Vaya SAMHSA System of Care Grant

Year 1, Annual Evaluation Report

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Complex Systems Innovations

Complex opportunities
Sustainable solutions

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Contents

Introduction

The following evaluation report reviews and summarizes data from the following sources to address goals, objectives, and evaluation questions:

1. National Outcomes Measure (**NOMS**) data.
2. SAMHSA required performance measures (**IPP** data).
3. Triple Screen (**TS**) Data consisting of trauma, resilience, and social determinants of health (**SDOH**) data.
4. Process data tracked from…
    a. Process notes completed after collaborative meetings, trainings, and SOC related meetings.
    b. Meeting minutes and agendas from Children's Collaboratives and SOC Collaboratives.
    c. Project Implementation Team (**PIT**) meetings and materials.
    d. Governance Board (**GB**) meetings and materials.
5. Referral and treatment tracking.
6. Review and incorporation of county specific information such as, but not limited to, County Community Health Reports, SDOH data, minutes from Wellness Meetings, and needs assessments.

The System of Care Implementation Team (**SOC-IT**) has focused Year 1 on the following:

- Supporting and expanding trainings to improve the mental health workforce, both professional and community members.
- Developing a Social Determinants of Health spreadsheet by county for family partners and providers
- Educating about Systems of Care.
- Working to expand family and youth participation and membership in Children's and SOC Collaboratives.
- Developing, educating, and informing the Governance Board.
- Leading the Project Implementation Team in monthly and bimonthly meetings.
- Working closely with the System of Care Evaluation Team (**SOC-ET**) to support data collection and facilitating requests to stakeholders.

Demographics of SOC Enrolled

Demographic data is summarized from Triple Screen data after being compared, when possible, to NOMS data. Total sample enrolled = 36.

<u>Gender</u>

Male: 18 (50.0%)

Female: 17 (47.2%)

Other: 1 (2.8%)

Race

White: 31 (86.1%)

Black/African American: 1 (2.8%)

Dual/Other: 4 (11.1%)

Ethnicity

Non-Hispanic: 34 (94.4%)

Hispanic: 1 (2.8%)

Refused: 1 (2.8%)

Age in Years

Minimum: 2

Maximum: 18

Average: 12.9

County: Data has been collected from two of seven counties.

McDowell: 24 (66.7)

Polk: 12 (33.3)

Referral and Assessment Data

The provider agency (Youth Villages, or YV) is tracking outreach efforts, intakes and youth/families that complete screening assessments, National Outcomes Measures (NOMS), treatment provided, treatment referrals/completed and referrals/follow-through with resources for social driver needs. In total, 95 separate youth have contact, outreach, assessment and/or treatment data. This is less than predicted and has resulted in fewer than forecasted NOMS and Triple Screens completed (Table 1). Not all TS completions are expected to include NOMS while all NOMS are expected to include a TS. Thus, there are 13 TS's completed that do not have NOMS. NOMS are being completed for youth that engage and are either referred for treatment, with continued contact with Youth and/or Family Support Partners (Y/F Partner) or that are receiving exclusively Y/F Partner services with emphasis on maintaining frequency of contacts. The primary provider agency, Youth Villages, is also tracking outreach efforts for families. There have been several discussions by the SOC-ET with Youth Villages to increase Triple Screens and to complete them sooner as part of the outreach effort, especially with the high number of trauma experiences reported, to expedite agreement for youth/families to enter treatment.

Table 1. Screening Tool Rate of Completion Summary				
Screening Source	**Goal**	**Actual**	**Deficit**	**% Met**
NOMS	30	17	13	56.7
Triple Screen Only	100	19	80	19.0
Total	**130**	**36**	**94**	**27.7**

The Triple Screen (TS) was selected to address key concerns noted in County Community Health Reports and Collaboratives. Issues related to high levels of stress, trauma, suicidality, and family fragmentation were consistent across the counties. The TS is administered at baseline within 30 days of contact with the family by Y/F Partners. Initially, Y/F Partners were expected to collect TS data as soon as possible and no longer than two-weeks from first contact. This was raised to a month based on concerns over rapport and engagement by Y/F Partners. The time of one month has not resulted in significant, or even marginal, increases in recruitment. The SOC-ET is working with Youth Villages to address this issue. The analysis that follows will address each screener separately, summarizing data collected on 36 individuals. This is insufficient for confidence in detecting trends. It is useful as an initial snapshot. The Y/F Partners were asked to administer the screeners in the following order, with data summarized the same:

1. SDOH: NC Public Health Social Determinants of Health Screening Tool
2. Trauma: Pediatric ACEs and Related Life Events Screener (PEARLS).
3. Resilience: Child and Youth Resilience Measure (CYRM-R) or, for youth age 18 or older, the Adult Resilience Measure (ARM-R).

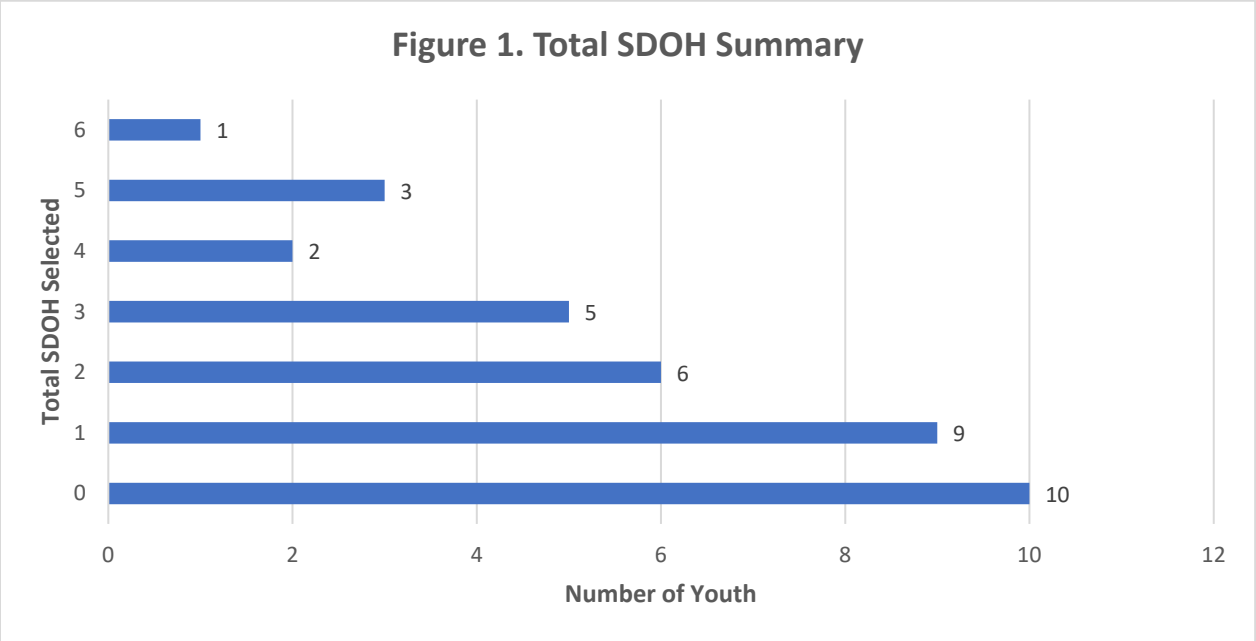
Findings are evaluated by the Y/F Partner and discussion is limited to the comfort level of the caregiver or child/youth that completed the TS. For the Trauma and Resilience tools, the wording but not content of items is changed slightly for whom the respondent is, whether caregiver or youth. High levels of trauma, lower levels of resilience and high numbers of SDOH needs are reviewed with the Y/F Partner supervisor and decisions regarding treatment are collaboratively addressed with the youth/family. Measurement-based care has been emphasized in trainings.

Social Determinant of Health Screener Summary

Table 2 and Figure 1 summarizes SDOH items validated by enrolled families. The SDOH form is completed by the caregiver. The most common need is transportation. Concern over housing and being homeless (n = 2) are a somewhat common concern. Of interest are the safety questions with a larger proportion than expected feeling unsafe (13.9%), having been physically assaulted (25.0%) or experienced emotional abuse (27.8%) in the last year. For comparison, being physically hurt in the last year (Item 8) percentage is 6.85 and emotional abuse in the last year is 10.62 percent using the same form for a separate SOC initiative with the understanding

that the much larger sample size (1,250) urges caution when comparing. The average number of SDOH's selected is 1.8 (s.d. = 1.7).

