## Fact Sheet on Programmatic Example

## (Note: this is just an example of the type of evidenced based or promising practice that may implement all or part of a BSK strategy.)

**Strategy to be Addressed:**

Helping youth stay connected to their families, caregivers and communities – Prevention of homelessness and out-of-home placement

**Program Name:**

Project SAFE

Children's Crisis Outreach Response System (CCORS)

**Brief Program Description:**

Project SAFE - enables parents and caregivers of at-risk youth and young adults to seek support and services, in advance of a YYA running away or becoming homeless. The program has two major goals: 1) prevent YYA homelessness: and 2) promote healthier family functioning.

Project SAFE's core components include Phone Part A, which is a 90-minute phone consultation with a master's level therapist (hereinafter referred to as "counselor"), and Phone Part B, a brief follow-up call two weeks later. During Phone Part A, the counselor and parent/caregiver create an action plan with steps for both the parent/caregiver and YYA to support the parent/caregiver in strengthening family management and parenting skills, understanding adolescent development, and improving family communication. In addition, the counselor provides referrals to programs within the agency as well as to applicable external services.

CCORS - currently serves children, youth and families in King County, providing crisis services, non-emergency outreach and stabilization services for children from age 3 to 18who are not currently enrolled in public mental health services. CCORS provides more intense stabilization services for youth, including those enrolled in public mental health services. CCORS builds on a family's and youth's strengths to provide creative and flexible solutions that focus on teaching and modeling parenting and problem-solving skills to manage behavior and avoid out of home placement. CCORS helps families achieve stability, helps prevent future crises, and helps children remain in their home. CCORS services include:

- Mobile crisis outreach - Specially trained teams go to a family's home to help de-escalate a situation. The team works with the family to put in place ongoing services and

supports to prevent future crises. Outreach services include mental health and suicide risk assessments and links to community resources.

- Non-emergent outreach appointments - Appointments are provided within 24-48 hours for those families who are not in acute crisis but need quick support and linkage to services.
- Crisis stabilization services - Based on the family's needs, in-home support is available for up to 8 weeks following the initial acute crisis.

**Prevention Results Achieved Elsewhere or in K.C. Pilot:**

Project SAFE - The National Alliance to End Homelessness has recognized Project SAFE as a best practice and an exemplary model for youth homelessness prevention programming, because it is one of the few YYA programs nationally to adopt a family systems perspective.

Project SAFE was launched by Cocoon House in Snohomish County in 2001.

A 2013 evaluation of Project SAFE by Cardea over a five-year period from July 2008 through June 2013, examined approximately 1500 Part A phone calls and 700 Part B follow up calls. Key findings included:

- Parents and caregivers were overwhelmingly satisfied with Project SAFE;
- At follow-up, about two-thirds of callers had fully or mostly implemented their action plans;
- More than half of callers reported sustained, improved outlooks;
- About three-fourths of callers reported that the situation with their youth had improved. The odds that the situation had improved were six times greater if parents/caregivers adhered to their action plans;
- Nearly all callers reported their youth were living at home. The odds of the youth living at home were four times greater if parents/ caregivers adhered to their action plans.

CCORS - A 2012 evaluation of CCORS examined five years of CCORS data and found that in the vast majority of cases the goal of the referral to CCORS was met. Goals include: 1) working with family/caretaker to help a child/youth to stay safely in their home (88% of cases); 2) 75% of those children/youth in crisis who may have been hospitalized without this program, were able to be diverted to less restrictive settings that addressed their needs; 3) those children/youth who had to transition from their home were primarily placed in the home of a relative or other natural support; 4) only a very small number of children/youth (5%) were hospitalized voluntarily, and an even smaller number were hospitalized involuntarily; 5) Department of Children and Family Services (DCFS) placement was avoided in most cases; 6) those

children/youth without current homes or waiting for placement at the time of referral were found appropriate homes back with their family, with a relative or in an adoptive home.

**Target Population and number of people served:**

Project SAFE - targets parents or caregivers of youth ages 12-17 who have run away or are at risk of running away. Project SAFE conducted an average of 299 unique telephone consultations per year with eligible households, with a range of between 280 to 325 annual consultations.

CCORS - serves approximately 800 children, youth and their families/caregivers a year.

**Estimated Cost to Administer:**

Project SAFE average cost per household for telephone consultations are approximately $317; if a family/household needs more intensive prevention services, the cost per household is under $2,000. Annual cost for the program is approximately $150,000.

CCORS costs approximately $3 million per year for county-wide coverage. CCORPS is currently accessed by families and caretakers through the King County Crisis Clinic hotline. Expanded outreach and dissemination of information about the program could significantly expand demand for the program.

**Estimated Cost Savings to Community:**

Project SAFE - The Cardea evaluation of Project SAFE at Cocoon House in Snohomish County found that for every $1 spent on prevention and early intervention services to prevent homelessness, $5.04 is saved in homeless housing costs and other costs associated with homelessness.

CCORS - prevents costly out of home placements and hospitalizations. Over the five-year period of 2008-2011 total savings from hospital diversions were estimated at $3.8 million to $7.5 million; and prevention of out of home placements avoided DCFS costs of approximately $2.8 million.

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# Project SAFE:

## A review of a family systems model to prevent teen homelessness in Snohomish County

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CARDEA
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# EXECUTIVE SUMMARY

Cocoon House is the only organization in Snohomish County specifically focused on serving at-risk and homeless youth. In line with its mission to "empower young people, families, and the community to break the cycle of homelessness through outreach, housing, and prevention," it offers a continuum of services, including street outreach, parenting classes, parent support groups, residential shelters, and linkage to internal and external drug treatment, mental health, and social services.

Since 2001, Project SAFE has enabled parents and caregivers of at-risk youth to seek support and services, in advance of the youth running away or becoming homeless. The program's two major goals are: 1) prevent youth homelessness, and 2) promote healthier family functioning. In 2006, the National Alliance to End Homelessness recognized Project SAFE as a best practice and an exemplary model for youth homelessness prevention programming, because it was one of the few programs nationally to adopt a family systems perspective.

Project SAFE's core components include Phone A, a 90-minute phone consultation with a Master's level therapist (hereinafter referred to as "counselor"), and Phone B, a brief follow-up call two weeks later. During Phone A, the counselor and parent/caregiver create an action plan with steps for both the parent/caregiver and youth to support the parent/caregiver in strengthening family management and parenting skills, understanding adolescent development, and improving family communication. In addition, the counselor provides referrals to Cocoon House programs and external services.

In October 2013, Cocoon House engaged Cardea to conduct an independent evaluation of Project SAFE implementation (July 2008 – June 2013).

This review had three objectives:

1. Describe parents/caregivers who accessed Project SAFE, including demographic and other background characteristics, as well as reasons for calling and ongoing concerns
2. Describe the services provided during the phone consultations, including the joint action plans developed, and referrals to both Cocoon House programs and other external services
3. Determine the extent to which Project SAFE met outputs and short-term outcomes, as outlined in project logic models, including change in hopefulness and frustration with the current situation and perception that the youth will leave home

The review examined data collected by Project SAFE staff during 1,494 unique phone consultations and 697 follow-up calls, and included extensive qualitative analysis of a subsample of case notes from 325 calls.

*I think parents who are struggling...*
*don't feel successful,*
*don't feel like they have any strengths,*
*and have often been told*
*that they're not good parents...*
*Parents feel accepted, supported,*
*and encouraged by Cocoon House staff.*
*Staff are knowledgeable and*
*well-trained... and they're willing*
*to take the time it takes*
*to help parents become successful.*

—Community partner at Housing Hope

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## RESULTS

### Project SAFE supported a diversity of families facing serious challenges

Most Project SAFE consultations were with female callers, and about one-quarter of callers were people of color. While Project SAFE served male and female youth age 8-25 years, most youth were age 13-17 years. Nearly one-third were youth of color. Most youth lived in two-adult households in Snohomish County with annual incomes below the county median. Nearly one-third had experienced changes in parent or guardianship. More than one-third of youth had parents who suffered from substance abuse or mental health issues, and over one-quarter had either experienced or witnessed domestic violence or sexual assault. Over half of youth had previously run away, been told to leave, or been legally removed from their homes.

### Callers reported distress, due to ongoing concerns about their youth

The majority of callers reported high levels of frustration and believed that their youth would leave home. Most reported several distinct concerns about their youth, including problems at school, disrespectful or defiant behavior, mental health issues, and drug/alcohol use. More than one-third of youth had prior involvement in the legal system. Many families had previously accessed Cocoon House's emergency shelter or other services, as well as external services such as counseling, therapy, or drug and alcohol treatment.

### Despite ongoing concerns, callers had positive aspirations for their youth

Over half of callers said they wanted their youth to succeed in school. Many expressed positive hopes for their youth's future outlook and relationships with the family, and indicated that they wanted their youth to have a happy, healthy, or fulfilling life. Half of callers specifically indicated that they hoped to have a better relationship with their youth.

### Most callers followed up on the action plans they developed with Project SAFE counselors

At Phone B, nearly two-thirds of callers had "fully" or "mostly" adhered to the action plans they developed with Project SAFE counselors. Plans included referrals to Cocoon House services, such as parenting classes and support groups, as well as external services.

### Callers' outlook improved, and these improvements were sustained over time

More than half of callers reported improved outlook at the end of Phone A. After two weeks, callers reported sustained improvements in hope, frustration, and a decreased perception that their youth would leave home.

### At follow-up, most callers reported that the situation with their youth had improved

During Phone B, about three-fourths of callers reported that the situation with their youth "dramatically" or "somewhat" improved. Adherence to the action plan was the strongest predictor of improvement. Parents/caregivers with youth who had no history of living out of home were also more likely to report improvement.

### At follow-up, nearly all callers reported that their youth were living at home

During Phone B, nearly all callers reported that their youth were living at home. Youth were most likely to be living at home, if their parents/caregivers had adhered to their action plans and the youth had no history of living out of home.

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## CONCLUSIONS

This review found that Project SAFE promotes family cohesiveness by providing support and resources for parents and caregivers. By supporting parents/caregivers in expressing concerns and aspirations for their youth and by guiding them in developing action plans to address the complex issues that they and their youth are facing, Project SAFE addresses the root causes that are often precursors to youth homelessness.

Through Project SAFE, Cocoon House supports over 250 families each year. A Project SAFE phone consultation costs just $317, and the cost of full prevention services is estimated to be under $2,000. These costs are less than the cost of an average shelter stay at Cocoon House ($2,389 per youth), substantially less than the cost of long-term housing at Cocoon House ($13,882 per youth, per year), and far less than the cumulative costs of the many adverse outcomes of chronic homelessness, estimated to range from 7,500 to $40,000 per person, per year.[1]

This review sheds new light on the challenges that Project SAFE callers face, as well as parents'/caregivers' desire and effort to reconcile conflict and improve their relationship with their youth. Follow-up data on client satisfaction, outlook, and improvements suggest that Project SAFE is successfully meeting this need, providing further evidence to support the efficacy of Project SAFE in fostering family cohesion and preventing youth homelessness.

### Key Results: In Brief

- Parents and caregivers were overwhelmingly satisfied with Project SAFE.
- At follow-up, about two-thirds of callers had fully or mostly implemented their action plans.
- More than half of callers reported sustained, improved outlooks.
- About three-fourths of callers reported that the situation with their youth had improved. The odds that the situation had improved were six times greater, if parents/caregivers adhered to their action plans.
- Nearly all callers reported their youth were living at home. The odds of the youth living at home were four times greater, if parents/caregivers adhered to their action plans.

[1] Please see references 11-13 in the main report

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# INTRODUCTION

## Background

According to the 2012 *Point in Time* report, a joint effort of the Snohomish County Office of Housing, Homelessness, and Community Development and the Homeless Policy Task Force, approximately 300 teens are homeless on any given night, and over 1,300 teens are homeless in Snohomish County at some point each year.[1]

The National Network for Youth reports that youth who experience homelessness face an increased risk of mental health problems, substance abuse issues, criminal activity and victimization, unsafe sex, teen pregnancy, and poor educational opportunities.[2] Without assistance, most homeless youth are at extremely high risk of chronic or episodic homelessness, unemployment, and poverty as adults.[3] Therefore, prevention and early intervention of youth homelessness is critical.

Fortunately, Snohomish County has a variety of organizations that provide supportive services to youth and their families. Cocoon House is the only organization in Snohomish County specifically focused on serving at-risk and homeless youth. Its mission is to "empower young people, families, and the community to break the cycle of homelessness through outreach, housing, and prevention." Since 1991, Cocoon House has worked to decrease risk factors and build protective factors associated with youth homelessness through a continuum of services, including street outreach, parenting classes, parent support groups, residential shelters, and linkage to external drug treatment, mental health, and social services.

In the late 1990s, Cocoon House noticed an increase in calls from parents and caregivers who were concerned and proactively seeking advice about how to prevent their youth from running away or who had reached a critical point in addressing behavioral and other issues. Parents and caregivers were primarily concerned about their youth's drug use, violent behavior, running away, family conflict, and promiscuity. They also expressed frustration, because they felt there were no services available until their youth ran away.

To address these issues, Cocoon House launched Project SAFE in 2001. Cocoon House developed the components of Project SAFE, based on risk and protective factors for child maltreatment. Although children are not responsible for harm inflicted on them, certain characteristics have been found to increase risk of maltreatment.[4] Project SAFE was developed to address parental risk factors connected to challenging youth behaviors.

Key risk factors for maltreatment include parents' lack of understanding of children's needs, child development, and parenting skills; parents' history of child maltreatment in family of origin; substance abuse and/or mental health issues (including depression in the family); parental characteristics such as young age, low education, single parenthood, large number of dependent children, and low income; non-biological, transient caregivers in the home (e.g., mother's male partner); and parental thoughts and emotions that tend to support or justify maltreatment behaviors. Family risk factors include social isolation; family disorganization, dissolution, and violence (including intimate partner violence); and parenting stress, poor parent-child relationships, and negative interactions.

In 2006, the National Alliance to End Homelessness recognized Project SAFE as a best practice and an exemplary model for youth homelessness prevention programming, because it was one of the few programs nationally to adopt a family systems perspective.[5]

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## Program Description

Project SAFE is designed to prevent youth homelessness by enabling parents and caregivers of at-risk youth to seek support and services, in advance of the youth running away or becoming homeless. The program's two major goals are: 1) prevent youth homelessness and 2) promote healthier family functioning.

While Project SAFE has evolved over the last 13 years, core components include phone consultation, support groups, and parenting classes/education. Program modifications prior to 2008 included lengthening the phone consultation from 75 to 90 minutes, shifting from an eight-week support group series to drop-in, weekly support groups, and using different models for providing parenting classes/education. In addition, to respond to the needs of Hispanic/Latino parents and caregivers, Cocoon House began designing services for Hispanic/Latino families in 2008.

*Oftentimes, it doesn't take*
*a huge intervention to shift*
*what's going on in a family system.*
*It's a place to be heard,*
*to talk through what's going on,*
*to gain skills and perspective.*
*Ultimately, the family is the best place*
*for a young person to grow up,*
*if it can be a safe place.*

—Cocoon House staff

Project SAFE outreach locations include schools and school counselors, family resource centers, human service agencies, low-income housing, libraries, police departments, YMCAs, juvenile detention centers, PTAs, and community resource fairs. Project SAFE also reaches out to Hispanic/Latino parents and caregivers through additional locations including Familias Unidas (family support center that is a program of Lutheran Community Services Northwest) and Latino Parent Nights at schools.

*Usually what I hear from the families...*
*is how relieved they are that there is*
*access to these services...[and] that*
*Cocoon House has made a tremendous effort*
*to maintain diversity on their staff,*
*so our families feel understood*
*not only in their same language,*
*but culturally.*

—Community partner at Familias Unidas

As of 2008, services for parents/caregivers include:

- One 90-minute phone consultation with a Master's level therapist (hereinafter referred to as "counselor"), followed by a brief follow-up call two weeks later
- Drop-in weekly support groups, facilitated by a counselor, to help rebuild the parents'/caregivers' ability to connect with their youth and to strengthen their confidence in parenting
- Parenting classes, offered as a three-week series and as standalone classes
- Access WayOUT seminars, a series for youth and their parents/caregivers to build communication, decision making skills, and an understanding of the personal differences that can cause conflict

To access services, parents and caregivers call Cocoon House and speak with an intake coordinator. Services are available

in English and Spanish. The intake coordinator schedules Phone A, a 90-minute phone consultation between the parent/caregiver and a counselor, within a few days of the initial call. Cocoon House intentionally delays the phone consultation to allow the caller to de-escalate from the precipitating stress and make appropriate arrangements for this call.

Phone A is designed to:

- Assist parents and caregivers in exploring their relationship with their youth
- Help parents and caregivers reflect on their role as a parent/caregiver and as a youth themselves
- Discover aspirations for themselves and their youth
- Validate parents'/caregivers' experience and emotions
- Provide support and resources

Together, the counselor and parent/caregiver create an action plan with steps for both the parent/caregiver and youth to support the parent/caregiver in strengthening family management and parenting skills, understanding adolescent development, and improving family communication. In addition, the counselor provides referrals to Cocoon House programs and other external services (e.g., anger management classes, drug treatment, mental health counseling).

Two weeks after Phone A, the counselor contacts callers who agree to participate in Phone B, a follow-up call to measure the parents'/caregivers' adherence to the action plan, including follow-through with referrals. During the call, the counselor works with the parent/caregiver to provide support in reflecting on successes and challenges with the action plan and in making adjustments, as needed and appropriate. Six months after Phone A, the counselor attempts to contact those who agree to participate in Phone C, an additional follow-up call to collect data about longer-term outcomes.

## Findings from Earlier Evaluations

Earlier evaluations of Project SAFE have contributed to understanding the ways in which the program improves family functioning and family management skills. In 2008, a graduate class at Seattle Pacific University conducted an evaluation and found that families engaged in more youth- and family-focused treatment and adult self-care, after participating in Phone A. In addition, follow-up data from 2010-2011 revealed that youth were engaged in less risky behaviors. During this time period:

- 89% of parents/caregivers reported reduced frustration
- 75% of parents/caregivers reported a renewed sense of hope
- 91% of parents/caregivers reported reduced stress
- 63% of parents/caregivers reported a decreased perception that their youth would run away

## Purpose of this Report

In October 2013, Cocoon House engaged Cardea to conduct an independent evaluation of five years (July 2008 – June 2013) of Project SAFE implementation, using existing data collected by Project SAFE staff.

Given the data available, this review had three objectives:

1. Describe parents and caregivers who accessed Project SAFE, including demographic and other background characteristics, as well as reasons for calling and ongoing concerns
2. Describe the services provided during the phone consultations, including the joint action plans developed, and referrals to both Cocoon House programs and other external services
3. Determine the extent to which Project SAFE met outputs and short-term outcomes, as outlined in project logic models, including change in hopefulness and frustration with the current situation and perception that the youth will leave home

# METHODS

In October 2013, Cocoon House and Cardea defined project goals and timelines and discussed Cocoon House's data system and available data. Given changes in Cocoon House's data system prior to 2008 and an interest in focusing on more recent Project SAFE activities, Cocoon House and Cardea agreed to review data from July 2008 through June 2013.

## Project SAFE Data Collection Tools

Across Phone A and Phone B, counselors collect quantitative data on caller and youth demographics, family and living situation, attitudes, and perceptions about the future. In addition, they write extensive case notes to document reasons for calling, callers' concerns about their youth, aspirations and natural supports, and action plans developed at the end of Phone A. Counselors use a common form for data collection and case notes, and Cocoon House's Prevention Specialist enters the data into a Microsoft Access database. Each caller and youth is assigned a unique identifier. Data from Phone C were not included in this evaluation, due to low response rate and limited information collected.

## Measures

During Phone A, counselors document caller and youth demographic and background characteristics, including sex, age, race/ethnicity, (dis)ability status, and whether they have ever received counseling. They collect additional information about the caller only, including household size and makeup, youth custody arrangement, sources of income, household income level (estimated according to income ranges, if callers are uncomfortable divulging an exact income level), veteran status, and immigrant/refugee status. Callers are also asked if their youth has ever been involved in the legal system, is currently living at home, has ever been out of home (i.e., ran away, in a shelter, lived with friends/relatives, or in foster care) and has ever stayed at Cocoon House's emergency shelter. In addition, callers are asked if they have ever contacted Cocoon House's emergency shelter.

