Idaho Youth Empowerment Services (YES) Family Survey Results 2020

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Abstract

Objective: This report presents findings of the 2020 Idaho Youth Empowerment Services (YES) statewide family survey. The survey was commissioned by the Idaho Department of Health and Welfare, Division of Behavioral Health (DBH) and completed by investigators at Boise State University. The overarching aims of the survey were to assess families' experiences and outcomes of care in Idaho's YES system and to guide service improvement efforts.

Method: We conducted a cross-sectional, postal mail survey of 3,999 caregivers of youth who had participated in YES behavioral health services from July 1, 2019 to Dec 30, 2019. Using the Idaho CANS database as a sampling frame, DBH selected a stratified random sample of caregivers and mailed them a survey regarding the experiences and outcomes of care for one randomly selected youth within their household. Survey items addressed the areas of (1) the extent to which families' service experiences reflected the YES principles of care (family-centered, strengths-based, and youth-focused), (2) quality indicators for the YES Practice Model, (3) adequacy of safety/crisis planning, (4) experience with the CANS (Child and Adolescent Needs and Strengths) assessment, (5) participation in services, and (6) service outcomes including youth functioning, mental health, out-of-home placements, and caregiver self-efficacy to access services and supports. Statistical analyses described YES participants' experiences and outcomes of care statewide, examined which service experiences were most predictive of youth outcomes, and tested for disparities in outcomes and experiences based on youth sex, ethnicity, race, and age.

Results: A total of 352 caregivers responded to the survey, representing a response rate of 9.4%. There was no difference in response rate across Regions. Statewide, respondents gave YES services high marks on items assessing family-centered care; however, there was room for improvement in the areas of strengths-based care and youth-focused care. Ratings were high on YES Practice Model quality indicators of respect for family culture, agreement with treatment goals, and providers demonstrating commitment to youth and families. Ratings were low on accessibility of services, development of effective safety plans and participants' experience with the CANS. A combination of four experience of care items, labeled *Indicators of Success*, predicted improved youth outcomes across multiple domains and may serve as targets for service improvement (focus on strengths; youth is active participant in planning; frequent measurement and monitoring of outcomes; effective safety plan in place). Other strong predictors of service outcomes included caregivers' level of confidence to access services and supports their youth needs as well as the family's ability to easily access needed services. There was evidence that youth of color experienced less family-centered care compared to white youth and that older youth (ages 12 to 18 years) experienced worse service outcomes compared to younger youth (ages 11 and under).

Conclusions and Recommendations: Results of this survey offer targets for quality improvement of YES services in Idaho and provide a baseline for measuring progress in the future.
(June 30, 2020)

Executive Summary

Why did we conduct this survey?

The Idaho Department of Health and Welfare, Division of Behavioral Health (DBH) is committed to improving behavioral health services for Idaho youth. With that goal in mind, DBH partnered with Boise State University (BSU) in 2020 to complete a statewide survey designed to assess families' experiences and outcomes of behavioral health care within the Idaho Youth Empowerment Services (YES) system. The YES system is designed to support youth with emotional and behavioral disorders and their families to achieve their goals for well-being. The aim of the 2020 YES family survey was to assess the quality and outcomes of YES behavioral health services from the perspective of families so that areas for quality improvement could be identified.

How did we do it?

Questions on the 2020 YES family survey were designed in partnership with Idaho families, DBH, and BSU investigators. The survey included 41 questions asking about families' experiences of care, services they received, and service outcomes. The survey was delivered via postal mail to a stratified random sample of 3,999 caregivers of youth who had participated in YES behavioral health services from July 1, 2019 to Dec 30, 2019. Caregivers were randomly sampled to ensure adequate representation across all seven DBH Idaho regions. Caregivers were mailed a pre-survey letter informing them about the project. One week later, they were mailed the survey itself with an invitation to complete it and a postage paid envelope to return it. The survey asked about one randomly selected youth within the household who had participate in YES behavioral health services. A total of 352 caregivers responded to the survey (9.4%).

What did we learn?

There are opportunities to increase caregiver engagement with the YES family survey. The response rate of 9.4% for the 2020 YES family survey was low but is fairly typical of mailed surveys completed during the last 10 years. Ideally, the response rate would be as high as 75% or more to increase confidence that the survey results generalize to the entire population. The following steps are recommended to improve the YES family survey response rate:

(1) Use multiple follow-ups – sending follow-up invitations to the survey using multiple modalities (e.g., postcard, letter, telephone call, text) is an evidence-based approach to improve survey response rates,

(2) print survey materials on DBH letterhead and use DBH branding to make it clear that the survey is officially sanctioned by DBH – there is evidence that response rates are higher to official government-sponsored surveys,

(3) conduct pre-survey outreach to families, family advocacy groups, providers, and other stakeholder groups to inform them about the survey and to encourage families to participate,

(4) inform families about the goals and value of the survey when they initially enroll in services and at annual reviews,

(5) widely share results of the survey with family advocacy groups and other stakeholders to demonstrate the value of the results for improving services.

Families expressed a need to make behavioral health services for youth more accessible. More than 1 out of every 5 caregivers (21%) indicated they cannot "easily access the services my child needs most." This suggests essential behavioral health services are not accessible for many families who need them. This is an important finding because caregivers who indicated they could not access services their youth needed also reported their youth had significantly less improvement in well-being and was more likely to be psychiatrically hospitalized or placed in an out-of-home setting in the previous 6 months. Improving access to community-based services that families need can improve youth and family well-being and reduce overall system costs.

There is a need to improve behavioral health crisis response services for youth in Idaho. Less than half of caregivers (48%) who believe their youth needs a safety/crisis plan have been helped to make one by their behavioral health provider and one-third of caregivers (33%) do not believe their family's current plan will be useful in times of crisis. These are important deficits in families' YES experiences, especially since having a safety/crisis plan that the family felt confident in was associated with significantly lower risk of youth psychiatric hospitalization and improved youth outcomes in the last 6 months.

In addition to improving safety/crisis planning, there is also evidence that access to face-to-face crisis support services needs to improve for youth in Idaho. Of the 20 youth whose caregivers indicated they were psychiatrically hospitalized in the last 6 months, 72% never received a face-to-face visit from a behavioral health professional at the time and location of the behavioral health crisis. This suggests a need to improve access to crisis intervention services within the YES system.

The availability of Wraparound services for youth is increasing in Idaho, however, there is more work to be done. Beginning in 2019, Idaho began scaling up Wraparound, a community-based service designed to support youth with the most severe behavioral health needs to live successfully in their home and community. Overall, 5.6% of caregivers (*n* = 19) indicated their youth had participated in Wraparound during the last six months. Of the 32 youths who experienced an out-of-home placement in the last 6 months, 78% did not participate in Wraparound. This suggests a need to continue improving access to Wraparound services for youth with the most pressing behavioral health needs in Idaho.

There is evidence that some service experiences are good predictors of improved youth outcomes and reduced out-of-home placements; steps could be taken to make these experiences more common for families. Our analyses identified four questions on the YES 2020 family survey that were robust predictors of improved youth well-being, reduced out-of-home placements (including reduced psychiatric hospitalizations), and improved caregiver empowerment. Youth who scored high on these items were 10 times less like likely to experience an out-of-home placement compared to youth who scored low on these items. Working to improve families' experiences of care in these four areas may support improved youth outcomes. The four items assessed:

(1) the extent to which services focused on the youth's strengths ("The services my child/youth receives focus on what he/she is good at, not just on problems"),
(2) the extent to which the youth was an active participant in service planning ("My child/youth is an active participant in planning his/her services"),
(3) the extent to which the provider and family routinely measured and monitored progress toward the youth and family's goals ("The provider often works with our family to measure my child/youth's progress toward his/her goals"), and
(4) the adequacy of safety/crisis planning ("I feel confident that my family's safety/crisis plan will be useful in times of crisis").

Many families indicated their services were family-centered; however, there were important disparities for youth of color. A large majority of caregivers indicated that the services they received were respectful of their family's language, religion, race/ethnicity, and culture (92%); however, scores on this item were significantly lower for caregivers of youth of color. Caregivers of youth of color also reported significantly worse experiences with regard to being listened to by the provider, having a central voice in decision-making about their child's services, and services being available at times and locations that are accessible. These responses point to the need for additional assessment of the service experiences of youth of color in order to develop strategies for closing this gap.

Families reported concerns regarding the Child and Adolescent Needs and Strengths (CANS) tool. In 2019, Idaho implemented the CANS assessment statewide as the primary tool for assessing youths' behavioral health needs and strengths, determining eligibility for behavioral health services, and monitoring change in youth well-being. All caregivers who responded to the 2020 YES family survey had one or more CANS assessment completed on their youth as evidenced by DBH records; however, results from the survey suggest there is room for improvement with the CANS tool. About 1 out of every 3 caregivers (35%) who reported on their experience with the CANS did not feel that the CANS accurately reflected their youth and family's needs. A similar percentage of caregivers (32%) also indicated that the CANS assessment did little to help their youth. About 1 in 5 caregivers (21%) indicated the CANS did not help them develop a positive shared vision for the future with their provider and a similar percentage were also not made aware of the services their youth was eligible for after completion of the CANS. Further evaluation is also needed to understand why 35% to 40% of caregivers indicated they were unable to report on their experience of their youth's most recent CANS. These findings suggest many families are not seeing value in the CANS assessment as it is currently used in the YES system. Working to improve implementation of the CANS or changing the way it is used in the system (e.g., use it as an initial assessment or annual assessment and rely on other measures to monitor change in well-being) may help improve services in this area.

Empowering caregivers is an important step on the way to improving youth well-being and actions should be taken to improve caregiver supports in the YES system. In this survey, an important predictor of improvement in youth well-being and reduced out-of-home placements was the extent to which caregivers felt that they had improved in the last 6 months in their ability to effectively access the services and supports their youth needs. This finding highlights the importance of empowering caregivers to access services and supports. Ways of doing this may include: changing system processes and structures so that caregivers can more easily access services their youth needs (that is, system-level change), increasing supports such as service coordination which are designed to assist caregivers in navigating systems, and working directly with caregivers to improve their skills and confidence in advocating for and accessing services their youth needs.

Caveats. Although the 2020 YES family survey was designed to generate a representative picture of the experiences of care of Idaho families who participated in YES services, the low response rate of 9% makes it difficult to determine how generalizable these results are. The survey results reflect the experiences and perceptions of the 352 Idaho caregivers who responded; however, it is unknown to what extent these caregivers' experiences are representative of the experiences of the other caregivers and families who did not respond to the survey. These data are best interpreted as helpful information to *begin* a conversation about improving the quality of behavioral health services for youth in Idaho.

Conclusion

Results from this survey reflect the experiences and perceptions of caregivers of Idaho youth who participated in YES behavioral health services in 2019 and who elected to share their experiences by responding to the survey. These results highlight potential areas of strength in Idaho's YES system as well as areas of potential need for growth and improvement. It is our hope that these results can support the improvement of services for Idaho youth who experience emotional and behavioral challenges and their families.

1. Introduction

This report presents findings of the 2020 Idaho Youth Empowerment Services (YES) statewide family survey. The survey was commissioned by the Idaho Department of Health and Welfare (IDHW) Division of Behavioral Health (DBH), and completed by investigators at Boise State University. The overarching aims of the survey were to assess families' experiences and outcomes of care in Idaho's YES system and to guide efforts to further improve the system.

The Department launched the YES system transformation in 2014 in response to the Jeff D. Settlement Agreement which was negotiated following the 1980 Jeff D. class action lawsuit. The goals of the Settlement Agreement and the YES system are to address deficits in Idaho's mental health service system for youth related to (1) the mixing of adults and juveniles at State Hospital South, and (2) the provision of community-based mental health services to children with Serious Emotional Disturbance (SED).
Youth who experience SED are those whose daily functioning is severely impaired by a mental disorder as determined by a qualified mental health professional based on established criteria (see Box 1). Under the terms of the Settlement Agreement, the State of Idaho is directed to ensure that youth with SED and their families have timely access to a full array of community-based mental health services and supports to meet their needs. In addition, these services and supports are to be delivered in accordance with practice principles as outlined in the Settlement Agreement's Practice Model. The YES family survey is designed to provide a statewide representative picture of the extent to which families perceive that YES services and supports are provided in accordance with the YES principles of care and Practice Model.

Continuous quality improvement is an essential aspect of any effective service system, and the goal of the YES family survey is to aid IDHW in assessing the quality and outcomes

Box 1. Definitions of Serious Emotional Disturbance

US Substance Abuse and Mental Health Services Administration

Pursuant to section 1912(c) of the Public Health Service Act, as amended by Public Law 102-321 "children with serious emotional disturbance" are persons:

a. From birth up to age eighteen (18),

b. who currently or at any time during the past year,

c. have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM),

d. that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities.

Idaho Administrative Code (16.07.37)

To be eligible for children's mental health services through a voluntary application to the Department, the applicant must:

a. Be under eighteen (18) years of age,

b. reside within the State of Idaho,

c. have a DSM-IV-TR Axis I diagnosis (a substance use disorder alone, or a developmental disorder alone, does not constitute an eligible Axis I diagnosis, although one more of these conditions may coexist with an eligible Axis I diagnosis), and

d. have a substantial functional impairment as assessed by using the Child and Adolescent Functional Assessment Scale (CAFAS) or the Preschool and Early Child Functional Assessment Scale (PECFAS) with a full eight (CAFAS) or seven (PECFAS) scale score of 80 or higher with "moderate" impairment in at least one of three areas including: Moods/ emotions, Thinking, or Self-harm.

of YES behavioral health services so that targets for quality improvement can be identified. The YES family survey was first fielded in 2019. In that initial pilot test, the survey was administered only to youth who had received mental health services directly from DBH staff. In 2020, the survey sampling frame was expanded to include all youth who participated in YES services. The goal of the expansion was to get a representative picture of the quality and outcomes of YES services regardless of a youth's point of entry into the system. The YES survey was conducted in conjunction with other improvement efforts, and represents only one aspect of the Idaho State's overarching strategy to continually assess and improve the quality and effectiveness of YES. The Department's stated goals in conducting the survey were to:

(1) Obtain a statewide cross-sectional assessment of the quality and outcomes of YES from the perspective of parents and caregivers of youth who participate in behavioral health services through any YES system entry point,

(2) Identify targets to improve service quality and outcomes, and

(3) Establish a systemwide baseline for measuring progress over time.

Figure 1. Idaho Department of Health and Welfare Regions

In this report, we present the results of the 2020 YES family survey and provide recommendations for continued efforts to improve the quality and outcomes of Idaho's YES system. Some sections of the survey refer to Idaho Health and Welfare Regions which are shown in Figure 1.

2. Method

2.1 Item Development

Items for the 2020 YES survey built on prior developmental work completed in 2019 as part of the initial YES family survey. Details of the item development process for the 2019 items is provided in the YES Family Survey 2019 report, but briefly, items were developed using an iterative, partnered process that included family members, representatives of DBH, and the research team. The initial item development process proceeded through stages including:

(1) delineation of the key content domains to be assessed by the survey,

(2) identification of potentially relevant items in the empirical literature,

(3) evaluation and modification of item content within each domain,

(4) review of items and pilot testing with stakeholders, as well as formal assessment of reading level, and

(5) final revision of items within each content domain.

For 2020, many of the items from 2019 were retained including those focusing on the YES principles of care, YES Practice Model, service participation, and service outcomes. In addition, changes were made to the survey directions and items in response to stakeholder feedback, and new items were developed and fielded reflecting emerging priorities of the State and its most recent quality improvement efforts. Specifically, items were added to the 2020 survey assessing families' experiences with the Child and Adolescent Needs and Strengths (CANS) assessment, which was implemented statewide in 2019. Development of these items occurred in a partnered process that involved families, DBH staff, and the research team, similar to the development process used for the original items. In total, the YES 2020 family survey included 41 items assessing the following domains:

(1) YES principles of care (family-centered, strengths-based, and youth-focused),
(2) quality indicators for the YES Practice Model,
(3) safety/crisis planning,
(4) CANS assessment,
(5) services the youth participated in, and
(6) service outcomes.

The target population for the YES 2020 family survey was all youth who participated in YES services from July 1, 2019 to December 30, 2019. Target respondents were parents or caregivers of these youth.

2.2 Survey Fielding Procedure

One of the Department's primary goals in conducting the survey was to protect the privacy and confidentiality of YES participants. In order to accomplish this, the team developed a survey fielding procedure which ensured that (a) Boise State University would not have access to identifying information about YES participants, and (b) Division of Behavioral Health staff would not have access to respondents' answers and therefore would not know how respondents answered the survey questions. This was accomplished by designing the survey so that mail merges and the mailing of the survey invitation letters and survey documents was handled completely by the Idaho Department of Health and Welfare print shop and mail room; thus, researchers at Boise State University did not have access to participants' names or addresses. In order to protect the confidentiality of respondents' answers, survey responses were returned via Business Reply Envelope to Boise State University. This process ensured that the Department of Health and Welfare could not ascertain how any respondent answered the questions.

