Cayuga County Families Access to Services Team

Year Three
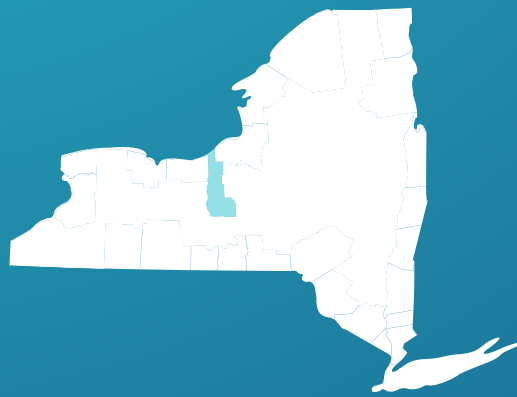
Project Overview

In October 2016, Cayuga County received a four-year System of Care Expansion grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to enhance their current System of Care (SOC) through an initiative called Families Access to Services Team (FAST). Cayuga County developed their SOC in two ways. First, they aimed to improve accessibility to programs for at-risk children/youth and their families through an expanded multi-systems single point of access process. Cayuga County Community Mental Health Center (CCCMHC) leads FAST, in partnership with various providers within Cayuga County, including the Auburn School District, Boards of Cooperative Educational Services (BOCES), Cayuga Counseling, Cayuga Centers, Department of Social Services (DSS), parent partners, and Probation. Second, Cayuga County expanded their SOC by increasing their service options and capacity. Cayuga County expanded the use of four programs: SafeCare, Positive Parenting Program (Triple P), Functional Family Therapy (FFT), and Multisystemic Therapy (MST). In addition to these programs, Cayuga County is participating in the New York State (NYS) High Fidelity Wraparound (HFW) pilot as part of their SAMHSA grant. Table 1 outlines each of the SAMHSA-funded FAST programs in more detail.

Table 1. SAMHSA FAST program description and capacity[1]

FAST Program	Description	Target Age of Child	Maximum Caseload	Duration of Program
Functional Family Therapy (FFT)	A home-based family therapy focused on strengths. FFT develops motivation and behavior change.	10-18	12	Generally 2-4 months, but could be up to 6 months
Multisystemic Therapy (MST)	A home-based family therapy that focuses on strengths and family-defined goals, while identifying how systems affect the youth and family.	11-18	10	3-5 months
SafeCare	A home visitation parent-training program that targets risk factors for child maltreatment, includes both regular SafeCare and SafeCare Family Fusion.	0-5	30	Up to 6 months
Positive Parenting Program (Triple P)	An in-home positive parenting intervention focused on promoting healthy relationships and behavior management, includes both regular Triple P and Primary Care Triple P.	2-12	12	2.5 months
High Fidelity Wraparound (HFW) pilot	A method of program delivery that is comprehensive, holistic, youth and family-driven, where the youth and family work with a facilitator and a team to create and work on a plan of care.	12-21	10	TBD

The Center for Human Services Research (CHSR) partnered with Cayuga County to lead the evaluation of FAST. The evaluation plan was designed to examine the SAMHSA-funded programs and the goals and objectives within Cayuga County FAST. This report focuses on the evaluation of the first three years of the four-year grant. The following sections describe evaluation data collection procedures, analyses, findings, and recommendations.

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[1] Information in table obtained from Cayuga County Mental Health for FFT, MST, SafeCare, and Triple P. Information for HFW obtained from source https://nwi.pdx.edu/wraparound-basics/. Note that only half of the total MST and FFT cases are funded through SAMHSA; only cases funded by SAMHSA are included in the evaluation.

Data Sources and Methods

Data in this report comes from surveys of project leads, administrative records, caregiver interviews, and FAST documents (e.g., rosters and FAST agendas).

The dataset includes all case data entered into the data systems as of October 1, 2019. Two sources supplied data on SOC infrastructure in Cayuga County. Infrastructure, Development, Prevention, and Mental Health Promotion (IPP) data was collected quarterly from lead representatives in Cayuga County on their infrastructure activities through Year Three. The NYS SOC Implementation Survey provides additional data on SOC infrastructure development for 2019 and 2020.

Program participant data was collected from several sources. Program providers supplied administrative records data for all participants at the time of enrollment (via FAST referral) and discharge from programs. In addition, a local data collector interviewed some participants, which provided additional information about their experiences and impressions of programs. Participant data obtained from administrative records and interviews (when applicable) were available for a total of 450 episodes of care.

For most of the FAST program data, means are reported by program to allow for comparisons across the programs. For outcome measures, paired samples t-tests were calculated to determine if key characteristics significantly changed between baseline and discharge from programs.

Results and Discussion

The following section describes evaluation findings, divided into five sections: (1) SOC infrastructure, (2) program characteristics, (3) participant characteristics, (4) outcomes, and (5) early findings from the HFW pilot. Important findings are bolded for emphasis.

SOC Infrastructure

Building and sustaining a System of Care requires certain key components to be in place. Policy development, an effective workforce, and formal organizational partnerships within the community support the System of Care approach.

Cayuga County built their SOC infrastructure by addressing these key areas. Throughout the grant, Cayuga County set goals for each of the four IPP indicators described below. Cayuga County regularly compares their progress on indicators with their goals to track SOC infrastructure development. Table 2 describes the key infrastructure areas and the Cayuga County totals per key area through Year Three.

Table 2. IPP indicators and total number of reported indicators through Year Three

Focus Area	Indicator ID	Definition	Total
Policy Development	PD1	The number of policy changes completed as a result of the grant.	21
Workforce Development	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.	249*
	WD5	The number of consumers/family members who provide mental health-related programs as a result of the grant.	13**
Partnership/ Collaborations	PC1	The number of organizations that entered into formal written inter/intra-organizational agreements (e.g., MOUs/MOAs) to improve mental health-related practices/activities that are consistent with the goals of the grant.	25

*Note: *Counted per training; if a person attended multiple trainings, they are counted multiple times. **Counted per quarter, so if a peer served in more than one quarter, they are counted for each quarter.*

By the end of Year Three, Cayuga County established 21 policies to address specific county and mental health program needs. Policies regarding specific programs (e.g., respite, PINS, mobile crisis, High Fidelity Wraparound (HFW)), FAST guidelines, referral processes, funding, Health Homes Serving Children, EHR documentation, and data collection were developed or modified to help connect partners, streamline procedures, and increase accessibility to programs. Figure 1 shows the number of policies established per year compared to the goals set by Cayuga County. **Goals were consistently surpassed each year over the three-year period. The majority of policies were established in year one; this pattern was expected, as more policies were needed initially to prepare for program implementation**. Cayuga County continued to develop policies and procedures through the end of Year Three.

Cayuga County aimed to build an effective workforce that emphasized SOC values and principles through various trainings and by adding consumers (i.e., peers) as program providers. By the end of Year Three, 249 people in the mental health and related workforce were trained in various practices and procedures. Figure 2 displays the number of staff trained per grant year, compared to the goals set by Cayuga County. While goal attainment fell short in Year Three, the county still exceeded their original goals for the other years. **More staff were trained during the first two years of the project, again consistent with program start-up**. Trainees included FAST providers, therapists, care managers, case managers, supervisors, family peer advocates, youth peer advocates, and evaluation staff. Staff attended trainings, webinars, and workshops that covered multiple topics: complex trauma, DBT skills, evaluation, evidence-based programming, mental health, NYS SOC High Fidelity Wraparound, respite, restorative justice, social marketing, system of care, trauma-informed yoga, truancy, and youth and family peer services. Trainings covered specific practices, skills, tools, policies, procedures, and documentation. This diversity in trainings reflects the wide

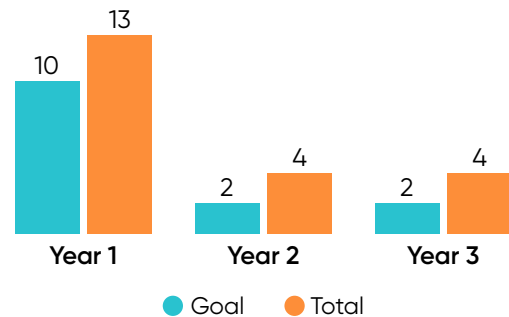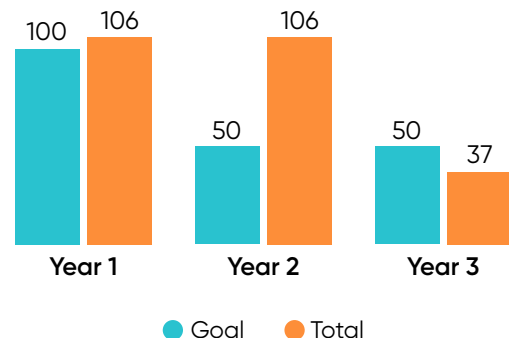### Figure 1. Number of reported PD1 indicators (policies) and goals by year

Figure 2. Number of reported WD2 indicators (trained staff) and goals by year

range of children's mental health programs that are available in Cayuga County. In addition to these standard trainings, staff attended and participated in other learning events related to children's mental health issues, such as the Annual Research and Policy Conference on Child, Adolescent, and Young Adult Behavioral Health in Tampa; Cayuga County's Mental Health Awareness Day; and the NYS SOC Summit.