During Phone A, counselors document case notes in several open-ended fields—reason for calling/presenting concerns; what prompted the call; history of concerns; history relevant to concerns; aspirations for the youth; impact of concerns on caller; caller aspirations for self; natural supports; and action plan (caller and youth-related).

At the beginning and end of Phone A and at the end of Phone B, counselors document the caller's level of hopefulness and frustration with the current situation, the likelihood that the youth will end up leaving home, and their assessment of the callers' self-sufficiency. During Phone B, counselors also document the caller's satisfaction with Phone A, adherence to the joint action plan, change in the situation with the youth, and whether the youth is living at home.

## Data Extraction

Cardea worked with Cocoon House and its information technology consultant to export all Project SAFE quantitative and qualitative measures stored in the Access database. Data were exported to Microsoft Excel and transferred to Cardea via secure, encrypted email. Prior to June 2011, all written case notes were typed and entered into the Access database. During the period June 2011 through June 2013, counselors wrote case notes, scanned or typed them in Microsoft Word, and saved these case notes as separate PDF documents. These documents were exported and provided to Cardea on a CD.

## Data Management and Cleaning

After successfully exporting all Project SAFE fields from Access to Excel, Cardea worked with Cocoon House to decipher variable names, in the absence of an existing

codebook. Cardea then matched variables by name to data collection tools, when possible; worked with Cocoon House to identify unclear variable names and codes; reconciled small differences between electronic and hard copy forms; and identified appropriate variables to use in analyses. Any out-of-range values were set to missing. To provide geographic context, zip-code tabulated Rural-Urban Commuting Area (RUCA) codes were imported, and callers' zip codes were used to determine county and city of residence.

Given the large number of measures available and overlap between constructs, Cardea created several composite variables to use in analyses:

- *Race/ethnicity*—creation of a single race/ethnicity measure for Hispanic/Latino callers, due to homogeneity in caller-reported race
- *Improved outlook*—improvements in at least two measures and no declines within the caller-rated outlook measures of hope, frustration, and perception that their youth will leave home
- *Self-sufficiency*—equal weighting of three counselor-rated self-sufficiency measures: 1) human relations, 2) support systems, and 3) access to services, given high levels of internal consistency (Cronbach's alpha >0.9) in these measures
- *Adherence with action plan*—caller's self-reported level of adherence to their action plan, collapsed into two categories: 1) high levels of adherence (reported taking 51% or more action steps); and 2) low levels of adherence (reported taking 50% or less action steps)

Client identifiers were modified to be compatible with Excel. Open-ended case notes were exported from Excel to individual Word files using the add-in Individual Merge Letters version 3.0, and were then exported to QSR NVivo 8 for qualitative analysis. Additional data from approximately 300 PDFs were transcribed directly into NVivo.

## Analysis

Quantitative data were imported into SPSS version 19 for analysis. Frequencies were run on all measures, and crosstabs and 95% confidence intervals were used to examine associations between caller and youth demographic and background characteristics and all outcome measures. In addition, multivariate logistic regression, controlling for youth's history of living outside of the home; youth's history with the criminal justice system; youth's sex, age, and race; caller's immigration status; and caller's improvement in outlook was used to examine whether youth were living at home and whether the caller reported that the situation had improved at Phone B. Crosstab and logistic regression results are reported where statistically significant ($p < .05$).

A random sample of 325 records (65 calls per year) was selected for more extensive qualitative analysis. Qualitative case notes were coded using thematic content analysis. Content areas were developed, based on the open-ended questions on the data collection tool for Phone A—ongoing concerns about the youth (reason for calling/presenting concerns, history of concerns, and history relevant to concerns), immediate reason for calling, impact of concerns on caller, caller's natural supports, aspirations for youth, aspirations for caller, specific action steps for youth, and specific action steps for caller. Cardea reviewed 100 records to identify common themes under each of these content areas and shared these themes with Cocoon House to develop a final list. A coding matrix was also generated to assign a dichotomous (yes/no) outcome for each caller on each theme (e.g., Did the caller report any concerns about youth drug/alcohol use?). Data were then exported to Excel and merged with the quantitative data in SPSS for further analysis. Frequencies were computed for each qualitative theme, and crosstabs and chi-square goodness-of-fit analyses were used to examine associations between demographic characteristics and qualitative themes.

The vast majority of calls were from parents and caregivers, regarding a youth living in their home. In reviewing the qualitative data, three calls were identified that did not fit Project SAFE's primary target audience. These cases were included in the quantitative analysis because there was no quantitative measure indicating the caller's relationship to the youth, but were excluded from the qualitative analysis.

Cocoon House allows individual callers to access Project SAFE once a year for each youth. If two parents/caregivers of the same youth want to access Project SAFE, their phone consultations are conducted/entered as separate calls. Duplicate callers/youth were not removed from the analyses for this evaluation. There were no significant demographic or outcome differences between parents and caregivers who accessed Project SAFE once vs. more than once.

### Interviews

To provide additional context for the report, Cardea conducted brief, semi-structured qualitative interviews with five staff from Cocoon House and five staff from partner agencies.

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# RESULTS

During the period July 2008 – June 2013, counselors conducted 1,494 unique phone consultations, with an average of 299 consultations per year. Call volumes varied between 5% and 9% each year, with a range of 280-325 consultations per year. There were no apparent seasonal patterns in call volume.

## CHARACTERISTICS OF CALLERS

More than 80% of Project SAFE consultations were with female callers. The median age of callers was 43 years (Table 1).

Nearly three-quarters of callers (74.0%) were non-Hispanic white, followed by Hispanic/Latino (10.0%). Approximately 3.1% and 2.5% of consultations were with Black/African American and Asian callers, respectively.

Consultations with Hispanic/Latino callers increased over time. In 2008-2009, less than 1% of callers were Hispanic/Latino, and, by 2012-2013, nearly one-fifth of callers were Hispanic/Latino. Counselors provided 97 consultations to callers who identified as immigrants or refugees (6.5%), and nearly two-thirds of these callers (62.9%) were Hispanic/Latino.

Fifteen percent (15.0%) of consultations were with callers who identified as (dis)abled. Nearly four percent (3.9%) of consultations were with veterans.

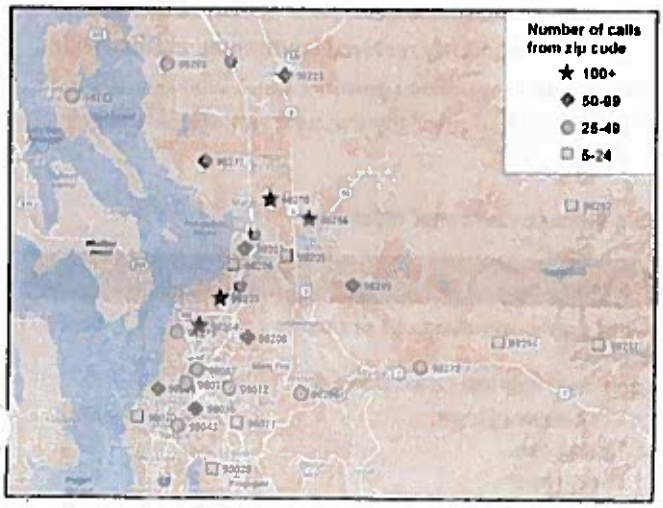
**Table 1. Demographic characteristics of Project SAFE callers (N=1,494)**

| Caller Demographics | Number | % |
|---|---|---|
| **Sex** | | |
| Female | 1,199 | 80.3 |
| Male | 295 | 19.7 |
| **Age range*** | | |
| 20 years or younger | 3 | 0.2 |
| 21-30 years | 41 | 2.8 |
| 31-40 years | 553 | 37.2 |
| 41-50 years | 602 | 40.5 |
| 51-60 years | 242 | 16.3 |
| 61 years and older | 47 | 3.2 |
| **Race/ethnicity** | | |
| Non-Hispanic white | 1,106 | 74.0 |
| Black/African American | 46 | 3.1 |
| Hispanic/Latino | 150 | 10.0 |
| Asian | 37 | 2.5 |
| Native Hawaiian/ Other Pacific Islander | 20 | 1.3 |
| American Indian/Alaska Native | 21 | 1.4 |
| More than one race | 7 | 0.5 |
| Unknown | 107 | 7.2 |
| **Immigrant or refugee*** | 97 | 6.5 |
| Hispanic/Latino | 61 | 4.1 |
| **(Dis)abled*** | 224 | 15.0 |
| **Veteran** | 58 | 3.9 |
| **Caller residence** | | |
| Snohomish County | 1,349 | 90.3 |
| Everett | 387 | 25.9 |
| **Lives in urban area**** | 1,458 | 99.6 |

*6 missing/unknown
**30 missing/unknown

While the vast majority of callers (90.3%) were Snohomish County residents and more than one-quarter (25.9%) lived in Everett, the program reached families beyond Snohomish County. About four percent (3.8%) of callers were King County residents. Nearly all callers lived in urban areas (**Figure 1**).[5]

**Figure 1. Callers' zip codes (N=1,377)**




## CHARACTERISTICS OF YOUTH

Callers sought consultation for male (52.5%) and female youth (47.5%) at relatively equal rates. The median age of youth was 15 years, with 86.2% of youth age 13-17 years. About half (51.6%) were age 13-15 years, and one-third (35.0%) were age 16-17 years (**Table 2**).

Similar to callers, the most frequently reported race for youth was non-Hispanic white (65.5%), followed by Hispanic/Latino (11.3%). Black/African American and Asian youth represented 3.3% and 2.2% of the calls, respectively. Eight percent (8.0%) of the youth were (dis)abled. Youth attended 128 schools.

**Table 2. Demographic characteristics of Project SAFE youth (N=1,494)**

| Youth Demographics | Number | % |
|---|---|---|
| **Sex** | | |
| Female | 710 | 47.5 |
| Male | 784 | 52.5 |
| **Age range*** | | |
| 9 years or younger | 6 | 0.4 |
| 10-12 years | 119 | 8.0 |
| 13-15 years | 767 | 51.6 |
| 16-17 years | 521 | 35.0 |
| 18-20 years | 71 | 4.8 |
| 21 years and older | 3 | 0.2 |
| **Race/Ethnicity** | | |
| Non-Hispanic white | 979 | 65.5 |
| Black/African American | 50 | 3.3 |
| Hispanic/Latino | 169 | 11.3 |
| Asian | 33 | 2.2 |
| Native Hawaiian/ Other Pacific Islander | 19 | 1.3 |
| American Indian/Alaska Native | 31 | 2.1 |
| More than one race | 41 | 2.7 |
| Unknown | 172 | 11.5 |
| **Identified as (dis)abled** | 119 | 8.0 |
| **Number of schools represented** | 128 | - |

*7 missing/unknown

Youth most commonly lived in two-adult households (43.9%). Excluding those for whom living situations were unknown, 40.2% of youth lived in single-parent households. Most callers (80.4%) had full custody of their youth. "Full custody" included situations in which the youth lived full-time in a single household with either one or two parents, while shared custody implied the youth split time between different households (**Table 3, next page**).

About 30% of youth lived in large households with five or more individuals. In contrast, according to 2010 U.S. Census data, only about 11% and 9% of Snohomish County and Everett households had five or more individuals.[6]

[5] As defined by the U.S. Census Bureau, Rural-Urban Commuting Area Codes (RUCAs) are measures used to characterize the nation's Census tracts according to their rural or urban status.

COCOONHOUSE
Because Every Child Needs A Home

**Table 3. Contextual factors of youth's environment (N=1,494)**

| Contextual Factor | Number | % |
|---|---|---|
| **Youth lives with...** | | |
| Two adults (couple) | 656 | 43.9 |
| Mother | 415 | 27.8 |
| Father | 71 | 4.8 |
| None | 61 | 4.1 |
| Other | 5 | 0.3 |
| Unknown | 286 | 19.1 |
| **Custody status** | | |
| Full custody | 1,201 | 80.4 |
| Shared custody | 137 | 9.2 |
| Guardianship | 3 | 0.2 |
| None | 8 | 0.5 |
| Unknown | 145 | 9.7 |
| **Household size** | | |
| Five or more household members | 440 | 30.4 |
| Less than five household members | 1,006 | 69.6 |

Nearly three-quarters of youth (72.5%) lived in households with annual incomes below the average median household income for Snohomish County.[7] A similar percentage (74.4%) lived in households that received at least some income from employment, and nearly one-quarter (22.0%) lived in households that received some form of public assistance (Table 4).

**Table 4. Annual household incomes/sources (N=1,494)**

| Characteristic | Number | % |
|---|---|---|
| **Annual household income*** | | |
| Less than $25,000 | 512 | 34.3 |
| $25,000-$50,000 | 453 | 30.3 |
| $50,000-$75,000 | 212 | 14.2 |
| Greater than $75,000 | 250 | 16.7 |
| Unknown | 67 | 4.5 |
| **Below Snohomish County median income** | 1,083 | 72.5 |
| **Sources of income**** | | |
| Employment | 1,111 | 74.4 |
| Public assistance | 329 | 22.0 |
| More than one source of income | 237 | 15.9 |

*48 missing/unknown; callers were often reluctant to disclose exact household incomes, so counselors provided estimates.
**Callers could report several sources of income.

More than half of the youth (55.4%) had a history of living outside of the home. About three-quarters of these youth were age 12-16 years when they first left home; the median age at which they first left home was 15 years. Many had prior contact with Cocoon House; 14.4% of youth had stayed at Cocoon House's emergency shelter, and 20.1% of callers reported that they had contacted Cocoon House's emergency shelter. More than half of the youth (56.9%) had received counseling, and nearly one-fourth of the callers (21.5%) had previously received counseling. History with the legal system was also common; more than one-third of youth (34.4%) had prior involvement in the legal system (Table 5).

**Table 5. Youth and caller histories**

| History | Number | % |
|---|---|---|
| **Youth previously lived out of home (N=1,485)** | 822 | 55.4 |
| **Age youth first left home (N=365)** | | |
| 11 years or younger | 40 | 11.0 |
| 12-14 years | 137 | 37.5 |
| 15-16 years | 148 | 40.5 |
| 17 years and older | 40 | 11.0 |
| **Prior contact with Cocoon House** | | |
| Youth used emergency shelter (N=1,484) | 214 | 14.4 |
| Caller contacted emergency shelter (N=1,454) | 296 | 20.1 |
| **Counseling history** | | |
| Youth received counseling (N=1,443) | 821 | 56.9 |
| Caller received counseling (N=1,421) | 306 | 21.5 |
| **Youth history with legal system (N=1,472)** | 506 | 34.4 |

## PHONE A — 90-MINUTE PHONE CONSULTATION

### Concerns about Youth

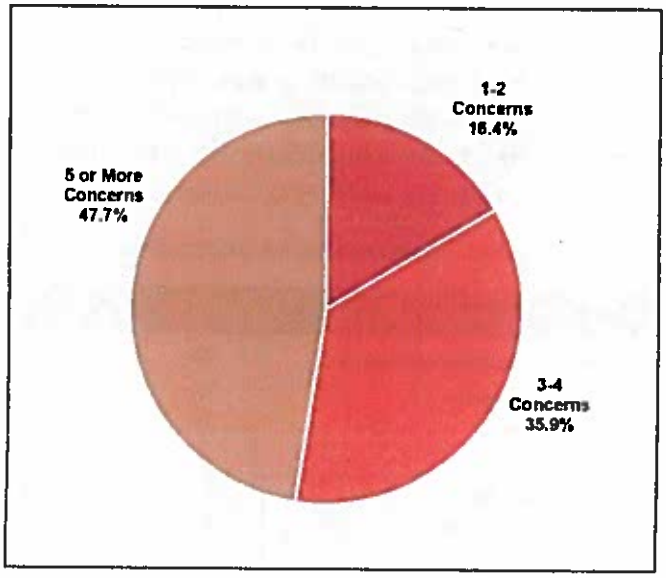
Among records selected for more extensive qualitative analysis, callers' two most common ongoing concerns were problems in school (67.1%) and disrespectful or defiant behavior such as lying, breaking rules, and general rudeness (59.1%). Mental health challenges were also common (44.9%), including depression, bipolar disorder or other mental health diagnoses, cutting, and suicide threats or attempts. Forty-one percent (41.2%) of callers were concerned about their youth's drug or alcohol use. Callers most commonly mentioned marijuana, but heroin, methamphetamines, ecstasy, and other drugs were also of concern. Over a quarter of the youth (28.3%) had run away from home (**Table 6**).

**Table 6: Callers' ongoing concerns about youth (N=326)**

| Concern | Number | % |
|---|---|---|
| **Problems at school** | 218 | 67.1 |
| Performance | 175 | 53.8 |
| Attendance | 92 | 28.3 |
| **Behavioral issues** | | |
| Disrespectful or defiant | 192 | 59.1 |
| Running away | 92 | 28.3 |
| Abusive or threatening | 86 | 26.5 |
| Criminal or illegal activity | 73 | 22.5 |
| Anger issues | 58 | 17.8 |
| Not adhering to ARY terms‡ | 25 | 7.7 |
| **Behavioral health** | | |
| Mental health issues | 146 | 44.9 |
| Drug/alcohol use | 134 | 41.2 |
| **Social** | | |
| Friends – bad influence | 63 | 19.4 |
| Isolated | 34 | 10.5 |
| Bullying victim | 11 | 3.4 |
| **Sex/pregnancy** | 48 | 14.8 |
| **Other** | 103 | 31.7 |

Nearly all callers expressed multiple concerns about their youth, with 47.7% of callers reporting five or more concerns (**Figure 2**).

**Figure 2. Number of concerns about youth (N=323)**




When asked about immediate concerns that prompted their call, callers' responses varied. However, the most common responses were "feeling overwhelmed" or "giving up" (20.3%), youth problems at school (13.5%), disrespectful or defiant behavior (13.5%), and running away (12.0%).

*I'm burned out.*
*I don't even try to work things out with him because he upsets me.*

‡ At-Risk Youth (ARY)—Under Washington State law, parents/guardians can file an ARY petition to receive assistance and support from the juvenile court in maintaining the care, custody and control of a child under age 18 and to assist in the resolution of family conflict, after alternatives to court intervention have been attempted, http://www.kingcounty.gov/courts/JuvenileCourt/chins.aspx.

Nearly 10.0% of callers had heard about Cocoon House parenting classes or support groups and were interested in accessing these services (**Table 7**).

Callers were significantly more concerned about problems at school for male vs. female youth (72.2% vs. 60.7%). They more commonly expressed concerns about social engagement (36.6% vs. 24.4%) and sex/pregnancy (22.1% vs. 8.9%) for female vs. male youth. The frequency of behavioral concerns varied significantly by year, ranging from to 90.8% in 2011-2012 to 69.2% in 2012-2013. The frequency of social concerns declined significantly over time, ranging from 43.1% in 2008-2009 to 21.5% in 2012-2013.

**Table 7. Callers' immediate reasons for calling (N=325)**

| Reason | Number | % |
|---|---|---|
| **Parent overwhelmed/giving up** | 66 | 20.3 |
| **Problems at school** | 44 | 13.5 |
| Performance | 31 | 9.5 |
| Attendance | 13 | 4.0 |
| **Behavioral issues** | | |
| Disrespectful or defiant | 44 | 13.5 |
| Running away | 39 | 12.0 |
| Criminal or illegal activity | 26 | 8.0 |
| Abusive or threatening | 21 | 6.5 |
| Not adhering to ARY terms | 12 | 3.7 |
| Anger issues | 8 | 2.5 |
| **Behavioral health** | | |
| Drug/alcohol use | 28 | 8.6 |
| Mental health issues | 26 | 8.0 |
| **Social** | | |
| Friends – bad influence | 5 | 1.5 |
| Isolated | 1 | 0.3 |
| **Other reasons** | | |
| Interested in Cocoon House services | 32 | 9.8 |
| Youth living out of home | 14 | 4.3 |
| Sex/pregnancy | 7 | 2.2 |
| Youth domestic violence/sexual assault victim | 6 | 1.8 |
| Other | 55 | 16.9 |
| **Median number of concerns = 4** | | |

On average, callers reported significantly fewer concerns about Hispanic/Latino youth (mean=3.3) than youth of other races/ethnicities (mean=4.5 for non-Hispanic white youth; mean=4.3 for youth of other race/ethnicity). Specifically, callers reported fewer school and behavioral health concerns for Hispanic/Latino youth.

