Vaya SAMHSA System of Care Grant

Year 2, Annual Evaluation Report

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Complex Systems Innovations

Complex opportunities
Sustainable solutions

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Abbreviations

ACEs = Adverse Childhood Experiences

ARM-R = Adult Resilience Measure

ANOVA = Analysis of Variance

CI = Collective Impact

CYRM-R = Child and Youth Resilience Measure

DDDM = Data-Driven Decision-Making

GB = Governance Board

IPP = Infrastructure Development, Prevention, and Mental Health Promotion data.

JCPC = Juvenile Crime Prevention Council

JJ = Juvenile Justice

LFC = Lead Family Coordinator

LGBTQ+ = Lesbian, Gay, Bisexual, Transgender, and Queer populations

PIT = Project Implementation Team

PD = Project Director

MBC = Measurement Based Care

NOMS = National Outcomes Measures System

PEARLS = Pediatric ACEs and Related Life Events Screener

RBA = Results Based Accountability

Sd = Standard Deviation

SDOH = Social Determinants of Health

SOC-ET = System of Care Evaluation Team

SOC-IT = System of Care Implementation Team

TS = Triple Screen

Y/FP = Youth or Family Partner (Peer Support Specialists)

YV = Youth Villages

List of Tables and Figures

Introduction

The 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. Phase 1 of Key Stakeholder interview data, full report included as a section of the annual report.
7. Phase 2 of Key Stakeholder Interview data, update as data collection for Phase 2 is in progress.
8. Review and incorporation of county specific information such as, but not limited to, County Community Health Reports, SDOH data, minutes from Collaborative Meetings, and needs assessments.
9. Collaborative development tracking information specific to (1) developing collaborative infrastructure and (2) providing Results Based Accountability (**RBA**) training and supporting development of RBA specific project.
    a. County specific information when available for RBA projects funded via SOC Grant dollars.
10. Frequency coding for key information to support the process evaluation and to track communication and investment by county collaboratives and other stakeholders specific to RBA projects and collaborative development.

The System of Care Implementation Team (**SOC-IT**) has focused Year 2 on the following:

- Supporting and expanding trainings to improve the mental health workforce, both professional and community members.

- Focused on Social Determinants of Health (SDOH) screening and resource documentation for Youth and Family Partners (**Y/FP**) to more efficiently serve the families they are providing direct services to.
- Participated in, and often led, Collaborative meetings to further understanding an implementation of SOC principles and practices. This is imperative given the states focus on SOC and collaborative development.
- Supported collaborative development for efficient and sustainable infrastructure with emphasis on data management and RBA projects.
- Educating about Systems of Care.
- Stakeholder engagement via continuous contact with the Project Director (PD) and the previously noted Qualitative Sub-Study of via Key Stakeholder Interviews.
- Working to expand family and youth participation and membership in Children's and SOC Collaboratives.
- Developing, educating, and informing the Governance Board through regular meetings.
- Participating with 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.

Client Demographic Summary

Demographics are taken from the Triple Screen data. The TS and NOMS data were compared and only minor differences were noted and the larger number of completed Triple Screens more accurately describes who is being served and the communities. Since the TS demographic data is straightforward and easily collected, it is likely accurate.

Gender

Male: 134 (41.1%)

Female: 168 (51.5%)

Trans: 11 (3.4%)

Other: 5 (1.5%)

Refused: 9 (2.4)

Race

White: 261 (84.5%)

Black/African American: 20 (6.1%)

Alaskan Native: 1 (0.3)

Asian: 1 (0.3)

Dual/Other: 26 (8.4%)

Ethnicity

Non-Hispanic: 262 (86.2%)

Hispanic: 38 (12.5%)

Refused: 26 (8.0%)

Age in Years

Minimum: 0.5

Maximum: 21

Average: 11.3

Referral and Screening

The primary 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. Year 3 will see an improvement in some of those processes to ensure all data is captured and to streamline reporting. Not all TS completions are expected to include NOMS while all NOMS are expected to include a TS. Thus, there are 257 TS's completed that did not include NOMS data collection. 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. Thus, YV and other SOC members have started to use the TS at community events. Those completing are able to discuss any questions of concern and to ask for additional help or services. Our assumption is that there is a qualitative difference between those seeking treatment and those completing a TS at an event.

Enrollment

Enrollment data for Years 1 and 2 are summarized in Table 1. Year 1, when COVID was more influential, and the system was being learned showed a clear deficit. Year 2 demonstrates a clear achievement that not only erased the deficit from Year 1 but surpased the total combined expected. NOMS data collection improved and erased part of the deficit from Year 1 and this remains a focus, not only for baseline but follow-up NOMS data (see NOMS reporting section below). Overall, the grant is now slightly behind in enrollment for NOMS and surpassing for TS.

Table 1. Screening Tool Rate of Completion Summary

	Year 1				Year 2				Combined			
Screening Source	**Goal**	**Actual**	**Deficit**	**% Met**	**Goal**	**Actual**	**Deficit**	**% Met**	**Goal**	**Actual**	**Deficit**	**% Met**
NOMS	30	16	14	46.7	50	54	+4	108.0	80	70	10	87.5
Triple Screen Only	100	20	80	20.0	200	306	+106	153.0	300	326	+26	108.7
Total	**130**	**36**	**94**	**27.7**	**250**	**360**	**+110**	**144.0**	**380**	**397**	**+16**	**104.5**

Triple Screen

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 completed for each individual served by a Y/FP. The TS has been used for several events as well which allows a comparison between those seeking mental health care and often with complex presenting issues and representatives of the general public. Numbers are adequate to consider trends in the TS data and what this means overall and for some counties. When numbers are sufficient, we will compare TS data by gender, race/ethnicity, and county. Note that we combine Years 1 and 2 since Year 1 was during the first main year of COVID-19 and data collection did not meet objectives. The assumption is that Year 3 will continue to improvement in data collection which will allow for a comparison analysis next year.

The TS is completed after adequate engagement has been reached with families served by Youth and Family Partners (**Y/FP**). Initially, Y/FP 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 did not result in significant, or even marginal, increases in recruitment. At this time, best judgment when families are ready for the TS is being used. The analysis that follows will address each screener separately, summarizing data collected on 326 individuals. The Y/F Partners were asked to administer the screeners in the following order:

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**).

After administration, 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. Discussion of TS data and NOMS data were considered opportunities for measurement-based care (**MBS**) for working with families and for aggregating for data-driven decision-making (**DDDM**) for performance evaluation. To that end, three meetings with the Youth Villages team were completed by the SOC-ET with directed discussion of data findings and how to apply the data from a MBC framework for families served.

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/FP supervisor and decisions regarding treatment are collaboratively addressed with the youth/family.

TS data by County is listed next with the number and (%) of the total. Data availability is directly related by whether a Y/FP is serving the County. County comparisons will be completed only for

McDowell, Polk, and Wilkes counties. The smaller numbers for other countries can distort comparisons to counties with larger numbers. As TS's are completed in counties, more will be added for comparison.

- Alleghany = 23 (7.1)
- Alexander = 12 (3.7)
- Ashe = 22 (6.7)
- Caldwell = 10 (3.1)
- McDowell = 89 (27.3)
- Polk = 125 (38.3)
- Wilkes = 45 (13.8)

SDOH is reported first. There is a surprisingly low number of SDOH's reported by the youth and families surveyed compared to identical questions asked in other SOC initiates in the state. Total SDOH scores are presented and then compared for those that have been served by Youth Villages (SERVED) and those that were screened in various community events that were not focused on families with mental health services needs (EVENTS). Trauma and Resiliency are summarized after. Total endorsed items, comparisons by gender, SERVED/EVENT data comparison and by county are reported. When useful, tests of significance compare whether there are findings not likely due to chance. Race and ethnicity are not included in this analysis due to limited non-white respondents. This will be added in Year 3 if there is sufficient data collection for persons of color and that self-describe as LGBTQ+.

Social Determinants 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 are utilities at 20.6%, slightly higher for the Served population. Transportation is a close second (19.8%) though more likely in the Service group (23.4%) vs. the Event group (14.2%). Concern over housing (11.7%) and not having housing (10.2%) are a somewhat common concern. Of interest are the safety questions with a larger proportion than expected feeling unsafe (17.6%), which increased from 13.9% in Year 1. Having been physically assaulted (12.3%) or experienced emotional abuse (12.0%) in the last year have both reduced nearly in half, but with the larger sample size this is likely a more accurate estimate. The average number of SDOH's selected for all respondents is 1.36 (Sd = 1.83). For those receiving services, the average is slightly higher (1.44, Sd = 1.74) compared to Event attendees (1.23, Sd = 1.96).

Table 2: Summary of SDOH Needs Selected by Families (Yes responses unless where indicated)

		Served		Event		Total	
#	Screener Item	n	%	n	%	n	%
1	Within the past 12 months, did you worry that your food would run out before you got money to buy more?	24	12.1	21	16.5	45	13.8

Table 2: Summary of SDOH Needs Selected by Families (Yes responses unless where indicated)							
		Served		Event		Total	
#	Screener Item	n	%	n	%	n	%
2	Within the past 12 months, did the food you bought just not last and you didn't have money to get more?	23	11.6	20	15.7	43	13.2
3	Do you have housing? (***NO***)	23	11.6	20	15.7	33	10.2
4	Are you worried about losing your housing?	32	16.3	6	4.8	38	11.7
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?	42	21.2	25	19.7	67	20.6
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?	46	23.4	18	14.2	64	19.8
7	Do you feel physically and emotionally safe where you currently live? (***NO***)	36	18.3	21	16.5	57	17.6
8	Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by someone?	27	13.6	13	10.3	40	12.3
9	Within the past 12 months, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?	27	13.6	12	9.4	39	12.0
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?	14	7.2	4	3.2	18	5.6
	Total n = 326; Receiving Services (Served) n = 198; Event n = 128						

No needs or a low number of identified SDOH needs are more common in the Service group (Figure 1). Slightly over half of the Event group had no SDOH needs compared to 35.9% of Service recipients. Higher number of SDOH needs were relatively consistent between the two groups. SDOH supports are often the first request by Service families.

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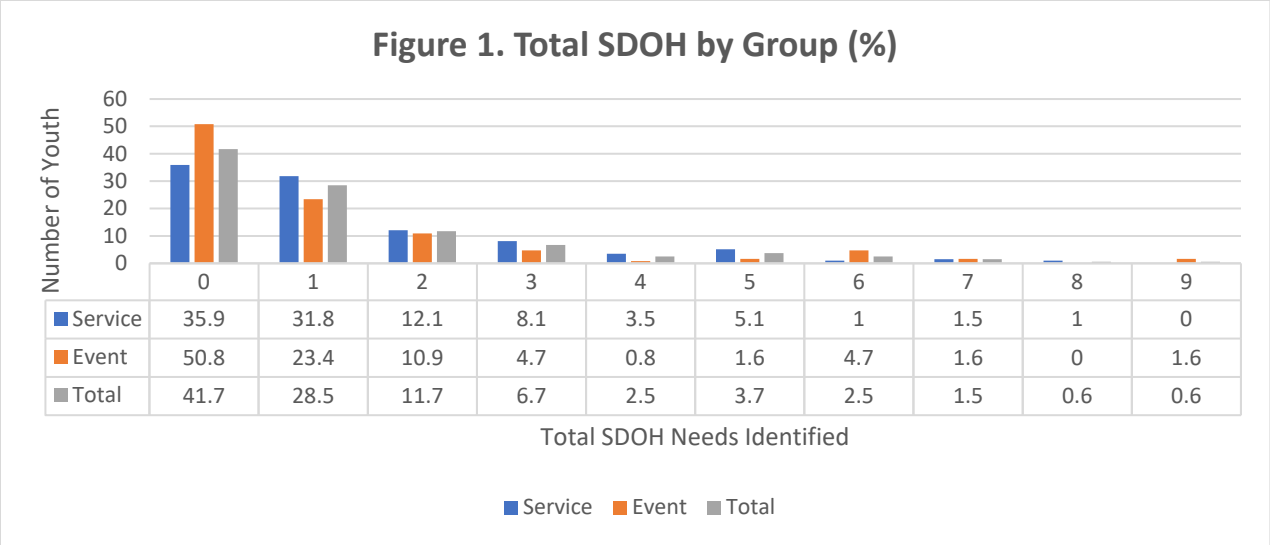


	0	1	2	3	4	5	6	7	8	9
Service	35.9	31.8	12.1	8.1	3.5	5.1	1	1.5	1	0
Event	50.8	23.4	10.9	4.7	0.8	1.6	4.7	1.6	0	1.6
Total	41.7	28.5	11.7	6.7	2.5	3.7	2.5	1.5	0.6	0.6

Trauma and Life Events Data Summary

Trauma and life events are important constructs with each question reviewed next. 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. 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] 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, divorce, incarceration, heart conditions and other outcomes. Risk increases with each additional trauma experience. Risk is further exacerbated by exposure to life events.

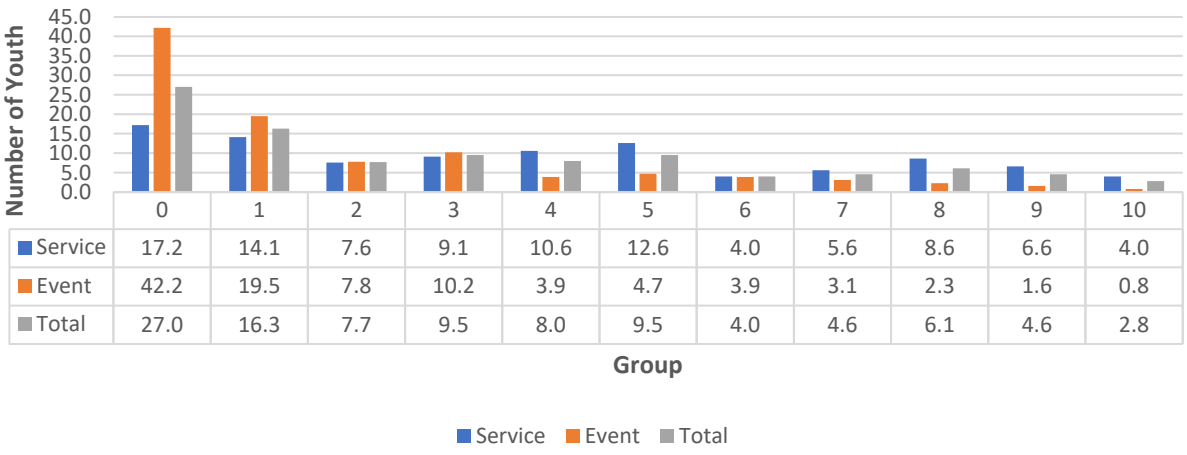
The total possible score for the Trauma section is 10. The average for those screened for the SOC is 3.1 (Sd = 3.0), at the noted critical level, notably lower than Year 1: 5.6 (Sd = 2.8). and the median is 2, lower than 5 from Year 1. This suggests improvement but we note that this combine Served and Event youth. For youth Served only, the average increases to 4.03 (Sd = 3.1) and lowers to 2.3 for Event youth (Sd = 2.1, Median = 1). Regression to the mean is expected but Served youth with an average *and* a Median score of four suggests high levels of trauma and certainly higher than Event youth in the same communities.

Figure 2 reviews the number of traumas experienced by percentages of youth for Year 1, Year 2 and combined. Only 17.2 percent of Served youth had no traumatic events compared to 42.2% for the Event group. For all youth combined, 27.0% of youth experienced no traumatic events across all ages. To put into perspective, 238 out of 326 youth with data experienced at least one

[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.

trauma. For youth with three or more trauma experiences, those considered at elevated risk, 61.1% of youth Served meet that criteria compared to 30.5% of Event youth, literally one-half the number. 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.

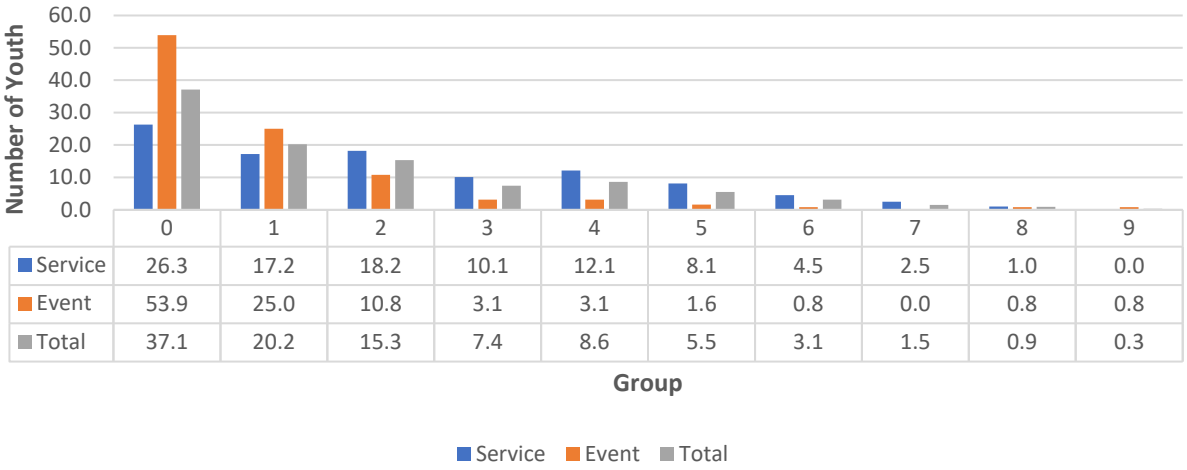
Figure 2. Total Trauma Events (%)



	0	1	2	3	4	5	6	7	8	9	10
Service	17.2	14.1	7.6	9.1	10.6	12.6	4.0	5.6	8.6	6.6	4.0
Event	42.2	19.5	7.8	10.2	3.9	4.7	3.9	3.1	2.3	1.6	0.8
Total	27.0	16.3	7.7	9.5	8.0	9.5	4.0	4.6	6.1	4.6	2.8

Pattern of findings are similar for Life Events experienced (Figure 3). Those served by F/YP have higher numbers of events with higher in most of the comparisons for number of events. Like trauma, there are nearly twice as many youth in the Events category with no life events history compared to the Service group. Overall, distributions are consistent with trauma findings

Figure 3. Total Life Events (%)



	0	1	2	3	4	5	6	7	8	9
Service	26.3	17.2	18.2	10.1	12.1	8.1	4.5	2.5	1.0	0.0
Event	53.9	25.0	10.8	3.1	3.1	1.6	0.8	0.0	0.8	0.8
Total	37.1	20.2	15.3	7.4	8.6	5.5	3.1	1.5	0.9	0.3

Cross-tabulating total trauma by total adverse experiences for the total sample, 72 youth (22.1%) had no traumatic and no negative life events. For the Served group, 27 youth (13.6%)

have no trauma/life events compared to the 45 youth (35.2%) of the Event group. An analysis was completed to detect any trends in distribution between those with high trauma and high adverse life event scores, defined as having three or more in each assessment. Eighty-two (82) youth (25.2%) of the total sample were at this risk level. For those being Served 69 (34.8%) are at high risk. For the Event group, 13 (10.2%) are in the high-risk category. We reviewed the data in the ways described to determine the degree of trauma, including the trauma of life events, across the youth sampled to date. We note the following:

- Youth in the Service group have notably higher levels of traumatic experiences. This will be further assessed in the item level analysis summarized next.
- Trauma is not isolated to those seeking care. Some youth in the Event group have experienced a little, some or a lot of trauma and while determining if they are not receiving the care they need it beyond the reach of the data, it is clear that trauma is effecting youth across the community.

The following Tables (3 - 8) provide an item level analysis for trauma and life events starting with comparing by gender across the total sample (Table 3). While the total number in the table includes all respondents, some individuals that did not identify as male or female are excluded from that analysis due to low numbers. Each iteration of the analysis will review the frequency of each category for inclusion. There is consistent similarity between male and female respondents. A Chi-Square analysis along with an Uncertainty Coefficient was completed for each question by gender. There were no significant differences between genders (data not shown).

