



Texas System of Care

Achieving Well-Being for Children and Youth

REPORT / CHILDREN'S MENTAL HEALTH
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Achieving a Texas System of Care: Final Evaluation Report

Submitted to the Substance Abuse and Mental Health Services Administration



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Introduction

Goals of the Texas System of Care Grant

In July 2013, Texas Health and Human Services Commission and partner agencies embarked on an initiative to expand the System of Care framework within the state. The purpose of *Achieving a Texas System of Care* was to use the System of Care framework and practices statewide to plan and deliver services to children and youth with severe emotional disturbances (SED) and their families. To that end, the initiative aimed to utilize effective strategies to build support for System of Care implementation, develop policies and realign financing strategies in support of System of Care implementation, create cross-system training infrastructures, enhance access to effective services and supports, and support communities in implementing and sustaining the System of Care values and principles. Texas System of Care focused on four major goals, each having associated objectives and activities.

Goal 1: Develop and Strengthen Leadership and Support. Texas aimed to build greater support for system of care principles and values by creating and/or enhancing state, regional, and local governance structures, as well as align state initiatives with the system of care framework. The Texas System of Care initiative also aimed to increase and strengthen family and youth voice and opportunities for leadership and decision-making roles at both state and local levels. Additionally, Texas aimed increase the sustainability of the System of Care by addressing barriers to policy and regulatory practices and embedding supportive policies. Lastly, Texas System of Care aimed to utilize communication and social marketing approaches to build awareness and support for the SOC framework and reduce misinformation and stigma associated with children with emotional and behavioral health disorders.

Goal 2: Enhance Access to Effective Services and Supports. Texas System of Care intended to strengthen the infrastructure to support workforce development, increasing the number of mental health providers able to provide high-quality services and supports to families. A particular focus was to increase the number of evidence-based and promising practices available to children, youth, and families. Lastly, Texas System of Care aimed to assist communities in increasing their capacity to provide a wide array of high-quality, coordinated, culturally and linguistically competent services and supports for children, youth and families.

Goal 3: Maximize Efficient, Sustainable Financing Strategies. Recognizing the importance of financing, Texas System of Care aimed to align existing federal, state, and local resources to support sustainable infrastructure and service delivery. Additionally, Texas System of Care wanted to capitalize on any system or financing reform opportunities to ensure ongoing support of the System of Care values and principles. Lastly, the initiative aimed to assist communities with implementing creative local financing approaches, such as braided or blended funding.

Goal 4: Create Accountable Systems. Texas also aimed to strengthen existing quality improvement and outcomes monitoring systems to ensure accountability and data-informed decision-making. Texas System of Care strived to enhance the use of evaluation tools that align with System of Care principles and increase the role of youth and families in evaluation and quality improvement processes. The initiative also aimed to increase the use of technology for data management and decision-making and monitor key system indicators to guide transformation efforts.

Overview of the Evaluation

The primary aim of the evaluation was to monitor and document progress toward the goals of the proposed project, barriers encountered, and the impact of activities on organizations, communities, and individuals. The evaluation was developed to provide on-going feedback to the initiative on barriers, quality of care, and outcomes, allowing for a quality improvement feedback loop and adjustments over the project period. The evaluation addressed the following overarching questions:

- To what extent has the State of Texas implemented what it proposed in the strategic plan?
- What progress has been made toward the achievement of long-term goals?
- How much have the implemented changes affected the way services are delivered?
- How much have the implemented changes affected the perspectives and the satisfaction levels of stakeholders?
- What differences have the implemented changes made at the system level?

Evaluation Questions. Texas conducted a process evaluation identifying effective strategies, goal attainment and impact on organizations, communities, children, youth, and families. The evaluation focused on three levels of impact – the state, community, and family levels. The following key questions were measured, and each was assessed with a variety of indicators:

- Has the state established an effective System of Care expansion oversight committee?
- Has the state increased the awareness of stakeholders in System of Care principles and practices, state efforts at expansion of System of Care and the value of such efforts?
- Has the state changed policies, regulations, contracts, or interagency agreements that facilitate the expansion of System of Care?
- Has the state increased its capacity to provide training and technical assistance to child-serving providers and service systems to support System of Care expansion?
- Have the selected community expansion sites increased their capacity to implement System of Care principles and practices?
- Have the selected Performance Sites demonstrated improved service delivery as a result of the cooperative agreement?
- Do children, youth, and families experience decreased symptomatology and improved functioning from services and supports?

Methodology. The evaluation utilized a variety of methods because of the multiple goals, strategies, and action steps. Evaluation staff members reviewed documentation of project meetings, reports, contracts, agreements and written plans. Evaluation staff also actively participated in project meetings, including quarterly governance board meetings and weekly project management staff meetings. Staff collected a variety of surveys to address relevant questions and collected data from website analytics to measure project impact. At the state level, interviews of stakeholders, including state leaders and families, were conducted to measure awareness of project goals and perceived impact. Since the evaluation does not involve random assignment of sites or individuals, efforts were made to provide comparative perspectives through two data analytic designs:

- Repeated measures – many of the state and community level activities occur over time. Both retrospective data and data collected at regular intervals throughout the project is used in analyses. Service performance and outcome data was also collected at multiple time points.
- Benchmarking – for some activities at the community level, the evaluation team utilized national or state comparison sites in data analysis. Many of the child and family outcomes that are collected mirror outcomes currently collected in the mental health system and comparisons to national or state norms were used.

The specific measures and analyses used in the various evaluation components will be described in each section of the report.

Organization of the Report. First, the evaluation report summarizes the findings on the development of state-level infrastructure to support System of Care expansion, including the establishment of an effective governance body, the development of champions, the establishment of effective policies, the development of financing aligned with desired services and supports, and the establishment of avenues for family and youth voice. The report then focuses on changes at the community level. Since Texas System of Care aimed to increase readiness throughout the state, the evaluation includes both an examination of communities across the state, as well as the expansion communities who received funding to implement the System of Care framework. The report also summarizes the outcomes of children, youth, and families who received services within System of Care communities. Lastly, the Texas System of Care initiative included several large initiatives that aimed to enhance services and supports in the state, and evaluations of each of these initiatives are reported. These sub-reports include an evaluation of the expansion of wraparound planning, system changes to support transition-age youth, and improvements to residential treatment services.

Expansion of State Infrastructure and Financing

Child and Youth Behavioral Health Subcommittee

Membership of State Oversight Committee. At the beginning of the initiative, Texas had a System of Care oversight committee, with membership dictated in state statute. The committee, named the System of Care Consortium, included representatives from state agencies overseeing mental health, substance abuse, Medicaid and CHIP, child protective services, education, juvenile justice, and the council on offenders with medical or mental impairments. In addition, the statute required a parent representative. Many other state stakeholders and family members regularly attended and participated in meetings. During the 84th Legislative Session, state legislators expressed a desire for integrating many aspects of health and human services and eliminated the requirement of a state oversight committee. Alternatively, the Legislature granted the Executive Commissioner of the Health and Human Services Commission the authority to determine necessary interagency committees. In 2015, a new oversight committee was developed that incorporated several existing committees that supported issues of children’s mental health and trauma-informed care. The resulting entity, named the Children and Youth Behavioral Health Subcommittee, reported to the Behavioral Health Advisory Committee (BHAC). Membership of the new subcommittee was expanded to include representatives of community partners, a non-profit focused on trauma-informed care, a non-profit focused on suicide prevention, an academic partner, and two family and two youth representatives.

Assessment of System of Care State Expansion Strategies. At the end of the grant period, CYBHS members were asked to examine the state’s use of strategies deemed to be effective for expanding the system of care framework, based on the work of Stroul and Friedman (2013). Eleven members or other key stakeholders responded to the survey. Information on implementation of strategies is categorized into the following key approaches:

- Implementing policy, administrative, and regulatory changes (14 strategies)
- Developing or expanding services and supports based on the system of care philosophy and approach (11 strategies)
- Creating or improving financing strategies (13 strategies)
- Providing training, technical assistance, and coaching (3 strategies), and
- Generating support (10 strategies).

Respondents rated the overall progress to date in expanding the System of Care approach statewide with an average rating of 2.60 ($SD=0.97$), reflecting responses midway between “moderate” and “significant.” Ratings for each of the approach areas are reflected in Table 1, along with the highest and lowest rated strategies. Respondents reported the greatest progress in the areas of training and technical assistance and improved financing. They reported the least progress, although still “moderate,” in generating support (buy-in) and expanding services and supports.

Table 1. *Ratings on Statewide Expansion Strategies for Implementation*

Domain	Average Rating (standard deviation)	Lowest Rated Strategy	Highest Rated Strategy
Policy/Regulatory changes	2.14 (0.49)	Incorporating requirements for elements of the system of care philosophy and approach in RFPs and contracts with providers and managed care organizations to support expansion of the system of care approach.	Developing and implementing strategic plans that establish the system of care philosophy and approach as goals for the state's service delivery system to support expansion of the system of care approach.
Expanding Services and Supports	2.03 (0.45)	Creating or expanding care management entities to serve as the focal point of accountability and responsibility for managing the services, cost, and care management for children with extensive service needs and their families to support extension of the system of care approach.	Creating or expanding an individualized, wraparound approach to service planning and delivery to support expansion of the system of care approach.
Improving Financing	2.83 (0.98)	Implementing case rates or other risk-based financing approaches to increase flexibility in financing services and supports to support expansion of the system of care approach.	Obtaining new or increased funds from other child-serving agencies to finance infrastructure and/or to support expansion of the system of care approach AND Obtaining new or increased local funds (e.g., taxing authorities, special funding districts, country funds) to finance infrastructure and/or services to support expansion of the system of care approach.

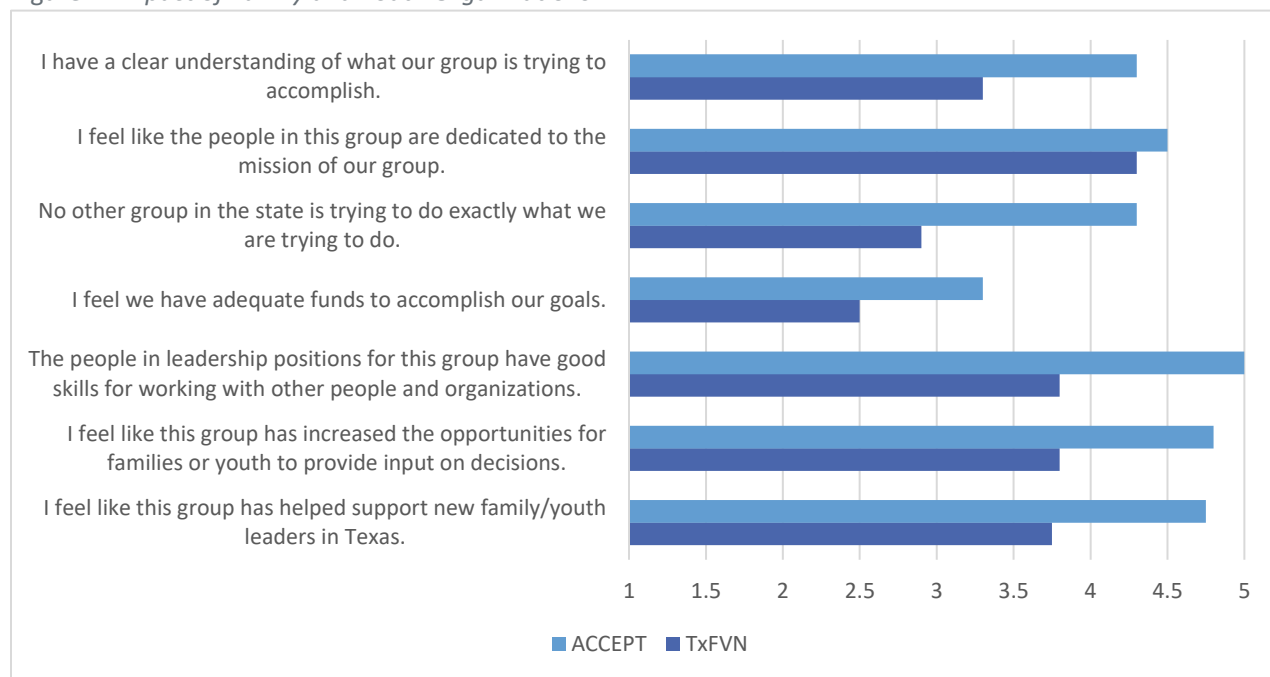
Training and Technical Assistance	2.82 (0.24)	Providing ongoing training on evidence-informed and promising practices and practice-based evidence approaches to support high quality and effective service delivery to support expansion of the system of care approach.	Creating the capacity for ongoing training, technical assistance, and coaching on system of care and evidence-informed services (e.g., institutes, center of excellence, TA center, other intermediary organizations, partnerships with higher education) to support expansion of the system of care approach.
Generating Support	2.02 (0.25)	Using data on the outcomes of system of care and services to promote expansion of the system of care approach.	Generating political and policy-level support for the system of care philosophy and approach among high-level administrators and policy makers at the state level for expansion of the system of care approach.

Note: Implementation Scale – 0=‘None’, 1=‘Some’, 2=‘Moderate’, 3=‘Significant’, 4=‘Extensive’

Texas Family Voice Network and Allies Cultivating Change by Empowering Positive Transformation

The Texas Family Voice Network (TxFVN) is a collaboration of family members and leaders, as well as family-run organizations and advocacy organizations committed to advocating for children and families. The Network was established during the Texas System of Care planning initiative and continued to strengthen and grow over the course of the current period. Allies Cultivating Change by Empowering Positive Transformation (ACCEPT) is a cross-system group of youth and young adults ages 13-25 from across Texas who use their lived experience and expertise to help inform and drive system improvements. ACCEPT advocates for embracing youth voice in meaningful, authentic ways. ACCEPT was established during the grant period and has become a state chapter of Youth MOVE during the initiative. To better understand the impact of developing these structures, members were surveyed to understand their perceptions. Respondents to the survey included four members of ACCEPT and eleven members of TxFVN. Two family respondents provided demographic information only and were excluded from other analyses. Results of the survey, illustrated in Figure 1, show that the members of ACCEPT feel strongly that the group leaders are skilled, that the group has increased opportunities for members, and that the group has helped support new youth leaders. Members of TxFVN were more mixed in their responses. TxFVN members felt like members were dedicated to the mission of the group. Members were neutral to disagreeing with the statement that no other group is doing the same activities. Both TxFVN and ACCEPT members reported lower agreement with the adequacy of funding to accomplish their goals.

Figure 1. *Impact of Family and Youth Organizations*



Changes to Financing of System of Care Aligned Activities

Medicaid Waivers. In September 2013, HHSC applied for and received an 1115 Medicaid Transformation Waiver. This waiver allowed regions within the state to partner in identifying local health care needs and proposing projects to enhance the quality of services, expand access to health care services, and reduce the use of health care within inappropriate settings (e.g. emergency rooms, jails, hospitals). A total of 403 proposals initially submitted addressed behavioral health needs, and all but one Local Mental Health Authority (LMHA) proposed a transformation project. Many of the projects included children with severe emotional disturbances and proposed creative solutions to meet critical local needs. Local agencies have utilized the 1115 Medicaid Transformation Waiver to support many aspects of their local systems of care, such as expanding access to wraparound planning, hiring family partners, and implementing new evidence-based practices. Over the five-year waiver period, the 1115 Waiver initiative was expected to provide \$237,326,989 to behavioral health projects solely targeting children and adolescents and \$698,932,836 to projects targeting individuals across the lifespan.