## Circumstances Affecting Relationship

Although not explicitly prompted, some callers provided additional context about family circumstances affecting their relationship with their youth. In 40.3% of initial consultations, callers mentioned that they were single parents. Nearly a third reported that youth had lived with different sets of parents/guardians throughout their lives. In many cases, youth experienced multiple disruptive experiences. Many callers reported that youth had "bounced around" between parents, grandparents, or other relatives. In some cases, these living arrangements were made without legal custody arrangements. In other cases, legal custody changes had occurred. A number of callers described Child Protective Services (CPS) intervention or foster care experiences. For example, one caller reported that the youth had lived with her mother until age seven. When the mother moved the family into a homeless shelter, the youth went to live with her father. CPS later forcibly removed the youth from the father, due to physical abuse, and returned her to the mother's custody (**Table 8, next page**).

In more than one-third of consultations (36.0%), at least one of the youth's parents/caregivers suffered from substance abuse or mental health issues. In more than one-quarter (27.7%), the youth had either experienced or witnessed domestic violence or sexual assault (DV/SA). In 10.8% of cases, callers stated that, despite their concerns, the youth had a close relationship with one or both parents. In three cases, callers described the youth as a "good kid" and indicated that they were calling to prevent potential problems.

**Table 8. Additional context and family issues (N=325)**

| Context/issue | Number | % |
|---|---|---|
| **Family composition** | | |
| Parent – single, absent, or divorced | 131 | 40.3 |
| Youth's parent/guardian changed | 95 | 29.2 |
| Housing instability/basic needs | 54 | 16.6 |
| **Domestic violence/sexual assault** | | |
| Youth – victim of DV/SA | 60 | 18.5 |
| Youth – witnessed DV/SA | 42 | 12.9 |
| **Parents – behavioral health issues** | | |
| Substance abuse | 73 | 22.5 |
| Mental health | 58 | 17.8 |
| **Positive/affirming circumstances** | | |
| Youth has close relationship with parent(s) | 35 | 10.8 |
| Youth is a "good kid" | 3 | 0.9 |
| **Other family issues** | 189 | 58.2 |

In 25.5% of consultations, callers explicitly mentioned that their concerns persisted despite their youth having previously accessed services, such as counseling, therapy, support groups, drug or alcohol treatment. In 8.0% of consultations, youth had accessed services at Cocoon House.

## Impact of Situation with Youth

When asked how the situation with their youth was impacting the caller, nearly three-quarters of callers (72.9%) described emotional distress. Fourteen percent (14.2%) of callers also reported physical symptoms such as not eating or sleeping. Callers also mentioned negative impact on other children in the family, social isolation, and alcohol or drug use (**Table 9**).

**Table 9. Impact of situation on callers (N=325)**

| Impact | Number | % |
|---|---|---|
| Emotional distress | 237 | 72.9 |
| Physical symptoms | 46 | 14.2 |
| Affecting employment/finances | 18 | 5.5 |
| Social isolation | 19 | 5.8 |
| Affecting other children in the family | 16 | 4.9 |
| Alcohol or drug use | 3 | 0.9 |

*It's hard.*
*It's frustrating [and] disappointing.*
*It feels like you're failing as a parent.*
*You want to be able to help him yourself, [but] constantly struggling with him is hard. You feel defeated all the time.*

## Caller Aspirations and Natural Supports

After characterizing the situation with the youth, counselors encouraged callers to consider the positive outcomes they would like to achieve. Over half of callers (51.7%) reported that they wanted their youth to succeed in school. Thirty-eight percent (37.5%) hoped their youth would return to/stay in school, and 17.5% hoped their youth's grades would improve (**Table 10**).

**Table 10. Callers' aspirations for youth (N=325)**

| Aspiration | Number | % |
|---|---|---|
| **School success** | 168 | 51.7 |
| Better attendance/graduation | 122 | 37.5 |
| Better grades | 57 | 17.5 |
| **Outlook and relationships** | | |
| Happy and healthy | 126 | 38.8 |
| Engage with family | 48 | 14.8 |
| **Behavior changes** | | |
| Stop disrespectful/defiant behaviors | 119 | 36.6 |
| Mental health evaluation/treatment | 59 | 18.2 |
| Drug/alcohol free | 43 | 13.2 |
| Return/stay at home | 30 | 9.2 |
| **Median number of aspirations = 2** | | |

Many callers also expressed positive hopes for their youth's future outlook and relationship with the family. Nearly 40% indicated that they wanted their youth to have a happy, healthy, or fulfilling life. Fifteen percent (14.8%) hoped their youth would communicate more or spend more time with the family.

> *I want to see a smile on her face... true joy. I want to see her participate and look forward to something, I want her to know she is welcome in this home.*

Callers also hoped that youth would change their behavior—stop disrespectful or defiant behaviors (36.6%), get mental health evaluation or treatment (18.2%), stop using drugs or alcohol (13.2%), and return or stay at home (9.2%).

When asked about aspirations for themselves, most callers said they wanted a better relationship with their youth (50.2%) or just wanted to "feel better" (31.7%). A small number of callers expressed desires for self-care or self-improvement, such as education or career development (14.8%) and more time for recreation or relaxation activities such as exercise, gardening, or travel (8.0%). Other aspirations included dating and forming/maintaining friendships (**Table 11**).

**Table 11. Callers' aspirations for self (N=325)**

| Aspiration | Number | % |
|---|---|---|
| **Outlook and relationships** | | |
| Better relationship with youth | 163 | 50.2 |
| Feel better | 103 | 31.7 |
| Peaceful home | 25 | 7.7 |
| Feel safe | 14 | 4.3 |
| **Self-care/improvement** | | |
| Education/career development | 48 | 14.8 |
| Recreation/relaxation activities | 26 | 8.0 |
| Learn English | 4 | 1.2 |
| **Other** | 55 | 16.9 |
| **Median number of aspirations = 1** | | |

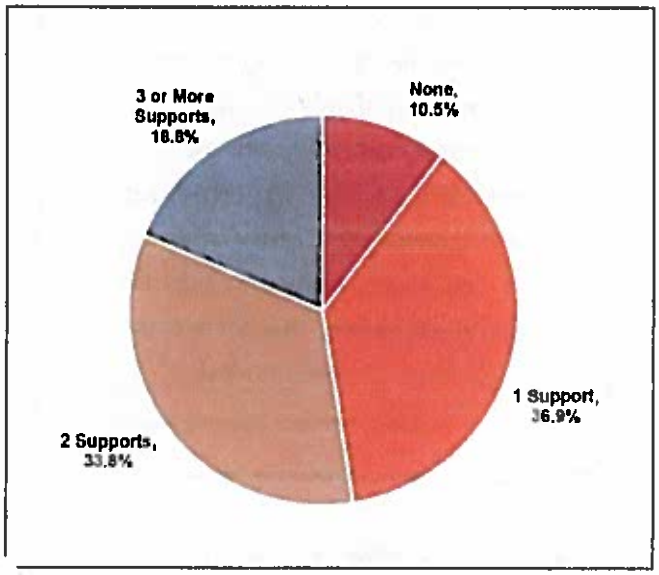
Counselors also asked callers about who they turn to for support. While about 10% of callers reported they had no natural supports, most indicated that they rely on family, friends, or a spouse or partner for support. Some callers relied on more formal support systems, such as religious institutions and support groups (**Table 12**).

**Table 12. Callers' natural supports (N=325)**

| Support | Number | % |
|---|---|---|
| Family | 149 | 45.8 |
| Friends | 140 | 43.1 |
| Partner | 126 | 38.8 |
| Religious institution | 62 | 19.1 |
| Support group or counseling | 44 | 13.5 |
| No natural support | 34 | 10.5 |
| Solo relaxation activities | 18 | 5.5 |

More than half of callers (52.6%) reported multiple sources of support (**Figure 3**).

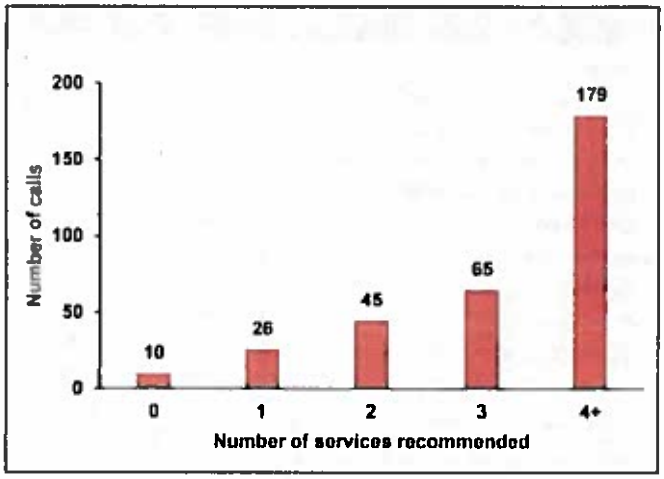
**Figure 3. Number of natural supports (N=325)**




## Action Planning

At the end of Phone A, counselors assisted callers in developing an action plan with specific action steps for both the caller and youth. Counselors recommended an average of four services per caller, and all but two callers had at least one action step documented (**Figure 4**). The number of services recommended increased over the years of the project.

**Figure 4. Number of services recommended per call (N=325)**




Counselors recommended counseling or mental health evaluation or treatment for over 60% of youth. In some cases, they documented referrals to specific agencies that could provide these services. More than half of youth (56.9%) were referred to Cocoon House services, the majority of which were referrals to WayOUT. Other Cocoon House services included U-Turn (resource and drop-in center), Teen Parent Advocate services, and Cocoon House shelters. Counselors recommended drug or alcohol evaluation/treatment for 20.6% of youth, although referrals to specific agencies were not often documented. Counselors recommended more or continued extracurricular activities for 20.0% of youth. Other recommended services included anger management classes, support groups, and basic needs, such as Housing Hope, WIC, and DSHS where teen parents can get free infant formula and supplies (**Table 13, next page**).

**Table 13. Specific action steps for youth (N=325)**

| Action Step | Number | % |
|---|---|---|
| **Services for youth** | | |
| Counseling/mental health services | 200 | 61.5 |
| Cocoon House services | 185 | 56.9 |
| Drug/alcohol evaluation/treatment | 67 | 20.6 |
| Extracurricular activities | 65 | 20.0 |
| Other services | 60 | 18.5 |
| **Behavior changes** | | |
| School – improve attendance | 65 | 20.0 |
| School – improve grades | 27 | 8.3 |
| Spend time with family | 27 | 8.3 |
| Respect/follow rules | 82 | 25.2 |
| **No steps documented** | 22 | 6.8 |
| **Median number of action steps = 2** | | |

Counselors also helped callers identify action steps to improve their parenting skills and address personal challenges. They referred a third of callers (33.5%) to Cocoon House's parenting classes, and over half (56.6%) to its parenting support groups. In 68.3% of consultations, counselors recommended that the caller access external services not provided at Cocoon House, such as counseling, individual or family therapy, or mental health evaluation. In some cases, they documented referrals to specific agencies that could provide these services. Nearly a third of callers were encouraged to work on specific parenting skills, such as establishing rules and consequences, active listening, or reducing their desire to micro-manage. Counselors frequently recommended the book *Positive Discipline for Teenagers*. In 13.2% of cases, counselors encouraged callers to engage in self-care activities, such as exercise, stress reduction and relaxation techniques, and to use the support systems they had previously identified (**Table 14**).

*I've heard they're non-judgmental, accepting, and supportive. But, I've also heard that they're going to be really honest and hold you accountable. Most parents that come out of Project SAFE will say, "The biggest [thing] I learned is that what I have control over is me. And, when I change my interactions and my thinking...that changes the dynamic in the relationship."*

—Community partner at Housing Hope

**Table 14. Specific action steps for callers (N=325)**

| Action Step | Number | % |
|---|---|---|
| **Services for caller** | | |
| External services | 222 | 68.3 |
| Cocoon House support group/ services | 184 | 56.6 |
| Cocoon House parenting classes | 109 | 33.5 |
| ARY or CHINS[1] | 49 | 15.1 |
| Basic needs | 18 | 5.5 |
| **Skills and relationships** | | |
| Specific parenting skills | 100 | 30.8 |
| Relationship building | 87 | 26.8 |
| **Self-care** | 43 | 13.2 |
| **Other** | 29 | 8.9 |
| **No action steps documented** | 6 | 1.8 |
| **Median number of action steps = 3** | | |

[1] A Child in Need of Services (CHINS)—Under Washington State law, court order mandates temporary placement (for up to six months) of the child in a residence other than the home of his/her parent, due to a serious conflict between parent and child or inability to provide the child with basic needs (food, healthcare, shelter, clothing, education, etc.) after reasonable efforts have been made to prevent the need for removal of the child from the parental home, http://www.kingcounty.gov/courts/JuvenileCourt/chins.aspx.

## Immediate Outcomes — Phone A

To measure the immediate impact of Phone A, callers are asked to respond to a number of Likert-scaled questions at the beginning and end of the consultation:

*On a scale of 1-5, 1 being "I am not at all hopeful" to 5 being "I am very hopeful that with help the situation can get better," where are you?*

*On a scale of 1-5, how frustrated are you feeling about the situation with your teen: 1 being "I am not frustrated" to 5 being "I am very frustrated," where are you?*

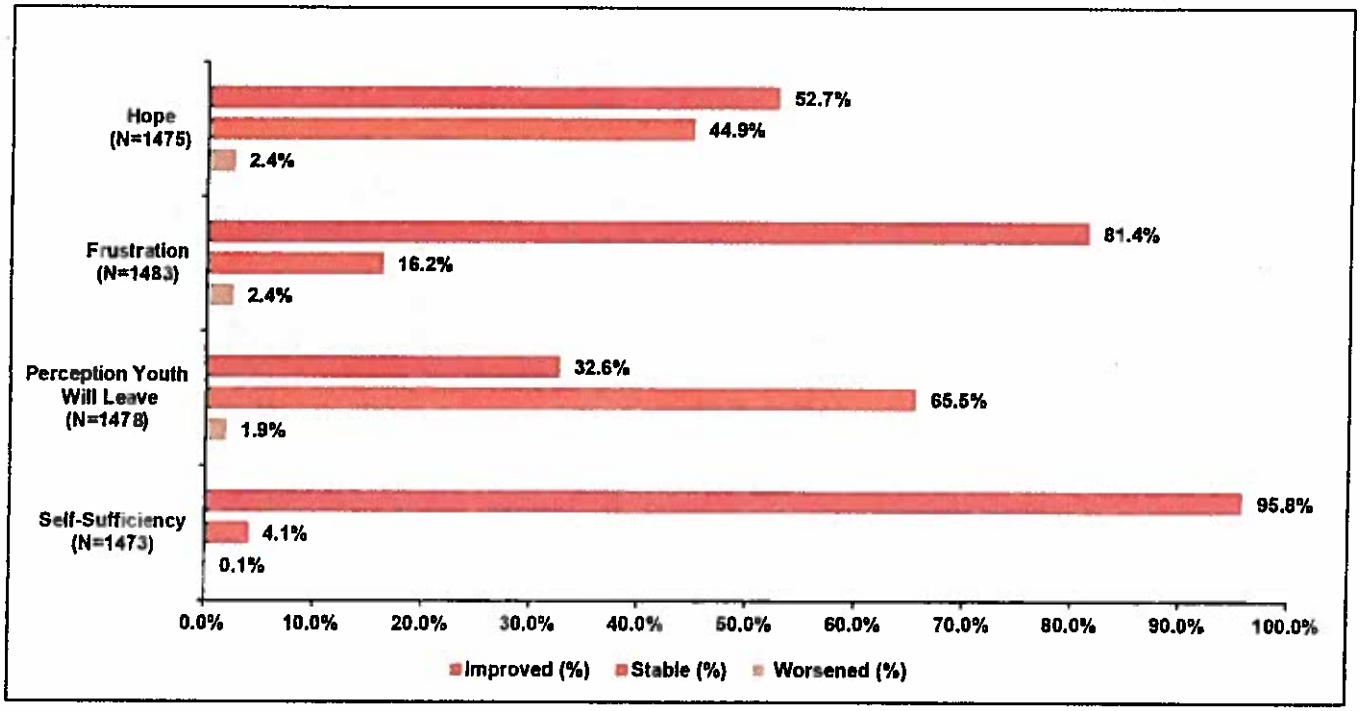
*What do you believe at this moment is the likelihood that [the youth] will end up leaving your home? 1: Definitely not (minimal), 2: Unlikely (somewhat), 3: A strong possibility (moderate), 4: Highly likely (severe), 5: Absolutely sure (extreme)*

In addition, at the beginning and end of Phone A, the counselor rates the caller on three self-sufficiency measures: 1) human relations, 2) support systems, and 3) access to services. They rate callers on a 10-point scale that consists of indicators of specific behavior and conditions that illustrate achievement of self-sufficiency.

At the end of Phone A, 52.7% of callers reported being more hopeful, and 81.4% reported being less frustrated than at the beginning of the call. One-third of callers (32.6%) reported improvements in perception that the youth would leave home (**Figure 5**).

Very few callers reported that their outlooks worsened by the end of the call; the majority of those whose outlooks did not improve experienced no change in outlook. In addition, by the end of the call, almost all of the counselors (95.8%) reported that callers had improved self-sufficiency.

**Figure 5. Callers' change in outlook between the beginning and end of Phone A**



More than half of callers (56.9%) reported improved outlook. The percentage of callers reporting improved outlooks did not differ substantially, based on the youth's sex. However, callers with younger youth reported improved outlooks less frequently than those with older youth. While 58.6% of callers with youth age 16-17 years reported improved outlooks, only 43.1% of callers with youth age 10-12 years, and 55.1% of those with youth age 13-15 years reported improved outlooks.

There were no notable differences in improved outlook according to the youth's racial/ethnic background. However, 61.3% of callers who identified as immigrants or refugees reported improved outlooks, a higher rate than callers overall.

Over the five-year period, the percentage of callers with improved outlooks increased from 52.2% to 63.6%. There was an increase of almost 7% between June 2011 and June 2012.