Table 3: Summary of Trauma Factors Selected by SOC Participants and Gender

		Male		Female		Total	
#	Screener Item	n	%	n	%	n	%
1	Has your child ever lived with a parent/caregiver who went to jail/prison?	46	34.3	59	35.1	105	34.8
2	Do you think your child ever felt unsupported, unloved and/or unprotected?	41	30.6	49	28.2	90	29.8
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*)	56	41.8	73	43.5	129	42.7
4	Has a parent/caregiver ever insulted, humiliated, or put down your child?	37	27.6	44	26.2	81	26.8
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?	51	38.1	63	37.5	114	37.7
6	Has your child ever lacked appropriate care by any caregiver?	28	20.9	34	20.2	62	20.5

Table 3: Summary of Trauma Factors Selected by SOC Participants and Gender							
		Male		Female		Total	
#	Screener Item	n	%	n	%	n	%
	(*for example, not being protected from unsafe situations, or not cared for when sick or injured even when the resources were available*)						
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?	59	44.0	62	36.9	121	40.1
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?	25	18.7	28	16.7	53	17.5
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*)	14	10.4	28	16.7	42	13.9
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*)	55	41.0	63	37.5	118	39.1
	Total = 302; Male n = 134; Female n = 168						

The same analysis was completed comparing Served to Event (Table 4). As data accrues, we'll add layers for gender, race/ethnicity and county when data is sufficient. Unlike gender, the differences are stark. Comparison for every item is significantly higher for Served youth, though we reiterate that this does not make the Event group trauma free. Combining responses for specific items to develop a preliminary difference in profile, Served youth are more likely to be isolated, in fear, bullied, and living in a changing and unsafe environment. They are also more likely to have parents with mental health or substance use issues. Possibly due to a still limited sample size, having parents with both mental health and substance use issues are noted for only 12 youth, and of those seven are in the Served group. Special attention should be given to items 2, 4, 8, and 9, as these are significant differences in the scores and all related to the youth. Parent related questions of special note, and one reason we recommend an emphasis on parent health and support, are questions 3, 5, 7 and 10.

Table 4: Summary of Trauma Factors by Served or Event Status							
		Served		Event		X^2	p-value
#	Screener Item	n	%	n	%		
1	Has your child ever lived with a parent/caregiver who went to jail/prison?	79	39.9	35	27.6	5.174	.023
2	Do you think your child ever felt unsupported, unloved and/or unprotected?	87	43.9	15	11.8	37.087	.000
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*)	104	52.5	41	32.3	12.829	.000
4	Has a parent/caregiver ever insulted, humiliated, or put down your child?	77	38.9	18	14.2	22.848	.000
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?	90	45.5	35	27.6	10.469	.001
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*)	53	26.8	14	11.0	11.719	.001
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?	98	49.5	38	29.9	12.181	.000
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?	46	23.2	12	9.4	10.026	.002
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*)	40	20.2	9	7.1	10.395	.001
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*)	105	53.0	27	21.3	32.379	.000
	Total n = 326; Receiving Services (Served) n = 198; Event n = 128						

For the first time, there is sufficient data to compare some of the counties (Table 5). While only two of the questions have statistically significant differences, the trends are markedly similar for all questions. Item 2 also approaches significance. Exposure to sexual abuse and changes in familial relationships, e.g., divorce, are significantly more likely in McDowell and Wilkes counties. Polk county, with the data at hand, still low samples for each county suggests we focus on possible trends, tends to have the least amount of identified trauma, though this is not for each question. Overall, Wilkes County has the highest trauma levels, but this may be an artifact of sampling as the overall trauma recorded for the first youth in the program was significantly higher than what is seen now. Wilkes is equally likely to trend down.

Table 5: Summary of Trauma Factors Selected by County									
		McDowell		**Polk**		**Wilkes**		**X^2**	**p-value**
#	**Screener Item**	**n**	**%**	**n**	**%**	**n**	**%**		
1	Has your child ever lived with a parent/caregiver who went to jail/prison?	27	30.7	42	33.6	21	46.7	3.525	.172
2	Do you think your child ever felt unsupported, unloved and/or unprotected?	35	39.8	33	26.4	19	42.2	5.895	.052
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*)	37	42.0	52	41.6	27	60.0	4.986	.083
4	Has a parent/caregiver ever insulted, humiliated, or put down your child?	28	31.8	31	24.8	17	37.8	3.040	.219
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?	42	47.7	46	36.8	16	35.6	3.075	.215
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*)	24	27.3	20	16.0	12	26.7	4.651	.098
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,	42	47.7	49	39.2	23	51.1	2.583	.275

Table 5: Summary of Trauma Factors Selected by County									
		McDowell		Polk		Wilkes		X^2	p-value
#	Screener Item	n	%	n	%	n	%		
	kicked, punched beaten up or hurt with a weapon?								
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	14.8	21	16.8	10	22.2	1.179	.555
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*)	18	20.5	9	7.2	12	26.7	12.738	.002
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*)	49	55.7	37	29.6	25	55.6	17.824	.000
	McDowell, n = 88; Polk, n = 125; Wilkes, n = 45								

The same series of analyses were completed for the Life Events items. Table 6 reviews total score distributions and compares by gender. Question 8 and 9 are included but we note that the wrong assessment was used for some teens, has since been corrected, and this data is incomplete. Only question 8 regarding arrest history was significantly different (**$X^2 = 8.629$, $p \leq .003$)**. Males were more likely to be incarcerated or detained. Overall, trauma and life events are relatively evenly distributed for youth surveyed.

Table 6: Summary of Life Events Selected by SOC Participants and Gender							
		Male		Female		Total	
#	Screener Item	n	%	n	%	n	%
1	Has your child ever seen, heard, or been a victim of violence in your neighborhood, community or school?	42	31.3	37	22.0	88	27.1

Table 6: Summary of Life Events Selected by SOC Participants and Gender							
		Male		Female		Total	
#	Screener Item	n	%	n	%	n	%
	(*for example, targeted bullying, assault or other violent actions, war or terrorism*)						
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*)	34	25.4	32	19.0	83	25.5
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*)	29	21.6	36	21.4	71	21.8
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?	30	22.4	34	20.2	70	21.5
5	Has your child ever been separated from their parent or caregiver due to foster care, or immigration?	35	26.1	32	19.0	74	22.8
6	Has your child ever lived with a parent/caregiver who had a serious physical illness or disability?	35	26.1	41	24.4	83	25.5
7	Has your child ever lived with a parent or caregiver who died?	24	17.9	25	14.9	15	15.7
8	Has your child ever been detained, arrested or incarcerated? (*Teen only*)	21	20.4	6	6.2	28	12.8
9	Has your child ever experienced verbal or physical abuse or threats from a romantic partner? (*Teen only*) (*for example, a boyfriend or girlfriend*)	6	5.8	11	11.3	20	9.1
	Total = 302; Male n = 134; Female n = 168						

Identical to trauma questions, those in the Served group are significantly more likely to experience each of the life events (Table 7). Some questions are important to consider as more data is collected. Being separated from a parent due to foster care (most likely given the respondent sample) or immigration is extremely different. The Service youth are also much more likely to have a parent with a physical illness or disability. This can be anxiety and depression producing as well as having children take on parental roles they are unprepared for. If this trend continues it may be useful for the PIT to consider ways to further examine the issue.

Table 7: Summary of Life Events by Served or Event Status							
		Served		Event		X^2	p-value
#	Screener Item	n	%	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*)	69	34.8	19	15.0	14.499	.000
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*)	64	32.3	19	15.0	12.266	.000
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*)	57	28.8	14	11.0	14.301	.000
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?	51	25.8	19	15.0	5.337	.021
5	Has your child ever been separated from their parent or caregiver due to foster care, or immigration?	62	31.3	12	9.4	21.034	.000
6	Has your child ever lived with a parent/caregiver who had a serious physical illness or disability?	70	35.4	13	10.2	25.669	.000
7	Has your child ever lived with a parent or caregiver who died?	39	19.7	12	9.4	6.142	.013
	Receiving Services (Served) n = 198; Event n = 128						

Life Events are more similar across the three counties in the analysis (Table 8). Two items are significantly different, a child being separated is much more likely in McDowell and Wilkes counties, and having a parent/caregiver that died is more likely in the Wilkes sample and somewhat more in McDowell. Two questions are approach significance, items 1 and 3, with Polk county having the lowest percentage in both items.

Table 8: Summary of Life Events by County									
		McDowell		Polk		Wilkes		X^2	p-value
#	Screener Item	n	%	n	%	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*)	31	35.2	27	21.6	16	35.8	5.947	.051
2	Has your child experienced discrimination?	29	33.0	29	23.2	10	22.2	3.012	.222

Table 8: Summary of Life Events by County									
		McDowell		Polk		Wilkes		X^2	p-value
#	Screener Item	n	%	n	%	n	%		
	(*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*)								
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*)	25	28.4	26	20.8	11	24.4	1.643	.440
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?	28	31.8	22	17.6	10	22.2	5.882	.053
5	Has your child ever been separated from their parent or caregiver due to foster care, or immigration?	29	33.0	17	13.6	18	40.0	17.117	.000
6	Has your child ever lived with a parent/caregiver who had a serious physical illness or disability?	26	29.5	29	23.2	15	33.3	2.112	.348
7	Has your child ever lived with a parent or caregiver who died?	17	19.3	12	9.6	12	26.7	8.384	.015
	McDowell, n = 88; Polk, n = 125; Wilkes, n = 45								

Resilience Assessment Summary

Analysis of resilience data is completed similar to trauma and life events. Resilience questions each had three options versus a yes or no response. These include no, sometimes, and yes. Table summarizes responses for each of the 17 questions along with a mean score (Table 9). Tests for significance were completed when relevant using the independent sample t-test, the Analysis of Variance (**ANOVA**) F-test, or the Pearson Correlation (r). For average scores, review of scale development data suggests that any average score of 2.50 or less out of the possible 3.0 are areas of concern when applying data to groups. For the combined 326 respondents, questions around being able to talk to family about feelings (Q8), feeling supported by friends (Q9), and feeling that they belong in school (Q10) are the risk questions when considering overall resilience. Limited number of youth selected 'no' for most questions which suggests that resilience may be challenged but it is not impaired.

Table 9: Summary of Resilience Scores Selected by SOC Participants (n = 326)								
#		No		Sometimes		Yes		Mean Item Score
		n	%	n	%	n	%	
1	I get along with people around me	13	4.2	122	37.4	178	56.9	2.53
2	Getting an education is important to me	38	12.2	68	21.9	205	65.9	2.54
3	I know how to behave/act in different situations (such as school, home and church)	30	9.6	66	21.0	218	69.4	2.60
4	My parent(s)/caregiver(s) really look out for me	14	4.5	25	8.0	272	87.5	2.83
5	My parent(s)/caregiver(s) know a lot about me (for example, who my friends are, what I like to do)	22	7.1	50	16.1	39	75.8	2.70
6	If I am hungry, there is enough to eat	13	4.1	11	3.5	291	92.4	2.88
7	People like to spend time with me	13	4.2	70	22.6	227	73.2	2.69
8	I talk to my family/caregiver(s) about how I feel (for example when I am hurt or sad)	54	17.4	92	29.7	164	52.9	2.35
9	I feel supported by my friends	37	11.9	83	26.6	192	61.5	2.50
10	I feel that I belong/belonged at my school	58	18.8	76	24.7	174	56.5	2.38
11	My family/caregiver(s) care about me when times are hard (for example if I am sick or have done something wrong)	10	3.2	28	8.3	277	88.5	2.85
12	My friends care about me when times are hard (for example if I am sick or have done something wrong)	24	7.8	60	19.4	225	72.8	2.65
13	I am treated fairly in my community	30	9.5	51	16.2	234	74.3	2.65
14	I have chances to show others that I am growing up and can do things by myself	14	4.5	37	11.9	261	83.7	2.79
15	I feel safe when I am with my family/caregiver(s)	10	3.2	24	7.7	279	89.1	2.86
16	I have chances to learn things that will be useful when I am older (like	13	4.2	20	6.4	279	89.4	2.85

Table 9: Summary of Resilience Scores Selected by SOC Participants (n = 326)								
#		No		Sometimes		Yes		Mean Item Score
		n	%	n	%	n	%	
	cooking, working, and helping others)							
17	I like the way my family/caregiver(s) celebrates things (like holidays or learning about my culture)	17	5.5	26	8.4	266	86.1	2.81

Resilience differences by gender, again focusing on those identifying as male or female, are summarized in Table 10. Unlike trauma and life events that had no significant differences by gender, there are some questions to consider. Female respondents are significantly more likely to believe that getting an education is important, they are able to talk to caregivers though this is still borderline in the risk level, feel supported by friends, feel that they belong in school, have friends that care about them when times are hard, and have opportunities to develop independence. The difference in total scores is borderline significant ($t = 1.737$, $p \leq .083$).

Table 10: Summary of Resilience Mean Item Scores by Gender							
		Male		Female		t-test	p-value
#		Mean	Sd	Mean	Sd		
1	I get along with people around me	2.47	0.61	2.58	0.55	1.663	.097
2	Getting an education is important to me	2.29	0.78	2.70	0.81	4.980	.000
3	I know how to behave/act in different situations (such as school, home and church)	2.51	0.71	2.65	0.63	1.762	.079
4	My parent(s)/caregiver(s) really look out for me	2.82	0.49	2.86	0.46	0.615	.539
5	My parent(s)/caregiver(s) know a lot about me (for example, who my friends are, what I like to do)	2.71	0.55	2.74	0.57	0.427	.670
6	If I am hungry, there is enough to eat	2.90	0.41	2.87	0.48	-0.642	.521
7	People like to spend time with me	2.54	0.57	2.75	0.51	1.707	.089
8	I talk to my family/caregiver(s) about how I feel (for example when I am hurt or sad)	2.26	0.79	2.47	0.73	2.461	.014
9	I feel supported by my friends	2.38	0.73	2.64	0.64	3.219	.001
10	I feel that I belong/belonged at my school	2.26	0.79	2.53	0.74	2.974	.003

Table 10: Summary of Resilience Mean Item Scores by Gender							
		Male		Female		t-test	p-value
#		Mean	Sd	Mean	Sd		
11	My family/caregiver(s) care about me when times are hard (for example if I am sick or have done something wrong)	2.87	0.40	2.85	0.45	-0.442	.659
12	My friends care about me when times are hard (for example if I am sick or have done something wrong)	2.54	0.65	2.74	0.58	2.765	.006
13	I am treated fairly in my community	2.64	0.66	2.69	0.63	0.602	.548
14	I have chances to show others that I am growing up and can do things by myself	2.72	0.59	2.86	0.42	2.362	.019
15	I feel safe when I am with my family/caregiver(s)	2.88	0.43	2.87	0.42	-0.112	.911
16	I have chances to learn things that will be useful when I am older (like cooking, working, and helping others)	2.81	0.51	2.88	0.42	1.239	.217
17	I like the way my family/caregiver(s) celebrates things (like holidays or learning about my culture)	2.83	0.48	2.83	0.49	-0.059	.953
	TOTAL Resilience Score	**42.62**	**10.54**	**44.70**	**10.20**	**1.737**	**.083**

Differences in resilience by group, Served or Event, again show stark differences (Table 11). Fifteen of 17 questions have the Served group with significantly lower average resilience scores, one is borderline, and only "If I am hungry, there is enough to eat" is not significant. The total scores are not significantly different, but the pattern of lower scores for Served is important to consider. The youth in the Services group are significantly more likely to have higher averages in all trauma scores, most life events scores, and nearly all resilience scores. Together, this defines a population at risk.

Table 11: Summary of Resilience Mean Item Scores by Served/Event Status							
		Served		Event		t-test	p-value
#		Mean	Sd	Mean	Sd		
1	I get along with people around me	2.46	0.60	2.64	0.52	2.609	.010
2	Getting an education is important to me	2.40	0.78	2.76	0.49	4.460	.000
3	I know how to behave/act in different situations (such as school, home and church)	2.54	0.71	2.69	0.56	1.978	.049
4	My parent(s)/caregiver(s) really look out for me	2.79	0.52	2.90	0.40	1.937	0.54

Table 11: Summary of Resilience Mean Item Scores by Served/Event Status							
		Served		Event		t-test	p-value
#		Mean	Sd	Mean	Sd		
5	My parent(s)/caregiver(s) know a lot about me (for example, who my friends are, what I like to do)	2.60	0.65	2.86	0.43	3.898	.000
6	If I am hungry, there is enough to eat	2.88	0.42	2.88	0.45	-0.026	.980
7	People like to spend time with me	2.58	0.62	2.87	0.34	4.706	.000
8	I talk to my family/caregiver(s) about how I feel (for example when I am hurt or sad)	2.17	0.79	2.66	0.60	5.843	.000
9	I feel supported by my friends	2.33	0.75	2.77	0.50	5.758	.000
10	I feel that I belong/belonged at my school	2.20	0.84	2.67	0.57	5.381	.000
11	My family/caregiver(s) care about me when times are hard (for example if I am sick or have done something wrong)	2.79	0.51	2.95	0.26	3.112	.002
12	My friends care about me when times are hard (for example if I am sick or have done something wrong)	2.53	0.69	2.84	0.43	4.322	.000
13	I am treated fairly in my community	2.49	0.74	2.90	0.35	5.686	.000
14	I have chances to show others that I am growing up and can do things by myself	2.72	0.57	2.92	0.34	3.426	.001
15	I feel safe when I am with my family/caregiver(s)	2.79	0.51	2.97	0.22	3.505	.001
16	I have chances to learn things that will be useful when I am older (like cooking, working, and helping others)	2.81	0.53	2.92	0.29	2.153	.032
17	I like the way my family/caregiver(s) celebrates things (like holidays or learning about my culture)	2.73	0.61	2.93	0.28	3.476	.001
	TOTAL Resilience Score	**42.78**	**8.87**	**44.51**	**12.91**	**1.434**	**.153**

Significant county differences were found for some questions (Table 12). Total scores were not significantly different ($F = 0.217$; $p \leq .805$). The decision to address individual scores was because the review of total score findings did not tell the story of what youth are experiencing by gender, group or county. The differences noted in specific questions become obscured by the focus on the differences in average total scores. There is also concern not to overinterpret. For instance, question four is significantly different for the question “My parent(s)/caregiver(s) really look out for me.” Yet, none of the averages are in the risk range but they are still different enough to be recognized by the analysis. Question 12 finds Wilkes average score in the high-risk

range. None of the other significant questions have differences in the risk range. This is still useful information, resilience is perceived differently in counties by youth that live not that far apart, and the story behind that should be investigated.