Another workforce development indicator tracks the number of peer advocates added to the SOC to support the youth and family voice in programs. Peers have a unique viewpoint based on their own lived experience navigating through mental health issues and systems and can offer guidance and support through that lens. Their work highlights the youth and family perspectives regarding programs, which is a key component of the System of Care approach. Figure 3 displays the number of peers providing services per grant year compared to the goals set by Cayuga County. While goal attainment fell short in Year One, the county met or exceeded their goals for the other years. Family peers were included early on, with a youth peer coming on in Year Two when HFW was added to Cayuga County's service array. **During the first three years, peers provided support, advocacy, and interventions to families receiving mental health services, attended FAST meetings, and participated as board members for Peers of Cayuga County.**

Building relationships with community partners strengthens a SOC. Figure 4 describes the number of formal agreements per year compared to the goals set by Cayuga County. Throughout the grant, agreements were put in place between multiple entities to establish and streamline referral processes, increase and improve program delivery, and solidify agency and system participation in Cayuga County's SOC efforts. More agreements were established in Year One than in any other year, which is necessary to prepare for program implementation. While goal attainment fell short in Year Two, the county met or exceeded their goals for the other years.

Figure 3. Number of reported WD5 indicators (consumers providing services) and goals by year
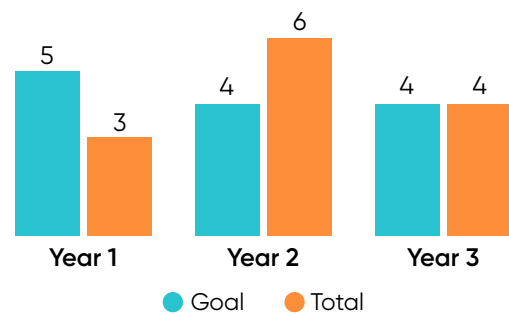
Figure 4. Number of reported PC1 indicators (formal agreements with partners) and goals by year

Early on, the county identified and contracted with specific agencies and systems to participate in FAST meetings and Cayuga County's SOC meetings. FAST partnered with multiple Health Homes Serving Children to better link and coordinate programs for families. Contracts were also established to create and expand programs, such as SafeCare, FFT, and MST. **A focus on collaborating with Cayuga County schools was evident by the multiple agreements between the county and the school districts.** Districts can now make referrals to FAST, and school staff will be trained in DBT so they can teach those skills in the classroom.

Another important tool to understand the local SOC is the SOC Implementation Survey (most items obtained from Stroul, Dodge, Goldman, et al., 2015) which Cayuga County completed the past two years as part of NYS's data collection efforts. This tool is designed to "assess progress in a community or region implementing the system of care approach for children, youth, and young adults with behavioral health challenges and their families," and thus is a great source for further exploration of SOC infrastructure development. This tool explores five major areas of SOC implementation: an existing plan for the system of care approach, service delivery guided by system of care values and principles, services and supports based on the system of care approach,

system infrastructure based on the system of care approach, and perceived commitment to the system of care philosophy and approach. In addition to these areas, a final item evaluates overall perception of SOC implementation.

Comparison between domains were based on the mean subscale score for each domain. Subscale scores ranged from 0 (generally indicating no SOC implementation) to 4 (generally indicating extensive SOC implementation).

Table 3 displays the mean subscale scores from 2019 and 2020 for both Cayuga County and NYS. Cayuga County scored higher than NYS on almost all subscales, except for implementation of a culturally and linguistically competent approach and perceived commitment of youth and family leaders. Scores between 2019 and 2020 were similar for Cayuga County, with the largest increases in strategic planning, incorporation of data and accountability, implementation of an evidence-informed approach, and overall SOC implementation. The largest decreases were in implementation of a family-driven approach, perceived commitment of family and youth leaders, and perceived commitment of managed care organizations.

Table 3. Mean subscale scores for Cayuga County and NYS by year

		2019		2020	
		Cayuga	NYS	Cayuga	NYS
	N:	33	604–930	8–10	261–420
Strategic Planning		3.26	2.31	3.89	2.01
Implementation of SOC Principles					
Individualized Wraparound Approach		3.33	2.75	3.26	2.63
Family-Driven Approach		3.32	2.83	2.78	2.71
Youth-Guided Approach		2.73	2.40	2.38	2.23
Coordinated Approach		3.15	2.70	3.07	2.61
Culturally and Linguistically Competent Approach		2.20	2.22	1.93	2.07
Evidence-Informed Approach		3.40	2.58	3.88	2.39
Least Restrictive Approach		3.43	2.80	3.78	2.64
Service Array		2.93	2.36	3.08	2.11
Data and Accountability		2.50	2.66	3.55	2.54
Services					
Home- and Community-Based Treatment		2.78	2.29	2.96	2.18
Out-of-Home Treatment		2.68	2.00	2.82	2.04
Infrastructure		2.88	2.16	3.11	2.10
Perceived Commitment					
Child-Serving Systems		2.89	2.40	2.87	2.34
Policy and Decision Makers		3.11	2.40	3.40	2.35
Providers		3.33	2.81	3.30	2.73
Family and Youth Leaders		3.13	2.64	2.60	2.63
Managed Care Organizations		2.93	2.35	2.44	2.31
Overall Assessment		3.04	2.29	3.50	2.17

Note: That the number of respondents was smaller in 2020 for both groups, as a more targeted sampling approach was implemented.

Program Characteristics

This section includes information about referrals, program completion, length of episode of care, and number of participants served during the first three years of the SAMHSA grant. This information will describe the flow of participants to and through programs and can help to identify strengths and inefficiencies in these processes.

Figure 5 displays the enrollment status of youth and families who were referred to the SAMHSA-funded FAST programs, including whether the case was enrolled in a program, not opened, or remains pending. **Over three-quarters of referrals enrolled into programs**, and an additional 1% of cases were pending enrollment. About a fifth of cases referred to SAMHSA FAST programs never enrolled. Reasons for cases not opening were available for 108 out of 125 cases. The most common reasons for not enrolling were that family/youth declined or refused programs (47%), the program provider was unable to engage the family/youth (27%), referral included multiple members of the same family who were enrolled in programs, but only one member could be identified for evaluation purposes (12%), and youth was served by another program or service system (7%).

Figure 5. Enrollment status of cases coming through FAST (N=580)
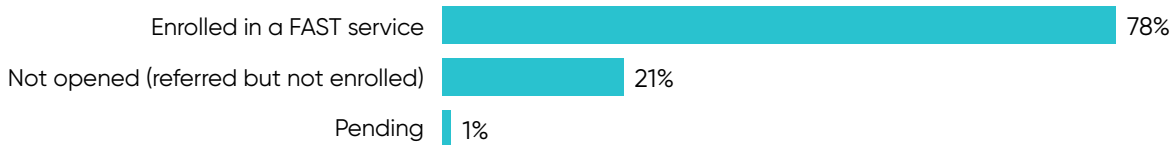

Figure 6 displays enrollments and discharges by grant year. Enrollments and discharges were lower in Year One because the programs started to rollout in the winter of 2017, and therefore, only a partial year of program operation is reflected, whereas Years Two and Three reflect full years of program operation. **Program enrollments and discharges were consistent for Years Two and Three.** FAST program placements and enrollments and discharges appear to be somewhat consistent between years, such that FAST fills all available slots for programs, and youth and caregivers are appropriately flowing through programs. This is evidenced by similar numbers served in Years Two and Three as well as "even" enrollments and discharges. This information can be helpful in planning for program capacity in future years.

Figure 6. Enrollment and discharge counts per grant year (N Enrolled=450, N Discharged=411)
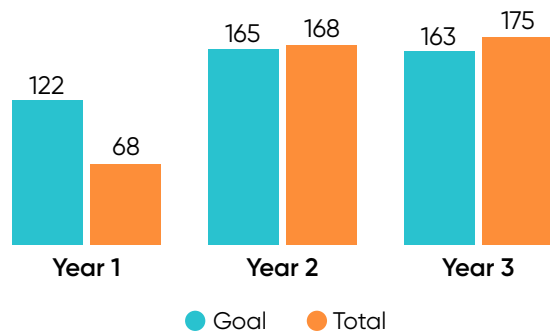
Note: Some youth and caregivers may be included more than once, if they completed the same program more than once, or completed more than one program.

Figure 7 displays the distribution of referrals to SAMHSA-funded programs. Consistent with last year (not displayed), **a greater proportion of cases were referred to Triple P and SafeCare than other programs.** Some MST and FFT slots are funded from other sources, so there are fewer SAMHSA-funded slots available for these two programs, likely leading to fewer referrals. The low rate of referrals to HFW likely reflects the very high needs eligibility criteria for this program.

