# Bernalillo County Behavioral Health Initiative: Peer Drop-In Center Process Evaluation

**Prepared by:**
Keith D. Wilkins, M.A.
Paul Guerin, Ph.D.

**Prepared for:**
Bernalillo County
Department of Behavioral Health Services

UNIVERSITY OF NEW MEXICO, INSTITUTE FOR SOCIAL RESEARCH
CENTER FOR APPLIED RESEARCH & ANALYSIS
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# INTRODUCTION

In January of 2018, the County of Bernalillo posted a Request for Proposal (RFP) that identified the need for "*A peer operated, recovery oriented drop in center…This will be a place where people can gather to support each other and to encourage self-directed planning for recovery and building resilience. It could include classes on recovery through employment, through life skills, personal responsibility, wellness, community living skills, socialization and more*" (RFP 24-18-JZ: 3). By August of 2018, Bernalillo County contracted both New Day Youth and Family Services, and Albuquerque Center for Hope and Recovery to establish Peer Support Drop-In Centers (PDI) and provide services within the community (CCN 2018-0602; CCN 2018-0638). Their initial contracts covered a 2-year period and ended in August of 2020. The County of Bernalillo renewed both 2-year contracts in September of 2020. The contracted goals and objectives of the peer support drop-in centers aimed to increase access and referral to social support services pertaining to: general peer support, housing and employment opportunities, decreased substance usage, physically and psychologically safe environments, basic needs items, and life skills classes. New Day's contracted service goals and objectives were modified in October 2020, reflecting a new commitment to providing "safety and stability, positive relationships and connections to ongoing support" (CCN 2020-0644: 3).

The PDI providers—New Day Youth and Family Services (ND), and Albuquerque Center for Hope and Recovery (ACHR)—agreed to provide services to different vulnerable populations within the community. Specifically, ND targets youth between 16-22 years of age, who are experiencing homelessness, are precariously housed, or are disaffected. ND offers that population access to vital necessities (shower access, shoes, clothing, food, hygiene products, etc.), external program and resource referrals, and community activities that encourage socialization and relationship building. The ND PDI also hosts external programs and services that support the same population.

The second PDI, ACHR, targets adults (18+) experiencing housing instability, mental illness, substance use, and/or disability. ACHR offers three categories of services to their target population: (1) a UNM Pathways program, (2) relationship building and life skills group classes that aim to develop support networks and cultural capital—which includes an *Addicts 2 Athletes* physical fitness program to aid substance abuse and addiction recovery, and (3) employment resources offered through a federally funded Ticket to Work program.

In general, peer-support drop-in centers fall under the category of consumer-operated services and can follow several different models: (1) mutual support groups, (2) multiservice agencies, (3) independent living centers, (4) peer-run drop-in programs, and (5) specialized supportive services. The drop-in center model typically includes referral and resource connection to external social services like housing or employment, but can also operate as multiservice agencies, providing "support and activity groups, telephone and computer access, shower and laundry facilities…and creative expression sessions (Substance Abuse and Mental Health Services Administration 2011:17). Drop-in centers' primary strategy is to empower individuals and provide services that satisfy basic needs (Slesnick et al. 2008:730). In order to realize program goals, the peer-run drop-in center model emphasizes the inclusion of staff who have similar experiences to their target population, which often include former consumers. Research on efficacy generally finds benefit for those who frequently attend consumer-operated drop-in centers, especially in their ability to increase self-esteem, self-appraisal, and empowerment (Brown 2009; Mowbray and Tan 1993; Vayshenker et al. 2016). Similarly, studies have

also found improvement for consumers' quality of life, sense of social support, and social functioning (Chamberlin, Rogers, and Ellison 1996; Nelson et al. 2007; Yanos, Primavera, and Knight 2001). A notable federal multisite study conducted by Campbell and colleagues (2009) also found that participation in consumer-operated services increased well-being—although greater consumer choice in services reduced the strength of that effect.

The two PDI providers have implemented their own unique variations of the Peer-Support Drop-in Center models, but to what extent, is currently unknown. Both programs have made different sets of resources and supports available, and to different populations. To this point, the County of Bernalillo has specifically included contractual obligations for the PDI providers, indicating that:

> *Through this agreement, the Contractor agrees to work collaboratively with the County, or an agency working on behalf of the County, to perform a structured evaluation of any program activities funded through this contract. Program evaluations may take several forms, depending on the maturity of the pilot in question, the needs of the County, and the interests of the provider. Program evaluations can be understood as systematic ways of assessing and describing a program's strengths and weaknesses to help inform future decisions.* (CCN 2018-0602: 19)

Working on behalf of the County, UNM ISR is fulfilling the function described above, to systematically assess and describe the PDI programs' strengths and weaknesses and inform future decisions. Our intent is to determine to what degree PDI providers adhere to their respective program models, and whether their program models deploy best practices associated with positive outcomes in the research literature. Overall, we aimed to answer four questions:

1. To what degree do the two PDI programs adhere to their respective program designs?
2. How well do the two PDI programs deploy respective best practices for PDI delivery?
3. To what degree do programs serve clients?
4. What is the feasibility of an outcome evaluation based on program structure and adherence?

# LITERATURE REVIEW

## Brief Historical Overview

Peer support and peer-run services are the culmination of lay opposition to traditional and professional mental health services, beginning as far back as the 18TH century when early advocates hoped to regulate asylums and decrease the population of incarcerated individuals (McCandless 1978). *The Alleged Lunatics' Friend Society* was an early example of this shift, which was established by former patients of mad houses in 1845. Its primary objectives were "to campaign for changes in the lunacy laws…*to offer help to discharged patients,* and to convert the public to an enlarged view of Christian duties and sympathies" (Hervey 1986:253; emphasis added). Over sixty years later in 1909, another notable group emerged, *The National Committee for Mental Hygiene (NCMH)*. NCMH was also founded by a former institutionalized patient, Clifford Wittingham Beers, who spent three years in a mental state hospital and published a seminal book about his asylum experiences, *A Mind That Found Itself: An Autobiography* (1908). In that book, Beers documented his journey back to sanity and depicted the ways in which traditional mental health treatments had *inhibited* his path to recovery. Inspired by Beers' book, local chapters of the Mental Hygiene organization spawned in several U.S. states and eventually transformed into today's *Mental Health America* (MHA) (Parry 2010); a patient advocacy group intent on protecting "*the rights and dignity of individuals with lived experience and ensure that peers and their voices are integrated into all areas of*" mental health advocacy (2019). By the 1930s, Alcoholics Anonymous established itself and 20 years beyond that, expanded to include Narcotics Anonymous (Gross 2010). Alcoholics Anonymous heralded the modern sense of the self-help movement, expanding the concept of recovery into sharing "experience, strength, and hope" as a therapeutic approach (Substance Abuse and Mental Health Services Administration 2011:4). In sum, peer support has stemmed from a desire for reductions in incarceration, greater patient advocacy, and the inclusion of patients' voices in their own treatment and pathways to recovery.

## Clubhouse Model

One of the first program models of peer support included the Clubhouse format. Founded in 1948, the 'clubhouse' was established by former patients of Rockland State Hospital "to provide immediate refuge and to help its members regain a normal life" (Macias et al. 1999:181). It ultimately developed into the organization known as *Fountain House, Inc.* The clubhouse model gained such widespread popularity and support that in 1977 the National Institute of Mental Health awarded Fountain House a multi-year grant to develop a national clubhouse training program (Propst 1997:54). The model focuses on developing a consumer-run community designed to foster employment and internship opportunities. For this reason, clubhouses have been articulated as 'intentional communities' or independent centers "using a social franchise approach" to promote recovery (Raeburn et al. 2013:376). In contrast to the peer drop-in center model, clubhouses are designed to allow staff and members to "*work side by side to perform jobs essential to the operation of the clubhouse, such as food preparation, maintenance, member orientation and reception services, clerical work…members take part in all aspects of clubhouse governance and operations*" (Mowbray et al. 2006:167). Clubhouses therefore offer members equal ownership and power over the space they receive support in, and also offer prevocational work experiences and social interaction with other members living with mental illness. Inspired by the

clubhouse model, consumer-run drop-in centers emerged as a less formal alternative (Mowbray, Robinson, and Holter 2002).

## Peer Drop-In Center Model

Born from the 'Social Clubs' associated with Fountain House Inc. clubhouses, the peer drop-in center is a more informal alternative to the clubhouse model providing members with "support, recreation, and social interaction" in low- to no-barrier environments (Mowbray et al. 2002:249). Drop-in centers ultimately aim to develop trust, promote positive identity, and teach social and vocational skills. Peer drop-in centers further aim to encourage and support isolated and disenfranchised populations to address their fundamental and unique needs, at their own pace, and in their own time. As a result of these broad aims, no *single* peer drop-in center model exists. However, a report by the Toronto Drop-In Network (Meagher and Street 2008:7–8) found that drop-in centers tend to lie on a spectrum of three service philosophies:

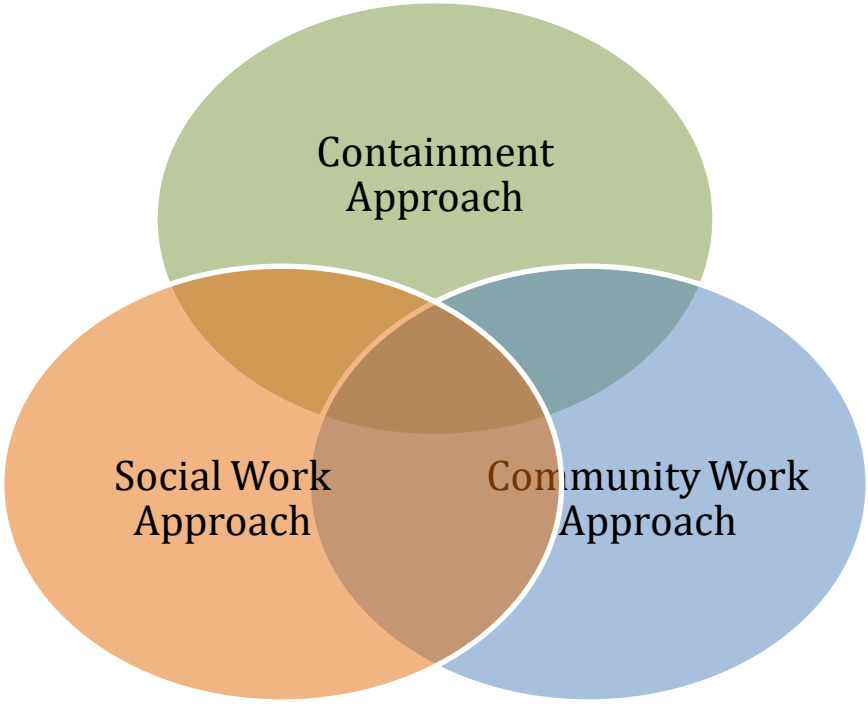


*Figure 1*

**Containment Approach:** Drop-In Centers create safe-havens and promote spaces of acceptance and tolerance for clients.

**Social Work Approach:** Drop-In Centers foster social change for clients. Targeted interventions are offered, and typically include case work.

**Community Work Approach:** Drop-In Centers establish environments to empower clients and encourage them to mobilize theirs and peers' resources to change their lives (decreased professional reliance).

Meagher and Street (2008) clarify that these three philosophies can and do operate in combination at drop-in centers, and often "flex to accommodate changing needs and opportunities" (10). Research has similarly tried to clarify *common service ingredients* among drop-in centers. Table 1 summarizes those found in the literature.

**Table 1. Summary of Common Service Ingredients at Drop-In Centers**

| | |
|---|---|
| **Basic Needs** | |
| • Food | • Washer and Dryer |
| • Showers | • Telephone |
| • Housing Assistance | • Mailing Address |
| • Transportation | • Clothing |
| • Daily Living Assistance | |
| **Social and Vocational Skills** | |
| • Socialization Opportunities | • Life Skills Classes |
| • Education and Recreational Activities | • Emotional Support |
| • Job Assistance Resources/Programs | • Befriending Clients |
| • Social Support | • Physical Support |
| • Daytime Activities | |
| **Identity Transformation** | |
| • Discussion | • Safe Space |
| • Goal Setting | • Socialization |
| • Role Modeling | |

Source(s): (Meagher and Street 2008; Mowbray et al. 2002; National Voices 2015)

Despite these commonalities, organizational size, resources, and philosophy ultimately determine the scope of services at a drop-in center. Indeed, research has noted considerable variation in service provision among consumer-run drop-in centers in particular. In a survey of Michigan consumer-run drop-in centers, Mowbray and colleagues assessed the operations, services, and structure of 32 PDIs. The authors found that among their sample, most organizations provided clients with: use of a telephone (91%), clothing (75%), transportation (72%), help finding jobs (69%), a mailing address (62%), food (47%), specialized services (34%), use of a washer and dryer (22%), and showers (16%) (253). Further, Mowbray et al. found the majority (56.2%) of drop-in centers were ***not*** required by funding sources to provide particular services. And drop-In centers with contractually obligated services specifically provided: self-help groups and peer support (31.3%) and/or psychosocial and skills training (9.4%).

## Peer Drop-In Centers: The Evidence

Rigorous evidence on the effects of peer drop-in centers is largely absent. One comprehensive review by the SAMHSA (2011) revealed that correlational evidence primarily exists, and associates drop-in centers to broad client effects like: general life satisfaction, self-reported influence on housing, finances, self-esteem, locus of control, and hope for the future (Chamberlin et al. 1996; Kaufmann, Schulberg, and Schooler 1995; Mowbray and Tan 1993). Other interview evidence among 673 new clients at self-help PDIs similarly documents correlational effects in multivariate and chi-square analyses, suggesting PDIs are associated with clients who exhibit fewer acute symptoms, higher levels of social functioning, and fewer life stressors in the past 30 days (Segal, Hardiman, and Hodges 2002:1149). Research by Vayshenker et. al (2016) found client attendance in a PDI at 6-month follow-up was also associated with

significant improvements in internalized stigma, self-esteem, self-efficacy, and autonomy. Critically, the authors emphasized no statistically significant differences were observed between non-attendees, moderate attendees, or high-attendees across five important outcomes: (1) hopelessness, (2) social functioning, (3) symptom severity, (4) coping with symptoms, or (5) substance use. Yet, other research has found when patients with severe mental illness were randomly assigned to peer recovery mentors or non-peer mentors, patients with peer mentors had significantly fewer hospital admissions and fewer days in the hospital (Sledge et al. 2011).

In sum, PDI and peer-support document correlational evidence between PDI-use and benefits, but lack strong consensus as a result of absent random control trial evidence. As described in one notable policy paper by Davidson et al. (2012), peer staff appear to function primarily as a "*bridge between clients and other [clinical] staff*". Therefore, peer support may function best when integrated within models of drop-in centers that 'bridge' clients to an array of services. The connections and resources drop-in centers establish are paramount in that case, and should have established and *clear* interventions. Those factors become especially important when complimenting a continuum of clinical and behavioral health services.

# METHODOLOGY

UNM ISR's CARA was tasked with evaluating two organizations funded by the Bernalillo County Behavioral Health Initiative to provide Peer Drop-in Centers (PDI): (1) New Day Youth and Family Services and (2) the Albuquerque Center for Hope & Recovery. Beyond various program materials and documents from each PDI, the evaluation included three data sources:

- Electronic client data
- Structured interviews with PDI staff
- Observations of PDI services

## Client Data

Both New Day (ND) and the Albuquerque Center for Hope & Recovery (ACHR) collect and record client data in an electronic record keeping system called *Apricot Social Solutions*. ND and ACHR collect different kinds of client information and a single standard request was not possible. In general, ISR requested access to all systematically collected client information from both PDIs, from the beginning of record collection and extending to the time of data retrieval. Contact details and health information were specifically excluded from ISR's request. Additionally, ND and ACHR collect open-ended *case note* records for clients documenting their progress. ACHR's database contained thousands of client records and ND's captured hundreds of clients under 18 – ISR determined *case note* records were impractical to collect, organize, and systematically de-identify. C*ase notes* were therefore not requested by ISR. With assistance from staff at ND and ACHR, ISR was able to review all other *categories* of data within PDI Apricot systems. ISR then coordinated with pertinent staff and submitted a complete list of requested data. Appendix C contains the final lists of data that ISR requested from the PDIs. In total, ISR received 15 electronic files from ACHR and 3 from ND. In order to maintain client privacy, ISR established secondary copies of Apricot records and replaced ND and ACHR identifiers with new randomized client IDs. Subsequently, original client records were erased from UNM servers.

## Staff Interviews

To supplement electronic data on PDI processes, ISR conducted interviews with current ACHR and ND staff. A total of 12 interviews were planned: 7 with ACHR staff and 5 with ND. One interview was never confirmed, meaning eleven interviews were ultimately completed which totaled more than 32 hours of recorded interview time. PDI interviews began in August 2021 and concluded in September 2021. PDI staff were initially sent a recruitment e-mail and flyer with information about the content, structure of interviews, and participant privacy protections. PDI staff who responded to recruitment e-mails were thanked and then sent copies of UNM ISR's Informed Consent form to review prior to the interview. Interviews were conducted at a time and location participants preferred, which included virtual Zoom interviews to offer both convenience and safety during the COVID-19 pandemic. In-person interviews followed all pertinent UNM guidelines, specifically steps documented in the OVPR memo dated 5/11/2020. ISR also complied with any PDI-specific in-person COVID-19 guidelines. Informed consent was obtained physically during in-person interviews and obtained verbally in the case of virtual

interviews. All relevant informed consent documentation is stored physically at UNM ISR or on UNM ISR secure servers.

Following participants' approval via informed consent forms and procedures, interviews were audio recorded according to two methods: (1) digital audio recordings using an H1n Handy Recorder device, or (2) recorded through Zoom's cloud. Once an interview was completed, recording data were copied directly to UNM secure servers and deleted from the Zoom cloud space or recording device. Interviews were ultimately transcribed by *TranscribeMe!*, a HIPPA-compliant human transcription company. Audio files with anonymous file names were uploaded to the *TranscribeMe!* website and once completed, data were transferred directly to UNM secure servers. Uploaded audio files and transcriptions were then deleted from *TranscribeMe!'s* website. Transcriptions were downloaded as Microsoft Word documents, and organized and analyzed using Microsoft Excel.

## Service and Exploratory Observations

In addition to interviews and electronic client data, UNM ISR planned service observations at both PDIs in September 2021. In total, ISR conducted fourteen service observations at ACHR (7) and ND (7). Service observations were scheduled according to service *availability*. PDI services identified in the process map, in some cases, were no longer offered. Additionally, some services did not qualify for observation, as both PDIs can host many external activities or programs. The *Life Skills Academy* (LSA) reflected such a program and is frequently hosted at the ND PDI. ISR and ND staff agreed the LSA did not count as a PDI service, because it is neither organized by the PDI, nor supported through BHI PDI funds. ACHR similarly offers two programs that did not qualify for observation: UNM Pathways and Ticket to Work. In both cases, ACHR is separately funded by UNM and the Social Security Administration to provide those supports, and follows pre-determined client vetting and program procedures. Ultimately, ISR scheduled observations to intentionally capture services and activities directly sponsored and led by PDI staff.

In order to systematically organize observations, ISR prepared a service observation guide, which can be reviewed in Appendix E. Depending on the PDI, service observations were supplemented by either (A) a Nurtured Heart Approach checklist, or (B) a Peer Support Competency checklist. The Peer Support Core Competencies were derived from peer support program fidelity documents found at the Substance Abuse and Mental Health Services Administration (SAMHSA) website. UNM ISR drafted a checklist based on SAMHSA's list of competencies and identified those features demonstrated during individual services. Similarly, ISR drafted a Nurtured Heart Approach Checklist based on Hektner and colleagues (2013) review of the Nurtured Heart Approach (NHA) stands. ISR evaluators determined how frequently NHA stands were evidenced in individual activities and services using a 7-point Likert-scale: (1) Not Observable, (2) Rarely, less than 10% of Opportunities, (3) Occasionally, about 30% of opportunities, (4) Sometimes, about 50% of opportunities, (5) Frequently, about 70% of opportunities, (6) Usually, about 90% of opportunities, and (7) Every opportunity. ISR organized and analyzed all observational data using Microsoft Excel.

ISR also completed twenty "*general*" service observations at ND and ACHR. These exploratory observations were designed to assess more subtle supports in action at PDIs— (1) the number of client drop-ins, and (2) broad categories of supportive service use. For both organizations, ISR reviewed PDI operational hours and drafted ten different observations: two observations for the same hour, but on

different days of the week. Our intention was to purposefully sample different times of day, on different days of the week in order to accumulate more representative data on client participation. Still, these observations were exploratory in nature and provide limited anecdotal understandings of services and general drop-in processes. The General Observation Guide for these observations is located in Appendix E.

# ALBUQUERQUE CENTER FOR HOPE & RECOVERY (ACHR)

## Process & Logic Model

UNM ISR's CARA and the Albuquerque Center for Hope & Recovery (ACHR) worked to develop a process and logic map for services – documents which did not previously exist. Figure 2 & 3 reflect that collaborative work and describe ideal processes at the PDI. As the process map describes, clients enter through one of three pathways:

(1) Former clients refer new clients
(2) An external organization refers a new client
(3) An existing client is referred to another ACHR program

According to Figure 2, ACHR clients are initially documented by a physical sign-in log that ideally captures all clients who drop-in. If the client is a new drop-in, ACHR staff create a unique record/profile for the client in their Apricot database. Staff record a new drop-in client's demographic information, social determinants of health, and contact details. After initial documentation, a Certified Peer Support Worker (CPSW) assesses the drop-in client and administers an initial Arizona Self-Sufficiency Matrix (ASSM) assessment. The ASSM collects 19 domains of need, from housing instability to safety concerns. Additionally, CPSWs determine whether a client meets sobriety standards to receive services. ACHR's sobriety standard was described as a flexible criterion that depends on the specific needs of the client. For example, a client who enters the PDI after using drugs, but requests help finding a rehab center, would be assisted. Inversely, a client who wanted to use drugs in ACHR's restroom would be asked to leave and return when sober. Aside from flexible sobriety criteria, no other declared standards existed to receive services at the PDI. While ACHR noted they typically receive adults, ACHR can support minors and assist them with finding age-appropriate programs.

After initial assessment, clients then receive support according to six service categories:

1. Addicts 2 Athletes
2. Virtual Coffee
3. Choice Recovery
4. Art & Soul
5. UNM Pathways
6. Ticket to Work

Critically, UNM Pathways and Ticket to Work are separately funded programs and data for both are stored outside the ACHR database. UNM ISR's CARA therefore did not assess either program, but did review general participation over time. As clients receive services, CPSWS ideally document client progress according to two standards: (1) maintenance of sobriety and (2) ASSM updates at standardized 3, 6, 9, and 12 months.

ACHR declared two checkpoints following a clients' engagement in services. Firstly, ACHR staff follow-up every 2-months to assess whether a client has continued to access services, and if not, reach-out through text or phone to follow-up. If the follow-up is successful, the client ideally resumes use of services or is referred to internal/external programs. Regardless of whether a client disengages, all clients can be referred to internal or external programs/services. Importantly, no client is formally disenrolled, but can be considered "inactive" after an absence of more than 6 months.

