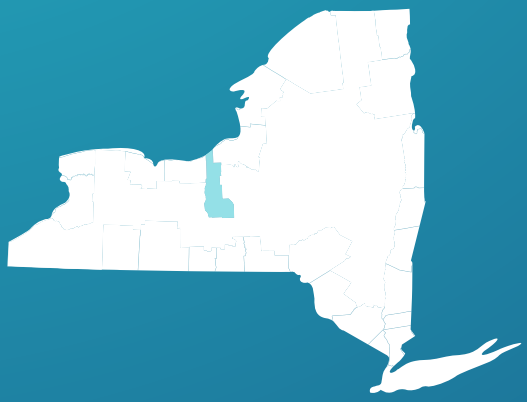
Cayuga County Families Access to Services Team

Year Four



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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 joined the New York State (NYS) High Fidelity Wraparound (HFW) pilot as part of their SAMHSA grant.[1] Table 1 outlines each of the SAMHSA-funded FAST programs in more detail.

Table 1. SAMHSA FAST program description and capacity[2]

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.

[1] FAST ended their participation in the HFW pilot 7/1/20

[2] 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 July 1, 2020. 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 Four, Quarter Three.

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. Additional data about the HFW pilot program was available from the Wrap-NY website, which contains digital health information. Participant data were obtained from administrative records and interviews (when applicable) for a total of 565 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 six sections: (1) SOC implementation, (2) SOC infrastructure, (3) program characteristics, (4) participant characteristics, (5) family outcomes, and (6) findings specific to the HFW pilot program. Important findings are bolded for emphasis.

SOC Implementation

In early 2019 and 2020, two surveys were distributed statewide to understand more about SOC implementation at the county-level. This section reviews the overall findings. County representatives from child-serving systems received the SOC Implementation survey (adapted from Stroul, Dodge, Goldman, Rider, & Friedman, 2015) which is designed to "…assess progress in a community or region implementing the SOC approach…"

The following table shows the mean section scores for Cayuga County and New York State (NYS) for both the 2019 and 2020 survey administration. **Cayuga County average scores were higher than NYS averages in nearly all domains, suggesting that Cayuga County had strong SOC implementation among NYS counties**. In addition, compared to other counties, Cayuga County was among the highest scoring NYS counties on overall SOC implementation in both 2019 and 2020 (not pictured).

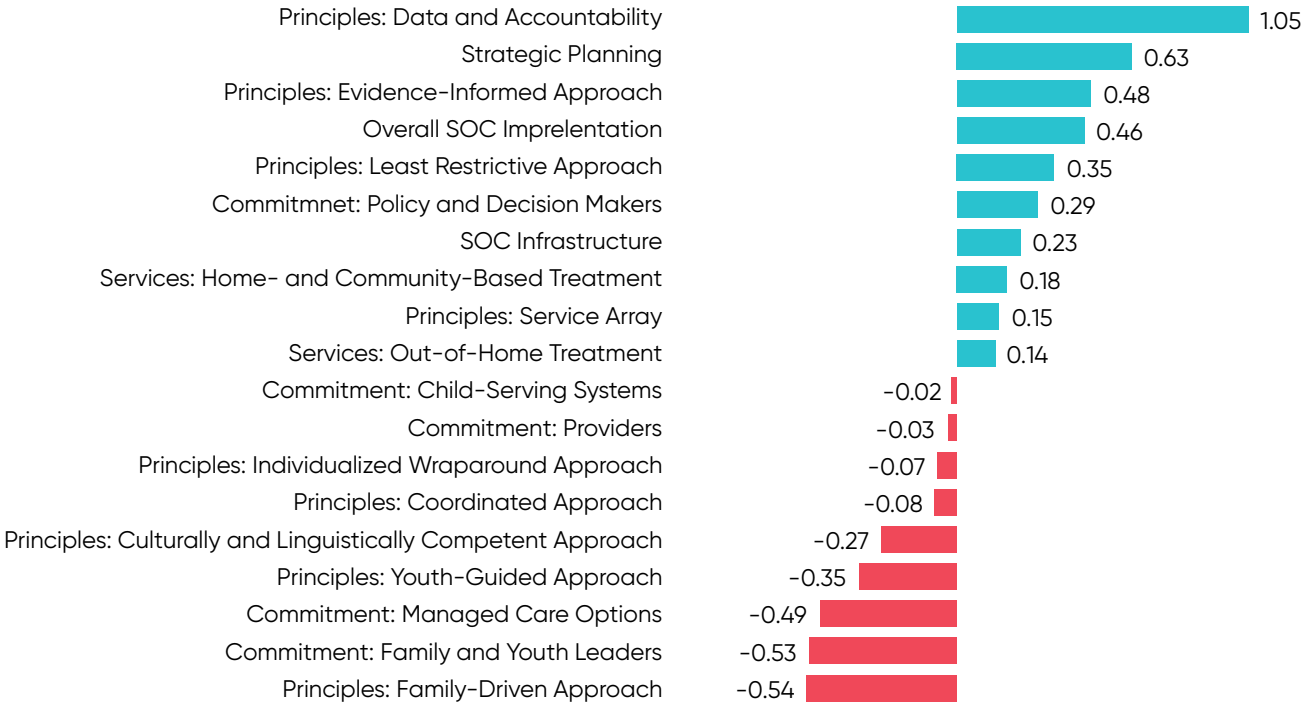
Examining the 2020 Cayuga County results can help to identify areas of strength and weakness. Challenging areas were those with the lowest scores: culturally and linguistically competent approach, youth-guided approach, and commitment of managed care organizations; whereas areas of strength are those with the highest scores: strategic planning, evidence-informed approach, and least restrictive approach.

Table 2. Mean scores on survey subscales in 2019 and 2020, NYS and Cayuga County

	2019		2020	
	Cayuga	NYS	Cayuga	NYS
Strategic planning	3.26	2.28	3.89	2.01
Principles				
Individualized Wraparound Approach	3.33	2.70	3.26	2.63
Family-Driven Approach	3.32	2.80	2.78	2.71
Youth-Guided Approach	2.73	2.38	2.38	2.23
Coordinated Approach	3.15	2.68	3.07	2.61
Culturally and Linguistically Competent Approach	2.20	2.17	1.93	2.07
Evidence-Informed Approach	3.40	2.55	3.88	2.39
Least Restrictive Approach	3.43	2.76	3.78	2.64
Service Array	2.93	2.32	3.08	2.11
Data and Accountability	2.50	2.68	3.55	2.54
Services				
Home- and Community-Based Treatment	2.78	2.27	2.96	2.18
Out-of-Home Treatment	2.68	2.10	2.82	2.04
Infrastructure	2.88	2.15	3.11	2.10
Commitment				
Child-Serving Systems	2.89	2.43	2.87	2.34
Policy and Decision Makers	3.11	2.39	3.40	2.35
Providers	3.33	2.79	3.30	2.73
Family and Youth Leaders	3.13	2.65	2.60	2.63
Managed Care Organizations	2.93	2.36	2.44	2.31
Overall Assessment	3.04	2.26	3.50	2.17

Examining change in scores between the two administrations indicates areas that improved or declined over the year. Figure 1 shows the difference between 2020 and 2019 average scores for Cayuga County. Data and accountability and strategic planning were on average more than a half a point higher in 2020 compared to 2019, whereas family-driven approach and commitment of family and youth leaders were on average more than a half a point lower in 2020 compared to 2019. Although Cayuga County implementation in these declining areas is still higher than NYS averages, it may be beneficial to focus efforts on the youth and family-driven aspect of the local SOC. In addition, **the mean overall assessment of SOC Implementation was nearly a half a point higher in 2020 compared to 2019, suggesting respondents perceived stronger county SOC implementation.**

Figure 1. Difference in mean subscale scores between 2019 and 2020, Cayuga County



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 all support the System of Care approach.