The survey procedure was designed based on empirically-supported best practices described by Dillman et al. (2009). The survey was fielded from February 18, 2020 to April 6, 2020. The survey began with a pre-survey letter designed to inform participants that the survey would be forthcoming, that it was a legitimate request from the Idaho Department of Health and Welfare, and that their participation was kindly requested. Next, the survey itself was mailed out with an invitation letter and a return envelope. In total, participants received two contacts about the survey.

2.3 Sampling Frame and Strategy

The sampling frame was developed by the Idaho Department of Health and Welfare, Division of Behavioral Health to include all families of youth who had participated in YES behavioral health services (either active or closed cases) from July 1, 2019 to Dec 30, 2019. As part of the YES system, DBH maintains a database of CANS assessments which are required in order to assess each youth's need for YES services. This database represents all youth who participated in the YES system and it served as the sampling frame. In order to obtain accurate estimates of population parameters, researchers determined a sample of 4,000 youth was needed. In order to ensure the sample was representative of the entire State of Idaho, DBH staff drew a proportionate stratified random sample of youth from each of IDHW's seven Regions (see Figure 1). That is, the total sample of 4,000 potential respondents was divided up based on the proportion of the total Idaho youth population living in each Region of the State. For example, Region 1 includes 11.8% of all youth who participated in YES services during the target period, so 473 youth (11.8%% of 4,000) were randomly selected by DBH in Region 1. Prior to sampling, DBH identified households with more than one youth receiving services and randomly selected one youth from each household to include in the sampling frame.

The final sample included N = 3,999 youth selected via a proportionate stratified random sample to represent all youth who participated in YES services across the entire State of Idaho during the target period.

3. Results

3.1 Youth Sample

A total of 352 surveys were completed and returned by caregivers describing the experiences and outcomes of their youth. On average, youths in the sample were 11.2 years old (standard deviation = 3.7 years) with a median of 18 months in services (*SD* = 31.1 months). The sample included both female (*n*=154, 45%) and male (*n*=189, 55%) youths. The racial and ethnic composition of the sample was highly homogenous, reflecting Idaho's larger population of youth. Most youths were identified as White (*n*=300, 88%) and non-Hispanic/Latino (*n*=289, 84%). The following race categories each included less than 2% of the total sample: American Indian/ Alaskan Native, Native Hawaiian/ Other Pacific Islander, Black, Other, or Unknown. These frequencies are withheld to respect respondents' privacy.

3.2 Survey Response Rate

Survey response rates can be calculated in a number of ways, reflecting different types of information. In this section we present two types of response rate:

(a) a *raw response rate*, which uses the total population of interest as the denominator, and

(b) an *effective response rate*, which uses the number of deliverable surveys as the denominator.

The latter response rate excludes letters that were rejected as undeliverable. These response rates provide different but complimentary information. The *raw response rate* indicates the percentage of the total potential population who responded to the survey; consequently, it may be most informative for understanding the extent to which the survey sample is representative of the total population. The *effective response rate* provides information on the percentage of the population who actually received the survey and responded. This information is useful for understanding the likelihood of responding to future survey administrations because only people who actually received the survey can respond.

Table 1 shows the raw and effective survey response rates for the overall sample as well as the percentage of surveys that were returned as undeliverable. The overall raw response rate was 8.8% with a range of 7.4% (Region 1) to 10.8% (Region 5). The overall effective response rate was 9.4% with a range from 8.0% to 11.4%. Statistical analyses indicated that response rates (raw and actual) and the percentage of undeliverable surveys did not vary significantly across regions.

Table 1. Survey Response Rates

Region	N of Mailed Surveys	Raw Response Rate	Effective Response Rate	% Undeliverable
1	475	7.4%	8.0%	7.8%
2	130	10.0%	11.1%	10.0%
3	901	8.2%	8.7%	6.1%
4	1,061	9.0%	9.7%	6.9%
5	406	10.8%	11.4%	4.7%
6	262	7.6%	8.2%	6.9%
7	764	9.2%	9.9%	7.1%
Total	3,999	8.8%	9.4%	6.7%

3.3 Families' Experiences of Care

In order to assess youth and families' experiences of care within the Idaho YES system, caregivers were asked to answer questions about the mental health services their child/youth received in four domains: (1) the extent to which services they received embodied YES principles of care (family-centered, strengths-based, and youth-focused), (2) the extent to which services were provided in accordance with the YES Practice Model as reflected by quality indicators, (3) their experience with safety/crisis planning, and (4) their experiences with the CANS assessment.

Caregivers were assured that their answers were confidential and would not affect current or future services they receive. Prior to answering these questions, caregivers were asked to think of the mental health provider who worked with their child or youth the most during the last six months and to rate that provider.

The providers that caregivers indicated they were rating are shown in Table 2.

3.4 Criteria for Evaluating Services

Cut scores are values on a scale or item that help to evaluate whether a certain benchmark for success was met or not met. In order to provide an assessment of the YES system's performance, we developed cut scores for the YES family survey items to determine whether benchmarks for success were being met on each item. It is important to note that at the present time, the cut scores used in this report have not yet been empirically validated; instead, they are based on logic and reasoning and will be evaluated

Table 2. Providers Rated by Caregivers for the YES 2020 Family Survey

Type of Provider	*N*	%
Counselor/Therapist/ Psychotherapist	265	75.3
Medication Prescriber	15	4.3
CBRS provider	7	2.0
Respite Provider	5	1.4
Case manager	3	0.9
Substance use counselor	1	0.3
Wrap-around coordinator	0	0.0
Other: HI worker (n=3) Not specified (n=2) DD Services PreK teacher Neurofeedback Behavior interventionist [specific] Facility PHP program [name] Youth services Food therapist	13	3.7
More than one	36	10.2
No answer	7	2.0
Total	352	100.0

as the survey is fielded in future years.

Item cut scores are based on the percentage of respondents who either (a) agreed or strongly agreed with the item, thereby indicating that it did reflect their experience, or (b) disagreed or strongly disagreed with the item, thereby indicating that it did not reflect their experience. Given that nearly all of the items are positively worded, higher percentages of agreement indicate better system performance and higher percentages of disagreement represent poorer system performance.

The cut score for agree/strongly agree was set at 80%. That is, if 80% or more of respondents indicated that they *Agreed* or *Strongly Agreed* that the item reflected their experience, this was labeled an area of strength for the Idaho YES system. Eighty percent agreement means that 4 out of every 5 people indicated their experiences met the criterion. This cut score was based on reasoning that if 4 out of 5 participants endorse an item, it is likely an area of strength for the system.

The cut score for disagree/strongly disagree was set at 20% so that if 20% or more of respondents indicated that they *Disagreed* or *Strongly Disagreed* with an item, that indicated a potential area for system improvement. Twenty percent represents 1 in 5 respondents. This cut score was based on the idea that if 1 or more in every 5 respondents indicated that their experience did not meet a criterion, this indicated an area in need of attention for system improvement. The Figures below show these cut lines for each item as well as the percentage of respondents who fell into each category.

3.5 YES Principles of Care

An essential aspect of Idaho's YES system is the delivery of services and supports to youth and families based on a set of core Principles of Care as outlined in the Settlement Agreement. In partnership with representatives from DBH and families, our research team developed items to assess three of these principles, which were identified as top priorities by the Departmental. The principles we assessed included:

- *Family-centered*,
- *Strengths-based*, and
- *Youth-focused* (referred to as individualized care in the Settlement Agreement).

In this section, we present results of the survey items designed to measure these principles.

3.5.1 Family-Centered Care

In accordance with the Settlement Agreement, family-centered care was defined based on the definition in Box 2 for the purpose of item development.

Two items assessed the extent to which parents and caregivers experienced YES services as family-centered:

(1) The provider encourages me to share what I know about my child/youth's strengths and needs.

(2) My child and I are the main decision-makers when it comes to planning my child/youth's services.

Respondents were instructed to think about their experiences with services during the last six months (or however long they had been in services if less than six

Box 2. Defining Family-Centered Principle of Care

Services and supports are family-centered when they emphasize family strengths and maximize family resources. Family experience, expertise, and perspective are welcomed. Families are active participants in solution and outcome-focused planning and decision-making.

months) and to rate how much they agreed or disagreed with each statement on a scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree)*. Figure 2 shows the percentage of respondents who agreed/strongly agreed or disagreed/strongly disagreed with each item.

Table 3 shows the average response on each item for the family-centered principle of care as well as the percentage of respondents who either (a) agreed or strongly agreed, or (b) disagreed or strongly disagreed.

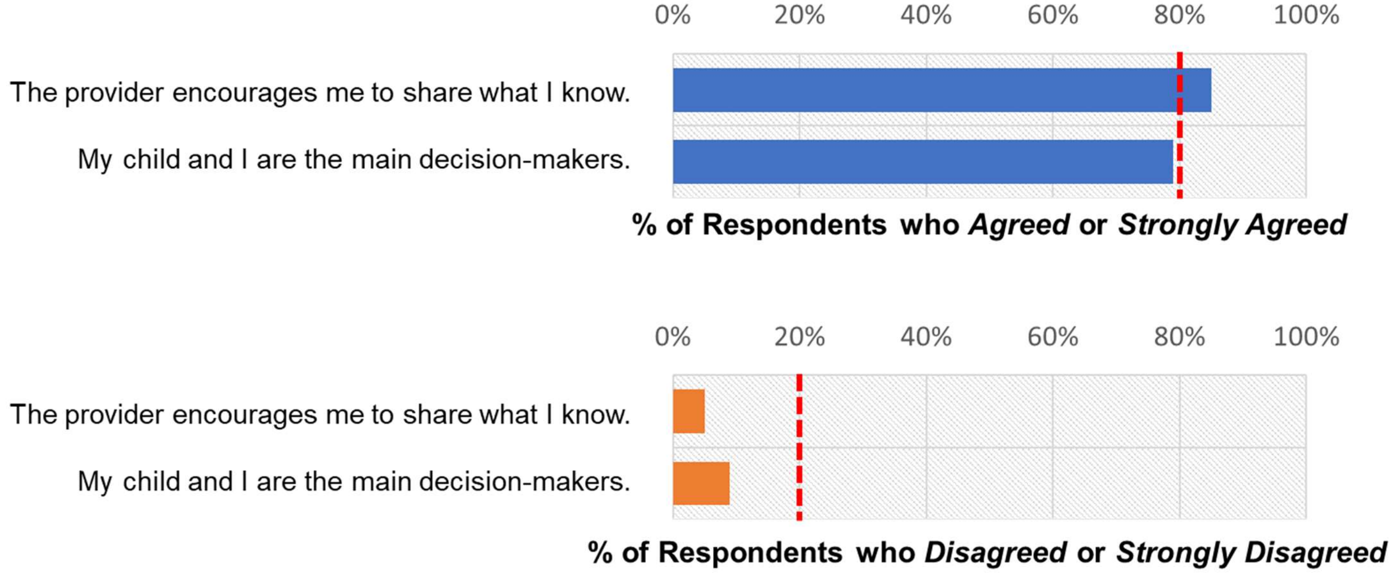
Over 80% of respondents agreed or strongly agreed with the item, “The provider encourages me to share what I know about my child/youth’s strengths and needs” and only 5% disagreed. This suggests that this is an area of strength for the state in terms of delivering services that actively elicit parent and caregiver knowledge regarding their child/ youth’s unique strengths and needs.

3.5.2 Strengths-Based Care

Consistent with the Settlement Agreement, strengths-based care was defined as is shown in Box 3 for the purpose of item development.

Two items assessed the extent to which parents and caregivers experienced YES services as strengths-based: (1) The services my child/youth receives focus on what

Figure 2. Percentage of Caregivers who Agreed or Disagreed with Family-Centered Care Items



Note: Item wording is abbreviated for formatting purposes.

Table 3. Descriptive Statistics for Family-Centered Care Items

Item	Mean	Std. Deviation	% Agree or Strongly Agree	% Disagree or Strongly Disagree	N Valid (out of 352)
The provider encourages me to share what I know about my child/youth’s strengths and needs.	4.3	0.93	85%	5%	351
My child and I are the main decision-makers when it comes to planning my child/youth’s services.	4.1	1.04	79%	9%	351

Note: Scores on each item range from 1 to 5 with higher scores indicating greater agreement.

Box 3. Defining Strengths-Based Principle of Care

Services and supports are strengths-based when they are planned and delivered in a manner that identifies, builds on, and enhances the capabilities, knowledge, skills, and assets of the child/ youth and his or her family, community, and other team members.

he/she is good at, not just on problems.

(2) The provider talks with us about how we can use things we are good at to overcome problems.

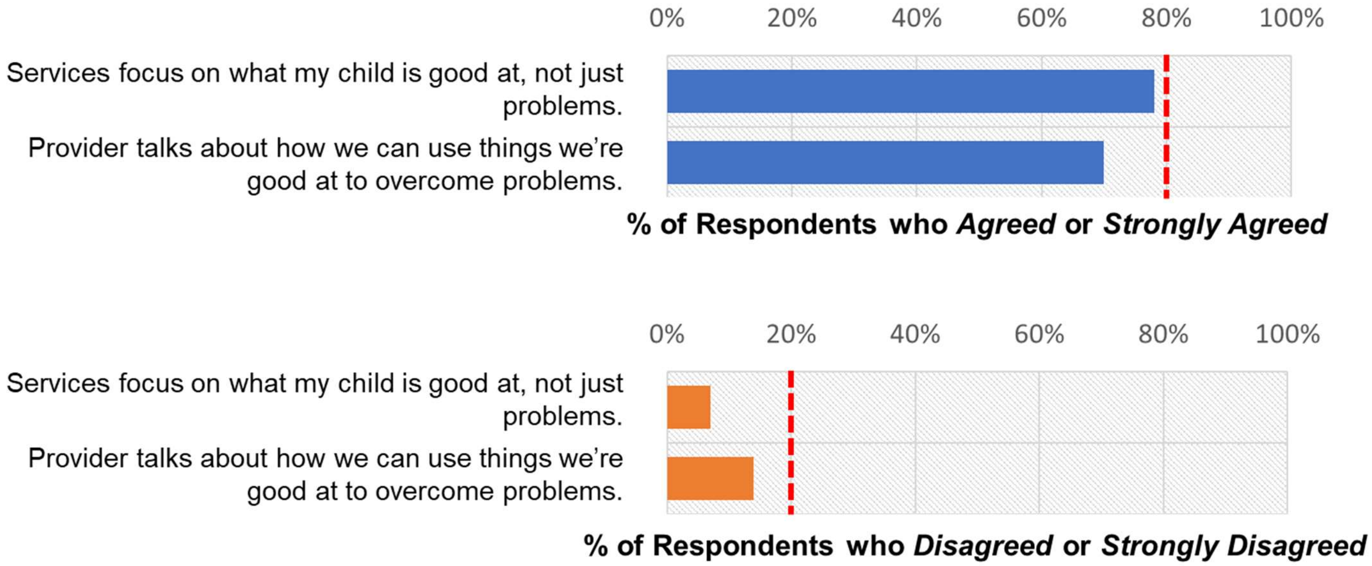
Table 4 shows the average response on each of the strengths-based principle of care items and Figure 3 presents the percentage of respondents who responded positively or negatively.

None of the items met the criteria indicating it was an area of strength or weakness for the system. This may be of concern given that the item "The services my child/youth receives focus on what he/she is good at, not just on problems" was among the most predictive of child outcomes (higher scores on this item predicted better outcomes). This item was significantly related to: improved child functioning and mental health as measured via the Child Outcome scale (*r* = 0.29, *p* < .001), reduced risk of psychiatric hospitalization in the last six months (*r* = -0.12, *p* = .026), and reduced risk for out-of-home placements (*r* = -0.16, *p* = .004).

3.5.3 Youth-Focused Care

Consistent with the Settlement Agreement's definition of individualized care, youth-focused care was defined as is

Figure 3. Percentage of Caregivers who Agreed or Disagreed with Strengths-Based Care Items



Note: Item wording is abbreviated for formatting purposes.

Table 4. Descriptive Statistics for Strengths-Based Care Items

Item	Mean	Std. Deviation	% Agree or Strongly Agree	% Disagree or Strongly Disagree	N Valid (out of 352)
The services my child/youth receives focus on what he/she is good at, not just on problems.	4.1	0.97	78%	7%	351
The provider talks with us about how we can use things we are good at to overcome problems.	3.9	1.1	70%	14%	350

Note: Scores on each item range from 1 to 5 with higher scores indicating greater agreement.

Box 4. Defining Youth-Focused Principle of Care

Services, strategies, and supports are youth-focused when they are individualized to the unique strengths and needs of the youth. The youth's experience, expertise, and perspective are welcomed. The youth is an active participant in planning and decision-making.

shown in Box 4 for the purpose of item development. Two items assessed the extent to which parents and caregivers experienced YES services as youth-focused:

(1) My child/youth is an active participant in planning his/her services.

