28	15

Table 59

NCFAS Domain Score Changes Pre- to Post-IHBS: Oʻahu (n=151)

NCFAS Domain	Negative Change	Positive Change	No Change	Post-NCFAS Scores at or above Baseline/Adequate
Environment	3%	51%	46%	75%
Parental Capabilities	1	85	14	74
Family Interactions	0	68	32	81
Family Safety	0	93	7	87
Child Well-Being	3	65	32	74

Table 60

NCFAS Domain Score Changes Pre- to Post-IHBS: Hawaiʻi Island (n=47)

NCFAS Domain	Negative Change	Positive Change	No Change	Post-NCFAS Scores at or above Baseline/Adequate
Environment	4%	28%	68%	55%
Parental Capabilities	4	68	28	38
Family Interactions	17	28	55	55
Family Safety	0	85	15	62
Child Well-Being	0	47	53	51

Changes in Safety Assessments by the Crisis Response Team

There were 72 children served by IHBS for whom both an Initial Safety Assessment and a Final Safety Assessment were completed by the CRT caseworker (48% completion rate). All children who were assessed to have a safety risk when IHBS began, were assessed to no longer have that safety risk at the completion of IHBS. However, there were eight children who were NOT assessed as having impending danger at the Initial Assessment, but this Safety Factor was noted at the Final Safety Assessment (see Table 61). In addition, there were five children who had not had parental substance abuse or a lack of parental knowledge or skills noted at the Initial Safety Assessment, but this was noted in the Final Safety Assessment. All eight children were placed into foster care following IHBS.

Table 61

Changes in Safety Assessments on O'ahu (n=72)

Safety Factor	O'ahu	
	Initial Assessment	Final Assessment
Impending danger to child	54%	0
Violent caregiver	50	11% (all new)
Child fearful of harm	26	0
Inadequate supervision	21	0
Parental substance abuse	18	7 (all new)
Child lacks protective skills	18	0
Lack of parental knowledge and skills	11	7 (all new)
Cannot meet child's immediate needs	10	7
Hazardous living conditions	4	0
Parent negativity toward child	4	0
Credible threat toward child	3	0
Parental mental illness	0	7 (all new)

On Hawai'i Island, there were 23 children for whom both an Initial and Final Safety Assessment were completed before and after receiving IHBS (49% completion rate). Most children were assessed to no longer have any Safety Factors present after IHBS (see Table 62). However, there were still 22% of those assessed to parental substance abuse and 9% to still have impending danger to the child after the completion of IHBS.

Table 62

Changes in Safety Assessments on Hawai'i Island (n=23)

Safety Factor	Hawai'i Island	
	Initial Assessment	Final Assessment
Parental substance abuse	35%	22%
Violent caregiver	26	0
Inadequate supervision	26	0
Impulsive parent	26	0
Cannot meet child's immediate needs	26	0
Impending danger to child	22	9
Child fearful of harm	22	0
Child lacks protective skills	9	0

Other Service Outcomes

Goals of Treatment Met

The IHBS model of service implemented in the Hawai'i Waiver Demonstration was a behavioral, skill-building approach to improving parenting and family functioning. Therapists and family members worked together to set individualized goals and find and practice productive ways to achieve them. Therapists and families together assessed whether goals were met over the course of treatment.

On O'ahu, about four-fifths of families completed all of their goals during IHBS (see Figure 73). Only 9% completed none of their goals.

On Hawai'i Island, over two-thirds of families completed all of their goals during IHBS (see Figure 73). Only 14% of families achieved none of the goals that they set.

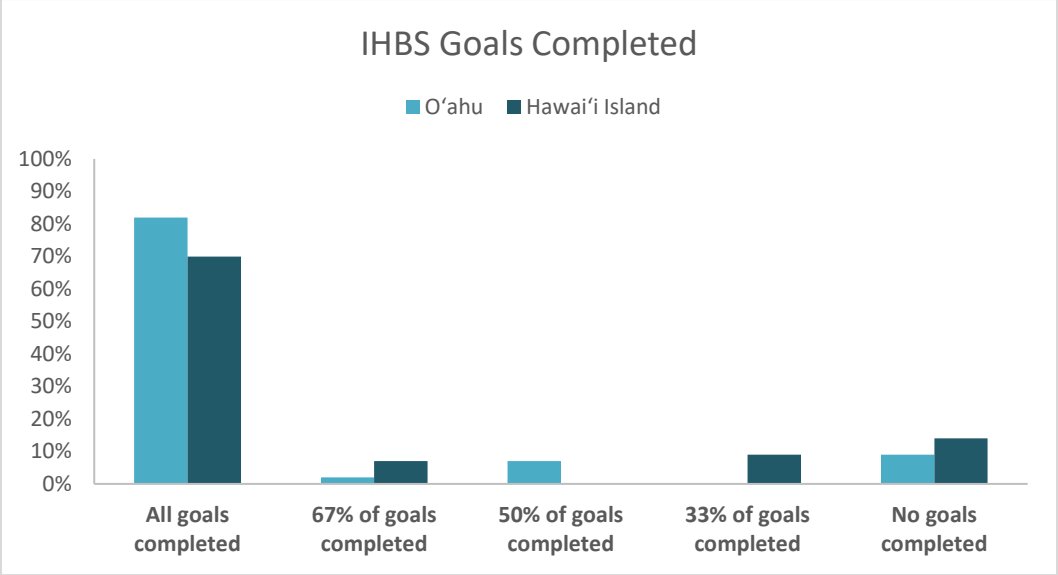


Figure 73. IHBS Goals Completed

Final CRT Disposition

Over half of the children receiving IHBS services on O'ahu had their CPS cases closed by the CRT unit after receiving IHBS (see Figure 74). Only 11% were referred on to CWS for additional services. Another 22% were diverted to Voluntary Case Management.

Over two-thirds of the children who received IHBS on Hawai'i Island had their cases closed at the end of the IHBS intervention (see Figure 74). Another 11% were diverted to Voluntary Case Management. Only 2% of children were referred to CWS after receiving IHBS.

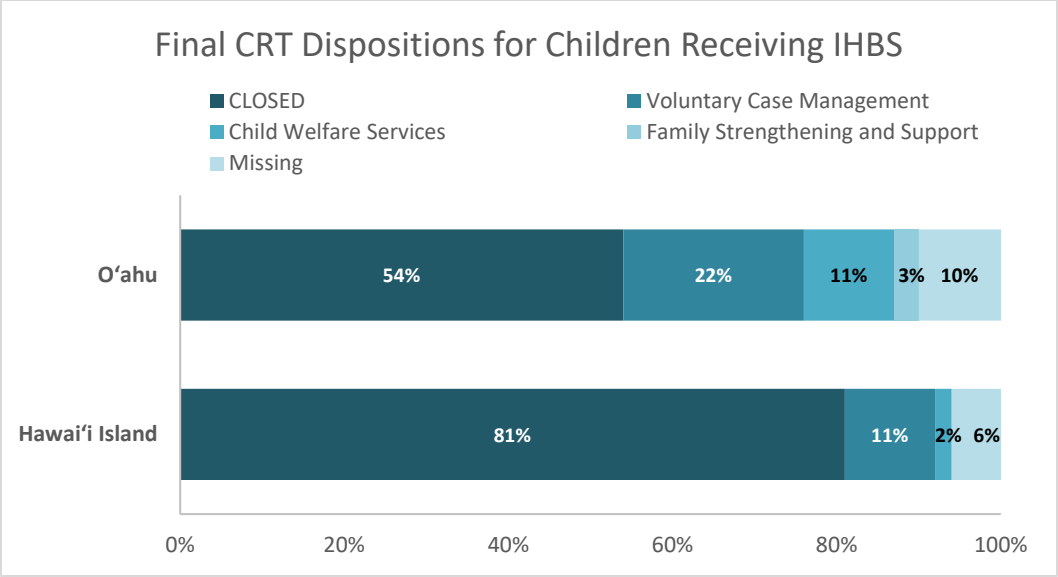


Figure 74. Final CRT Dispositions for Children Receiving IHBS

Parent Satisfaction

Of the 140 parents who completed a Parent Feedback Survey after completing IHBS on O'ahu, about two-thirds of parents said that their situation was a lot better after completing IHBS (see Table 63). Another 31% said that their situation was a little better.

Overall, all respondents were either very satisfied (80%) or satisfied (20%) with the services they received (see Table 63).

Table 63
Parent Perceptions of IHBS

	O'ahu
Your situation now, compared to when you began IHBS	(n=140)
A lot better	63%
A little better	31
About the same	4
A lot worse	2
Overall, how satisfied are you with these services?	(n=135)
Very satisfied	80%
Satisfied	20

Correlates of Placement after IHBS

Due to the low number of children experiencing placement after receiving IHBS, the evaluation cannot analyze correlates of child placement for those receiving IHBS.

Family Wrap Hawai‘i (Wrap)

Implementation of Family Wrap Hawai‘i
Service Fidelity of the Wrap Process
Child Outcomes After Wrap

Family Wrap Hawai‘i

Implementation of Family Wrap Hawai‘i

The Wrap intervention was provided by one Purchase of Service contractor, EPIC ‘Ohana, on both islands. EPIC ‘Ohana had provided a prior demonstration of wraparound services, and staff were familiar with the values, principles and techniques of the wraparound model.

Children were eligible for Wrap if they had been in continuous out-of-home care for a minimum of nine months, and if the case goal was reunification. The child or youth was referred by the child welfare caseworker, who was to ask the child and family if they were interested in participating in Wrap. To make the referral to Wrap, the caseworker contacted the Wrap program and completed an Initial *Child and Adolescent Needs and Strengths*. The Initial *CANS* was required to be completed to make the referral to Wrap, and was to be used as part of engagement and case planning in the Wrap process.

The Wrap facilitator or negotiator then contacted the family to explain the Wrap process to the family and secure the family's consent to participate. The facilitator conducted a first visit with the family and the youth to explain the Wrap process and how it can be helpful. In the wraparound model, the family drives the process and invites any family members or other parties that they think will be helpful to supporting them and helping them meet their goals. It is a strengths-based and client-centered process. Parents are introduced to the availability of a parent partner, and youth were invited to meet with a youth partner. In the first visit, the family story is discussed and formulated; discussions begin then about functional strengths and underlying needs, with some discussion of the family's goals.

Wrap is a strengths-based and client-centered process. If desired, the family can request a cultural consultant and the youth can request a youth partner, both of whom provide support throughout the process. The Wrap facilitator leads a monthly meeting with the family and other attendees, to help operationalize the goals of the family that will help lead to reunification, and identify any barriers and plans to ameliorate them. The facilitator was responsible for providing an effective group process using the Ten Principles of Wraparound. In between meetings, the navigator checked in with team members regarding their agreed upon tasks and offering support when there were roadblocks.

The *Child and Adolescent Needs and Strengths* tool was to be completed by the CWS caseworker every six months during the period that the family was participating in the Wrap process.

Meetings were held in person on a monthly basis, for about nine months. After the Wrap process ended, the Wrap facilitator communicated the progress and status of the family to the CWS caseworker, and the CWS caseworker completed a Final *CANS* assessment, to assess with the child and family the progress made during Wrap.

Wrap Workflow Chart

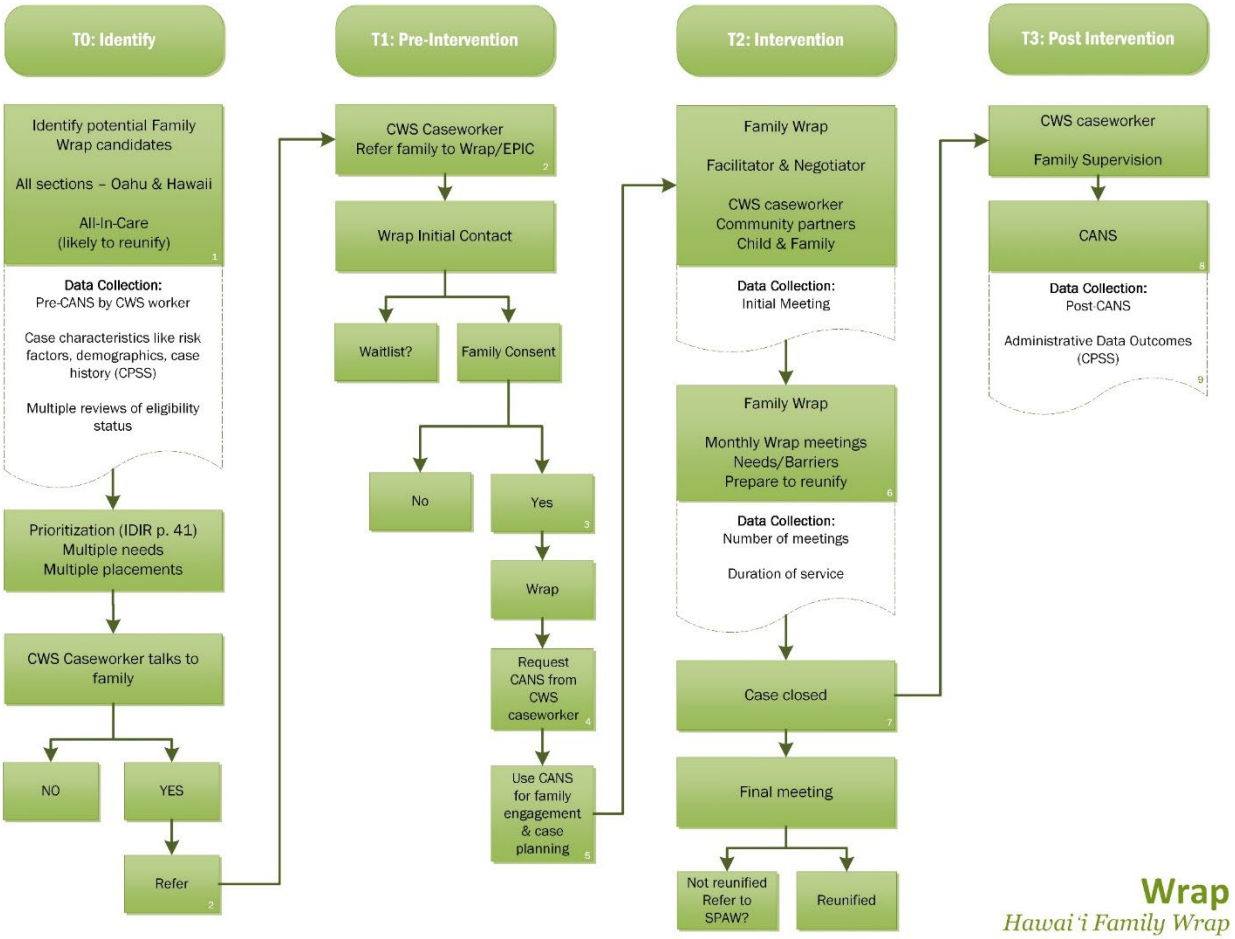


Figure 75. Wrap Workflow Chart

Staffing

O‘ahu

The Wrap program staff on O‘ahu consisted of one operations manager, one supervisor, three facilitators, and two navigators (see Table 64). At the start of the Demonstration, the intervention was staffed with existing staff at EPIC ‘Ohana who had extensive experience and training in facilitation. Staff education was at the bachelor and master’s degree level with the majority of staff holding a master’s degree. When implemented, the staff had an average of 20 years of experience working with children and families.

The navigator provided links and connections to resources in the community to support the team plan. The navigator gathered information about formal and informal resources in the community that might be helpful to the family. Because housing is a common barrier to reunification, navigators interfaced with the housing and homeless services community. Navigators also connected families to legal services (e.g., for unpaid traffic violations that were barriers to employment).

The intervention underwent significant staffing changes in 2017. In February 2017, the operation manager left the organization. Then in mid-2017 the program lost a facilitator and the Wrap supervisor transitioned to manage another program at EPIC ‘Ohana. The program also on-boarded new staff over the course of the Demonstration to increase service capacity as the program grew. A core team of leaders, including the CEO of EPIC ‘Ohana and quality assurance manager, supported the intervention through these changes and continued to lead the intervention team through the end of the Waiver Demonstration.

Not included in the table below are parent partners and youth partners. Parent partners were individuals who provided peer-to-peer support to parents or guardians participating in Wrap meetings who chose to have their support. The role was one of supporter and ally. In this Demonstration, parent partners were provided by a subcontractor. Youth partners were young adults with lived experience in the Child Welfare System. The youth partner role was also as supporter and ally. Youth partners were employed by EPIC ‘Ohana.

Table 64

Wrap Staffing 2015 - 2018: O'ahu & Hawai'i Island

Position	Positions in Contract	Positions filled – Waiver start	Positions Filled – Summer 2018
	Number	Number	Number
Operations Manager	1	1	1
Supervisor/Manager	1	1	1
Facilitator	2	2	5
Navigator	2	2	3
Total	**6**	**6**	**10**

Note. EPIC 'Ohana holds several contracts with DHS. These counts represent the position FTE to the organization, not the % of time budgeted to the contract.

Hawai'i Island

At the beginning of the Demonstration, O'ahu Wrap staff also covered cases on Hawai'i Island. In the second year of the Demonstration, three part-time staff (a facilitator, navigator and recorder) were hired on Hawai'i Island. Two former Hawai'i Island navigators transitioned into a Wrap facilitation role in 2018 – one in East Hawai'i and one in West Hawai'i. EPIC 'Ohana faced challenges in hiring new Hawai'i Island navigators and had to supplement by flying O'ahu navigators to Hawai'i Island to provide services.

Training for and about the Wrap Process

EPIC ‘Ohana

EPIC ‘Ohana Wrap staff participated in an extensive training program. Training included core training on the Wrap model (both through EPIC and through the National Wraparound Implementation Center’s (NWIC) *Intro to Wraparound Training*), training with partner agencies, assessment tool training (*CANS*), facilitation training, data collection and information systems training, cultural awareness, child welfare law, human trafficking prevention, youth engagement, communication and collaboration training, and community resource building. The Wrap Team participated in in-house workshop-style “huddles” to strengthen the internal team dynamic, streamline processes, and exchange ideas and techniques to constantly ensure quality and to stay updated on the latest in Wraparound around the nation. In 2018, EPIC ‘Ohana also launched the Family Wrap Team Learning Community – workshop-style full-day sessions that allow staff members to exchange ideas, share techniques they had tried, and strengthen team dynamics. Selected Wrap staff attended the National Wraparound Institute’s annual conference each year.

Child Welfare Services Branch

All line-staff and supervisors received both a Wrap Hawai‘i Training through the CWS Staff Development office and participated in *CANS* training. The initial training on *CANS* was provided by Dr. John Lyons who authored the tool and follow-up training and certification on the *CANS* was provided through the CWS Staff Development Office.

Training about the wraparound model was provided by Patricia Miles, an early developer of wraparound and the author of training and implementation guides. Patricia Miles traveled to each island through the CWS Staff Development Office. She also provided training to EPIC staff and to parent partners.

Number of Children and Youth Served by Wrap

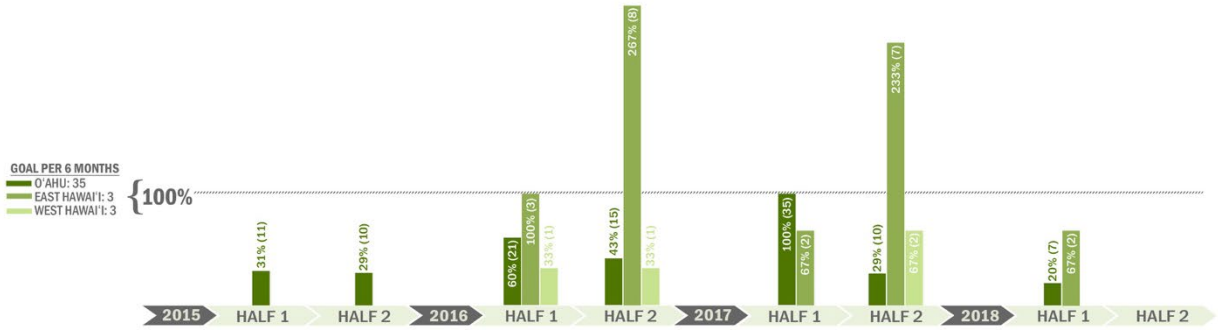


Figure 76. Number of Children in Wrap Sample on O'ahu and Hawai'i Island

The Wrap intervention had a slow start in the first two years of the Demonstration on O'ahu, and a fast start on Hawai'i Island, relative to expectations (Figure 76). On O'ahu, the Wrap program served twenty-one children in the first year of the Demonstration, fewer than one-third of projections. The 109 children served in O'ahu from 2015 to 2018 were in 47 families.

On Hawai'i Island, the Demonstration began in October of 2015, and it was expected that six children per year would participate in the Wrap Process. Hawai'i Island largely exceeded those projections in both 2016 and 2017, mostly due to children served in East Hawai'i. The 22 children served in East Hawai'i were in 11 families, and the four children served in West Hawai'i were in three families.

The Hawai'i Long-Stayer Population

On both O'ahu and Hawai'i Island, the number of children who were Long-Stayers (in care at least nine months) increased each year of the Waiver Demonstration from 2015 through 2017 (see Figure 77)[1].

[1] Complete data for 2018 was unavailable at time of this report.

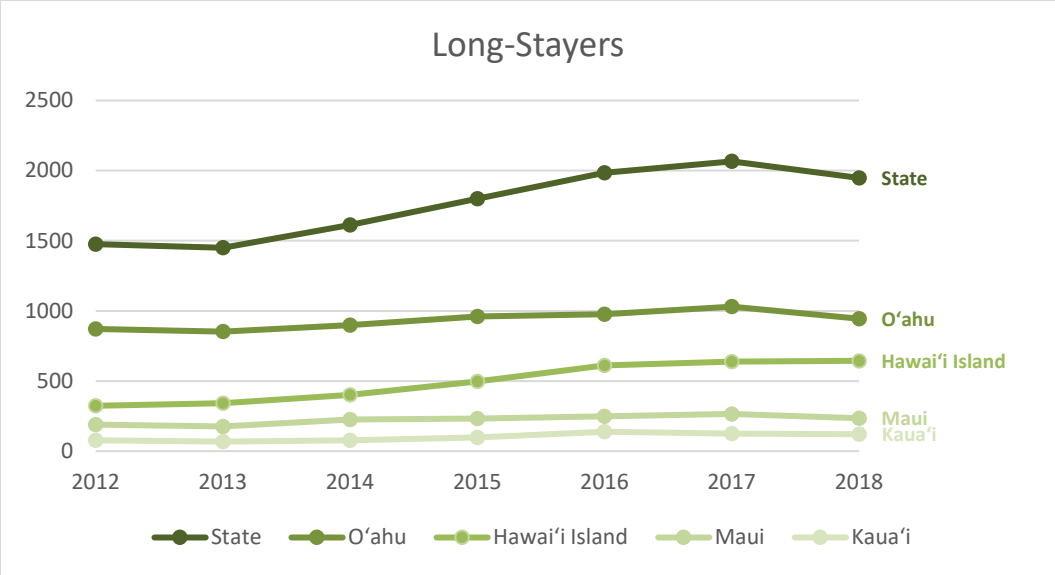


Figure 77. Long-Stayers[2]

Wrap Penetration Rate

Very few of the children and youth who were Long-Stayers received Wrap services (see Tables 65 & 66). On O'ahu, from 8% to 10% of Long-Stayers received Wrap services each year. On Hawai'i Island, from 3% to 4% of Long-Stayer children received Wrap each year. The reader is cautioned that the child's status of whether s/he was "likely to reunify" is unknown, and this is the penetration rate for all Long-Stayer children and youth. However, reunification is the most common case goal for children and youth in care.

Table 65
Long-Stayers, O'ahu

	Wrap		
	2015	**2016**	**2017**
Number of Long-Stayers	959	975	1030
% Receiving Wrap	8%	10%	8%

Table 66
Long-Stayers, Hawai'i Island

	Wrap		
	2015	**2016**	**2017**
Number of Long-Stayers	497	610	638
% Receiving Wrap	4%	4%	3%

[2] Detailed numerical tables for all figures are included in Chapter Eight Appendix.

Knowledge and Impressions of Wrap after the First Year

In focus groups with CWS staff, Wrap was generally accepted as a very good and effective model, although getting Wrap referrals from CWS caseworkers was a challenge in the beginning of the Demonstration. The providers themselves made suggestions for referrals from the All-in-Care list, which was not the intended model.

CANS assessments were noted as a potential barrier to referrals as they added additional paperwork onto the already cumbersome paperwork required for a case. In addition, the *CANS* assessment was often not perceived by CWS staff as being useful to the case. The *CANS* assessment is focused on the child, whereas Wrap operated at the family level. The Purchase of Service provider also did their own separate assessment of family strengths and needs.

Another concern noted by those child welfare staff who might refer a child to Wrap concerned the eligibility criterion that a child must have been in foster care for nine months or longer to be eligible for services. Caseworkers wanted to be able to access Wrap services sooner, especially if family reunification was the goal.

There was a significant amount of training in some areas (*CANS*), but very little in others (new data entry in SHAKA, and the Wrap referral process). Hawai‘i Island staff did not receive the same training as O‘ahu staff when they began their implementation.

CWS staff noted the benefit that culturally-specific resources are available from the community and are utilized by Wrap when the child’s culture is identified prior to the service.

Knowledge and Impressions of Wrap after the Second Year

After the first year of the Demonstration, child welfare caseworkers with responsibilities to refer families to Wrap were asked to respond to questions in three primary areas; their perceived knowledge about the interventions, positive and negative perceptions about the interventions, and scenarios testing their knowledge of referral criteria.

Knowledge about the Wrap Process

A large number of child welfare staff (n=50) answered questions regarding their knowledge of the Wrap process. Table 67 shows that perceptions of knowledge about the Wrap process were high, like that for Short-Stayer interventions, and respondents felt high levels of knowledge about Wrap. The majority of respondents felt that they had enough information to understand the overall purpose of the Wrap Process, and understood how the process was meant to help children and families. There was less agreement in general that the trainings for the Wrap Process made the need for the service clear.

The majority of respondents felt that they had enough information to understand the overall purpose of the Wrap process, and understood how the process is meant to help children and families.

The last two questions had low levels of agreement, meaning that few respondents felt that the goal of Wrap was unclear, and few felt that they were not sure which cases should go to Wrap.

Table 67

Knowledge about the Wrap process

Agreement with Statements	Wrap	
	O'ahu (n=32)	**Hawai'i Island** (n=18)
I have received enough information about Wrap to understand its overall purpose.	75%	94%
It is clear how Wrap is meant to help children and families.	75	89
Wrap trainings made the need for the intervention clear to me.	59	61
I am not sure which cases should go to Wrap.	9	11
The main goal of Wrap is not clear to me.	3	6

Perceptions of the Wrap Process

Respondents were asked a set of questions regarding their agreement with a variety of perceptions about the Wrap process. Responses were on a five-point scale, with a higher score indicating higher agreement. Mean scores on agreement are presented in Table 68.

Respondents felt that they understood the Wrap process well. Perceptions of the Wrap process were positive, particularly in terms of it having advantages relative to prior approaches (mean agreement scores of 3.7 on O'ahu and 3.8 on Hawai'i Island). Respondents on both islands registered high levels of agreement that the intervention was compatible for the local context. However, concerns about the time commitment required of child welfare caseworkers whose clients participated in Wrap were also high.

Table 68

Perceptions of the Wrap process

Mean Scores	Wrap	
	O'ahu (n=32)	**Hawai'i Island** (n=18)
Positive Perceptions of Wrap		
Knowledge about Wrap	3.9	4.0
Wrap has advantages relative to prior approaches	3.7	3.8
Wrap is compatible with local context	3.6	3.6
Positive peer buy-in about Wrap	3.5	3.5
Negative Perceptions of Wrap		
Negative concerns re: time commitment for Wrap	3.3	3.4
Negative risk concerns about Wrap	3.0	3.1

Knowledge of Eligibility Criteria for Referrals to Wrap

One scenario was presented for a child in circumstances appropriate for a Wrap referral. In the scenario, Marco had been in care ten months, and reunification was a goal. Wrap was the appropriate referral in this scenario.

> Marco is a 12-year-old boy from the Marshall Islands who has been in foster custody for ten months. Marco has a serious hearing disorder, and has had a hard time adjusting to life in Hawai'i. He hates school because he is bullied. Marco often runs away from his foster home and goes to his grandmother's house. His grandmother cannot fully care for him and she has a hard time getting him to go to school. Marco's parents have four other children and feel that Marco is just a "rascal." They say they are willing to participate in services, but frequently miss appointments and have not taken the required drug tests. There are often discrepancies in what they say when they describe why they have not been compliant.

In Marco's reunification scenario, 52% of respondents indicated that, indeed, the family should be referred to Wrap (see Table 69). Another 20% would refer the family to SPAW and 14% of respondents selected "other." In the "other" category of responses, some respondents would "file a motion to terminate as to follow timelines," and "discuss 'Ohana conferencing."

Table 69
Wrap Scenario of Maltreatment Report

Referral Decision	**Wrap**
	Scenario: Marco's family not compliant (n=49)
Refer to Wrap	52%
Refer to SPAW	20
Continue with case management	14
Other	14

Service Fidelity of the WRAP Process

Eligibility

The eligibility criteria for a referral to Wrap were that (1) the child had been out of home for at least nine months and (2) the child was considered "likely to reunify."

Using Hawai'i administrative data analyzed by Chapin Hall Center for Children at the University of Chicago, the evaluation analyzed placement "spells" for children in foster care. A "spell" is defined as the length of time between removal from home and exit from care. A spell can contain multiple placements, if a child moves between foster homes, to group care, or other forms of being in care under CWS.

Almost all children and youth served by Wrap had been in care in their current removal episode for at least nine months at the time of their first Wrap meeting (see Figure 78).

On average, youth served by Wrap on O'ahu had been in care for 27 months at the time Wrap began, and youth served by Wrap on Hawai'i Island had been in care 34 months at the first Wrap meeting (see Figure 78). Over half of youth served by Wrap on Hawai'i Island had been in care over 2.5 years.

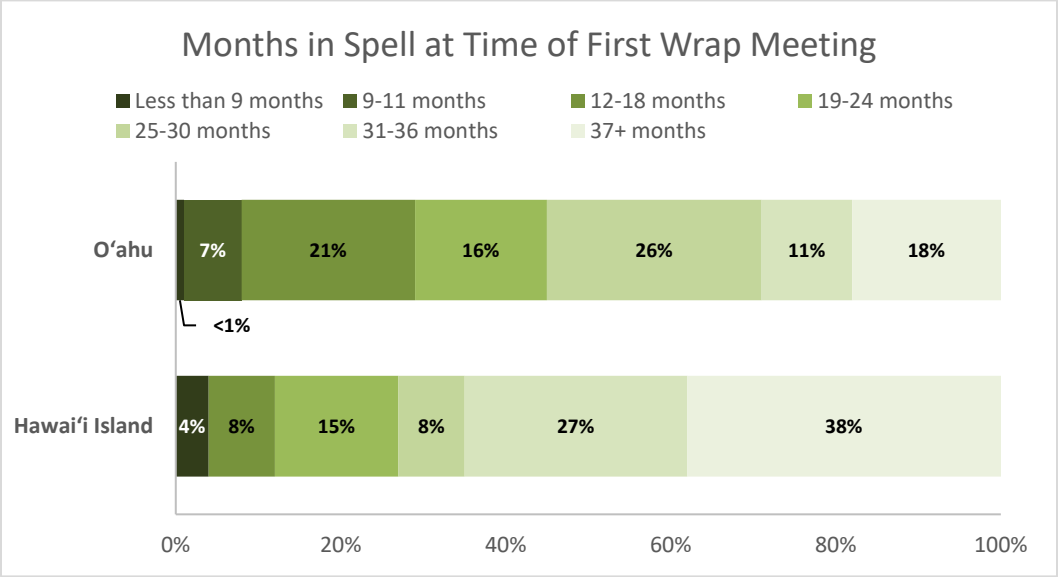


Figure 78. Months in Spell at Time of First Wrap Meeting

There was no reliable indication in the case files of whether a child was "likely to reunify." However, as discussed earlier, the CWS caseworker and Wrap personnel discussed the appropriateness of the child and family for Wrap services at the point of referral to Wrap.

Some referrals were made for families where a family court judge was close to denying a finding of "reasonable efforts" by CWS. Reunification was still considered, and no permanency plan had yet been ordered, but substantial barriers to reunification existed.

Service Provision

Details and Duration of the Wrap Process

On average, on Oʻahu, staff from the Wrap program made contact with a referred family one week after the initial referral to Wrap (see Table 70). Family consent was often obtained in the month after that, with 62% of youth having consent within two weeks of the referral and 86% having consent within a month of referral.

On Hawaiʻi Island, contact by the Wrap program was made within one day of the referral, on average, with all families being contacted within three days of the initial referral (see Table 70). Family consent was obtained, on average, five days after referral, with all youth having consent within two weeks of the referral.

On average, the first Wrap meeting took place 37 days after family consent was obtained on Oʻahu (see Table 70). On Hawaiʻi Island, the first Wrap meeting took place 21 days after consent was obtained.

On Oʻahu, the number of Wrap meetings held ranged from one to 17 meetings (see Table 70), with an average of seven meetings. The average length of the Wrap intervention was about eight months.

On Hawaiʻi Island, the number of Wrap meetings ranged from two to 14 meetings (see Table 70), with an average of five meetings. On average, the case closed to Wrap in just over six months.

Table 70

Service Delivery in Wrap

Days to Initial Contact by Wrap	**Wrap**	
	O'ahu (n=109)	**Hawai'i Island** (n=26)
Days to Initial Contact by Wrap		
Range	0 to 98 days	0 to 3 days
Avg. number of days to initial contact	7 days	1 day
Days to Family Consent		
Avg. number of days to family consent	20 days	5 days
Consent received within 14 days	62%	100%
Consent received within 30 days	86	100
Days to Initial Wrap Meeting		
Avg. number of days to initial meeting	37 days	21 days
Length of Service		
Range of meetings	1-17 meetings	2-14 meetings
Avg. number meetings	7 meetings	5 meetings
Avg. length of service	7.7 months	6.3 months
9 + months	36%	8%
6 – 9 months	23	46
< 6 months	41	46

Note. 100% of families who consent to Wrap participate in an initial Wrap meeting.

Profiles of Children and Youth Served by Wrap

Demographic Characteristics

On O'ahu, more males participated in Wrap (61%) than did females (see Figure 79). In terms of race, more than half of participating youth were Hawaiian/Pacific Islander (61%); more than half were White (60%); more than half were Asian (54%)[3]. In terms of ethnicity, the most frequent ethnicities of Wrap participants were Hawaiian/Part Hawaiian (46%) and Filipino (12%). The mean age at which youth on O'ahu were referred to Wrap was seven years old. More than half of Wrap youth were age 10 or younger.

On Hawai'i Island, more Wrap participants were female (81%) (see Figure 79). In terms of race, many participants were identified as White (69%), followed by Hawaiian/Pacific Islander (62%) and Asian (42%). In terms of ethnicity, many Wrap participants were identified as Hawaiian/Part Hawaiian (39%), and mixed (not Hawaiian/part Hawaiian) (35%). On average, the youth served by Wrap on Hawai'i Island were six years old. More than 80% were age ten or younger.

[3] Hawai'i has a diverse population. Most people identify with more than one race.

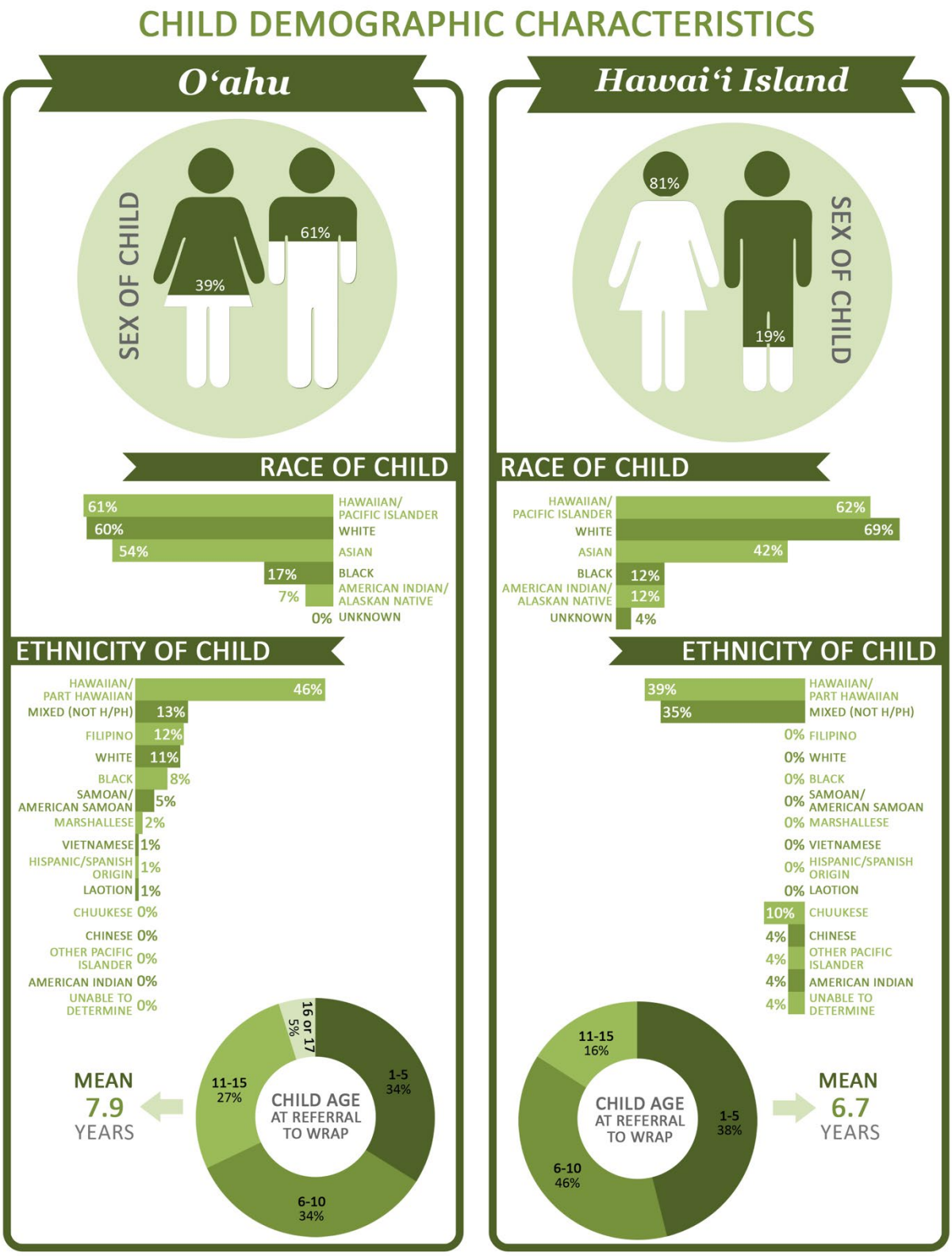


Figure 79. Child Demographic Characteristics

Child's History of Maltreatment and Removal

The CPSS database was searched for all prior confirmed reports of maltreatment, in regard to threatened neglect, threat of abuse, physical neglect, physical abuse, and sexual abuse. Other types of maltreatment were not reliably tracked, and thus not reported. These reports could include the report that led to this removal episode, and could include other prior reports as well. Children served by Wrap on Oʻahu were most likely to have been reported to CPS in the past for threatened neglect (73%), the threat of abuse (68%), or physical neglect (22%). Few had prior confirmed reports of physical abuse or sexual abuse (see Figure 80).

On Hawaiʻi Island, children served by Wrap were most likely to have prior confirmed reports of threatened neglect (58%), threat of abuse (58%), or physical neglect (54%). Few had prior reports of physical abuse or sexual abuse (see Figure 80).

On average, on Oʻahu, children served by Wrap were six years old when first taken into care in Hawaiʻi (see Figure 8.14). Over half (55%) were younger than six when removed.

On Hawaiʻi Island, children served by Wrap were three years old when first removed from home, on average (see Figure 81). About three-quarters of children served by Wrap on Hawaiʻi Island (73%) were younger than six when first taken into care.

Most children had not been in foster care prior to their current removal. On Oʻahu, 26% had been removed before, and most of these children had experienced between one and three prior placement homes. Another child had experienced five prior placement homes (see Figure 82).

On Hawaiʻi Island, 19% of children served by Wrap had experienced foster placement before their current removal from home. For 8% of children, their history of placements prior to their current removal consisted of one or two placement homes. For 11%, their prior removal(s) were comprised of four or five separate placements.

Over half of the children served by Wrap on Oʻahu (70%) were currently in a paid foster care setting (see Figure 83). One-fifth (20%) were in paid relative care.

On Hawaiʻi Island, two-thirds of children served by Wrap (69%) were in a paid foster care setting at the time of referral to Wrap (see Figure 83), followed by those in paid relative care (15%).

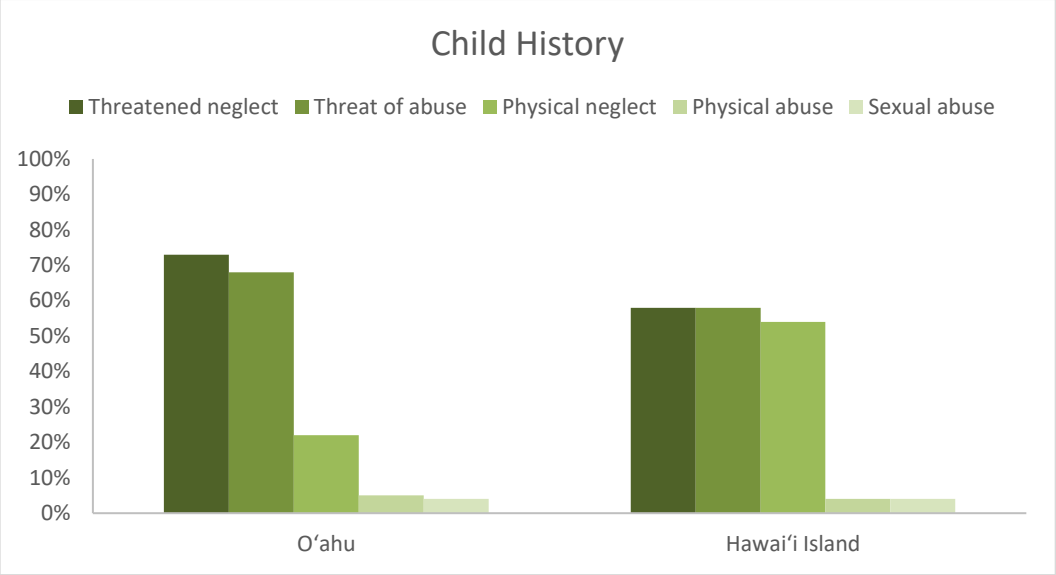


Figure 80. Child History

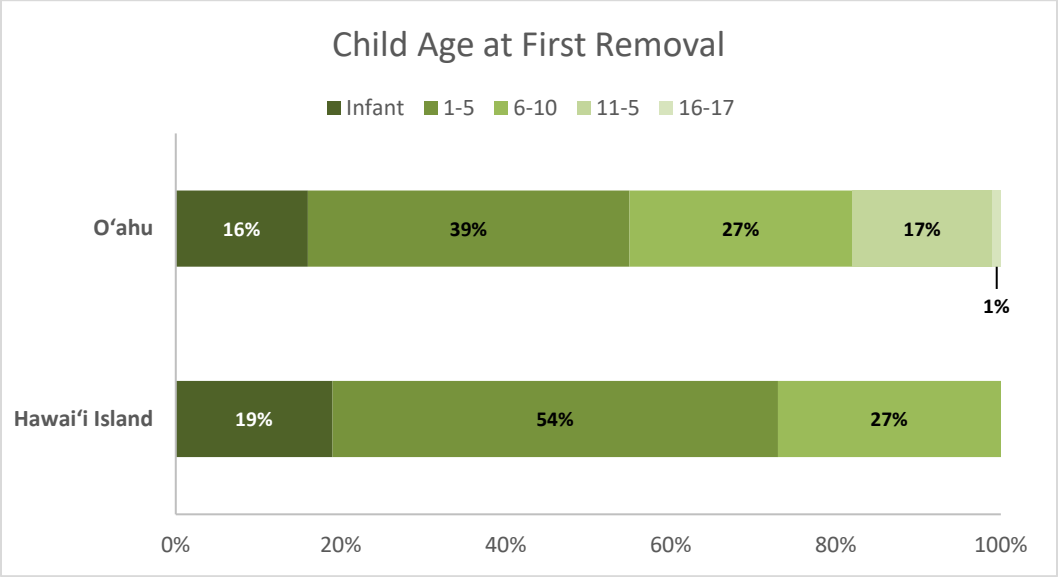


Figure 81. Child Age at First Removal

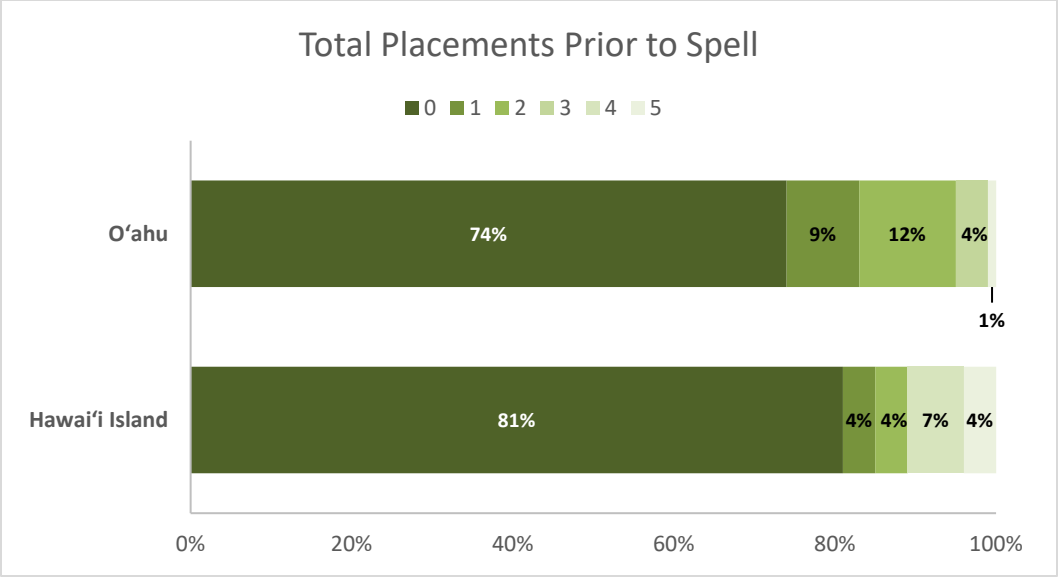


Figure 82. Number of Placements Prior to Current Spell

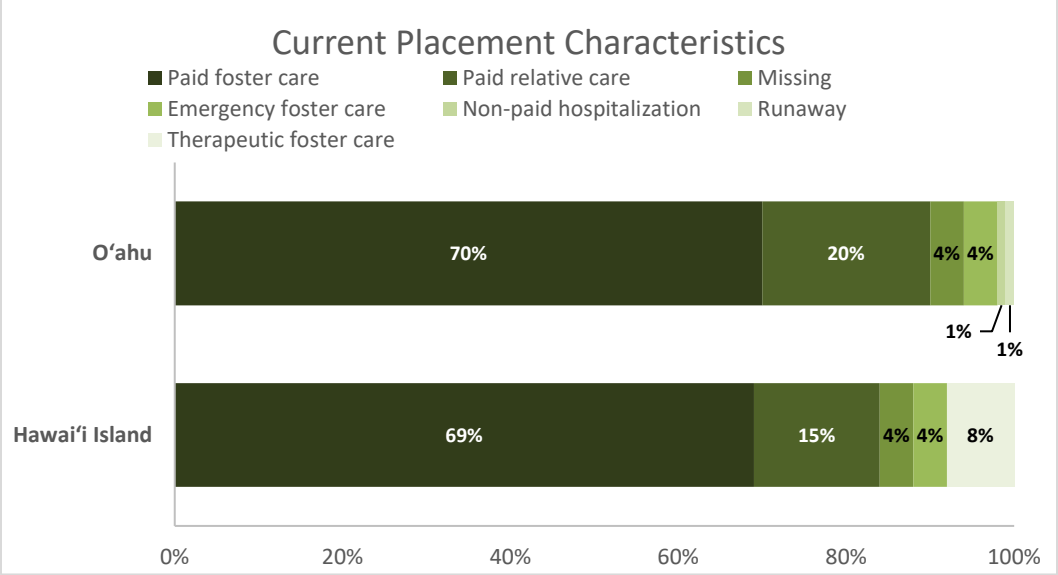


Figure 83. Type of Placement at Start of Wrap

Child Well-Being at Referral to Wrap

There were 18 Initial *CANS* completed on O‘ahu (a 17% completion rate), and 19 Initial *CANS* completed on Hawai‘i Island (a 73% completion rate).

There are six domains on the *Child and Adolescent Needs and Strengths* that pertain to all children and are not limited to a subset of children due to age or specific challenge: Youth Strengths, Life Domain Functioning, Trauma Experiences and Stress Symptoms, Youth Risk

Behaviors, Behavioral/Emotional Needs, and Caregiver Needs. The Youth Strengths domain is the only domain focused on identifying child strengths.