During the 84th Legislative session, Texas appropriated additional state funding to expand the YES Waiver from a pilot initiative to statewide coverage. In February 2015, a state roll-out was begun, resulting in the addition of YES Waiver services and supports in all Texas counties. This has allowed children who would not otherwise be eligible for Medicaid to gain eligibility based on their personal financial status, rather than their parent's. The YES Waiver expansion has allowed for the provision of non-traditional services and supports that many families cannot access. The YES Waiver has also allowed for many children who are at risk for placement in a psychiatric hospital or residential treatment center to receive intensive community-based services and avoid out-of-home care, resulting in cost-savings to the health care system. The initial state funding for the Waiver expansion was \$58,611,348 over the biennium.

Medicaid. Texas underwent significant changes during the grant period as Medicaid managed care was rolled out across the state and a managed care carve-out in the Dallas and surrounding areas was disbanded. Efforts were focused on maintaining state support for the use of evidence-based practices and strengths-based assessment tools as this change occurred. Texas System of Care strived to support the inclusion of parent peer support within the Medicaid State Plan, but this policy change has not been successful at this time. During the 85th Legislative Session, Texas passed a law supporting regulation and enforcement of behavioral health parity, which may result in increased Medicaid funding for behavioral health services.

State Funding. The primary state general revenue funding used to support the broad mission of Texas System of Care was a new appropriation for a program to prevent the relinquishment of children with severe emotional disturbances to the child welfare system in order to access residential treatment. The program was established in the 83rd Legislative Session with an initial investment of \$2,000,000. The Texas Department of State Health Services (DSHS) and Texas Department of Family and Protective Services (DFPS) partnered to develop a program in which children referred to DFPS for the sole purpose of accessing intensive mental health services were referred to LMHAs for an eligibility assessment. Children were then placed in state-contracted residential treatment programs. The initiative required collaboration between the LMHA and the residential programs to ensure that caregivers were actively involved in family therapy and other services while the child was in placement, that there was on-going communication about the family's needs and progress, and strong continuity of care as the child returned to his or her community. Additional investments to the program were made in both the 84th and 85th Legislative Sessions.

Block Grants. DSHS (later HHSC) continued to use block grant funding to support select initiatives consistent with the System of Care values and principles. This funding allowed for the initial establishment of wraparound fidelity monitoring, studies of the impact of parent peer support, and an examination of best practices and current needs of transition-age youth. Texas utilized additional Block Grant funding to establish ten coordinated specialty care teams for youth and young adults with early onset psychosis and to create youth recovery centers for adolescents recovering from substance use disorders. In addition to the Behavioral Health Block Grant, Maternal and Child Health within DSHS utilized Title V Block Grant funding to support suicide prevention training activities and expansion of youth and adult partnerships.

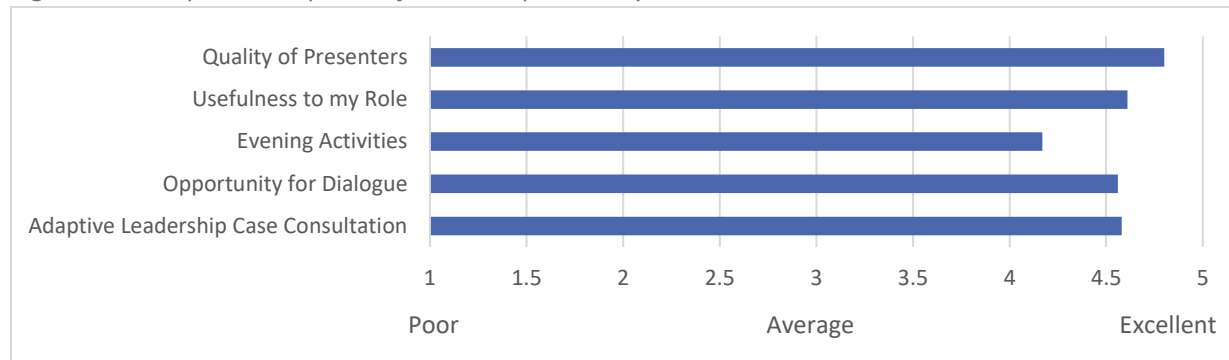
Leadership Development

One approach that Texas System of Care undertook to develop champions for System of Care was to invest in a three-day Leadership Academy. The event was hosted at a local hotel near Austin and included personal invitations to 50 participants. Participants included key agency leaders within various state agencies, leaders from each System of Care community in Texas (sustained and currently funded), family members from each System of Care community, and Texas System of Care staff. Attention was paid to the diversity of participants, with ten participants identifying as Hispanic and eight identifying as Black. There were nine family members and two young adults. Ellen Kagen and Shannon Crossbear facilitated the training event, using a curriculum developed by Georgetown University.

Participants reported an overall high rating of the event, with a mean rating of 4.45 ($SD=0.75$) on a scale of 1 (unacceptable) to 5 (exceeded expectations). Participant ratings of the experience are illustrated in Figure 2. Participants rated the quality of the presenters/facilitators highest ($M=4.80$). The evening activities were

rated the lowest ($M=4.17$). A review of comments suggested that many participants found the evening activities to result in very long days, with participants also reflecting on some discomfort during a group experience called “filling the void.”

Figure 2. *Participant Perceptions of Leadership Academy*



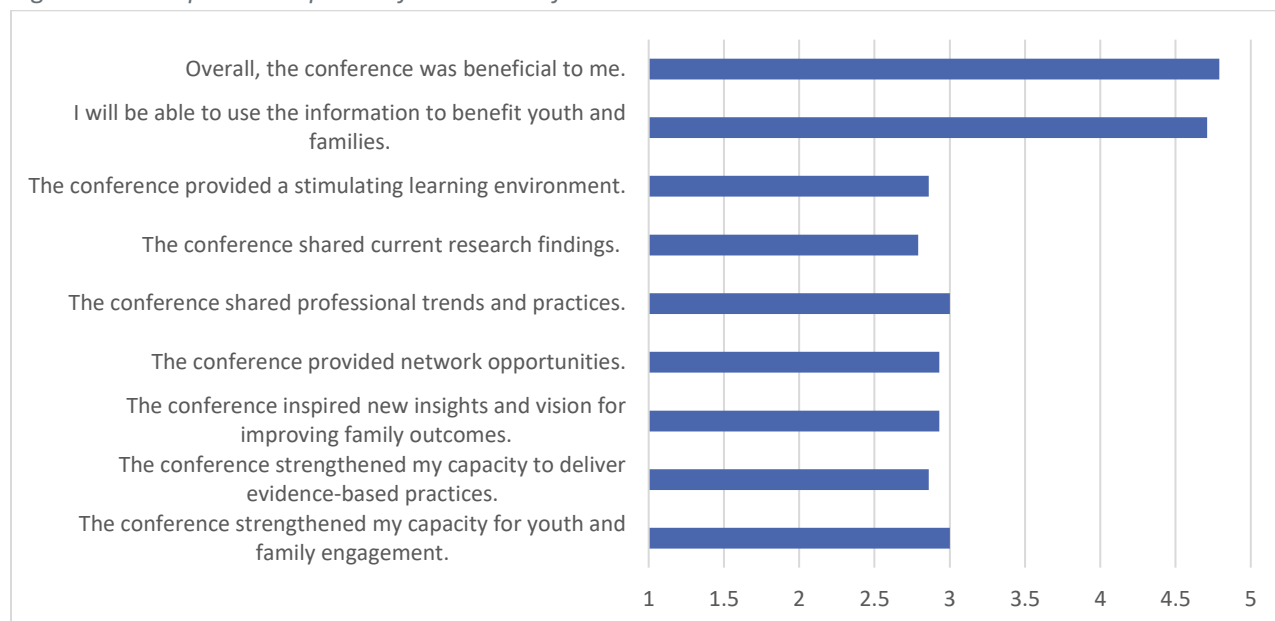
Participants were asked to identify three action steps that they would take over the next few months because of the leadership training. These items were coded to identify the most actionable elements of the training. The most frequently reported activity related to examining your and other’s values and considering the impact of those values during interactions. Over half of respondents (61%) identified this as a step they planned to take in the coming months. Participants also planned to try to use adaptive solutions for adaptive challenges, rather than focusing on technical solutions (29%). Other common action steps identified by participants was to examine personal mental models and assumptions and how they impact behaviors (27%) and to focus on creating a dialogue and using inquiry questions more often (37%).

System of Care State Conference

Texas System of Care continued to advance the readiness of communities by hosting a statewide conference in June 2017 in Austin. The Summit kicked off with a pre-conference networking meeting of System of Care communities. Community participants rated the meeting an average 4.5 on a scale of 1 to 5, indicating that the meeting was beneficial to them. Several participants indicated that learning about the barriers experienced by different communities and strategies to overcome those barriers was the most helpful part of the event. Others found the media training to be particularly helpful.

The three-day primary conference included keynote presentations and breakout sessions in five tracks, covering Youth Voice, Family Voice, Community-based Services and Supports, Cultural and Linguistic Competency, and System of Care 101. Many presentations were provided by family leaders, youth leaders, and local SOC community members. Keynote addresses and some breakout sessions were broadcast through a web-based platform, allowing participation from individuals across the state. Participants rated each session as well as the conference overall. Results of the overall conference ratings are presented in Figure 3. Ratings demonstrated that participants felt the conference was highly beneficial to them, with an average rating of 4.79 on a scale of 1 (strongly disagree) to 5 (strongly agree), and information could be used to benefit youth and families ($M=4.71$). Average ratings of the extent to which conference objectives were met ranged from 2.79 to 3.0 on a scale of 1 (not met at all) to 3 (completely met).

Figure 3. *Participant Perceptions of the SOC Conference*



Ratings of individual presentations and workshops ranged from 3.4 to 4.0 on a scale of 1 to 4, with 1 indicating “poor” and 4 indicating “excellent”. The highest rated workshops, with an average rating of 4.0, included Adolescent Substance Use: Engage the Youth to Save the Youth, Building a Stronger Foundation for the Future: SOC Infrastructure and Sustainability, Sustaining SOC Core Leadership in Dallas, Moving Mountains: Reimagining Congregation and Community Partnerships, System Changers! Empowering Families at the System Level.

Communication

Website. Texas System of Care maintained a website at www.txsystemofcare.org that provided information about grant activities, housed webinars and reports, and provided blog content. The primary audience for the website is internal constituents, such as state agency partners and community system of care stakeholders, as well as child-serving providers. Website traffic was monitored throughout the grant period, with the number of users in a quarter ranging from 600 to 3,587, with an average of 2,274 users each quarter ($SD=980$). The highest rates were during the quarter celebrating Children’s Mental Health Awareness and time periods during which Texas System of Care sponsored conferences, with the website housing conference resources.

E-Newsletter. One of the primary communication tools used by Texas System of Care is a bi-weekly electronic newsletter. The newsletter provides information on grant activities, opportunities to provide input or get involved, training events and webinars, grant opportunities, and new resources. The e-newsletter is distributed to between 650 and 750 individuals, as well as posted on the website and shared through social media. The e-newsletter is evaluated through its reach and open rate, around 20%, which is slightly less than the average open rate for non-profits (26%) and higher than the global open rate of 6% (as measured by MailChimp).

Social Media. Texas System of Care utilized social media channels to engage a broader audience, including thought leaders, individuals interested in mental health, and the general public. Texas System of Care hosted a Facebook page. Postings on Facebook included information about System of Care activities, accomplishments of System of Care communities, and informational articles relevant to children and families. The quarterly reach of the Facebook page ranged from 1,668 at the beginning of the grant period to 32,503, with an average reach of 9,993 per quarter ($SD=8,760$). The Texas System of Care twitter feed shared news articles, information from partner organizations, and engagement in national, state, and conference discussions, using hashtags. The number of impressions ranged from 100 at the beginning of the grant to 108,362, with an average of 26,081 per quarter ($SD=27,600$). Texas System of Care hosted a Pinterest account for five quarters with minimal reach (average of 101 views per quarter), but opted to focus efforts on other social media platforms. During the third quarter of the second grant year, Texas System of Care launched a YouTube page, which was used to share educational content and social marketing videos. Content is organized into different areas, and users can follow the site for updates. This has proven to be successful at engaging the audience with an average of 1,677 views per quarter ($SD=612$).

Children’s Mental Health Awareness Day. There were four opportunities for Children’s Mental Health Awareness Day events during the grant period. Texas System of Care hosted four primary awareness day events, each involving speeches at the state capitol, followed by a one-mile walk to a community park. At the park, fun activities and performances were hosted, along with food and music. The theme for the first and second year was *Stand Up and Soar for Children’s Mental Health*, which was associated with green shoes and the kite logo. In the third year, the theme *Finding Help, Finding Hope* was undertaken with superheroes, and in the fourth year the theme *Flight 2 Freedom* was chosen and linked to a butterfly logo. There were an estimated 100 attendees during the initial two years and 200 attendees in the final two years. In a survey following the third event, 93% of respondents reported that they “enjoyed the event Finding Help, Finding Hope.”

“It was a way to honor our children who struggle with mental health challenges and their families.”

“The events at the park were fun. My kids enjoyed the bounce house and flavored ice.”

“A great cause, well organized, and provided opportunities to engage everyone.”

Expansion of System of Care Communities

Overview of Approach

Texas System of Care had a statewide approach to system of care community development and strategies focused on building readiness and enhancing implementation in all communities. Strategies were targeted to the readiness of the community, with areas in early stages of readiness (pre-contemplation and contemplation) targeted through social marketing strategies, webinars, and trainings. Communities in early stages of change received opportunities to participate in targeted change activities through a learning collaborative model and peer-to-peer support from experienced communities. Communities in active implementation or working on improving and sustaining their system of care received targeted technical assistance, peer-to-peer support, and quality improvement opportunities. A network of System of Care communities was developed in which information could be shared from the communities to state agencies and from state agencies to communities.

The Texas System of Care initiative also directly funded system of care implementation in four regions over the course of the grant. In the initial 16 months of the grant, Bexar County (San Antonio) served as a “performance site,” striving to fully implement system of care within the community. The Tropical Texas Valley region of Texas, inclusive of Cameron, Willacy, and Hidalgo counties, initially served as a “development site,” with the goal of building collaborations and developing a strategic plan. In Year 2, Bexar County was notified it was awarded a Children’s Mental Health Initiative cooperative agreement from SAMSHA. Texas System of Care then shifted financial support to two additional regions of the state - Dallas County (Dallas), and the Coastal Plains region, which includes nine rural counties on the southeast coast of Texas. Tropical Texas Valley region was shifted to a performance site, and took on responsibility for service delivery and child-level data collection. Expansion communities received small awards - \$25,000 for development sites and \$75,000 for performance sites – to develop or strengthen their governance structure, establish and implement a strategic plan, provide training meeting the needs of the community, and other tasks intended to strengthen their implementation of system of care values and principles.