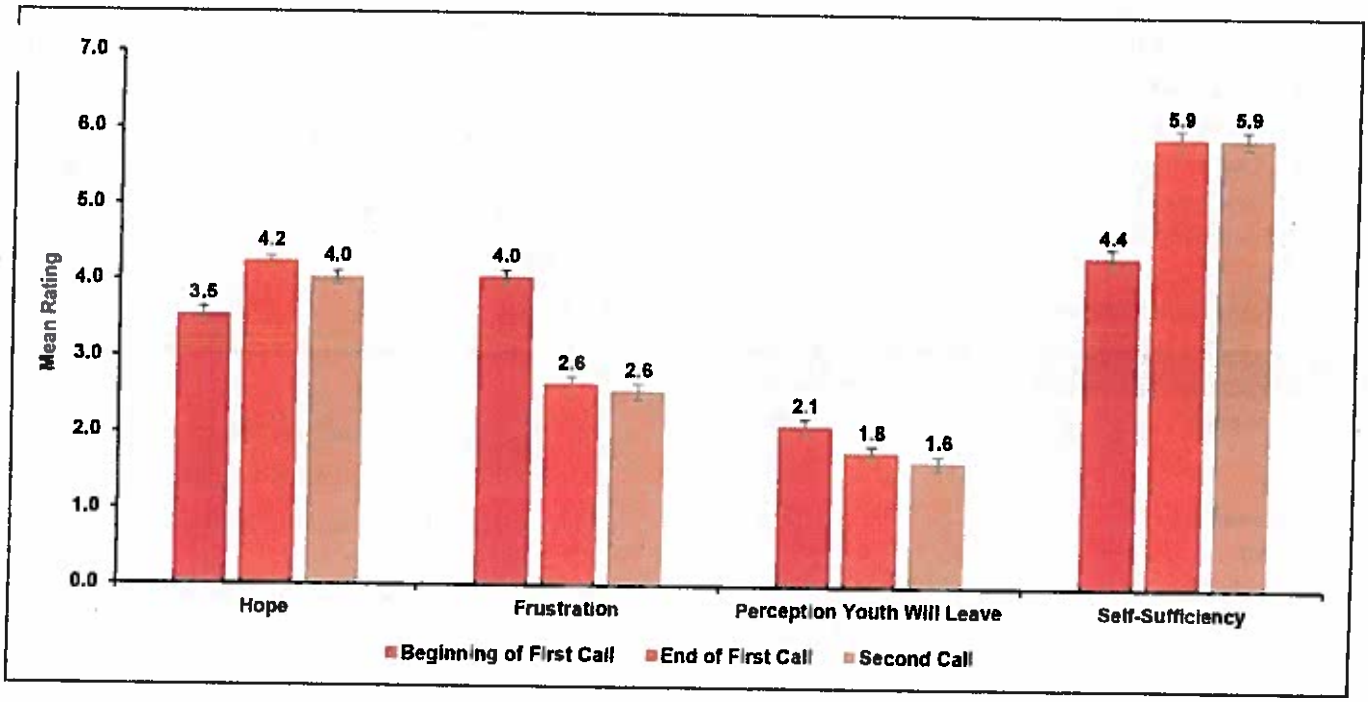
## SHORT-TERM OUTCOMES — PHONE B

### Outlook

Follow up data were available for the 697 callers who participated in Phone B. At the beginning of Phone B, callers are asked to respond to the same set of Likert-scaled questions that were asked at the beginning and end of Phone A. In addition, at the beginning of Phone B, callers are asked the extent to which the situation with their teen improved ("improved dramatically," "improved somewhat," "stayed the same," or "gotten worse"), and how fully they were able to follow up on their action plans ("fully/took all actions," "mostly/51%-75% of actions," "partially/26-50% of actions," "a little bit/1-25% of actions," or "no follow up").

Callers' mean levels of hope and self-sufficiency increased, and mean levels of frustration and perception that youth would leave the home decreased (**Figure 6**). Changes in hope, frustration, and self-sufficiency were significant. In addition, there were no reversions in outlook at follow-up, suggesting that these changes were sustained over time. However, the rate of follow-up between Phone A and Phone B (53.5%) may limit the generalizability of these measures to callers who did not participate in Phone B.

**Figure 6. Mean hope, frustration, perception youth will leave home, and self-sufficiency for callers with data at all three points (N=570)**



## Satisfaction and Adherence to Action Plan

Nearly all callers (97.8%) reported that the consultation was either "totally helpful" or "pretty helpful." There were no notable differences by youth's sex, age, race/ethnicity, or caller's identity as immigrant/refugee (**Table 15**).

**Table 15. Level of satisfaction with phone consultation (N=686)**

| Level of Satisfaction | Number | % |
|---|---|---|
| **Satisfied** | **671** | **97.8** |
| Totally helpful | 532 | 77.6 |
| Pretty helpful | 139 | 20.3 |
| **Neutral** | **15** | **2.2** |
| Moderately helpful | 15 | 2.2 |
| Helped a bit | 0 | 0.0 |
| **Didn't help at all** | **0** | **0.0** |

About two-thirds of callers (64.0%) reported that they "fully" or "mostly" followed up with the action plans they developed with counselors (**Table 16**). Adherence did not differ significantly, based on the youth's sex, age, or race/ethnicity. Callers who identified as immigrants/refugees reported lower rates of adherence; only 48.4% reported that they fully or mostly implemented their plans.[1]

**Table 16. Level of adherence with action plan (N=697)**

| Level of Adherence | Number | % |
|---|---|---|
| **High adherence** | **446** | **64.0** |
| Fully | 114 | 16.4 |
| Mostly | 332 | 47.6 |
| **Low adherence** | **246** | **35.3** |
| Partially | 132 | 18.9 |
| A little bit | 83 | 11.9 |
| No follow up | 31 | 4.4 |
| **Unknown** | **5** | **0.7** |

Those who perceived a high risk of their youth leaving home during Phone A reported lower levels of adherence. Only 25% of callers who thought their youth was "highly likely" to leave home reported high levels of adherence. However, those who were "absolutely sure" their youth would leave reported high levels of adherence more frequently (32.4%) than those who thought their youth was "highly likely" to leave.

Of the 325 Phone A consultations included in the qualitative analysis, 174 completed Phone B. Cocoon House counselors did not document extensively during Phone B, but limited case notes were available for 133 calls. Most notes documented positive outcomes, such as the youth or parent/caregiver had entered into counseling, the youth had returned to school or improved school performance, communication between the youth and parent/caregiver had improved, or the youth's behavior had improved. In some cases, continuing challenges were documented, such as the youth ran away, the youth hurt someone, the parent/caregiver continued to feel fearful, CPS took the youth, or the family was experiencing poverty or homelessness. Due to potential selection biases in which callers participated in Phone B, as well as potential variation and bias in what counselors chose to document in case notes, these data were not quantified.

*Our call gave me*
*the encouragement to see*
*I could do this. I feel incredible.*

[1] Data on barriers to adherence were not available.

## Changes in Situation and Housing

About three-fourths of callers (76.0%) reported that the situation with their youth "dramatically" or "somewhat" improved after the phone consultation. Only 6.3% of callers reported that the situation "got worse" (**Table 17**).

**Table 17. Change in situation with the youth (N=697)**

| Change | Number | % |
|---|---|---|
| **Improved** | 530 | 76.0 |
| Dramatically improved | 113 | 16.2 |
| Improved somewhat | 417 | 59.8 |
| **Stayed the same** | 118 | 16.9 |
| **Got worse** | 44 | 6.3 |
| **Unknown** | 5 | 0.7 |

There were no substantive differences in reports that the situation had improved, based on youth's sex or age. Callers with Hispanic/Latino youth were most likely to report that their situations had improved (82.4%).

Callers who identified as immigrants/refugees and those who identified as both Hispanic/Latino and immigrants/refugees reported improved situations 83.9% and 94.4% of the time, respectively.

Nearly all callers (89.8%) reported that their youth were living in the home. Older youth were out of home at higher rates (12.5% of youth age 16-17 years) than younger youth (9.9% of youth age 13-15 years).[1] Only one caller with a youth under the age of 13 reported that the youth was out of home. There were no notable sex differences in the rate at which youth left home.

Callers with Black/African American youth reported that their youth were out of home 21.4% of the time, compared with 10.1% of those with non-Hispanic white and 12.2% of those with Hispanic/Latino youth. Those who identified as immigrants/refugees reported that their youth were out of home 16.1% of the time. There were not enough records to test these differences for significance.

## Predictors of Situation and Housing

Adjusting for demographic characteristics and situational histories that might influence this relationship, the greatest predictors of whether the situation improved and whether youth were living at home at Phone B were: 1) if the youth had no history of living out of home at Phone A, and 2) if the callers "fully" or "mostly" adhered to their action plans.

Eighty-four percent (84.0%) of callers with youth who had no history of living out of home reported that their situations improved, compared with just 70.0% of those with youth who had a history of living out of home. The odds that the situation improved were nearly doubled if the youth had no history of living out of home, compared to cases in which the youth had a history of living out of home (OR=1.9, 95% CI=1.3-3.0) (**Figure 7, next page**).[2]

Ninety-eight percent (97.7%) of callers with youth who had no history of living out of home reported that their youth were living at home at Phone B, compared with 83.7% of those with youth who had a history of living out of home. The odds were nine times greater that the youth were living at home at Phone B if the youth had no history of living out of home, compared to cases in which the youth had a history of living out of home (OR=9.0, 95% CI=3.7-21.8).

[1] There were not enough youth over the age of 17 years with follow-up information to report meaningful differences.

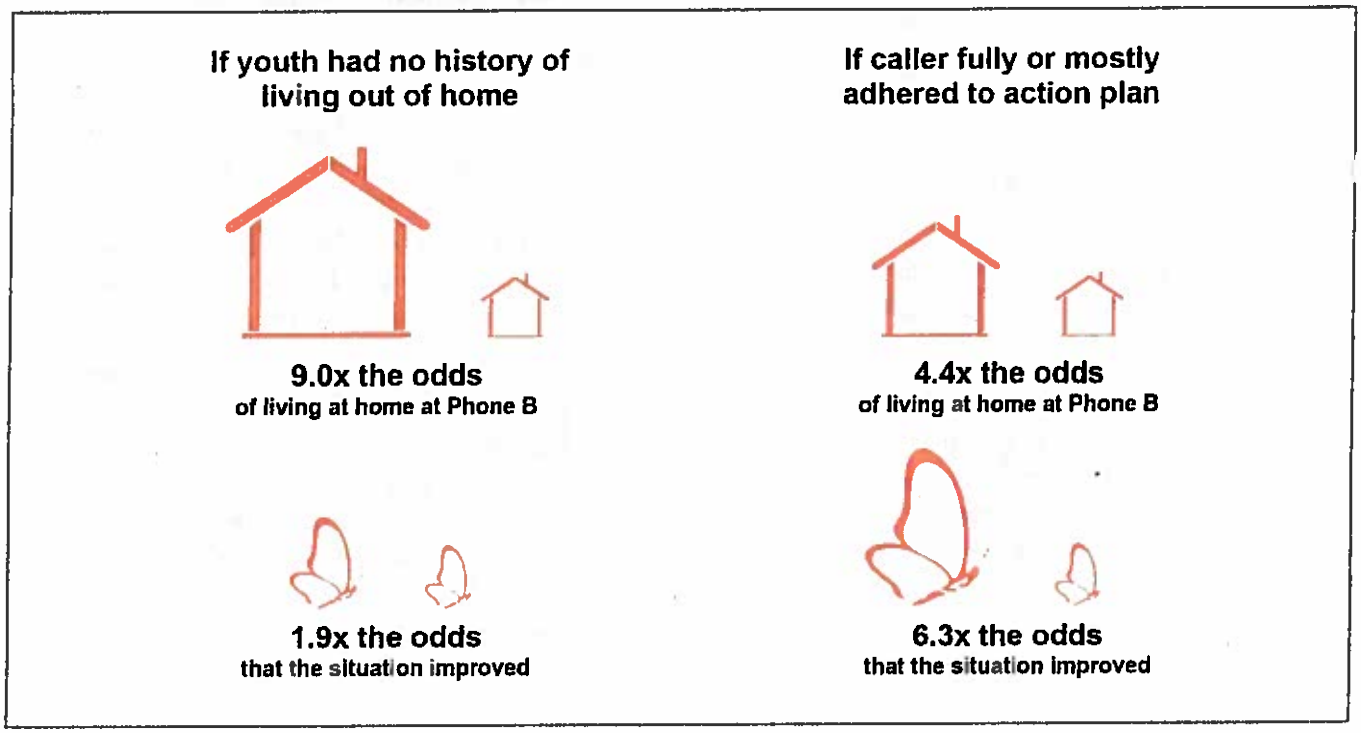
[2] An odds ratio (OR) represents the chances that an outcome will occur, given a particular characteristic or condition, compared to the chances of that outcome occurring in the absence of the particular characteristic or condition. A 95% confidence interval (CI) represents the reliability of an estimated statistic.

Eighty-eight percent (88.1%) of callers who "fully" or "mostly" implemented their action plans reported that their situations improved, compared with 55.3% of those who reported lower levels of adherence to their action plans. The odds that the situation had improved were six times greater if the caller "fully" or "mostly" adhered to the action plan, compared to those reporting lower levels of adherence (OR=6.3; 95% CI: 4.2-9.4).

Finally, 95.3% of callers who "fully" or "mostly" implemented their action plans reported that their youth were living at home, compared with 80.1% of those who reported lower levels of adherence to their action plans. The odds that the youth were living at home were more than four times greater if the caller had "fully" or "mostly" adhered to the action plan, compared to those who reported lower levels of adherence (OR=4.4; 95% CI: 2.5-7.7).

Callers' outlook at the end of Phone A was not associated with levels of satisfaction or adherence to their action plans. In addition, outlook was not a significant predictor of whether callers reported that their situations improved or whether their youth were out of home at Phone B.

**Figure 7. Predictors of living at home and improved situation at Phone B**



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## DISCUSSION

This review had three, primary objectives:

1. Describe parents/caregivers who accessed Project SAFE, including demographic and other background characteristics, as well as reasons for calling and ongoing concerns
2. Describe the services provided during the phone consultations, including the joint action plans developed, and referrals to both Cocoon House programs and other external services
3. Determine the extent to which Project SAFE met outputs and short-term outcomes, as outlined in project logic models, including change in hopefulness and frustration with the current situation and perception that the youth will leave home

### Project SAFE supported a diversity of families facing serious challenges

Most Project SAFE consultations were with female callers, and about one-quarter of callers were people of color. While Project SAFE served male and female youth age 8-25 years, most youth were age 13-17 years. Nearly one-third were youth of color. Most youth lived in two-adult households in Snohomish County with annual incomes below the county median. Nearly one-third had experienced changes in parent or guardianship. More than one-third of youth had parents who suffered from substance abuse or mental health issues, and over one-quarter had either experienced or witnessed domestic violence or sexual assault. Over half of youth had previously run away, been told to leave, or been legally removed from their homes.

### Callers reported distress, due to ongoing concerns about their youth

The majority of callers reported high levels of frustration and believed that their youth would leave home. Most reported several distinct concerns about their youth, including problems at school, disrespectful or defiant behavior, mental health issues, and drug/alcohol use. More than one-third of youth had prior involvement in the legal system. Many families had previously accessed Cocoon House's emergency shelter or other services, as well as external services such as counseling, therapy, or drug and alcohol treatment.

> *I don't know of any other low-cost or free service like [Project SAFE] for families in crisis, so it's extremely vital, helpful, and important.*
>
> —Community partner in a Snohomish County School District

### Despite ongoing concerns, callers had positive aspirations for their youth

Over half of callers said they wanted their youth to succeed in school. Many expressed positive hopes for their youth's future outlook and relationships with the family and indicated that they wanted their youth to have a happy, healthy, or fulfilling life. Half of callers specifically indicated that they hoped to have a better relationship with their youth.

### Most callers followed up on the action plans they developed with Project SAFE counselors

At Phone B, nearly two-thirds of callers had "fully" or "mostly" adhered to the action plans they developed with Project SAFE counselors. Plans included referrals to additional Cocoon House services, such as parenting classes and support groups, as well as external services.

### Callers' outlook improved, and these improvements were sustained over time

More than half of callers reported improved outlook at the end of Phone A. After two weeks, callers reported sustained improvements in hope, frustration level, and a decreased perception that their youth would leave home.

### At follow-up, most callers reported that the situation with their youth had improved

During Phone B, about three-fourths of callers reported that the situation with their youth "dramatically" or "somewhat" improved. Adherence to the action plan was the strongest predictor of improvement. Parents/caregivers with youth who had no history of living out of home were also more likely to report improvement.

### At follow-up, nearly all callers reported that their youth were living at home

During Phone B, nearly all callers reported that their youth were living at home. Youth were most likely to be living at home, if their parents/caregivers had adhered to their action plans and the youth had no history of living out of home.

## Considerations

These findings highlight several considerations for potential program and data collection enhancements. Callers who "fully" or "mostly" implemented their action plans experienced positive outcomes. However, over one-third of callers reported lower levels of adherence to their action plans. Collecting data on barriers to adherence may help identify opportunities to provide additional support to these parents and caregivers.

In particular, while Project SAFE appears to successfully engage immigrant/refugee parents and caregivers, Cocoon House may want to explore opportunities to support these parents and caregivers in following through with the action plans they develop with counselors. Similarly, since youth who had a history of living out of home were at highest risk of leaving home, Cocoon House may want to explore opportunities to support parents and caregivers of these youth in mediating challenging situations.

In addition, recent efforts to reach out to Hispanic/Latino families have been very successful. Cocoon House may want to explore opportunities for targeted outreach to recruit an even broader diversity of parents/caregivers, particularly males.

Where possible, greater alignment of program goals and data collection instruments could enable more comprehensive assessment of the extent to which program goals are achieved. For example, a focus on linkage to services would support and strengthen evaluation findings. In addition, any available data on enrollment and participation in Cocoon House services would provide a means to validate and quantify the extent to which callers follow up on the action plans, and any evaluation of these services could provide evidence to support the continuum of services and longer-term outcomes related to preventing youth homelessness.

Moreover, future Project SAFE evaluations would be strengthened by revisions to data collection instruments, with a focus on adding and clarifying some quantitative measures (e.g., caller's marital status, relationship to the youth, country of origin and number of years in the U.S.; and youth's sexual orientation and gender identity) and protocols for collecting these measures. Providing closed-ended response options to characterize callers' concerns, aspirations, and action steps would greatly enhance the efficiency of any future evaluations.

This review provides a robust description of Project SAFE. However, less than half of callers (46.5%) participated in Phone B, which may have influenced the reported outcomes. In addition, because parents/caregivers often contact Project SAFE when they are in crisis, improvements at Phone B could be the result of a natural decline in that crisis. However, Project SAFE intentionally delays Phone A to allow the caller to de-escalate from the precipitating stress. As a result of natural changes in staffing over time, there may have been differences in the ways in which information was asked or recorded over the five-year period of this review.

## CONCLUSIONS

As recognized by the National Alliance to End Homelessness, Project SAFE is a best practice and an exemplary model for youth homelessness prevention programming because of its family systems approach.

This review found that Project SAFE promotes family cohesiveness by providing support and resources for parents/caregivers. This family systems approach is grounded in the literature around causes of youth homelessness. Many youth leave home as a result of problems in the home, such as conflict with parents or caregivers, physical and sexual abuse, a family member's mental health or substance abuse issues, neglect or a parents'/caregivers' inability to address the youth's mental health or (dis)ability, or because parents or caregivers cannot afford to care for them.[8] All of these causes were commonly reported among parents and caregivers who accessed Project SAFE.

In addition, according to the National Runaway Switchboard, 47% of homeless youth indicate that conflict with their parent or guardian is a major problem, and over 50% of youth in shelters and on the streets report that their parents either told them to leave or knew they were leaving but did not care.[9] By supporting parents and caregivers in expressing their frustrations, articulating positive aspirations for their youth, and guiding them in developing action plans to address the multiple, complex challenges that they and their youth are facing, Project SAFE addresses the root causes that are often precursors to youth homelessness.

Moreover, interventions to prevent youth homelessness are known to be cost saving. A cost-benefit analysis conducted by New Avenues for Youth found that $5.04 is saved for every $1 spent on prevention and early intervention for homelessness.[10] At Cocoon House, a Project SAFE phone consultation costs just $317, and the cost of full prevention services is estimated to be under $2,000. This is less than the cost of an average shelter stay at Cocoon House ($2,389 per youth), substantially less than the cost of long-term housing at Cocoon House ($13,882 per youth, per year), and far less than the cumulative costs of the many adverse outcomes of chronic homelessness, estimated to range from $7,500 to $40,000 per person, per year.[11,12,13]

Furthermore, recent evaluations of other Cocoon House prevention services provide evidence that involving the parents and caregivers is an effective way to prevent shelter stays. A 2010-2011 analysis found that, in 87% of cases when shelter staff contacted the youth's parent/guardian prior to admission, a stay in Cocoon House's emergency shelter was avoided.

> *It's a lot more complex than it seems, but the strength of the program is in the simplicity of it.... intense therapeutic interaction at the right moment.*
>
> —Cocoon House staff

Through Project SAFE, Cocoon House supports over 250 families each year. This review sheds new light on the challenges that Project SAFE callers face, as well as parents'/caregivers' desire and effort to reconcile conflict and improve their relationship with their youth. Follow-up data on client satisfaction, outlook, and improvements suggest that Project SAFE is successfully meeting this need, providing further evidence to support the efficacy of Project SAFE in fostering family cohesion and preventing youth homelessness.