In this sample of children referred to Wrap, and for whom an Initial *CANS* was completed, there were a multitude of strengths identified (see Table 71). On both O'ahu and Hawai'i Island, the most commonly identified strength was the youth's cultural identity. Not only was cultural identity the most common strength, it was also the most often identified as a centerpiece strength.

The most common additional strengths identified for youth on O'ahu were their family, community life, optimism, interpersonal skills, and educational assets, and of these, family life and educational assets were often a centerpiece.

On Hawai'i Island, the most common strengths, after cultural identity, were optimism, interpersonal skills, educational assets, and their family. The most common centerpiece strengths were natural supports, resiliency, and family, and relationship stability.

Table 71
Wrap: Initial CANS, Youth Strengths

Youth Strengths	**O'ahu** (n=18)			**Hawai'i Island** (n=19)		
	Identified	**Useful**	**Centerpiece**	**Identified**	**Useful**	**Centerpiece**
Family	50%	6%	44%	37%	21%	37%
Community Life	44	17	28	16	32	32
Optimism	39	33	28	26	42	21
Interpersonal	33	39	28	37	47	16
Educational	28	28	44	16	47	32
Youth Involvement	28	33	17	21	26	21
Relationship Stability	22	33	33	37	26	37
Resiliency	22	50	17	26	21	42
Talents/Interests	17	28	39	11	47	26
Spiritual/Religious	17	33	11	26	0	21
Problem Solving	17	61	11	37	37	16
Cultural Identity	11	17	56	16	5	79
Natural Supports	11	44	22	26	26	47

When referred to Wrap, children on O'ahu had the highest levels of need in Life Functioning and Trauma Experiences and Stress Symptoms. In the other domains of Behavioral/Emotional Needs, Youth Risk Behaviors, and Caregiver Needs, the levels of need were much lower (see Table 72).

On Hawai‘i Island, the levels of need were high in every domain of functioning. The highest levels of need assessed were in regard to Life Functioning and Caregiver Needs. Assessments of need were also high in the areas of Trauma Experiences and Stress Symptoms, and Behavioral/Emotional Needs (see Table 72).

Table 72
Wrap Initial CANS Domain Scores

***CANS* Domain Score**	**Wrap**		
	Range	**O‘ahu** (n=18)	**Hawai‘i Island** (n=19)
Life Functioning	0 to 20	6.1	6.7
Trauma and Stress	0 to 13	4.8	5.0
Behavioral/Emotional Needs	0 to 9	1.9	3.7
Youth Risk Behaviors	0 to 20	1.9	1.4
Caregiver Needs	0 to 20	1.2	6.2

On O‘ahu, among the eighteen youth for whom an Initial *Child and Adolescent Needs and Strengths* was completed, there were few items on the assessment that were indicated as a need that was “Immediate” or “Need to Act” for more than two youth. In the Life Functioning domain, five children were assessed to have pressing behavioral/emotional needs, and four children were assessed to be adjusting to trauma. No other items on the *CANS* were noted for more than two children at the beginning of Wrap.

On Hawai‘i Island, more children and youth were indicated to have needs that were “Immediate” or “Need to Act,” and the number of needs noted to be pressing were higher than on O‘ahu. Needs in the Life Functioning domain that were noted by more than two children/youth included: behavioral/emotional needs and adjustment to trauma. In the domain of Caregiver Needs, the needs presented by more than two caregivers were residential stability (37%), mental health (26%), family stress (21%), supervision (21%), social resources (21%), and assessibility to care (16%).

On Hawai‘i Island, in the domain of Trauma Experiences and Stress Symptoms, more than two children were said to have pressing needs in the areas of neglect (39%), emotional abuse (33%), witness to family violence (33%), hyperarousal (22%), sexual abuse (17%), attachment (17%), and affect regulation (17%). In the domain of Behavioral/Emotional Needs, four children/youth were noted to have anxiety, and three were impulsive/hyperactive.

Complete tables of all Initial *CANS* items can be found in the Chapter Eight Appendix.

Adult and Youth Surveys on Service Fidelity

In the third year of the Demonstration, the evaluators analyzed written surveys that were completed by Wrap participants at the conclusion of their Wrap Process. In the adult questionnaire, respondents were asked to respond to ten scaled questions. Answer options were "very much," "somewhat," "neutral," "hardly," and "not at all."

Adult respondents included family members as well as service providers and community partners who participated in the meetings. A total of 192 completed surveys were received, from 41 participating Wrap family groups.

In the questionnaire given to youth participants, there were eight scaled questions that reflected the values and principles of Wrap. There were 20 youth respondents from seven families.

Adult Feedback on Fidelity

Adult participants were generally satisfied with the Wrap Process and expressed positive feedback about their experiences (see Table 73). For all ten items included in the questionnaire, most respondents (87-97%) indicated relatively high levels of agreement, which translates into high fidelity.

Agreement that the Wrap Process had been faithful to the values and principles of wraparound was very high in all aspects, with at 87% of respondents indicating "very much" agreement with the ten statements describing Wrap processes.

The items with the highest agreement were in regard to Wrap tailoring the service to individual family's needs (97% very much agreed), helping everyone communicate better (95% very much agreed), and being respectful and responsive to the family's culture (94% very much agreed).

Table 73

Wrap Adult Survey (n=192)

	Very much	Somewhat	Neutral	Hardly	Not at all	Missing
Family Perceptions of Wrap Process						
Has this Wrap process helped you to recognize and appreciate this family's strengths?	89%	9%	1%	-	-	1%
Do you think the Wrap meetings have been respectful and responsive to this family's culture?	94	5	-	-	-	1
Wrap Plan Development						
Do you feel this Wrap process has encouraged this family to have a say in their plan?	93	6	1	-	-	-
Is the plan this Wrap team's developing tailored to meet the specific needs of this family?	97	3	-	-	-	-
Personal Experience						
Do you feel that your feelings and concerns were heard and addressed?	93	5	2	-	-	-
Has this Wrap process helped to improve the team's communication with each other?	95	4	-	-	-	1
General Wrap Process						
Has the follow-up on tasks between meetings been helpful?	90	7	1	-	-	2
Have you seen positive progress because of Wrap?	87	8	2	-	-	3
Wrap Engagement						
Has the Wrap process help you feel engaged as a member of the team?	92	5	2	-	-	1
Have family, friends, and community supporters been encouraged to be a part of this Wrap team?	89	6	1	1%	-	3

The adult questionnaire also included space to provide open-ended comments and suggestions on program improvement, as well as any additional comments (see Table 74). Although not all respondents chose to leave a written response, 38% of the respondents who did respond offered "kudos to Wrap staff." Other respondents indicated that Wrap "helped improve communication/updates," (5%) and contributed to reunification (6%).

Table 74
Wrap Adult Survey

Any thoughts on how Wrap can be improved? Any additional comments?	(n=192)
Kudos to Wrap staff	38%
Helped improve communication/updates	5
Contributed to reunification	6
Offer more guidance/time/funding/time management	4
Family needs to remain connected through process/do assignments/ participate	4
Busted barriers (incl. positive comments re: Flex Funding, Community Connections)	2
Effectively gathered necessary people	2
Organized/kept focused	2
Gains (ex., gained confidence, obtained goals)	2
Location/Parking	2
Hostility among team members	1
Not effective because of parent(s)	1
Technical difficulties (ex., cannot hear over phone)	1
Having final meeting later in the process	1

Youth Feedback on Fidelity

The questionnaire for youth centered around three basic principles and practices in Wrap: the collaboration of a youth partner, the progress achieved by the Wrap process, and the youth feeling respected and involved (see Table 75).

Youth were generally satisfied with their experiences with the youth partners (see Table 75). Nearly all participants (95%) expressed that the experience of having a youth partner was good or great. An equal number of participants (95%) indicated that they felt their youth partner heard what they wanted. Finally, when asked if meeting with the youth partner helped youth to grow personally, 85% responded that it had.

Another two items referenced participating families, and their progress in the Wrap process (see Table 75). When asked if the Wrap team plan was a good fit for the youth's family, and helped improve the family's situation, 80% of youth participants felt that it had been a good fit and helped improve the family's situation. Youth were also asked if the Wrap process helped

their family get along better. A full 85% felt the process had helped their family get along better.

An additional three items addressed the youths' involvement in the Wrap process (see Table 75). Youth were asked if the Wrap process helped them have a say in their family's plan, and 90% agreed that it had. Almost all participants (95%) reported that they felt the Wrap meetings were respectful to their family's culture. Almost all (90%) indicated that the process had helped them appreciate their family's strengths.

Only 50% of respondents chose to leave comments to open-ended questions about what they best liked about Wrap. Of those that did, 50% reported that their favorite activity was going out to eat with their youth partners. Another 40% indicated that their favorite activity with their youth partner was engaging in social activities such as meeting, playing games, and spending time together.

Table 75

Wrap Youth Survey (n=20)

	Great	Good	Neutral	Poor	Terrible
Youth Partners					
How was your experience having a Youth Partner during your time with Wrap?	75%	20%	0	0	5%
Did you feel like the Partner heard what you wanted?	85	10	0	0	5
Has meeting with the Youth Partner helped you to personally grow in any way?	70	15	10%	0	5
Family Progress in Wrap Process					
Do you feel like the Wrap team plan was a good fit for the family? Did it help improve your family's situation?	75	5	10	5%	5
Has this Wrap process helped your family? Does your family get along better now?	80	5	10	0	5
Youth Interactions					
Do you feel this Wrap process helped you to have a say in your family's plan?	85	5	5	0	5
Do you think the Wrap meetings have been respectful to your family's culture?	80	15	0	0	5
Has this Wrap process helped you to notice and appreciate your family's strengths?	85	5	5	0	5

Adult Interview Feedback on Fidelity to Wraparound Values

Three members of the Evaluation Team conducted in-person or telephone interviews with Wrap participants. The themes included the ten Wrap principles of the Wraparound process, as well as questions about what the participants liked, challenges they saw, suggestions for changes, and an additional story about their experience. Their responses are summarized below.

Wrap Principle One: Family Voice and Choice

In Family Wrap Hawai'i, the EPIC facilitators are trained to intentionally elicit and prioritize the family/youth's perspectives. The Wrap team's planning efforts are grounded in the family's own perspectives and the team strives to offer and provide options and choices that reflect the family's values, preferences, and priorities.

Reflections

Every participant answered with an enthusiastic "Yes" and two with an "Absolutely," when asked if their voice and choice were honored. Respondents added comments like:

"Yes they would listen and help us out and give us ideas."

"Yes. They listened and took into consideration what I said."
"Absolutely. Taking into consideration our lifestyle, what our goals were for our son."

"Yes. Before Wrap was involved, I never had a voice…. With Wrap it was the first time anyone took me seriously. They represent me. They listened to my kids too. Nothing seemed to help until EPIC came in."

"…We had a family statement we had to come up with, and we read it at every meeting and it became very meaningful and helpful to us."

"I felt like I was directing how things were going for me and my family."

Wrap Principle Two: Inclusiveness and Natural Supports

In Family Wrap Hawai'i, the Wrap team should actively seek out and encourage full participation of Wrap members drawn from the family's networks, friends and community

supporters. These natural supports may well become sources of support for the family as the Wrap plans emerge. In the interviews, participants were asked if they knew that they could invite other people into the Wrap circle and were these members helpful.

Reflections

Every family said they knew that they could invite other family members or community supporters to the group. Some would give a list to EPIC and the facilitator would contact the potential invitee and make arrangements to include them. Others said that while they knew about this option, it was hard to get others to attend the meetings.

> *"I appreciated my brother and cousin coming for support."*

> *"I liked the idea that grandparents were included."*

Wrap Principle Three: Extra Supports

The Evaluation Team asked this question to discern if the families noticed any differences in the array and type of services they received from the traditional case management services they were receiving from the Child Welfare Services Branch and their experiences with Family Wrap Hawai'i.

Reflections

All respondents noted that EPIC offered additional support and help through Family Wrap. Even when a respondent could not think of any particular extra support, they responded that they knew EPIC was there to provide extra help and support. Multiple participants also mentioned that Wrap/EPIC staff helped them obtain concrete services such as essential everyday items including beds, miscellaneous furniture, and a refrigerator.

> *"Definitely. Extra, super support. You could tell they really cared about our family."*

> *"The texting was great. You text them and they text right back."*

> *"Everything is transparent, all emails went out to everyone, even between meetings."*

> *"It was really important to have our resources and support."*

"Helped take the pressure off me. Epic knew about additional resources. They got me into a program I needed immediately. I had been on the waitlist before."

Wrap Principle Four: Shared Decision-Making

Family Wrap Hawai'i is a collaborative process. An important principle of Wraparound is that decisions are made collaboratively with all the team members participating, and the best decisions are those that are made when all members feel that their ideas have been heard and seriously considered. While it is recognized that there are some constraints around shared decision-making, and the child's safety and protection are always paramount, the Wrap facilitator works with the professionals, family members and others to jointly discuss a broad array of options and work towards finding solutions that provide complete transparency and full inclusion with the family.

Reflections

All of the participants agreed that the team worked collaboratively.

"I felt included in all the decisions about my family. The team listened to everyone."

"There were no decisions going on behind your back, which is very stressful. Wrap cut a lot of that out."

"I was involved in the decisions."

"Everyone is in the same room, so decisions can be made quickly, not like CPS where you have to wait on the social workers."

Wrap Principle Five: Cultural Respect and Responsiveness

The Wraparound process demonstrates respect for the family's values, preferences, culture, beliefs, and identity of the child and the family members. This requires the facilitator to ensure that all members interact in ways that respect diversity. Families in Hawai'i come from a vast array of cultural heritages, ethnicities, religious orientation, gender preferences and family traditions. The Wrap process must ensure that the families feel comfortable and that their traditions are respected.

Reflections

There were many statements from participants about the respect shown for culture and traditions.

"Yes, very sensitive and compassionate."

"Yes, really 'ohana kine. We sat in a circle and talk story."
"With EPIC everything was cool, and they don't judge you or anything."

"Yes, they try not to color anything with their own beliefs. We opened with a prayer which was very important to our family."

"Yes, to a certain point, but our generation was brought up a little different than how things are done now."

"Yes. They asked if we wanted an interpreter, which we needed. They respected that and they asked about our culture. They tried to understand about our background."

Wrap Principle Six: Individualized Planning

This principle aims to achieve goals, laid out with the family members, customized specifically for each individual family. Rather than "fit" a child or youth into a program that exists, the idea is to develop a unique, individualized plan of programs and services developed precisely for that youth and family. Parents often complain that they are required to go through anger management classes or parenting classes that do not seem designed to meet the particular needs of their family. Wrap teams often may be required to find and deliver services that are outside the traditional service environment. This may include finding or designing creative, community-based resources.

Reflections

Most participants made positive and specific comments regarding the individualized goals for their family. Several commented on the benefit of having these goals visible at every meeting to see the progress they made and the areas they still needed to work on.

"They helped us clear up the house, so I could get my child back."

"They really adjusted the different plans according to the terms we could meet. They accommodated our schedules."

"The pushed me to keep going and never give up. I wanted to give up but they wouldn't let me."

Wrap Principle Seven: Strengths-Based

The Wrap team works to identify, build and enhance the capabilities of the child and family. The team focuses on the knowledge, skills and assets already within the family and these are recognized and validated as strengths the family can draw upon as it goes forward.

"Yes. When we talked about ourselves they wrote down our strengths as well as things that we needed help with, to help us build up ourselves and give us confidence. To remind us that even though you messed up and ended up in this situation, these are your good traits and you have to remember about yourself. They even helped us see the good things about each other, because we had lost sight of everything. It was positive and good."

Reflections

Focusing on individual participant's strengths was a highlight for many participants. It became evident that Wrap was more than just a process to reunify children with their family, it was a therapeutic process that built stronger families.

"One of the hard things with CPS is especially the longer your case is open is that it brings so much negativity into your life, and that build up."

"Wrap focused on the positive but there were problems in the foster care system that needed to be worked on."

"Yes, that was the first thing we went over when we started with EPIC and then at the beginning of every meeting."

"Yes, they try to make the negative better and figure out the positive."

"They tried to get our son to see that his greatest strength was his family. We are his village, and it might be small, but it is strong."

Wrap Principle Eight: Don't Give Up on the Family/Unconditional Support

The Wrap team does not give up trying to assist a family. It does not blame or reject a family and understands and appreciates the challenges many of these families face. Setbacks are to be expected. The team will continue to work with a family towards achieving goals until the team agrees that formal Wrap services are no longer necessary. Adverse events or outcomes indicate that there needs to be a revision of the Wrap plan so that more positive outcomes can be expected.

Reflections

A highlight of participating in Wrap for all respondents was that they felt continual support. Even when they wanted to quit, Wrap staff continued to remind them of their end goals and individual strengths.

> *"They went above and beyond."*
>
> *"When you see someone so willing to help you, you want to move forward."*
>
> *"They didn't want to give up; they kept pushing and gave us homework, so the next time we went over the homework. Sometimes it got messed up because we had to keep rescheduling the appointments."*
>
> *"They helped a lot, and sometimes one of them would meet with me outside of the circle."*
>
> *"They are willing to come to the house to talk to me about helping my brother-in-law."*

Wrap Principles Nine and Ten: Follow-Up and Follow-Through

The question here was intended to see if the Wrap team communicated with the family members about the plans for the next meeting, or issues that were discussed in the circle. Follow-through was asking about if the team involved actually did what they said they would do.

> *"They always contacted me after a meeting to check in, to talk story. I never felt that they forgot about us. But sometimes things took a long time to get done."*

Reflections

Participants agreed that Wrap strategies and staff continually facilitated transparent actions that helped ensure follow-through of all Wrap meeting participants.

> *"It's hard with CPS. Like they can turn into your enemy and everything seems against you. In Wrap, your worker goes as an in-between and there's accountability."*
>
> *"Wrap case manager would send out the list of tasks, follow up to check in on progress and it helped us to all work together and move."*
>
> *"Once we had Wrap going, it really started to alleviate a lot of problems. Wrap*

pinpointed all of the problems and made it so we couldn't hide from our problems."

"They always did what they said they were going to do. All agreements were met."

"They were very good about follow-up and paperwork and all that stuff."

"I really liked the parent supporters. They were people like us, who had been through the system. You could call them and talk to them and they would help us."

"We got emails with minutes from the meetings."

"Yes, following through was the awesome part."

"Yes, very clear. You were never guessing what you have to do. He would send me texts about what he had to do and then send me texts about what was being done."

"There were lots of emails. You couldn't say you didn't know. You could see that they were working towards the end goal."

What did you like best about the experience with Wrap?

Below are a series of quotes that exemplify the answers provided by participants.

"Having extra support. Before Wrap, it was me battling with social workers. Wrap worked as a team to help us get so much more accomplished."

"The support they provided. Once the meetings started, positive things happened. They focused clearly on the goals and asked for my input."

"The support and the focus. They call you. And the food!"

"They make you feel welcome. They always respond to you."

"It's like you have an army trying to help fight the battle, rather than just try to do it yourself."

"Not having Wrap for anyone in a situation like we were in would make it harder to navigate the whole process. Their knowledge, influence, they knew the steps and what would come next."

"The best thing is they know they job and do it well. They connect well with people."

What were some of the challenges?

Below are a series of quotes about challenges recalled by participants:

"The meetings are time consuming. It wasn't wasted time, but I had to get children from three different schools and it was difficult to make the meetings."

"Language challenges being on the phone. There was a translator, but it was hard."

"The meetings are time consuming. It wasn't wasted time, but I had to get children from three different schools and it was difficult to make the meetings. "

"It didn't really work for us. I wasn't interested in the process, so I can't remember what happened, so I don't know what was good. Nothing really changed. Being able to make the meetings was hard. I didn't need any extra services. I just joined to see how it worked."

The amount of time spent in Wrap (too little? too much? about right?)

"I think it was enough time, but even a little more time would have been nice."

"Perfect amount of time. Once we started, everything started moving along."

Recommendations for change?

The following are recommendations for change made by Wrap participants:

"Maybe getting bigger, like offering this to more people."

"Maybe share some movies or clips of what others experience. In the beginning you don't know what to expect."

"I would have liked a video chat rather than the phone."

"There probably should be an answer to that, but I feel that since it was such a positive experience, I can't say there is anything I would change. It worked for us culturally, our family values, the way it was structured and planned out, trying to get everyone involved."

"I would have appreciated a recap letter about the outcomes, after the case closed. Maybe some kind of progress report would be nice (a grandfather's comments, about his

granddaughter who had turned 18).”

A Story?

As suggested by EPIC ‘Ohana, the interviewer asked the participant if he or she had any memory or story they would like to share about their Wrap experience. Six participants shared an additional story. Below are some of the comments.

“We were blessed with the facilitator we had, with the way she was, how she handled everything; she made us comfortable. She was perfect for the job. She helped us stay focused, really focused. Someday I’d like to be a parent supporter.”

“Once the meetings started, I felt like I was in control and they were trying to help me do the things I needed to do. I hope it can be extended to other families. Grandparents need to have more of a say and they do in Wrap.”

“They communicate well, but you have to do your part.”

“They got your back. For me, they helped motivate me and make me feel calm about the things. The people were perfect.”

“The emails show you what’s going on at the meetings and between the meetings. Sometimes the court dates gets put off and you are just waiting. But Wrap is different because you could see progress and the meetings were more frequent.”

“They were very knowledgeable in things we might have had to participate in. They briefed us and never kept us in the dark. The Wrap team we had was probably the best you could have asked for.”

Summary of Participant Perceptions

Clearly, these participants of Family Wrap Hawai‘i, who agreed to be interviewed, had very good experiences with the Wraparound process. One participant, who was somewhat negative, explained that she did not really want to get involved in Wrap and did not think they helped much. However, most of her concerns centered on other parts of the CPS system (e.g., the courts, the foster care system). We could discern several themes from the participants’ comments.

Respect

All of the respondents noted that they were treated with respect. Some suggested this was different from the “traditional” CPS system. They noted that they appreciated being able to

include other family members and supporters in their meetings and they noted the emphasis on collaboration and shared decision-making. Being a part of the decision-making about their child was extremely important. Some mentioned being so much better informed about what the system was and others mentioned that no decisions were made without them or behind their back. All noted that they felt respected and Wrap was responsive to their families.

Individualized and Strengths Focused

All responded that they felt the Wrap experience was unique and directed at their family's needs and not filled with cookie cutter programs and responses. Most agreed that the Wrap team found the strengths within the family and commented on them frequently.

Structure

The time spent on Wrap meetings seemed very good to most of the respondents. Several noted how they really liked the responsiveness of the Wrap staff and mentioned getting emails and text messages that kept them up to date on the progress of their case. Most agreed that the Wrap staff both followed up between meetings and followed through on doing what they said they would do. Many also liked the concrete goals and specific activity plans that were developed in the circles.

Benefits

Several respondents commented on the strong advocacy that the Wrap staff provided for their child. Several also noted the non-confrontational style of the EPIC staff and drew distinctions between Wrap and traditional CPS, which often made them feel defensive. The belief that the Wrap team would "never give up" was very positive and common.

Other Issues

The interviewers noted they heard words like "non-judgmental", "transparent", "timely," and "accountable" as families described their experiences with Family Wrap Hawai'i.

"Responsiveness" was mentioned often as families were often surprised that Wrap staff would text them and give them their cell phone numbers so families could easily connect with the team members. While aware that CPS has large caseloads and many other structural and system barriers, many families mentioned the ease with which the Wrap staff could "make things happen for them."

Conclusions from Parent Perceptions

These respondents clearly identified, and gave evidence for, the Family Wrap Hawai'i program

following the model and principles of the Wraparound model. They often noted the distinctions of individualized service planning, concrete solutions and supports, rapid responses and feeling involved and included in communications and decision-making about their child. They emphasized that these elements are different from the approaches they had experienced in traditional child welfare services. These are the hallmarks of a Wraparound model and are often made possible by the low caseloads afforded a Wraparound team, as well as the family empowerment philosophy of Wraparound programs. Many of these elements, which were so appreciated by the respondents, are really the best practices in all child welfare services. Many of these practices could (and perhaps should) be translated into traditional child welfare practice. This would require extensive training as well as support by supervisors and administration.

An overarching theme from the respondents was the feeling of respect and inclusion in the decision-making processes being made about their child. Getting information about the "system", what is happening to their child and what is likely to happen is extremely important to the families involved with CWS. Many respondents noted that the Wrap staff routinely called them back very quickly and even gave out their cell phone number so that families could leave messages and the messages were quickly returned. Families mentioned that it is difficult to talk to their social worker by calling into the CWS "system", and often the calls are not returned in a timely fashion.

The feeling that family members "have some control" over decision-making is a hallmark of the Wraparound approach. And while this may be challenging to accomplish within the traditional child welfare services bureaucracy, it is so important to families that attempts by CWS to provide families with more information, and to make a more rapid responses to questions and concerns, should be attempted. Including and involving families in the decisions and strategies being worked on is a "best practice" in social work and child welfare work. Many of the respondents in these interviews named specific workers as being extremely helpful, compassionate and very understanding. It is likely that the extensive training in family empowerment and the basic Wraparound principles conducted by EPIC 'Ohana has resulted in staff who buy into these practices and thus are able to implement them successfully.

Child Outcomes After Wrap

Hypotheses

Providing Wrap to those in foster care nine months or longer will reduce the length of stays in foster care.

Providing Wrap will increase the percentage of children achieving permanency through reunification.

Providing Wrap will reduce the number of re-entries into foster care.

Providing Wrap will reduce the percentage of children placed in institutional settings.

Providing Wrap will improve the well-being of children and youth.

Outcomes

Length of Stays in Foster Care

On both Oʻahu and Hawaiʻi Island, the median duration of care for all children in care has increased, starting in 2014, one year prior to the Waiver Demonstration (see Figure 84). Hawaiʻi Island has seen the most dramatic increases in the median length of care, reaching a median length of sixteen months in care for children who were in foster care in 2016. It has decreased slightly in 2017 and 2018.

Given the low penetration rates for the Wrap service (Wrap was provided to fewer than 10% of Long-Stayers), the overall lengths of stay on Oʻahu and Hawaiʻi Island cannot be attributed to the provision of Wrap services during the Waiver Demonstration.

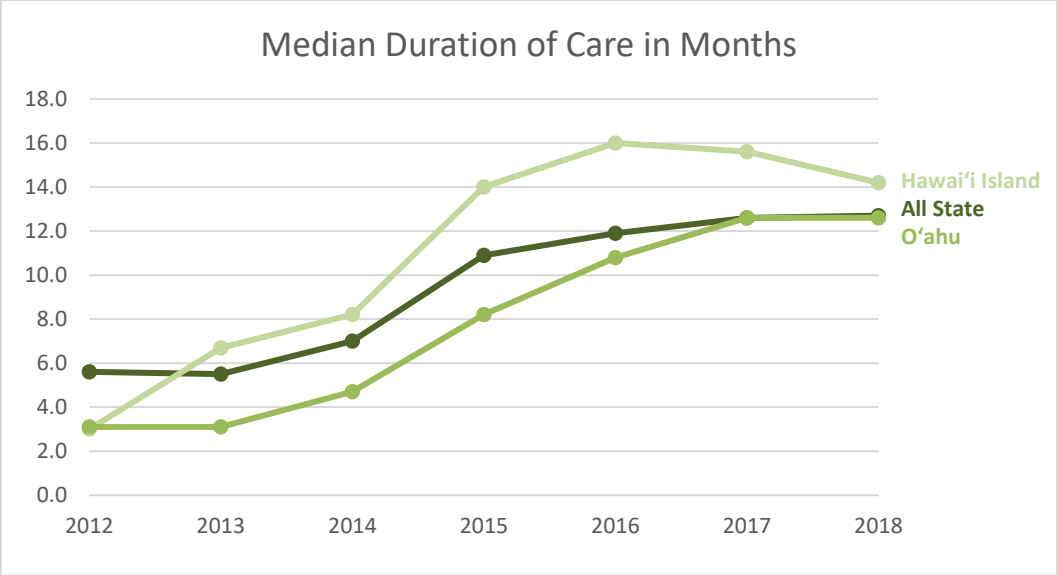


Figure 84. Median Duration of Care in Months, All Children in Care

Reunification and Other Permanency

Because children and youth can move to permanency before a Wrap case officially closes, the evaluation examines permanency outcomes for all Wrap participants, not only those with closed cases.

Of the 109 children and youth participating in Wrap on O'ahu, 73% reunited with their birth families (see Figure 85). Another 8% achieved guardianship, and 5% were adopted. Only 12% of children served by Wrap were still in care at the end of the Waiver Demonstration, and 2% had aged out of care without a permanency outcome. The average length of time to reunification was about five months after the first Wrap meeting (see Table 76).

Of the 26 children and youth participating in Wrap on Hawai'i Island, a full 69% were reunified with their families, according to the state administrative database (see Figure 85). One child was adopted, and one child achieved guardianship by the end of the Waiver Demonstration. About one-fifth of those served by Wrap on Hawai'i Island were still in care at the end of the Demonstration. The mean length of time to reunification for those reunified was about four months (see Table 76).

Of the 109 children and youth participating in Wrap on O'ahu, 73% achieved reunification.

The average length of time to reunification was within five months of the first Wrap meeting.

Of the 26 children and youth participating in Wrap on Hawai'i Island, 69% were reunified with their families.

The mean length of time to reunification was four months.

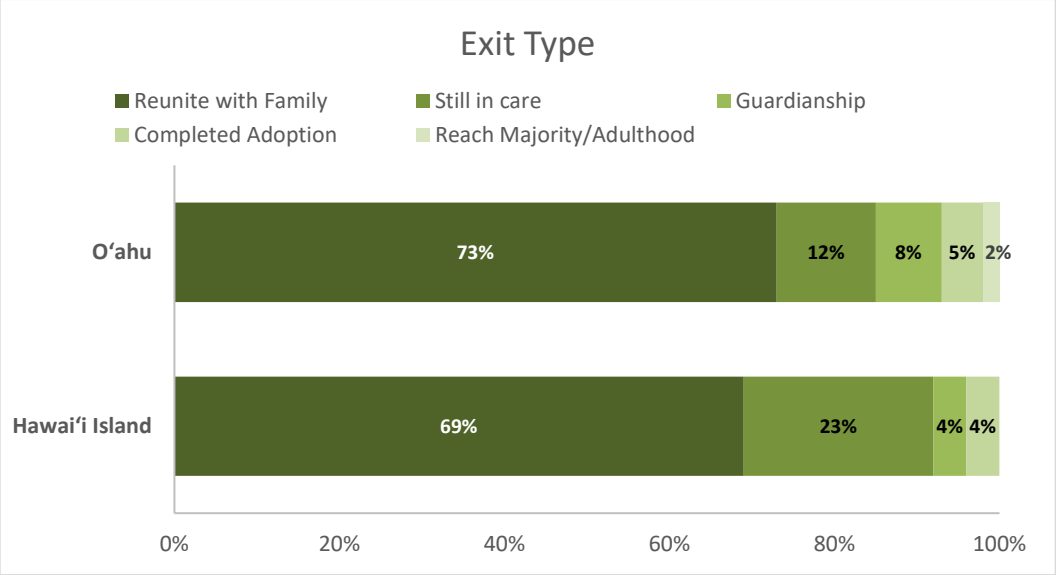


Figure 85. Exit Type for Wrap Participants

Table 76

Average Time from First Wrap Meeting to Reunification for those Children Reunified

	Wrap	
	O'ahu (n=69)	**Hawai'i Island** (n=17)
Average time to reunification	5.1 months	4.4 months

Note. Eleven (11) reunifications on O'ahu and one on Hawai'i Island were excluded from this analysis due to missing or incorrect data.

Foster Care Re-Entry

A subsequent re-entry to foster care is a possibility for those children who were reunified, adopted, or placed into guardianship. Among the 94 children on O'ahu with those outcomes, 21% had a subsequent re-entry to foster care (see Table 77). The average length of time to re-entry was twelve months.

Among the 20 children on Hawai'i Island who were reunified, adopted, or placed into guardianship after Wrap, two children, or 10% had a subsequent re-entry into foster care (see Table 77). The average length of time to re-entry was about two and half years, with the caveat that this is an average of two children's experiences.

Table 77

Subsequent Removals among Children Reunified, Adopted or in Guardianship

	Wrap	
	O'ahu (n=94)	**Hawai'i Island** (n=20)
Yes	21%	10%
No	79	90
Average Time to Re-entry	12 months	29 months

Placement in Institutional Settings

No children served by Wrap were in institutional care at the start of Wrap services. No children went into institutional care after beginning Wrap services.

Changes in Child Well-Being

Six of 109 Final *CANS* were completed on O'ahu (6% completion rate), and five of 26 Final *CANS* were completed on Hawai'i Island (19% completion rate). Therefore, there are insufficient Final *CANS* for an analysis of change in child well-being.

Selection of Comparison Groups

For comparisons, the evaluators selected those children who were in out-of-home care for a duration of at least nine months in any of the years of 2015 through 2017 (the Waiver years[4]), on O'ahu or Hawai'i Island. This is the sample of Long-Stayer children eligible for Wrap or SPAW. This produced a sample of 2,503 unique unduplicated children; 1,619 on O'ahu and 884 on Hawai'i Island.

A total of 132 children who received Wrap were in this sample of 2,503 Long-Stayer children with complete eligibility data. We compared the 2,371 children who did not receive Wrap to the 132 children who received Wrap in this sample. No differences between groups were statistically significant (see Table 78).

[4] Those in care for nine months of 2018 would not be eligible for Wrap, since entry into the Demonstration evaluation sample ended in September, 2018.

Table 78

Comparison of Long-Stayers who Did and Did Not Receive Wrap, 2015-2017

	Received Wrap (n=132)	**Did Not Receive Wrap** (n=2,371)
Gender		
Male	54%	50%
Female	46	50
Avg. age at first removal	5.3 years old	4.7 years old
Avg. duration of this spell	29 mos.	28 mos.
Avg. num. of places in this spell	3.3 places	3.6 places
Avg. num. of moves in this spell	2.3 moves	2.6 moves
Avg. num. of total places, all spells	3.8 places	4.1 places
Avg. total months in care, all spells	31 mos.	30 mos.

Using Propensity Score Matching (PSM), comparison groups were selected from all children in care who were in care for at least nine months (Long-Stayers) during the years of 2015-2017. The groups were matched by island, and were matched on age at first removal, average duration of current spell in foster care, average number of places in the current spell, and the average total days in care, all spells (lifetime).

This produced two comparison groups, one on O‘ahu (n=108) and one on Hawai‘i Island (n=24) (see Tables 79 and 80). The number of children in the groups who received Wrap are slightly smaller than the total number of children who received Wrap on each island, due to children being omitted due to key missing data. The goal of Propensity Score Matching is to produce comparable groups, and indeed, the two groups were similar on these four historical factors on O‘ahu. The PSM procedure produced a comparison group on Hawai‘i Island that was significantly older at their first removal, on average, but was comparable on all other historical factors, with the difference probably due to small samples.

There is an important caveat, mentioned earlier, that one of the eligibility criteria for a referral to Wrap was that the child and family were considered “likely to reunify.” There was no reliable recording of likelihood to reunify in case records. There was a field in the administrative database to enter the child’s case goal, but this field was found to be highly unreliable; caseworkers noted that they often did not update it if or when it changed. In addition, the data field was dynamic, in that it was overwritten in the administrative data if it was changed, and there was no way to extract what the case goal was on the day the child was referred to Wrap. There was no way, therefore, to ensure that the children in the matched comparison group also all had the case goal of reunification.

On both islands, and in both the Wrap and the comparison groups, the children had had challenging histories in foster care. On average, the children who received Wrap on O'ahu, and the children in the matched comparison group, were five years old when first taken into out-of-home care, had been in their current foster care spell for over two years, their current spell had consisted of about three different placements, and they had been in care across all spells for over two years.

On Hawai'i Island, on average, the children who received Wrap and their matched comparison children had been in their current foster care spell for about 2.5 years, had experienced an average of three to four different placements in that spell, and had spent around three years in care across their lifetimes. The children in the Wrap group were an average of 3 years old when first taken in to out-of-home care, while the children in the matched comparison group were an average of 6 years old.

Table 79

Histories in Out-of-Home Care, Wrap versus Comparison Group; O'ahu

O'ahu	**Wrap**	
	Received Wrap (n=108)	**Matched Comparison Group** (n=108)
Avg. age at first removal	5.7 years old	5.4 years old
Avg. duration of this spell	27 mos.	26 mos.
Avg. num. places in this spell	3.2	2.8
Avg. total mos. in care, all spells	29 mos.	28 mos.

No significant differences between matched groups at p<.01

Table 80

Histories in Out-of-Home Care, Wrap versus Comparison Group; Hawai'i Island

Hawai'i Island	**Wrap**	
	Received Wrap (n=24)	**Matched Comparison Group** (n=24)
Avg. age at first removal	3.4 years old	6.3 years old
Avg. duration of this spell	34 mos.	29 mos.
Avg. num. places in this spell	3.6	4.8
Avg. total mos. in care, all spells	39 mos.	33 mos.

No significant differences between matched groups at p<.01.

Reunification and Other Permanency

Children who received Wrap were three times more likely to be reunified with their families than those children in the matched comparison groups, on both O‘ahu and Hawai‘i Island (see Figure 86 and Figure 87), despite equivalent challenging histories in out-of-home care. Children in the matched comparison groups more frequently had the permanency outcomes of adoption or guardianship.

As mentioned, while the children who received Wrap were thought “likely to reunify,” there is no reliable indicator of the likelihood of reunification in case data. Therefore, it is possible (but unknown) that more children in the matched comparison groups were considered unlikely to reunify. If the case goal for a child was adoption or guardianship, they would not be referred for Wrap services. There is no way to exclude those children from the matched comparison groups, so it is not surprising, perhaps, that the comparison groups were more likely to contain children who achieved adoption or guardianship.

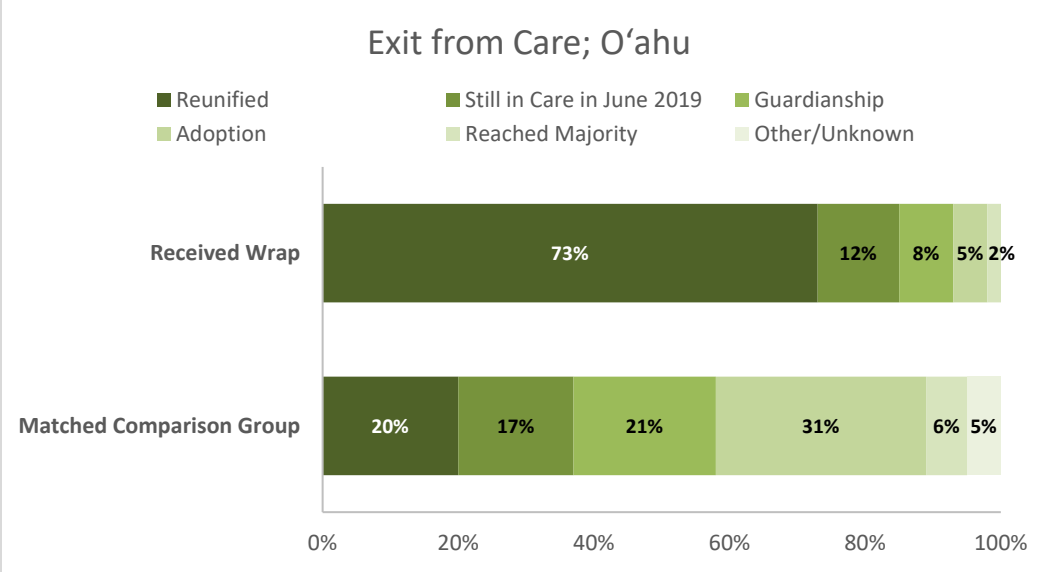


Figure 86. Exit from Care; O‘ahu

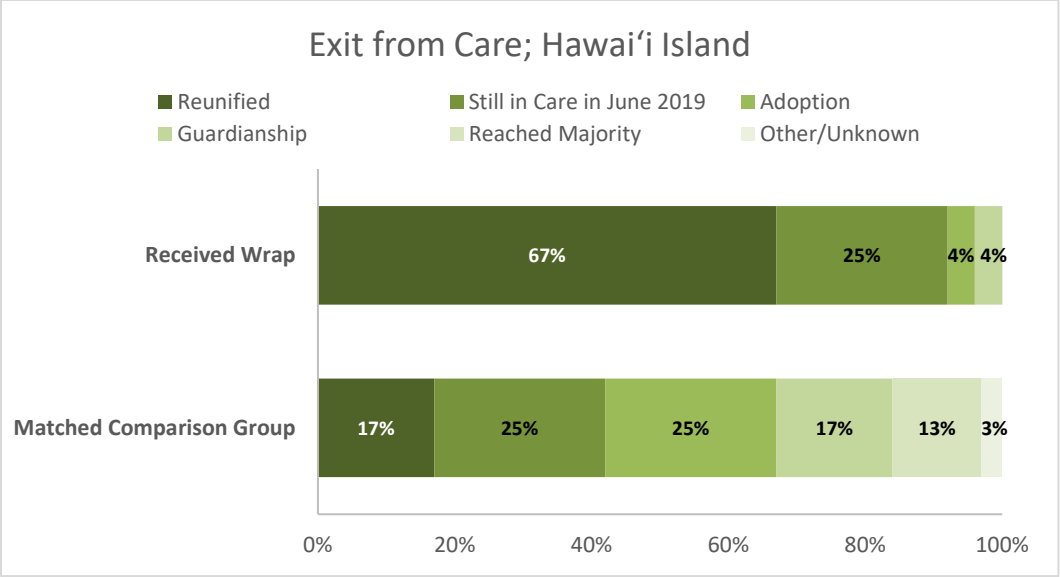


Figure 87. Exit from Care; Hawai‘i Island

Correlates of Permanency Outcomes Following Wrap

Given that there were no significant differences between O‘ahu and Hawai‘i Island in the characteristics of children served, the characteristics of services delivered, or the outcomes achieved, we combined the children and youth served on both islands to conduct an overall analysis of the child and service characteristics that were associated with permanency outcomes.

For this analysis, the five permanency outcomes of reunification, adoption, guardianship, aging out of care, and still in care on June 30, 2019 were combined into a three-category outcome:

- Reunification (n=98)
- Adoption or guardianship (n=16)
- Aged out of care or still in care on June 30, 2019 (n=21)

The following child characteristics were tested for association with the three categories of permanency above using chi-square and ANOVA:

- Demographics:
    - Child sex
    - Child’s age at Wrap enrollment
- Child’s History:
    - Any history of physical abuse
    - Any history of physical neglect
    - Any history of sexual abuse
    - Child’s age at current removal
    - Child’s age at first removal
    - Is this the child’s first time being in out-of-home care?
    - Duration of current spell[5] in out-of-home care at first Wrap meeting
- CANS Initial Assessment Domain Scores (n=23)
    - Trauma
    - Life Skills
    - Caregiver Needs
    - Behavioral/Emotional Challenges
    - Youth Risks
- Wrap Service Characteristics
    - Length of Wrap service
    - Number of Wrap meetings
    - Number of days between referral and first contact by Wrap
    - Number of days from referral to family consent
    - Number of days from consent to first Wrap meeting

[5] “Spell” is defined as the period of time between an entry and exit from out-of-home care. A spell can contain multiple “placements,” defined as individual homes/settings that a child experiences while in out-of-home care.

Results

There were no significant differences in permanency outcomes for boy and girls, or depending on the age of the child when participating in Wrap (mean of 5.5 years old, regardless of permanency outcome).

The only significant correlates of permanency outcome are presented in Table 81. This table is presented in row percentages, showing the percentage of children with (or without) a certain characteristic that achieved reunification, adoption/guardianship, or were still in care or aged out of care by June, 2019.

For example, reunification occurred much less frequently when a child was identified as having a history of sexual abuse. Only 20% of those with a history of sexual abuse were reunified (see Table 81). However, the likelihood of adoption/guardianship was much higher for these children/youth (60% of those with a history of sexual abuse were adopted/in guardianship). Permanency outcomes were not associated with any other type of history of maltreatment.

The length of time that a child had been in out-of-home care when Wrap began did not differ between those who were reunified (had been in care 20 months), those adopted or in guardianship (had been in care 20 months), or those who aged out or were still in care in June 2019 (had been in care 17 months). For most children participating in Wrap, this was their first spell in out-of-home care, and having a prior out-of-home spell was not associated with poorer permanency outcomes.

The *CANS* Domain Score that differed between the three permanency outcomes was the Trauma Domain score. Children who were reunified had begun Wrap with the lowest Trauma scores, while those who either aged out of care or were still in care in June 2019 had much higher Trauma scores when they started Wrap services, on average.

Permanency outcomes were not related to the length of the Wrap process, nor were they related to the number of Wrap meetings. Children who eventually reunified, were adopted, or in guardianship moved most quickly from referral to providing consent for Wrap services, and those reunified moved most slowly from providing consent to the first Wrap meeting.

Table 81

Child and Service Characteristics Associated with Permanency Outcome

Characteristic	Wrap			
	Permanency Outcome			
	Reunification (n=98)	**Adoption/ Guardianship** (n=16)	**Aged Out/ Still in Care** (n=21)	X^2 or F
Child's History				
History of Sexual Abuse				X^2=12.2**
No	75%	10%	15%	
Yes	20	60	20	
CANS Initial Assessment Score				
Avg. Trauma Domain Score	3.4	4.0	8.3	F=4.3*
Wrap Service				
Mean number of days, referral to consent	15 days	14 days	32 days	F=5.7**
Mean number of days, consent to first Wrap meeting	37 days	33 days	22 days	F=3.9*

* p < .05

** p < .01

Safety, Permanency, and Well-Being (SPAW)

Implementation of the SPAW Meetings
Service Fidelity of the SPAW Meetings
Child Outcomes After SPAW

Safety, Permanency, and Well-Being (SPAW) Meetings

Implementation of the SPAW Meetings

The Safety, Permanency and Well-Being (SPAW) meetings were one of the two Waiver interventions targeted at "Long-Stayers," or children and youth who had been in foster care for at least nine months. The SPAW meetings were specifically for youth who had been deemed "unlikely" to be reunified, based on an assessment of their current case situation, to help identify and make progress toward another, more permanent solution for the child.

Referrals of SPAW-eligible children/youth were to be made by the CWS caseworker, accompanied by a completed Initial *CANS* assessment. Early in the Waiver Demonstration, the SPAW team also initiated reviewing the CWS All-In-Care list (all children currently in out-of-home care), and called caseworkers to ask about potentially eligible children/youth.

The SPAW process was planned as one meeting, with a period of preparatory work done by the SPAW team prior to the meeting, and continuing monitoring by the SPAW team after the meeting. The SPAW meeting was led by a SPAW facilitator, and comprised of the caseworker and an interdisciplinary group called "decision makers," defined as others associated with the child's situation, who can make decisions about the child's case that could help "bust barriers" preventing permanency for the child. They were invited to the meeting by the SPAW coordinator. These barrier-busters could include professionals from the DOE, DOH, CAMHD or the Court. Notably, the child/youth/family were not invited to the SPAW meeting.

At the SPAW meeting, the group was to discuss and agree on a Permanency Rating for the child's or youth's current situation. SPAW facilitators led the meetings, and encouraged "out-of-the-box" thinking and the generation of solutions that might move past where the case was "stuck." Team brainstorming solutions focus around what SPAW programs nationwide call "The Five Questions": (1) What will it take to achieve permanency? (2) What can we try that has been tried before? (3) What can we try that has never been tried? (4) What things can we do concurrently? (5) How can we engage the youth in planning for permanence?

Action Plans were formed at each meeting, often with tasks for several members of the meeting. The SPAW team then followed up personally with SPAW attendees to check on the progress being made towards completion of tasks in the Action Plan. At the conclusion of the SPAW process (roughly 90 days later), the facilitator would record a second Permanency Rating, based on the child's or youth's situation post-SPAW.