Table 2: Summary of SDOH Needs Selected by Families (n=36)			
#	**Screener Item**	**n**	**%**
1	Within the past 12 months, did you worry that your food would run out before you got money to buy more?	4	11.1
2	Within the past 12 months, did the food you bought just not last and you didn't have money to get more?	4	11.1
3	Do you have housing? (*NO*)	2	5.6
4	Are you worried about losing your housing?	8	22.2
5	Within the past 12 months, have you or your family members you live with been unable to get utilities (heat, electricity) when it was really needed?	6	16.7
6	Within the past 12 months, has lack of transportation kept you from medical appointments, getting your medicines, non-medical meetings or appointments, work, or from getting things that you need?	14	38.9
7	Do you feel physically and emotionally safe where you currently live?	5	13.9
8	Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by someone?	9	25.0
9	Within the past 12 months, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?	10	27.8
10	Are any of your needs urgent? For example, I don't have food for tonight, I don't have a place to sleep tonight, I am afraid I will get hurt if I go home today?	3	8.3



Trauma Screener Summary

The PEARLS trauma screener has two sections, the first asking ten questions on trauma experiences and the second section asks seven questions (younger children) or nine questions (teen) related to negative life events. A total score is summed for each section. Research of ACEs suggests that three or more trauma experiences suggests a high risk for traumagenic responses that can affect development, relationships, educational achievement, substance use risk, tobacco use, and other outcomes. Risk increases with each additional trauma experience. Risk is further exacerbated by exposure to life events.

The total possible score for the Trauma section is 10. The average for those screened for the SOC is 5.6 (s.d. = 2.8) and the median is 5. This is substantively higher than studies that review ACE exposure across states. The Child Trends research brief, selected because of its strong methodology, found that for North Carolina, at that time, 52 percent of youth aged birth to seventeen experienced no ACE exposure, 36 percent experienced 1-2 and 12 percent experienced three or more.[1] Studies have indicated that exposure to even one ACE, with three or more being high risk for traumagenic responses, are critical for intervention. This suggests a high level of trauma for the limited sample enrolled to date. Table 3 reviews the number and percent of youth experiencing each trauma experience (n = 36). Figure 2 reviews the total number of items experienced by youth. Only six youth have two or less ACE experiences, suggesting that 83.3 percent of youth screened have ACE scores in the high-risk range, significantly more than 12 percent. If this trend continues with increased enrollment, then youth in the SOC catchment area are at a markedly higher risk of trauma then found in the Child Trend study.

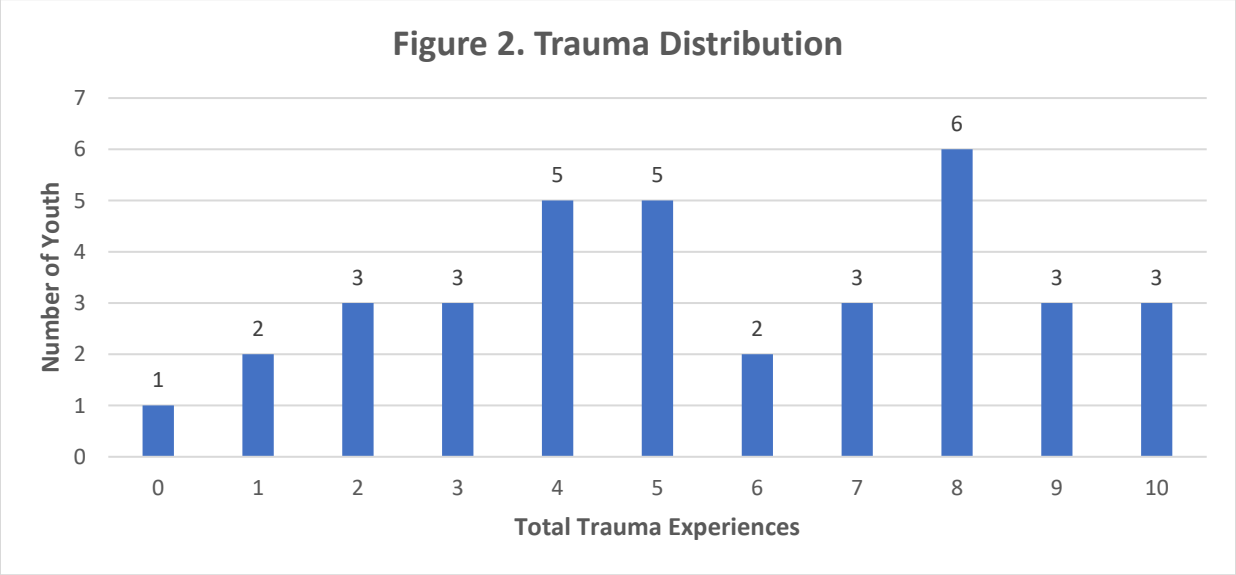
While all the questions in the survey are elevated, the three with the highest incidence are children witnessing a parent being insulted and humiliated, the child feeling unsupported, unloved, and unprotected and, the third most likely, two having the same percentage of 63.9 of youth, are the child living with a parent with a mental health issue or with a parent with a substance use issue. The latter percentage is similar to other SOC projects the SOC-ET has been involved in with greater than 50 percent of parents with mental health and/or substance use issues.

Table 3: Summary of Trauma Factors Selected by SOC Participants (n=36)

#	Screener Item	n	%
1	Has your child ever lived with a parent/caregiver who went to jail/prison?	19	52.8
2	Do you think your child ever felt unsupported, unloved and/or unprotected?	26	72.2
3	Has your child ever lived with a parent/caregiver who had mental health issues? (*for example, depression, schizophrenia, bipolar disorder, PTSD, or an anxiety disorder*)	23	63.9
4	Has a parent/caregiver ever insulted, humiliated, or put down your child?	19	52.8

[1] Sacks, V.H., Murphey, D., & Moore, K. (2014). Adverse Childhood Experiences: National and State-Level Prevalence. Published by Child Trends with support from Annie E. Casey Foundation.

Table 3: Summary of Trauma Factors Selected by SOC Participants (n=36)			
#	Screener Item	n	%
5	Has the child's biological parent or any caregiver ever had, or currently has a problem with too much alcohol, street drugs or prescription medications use?	23	63.9
6	Has your child ever lacked appropriate care by any caregiver? (*for example, not being protected from unsafe situations, or not cared for when sick or injured even when the resources were available*)	16	44.4
7	Has your child ever seen or heard a parent/caregiver being screamed at, sworn at, insulted or humiliated by another adult? Or has your child ever seen or heard a parent/caregiver being slapped, kicked, punched beaten up or hurt with a weapon?	28	77.8
8	Has any adult in the household often or very often pushed, grabbed, slapped or thrown something at your child? Or has any adult in the household ever hit your child so hard that your child had marks or was injured? Or has any adult in the household ever threatened your child or acted in a way that made your child afraid that they might be hurt?	13	36.1
9	Has your child ever experienced sexual abuse? (*for example, anyone touched your child or asked your child to touch that person in a way that was unwanted, or made your child feel uncomfortable, or anyone ever attempted or actually had oral, anal, or vaginal sex with your child*)	11	30.5
10	Have there ever been significant changes in the relationship status of the child's caregiver(s)? (*for example, a parent/caregiver got a divorce or separated, or a romantic partner moved in or out*)	22	61.1