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# Children's Crisis Outreach Response System (CCORS)

## Five Year Data and Outcomes Summary, 2007-2011

## August 2012

**King County Regional Support Network (RSN)**

**Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) of the Department of Community and Human Services (DCHS)**

**King County, Washington State**

**Prepared with Data and Input from:**

**The Young Men's Christian Association (YMCA) of Greater Seattle (Contractor)**

## Executive Summary

King County's Children's Crisis Outreach Response System (CCORS) has been in operation since 2005, with full implementation and data collection beginning in 2007. Although data summaries have been created periodically for quality improvement activities, this is the first report including data from five years of operation, and for all CCORS program components. CCORS serves the entire county 24 hours a day, seven days a week. CCORS Crisis, Non-emergent Outreach, and Stabilization services are available for youth age three to eighteen who reside in King County and are not currently enrolled with a community mental health agency. CCORS Intensive Stabilization Services (CCORS-ISS) serves youth with more intensive needs, including those who are enrolled in public mental health services. CCORS Crisis Stabilization Beds (therapeutic foster homes) are also available to provide short-term, out of home stabilization as an alternative to hospitalization. CCORS is funded with federal and state dollars, Federal Block Grant funds, and Mental Illness and Drug Dependency (MIDD) county sales tax (.1%) funds. CCORS-ISS is co-funded by the King County Regional Support Network (RSN) and the Division of Children and Family Services (DCFS), Region Two (South) of Washington State's Children's Administration.

CCORS is operated by the Young Men's Christian Association (the YMCA, or "Y") of Greater Seattle, via a contract with the King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) of the Department of Community and Human Services (DCHS).

**CCORS has achieved the following goals:**

- Engagement with county system partners, including child welfare, juvenile court, schools, local hospitals, law enforcement, Designated Mental Health Professionals (DMHPs) and developmental disabilities;
- Development of an operational structure that successfully engages families, children/youth and natural supports, and is mobile enough to serve the entire county;
- Integration of parent partners and advocates into their outreach teams;
- Achievement of the vast majority of goals expressed in referrals, particularly placement prevention and stabilization in clients' living situations; and,
- Diversion of the majority of those referred for hospitalization to integrated community-based services and supports structured in their home.

The number of referrals to CCORS has consistently risen over time, and the program is now serving nearly twice the number of clients it initially served five years ago (approximately 1,100 in 2011). Increased MIDD funding was made available in 2010 to increase staffing levels. While the rising demand for CCORS services remains an ongoing challenge, the "Y" has been successful in meeting program goals and continuing to improve the program over time.

**A note from a CCORS staff**

I was sitting in the dentist's chair yesterday, exchanging pleasantries with the hygienist. She asked what I used to do at the YMCA; that was the opening she needed to share her story with me.

An incident with her fourteen year old daughter led to a visit from CCORS responders, and follow-up services she can't say enough about. She was especially impressed by the skill with which the CCORS on-call caseworkers defused the situation, and were able to engage her daughter in a discussion of safe boundaries for all. Follow-up services have included group counseling and conflict resolution classes; her daughter has reached the stage of recognizing her responsibility for the quality of her family relationships. This mom believes that without the caring and expertise of the CCORS staff, she might not have been able to stop her daughter's downward spiral. Now, they're a family on the mend, with a positive view of the future.

So, to all of the CCORS staff ... keep it up! You are making an incredible, indelible difference for children and families in our community.

## Table of Contents

# Part One: CCORS Program Combined Data

## CCORS Program Overview

The Children's Crisis Outreach Response System (CCORS) program offers short term, community-based, and family-centered services with the goal of crisis prevention and placement stabilization. It is operated by the YMCA of Greater Seattle, which has seventeen branch offices across King County. CCORS services are available to children, youth and families 24 hours a day, seven days a week, 365 days a year. Services are "no-decline" for children/youth who meet criteria. CCORS Crisis Emergent and Non-Emergent Outreach serves children and youth (ages three to eighteen) in King County who meet the crisis services eligibility criteria in the King County Regional Support Network's (RSN) Policies and Procedures Manual (P&P), and who are not currently receiving services through an RSN contracted mental health agency. This includes youth who are Medicaid eligible but have not yet been connected to mental health services, and those who are not Medicaid eligible, including those who have no insurance or have private insurance.

The CCORS program utilizes strength-based, individualized approaches via teams that include Crisis Intervention Specialists (Mental Health Professionals), Family Advocates, and Parent Partners. Teams go out into the community to meet the referred youth and families. CCORS partners with families, as well as other professionals and systems, and uses short-term, evidence-based, crisis intervention strategies. The CCORS program is a unified program composed of various program components, described below.

**RSN-contracted providers, including CCORS, have these goals in common:**

- Provide effective prevention and intervention strategies for those most at-risk and most in need to reduce or prevent more acute illness, high-risk behaviors, incarceration, and other emergency medical or crisis responses;
- Reduce the number of people with mental illness and chemical dependency using costly interventions like jail, emergency rooms, and hospitals;

**CCORS also aims to:**

- Create a single, integrated, County-wide, comprehensive system of crisis outreach response, stabilization intervention, family reunification, and transition to community supports for children and youth; and,
- Ensure the safety of children/youth, and their families and/or caregivers who are facing crisis situations.

## CCORS Program Components

**Crisis Outreach Services and Non-Emergent Outreach (NEO):** Provides crisis telephone response 24 hours a day, seven days per week and includes immediate access to a mental health professional, as well as an outreach team that, at minimum, consists of a Children's Mental Health Specialist and a Family Advocate who are trained in crisis management. Crisis Outreach services provide rapid face-to-face response at the site of the escalating behavior. Teams develop crisis safety plans with family and client input. Teams also provide crisis outreach to children/youth not engaged with a RSN-contracted mental health agency who have been referred for inpatient hospitalization. Teams provide client access to Crisis Stabilization Beds as needed as an alternative to hospitalization or placement disruption, and provide referrals for voluntary hospitalization or coordination with the DMHPs (Designated Mental Health Professionals) for involuntary hospitalization when needed, while keeping clients in the least restrictive option available that is clinically appropriate.

**Intensive Stabilization Services (ISS):** Children or youth in this program are screened and referred by a King County Regional Support Network (RSN) or Division of Children and Family Services (DCFS) gatekeeper. ISS serves families where functioning of the child and/or family is severely impacted due to significant emotional or

behavioral problems, in cases where the client is not served via DCFS' Behavioral Rehabilitation Services (BRS) and the client's living situation and/or safe maintenance in the community is at risk.

**Crisis Stabilization Beds (CSBs), (also known as Hospital Diversion Beds):** CSBs are designed for CCORS clients who would likely be hospitalized or experience another out of home placement without the use of a CSB, or are enrolled in RSN-contracted mental health services and are in need of a CSB for hospital diversion. Access or intake to the CSBs is obtained through the CCORS team and intakes are available 24 hours a day, seven days a week. The length of stay for a child/youth receiving crisis outreach services does not extend beyond 14 days without approval of County staff, however children/youth involved in ISS may remain in a CSB for up to 90 days with approval of the program gatekeepers.

**CCORS Provides:**

- Prompt referral and linkage to mental health, child serving, and other appropriate providers, including outpatient services in contracted mental health and/or substance abuse treatment agencies if eligible;
- Psychiatric evaluation and medication management services when clinically indicated and not available through other resources;
- Community-based, in-home stabilization services available 24/7 to the child/youth and family including teaching, and coaching the parent(s) and the child/youth to develop skills and strategies to manage the crisis behavior;
- In-home stabilization services at a level of urgency, intensity, and frequency that result in rapid stabilization of the child/youth in the home environment;
- Stabilization services as needed for up to eight weeks;
- Partnering with the child/youth and family to develop an Action Plan that identifies the priority needs of the family detailing specific, concrete action steps to stabilize those needs;
- A discharge summary that includes, at a minimum, a description of the initial crisis behavior, the priority needs, action steps that were implemented to meet those needs, and recommendations for ongoing services and support;
- Copies of the discharge summary to the family, the referral source, and the ongoing treatment provider after discharge from CCORS; and,
- Coordinated care with new or existing community providers, including but not limited to other treatment providers, DCFS social workers, and school staff.

## Note on Data and Data Availability

The data in this report is combined from the following sources:

- King County RSN Client Information Database
- YMCA Monthly CCORS Data Reports
- CCORS-ISS Quarterly Data Reports
- CCORS-ISS Outcomes Summaries (2010 and 2011)

It is important to note that the monthly and quarterly data reports changed over time, and therefore some data categories were combined for this report in order to provide consistency within a data category for all years. Additionally, some data was collected only for some quarters, years, or months. Separate CCORS-ISS reports were not initiated until the first quarter of 2008. Some information has been collected by the YMCA only for CCORS-ISS clients. Much of the data is hand-entered by the YMCA, and other data (such as demographics) arose from or was compared against data in the King County database. Due to high variability in data content and report format (often a result of continuous quality improvement efforts), some caution is advised in the use and interpretation of this data.

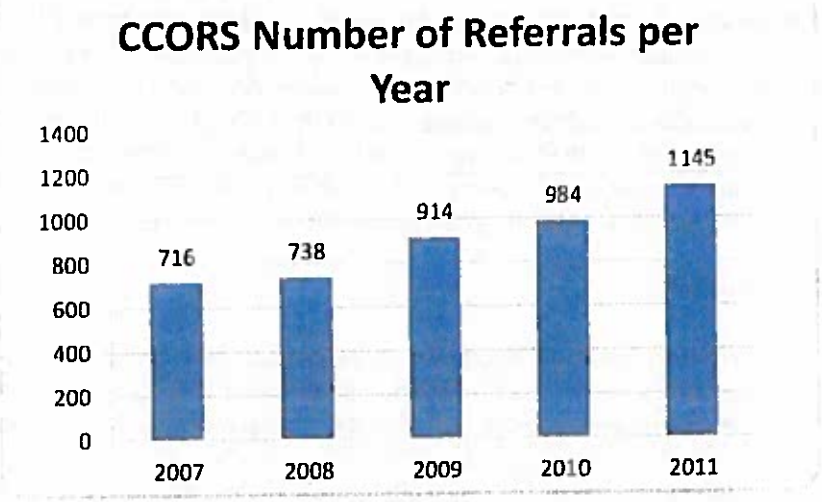
## CCORS Referral Rate and Program Usage: Combined Data

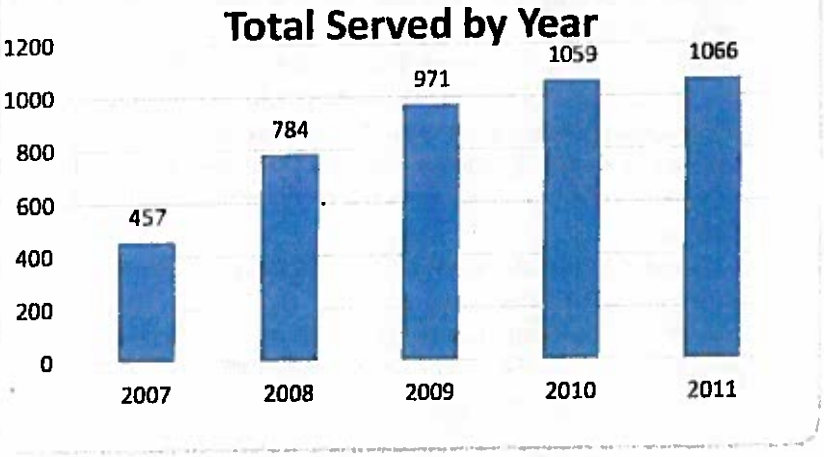
### How many clients does CCORS serve?

The number of children/youth referred to the Children's Crisis Outreach Response System (CCORS) has increased significantly over the last five years as programs, families, and communities hear about the program, and the program builds on its success. As the number of referrals has risen, so has the number of clients served per year. CCORS is a "no-decline" program for those who meet criteria. From 2010 to 2011, the number of both referrals and clients served per year appeared to have leveled out at almost 1,100 clients, but both continue to rise.

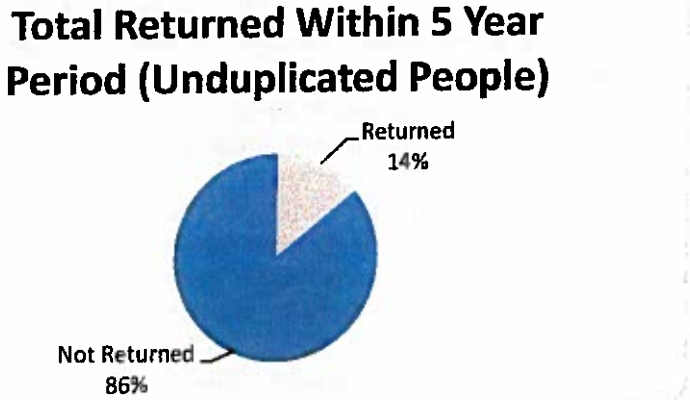
CCORS does see some return clients, often because some families have only CCORS to turn to when their families experience a crisis due to a child or youth's emotional or behavioral needs, particularly those without Medicaid coverage. However, the return rate overall is relatively low. Within five years (2007-2011), only 14 percent of clients returned to CCORS services. The return rate within one calendar year, however, has been increasing over time (see next page).

At this point we cannot track returns by Medicaid/Non-Medicaid status, but this data will be tracked in the future.

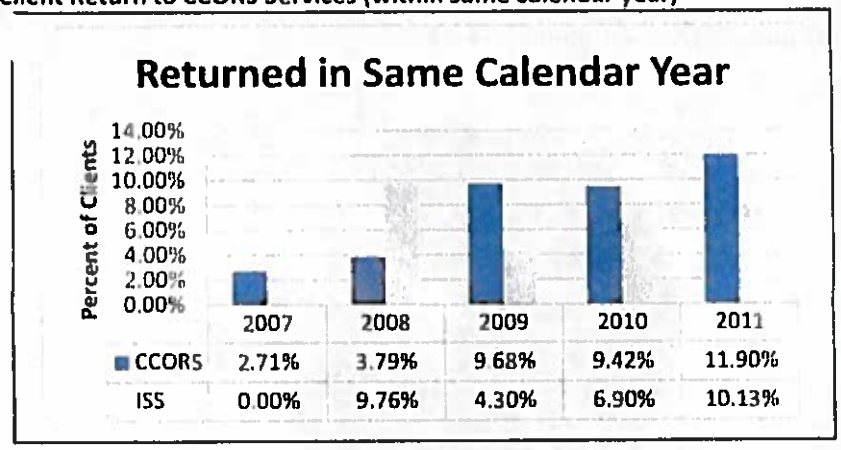


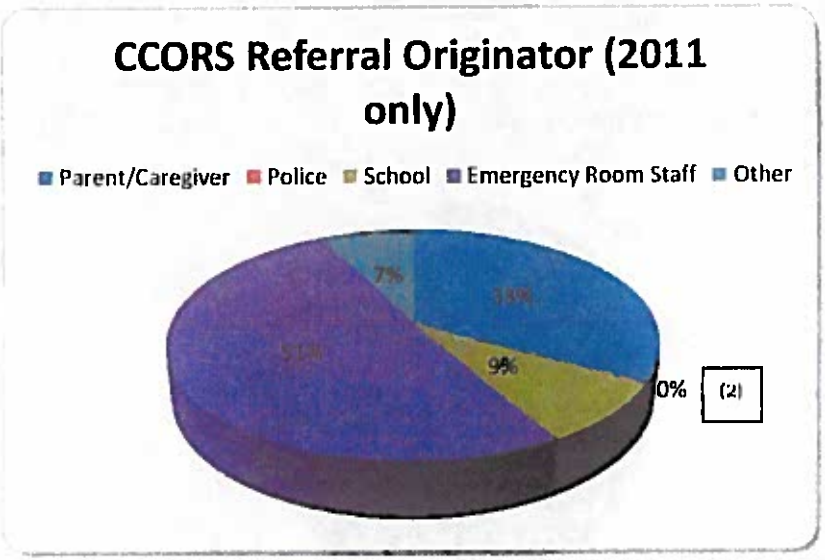

**Client Return to CCORS Services (within five years)**



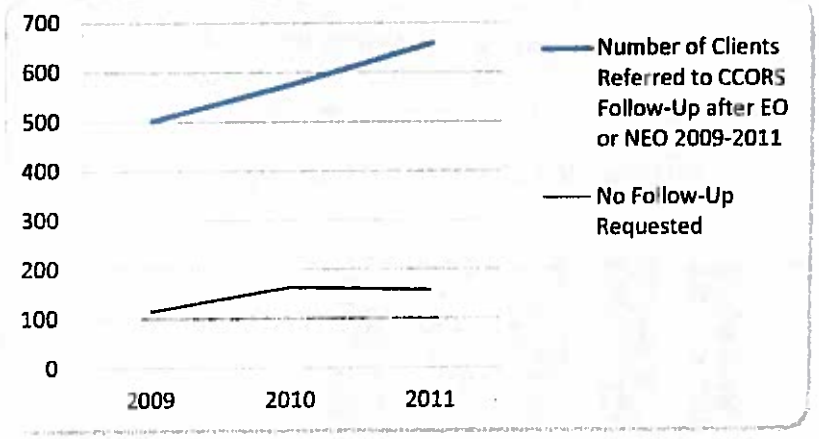
**Client Return to CCORS Services (within same calendar year)**




**Referral Source for CCORS (2011 only)**




**Clients Referred to CCORS Services after Outreach (2009-2011)**




## Who refers children and youth to CCORS?

In 2011 CCORS began to collect data on the referral source. As expected, based on the crisis status of clients (see data below), approximately half of the referrals in 2011 originated from hospital emergency room staff seeking to find less restrictive options for young clients in crisis.

However, a significant proportion (approximately 30 percent) of the referrals came from parents or caregivers who contacted CCORS directly to request assistance with their children. Although we do not yet have comparison data, it will be interesting to see if 2012 data follows a similar or different pattern.

## Follow-Up

The number of CCORS Emergency Outreach (EO) or Non-Emergent Outreach (NEO) cases that were referred to CCORS program follow-up has increased over time, giving families additional needed support services.

## Client Demographics: Combined Data

### Client Demographics

**Race/Ethnicity**

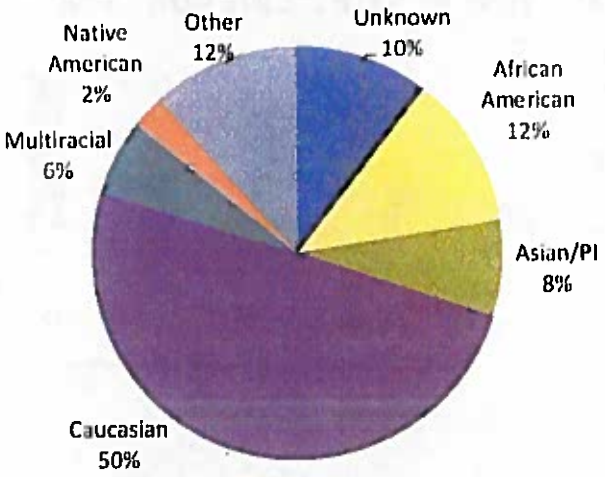
Approximately half of CCORS clients are Caucasian. The second most numerous client population is African-American/Black. The population served by ISS is somewhat more diverse than CCORS, but both programs serve a higher proportion of non-Caucasian families than the percentage of non-Caucasian families in the general population.

CCORS staff work with interpreters as needed and make their materials available in multiple languages. Perhaps reflecting the increasing diversification of King County's population, the percentage of clients who identified as either "multiracial" or "other" racial/ethnic category is significant (approximately 20 percent).