Cayuga County built their SOC infrastructure by addressing key areas. Throughout the grant, Cayuga County set goals for each of the four indicators described below. Cayuga County regularly compared their progress on indicators with their goals to track SOC infrastructure development. Table 3 describes the key infrastructure areas and the Cayuga County totals per key area through Year Four, Quarter Three.

Table 3. IPP indicators and total number of reported indicators through Year Four, Quarter Three

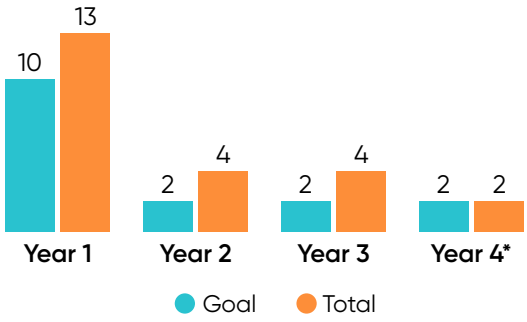
Focus Area	Indicator ID	Definition	Total
Policy Development	PD1	The number of policy changes completed as a result of the grant.	23
Workforce Development	WD2	The number of people in the mental health and related workforce trained in mental health-related practices/activities that are consistent with the goals of the grant.	276*
	WD5	The number of consumers/family members who provide mental health-related programs as a result of the grant.	21**
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.*

Policy Development

By the end of Year Four, Quarter Three, Cayuga County established 23 policies to address specific county and mental health program needs. Policies regarding specific programs (e.g., respite, PINS, mobile crisis, HFW), FAST guidelines, referral processes, funding, Health Homes Serving Children, telehealth/COVID-19 practices, EHR documentation, and data collection were developed or modified to help connect partners, streamline procedures, and increase accessibility to programs. Figure 2 shows the number of policies established per year compared to the goals set by Cayuga County. Goals were consistently met or surpassed each year over the four-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.**

Figure 2. Number of reported PD1 indicators (policies) and goals, by year



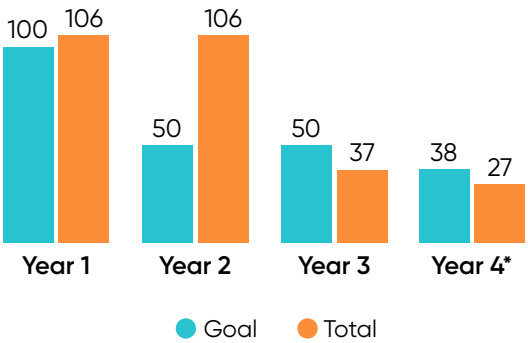
Note. *Numbers reflect goal and total reported indicators for three-fourths of the year (through Year Four, Quarter Three).

Workforce Development

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 Four, Quarter Three, 276 people in the mental health and related workforce were trained in various practices and procedures. 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, LGBTQ+, 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 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's Mental Health Awareness Day; the NYS SOC Summit; and the Annual SPOA Conference.

Figure 3 displays the number of staff trained per grant year, compared to the goals set by Cayuga County. **Trainings were more prevalent in the earlier years of the grant, which is consistent with initiation of SOC focus and new priorities.** While goal attainment fell short in Years Three and Four, the county still exceeded their original goals for the other years. Fewer training attendees in Year Four could be explained by COVID-19 leading to the suspension and cancellation of in-person trainings and the Tampa Conference. In addition, Year Four numbers do not reflect the entire year so Cayuga staff may attend additional trainings in the final quarter of Year Four.

Figure 3. Number of reported WD2 indicators (trained staff) and goals, by year



Note. *Numbers reflect goal and total reported indicators for three-fourths of the year (through Year Four, Quarter Three).

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

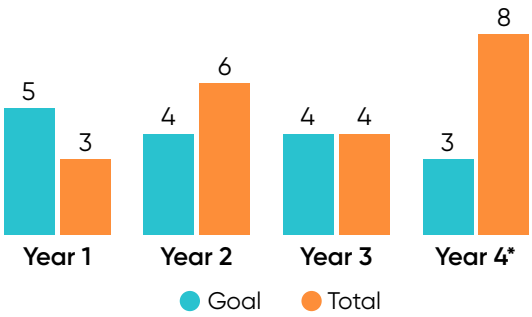
regarding programs, which is a key component of the System of Care approach. Figure 4 displays the number of peers providing services per grant year compared to the goals set by Cayuga County. While goal attainment fell short in Year One, the county met or exceeded their goals for all subsequent years. 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. **Throughout the project, peers provided support, advocacy, and interventions to families receiving mental health services, attended FAST meetings, and participated as members of the Cayuga County Board.**

Partnership and Collaborations

Building relationships with community partners strengthens an SOC. Figure 5 displays 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 Years Two and Four, the county met or exceeded their goals for the other two years.

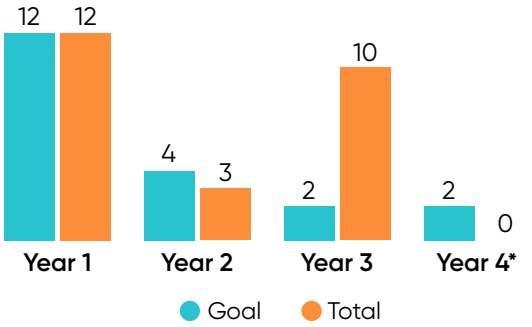
Early on, the county identified and contracted with specific agencies and systems to participate in FAST meetings and Cayuga County's SOC meetings. FAST partnered with multiple Health Homes Serving Children to better link and coordinate programs for families. Contracts were also established to create 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.

Figure 4. Number of reported WD5 indicators (consumers providing services) and goals, by year[3]



Note. *Numbers reflect goal and total reported indicators for three-fourths of the year (through Year Four, Quarter Three).

Figure 5. Number of reported PC1 indicators (formal agreements with partners) and goals, by year



Note. *Numbers reflect goal and total reported indicators for three-fourths of the year (through Year Four, Quarter Three).

Program Characteristics

This section includes information about referrals, program completion, lengths of episodes of care, and number of participants served during 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.

Program Enrollments and Discharges

Figure 6 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 SAMHSA program, not opened, or was pending. **Nearly three-quarters of all referred cases enrolled into programs**, and an additional 1% of cases were pending enrollment. About a quarter of cases referred to SAMHSA FAST programs never enrolled. Reasons for cases not

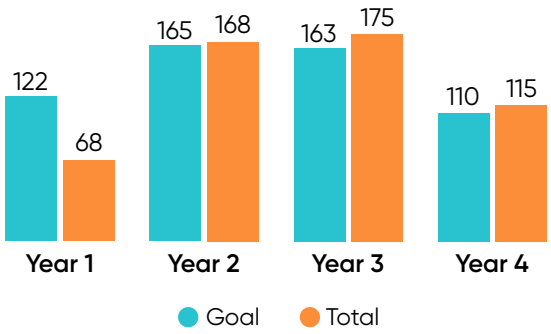
[3] *Note peer counts are cumulative for each quarter a peer provides services, e.g., if one peer provides services for two quarters, the response on this indicator is two.*

opening were available for 169 out of 190 cases. The most common reasons for not enrolling were that family/youth declined or refused programs (40%), the program provider was unable to engage the family/youth (22%), referral included multiple members of the same family who were enrolled in programs, but only one member could be identified for evaluation purposes (6%), and youth was served by another program or service system (6%).