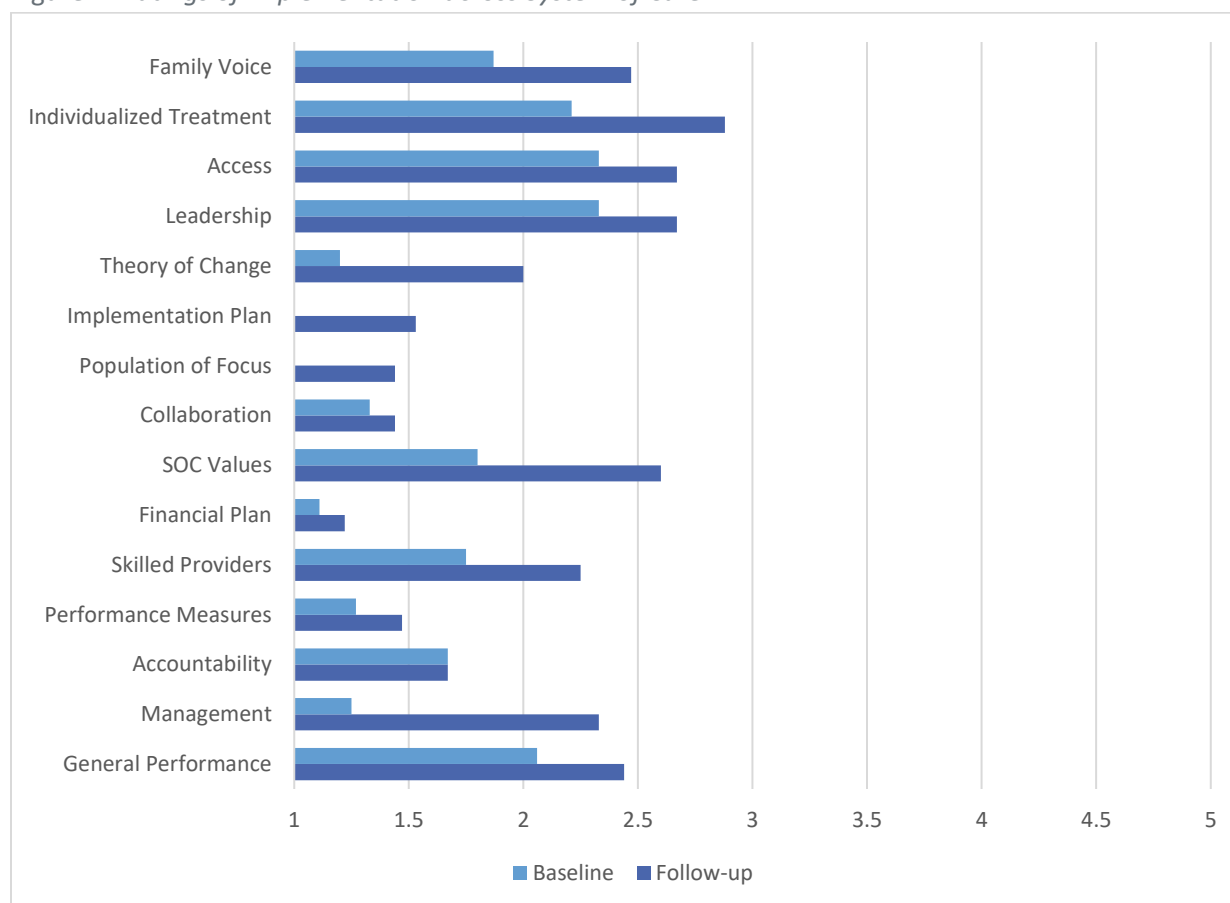
Measuring Implementation within System of Care Expansion Communities

System of Care Implementation Survey. To assess the level of implementation of various elements of System of Care over the course of the grant, the System of Care Implementation Survey (SOCIS; Boothroyd, Greenbaum, Wang, 2011) was completed during an early interview with each site at initiation of their project. A team of System of Care staff completed the measure after gathering information about community readiness along all of the components of the measure and developed a consensus rating. Community leaders were not asked to directly rate their status at initiation because the team’s experience is that many concepts are not fully understood by communities until they have

more opportunities to learn about System of Care. At the end of the project, the three remaining communities were asked to complete their ratings of implementation.

Average scores on the SOCIS scales were calculated for the three sites at baseline and at follow-up. Results are presented in Figure 4. The SOC expansion sites reported some progress on all but one of the SOCIS domains. The greatest progress was seen on Management and Governance, which relates to defined decision-making structures. Additional areas with significant change were implementation of SOC Values and Principles, availability of Skilled Providers, and Individualized, Comprehensive, Culturally Competent Treatment. A benchmark of three has been used to define adequate implementation (Kutash, Greenbaum, Wang, et al., 2011) of the System of Care element. No element reached this criterium when averaged across the three sites, indicating that the sites have more progress to make to be a fully implemented System of Care communities. Two sites, Dallas County and the Tropical Texas region, had several elements reaching this threshold.

Figure 4. *Ratings of Implementation across System of Care*



Qualitative Feedback from Community Leaders. As a final rating of progress, all three local project directors were asked to outline their greatest achievements and barriers to system of care implementation. Overall there were common trends among all three sites.

Greatest Achievement

All three sites noted their greatest achievement was providing a venue for child-serving agencies to come together, improve relationships, and foster a better understanding of each agency's purpose.

Greatest Barriers

Each project director reported time and money as the greatest barriers to making progress within their community. All local project directors are clinical leaders within their local public mental health organization and the role for system of care implementation was an addition to other management duties. All three local project directors noted it was difficult to move the initiative forward on top of their other duties. Further, since all three sites were provided limited funds, they struggled to establish initial infrastructure for their governance boards.

System of care values and principles

All sites felt they had made moderate to enduring impact on increasing access to effective services and supports and enhancing the cultural responsiveness of service systems, but sites were mixed on their progress to develop a cross-agency leadership group and strengthen youth and family voice. All sites struggled to leverage resources and make data-driven decisions.

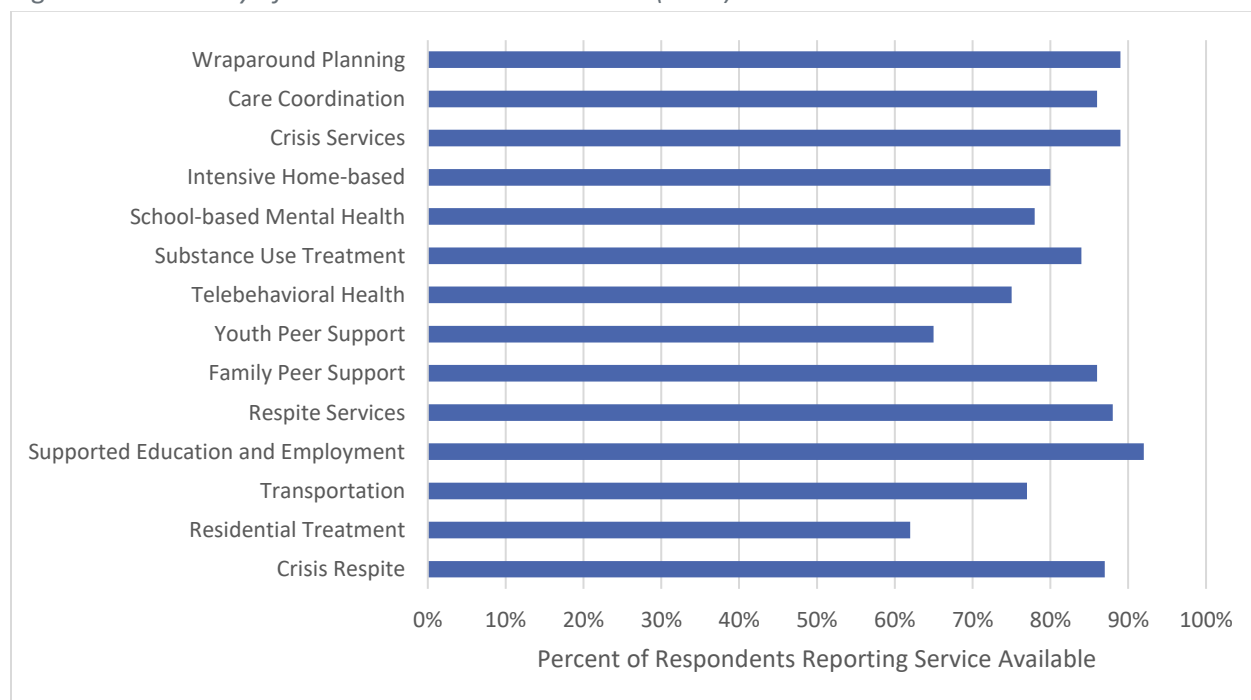
Measuring Statewide Progress

Methodology. Many aspects of Texas' initiative aimed to enhance implementation of the System of Care framework statewide, through training, social marketing, and policy changes. However, assessing progress was challenging, as community leaders and stakeholders may not have identified the changes as a part of "System of Care." Texas System of Care conducted two surveys, in 2015 and 2017, aimed at reaching key leaders in all 254 counties in Texas to gauge changes throughout the state. The survey was targeted to participants of Community Resource Coordination Groups (CRCGs), regional cross-agency groups tasked with identifying resources for children, adults, and families that exceed the capacity of one agency. CRCG members are actively engaged in discussions around community behavioral health resources and are likely to be very aware of the strengths and gaps within their local communities. CRCGs generally include the primary child-serving agencies within the community, and therefore provide an opportunity to sample leadership from various sectors. CRCGs were asked to forward the survey to any additional system leaders within their communities who were not currently participating on the CRCG. The survey was also distributed to System of Care leads in all communities with an active System of Care, with similar instructions.

The survey included items intended to assess the implementation of the System of Care framework and the strength of interagency collaboration within the community. Survey items included questions from the Rating Tool for Community Implementation of the System of Care Approach (Stroul, 2012) and the Wilder Collaboration Factors Inventory (Mattessich, Murraray-Close, & Monsey 2001). Additional items were developed to assess unique aspects of the current statewide System of Care initiative. The survey was created in collaboration with staff from the Texas System of Care (TxSOC) grant and the CRCG statewide data team. In 2015, 668 community members accessed the survey, with 424 completing more than initial descriptive data, enabling use in the final analysis. Respondents represented 249 out of the 254 Texas counties and a wide variety of roles, with the greatest representation from non-profit community organizations, state agencies, local mental health authorities, and juvenile justice staff. In 2017, 536 individuals accessed the survey, with all counties in the state represented.

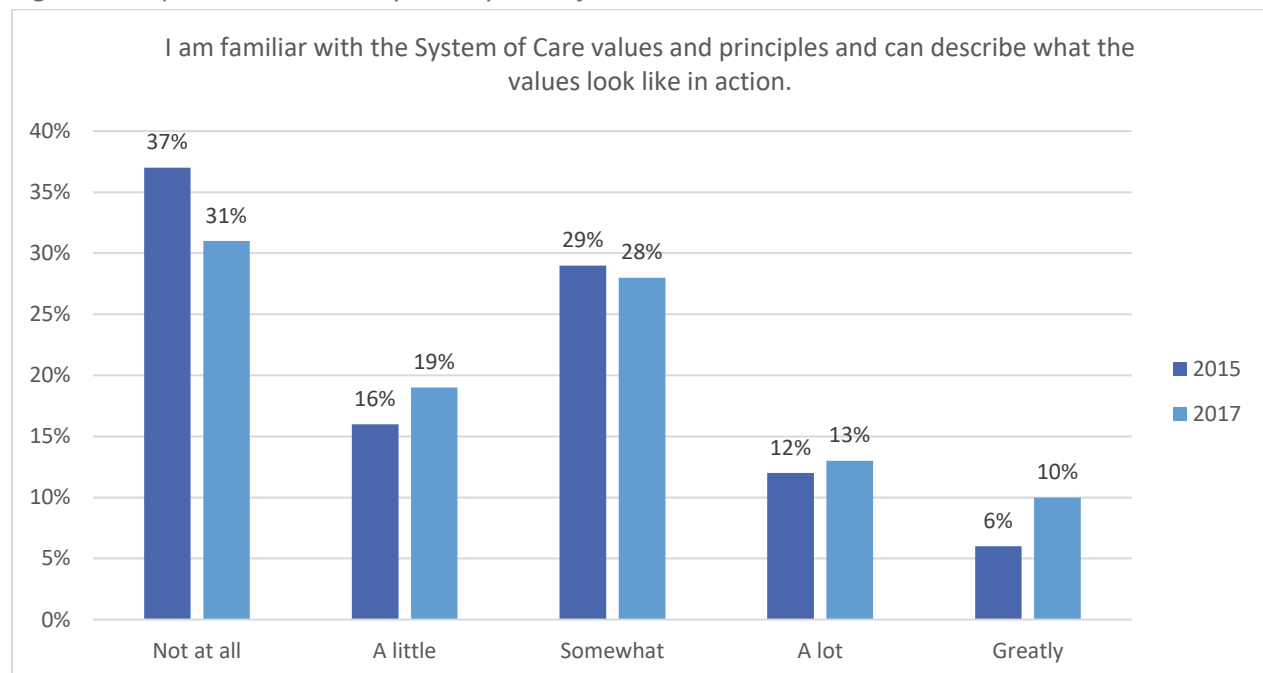
Service Availability. In order to examine the adequacy of the service array within communities, respondents were asked to indicate whether specific services were available within their region. Statewide availability is presented in Figure 5. Overall, respondents described the greatest availability of supported education and employment, crisis services, and wraparound planning. The most limited availability was found for residential treatment, youth peer support, tele-behavioral health services, and transportation. While promising, there is some concern that the data may over-represent the availability of some services, which are generally known to only exist in select regions, such as the provision of supported education and employment for young people and intensive home-based services. This may suggest that even multi-stakeholder planning groups, such as CRCGs and System of Care governance bodies, may not be fully aware of what services are offered in their communities or may assume that services available to adults are also available to children and adolescents.

Figure 5. *Availability of Services in Texas Communities (2017)*



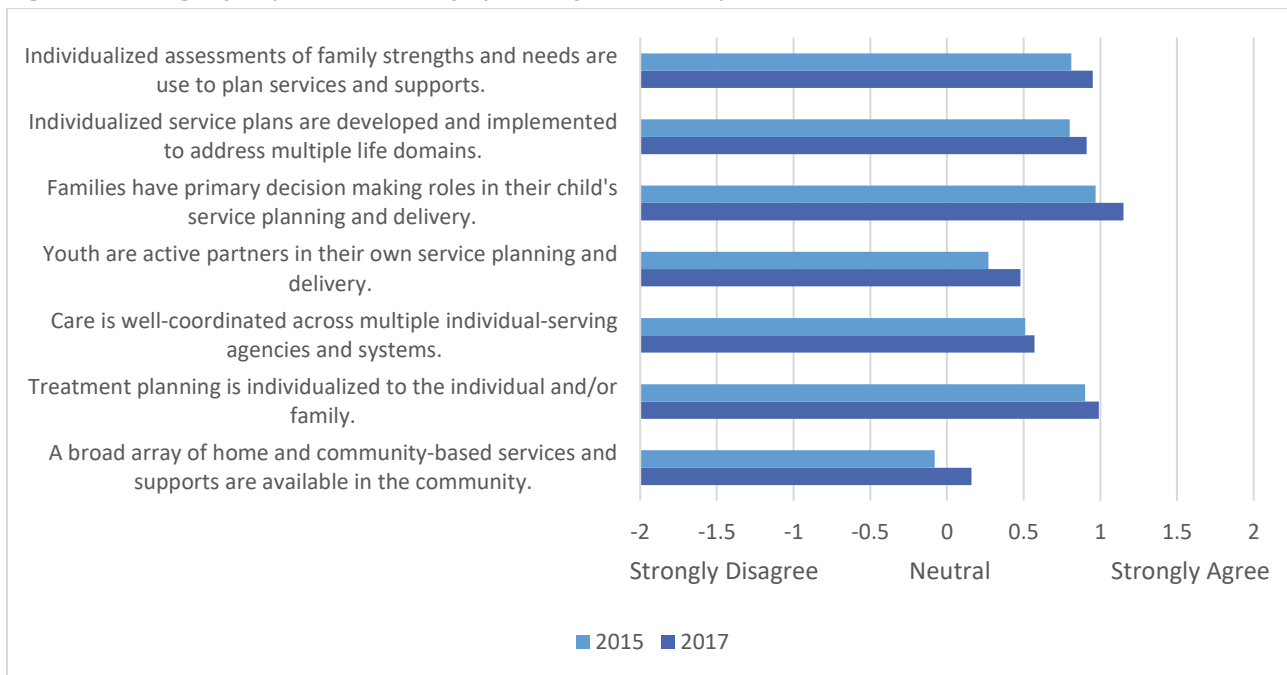
Awareness of System of Care Values and Principles. Participants were asked about their familiarity with System of Care values and principles, including how to put them in practice. In 2015, over half (53%) expressed no or little familiarity. There was a large proportion (29%) with some familiarity, and a smaller portion (18%), who described significant familiarity with the concepts. The overall distribution looked similar in 2017; however, a smaller proportion of respondents reported no familiarity and a greater proportion described a “great” familiarity.

