Vaya SAMHSA System of Care Grant

Year 3, 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

ET = Evaluation Team

FFA = Family Functioning Assessment

GB = Governance Board

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

IT = Implementation Team

IET = Combined Implementation and Evaluation Team

HFW = High Fidelity Wraparound

JCPC = Juvenile Crime Prevention Council

JJ = Juvenile Justice

LFC = Lead Family Coordinator

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

MBC = Measurement Based Care

NOMS = National Outcomes Measures System

PD = Project Director

PEARLS = Pediatric ACEs and Related Life Events Screener

PIT = Project Implementation Team

PRTF = Psychiatric Residential Treatment Facilities

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. Weekly Results Based Accountability (**RBA**) meetings with System of Care Coordinators (**SCC**) and Family Partners (**FPs**).
7. Twice weekly System of Care Office Hours where SCC and FPs attend and present issues to discuss with the CSI team and each other.
8. Evaluation support for specific SOC Grant supported organizations in relation to data management, development of measurement tools, and databases as needed.
9. 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.
10. 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. Tracking of RBA specific sessions with individually developed tools to support RBA planning, data discussion, development of measurable objectives, action planning, gap identification, and assessment of systems change.
    b. County specific information when available for RBA projects funded via SOC Grant dollars.
11. 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 3 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 serve the families more efficiently 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.
- Identifying organizations in need of SOC support and providing them resources, implementation, and evaluation support.
- Addressing network connections within and, when possible, between counties to develop broader and more dense communication and direct service connections.
- 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.
- Stakeholder engagement via continuous contact with the Project Director (**PD**) and the SOC-ET providing in-depth implementation support.

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 SERVICE and the communities. Since the TS demographic data is straightforward and easily collected, it is likely accurate. Up through Year 3, 526 youth were screened.

Gender, n (%)

Male: 226 (44.4)

Female: 262 (51.0)

Trans: 17 (3.3)

Other: 5 (1.0)

Refused: 3 (0.4)

Race, n (%)

White: 399 (80.9)

Black/African American: 42 (8.5)

Alaskan Native: 1 (0.2)

American Indian: 3 (0.6)

Asian: 2 (0.4)

Dual/Other: 43 (8.7)

Refused: 3 (0.6)

Ethnicity, n (%)

Non-Hispanic: 430 (87.9)

Hispanic: 55 (11.2)

Refused: 9 (0.8)

Age in Years

Male: *Mean*: 11.4; *Median*: 12.0

Female: *Mean*: 10.4; *Median*: 11.0

Trans: *Mean*: 15.3; *Median*: 13.0

Total: *Mean*: 11.0; *Median*: 12.0

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. 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 surpassed 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	**Goal**	**Actual**	**%**	**Deficit**
NOMS				
Year 1	30	16	53.3	-14
Year 2	50	54	108.0	+4
Year 3	50	54	108.0	+4
Total/Combined	**130**	**124**	**95.4**	**-6**
Triple Screen				
Year 1	100	20	20.0	-80
Year 2	200	306	153.0	+106
Year 3	200	200	100.0	0
Total/Combined	**500**	**526**	**105.2**	**+26**

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 SERVICE by a Y/FP. The TS has been used for several EVENTs as well which allows a comparison between those seeking mental health care, 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. For this report there is sufficient TS data to compare for gender, race/ethnicity, and county. We combine data from program start. Trend analysis by year did not produce any significant differences.

The TS is completed after adequate engagement has been reached with families SERVICE 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/FP. The time of one month did not result in significant, or even marginal, increases in recruitment. Best judgment when families are ready for the TS is being used based on rapport is the current plan. The analysis that follows will address each screener separately, summarizing data collected on 526 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 aged 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 (**MBC**) for working with families and for aggregating for data-driven decision-making (**DDDM**) for performance evaluation. Turnover has resulted in less predictable data collection and for the Evaluation Team (**ET**) to offer training on the proper administration and use of the TS. To that end, two training 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 SERVICE. Y/FP are not clinically trained and while TS information has been useful for program level evaluation, use for MBC is not consistent.

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 summarized in Table 2. Data availability is directly related by whether a Y/FP is serving the County. Last report, county comparisons included McDowell, Polk, and Wilkes counties. This year, only Caldwell has insufficient data to include in comparisons. As TS's are completed in counties, more will be added for comparison.

Table 2. Summary of Change in Data Collection for TS by County (n = 522)

County	Year 1-2		Year 1-3		Change	
	n	%	n	%	n	%
Alleghany	23	7.1	41	7.9	18	0.8
Alexander	22	3.7	40	7.7	18	3.9
Ashe	22	6.7	34	6.5	12	-0.2
Caldwell	10	3.1	17	3.3	7	0.1
McDowell	89	27.3	129	24.7	40	-2.6
Polk	125	38.3	197	37.7	72	-0.6
Wilkes	45	13.8	61	11.7	16	-2.1
Other			3	0.6	3	0.6

Difficulty in recruiting youth for services has been a continuing issue. To improve data collection for Triple Screen data, the Evaluation Team worked with Providers to complete Triple Screens during community events, trainings, and other non-clinical interactions. This resulted in a data that provided additional insight into communities as well as a comparison group to assess differences in trauma and other needs for persons served. The distribution of children provided direct services (SERVICE) and youth from community events (EVENTS) is not even between counties. Table 3 summarizes the distribution across the six counties with sufficient data.

Table 3. Comparison of SERVICE vs. EVENTS Groups Surveyed					
County	**Total**	**SERVICE Group**		**EVENTS Group**	
		n	**%**	**n**	**%**
Alexander	41	5	12.2	36	87.8
Alleghany	40	15	37.5	25	62.5
Ashe	34	14	41.2	20	58.8
McDowell	129	76	58.9	53	41.1
Polk	197	109	55.3	88	44.7
Wilkes	61	59	96.7	2	3.3
TOTAL	**502**	**278**	**55.4**	**224**	**44.6**

Alexander has the lowest number of SERVICE with 12.2 percent of the number surveyed compared to other counties. The reverse is true for Wilkes County, contributing to the higher perceived need that will be seen further in this report. Polk, with the highest number surveyed and better equality for SERVICE and EVENTS group numbers is likely the closest approximation to population exposures.

Social Determinants of Health Screener Summary

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. To ascertain the strength of difference a comparison analysis was completed with other SOC youth data.

The Vaya SOC SDOH total score (n = 576) was compared, matching by age, race, ethnicity, and gender, to youth enrolled in a separate, urban, and mixed (rural/urban) cohort of youth (n = 1,253). The following were noted:

- VAYA SOC:
  - Percent with no SDOH = 43.3.
  - Average number of total SDOHs selected = 1.45 (Total Sample)
  - Average of total SDOHs selected = 1.60 (Y/FP SERVICE Only)
- Comparison Sample:
  - Percent no SDOH = 13.1
  - Average number of total SDOHs selected = 4.38 (all SERVICE)
- Comparison statistic for total SDOHs, independent sample t-test:
  - $t = 15.442$, $p \leq .000$

Information from Y/FP interactions with families suggests larger deficits in SDOHs than reported. This was discussed in Project Implementation Team (**PIT**) and Governance Board (**GB**) meetings. Rural families lean more towards self-sufficiency and may not recognize a SDOH deficit when present as they may have learned to do without or adapt to the deficit. However, this does not limit the impact of the deficit. Hence, youth and families may have higher levels of

unaddressed baseline stress with the impact on health and quality of life. This could be a contributing factor to the high levels of youth depression, suicidality, and generational trauma.

Total SDOH scores are presented and then compared for those that have been provided services via Y/FP or other services, e.g., Multisystemic Therapy, by Youth Villages (**SERVICE**) and those that were screened in various community events that were not focused on families with mental health service needs (**EVENTS**). Total endorsed items, comparisons by gender, SERVICE/EVENTS data comparison, and for the first time, by race, ethnicity, and county are reported. When significant, tests of significance compare whether there are findings not likely due to chance. Note that any significant results in Tables are placed in **BOLD** and significance was determined at the .05 level.

Table 4 and Figure 1 summarize SDOH items validated by enrolled families. The Pearson Chi-Square (χ^2) test is used to determine significant differences between SERVICE and EVENTS families. **SDOH needs are significantly higher for the SERVICE group for all questions**. The SDOH form is completed by the caregiver. The most common need is utilities and not feeling currently safe at 39.1%. Safety concerns have increased markedly from Year 2 (17.6%), trending up from year 1 as well (13.9%). Food insecurity, both questions, are a key concern. There was frequent discussion about linking families to food banks and other resources. In the qualitative data, over the life of the grant, food security was noted 185 times. Thus, food security appears to be a strong concern across counties. Those unhoused reduced from 10.9 to 6.9 percent. However, concern about losing housing increased from 11.7 to 29.3 percent. (NOTE: In all subsequent SDOH tables, the questions are shortened to save space)

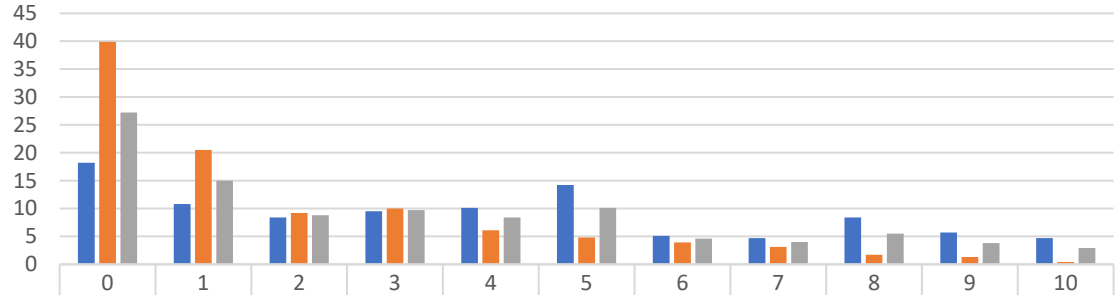
Table 4. Summary of SDOH Needs by Families and Group (Yes responses unless where indicated)

#	Screener Item	SERVICE		EVENTS		Total		χ^2	p-value
		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?	117	40.2	60	26.3	177	34.1	10.976	**.001**
2	Within the past 12 months, did the food you bought just not last and you didn't have money to get more?	124	42.6	32	14.0	156	30.1	49.658	**.000**
3	Do you have housing? (***NO***)	28	9.6	8	3.5	36	6.9	19.312	**.000**
4	Are you worried about losing your housing?	119	40.9	33	14.5	152	29.3	43.087	**.000**
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?	139	47.8	64	28.1	203	39.1	20.725	**.000**
6	Within the past 12 months, has lack of transportation kept you from medical appointments, getting your medicines,	79	27.1	20	8.8	99	19.1	27.964	**.000**

Table 4. Summary of SDOH Needs by Families and Group (Yes responses unless where indicated)									
#	Screener Item	SERVICE		EVENTS		Total		χ^2	p-value
		n	%	n	%	n	%		
	non-medical meetings or appointments, work, or from getting things that you need?								
7	Do you feel physically and emotionally safe where you currently live? (***NO***)	140	48.1	86	27.6	203	39.1	31.046	**.000**
8	Within the past 12 months, have you been hit, slapped, kicked, or otherwise physically hurt by someone?	66	22.7	17	7.5	83	16.0	22.055	**.000**
9	Within the past 12 months, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?	61	21.0	12	5.3	73	14.1	26.067	**.000**
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?	156	53.6	55	24.2	211	40.7	45.594	**.000**
Total n = 519; Receiving Services (SERVICE) n = 291; EVENTS n = 228									

No needs or a low number of identified SDOH needs are more common in the EVENTS group (Figure 1). About twice as many in the EVENTS group had no SDOH needs. Larger number of SDOH needs were consistently higher for the SERVICE group. SDOH support is often the first request by SERVICE families.

Figure 1. Total SDOH By Group (%)



	0	1	2	3	4	5	6	7	8	9	10
SERVICE	18.2	10.8	8.4	9.5	10.1	14.2	5.1	4.7	8.4	5.7	4.7
EVENTS	39.9	20.5	9.2	10	6.1	4.8	3.9	3.1	1.7	1.3	0.4
Total	27.2	15	8.8	9.7	8.4	10.1	4.6	4	5.5	3.8	2.9

Table 5 displays SDOH needs by primary youth gender, segmenting by SERVICE and EVENTS. A test for statistical significance was completed. There were no significant differences detected (data not shown). This means that gender within SERVICE or EVENTS groups are not significantly different, meaning there is no difference on SDOHs for families that have male, female, or transgender youth.

Table 6 summarizes SDOH differences by some of the race categories, including a test for significance using the Pearson χ^2 statistic. Due to low numbers, White, Black, and Other, which includes 2-or-more races and other possible race combinations, were assessed and others were dropped from this analysis only. Noted earlier, there are other population groups in the SERVICE category in the program though the counties are predominantly White. While there are some significant differences the large difference in sample size between the three race values are likely skewing results. Of the five significant results, one showed a higher level of impact for Black respondents, currently being unhoused, while the remaining showed higher impact on White respondents.

Table 7 combines group status (SERVICE/EVENTS) with race to determine if there are significant differences between races for respondents by group. Black respondents except for being unhoused have lower levels of risk than White. Other races identified tend to be closer to White respondents in percentage affected. This results in multiple significant findings. Of interest, the three race options tend to be closer in percentage affected in the EVENTS category, those not in direct services. We explored this by coding qualitative data for SDOH and race. **Tentatively, it was found that Black respondents were more likely to be linked with support and resources in faith-based groups that specifically address SDOH needs and have strong support from extended family and from community groups**. Black communities tend to experience greater levels of isolation, necessitating a stronger response from within their race specific community. There are greater levels of skepticism and vigilance in the community as well, further reinforcing isolation. Black communities also tended to have greater levels of a generalized perceived threat, what one interview respondent referred to as “driving while Black, even when not driving”. This is especially true for the SERVICE group where over three-quarters of the respondents selected feeling unsafe in their community.

An identical analysis was completed for ethnicity, comparing 430 non-Hispanic/Latino individuals with the 55 that indicated Hispanic or Latino heritage. In Table 8, two SDOH are found to be significantly different. Hispanic/Latino families are more likely to have issues with utilities, suggesting a tight budget. Non-Hispanic/Latino respondents are more likely to have issues with transportation.

Table 5. Summary of SDOH Needs by Youth Gender and Group (Yes responses unless where indicated)													
		SERVICE GROUP						EVENTS GROUP					
#	Screener Item	Male		Female		Trans		Male		Female		Trans	
		n	%	n	%	n	%	n	%	n	%	n	%
1	Worry food would run out in last 12-months	57	40.4	54	41.2	3	33.3	17	20.0	36	27.8	3	50.0
2	Food DID run out in the last 12-months	54	38.3	58	44.3	5	55.6	8	9.4	20	15.5	2	33.3
3	Do not have housing	12	5.3	14	5.4	2	13.3	4	1.8	4	1.5		
4	Worry about housing	54	38.3	51	38.9	6	66.7	9	10.6	19	14.7	2	33.3
5	Utility concerns last 12-months	65	46.1	54	48.9	4	44.4	20	23.5	39	30.2	3	50.0
6	Transportation concerns last 12-months	38	27.0	36	27.5	2	22.2	6	7.1	12	9.3		
7	Feel unsafe where currently living	66	46.8	69	52.7	4	44.4	22	25.9	36	27.9	2	33.3
8	Physically assaulted in last 12-months	33	23.4	26	19.8	3	33.3	4	4.7	13	9.3		
9	Emotionally humiliated/abused in last 12-months	19	13.5	34	26.0	3	33.3	2	2.4	8	6.2	1	16.7
10	Number with urgent/immediate needs noted	76	53.9	66	50.4	5	55.6	17	20.0	32	25.0	1	16.7
Total n = 501; Male = 226; Female = 260; Transgender = 17													

Table 6. Summary of SDOH Needs by Race (Yes responses unless where indicated)									
#	Screener Item	White		Black		Other		χ^2	p-value
		n	%	n	%	n	%		
1	Worry food would run out in last 12-months	140	25.6	9	21.4	18	41.9	4.360	.113
2	Food DID run out in the last 12-months	126	32.1	10	23.8	11	25.6	1.907	.405
3	Do not have housing	33	8.3	8	19.0	7	16.3	16.950	**.000**
4	Worry about housing	120	30.5	9	21.4	13	30.2	1.512	.469
5	Utility concerns last 12-months	160	40.7	8	19.0	25	58.1	13.591	**.001**
6	Transportation concerns last 12-months	87	22.1	4	9.5	4	9.3	7.107	**.029**
7	Feel unsafe where currently living	173	44.0	10	23.8	19	44.2	6.424	**.040**
8	Physically assaulted in last 12-months	68	17.3	4	9.5	7	16.3	1.666	.435
9	Emotionally humiliated/abused in last 12-months	59	15.0	3	7.1	5	11.6	2.174	.337
10	Number with urgent/immediate needs noted	168	42.9	9	21.4	19	44.2	7.383	**.025**
Total n = 478; White n = 393; Black n = 42; Other = 43									

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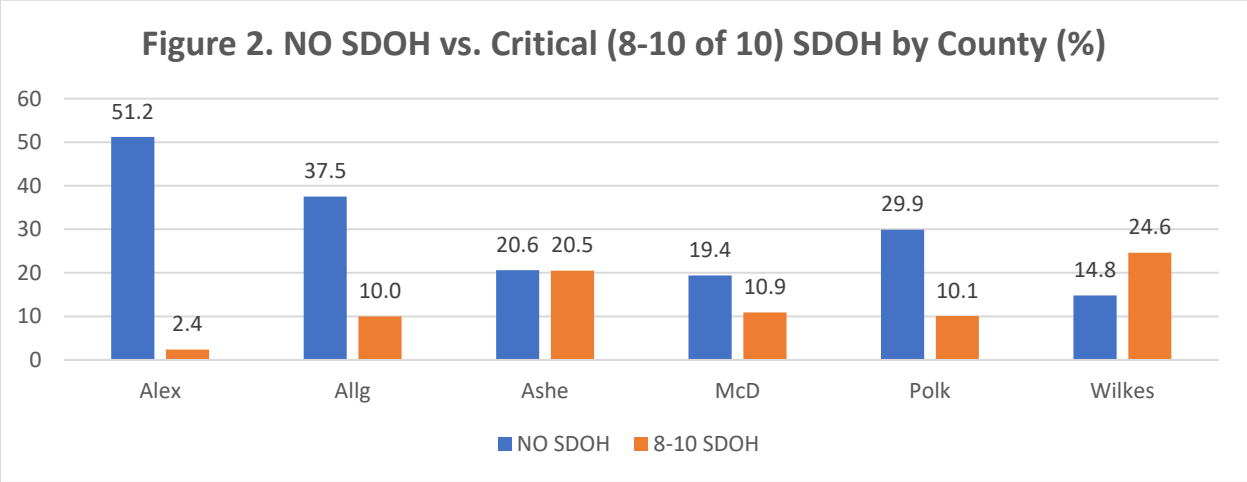
Table 7. Summary of SDOH Needs by Primary Youth Race and by Group (Yes responses unless where indicated)															
		SERVICE GROUP						EVENTS GROUP						Stats	
#	Screener Item	White		Black		Other		White		Black		Other		χ^2	p-value
		n	%	n	%	n	%	n	%	n	%	n	%		
1	Worry food would run out in last 12-months	98	43.8	3	10.3	12	50.0	42	24.9	6	46.2	6	31.6	12.785	**.002**
2	Food DID run out in the last 12-months	104	46.4	6	20.7	8	33.3	22	13.0	4	30.8	3	15.8	7.879	**.019**
3	Do not have housing	14	6.3	5	11.9	8	18.6	9	5.3	6	14.3	5	11.6	27.647	**.000**
4	Worry about housing	95	42.4	6	20.7	10	41.7	25	14.8	3	23.1	3	15.8	5.072	.079
5	Utility concerns last 12-months	114	50.9	4	13.8	16	66.7	46	27.2	4	30.8	9	47.4	17.671	**.000**
6	Transportation concerns last 12-months	71	31.7	3	10.3	2	8.3	16	9.5	1	7.7	2	10.5	10.696	**.005**
7	Feel unsafe where currently living	101	45.1	22	75.9	11	45.8	50	29.6	3	23.1	6	31.6	9.804	**.007**
8	Physically assaulted in last 12-months	54	24.1	4	13.8	7	29.2	14	8.3					1.996	.369
9	Emotionally humiliated/abused in last 12-months	50	22.3	2	6.9	5	16.7	9	5.3	1	7.7	1	5.3	3.993	.136
10	Number with urgent/immediate needs noted	129	57.6	7	24.1	12	50.0	39	23.2	2	15.4	7	36.8	11.671	**.003**
Total n = 478; White n = 393; Black n = 42; Other = 43															

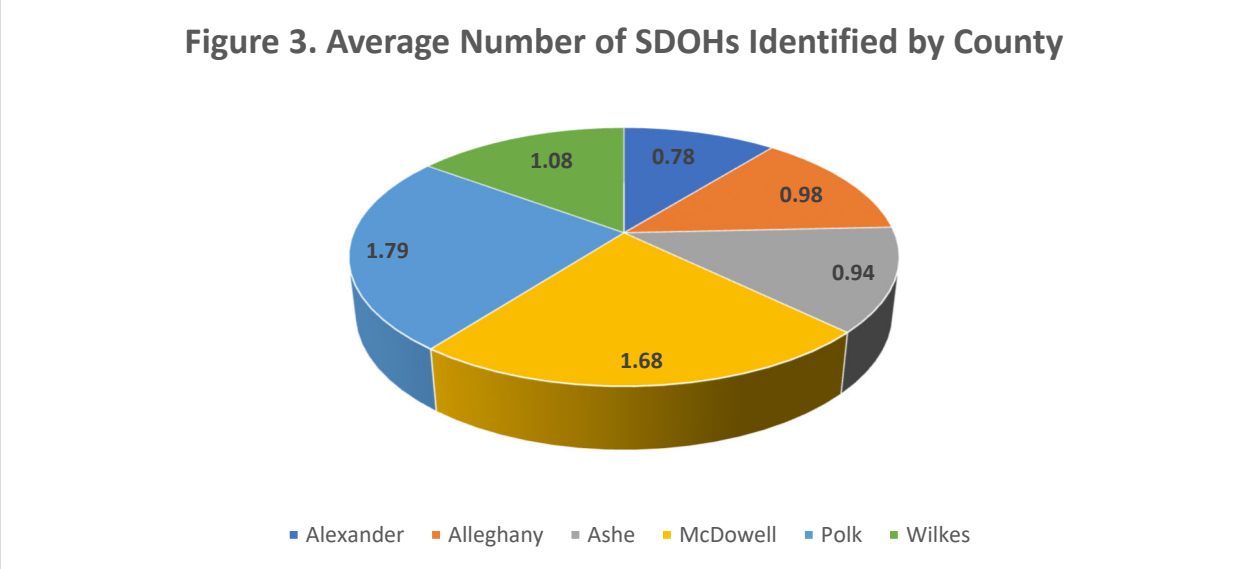
Table 8. Summary of SDOH Needs by Ethnicity (Yes responses unless where indicated)							
#	Screener Item	Non-Hispanic		Hispanic		χ^2	p-value
		n	%	n	%		
1	Worry food would run out in last 12-months	80	18.5	8	14.5	0.541	.462
2	Food DID run out in the last 12-months	71	16.5	7	12.7	0.517	.472
3	Do not have housing	44	10.3	2	3.6	2.484	.115
4	Worry about housing	55	12.9	8	14.5	0.123	.725
5	Utility concerns last 12-months	76	17.7	17	30.9	5.467	**.019**
6	Transportation concerns last 12-months	93	21.8	8	14.5	9.162	**.010**
7	Feel unsafe where currently living	65	15.2	9	16.4	0.055	.814
8	Physically assaulted in last 12-months	58	13.5	5	9.1	0.845	.358
9	Emotionally humiliated/abused in last 12-months	64	14.9	5	9.1	1.341	.247
10	Number with urgent/immediate needs noted	32	7.5	5	9.1	0.167	.683
Total n = 489; Non-Hispanic or Latino n = 430; Hispanic or Latino n = 55							

The final SDOH analysis compares six of the seven counties, noted earlier that Caldwell County does not have sufficient data as of this report. Table 9 compares with the questions shortened to save space. There is marked variance within questions and comparing between questions. Overall, Ashe, Wilkes, and McDowell have larger needs for identified SDOHs.

Table 9. Summary of SDOH Needs Selected by County (YES % Only)								
ITEM	Alex	Allg	Ashe	McD	Polk	Wilkes	χ^2	p-value
Worry food would run out in last 12-months	30.0	19.5	41.2	35.5	34.2	42.6	6.950	.224
Food DID run out in the last 12-months	22.5	7.3	32.4	35.5	28.6	44.3	18.990	**.002**
Do not have housing	4.9	12.5	2.9	12.4	13.2	3.3	8.996	.110
Worry about housing	7.3	12.5	44.1	30.6	30.1	41.0	22.836	**.000**
Utility concerns last 12-months	17.1	32.5	52.9	50.0	35.2	41.0	19.346	**.002**
Transportation concerns last 12-months	12.2	10.0	20.6	24.2	14.8	31.1	13.695	**.018**
Feel unsafe where currently living	14.6	27.5	44.1	50.0	41.3	52.5	22.178	**.000**
Physically assaulted in last 12-months	2.4	10.0	26.5	13.7	15.8	26.2	14.873	**.011**
Emotionally humiliated/abused in last 12-months	4.9	2.5	17.6	16.9	10.2	27.9	21.107	**.001**
Number with urgent/immediate needs noted	24.4	25.0	41.2	55.6	34.9	49.2	24.661	**.000**
Alex = Alexander; Allg = Alleghany; McD = McDowell								

Figure 2 depicts the percentage of individuals in each county with NO identified SDOH needs and those with eight or more needs (8-10 possible), considered critical/survival risk level. Alexander has the least documented needs followed by Alleghany and Polk. Wilkes and Ashe have the largest needs compared between counties. Figure 3 summarizes the average number of total SDOH needs identified by county. As a reminder, the number of identified SDOH needs for the sample SERVICE to date by the Vaya SOC is substantially lower than the matched group from a separate evaluated SOC initiative in four counties that were more urban and urban/rural mix. While the analysis is accurate, the confidence that this reflects true SDOH needs is not strong.





Trauma and Life Events Data Summary

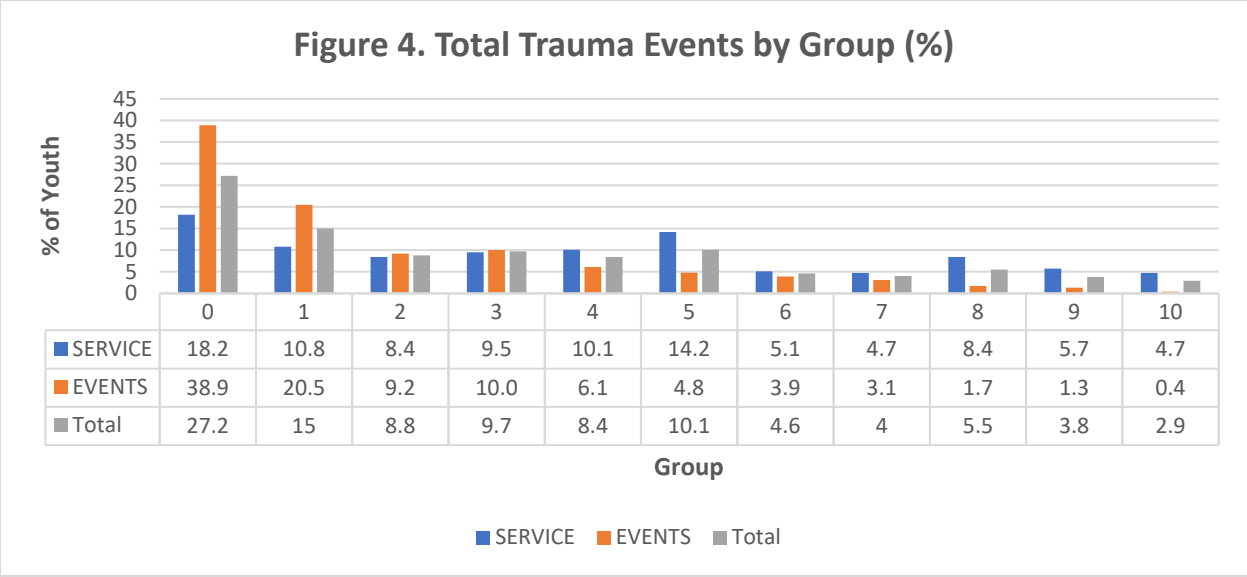
Trauma and life events often impact functioning, mental health, self-esteem, and other constructs important for children and youth success currently and into adulthood. The PEARLS

is the Adverse Childhood Experiences (ACE) version trauma screener for children and 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, e.g., being a victim of bullying or discrimination. 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 17 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. Two or more may affect development, stability, quality of life, and health if there are other problematic factors the person is exposed to. Thus, 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 Year 3 of the project is 3.1 (Sd = 3.0), meaning at least half of youth are at the noted critical level/ This is equal to Year 2 but notably lower than Year 1: 5.6 (Sd = 2.8), and the median remains 2, lower than 5 from Year 1. This suggests improvement but we note that this combined SERVICE and EVENTS youth. For SERVICE youth only, the average increases to 4.00 (Sd = 3.1), as does the median, and lowers to 1.9 for EVENTS youth (Sd = 2.3, median = 1). Regression to the mean was expected and with Years 2 and 3 being nearly identical, this is likely closer to the real distribution of trauma, at least for the sample. There are still insufficient numbers for a confident population estimate. SERVICE youth with an average *and* a Median score of four suggests high levels of trauma, well above the risk level noted in the Child Trends document, and certainly higher than EVENTS youth in the same communities.

Figure 4 reviews the number of traumas experienced by percentages of youth for Year 1, Year 2 and combined. For youth in SERVICE, 18.2 percent had no traumatic experiences compared to over twice the number in the EVENTS Group (38.9%). Both are lower than what the Child Trends analysis noted for all of North Carolina. For all youth combined, 27.2 percent of youth experienced no traumatic EVENTs across all ages, again, only half of what was noted in the 2014 Child Trends report. **To put this into perspective, 143 out of 525 youth with data experienced no traumatic events and 382 youth had at least one, combining SERVICE and EVENT youth.** The difference in exposure For youth with three or more trauma experiences, those considered at elevated risk, found 62.6% of SERVICE youth meet criterion, an increase over the 61.7 percent from the previous report, compared to 31.4 percent of EVENTS youth, about one-half the number. In summary, slightly over half of all youth, 49.0 percent, have an elevated risk level of traumatic experiences. If this trend continues with increased enrollment,

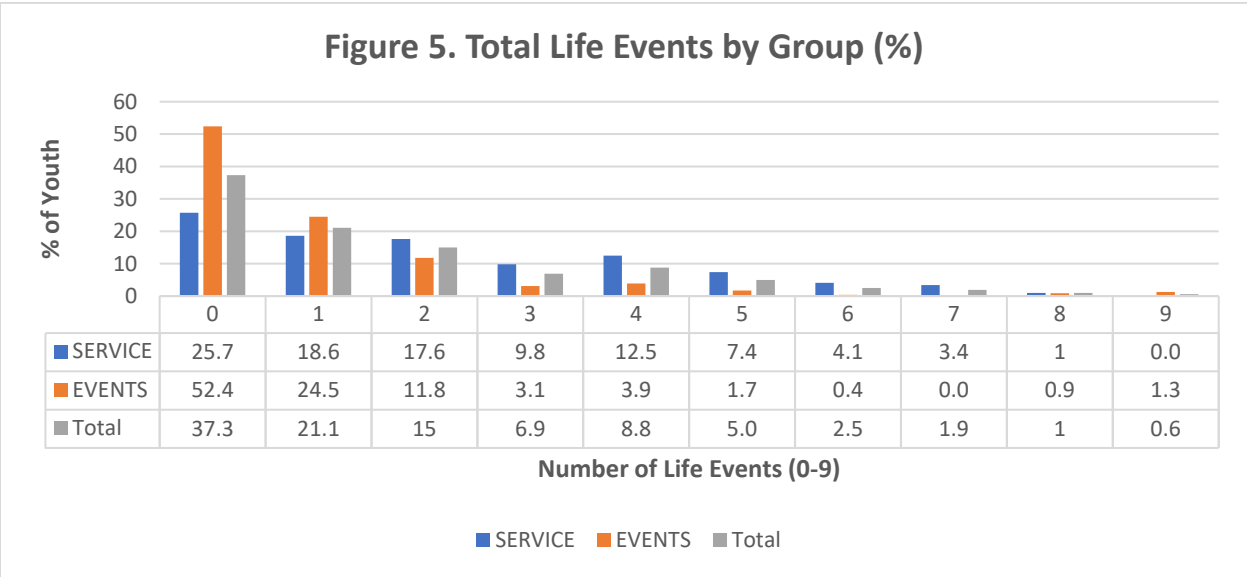
[1] Sacks, V.H., Murphey, D., & Moore, K. (2014). Adverse Childhood Experiences: National and State-Level Prevalence. Published by Child Trends with support from Annie E. Casey Foundation.



	0	1	2	3	4	5	6	7	8	9	10
SERVICE	18.2	10.8	8.4	9.5	10.1	14.2	5.1	4.7	8.4	5.7	4.7
EVENTS	38.9	20.5	9.2	10.0	6.1	4.8	3.9	3.1	1.7	1.3	0.4
Total	27.2	15	8.8	9.7	8.4	10.1	4.6	4	5.5	3.8	2.9

then youth in the SOC catchment area are at a much higher risk of trauma than found in the Child Trend study.

Findings are similar for Life Events experienced (Figure 5). Those serviced by F/YP have higher numbers of life events. Like trauma, there are nearly twice as many youths in the EVENTS category with no negative life event history compared to the SERVICE group. Overall, distributions are consistent with trauma findings.



	0	1	2	3	4	5	6	7	8	9
SERVICE	25.7	18.6	17.6	9.8	12.5	7.4	4.1	3.4	1	0.0
EVENTS	52.4	24.5	11.8	3.1	3.9	1.7	0.4	0.0	0.9	1.3
Total	37.3	21.1	15	6.9	8.8	5.0	2.5	1.9	1	0.6

Cross-tabulating total trauma by total adverse experiences for the total sample, 112 youth (21.3), lower than last report (22.1%), had no traumatic and no negative life events. For the SERVICE group, 43 youth (14.5%) have no trauma or life events compared to the 66 youth (29.7%) of the EVENTS 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. For youth from both groups (SERVICE/EVENTS) 129 (24.5%), down slightly from last report (25.2%), were at this higher risk level. For those from the SERVICE group 122 (41.2%), a substantial increase from 34.8% in the last report, are at high risk. For the EVENTS group, 23 (10.0%), a slight decrease from the last report (10.2%) are in the high risk category.

We note the following:

- Youth in the SERVICE group have notably higher levels of traumatic experiences. This will be further described in the item level analysis next.
- Trauma is not isolated to those seeking care. Some youth in the EVENTS group have experienced a little, some, or a lot of trauma. We cannot determine from the data available if they are receiving the care they need. It is clear that trauma is affecting youth across the community.
- Trauma continues to be higher for youth in the communities served compared to other SOC initiatives in the state. A possible reduction, regression to the mean, did not occur in Year 3. Numbers stabilized at Year 2 levels after reducing from Year 1 to Year 2.