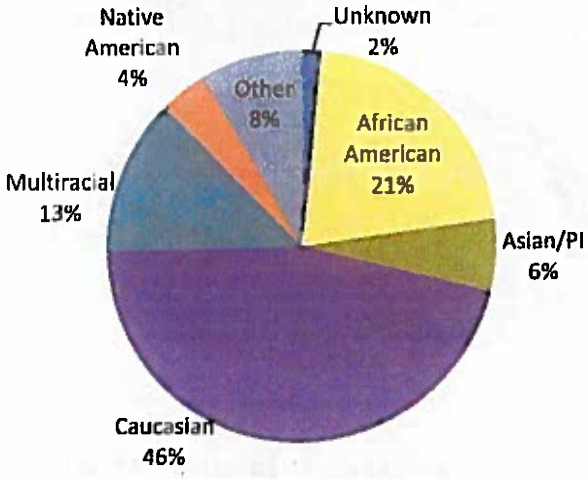
The percentage of clients that identify as Hispanic/Latino has been roughly steady at about 15-20 percent of families.

There has been discussion on the possibility of broadening CCORS' documented racial/ethnic categories to gain a clearer picture of the content of the racial "other" and "multiracial" categories. King County's database currently has a set number/type of categories, but contracted programs can use an expanded list if they choose to do so.

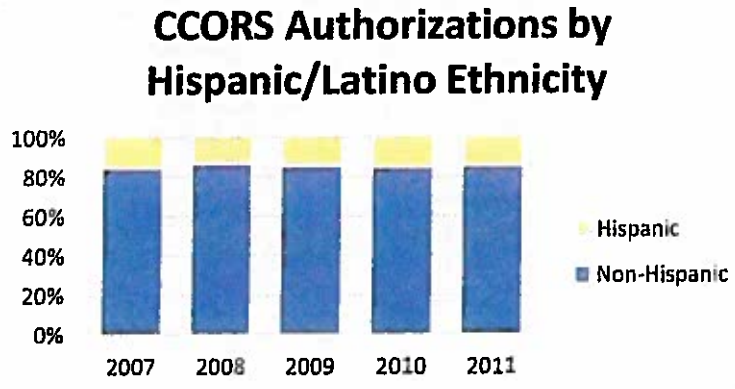
**CCORS (non-ISS) Authorizations by Race**



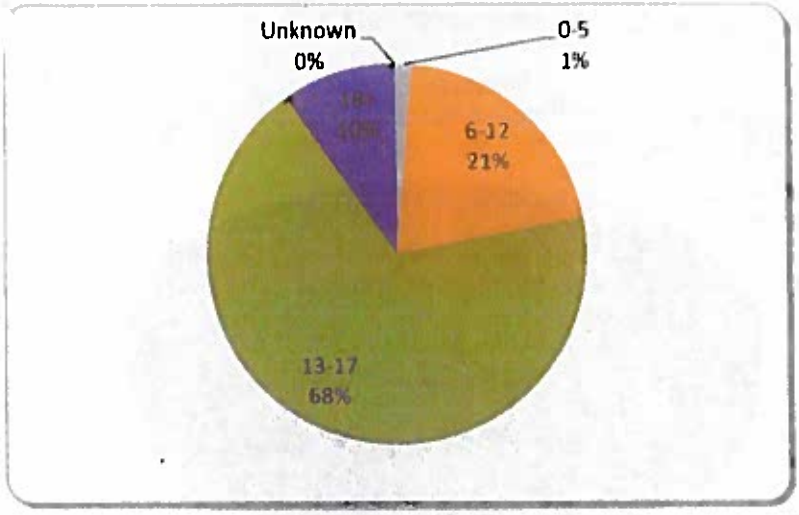

**CCORS-ISS Authorizations by Race**



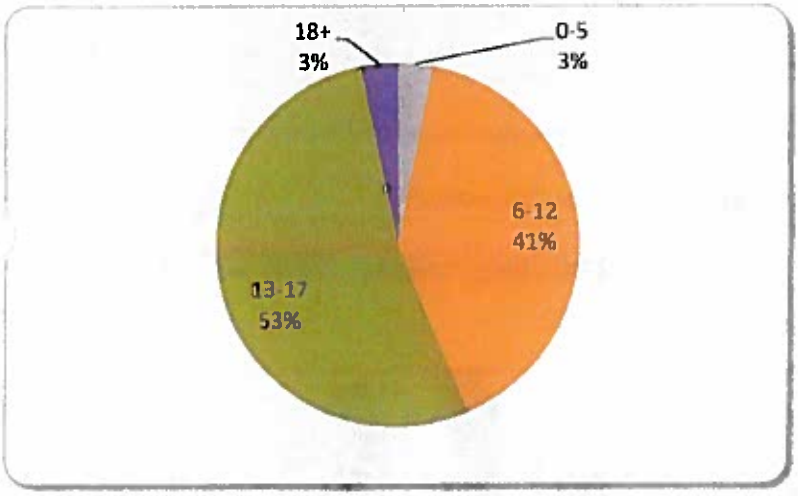

**CCORS Authorizations: Hispanic/Latino Ethnicity (2007-2011)**[1]



**CCORS (non-ISS) Authorizations by Age (2007-2011)**




**CCORS-ISS Authorizations by Age (2007-2011)**




### Client Age

The majority of clients served by CCORS are age thirteen to seventeen. A higher proportion of thirteen to seventeen year olds are served by CCORS-ISS than by "regular" CCORS. There are some clients that are categorized as "eighteen plus;" these are clients that turn eighteen while they are being served by CCORS. This transition age population is often a group that lacks sufficient services. CCORS is one program that concretely assists "almost eighteen" year-olds in need of support.

The next highest age group is six to twelve year-olds, which is more often served by ISS. There is also a higher population of children under five in ISS services than in "regular" CCORS.

## A Note Regarding CCORS Program Development

In late 2009, King County RSN staff began a process with CCORS/YMCA staff to improve the CCORS program. Looking at the data from the first two to three years of the program, staff noticed that caseloads and response times in CCORS were rising, immediate health/safety issues needed greater attention, and clients were staying longer in the program than the program design suggested. Even though CCORS was designed as a short-term crisis intervention and stabilization program, clients were not being transitioned out of CCORS to other long-term supports as quickly as needed. The service delivery process needed to be reviewed and improved.

As a result, RSN and CCORS staff went through an intensive process of case review, coaching and program evaluation throughout most of 2010 in order to align the program more closely with its intended goals. Through a great deal of shared work and effort, the program was successfully re-aligned.

## CCORS Outcomes: Combined Data

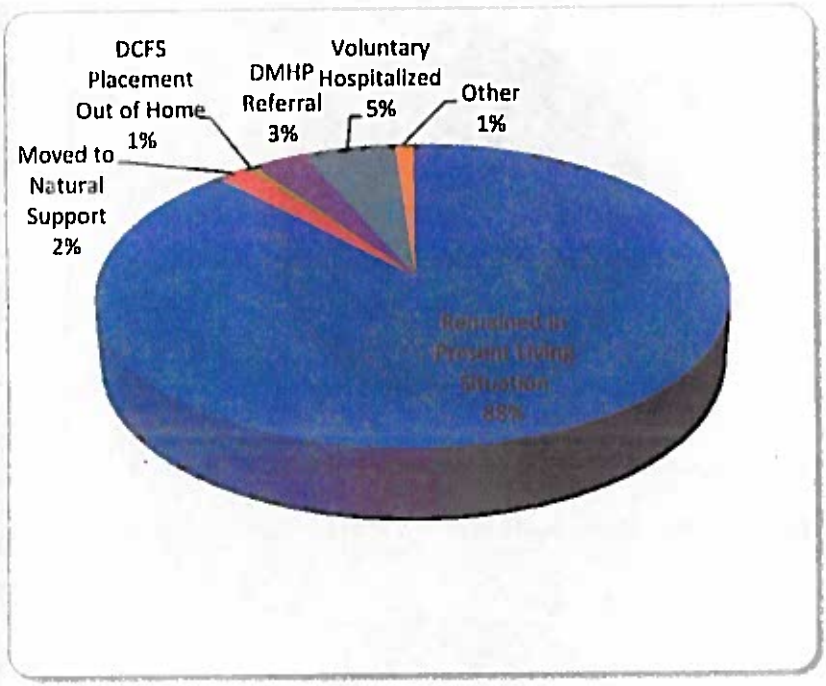
### Outcomes

Examining five years of CCORS data, it is clear that in the vast majority of cases, the goal of the referral was achieved. Children and youth who were referred out of the concern that they would not be able to stay safely in their home, were able to stay safely in their home (88 percent). Those referred for hospital diversion were kept in less restrictive settings that addressed their needs (approximately 75 percent).

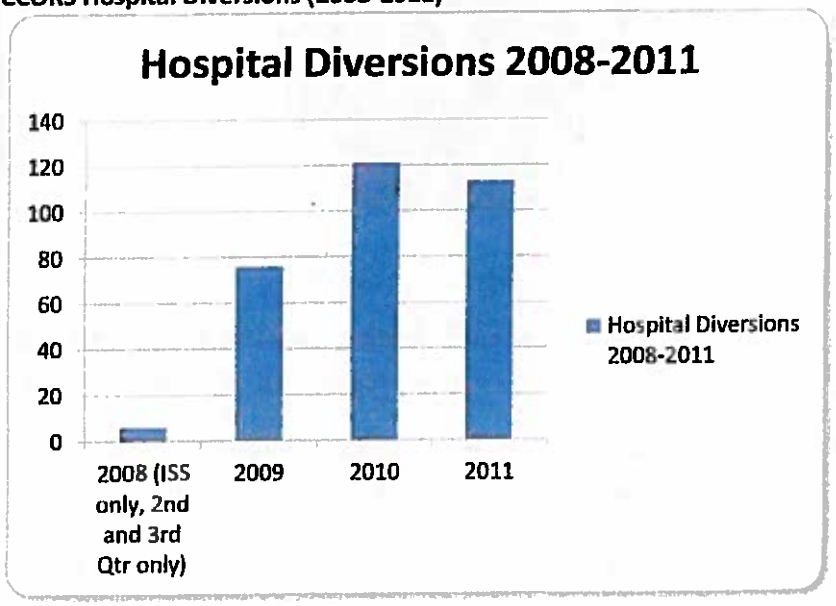
Those who had to transition from their home mostly went to relatives' homes or natural supports, or when needed (and in small numbers), entered hospital beds predominantly via voluntary admissions. DCFS placement was avoided in most cases.

Those without homes or "waiting for placement" at time of referral were overwhelmingly found appropriate homes, mostly birth, adoptive, or relative homes.

**CCORS Outcomes, Combined Years 2007-2011**

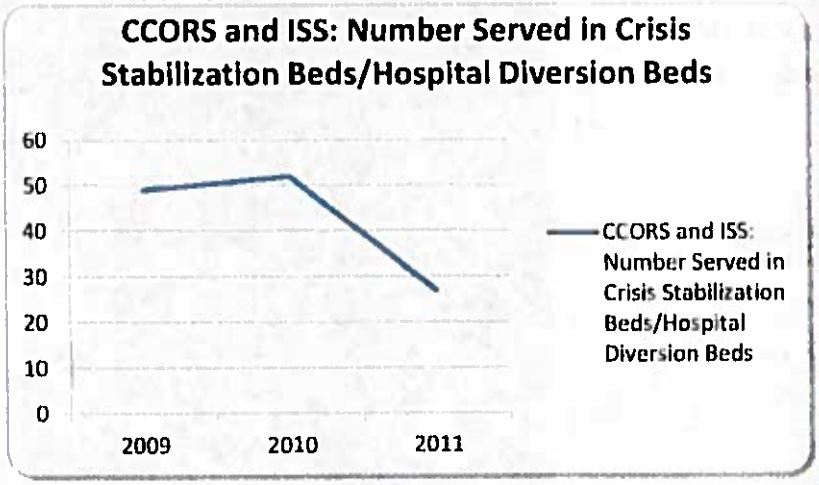



**CCORS Hospital Diversions (2008-2011)[ii]**

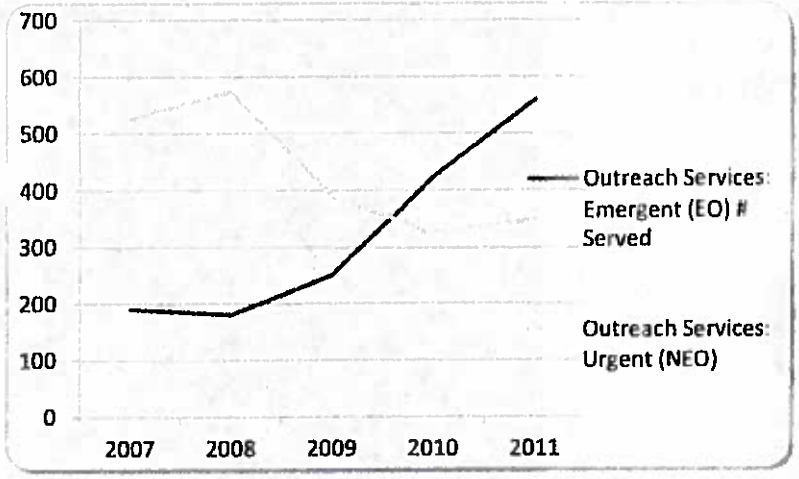


## Service Type: CCORS Combined Data

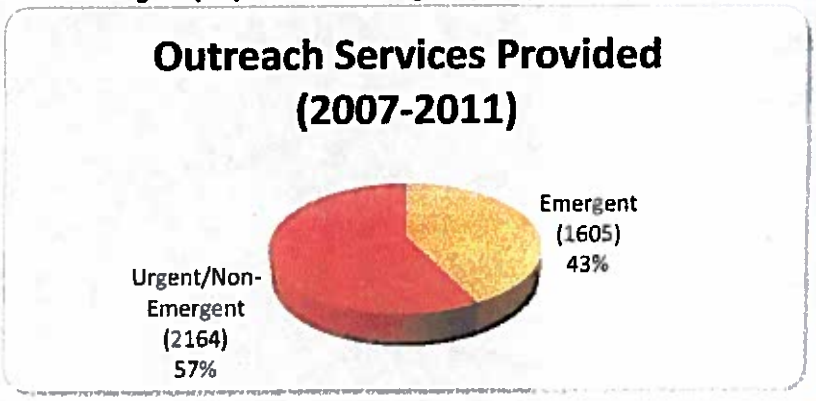
**Crisis Stabilization Bed Usage[iii]**




**CCORS Emergent Outreach and Non-Emergent Outreach Rates**




**CCORS Emergent (EO) and Non-Emergent (NEO)[iv] Outreach Total**




### Service Type, Location and Response Time

**Crisis Stabilization Beds**

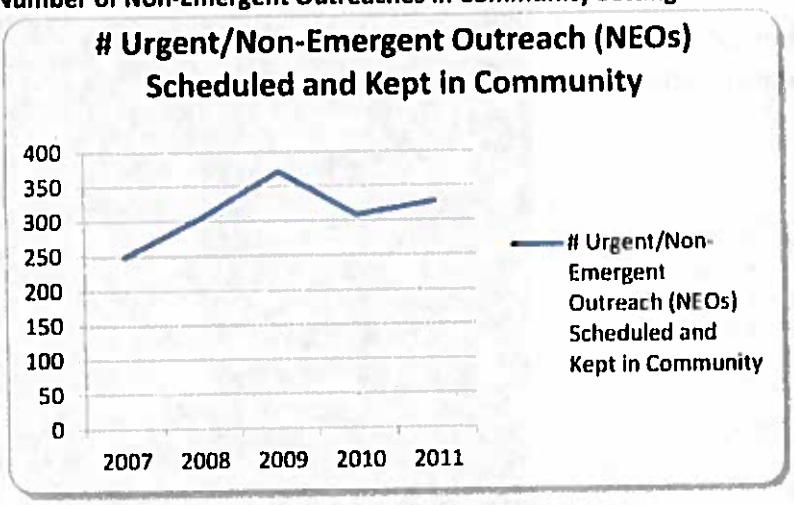
The use of Crisis Stabilization Beds (CSBs)/Hospital Diversion Beds as an alternative to hospitalization peaked in 2010 and has been decreasing since that time. This may be due to improved crisis plan development with client families including outreach to natural supports and wraparound safety plans, and the successful utilization of these crisis plans during CCORS program engagement. It also may be due to increasing communication by the RSN and the YMCA to the community about available in-home services.

This is significant, since according to CCORS staff that have been there since the program's inception, the intensity of client needs has increased. This conclusion is difficult to examine with the current data, but is worthy of additional analysis in the future.

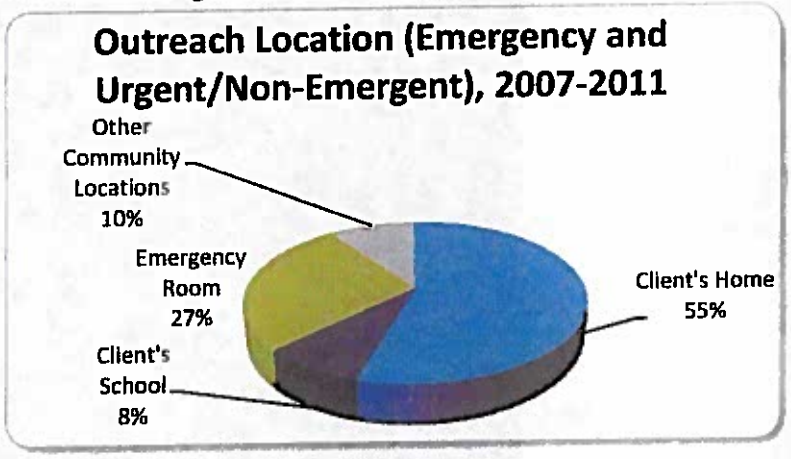
Over time, emergent outreaches have outpaced non-emergent outreaches. This designation is provided to CCORS by the Crisis Clinic, which screens community referrals, but it also may point to the effect on families of recession, unemployment, and financial stress.

## Outreach Locations: CCORS and CCORS-ISS

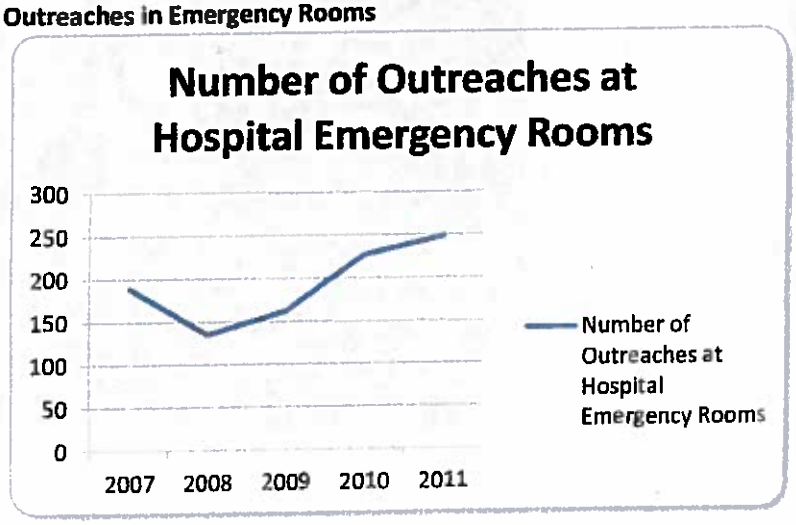
**Number of Non-Emergent Outreaches in Community Settings**




**Location of Emergent and Non-Emergent Outreaches: Total %s**




**Outreaches in Emergency Rooms**




### Emergent Outreach and Non-Emergent Outreach

CCORS Emergent Outreach (EO) started out as secondary in the number of clients served in comparison to Non-Emergent Outreach (NEO), but in 2009 EOs surpassed NEOs, and the number of EOs has continued to climb. Overall NEOs have been provided more often in the past five years than EOs.

### Locations

CCORS staff is highly mobile and accessible in the field via laptops and cell phones. They go to client homes, schools, and other locations such as coffee shops or parks-- wherever the client is located when they are having a crisis.

The entirety of King County is served (over 2,000 square miles), so teams sometimes travel long distances to reach the families.

The number of outreach events ("outreaches") that take place in hospital Emergency Rooms has risen since 2008, representing approximately 25 percent of outreaches.

Nevertheless the majority of outreaches occur in the community, mostly in the client's home.