SPAW Workflow Chart

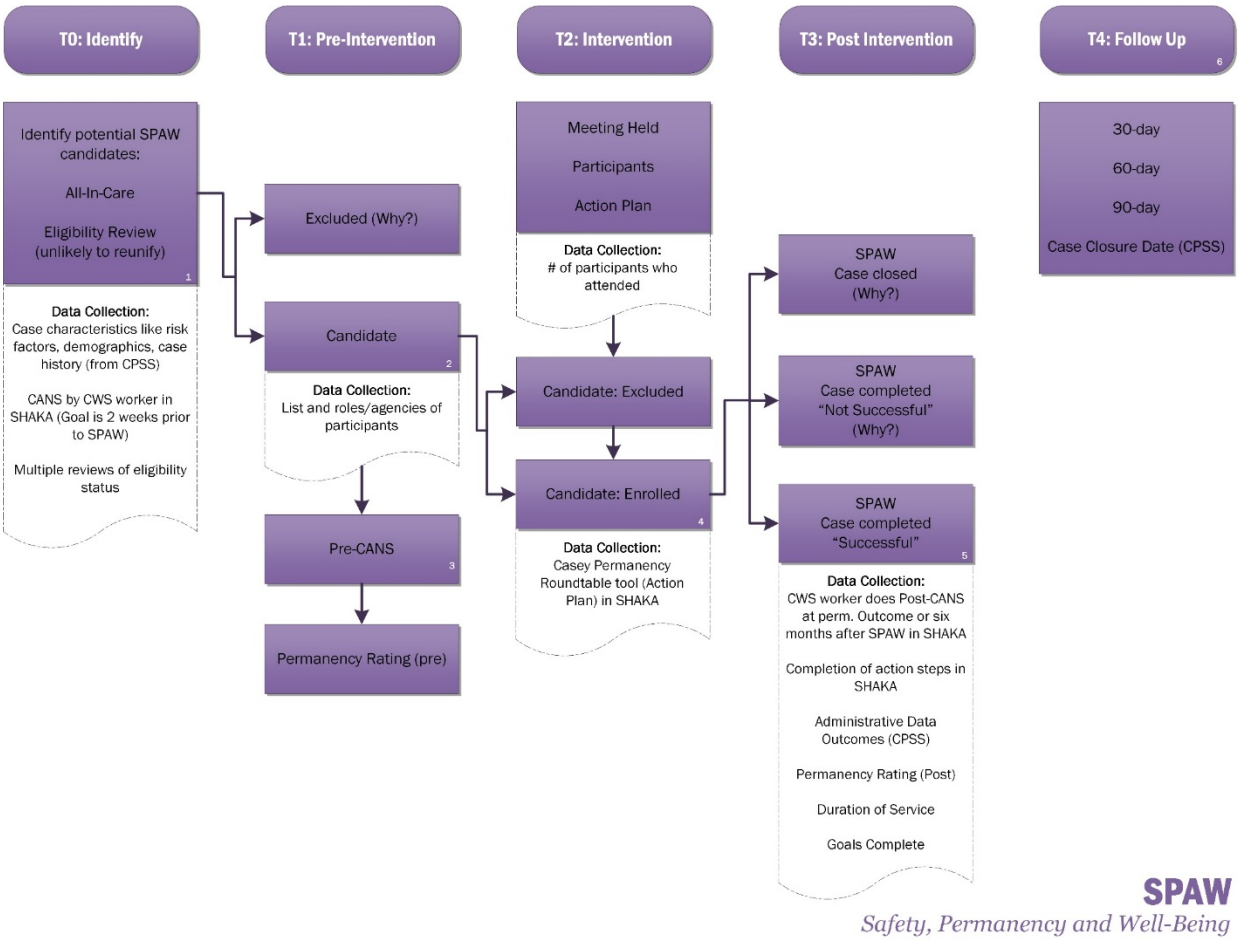


Figure 88. SPAW Workflow Chart

Staffing

O‘ahu

SPAW staffing data are presented in Table 82. The SPAW program was late to staff up at the start of the Demonstration. The program manager and a SPAW coordinator were hired in April 2015, followed by two facilitators in May, 2015 and a second coordinator in June. By June 2015, the staff consisted of one program manager, two facilitators, and two coordinators. The staff education level was at the associate through master’s degree level with majority of staff holding a master’s degree. At the beginning of the Demonstration, the staff had an average of 14.4 years of experience working with children and families. The SPAW intervention was fully staffed with one program manager, three facilitators, and three coordinators in 2016. Although the program experienced some turnover during the Demonstration, the intervention maintained the adequate staffing to meet demand throughout the implementation process. At the end of the Demonstration, the staff consisted of one program manager, two facilitators, and two coordinators with an average of 14.2 years of experience working with children. Staff education levels remained unchanged from June 2015.

Table 82
SPAW Staffing 2015 - 2018: O‘ahu and Hawai‘i Island

Position	Positions in Contract	Positions filled – April 2015	Positions Filled – July 2016	Positions Filled - Summer 2018
	Number	Number	Number	Number
Program Manager	1	1	1	1
Lead Facilitator	1	0	1	1
Facilitator/Specialist	2	0	2	1
Coordinator	3	1	3	2
Total	**7**	**2**	**7**	**5**

Hawai‘i Island

O‘ahu SPAW staff also covered cases on Hawai‘i Island.

Training for and about the SPAW Meetings

SPAW Provider

Contracted SPAW staff received core SPAW training from Casey Family Programs upon hire. They also received training on CWS core curriculum, EEO, human trafficking, suicide

intervention, facilitation skills, LGBTQ awareness, trauma informed care, family strengthening, HIPAA, assessment tool training (*CANS*), community resource building, and strengths-based supervision.

Child Welfare Services Branch

All line-staff and supervisors received SPAW values training, SPAW skills training, and *CANS* training. The initial training on *CANS* was provided by Dr. John Lyons who authored the tool. Follow-up and new hire training and certification on the *CANS* was provided through the CWS Program Development Office and Staff Development Office. Likewise, the initial SPAW trainings were conducted by representatives of Casey Family Programs and follow-up and new hire training was provided through the CWS Staff Development Office.

Number of Children and Youth Served by SPAW

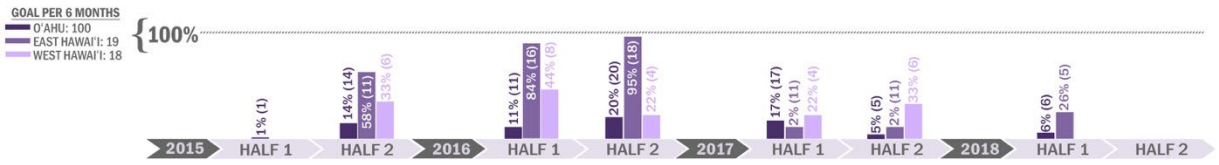


Figure 89. Number of Children in SPAW Sample on O‘ahu and Hawai‘i Island

The projections for the SPAW intervention were to serve 200 children per year on O‘ahu and 73 children on Hawai‘i Island per year. These were ambitious goals, and may be related to the early perception of the SPAW intervention as consisting of only one formal meeting.

The SPAW program on O‘ahu had the lowest referral rate of all Demonstration interventions, at 10% of projections overall. The number of children and youth who were referred to and served by SPAW never exceeded 31 in any given year of the Demonstration (see Figure 89). Referrals were highest in the second year of the Demonstration, declining sharply after that. A total of 74 children and youth on O‘ahu were served by SPAW.

In East Hawai‘i, the number of children and youth participating in a SPAW meeting almost met projections in the second year of the Demonstration, declining after that. A total of 54 children and youth were served by SPAW over the course of the demonstration. In West Hawai‘i, a total of 28 children and youth participated in a SPAW meeting. The highest rates of participation were in the first full year of the Demonstration on Hawai‘i Island.

A total of 20 youth had more than one SPAW experience (11 on O'ahu, nine on Hawai'i Island had another SPAW process after their first SPAW experience was concluded). The evaluation counts each youth only once in the analysis, using the first SPAW experience.

The Long-Stayer Population

On both O'ahu and Hawai'i Island, the number of children who were Long-Stayers (in care at least nine months) increased each year of the Waiver from 2015 through 2017 (see Figure 90)[1].

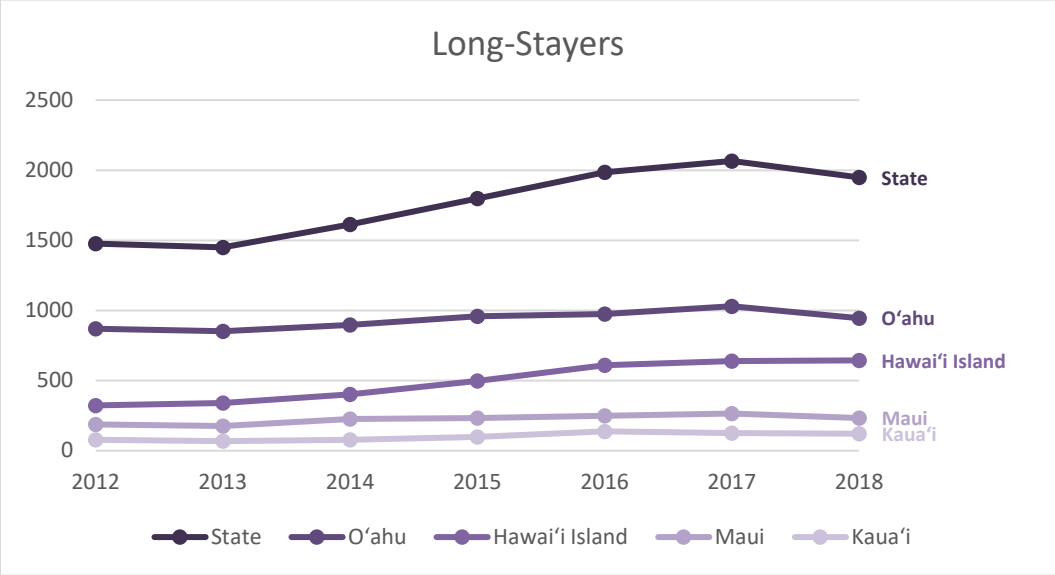


Figure 90. Long-Stayers[2]

SPAW Penetration Rate

Small proportions of long-stayers on O'ahu and Hawai'i Island received SPAW services (see Tables 83 and 84). On O'ahu, from 6% to 8% of eligible Long-Stayers received SPAW services each year. On Hawai'i Island, from 11% to 14% of eligible children received SPAW each year. The reader is cautioned that it is unknown how many Long-Stayers were also considered "unlikely to reunify."

[1] Complete data for 2018 was unavailable at time of this report. The numbers presented for 2018 encompass the first nine months of 2018.

[2] Detailed numerical tables for all figures are included in Chapter Nine Appendix.

Table 83
Long-Stayers, O'ahu

	SPAW		
	2015	**2016**	**2017**
Number of Long-Stayers	959	975	1030
% Receiving SPAW	7%	8%	6%

Table 84
Long-Stayers, Hawai'i Island

	SPAW		
	2015	**2016**	**2017**
Number of Long-Stayers	497	610	638
% Receiving SPAW	14%	13%	11%

Experiences and Impressions of SPAW after the First Year

CWS staff were asked about SPAW in focus groups after the first year of the Waiver Demonstration. Like Wrap, SPAW also faced issues with low referral rates over the first year of the intervention. To address this, SPAW referral process became a 'pull' process from the contracted provider rather than a 'push' from CWS. SPAW personnel screened CWS's All-in-Care list to identify cases that might be suitable for SPAW and then contacted the CWS supervisor to discuss the case and a potential referral.

Hawai'i Island staff noted that they did not receive the same training as O'ahu staff, when they began their implementation. In addition, on both islands, staff felt that training of CWS line staff on the SPAW model focused primarily on *CANS* completion.

Experiences and Impressions of SPAW after the Second Year

Child Welfare caseworkers with responsibilities to refer families to SPAW were asked to respond to questions in three primary areas; their perceived knowledge about the intervention, positive and negative perceptions about the intervention, and a scenario testing their knowledge of referral criteria.

Knowledge about the SPAW Process

A large number of child welfare staff (n=50) answered questions regarding their knowledge of SPAW. Table 85 shows that perceptions of knowledge about SPAW were high. The majority of respondents felt that they had enough information to understand the overall purpose of the SPAW meeting. Fewer, however, understood how SPAW was meant to help children and families. There was less agreement in general that the training for SPAW made the need for the intervention clear.

The majority of respondents felt that they had enough information to understand the overall purpose of the SPAW meeting. Fewer, however, understood how SPAW was meant to help children and families.

The last two questions had low levels of agreement, meaning that few respondents felt that the goal of SPAW was unclear, and few felt that they were not sure which cases should go to SPAW.

Table 85
Knowledge of the SPAW Meeting

	SPAW	
	O'ahu (n=32)	**Hawai'i Island** (n=18)
I have received enough information about SPAW to understand its overall purpose.	78%	94%
SPAW trainings made the need for the intervention clear to me.	53	67
It is clear how SPAW is meant to help children and families.	47	72
I am not sure which cases should go to SPAW.	16	0
The main goal of SPAW is not clear to me.	6	0

Perceptions of the SPAW Process

Respondents were asked to respond to a set of questions regarding their agreement with a variety of perceptions of the SPAW process. Responses are on a five-point scale, with a higher score indicating higher agreement. Mean scores on agreement are presented in Table 86.

Perceptions of SPAW were largely positive. Generally, perceptions about SPAW were more positive on Hawai'i Island than on O'ahu. Respondents on Hawai'i Island registered higher levels of agreement that the intervention was compatible for the local context for the SPAW

intervention (mean of 3.8 vs. 3.5 on O‘ahu). On Hawai‘i Island, concerns about the time commitment required were higher (mean of 3.6) than on O‘ahu (mean of 3.3).

Table 86
Perceptions of SPAW Process

Mean Scores	SPAW	
	O‘ahu (n=32)	**Hawai‘i Island** (n=18)
Positive Perceptions of SPAW		
Knowledge about SPAW	3.7	4.0
SPAW is compatible with local context	3.5	3.8
SPAW has advantages relative to prior approaches	3.4	3.6
Positive peer buy-in about SPAW	3.1	3.4
Negative Perceptions of SPAW		
Negative concerns re: time commitment for SPAW	3.3	3.6
Negative risk concerns about SPAW	3.0	3.2

Knowledge of the Eligibility Criteria for Referrals to SPAW

In a scenario, Alexis had been living with her aunt and uncle since birth, her mother’s parental rights were terminated, and her aunt and uncle were willing to adopt. SPAW would be the appropriate referral in this scenario.

> Alexis is a 3-year-old girl who was taken away from her parents at birth. Her birth mother was addicted to drugs, and Alexis was exposed to methamphetamines before she was born. This was the mother’s third child taken away by CWS. Alexis’s birth mom has had her parental rights terminated, however she still calls CWS frequently and wants to find out how she can get her children back. Alexis has been in a kinship resource caregivers home with her two siblings for a year and a half. The caregivers are her aunt and uncle. They are open to the idea of adopting Alexis, but the uncle is worried that his wife (the auntie) will not be able to protect the children from their mother as soon as CWS is not involved.

In the scenario, 49% of respondents would refer the case to SPAW, but 31% indicated an “other” course of action (see Table 87). Open-ended responses included “‘Ohana conference with mother and relative caregivers,” “proceed with adoption without SPAW,” and “move immediately toward adoption based on federal timelines.”

Table 87

Wrap and SPAW Scenarios of Maltreatment Reports

Referral Decision	SPAW
	Scenario: Alexis in kinship home (n=49)
Refer to SPAW	49%
Continue with case management	12
Refer to Wrap	8
Other	31

Service Fidelity of the SPAW Meetings

Eligibility

The eligibility criteria for SPAW were that (1) the child has been out of home for at least nine months, and (2) the child was considered "unlikely to reunify."

On average, the youth served by SPAW had been in continuous care for over three years.

Of the 74 youth served by SPAW on Oʻahu, none had been in care fewer than nine months at the time of his/her first SPAW meeting (see Figure 91). On Hawaiʻi Island, one youth had been in care fewer than nine months. On average, however, the youth served by SPAW had been in continuous care for over three years. On Oʻahu, the average length of time in care was over 3.5 years, and on Hawaiʻi Island, over 4.5 years.

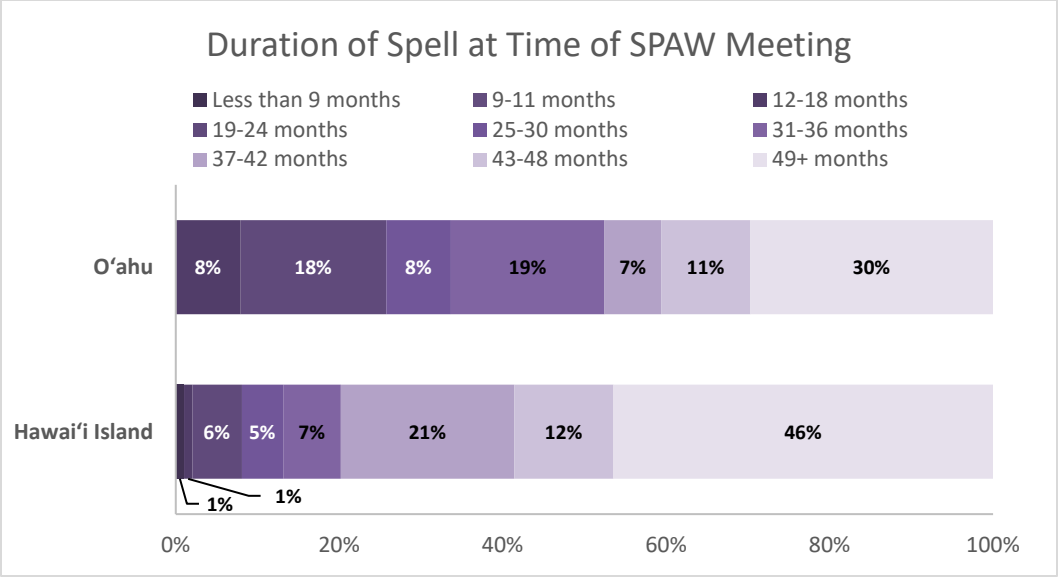


Figure 91. Duration of Spell at Time of SPAW Meeting

There was no reliable indication in the case files of whether a child was "unlikely to reunify." However, as discussed earlier, SPAW personnel made frequent calls to CWS caseworkers about children listed on the "All In Care" list of all children in foster care, to ask whether Long-Stayer children on their caseload were an "unlikely to reunify" child, and therefore an appropriate referral for SPAW services.

Service Provision

SPAW Meeting Participation

SPAW meetings enjoyed active participation. While there is some missing data for this activity, for the cases with data recorded, the number of participants invited to a SPAW meeting on O'ahu ranged from seven to 18 participants, with an average of eleven participants invited (see Table 88). Participation was high, with an average of nine invited participants attending the meeting.

Hawai'i Island saw similar results in the number of participants invited (range from two to 17, with an average of eleven participants invited) (see Table 89). On average, eight participants attended, with a range from two to 15.

The survey of SPAW participants conducted in late 2018 (discussed further below) found that the majority of SPAW participants were SPAW staff, CWS caseworkers, and partners from Child and Adolescent Mental Health and Development, and the Department of Health.

Table 88

Number of Participants Invited and Attending SPAW Meeting

SPAW Participation	SPAW	
	Oʻahu (n=66)	**Hawaiʻi Island** (n=79)
Range – participants invited	7 to 18 participants	2 to 17 participants
Avg. number participants invited	11 participants	11 participants
	(n=64)	(n=78)
Range – participants attended	6 to 16 participants	2 to 15 participants
Avg. number participants attended	9 participants	8 participants

Action Plans

One of the critical elements of a SPAW meeting was the development of an Action Plan. The Action Plan consisted of actions for the members of the SPAW meeting to achieve, not necessarily the child or youth. On both Oʻahu and Hawaiʻi Island, the majority of SPAW meetings set either two or three action goals (see Figure 92).

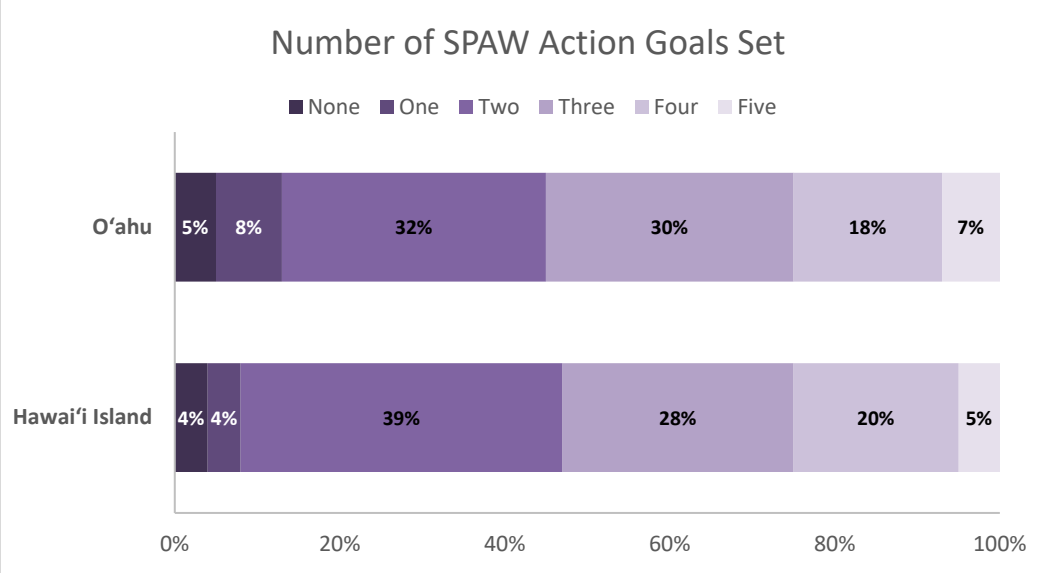


Figure 92. Number of SPAW Action Goals Set

On Oʻahu, almost half of all SPAW meetings completed all goals in the action plan by SPAW case closure (see Table 89). On average, 66% of Action Plan goals were completed for SPAW meetings on Oʻahu.

On Hawaiʻi Island, over one-third (39%) of SPAW meetings were closed after meeting all goals on the Action Plan (see Table 89). On average, over half (55%) of Action Plan goals were completed for SPAW meetings on Hawaiʻi Island.

Table 89

SPAW Action Plan Completion

Action Plan Completion	SPAW	
	Oʻahu (n=70)	**Hawaiʻi Island** (n=78)
Avg. pct. of goals completed	66%	55%
Cases with all goals completed	49	39
Cases with at least half of goals completed	73	62
Cases with no goals completed	4	18

Time from SPAW Meeting to Case Closure

The expected length of time from a SPAW meeting to SPAW case closure was 90 days. Indeed, the average length of time from meeting to SPAW case closure on both Oʻahu and Hawaiʻi Island was a little over 90 days (see Table 90). Almost all cases were closed to SPAW in under six months.

Table 90

Time from SPAW Meeting to SPAW Case Closure

Time from Meeting to Case Closure	SPAW	
	Oʻahu (n=74)	**Hawaiʻi Island** (n=82)
Range	82 to 292 days	66 to 450 days
Avg. length of service	101 days	96 days
Closed in 3 months or less	22%	48%
Closed in between 3 and 6 months	77	51
Closed after 6 months	1	1

Note. Calculated based on days between SPAW meeting and SPAW closed date.

Foster Care Case Mining for SPAW Referrals

As indicated in the Workflow Chart, the initial step in the SPAW process was to identify potential candidates for SPAW by reviewing the "All-In-Care" list. This is a list in the SHAKA interface, accessible to all CWS caseworkers as well as SPAW providers, that lists all children and youth who are currently in out-of-home care. The initial specification of the SPAW model and theory of change did not specify who was responsible for doing this review of eligible children and youth.

Referrals to SPAW were slow in the first year of the Demonstration, so the SPAW providers began to review the All-In-Care list, to assess childrens' eligibility for the SPAW intervention.

When a possible candidate was identified, the SPAW provider contacted the caseworker or supervisor to discuss whether SPAW might be an appropriate referral. Children who were moving toward permanency and expected to achieve permanency in the next six months were not considered for SPAW.

A child or youth could be reviewed multiple times over several months. While a child might not be eligible at one point in time, because the case might be moving toward reunification for example, if that status changed, s/he might become eligible for SPAW.

The evaluation did a review of the case mining activity after the first two years of the Demonstration. SPAW and CWS personnel conducted over 1200 such reviews in the first two years of the Waiver Demonstration; 768 on Oʻahu, and 451 on Hawaiʻi Island (see Table 91). These were not unique children, but unique instances of case reviews on children in care. For both islands, there was a burst of case review activity when the Waiver Demonstration was first implemented, followed by variable, sometimes heavy, review activity in the months following.

There were 42 children and youth on Oʻahu who received a complete SPAW intervention in the first two years of the Waiver Demonstration. There were a variety of stages of determination of eligibility for SPAW, as noted in the process evaluation methodology, and these were tracked in SHAKA. Table 92 shows that, of the 42 children who did ultimately receive the SPAW intervention on Oʻahu, several had previously been removed from the eligibility list, then reinstated, or excluded at one point in time, only to eventually receive the service. It should be noted that these eligibility statuses were a new element of data collection for the Waiver Demonstration evaluation, and data extraction demonstrates errors in data entry; e.g., all children who received SPAW should have been noted at one time to have been "enrolled," although only 37 out of 42 had this designation.

On Hawaiʻi Island, there were 59 children and youth who received a complete SPAW intervention in 2015-2016. Again, Table 92 illustrates the many reviews that occurred for a case and the different status changes that could occur. Two children were initially removed from eligibility, only to eventually receive the service. Also 17 children were excluded at some point for not meeting eligibility for SPAW, only to become eligible later.

Table 91

Number of SPAW Initial Reviews Conducted by Month

Month of Review	O‘ahu		Hawai‘i Island	
	2015	2016	2015	2016
January	0	76	0	29
February	0	15	0	22
March	0	16	0	19
April	0	5	0	1
May	324	101	1	28
June	63	0	0	13
July	0	29	0	13
August	25	53	1	12
September	21	10	261	28
October	5	9	0	1
November	4	7	0	14
December	0	5	7	1
Total Reviews	**442**	**326**	**270**	**181**

Note. Counts of cases initially reviewed during case mining process – not all reviewed cases become SPAW cases.

Table 92

Number of SPAW Clients at Each Eligibility Status

Eligibility Status	O‘ahu (n=42)		Hawai‘i Island (n=59)	
	Count	%	Count	%
Initial review	42	100%	59	100%
Removed	4	10	2	3
Candidate	16	38	25	42
Excluded	11	26	17	29
Enrolled	37	88	28	47
Coordinate	40	95	55	93
Completed meeting	42	100	59	100
Follow-up	34	81	59	100
Closed	37	88	42	71

Note. Status changes of actual SPAW clients served.

Profiles of Children and Youth Served by SPAW

Demographic Characteristics

On both O‘ahu and Hawai‘i Island, children and youth referred to SPAW were slightly more likely to be female than male (see Figure 93). In terms of race, about two-thirds of children referred to SPAW on O‘ahu were Hawaiian/Pacific Islander (64%), over half were White (55%), and one-fourth were Asian (27%). In terms of ethnicity, almost half of the children referred were Hawaiian/Part Hawaiian (42%).

The distribution of race for children referred to SPAW on Hawai‘i Island was more heavily Hawaiian/Pacific Islander: almost three-fourths of children were Hawaiian/Pacific Islander (73%), over half were White (54%), and a little over one-fourth were Asian (28%). In terms of ethnicity, over half (57%) were Hawaiian/Part Hawaiian (see Figure 93).

The mean age of children and youth participating in SPAW was ten years old on both O‘ahu and Hawai‘i Island (see Figure 93). On both O‘ahu and Hawai‘i Island, over half of youth referred to SPAW were between the ages of 11 and 17.

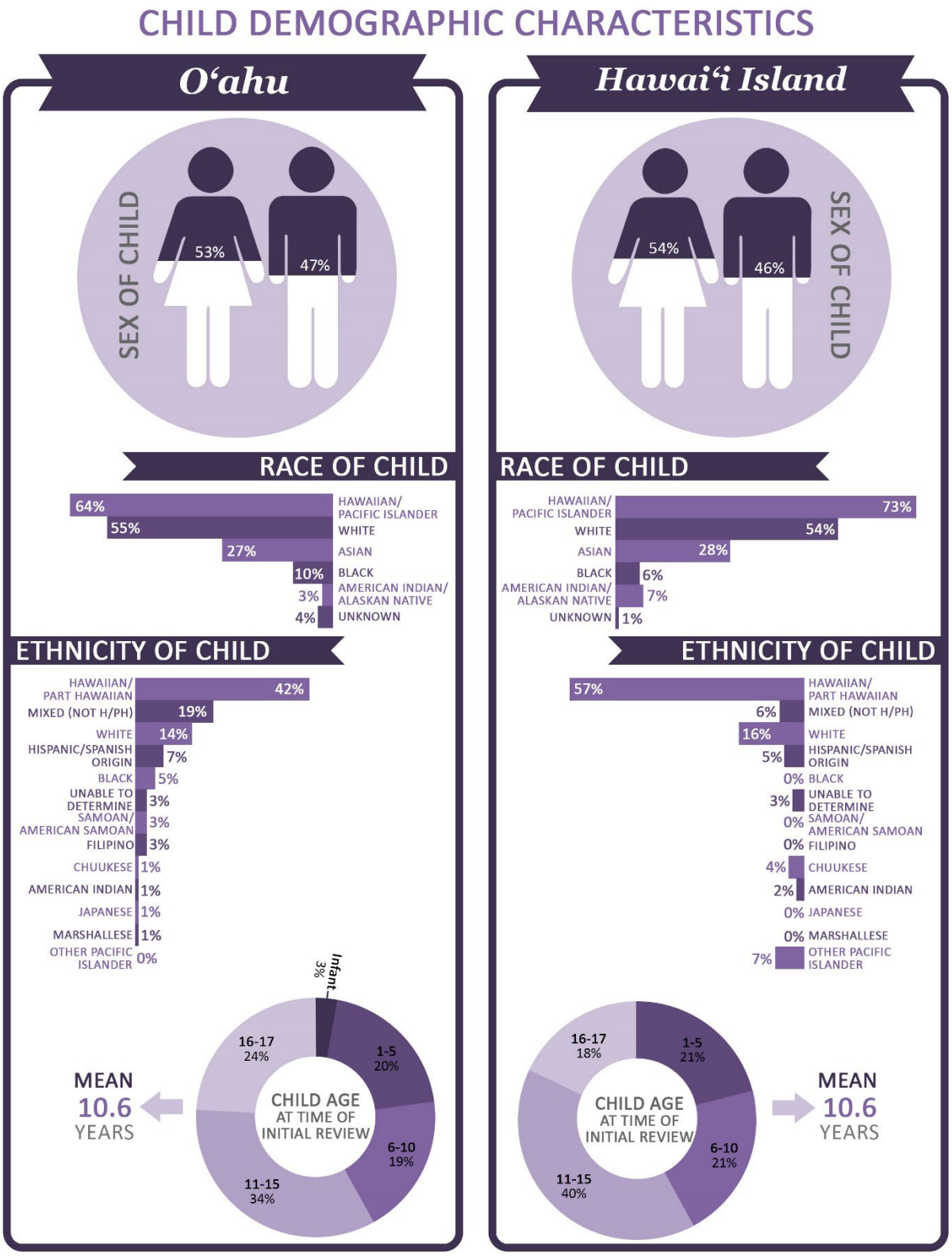


Figure 93. Child Demographic Characteristics

History of Maltreatment and Removal

The CPSS database was searched for all prior reports of maltreatment. This could include the report that lead to this removal episode, and could include other prior reports as well. Children served by SPAW on O'ahu were highly likely to have a prior report of threatened neglect (85%) and or the threat of abuse (80%) (see Figure 94). Much less common were prior reports of physical neglect (23%) or physical abuse (16%). Few youth participating in SPAW on O'ahu had prior reports of sexual abuse (3%).

On Hawai'i Island, youth participating in SPAW were highly likely to have a history of threatened neglect (81%) or a threat of abuse (78%) (see Figure 94). About a fourth of SPAW participants on Hawai'i Island had a prior report of physical neglect (27%). Lower numbers of youth had prior reports of physical abuse (13%) or sexual abuse (9%).

On average, SPAW participants on O'ahu were six years old when first taken into care (see Figure 95). Only 15% were younger than one year old when taken into care. On Hawai'i Island, 16% of SPAW participants had been first removed when younger than one year old. Fewer than half of SPAW youth on Hawai'i Island were age five or younger when first removed from home.

Over half of children served by SPAW had no prior experience in foster care prior to their current removal episode (61% on O'ahu; 62% on Hawai'i Island) (see Figure 96).

Youth participating in SPAW on O'ahu were in a variety of out-of-home settings at the time of the SPAW meeting (see Figure 97). Half of the youth were in a paid foster home, and 15% were in a paid relative placement. Another 15% were in a non-paid foster care setting, and 8% were in non-paid residential care.

On Hawai'i Island, a large proportion of SPAW participants (66%) were in a paid foster care setting (see Figure 97). Another 9% were in a paid relative placement.

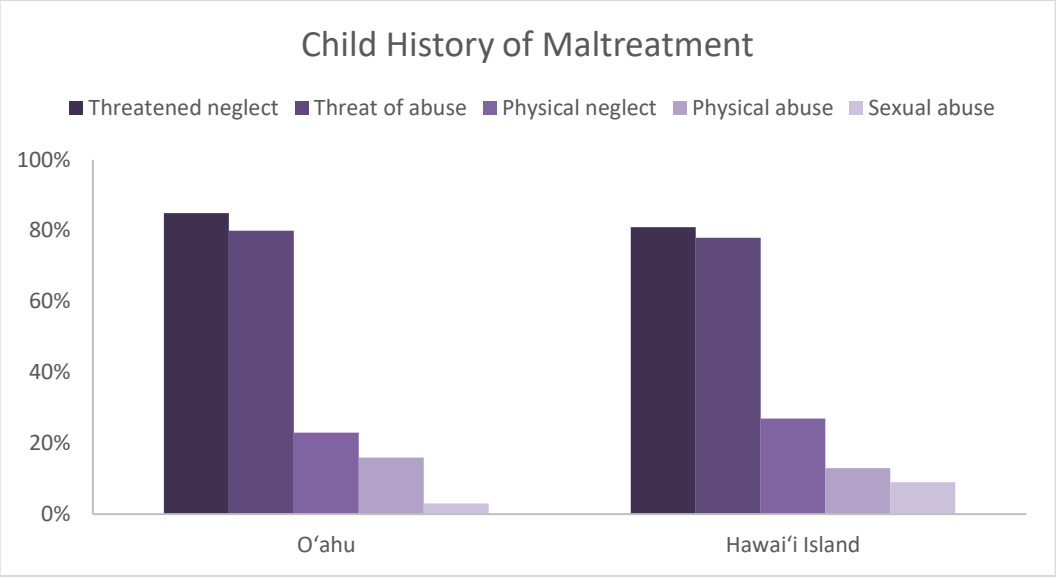


Figure 94. Child History of Maltreatment

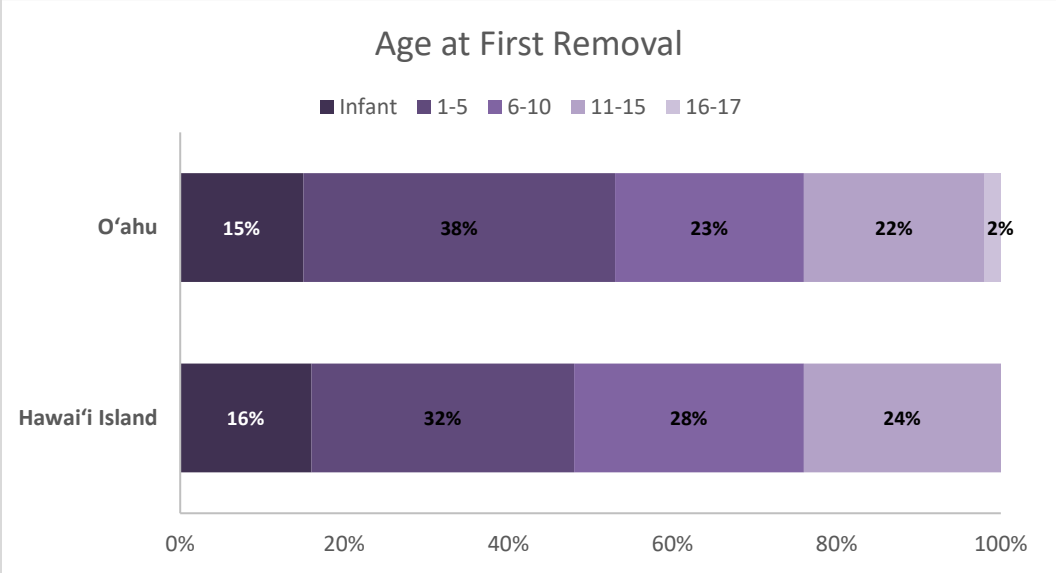


Figure 95. Age at First Removal

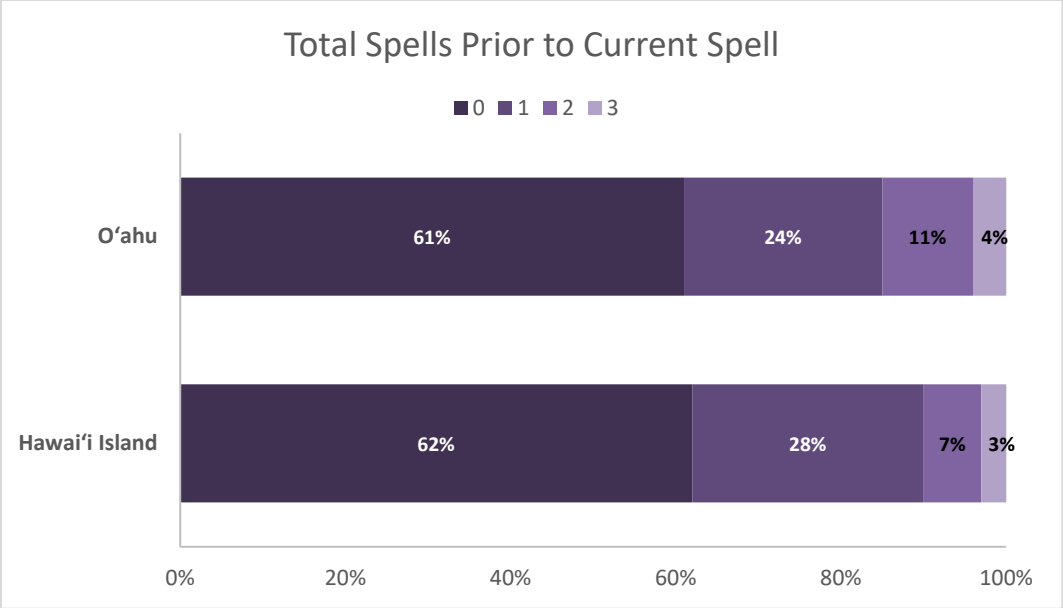


Figure 9.6. Total Spells Prior to Current Spell

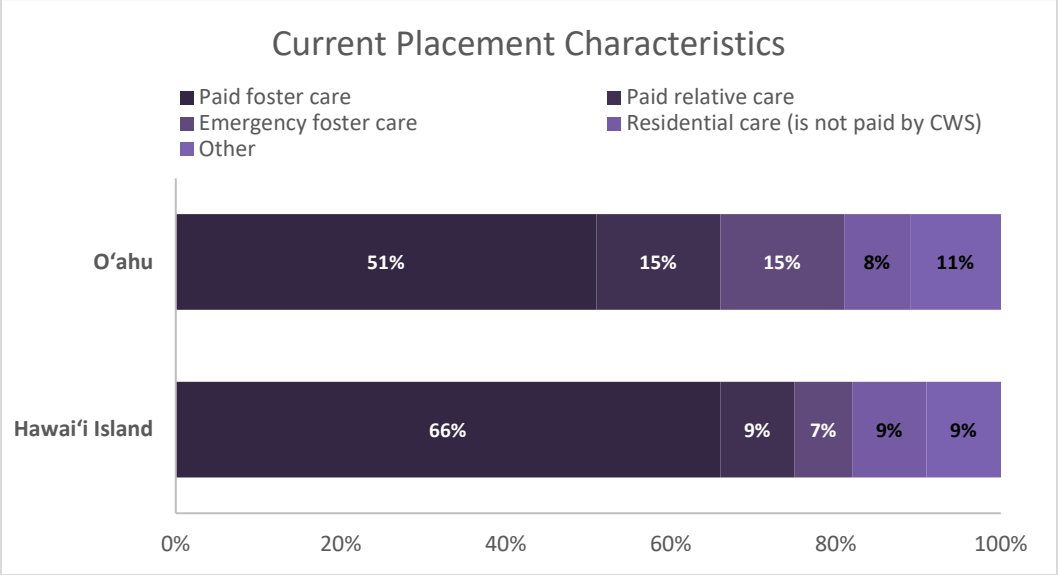


Figure 97. Type of Placement at Start of SPAW

Permanency Ratings at First SPAW Meeting

Using the Casey Family Programs model of Safety, Permanency and Well-Being Meetings, the SPAW meeting participants agreed on a SPAW Initial Permanency Rating, on a six-point scale:

1. Permanency achieved – in adoption, legal guardianship, etc., not emancipation
2. Very good – with family or in a family setting all believe to be lifelong

3. Good – in a family setting all believe to be lifelong; plan for stability is in place; all committed to plan; permanency issues are near resolution
4. Fair – in a family setting all believe could be lifelong; plan for stability is in place; all committed to plan; permanency issues are being addressed
5. Marginal – in a family setting all believe could be lifelong; developing a plan to achieve safety and stability
6. Poor – living a home that is not likely to endure; failure to resolve adoption/guardianship issue

The majority of youth on O'ahu who were referred to SPAW were initially rated as either marginal (39%) or poor (29%) in their permanency circumstances at the SPAW meeting (see Figure 98). On Hawai'i Island, almost all children and youth referred to SPAW were rated as either marginal (43%) or poor (30%) in their permanency circumstances (see Figure 98).

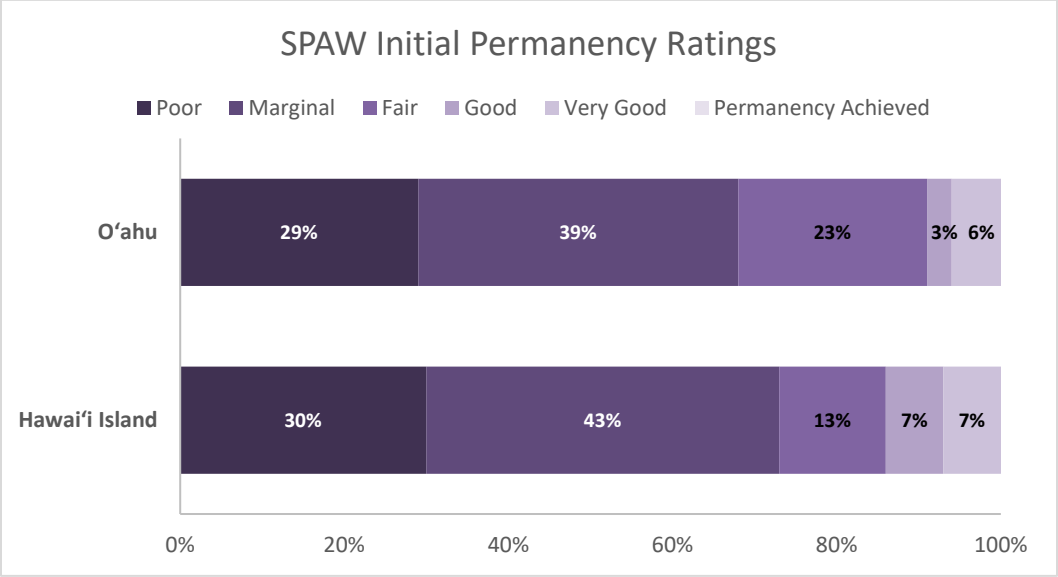


Figure 98. SPAW Initial Permanency Ratings

Child Well-Being at Referral to SPAW

There were 28 Initial *CANS* completed on O'ahu (for 74 children served), for a 38% completion rate. There were 68 Initial *CANS* completed on Hawai'i Island (for 82 children served) for an 83% completion rate.

There are six domains on the *Child and Adolescent Needs and Strengths* assessment that pertain to all children and youth and are not limited to a subset of children due to age or specific challenge: Youth Strengths, Life Domain Functioning, Trauma Experiences and Stress Symptoms, Youth Risk Behaviors, Behavioral/Emotional Needs, and Caregiver Needs. The Youth Strengths domain is the only domain focused on identifying child and youth strengths.

In this sample of children and youth referred to SPAW, and for whom an initial *CANS* was completed, there were a multitude of strengths identified (see Table 93). On both O'ahu and Hawai'i Island, the strength most noted as a centerpiece for youth was their cultural identity (57% of O'ahu youth; 63% of Hawai'i Island youth).

On O'ahu, other common strengths that were noted as a centerpiece or a useful strength included educational assets, community life, and talents/interests. The least common centerpiece strengths were relationship stability and family (see Table 93).

On Hawai'i Island, after cultural identity, the most common centerpiece or useful strengths were educational assets, talents/interests, and youth involvement (see Table 93). Many youth on Hawai'i Island were also noted to have the useful strengths of resiliency, optimism, and natural supports.

Table 93
SPAW: Initial CANS, Youth Strengths

Youth Strengths	**O'ahu** (n=28)			**Hawai'i Island** (n=68)		
	Identified	**Useful**	**Centerpiece**	**Identified**	**Useful**	**Centerpiece**
Relationship Stability	43%	14%	4%	27%	25%	21%
Talents/Interests	29	18	36	29	19	32
Resiliency	29	14	29	12	38	24
Interpersonal	25	29	21	35	35	24
Community Life	25	11	39	28	28	29
Problem Solving	25	46	14	34	27	27
Family	21	36	4	31	22	24
Optimism	21	46	14	30	38	21
Spiritual/Religious	18	7	32	10	15	16
Cultural Identity	14	18	57	10	21	63
Natural Supports	14	29	14	22	37	21
Youth Involvement	7	54	25	18	32	25
Educational	0	32	46	10	46	38

When referred to SPAW, children on O'ahu had the highest levels of need in Life Functioning and Trauma Experiences and Stress Symptoms (see Table 94). Youth were also noted to be high need in Behavioral/Emotional Needs.

On Hawai‘i Island, the levels of need were as high or higher than O‘ahu in every domain of functioning. The highest levels of need were in regard to Life Functioning, Trauma Experiences and Stress Symptoms, and Behavioral/Emotional Needs (see Table 94).

Table 94
SPAW: CANS Domain Scores

CANS Domain Score	SPAW		
	Range	O‘ahu (n=28)	Hawai‘i Island (n=68)
Life Domains	0 to 24	7.8	7.8
Trauma	0 to 20	5.7	7.6
Behavioral/Emotional	0 to 14	4.2	4.6
Youth Risks	0 to 22	2.6	3.3
Caregiver Needs	0 to 39	2.6	2.9

In the area of Life Domain functioning, youth on both O‘ahu and Hawai‘i Island were most commonly assessed to have the following “Immediate” or “Need to Act” needs: behavioral/emotional needs, family needs, adjustment to trauma, and social functioning needs (see Table 95). These Life Functioning needs were most often noted as “Need to Act” rather than “Immediate.”

Table 95
SPAW: Initial CANS, Life Domain Functioning

Life Domain Functioning	O‘ahu (n=28)		Hawai‘i Island (n=68)	
	Act	Immediate	Act	Immediate
Behavioral/Emotional	32%	7%	38%	6%
Family	25	18	25	6
Adjustment to Trauma	25	7	18	7
Social Functioning	18	7	19	3
Living Situation	11	11	13	12
Recreational	4	7	12	7
Sleep	4	0	6	2
Legal/JJ	4	0	4	2
Medical	4	0	2	0
Physical	4	0	0	0
Cultural Differences	4	0	0	0
Daily Living	0	4	7	0
Developmental	0	4	6	2
Substance Use	0	0	4	2
Language	0	0	0	0

In regard to Trauma Experiences and Stress Symptoms, few youth on O'ahu were noted to have high needs (see Table 96); the most common needs were for emotional abuse (19%) and being a witness to family violence (16%).

On Hawai'i Island, however, there were several Trauma Experiences and Stress Symptoms affecting youth at the time of their referral to SPAW (see Table 96). The most common were emotional abuse (46%), physical abuse (36%), neglect (36%), and being a witness to family violence (27%). Many youth were noted to exhibit Trauma Stress Symptoms, especially grief/loss and attachment symptoms.

Table 96
SPAW: Initial CANS, Trauma Experiences and Stress Symptoms

Trauma Experiences	**O'ahu** (n=28)		**Hawai'i Island** (n=68)	
	Act	**Immediate**	**Act**	**Immediate**
Emotional Abuse	15%	4%	32%	14%
Witness to Family Violence	12	4	15	12
Physical Abuse	8	4	29	7
Neglect	4	12	14	22
Witness/Victim - Criminal Acts	4	0	10	0
Sexual Abuse	0	0	14	5
Witness to Community Violence	0	0	3	3
Medical Trauma	0	0	0	2
Natural Disaster	0	0	0	0
Trauma Stress Symptoms				
Attachment	19%	4%	14%	12%
Affect Regulation	19	4	14	9
Trauma Grief/Loss	12	8	20	7
Hyper-arousal	8	0	12	3
Dissociation	8	0	3	0
Re-experiencing	4	4	10	2
Avoidance	4	4	7	3
Numbing	0	4	5	2

At least one-fifth of youth on O'ahu were noted to have Behavioral/Emotional needs (see Table 97). The most common needs were in externalizing symptoms: oppositional behavior (24%), anger control (24%), conduct disorders (20%), and impulsivity/hyperactivity (16%). Much less common were depression (12%) and anxiety (8%).

On Hawai'i Island, youth referred to SPAW exhibited a range of externalizing and internalizing behaviors (see Table 97). The most commonly assessed were anxiety (28%),

impulsivity/hyperactivity (26%), and depression (17%). Less common were oppositional behavior (15%), conduct disorders (10%), anger control (10%), and psychosis (2%).