Figure 6. *Respondents Familiarity with System of Care*



System of Care Strengths and Gaps. Participants were asked to respond to several questions about the community’s level of implementation of key features of a successful System of Care, focused around care coordination processes. Figure 7 presents these findings over two time-periods. Respondents reported that the greatest implementation was in families having primary decision-making role in their child’s treatment, with ratings reflecting responses between “agree” and “strongly agree.” This served as a strength of the system at both time points. The weakest implementation reported by participants was the array of home and community-based services and supports, with respondents generally reflecting a neutral response to whether a broad array of services and supports is available in their community. Change over time in the extent of implementation was also examined for each of the items. Respondents rated improvements in the level of implementation for individualized assessment of family strengths and needs ($t=2.1072$, $df=804$, $p=.0354$), families having primary decision-making roles in care ($t=2.8879$, $df=804$, $p=.0040$), youth being active partners in their service planning and delivery ($t=2.5343$, $df=793$, $p=.0115$), and the availability of a broad array of home and community-based services and supports ($t=2.7245$, $df=800$, $p=.0066$). Other items also demonstrated greater implementation at the follow-up survey, but did not reach statistical significance.

Figure 7. *Ratings of Implementation of System of Care Principles within Care Coordination*



Impact of Services on Children and Families

Overview of Methodology

Local system of care expansion communities enrolled youth who were participating in wraparound programs into the cross-site evaluation protocol. Parents and/or youth completed instruments at program entry, at 6-months in care, and at discharge from services. Families could decline to participate in the evaluation, in which only administrative data was collected. One measure was collected through an interview format and additional measures were collected in paper-and-pencil format. If literacy was an issue, all measures were collected through an interview. Youth self-report was gathered for all youth age 11 or older.

Outcomes of participation in services and supports was measured through change on each of the measures. A dependent t-test was used to measure the statistical significance of the change, based on the last available assessment. Data is limited in a number of circumstances, with missing interviews and instruments. This is due to both a delay in the selection and approval of cross-site instruments, as well as issues with adding data collection responsibilities to the job of wraparound facilitators. The largest impact of these data issues is a limited number of follow-up assessments. Overall, this is likely to significantly impact the generalizability of findings. All results should be considered exploratory in nature and not conclusive.

Measures. Parents or other caregivers of children and youth participating in the initiative were asked to complete the following measures:

- *National Outcome Measure (NOMS)*. This interview instrument asks about demographics and current functioning in a variety of domains. The NOMS includes six questions that make up the Kessler 6 screening, which has been used in epidemiology studies to estimate serious mental illness. The instrument also includes six questions focused on a perception of social connectedness.
- *Pediatric Symptom Checklist (PSC)*; Gardner, Murphy, Childs, Kelleher, Pagano, et al., 1999). This 17-item instrument is a screening of social, emotional, and behavioral problems in children. In addition to a total score, the PSC provides three subscales, measuring internalizing problems, inattention, and externalizing problems. Both parent-report and youth-report versions were utilized. A score of 15 or higher on the total score suggests the presence of a mental health problem, with cut-offs of 5 or higher on the internalizing subscale and 7 or higher on attention and externalizing subscales indicating concerns.
- *Columbia Impairment Scale (CIS)*; Bird, Shaffer, Fisher, & Gould, 1993). The CIS is a 13-item measure of functional impairment across multiple life domains. The total score reflects the severity of impairment, with a score of 15 or greater suggesting clinically significant impairment. Both parent and youth versions were utilized.

Characteristics of Children Served

Demographics. A total of 136 families were enrolled in the services component of the System of Care initiative. The majority (85.3%) were served by the Tropical Texas System of Care, with 14.0% served within Bexar County, and one family (0.7%) served by the Coastal Plains System of Care. A majority of the children

(54.3%) were female, with eight children missing data on gender. Age could be calculated for 84.6% of the sample, with a mean age of 13.3 years ($SD = 4.5$) and a median age of 14. The population was overwhelmingly Hispanic, with 97.5% identifying as Hispanic and 2.5% as White, non-Hispanic. Of those identifying as Hispanic, 1.7% identified as American Indian with the rest identifying as White. Four families (5.9%) reported having one or more family members in the military.

Mental Health Need. The results of several measures of behavioral health needs are summarized in Table 2. The Kessler 6 (K6), which provides a screen for serious mental illness, was completed by 52 families. While the K6 has been shown to have strong prediction within adult populations, research has shown it is stronger in identifying adolescents with internalizing disorders, but lacks the ability to adequately identify youth with primarily behavioral issues (Green, Gruber, Sampson, Zaslavsky, & Kessler, 2010). The mean score on the K6 for the SOC sample is 9.92 ($SD = 5.6$), which is greater than 95% of adolescents within a national sample (Green, et al., 2010). Using the adult cut-off of 13 for severe mental illness, 36.5% of the adolescents scored at or above this range; however, this is likely an underestimate for youth with externalizing difficulties. The Pediatric Symptom Checklist measures symptomatology and mean scores for parent and youth scales are presented in Table 2. Results suggest that most youth showed elevations found to predict mental health disorders (≥ 15), with parents reporting slightly more problems than the youth. Subscales suggest that internalizing problems are the most common, followed by externalizing problems, and attentional problems. Comorbid symptom areas were also common in the sample. The Columbia Impairment Scale measures impairment in various functional domains and results suggest almost all of the youth have significant areas of functional impairment. Similar to the PSC, parents reported slightly higher levels of impairment than youth on the Columbia Impairment Scale. The perception of social connectedness was measured on a brief instrument, with a scale ranging from “-2” representing strong disagreement with social connection items to “2” representing strong agreement. Overall, youth report a neutral to slightly positive impression of their social connectedness.

Table 2. *Baseline Scores on Mental Health Measures*

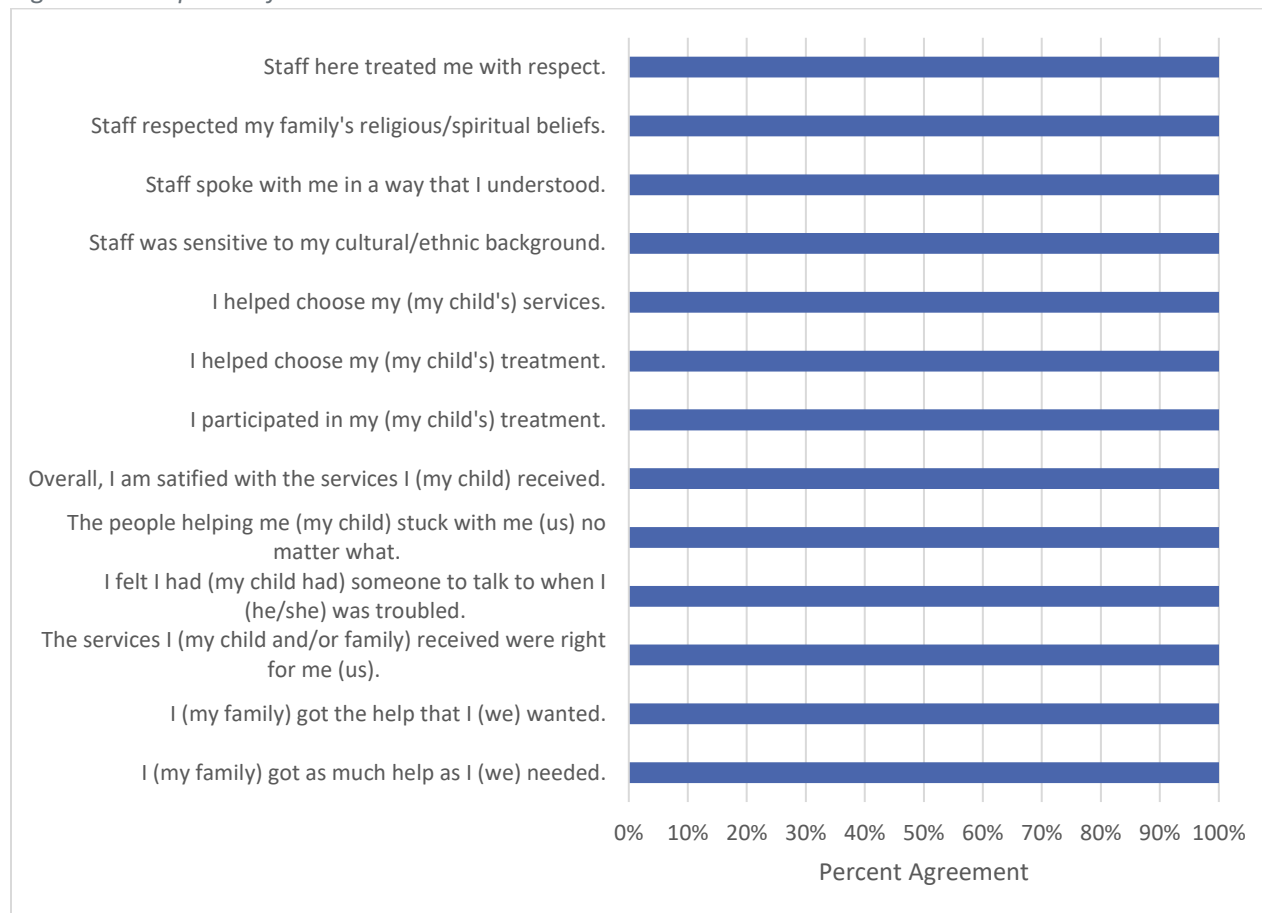
Measure	Mean	Standard Deviation	Percent above Clinical Cut-off
Kessler 6 Distress Scale ($n=52$)	9.92	5.6	36.5%
PSC Total Score – Youth ($n=39$)	17.87	5.14	74.4%
PSC Internalizing – Youth ($n=39$)	5.67	2.00	74.4%
PSC Attention Subscale – Youth ($n=39$)	5.92	2.29	38.5%
PSC Externalizing Subscale – Youth ($n=39$)	6.28	3.48	48.7%
PSC Total Score – Parent ($n=56$)	20.93	5.59	82.1%
PSC Internalizing – Parent ($n=56$)	6.43	2.37	75.0%
PSC Attention Subscale – Parent ($n=56$)	6.52	2.23	51.8%
PSC Externalizing Subscale – Parent ($n=56$)	7.98	3.46	64.3%
Columbia Impairment – Youth Report ($n=41$)	24.05	10.17	85.4%
Columbia Impairment – Parent Report ($n=61$)	27.87	11.26	90.2%
Social Connectedness ($n=77$)	0.74	1.01	N/A

Thirteen youth (17.6%) or caregivers of youth reported that the youth spent one or more nights in a hospital for a mental health problem in the previous 30 days. Fourteen (19.2%) reported going to the emergency room one or more times for a psychiatric problem during this time period. Only three youth (4.0%) reporting having been arrested in the past 30 days.

Outcomes of Services

Satisfaction with Services. Families were asked about their perceptions of the care that they received within the wraparound program at follow-up intervals. Figure 8 illustrates the proportion of families who report positive impressions (“agree” or “strongly agree”) of their care. Respondents consistently reflected that they were satisfied with the services that they received, that they were able to choose their services and support, and participated in treatment. The highest rated items, those with the most “strongly agree” responses, were the perception that staff would stick with the family no matter what and that they (or their child) had someone to talk to when troubled.

Figure 8. *Perceptions of Care*



Outcomes of Services. Only a small sample of youth served by the System of Care initiative had complete baseline and follow-up measures. Because of the small sample sizes, any findings should be considered exploratory rather than definitive. Changes in the core measures in the study are presented in Table 3. In

general, parent responses suggested improvements over time. Youth responses were more varied, but overall seemed to suggest no change. Despite the small sample, there were statistically significant reductions in distress on the Kessler 6 ($t=-3.6$, $p=.0057$), as well as greater social connectedness ($t=2.16$, $p=.04$).

Table 3. *Changes on Measures of Mental Health Functioning*

Measure	Baseline Mean / SD	Follow-up Mean / SD	Change M / SD	Paired t-test	Probability
Kessler 6 Distress Scale ($n=10$)	9.70 (4.72)	7.50 (4.70)	-2.20 (.61)	$t=-3.6$	$p=.0057$
PSC Total Score – Youth ($n=8$)	16.25 (5.18)	16.75 (6.16)	0.50 (2.31)	$t=0.22$	$p=.83$
PSC Internalizing – Youth ($n=8$)	4.88 (1.13)	5.13 (1.55)	0.25 (0.75)	$t=0.33$	$p=.75$
PSC Attention Subscale – Youth ($n=8$)	5.88 (2.17)	5.63 (2.50)	-0.25 (1.16)	$t=0.22$	$p=.83$
PSC Externalizing Subscale – Youth ($n=8$)	5.50 (4.17)	6.00 (3.07)	0.50 (1.02)	$t=0.49$	$p=.64$
PSC Total Score – Parent ($n=9$)	22.44 (6.86)	19.78 (4.76)	-2.67 (2.52)	$t=-1.06$	$p=.32$
PSC Internalizing – Parent ($n=9$)	6.89 (2.37)	6.44 (2.30)	-0.44 (1.04)	$t=-0.43$	$p=.68$
PSC Attention Subscale – Parent ($n=9$)	6.44 (2.30)	6.11 (1.90)	-0.33 (0.76)	$t=-0.44$	$p=.67$
PSC Externalizing Subscale – Parent ($n=9$)	9.11 (3.22)	7.22 (2.68)	-1.89 (1.09)	$t=-1.74$	$p=.12$
Columbia Impairment – Youth Report ($n=9$)	26.78 (11.17)	22.00 (6.82)	-4.78 (2.58)	$t=-1.86$	$p=.10$
Columbia Impairment – Parent Report ($n=12$)	29.00 (14.47)	23.33 (9.17)	-5.67 (5.78)	$t=-.98$	$p=.35$
Social Connectedness ($n=20$)	0.44 (1.18)	0.99 (.84)	0.55 (0.25)	$t=2.16$	$p=.04$

Expansion of Wraparound Planning

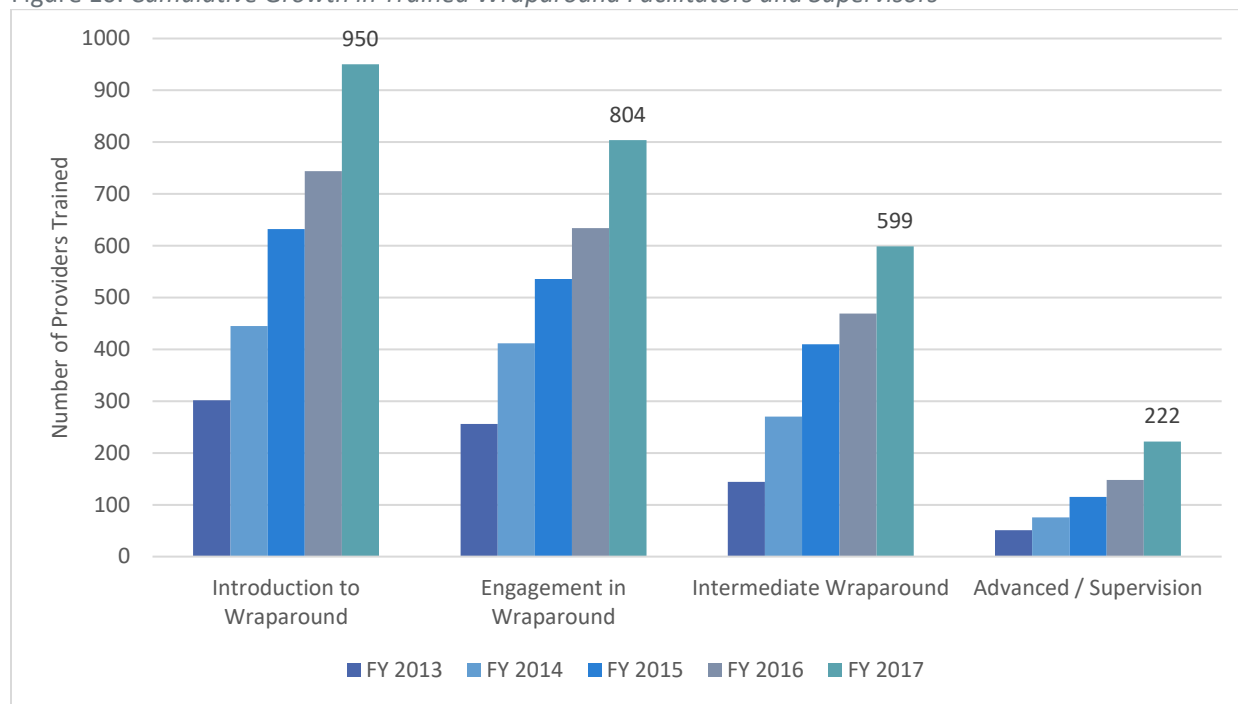
Overview of Wraparound Expansion Strategies

The state public mental health authority has supported the use of a wraparound planning approach within the public mental health system since the 1990's, but there was no consistent model or training approach promoted in the state. One goal of the System of Care strategic plan was to "create infrastructure to support high fidelity wraparound practice throughout the state." To support this effort, Texas established a standard training, utilizing the National Wraparound Initiative model, and developed on-going training for wraparound facilitators and their supervisors. Texas also established an initiative to develop in-state wraparound coaches, at both an academic setting within the University of Texas at Austin and in established System of Care communities across the state. Texas also worked to create an on-going wraparound fidelity monitoring program and implement it throughout the wraparound programs. Texas collaborated with the University of Washington to conduct an extensive wraparound evaluation, called WrapSTAR, within the primary System of Care expansion community in the South Texas Valley region. Evaluation of these efforts is described in the following sections.