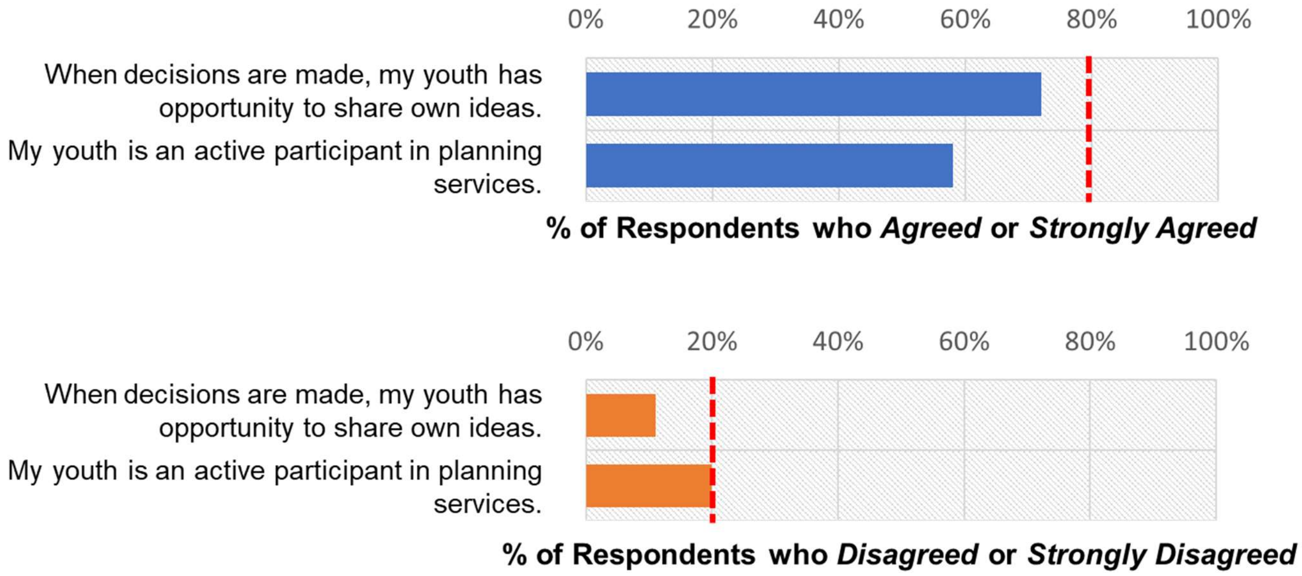
(2) When decisions are made about services, my child/youth has the opportunity to share his/her own ideas.

Table 5 presents means and standard deviations of these items and Figure 4 shows the percentage of respondents who rated each item positively or negatively. Twenty percent of caregivers disagreed or strongly disagreed with the item "My child/ youth is an active participant in planning his/her services," suggesting this is an area in need of improvement.

3.6 Quality Indicators for the YES Practice Model

Building on the YES Practice Model outlined in the Settlement Agreement, as well as literature on quality indicators for behavioral health services, 14 items were developed to assess the quality of mental health services delivered to YES participants. These quality indicators described the extent to which YES services were provided in accordance with the YES Practice Model across the

Figure 4. Percentage of Caregivers who Agreed or Disagreed with Youth-Focused Care Items



Note: Item wording is abbreviated for formatting purposes.

Table 5. Descriptive Statistics for Youth-Focused Care Items

Item	Mean	Std. Deviation	% Agree or Strongly Agree	% Disagree or Strongly Disagree	N Valid (out of 352)
My child/youth is an active participant in planning his/her services.	3.6	1.23	58%	20%	351
When decisions are made about services, my child/youth has the opportunity to share his/her own ideas.	3.9	1.07	72%	11%	351

Note: Scores on each item range from 1 to 5 with higher scores indicating greater agreement.

Box 5. Defining YES Practice Model Quality Indicators

Quality indicators are criteria that define and operationalize the extent to which services are provided in accordance with the YES Practice Model as outlined in the Settlement Agreement. They address the extent to which core Practice Model principles and functions are delivered by providers as intended by the Settlement Agreement.

following processes:

(1) Engagement,

(2) Assessment,

(3) Care planning and implementation,

(4) Teaming,

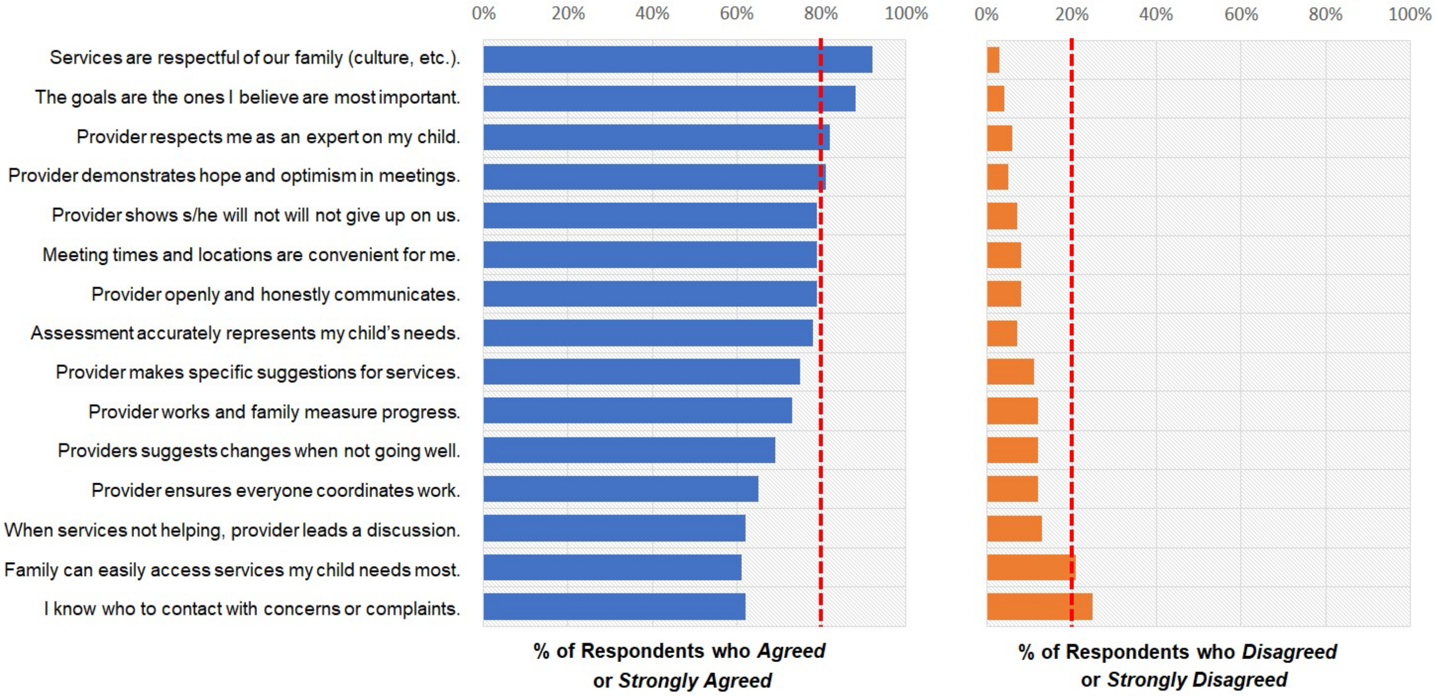
(5) Monitoring and adapting,

(6) Transition.

Table 6 presents descriptive statistics for the 15 items addressing YES Practice Model quality indicators. The Table shows means and standard deviations for each item. Figure 5 shows the percentage of caregivers who agreed or disagreed with each item. Four quality indicators were identified as system strengths based on the criterion that 80% or more of caregivers agreed or strongly agreed with the item. These included items addressing respect shown for families' culture and other characteristics, caregivers' belief that the goals their child/youth was working on are the ones that are most important, caregivers feeling respected as experts on their child/youth, and the provider expressing hope and optimism in meetings.

Two quality indicators met criteria indicating they are an area of concern for the system: one focused on caregivers knowing who to contact if they have a complaint or concern about services and the other focused on caregivers' ability to "easily access the services my child needs most." Of all the individual items on the survey, the one that most predicted youth outcomes was, "My family can easily access the services my child needs most." This item was significantly related to improved child outcomes as measured via the Child Outcome scale (r = 0.35, p < .001), reduced risk of psychiatric hospitalization in the last six months (r = -0.18, p = .001), and reduced risk for out-of-home placements (r = -0.22, p < .001). This suggests improving caregivers' access to services may be an area of

Figure 5. Percentage of Caregivers who Agreed or Disagreed with Practice Model Quality Indicators



Note: Item wording is abbreviated for formatting purposes.

Table 6. Descriptive Statistics for YES Practice Model Quality Indicators

Item	Mean	*SD*	% Agree or Strongly Agree	% Disagree or Strongly Disagree	N Valid (out of 352)
Services we receive are respectful of our family's language, religion, race/ethnicity, and culture.	4.5	0.81	92%	3%	351
The goals we are working on with the provider are the ones I believe are most important for my child/youth.	4.3	0.89	88%	4%	350
The provider respects me as an expert on my child/youth.	4.2	0.99	82%	6%	351
The provider demonstrates hope and optimism in meetings with my family.	4.2	0.98	81%	5%	350
The provider who has been working with my child and family shows that he/she will not give up on us.	4.2	1.04	79%	7%	349
Meetings with the provider occur at times and locations that are convenient for me.	4.2	1.04	79%	8%	350
I feel that the provider openly and honestly communicates with my family.	4.2	1.06	79%	8%	348
The assessment completed by the provider accurately represents my child/youth’s needs.	4.1	0.99	78%	7%	349
The provider makes specific suggestions about what services might benefit my child/youth.	4.0	1.08	75%	11%	350
The provider often works with our family to measure my child/youth's progress toward his/her goals.	4.0	1.12	73%	12%	350
The provider suggests changes in my child/youth’s treatment plan or services when things aren’t going well.	3.9	1.03	69%	12%	351
The provider makes sure everyone on my child’s treatment team is working together in a coordinated way.	3.8	1.11	65%	12%	351
When services are not helping, the provider leads my child/youth’s team in a discussion of how to make things better.	3.8	1.16	62%	13%	349
My family can easily access the services my child needs most.	3.6	1.29	61%	21%	350
I know who to contact for help if I have a concern or complaint about my provider.	3.6	1.36	62%	25%	347

Note: Scores on each item range from 1 to 5 with higher scores indicating greater agreement. SD = standard deviation.

emphasis for system improvement efforts.

3.7 Safety/Crisis Planning

Two questions on the 2020 YES family survey assessed families’ experiences of safety planning with their provider. For these items, a safety/crisis plan was defined as “a written document that says what you, your child, and others will do in times of crisis; it often says who you can contact and lists coping skills or resources to use in a crisis.” Caregivers were asked to rate how much they agreed or disagreed with two statements assessing their experience with safety/crisis planning or to mark "Not applicable" if, in their opinion, their child did not need a safety/crisis plan.

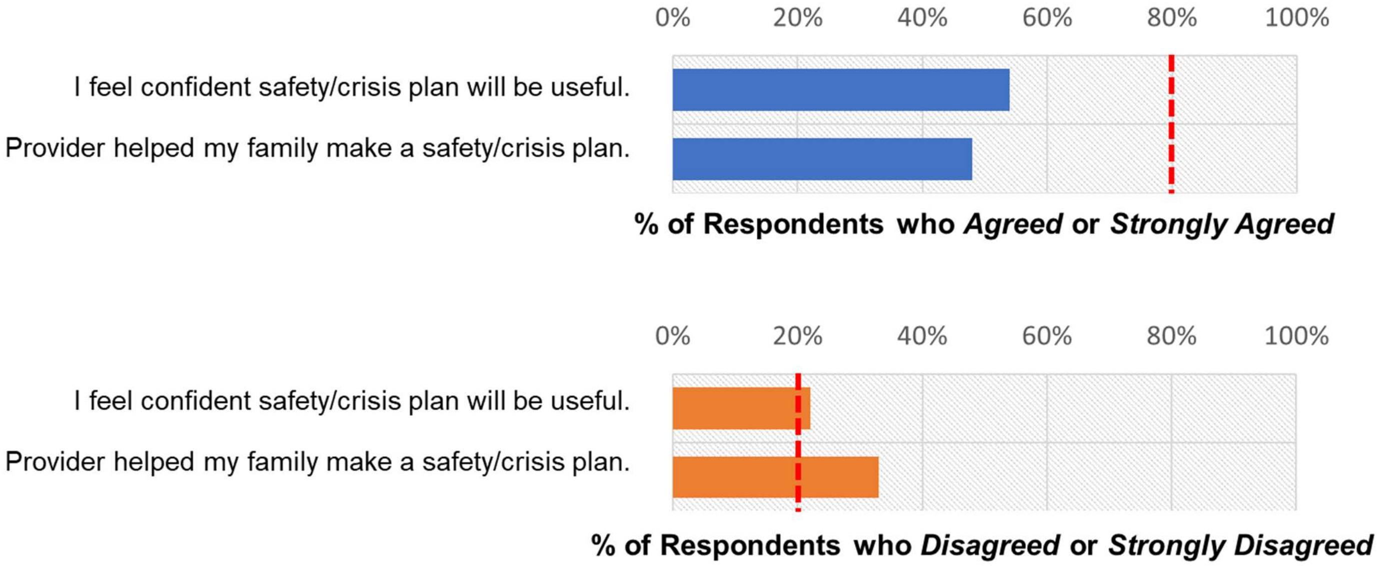
On both questions, 39% of caregivers indicated “Not applicable,” indicating that they did not feel their child needed a safety/crisis plan at the time of the survey.

Table 7. Descriptive Statistics for Safety/Crisis Planning Items

Item	Mean†	Std. Deviation†	% Agree or Strongly Agree†	% Disagree or Strongly Disagree†	N Valid (out of 352)
The provider helped my family make a safety/crisis plan.	3.20	1.43	48%	33%	207
I feel confident that my family's safety/crisis plan will be useful in times of crisis.	3.40	1.23	54%	22%	201

† Means, standard deviations, and percentages only include respondents who indicated safety/crisis planning was applicable to their youth. N valid shows the number of youths included in each analysis.

Figure 6. Percentage of Caregivers who Agreed or Disagreed with Safety/Crisis Planning Items



Note: Item wording is abbreviated for formatting purposes. Chart excludes respondents who indicated their youth did not need a safety/crisis plan.

Table 7 and Figure 6 show the safety/crisis planning items and caregivers' responses. As is indicated in the Table, one-third of caregivers (33%) who believed that their child needed a safety/crisis plan were not assisted in developing such a plan by their service provider. In addition, more than 1 in 5 caregivers (22%) lacked confidence that their child's safety/crisis plan would help in times of crisis. These responses suggest safety/crisis planning is an area for improvement in YES services.

3.8 Experience of the CANS Assessment

The Child and Adolescent Needs and Strengths or CANS is an assessment tool used by the Idaho YES system to determine youth's eligibility for services, identify an appropriate level of care, and guide service planning. Caregivers were asked about their experiences with this assessment in two broad domains: (1) CANS experience, and (2) CANS value. Items related to CANS experience assessed caregivers' perceptions of the accuracy of the CANS, the extent to which it contributed to a positive shared vision with the provider, and the extent to which the provider explained services the family was eligible for after completing the CANS. Items related to CANS value assessed families' perceptions of the value added by completing the CANS—did it contribute to improving their youth's well-being? Caregivers were asked to rate how much they agreed, disagreed, or were neutral regarding statements about their youth's most recent CANS assessment. If the caregiver was unsure or didn't know the answer, they were asked to select the response option marked "Don't Know." Caregivers were not asked to indicate why they felt unable to answer the CANS questions.

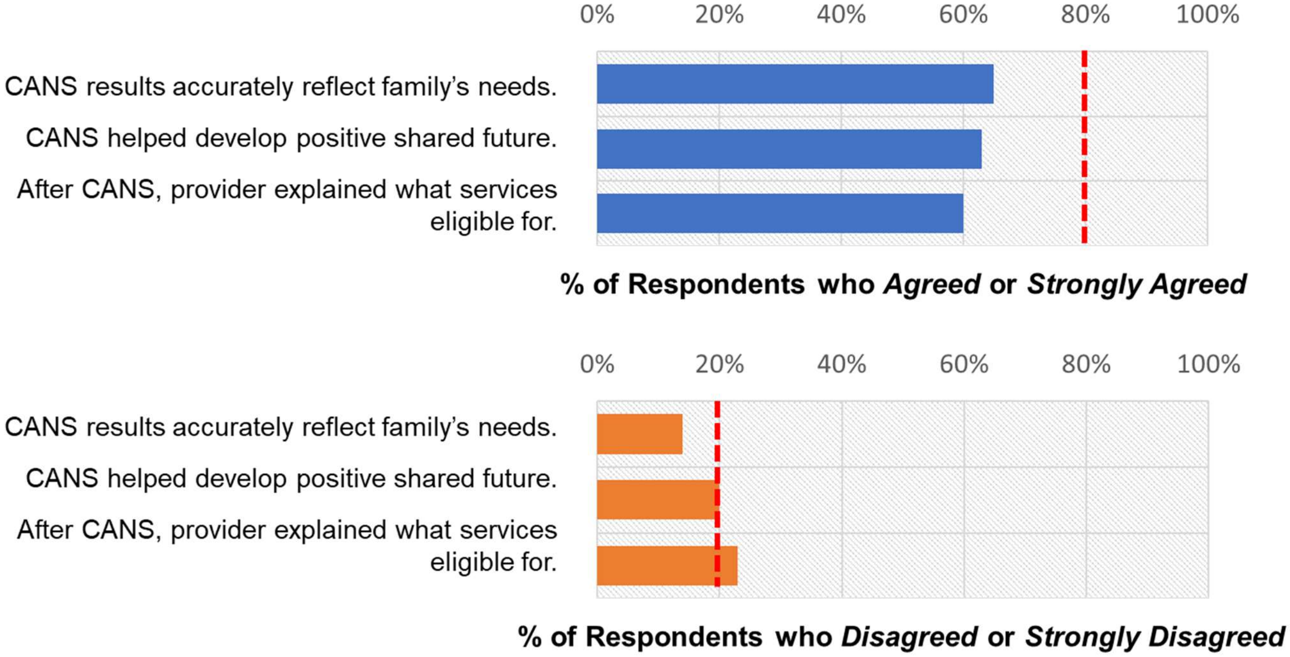
Missing data on the five CANS questions was minimal

Table 8. Descriptive Statistics for CANS Experience Items

Item	Mean†	Std. Deviation†	% Agree or Strongly Agree†	% Disagree or Strongly Disagree†	N Valid (out of 352)
The results of the CANS accurately reflect my family's needs.	3.73	1.05	65%	14%	201
The CANS assessment helped me, my child/ youth, and our providers develop a positive shared goal for the future.	3.62	1.21	63%	20%	214
After completing the CANS, the provider explained what services my child/ youth is eligible for.	3.54	1.27	60%	23%	218

† Means, standard deviations, and percentages exclude respondents who indicated "Don't know." N valid shows the number of respondents included in each analysis.