Figure 6. Enrollment status of cases coming through FAST (N=763)

Figure 7 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. Year Four includes the first three quarters of the year. **Program enrollments and discharges were consistent for the last three years.** 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, Three, and Four as well as "even" enrollments and discharges. Although the full year was not included in this figure, it appears that Year Four will have fewer enrollments and discharges than previous years. If the current rate continues, there will be about 147 enrollments and 153 discharges. This likely reflects the winding down of SAMHSA-funded programs as well as slower activity due to changes due to COVID-19. This information can be helpful in planning for program capacity in future years.

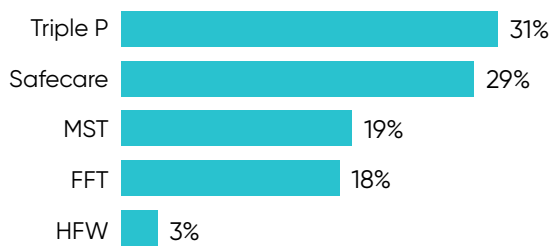
Figure 7. Enrollment and discharge count, by year (N Enrolled=565, N Discharged=528)



Program Referrals

Figure 8 displays the distribution of referrals to SAMHSA-funded programs. Consistent with last year (not displayed), a greater proportions 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 and limited capacity for this program.

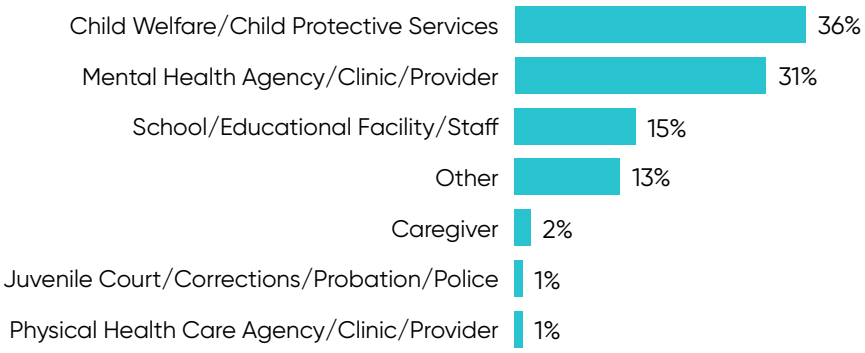
Figure 8. Programs to which cases are referred (N=757)



Note: Six referrals did not have a program identified.

Figure 9 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.** Within the "other" category, care managers (15 cases), Family Preservation Program (eight cases), peer partners (three cases), and crisis services (three cases) were frequently indicated as referral sources.

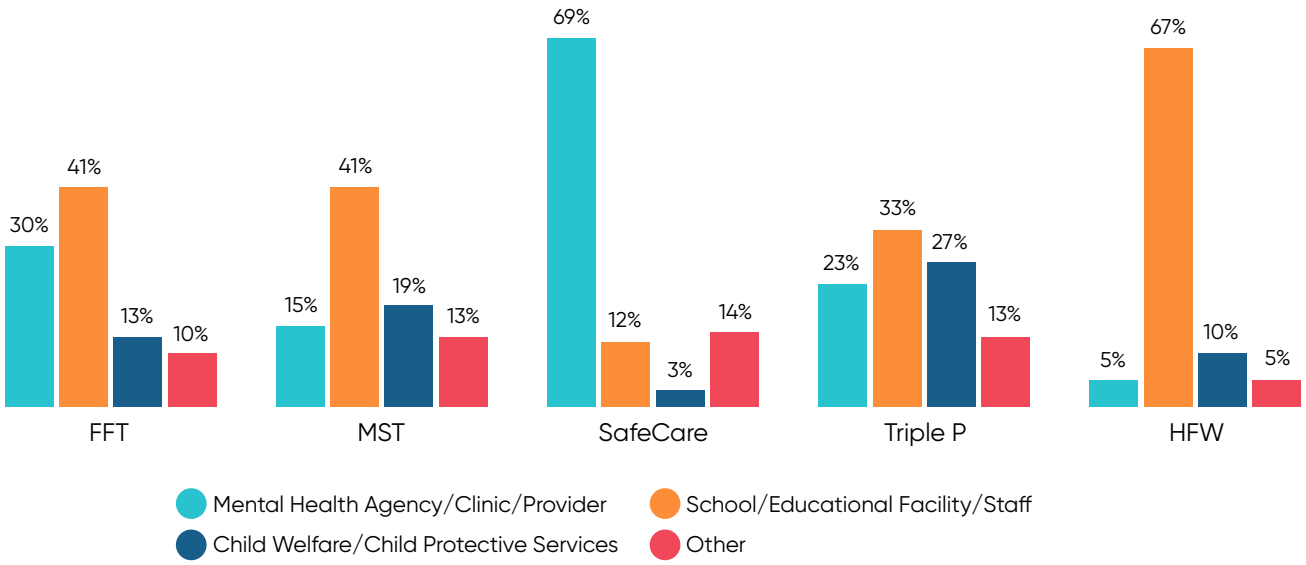
Figure 9. Referral source (N=548)



Note: Referral source was not reported for 17 episodes of care.

Referral sources varied by program, displayed in Figure 10. **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, 10% of HFW cases were referred from Juvenile Court (not displayed).

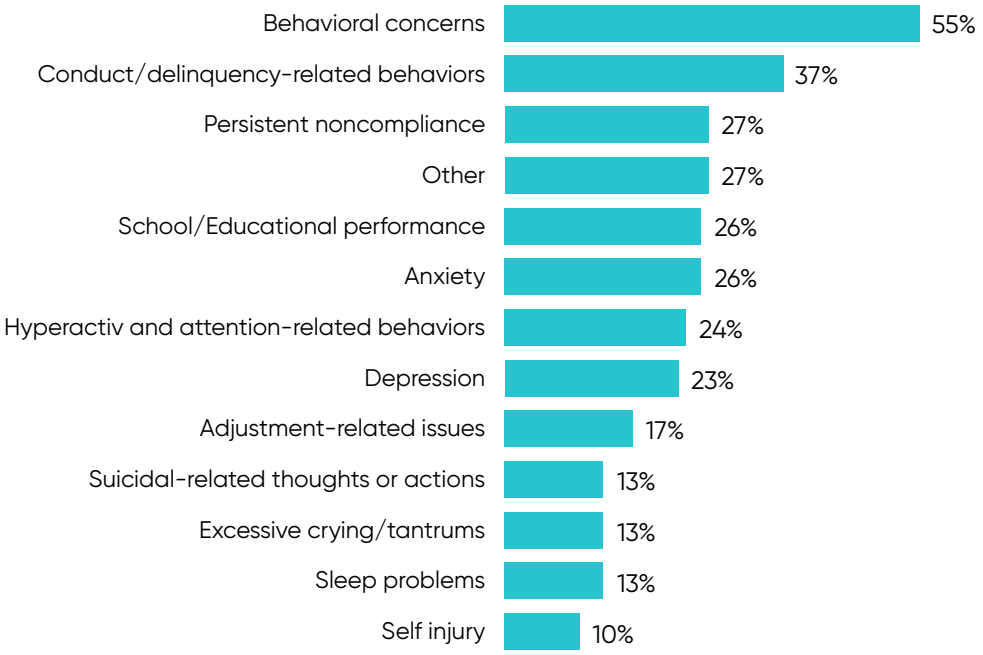
Figure 10. Referral source by program for top four referral sources (N=548)



Note: Referral source was missing for 17 cases. Referral sources from family court, juvenile court, caregivers, early intervention, intellectual disabilities, and physical health care were less common and therefore are not displayed.