# Part Two: Children's Crisis Outreach Response System- Intensive Stabilization Services (CCORS-ISS) Data 2008-2011

## CCORS-ISS Overview

CCORS-ISS works to prevent out of home placement, placement disruption, or hospitalization by providing immediate crisis stabilization, creative and flexible problem solving, and strengths-based skill development within the home/community environment. CCORS-ISS is co-funded by the King County Regional Support Network (RSN) and Region Two South (2S) Children's Administration's Division of Children and Family Services (DCFS). Services are provided by an Outreach Team which includes a Children's Mental Health Specialist, Family Advocate, and/or Parent Partner who are trained in crisis management.

For children involved with Child Protection, Child Welfare, or Family Reconciliation Services (FRS) who are referred by DCFS, the referral is screened by the Region 2S DCFS Gatekeepers. Via CCORS, children involved with DCFS are able to maintain placements, improve their level of functioning, and decrease placement disruptions. For children involved in community mental health services, referrals are screened through the King County RSN CCORS-ISS gatekeeper. Families receive tailored support, services are provided with family input and engagement, and parents/guardians learn skills needed to appropriately manage and meet the needs of the child in their home. In addition, families that are not involved with DCFS are often able to avoid new or additional child welfare involvement as a result of assistance received from CCORS-ISS.

The CCORS-ISS program component was initiated in the third quarter of 2007. The first data report was prepared for the first quarter of 2008. In 2007 a total of 20 referrals per month were permitted as per budget restrictions; 10 each by DCFS and the RSN. Due to state budget cuts to DCFS, in 2009 the slots were reduced to a total number of 17 referrals per month, or 8.5 each by DCFS and the RSN.[v]

### Ongoing Performance Monitoring

Region 2S DCFS, the King County RSN and the Agency Subcontractor (YMCA of Greater Seattle) utilize data to monitor, evaluate, and improve the program. Performance monitoring includes:

- Monthly CCORS-ISS Operations meetings with representatives from Region 2S DCFS, King County RSN and CCORS-ISS program supervisors, and managers from the YMCA.
- Periodic Oversight Committee meetings which include all staff who attend the monthly operations meeting along with representatives from the Crisis Clinic and King County Crisis and Commitment Services.
- Annual contract compliance audits by the King County Regional Support Network (RSN), which includes review of clinical records.

## Referral Sources and Cross-Agency Collaboration: ISS

CCORS-ISS services are provided with intensive family engagement and community partner engagement, using a wraparound philosophy that is consistent with Washington State DCFS' Family-Centered Practice Model.

CCORS-ISS teams work collaboratively with any other involved partners (such as school systems, juvenile detention, developmental disabilities, etc.) to help engage needed services, reduce service duplication, and establish long-term supports that benefit the family. As noted above, CCORS-ISS teams include parent partners, and/or family advocates as well as mental health professionals.

### Referral Sources: ISS

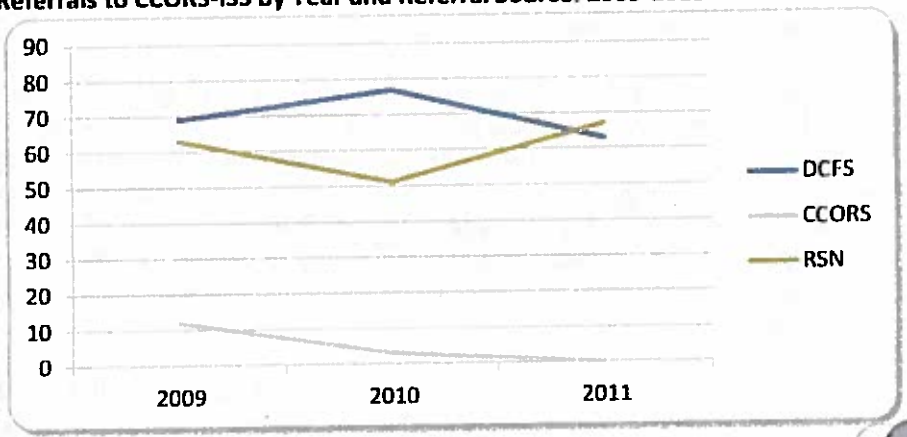
The majority of referrals (65%) to CCORS-ISS are made by the Division of Children and Family Services (DCFS, aka Child Welfare).

DCFS referrals peaked in 2010 and have somewhat declined since that time, mainly due to the reduction of funding from DCFS to CCORS-ISS in 2009. Referrals from the RSN have risen slightly over time since 2010.

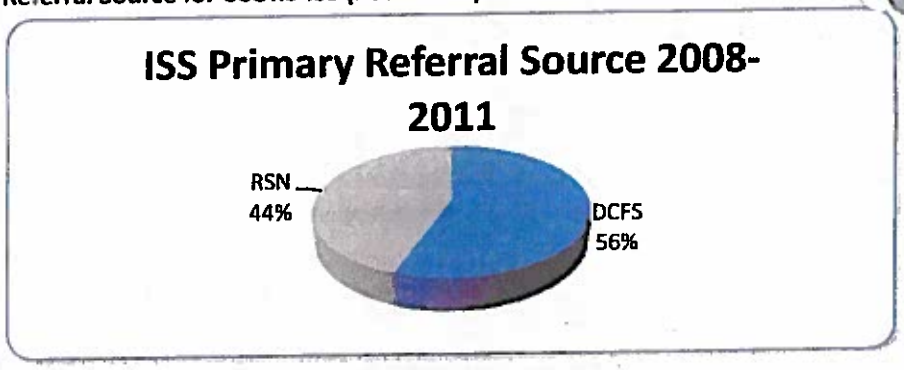
Initially, some CCORS-ISS referrals were routed to the RSN gatekeeper via the CCORS program, but now these referrals are infrequent since there is increased screening at the front-end and therefore fewer cases transitioning from regular CCORS to CCORS-ISS .

It is notable that a large proportion of all families referred to the program (approximately 75 percent) have some form of DCFS involvement, regardless of the referral source.

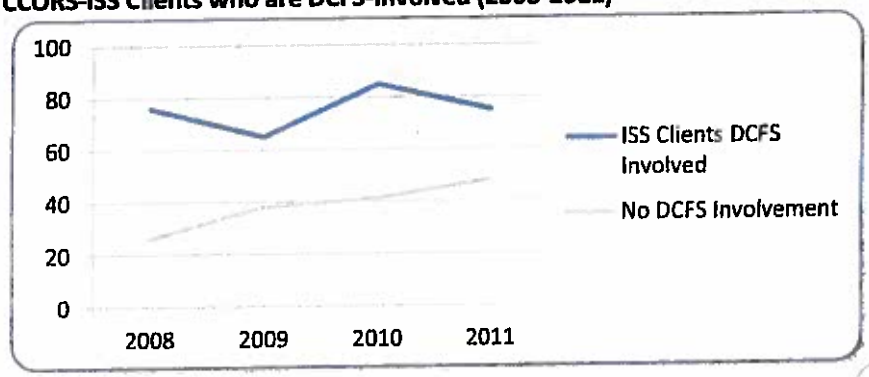
**Referrals to CCORS-ISS by Year and Referral Source: 2009-2011**




**Referral Source for CCORS-ISS (2008-2011)**




**CCORS-ISS Clients who are DCFS-Involved (2008-2011)**



## Client Demographics and Highly Served Populations: ISS

### Demographics

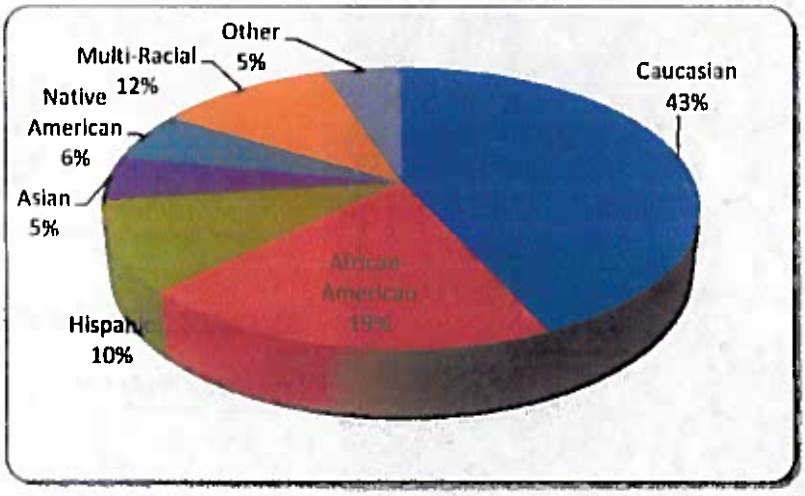
Less than half of ISS clients are Caucasian, making for a more diverse population than "regular" CCORS (see Part One above). Approximately a fifth of clients identify as African-American/Black, with a large proportion of multi-racial- identified clients.

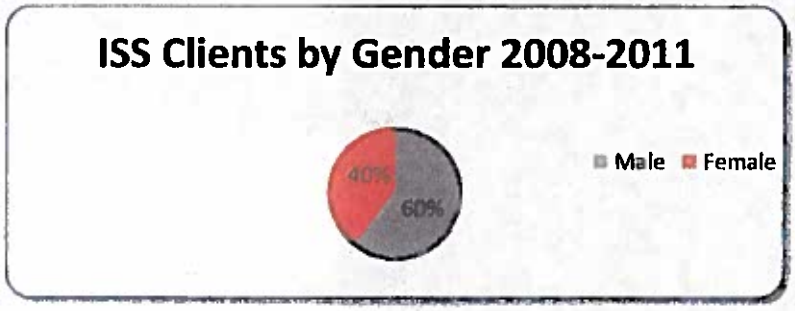
Two-thirds of ISS clients are male, and approximately half are age thirteen to seventeen. Approximately 45 percent of the clients are age six to twelve, with the remainder under five years old.

three-quarters of ISS clients are Medicaid eligible. This reflects the fact that ISS referrals have to be routed through either the RSN or DCFS. All DCFS clients with open cases are Medicaid eligible, and the vast majority of clients referred through the RSN are already connected to and working with a community mental health agency contracted with the RSN.

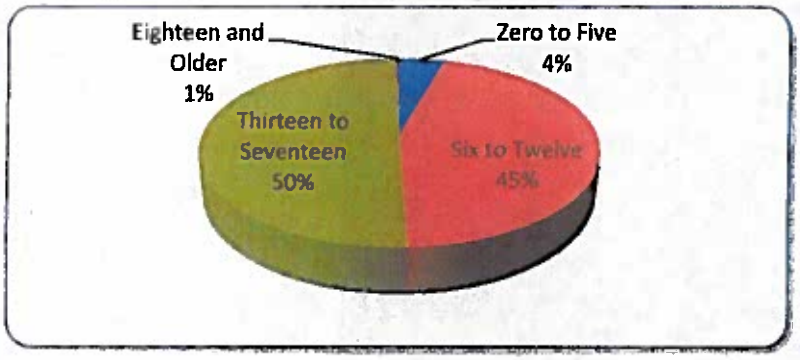
There is, however, a significant sub-population of clients that are served by therapists funded by private health insurance, who are referred directly to the RSN gatekeeper.

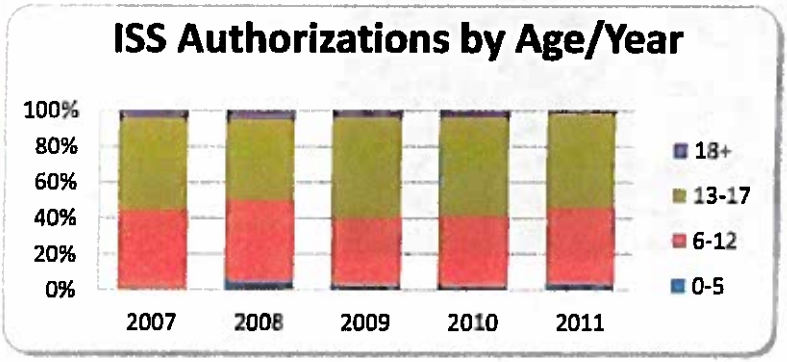
**CCORS-ISS Clients by Race/Ethnicity (2008-2011)**




**ISS Clients by Age 2008-2011**

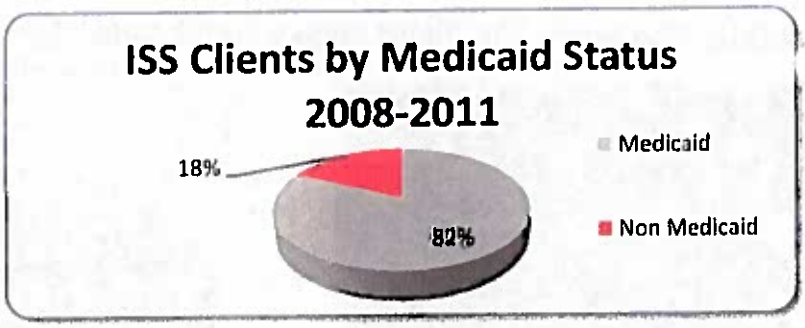


## Response Time, Service Length and Clients Served

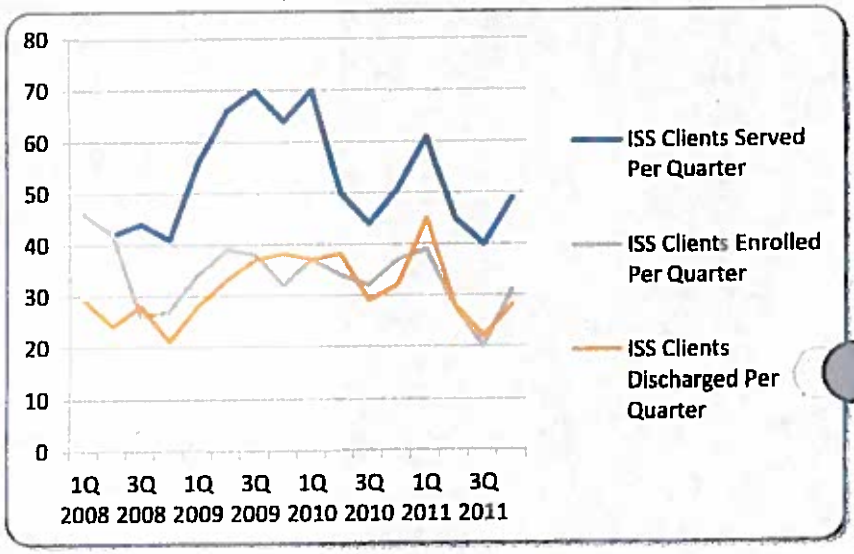
There was a peak in the number of clients served by ISS toward the end of 2009 and the first half of 2010. This reflects the development of the CCORS program during that time as it worked with the RSN to increase service intensity and decrease service duration (see Note on page nine). Other than that shift, the numbers of clients ISS took into the program (enrolled), exited from the program (discharged) and continued work with (served) has remained relatively consistent at approximately 25-35 clients per category per quarter. Numbers rose in 2011 however, particularly in the last half of the year.

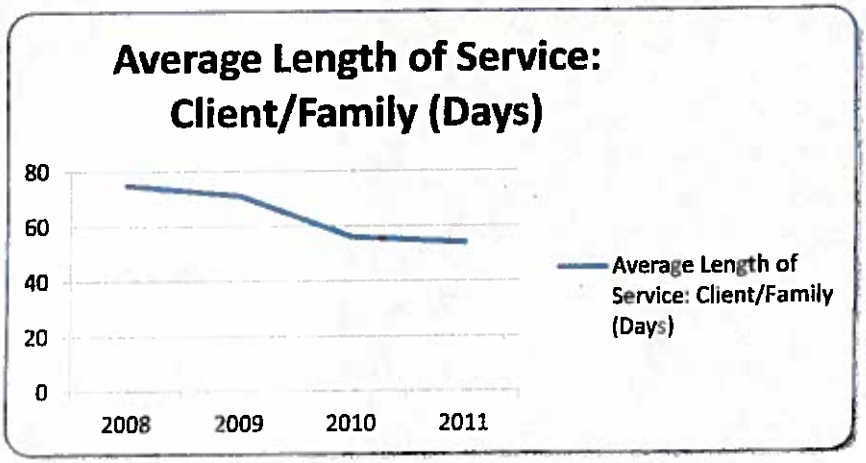
The average number of days client families receive services has declined, in order to more closely conform with program design, to an average of just under sixty days. As services decreased in length they increased in intensity, in order to orient the program towards rapid stabilization and connections to ongoing support.



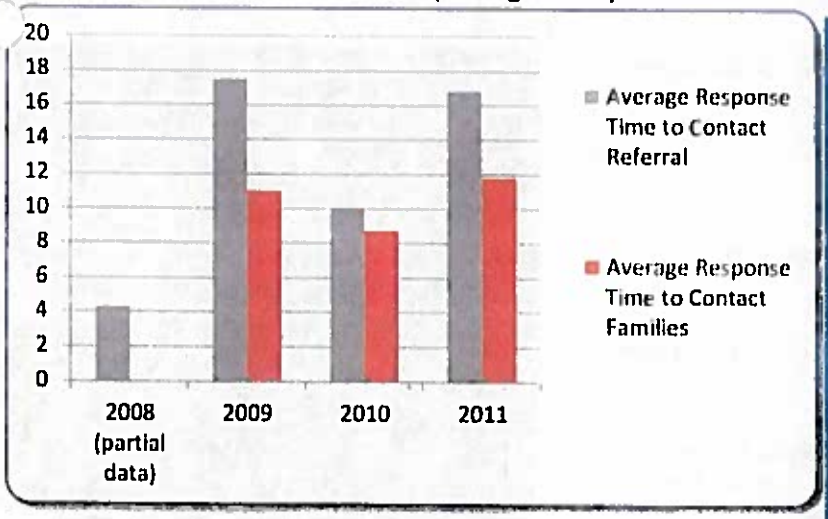

## Response Time, Service Length, and Clients Served: ISS

**CCORS-ISS Clients Served, Enrolled and Discharged per Quarter**

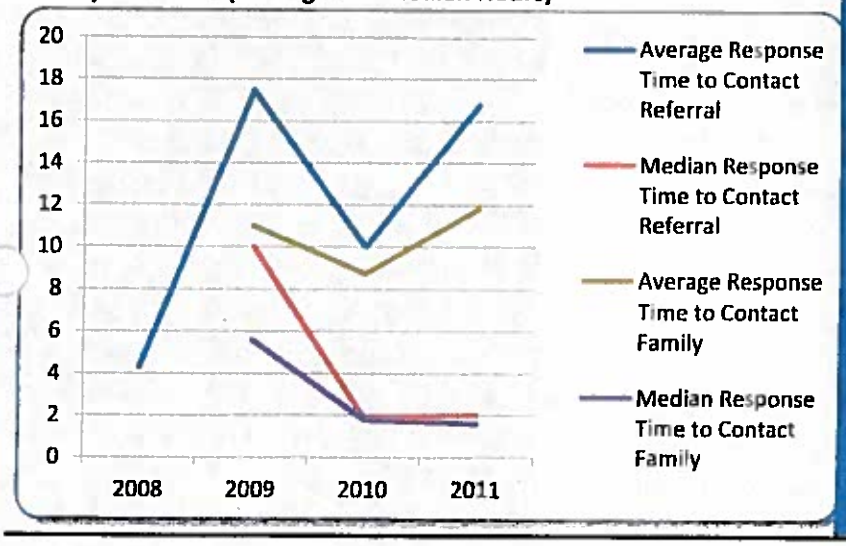


**ISS Response Time to Contact Referral (Average Hours)**




**ISS Response Time (Average and Median Hours)**



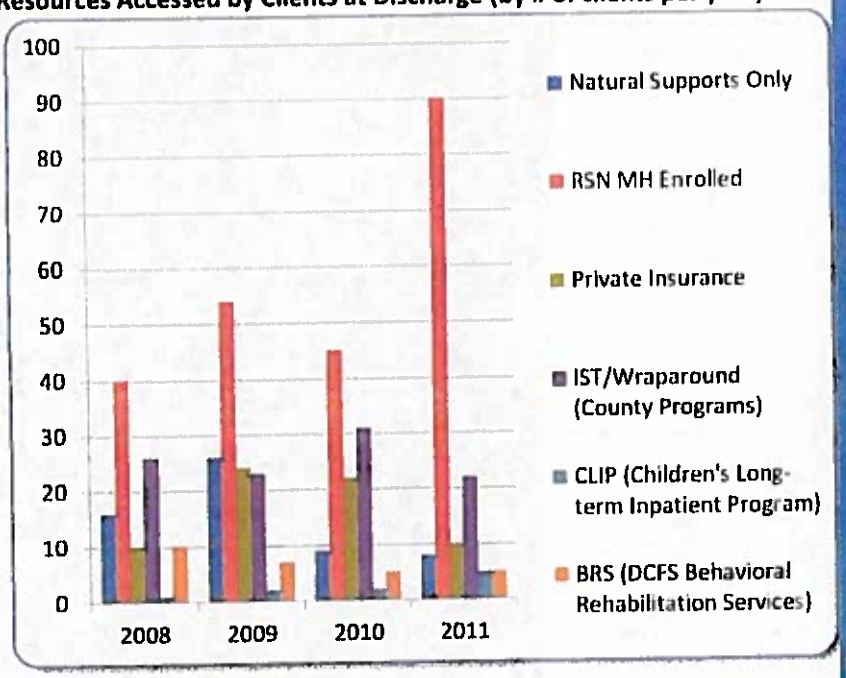

## Referral Response Time

As the program has matured, the time it takes to respond to the initial referral and the family/client has evolved. Response time dropped from 2009 to 2010. In 2011 the average response time increased. The range (highest versus lowest time to respond) also increased, with some very short and some very long response times.