Finally, if a client achieves long-term sobriety/stability ACHR aims to achieve any of three outcomes:

(1) Client achieves their personal definition of success
(2) Client begins pathway to become a Certified Peer Support Worker (CPSW)
(3) Client Achieves specific program success – UNM Pathways, Ticket to Work, or Addicts 2 Athletes

Figure 3, ACHR's logic map, summarized the rationales behind PDI work. Specifically, client referral should lead to an initiation and orientation, then service provision, and ultimately, sustained peer support. ACHR believes that through staff representation and role-modeling, clients understand recovery is possible and that "positive life change" can be achieved – fostering hope and promoting program engagement. Figure 3 also revealed ACHR offers a wide array of support. Primary outputs can include: Job interviews, Job placement, Housing Vouchers, Benefits Applications, Real IDs, Case Management, and Physical Fitness. Further, ACHR identified a significant range of outcomes – 19 in total. Outcomes could be as broad as "*barriers begin to resolve themselves*", or as specific as "*positive forward movement on ASSM."*

In sum, ACHR's process and logic maps provided an overview of the myriad support ACHR provides. They also describe how ACHR expects clients to change by serving as role models of hope and recovery through staff's lived experience. Clients' recognition of possibility empowers them to participate in services, supports, and/or programs. Overall, ACHR allows broad inclusion criteria, with the exception of a sobriety standard and an intent to serve those with mental health issues or substance use disorders. No clear *exclusion* criteria existed though and ACHR would ideally support any individual who seeks assistance. Figures 2 & 3 further indicated an important aspect of ACHR's PDI: change can be as specific or broad as clients desire. Several specific individual outcomes were identified:

1. Increased self-esteem
2. Increase in coping skills
3. Improved health
4. Improved physical fitness
5. Sustained sobriety
6. Financial, Housing, Educational, Familial stability
7. Established support system
8. Mentoring others in recovery
9. Completes steps toward probation fulfillment
10. Completion of legal obligations
11. Positive increase in ASSM
12. Meeting program milestones
13. A2A graduation
14. Recovery Court requirements met
15. Recovery Court graduation

ACHR's achievement of individual outcomes ideally culminates in five specific social outcomes and impacts:

1. Reduction in Crime
2. Reduction in ER use
3. Reduction in involvement with law
4. Reduction in Homelessness
5. Reduced recidivism

## Evidence-Based Practices

In order to realize the outcomes described in process and logic maps, ACHR identified Certified Peer Support Work as their evidence-based practice. In interviews, all staff identified peer support work as the primary strategy deployed at the center and the majority (3/5 staff) had obtained Certified Peer Support Worker (CPSW) status; the remaining two ACHR staff had their Masters in Social Work. Additionally, all ACHR staff had an average of 5.9 years of experience in their field of work.

Staff identified other strategies that incorporated peer support, but lacked an evidence-base or "intervention" status. As one ACHR staff member described:

> *As far as evidence-based practices are concerned, I know that peer support is an EBP, but to be more specific, we use group and one-on-one settings so that, again, folks can kind of get the best of both worlds, depending on what their needs are. We do goal identification and prioritization for each of them. And it's an evidence-based practice because it's tailored to each individual. But what makes it difficult to describe as an evidence-based practice is it's not exactly the same. So sometimes it's hard to duplicate because it's different for every person. There might be the same type of structure for every person, but it looks so different because we're not clinical I can't say that we use any evidence-based treatments because we don't do any "treatments".*

In general, peer support workers in New Mexico must establish:

- Three years of sobriety
- Self-identify as a current or former consumer of mental health and/or substance abuse services
- Be 18 or older
- Have obtained a High School diploma or GED
- Complete 40 hours of supervised hours with direct client contact in a behavioral health agency (New Mexico Human Services Department 2021).

CPSWs incorporate their experiences and knowledge from their own recovery into a "…wide array of non-traditional service options" (ACHR Response to RFP 2018: 21). Research documenting the effect of peer support workers has found that their role facilitates improved (1) Communication, (2) Care access, (3) Cultural competence, (4) Empathy, (5) Empowerment, (6) Sense of Control, and (7) Care compliance (Davidson et al. 2012; Griswold et al. 2010; Sells et al. 2008). The same research also emphasizes peer support workers' association with decreased consumer stigma, use of crisis services, and improved physical or psychological health problems.

The Substance Abuse and Mental Health Services Administration (SAMHSA) provides comprehensive information on peer support workers and consumer operated programs. In 2015, the SAMHSA led the Bringing Recovery Supports to Scale Technical Assistance Center Strategy project (BRSS TACS) with the express goal of establishing core competencies for peer workers. The resulting document (Substance Abuse and Mental Health Services Administration 2015:3) identified five principles and values to guide work:

| | |
|---|---|
| **Recovery-Oriented** | Peer workers work to establish hope for clients and build on strengths. Recovery-oriented work promotes client empowerment. |
| **Person-Centered** | Peer recovery support services are always directed by the client engaging in services. Peer recovery support follows the hopes, goals, and preferences of the individual served. |
| **Voluntary** | Peer workers do not dictate the types of services provided or the elements of recovery that guide work with peers. Participation is always client choice. |
| **Relationship-Focused** | The relationship between the peer worker and peer is respectful, trusting, empathetic, collaborative, and mutual. |
| **Trauma-Informed** | Peer support utilizes a strengths-based framework emphasizing physical, psychological, and emotional safety. Peer support also creates opportunities for clients to rebuild a sense of control and empowerment. |

Additionally, the same document identified 12 categories of competencies to "guide delivery and promote best practices in peer support" (SAMHSA 2015: 2). Core Competencies therefore fundamentally describe "the knowledge, skills, and attitudes a person needs to have in order to successfully perform" peer support work. Core Competencies ultimately describe 12 general features:

| | | |
|---|---|---|
| **I** | **Engages peers in collaborative & caring relationships** | These competencies include interpersonal skills, knowledge about recovery from behavioral health conditions and attitudes consistent with a recovery orientation. |
| **II** | **Provides support** | The competencies in this category are critical for the peer worker to provide the mutual support people living with behavioral health conditions may want. |
| **III** | **Shares lived experiences of recovery** | Peer workers need to be skillful in telling their recovery stories and using their lived experiences as a way of inspiring and supporting a person living with behavioral health conditions. |
| **IV** | **Personalizes peer support** | These competencies help peer workers to tailor or individualize the support services provided to and with a peer. By personalizing peer support, the peer worker operationalizes the notion that there are multiple pathways to recovery. |
| **V** | **Support recovery planning** | Recovery often leads people to want to make changes in their lives. Recovery planning assists people to set and accomplish goals related to home, work, community and health. |

| | | |
|---|---|---|
| **VI** | **Links to resources, services, and supports** | Peer workers apply these competencies to assist other peers to link to resources or services both within behavioral health settings and in the community. It is critical that peer workers have knowledge of resources within their communities. |
| **VII** | **Provides information about skills related to health, wellness, and recovery** | These competencies describe how peer workers coach, model or provide information about skills that enhance recovery. |
| **VIII** | **Helps peers to manage crises** | These competencies assist peer workers to identify potential risks and to use procedures that reduce risks to peers and others. |
| **IX** | **Values communication** | These competencies provide guidance on how peer workers interact verbally and in writing with colleagues and others. |
| **X** | **Supports collaboration and teamwork** | These competencies provide direction on how peer workers can develop and maintain effective relationships with colleagues and others to enhance the peer support provided. |
| **XI** | **Promotes leadership and advocacy** | These competencies describe actions that peer workers use to provide leadership within behavioral health programs to advance a recovery-oriented mission of the services. |
| **XII** | **Promotes growth and development** | These competencies recommend specific actions that may serve to increase peer workers' success and satisfaction in their current roles and contribute to career advancement. |

*Table 2 - Summary Core Competencies outlined in SAMHSA (2015: 4-7)*

In order to confirm the presence of ACHR's evidence-based practice, ISR evaluators developed a checklist (Appendix E) in order to detect the presence of each feature described within the 12 Core Competencies. The rest of this report is organized to summarize the data UNM ISR's CARA collected and evaluated to verify the processes in place at ACHR. We accomplish that according to each phase of peer support ACHR identified: Client Induction, Services & Activities, and Outcomes. We end the ACHR section of this report with a short discussion about the feasibility of an outcome evaluation, conclusions, and recommendations.

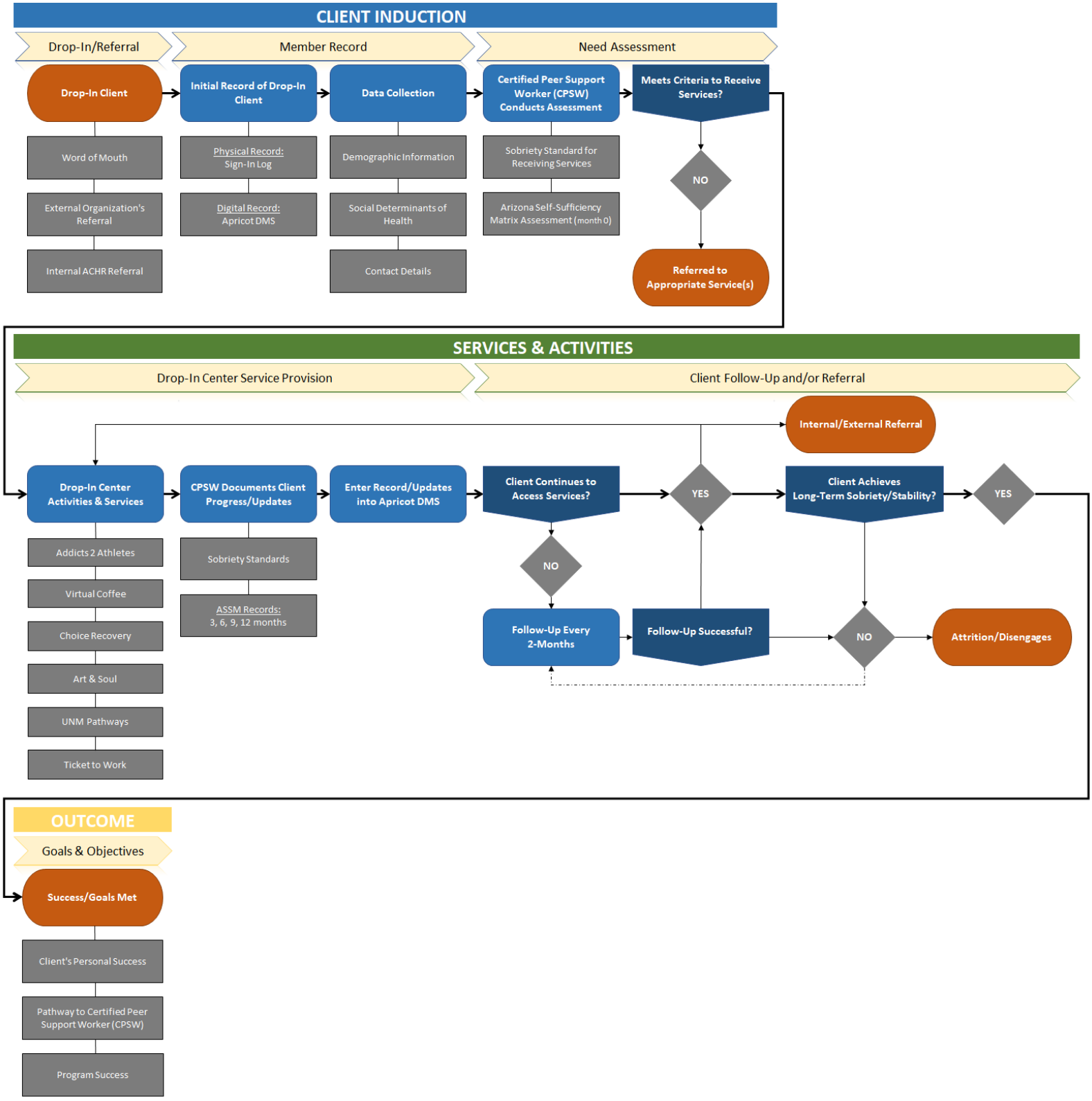


*Figure 2- ACHR Process Map*

## Albuquerque Center for Hope & Recovery (ACHR) Logic Model

**Purpose:** The purpose of the organization is to support and provide services to persons with barriers and disabilities. The organization may include peer support services, advocacy groups, educational and social projects, and programs for public information and education.

### Process

**Inputs/Resources**

- Peer Support: CPSW and PSW
- Interns
- Reciprocal Peer support (Member to Member)
- Community resources and partnerships
- Two Buildings
- Technology Online engagement
- Environment within our agency
- Incentives

**Program Inclusion Criteria:**

- Someone experiencing MH/SUD
- The motivation to engage in recovery
- Metro Court, Pathways and TTW have specific criteria

**Activities**

**Referral:** Walk-ins; word of mouth; SSA; DVR; CFB; BHI; Metro Court; Community Engagement (Outreach); Social Media; Community Events; Constant Contact; Community Partners; OPRE

↓

**MEMBER INITIATION**: Welcome in; 'What brings you here'; tour; Member profile; ASSM (month 0); Orientation; schedule of classes; screen for crisis

↓

**SERVICE PROVISION:** Schedule with appropriate staff member; Program eligibility (PRN); Set up recurring meetings (1-2x/week); Each internal program has specific steps; ASSM (3, 6, 9 and 12 months), determining attainable and self-prioritized goals

↓

**PEER SUPPORT MAINTENANCE:** Continued opportunity for drop-in services and additional programming (Ideally would start again at service provision.) Reassessment of ASSM (at month 'zero')

**Outputs**

- Job interviews
- Job Placement
- Housing Vouchers
- Housing Placement
- Benefits Applications
- Real IDs
- Case Management
- Physical Fitness

**ACHR Theory of Change:**

**Through lived experience we focus on providing hope for others by representing the potential for sustained positive life change. Recovery is possible!**

**Peer-ness Assumptions:**

**Recognition that change is necessary.**

**Relapse happens.**

**An even playing field**

### Individual Outcomes

**Short Term Outcomes**

- Positive life change
- Harm reduction or sobriety
- Barriers begin to resolve themselves
- Increased self-esteem
- Steps to probation fulfillment
- Positive social engagement

**Intermediate Outcomes**

- Meeting program milestones
- A2A graduation
- Recovery Court requirements and graduation
- Relationship building
- Maintained sobriety
- Improved health and physical fitness (A2A)

- Positive life change
- Harm reduction or sobriety
- Barriers begin to resolve themselves

**Long Term Outcomes**

- Gain stability (financial, familial, educational, housing, etc.)
- Positive forward movement on ASSM
- Established support system
- Increased coping skills
- Mentoring others in recovery
- Completion of legal obligations
- Improved health

- Positive life change
- Harm reduction or sobriety
- Barriers begin to resolve themselves

**External Factors:**

**NEGATIVE: Lack of motivation, little/no external support system, lack of transportation, criminal history, uninterested in partnering, enabling 'support' system, low educational attainment, disability, health issues, external organizational/process/policy changes, lack of technology, peer pressure, LEP, diagnosis outside of SOW**

**POSITIVE: A willingness to engage in recovery, accountability, open mind, strong support system, no criminal history, diploma/GED+**

**Social Outcomes**

- Family reunification
- Less strain on community resources
- Crime reduction
- Reduction of ER use
- Less involvement with law enforcement
- Reduction in homelessness

**Impacts**

- Reduced recidivism
- Sustained recovery
- Improved community safety

*Figure 3- ACHR Logic Model*

## Client Induction

ACHR's process map identified three aspects to client Induction:

(1) Drop-in/referral of client to PDI
(2) Creation of physical and digital client records
(3) Assessment of client needs

### Drop-In/Referral

Client induction at ACHR begins with a new client drop-in who is referred in one of three ways: (1) by previous clients, (2) an external organization, or (3) by ACHR staff or clients. Systematic client data is not collected on how clients were referred to the PDI. But interviews with staff revealed they do receive clients through all manner of mediums – walk-ins, phone calls, e-mails, and word of mouth. One staff member explained:

> *Like I said, our door is open to anyone, whether it's you're coming in and you just want to have a cup of coffee. We had a gentleman come in yesterday who walked all the way from-- where in the heck was he at? It's somewhere down South. He just got out of jail and he walked like 40 miles here. He just needed a drink of water and want to use the phone, come on in.*

Client data did provide insight on general client sign-ins over time though. Client sign-ins are recorded on physical logs that are subsequently entered into the electronic record system. While the client data only details the date and client who signed-in, the physical log also collects details on the client's reason for their visit, month/day of birth, and their initials. The physical sign-in log is located with a staff member at the entrance to the primary 913 2nd street location, or on a clipboard with a staff member at the satellite locations. Table 3 summarizes total sign-ins by year at all ACHR locations from the beginning of their contract date, to the time of data retrieval.

**Table 3. ACHR Sign-Ins for BHI Contractual Range (2018 – 2021)**

| | Total Sign-Ins | Average Sign-Ins per Client | Median Sign-Ins per Client | Unique Clients |
|---|---|---|---|---|
| Year 1 | 4,002 | 5.05 | 2.00 | 792 |
| Year 2 | 3,128 | 5.42 | 2.00 | 577 |
| Year 3 | 1,371 | 8.26 | 2.00 | 166 |
| **All Years** | **8,501** | **5.54** | **2.00** | **1,241** |

Source: ACHR Apricot Social Solutions records (2021).

Overall, ACHR documented 8,501 client sign-ins with the average client signing-in about 5 times, and 50% of all clients signing-in two times or more. ACHR has supported a total of 1,241 unique clients in the past three years, with the greatest number of unique clients occurring in Year 1. Year 3 – *September 3, 2020* to *July 21, 2021* – has supported the fewest number of unique clients, although this reflects an incomplete year by 2 months and the height of the COVID-19 pandemic. While Year 3 had fewer unique clients, the average number of PDI visits per client was higher than all other years. Despite a higher average, the median number of sign-ins was equal regardless of year—indicating some clients are signing-in at the PDI much more often than the typical client. Indeed, just 20 clients accounted for 60% of all sign-ins in Year 3, with the most frequent client dropping-in 86 times.

As a percentage of all unique clients from September 13th, 2018 to July 21st, 2021, UNM ISR's CARA could confirm the number of unique clients received in the past 6-months and 12-months – summarized in Tables 4 and 5 below. A little over 100 unique clients signed-in over the past 6-months, and a little over 200 unique clients signed-in over the past 12 months.

**Table 4. ACHR Clients who have signed-in in past 6-months**

| | Frequency | Percent |
|---|---|---|
| Inactive | 1,127 | 90.8% |
| Active | 114 | 9.2% |
| **Total** | **1,241** | **100.0%** |

Source: ACHR Apricot Social Solutions records (2021).

**Table 5. ACHR Clients who have signed-in in past 12-months**

| | Frequency | Percent |
|---|---|---|
| Inactive | 1,038 | 83.6% |
| Active | 203 | 16.4% |
| **Total** | **1,241** | **100.0%** |

Source: ACHR Apricot Social Solutions records (2021).

## Member Records

Table 19 in the appendix summarizes client demographics by contractual year. In general, clients across all years tended to be:

- Male
- Hispani-x/Latin-x or White
- Between 25 and 44 years of age
- Had no income
- Were unemployed
- Had no children
- Were uninsured

While not described in ACHR's process map, completion of an ACHR orientation is documented in the client data. Table 6 describes the proportion of client drop-ins each year who have ever received an orientation (unique by year only). In general, most ACHR clients have not completed an orientation. Most ACHR clients in Year 3 had ever received orientations – an increase of about 27% from Year 1. Still, only 38% of all clients who signed-in between 2018 and 2021 had ever received an orientation according to ACHR records.

**Table 6. Has ACHR client received orientation, by year (2018 – 2021)**

| | **Year 1** | | **Year 2** | | **Year 3** | | **All Years** | |
|---|---|---|---|---|---|---|---|---|
| | Count | Percent (%) | Count | Percent (%) | Count | Percent (%) | Count | Percent (%) |
| Yes | 259 | 32.7% | 260 | 45.1% | 95 | 59.0% | 471 | 38.0% |
| No | 515 | 65.0% | 302 | 52.3% | 66 | 41.0% | 738 | 61.0% |
| **Total** | **774** | **100.0%** | **562** | **100.0%** | **161** | **100.0%** | **1,209** | **100.0%** |
| **Missing** | **18** | **2.3%** | **15** | **2.6%** | **5** | **3.0%** | **32** | **2.6%** |

Source: ACHR Apricot Social Solutions records (2021).

While not formally identified in ACHR's process map, client data also recorded information on client enrollments by ACHR location. Table 7 summarizes that data and details how roughly 60% of all ACHR client enrollments occurred at the PDI located at 913 2nd Street. Additionally, around 17% of clients were enrolled at the Westside Community Center, and nearly 8% of clients at the Unser Library. Figure 11 in Appendix B illustrates client enrollments by location, as a portion of total monthly enrollments.

**Table 7. ACHR Client Enrollments by Location (2018 - 2021)**

| Site | Frequency | Percent |
|---|---|---|
| 913 2nd St. | 409 | 58.3% |
| Unser Library | 59 | 8.4% |
| Westside Community Center | 122 | 17.4% |
| **Total** | **701** | **100.0%** |
| **Missing** | **111** | **15.8%** |

Source: ACHR Apricot Social Solutions (2021)

In sum, client data suggested ACHR has supported 8,501 clients since 2018 and have assisted an increasingly vulnerable population each year. Despite that, ACHR has progressively supported fewer unique clients each year since 2018 – a decline occurring before the COVID-19 pandemic in March 2020. The number of sign-ins and unique clients did drop most significantly in 2020 though, reflecting 34% and 20% of their 2018 counts (respectively). Considering these changes, the typical client ACHR has assisted has been male, Hispani-x/Latin-x, White, impoverished, young adult, unemployed, childless, and uninsured. Critically, ACHR does not collect systematic data in the Apricot system which would describe their primary exclusion and inclusion criteria: whether clients are sober, or experiencing substance use or mental health disorders.

## Need Assessment

Need Assessment was captured by ACHR in two ways: Arizona Self-Sufficiency Matrix (ASSM) assessments, and case notes by staff members. UNM Pathways and Ticket to Work also have unique assessment criteria, but were not reviewed since data were inaccessible to ISR evaluators. Case notes too were not evaluated in lieu of the time required to clean, organize and analyze that information. Staff did readily indicate ASSM progress was used at the PDI. Some confusion existed, though, about the reliability and consistency with which it was administered. One staff member explained there was general difficulty in administering the ASSM to clients who quickly enter and leave:

ACHR STAFF*: I've done my first assessment. So, yeah, it was little tough. [laughter] It's just a lot of learning, I guess, but, like I said, I'm always up for a new challenge and trying something different, but I think, yeah, it's a little tough, especially with the ASSM, with the 3, 6, 9, and 12 because there are so many people that come through the doors. I wish there was a little bit better of a way to grab that file out or maybe color-coding it or numbering it in a different section. We're still trying to figure out different ways to pull those files on the 3, 6, 9, and 12. And, also, we have a lot of members who come for intake, come for orientation, and then you don't see them for 6, 7 months, 10 months, 2 years, and they popped in the door and you will say, "Well, where have you been?" [laughter] So it's really difficult to keep those consistent.*

INTERVIEWER: So, when you have someone who's in that situation where they come back in 7 months, do you give them a sort of 3-month ASSM? Or do you count it as the 6-month? Or how do you end up…?