Agencies referred participants to services for diverse reasons. The reasons for referral that were present in 10% or more of cases are displayed in Figure 11.[4] **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, and persistent non-compliance was present in over a quarter of cases. The next most common reason for referral was "other;" about 40% of the "other" responses indicated a need or desire for parenting skills/assistance. The number of reasons for referral per case varied from 1-21, with an average of four reasons for referral.

Figure 11. Most common reasons for referral (N=557)



Note: Referral reasons missing for eight cases.

Reasons for referral varied by program (see Table 4). **Behavioral concerns and conduct were common reasons for referral across all programs, with the exception of SafeCare.** Anxiety and depression were the most common reasons for referral for HFW (each present in over three-quarters of the participants). 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; where parenting and/or a need for parenting classes was frequently indicated. **MST and HFW both had an average of five reasons for referral indicated, suggesting that these youth had particularly complex needs.**

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

Table 4. Top referral reasons and mean number of reasons, by program (N=544)

FFT Mean # of reasons= 4 N=95	MST Mean # of reasons=5 N=109	SafeCare Mean # of reasons= 2 N=161	Triple P Mean # of reasons= 4 N=158	HFW Mean # of reasons= 5 N=21
Behavioral concerns (64%)	Behavioral concerns (71%)	Other (primarily need for parenting skills) (60%)	Behavioral concerns (75%)	Anxiety (81%)
Conduct (48%)	Conduct (64%)		Conduct (43%)	Depression (76%)
Depression (47%)	School performance (50%)		Hyperactive and attention-related behaviors (41%)	Behavioral concerns (67%)
Anxiety (44%)	Persistent noncompliance (41%)		Persistent noncompliance (36%)	Conduct (62%)
Persistent noncompliance (35%)	Depression (40%)		School performance (33%)	School performance (57%)
	Anxiety (39%)			Suicide-related thoughts or actions (33%)

Note: Referral reasons missing for two FFT cases, three SafeCare cases, and three Triple P cases.

Program Participation and Completion

Figure 12 displays the number of youth served in each of the programs across all 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 13 displays the percentage of enrollees who completed each program by the grant year in which they were discharged. Successful completion of a program is defined as the participants completing all sessions of the program (i.e., the participant did not drop out early). **More than three-quarters of participants who were discharged from their programs in Year Four successfully completed their program.** SafeCare and MST had the highest and HFW had the lowest completion rates in Year Four. Overall, completion rates generally improved after the first year of the grant, though there was variation by program.

Figure 12. Number of youth served in each SAMHSA-funded program (N=565)

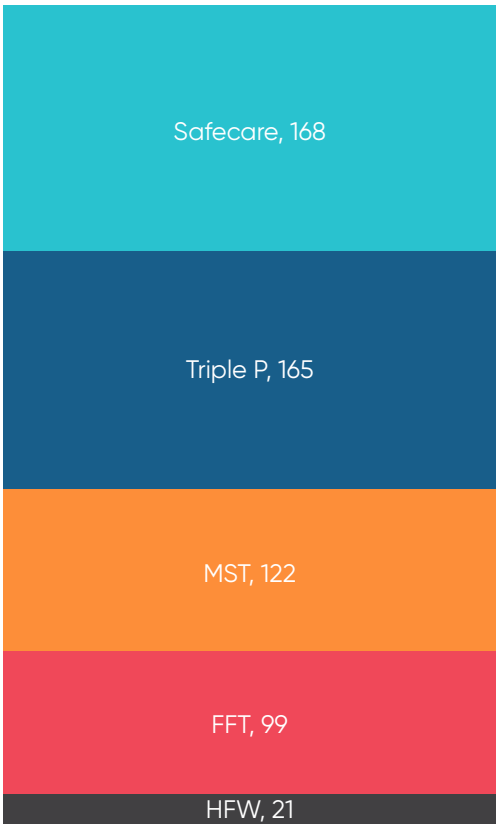
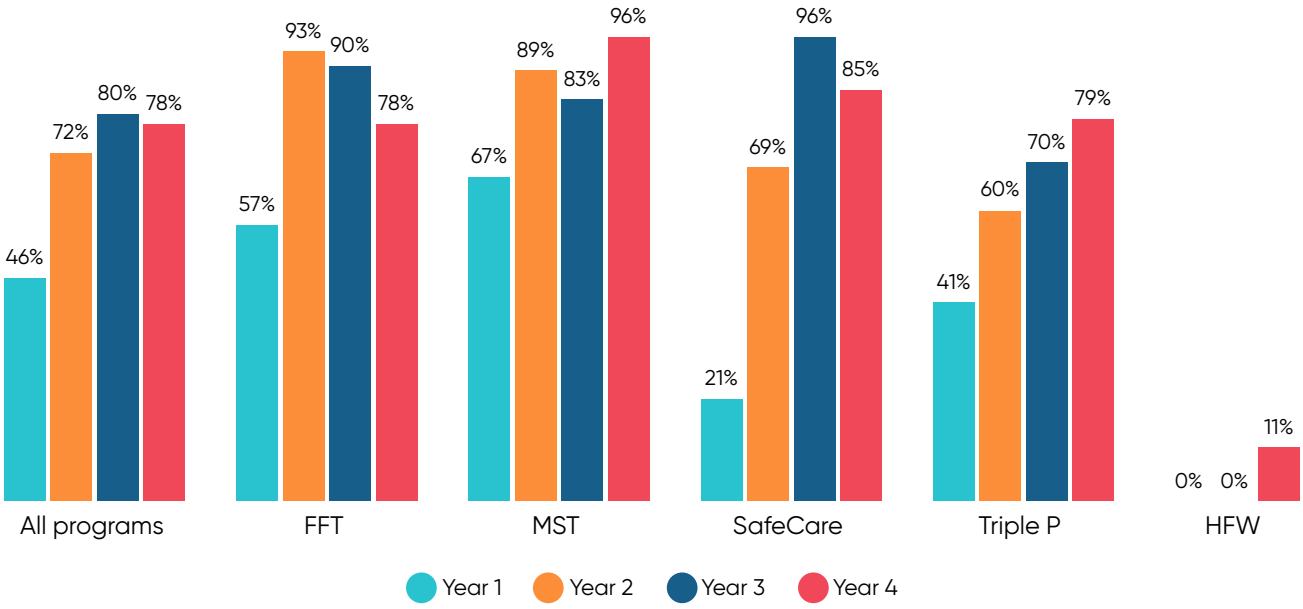


Figure 13. Percentage of participants discharged in each year who successfully completed program (N=526)



The following two tables display the average length of stay and number of sessions completed by program. Table 5 displays the average length of stay for those who successfully completed a program (i.e., successful completions) compared to those who dropped out early and did not complete their program (i.e., unsuccessful completions), displayed by program. **Participants who successfully completed a program participated about two weeks longer on average than those who did not complete their program.** Interestingly, those who did not successfully complete the program were enrolled for about 3.20 months on average which is still a sizable "dose" of the program. Successful completers were in the program longer than unsuccessful completers for all programs except for Triple P, where the length of time in the program was comparable between successful and unsuccessful completers.