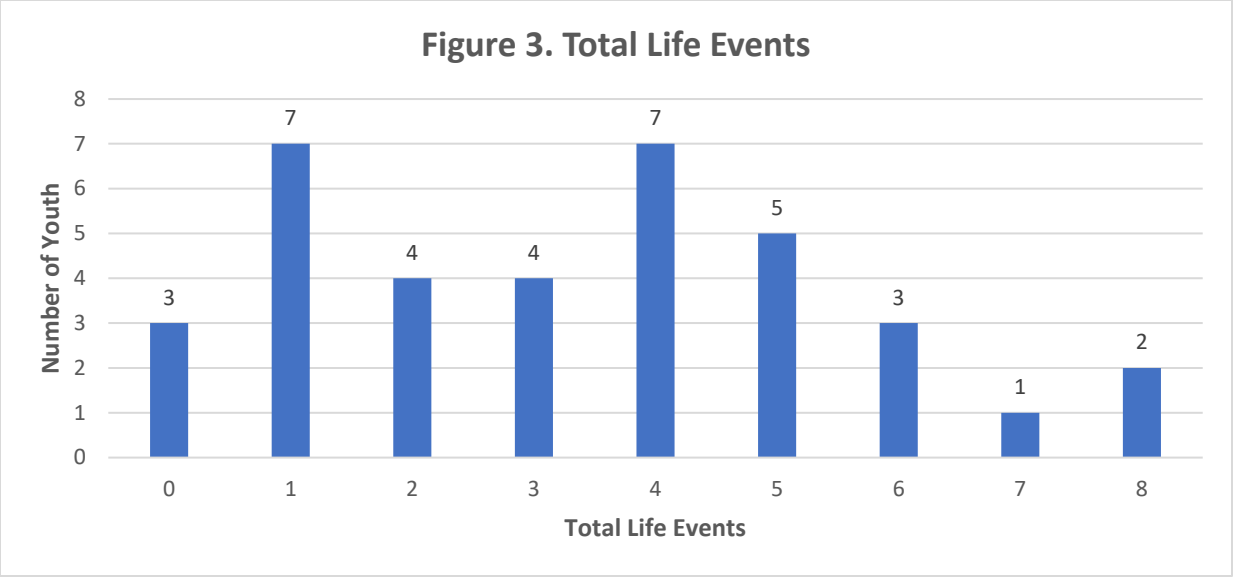
Adverse life events other than trauma are also elevated for youth (Table 4 and Figure 3). Almost 60 percent of youth are or have lived with a parent with a serious physical illness or disability.

This may or may not be mental illness or substance addiction as noted above. Over half of the children have been separated from the parent due to foster care or immigration issues. Since nearly all youth screened are Caucasian/white, this suggests that immigration issues are less likely and foster care more likely. Like trauma, two items have the same percentage for third place, with 47.2 percent of youth having witnessed or been victimized by violence in their community or school and/or having experienced discrimination. Fourteen of the 36 youth have two or fewer life events selected, with 61.1 percent having three or more.

Cross-tabulating total trauma by total adverse experiences, only one youth had zero trauma and adverse life experiences. Only three youth have two or less trauma and two or less adverse life events. Again, if this small sample becomes the trend, then there are many youths at high risk of traumagenic responses based on high trauma and negative life event exposures. An analysis was completed to detect any trends in distribution between those with high trauma and high adverse life event scores (data not shown). Twenty-eight (28) percent have both a trauma score of seven or higher and an adverse life event of five or higher. This will be updated as data accrues.

Table 4: Summary of Life Events Selected by SOC Participants (n=36)

#	Screener Item	n	%
1	Has your child ever seen, heard, or been a victim of violence in your neighborhood, community or school? (*for example, targeted bullying, assault or other violent actions, war or terrorism*)	17	47.2
2	Has your child experienced discrimination? (*for example, being hassled or made to feel inferior or excluded because of their race, ethnicity, gender identity, sexual orientation, religion, learning differences, or disabilities*)	17	47.2
3	Has your child ever had problems with housing? (*for example, being homeless, not having a stable place to live, moved more than two times in a six-month period, faced eviction or foreclosure, or had to live with multiple families or family members*)	15	41.7
4	Have you ever worried that your child did not have enough food to eat or that the food for your child would run out before you could buy more?	12	33.3
5	Has your child ever been separated from their parent or caregiver due to foster care, or immigration?	19	52.8
6	Has your child ever lived with a parent/caregiver who had a serious physical illness or disability?	21	58.3
7	Has your child ever lived with a parent or caregiver who died?	10	27.9
8	Has your child ever been detained, arrested or incarcerated? (*Teen only*)	7	19.4
9	Has your child ever experienced verbal or physical abuse or threats from a romantic partner? (*Teen only*) (*for example, a boyfriend or girlfriend*)	3	8.3



Resilience Screener Summary

The CYRM-R resilience screener asks 17 questions in three different forms with wording adapted to the age of the respondent and whether the caregiver or child/youth is answering. Unlike the trauma and SDOH tools with values of Yes or No for each question, the CRYM-R has response options of No, Sometimes and Yes. Table 5 reviews responses and percentages for each response choice as well as the average score for each item. Any average at or below 2.50 (in bold in Table 5) is considered a resilience deficit and shared issue that Collaboratives and service providers should consider. The lowest average score is for youth feeling able to talk to their family/caregiver about how they feel. Feeling that they belong in school and are treated fairly in the community are also low. Having an education is the third lowest average and support by friends is also low. The range of scores are 28 to 51 from a possible total of 54 with an average of 42.3 (s.d. = 5.7) and a median score of 43.

Table 5: Summary of Resilience Scores Selected by SOC Participants

#		No		Sometimes		Yes		Mean Item Score
		n	%	n	%	n	%	
1	I get along with people around me	1	2.8	18	50.0	17	47.2	**2.44**
2	Getting an education is important to me	9	25.0	12	33.3	15	41.7	**2.17**
3	I know how to behave/act in different situations (such as school, home and church)	5	13.9	8	22.2	23	63.9	**2.50**
4	My parent(s)/caregiver(s) really look out for me	1	2.8	7	19.4	28	77.8	2.75

Table 5: Summary of Resilience Scores Selected by SOC Participants								
#		No		Sometimes		Yes		Mean Item Score
		n	%	n	%	n	%	
5	My parent(s)/caregiver(s) know a lot about me (for example, who my friends are, what I like to do)			14	38.9	22	61.1	2.61
6	If I am hungry, there is enough to eat			2	5.6	34	94.4	2.94
7	People like to spend time with me	4	11.1	14	38.9	18	50.0	**2.39**
8	I talk to my family/caregiver(s) about how I feel (for example when I am hurt or sad)	13	36.1	12	33.3	11	30.6	**1.94**
9	I feel supported by my friends	5	13.9	18	50.0	13	36.1	**2.22**
10	I feel that I belong/belonged at my school	12	33.3	11	30.6	13	36.1	**2.03**
11	My family/caregiver(s) care about me when times are hard (for example if I am sick or have done something wrong)	1	2.8	8	22.2	27	25.0	2.72
12	My friends care about me when times are hard (for example if I am sick or have done something wrong)	5	13.9	13	36.1	18	50.0	**2.36**
13	I am treated fairly in my community	8	22.2	11	30.6	17	47.2	**2.25**
14	I have chances to show others that I am growing up and can do things by myself	2	5.6	7	19.4	27	75.0	2.69
15	I feel safe when I am with my family/caregiver(s)	1	2.8	10	27.8	25	69.4	2.67
16	I have chances to learn things that will be useful when I am older (like cooking, working, and helping others)	2	5.2	3	9.3	31	86.1	2.81
17	I like the way my family/caregiver(s) celebrates things (like holidays or learning about my culture)	2	5.2	5	13.9	29	80.6	2.75

A Pearson Correlation statistic was used to determine the degree of relationship between trauma, life events, and resilience. It was hypothesized that trauma and negative life events

would be positively correlated to each other and negatively correlated with resilience. A negative correlation is not a qualitative assessment but an indication of direction of the relationship. Thus, as trauma increases, resilience is hypothesized to decrease. Table 6 summarizes this information for the whole sample and when bifurcating the resilience score at the midway point of the distribution (score = 39, halfway between the range of 28-51). Table 5 compares each combination of variable, the summary Pearson statistic (r), and the p-value for significance. As a reminder, a perfect correlation score is 1.00 or -1.00, meaning that there is perfect symmetry in direction. This is rarely achieved. Larger sample sizes tend to lead to more statistically but not necessarily materially significant results. A sample size of 36 would not be expected to have strongly significant relationships. Except for one correlation, the direction is as predicted. Three are statistically significant, with a strong correlation between trauma and negative life events. There is the expected negative correlation between trauma experiences and resilience and negative life events, both significant. Selecting only cases with higher or lower than average resilience scores, we find that the relationship is mostly in the same direction except for lower resilience scores and life events. The pattern will be interesting to assess as data accrues and updates will be included in future reports. The expected challenge to resilience from trauma experiences is confirmed.