ACHR STAFF: *Well, you usually count it for the three months. And I do the last-- no, maybe I didn't do it like that because I had a gentleman come in for an intake and he didn't show up. And it had already been a year, so I did the year.*

Once administered, staff indicated that information was used to plan and orchestrate their recovery. One staff member was emblematic, explaining:

> *What it does, is allows an individual to highlight and see on paper areas that are in their life that may need attention or may need progress in some way. So, it ranges everything from mental health, child care, employment, education, self-sustainability, housing, the ability to meet basic daily needs such as food, hygiene, stuff like that. And it's all on a scale of 1 to 10, or 1 to 5. And so being able to categorize yourself in these areas, you ended up with a total at the end. That's not necessarily a total that we use. We're more concerned with the 1 through 5 places, because that's going to show us where an individual is needing services or growth or whatever it may look like. And from there, again, it's not like, "Hey, you scored a two on your education. You have to go get your GED." No, it's like, "Okay, well, out of these, what do you prioritize? What is something that you want to work towards? What are your goals, again?" And a lot of times that works out a lot better than having to point fingers like, "Hey, you need to do this, this, and that in order to be successful," because that's, again, labeling, and it's very stigmatizing. So, we use those to identify these pieces, but then also what is it that you want to work on? What is it that you feel like is most important right now, and let them prioritize and figure it out and then help them with whatever is it they need help.*

Need Assessment is an important aspect of service delivery that even ACHR staff noted required greater consistency in its deployment with clients. Figure 4 (below) illustrates ACHR ASSM administration over time. The chart indicates that in general, ACHR has yet to fully implement the use of the ASSM. Indeed, the total unique clients who have ever been assessed by the ASSM, reflect less than 1/5 of all received clients in the past three years. Beyond that, just twenty-one clients in the past three years have ever received a follow-up ASSM; and just two clients have ever been administered a third ASSM. In total, 211 unique clients have ever had an ASSM administered; about 17% of the 1,241 clients who have ever signed-in at ACHR since 2018.

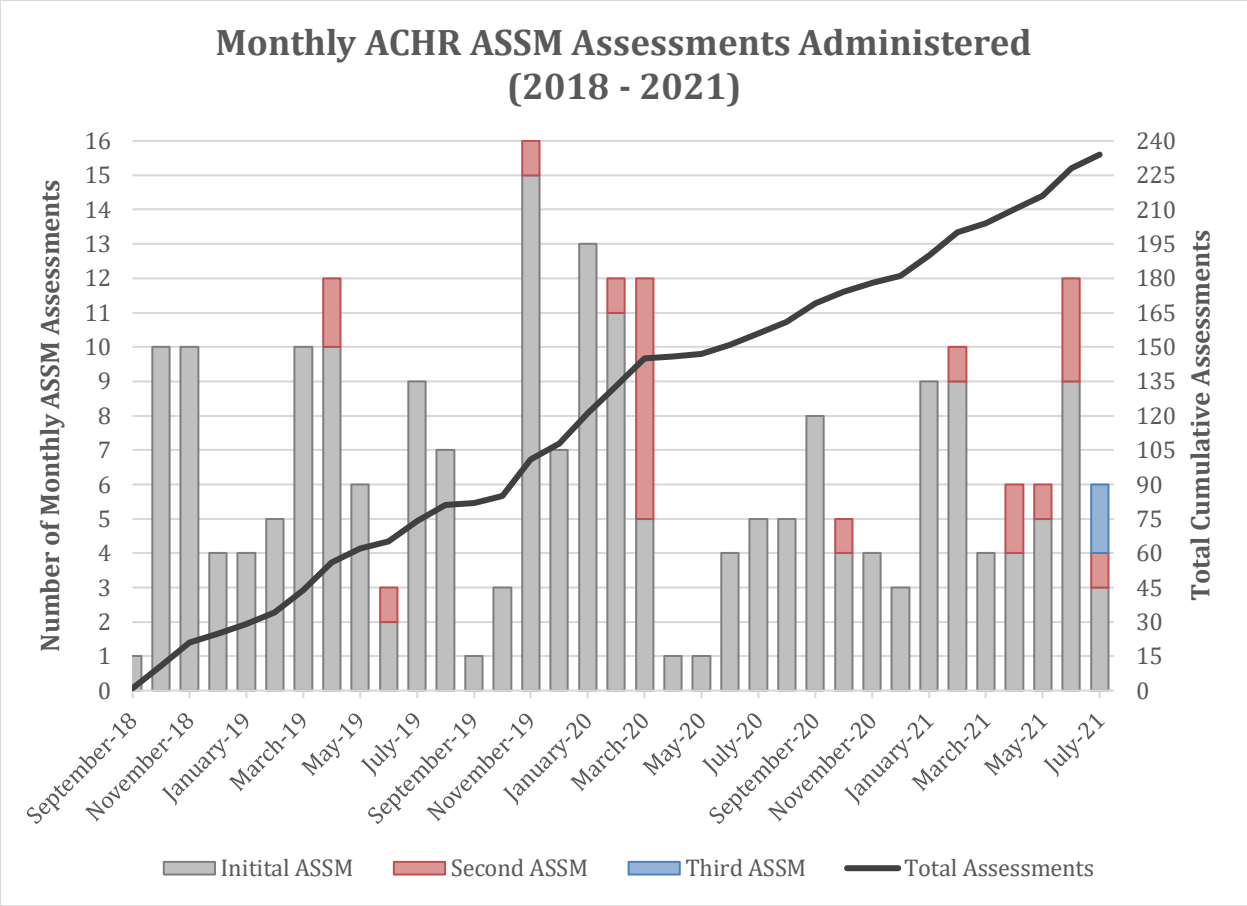


*Figure 4*

**Table 8. Summary of ASSM Data**

| | Year 1 | | | Year 2 | | | Year 3 | | | All Years | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | ASSM 1 | ASSM 2 | ASSM 3 | ASSM 1 | ASSM 2 | ASSM 3 | ASSM 1 | ASSM 2 | ASSM 3 | ASSM 1 | ASSM 2 | ASSM 3 |
| Average Client Score | 53.5 | 63.3 | - | 56.7 | 67.3 | - | 49.6 | 55.9 | 40.5 | 53.5 | 63.0 | 40.5 |
| Median Client Score | 55.0 | 59.0 | - | 56.0 | 68.0 | - | 46.5 | 53.0 | 40.5 | 54.0 | 66.0 | 40.5 |
| Avg. Time Btwn. ASSM (Months) | - | 6.3 | - | - | 4.4 | - | - | 3.7 | 3.0 | - | 3.7 | 3.0 |
| Min. [*Lowest Possible -1*] | 2 | 56 | 0 | 18 | 24 | - | 14 | 37 | 38 | 2 | -2 | 0 |
| Max. [*Highest possible - 90*] | 85 | 79 | 0 | 90 | 88 | - | 81 | 79 | 43 | 32 | 6 | 10 |
| Number of Unique Clients | 78 | 4 | 0 | 73 | 12 | 0 | 64 | 9 | 2 | 211 | 21 | 2 |
| **Total Unique Clients w/ ASSM** | | **77** | | | **70** | | | **64** | | | **211** | |

Source: ACHR Apricot Social Solutions (2021)

## Services & Activities

ISR was able to assess all service participation recorded in Apricot. According to that data, ACHR has established a wide array of support groups, clubs, classes, and socialization opportunities: 46 distinct services and activities in total. The complete list of classes and activities is summarized by year in Table 20 (Appendix B). Across all years, 12 services accounted for nearly 95% of ACHR support, three of

which were identified in the process map. Figure 4 summarizes the top services (≥95.0% of offered support) by year, in descending frequency.

**Summary of Frequently Offered ACHR services by year (≥95.0%; descending frequency)**

| Year 1 | Year 2 | Year 3 | All Years |
|---|---|---|---|
| Addicts 2 Athletes | Addicts 2 Athletes | Addicts 2 Athletes | Addicts 2 Athletes |
| Peer Support Group | Peer Support Counseling | Peer Support Counseling | Peer Support Counseling |
| Art Empowerment | Job Development | General Services | Peer Support Group |
| 4 Agreements | Peer Support Group | Job Development | Job Development |
| Anger Management | General Services | Peer Support Group | General Services |
| Life Skills | Orientation | UNM Pathways | Art Empowerment |
| Job Development | Anxiety | Parenting | Anger Management |
| Peer Support Counseling | Art Empowerment | | 4 Agreements |
| Anxiety | UNM Pathways | | Anxiety |
| Smart | Anger Management | | Orientation |
| Remix | | | Life Skills |
| Yoga | | | UNM Pathways |

*Figure 5*

When limited to ACHR's third year (*September 13, 2020 – July 21, 2021*) – which also captures the COVID-19 pandemic – service diversity dropped dramatically, with nearly 98% of all services captured by just seven categories – two of which are expressly identified in ACHR's process map. With ACHR's assistance, ISR collapsed services into 15 broader categories. Those categories simplified client participation and clearly identified process map services.

**Table 9. Summary of ACHR Simplified Service Categories by Year**

| | Year 1 | | Year 2 | | Year 3 | | All Years | |
|---|---|---|---|---|---|---|---|---|
| Service | Count | Percent (%) | Count | Percent (%) | Count | Percent (%) | Count | Percent (%) |
| Addicts 2 Athletes | 1,435 | 52.1% | 1,871 | 60.7% | 1,069 | 61.4% | 4,375 | 57.7% |
| Peer Support Group | 1,009 | 36.7% | 447 | 14.5% | 111 | 6.4% | 1,567 | 20.7% |
| Peer Support Counseling | 90 | 3.3% | 305 | 9.9% | 257 | 14.8% | 652 | 8.6% |
| Job Development | 92 | 3.3% | 165 | 5.4% | 115 | 6.6% | 372 | 4.9% |
| General Services | 11 | 0.4% | 132 | 4.3% | 138 | 7.9% | 281 | 3.7% |
| Intake/Orientation | 67 | 2.4% | 79 | 2.6% | 1 | 0.1% | 147 | 1.9% |
| UNM Pathways | 6 | 0.2% | 45 | 1.5% | 43 | 2.5% | 94 | 1.2% |
| Choice Recovery | 14 | 0.5% | 6 | 0.2% | 6 | 0.3% | 26 | 0.3% |
| Virtual Coffee | 0 | 0.0% | 22 | 0.7% | 0 | 0.0% | 22 | 0.3% |
| Special Event | 17 | 0.6% | 0 | 0.0% | 0 | 0.0% | 17 | 0.2% |
| Health Education | 0 | 0.0% | 9 | 0.3% | 0 | 0.0% | 9 | 0.1% |
| Ticket to Work | 8 | 0.3% | 0 | 0.0% | 0 | 0.0% | 8 | 0.1% |
| Journaling | 4 | 0.1% | 0 | 0.0% | 0 | 0.0% | 4 | 0.1% |
| 12 Step Program | 0 | 0.0% | 2 | 0.1% | 0 | 0.0% | 2 | 0.0% |
| Clinical Services | 0 | 0.0% | 1 | 0.0% | 0 | 0.0% | 1 | 0.0% |
| **Total** | **2,753** | **100.0%** | **3,084** | **100.0%** | **1,740** | **100.0%** | **7,577** | **100.0%** |

Source: ACHR Apricot Social Solutions (2021)

Overall, Table 9 reveals three service categories accounted for 87% of all ACHR support: Addicts 2 Athletes, Peer Support Groups, and Peer Support Counseling. Job Development accounted for nearly 5% of all services, and UNM Pathways for roughly 1%. General services and intake/orientation accounted

for about 5.6% of support – services ranging from provision of a cup of coffee or a snack, to accessing computers or providing temporary shelter and safety. It is important to note two of ACHR's expressly identified services in the process map – Choice Recovery and Virtual Coffee – reflected less than one percent of all support since 2018 (0.6%). In Year 3 specifically, those same services reflected about 0.3% of all support.

ISR did request program curriculums and documents, but ACHR explained they do not have formalized curriculums or service structures for the majority of supports— with the exception of (1) *Addicts 2 Athletes* and (2) *Choice Recovery*. Instead, most services are ad hoc. An ACHR staff member informally explained how staff generally select activities and curriculums from a designated filing cabinet, depending on the immediate needs of the class, staff member, or clients. Therefore, no *consistent* curriculum or program structure existed for many supportive services, outside of the two mentioned already. The process evaluation was significantly limited as a result and struggled to conceptualize a consistent/standard ACHR client experience. ISR therefore organized several service observations in September 2021 to supplement client data and offer limited qualitative data on the processes in action for currently available ACHR services.

## Program/Service Observations

In September 2021, ISR conducted 6 of 10 planned observations for available ACHR services. ISR staff sat-in on four different kinds of services: Addicts 2 Athletes (A2A), Choice Recovery, Morning Coffee, and Creative Writing. Observations were initially scheduled to afford ISR two opportunities to observe each service. The final schedule reflects adaptations to both cancelled services and a quarantine period following a COVID-19 exposure. Because of the COVID-19 exposure, two services were unobservable and meant only one creative writing service could be observed. Choice Recovery could only be observed once as well, because of client non-attendance. Lastly, a Morning Coffee was cancelled by ACHR and ISR subsequently could observe just one instance. Table 10 provides an overview of scheduled observations.

**Table 10. Summary of ACHR Service Observation Results**

| # | Program/Service | Date | Observable? | Duration (hh:mm:ss) | Clients Attended |
|---|---|---|---|---|---|
| 1 | Creative Writing | 9/1/2021 | Observed | 1:02:00 | 2 |
| 2 | Addicts 2 Athlete | 9/10/2021 | Observed | 1:00:00 | 4 |
| 3 | Morning Coffee | 9/13/2021 | CANCELLED | n/a | n/a |
| 4 | Choice Recovery | 9/15/2021 | COVID-19 | n/a | n/a |
| 5 | Creative Writing | 9/15/2021 | COVID-19 | n/a | n/a |
| 6 | Addicts 2 Athletes | 9/17/2021 | Observed | 1:00:00 | 3 |
| 7 | Morning Coffee | 9/20/2021 | Observed | 1:13:00 | 1 |
| 8 | Choice Recovery | 9/22/2021 | NO CLIENTS | 0:23:00 | 0 |
| 9 | Creative Writing | 9/22/2021 | Observed | 1:08:00 | 3 |
| 10 | Choice Recovery | 9/29/2021 | Observed | 0:59:00 | 1 |

***Addicts 2 Athletes (A2A)* –** ISR had two opportunities to observe A2A classes. Four clients participated in the first observation and three clients in the second observation. Each consisted of 30-minute physical exercises structured and led by an ACHR staff member. Clients participated over Zoom, with the exception of one client in the second observation who was physically present. Clients in both observations were engaged and active, and appeared to follow the workout as it was displayed on a virtually shared computer screen. Following the 30-minute workout, an ACHR member led a 30-minute conversation that guided clients through an ice-breaker, a check-in, and client-centered recovery-oriented motivational talking points. The ice-breaker lasted about 10-minutes and in one instance included the following: *Name a high-point of your week, your favorite dance move, goal for the week, and favorite cartoon*. After the ice-breaker, the staff member asked clients to describe what happened during their week and/or anything they wanted to discuss. Participants in each observation were social, friendly, and appeared to know each other well. Clients described intimate aspects of their lives and were highly supportive of ACHR as a place *for* recovery. In another observation, one client described feeling they had ownership at the center and this aspect encouraged their sustained engagement. Lastly, the final ten minutes of both observations were devoted to good-byes, encouraging inter-client support, and emphasizing the importance of asking for help. In both observations, A2A lasted exactly one hour.

***Choice Recovery* –** One observation was completed for Choice Recovery. This service was led by a single ACHR staff member and was described as originally being offered in a group format pre-pandemic. ACHR ultimately modified the format to one-on-one, because of staff perceptions that it made clients feel less vulnerable, was less pedantic in structure, more personal, and made clients feel safer. Staff also explained that ISR's observations captured the first few instances of this *new* Choice Recovery format. The first observation was unsuccessful because the client did not attend, but the second observation was possible. In general, Choice Recovery reflected a guided conversation where the client was engaged in informal discussions centering around: Goal successes, goal planning (short and long-term), what's happening in their life (generally and specifically), strategies staff member has deployed in their own recovery, and then ultimately ended with depictions of hope (e.g. "*If I can do it, then you can definitely do it*"). Importantly, the client did not bring their *Choice Recovery Board* and so ISR was unable to observe how the only formal document to this service would typically be used. The session lasted about 59 minutes. Importantly, the session included about 20 additional minutes that could not be observed, because the client arrived to ACHR earlier than scheduled. Despite this, the ACHR staff member and client summarized their earlier discussion which was encapsulated in the above description.

***Creative Writing* –** ISR was able to observe Creative Writing groups on two occasions, each lasting a little over an hour. Both times, an ACHR staff member organized the group around three elements: (1) Discussion of what happened in previous class, (2) Description and engagement in an activity, and (3) 20-30 minutes of reflection. In both observations, clients were engaged and friendly. The activity in the first observation involved a '*Genie*' exercise where clients were tasked with describing five wishes. Progressively, clients were asked to limit those wishes to three, and then finally, to a single wish. Discussion and reflection centered around what desires became increasingly important, and to reflect on what that revealed about clients. The activity ended with a short conversation about goal setting, where both clients described recent personal successes and the importance of making incremental steps toward recovery. The session ended with an assignment for the next group: *Write about things you're grateful for*.

In the second observation, the class focused on reading a short excerpt aloud in which the author has written a letter to their younger self. The activity posed three questions about the reading: (1) What does the writer learn about themselves in the exercise, (2) How would writing to a future self be different in nature and quality, and (3) If you were to write to your younger self, at what age would you choose to write to yourself? The group ended with a discussion of looking beyond the immediate consequences of their actions and seeing the bigger picture in life. As the ACHR staff member described, "*Good or bad aren't important; this is how we've lived and the journey we faced.*" The session ended with a writing assignment for the following week: *write about things that make you happy; that you've been happy about before, or think would make you happy in the future*.

***Morning Coffee –***Morning Coffee was the most informal of observed services and was, at its core, an hour of open-ended conversation with ACHR-provided tea/coffee. One client attended and candidly discussed recent fears in their daily life, moments of vulnerability, the effects of the pandemic, and stigma surrounding their identity. The ACHR staff member actively listened, validated, and engaged the client in discussion. The staff member also offered their own anecdotes related to the client's thoughts and feelings. Following the conversation, the ACHR staff member led the client in a short, guided meditation. ACHR staff emphasized the importance of practicing mindfulness and the client indicated "*it really helps*" before departing. The observation lasted an hour and 13 minutes and a single client attended.

Five conclusions were made about service observations:

(1) Services primarily supported community, hope, and goal setting
(2) Services generally maintained a core format
(3) Services and client discussion were overwhelmingly informal
(4) Informal supports occasionally led to meaningful need identification and support
(5) ACHR service observations evidenced the majority of Peer Support Core Competencies

**CONCLUSION 1:** Observations of services were replete with examples of ACHR staff establishing the importance of supporting each other, maintaining hope, and setting goals. *A2A* and *Choice Recovery* were the clearest examples of that type of support. In particular, informal discussion in A2A focused on themes related to maintaining sobriety, how sobriety required group support, and that clients should support each other. Clients in A2A were very comfortable sharing intimate details with each other and positively reinforced the goals and desires of one another. Emblematic of that support, in one observation an ACHR staff member highlighted how one regular attendee of A2A had recently experienced a "hiccup" in their sobriety. The staff member encouraged clients to offer their support and positive reinforcement. The A2A group appeared comfortable and supportive of that request. One client ultimately described their gratitude with ACHR, and explained they felt the organization was welcoming to those who relapse, and how important it was that ACHR lacked judgement toward difficulties in maintaining sobriety.

Similarly, *Choice Recovery* involved deeply personal and informal discussions about the client's previous relapses, but emphasized that greater progress had been maintained overall. ACHR staff highlighted the importance of setting goals, especially as it related to the client's family. Staff also described how they could envision the client as a coworker (CPSW) in the future—a goal the client emphasized aspiring to. Staff reiterated CPSW requirements (2 years sobriety, CPSW coursework, etc.) and conveyed to the

client that staff themselves modeled how realistic the goal was for them – that if staff could achieve CPSW status considering their own histories, that even *they* (the client) could too.

**CONCLUSION 2:** Two of the observed services clearly had core formats. Specifically, A2A and the Creative Writing group. A2A was consistently divided into three components: (1) Workout, (2) Ice-breakers/catch-up, and (3) informal discussion around sobriety and recovery. Creative Writing group also had a familiar pattern: (1) Review of previous session and 'homework', (2) Engagement in a writing exercise/activity, and (3) Reflection and set-up for the following session. And while Choice Recovery could only be observed once, ACHR staff provided ISR with a key artifact of that service -a *Choice Recovery Board.* That program document indicated a predictable pattern conceivably occurs with that service as well. The *Choice Recovery Board* ideally establishes organization and routines for a client. The board itself contains pertinent labels for *time*, *location*, *sponsor*, and *contact details* for several categories: Meetings, IOP, Counseling and therapy, Sober/Transitional Living, Testing facility, Volunteer/Service, and Allies. The board also contains open-ended sections to elaborate on several other items: Client needs, Short-term goals, Successes, Long-term goals, Achievements, Healthy hobbies, interests, passions, and Problems and their associated solutions. A yearlong calendar is also attached to the board. While ISR could not confirm whether Choice Recovery maintained a consistent format based on our single observation, the program artifact suggested it was possible.

**CONCLUSION 3:** Despite the core format some ACHR services evidenced, observations revealed they were overwhelmingly informal. In particular, guided discussions tended to be free-form and often lacked expressly stated goals or objectives. For example, in one observation during Creative Writing group, discussion often drifted away from structured questions (e.g. what would you say to your younger self?) to tangential personal topics (e.g. conversations about personal experiences and family history). Overall, the group lacked any declared overarching purpose, objective, or goal. And while the group maintained a predictable format: Review, activity, and reflection—only a minimal few minutes were devoted to connecting the groups' topics back to recovery or sobriety. To this point, the most formal ACHR service, A2A, was highly dependent on clients' input and at times seemed strained to focus on any specifically prompted topic. A2A seemed primarily focused on offering clients opportunities to connect with *other* clients, rather than achieving any specific outcome or understanding. It was also unclear whether ACHR staff documented or held clients accountable for any directly expressed goals or struggles in A2A. With the exception of the workout itself, *A2A* lacked any overarching prescription and supported clients with general positive reinforcement or opportunities for community building – again, without a formal design to encourage either aspect. Informality can be both beneficial and problematic. While it may promote client comfort and safety, excessive informality can ultimately result in highly variable quality and content. As a result, doubt remains whether any one client experience at ACHR can be comparable to another's.

**CONCLUSION 4:** ISR staff observed several instances where informal conversations led to meaningful identification of client need. As previously described, Creative Writing group often oscillated between structured activity and tangential topics. In one case, tangential discussion led one client to describe their frustration and anxiety with computers – ACHR staff quickly responded and described an available computer class explicitly geared toward promoting familiarity and understanding of technology basics. In a separate instance, a client expressed fear and confusion about their credit score because of a past event. An ACHR staff member responded by describing what is or is not included in credit history, tips for receiving *free* credit histories and reports, and how ACHR could help them with that process.

Further, one observation suggested service informality could also lead to meaningful *outcomes.* One drop-in explained they were not "*even gonna come in but saw the door open*." That particular client initially described needing adequate clothing, but afterward revealed they also wanted help finding a rehab facility willing to accept clients with an ankle bracelet for a misdemeanor crime. The client admitted they were presently intoxicated and wanted rehabilitation immediately. ACHR staff responded to that client's needs by immediately providing them with new socks and presenting a form for them to complete. ACHR staff then began calling rehab facilities on the client's behalf. ACHR ultimately called two facilities and were able to get the drop-in into rehab within the hour.