Figure 7. Programs to which cases are referred (N=577)

Program	Percentage
FFT	18%
MST	18%
SafeCare	30%
Triple P	32%
HFW	3%
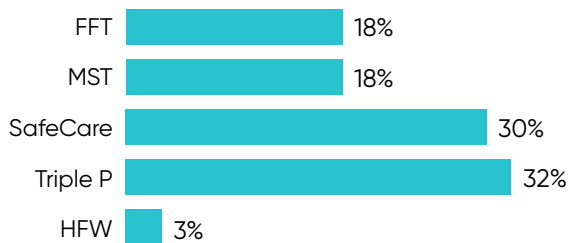
Note: Three referrals that did not enroll did not have a program identified.

Figure 8 shows the most common agencies that referred participants. **Referrals were most likely to come from child welfare, mental health, and schools, accounting for over 80% of referrals.**
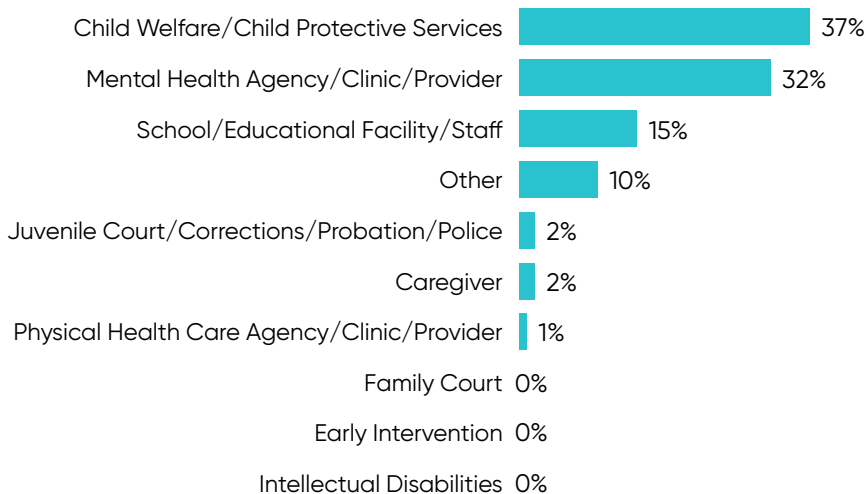
Figure 8. Referral source (N=419)

Referral source	Percentage
Child Welfare/Child Protective Services	37%
Mental Health Agency/Clinic/Provider	32%
School/Educational Facility/Staff	15%
Other	10%
Juvenile Court/Corrections/Probation/Police	2%
Caregiver	2%
Physical Health Care Agency/Clinic/Provider	1%
Family Court	0%
Early Intervention	0%
Intellectual Disabilities	0%

Note: Referral source was not reported for 31 episodes of care.

Referral sources varied by program, displayed in Figure 9. **Mental health was the top referral source for all programs except SafeCare, which received most of its referrals from child welfare agencies.** The Triple P program had a greater proportion of school referrals than other programs. Also, notably, 17% of HFW cases were referred from Juvenile Court (not displayed).

Figure 9. Referral source by program for top four referral sources (N=396)

- Mental Health Agency/Clinic/Provider
- Child Welfare/Child Protective Services
- School/Educational Facility/Staff
- Other
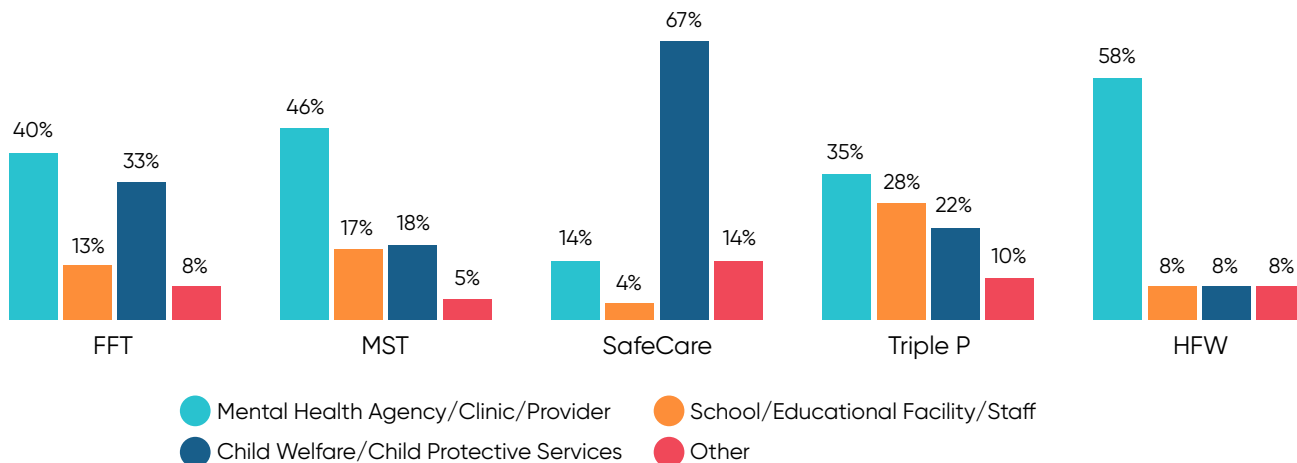
Note: Referral sources from family court, juvenile court, caregivers, early intervention, intellectual disabilities, and physical health care are not displayed.

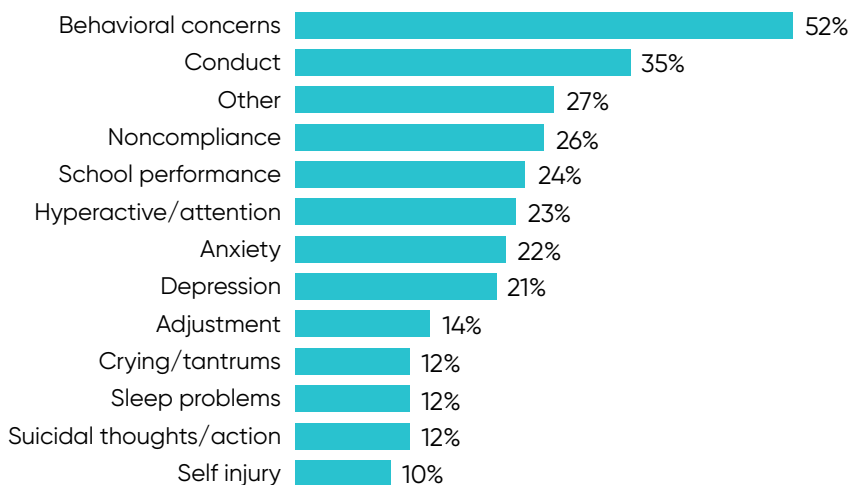Agencies referred participants for diverse reasons. The reasons for referral that were present in 10% or more of cases are displayed in Figure 10[2]. **Behavioral concerns (e.g., aggression, defiance, acting out, impulsivity, excessive over-activity) were the most frequent reasons for referral, present in over half of the cases.** Conduct concerns (e.g., physical aggression, verbal abuse, non-compliance, police contact) were also present in over one third of cases. The next most common reasons for referral was "other;" over 60% of the "other" responses indicated a need or desire for parenting skills/assistance.

Figure 10. Most common reasons for referral (N=400)

Reason	Percent
Behavioral concerns	52%
Conduct	35%
Other	27%
Noncompliance	26%
School performance	24%
Hyperactive/attention	23%
Anxiety	22%
Depression	21%
Adjustment	14%
Crying/tantrums	12%
Sleep problems	12%
Suicidal thoughts/action	12%
Self injury	10%

[2] Other reasons were present in fewer than 10% of cases that include (in order of prevalence): learning disability, maltreatment, home not meeting needs, separation problems, substance use, attachment problems, intellectual disabilities, pervasive developmental disability, specific developmental disability, eating disorder, health concerns, excluded from preschool childcare due to behavioral/developmental problems, psychosis, feeding problems.

Reasons for referral varied by program (see Table 4). **Behavioral concerns and conduct were common across programs, with the exception of SafeCare.** In general, common reasons for referral were consistent with the age of the population served by the program (e.g., hyperactivity and attention challenges for the younger population and anxiety and/or depression for the adolescent population). About 60% of the reasons for referral to SafeCare were "other" responses; about two-thirds of these specified challenges with parenting and/or a need for parenting classes. **MST and HFW both had an average of five reasons for referral indicated, suggesting that these youth had particularly complex needs.** This average was lower than the first two years of the grant, when both programs had an average of six reasons for referral (not displayed). This decrease may indicate that youth enrolled in MST and HFW in Year Three may have slightly less complex needs than in the prior two years.

Table 4. Top referral reasons and mean number of reasons by program (N=421)

FFT Mean # of reasons= 4 N=70	MST Mean # of reasons=5 N=81	SafeCare Mean # of reasons= 2 N=130	Triple P Mean # of reasons= 4 N=128	HFW Mean # of reasons= 5 N=12
Behavioral concerns (66%)	Behavioral concerns (72%)	Other (primarily need for parenting skills) (60%)	Behavioral concerns (71%)	Behavioral concerns (75%)
Depression (44%)	Conduct (64%)		Conduct (42%)	Anxiety (75%)
Conduct (43%)	School performance (51%)		Hyperactive and attention-related behaviors (38%)	Conduct (67%)
Anxiety (39%)	Depression (42%)		Persistent noncompliance (33%)	Depression (67%)
Persistent noncompliance (34%)	Persistent noncompliance (40%)			School performance (50%)
	Anxiety (37%)			Suicide-related thoughts or actions (33%)
				Hyperactive and attention-related behaviors (33%)

Figure 11 displays the number of youth served in each of the programs across all three grant years. SafeCare served the most youth, followed by Triple P, MST, FFT, and HFW. These rankings are consistent with data on referrals and capacity, such that programs with more referrals and higher SAMHSA-funded capacity also served more participants. MST and FFT serve additional youth with other funding sources (not displayed).