The following Tables (10 - 24) provide an item level analysis for trauma and life events starting with comparing by SERVICE/EVENTS, then gender, gender x SERVICE/EVENTS, race, race x SERVICE/EVENTS, ethnicity, ethnicity x SERVICE/EVENTS, and finally by County. Table 10 will include the full question from the PEARLS. Other trauma-related tables will have the questions shortened for brevity. The most prevalent type of trauma is having a parent with a mental health issue (49.3% of respondents). This reinforces the family first approach central to SOC. Having a parent/caregiver with a substance use issue is common (39.5%). Clearly, those recruited into services (SERVICE group) have higher numbers of trauma experiences for all the trauma questions. We note from service data tracking for IPP that a smaller number of youths are referred for trauma-specific EBPs, an issue with availability as well as willingness. Stigma and denial of need for mental health services, and for trauma experiences, remains high.

While those in the SERVICE group clearly have significantly higher exposure to virtually every type of trauma (Table 10), there are many children and youth in the community that came to events and were screened that were also exposed to trauma and may be going untreated. Youth suffering in silence or reacting via anxiety, depression, substance use, suicidality, and/or criminal behavior are clearly an issue when reviewing the minutes, field notes, and other documentation for the ongoing qualitative analysis. Concern for trauma, resilience, youth feeling unrooted or uncared for were coded in qualitative analysis 128 times in Year 1, 214 times in Year 2, and 371 times in Year 3, an increase of 67.5 percent from Year 2 to Year 3. When further segmenting narrative segments from reactive responses due to new data, incidences, and community concerns and those from active planning to de-stigmatize trauma, youth mental health and to increase resilience, the reactive responses alone increased by 20.3

percent. This suggests that there are more planned responses to trauma and the SOC has been successful in shining a light on the issue and in motivating communities to address resilience.

Table 10. Summary of Trauma Item Scores by Group (Yes responses)

#	Screener Item	SERVICE		EVENTS		Total		χ^2	p-value
		n	%	n	%	n	%		
1	Has your child ever lived with a parent/caregiver who went to jail/prison?	111	40.5	54	26.3	165	34.4	10.426	**.001**
2	Do you think your child ever felt unsupported, unloved and/or unprotected?	118	43.1	31	15.1	149	31.1	42.728	**.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*)	157	57.3	79	38.5	236	49.3	16.516	**.000**
4	Has a parent/caregiver ever insulted, humiliated, or put down your child?	111	40.5	31	15.1	142	29.6	36.242	**.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?	131	47.8	58	28.3	189	39.5	18.700	**.000**
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*)	75	27.4	19	9.3	94	19.6	24.367	**.000**
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?	143	52.2	61	29.8	204	42.6	24.137	**.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?	62	22.6	16	7.8	78	16.3	18.900	**.000**

Table 10. Summary of Trauma Item Scores by Group (Yes responses)									
#	Screener Item	SERVICE		EVENTS		Total		χ^2	p-value
		n	%	n	%	n	%		
	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?								
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*)	58	21.2	12	5.9	70	14.6	22.040	**.000**
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*)	148	54.0	52	25.5	200	41.8	39.099	**.000**
Total n = 519; Receiving Services (SERVICE) n = 291; EVENTS n = 228									

Those screened in EVENTS appear to have stronger family functioning and connection. For instance, there is a 28 percent lower number in Item 2, having ever felt unsupported or unloved, in the EVENTS group. SERVICE youth had changes in caregiver status, e.g., divorce, 28.5 percent more frequently. Similarly, there is 25.4 percent less for EVENTS youth for ever having been insulted or humiliated by a caregiver and 18.1 percent less for ever having lacked appropriate care by a caregiver. EVENTS youth were 22.6 percent less likely to have witnessed domestic violence. Youth in the SERVICE group were 3.6 times more likely to be sexually abused. On average, SERVICE youth experienced each trauma item 20.52 percent more frequently than EVENTS youth.

The number in Table 11 includes most respondents, though some individuals that did not identify as male, female, or transgender are excluded from the analysis due to low numbers. There is consistent similarity between male and female respondents. A Chi-Square analysis was completed for each question by gender. There was only one significant difference between genders, with female youth more likely to have experienced sexual abuse ($\chi^2 = 7.273$, $p \leq .028$). Other tests for significance are not shown.

Table 11: Summary of Trauma Item Scores by Gender (Yes responses)									
		Male		Female		Trans		Total	
#	Screener Item	n	%	n	%	n	%	n	%
1	Caregiver jailed.	74	32.7	90	34.5	6	40.0	170	33.9
2	Child felt unsupported, unloved, unprotected.	62	27.4	78	30.7	7	46.7	147	29.3
3	Caregiver with mental health issue.	102	45.1	125	48.1	11	73.3	238	47.5
4	Caregiver insulted, humiliated, put down child.	63	27.9	70	26.9	8	53.3	141	28.1
5	Caregiver with substance use issue.	85	37.6	103	39.6	7	46.7	195	38.9
6	Child lacked appropriate care by caregiver.	44	19.5	48	18.5	2	13.3	95	18.8
7	Child witnessed domestic violence of any type.	97	42.9	98	37.7	7	46.7	202	40.3
8	Caregiver threatened or perpetrated physical harm.	37	16.4	38	14.6	3	20.0	78	15.6
9	Child experience sexual abuse.	21	9.3	41	16.2	4	26.7	67	13.4
10	Significant changes in child's caregivers, e.g., divorce.	93	14.2	98	37.8	6	40.0	197	39.4
Total = 501; Male n = 226; Female n = 260; Transgender n = 15									

Table 12 displays trauma data by gender and which group the respondent was from, treatment (SERVICE) or community (EVENTS). Only sexual abuse differences were significant, male (n = 19), female (n = 34), transgender (n = 3), $\chi^2 = 7.674$. $p \leq .022$.

For the first time there is sufficient data for comparison of trauma by race (Table 13). Noted earlier, White, Black, and Other have enough for comparison. Five of ten items have significant differences. While the focus is on percentages, the difference in sample size between groups should be considered for confidence in findings. There are much larger number of White youths screened, consistent with the makeup of the communities, which can skew findings.

Assuming accuracy, Black respondents have less exposure to trauma factors compared to White respondents for all items and less than the Other youth respondents for nine of ten items. White youth trauma exposures for caregiver with a mental health issue, caregiver with a substance use issue, child lacking appropriate care, exposure to domestic violence, and exposure to changes in relationships are all significantly elevated compared to the other two groups, especially compared to Black youth. This suggests that trauma is not a primary reason for Black youth to be entering treatment. This hypothesis is tested by assessing for group differences (SERVICE/EVENTS), summarized in Table 14.

An analytic note is included here as it is relevant to Table 14 and subsequent tables. Some cells for comparison using the Pearson Chi-Square test do not have sufficient numbers for comparison, possibly violating the assumptions of the statistic. To compensate, the Fisher's Exact test was used to verify results. If a different finding is noted that impacts whether a finding is significant, this will be noted.

Table 12: Summary of Trauma Item Scores by Gender and Group (Yes responses)													
		SERVICE GROUP						EVENTS GROUP					
#	Screener Item	Male		Female		Trans		Male		Female		Trans	
		n	%	n	%	n	%	n	%	n	%	n	%
1	Caregiver jailed.	57	40.4	54	41.2	3	33.3	17	20.0	36	27.9	3	50.0
2	Child felt unsupported, unloved, unprotected.	54	38.3	59	44.3	5	55.6	8	9.4	20	15.5	2	33.3
3	Caregiver with mental health issue.	75	53.2	76	58.0	6	66.7	27	31.8	49	38.0	5	83.3
4	Caregiver insulted, humiliated, put down child.	54	38.3	51	38.9	6	66.7	9	10.6	19	14.7	3	33.3
5	Caregiver with substance use issue.	65	46.1	64	48.9	4	44.4	20	23.5	39	30.2	3	50.6
6	Child lacked appropriate care by caregiver.	38	27.0	36	27.5	2	22.2	6	7.1	12	9.3		
7	Child witnessed domestic violence of any type.	75	53.2	62	47.3	5	55.6	22	25.9	36	27.9	2	33.3
8	Caregiver threatened or perpetrated physical harm.	33	23.4	26	19.8	3	33.3	4	4.7	12	9.3		
9	Child experience sexual abuse.	19	13.5	34	26.0	3	33.3	2	2.4	8	6.2	1	16.7
10	Significant changes in child's caregivers, e.g., divorce.	76	53.9	66	50.4	5	55.6	17	20.0	32	25.0	1	16.7
Total n = 501; Male = 226; Female = 260; Transgender = 15													

Table 13: Summary of Trauma Item Scores by Race (Yes responses)									
#	Screener Item	White		Black		Other		χ^2	p-value
		n	%	n	%	n	%		
1	Caregiver jailed.	140	35.6	9	21.4	18	41.9	4.360	.113
2	Child felt unsupported, unloved, unprotected.	126	32.1	10	23.8	11	25.6	1.807	.405
3	Caregiver with mental health issue.	207	52.7	11	26.2	13	30.2	16.850	**.000**
4	Caregiver insulted, humiliated, put down child.	120	30.5	9	21.4	13	30.2	1.513	.469
5	Caregiver with substance use issue.	160	40.7	8	19.0	26	58.1	13.591	**.001**
6	Child lacked appropriate care by caregiver.	87	22.1	4	9.5	4	9.3	7.107	**.028**
7	Child witnessed domestic violence of any type.	173	44.0	10	23.8	19	44.2	6.424	**.040**
8	Caregiver threatened or perpetrated physical harm.	68	17.3	4	9.5	7	16.3	1.666	.435
9	Child experience sexual abuse.	59	15.0	3	7.1	5	11.6	2.174	.337
10	Significant changes in child's caregivers, e.g., divorce.	168	42.9	9	21.4	19	44.2	7.393	**.025**
Total n = 477; White = 392; Black = 42; Other = 43									

Seven of ten tests associating trauma factors with race within and between SERVICE and EVENTS groups are found to have significant differences. An interesting dichotomy is present when reviewing the data. For the SERVICE group, White youth have higher percentages of exposure than Black youth for all trauma factors and the Other group has higher percentages than White respondents on three factors. This is consistent with the data in Table 12. However, for the EVENTS group, Black respondents have higher percentages than White or Other respondents on six of ten items. Other respondents have higher percentages than White on two items as well. This confirms, tentatively given the small number of Black youth served, that they are entering into service with F/YPs and other services for reasons other than trauma. This also may suggest that Black youth do experience trauma at elevated levels in the community and may not be seen for trauma when coming into contact for service. That final statement is stated with care given the low numbers of Black youth recruited, as noted, and clear issues of trust that have been raised and represented in qualitative data.

Another first noted earlier is that there is sufficient ethnicity data for a preliminary comparison analysis. Ethnicity is summarized in Table 15 for trauma factors. Hispanic respondents report less exposure to all trauma factors compared to non-Hispanic respondents, with two reaching significance: non-Hispanic have significantly higher levels of trauma exposure for caregivers with mental health and/or substance use issues.

Table 14: Summary of Trauma Item Scores by Race and Group (Yes responses)															
		SERVICE GROUP						EVENTS GROUP						Stats	
#	Screener Item	White		Black		Other		White		Black		Other		χ^2	p-value
		n	%	n	%	n	%	n	%	n	%	n	%		
1	Caregiver jailed.	98	43.8	3	10.3	12	50.0	42	24.9	6	46.2	6	31.6	12.785	**.002**
2	Child felt unsupported, unloved, unprotected.	104	46.4	6	20.7	9	33.3	22	13.0	4	30.8	3	15.8	7.879	**.019**
3	Caregiver with mental health issue.	142	63.4	6	17.2	8	33.3	65	38.5	6	46.2	5	26.3	27.647	**.000**
4	Caregiver insulted, humiliated, put down child.	95	42.4	6	20.7	10	41.7	25	14.8	3	23.1	3	15.8	5.072	.079
5	Caregiver with substance use issue.	114	50.9	4	13.8	16	66.7	46	27.2	4	30.8	9	47.4	17.671	**.000**
6	Child lacked appropriate care by caregiver.	71	31.7	3	10.3	2	8.3	16	9.5	1	7.7	2	10.5	10.696	**.005**
7	Child witnessed domestic violence of any type.	123	54.9	7	24.1	13	54.2	50	29.6	3	23.1	6	31.6	9.804	**.007**
8	Caregiver threatened or perpetrated physical harm.	54	24.1	4	13.8	7	29.2	14	8.3					1.996	.369
9	Child experience sexual abuse.	50	22.3	2	6.9	4	16.7	9	5.3	1	7.7	1	5.3	3.993	.136
10	Significant changes in child's caregivers, e.g., divorce.	128	57.8	7	24.1	12	50.0	39	23.2	2	15.4	7	36.8	11.671	**.003**
Total n = 478; White = 393; Black = 42; Other = 43															

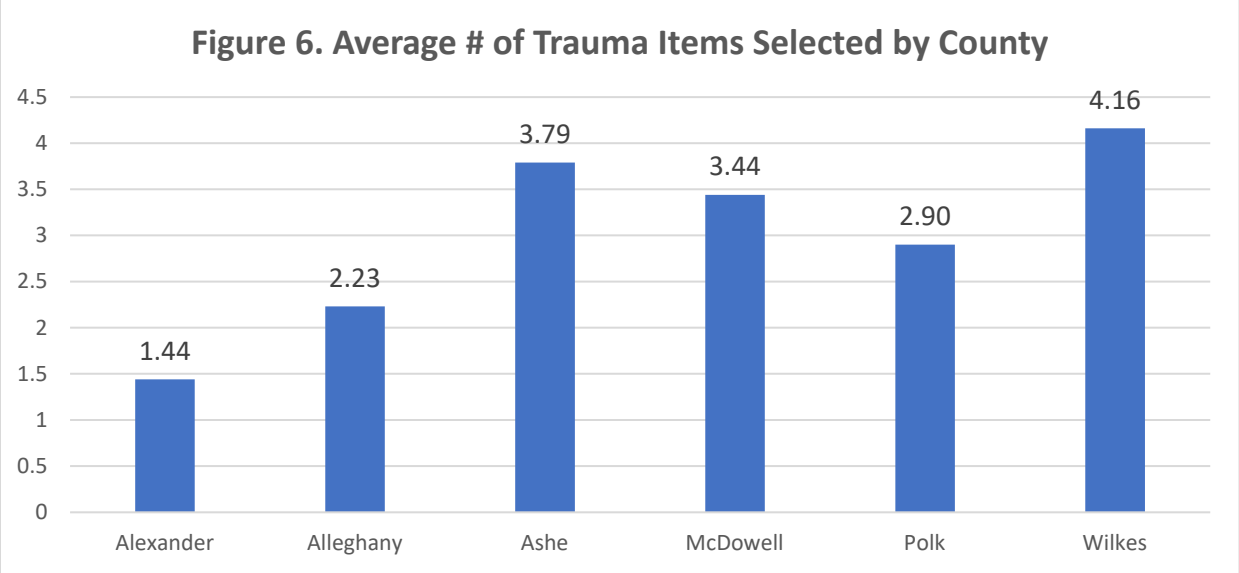
Table 15: Summary of Trauma Item Scores by Ethnicity (Yes responses)							
#	Screener Item	Non-Hispanic		Hispanic		χ^2	p-value
		n	%	n	%		
1	Caregiver jailed.	151	35.6	14	25.5	2.225	.136
2	Child felt unsupported, unloved, unprotected.	138	32.5	11	20.0	3.576	.059
3	Caregiver with mental health issue.	219	51.7	17	20.9	8.380	**.004**
4	Caregiver insulted, humiliated, put down child.	129	30.4	13	23.6	1.076	.300
5	Caregiver with substance use issue.	177	41.7	12	21.8	8.093	**.004**
6	Child lacked appropriate care by caregiver.	87	20.5	7	12.7	1.874	.171
7	Child witnessed domestic violence of any type.	186	43.9	18	32.7	2.471	.116
8	Caregiver threatened or perpetrated physical harm.	71	16.7	7	12.7	0.577	.448
9	Child experience sexual abuse.	64	15.1	6	10.9	0.683	.408
10	Significant changes in child's caregivers, e.g., divorce.	179	42.3	21	28.2	0.342	.559
Total n = 479; Non-Hispanic or Latino n = 424; Hispanic or Latino n = 55							

Group differences along with ethnicity were evaluated as well (Table 16). Findings were consistent with Table 14, only caregivers with mental health issues or with substance use issues were found to be significantly different.

County differences are evaluated in Table 17. Note that only Yes percentages are shown. Eight of 10 questions had significant differences. The reason for differences is difficult to state with confidence with the data at hand. Wilkes County has the highest level of reported trauma for eight items and second highest for one other. Caregiver mental health and substance use issues are the most selected for all counties. Alexander, Alleghany and Polk counties are consistently lower for all trauma factors when compared to other counties. However, all show the need for support as trauma factors are impactful to youth and families across all counties. The average number of trauma items selected by county are summarized in Figure 6. It was stated earlier that more than three exposures place a youth at high risk for a variety of negative outcomes. Ashe (3.79), McDowell (3.44) and Wilkes (4.16) counties are above the high-risk level. All three counties are taking proactive measures to address these issues but are, like most rural counties, attempting to do more with less and are having difficulties securing resources, filling open positions, attracting and retaining qualified providers, and combatting a combination of inertia, denial and stigma.

Table 16: Summary of Trauma Item Scores by Ethnicity and Group (Yes responses)											
		SERVICE GROUP				EVENTS GROUP				Stats	
#	Screener Item	Non-Hispanic		Hispanic		Non-Hispanic		Hispanic		χ^2	p-value
		n	%	n	%	n	%	n	%		
1	Caregiver jailed.	103	41.5	8	30.8	48	27.3	6	20.7	2.225	.136
2	Child felt unsupported, unloved, unprotected.	109	44.0	9	34.6	29	16.5	2	6.9	3.576	.059
3	Caregiver with mental health issue.	146	58.9	11	42.3	73	41.5	6	20.7	8.380	**.004**
4	Caregiver insulted, humiliated, put down child.	101	40.7	10	38.5	28	15.9	3	10.2	1.076	.300
5	Caregiver with substance use issue.	122	49.2	9	34.6	55	31.3	3	10.3	8.093	**.004**
6	Child lacked appropriate care by caregiver.	69	27.8	6	23.1	18	10.2	1	3.4	1.874	.171
7	Child witnessed domestic violence of any type.	130	52.4	13	50.0	56	31.8	5	17.2	2.471	.116
8	Caregiver threatened or perpetrated physical harm.	55	22.2	7	26.9	16	9.1			0.577	.448
9	Child experience sexual abuse.	52	21.0	6	23.1	12	6.8			0.063	.802
10	Significant changes in child's caregivers, e.g., divorce.	135	54.4	13	50.0	44	25.1	8	27.6	0.186	.666
Total n = 479; Non-Hispanic or Latino n = 424; Hispanic or Latino n = 55											

Table 17. Summary of Trauma Item Scores by County (Yes % Only)								
ITEM	**Alex**	**Allg**	**Ashe**	**McD**	**Polk**	**Wilkes**	**χ^2**	**p-value**
Caregiver jailed.	19.5	30.0	41.2	35.5	34.2	42.6	6.950	.224
Child felt unsupported, unloved, unprotected.	7.3	22.5	32.4	35.5	28.6	44.3	18.980	**.002**
Caregiver with mental health issue.	34.1	50.0	58.8	46.0	46.9	60.7	8.986	.110
Caregiver insulted, humiliated, put down child.	7.3	12.5	44.1	30.6	30.1	41.0	22.836	**.000**
Caregiver with substance use issue.	17.1	32.5	52.9	50.0	35.2	41.0	19.346	**.002**
Child lacked appropriate care by caregiver.	12.2	10.0	20.6	24.2	14.8	31.1	13.694	**.018**
Child witnessed domestic violence of any type.	14.6	27.5	44.1	50.0	41.3	52.5	22.176	**.000**
Caregiver threatened or perpetrated physical harm.	2.4	10.0	26.5	13.7	15.8	26.2	14.873	**.011**
Child experience sexual abuse.	4.9	2.5	17.6	16.9	10.2	27.9	21.107	**.001**
Significant changes in child's caregivers, e.g., divorce.	24.4	25.0	41.2	55.6	34.9	49.2	24.661	**.000**
Alex = Alexander; Allg = Alleghany; McD = McDowell								



The same series of analyses were completed for the Life Events items of the PEARLS assessment. All items were significantly more likely to be endorsed for the SERVICE Group except for the final item for teen respondents only regarding abuse from a partner (Table 18). 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. Being separated for foster care or immigration issues was significantly more likely for the SERVICE group (31.6% vs. 10.5%). Being bullied was over twice as frequent for the SERVICE group. Discrimination experiences were nearly twice as frequent as well. Problems with housing were nearly three times as frequent. This finding is inconsistent with the SDOH data. SERVICE youth are three times as likely to have a caregiver with a physical disability and twice as likely to have a parent that died. This can be anxiety and depression producing as well as having children take on parental roles that they are unprepared for. Item language is reduced for the other tables addressing life events.

Table 18: Summary of Life Event Item Scores by Group (Yes responses)

#	Screener Item	SERVICE		EVENTS		Total		χ^2	p-value
		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*)	106	36.4	39	17.1	145	27.9	23.703	**.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*)	94	32.3	40	17.5	134	25.8	14.538	**.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*)	88	30.2	27	11.8	115	22.2	25.089	**.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?	78	26.8	38	16.7	116	22.4	7.570	**.006**
5	Has your child ever been separated from their parent or caregiver due to foster care, or immigration?	92	31.6	24	10.5	116	22.4	32.758	**.000**
6	Has your child ever lived with a parent/caregiver who had a serious physical illness or disability?	89	30.6	24	10.5	113	21.8	30.197	**.000**

Table 18: Summary of Life Event Item Scores by Group (Yes responses)									
#	Screener Item	SERVICE		EVENTS		Total		χ^2	p-value
		n	%	n	%	n	%		
7	Has your child ever lived with a parent or caregiver who died?	55	18.9	23	10.1	78	15.0	7.775	**.005**
8	Has your child ever been detained, arrested or incarcerated? (*Teen only*)	41	18.9	10	9.3	51	15.7	5.060	**.024**
9	Has your child ever experienced verbal or physical abuse or threats from a romantic partner? (*Teen only*) (*for example, a boyfriend or girlfriend*)	27	12.4	11	10.2	38	11.7	0.356	.551
Total n = 519; Receiving Services (SERVICE) n = 291; EVENTS n = 228									

Table 19 compares life event experiences by gender. Experiencing discrimination is the only significant association ($X^2 = 20.030$, $p \leq .000$). Three other life events were borderline significant. Separated due to foster care, ($X^2 = 5.099$, $p \leq .078$), due to female youth being placed in foster care less frequently; being detained/incarcerated, ($X^2 = 5.881$, $p \leq .053$), with more males being detained; and, being threatened by a romantic partner, which was more likely for female and transgender respondents ($X^2 = 5.871$, $p \leq .053$).

Table 19: Summary of Life Event Item Scores by Gender (Yes responses)									
		Male		Female		Trans		Total	
#	Screener Item	n	%	n	%	n	%	n	%
1	Victim of violence in neighborhood, community, or school.	64	28.3	69	26.5	4	26.7	137	27.3
2	Experienced discrimination.	54	23.9	58	22.3	11	73.3	123	24.6
3	Had problems with housing.	47	20.8	60	23.1	2	13.3	109	21.8
4	Did not have enough food to eat or food ran out before more could be bought.	48	21.2	59	22.7	3	20.0	110	22.0
5	Separated due to foster care or immigration.	60	26.5	47	18.1	3	20.0	110	22.0
6	Caregiver has a serious physical illness or disability.	50	22.1	55	21.2	3	20.0	108	21.6
7	Parent or caregiver died.	36	15.9	39	05.0			75	15.0
8	Teen was detained, arrested, or incarcerated.	31	19.9	18	12.4			49	15.6
9	Teen was verbally or physically threatened by a romantic partner.	11	7.1	23	15.9	2	14.3	36	11.4
Total = 501; Male n = 226; Female n = 260; Transgender n = 15									

Table 20: Summary of Life Event Item Scores by Gender and Group (Yes responses)													
		SERVICE GROUP						EVENTS GROUP					
#	Screener Item	Male		Female		Trans		Male		Female		Trans	
		n	%	n	%	n	%	n	%	n	%	n	%
1	Victim of violence in neighborhood, community, or school.	49	34.8	49	37.4	3	33.3	15	17.6	20	15.5	1	16.7
2	Experienced discrimination.	44	31.2	36	27.5	7	77.8	10	11.6	22	17.1	4	66.7
3	Had problems with housing.	39	27.7	44	33.6	2	22.2	8	9.4	16	12.4		
4	Did not have enough food to eat or food ran out before more could be bought.	35	24.8	38	29.0	2	22.2	13	15.3	21	16.3	1	16.7
5	Separated due to foster care or immigration.	50	35.5	37	28.2	2	22.2	10	11.8	10	7.8	1	16.7
6	Caregiver has a serious physical illness or disability.	42	29.8	41	31.3	2	22.2	8	9.4	14	10.9	1	16.7
7	Parent or caregiver died.	29	20.6	23	17.6			7	8.2	16	12.4		
8	Teen was detained, arrested, or incarcerated.	27	24.1	12	13.5			4	9.1	6	10.7		
9	Teen was verbally or physically threatened by a romantic partner.	6	5.4	17	19.1	2	22.2	5	11.4	6	10.7		
Total n = 501; Male = 226; Female = 260; Transgender = 15													

Table 20 (previous page) reviews gender data by group. Transgender individuals were significantly more likely to experience discrimination within SERVICE ($X^2 = 9.975$, $p \leq .007$) and EVENTS groups ($X^2 = 12.452$, $p \leq .000$). Males within the SERVICE group were borderline for significance in experiencing incarceration ($X^2 = 5.846$, $p \leq .054$), though interestingly not in the EVENTS group. Female and transgender youth experienced more partner violence than males, but only in the SERVICE group ($X^2 = 9.887$, $p \leq .007$).

Life events were associated by race, again limited to White, Black, and Other categories, with one significant finding (Table 21). Those in the other category experienced significantly more discrimination than White or Black counterparts ($X^2 = 10.616$, $p \leq .005$). It is interesting that life events, even ones that reflect community, if not values, or at least priorities, such as discrimination and violence, appear to be more equally distributed than trauma experiences. Other events such as physical illness and death are a mix of happenstance and possible life choices that can affect any youth.

Table 21: Summary of Life Event Item Scores by Race (Yes responses)

#	Screener Item	White		Black		Other		χ^2	p-value
		n	%	n	%	n	%		
1	Victim of violence in neighborhood, community, or school.	109	27.7	11	26.2	12	27.9	0.047	.977
2	Experienced discrimination.	93	23.7	12	28.6	20	48.5	10.616	**.005**
3	Had problems with housing.	91	23.2	8	19.0	8	18.3	0.757	.685
4	Did not have enough food to eat or food ran out before more could be bought.	96	24.4	7	16.7	5	11.6	4.556	.102
5	Separated due to foster care or immigration.	99	25.2	7	16.7	6	14.0	3.902	.142
6	Caregiver has a serious physical illness or disability.	90	22.9	6	14.3	8	18.6	1.930	.361
7	Parent or caregiver died.	55	14.0	6	14.3	9	20.9	1.496	.473
8	Teen was detained, arrested, or incarcerated.	38	15.4	4	14.3	5	17.2	0.099	.952
9	Teen was verbally or physically threatened by a romantic partner.	33	13.4	1	3.6	5	6.9	3.087	.214
Total n = 477; White = 392; Black = 42; Other = 43									

Analysis of race category by group was completed (Table 22). Discrimination was significant for the SERVICE group with more discrimination experienced in the Other group ($X^2 = 6.110$, $p \leq .047$) and nearly significantly in the EVENTS group ($X^2 = 5.513$, $p \leq .076$). Black respondents had similar experiences as White respondents in the SERVICE group and were slightly elevated in the EVENTS group. Qualitative data was reviewed for race related information. Of note, several comments noted that being in a mixed couple relationship was more stressful as it was

Table 22: Summary of Life Event Item Scores by Race and Group (Yes responses)													
		SERVICE GROUP						EVENTS GROUP					
#	Screener Item	White		Black		Other		White		Black		Other	
		n	%	n	%	n	%	n	%	n	%	n	%
1	Victim of violence in neighborhood, community, or school.	83	37.1	8	27.6	9	37.5	26	15.4	3	23.1	3	15.8
2	Experienced discrimination.	66	29.5	9	31.0	13	54.2	27	16.0	3	23.1	7	36.8
3	Had problems with housing.	70	31.3	6	20.7	6	25.0	21	12.4	2	15.4	2	10.5
4	Did not have enough food to eat or food ran out before more could be bought.	65	29.0	5	17.2	3	12.5	31	18.3	2	15.4	2	10.5
5	Separated due to foster care or immigration.	80	35.7	5	17.2	5	20.8	19	11.2	2	15.4	1	5.3
6	Caregiver has a serious physical illness or disability.	70	31.3	5	20.7	8	33.3	20	11.8				
7	Parent or caregiver died.	43	19.2	6	20.7	4	16.7	12	7.1			5	26.3
8	Teen was detained, arrested, or incarcerated.	30	17.6	4	20.0	4	20.0	8	10.5			1	11.1
9	Teen was verbally or physically threatened by a romantic partner.	23	13.5	1	5.0	2	10.0	10	13.2				
Total n = 478; White = 393; Black = 42; Other = 43													

viewed as…

> "…unnatural. There is a lot of bigotry in our communities against people of color but even more against mixed race couples, especially Black and White couples. For White women with a Black man, it's viewed as a problem with their family and character. For a White man with a Black woman, it's almost like pity. Like they couldn't do any better. (Key Stakeholder Interview)."

One other significant finding is noted, though this appears to be by chance. Other youth in the EVENTS group were more likely to have had a parent that had died ($X^2 = 9.429$, $p \leq .009$).

Ethnicity differences for life events were completed and summarized in Table 23. Non-Hispanic individuals were significantly more likely to be placed in foster care. Two other questions were close to significance with non-Hispanic youth more likely to experience community or school violence and to have problems with housing. The analysis with ethnicity assessed by group was completed as well. There were no results significant or close to significant (data not shown).

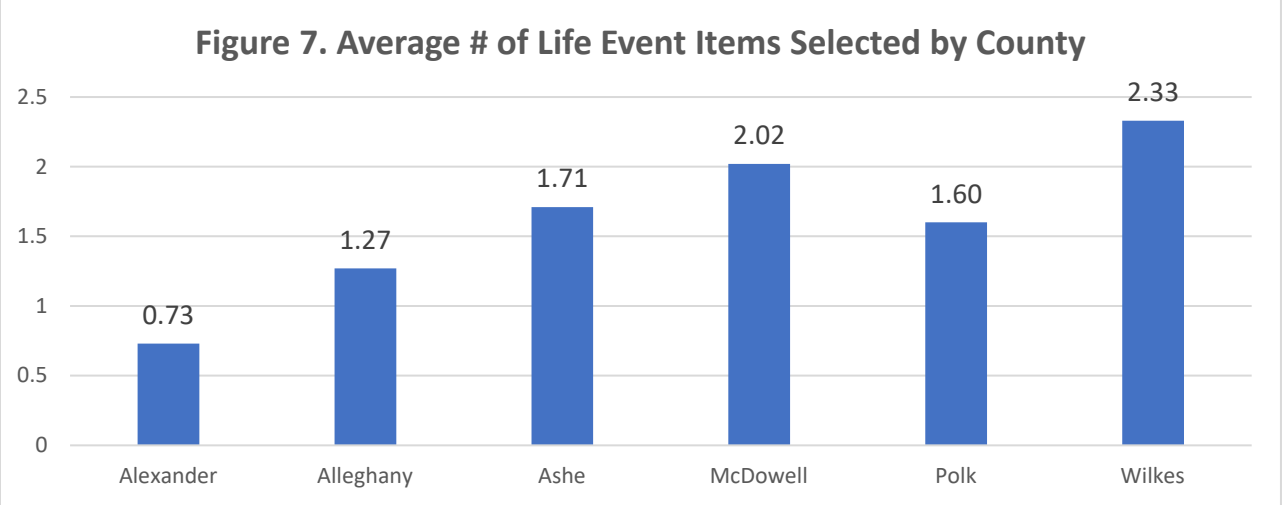
Table 23: Summary of Life Event Item Scores by Ethnicity (Yes responses)

#	Screener Item	Non-Hispanic		Hispanic		χ^2	p-value
		n	%	n	%		
1	Victim of violence in neighborhood, community, or school.	126	29.7	10	18.2	3.186	.074
2	Experienced discrimination.	117	27.6	10	18.2	2.214	.137
3	Had problems with housing.	104	24.5	7	12.7	2.808	.051
4	Did not have enough food to eat or food ran out before more could be bought.	96	22.6	16	29.1	1.130	.288
5	Separated due to foster care or immigration.	104	24.5	6	10.6	5.104	**.024**
6	Caregiver has a serious physical illness or disability.	97	22.9	8	14.5	1.975	.160
7	Parent or caregiver died.	66	15.6	7	12.7	0.304	.582
8	Teen was detained, arrested, or incarcerated.	41	15.0	4	14.3	0.009	.924
9	Teen was verbally or physically threatened by a romantic partner.	36	13.1	1	3.6	2.163	.141
Total n = 479; Non-Hispanic or Latino n = 424; Hispanic or Latino n = 55							

Life events, many of which would be expected to be equally distributed, do show some significant differences in distribution across the six counties with data (Table 24). Ashe, McDowell, and Wilkes counties have higher levels of community and school violence, approaching significance. Wilkes, and to a degree McDowell, drive the significant difference in separations due to foster care, most likely, or immigration. Wilkes, Ashe and, McDowell counties are more likely to have parents/caregivers with a disability or serious illness for respondents. Wilkes, Alleghany and Ashe are elevated for parents or caregivers that have died. Sample size limits generalization to county populations and these findings are cautionary only.

Table 24. Summary of Life Event Item Scores by County (Yes % Only)								
ITEM	**Alex**	**Allg**	**Ashe**	**McD**	**Polk**	**Wilkes**	**χ^2**	**p-value**
Victim of violence in neighborhood, community, or school.	17.1	18.9	31.3	32.8	24.7	38.0	9.544	.089
Experienced discrimination.	11.4	21.6	25.0	32.8	27.5	20.3	8.264	.142
Had problems with housing.	11.4	10.8	15.6	27.7	25.3	27.1	9.234	.100
Did not have enough food to eat or food ran out before more could be bought.	14.3	13.5	18.8	30.3	24.2	22.0	7.243	.203
Separated due to foster care or immigration.	8.6	10.8	18.8	28.6	18.5	42.4	24.255	**.000**
Caregiver has a serious physical illness or disability.	2.9	10.8	25.0	28.6	18.0	33.9	20.138	**.001**
Parent or caregiver died.		18.9	15.6	18.5	10.1	28.8	19.932	**.001**
Teen was detained, arrested, or incarcerated.	4.3	16.3	18.2	14.0	13.4	15.1	4.432	.489
Teen was verbally or physically threatened by a romantic partner.	13.0	15.8	27.3	10.5	11.0	9.4	5.611	.346
Alex = Alexander; Allg = Alleghany; McD = McDowell								

The last life events analysis displays the average number of life event items selected by youth from their respective counties (Figure 7). Consistent with table data, Wilkes and McDowell youth assessed have the highest averages followed by Ashe and then Polk. Alexander county, like for trauma, has markedly lower average life events though the number surveyed are comparable to Alleghany and Ashe. We remind that this is likely impacted by data collection for those from SERVICE and EVENTS groups for all counties and should be considered as estimates for community and treated groups.