**CONCLUSION 5:** ISR collected systematic documentation in service observations recording evidence of 63 separate core competencies described by the SAMHSA as critical to providing peer support (Appendix E). The SAMHSA details competencies according to 12 categories:

| | | | |
|---|---|---|---|
| **I** | Engages peers in collaborative & caring relationships | **VII** | Provides information about skills related to health, wellness, & recovery |
| **II** | Provides Support | **VIII** | Helps peers to manage crises |
| **III** | Shares lived experiences of recovery | **IX** | Values communication |
| **IV** | Personalizes peer support | **X** | Supports collaboration & teamwork |
| **V** | Supports recovery planning | **XI** | Promotes leadership & advocacy |
| **VI** | Links to resources, services, & supports | **XII** | Promotes growth and development |

ISR found that across seven completed service observations, ACHR evidenced 52 peer competencies; meaning 11 competencies were unobserved. Categories I – VI encompassed 29 features of peer support and ACHR evidenced each over the course of observations. Table 11 summarizes which features were observed by service observation. Category XI reflected the most unobserved set of competencies and included four features:

1. Uses knowledge of legal resources and advocacy organization to build an advocacy plan
2. Participates in efforts to eliminate prejudice and discrimination of people who have behavioral health conditions and their families
3. Educates colleagues about the process of recovery and the use of recovery support services
4. Maintains a positive reputation in peer/professional communities

**Table 11. Summary of Peer Support Core Competencies**

| | Category I | | | | | Category II | | | | | Category III | | | | Category IV | | | | Category V | | | | | Category VI | | | | | | Category VII | | | | | | Category VIII | | | | | Category IX | | | | | | Category X | | | | | | Category XI | | | | | | | Category XII | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 | 6 | 1 | 2 | 3 | 4 | 5 | 6 | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 | 6 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 1 | 2 | 3 | 4 |
| Observation 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 0 | 1 | 1 | 0 | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 1 | 1 | 0 | 1 | 0 | 0 | 1 | 0 | 1 | 1 | 1 | 1 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| Observation 2 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 0 |
| Observation 3 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 1 | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Observation 4 | 1 | 1 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 1 | 0 | 1 | 1 | 0 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Observation 5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Observation 6 | 1 | 1 | 0 | 1 | 0 | 1 | 1 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 1 | 0 | 1 | 1 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Observation 7 | 1 | 1 | 0 | 1 | 1 | 1 | 1 | 1 | 0 | 0 | 1 | 1 | 1 | 1 | 0 | 0 | 1 | 1 | 1 | 0 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total Times Observed** | **6** | **6** | **3** | **6** | **5** | **6** | **4** | **5** | **2** | **2** | **4** | **5** | **5** | **3** | **3** | **4** | **4** | **5** | **5** | **1** | **3** | **4** | **2** | **4** | **1** | **2** | **2** | **1** | **2** | **2** | **1** | **1** | **1** | **0** | **3** | **2** | **4** | **3** | **0** | **1** | **6** | **5** | **3** | **0** | **0** | **3** | **1** | **1** | **0** | **0** | **2** | **1** | **1** | **1** | **0** | **0** | **0** | **1** | **0** | **0** | **0** | **2** | **1** | **2** |

The features above were difficult to assess and the absence of them in observations should not be construed as evidence they do not occur. Similarly, the other remaining *unobserved* competencies were difficult to assess with limited observations, but ultimately included an additional seven features:

1. Educates family members and other supportive individuals about recovery and recovery supports
2. Takes action to address distress or a crisis by using knowledge of local resources, treatment, services and support preferences of peers
3. Conveys their point of view when working with colleagues
4. Documents information as required by program policies and procedures

5. Coordinates efforts with health care providers to enhance the health and wellness of peers
6. Coordinates efforts with peers' family members and other natural supports
7. Recognizes the limits of their knowledge and seeks assistance from others when needed

Overall, ACHR services evidenced about 83% of all peer support competencies. Just 17% of competencies were unobserved by ISR evaluators. Nearly 43% of all core competencies were evidenced in most service observations (3 – 6 services), while 39% were observed infrequently (1 -2 services). ISR therefore concluded ACHR demonstrated most peer support core competencies and a minority (11) of peer support features were unobserved.

## Outcomes

As described previously, many ACHR-identified outcomes were broad and beyond the scope of the process evaluation. With that said, three of those outcomes had potential to be captured:

1. Program completion
2. A2A Graduation
3. Positive increase in ASSM

The first of those outcomes, *program completion*, reflected an important limitation of the ACHR PDI—only three services have defined parameters for "completion": UNM Pathways, Ticket to Work, and Addicts 2 Athletes. UNM Pathways and Ticket to Work were excluded from the current process evaluation for two reasons. Firstly, program data for both were unavailable for ISR review because client data is stored on non-ACHR servers. Secondly, UNM Pathways and Ticket to Work are unique programs outside the PDI, with separate funding sources. While overlap can and does occur with PDI clients, ACHR operates more like a contractor for UNM Pathways and Ticket to Work, which is why ACHR does not store those client program data in their Apricot system.

Despite those limitations, ACHR's A2A service is by far the most structured component of the PDI, following an 8-week curriculum with conversational focuses for each week. ACHR provided ISR with A2A program materials, but those documents did not appear to correlate with the observations ISR conducted. The two observed A2A conversational components and exercise regimen did not clearly map onto any week in the provided curriculum. That observation provided further evidence that many ACHR programs are largely ad hoc and frequently change or deviate from curriculums. Further, client data ISR was provided with did not reveal any systematic data collection on A2A program completion, or for completion of any other ACHR PDI service.

Finally, ASSM progress was the only actively recorded PDI outcome. The ASSM tracks client progress across 19 categories of need and reflected the most systematic and practical outcome described in ACHR's process map. The ASSM ultimately monitors client changes within five well-defined 'steps'. For example, step 2 of the *Legal* category describes a client with "*current charges/trial pending, noncompliance with probation/parole*", and step 3 indicates a client is "*fully compliant with probation/parole terms*". The *Legal* category is fully resolved once a client lacks criminal justice involvement for 12 months, or has no felony criminal history. And more importantly, ACHR also records the amount of time clients spend in individual services. That data could potentially be used in an outcome evaluation to determine whether increasing time spent in ACHR services leads to greater

progress in the ASSM. Unfortunately, ACHR does not *consistently* collect data on the time clients spend in services. As table 21 in Appendix B illustrates, roughly 90% of all data on service time is missing.

## Discussion

Overall, ISR found ACHR received over 1,200 clients since 2018 and those clients reflect a vulnerable population in need of support. While sign-in data could verify, on average, clients signed-in to the center a little over 5 times, nearly 50% of clients dropped-in just two times or fewer, and 20 clients in Year 3 accounted for 60% of all sign-ins. Importantly, electronic data did not contain systematic data on referral sources to ***or*** from the center. That information is vital for understanding whether some clients receive the help they are looking for. And although ACHR collects *contact details* about who referred clients to the PDI, that data does not capture *kinds* of referrals (e.g. rehab, case management, food pantry, housing programs, etc.). ACHR does collect ASSM data on clients in order to identify their needs and, conceivably, offer needed resources to ameliorate deficiencies. But ASSM data has infrequently been assessed on clients, with just 17% of all sign-ins receiving an ASSM assessment. Further, just 21 clients have ever received *follow-up* ASSMs in the past three years and just two clients have ever been administered a third ASSM.

Following need assessment, the ACHR process map identified just one criterion for clients to receive services: sobriety while at the PDI. Data for that criterion are not recorded and could not be assessed. Age criteria were not specified by ACHR, although informal conversations suggested ACHR intentionally focuses on helping adults (18+). ISR found that informal criterion was often met and less than 2.0% of ACHR clients were between the ages of 12 and 18.

Orientation/Intake was not explicitly described in the process map, but interviews revealed it was an important aspect of ACHR processes – client data collection sometimes occurs in orientations and it operates as an informal activity that introduces clients to the PDI, staff, and available services. ISR found that orientation/intake occurred infrequently across all years, and particularly in Year 3 where just *1* client orientation took place. Staff interviews suggested orientations were largely informal and modified after the COVID-19 pandemic. While ACHR orientations were originally conducted in groups, they now take place one-on-one at formal intake. As one staff member described:

> *So, we used to* [conduct orientations]*. It used to be done every Wednesday. So, from that Thursday to Tuesday, if you came, you'd fill out your member profile and all that stuff, we'd ask you to come back that following Wednesday and go through an orientation. And in that orientation, we'd go through that member profile, we'd go through the packet, code of conduct, guidelines, all that stuff. Since COVID has been about, we weren't obviously able to host groups that size, so we started breaking them down into individual orientations. So, all of those pieces that we would go over in a group setting or an orientation, they are now just one-on-one when we're conducting the intake.*

However, despite the adaptations to COVID-19, client data suggested that while over 1,200 unique clients have ever signed-in at ACHR, only 471 orientations have been completed. This is a critical detail considering interviews revealed orientations provide important information about what the PDI can and does offer clients. Ultimately, fidelity to client induction remains overwhelmingly undetermined. With

that said, to the extent ACHR receives clients and documents demographic criteria, ISR could confirm 38% of 1,241 unique clients in the past three years received ACHR orientations. This was critical considering that Table 19 in the Appendix indicates between 18.5% and 77.6% of demographic details are missing. Importantly, fidelity to referral could not be evaluated and need assessment data was overwhelmingly missing as well.

In terms of services, ACHR has offered a wide array of support since 2018. ISR ultimately simplified 73 unique service categories of support into 46 distinct types. With assistance from ACHR staff, those were further collapsed into 15 broader categories that clearly captured services specified in ACHR's process map. Importantly, Art & Soul was collapsed by ACHR into *Peer Support Groups.* ISR therefore analyzed service data in terms of Peer Support Groups and Peer Support Counseling, in place of *Art & Soul*. Subsequently, of the resulting seven process map services, just *three* accounted for 87% of all services provided since 2018: *Addicts 2 Athletes*, *Peer Support Group*, and *Peer Support Counseling*. The final two categories of services – *Choice Recovery* and *Virtual Coffee* – amounted to less than 1% of support. Altogether, those two infrequently offered services reflected just *48 instances* of support over three years. This was in stark contrast to the most frequently offered services that accounted for *6,594 instances*. "Instances" here described total classes offered to unique people.

One of the most important aspects of service provision, was that PDI services were overwhelmingly informal and subject to change frequently. As one staff member described while answering a question about updating services and trainings:

INTERVIEWER: So, would you say that pretty much updates or modifications are pretty much informal or staff kind of approach it in informal ways?

ACHR STAFF: *Yeah, because a lot of the stuff that we train on, they're not super curriculum-driven. I mean, A2A is curriculum, but it's not ours. So, we can't officially update it. We can just make changes and the founder knows that we're doing that and he's like, "No, yeah, you guys are successful. Do what you need to do with it."…Things like mental health first aid, they go to it, we can't modify it, but they go to the new ones every two years and see if there's anything new there. For instance, if we're doing our recovery art therapy group-- it's not art therapy. It's recovery art, we call it something specific. "Art Empowerment." If there's not a curriculum, there's just* [Staff] *will kind of update what we're working on with the members who are coming to that course are working on.*

*Every year that we have interns through the masters of social work program, one of the things that I have every single intern do is on their second semester, create a proposal for a new type of group. Then they have to build out the group and then before they leave their second semester, they have to actually start implementing that group. So, some of those groups we've actually adopted and they're still happening at the center. For instance, our journaling group. We use that as a recovery group because one of our interns was like, "Oh, I'm going to do a journaling group." It was like a stem off of the art group, but she did journaling specifically into writing prompts. And we still have journaling*

> *group. So, we're always updating our trainings in that way, too, because students have really fresh eyes and they're coming into it and they've only been there four months, 18 hours a week before they're asked to propose a new group. And they have to propose a group that we're not currently doing. And then I have them bring research. And like, "What would this group look like? Who's invited? How many times a week? Is it open?*

ACHR client data and service observations largely suggested processes frequently change and reaffirmed the description above. While program adaptability may be perceived positively, it severely limited the ability of the current process evaluation to confirm fidelity to any standard model. To this point, one staff member described Job Development as a combination of formal and informal processes. And while Job Development could follow standard worksheets, it was not necessarily the *norm.* In general, job development encompassed modeling a variety of skills and guidance in impromptu ways. One ACHR staff member explained:

> *They can be both. For the job coaching member, that's very formal. That's at their place of work. That's dealing with supervision and management in his line of work. But also, informal, and we've gone out and I've met individuals at a McDonald's to figure out the best way to write their resume or to gear their resume for a certain position. So, it can go either way… the goal is to be able to teach and refine an individual's skills in acquiring employment and feeling a level of empowerment. I've had a lot of-- not a lot of individuals, but I've had situations where individuals will come in and we go through a resume, cover letter and all that stuff, and they're just like, "Well, what now?" I'm like, "Well, you need to go out and apply and go through the interview process…And so that's how I go about job development, and that's my goal, is to give them the skills needed to do and find, maintain successful employment on their own.*

The lack of standard procedures and curriculums was all the more limiting when considering the absence of key data collection on short-term outcomes specific to services (e.g. Journaling completion, A2A completion, employment changes, etc.). Additionally, programs that *do* have curriculums and could be observed, namely *A2A*, deviated from curriculum materials. That deviation was substantial and ISR evaluators could not correlate *A2A* services to the curriculum provided. While the curriculum outlined 8-weeks of lessons, group questions, and exercise components, *A2A* in observations appeared to operate a flipped curriculum. That is, while the official curriculum emphasized the talk and lesson components rather than exercise regimens, ACHR appeared to emphasize shared exercise and de-emphasized lessons and group discussion topics. As such, *A2A* appeared to reflect a broad effort at community-building sustained by shared exercise regimens.

In sum, ACHR services are largely ad hoc despite familiar patterns like those described for Creative Writing Group or *A2A*. While ACHR staff appeared to have access to a substantial library of service activities and an A2A 8-week curriculum, overall, no *standard* model to services and activities existed. To the extent that ACHR provides services to clients, ISR could confirm that services described in the process map have occurred since 2018. Importantly, not all services have been provided equally, with 87% of support offered through *A2A,* Peer Support Groups, and Peer Support Counseling. To that point, two services – Virtual Coffee and Choice Recovery, accounted for less than 1% of support since 2018. This disparity in service utilization is a critical feature in the face of another aspect of the PDI – just 38%

of ACHR clients have received orientations. This fact coupled with service-use data may indicate that ACHR services are under-utilized because clients are unaware of them.

In the absence of a standard model or clear, established service processes though, ACHR evidenced most features of peer support core competencies. As described previously, across all observations ACHR demonstrated 83% of all competencies ISR evaluators could assess. In particular, six core competency categories were clearly evidenced across all service observations:

1. Engages peers in collaborative & caring relationships
2. Provides Support
3. Shares lived experiences of recovery
4. Personalizes peer support
5. Supports recovery planning
6. Links to resources, services, & supports

Only 11 features of core competencies remained unobserved:

1. Uses knowledge of legal resources and advocacy organization to build an advocacy plan
2. Participates in efforts to eliminate prejudice and discrimination of people who have behavioral health conditions and their families
3. Educates colleagues about the process of recovery and the use of recovery support services
4. Maintains a positive reputation in peer/professional communities
5. Educates family members and other supportive individuals about recovery and recovery supports
6. Takes action to address distress or a crisis by using knowledge of local resources, treatment, services and support preferences of peers
7. Conveys their point of view when working with colleagues
8. Documents information as required by program policies and procedures
9. Coordinates efforts with health care providers to enhance the health and wellness of peers
10. Coordinates efforts with peers' family members and other natural supports
11. Recognizes the limits of their knowledge and seeks assistance from others when needed

ISR evaluators observed examples of meaningful support that are not documented within client data. The instance described earlier where ACHR staff assisted a drop-in find a rehab facility within an hour of their visit, did not appear to be recorded and electronic data did not reflect those kinds of work. Indeed, ACHR may want to consider such instances as meaningful outcomes for clients, but do not appear to systematically document them. Further, ISR observed other instances where clients were provided access to computers, food, or other meaningful resources which are not captured in client data.

Overall, we consider ACHR to be on the path to evaluation. A limited outcome evaluation could be possible if ASSM assessments and data capturing time spent in ACHR services are consistently recorded for clients. However, without clear and consistent service processes, attributing client change to ACHR is problematic – particularly because no consistent client experience could be reliably depended on. Despite that, most peer support core competencies were demonstrated in ACHR services ISR evaluators could observe. ACHR is ultimately contracted by Bernalillo County to help "*participants (18 years and older) increase their quality of life by assisting with recovery from mental health and/or co-occurring substance use disorders. The ultimate goals [are] centered on the self-reporting of clients' ability to procure resources, secure housing and/or sustainable employment, decrease use of substances, and*

*overcome other barriers to a healthy life*" (CCN#2018-0638). As such, ASSM data could meaningfully capture those outcomes if it were consistently administered to drop-in clients. It is important to note the ASSM is *not* a validated tool for assessing self-sufficiency. And more critically, research has found that the ASSM does not appear to correlate with self-sufficiency when compared to professional evaluations of self-sufficiency (Bannink et al. 2015). With that said, high-scores on the ASSM do describe meaningful outcomes – a transition from 1 to 5 can reflect a difference between homelessness and becoming housed, joblessness to gaining full-time employment, having no income to accumulating 'sufficient income', etc.

In sum, ACHR lacks clear service processes and comprehensive data records, but staff very clearly evidence standard core competencies established by SAMHSA for peer support workers. Additionally, outcome evaluations could be possible if data collection, procedures/curriculums, and clear outcomes are identified.

## Recommendations

Considering the conclusions above, UNM ISR's CARA developed several recommendations to assist ACHR in developing their PDI for an outcome evaluation in the future:

| | |
|---|---|
| Create Formal Processes and Procedures | ACHR's programming and services are generally ad hoc and would benefit from greater structure and organization. The PDI should establish class and activity curriculums – this would offer consistency in service delivery and allow clients to expect common standards in support. |
| Improve Delivery of Client Orientations | ACHR should ensure that clients are aware of resources and services they offer – at present, a minority of clients have received orientations. |
| Collect Programming/Service Completion Data | While ACHR collects information on client participation in services, they do not systematically collect data on *completion*. Services like A2A, UNM Pathways, and Ticket to Work, reflect meaningful outcomes upon program/service completion. |
| Refine Process and Logic Maps | ACHR's process maps established a working draft of PDI processes. However, the current process map does not accurately reflect all services. ACHR should update their process map to capture the work they do, and link this to *measurable* outcomes and data collection points. |

| | |
|---|---|
| Implement “Backward Design” philosophy | ISR recommends that in tandem with refining their process and logic maps, ACHR should implement “backward design” planning—this educational model of curriculum development identifies measurable end goals/objectives, and works backwards so activities, resources, and education support identified goals/objectives. This type of planning would help to ensure PDI programming and services are clearly connected to proposed client changes. Additionally, it would help identify measurable outcomes. |
| Collect Data on Measurable Outcomes | ACHR has identified the ASSM as a critical assessment of client need and change—currently about 17% of sign-in clients were administered the ASSM. ACHR should improve that metric to better document the outcomes they achieve with clients. |
| Establish Recurring Programming | ACHR interviews and client data revealed the PDI has offered many different services that generally fall under “peer support”. However, ACHR should establish recurring programming, like A2A, in order to offer a consistent client experience. |
| Maintain Peer Support Core Competencies | ISR evaluators frequently observed ACHR’s greatest strength was their demonstration of peer support core competencies. Peer support has an established evidence base and is associated with improved outcomes in the literature. Amid other changes, ACHR should sustain this feature of their PDI. |

# NEW DAY YOUTH AND FAMILY SERVICES (ND)

The process evaluation for New Day Youth and Family Services is organized according to the process map in Figure 6. This section begins by first describing the process and logic models developed with the help of New Day staff. Afterward, the report provides an overview of the Evidence-Based Practice(s) in use at the New Day Peer Drop-In Center, and then assesses each level of the process map: Client Induction, Services & Activities, and Outcomes. The report concludes with a short summary of findings and ISR recommendations.

## Process & Logic Models

ISR and New Day (ND) worked together in the Winter and Spring of 2021 to develop a process map that captured activities and services at the PDI (Peer Drop-In Center). Figure 6 reflects the final model and details how clients drop-in, are recorded, and receive services. Additionally, ND staff identified outcomes and goals reflecting client deliverables. In summary, clients at the ND PDI– which staff and youth colloquially call *The Space* – enter through any of four pathways:

(1) Current/previous client, recruits a new client
(2) An external organization refers a new client
(3) An internal New Day staff member refers a new client (Street Outreach, TLP, etc.)
(4) A new client is recruited through marketing materials (social media, flyers, etc.)

Once at *The Space*, clients are recorded through two collection points: A *Sign-In* sheet located on a table near the entrance, and a *4th Visit Engagement Form*. Clients must meet one criterion to receive services: be between 16 and 22 years of age (inclusive). If clients meet these criteria, they receive services according to three pillars of support:

**Physical Supports:** Clients are provided a "Safe Space" where they are protected from the elements, threats of physical or emotional violence, and are able to express themselves. Additionally, amenities like food, board and video games, computer access, art supplies, and free Wi-Fi are available. Beyond this, *The Space* offers donations to clients based on need, and includes basic resources like clothing, hygiene items, shoes, and bus passes. While need was broadly defined, ND staff explained no standard procedure/policy yet existed. In general, need was assessed by individual staff ad hoc, but focused on frequency of requests and demonstrated need. For example, staff explained a client asking twice in one day for shoes might be denied. Similarly, a client without shoes has a demonstrable need for that clothing and would be taken to the donations room at *The Space.*

**Emotional & Educational Support:** Clients are provided opportunities to engage in classes offered by another ND program, the Life Skills Academy. Additionally, ND's PDI aims to provide community-building activities, support from positive adults, connections to community resources and supports external to the PDI (NM Workforce Solutions, UNM, etc.), and finally, support from and connection to other youth.

**Peer Support:** The third pillar of support included peer support from a youth with similar life experiences to the target population(s) and who had not been enrolled in New Day services for a period of two years. At the time ND and ISR worked to develop their process map, no peer support program had yet been established. However, plans were in place to develop and offer peer support in February of 2021. Their goal with peer support was to offer a paid position where a peer would engage drop-in clients and assist with activities in *The Space*.