Figure 12 displays the percentage of enrollees who completed each program by grant year. Successful completion is defined as the participants completed all sessions of the program (i.e., the participant did not drop out early). On average, about 80% of participants who were discharged from their programs in Year Three were successful completions. SafeCare and FFT had the highest completion rates in Year Three. Overall, completion rates generally improved over the course of the grant, though there was variation by program.

Figure 11. Number of youth served in each SAMHSA-funded program (N=450)

Safecare, 136

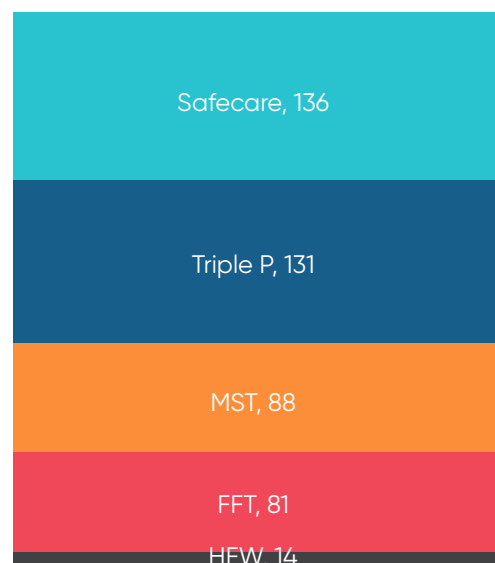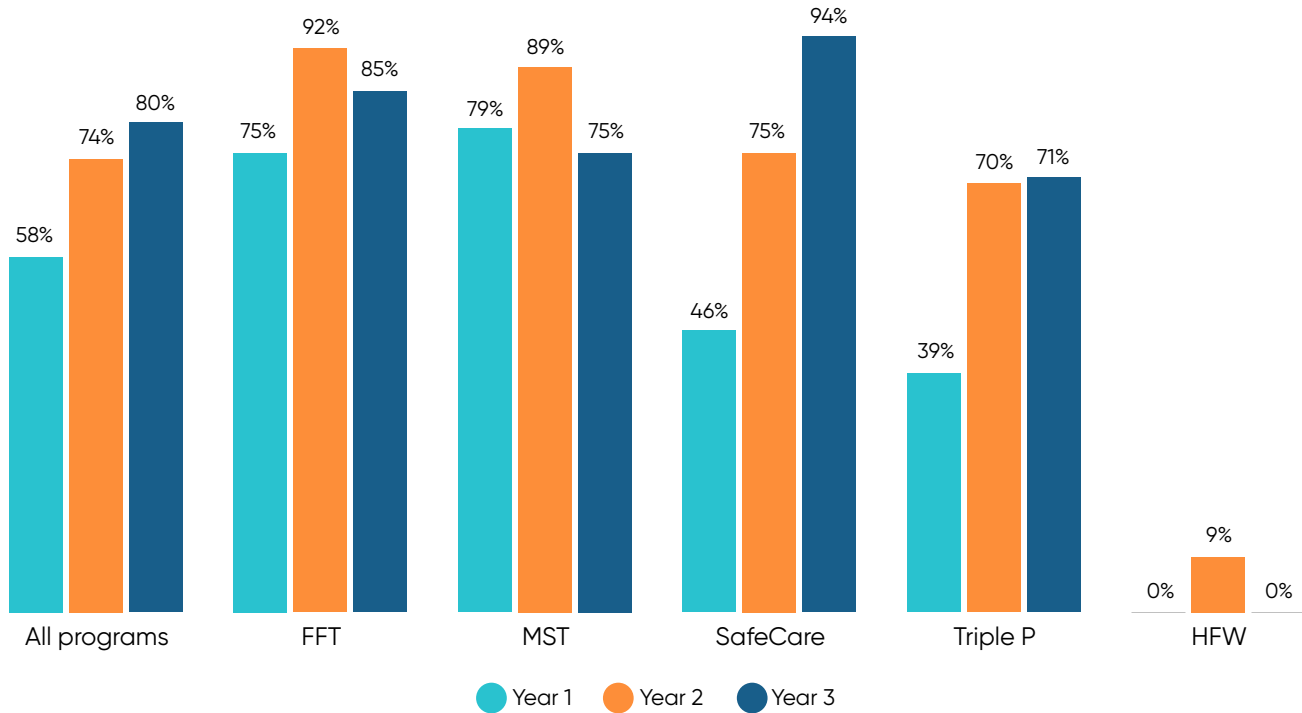Triple P, 131

MST, 88

FFT, 81

HFW, 14

Figure 12. Percentage of participants discharged in each year who successfully completed program (N=404)

Note: Program completion data missing for seven cases.

The following two tables display the average length of stay and number of sessions completed by program. Because the different versions of SafeCare and Triple P vary in their duration and number of sessions, the versions are listed separately in the tables. Table 5 displays the average length of stay for those who completed and did not complete a program, displayed by program. **Participants who completed a program participate for about one month longer on average than those who do not complete a program (difference was significant, F=1.27, p<.05).** Interestingly, even those who did not successfully complete the program were enrolled for about 3.24 months on average which is still a sizable "dose" of the program.

Table 5. Mean months in program, by status at discharge (N=406)

	Successful Completions		Unsuccessful Completions	
	N	Mean	N	Mean
FFT	59	4.60	11	2.52
MST	62	4.74	14	2.08
SafeCare	40	5.32	28	3.01
SafeCare FF	51	3.48	7	2.93
Triple P	67	2.76	44	2.90
PC Triple P	9	2.29	2	3.96
HFW	1	16.07	11	7.49
All Programs	**289**	**4.07**	**117**	**3.24**

Note: Months were counted as four weeks/28 days. Three PC Triple P and one Triple P closed cases are not marked as complete/incomplete because they were restarted due to change in provider; one FFT case missing completion status.

However, enrollment duration only shows part of the dosage picture because participants could be in the program, but not attending sessions frequently. Therefore, it is also important to examine the number of sessions attended. Table 6 displays the average number of sessions completed by program. Typically, those who did not successfully complete their program attended fewer than a third as many sessions as those who did successfully complete. Interestingly, those who did not successfully complete the program were enrolled about 75% as long as successful completers but attended less than a third as many sessions, indicating that non-completers were attending sessions less frequently than completers. **This pattern may indicate that families who do not successfully complete the program struggle to fully engage or commit to the program.**

Table 6. Number of sessions completed by program, by status at discharge (N=375)

	Successful Completions		Unsuccessful Completions	
	N	Mean	N	Mean
FFT	59	14.80	12	4.58
MST	54	41.61	11	17.10
SafeCare	39	18.64	26	4.56
SafeCare FF	49	11.24	7	3.00
Triple P	72	9.48	38	3.68
PC Triple P	8	5.00	2	3.50
HFW	1	3.00	7	1.64
All Programs	**274**	**18.42**	**101**	**5.01**

Note: Three PC Triple P and one Triple P closed cases are not marked as complete/incomplete because they were restarted due to change in provider; one FFT case missing completion status. Remaining 31 missing cases missing number of completed sessions. Number of sessions for HFW only includes child and family team meetings (CFTMs).
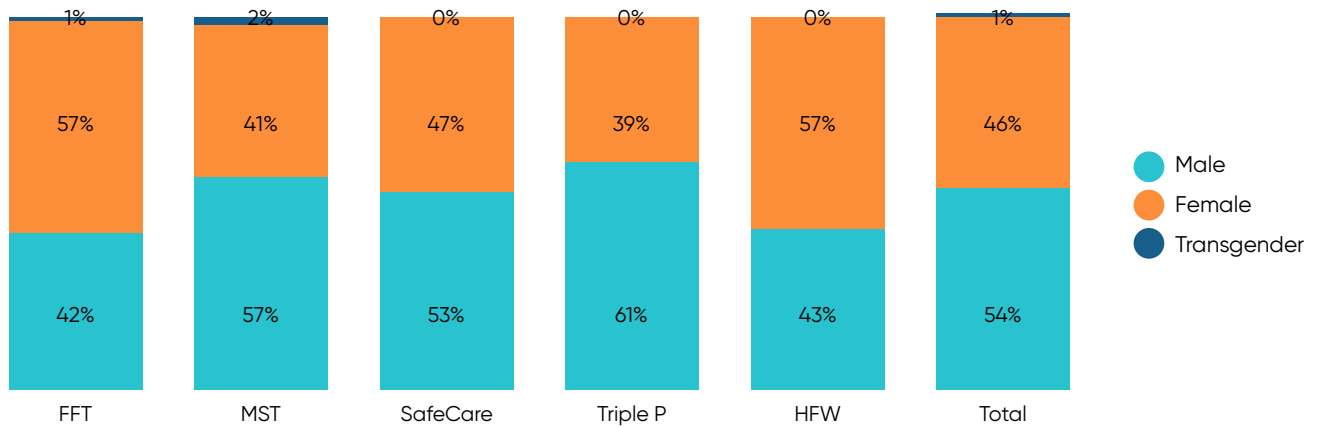
Participant Characteristics

This section focuses on the characteristics of program participants at baseline. This information is helpful for identifying and understanding characteristics of the program population and determining whether there are any gaps in this population.