Workforce Development to Support Wraparound

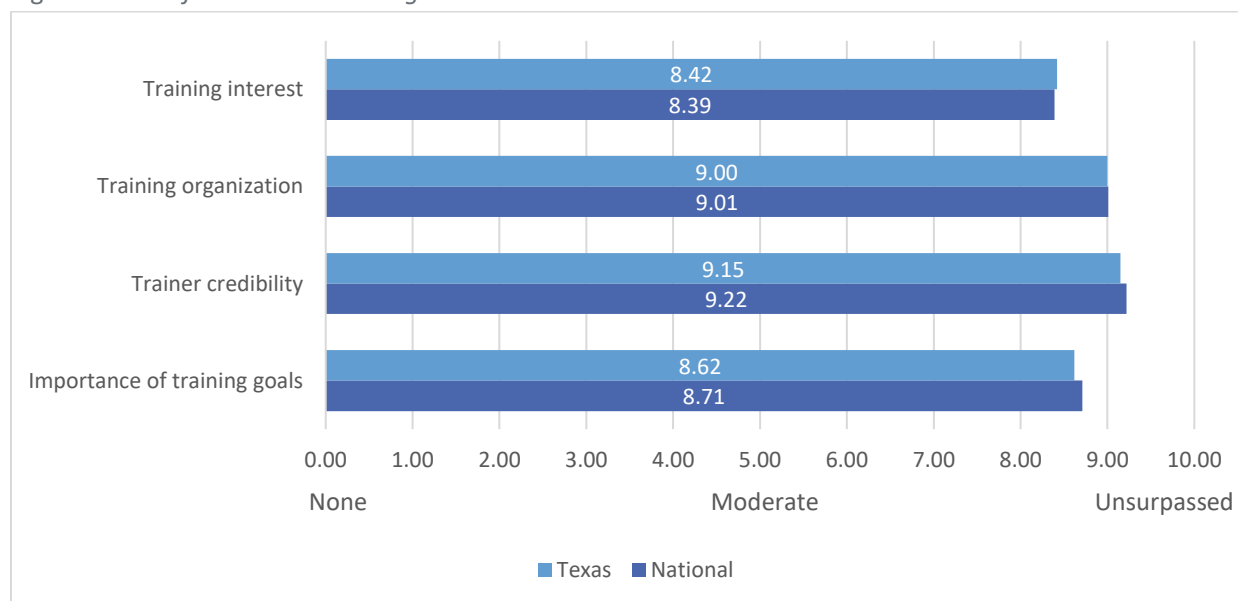
Number of Staff Trained. Workforce training in wraparound consisted of a quarterly wraparound training series, consisting of Introduction to Wraparound (3-days), Engagement in Wraparound (1-day) and Intermediate Wraparound (2-days). In addition, supervisors were required to attend the Advanced Wraparound training (2-days). During the grant period, four to five training series were conducted each year. A total of 648 wraparound staff received the Introduction to Wraparound training. Eighty-five percent ($n=548$) attended the second training in the series, Engagement in Wraparound. Seventy percent ($n=455$) went on to receive the third training in the series, Intermediate Wraparound. By the end of the grant period, almost 600 facilitators and supervisors had received the three-training series. Lastly, 171 wraparound supervisors received the Advanced Wraparound training. Figure 10 illustrates the growth in trained facilitators each year of the grant period, starting with the existing capacity in FY2013.

Figure 10. Cumulative Growth in Trained Wraparound Facilitators and Supervisors



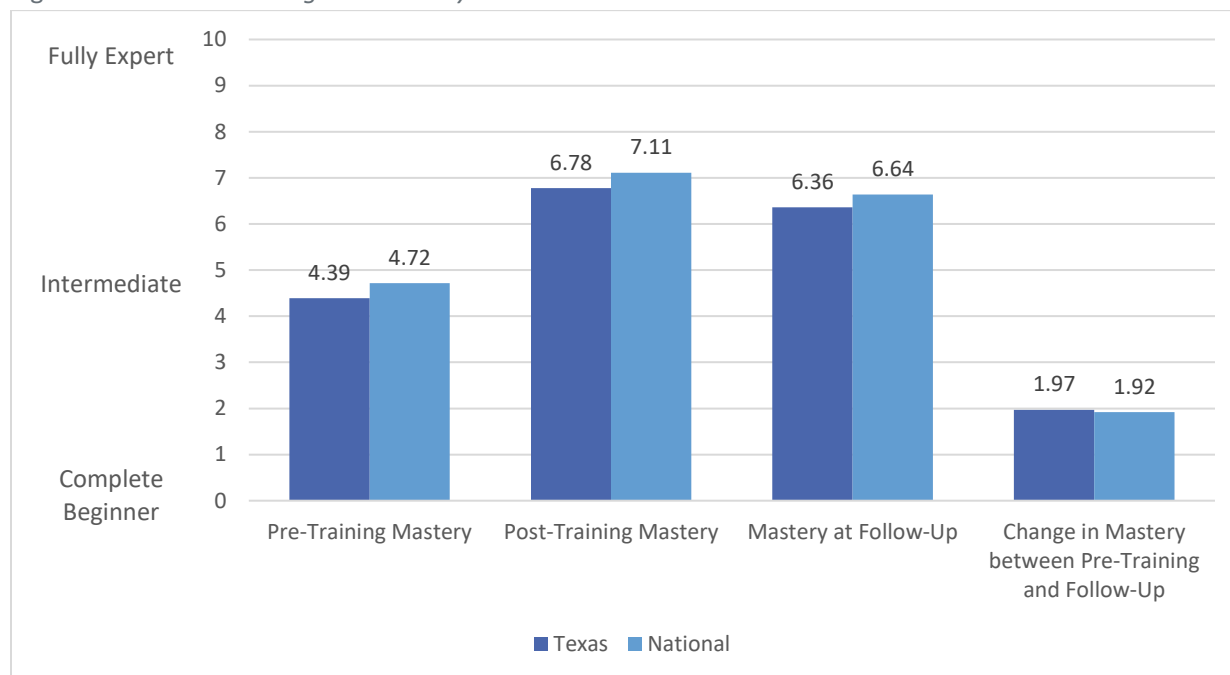
Satisfaction with Training. Participants in each wraparound training event completed the Impact of Training and Technical Assistance (IOTTA; Walker & Bruns, n.d.) at the completion of the training. Participant perceptions of the trainings are summarized in Figure 11. Overall, training satisfaction across the variety of areas were similar to those seen in other states and regions supported by NWI. Participants found the trainers to be highly credible and found the training goals to be very important.

Figure 11. Satisfaction with Training



Training participants were contacted by evaluators from the University of Washington after the initial training to gather additional follow-up information on the impact of the training. As depicted in Figure 12, Texas participants started the training with an intermediate level of mastery, slightly lower than the national mean. However, they showed a similar increase in mastery at both post-training and follow-up surveys, representing an increase of 44.9% of the initial mastery score.

Figure 12. *Perceived Changes in Mastery*



Wraparound in the Expansion Community

Overview of WrapSTAR. The Wraparound Structured Assessment and Review (WrapSTAR) process provides an objective and comprehensive evaluation of implementation of wraparound care coordination used in a System of Care for children, youth, and families. WrapSTAR goes beyond merely measuring a site’s adherence to the wraparound model (aka, “fidelity”) to also assess key implementation drivers rooted in years of implementation science research, as well as community and system supports found to be essential for sustaining a wraparound initiative. WrapSTAR rigorously measures fidelity and outcomes using a suite of standardized instruments specifically designed to assess wraparound practice and then systematically combines these data to offer provider organizations comprehensive ratings of their fidelity and outcomes based on key indicators of high-quality practice. To provide the most actionable information possible, the WrapSTAR process also includes an in-depth review of support to wraparound implementation guided by the National Implementation Research Network’s (NIRN) Implementation Drivers Framework. This framework identifies three categories of implementation drivers that support and sustain the implementation of a service model such as wraparound:

1. *Competency Drivers* are mechanisms to develop, improve, and sustain workforce capacity to implement an intervention as intended in order to benefit youth, families, and communities.

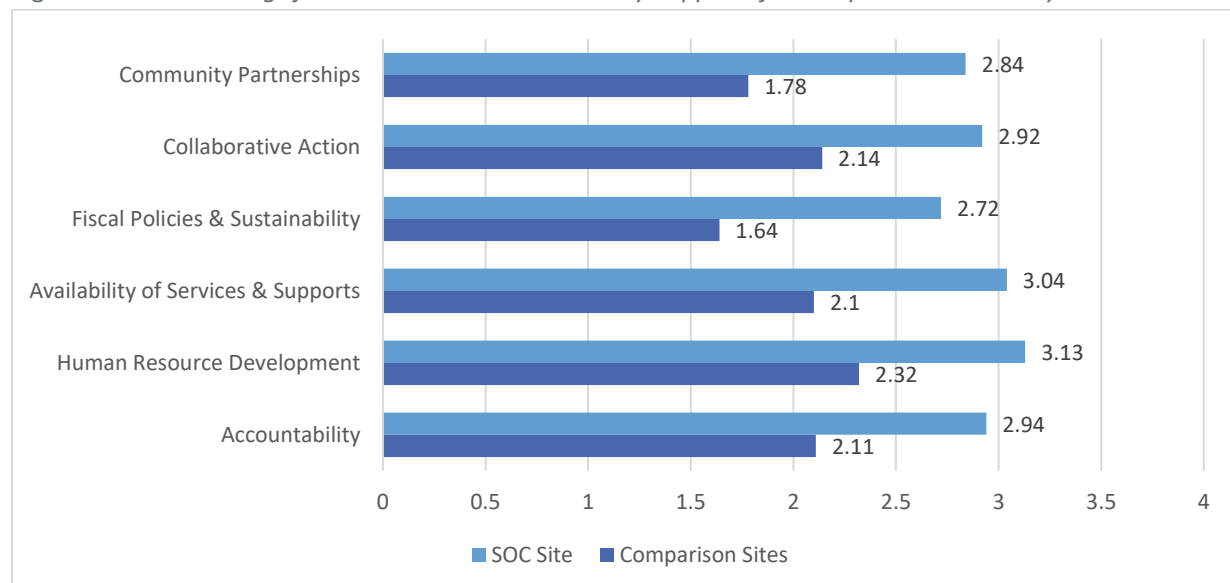
2. *Organization Drivers* are mechanisms to create and sustain hospitable organizational and system environments for effective services.
3. The *Leadership Driver* focuses on providing the right leadership strategies for the type of challenges faced by organizations.

This report will highlight some of the findings from the WrapSTAR report to illustrate the information provided to the community to facilitate quality improvement initiatives.

Community Supports. The Community Supports for Wraparound Inventory (CSWI; Walker & Sanders, 2011) assesses the system context for wraparound. It presents 42 community or system variables that ideally are in place in communities that aim to implement the wraparound process. Respondents rated the System of Care community based on how closely it resembles a “fully implemented” wraparound initiative on subsections such as collaborative action, fiscal policies and sustainability, and accountability. The CSWI was administered to staff and stakeholders via an online Qualtrics survey. Results are displayed in Figure 13 for the averages from the 23 completed surveys, and additional data are shown from comparison sites to aid interpretation. The scores range from “0” for least developed to “4” for fully developed.

Average scores on the CSWI domains are shown in Figure 13. Overall, the System of Care site demonstrated strong community structures to support the wraparound program, with most elements approaching the “almost there” rating. Human Resource Development was a strength for the community, with elements including clear wraparound and partner agency job expectations, reasonable caseload sizes, regular supervision, and reasonable compensation. The Availability of Services and Supports was also a strength, including elements such as access to services/supports that support plans of care, resources devoted to natural community supports, access to peer services, crisis response, and others.

Figure 13. Mean Ratings for Domains on the Community Supports for Wraparound Inventory



Organizational Functioning. The Survey of Organizational Functioning (SOF; Simpson & Flynn, 2007) assesses organizations' climate, job attitudes, workplace practices, and readiness for change in the face of adopting a new practice. For the purposes of WrapSTAR, only the 14 (of 31) subdomains that specifically align with the NIRN implementation drivers' framework are measured. Specifically, the SOF domains and subdomains included are

- *Resources:* Offices, Computer Access, Staffing
- *Organizational Climate:* Mission, Cohesion, Autonomy, Communication, Stress, Change
- *Job Attitudes:* Burnout, Satisfaction, Director Leadership
- *Workplace Practices:* Collective Responsibility, Focus on Outcomes.

The SOF was administered to facilitators, supervisors, and peer partners via an online Qualtrics survey consisting of 79 Likert-rated statements. The findings are presented in Table 4, with mean scores on the scales reflecting staff perceptions of how positive or negative their organization is on the domain, with a response scale of 1 to 5 (1 = strongly disagree, 5 = strongly agree, 3 = neutral). No domain demonstrated overall negative responses from staff, with most reflecting responses between "neutral" and "agree". Staff reported strengths of the organization to be the leadership of the director and the personal satisfaction they receive from their job. Areas with room for improvement included communication within the organization and stress experienced by the workforce.