Table 97
SPAW: Initial CANS, Youth Behavioral/Emotional Needs

Youth Behavioral/Emotional Needs	O'ahu (n=28)		Hawai'i Island (n=68)	
	Act	**Immediate**	**Act**	**Immediate**
Oppositional	20%	4%	15%	0
Anger Control	20	4	8	2%
Conduct	20	0	10	0
Impulse/Hyper	16	0	24	2
Depression	12	0	15	2
Anxiety	8	0	26	2
Psychosis	0	0	2	0

Participant Feedback on SPAW Meetings

In the final year of the Demonstration, the evaluators conducted telephone interviews with professional personnel who had participated in multiple SPAW meetings, to assess what they saw as the most effective elements of SPAW, the challenges to SPAW being effective, if and how SPAW had evolved over the course of the Demonstration, and any recommendations for SPAW after the Demonstration. The three groups of respondents were (1) child welfare caseworkers, (2) the SPAW coordinators and facilitators, and (3) members of other providers and partner agencies. Given their different roles in the SPAW meeting, their responses are discussed separately.

The Most Effective Elements of SPAW

By far, most of the respondents said that the most effective element of SPAW was its ability to convene the "right" decision makers so that immediate decisions could be made. The ability of SPAW to convene the right people in order to creatively think of new strategies, and make plans to implement them, was appealing to all who participated. The phrases "think out of the box" and "creative brainstorming" were mentioned multiple times as extremely helpful strategies in the generation of new possibilities and action plans.

As these SPAW cases had been in the system for at least nine months, moving these children to permanency was a challenging goal. While many of these cases had been "sitting" in the system with little or no action being taken, some caseworkers noted that reason for this was that the youth were in a stable foster home and therefore did not warrant a change at this time. They were aware of the federal requirements for timeliness.

Other comments about what made SPAW effective centered on the skills and strategies of the SPAW staff. Many noted that the SPAW facilitators were good group leaders and ensured that the discussion was non-judgmental, even though the SPAW cases that were the subject of the meetings had been "stuck" in the CWS system for a considerable time.

The SPAW Staff (Coordinators and Facilitators)

The SPAW staff agreed that bringing the group of colleagues together, all whom were relevant to the youth in question, was crucial to the success of SPAW. Some commented that this helped the SPAW members start moving in the same direction and it improved the overall communication by having all state and private sector partners engaged in the plans and goals for the family. Several noted that SPAW reminded participants about the urgency of getting children and youth into permanency, and the SPAW process identified new ideas and strategies that previously were not considered or attempted.

An interesting finding regarded the comments made about addressing barriers and conflicts. Several of the SPAW staff felt that the structure of the facilitated meetings, and the Five Questions asked at the beginning of each SPAW, helped "attack permanency barriers" such as legal issues, policy barriers, interstate issues and programs. The Five Questions identified what steps had already been taken and what needed to be done. One person noted that very few external *systemic* problems were identified by SPAW, but rather it was the CWS policies and procedures that needed to be clarified. One respondent noted that the largest barrier was the CWS staff not following through with the agreed-upon activities. This same person also noted that SPAW staff often provided assistance and support to CWS workers when they seemed overwhelmed. Another noted that collaborating with external partners is new to CWS and was not always well-utilized.

Others noted that SPAW facilitation motivated the team to strive for accountability on completing the identified tasks and achieve the goal of permanency. Another respondent suggested that facilitation allows for transparency and that "transparency is KEY." The facilitation is designed to easily re-frame negative communication and provide a more non-judgmental atmosphere.

The CWS Staff

All of the interviewed CWS staff commented on the benefits of conducting facilitated meetings that brought the right people to the table, and assisted in "out-of-the-box" and creative thinking. All CWS staff participants appreciated the skills of the facilitators, and the SPAW staff who identified eligible cases and assisted with follow-up and reminders about the tasks needed to achieve permanency. One worker specifically noted the benefit of convening an interdisciplinary group of people, and all noted the benefit of having people present who could

make immediate decisions. The CWS caseworkers commented on the excellent preparation of the SPAW staff and their ability to build important relationships. One noted the non-judgmental and calm atmosphere that the SPAW team created; and all appreciated having the support from the provider/partners.

The Providers/Partner Agencies

The partner agency providers mentioned that one benefit of SPAW is assembling all the necessary participants in a face-to-face setting to brainstorm strategies and plans. The facilitated process was beneficial and prevented the group from drifting from the established goals. They also found that the structure of the SPAW process was helpful. One respondent specifically mentioned that having a facilitator who was objective, neutral, not part of the "system," and who provided a neutral tone was a big advantage. Another provider mentioned the importance of having representatives from children's schools present at the meetings. Another noted that the partners attending SPAW meetings learned about how much goes on behind the scene at CWS, while another stated that members learn to value and gain more confidence in the other departments that participate in the meetings.

Challenges to SPAW Being Effective

SPAW Staff

The SPAW staff noted that the meetings do not easily lend to resolving the *internal* barriers within CWS for difficult-to-place youth referred to SPAW. Many noted the challenge of not getting sufficient buy-in from the CWS workers for the SPAW intervention. Specifically, the SPAW staff noted that CWS workers continuously complained that they were overworked and overwhelmed, and that they viewed SPAW as another initiative that required more time and energy from them, which they did not have. SPAW staff also noted that the number of cases referred to SPAW was small. SPAW was seen primarily as more work for the CWS staff and without very good outcomes, and SPAW staff perceived that some child welfare workers saw the SPAW case mining (when SPAW staff went into the lists to find cases) as an attempt to "catch staff doing poor paperwork."

Barriers noted within CWS by SPAW staff:

- Follow-up tasks were not completed;
- There was little accountability for CWS workers who did not complete their tasks;
- Internal delays due to untimely paperwork processing results in court continuances;
- There are no resources to help families with tangible needs;
- SPAW staff is expected to do much more than what is in the job description;
- The referral process never took off. SPAW had to find eligible cases; this enabled CWS workers to not locate or work with the Long-Stayers;

- There was a lack of engagement with the parents, youth and/or resource caregivers;
- There was insufficient evidence-based clinical consultation regarding parent progress;
- Continuing required use of *CANS* without eliminating existing assessment tools (duplication) was communicated as a hassle from the workers.

The CWS Staff

The theme of the CWS workers' responses was that the *premise* of SPAW was great. However, it was very time consuming for workers, which resulted in it being seen as another initiative that failed to relieve them of any existing tasks. CWS staff participants indicated they felt overwhelmed and did not see any real success with the SPAW outcomes. This lack of buy-in was noted by the CWS workers, as well as by the SPAW team.

Specific comments included:

- There is only one SPAW meeting and plan, which is not reassessed or adjusted;
- Although the meeting is scheduled for one hour, it often goes overtime;
- There are a lack of resources for permanency on the neighbor islands;
- I haven't seen any success in SPAW actually getting a youth into permanency, thus I'm not motived to refer;
- Duplicative since we already meet with our partner agencies;
- Sometimes we know where we are going so SPAW isn't necessary.

Partners/Providers

The partners seemed quite positive about the SPAW process. However, they noted that they were often unable to obtain nor access the resources they needed. One respondent noted that these are very tough cases and there is seldom a new thing out there that will solve the problem. Another noted that the CWS workers needed to more consistently follow up, return phone calls, and do their assigned tasks on the action plans. There was no follow-up in many cases.

Evolution of SPAW Over Time

In the interviews, SPAW participants (all of whom had participated in multiple SPAW meetings) were asked if they had seen the SPAW process evolve over the course of the Waiver Demonstration, and if so, had that improved or detracted from the process.

SPAW Staff

While many respondents opted not to answer this question, or said they saw no change, the SPAW staff made some interesting comments. One commented that when SPAW workers

started providing more hands-on help for the CWS caseworkers, the buy-in improved. However, without the extra help, the CWS caseworkers thought SPAW was too much work with too few positive outcomes and thus did not refer cases to SPAW.

One line of thought was to find ways to begin to address some of the internal issues within CWS by meeting in smaller groups and requiring less involvement with the external systems players.

It seemed that there had been some attempts to initiate pre-SPAW meetings to get sufficient information from the CWS workers, *before* a SPAW meeting was organized. While some SPAW staff witnessed a gradual positive shift among CWS workers, supervisors and administrators, and subsequently received more referrals, the overall referral numbers remained low.

When SPAW began to pull cases from the "All-In-Care List" to the meetings, the referral numbers increased, but some saw this as an inappropriate role for the SPAW staff and an abrogation of the CWS workers' jobs.

The *CANS* assessment was viewed as helpful to the team members as it focused on the strengths of the youth. In the beginning, the SPAW process was very strict and rigid, and that was good for developing Action Plans. However, after the process requirements changed, there seemed to be too many tasks associated with each case, and the SPAW group could not focus on the [one or two] main concerns.

A serious evolution change occurred when CWS altered the SPAW process and focused on runaways. The goals began to focus on placement stability, not permanency. This also changed the members involved in the meetings, and the role of the members shifted to become more like group consultants.

CWS Staff

Most of the workers did not say that the SPAW process had changed over time. Some explicitly mentioned this as an indicator of staying faithful to the SPAW model. The CWS staff agreed that when SPAW staff helped to find eligible cases and relieve CWS staff from having to do this, SPAW became more "do-able." However, many respondents indicated that the impact of SPAW was not visible, and caseworkers continued to see SPAW as more of a burden and distraction from the work they needed to do.

Partners

Most participants from this category also did not mention seeing any evolution over time. However, one respondent noted the master practitioners' confidence increased over time. Another offered that the facilitators took on a more problem-solving role, and moved away from the neutral facilitation role.

Recommendations from SPAW Participants

During the interviews, respondents made several recommendations and suggestions to improve the SPAW process. One suggestion was that the SPAW team utilize a two-step process. The first step would be to work *internally* with CWS to discuss any case barriers, *before* convening a SPAW meeting. The idea was that many challenges could be resolved within CWS, without requiring the partners' involvement. Another suggestion was to hold electronic meetings. Other recommendations referred specifically to the processes within CWS. For example, it was suggested that expediting the internal CWS decision-making process, as recommended in the recent PIP, would be helpful. Another suggestion was to increase the supervision of CWS staff, in order to increase the accountability of caseworkers' actions. Finally, it was recommended that DHS consider pacing the implementation of new initiatives, so as to not overwhelm CWS staff.

Conclusions from SPAW Participant Perceptions

The interviews laid out some important themes to consider when assessing the SPAW intervention. Clearly, the idea of bringing crucial players to the table to discuss a case "stuck" in the foster care system appeals to everyone. Almost all respondents noted the benefit of brainstorming new ideas, thinking "out of the box" and getting help in developing innovative action plans to move the foster youth into permanency. Another concept often mentioned was the ability of the group to have decision-makers at the table, thus allowing decisions to be made during the meeting. Thus, the theoretical framework of the SPAW meetings was understood and appreciated.

However, there was a problem with the buy-in and implementation of the SPAW process among the CWS workers. The units did not make sufficient referrals to SPAW. Attempts to increase referrals using the SPAW staff to find and select cases for the unit supervisor's consideration (called case mining of the All-In-Care List) did unearth more cases that were eligible. However, while some CWS staff saw that process as helpful, this demonstrates a lack of buy-in from the CWS staff. By not looking for cases to refer to SPAW within their own caseload, the CWS workers may have been abrogating their responsibility to take action on these long-stayer cases. It was not the design of SPAW to utilize their staff to bring in referrals.

Another theme from the CWS workers was that SPAW did not appear to be very successful in actually moving youth into permanency. CWS workers saw participating in SPAW as a time burden that added more work to their schedules and was sometimes unnecessary. The theme of child welfare workers being overwhelmed, overworked, and not included in the design of the new initiatives was present here, as well as in the earlier focus groups about the other Waiver interventions.

Child Outcomes After SPAW

Hypotheses

Providing SPAW meetings to those in foster care nine months or longer will reduce the length of stays in foster care.

Providing SPAW will increase the likelihood of a permanent placement.

Providing SPAW will reduce the percentage of children placed in institutional settings.

Providing SPAW will improve child and youth well-being.

Outcomes

Length of Stays in Foster Care

On both Oʻahu and Hawaiʻi Island, the median duration of care for all children in care has increased, starting in 2014, one year prior to the Waiver Demonstration (see Figure 99). Hawaiʻi Island has seen the most dramatic increases in the median length of care, reaching a median length of sixteen months in care for children who were in foster care in 2016. It has decreased slightly in 2017 and 2018.

Given the low penetration rates for the SPAW service (SPAW was provided to fewer than 15% of Long-Stayers), the overall lengths of stay on Oʻahu and Hawaiʻi Island cannot be attributed to the provision of the SPAW service during the Waiver Demonstration.

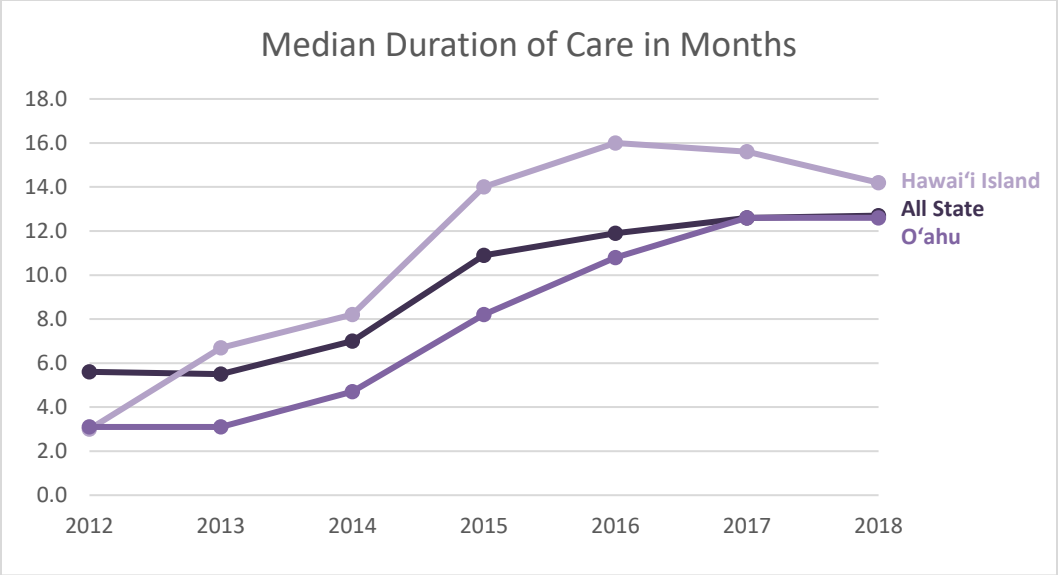


Figure 99. Median Duration of Care in Months, All Children in Care

Permanency

Although the SPAW intervention was intended for children and youth for whom reunification was deemed unlikely, 22% of SPAW youth on O'ahu were reunified with their families (see Figure 100). Another 24% of children achieved guardianship and 10% were adopted. Almost one-fourth of children served by SPAW on O'ahu aged out of care before finding permanency. For those who were reunified, the average time from the first SPAW meeting to reunification was eight months (see Table 98). For those achieving guardianship, the average time was 1.5 years after the first SPAW meeting. For those adopted, the average time from the SPAW meeting to exit to an adoptive family was about one year.

On Hawai'i Island, few children served by SPAW were reunified with family (6%). However, 23% achieved guardianship and 10% were adopted by the end of the Waiver Demonstration (see Figure 100). Over one-third of children served by SPAW on Hawai'i Island were still in care at the end of the Waiver Demonstration. For those who were reunified, the average time from the first SPAW meeting to reunification was 1.5 years (see Table 98). For those achieving guardianship, the average time was 1.5 years after the first SPAW meeting. For those adopted, the average time from the SPAW meeting to exit to an adoptive family was almost two years.

These permanency outcomes for youth occurred long after the conclusion of their SPAW meeting, and could explain the perception of SPAW participants and caseworkers that SPAW was not achieving permanency for many youth.

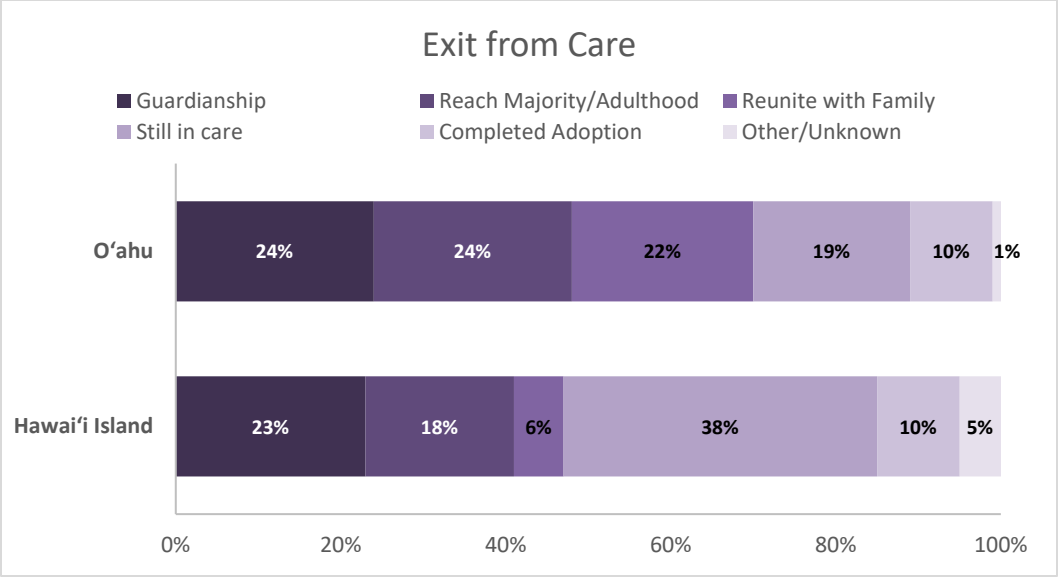


Figure 100. Exit from Care

Table 98

Average Time from SPAW Meeting to Exit from Care (children reunified, adopted or in guardianship)

	SPAW	
	O'ahu (n=69)	**Hawai'i Island** (n=17)
Adoption	(n=7)	(n=8)
Average time to Adoption	13.6 months	21.8 months
Guardianship	(n=18)	(n=19)
Average time to Guardianship	18.4 months	17.2 months
Reunification	(n=16)	(n=5)
Average time to Reunification	8.2 months	20.1 months

One child who exited care to reunification, adoption or guardianship following SPAW experienced a re-entry to foster care (see Table 99). That re-entry occurred 18 days after exiting care.

Table 99

Subsequent Removals among Children Reunified, Adopted or in Guardianship

	SPAW	
	O'ahu (n=41)	**Hawai'i Island** (n=32)
Yes	2%	0
No	98	100%
Average Time to Re-entry	18 days	-

Changes in Permanency Ratings

While Initial Permanency Ratings were determined by the participants at the SPAW meeting, a second, Final Permanency Rating, was made by the SPAW coordinator at the 90-day mark or when the case was closed to SPAW. On Oʻahu, there were 58 youth for whom there were both Initial and Final Permanency Ratings (see Figure 101). Ratings improved by about one rating, from a mean of 4.9, or "marginal" at the SPAW meeting, to 3.8, or "fair to good" 90 days later. 10% of participants were noted to have achieved permanency in the Final Permanency Rating.

On Hawaiʻi Island, there were 70 youth with both an Initial and a Final Permanency Rating (see Figure 102). On average, ratings improved by about one rating category, from a mean of 4.8, or "marginal" at the SPAW meeting, to 3.7 or "fair to good" 90 days later. Only 4% were said to have achieved permanency at the Final Permanency Rating.

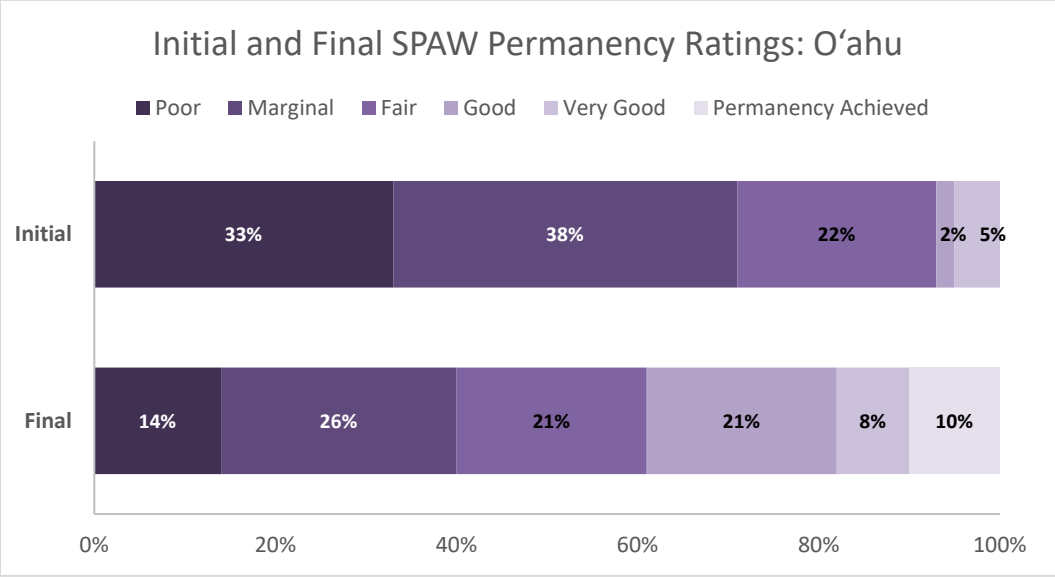


Figure 101. Initial and Final SPAW Permanency Ratings: Oʻahu

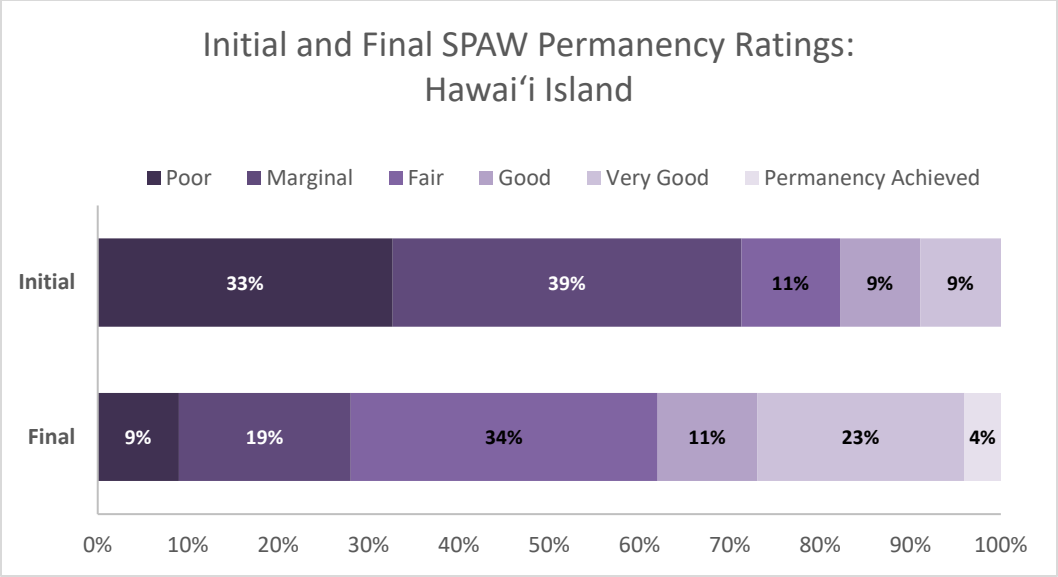


Figure 102. Initial and Final SPAW Permanency Ratings: Hawai‘i Island

Children Placed in Institutional Settings

Six children on O‘ahu and seven children on Hawai‘i Island were in institutional care at the time of their SPAW meeting (see Table 100). On O‘ahu, two of those six children were still in residential care in June 2019 (see Table 101). On Hawai‘i Island, one of the seven children in residential care was still in residential care in June 2019. Two of the six children on O‘ahu and three of the seven children on Hawai‘i Island aged out of care.

Table 100
Exit Type for Children in Institutional Care at First SPAW meeting

	SPAW	
	O‘ahu (n=6)	**Hawai‘i Island** (n=7)
Guardianship	1	1
Reach Majority/Adulthood	2	3
Reunite with Family	0	2
Still in care	3	1

Table 101

Last Placement Type in Spell as of Spell Censor Date or Exit

	SPAW	
	Oʻahu (n=6)	**Hawaiʻi Island** (n=7)
Foster Care	3	3
Kinship Care	1	2
Residential Treatment	2	1
Runaway	0	1

Changes in Child and Youth Well Being

There were no significant differences in *CANS* domain scores between children's Initial and Final *CANS* on Hawaiʻi Island (see Table 102). There were too few completed Final *CANS* assessments on Oʻahu to conduct an analysis of change.

Table 102

Changes in CANS Domain Scores; Hawaiʻi Island (n=22)

***CANS* Domain Score**	SPAW		
	Range	**Initial**	**Final**
Trauma Experiences and Stress Symptoms	0 to 14	8.3	6.0
Life Functioning	0 to 24	6.3	5.6
Behavioral/Emotional Needs	0 to 13	4.7	4.9
Youth Risks	0 to 15	2.0	1.9
Caregiver Needs	0 to 8	1.1	0.8

Selection of Comparison Groups

For comparisons, the evaluators selected those children who were in out-of-home care for a duration of at least nine months in any of the years of 2015 through 2017 (the Waiver years[3]), on O'ahu or Hawai'i Island. This is the sample of Long-Stayer children eligible for Wrap or SPAW. This produced a sample of 2,503 unique, unduplicated children; 1,619 on O'ahu and 884 on Hawai'i Island.

A total of 149 children who received SPAW were in this sample of 2,503 Long-Stayer children. We compared the 2,354 children who did not receive SPAW to the 149 children who received SPAW in this sample.

Children who received SPAW had significantly more complicated histories in out-of-home care than those who did not receive SPAW (see Table 103). While they were significantly older when first placed into out-of-home care, their removal episode (spell) when they received SPAW lasted an average of four years, compared to a two-year removal episode, on average, for those Long-Stayers who did not receive SPAW. They had experienced more moves during care, and had experienced a greater number of placements and total days in care over their lifetimes.

Table 103
Comparison of Long-Stayers who Did and Did Not Receive SPAW, 2015-2017

	Received SPAW (n=149)	**Did Not Receive SPAW** (n=2,354)
Gender		
Female	53%	50%
Male	47	50
Avg. age at first removal***	6.3 years old	4.7 years old
Avg. duration of this spell***	49 mos.	26 mos.
Avg. num. of places in this spell***	8.0 places	3.2 places
Avg. num. of moves in this spell***	7.0 moves	2.3 moves
Avg. num. of total places, all spells***	9.4 places	3.8 places
Avg. total mos. in care, all spells***	57 mos.	29 mos.

*** Difference between groups is significant at $p < .001$

Using Propensity Score Matching (PSM), comparison groups were selected from all children in care who were in care for at least nine months (Long-Stayers) during the years of 2015-2017.

[3] Those in care for nine months of 2018 would not be eligible for SPAW, since entry into the Demonstration evaluation sample ended in September, 2018.

The groups were matched by island, and matched on age at first removal, average duration of current spell in foster care, average number of places in the current spell, and the average total days in care, all spells (lifetime).

This produced two comparison groups, one on O'ahu (n=67) and one on Hawai'i Island (n=66) (see Table 104 and Table 105). The number of children in the groups who received SPAW are slightly smaller than the total number of children who received SPAW on each island, due to children being omitted due to key missing data. The goal of Propensity Score Matching is to produce comparable groups, and indeed, the two groups were similar on these four factors.

There is an important caveat, mentioned earlier, that one of the eligibility criteria for a referral to SPAW was that the child and family were considered "unlikely to reunify." There was no reliable recording of likelihood to reunify in case records. There was a field in the administrative database to enter the child's case goal, but this field was found to be highly unreliable; caseworkers noted that they often did not update it if and when it changed. In addition, the data field was dynamic, in that it was overwritten in the administrative data if it was changed, and there was no way to extract what the case goal was on the day the child was referred to SPAW. There was no way, therefore, to ensure that the children in the matched comparison group were also considered unlikely to reunify.

On both islands, however, and in both the SPAW and the comparison groups, the children had had long and challenging histories in foster care. On average, the children who received SPAW on O'ahu, and the children in the matched comparison group, were six years old when first taken into out-of-home care, had been in their current foster care spell for over three years, their current spell had consisted of about six different placements, and they had been in care across all spells for about four years (see Table 104).

Table 104
Histories in Out-of-Home Care, SPAW versus Comparison Group; O'ahu

O'ahu	**SPAW**	
	Received SPAW (n=67)	**Matched Comparison Group** (n=67)
Avg. age at first removal	6.4 years old	6.6 years old
Avg. duration of this spell	42 mos.	41 mos.
Avg. num. places in this spell	6.7	6.0
Avg. total mos. in care, all spells	49 mos.	45 mos.

No significant differences between matched groups at p<.01

On Hawai'i Island, on average, the children who received SPAW and their matched comparison children were around six or seven when first taken into out-of-home care, had been in their current foster care spell for over three years, had experienced an average of five to seven

different placements in that spell, and had spent over four years in care across their lifetimes (see Table 105).

Table 105
Histories in Out-of-Home Care, SPAW versus Comparison Group; Hawai'i Island

Hawai'i Island	**SPAW**	
	Received SPAW (n=66)	**Matched Comparison Group** (n=66)
Avg. age at first removal*	6.2 years old	7.0 years old
Avg. duration of this spell	47 mos.	43 mos.
Avg. num. places in this spell	7.4	5.7
Avg. total mos. in care, all spells	53 mos.	51 mos.

No significant differences between matched groups at p<.01

Permanency

Despite equivalent and challenging histories in out-of-home care, children who received SPAW were more likely to achieve guardianship on both O'ahu and Hawai'i Island (see Figure 103 and Figure 104). Children who received SPAW on O'ahu also were more likely to reunified with family, although they had been considered "unlikely to reunify." Children in the comparison groups had higher rates of adoption, however.

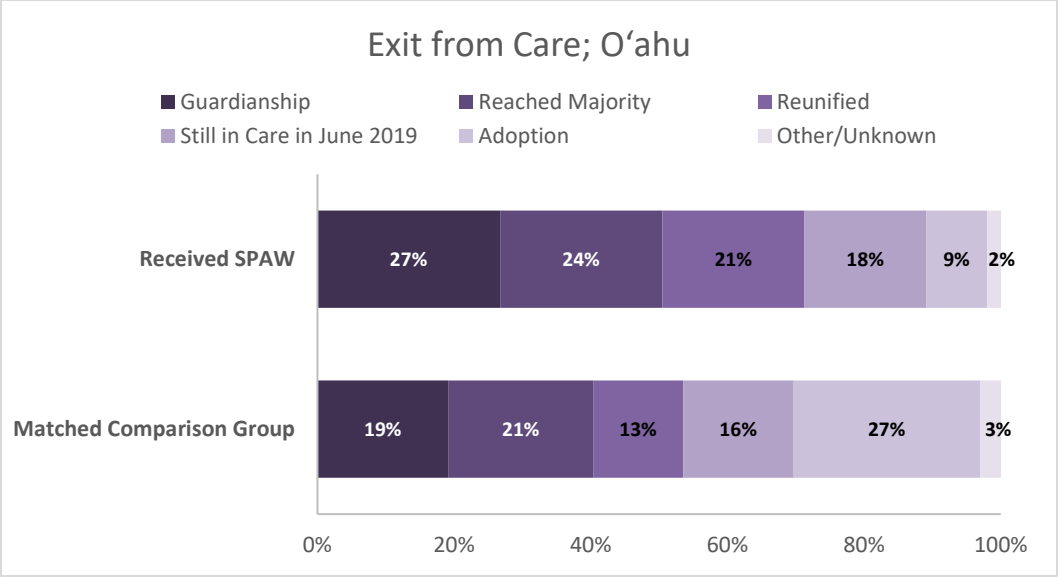


Figure 103. Exit from Care; O‘ahu[4]

Overall chi-square not statistically significant at p<.05

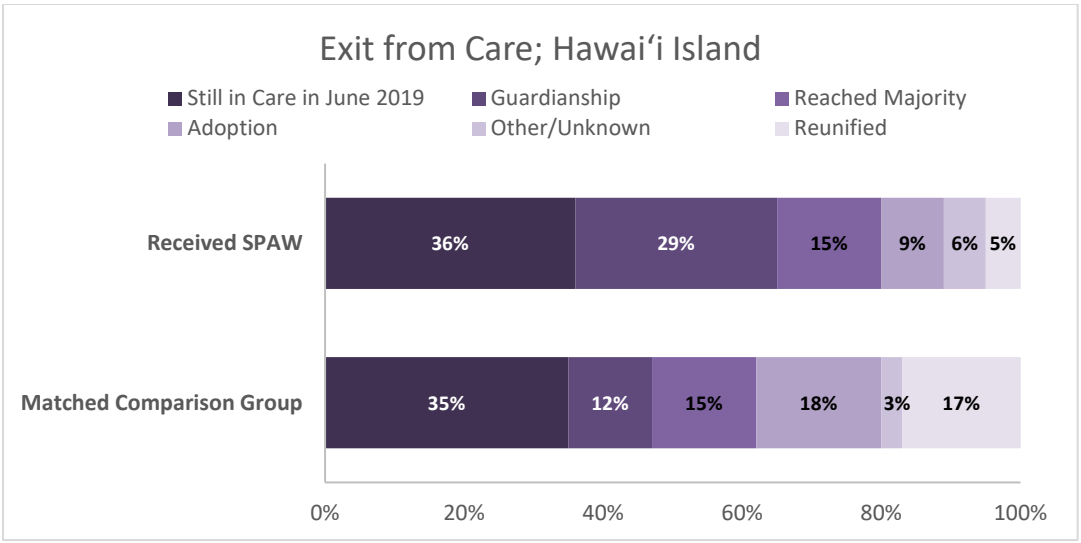


Figure 104. Exit from Care; Hawai‘i Island[5]

Overall chi-square is statistically significant at p<.05

[4] Proportional outcomes for the “Received SPAW” group in Figure 9.40 are slightly different than those in Figure 9.29 due to missing cases in Figure 9.40.

[5] Proportional outcomes for the “Received SPAW” group in Figure 9.41 are slightly different than those in Figure 9.29 due to missing cases in Figure 9.41.

Correlates of Permanency Outcomes Following SPAW

Given that there were no significant differences between O‘ahu and Hawai‘i Island in the characteristics of children served, the characteristics of services delivered, or the outcomes achieved, we combined the children and youth served on both islands to conduct an overall analysis of the child and service characteristics that were associated with permanency outcomes.

For this analysis, the five permanency outcomes of reunification, adoption, guardianship, aging out of care, and still in care on June 30, 2019 were combined into a three-category outcome:

- Reunification (n=21)
- Adoption or guardianship (n=52)
- Aged out of care or still in care on June 30, 2019 (n=83)

The following child characteristics were tested for association with the three categories of permanency above using chi-square and ANOVA:

- Demographics:
    - Child sex
    - Child’s age at SPAW enrollment
- Child’s History:
    - Any history of physical abuse
    - Any history of physical neglect
    - Any history of sexual abuse
    - Child’s age at current removal
    - Child’s age at first removal
    - Is this the child’s first time being in out-of-home care?
    - Duration of current spell[6] in out-of-home care at first SPAW meeting
    - Number of placements prior to current spell
    - Number of spells prior to current spell
    - Number of months in care prior to current spell
- CANS Initial Assessment Domain Scores (n=88)
    - Trauma
    - Life Skills
    - Caregiver Needs
    - Behavioral/Emotional Challenges
    - Youth Risks
- SPAW Service Characteristics
    - Length of SPAW service
    - Number of days between initial case review and SPAW meeting

[6] “Spell” is defined as the period of time between an entry and exit from out-of-home care. A spell can contain multiple “placements,” defined as individual homes/settings that a child experiences while in out-of-home care.

- Number of members attending SPAW meeting
- Initial Permanency Rating
- Final Permanency Rating
- Action Plan % completion
- Was child "re-SPAWed" (received a second SPAW experience)?
- Did child also receive Wrap?

Results

The only significant correlates of permanency outcome are presented in Tables 106 and 107. These tables are presented in row averages (e.g., the average age for those reunified, those adopted/in guardianship, those still in care/aged out) or in row percentages, showing the percentage of children with (or without) a certain characteristic that achieved reunification, adoption/guardianship, or were still in care or aged out of care by June, 2019.

For example, the child's age at the time of the SPAW meeting was highly predictive of permanency outcome. Those who were adopted or exited to guardianship were the youngest at the time of the SPAW meeting (mean age of 8 years old), while those who were reunified were a year older, on average. Those who did not exit to permanency by June 2019 were the oldest, at an average of 13 years old at the time of the SPAW meeting. There were no significant differences in permanency outcomes for boy and girls.

A positive exit to permanency (reunification, adoption, guardianship) was much less likely when the child had a history of physical neglect or physical abuse. Looking at Table 106, when children receiving SPAW were "yes" on having a history of physical neglect only 3% reunified, and only 18% were adopted/in guardianship, while 79% of those with a history of physical neglect either aged out of care or were still in care in June, 2019. The same pattern was true for those with a history of physical abuse, and also true for those with a history of threatened neglect, with slightly better permanency outcomes. Other types of prior maltreatment were not associated with permanency outcomes.

A child's history in out-of-home care was also highly predictive of permanency outcome. Those who exited care to adoption or guardianship were less likely to have had any experiences in care prior to the current placement. Those who did not achieve permanency were more likely to have experienced prior removals, had a higher number of prior placements, and had been in care an average of one year before their current spell in care.

The *CANS* Domain Scores that differed between the three permanency outcomes were the Life Skills Domain and the Youth Risk Domain score. Children who were adopted or exited to guardianship had the lowest Life Skills scores and the lowest Youth Risks scores. However, there is no age adjustment for the Life Skills and Youth Risks Domains, so those children who are older could simply have experienced more skills and risks. Indeed, there was a strong

positive correlation between a child's age and their scores on Life Skills and Youth Risks, and younger children were most likely to exit to adoption or guardianship, so these lower domain scores are probably an artifact of a child's younger age at administration of the *CANS*.

SPAW members created an Initial Permanency Rating at the SPAW meeting, based on set criteria, choosing from a scale from Very Good to Poor. There was a relationship between the Initial Permanency Rating and the child's eventual permanency outcome. Ratings of Very Good or Good were most likely for those children who were adopted or achieved guardianship. However, some of those rated Fair, Marginal, or Poor were ultimately reunified with their families. Similarly, the children for whom a greater proportion of the SPAW Action Plan was completed by members were most likely to be adopted or in guardianship by June 2019.

Eight children who had a SPAW meeting went on to participate in the Wrap process. Four of those children were reunified with their families, and two were adopted.

Table 106

Child Characteristics Associated with Permanency Outcomes

Characteristic	SPAW			
	Permanency Outcome			
	Reunification (n=21)	**Adoption/ Guardianship** (n=52)	**Aged Out/ Still in Care** (n=83)	X^2 or F
Demographics				
Child's mean age at SPAW mtg	9.2	8.0	12.6	F=16.7***
Child's History				
Physical neglect				X^2=15.0***
Yes	3%	18%	79%	
No	17	39	44	
Threat of neglect				X^2=16.7***
Yes	15%	39%	46%	
No	4	7	89	
Physical abuse				X^2=9.8**
Yes	9%	9%	82%	
No	14	38	48	
Is this child's first spell?				X^2=7.1*
Yes	15%	40%	45%	
No	10	23	67	
Child's mean age at first removal	7.2	5.9	9.9	F=12.2***
Mean number of placements prior to current spell	1.4	0.5	1.9	F=5.7**
Mean months in care prior to current spell	9.1	3.8	11.5	F=3.8*
CANS Initial Assessment Score				
Life Skills Score	9.3	3.5	9.5	F=13.7***
Youth Risk Score	4.6	0.9	3.7	F=4.4*

Table 107

Service Characteristics Associated with Permanency Outcomes

Characteristic	SPAW			
	Permanency Outcome			
	Reunification (n=21)	**Adoption/ Guardianship** (n=52)	**Aged Out/ Still in Care** (n=83)	X^2 or F
SPAW Service				
Number of members at mtg	10	8	10	F=16.7***
Initial Permanency Rating				X^2=29.5***
Very Good	0	80%	20%	
Good	0	63	37	
Fair	11%	35	54	
Marginal	18	41	41	
Poor	14	9	77	
Final Permanency Rating				X^2=28.2**
Permanency Achieved	45%	22%	33%	
Very Good	5	52	43	
Good	10	65	25	
Fair	8	33	59	
Marginal	18	25	57	
Poor	7	7	86	
Avg. Action Plan % Completion	59%	74%	52%	F=4.9*
Did child also receive Wrap				X^2=9.8**
Yes (n=8)	50%	25%	25%	
No	11	34	55	

* $p < .05$

** $p < .01$

*** $p < .001$

The Cost Study

Trends in Foster Care and Costs, Pre-Waiver and Waiver Years
Cost of the Waiver Interventions
Summary

Cost Study

Trends in Foster Care and Costs, Pre-Waiver and Waiver Years

The fundamental question underlying the cost study is whether, given the capped allocation and the utilization of foster care over the term of the Waiver, there were any savings that could be redirected to services intended to reduce the use of foster care. Without those savings, it isn't necessary to track the impact of fiscal flexibility on the state's ability to invest in services other than foster care. As we show, the state did increase its investments in services designed to reduce the demand for foster care. However, given the increase in foster care utilization and per diem rates, the revenue needed to support those services would have had to come from sources other than the capped allocation for IV-E foster care maintenance.

We lay out the findings from the cost study as follows. In Table 108, we show the total number of care days provided during the Waiver alongside the capped allocation. We then show how much the capped allocation would have had to grow if the capped allocation had kept pace with the increase in both care days and foster care payments. We focus on room and board payments because those expenditures are relatively easy to isolate from other types of spending and because changes in room and board payments go to central purpose of the Waiver. A reduction in the use of foster care relative to expected utilization (i.e., the level of utilization built into the capped allocation) releases those funds for investment elsewhere in the system.

Room and board costs are a function of total days of care provided and the unit cost paid for each of those days. In turn, the number of days provided is a function of admissions to foster care and the average time spent in care by each of the admitted children. To show how each of these so-called *drivers* of board and maintenance costs affected spending during the Waiver, we provide two related analyses. First, we track the number of children admitted to care and their length of stay. We focus on admissions and length of stay because the Waiver-supported interventions were designed to slow the rate of entry and increase the rate of exit. Our findings indicate that, although rates of admission to foster care among children served by the Waiver-supported interventions were low, there is limited if any evidence that the interventions reduced the number of admissions overall. One could argue that those services slowed the rate of growth, but that does not alter the basic dynamics that connect care days and expenditures in the context of a capped allocation. The capped allocation did not grow at a rate commensurate with the overall change in admissions. We also show that the length of stay for children admitted increased substantially during the Waiver. A piece of this analysis examines the length of stay among the children referred to the interventions meant to reduce length of stay among young people in care at least nine months.

Second, we analyze the cost per day of care provided. At the start of the Waiver (2015), DHS did increase the room and board rates so to some extent the increased costs are attributable to that change. To understand the impact of those changes, we examine how the unit cost increase would have affected spending under two scenarios. The first scenario estimates the cost of board and maintenance given no change in the care days; the second estimates total costs after holding unit costs constant. Viewed from both perspectives, the analysis divides the cost increase into the share tied to the increase in paid days and the portion attributable to the unit cost increase.

We close out the cost study with an overview of spending across all child welfare programs. Hawai'i did increase spending for child welfare services of all kinds including in-home and out-of-home care. We track the source of those increases to the state contribution and other federal sources.

Total Care Days Provided

The central question for Waiver cost studies relates changes in the utilization of foster care to board and maintenance payments, with a particular emphasis on the federal share of the board and maintenance payments. If the days of care provided increase at a rate that exceeds the board and maintenance share of the federal capped allocation, there are no *savings* to redirect. In the section below, we address the first component of this analysis: total paid care days. The analysis of care days incorporates a count of all care days by type of care, which was extracted from a file built from the administrative records used to track admissions to care, length of stay, and type of care provided. Evaluators were not able to isolate care days that were specifically eligible for IV-E reimbursement. As the analysis proceeds, we focus on all DHS paid care days. Other types of care are included in this basic inventory of days provided, but these days are not paid for by DHS.

Total care day utilization, which has increased each fiscal year since FY 2013, reached a peak of 593,539 days in FY 2019, a 42 percent increase in total care day utilization over the number provided in FY 2012 (see Table 108). Changes in care days paid by DHS have increased even more dramatically. In particular, kinship care and foster care both increased by at least 50 percent between fiscal years 2012 and 2019. Although a much smaller component of the total, care days listed as other care days have declined by 24 percent, with three notable exceptions: children and young people on runaway status, children in hospitals, and children in a detainment status.

Table 108

Care Day Utilization by Placement Type and State Fiscal Year

	Pre-Waiver Years			Waiver Years					Change
	2012	2013	2014	2015	2016	2017	2018	2019	FY 12 - 19
Total Number of Care Days	417,761	403,208	406,221	454,472	511,058	555,928	563,611	593,539	175,781
DHS Paid Care Days	375,535	368,590	374,062	423,726	473,923	519,843	529,091	559,476	184,153
Kinship Care	187,288	187,132	195,337	207,360	227,975	252,445	266,858	281,955	94,667
Foster Care	183,698	178,158	175,015	212,768	242,320	263,339	258,205	275,104	91,406
Emergency	4,337	3,242	3,708	3,598	3,628	4,059	4,028	2,417	-1,920
Group Home	212	58	2						
Other Care Days*	42,226	34,618	32,160	30,749	37,135	36,086	34,522	34,064	-8,162
Residential	13,176	10,476	8,449	8,986	10,044	8,039	6,124	6,510	-6,666
Unknown	9,059	4,958	5,886	4,875	5,801	4,795	4,095	5,166	-3,893
Runaway	6,554	7,192	7,361	6,421	8,110	8,303	8,876	8,371	1,817
Other	5,401	3,865	2,609	4,126	5,320	7,397	5,827	4,924	-477
In-Home	4,201	3,025	3,061	1,920	3,537	2,656	3,753	2,896	-1,305
Hospital	2,002	2,528	1,798	1,909	2,492	2,927	3,193	3,938	1,936
Detainment	1,833	2,574	2,996	2,512	1,831	1,969	2,654	2,259	426
Year-Over-Year % Change									
Total Care Days		-3.50%	0.70%	11.90%	12.50%	8.80%	1.40%	5.30%	42%
DHS Paid Care Days		-1.88%	1.46%	11.72%	10.59%	8.83%	1.75%	5.43%	49%
Kinship Care		-0.10%	4.40%	6.20%	9.90%	10.70%	5.70%	5.70%	51%
Foster Care		-3.00%	-1.80%	21.60%	13.90%	8.70%	-1.90%	6.50%	50%
Emergency		-25.20%	14.40%	-3.00%	0.80%	11.90%	-0.80%	-40.00%	-44%
Group Home		NA	NA	NA	NA	NA	NA	NA	NA
Other Care Days*		-21.98%	-7.64%	-4.59%	17.20%	-2.91%	-4.53%	-1.34%	-24%
Residential		-20.50%	-19.30%	6.40%	11.80%	-20.00%	-23.80%	6.30%	-51%
Unknown		-45.30%	18.70%	-17.20%	19.00%	-17.30%	-14.60%	26.20%	-43%
Runaway		9.70%	2.30%	-12.80%	26.30%	2.40%	6.90%	-5.70%	28%
Other		-28.40%	-32.50%	58.10%	28.90%	39.00%	-21.20%	-15.50%	-9%
In-Home		-28.00%	1.20%	-37.30%	84.20%	-24.90%	41.30%	-22.80%	-31%
Hospital		26.30%	-28.90%	6.20%	30.50%	17.50%	9.10%	23.30%	97%
Detainment		40.40%	16.40%	-16.20%	-27.10%	7.50%	34.80%	-14.90%	23%

*Other care days refer to care days provided that are not reimbursed by DHS. These care days are not used to compute the average daily cost. NA – not applicable.

The most significant change in care day utilization occurred as Hawai‘i entered the Waiver. In FY 2015, the first year of the Waiver, total paid days increased by almost 12 percent over the total provided in 2014. The following year, foster care utilization increased again by another 11 percent. Thereafter, the rate of growth year-over-year slowed.

A closer look at care day utilization by state fiscal year and county shows that care day utilization increased substantially in the Waiver counties, including a 10 percent increase in 2015 over 2014 and an additional 14 percent the following year (see Table 109). From 2014-2015, care days increased 24 percent on Hawai‘i Island, then increased another 36 percent from 2015-2016. By comparison, annual care day utilization changed less than 6 percent each year on O‘ahu. Importantly, neither county experienced any reduction in care day use during Waiver implementation, which was the expected direction of change given investments intended to reduce admissions and increase the rate of exit among Long-Stayers. The evidence also indicates that substantial increases were observed on Kaua‘i and Maui, although Maui’s care day utilization did decline in 2016 as compared with 2015. As such it was the only place in Hawai‘i where that was true.