Figure 13 displays participant gender both by program and across all programs[3]. **Overall, in Cayuga County, 54% of youth served are male and 46% are female (not displayed), which is consistent with the overall distribution of males vs. females served in SAMHSA-funded programs[4].** Triple P serves the largest proportion of males, whereas FFT and HFW serve the largest proportion of females.

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[3] US Census data provides the sex information for children in Cayuga County. In order to compare county level sex breakdowns and program level sex breakdowns, some assumptions were made. Although sex and gender may differ, since SAMHSA offered a transgender option for their gender item, it is likely that for individuals whose sex does not match their gender, the transgender option would be selected. Therefore, for the remaining participants, it is likely that their biological sex matched their gender on this item.

[4] County data obtained from Table S0101, American Community Survey, 2017 5-yr estimates.
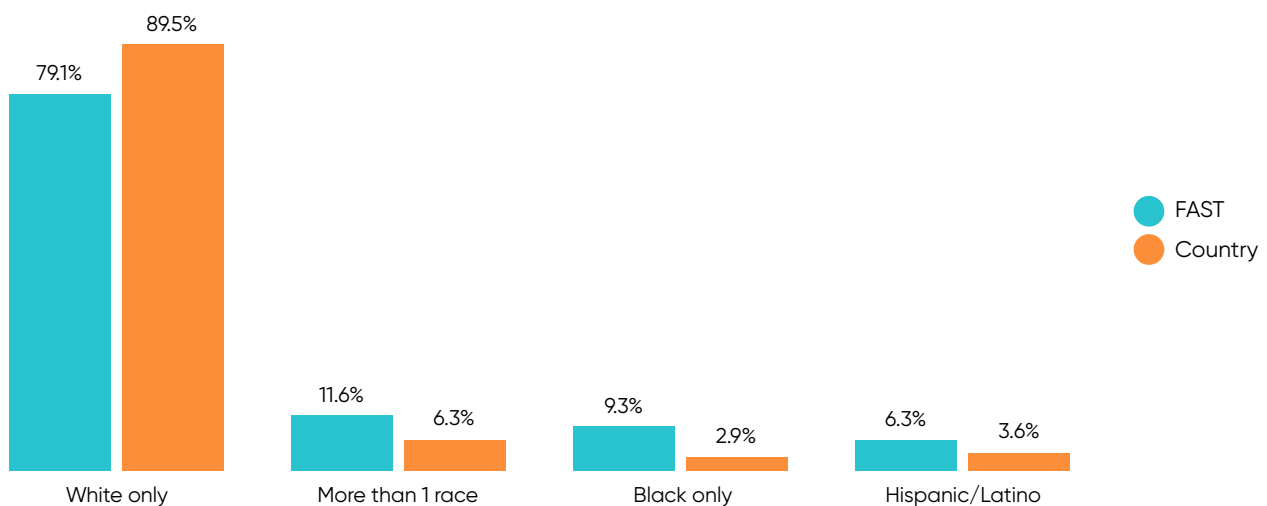
Figure 13. Participant gender, by program and overall (N=448)

Legend: Male (teal), Female (orange), Transgender (dark blue)

Program	Male	Female	Transgender
FFT	42%	57%	1%
MST	57%	41%	2%
SafeCare	53%	47%	0%
Triple P	61%	39%	0%
HFW	43%	57%	0%
Total	54%	46%	1%

Note: Gender not reported for two participants.

Figure 14 displays the race and ethnicity of the program population compared to US Census Cayuga County estimates for residents under the age of 18.[5] In order to compare the race and ethnicities of the program population with the US Census data, the information below is presented in exclusive categories (i.e., more than one option could not be selected for the US Census data). **The SAMHSA-funded programs served a population that was more diverse than youth in Cayuga County in general.** These programs served a greater proportion of Black, Hispanic/Latino, and multiracial youth, and a smaller proportion of White youth, than would be expected given the population of the county. Within the service population, all those who selected more than one race selected two races. In most cases (91%), Black and White were selected, with 7% selecting White and American Indian, and 2% selecting White and Asian.

Figure 14. Race and ethnicity sample characteristics (Race N=378, Hispanic/Latino N=379), compared to county estimates

Legend: FAST (teal), Country (orange)

Category	FAST	Country
White only	79.1%	89.5%
More than 1 race	11.6%	6.3%
Black only	9.3%	2.9%
Hispanic/Latino	6.3%	3.6%

[5] County estimates obtained from American Community Survey 5-yr estimates, 2017, table S0901
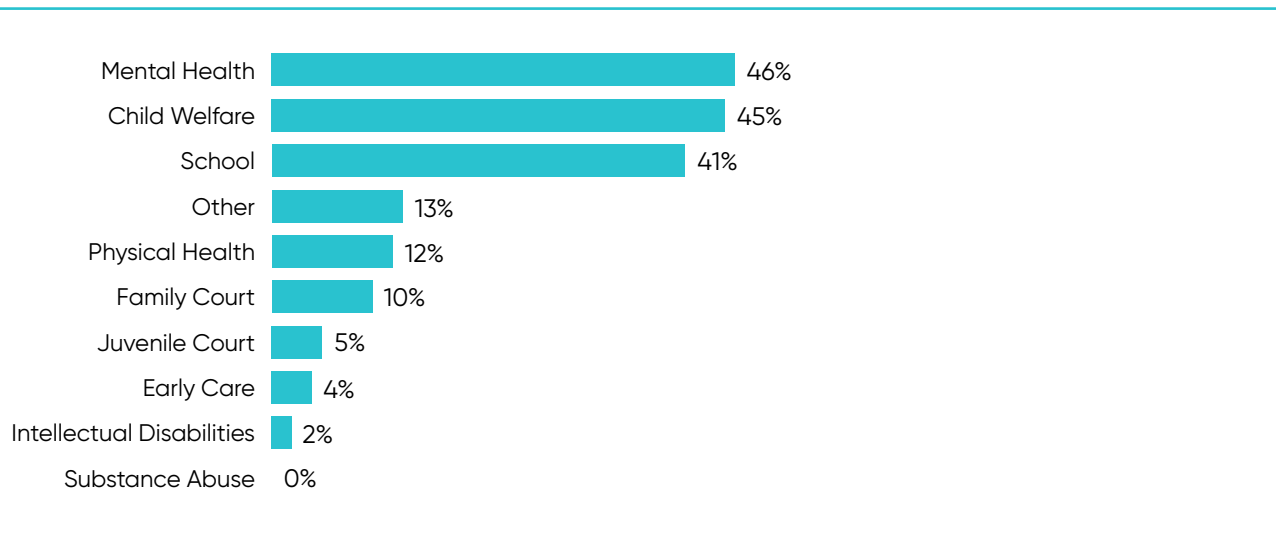
The average age of the participant by program and across all programs is displayed in Figure 15. **Cayuga County FAST programs served a wide age range of youth, averaging from two years old in SafeCare to about 14 years old in MST and HFW.** On average, youth in these programs were about eight years old. The average age of program participants was consistent with the guidelines for programs (see Table 1). SafeCare and Triple P are both parenting focused, and tend to serve younger children, whereas FFT, MST, and HFW are more youth focused and tend to serve adolescents and teens. With the exception of Triple P, the average age of the youth served was towards the lower end of the program range.

Figure 15. Average age, by program and overall (N=450)

Program	Average Age
FFT	12.86
MST	13.65
SafeCare	2.07
Triple P	7.27
HFW	14.36
Total	8.18
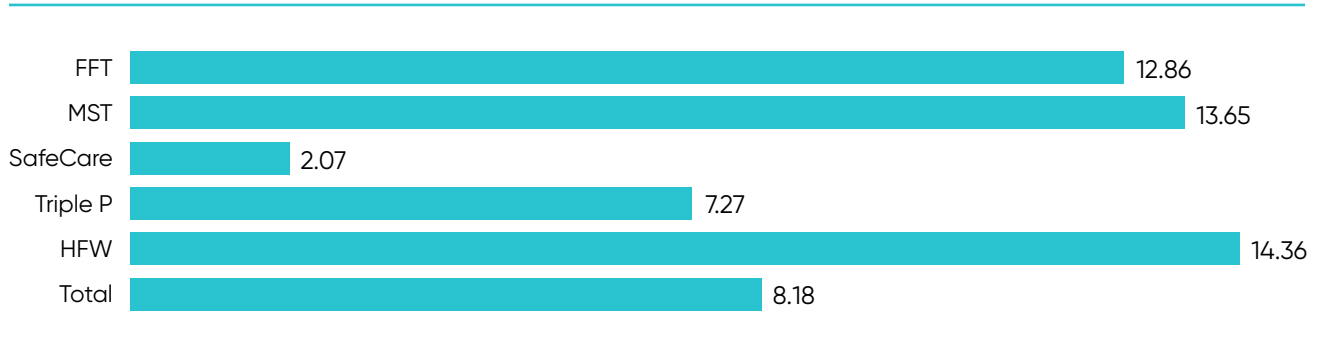
Participants were involved in a variety of agencies at baseline, as seen in Figure 16. **Agency involvement mirrored referral source, such that the top three systems were mental health, child welfare, and school.**

Figure 16. Agency involvement at baseline, most common (N=418)

Agency	Percent
Mental Health	46%
Child Welfare	45%
School	41%
Other	13%
Physical Health	12%
Family Court	10%
Juvenile Court	5%
Early Care	4%
Intellectual Disabilities	2%
Substance Abuse	0%

On average, participants in FAST programs were involved in 1.79 agencies at baseline (ranging from 1.67 for SafeCare to 1.85 for MST). HFW participants were involved in 2.67 agencies on average, which may be due to the high acuity and multiple system involvement requirements for HFW.