Table 12: Summary of Resilience Scores Selected by SOC Participants (n = 252)									
#		McDowell (n = 88)		Polk (n = 120)		Wilkes (n = 45)		F	P-value
		M	Sd	M	Sd	M	Sd		
1	I get along with people around me	2.53	0.55	2.54	0.55	2.38	0.68	1.456	.235
2	Getting an education is important to me	2.41	0.79	2.62	0.60	2.47	0.79	2.283	.104
3	I know how to behave/act in different situations (such as school, home and church)	2.62	0.67	2.35	0.58	2.56	0.73	0.361	.697
4	My parent(s)/caregiver(s) really look out for me	2.78	0.49	2.95	0.26	2.73	0.62	5.933	.003
5	My parent(s)/caregiver(s) know a lot about me (for example, who my friends are, what I like to do)	2.73	0.56	2.72	0.57	2.60	0.69	0.828	.438
6	If I am hungry, there is enough to eat	2.90	0.38	2.92	0.36	2.78	0.60	1.894	.153
7	People like to spend time with me	2.69	0.54	2.70	0.56	2.50	0.67	2.170	.116
8	I talk to my family/caregiver(s) about how I feel (for example when I am hurt or sad)	2.26	0.79	2.38	0.42	2.24	0.63	0.829	.438
9	I feel supported by my friends	2.56	0.64	2.46	0.67	2.36	0.86	1.366	.257
10	I feel that I belong/belonged at my school	2.46	0.76	2.39	0.77	2.23	0.91	1.262	.285
11	My family/caregiver(s) care about me when times are hard (for example if I am sick or have done something wrong)	2.86	0.71	2.90	0.35	2.73	0.62	2.473	.086
12	My friends care about me when times are hard (for example if I am sick or have done something wrong)	2.63	0.63	2.72	0.54	2.44	0.79	3.078	.048
13	I am treated fairly in my community	2.58	0.72	2.67	0.61	2.60	0.72	0.463	.630

Table 12: Summary of Resilience Scores Selected by SOC Participants (n = 252)									
#		McDowell (n = 88)		Polk (n = 120)		Wilkes (n = 45)		F	P-value
		M	Sd	M	Sd	M	Sd		
14	I have chances to show others that I am growing up and can do things by myself	2.79	0.51	2.83	0.42	2.60	0.72	3.433	.034
15	I feel safe when I am with my family/caregiver(s)	2.83	0.46	2.90	0.33	2.71	0.66	2.942	.055
16	I have chances to learn things that will be useful when I am older (like cooking, working, and helping others)	2.81	0.50	2.91	0.32	2.69	0.70	3.506	.032
17	I like the way my family/caregiver(s) celebrates things (like holidays or learning about my culture)	2.83	0.51	2.83	0.46	2.61	0.69	3.036	.050

A key analysis was to review via correlation the relationships between trauma, life events, and resilience scores for direction and strength (Table 13). Trauma and life events were expected to be strongly correlated and they are. Resilience was expected to be negatively correlated to trauma and life events, meaning that as one increased (trauma/life events) the other decreased (resilience). This also proved to be accurate but not significant for the whole sample. We also bifurcated the resiliency score at the mean and at the median and correlated with the accompanying trauma and life event scores. Four relationships become significant. When resilience is greater than the mean or the median for trauma and life events, the number of negative experiences is significantly lower, meaning that there are less challenges for the youth and resilience is stronger. What this suggests is that interventions targeted to improve resilience, which has started already in several counties, continues, and receives the support needed to be effective. A resilience increases, the lasting effects of negative trauma and life event histories can be ameliorated, and this data gives a way to track that.

Table 13. Pearson Correlation Summary for Trauma, Life Events, and Resilience Scores				
Variable 1	Variable 2	n	r	p-value
Trauma	Life Events	326	.734	.000
Resilience	Trauma	326	-.064	.249
Resilience	Life Events	315	-.071	.203
Resilience ≤ Sample Mean	Trauma	132	.156	.074
Resilience ≤ Sample Mean	Life Events	132	.103	.241
Resilience > Sample Mean	Trauma	184	-.343	.000
Resilience > Sample Mean	Life Events	184	-.307	.000
Resilience ≤ Sample Median	Trauma	168	.089	.251

Table 13. Pearson Correlation Summary for Trauma, Life Events, and Resilience Scores				
Variable 1	**Variable 2**	**n**	**r**	**p-value**
Resilience ≤ Sample Median	Life Events	168	.026	.740
Resilience > Sample Median	Trauma	148	-.172	.036
Resilience > Sample Median	Life Events	148	-.194	.018

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 Measures (IPP) Data Summary

Table 14 summarizes performance measure data for Year 2. Quarter 2 had several large trainings that were beneficial for the communities. Targeted for improvement is tracking the number of persons for referred and engaged in treatment.

Table 14. IPP Data Summary for Grant Year 2					
Metric	**Q1**	**Q2**	**Q3**	**Q4**	**Total**
WD2	68	430	96	28	622
WD5	4	30	0	24	58
T3	20	25	19	19	83
O1	43	86	143	76	348
R1	11	17	15	20	63
AC1	3	7	8	5	23
AC1 %	27.3	41.2	53.3	25.0	36.5

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

Information was compiled in the Field Note Data Registry generated for this project. All trainings are tracked including number of professionals, number of community members, and number of family members and youth that receive services. Professionals included all that work with children/youth including clinicians, other MH/SU providers, educators that work daily with children and related. Q2 trained many professionals across multiple counties in Resilience focused interventions and system change strategies.

WD5: THE NUMBER OF CONSUMERS / FAMILY MEMBERS WHO PROVIDE MENTAL HEALTH-RELATED SERVICES AS A RESULT OF THE GRANT

Information is compiled in the Field Note Data Registry for the project. Family members and youth are tracked for trainings that allow them to intervene and provide support for individuals, e.g., in Mental Health First Aid.

T3: THE NUMBER OF PEOPLE RECEIVING EVIDENCE -BASED MENTAL HEALTH–RELATED SERVICES AS A RESULT OF THE GRANT

Data is aggregated from provider organizations funded through grant dollars. A tracking system is in place, Clinical Tracking Registry, and reviewed regularly. All individuals completing a NOMS are receiving mental health related services and make up most of the numbers. In most cases these are a combination of Youth and Family Partner (Peer Support) services as well as school-based services or general community counseling.

O1: THE NUMBER OF INDIVIDUALS CONTACTED THROUGH PROGRAM OUTREACH EFFORTS

Outreach efforts are tracked in the Clinical Tracking Registry to limit duplication to the extent possible. Most of the persons tracked for this measure completed a Triple Screen to determine if they would need additional services and as part of the linkage process to Family and Youth Partners. Triple Screens include trauma, resilience and SDOH screenings.

R1: THE NUMBER OF INDIVIDUALS REFERRED TO MENTAL HEALTH OR RELATED SERVICES

Youth and families with complex needs are referred to enhances services, e.g., multisystemic therapy and others. These are individuals that received Youth and Family Partner services in some cases or were determined to be of high need and referred immediately. These individuals are documented in the Clinical Tracking Registry.

AC1: THE NUMBER AND PERCENTAGE OF INDIVIDUALS RECEIVING MENTAL HEALTH OR RELATED SERVICES AFTER REFERRAL

Referral to services were noted in performance measure R1 and are tracked for engagement through provider internal systems and entered into the Clinical Tracking Registry.

A more detailed review of IPP data is offered in Table 15.

Table 15. Summary of IPP Data Objective Status as Met or Unmet

IPP	Description	Goal	Year 2	Status
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	**622**. Summed from 230 Field Note records that cover the annual report period. Resources for Resilience: 221 Mental Health First Aid – Youth: 47 WRAP: 48 QPR: 79 Child and Family Teams: 8 Centers for Trauma Resilience: 16 JJTC: 187	**MET**

Table 15. Summary of IPP Data Objective Status as Met or Unmet				
IPP	**Description**	**Goal**	**Year 2**	**Status**
			Other: 16	
WD5	The number of consumers/family members who provide mental health-related services as a result of the grant.	10	**58**. Summed from training and after training contacts. Individuals that received WRAP, QPR, Resilience or MHFA.	**MET**
T3	The number of people receiving evidence-based mental health-related services as a result of the grant.	30	**83**. Tracked through Provider systems and linked with Evaluation Team.	**MET**
O1	The number of individuals contacted through program outreach efforts.	100	**348**. We are including those that were involved with outreach and that matriculated into treatment.	**MET**
R1	The number of individuals referred to mental health or related services.	36	**63**. Includes family members referred to services and other resources that reduce stress and positively affect family health.	**MET**
AC1	The number and percentage of individuals receiving mental health or related services after referral.	80%	**23 of 63** of youth in system. **36.5%** received or are receiving treatment after referral.	**UNMET**

National Outcomes Measurement Systems Data Summary

Select NOMS data is summarized below. Most of this section is baseline data. 6-month follow-up data and discharge data is limited. A clear area for improvement is follow-up data collection and developing a timeframe for discharge so persons not being served are not represented in SPARS as needing follow-up data when they are in effect no longer part of the program. For this report, the following NOMS data was used:

- Baseline = 70
- 6-month follow-up = 10
- Discharge = 17

Diagnosis Data

There are three fields for diagnoses to be entered. The primary diagnosis is listed next by frequency and alphabetized when frequencies are equal. Secondary and tertiary diagnoses are reported after and combined. Anxiety, behavior, and attention diagnoses predominate. There is minimal substance use reported but this is typical for youth to require time and trust to disclose.

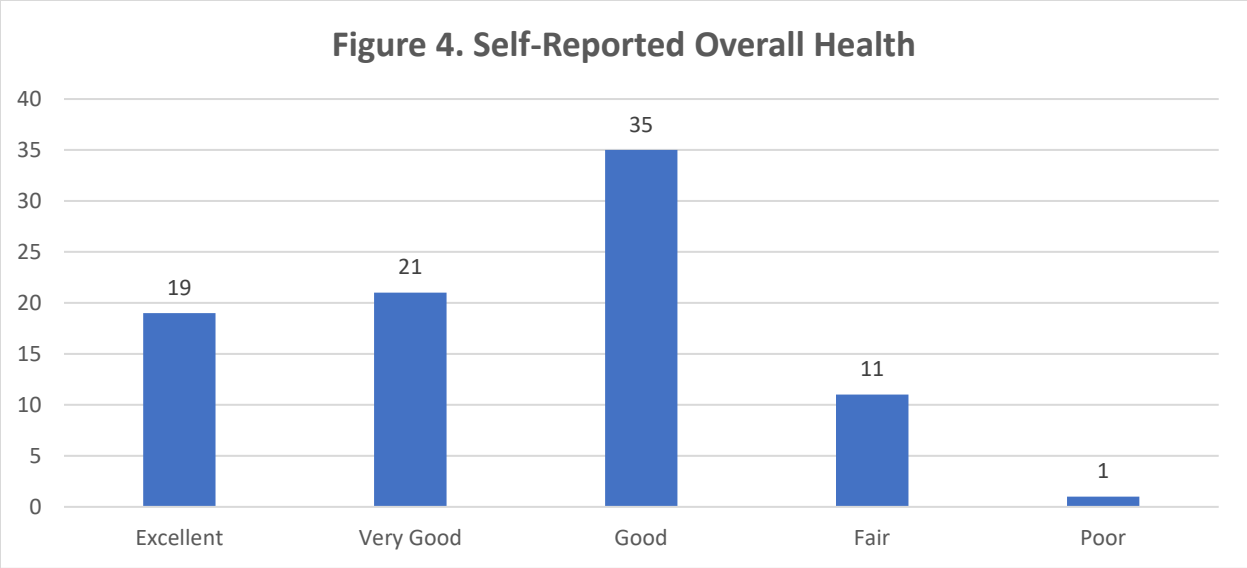
<u>Primary Diagnosis</u>

- Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders = 22
- Attention Deficit Hyperactivity Disorder = 11
- Conduct Disorder = 6
- Intellectual Disabilities = 6
- Major depressive disorder, recurrent = 6
- Persistent mood (affective) disorders = 4
- Alcohol use disorder, unspecified = 1
- Alcohol use disorder, moderate/severe, in remission = 1
- Bipolar disorder = 1
- Cannabis use disorder, unspecified = 1
- Cannabis use disorder, uncomplicated, moderate/severe = 1
- Major depressive disorder, single episode = 1
- Tobacco use disorder = 1
- Tobacco use disorder, in remission = 1

Secondary and Tertiary Diagnoses

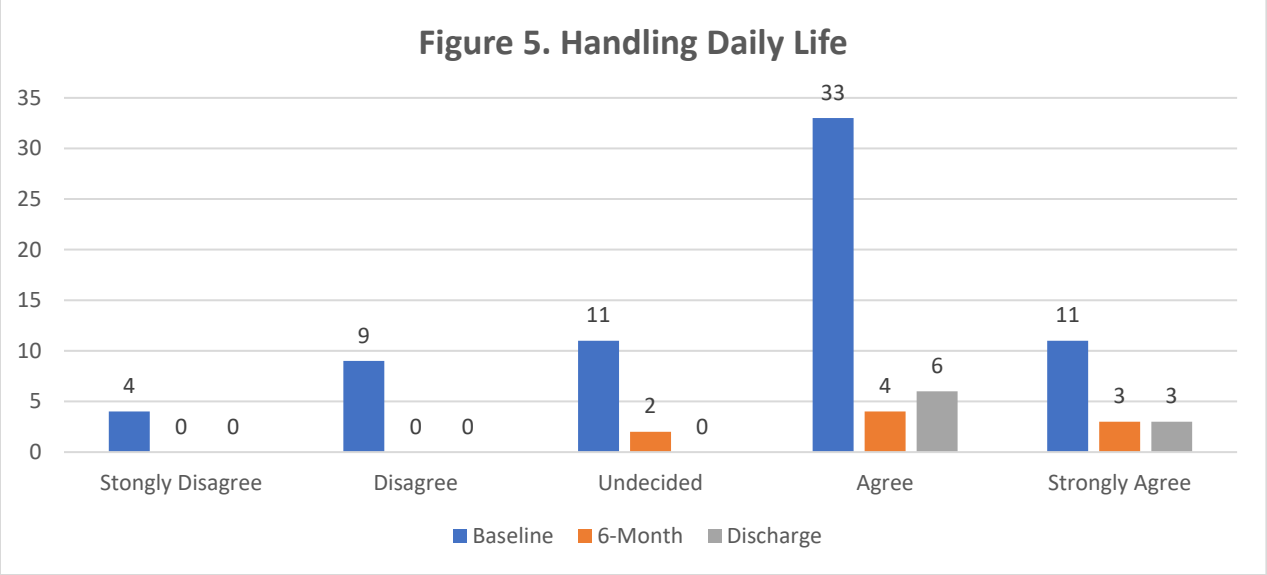
- Attention Deficit Hyperactivity Disorder = 19
- Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders = 18
- Conduct disorder = 13
- Major depressive disorder, recurrent = 5
- Major depressive disorder, single episode = 3
- Persistent mood (affective) disorders = 2
- Unspecified mood (affective) disorders = 2
- Disorders of social functioning with onset specific to childhood or adolescence = 1
- Intellectual Disabilities = 1
- Manic episode = 1
- Other behavioral and emotional disorders with onset usually occurring in childhood and adolescence = 1
- Sleep disorder not due to a substance or known physiological condition = 1
- Tobacco use disorder = 1

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. Seventy-five of 87 have good to excellent health. This is consistent with other analyses by the SOC-ET.

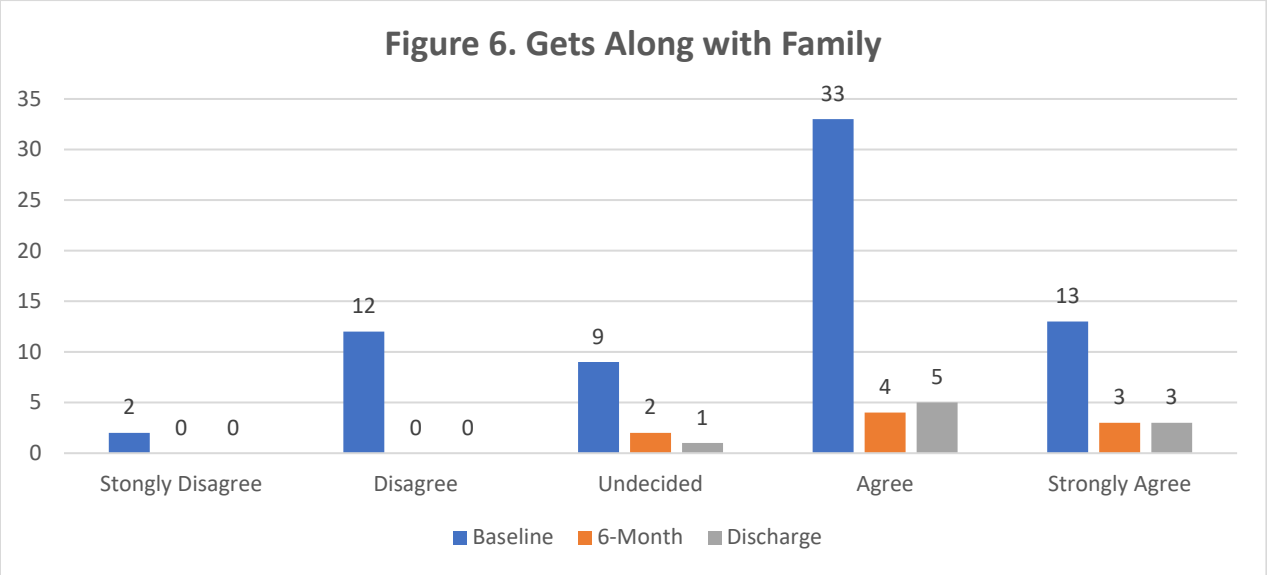


Functioning Data

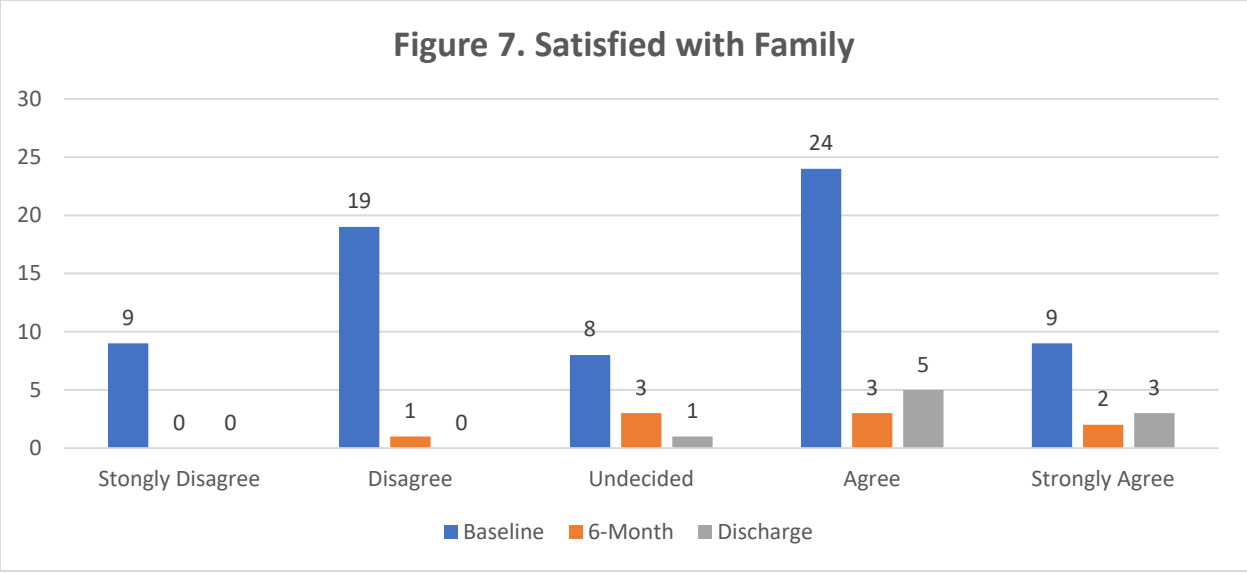
The NOMS assessment asks a series of questions around handling daily life stressors, coping and relationships with caregivers. Baseline and follow-up data are presented in a series of figures. Limited follow-up data requires caution in interpretation. It appears that about 35 percent of youth are not or undecided in handling daily life well (Figure 5). Follow-up data has nearly all respondents agreeing or strongly agreeing that they are handling daily life. When cross-referencing by unique ID, most respondents follow-up scores of agree or strongly agree also had these scores at baseline. Thus, improvement cannot be discerned yet for those with lower baseline scores.