Figure 7. Percentage of Caregivers who Agreed or Disagreed with CANS Experience Items



Note: Item wording is abbreviated for formatting purposes. Chart excludes respondents who indicated "Don't know."

(range of missing values = 2.6% of participants to 3.4%). However, on all of the CANS questions, a large percentage of caregivers (35% to 40%) marked the response indicating they were "Unsure" or "Don't Know" [how to rate the CANS experience]. These high percentages may suggest that caregivers are either not aware of CANS assessments being completed or did not feel they had sufficient knowledge of the experience to form an opinion about it.

Table 8 shows caregivers' responses to the questions asking about their CANS experience and Figure 7 presents the percentages of caregivers who agreed or disagreed with each item. Two of the three CANS experience items met the criteria indicating they are a potential area in need of system improvement. Caregivers' responses to these items indicated concerns regarding the extent to which completing the CANS contributed to developing a positive shared goal for the future as well as whether providers explained what services the youth was eligible for based on the results of the CANS. These low marks may indicate an area in need of system improvement; however, it should be noted that these CANS items were not predictive of youth out-of-home placement or psychiatric hospitalization (r's = -0.01 to 0.02, all p's > .05) although they were related to higher improvement on the Child Outcome scale (r's = 0.31 to 0.42, all p's < .05)

Table 9 shows caregivers' responses to items addressing the perceived value of the CANS assessment for their child's care and Figure 8 presents the percentage of caregivers who agreed or strongly agreed with these items. Because these items were negatively worded (i.e., higher scores are worse), Figure 8 only shows the percentage of caregivers who agreed or strongly agreed with these negatively-worded items. Percentages above 20% indicate an area in potential need of improvement. Both items fell above the 20% cut score, indicating that more than 1 in 5 caregivers questioned the value of the CANS for improving their youth's care. Similar to the CANS Experience items described above, the CANS Value items were significantly related to variation in the Child Outcome scale (r's = -0.18 and -0.25, all p's < .05) but were not related to increased risk of psychiatric hospitalization or new out-of-home placement in the last six months (r's = 0.05 to 0.10, all p's < .15).

Some caregivers provided written feedback about the CANS by writing comments on the survey form even though it did not include a place to provide written comments. Themes from these comments focused on:

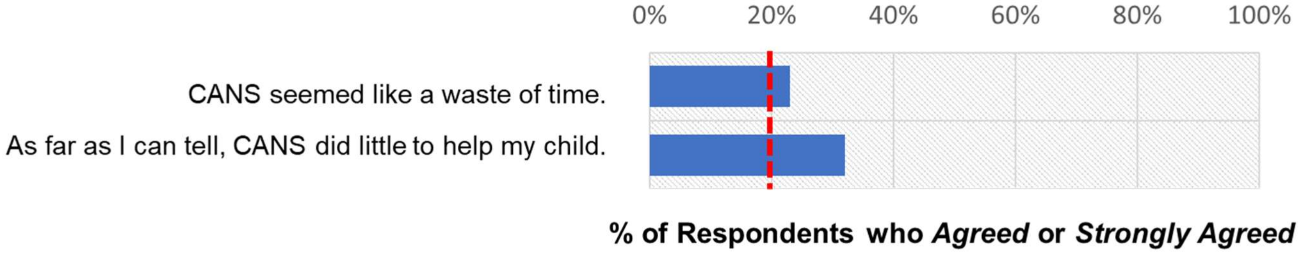
- Not having heard of the CANS
- The CANS assessment not being helpful
- The perceived burden of having to do the CANS every six months
- The CANS being too long, especially after the first two administrations

4.0 Service Outcomes for Youth

One key aim of the YES 2020 survey was to assess the outcomes of YES services from the perspective of parents and caregivers of youth. Outcomes were defined as the results or consequences of services. To assess YES outcomes, our research team used items assessing five domains, which reflect domains outlined in the literature on mental health service outcomes for youth, as well as the perspectives and priorities of representatives of DBH and family participants. The outcomes assessed included the extent to which caregivers believed their youth or family had experienced improvement during the last six months in the areas of:

- ❖ Youth psychosocial functioning and overall mental health,
- ❖ Caregiver self-efficacy to access services and supports their youth needs,
- ❖ Perceived service impact,
- ❖ Youth psychiatric hospitalizations, and
- ❖ Youth out-of-home placements.

Figure 8. Percentage of Caregivers who Agreed with CANS Value Items



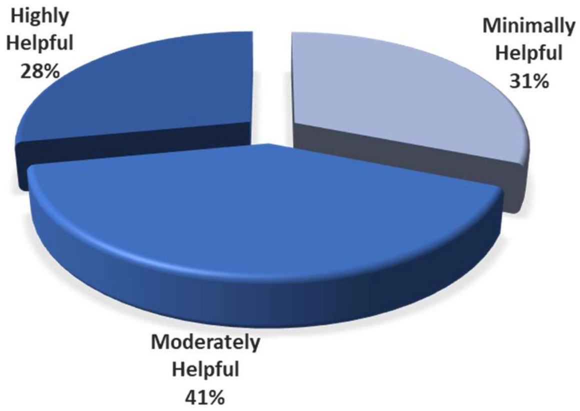
Note: Item wording is abbreviated for formatting purposes. Chart excludes respondents who indicated "Don't know."

Table 9. Descriptive Statistics for CANS Value Items

Item	Mean†	Std. Deviation†	% Agree or Strongly Agree†	% Disagree or Strongly Disagree†	N Valid (out of 352)
The CANS assessment seemed like a waste of time.	2.52	1.26	23%	53%	217
As far as I can tell, the CANS assessment did little to help my child/ youth.	2.74	1.51	32%	47%	212

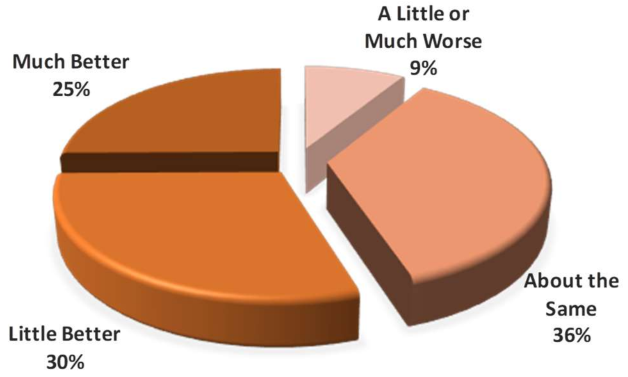
† Means, standard deviations, and percentages exclude respondents who indicated "Don't know." N valid shows the number of youths included in each analysis.

Figure 9. Perceived Impact of Youth Services



Note: N = 342

Figure 10. Change in Caregiver's Self-Efficacy to Access Needed Services in the Last 6 Months



Note: N = 342

4.1. Perceived Service Impact

Perceived service impact is defined as the extent to which caregivers believed that the mental health services their youth received were helpful in improving the youth's well-being. This measure captures the extent to which caregivers attributed improvement in their child's well-being to services they received during the last six months. We assessed perceived service impact using a single item:

(1) On a scale from 1 to 10, where 1 is the least help possible and 10 is the most help possible, how much was your child/ youth helped by the mental health services he/she received in the last 6 months?

In order to summarize scores on this item, we partitioned caregivers' responses into three categories: minimally helpful (1 to 6), moderately helpful (7 and 8), and highly helpful (9 and 10). Figure 9 and Table 10 provide descriptive statistics for this item. On average, caregivers rated their youth's services as moderately helpful; however, nearly one-third of respondents (31%) indicated services were only minimally helpful.

4.2 Caregiver Self-Efficacy to Access Services and Supports

Parents and caregivers play an essential role in youths' lives and as members of an effective system-of-care. Accordingly, one important outcome is caregivers' level of self-efficacy, that is, their personal confidence, in their ability to access services and supports that their child or youth needs. We assessed caregivers' self-efficacy via the following question:

(1) Compared to 6 months ago, how would you rate your ability to effectively access services and supports your child/youth needs?

Figure 10 shows the distribution of participants' responses to this question.

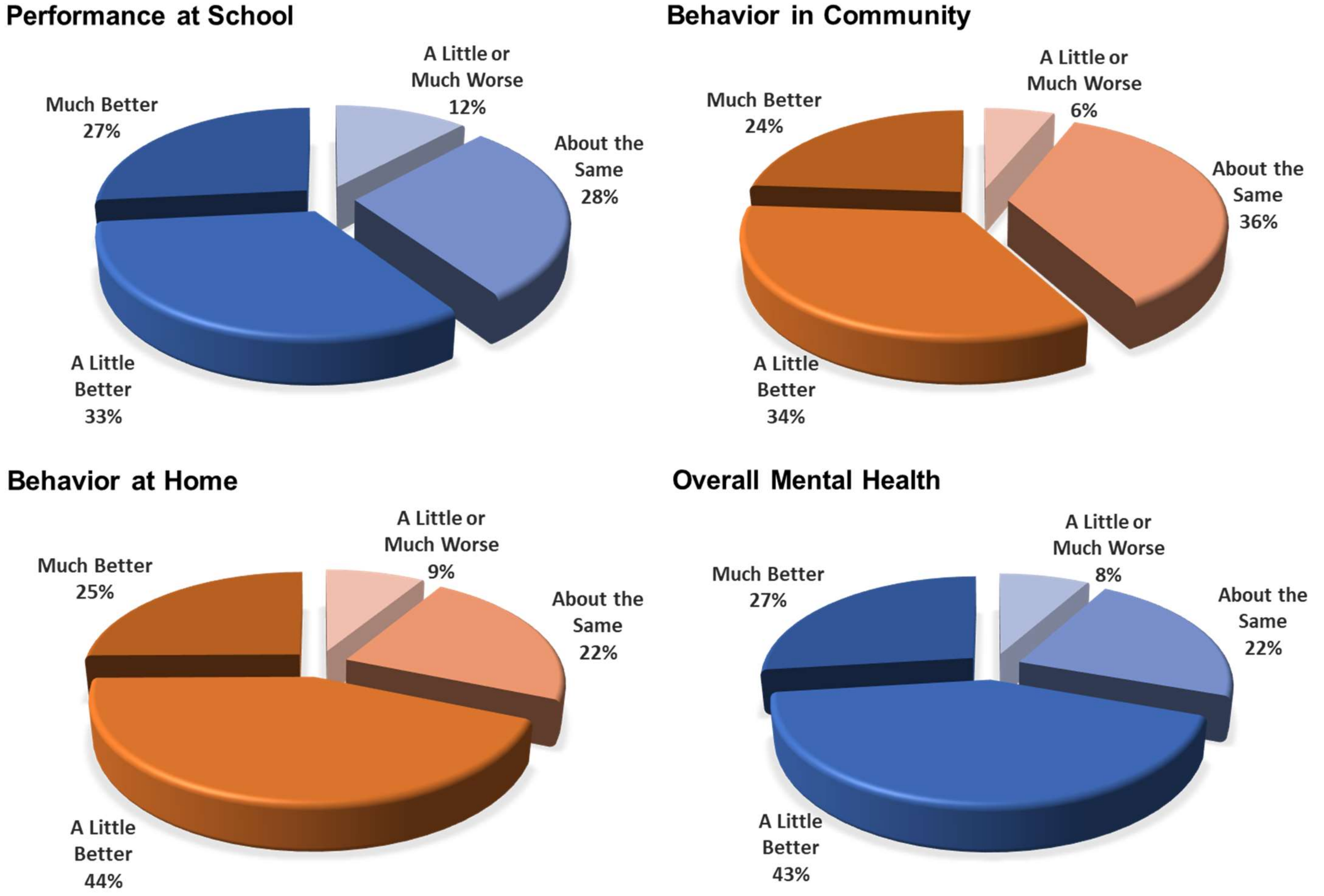
4.3 Youth Psychosocial Functioning and Mental Health

Improvement in youth's psychosocial functioning and overall mental health during the last six months was assessed using four items which addressed the youth's functioning at home, at school, and in the community, as

Table 10. Descriptive Statistics for Perceived Service Impact

Item	Mean	Std. Deviation	% Minimally Helpful (1 to 6)	% Moderately Helpful (7 and 8)	% Highly Helpful (9 and 10)	N Valid (out of 352)
On a scale from 1 to 10, where 1 is the least help possible and 10 is the most help possible, how much was your child/ youth helped by the mental health services he/she received in the last 6 months?	7.08	2.39	31%	41%	28%	345

Figure 11. Changes in Youth Functioning and Overall Mental Health During the Last 6 Months



Performance at School

Behavior in Community

Behavior at Home

Overall Mental Health

well as his or her overall mental health. Items assessing these domains were:

(1) Compared to 6 months ago, how would you rate your child/youth's behavior at home now (e.g., getting along with family members, following rules, helping around the house)?

(2) Compared to 6 months ago, how would you rate your child/youth's performance at school now (e.g., attendance, behavior, grades)?

(3) Compared to 6 months ago, how would you rate your child/youth's behavior in the community now (e.g., behavior in public places, participation in positive activities, involvement with law enforcement)?

(4) Compared to 6 months ago, how would you rate your child/youth's overall mental health now?

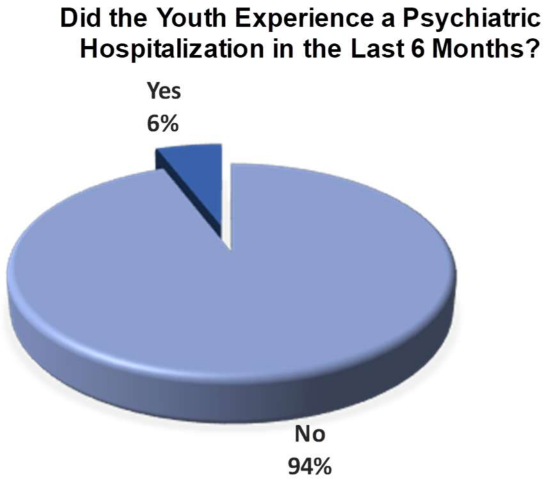
Figure 11 shows the distribution of ratings provided by caregivers across the State (*N*s = 339 to 342).

4.4 Youth Psychiatric Hospitalizations

An important goal of any system-of-care is to reduce the number of times youth are placed in restrictive out-of-home placements such as psychiatric hospitalization. While hospitalizations can play a key role in stabilizing youth and aiding in the recovery process, effective systems-of-care find ways to support youth in the community so that the frequency of re-entry into hospitals is minimized. In this section, we present data on caregivers' reports of the number of times their youth were hospitalized for a psychiatric issue during the last six months. Respondents answered the question:

(1) In the last 6 months, how many total nights did your child/youth spend in a hospital due to problems with behaviors or feelings?

Exhibit 1. Total Number of Nights Youth Spent in the Hospital for Psychiatric Reasons



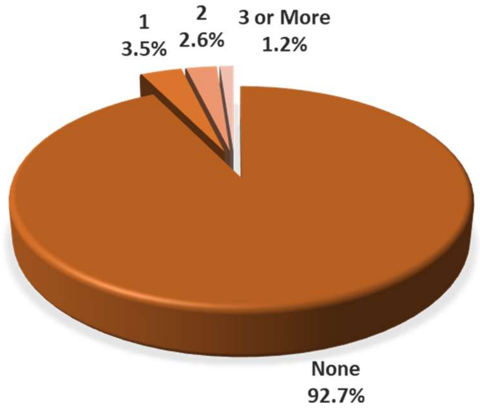
In the last 6 months, how many total nights did your child/youth spend in a hospital due to problems with behaviors or feelings?

# of Nights	Frequency	Percent
None	325	94.2
1 to 2	3	.9
3 to 7	4	1.2
8 or more	13	3.8
Total	345	100

Exhibit 1 shows the number of youths who experienced a psychiatric hospitalization during the last six months, as reported by caregivers, broken down by length of stay. Overall, 5.8% of youth (*n* = 20) experienced a psychiatric hospitalization during the last six months according to caregivers.