Table 4. *Responses to the Survey of Organizational Functioning Domains and Subdomains (n=16).*

	Mean	SD
Resources Domain	3.68	.34
Offices	3.89	.64
Staffing	3.69	.53
Computer Access	3.46	.42
Organizational Climate Domain	3.65	.29
Mission	3.98	.35
Cohesion	3.75	.59
Autonomy	3.78	.52
Communication	3.28	.82
Stress* (<i>Reverse scored for adjusted domain mean</i>)	3.34	.77
Change	3.75	.41
Job Attitudes Domain	3.98	.22
Burnout* (<i>Reverse scored for adjusted domain mean</i>)	3.75	.61
Satisfaction	4.15	.48
Director Leadership	4.03	.60
Work Practices Domain	3.83	.38
Collective Responsibility	3.96	.41
Focus on Outcomes	3.69	.43

Wraparound Fidelity Index – Short Form. The Wraparound Fidelity Index - Short Form (WFI-EZ; Sather, Bruns, & Hensley, 2012) is designed to assess the extent to which the core activities of wraparound are being implemented, according to the model defined by the National Wraparound Initiative. The purpose of this evaluation is to determine the extent to which the services and supports that are being received by youth and families enrolled in services adhere to those primary activities of the wraparound process on an individual youth or family basis. This survey is separated into four sections: 1) Basic information; 2) Experiences in wraparound; 3) Satisfaction; and 4) Outcomes. These scores produce a Total Fidelity score as well as Key Element scores, which are calculated as percentages of the total possible scores. The Key Elements are sorted into the following: outcomes-based, effective teamwork, natural and community supports, and strengths- and family-driven. The WFI-EZ was administered to youth, parents/caregivers, facilitators, and team members via an online survey through the WrapTrack system, or in person with a paper version of the survey. The following includes national means to help with interpretation. A total of 58 surveys were completed, reflecting the responses of 21 caregivers, 16 team members, 15 facilitators, and 6 youth.

WFI-EZ fidelity items are aggregated to represent a Total Fidelity Score. Individual fidelity items are scored from 0 (low fidelity) to 2 (high fidelity), and the overall score represents the percentage of available fidelity points. Figure 14 shows the overall fidelity scores of the System of Care community in comparison to the national mean. The site has a total fidelity score of 73.3%, which was slightly lower than the national mean of 74.2%. Summary scores for the key elements of wraparound are presented in Figure 15. These scores provide further clarification on relative strengths and weakness within the program. The highest fidelity scores, representing relative strengths for the wraparound program, are having a wraparound process that is strength- and family-driven and outcomes-based. The lowest areas of fidelity for the SOC site include the development of effective teams to support the wraparound process and the inclusion of natural and community supports. These key elements are also lower for the national sample, as well, suggesting they are more challenging elements of wraparound fidelity.

Figure 14. *Total Fidelity Score*

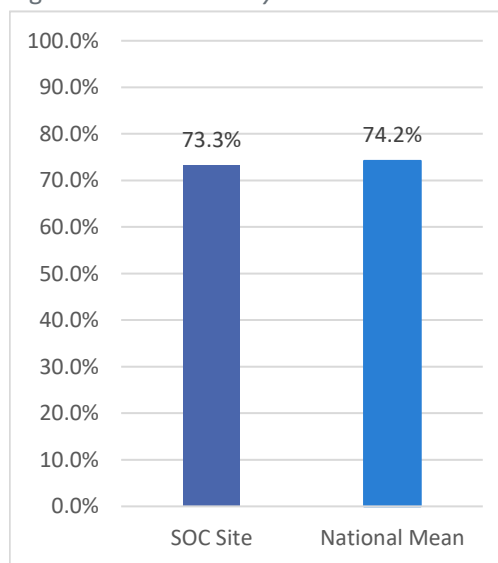
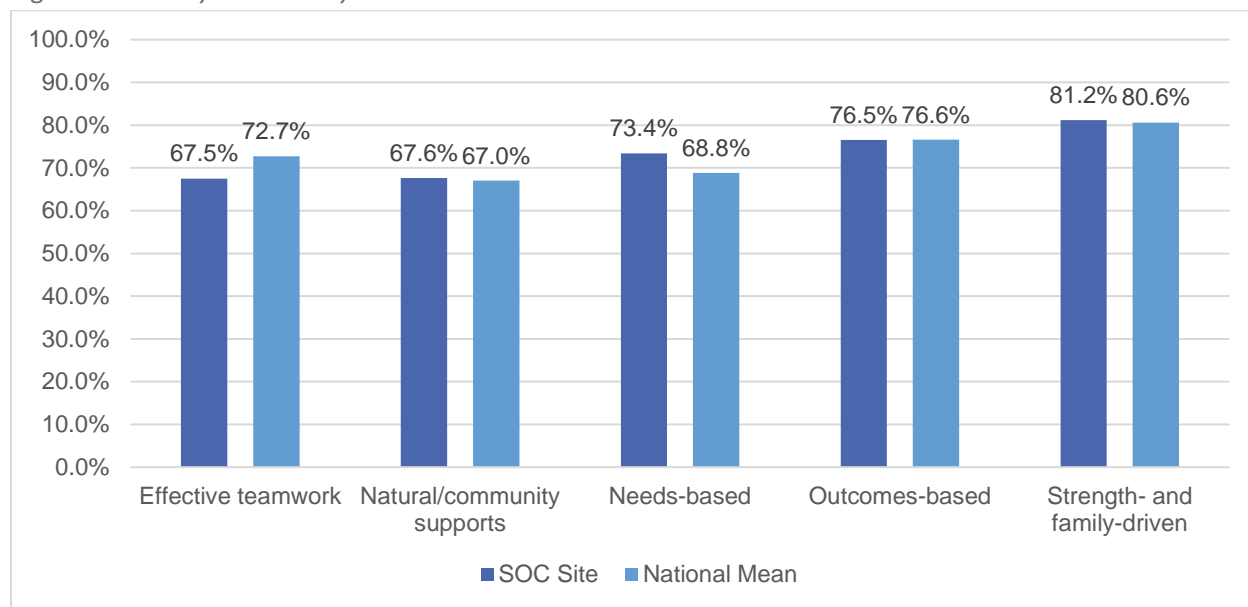
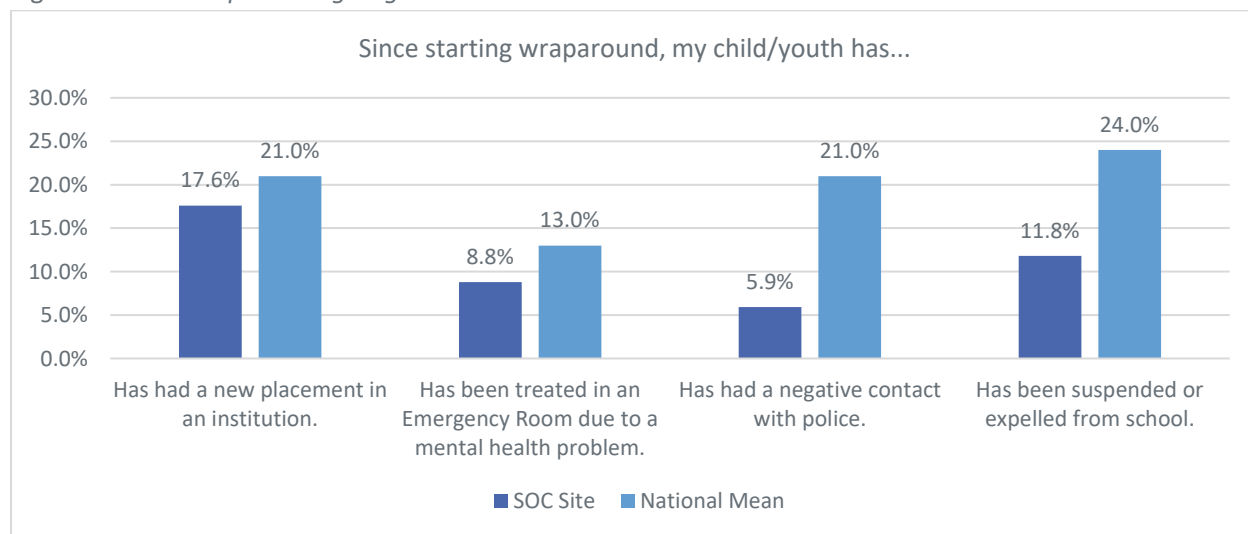


Figure 15. *Fidelity Scores - Key Elements*



Outcomes are assessed through caregiver reports. Reports are presented on the occurrence of key negative events. Figure 16 illustrates the item responses given by families surveyed with the WFI-EZ and the national means. Generally, the data indicate that the outcomes for youth receiving wraparound planning at the System of Care expansion site are better than those found in the average wraparound program in the country. While lower than the national mean, the site still had a fair number of youth, almost 1 in 5, have an institutional placement after starting wraparound.

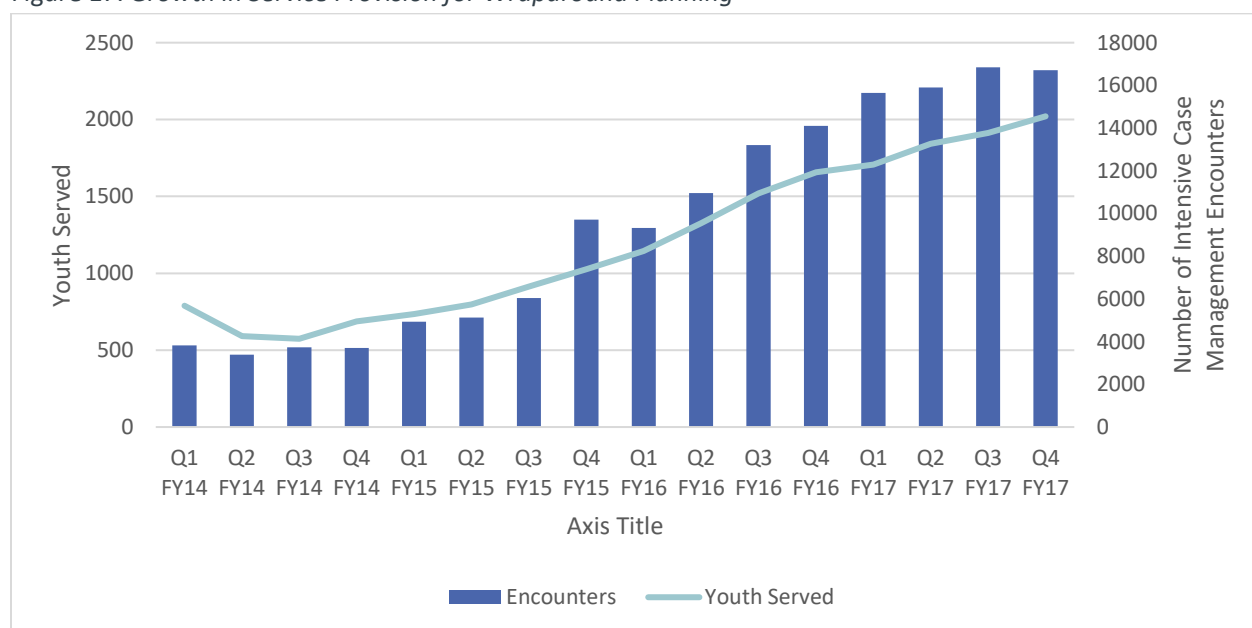
Figure 16. *Youth Experiencing Negative Outcomes*



State Wraparound Process and Outcome Impacts

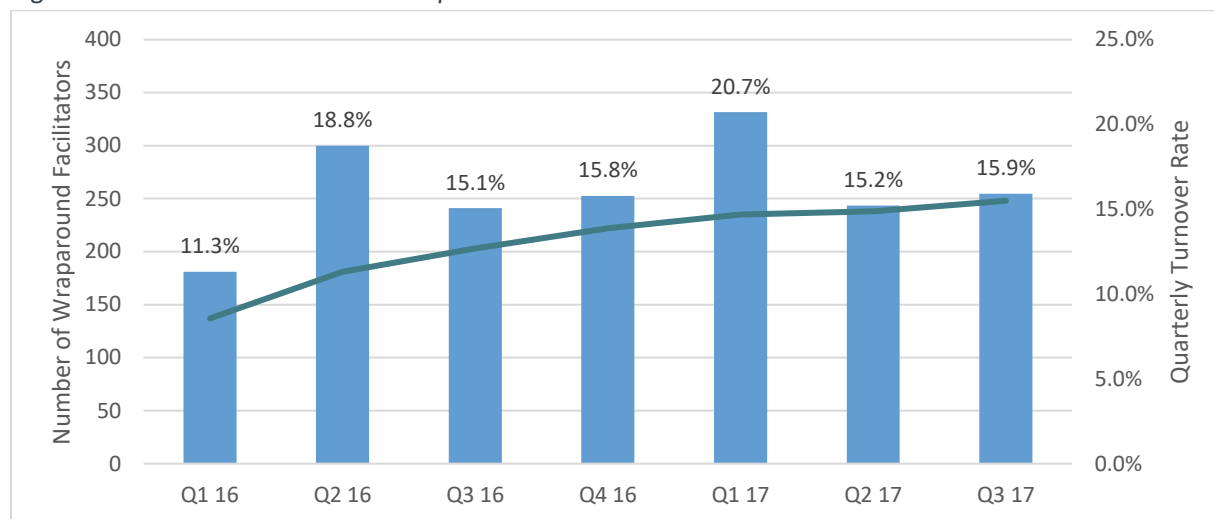
Growth in Services. Texas supports the provision of wraparound facilitation through the Medicaid service of targeted case management. Within Texas’ administrative code, intensive case management is defined as “a focused effort to coordinate community resources that assist a child or adolescent in gaining access to necessary care and services appropriate to the child’s or adolescent’s needs.” The code requires the use of a wraparound planning process. The growth of wraparound in Texas can, at least in part, be tracked by the increase in the use of intensive case management over time, as well as the number of families served with this service. Figure 17 illustrates the impact of policy and financing changes that resulted in statewide implementation of wraparound. The results demonstrate the increase in the number of youth served using wraparound planning, but also illustrate that the growth in encounters has been greater than the growth in youth, suggesting an increasing “dosage” for each family, as well.

Figure 17. *Growth in Service Provision for Wraparound Planning*



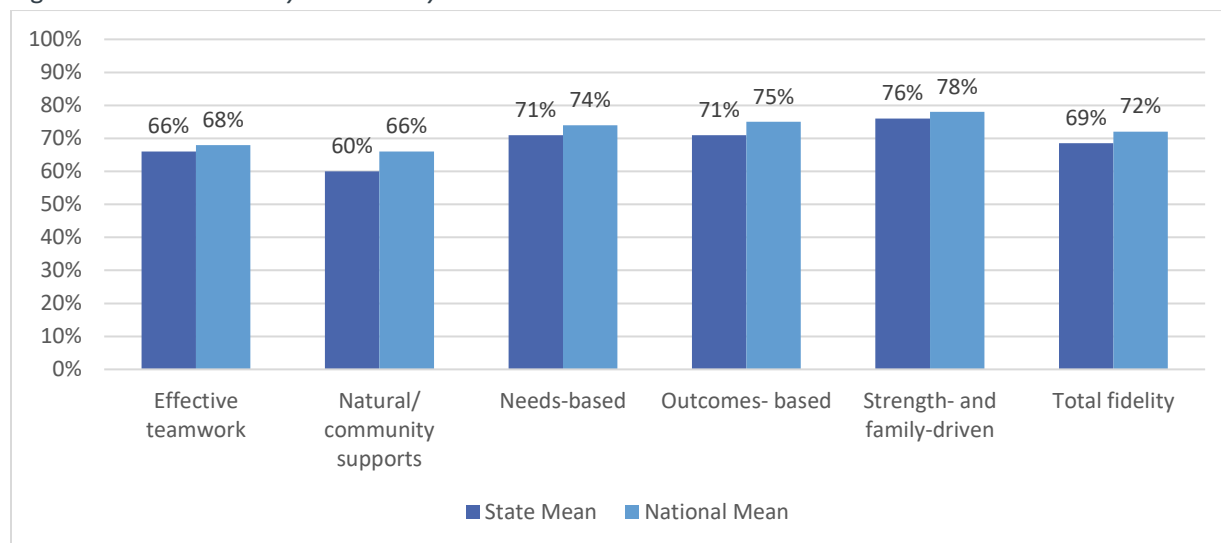
Wraparound Facilitator Turnover. Wraparound programs began increasing capacity significantly following the statewide expansion of the YES Waiver program. Since staff turnover is a critical issue for ensuring a return on the investment in staff training and competency, as well as being a primary factor in quality of care and high team functioning, the quarterly turnover rates for organizations was measured and tracked. State turnover rates for staff providing wraparound facilitation are presented in Figure 18, with an overlay of the number of active facilitators. As illustrated in the graph, the number of wraparound facilitators has grown over the two years, with 248 facilitators in Quarter 3, FY2017. Quarter 4 in 2017 saw continued growth to 267 facilitators. The quarterly turnover averaged 16.9% over the course of the two years, with some minor fluctuations. Texas would like to see a decline in the staff turnover, as programs become more established and supervisors develop additional skill in supporting facilitators.