Resilience Assessment Summary

Analysis of resilience data is follows the same patterns as for trauma and life events. Resilience questions each had three options versus a yes or no response. These include no, sometimes, and yes. Table 25 summarizes responses for each of the 17 questions along with item mean scores. 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 interpreting 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 507 respondents, questions around being able to talk to family about feelings (Q8, average = 2.40) and feeling that they belong in school (Q10, 2.46) are elevated for risk when considering overall resilience. Two other questions, getting along with people around me (Q1, 2.53) and feeling supported by friends (Q9, 2.51) approach high risk. Limited number of youths selected 'no' for most questions which suggests that resilience may be challenged but it is not impaired.

Table 25: Summary of Resilience Scores Selected by SOC Participants (n = 507)

#		No		Sometimes		Yes		Mean Item Score
		n	%	n	%	n	%	
1	I get along with people around me	17	3.4	202	40.1	285	56.5	*2.53*
2	Getting an education is important to me	50	10.0	102	20.4	348	69.6	2.60
3	I know how to behave/act in different situations (such as school, home and church)	37	7.4	114	22.7	352	70.0	2.63
4	My parent(s)/caregiver(s) really look out for me	18	3.6	39	7.8	446	88.7	2.85
5	My parent(s)/caregiver(s) know a lot about me (for example, who my friends are, what I like to do)	29	5.8	71	14.1	403	80.1	2.74
6	If I am hungry, there is enough to eat	15	3.0	28	5.5	463	91.5	2.89
7	People like to spend time with me	15	3.0	122	24.4	362	72.5	2.70
8	I talk to my family/caregiver(s) about how I feel (for example when I am hurt or sad)	71	14.2	159	31.8	270	54.0	**2.40**
9	I feel supported by my friends	48	9.8	146	29.1	306	61.1	*2.51*
10	I feel that I belong/belonged at my school	68	13.7	133	26.9	294	59.4	**2.46**
11	My family/caregiver(s) care about me when times are hard (for	13	2.6	40	7.9	451	59.5	2.87

Table 25: Summary of Resilience Scores Selected by SOC Participants (n = 507)								
#		No		Sometimes		Yes		Mean Item Score
		n	%	n	%	n	%	
	example if I am sick or have done something wrong)							
12	My friends care about me when times are hard (for example if I am sick or have done something wrong)	33	6.6	404	20.2	365	73.1	2.67
13	I am treated fairly in my community	36	7.1	86	17.0	385	75.9	2.69
14	I have chances to show others that I am growing up and can do things by myself	19	3.8	54	10.7	431	85.5	2.82
15	I feel safe when I am with my family/caregiver(s)	14	2.8	41	8.1	449	89.1	2.86
16	I have chances to learn things that will be useful when I am older (like cooking, working, and helping others)	16	3.2	35	6.9	453	89.9	2.87
17	I like the way my family/caregiver(s) celebrates things (like holidays or learning about my culture)	25	5.0	43	8.6	431	86.4	2.81

Differences in resilience by group, SERVICE or EVENT, show stark differences (Table 26). Only one of 17 questions is not significant between groups "If I am hungry, there is enough to eat." In all cases, youths seeking treatment have lower resilience average scores compared to community counterparts. This strongly suggests a key treatment goal or at least an area of focus, though there is no evidence that resilience is being targeted at the individual level. This is a clear opportunity to ensure that measurement-based care is considered. For the EVENTS group, no questions are at or below the 2.50 average benchmark for high risk. For the SERVICE group, five questions cross the high risk threshold and three others approach it. The five questions at risk include 'I get along with people around me', 'getting an education is important to me', 'I talk to my family about how I feel', 'I feel supported by my friends', and 'I feel that I belong in my school.' The three questions approaching risk are 'I know how to behave in different situations', 'my friends care for me when times are hard', and 'I am treated fairly in my community.' These are listed to draw attention to commonalities between items. **Together, these questions suggest that respondents feel isolated, are not connected to their schools or**

communities, and have trouble interacting with others and knowing how to tailor behaviors based on context.

Table 26: Summary of Resilience Mean Item Scores by Group						
Item	**SERVICE**		**EVENTS**		**t-test**	**p-value**
	Mean	**Sd**	**Mean**	**Sd**		
I get along with people around me	2.45	0.59	2.65	0.51	3.945	**.000**
Getting an education is important to me	2.46	0.75	2.78	0.46	5.353	**.000**
I know how to behave/act in different situations (such as school, home and church)	2.57	0.66	2.70	0.54	2.343	**.020**
My parent(s)/caregiver(s) really look out for me	2.81	0.50	2.91	0.35	2.568	**.011**
My parent(s)/caregiver(s) know a lot about me (for example, who my friends are, what I like to do)	2.65	0.62	2.87	0.40	4.550	**.000**
If I am hungry, there is enough to eat	2.88	0.40	2.89	0.40	0.368	.713
People like to spend time with me	2.60	0.59	2.82	0.38	4.733	**.000**
I talk to my family/caregiver(s) about how I feel (for example when I am hurt or sad)	2.21	0.77	2.65	0.58	7.016	**.000**
I feel supported by my friends	2.35	0.71	2.73	0.53	6.514	**.000**
I feel that I belong/belonged at my school	2.31	0.78	2.66	0.58	5.576	**.000**
My family/caregiver(s) care about me when times are hard (for example if I am sick or have done something wrong)	2.82	0.48	2.93	0.27	2.876	**.004**
My friends care about me when times are hard (for example if I am sick or have done something wrong)	2.54	0.67	2.83	0.42	5.573	**.000**
I am treated fairly in my community	2.56	0.68	2.86	0.40	5.736	**.000**
I have chances to show others that I am growing up and can do things by myself	2.76	0.54	2.90	0.34	3.435	**.001**
I feel safe when I am with my family/caregiver(s)	2.80	0.50	2.95	0.25	4.210	**.000**
I have chances to learn things that will be useful when I am older (like cooking, working, and helping others)	2.84	0.48	2.91	0.33	1.991	**.047**
I like the way my family/caregiver(s) celebrates things (like holidays or learning about my culture)	2.74	0.60	2.92	0.31	4.123	**.000**
TOTAL Resilience Score	**43.44**	**8.23**	**44.46**	**12.57**	**1.120**	**.263**
SERVICE n = 291; EVENTS n = 213						

Total scores are not significantly different, but the pattern of lower scores for SERVICE 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.

Differences in resilience for gender by item and for a total resilience score are summarized in Table 27. Total scores are not significantly different, but six item scores are. Not including transgender youth with the smaller sample size of 17 was considered. An analysis was completed without transgender youth to determine differences in item score significance. When comparing Male and Female, two of six items, "I am treated fairly in my community" and "I Like the way my family celebrates things" are no longer significant. Significance for these two items is driven by the addition of scores from transgender youth and not based on differences in youth that identify as male or female. Of interest is the comparison of high risk between groups. Three items were not significant between groups because all groups were at or approaching high risk, suggesting areas for intervention. These include 'I get along with people around me', 'I talk to my family about how I feel', and 'I feel that I belong in my school.'

Table 27: Summary of Resilience Mean Item Scores by Gender

Item	Male		Female		Trans		F	p-value
	Mean	Sd	Mean	Sd	Mean	Sd		
I get along with people around me	2.51	0.59	2.57	0.54	2.44	0.51	0.925	.397
Getting an education is important to me	2.42	0.74	2.72	0.58	2.81	0.40	13.736	**.000**
I know how to behave/act in different situations (such as school, home and church)	2.58	0.66	2.86	0.59	2.69	0.60	1.156	.316
My parent(s)/caregiver(s) really look out for me	2.86	0.43	2.85	0.46	2.63	0.62	2.045	.131
My parent(s)/caregiver(s) know a lot about me (for example, who my friends are, what I like to do)	2.76	0.51	2.76	0.55	2.44	0.81	2.746	.065
If I am hungry, there is enough to eat	2.90	0.39	2.87	0.43	2.94	0.25	0.568	.567
People like to spend time with me	2.67	0.54	2.74	0.49	2.63	0.62	1.473	.230
I talk to my family/caregiver(s) about how I feel (for example when I am hurt or sad)	2.38	0.72	2.44	0.71	2.13	0.81	1.526	.218
I feel supported by my friends	2.44	0.69	2.61	0.63	2.44	0.81	3.694	**.026**
I feel that I belong/belonged at my school	2.42	0.73	2.53	0.69	2.19	0.91	2.780	.063
My family/caregiver(s) care about me when times are hard (for example if I am sick)	2.90	0.34	2.84	0.45	2.75	0.58	1.722	.171
My friends care about me when times are hard (for example if I have done something wrong)	2.59	0.63	2.73	0.56	2.81	0.40	4.094	**.017**
I am treated fairly in my community	2.67	0.61	2.75	0.57	2.25	0.68	5.732	**.003**

Table 27: Summary of Resilience Mean Item Scores by Gender								
Item	**Male**		**Female**		**Trans**		**F**	**p-value**
	Mean	**Sd**	**Mean**	**Sd**	**Mean**	**Sd**		
I have chances to show others that I am growing up and can do things by myself	2.77	0.55	2.87	0.42	2.63	0.50	3.231	**.040**
I feel safe when I am with my family/caregiver(s)	2.88	0.40	2.87	0.42	2.63	0.50	2.873	.058
I have chances to learn things that will be useful when I am older (like working, and helping others)	2.85	0.45	2.89	0.39	2.81	0.54	0.828	.438
I like the way my family/caregiver(s) celebrates things (like holidays or learning about my culture)	2.85	0.46	2.82	0.49	2.38	0.81	6.917	**.001**
TOTAL Resilience Score	**43.76**	**9.73**	**44.32**	**10.68**	**41.06**	**12.07**	**0.877**	**.417**
Male = 228; Female = 262; Transgender = 17								

Female youth had the highest resilience score for 10 of the 17 items, were at high risk for only one item, and approached high risk for two others. Male youth had the highest resilience scores for five items, were at high risk for four items, and border risk for three others. Transgender youth were at high risk for the six items.

Differences by race were completed (Table 28). Only item 11, 'caregiver support when times are hard' was statistically significant (F = 3.399, p-value ≤ .034). Overall, Black youth demonstrate less resilience, though difference in sample size between groups must be considered and this is a tentative finding pending additional recruitment. Black youth have lower average resilience scores for 15 of 17 questions compared to Whites and 14 of 17 compared to the Other youth category. The one item where Black average scores are higher than the other two groups is for the 'I talk to my family about how I feel' (Item 8).

Table 28: Summary of Resilience Scores by Race (n = 252)							
#		**White**		**Black**		**Other**	
		M	**Sd**	**M**	**Sd**	**M**	**Sd**
1	I get along with people around me	2.54	0.54	2.46	0.76	2.56	0.55
2	Getting an education is important to me	2.61	0.66	2.49	0.76	2.48	0.71
3	I know how to behave/act in different situations (such as school, home and church)	2.57	0.64	2.74	0.64	2.77	0.53
4	My parent(s)/caregiver(s) really look out for me	2.86	0.43	2.74	0.64	2.88	0.32
5	My parent(s)/caregiver(s) know a lot about me (for example, who my friends are, what I like to do)	2.76	0.53	2.62	0.71	2.77	0.53

Table 28: Summary of Resilience Scores by Race (n = 252)							
#		White		Black		Other	
		M	Sd	M	Sd	M	Sd
6	If I am hungry, there is enough to eat	2.91	0.36	2.76	0.63	2.86	0.47
7	People like to spend time with me	2.70	0.51	2.59	0.67	2.71	0.46
8	I talk to my family/caregiver(s) about how I feel (for example when I am hurt or sad)	2.41	0.71	2.49	0.76	2.30	0.77
9	I feel supported by my friends	2.54	0.65	2.41	0.82	2.40	0.66
10	I feel that I belong/belonged at my school	2.46	0.71	2.28	0.92	2.50	0.71
11	My family/caregiver(s) care about me when times are hard (for example if I am sick or have done something wrong)	2.89	0.37	2.72	0.65	2.84	**0.37**
12	My friends care about me when times are hard (for example if I am sick or have done something wrong)	2.69	0.57	2.54	0.76	2.60	0.63
13	I am treated fairly in my community	2.71	0.59	2.49	0.76	2.63	0.54
14	I have chances to show others that I am growing up and can do things by myself	2.83	0.46	2.72	0.65	2.79	0.41
15	I feel safe when I am with my family/caregiver(s)	2.87	0.38	2.74	0.64	2.91	0.37
16	I have chances to learn things that will be useful when I am older (like cooking, working, and helping others)	2.88	0.40	2.77	0.63	2.91	0.29
17	I like the way my family/caregiver(s) celebrates things (like holidays or learning about my culture)	2.84	0.47	2.69	0.66	2.88	0.41
	TOTAL Resilience Score	**44.08**	**10.05**	**41.02**	**14.98**	**45.51**	**4.44**
White n = 399; Black n = 42; Other n = 43							

With the same concern for sample size mitigating confidence, Hispanic/Latino youth have higher resilience scores on 12 of 17 items (Table 29). The total resilience score nears significance ($p \leq .080$). Four items are significantly different, all favoring Hispanic/Latino youth: 'getting an education is important to me', 'parents really look out for me', 'people like to spend time with me', and 'I am treated fairly in my community.' Increase in sample size will help to determine whether the findings remain consistent.

Table 29: Summary of Resilience Mean Item Scores by Ethnicity						
Item	Non-Hispanic		Hispanic		t-test	p-value
	Mean	Sd	Mean	Sd		
I get along with people around me	2.52	0.57	2.56	0.57	0.409	.684
Getting an education is important to me	2.58	0.68	2.74	0.56	1.977	**.050**
I know how to behave/act in different situations (such as school, home and church)	2.61	0.63	2.69	0.54	0.965	.338
My parent(s)/caregiver(s) really look out for me	2.83	0.47	2.93	0.26	2.127	**.038**

Table 29: Summary of Resilience Mean Item Scores by Ethnicity						
Item	**Non-Hispanic**		**Hispanic**		**t-test**	**p-value**
	Mean	**Sd**	**Mean**	**Sd**		
My parent(s)/caregiver(s) know a lot about me (for example, who my friends are, what I like to do)	2.74	0.56	2.81	0.44	1.174	.244
If I am hungry, there is enough to eat	2.90	0.39	2.80	0.45	1.559	.124
People like to spend time with me	2.68	0.53	2.83	0.38	2.559	**.012**
I talk to my family/caregiver(s) about how I feel (for example when I am hurt or sad)	2.37	0.73	2.46	0.72	0.870	.388
I feel supported by my friends	2.49	0.68	2.63	0.59	1.567	.121
I feel that I belong/belonged at my school	2.43	0.73	2.61	0.66	1.856	.068
My family/caregiver(s) care about me when times are hard (for example if I am sick or have done something wrong)	2.86	0.43	2.91	0.29	1.062	.291
My friends care about me when times are hard (for example if I am sick or have done something wrong)	2.67	0.60	2.67	0.58	0.000	1.00
I am treated fairly in my community	2.66	0.63	2.83	0.42	2.602	**.011**
I have chances to show others that I am growing up and can do things by myself	2.82	0.48	2.78	0.50	0.569	.571
I feel safe when I am with my family/caregiver(s)	2.85	0.44	2.93	0.26	1.864	.065
I have chances to learn things that will be useful when I am older (like cooking, working, and helping others)	2.87	0.43	2.85	0.41	0.252	.802
I like the way my family/caregiver(s) celebrates things (like holidays or learning about my culture)	2.81	0.51	2.76	0.58	0.633	.529
TOTAL Resilience Score	**43.73**	**10.32**	**15.82**	**7.89**	**1.774**	**.080**
Non-Hispanic n = 430; Hispanic/Latino n = 55						

Significant county differences were found for some questions (Table 30) and total scores were significantly different ($F = 3.306$; $p \leq .006$). The difference in sampling for each County is restated here as a likely reason behind differences. This is validated through a simple count. Alexander County, with the lowest number of SERVICE youth has the highest average score on 12 items. Wilkes, with the highest number of SEVICE youth has the lowest average score on 14 items. This parallels the SERVICE compared to EVENTS analysis above (Table 26).

Table 30. Summary of Resilience Item Scores by County (Yes % Only)								
ITEM	**Alex**	**Allg**	**Ashe**	**McD**	**Polk**	**Wilkes**	**F**	**p-value**
I get along with people around me	2.73	2.44	2.66	2.51	2.52	2.41	2.009	.076
Getting an education is important to me	2.76	2.55	2.84	2.48	2.64	2.49	2.647	**.023**
I know how to behave/act in different situations (such as school, home and church)	2.62	2.50	2.52	2.63	2.70	2.58	1.075	.373
My parent(s)/caregiver(s) really look out for me	2.90	2.94	2.81	2.82	2.92	2.74	2.306	**.044**
My parent(s)/caregiver(s) know a lot about me (for example, who my friends are, what I like to do)	2.90	2.76	2.77	2.73	2.76	2.64	1.137	.340
If I am hungry, there is enough to eat	2.87	2.88	2.91	2.90	2.90	2.82	0.444	.817
People like to spend time with me	2.85	2.61	2.84	2.67	2.70	2.50	3.029	**.011**
I talk to my family/caregiver(s) about how I feel (for example when I am hurt or sad)	2.74	2.33	2.68	2.30	2.41	2.25	3.914	**.002**
I feel supported by my friends	2.79	2.34	2.66	2.56	2.51	2.30	3.701	**.003**
I feel that I belong/belonged at my school	2.73	2.16	2.48	2.45	2.51	2.30	3.041	**.010**
My family/caregiver(s) care about me when times are hard (for example if I am sick or have done something wrong)	2.92	2.91	2.84	2.89	2.91	2.77	1.399	.223
My friends care about me when times are hard (for example if I am sick or have done something wrong)	2.92	2.64	2.81	2.63	2.71	2.48	3.580	**.003**
I am treated fairly in my community	2.95	2.67	2.79	2.62	2.68	2.64	2.106	.064
I have chances to show others that I am growing up and can do things by myself	2.90	2.94	2.81	2.80	2.85	2.61	3.283	**.006**
I feel safe when I am with my family/caregiver(s)	3.00	2.91	2.97	2.85	2.89	2.70	3.516	**.004**
I have chances to learn things that will be useful when I am older (like cooking, working, and helping others)	2.92	2.91	2.91	2.86	2.88	2.74	1.445	.207
I like the way my family/caregiver(s) celebrates things (like holidays or learning about my culture)	2.95	2.88	2.94	2.82	2.83	2.60	3.527	**.004**
TOTAL Resilience Score	**45.76**	**38.03**	**44.53**	**43.85**	**44.85**	**43.39**	**3.306**	**.006**
Alex = Alexander; Allg = Alleghany; McD = McDowell								

A key analysis was to review via correlation the relationships between trauma, life events, and resilience scores for direction and strength (Table 31). 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 all calculations. We also bifurcated the resiliency score at the mean and at the median and correlated with the accompanying trauma and life event scores. Two relationships remained significant. When resilience is greater than 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. As 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 31. Pearson Correlation Summary for Trauma, Life Events, and Resilience Scores

Variable 1	Variable 2	n	r	p-value
Trauma	Life Events	526	.707	.000
Resilience	Trauma	325	-.079	.072
Resilience	Life Events	525	-.094	**.031**
Resilience ≤ Sample Mean	Trauma	173	.071	.353
Resilience ≤ Sample Mean	Life Events	173	.017	.825
Resilience > Sample Mean	Trauma	334	-.070	.200
Resilience > Sample Mean	Life Events	334	-.080	.142
Resilience ≤ Sample Median	Trauma	270	-.002	.978
Resilience ≤ Sample Median	Life Events	270	-.047	.446
Resilience > Sample Median	Trauma	237	-.175	**.007**
Resilience > Sample Median	Life Events	237	-.153	**.019**

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 32 summarizes performance measure data for Year 3. Targeted for improvement is tracking the number of persons for referred and engaged in treatment.

Table 32. IPP Data Summary for Grant Year 3					
Metric	**Q1**	**Q2**	**Q3**	**Q4**	**Total**
PD1	2	3	0	2	7
WD2	18	35	52	39	144
WD5	3	10	44	42	99
T3	3	10	43	23	79
O1	23	15	83	59	180
R1	6	13	14	10	51
AC1	3	11	12	7	33
AC1 %	50.0	84.6	85.7	70.0	64.7

PD1: THE NUMBER OF POLICY CHANGES COMPLETED AS A RESULT OF THE GRANT.

Policy changes include the following: (Q1.1) Increasing Youth and Family Partner employment and availability to families in need; (Q1.2) establishing RBA and data driven decisions as part of two Collaboratives; (Q2.1) establishing SOC Coordinators and Family Partner teams for each active Collaborative in the Vaya area; (Q2.2) establishing Triple Screen data collection at events in grant served counties; (Q2.3) including SOC principles as part of collaborative education and support. (Q4.1) Vaya has developed and adopted a different contract model to support programs across grant counties. (Q4.2) The Evaluation Team has worked with NC Families United and Parent2Parent to adopt a new measurement system to better document their impact, sustainability, and create a structure to grant additional grant and other resources.

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 through review of (1) Field Note Data Registry, (2) Collaborative Meeting minutes across the seven counties, (3) Governance Board meetings, and (4) Project Implementation Team meetings. 144 were included in the field note (Table 32). There were a number of trainings completed by CULA and others, n = 500, that were not entered into the Field Note but were funded by the SOC. These included professionals which are estimated to be one-quarter of those trained. Total professionals trained = 125 + 144 = 269.

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

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 enhanced 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 33.

Table 33. Summary of IPP Data Objective Status as Met or Unmet

IPP	Description	Goal	#	%	Year 3	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	144	320	Summed from 108 Field Note records that cover the annual report period. Mental Health First Aid – Youth: 30 WRAP: 12 QPR: 40 Trauma and Resilience: 5 HOPE: 19 Results Based Accountability: 24 Other: 14	**MET**
WD5	The number of consumers/family	10	99	990	Also summed from 108 Field Note records.	**MET**

Table 33. Summary of IPP Data Objective Status as Met or Unmet						
IPP	**Description**	**Goal**	**#**	**%**	**Year 3**	**Status**
	members who provide mental health-related services as a result of the grant.				Mental Health First Aid: 61 QPR: 20 Why Try: 12 Trauma and Resilience: 6	
T3	The number of people receiving evidence-based mental health-related services as a result of the grant.	30	79	263	Tracked through Provider systems and linked with Evaluation Team.	**MET**
O1	The number of individuals contacted through program outreach efforts.	100	180	180	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	51	142	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%	33	65	**33 of 51** of youth in system.	**UNMET**

National Outcomes Measurement Systems Data Summary

Select NOMS data is summarized below. There is limited data for repeated measures comparison but it is completed when possible. We note that SPARS required the use of the new NOMS tool in Year 3. This required merging data from the two tools. The new tool removed some questions previously reported and for other questions reduced the number of value choices from Likert to dichotomous (Yes/No) which we found limited analysis and interpretation. For this report, the following NOMS data was used:

- Baseline = 124
- 6-month follow-up = 27
- Discharge = 79

Diagnosis Data

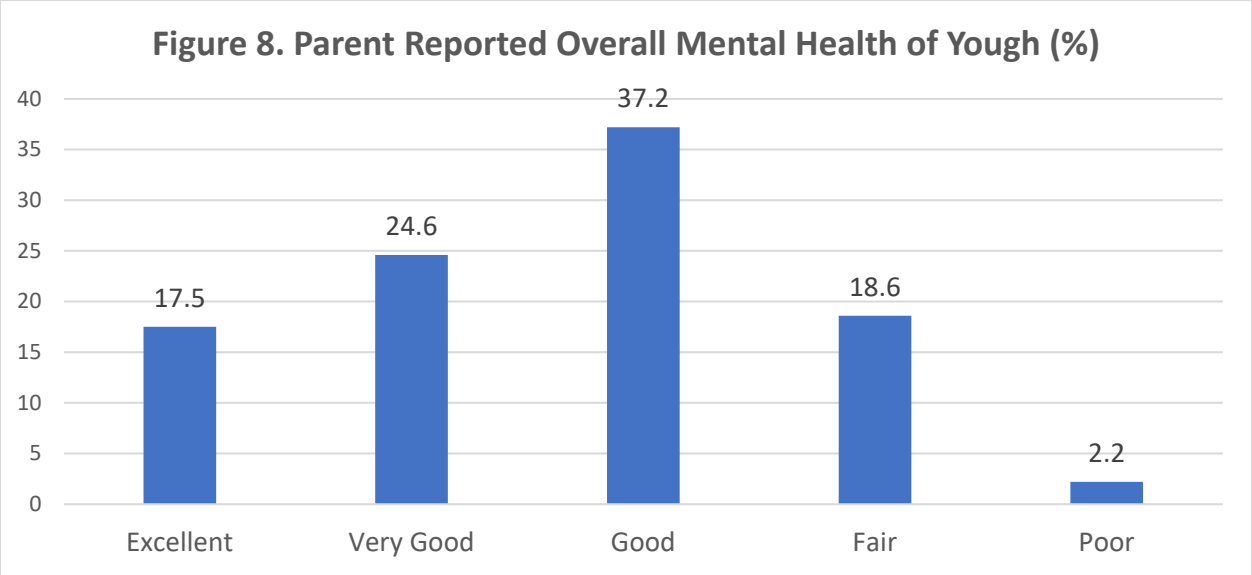
There are three fields for diagnoses to be entered. We combine them to better understand the range of diagnoses (Table 34). Diagnoses are listed by most to least prevalent. Also, because these diagnoses have a range of practitioners, they should be considered accurate with caution. Anxiety, behavior, and attention diagnoses predominate. There is minimal substance use reported but this is typical for youth to require time and trust to disclose.

Table 34. Frequency of Diagnoses Entered into SPARS System via NOMS Data		
	n	%
Attention-deficit hyperactivity disorders	68	22.1
Anxiety, dissociative, stress-related, somatoform, and other nonpsychotic mental disorders	52	16.9
Conduct disorders	34	11.1
Major depressive disorder, recurrent	27	8.8
Generalized anxiety disorder	22	7.2
Post traumatic stress disorder, unspecified	15	4.9
Intellectual disabilities	13	4.2
Persistent mood [affective] disorders	10	3.3
Major depressive disorder, single episode	8	2.6
Other anxiety disorders	8	2.6
Other behavioral and emotional disorders with onset usually occurring in childhood and adolescence	7	2.3
Unspecified mood [affective] disorder	6	2.0
Acute stress disorder; reaction to severe stress, and adjustment disorders	6	2.0
Tobacco use disorder, mild/moderate/severe	4	1.3
Pervasive and specific developmental disorders	4	1.3
Cannabis use, unspecified	3	1.0
Adjustment disorders	3	1.0
Cannabis use disorder, uncomplicated, moderate/severe	2	0.7
Obsessive-compulsive disorder	2	0.7
Problems related to housing and economic circumstances	2	0.7
Alcohol use disorder, moderate/severe, in remission	1	0.3
Alcohol use, unspecified	1	0.3
Tobacco use disorder, mild/moderate/severe, in remission	1	0.3
Manic episode	1	0.3
Bipolar disorder	1	0.3
Sleep disorders not due to a substance or known physiological condition	1	0.3
Disorders of social functioning with onset specific to childhood or adolescence	1	0.3
Social phobias (Social anxiety disorder)	1	0.3
Schizoid personality disorder	1	0.3
Problems related to upbringing	1	0.3
Other problems related to primary support group, including family circumstances	1	0.3

Functioning Data

A key NOMS question asks about overall health. For the new NOMS version this is changed to overall mental 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 8 summarizes mental health selections. Out of 183 with data, 145 (79.2%) youth are rated by

parents as having good, very good or excellent mental health. This appears elevated given the number of issues and experiences that youth in treatment are experiencing. Qualitative data, trauma and NOMS data suggests that overall functioning may be perceived by parents or youth, depending on who completes, as higher than other data would support.



The NOMS assessment asks a series of questions around handling daily life stressors, coping and relationships with caregivers. Baseline, follow-up data and discharge data are presented in a series of figures. Previous reports had a wider selection of values. An assessment for significance of change using the Pearson Chi-Square (χ^2) and assessed further by the Likelihood Ratio was completed for each of the following. For Figures 9-14, questions were changed to Yes/No. There is more follow-up and substantially more discharge data compared to last report. The impact of treatment for general coping, 'Youth Handles Daily Life' trends up, improving, for youth from baseline to discharge (Figure 9), though the improvement is not significant ($p \leq .155$).

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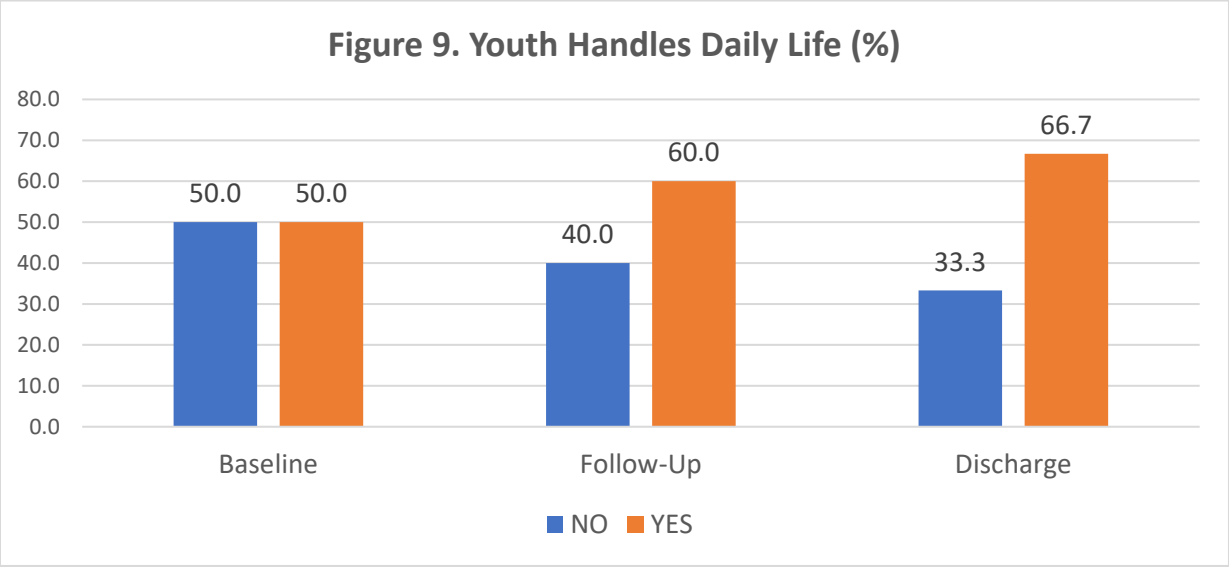
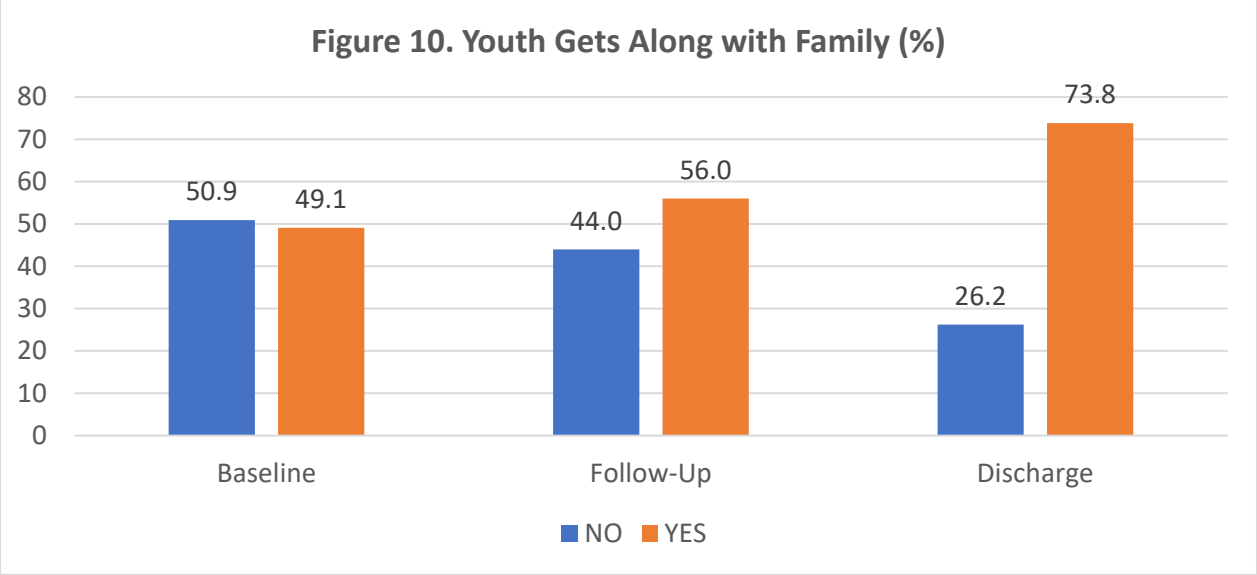
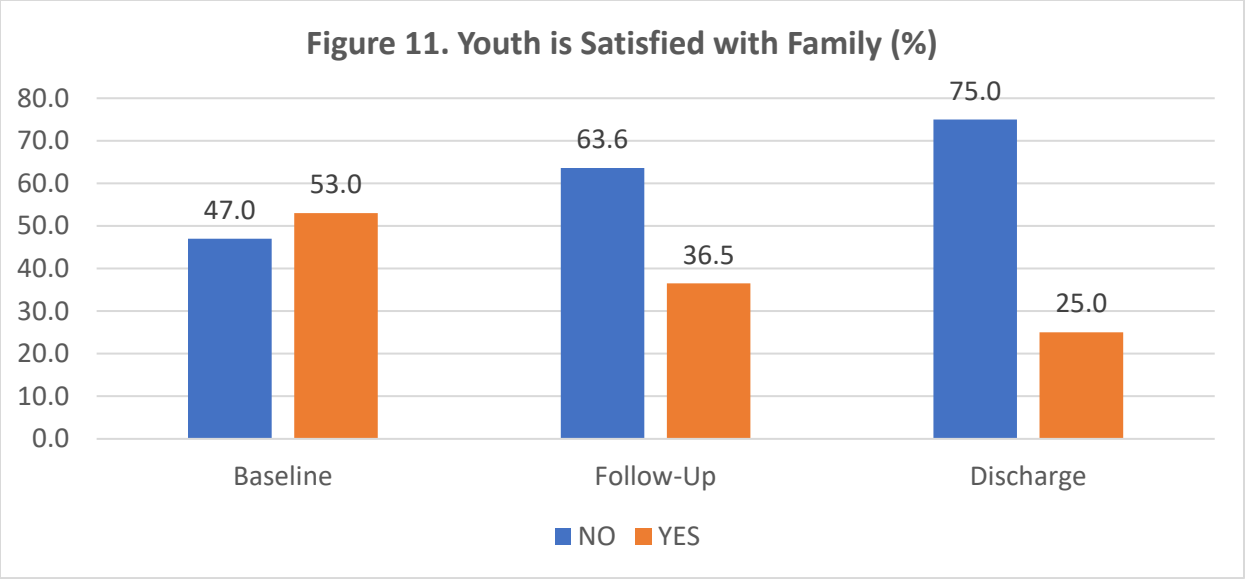


The next question queries respondents how well youth get along with their family (Figure 10). A big emphasis of Family and Youth Partners is family communication, focusing on strengths, addressing behaviors, and fostering connection in and out of the family. Getting along with family, a proxy for communication and connection, improves significantly from baseline, into follow-up, and even more at discharge (χ^2 7.609, $p \leq .022$).