Table 5. Mean months in program, by status at discharge (N=526)

	Successful Completions		Unsuccessful Completions	
	N	Mean	N	Mean
FFT	77	4.31	16	2.76
MST	85	4.42	15	1.97
SafeCare	114	3.99	39	2.80
Triple P	105	2.45	54	2.51
HFW	1	9.50	20	7.12
All Programs	**382**	**3.74**	**144**	**3.20**

Note: Months were counted as 30 days. One Triple P and 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 half as many sessions as those who did successfully complete. Interestingly, those who successfully completed the program completed on average 4.84 sessions a month compared to 1.52 sessions a month for unsuccessful completers. **This pattern may indicate that families who do not successfully complete the may struggle to fully engage or commit to the program.**

Table 6. Number of sessions completed by program, by status at discharge (N=507)

	Successful Completions		Unsuccessful Completions	
	N	Mean	N	Mean
FFT	74	13.86	16	4.65
MST	76	39.11	12	17.08
SafeCare	110	14.83	39	4.16
Triple P	105	8.88	54	3.56
HFW	1	4.00	20	2.20
All Programs	**366**	**18.10**	**141**	**4.85**

Note: One Triple P and one FFT case missing completion status. Remaining 19 missing cases were missing number of completed sessions. Number of sessions for HFW only includes child and family team meetings (CFTMs).

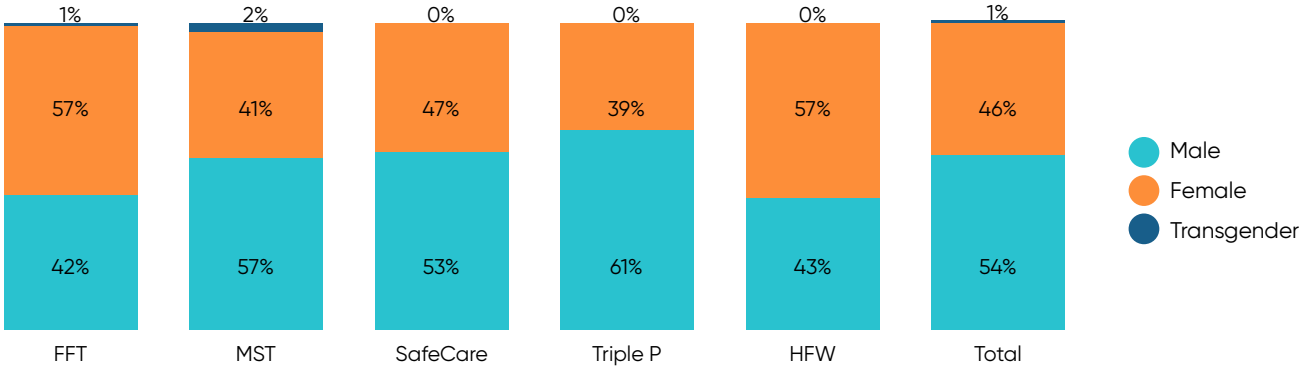
Participant Characteristics

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.

Gender

Figure 14 displays participant gender both by program and across all programs. **In Cayuga County, 52% of youth are male and 48% are female according to US Census data (not displayed); in SAMHSA-funded programs, males are slightly over-distributed (57%) compared to county youth.**[5,6] Triple P serves the largest proportion of males (65%), whereas FFT and HFW serve the largest proportion of females (55% and 57% respectively).

Figure 14. Participant gender, by program and overall (N=557)



Note: Gender missing for eight participants.

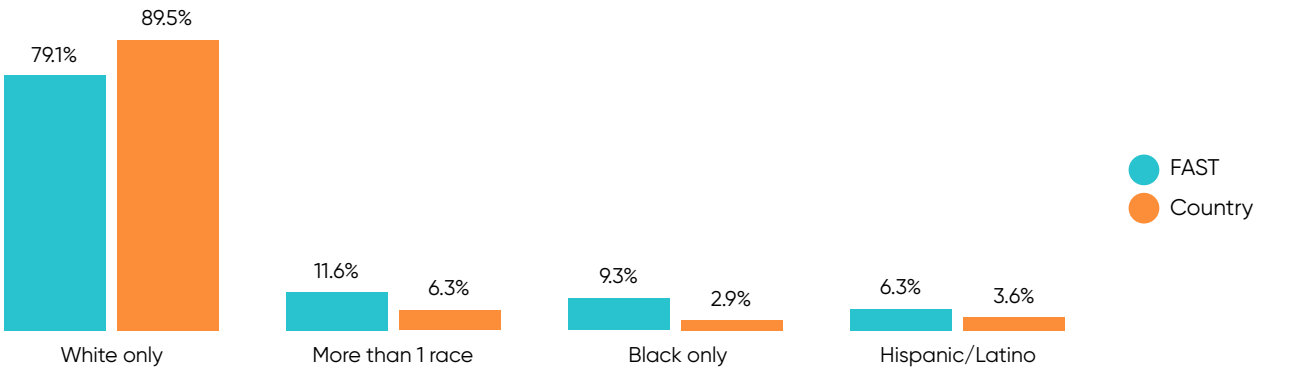
[5] US Census data provides the sex information for children in Cayuga County. In order to compare county level sex breakdowns and program level sex breakdowns, some assumptions were made. Although sex and gender may differ, since SAMHSA offered a transgender option for their gender item, it is likely 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.

[6] County data obtained from Table S0101, American Community Survey, 2018 5-yr estimates.

Race and Ethnicity

Figure 15 displays the race and ethnicity of the program participants compared to US Census Cayuga County estimates for residents under the age of 18.[7] In order to compare the race and ethnicities of the program population with the US Census data, the information is presented in exclusive categories (i.e., more than one option could not be selected for the US Census date). **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 youth who selected more than one race, 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 (88%), Black and White were selected, with 5% selecting White and American Indian, 5% selecting White and Asian, and 2% selecting Black and Asian.

Figure 15. Race and ethnicity sample characteristics (Race N=470, Hispanic/Latino N=474), compared to county estimates

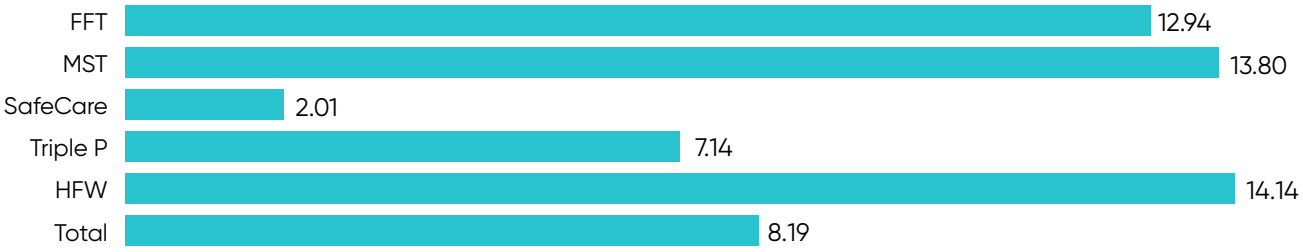


Note: Race/ethnicity missing for 91 participants.