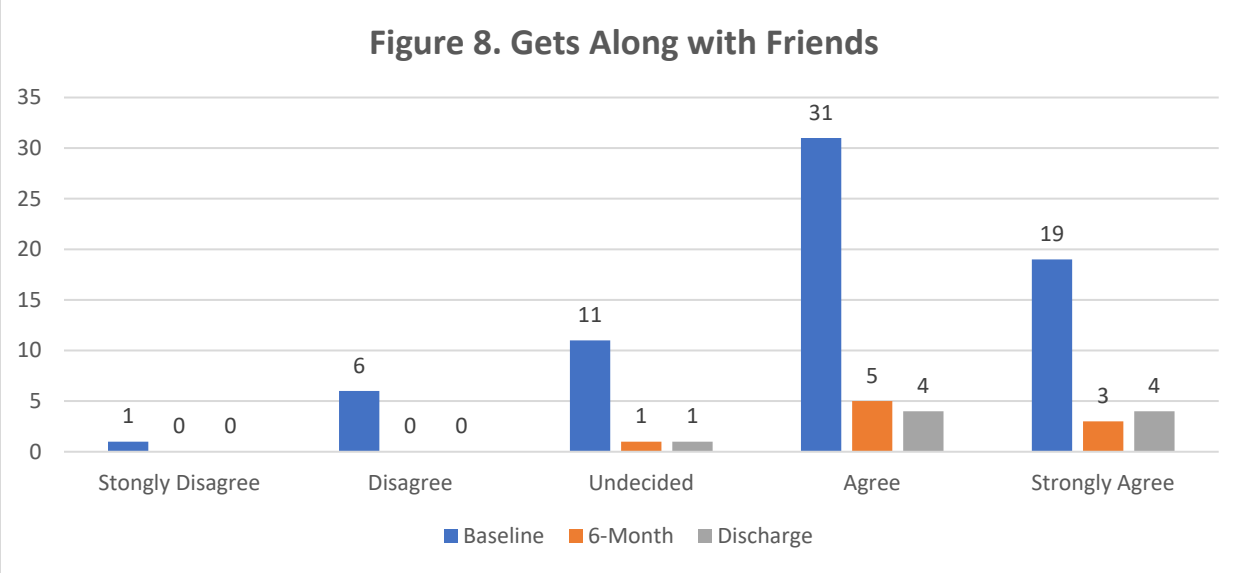
The next question queries respondents how well they get along with their family (Figure 6). About one-quarter of respondents are reported as not getting along with family or undecided. Matched follow-up finds seven youth that had undecided or lower scores improving at follow-up. This is stronger evidence of program impact.



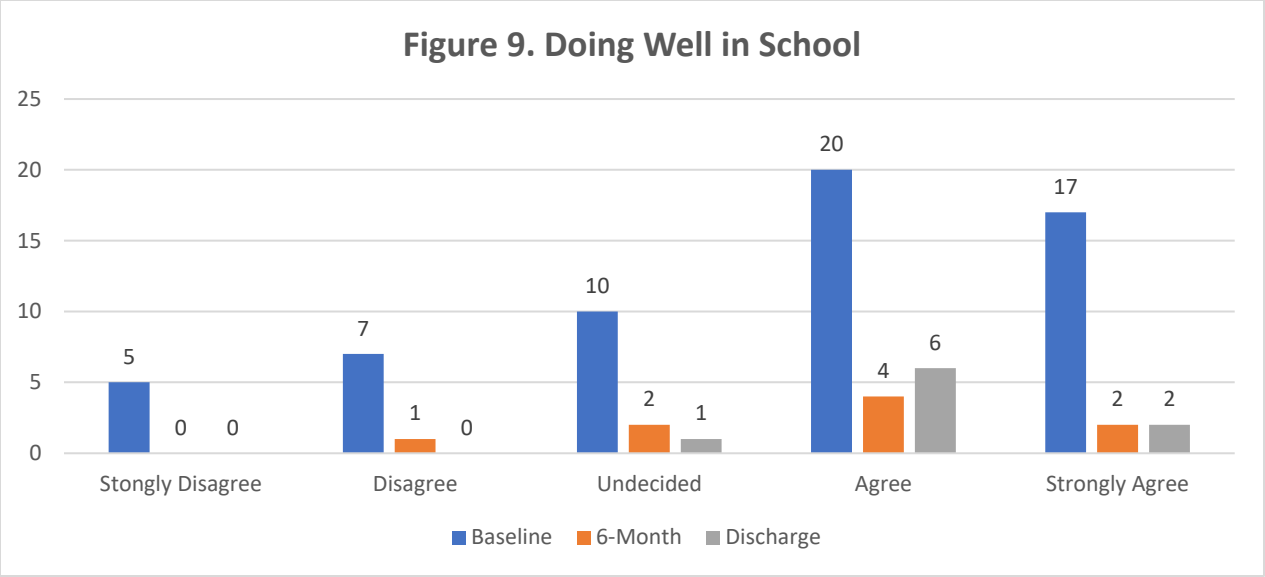
The next question reported is the last question in the NOMS cluster on functioning and is likely last to keep it further away from the previous question. We report it here because it relates to the previous question and reveals inconsistency in responses. This question asks whether the youth is satisfied with their family (Figure 7). It could be assumed that getting along would be consistent with satisfaction but that does not appear here. A Pearson Correlation was completed to determine consistency in direction and strength of these two responses. The findings were positive as expected, meaning responses from the two questions moved in the same direction, and was significant, but not of the magnitude expected ($r = .453$, $p \leq .000$). For getting along with family, 14 youth disagreed or strongly disagreed. This increases to 28, fully twice as many, for being satisfied with family. Eleven of 18 youth with follow-up data did report an increase in satisfaction with family.



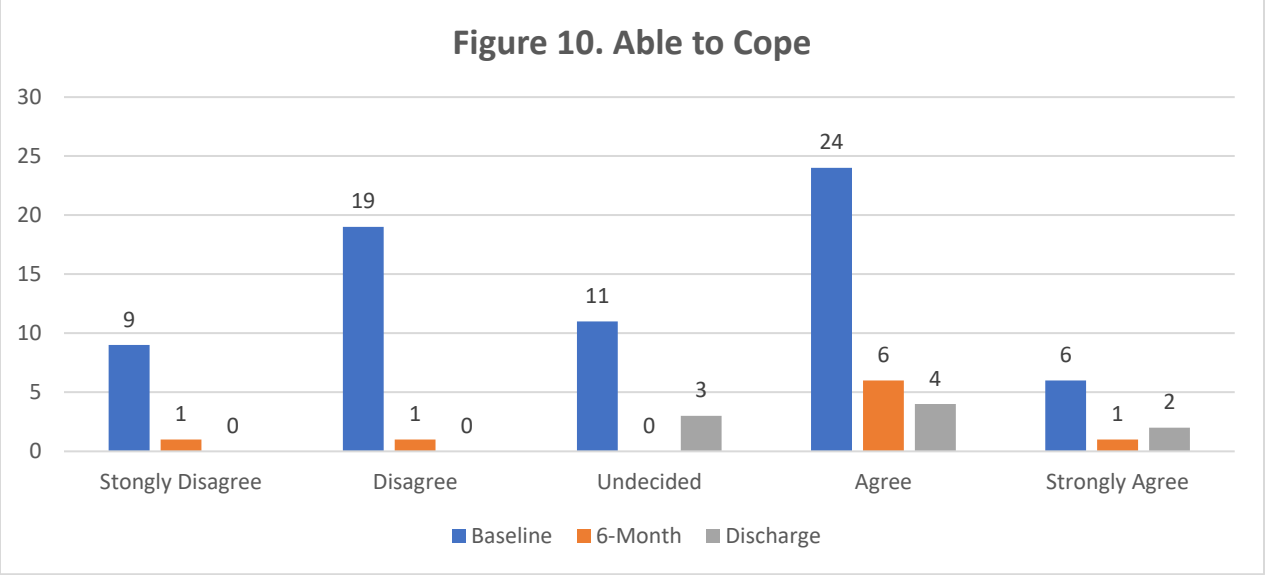
Youth were asked whether they were getting along with friends as well as with family (Figure 8). Past experiences with SOC grants suggests that this tends to be high at baseline and improves with service support. This is partially accurate. Compared to two other SOC grant evaluations, a smaller number of youth are in the agree and strongly agree responses at baseline. This will be monitored as more data is collected. Twenty-one percent of youth report being undecided or disagreeing at some level for getting along with friends. For the other grants noted, this was around 12%. Eight of 18 youth with follow-up data report improvement.



Respondents are asked to rate their level of agreement with how well they are doing in school (Figure 9). Approximately 29 percent are undecided or disagree at some level that they are doing well in school at baseline. This drops only slightly to 22 percent at follow-up, though the sample for follow-up is quite small. Nine of 18 do report an improvement in level of agreement.



The final question in this cluster reports on ability to cope (Figure 10). This is typically the area reporting greatest need and is so here as well. Of the 69 baseline surveys, 42% are undecided or disagree whether they can cope. This reduces to 11.1% for follow-up scores, a clear improvement. Ten of 18 respondents have improved when matched pairs are analyzed.



Functioning as a cluster or construct has improved though this is tentative with the small number of follow-up responses. This suggests that Y/FP and other interventions are successful, likely along with other improvements in the lives of the family that contribute to youth functioning.

Emotional/Mood Symptoms Data

A series of questions asking about symptoms related to mood are summarized in Table 16. There are only six follow-up responses in the NOMS data so baseline symptom experiences are reported only. It is unclear why this data is only collected for some at baseline but an inquiry will be made. Each question has the same pattern: "During the past 30 days, about how often did you feel _____." Being restless and everything being an effort are the most indicated as problematic. Feeling worthless and hopeless are usually warning signs for suicidal ideation and should be monitored by the Y/FP's.

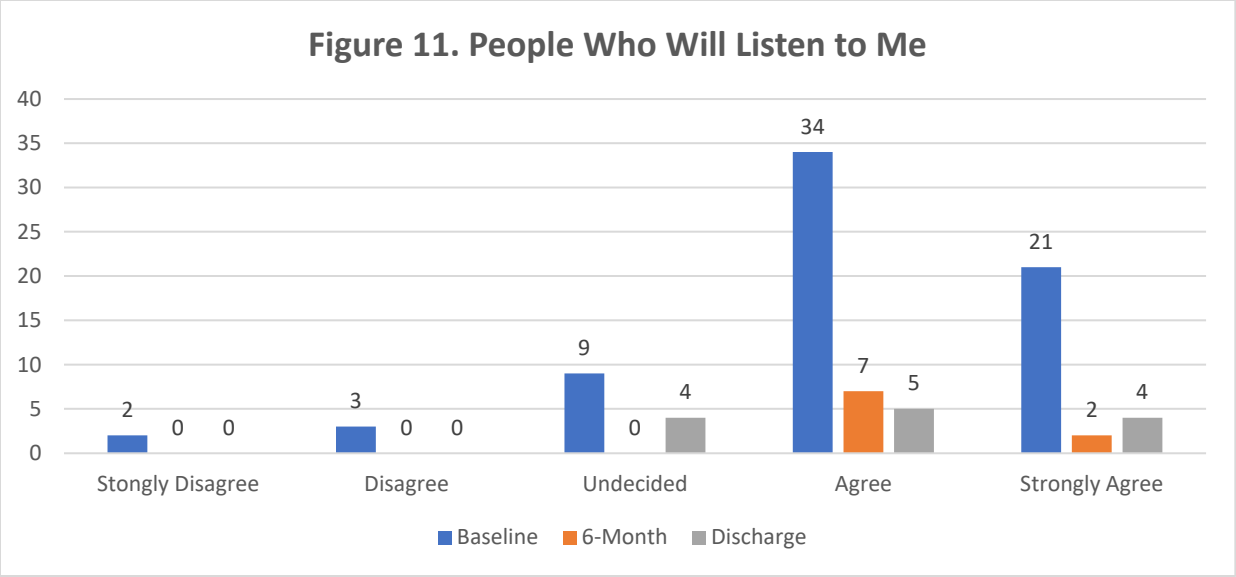
Table 16. Summary of Emotional Symptom Data (n = 26)

Question	None of the Time		A Little of the Time		Some of the Time		Most of the Time		All of the Time	
	n	%	n	%	n	%	n	%	n	%
Nervous	6	23.1	4	15.4	7	26.9	7	26.9	2	7.7
Hopeless	13	50.0	7	26.9	4	5.7	2	7.7		
Restless	6	23.1	1	3.8	4	15.4	11	42.3	4	15.4
Depressed	15	57.7	4	1.4	3	11.5	2	7.7	2	7.7
Everything is an Effort	7	29.2	4	16.7	5	20.8	4	16.7	4	16.7
Worthless	15	57.7	5	19.2	3	11.5	1	3.8	2	7.7

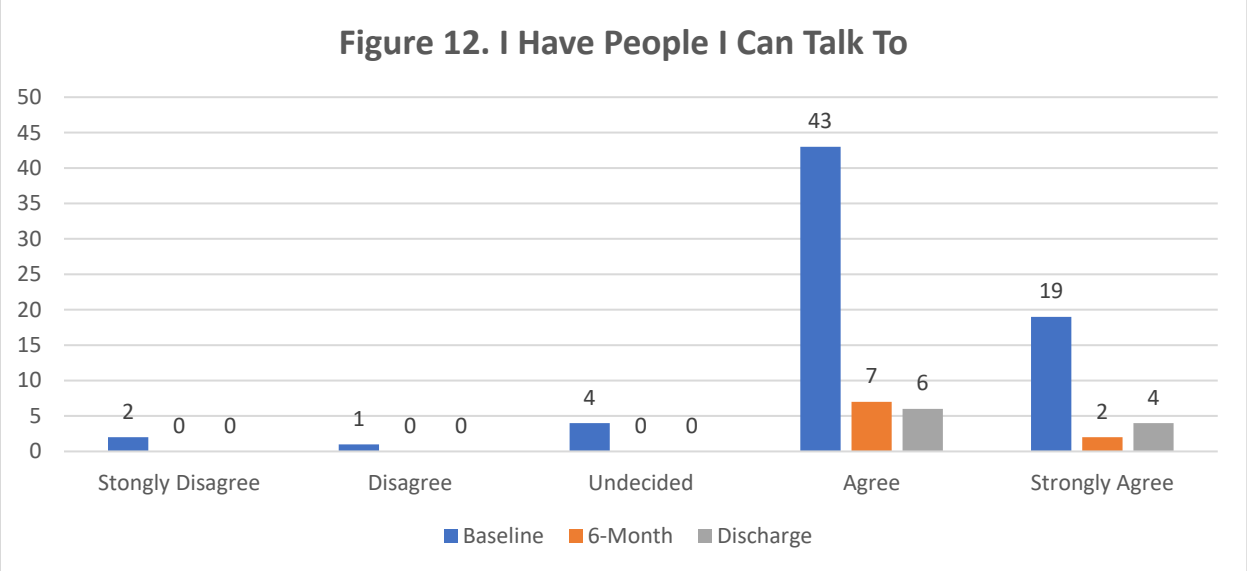
Social Connectedness Data

Connectedness is critical for resilience, self-esteem, academic success, and positive socialization. Social connectedness is assessed in four questions. The same form of analysis and reporting as functioning data is completed here as there are 69 baselines and 19 follow-up (combined 6-month and discharge) that can be reported. This is sufficient follow-up to get an idea of impact. Information is being reviewed for the functioning and social connectedness questions to determine if combining questions would be appropriate to have construct scores for each group. The degree of change for each question would partially determine that and additional follow-up data is needed.

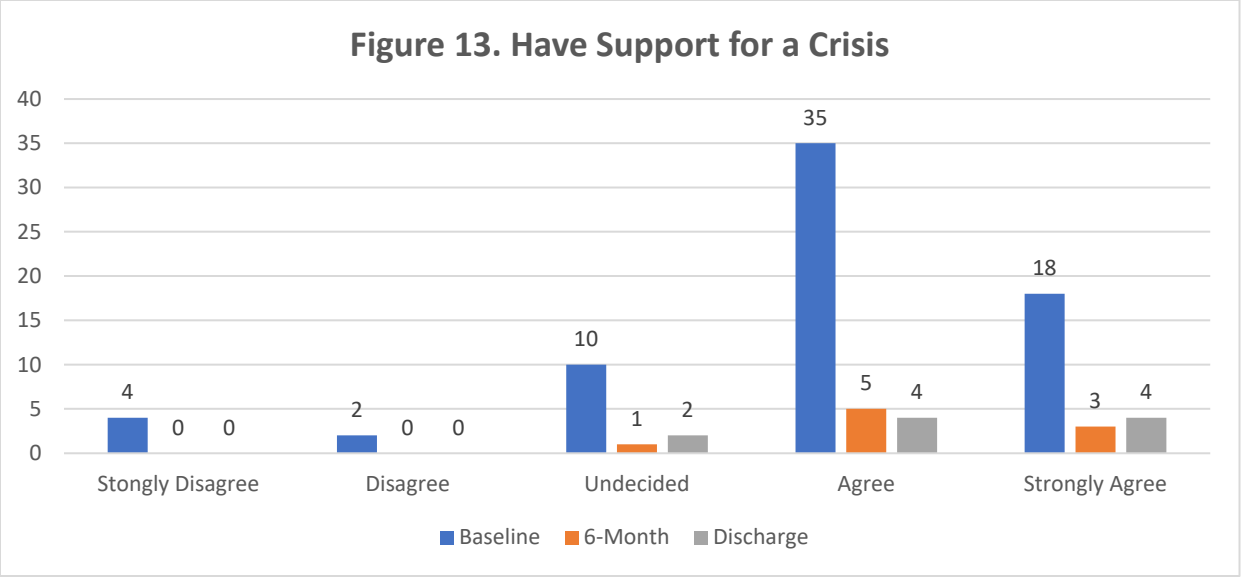
The first question assesses in general whether the youth believe that they have people that will listen to them and understand them when they have a need to talk (Figure 11). At baseline, 15 of 69 (20.2%) reported uncertainty or unavailability of support. At follow-up, eight of 19 matches (42%) improved, suggesting intervention effectiveness.



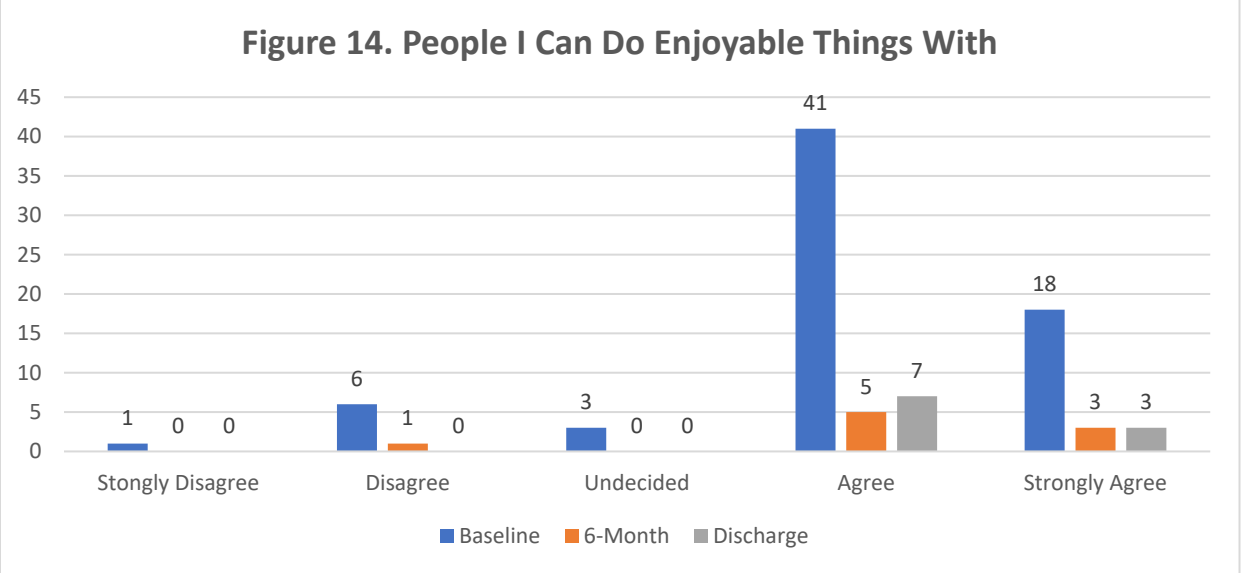
A reasonable extension of if you have people who will listen to you is do you have people you are comfortable talking to. Only seven at baseline (10%) were undecided or disagreed (Figure 12). This is a strong baseline score suggesting a ceiling effect at follow-up. Seven of 19 (36.8%) showed improvement. However, most of the other matches were matched scores for agree or strongly agree, showing no improvement but also no real need to improve.