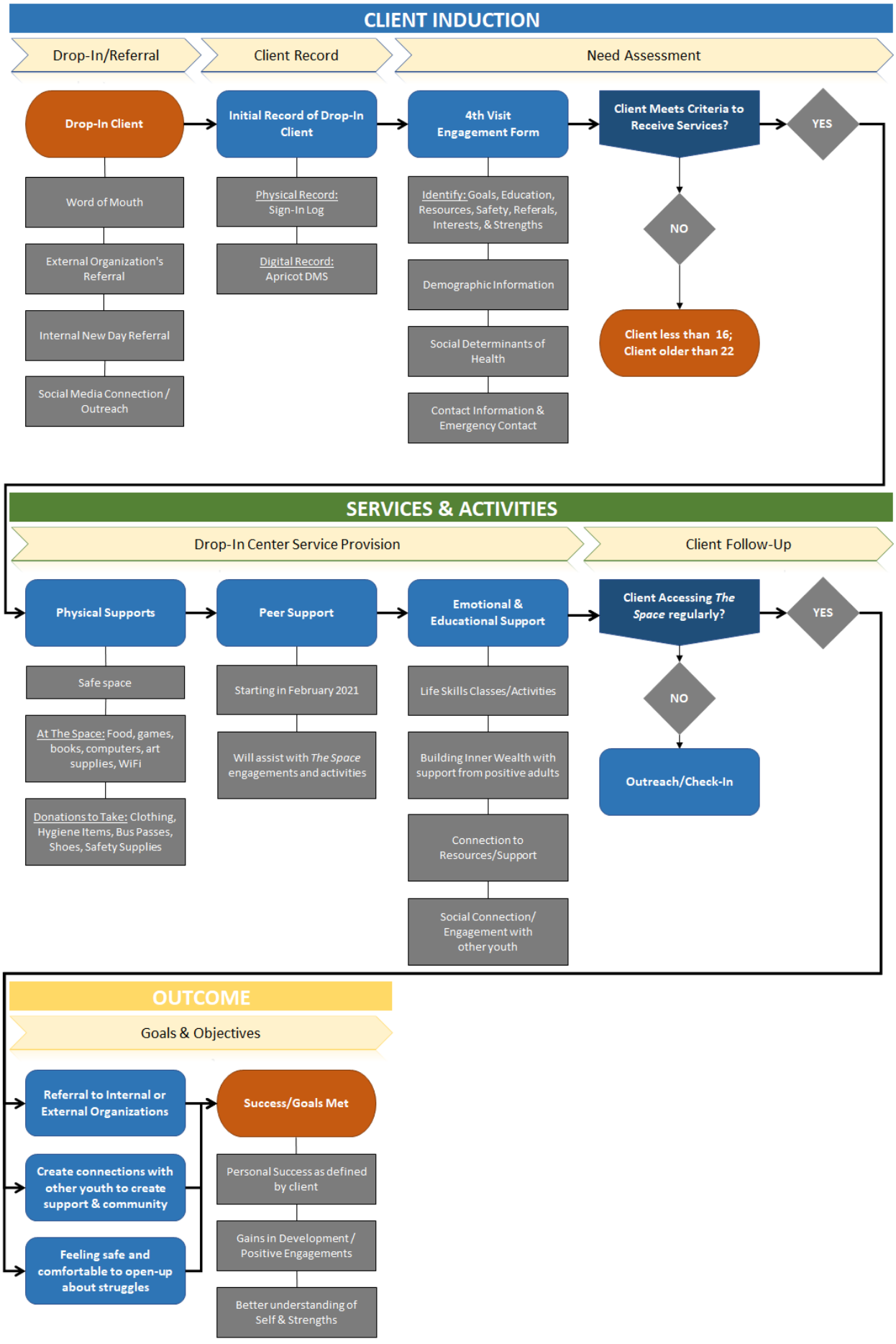


*Figure 6 - New Day Process Map*

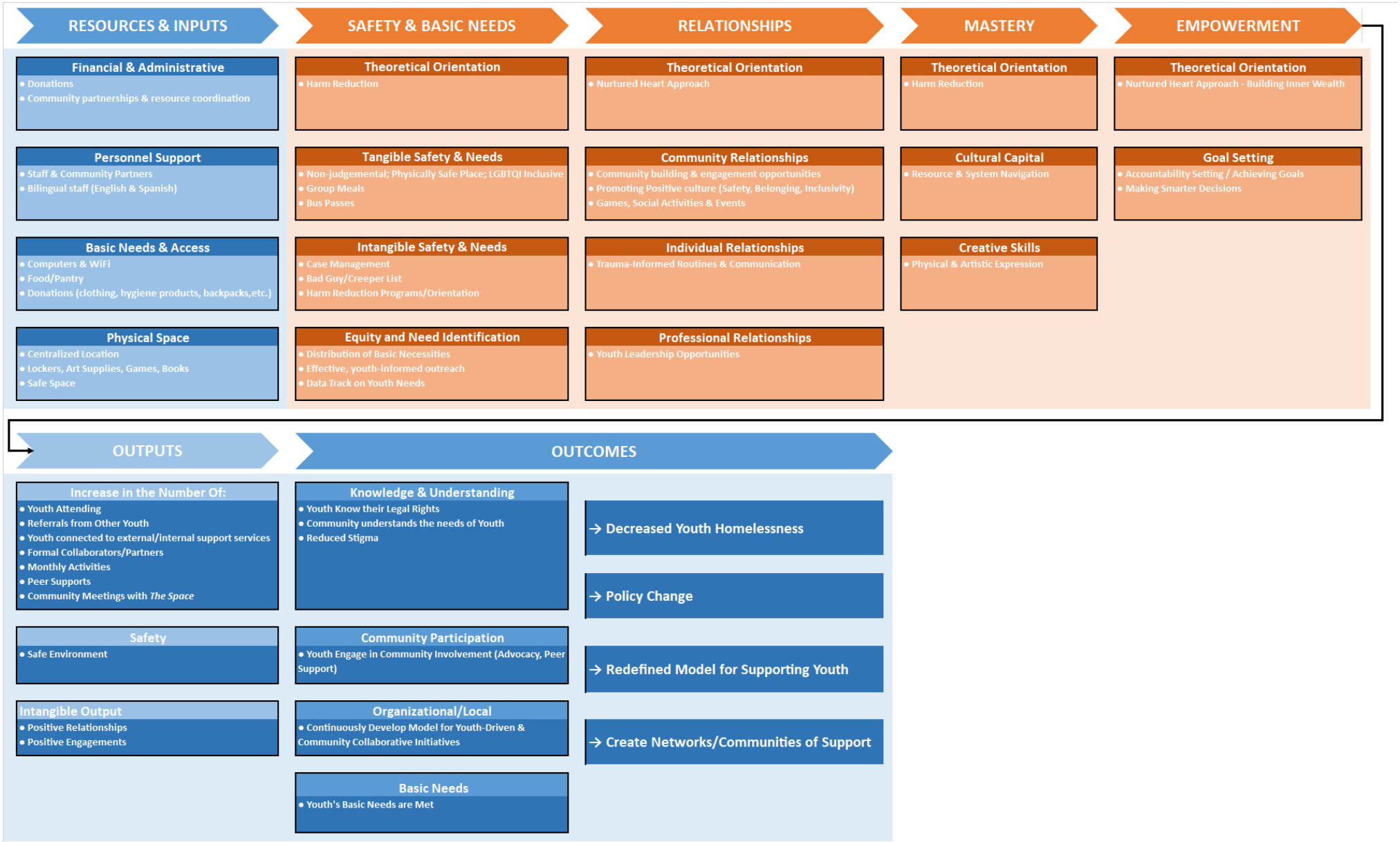


*Figure 7 – New Day Logic Map*

If a youth routinely enters the space, informal check-ups/follow-up can occur, especially for youth drop-ins who uncharacteristically stop attending. Ultimately, three primary outcomes signal client success at the ND PDI:

1. Client referral to either internal or external organizations
2. Connections with other youth to create support & community
3. Feeling safe and comfortable to open-up about struggles

Additionally, three other broader goals/objectives were noted:

1. Personal success as defined by client
2. Gains in development and positive engagements, broadly
3. Better understanding of self & strengths

While ND's process map provided some specific details about a client's journey at the PDI, ND's logic map was less descriptive about how clients were expected to change. One iteration of ND's logic model was developed with assistance from UNM's Evaluation Lab in 2019, but that earlier document was determined to be out of date. Additionally, many elements of the 2019 logic model were overly-broad and failed to describe the theory of change behind PDI processes or how outcomes might be achieved. For that reason, Figure 4 illustrates ND's renewed and re-organized logic model in 2021. Except for section sub-headings, descriptions reflect the work of ND's staff. Unfortunately, the model depicted in Figure 4 still leaves confusion about how clients are expected to change. For example, some of the listed activities and direct products (orange elements) instead reflect *resources and inputs*. And features like providing a physically safe place, meals, bus passes, etc. are conceivably *still* resources 'plugged-in' to the PDI. Further, elements like "Trauma-informed routines & communication" are arguably *program assumptions*, rather than specific activities or direct products of the program. *Outputs* similarly describe many hard-to-define features such as "positive engagements and relationships", or describe program *inputs,* as with "*safe environment".* Features like "Continuously Develop Model for Youth-Driven & Community Collaborative Initiatives" are also unclearly connected to ND's activities and services; likewise, with "Community understands the needs of youth" and "reduced stigma". Finally, community-level impacts were again broad, with the exception of "Decreased Youth Homelessness" which was specific and potentially measurable.

In sum, ND's logic model explicitly described myriad *resources* and *inputs* made available to drop-in clients. Figure 7 ultimately emphasizes the presence of a wide array of community partnerships, relationship-building activities, professionalization opportunities, and general client support centered around *The Space*. Indeed, ND's logic map reinforced this as it clearly identified that the primary outputs of the program are to increase: (1) the number of monthly activities, (2) youth attendance, and (3) referrals. And more generally, ND's PDI aims to (1) form relationships between youth, (2) increase PDI participation, and (3) maintain a safe environment. With that said, details about ND's theory of change were underdeveloped and did not clearly illuminate *why* and *how* fundamental resources would lead to desired outcomes and outputs.

## Evidence-Based Practices

Despite the limitations of ND's logic map, ND staff specifically identified strategies they use to create change among clients in interviews and informal conversations. Overall, no single approach or intervention was prioritized in practice and confusion existed among staff about what qualified or counted as an Evidence-Based Practice (EBP). For instance, some participants described "WRAP training" (wraparound services), Managing Aggressive Behavior (crisis management training course), or Positive Youth Development as EBPs. However, all respondents consistently identified Nurtured Heart Approach (NHA), Motivational Interviewing, and/or a "trauma-informed care model" (4 out 5 interviewed staff) in their lists of EBPs. The 2018 contract signed by ND similarly cited the NHA as ND's EBP, and the renewed contract in 2020 alternatively identified the "Trauma Recovery Model (TRM) to provide engagement and service connection to young people" (CCN 2020-0644:3). Neither the NHA nor the TRM are supported by an evidence base.

First, the NHA describes a strategy for parents of children with emotional behavioral disorders to promote positive behavior. The NHA accomplishes that by limiting interactions with youth according to three stands (rules):

| | |
|---|---|
| **(1) Refuse to Energize Negativity** | Extinction procedure whereby parent halts reactions to negative behavior. Consequences are delivered calmly and with flat affect. |
| **(2) Energize Success** | Parents provide attention to desirable and/or positive behaviors in order to "catch your child being good." Reinforce desired behaviors. |
| **(3) Limits and Consequences** | Parents implement "resets" when rules that have been clearly explained are violated. Resets consist of a "time-out" period in which the child's behavior is expected to halt. Parents then forgive the behavior and resume what they were doing prior to rules being violated. |

*Summary of the NHA from article by (Hektner et al. 2013)*

But while the NHA might be considered a useful and straightforward strategy for youth with challenging behaviors or backgrounds, it does not yet have an evidence base supporting its effectiveness. Even the creator of the NHA identifies on their personal website (HowardGlasser.com) the NHA is an "*Evidenced-Informed Practice"* – and only according to one published article by Hektner et al. (2013). The same article clarifies the "NHA appears to promote effective and validated parenting practices, *but its effectiveness now needs to be tested empirically*" (2013:425 [Italics added]). To our knowledge, only two published research articles have discussed testing the effectiveness of the NHA, one of which simply proposes a protocol for that purpose (Nuño et al. 2019). The second published evidence on the NHA was conducted by Kausik and Hussain (2020) and studied a *novel* intervention integrating the NHA with Self-Determination Theory (SDT). Those authors found the integrated intervention significantly improved basic needs satisfaction, and academic motivation and self-efficacy. Despite those improvements, Kausik and Hussain's evidence lacked any control group and was significantly undermined by a limited and homogenous sample of seven youth.

Second, the Trauma Recovery Model (TRM) describes an approach emphasizing the importance of addressing basic psychological needs of trauma victims according to Maslow's hierarchy. The publicly available Trauma Recovery Model (TRM) pyramid can be reviewed in Appendix F. Developed by Tricia Skuse and Jonny Matthew (TRM Academy 2018), TRM is an approach "to develop systems, structures and staff culture" (3) for responding to youth with challenging behaviors and/or experiences. That is, TRM is not an intervention, but an approach to improve intervention outcomes. And like the NHA, the TRM is not an EBP. A peer-reviewed article co-authored by Tricia Skuse and Jonny Matthew clarify this, explaining "Essentially, [TRM] it is based on a form of relational therapy that aims to mitigate the impact of developmental trauma in order to facilitate effective cognitive interventions" (Evans et al. 2020:63). Indeed, that 2020 article reviews the practical implementation of an Enhanced Case Management that integrates a TRM approach.

In the course of staff interviews, Motivational Interviewing was also consistently described by all staff as an EBP used at the PDI (5/5 interviews). In fact, Motivational Interviewing (MI) is an established EBP. It remained unclear, however, how MI was integrated into service delivery. The logic and process maps developed alongside ND staff do not describe how MI is integrated at the PDI. Those maps instead identify the NHA and TRM. The NHA was also the most evident strategy at the PDI. Limited service observations noted how staff were often quick to identify clients' successes and strengths, and to develop conversations around empowerment, choice, and seeking help or resources. In our view, this epitomized Stand 2 under the NHA. Further, staff readily and easily described the NHA as an active practice. When asked which EBP(s) were used at the ND PDI, one emblematic interviewee explained:

> *So, definitely, Nurtured Heart is the number one, and Nurtured Heart training, it basically teaches you how to professionally talk to youth, how to professionally encourage them, how to do it in a way that's actually going to affect them, not just like, "Oh, you did a great job today." It's like you need to point out how they did a great job, what you've noticed in them, and then how that's a good thing. And that was actually my first day of work, was that training.*

Regardless of which strategies do or do not have an established evidence base though, a more fundamental concern was evident in discussions about EBPs at the ND PDI: multiple practices and strategies appear to be used ad hoc with clients. As a result, it is not clear what a consistent client experience looked like. In terms of evaluation, this feature is a significant barrier. Determining efficacy is hindered by wide variation in how staff might and do respond to different clients. This variation may be viewed as a critical strength by ND's PDI, who may consider the practice responsive to unique needs and concerns. However, ad hoc processes obscure program weaknesses, as well as strengths, because no single strategy can therefore be evaluated. And perhaps more importantly, attributing client change is problematic.

In summary, ND's process map provided direction for a *limited* process evaluation. The logic model, however, lacked clear and consistent descriptions of how ND aims to organize the delivery of PDI services and activities and affect client change. Still, ND specifically identified the NHA and TRM in their contracts, and staff regularly identified them as the most important strategy/approach they use while interacting with clients. The NHA and TRM are not evidenced-based practices though and the PDI does not clearly prioritize a single EBP or strategy with clients. This feature of the ND PDI significantly limits which client outcomes can reasonably be attributed to the PDI as a result of participation in their PDI program.

## Client Induction

Client Induction at New Day (ND) was identified as involving three distinct elements:

1. Drop-In/referral to the PDI
2. Creation of physical and digital records about a client
3. Assessment of a client's need

### Drop-In/Referral

ND's map (Figure 6) illustrates how clients primarily enter the PDI: through drop-ins or referrals. Referrals were described as primarily occurring by word of mouth, an external referral, an internal referral, or through outreach efforts. Interviews with staff aligned with this, reinforcing that word of mouth, outreach efforts, and Serenity Mesa referrals were the primary way new clients found out about the PDI. Client referrals were also captured more comprehensively by ND's Apricot data management system. ISR's CARA received data on referrals to the PDI, from the beginning of data collection up until data retrieval – December 2018 to July 21st, 2021. Table 12 details the proportion of referrals from each category of source. Process map and staff perceptions were generally supported by the data. Eighty-three percent of all client profiles (327 of 395) included information about referral source, and 68 records in total were missing (17.2%). ND Staff/Street Outreach, (34.9%), Word of Mouth referrals from peers or other youth (20.8%), School referrals (14.7%), and Serenity Mesa referrals (12.2%) accounted for the vast majority (82.6%) of client induction since 2018.

**Table 12. Client Referral Source at New Day PDI (2018 - 2021)**

| Referral Source | Number of Clients | Valid Percent | Cumulative Percent |
|---|---|---|---|
| New Day Staff/Outreach | 114 | 34.9% | 34.9% |
| Another Youth/Peer | 68 | 20.8% | 55.7% |
| School | 48 | 14.7% | 70.3% |
| Serenity Mesa | 40 | 12.2% | 82.6% |
| Community Partner | 24 | 7.3% | 89.9% |
| Community Workers | 18 | 5.5% | 95.4% |
| Social media/Internet | 9 | 2.8% | 98.2% |
| Family member, Friend, or Significant Other | 4 | 1.2% | 99.4% |
| Community Event | 1 | 0.3% | 99.7% |
| Unknown | 1 | 0.3% | 100.0% |
| **Total** | **340** | **100.0%** | |

Source: New Day Apricot Data Solutions records (2021).

Interestingly, not all referral sources consistently recruited youth. For example, over 50% of all school and community worker referrals occurred before May 2019. Additionally, most referrals from outreach (57.0%), Serenity Mesa (50.0%), marketing (55.6%), and family or friends (50.0%) occurred *after* January 2021. Table 18 in the Appendix summarizes each referral source by cumulative percent. Client data therefore suggested most clients in the past 8-months were referred through street outreach efforts (45.1%). Word of mouth (18.8%) and Serenity Mesa (17.4%) referrals accounted for the overwhelming majority of other client recruitment in recent months.

Like client referrals, drop-ins were also captured by ND's client data. That data was collected by physical sign-in logs subsequently entered into Apricot. The data revealed ND documented over 2,400 sign-ins over 31 months of operation. This meant, on average, ND supported 77.7 drop-ins per month. Importantly, ND's sign-ins were also overwhelmingly recent – over 50% of all sign-ins occurred in the most recent 8-months – 1,340 out of 2,410 total sign-ins. Between December 2020 and July 2021, ND's PDI supported an average of 167.5 sign-ins per month; in contrast to an average of 46.5 sign-ins between December 2018 and November 2020. When limited to unique client visits per month, however, ND's PDI supported an average of 23 unique clients per month for the first 23 months of operation; and 58.5 unique clients on average per month since January 2021. Lastly, the average client signed-in about 6 times, while 50% of all clients visited *The Space* two times or fewer.

**Table 13. New Day Peer Drop-In Center Sign-Ins**

| | Since PDI Start | December 2018 - November 2020 | December 2020 - July 2021 |
|---|---|---|---|
| Total sign-ins | 2,410 | 1,070 | 1,340 |
| Average sign-ins per month | 77.7 | 46.5 | 167.5 |
| Average unduplicated clients per month | 32.4 | 23.3 | 58.5 |
| Average sign-ins per client | 6.1 | 5.3 | 5.2 |
| Median sign-ins per client | 2.0 | 2.0 | 2.0 |
| **Total Unique Clients** | **395** | **204** | **259** |

Source: New Day Apricot Data Solutions records (2021).

While ND did not specifically describe an intended demographic beyond a single age group (16 – 22), additional demographic data were available. Age, by far, was the most consistently assessed demographic category—100% of client profiles included data on age. Table 14 summarizes the client age distribution for the ND PDI. In summary, 95% of clients fell within the boundaries of 16 – 22. Roughly 5% of clients fell outside the formal age criteria—11 documented clients younger than 16 years of age (2.8%), and eight clients were older than 22 (2.0%). Interviews and informal conversations with staff revealed age criteria were not strictly enforced. Rather, age criteria have been guidelines that do bend in cases. As one staff member explained:

> *So, for the space, we accept youth from 16 to 22. If they're going to a class, they can be a little bit younger. I think it's from 12 to 15, maybe. And sometimes, we do have the safe homecoming. And the safe home, most of them, they're not of age to even be in the space. So sometimes, they'll want to hang out in the space instead of going to the class. And we have to be like, "Actually, you can't. You have to go into the class, and then you have to leave when the class is over. You can't really hang out. You can grab a snack or whatever. But, yeah, we can't do that."*

Additionally, staff indicated unique situations sometimes occur where youth enter the program on the cusp of turning 23. Staff described what they considered a nonsensical cut-off, and instead were willing to provide services through 23, but not beyond 24. This was evidenced by client data which indicated clients older than 22 received support. Clients older than 22 accessed the ND PDI an average of 7.3 times, with one individual accessing *The Space* 45 times.

Clients younger than 16 accessed *The Space* an average of three times, with the most engaged youth signing-in 11 times.

**Table 14. Client Age Distribution at New Day PDI (2018 - 2021)**

| Client Age | Frequency | Percent | Cumulative Percent |
|---|---|---|---|
| Younger than 16 | 11 | 2.8% | 3.5% |
| 16 | 9 | 2.3% | 5.1% |
| 17 | 36 | 9.1% | 14.2% |
| 18 | 81 | 20.5% | 34.7% |
| 19 | 92 | 23.3% | 58.0% |
| 20 | 78 | 19.7% | 77.7% |
| 21 | 75 | 19.0% | 96.7% |
| 22 | 5 | 1.3% | 98.0% |
| 23 | 8 | 2.0% | 100.0% |
| **Total** | **395** | **100.0%** | |

Source: New Day Apricot Data Solutions records (2021).

Table 19 in the Appendix further summarizes ancillary demographic characteristics for clients at the ND PDI. Overall, data revealed the majority of clients were:

- LGBTQIA+ (39.0%)
- Non-white (46.6%)
- Hispani-x/Latin-x (63.9%)
- Had a disability (45.0%)

Over a quarter of clients had some kind of involvement with protective services (27.6%) and about one-fifth of clients had some form of juvenile justice system involvement (19.3%). And despite an average client age of 19.1, more than 50% of clients reported the last grade they attended was 10$^{th}$ grade—suggesting many clients were a year or more behind in their formal education.

In general, 95% of ND PDI clients met ND's age criteria to receive services at *The Space*. A small proportion of clients were younger than 16, but interviews with staff suggested those instances reflected unique cases when younger clients participated in programs like the ND Life Skills Academy (LSA). Staff affirmed that clients younger than 16 were prohibited from lounging at the PDI, but were able to access resources like snacks. Client data revealed less than 3% of clients fell below the age criteria and 2.0% of clients were above. While no other formal criteria existed for youth to access the PDI, clients were fairly diverse across three measures: sexual orientation, race, ethnicity, and disability status.

## Need Assessment

After a client drops-in at the PDI, ND assesses client need(s) through a *4$^{th}$ Visit Engagement Form*. Youth fill-out that form and submit it to staff. ND staff explained the form was ideally administered on a clients' 4$^{th}$ visit to the PDI. However, they also explained the form could be administered at other time points—earlier or later depending on the youth's engagement. Staff described that, in their view, excessive documentation could be perceived by youth as overly-burdensome and ultimately decrease client participation. Fulfilling a mandate to remain low-barrier, however, made it unclear how consistently the *4$^{th}$ Visit Engagement Form* had been administered.

Data from the *4th Visit Engagement Form* captured a wide array of client information: from preferred client name to referral sources. Three aspects of the form were essential for assessing client need at the PDI: (1) *Do you need help with: Housing, Food, Mental Health, Medical, Transportation, Job Support, Education, or Other*; (2) *Do you Feel safe in your current situation*; and (3) *Are you experiencing homelessness or worried you might be soon?* Those three items are summarized in Table 15 below.

**Table 15. Summary of Client Need Data at ND PDI**

| Client Needs Help With: | Count | Percent |
|---|---|---|
| Housing | 46 | 36.2% |
| Food | 27 | 21.3% |
| Mental Health | 35 | 27.6% |
| Medical | 14 | 11.0% |
| Transportation | 37 | 29.1% |
| Job Support | 50 | 39.4% |
| Education | 29 | 22.8% |
| Other | 6 | 1.5% |
| Currently in Unsafe Living Situation | 24 | 18.0% |
| Experiencing Homelessness or At-Risk of Homelessness | 34 | 26.8% |
| **Missing Client Data on Need** | **273** | **68.3%** |

Source: New Day Apricot Data Solutions records (2021).