Age

The average age of the participant by program and across all programs is displayed in Figure 16. **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 program guidelines (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 16. Average age, by program and overall (N=559)



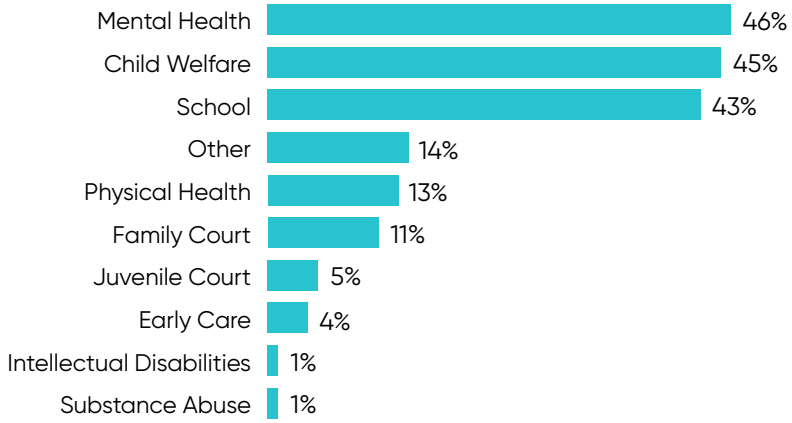
Note: Age missing for 7 participants.

[7] County estimates obtained from American Community Survey 5-yr estimates, 2018, table S0901

Agency Involvement

Participants were involved in a variety of agencies at baseline, as seen in Figure 17. **Agency involvement mirrored referral source, such that the top three were mental health, child welfare, and school.** FAST programs served few youth with juvenile court, early care, intellectual disability, and substance abuse agency involvement.

Figure 17. Agency involvement at baseline, most common (N=541)



Note: Agency involvement missing for 24 participants.

On average, participants in FAST programs were involved in 1.81 agencies at baseline (ranging from 1.68 for SafeCare to 1.85 for MST). HFW participants were involved in 2.52 agencies on average, which may be due to the high acuity and multiple system involvement requirements for HFW.

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 and family court, whereas has the largest proportion of cases involved in substance abuse, juvenile court, school, and mental health, and physical health.**

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

	FFT	MST	SafeCare	Triple P	HFW	All Programs
N	95	106	164	157	21	543
Mental Health	61%	60%	14%	55%	90%	46%
Child Welfare	31%	25%	84%	29%	14%	45%
School	46%	54%	16%	56%	95%	43%
Physical Health	16%	14%	9%	14%	24%	13%
Family Court	6%	7%	21%	6%	0%	11%
Juvenile Court	8%	11%	0%	1%	19%	5%
Early Care	0%	0%	11%	1%	0%	4%
Intellectual Disabilities	1%	1%	1%	2%	0%	1%
Substance Abuse	2%	0%	1%	0%	5%	1%
Other	16%	15%	12%	17%	5%	14%

Note: Agency involvement missing for 24 participants.

Family 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.

Youth Symptoms

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 0 ("never," indicating that this symptom is never present) to 2 ("often," indicating the symptom is often present) scale.

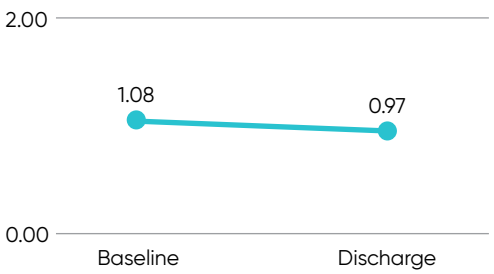
Table 8 displays the average score on the PSC at baseline and discharge from programs. Figure 18 displays the overall average change in PSC score over time. At both time baseline and discharge, the average score on the PSC was around the midpoint of the scale, corresponding with a score of "sometimes." Across all programs, **the average score on the PSC decreased by 0.12 points between baseline and discharge** (see Figure 18). **This reduction was statistically significant (t = 3.80, p < 0.001), suggesting a decrease in symptomology by program discharge.** This effect size is considered to be between a small and medium effect[8], *Cohen's d* = 0.32

Table 8. Means for paired samples on the PSC, overall and by program (N=104)

		Baseline	Discharge
FFT	34	1.06	0.98
MST	28	1.11	0.96
Triple P	28	1.10	0.96
HFW	11	1.29	1.22
All Programs	104	1.11	0.99

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 18. Mean for paired samples on the PSC, over program tenure (N=104)



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

Youth Impairment

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 19 displays the overall average change in CIS score over time. At both baseline and discharge, 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 0.13**; this reduction was statistically significant (t = 2.02, p = 0.046). This effect size is considered a medium to large effect, *Cohen's d* = 0.65.

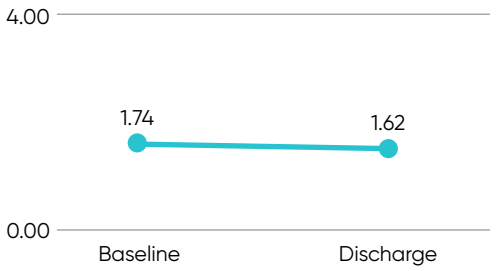
[8] Cohen's D effect sizes are generally considered small at 0.2, median at 0.5, and large at 0.8 based on ranges in Cohen, 1988.

Table 9. Means for paired samples on the CIS (N=105)

		Baseline	Discharge
	N	Mean	Mean
FFT	34	1.70	1.66
MST	28	1.88	1.64
Triple P	29	1.67	1.56
HFW	11	2.14	1.99
All Programs	105	1.78	1.65

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 19. Mean for paired samples on the CIS, over program tenure (N=105)



Note: Difference is significant (t = 2.02, p = 0.046)

Caregiver Strain

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.

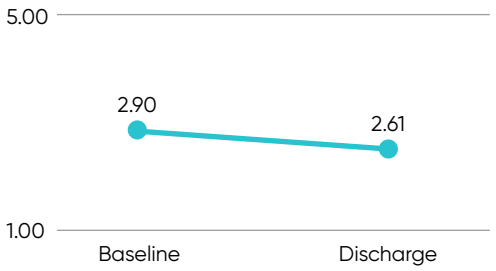
Table 10 displays the average score on the CSQ at baseline and discharge from programs. Figure 20 displays the overall average change in CSQ score over time. At both baseline and discharge, the average score on the CSQ was slightly below the midpoint of the scale, indicating that average caregiver strain was between "a little" and "somewhat" (See Table 10). **The average score on caregiver strain decreased between baseline and discharge by 0.29 points, and this reduction was statistically significant ($t = 4.23$, $p < 0.001$), 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). This effect size is considered a medium to large effect, *Cohen's d* = 0.74.

Table 10. Means for paired samples on the CSQ (N=119)

		Baseline	Discharge
	N	Mean	Mean
FFT	35	2.97	2.65
MST	28	3.05	2.74
Triple P	40	2.69	2.34
HFW	11	3.46	3.35
All Programs	119	2.90	2.61

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.

Figure 20. Mean for paired samples on the CSQ, over program tenure (N=119)



Note: Difference is significant (t = 4.23, p < 0.001)

Table 11. Means for paired samples on the CSQ subscales, across all programs (N=119)

	Baseline	Discharge
	Mean	Mean
Objective	2.82	2.54
Externalized	2.18	1.98
Subjective Internalized	3.55	3.19

Family Empowerment

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).[9] 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, because these programs serve older youth.