Part of strong social connection is having one or more resourceful and caring individuals to turn to when in crisis (Figure 13). About 23% of youth report not having someone for a crisis at baseline. All six youth that disagreed at some level improved. Overall, for matched pairs, 12 of 19 (63%) improved in having someone to help with a crisis. This is considerable progress and will hopefully continue as more youth are enrolled and supported for at least 6-months.



The final question for this section asks youth if they have someone they can do enjoyable things with, to just have fun (Figure 14). Most youth affirmed this at baseline (87%) with some improvement noted at follow-up: 7 of 19 (36.8%). However, seven other respondents had baseline and follow-up at the agree or strongly agree level, limiting improvement potential on the available scale.



Other frequencies were run to capture distributions and most of the data is too sparse to comment on. These include number of youth that…:

- Tobacco use = 5
- Alcohol use = 4
- Cannabis use = 6

- Being hospitalized = 3
- Going to the Emergency Room = 5
- Incarcerated = 6

Satisfaction with Services

Individuals with follow-up or discharge NOMS are asked to rate services on a number of metrics. All questions use strongly disagree to strongly agree. No questions received a disagree or strongly disagree response and these are eliminated from Table 17. Treated respectfully, communicated with clearly, being available during a crisis and overall satisfaction were high. Including parents in planning and treatment can be reviewed for any tweaks for improvement. In most cases the families got the help they wanted and needed. Person-centered planning and including families as much as possible are excellent ideas that can have access and other barriers that impede them. Overall, the services are very well received and other areas in this report have evidence that supports impact.

Table 17. Summary of Satisfaction Related Questions (n = 19)

Question	Undecided		Agree		Strongly Agree	
	n	%	n	%	n	%
Treated with Respect			4	21.1	15	78.9
Respected religious beliefs			5	26.3	14	73.7
Spoke in an understandable way			3	15.8	16	84.2
Sensitive to culture	1	5.6	4	22.2	13	72.2
Freedom to choose child's services			8	42.1	11	57.9
Included in planning treatment goals	2	10.5	5	26.3	12	63.2
Participated in child's treatment	2	10.5	6	31.6	11	57.9
Satisfied with services			6	31.6	13	68.4
Team 'stuck with us'			5	26.3	14	73.7
Talked to me when troubled			10	52.6	9	47.4
We had the right services	1	5.3	6	31.6	12	63.2
Got the help we wanted	1	5.3	8	42.1	10	52.6
Got the help we needed	3	15.6	7	36.8	9	47.3

Combined Analysis

We combine data from the NOMS and Triple Screen in this section when possible given the limited NOMS data. The objective is to better tell the story of the youth and families served by integrating data. There is limited data to date and this first analysis will review NOMS data fields with sufficient data with trauma, life events and resilience data from the Triple Screen. The Spearman Rho Correlation Coefficient (Ƥ) will be used to determine the direction and strength of relationships (Table 18). There are some surprising findings. Three hypotheses are tested.

- Hypothesis 1: Increased number of trauma exposures will be significantly associated with decreasing functioning, health, and social connectedness. (Negative correlation)
- Hypothesis 2: Increasing number of life event scores will be significantly associated with decreasing functioning, health, and social connectedness. (Negative correlation)
- Hypothesis 3: Increasing resiliency measured by the resilience total score will be significantly associated with increasing functioning, health, and social connectedness. (Positive correlation)

The correlation analysis finds that increasing trauma scores results in significantly impaired functioning, specifically for handling daily life, getting along with family and friends, the ability to cope, and being satisfied with family. While in many ways common sense, it is somewhat startling to see this so clearly with such a small sample of youth. Further, accumulating trauma is significantly associated with reduction in overall health and is borderline significant for poor perception of support from family. No other social connectedness question is statistically significant. Hypothesis 1 is met for functioning and health but unmet for social connectedness, though the predicted direction of the correlation is confirmed.

Table 18. Correlation Analysis Summary for Trauma, Life Event and Resilience Scores with Selected Constructs/Questions from NOMS Survey

Functioning Questions	Ƥ	p-value	Health and Social Connectedness	Ƥ	p-value
Total Trauma Score					
Handling Daily Life	-.310	.015	Overall Health	-.267	.038
Gets Along with Family	-.406	.001	Listen and Understood	-.230	.069
Gets Along with Friends	-.390	.002	Comfortable Talking	-.164	.200
Doing Well in School	-.104	.458	Support from Family	-.247	.051
Ability to Cope	-.339	.007	Enjoyable People	-.131	.305
Satisfied with Family	-.320	.011			
Total Life Events Score					
Handling Daily Life	-.039	.763	Overall Health	.024	.853
Gets Along with Family	-.217	.091	Listen and Understood	.026	.841
Gets Along with Friends	-.157	.228	Comfortable Talking	-.098	.447
Doing Well in School	-.119	.395	Support from Family	-.071	.580
Ability to Cope	-.080	.539	Enjoyable People	-.126	.327
Satisfied with Family	-.044	.736			
Total Resilience Score					
Handling Daily Life	.006	.961	Overall Health	-.027	.838
Gets Along with Family	.026	.845	Listen and Understood	.010	.941
Gets Along with Friends	.006	.965	Comfortable Talking	.051	.693
Doing Well in School	.083	.556	Support from Family	.082	.528

Table 18. Correlation Analysis Summary for Trauma, Life Event and Resilience Scores with Selected Constructs/Questions from NOMS Survey					
Functioning Questions	**Ƥ**	**p-value**	**Health and Social Connectedness**	**Ƥ**	**p-value**
Ability to Cope	.067	.609	Enjoyable People	.090	.488
Satisfied with Family	.005	.971			

No functioning, health or social connectedness scores are notably associated with total life events score, though all but one is in the hypothesized direction. Hypothesis 2 is not met. Total resilience scores are markedly unassociated with functioning, health and connectedness though all but health are in the expected direction where, for example, functioning increases as resilience increases. Stronger resilience is supposed to be related to improvements in all question areas selected as noted in the hypothesis. Hypothesis 3 is also not met.

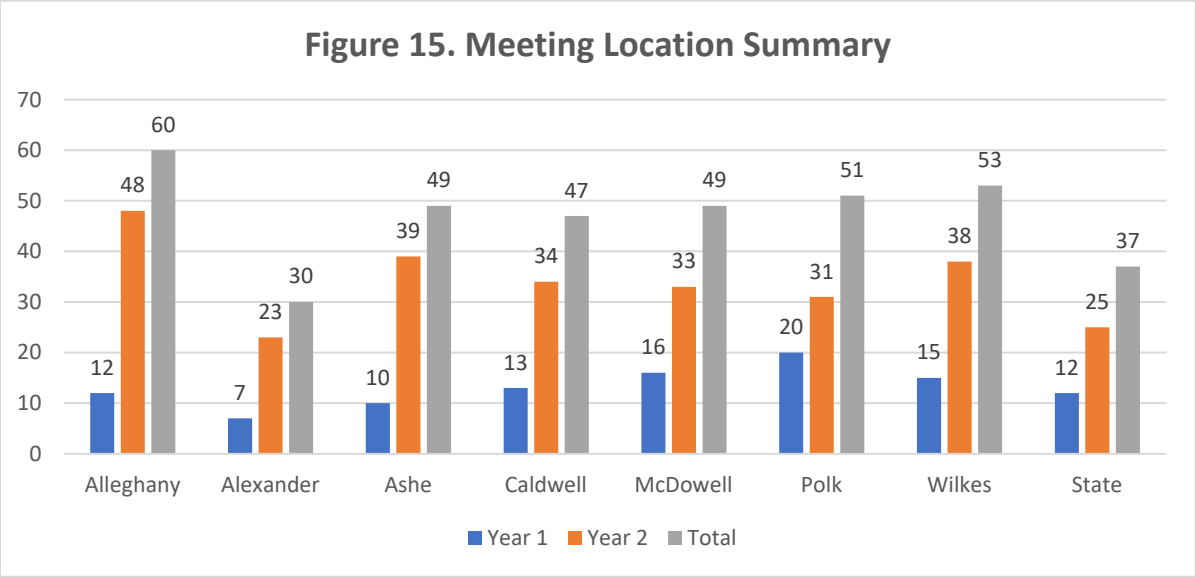
Collaborative Support and Training (Field Note)

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. We include Year 1 and Year 2 data for comparison and to summarize the collaborative support. 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 field note also tracks training information including which trainings were offered and the number of those that attended. This information was reported in the IPP Data section and is not repeated here.

The second major source of information is process tracking information from the combined SOC-IT and SOC-ET efforts with collaboration support. Collaboratives are essential for disseminating the principles and information around SOC and for planning/supporting activities and trainings to improve mental health infrastructure for children in the seven target counties. Information includes extraction from meeting agendas, minutes and documents/information shared at meetings.

The SOC-IT and/or SOC-ET attended 197 meetings documented in the field note, a substantial increase over the 65 in Year 1. This does not include all contacts as noted earlier. Figure 15 summarizes the number of meetings attended specific to each county for Years 1 and 2 as well as meetings that were related to state SOC information and activities. The total is greater than the number of meetings because 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 in Year 1 was held in Rutherford County, outside the catchment area, but relevant to SOC implementation in the target counties. Year 2

had one meeting in High Country County to meet with the local National Alliance for the Mentally Ill (NAMI) group and one other for Lead Family Coordinators in an unspecified county.



Content of meetings was assessed in the field note by selecting the information categories most relevant to the meeting. One new category, School Mental Health, was introduced in Year 2 in response to an initiative at the state level. Total numbers are also greater than the number of meetings held since it was common to discuss multiple topics in meetings. Table 19 lists meeting content by total number of each content area addressed from most to least for Year 2. We included Year 1 for comparison of areas of focus and what was prioritized. While in Year 1 the most common topic was systems of care, reasonable as the stakeholders learned about SOC and the grant, this was strongly replaced by the emphasis on family and youth involvement and voice. An increase of approximately 2.5 times. Collaborative development and support, only a target topic twice in Year 1, was the second most included topic with 79 meetings in Year 2. The next four topics, SOC to trauma/resilience were in line with SOC Year 2 goals and provides strong process level data that the implementation plan for Year 2 was followed with fidelity.

The topic of sustaining the gains from the SOC grant seed dollars has increased a great deal in Year 2 and is noted and accounts for the increase in emphasis on stable funding. The state required collaboratives to better understand data and how it is used for planning and outcomes and used RBA as the approach. Hence, the increase in RBA from eight mentions in Year 1 to 52 in Year 2. Other notable changes are the focus on training, juvenile justice, prevention, policy, promotion, and special education services and systems in the school districts.

There were also some notable decreases, two of which are worthy of further review as barriers to family stability. Supporting parents is especially important given the high percentage of parents with mental health and substance use issues from Triple Screen data. The topic of parent mental health and substance use treatment decreased from a meager 20 mentions in

Year 1 to only eight in Year 2. We remind the reader that 42.7 percent of youth assessed by the SOC have a parent with a mental health and substance use disorder. While the sample size may not be compelling, we add that a SOC Expansion Grant completed in central North Carolina and ending last year had 48.9% of youth with a parent with mental health and/or substance use issues with a sample size of 3,216. The other area of concern is the reduction of emphasis on children in foster care. The leading reasons for children in foster care according to the NC Opioid Dashboard is parents use of opioids. We strongly recommend that parent health be a clear focus when possible in Year 3.

Table 19. Summary of Meeting Content Frequency							
Content	**Y1**	**Y2**	**Total**	**Content**	**Y1**	**Y2**	**Total**
Family Youth and Involvement/Voice	41	107	148	Mental Health and/or Substance Use Promotion	8	37	45
Collaborative Support, Development or Technical Assistance	2	79	81	Special Education/Education System	18	33	51
System of Care (SOC) – General	51	76	127	Other	11	30	41
Resource Development	28	58	86	Social Determinants of Health (SDOH)	22	14	36
Service Delivery/Treatment Services	44	54	98	COVID-19	14	13	27
Trauma & Resilience	29	54	83	Medicaid	13	13	26
Funding, Grants	31	52	83	School Mental Health		13	13
Results Based Accountability (RBA)	8	52	60	Historical Trauma/Cultural Sensitivity	10	13	23
Training Planning or Impact Discussion	16	51	67	Child Welfare other than Foster Care	6	12	18
Juvenile Justice	10	51	61	Intellectual or Developmental Disabilities	12	11	23
Mental Health and/or Substance Use Prevention	23	48	71	Parent Mental Health and/or Substance Use Needs/Treatment	20	8	28
Family/Youth Advocacy	30	46	76	Foster Care	20	7	27
Policy & Practices	20	37	57				

The following is an alphabetical list of “Other” content areas from the narrative text field included in the field note.

- Discussion about date and logistics of proposed "Family Fun Day" to increase awareness of programs and recruit families/youth for future projects
- Discussion of how to "refocus" Youth Task Force because of new leadership and fewer members
- Discussion of recruiting, training and support for families and youth

- Early Childhood services
- Family engagement and advocacy. Millie shared services and resources offered by FREDLA; Discussion with Stacy to provide training and support to collaboratives around family engagement.
- Increase awareness around mental health issues and resources in the community
- Introduced and discussed formation of Child Collaborative in Alexander County with Group
- Leadership planning or role development (x2)
- LGBTQIA youth mental health
- Meeting between Vanessa and Justin Kearly/NC Health Equity Grant. Discussed grant and potential youth collaboration.
- Met with Robin who is the head of a Youth Move chapter that serves the above counties
- Overview of work to date and break out into workgroups to begin outreach for grant.
- Partnership opportunities, reboot of SOC meeting (x2)
- Planning a community resource fair
- Planning for Community Safety Fair
- Plans for RBA Project
- RBA project planning and Meeting agenda discussion
- Selecting and next steps for Collaborative Project
- Services around Child and Youth Special Healthcare needs
- Specific acute needs of Latinx community in McDowell County
- Specific resources for the Latinx community
- Subgroup meeting to discuss proposal of "resilience corners" for the high school and how the grant/task force could support
- Suicide awareness, mental health awareness, community building
- Sustainability for LFC position/work
- Transitional Age Youth Expo discussion
- Wide range of topics discussed including climate of the county, people to contact re: collaborative, date/time, mission statement and leadership ideas.

Counties, as expected, have different priorities and Table 20 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. There is a fair amount of diversity noted across counties. Some had more obvious areas of focus, e.g., Alexander’s focus on Family/Youth Voice and Juvenile Justice. Noted prior, the focus on collaborative development and RBA were state led and thus expected. Below Table #, the analysis from Year 1 is included for those interested in comparing (Table 21).

Table 20. YEAR 2 Meeting Content by Location County									
Content Area	**n**	**Alleghany**	**Alexander**	**Ashe**	**Caldwell**	**McDowell**	**Polk**	**Wilkes**	**State**
Family Youth Involvement/Voice	107	27	11	14	7	19	14	17	16
Collaborative Support, Development or Technical Assistance	79	18	2	12	1	16	15	15	3
System of Care (SOC) – General	76	18	8	7	6	14	7	11	14
Resource Development	58	16	5	11	2	12	7	2	5
Service Delivery/Treatment Services	54	8	4	12	7	13	5	6	3
Trauma & Resilience	54	12	2	10	7	5	12	5	2
Funding, Grants	52	15	5	9	3	9	7	6	3
Results Based Accountability (RBA)	52	8	2	5		8	15	10	3
Training Planning or Impact Discussion	51	16	3	5	5	7	15	5	3
Juvenile Justice	51	4	11	4	11	4	2	18	2
Mental Health and/or Substance Use Prevention	48	12	1	12	1	13	7	3	1
Family/Youth Advocacy	46	19	5	9	5	7	5	8	7
Policy & Practices	37	10	3	2	3	6	2	4	6
Mental Health and/or Substance Use Promotion	37	8		5	1	10	9	3	2
Special Education/ System	33	3	2	9	4	6	3		6
Other	30	5	1	7		5	3	3	5
Social Determinants of Health (SDOH)	14	4	2	3		4	1		1
COVID-19	13	8		1	1	1		2	1
Medicaid	13		2	1	2	1	3		3
School Mental Health	13	1	1	3	1		2	1	3
Historical Trauma/Cultural Sensitivity	13	2		1	5	2	2	1	
Child Welfare other than Foster Care	12	1	5			4	1		1
Intellectual or Developmental Disabilities	11			1	2	3	1		4
Parent Mental Health and/or Substance Use Needs/Treatment	8	2		1		3	2		
Foster Care	7	1	2		1	1	1	1	

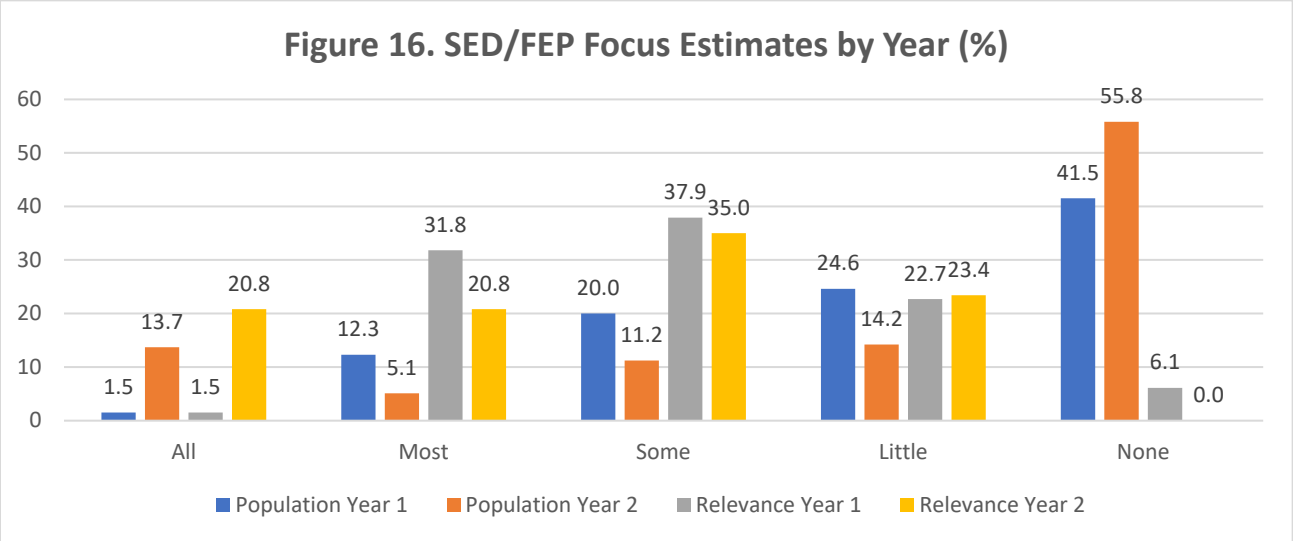
Table 21. YEAR 1 Meeting Content by Location County									
Content Area	**n**	**Alleghany**	**Alexander**	**Ashe**	**Caldwell**	**McDowell**	**Polk**	**Wilkes**	**State**
System of Care (SOC) – General	51	11	7	6	5	10	16	9	8
Service Delivery/Treatment Services	44	8	4	5	3	4	10	8	4
Family Youth Involvement/Voice	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		

A final request 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.