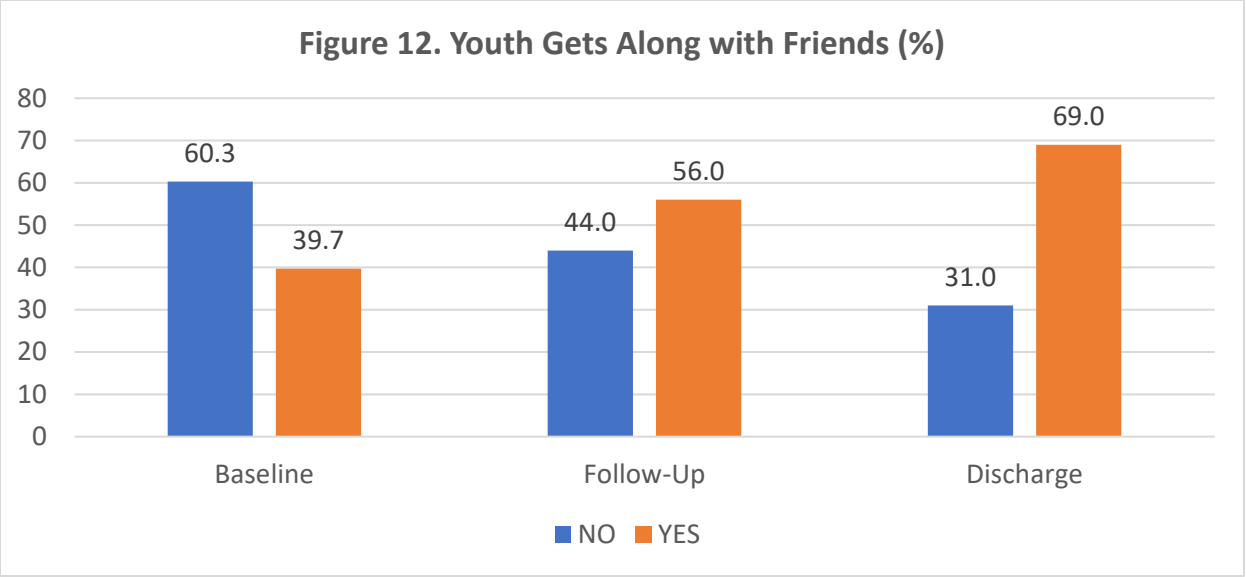


The next question reported is the last question in the NOMS cluster on functioning and is likely last to place it further away from the question of getting along with famliy. We report it here because it relates to the previous question and reveals inconsistency in responses. This question asks whether youth are satisfied with their family (Figure 11). It could be assumed that getting along would be consistent with satisfaction but that does not appear here. Satisfaction

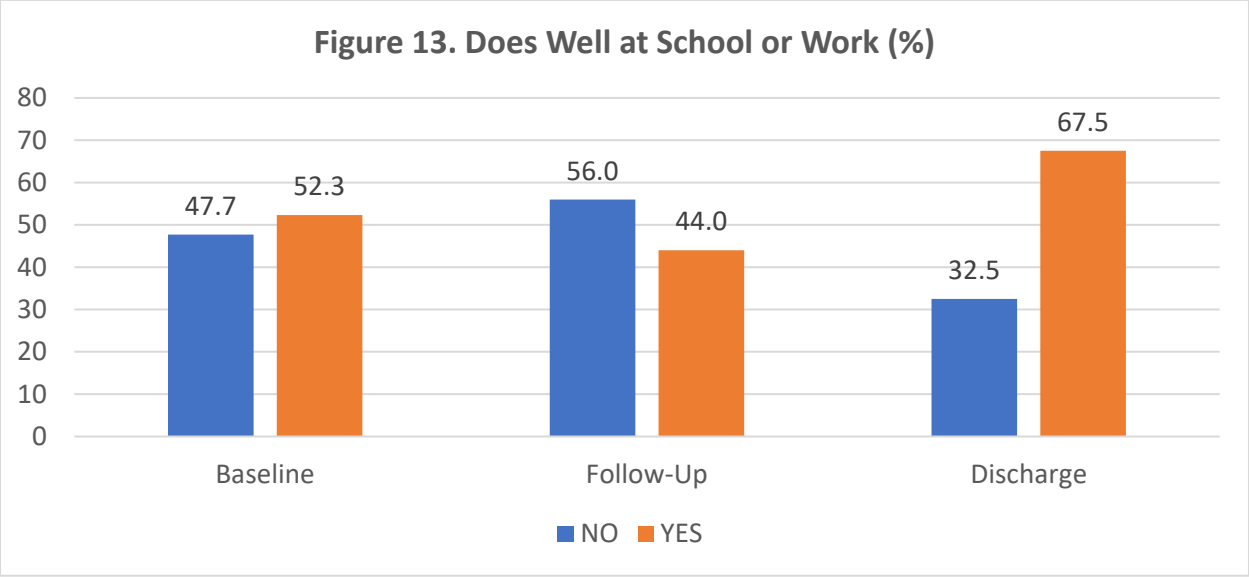


trends down, though not significantly ($p \leq .137$). An additional analysis using the qualitative database noted the following. As youth improves, they are more likely to have satisfactory relationships with extended family and families of peers as socialization and confidence increases. As they become more self-aware and stable, they begin to compare their lives to others, as teens often do, and find some areas wanting. It was also noted eleven times in qualitative data that as youth and families increase communication, they are challenged with forgiving each other, which is often difficult and takes more time than youth remain in care. However, it is also clear that the process of forgiveness is routinely started as part of treatment. This reduces satisfaction but not affection for their immediate family. Further, when addressing satisfaction with age, we divided the age by above and below median age and found that the reduction in satisfaction was driven more by older youth, and significantly so (χ^2 5.891, $p \leq .049$). This corresponds with growth of independence and contemplating launching from the family of origin or, in some case, from fostering situations.

Youth were asked whether they were getting along with friends as well as with family (Figure 12). Past experiences with SOC grants suggest that this tends to be high at baseline and improves with service support. This is partially accurate. Compared to four other system of care or similar evaluations, higher percentages of youth indicate they do not get along with friends at baseline though this improves significantly from baseline to discharge (χ^2 11.293, $p \leq .004$). This will continue to be monitored as more data is collected. Slightly more than 60 percent at baseline were labeled, by parent or self, as <u>not</u> getting along with friends. Treatment and support of the youth raised confidence and social capacity so at discharge, 69 percent were stated to get along with friends, a 30 percent improvement.

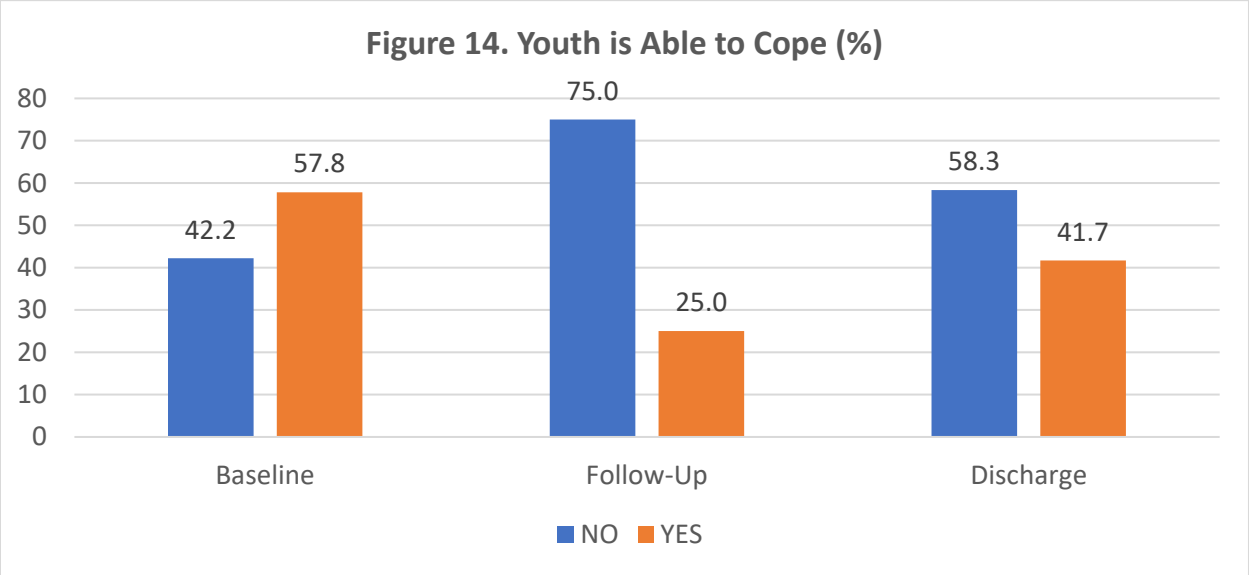


Respondents are asked to rate whether they are doing well in school or, in some cases, at work (Figure 13). Findings are not significant ($p \leq .133$), but the pattern is noteworthy and supported by interview and other narrative data. At baseline, slightly above 50 percent of youth are doing well. Treatment and support often allow the emergence of emotions that are hard to understand and cope with. This may lead to reduction in doing well in school at follow-up, especially for male youth, hence follow-up has a lower percentage doing well in school. With sufficient time in treatment, stability allows for more academic and employment success, which is shown by the large increase at discharge.



The final question in this cluster reports on ability to cope (Figure 14). The impact of challenging emotional issues, being in treatment, reconnecting with family and friends, gaining independence, addressing trauma, finding that parents and other caregivers are flawed, and

reducing substance use as a coping mechanism, all noted no less than 10 times and as many as 34 times in qualitative data, helps to explain the unexpected and nearly significant findings in response to the coping question (χ^2 5.147, $p \leq .076$). Youth, either self-rated or by parent, are considered more able to cope at baseline than at follow-up, which sharply decreases, and at discharge, where the numbers are almost exactly reversed with baseline scores.



Functioning as a cluster or construct has improved though this is not completely consistent and still requires additional follow-up data. 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 35. Each question has the same pattern: “During the past 30 days, did you (your child) feel nervous, hopeless, restless, etc.” Some interesting trends are noted. Not feeling nervous increased from 32.4 percent to 55.9 percent at discharge. While not significant, being nervous or anxious is a primary emotion that impedes meeting academic, family, and friend obligations. Reduction in hopelessness and worthlessness are both significant and critical as these are two emotions strongly linked with suicidality. Oddly, being restless improved, but only slightly, but could be the result of youth gaining a sense of energy and learning to deal with it. Being restless is the opposite of depression, and depression improved at a near significant level but, as is the want with depression, slowly, and more improvement is shown at discharge. Improvement in felt energy was noted over 30 times in qualitative data and is consistent with the strongest change with the reduction in ‘everything is an effort.’ This can snowball into greater successes for youth and the Y/FPs are commended for their effort to support improvement in youth.

Table 35. Summary of Emotional Symptom Data by Administration (NO %)					
Question	**Baseline**	**Follow-Up**	**Discharge**	**χ^2**	**p-value**
Nervous	32.4	41.2	55.9	5.220	.074
Hopeless	58.8	75.0	91.2	11.656	**.003**
Restless	29.4	25.0	23.5	0.439	.803
Depressed	64.7	68.8	85.3	4.738	.094
Everything is an Effort	39.1	56.3	76.5	12.561	**.002**
Worthless	63.2	81.3	88.2	.7.824	**.020**

Social Connectedness Data

Connectedness is critical for resilience, self-esteem, academic success, and positive socialization. Social Connectedness is measured with six NOMS questions. Findings are somewhat contradictory to the functioning and emotional symptom data in the previous two subsections. Baseline in most cases is quite high, limiting the ability to improve. The previous report used figures for each question as most of the data was baseline. This time, information on Social Connectedness data is summarized in Table 36. For this cluster of questions, positive experiences and improvement is demonstrated with 'Yes' responses. 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 change in values with the new NOMS may limit this. The degree of change for each question would partially determine that and additional follow-up data is needed.

Table 36. Summary of Social Connectedness Data by Administration (YES %)					
Question	**Baseline**	**Follow-Up**	**Discharge**	**χ^2**	**p-value**
Child/youth is happy with their friendships	80.0	93.2	92.0	2.140	.343
Have people to do enjoyable things with	91.5	92.3	84.3	2.226	.328
Feels that they belong in the community	75.9	76.9	84.0	0.584	.747
In a crisis, would have support from family and friends	93.9	92.3	61.9	16.934	**.000**
Have family and friends supportive of their recovery	92.4	96.2	78.4	8.699	**.013**
They child/youth generally accomplishes what they set out to do	96.7	84.6	96.3	2.775	.250

The child being happy with their friendships has a ceiling issue but does show improvement. Of note for several other connectedness questions is the often abrupt reduction at discharge. Interview and other data suggests that youth and families may end treatment rapidly, is unplanned, or, when planned, can be accompanied with concerns for being ready. Some youth may be responding to the loss of a key anchor for the family when the Y/FP is no longer as

available, if available at all. The sharp decrease for support in a crisis and having family or friends supportive of recovery is not otherwise explainable and will be monitored as additional discharge data accrues.

Satisfaction with Services

Individuals with follow-up or discharge NOMS are asked to rate services on a number of metrics. Downloading old and new NOMS, questions have been altered or are offered only as Yes/No responses. We divide the questions into old and new NOMS questions for which version the client was administered at discharge. Satisfaction is very high regardless of version. The total number completing each question, the number in agreement, indicating a positive experience, and the percentage with positive experiences are summarized in Tables 36 and 37.

Reduction of data from more options in the Old NOMS resulted in common responses. The same person was not satisfied with the services. Thus, 25 of 26 individuals with discharge perception of data were satisfied to highly satisfied with services (Table 37). This is strongly supported in qualitative interviews, PIT meeting data, Family Partner extractions, and SOC Coordinators where success stories, family updates, and related information is routinely shared. Results were similar with slightly more variance in some questions for new NOMS questions (Table 38).

Table 37. Summary of Old NOMS Version Perception of Care Questions

Question	Total Responses	Total Positive	% Positive
Treated with Respect	26	25	96.2
Respected religious beliefs	26	25	96.2
Spoke in an understandable way	26	25	96.2
Sensitive to culture	26	25	96.2
Freedom to choose child's services	26	25	96.2
Included in planning treatment goals	26	25	96.2
Participated in child's treatment	26	25	96.2
Satisfied with services	26	25	96.2
Team 'stuck with us'	26	25	96.2
Talked to me when troubled	26	25	96.2
We had the right services	26	25	96.2
Got the help we wanted	26	25	96.2
Got the help we needed	25	24	96.0

Table 38. Summary of NEW NOMS Version Perception of Care Questions

Question	Total Responses	Total Positive	% Positive
Staff believed the child could grow, change, and recover	40	40	100
Family felt free to complain	40	39	97.5
Family was educated on child's rights	40	39	97.5

Table 38. Summary of NEW NOMS Version Perception of Care Questions			
Question	**Total Responses**	**Total Positive**	**% Positive**
Staff encouraged child to take responsibility for their life	40	39	97.5
Staff informed about side effects to watch out for	40	33	82.5
Staff respected release of information and confidentiality around treatment	41	41	100
Staff was sensitive to cultural background of child, e.g., race, religion, language	45	45	100
Staff helped child and caregiver with information to manage their illness	41	39	95.1
Family was encouraged to use consumer-run programs	40	40	100
Family/child felt comfortable asking questions about medication and treatment	41	39	95.1
Child/family decided on child's treatment goals	45	42	93.3
Child/family liked the services received	44	44	100
Child/family would still get services from the provider if there were other choices	38	37	97.4
Child/family would recommend agency	40	40	100

Combined Analysis

We combine data from the NOMS and Triple Screen in this section when possible. The objective is to better tell the story of the youth and families services received by integrating data. We review NOMS data fields with sufficient data with trauma, life events and resilience data from the Triple Screen. Because of the change in the NOMS, the independent sample t-test is applied to dichotomous data, yes and no responses for clusters of questions, with total scores. There are some surprising findings. Three hypotheses are tested.

- Hypothesis 1: Youth identified as having problems with functioning will have higher numbers of trauma exposures and life events and will have lower resilience scores.
- Hypothesis 2: Youth identified as having problems with social connectedness will have higher numbers of trauma exposures and life events and will have lower resilience scores.
- Hypothesis 3: Youth identified as having problems with emotion related symptoms will have higher numbers of trauma exposures and life events and will have lower resilience scores.

Hypothesis 1. Functioning questions are associated with trauma, life events, and resiliency scores in Table 39. Limited sample size should be considered when interpreting findings. Number of trauma experiences trend higher when functioning is identified as problematic (Yes

Problem). Getting along with family is nearly significant and getting along with friends is significant. Having problems getting along with friends is related to higher levels of trauma. Associations with life events is similar with getting along with friends more difficult for youth with higher number of life events. Narrative data suggests that increased trauma and life events affects socialization opportunities, lowering capacity for peer-to-peer socialization. Lower resiliency is significantly associated with ability to cope and being satisfied with ones family. There appears to be evidence supporting Hypothesis 1 that trauma reduces functioning, affects social connectedness, especially for peer relationships, and challenges some aspects of resilience.

Table 39. Summary of Functioning Questions Associated with Trauma, Life Events and Resiliency Total Scores

Functioning Questions	No Problem		Yes Problem		Stats	
	n	Mean	n	Mean	t-test	p-value
TRAUMA						
Handling Daily Life	53	4.21	50	4.96	1.285	.202
Gets Along with Family	55	4.05	48	5.19	1.952	.054
Gets Along with Friends	64	4.03	39	5.51	2.515	**.013**
Doing Well in School or Work	46	4.65	49	4.55	0.163	.871
Ability to Cope	33	4.08	44	5.05	1.474	.145
Satisfied with Family	36	4.00	41	5.17	1.777	.080
LIFE EVENTS						
Handling Daily Life	53	2.45	50	2.64	0.472	.638
Gets Along with Family	55	2.36	48	2.75	0.976	.331
Gets Along with Friends	64	2.16	39	3.26	2.793	**.006**
Doing Well in School in Work	46	2.46	49	2.67	0.519	.605
Ability to Cope	33	2.64	44	2.55	0.192	.849
Satisfied with Family	36	2.64	41	2.54	0.217	.829
RESILIENCY						
Handling Daily Life	52	42.87	49	43.04	0.135	.893
Gets Along with Family	54	42.87	47	42.89	0.018	.986
Gets Along with Friends	63	43.14	38	43.24	0.077	.938
Doing Well in School or Work	45	42.27	49	43.96	1.342	.183
Ability to Cope	33	43.97	43	40.47	2.209	**.030**
Satisfied with Family	35	43.97	41	40.29	2.341	**.022**

Social connectedness data is collected only at baseline. There was insufficient follow-up data for the question ‘youth has family and friends supportive of their recovery.’ There are smaller numbers to associate with most social connectedness questions and while the data is displayed (Table 40), conclusions are speculative, trends are evident. For trauma, support by family and for recovery reduces as trauma experiences increase. Indeed, for all questions, functioning decreases as trauma increases. The same trend is present for all life events, but not significant.

Where social connectedness is most strongly associated is with resilience. The lower the resilience, the more that youth are indicated to have problems with each connectedness item, four of five significantly so. Hypothesis 2 is supported with greater confidence. All items trend in the hypothesized direction. Trauma tends to cause a sense of isolation that is perceived as lack of support in general and for recovery. These two items both approach significance. As noted, resilience is strongly affected by lack of social connection. Four of the five items are significantly different and the final one approaches significance. This suggests that improving social connections for youth, engaging them in peer-led self-help support and other peer influenced opportunities will increase resilience.

Table 40. Summary of Social Connectedness Questions Associated with Trauma, Life Events and Resiliency Total Scores

Social Connectedness	No Problem		Yes Problem		Stats	
	n	Mean	n	Mean	t-test	p-value
TRAUMA						
Child/youth is happy with their friendships	18	3.94	5	5.40	1.006	.326
Have people to do enjoyable things with	96	4.57	10	4.90	0.330	.715
Feels that they belong in the community	17	3.76	5	6.00	1.548	.137
In a crisis, would have support from family and friends	97	4.43	9	6.44	1.959	.052
They child/youth generally accomplishes what they set out to do	17	3.59	6	6.17	2.026	.056
LIFE EVENTS						
Child/youth is happy with their friendships	18	2.33	5	3.60	1.307	.205
Have people to do enjoyable things with	96	2.58	10	3.40	1.195	.235
Feels that they belong in the community	17	2.29	5	3.40	1.110	.280
In a crisis, would have support from family and friends	97	2.57	9	3.67	1.542	.126
They child/youth generally accomplishes what they set out to do	17	2.18	6	3.83	1.894	.072
RESILIENCY						
Child/youth is happy with their friendships	17	46.65	5	42.00	3.063	**.006**
Have people to do enjoyable things with	94	43.56	10	36.50	3.494	**.001**
Feels that they belong in the community	16	46.38	5	43.00	1.946	.067

Table 40. Summary of Social Connectedness Questions Associated with Trauma, Life Events and Resiliency Total Scores						
Social Connectedness	**No Problem**		**Yes Problem**		**Stats**	
	n	**Mean**	**n**	**Mean**	**t-test**	**p-value**
In a crisis, would have support from family and friends	95	43.38	9	37.67	2.625	**.010**
They child/youth generally accomplishes what they set out to do	16	46.63	6	42.83	2.514	**.021**

A higher number of trauma experiences are significantly related to feelings of hopelessness, restlessness, and worthlessness (Table 41). We have noted in other reports that feeling hopeless and especially worthless are related to suicidality. This suggests a possible treatment focus, to address these feelings for those with at least four trauma experiences. All life events are higher for youth with emotional challenges as described, though not significantly so. Surprisingly, emotional issues are not related to resilience as measured in this project. This may change with additional data. Hypothesis 3 is partially supported with current data.

Table 41. Summary of Emotion Related Symptom Questions Associated with Trauma, Life Events and Resiliency Total Scores						
Functioning Questions	**No Problem**		**Yes Problem**		**Stats**	
	n	**Mean**	**n**	**Mean**	**t-test**	**p-value**
TRAUMA						
Nervous	21	4.05	36	4.25	0.235	.815
Hopeless	20	3.54	37	5.35	2.163	**.035**
Restless	18	2.94	39	4.74	2.089	**.041**
Depressed	40	3.75	17	5.18	1.605	.114
Everything is an Effort	23	3.70	30	4.53	0.941	.351
Worthless	38	3.50	19	5.53	2.416	**.019**
LIFE EVENTS						
Nervous	21	2.33	36	2.50	0.315	.754
Hopeless	20	2.14	37	3.00	1.658	.103
Restless	18	1.83	29	2.72	1.651	.104
Depressed	40	2.20	17	3.00	1.462	.149
Everything is an Effort	23	2.17	30	2.60	0.787	.435
Worthless	38	2.21	19	2.89	1.283	.205
RESILIENCY						
Nervous	20	43.90	36	43.75	0.108	.915
Hopeless	20	42.65	36	44.44	1.309	.196
Restless	17	45.47	39	43.08	1.692	.093
Depressed	39	44.41	17	42.41	1.402	.167
Everything is an Effort	22	45.00	30	43.10	1.349	.183
Worthless	37	44.38	19	42.79	1.101	.276

Small Project Implementation Support

Two projects were assisted in evaluation this year that were funded via SOC dollars and are briefly described.

Aspire Inc. is offering a year-round culinary training experience with special emphasis for summer camps to train youth and provide an outlet for the summer. Aspire offers youth support groups and other groups, networking opportunities, and resources as well. The Evaluation Team met with Aspire and developed a retrospective pre- post-test to measure impact of the camp experience. Aspire also collected a small amount of Triple Screen data. The project is highly popular, impactful, and the food is in demand for local events. The pre-post survey is included at the end of the report in Appendix 1.

Family Support Network/Parent 2 Parent (FSN/P2P) was assisted with capacity development on a larger scale. Project objectives include:

1. Develop program level objectives to determine impact and assist with applying for grant funding and other resources. This includes developing an Excel-based data storage and reporting system, training the FSN/P2P team in data management, and extracting data to support reporting expectations.
2. Develop a post-support survey for parents/caregivers to complete for support that FSN/P2P provides for IEP/504 plan meetings. A consistent issue across the grant counties is communication challenges between parents and schools for development and implementation of IEPs with fidelity.

Several meetings were held to determine data tracking needs and to better understand FSN/P2P relationship with Appalachian State University and their capacity to help with data management. The ET developed an interview guide to collect information to define and document data fields that will track process and impact objectives. This will support finalizing program objectives and developing data fields for consistency. There were some delays in completing the interviews, but they were finally completed in December of 2023 (Year 4). The ET has just started analysis, but it appears that FSN/P2P staff have a wide variance in understanding data, objectives, data management, data entry, storage, analysis, etc. The interview guide is included in Appendix 1.

During the evaluation process for Objective 1, Objective 2 for IEP tracking support emerged. The ET met with the leadership of FSN/P2P and discussed potential data points to track to determine success of IEP/504 plan support. A retrospective pre-post survey was developed to be administered after support and completion of IEP meetings. This was recently approved and will be used next year. This survey is also included in Appendix 1.

Implementation Support

The evaluation team substantially increased support of implementation in Year 3. This included trainings in RBA, applying RBA to specific projects, finalizing the SOC Coordinator online Collaborative/Task Force Evaluation Surveys, providing twice weekly Office Hours starting in June for all SOC Coordinators and Family Partners to attend, individual SOC Coordinator support scheduled when requested, and expanding Family Partner support to increase capacity for targeting systems change. We will address each of these individually.

SOC Coordinator and Family Partner Training: Focus on RBA, Data, and Systems

The ET in its role as Implementation Support designed and provided three training sessions to primarily SOC Coordinators with Family Partner participants in some trainings. These were further addressed in Office Hours description in this section and in individual county collaborative report sections in a later section. An outline of each training is listed next:

Training 1: System of Care: Successful Models and Infrastructure

- **Common elements found in effective collaboratives**: Strong leadership, a climate for change, diverse membership, flexibility and adaptability, relationship among members, formal and informal structures and processes, outcomes oriented accountability, clear shared vision and goals, and core staff responsible to the collaborative as a whole.
- **Successful models of collaboration**: Involving all key stakeholders, supporting visionary leadership, shared vision across members, building leadership at all levels, establishing and monitoring communication and decision-making processes, embedding conflict resolution pathways, and focusing on institutionalizing change as a facet of systems change.
- **Collaborative domains**: Each addressed with effective and ineffective examples. Policy, administration, resource development, service delivery, staff development, external evaluation, and internal evaluation.
- **Establishing roles of leadership and support (SOC Coordinator):** Leadership structure (e.g., chair, vice chair, president, secretary, etc.), facilitator role (SOC Coordinator and, at times, Family Partner), and Chair role (communicator, agenda setter, membership nurturer, etc.).
- **Infrastructure:** Vision, mission, goals, objectives, agendas, bylaws, data sharing, budget, recruitment, and retention, etc.
- Examples and discussion of achievements by collaboratives:
    - Establishment of procedures for information sharing between agencies.
    - Establishment of community transportation networks.
    - Assistance in obtaining federal, state and private foundation grants to schools and communities.
    - Assistance in the creation of safe and secure schools.

- Assistance in the increase of attendance rates.

Training 2: Data and Collaborative Participation

- Expansion on type and use of data
  - Risk factors and Protective factors
    - Individual, relationship, community, societal
- Introduced…
  - Influence
  - Feasibility
  - Noise
- Assessing the audience
- Exploring ways to present data
- Numbers and stories… deciding on what is more compelling, in combination, for each collaborative membership
- How long to look at data and how do you know when it is time to move forward?
- Data interrogation and saturation
  - What is necessary and what is sufficient?
- Tips for success
  - Determine what use you will get with the data.
  - What is the amount the collaborative can handle?
  - Be careful not to experience data fatigue.
  - Focus on the story and bring them back to the next piece of data.
- Basic data understanding for collaboratives:
  - What actions will make a difference and what data is needed?
  - Don't mistake correlation for causation!
  - What data supports your conclusions?
  - How to use data to know impact.
- Combine with the RBA process:
  - What is the problem?
  - What data supports it?
  - What do you wish to solve for?
  - What impact do you wish to have?
  - What intervention/ solution will you use?
  - What is your baseline and how will you know you have succeeded?
- Make it personal.
  - Use different approaches to entice.
    - Local expert; Systems case review; Trend data

Training 3: RBA as a Consistent Data-Driven Approach

- Planning an RBA experience

    - Community Event
    - System Trends
    - System Case Review
- The Influence Matrix
    - Influence
        - Description, high and low influence examples
    - Feasibility
        - Description, high and low feasibility examples
- Making influence/feasibility examples
    - ACT: High influence/high feasibility
    - CHANGE: Low influence/high feasibility
    - BUY IN: High influence/Low feasibility
    - RE-DESIGN: Low influence/Low feasibility
- An RBA Consistent Problem-Solving Path
    - Identify the problem → Decide what to change → Data – select risk and protective factors → Set clear objectives → Plan and implement action → Evaluate for impact
- Youth suicide risk and protective factors, example of the pathway
- Applying the I/F matrix
- Identifying the problem and deciding what to change, in-depth
- Connecting risk factors, protective factors, the matrix and planning action
- Walk through an example in detail

SOC Coordinator Collaborative Survey

Assessing Collaboratives include SOC Coordinators since they have the most direct contact, ongoing, with each Collaborative. A survey was designed and Coordinators were asked to rate their collaboratives on a number of metrics. This was used once in Year 3 as a pilot and reported in last year's Annual Report and will be administered quarterly in Year 4. This will support infrastructure development and sustainability of the Collaboratives. The fourth administration will include at least Collaborative leadership to assess for differences in point of view. Sections of the survey include:

- Population of focus
- Level of understanding of state and local SOC expectations.
- Infrastructure
- Community engagement
- Data understanding and data management
- Application of RBA
- Perceived influence in the community
- Membership stability

- Membership diversity
- Rating on list of competencies
    - Cohesiveness
    - Roles and norms
    - Effective interpersonal communication
    - Commitment to specific and clear goals
    - Interdependence
    - Inclusivity
    - Problem solving
    - Decision-making
    - Conflict resolution

Office Hours

Office hours were designed to have planned and available technical support for evaluation and implementation of the grant. They have been well attended except for some SOC Coordinators with competing meeting times. The two times each week for one hour selected were set via the results of a poll. The times most available to the attendees were selected. Individual SOC Coordinator support via one-on-one meetings have been scheduled *ad hoc* and are described in the next sub-section.

An agenda is built at the beginning of each session as the participants guide the topic and the ET provides technical assistance and supports peer-to-peer support. Each session some SOC Coordinators or Family Partners attend to listen and learn. If agenda items are light, the ET uses the time to reinforce systems change, RBA, and collaborative infrastructure support. A representative sample of content addressed during Office Hours includes the following:

- Collaborative leadership development and support.
    - Leadership qualities: Forward thinking, lead by example, delegate well and effectively, strengths-based leadership, risk taker, ensuring open communication.
- Determining who is missing from the Collaborative and ensuring cross-sectional participation.
    - Addressed needed memberships in collaboratives including DJJ, DSS, Public Health, schools, criminal justice, and related.
- Survey development and planning to develop surveys that are fair, objective, targeted, and non-blaming. Discussed basic measurement requirements to maximize effectiveness of using surveys and linking them to clear objectives.
- Systems change.
- Linking data to RBA, systems change, and moving Collaboratives from inertia to taking on challenges.

- Understanding family needs and how this affects system of care including seemingly unrelated topics such as Elder Abuse.
- Referral to treatment services and how the Collaborative can help support services in the community.
- Identification of tools needed such as checklists for measurement of influence and feasibility.
- Discussed adapting a Family Functioning Assessment (FFA) for Vaya providers to use and to provide additional data for collaborative decision-making.
- Helped to support development of a family survey, reviewed drafts, and helped to design protocol for data collection and analysis.
- Better identifying and incorporating risk and protective factors.
    - Focused on school related supports, attendance issues, and school connection as a protective factor.
- Addressed and applied influence, feasibility, risk factors, and protective factors to collaborative education and work.
- Updated review of collaborative meetings, e.g., Alexander County, and planned for next steps.
- Discussed development of LICC's in target counties lacking the support. Several collaboratives are choosing to focus on younger children, age 5 or younger.
- Discussed giving tasks to collaboratives to keep them engaged. This included having them find articles to share and summarize and other content and context specific supports.
- Focused on defining by percentage how much time is spent with each collaborative development activity. This is being formalized into a support document for SOC Coordinators.
- Focused on recruitment and defined a recruitment and onboarding process for new collaborative members.
- Discussed 'what is success' for a collaborative.
- Discussed development of an ongoing Readiness Assessment for Collaboratives based on the collaborative life cycle.
- Discussed school dropout rates and determining a menu of reasons why youth leave schools and how this could be developed via brief interviews and surveys.
- Focused on substance use in families and how recovery, or lack therein, contributes to foster care and related.

Office Hours Evaluation

After three months, an Office Hours Evaluation Survey was disseminated. Thirteen (13) of 17 possible respondents to the survey completed the survey (76.5%). Responses are summarized with discussion points or responses interspersed with possible changes to Office Hours. Questions are summarized individually.

During the past two weeks, how many times have you attended office hours?

None = 3
One = 5
Two = 2
Three = 2
Four = 1

Reasons for attending office hours?

I learn tools that support me with doing my job = 9

To request help with a specific question or problem = 7

I get reassurance that I am doing the right thing = 6

My supervisor or colleague recommended I attend = 0

I feel obligated to attend = 0

Other = 4

1. Guidance
2. To hear others' questions and learn
3. To offer additional support and guidance for the team
4. To learn and support participants

Reasons for NOT attending office hours?

I have conflicting appointments = 8

I feel confident in my abilities = 2

I do not have time = 1

I did not know I could attend = 1

I do not find it helpful = 0

I did not know about it = 0

Other = 5

1. I feel like I am at a standstill with my collaboratives and working on establishing relationship and networking so I am not sure what to ask for the meetings, therefore I do not attend.
2. I may have a more pressing task and not a current question.
3. The time I went I felt it was more fitting for an SOC Coordinator and not for a Family Partner.
4. Scheduling conflicts, other managers attending already so don't want to overwhelm with too much leadership.

5. I feel like I use my office time hours during our weekly Monday RBA meeting.

Discussion: Reasons for attending office hours were as predicted and are consistent with the design. Reasons for not attending office hours focuses on having conflicting appointments. Having a set schedule guarantees the time but schedules likely have changed. The two times were selected from polling all SOC Coordinators and Family Partners for a single time. Results found two times covered all respondents and two office hours were scheduled. CSI will discuss options with the Project Director and others at Vaya. Attending office hours to address collaboratives at a standstill would be a good use of the time.

A separate time for Family Partners is being implemented to provide support from CSI. It will be important to make sure that splitting of the two groups is not reinforced as both are integral to system change.

Use of the three current tools developed to support SOC Coordinators and Family Partners.

Have you utilized the Managing Collaborative Development tool?

Yes = 6

Read it but not used it = 5

No = 1

Did not recognize the tool = 1

Have you utilized the Systems, Systems Thinking, Systems of Care and Systems Change tool?