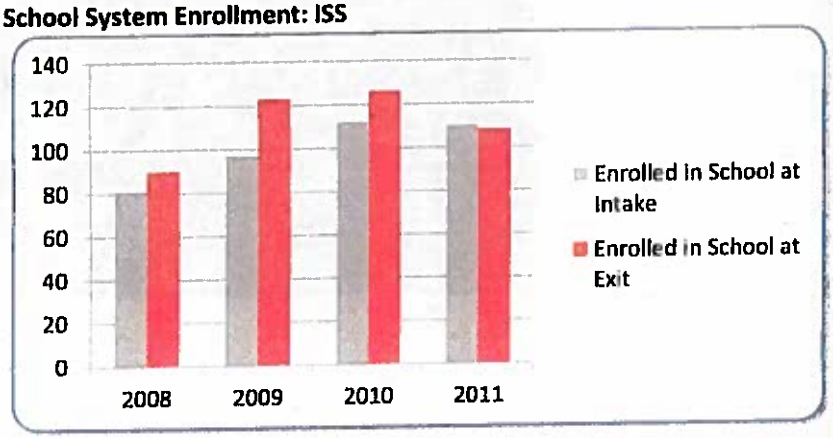
The response time for CCORS Emergent Outreach (EO) services has been averaging approximately 62 minutes, well under the contract expectation of under two hours. (Not depicted in graphs.)

## Service Outcomes: ISS

**Resources Accessed by Clients at Discharge (by # of clients per year)**




**School System Enrollment: ISS**




### Outcomes

CCORS-ISS tracks what resources the client families have been able to access at the time a family is discharged from ISS. Often, these are resources that the ISS program has helped families access and/or to engage more successfully. Over time, ISS has become more and more successful at ensuring clients who are eligible for Medicaid are connected to an RSN contracted mental health provider and enrolled in services at exit.

The proportion of families that only have natural supports (no system supports) at exit has declined over time. It is important to note however, that ISS does work to help families enhance their natural support systems, regardless of what other resources they access.

The number of clients engaged in IST or Wraparound (county programs) has been relatively constant, but the numbers that are admitted to CLIP (Children's Long-term Inpatient Program) at exit has slightly increased. This may be due to the severity of client needs that CCORS staff have noted, and/or the intentional use of CCORS as a diversion attempt for clients who are being considered for CLIP.

Overall, more clients are enrolled in school at exit than at intake, however, in 2011 the numbers decreased.

## Stabilization of Living Situation/Out of Home Placement Prevention: ISS

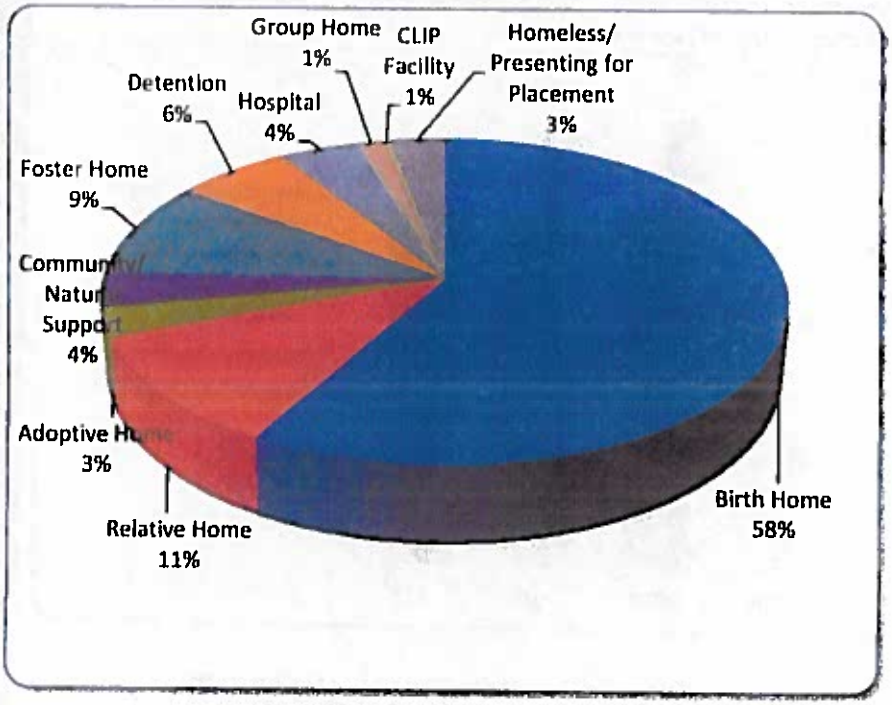
### Stabilization

The ISS program is highly successful at stabilizing children and youth in their own homes, even in situations where the family initially requested that the child/youth be placed outside of the home. The vast majority (98 percent) of those referred for placement prevention or stabilization in the home exit the program with those goals achieved.

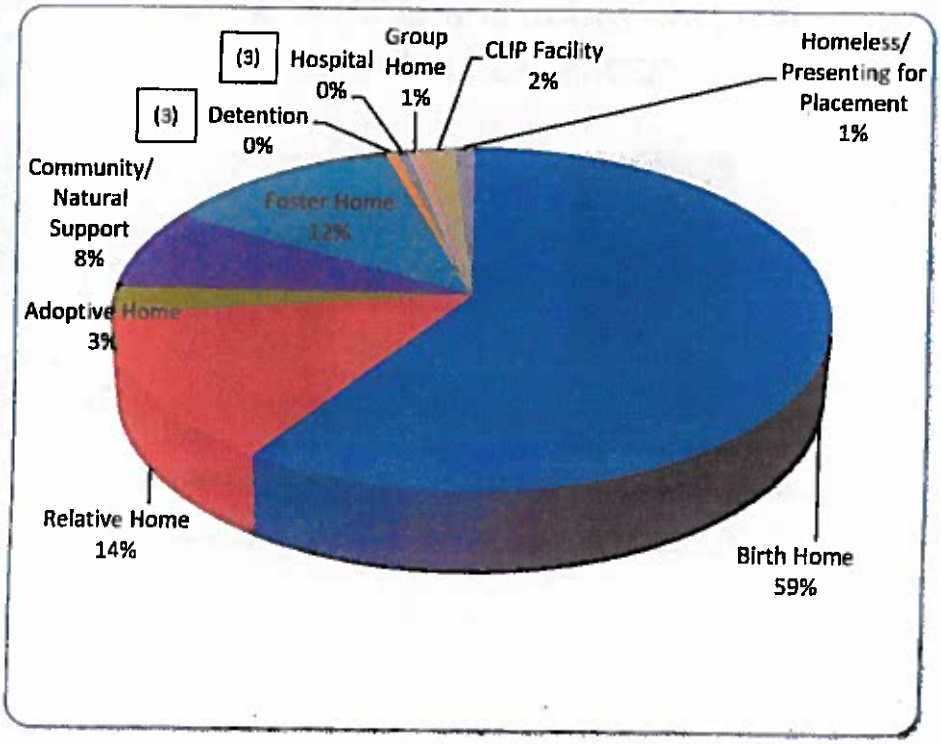
At exit, compared to intake, more clients are living in their birth home and more are stabilized in relative's or community/natural support's homes. Fewer are in detention, homeless/in need of placement, or in the hospital. There is no significant increase in the number of children/youth in foster homes at exit.

These significant successes can be attributed to CCORS' philosophy of meeting the client and the family where they are, both geographically and emotionally, and engaging the family and community to build supports that allow clients with significant emotional and behavioral challenges to live successfully in community.

**ISS Living Arrangements at Intake[vi] 2008-2011**

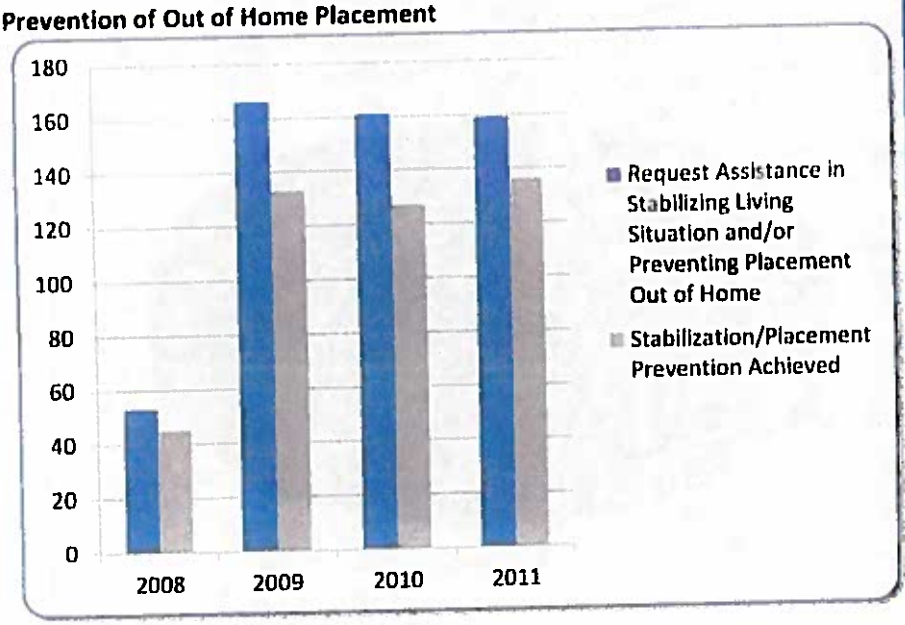



**ISS Living Arrangements at Exit[vii] 2008-2011**



## Stabilization and Hospital Diversion: ISS

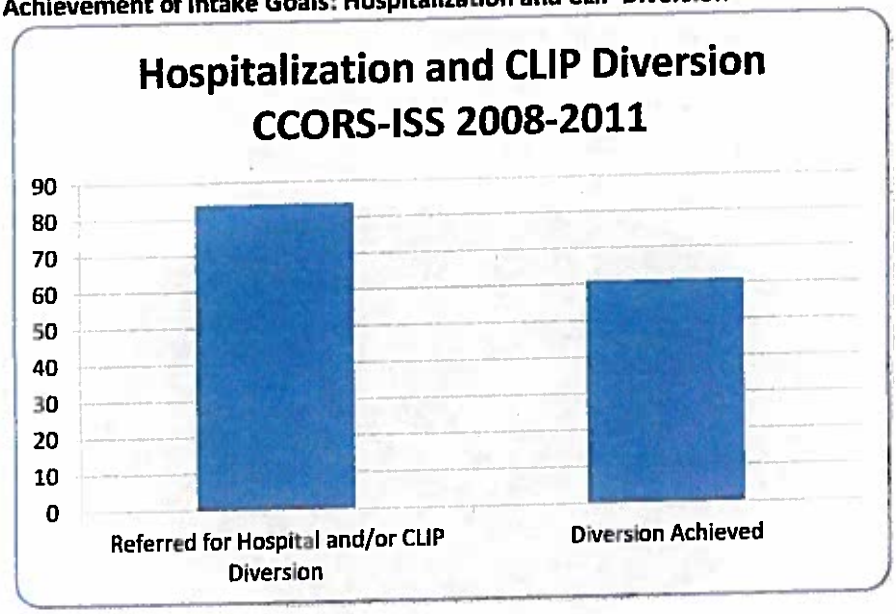
**Achievement of Intake Goals: Stabilization of Living Arrangement and Prevention of Out of Home Placement**




### Hospital Diversion

Even though ISS clients overall represent a client pool with more complex or intensive needs than "regular CCORS", almost three quarters (73 percent) of clients referred for hospital diversion, including CLIP diversion, were successfully diverted from hospitalization and stabilized in their home or a less-restrictive and less costly community setting.

**Achievement of Intake Goals: Hospitalization and CLIP Diversion[viii]**



## Rough Estimate of Cross-System Program Savings: CCORS and CCORS-ISS

It is only possible to give an extremely rough and conservative estimate of the cost savings achieved by the CCORS program in the past few years. Below are a few estimates based on average costs:

| Type of Savings | Approximate Estimate- Savings | Estimate Type |
|---|---|---|
| **Hospital Diversions** (Mental Health Costs Avoided) | **2008 (partial data):** Between $72,900 (cost estimate $900/day) and $142,641(cost estimate $1,761/day)<br>**2009:** Between $923,400 and $1,806,786<br>**2010:** Between $1,470,150 and $2,876,593<br>**2011:** Between $1,372,950 and $2,686,405<br><br>**2008-2011 Total:** Between $3,839,400 and $7,512,425 | The average cost of one day of child/youth psychiatric hospitalization during the time period of this report ranged from $900-$1,761. This estimate takes the number of youth documented as "hospital diverted" during these years and multiplies it by the average length of stay for King County youth (13.5 days, based on an average of 9 days for voluntary admissions and 18 days for involuntary admissions (ITAs)). |
| **Placement Prevention** (DCFS Costs Avoided) | **2007-2011 Total**: $2.8 million | Considering the relatively high needs of the youth served by CCORS and diverted from out-of-home placement per year, an estimate of the average monthly cost of DCFS placement was used to estimate savings ($1,100). This estimate is higher than a "level four" foster care placement, but significantly lower than a BRS (group care) placement, which is where many of these youth might have gone. The estimate includes a projected cost of 30 days of placement for each placement-diverted youth. This estimate does not include any other costs associated with placement, which can be significant. |
| **Total Estimate Cross-System Total Savings:** approximately $8.5 million | | |

Of course any discussion of cost savings does not include savings based on reduction in emotional distress or decrease of family/client dysfunction immediately or over time, which can lead to financial savings in many areas.

**Toward a Brighter Future (excerpt from a letter from a parent)**

I was really scared something was going to happen to my ten year old daughter, Lila (pseudonym). She was getting into a lot of trouble at school and at home. Then she started saying stuff like, "I hate my life, I don't want to be around anymore." It was time to get some help. I called the Y's CCORS program and the next day they were at my door. They talked to me like I was a human being, like I was an okay parent. They were there to listen and give me little things to help. ..if it wasn't for them I am afraid I would never be able to say "help my child" without being afraid of someone coming in and taking my kids away...It has really helped her self esteem. Her grades are going up; she's coming home and doing her homework. She's not fighting with her brother anymore; she's not fighting with her Mom and Dad. She's engaging with people she doesn't normally engage with. She's gotten confidence; she's proud of herself and that's the main thing that is phenomenal. She went from hating herself one week to acing a math test, going the distance. Now she believes in herself. There's no stopping her. I really think they helped save Lila's life.

## Next Steps

The CCORS Program engages in a continual process of quality improvement. This includes case reviews, regular meetings, collaborative problem-solving meetings, data gathering and data reviews. This five year data and outcomes summary will assist CCORS, King County, DCFS, and their partners to identify successes, areas of improvement, and paths to take to continue to improve the program.

There are some areas of improvement that have already been identified:

- Analysis of the "outliers" for CCORS program response time; cases where there are extremely long response times that have elevated the average response time for the program over time. These outliers may have to do with geography or other challenges, or may be related to other unknown factors. It would be helpful to determine those factors and devise strategies to help standardize program response and timeliness of services.

- Identify ways staff can prioritize and effectively "juggle" multiple cases without increasing staff burnout, which is a significant factor in staff retention. This issue may also relate to training needs and/or the need for standardized tools for assessment and intervention.

- Even though CCORS actively reaches out to partners across the county, there is a need for increased and strengthened collaborations with other system partners, given the complex needs of CCORS clients.

- CCORS, and particularly CCORS-ISS clients are highly diverse- a diversity that is not completely reflected in the staff makeup. Progress has been made, however nearly a quarter of staff now identifies as African-American. Recruiting, training, and retaining diverse personnel and strengthening partnerships with diverse community-based organizations are key in helping clients and families engage.

- DCFS partnership building for CCORS-ISS: considering the high percentage of CCORS-ISS clients that have DCFS involvement even if clients are not referred by DCFS, and the concurrent high involvement of DCFS clients in mental health services, it seems apt to consider ways in which the RSN and DCFS could increase collaboration on referrals where cases are highly complex and multi-system involved. This is especially important since the number of youth referred appears to be rising while the number of available slots is static due to limited funding availability and the 2009 funding decrease from DCFS.

- Strengthening partnerships with schools: although CCORS has documented success in retaining and re-engaging clients with schools, the rate of client school engagement decreased in 2011 in comparison with 2009 and 2010.

The YMCA is also in the process of selecting a new data system that will significantly reduce the number of times data is entered and therefore improve the clarity and accuracy of the data. It is hoped that this will enable more complex and accurate data analysis in upcoming years.

**Endnotes**

[i] Although CCORS reports the standard King County data categories for race and ethnicity, they also collect additional information. They are considering increasing the number of race/ethnicity options in their data reporting form in order to help account for the numerous "unknown" and "multiracial" responses. They may also initiate some tracking of immigrant and refugee families they serve. It's important to note that some families see Latino/Hispanic heritage as an "ethnicity," others as a "race," or families may use the "other" category to denote their Latino heritage.

[ii] The overall percentage of hospital diversions per year does not directly correlate to the individual cases. Hospital diversions are counted per month, and not linked to initial referral reasons in the current data system. This will be remedied when CCORS' data system updates.

CCORS staff also felt that usage of crisis beds may have been reduced due to the need for contracted mental health agencies to transport clients to the crisis beds, which requires funding and support for mental health staff who may face risks (e.g. assault) if they transport a youth in distress. Additionally if a client referred to a CSB is not a current CCORS client, the referring mental health agency needs to provide case management during the CSB stay. Some parents/families also refuse when the CSB is offered, sometimes because they can't have communication with the therapeutic foster home that the CSB is located in, as a result of the safety guidelines in place for the foster family and their children.

[iv] For an explanation of CCORS Emergent Outreach (EO) and Non-Emergent Outreach (NEO) please see the description on page four.
[v] Toward the end of the month, DCFS and the RSN either discuss available ISS slots and determine which system needs remaining slots or the number of referrals alternate by month, thus addressing the ".5" client slot.
[vi] Note: Living arrangements of clients at intake and exit per year does not directly correlate to the individual cases. Entry/Exit Arrangements are counted per month, and not linked to initial referral reasons in the current data system.
[vii] See above.
[viii] A note on CLIP diversion: only one "CLIP diversion" was specifically noted one case that was referred for CLIP diversion in 2009, with the diversion achieved. Data gathering on CLIP and hospital diversions altered over time, with CLIP diversions mostly included in the 'hospital diversion' category. This data gathering will improve over time.