- 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**)

Findings are summarized in Figure 16. 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%) in Year 1 and reduced somewhat to 30.0% in Year 2. A noticeable change, however, is SED as the exclusive topic of meetings increasing from 1.5% 13.7%. There were concomitant reductions in 'most' and 'some' of the time but in this case we can state that this was quality over quantity. The topics discussed were relevant to the population some to all of the time over two-thirds of the time (71.2%) in Year 1. This increased to 76.6% in Year 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. Review of qualitative data suggests that the focus on developing the collaboratives, improving their data management capacity, and providing support for completion of RBA projects accounted for the increase in the 'none' selection for population but also for the reduction to zero of collaborative meetings having no relevance to the SED/FEP population.



Collaborative/Task Force Support

Part of the SOC-ET's task starting partway through Year 2 was to further development of the County SOC Collaboratives or Task Forces (hereafter referred to as Collaboratives) with additional emphasis on children, youth and family mental health and wellness. This started with a readiness assessment that is summarized in the next sub-section. A brief overview of each collaborative follows. In addition, the SOC-ET has been supporting development of an RBA framework and use of RBA in each collaborative. Progress has hinged on the preparedness of the collaboratives including stability and leadership. All collaboratives have shown progress.

Readiness Assessments (RA)

Readiness was estimated via combining survey and interview data for five collaboratives. Resource limitations had five collaboratives as primary support targets though all seven collaboratives are being engaged. An electronic survey was used to assess specific information and Collaborative leadership was interviewed. The first RA question inquired the degree that the collaborative focused on the SOC grant target group, children birth to 21 years with or at risk of a serious emotional disturbance (SED) or a first episode psychosis (FEP):

- 2 = Yes, exclusively
- 3 = Not specifically but do include the target group as described

The NC State Government has increased focus on SOC as a mandatory model to be incorporated at into the MH/SUD service system for children/youth. This would require that each Collaborative understand what SOC is, the expectations of the state, and how the grant funded counties fits into the overarching SOC focus (Table 22). As can be seen, additional work was required to better embed what SOC is into the collaboratives.

Table 22. Collaborative Understanding of SOC

Readiness Assessment Question	Very Well	Good	Somewhat	Not Well
Understand SOC principles and practices	2	1		2
SOC expectations of the state		1	2	2
How the SOC grant fits into state SOC expectations		2	1	2

Infrastructure and documentation for collaboratives is essential for efficient implementation of activities, as a buffer against turnover impacts, support for data-driven decision-making and for remaining consistent with collaborative missions. A series of questions were asked to determine level of infrastructure (Table 23). The Collaboratives when first engaged had the basics of infrastructure in place and required support to further enhance their capabilities. An unfortunate level of turnover in leadership and membership for several collaboratives impeded internalization of support and continues to be an issue. Collaboratives are not required to have all the items listed in Table 23. It was strongly recommended that the first six items were completed as part of efficient leadership and ensuring against loss of collaborative capacity for when leadership turnover occurred.

Table 23. Infrastructure Summary for Collaboratives

Item	Yes	Partial	No	N/A
Mission/Mission Statement	4	1		
Vision/Vision Statement	2	1	2	
Written purpose of the collaborative	2	1	2	
Clearly defined roles	1	3	1	

Table 23. Infrastructure Summary for Collaboratives				
Item	**Yes**	**Partial**	**No**	**N/A**
Clearly defined goals and/or objectives or outcomes		4	1	
Job/leadership descriptions		1	4	
Organizational chart		1	4	
Bylaws and/or guidelines for operations	1		4	
Board of Directors of some other advisory group		4		1

Community engagement, sharing of information, networking and resource development and sharing are key for collaborative success. Having a varied membership and ensuring that members were of the community whenever possible strengthens collaboratives and improves their impact. Questions targeting community engagement were asked with a wide variation in responses (Table 24). Generating and sharing information and resources were the strongest for respondents but also emphasized the limitation of focusing on sharing provider information and related without challenging the development of community SOC. Each question was asked for how well the collaborative did the following:

Table 24. Community Engagement Summary					
Item	**Very Well**	**Good**	**Somewhat**	**Not Well**	**N/A**
Share information	1	4			
Generate information	1	3	1		
Share resources	3	1	1		
Develop resources		2	1	1	1
Identify barriers to services and supports	1	1	3		
Identify solutions to overcome barriers	2	1	1		1
Connect agencies with each other, building denser networks	1	3	1		
Help reach consensus between organizations	1	1	1	1	1

Understanding data, managing data, collecting, analyzing and using data for decision-making is strongly emphasized for supporting collaboratives and for embracing RBA as standard operation of the collaborative. Hence, a series of questions assessing confidence levels in the basics of data was asked in the RA (Table 25). Overall, confidence was moderate to low for data management. This does not mean a lack of capacity but more the lack of time and willingness to engage with data for the collaboratives. Many of the members work with data and in some cases lead the use of data in their home organizations. Elevating collaboratives to be more impactful using data was not a common thought for collaborative members though nearly all saw the reason and the possible effect of doing so.

Table 25. Perceived Data Management Capacity				
Item	**Very Confident**	**Confident**	**Somewhat Confident**	**Not Confident**
Collecting data specific to your objectives	1	2	1	1
Storing and managing data	1	1	2	1
Reviewing, cleaning, and validating data	1	1	2	1
Data analysis		2	2	1
Reporting/sharing results	1	2	1	1

Collaboratives sustain and thrive in part based on their ability to influence the community and the organizations with similar visions and target populations. Influence for the survey was defined as making substantive and measurable changes directly or through leveraging networks to meet the collaboratives mission and goals. No respondents believed they were very influential with none selecting highly influential or influential as value options.

- 2 = Somewhat influential
- 1 = Not influential at all
- 2 = N/A, collaborative was less than one year old

Stable collaborative membership is essential for facilitating, sustaining the collaborative, meeting objectives and for influence. Stability for the assessment was defined as at least half of the membership regularly attending meetings and/or membership remains stable and involved for at least a year. Again, there was a wide variation in responses:

- 1 = Very stable
- 2 = Stable
- 1 = Somewhat stable
- 1 = Unstable

Each collaborative was asked if they would like to discuss support to complete a SWOT (Strengths, Weak, Opportunities, Threats) analysis. All five agreed they would like to discuss the option and this was included as part of ongoing communication. While no formal SWOT process was started elements were included in support of collaboratives. Collaboratives were also asked whether they completed any type of reports or other summaries for their collaboratives. None of the collaboratives are doing so though the RBA projects are being documented with support.

The final question for the RA was for the respondents to select where their collaborative is in its development using the forming, storming, norming, performing, or mourning/reforming scale. Forming and Storming were selected:

- 3 = Forming: Beginning stages of development. Mission and vision are forming, target population and preliminary reasons are being defined, orientation is a focus, structure is being created, goals defined, leadership and roles/tasks defined.
- 2 = Storming: Negotiation of member assignments, skill development, goals are further specified along with objectives and outcomes, possible conflicts, more engagement and buy-in and member retention, roles and tasks are further established, and the members are learning to work together.

Current State of the Collaboratives and RBA Project Summaries

The SOC-ET is supporting collaboratives in infrastructure development, data management and RBA projects. A brief summary of the current status of each collaborative follows. For those with established RBA projects, review of data and other information is summarized.

Alexander County Child Collaborative

The Alexander Collaborative was re-established in July and has been focused on growing their membership and supporting the required county Community Health Assessment. Top issues identified were substance abuse, abuse and neglect, and poverty. Members are in the process of locating data to guide development for goals and the mission statement.

Members that are from partnering service providers and other resource organizations are locating and organizing child well-being data. Alexander County is medically underserved for both physical and mental health needs. For instance, the Health Department has shared data on infant mortality. There has been a significant increase in infant deaths rising from 5.3 2008-2012 to 7.3 2013-2017. There is no clear indication of the cause of the rise, but this does indicate a need for "safe sleep" education for parents and caregivers. The DSS representative on the Collaborative reports they need more therapeutic placement for foster kids who have suffered severe trauma. The Taylorsville Times news is planning on writing a story on DSS. The need for parenting education was also discussed.

A representative from the Taylorsville Police Department reported that narcotic use in Alexander County is overwhelming. Meth and Fentanyl are big issues in the community. Alexander is a poor, rural county with a small population. In total, there is one narcotics officer in the town of Taylorsville, and two in Alexander County. The problem of substance abuse is greater than the resources available. There are two local SUD service providers that provide limited services to youth and adults. Families often must receive care out of county.

Davis Hospital in nearby Iredell County will be transitioning in the near future to a Behavioral Health Facility only and will be able to serve persons from Alexander County, but this still requires transportation out of county which is a strain on families. Other MH/SU services out of county for Alexander include Jonas Hill, Holly Hills (for pediatric patients); Child Behavior Health Unit in Charlotte; Caiyalynn Burrell Child Crisis Center in Asheville; Monarch in Charlotte (for immediate help).

Planned Next Steps:

- Finalize a target for the RBA Process and implement with SOC-IP and SOC-ET support.
- Seek out and identify additional mental health providers for Alexander County.
- Figure out how to increase the providers coming into this community.
- Recruit more members to become involved in the collaborative especially parents, faith-based leaders, local medical providers, senior center employees, and others who serve families in the County.

Alleghany Youth Task Force

Alleghany developed their mission and direction this year while undergoing changes in leadership and focus.

> Mission: To promote health and wellness, provide education materials, recommend services for youth in our area, and provide trauma-informed material/resources to caregivers and organizations.

The task force incorporates the ACES survey to explain how trauma can affect youth and a community, consistent with the trauma assessment completed for the SOC. Task Force objectives are to destigmatize mental/behavioral health, create inclusive and safe environments, to build resiliency, and to positively influence the health and wellness of the community.

Each Collaborative/Task Force was asked to identify a group priority. Alleghany selected Family and Youth Engagement. Information supporting this choice includes:

- The top priorities from the Community Health Improvement Plan from 2022: 1) Family & social support; 2) Mental/ Behavioral Health; 3) Substance Use and Misuse
- This Task Force is driven by the Western Youth Network to fulfill several internal grant program objectives. Vaya has struggled to share and develop in this space.
- The WYN Community Health team uses the 7 Strategies for Community Change which is vital in preventing substance misuse and supporting mental health. Successful implementation of these strategies discourages alcohol and substance use among youth.

As a project, Vaya participated in their Resiliency table at community safety event and collected 39 surveys of individuals who came to the table. CSI developed the survey and process of intentionality at the event. The following summarizes the information from the event:

Four questions were asked in a brief survey after receiving information about resiliency and its importance to health and wellbeing/wellness for youth. The first two questions used a retrospective pre- post format. This was moderately successful but the responses from some of the respondents suggested that how to answer the questions was not clear. Overall, most of the 39 respondents followed directions for completing the survey. Respondents were asked to

select their agreement on an eight-point scale that included strong disagreement, score of 1, to strong agreement, score of 8. To test if there were significant improvements for paired questions, the paired sample t-test was used. This determines if the change in average scores was likely due to the activity/intervention or was possibly a product of chance. For the two questions, the following information is given. The average score before the activity (baseline) and after (follow-up). The standard deviation (Sd) at before and after. The Sd is an indicator of likeness or similarity between respondent scores. The smaller the number, the higher the shared understanding. The t-score, which is the statistical result of comparing baseline and follow-up averages for how much change occurred, is noted. Lastly, the p-value, which determines if the result of the t-test analysis is significant. Any score of .05 or smaller indicates that the results are unlikely due to chance. If the finding is exactly .05, then the results are 95% likely to NOT be due to chance, meaning the activity was a change agent.

Question 1. "I understand how resiliency is important to my child's health and wellbeing."

Before Activity Score

Average: 7.05
Standard Deviation (Sd): 1.76

After Activity Score

Average: 7.89
Sd: 0.31

Paired Sample t-Test Result

t = 3.080
p = .004

Most respondents had a strong agreement prior to the activity that resilience is important to health and wellbeing. In fact, 28 of 39 respondents selected the highest agreement level at pre-test (before activity), which resulted in a strong ceiling effect for the data. The before activity Sd had a higher level of spread, indicating lower agreement between participants, which decreased significantly after the activity, suggesting that the group were answering similarly after exposure to the activity. This is further supported by the increase in average score. Despite these limitations, the t-test findings suggests that there was significant improvement in understanding the importance of resiliency.

Question 2. "Have you practiced resiliency 'connection' with your child before today and will you after today?"

Before Activity Score

Average: 6.58
Standard Deviation (Sd): 2.09

After Activity Score

Average: 7.57
Sd: 1.30

Paired Sample t-Test Result
t = 3.277
p = .002

The activity identified the purpose and benefits of connecting with a child to develop their resiliency. Like question 1, the average at baseline was high but not as high, providing additional room for improvement. The after-activity score was higher, demonstrating an impact. The reduction in Sd scores indicates that the respondents improved in their common agreement for engaging in more resiliency connection activities. The t-test results show a strong and statistically significant change in willingness to engage in connection activities.

Questions 1 and 2 suggest that respondents had a change in understanding and willingness to engage in connection activities with their children that was greater than chance and likely due to engaging in resiliency activities and dialogue with Task Force members at the safety event.

Question 3. "Resilience activities to do when you get home, what will you use and how?"

Three options for activities were included on the survey as well as space to enter other resilience connection activities. Of the 39, 24 respondents indicated that they would (1) read a book together with their child; (2) color together; and (3) play music together. The same score of 24 is a coincidence as the affirmative responses were distributed across the respondents and do not represent the same 24 people with identical responses. Additional connecting activities written by respondents included:

- Going outside or walking
- Walking/running together
- Playing outside
- Having a dance party or cooking together
- Playing in sand together.

Question 4. "Did you know about the Alleghany Youth Task Force prior to today?"

This was a yes/no response question. Seven of 39 respondents, around 18 percent, had heard of the Task Force before. This implies that improving the visibility of the Task Force and the good work being done is needed.

Question 5. "Please share your contact information below if you would like to be involved in the Alleghany Task Force."

Those interested were asked to write in their first name, phone number and email address if interested. Only four individuals did not put some information into the survey. Most entered

their full name and both or either an email address or phone number. A spreadsheet with all data, including contact information, is included back to the Task Force.

A concern is that the information was often illegible, especially for name and email. Data entry had two individuals review each submission and to come to a consensus when needed. Improvements to the survey have been noted and the survey updated for the next safety event or other event that would allow resiliency to be targeted.

Ashe Youth Task Force

The Ashe Youth Task Force also developed their mission this year and is concentrating on recruitment and retention of members. The ACES survey is also incorporated. Alleghany and Ashe Task Forces are coordinated.

> Mission: to promote health and wellness, provide education materials, recommend services for youth in our area, and provide trauma-informed material/resources to caregivers and organizations.

The Group Priorities include**:** Trauma and Resilience, Family and Youth Engagement

The SOC-ET helped the group develop the funding proposal using an RBA framework for Resiliency Kits for 950 students grades 9-12 to increase emotional management and regulation. The team also helped in the development of a survey that will be launched by the school district when the resiliency kits are completely assembled and ready for distribution.

Caldwell County Child Collaborative

Caldwell County has not required as much support. However, there are clear indicators that there are reach barriers in the county and fragmentation that is preventing incorporation and collaboration with marginalized populations including Spanish speaking and the LGTBQ+ population. The SOC-ET completed a 4-hour training focused on SOC principles and activities, data management, and RBA. In retrospect, this was too long and without sufficient shared activities for impact. Other notable events:

- The Child Collaborative is heavily aligned with JCPC and have focused on a project sponsoring art classes and an art show with JJ youth.
- The SOC-ET completed a 4-hour training focused on SOC principles and activities, data management, and RBA. In retrospect, this was too long and without sufficient shared activities for impact. This was for the “Know Your Neighbor” Team and grant.
- Staff attended a strategic planning session that followed to help create goals, objectives and actions steps from the county data represented.

McDowell County Child Collaborative

The McDowell County Child Collaborative has the following mission:

Mission: To build and enhance meaningful connections between families, youth, agencies, and the greater community.

Objectives of the collaborative are to develop partnerships to strengthen, support, and advocate for families while identifying and addressing gaps in resources. The Collaborative strives to be equitable and inclusive in connections and communication, recognizing the unique strengths and value of every individual.

The collaborative selected the following Group Priorities**:** Family and Youth Engagement, Agency Educational Outreach, and Support for Children/Youth with Severe Emotional Disorders

- The collaborative was motivated by the $5,000 from Vaya to develop a survey to provide a cross section of data regarding the status of youth and their perceived needs for increasing youth and family engagement. This is in process.
- The SOC-ET completed a presentation on the McDowell County geographics, SDOH, mental Health, other health data followed by an RBA introduction with the Collaborative. The full SOC team worked with the collaborative to prepare an RBA event with families and residents of McDowell County this was offered in Year 3 and will be detailed in that report. The SOC-ET trained facilitators to assist in the breakout sessions.
- The SOC-ET is working with the Lead Family Coordinator (LFC) to develop family engagement in and outside of the collaborative setting. Key questions raised by the collaborative that are guiding this work include:
    - Can we bring people to the collaborative with a problem that needs to be solved for? Can we look at safety in the school which has less stigma? Sharing success stories brought more people to the table because they saw changes.
    - What does a safe school look like?
- Family Partners are in the process of developing a subcommittee of families to discuss mental health problems, systemic barriers, and collective solutions to then be presented to the collaborative.

Polk Community Resource Collaborative

The Polk Collaborative has been the most active of the counties and has accomplished a lot with a strong leadership team.

Mission**:** Our focus is to bring together agencies that foster support for youth and their families

Group Priority**:** Trauma and Resilience

Objectives of the collaborative are to build relationships between families and agencies to support resiliency for the youth of Polk County. This includes building capacity of families and agencies to support resiliency for the youth of Polk County**.** A two year plan was developed with

additional years being considered as the collaborative supports the development of a strategic plan:

Year 1: Increase awareness and knowledge of mental health, trauma, resilience, and stigma [replicate all 3 years]. Define mental health, trauma and resilience and start small.

- Create natural community supports for children and families.
    - Feature Movies to build awareness on Trauma & Resiliency: Resilience, Broken Places, Paper Tigers, Connecting the Dots
        - Collect attendance & Education gained

Year 2: Increase number of people trained in Trauma, Resiliency, MHFA

- Make trainings available to build awareness and education on "how" to support
    - The Module Training through the Center for Trauma Resilient Communities
    - Youth and Adult Mental Health First Aid Training for community
- Create a network of resources.

The SOC-ET helped the Collaborative put together a project funding proposal using the RBA framework, developed the pre/ post survey for the movie viewing events and created pathways for other organizations to use this survey and share results. The following summarizes the process and data. This includes information from Blue Ridge, Henderson County data. It is included here to begin the process of having multi-county data to compare for this specific resilience building project. Vaya is tasked with supporting 31 counties for SOC development including the targeted counties for the SAMHSA SOC grant. Henderson County is a Vaya catchment county and not one of the SOC grant counties but is adjacent.

Five questions were asked of each viewer using a retrospective pre- post-test format that required only one administration to collect baseline and follow-up scores. A total of 69 viewers completed the survey. All surveys were completed in full. Each question is summarized in a separate table. Pre- and post-viewing average and Sd are included for each movie viewing group (Saluda UMC, Tryon, High School, DSS and Blue Ridge), and in total. The question verbiage is included in the second row of each table. The paired sample t-test was used to determine for *the total score only* whether there was a significant increase of knowledge/understanding for each question. Any p-value .05 or smaller would suggest that knowledge significantly improved for the question content.

Average scores are based on a five-point scale for self-reporting how much each respondent knew the question statement prior to viewing the movie and then again after. If a respondent selected "not at all" at baseline, that is the numeric equivalent of 1. The other value options are: 2 = slightly knew; 3 = somewhat; 4 = moderately, and 5 = knew a lot. These are standard Likert scale values.