Yes = 6

Read it but not used it = 6

No = 1

Did not recognize the tool = 0

Have you utilized the Asking System and RBA Questions tool?

Yes = 4

Read it but not used it = 5

No = 3

Did not recognize the tool = 1

How helpful are these tools in doing your job?

Extremely Helpful = 6

Helpful = 5

Somewhat helpful = 1

N/A (Do not use them) = 1

Which of the two current office hours is most convenient for you?

Wednesday, 9:00 a.m. = 6

Thursday, 2:00 p.m. = 7

Discussion: The tools were added to support office hours and to have sustainable support available for when the grant ends. The tools appear to be helpful. A follow-up question for office hours, when time allows, will be to ask how and in what circumstances the information from the tools are being used. This could support additional training. One inconsistency noted in responses is the time most convenient. Attendance at the Wednesday office hours is notably higher than Thursday, but Thursday is listed as the most convenient time. This will also require further discussion.

Suggestions to Improve Office Hours

Respondents entered information into the available narrative field.

1. FYI - A few of us are attending a book club based on Trying Hard Is Not Good Enough by Mark Friedman. As one of the older participants, it is helpful to my learning style to have a book I can read and refer back to, highlight etc.
2. It would be helpful to have a visual (maybe as we log in) of previously discussed topics/ questions/issues addressed over the last couple of weeks in office hours.
3. The tools are helpful for all levels of learning. Even as someone who has had more experience with SOC and RBA, I still need refreshers and tools to share with others (and the ones you've created are perfect). You do a great job of supporting all levels of learning and using the individual questions brought to you as universal teaching moments for all.

SOC Coordinator Support

Several SOC Coordinators have engaged with the ET for one-on-one support. Seven areas have emerged that are consistent asks. All SOC Coordinators supported individually were also supported in office hours. Careful tracking of content helped development of support documents generated to address consistent needs across SOC Coordinators and Family Partners. Three were completed during the reporting period and can be found in Appendix 2.

1. Support Document 1: Managing Collaborative Development
2. Support Document 2: Systems, Systems Thinking, Systems of Care, and Systems Change
3. Support Document 3: Asking System and RBA Questions

The seven areas of support are briefly outlined below:

1. Moving Collaboratives to Action: Specifically, engaging collaboratives to move from agency descriptions to RBA and systems change. Some Coordinators have been frustrated by the dichotomy of Collaborative members knowing the need for and insisting on systems change while also not wanting to work outside of the monthly meeting. This has led to inertia and frustration that has affected retention of leadership and members. Support documents 1 and 2 were partially designed based on this issue. Several Collaboratives have been in existence for some time and are comfortable with resource sharing and discussing problems. They tend to be more deficit based and the Implementation Team has been working to introduce data and discuss resources for a more strengths-based approach.
2. Onboarding SOC and RBA to New Collaboratives: How to introduce the work of SOC and RBA to new Collaboratives, or restructuring existing Collaboratives that have been on hiatus or are experiencing rapid change in membership. Survey data from SOC Coordinators found that Collaboratives are clear on the goals of the SOC grant but are less clear on what the state expects. Support documents 1 and 3 have been helpful in supporting development of the Collaboratives and using systems and RBA language consistently. Latest technical assistance has been to support discussion and activities while labeling suggestions or plans that are consistent with RBA and systems change as they arise. The goal is to demystify RBA and to reinforce that the logic of 'reverse engineering' is already part of the Collaboratives process.
3. Addressing School Absenteeism: School absenteeism has emerged as a key issue with a strong system focus ideal for an RBA approach in several very rural counties with limited resources. Defining what school absenteeism is, establishing when it becomes a concern for different stakeholder groups, the interaction with school mental health, its relationship to high levels of youth trauma, community values for education, youth suicide, and the ability for communities to unite on a key issue have all come together as part of the school attendance crisis. Support was offered for data interpretation, communication ideas for key stakeholder groups, and survey development for teachers, parents and youth that would be worded appropriate to each group but have the ability to be compared on key metrics were provided. A sample of a survey is included in Appendix 1.
4. Focus on High Cost Interventions: Several Coordinators are working to expand the understanding of SOC to include wellness promotion, prevention for high risk youth, targeted and least intrusive interventions for youth/families in need, and finally to support high cost, high disruption services like Psychiatric Residential Treatment Facilities (PRTF). PRTFs have been a clear immediate focus based on small numbers of youth that have high needs. These tend to result in solutions and issues with low overall influence and feasibility for intervention. Areas identified that detract from PRTF success include lack of sibling support, under-utilization and/or poor access to Mobile Crisis Treatment to maintain the youth in-home, poor access and at times complete

misunderstanding of High-Fidelity Wraparound (HFW) services, and the lack of a Family Functioning Assessment (FFA) that would help in creating a less family disruptive plan. Improving understanding of SOC and a continuum of care that includes non-treatment related resources was clearly identified as a need and a possible approach to reduce reliance on high cost, low feasibility interventions.

5. Developing Collaborative Leadership: There has been considerable turnover in leadership positions and the absence of leadership willing to guide the Collaboratives in some counties. A support document for Collaborative Leadership Development and Support is in process. Suggestions to focus on strengths, introduce small digestible amounts of information and suggestions, be reinforcing, for the SOC Coordinators to complete key tasks like agenda development, meeting minutes, sharing documents, gathering initial data, and related have helped to stabilize leadership. However, this is fragile, hence the development of the support document. Initial list of Leadership Qualities was developed: Forward thinking, lead by example, delegate well and effectively, strengths based and builds on strengths, risk taker, makes sure all parties are heard, and strong management and organizational skills.
6. Maintaining Focus on the Mission: How to engage collaboratives when some members are pushing the Collaborative to invest time and resources away from Mission consistent objectives has been an issue for small number of Collaboratives. This has resulted in some friction and even the formation of sub-committees to address key issues and to engage key constituencies, e.g., youth and family members. Guidance has been provided along with direct engagement with Collaboratives to help address areas of concern, find common ground, and to reinforce the overall mission of system change.
7. Improving IEP/504 Plan Understanding: Issues with behavior and absenteeism as well as increasing numbers of students needing IEP/504 planning has emerged toward the end of the year for several counties. This has come to the attention of Collaboratives and Family Partners. Planning is in process to support this issue.

Family Partner Expanding Support

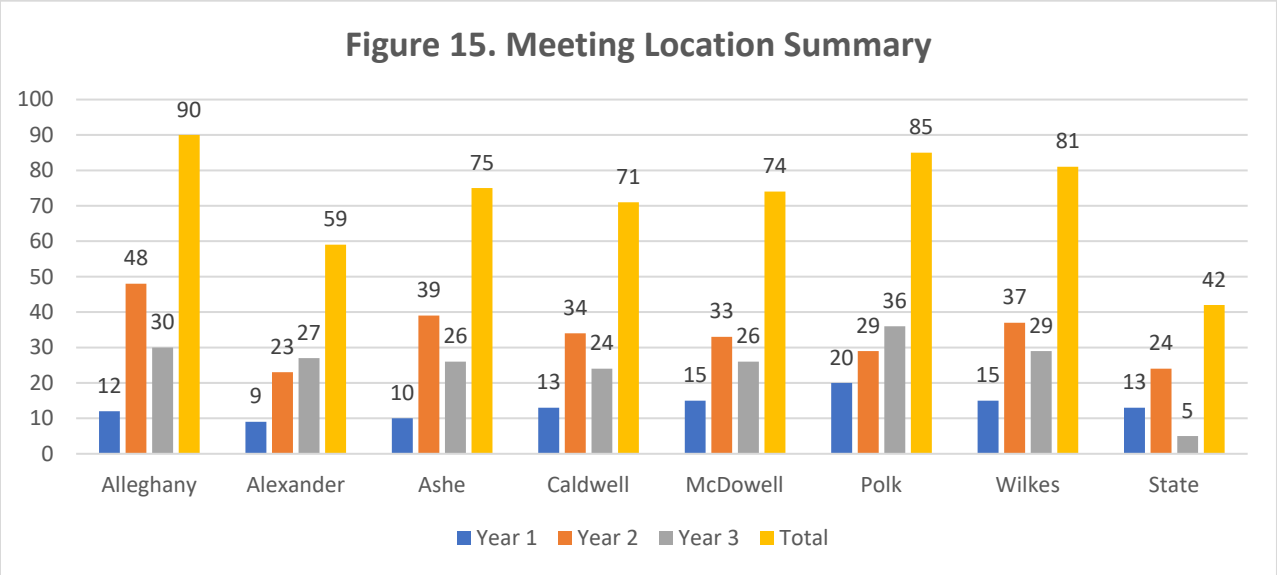
Towards the end of Year 3, it became more apparent that the information for the SOC Coordinators did not resonate clearly for Family Partners given their different professional and employment expectations. Still in the planning phase, the ET has met twice with the Team Lead of the FP's and twice with the FP membership at Vaya. The next goal is to design an objective for the team to apply RBA and systems change within the parameters of their experiences. Like area of support 2 in the previous section, the goal will be to help FPs identify the systems change activities they are already engaged with. Then, to have them make minor shifts in emphasis to help engage families and youth receiving direct services in becoming systems change agents themselves.

Collaborative Support and Training – Field Note Summary

Evaluation of collaborative support and their contribution to the System of Care is primarily from two sources of data. 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 ET. We include data for Years 1-3 for comparison. The field note information summarized for this report are specific to meetings and trainings. Meeting data is summarized 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. This information is summarized in more detail in two sections: The Collaborative/Task Force Support and, new to this report, Implementation Support.

The SOC-IT and/or SOC-ET attended 163 meetings in Year 3, 108 documented in the Field Note, with checks in place for confidence in the estimate. Figure 15 summarizes the number of meetings attended specific to each county for Years 1-3 as well as meetings that were related to state SOC information and activities. Differences in number do not reflect preference or capacity, simply scheduling by county collaboratives and other leadership.



Content of meetings was assessed in the field note by selecting the information categories most relevant to the meeting. Total numbers are greater than the number of meetings held since it was common to discuss multiple topics in meetings. Table 42 lists meeting content by total number of each content area addressed from most to least. We include Years 1-3 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 replaced by the emphasis on family and youth involvement and voice in Years 2 and 3. Collaborative development and support, only a target topic twice in Year 1, was the second most included topic with 79 meetings in Year 2 and seventh in Year 3 as collaboratives developed more sustainable infrastructure. Specific for Year 3, Results Based Accountability (RBA) was the second most addressed topic. This is followed by trauma/resilience, service delivery, SOC, and mental health/substance use disorder prevention.

Two content areas are emphasized. The first is foster care, which is often brought up but not addressed in-depth in collaborative meetings, hence the low number in Year 3. Foster care has reached crisis levels in NC. We hypothesize that the focus on foster care in collaboratives will change given the number beginning to make this a primary focus. Second, addressing parent mental health and substance use issues is recommended to increase as a primary focus. Given the numbers of parents/caregivers stated to have mental health or substance use issues in the Triple Screen data, a more family focus with emphasis on parents with issues that interfere with parenting or model unhealthy/risky behavior will help to address some of the generational cycles noted. Further, these two issues meet, or perhaps better described as collide, given that combined across target counties nearly 70 percent of children are placed in foster care due to parental substance use.

Table 42. Summary of Meeting Content Frequency

Content	Y3	Y2	Y1	Total	Content	Y3	Y2	Y1	Total
Family/Youth Involvement	97	104	40	241	Special Education	26	33	18	77
SOC	65	74	50	189	Policy	9	36	20	65
Service Delivery	67	54	44	165	SDOH	26	14	22	62
Trauma/Resilience	75	53	29	157	Other	18	28	3	49
Collaborative Support	58	77	2	137	**Foster Care**	**17**	**7**	**20**	**44**
RBA	78	50	7	135	School Mental Health	30	13		43
MH/SUD Prevention	60	48	22	130	**Parent MH or SUD Issues**	**12**	**8**	**20**	**40**
Resources	42	56	27	125	Historical Trauma	8	13	10	31
Funding	41	51	31	123	Medicaid	6	12	13	31
Family/Youth Advocacy	36	45	29	110	COVID-19	3	13	14	30
MH/SUD Promotion	47	37	8	92	IDD	5	11	12	28
Training Planning	20	48	15	83	Child Welfare (Not FC)	8	12	6	26
Juvenile Justice	20	50	10	80					

To better assess trends in content, Table 43 summarizes the content areas from Table 42 by ranking them by frequency for Years 3-1, starting with rankings for Year 3 numbered 1-25. Family/Youth involvement remains a primary area of focus. However, qualitative data and review of attendance at trainings, collaboratives, and related suggests that success in recruiting and retaining family and youth members in most collaboratives is elusive. Some counties have or are considering family or youth groups as a way to include their voices since recruiting into the collaboratives has been unsuccessful. This is recommended with the caveat of inquiring how the groups expect, if at all, to affect system change. Further, planning to engage and eventually integrate some members of family groups into collaboratives will improve

Table 43. Trend (Ranking) Data for Meeting Content

Content	Y3	Y2	Y1	Content	Y3	Y2	Y1
Family/Youth Involvement	1	1	3	Special Education	13	15	13
RBA	2	8	21	Training Planning	15	10	14
Trauma/Resilience	3	6	5	Juvenile Justice	15	8	18
Service Delivery	4	5	2	Other	17	16	23
SOC	5	3	1	Foster Care	18	25	10
MH/SUD Prevention	5	10	8	Parent MH or SUD Issues	19	24	10
Collaborative Support	7	2	24	Policy	20	14	10
MH/SUD Promotion	8	13	20	Historical Trauma	21	19	18
Resources	9	4	7	Child Welfare (Not FC)	22	21	22
Funding	10	7	4	Medicaid	23	21	16
Family/Youth Advocacy	11	12	5	IDD	24	23	17
School Mental Health	12	18		COVID-19	25	20	15
SDOH	13	17	8				

understanding of lived experiences of youth and families and the system of care. RBA training and focus, as noted, has increased from the rank of 21, to 8 in Year 2, and now is second in Year 3. Collaborative support and mental health/wellness prevention have increased substantially as well with the focus of the team and the SOC Coordinators on developing sustainable collaborative infrastructure. Mental health/substance use prevention activities have remained stable. However, improvement in mental health/substance use promotion, with emphasis on wellness and community health has increased and is in line with SOC values.

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 44 summarizes content areas by county for Year 3. We reproduce and reorder to the priorities from Year 3 for Year 2 (Table 45) and Year 1 (Table 46). This is important for tracking priorities within and between counties. Note that total numbers are lower than in Table 41 because some meetings recorded were not Collaborative or Task Force and others were reported in a separate Field Note specific to track specific issues for the ET. This trend information offers additional opportunities to compare county Collaboratives/Task Forces and to determine priorities. It also supports planning for the change continuum: data → objective selection → action → system change. There is a fair amount of diversity noted across counties. Some had more obvious areas of focus, e.g., focus on Family/Youth Voice and RBA. Year 4 will see a return to greater use of the original Field Note as the subgroup analysis from the separate Field Note was completed.

Table 44. Year 3 Meeting Content by County								
Content Area	**n**	**Alleghany**	**Alexander**	**Ashe**	**Caldwell**	**McDowell**	**Polk**	**Wilkes**
Family/Youth Involvement	52	4	10	5		10	13	10
RBA	38	3	10	2	3	7	9	4
Trauma/Resilience	34	7	5	5	1		14	2
Service Delivery System	36	3	7	6	5	5	9	1
System of Care	34	2	7	2	2	4	9	8
MH/SUD Prevention	39	9	8	6	3	6	4	3
Collaborative Support	33	1	10	3	1	5	5	8
MH/SUD Promotion	27	5	4	3		6	5	4
Resource Development	31	6	6	2	2	3	10	2
Funding, Grants	24	2	7	2	2	1	8	2
Family/Youth Advocacy	17		4	1		3	6	3
School Mental Health	23		4	6	2	3	8	
SDOH	13	2	5	2			4	
Special Education	10		1	2		3	4	
Training Planning	9		4			1	4	
Juvenile Justice	10		4	1	4		1	
Other	16	5	2	1	1	2	5	
Foster Care	8		3				4	1
Parent MH or SUD Issues	7	2	2	1			2	
Policy & Practices	5		1	1			3	
Historical Trauma	3						3	
Child Welfare (Not FC)	4		2				2	
Medicaid	4				1		2	1
Intellectual/Development Dis	2					1	1	
COVID-19	1		1					

Table 45. Year 2 Meeting Content by County								
Content Area	**n**	**Alleghany**	**Alexander**	**Ashe**	**Caldwell**	**McDowell**	**Polk**	**Wilkes**
Family/Youth Involvement	109	27	11	14	7	19	14	17
RBA	48	8	2	5		8	15	10
Trauma/Resilience	53	12	2	10	7	5	12	5
Service Delivery System	55	8	4	12	7	13	5	6
System of Care	71	18	8	7	6	14	7	11
MH/SUD Prevention	49	12	1	12	1	13	7	3
Collaborative Support	79	18	2	12	1	16	15	15
MH/SUD Promotion	36	8		5	1	10	9	3
Resource Development	55	16	5	11	2	12	7	2
Funding, Grants	54	15	5	9	3	9	7	6
Family/Youth Advocacy	58	19	5	9	5	7	5	8
School Mental Health	9	1	1	3	1		2	1
SDOH	14	4	2	3		4	1	
Special Education	27	3	2	9	4	6	3	

Table 45. Year 2 Meeting Content by County								
Content Area	**n**	**Alleghany**	**Alexander**	**Ashe**	**Caldwell**	**McDowell**	**Polk**	**Wilkes**
Training Planning	56	16	3	5	5	7	15	5
Juvenile Justice	54	4	11	4	11	4	2	18
Other	24	5	1	7		5	3	3
Foster Care	7	1	2		1	1	1	1
Parent MH or SUD Issues	8	2		1		3	2	
Policy & Practices	30	10	3	2	3	6	2	4
Historical Trauma	13	2		1	5	2	2	1
Child Welfare (Not FC)	11	1	5			4	1	
Medicaid	9		2	1	2	1	3	
Intellectual/Development Dis	7			1	2	3	1	
COVID-19	13	8		1	1	1		2

Table 46. Year 1 Meeting Content by County								
Content Area	**n**	**Alleghany**	**Alexander**	**Ashe**	**Caldwell**	**McDowell**	**Polk**	**Wilkes**
Family/Youth Involvement	47	9	5	4	5	6	11	7
RBA	8	2	1	1		1	1	2
Trauma/Resilience	30	6	2	1	3	4	11	3
Service Delivery System	42	8	4	5	3	4	10	8
System of Care	64	11	7	6	5	10	16	9
MH/SUD Prevention	22	4	2	1	3	6	4	2
Collaborative Support	2		1			1		
MH/SUD Promotion	8	1			1	3	2	1
Resource Development	25	5	2	3	2	2	8	3
Funding, Grants	32	7	3	2	3	4	9	4
Family/Youth Advocacy	33	8	4	2	3	6	7	3
SDOH	24	6	2	1	2	4	6	3
Special Education	23	4	1	2	3	3	8	2
Training Planning	20	5	1	1	2	1	7	3
Juvenile Justice	10	1	1		2		6	
Other	3		1		1		1	
Foster Care	23	2	3	1	1	4	8	4
Parent MH or SUD Issues	23	4	2	2	1	4	5	5
Policy & Practices	20	5	2	1	3	2	4	3
Historical Trauma	10	1	1		4	1	3	
Child Welfare (Not FC)	6	1			1	1	3	
Medicaid	16	2	2	1	2	3	5	1
Intellectual/Development Dis	14	1	2	1	1	3	3	3
COVID-19	13	2	2	3	1	1	4	

The content areas summarized in Tables 44-46 were combined and now represented as percentages in Table 47. This can be shared with collaboratives for them to see how emphasis

they have on specific content areas compares to other county collaboratives. This information can help collaboratives to connect with other collaboratives with similar priorities.

Table 47. Three-Year Combined Data on Content Areas by County (%)

Content Area	n	Alleghany	Alexander	Ashe	Caldwell	McDowell	Polk	Wilkes
Family/Youth Involvement	210	19.0	10.0	11.0	10.5	16.7	16.7	16.2
RBA	94	13.8	13.8	8.5	3.2	17.0	26.6	17.0
Trauma/Resilience	117	21.4	7.7	13.7	9.4	7.7	31.6	8.5
Service Delivery System	133	14.3	11.3	17.3	11.3	16.5	18.0	11.3
System of Care	169	18.3	13.0	8.9	7.7	16.6	18.9	16.6
MH/SUD Prevention	110	22.7	10.0	17.3	6.4	22.7	13.6	7.3
Collaborative Support	114	16.7	11.4	13.2	1.8	19.3	17.5	20.2
MH/SUD Promotion	71	19.7	5.6	11.3	2.8	26.8	22.5	11.3
Resource Development	111	24.3	11.7	14.4	5.4	15.3	22.5	6.3
Funding, Grants	110	21.8	13.6	11.8	7.3	12.7	21.8	10.9
Family/Youth Advocacy	108	25.0	12.0	11.1	7.4	14.8	16.7	13.0
SDOH	32	3.1	15.6	28.1	9.4	9.4	31.3	3.1
Special Education	51	23.5	17.6	11.8	3.9	15.7	21.6	5.9
Training Planning	60	11.7	6.7	21.7	11.7	20.0	25.0	3.3
Juvenile Justice	85	24.7	9.4	7.1	8.2	10.6	30.6	9.4
Other	74	6.8	21.6	6.8	23.0	5.4	12.2	24.3
Foster Care	43	23.3	9.3	18.6	4.7	16.3	20.9	7.0
Parent MH or SUD Issues	38	7.9	21.1	2.6	5.3	13.2	34.2	15.8
Policy & Practices	38	21.1	10.5	10.5	2.6	18.4	23.7	13.2
Historical Trauma	55	27.3	10.9	7.3	10.9	14.5	16.4	12.7
Child Welfare (Not FC)	26	11.5	3.8	3.8	34.6	11.5	30.8	3.8
Medicaid	21	9.5	33.3	0.0	4.8	23.8	28.6	0.0
Intellectual/Development Dis	29	6.9	13.8	6.9	17.2	13.8	34.5	6.9
COVID-19	23	4.3	8.7	8.7	13.0	30.4	21.7	13.0

There are several potential hypotheses and interpretations that can be made over three years of grant activity. We offer a sample next with the caveat that interpretations were reinforced by additional data, e.g., Triple Screen, NOMS, qualitative. A 'deeper dive' into the collaboratives is underway with a mixed data review of collaborative process, products, and impact as a separate report.

- Alexander county had the least focus on Trauma/Resilience, but also had the least number of youths directly served, skewing the Triple Screen numbers toward EVENTS youth, giving the appearance of possibly less trauma issues in the county.
- Caldwell Collaborative is well established and tends toward focusing on other issues and valuing their independence. They have some of the lowest focus on RBA training, having experienced RBA training from other sources in the past, and the least amount of support for collaborative development. They have a strong focus on the child welfare system with a surprisingly small focus directly on foster care.

- Polk county has found time to address a number of content issues consistently and have a well-rounded approach to managing the needs of the collaborative and the community.

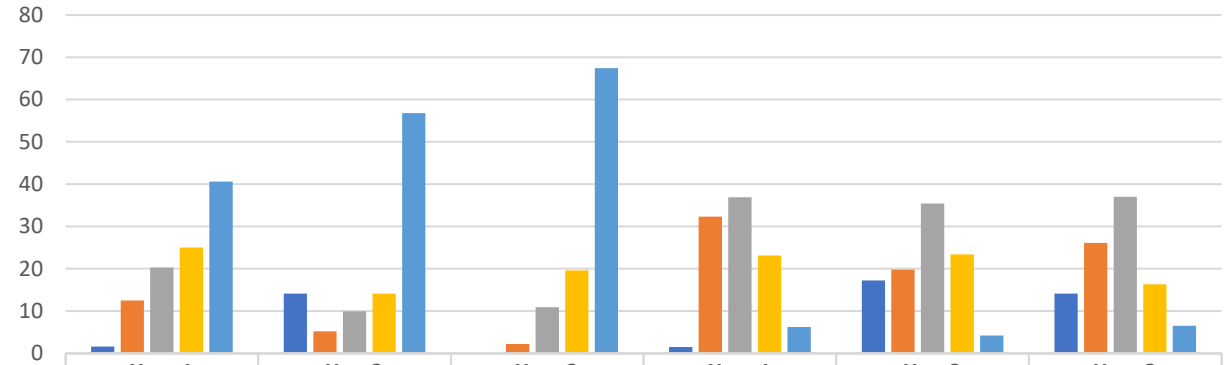
A final request of the team members completing the field note was to estimate the amount that meetings were focused on the SOC specific population in two ways, with a value range of none to all.

- 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 13 percent of the time in Year 3, significantly reduced from 30 percent in Year 2 which reduced from 34 percent in Year 1. A noticeable change, howe++ver, is SED as the exclusive topic of meetings zero percent of the time in Year 3 after increasing in Year 2. Narrative data finds that Collaborative members have broadened concern based on community data to all youths and no longer distinguish youth with SED unless they are in foster care, residential treatment, special education, have behavioral issues, or are involved with juvenile justice. Trauma is seen as an underlying indicator across most cases, given the prevalence, along with suicidality being a common issue. There have been a number of successful youth suicides across multiple counties and recent data suggesting large number of teens have contemplated suicide in the past year has broadened the focus to all youth.

The topics discussed were relevant to the population 'some', 'most' and 'all' of the time over two-thirds of the time (71.2%) in Year 1. This increased to 76.6% in Year 2 and again increased to 77.2% in Year 3. What this means is that the focus of efforts would be appropriate nearly 80 percent of the time to youth with SED/FEP but the population discussed were not specifically labeled as such. Several references were used across Collaboratives with the following consistently used: Youth at risk, youth in trouble, depressed youth, lonely or isolated youth, and "what most youth are experiencing." 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 in part for the focus from SED/FEP to all youth. Building skills to engage with systems change has been beneficial but also broadened the understanding of Collaborative members to engage SOC at promotion, prevention, and intervention. While actions remain relevant to the target population of the grant, the understanding of what constitutes youth with or at risk of SED has generalized.

Figure 16. SED/FEP Focus Estimates by Year (%)



	SED/FEP Population			Relevance		
	Year 1	Year2	Year 3	Year 1	Year2	Year 3
All	1.6	14.1	0.0	1.5	17.2	14.1
Most	12.5	5.2	2.2	32.3	19.8	26.1
Some	20.3	9.9	10.9	36.9	35.4	37.0
Little	25.0	14.1	19.6	23.1	23.4	16.3
None	40.6	56.8	67.4	6.2	4.2	6.5

Collaborative/Task Force Support

Part of the SOC-ET's task starting Year 3 was to further development of the County SOC Collaboratives or Task Forces with additional emphasis on children, youth and family mental health and wellness. Tasks include but are not limited to improving infrastructure, data management, RBA training and implementation, defining measurable objectives, action planning, and emphasizing sustainable systems change. Collaboratives vary in their readiness and capacity to step beyond the basic level of Collaboratives defined as sharing organizational updates and, when needed, discussing specific families in need. This section describes the application of the material as described in the Implementation Support section above. Readiness assessments were not completed this year but are scheduled for quarterly implementation next year as a way to track progress. There may be some confusion as the State System of Care team from the newly formed State Department of Child and Family Well-Being asked what the ET was doing to measure Collaborative Impact. We only recently found out that they borrowed several questions from the grant Readiness Assessment for their biannual evaluation and we are pursuing data access for that information to avoid duplication.

Alexander County Child Collaborative

The Alexander County SOC collaborative has the strong leadership of a chair that is well respected with many community connections. Over the past year the collaborative members have participated in several RBA workshops facilitated by the Combined Implementation and Evaluation Team (**IET**). Based upon data gathered from a variety of sources, the Collaborative decided to pursue a project focused upon improving mental health awareness and access. The

Collaborative formed subgroups based upon the unique needs of children aged 0-5 and youth aged 6-18. Some planning divided the latter group into 6-12 and 13-18 but similar suggestions has resulted in recombining them. Preliminary objectives span from closing the communication loop of interagency referrals to developing a crisis response system supportive of the unique needs of individuals diagnosed with behavioral health conditions.

Membership of Alexander County has increased. This has resulted in inconsistent representation present at different meetings that convened for varied purposes. For instance, different members may be present for data discussions, objective development, and action planning. This has slowed the implementation of impact, action and systems change processes. Another key process issue is having a single leader, even though the leader, dedicated and skilled, receives excellent support from the SOC Coordinator. The leader works to engage as many members as possible in decision-making. This is admirable for consensus, but it also delays progress as large numbers weigh in on often non-critical decisions.

To support the Collaborative, the IET developed presentations and consensus development opportunities over the course of the year. Four presentations were completed with material developed, presented, and planning facilitated by the IET. In-between each presentation, many contacts and leadership meetings were held to support the follow-up presentations, planning, and implementation for change. An overview of content for each presentation is next.

First Presentation: Targeted data, setting the stage for objective development.

- Defining health and mental health in Alexander County.
- Discussion of what impact the Collaborative can have.
- County demographics.
- County SDOH and well-being data (food insecurity, transportation, internet access, child care, wages, insurance, work force, education, teen birth rate, infant mortality rate, etc.).
    - Special emphasis on child abuse/neglect and foster care data.
- Perceptions of problems in the community.
    - Top reasons for poverty in the community.
    - Family identified needs.
    - Quality of life.
- Selecting priority issues.
- What to do next.
    - Determine what problem to focus on.
    - What data supports the problem and how will we tell the story behind the data.
    - Define the impact desired and how to achieve it.
    - Set goals, measurable objectives, and action steps.
    - Determine evaluation, how to measure baseline and progress made.
- Example of Collective Impact.
- How to measure impact (Review, Create, Establish).
- The story behind the numbers (What is helping? What is hurting?).

Second Presentation: Goals, objectives, and action

- Defining the problem and barriers.
    - Problem Statement 1: "There are many barriers for families of Alexander County in seeking Support for Mental Health including Cultural Beliefs, Stigma, Lack of Resources and lack of Education."
- Why does the problem exist?
- Barriers to families and individuals seeking care.
- What needs to change? (Beginning identification of objectives).
- What can the Collaborative commit to as part of the solution?
- Goals 1-3, linked objectives, and action steps.
    - Not further defined as the initial planning changed over time.

Third Presentation: Goals, objectives, and action, Part 2.

- Detailed introduction of risk and protective factors.
- Building resilience, coping with adversity and adapting to change.
- Discussion of the key RBA concepts of Influence and Feasibility (I/F).
    - Applying I/F to selected risk factors and protective factors in I/F Analysis
    - Selected Influence Questions:
        - Will this lead to significant change in the problem or key goal?
        - Can it be measured?
        - Can it happen often enough for change to happen (dosage)?
        - Are those to be included available and willing?
        - Does it make plain sense to those considering?
    - Selected Feasibility Questions
        - Is the factor changeable at the person level and/or community level?
        - Are there limited barriers to implementation?
        - Is there sufficient interest to see it through?
        - Will the community accept the idea?
        - Can the activity be completed with the resources at hand?
- Review of barriers
- Determining what needs to change?
- What can the group commit to?
- Review of goals and objectives, next iteration.

Fourth Presentation: RBA update and next steps.

There were four-months between this presentation and the previous. Turnover in membership, issues with scheduling, and change in a key member of the IET resulted in a slowdown. In-between, smaller meetings were held to finalize objectives for 0-5 and 6-18 youth populations.

- Alexander RBA and data history
- With the end in mind, what will success look like in Alexander County?
- Why RBA?

    - Collective Impact
    - Systems Change
- Sustainable improvements
- Updated statement of impact:
    - Families with children aged 0-5 will see an 50% increase in positive social ability and emotional regulation, i.e., positive interactions, anger management, social connections. By August 2024 families will increase knowledge of what is developmentally appropriate for their child.
- Drafting objectives for older children and youth
    - Discussion of dividing the 6-18 group to 6-12 and 13-18.
        - Collect sufficient detail to better define the need, strengthen the system and increase communication and confidence in the providers servicing the county.
- RBA next steps
    - I/F analysis
- *System Change Question*: How can we create common ground among the stakeholders we have now?
- *System Change Question*: Once our objectives are met, what interventions (plural!) could enable us to achieve sustainable, breakthrough change?

Based on the meetings outlined and other contacts, an initial Impact Statement was generated:

> By August 2024: (1) Families with children aged 0-5 will see a 50% increase in positive social ability and emotional regulation, i.e., positive interactions, anger management, social connections. (2) Families will increase knowledge of what is developmentally appropriate for their child.

Alleghany Youth Task Force

The Alleghany Task Force had multiple issues with leadership and membership this year. Much of what was described in the previous annual report no longer holds true. Both Alleghany and Ashe share the same leadership. Both took the summer months off from Task Force work or meetings. There is a new SOC Coordinator that has been doing excellent work in helping the Task Forces define issues and become more intentional in their activities.

The State of the County Health Report was discussed in several meetings. Three target areas for County focus were considered for adoption by the Task Force:

1. Substance Use and Misuse Prevention - Drugs, alcohol, and tobacco; including misuse or abuse of prescription drugs and use of e-cigarettes or other devices for nicotine delivery;
2. Family and Social Supports - Increased community and social supports in places where people live, learn, work, play and pray; and
3. Mental/Behavioral Health - Depression, anxiety, emotional wellbeing, suicide prevention, and support/intervention for those with mental illness.

The SOC Coordinator was tasked with finding five key individuals for Allegheny and Ashe Task Forces, e.g., DJJ, DSS, School, CPS, Providers. Providing information on what a Task Force is and to develop a one-page overview of the information developed with the core membership was completed. The one-page overview was used with targeted emails and phone calls to recruit additional influential members.

Ashe Youth Task Force

The Ashe Youth Task Force also confirmed development of their mission this year and is concentrating on recruitment and retention of members. The ACES survey is also incorporated as a talking point as trauma is a key concern of the group. Alleghany and Ashe Task Forces are coordinated to a degree which can be helpful but also can impede identity development. The focus remained on the school system and development of resilience in response to trauma. A Youth Mental Health Forum was proposed for early in Year 4.

> 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.

Caldwell County Child Collaborative

Caldwell County has requested little support. However, there are clear indicators that there are barriers to outreach and inclusion in the county and fragmentation that is preventing incorporation and collaboration with marginalized populations including Black, Spanish speaking and the LGTBQ+ population. The Child Collaborative is heavily aligned with JCPC and has focused on a project sponsoring art classes and an art show with JJ youth. Points of interest for Caldwell:

- It remains difficult to expand the focus of the Collaborative. As a group, they have a strong and linked membership. More marginalized groups find it difficult to be welcomed.
- An Art Program for Juvenile Justice involved youth was strongly supported this year. The Red Awning Gallery and other partners, along with Vaya, supported this project for much of the year. Youth art projects that reinforced youth creativity. Fund raising support to maintain the gallery.
- Lack of information sharing across programs, even though organizational updates are recurring during collaborative meetings.
- A number of youth 16-18 years of age waiting for Superior Court trials for violent felonies in jails. DJJ and detention are short-staffed.
- Increased juvenile crime and issues with school attendance have resulted in increased crimes of larceny by older teen youth.
- Substance use recovery services for youth are needed and this was brought up multiple times with emphasis on vaping and other issues throughout the year.

- Staff attended a strategic planning session to help create goals, objectives and actions steps from the county data represented.