Table 6. Pearson Correlation Summary for Trauma, Negative Life Events, and Resilience Scores

Variable 1	Variable 2	n	r	p-value
Trauma	Life Events	36	.623	**.000**
Resilience	Trauma	36	-.486	**.003**
Resilience	Life Events	36	-.422	**.010**
Resilience, 42.25 +	Trauma	19	-.275	.254
Resilience, 42.25 +	Life Events	19	-.398	.096
Resilience, 42.24 -	Trauma	17	-.206	.428
Resilience, 42.24 -	Life Events	17	.077	.769

Reviewing the interaction of trauma and resilience and offering a descriptive interpretation of youth with a high number of trauma experiences and low resilience scores, these youth can be described, as a group as feeling isolated, socially awkward, lacking direction or goals while seeing no value in education. They may describe themselves as being unsupported, unloved, different, and unworthy. Youth that would describe themselves this way are at increased risk for traumagenic responses, suicidal ideation, and to seek solace in substances to replace the pain they experience.

Mandatory Performance Measure (IPP) Data Summary

Specific IPP codes including the goal numbers, Year 1 numbers and status of Met or Unmet are summarized in Table 7. Five of seven performance measures were met. Those not met are due to case finding deficits and improvements in processes are being implemented and evaluated for success.

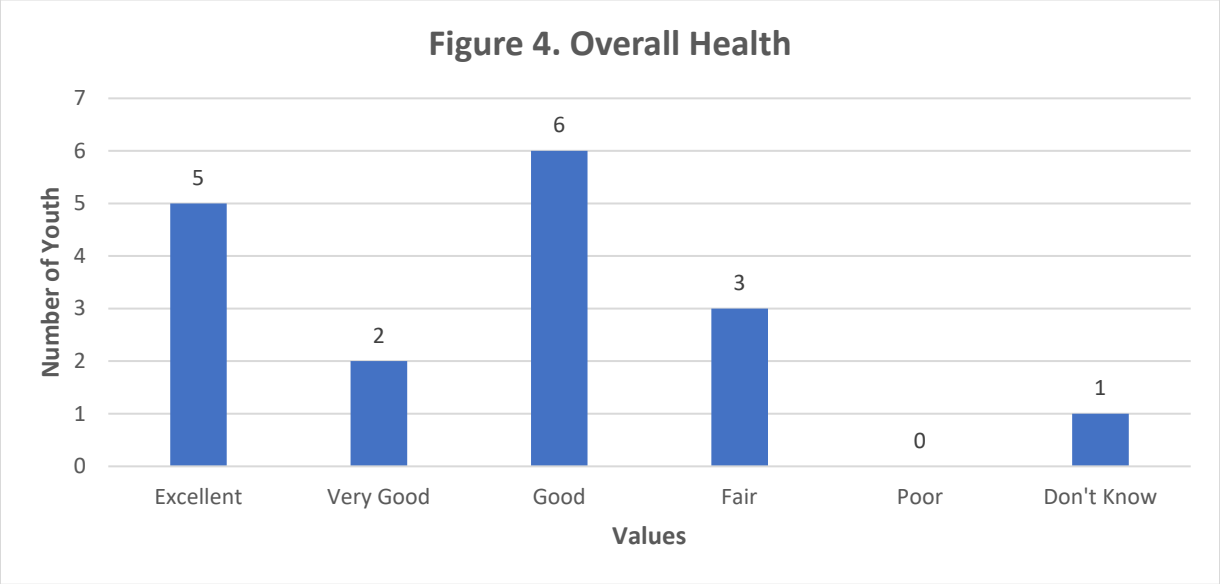
Table 7. Summary of IPP Data				
IPP	**Description**	**Goal**	**Year 1**	**Status**
PD1	The number of policy changes completed as a result of the grant.	5	**5**. Project Director communication.	**MET**
WD2	The number of people in the mental health and related workforce trained in mental health-related practices/activities that are consistent with the goals of the grant.	45	**116**. Summed from 82 Field Note records that cover the annual report period. Mental Health First Aid – Adults: 37 Mental Health First Aid – Youth: 9 WRAP: 9 QPR: 26 Family Partner Certification: 12 Collaborative Training: 23	**MET**
WD5	The number of consumers/family members who provide mental health-related services as a result of the grant.	10	**11**. Summed from training and after training contacts. Individuals that received WRAP or MHFA.	**MET**
T3	The number of people receiving evidence-based mental health-related services as a result of the grant.	30	**36**. Tracked through Provider systems and linked with Evaluation Team.	**MET**
O1	The number of individuals contacted through program outreach efforts.	100	**31**. We are including only those that were involved with outreach and not those that matriculated into treatment. If we count those as well the total is 73, still below the expected 100.	**UNMET**
R1	The number of individuals referred to mental health or related services.	36	**21**. Includes family members referred to services and other resources that reduce stress and positively affect family health.	**UNMET**
AC1	The number and percentage of individuals receiving mental health or related services after referral.	80%	**36 of 42** of youth in system. **85%** received or are receiving treatment after referral.	**MET**

NOMS Baseline Data

Select NOMS data is summarized below. All data is baseline as follow-up data is not yet available. We start with diagnosis data. Four individuals have “don’t know” as the selection for diagnosis and three had “none of the above” selected. There is a wide range of possible diagnoses included in NOMS for selection. Because of low numbers, all three diagnostic fields are combined.

- 6 = Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders
- 4 = Attention-deficit hyperactivity disorder
- 3 = Conduct disorder
- 2 = Intellectual disability
- 2 = Major depressive disorder, recurrent
- 1 = Unspecified mood (affective) disorder
- 1 = Major depressive disorder, single episode

A key NOMS question asks about overall health. This is tracked for changes in relation to number of services and associated, with sufficient data, for trauma and changes in resilience scores. Figure 4 summarizes health selections. Thirteen of 17 have good to excellent health. This is consistent with other analyses by the SOC-ET.



Symptom/Functioning data was reviewed and cannot be shared at this time as only five of 17 have data. The rest were either collected from a parent, and thus not estimated, or missing for other reasons. This will be addressed as Y/F Partners are completing the data collection and this is useful data for program evaluation. The items include questions that ask about the frequency of the youth being nervous, hopeless, restless, depressed, worthless, and the degree that everything is an effort. These are critical for associating with trauma and resilience data.

Social Connectedness is critical for supporting and enhancing resilience and baseline data is available for 17 youth that completed the NOMS. The data is summarized in Table 8. It would be more helpful if the questions specified caregivers/adults and youth/friends in separate questions. The baseline findings tend to be higher and not consistent with other measures, for instance some of the resilience questions. For the current sample, the majority of youth indicate a healthy level of social connectedness.

Table 8. NOMS Social Connectedness Data (n=17)										
NOMS Item	**Strongly Disagree**		**Disagree**		**Undecided**		**Agree**		**Strongly Agree**	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
I know people who will listen and understand me when I need to talk.	1	5.9	1	5.9	3	17.6	6	35.3	6	35.3
I have people that I am comfortable talking to about my [my child's] problems.	1	5.9	1	5.9	2	11.8	7	41.2	6	35.3
In a crisis, I would have the support I need from family and friends.	2	11.8			4	23.5	6	35.3	5	29.4
I have people with whom I can do enjoyable things.			2	11.8	2	11.8	9	52.9	4	23.5

Mental Health and Coping NOMS data demonstrate a greater degree of variance at baseline. Handling daily life, doing well in school and able to cope are usually items scored lower than others. This appears true for the latter two items. Baseline data is consistent with other system of care projects.