4.5 Youth Out-of-Home Placements

Figure 12. Number of New Out-of-Home Placements for Youth during the Last Six Months



N = 342

A key outcome indicator for systems-of-care is the extent to which the system can effectively support youth to live successfully in the community rather than in an out-of-home placement. New out-of-home placements occur when a youth is removed from her or his home or when a youth has an unsuccessful placement at one out-of-home placement and is moved to a new placement. We asked caregivers to report on the number of new out-of-home placements their youth had experienced in the last six months (or since beginning services) with the following question:

(1) In the last 6 months, how many times has your child/ youth had a new out-of-home placement (such as juvenile detention, psychiatric hospital, or treatment center) OR moved between out-of-home placements?

This question has some built in redundancy with other service usage questions on the survey, but it provides an overall index of the number of new out-of-home placements youth experienced during the rating period. Figure 12 shows the percentage of youth who experienced 1 or more new out-of-home placements based on this question. Overall, 7.3% of youth (*n*=25) experienced one or more new out-of-home placements during the rating

Table 11. Total Nights Youth Spent in Out-of-Home Services in the Last Six Months

	Psychiatric Hospital		Crisis Shelter	
# of Nights	N	%	N	%
None	325	94.2	338	98.0
1 to 2	3	.9	1	.3
3 to 7	4	1.2	2	.6
8 or more	13	3.8	4	1.2
Total	345	100	345	100

	Treatment foster care		Residential treatment center	
# of Nights	N	Percent	N	Percent
None	344	99.7	337	97.7
1 to 30	0	0	4	1.2
31 to 60	0	0	3	0.9
61 to 90	0	0	0	0.0
91 or more	1	.3	1	0.3
Total	345	100	345	100

period.

5.0 Youth and Family Participation in Services

In this section, we present data related to youth and families' participation in mental health services and supports as reported by caregivers. Caregivers were asked to report on their child/youth's use of specific services during the last six months. Services were selected by DBH as those of highest priority for tracking over time. These services provide an indicator of how responsive the YES system is to youth's needs.

5.1 Out-of-Home Services

Table 11 shows the total number of nights youth spent in out-of-home services by service type during the last six months based on caregivers' reports.

5.2 Community-based Services

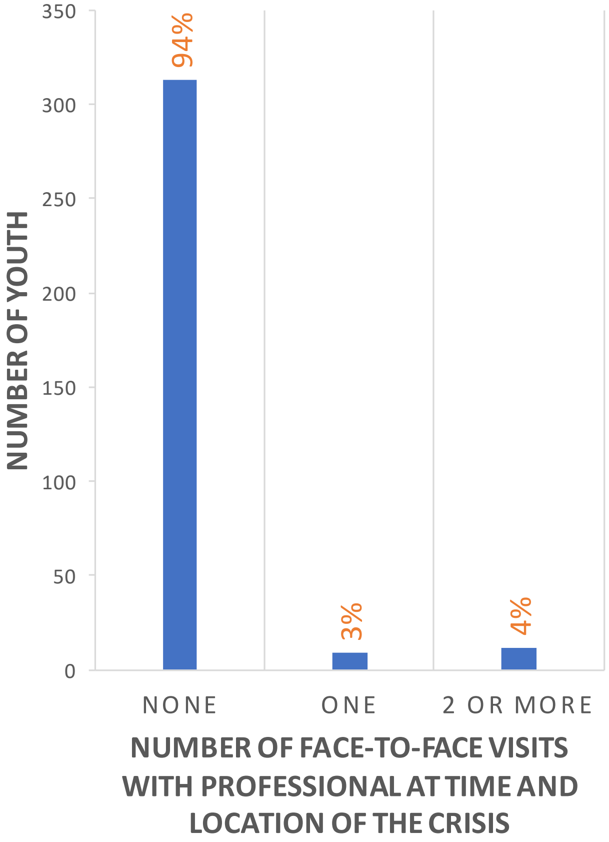
Community-based services are a critical aspect of any system-of-care. For the YES 2020 family survey, the Department prioritized two community-based services to assess due to their importance for keeping youth at home:

- Number of face-to-face crisis visits with a mental health professional at the time and location of the crisis,
- Use of Wraparound services.

5.2.1 Face-to-Face Visits with a Professional at the Time and Location of a Crisis

Exhibit 2 shows the number of youths who received a face-to-face visit from a mental health professional at the time and location of the crisis, broken out by the number of visits. Overall, 313 caregivers (93.7%) indicated that their youth did not receive a visit during a crisis and 21 caregivers (6.3%) reported that their youth did receive a visit.

Exhibit 2. Number of Youth who Received a Face-to-Face Visit with a Mental Health Professional at the Time and Location of a Crisis



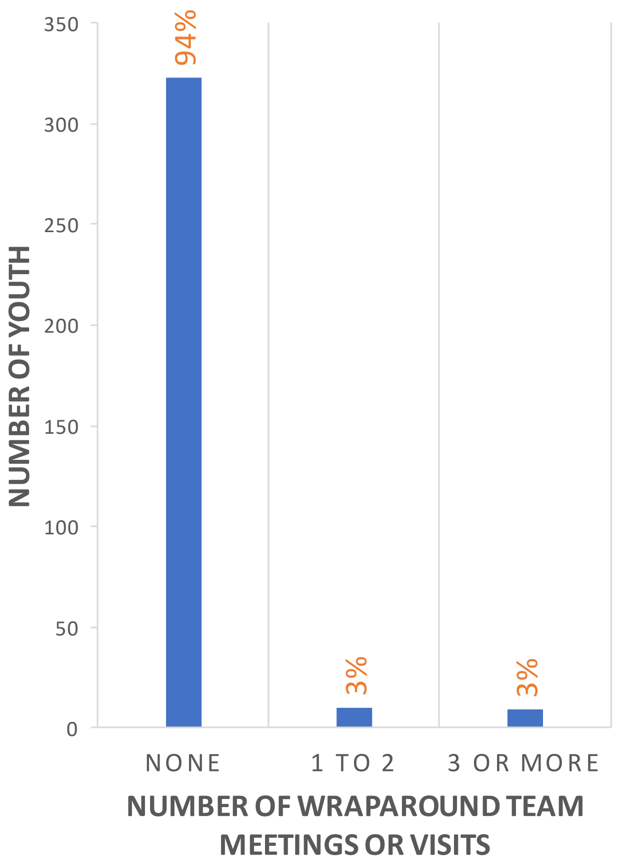
# of Visits	N	%
None	313	93.7
One	9	2.7
Two or More	12	3.6
Total	334	100

In order to assess whether youths with the most severe needs were more likely to receive a face-to-face visit during a crisis, we tested whether youths who experienced a psychiatric hospitalization or new out-of-home placement in the last six months were more likely to receive a face-to-face visit from a mental health professional during a crisis using chi-square statistical tests. Results of these analyses indicated that youths who experienced a psychiatric hospitalization or out-of-home placement during the last six months were significantly more likely to receive a face-to-face visit from a mental health professional at the time and location of the crisis (all *p*-values $\le$ 0.001). Specifically, 28% of youths who were psychiatrically hospitalized in the last six months received a face-to-face visit during a crisis compared to only 5% of youths who were not psychiatrically hospitalized (p = .001). This analysis indicates that youths who are at-risk of out-of-home placement are significantly more likely to receive a face-to-face crisis visit from a mental health professional; however, it also indicates that 72% of youths who were psychiatrically hospitalized (13 out of 18 youths) never received a face-to-face visit from a professional during a crisis. There are many challenges to providing face-to-face crisis services and not all youths who are at-risk of out-of-home placements require such a visit; however, the low percentage of youths who received this support suggests increasing crisis support is an area of potential improvement for Idaho's YES system.

5.2.2 Wraparound Participation

Exhibit 3 shows the number of Idaho youths who participated in Wraparound visits or meetings during the last six months based on caregiver reports. Overall, 5.6% of caregivers (*n* = 19) indicated their youth had participated in Wraparound during the last six months and 94.4% (*n* = 323) indicated their youth had not participated in Wraparound. This rate of participation rate is in line with expectations given that Wraparound is designed for youths with the most severe needs and Wraparound services are currently being scaled up across Idaho.

Exhibit 3. Number of Youth who Participated in Wraparound



# of Visits	N	%
None	323	94.4
1 to 2	10	2.9
3 or More	9	2.9
Total	342	100

In order to assess whether youths with the most severe needs were more likely to receive Wraparound, we conducted a statistical analysis (chi-square test) to determine whether youths who experienced a new out-of-home placement in the last six months were more likely to participate in Wrapround. Results of this analysis indicated that youths who experienced a new out-of-home placement during the last six months were significantly more likely to participate in Wraparound (*p*-value < 0.001). Specifically, 22% of youths who experienced a new out-of-home placement in the last six months had participated in Wraparound compared to only 4% of youths who had not experienced a new out-of-home placement. This indicates that youths who are at-risk of out-of-home placement are significantly more likely to participate in Wraparound compared to youths who are not at-risk of out-of-home placement, which is consistent with the goal of targeting Wraparound to youth at greatest risk of out-of-home placement. However, it also indicates that 78% of youths who experienced a new out-of-home placement in the last six months (that is, 25 out of 32 youths) did not participate in Wraparound. While Wraparound may not be appropriate for every youth who is at-risk of out-of-home placement, the low percentage of at-risk youths who participated in this service suggests that increasing access to Wraparound may be an area of improvement for Idaho's YES system.

6.0 Relationships Between Participants' Experiences of Care and Service Outcomes

This section presents analyses showing the relationships between scales measuring participants' experiences of care and youth outcomes. Survey measures are most valuable for identifying areas of service improvement when the items are associated with improvement in youth outcomes.

6.1 Correlations between Experiences of Care and Service Outcomes

Table 12 shows the bivariate correlations between scales measuring YES principles of care, YES Practice Model quality indicators, and the suite of YES outcomes described above. Statistically significant correlations are indicated

Table 12. Bivariate Correlations between Experiences of Care Scales and YES Outcome Indicators

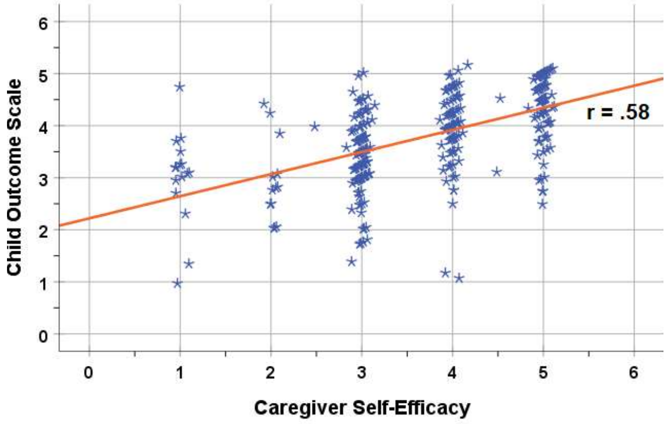
	Youth had a psychiatric hospitalization in the last 6 months	Youth had a new out-of-home placement in the last 6 months	Child Outcome Scale	Perceived Service Impact (item)	Caregiver's Self-Efficacy (item)
Family-Centered Care	-0.07	-0.09	0.26**	0.52**	0.41**
Strengths-Based Care	-0.08	-0.12*	0.33**	0.59**	0.41**
Youth-Focused Care	-0.07	-0.08	0.26**	0.50**	0.32**
YES Practice Model Quality Indicators	-0.09	-0.11*	0.32**	0.64**	0.48**
Safety/Crisis Planning†	-0.14*	-0.11	0.45**	0.52**	0.57**
CANS Experience	-0.08	-0.06	0.39**	0.50**	0.46**
Indicators of Success††	-0.20**	-0.20**	0.44**	0.62**	0.52**
Caregiver's Self-Efficacy (item)	-0.16**	-0.19**	0.58**	0.48**	-

Weak = 0.10	Moderate = 0.30	Strong = 0.50

Note: Table shows bivariate Spearman correlations. Values of 0.10 represent weak relationships, 0.30 represent moderate relationships, and 0.50 represent strong relationships. N's range from 344 to 351 due to missing data on some questions. † = Analysis only includes caregivers who responded to one or more safety/crisis planning questions. N's = 215-221. †† = Analysis only includes caregivers who responded to the safety/crisis planning question 25, N's = 196-202. * Correlation is statistically significant at the 0.05 level (2-tailed). ** Correlation is statistically significant at the 0.01 level (2-tailed).

with an asterisk(s) and color highlighting. A statistically significant correlation indicates that there is a reliable relationship between two variables such that, if we know the value of one variable, we can more accurately predict the value of the second variable. For example, Figure 13 shows a scatterplot of the relationship between Caregiver Self-Efficacy and the Child Outcome scale. The correlation between these scales is positive and statistically significant (Correlation $r = 0.58$, $p < 0.001$, $n = 340$), which means that as the score on Caregiver Self-efficacy increases (indicating higher caregiver perceptions that they can access the services and supports their child needs), youth outcomes also improve.

Figure 13. Scatterplot Showing the Correlation Between Caregiver Self-Efficacy and Child Outcome Scale



Note: N = 340

Correlations range in value from -1 to +1. The strength of a correlation does not depend on its sign (i.e., +/-) but rather on its absolute value. For example, a correlation of -0.6 is much stronger than a correlation of +.04. The sign of a correlation indicates the direction of the relationship (e.g., as one score increases the other score increases/decreases) and the value of the correlation indicates the strength of the relationship.

In Table 12, statistically significant correlations are highlighted in blue, light orange, or dark orange in order to show the strength of each correlation. According to frequently used guidelines from Cohen (1988), correlations can be interpreted as follows: |.10| = small, |.30| = moderate, and |.50| large. Thus, a correlation of 0.48 or -0.48 would be considered moderate-to-large and any correlation with an absolute value greater than or equal to 0.30 would be considered moderate in practical terms. Correlations highlighted in blue represent weak relationships, those highlighted by light orange represent moderate relationships and those highlighted by dark orange represent strong relationships.

In Table 12, variables that are conceptualized as predictors of outcomes are listed in the first column and variables that are conceptualized as outcomes are listed as column headers across the top. Appendix 1 shows the items that make up each of the scales as well as the reliability of each scale for readers who are interested.

Two important observations emerge from Table 12. First, some outcomes are more difficult to predict than others. For example, many experience of care scales had only weak or no statistically significant relationship with the outcomes of whether or not the youth experienced a psychiatric hospitalization or a new out-of-home placement in the last six months; however, several experiences of care were strongly related to perceived service impact. This demonstrates that some outcomes are easier to predict (perceived service impact) than others (psychiatric hospitalization).

Second, some experiences of care are stronger predictors of more outcomes than others. For example, the CANS Experience scale does not have statistically significant relationships with youth psychiatric hospitalization or new out-of-home placement whereas the Indicators of Success scale (see below for details) is significantly related to both of these outcomes as well as others.

The item assessing caregivers' level of self-efficacy is listed as both a predictor and an outcome in Table 12. This is because caregiver self-efficacy to access the services and supports their child/youth needs can be thought of as both a predictor or cause of more positive outcomes for their youth as well as an outcome of services (e.g., services should help increase caregivers' efficacy to meet their youths' needs). Results of these correlational analyses suggest that increasing caregivers' self-efficacy to access services their youth needs may support youth well-being.