Client data indicated greatest need for (1) Job Support, (2) Housing, and (3) Transportation. The lowest category of need was for Medical support (11.0%). The category "Other" captured a few esoteric write-in responses ranging from "*Bus pass*" and "*daughters school*," to "*good vibes*". Additionally, 26.8% of documented youth were experiencing or at-risk of experiencing homelessness, and 18.0% were either unsafe in their current living situation, or unsure of their safety. Two general conclusions were drawn from need assessment data: (1) a *minority* of documented clients have self-reported need, and (2) the vast majority of clients lacked any documentation of their need. Just 44% of clients who were administered the *4th Visit Engagement Form* self-reported any category of need. Critically then, 68.3% (273) of all PDI clients had *no* data at all about their needs. The only obvious common feature of clients without self-reported need was that they tended to be slightly younger than the average client (Average = 17.8|Median = 17.0).

## Services & Activities

Following client induction, the ND PDI offers services and activities to clients. Unfortunately, client data was not available for specific services and activities provided directly by the PDI. Informal discussions clarified the Life Skills Academy (LSA) does document class participation and could differentiate classes hosted at the PDIC. However, the LSA is not operated or sponsored by the PDI. With that said, PDI staff often referred to other ND programs hosted at the PDI, as PDI services and activities. This led ISR to ask ND staff to draft a list of services sponsored and organized by the center. Figure 10 reflects programming and services the ND PDI documented and sent to ISR in August 2021.

| Community Partners | | | |
|---|---|---|---|
| **Program** | **Agency** | **Services:** | **Frequency** |
| *WIOA* | YDI | Job Readiness, Jobs, Internships, GED, High School Diploma Help | Every other Tuesday |
| *CareLink* | NM Solutions | Medical Care Coordination | Once a month |
| *CAUSE NM* | UNM | Boundaries on dating/partner violence info | Once a month |
| *Opening Doors* | Hope Works | Case management | Not yet |
| *Legal Services* | Pegasus | Legal aid for a variety of services | Once a month |
| *Pop Up* | Esperanza | Bike repair and safety courses | September |
| *Planned Parenthood* | Planned Parenthood | Safe Sex Education | Twice a month |
| *Independent Futures* | YDI | Case management | Every Friday |
| **Community Members** | | | |
| **Name of Individual** | **Association** | **What do they provide?** | **When?** |
| Rebecca Sisneros | Workforce Solutions | Job Readiness Trainings | Every other Tuesday |
| Codi Chavez | Individual | Boxing Lessons | Every Friday |
| Gabby Campbell | Southwest College Intern | Art Therapy Groups/1on1 | Weekly 1 on 1's; every other Wednesday groups |

*Figure 10 - ND PDI List of Programs and Services*

Critically, none of the programs/services in Figure 10 reflected programs and services provided directly by PDI staff. Instead, ISR staff documented the programming/services below as directly provided by the ND PDI in September 2021:

*Provision of Sanitation and Hygiene Products*
*Donations: Clothing & Shoes*
*Provision of Food*
*Want to be in TLP?*
*Game night*
*Crafty Night*
*Puzzling*
*The Space Theater Movie Night*
*Karaoke Night*
*Bonfire*
*Dine, Discuss, & Discover*
*Self-Care Group: Your Mask First*

When ISR staff requested curriculum and/or materials for PDI programming/services, ND staff explained they were in the process of establishing documents related to program curriculum. Because of this, no curriculum or program materials were reviewed by ISR. Interviews with ND staff confirmed nearly all PDI programming and services are *informally* conducted without established curriculums or guidelines. One emblematic discussion depicted this feature of the ND PDI:

INTERVIEWER: And with referrals then, is there a formal process for which you give a referral or is there an informal process?

ND STAFF: *I mean, it's pretty informal. It's just out of conversations that we're having with the youth. If they say something that we know a service that could apply, we'll just say, "Okay. Well, you're dealing with this. Here, these people specialize in this." Or they'll come and specifically ask, "Hey, do you know where I can get help with this and then we just have places that we send them to. So, it's pretty conversationally based.*

INTERVIEWER: And so, then the same question for socialization events or activities, are those mostly formal or informal kind of gatherings?

ND STAFF: *I mean, I would say both. We try to have like a once a month bigger event, like last month we had with LSA and had the back to school thing. That was this month. Time does fly. Yeah, and then last month what did we do? We'll try to have one big event on a weekend that's more promoted and then weekly, we'll have just very chill bee puzzling craft nights, and those are very informal. It's just whoever's here. There are some people who will come for a specific game nights. But those are very informal.*

INTERVIEWER: And then for basic necessities in general, donations closet, is that a formal process or informal?

ND STAFF: *Right now, very informal. As we're kind of working out kind of policy and procedures for it. And I think it'll still be, it's just like, again, very conversational. Like, "Hey, do you guys have this?" Yeah, let's go in the back and look for it.*

This informality meant one feature of support ND listed in their process map – Physical Support – could not be evaluated. Client data could not describe the provision of resources to clients and ISR's evaluation specifically avoided collecting client-level details in the course of observations in order to protect the privacy of underage clients. Additionally, the second feature of support at ND's PDI – Peer Support – could not be evaluated either. Peer support has never been fully-implemented by ND's program. In the conclusion of this report we discuss the implications of a Peer Drop-In Center (PDI) that lacks peer support workers. Finally, it *was* possible to observe aspects of ND's third category of support– emotional and educational support – by observing programming/services at the center and collecting limited qualitative data on the delivery of programming/services.

## Programming/Service Observations

To better assess PDI service provision, ISR conducted field observations of ND services in September 2021. Ultimately, ISR planned 10 observations and completed four. Two services were cancelled by ND staff, three services lacked any client participation, and one service was unobservable by ISR staff as a result of COVID-19 exposure. Table 16 documents which services were observed, their duration, and the number of PDI clients who attended.

**Table 16. Summary of Field Observation Results**

| # | Program/Service | Date | Observable? | Duration (hh:mm:ss) | Clients Attended |
|---|---|---|---|---|---|
| 1 | Crafty Night | 9/9/2021 | Observed | 1:26:00 | 3 |
| 2 | Zine Workshop | 9/11/2021 | Observed | 1:49:00 | 3 |
| 3 | NM Workforce Solutions | 9/14/2021 | NO CLIENTS | 0:50:00 | 0 |
| 4 | Puzzling | 9/16/2021 | COVID-19 | n/a | n/a |
| 5 | Self-Care Group: Your Mask First | 9/18/2021 | CANCELLED | n/a | n/a |
| 6 | Sexual Decision-Making | 9/22/2021 | NO CLIENTS | 0:50:00 | 0 |
| 7 | Dine, Discuss, & Discover | 9/22/2021 | CANCELLED | n/a | n/a |
| 8 | Want to be in TLP? | 9/23/2021 | Observed | 1:15:00 | 1 |
| 9 | NM Workforce Solutions | 9/28/2021 | NO CLIENTS | 0:59:00 | 0 |
| 10 | Pegasus Legal Aid | 9/29/2021 | Observed | 1:16:00 | 1 |

Ultimately, ISR was able to observe four ND services: (1) Crafty Night, (2) a Zine Workshop, (3) a TLP program presentation, and (4) a Pegasus Legal Aid workshop. Two of the services – *Zine Workshop* and *Pegasus Legal Aid*—were hybrid services. This meant clients were allowed to physically be present at the center while the community partners led discussion remotely through Zoom. The remaining two services – *Crafty Night* and *Want to be in TLP?* – were led by ND staff and held in-person at the PDI. The content of these four services is summarized below:

> ***Crafty Night*** was organized around an approximately 8-minute long video that coached clients in relaxation exercises and presented an art exercise focused on defining and understanding onomatopoeia. Clients were asked to create their name as an anagram for other words that were onomatopoeic. The activity concluded by having clients color those words according to colors they associate with those sounds. Staff explained the video was developed by the ND board of directors sometime in 2020 to maintain client engagement in programming remotely during the pandemic. In total, *Crafty Night* lasted about an hour and twenty-six minutes and 3 clients participated.
>
> The ***Zine Workshop*** was organized around a paper-folding activity where clients crafted paper pamphlets which they used to draw panels and 'be themselves'. Workshop leaders explained social justice topics were ideal, but anything was permissible in terms of content. Workshop leaders solicited input from clients for music suggestions and spent half the activity time in relative silence, while members worked on their 'Zines'. The last forty minutes involved clients sharing their work with staff and workshop leaders, and receiving positive reinforcement. The activity closed with participants sharing their feelings and thoughts about the workshop. In total, the *Zine Workshop* lasted an hour and forty-nine minutes and 3 clients participated. Importantly, this was the first *Zine Workshop* held at the ND PDI.
>
> ***Want to be in TLP?*** was organized and led by a ND staff member who guided a PowerPoint presentation summarizing the critical elements of ND's Transitional Living Program (TLP). Clients were seated in front of a wall where the PowerPoint presentation was projected onto. The presentation was organized around seven core elements: (1) Introduction, (2) Goals of TLP, (3) What does it look like, (4) Eligibility, (5) Expectations, (6) Special circumstances/needs, and (7) Applying. Clients could and did ask questions

throughout the presentation, which the ND staff member promptly answered. Additionally, the ND staff member brought TLP program applications and was willing to guide clients while applying. The ND staff member also made clear a wait list for TLP existed. Because the staff member was part of the program, clients were considered officially wait listed once they handed their applications to them. In total, the TLP presentation lasted one hour and fifteen minutes and 1 PDI client participated.

***Pegasus Legal Aid*** was organized around an informal Q & A where clients could engage with a representative of Pegasus Legal Services for Children. Pegasus Legal explained they could assist with topics related to: Emancipation, name changes, enrolling in school again young parents with custody issues, and probation issues/questions. ND staff placed a laptop connected to Zoom on a table in the common area with the video feed turned off. Staff announced to the room they could ask Pegasus Legal any questions they might have. Despite 7 youth in the common area, only one engaged with Pegasus Legal Aid. The community partner provided the client with links to forms and information, and ultimately provided the youth with their contact information. In total, the Q & A lasted an hour and six minutes and one PDI client participated.

Five general conclusions were made about service observations:

(1) Consistent with interview data, most services are informal and unstructured
(2) Client needs were sometimes discussed during informal interactions/socialization
(3) Client attendance was low
(4) PDI programming was mostly provided by community partners or interns
(5) The Nurtured Heart Approach was practiced by staff; although 2/3 stands were rarely observed

**CONCLUSION 1:** As the ND PDI interviews and process/logic maps suggested, observed services were informal and unstructured. The clearest example of this was *Crafty Night*. This service was overseen by two New Day staff who guided clients through an 8-minute video and participated in the activity alongside them. Despite the organization of the video, participation was free-form and clients effectively did what they wanted. A ND staff member eventually told youth they could treat the activity as an "open art" session. Overall, *Crafty Night* presented clients with a general activity, rather than a class with an objective or purpose. To that point, no formal conclusion to *Crafty Night* occurred—staff and clients simply left the space over the course of the final 30 minutes. Similarly, the Zine Workshop encouraged a general activity – pamphlets or 'Zines' – and community partners/staff prioritized client self-expression. Pegasus Legal Aid likewise consisted entirely of an open-floor Q & A, and lacked structure or clear objectives, except to answer client-sponsored questions. In fact, only one client spoke to a Pegasus Legal Aid representative and the engagement lasted around 5-minutes.

**CONCLUSION 2:** Despite the lack of structure and formality to services, ISR staff observed that informal and unstructured interactions sometimes led to meaningful conversations between clients and staff about their circumstances, their needs, and what resources may be available. In a particularly clear example during *Crafty Night,* one client described their small stipend for food which their parents were providing them with. This led to a conversation between staff and the client about applying for their own food stamp money. The ND staff member explained they could use the computer at the center and they could help guide them through the application process. Similarly, during the Pegasus Legal Aid presentation, a client was working with ND staff on a farewell card for a ND intern. While writing, the

client described leaving the ND Transitional Living Program (TLP) and how their petition for an extension was denied. Coincidentally, the staff member led the TLP presentations at the ND PDI and offered to assist with re-petitioning – a process the ND staff member described as requiring the 'right keywords and structure'. These two examples evidenced what ND has consistently described as their greatest strength – prioritizing informal relationships that lead to critical information about client need. Ideally then, these informal relationships mean youth are more receptive to help and resources, because they have identified and asked for them. Critically though, the ND PDI does not collect comprehensive or consistent data on resource connections or referrals. And despite the presence of meaningful conversations, ISR staff did not observe whether ND staff followed-up on their offers, and client data could not confirm either.

**CONCLUSION 3:** During observations client participation was low and several times, non-existent. ND staff remarked this was an abnormal period of low participation. As one ND staff member described, dependable youth participation was considered a critical barrier in delivering services to their target population:

> *Well, I would say that more recently, in this last month, COVID and having to go back to a virtual platform, that was a barrier. Early on, COVID, not being able to invite our providers into the Space to have them share with young people, that was an issue. I think that sometimes some of the challenges might be like we'll have a resource provider come to the Space, and no youth show up. Or two young people show up, and they're not interested in talking to them. So sometimes, we know that specific youth actually need a certain resource. But then on the day that we have the resource, they don't come. And the team might call out to them and be like, "Hey, this is [ND Staff] calling from the Space. So-and-so's here. Are you going to be coming by today?" "Well, we'll try." So, I think the erratic nature of where youth choose to show up and when, you just can't plan for it. You can set your plans in place, but sometimes, it's a waste because no one shows up. So those are some-- but I wouldn't say that there's any-- we haven't really had any issues with-- there's been no shortage of resources, I'll say. Our partners have been really eager to come out and work with us and connect and to interface with the youth. And so, they are ready and poised to do it. It's just a matter of being able to deliver on youth being here. And they're kind of fickle sometimes.*

Importantly, data is not collected that could verify September's participation was abnormal and/or related to remote programming. Virtually no data is collected on the PDI activities and programming clients do or do not attend. The one exception being client participation is collected for Life Skills Academy (LSA) classes. The LSA is a distinct program however and was not considered by either ND or ISR staff as a component organized, funded, or directed by the PDI. Alternatively, ND staff explained programming and service data could be gleaned from End-of-Shift (EOS) reports staff completed daily. However, that data was distributed across various e-mails and notes between staff, and was not readily organized or available. Additionally, EOS data often contain identifiable and protected information about clients and ND was not able to provide ISR staff with EOS data by the end of July 2021 for evaluation purposes. In sum, low participation for the month of September 2021 could be the result of an abnormal period of time, but ISR staff could not confirm this was true.

**CONCLUSION 4:** Most PDI services were provided by community partners and, like other PDI services, were informal and unstructured. Despite being unable to directly observe service delivery of either *Sexual Decision-Making* or *NM Workforce Solutions,* the representatives for both programming

ultimately held Q & A services when clients failed to attend. The community partner leading *Sexual Decision-Making* explained they had originally planned a 1-hr activity with youth who RSVP'd, but then improvised an open forum for any interested clients. The *Sexual Decision-Making* service ISR staff attended was also only the second time the programming was offered. Indeed, five of the ten planned service observations were for new programming: *Zine Workshop, Self-Care Group: Your Mask First, Sexual Decision-Making, Dine, Discuss & Discover,* and *Pegasus Legal Aid.* And perhaps because of this*, s*ervices were also sporadic. Notably, the *Self-Care Group: Your Mask First* was cancelled because a ND intern who planned and led the service, decided to intern elsewhere. *Art Therapy* too had been provided for several months, but ceased after September 2021, once the intern providing it completed their educational requirements. To that point, *Art Therapy, Dine, Discuss, & Discover,* as well as *Self-Care Group: Your Mask First* were organized and led by interns and ended once those interns left the PDI. It was therefore unclear whether the ND PDI offered consistent services and activities beyond three basic and broad service categories: basic resources and hygiene products, a safe physical environment, and socialization/community-building exercises.

**CONCLUSION 5:** Finally, ISR staff collected notes during service observations about the presentation of the three Nurtured Heart Approach (NHA) stands. Table 17 (below) summarizes those notes and the Nurtured Heart Approach Checklist in Appendix E documents how notes were taken during observations.

**Table 17. Summary of Service Observations NHA Stand evidence**

| Observation | Number of Youth in PDI | Stand 1 | Stand 2 | Stand 3 |
|---|---|---|---|---|
| 1 | 2 | 1 | 6 | 1 |
| 2 | 3 | 0 | 6 | 0 |
| 3 | 1 | 0 | 0 | 0 |
| 4 | n/a | n/a | n/a | n/a |
| 5 | 0 | n/a | n/a | n/a |
| 6 | 4 | n/a | n/a | n/a |
| 7 | 0 | n/a | n/a | n/a |
| 8 | 1 | 0 | 6 | 0 |
| 9 | 5 | n/a | n/a | n/a |
| 10 | 5 | 6 | 6 | 1 |
| **Average** | **3.0** | **1.4** | **4.8** | **0.4** |
| **Median** | **3.0** | **0.0** | **6.0** | **0.0** |

As Table 17 details, Stand 2 - Reinforcement of positive behaviors – was the most consistently observed feature of the NHA during PDI services. ISR researchers often observed ND staff supporting client interests, help-seeking behavior, planning and goal setting, and positive decision-making. As described earlier, a client during *Crafty Night* identified their struggle to obtain enough food and ND staff reinforced the importance of identifying their own needs and seeking help through food stamps. That feedback was followed by a clear offer to support the client's decision.

Stand 1 – *Clearly identifying negative behaviors and demonstrating calm reactions in response to negative behaviors* – and Stand 3 – *identify expectations and consequences of negative behaviors* – were not consistently observed across services. A score of "0" indicated ISR staff were unable to observe a stand "in action"; a score of 1, however, indicated missed opportunities to evidence an NHA stand. Ultimately, ISR staff observed two instances of Stand 1 and 3 in action. One clear instance occurred during *Crafty Night* where a client repeatedly interrupted and swore while a second client described

their situation to ND staff. ND staff were calm and limited attention to the client's behavior, but also did not clearly identify the behavior as negative, nor outline any consequences. For that reason, ISR staff scored both Stand 1 and 3 as evidenced "*Rarely, less than 10% of opportunities*." The only other observed instance of Stand 1 and 3 occurred while observing *Pegasus Legal Aid*. A client entered *The Space* claiming another drop-in had stolen their phone. That client began yelling, swearing, and acting aggressively toward the other youth. ND staff quickly and calmly intervened, and explained if the youth wanted to remain in the center they would have to be calm and respect other clients in *The Space.* Another client sitting in the common area also calmly reinforced staff's explanation of PDI rules. While the disaffected youth unhappily left the PDI, ISR researchers did conclude it was clearly emblematic of the NHA's first and third stands. Altogether though, stand 1 and 3 were infrequently observed by ISR.

## Outcomes

Outcomes were the *least* evident aspect of ND processes in *The Space*. As described earlier, the process and logic maps identified very broad goals and objectives. While ISR observations did not openly contradict identified outcomes in the process map, very little could be confirmed. Some identified outcomes like "*personal success as defined by client*" or "*better understanding of self & strengths*" were not easily observed. However, two other outcomes – (1) *Referral to Internal or External Organizations* and (2) *Creating connections with other youth to foster support & community* – were possible to assess in service observations. We did *not* observe the second outcome in action, and in fact, our limited observations suggest low participation could ultimately limit ND's ability to foster support and community between youth. With that said, our observation of *Want to be in TLP?* was the clearest example of the first outcome, as well as structured and purposeful programming with a measurable outcome – clients were given hardcopies of a TLP application and encouraged to submit as soon as possible. ISR could clearly observe clients completing the application during the service, although it was not evident if clients eventually submitted them. What is more, submission of TLP applications is not captured within PDI client data.

Finally, ISR discussions and interviews with staff revealed identified outcomes were somewhat artificial. When ISR asked ND staff about how clients formally leave the PDI, staff explained no formal conditions existed. Broadly, clients leave when they stop returning to the PDI. New Day (ND) staff members explained:

> *I would say that the only way that they formally leave is if they were moving out of this state or city. We've had a few young people move entirely out of the city or the state. That's the strange thing about it, right? I feel like if-- there's not really an enrollment process in the sense there's not an end date. You can come whenever. And we haven't had to have the opportunity-- or we haven't had the opportunity, thankfully, that someone had to be permanently removed and that they just couldn't come back.*
>
> -ND Staff #1

*We don't really have a completed program when-- I mean, they would kind of age out. We do have the age range of 16 to 22, but if there have been youth-- there have been youth who started coming when they are 21. They've just been in and out of systems all through the while they're 22. And so, we have maybe one 23-year-old that's still using some services. But yeah, other than that, there's not really any way to kind of graduate the drop-in center. We're just kind of like-- we're just here whenever they need us.*

-ND Staff #2

*Basically, [clients participate] till they age out. Yeah. And then, some of them will say like-- again, if it's moving-- it's usually outside circumstances.*

-ND Staff #3

In sum, as long as a client meets age criteria, clients can easily return and continue using the PDI. While ease of access is a primary feature of the drop-in center model, the absence of formal and structured programming, or systematic data collection made it unclear what meaningful outcomes could confidently be attributed to ND programming.

## Discussion

Overall, ISR could confirm the ND PDI has documented over 2,400 clients since 2018 and that those clients reflect a diverse demographic in terms of sexual orientation, race, ethnicity, and disability. A small percentage (approximately 5%) of documented clients were outside ND's declared age criteria and ND staff explained this occurred infrequently under special circumstances. Still, it is worth noting that current sign-in data suggested ND's PDI supports clients between 13 and 23 years of age – as opposed to the official criteria of 16 – 22. ND may want to modify age criteria if they faithfully serve a wider client-base.

Client data suggested that despite operating for over 31-months, more than 50% of clients were supported in the most recent 8-months. Informal conversations with staff revealed ND was asked to leave their former PDI at the Wells Park Community Center in the Spring of 2020. ISR therefore asked ND to submit a timeline of PDI operations (Appendix G), revealing three important events that impacted their PDI program:

- ND lacked a physical space for a PDI program between April 2020 and November 2020
- ND purchased a new building in December 2020 to operate the PDI
- ND's PDI was formally under construction between December 2020 and July 2021

Based on this, ISR concluded ND operated three distinct programs between 2018 and 2021:

1. The PDI at Wells Park Community Center
2. The "Pop-Up Drop-In Center"
3. *The Space* at 142 Truman St. NE

Significant differences existed between each PDI program. For example, for 7-months in 2020 ND lacked a physical center and instead operated a street outreach program they called a "Pop-Up Drop-In Center". The pop-up drop-in center described a model in which ND staff drove to public spaces where clients could gather, and ND would provide resources, help, and activities. Important features were

markedly different though, especially the chief component of ND's PDI, a "*Safe Space*." From April to November of 2020, that critical feature was effectively absent until ND obtained a physical space to operate the PDI. Additionally, informal conversations indicated ND implemented a formal restructure of their program in July 2020. The restructure integrated two new roles: (1) a Community Connection Director, and (2) a Street Outreach/Drop-In Center Program Manager. Those roles consolidated direction of ND's Street Outreach and Drop-In Center programs under one roof. Lastly, the partnerships, staff, and physical space were significantly different at *The Space,* compared to the PDI at the Wells Park Community Center-- a fact confirmed by ND staff who differentiated the 2019 logic model from the one they ultimately submitted in the present process evaluation.

ISR's ability to evaluate the ND PDI across PDI programs was significantly limited by program changes over time. Client data across all periods was limited to available electronic records – data effectively capturing drop-ins, client demographics, and limited client information on need. This also meant service observations and interviews with staff could only be attributed to the PDI at 142 Truman St. occurring after July 2021. Therefore, ISR interviews and observations qualitatively explored the most recent PDI processes.