Table 109

DHS Paid Care Days and Year-over-Year Percentage Change by County and State Fiscal Year

	Pre-Waiver Years			Waiver Years				
	2012	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
Total Paid Days	375,534	368,590	374,062	423,725	473,923	519,842	529,091	559,475
Y-o-Y % Change		-2%	1%	13%	12%	10%	2%	6%
Waiver Counties	304,129	301,168	306,853	338,346	384,330	416,015	425,499	457,514
Y-o-Y % Change		-1%	2%	10%	14%	8%	2%	8%
Oʻahu	227,996	226,610	222,318	233,410	241,883	247,468	247,001	268,219
Y-o-Y % Change		-1%	-2%	5%	4%	2%	0%	9%
Hawaiʻi	76,133	74,558	84,535	104,936	142,447	168,547	178,498	189,295
Y-o-Y % Change		-2%	13%	24%	36%	18%	6%	6%
Rest of Hawaiʻi	69,698	65,899	67,209	85,380	88,130	102,421	102,064	101,208
Y-o-Y % Change		-5%	2%	27%	3%	16%	0%	-1%
Kauaʻi	20,290	17,255	17,422	19,472	28,059	32,699	33,092	30,287
Y-o-Y % Change		-15%	1%	12%	44%	17%	1%	-8%
Maui	49,408	48,644	49,787	65,908	60,071	69,722	68,972	70,921
Y-o-Y % Change		-2%	2%	32%	-9%	16%	-1%	3%
Missing (no county ID)	1,708	1,523	1	0	1,463	1,406	1,528	753
% Change		-11%	NA	NA	NA	-4%	9%	-51%

Spending for Board and Maintenance

In the Waiver context, states accept flexibility over the use of federal Title IV-E board and maintenance expenditures in exchange for a capped allocation. Under pre-Waiver terms and conditions, federal funds come to the state on an entitlement basis for board and maintenance. Regardless of the unit cost or the number of paid days, the federal government reimburses states for its share of the cost of care provided to federally eligible children. When the cost of foster care is rising, the entitlement system works well insofar as the federal share rises automatically. However, when states wish to reduce their reliance on foster care, the state forgoes the federal share of the foster care no longer needed. Under the Waiver, the state retains the federal share of the cost of foster care that is not provided. Thus, the Waiver provides a way to use federal resources to support the cost of alternatives to foster care.

A central question for the cost study, then, has to do with how the capped allocation compares with the cost of care given the number of days provided. It is an important question for two reasons. First, because the capped allocation places an upper limit on federal reimbursement for the care provided, the state is placed at financial risk if the cost of care rises at a rate that exceeds the increase in the federal share of those costs. Second, if the state is able to reduce the demand for foster care to a level below the growth assumptions built into the capped allocation, the difference can be directed to the services needed to reduce the demand for the foster care. This is the virtuous cycle the Waiver is intended to spark: spending on services reduces the demand for foster care which generates savings that can be reinvested in the services that reduce the need for foster care.

In Tables 108 and 109, we showed that the demand for foster care, as measured by the number of care days provided, increased in Hawai‘i over the term of the Waiver. On its face, those changes would suggest that the first precondition of the Waiver was not met: care day utilization did not fall during the Waiver. However, before judging the financial consequences of the state’s rising demand for foster care, it is important to consider the growth assumptions built into the capped allocation. This analysis is presented in Table 110.

Three basic pieces of information are provided in Table 110: the cost of board and maintenance per diem payments compiled from state budget documents, the capped allocation for IV-E foster care maintenance negotiated by Hawai‘i, and the paid number of care days from Table 108. Evaluators were not able to isolate care days or per-diem payments that were specifically eligible for IV-E reimbursement. However, based on SFY 2014 the capped allocation was very close to (96% of) the total board and maintenance expenditures going into the Waiver.

In addition, we show how each amount grew over the Waiver years along with two extrapolations. The first shows how the capped allocation would have changed had the capped allocation kept pace with the changes in the cost of care. The second shows how the capped allocation would have changed if the capped allocation had kept pace with changes in care days provided.

As shown, the capped allocation increased by 7.3 percent on average each year of the Waiver. By comparison, the cost of care increased at a rate that was substantially higher (16.1% on average) than the growth built into the capped allocation. As shown, care days also increased over the Waiver at a rate (8.5% on average) that was slightly higher than the capped allocation. When these growth rates are applied to the capped allocation, the results show a widening gap between the capped allocation and the capped allocation needed to maintain a rate of growth commensurate with the change in the cost of care paid out by DHS. Specifically, in SFY18, DHS would have had $472,783 in reserve because the capped allocation grew by 7 percent but the cost of care increased by just 1.5 percent. Care days similarly increased by just 1.8 percent in SFY18, resulting in a surplus of $449,802. However, with the exception of state fiscal year 2018, the cost of care increased at rates that exceeded the growth built into the capped allocation resulting an estimated deficit. Care days also grew more rapidly than the capped allocation in SFY2015-2017, yet this flipped in SFY2018-2019 when the capped allocation grew more than the increase in care days.

In sum, the capped allocation did not keep up with changes in the overall cost of care on a percentage basis. Because the capped allocation did keep pace with costs tied to increases in the number of days provided, changes to the underlying unit costs must account for the basic discrepancy between the overall board and maintenance costs and the capped allocation. We turn to that question later in the *Report*. With that said, the evidence suggests that there was little in the way of surplus federal revenue available to redirect even though the capped allocation grew by roughly 7 percent per year. The reasons why are three-fold: admissions increased, length of stay increased, and the unit cost of care went up because DHS raised the rate paid for each day of care. We cover these changes in the sections that follow.

Table 110

Board and Maintenance Spending over the Title IV-E Waiver Period by State Fiscal Year

	2014 Pre	2015	2016	2017	2018	2019
Cost of foster care – B & M	$6,453,974	$8,649,661	$9,930,123	$10,808,887	$10,968,674	$13,329,376
Capped allocation – B & M[1]	$6,212,856	$6,752,489	$7,116,542	$7,642,088	$8,227,843	$8,846,547
Capped allocation percent of B & M	96.3%	78.1%	71.7%	70.7%	75.0%	66.4%
Paid care days provided	374,062	423,725	473,923	519,842	529,091	559,475
Change in cost of care		34.0%	14.8%	8.8%	1.5%	21.5%
Change in capped allocation		8.7%	5.4%	7.4%	7.7%	7.5%
Change in paid days		13.3%	11.8%	9.7%	1.8%	5.7%
Change in allocation if allocation keeps pace with total cost	$6,212,856	$8,326,513	$7,752,101	$7,746,319	$7,755,060	$9,998,657
Change in allocation if allocation keeps pace with care day changes	$6,212,856	$7,037,733	$7,552,445	$7,939,181	$7,915,187	$8,859,317
Gap between allocation and growth in cost	$0	($1,574,024)	($635,559)	($104,231)	$472,783	($1,152,110)
Gap between allocation and growth in care days	$0	($285,244)	($435,885)	($164,000)	$449,802	$146,190

[1] QPS Quarterly Payment Schedule adjusted for state fiscal years

Admissions to Foster Care

Overall, spending for out-of-home care (i.e., board and maintenance payments) increased during the Waiver as did the number of care days provided. Of course, the two go hand-in-hand if the unit costs do not change. In this section, we consider the reasons why care day utilization increased. To do this, we decompose the care day increase into its constituent parts: the number of admissions and the days each child admitted stayed in care on average.

Table 111 shows the average number of children admitted to foster care for the first time for the pre-Waiver years alongside the same average for the Waiver years. For the state of Hawai‘i as a whole, the average annual number of admissions increased by 11 percent, with a 7 percent increase in Waiver county admissions and a 21 percent increase in the rest of Hawai‘i (i.e., Kaua‘i and Maui). With increases of 32 and 44 percent, the most notable admission changes were in Hawai‘i and Kaua‘i counties, respectively. Of the two Waiver counties, O‘ahu did register a slight drop (-2%) in admissions, which is consistent with the Waiver theory and the investments in CRT and IHBS.

Table 111
Average Number of Children Admitted to Foster Care by County and Waiver Period

	Pre-Waiver Average (2012-2014)	Waiver Average (2015-2019)	Difference as %
State Total	**1096**	**1218**	**11%**
Waiver Counties	886	953	7
Hawai‘i	244	322	32
O‘ahu	642	630	-2
Other Counties	201	243	21
Kaua‘i	44	63	44
Maui	157	180	15

Length of Stay

The time each admitted child spends in care is the second driver of care days. Two Waiver interventions (i.e., Wrap and SPAW) were designed to address length of stay, so one should expect to see a drop in average length of stay, especially for children in care nine months or more. To that end, Table 112 provides a summary of length of stay for children admitted in the years leading up to the Waiver (2012 through 2014) and during the Waiver (2015 through 2019). For the summary, we asked three simple questions: Of all children admitted between the years of 2012-2014 and 2015-2019, how long did it take for the first 25 percent to leave care; the first 50 percent; and, the first 75 percent? The 50th percentile or the median is comparable to the average length of stay. For example, for the state of Hawai‘i, the median duration for children admitted to care during the pre-Waiver years was six months. That means

that one-half the children admitted during those years left within six months; the remaining children were in care for more than six months.

Regarding length of stay, Table 112 shows that children are spending considerably more time in care during the Waiver years than they did in the pre-Waiver years. Focusing on the 50th percentile or the median (the middle panel of Table 112), the median length of stay reported for Hawai‘i and O‘ahu increased by 150 and 208 percent, respectively. The increase on Kaua‘i was more modest (67%) whereas in Maui the median duration actually declined. The first quartile also increased (*How long did it take the first 25% of children to exit care?*) significantly. For the state as a whole, 25 percent of the children who entered care prior to the Waiver (2012-2014), stayed in care for less than two weeks (.4 months). For the Waiver years, the comparable statewide figure is 1.5 months, an increase of 275 percent.

Increases in length of stay in the Waiver counties of Hawai‘i and O‘ahu were more substantial, rising from .5 to 2.9 months (480%) on Hawai‘i Island and from .2 to 1.1 (450%) on O‘ahu. There was also a substantial increase in the 75th percentile duration (*How long did it take the first 75% of children to exit care?*). Prior to the Waiver years, 25 percent of the children admitted on Hawai‘i Island stayed more than 23.9 months (75% percent stayed less than 23.9 months); for children admitted during the Waiver years, the comparable figure reached 32 months, an increase of 34 percent. The increase on O‘ahu (8%) was smaller. The change in the 75th percentile was smaller still in the non-Waiver counties.

Table 112

Placement Duration (in months) by Quartile, Island, and Waiver Period

Quartile Duration	State and Island	Pre-Waiver Average (2012-2014)	Waiver Average (2015-2019)	Difference as %
How long did it take the first 25% of children to exit care?	All State	0.4	1.5	275%
	Waiver counties			
	Hawai‘i	0.5	2.9	480
	O‘ahu	0.2	1.1	450
	Other counties			
	Kaua‘i	1.9	5.6	195
	Maui	2.8	2	-29
How long did it take the first 50% of children to exit care? (i.e., the median?)	All State	6.0	12.0	100
	Waiver counties			
	Hawai‘i	6.0	15.0	150
	O‘ahu	3.6	11.1	208
	Other counties			
	Kaua‘i	9.3	15.5	67
	Maui	10.6	9.7	-8
How long did it take the first 75% of children to exit care?	All State	21.0	24.9	19
	Waiver counties			
	Hawai‘i	23.9	32.0	34
	O‘ahu	21.2	22.8	8
	Other counties			
	Kaua‘i	20.7	21.7	5
	Maui	18.4	19.2	4

The Unit Cost of Care

As shown, the total cost of board and maintenance increased over the Waiver years as did the number of admissions (notwithstanding a slight decline in O‘ahu) and the average time spent in care by children admitted. To further understand the dynamics behind this increase in total board and maintenance costs, our attentions turns now to the cost per day of care.

Table 113 reports the room and board rates as published by DHS. Room and board rates increased in Hawai‘i the year the Waiver was implemented (FY2015), and again in FY2019. Prior to 2015, Hawai‘i had a base monthly rate of $529 or approximately $17.34 per day. Beginning in state fiscal year 2015, the room and board rate was increased and tiered by age group (see Table 113). The magnitude of the increase varied, with the rate paid for adolescents increasing by 27.8 percent. For younger children, the increase was 22.9 percent (6- to 11-year old

children) and 8.9% (for children under the age of 6). In addition, a $570 per month difficulty of care allowance (DOC) was added to what the state reimbursed foster families. Foster families receive the difficulty of care supplement if the young person they are fostering requires more intensive physical, emotional, psychological or behavioral care as determined by a treating professional.[1] The state also added a clothing allowance of $600 per year.

DHS adjusted the rates again in 2019. The monthly rates were increased again so that the increase over what DHS was paying in 2012-2014 was 22.7 percent, 40.3 percent, and 46.7 percent for the age groups 0 to 5, 6 to 11, and 12 and older, respectively. The clothing allowance was also increased and tiered by age group. Finally, although the difficulty of care rate of $4.75 per hour did not change in 2019, the cap of 120 hours per month was waived meaning that families could report more DOC hours.

Table 113
DHS Official Room and Board Rates

		Monthly R & B Rate	Per Diem Rate	Change since pre-Waiver rates (%)
Pre-Waiver				
2012 to 2014	Base	$529	$17.34	-
Waiver				
2015 to 2018	Age 0-5	$576	$18.89	8.9%
	Age 6-11	$650	$21.31	22.9
	Age 12+	$676	$22.16	27.8
2019	Age 0-5	$649	$21.28	22.7
	Age 6-11	$742	$24.33	40.3
	Age 12+	$776	$25.44	46.7

Table 114 shows the total spending on room and board as derived from DHS budget documents. Whereas the board and maintenance figures provided in Table 110 reflect costs across a variety of payment categories including DOC payments, clothing allowance, extended foster care payments, and other costs, the room and board totals in Table 114 refer to the payments based on the per diem payments only. Table 114 also shows the total number of care days provided. These would be the days that were used to drive the overall room and board costs, as reflected in Table 113. The idea behind this presentation is to establish the connection between the days provided and the cost of those days. Notwithstanding, differences in counting rules and other reporting idiosyncrasies, we expect the per diem rate as calculated and the per diem rates reported in Table 113 to be quite close.

As expected, the differences are negligible and likely to due to the fact that the average daily costs found in Table 114 are not adjusted for the age composition of the caseload. Adding care days by age would weight the average daily cost in alignment with the tiered rates introduced

[1] The difficulty of care rate, during this period, was equivalent to $4.75 per hour for up to 120 hours or $570 per month.

in 2015. That said, there is the expected jump in the per diem rate in 2015 as compared to 2014, from $17.25 to $20.41 and again in 2019 to $23.82. Again, these figures are in line with the simple average daily rate reported for the covered years (i.e., the average is not weighted by the size of the population to account for the age-differentiated rates).

Table 114

Average Daily Room and Board Costs for Out-of-Home Placements

	Pre-Waiver			Waiver				
	2012	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
Total R & B Payments	$6,468,361	$6,319,291	$6,453,974	$8,649,661	$9,930,123	$10,808,887	$10,968,674	$13,329,376
Total Paid Care Days	375,535	368,590	374,062	423,726	473,923	519,843	529,091	559,476
Average Daily Cost	$17.22	$17.14	$17.25	$20.41	$20.95	$20.79	$20.73	$23.82
R & B - Foster Care	$3,036,911	$2,897,452	$2,896,525	$4,196,416	$4,970,841	$5,374,921	$5,222,234	$6,368,096
Foster Care Days	183,698	178,158	175,015	212,768	242,320	263,339	258,205	275,104
Average Daily Cost	$16.53	$16.26	$16.55	$19.72	$20.51	$20.41	$20.23	$23.15
R & B - Kinship	$3,362,195	$3,366,619	$3,499,912	$4,388,333	$4,889,400	$5,341,143	$5,672,821	$6,899,604
Relative Care Days	187,288	187,132	195,337	207,360	227,975	252,445	266,858	281,955
Average Daily Cost	$17.95	$17.99	$17.92	$21.16	$21.45	$21.16	$21.26	$24.47
R & B - Emergency	$69,255	$55,220	$57,537	$64,912	$69,882	$92,823	$73,619	$61,676
Emergency Care Days	4,337	3,242	3,708	3,598	3,628	4,059	4,028	2,417
Average Daily Cost	$15.97	$17.03	$15.52	$18.04	$19.26	$22.87	$18.28	$25.52

Expenditure Increase – Care Days or Unit Costs?

As already noted, simple room and board expenditures for out-of-home care in Hawai'i doubled over the course of the Waiver, from $6.5 million in the year before the Waiver started (2014) to more than $13 million in 2019 (see Table 114).[2] As for why expenditures increased, there are two reasonable hypotheses. The first connects the increase to rate adjustments in 2015 when the state bumped the per diem rate upward from roughly $17.25 per day to about $20.79 per day, an increase of about 34 percent. A second increase in SFY 2019 raised the average daily unit cost of care to $23.82, an increase of 13 percent. The second hypothesis links the expenditure increase to the fact that care days provided were also increasing because of rising admissions and longer lengths of stay on the part of children admitted. For example, in 2014, Hawai'i provided 374,060 paid care days. The following year (2015) the state provided 423,726 days of paid care, for an increase of just over 13 percent.

On the basis of this comparison it is, perhaps, reasonable to conclude that the cost increases over the period of the Waiver were the result of rate adjustments on balance. However, after the initial rate increase, the unit cost of care remained stable while the cost of care continued to rise, an outcome that is only possible if the number of days provided is also rising. To unpack the relative contribution of rate versus care day increases as factors driving the overall expenditure increase, we developed two simple models intended to further isolate the rate and care day increases.

In the first model, we held the care days (approximately) constant.[3] That is, for the Waiver years (2015 through 2019), we assumed that the number of care days remained at a level commensurate with the average of the preceding three years. That assumption is consistent with what was observed between 2012 and 2014, when the number of care days hovered around an average of about 372,000 days. In the projection, we *assume* that care days fluctuate within a narrow band around 372,000 days. With that assumption in place, we varied the unit cost according the payment schedule put in place. Specifically, we estimate the unit case increased from $17.25 in 2014 to $20.79 in 2015 where it remained through 2018 then

[2] On a percentage basis, the room and board increase was a bit higher than the reported increase for all board and maintenance-related expenditures. The latter category includes DOC allowance, adoption assistance payments and a host of other costs often, but not necessarily related to the cost of providing foster care. For that reason, in this section, we focus on room and board as the least ambiguous measure of what it cost DHS to provide placements for children. Of course, the total costs are higher, given the DOC and clothing allowances plus other add-ins. Nevertheless, the room and board costs provide a reasonable way to assess the care day/cost dynamics at work over the eight years from 2012 through 2019.

[3] To set the care day projection, we used the simple three-year moving average. That is, the 2015 care day count was the average of three preceding years. We repeated that process for 2016, 2017, and 2018. Thus, the estimate for 2016 was based on 2013, 2014, and 2015. We also replicated that approach for the model that held the unit cost constant.

increased to $23.82 in 2019.[4] For the second model, we reversed the strategy: we held the unit cost constant at the pre-Waiver level ($17.25) throughout the Waiver time period and allowed the care days provided to increase as observed in the administrative data. In the end, when the actual expenditures are compared with the expenditures from the two models, we can make a more reasoned judgment as to why costs increased over the course of the Waiver.

The results of this analysis are presented in Table 115, which is structured as follows. The actual (or observed) information is found in the first panel, which includes total expenditures, actual paid care days, the unit cost paid, and the year-over-year changes in expenditures and paid care days. These are all sourced from prior tables. The second panel of information shows the results from the two models. The specific assumptions adjusted in each model are found in the shaded rows. The first set shows how expenditures would have changed if the number of care days had remained relatively constant and the unit cost increased as it did. The second set shows how expenditures would have increased if the unit cost had been left at pre-Waiver levels and the care days increased as they did. The remaining rows summarize the changes, showing actuals versus the model results. Together, the results provide a way to better understand why total room and board expenditures increased.

[4] The unit cost was calculated by dividing total care expenditures by the number of paid care days provided. As in prior examples, the total number of paid care days is based on DHS paid days (see Table 10.1) for the categories: kinship care, foster care and emergency care.

Table 115

Room and Board Expenditures, Paid Days, and Unit Costs by State Fiscal Year and Projection Models

	Pre-Waiver Years			Waiver Years				
	2012	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
Actual								
Expenditures ($)	$6,468,361	$6,319,291	$6,453,974	$8,649,661	$9,930,123	$10,808,887	$10,968,674	$13,329,376
Care days (Days)	375,535	368,590	374,062	423,726	473,923	519,843	529,091	559,476
Unit cost	$17.22	$17.14	$17.25	$20.41	$20.95	$20.79	$20.73	$23.82
Y-o-Y change $		-2.3%	2.1%	34.0%	14.8%	8.8%	1.5%	21.5%
Y-o-Y change Days		-1.8%	1.5%	13.3%	11.8%	9.7%	1.8%	5.7%
		-0.46%	0.58%	18.32%	2.65%	-0.76%	-0.29%	
Projected								
Care days constant	375,535	368,590	374,062	372,638	371,743	372,814	372,399	372,319
Unit cost (actual)	$17.22	$17.14	$17.25	$20.41	$20.95	$20.79	$20.73	23.68
Expenditures	$6,468,361	$6,319,291	$6,453,974	$7,606,791	$7,789,152	$7,751,770	$7,720,257	$8,816,506
Y-o-Y change unit cost		-0.5%	0.6%	18.3%	2.6%	-0.8%	-0.3%	13.9%
Y-o-Y change $		-2.3%	2.1%	17.9%	2.4%	-0.5%	-0.4%	13.9%
Care days (actual)	375,535	368,590	374,062	423,726	473,923	519,843	529,091	559,476
Unit cost constant	$17.22	$17.14	$17.25	$17.21	$17.20	$17.22	$17.21	$17.21
Expenditures	$6,468,361	$6,319,291	$6,453,974	$7,293,054	$8,153,492	$8,953,399	$9,107,288	$9,630,561
Y-o-Y change unit cost		-0.5%	0.6%	-0.2%	0.0%	0.1%	-0.1%	0.0%
Y-o-Y change $		-2.3%	2.1%	13.0%	11.8%	9.8%	1.7%	5.7%
Projected costs								
Actual	$6,468,361	$6,319,291	$6,453,974	$8,649,661	$9,930,123	$10,808,887	$10,968,674	$13,329,376
Care days constant	$6,468,361	$6,319,291	$6,453,974	$7,606,791	$7,789,152	$7,751,770	$7,720,257	$8,816,506
Unit cost constant	$6,468,361	$6,319,291	$6,453,974	$7,293,054	$8,153,492	$8,953,399	$9,107,288	$9,630,561
Difference in expend.								
Actual	$0	$0	$0	$0	$0	$0	$0	$0
Care days constant	$0	$0	$0	$1,042,870	$2,140,971	$3,057,117	$3,248,417	$4,512,870
Unit cost constant	$0	$0	$0	$1,356,607	$1,776,631	$1,855,488	$1,861,386	$3,698,815
Difference as % of actual								
Actual	NA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Care days constant	NA	0.0%	0.0%	13.7%	27.5%	39.4%	42.1%	51.2%
Unit cost constant	NA	0.0%	0.0%	18.6%	21.8%	20.7%	20.4%	38.4%
Difference in expend. Y-o-Y								
Actual	NA	($149,070)	$134,683	$2,195,687	$1,280,462	$878,764	$159,787	$2,360,702
Care days constant	NA	($149,070)	$134,683	$1,293,177	($18,605)	$22,255	($8,635)	$1,074,339
Unit cost constant	NA	($149,070)	$134,683	$839,080	$860,439	$799,906	$153,889	$523,274

Starting with the model that holds care days constant, there was a one-time 20.5 percent increase in the unit cost in 2015 as compared to the 2014. As a result, total expenditures increased, as expected, by a commensurate amount. The increase in total expenditures was slightly lower because the projected care days (based on a three-year moving average) dipped slightly in 2015 as compared to 2014. After 2015, because the care days and the unit cost both remain relatively stable, total expenditures fluctuate around $7.7 million. As such, this is the increase in cost of each care day.

In contrast, results derived from the model that holds rates paid at pre-Waiver levels along with the observed number of care days shows a 13 percent increase in expenditures between 2014 and 2015, a change that is below the expenditure change attributed to the unit cost adjustment that happened in 2015. From that comparison, 2014 and 2015, one can conclude that the impact of the rate change was larger than the impact from the increased number of care days provided. In concrete terms, actual expenditures in 2015 were $8.65 million. If the care day total had stayed roughly the same, the unit cost increase would have resulted in total expenditures of $7.75 million, a difference of about $900 thousand. If the unit cost had stayed the same, the increase in care days provided would have resulted in total expenditures of $7.3 million, which is less than the increase attributable to the unit cost change. For 2015, then, one can say the unit cost change was the more important factor underlying the jump in total expenditures for out-of-home care.

For subsequent years, the narrative flips. That is, from 2016 through 2018, the driver of the cost increase was the change in the number of care days provided. For example, from 2016 to 2017, the observed cost increase was about $878 thousand. Had the care days been held constant, the difference in total expenditures would have been negligible ($22,255) and only because of the slight variation in care days and the constant daily rate. Had the rate paid in 2017 been held to the pre-Waiver level (approximately $17.21), then the increase in days provided would have pushed total expenditures up by $799,906, which is close to the observed change. In other words, the change in overall expenditures for the years 2016, 2017, and 2018 was prompted by the change in care days rather than the rate change induced in 2015. The rate increase was important, but the impact was for all intents and purposes a factor in the transition year, from 2014 to 2015. In SFY 2019, the narrative flips again, when the average per diem reimbursement was increased, pushing the cost of care higher than the increase that foster care utilization would account for by itself.

Cost of the Waiver Interventions

The Waiver program is predicated on the idea that states use more foster care than necessary to meet the needs of children and families. Over-utilization arises when more children are admitted to care than necessary because preventative services aren't available, children linger too long in foster care because the services to help families get back on their feet aren't available, children spend too much time at higher levels of care because well-trained foster families are in short supply, or some combination of the foregoing. The Waiver program is also predicated on the idea that the cost of providing services that reduce admissions to care, shorten length of stay, and/or reduce the need for costly high-end care will fit within what would have been the cost of providing foster care by itself. This latter point speaks to the issue of cost neutrality: investments in alternatives to foster care plus the foster care ultimately provided will equal the cost of foster alone given the reductions in foster care induced by the investments made by the state.

Within this context, the cost of the alternatives to foster care, their expected impact on foster care utilization, and any observed changes in foster care utilization are linked considerations that help judge how close the Waiver came to meeting the underlying expectations. In an earlier section, we established that overall utilization of foster care did not decline because both admissions and length of stay increased. Given the increase in the capped IV-E allocation increased by 7.5 percent per years on average, the cost of a foster care increase was built into the fiscal underpinnings. Put another way, if foster care utilization had not increased, the capped allocation would have provided substantial support for the service alternatives provided by DHS. However, as it turned out, by our estimate, the capped allocation probably cost the state federal reimbursement in the latter years of the Waiver because the increase in care days provided exceeded the growth built into the capped allocation.

Although the foster care population grew more quickly than the capped allocation did, knowing the cost of interventions provided adds a layer of usable insight as it pertains to adding service capacity and what might be gained from that added capacity in the way of expected benefits. As already described, DHS invested in four Waiver-supported interventions. CRT and IHBS targeted admissions to care whereas Wrap and SPAW targeted the length of time spent in foster care. There is some very modest evidence that admissions to foster care were affected by CRT and IHBS but the impact was small because the programs were not large enough to have a population-level effect of the sort needed to generate system-wide savings. The evidence of an effect of Wrap and SPAW on length of stay is even thinner. Again, the main issue is one of scale. There were simply too few cases served to generate a reduction in foster care utilization at the system level.

Looking ahead, DHS still has to manage investments in alternatives to foster care with the hope that those investments will pay-off as a measurable reduction in the use of foster care. If that happens, then savings induced by those investments help underwrite the cost of the interventions. For that reason, given the limitations of the financial data, we want to isolate

the cost of the Waiver interventions so that DHS has a firm grasp on what it takes to generate reductions in the use of foster care. Importantly, though the total budget commitment for child welfare services is a concern for state budget offices, states are not obliged to operate in a cost neutral way when it comes to investments in services for children at home. The cost of those services along with the expected benefit helps states understand their bottom-line financial commitment to vulnerable children and families.

Reducing Admissions to Foster Care

DHS invested in two interventions designed to reduce admissions to foster care: The Crisis Response Team and Intensive Home-Based Services. The CRT was embedded within the CPS operations of the DHS; IHBS relied on private agencies as the service provider. Because the delivery mechanism differed, accounting for costs differs as well. For CRT, we had to rely on time use estimates acquired through a survey in combination with the average hourly rate for the staff involved. IHBS costs were wrapped up in contracts with provider agencies. Because the IHBS costs were added to existing contracts used to support a range of services it is difficult to pinpoint the exact cost of IHBS services. Details of how we approached the cost estimates follow.

Crisis Response Team

For the CRT, we divided the cost estimate into two components: the amount of time spent on CRT-related activities and the unit cost of that time based on the average annual salary of the staff charged with CRT-related functions. Time use estimates were based on surveys sent to the 24 CRT team members on O'ahu and the 25 staff on Hawai'i Island who were identified as associated with CRT (see Chapter 10 Appendix). Table 116 below summarizes the number of full- and part-time staff along with their hours spent on the CRT.

Table 116
Combined Staffing and Cost Estimates for the Crisis Response Team

		Total Staff	Fulltime	Part time	Avg PT hrs./week	% FTE	Total FTE	Avg. Salary	Annual Cost
Hawai'i	Supervisors	4	0	4	3.50	0.09	0.35	$66,000	$23,100
	Direct Service	14	0	14	11.00	0.28	3.85	$54,000	$207,900
	Assistant	5	0	5	8.30	0.21	1.04	$42,000	$43,575
	Leadership	2	0	2	3.00	0.08	0.15	$82,000	$12,300
	Total	25	0	25			5.39		$286,875
O'ahu	Supervisors	2	1	1	4.00	0.10	1.10	$66,000	$72,600
	Direct Service	14	5	9	22.00	0.55	9.95	$54,000	$537,300
	Assistant	7	5	2	24.00	0.60	6.20	$42,000	$260,400
	Leadership	1	0	1	3.00	0.08	0.08	$82,000	$6,150
	Total	24	11	13		0.00	17.33		$876,450

The number of total staff is based on the CRT staff roster as of February 2018. On O'ahu, an existing DHS unit was converted to a CRT team resulting in a full-time team of one Supervisor, five direct service Social Workers, four Social Service Assistants, and one Secretary.[5] The remaining staff on O'ahu are on the CRT part-time, and their average hours spent on CRT activities are based on survey responses from staff in those positions. All staff on Hawai'i Island are considered part-time on the CRT as they have other responsibilities. The number of full and part time FTEs are added together to arrive at a total FTE for each title, then multiplied by the average salary for that title to calculate an annual cost. Average salary information is publicly available on the DHS website, and the salary levels used are approximate salaries for nonsupervisory and supervisory employees in white collar positions for SFY 2019.[6]

Based on these results, the CRT costs approximately $286,875 annually to staff on Hawai'i Island and $876,450 on O'ahu. Regarding the total cost of operation over the term of the Waiver, estimates are a bit more difficult given when CRT was implemented in full. Based on the implementation study, we estimate that CRT was fully staffed on Hawai'i Island for 3.5 years and 4 years on O'ahu. When those estimates are multiplied by the estimated annual operating cost, the gross cost of CRT was $4.51 million, as show in Table 117 below.

Table 117
CRT Estimated Costs

	Annual Cost	Years Fully Staffed	Total
Hawai'i	$286,875	3.5	$1,004,063
O'ahu	$876,450	4	$3,505,800
Total			**$4,509,863**

Intensive Home-based Services (IHBS)

In contrast to how CRT was implemented, IHBS services were managed through contracts with the private sector. On the one hand, the funds allocated through the contract are relatively easy to track through contract and vendor numbers (see Methodology chapter). On the other, because the contracts with IHBS vendors support other services, the amount of those contracts set aside specifically for IHBS could only be estimated by DHS. Those estimated costs are found in Table 118 below.

[5] Information provided by Mimari Hall in January 2016. It is important to note that the CRT team retains some essential CPS functions. Among other things, that means CRT-related duties account for a portion of total time spent on the job. The cost of CRT reflects the added duties rather than 'whole' positions.
[6] https://dhrd.Hawai'i.gov/state-hr-professionals/class-and-comp/salary-schedules/bu-03-white-collar-non-supervisor-bu-04-white-collar-supervisor/

The total cost for IHBS services is estimated to have been $4.44 million over the entire Waiver period, with about two-thirds of the five-year total having been spent on O'ahu. Year-over-year growth in the funding was uneven after the initial infusion of funds between 2015 and 2016. Specifically, from 2017 to 2018 the estimated budget for IHBS increased by 34.7 percent, with the largest increase on Hawai'i Island (54.5%). Between 2018 and 2019, budget growth declined to 8.5 percent overall.

Table 118
Estimated Expenditures for IHBS Services by Fiscal Year

	2015	2016	2017	2018	2019	Total
Total	$283,181	$848,471	$868,193	$1,169,380	$1,268,554	$4,437,779
IHBS-Hawai'i	$0	$280,221	$336,222	$519,387	$537,127	$1,672,957
IHBS-O'ahu	$283,181	$568,250	$531,971	$649,993	$731,427	$2,764,822
Percent of Total						
IHBS-Hawai'i	0.0%	33.0%	38.7%	44.4%	42.3%	37.7%
IHBS-O'ahu	100.0%	67.0%	61.3%	55.6%	57.7%	62.3%
Year-over-Year Change						
Total		199.6%	2.3%	34.7%	8.5%	
IHBS-Hawai'i		NA	20.0%	54.5%	3.4%	
IHBS-O'ahu		100.7%	-6.4%	22.2%	12.5%	

Reducing Time Spent in Out-of-Home Care

To address how long children spend in care, DHS invested in Wrap and SPAW services by contracting with private agencies. Both programs targeted children in care for more than nine months, with the expectation that Wrap and SPAW services would increase the likelihood of exiting care to permanency. Much like IHBS services, the fact that SPAW and Wrap services were purchased from private agencies means the cost of the services are a bit easier to identify, although not entirely so. In addition, the contracts were structured in such a way that disaggregating by island was not possible.

The funds set aside for Wrap and SPAW services through the contractual mechanisms are displayed in Table 119. As with IHBS, there was an infusion of funds as the Waiver transitioned from 2015 to 2016. There was a second infusion of funds from 2016 to 2017 but then a pull-back in funding in 2018 of about 17 percent more or less evenly divided by Wrap and SPAW. Funds were reduced again by one percent in 2019, although support for Wrap services did rise in the final year of the Waiver but only to a level commensurate with spending in 2016.

Table 119

Estimated Expenditures for Contracted Waiver Interventions by State Fiscal Year

	2015	2016	2017	2018	2019	Total
Total	$59,682	$866,702	$1,093,739	$904,326	$894,384	$3,818,832
Wrap	$0	$521,820	$613,583	$513,274	$527,420	$2,176,096
SPAW	$59,682	$344,882	$480,156	$391,052	$366,964	$1,642,736
Percent of Total						
Wrap	0.0%	60.2%	56.1%	56.8%	59.0%	57.0%
SPAW	100.0%	39.8%	43.9%	43.2%	41.0%	43.0%
Year-over-Year Change						
Total		1352.2%	26.2%	-17.3%	-1.1%	
Wrap		NA	17.6%	-16.3%	2.8%	
SPAW		477.9%	39.2%	-18.6%	-6.2%	

Cost Per Child

Total spending over each of the interventions provides a general sense of what it cost to mount programs intended to reduce the utilization of foster care in the manner described previously. Adding the number of children and families touched by those resources provides a more precise way to estimate cost. These data, which are displayed in Table 120, were used to compute the average cost per child served by each program.

When program expenditures are combined with the number of children served (see Table 120), the results indicate that the interventions selected by DHS were expensive to operate. On Hawai'i Island, the IHBS cost was $10,521 per child compared to $7,071 on O'ahu. Wrap ($12,434) and SPAW ($8,338) services were also expensive to operate.

Regarding the benefits associated with the interventions (i.e., averted placement costs), the cost of Wrap and SPAW appear to have exceeded the savings from reduced foster care, given the evidence that suggests there was no reduction in length of stay to offset the cost of the intervention. As for CRT and IHBS, the cost relative to the benefit is a more complicated matter. There is no ambiguity surrounding services delivered to children in foster care. A reduction in length of stay is a reduction in the cost of foster care. In the case of prevention, a benefit measured as averted placement days is harder to compute. The essential question from a cost perspective is the expected placement rate. From the implementation study, we know the IHBS population was at-risk, but we cannot say with certainty what the placement rate would have been in the absence of the program. Prevention programs often have to contend with a *widening of the net effect* that expands the referred population to include families that stand to benefit from the services provided but whose children are not, when all is said done, candidates for foster care. In terms of risk modeling, this is the problem of false positives. To maximize the benefit of a prevention program, serving everyone at risk maximizes

the benefit. However, that same strategy maximizes the cost because of the large number of families served whose children would not have been placed. Families in that situation gain the benefit of the services provided but those services do not reduce placements. In summary, for CRT and IHBS, to judge the cost of providing those services relative to the expected benefit, we need to know the cost per placement averted and the average length of time spent in foster care associated with those averted placements. Those figures are not available.

Table 120
Estimated Per-Child Costs of Waiver Interventions

	Total Expenditures SFY 2015-2019	Total Child Cases[7]	Average Cost per Case
CRT-Hawai'i	$1,004,063	484	$2,074.51
CRT-O'ahu	$3,505,800	1967	$1,782.31
IHBS-Hawai'i	$1,672,957	159	$10,521.74
IHBS-O'ahu	$2,764,822	391	$7,071.16
Wrap	$2,176,096	175	$12,434.83
SPAW	$1,642,736	197	$8,338.76
Total	$12,766,474		

Summary

Waivers are meant to increase state investments in preventive services. The Waiver accomplishes this goal by making it easier to invest the federal share of room and board payments into preventive services. The intended cycle is a virtuous one. Preventive services paid for with federal dollars matched by local dollars reduce the demand for foster care. The lower demand increases the pool available for investment in preventive services which triggers more savings against the projected demand. There is, of course, a limit to how low the demand for foster care will likely go, but if that limit is reached, the system will at that point have a better blend of preventive services investments relative to the cost of foster care. Waivers are meant to bring social policy, which favors keeping young people out of foster care, and fiscal policy--which incentivizes out-of-home care through the per diem reimbursement mechanism -- into closer alignment. The opportunity to reinvest board and maintenance payments into preventive services is the trigger.

Whether states are able to engineer such a transition is one reason the federal Waiver program was launched as a demonstration program. Total demand for foster care lies outside the absolute control of a state. This means the projected demand used to drive the capped allocation and the actual demand may fall out of sync. For example, as we have seen across the

[7] Total Child Cases is children served in the first four years of the Demonstration. Expenditures in Table 10.13 are for five fiscal years, but there was very little Waiver-specific spending in SFY2015.

US, the demand for foster care increased as the localities struggled to address the use of opioids by parents raising children. When this happens, if actual demand exceeds the projected demand, the capped allocation that is integral to the Waiver idea turns less desirable, relative to pre-Waiver business as usual. If, however, states are able to engineer a reduction in foster care utilization relative to what the capped allocation accommodates, states can retain the difference and use the balance to invest in services. The Waiver Demonstrations test this idea.

In our analysis, we set out to determine how the state's capped allocation squared up against the actual utilization of foster care. To do this, we focused on the number of children admitted to foster care, their length of stay, and the unit cost of their care. Each of these is a fundamental driver of what it costs to provide foster care. Against the capped allocation, we were looking to determine whether the cost of board and maintenance as reported by DHS dipped below the board and maintenance set aside within the capped allocation. If such a gap could be identified then there is reason to check whether the fund balance (after taking the room and board deductions) was converted into an investment in preventive services.

As it turns out, on the whole (i.e., with minor exceptions), admissions to care increased, length of stay increased, and the state of Hawai'i increased the daily rate paid to foster caregivers. Relative to the capped allocation for foster care maintenance, which increased by about 7 percent on average each year, the cost of providing care increased more rapidly. Specifically, the net shortfall in the capped allocation through state fiscal year 2019 stands at nearly $3 million (see Table 110, *gap between capped allocation and growth in cost*). In FY 2018, the difference was favorable (i.e., after paying for foster care, there was about $470,000 left in the capped allocation). However, for all other years during the demonstration, the capped allocation did not keep pace with the increase in costs overall. The biggest shortfalls came in state fiscal years 2015 and 2019 when the state increased the daily rate used for reimbursing foster families. These increases coincided with upticks in the number of days reimbursed. For those two reasons, the capped allocation shortfall reached about $1.6 million SFY 2015 and $1.2 million in SFY 2019. The state of Hawai'i did in fact increase their spending on preventive services during the Waiver period, but did so, by all accounts, without a substantial contribution from the capped allocation for foster care maintenance.

Implications for Hawai‘i under the Family First Prevention Services Act (FFPSA)

The Nature of Child Maltreatment in Hawai‘i
Correlates of Child Removal Following a Crisis Response
Some Implications for Future Planning

IMPLICATIONS FOR HAWAIʻI UNDER THE FAMILY FIRST PREVENTION SERVICES ACT

In the final year of the Waiver Demonstration, the State of Hawaiʻi began to plan for the transition to the new federal regulations for child welfare services under the Family First Prevention Services Act (FFPSA). Under FFPSA, each state is required to develop a prevention services plan for the state, and those prevention services must be provided to "candidates for foster care," i.e., those at imminent risk of entering foster care for whom prevention services could keep them safely at home. Each state can define for itself who the "candidates" are, i.e., those in the state who are at risk of placement into foster care. Following the definition of "candidates," the state develops a prevention plan by identifying the types of services, including evidence-based services, that the state will use to serve families in their efforts to keep children safe while preventing placement where possible.

Hawaiʻi Child Welfare Services does not currently have a systematic assessment of imminent risk of placement into foster care. This makes identification of candidates difficult. However, Hawaiʻi Child Welfare Services does have assessments of safety factors and precipitating conditions for those reported for child maltreatment.

This evaluation of the Waiver Demonstration on Oʻahu and Hawaiʻi Island, specifically the Crisis Response Team, illuminates which of those safety factors and precipitating conditions are most common among children and families touched by the child welfare system, contributing to a discussion of current "candidate" populations.

The analysis of the placement outcomes for children who received a Crisis Response is also illuminating regarding (1) the differences in child maltreatment populations that are referred by law enforcement, schools, and hospital sources, and (2) the types of risk factors that are currently most predictive of child placement on Oʻahu and Hawaiʻi Island.

The Nature of Child Maltreatment in Hawaiʻi

Every year, the State of Hawaiʻi publishes an annual statistical report on the scope and nature of child maltreatment reports from the prior year (see State of Hawaiʻi DHS, *Child Abuse and Neglect Report* at www.humanservices.hawaii.gov/reports). From the most recently published *Report* (2017), the threat of harm (abuse or neglect) is the most predominant type of maltreatment reported to Hawaiʻi Centralized Intake, with reports of the threat of harm being seven times as frequent as reports of physical abuse or physical neglect, and fifteen times that of reports of sexual abuse. The highest confirmation rates of child maltreatment in Hawaiʻi are

for threatened harm (35%) and child neglect (35%), while the confirmation rates for sexual abuse and physical abuse are lower, at 28% and 23%, respectively.

There are important differences in child maltreatment reports between the more populous Oʻahu, and the more rural Hawaiʻi Island. Reports of physical abuse outnumber reports of neglect on Oʻahu, while the pattern is reversed on Hawaiʻi Island. However, the confirmation of neglect is much more likely than the confirmation of physical abuse, regardless of where the child lives (DHS, 2017). For example, on Oʻahu, the confirmation rates for neglect and abuse are 34% and 22%, respectively, and on Hawaiʻi Island, the confirmation rates for neglect and abuse are 33% and 19%, respectively.

There is evidence in the research literature on child abuse that the incidence of physical abuse in the general population of U.S. children has been declining, while the incidence of neglect has held steady (Sedlak, *et al*, 2010). Possible explanations for a decline in child physical abuse are increased public education efforts about preventing physical abuse and safe discipline practices.

While physical abuse is largely a result of the commission of an act (abuse), child neglect is an act of omission (not adequately caring for the child). More than physical abuse, child neglect is often associated with deprivation of both parents and children; parents living in social isolation, in poor housing conditions, with lack of access to medical care, lack of adequate supervision of children in parents' absence, and parents having mental or developmental challenges. Many of these circumstances and conditions occur most for those living with income insufficiency.

While the poverty rate in the US has been slightly decreasing for the past four years, the poverty rate in Hawaiʻi remains above the national average (Fox, 2019). The only population in the US for whom poverty is worsening is adults, aged 25 and over, without a high school diploma. Without substantial improvements in the financial conditions of families in the US and Hawaiʻi, there is little reason to expect that the incidence of child neglect will decline. This population remains at risk for reports of child maltreatment and possible child removal.

Incidence of Risk and Safety Factors in Child Maltreatment Reports in Hawaiʻi

This evaluation of the Waiver Demonstration examined the risk and safety factors present in children referred to the Crisis Response Team. Under the Waiver Demonstration, the Crisis Response Team was instituted to respond, within two hours, to reports from law enforcement, hospitals, and schools where the child was judged to be at imminent risk of removal. Experienced CRT caseworkers then made an assessment of risk and safety factors. An analysis of the children disposed by Intake to the CRT, and thus with completed assessments, provides empirical data on the most common risk and safety factors among this population.

Precipitating Factors

Precipitating factors are those conditions and circumstances that are considered to contribute to the maltreatment under investigation. On both Oʻahu and Hawaiʻi Island (see Table 121), the most common precipitating factors identified at intake were unacceptable child rearing practices, an inability to cope with the responsibilities of parenting, a parent's lack of tolerance of child behavior, a loss of control during discipline, and drug abuse in the household.

What is notable about the assessments done at Centralized Intake is that the majority of intakes on child maltreatment on Oʻahu and Hawaiʻi Island disposed to a Crisis Response cite the same five precipitating factors. In a list of 22 possible precipitating factors, only these five factors (and only four factors on Hawaiʻi Island) are identified for more than ten percent of children identified as a victim of maltreatment: unacceptable child rearing practices, an inability to cope with the responsibilities of parenting, a parent's lack of tolerance of child behavior, a loss of control during discipline, and drug abuse in the household. The preponderance of risk factors thus identified at Intake focus on problems with parenting, with the additional risk factor of substance abuse by the parents or in the household.

Centralized Intake Unit personnel seldom indicate the presence of parental mental illness, domestic violence, insufficient income, or hazardous living conditions as a precipitating factor for children referred to the CRT. These were rare for those children disposed to the Crisis Response Team, even though those disposed to CRT were considered at imminent risk of removal. These factors were rarely indicated as precipitating factors for all child maltreatment victims in Hawaiʻi (DHS, 2017), as well.

Table 121

Precipitating Factors Among Those Referred to the CRT

Precipitating Factors[a]	**CRT**	
	O'ahu (n=1166 victims)	**Hawai'i Island** (n=337 victims)
Unacceptable child rearing practices	63%	29%
Inability to cope with parenting	37	26
Lack of tolerance of child behavior	19	12
Loss of control during discipline	18	7
Drug abuse	14	17
Spouse abuse/fighting	9	8
Mental health problem	9	8
Alcohol abuse	7	3
Heavy/continuous child care responsibility	7	2
Inadequate housing	6	4
Family discord	5	9
Police/court record (not traffic)	3	5
Broken family	2	9
Chronic family violence	2	7
Parental history of abuse	2	4
New baby in home	1	4
Recent relocation	1	2
Incapacity due to handicap/illness	1	1
Insufficient income	1	1
Social isolation	0	1
Mental retardation	0	1
Normal authoritarian discipline	0	1

[a]Multiple response

Safety Factors

At the time of the disposition to CRT, if the child was said to be at risk of harm, the Intake Unit also indicated which of 15 safety factors existed for the child, and could indicate more than one. Safety factors are those circumstances and conditions that are a threat to the child's ongoing safety. Among those children disposed to the Crisis Response Team from 2015-2018, most had multiple safety factors indicated at Intake.

Safety factors for children at risk were similar between Oʻahu and Hawaiʻi Island (see Table 122). Several factors were indicated for more than 15% of those referred on either island, and included severe/present/impending danger to the child, caregiver violent behavior, parent impulsivity, inadequate supervision, parental substance abuse, inability to meet the immediate needs of the child, and the child being fearful of harm.

The safety factors of severe danger, caregiver violent behavior, parent impulsivity, and the child being fearful of harm are considered by many to be associated with physical abuse, while inadequate supervision, drug abuse in the household, and inability to meet the immediate needs of the child are frequent correlates of child neglect.

Table 122
15 Safety Factors from Intake Tool

Safety Factors among those at risk of future harm[a]	**CRT**	
	Oʻahu (n=1654)	**Hawaiʻi Island** (n=400)
Caregiver violent behavior	33%	36%
Severe/present/impending danger	33	29
Parent impulsivity	32	32
Inadequate supervision	20	26
Parental substance abuse	18	22
Cannot meet immediate needs	18	17
Child fearful of harm	17	18
Lack of parental knowledge/skills	12	11
Child lacks protective skills	8	15
Child whereabouts unknown/flight risk	7	7
Parental mental illness	6	3
Credible threat to child	4	2
Death of child in household	1	3
Parent negative toward child	1	2
Hazardous living conditions	1	<1

[a]Multiple response

Correlates of Child Removal Following a Crisis Response

Referring again to the state's annual *Child Abuse and Neglect Report* (2017), the two most common types of reporters of child maltreatment in Hawai'i are law enforcement personnel and medical personnel. In 2017, these two groups comprised 54% of all reports of child maltreatment in Hawai'i (27% from each group of personnel). School personnel made an additional 21% of the reports of child maltreatment in Hawai'i that year. These three types of reporters comprise the majority of reports that come to Centralized Intake for disposition.