The movie viewing has been the focus of the RBA project in Polk County, and it will be useful for Polk to have a comparison and Henderson County is the first available. The SOC-ET has offered to continue updating the analysis if additional Henderson or other county viewings are completed and the evaluation tool designed for the project is used. The comparatively large number of persons completing the screening in one sitting for Henderson County (n = 35) just makes the confidence threshold for using the paired sample t-test without violating the assumptions of the statistic. Each table includes Polk, Henderson, and Total by question.

Question 1 (Table 26) asked the level of knowledge/awareness about Adverse Childhood Events (ACEs). Baseline scores were, on average, between 'slightly knew' and 'somewhat knew' about ACEs for Polk County and the baseline was notably higher for Henderson County. A higher baseline was consistent for Henderson responses with few exceptions. After the viewing the average increased between 'moderately knew' and 'knew a lot'. Specific to Polk County, the Tryon group had the lowest baseline knowledge and the Department of Social Services (DSS) group, as expected given the expectations of the organization, was highest. We note here, and for the other questions as well, that the Sd also consistently lowered. As a reminder this is important because it indicates that the group had a stronger *common* knowledge at post-test than at pre-test. To avoid redundancy, we will not note this for other questions. There was a strong statistically significant change in scoring average for all respondents combined with a p-value of .000 for Polk County, meaning there was less than 1 in 1,000 that these findings were simply due to chance. The improvement was also significantly higher for Henderson County though the high baseline score imposed a ceiling effect on the follow-up responses.

Table 26. Resilience Movie Question 1 Summary

"I knew about Adverse Childhood Experiences (ACEs)."

Group	N	Baseline		Post-Viewing			
		Average	Sd	Average	Sd	t-score	p-value
Saluda UMC	25	2.84	1.52	4.56	0.59	10.689	.000
Tryon	19	2.68	1.49	4.47	0.77		
High School	10	3.00	0.94	4.60	0.70		
DSS	15	3.47	1.46	4.73	0.59		
Polk Total	**69**	**2.96**	**1.43**	**4.58**	**0.65**		
Blue Ridge	35	4.23	1.44	4.71	0.46	2.051	.048
TOTAL	**104**	**3.38**	**1.55**	**4.63**	**0.59**	**8.967**	**.000**

The pattern of responses was similar for question 2 with its focus on outcomes related to elevated ACE experiences. The change in average knowledge is closer to the highest score, 'knew a lot,' which is important for planning. Knowing that higher number of ACEs leads to a wide variety of poor health and quality of life outcomes is motivating for developing community change strategies (Table 27). Polk and Henderson were consistent in level of gain. Brief

responses included by some respondents suggests that ACEs linked to mental health and substance use issues, including tobacco use, alcohol, and other substances, was known or logically assumed compared to heart disease and cancer. One respondent noted that the direct link between trauma and "self-medication to avoid the pain" was understandable.

Table 27. Resilience Movie Question 2 Summary

"I knew that a high number of ACEs can lead to alcohol use, smoking, diabetes, heart disease and cancer."

Group	N	Baseline		Post-Viewing			
		Average	Sd	Average	Sd	t-score	p-value
Saluda UMC	25	3.16	1.46	4.72	0.54	9.887	.000
Tryon	19	2.84	1.57	4.84	0.50		
High School	10	2.90	1.20	4.70	0.68		
DSS	15	3.47	1.60	4.80	0.41		
Polk Total	**69**	**3.10**	**1.48**	**4.77**	**0.52**		
Blue Ridge	35	3.91	1.25	4.83	0.38	4.715	.000
TOTAL	**104**	**3.38**	**1.45**	**4.79**	**0.48**	**10.579**	**.000**

Baseline scores were slightly higher than predicted for question 3, especially notable for Blue Ridge (Table 28). This is due to including sleep and education as resilience building as this is more common knowledge. One respondent noted that mindfulness and meditation "…is not something kids learn in schools, and it might be too 'new age' for our area." Change in average scores was strongly significant for Polk, Henderson and overall.

Table 28. Resilience Movie Question 3 Summary

"I knew that mindfulness, meditation, sleep, and education can help build children's resilience."

Group	N	Baseline		Post-Viewing			
		Average	Sd	Average	Sd	t-score	p-value
Saluda UMC	25	3.52	1.33	4.84	0.37	8.581	.000
Tryon	19	3.58	1.31	4.79	0.42		
High School	10	3.00	0.82	4.70	0.48		
DSS	15	3.87	1.46	4.80	0.41		
Polk Total	**69**	**3.54**	**1.29**	**4.80**	**0.41**		
Blue Ridge	35	4.29	0.93	4.80	0.47	4.336	.000
TOTAL	**104**	**3.79**	**1.23**	**4.80**	**0.43**	**9.130**	**.000**

Question 4 had the highest baseline score and while still strongly significant, had a ceiling effect with the baseline average over 4.00 on a five-point scale for Polk County and over 4.5 for

Henderson County. This question was included also for a validity check. Including a common knowledge question and expecting a higher baseline score, which was confirmed, improves confidence in other findings. Qualitative data from interviews and other narrative information supports the need for improving/increasing consistent and nonjudgmental adult support for youth in the SOC grant area.

Table 29. Resilience Movie Question 4 Summary

"I knew that a relationship with a consistent caring adult grows a child's resilience."

Group	N	Baseline		Post-Viewing			
		Average	Sd	Average	Sd	t-score	p-value
Saluda UMC	25	4.60	0.71	4.92	0.28	4.854	.000
Tryon	19	4.11	1.10	4.74	0.45		
High School	10	4.20	0.79	4.90	0.32		
DSS	15	4.40	1.24	4.93	0.26		
Polk Total	**69**	**4.36**	**0.97**	**4.87**	**0.34**		
Blue Ridge	35	4.54	0.66	4.91	0.28	3.186	.003
TOTAL	**104**	**4.42**	**0.88**	**4.88**	**0.32**	**5.799**	**.000**

Question 5 (Table 30) had a stronger than expected baseline average score for Polk and for Henderson with a higher level of difference by respondent group within Polk County. This question was included to emphasize that systematic approaches to addressing youth resilience in communities can have major quality of life and cost saving impacts. While knowledge significantly increased, we note that the standard deviation reduction was still strong, but less than other questions and suggests that this topic area be emphasized in follow-up discussions.

Table 30. Resilience Movie Question 5 Summary

"I knew that trauma changes the brain and working on resilience can change it back."

Group	N	Baseline		Post-Viewing			
		Average	Sd	Average	Sd	t-score	p-value
Saluda UMC	25	3.32	1.31	4.68	0.69	8.573	.000
Tryon	19	3.11	1.49	4.42	0.77		
High School	10	2.60	0.97	4.80	0.52		
DSS	15	4.33	1.18	4.93	0.26		
Polk Total	**69**	**3.38**	**1.38**	**4.68**	**0.63**		
Blue Ridge	35	3.94	1.28	4.69	0.53	4.626	.000
TOTAL	**104**	**3.57**	**1.37**	**4.68**	**0.60**	**9.534**	**.000**

The DSS group responses have an interesting pattern. For four of five questions, the DSS baseline average is highest, again as expected given the knowledge expectations of DSS workers. Baseline Sd is also highest for three questions, suggesting that there is a wider dispersal of higher and lower understanding of DSS worker ACE's knowledge at baseline, perhaps due to time in position. Specific to Polk County, post viewing responses, DSS has the highest average in three questions and the lowest average Sd for four questions. DSS workers appeared to benefit in knowledge increase and also improvement in common understanding. Given the high turnover in DSS positions, new workers might benefit from viewing the Resilience Movie as part of their introduction to working with youth that have trauma experiences.

Overall, the impact in knowledge increase was positive, stronger in some ways than expected, and even impacted common knowledge areas. This type of event for increasing community understanding of resilience and the relationship to childhood trauma is impactful for increasing knowledge and offers opportunities to discuss next steps in improving resilience.

Wilkes Task Force

Wilkes has had particularly challenging issues with leadership turnover but have strongly responded through creating a viable task force.

> Mission: The Wilkes Youth and Family Collaborative, through a System of Care framework, brings together family members, youth, and community-serving organizations to share information, build meaningful partnerships, identify barriers to care, and enhance the quality and availability of resources to support, empower, and improve health outcomes for children, youth, families, and the community as a whole.

Group Priority: Family and Youth Engagement, Agency Educational Outreach, and Support for Children/Youth with Severe Emotional Disorders.

In August 2022, the Task Force experienced a leadership change early in the year where both co-chairs resigned due to job promotions and could no longer commit to the collaborative. In the absence of a plan that they were beginning to formulate prior to leadership departure, they went back to basics of finding a new leader, wanting to rename the collaborative, new meeting time and date, having agencies present on what programs they offer in the community and increasing membership.

Next Steps for RBA project idea & group discussion:

- Experiential fair or possible change to Membership Focused Event. While the group still wants to keep the Experiential Fair idea for a future project, they feel the needs and abilities of the group have changed and the idea should be postponed until membership and leadership are further solidified.
- This will change the RBA project focus to Increasing membership due to leadership changes and needs for a more diverse and consistent membership team. The task force

discussed a social event focused on recruiting to help introduce community members/stakeholders to SOC values/purpose and target groups doing similar work. Possible pathways to implementation that are being discussed include:

- Use a survey to gather opinions from provider organizations to focus the RBA project
- Decide on possible RBA planning meetings including, but not limited to, a luncheon, after hours meetings, formal invitations and meetings, with emphasis on face-to-face meetings pending the pandemic, and to engage the Kids at Work JCPC program to involve local youth.
- A corollary is to decide who to include in invitations, e.g., JCPC, providers, County Commissioners, DSS, DJJ, school social workers, hospital staff, and vocational rehabilitation, and information to present to the group or groups, targeting communication for maximum effect.

Key Barrier noted that crossed over multiple coding and analysis findings relevant to the Collaboratives but also Service Providers: ***SOC is not understood as an overarching philosophy to grow resources and communication and viewed as competition or redundancy by some collaboratives and providers.*** This is emphasized as a barrier to the grant but also the states focus on SOC.

Goals 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 following is a review of the 5 goals and 23 objectives (Table 31). The status of all goals will remain "in process" at least through Year 3.

Table 31. 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 31. 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	Year 1 objective that was met and reported in the Year 1 Annual Report.	**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.	Year 1 objective that was met and reported in the Year 1 Annual Report. All counties are aware of the grant, grant goals, implementation and necessary evaluation goals and activities. The role out was across all counties and not phased in as originally planned.	**MET**
O3	85% participants will rate interaction with the Vaya-SOC program as satisfactory or highly satisfactory biannually.	The diverse capacity between collaboratives limits comparability of satisfaction ratings. Satisfaction was extracted from field notes and interaction with Y/FP's. Formal evaluation of satisfaction is important and will be a focus for Year 3 but was considered a burden with the number and type of activities as outlined in the Collaborative Support section of the report. Noted above, the SOC-IT completed 197 field notes for the county collaborative meetings, trainings, and other meetings they attended, over twice as many as last year, with an additional 30 field notes in the SOC-ET specific version of the note. Approximately the same 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. Finally, for the youth that have been discharged from the program, 100% agreed or strongly agreed that they were satisfied with the program.	**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. Qualitative extraction of process notes, the continuous documentation of collaborative support, Governance Board meetings, and the county level RBA projects completed or in	**MET**

Table 31. Summary Progress Status for Goals and Objectives			
#	**Goals and Objectives**	**Discussion**	**Status**
		process to date 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. Reviewing qualitative data, of the 41 segments coded for impact, 39 viewed the SOC as impactful for meeting its goals or supporting the objectives of community collaboratives and stakeholders (95.1%)	
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. Data extraction found 83 mentions of COVID-19 and that these had effected the gamut of services and resources. Preliminary network and communication data strongly suggested that COVID-19 limited contacts, resulting in turf guarding and organization survival focus. It is noted that the level of meetings and contacts, including the numbers of people trained, much increased in Year 2. Overall, there is suggestions that the network is strengthening and plans for collecting network data is underway.	**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	This objective has been updated. The state has moved to centralize SDOH information in NC. The SOC-ET led the effort to update lists of SDOH	**MET**

Table 31. Summary Progress Status for Goals and Objectives			
#	**Goals and Objectives**	**Discussion**	**Status**
	partners. Continue to develop at least 10 additional providers/organizations each year to collect SDOH data across different stakeholder groups	resources for each target county and to add additional ones that were forwarded by Y/FP and others. Y/F Partners are collecting SDOH data using the state developed tool as part of the TS described above. The objective language will be updated to focus on updating the SDOH catalogues and to support resources in signing up to the state registry.	
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	Year 1 objective that was met and reported in the Year 1 Annual Report. This objective is now met with the TS being introduced at community events and its used discussed in community collaboratives.	**MET**
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	Follow-up administrations of the SDOH form and the resilience screener will start by Quarter 2 of year 3. We are behind in this goal as we have been working with YV to develop a more consistent reporting structure for all forms of data and to report those with more regularity.	**UNMET**
	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	All Y/F Partners received mandatory training required by Youth Villages as well as trainings prepared by the SOC-IT and SOC-ET within the expected timeframe.	**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 including the	**MET**

Table 31. Summary Progress Status for Goals and Objectives			
#	**Goals and Objectives**	**Discussion**	**Status**
	supervisors, the LFC and PD annually.	meetings specific to Measurement-Based Care noted earlier. Reiterating, for the youth that have been discharged from the program, 100% agreed or strongly agreed that they were satisfied with the program which was largely contact with Y/FP's.	
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.	Data finds that 48 of 52 youth tracked by YV (92.3%) of youth and families attended 70% or more of sessions.	**MET**
O13	80% of consumers with a Y/FP will be meeting more than half of their clinical goals	Year 3 updates will address clinical goals and tracking with more efficiency. At this time, there is data for clinical tracking for 52 youth tracked but for only half on what could be considered clinical goal information in the information submitted to the SOC-ET. Preliminary findings suggests that most youth, approximately 85%, are meeting their clinical goals. However, this requires greater precision and will be addressed in Year 3.	**Partially 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)	Of the 19 with follow up data in NOMS, 17 (89.5%) have improvements in at least two of the Social Connectedness questions, suggesting sufficient improvement.	**MET**
	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**
O16	90% of persons trained, including Vaya-SOC	All trainings on the SOC and the evaluation plan were viewed as satisfactory. Training for the GB was	**MET**

Table 31. Summary Progress Status for Goals and Objectives			
#	**Goals and Objectives**	**Discussion**	**Status**
	personnel and community participants, will rate trainings as satisfactory or highly satisfactory and effective or highly effective.	viewed as highly satisfactory. Trainings in Mental Health First Aid, Question-Persuade-Refer and others are not independently reviewed for satisfaction. However, comments suggest satisfaction is high.	
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. 622 individuals were trained (see IPP section, specifically WD2).	**MET**
	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 were served with EBP's in Year 1. Year 2 goal was 36 youth served. 54 youth were enrolled. This surpassed both the 36 and the 50 expected to be enrolled. Year 3 expectations per the grant narrative is also 50.	**MET**
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, 58 youth were in treatment and rated as high risk when combining Triple Screen and NOMS data. Of these, 17 have been discharged. Of the 41 remaining, 35 (85.4%) are in treatment and working toward 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. This information may not be available and this objective may have to be changed or discontinued.	**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. The process for determining trauma related goals remains elusive.	**In Process**

Table 31. Summary Progress Status for Goals and Objectives			
#	**Goals and Objectives**	**Discussion**	**Status**
O22	70% of youth receiving a CALOCUS assessment will improve functioning after 6-months of services	CALOCUS data is not available. This objective may be changed or requested for elimination. CALOCUS data will be confirmed as available or not pending any request for change.	**In Process**
O23	85% of families and youth receiving services will have a positive perception of care (NOMS data)	Perception of care is strong and positive. For the 13 NOMS questions used to measure this objective, the lowest two have a 90.5% positive rating and seven have 100% agreeing or strongly agreeing with treatment satisfaction, impact and positive perception.	**MET**

Qualitative Sub-Study/Process Evaluation Supplement

A qualitative sub-study was started in Year 2. This was started by completing a readiness assessment for five collaboratives. At this time there are two phases to the study. Each is based on key information interviews using a semi-structured interview guide. Phase 1 completed 20 interviews. Each person interviewed was asked to name two others to interview. The first was a person that would have content knowledge for their county. The second was someone unique, someone that most would not view as a leader but that was strongly engaged with the community. Phase 1 is the between county analysis focused on determining common concerns, resources, and assets as well as assessing for other issues. Phase 2 is ongoing with up to 31 possible interviews and is the within county data collection where additional stakeholders from each county are being interviewed to further drill down on content. Thirteen (13) have been completed and others scheduled or being pursued for scheduling.

The analysis has been in three stages.

1. Single Code Summaries and Frequencies: Frequencies of a prior, emergent and sub-codes were completed. This gives a numeric approximation of the frequency of topics and how they are across counties.
2. Crosstabs or Cross Coded Content: This analysis is used to recognize relationships between codes and their content to further determine relationships of ideas and issues in each county.
3. Multi-Content Linkage and Dara Driven Relationships and Interpretations: Relationships between codes, documents, and memos are developed using the networking function in the qualitative software (Atlas.Ti).

Selected Contact for this report includes the following:

1. Common Obstacles and Gaps
2. Mental Health and Substance Use

3. Marginalized Populations
4. Trainings
5. Who should be trained
6. Deficits
7. Community strengths
8. Level 3 Examples

Common Obstacles and Gaps

There were several gaps noted. The most commonly noted are included here. The more in-depth report that will include Phase 2 is in process.

Transportation was noted by all 20 respondents. There is minimal public transportation available to those most in need. Options are located in towns and not available to most rural areas. In some areas there are no options other than volunteer from faith-based organizations, some provider organizations, and school systems though rare due to cost. Even when available, public transportation crossed coded with stigma 21% of the time, suggesting that this is a proxy for viewing poor citizens as lesser.

The other area that all respondents brought up, and it is noted here that no prompts were used, was stigma. Stigma also cross-coded with a lot of other content. Stigma was cumulative with other factors to produce disproportionate impacts on some youth. Stigma is directly addressed for MH/SU in several counties but addressing race/ethnicity and the LGBTQ+ population, not as much. Some respondents noted that communities are segmented by race and that it is rarely addressed openly.

Parental absence for various reasons and the rise in foster care placements was noted by 14 respondents. Reasons for parental absence was cross-coded with the following:

- Parental MH/SU conditions: 12 respondents. This is noted again and consistent with other data cited in this report.
- Stigma and Shame: 9 respondents. How to reach families, counter stigma, engage and activate families, and to better utilize resources were linked to this cross-code.
- Incarceration: 8 respondents: Substance use was the assumed but not validated belief for incarcerations. This was also cross-coded with trauma and domestic violence.
- Resilience challenges: 7 respondents: Resilience was a common discussion, partially due to the focus of the SOC. What resilience means and how to promote it was wide ranging. A recommendation would be to review concepts of resilience and to obtain some level of consistency. A common definition is likely to far a reach at this point in collaborative development.

Physical health services and the lack of pediatric care, primary care and specialty care, on top of MH/SU services was noted by 11 respondents. This was often linked with the rising level of elderly moving into several of the counties and the effect of raising property costs and often

making it difficult for local families to compete. The new families often have the means to travel for services that locals do not.

Mental Health and Substance Use

Causes and reasons for MH/SU issues were a key focus. The following were consistently noted as reasons for youth MH/SU issues:

- Substance abuse and family dynamics
- Trauma
- Poverty
- Domestic Violence
- Access to qualified programs within a reasonable travel distance

Lack of reliable, qualified, and confidential mental health services were stated by 17 of the 20 respondents.