Figure 18. State Turnover Rate in Wraparound Facilitators



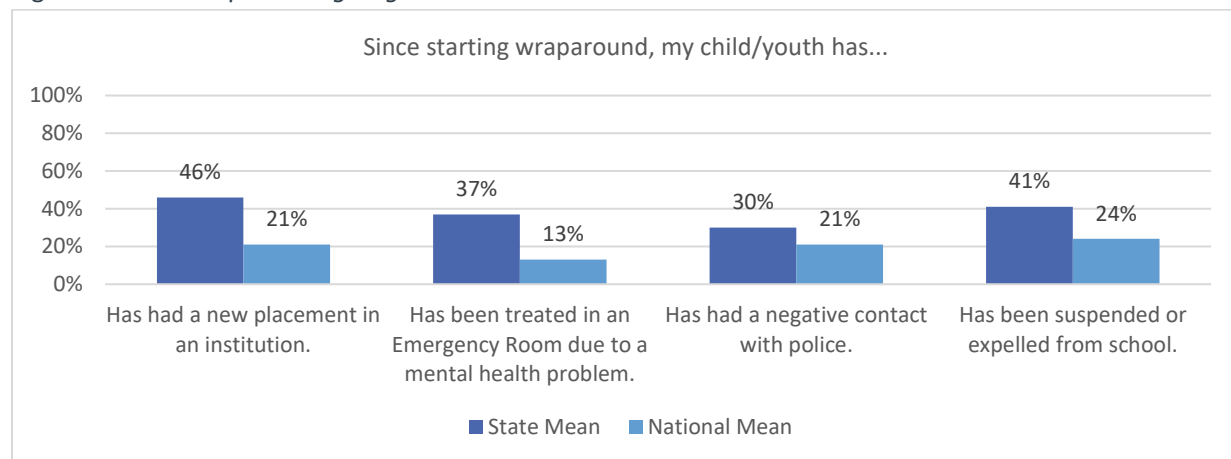
Wraparound Fidelity. Wraparound fidelity was measured using two different methodologies over the course of the project period. Initially, all families involved in wraparound who agreed to participate were assessed after reaching six months in the wraparound program. The state mental health authority then opted to change the methodology to limit wraparound fidelity measurement to those families involved in wraparound within the YES Waiver and wraparound fidelity was measured through an annual organizational snapshot, sampling families who had been involved in wraparound for at least three months and no more than fifteen months. The data making up the aggregate state wraparound measures includes ten organizations implementing wraparound, with sites captured at various time points during the grant period. Overall, the fidelity in Texas communities is slightly lower than the national mean across all key elements of wraparound (see Figure 19). Texas wraparound programs had the highest fidelity ratings on elements measuring strength- and family-driven, with the lowest ratings on items measuring the inclusion of natural and community supports.

Figure 19. Overall Fidelity Scores - Key Elements



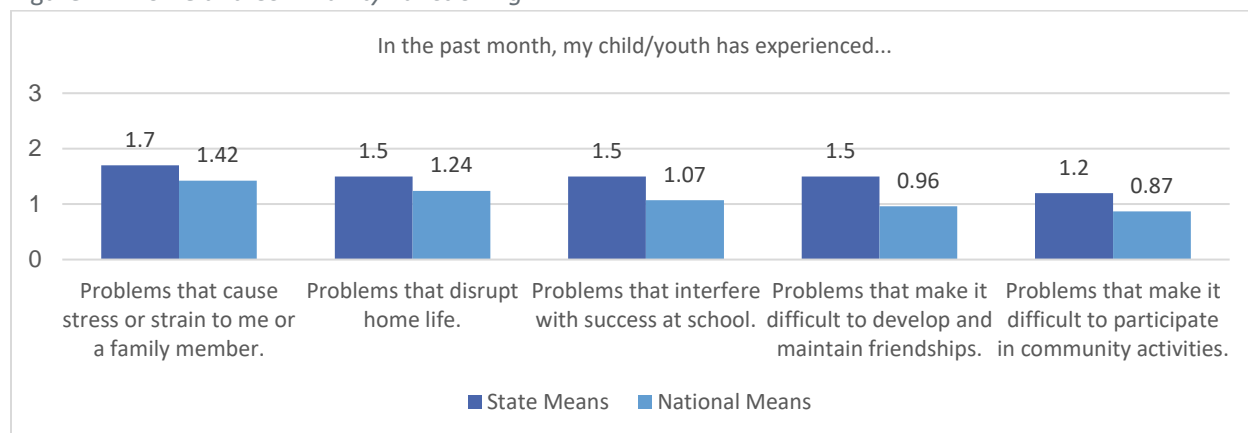
Wraparound Outcomes. Outcomes are assessed through caregiver reports on the WFI-EZ. Reports are presented on the occurrence of key negative events, as well as the experience of negative community functioning. Figure 20 illustrates the item responses given by families surveyed with the WFI-EZ and the national means. Generally, the data indicates that the outcomes for youth enrolled in wraparound are poorer than those found in the average wraparound program in the country. Youth in Texas' programs were significantly more likely to have had a new placement in an institution and more likely to have been treated in an emergency room due to a mental health problem compared with either national means. The incidence of placement in an institution is quite high (46%). The incidence of treatment within an emergency room and suspension or expulsion from school were also quite high in Texas, as much as twice or three times the incidence in other programs.

Figure 20. *Youth Experiencing Negative Outcomes*



Additional outcome questions ask about the youth's problematic functioning within different life domains. Responses are measured on a scale ranging from very much (3), a good deal (2), a little bit (1), and not at all (0). Higher scores indicate more problematic functioning. Figure 21 illustrates caregivers' perceptions of youth functioning in the past month, in comparison to national means. Generally, the responses indicate that caregivers continue to experience moderate impacts (between "a little bit" and "a good deal") of stress and strain related to issues that brought the family to wraparound, that those problems disrupt home life and impede the youth's success at school. Caregivers report also experiencing moderate impacts (between "a little bit" and "a good deal") on problems impacting the youth's ability to maintain friendships and participate in community activities. Families in Texas wraparound programs report more problematic functioning than reported in national means, and greater stress and strain to family members.

Figure 21. *Home and Community Functioning*



Qualitative Feedback from Caregivers. Caregivers shared their impressions on the wraparound program, outcomes for their families, and opportunities for improvement as a part of the fidelity interview. Qualitative feedback varied significantly across the sites and was shared directly with each participating organization as a part of quality improvement activities. Therefore, thematic summary of these comments is inappropriate. However, select critical and positive comments are presented below to illustrate this feedback.

Parent Feedback on Opportunities for Improvement

- We were in the enrollment process longer than wraparound. Our team doesn't focus on anyone but the child with mental health needs. When you have a family with more children who are not involved in YES Waiver, these kids feel left out and feel like the child with the mental illness gets special attention.
- The main thing I suggest is that once a case manager is in place, a child should not have to go through more than two case managers. They should only have one case manager. My child has PTSD and having five case managers triggers her because she feels like she is being dumped onto others. It's hard to trust and feel comfortable.
- My daughter is in and out, doing good and then bad and the team has [been] talking about discharging and she might not be ready. Sometimes it feels like they don't understand why she has fall backs.

Parent Feedback on Positive Aspects of Wraparound

- We are on our second wrap facilitator since we've started. We have an amazing facilitator that 'gets' [youth's name] and our family. The facilitator just gets us! I cried at our last meeting and the facilitator just knew what was going on. The experience is quite profound. We all feel very comfortable. I am infinitely grateful for that. The program has been so beneficial. We have increased communication in ways that weren't ever possible before.
- I was getting ready to let him go; it was really challenging. The YES Waiver gave me parenting classes, which taught me how to calm down when he acted out. It really helped me. I felt like I had no one, no information, no help so when I started the parenting classes, I saw all those parents who understood and I thought: "I am not by myself with this."
- We've been through a lot of RTC's and psychiatric hospitals and this has been the only program that has worked for us.

Transition-Age Youth Initiatives

State Policy Initiatives

To explore the current “state-of-the-state” for services to transition-age youth, a report was developed that reviewed national best practices, summarized current specialized services in Texas, and analyzed state administrative data within the mental health system. The report highlighted some gaps for youth and young adults with significant mental health challenges. Data was explored on the 8,961 youth who reached 17 years of age in FY2015 or FY2016 while receiving children’s mental health services (excluding crisis services). Of these youth, 1,607 (17.9%) used adult mental health services at some point in the following year. The vast majority (78.8%) of youth who transitioned into the adult system were authorized for Basic Services with Skills Training (A1S). Youth age 16 to 17 also had a very different diagnostic profile than young adults served in the system, suggesting that changes in diagnostic eligibility between the two systems are a prime reason for a lack of transition.

A state-level transition-age youth committee met over two years to discuss opportunities for improving mental health services for transition-age youth. Due to the existing gaps and to better align with Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements, the state mental health authority created a new level of care targeting transition-age youth. This level of care, which will cover ages 16 to 20, allows providers to continue to provide available services to eligible young people. The transition-age youth committee continues to meet to identify opportunities to support this system change.

Supported Employment and Supported Education Pilot

Overview. Texas System of Care reviewed gaps in the system and potential evidence-based practices and decided to initiate a pilot study of supported employment and education (SE/SEd), adapted for transition-age youth. The Individual Placements and Supports (IPS) model of supported employment has been adapted previously (Ellison et al., 2015; Klodnick et al., 2015) to better meet the unique needs of this population. In January 2016, four mental health providers, representing 16 counties, attended a three-day workshop that provided an overview of SE/SEd, trained in select activities and skills, and provided opportunities for discussions of implementation facilitators and barriers. Each team had an opportunity to begin planning for how the service would be implemented within their unique organizational structure. All providers of SE/SE also participated in the online training in IPS for adults. Monthly consultation calls with national experts at Thresholds, Inc. and TIEMH staff offered on-going support for implementation and problem solving.

Notes from the on-going technical assistance calls were coded and analyzed for themes. Research questions included: (1) what challenges do providers face in engaging transition-age youth; (2) how did providers plan to implement the adapted IPS model in their agency; (3) what made the implementation process successful; and (4) what barriers did providers experience during implementation? Some of the themes identified in the evaluation are summarized below.

Results: Engagement of Transition-age Youth. Providers reported that almost all youth and young adults, when presented with the program, expressed a strong desire to obtain employment and/or to enroll in an educational program. Despite this, providers struggled to engage clients due to various barriers. Communication barriers were a common problem, with clients not returning calls, having disconnected phones, and agency prohibitions on texting noted most frequently. One organization had significant struggles with the referral process. Clients who noted employment as a goal in their intake were referred to SE/SE; however, the referral occurred with a host of additional referrals (e.g., psychiatry, therapy, anger management) which appeared to reduce the likelihood that clients would follow-up with their SE referral due to oversaturation of services. Agencies also noted that parental involvement served as a barrier to engagement at times. Some parents were overly involved with the process, which limited the youth/young adults' perception of independence and personal investment in the program. Some other parents discouraged the youth/young adults' involvement due to fear of losing financial benefits.

The review also identified facilitators of youth/young adult engagement. Providers reported that being able to meet with clients face-to-face during the initial intake increased the likelihood of engagement with services. The use of motivational interviewing techniques (e.g., open-ended questions and reflective listening) as well as assertive engagement (i.e., continuing to attempt to make contact despite early failures) also increased the likelihood of engagement. Finally, providers found that informational flyers helped families understand the differences between the employment services they offered and those provided by the Department of Assistive and Rehabilitative Services and the Texas Workforce Commission (more placement-based employment services).

Results: Financial Barriers. Two primary financial barriers were identified for implementation of SE/SEd for transition-age youth. Two participating sites noted a lack of funding for staffing and/or building a new program to serve transition-age youth. The agencies were coached on strategies to incorporate the services into existing programs, but the sites still identified financial constraints that made full implementation challenging. Many of the additional costs were related to the development of an employer network and retention of this network, which involves both time for relationship development and employer appreciation events and incentives. Employer development is not a billable service under current guidelines. Other financial barriers resulted because any services provided over the phone or in the car cannot be billed. As this age group tends to be more transient than older or younger populations, case management and skills training was often performed over the phone or in the car. Productivity requirements, put in place to ensure financial sustainability, also served as a barrier to full implementation. Engagement of this age group requires more relationship-building and career exploration than older populations, neither of which are billable services.

Results: Coordination with Mental Health Services. Research has demonstrated that youth and young adults who are engaged in supported employment services are more likely to engage in clinical services, such as medication services and therapy. However, pilot sites reported challenges with coordination with other services and supports and providers reported that they felt responsible for any coordination with other providers. SE/SEd providers noted that clinical staff appeared to see employment services as a privilege for clients rather than a need. Providers reported that clinical staff often commented that a youth/young adult was not ready for or capable of obtaining employment, with the implication that they would need to be stabilized through medication, therapy, etc. before engaging in supported employment. Some issues with "competition" for the client's time, focused on meeting productivity requirements, also arose. Supported

employment providers spent a significant amount of time providing information about the services to clinical staff, conducting trainings, advocating for the need to participate in clinical team meetings and intakes, and developing relationship with other staff. This effort, along with positive outcomes experienced by youth, seemed to increase referrals to the program over time.

First Episode Psychosis Programs

In 2014, SAMSHA directed the Texas Health and Human Services Commission (HHSC) to allocate 5% of its Mental Health Block Grant funding to create pilot first episode psychosis (FEP) programs in the state. Texas rolled out programs in Harris and Dallas counties, with each program evaluated independently in 2016. In 2017, Texas rolled out coordinated specialty care clinics in six additional communities to serve transition-age youth with early onset psychosis. A cross-site formative evaluation was conducted, focused on the experiences of the various agencies in the implementation process, as well as an initial exploration of outcomes utilizing existing administrative measures.

Qualitative Results. Semi-structured interviews were conducted with program leads from all FEP programs, as well as a sample of all other team members (e.g., psychiatric provider, supported employment specialist, peer provider) for a total of 40 interviews. Each of the team members reported that training by OnTrackNY was helpful in implementing the coordinated specialty care clinics and hoped to continue regular coaching calls beyond the one year that was initially planned. The structure of the teams adhered to the OnTrackNY model, with many agencies also including peer support providers on the team. Teams had some struggles identifying eligible young people initially, but teams were close to full or full by the end of the evaluation period. Most agencies reported that internal referrals and referrals from local hospitals were the most common. Providers shared that involving family members was an important aspect of success, and noted that engaging families early in the treatment process was more successful. Providers also reported that the frequent communication and clear team roles aided in the overall success of the program. One of the barriers identified by a number of providers was the difficulty in determining eligibility, primarily due to getting reliable information about initial symptom presentation and treatment history.