McDowell County Child Collaborative

McDowell Mission was finalized: "The McDowell County Child Collaborative works to build and enhance meaningful connections between families, youth, agencies, and the greater community. The Collaborative develops partnerships to strengthen, support, and advocate for families while identifying and addressing gaps in resources. The Collaborative strives to be equitable and inclusive in our connections and communication, recognizing the unique strengths and value of every individual."

Currently, the McDowell Collaborative is motivated by expression of family and provider concerns of IEP and 504 plans not being followed. A new partnership is being developed to help train parents with the thought of including all voices to lower resistance. The SOC Coordinator is working with the McDowell County Schools to develop a series of trainings aimed at educating and empowering parents and caregivers on their rights in the IEP/504 process, as well as how to make the most of associated resources. The Family Support Network is being approached to help with this process.

The McDowell County Child Collaborative engaged in several planning and RBA related meetings through May of 2023. Disruption in leadership and direction stagnated progress. A successful RBA Event in March was attended by parents and youth. The facilitators at that time did not know that participants did not include the regular Collaborative body. Objectives and action planning were completed for three gaps described below, but these were not fully accepted for action planning by the Collaborative afterward.

- December 2022: Major RBA planning meeting was held over 2.5 hours. Three objectives and preliminary planning were completed.
    1. Need more mental health professionals and peer support specialists in community and schools to provide quicker access to mental health care.
    2. Drugs are everywhere and too easy to access. It is generational as children are watching their parents do it (Why are they easy to access?)
    3. Mental health stigma, cultural bias and lack of information create misinformation.
- Each group identified a strategy to the problem then answered the following questions:
    a. Why the problem exists
    b. Story behind the data
    c. Data needed
    d. How will impact be achieved
    e. What can the McDowell Children's Collaborative commit to
    f. Goal, objectives, action steps
    g. Parking lot solutions and resources

- January-March 2023: Sub-group meetings for the three problem areas identified were held with members that populated them in the December meeting. Work was completed to improve precision and to develop initial action plans.
- March 2023: Collaborative meeting focused on deeper description of the December and January meetings and what was developed. The meeting also described what Family Partners did and how to be referred to a FP for services.
    - Topics that groups thought were important to action plan for:
        - Building connections through community activities. Ex: Carlos from CULA facilitates Vida Activa. The whole family is encouraged to attend to increase tools/skills in mental health and resiliency. Also provides an opportunity to build stronger bonds with CULA staff.
        - Education on substance use, the difference between glamorizing and actuality.
        - Educating stakeholders: how we would communicate (ex: outreach is better for Hispanic population, what the message would be)
        - Early detection in childcare programs and well childcare visits at pediatric offices.
- April 2023: Presented goals, objectives, and suggested activities to the full Collaborative. Respondents listened but were not enthusiastic.
- May-June 2023: IET supported the McDowell Resilience Initiatives in meetings.

Polk Community Resource Collaborative

Most current focus is planning for an event in an effort to garner support from the larger community regarding the crisis of limited availability of placement options for children in foster care. In partnership with Crossnore Communities for Children (Crossnore), Polk DSS and Saluda a community event is being planned for February 2024. Members of the community will be invited to participate in a foster care simulation experience facilitated by Crossnore. This will be followed by a resource fair offering a variety of ways in which individuals may provide support to children and youth in foster care.

The Polk Collaborative has been the most active of the counties and has accomplished several objectives with a strong leadership team. This included branching out to additional areas more peripheral to the focus of the SOC Collaborative expectations. In response, the members agreed to forming a Mental Health Subgroup that retains focus on the SED/SMI population, their families, and needs. A planning process was completed in June of Year 3 with discussion of the following:

- Determine priorities of problem areas to address.
- Define data on hand and data needs for the problem and how to tell the story about the data.
- Define the parameters of the impact and actions to achieve impact.

- Set measurable objectives and action steps, furthering the focus on impact.
- Set an evaluation process to measure baseline, progress made, and if there are generalizable impacts.

Several formal and informal RBA experiences and communications presented Polk County data and facilitated communication that resulted in problem identification, listed next:

1. Need consistent, culturally and language appropriate, service triggers requiring a strong understanding of the service delivery system for all system stakeholders and family members, including behavioral health, physical health, substance use, relationship counseling, and SDOH needs.
2. Addressing the family problem as a system embedded in the community and ensuring engagement by systems that address identified needs at the earliest detection in age and culturally appropriate ways while also attending to the needs of the family as whole for safety, housing, nutrition, and income.
    a. Behavioral Health, Mental Health and Substance Use Service Provider Network Mapping/ Resource Description: referral criteria and referral process; cost; wait list; specialties and issues covered; where are service provided: home, office, community school, other.
        i. VAYA Case Management/ SOC Coordinator/ Family Partner
        ii. The Network Mapping and Resource Description will establish a baseline: identify gaps in services, capacity challenges/ opportunities, successful coverage and services, services available on paper but not really covering the area; earliest detection; language and subgroups services DEI; resource referral system for SDOH safety, housing, nutrition, transportation and income. Use for the Network Mapping and Resource Description is to better inform stakeholders on financial and human resources needed to fulfill the need. Data for soliciting funds to fulfill needs identified in larger plan.
3. Early identification of problems for families that include promotion and prevention for universal (promotion) and targeted (prevention) opportunities at the community level.
4. Immersive services for families that require intervention and support while involved with key systemwide organizations (e.g., DSS, DJJ, School/ESE, Early Intervention), to address quality of life, respite, and family nurturing issues to strengthen and maintain the family.
    a. County wide shared plans across governmental, service, education, recreation, faith-based and others as identified to help meet the whole person/whole family needs identified and sharing responsibility in the community for helping families in distress.

    b. County wide shared plans across governmental, service, education, recreation, faith-based and others as identified that will engage mentors and other prevention approaches to reduce the need for intervention services.
5. Review of the promotion/prevention/intervention continuum of family support and preservation models and EBPs to introduce or reinforce into the county in a sustainable way, including monitoring for less restrictive services and family reunification as soon as clearly articulated objectives are met. Suggested services included EPSDT (Early and Periodic Screening Diagnostic and Treatment), Homebuilders Family Preservation Model, Grief Counseling, Trauma-Informed and Specific Services, Good Neighbors, Healthy Impact, Diversion Programs, and Case Management.
6. Information sharing agreements and possibly the use of a "quality of life" record that will address the needs of the family and each individual while limiting multiple 'telling of the story' and focusing on strengths-based approaches instead of deficit based.
    a. Service Provider Mapping
    b. Other Resource/ asset map to identify what services exist for ages, type of intervention, access, insurance/ payment requirement, who refers and is there a referral loop back on acceptance/ successful completion,

A key RBA related accomplishment for Polk was the RBA Youth and Family Case Review in May 2023. This was well attended and was central to further identifying the problem areas listed above. Documentation of the process is found in Appendix 3. As often happens with Collaboratives, changes in membership have delayed progress and the focus has shifted to foster care. This is still in line with much of the work completed but requires additional effort to align all stakeholders.

The Family Partner supported through the grant with Youth Villages along with the Lead Family Coordinator supported the development of a Family Support Group in a low-income apartment complex in Polk County, the Kare Council. The group meets twice monthly with a range of 2-11 attendees. The membership has grown with an initial focus on having a food pantry to address immediate needs. The apartment complex was sold to another company and some restrictions have been applied, e.g., having to be a resident of the complex, which reduced some membership for members that had moved out of the complex but wished to stay involved. A new site is being explored and a YMCA being built across from the apartments may offer a solution. This has been a successful group despite obstacles and work is being done to slowly introduce a more systems change focus to expand their leverage in the community.

During the year, one of the key members of the Polk Collaborative requested support in completing a Duke Endowment Grant application form the IET. This was supported and submitted, but not funded. Recent feedback may result in funding after all, and this is being monitored. The IET will continue to support this effort.

The Resilience Movie screenings and data collection has continued, but mostly outside of Polk County and that data has not been available to the IET. This has been requested and is in process. Including the data already collected and reported in last years annual report to include new data will help to sustain the focus on resilience and trauma in Polk and surrounding communities.

Wilkes Task Force

Wilkes has had particularly challenging issues with leadership turnover but have strongly responded through creating a viable task force. Two leaders emerged and the SOC Coordinator has been working closely with them to improve membership, attendance, and focus of the Collaborative. Co-chairs have been elected to lead the collaborative. Membership and structure building is ongoing. The collaborative members are motivated to develop project ideas. They would like to increase family voice in the group prior to selecting a project. Collaborative members have been charged with inviting family participation as well as soliciting family ideas regarding community needs.

A SOC RBA presentation was completed with the Collaborative during the year by the IET:

- Population estimates
- Economic stability
- Mental health incidence and prevalence estimates
- Children in foster care and those in foster care due to substance use of parents (61.8%) compared to the state as a whole (45.3%)
- Opioid issues
- Delinquency rates
- Child health risk indicators (abuse/neglect, substance abuse, mental illness, single-parent households, intimate partner violence, food insecurity, children in poverty, high school completion, median household income, children eligible for free or reduced lunch, housing problems, teen birth rate, and low birthweight)
- SDOH and Wellbeing estimates
- Review of four priority issues from the Wilkes Community Health Assessment
    - Obesity and chronic disease
    - Mental health and substance abuse
    - Access to care
    - Tobacco and smoking
- What to do next

Mentimeter was used during a subsequent presentation to identify priorities. These are included in Appendix 3. Based on the data from the presentation and multiple feedback opportunities, the following planning steps were developed then, unfortunately, stopped with turnover in leadership and membership.

1. Review current information
2. Set meeting with SOC Coordinator and current leadership:
    a. Review perspectives of who would be good stakeholders for the project.
    b. Discuss what approach makes the most sense.
        i. Data first.
        ii. Data for 1 or 2 Specific Organizations.
            1. Come up with an end goal to ask for help with "can you share with us XYZ."
    c. Emails to identified stakeholders inviting them to the meeting with appropriate information.
    d. Calls to primary stakeholders to ensure participation.
        i. Invite people who are action oriented and want to do something about the current system.
3. Finalize the RBA process.
        i. Complete a Systems Based Case Study

Effort was made to engage other entities focused on youth mental health in Wilkes County. Wilkes geographically is a large county that requires a clear approach for engaging representation across stakeholder groups, marginalized populations, and geographic locations.

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 following is a review of the 5 goals and 23 objectives (Table 48). The status of all goals will remain "in process" until end of project.

Table 48. 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 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.	**In Process**
O1	By month 4, finalize membership on the	Year 1 objective that was met and reported in the Year 1 Annual Report.	**MET**

Table 48. Summary Progress Status for Goals and Objectives			
#	**Goals and Objectives**	**Discussion**	**Status**
	Governance Board, develop the GB training, and hold the first GB meeting		
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 but was considered a burden with the number and type of activities as outlined in previous sections. Noted above, the SOC-IT completed 106 field notes for the county collaborative meetings, trainings, and other meetings they attended, with an additional 60 field notes in the SOC-ET specific version of the note. Many other 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 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	**MET**

Table 48. Summary Progress Status for Goals and Objectives			
#	**Goals and Objectives**	**Discussion**	**Status**
		the 62 segments coded for impact, 59 viewed the SOC as impactful for meeting its goals or supporting the objectives of community collaboratives and stakeholders (95.2%)	
O5	System analysis completed by the SOC-ET will indicate a larger number of connections and improvement in network satisfaction by surveyed SOC stakeholders each year	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. Attendance increased by an average of 13.3% for meetings. Network density, the rate of being at the same meetings by members of collaboratives and other bodies, increased by 4.6%. The effect of COVID appears to be decreasing and was a consistent barrier since project start. Last year, there were 83 mentions of COVID as a reason for reduced contacts, particularly for planned meetings and events. This decreased to 15 for Year 3. Overall, there is suggestions that the network is strengthening.	**MET**
	GOAL 2:	Health disparities are being systematically assessed for a portion of outreach and treatment recipients. The data is collected systematically using a State created and approved form targeting social drivers/social determinants of health. As noted, recruitment is slower than expected. A unique identifier is being used for all assessments and other data collection. This will allow SDOH and other data to be associated with NOMS social connectedness and suicidal ideation data. The SOC-ET is working with the primary provider agency to increase recruitment, outreach and completion of Triple Screens.	**In Process**
O6	By month 4, have introduced the state SDOH data collection form to principle partners. Continue to develop at least 10 additional providers/organizations to provide needed services and resources each year.	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 resources for each target county and to add additional ones that were forwarded by Y/FP and others. Changes in resources outpace the ability to document. Several Collaboratives have expressed intention to create resource guides but none have done so for that reason. The ET has tracked the number of new resources available across counties. There were 16 new resources including agencies like	**MET**

Table 48. Summary Progress Status for Goals and Objectives			
#	**Goals and Objectives**	**Discussion**	**Status**
		ASPIRE and WYLD (see Wilkes County above), supporting youth.	
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 have been unsuccessful. Given the time left in the project we do not believe that significant changes can occur. This objective will not be reported on in future reports and is considered unmet for the duration of the project. This will be revisited if sufficient follow-up data is received during Year 4.	**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. Most 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. New hires were trained within 90 days for the grant, or less.	**MET**
O11	80% of Y/FP's will be rated as satisfactory or highly satisfactory for position responsibilities by persons SERVICE, providers, supervisors, the LFC and PD annually.	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 meetings specific to Measurement-Based Care noted earlier. Reiterating, for the youth that have been discharged from the program, 100% agreed or	**MET**

Table 48. Summary Progress Status for Goals and Objectives			
#	**Goals and Objectives**	**Discussion**	**Status**
		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 42 of 51 youth tracked by YV (82.4%) 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 51 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.	**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)	Due to changes from old to new NOMS, value options changed and the number respondents by type as well. For this report, we summed all the possible responses per question that had a follow-up response for the denominator. This was 93. For the numerator, we included any responses that indicate good social connectedness at follow-up that had poor SC at baseline (Bad → Good) or retained good at follow-up (Good → Good), n = 85. Improvement = 91.4%.	**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 personnel and community participants, will rate	All trainings offered on RBA, Systems Change, etc. were rated as satisfactory or highly satisfactory. Training for the GB was viewed as highly satisfactory. Direct trainings = 100%. Trainings in	**MET**

Table 48. Summary Progress Status for Goals and Objectives			
#	**Goals and Objectives**	**Discussion**	**Status**
	trainings as satisfactory or highly satisfactory and effective or highly effective.	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 4 required 256 individuals trained to meet the objective. 269 were trained this year. From project start, 963 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.**	Many 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	Year 3 expectations per the grant narrative is 53, including the increase in expectation of 5%. 54 were served in Year 3.	**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.	Over the course of the grant, 124 youth have been enrolled and 78 (62.9%) have been discharged. For year 3, 72 youth were in treatment and rated as high risk when combining Triple Screen and NOMS data. Of these, 23 have been discharged. Of the 49 remaining, 41 (83.7%) 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 in service meets this criterion. Cannot be evaluated. Given the time left in the project we do not believe that significant changes can occur. This objective will not be reported on in future reports and is considered unmet for the duration of the project.	**UNMET**
O21	70% of youth with SED that have a trauma related goal will meet or exceed treatment goals after being SERVICE for 6-months per provider report	No youth in service meets this criterion. Given the time left in the project we do not believe that significant changes can occur. This objective will not be reported on in future reports and is considered unmet for the duration of the project.	**UNMET**
O22	70% of youth receiving a CALOCUS assessment will	CALOCUS data is not available. Given the time left in the project we do not believe that significant	**UNMET**

Table 48. Summary Progress Status for Goals and Objectives			
#	**Goals and Objectives**	**Discussion**	**Status**
	improve functioning after 6-months of services	changes can occur. This objective will not be reported on in future reports and is considered unmet for the duration of the project.	
O23	85% of families and youth receiving services will have a positive perception of care (NOMS data)	Perception of care is strong and positive. Combining data from old and new NOMS, there were 912 responses to perception of care questions. Of these, 881 were positive, 96.6%.	**MET**

Qualitative Sub-Study/Process Evaluation Supplement

A qualitative sub-study was started in Year 2 and continued. This was started by completing a readiness assessment for five collaboratives. There are two phases to the study. Each is based on different but complimentary data sets, some of which continues to accrue. key information interviews using a semi-structured interview guide. Thematic analysis included data from both phases in Year 3.

- **Phase 1** completed 20 initial 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. Fifteen additional interviews were completed for a total of 35.
- **Phase 2** collects, reviews, and enters for analysis a number of documents, recordings, reports, and related materials from the list of data sources at the beginning of this report. For example, process notes, narrative data from surveys, meeting materials, community health reports, etc.
    - Interviews for specific projects, 16 completed in Year 3, were also included for coding after transcribing.
    - Total number of sources of all types = 311

The analysis has been in three stages.

1. Single Code Summaries and Frequencies: Frequencies of planned and emergent codes were completed. This gives a numeric approximation of the frequency of topics with differences that can be assessed for counties, professional status, etc. when needed.
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 for the project as a whole and by sectioning, e.g., time, location, stakeholder group.

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. Some sections remain from the Year 2 report with updated frequency numbers and commentary when changes were significantly different. This is partially updated as monthly coding and review of qualitative data has not altered a lot of the information. Frequencies are updated and the Collaborative section is new.

1. Common Obstacles and Gaps
2. Collaboratives
3. Mental Health and Substance Use
4. System Levels Obstacles
5. Level 3 Examples

Common Obstacles and Gaps

There were several gaps noted. The most commonly noted are included here.

Transportation was noted by 32 sources. This issue has increased and was cross-coded with stigma (14%), employment (31%), reasonable access to services (42%), recreation (44%), nutrition (17%), and safety codes (11%). There is minimal public transportation available to those most in need. Options are in towns and not available in most rural areas. In some areas there are no options other than volunteers from faith-based organizations, some provider organizations, and school systems.

Trauma is another common obstacle that was cross coded with the following. Trauma is addressed in greater depth in the next section. Family functioning (28%), safety (34%), social connections (53%, and consistent with NOMS data), self-worth/self-esteem (20%), belief in future (44%), educational success (39%), and trust in others (47%).

> "The kiddos we work with have all had such terrible trauma. But it's also their parents and then their parents. They try and normalize it but all that does is bury it. So many of our families have domestic violence issues, addiction, obesity, depression, and the kids are getting more and more suicidal. I'm afraid to look at the news anymore. Kids walk around with these distant looks and so few of them can begin to describe what they think will happen or want to happen in their futures."

Another primary obstacle, and it is noted here that no prompts were used, was stigma. Stigma was cross coded with additional codes. 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. Seven interview respondents, reinforced in some documents, noted that communities are segmented by race that it is rarely addressed openly and that there is overt hostility to the LGBTQ+

population. Even when assured of confidentiality, anxiety and self-protection prevented elaboration.

Parental absence for various reasons and the rise in foster care placements was noted by 36 sources, an increase from 14 in the Year 2 report. Reasons for parental absence was cross coded with the following, with last years in parentheses:

- Parental MH/SU conditions: 33 (12) respondents. This is noted again and consistent with other data cited in this report. An area that does not received enough attention given the impact on youth lives and well-being, as well the leading cause for youth to be in foster care, is parental/caregiver mental health conditions.

  > "A lot of the families we work with and that send their kids to us have mental health problems. It's all the kids see, so it's all that they know. I've heard kids competing, trying to be funny, about which of their parents is crazier. Having addicted parents and siblings is so common now."

- Stigma and Shame: 17 (9) respondents. How to reach families, counter stigma, engage and activate families, and to better utilize resources were linked to this cross-code.
- Incarceration: 31 (8) respondents: Substance use was the assumed but now validated belief for incarcerations as well as youth foster care as noted. This was also cross-coded with trauma and domestic violence.
- Resilience challenges: 41 (7) respondents: Resilience was a common discussion, partially due to the focus of the SOC but also as a key intervention area for some collaboratives and school systems. 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.

We note that the numbers for all the above increased a great deal due to intentional focus by Collaborative leadership, SOC Coordinators, IET, Governance Board, and others. Several of these were also issues for RBA discussions during Collaborative meetings.

Collaboratives

Collaboratives and Task Forces are described here regarding infrastructure, leadership, scheduling/managing/documenting, community leverage, targeted objectives, and systems change. Much of the SOC Coordinator work has been directly tied to Collaboratives, supporting, guiding, at times leading, and recruiting.

- Infrastructure: 163 sources. A Collaborative is an entity that can thrive, survive, or disband. It relies on consistent and adaptive planning and implementation. Sources referred to one or more of the following: mission/mission statement, vision/vision statement, written purpose/description, role definition, goals/objectives, leadership, bylaws or guidelines. Other than mission and measurable objectives, Collaboratives were resistant for engaging in other infrastructure development. The listed components

help to build sustainability and faster adaptation to membership and leadership turnover.

> "I bring up bylaws and they look at me like I'm speaking in tongues. They want to do the work but end up doing the same thing over and over. Membership is stable but it's like it's a chance to socialize and get away from work."

- Leadership: 121 sources. Recruiting and maintaining leadership has been problematic for most collaboratives. Coordinators have augmented and at times stepped in as Collaborative leaders. Questions about supporting, training, recruiting and retaining leaders in Collaboratives were raised in Office Hours nine times. Unstable or at risk leadership is a threat to Collaborative functioning.
- Managing: 204 sources. Managing Collaboratives included references/codes for agenda's, minutes, copying and similar preparation, scheduling, communicating, presentations, planning, and guiding. The least impactful but most common Collaborative type is organizational updates, resource describing, and, inconsistently, case/family/youth crisis staffing. These are certainly useful functions but run the risk of repetitiveness. A repetition code was used and 11 instances of losing interest in attending was noted.
- Focus on Objectives: 171 sources. Setting measurable goals and objectives, data support, RBA and related codes were used to describe Collaboratives work to move beyond organizational updates. Collaboratives need support in identifying measurable objectives and planning actions to support change. The IET helped to produce many of the agreed upon objectives after many meetings to describe strengths and needs and define priorities.
- Leverage and Influence: 59 sources. Collaboratives can become influential and havens for data-driven decision-making. This is a higher form of Collaborative that works to connect siloes and guide collective community change. A few counties are engaging regularly at this level.
    - A key task for all Collaboratives is to determine what other groups are operating in the same area and how they can ensure that duplication is not occurring and to plan to work together when possible. For example, several counties have Substance Use collaboratives attempting to attract and engage the same resources.
- Systems Change: 37 sources. Systems change is the highest level of Collaborative that increases influence and is fully welcoming of a community's diversity and resources. Full community representation has been elusive in most counties. Systems change also relies on having youth and family representation. Noted elsewhere in this report, family and youth representation has been inconsistent and difficult to maintain. Collaboratives continue to struggle with how to have an equal voice from individuals that represent some of the very cases that the Collaboratives struggle to support.

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 and resilience deficits
- Poverty
- Domestic Violence
- Access to qualified programs within a reasonable travel distance

Lack of reliable, qualified, and confidential mental health services were identified by 81 sources.

> "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. Seventeen (17) sources identified either confusion or disagreement with the national conversation as well as not knowing how to pay for services added to the problem. Twenty-one (21) sources noted that NC not being a Medicaid expansion state was clearly more political then data based and frustrated them. However, 61 sources noted that this will likely improve given NC moving to Medicaid expansion starting in December of 2023, past the reporting period for this document and not otherwise addressed.

> "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."

"Culture war" issues have split communities and interfered with a focused and targeted response for youth. Some parents have openly stated they give up trying to help anything because they are surrounded by 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 (27 resources). 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 increased from seven respondents to 114 sources for this report. Youth substance use and trauma/resilience were the two issues with the largest increase in frequency. When cross coding for source, law-enforcement, schools, juvenile justice, personal responsibility, stigma, and foster care were the most cross-coded with substance use. There is strong evidence of an implicit bias against substance using individuals and general disbelief that SUD is really a disease process. 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"

For the Year 2 Annual Report, a then emergent, issue was raised by three respondents was now noted in 61 sources. Social-emotional learning in schools as problematic is being pushed against by parents and professionals. 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 42 times in Year 2 and an astounding 94 times in Year 3:

> "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."

System Level Obstacles

There were several community level and systems obstacles noted. This starts with lack of community-buy in, coded as same, noted by 55 sources, increase from 15 in Year 2. 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 63 sources and cross-coded 51 times. This has led to not prioritizing connectedness in communities (32 sources). 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.

Understanding systems and systems change, or more accurately, not understanding them was coded 188 times from 44 sources. This has resulted in expanding the RBA model to include systems change as a critical focus. Combined evidence suggests that RBA and Collaborative efforts, provider services, state and local agencies (e.g., DSS, JJ), are not adequately supporting, think of as crosspollinating, and instead end up reinforcing silo isolation vs. silo communication or, more rarely, integration. Systems require structures and the IET actively worked against the often reflexive use of 'breaking down silos.' Silos often exist for reasons that will be structurally impregnable and thus coexistence and mutual support are preferred.

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 44 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 22 sources 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."

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 3 addressed recruiting families into services and addressed barriers. This remains problematic but is more critical for completing follow-up data collection which is well belowe the 80 percent expectation from SAMHSA. Earlier in this report the number of persons

engaged trainings and meetings were reported. For collaborative and other community meetings, it has been extremely difficult to engage family and youth. This suggests a barrier to family and youth unaffiliated with employment remains strong. A solution suggested was to have families, parents, and youth engage in their own groups. This would be beneficial to increase the voice of lived experience into the system of care process. On the other hand, this also reinforces silos as well as the potential for youth and families to feel unwelcome and unaccepted as full contributing members to an improving system of care.

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 met requirements with a small surplus. Because many triple screens were captured in bulk and events this allowed for an unplanned comparison group. The expectation during the planning phase was that the primary provider, Youth Villages, would be screaming a number of youth through the seven county area and then we're rolling those most in need. It is unknown how many youth enrolled at Youth Villages and placed immediately into other evidence based practices might have been eligible for F/YP services.

There was good momentum at the end of Year 2 for NOMS and enrollment. It is unclear but likely due to turnover in Y/FP positions that NOMS enrollment did not meet sufficient numbers to continue to make up for Year 1 but didn't meet numbers for Year 2, again with a small surplus period. Again addressing the triple screen, having the unplanned comparison group aids prevention efforts for general public estimates and not only for youth in service.

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 (120 segments). 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 in service is compounded by strong racial and ethnic negative beliefs for persons of color and the LGTBQ+ population. This was noted in 69 segments.

Informing families was linked with recruiting family and youth into Child and SOC Collaboratives (71 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 (33 segments). Marginalization and racism were noted with more frequency and it is almost a

visible secret that provokes a sense of helplessness. While there was a clear desire to engage youth and family and collaborative efforts, how to do so was unclear and unsuccessful in many cases. Empowering families and youth to be part of the solution by first linking them with other family and youth resulting information that could be taken back to collaboratives is the current plan for several counties. Family and Youth Voice as a Collaborative topic was the most selected topic for Field Notes in Years 2 and 3, up from the number three ranking from Year 1. 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 remain clear barriers. Overall, the number of families and youth informed is stable and slowly increasing.

***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. 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 as unidirectional for those in most need and reciprocal for those in less need, emphasizes connection with caregivers, acquaintances, or community. This was noted 105 times, up from 61 times in Year 2, in qualitative segments. Connectedness was related to having necessary community resources, detection of youth at risk, trauma, and resilience. Deficits in social isolation connectedness we're strongly linked to trauma experiences one combining NOMS and triple screen data. Recommended earlier in the report, this provides an additional Ave. for intervention bye the greater system of care. Social isolation, defined as youth perception of isolation and feeling unsupported, was coded 71 times, up from 33 in Year 2, 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 54 times, a decrease from 71 times in Year 2, with emphasis on having safe social opportunities for youth in rural areas and, again, resilience.

Resilience itself was coded 197 times in Year 3. What cross coding for trauma, stigma, substance use, and other related factors, it becomes clear that there is not a shared understanding of what resilience is which impedes the ability to target interventions to improve it. We recommend that resilience as a broader construct for identity, adaptability, perceived

self worth, and connectedness be better defined and considered a multi level construct. By this we mean that resilience can be an individual experience, a familial construct, and organizational construct, and the humidity level construct. Addressing resilience through the developing model that includes RBA, collective impact, systems change, and data management targeted to resilience across the four levels may have a greater opportunity of improving resilience at the individual level for youth. Resilience for other individuals in the family especially parents and caregivers, considering the high number of parents identified through triple screens with mental health and substance use issues should also be targeted.

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.

***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 triple screen we're emphasized as required for follow up with unfortunately limited data collected.

***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 (44 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. Data-driven decision making was coded only 28 times this year compared to 42 last year and is linked to measurement-based care as a separate code (26 segments for this year compared to 39

segments for last year), and both are linked with the Clinical Services code (77 segments for Year 3, up from 41 segments from Year 2). What this suggests is that clinical services is focused on access and delivery and not necessarily effectiveness and impact one considered by the community. 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 continues. Specific to policy changes, this has been difficult to both track and attribute to the SOC with the emphasis on Tailored Plan, Medicaid Expansion, 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. There were 29 segments that addressed family and youth understanding of system of care. There was consistent confusion found with cross coating between system of care and service delivery system. It is unclear whether this distinction results in any differences or treatment or understanding of treatment. Shown earlier, services have been very well received with high levels of satisfaction. Distinguishing between a SOC and a service delivery system will be assessed for importance in year four. Regarding influence, families that have engaged with community collaboratives or with family support groups appear to feel that they have higher levels of influence regarding SOC. What the data appears to support is that the combined voice of youth and families is more effective and prompting and supporting change than individual youth and families. Youth Partners have addressed the Governance Board and some Collaborative meetings. However, there is no indication that these experiences last much further than the end of the meeting. 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.

***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 47 for discussion of 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. 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. 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. Scattered somewhat in this report and reviewing codes and interactions of codes for network, communication, sustainability, inclusion, lived experience, and systems change, it appears that network communication have increased approximately 33% based on frequency of codes and specific intersection of codes. It appears the impact has been mostly clarifying and defining versus systems change. Hence, and as noted, the emphasis in Year 4 will be on systems change and accompanying policies and practices that will sustain this change post grant funding. 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. A survey link will be sent quarterly to key partners starting in Year 4 to have them simply indicate if they have had direct contact in relation to system of care or service delivery system in that quarter. This will include the ability to indicate if these contacts are perceived as being attributable to the work of the IET or not. Impact can be measured by the impact of RBA projects as well and is considered to have been successful.

Appendix 1: Small Project Documents

Aspire Kids at Work, Post Camp Impact Survey

Parent 2 Parent Interview Guide

Parent to Parent IEP Meeting Follow-Up Survey

Cherokee County School Assessment

ASPIRE KIDS AT WORK

Post Camp Impact Survey

Unique ID _____

Student Name _____

Date _____

Please CAREFULLY circle how you would rate yourself on the following questions BEFORE camp and now AFTER camp.

I am employable.					
BEFORE Camp	Agree	Somewhat Agree	In the Middle	Somewhat Disagree	Disagree
AFTER Camp	Agree	Somewhat Agree	In the Middle	Somewhat Disagree	Disagree

I am confidence in myself.					
BEFORE Camp	Agree	Somewhat Agree	In the Middle	Somewhat Disagree	Disagree
AFTER Camp	Agree	Somewhat Agree	In the Middle	Somewhat Disagree	Disagree

I am connected to friends.					
BEFORE Camp	Agree	Somewhat Agree	In the Middle	Somewhat Disagree	Disagree
AFTER Camp	Agree	Somewhat Agree	In the Middle	Somewhat Disagree	Disagree

I am connected to family.					
BEFORE Camp	Agree	Somewhat Agree	In the Middle	Somewhat Disagree	Disagree
AFTER Camp	Agree	Somewhat Agree	In the Middle	Somewhat Disagree	Disagree

I can resolve conflicts with others.					
BEFORE Camp	Agree	Somewhat Agree	In the Middle	Somewhat Disagree	Disagree
AFTER Camp	Agree	Somewhat Agree	In the Middle	Somewhat Disagree	Disagree

I understand my feelings.					
BEFORE Camp	Agree	Somewhat Agree	In the Middle	Somewhat Disagree	Disagree
AFTER Camp	Agree	Somewhat Agree	In the Middle	Somewhat Disagree	Disagree

I know how to solve problems.					
BEFORE Camp	Agree	Somewhat Agree	In the Middle	Somewhat Disagree	Disagree
AFTER Camp	Agree	Somewhat Agree	In the Middle	Somewhat Disagree	Disagree

I can set goals for myself.					
BEFORE Camp	Agree	Somewhat Agree	In the Middle	Somewhat Disagree	Disagree
AFTER Camp	Agree	Somewhat Agree	In the Middle	Somewhat Disagree	Disagree

I have good control of my emotions.					
BEFORE Camp	Agree	Somewhat Agree	In the Middle	Somewhat Disagree	Disagree
AFTER Camp	Agree	Somewhat Agree	In the Middle	Somewhat Disagree	Disagree

Parent 2 Parent Interview Guide

Purpose: To develop a targeted, Excel based, data system to track who is served, encounters, impact objectives, and other relevant data.

The interview will last from 30-60 minutes. Please answer questions thoroughly. If you think of something to add post interview, include the information in an email and please send to Dr. Walby, L'Oreal Glenn and Faustine Judd.

1. What data are you collecting that describes the youth and families served? The following were sent in emails. Please confirm if the following information is collected and add other data not included.

- Gender (Values?)
- Age (Age in years? DOB?)
- Race/ethnicity (Values?)
- Parent type (mother, father, grandmother, or other)

2. Where is this information kept? What is the data management system or software program used? What would you be comfortable using?

3. What are your suggestions for assessing impact of your program? How do you/will you know that you are making a difference? What do you measure or assess individually for families that may be able to be aggregated as a program impact measure?

4. Are there common factors or descriptions that families have that help you determine which families have more complex or intense needs that will require more time and effort? Examples: Families with children that have complex medical needs, families with children on the spectrum or families with parents that have chronic medical, mental health or substance use conditions.

5. How have you used information in P2P or other times to evaluate the effectiveness and efficiency of your program, project, or organization?

6. How do you track the number and length of encounters for families you work with? Do you have any suggestions to improve tracking encounters, contacts, referrals for resources, if families followed through with a referral or other direct service provided to families?

7. How do P2P team members share information, resources, and needs of individual families to maximum impact and support? What could be done to improve information sharing and help parents accept additional and/or outside supports, including providers and resources?

8. How have you measured satisfaction with P2P programs? How would you suggest doing so in the future?

9. If you had the ability to suddenly have a database that would prove that your program is effective and should be supported and even expanded to help more families, what would be in that database?

Family Support Network

Post IEP Support Survey

Family Name Date:

Please answer all questions. For the first part of each question (**Before IEP Support**) think of your confidence level before receiving support/training in IEP development, IEP meetings, and related. Then answer how confident you are now after receiving support (**After IEP Support**).

I understand the IEP process.				
	Not Confident	**Somewhat Confident**	**Confident**	**Very Confident**
Before IEP Support	0	1	2	3
After IEP Support	0	1	2	3

I feel supported with developing the IEP.				
	Not Confident	**Somewhat Confident**	**Confident**	**Very Confident**
Before IEP Support	0	1	2	3
After IEP Support	0	1	2	3

I have confidence I can attend an IEP meeting and make myself heard.				
	Not Confident	**Somewhat Confident**	**Confident**	**Very Confident**
Before IEP Support	0	1	2	3
After IEP Support	0	1	2	3

I feel I can control my emotions and support my child in the IEP meeting.				
	Not Confident	**Somewhat Confident**	**Confident**	**Very Confident**
Before IEP Support	0	1	2	3
After IEP Support	0	1	2	3

I felt comfortable in having/inviting the support at the IEP meeting that I wanted.				
	Not Confident	**Somewhat Confident**	**Confident**	**Very Confident**
Before IEP Support	0	1	2	3
After IEP Support	0	1	2	3

The following questions are for after IEP meetings and tracking how your child is doing.