Recalling the results of the analyses of outcomes of the Crisis Response Team, this evaluation found that the children disposed to the CRT differed in their risk factors and their placement outcomes, depending on whether the report of their maltreatment came from law enforcement, schools, or hospitals (the three eligible report sources for a disposition to the CRT).

Under the Waiver Demonstration, children reported by law enforcement and disposed to the CRT were most likely to be removed from home following a Crisis Response (55% on O'ahu and 60% on Hawai'i Island), although about half of those removed returned home within 30 days, often within one week. The majority of children thus removed were placed into emergency foster care or a regular foster home (59% on O'ahu and 74% on Hawai'i Island), while only 20% on O'ahu and 11% on Hawai'i Island were placed with relatives.

The biggest predictor of child removal among law enforcement-reported children was drug abuse in the household. It may be that children are removed from home because parents are taken into custody for drug charges and no parent remains at home (data on parental arrest was not available to the evaluation). Another key predictor of removal was that the type of maltreatment was child neglect (physical neglect or threatened neglect). Other important predictors of child removal for law enforcement-reported children on both O'ahu and Hawai'i Island were the inability to cope with parenting responsibilities, and unacceptable child rearing practices.

Children reported by schools and disposed to the CRT were much less likely than law enforcement-reported children to be removed from home following a Crisis Response (27% on O'ahu and 26% on Hawai'i Island). Again, about half of those removed returned home within 30 days. The most significant predictor of child removal for school-reported children was the older age of the child, particularly adolescence. The older the child was at the time of the report, the higher the likelihood of removal following a Crisis Response. Physical abuse and a parent's lack of tolerance of child behavior were also significant predictors of removal for this population.

Children reported by hospitals and disposed to the CRT on O'ahu had the lowest likelihood of removal (26%). However, removals following a hospital report were much higher on Hawai'i Island (43%). Few of these children that were removed were Short-Stayers; most of those removed after a hospital report remained in care longer than 30 days. While removal rates for hospital-reported children on Hawai'i Island were low early in the Waiver Demonstration, removal rates dramatically increased from 2015 to 2018, with 75% of hospital-reported children receiving a Crisis Response on Hawai'i Island in 2018 being removed on the same or next day. The key predictors of removal for all hospital-reported children following a Crisis Response were drug abuse and physical neglect.

Some Implications for Future Planning

About one-quarter of all children reported for child maltreatment in 2017 in Hawai'i were reported to Centralized Intake by law enforcement personnel (DHS, 2017). When children reported by law enforcement were disposed for a Crisis Response during the Waiver Demonstration, the likelihood of child removal was high, and the likelihood of a short stay in out-of-home care was also high. Few of these children were placed with relatives upon removal, particularly on Hawai'i Island. Drug abuse and child neglect were most typical of those who were placed into care immediately following a Crisis Response. As candidates, serving this population of children and families will require a strong partnership with the law enforcement community, as well as renewed supports for identification of appropriate relative placements in the immediate aftermath of a law enforcement report. Evidence-based services for parents with substance abuse issues will be paramount.

Compared to children reported by law enforcement and hospitals, the children reported by schools and disposed for a Crisis Response were more likely to be victims of physical abuse, and those with physical abuse were likely to be removed from home following CRT. Many of the precipitating factors involving parenting were also predictive of removal, including lack of tolerance of child behavior, inability to cope with parenting, unacceptable child rearing practices, and loss of control during discipline. An appropriate service to prevent placement for this population of candidates, based on the Waiver Demonstration, is Intensive Home-Based Services. IHBS is a cognitive-behavioral skill-based intervention with a strong focus on improvement of parenting skills.

When children reported by hospitals were disposed for a Crisis Response, they were likely to be victims of child neglect or the threat of abuse. There were significant differences in the children reported by hospitals on O'ahu and on Hawai'i Island during the Waiver Demonstration, in that the removal rate for those on Hawai'i Island dramatically increased over the course of the Demonstration, and the key predictor of child removal was the parent's inability to provide adequate supervision. Children who were removed on Hawai'i Island were likely to remain in care after removal. This population of candidates on Hawai'i Island appears to be of pressing concern, and suggests the need for further research on this social and medical phenomenon.

Finally, as indicated throughout this *report*, the state of Hawai‘i is in the midst of building and transitioning from legacy data systems to a new comprehensive CCWIS. Based on the experiences in this evaluation, it will be important for the state to seek out an evaluation partner with experience in the following areas: state of Hawai‘i legacy data systems, data cleaning, merging disparate databases, and a history of successful collaboration with both administrators, practitioners and data systems managers. Additionally, experience translating and communicating complex data and analyses to a variety of audiences, both familiar and unfamiliar with data and the evaluation process, would be beneficial. These proficiencies will enable the FFPSA evaluator to “hit the ground running,” to create a strong data feedback loop which supports the necessary data-informed decision making required by FFPSA. It will also contribute to the state’s ongoing efforts to build and transition to a new and more comprehensive data system.

Summary and Conclusions

Summary of Findings
Implementation Science Analysis
Conclusions

SUMMARY OF FINDINGS

The five-year Hawai‘i Title IV-E Waiver Demonstration was an enormous endeavor, drawing on the efforts and expertise of individuals and organizations across Hawai‘i and the nation. The planning for the Demonstration encompassed the two years prior to its implementation in 2015, and drew from trends in Hawai‘i’s own administrative data, the expertise of Casey Family Programs and other evidence-based partners, and the investment and expertise of child welfare practitioners and community partners across the state.

The Hawai‘i Demonstration was ambitious; few other Waiver Demonstration sites in the U.S. introduced as many as four new services to their child welfare array. The implementation of four new interventions and one new assessment tool required the coordination of hundreds of administrators and practitioners in public and private agencies, the development and provision of year-round training and staff support for these new practices and tools, the development of new IT infrastructure to support the collection and recording of the new case information required for the Demonstration and its evaluation, and new staffing and hiring for new units and private contractors.

The evaluation itself was the most ambitious investigation into the process, outcomes and costs of selected Hawai‘i child welfare services to date. The US Children’s Bureau required, as part of the terms and conditions of the Waiver Demonstration, that the Demonstration have a comprehensive evaluation of process, outcomes, and costs, conducted by an independent party. This necessitated a comprehensive review of the two administrative data systems used by DHS, as well as those used by private providers. None of these systems, including the two used by DHS, are linked in a way that supports evaluation, much less data-driven decision making. In addition, DHS did not categorize and track child welfare expenditures in a way that allowed evaluators to precisely identify the costs of separate interventions. For the process and outcome evaluations, developing and executing a protocol that would identify the correct case data, extract the correct elements from each data base, and match and merge data elements into one evaluation database was a herculean effort, performed multiple times over the five years of the Demonstration by the Evaluation Team and managers of databases. Many lessons, pertinent to the state’s plan for a new CCWIS data system, and the state’s interest in better fiscal organization of expenditures, are provided in this *Report*.

As evidenced by this fairly comprehensive evaluation, there are many lessons to be learned from the Waiver Demonstration, both in terms of its overall implementation, the four separate interventions, the assessments and data quality, and the fiscal costs of child welfare services in Hawai‘i. This chapter will organize those lessons into six sections: Waiver leadership and infrastructure, process and outcomes of the four new interventions, and the fiscal analysis. After summarizing the lessons learned, the chapter will provide an analysis of the Demonstration using an implementation science framework, and conclude with some general implications for future policy and practice in Hawai‘i child welfare.

Waiver Leadership and Infrastructure

Overall Implementation of the Waiver Demonstration

The Project Manager for the Hawai'i Title IV-E Waiver Demonstration came to the Waiver Demonstration with experience in overseeing Demonstration projects, and this was of great benefit to the Demonstration. Before the Demonstration officially began in January 2015, she formed eight Workgroups to obtain staff and community input into the design and development of each intervention and other crucial supportive activities. These Workgroups were each comprised of CWS section administrators, program development members, private contractors, community partners where applicable, and key CWS staff. The formation and frequent meetings of the Workgroups in the initial year of the Demonstration resulted in early clarifications and refinements of program, policies and procedures.

Monthly meetings of key Waiver leaders and partners focused on communication across interventions about utilization of the four interventions, use of the *Child and Adolescent Needs and Strengths* assessment, celebrating program successes, and problem solving when barriers were identified. Monthly meetings were well attended throughout the five years of the Demonstration, including the in-person attendance of members from neighbor islands.

The CRT response met and exceeded the projected number of children to be served by 2018 (see Table 123). However, not all intakes that were eligible for a CRT response were disposed by Intake to the CRT. CRT supervisors and CWS administrators acknowledged that CRT staffing levels were not sufficient to fully serve all eligible intakes. The Intake Unit appeared to make dispositions to CRT unevenly, with disposition patterns varying by whether the source of the maltreatment report was law enforcement, schools, hospitals, or other sources. Even with existing staffing levels, the CRT intervention exceeded the number of children expected to be served by 2018.

One consistent implementation challenge discussed in the monthly meetings was the low referral rate of children and families to the three Waiver interventions of IHBS, Wrap, and SPAW (see Table 123). In the *Initial Design and Implementation Report* (DHS, *IDIR*, 2015), DHS set goals for the number of children and families to be served by each intervention, consistent with outcome and fiscal goals for the Waiver Demonstration. Table 12.1 shows the percentage of the goal met by the number of children served, based on official counts of children served made by DHS to the Administration for Children and Families in the *Semi-Annual Reports* on the Waiver Demonstration. The Wrap intervention on Hawai'i Island was close to meeting the projected goals by 2018, but all other interventions met around 50 percent of their target population or less. Focus groups and interviews with CWS staff and providers of the three interventions cited the impact of slow staffing up, confusion about referral criteria, caseworker concerns that an added service for a child/family would increase their own workload, and caseworker and supervisor fatigue with new initiatives.

Table 123

*Progress toward Goals for Number of Children to be Served, 2015-2018**

Intervention	O‘ahu	Hawai‘i Island
CRT	147%	105%
IHBS	53%	50%
Wrap	53%	85%
SPAW	13%	41%

* The figures above are based on the projected goals to be met by 2018, not 2019, the end of the Waiver Demonstration.

The projection goals set in the *IDIR* did not set the expectation that each Waiver intervention would serve all eligible children on O‘ahu and Hawai‘i Island (see Table 124). In fact, while the CRT met and exceeded the projected number of children to be served on both O‘ahu and Hawai‘i Island, the number of children served was less than half of the number of eligible intakes, and, in some years, CRT was provided to about one-fifth of the intakes that were eligible for a CRT response.

The penetration rate for the Intensive Home-Based Services intervention is unknown, given that the eligible population was those children and families who agree to fully participate in a home-based intensive intervention. The overall number of CWS families who would meet that criterion is unknown. What is known is that 8 percent to 11 percent of children seen by the CRT were subsequently served by IHBS, and that the IHBS providers experienced low caseloads for much of the first two years of the Waiver Demonstration.

The Wrap and SPAW interventions served small proportions of the population of Long-Stayers (those children who had been in out-of-home care for at least nine months during the Waiver Demonstration) on both O‘ahu and Hawai‘i Island. Feedback from CWS caseworkers, who were responsible for referring eligible children and families to these interventions, indicated a fear that adding this service would increase their workload. Those caseworkers who had once referred a child/family, or knew a peer caseworker who had, were more likely to refer to Wrap and/or SPAW.

Table 124

Penetration Rates (proportion of eligible children who received the intervention), 2015-2018

Intervention	O‘ahu	Hawai‘i Island
CRT	20% to 30% of intakes	22% to 44% of intakes
IHBS*	Unknown (8% of CRT children)	Unknown (11% of CRT children)
Wrap	8% to 10% of Long-Stayers	3% to 4% of Long-Stayers
SPAW	6% to 8% of Long-Stayers	11% to 14% of Long-Stayers

*due to eligibility criterion of voluntary participation, true size of IHBS-eligible population is unknown.

The full implementation of the Waiver Demonstration was hindered by incomplete definitions of key eligibility criteria for each of the four Waiver interventions. For the CRT and IHBS interventions, children were eligible if they were at imminent risk of placement. Prior to the

Waiver Demonstration, the Intake Unit did not make an assessment of imminence of risk of placement, but did make an assessment of imminence of risk of harm to the child. Discussions in the intervention workgroups could not reach consensus on how to assess imminent risk of placement, and this was therefore not added to assessment instruments. The evaluation used imminent risk of harm as a proxy for this eligibility criterion in data analysis, but it is unknown to what extent the assessment of imminent risk of harm influenced disposition decisions by the Intake Unit and the Crisis Response Team.

Similarly, the IDIR stated that children and families were eligible for the Wrap intervention if they were "likely to reunify," and were eligible for the SPAW intervention if they were "unlikely to reunify." There are no such assessments in the case records. The child's legal case goal is to be logged in the CWS administrative database, but evaluators were cautioned that this (1) data entry of the child's case goal was not always done in a timely manner, and (2) this data field is dynamic (changes over time), and could not be extracted for the historic date on which the child was considered for a referral to Wrap or SPAW.

The lack of clear definitions and recordings of key eligibility criteria for the four interventions created confusion for CWS caseworkers and supervisors, as reflected in focus groups and interviews throughout the Waiver Demonstration. This no doubt contributed to the low referral rates for IHBS, Wrap, and SPAW, and for the differential disposition patterns from Intake to the CRT for children reported by law enforcement, schools, and hospitals.

Finally, the implementation of the Waiver Demonstration required an enhanced data infrastructure and a much more vigilant dedication to the recording of case data than Hawai'i Child Welfare Services had experienced before. Data managers of the CPSS administrative data system and the SHAKA data interface made critical and timely revisions to their respective data systems for the recording and gathering of data fields that (1) identified children and families participating in the Waiver, (2) collected key information on client and service characteristics and case outcomes and (3) allowed for convenient entry of new and existing assessment tools. New training on when, where, and how to enter data into these fields and interfaces was provided by the Staff Development Office to existing caseworkers and new hires. In addition, members of the Evaluation Team made in-person visits to all units on O'ahu and Hawai'i Island, to provide an overview of the Waiver Demonstration and identify the critical data elements needed for the evaluation.

Despite these efforts, complete and accurate data entry was found to be quite poor in the first year of the Demonstration, and was slow to improve. Again, the number of children and families included in the evaluation sample is clearly lower than the total number served, due to caseworkers not identifying Waiver children in administrative data, or providing incomplete or incorrect data on Waiver children. Despite the provision of detailed, intervention-specific data from the partner agencies, the lack of DHS administrative data made it impossible to include these cases in the evaluation database. The Evaluation Team and Waiver leadership had regular conversations to identify and rectify missing or incorrect data, and this did increase the number of cases included in the evaluation. As noted in Chapter Four of this *Report*, consistent

communication and training around data entry and a strong data feedback loop do make a difference in data entry behaviors. Continuing and expanding upon the strategies identified in Chapter Four should help the branch to significantly improve its data practices and support improved data-informed decision making at all levels of the branch.

In another example, the required assessment of fifteen safety factors at intake and again after disposition to CRT is often not completed accurately. CWS Leadership cautioned that caseworkers often find one safety factor that applies to the maltreatment case and check that box, rather than assessing whether each and every safety factor applies. Similarly, on the list of 22 possible precipitating factors leading to the maltreatment, only five were consistently indicated at intake. This explains why the majority of families with an intake to Child Welfare Services in Hawai'i is reported as having risks related to parenting, while very few are reported to have difficulties with income, housing, mental health, or social isolation, known correlates of family stress and child maltreatment.

Implementation of the *Child and Adolescent Needs and Strengths* Assessment

Most evaluation of service fidelity in the Waiver Demonstration is related to the four separate interventions, and is discussed there. However, Waiver leadership introduced and implemented the *Child and Adolescent Strengths and Needs* assessment, to be completed by any CWS caseworker who was referring a child and family to either Wrap or SPAW. All DHS caseworkers on O'ahu and Hawai'i Island received training on the *CANS* early in the Waiver Demonstration. Feedback on the initial training, which was provided by the *CANS* creator, was not positive. Use of the *CANS* requires that users pass a test to be certified, and that they be re-certified annually. This was cited as a barrier to *CANS* use in a survey of caseworkers.

The *Child and Adolescent Needs and Strengths* was to be completed at least twice, once at the time of referral to Wrap or SPAW, and once again, when that service was completed. The *CANS* was also to be completed at six-month intervals during the Wrap or SPAW intervention. The evaluation collected only those *CANS* assessments that were completed at the beginning ("Initial *CANS*") and end ("Final *CANS*") of the Wrap or SPAW intervention.

Completion rates for the Initial *CANS* were low, and completion rates for the Final *CANS* were even lower. Completion rates were highest in the first year of the Waiver Demonstration, but dropped after that. Many caseworkers did not attempt to re-certify after the first year of the Demonstration. Caseworker feedback indicated that completion of the *CANS* was time-consuming, and that they did not find it useful to practice, particularly for the Wrap intervention (a family-focused, not child-focused, process). In the last two years of the Demonstration, DHS and Waiver Leadership discussed modifications to the *CANS*, and formed a task force to explore combining multiple child and family assessments and the *CANS* into one, more efficient, less cumbersome and redundant assessment.

Crisis Response Team

CRT Implementation Fidelity

The Crisis Response Team was developed and implemented as a critical element of the state's strategy to reduce short stays in care. It was designed as an immediate, two-hour response by CWS caseworkers to a target population of children known to be at high risk of out-of-home placement, particularly short-term placement.

The Crisis Response Team (on Oʻahu) and the Crisis Response by caseworkers (on Hawaiʻi Island) met and exceeded the projected number of children they would serve over the course of the Waiver Demonstration. By responding to 2,163 children on Oʻahu and Hawaiʻi Island in 2015-2018, the CRT impacted more than ten times the number of children served by IHBS, Wrap, or SPAW.

Both Intake staff and CRT caseworkers received training at the beginning of the Waiver Demonstration about the CRT intervention, in terms of which intakes were eligible and appropriate and the nature of the response itself. One of the Intake supervisors was a member of the CRT Workgroup, to help develop intake procedures, including eligibility and disposition of intakes to the CRT.

Staffing for CRT (the CRT unit on Oʻahu and CWS caseworkers on Hawaiʻi Island) was fairly robust throughout the Waiver Demonstration, but had its challenges. The two-hour Crisis Response was a stressor for those non-CRT staff working after-hours, swing shift, and graveyard shifts, particularly on Oʻahu. There were also staffing losses in Centralized Intake over the course of the Demonstration, resulting in a procedural shift to utilize an answering service to field child maltreatment calls in late 2017. This resulted in short delays in Intake dispositions, but even a short delay was significant when reporters of child maltreatment expected a response within two hours.

The criteria for CRT were concrete: a report of maltreatment came from law enforcement, schools, or hospitals, and the child was at imminent risk of placement. However, there were far more children meeting these two criteria than there were CRT staff able to respond to them. The Intake Unit made judgement calls about which eligible reports should be disposed to the CRT, and these additional criteria were unclear. At the end of the first year of the Demonstration, CWS staff, including Intake staff, expressed confusion about eligibility and the pathways to the CRT. At the end of the second year the confusion continued; fewer than half of ten Intake Unit staff surveyed correctly chose a disposition to the CRT when given two scenarios of children eligible for a CRT response.

While the total number of intakes from law enforcement on Oʻahu and Hawaiʻi Island slightly declined over the course of the Waiver Demonstration, the number of intakes from schools and

hospitals dramatically increased. However, the proportion of school and hospital intakes that were disposed by Intake to the CRT never reached more than 20 percent, and declined after 2016.

The Intake Unit and the Crisis Response Team operated in a changing landscape of child maltreatment in Hawai‘i. Over the course of the Waiver Demonstration, there were significant changes in the nature of child maltreatment reports and intakes in Hawai‘i. The number of intakes increased and the number of victims of child maltreatment increased. There were increases in the proportions of victims said to suffer from the threat of abuse and threatened neglect, and increases in the number of victims said to have experienced more than one type of harm. O‘ahu and Hawai‘i Island saw increases in the percentage of intakes involving caregiver violent behavior and parent impulsivity, as well as parental inability to meet the child’s immediate needs. This shifting landscape in the child maltreatment environment, and differential patterns in the children disposed to the CRT from 2015 to 2018, complicated the evaluation of CRT services and outcomes.

CRT Service Fidelity

Service Fidelity by Intake Unit

One of the two key criteria for referring an intake to the CRT was that the report originated with law enforcement, hospitals, or schools. The other criterion was an assessment that the child was at imminent risk of placement. There was no such assessment recorded at intake. In the absence of an assessment by the Intake Unit of imminence of risk of placement, the evaluation used imminent risk of harm as a proxy for this criterion. While almost all children assessed as being at imminent risk of harm were disposed by Intake to either the CRT or to Child Welfare Services, rather than to a diversionary response service, there was great variation in whether children were disposed to the Crisis Response Team, depending on whether the report came from law enforcement, schools or hospitals. About 50 percent of intakes from law enforcement were disposed to the CRT, compared to around 15 percent to 20 percent of hospital intakes and 15 percent to 20 percent of school intakes.

A rigorous analysis comparing those intakes that were referred to the CRT, versus those referred to Child Welfare Services, found that those intakes with the highest preponderance of risk factors were often disposed directly to Child Welfare Services, not the Crisis Response Team. Identifying one unique profile for children whose intakes were disposed for a Crisis Response was difficult; the single best predictor of whether an intake was disposed to the CRT was that the source of the report was law enforcement.

Attempts to develop a profile of children who received a CRT response was difficult. A profile of the risk factors experienced by children seen by the CRT varied greatly, depending on whether the report of maltreatment came from law enforcement, hospitals, or schools. Those families reported by law enforcement were especially likely to have prior experience with CPS,

a known criminal history, and contain a victim of neglect. Those children reported by schools were especially likely to be a victim of physical abuse and their maltreatment met the legal definition of harm. Children reported by hospitals and seen by the CRT were different between Oʻahu and Hawaiʻi Island; hospital-reported children on Oʻahu were more likely to suffer from physical abuse, while those on Hawaiʻi Island were more likely to suffer from neglect.

Service Fidelity by Crisis Response Team

About 85 percent of the intakes disposed for a Crisis Response were the subject of a report by law enforcement, hospitals, or schools. Intakes for children reported by other sources were sometimes disposed to the CRT, often as a courtesy to partner agencies or professionals. Almost all children seen by the CRT were said to be at imminent risk of harm.

Most intakes disposed to the Crisis Response Team on Oʻahu had a face-to-face contact with the victim by a CRT caseworker within the two-hour window specified by the model. Meeting the two-hour window was more difficult on Hawaiʻi Island; only 65 percent of intakes disposed for a Crisis Response reported that victims were seen within two hours of the disposition from Intake. This confirmed the concern voiced in focus groups and elsewhere that large geographical catchment areas on Hawaiʻi Island would make a two-hour response difficult. The two-hour response time was also impacted by a shift in 2017 to using an answering service at all hours for child maltreatment reports statewide. On Hawaiʻi Island, especially, CWS/CRT supervisors received calls directly from law enforcement sources waiting for a CRT response when the Intake Unit had not yet disposed the case to them.

Over two-thirds of children seen by the CRT had their CRT case closed the same day as the disposition to the CRT. Children on Hawaiʻi Island were much more likely to have their CRT case closed on the same day, with a shift of the case to Child Welfare Services. This reflects the key difference between Oʻahu and Hawaiʻi Island in the provision of a Crisis Response. On Oʻahu, there was a specialized unit dedicated to CRT cases, while on Hawaiʻi Island, CWS caseworkers provided a Crisis Response to appropriate cases, meaning they conducted an in-person safety assessment within two hours, and then, more often than on Oʻahu, immediately disposed the case to the next appropriate service, sometimes provided by the same caseworker that had conducted the CRT face-to-face response.

Some in Hawaiʻi have raised the question of whether a Crisis Response is best delivered by a specialized unit, such as on Oʻahu, or as a section-wide response provided to those at highest risk of placement, such as on Hawaiʻi Island. Certainly, a greater proportion of children seen on Oʻahu were “held” by the CRT unit, even though the number of additional CRT visits, after the initial response, was not higher on Oʻahu. There were not substantial differences in placement outcomes between children receiving CRT on Oʻahu and on Hawaiʻi Island, and what differences there were reflect the changing nature of child maltreatment in each site. The process and outcome data collected and analyzed by this evaluation cannot provide further light on the

question of how best to structure a Crisis Response. However, this evaluation finds that greater specificity and clarity about the pathway to a Crisis Response is greatly needed.

Child Outcomes Following CRT

Given the different risk profiles for children, according to the source of their report of maltreatment, the evaluation reports placement outcomes separately for each group of children. Given that the goal of the CRT was to prevent immediate and short-term placement, the evaluation examined whether removals occurred on the same or next day after the disposition to the CRT, and whether children who were removed returned home quickly (suggesting that placement could have been avoided, sometimes by locating relatives for the initial placement home).

Outcomes for Children Reported by Law Enforcement

Children reported by law enforcement had the highest same/next day placement rates (55% percent on Oʻahu and 60 percent on Hawaiʻi Island). About half of those removed were short-stayers, in that they entered and exited care within 30 days. Those law enforcement-reported children who did experience a short stay in care had extremely short stays, averaging six days in care on Oʻahu and four days in care on Hawaiʻi Island. The majority of short-stayers were discharged from care within five days.

Over the course of the Waiver Demonstration, the percentage of law enforcement-reported children who experienced same/next day placement held steady on Oʻahu from 2015-2017, at around 50% of the children seen by the CRT. However, in 2018, the placement rate jumped to 69 percent. On Hawaiʻi Island, the percentage of law enforcement-reported children experiencing same/next day placement steadily and dramatically *decreased* each year of the Waiver Demonstration, from 91 percent of children seen by the CRT in 2015 to 36 percent of children seen in 2018.

When law enforcement-reported children were removed from home after a CRT response, only 20 percent of removed children on Oʻahu and 10 percent of removed children on Hawaiʻi Island were placed with relatives in a paid setting for their initial placement. More children were placed in emergency foster homes for their initial placement. Over half of all children reported by law enforcement on Hawaiʻi Island who were removed the same or next day were placed in a paid foster home with non-relatives.

Outcomes for Children Reported by Hospitals

On Oʻahu, children seen by the CRT after a maltreatment report by a hospital were the least likely group of children to experience a same/next day removal (26%). On Hawaiʻi Island, they were less likely than law enforcement-reported children (43%), but more likely than school-

reported children to experience same/next day removal. However, when children were removed, those reported by hospitals were unlikely to have a short stay in care (9% on O‘ahu and 14% on Hawai‘i Island). The small group of children reported by hospitals who experienced a short stay in care were, on average, discharged from care within seven days (on O‘ahu) or eight days (on Hawai‘i Island).

From 2015 to 2018, children reported by hospitals on O‘ahu experienced low rates of removal, at between 20 percent and 30 percent each year, and this rate held fairly steady throughout the Waiver Demonstration. On Hawai‘i Island, however, the percentage of hospital-reported children experiencing same/next day removal increased dramatically, from 11 percent of such children in 2015 to 75 percent in 2018.

On O‘ahu, those children reported by hospitals were the most likely to be placed in a paid setting with relatives for their first placement upon same or next day removal. On Hawai‘i Island, however, children reported by hospitals were extremely unlikely to be placed with relatives.

Outcomes for Children Reported by Schools

About one-quarter of all children seen by the CRT on O‘ahu whose report came from schools were removed on the same or next day (27%), and more than half were short-stayers. On Hawai‘i Island, about one-quarter of school-reported children experienced same or next day removal (26%), as well, and about half were short-stayers. For those school-reported children who did experience a short stay in care, the average length of short-stay on O‘ahu was nine days; four days on Hawai‘i Island.

Over the course of the Waiver Demonstration, the percentage of school-reported children experiencing removal on each island varied greatly each year, with increases and decreases between 10 percent and 20 percent each year. There was no discernable pattern in placement rates over time.

Use of relative placements varied greatly between O‘ahu and Hawai‘i Island. While 22 percent of school-reported children on O‘ahu were placed with relatives for their initial placement, only 3 percent of school-reported children on Hawai‘i Island were placed with relatives. Use of an emergency foster home was much more likely on both islands.

Correlates of Removal Following a CRT Response

Regardless of whether the report came from law enforcement, hospitals, or schools, the strongest predictor of a child being removed was drug abuse in the home, either when noted by Intake or by the CRT caseworker on the Initial Safety Assessment. This was true on both O‘ahu and Hawai‘i Island. Almost all children who had been reported by law enforcement and were noted as having drug abuse as a risk factor were removed following a CRT response.

For children reported by law enforcement and receiving a CRT response, drug abuse in the home was a strong predictor of removal, as well as child neglect (physical or threatened). It may be that child removal occurred because parents were taken into custody by law enforcement, leaving no one at home to care for the child(ren). For children reported by schools, removal was highly associated with older age of the child, especially adolescence. In addition, parental characteristics, such as a lack of tolerance of child behavior, an inability to cope with parenting, loss of control during discipline, and unacceptable child rearing practices, were predictive of child removal. For children reported by hospitals, child neglect was the best predictor of removal.

Correlates of a Longer Stay in Care Following a CRT Response

Because the Crisis Response was designed to prevent unnecessary placement, and to prevent a short stay in care (defined as entering and exiting care in 30 days or less), the evaluation examined those characteristics of children and families that were associated with a short stay in care following CRT. There were no indicators that predicted a short stay in care.

However, there were several characteristics that were associated with a longer stay in care. Those who stayed in care longer than 30 days once removed were more likely than short-stayers to have experienced child neglect, and have substance abuse in the home.

Child Outcomes After CRT Compared to Pre-Waiver Years

Children who received CRT during the Waiver Demonstration were compared to all children with an Intake from law enforcement, hospitals or schools on Oʻahu or Hawaiʻi Island who were also assessed by Intake to be at imminent risk of harm, in the years 2012 through 2014 (the "pre-Waiver years").

Children receiving a Crisis Response during the Waiver Demonstration had higher rates of removal than comparable children in the pre-Waiver years. The increase in removal rates from pre-Waiver years to Waiver years was especially significant for those children reported by hospitals on Hawaiʻi Island.

The proportion of removed children who experienced a short stay in placement also increased during the Waiver years, on both Oʻahu and Hawaiʻi Island. Children reported by law enforcement, who had the highest placement rates, were most likely to have a short stay in placement.

After a CRT response on Oʻahu, more children were placed with relatives in their initial out-of-home placement than before the Waiver Demonstration. There was no such increase on Hawaiʻi Island.

The search for an explanation of why removal rates increased from pre-Waiver years to Waiver years for children from comparable sources is complicated. As the Waiver Demonstration was being implemented, the state of Hawai'i was experiencing significant changes in the types of maltreatment that were being reported to Child Protective Services. Compared to pre-Waiver years, a child welfare intake was much more likely to list multiple forms of maltreatment of the child, was much more likely to identify children as victims, and was more likely to identify the risk factors of caregiver violent behavior, child lack of protective skills, and the parent's inability to meet the child's immediate needs.

Intensive Home-Based Services

IHBS Implementation Fidelity

Hawai'i used the HOMEBUILDERS model of Intensive Home-Based Services in their Waiver Demonstration. For an entity to use the HOMEBUILDERS model, they must agree to a number of requirements to ensure model fidelity. Personnel from the Institute for Family Development, in Tacoma, Washington, conducted the training on the HOMEBUILDERS model, served as consultants to Hawai'i, and monitored service fidelity by each family therapist throughout the Demonstration.

There were a number of requirements of the IHBS model that hindered implementation during the early years of the Demonstration. There are strict criteria for eligibility for IHBS, and CWS staff in focus groups expressed confusion about those referral criteria. In a survey in Year Two, only one-third and one-fifth of CWS staff, respectively, could correctly identify when to refer the children in two scenarios to IHBS. Complicating this further, a key element of the HOMEBUILDERS model is a lengthy training period for new therapists. Following an initial training period, new therapists must also shadow the IHBS supervisor over the course of two cases, before being authorized to serve their own cases. This resulted in an initial inability to take very many referrals, as therapists were hired, trained, and supervised before serving families. In turn, the resulting slow startup meant that IHBS staff, once they were ready to serve families, sometimes had no cases to serve. There was high turnover in staff, particularly on Hawai'i Island, in the first year of the Demonstration.

The pattern of service implementation for IHBS varied by island. On O'ahu, the most children served by IHBS were referred in the first year of the Demonstration. Numbers declined each year after that. However, there is an important caveat; IHBS was expanded to families outside the original Demonstration criteria in 2017, and the evaluation did not include those families in the evaluation sample, in order to preserve consistency of cases evaluated. On Hawai'i Island, implementation had a very slow start but served about 75 percent of the projected number of children in 2016 and 2017.

IHBS Service Fidelity

Service fidelity appeared to be fairly high throughout the Demonstration; not surprising given the role of fidelity monitoring by the Institute for Family Development throughout the Demonstration. All families on O'ahu were met by their IHBS therapist within 24 hours of referral, as were 70 percent of families on Hawai'i Island. All families in IHBS were served for six weeks or less, with an average duration of service of 30 days on O'ahu and 33 days on Hawai'i Island. Services were indeed intense, with therapists devoting an average of five face-to-face sessions per week to families on O'ahu, and four sessions per week to families on Hawai'i Island.

The HOMEBUILDERS model of Intensive Home-Based Services is cognitive-behavioral in nature, and therapists focus on helping families learn new skills in parenting and other family interactions, as well as acquiring helpful community resources. Due to the skill-building nature of the intervention, families whose risks center around parenting, discipline, and intolerance of child behavior are most appropriate for this service. Indeed, an analysis comparing those CRT children referred and not-referred to IHBS found that those referred were significantly more likely to have these sorts of precipitating factors.

A survey of parents who had received IHBS on O'ahu found that most families experienced high levels of service fidelity, indicated by agreement with statements regarding therapist availability at all hours, timely responses to calls for help, scheduling of visits at convenient times for the family, learning of new skills, being connected with community resources, feeling understood by the therapist, and feeling like one's culture and values were respected.

Child Outcomes Following IHBS

The IHBS intervention was extremely successful in preventing placement among those families who completed the service. Only 9 percent of children on O'ahu experienced out-of-home placement within 90 days of completion of IHBS, and no children served on Hawai'i Island experienced placement in this time frame.

In addition, few families had a new intake for a report of child maltreatment in the six months following their IHBS experience (7% of families on O'ahu and no families on Hawai'i Island). Fewer still had a new referral to CWS for investigation in the six months following that intake.

Pre- and post-IHBS assessments by IHBS therapists found that families made the biggest improvements in family safety, and the smallest improvements in the physical environment. Pre- and post-IHBS safety assessments by CRT caseworkers showed substantial declines in family risks, particularly regarding impending danger to the child, violent caregivers, and inadequate supervision.

Given the low number of children with poor outcomes, it was not possible to compare successful and unsuccessful cases to identify correlates of IHBS success. Given the requirement that families fully volunteer for these intensive services, it was not possible to extract a comparable group of non-IHBS child welfare clients for analysis of differences.

Family Wrap Hawai‘i

Wrap Implementation Fidelity

The Wraparound process was provided by the same private provider on both islands. EPIC ‘Ohana had tested a version of wraparound services previously, so was familiar with the values, principles, and techniques of the model. In addition to having this prior experience, the Wrap staff participated in extensive training on the Wraparound model, both at the beginning of the Demonstration and throughout all following years. The Wrap staff participated in in-house workshop style “huddles” to strengthen the internal team dynamic and ensure ongoing fidelity and service quality.

The two primary roles of the CWS caseworker in the Wrap process were to suggest Wrap to eligible and appropriate families, and to complete an Initial and Final assessment of the *Child and Adolescent Needs and Strengths*. Given that children, youth and families were referred for Wrap services by CWS caseworkers, CWS line staff and supervisors received training about Wrap through the CWS Staff Development office. A one-day training on the *CANS* was provided to CWS line staff at the beginning of the Waiver Demonstration, and follow-up training was provided by the Staff Development office.

Adoption of Wrap services was relatively positive, in that CWS caseworkers expressed confidence in the service and had positive perceptions of it for their families. Most saw it as low risk, but there was some concern about the time commitment required of CWS caseworkers whose clients participated in Wrap. Despite these positive views, overall utilization of Wrap was lower than initial projections for the Demonstration. Only East Hawai‘i met or exceeded projections for most of 2016 and 2017.

While CWS caseworkers were responsible for identifying and referring children and families for the Wrap process, in reality, families came to Wrap through a variety of paths. EPIC ‘Ohana, the provider of Wrap, also provided other services to families receiving Child Welfare Services or other diversionary programs, and families were known to self-refer upon learning about Wrap. Wrap personnel also identified appropriate families and then contacted the CWS caseworker about a possible referral to Wrap.

The one area where the implementation of Wrap was unsuccessful was in the completion of the *Child and Adolescent Needs and Strengths* assessment by CWS caseworkers. Caseworkers found the *CANS* lengthy to complete and did not perceive it as useful to the case. In addition,

Wrap providers had their own assessment of family strengths and needs, and did not find an assessment focused primarily on the child to be useful to a family-focused and family-driven process. The Wrap process often proceeded without a completed *CANS*.

Wrap Service Fidelity

The two eligibility criteria for the Wrap intervention were that (1) the child had been in out-of-home care for at least nine months, and (2) the child was considered "likely to reunify." Indeed, all children served by Wrap had been in care for at least nine months, and many had been in care much longer. On Hawai'i Island, over half of the children served by Wrap had been in care for over 18 months. This was true for one-third of the children served by Wrap on O'ahu.

There was no reliable indication in data files whether children served by Wrap were considered "likely to reunify." However, the CWS caseworker responsible for the child discussed the child's case goal of reunification with Wrap personnel at the time of a referral of the child and family for Wrap services.

Most families referred to Wrap were contacted with a week of the referral. Families discussed their participation and the resources and supports provided by Wrap with Wrap personnel, and their consent to participate usually occurred within two weeks. The first Wrap meeting then occurred within five weeks on O'ahu and three weeks on Hawai'i Island. Wrap meetings with a family were to occur monthly, and this occurred on both O'ahu and Hawai'i Island. The average length of the Wrap service with a family was six to seven months.

Children who participated in Wrap were most likely to have been reported to Child Protective Services for the threat of abuse or threatened neglect (and, on Hawai'i Island, physical neglect). Most were in their first removal episode, and their current placement was a paid non-relative foster home.

Child Outcomes Following Wrap

Wrap was very successful in helping children and families to achieve reunification. Over two-thirds of all children served were reunified, and the average length of time from the first Wrap meeting to reunification was four to five months, on average. An additional 13 percent of children on O'ahu and 8 percent of children on Hawai'i Island were adopted or achieved guardianship following Wrap.

Among those children who were reunified, adopted, or in guardianship following Wrap, 21 percent on O'ahu and 10 percent on Hawai'i Island subsequently re-entered foster care. The average time to re-entry was one year on O'ahu and two years on Hawai'i Island.

Comparison groups of children on O‘ahu and Hawai‘i Island who were Long-Stayers (had been in care at least nine months) during the Waiver years but did not receive Wrap were formed using Propensity Score Matching, matching children on their histories in foster care. Children receiving Wrap were significantly more like to achieve reunification than their matched counterparts, both on O‘ahu and on Hawai‘i Island.

Correlates of Reunification Following Wrap

Children who were least likely to reunify with their families following Wrap were those with a history of sexual abuse, and those scoring higher on the Trauma Domain of the *Child and Adolescent Needs and Strengths* assessment. However, those with a history of sexual abuse were most likely to exit foster care to adoption or guardianship. Those children who remained in care following Wrap were those whose families had taken the longest to provide consent to participate in Wrap.

Safety, Permanency, and Well-Being Meetings

SPAW Implementation Fidelity

The SPAW meetings were provided on both O‘ahu and Hawai‘i Island by the same provider. SPAW personnel received training from Casey Family Programs, developer of the SPAW model, upon hire. All CWS caseworkers received training on SPAW values and skills in the first year of the Waiver Demonstration. In addition, all CWS received training on the *Child and Adolescent Needs and Strengths* assessment at the beginning of the Demonstration, necessary for a referral of a child’s case for a SPAW meeting. However, focus groups with CWS caseworkers found that they felt the primary focus of SPAW training was on the completion of the *CANS*, and not on the SPAW referral or SPAW process.

In contrast with the Wrap process for reunification, the SPAW process does not include the child or family in the meeting. Rather, the meeting convenes the child’s caseworker and other professionals to review the child’s history and status in care, identify where there might be barriers to achieving permanency, and brainstorm solutions to those barriers. The professionals invited to attend are expected to be in a position of leadership where they can authorize services or decisions that will provide the “barrier busting” often required to achieve that movement toward permanency.

Whereas the SPAW model developed by Casey Family Programs consists of several such meetings for each child’s case under review, the SPAW process in the Hawai‘i Waiver Demonstration was to consist of one meeting per child, with one possible additional meeting, when needed. At this first meeting, led by a SPAW facilitator, participants were to develop a Permanency Goal for the child and an Action Plan of concrete steps on a timeline to be taken by

meeting participants to help achieve that goal. SPAW personnel then followed up with participants to assess progress on the Action Plan and movement toward permanency.

SPAW, like Wrap, experienced low rates of referral throughout the Demonstration, at under 10 percent of projections on O'ahu and under 15 percent of projections on Hawai'i Island. Feedback from CWS caseworkers indicated that they anticipated that a SPAW review of a child on their caseload would invite criticism and increase their workload. Many cited the burden of completing a *CANS* assessment as part of a referral to SPAW. Indeed, given low referral rates, the SPAW referral process became a "pull" process from the SPAW provider, rather than a "push" process from CWS. SPAW personnel routinely and frequently reviewed the online list of all CWS children in care (the "All-In-Care" list) to identify possible appropriate candidates for SPAW, then contacted the CWS supervisor to discuss the case as a potential referral. SPAW personnel noted that hours of work often went into reviewing the All-In-Care list and contacting supervisors, sometimes repeatedly over months as the child's case status changed, to identify possible referrals.

SPAW Service Fidelity

The two eligibility criteria for the referral of a child's case for a SPAW process were that (1) the child had been in out-of-home care for at least nine months, and (2) the child was considered "unlikely to reunify." Indeed, almost all children served by SPAW had been in care at least nine months, and most had been in care much longer. On O'ahu, the average length of time in care for a SPAW child, in his or her current removal episode, was over 3.5 years, and on Hawai'i Island, the average length of care, in a SPAW child's current removal episode, was more than 4.5 years.

There was no indication in case data available to the evaluation of whether a child was considered "unlikely to reunify." However, SPAW personnel, in their periodic contacts with CWS supervisors, asked whether long-stayer children on their caseload were an "unlikely to reunify" child and therefore an appropriate referral for SPAW.

SPAW meetings enjoyed active participation. An average SPAW meeting had nine participants on O'ahu, and eight participants on Hawai'i Island. Most participants who were invited to a SPAW meeting attended it. The majority of SPAW meeting participants were the child's caseworker, SPAW facilitators, and partners from Child and Adolescent Mental Health Division and the Department of Health. Given that the SPAW model parameters in Hawai'i called for one meeting, most SPAW cases were initiated and terminated within six months.

A survey of SPAW participants in the fourth year of the Demonstration found that most participants were impressed with the fidelity of SPAW meetings to the original model, noting the neutrality and skill of SPAW facilitators, the importance of including decision makers in the meeting so that immediate decisions could be made, and the benefit of brainstorming and "out of the box" thinking. However, some commented on how, for some cases, the SPAW process

was not focused on barrier busting, but on a push to enact the current case plans with renewed energy.

The children and youth receiving a SPAW meeting had considerably more complicated histories with Child Welfare Services than those served by Wrap, which is not surprising, given that these were children considered "unlikely to reunify" and whose case was somehow "stuck." Over one-third of those served on both Oʻahu and Hawaiʻi Island had been in and out of foster care prior to their current removal episode. The majority were in a paid non-relative foster home at the time of the meeting, but SPAW also held meetings for children in residential care, who were runaways, and who were in paid therapeutic settings. The most common assessment of the child's level of permanency at the time of the meeting was "marginal."

Child Outcomes Following SPAW

Although the SPAW process was intended for children and youth for whom reunification is deemed unlikely, reunification was achieved following SPAW for 22 percent of the children served on Oʻahu and 6 percent of the children served on Hawaiʻi Island. Another 10 percent on Oʻahu and 10 percent on Hawaiʻi Island were adopted following SPAW. These outcomes took time; the average length of time from the SPAW meeting to reunification was eight months on Oʻahu and 20 months on Hawaiʻi Island. The average length of time to adoption was 14 months on Oʻahu and 22 months on Hawaiʻi Island.

Many children achieved guardianship following SPAW. Guardianship was the most common type of an exit from care for children and youth who had a SPAW meeting. The average length of time from the SPAW meeting to guardianship was 18 months on Oʻahu and 17 months on Hawaiʻi Island.

Comparison groups of children who were Long-Stayers on Oʻahu and Hawaiʻi Island during the Waiver years and did not receive SPAW were formed using Propensity Score Matching, matching children on their histories in foster care. Children who received SPAW on Oʻahu were significantly more likely to leave care by achieving reunification or guardianship than their matched counterparts. Children who received SPAW on Hawaiʻi Island were significantly more likely to leave care by achieving guardianship than their matched counterparts.

Correlates of Permanency Following SPAW

Several characteristics of children who had received SPAW were predictive of an exit to reunification, adoption, or guardianship (defined here as permanency), rather than staying in care or aging out of care without a permanent family. Although those with a SPAW meeting were seldom young, those who exited to permanency were three or four years younger, on average, at the time of the SPAW meeting. Permanency was less likely when the child had a history of physical neglect or physical abuse, or had prior experiences of removal.

Those children who exited care to adoption or guardianship following SPAW were especially likely to be younger when first removed from home, and had had fewer different placement settings overall. The members of the SPAW meeting rated these children closest to a permanent outcome at the time of the meeting. Those who achieved adoption or guardianship had a SPAW process with the highest proportion of their Action Plans completed.

Child Welfare Expenditures Under the Waiver

The theory of the Waiver Demonstrations across the U.S. is that the cost of providing and administering Waiver Demonstration interventions should be offset by the savings produced by a shrinking foster care population. In Hawai‘i, the state sought to shrink the size of the foster care population through (1) decreasing the number of children entering foster care (particularly Short-Stayers) and (2) increasing the number of Long-Stayer children exiting foster care. Therefore, the cost study examined the expenditures on Waiver interventions, the size of the foster care population in Hawai‘i, as well as the expenditures of the Social Service Division toward Child Protection and Child Welfare Services (services, room and board payments, and administration).

To do so required the cost evaluators to consider all children entering and exiting care, not only those touched by a Waiver intervention. By implementing the four interventions of CRT, IHBS, Wrap, and SPAW, the state (and the federal government, in the theory underlying waivers) expected to see the overall foster care population, and associated foster care costs, decrease once the Waiver Demonstration was implemented.

Expenditures on Waiver Interventions

Together, the cost of the four Waiver interventions totaled more than $12 million. Because the CRT intervention on O‘ahu consisted of a new specialized unit, it was the most expensive intervention in the Demonstration, at an estimated $3.5 million across four fiscal years. However, the CRT unit on O‘ahu also served the most children in the Demonstration. The per-child cost of providing a Crisis Response on O‘ahu was $1,782. Because the Crisis Response was provided by existing staff on Hawai‘i Island, the overall cost of providing CRT was less, at $1 million over four fiscal years. However, the Hawai‘i Island Crisis Response served fewer children and was thus more expensive on a per-child basis, at $2,075 per child.

The IHBS intervention was an expensive intervention, costing $2.8 million on O‘ahu and $1.7 million on Hawai‘i Island, over four years. IHBS was provided through contracts to private providers. Because of low referral and utilization rates, however, the per-child costs of providing IHBS were very high. The per-child cost was $7,071 on O‘ahu and $10,522 on Hawai‘i Island.

The overall costs of providing Wrap and SPAW on both islands were lower than those of CRT or IHBS. Wrap had an overall cost (including both islands) of $2.2 million over four fiscal years. SPAW had an overall cost (including both islands) of $1.6 million over four fiscal years. Again, Wrap and SPAW were provided through contracts to private providers. However, due to low referral and utilization rates, the per child costs of providing Wrap were $12,435 per child and, for SPAW, $8,339 per child.

Changes in the Size of the Foster Care Population

Looking first at the statewide foster care population in Hawai‘i, the number of children in out-of-home care on September 30 of each year increased every year between 2012 (three years prior to the Waiver Demonstration) to 2019. The total increase statewide was 40 percent; however, on Hawai‘i Island, the foster care population increased 104 percent in that same time period. Of course, the size of the foster care population is dependent on (1) the number of children entering care, and (2) the number of children exiting care. The cost study found that, from the three pre-Waiver years to the five Waiver years, the number of children entering care on O‘ahu held fairly steady (a negligible 2% decrease), and rose by 32 percent on Hawai‘i Island. There were also increases on Maui (15% increase) and Kaua‘i (44% increase).

The number of children exiting care also decreased over time; children stayed in foster care longer. The length of time in care translates into the cost driver of “paid care days” or the number of days in care across all children. If one child is in care for 50 days and another child is in care for 100 days, between them, the state has paid for 150 “paid care days.” The cost study found that the number of paid care days increased every year from 2013 to 2019, resulting in a 42 percent increase in paid care days between 2012 and 2019. Within this figure, the expenditures for kinship care rose by 51 percent and for foster care by 50 percent. Again, paid care days saw a small increase on O‘ahu but increased dramatically on Hawai‘i Island.