Some of the agencies with less youth involvement overall have greater proportions of youth at the program level. Table 7 displays the proportion of cases with various agency involvement at baseline by program. Across all programs early care, substance abuse, and juvenile court involvement are rare, but some programs have

greater proportions of cases involved in these agencies. **SafeCare has the largest proportion of cases involved in early care across the programs. HFW has the largest proportion of cases involved in substance abuse and juvenile court across the programs.**

Table 7. Percent of cases involved in each agency, by program (N=418)

	FFT	MST	SafeCare	Triple P	HFW	All Programs
N	70	79	132	125	12	418
Mental Health	64%	58%	15%	55%	92%	46%
Child Welfare	31%	28%	82%	26%	25%	45%
School	40%	49%	17%	56%	100%	41%
Physical Health	14%	11%	10%	13%	17%	12%
Family Court	6%	9%	18%	6%	0%	10%
Juvenile Court	6%	16%	0%	2%	25%	5%
Early Care	0%	0%	12%	2%	0%	4%
Intellectual Disabilities	1%	1%	2%	2%	0%	2%
Substance Abuse	0%	1%	0%	0%	8%	0%

Outcomes

This section focuses on changes in outcome measures between baseline and discharge from programs. Variables analyzed include symptoms, functioning, empowerment, strain, parenting competence, and perception of care.

The Pediatric Symptoms Checklist (PSC) was used to determine changes in symptoms between the start and end of programs. This tool measures symptoms associated with the child's behavior, emotions, and learning (Jellinek, Murphy, et al., 1999). There are multiple versions of this instrument for different participant ages. This analysis was restricted to the general PSC (which assesses older youth), as other versions lacked adequate pre- and post-enrollment matched data. Scoring for the PSC is on a 1 ("never," indicating that this symptom is never present) to 3 ("often," indicating the symptom is often present) scale.
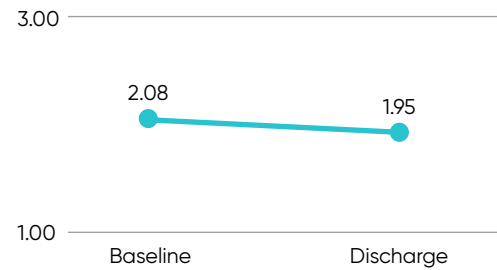
Table 8 displays the average score on the PSC at baseline and discharge from programs. Figure 17 displays the overall average change in PSC score over time. At both time points, the average score on the PSC was around the midpoint of the scale, corresponding with a score of "sometimes." Across all programs, **the average score on the PSC decreased by 0.13 points between baseline and discharge. This reduction was statistically significant (t=3.98, p<0.001), suggesting a decrease in symptomology by program discharge.**

Table 8. Means for paired samples on the PSC, overall and by program (N=86)

	N	Baseline Mean	Discharge Mean
FFT	28	2.03	1.94
MST	16	2.14	1.90
Triple P	36	2.09	1.95
All Programs	86	2.08	1.95

Note: Program means only included for programs with five + paired sets of data on the PSC. All Programs includes all sets of paired data on the PSC.

Figure 17. Mean for paired samples on the PSC, over program tenure (N=86)

Note: Difference is statistically significant (t=3.98, p<0.001)

The Columbia Impairment Scale (CIS) was used to determine changes in impairment between the start and end of programs. This tool measures areas where the child needs help in functioning in various domains such as with family, peers, or in school (Bird, Shaffer, et al., 1993). Scoring for the CIS is on a 0 ("no problem") to 4 ("very bad problem") scale.

Table 9 displays the average score on the CIS at baseline and discharge from programs. Figure 18 displays the overall average change in CIS score over time. At both time points, the average score on the CIS was below the midpoint of the scale, indicating that impairment in the domains of the CIS was typically neither high nor low. **The average score on impairment decreased between baseline and discharge by 0.11**, however this reduction was not statistically significant (*t*=1.57, *p*=0.12).

Table 9. Means for paired samples on the CIS (N=88)

	N	Baseline Mean	Discharge Mean
FFT	27	1.66	1.62
MST	16	1.66	1.45
Triple P	37	1.72	1.62
All Programs	88	1.69	1.58

Note: Program means only included for programs with five + paired sets of data on the CIS. All Programs includes all sets of paired data on the CIS.

Figure 18. Mean for paired samples on the CIS, over program tenure (N=88)
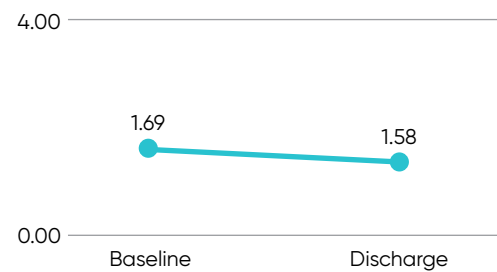
Note: Difference is not significant (t=1.57, p=.12)

The Caregiver Strain Questionnaire (CSQ) was used to determine changes in caregiver strain between the start and end of programs. This tool measures how things have been with the family/household (Brannan, Heflinger, & Bickman, 1997). It contains three subscales: objective strain (observable disruptions to life), externalized strain (negative feelings that are projected outward, such as anger, resentment, and embarrassment), and subjective internalized strain (negative internalized feelings, such as worry, guilt, and fatigue). Scoring on the CSQ is on a 1 ("not at all", indicating the item is not an issue) to 5 ("very much," indicating the item was very much an issue) scale.

Table 10 displays the average score on the CSQ at baseline and discharge from programs. Figure 19 displays the overall average change in CSQ score over time. At both time points, the average score on the CSQ was slightly below the midpoint of the scale, indicating that average caregiver strain was between "a little" and "somewhat." **The average score on caregiver strain decreased between baseline and discharge by 0.31 points, and this**

reduction was statistically significant (*t*=3.61, *p*<0.001), suggesting caregivers experienced less strain after participating in the programs. Average scores on all subscales of caregiver strain had lower means at discharge compared to baseline (see Table 11).

Table 10. Means for paired samples on the CSQ (N=85)

	N	Baseline Mean	Discharge Mean
FFT	28	3.00	2.69
MST	16	2.86	2.47
Triple P	34	2.63	2.27
All Programs	85	2.81	2.50

Note: Program means only included for programs with five + paired sets of data on the CSQ. All Programs includes all sets of paired data on the CSQ.

Table 11. Means for paired samples on the CSQ subscales, across all programs (N=85)

	Baseline Mean	Discharge Mean
Objective	2.73	2.48
Externalized	2.12	1.87
Subjective Internalized	3.45	3.00

Figure 19. Mean for paired samples on the CSQ, over program tenure (N=85)

Note: Difference is significant (t=3.61, p<0.001)

Data from the Family Empowerment Scale (FES) was used to determine changes in family empowerment between the start and end of programs. This tool measures how able the caregiver feels to take care of situations involving their family, their youth, and the youth's services (Koren, Dechillo, & Friesen, 1992)[6]. Scoring on the FES is on a 1 ("never," indicating low empowerment) to 5 ("very often," indicating high empowerment) scale. The FES was only administered to caregivers of youth in FFT, MST, and HFW, which are programs serving older youth.
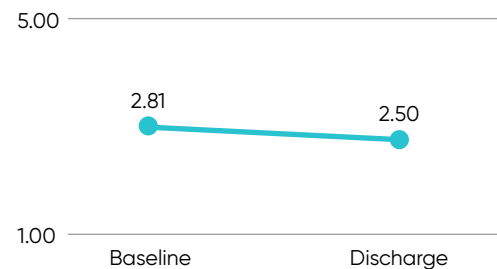
Table 12 displays the average score on the FES at baseline and discharge from programs. Figure 20 displays the overall average change in FES score over time. At both time points the average score on the FES was around a 4, corresponding with "often." Thus, caregivers tended to feel above-average empowerment at both baseline and discharge. **The average score on family empowerment increased between baseline and discharge by 0.28 points, which was statistically significant (*t*=-3.17, *p*=0.004), suggesting family empowerment improved over the course of program participation.**

Table 12. Means and for paired samples on the FES (N=25)

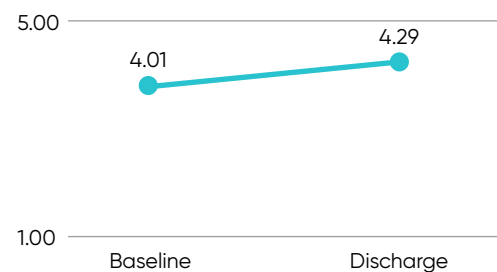|	N	Baseline Mean	Discharge Mean
FFT	15	3.88	4.24
MST	6	4.22	4.55
All Programs	25	4.01	4.29

Note: Program means only included for programs with five + paired sets of data on the FES. All Programs includes all sets of paired data on the FES.