I communicate well with the school after the IEP meeting.				
	Not Confident	**Somewhat Confident**	**Confident**	**Very Confident**
Before IEP Support	0	1	2	3
After IEP Support	0	1	2	3

I can focus on academic/behavior needs when communicating with the school system.				
	Not Confident	**Somewhat Confident**	**Confident**	**Very Confident**
Before IEP Support	0	1	2	3
After IEP Support	0	1	2	3

I feel confident on talking with the school about adaptations needed for academic and behavioral success with the school system.				
	Not Confident	**Somewhat Confident**	**Confident**	**Very Confident**
Before IEP Support	0	1	2	3
After IEP Support	0	1	2	3

I know how to make myself respectfully and assertively heard if the IEP is not being followed at school.				
	Not Confident	**Somewhat Confident**	**Confident**	**Very Confident**
Before IEP Support	0	1	2	3
After IEP Support	0	1	2	3

Please include any additional comments that will help us do a better job:

Cherokee County School Assessment

In an effort to improve school attendance and communication between parent and school, we are asking you to complete this short survey. Questions are on the front and back

Grade of student: _____	Gender of student (circle one): M F

1. When I missed school, I stayed home because…(check all that apply)

☐ Did not have a ride to school	☐ Missed the bus	☐ Have a conflict with peers
☐ Hard time getting up in the morning (check all that apply) __ stayed up too late because of homework, watching TV, playing video games, or other __ trouble sleeping so I can't fall asleep	☐ I have anxiety or feel nervous about going to school	☐ I don't feel like I fit in at school
☐ I feel the school work is too difficult and I don't understand it.	☐ I feel depressed or sad and don't have the energy to go to school	☐ I feel stressed or overwhelmed and don't want to go to school
☐ I was sick	☐ I have physical issues that keep me from going to school sometimes	☐ I have a conflict with a teacher, principal or other staff member at school
☐ I don't have any friends at school	☐ Sometimes I have to stay home to take care of my younger siblings	☐ I sometimes don't have shoes or clothing to go to school
☐ I find school boring	☐ I didn't do my homework	☐ I don't like school, so I wanted to stay home

2. When I do stay at home and do not go to school, I spend my time….(check all that apply)

Watch tv/movies

Play video games

Stay on social media sites (Instagram, youtube, facebook, snapchat, text, twitter (X), Tiktok,

Take care of my sibling

Go to work with my parent/guardian

Work and make money

Do household chores

I don't do anything, I am sick

3. I am in the following activities in school (check all that apply)

Band/chorus

Sports team

Art class

Robotics

4. I am involved in these activites outside of school….(check all that apply)

I attend Church or belong to a church group

Recreational sports

Have a gym membership

Go to the park regularly

5. I think my peers like me

A lot somewhat a little not at all

6. I like myself

A lot somewhat a little not at all

7. I enjoy school

A lot somewhat a little not at all

8. My parents/guardian like my school

A lot somewhat a little not at all

9. How comfortable do you feel talking with your teacher if you have a problem

Very comfortable somewhat comfortable a little comfortable not at all

10. How much do Do you like your school?

A lot (I love my school) somewhat a little not at all (I don't like my school)

11. Who would you feel most comfortable at the school to contact if you had a problem?

- ☐ Counselor
- ☐ Teacher
- ☐ Principal
- ☐ School nurse
- ☐ Social worker
- ☐ SRO
- ☐ EC teacher
- ☐ Other:(please list) _____

Appendix 2: Evaluation Team Collaborative Support Documents

Support Document 1: Managing Collaborative Development

Support Document 2: Systems, Systems Thinking, Systems of Care, and Systems Change

Support Document 3: Asking System and RBA Questions

Managing Collaborative Development

This is a short resource for managing time and members of collaboratives. The term Collaboratives is used broadly to include Task Forces and other group types.

FIRST AND MOST…

COLLABORATIVE DEVELOPMENT AND SYSTEM CHANGE WORK IS SLOW AND HARD!!

Levels of Collaboration

This is added to help you gauge where your collaboratives are in their collaborative development process. Types of collaboratives are listed from the least to the most integrated. Higher levels of integration lead to more collaboration with shared agendas and resources. However, collaboratives must understand and respect each member and member organization's self-interest (structure, agenda, values, culture) and their relationships, history, and linkages with other members. Where are each of your collaboratives on the following?

Networking: Networking involves intermittent exchanges of information for mutual benefit through dialogue, common awareness, understanding, and creating a base for support. This is often the sharing of institutional knowledge, accomplishments, resources and needs during resource exchanges as part of the collaborative. This is the default level of collaboratives and will have little influence on system change.

Cooperating: Encompasses short and informal relationships without clearly defined missions or structure. These are internal groups, often based on training or common interests, that is the beginning of collaboration. The main purpose of cooperating is to get tasks done while limiting duplication of services. Collaboratives heavy in service providers will often use the time to cooperate on specific cases or identified common needs. Each organization retains separate resources and authority, so no risk exists.

Coordinating: This includes exchanging information and altering activities for mutual benefit and to achieve a common purpose. The relationships are more formal, longer term, and focus on specific goals, efforts, or programs. This is a positive level that may be the best a collaborative can do and should be nurtured and rewarded. Here is where common and shared purpose with some level of shared risk originates. Coordination requires planning, division of roles and responsibilities, and communication. Resources and rewards are shared. Although each organization still retains separate resources and authority, risk increases.

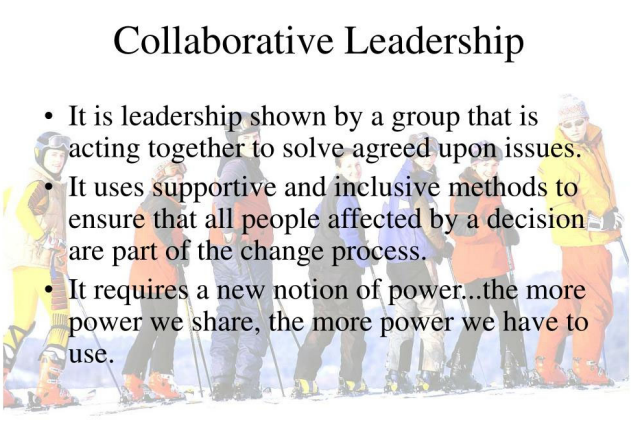
Collaborating: This level signifies a more durable relationship. As a reminder, half of all collaboratives do not see their first birthday and 75% do not see their second. However, they may continue to exist for a long time at a networking level with occasional forays into cooperation but are not a true collaborative. Separate organizations enter into a

new structural arrangement with formal roles and full commitment to a common mission. This is difficult and will often take 4-5 years before fully coalescing. Comprehensive planning and clear communication channels are needed at all levels. Consensus is used in shared decision making. This requires strong leaders that communicate between meetings and lead between meetings. Risk increases as each organization contributes resources and reputation. Partners jointly secure or share resources which contributes to sustainability of all partners. Trust levels and productivity are high, but power may not be equally shared. True collaboration has the highest potential for system change.

Another way to think of collaboratives is on a continuum of problem setting to objective selection to implementation and assessment of impact. You will recognize that continuum as Results-Based Accountability that can be used across any level of collaborative.

Essential Characteristics of Collaboration

What exactly is a collaborative supposed to do? What characterizes a Collaborative, so you know it when you see it? There are five characteristics of a successful collaborative. Think of each of your collaboratives based on their level of collaboration described above. The higher the level of collaboration attained the more each characteristic will emerge as an observable process. Questions to ask about your collaborative are included for each characteristic.



1. *Shared creation: Joint action for mutual benefit*.
    a. How well do they work as a team?
    b. Who carries the most load?
    c. How invested are the members?
2. *Interdependence and reciprocity*.
    a. Is there mutual support?
    b. Volunteers to take on specific tasks?
    c. Do a range of participants contribute during meetings?
    d. Is there any system-change planning or activities between meetings?
3. *Mutual authority and accountability*.
    a. Do members hold each other accountable?
    b. Does leadership lead?
    c. Are there timeframes and deadlines set?
    d. Are measurable objectives set?
4. *Shared responsibility, risks, resources, and rewards*.

a. Is there an agenda for each meeting?
b. How much contact is happening between members between meetings?
c. Is there a strong leadership team?
d. How well are the SOC Coordinators and Family Partners integrated as part of infrastructure and implementation support?

5. Inherent conflict and dynamic tensions. People will not always get along and there will be times when some members may prioritize their host organization/employer's agenda over the collaborative. There may be disagreements on problems, data, objectives, approach, and assessment of impact. Mature collaboratives have conflict resolution practices in place. Conflict is not inherently bad. It's an indication of the need for consensus and for change/growth. Those that are content do not seek to change even if they are not meeting the mission they are entrusted with.
    a. Is there conflict? If so, is it between the same or different members?
    b. Is conflict based on the agenda, mission, and objectives of the collaborative or spills into the collaborative from member agendas?
    c. Are there conflict resolution practices in place?

<u>Time Management</u>

The following is a useful way to think about how you are spending your time working with and for your collaboratives. The timeframes are estimates of working with a collaborative with monthly meetings and, for best practice, having at least one sub-committee or Leadership Team meeting per month as well. The full collaborative meeting should be almost scripted by the time it is held. You'll know what the objectives are, and you'll manage the meeting, with leadership, to meet the objectives.

5% - Full Collaborative Meeting, including invitations and reminders, technology management, determining a recorder/minutes taker, location management and preparation, developing the agenda, food or other incentives, holding the actual meeting, and any post-collaborative assessment distribution, e.g., an online survey.

20% - Sub-committee and/or Leadership Team meetings. This includes individual contacts with Leadership. Same meeting preparation and implementation as listed under Full Collaborative Meeting.

35-40% - individual contacts with collaborative members. Email, phone, or other contact with individual members, with emphasis on those that are part of completing some action or event. This will also include assisting in recruiting new members, debriefing members about meetings, asking for clarification on issues, and providing encouragement.

30-35% - Resource Development, Training and Research. Resource finding, research review, including research of community data, engaging in technical assistance, RBA and other planning, planning next steps, data analysis, literature review, and development of

collaborative materials. Emphasis on comparative data for county review when possible to help determine impact of actions.

Recruiting New Members to Collaboratives

This is a rough estimate of how time should be divided for successfully recruiting new individuals into a collaborative.

20% - Explaining the collaborative with careful emphasis on the following in the amounts that make the most sense for marketing the collaborative to your potential member/agency.

- Mission/Mission statement
- Purpose of the collaborative
- Leadership
- Membership
- Longevity, length of operation
- A key risk factor or concern in the community that the collaborative is targeting, e.g., youth substance use, youth in care, trauma, youth suicide, etc. Something emotional that will connect.
- A key positive factor, protective factor, or strength, possibly a recent successful activity that shows the collaborative in the community doing good work. Emphasize strengths.

40% - Their turn to tell you who they are with you using prompts and good listening skills.

- Are they a parent, provider, resource representative, some combination… this will guide what to prompt for next.
- If a parent, relative or community member… who is a person impacted in their life or someone they know around youth mental health?
- If you had the power to improve one thing that would improve youth mental health, or the problem as defined in the mission/purpose, what would it be?
    - This will frequently be something with high influence but low feasibility. Be ready to respond to impracticalities by addressing something achievable on the way to their wished for improvement.
- Show genuine interest in them as people and as an influencer.
- Ask them what they could bring to the collaborative that would be helpful to the mission.

- Don’t frighten them off by emphasizing time or resource commitment. Focus on their lived or professional experience and the need of the collaborative for guidance and support.

20% - Explain the meeting schedule, how contacts are made, your role as an infrastructure support, and get their contact information.

- Determine and rank their two favorite modes of contact. For most it will be either text then email or email then text.
- Have a one-page not-crowded description of the collaborative or task force and ask if you can send that to them via email.
- Follow-up with a fast email or text within 24-hours.

20% - Follow-up with a set schedule to get in the habit of contacting members. Per the Time Management Section above, 35-40% of collaborative work is you contacting individuals.

- Send reminders of meetings a couple of days before. Send the agenda two days before if possible, or at least the day before. Keeping them engaged between meetings is critical since 95% of the work happens there.
- Send a 1-2 page synopsis as well. Start each meeting going over the synopsis for a set time, 5-minutes to read, 5-minutes for questions, to get everyone caught up and avoid the time loss in constantly bringing others up to speed.

Keys to Management

- 95% of collaborative work happens between meetings (purposeful redundancy 😊).
- Constant communication is imperative. Not just with leadership, but with the whole membership.
- Keeping the collaborative minimally on the radar of the membership between meetings helps to improve cohesion and growth.
    - Suggestion: At least once per month, the SOC Coordinator and Family Partner should each send a brief email, no more than 10 lines, to all members. Provide a new ‘nugget’ of information, data point, story, or suggestion via an update, a website link, or a document relevant to the system change work of the collaborative.

The SOC Coordinator should review each of the following important functions of a successful community collaborative and then works with leadership to ensure that these are fitted to the collaborative.

1. The collaborative serves a defined community recognized by those within it as a community (a common location or experience) but also serves the broader community. Starting small and working up to the whole community, with plans to engage all, supports early success.
2. Is viewed by community residents as representing and serving them. If you hear too often by residents that they do not know the collaborative, then community engagement and recognition is needed.
3. Reflects the community's diversity. Stigma, bias, and discrimination are key reasons why some collaboratives never get beyond networking.
4. Addresses the problem(s) in a systematic, comprehensive, and timely manner. This is why planning and building a solid base is so important.
5. Builds community independence and capacity. The community eventually owns the collaborative and counts on it as a leader.

Committees

The following is not an exhaustive list of potential committees. Committees may be referred to as work groups, subcommittees, boards, etc. The name is less important than the expectations and structure. Committees may be permanent (e.g., leadership) or ad hoc (e.g., action committees). Committees are designed for a specific purpose. This should be documented with an indication of permanency or expected time of operation, membership, available resources, purpose, objectives, reporting expectations, and related. The use of committees allows a wider group of collaborative members to engage in direct action while preventing a small number of members from doing most of the work and becoming overwhelmed.

Leadership, Steering or Governance: This is the ESSENTIAL committee or work group. It's important for Leadership to meet at least once between meetings. This time can be used to assess barriers, review work completed, make decisions on agendas, discuss membership, address issues with members or stakeholders, discuss other committees, make plans for events or actions, etc.

Fund Raising: For mature collaboratives that are looking to expand their influence or make the move to become a 501c3, fund raising is critical. However, for some, having a small amount of dollars on hand to support new or regular events, having 'swag' at events, paying for training or other costs that would support their mission and should be considered. How the money would be managed and where it would be kept would be decided by leadership and the responsibility of the committee.

Advisory: An advisory committee or group is an external group that provides oversight to the collaborative and helps to guide decisions. Mature collaboratives that are moving toward independence (e.g., becoming a 501c3), that are part of larger systems and have influence (e.g., Family Support Network), or receive funding from the government or endowment may have an Advisory Group. There are some local collaboratives that will also have an Advisory Group to help them with specific areas of growth and sustainability.

Action: Action Committees are short-term groups that are set to accomplish a clear objective, e.g., planning a specific event or training. They may be formed to go after a specific opportunity, review a community event and its impact on the collaborative/community, recruit members, etc.

Data Management: Despite the focus on data and RBA, collaboratives are still data shy and members are often concerned that they'll be asked to manage data they don't understand or lack experience with. Having a data management committee will help to keep data as central to the collaborative and to support innovative methods for using data as part of the collaborative process for selecting problems, setting measurable objectives, and evaluation.

Education and Training: Collaboratives may have a purpose or objective related to training members, the community, or working with education of youth. Having a permanent E&T Committee has been found to be helpful in working with the pragmatics, resources, and communication needs of planning for trainings, certifications, and related. While a training action committee is sufficient for periodic or 'one and done' trainings, having a dedicated committee improves the experience for participants and allows the committee to ensure that the training supports the system of care and maintains content integrity.

System Change

System Change is the goal of SOC Collaboratives. However, system change is the long-term goal that all actions, experiences, and events are framed in. There are three concepts that merge to become system change. A separate document provides more detail.

1. A **system** is a configuration of parts connected by a web of relationships towards a purpose. It can be an ecosystem, such as the marine environment, the food system or socially created systems such as education and health. Systems can be small, such as organizations, or large, such as the whole economy. A SOC is the system of parts that all

work together to improve child, youth, and family mental health and substance use needs while also wrapping in resources that improve quality of life as promotion and prevention opportunities.

2. A **systems approach** shifts the focus from individual parts to how the parts are organized, recognizing that interactions of the parts are not static and constant but dynamic and fluid. Success and impact for youth and families is based on how well the parts interact, not just how well a single organization provides a specific service. This is why you will see issues get worse or go unchanged, e.g., youth suicide or substance use, parent substance use or family trauma, despite having access to EBP's that are supposed to help a family with their problems.
3. **Systemic change** is where relationships between different aspects of the system have changed towards new outcomes and goals. This is driven by transformational, not incremental change. This is the heavy lift of SOC's that takes intentional time and effort.

Systems, Systems Thinking, Systems of Care, and Systems Change

This document is an overview of key concepts with examples. You can use the navigation pane to click to topics of interest.

What is a System?

A system is a group of interacting or interrelated elements that act according to a set of rules to form a unified whole. A system, surrounded and influenced by its environment, is described by its boundaries, structure, and purpose, and is expressed in its functioning.

> *Big Example*: The State Government.
>
> *Middle Example*: Vaya, DSS or DJJ.
>
> *Small Example*: Planning an event or organizing your closet.

With a system perspective you gain the ability to…

1. Understand **interrelationships** and how these can support system growth or system paralysis.
2. Have a commitment to multiple **perspectives**. You are looking for the most efficient path to system change and efficiency but realize there are many paths.
    a. People in their own system *view their path as the only path* to system change. Your vision needs to be broader.
3. An awareness of **boundaries** in and around systems that limits or enhances access to energy, resources, and a shared agenda.

The (not so) Mysterious Ways of a Systems Thinker

Assess yourself against the following list of being a 'systems thinker.' This, for all of us, will be a constant work in progress. The more conscious you make it, the closer you'll be to achieving it.

- Sees the whole picture.
- Changes perspectives to see new leverage points in complex systems.
- Looks for interdependencies.
- Considers how mental models (beliefs, perceptions, histories, shared thoughts) create our futures.
- Pays attention and gives voice to the long-term ("…with the end in mind.").
- "Goes wide" (uses peripheral vision) to see complex cause and effect relationships.
- Finds where unanticipated consequences emerge, positive and negative.
- Focuses on structure, not on blame.
- Holds the tension of inconsistencies, paradox, disagreement and controversy *without trying to resolve it quickly*. This can be anxiety producing but **pain = change**. No one changes when they are comfortable, including Collaboratives or Systems.

    - Don't rush in to resolve, hence the focus on data before action. Clear objectives are needed to guide the selection of the right activities and how to evaluate impact. Systems change slowly and can regress quickly. Hence a structured and measured approach.

- Makes systems visible through causal maps, figures, data presentations, and clear measurable objectives.
- Seeks out stocks or accumulations of stories ("tell the story of the data") and uses stories as leverage and movement against the time delays/inertia they can create. Stories are motivators but can also freeze growth through system trauma.
    - Tells the story behind the data to bring the system alive and make it personal to stakeholders.
- Watches for "win/lose" mindsets, knowing they usually make matters worse in situations of high interdependence. ALL communities have high interdependence even though some groups may deny this causing harm to themselves or other groups. This is how disenfranchisement grows and keeps some groups out. Denial of connection weakens everyone. If people are living in the same community, whether 100 feet apart or on the other side of the county, they are connected.
- Sees oneself as part of, not outside of, the system, but still needs to keep an outsider perspective to see the whole picture.

System of Care

A System of Care (SOC) is responsible for finding and sustaining the most efficient and adaptive system and system components targeted to specific populations or issues, e.g., youth mental

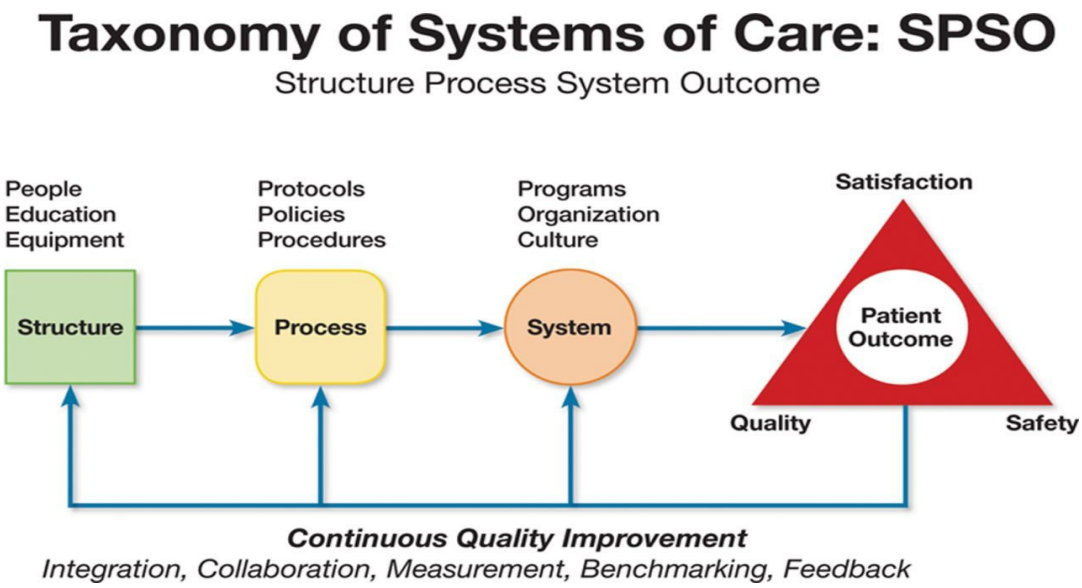
health and substance use. Because the focus is on the system it also includes how the target group is part of larger groups, e.g., families, communities, school systems, provider networks, faith-based groups, criminal justice, social services, and others. A successful SOC includes the following:

1. Family driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided.
    a. How well is your SOC stakeholders allowing the lived experience of family and youth to guide their professional and natural support decisions?
2. Community based, with the locus of services, as well as system management, resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level.
    a. Does your SOC collect data on needs regularly, adapt to changing needs, respond as a collective, and support the broadest range of relationships?
3. Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports.
    a. What is the level of overt and covert engagement and welcoming for all groups in your catchment area(s)?
4. Focus on the service delivery system but expands past it to include promotion and prevention for an integrated system of resources, policies, and practices that meet families where they are at and provide the type and amount of support needed for optimal quality of life.
    a. How well is your SOC focused on wellness and quality of life?

System of Care values:

1. Interagency Collaboration
2. Accountability to Results
3. Individualized Strength-based Approach
4. Child and Family Partnership
5. Cultural Competence
6. Community-based Services and Supports

A SOC focuses on continuous review, communication, action planning, reverse engineering ("with the end in mind…RBA"), and continuous quality improvement. The smallest action, e.g., planning an event for a new school year, completing a community resource guide, can and should be reframed and reimagined as needed to address system goals and system change. This leads directly into system change. The Structure Process System Outcome (SPSO) model addresses the resources needed to support change with emphasis on information and data to plan for system change.



Systems of Care change overtime and rarely go according to plan. Key ideas to drive focus and action are listed next. Think of these as optimal change processes that will require constant review, nourishment, and adaptation. (The following is taken from the Child Welfare Information Gateway).

1. Principle and Value Guided: SOC driven by the focus on the welfare of children are guided by the six values listed above. While definitions of these principles vary in the literature, they represent the foundation for creating a more effective child welfare system based on change and ongoing evolution. The goal of a **principle-guided change process** is to operationalize each value throughout the child welfare system, with each value embodied in, and guiding the work of, administration policies and practices (DeCarolis, Southern, & Blake, 2007).

2. Continuous Change Process: a system of care systematically promotes and manages system change efforts, including building a system of care and sustaining operation of the system. Like building or remodeling a house, constructing systems of care requires advance work, such as planning, identifying, and gathering essential resources and partners, and continuous quality improvement, to create a shared and compelling vision of desired outcomes. Once built, a system of care operates in a larger context of changing political, legislative, fiscal, and service issues. To maintain effectiveness, a system of care must continuously adapt to the environment. With the guiding principles and infrastructure as constants, the systems of care approach provide a framework for building and maintaining organizational and community capacity to successfully navigate the complexities of systems change.

3. Developmental Systems Change: In a stage-based developmental process, the systemic change necessary to achieve improved outcomes for children and their families takes time to mature. Often supported by Federal, State, or private foundation funding, the initial stages of establishing a system of care may take 3—6 years. Building the infrastructure of a system of

care requires time to craft a shared vision, develop a theory of change, develop strategic and action plans, establish governance structures, and foster the trust necessary to formalize and sustain long-term commitments. As the system develops, policy, practice, financing, and leadership will require adjustments, and a deepening commitment to the principles and goals will be necessary. This cyclical change process calls for revisiting earlier commitments and decisions at frequent intervals during the building stages and at regular intervals in sustaining operations. Because systems of care continuously monitor and adapt to changes in the environment, agencies adopting this approach operate as learning organizations characterized by purposeful and insightful agility (Senge, 1990).

4. Results Focused: **This is why RBA is used**. Promoting systemic change in child welfare is meaningless unless the **changes lead to better outcomes for children and families**. Given the fiscal constraints and mandates that affect child welfare systems, decision-makers (which includes Collaborative Members) must be able to reliably determine if changes initiated through a systems of care approach are enabling better outcomes, and that changes can be attributed to the actions taken by the SOC. In addition, they need to understand the impact of systemic change in relation to Federal and State mandates. Because systems of care often require collaboration with other departments, agencies, or organizations, their respective objectives for demonstrating results or impacts must also be addressed. Therefore, a well-designed data focus, data management, and data use process with timely collection of data, shared with stakeholders, and used to adjust, is a vital element of any systemic change process.

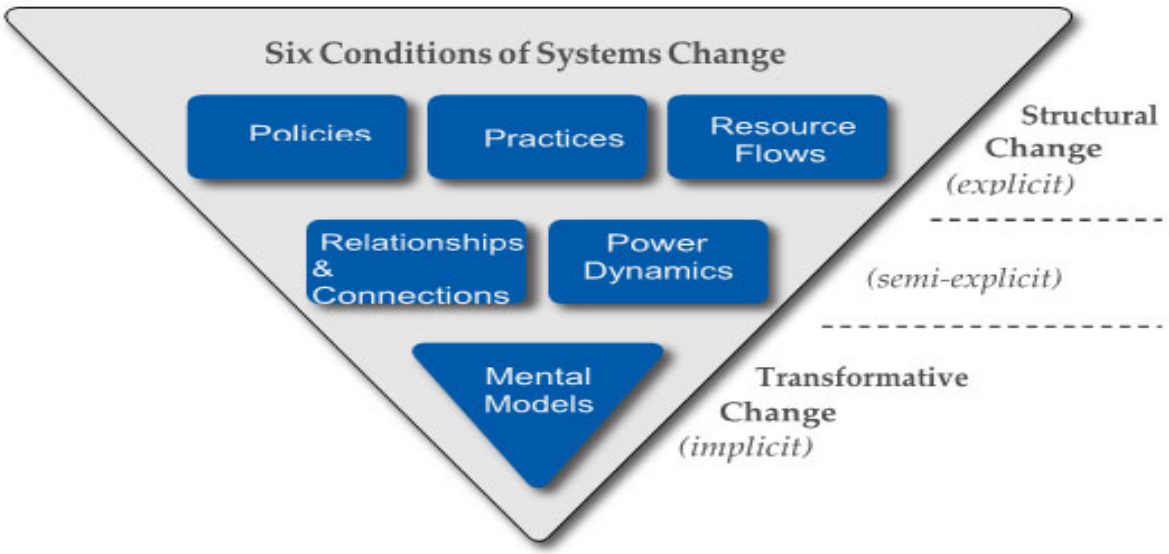
System Change

Before diving into systems change, we first review several areas that have emerged in the process evaluation for the contract counties that are likely relevant across the Vaya catchment area. Thinking in systems, planning on how to make changes in problem areas (listed next), should bring significant relief to and increase in quality of life for youth and families in your counties. These are key barriers impeding SOC progress to date and should be considered when discussing objectives with your collaboratives.

1. **Significant unmet need for mental health care**. This includes health and quality of life promotion, prevention for those at risk, and interventions for those in need.
2. **Overuse of restrictive settings**. Much focus has been on finding placements for youth instead of fostering a system to build family capacity.
3. **Limited home- and community-based service options**. Too few providers, in some counties no or almost no local providers, due to fiscal, policy and legislative restrictions, limit the ability to provide sustainable services in lived environments.
4. **Lack of cross-agency coordination**. Collaboratives are focused on the least integrated level, networking and shared discussion of resources, vs. systems change to increase capacity of all stakeholders.

5. **Lack of partnership with families and youth**. Recruiting and engaging family and youth remains a struggle and often focuses on creating family and youth groups outside of collaboratives and other multi-stakeholder groups that should integrate the best of professional promotion, prevention, and intervention with the lived experience of those that really know, through experience, the system of care.

For a successful SOC, structural change is the ongoing and observable goal with changes in policies, practices, and resource flow. This influences, and is influenced by, the semi-explicit aspects of who controls what (power) and the relationship and connections. Where most systems change falls short is in the (very difficult) effort of making ***transformative change***. **This requires understanding the conditions needed for system change supported by a shared belief system and shared understanding and agreement on SOC values and how they should guide the SOC and its components, including the service delivery system.**



What is System Change?

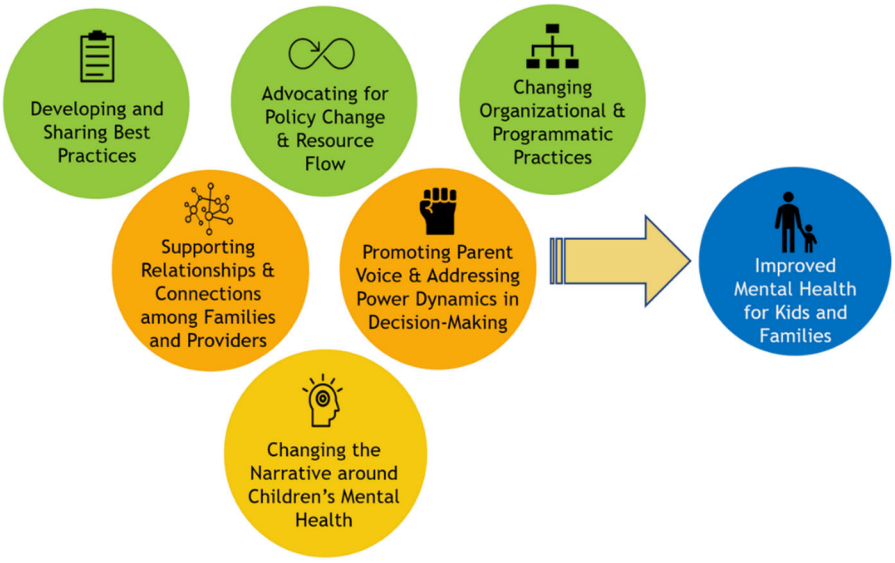
Before jumping in… Systems Change is most effective when using a model, or a blending of models, in a planned fashion to meeting change goals. This guides action and reduces the stress on the SOC Coordinators and Family Partners as they work with collaboratives/task forces, LICC's and other bodies within a SOC framework. This helps to answer 'what do we do next' to maintain momentum and avoid the anxiety of being stalled, and, as all things do in a SOC, relies on collecting and sharing information (data).

Why is Systems Change Important?

Systems change can be defined as shifting component parts of a system, and the pattern of interactions between these parts, to ultimately form a new system that behaves in a **qualitatively different way**. Addressing thinking in systems again, key tactics for engaging systems change is …

1. Seeing the whole rather than just parts;
2. Seeing patterns of change rather than static snapshots;
3. Understanding key interconnections within a system and between systems;
4. Engaging different perspectives;
5. Constantly learning and adapting; and
6. Probing assumptions.

What Does Changing a System Actually Look Like?



The collaborative and other partners must consider why the current system is no longer fitting its purpose through the change in need that a community has experienced, change in resources, or other reasons. Systems must adapt and a key red flag for knowing that a system has stagnated/not adapted is to see worsening or no improvement in key metrics selected (data!).

System change often involves a series of shifts that work together to disrupt the status quo and create systemwide change. There are no silver bullets, but rather a jigsaw of solutions that must be pieced together, adapting as we learn more about what works and what doesn't. Keys to helping system change…

1. Clearly define the problem.
    a. Have a clear impact statement and purpose in mind that will be influential and feasible, over time, to make the changes in the system needed to produce the overall goal of a SOC: Effective and efficient promotion, prevention and intervention for mental health and substance use issues for children, youth and families that improves quality of life for all community members.
2. Know where you want to go (…with the end in mind).
    a. Set clear and measurable objectives that are influential and feasible.
3. Select data, risk, and protective factors known to be linked with the objectives.
    a. Tell the story behind the data, ensuring that the data selected is linked to influential outcomes if changed, and is possible (feasible) to be changed.

4. Select activities, interventions, and events (triangulate with multiple approaches) that will change the selected factors related to the objectives that are related to the problem.
    a. Do you see the pathway in that statement (identified problem → risk/protective factors → measurable objective → targeted action → evaluate for attributable impact)? Ensuring at all stages, at the risk of being redundant, that the selections are impactful (influential) and can be accomplished with the personnel and resources available (feasibility).
5. Build a feedback process to measure impact and to estimate to the degree possible that what you did is what caused the change.
    a. Getting the SOC, Collaboratives, stakeholders, etc. used to collecting and using data at all stages of the change process is critical to knowing what has changed.

How do you Apply Systems Change?

This is where action takes place. Pinpointing critical actions (high leverage, high feasibility), on which to focus will help to change the system AND identify more effective solutions that will help to understand the cascading impacts of combining interventions. Like building a home, it takes a while to get the base done, then the rest of the structure appears to pop up quickly, followed by a slowing down to take care of all the important details. Three general elements needed for any model of systems change include…

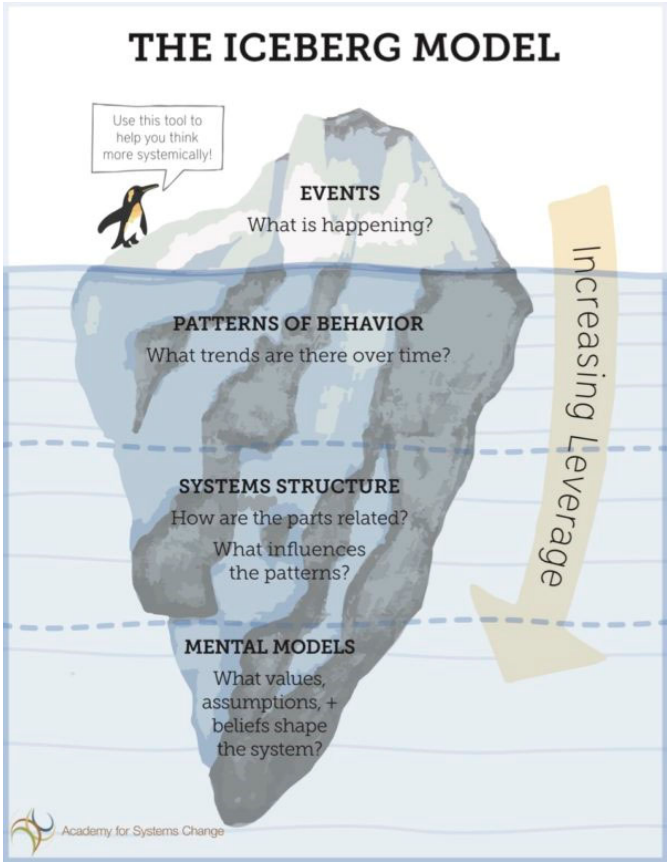
> **Determining points of leverage and the required transformations**: Deepening understanding of the system, its patterns, and interconnections to identify the shifts that will be most effective to bring about systemwide change.
>
> **Learning about what drives change**: Embracing complexity and gathering insights from past and present examples of change to identify drivers that may accelerate pace and scale, while mitigating unintended consequences.
>
> **Effectively aligning change agents and mobilizing action**: Deeply engaging and collaborating with the range of stakeholders in the system toward a path in which each is uniquely motivated and has a distinct role to play in shepherding the change.