Table 9. NOMS Mental Health and Coping Data (n = 16)										
	Strongly Disagree		**Disagree**		**Undecided**		**Agree**		**Strongly Agree**	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Handling daily life	1	6.3			5	31.3	7	43.8	3	18.8
Gets along with family	1	6.3	2	12.5	1	6.3	9	56.3	3	18.8
Gets along with friends			1	6.3	4	25.0	7	43.8	4	25.0
Doing well in school	2	12.5	3	18.8	4	25.0	2	12.5	5	31.3
Able to cope	1	6.3	4	25.0	3	18.8	7	43.8	1	6.3
Satisfied with family	2	12.5	3	18.8	3	18.8	8	50.0		

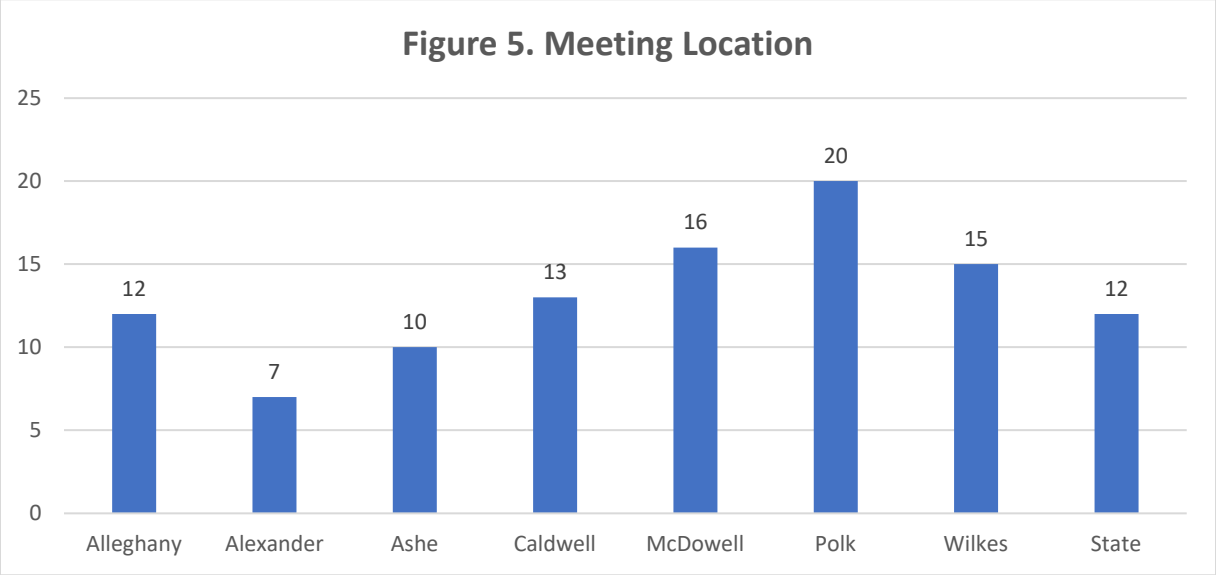
NOMS data appears to be relatively consistent with previous efforts. Follow-up data is critical for assessing program impact as well as being a mandatory obligation for SAMHSA. Linking data for NOMS and Triple Screen will be helpful for providers and collaboratives and an analysis plan is in place to complete analysis and share findings.

Collaborative Support and Training

Collaborative data is primarily from two sources. The first is a structured field note completed after collaborative meetings, trainings, and other meetings of sufficient importance to

document using the note. The SOC-IT completes the field note which is accessed through a link from the Alchemer survey development site. The field note information summarized for this report are specific to meetings and trainings. Meeting data will summarize by county, content of meetings, content of meetings by county, attendance data for meetings, and two questions focused on how relevant meetings were to the SOC. The second major source of information is meeting agendas, minutes and documents/information shared at meetings. The latter source of information is included in the last section of this report. The field note also tracks training information and will summarize which trainings were included in the field note and numbers that attend.

The SOC-IT attended 65 meetings documented in the field note. This does not include all contacts as noted earlier. Figure 5 summarizes the number of meetings attended specific to each county as well as meetings that were related to state SOC information and activities. The total here is 105 as multiple counties were represented at some meetings. Differences in number do not reflect preference or capacity, simply scheduling by county collaborative and other leadership. One meeting was held in Rutherford County, outside the catchment area, but relevant to SOC implementation in the target counties.



Content of meetings was assessed in the field note by selecting the information categories most relevant to the meeting. Thus, total numbers are also greater than the number of meetings held. Table 10 lists meeting content by total number of each content area addressed from most to least. Not surprisingly, the most common topic was systems of care. Family youth involvement and voice were highly represented but generally not successful as family and youth involvement has not been strong in any collaborative. This may be due to the limited focus on collaborative support, the least indicated topic area. Noted elsewhere in this report, Year 2 will include a coordinated and focused effort on building collaborative capacity that will also include improving family and youth voice. Other content with higher frequencies

consistent with the SOC design including family/youth advocacy, resource development, SDOH's, and parent mental health and substance use issues. Supporting parents is especially important given the high percentage of parents with mental health and substance use issues from Triple Screen data. Prevention and promotion efforts are of interest to some collaboratives and the SOC-IT can support these going forward. The eleven other responses entered in are listed below the table verbatim.

Table 10. Summary of Meeting Content Frequency

Content	#	Content	#
System of Care (SOC) – General	51	Special Education/Education System	18
Service Delivery/Treatment Services	44	Training Planning or Impact Discussion	16
Family Youth Involvement/Voice	41	COVID-19	14
Funding, Grants	31	Medicaid	13
Family/Youth Advocacy	30	Intellectual or Developmental Disabilities	12
Trauma & Resilience	29	Other	11
Resource Development	28	Historical Trauma/Cultural Sensitivity	10
Mental Health and/or Substance Use Prevention	23	Juvenile Justice	10
Social Determinants of Health (SDOH)	22	Mental Health and/or Substance Use Promotion	8
Parent Mental Health and/or Substance Use Needs/Treatment	20	Results Based Accountability (RBA)	8
Foster Care	20	Child Welfare other than Foster Care	6
Policy & Practices	20	Collaborative Support, Development or Technical Assistance	2

List of Other content areas:

- Combining McDowell Youth Forward w/Child Collaborative
- Communication with School Systems
- Community Training
- Discussion of planning Youth Summit to promote Youth Voice
- Meeting with Youth GB member and other Polk County stakeholder to discuss strengths and needs of youth in county
- New Leadership
- Presentation on 988 status/service; House/Senate Bills and Budget
- Redefining SOC and training materials
- resources, trainings, updates
- Updates on Vaya involvement w/Polk Stakeholders
- Vocational Rehabilitation

Counties, as expected, have different priorities and Table 11 summarizes content areas by county. It is noted that the numbers in counties may exceed the number in the 'n' column

because more than one county may have been represented in a meeting. Polk appears to have the most diverse and consistent focus on different content areas closely followed by Alleghany and McDowell. This does not represent quality of meetings and any conclusions with available data is speculative. Year 2 will compare Year 1 to Year 2 to determine if there are proportional change to content area focus across years.

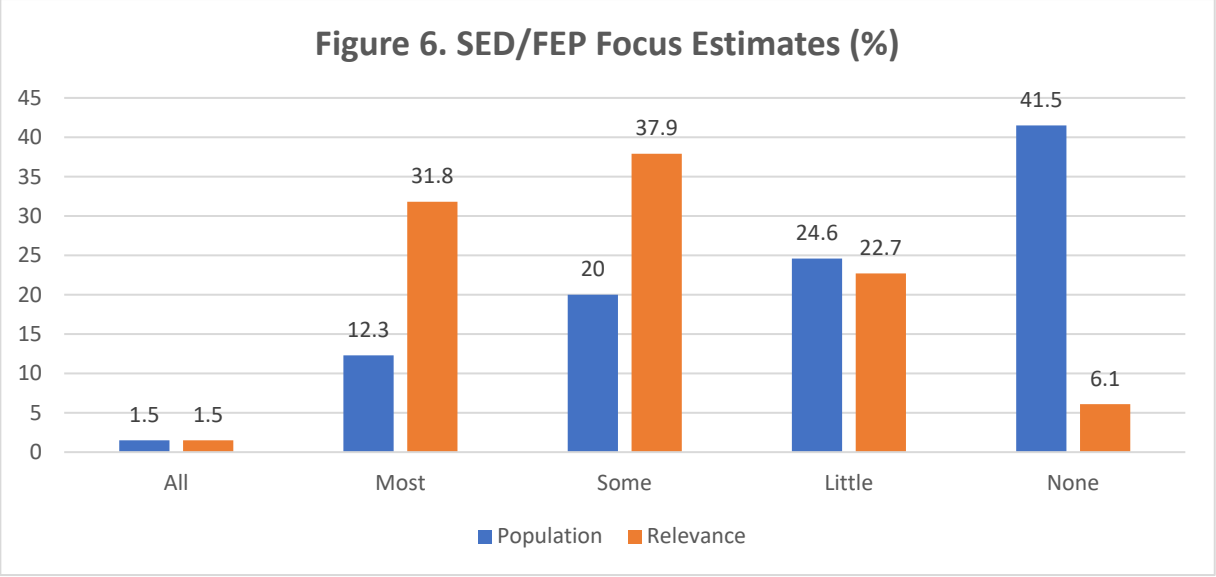
Table 11. Meeting Content by Location County