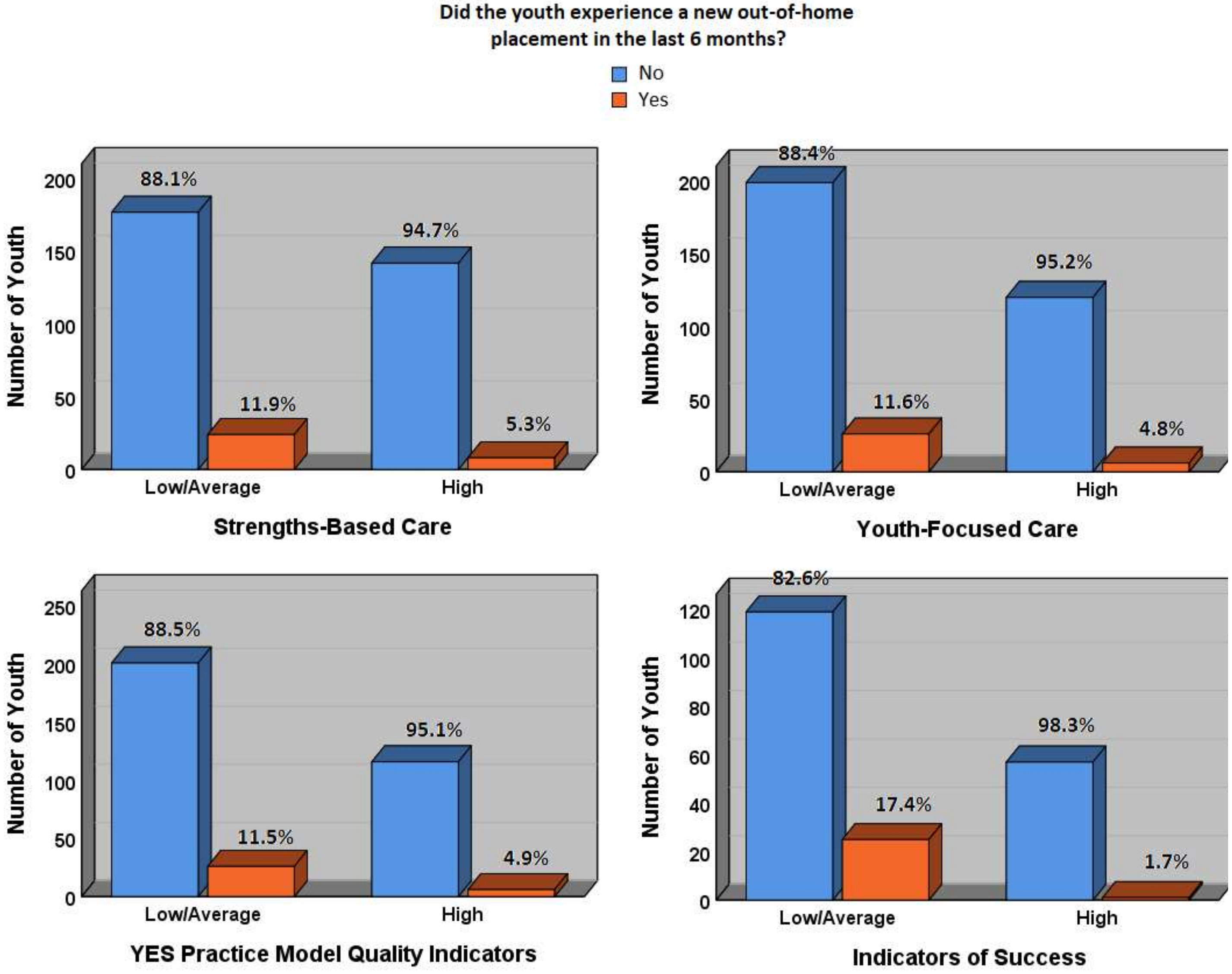
6.2 High versus Low Scores on Experiences of Care Scales and Relationships to Service Outcomes

Table 13. Relative Risk of Out-of-Home Placement for Youth with High vs. Low Scores on Experiences of Care Scales

		% of Youth with Out-of-Home Placement in Last 6 Months				
Experience of Care Scale	% of Youth in High-Scoring Group	Low Score Group	High Score Group	X^2_{LR} p-value	Relative Risk for Low-Scoring Group	N
Indicators of Success	28.7%	17.4%	1.7%*	.001	10.1	202
Youth-Focused Care	35.9%	11.6%	4.8%*	.026	2.4	351
YES Practice Model Quality Indicators	35.0%	11.5%	4.9%*	.035	2.3	349
Strengths-Based Care	42.7%	11.9%	5.3%*	.029	2.2	351
Safety/Crisis Planning	22.2%	15.1%	8.2%	.188	1.9	221
Family-Centered Care	57.0%	11.3%	7.5%	.228	1.5	351
CANS Process	24.3%	13.0%	11.5%	.786	1.1	214

Note: Overall, 9.1% of youth had an out-of-home placement (32 out of 351 youth), as measured by Q22, Q36-Q39.

Figure 14. Percentage of Youth Experiencing a New Out-of-Home Placement by High vs. Low/Average Scores on Experience of Care Scales



Another way to examine the relationship between youth outcomes and experiences of care is to divide respondents' scores on each of the Experiences of Care scales into high versus low categories. For each respondent, their score on each experience of care scale was categorized as either: (a) *High* (scale score ≥ 4.5), or (b) *Low/Average* (scale score < 4.5). Respondents in the *High group* had an average response of *Strongly Agree* on all items for a particular scale, indicating a very positive experience in that area.

Table 13 shows the percentage of respondents who scored in the *High* category and in the *Low/Average* category on each of the Experiences of Care scales. Only 22.2% of respondents scored in the High group for the Safety/Crisis Planning scale whereas 57% of respondents scored in the High group for Family-Centered Care. This indicates that many families (57%) experienced a high level of family-centeredness in their services whereas relatively few families (22.2%) experienced positive safety/crisis planning. These results provide additional information for understanding which areas are strengths and potential weaknesses for the Idaho YES system.

In order to better understand which experiences of care were most predictive of service outcomes, statistical analyses were conducted testing whether youths who scored in the High group on each of these scales were more or less likely than youths who scored in the low/average group to experience a new out-of-home placement (including psychiatric hospitalization). Table 13 compares the percentage of youths who experienced a new out-of-home placement for those in the High versus Low groups on each experience of care scale. Results indicated that four experiences of care scales predicted significantly lower risk of out-of-home placement: Indicators of Success, Youth-Focused Care, YES Practice Model Quality Indicators, and Strengths-Based Care. Youths who scored low/average on the Indicators of Success scale were 10.1 times more likely to experience a new out-of-home placement compared to youths who scored high on Indicators of Success (relative risk = 10.1). Youths who scored Low/Average on scales assessing Youth-Focused Care (relative risk = 2.4), Practice Model Quality Indicators (relative risk = 2.3), and Strengths-Based Care (relative risk = 2.2) were all more than two times as likely to experience a new out-of-home placement compared to youths who scored High on these scales.

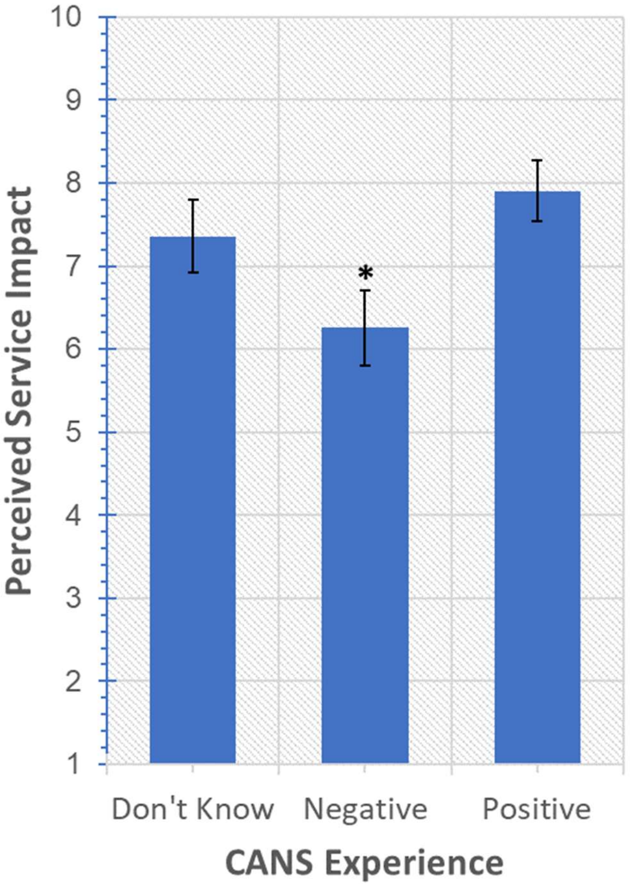
Figure 14 presents the same information visually using clustered bar charts. The charts show that youths who scored High on these scales were significantly less likely to experience new out-of-home placements compared to their peers who scored in the Low/Average range on these scales. This suggests that the Idaho YES system should work to increase the number of youths who score in the High range on these scales.

6.3 Relationship between CANS Experience and Service Outcomes

This section further examines the relationship between items assessing participants' experience with the CANS and service outcomes. An unexpected result of the CANS questions was that a high percentage of caregivers indicated they did not know or were unsure about their most recent CANS experience. While the reasons for this are unknown, it seemed instructive to test whether service outcomes differed across three groups: (1) caregivers who indicated they didn't know about the CANS experience, (2) caregivers who indicated they had a negative CANS experience (as indicated by a score of Strongly Disagree to Neutral on the CANS Experience items), and (3) caregivers who indicated they had a positive CANS experience (as indicated by agreeing or strongly agreeing with the CANS Experience items). Statistical analyses were conducted to test whether these three groups differed significantly on Perceived Service Impact and the Child Outcome Scale.

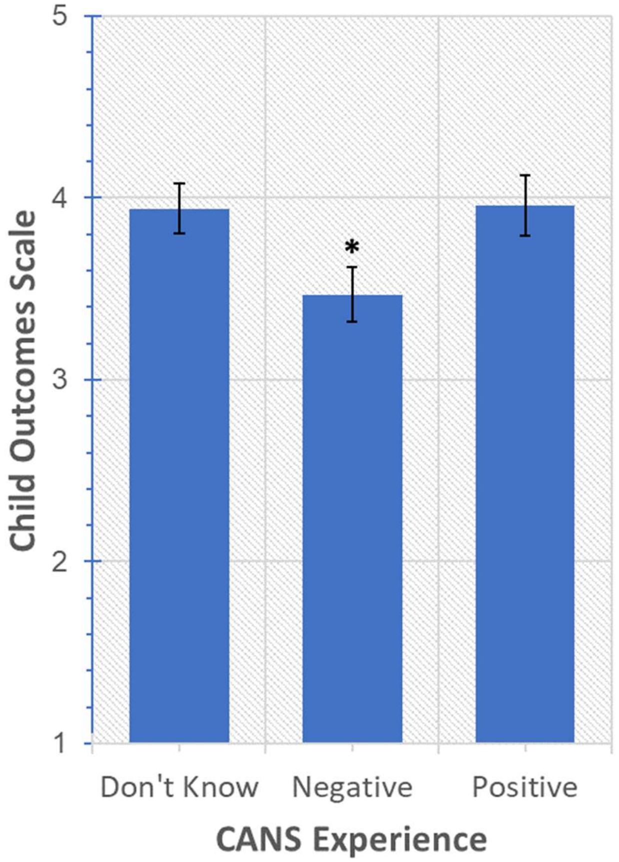
Results are shown in Figures 15 and 16. As is shown in Figure 15, caregivers who had a negative experience with the CANS rated their YES services as significantly less helpful (mean = 6.26, standard deviation = 2.37, *n* = 105) than both caregivers who had a positive experience with the CANS (mean = 7.90, standard deviation = 1.91, *n* = 104) and caregivers who were unsure of their CANS experience (mean = 7.36, standard deviation = 2.35, *n* = 110). Interestingly, however, there was no significant difference in Perceived Service Impact between caregivers who had a

Figure 15. Relationship Between CANS Experience and Perceived Service Impact



Note: N = 319. Participants are divided into three groups based on the average of their three CANS Experience items. Negative indicates the average response to the items was < 4; positive indicates the average response was 4 or higher. Don't Know indicates the respondent answered all three items with a 'Don't Know' response. Asterisk indicates the difference between that group mean and the others is statistically significant at $p < .05$.

Figure 16. Relationship between CANS Experience and Child Outcome Scale



Note: N = 322. Participants are divided into three groups based on the average of their three CANS Experience items. Negative indicates the average response to the items was < 4; positive indicates the average response was 4 or higher. Don't Know indicates the respondent answered all three items with a 'Don't Know' response. Asterisk indicates the difference between that group mean and the others is statistically significant at *p* < .05.

positive CANS experience versus those who were unsure or didn't know about their CANS experience. The same pattern was evident for the Child Outcome Scale (see Figure 16). There was also no significant difference in rates of youth out-of-home placement or psychiatric hospitalization among these three groups. The fact that outcomes did not differ between participants who had a positive experience with the CANS versus those who indicated they 'didn't know' about the CANS, raises interesting questions about other factors that are related to improvement in youths' well-being and how the CANS assessment may complement those factors.

6.4 Indicators of Success Scale

Based on an item-by-item analysis from the 2019 YES family survey, we identified four items from the YES family survey that had the strongest correlations with youth out-of-home placements, new psychiatric hospitalizations, psychosocial functioning, parent self-efficacy, and perceived service impact. These four items were combined into a scale called the *Indicators of Success* scale. Items on the *Indicators of Success* scale came from the domains of strengths-based care, youth-focused care, and YES Practice Model quality indicators; they included:

- The services my child/youth receives focus on what he/she is good at, not just on problems.
- My child/youth is an active participant in planning his/her services.
- The provider often works with our family to measure my child/youth's progress toward his/her goals.
- I feel confident that my family's safety/crisis plan will be useful in times of crisis.

Given the strong performance of these items in the 2019 YES family survey, we tested whether the same four items would be strongly predictive of outcomes in the 2020 YES family survey. Results of these analyses are shown in Table 12 (above) and in Figure 14 (above).

As is shown in Table 12, the Indicators of Success scale was highly predictive of youth outcomes in this sample; indeed, this scale was a stronger predictor of youth outcomes than any other scale. In addition, as is shown in Table 13 and Figure 14, youth who scored High on the Indicators of Success scale were much less likely to experience a new out-of-home placement compared to youth who scored Low/Average on this scale. As is shown in Figure 14, only 1.7% of youths (*n*=1) who scored High on the Indicators of Success scale experienced a new out-of-home placement in the last 6 months, compared to 17.4% of youths (*n*=25) who scored in the Low/Average range. Overall, youths who scored in the low/average range on this scale were 10.1 times more likely to experience a new out-of-home placement than youth who scored in the high range.

7.0 Assessment of Disparities in Youth Outcomes by Youth Characteristics

Cultural competency is an essential principle of the Idaho YES system-of-care. This principle stresses the importance of delivering services in a culturally competent manner that respects all youth and families. When services are provided in this way, youth and families' experiences and outcomes of care should not exhibit systematic differences based solely on the youth's characteristics such as sex, race, ethnicity, or age. In this section, we present analyses comparing youths' experiences of care and outcomes as reported by caregivers across youth sex, race, ethnicity, and age. Because of the small sample sizes of youth who are members of minority ethnic and racial groups, these analyses cannot provide definitive answers regarding disparities in experiences of care and outcomes due to low statistical power; however, they can provide an indication of areas where there appear to be disparities.

The analyses below indicate whether there was a statistically significant difference in experiences of care or service outcomes across demographic groups and the magnitude or practical size of these differences using an effect size called Cohen's *d* (for difference). Effect sizes indicate how large the difference is between group means. We use the well-established effect size suggested by Jacob Cohen called Cohen's *d* where values of *d*=0.1 to 0.3 are considered small, *d*=0.4 to 0.7 are considered medium, and 0.8 or above are considered large.

7.1 Experiences and Outcomes of Care by Youth Sex

Table 14 presents analyses comparing male versus female YES participants on each of the experiences of care scales and service outcomes. Caregivers of female YES

Table 14. Variation in Experiences and Outcomes of Care by Youth Sex

Scale	Youth Gender	n	Mean	Std. Deviation	t	df	Sig. (2-tailed)	Cohen's d
Strength-Based Scale	Male	189	3.92	0.97	1.37	341	0.172	0.14
	Female	154	4.06	0.90				
Family-Centered Scale	Male	189	4.17	0.88	1.46	341	0.144	0.16
	Female	154	4.31	0.84				
Youth-Focused Scale	Male	189	3.61	1.00	2.92	341	0.004*	0.31
	Female	154	3.93	1.02				
YES Quality Indicators	Male	189	4.02	0.83	1.00	341	0.314	0.11
	Female	154	4.11	0.82				
Indicators of Success	Male	111	3.73	0.84	1.27	198	0.205	0.18
	Female	89	3.88	0.84				
Out of Home Placements	Male	185	0.11	0.36	0.78	336	0.436	0.08
	Female	153	0.08	0.34				
Psychiatric Hospitalizations	Male	189	0.05	0.22	0.40	341	0.681	0.04
	Female	154	0.06	0.24				
Child Outcome Scale	Male	188	3.69	0.82	2.59	339	0.010**	0.28
	Female	153	3.92	0.81				
Behavior at Home	Male	188	3.73	0.96	1.95	339	0.052	0.21
	Female	152	3.93	1.00				
Performance at School	Male	186	3.62	1.08	1.83	335	0.067	0.2
	Female	151	3.83	1.00				
Behavior in the Community	Male	187	3.64	0.91	2.29	335	0.022*	0.25
	Female	150	3.87	0.92				
Overall Mental Health	Male	188	3.76	0.91	2.35	339	0.019*	0.25
	Female	153	4.00	0.97				
Caregiver Self-Efficacy	Male	187	3.59	1.00	1.58	334	0.116	0.17
	Female	153	3.77	1.09				
Perceived Service Impact	Male	184	6.94	2.24	1.68	334	0.093	0.18
	Female	152	7.37	2.44				

Note: *N*'s range from 200 to 343 due to some missing values. Values of *d*=0.1 to 0.3 are considered small, *d*=0.4 to 0.7 are considered medium, and 0.8 or above are considered large.