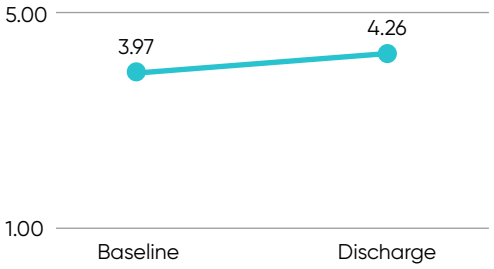
Table 12 displays the average score on the FES at baseline and discharge from programs. Figure 21 displays the overall average change in FES score over time. At both baseline and discharge the average score on the FES was around a four, corresponding with "often" (See Table 12). Thus, caregivers tended to feel above-average empowerment at both baseline and discharge. **The average score on family empowerment increased between baseline and discharge by 0.29 points, which was statistically significant (t = -4.87, p < 0.001), suggesting family empowerment improved over the course of program participation.** This effect size is considered a small to medium effect, *Cohen's d* = 0.43.

Table 12. Means for paired samples on the FES (N=51)

		Baseline	Discharge
	N	Mean	Mean
FFT	22	3.98	4.28
MST	18	4.03	4.35
HFW	11	3.83	4.07
All Programs	51	3.97	4.26

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 21. Mean for paired samples on the FES, over program tenure (N=51)



Note: Difference is significant (t = -4.87, p < 0.001)

Parenting Sense of Competence

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," indicating that the parent does feel competent on an item) 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 22 displays the overall average change in PSOC score over time. At both baseline and discharge, the average score on the PSOC was between a four and a five, indicating caregivers tended to "agree" or "somewhat agree" in their competence on the items (see Table 13). **The average score on parenting competence increased between baseline and discharge by 0.12 points, and this increase was statistically significant (t = -2.20, p < 0.031), suggesting feelings of parenting competence improved over the course of program participation.** This effect size is considered a small to medium effect, *Cohen's d* = 0.46.

[9] 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.

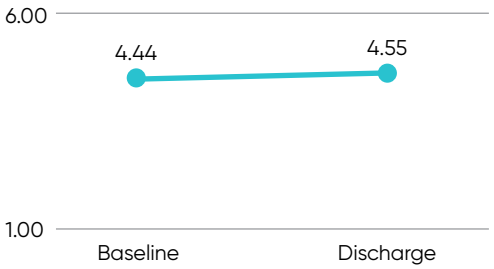
This increase was seen primarily in the Triple P families, who tended to have lower baseline scores, and thus greater room for improvement in parenting competence.

Table 13. Means for paired samples on the PSOC (N=76)

		Baseline	Discharge
	N	Mean	Mean
Triple P	39	4.14	4.34
SafeCare	37	4.75	4.78
All Programs	76	4.44	4.55

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 22. Mean for paired samples on the PSOC, over program tenure (N=76)



Note: Difference is significant (t = -2.20, p < 0.031)

Perception of Care

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.

Figure 23 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". **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.**

Figure 23. Mean perception of care per item at discharge (N=249)

HFW 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 has served 21 youth in this program. This section includes 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. The following findings should be interpreted with caution due to the small number of participants in the HFW program.

Length of Stay and Meeting Productivity

Table 15 displays the average length of stay and number of child and family team meetings (CFTMs) completed for Cayuga County HFW compared to the state averages. In Cayuga County, 10% (i.e., 2 of 21) of HFW cases were discharged in the transition phase, compared to 22% in NYS. Cayuga's cases that discharged in transition had fewer CFTMs and were in HFW longer than the NYS' average. Cayuga County's percentage of successful discharge was moderate (about half of the counties had better rates, and about half had worse rates), so Cayuga County is not alone in facing challenges getting families to transition. The length of stay (LOS) and number of CFTMs for early discharges were very similar between Cayuga and NYS (see Table 15). **Although there is room for improvement, Cayuga County's HFW completion rate was only slightly lower than 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		
	Mean Months	Mean # CFTMs	N	Mean Months	Mean # CFTMs	N
Discharged after transition	13.10	3.50	2	11.77	7.03	38
Discharged prior to transition	7.35	1.90	19	8.34	2.47	136

Program Fidelity

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, identifying youth and caregiver functional strengths, and using positive wording in the family vision.** Most of the lowest scores reflected a lack of documentation of different elements, indicating that these items were typically missing from the Wrap-NY website.

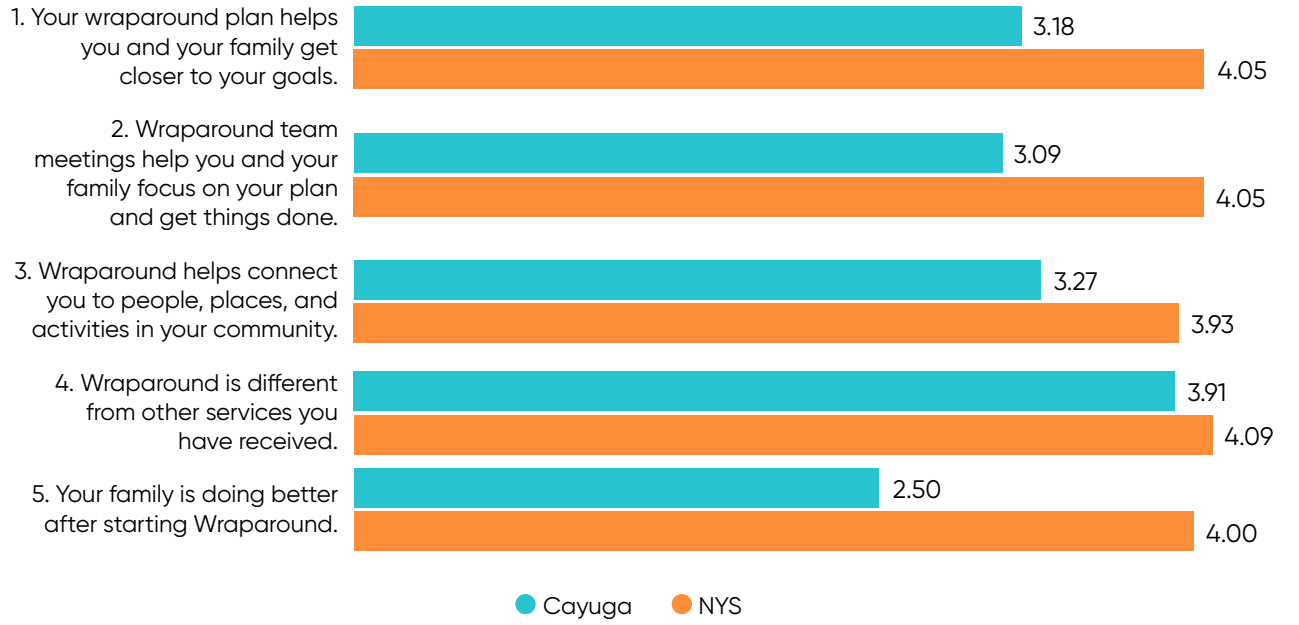
Table 16. Percent of elements present in the 45-Day Review, Cayuga County compared to NYS (Cayuga County N=18, NYS N=201)

		Cayuga	NYS
	N	18	201
1. Is there a crisis plan?		61%	60%
If yes, does it ensure location of crisis behavior is indicated? (e.g. acting out in school, withdrawing at home, etc.)		18%	23%
If yes, does it identify triggers that precipitate the crisis behavior? (and crisis behavior links to reason for referral)		82%	88%
2. Were any crisis events recorded?		0%	4%
If yes, was crisis plan updated within 24 hours?		0%	13%
If yes, was CFT held within 72 hours of a crisis event?		0%	0%
If no, should crisis event(s) have been recorded?		28%	15%
3. Did the POC include the family story?		39%	46%
If yes, did it include the family's culture?		60%	23%
4. Did the POC include youth strengths?		28%	39%
If yes, is at least one functional?		60%	54%
5. Did the POC include caregiver strengths?		28%	33%
If yes, is at least one functional?		60%	33%
6. Did the POC include youth needs?		17%	34%
If yes, is at least one underlying?		67%	51%
7. Did the POC include caregiver needs?		17%	25%
If yes, is at least one underlying?		33%	66%
8. Did the POC include the family vision?		22%	36%
If yes, was it positively worded?		75%	63%
If yes, was it about family and youth?		100%	78%
If yes, was it long-range?		75%	71%

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 24 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 lower than NYS on average.