Figure 20. Mean for paired samples on the FES, over program tenure (N=25)

Note: Difference is significant (t=-3.17, p=0.004)

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[6] Scores can be presented by subscales and/or as the total score. The FES has subscales focused on family, programs system, and community. To maintain brevity of interviews, interviews included the family and programs system items. Data presented is the average of the family and programs system subscale combined.

Data from the Parenting Sense of Competence Scale (PSOC) was used to determine changes in feelings of parenting competence between the start and end of programs. This tool measures how skilled a caregiver feels on different aspects of parenting (Gibaud-Wallston & Wandersman, 1978). Scoring on the PSOC is on a 1 ("strongly disagree," indicating that the parent does not feel competent on an item) to 6 ("strongly agree") scale. The PSOC was only administered to caregivers of youth in Triple P and SafeCare, because these programs focus on parenting.

Table 13 displays the average score on the PSOC at baseline and discharge from programs. Figure 21 displays the overall average change in PSOC score over time. At both time points, the average score on the PSOC was between a 4 and a 5, indicating caregivers tended to "agree" or "somewhat agree" in their competence on the items. **The average score on parenting competence increased between baseline and discharge by 0.16 points, and this increase was statistically significant (t=-2.24, p<0.03), suggesting feelings of parenting competence improved over the course of program participation. This increase was seen primarily in the Triple P families**, who tended to have lower baseline scores, and thus greater room for improvement in parenting competence.

Table 13. Means for paired samples on the PSOC (N=50)

		Baseline	Discharge
	N	Mean	Mean
Triple P	31	4.15	4.42
SafeCare	19	4.59	4.55
All Programs	50	4.32	4.47

Note: Program means only included for programs with five + paired sets of data on the PSOC. All Programs includes all sets of paired data on the PSOC.

Figure 21. Mean for paired samples on the PSOC, over program tenure (N=50)
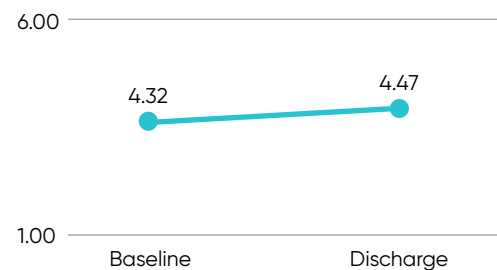
Note: Difference is significant (t=-2.24, p<0.03)

At discharge, interviewees reported on their perception of care. Perception of care was reported on a 1 ("strongly disagree," indicating a negative perception of care) to 5 ("strongly agree," indicating a positive perception of care) scale.

Table 14 presents the average perception score per program at discharge. Figure 22 displays the average perception score per item. **Participants had a positive impression of the programs**, evidenced by average scores for all items falling between "agree" and "strongly agree" (4 and 5). **Slightly higher scores were observed for items reflecting how participants were treated by providers, whereas slightly lower scores were observed on items focusing on family choice in programs**. When breaking down perception by program, **perception of care was high across all of the SAMHSA programs**, however the average score for HFW was lower than other programs.

Table 14. Mean perception of care at discharge by program (N=175)

	N	Mean
FFT	36	4.46
MST	25	4.3
HFW	15	3.94
Triple P	63	4.36
SafeCare	44	4.39
All Programs	175	4.41

Figure 22. Mean perception of care per item at discharge (N=175)

Item	Mean
All items	4.41
Treated with respect	4.64
Spoke in way understood	4.62
Sensitive to culture	4.60
Respected religious beliefs	4.57
People stuck with us	4.51
Participated in treatment	4.49
Satisfied with services	4.46
Choose treatment	4.40
Someone to talk to	4.37
Choose services	4.36
Right services	4.18
Got help wanted	4.13
Got help needed	4.07

High Fidelity Wraparound Pilot Program

Cayuga County participates in the High Fidelity Wraparound (HFW) Pilot Program, New York State System of Care (NYS SOC). Cayuga County enrolled their first youth in HFW in January 2018 and had served 14 youth in this program by the end of Year Three. This section includes some findings related to program characteristics, program fidelity, and outcomes that are specific to the HFW program and offer comparison to New York State-level statistics. There are few HFW participants in Cayuga County, so the following findings should be considered preliminary.

Table 15 displays the average length of stay (LOS) and number of child and family team meetings (CFTMs) completed for Cayuga County HFW compared to the state averages. In Cayuga County, 8% (i.e., 1 of 12 cases) of HFW cases were discharged in the transition phase, compared to 15% in NYS. Cayuga's one case that discharged in transition had fewer CFTMs and was in HFW longer than the NYS' average; however, since this information is based on a single case, it should be interpreted with caution. Only about 50% of sites in NYS have had at least one family discharge after completing a transition phase, so Cayuga County is not alone in facing challenges getting families to transition. The LOS and number of CFTMs for early discharges were very similar between Cayuga and NYS. **Although there is room for improvement, Cayuga County's HFW completion rate is somewhat consistent with the state as a whole.**

Table 15. Average length of stay and number of CFTMs completed, Cayuga County and NYS (Cayuga County N=12, NYS N=113)

	Cayuga			NYS		
	N	Mean Months	Mean # CFTMs	N	Mean Months	Mean # CFTMs
Discharged after transition	1	16.07	3.0	30	10.58	6.4
Discharged prior to transition	11	7.49	1.40	83	6.65	2.1

Table 16 displays Cayuga County's results on the 45-Day Review compared to NYS as a whole. This review involves assessment of documentation for each case as it reaches 45 days post-enrollment and provides an overview of how closely documentation adheres to HFW model fidelity. Although scores for Cayuga County are generally quite low, they are similar to scores for NYS, suggesting others struggle to meet these documentation standards. **Areas where Cayuga County particularly exceeded the NYS' scores were: including culture in the family story, identifying youth underlying needs, and identifying youth and caregiver functional strengths.** However, Cayuga County struggled to identify caregiver underlying needs at a greater rate than NYS. Most of the lowest scores reflected a lack of documentation of different elements, indicating that these items were typically missing from the system. **HFW providers could improve these scores by entering more documentation into the online WRAP-NY system.**
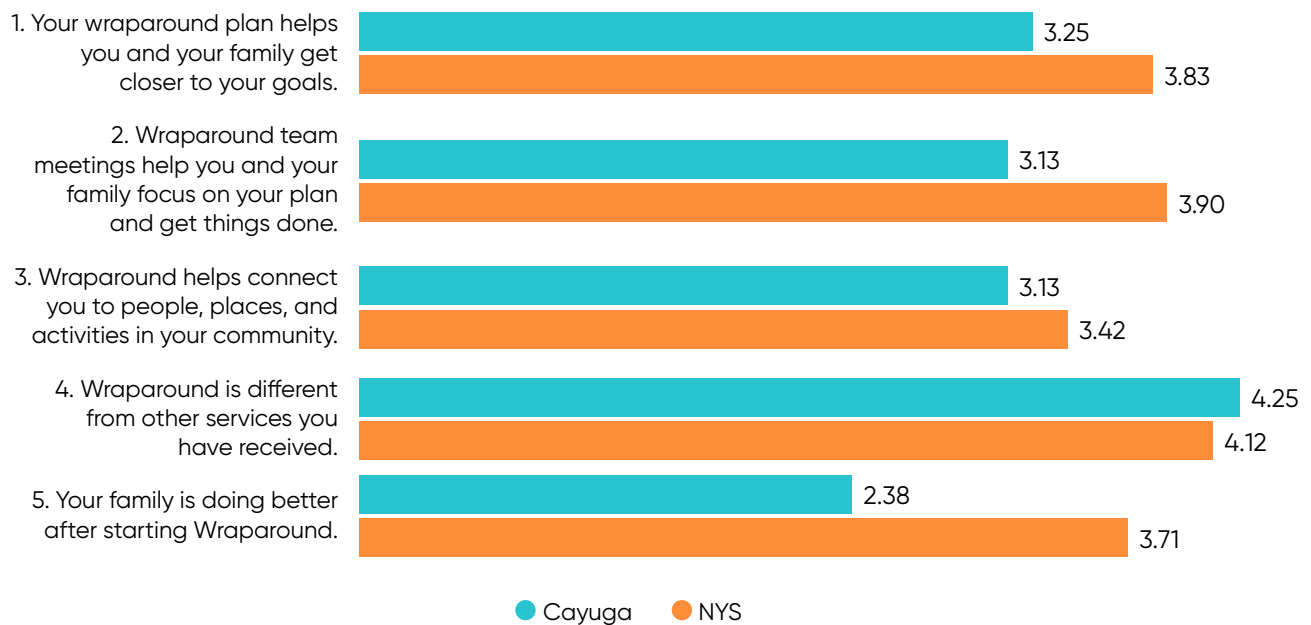
Table 16. Percent of elements present in the 45-Day Review, Cayuga County compared to NYS (Cayuga County N=13, NYS N=169)