Five general conclusions were made about the ND PDI based on service observations and interviews:

1. ND PDI processes are overwhelmingly unstructured and informal, with the exception of TLP presentations
2. Informal interactions between clients and ND staff did elicit meaningful client needs and avenues for positive change
3. Client attendance was low during the observation period; ISR could not verify whether this was abnormal
4. PDI programming is primarily organized and led by community partners and ND interns
5. The Nurtured Heart Approach (NHA) was practiced by ND staff, but two NHA stands were infrequently observed

Perhaps most importantly, observations and interviews revealed ND's PDI has yet to realize a peer support component in programming/services. Rather than a Peer Drop-In Center, ND presently operates a drop-in center more similarly organized to a community center. To emphasize this point, a 2016 strategic plan drafted by Seattle Parks and Recreation outlined guiding principles of their community center that included: (1) Meet the needs of a changing community, (2) Promote social equity, and (3) Ensure safety, cleanliness, and accessibility – principles in alignment with the primary directives of the ND PDI. Additionally, Seattle Parks and Recreation described their community center program model as offering "*a variety of recreational and lifelong learning programs, classes, and activities*" (2016:16). With the exception of community partner programming and TLP presentations, ND's PDI overwhelmingly offers recreational services and activities like: Yoga, Karaoke Night, Puzzling, Boxing, Crafty Night, Movie Night, etc. While ND staff assist clients with internal and external referrals, ISR did not have the opportunity to observe this feature and Apricot data on referrals were not available for review. Ultimately, in ISR's view, ND PDI programming has yet to focus on features beyond recreational or socialization activities, or clearly implement youth peer support workers which would meet the purpose of the BHI funding for Peer Drop-In Centers – peer support.

Finally, it is important to emphasize limited client data suggest ND ultimately reaches a somewhat diverse client-base. Some clients also drop-in at *The Space* often, with forty-seven documented clients

having visited the center 10 or more times—and three clients visited 90 or more times. ND's PDI has also recently begun to serve as a hub for other ND programs and services—like with TLP, Wrap-Around, or Street Outreach. With that said, each of those are unique programs that should be considered separate from the PDI. Currently, fuzziness exists around what ND considers PDI services and programs. For example, if a Wrap-Around coordinator consistently meets with clients at the PDI, does that count as work performed by the center, work by Wrap-Around, or both? And when Street Outreach coordinators pick-up disadvantaged youth on the street and take them to the PDI, where does one program begin and the other end?

In conclusion, we outline several recommendations that ISR hopes will improve the ND PDI program and offer a path towards more robust evaluation in the future. Presently, however, significant program disruptions, a dearth of key program data, ill-defined processes and program structure, and the absence of peer support workers prohibitively undermine any immediate outcome evaluation. We therefore recommend the following:

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## Recommendations

| | |
|---|---|
| Incorporate Peer Support Workers into PDI | Create pathways for current and/or former clients to become peer support workers. This would bring the ND PDI in alignment with the literature on peer support work and SAMHSA guidelines on Peer Drop-in Centers. |
| Create Formal Processes and Procedures | ND's programming and services are generally ad hoc and would benefit from greater structure and organization. The PDI should establish class and activity curriculums – this would offer consistency in service delivery and allow clients to expect common standards in support. |
| Improve delivery of 4th Visit Engagement Form | ND's engagement form is vital for assessing client need. Currently, ND has systematically assessed need for less than one-third of clients. Need assessment can and should be extended beyond informal conversations/interactions. |
| Collect Programming/Service Data | Client participation in ND programming and services should systematically be collected. Ideally, this would include duration of client participation and activity type. Importantly, this information is collected for LSA classes and could easily be extended to the PDI. |
| Refine Logic Maps | ND's logic map should answer specific questions: (1) What specific (measurable) ways are clients expected to change by participating at the PDI? And (2), in what ways do resources, services, and programming *effect* that client change? |

| | |
|---|---|
| Implement “Backward Design” philosophy | ISR recommends that in tandem with refining their logic model, ND should implement “backward design” planning—this educational model of curriculum development identifies measurable end goals/objectives, and works backwards so activities, resources, and education support identified goals/objectives. This type of planning would help to ensure ND PDI programming and services are clearly connected to proposed client change. Additionally, it would help identify measurable outcomes. |
| Collect Data on Measurable Outcomes | ND’s program would benefit from clear and measurable outcomes. ND identified *connections with other youth* and *client referrals* in their process map which are measurable outcomes that ND does not collect data for. ISR recommends collecting systematic data on those features. |
| Establish Recurring Programming | ND programming directly provided by the PDI tended to be transient and dependent on what ND interns were capable of offering. This meant that services like *Art Therapy,* Dine, Discuss, & Discover, and Self-Care Group, were suspended once interns left the PDI. Establishing curriculums and formal procedures/processes for ND programming would help provide a consistent experience for all PDI clients. |
| Identify and Implement Evidence-Based Practice | As outlined earlier, ND’s identified EBPs are not evidenced-based. With that said, Motivational Interviewing (MI) and Peer Support are established EBPs. Importantly, ND should identify and implement an EBP, and develop an implementation blueprint to identify how EBPs are integrated into the PDI (Powell et al. 2015). |
| Update Client Age Criteria to Receive Support | ISR documented client recipients outside the declared 16 -22 restrictions described in the formalized Process Map. This information should be updated to reflect current practice, or develop processes that more clearly differentiate between PDI clients and external program clients. |
| Maintain Outreach Efforts | Finally, electronic data suggested ND reaches a diverse and robust client base and therefore should sustain that program strength. |

# CONCLUSION

Bernalillo County, through the Behavioral Health Initiative (BHI), supports two different Peer Drop-In Centers (PDI). ACHR intentionally supports adults 18 and older, and ND aims to support youth between 16 and 22. However, only one PDI contains a peer support element – ACHR. ACHR has established and sustained a peer drop-in center and clearly evidenced the majority of core competencies outlined by the SAMHSA. Additionally, ACHR is the nearest of the PDIs to becoming evaluable. ACHR's ASSM and data collection on client service participation would be satisfactory starting points for conducting a limited outcome evaluation, provided ACHR improve (1) administration of ASSM and (2) service data collection. Especially important, no standard procedures/curriculums appear to be established or followed, with the exception of two programs that ostensibly fall outside the PDI: UNM Pathways and Ticket to Work. Clear policies and procedures should therefore also be established prior to any future outcome evaluation.

In regards to ND, their PDI has yet to establish a peer support component and services in general reflect informal activities focused on building relationships and community with youth. Still, that endeavor did not appear to be systematic or function according to a standard model of support. Limited observations suggested the presence of an evidence-*informed* youth change strategy, the Nurtured Heart Approach (NHA). Importantly, only one of the NHA stands was demonstrated frequently and two of the three NHA stands were infrequently observed. Observations also suggested meaningful identification of client need did occur through informal conversations in the course of services and activities. But broadly, ND services and activities lacked systematic or standard processes. Data collection on service provision and short-term goals or outcomes was also entirely absent. To that point, identified outcomes were equally broad which left confusion about what specific goals and objectives ND hoped to achieve with clients. Despite that, ISR did observe frequent provision of basic resources like food, water, shelter, and computers. Additionally, youth were afforded many socialization opportunities and access to positive role models eager to offer help and support. With that said, those resources were provided on an ad hoc basis, and ND staff often candidly described improvising documented policies and procedures as they responded to problematic situations. Ultimately, these features limited the scope and ability of ISR to conduct an evaluation of processes.

ISR has suggested for each PDI a set of recommendations which we hope will prepare PDIs for an outcome evaluation in the future. Bernalillo County performance measures for PDIs could meaningfully support improvement by establishing reporting requirements that reflect intended changes. Specifically, while Bernalillo County performance measures capture client demographics, sign-ins, and a handful of outcomes, they do not capture other specific resources PDIs clearly support clients with: food, water, computer access, etc. For example, Bernalillo County collects performance measures on ACHR peer support hours, but *not* hours of support for *specific services*. A2A is a clear exception where ACHR reports hours of A2A classes, number of 8-week classes, and A2A graduates. However, both A2A and job outcomes are reported by ACHR in performance measures, but are not systematically collected in electronic records.

For the ND PDI, performance measures include reporting on the number of services provided, new and returning youth, number of referrals, and youth participation. Perhaps better performance metrics would capture instead the specific services ND *consistently* offers youth, the number of hours of support in those specific services, and the amount and type of referrals to which youth were successfully

connected. Ultimately, improved alignment of PDI data collection and Bernalillo County performance measures could offer a productive strategy for preparing PDIs for outcome evaluation.

Finally, ISR would like to emphasize the present process evaluation should be used to *improve* PDI processes. Evaluation is intended to identify which aspects of programs are most effective and which need refining. Evaluation should also be considered a single part of an iterative assessment; one that does not end here. We sincerely hope that Bernalillo County, and the PDIs at New Day and Albuquerque Center for Hope & Recovery find the present report useful and constructive.

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# APPENDIX A

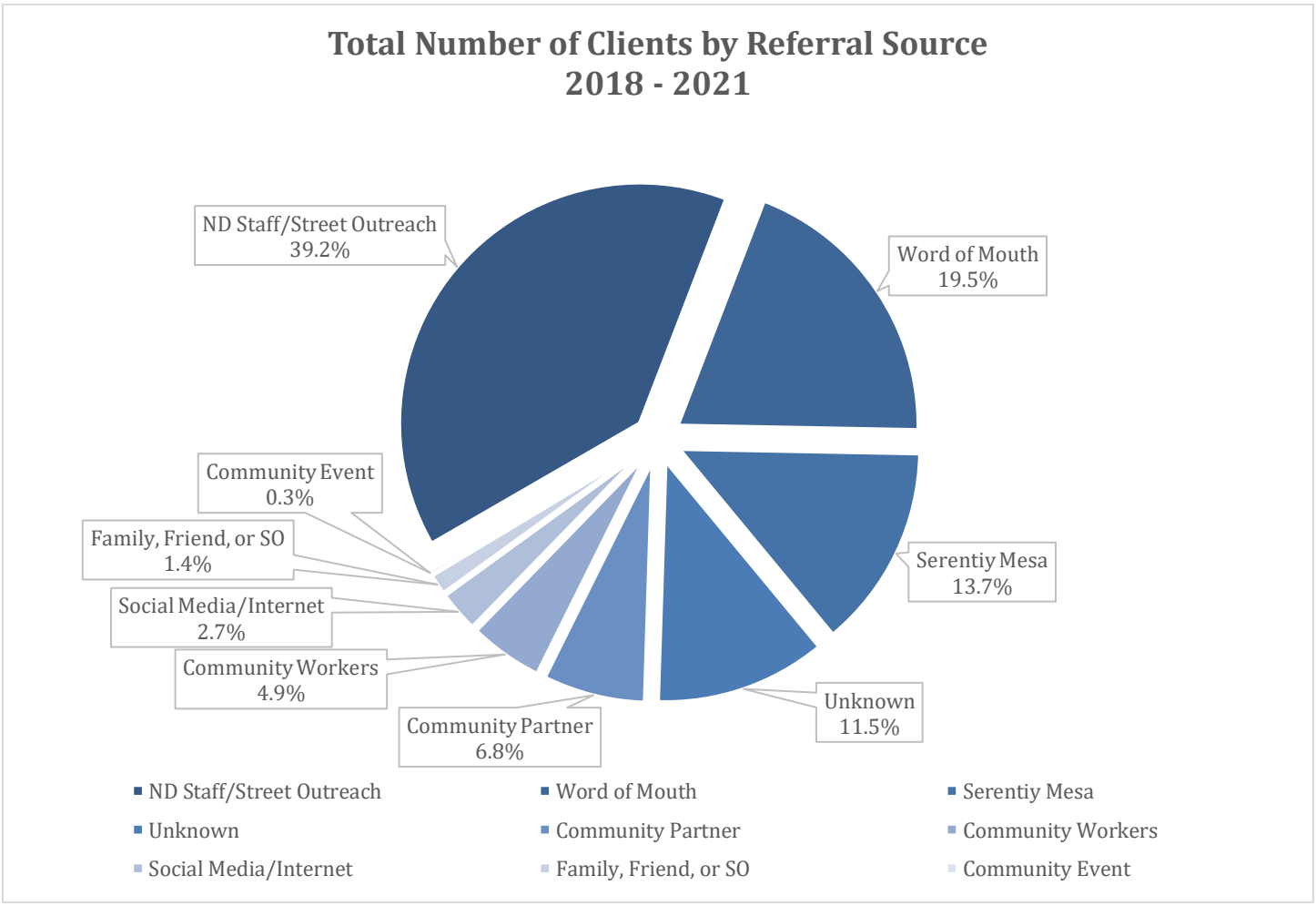



*Figure 11- Pie Chart of ND PDI Referral Sources*

**Table 17. ND PDI Referral Sources – Cumulative Percent over time (2018 -2021).**

| Date | ND Staff/ Street Outreach | Word of Mouth | School | Serenity Mesa | Community Partner | Community Worker | Social Media/Internet | Family, Friends, or SO | Community Event | Unknown | All Referrals |
|---|---|---|---|---|---|---|---|---|---|---|---|
| December-18 | 5.3% | 4.4% | 14.6% | 0.0% | 4.2% | 5.6% | 0.0% | 0.0% | 0.0% | 0.0% | 5.3% |
| January-19 | 5.3% | 7.4% | 14.6% | 0.0% | 8.3% | 11.1% | 11.1% | 0.0% | 0.0% | 0.0% | 6.8% |
| February-19 | 7.9% | 13.2% | 14.6% | 0.0% | 8.3% | 16.7% | 11.1% | 0.0% | 0.0% | 0.0% | 9.1% |
| March-19 | 14.9% | 16.2% | 35.4% | 12.5% | 8.3% | 33.3% | 22.2% | 0.0% | 0.0% | 0.0% | 17.6% |
| April-19 | 17.5% | 20.6% | 52.1% | 12.5% | 12.5% | 61.1% | 22.2% | 0.0% | 0.0% | 0.0% | 23.5% |
| May-19 | 21.1% | 23.5% | 75.0% | 12.5% | 16.7% | 61.1% | 22.2% | 0.0% | 0.0% | 0.0% | 29.1% |
| June-19 | 22.8% | 32.4% | 75.0% | 12.5% | 16.7% | 66.7% | 22.2% | 0.0% | 0.0% | 0.0% | 31.8% |
| July-19 | 23.7% | 33.8% | 75.0% | 15.0% | 16.7% | 66.7% | 22.2% | 0.0% | 0.0% | 0.0% | 32.6% |
| August-19 | 24.6% | 35.3% | 75.0% | 15.0% | 25.0% | 66.7% | 22.2% | 0.0% | 0.0% | 0.0% | 33.8% |
| September-19 | 24.6% | 35.3% | 77.1% | 22.5% | 29.2% | 66.7% | 22.2% | 0.0% | 0.0% | 0.0% | 35.3% |
| October-19 | 25.4% | 39.7% | 79.2% | 25.0% | 29.2% | 72.2% | 22.2% | 0.0% | 0.0% | 100.0% | 37.9% |
| November-19 | 27.2% | 39.7% | 81.3% | 25.0% | 29.2% | 72.2% | 22.2% | 0.0% | 100.0% | 100.0% | 39.1% |
| December-19 | 30.7% | 41.2% | 85.4% | 25.0% | 29.2% | 77.8% | 33.3% | 0.0% | 100.0% | 100.0% | 42.6% |
| January-20 | 30.7% | 41.2% | 85.4% | 25.0% | 29.2% | 77.8% | 33.3% | 0.0% | 100.0% | 100.0% | 42.6% |
| February-20 | 30.7% | 41.2% | 85.4% | 25.0% | 29.2% | 77.8% | 33.3% | 0.0% | 100.0% | 100.0% | 42.6% |
| March-20 | 30.7% | 41.2% | 85.4% | 25.0% | 29.2% | 77.8% | 33.3% | 0.0% | 100.0% | 100.0% | 42.6% |
| April-20 | 30.7% | 41.2% | 85.4% | 25.0% | 29.2% | 77.8% | 33.3% | 0.0% | 100.0% | 100.0% | 42.6% |
| May-20 | 30.7% | 41.2% | 85.4% | 25.0% | 29.2% | 77.8% | 33.3% | 0.0% | 100.0% | 100.0% | 42.6% |
| June-20 | 30.7% | 41.2% | 85.4% | 25.0% | 29.2% | 77.8% | 33.3% | 0.0% | 100.0% | 100.0% | 42.6% |
| July-20 | 37.7% | 48.5% | 85.4% | 27.5% | 37.5% | 77.8% | 33.3% | 25.0% | 100.0% | 100.0% | 47.9% |
| August-20 | 37.7% | 55.9% | 85.4% | 30.0% | 41.7% | 77.8% | 33.3% | 25.0% | 100.0% | 100.0% | 50.3% |
| September-20 | 42.1% | 57.4% | 85.4% | 32.5% | 41.7% | 83.3% | 44.4% | 50.0% | 100.0% | 100.0% | 53.2% |
| October-20 | 43.0% | 58.8% | 85.4% | 32.5% | 54.2% | 83.3% | 44.4% | 50.0% | 100.0% | 100.0% | 54.7% |
| November-20 | 43.0% | 60.3% | 85.4% | 37.5% | 54.2% | 88.9% | 44.4% | 50.0% | 100.0% | 100.0% | 55.9% |
| December-20 | 51.8% | 61.8% | 85.4% | 45.0% | 91.7% | 88.9% | 44.4% | 50.0% | 100.0% | 100.0% | 62.6% |
| January-21 | 57.9% | 66.2% | 87.5% | 50.0% | 91.7% | 88.9% | 44.4% | 100.0% | 100.0% | 100.0% | 67.1% |
| February-21 | 63.2% | 69.1% | 87.5% | 50.0% | 91.7% | 88.9% | 44.4% | 100.0% | 100.0% | 100.0% | 69.4% |
| March-21 | 64.9% | 70.6% | 87.5% | 50.0% | 91.7% | 94.4% | 44.4% | 100.0% | 100.0% | 100.0% | 70.6% |
| April-21 | 81.6% | 73.5% | 87.5% | 80.0% | 95.8% | 100.0% | 88.9% | 100.0% | 100.0% | 100.0% | 82.4% |
| May-21 | 87.7% | 82.4% | 97.9% | 90.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 90.0% |
| June-21 | 97.4% | 97.1% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 98.2% |
| July-21 | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |

Source: New Day Apricot Social Solutions records (2021).

**Table 18. Summary of ND PDI Client Demographics**

| Characteristic | Count | Percent (%) |
|---|---|---|
| **SEXUAL ORIENTATION:** | | |
| Straight | 199 | 61.0% |
| LGBTQIA+ | 127 | 39.0% |
| **TOTAL** | **326** | **100.0%** |
| **GENDER IDENTITY:** | | |
| Male | 188 | 47.6% |
| Female | 169 | 42.8% |
| Transgender | 29 | 7.3% |
| Gender Non-Conforming | 9 | 2.3% |
| **TOTAL** | **395** | **100.0%** |
| **RACE:** | | |
| White | 171 | 53.4% |
| American Indian, Alaskan Native, or Native Hawaiian | 78 | 24.4% |
| Asian | 16 | 5.0% |
| Black or African American | 55 | 17.2% |
| **TOTAL** | **320** | **100.0%** |
| **LAST YEAR OF SCHOOL ATTENDED:** | | |
| Grade 10 or less | 140 | 56.0% |
| Grade 11 | 16 | 6.4% |
| Grade 12/GED | 71 | 28.4% |
| College/Trade School | 23 | 9.2% |
| **TOTAL** | **250** | **100.0%** |
| **MEAN** | **10.6** | |
| **ETHNICITY:** | | |
| Non-Hispanic/Non-Latinx | 127 | 36.1% |
| Hispanic/Latinx | 225 | 63.9% |
| **TOTAL** | **352** | **100.0%** |
| **HAS DISABILITY:** | | |
| Yes | 100 | 45.0% |
| No | 122 | 55.0% |
| **TOTAL** | **222** | **100.0%** |
| **TRIBAL AFFILIATION** | | |
| Yes | 41 | 17.4% |
| No | 194 | 82.6% |
| **TOTAL** | **235** | **100.0%** |
| **PRIMARY LANGUAGE:** | | |
| English | 371 | 93.9% |
| Spanish | 18 | 4.6% |
| Other language | 6 | 1.5% |
| **TOTAL** | **395** | **100.0%** |
| **IMMIGRANT STATUS:** | | |
| U.S. Citizen | 264 | 97.1% |
| Immigrant, Refugee, or Asylum Seeker | 8 | 2.9% |
| **TOTAL** | **272** | **100.0%** |
| **PROTECTIVE SERVICES INVOLVEMENT:** | | |
| Currently in Custody or Was Previously | 107 | 27.6% |
| Not in Custody | 280 | 72.4% |
| **TOTAL** | **387** | **100.0%** |
| **JUVENILE JUSTICE INVOLVEMENT:** | | |
| Involved | 63 | 19.3% |
| Not Involved | 263 | 80.7% |
| **TOTAL** | 326 | 100.0% |

Source: Apricot Data Solutions records (2021).