As a result, the cost study did not find that the size of the foster care population decreased during the Waiver. An increase in both the number of entries into out-of-home care and the number of days in care paid by the state were largely driven by increases on Hawai‘i Island in both categories (as well as neighbor islands, outside of the Waiver).

Changes in Spending for Foster Care Board and Maintenance

Under the conditions of the state’s Title IV-E Waiver, the capped allocation for Title IV-E funds provided to the state increased by 7.3 percent each year of the Waiver, on average. If the state’s expenses stayed below an increase of 7.3 percent each year, savings would accrue. Foster care expenses increased each year, however, with the largest increases in the early years of the Waiver. The documented increase in the cost of care was 34% in 2015, another 15% in 2016, and another 9% in 2017, each higher than the capped allocation. The cost of care increased by only 1.5% in 2018, but increased by 22% in 2019.

It is also important to note that the state increased the room and board rate paid to foster carers in SFY2015, and again in SFY2019. These allowances were tiered by age group. In addition, a “difficulty of care” allowance was added to what the state reimbursed families, and a clothing allowance was added as well. The cost study performed a series of models to predict the impact on foster care expenditures if the room and board rate had remained the same over

time, and if the number of paid care days remained the same over time. These models found that the increase in room and board rate was the more important factor in the increase in foster care expenditures from 2014 to 2015. However, after 2015, the increase in paid care days (i.e., the increasing size of the foster care population) was the main driver of the increase in foster care expenditures. In 2019, when the room and board rates were raised again, the increase in foster care expenditures is largely attributed to the rate increase, not the paid days in care.

Fiscal Impact of the Waiver Demonstration

During the Waiver Demonstration years, both the number of children entering foster care and the amount of time that children were in out-of-home care increased. Costs of foster care increased, due to increased room and board rates, and an increasing population in care. There were different trends on Oʻahu and Hawaiʻi Island; increases in the number of foster care entries and the cost of foster care on Hawaiʻi Island dwarfed those on Oʻahu. Due to these rising expenditures, there were no cost savings realized by the Waiver Demonstration.

IMPLEMENTATION SCIENCE ANALYSIS

Using an implementation science framework, we can assess the success of the implementation of the Hawai'i Title IV-E Waiver Demonstration in three main components: Implementation Leadership, Data and Feedback Loops, and Implementation Infrastructure. As discussed in the evaluation methodology, an implementation science approach posits that each of these components builds its implementation in phases, from Exploration (of the Demonstration), to Installation, to Initial Implementation, to Full Implementation. Full implementation of new policies and practices takes time, and the implementation science framework gave this evaluation a structure with which to assess how far into full implementation the Waiver Demonstration succeeded, and where progress in implementation was impeded.

The Waiver Demonstration had variable success in fully implementing the Waiver Demonstration, discussed below, and summarized in Tables 125 through 127. In implementation science, a framework in phases recognizes and emphasizes the incremental nature of systems change. Systems change occurs over time, and in large administrative systems such as child welfare, can take many years. The Waiver Demonstration in Hawai`i exemplified the incremental progress that naturally occurs, and this evaluation identifies where systems change was more or less challenging.

Implementation Leadership

Exploration Phase - ACHIEVED

Where the Waiver Demonstration has been successful, credit can often be given to the collective efforts of CWS Leadership, the Waiver Demonstration Project Manager, and the private agency partners. With the support of leadership, the Project Manager instituted a straightforward array of workgroups, and supplied each with the materials and supports that would be useful to them. The creation of these workgroups and the supports provided were important foundational components of the Waiver Demonstration.

Installation Phase – PARTIALLY ACHIEVED

Each intervention had a Workgroup that met frequently to better define each Waiver intervention. Partners spent significant time in developing a theory of change for each of the four interventions. They also welcomed members of the Evaluation Team in the development of workflow charts to flesh out the specific details of the process of each intervention and key decision points during the first year of implementation. This partnership between Workgroup members and the Evaluation Team helped to clarify not only vagaries of data collection, but the components of best practice in each intervention.

Training for the IHBS, Wrap, and SPAW interventions was thorough and of high quality. The training was often provided by those on the US mainland who had high identification with the intervention, such as staff from the Institute for Family Development (HOMEBUILDERS) for Intensive Home-Based Services, Patricia Miles for Wraparound, and staff from Casey Family Programs for SPAW.

CANS training efforts were not as successful. In the run-up to the Waiver Demonstration, *CANS* and *CANS* training were introduced as relevant "only" to those caseworkers who might refer a case to Wrap or SPAW, rather than being introduced as a means to providing more/better information about a child or youth. Even though the training provided by Dr. Lyons pre-Waiver focused on the use of the *CANS* as part of a "service planning process," this message was contrary to how the use of *CANS* had been initially introduced by CWS (as a requirement for referral); training sessions were evaluated as confusing and not practical enough.

Initial Implementation Phase – PARTIALLY ACHIEVED

The four Waiver interventions experienced varying levels of success, in terms of referrals to interventions, and outcomes of interventions. Of the four Demonstration interventions, the Crisis Response Team had the highest uptake levels. The Branch was well-positioned from the beginning of the Waiver Demonstration to implement a Crisis Response, because many had acknowledged and critiqued the absence of social worker availability at the time of first response. The Branch was largely applauded for implementing an important innovation with federal support.

Despite frequent meetings of the Workgroups to further develop and refine the four interventions, however, all four interventions were plagued throughout the Demonstration by confusion about their eligibility criteria. Most importantly, there were no clear operationalizations of which children were at imminent risk of placement, were likely to reunify, and were unlikely to reunify. This made patterns of disposition to the Crisis Response Team incoherent, and largely suppressed the referral rates to IHBS, Wrap, and SPAW.

For those children and families who were referred to IHBS, Wrap, or SPAW, these interventions enjoyed very high levels of treatment fidelity. All three interventions were supported by high quality training and consultation, and the fidelity was evidenced in process metrics. Providers of these services largely followed eligibility criteria, treatment length, dosage and intensity of services, structure and participation in meetings, and so on. In addition, feedback from parents, youth, and participants, in surveys and interviews, emphasized that these services exemplified the values and principles of strengths-based approaches, individualized service plans, and honoring families' culture and self-determination.

Data and Feedback Loops

Exploration Phase – PARTIALLY ACHIEVED

Continuous and consistent messaging of the goals, best practices, and results of a Demonstration are critical to sustained energy and commitment to any five-year endeavor. CWS implemented many strategies in the initial phase of the Waiver Demonstration to support communication between Waiver Demonstration members and partners.

Continuous and consistent messaging of the goals, best practices, and results of a Demonstration are critical to sustained energy and commitment to any five-year endeavor.

The development of the components of the Waiver Demonstration, and the creation of the *Initial Design and Implementation Report*, was largely managed by CWS Leadership and contracted consultants. A broader coalition of staff and community partners was not effectively utilized in building the Demonstration. Thus, when the Demonstration began, the burden of educating staff and community partners on the particulars of the innovative practices and interventions was high, and the need for clear communication was critical.

Installation Phase – NOT YET ACHIEVED

The Waiver Demonstration Project Manager and Child Welfare Leadership instituted a monthly meeting of Waiver partners (CWS section administrators, executives, private providers, court liaison, evaluators), which helped to sustain a shared vision and accountability. The agenda centered around a sharing of updates, and facilitated a reporting out of the number of children and families served by the interventions, allowing for celebrations and acknowledgement of referrals, uptake, and outcomes. Increasing the use of, and referral to, interventions was applauded and recognized.

The monthly Waiver meetings were well-attended, even though the members included busy child welfare administrators and practitioners, private agency leads, community partners, and important personnel from other islands, who attended in person every month. The content and the relationships were obviously compelling.

The Demonstration would perhaps have benefitted from sharing champions' strategies and techniques for uptake and successful outcomes as a component of training for the interventions.

Over the first two years of the Demonstration, "champions" or "heroes" of the Waiver Demonstration came to be implicitly identified and held up as successful implementers of interventions in the monthly Waiver meetings. However, they were often celebrated as having unique talents and skills; the Demonstration would perhaps have benefitted from more sharing of champions' strategies and techniques for uptake and successful outcomes as a component of training for the interventions.

The culture of the child welfare organization in Hawai'i is one that focuses on the currency of "talking story": the successes of the Waiver Demonstration were primarily communicated in anecdotes about specific cases. On the one hand, given the difficulties in acquiring and verifying data, there was not much evaluative data to report on throughout the Demonstration. Once limited data was available to inform administrators and practitioners about the status of the Demonstration (in the *Interim Evaluation Report*), many were skeptical, given their comfort with anecdotal experiences.

On the other hand, Waiver leadership, CWS staff, and intervention providers were eager for constructive feedback on the progress of the Waiver Demonstration. Positive feedback provides a needed incentive to maintain buy-in to, and excitement for, any Demonstration and serves as a balance to feedback regarding challenges and pitfalls that are an inevitable part of any large-scale implementation. Unfortunately, the complexity of the data platforms hindered the evaluators' abilities to provide timely feedback and created a clunky feedback loop. As a result, rather than focusing on communicating positive Waiver outcomes in the first half of the Demonstration, the Evaluation Team spent more time in the first two years on the message of messy data and the inability to report reliable outcomes. Because of the inability of CWS or the Evaluation Team to report out a timely demonstration of key successful outcomes of interventions, partners did not receive timely feedback and encouragement on the success/benefits of each intervention.

The Evaluation Team developed four "One-Pagers" to describe the Waiver interventions, their goals, the eligibility criteria, and critical data elements to be collected for the evaluation. These were very well received and were a hallmark of the communications efforts of the Demonstration. The success of the One-Pagers demonstrates that investing time in communication efforts can reap significant benefits for both implementation and evaluation efforts. Infographic tools are particularly powerful as they allowed the Team to convey findings in an accessible and appealing format that was well received.

The efforts of the Evaluation Team and CPSS and SHAKA data managers in supporting quality and timely data entry for Waiver cases had positive but limited effects in increasing data accuracy. Many of those with lengthy experience in the Child Welfare Services Branch were frankly skeptical about the utility of the data collected in CPSS and SHAKA. Exhortations by the Evaluation Team to be vigilant about entering data and entering it accurately were not always successful. Instead of creating and supporting information feedback loops about the results of the Demonstration, the lack of data created information feedback loops that were reliant on anecdotal experiences. Given the lengthy process of gathering, verifying, and assembling data from the two administrative databases, the size of the positive outcomes achieved by IHBS, Wrap, and SPAW were largely unknown until the end of the Demonstration.

Although data entry was a challenge, the Demonstration did provide significant learning opportunities at all levels of the organization and for the Evaluation Team. Those lessons learned are detailed in the *Interim Evaluation Report*, multiple presentations given by the evaluators to DHS staff and partner organizations and in Chapter Four of this *Report*. Not only are CWS caseworkers, support staff and supervisors more familiar with data entry practices, but CWS now has insight into how data from the two legacy databases can be merged and utilized to improve practice and help children and families served by CWS. The conclusions presented in this *Report* serve not only to evaluate the success of the Demonstration, but also to give DHS staff and administrators insight into their own practice and identify areas of strength and challenge in order to improve services going forward. The lessons learned through this evaluation can also be applied in the state's efforts to build and implement a new CCWIS in the coming years and to inform the design and implementation of the state's FFPSA plan.

The Intensive Home-Based Services, Wrap, and SPAW interventions had mixed perceptions among those who might refer a child or family to the intervention. For example, IHBS was seen as a very useful approach: it was one-on-one, intensive, in the home, skill-building with high-risk families. On the other hand, the IHBS agency/model was seen as very selective of who they would/could serve. This resulted in self-perpetuating low referral rates in the first two years of the Waiver Demonstration, which also contributed to some turnover in IHBS therapists. Then, when the state realized Waiver cost-savings in the second year of the Waiver and wanted to expand the provision of IHBS to children/families outside the original population, the argument was perceived as based more on the need to use a contracted service, given the lack of a basis of widespread and numerous positive case outcomes.

Caseworkers who might refer a child or family to Wrap or SPAW often felt that making a referral would increase their own caseload by involving the caseworker in the intervention. For SPAW particularly, caseworkers expressed a concern that the SPAW meeting would result in added scrutiny and criticism of the casework done that had led to a "stuck" case.

During meetings prior to implementation of the Demonstration, one of the Waiver partners was a communications consultant, charged with managing the messaging strategy for the Waiver Demonstration, and telling the Waiver story, both within CWS and to the public and community partners. That communications work moved to within the Waiver leadership team

early in the Demonstration. While those inside the organization were well aware of the interventions, interviews with Family Court judges supported the notion of increased communications efforts in the community and with the public.

Initial Implementation Phase – NOT YET ACHIEVED

A well-functioning, timely, and user-friendly data and feedback loop system was not realized during the Waiver Demonstration. The two data systems used by Hawai'i Child Welfare Services are woefully inadequate to support data-driven practice, as evidenced in this *Report*.

The state has a variety of tools to support the assessment of risk and safety, and to support decision making at intake and throughout the life of the case. This evaluation has found that the use of these tools is often seen as a paperwork burden rather than a support of best practice. Data goes in to information systems, but is not summarized or fed back to supervisors or line staff in a timely or meaningful way to support decision making or to see the impact of evidence-based practice in one's own practice. The CWS Branch is exploring ways to strengthen the connection between these tools and informed practice decisions, while perhaps streamlining required documentation.

Implementation Infrastructure

Exploration Phase – PARTIALLY ACHIEVED

The Child Welfare Services Branch created a new Crisis Response Team unit on O'ahu, and trained that unit, and experienced caseworkers on Hawai'i Island, in the importance of a two-hour response and assessment, and identifying relatives for placement when possible. CWS also contracted with well-established contracted providers for the IHBS, Wrap, and SPAW interventions, and supplied them with high quality training in each of these intervention models. The IHBS model required that therapists be coached and supported by the Institute for Family Development, and this service on O'ahu and Hawai'i Island closely adhered to treatment fidelity in an intensive and highly structured model. Practitioners of Wrap and SPAW utilized ongoing training and consultation with national experts to support treatment fidelity, as well.

Installation Phase – PARTIALLY ACHIEVED

Coaching and support of the *Child and Adolescent Needs and Strengths* assessment were difficult throughout the Demonstration. Use of the *CANS* requires that users are certified annually, by passing an on-line certification exam. Not everyone passed the initial certification, and many never attempted to attain certification after the first year of the Demonstration. Leadership initially encouraged section administrators and supervisors to monitor and support

CANS usage, but this diminished over the course of the Demonstration, and use of the *CANS* was finally abandoned.

The Long-Stayer interventions of Wrap and SPAW were provided by private providers, and surveys of participants in these services noted high treatment fidelity. Both Wrap and SPAW required a referral by a CWS caseworker, with the added burden of a *CANS* assessment. This evaluation has provided numerous forms of evidence that, once services were implemented, there was a disconnect in this referral process. Referral to Wrap and SPAW felt, to some caseworkers, like a handoff and a loss of control over their case, rather than an opportunity for increased support and creative solutions. Many caseworkers saw such a referral as added scrutiny of how they had already served the child and family. Others did not see the value of a *CANS* assessment above what they already knew about a child and family. Partnerships between public and private partners require communication and nurturance, and the Demonstration would have benefitted from a clearer message about the benefits to children and families of shared information and shared decision-making.

As noted elsewhere, the Child Welfare Services Branch gathers a large amount of case data in the CPSS and SHAKA administrative databases. However, both caseworkers and administrators are severely hampered in their ability to use that data, both in case review and case planning, as well as in strategic planning by the Department. Neither program administrators nor the Evaluation Team could access immediate information from data systems on the level of implementation fidelity, treatment fidelity, or case outcomes while the Demonstration was implemented.

Initial Implementation Phase – NOT YET ACHIEVED

The supervisors and caseworkers who carried out the four Waiver Demonstration interventions, and the oversight of the *Child and Adolescent Needs and Strengths* assessment, were steadfast in seeing the Demonstration through for five years. The monthly meetings of the Waiver leaders and partners were well-attended, and anecdotes of successful cases served by each of the four interventions were shared and celebrated. These meetings were also an opportunity to identify challenges to implementation, and these were discussed, and sometimes this brainstorming produced possible solutions. However, without a well-functioning data system to monitor treatment fidelity, or even to track in real time the number of families served, no one had a clear sense of just how low the penetration rates were for all of the Waiver interventions, or how successful any of the interventions were, until the Demonstration was completed.

While the monthly Waiver meetings provided the opportunity for brainstorming and problem solving, there was concern that administration did not always follow through on these solutions. The feedback loop between those involved in the assessments and interventions, and those in administration, was not a complete circle and some felt that CWS Leadership could have done more in terms of encouraging the paradigm shift that was the Demonstration,

monitoring and maintaining accountability for implementation efforts, and continuing to support training and coaching throughout the Demonstration.

Table 125

Implementation Leadership: Levels of Achievement

Core Component	IMPLEMENTATION LEADERSHIP	
Overview:	**Competent teams and leaders are selected and the leaders prepare a plan based on best practices to successfully implement the intervention, and oversee its implementation**	
Phase	**Competency**	**Successful Implementation**
Exploration	Form leadership teams that have: (1) knowledge of the interventions in order to make informed decisions (e.g., regarding adaptations, fidelity); (2) knowledge of the implementation infrastructure needed to successfully implement this project; (3) knowledge of data-informed decision-making processes, and (4) knowledge of ways to achieve systems change.	• **ACHIEVED**
	Develop work plans and communication plans: (1) create a plan to promote clear, consistent and frequent communication; (2) prepare necessary documents, protocols and plans to achieve success; (3) develop common terms of reference	• **ACHIEVED**
Installation ***(Setting the Stage)***	Develop leadership competencies: (1) identify knowledge and skills necessary for successful implementation, including coaching; (2) develop those competencies, knowledge and skills for all levels of leadership	• **PARTIALLY ACHIEVED** ○ Staff voiced concerns about lack of buy-in and ownership of the Demonstration by administrators and supervisors.
	Assure resources to support innovations: (1) identify resources needed to implement interventions; (2) make action plan to obtain the resources; (3) obtain necessary resources and partnerships to ensure the necessary competencies needed to support and sustain implementation.	• **PARTIALLY ACHIEVED** ○ Training on assessments and referral criteria was confusing and incomplete.
Initial Implementation (*Rollout)*	Trouble shoot and problem solve: (1) identify problems, obstacles and barriers after the initial rollout of the intervention; (2) address identified problems with solutions; (3) monitor and conduct follow up to see if problems were resolved; (4) document adaptations related to problem-solving issues	• **PARTIALLY ACHIEVED** ○ Low referral rates for IHBS, Wrap, and SPAW were identified early and often, and not resolved. ○ A lack of key referral criteria for CRT, Wrap and SPAW was identified early and often, and not resolved.
	Use data to promote improvement: (1) use data and feedback to make necessary changes and adaptations to improve the interventions and the implementation of the interventions; (2) document these adaptations and changes	• **NOT YET ACHIEVED** ○ State data systems do not allow for timely feedback loops on implementation or necessary changes.
Full Implementation	Use improvement cycles: (1) establish and institutionalize protocols for trouble shooting and problem solving; (2) conduct periodic, continuous quality control to promote desired outcomes and improved success	
	Develop and test enhancements: (1) pilot adaptations and modifications that can enhance the success of the intervention	

Table 126

Data and Feedback Loops: Levels of Achievement

Core Component	**DATA AND FEEDBACK LOOPS**	
Overview:	**Use data and feedback loops to drive decision-making and promote continuous improvement.**	
Phase	**Competency**	**Successful Implementation**
Exploration	Conduct needs assessment: (1) conduct a data-driven needs assessment to establish prevalence of need for program; (2) select targeted areas to address need(s)	• **ACHIEVED**
	Assess existing data systems, data collection practices and available data: (1) assess the quality and quantity of data available, (2) collect baseline data or develop an immediate plan to obtain baseline data; (3) assess data collection practices; (4) assess the data management system/database to identify problems/barriers/challenges	• **ACHIEVED**
	Determine fit and feasibility of intervention(s): (1) conduct a formal assessment of community readiness for the project; (2) review and identify programs, practices and interventions that match target areas and address the identified needs; (3) assess potential barriers to implementing the proposed/selected interventions	• **ACHIEVED**
	Assess staff and stakeholder readiness: (1) assess staff qualifications; (2) assess staff readiness to implement a new project; (3) develop methods to promote buy-in for staff and stakeholders	• **PARTIALLY ACHIEVED** ○ Staff were not optimally involved in the development of the Demonstration and interventions.
Installation ***(Setting the Stage)***	Assess and address data infrastructure gaps related to the new innovations/interventions: (1) evaluate the data administration systems and collection processes and steps; (2) identify obstacles, challenges, barriers to data entry and management; (3) create a plan to overcome these obstacles	• **NOT YET ACHIEVED** ○ While data infrastructure gaps were acknowledged, a new CCWIS system was hoped to address these gaps. It never materialized.
	Institute and establish policy-practice feedback loops: (1) create a plan that will help move the interventions/changes in practice forward; (2) develop assessments to understand how the plan and new interventions are working; (3) develop protocols to make changes to the next iteration of the plan	• **NOT YET ACHIEVED** ○ State data systems do not allow for timely feedback loops on implementation or necessary changes.
	Assess data system competencies: (1) data systems are up and running; (2) data systems are designed to measure what they need to measure; (3) use data to ensure successful communication within and outside organization	• **NOT YET ACHIEVED** ○ Data systems were not adequately modified to include key Waiver eligibility criteria.
Initial Implementation (*Rollout)*	Data systems are functioning for measuring and reporting fidelity and outcomes	• **NOT YET ACHIEVED**
	Track and improve fidelity - (1) use data to measure intervention and implementation fidelity and track progress in implementation (outcomes); (2) use data to make data-informed decisions to improve fidelity and implementation of intervention/practices	
Full Implementation	Conduct data collection and use data to evaluate outcomes	
	Collect data to support fidelity monitoring and improvement: (1) have an established data administration system and collection process that supports ongoing fidelity monitoring; (2) use this data for continual refinement	

Table 127

Implementation Infrastructure: Levels of Achievement

Core Component	IMPLEMENTATION INFRASTRUCTURE	
Overview:	**A focus on capacity needed to implement the intervention. The objective is to evaluate the Demonstration, not CWS in general, but changes to general capacity would hopefully come as a result of the Demonstration.**	
Phase	**Competency**	**Successful Implementation**
Exploration	Identify and assess necessary **individual-level** infrastructure elements that will be needed to support the PRACTICE of the new intervention (the personnel characteristics, knowledge and skills that are needed for the Demonstration)	• **ACHIEVED**
	Identify and assess necessary **organizational-level** infrastructure elements to support practice, organizational, and system change required for success implementation (i.e., authority vested in Demonstration Leaders, caseload limits, supervision and coaching, ongoing training schedules, supports of best practice, data-driven decision-making)	• **PARTIALLY ACHIEVED** ○ Limited use of coaching; challenges in supporting the timely and ongoing use of the CANS assessment; inability to rely on data-driven decision-making.
Installation (Setting the Stage)	Install necessary **individual-level** infrastructure elements to support practice, organizational, and system change: (1) select and recruit staff based on necessary skills, knowledge and characteristics; (2) train relevant staff in necessary skills, knowledge and processes; (3) routinize activities to increase buy-in	• **PARTIALLY ACHIEVED** ○ Champions within interventions were identified, but not adequately supported in training others and increasing buy-in.
	Install necessary **organizational-level** infrastructure elements to support practice, organizational, and system change (caseload limits, supervision and coaching regimens, training schedules, aids and supports of best practice, decision-making)	• **PARTIALLY ACHIEVED** ○ Training provided in first year of Demonstration was not equally maintained across interventions; low attention to increasing buy-in among staff throughout the Demonstration.
	Adapt strategic plans to develop necessary individual and organizational infrastructure elements identified: (1) utilize and incorporate data to provide feedback to staff and create other organizational elements to improve practice and organizational fidelity	• **NOT YET ACHIEVED** ○ Ongoing strategic planning was hampered by poor data system feedback loops.
Initial Implementation (Rollout)	Monitor and Improve necessary **individual-level** infrastructure elements to support practice, organizational, and system change, using data and feedback loops	• **NOT YET ACHIEVED** ○ Ongoing monitoring of practice fidelity was hampered by poor data system feedback loops.
	Monitor and improve necessary **organizational-level** infrastructure elements to support practice, organizational, and system change using data and feedback loops	• **NOT YET ACHIEVED** ○ Ongoing monitoring of organizational supports due to poor data system feedback loops hindered system change to support innovative and responsive practice.
Full Implementation	Maintain skillful practices: (1) individual and organizational skills, knowledge, and practices are fully functioning and incorporated into daily operations; (2) monitoring and feedback systems are thoroughly integrated into institutional practices	
	Produce more efficient and/or effective infrastructure to support outcomes: (1) data-driven feedback loops, along with monitoring systems are built into infrastructure to produce more effective and efficient processes to improve fidelity.	

CONCLUSIONS

The main lesson that runs through the evaluation findings is that the Waiver Demonstration in Hawai'i, like its larger child welfare service system, was implemented and executed by a cadre of experienced and dedicated professionals across child-serving agencies with long-standing and strong relationships with, and in support of, one another. DHS and its partners sought and maintained consultation and support from highly regarded and deeply experienced experts, both within the state and across the mainland, to build and implement four new approaches to prevention and permanency for the most vulnerable children and families they serve. The evaluation finds bountiful evidence of the best of intentions and commitment to implementing the Demonstration and its interventions thoughtfully and with fidelity.

However, those implementing and practicing the assessments and interventions, especially within DHS, were hampered by the current DHS data systems that are unable to provide comprehensive real-time data or communications on how the children, families, or the interventions were faring on the whole. Without a system that was able to sustain the necessary feedback loops, maintaining a commitment to the Demonstration waned, and the number of children and families served by the Demonstration did not suffice to affect the numbers of children in care in Hawai'i. As the State of Hawai'i DHS moves forward with both the design and implementation of a CCWIS and FFPSA plan, it will be important to consider the lessons learned about the state's data systems, data collection procedures and feedback loops to improve the outcomes of these future initiatives.

After the Waiver Demonstration was largely concluded, this evaluation found mixed positive results of four new interventions. Efforts to prevent child placement through a Crisis Response Team did not decrease the proportion of children being placed into out-of-home care immediately following the CRT response, and did not decrease the proportion of placed children who were short-stayers, or those who entered and exited care in 30 days or less. However, the nature of child maltreatment became more complex during the Demonstration (more children with multiple types of maltreatment, more children at imminent risk of harm, more children with caregivers with violent behavior, more parent impulsivity, and more parents who cannot meet the child's immediate needs). Indeed, an analysis of the correlates of removal following a Crisis Response found that, in general, parental substance abuse and child neglect continue to drive decisions to remove children from the home, even following CRT.

The Intensive Home-Based Services intervention was also new to Hawai'i, followed strict treatment fidelity requirements, and had very impressive outcomes. Few families experienced child placement within 90 days of completing four to six weeks of IHBS. IHBS therapists assessed most families as making improvements, with the strongest gains in family safety and family interactions. In addition, almost all families were assessed by CRT or CWS caseworkers as having improved in safety factors, including impending danger to the child and violent caregivers, from pre-to-post IHBS. The IHBS intervention was plagued by low uptake rates,

particularly in the early years of the Demonstration, and was perceived by many as having strict eligibility criteria. Toward the end of the Demonstration, these criteria were broadened (cases outside of Demonstration eligibility and thus not included in this evaluation), which will provide an opportunity for the state to assess the effectiveness of IHBS with larger numbers of children and families.

The Family Wrap Hawai'i process also followed national guidelines for wraparound services, and this evaluation found high treatment fidelity, as shown by process measures as well as surveys of adult and youth participants. Reunification is the goal of wraparound, and more than two-thirds of children and youth served by Wrap were reunified with their families following Wrap. The average length of time from the first Wrap meeting to reunification was four to five months. The likelihood of achieving reunification was decreased if the child had a history of sexual abuse or scored highly on the Trauma Domain on the *Child and Adolescent Needs and Strengths* assessment.

The Safety, Permanency, and Well-Being (SPAW) meetings were also based on a well-developed model of services for children and youth having difficulty achieving permanency. In the Waiver Demonstration, these services were directed at children and youth considered unlikely to reunify, and consisted of one meeting of professionals involved in the case who could bust barriers to the case not moving toward a permanent family for the child or youth. Again, participants in the SPAW meetings noted the high fidelity of the process. Although the children and youth referred for a SPAW meeting often had challenging histories, many did exit care to adoption, guardianship, or reunification, and only one of the children with these outcomes re-entered care by the end of the Demonstration. However, permanency was difficult to achieve for older children who had a longer history in out-of-home care. This population is growing in Hawai'i, and the Waiver Demonstration did not find an adequate means to stem this trend.

The four Waiver interventions did not reach enough children and families to make a substantial difference in the overall foster care population. Referring back to Table 12.2, the penetration rates for the four interventions were low. The CRT response was provided to between 20 percent and 44 percent of eligible children during the Demonstration, with much lower penetration rates for those children referred from schools and hospitals. The IHBS intervention was provided to eight percent to 11 percent of children who received CRT. While both of these interventions were aimed at reducing unnecessary placement into foster care, entries into foster care increased during the Waiver. It is unknown what the impact on foster care entries would have been if more children had received CRT and/or IHBS.

The penetration rates for Wrap and SPAW are also low. These interventions were provided to between three percent and 14 percent of Long-Stayer children in care during the Waiver years. While these interventions did realize reunifications, adoptions, and children moving into guardianship, these outcomes occurred for fewer than five percent of all Long-Stayers, which would not affect the size of the Long-Stayer population on O'ahu or Hawai'i Island.
The state of Hawai'i saw the size of the foster care population increase during the transition to the Waiver Demonstration, and increase even more during the Demonstration. This increase

was due both to more children entering care, and fewer children exiting care. At the same time, the state enacted increases in the foster care board and maintenance rate, in FY2015 and FY2019. These trends combined to produce an increase in expenditures on foster care under the Waiver Demonstration, rather than the expected decrease.

Finally, the analysis of outcomes after a Crisis Response suggests that more children are entering care, especially on Hawai‘i Island, due to parental substance abuse and child neglect. This trend mirrors that seen in mainland states. It will be important for new DHS policy and practice initiatives to join with other community partners in addressing these two long-standing challenges to family integrity and the safety, permanency, and well-being of children in Hawai‘i.

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Chapter 6 Appendix

CRT Figure Details
Disposition Patterns to CRT

CRT Figure Details

Table 6.1

Trends in Source of Report on O'ahu 2012 – 2017

O'ahu	CRT					
	2012	**2013**	**2014**	**2015**	**2016**	**2017**
Hospital	533	555	769	944	959	967
School	929	876	1031	947	1007	948
Law Enforcement	460	377	402	367	438	406

Table 6.2

Trends in Source of Report on Hawai'i Island 2012 – 2017

Hawai'i Island	CRT					
	2012	**2013**	**2014**	**2015**	**2016**	**2017**
Hospital	117	109	186	249	265	315
School	309	269	270	236	348	403
Law Enforcement	206	188	155	178	133	148

Table 6.3

Number of Victims by Year, O'ahu and Hawai'i Island

	CRT					
	2012	**2013**	**2014**	**2015**	**2016**	**2017**
O'ahu	2455	2103	2269	2125	2246	2466
Hawai'i Island	836	824	875	917	907	1019

Table 6.4

Proportion of Intakes with Types of Abuse

	CRT						
	2012	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
Threat of Abuse	63.05%	61.38%	63.53%	74.68%	78.26%	81.03%	82.28%
Physical Abuse	20.69	17.68	15.46	14.34	14.32	13.53	13.95

Table 6.5

Proportion of Intakes with Types of Neglect

	CRT						
	2012	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
Threatened Neglect	49.91%	57.81%	60.97%	67.89%	67.98%	76.47%	74.98%
Physical Neglect	21.58	18.19	13.60	13.68	11.68	10.11	12.59
Lack of Supervision	5.47	4.19	3.59	2.84	2.01	1.41	2.28
Medical Neglect	1.34	1.79	1.41	1.85	1.21	1.38	1.75

Table 6.6

Classification of Maltreatment

	CRT						
	2012	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
Maltreatment is Severe	3.42%	4.29%	4.87%	6.10%	5.19%	4.34%	2.59%
More than One Mal Type	55.72	57.78	57.31	70.10	71.67	78.36	77.83

Table 6.7

Classification of Harm

	CRT						
	2012	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
At Imminent Risk of Harm	94.01%	87.90%	88.11%	89.38%	89.51%	90.04%	93.49%
Meets Legal Def of Harm	42.05	37.24	32.69	31.18	32.04	25.91	29.02

Table 6.8

Trends in Physical Abuse Safety Factors

	CRT						
	2012	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
Caregiver Violent Behavior	39.58%	36.93%	35.00%	36.21%	37.70%	39.05%	45.06%
Parent Impulsivity	23.55	29.52	33.44	32.71	33.29	37.25	37.14
Present or Impending Danger	18.57	17.45	15.34	1.53	18.27	17.12	18.04
Child Lack of Protective Skills	7.09	8.59	10.50	9.82	8.23	11.76	11.33

Table 6.9

Trends in Neglect Safety Factors

	CRT						
	2012	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
Parental Substance Abuse	35.53%	30.53%	32.76%	34.04%	32.04%	34.10%	30.67%
Cannot Meet Immediate Needs	17.13	16.93	18.13	22.33	15.37	20.48	26.94
Inadequate Supervision	16.39	16.10	13.39	12.88	12.96	12.85	14.98
Lack of Parent Knowledge or Skill	9.60	9.56	8.42	8.32	16.95	12.70	7.88

Table 6.10

Dispositions as a Percentage of Intakes from Law Enforcement on O'ahu

O'ahu	CRT						
	2012	2013	2014	2015	2016	2017	2018
CWS	90.9%	83.8%	83.1%	33.8%	29.0%	33.3%	39.4%
CRT, CRTA, CRTC				54.2	54.8	51.7	47.5
Diverted (FSS/VCM)	5.4	14.1	15.4	10.9	13.2	13.3	11.7
No Action	0.0	0.8	0.2	0.5	1.8	1.2	0.0

Table 6.11

Dispositions as a Percentage of Intakes from Law Enforcement on Hawai'i Island

Hawai'i Island	CRT						
	2012	2013	2014	2015	2016	2017	2018
CRT, CRTA, CRTC				18.5%	60.2%	64.9%	45.0%
CWS	94.7%	91.5%	86.5%	71.9	33.1	29.1	47.7
Diverted (FSS/VCM)	4.4	6.9	13.5	9.6	6.8	5.4	7.4

Table 6.12

Dispositions as a Percentage of Intakes from Hospitals on O'ahu

O'ahu	CRT						
	2012	2013	2014	2015	2016	2017	2018
CWS	79.7%	68.5%	70.4%	53.1%	51.4%	54.3%	52.8%
CRT, CRTA, CRTC				12.9	21.7	14.9	16.9
Diverted (FSS/VCM)	16.7	29.7	28.1	32.3	25.8	29.7	28.7
No Action	2.1	1.6	0.5	0.3	0.1	0.2	0.7

Table 6.13

Dispositions as a Percentage of Intakes from Hospitals on Hawai'i Island

Hawai'i Island	CRT						
	2012	2013	2014	2015	2016	2017	2018
CWS	75.2%	85.3%	75.8%	67.9%	58.1%	61.3%	62.2%
CRT, CRTA, CRTC				6.0	22.3	14.6	9.5
Diverted (FSS/VCM)	17.1	14.7	21.0	23.3	19.6	24.1	28.4
No Action	7.7	0.0	2.2	2.0	0.0	0.0	0.0

Table 6.14

Dispositions as a Percentage of Intakes from Schools on O'ahu

O'ahu	CRT						
	2012	2013	2014	2015	2016	2017	2018
CWS	63.0%	62.4%	52.6%	31.6%	24.1%	42.2%	36.8%
CRT, CRTA, CRTC				21.6	25.2	12.7	7.4
Diverted (FSS/VCM)	34.9	36.2	46.7	46.5	50.0	44.1	54.4
No Action	0.1	0.0	0.0	0.0	0.2	0.3	0.2

Table 6.15

Dispositions as a Percentage of Intakes from Schools on Hawai'i Island

Hawai'i Island	CRT						
	2012	2013	2014	2015	2016	2017	2018
CWS	71.2%	71.4%	70.0%	48.3%	33.9%	53.1%	46.9%
CRT, CRTA, CRTC				4.7	23.9	11.7	8.1
Diverted (FSS/VCM)	24.9	26.8	29.6	47.0	42.2	34.0	45.0
No Action	0.0	0.0	0.0	0.0	0.0	1.2	0.0

Table 6.16

Percentage of Dispositions by Day of Week on O'ahu

O'ahu	CRT						
	Sun	Mon	Tues	Weds	Thurs	Fri	Sat
CRT	17%	12%	10%	11%	11%	13%	23%
CWS	53	50	52	51	50	47	43
Diff Resp	27	36	36	35	36	38	30

Table 6.17

Percentage of Dispositions by Day of Week on Hawai'i Island

Hawai'i Island	CRT						
	Sun	Mon	Tues	Weds	Thurs	Fri	Sat
CRT	7%	11%	11%	12%	7%	14%	23%
CWS	51	56	61	57	59	52	43
Diff Resp	32	32	27	30	34	32	33

Table 6.18

Source of Maltreatment Report

	Oʻahu (n=1745)	**Hawaiʻi Island** (n=418)
Source of Maltreatment Report		
Law enforcement	33%	42%
School	28	27
Hospital	24	17
Other	8	9
Public social agency	3	4
Relative	2	1
Court	2	<1
At imminent risk of harm	95%	96%

Table 6.19

CRT Two-Hour Response

Time from Referral to CRT Contact	**CRT**	
	Oʻahu (n=901 intakes)	**Hawaiʻi Island** (n=223 intakes)
2 hours or less	88%	65%
1 to 60 minutes	45%	35%
61 to 120 minutes	43	30
2+ hours to 12 hours	8	18
12+ hours to 24 hours	1	3
More than 24 hours	1	2
Negative number	1	1
0 minutes	<1	10
Missing	<1	0

Table 6.20

Average CRT Response Time by Day of the Week

	CRT						
	Sun	**Mon**	**Tue**	**Wed**	**Thurs**	**Fri**	**Sat**
Hawaiʻi	1.92	2.45	1.43	1.78	2.72	2.35	2.03
Oʻahu	1.80	1.28	1.45	1.32	1.40	1.55	1.35

Note. These averages are calculated by intake and not by child.

Table 6.21

Initial Safety Assessments Completed

		CRT			
		O'ahu		**Hawai'i Island**	
		Number Completed	Completion Rate (%)	Number Completed	Completion Rate (%)
2015	Half 1	112	58%	-	-
	Half 2	165	61	46	100%
2016	Half 1	329	87	87	88
	Half 2	281	91	56	64
2017	Half 1	159	74	65	87
	Half 2	101	80	43	59
2018	Half 1	112	68	33	100
	Half 2	74	83	4	100
Total		**1333**	**76%**	**334**	**80%**

Note. Waiver began in October 2015 for Hawai'i Island

Table 6.22

Initial Dispositions for Children from CRT

Initial CRT Disposition	**O'ahu** (n=1745)	**Hawai'i Island** (n=418)
Child Welfare Services	58%	64%
Crisis Response Team	16	1
Intensive Home-Based Services	9	12
Voluntary Case Management	9	3
CLOSED	6	19
Family Strengthening Services	2	1

Table 6.23

Child and Family Demographic Characteristics

Demographic Characteristics	**CRT**	
	Oʻahu (n=1745)	**Hawaiʻi Island** (n=418)
Sex of victim		
Female	51%	58%
Male	49	42
Number of children in home		
Mean	3	3
Mode	3	3
Range	1 to 11 children	1 to 10 children
Number of adults in home		
Mean	2	2
Mode	2	2
Range	1 to 8 adults	1 to 7 adults
Age of child		
Infant	12%	12%
1 – 5 years	29	28
6 – 10 years	25	25
11 – 15 years	25	25
16 or 17 years	9	10
Mean age	7.6 years	7.6 years

Table 6.24

Race and Ethnicity of Victim

Race and Ethnicity	CRT	
	Oʻahu (n=1745)	**Hawaiʻi Island** (n=418)
Race of victim[a]		
Hawaiian/Pacific Islander	56%	58%
White	48	52
Asian	44	35
Black	12	4
American Indian/Alaskan Native	4	3
Unknown	1	3
Ethnicity of victim		
Hawaiian/Part Hawaiian	35%	45%
White	14	16
Mixed (not H/PH)	13	20
Filipino	8	3
Samoan/American Samoan	8	1
Black	6	2
Chuukese	5	4
Hispanic/Spanish Origin	4	1
Chinese	1	1
Japanese	1	1
Marshallese	1	1
Other Pacific Islander	1	1
Vietnamese	1	1
Unable to determine	1	1
Missing	1	1
Kosraean	<1	1
American Indian	<1	0
Korean	<1	0
Laotian	<1	0
Tongan	<1	0
Palauan	<1	0
Alaskan Native	0	1

[a]Multiple response.

Table 6.25

CRT Same or Next Day Removals: Oʻahu

Oʻahu	**Source of Report**				
	Law Enforcement (n=573)	**School** (n=495)	**Hospital** (n=423)	**Other** (n=254)	**Total** (n=1745)
No Removal	45%	73%	74%	45%	60%
Same or Next Day Removal	55	27	26	55	40
Removed and Short-Stay	31	17	9	22	20

Table 6.26

CRT Same or Next Day Removals: Hawaiʻi Island

Hawaiʻi Island	**Source of Report**				
	Law Enforcement (n=176)	**School** (n=115)	**Hospital** (n=70)	**Other** (n=57)	**Total** (n=418)
No Removal	40%	74%	57%	61%	56%
Same or Next Day Removal	60	26	43	39	44
Removed and Short-Stay	28	13	14	23	21

Table 6.27

CRT Same or Next Day Removals, Victims only: Oʻahu

Oʻahu	**Source of Report**				
	Law Enforcement (n=409)	**School** (n=295)	**Hospital** (n=262)	**Other** (n=200)	**Total** (n=1166)
No Removal	25%	56%	59%	32%	42%
Same or Next Day Removal	75	44	41	68	58
Removed and Short-Stay	42	27	14	27	29

Table 6.28

CRT Same or Next Day Removals, Victims only: Hawaiʻi Island

Hawaiʻi Island	**Source of Report**				
	Law Enforcement (n=142)	**School** (n=87)	**Hospital** (n=61)	**Other** (n=47)	**Total** (n=337)
No Removal	30%	72%	57%	70%	51%
Same or Next Day Removal	70	28	43	30	49
Removed and Short-Stay	31	10	10	11	18

Table 6.29

CRT Same or Next Day Removals, 2015 – 2018: Oʻahu

Oʻahu	**CRT**			
	2015	**2016**	**2017**	**2018**
Hospital	27%	23%	31%	24%
School	20	27	40	29
Law Enforcement	54	52	48	69

Table 6.30

CRT Same or Next Day Removals, 2015 – 2018: Hawaiʻi Island

Hawaiʻi Island	**CRT**			
	2015	**2016**	**2017**	**2018**
Hospital	11%	38%	50%	75%
School	67	11	43	50
Law Enforcement	91	72	47	35

Table 6.31

Length of Short-Stay for Same/Next Day Removals: Oʻahu

Oʻahu	**Source of Report**				
	Law Enforcement (n=180)	**School** (n=83)	**Hospital** (n=38)	**Other** (n=55)	**Total** (n=356)
1 to 5 Days	72%	47%	66%	53%	63%
6 to 10 Days	9	30	18	16	16
11 to 20 Days	15	11	5	16	13
21 to 30 Days	4	12	11	15	8
Avg Length of Short Stay	5.8 days	8.4 days	6.1 days	8.7 days	6.9 days

Table 6.32

Length of Short-Stay for Same/Next Day Removals: Hawaiʻi Island

Hawaiʻi Island	**Source of Report**				
	Law Enforcement (n=50)	**School** (n=15)	**Hospital** (n=10)	**Other** (n=13)	**Total** (n=88)
1 to 5 Days	86%	93%	60%	77%	83%
6 to 10 Days	8	0	30	0	8
11 to 20 Days	2	7	0	0	2
21 to 30 Days	4	0	10	23	7
Avg Length of Short Stay	4.0 days	3.3 days	7.5 days	7.8 days	4.9 days

Table 6.33

First Placement Setting, 2015 – 2018: All CRT Children With Same/Next Day Removal; Oʻahu

Oʻahu	**Source of Report**				
	Law Enforcement (n=314)	**School** (n=134)	**Hospital** (n=109)	**Other** (n=139)	**Total** (n=696)
Paid Placements	**90%**	**90%**	**71%**	**90%**	**87%**
Emergency Foster Care	35	38	17	30	32
Room & board – Foster care	24	25	21	27	24
Room & board – Relative care	20	22	25	24	22
Room & board – Emergency shelter	11	5	8	9	9
Non-Payment Placements	**10%**	**10%**	**29%**	**10%**	**13%**
Missing data	7	7	2	6	6
Child elsewhere	2	2	8	3	3
Hospitalization	1	1	17	0	3
Residential treatment	<1	0	1	0	<1
Child with non-custodial legal parent	<1	0	0	0	<1
Detainment of a minor	<1	0	0	0	<1
Child runaway	0	0	1	1	<1

Table 6.34

First Placement Setting, 2015 – 2018: All CRT Children With Same/Next Day Removal; Hawaiʻi Island

Hawaiʻi Island	**Source of Report**				
	Law Enforcement (n=105)	**School** (n=30)	**Hospital** (n=30)	**Other** (n=22)	**Total** (n=187)
Paid Placements	**86%**	**87%**	**50%**	**95%**	**82%**
Room & board – Foster care	60	64	43	68	59
Emergency Foster Care	14	17	0	9	12
Room & board – Relative care	10	3	7	18	9
Room & board – Emergency shelter	1	3	0	0	1
Room & board - Adoption Subsidy	1	0	0	0	1
Non-Payment Placements	**14%**	**13%**	**50%**	**5%**	**18%**
Child elsewhere	6	7	17	0	7
Hospitalization	5	0	33	0	8
Missing data	3	3	0	0	1
Residential treatment	0	3	0	0	1
Child runaway	0	0	0	5	1

Table 6.35

First Placement Setting for Same-Next Day Removals: O'ahu

Placement Type	Total (n=696)	Short-Stayer (n=356)	Placed > 30 days (n=340)
Paid Placements	**87%**	**82%**	**91%**
Emergency Foster Care	32	38	25
Room and board – Foster care	24	19	29
Room and board – Relative care	22	17	27
Room and board – Emergency shelter	9	8	10
Non-Payment Placements	**13%**	**18%**	**9%**
Missing data	6	11	1
Hospitalization	3	3	4
Child elsewhere	3	3	4
Residential treatment	<1	<1	<1
Child runaway	<1	1	<1
Child with non-custodial legal parent	<1	<1	0
Detainment of a minor	<1	<1	0

Table 6.36

First Placement Setting for Same-Next Day Removals: Hawai'i Island

Placement Type	Total (n=187)	Short-Stayer (n=88)	Placed > 30 days (n=99)
Paid Placements	**82%**	**79%**	**85%**
Room and board – Foster care	59	64	55
Emergency Foster Care	12	9	14
Room and board – Relative care	9	5	14
Room and board – Emergency shelter	1	1	1
Adoption – Room and Board Subsidy	1	0	1
Non-Payment Placements	**18%**	**21%**	**15%**
Hospitalization	8	7	9
Child elsewhere	7	9	5
Missing data	1	4	0
Residential treatment	1	1	0
Child runaway	1	0	1

Table 6.37

Final Dispositions for Children from CRT who did not receive IHBS

Final CRT Disposition	O'ahu (n=1575)	Hawai'i Island (n=366)
Child Welfare Services	65%	74%
CLOSED	16	22
Voluntary Case Management	12	3
Missing	5	<1
Family Strengthening Services	2	1

Table 6.38

Number of Children Entering Care

	CRT						
	2012	2013	2014	2015	2016	2017	2018
All State	1,163	1,054	1,071	1,238	1,233	1,160	1,251
O'ahu	657	668	601	655	634	565	664
Hawai'i Island	288	197	248	320	336	286	377

Table 6.39

Same or Next Day Removals, O'ahu and Hawai'i Island

	CRT			
	O'ahu		Hawai'i Island	
	Pre-Waiver	Waiver	Pre-Waiver	Waiver
Law Enforcement	38%	55%	37%	60%
School	16	27	14	27
Hospital	12	26	10	43

Table 6.40

Short Stayers, O'ahu and Hawai'i Island

	CRT			
	O'ahu		Hawai'i Island	
	Pre-Waiver	Waiver	Pre-Waiver	Waiver
Law Enforcement	23%	32%	19%	29%
School	10	17	9	14
Hospital	4	9	1	14

Table 6.41

Placement After Law Enforcement Intake, Oʻahu

Oʻahu Law Enforcement Placements	**CRT**	
	Pre-Waiver	**Waiver**
Placed with Relatives	9%	20%
Placed in Emergency Foster Home	38	35
Placed in Paid Foster care	28	24
Other	25	21

Table 6.42

Placement After Law Enforcement Intake, Hawaiʻi Island

Hawaiʻi Island Law Enforcement Placements	**CRT**	
	Pre-Waiver	**Waiver**
Placed with Relatives	14%	11%
Placed in Emergency Foster Home	14	14
Placed in Paid Foster care	51	60
Other	21	15

Table 6.43

Placement After School Intake, Oʻahu

Oʻahu School Placements	**CRT**	
	Pre-Waiver	**Waiver**
Placed with Relatives	15%	22%
Placed in Emergency Foster Home	43	38
Placed in Paid Foster care	32	26
Other	10	14

Table 6.44

Placement After School Intake, Hawaiʻi Island

Hawaiʻi Island School Placements	**CRT**	
	Pre-Waiver	**Waiver**
Placed with Relatives	5%	3%
Placed in Emergency Foster Home	2	17
Placed in Paid Foster care	81	63
Other	12	17

Table 6.45

Placement After Hospital Intake, O‘ahu

O‘ahu Hospital Placements	**CRT**	
	Pre-Waiver	**Waiver**
Placed with Relatives	19%	25%
Placed in Emergency Foster Home	7	17
Placed in Paid Foster care	31	21
Other	43	37

Table 6.46

Placement After Hospital Intake, Hawai‘i Island

Hawai‘i Island Hospital Placements	**CRT**	
	Pre-Waiver	**Waiver**
Placed with Relatives	6%	7%
Placed in Emergency Foster Home	0	0
Placed in Paid Foster care	42	43
Other	52	50

Patterns in Dispositions to the Crisis Response Team versus Child Welfare Services

The number of children referred for a CRT response met (on Hawai‘i Island) or exceeded by 40% (on O‘ahu) the goals of the Demonstration. On the other hand, fewer than half of all eligible intakes were referred for a Crisis Response.