Table 15. Variation in Experiences and Outcomes of Care by Youth Ethnicity

Scale	Youth Ethnicity	n	Mean	Std. Deviation	t	df	Sig. (2-tailed)	Cohen's d
Strength-Based Scale	Non-Latino	289	3.97	0.95	1.30	334	0.197	0.14
	Latino	47	4.16	0.76				
Family-Centered Scale	Non-Latino	289	4.25	0.86	0.06	334	0.953	0.01
	Latino	47	4.26	0.86				
Youth-Focused Scale	Non-Latino	289	3.76	1.02	0.32	334	0.752	0.04
	Latino	47	3.81	0.99				
YES Quality Indicators	Non-Latino	289	4.06	0.83	0.78	334	0.437	0.09
	Latino	47	4.16	0.68				
Indicators of Success	Non-Latino	165	3.78	.85	0.80	198	0.423	0.15
	Latino	35	3.91	.81				
Out of Home Placements	Non-Latino	285	0.10	0.35	0.56	329	0.580	0.06
	Latino	46	0.07	0.25				
Psychiatric Hospitalizations	Non-Latino	289	0.06	0.24	0.54	334	0.592	0.06
	Latino	47	0.04	0.20				
Child Outcome Scale	Non-Latino	287	3.79	0.80	0.08	332	0.941	0.01
	Latino	47	3.80	0.87				
Behavior at Home	Non-Latino	287	3.83	0.97	0.32	331	0.754	0.04
	Latino	46	3.78	0.99				
Performance at School	Non-Latino	285	3.73	1.02	0.79	328	0.432	0.08
	Latino	45	3.60	1.14				
Behavior in the Community	Non-Latino	285	3.73	0.91	0.48	328	0.634	0.06
	Latino	45	3.80	0.97				
Overall Mental Health	Non-Latino	286	3.86	0.92	0.34	331	0.741	0.04
	Latino	47	3.91	1.08				
Caregiver Self-Efficacy	Non-Latino	287	3.65	1.06	0.91	331	0.372	0.1
	Latino	46	3.80	0.93				
Perceived Service Impact	Non-Latino	283	7.05	2.35	1.68	327	0.094	0.19
	Latino	46	7.67	2.14				

Note: *N*'s range from 200 to 336 due to some missing values. Values of *d*=0.1 to 0.3 are considered small, *d*=0.4 to 0.7 are considered medium, and 0.8 or above are considered large.

participants reported their services were significantly more Youth-Focused than caregivers of male YES participants (*p* = .004), and this represented a small effect size of *d* = 0.31. In addition, caregivers of female YES participants reported their youth had significantly greater improvement compared to their male counterparts in the areas of behavior in the community (*d* = 0.25), overall mental health (*d* = 0.25), and the Child Outcome total score (*d* = 0.28). These results suggest female youths experience more youth-centered services and better service outcomes compared to male youths; however, the practical size of these effects is small.

7.2 Experiences and Outcomes of Care by Youth Ethnicity

We examined differences in youths' and families' experiences of care and outcomes based on the youth's ethnicity; that is, whether or not the youth was identified as Latino/Hispanic or non-Latino/Hispanic. Only 13.7% (*n*=47) of caregivers identified their youth's ethnicity as Latino/Hispanic, resulting in extremely low statistical power to detect differences between groups. Because of this, interpreting the measures of effect size was focused on, which gives a better indication of whether or not these two groups of participants had different experiences and outcomes. Table 15 shows the analyses. There were no statistically significant differences in youths' reported experiences or outcomes of care based on ethnicity and all effect size values were small. Based on these results, we conclude there was no evidence of variation in YES service

Table 16. Variation in Youth Experiences and Outcomes of Care by Youth Race

Scale	Youth Race	n	Mean	Std. Deviation	t	df	Sig. (2-tailed)	Cohen's d
Strength-Based Scale	White	294	4.00	0.95	0.82	333	0.411	0.09
	Youth of color	41	3.87	0.93				
Family-Centered Scale	White	300	4.28	0.82	2.54	339	0.011*	0.41
	Youth of color	41	3.91	1.06				
Youth-Focused Scale	White	294	3.80	1.03	1.46	333	0.145	0.16
	Youth of color	41	3.55	1.01				
YES Quality Indicators	White	294	4.10	0.82	1.67	333	0.959	0.18
	Youth of color	41	3.87	0.87				
Indicators of Success	White	177	3.80	0.86	0.38	199	0.704	0.08
	Youth of color	24	3.86	.63				
Out of Home Placements	White	290	0.10	0.34	0.36	328	0.722	0.04
	Youth of color	40	0.08	0.27				
Psychiatric Hospitalizations	White	294	0.06	0.24	0.25	333	0.801	0.02
	Youth of color	41	0.05	0.22				
Child Outcome Scale	White	292	3.81	0.81	0.88	331	0.378	0.10
	Youth of color	41	3.69	0.86				
Behavior at Home	White	292	3.87	0.97	2.03	331	0.043*	0.22
	Youth of color	41	3.54	1.00				
Performance at School	White	290	3.73	1.04	0.45	328	0.651	0.05
	Youth of color	40	3.65	1.10				
Behavior in the Community	White	290	3.76	0.89	0.26	328	0.795	0.03
	Youth of color	40	3.72	1.06				
Overall Mental Health	White	291	3.88	0.94	0.32	330	0.749	0.03
	Youth of color	41	3.83	0.92				
Caregiver Self-Efficacy	White	291	3.70	1.05	1.19	330	0.235	0.13
	Youth of color	41	3.49	1.12				
Perceived Service Impact	White	288	7.16	2.36	0.40	326	0.689	0.04
	Youth of color	40	7.00	2.41				

Note: *N*'s range from 201 to 341 due to some missing values. Values of *d*=0.1 to 0.3 are considered small, *d*=0.4 to 0.7 are considered medium, and 0.8 or above are considered large.

experiences or outcomes based on youth ethnicity.

7.3 Experiences and Outcomes of Care by Youth Race

Table 16 shows differences in youths' experiences and outcomes of care by youth race. Due to the very small number of youths of color, we combined all non-majority racial groups into a single category for these analyses. Due to the very small number of youths who identified as non-White, these analyses also have low statistical power to detect significant differences where they exist. Despite this, there was evidence that youths of color and white youths had different experiences and outcomes of care in two areas. Caregivers of white youths reported significantly higher scores on family-centeredness compared to caregivers of youths of color with a medium effect size of *d* = 0.41. In addition, caregivers of youths of color reported significantly less improvement in their youth's behavior at home with a small effect size of *d* = 0.21. These analyses suggest that youths of color experienced significantly less family-centered services and significantly less improvement in their behavior at home.

In order to obtain more specific information on service differences between youths of color compared to white youths, differences between these groups were tested on all 21 items assessing youths' experiences of care. These analyses revealed that caregivers of white youths reported significantly higher scores on the following items:

- The provider encourages me to share what I know

Table 17. Variation in Experiences and Outcomes of Care by Youth Age (0 to 11 years vs. 12 to 18 years)

Scale	Youth Age	n	Mean	Std. Deviation	t	df	Sig. (2-tailed)	Cohen's d
Strengths-Based Scale	0-11	175	4.07	0.96	1.58	342	0.116	0.17
	12-18	169	3.91	0.92				
Family-Centered Scale	0-11	177	4.31	0.87	1.65	342	0.101	0.14
	12-18	167	4.16	0.85				
Youth-Focused Scale	0-11	175	3.61	1.08	2.95	342	0.003**	0.32
	12-18	169	3.93	0.92				
YES Quality Indicators	0-11	175	4.13	0.86	1.57	342	0.117	0.16
	12-18	169	4.00	0.79				
Indicators of Success	0-11	92	3.83	0.80	0.47	199	0.637	0.08
	12-18	109	3.77	0.85				
Out of Home Placements	0-11	173	0.05	0.29	2.26	337	0.025*	0.25
	12-18	166	0.13	0.36				
Psychiatric Hospitalizations	0-11	175	0.02	0.15	2.91	342	0.004**	0.32
	12-18	169	0.094	0.30				
Child Outcome Scale	0-11	174	3.88	0.79	2.15	341	0.033*	0.23
	12-18	169	3.69	0.85				
Behavior at Home	0-11	174	3.91	0.91	1.69	339	0.091	0.19
	12-18	167	3.73	1.05				
Performance at School	0-11	172	3.77	1.01	0.97	336	0.332	0.11
	12-18	166	3.66	1.07				
Behavior in the Community	0-11	174	3.84	0.92	1.98	336	0.049*	0.21
	12-18	164	3.64	0.94				
Overall Mental Health	0-11	174	4.02	0.87	2.98	339	0.031*	0.33
	12-18	167	3.72	0.99				
Caregiver Efficacy	0-11	173	3.77	1.07	1.69	339	0.091	0.19
	12-18	168	3.58	1.00				
Perceived Service Impact	0-11	173	7.28	2.27	1.22	335	0.225	0.13
	12-18	164	6.97	2.41				

Note: N's range from 92 to 344 due to some missing values. Values of *d*=0.1 to 0.3 are considered small, *d*=0.4 to 0.7 are considered medium, and 0.8 or above are considered large.

about my child/youth's strengths and needs.

- Meetings with the provider occur at times and locations that are convenient for me.
- My child and I are the main decision-makers when it comes to planning my child/youth's services.
- Services we receive are respectful of our family's language, religion, race/ethnicity, and culture.

7.3 Experiences and Outcomes of Care by Youth Age

Table 17 shows differences in youths' experiences and outcomes of care by youth age. For this analysis, youths were divided into two groups based on their age (1) ages 0 to 11 years, and (2) ages 12 to 18 years. Results indicated that caregivers of older youths reported significantly higher scores on the Youth-Focused Scale. This is not surprising since older youth are more able to participate in planning their care. Results also indicated that older youths had more negative service outcomes than younger youths, including significantly higher rates of out-of-home placement and psychiatric hospitalization within the last six months as well as significantly less improvement in their psychosocial functioning and overall mental health. These findings reflect the fact that as youth age they become at higher risk for out-of-home placement. They also suggest that older youths do not fare as well as younger youths within Idaho's YES system.

8.0 Summary of Findings and Targets for Quality Improvement

Survey Procedure. The effective response rate (*N* of responses / *N* of delivered surveys) for this survey was 9% which is in line with national averages for surveys but still lower than desired. The low response rate introduces the possibility of bias. The 9% of caregivers (*N* = 352) who responded represent their perceptions and experiences; however, their experiences may differ from caregivers who did not respond. If all caregivers responded, it is possible the results would differ. To address this, steps should be taken to improve the response rate in future years.

One challenge that arose this year during the survey was that some participants were confused about whether the survey was from Boise State University or IDHW. Questions from community members about this issue ultimately led the Boise State University Institutional Review Board to rule that planned follow-up communications for this survey needed to only include IDHW letterhead and branding. The goal was to ensure participants understood that BSU did not have access to individuals' identifiable information. Given this requirement, IDHW and the research team agreed to cancel the planned follow-up postcard and survey. Eliminating these follow-ups likely reduced the response rate. In a previous pilot test of the YES family survey (2019), the effective response rate with two follow-ups was 15%.

In order to increase the response rate in future years the following steps are recommended:

(1) Use a one-page (front and back) survey format,

(2) implement a pre-survey letter and multiple follow-ups,

(3) print survey materials on IDHW letterhead and use IDHW branding to make it clear to participants that the survey is officially sanctioned by IDHW and their information is safe,

(4) conduct pre-survey outreach to family advocacy groups, providers, and other stakeholders to inform them of the importance of the survey and encouraging families to participate,

(5) Inform families about the survey when they enroll in services and complete annual reviews, consider providing information about the survey during the initial CANS assessment,

(6) widely share results of the survey with family advocacy groups and other stakeholders to demonstrate the value of the results for improving services,

(7) in future survey invitations, briefly state specific examples of how the survey informed improved services,

(8) invite families and other stakeholder groups to further inform the content areas to be assessed by the survey.

Prior research sponsored by the Department showed that the 1-page survey currently in use increased the response rate. Additional research should be conducted to evaluate the impact of using different modalities to increase the response rate, such as using phone administration, online administration, or in-person administration (for example, delivered by providers).

Survey Design. The 2020 YES family survey included new items related to the YES Practice Model and the CANS. New items related to the YES Practice Model included:

- ➢ The provider respects me as an expert on my child/youth.
- ➢ My family can easily access the services my child needs most.
- ➢ The provider who has been working with my child and family shows that he/she will not give up on us.
- ➢ I feel that the provider openly and honestly communicates with our family.
- ➢ The provider demonstrates hope and optimism in meetings with my family.

Analyses of these five new items indicated that with one important exception (described below), participants rated these items very high (79-82% of participants agreed or strongly agreed with four of the items) and, partly as a result of the universally high ratings, none were strongly related to service outcomes for youth. Future surveys may be strengthened by identifying other quality indicators that set a higher bar for agreement. Such items may be more predictive of youth outcomes and may help stakeholders identify areas for system improvement.

The important exception to this rule is the item "My family can easily access the services my child needs most." This item was the strongest single-item predictor of service outcomes. Higher scores on this item were significantly related to greater improvement on the Child Outcome scale ($r = 0.35$, $p < 0.001$), reduced risk of psychiatric hospitalization in the last six months ($r = -0.18$, $p = 0.001$), and reduced risk of out-of-home placement ($r = -0.22$, $p < 0.001$). Based on this analysis, it is recommended to retain this item for future surveys.

New CANS items are shown in section 3.8, above. Somewhat surprisingly, a large percentage of caregivers (35% to 40%) indicated they were "Unsure" or did not know how to rate their CANS experience (this response was separate from a Neutral response which indicated neither strong disagreement nor agreement with the item). Analysis of the CANS items indicated that service outcomes were not significantly different for participants who were unsure about their CANS experience compared to those who had a positive CANS experience; although, service outcomes were significantly better for these two groups of respondents compared to respondents who had a negative CANS experience. These findings reflect the early implementation of CANS in Idaho and raise two questions:

1. Why are so many caregivers unsure how to rate their most recent CANS experience?
2. What does it mean that service outcomes are equivalent for youth whose caregivers are unsure about their CANS experience versus those who had a very positive experience?

Answering these questions will be important as the State continues to evaluate the utility and place of the CANS within the YES system. In addition, further psychometric analysis of these CANS-related items is warranted given their preliminary stage of development.

YES Principles of Care. Statewide, participants gave YES services high marks on items assessing the extent to which care was family-centered; consequently, this appears to be an area of relative strength across the State. For example, 85% of respondents agreed or strongly agreed with the item asking whether the provider encouraged them to share what they know about their child/youth and 57% of respondents were in the high-scoring group on the family-centered rating scale (see Table 13).

In contrast to the high marks for family-centered care statewide, there appears to be room for improvement in the extent to which YES services are strengths-based and youth-focused. None of these items met the threshold for a system strength (i.e., 80% agreement). Furthermore, less than half of participants were in the high scoring group for these two scales (see Table 13). This is especially important, since high scores on these two scales were significantly related to lower risk of new out-of-home placement; specifically, youths whose experience rated high on these scales were more than twice as likely to avoid a new out-of-home placement compared to their peers. Providing training to clinicians in strategies for using a strengths-based approach and engaging youth alongside their caregivers may result in higher ratings in this area.

YES Practice Model Quality Indicators. Statewide, several strengths were noted in the area of YES Practice Model quality indicators. Specifically, the following items met the cut score of agreement by 80% or more of respondents and likely represent system strengths:

- Services we receive are respectful of our family's language, religion, race/ethnicity, and culture,
- The goals we are working on with the provider are the ones I believe are most important for my child/youth,
- The provider respects me as an expert on my child/youth,
- The provider demonstrates hope and optimism in meetings with my family.

Statewide, two quality indicators for the YES Practice Model may require attention based on 1 in 5 or more respondents (>20%) giving a rating of *Disagree* or *Strongly Disagree*. These included:

- My family can easily access the services my child needs most,
- I know who to contact for help if I have a concern or compliant about my provider.

As noted above, the item regarding access to services was strongly related to numerous service outcomes and therefore warrants special attention. That caregivers perceive they cannot access services their child needs suggests additional work is needed to develop the YES service array in Idaho.

In addition to the quality indicators that met the 20% cut off for areas of weakness, the following items also had 10% or more of caregivers who disagreed or strongly disagreed with the item. While 10% may not seem like a large percentage of respondents, it represents 1 out of every 10 youth with SED in the State and therefore warrants some attention. Potential areas of improvement for the YES system include:

- When services are not helping the provider leads my child's treatment team in a discussion of how to make things better (13% *Disagree* or *Strongly Disagree*),
- The provider makes sure everyone on my child's treatment team works together in a coordinated way (12% *Disagree* or *Strongly Disagree*),
- The provider suggests changes in my child/youth's treatment plan or services when things aren't going well (12% *Disagree* or *Strongly Disagree*),
- The provider often works with our family to measure my child/youth's progress toward his/her goals (12% *Disagree* or *Strongly Disagree*),
- The provider makes specific suggestions about what services might benefit my child/youth (11% *Disagree* or *Strongly Disagree*).

Safety/Crisis Planning. The 2019 YES family survey highlighted a system gap in the adequacy of safety/crisis planning for YES participants. Results from the 2020 YES family survey, which includes the entire YES system, echo these results and indicate this may be an important area in need of service improvement. Of caregivers who indicated that they believed their child/youth needed a safety/crisis plan, more than 1 in 5 (20%) disagreed or strongly disagreed with items assessing the adequacy of safety/crisis planning. One-third of respondents (33%) disagreed or strongly disagreed with the item "The provider helped my family make a safety/crisis plan." This represents a basic level of preparedness for meeting a youth and family's needs as well as avoiding out-of-home placements. In addition, 22% of caregivers who thought their child needed a safety/crisis plan disagreed with the item, "I feel confident that my family's safety/crisis plan will be useful in times of crisis." This indicates that more than 1 in 5 caregivers of youth with SED, who believe their youth needs a safety/crisis plan, are not confident in what they will do when a crisis emerges. Addressing this gap may be an important focus of service improvement efforts.