> "Outside the county, the smaller practices, most people do not know what is available, everybody knows Vaya, but there is not a lot of knowledge of the other places. Really, there is a lack of qualified service providers and even a subtle push by some to keep new practices out even though they have a waiting list."

Mental health is not viewed as "real issue" by some community members, as noted more than once in this report, but also by persons in authority and that influence policy and resources. Eight respondents stated that either confusion or disagreement with the national conversation as well as not knowing how to pay for services added to the problem. Over half noted that NC not being a Medicaid expansion state was clearly more political then data based and frustrated them.

> "There is a piece of this. Part of our national conversation seems to be around mental health being an issue . . .if that is going to be part of that conversation, where is the Mental Health lobby going, "Well give me those dollars." … how quickly are they coming into the system, because we do have a mental health crisis in this country we have known about for a while."

Youth are viewed as being caught in the middle. A lot of anger was expressed over what was considered government overreach on mask mandates and some parents have openly stated they give up trying to help anything because they are surrounded by "culture war issues" that are personally meaningless to most families yet central topics, e.g., books, transgender, and LGBTQ+.

> "Some parents are using these issues to gain control over parts of the community and education and state this is for freedom why they reduce the choices of others. Maddening."

As youth age there becomes less resources available to them of all types, clinical, educational, and recreational. One respondent noted that there is really a lot to do, but that youth need to want to and enjoy the outdoor options and if they don't they are sidelined. Engaging youth in MH/SU prevention and discussion was labeled as 'engaged' for elementary school children, 'less engaged' for middle school, and 'little to no engagement' for high school. This was linked by several respondents as not viewing MH as a real issue, it goes unacknowledged, and these same felt that anxiety and depression is increasing.

One solution was increasing telehealth options that would also improve confidentiality. However, connectivity and cost for families was noted by five respondents. This was linked as well to larger subsystems in the community that could "make or break" helping or stigmatizing and criminalizing MH/SU, specifically law-enforcement, juvenile justice, child welfare, large providers like Youth Villages, public health and education systems, all mentioned minimally four times by respondents.

Physical challenges are visible, easier to understand and "… not viewed as the fault of the child, it's God's will and people respond to that." While more accepted, there is still a lack of resources available. This included developmental disabilities, cancer and other issues. This also linked in the data to lack of medical care providers and facilities, and transportation.

Youth substance use had what 7 respondents referred to in some way as having an implicit bias, meaning that the youth or family are the cause and should be punished, ignored, or both. This extends to MH issues in general that remain uncomfortable for many.

> "Funeral of a youth whose mother had committed suicide and no one acknowledged that there was anything wrong in her life"

A new, emergent, issue was raised by three respondents and is included in this report as an example of power and transparency issues noted by several respondents. There was dismay that social-emotional learning in schools, what one noted was suddenly finding ulterior motives in the frequently used Ages and Stages questionnaires, should no longer be taught but left to families. There was concern that many families do not have the time to help with reading and math much less systematic focus on social-emotional development. It was noted that this ignores the constant social context of classrooms and schools. This was cross-coded to the high number of parents with MH/SU issues, incarceration, and their one unresolved traumas, and how unrealistic it is to expect them to teach healthy social-emotional development. Respondents also noted that this had become politicized with the new emphasis on linking this to grooming behavior of pedophiles and how there is no data to support this and it ignores decades of providing support to raise healthy children.

Finally, stigma and intergenerational trauma were cross-coded with MH/SU for youth:

"Therapy, recovery and resources are for the crazy people or those who are not well. …The moment someone says they want to get these services, they are judged …[for that]. That kind of stigmatization can keep somebody from reaching out and that is when depression and anxiety kick in and in extreme cases that is when …thoughts of self-harm occur. A lot of people are left to fight that battle alone and will not seek help from anyone."

"The other thing is cultural and generational trauma…everyone before us did it this way so this is how it must be."

Marginalized Populations

Respondents were asked to list which sub-groups in their communities were the most marginalized, with less access to resources and at greater risk of being stigmatized. The frequencies are listed from most to least:

- LGBTQ+: 19
    - Ranging from active hostility to pronoun use. This was equated with denying two biological genders that has become prominent as an accusation regardless of how often or who said it.
- Black/African American: 16
    - The acronym BIPOC, "Black, Indigenous, and People of Color" was used by some respondents and also noted that this was used by some as pejorative.
    - Some counties have the Black population as the only population decreasing
- Hispanic/Latino: 14
- Low income/Poverty: 10
- Cross-code: 3 respondents noted that this is the majority of the county population
    - Cross-code: Strong association to substance use codes
    - Cross-code: Homeless population – "consistently viewed as a defect or a choice to be homeless."
- Children in foster care: 7
- Native Americans: 5
- Persons with disabilities: 4
- Biracial: 4
- Asian: 4

Stigma cross-coded strongly with this content area. Attitudes toward MH counseling is still strongly "blame the victim" and considered personal failing. Conversely, it was common in all counties to hear that people want to help others, to pull together.

A common concern across counties is the impact of beliefs and behaviors that inspire marginalization for sub-population groups. This is not specifically intentional, at least rarely, but embedded across time and social processes resulting in distrust. Verbalization of needed

changes are common, but these are not backed up by a strategic process for eroding the barriers and planning of the steps needed to engage all members as a united community. Persons of color, non-English as a primary language, and the LGTBQ+ communities express that they live under an umbrella of dread and either limit contact and isolate in their own communities, even if this creates barriers to resource access or limits engagement with the dominant community. Some respondents noted that those in poverty are the most marginalized regardless of race, creed, or gender/sexual identity though persons of color tend to have increased exposure.

Trainings

Trainings were specifically queried and frequencies are listed next. This should be expanded to include larger groups and to ensure engagement by marginalized populations to improve accuracy of what is wanted. This could start with memberships at collaboratives which for some are large. For clarity, this and other lists were not provided, and respondents asked to select from. These were generated by respondents.

- Trauma informed and resiliency trainings: 17
    - Cross-code: Resilience. Building a resilient community. Tailored to age groups: 5
    - Cross-code: Intergenerational. Intergenerational poverty and trauma: 4
- Youth mental health: 15
- Adult mental health: 12
- Knowledge of community resources: 11
- Understanding the LBGTQ+ population – “a gentle approach”: 10
- RBA: 8
- Inclusion and acceptance: 6
- Suicide prevention: 5
- Parenting support: 5
- System of Care – how it works, the nuts and bolts, and how to fit it into rural communities: 5. Six respondent noted that this is less of a priority because of the good work by the SOC-IT completed in the first two years.
    - “SOC is becoming a real common term and use in the communities. It’s not the mystery it once was.”
- (1-3 for the following)
    - Compassionate informed communities
    - Workforce and community development
    - Understanding the mountain survival culture
    - Question, Persuade, Refer (QPR)
    - Darkness to Light
    - Cost of Poverty exercise, simulation
    - Racial equity training
    - Panorama – an online program that surveys students and provides analytics

Who Should be Prioritized for Training?

Another frequency list was generated by asking respondents their priorities and preferences for who should be approached to receive training. It was noted but not challenged that family, parents, youth and community members were not prioritized to the degree that the SOC approach requires.

- School system: 16
- County and City leaders: 15
- Social service workers: 14
- Businesses: 9
- Clergy and other faith leaders: 7
- Volunteer and community-based organizations: 6
- Family, parents, or youth: 6
- Medical professionals, community, and ER: 5
- Community members: 4
- Law enforcement: 3
- Those working with migrant workers: 2

System Level Obstacles

There were a number of community level and systems obstacles noted. These are explicated further in the upcoming Phase 1 and Phase 2 combined report and are noted here. This starts with lack of community-buy in, coded as same, noted by 15 respondents. This was noted by several as not deliberate, but a matter of culture and families dealing with their own issues with limited resources. Organizations were viewed as not helping with this as strong silos/not sharing information was noted by 13 respondents and cross-coded over 30 times. This has led to not prioritizing connectedness in communities (11 respondents). This is viewed as a critical issue as not focusing on prioritizing leads to passive acceptance of marginalization and focusing on differences instead of commonalities.

Lack of understanding and even anxiety related to data was noted (9 respondents). There is recognition that data is the key to knowing, proving and tracking improvement with the focus too much on collecting and analysis and not on how to tell the story of the data that you have. The end result is the most important part, hence the focus on RBA. This relates to focusing on actions without consideration of root causes. Action to be seen that you are doing something was noted by some respondents as better than being perceived as doing nothing at all even if that time is being used to plan for success.

Another system level concern is the consistent and persistent barrier between professional decision makers and community members. This includes large systems as previously listed, e.g., law-enforcement, child welfare, but also providers and others. There is a shared concern that families are expected to accept that things will be done to them and not with them, which

increases stigma (cross-coded 11 times), family choice, and willingness to engage with evidence-based and other services.

> "The culture of Machismo that affects everyone. It effects the male's mental health and the female feels powerless. Male may have a sense of authority and may not know that he is doing harm to the people around him."

> "Lack of support system. Who can you go to when having an issue at school or work. A lot of times people say talk to family, but Family may be what is causing the harm and wanting to seek help somewhere else."

Several of the following ties to focusing on parts of health, such as MH, SU, physical, spiritual, family, and economic health, all listed by respondents, and not whole person or integrated health. The system the way it is structured reinforces segmentation and some noted the Tailored Plan as an opportunity to address this community-wide and not only for the specific clientele envisioned. Related to this is what some note as:

> "The penchant of some to deny facts, to not accept data, to base their thinking on ideology and not reality. I know that is strong but it is frustrating when you see that influencing how people think and make decision and their children suffer."

A final issue noted by several respondents is the lack of transparency with community decision-makers and policy influencers.

> "A lot of the decisions are made by county commissioners, sometimes they make the decisions without public input – sessions are closed doors, if you want to speak you have to apply and then citizens can only address open sessions. Public comments are not made part of the general meetings."

> "In the past, the way some of the govt has been run it was thought a certain group of people to control and no one from the outside could have any opinions. Heard people say they won't go to the commission because they were all "first baptist mafia". The rumor mill was passed down, may have been that way many, many years ago during my grandparents time."

Community Strengths

It was noted that the communities of focus were better at supporting individuals crises, like the loss of a loved one or property damage, and other personal tragedies but unable to take a systems approach. This could be reframed as the communities already having the compassion and capacity that needs to be scaled up to include those in crisis that they do not know but are feeling and experiencing the same way as those they do know.

> "Things are happening, but we are not putting the pieces together."

As one person noted, “if the community believes something is missing, they’ll fight for it.” The hardest part is convincing that the need is real, that it affects the community, that, for some, it may directly affect them, and that it should be a priority amongst many issues. Some noted that apathy is at a critical level as “the problems are just too big and too hard to understand.” The fact that everyone knows everyone else’s business and collude in secrecy was viewed as a barrier that could be reframed as a strength.

Faith groups are actively prioritizing youth needs and require additional support and a recommendation is to help faith communities to network within and between counties. This could include networking local business that give support to different groups as they are often easier to engage than large companies.

School systems were viewed by some as part of the solution. It depends on the leadership in the county and in the schools. Helping groups that are marginalized and abused was felt by some respondents as a key to helping youth and to pull the community together (first quote), but was not always shared (second quote).

> “They requested a Training specifically for LBGTQ.+ for staff at the high school because there have been issues Misgendering, turning a blind eye to some issues that were going on between students in the class room [bullying]. Proper use of pronouns by other students Were able to purchase a training and will be Implementing training this fall with staff. Most teachers are accepting. It is good that we have a supportive administration in the High School.”

> “While most are supportive, there was one conversation he recalled with one of the people in power who said that the kids’ family problems were not any concern of the school. Referring to students who may be having problems because of sexual and other physical or mental abuse in their family that is affecting their performance in school.”

Level 3 Analysis Examples

Level 3 analyses both uncover emergent issues and confirm possible or known issues. Three examples are given. Each of these are rooted in the data, at times are internally contradictory, and reflect the complexity of the communities.

1. Division of Assets and Competing Perspectives
    - The “haves and have nots” divide counties and the ‘have nots’ have a limited voice and influence.
    - Silos are stressing the system while at the same time supporting the system.
    - There is a disbelief in the welfare system, that people are gaming it for their own needs, while at the same time are also living in visible poverty.
    - People are stuck between the past and the future which is limiting the present and often making it untenable.
        - “We look to the past, are confused by the present, and fear the future.”

    - "We need a narrative of hope.
2. Engaging Communities, Families, and Youth
    - Parent groups led by parents are strongly needed so parents can recognize common issues and work together.
    - Too many communities are also seen as "going through the motions" and not looking to have an impact or to change anything. This was noted by some as 'checking the box.'
    - Trauma is not recognized as problematic but accepted as normal behavior that no one wants to talk about but that should be endured quietly. This was especially noted for the BIPOC and LGBTQ+ populations. It's noted that local church systems may have the cultural power for providing support while working against shaming.
3. Hard Lessons Learned
    - Loss of industry has impacted community identity and self-worth. This impedes tolerance to ambiguity and the time needed to make changes and increases indifference while lowering persistence. This leads to a hesitancy to invest in resources to improve lives at the community level.
    - Pay for local populations remains low though the median income for many is around the state level. This also relates to increasing costs as outsiders move in and purchase properties. Low pay and stress results in high turnover in jobs that have clear responsibility for the lives of children and families, e.g., DSS.
    - Adapting to the pandemic was not consistent for many reasons and was often politicized and remains a current problem.
    - Lack of investment in parks, common areas, and inclusive events has reinforced marginalization and connectedness. It was noted that money goes toward hard infrastructure, which is important but should not take all the resources.

Evaluation Question Summary

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 2 expanded on Year 1 and introduced additional ways to recruit client families into direct SOC services via Youth Villages as well as attempting to engage families, parents and youth in county collaboratives and other SOC supported projects. Earlier in this report the number of persons engaged trainings and meetings were reported. Specifically, there were 54 community members that include family members trained. For collaborative and other community meetings, it has been extremely difficult to engage family and youth. Field Note data finds that 10 family members and 5 youth specifically self-identified while attending in meetings. Professionals who are also parents of youth with MH/SU issues were more likely to attend and to identify in their dual roles with 186 total attendees. This suggests a barrier to family and youth unaffiliated with employment remains strong.

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. The number of Triple Screens and NOMS data collections increased to numbers needed to make up for Year 1 deficits and to set the stage for a successful Year 3. There is good momentum at the end of Year 2 and more Triple Screen assessments in community events would be welcome to better understand the distribution of SDOH, trauma and resilience experiences in youth. This would aid prevention efforts for general public estimates and not only for youth in service. The need for more persons enrolled to meet grant requirements and to better understand the same issues for families served is needed as well.

Understanding youth and family resource and clinical needs 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 (61 segments). The number of families and youth trained or engaged in Collaboratives was much larger in Year 2 but is likely an anomaly with the large number trained in resilience related information (see Collaborative Support and Training and IPP Sections). A decrease in Year 3 is expected. Qualitative responses in interviews and document analysis, as well as direct contact with YV team members, AG members, etc., suggests that there are some common, if not stereotypic, beliefs and perceptions about families with mental health issues that are at best benevolent due to serving large numbers of families and the stress that entails, and at worse stereotyping families as ‘less than’ other families. A new coding scheme to include stigma was introduced partway through Year 2 and with findings to be detailed in future reports. It appears that stigmatizing beliefs for persons served is compounded by strong racial and ethnic negative beliefs for persons of color and the LGTBQ+ population.

Informing families was linked with recruiting family and youth into Child and SOC Collaboratives (52 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 (17 segments). Marginalization and racism were noted with more frequency in the Qualitative Sub-Study section then in official documentation. In some ways it’s almost a visible secret that

provokes a sense of helplessness. 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. Family and Youth Voice as a Collaborative topic increased the most selected topic for Field Notes, up from the number three ranking from Year 1, with the total number up 261% from Year 1. Family and Youth Advocacy dropped from the fifth place ranking to number twelve in Year 2 though the actual number of times increased by 153%. The SOC-ET reiterates the recommendation 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." The SOC-IT is working against a strong current of distrust and segmentation of the communities by race, ethnicity, prosperity, and length of time in the community. Applying strategies based on Collective Impact and managing expectations using RBA to direct objectives will build successes though this is likely to be slow and to require some high visibility opportunities to help community members to appreciate the experience of community beyond their usual groupings. Feeling respected and valued as well has having a shared voice and a real role in the collaborative may support long-term engagement.

There has certainly been a larger number of youth and families not only informed but engaged in training opportunities and community events. There remains clear barriers. Overall, the number of families and youth informed increases consistently.

Recommendation: Develop a one pager once a month to distribute to collaboratives of positive stories and collaborative successes.

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

The amount of follow-up NOMS data remains below expectations for tracking connectedness or awareness of youth/families. Baseline data suggests that there is a level of social connectedness (NOMS data) but also a sense of isolation (Triple Screen data). Just less than 80% of youth surveyed using the NOMS agreed or strongly agreed that they were well connected, leaving limited room for improvement. All nine (100%) of youth at 6-months state they are well connected but only 69% at discharge (n = 13). This is reported with no confidence on predictive ability for youth served as the sample size is too small. 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 61 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 33 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 71 times with emphasis on having safe social

opportunities for youth in rural areas and, again, resilience. The focus on creating opportunities for youth in often isolated communities was one of the most increased codes for the year. This is consistent with the focus on youth and family engagement noted in the Field Note data. This also came with increased number, or at times increased awareness of community events and opportunities for youth. 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 and SOC related professionals need support in defining and addressing.

The increase in focus on youth activities and positive social networking parallels the efforts to improve resilience. Resilience as a key topic, as well as building stronger awareness of mental health and substance use prevention and intervention for youth, in Collaboratives RBA projects, community events, and school focus (18 segments), suggests that developing connectedness and awareness is successful but will require consistent effort to reach enough youth and families to make measurable impacts.

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

There is insufficient data to determine this as of this report. The small numbers of NOMS 6-month data collected is too little to have confidence in analysis. SDOH and Resilience as part of the TS will be introduced as required for follow-up by the second quarter of Year 3. Attempts to engage families in youth in focus groups have been unsuccessful despite persistent efforts. 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 (see IPP data section). 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). We state here again that this is an underserved area with data noted elsewhere in this report that needs to be addressed. If parents have MH/SU efforts they are struggling with, the chance that they will successfully engage with their youth with their own MH issues is greatly reduced. Also, taking a family first approach suggests that engaging parents is appropriate. 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. To date, this has not been successful but efforts will continue.

***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 to focus efforts on common indicators within and between organizations in counties and within Children and/or SOC Collaboratives. This is being tracked via SOC-IT and SOC-ET interactions with Collaboratives. This requires an understanding of how to collect, clean, validate, store, analyze and report data, the focus of RBA projects, trainings provided, and

general support for Collaboratives. 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 (28 segments) has not been consistent with turnover in some collaboratives while it may be steady but also stagnant in others. Almost all codes have been related to turnover and inability to confirm leadership in Collaboratives. However, three Collaboratives have strong leadership and have benefited the most from support and RBA guidance. DDD (42 segments) is linked to measurement-based care as a separate code (39 segments), and both are linked with the Clinical Services code (41 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 and will be continuing into Year 3. Specific to policy changes, this has been difficult to both track and attribute to the SOC with the emphasis on Tailored Plan and other large changes, including changes in the number of Counties that Vaya serves.

***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 much improved success in meeting goals and objectives for Year 1 (see Table 22 for discussion of each *a priori* goal and objective). 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?*

Collaborative readiness assessments and interviews used a retrospective approach when possible as some collaboratives, though established, did not have organizational information available with new leadership. Responses suggest that networks are relatively stable with key organizations attending with some frequency and breadth of peripherally engaged organizations and individuals in some counties. Network density will be assessed in Year 3 to establish baselines and change. This is labor intensive for collaboratives so the process will be used as part of infrastructure development and RBA projects. Impact is as yet difficult to meet as the RBA projects and other planning has been focused more on engaging communities than impact.