On O‘ahu, over the course of the Demonstration, a CRT response was provided to an average of 52% of intakes from law enforcement, and 16% of intakes from hospitals and schools. On Hawai‘i Island, a Crisis Response was provided to an average of 58% of intakes from law enforcement, 15% of intakes from hospitals, and 16% of intakes from schools. Almost all children referred to CRT were identified as being at imminent risk of harm, a proxy for imminent risk of placement, the other criterion for eligibility for the CRT.

The evaluators had discussions with DHS leadership and practitioners to try to identify what made the difference between a disposition to CRT and a disposition elsewhere, given that no other eligibility criteria were identified in the Demonstration. Anecdotal evidence from these discussions suggested that children identified as (or considered) at risk of harm were indeed disposed for a CRT response, but that children who were judged to be at a higher risk of placement (not harm), based on a number of risk factors known at Intake, were referred directly to Child Welfare Services. The rationale for this decision was the prediction that a CRT response would ultimately lead to a disposition to Child Welfare Services, so not to waste time on a CRT response.

Based on detailed analyses of disposition patterns (see Appendix), identifying differential risk profiles for children reported by law enforcement, schools, and hospitals, the evaluation compares outcomes in them separately.

The evaluation tested this assertion.

As mentioned earlier, the evaluation had a data file of All Intakes (reports of maltreatment) from the years 2012-2018. These years encompass the three years prior to the Waiver Demonstration (2012-2014), and almost four years of the Waiver Demonstration (2015-the first nine months of 2018). For each report of maltreatment, the following data are known to Intake at the time of the report and disposition.

1. Age, sex, ethnicity of the child(ren)
2. Details of the report: date, type(s) of maltreatment, source of the report, perpetrator
3. Family risk factors of whether the child had prior experience with Hawai‘i CPS, whether the parents had a criminal history and/or received HAWI benefits (a proxy for poverty)

4. Whether the maltreatment met the legal definition of harm, and whether the child was at imminent risk of future harm
5. Island

The All Intakes file also has the resulting disposition by Intake: No Action, Differential Response to Voluntary Case Management or Family Strengthening Services, disposition to Child Welfare Services, and (during the Waiver years) disposition to the Crisis Response Team.

Our goal was to identify the risk factors and other characteristics that distinguish children disposed to the CRT during 2015-2018.

Testing Assumptions about the Risk Factors

We assumed that children disposed to CRT or CWS were at a higher risk of harm than those referred to Voluntary Case Management (VCM) or Family Strengthening Services (FSS), or where no action was taken.

To test this assumption, we selected children with a report of maltreatment in 2012-2018, for whom (1) this was their first intake for a report of maltreatment in that period (to control for the effect of historical factors that we could not test), (2) there was "no prior CPS experience," and (3) they were living on Oʻahu or Hawaiʻi Island.

We compared two groups of children: (1) those disposed by Intake to CRT or Child Welfare Services, and (2) those disposed to Voluntary Case Management, Family Strengthening Services, or No Action taken.

Those disposed to CRT or CWS were significantly different ($p < .001$) than those receiving differential response or no response in the following ways:

1. They were identified at Intake as a victim.
2. The report came from a private physician, a hospital, a nurse, a day care provider, law enforcement, or present caretaker other than parent.
3. The type of maltreatment was physical abuse, physical neglect, sexual abuse, threat of abuse, or threatened neglect.
4. The parent had a criminal history.
5. The allegation met the legal definition of harm.
6. The child was at imminent risk of harm.

So yes, those children disposed to CRT or CWS were significantly more likely to have a variety of standard risk factors. The higher incidence of different risk factors for those children disposed to CRT and CWS confirmed our assumption that these children were higher risk than those diverted to voluntary services or with no action taken.

Profiles of Children Disposed to the CRT

The reader will recall that the two eligibility criteria for a disposition to CRT are:

1. Source of report is law enforcement, hospitals, or schools, and
2. Child is at risk of imminent placement (because CPS assessments do not have such an indicator, risk of imminent harm was used as a proxy).

However, the analysis of dispositions to the CRT demonstrates that the disposition of children from Intake to the CRT varied greatly, depending on whether the source of the report was law enforcement, hospitals, or schools. As previously specified, 53%-60% of law enforcement reports were disposed to CRT in the first full year of implementation on Oʻahu and Hawaiʻi Island. Only 12%-22% of hospital reports were so disposed in the same time frame, and 20%-25% of school reports. Almost all children disposed to CRT were judged to be at imminent risk of harm, so clearly other criteria besides the two stated eligibility criteria were influencing a disposition by Intake to the Crisis Response Team, given these very different patterns of disposition by Intake.

To further investigate the influences on dispositions to CRT, we limited our analyses to only dispositions in 2016. This was the first true and full year of the Waiver Demonstration, and it is the year that had the most CRT referrals on both islands. The Evaluation Team heard anecdotally that disposition patterns within Intake shifted over time in the Waiver, and analyses demonstrated that disposition patterns changed over the years of the Waiver Demonstration. To avoid the confounding of changing disposition patterns, we limited our test to 2016; what is probably the year truest to disposition criteria.

Binary logistic regression was used to identify the key predictors of a disposition to CRT versus to CWS. The sample of 4,021 children was those children (1) who were the subject of a maltreatment report in 2016, (2) on Oʻahu or Hawaiʻi Island, (3) not currently in out-of-home care, and (4) disposed to either CRT or CWS. The dependent variable was the binary outcome of a disposition to either CRT or CWS. The independent variables (those that might influence whether a report was disposed to CRT versus CWS) were:

- The source of the report
- The type of maltreatment was threat of abuse
- The type of maltreatment was threatened neglect
- The maltreatment met the legal definition of harm
- The child was at imminent risk of harm
- The child was identified as a victim
- The family had prior experience with CPS
- The family had prior criminal history
- The family received HAWI (financial or food) assistance
- The child's age at time of the report

In this 2016 sample, the key predictor of a disposition to Child Welfare Services, not the CRT, was that the report was from law enforcement, schools, and hospitals, in that order. These three sources of the report were more predictive of a referral to CWS than all other factors in the model. After that, the difference between being referred to CRT or CWS is less clear. In a binary logistic regression, significant predictors of going to CRT (rather than CWS), were:

- Being classified as a victim,
- Having a family criminal history,
- Meeting the legal definition of harm, and
- NOT receiving HAWI (financial or food) assistance.

Being at risk of imminent harm (an eligibility criterion) was NOT a predictor of a disposition to CRT, given that almost everyone disposed to either CRT or CWS was classified as being at risk of harm.

The overall model correctly predicted 45% of the children disposed to the CRT, and 92% of the children disposed to Child Welfare Services.

The source of the report being law enforcement, school, or hospital still predicted a disposition to Child Welfare Services, which is bolstered by the previously demonstrated low overall disposition rates to the CRT from these three sources. However, the majority of children disposed to the CRT were from these three sources. Therefore, we performed the same logistic regression on the same 2016 intakes, but this time, performed the analysis on ONLY reports from law enforcement, then ONLY reports from schools, then ONLY reports from hospitals.

This was clarifying. It appears that, after Intake knew the source of the report (law enforcement vs. school vs. hospital), the decision making about whether to dispose the case to CRT or CWS differed, depending on the source of the report.

Reports from Law Enforcement

The key predictors of a disposition of a law enforcement report to CRT rather than CWS were:

- The child was at risk of imminent harm
- The family was not receiving HAWI benefits

This model correctly predicted 86% of dispositions to CRT and 30% of dispositions to CWS.

Reports from Schools

The key predictors of a disposition of a school report to CRT rather than CWS were:

- The child was a victim
- The maltreatment did not meet legal definition of harm

The child being at imminent risk of harm was not a predictor for a disposition to the CRT.

This model correctly predicted 58% of dispositions to CRT, and 70% of dispositions to CWS.

Reports from Hospitals

The key predictors of a disposition of a hospital report to CRT rather than CWS were:

- The child was at risk of imminent harm
- The family had criminal history
- The child was not a victim
- The maltreatment did not meet legal definition of harm
- The family was not receiving HAWI benefits

This model correctly predicted 23% of dispositions to CRT and 96% of dispositions to CWS.

The Source of Report Influenced Differential Dispositions to the CRT

So, indeed, the characteristics of the maltreatment and the family were influential in making a disposition to either CRT or CWS, but they varied by the source of report.

Intake did appear to follow the two key eligibility criteria of when to refer a report to the CRT, particularly when the source of the report was law enforcement.

Once Intake knew what the source of the report was, then other judgement calls were made. For example, when the source was police, Intake DID follow the criterion of imminent risk of harm.

When the source of report was schools, fewer children were referred to the CRT, and many were sent to diversionary programs like Voluntary Case Management. Intake did send reports with victims to the CRT, but again, those children did not meet the legal criteria of imminent risk of harm.

When the source of report was hospitals, Intake did follow the criterion of imminent risk of harm, but the child was likely not to be a victim. The maltreatment was not likely to meet the legal def of harm. Also, the family having a criminal history was a significant predictor of a referral to the CRT. These findings are confusing, but this set of indicators was the least accurate in predicting a disposition among hospital reports.

Therefore, the source of the report significantly distinguished between decision-making patterns in disposing a report to the Crisis Response Team.

Chapter 7 Appendix

IHBS Figure Details

IHBS Figure Details

Table 7.1
Children Referred from CRT to IHBS

	IHBS	
	Oʻahu (goal of 70 children/yr)	**Hawaiʻi Island** (goal of 33 children/yr)
2015	68	2
2016	50	23
2017	47	25
2018	2	4
Total	**167 children**	**54 children**

Table 7.2
Source of Maltreatment Report for Children Referred from CRT to IHBS

Source of Maltreatment Report	**Oʻahu** (n=167 referrals)	**Hawaiʻi Island** (n=55 referrals)
School	54%	29%
Hospital	24	35
Law enforcement	18	29
Private physician	4	7

Table 7.3
IHBS Response Time

Response Time	**IHBS**	
	Oʻahu (n=66 referred families)	**Hawaiʻi Island** (n=27 referred families)
Within 24 hours	100%	70%
0 to 2 hours	17	11
2+ to 6 hours	26	11
6+ to 12 hours	17	15
12+ hours	40	59
Missing	0	4
Range	<1 to 24 hours	<1 to 137 hours
Mean Response Time	10.3 hours	21.1 hours

Table 7.4

Number of CRT Visits for Completed IHBS Cases

Number of Visits	**IHBS**	
	O‘ahu (n=151 children)	**Hawai‘i Island** (n=47 children)
No visits	3%	34%
1 visit	21	21
2 visits	15	8
3 visits	26	6
4 visits	12	11
5 visits	11	11
6 visits	5	7
More than 6 visits	7	2
Range	0 to 8 visits	0 to 7 visits
Mean	3 visits	2 visits

Table 5

Final Safety Assessment Completion Rates

Year	**O‘ahu** (n=151)	**Hawai‘i Island** (n=47)
2015	38%	0
2016	48	83%
2017	64	12
2018	50	25

Table 7.6

Child and Family Demographic Characteristics

Demographic Characteristics	**O'ahu** (n=151)	**Hawai'i Island** (n=47)
Sex of child		
Male	52%	48%
Female	48	52
Number of children in home		
Mean	3 children	3 children
Mode	3 and 5	3
Range	1 to 8	1 to 10
Number of adults in home		
Mean	2 adults	2 adults
Mode	2	2
Range	1 to 6	1 to 7
Child age		
Mean	6.8 years	5.5 years
Mode	1 and 6	Under 1
Range	Infant to 17	Infant to 17

Table 7.7

Race and Ethnicity of Child

Race and Ethnicity	IHBS	
	O'ahu (n=151)	**Hawai'i Island** (n=47)
Race of child[a]		
Asian	66%	36%
White	58	66
Hawaiian/Pacific Islander	46	60
Black	15	2
American Indian/Alaskan Native	1	0
Unknown	0	0
Ethnicity of child		
Hawaiian/Part Hawaiian	37%	46%
Mixed (not H/PH)	19	23
Filipino	19	2
White	10	15
Samoan/American Samoan	7	2
Black	3	2
Hispanic/Spanish Origin	1	0
Korean	1	0
Chinese	1	0
Chuukese	1	0
American Indian	1	0
Marshallese	0	6
Other Pacific Islander	0	4

[a]Multiple response

Table 7.8

Children in Care after IHBS

Days in Care	O'ahu (n=151)	Hawai'i Island (n=47)
No removal within 90 days	91%	100%
Short Stayers (1 – 30 Days)	3	
Placed > 30 days (31+ Days)	6	

Table 7.9

IHBS Goals Completed

Goal Completion	**O'ahu** (n=149)	**Hawai'i Island** (n=43)
All goals completed	82%	70%
67% of goals completed	2	7
50% of goals completed	7	0
33% of goals completed	0	9
No goals completed	9	14

Table 7.10

Final CRT Dispositions for Children Receiving IHBS

Final CRT Disposition	**O'ahu** (n=151)	**Hawai'i Island** (n=47)
CLOSED	54%	81%
Voluntary Case Management	22	11
Child Welfare Services	11	2
Family Strengthening and Support	3	0
Missing	10	6

Chapter 8 Appendix

Wrap Figure Details
Initial Wrap CANS Items

Wrap Figure Details

Table 8.1
Long-Stayers

	Wrap						
	2012	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
State	1476	1450	1613	1799	1985	2066	1948
O‘ahu	870	852	898	959	975	1030	944
Hawai‘i Island	323	341	402	497	610	638	644
Maui	188	176	225	233	249	265	234
Kaua‘i	77	68	78	98	138	125	120

Table 8.2
Months in Spell at Time of First Wrap Meeting

Months in Spell	**Wrap**	
	O‘ahu (n=109)	**Hawai‘i Island** (n=26)
Less than 9 months	<1%	4%
9-11 months	7	0
12-18 months	21	8
19-24 months	16	15
25-30 months	26	8
31-36 months	11	27
37+ months	18	38
Mean	27 months	34 months

Table 8.3

Child Demographic Characteristics

Demographic Characteristics	Wrap	
	Oʻahu (n=109)	**Hawaiʻi Island** (n=26)
Sex of child		
Male	61%	19%
Female	39	81
Race of child[a]		
Hawaiian/Pacific Islander	61%	62%
White	60	69
Asian	54	42
Black	17	12
American Indian/Alaskan Native	7	12
Unknown	0	4
Ethnicity of child		
Hawaiian/Part Hawaiian	46%	39%
Mixed (not H/PH)	13	35
Filipino	12	0
White	11	0
Black	8	0
Samoan/American Samoan	5	0
Marshallese	2	0
Vietnamese	1	0
Hispanic/Spanish Origin	1	0
Laotian	1	0
Chuukese	0	10
Chinese	0	4
Other Pacific Islander	0	4
American Indian	0	4
Unable to determine	0	4
Child age at referral to Wrap		
1-5	34%	38%
6-10	34	46
11-15	27	16
16-17	5	0
Mean age at referral to Wrap	7.9 yrs	6.7 yrs

[a]Multiple response

Table 8.4
Child History of Maltreatment

History	Wrap	
	O'ahu (n=109)	**Hawai'i Island** (n=26)
History of:		
Threatened neglect	73%	58%
Threat of abuse	68	58
Physical neglect	22	54
Physical abuse	5	4
Sexual abuse	4	4

Table 8.5
Child Age at First Removal

Child age at first removal	Wrap	
	O'ahu (n=109)	**Hawai'i Island** (n=26)
Infant	16%	19%
1-5	39	54
6-10	27	27
11-15	17	0
16-17	1	0
Mean age at first removal	6.2 years	3.8 years

Table 8.6
Number of Placements Prior to Current Spell

	Wrap	
	O'ahu (n=109)	**Hawai'i Island** (n=26)
Is this child's first spell?		
Yes	74%	81%
No	26	19
Total placements prior to spell		
0	74%	81%
1	9	4
2	12	4
3	4	0
4	0	7
5	1	4

Table 8.7

Current Placement Characteristics

Type of Placement at Start of Wrap	Wrap	
	Oʻahu (n=109)	**Hawaiʻi Island** (n=26)
Paid foster care	70%	69%
Paid relative care	20	15
Missing	4	4
Emergency foster care	4	4
Non-paid hospitalization	1	0
Runaway	1	0
Therapeutic foster care	0	8

Table 8.8

Median Duration of Care in Months, All Children in Care

	Wrap						
	2012	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
All State	5.6	5.5	7.0	10.9	11.9	12.6	12.7
Hawaiʻi Island	3.0	6.7	8.2	14.0	16.0	15.6	14.2
Oʻahu	3.1	3.1	4.7	8.2	10.8	12.6	12.6

Table 8.9

Exit Type for Wrap Participants

	Wrap	
	Oʻahu (n=109)	**Hawaiʻi Island** (n=26)
Reunite with Family	73%	69%
Still in care	12	23
Guardianship	8	4
Completed Adoption	5	4
Reach Majority/Adulthood	2	0

Table 8.10

Exit from Care; Oʻahu

Oʻahu	**Wrap**	
	Received Wrap (n=108)	**Matched Comparison Group** (n=108)
Reunified	73%	20%
Still in Care in June 2019	12	17
Guardianship	8	21
Adoption	5	31
Reached Majority	2	6
Other/Unknown	0	5

Overall chi-square is statistically significant at p<.001

Table 8.11

Exit from Care; Hawaiʻi Island

Hawaiʻi Island	**Wrap**	
	Received Wrap (n=24)	**Matched Comparison Group** (n=24)
Reunified	67%	17%
Still in Care in June 2019	25	25
Adoption	4	25
Guardianship	4	17
Reached Majority	0	13
Other/Unknown	0	3

Overall chi-square is statistically significant at p<.01

Initial Wrap CANS Items

CANS Table 8.12

Wrap: Initial CANS, Life Domain Functioning

Life Domain Functioning	O'ahu (n=18)		Hawai'i Island (n=19)	
	Act	Immediate	Act	Immediate
Behavioral/Emotional	22%	6%	37%	0
Adjustment to Trauma	17	6	21	5%
Social Functioning	11	6	11	0
Medical	11	0	5	0
Family	6	6	0	11
Sleep	6	0	5	0
Intellectual/Developmental	6	6	5	5
Daily Living	6	0	11	5
Living Situation	0	6	5	0
Recreational	0	11	0	0
Substance Use	0	0	0	0
Physical	0	0	0	5
Legal/Juvenile Justice	0	0	0	0
Language	0	0	0	5
Cultural Differences	0	0	0	0

CANS Table 8.13

Wrap: Initial CANS, Permanency Caregiver Strengths and Needs

Permanency Caregiver Strengths and Needs	O'ahu (n=18)		Hawai'i Island (n=19)	
	Act	Immediate	Act	Immediate
Social Resources	11%	0	16%	0
Supervision	6	0	16	5%
Involvement	6	0	0	0
Knowledge	6	0	5	0
Organization	6	0	5	5
Physical	6	0	5	0
Safety	6	0	5	5
Residential Stability	0	0	32	5
Mental Health	0	0	26	0
Substance Abuse	0	0	0	11
Developmental	0	0	0	0
Accessibility to Care	0	0	16	0
Family Stress	0	6%	5	16

CANS Table 8.14

Wrap: Initial CANS, Youth Risk Behaviors (Youth over 3 years old)

Youth Risk Behaviors	O'ahu (n=18)		Hawai'i Island (n=19)	
	Act	**Immediate**	**Act**	**Immediate**
Bullying	11%	0	11%	0
Intentional Misbehavior	11	0	0	0
Runaway	6	0	0	0
Suicide Risk	0	6%	0	0
Self-Mutilation	0	6	0	0
Other Self Harm	0	6	0	0
Danger to Others	0	0	0	0
Cruelty to Animals	0	0	5	0
Exploited	0	0	0	0
Delinquent Behavior	0	0	0	0
Fire Setting	0	0	0	0
Sexually Reactive	0	0	0	0
Sexual Aggression	0	0	0	0
Hyper-sexuality	0	0	0	0

CANS Table 8.15

Wrap: Initial CANS, Youth Behavioral/Emotional Needs

Youth Behavioral/Emotional Needs	O'ahu (n=18)		Hawai'i Island (n=19)	
	Act	**Immediate**	**Act**	**Immediate**
Oppositional	12%	0	6%	0
Impulse/Hyper	6	0	11	6%
Conduct	6	0	0	0
Psychosis	0	0	0	0
Depression	0	6%	0	0
Anxiety	0	6	22	0
Anger Control	0	6	6	0

CANS Table 8.16

Wrap: Initial CANS, Trauma Experiences and Stress Symptoms

Trauma Experiences	**O'ahu** (n=18)		**Hawai'i Island** (n=19)	
	Act	**Immediate**	**Act**	**Immediate**
Emotional Abuse	11%	6%	33%	0
Physical Abuse	6	6	11	0
Neglect	6	6	39	0
Witness to Family Violence	6	6	33	0
Sexual Abuse	0	0	17	0
Medical Trauma	0	6	0	0
Natural Disaster	0	0	0	0
Witness to Community Violence	0	0	0	0
Witness/Victim - Criminal Acts	0	6	6	0
Trauma Stress Symptoms				
Affect Regulation	6	0	17	0
Trauma Grief/Loss	0	6	6	0
Re-experiencing	6	0	6	0
Attachment	0	6	11	6
Hyper-arousal	0	0	22	0
Numbing	6	0	0	0
Avoidance	6	0	0	0
Dissociation	0	0	0	0

Chapter 9 Appendix

SPAW Figure Details

SPAW Figure Details

Table 9.1
Long-Stayers

	SPAW						
	2012	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
State	1476	1450	1613	1799	1985	2066	1948
O‘ahu	870	852	898	959	975	1030	944
Hawai‘i Island	323	341	402	497	610	638	644
Maui	188	176	225	233	249	265	234
Kaua‘i	77	68	78	98	138	125	120

Table 9.2
Duration of Spell at Time of SPAW Meeting

	SPAW	
	O‘ahu (n=74)	**Hawai‘i Island** (n=82)
Less than 9 months	0	1%
9-11 months	0	0
12-18 months	8%	1
19-24 months	18	6
25-30 months	8	5
31-36 months	19	7
37-42 months	7	21
43-48 months	11	12
49+ months	30	46
Mean	44 months	54 months

Table 9.3
Number of SPAW Action Goals Set

Number of Action Goals Set	SPAW	
	O‘ahu (n=74)	**Hawai‘i Island** (n=81)
None	5%	4%
One	8	4
Two	32	39
Three	30	28
Four	18	20
Five	7	5

Table 9.4

Child Demographic Characteristics

Demographic Characteristics	SPAW	
	O'ahu (n=74)	**Hawai'i Island** (n=82)
Sex of child		
Female	53%	54%
Male	47	46
Race of child[a]		
Hawaiian/Pacific Islander	64%	73%
White	55	54
Asian	27	28
Black	10	6
American Indian/Alaskan Native	3	7
Unknown	4	1
Ethnicity of child		
Hawaiian/Part Hawaiian	42%	57%
Mixed (not H/PH)	19	6
White	14	16
Hispanic/Spanish Origin	7	5
Black	5	0
Unable to determine	3	3
Samoan/American Samoan	3	0
Filipino	3	0
Chuukese	1	4
American Indian	1	2
Japanese	1	0
Marshallese	1	0
Other Pacific Islander	0	7
Child age at time of initial review		
Infant	3%	0
1-5	20	21%
6-10	19	21
11-15	34	40
16-17	24	18
Mean age at initial review	10.6 years	10.6 years

[a]Multiple response

Table 9.5

Child History of Maltreatment

History	SPAW	
	Oʻahu (n=74)	**Hawaiʻi Island** (n=82)
History of:		
Threatened neglect	85%	81%
Threat of abuse	80	78
Physical neglect	23	27
Physical abuse	16	13
Sexual abuse	3	9

Table 9.6

Age at First Removal

Age at first removal	SPAW	
	Oʻahu (n=74)	**Hawaiʻi Island** (n=82)
Infant	15%	16%
1-5	38	32
6-10	23	28
11-15	22	24
16-17	2	0
Mean age at first removal	6.2 years	6.3 years

Table 9.7

Total Spells Prior to Current Spell

	SPAW	
	Oʻahu (n=74)	**Hawaiʻi Island** (n=82)
Is this child's first spell?		
Yes	61%	62%
No	39	38
Total spells prior to current spell		
0	61%	62%
1	24	28
2	11	7
3	4	3

Table 9.8

Type of Placement at Start of SPAW

Type of Placement at Start of SPAW	SPAW	
	Oʻahu (n=74)	**Hawaiʻi Island** (n=82)
Paid foster care	51%	66%
Paid relative care	15	9
Emergency foster care	15	7
Residential care (is not paid by CWS)	8	9
Other	11	9

Table 9.9

SPAW Initial Permanency Ratings

Initial Permanency Ratings	SPAW	
	Oʻahu (n=69)	**Hawaiʻi Island** (n=80)
Poor	29%	30%
Marginal	39	43
Fair	23	13
Good	3	7
Very Good	6	7
Permanency Achieved	0	0

Table 9.10

Median Duration of Care in Months, All Children in Care

	SPAW						
	2012	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
All State	5.6	5.5	7.0	10.9	11.9	12.6	12.7
Hawaiʻi Island	3.0	6.7	8.2	14.0	16.0	15.6	14.2
Oʻahu	3.1	3.1	4.7	8.2	10.8	12.6	12.6

Table 9.11

Exit from Care

	SPAW	
	Oʻahu (n=74)	**Hawaiʻi Island** (n=82)
Guardianship	24%	23%
Reach Majority/Adulthood	24	18
Reunite with Family	22	6
Still in care	19	38
Completed Adoption	10	10
Other/Unknown	1	5

Table 9.12

Initial and Final SPAW Permanency Ratings: Oʻahu

Permanency Ratings	**SPAW**	
	Oʻahu (n=58)	
	Initial	**Final**
Poor	33%	14%
Marginal	38	26
Fair	22	21
Good	2	21
Very Good	5	8
Permanency Achieved	0	10
Mean Rating	4.9	3.8††

††p<.01

Table 9.13

Initial and Final SPAW Permanency Ratings: Hawaiʻi Island

Permanency Ratings	**SPAW**	
	Hawaiʻi Island (n=70)	
	Initial	**Final**
Poor	33%	9%
Marginal	39	19
Fair	11	34
Good	9	11
Very Good	9	23
Permanency Achieved	0	4
Mean Rating	4.8	3.7††

††p<.01

Table 9.14

Exit from Care; Oʻahu

Oʻahu	**SPAW**	
	Received SPAW (n=67)	**Matched Comparison Group** (n=67)
Guardianship	27%	19%
Reached Majority	24	21
Reunified	21	13
Still in Care in June 2019	18	16
Adoption	9	27
Other/Unknown	2	3

Overall chi-square not statistically significant at p<.05

Table 9.15

Exit from Care; Hawai'i Island

Hawai'i Island	**SPAW**	
	Received SPAW (n=66)	**Matched Comparison Group** (n=66)
Still in Care in June 2019	36%	35%
Guardianship	29	12
Reached Majority	15	15
Adoption	9	18
Other/Unknown	6	3
Reunified	5	17

Overall chi-square is statistically significant at p<.05

Chapter 10 Appendix

Expenditure Detail
CRT Survey Results
Number of Children in Foster Care

Expenditure Detail

To understand how overall spending changed over the period from 2012 through 2019, we have assembled a series of tables that summarized spending by program area, location of spending, revenue source, and whether the spending is for children in out-of-home care, or those receiving in-home service type. The Social Services Division (SSD) expenditures for child welfare services (CWS), which serves as the source for the summaries that follow, are organized into three main program areas: CPS, CPS payments, and a portion of general support. General support includes some expenditures that can be allocated 100% to CWS, including administrative costs associated with the foster care IV-E program, Medicaid for children in care, and adoption assistance administration. Additionally, 79% of overall general support is allocated to CWS, including administrative and overhead costs. Most CPS payments are for out-of-home placement room and board costs, as well as adoption and guardianship assistance. The majority of CPS spending is for direct services provided by DHS and contracted vendors, including services to children who are in out-of-home placements as well as families receiving in-home services.

In FY 2014, the year prior to Waiver implementation, child welfare spending totaled $112 million, of which CPS was 55 percent, CPS payments accounted for 43 percent of the spending, and administrative costs funded through general support were just about 2 percent of spending. Since then, CPS and CPS payments have both risen – CPS rose sharply in the years during Waiver implementation, while CPS payments increased following the Waiver start date in 2015 and again in the last year of the Waiver, 2019. Overall, CPS has remained slightly more than half of the budget while CPS payments are slightly less than half and general support has remained 1-2% of the budget. Total spending has increased in each of the program areas during the Waiver demonstration—CPS expenditures have increased 22%, CPS payments have increased 38% and general support has increased 44% from 2014-2019.

Table 10.1

Major Program Areas of Child Welfare Services Spending

	Pre-Waiver Years			Waiver Years					
	2012	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**Trends**
Total	**$111,488,822**	**$108,805,539**	**$112,252,258**	**$122,703,464**	**$126,389,998**	**$129,240,029**	**$129,806,499**	**$145,506,286**	
CPS	$57,965,430	$58,475,944	$62,074,105	$62,681,407	$66,046,318	$68,277,274	$70,076,418	$75,970,861	
CPS Payments	$52,246,687	$49,170,325	$48,300,634	$57,919,868	$58,658,447	$58,694,876	$58,119,739	$66,832,807	
Gen Support	$1,276,704	$1,159,269	$1,877,519	$2,102,189	$1,685,233	$2,267,879	$1,610,342	$2,702,619	
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	
CPS	52%	54%	55%	51%	52%	53%	54%	52%	
CPS Payments	47%	45%	43%	47%	0	45%	45%	46%	
Gen Support	1%	1%	2%	2%	1%	2%	1%	2%	
Y-o-Y Change									2014-2019
CPS		1%	6%	1%	5%	3%	3%	8%	22%
CPS Payments		-6%	-2%	20%	1%	0%	-1%	15%	38%
Gen Support		-9%	62%	12%	-20%	35%	-29%	68%	44%

Expenditures by Revenue Source

The Waiver Demonstration allows for more flexible use of IV-E funds to prevent and shorten out-of-home stays. Accordingly, the cost evaluation needs to review changes in IV-E and other revenue streams associated with out-of-home and in-home spending. Over the past five years, general state funds for foster care have been the largest revenue source for CWS, closely followed by Title IV-E funds which includes foster care room and board as well as adoption and guardianship assistance. Approximately ten percent of overall revenue is federal block grants (e.g., Title XX Social Services Block Grants) that are spent on direct services. The "federal other" category includes revenue from various sources—Title IV-B, Medicaid, Children's Justice Act, etc.—and is spread across all service types and fluctuates from year to year as federal grants change.

Table 10.2

Service Type by Federal and General Revenue Source, State Fiscal Years 2012-2019

	Pre-Waiver Years			Waiver Years					
	2012	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**Trends**
Total	**$111,488,822**	**$108,805,539**	**$112,252,258**	**$122,703,464**	**$126,389,998**	**$129,240,029**	**$129,806,499**	**$145,506,286**	
General CWS	$36,671,890	$32,439,378	$31,842,006	$38,805,504	$38,146,606	$38,416,210	$39,844,689	$44,533,788	
Title IV-E	$32,062,196	$30,206,160	$28,029,110	$32,320,400	$34,317,504	$34,773,461	$32,946,417	$41,807,631	
General Direct Grant	$26,332,801	$30,058,598	$34,312,585	$32,546,535	$37,383,135	$36,605,389	$37,623,894	$37,017,307	
Federal Block Grant	$12,286,056	$11,489,499	$13,548,787	$15,225,262	$10,699,867	$13,818,470	$13,382,753	$16,503,674	
Federal Other	$3,234,262	$3,651,275	$2,962,369	$2,641,114	$4,608,969	$4,164,451	$4,653,356	$4,404,460	
General Support	$901,618	$960,629	$1,557,400	$1,164,649	$1,233,916	$1,462,047	$1,355,391	$1,239,426	
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	
General CWS	33%	30%	28%	32%	30%	30%	31%	31%	
Title IV-E	29%	28%	25%	26%	27%	27%	25%	29%	
General Direct Grant	24%	28%	31%	27%	30%	28%	29%	25%	
Federal Block Grant	11%	11%	12%	12%	8%	11%	10%	11%	
Federal Other	3%	3%	3%	2%	4%	3%	4%	3%	
General Support	1%	1%	1%	1%	1%	1%	1%	1%	
Y-o-Y Change									2014-2019
General CWS		-12%	-2%	22%	-2%	1%	4%	12%	40%
Title IV-E		-6%	-7%	15%	6%	1%	-5%	27%	49%
General Direct Grant		14%	14%	-5%	15%	-2%	3%	-2%	8%
Federal Block Grant		-6%	18%	12%	-30%	29%	-3%	23%	22%
Federal Other		13%	-19%	-11%	75%	-10%	12%	-5%	49%
General Support		7%	62%	-25%	6%	18%	-7%	-9%	-20%

Proportionally, revenue sources have remained fairly stable from 2012-2019. General Child Welfare Services (CWS) accounts for approximately one-third of the budget, and Title IV-E and general revenue for direct services make up more one-quarter of total expenditures. Yet each of these funding sources has increased during the Waiver demonstration. Title IV-E and other federal revenue both increased by 49% from 2014-2019. General revenue for CWS also increased substantially by 40% from SFY 2014-2019, while general direct grants increased slightly by 8% overall. Federal block grants and other federal revenue have also increased from 2014-2019. The only revenue source that decreased overall during the Waiver is general support for SSD administration.

Spending for Services

As noted above, Waiver interventions are expected to shift spending from out-of-home placement and related services to in-home and preventative services. Accordingly, the cost study closely tracks spending on different types of services before and after Waiver implementation. As described in the Methodology, we were able to distinguish expenditures associated with various service types using appropriations codes. There are clear appropriation codes for out-of-home room and board payments, adoption, and guardianship assistance in the expenditure data. However, categorizing and separating *services* for children who are placed out-of-home from services delivered at home is less clear cut in the fiscal data. Whenever possible, we assign services that are specifically for children remaining in-home as "in-home" services. For example, IHBS is considered an in-home service. Services and appropriations that could be for either prevention or for children in out-of-home care are categorized as "direct services". The direct services category includes both purchased services and DHS-provided services included under appropriation 101 for general child welfare services.

Direct services and adoption assistance payments make up the majority of CWS spending. Out-of-home includes client expenditures for foster care, kinship care, and emergency shelters. In addition to the base per diem maintenance payments included in the unit cost analysis (see Table 10.7), total out-of-home spending includes difficulty of care payments and the clothing allowance. Out-of-home spending more than doubled during Waiver implementation, from $8 million in 2014 to more than $22 million in 2019—an increase of 179%. The largest increases in out-of-home spending were in state fiscal years 2015 and 2019 when Hawai'i increased the per diem and difficulty of care rates for foster care. Extended care, which includes independent living, higher education, and extended foster care, remained relatively stable during Waiver implementation at about 2% of total expenditures. Guardianship assistance nearly tripled during the demonstration from $1 million in 2014 to $3 million in 2019. Spending for direct services increased slightly (10%) during Waiver implementation, and in-home services increased from $6.8 million in 2014 to $9.4 million in 2019—a 36% increase. Although the increases in out-of-home spending are not in the expected direction, the increases in in-home spending are consistent with what is expected as part of the Waiver interventions.

Table 10.3

Spending by Service Area, State Fiscal Years 2012-2019

	Pre-Waiver Years			.Waiver Years					
	2012	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**Trends**
Total	$111,488,822	$108,805,539	$112,252,258	$122,703,464	$126,389,998	$129,240,029	$129,806,499	$145,506,286	
Out-of-Home	$16,461,827	$10,222,703	$8,110,845	$11,363,896	$12,227,494	$13,853,235	$15,950,296	$22,607,261	
In-Home	$3,361,897	$4,608,661	$6,866,809	$7,661,437	$8,290,282	$7,806,182	$8,074,986	$9,364,710	
Direct Service	$38,097,169	$40,518,997	$43,955,036	$42,747,893	$44,399,680	$46,780,530	$47,582,419	$48,366,867	
Extended Care	$2,263,856	$2,366,849	$2,089,921	$2,632,043	$2,192,330	$2,415,079	$2,136,657	$2,777,352	
Adoption Assist	$44,510,214	$44,775,167	$43,396,081	$48,810,001	$49,795,812	$48,072,359	$46,205,763	$49,373,825	
Guardianship			$1,053,855	$1,441,854	$1,803,715	$2,305,695	$1,788,181	$3,080,809	
Permanency Assist	$5,709,749	$5,254,299	$5,063,586	$6,411,130	$6,223,883	$6,215,990	$6,682,555	$8,031,885	
General Support	$1,084,110	$1,058,863	$1,716,125	$1,635,210	$1,456,802	$1,790,959	$1,385,642	$1,903,577	
Total, Percent	100%	100%	100%	100%	100%	100%	100%	100%	
Out-of-Home	15%	9%	7%	9%	10%	11%	12%	16%	
In-Home	3%	4%	6%	6%	7%	6%	6%	6%	
Direct Service	34%	37%	39%	35%	35%	36%	37%	33%	
Extended Care	2%	2%	2%	2%	2%	2%	2%	2%	
Adoption Assist	40%	41%	39%	40%	39%	37%	36%	34%	
Guardianship	0%	0%	1%	1%	1%	2%	1%	2%	
Permanency Assist	5%	5%	5%	5%	5%	5%	5%	6%	
General Support	1%	1%	2%	1%	1%	1%	1%	1%	2014-2019
Total, Y-o-Y Change		-2%	3%	9%	3%	2%	0%	12%	30%
Out-of-Home		-38%	-21%	40%	8%	13%	15%	42%	179%
In-Home		37%	49%	12%	8%	-6%	3%	16%	36%
Direct Service		6%	8%	-3%	4%	5%	2%	2%	10%
Extended Care		5%	-12%	26%	-17%	10%	-12%	30%	33%
Adoption Assist		1%	-3%	12%	2%	-3%	-4%	7%	14%
Guardianship				37%	25%	28%	-22%	72%	192%
Permanency Assist		-8%	-4%	27%	-3%	0%	8%	20%	59%
General Support		-2%	62%	-5%	-11%	23%	-23%	37%	11%

CRT Survey Results

In February 2018, the CRT survey was sent to the 24 CRT team members on Oʻahu and the 25 staff on Hawaiʻi Island who were identified as associated with CRT. A total of 15 Oʻahu staff and 21 Hawaiʻi staff responded, yielding response rates of 63 percent and 84 percent respectively. Respondents, who were asked to provide their job title, represented a variety of positions on the CRT including Supervisors, Human Service Professionals, and Social Service Assistants (see Tables 10.16 and 10.17 below). Those job titles were mapped to three major job categories to allow for analysis of time use by role type—direct supervisors, direct service, and indirect administration. The majority of respondents were direct service workers –those who would be expected to spend the most time on CRT activities. Titles can be linked to approximate salary, in order to generate an estimate of the costs associated with the CRT staffing structure.

Table 10.4
What is your current title?

Oʻahu (n=16)	**CRT**				
	Job Category				
	Direct Supervisor	Direct Service	Indirect Admin	Missing	Total
Supervisor	2	-	-	-	2
Social Worker	-	3	-	-	3
Social Service Assistant	-	-	3	-	3
Secretary	-	-	1	-	1
Assessment Worker	-	1	-	-	1
Child Adult Protective Services	-	3	-	-	3
Other	1	-	-	-	1
Missing	-	-	-	2	2
Total	3	7	4	2	16

Table 10.5

What is your current title?

Hawai'i Island (n=21)	CRT				
	Job Category				
	Direct Supervisor	Direct Service	Indirect Admin	Missing	Total
Supervisor	1	-	-	-	1
Social Worker	-	1	-	-	1
Social Service Assistant	-	-	4	-	4
Secretary	-	-	2	-	2
Section Administrator	2	-	-	-	2
Child Adult Protective Services	-	3	-	-	3
Human Services Professional	-	4	-	-	4
Other	-	-	-	3	3
Missing	-	-	-	1	1
Total	3	8	6	4	21

Depending on the circumstances of the case, intakes assigned to the CRT may be referred for either closure, additional child welfare services (CWS), to IHBS, or to Differential Response. The CRT survey asked respondents how much time (typically) they spent overall on each type of CRT cases. These time estimates are particularly relevant for estimating costs for Hawai'i Island, where CRT staff typically have other DHS duties outside of the CRT (see Table 10.18).

The majority of direct service staff on Hawai'i Island spend between 1-5 hours on cases that are transferred to Child Welfare Services (CWS) after they are screened by CRT. Cases referred to IHBS typically take more time, with six out of eight direct service staff reporting 5-7 hours of time needed. There is more variation in time reported for cases that go to differential response, between 0.5-9 hours. Most direct service staff reported that when a case closes quickly, it takes less than three hours of CRT time.

Table 10.6

On average, how many hours do you spend on each type of CRT case?

Hawai'i Island (n=21)	CRT				
	Job Category				
	Direct Supervisor	Direct Service	Indirect Admin	Missing	**Total**
Estimated Time Spent on CRT Cases Sent to CWS					
I haven't had this type of case	1	-	-	-	**1**
Less than 1 hour	1	-	3	-	**4**
1 – 3 hours	1	3	2	1	**7**
3 – 5 hours	-	2	1	-	**3**
5 – 7 hours	-	1	-	2	**3**
7 – 9 hours	-	-	-	1	**1**
9 – 12 hours	-	1	-	-	**1**
12 – 15 hours	-	1	-	-	**1**
Total	**3**	**8**	**6**	**4**	**21**
Estimated Time Spent on CRT Cases Sent to IHBS					
I haven't had this type of case	1	-	3	1	**5**
Less than 1 hour	1	-	-	1	**2**
1 – 3 hours	1	3	1	-	**5**
3 – 5 hours	-	3	2	-	**5**
5 – 7 hours	-	2	-	1	**3**
12 – 15 hours	-	-	-	1	**1**
Total	**3**	**8**	**6**	**4**	**21**
Estimated Time Spent on CRT Cases Sent to Differential Response					
I haven't had this type of case	1	-	3	3	**7**
Less than 1 hour	1	3	2	1	**7**
1 – 3 hours	1	1	-	-	**2**
3 – 5 hours	-	1	1	-	**2**
5 – 7 hours	-	2	-	-	**2**
7 – 9 hours	-	1	-	-	**1**
Total	**3**	**8**	**6**	**4**	**21**
Estimated Time Spent on CRT Cases that Closed					
I haven't had this type of case	-	-	3	1	**4**
Less than 1 hour	1	3	2	1	**7**
1 – 3 hours	1	3	-	1	**5**
3 – 5 hours	-	-	1	1	**2**
5 – 7 hours	-	2	-	-	**2**
2- or more hours	1	-	-	-	**1**
Total	**3**	**8**	**6**	**4**	**21**

CRT staff on O‘ahu tend to report more time spent on CRT cases than Hawai‘i Island (see Table 10.19). This may be due to the fact that most staff on O‘ahu are full time on the CRT. Direct service staff reported spending between 1-12 hours on cases that are sent to CWS, with the majority of staff indicated these cases take at least 5 hours. The time spent on IHBS cases was varied—while a few staff reported these cases take more 12 hours of CRT time, the majority of staff indicated they require less than 7 hours. There was a split in responses for differential response cases and cases that close, with 3 direct service workers reporting these cases take less than 3 hours and the remaining 4 reporting they take 5-12 hours.

Table 10.7

On average, how many hours do you spend on each type of CRT case?

O'ahu	**CRT**				
	Job Category				
	Direct Supervisor	Direct Service	Indirect Admin	Missing	**Total**
Estimated Time Spent on CRT Cases Sent to CWS (n=14)					
Less than 1 hour	1	1	1	-	**3**
1 – 3 hours	1	-	-	-	**1**
3 – 5 hours	-	2	1	-	**3**
5 – 7 hours	-	1	1	1	**3**
7 – 9 hours	-	1	-	-	**1**
9 – 12 hours	-	2	-	-	**2**
18 – 20 hours	-	-	1	-	**1**
Total	**2**	**7**	**4**	**1**	**14**
Estimated Time Spent on CRT Cases Sent to IHBS (n=13)					
Less than 1 hour	1	2	1	-	**4**
1 – 3 hours	1	1	-	-	**2**
3 – 5 hours	-	-	1	-	**1**
5 – 7 hours	-	1	2	-	**3**
12 – 15 hours	-	1	-	-	**1**
15 – 18 hours	-	1	-	-	**1**
20 or more hours	-	1	-	-	**1**
Total	**2**	**7**	**4**	**-**	**13**
Estimated Time Spent on CRT Cases Sent to Differential Response (n=12)					
Less than 1 hour	1	2	1	-	**4**
1 – 3 hours	1	1	-	-	**2**
3 – 5 hours	-	-	1	-	**1**
5 – 7 hours	-	3	1	-	**4**
9 – 12 hours	-	1	-	-	**1**
Total	**2**	**7**	**3**	**-**	**12**
Estimated Time Spent on CRT Cases that Closed (n=14)					
Less than 1 hour	1	2	1	-	**4**
1 – 3 hours	1	1	-	1	**3**
3 – 5 hours	-	-	2	-	**2**
5 – 7 hours	-	3	1	-	**4**
7 – 9 hours	-	1	-	-	**1**
Total	**2**	**7**	**4**	**1**	**14**

Note. Total number of responses only includes those who had this type of case.

Number of Children in Foster Care

Earlier in the report, we showed how the average number of children admitted and the average length stay changed from the pre-Waiver to Waiver years. We did that to show the upward pressure on the number of care days provided while laying the groundwork for exploring with the capped allocation covered the rising cost of foster care in Hawai‘i. Another way to consider the upward pressure on utilization is to follow the rising number of children in out-of-home care. Although strongly correlated with care day, the number of children in foster care is a metric most policy makers and practitioners find easier to follow.

To that end, Table 10.20 shows how the population of children in foster care changed between 2012 and 2019. In 2012, there were 1,101 children in care (as of June 30, 2012); by June 30, 2019, the end of SFY 2019, that figure had grown to 1,610 children. From the standpoint of the Waiver, growth in the number of children in out-of-home care accelerated during the Waiver. Across Hawai‘i, the number of children in care increased 40%. This increase was the most pronounced in Hawai‘i county, where the number of children in care more than doubled from 272 children in 2014 to 556 children in 2019—a 104% increase.

Table 10.8

Point-in-Time Count of Children in Care at the End of the State Fiscal Year

County	Pre-Waiver Years			Waiver Years				
	2012	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
All State	1,101	1,138	1,154	1,333	1,521	1,516	1,594	1,610
Waiver counties								
Hawai‘i	262	249	272	385	482	512	530	556
Honolulu	644	695	647	679	747	698	774	739
Other counties								
Kaua‘i	53	54	54	77	94	107	90	81
Maui	140	137	177	189	193	194	195	203
All State	100%	100%	100%	100%	100%	100%	100%	100%
Waiver counties								
Hawai‘i	24%	22%	24%	29%	32%	34%	33%	35%
Honolulu	58%	61%	56%	51%	49%	46%	49%	46%
Other counties								
Kaua‘i	5%	5%	5%	6%	6%	7%	6%	5%
Maui	13%	12%	15%	14%	13%	13%	12%	13%
All State		3%	1%	16%	14%	0%	5%	1%
Waiver counties								
Hawai‘i		-5%	9%	42%	25%	6%	4%	5%
Honolulu		8%	-7%	5%	10%	-7%	11%	-5%
Other counties								
Kaua‘i		2%	0%	43%	22%	14%	-16%	-10%
Maui		-2%	29%	7%	2%	1%	1%	4%

Center on the Family
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College of Tropical Agriculture and Human Resources
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