Leverage is the Key

There are four ways to leverage SOC as a model for system change. These include:

1. Values/Beliefs
2. Goals
3. Information
4. Structures

Common across these are **moving from data to meaning**, which is an iterative process. Hence the need for planning actions and making sure they are always framed to system change, collect data, and evaluate for impact. When this cycle is set, what works can be kept and what does not can be improved or discontinued.



Leverage points are points of ***potential influence*** through which system of care planners/implementers can (*but may not*) choose to intervene in their current community context in order to produce an adaptive, efficient, and effective system of care. This CANNOT BE FORCED but can be illuminated through system thinking and communication. The ten leverage points defined below are accessible to system planners/implementers, but, again, may not be used at a given point in time. ***Local implementation factors represent the actual choices made for the purpose of system of care development.*** To be identified as a local implementation factor by the Implementation Team, factors must be both voiced by local planners/implementers as important to system of care development and observable and measurable to the Implementation Team, with support of an Evaluation Team when possible. Breaking it down to its most basic (believe it or not)…

- There will ALWAYS be options for change…
- Planners/leaders may or may not choose, for various reasons, to engage in one, some or all options…
- Actual choices made and implemented from the menu of options will impact and change the system in some way…
- A systems thinker approach will help to influence/leverage the feasible change available to improve the lives of children and families (this is where you come in)…
- Yes, it's maddening at times, but it's all based on choice, influence, and feasibility of the collective agreement and collective impact of stakeholders, including family and youth.

Values/Beliefs Leverage Points

Related to the intrinsic philosophy that is fundamental to the system of care, the six core values listed above, operationalizing the values, and guarding their integrity is important to implementing SOC within service delivery, promotion, prevention, resource sustainability, and related. **This has a lot to do with language and communication**. Modeling SOC and System Change language will improve the odds that **changes will be value guided and effective**. *FACT: The more change is influenced and embedded in SOC values and the focus on system change, the stronger and longer lasting the change*. Two leverage points are discussed next. As this leverage point is about vision and beliefs, the leverage points and examples are communication and idea based. Think of them as ways and content for communication that helps to move the SOC partners **from organizational agendas to a shared agenda, leveraging shared vision, determining what drives change, and planning action to change the system.** The iceberg model image reinforces one clear understanding of systems change and leverage. It all starts with beliefs and values.

1. **Power to Transcend Using SOC Values**: The ability to reflect upon SOC assumptions, tolerate discomfort, and be open to new ways of thinking and acting. Examples:

- The idea that there is always room for new growth and system development.
- The idea that no one discipline, philosophy or person provides all of the answers.
- The ideas that system goals will always evolve.
- The idea that regardless of the amount of effort and investment expended toward a particular goal, the system may need to reconsider its direction.

2. **Mindset of the SOC**: The shared understanding from which the SOC is developed. Being a systems thinker and encouraging others to do the same. This represents commonly held values and beliefs about what is important for children and families. Examples:

- System development grounded in system of care values and principles that are widely held within and across service sectors improves promotion, prevention, and intervention in a policy driven and sustainable way.
- Cross agency commitment to the idea that the needs of the child and family come first, and that including their voice is as imperative as oxygen.
- Nothing is done without the ability to prove that it works and that change was actually due to what the SOC did.
- True sustainable resources and strength is through collaboration and every stakeholder benefits from a SOC approach, from the individual youth to the largest organizational stakeholder.

Goals Leverage Points

These leverage points are related to the expectations and intended outcomes of system change. Planning, driving the use of data, developing feedback systems, clear measurable

objectives, and watching closely the process of change will lead to goal related leverage. There are three areas of leverage related to Goals:

3. **SOC Goals**: Broad level goals that direct the SOC and bring it under the control of a single plan. Examples:

- A system goal to serve children and families within their own communities.
- A system goal to increase the ability to provide culturally competent and individualized care.
- A system goal to serve all families in the environment they desire (home, office, school, etc.).

4. **SOC Self Organizing**: The power of stakeholders to change how the SOC responds or adapts to its environment. This includes changes in the system structure, information flow, and rules. System of care development efforts can be considered system self-organizing. Examples:

- Stakeholders create opportunities to provide innovative services and supports to individualize services.
- Stakeholders creating opportunities to co-locate interagency staff within the same office.
- Stakeholders creating opportunities to form interagency case management teams.

5. **SOC Rules**: Explicit and implicit rules that define the scope of action and boundaries of the SOC. Examples:

- Rules that add family members to key policy councils and collaboratives.
- Rules that establish interagency governance structures.
- Rules that delegate power and authority to service teams.
- Rules that allow for more flexible use of funds.

Information Leverage Points

This is related to data sharing, agreements to make data driven decisions, measurement-based care for Evidence-Based Practice implementation/evaluation, availability of feedback to system stakeholders, openness to findings and willingness to adapt, and related.

6. **Structure of SOC Feedback**: Structures that provide for the provision of feedback, response opportunities, change/adaptation support, where and when needed (flexible and tailored to stakeholder groups). Examples:

- Structures that support the dissemination of outcome data to planners and implementers in time for decision-making.
- Structures that support the availability of mental health assessments to dependency or juvenile court judges in time for critical decisions.

- Structures that support the timely availability of information for clinical decision-making.

7. **SOC Feedback**: Positive and negative feedback loops that provide information on system performance to stakeholders. Positive feedback loops provide information that reinforces the continuation of current practice. Negative feedback loops generally measure performance relative to a goal or standard and provide information that signals the need to make a change. *Examples of positive feedback loops*:

- Satisfaction surveys indicating improved family satisfaction.
- Placement reports indicating improved stability of placement.
- Reports on stability of staff.

Examples of negative feedback loops:

- Placement reports indicating increased rates of out-of-home placements.
- Budget reports indicating overspending.
- Reports on staff turnover.

Structured Leverage Points

Structural leverage is related to specified roles, responsibilities, and authorities that define organizational boundaries and enable an organization to perform its functions. Boundaries between organizations require connection and trust to set and sustain communication and sharing of resources, information, data, clients, and other inputs and outflows of the system.

8. **Structure of the SOC**: Physical arrangements, relationships, technology, communication, and decision points within the SOC that determine the breadth of environments in which a child and family can access support. Examples:

- Organizational relationships, defined roles and communication, MOU's or other agreements as needed, within and across traditional child-serving service sectors such as education, child welfare, juvenile justice, and mental health.
- Location and physical arrangement of offices and programs.
- Defined catchment areas of child service sectors that allows for needed redundancy but also supports long-term sustainability of provider services.

9. **SOC Stabilizers**: Structures and processes that maintain the SOC in its current state and act to buffer against change. There are two functions of buffers that require different interventions: the act of stabilizing to maintain progress made, and the process of destabilizing buffers to affect change and disrupt the status quo. Systems can get comfortable in their practices and diminish capacity for adaptation to new information.

Examples of maintaining:

- Structures and processes utilized to maintain family organizations, family support groups, youth groups, and natural supports.
- Funding mechanisms that stabilize braided or blended funding processes including seed dollars from grants/foundations, and sustainable finances through billing and government support.

Examples of destabilizing:

- Changing funding mechanisms such as Medicaid reimbursement rates and managed care eligibility guidelines.
- Limiting the power of professional guilds and unions to return the system to care-as-usual. Thus, the need for data collection and proving effectiveness AND attribution.

10. **Parameters of the System of Care**: Think of parameters as systems structures that are constants external to the SOC and are expected to remain relatively fixed over time. These require the system and its members to adapt with focus on maintaining the most effective and efficient system possible across the continuum loop of promotion-prevention-intervention-evaluation. Examples:

- State and federal laws, regulations, and guidelines that establish the mandates and authorities of child-serving sectors.
- Political and economic climate at the local, state, and federal levels.

Opportunities for action across the leverage points are not in a straight line, and acting on values and beliefs does not automatically lead to changes in mindset or effectiveness. However, actions related to values and beliefs generally enable or facilitate a greater range of change than accessing leverage points relating to structure and thus maximize the return on systems change efforts. The structures and processes that are established because of leveraging change through values and beliefs enable the continuous development and maintenance of a system of care.

Summary: It is useful to consider the relationship among system of care leverage points and local system implementation factors. **Leverage points describe the range of possible actions (and their likely impact) available to continuously develop a system**. These leverage points reflect potential for system change, but do not necessarily represent action taken at the local level to create system change. In contrast, identified local implementation factors represent actions taken to impact local system of care development. These actions are identified by local system planners and implementers as critical to their efforts and can be used repeatedly and over time to access points of leverage in system change. This is the purpose of RBA and other development models that focus efforts on SOC sustainable development. The factors described are characteristics of a well-functioning system of care. Synthesis of research suggests that the synthesis of leverage points and local implementation factors produces system change over time in the direction of an ideal and well-functioning system.

Methods and Models of System Change

The following is a list of system change methods that will be described in an upcoming support document and possible training. Its's helpful to know the leverage points, and to see some examples of what they are… but what do you do about that?? We list these to answer the question we expect you have about how to do the work now that the work as been more fully defined.

1. Results Based Accountability
2. Causal Loop Diagrams
3. Outcome Mapping
4. Process Monitoring of Impacts
5. Strategic Assumption Surfacing and Testing
6. System Mapping
7. Futures Practices
8. Changing of Patterns of Change

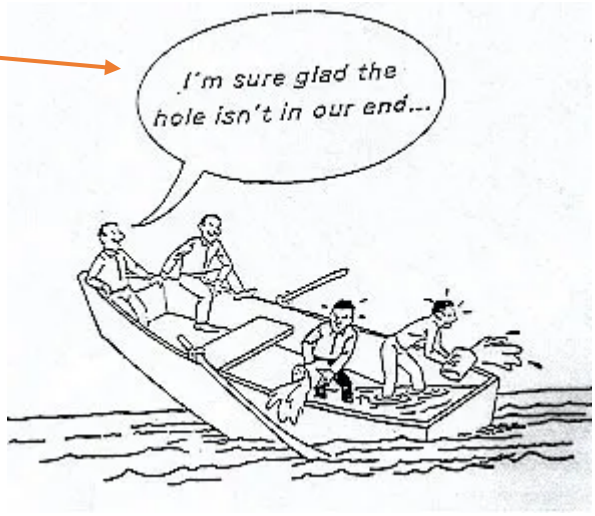
Asking System and RBA Questions

Our goal with this support document is for you to feel stuck less often and to further your ability to be a systems thinker and systems change agent.

One of the most effective ways to become a systems thinker and help others do the same is to ask powerful questions. You can do this whether you are a visual thinker, draw a systems map, create great data presentations, or expect others to use what you produce. It can help to remember that, while maps, data presentations, schematics, RBA spreadsheets, and other tools are great prompts to create catalytic conversations, asking good questions also opens the door to new ways of thinking, communicating, and understanding.

Systems thinking is a holistic practice because it helps you see that:

- **Everything is connected.**
- You have choices about furthering positive communication - connections or feeding dysfunctional ones.
- In order to make constructive choices, it helps to develop a systems aware thought process. This includes learning to seek connections, making data related choices, and cultivating your ability to act as a systems changer.



Further characteristics of a Systems Thinker…

Here are some of the most useful questions you can ask. As you read through them, you'll probably realize that they could have been categorized, but we decided to just mix them up so you can find unique ways to use them if you need them.

- Where do our best intentions fall short of achieving what we really care about?
- Why are we not as successful as we want to be despite our best efforts?
- What might be our responsibility for the obstacles we encounter in shortfalls we experience?
- Are there people who share similar aspirations to ours but have very different views about the nature of the problem and or the solution? If So what can we do to help align our respective efforts more effectively?
- What can we learn from a preliminary inquiry into specific events related to our issue, underlying trends or patterns of behavior over time, and a consideration of deeper systems structure?

- Which stakeholders are we comfortable engaging now, and what are their motivations for change?
- By contrast, which stakeholders might we not choose to engage at the outset and why? What might we miss by not involving them initially, and what strategies do we have for engaging them overtime?
- How can we create common ground among the stakeholders we engage now?
- How do we increase people's understanding of the issue in a way that integrates the richness of diverse perspectives with the simplicity required to act?
- How do we build support for an analysis that might be difficult to communicate or that challenges people's underlying beliefs and assumptions?
- What is the case for the status quo?
- What might we have to give up in order for the whole to succeed?
- What interventions could enable us to achieve attainable, sustainable, breakthrough change?
- What might be the unintended consequences of our proposed solutions?
- How do we ensure continuous learning and outreach?
- What is our systemic theory of change?
- How do we evaluate progress toward our vision using a system lens?
- What actions can we take to become better systems thinkers?
- What do we intend to do next?

Closing the Loop: Becoming a systems thinker is a way to improve your life, the life of those close to you, the life of the families you work with, your organization and community.

- Systems thinking is not just what you think. It's the actions that you create from your vision.
    - Set realistic goals.
    - Define clear indicators and metrics.
    - Think differently about the short and long term.
    - Look for consequences throughout the change process.
    - Commit to continuous learning.
- Becoming a more effective systems thinker means developing an emotional, behavioral, spiritual and cognitive capacities.

- The best way to learn is by doing, there are many resources available to help. Just ask!
- Remember that you should consider four key ingredients for systems change.
    1. People
    2. Design
    3. Systems
    4. Risk

People:

Who will use the system? – leads to an understanding of the diversity of people involved and their needs and capabilities (identify).

Where is the system? – leads to an understanding of the physical, organisational and cultural context of the system (locate).

What affects the system? – leads to an understanding of the political and policy landscape within which the system is situated (situate).

Design:

What are the needs? – leads to a common understanding of the needs for a system, taking account of the full range of stakeholders (explore).

How can the needs be met? – leads to a range of possible solutions that would help meet the needs identified by the explore phase (create).

How well are the needs met? – leads to an evaluation of possible concepts that could meet the needs identified by the explore phase (evaluate).

Systems:

Who are the stakeholders? – leads to a common view of the stakeholders and their individual interests, needs, values and perspectives (understand).

What are the elements? – leads to an agreed system boundary, architecture and details of the interfaces between all the system elements (organise).

How does the system perform? – leads to a complete, operational system that is proven to meet the stakeholder requirements (integrate).

Risk:

What is going on? – leads to an understanding of the system architecture and details of the interfaces between the elements (examine).

What could go wrong? – leads to a systematic assessment of the likelihood and potential impact of threats and opportunities in the system (assess).

How can we make it better? – leads to a range of possible solutions that would help mitigate the threats or exploit the opportunities (improve).

When not sure what to do next, ask a systems question!

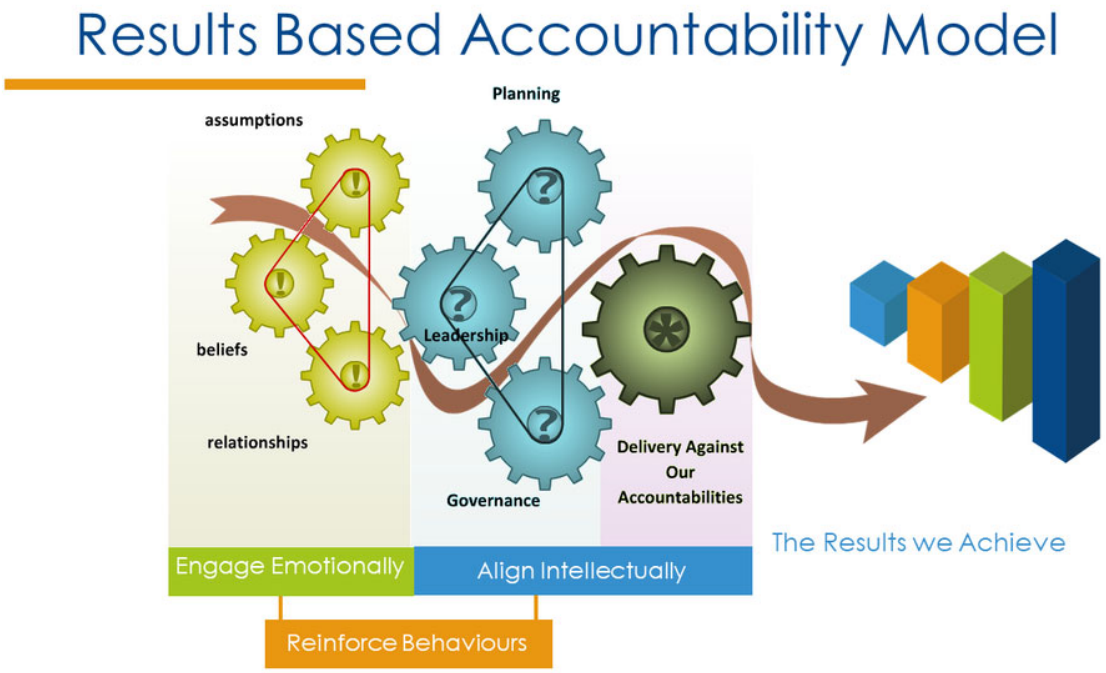
Results Based Accountability

RBA is completely driven by accountability. There are seven questions you should ask yourself and your stakeholders as you engage in the RBA process.

1. What are the quality of life conditions we want for the children, adults and families who live in our community?
2. What would these conditions look like if we could see them? How can we measure these conditions?

3. How are we doing on the most important of these measures?
4. Who are the partners that have a role to play in doing better?
5. What works to do better, including no cost and low-cost ideas?
6. What do we propose to do?

RBA incorporates beliefs, relationships, assumptions, leadership, and other stakeholders, but it is based on emotional responses that draws individuals to work cohesively for a shared purpose. Emotions are either, or both, negative (frustration, anger) or positive (hopeful, uplifting), that has a person FEEL that they need to be involved with a solution. This is ideal for SOC Coordinators and especially Family Partners.



Like Systems Change, a lot of what is effective in RBA depends on how the individuals involved, representing themselves, others with lived experience, or their professional lives, think and believe. In RBA these are referred to as Mental Models, or the training and experience influenced beliefs that people hold. The following shows the standard, often ineffective, mental model beliefs and expectations on the left. This will come out in the language people use and often is self-restrictive. The fight side are RBA Mental Models that you will see are consistent with Systems Change thinking. Embracing both will improve your work.

Standard Mental Models	RBA Mental Models
Data is something used against us.	We can use data for our own purposes. (The democratization of data).

Standard Mental Models	RBA Mental Models
Services solve the problems of people and communities.	Services help people and communities solve their own problems.
It is fair to hold the department of government responsible for solving the social problem parentheses e.g., (NCHDDS) or that Child Protection solves child abuse.	Social problems are matters of Population Accountability and are the shared responsibility of many partners across the community.
A planning framework cannot be any good if it's not complicated.	Simple frameworks like RBA can be powerful. Simple planning “containers” can hold complex content.
I can't change anything.	I can be a leader.
The future is shaped by others.	The future is shaped by me.
Data is about precise measurement.	Data is about approximation.
We can understand cause and effect if we study it hard enough.	Cause and effects are rarely simple. Think contribution not attribution.
All important actions cost money.	Much can be accomplished with no-cost and low-cost actions.
Experts know more than I do about my work.	I am an expert.
Outside evaluation is the only way to tell if our program is working.	We can evaluate our own work.
Improvement is when we meet our targets.	Improvement is turning the curve on important population indicators and performance measures.
There's a long list of performance measurement categories.	All performance measures can fit into three categories: how much did we do? How well we did we do it? Is anyone better off?
Clear language is impossible. Jargon is unavoidable. We can work around language confusion.	Clear language and language discipline are both possible and necessary.
Founders are overlords and grantees are serfs.	Funders and grantees are partners in improving results and outcomes for customers and communities.
We need permission.	We can just do it. Better to ask for forgiveness than permission.
People eventually burn out.	People get disconnected from purpose and can be rejuvenated by reconnecting to purpose. Program purpose is embodied in “is anyone better off?” measures.
Don't change horses in midstream.	We are always in midstream. Change when you need to.

Standard Mental Models	RBA Mental Models
Solutions can be stable.	There is no such thing as a steady state. If you're not getting better you're getting worse.
In times of cutbacks, hunkered down, scaled back, lower expectations.	In times of cutbacks, reconnect to purpose, reconnect to partners, find opportunities, find new ways of doing things.
Exclusive processes and secrets are necessary for self-defense.	The real power lies in inclusion, transparent processes, and shared purpose.
Diversity is a problem.	Diversity is a strength.
Differences of opinion are a problem.	Differences of opinion are healthy in the context of shared purpose.
Management, budgeting, and strategic planning, are three separate systems.	Management, budgeting, and strategic planning, are three parts of the single system.
The first thing you do is a mission statement.	Mission statements can come after development and use of performance measures.
It takes months of planning before anything can actually be done.	You can get from talk to action in one hour.
We start by analyzing what is wrong and then trying to fix it.	We start by defining the desired end state in terms of results and outcomes and then move toward it.
We need targets to motivate people and organizations to perform well.	Targets are OK if they are fair and useful, and if they produce aspirational behavior, not fear of punishment or gameplay.

Remember, this is for RBA and not for Collaborative Development that will have a different timeframe. Ask yourself if the righthand column left you feeling a little more free to work the problem.

Appendix 3: Individual County Documents

Polk County RBA Experience. Youth and Family Case Review

Wilkes RBA & Establishing Identity around Children's Mental Health

Wilkes Task Force Priorities (Mentimeter)

Polk County RBA Youth and Family Case Review

Our purpose today is to introduce another way of applying Results Based Accountability and telling the story of data to implement change.

Our goal for today is to do a systems and resource analysis of a family that received services for behavioral health and social services in Polk County.

Our long-term goals for Collaboratives are:

> To demystify RBA as a common sense thought process for meeting collaborative goals.
>
> To integrate RBA into everyday use across the Continuum of Change from problem selection to final review for impact.
>
> To embed data as central, understandable, and comfortable for collaboratives to engage in meeting objectives, developing resources, and addressing attainable and sustainable system change.

By the end of today, this subgroup will have picked up to three priorities for Polk County that will be investigated further for data support and to develop measurable and achievable objectives as members of the Child Mental Health subgroup.

What happens After That?

- The combined Implementation and Evaluation Teams (IET) for the SOC grant will help to find additional data based on the selected priorities.
- The IET will work with SOC Coordinators, Family Partners, and Collaborative Members to create data-supported measurable objectives to improve on the issues selected.
- Information on relevant risk and protective factors will be prioritized to help guide selection of activities to address the selected issues.
- Activities and tasks to directly affect the objectives will be selected, implemented, and measured for impact.

*****Disclaimer: This case is a hybrid of multiple closed cases from Polk and nearby counties, created with a fictitious name, age and family dynamics to protect confidentiality. The content was reviewed with a couple of stakeholders to vet the scenario, resources, system difficulties and care and if they were relevant to current practices, procedures, process, and services.***

Youth and Family Case Review

First Known Involvement

The review is about a 12-year-old female "Sarah" that entered the system via a report to DSS. She has four other siblings in the home ages 14, 11, 7 and 4 years of age. The biological mother and maternal grandparent care for the children. The biological father of all five children was removed 4 years prior and maternal grandfather died of natural causes two years prior. Mother is currently using substances and has mental health problems which may have started when her husband was removed. Children live at the grandmother's residence. Sarah had likely experienced neglect and possibly sexual abuse. She

and her siblings had experienced the loss of a parent, a grandparent and inconsistent support from the other biological parent, supplemented by the grandmother who is begrudgingly involved. A CPS Assessment was performed, and interventions were given to the family to prevent removal. The 7-year-old had a learning disability which triggered intensive in-home services that were provided possibly from Family Preservation. Intensive in-home services were completed successfully.

Second Involvement

A year later, grandmother was hospitalized for a stroke. Sarah is 13, she and her siblings were left with the 15-year-old to care for as biological mother is in and out of the home and in and out of jail due to substance use issues. Mother is deemed unsafe and is not supposed to be living in the house and visits with the children were to be supervised. No more relatives in the States to take care of the children. Grandmother is very resistant to intervention services. Recovery has taken months in the hospital. There is also a disabled adult living in the home. DSS assumes custody of the children, they were removed and placed in in a residential non-treatment-oriented group home two hours away so that they can stay together. They all received outpatient counseling while in the group home. After a year of medical care, grandmother returns home and DSS continues custody as the children are returned to grandmother's care. Another, intensive in-home services such as High Fidelity Wrap was placed in home for all family members. They complete intensive in-home services successfully. Grandmother is very angry with DSS.

Third Involvement

Another DSS report is filed that the disabled adult living in the home has inappropriately touched a child in the home, mom continues to visit the home, is using drugs and grandmother is unable to properly supervise. Sarah and two older siblings have been using substances and were recently arrested for damaging public property when living with grandmother. Juvenile Justice is involved, and they are all placed on probation. Children go back to the in a residential non-treatment-oriented group home two hours away. Sarah, who is now 15 years old, runs away from Group Home with a stranger for three weeks, uses meth and marijuana and is involved in sexual activity. She is found 2-3 hours away and there is suspicion that she may have been trafficked. DSS couldn't get her into a Level 3 Therapeutic Home. She is in and out of foster care homes, all the children are separated into multiple homes. Sarah would crawl out of the windows of foster care homes to get high and gone for days. The last set of foster care parents were the ones that Sarah was closest to, however, they were scared she would die from an overdose in their home and gave her up. Child had nowhere to go and had to stay at DSS office with staff. DSS cannot get Intercept Intensive in-home Services for foster care homes and the only substance abuse counselor in Polk is a male that she does not like. Sarah was placed in outpatient therapy for substance misuse throughout her stay in foster care placements. In between placements, there were a few crisis stabilization placements because level 3 or PRTF placements were not readily available. Ended up being placed in a Behavioral Health Crisis Unit for two weeks (normally stay is two days) and finally she gets placed in a level 3 upon discharge 1.5 hours away from grandmother.

Fourth Involvement

Sarah runs away from Level 3 care and is gone for months. When found and the multiple other times found after running away, Sarah is taken to the hospital under the influence for a medical exam. She

has bruises and is tested for sexually transmitted disease and/ or pregnancy. She is now 17 years old, there is not an immediate placement available to her. She stayed at DSS office for a couple of days and then admitted to a crisis stabilization unit for at least 30 days. She is discharged to a Psychiatric Residential Treatment Facility (PRTF). While there, she was groomed by the therapist and had a sexual relationship. Sarah shares her story with another client, who told her parents, who told the facility. Video tape from counseling session verified the report. Sarah did well in the crisis stabilization and PRTF, so well she was given leadership responsibilities. Child was discharged to a stepdown level 3, with a new therapist and starts over because that is what Medicaid requires. She runs away again. DSS found her two months before her 18th birthday. Nobody wants them in Foster Care at this age, no adult inpatient program would take her. DSS pulled strings to place Sarah into a therapeutic foster care home in a neighboring county. At 18, Sarah was invited and signed up for the Independent Living Program but decided to live with grandma, friends, and boyfriends instead. She is no longer in the DSS system.

Other Case Information to consider:

- Sarah was stable in treatment, while receiving individual support and in a smaller classroom setting performed well in school. Two younger children have IEPs and are doing well in mainstream school and likely to be adopted by foster care parents.
- Developed positive relationships with caring adults in day treatment and she did well in the program.
- The arts and writing were one of her strengths.
- After each runaway episode she was picked up under the influence. The Hospital would not admit her for being a danger to herself even after Narcan had been used several times to revive her.
- Every time the child returned it took a toll on DSS staff who had to spend many nights in the DSS office. There were only 15 staff and two needed to be there 24/7. They slept on cots outside the room the child slept in, had alarms on doors, showered there and got up in the morning to go to work down the hall.
- From the age of 12 to 18 years old Sarah had at least 20 placements.
- Multiple therapists entered the child's life at different points, and no one stayed consistent.
- Parental rights were terminated on both parents.
- Crisis treatment services were not helpful 4-6 weeks later. They were needed immediately.
- It takes the mobile unit hours for someone to come out to assess. An individual in crisis that is in danger to themselves or others.

Known System Barriers for Getting Children into Care & Brainstorming Solutions

- Facilities/ Providers are picking the lowest acuity kids.
- There is a 33% vacancy rate for beds so there should not be a problem placing kids. When trying to get a child placed into care there is a 10-page application process and facilities don't tell you up front if there is even a bed available.
- If a child is in a facility and needs to be placed elsewhere, the facility has 30 days to find another placement. If they cannot they are brought back to DSS staff. They don't have to have another placement to be clinically discharged.
- There is a 2-6 month wait to get into facilities.

- System change: The rules that providers follow need to change. LME-MCO does not have leverage with providers. Providers can refuse kids and release them when it is inappropriate, and they have not completed care.

Dynamics of Successful Cases: children and family receive and complete services demonstrating new skills and practicing effectively, child reunited with family and situation remains stable.

- Appropriate services are available, timely and accessible to help family heal together.
- Quality services in all levels and adequate staffing [no wait lists]
- Staff should not be at 100% of their caseload as it leaves no room to bring in another case.
- A consistent, stable adult in a child's life that can be there throughout the crisis and beyond.
- All systems rules/ structures work well together so when a child is being discharged the other service is lined up ready to go. Organizations will not let a child go without that placement.

Questions to Frame the Case Review [assuming this is common with families across the system]

- What services were needed that were not readily available ie. resources that don't exist, have a waiting list, do not serve the age of the child?
- What were not named that could have been used and at what point in the case?
- What system barriers were present? ie. policy and practices that didn't allow for services needed.
- What were barriers to success of interventions tried?
- What services and handoffs worked and when? Why did they work?

Questions to frame solution

- With the end in mind of creating stability, safety, and quality of life, what services, resources, and supports, were needed?
- Where were intervention points where services could have been introduced?
- What could have been done for prevention and when?

Wilkes RBA & Establishing Identity around Children's Mental Health

Attendance Needs: DJJ, DSS, Wilkes CAC

Next Steps:

- Tressy, Gary and Jonel will meet with John and Hal before April 27th Governance Board Meeting to get buy in and date.
- Jonel will meet with Caleb and discuss details.

What mental health data sets do we want to review?

- Foster care – opioid substance use dashboard and other sets that DSS has. Can Jonel get them to the table? Hal Wilson and John Blevins, Director
    - *Kids entering foster care last five year and why? By age, race, history*
    - *What interventions were given to children upon entry? Counseling, case plan, transportation barriers. What is missing to give stronger supports to families?*
    - *How many children come into care that were in nonsecure custody and not given case management prior?*
    - *How long were they in foster care?*
    - *How many reunifications plans were successful?*
    - *What types of treatments were they given and frequency?*
    - *How many in kinship care vs. foster care family vs. therapeutic foster care?*
    - *What support is available for families that choose Kinship Care? [monthly stipend, childcare, counseling]*
    - *Do they receive a mental health assessment?*
    - *If we could provide better support to prevent children coming into the system what would that look like? Increasing what protective factors*
    - *What is the caseload size? What should they be as it relates to best practice literature?*
    - *Do staff have support who are experiencing this very heavy stress and secondary trauma?*
    - *What is the burnout-turnover rate of frontline staff?*
- What are some solutions to these problems or how can we make this system better?
- What can the collaborative do to support?

What other data impacts or reveals children's mental health?

- School data
- Suicide rate
- Juvenile Justice
- Parent and Youth Substance Use Issues -Opioid Dashboard
- SDOH

https://www.ncdhhs.gov/opioid-and-substance-use-action-plan-data-dashboard

Wilkes needs an identity, purpose, and defined impact: [a person's emotional connection to their community]

- What is the greatest fear about your community?
- What gets you excited about your community?
- What is the community's greatest opportunity?

When thinking about wellbeing and self-care....what is a gift you would like to give yourself today?

Mentimeter

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Wilkes Task Force Project Priorities

→ 1. Agency Educational Outreach and Support for mental health children

→ 2. Youth and Family Engagement

→ 3. Trauma and Resilience

When thinking of childrens mental health what are the challenges and/ or areas that need support?

Mentimeter

- Access to transportation
- Greater need than available providers.
- Not enough providers
- Resources for family- child care transportation
- Respite for children that are awaiting authorization for leveled care.
- Increased education for families so they know what options are available to them
- More providers available
- Lack of substance abuse services for teens.
- Transportation, engagement, financial resources

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When thinking of childrens mental health what are the challenges and/ or areas that need support?

Mentimeter

Families aware of and access to service support. Removing stigma that is a barrier to reach out and obtain services.

Help with time management

Access to BH providers; available providers

Making families aware of resources

Getting youth and family to the table to make their own plans

Lack of providers to prescribe medications and not able to get Psych Evals done and transportation

Understanding of trauma by all community members

Transportation is always a barrier to access.

Stifma

When thinking of childrens mental health what are the challenges and/ or areas that need support?

Mentimeter

stigma with mental health

Peer support for families

stigma with mental health services

Support for children that may be living with other family members if parents are deceased

Generational issues that have not been addressed and cyclical stigma bringing a denial of the mental health situations.

Realtime intervention at time of trauma.

When you think about the inclusion of youth and family voice in the system what are the challenges or gaps?

Mentimeter

Finding family/youth leaders

Peers support for familes

stigma with mental health

lack of education to families about what resources are available and where to access them

Teaching parents to be strong advocates

Lack of parent engagement with older youth/teens

Lack of infrastructure that supports family voice

Shame

educating families and professionals about the value of family perspective

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When you think about the inclusion of youth and family voice in the system what are the challenges or gaps?

Mentimeter

Accessible training opportunities for families

(Specifically court ordered clients) Families feeling targeted versus supported by treatment team

lack of understanding of services available and how to use them

Time. Sick of system.

Asking family members to do one more thing when they're already overwhelmed

Inequity

Generational trauma

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When you think about trauma and resilience what are the challenges and gaps in the system?

Mentimeter

- Understanding how trauma impacts all areas of life
- How to implement trauma-informed practices, not just learn about them
- Implicit bias
- access to care
- Understanding how trauma is defined
- Families actively living with on-going trauma
- Recognizing trauma
- Funding to handle the issues.
- Burnout of providers

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When you think about trauma and resilience what are the challenges and gaps in the system?

Mentimeter

Inner agency coordination.

How to get everyone on the same page - leadership, providers, staff, families, etc.

COVID has limited resources

Determining the best ways to approach generational trauma and patterns

Support of community leaders for work (financial and otherwise)

Lack of trauma treatment providers

Support from community

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Choose the Wilkes Task Force project priority

Mentimeter