Content Area	n	Alleghany	Alexander	Ashe	Caldwell	McDowell	Polk	Wilkes	State
System of Care (SOC) – General	51	11	7	6	5	10	16	9	8
Service Delivery/Treatment Services	44	8	4	5	3	4	10	8	4
Family Youth Involvement/Voice	41	9	5	4	5	6	11	7	9
Funding, Grants	31	7	3	2	3	4	9	4	2
Family/Youth Advocacy	30	8	4	2	3	6	7	3	5
Trauma & Resilience	29	6	2	1	3	4	11	3	1
Resource Development	28	5	2	3	2	2	8	3	6
Mental Health and/or Substance Use Prevention	23	4	2	1	3	6	4	2	1
Social Determinants of Health (SDOH)	22	6	2	1	2	4	6	3	1
Parent Mental Health and/or Substance Use Needs/Treatment	20	4	2	2	1	4	5	5	2
Foster Care	20	2	3	1	1	4	8	4	5
Policy & Practices	20	5	2	1	3	2	4	3	3
Special Education/Education System	18	4	1	2	3	3	8	2	1
Training Planning or Impact Discussion	16	5	1	1	2	1	7	3	3
COVID-19	14	2	2	3	1	1	4		1
Medicaid	13	2	2	1	2	3	5	1	
Intellectual or Developmental Disabilities	12	1	2	1	1	3	3	3	1
Historical Trauma/Cultural Sensitivity	10	1	1		4	1	3		
Juvenile Justice	10	1	1		2		6		
Mental Health and/or Substance Use Promotion	8	1			1	3	2	1	
Results Based Accountability (RBA)	8	2	1	1		1	1	2	
Child Welfare other than Foster Care	6	1			1	1	3		
Collaborative Support, Development or Technical Assistance	2			1			1		

Attendance at meetings was strong over the course of the year. Meetings had from 2 to 38 members. A total of 896 were labelled as professionals in meetings with an average of 14 attendees per meeting (s.d. = 8.12). Attending, were also 33 self-identified as dual role, meaning they were a parent of or a person with a mental health or substance use condition as well as identifying as a professional. A clear concern is the very limited number of family members (4) and youth (5) that attended across the 65 meetings. This was a primary reason for the shift in focus for Year 2.

A final ask of the persons completing the field note was to estimate the amount that meetings were focused on the SOC specific population in two ways, with a value range of none to all. Findings are summarized in Figure 6. The SOC population of focus (SED/FEP) was a primary topic of content "some" to "all of the time" approximately one-third of the time (33.8%). However, the topics discussed were relevant to the population some to all of the time over two-thirds of the time (71.2%). This is encouraging as collaboratives and other decision-making bodies can be educated on the SOC and the population in ways that they would experience as relevant.

- To what degree did the meeting directly address, refer to or include children with Severe Emotional Disturbance (SED) or First Episode Psychosis (FEP)? (**POPULATION**)
- To what degree were the issues raised, discussions, presentations, materials, etc. RELEVANT to those with SED or FEP? (**RELEVANCE**)



SOC-IT members are also asked to track trainings completed and the number that attended. Attendees are identified as professional or community member, e.g., parent or youth. Training data is summarized below in Table 12. Collaborative development and support will have additional emphasis this next year as part of the overall SOC development in the target counties. A total of 127 individuals were trained this year. Given the effects of COVID and the

challenges of training in rural environments, training was successful. Additional focus on EBP training is in process by the grant recipient agency and the SOC-IT.

Table 12. Summary of Training and Attendance

Training Name	# Trainings	# Trained, Professional	# Trained, Community Member	Total Trained
Mental Health First Aid -Adult	2	37		37
Mental Health First Aid -Youth	1	3	6	9
Wellness Recovery Action Planning	7	4	5	9
Question, Persuade, Refer	7	26		26
Family Partner Certification	1	12		12
Collaborative Development and Support	2	34		34
TOTAL	**24**	**116**	**11**	**127**

Goal and Objectives Summary

The narrative designed for Vaya SOC requires a minimal level of county penetration, engagement of Youth and Family Partners, and active/reliable collaboratives. While there has been progress on each goal, the deficits in community and collaborative infrastructure as well as finding and hiring Y/F Partners were underestimated. Infrastructure continues to be developed with the projects GPO approval to alter the original plan to further develop collaborative infrastructure to meet the original goals. The Evaluation Plan was designed to meet the original narrative as well. It is being updated to reflect the changes in the implementation approach and plan.

Due to slower startup specific to the multi-county approach envisioned and the number of hires for Y/F Partner positions, with the associated impact on number of families enrolled in the service delivery arm of the SOC, changes in timing and methods for meeting some of the objectives outlined below have changed. These are outlined in Table 13. The status of all goals will remain “in process” at least through Year 3.

Table 13. Summary Progress Status for Goals and Objectives

#	Goals and Objectives	Discussion	Status
	GOAL 1: To facilitate and support grantee communities to implement system change for SOC expansion that includes the full participation of family and youth at all stages of the process.	Noted in the Collaborative Support and Training section above, involvement of Youth and Families in collaboratives has been limited. A great deal of effort by the SOC-IT has been focused on engaging youth and families, honoring their voice, and supporting the importance of lived experience. At this time, one time-limited objective was met. Three others are partially met, and one is in process.	**In Process**

Table 13. Summary Progress Status for Goals and Objectives			
#	**Goals and Objectives**	**Discussion**	**Status**
O1	By month 4, finalize membership on the Governance Board, develop the GB training, and hold the first GB meeting	The first Governance Board meeting was delayed past month 4 due to COVID-19 impacts on scheduling. The initial date was in the timeframe. The meeting was held with full attendance, the GB training was held as well as an introduction to the evaluation plan. This is considered met due to meeting all requirements but the date which was beyond the control of the SOC-IT.	**MET**
O2	By month 4, develop and present the Vaya-SOC implementation/evaluation plan/priorities to all Year 1 county stakeholders in at least 2 meetings. 85% of respondents will rate the training as informative or very informative. Repeat by month 14 for Year 2 counties.	The original evaluation plan was presented to the GB and updated at subsequent GB meetings. Evaluation of impact was assessed through email exchanges and review/acceptance of GB meeting minutes at subsequent meetings. The SOC-ET did not use a more structured approach but will begin using in Year 2 with GB membership established and some consistency in involvement noted.	**Partially Met**
O3	85% participants will rate interaction with the Vaya-SOC program as satisfactory or highly satisfactory biannually.	The diverse capacity between collaboratives limited comparability of satisfaction ratings. Satisfaction was extracted from some field notes. Also, with Y/F Partner focus primarily to two counties as the other counties struggled to find hires for Y/F Partner positions, there was a differential exposure to the SOC by counties. This limits comparability. This has led to the change in focus for Year 2. Noted above, the SOC-IT completed 82 field notes for the county collaborative meetings, trainings, and other meetings they attended. Approximately twice that number of additional meetings with individuals or small groups were completed and tracked but without a field note. Extraction from meeting minutes, emails and other documents suggests that at least 95% of persons involved are satisfied with progress, communication, and information from the SOC-IT and the SOC-ET updates with select findings at each GB meeting.	**Partially Met**
O4	85% participants will rate the Vaya-SOC program as impactful or highly impactful biannually via targeted surveys.	Issues with tracking impacts are similar to O3 described above. Two counties have received the most direct support by Y/F Partners which help to generate impact data. Changes in community health reports which are available for 2020 and becoming available soon for 2021 will be compared and reviewed for changes. This will not be directly	**Partially Met**