Quantitative Outcomes. Individuals who received services through the FEP programs were assessed regularly using the Child and Adolescent Needs and Strengths (CANS; Lyons, 2009) or the Adult Needs and Strengths Assessment (ANSA; Lyons & Walton, 2013). The analysis involved the development of factor scores utilizing items from the Risk Behavior and Emotional and Behavior Needs scales. The factor scores were utilized in a growth mixture model to identify the trajectories of individuals in the FEP program and propensity-matched individuals served outside of the FEP program. For the Internalizing Factor, two trajectories showed recovery for the FEP group, making up 68.5% of the sample, and only one showed recovery for the control group, representing 5.2% of the sample, a marked difference. For the Externalizing: Disinhibition Factor, one trajectory for each of the FEP (10.2%) and control (3.9%) groups showed recovery. For the Substance Abuse Factor, twice the proportion of the FEP (21.6%) group evinced a recovery trajectory relative to the control group (11.4%). Finally, for the Psychotic Disturbance Factor, a majority of individuals in the FEP (92.8%) and control (89.2%) groups showed low-stable symptoms. In the FEP group, the rest of the participants showed a recovery trajectory (7.2%), whereas the control group had an initial worsening followed by recovery group (6.1%) and a worsening group (4.8%). These preliminary findings suggest that the FEP program in adults may

offer more recovery benefits in a variety of psychopathology domains than the treatment-as-usual group, and may help to stabilize those with psychosis more quickly and effectively than the control group. Child samples were too small for analysis.

Building Bridges Initiative

Overview of the Building Bridges Pilot

To engage additional communities and behavioral health providers, Texas System of Care hosted a pilot project to support implementation of best practices identified through the Building Bridges Initiative (BBI), which seeks to “create strong and closely coordinated partnerships and collaborations between families, youth, community- and residentially-based treatment and service providers, advocates and policy makers.” Texas System of Care partnered with the Seclusion and Restraint Reduction Leadership Group, state agencies, and state non-profits to host a two-day training event in BBI practices. In conjunction with the training event, residential treatment providers and community mental health centers were invited to apply to be a part of a learning collaborative. Selected organizations were supported to travel to Austin for the training, participate in team-based planning activities, and offered technical assistance for six months to support implementation of changes. Training and technical assistance was provided by national experts through BBI and the Texas System of Care team members. State contracts for residential treatment providers funded through the Department of State Health Services (later HHSC) and the Department of Family and Protective Services, were also examined by national BBI experts to support alignment with best practices.

Engagement, Training and Policy Changes

Engagement. Texas System of Care received seven applications to participate in the BBI learning collaborative, with six representing residential treatment programs and one community mental health center. With a selection committee incorporating family members, three residential treatment programs and one community were selected. Each participating organization was asked to identify a team, inclusive of decision-makers, clinical staff, direct care staff, and family representatives. Unfortunately, none of the organizations successfully engaged a family representative. Following the initial training event, the one community provider declined further participation, stating that they already had strong collaborations with residential programs. The remaining three residential treatment providers participated in collaborative calls and individually tailored consultation and technical assistance to advance each center’s work toward their goals. To expand the reach of additional BBI efforts, an additional three centers were recruited prior to the second training event.

Training. The initial two-day training event included an opening keynote presentation by Beth Caldwell, providing an overview of the principles of Building Bridges and focusing on strategies to enhance family-driven and youth-guided care and build connections for the child with the community. An experienced director of a residential program shared best practices and outcomes that they achieved with BBI principles, and a family and youth panel shared what is most important to them while involved in residential care. A national expert also shared concrete strategies for providing trauma-informed care and reducing the use of restraints and seclusion. The second day of the conference offered the three residential treatment centers and one community provider the opportunity to participate in a four-hour facilitated strategic

planning session, resulting in the identification of each residential treatment program's BBI-related priorities, goals, and specific action steps towards implementation. Training participants completed evaluation instruments on both days of the event. On the initial day, 55 participants completed forms with 87.3% reporting that their goals for the training were fully met. Thirty-three percent of participants described the training event as "excellent," 47.3 percent as "very good," and 14.5% described it as "good". The remainder (5.5%) reported that they found it "fair." Review of the qualitative responses suggests that many participants found the presentations offered many new ideas about best practices, at times making them consider that their program was not implementing some critical practices. A small number of participants were "discouraged" by information that questioned outcomes of traditional residential care and felt that some of the information shared was not practical in Texas and that there would be barriers presented by current child welfare policies.

I felt like I was challenged to truly consider in what ways we can engage the whole family.

The teams participating in the second day of the event were even more satisfied with the planning activities and networking. All fifteen respondents indicated that the second day of the event met their goals, and

It helped us identify strategies to move towards implementing BBI principles.

86.7% described the event as "excellent," with the remaining participants describing it as "very good." Comments from the participants suggested that individuals appreciated the time spent planning next steps and problem-solving potential barriers. They also reported enjoying networking with other programs to hear about their challenges and struggles.

A second workshop was held in January 2017 and focused on enhancing parent participation in residential care. Attendance was limited and so this event was followed by two webinar events. The first webinar was held in February 2017 and focused on moving from controlling to collaborative practices. The second webinar was held in March 2017 and focused on partnering with families through family-driven practices. Both webinars were made available for reviewing online after the live events concluded.

Policy Changes. The Department of State Health Services held contracts with multiple residential treatment providers to support a new program intended to prevent parental relinquishment to child welfare to access intensive mental health treatment. Texas System of Care supported consultation to the state in reviewing these contracts for opportunities to strengthen the alliance with BBI principles. The contract requires residential programs to involve family members in family therapy, maintain weekly contact with the community mental health provider, and coordinate discharge to community services. The contract also prohibits any policy that limits child and family communication and visits. In interviews with community provider liaisons with the residential treatment center, one liaison indicated "the RTC has gotten better about involving families, even though at the beginning it was kind of foreign to them." Recommendations for changes to the contracts held by the Department of Family Protective Services, managing children under conservatorship, were also made, but contracts were still under negotiation at the conclusion of the grant period.

Impact of the Building Bridges Activities

Participating residential programs were asked to complete a qualitative survey asking for information about changes that had been undertaken and made to support BBI best practices. The survey also requested information on outcomes measured as a result of these efforts, challenges experienced during the change initiative and strategies undertaken to solve these problems. The results of these surveys are shared as case studies of the five programs who responded.

Site A. This program has been involved with the BBI initiative for 16 months. The site reported conducting training to improve staff skills at engaging families in treatment and increasing the amount of time youth spend with their family as they transition towards discharge. They have also increased the amount of time families are involved in family therapy. The organization reported that they have had two youth discharged from the facility since starting the BBI initiative, with both being unsuccessful. They shared that one barrier they experience is that the judge determines when a youth is returned to the community and that the youth's readiness may be overestimated. They shared that they have minimal data monitoring, but have noticed a reduction in the use of seclusions and that those that occur are generally briefer. They also noted some success in having peers provide feedback to youth on their behavior, increasing the youth's self-awareness and acceptance of feedback.

Site B. This program has been involved with the BBI initiative for 12 months. The center has focused primarily on increasing family involvement. The agency purchased technology devices to support the use of Skype for family therapy and family visits for families who could not afford these tools. They also increased their commitment to transporting youth for family visits, even as far as across the state. The site also reviewed all of their youth permanency plans and conducted planning meetings focused on youth without a clear plan. The agency has also reviewed their plans around reductions of seclusions and restraints, changed their staff training program, and utilizes an outdoor calming area. They also report success in recruiting a very diverse staff (77% non-Caucasian) and report the Board of Directors has also worked to increase their own diversity. The site reported some limitations in data monitoring because of a transition in their data reporting system.

Site C. This program has been involved in the BBI initiative for 16 months. The facility has strived to increase their awareness and coordination with community resources, despite youth coming from across the state. They have utilized a partnership with the Local Mental Health Authorities to identify local resources within the community and help connect families to these resources. The site is also working to increase engagement of families, by assigning a staff member to build an on-going relationship with families, increasing participation in family therapy (including Skype), and connecting with extended family members. They also provide at least monthly contact with family members following discharge to ensure successful transition. They noted that none of the youth discharged since participation have been readmitted to a psychiatric hospital or residential facility. The site continues to use a level system, but has made modifications to make it more individualized, including having youth participate in determining rewards and consequences.

Site E. This facility has been involved with BBI for 12 months. The agency has strived to redefine their outcome measurement system. Through consultation with Boys Town, they have created an outcome tracking system that screens youth and families 1 month, 6 months, and 12 months after discharge. They are

focusing on long-term functioning as a key indicator of success, rather than successful discharge. Data is limited at present, but the agency is aggregating and monitoring the data. The facility is also striving to establish a volunteer family advocate program, in which experienced family members provide support and connection to families of youth residing at the facility. They are also working to incorporate videoconferencing for family therapy and are awaiting approval from information security staff. This facility continues to utilize a level system, but has removed family phone calls and family visits from the level system. The facility has seen significant improvements in restraints, with a 50% reduction. They have been revising comfort rooms to include sensory feedback opportunities, training staff in collaborative problem solving, and teaching self-regulation techniques weekly. They also note that having leadership review videos of all restraints has led to changes and restraint reductions.

Site F. This program has been involved in BBI for 16 months. This program focused significantly on moving to a culture of collaboration. They have worked to change the physical environment to be more engaging, by having murals painted on walls, reducing stimulation through sound proofing, and creating sensory rooms within dorms. The facility has created a youth council, which provides recommendations for agency improvements and assists in staff hiring decisions. The center is working towards removing the level system, and currently has opened up phone calls with family and significant other to all youth. Staff have been trained in collaborative problem solving and efforts have been made to reduce staff turnover through Servant Leadership training for supervisors. This site has been able to reduce their use of restraints by 75%. The center is beginning to focus on improving engagement with families and community resources, recognizing that the youth come from across the state. They are working to develop a volunteer parent advocate program and have initiated web-based technology for family meetings. The agency does not have a formal follow-up process for youth following discharge or track post-discharge outcomes.

Lessons Learned and Next Steps

Summary of Key Findings

The evaluation of the System of Care initiative from 2013 to 2017 was multi-faceted, with selected key findings summarized below:

- The Texas System of Care initiative made significant progress in all of the key goal areas, including the development of awareness and buy-in from key stakeholders, the expansion of effective services and supports, the alignment of financial resources with System of Care values and principles, and the development of accountable data-driven systems. Highlights include the strengthening of a state oversight committee under the direction of HHSC, the increase in the number of communities actively working to build or enhance a local System of Care, expansion of non-traditional services and supports, expansion of evidence-based services for transition-age youth, the expansion of wraparound planning throughout the state, investment in the statewide expansion of YES Waiver, and the development of infrastructure to monitor fidelity and outcomes of wraparound.
- Texas System of Care supported the establishment of a youth leadership organization, serving as a state chapter of Youth MOVE. Members of ACCEPT youth leadership group felt strongly that the group leaders are skilled, that the group has increased opportunities for members, and that the group has helped support new youth leaders.
- Texas System of Care facilitated the development of a coalition of family leaders, focused on supporting families of children with mental health challenges. Members of the Texas Family Voice Network (TxFVN) felt strongly that members were dedicated to the mission of the group. Members were neutral to disagreeing with the statement that no other group is doing the same activities. Both TxFVN and ACCEPT members reported feeling the funding to accomplish their goals was inadequate.
- Communication and social marketing activities were associated with an increase in awareness of System of Care values and principles; however, many areas of the state and child-serving organizations remained unaware of the System of Care initiative.
- Texas made significant financial investment in children's mental health during the project period, including efforts to prevent the relinquishment of children to the child welfare system to access intensive treatment, the expansion of non-traditional services and supports, and the establishment of coordinated specialty care clinics for youth and young adults with early onset psychosis. Investment in family and youth peer support was not achieved.
- Although respondents in many areas of the state lacked an understanding of the key concepts of System of Care, activities were associated with a perceived increase in was a significant statewide impact on individualized assessment of family strengths and needs, families having primary decision-making roles in care, youth being active partners in their service planning and delivery, and the availability of a broad array of home and community-based services and supports.
- Youth served in System of Care communities demonstrated clinically significant symptoms and impairment in functioning when entering services. All families reported satisfaction with the care

that they received. While the sample sizes for examination of outcomes were small, statistically significant reductions in psychological distress and increases in social connectedness were observed.

- There has been a significant investment in training of wraparound facilitators and supervisors in Texas, with almost 600 individuals receiving the full three-segments of training by the end of the project period. Staff turnover in wraparound facilitators is a significant issue in many organizations, with some caregivers reporting frustration with having multiple facilitators.
- Texas has established a program for monitoring wraparound fidelity and outcomes and providing feedback to organizations for quality improvement. Aggregated across all sites who have been assessed to date, wraparound programs are performing poorer than the average program within the country. In addition, Texas wraparound programs show a greater proportion of negative events, such as institutional placements and use of emergency rooms to address mental health crises.

Lessons Learned

The findings from the evaluation have led to several lessons that have the potential to guide further expansion of the System of Care framework within the state.

- The development of community Systems of Care can be supported through low to moderate financial investment, in association with state training and technical assistance. This investment can allow community organizations to contribute staff time to the development and support of child behavioral health governance bodies, community strategic planning, and sharing of resources to support the achievement of local goals and outcomes.
- The development or expansion of effective services and supports is more effective when embedded in state policy and financing. Mental health provider organizations frequently lack the resources to implement new practices or services without targeted funding (e.g., grant funding), and alignment of state or federal funding and contracting is frequently necessary to sustain the practice beyond the initial program period.
- Communication and social marketing strategies are important to raising awareness and build buy-in from a variety of stakeholders. A multi-faceted approach is necessary to reach a variety of audience members, using specific strategies to target audiences. Targeting “hard-to-reach” communities with easily accessible, low-cost strategies can increase reach beyond the “early adopters.” Texas System of Care engaged new communities in children’s mental health awareness day activities by providing materials (e.g., butterfly toys) and a toolkit, allowing communities to plan events with minimal effort.
- Texas System of Care has used the learning collaborative framework to engage organizations in innovation, exposing representatives to key System of Care values, such as family and youth voice and cross-system collaboration. Learning collaboratives have allowed state agencies to define the resources needed for change, build interest across a broad array of providers, and identify likely barriers and challenges. Following these initial pilot projects, the state has supported changes in contracts and policies aligned with the initiative, allowing for further implementation and sustainability.
- Many of the gaps in care for transition-age youth are a result of policy and structural barriers. While workforce development is an important component of efforts to improve services to this age group, a systematic examination and modification to structural barriers within service systems is critical.

Next Steps

The Substance Abuse and Mental Health Services Administration has awarded Texas System of Care a four-year cooperative agreement to build further sustainability for the System of Care expansion within the state. The grant will focus on continuing the expansion of community Systems of Care, focused initially on Collin County and a twelve-county region in East Texas. Goals of the grant are to:

- increase leadership support for the system of care at the state level;
- develop a system that will allow children and youth referred by any child-serving agency to be served with high-fidelity wraparound when clinical eligibility is met;
- improve the capacity of Texas's public mental health system to support transition-age youth;
- improve continuity of care for children and youth in juvenile justice placements and residential treatment centers;
- continue development of youth and family voice and leadership in Texas's behavioral health system;
- reduce disparities in access to and use of services, and in outcomes in specialty populations;
- improve knowledge statewide about system of care and sustainability; and
- evaluate the system of care and engage in continuous quality improvement.

Texas System of Care will utilize the findings from this evaluation and the lessons learned in the initial expansion opportunity to continue to expand and sustain the System of Care framework within Texas. The next four years will focus on filling current gaps within the System of Care efforts, including enhancing collaborations with the juvenile justice, child welfare, and educational systems, further advancing the fidelity of wraparound planning, supporting youth with mental health challenges through the transition to adulthood, and reducing disparities in access, use, and outcomes within state services. Texas System of Care will aim to sustain these advancements through changes to state policies and financing practices and the development of infrastructure to support further community training and technical assistance and peer-to-peer learning opportunities. Evaluation activities will focus on documenting the cross-system impacts of System of Care and the cost-benefits of further investment.

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