Figure 24. Mean scores on Wraparound Scale items, Cayuga County and NYS (Cayuga County N=10-11, NYS N=107-108)



Conclusions and Recommendations

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

Summary of Findings

A summary of findings for each of the domains is presented below.

SOC Implementation

2020 SOC implementation survey findings suggest that the SOC in Cayuga County is strong, both compared to NYS and to earlier county scores. SOC implementation areas that were more challenging were culturally and linguistically competent approach, youth-guided approach, and commitment of managed care organizations, whereas areas of strength were strategic planning, evidence-informed approach, and least restrictive approach. In Cayuga County, the mean overall assessment of SOC Implementation was higher in 2020 compared to 2019, suggesting respondents perceived stronger SOC implementation in 2020. Looking closer into county responses identifies areas that improved: data and accountability and strategic planning and areas that decreased: family-driven approach and commitment of family and youth leaders.

SOC Infrastructure

Cayuga County dedicated many resources to developing their SOC during 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. Goals and practices around the infrastructure indicators generally started higher and declined as the grant progressed, consistent with additional activity and effort at the initiation of the grant.

Program Characteristics

Findings on program characteristics address program enrollments and discharges, program referrals, and program participation and completion. Child welfare and mental health accounted for about two-thirds of all referral sources, which is consistent with the program goals of parenting and mental health. Schools were the next most frequent referral source (15%); efforts were made during the grant to more intentionally collaborate with schools. 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 reason for MST, FFT, and Triple P. Anxiety was the top referral reason for HFW, and parenting needs was the top referral reason for SafeCare. MST and HFW both had an average of five reasons for referral, suggesting that these youth had complex needs.

Most cases referred to programs ended up enrolling 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 78% in the final year of the grant. The highest completion rate was MST (96%); HFW had the lowest rate (11%), but also the fewest enrollees/participants. Participants who completed a program completed on average 4.84 sessions a month compared to 1.52 sessions a month for unsuccessful completers.

Participant Characteristics

Findings on participant characteristics describe demographics of the program population, particularly gender, race/ethnicity, age, and agency involvement. Results were very consistent with those from earlier years. Overall, the gender distribution of program participants trended with a greater proportion of males than 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). Program participants were most likely to be involved in mental health, child welfare, and school services

Family Outcomes

Findings on outcomes reflected changes over time on several youth and caregiver measures. There were significant improvements in all outcome measures, evidencing improvement for both youth and caregivers. More specifically, improvements occurred in youth symptoms, youth impairment, caregiver strain, parenting sense of competence, and family empowerment. Improvements in youth symptoms, parenting sense of competence, and family empowerment were considered small to medium, whereas improvements in caregiver strain and youth impairment were medium to large. In addition, participants had a positive perception of the programs, particularly with how they were treated by providers.

HFW Pilot Program

The HFW pilot program in Cayuga County served 21 youth and young adults. Scores for fidelity of implementation documentation and wraparound adherence are relatively low in Cayuga County but are generally consistent with NYS' scores, indicating that others are also struggling with fidelity. In most areas, Cayuga County had more missing documentation than other NYS sites, but where documents were present, wraparound components were more likely to be in place. 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. In addition, participants tended 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. Cayuga County decided to end their participation in the pilot program in July 2020.

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 during the grant and high scores on the SOC implementation survey indicate a strong commitment to building an effective SOC infrastructure in the county. Continuing these efforts, along with focusing more specifically on some of their own challenging SOC areas (e.g., culturally and linguistically competent approach, youth-guided approach, and commitment of managed care organizations), 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 domain on the SOC implementation survey 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.
- **Focus on family-driven and youth-guided approach:** Cayuga County incorporated youth and family peer partners into their SOC efforts. However additional efforts may be needed to bolster this area od SOC implementation. On the 2020 SOC implementation survey, several areas reflecting services guided by youth and family had lower scores than in the previous year, including family-driven approach, youth guided approach, and commitment of youth and family leaders. Maintaining the family-driven, youth-guided services and building commitment of youth and family partners may be beneficial to continuing to strengthen the SOC.
- **Flow of programs is consistent:** The number of enrollments and discharges were very similar for all years, 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 characteristics have been very similar throughout the grant. 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, 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 retention in the program.
- **Outcomes data suggest family improvement:** All outcomes reflect significant improvements between baseline and discharge for both youth and caregivers. Youth symptoms and impairment decreased significantly. For caregivers, strain decreased and parenting sense of competence and family empowerment increased significantly. Perception of care at discharge was also strong. These findings suggests families experience improvement over the course of services.
- **Lessons learned from HFW pilot participation:** 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. In addition these youth tend to be older, which may require unique engagement methods. Even with a complex service

population and implementation challenges (e.g., youth not completing program, low fidelity), average family outcome measures still suggested improvement (e.g., lower symptoms/impairment and caregiver strain; higher family empowerment). It may be helpful to have conversations with the HFW participants and providers to better understand difficulties in implementing this program in Cayuga County to inform future programming for this more complex service population.

References

Bird, H. R., Shaffer, D., Fisher, P., & Gould, M. S. (1993). The Columbia Impairment Scale (CIS): pilot findings on a measure of global impairment for children and adolescents. International Journal of Methods in Psychiatric Research.

Brannan, A. M., Heflinger, C. A., & Bickman, L. (1997). The Caregiver Strain Questionnaire: Measuring the Impact on the Family of Living with a Child with Serious Emotional Disturbance. Journal of Emotional and Behavioral Disorders, 5(4), 212–222. https://doi.org/10.1177/106342669700500404

Gibaud-Wallston, J., & Wandersmann, L. P. (1978). *Development and utility of the Parenting Sense of Competence Scale*. John F. Kennedy center for research on education and human development.

Jellinek, M. S., Murphy, J. M., Little, M., Pagano, M. E., Comer, D. M., & Kelleher, K. J. (1999). Use of the Pediatric Symptom Checklist to screen for psychosocial problems in pediatric primary care: a national feasibility study. *Archives of pediatrics & adolescent medicine, 153*(3), 254–260.

Koren, P. E., DeChillo, N., & Friesen, B. J. (1992). Measuring empowerment in families whose children have emotional disabilities: A brief questionnaire. Rehabilitation psychology, 37(4), 305.

Stroul, B., Dodge, J., Goldman, S., Rider, F., & Friedman, R. (2015). Rating Tool for Implementation of the System of Care Approach for Children, Youth, and Young Adults with Behavioral Health Challenges and Their Families Community – State Version. *Toolkit for Expanding the System of Care Approach*. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

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