Table 13. Summary Progress Status for Goals and Objectives			
#	**Goals and Objectives**	**Discussion**	**Status**
		attributable to the SOC but will be helpful and weighted accordingly. A similar extraction process noted above suggests that the SOC is viewed as impactful and even a leader in the communities as the SOC-IT have helped to guide community collaborative efforts. There is insufficient data to estimate the degree of impact. This will be a focus for Year 2.	
O5	System analysis completed by the SOC-ET will indicate a larger number of connections and improvement in network satisfaction by surveyed SOC stakeholders each year (to be developed)	Baseline estimates of connections and relationships were estimated via Field Note data, attendance data at meetings, communication with the state SOC leadership, and review of meeting minutes and attendance logs. Networks were less structured and dense than expected but responses by community leaders directly related this to COVID-19. We note that the influence of COVID-19 changes in positivity rates could not be controlled for and likely affected network connections. The SOC-ET is developing a tool to assess networks and will use a retrospective version to track changes at first administration, estimating prior to COVID, during COVID and after COVID. Preliminary network and communication data strongly suggested that COVID-19 limited contacts, resulting in turf guarding and organization survival focus.	**In Process**
	GOAL 2: To prioritize and address health disparities and Social Drivers that contribute to isolation, suicidal ideation and family stress	Health disparities are being systematically assessed for a portion of outreach and treatment recipients. The data is collected systematically using a State created and approved form targeting social drivers/social determinants of health. As noted, recruitment is slower than expected. A unique identifier is being used for all assessments and other data collection. This will allow SDOH and other data to be associated with NOMS social connectedness and suicidal ideation data. The SOC-ET is working with the primary provider agency to increase recruitment, outreach and completion of Triple Screens.	**In Process**
O6	By month 4, have introduced the state SDOH data collection form to principle partners. Continue to develop at least 10 additional providers/organizations each	The NC State SDOH primary data collection form was introduced to the GB at the first meeting. Youth Villages Y/F Partners are collecting the data as part of the Triple Screen described above. Approximately 25 GB and community collaborative partnering organizations that have been introduced	**Partially Met**

Table 13. Summary Progress Status for Goals and Objectives			
#	**Goals and Objectives**	**Discussion**	**Status**
	year to collect SDOH data across different stakeholder groups	to the form. This objective is partially met as working to increase SDOH data collection is ongoing as the SOC-IT and SOC-ET collaborate to engage a larger number of organizations to complete the Triple Screen.	
O7	By month 4, have finalized the process for including the Triple Screening process at events that Vaya-SOC staff participate, with at least 80% of attendees completing the Triple Screening	COVID-19 reduced the number of events and the ability to use them as a recruiting option. The number of events pre-COVID varied by county. No Triple Screens were completed. It is unclear if events will be an option for completing Triple Screens in the future given that Triple Screens are completed after a period of outreach and contact with families as a process for recruiting for services.	**Unmet**
O8	By end of Year 1, for all participants in service delivery identifying any current needs, a plan will be in place for 90% of youth or families to address the need within 20 days of identification	All youth assessed for SDOH needs, trauma and resilience that have treatment or SDOH needs had a plan to address their needs within 20 days of identification. Plans varied by identified needs. Plans addressed referral to services, other needs that a community-based organization could address, and/or social driver needs.	**MET**
O9	By end of Year 2 and annually after, there will be reduction in SDOH needs identified by participating families for at least three of the SDOH's included in the NC State SDOH form Repeated Measures	SDOH data at baseline has been collected for only 36 respondents. Follow-up SDOH screeners will be a point of emphasis along with the rest of the Triple Screen. Recruitment will need to increase to adequately evaluate this objective.	**In Process**
	GOAL 3: **Increase number of trained Family and Youth Partners (F/YP) to support EBPs and service/support delivery**	The number of Y/F Partner hires was lower than expected for Year 1. The majority of objectives are met at this time. As these are preliminary results, the goals is assessed as partially met.	**Partially Met**
O10	80% of Y/FP's will complete all mandated training in specified timeframes	Three Y/F Partners were hired in Year 1. All received mandatory training required by Youth Villages as well as trainings prepared by the SOC-IT and SOC-ET.	**MET**
O11	80% of Y/FP's will be rated as satisfactory or highly satisfactory for position responsibilities by persons served, providers,	Reviewing meeting recordings, emails and other feedback, all current Y/F Partners (100%) are rated as highly satisfactory by Youth Villages supervisors, the LFC and the PD. Discussion of youth and family responses in meetings suggests same. NOMS	**MET**

Table 13. Summary Progress Status for Goals and Objectives			
#	**Goals and Objectives**	**Discussion**	**Status**
	supervisors, the LFC and PD annually.	follow-up data has not yet been collected for additional data on satisfaction.	
O12	80% of consumers with a Y/FP will have attended 70% or more of mandated treatment sessions (as determined by assessment and fidelity to EBPs), reported quarterly.	Preliminary data finds that 22 of 26 (84.6%) of consumers attended 70% or more of sessions. This data is preliminary as the provider's tracking system is not sufficiently specific and the SOC-ET will be helping them to improve this.	**MET**
O13	80% of consumers with a Y/FP will be meeting more than half of their clinical goals	Provider reports that youth/families referred for services are receiving the following with all receiving contact and support from Y/F Partners. • Foster Care: 2 youth, unknown what services after placement. • Psychological assessment: 2 youth, unknown what services after assessment, if any. • High fidelity wraparound: 1 youth • Intensive In-Home (IHH): 1 youth • LifeSet: 1 youth • Medication Management only: 1 youth • Level 2 placement: 1 youth • Outpatient Treatment: 17 youth • Youth or Family Partner only: 10 youth Preliminary findings suggests that most youth, approximately 85%, are meeting their clinical goals.	**MET**
O14	80% of youth/families receiving services will indicate an increase in social connectedness after at least 6-months in services (NOMS data and breakout NOMS social-connectedness section)	Follow-up NOMS data is not yet available for analysis. Baseline Social Connectedness data is summarized in the NOMS Baseline Data section above.	**In Process**
	GOAL 4: **Utilize or develop trainings to increase community stakeholders and organizations to improve community capacity and connectedness.**	Training implementation, tracking, and marketing have been successful in Year 1. The SOC Team focused on training and collaborative assessment and education.	**In Process**
O15	By end of month 4, develop a combined training calendar for all counties and determine needs, priorities and resources for addressing training priorities	Training calendars and resource guides for each county were completed. These were shared with the SOC-IT and the Project Implementation Team. All Y/F Partners have access to the materials.	**MET**

Table 13. Summary Progress Status for Goals and Objectives			
#	**Goals and Objectives**	**Discussion**	**Status**
O16	90% of persons trained, including Vaya-SOC personnel and community participants, will rate trainings as satisfactory or highly satisfactory and effective or highly effective.	All trainings on the SOC and the evaluation plan were viewed as satisfactory. Training for the GB was viewed as highly satisfactory. Trainings in Mental Health First Aid, Question-Persuade-Refer and others are not independently reviewed for satisfaction. They are not provided by the SOC-IT.	**MET**
O17	Numbers of individuals trained will increase by 5% each year, cumulatively across counties, as determined by provider and Vaya-SOC data	Year one was completed. 116 individuals were trained. Year 2 will require 122 individuals trained to meet the objective.	**In Process**
	GOAL 5: **Improve service access and impact of EBPs for families at risk or in need and SED/FEP children/youth.**	The majority of the objectives for this goal are in process. There is insufficient data to estimate "met" status.	**In Process**
O18	Number of youth served via EBP's will increase by 5% each year, cumulatively across counties, as determined by provider and Vaya-SOC data	34 youth are being served with EBP's at this time. Year 2 goal will be 36 youth served.	**In Process**
O19	80% of high-risk families/youth will be rated biannually as engaged and actively working toward clinical goals based on provider and consumer feedback.	At this time, 34 youth in treatment are high risk when combining Triple Screen and NOMS data. Of these, 30 (88.2%) remain engaged and working toward their clinical goals.	**MET**
O20	60% of older adolescents with SED, age 17-21, receiving services will improve life skills and capacity for independence after 6-months of services per results from the CLSA assessment	No youth served meet this criterion yet. Cannot be evaluated.	**In Process**
O21	70% of youth with SED that have a trauma related goal will meet or exceed treatment goals after being served for 6-months per provider report	No youth served meet this criterion yet. Cannot be evaluated.	**In Process**
O22	70% of youth receiving a CALOCUS assessment will	CALOCUS data is not available. This objective may be changed or requested for elimination. CALOCUS	**In Process**

Table 13. Summary Progress Status for Goals and Objectives			
#	**Goals and Objectives**	**Discussion**	**Status**
	improve functioning after 6-months of services	data will be confirmed as available or not pending any request for change.	
O23	80% of youth receiving services will indicate improvement in social connectedness (NOMS data)	No youth served meet this criterion as yet. There has been no youth with follow-up data collected via NOMS. Cannot be evaluated.	**In Process**
O24	85% of families and youth receiving services will have a positive perception of care (NOMS data)	No youth served meet this criterion as yet. There has been no youth with follow-up data collected via NOMS. Cannot be evaluated.	**In Process**

Evaluation Question (EQ) Preliminary Responses

The Evaluation Team is using a combination of quantitative and qualitative data, analytic methods, and state-of-the-art quantitative (SPSS, v. 22) and qualitative (Atlas.Ti, v8.4) to address *a priori* evaluation questions. Previous sections noted deficits in data availability and the team continues to work with stakeholders to build capacity and procedures for data collection. Codes are linked to text segments in the qualitative database. A segment may be from one sentence to a few paragraphs in length. For this first report, we coded basics that fit each evaluation question. Below we address quantitative data when relevant, discuss obstacles or challenges to data collection or analysis, and then list up to three descriptions of segments, if relevant. Evaluating frequencies of segments is another way to track process and to link with other findings. As data accrues and additional methods are used to collect information, the analysis will become increasingly detailed and will result in additional recommendations.