Improved youth functioning and perceived service impact. The average score on the Child Outcome Scale, which assessed improvement in youth functioning across three domains as well as overall mental health during the last six months, corresponded to an improvement rating between *About the Same* and *A Little Better* (Ave. = 3.78, standard deviation = 0.83). The average response on the Perceived Impact item fell within the moderately improved range (Ave. = 7.08, standard deviation = 2.39) with 31% of participants indicating services were minimally helpful to their youth. This suggests that many respondents do not perceive their youths have made major improvements in their well-being during the last six months, despite participation in YES services. Exploring the reasons for this and finding ways to improve youths' daily functioning at home, at school, and in the community represents an important area for service improvement in the State. For example, work within the system to develop targeted supports based on the CANS may improve youth outcomes and caregivers' perceptions of service effectiveness. Furthermore, monitoring how respondents' scores change over time will be an important area for ongoing evaluation.

Crisis Support. Overall, only 6% of respondents indicated they had received a face-to-face visit from a mental health professional at the time and location of a crisis during the last 6 months; however, youth who had experienced a psychiatric hospitalization or new out-of-home placement within the last six months were significantly more likely to have received such a visit. Despite this, results also indicated that 72% of youth who were psychiatrically hospitalized within the last six months and 75% of youth who experienced a new out-of-home placement in the last six months never received a face-to-face visit from a professional at the time and location of a crisis. These findings suggest a need to increase access to community-based crisis response services for youth and families.

Experiences of Care that are Associated with Youth Outcomes. Four scales were most predictive of youth service outcomes including improvement in functioning and overall mental health, reduction in risk of psychiatric hospitalization or new out-of-home placement, and perceived service impact: (1) the Indicators of Success Scale, (2) caregivers' self-efficacy to access services and supports for their youth, (3) quality of safety/crisis planning, and (4) the extent to which services were strengths-based. Targeting these areas for service improvement may support improvement in youth well-being.

In support of results from the 2019 YES family survey, the 2020 survey provided additional evidence that four items, labeled *Indicators of Success*, are significantly predictive of youth service outcomes in the Idaho YES system. Youth who scored high on these items were 10 times less likely to experience a new out-of-home placement compared to youth who scored low/average. The items were:

- The services my child/youth receives focus on what he/she is good at, not just on problems.
- My child/youth is an active participant in planning his/her services.
- The provider often works with our family to measure my child/youth's progress toward his/her goals.
- I feel confident that my family's safety/crisis plan will be useful in times of crisis.

Targeting these four items for improvement may support improved youth outcomes in Idaho.

In addition, it is important to note that caregiver self-efficacy was a strong predictor of all outcomes. This suggests that equipping caregivers with the confidence and skills they need to access services and supports for their youth may play a significant role in improving youth well-being.

Disparities in Outcomes. Minimizing disparities in youth outcomes based on youth sex, race, ethnicity, or age is an important goal of all systems of care including YES. Results of this survey provided some evidence that youth of color had more negative service experiences in the area of family-centered care than their white peers. Specifically, caregivers of youths of color reported more negative experiences with regard to: (a) the provider encouraging the caregiver to share what she/he knows about the child's strengths and needs, (b) meetings occurring at times and locations that are convenient, (c) the extent to which services were respectful of the family's language, religion, race/ethnicity, and culture, and (d) the extent to which the caregiver and child are the main decision-makers when it comes to planning services. In addition, caregivers of male YES participants reported less improvement in their youth's psychosocial functioning and mental health as well as less youth-centered care. Older youth also did not fare as well as younger youth across multiple service outcomes including out-of-home placements and improvement in overall functioning and mental health. Addressing these potential disparities in outcomes is important as the YES system seeks to enact its espoused value of cultural competency.

Caveats. These findings should be treated as descriptive information only. The study design does not support causal inferences; that is, these results do not confirm that any variable causes a change or improvement in any other variable. The results only show that certain types of experiences were associated with better or worse service outcomes as reported by caregivers. An additional limitation of this study is the low response rate. Findings should be interpreted within the context of these limitations.

The cut scores of 80% for agreement with positive items and 20% for disagreement with positive items are based on reasoning and do not currently have an empirical basis or support in the scientific literature. These values are based on our reasoning, which we have sought to make transparent in this report. Future research should seek to establish empirical cut scores for evaluating system performance on these items.

Results of this study should also be interpreted within historical context. The worldwide coronavirus (COVID-19) pandemic struck Idaho and the United States while the YES 2020 family survey was in the field. It is unknown how this historical circumstance affected participants' responses or the overall response rate; however, this context should be considered in comparing these findings with future data.

Because of differences in the populations surveyed and in the survey questions from 2019 to 2020, this report does not compare results from the two years. The 2019 YES family survey included only families that were served directly by DBH whereas the 2020 YES family survey included all families with youth who completed a CANS.

9.0 Conclusion

This report presents the experiences and outcomes of YES services as reported by caregivers who completed the 2020 Idaho yes family survey. Findings of this survey indicate several areas of strength as well as areas for improvement to continue building an effective system-of-care for Idaho youth who experience emotional and behavioral disorders and their families.

Appendix 1. Idaho YES Family Survey Scale Items and Reliabilities

Scale	Items	Scale Reliability (Cronbach's Coefficient Alpha)
Strengths-Based Care Scale	See Table 3.	0.77
Family-Centered Care Scale	See Table 4.	0.72
Youth-Focused Care Scale	See Table 5.	0.74
YES Practice Model Quality Indicators Scale	See Table 6.	0.95
Safety/Crisis Planning Scale	See Table 7.	0.86
CANS Experience Scale	See Table 8.	0.87
Child Outcome Scale	See Figure 11.	0.87

Alpha reliability values range from 0.0 to 1.0; higher values indicate higher reliability of the items.
Alpha values $\geq$ 0.70 are considered adequate.

Appendix 2. Glossary of Statistical Tests and Concepts

Statistic	Description/ Definition	Interpretation
Mean	The mean is the average of a set of scores. For example, the average rating of an item by a group of survey participants.	The mean is helpful for understanding the average or typical value in a sample. It should be interpreted using the full range of possible scores (e.g., 1 to 5 or 0 to 3).
Standard deviation	The standard deviation indicates how values are spread out in a sample. It shows much the scores were spread out around the mean.	Higher standard deviations indicate scores or answers to a question are more spread out and lower standard deviations indicate the scores were less spread out – people responded more similarly to each other.
Chi-square test	The chi-square test is used to assess whether there is a systematic relationship between two categorical variables or whether the relationship between the variables is simply due to random chance. For example, we might find that the percentage of youth who receive Wraparound services (yes/no) is slightly higher among those youth who had an out-of-home placement in the last 6 months compared to youth who did not have an out-of-home placement in the last 6 months. This difference may be relatively small and completely due to chance or it may be large enough that it is very unlikely we would observe that large of a difference simply due to chance. The chi-square test assesses how likely it is we would observe a difference that large simply by chance.	The chi-square test produces a probability value called *p.* If *p* is less than 0.05, we conclude that the relationship between the variables is so strong it is probably not due to chance; there is a systematic relationship between the two variables.
Bivariate correlation (correlation)	A correlation describes the strength of the linear relationship between two continuous variables. "Linear" means that it is a straight-line relationship—as one variable goes up the other goes up (or down). Figure 13 shows an example of a correlation line that shows how scores on one variable increase on average as scores on another variable also increase. Correlations tell us how strongly two variables are related to each other. "Bivariate correlation" means that it is a correlation between only two variables. The sign of the correlation – positive or negative – tells you whether one variable increases or decreases as the other variable increases.	The absolute value of the correlation tells you how strong the relationship between the variables is. A correlation of 0.0 indicates there is no relationship between the variables. Correlations of 0.1 or -0.1 represent weak relationships, values of 0.3 or -0.3 represent moderate relationships, and values of 0.5 or -0.5 represent strong relationships.
Spearman correlation	A Spearman correlation is a correlation that is used for ordinal data – that is, data that have categories (e.g., strongly disagree to strongly agree) rather than true continuous numbers (such as temperature). Spearman correlations are considered more appropriate for use with data like those analyzed in this survey.	Spearman correlation values are interpreted in the same way as other correlations, as described above.
Statistically significant	If the relationship between two variables is statistically significant, it means that it is very unlikely to observe a relationship that large between the two variables simply by chance alone; there is almost certainly a relationship between the variables. In other words, if we know something about the value of one variable, we can more accurately predict the value of the other variable.	Statistical tests are typically considered 'statistically significant' if the probability is 0.05 or less. Roughly, this means that the likelihood (or probability) of observing a relationship that strong merely by chance alone are less than 5%.
Cronbach's coefficient alpha	A frequently used statistic that indicates how reliable a set of items are for measuring a variable. When a scale is reliable it means that the items in the scale are all measuring the same thing.	Values range from 0.0 to 1.0. Higher values indicate higher reliability of the scale. Widely accepted scientific standards indicate that values of alpha greater than or equal to 0.7 indicate a scale has adequate reliability.

Appendix 3. Copy of 2020 YES Family Survey

BOISE STATE UNIVERSITY
COLLEGE OF HEALTH SCIENCES
School of Social Work

Idaho Department of Health & Welfare
Division of Behavioral Health

Experiences of Care and Outcomes for Youth & Families

Please help improve mental health services for children and families in Idaho by answering some questions about the mental health services your child/youth has received. Your answers are confidential and will not influence current or future services you receive.

For the following questions, please **rate the** **<u>mental health provider</u>** who has worked with your child/youth **<u>the most</u>** in the **<u>past 6 months</u>**.
In the box below, please indicate the **type** of provider you are rating:

○ Counselor/ Therapist/ Psychotherapist
○ Case Manager
○ Wrap-around coordinator
○ CBRS provider (Community Based Rehabilitation Specialist)
○ Medication prescriber (psychiatrist/ nurse practitioner/ physicain assistant)
○ Respite provider
○ Substance use counselor or therapist
○ Other (please write in): ____

Below are some statements that **<u>may or may not</u> describe the mental health services your child/youth received** from the provider you indicated above.

Please rate how much you **<u>Disagree</u>** or **<u>Agree</u>** with each statement. Please answer the questions based on the **<u>last 6 months</u>** OR if you have not participated in services for 6 months just base your answers on services you received so far.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. The **goals we are working on** with the provider are the ones **I believe are most important** for my child/youth.	○1	○2	○3	○4	○5
2. The provider **encourages me to share what I know** about my child/youth's strengths and needs.	○1	○2	○3	○4	○5
3. The services my child/youth receives **focus on what he/she is good at, not just on problems.**	○1	○2	○3	○4	○5
4. The assessment completed by the provider **accurately represents my child/youth's needs.**	○1	○2	○3	○4	○5
5. Meetings with the provider occur at **times and locations** that are **convenient for me.**	○1	○2	○3	○4	○5
6. My child/youth is an **active participant in planning** his/her services.	○1	○2	○3	○4	○5
7. The provider **respects me as an expert** on my child/youth.	○1	○2	○3	○4	○5
8. The provider makes sure everyone on my child's treatment team is **working together in a coordinated way.**	○1	○2	○3	○4	○5
9. **My child and I are the main decision-makers** when it comes to planning my child/youth's services.	○1	○2	○3	○4	○5
10. Services we receive are **respectful of our family's language, religion, race/ethnicity, and culture.**	○1	○2	○3	○4	○5
11. The provider often works with our family to **measure my child/youth's progress** toward his/her goals.	○1	○2	○3	○4	○5
12. When services are not helping, the provider **leads my child/youth's team in a discussion** of how to make things better.	○1	○2	○3	○4	○5
13. The provider talks with us about how we can **use things we are good at to overcome problems.**	○1	○2	○3	○4	○5
14. When decisions are made about services, **my child/youth has the opportunity to share** his/her own ideas.	○1	○2	○3	○4	○5
15. The provider **suggests changes** in my child/youth's treatment plan or services **when things aren't going well.**	○1	○2	○3	○4	○5
16. The provider **demonstrates hope and optimism** in meetings with my family.	○1	○2	○3	○4	○5
17. The provider **makes specific suggestions** about what services might benefit my child/youth.	○1	○2	○3	○4	○5
18. **I know who to contact** for help **if I have a concern or complaint** about my provider.	○1	○2	○3	○4	○5
19. My family can **easily access the services** my child needs most.	○1	○2	○3	○4	○5
20. The provider who has been working with my child and family shows that he/she **will not give up on us**.	○1	○2	○3	○4	○5
21. I feel that the provider **openly and honestly communicates** with my family.	○1	○2	○3	○4	○5

22. In the **last 6 months** how many times has your child/ youth had a **new out-of-home placement** (such as juvenile detention, psychiatric hospital, or treatment center) OR moved between out-of-home placements?	0 1 2 3+
23. On a scale from 1 to 10, where <u>1 is the least help possible</u> and <u>10 is the most help possible</u>, **how much was your child/ youth helped** by the mental health services he/she received in the **<u>last 6 months</u>?** (Circle your answer)	1 2 3 4 5 6 7 8 9 10

The statements below ask about your child and family's **safety/crisis plan**. A safety/crisis plan is a written document that says what you, your child, and others will do in times of crisis; it often says who you can contact and lists coping skills or resources to use in a crisis.

Please rate how much you **Disagree** or **Agree** with each statement. Please mark "**Not applicable**" only if, in your opinion, your child does **not need** a safety/crisis plan.

	Not Applicable	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
24. The provider helped my family make a **safety/crisis plan.**	○99	○1	○2	○3	○4	○5
25. I feel **confident** that my family's safety/crisis plan **will be useful in times of crisis**.	○99	○1	○2	○3	○4	○5

The CANS is a tool used by Idaho mental health providers to assess "**C**hild and **A**dolescent **N**eeds & **S**trengths."

Please rate how much you **Disagree** or **Agree** with each of the following statements about your child/ youth's **most recent** CANS assessment. If you are unsure or don't know, please mark "**Don't know**."

Please note that your most recent CANS may not have been completed by the provider you rated above.

	Don't Know	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
26. The results of the CANS **accurately reflect my family's needs**.	○99	○1	○2	○3	○4	○5
27. The CANS assessment helped me, my child/ youth, and our providers **develop a positive shared goal for the future**.	○99	○1	○2	○3	○4	○5
28. After completing the CANS, the provider **explained what services my child/ youth is eligible for**.	○99	○1	○2	○3	○4	○5
29. The CANS assessment seemed like a **waste of time**.	○99	○1	○2	○3	○4	○5
30. As far as I can tell, the CANS assessment **did little to help** my child/ youth.	○99	○1	○2	○3	○4	○5

Compared to 6 months ago, how would you rate…

	Much Worse	**A Little Worse**	**About the Same**	**A Little Better**	**Much Better**
31. … your child/youth's **behavior at home** now (e.g., getting along with family members, following rules, helping around the house)?	○1	○2	○3	○4	○5
32. … your child/youth's **performance at school** now (e.g., attendance, behavior, grades)?	○1	○2	○3	○4	○5
33. … your child/youth's **behavior in the community** now (e.g., behavior in public, participation in positive activities, involvement with law enforcement)?	○1	○2	○3	○4	○5
34. … your child/youth's **overall mental health** now?	○1	○2	○3	○4	○5
35. … **your ability** to effectively **access services and supports** your child/youth needs?	○1	○2	○3	○4	○5

In the **last 6 months**, how many total **nights** did your child/youth spend in…

36. A **hospital** due to problems with behavior or feelings?	○ None	○ 1 to 2	○ 3 to 7	○ 8 or more	
37. Crisis **shelter** for problems with behavior or feelings?	○ None	○ 1 to 2	○ 3 to 7	○ 8 or more	
38. **Treatment foster care**?	○ None	○ 1 to 30	○ 31 to 60	○ 61 to 90	○ 91 or more
39. A **residential treatment center** or group home?	○ None	○ 1 to 30	○ 31 to 60	○ 61 to 90	○ 91 or more

In the **last 6 months**, **how many times** has your child/youth participated in the following services?

40. Received a **face-to-face** visit from a mental health professional for **help with a crisis at the time and location of the crisis**

○ None ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 or more

41. Participated in **Wraparound team meetings or visits** with a Wraparound coordinator

○ None ○ 1 to 2 ○ 3 to 5 ○ 6 to 7 ○ 8 to 10 ○ 11 or more

Please answer the following questions to let us know a little about your child/youth.

What is your child/youth's age in years? _______ years

How long has your child/youth been participating in mental health services? _______ months

What is your child/youth's sex? ○ Male ○ Female ○ Other

Is your child/youth of Hispanic/ Latino origin? ○ Yes ○ No ○ Unknown

What is your child/youth's race (check all that apply)?

○ American Indian/ Alaskan Native ○ Native Hawaiian/ Other Pacific Islander

○ Asian ○ Black/ African American ○ White/ Caucasian ○ Other ○ Unknown

Thank you for sharing about your experience!

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