		Cayuga	NYS
	N	13	169
1. Is there a crisis plan?		62%	57%
If yes, does it ensure location of crisis behavior is indicated? (e.g. acting out in school, withdrawing at home, etc.)		25%	16%
If yes, does it identify triggers that precipitate the crisis behavior? (and crisis behavior links to reason for referral)		75%	88%
2. Were any crisis events recorded?		0%	4%
If yes, was crisis plan updated within 24 hours?		0%	0%
If yes, was CFT held within 72 hours of a crisis event?		0%	0%
If no, should crisis event(s) have been recorded?		23%	12%
3. Did the POC include the family story?		46%	44%
If yes, did it include the family's culture?		67%	17%
4. Did the POC include youth strengths?		23%	39%
If yes, is at least one functional?		100%	67%
5. Did the POC include caregiver strengths?		23%	32%
If yes, is at least one functional?		100%	43%
6. Did the POC include youth needs?		23%	33%
If yes, is at least one underlying?		67%	46%
7. Did the POC include caregiver needs?		23%	24%
If yes, is at least one underlying?		33%	70%
8. Did the POC include the family vision?		31%	37%
If yes, was it positively worded?		75%	68%
If yes, was it about family and youth?		100%	84%
If yes, was it long-range?		75%	81%

One outcome scale specific to the HFW program is the Wraparound Scale, which assesses whether basic elements of the HFW process were present. This scale is included as part of the reassessment and discharge interviews. Wraparound items were scored on a 1 ("strongly disagree," indicating care coordination was less reflective of Wraparound) to 5 ("strongly agree," indicating care coordination was more reflective of Wraparound) scale.

Figure 23 displays the mean caregiver scores per item. One report per family was included. In cases where multiple assessments were available per family, the most recent (last) assessment was included. **On average, participants were likely to agree that Wraparound was different from other services they had received, but were less likely to agree that they were doing better since starting Wraparound.** On most of the items, Cayuga County scored slightly lower than NYS on average.

Figure 23. Mean scores on Wraparound Scale items, Cayuga County and NYS (Cayuga County N=8, NYS N=51–52)

	Cayuga	NYS
1. Your wraparound plan helps you and your family get closer to your goals.	3.25	3.83
2. Wraparound team meetings help you and your family focus on your plan and get things done.	3.13	3.90
3. Wraparound helps connect you to people, places, and activities in your community.	3.13	3.42
4. Wraparound is different from other services you have received.	4.25	4.12
5. Your family is doing better after starting Wraparound.	2.38	3.71

Conclusions & Recommendations

This report examined infrastructure activities, program characteristics, individual characteristics of the participants served, changes in youth and caregiver outcomes, and satisfaction with programs. Many of the findings after three years of the SAMHSA grant mirror those found in prior years.

A summary of findings for each of the domains are described below.

SOC Infrastructure

Cayuga County dedicated many resources to developing their System of Care during the first three years of the grant by updating their policies, building a strong and effective workforce, and engaging and collaborating with organizations. Their focus on these activities was evident by the infrastructure goals they consistently met or exceeded. Cayuga County also scored high on the SOC Implementation Survey compared to NYS overall, suggesting these efforts have been fruitful.

Program Characteristics

Findings on program characteristics address the referral process and program completion. In general, results were very consistent with results from the first two years. Child welfare, mental health, and schools accounted for over 80% of all referrals sources. Referrals were most likely to come from child welfare for SafeCare and from

mental health for all other programs. Behavioral concerns (e.g., aggression, defiance, acting out, impulsivity, excessive over-activity) were the most frequent reasons for referral, present in over half of the cases, and was the top referral reasons across all programs except SafeCare. MST and HFW both had an average of five reasons for referral indicated (down from an average of six from the first two years), suggesting that these youth had complex needs.

Most referrals enrolled into programs. Of these referrals, more cases were referred to Triple P and SafeCare than other programs (likely because Triple P and SafeCare have larger SAMHSA-funded capacities than other programs). On average, programs had completion rates of 80%. The highest completion rate was SafeCare (94%); HFW had the lowest rate for Year Three (0%), but also the fewest participants. Participants who completed a program participated an average of one month longer than those who did not complete a program.

Participant Characteristics

Findings on participant characteristics report on the demographics of the program population, particularly gender, race/ethnicity, and age. Results were very consistent with those from the first two years. Overall, the gender distribution of program participants reflected the youth population in Cayuga County. Triple P served a greater proportion of male participants, whereas FFT and HFW served a larger proportion of female participants. The SAMHSA-funded programs served a population that was more racially/ethnically diverse than youth in Cayuga County in general. Cayuga County FAST programs served a wide range of youth averaging from less than two years old (in SafeCare) to about 14 years old (in MST and HFW).

Outcomes

Findings on outcomes reflect changes over time on several youth and caregiver measures. Results were very consistent with the findings from the Year Two report. Significant changes in youth outcomes were reflected by a significant reduction in scores on the Pediatric Symptoms Checklist. Significant changes in caregiver outcomes were reflected by a significant reduction in scores on caregiver strain, a significant increase in scores in parenting competence, and a significant increase in family feelings of empowerment, suggesting caregivers benefited from these programs. Changes in child impairment were not significantly different, however the mean trend was in the direction that suggested improvement. In addition, participants had a positive perception of the programs, particularly with how they were treated by providers.

HFW Pilot

Findings regarding the HFW pilot are preliminary because very few youth have been served in this program so far but may still be helpful for planning for Year Four and beyond. Scores for fidelity of implementation and wraparound adherence are relatively low but are generally consistent with NYS' scores, indicating that others are also struggling with fidelity. This challenge is likely a result of the pilot nature of this program, as it is new and still developing. In addition, Cayuga County has faced challenges in discharging youth after a transition phase. Again, this is a struggle for other sites statewide as well. With additional program development and coaching, scores will likely improve.

Takeaways and Recommendations:
This snapshot of the first three years of the grant provides some interesting takeaways and recommendations.

- **Continue to develop and maintain SOC infrastructure:** The number and various types of infrastructure activities developed through Year Three indicates a strong commitment to building an effective SOC infrastructure. Continuing these efforts, along with focusing more specifically on some of their own challenging SOC areas (e.g., cultural and linguistic competence and commitment of youth and family

leaders), will help Cayuga County better support implementation of children's mental health programs in their area and further sustain their SOC.

- **Highlight cultural strengths:** Cayuga County's lowest scoring infrastructure domain was cultural and linguistic competence, reflecting that stakeholders feel this is a challenge for the county. Lower scores may reflect a lack of awareness rather than a weakness. Cayuga County was effective at reaching and serving a population more diverse than the general county youth population. In addition, reflecting the family's culture in the family story was a strength for Cayuga County in HFW compared to NYS. Both of these pieces reflect cultural strengths of programs in Cayuga County. By highlighting strengths in the cultural competence domain, stakeholders may become more aware of these high points.

- **Flow of programs is consistent:** The number of enrollments and discharges were very similar for Years Two and Three, and therefore are likely indicative of the annual capacity for these programs. This information can be helpful for planning in future years.

- **Participant population is consistent:** The youth served in Year Three seem very similar to the youth served in Years One and Two. Administrators can use information on the gender, age, race/ethnicity, and agency involvement of participants to understand if they are reaching the populations they intend to reach.

- **Explore intervention strategies for families who struggle with engagement:** There were challenges engaging some families in programs. Interestingly, those who did not complete the program were in the program about 75% as long as completers but completed less than a third as many sessions, indicating non-completers were attending sessions less frequently than completers. Families who do not complete the program may struggle to fully engage or commit to the program. Identifying families with longer delays between sessions early on can signal that extra efforts are needed to address barriers to retain them in the program.

- **Monitor promising outcome data:** Some outcomes reflect significant improvements between baseline and discharge. Symptoms decreased significantly, caregiver strain decreased significantly, and parenting sense of competence and family empowerment increased significantly. For other outcomes (i.e., impairment), the means at baseline and discharge trended in the correct direction, although the change did not reach significance. Perception of care at discharge was also positive. Continued monitoring of these outcomes can ensure that programs are moving in the right direction.

- **Strategize ways to maximize program completion for HFW youth:** Youth in the HFW program have complex needs compared to youth in other programs. In addition to mental health challenges, these youth are more likely than those in other programs to have substance abuse and juvenile justice challenges and to be involved with more agencies at enrollment. These complex needs are likely contributing factors to struggles with getting youth and families to complete the program, with most stopping the program prior to completion. Finding ways to overcome these challenges and best help these high-needs youth will be necessary for the program to be successful.

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