***EQ1**. Are we informing a larger number of youth/families at risk?*

Year 1 establishes a baseline, partially through screening data, linkage to needed services, and tracking the number of family and youth that are trained in various content, e.g., MHFA or QPR. Screening data will require increased effort and the SOC-IT and SOC-ET are working with all stakeholders to address this issue and to find additional venues and safe/confidential methods for screening. This needs to expand to five additional counties and it is hoped that at least three more counties will be engaged in Year 2. At this time, the baseline for Year 1 is small and should be improved in Year 2. Informing youth was also tracked in qualitative methods by coding meeting minutes, emails, and transcripts from recordings. Recruiting and engaging families at all levels of the SOC has been a consistent point of communication for the SOC-IT. A mix of direct and tangential discussions have consistently addressed informing youth and families (32 segments). The number of families and youth trained or engaged in Collaboratives is small (see Collaborative Support and Training Section) with plans to better recruit and retain in process. Informing families was linked with recruiting family and youth into Child and SOC Collaboratives

(17 segments). There was also linkage with ensuring diversity and inclusiveness and concerns about overt racism in recruiting persons of color to have voice and agency in collaboratives (6 segments). There is clear effort to engage family and youth in collaboratives, led by the Project Director and SOC-IT, that is challenged mostly by the collaboratives not knowing how to engage families, how to convince youth and family to join and how to retain them. The SOC-ET recommends that parents and youth are engaged by convincing collaboratives that they should have full and equal membership and not be viewed as "token members to say we have some at meetings." Feeling respected and valued as well has having a shared voice and a real role in the collaborative may support long-term engagement.

***EQ2**. Has this made an impact on increasing connectedness and awareness?*

Follow-up data NOMS data is not yet available for tracking connectedness or awareness of youth/families of connection deficits. Baseline data suggests that there is a level of social connectedness (NOMS data) but also a sense of isolation (Triple Screen data). Completing an associative analysis of this information will require additional data. Reviewing qualitative data and codes for 'social connectedness,' 'social isolation,' and 'community support for youth,' the following is noted. Social connectedness, which is defined as youths unidirectional or reciprocal need for experiences of connection with caregivers, acquaintances, or community, was noted 33 times in qualitative segments. Connectedness was related to having necessary community resources, detection of youth at risk, trauma, and resilience. Social isolation, defined as youth perception of isolation and feeling unsupported, was coded 18 times with many of the segments co-coded with resilience, substance use and suicidality concerns. Community support for youth, defined as organized support from professionals or community members to enhance social/emotional development, was coded 14 times with emphasis on having safe social opportunities for youth in rural areas and, again, resilience. The overall content is mixed, ranging from, but not limited to, mental health related, faith-based, sports opportunities, and social media safety and access. Connectedness in general and how to systematically ensure safe opportunities is a clear concern that collaboratives appear to need support in defining and addressing.

***EQ3**. Did services result in youth/families being better off?*

This question will mostly be answered with quantitative data addressing linkage to resources, access to treatment, especially EBP's, and through completing qualitative interviews and focus groups with families. These are being planned and an initial focus group guide is nearing completion. For those recruited into Y/F Partner services, finding, and linking to resources has been consistent and successful. Youth and families in need of EBP's have been linked while those requiring outpatient counseling and willing to enter treatment have been served. A key concern for family health and its relationship to youth health are the many parents in need of mental health and or substance use treatment (see Referral and Assessment Data section). The

SOC-ET is working on a system to present that will help to track parent services confidentially outside of family and Y/F Partner services.

***EQ4**. How were shared metrics decided and used for decision-making and policy changes?*

Shared metrics is mostly related to engaging collaboratives and other decision-making bodies using a common platform, Clear Impact will hopefully be engaged at some point in Year 2, to focus efforts on common indicators within and between organizations in counties and within Children and/or SOC Collaboratives. This requires an understanding of how to collect, clean, validate, store, analyze and report data. Defining what is data is also a clear need as some collaboratives rely on anecdotal reports and stories in lieu of systematically collected and reasonably objective data, whether from self-report or external measures. Leadership and data-driven decision making (DDD) are two codes in use to address the work of collaboratives. Leadership (12 segments) has not been consistent with turnover in some collaboratives while it may be steady but also stagnant in others. DDD (32 segments) is linked to measurement-based care as a separate code (18 segments), and both are linked with the Clinical Services code (17 segments). Shared metrics and data are strongly linked in qualitative analysis and deficits are clear. This led to the SOC-ET suggestion to shift focus to improving the structure and DDD capacity of Collaboratives starting in Year 2.

***EQ5**. Are youth/families influential in developing a SOC that makes sense to them?*

Evidence for this question is limited given the small number of family and youth members engaged. Youth Partners have addressed the Governance Board and some Collaborative meetings. Discussion on PIT calls suggests that the youth voice was well received and coding of GB meetings and how Youth Partners responded to questions suggests that youth that know of the SOC agree with its purpose though this is also somewhat abstract to them. How SOC values are operationalized in collaboratives and how family and youth voice are included and respected will be related, fairly or not, to how influential they feel in supporting a SOC that makes sense to them. The lack of specific information to evaluate this question suggests that youth and families require additional support in understanding what the SOC is and why it is important to them and their communities. In turn, this requires finding and accessing willing families and youth which is also a challenge. This can be reinforced by supporting a selection of SOC relevant projects for the RBA requirement for collaboratives and to work closely with the state SOC to further engage youth and families.

***EQ6**. Are goals, objectives and performance indicators being met and collaboratively developed via Clear Impact™?*

Overall, there has been moderate success in meeting goals and objectives for Year 1 (see Table 13 for discussion of each *a priori* goal and objective). Clear Impact was not engaged for Year 1. The seven counties have a wide range of capabilities, focus, infrastructure, and capacity. Some do not have a functioning Children's/SOC Collaborative while others have an intact and

functioning organization. The wide range of capacity currently impedes the use of Clear Impact the way it was intended for this project. Instead, Alchemer, a survey service like Survey Monkey and, introduced at the end of Year 1, MentiMeter are being used for documenting collaborative capacity, communication and to capture information to help support collaborative development. Survey, interview, and review of collaborative meeting minutes are methods used to support and enhance a leadership structure for collaboratives that are just starting or restructuring due to changes in leadership. The same methods are being used to design and implement an organized readiness assessment process, and to begin procedures for selecting projects for state mandated but SOC relevant RBA and SOC specific projects. Clear Impact requires shared metrics across stakeholders and that level of collaboration is being developed/supported but is not yet realized within and between county SOC Children's Collaboratives. Qualitative analysis of field notes, review of meeting agendas and minutes, and extractions from meeting recordings are being used to track process and progress.

***EQ7**. Is network communication and impact improving?*

There is little data to address this evaluation question as yet. The SOC-ET will be administering a series of social network questions, structured as a retrospective review to gather baseline data and changes in Year 1 simultaneously, as part of Collaborative Readiness Assessments. The leadership in several Collaboratives has changed and the SOC-IT is acting as the leadership in one Collaborative. Impact measures are being planned for Year 2, assuming that leadership stabilizes, and the Collaboratives are able to address their RBA requirements.