# APPENDIX B

**Table 19. Summary of ACHR Client Demographics by Year**

| | Year 1 | Year 2 | Year 3 | All Years |
|---|---|---|---|---|
| **GENDER:** | | | | |
| Male | 75.6% | 69.3% | 69.2% | 62.9% |
| Female | 23.1% | 28.7% | 25.6% | 36.8% |
| Non-Binary | 1.3% | 2.0% | 2.6% | 0.3% |
| **TOTAL** | **100.0%** | **100.0%** | **100.0%** | **100.0%** |
| **MISSING** | **6.0%** | **0.0%** | **2.5%** | **18.5%** |
| **ETHNICITY:** | | | | |
| Non-Hispanic/Non-Latino | 49.4% | 45.5% | 53.8% | 48.6% |
| Hispanic/Latino | 49.4% | 47.5% | 41.0% | 51.4% |
| **TOTAL** | **100.0%** | **100.0%** | **100.0%** | **100.0%** |
| **MISSING** | **8.3%** | **6.5%** | **4.9%** | **27.6%** |
| **RACE:** | | | | |
| White | 65.8% | 44.6% | *51.3%* | 47.7% |
| African American | 3.9% | 14.9% | 12.8% | 7.9% |
| Asian | 0.0% | 0.0% | 0.0% | 0.5% |
| Multi-Racial | 2.6% | 5.0% | 2.6% | 5.1% |
| Native American/Alaskan Native | 7.9% | 8.9% | 15.4% | 12.6% |
| Other | 15.8% | 18.8% | 0.0% | 26.2% |
| **TOTAL** | **100.0%** | **100.0%** | **100.0%** | **100.0%** |
| **MISSING** | **11.6%** | **7.3%** | **15.2%** | **29.0%** |
| **CLIENT AGE:** | | | | |
| 12 - 18 | 1.4% | 2.0% | 0.0% | 1.7% |
| 18 - 24 | 4.1% | 8.9% | 0.0% | 13.0% |
| 25 - 44 | 60.8% | 52.5% | 61.5% | 50.4% |
| 45 - 64 | 33.8% | 32.7% | 35.9% | 32.7% |
| 65+ | 0.0% | 4.0% | 2.6% | 2.2% |
| **TOTAL** | **100.0%** | **100.0%** | **100.0%** | **100.0%** |
| **MISSING** | **10.8%** | **0.0%** | **0.0%** | **24.9%** |
| **CLIENT ANNUAL INCOME:** | | | | |
| 0$ | 83.8% | 72.3% | 56.4% | 69.6% |
| More than $10,000 | 12.2% | 22.8% | *25.6%* | 25.7% |
| Less than $20,000 | 2.7% | 5.0% | *15.4%* | 4.8% |
| **TOTAL** | **100.0%** | **100.0%** | **100.0%** | **100.0%** |
| **MISSING** | **11.9%** | **0.0%** | **2.5%** | **25.6%** |
| **CLIENT EMPLOYMENT STATUS:** | | | | |
| Not Employed | 86.5% | 84.2% | 61.5% | 82.3% |
| Full-Time Employment | 5.4% | 7.9% | *25.6%* | 9.3% |
| Part-Time Employment | 5.4% | 6.9% | 10.3% | 8.3% |
| **TOTAL** | **100.0%** | **100.0%** | **100.0%** | **100.0%** |
| **MISSING** | **12.9%** | **1.0%** | **2.5%** | **26.5%** |
| **NUMBER OF CHILDREN:** | | | | |
| 0 | 81.5% | 79.8% | 86.5% | 76.1% |
| 1 | 9.2% | 12.1% | 8.1% | 9.7% |
| 2 | 3.1% | 2.0% | 5.4% | 6.7% |
| 3 | 0.0% | 1.0% | 0.0% | 3.9% |
| 4 | 1.5% | 1.0% | 0.0% | 1.5% |
| 5 | 0.0% | 3.0% | 0.0% | 0.9% |
| 6 | 4.6% | 0.0% | 0.0% | 1.1% |
| **TOTAL** | **100.0%** | **100.0%** | **100.0%** | **100.0%** |
| **MISSING** | **21.7%** | **2.9%** | **5.1%** | **56.9%** |
| **INSURANCE:** | | | | |
| Medicare | 0.0% | 4.2% | 0.0% | 1.4% |
| Medicaid | 41.8% | 13.5% | 2.7% | 18.3% |
| Uninsured | 56.7% | 82.3% | *97.3%* | 80.2% |
| **TOTAL** | **100.0%** | **100.0%** | **100.0%** | **100.0%** |
| **MISSING** | **20.2%** | **5.0%** | **5.1%** | **77.6%** |

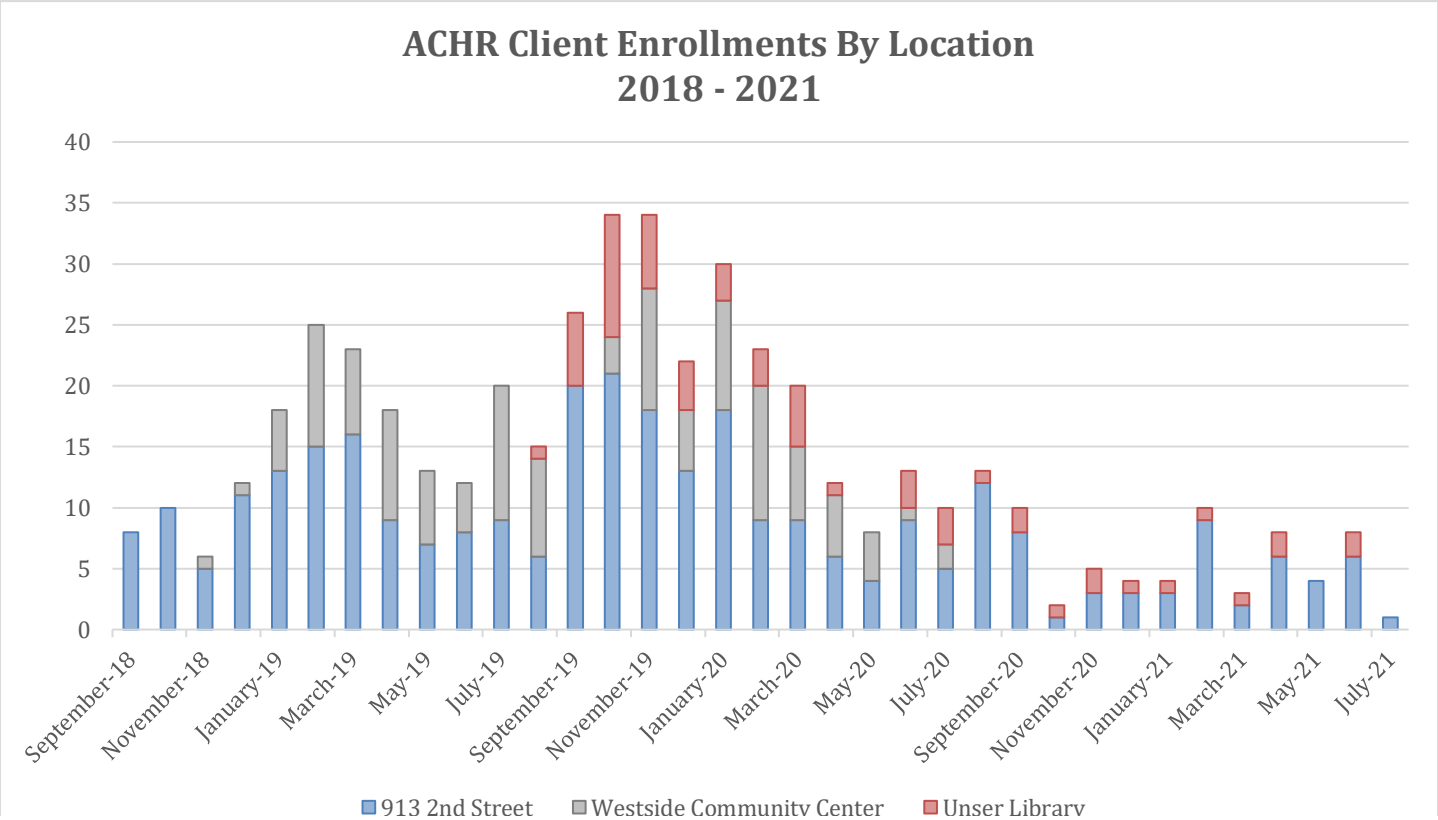



*Figure 12 - ACHR Monthly Client Enrollments*

**Table 20. Summary of ACHR Services by Year**

| | All Years | | Year 1 | | Year 2 | | Year 3 | |
|---|---|---|---|---|---|---|---|---|
| Service | Count | Percent (%) | Count | Percent (%) | Count | Percent (%) | Count | Percent (%) |
| 4 AGREEMENTS | 162 | 2.1% | 137 | 5.0% | 19 | 0.6% | 6 | 0.3% |
| AA/CA/NA | 2 | 0.0% | 0 | 0.0% | 2 | 0.1% | 0 | 0.0% |
| ADDICTS 2 ATHLETES | 4,375 | 57.7% | 1,435 | 52.1% | 1,871 | 60.7% | 1,069 | 61.4% |
| ANGER MANAGEMENT | 168 | 2.2% | 123 | 4.5% | 45 | 1.5% | 0 | 0.0% |
| ANXIETY | 154 | 2.0% | 80 | 2.9% | 74 | 2.4% | 0 | 0.0% |
| ART EMPOWERMENT | 250 | 3.3% | 172 | 6.2% | 69 | 2.2% | 9 | 0.5% |
| BOOK CLUB | 11 | 0.1% | 0 | 0.0% | 11 | 0.4% | 0 | 0.0% |
| BUS PASS | 2 | 0.0% | 0 | 0.0% | 2 | 0.1% | 0 | 0.0% |
| JOB DEVELOPMENT | 372 | 4.9% | 92 | 3.3% | 165 | 5.4% | 115 | 6.6% |
| CHOICE RECOVERY | 26 | 0.3% | 14 | 0.5% | 6 | 0.2% | 6 | 0.3% |
| DIFFICULTIES AND SUCCESSES | 1 | 0.0% | 0 | 0.0% | 0 | 0.0% | 1 | 0.1% |
| TICKET TO WORK | 8 | 0.1% | 8 | 0.3% | 0 | 0.0% | 0 | 0.0% |
| FORGIVENESS | 2 | 0.0% | 0 | 0.0% | 2 | 0.1% | 0 | 0.0% |
| GAME GROUP | 2 | 0.0% | 0 | 0.0% | 0 | 0.0% | 2 | 0.1% |
| GENERAL SERVICES | 279 | 3.7% | 11 | 0.4% | 130 | 4.2% | 138 | 7.9% |
| GETTING AHEAD | 9 | 0.1% | 0 | 0.0% | 9 | 0.3% | 0 | 0.0% |
| GOALS | 5 | 0.1% | 1 | 0.0% | 4 | 0.1% | 0 | 0.0% |
| HAIR CUT | 4 | 0.1% | 4 | 0.1% | 0 | 0.0% | 0 | 0.0% |
| HEALTH EDUCATION (COVID-19) | 2 | 0.0% | 0 | 0.0% | 2 | 0.1% | 0 | 0.0% |
| HEALTHY RELATIONSHIPS | 2 | 0.0% | 0 | 0.0% | 2 | 0.1% | 0 | 0.0% |
| HOPE REWIRED | 5 | 0.1% | 0 | 0.0% | 5 | 0.2% | 0 | 0.0% |
| ORIENTATION | 147 | 1.9% | 67 | 2.4% | 79 | 2.6% | 1 | 0.1% |
| JOURNALING | 4 | 0.1% | 4 | 0.1% | 0 | 0.0% | 0 | 0.0% |
| LIFE SKILLS | 128 | 1.7% | 102 | 3.7% | 26 | 0.8% | 0 | 0.0% |
| UNDER SUPERVISION | 4 | 0.1% | 0 | 0.0% | 4 | 0.1% | 0 | 0.0% |
| LIVING UNDER SUPERVISON | 1 | 0.0% | 0 | 0.0% | 1 | 0.0% | 0 | 0.0% |
| PEER SUPPORT GROUP | 409 | 5.4% | 212 | 7.7% | 150 | 4.9% | 47 | 2.7% |
| PANCAKE BREAKFAST | 17 | 0.2% | 17 | 0.6% | 0 | 0.0% | 0 | 0.0% |
| PARENTING | 68 | 0.9% | 22 | 0.8% | 18 | 0.6% | 28 | 1.6% |
| PEER SUPPORT COUNSELING | 652 | 8.6% | 90 | 3.3% | 305 | 9.9% | 257 | 14.8% |
| RECOVERY WITH WORDS | 2 | 0.0% | 2 | 0.1% | 0 | 0.0% | 0 | 0.0% |
| REMIX | 50 | 0.7% | 37 | 1.3% | 13 | 0.4% | 0 | 0.0% |
| SELF CARE | 12 | 0.2% | 3 | 0.1% | 2 | 0.1% | 7 | 0.4% |
| SINGLENESS OF PURPOSE | 9 | 0.1% | 0 | 0.0% | 0 | 0.0% | 9 | 0.5% |
| SMART | 70 | 0.9% | 70 | 2.5% | 0 | 0.0% | 0 | 0.0% |
| SUCCESSES & DIFFICULTIES | 2 | 0.0% | 0 | 0.0% | 0 | 0.0% | 2 | 0.1% |
| TELEMEDICINE MEETING | 1 | 0.0% | 0 | 0.0% | 1 | 0.0% | 0 | 0.0% |
| UNM PATHWAYS | 94 | 1.2% | 6 | 0.2% | 45 | 1.5% | 43 | 2.5% |
| VIRTUAL COFFEE | 22 | 0.3% | 0 | 0.0% | 22 | 0.7% | 0 | 0.0% |
| WEEKLY RECAP | 5 | 0.1% | 5 | 0.2% | 0 | 0.0% | 0 | 0.0% |
| WOMENS GROUP | 2 | 0.0% | 2 | 0.1% | 0 | 0.0% | 0 | 0.0% |
| YOGA | 37 | 0.5% | 37 | 1.3% | 0 | 0.0% | 0 | 0.0% |
| **Total** | **7,577** | **100.0%** | **2,753** | **100.0%** | **3,084** | **100.0%** | **1,740** | **100.0%** |

**Table 21. Total Number of Minutes Clients Spent Receiving ACHR Services**

| | Peer Support Counseling | | Peer Support Group | | General Services | | Job Development | | Clinical Services | | Ticket to Work | | Orientation | | UNM Pathways | | Addicts 2 Athletes | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Minutes | Count | Percent | Count | Percent | Count | Percent | Count | Percent | Count | Percent | Count | Percent | Count | Percent | Count | Percent | Count | Percent |
| 5 - 60 | 31 | 33.0% | 64 | 74.4% | 53 | 50.0% | 45 | 50.0% | 1 | 100.0% | 0 | 0.0% | 9 | 45.0% | 22 | 53.7% | 9 | 13.6% |
| 61 - 120 | 28 | 29.8% | 17 | 19.8% | 20 | 18.9% | 20 | 22.2% | 0 | 0.0% | 0 | 0.0% | 11 | 55.0% | 9 | 22.0% | 15 | 22.7% |
| 121 - 240 | 15 | 16.0% | 5 | 5.8% | 20 | 18.9% | 14 | 15.6% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 5 | 12.2% | 3 | 4.5% |
| 241 - 480 | 5 | 5.3% | 0 | 0.0% | 6 | 5.7% | 4 | 4.4% | 0 | 0.0% | 1 | 100.0% | 0 | 0.0% | 3 | 7.3% | 6 | 9.1% |
| 481 - 960 | 6 | 6.4% | 0 | 0.0% | 5 | 4.7% | 4 | 4.4% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 2 | 4.9% | 5 | 7.6% |
| >960 | 9 | 9.6% | 0 | 0.0% | 2 | 1.9% | 3 | 3.3% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 28 | 42.4% |
| **TOTAL** | **94** | **100.0%** | **86** | **100.0%** | **106** | **100.0%** | **90** | **100.0%** | **1** | **100.0%** | **1** | **100.0%** | **20** | **100.0%** | **41** | **100.0%** | **66** | **100.0%** |
| **MISSING** | **607** | **86.6%** | **615** | **87.7%** | **595** | **84.9%** | **611** | **87.2%** | **700** | **99.9%** | **700** | **99.9%** | **681** | **97.1%** | **660** | **94.2%** | **635** | **90.6%** |

# APPENDIX C

## ND Apricot Data Request – 6/25/2021

**DC ENGAGEMENT FORM**

- Date
- Service Site
- What Brings you Here?
- Do you Need Help with:
- Do you feel safe in your current situation? (SDOH)
- Are you experiencing Homelessness or worried you might be soon? (SDOH)
- What is your current living situation?
- How did you hear about us?

**CLIENT PROFILE FORM**

- Record ID
- Current Date
- Age
- Year of Birth
- Protective Services/State/Tribal
- Involvement in Juvenile Justice
- Immigrant Status
- Sexual Orientation
- Gender
- Race
- Ethnicity
- Tribal Affiliation?
- Primary Language
- Last Grade Attended
- School Status
- "Physical/Behavioral/Developmental Disability"
- Disability
- Primary Language

**PROGRAM ENROLLMENT FORM**

- Program Type
- Staff
- Service Start Date
- Current PS/State/Tribal involvement
- Client Location
- Program Enrollment
- Service Site
- Current Living Status
- Enrollment Status
- Total Days in Program
- Referral Source Relationship to Youth
- Reason for Referral
- Referral Details
- Currently Enrolled In:
- If Not Currently Enrolled:
- Education Enrollment Status
- Attendance Status

**DROP-IN CENTER ENROLLMENT DETAILS**

- What ignites your spark in life?
- What are two of your strengths?
- Current Education Status
- Any Specific Resources youth is looking for at the Drop-In Center?
- We want to make sure that this is a safe place for everyone - what makes you feel safe? Is there anything we can do to support your in feeling safe?
- Are there any goals you're working toward or that we could help you work toward?
- How can we be a better support for you?
- What do you see as barriers/challenges that may be preventing you from reaching your goals?
- Are there any groups, classes or activities you would like to see offered at The Space?
- Would you have any interest in taking on a leadership position in a group/class or starting your own class or group?

# ACHR Apricot Data Request – 5/27/2021

**SERVICE RECIPIENT PROFILES**

- Record ID
- Enrollment Date
- Membership Status
- Orientation Received?
- Peer Drop-In Location
- Insurance Provider
- Program Assignment
- Insurance Type
- Social Security Benefits
- Date of Birth
- Referral Source
- Gender
- Ethnicity
- Race
- Age
- Income
- Employment Status

**DAILY LOG-IN**

- Date of Service
- Type of Encounter
- Service Provided

**CLASS ATTENDANCE**

- Date of Class
- Type of Class or Activity (Class Attendance)

**ARIZONA SELF-SUFFICIENCY MATRIX ASSESSMENT**

- Survey Test Date
- Survey Milestone
- Total Score
- Case Notes

**SOUTH VALLEY DAILY LOG-IN**

- Date of Service
- Type of Encounter

**LIBRARY DAILY LOG-IN**

- Date of Service
- Type of Encounter

**LIBRARY DAILY LOG-IN**

- Date of Service
- Type of Encounter

**CLIENT FEEDBACK FORMS**
**SOUTH VALLEY CLIENT FEEDBACK FORMS**
**LIBRARY FEEDBACK FORMS**

# APPENDIX E

## Service Observation Guide

*Fill-Out section below prior to attending service/activity:*

**Observer Name(s):** _____
**Date (**mm/dd/yyyy**):** _____
**Service/Activity:** _____
**Provider Organization:** _____

---

*Fill-Out section below during observation of service/activity:*

**Time Started (**[12-hr] hh:mm am/pm**):** _____ **Time Ended (**[12-hr] hh:mm am/pm**):** _____
**Location:** _____
**Number of People (excluding observer(s)):** _____

**Notes to Observer**: Attend to the 12 Categories of Peer Core Competencies after conducting observations (attached).

| AREA OF OBSERVATION | FIELD NOTES |
|---|---|
| **PLANNED AGENDA**<br>• What features are anticipated at beginning of service/activity?<br>• Expressed goals/objectives | |
| **ARTIFACTS**<br>• Handouts, media, surveys, assessments, etc. | |
| **CONTENT**<br>• Specific topic(s)/key concepts communicated by provider or clients during service/activity | |
| **POPULATION**<br>• Describe ***who*** attended.<br>• What are the group characteristics (race, sex, age, titles, etc.?<br>• How many of each group? | |
| **ENVIRONMENT**<br>• Describe the surroundings.<br>• What does the room look like physically?<br>• What is the mood of the room? | |
| **SERVICE(S)/ACTIVITY(S)**<br>• List/Describe what service(s)/activity(s) were conveyed and/or offered to clients | |
| **SUMMARY**<br>• Brief overview of what occurred | |
| **ANALYTIC COMMENTS**<br>• Details regarding alignment of service(s)/activity(s) to goals/outcomes. What was *interesting* about observations | |

# Peer Support Core Competencies

Substance Abuse and Mental Health Services Administration (2015)

| Peer Support Core Competencies | | Description of Competencies | Observed/ Documented | Notes |
|---|---|---|---|---|
| **Category I:** Engages peers in collaborative and caring relationships | 1. | Initiates Contact with Peers | ☐ | Click or tap here to enter text. |
| | 2. | Listens to Peers with Careful attention to the content and emotion being communicated | ☐ | Click or tap here to enter text. |
| | 3. | Reaches out to engage peers across the whole continuum of the recovery process | ☐ | Click or tap here to enter text. |
| | 4. | Demonstrates genuine acceptance and respect | ☐ | Click or tap here to enter text. |
| | 5. | Demonstrates understanding of peers' experiences and feelings | ☐ | Click or tap here to enter text. |
| **Category II:** Provides Support | 1. | Validates peers' experiences and feelings | ☐ | Click or tap here to enter text. |
| | 2. | Encourages the exploration and pursuit of community roles | ☐ | Click or tap here to enter text. |
| | 3. | Conveys hope to peers about their own recovery | ☐ | Click or tap here to enter text. |
| | 4. | Celebrates peers' efforts and accomplishments | ☐ | Click or tap here to enter text. |
| | 5. | Provides concrete assistance to help peers accomplish tasks and goals | ☐ | Click or tap here to enter text. |
| **Category III:** Shares lived experiences of recovery | 1. | Relates their own recovery stories, and with permission, the recovery stories of others to inspire hope | ☐ | Click or tap here to enter text. |
| | 2. | Discusses ongoing personal efforts to enhance health, wellness, and recovery | ☐ | Click or tap here to enter text. |
| | 3. | Recognizes when to share experiences and when to listen. | ☐ | Click or tap here to enter text. |
| | 4. | Describes personal recovery practices and helps peers discover recovery practices that work for them | ☐ | Click or tap here to enter text. |
| **Category IV:** Personalizes Peer Support | 1. | Understands their own personal values and culture and how these may contribute to biases, judgements and beliefs | ☐ | Click or tap here to enter text. |
| | 2. | Appreciates and respects the cultural and spiritual beliefs and practices | ☐ | Click or tap here to enter text. |
| | 3. | Recognizes and responds to the complexities and uniqueness of each peer's process of recovery | ☐ | Click or tap here to enter text. |
| | 4. | Tailors services and support to meet the preferences and unique needs of peers and their families | ☐ | Click or tap here to enter text. |
| **Category V:** Supports Recovery Planning | 1. | Assists and supports peers to set goals and to dream of future possibilities | ☐ | Click or tap here to enter text. |
| | 2. | Proposes strategies to help a peer accomplish tasks or goals | ☐ | Click or tap here to enter text. |
| | 3. | Supports peers to use decision-making strategies when choosing services and supports | ☐ | Click or tap here to enter text. |
| | 4. | Helps peers to function as a member of their treatment/recovery support team | ☐ | Click or tap here to enter text. |
| | 5. | Researches and identifies credible information and options from various resources | ☐ | Click or tap here to enter text. |
| **Category VI:** Links to resources, services, and supports | 1. | Assists and supports peers to set goals and to dream of future possibilities | ☐ | Click or tap here to enter text. |
| | 2. | Develops and maintains up-to-date information about community resources and services | ☐ | Click or tap here to enter text. |
| | 3. | Assists peers to investigate, select, and use needed and desired resources and services | ☐ | Click or tap here to enter text. |
| | 4. | Helps peers to find and use health services and supports | ☐ | Click or tap here to enter text. |
| | 5. | Accompanies peers to community activities and appointments when requested | ☐ | Click or tap here to enter text. |
| | 6. | Participates in community activities with peers when requested | ☐ | Click or tap here to enter text. |
| **Category VII:** Provides information about skills related to health, wellness, and recovery | 1. | Educates peers about health, wellness, recovery and recovery supports | ☐ | Click or tap here to enter text. |
| | 2. | Participates with peers in discovery or co-learning to enhance recovery experiences | ☐ | Click or tap here to enter text. |
| | 3. | Coaches peers about how to access treatment and services and navigate systems of care | ☐ | Click or tap here to enter text. |
| | 4. | Coaches peers in desired skills and strategies | ☐ | Click or tap here to enter text. |
| | 5. | Educates family members and other supportive individuals about recovery and recovery supports | ☐ | Click or tap here to enter text. |
| | 6. | Uses approaches that match the preferences and needs of peers | ☐ | Click or tap here to enter text. |
| **Category VIII:** Helps peers to manage crises | 1. | Recognizes signs of distress and threats to safety among peers and in their environments | ☐ | Click or tap here to enter text. |
| | 2. | Provides reassurance to peers in distress | ☐ | Click or tap here to enter text. |
| | 3. | Strives to create safe spaces when meeting with peers | ☐ | Click or tap here to enter text. |
| | 4. | Takes action to address distress or a crisis by using knowledge of local resources, treatment, services and support preferences of peers | ☐ | Click or tap here to enter text. |

| | | | |
|---|---|---|---|
| | **5.** Assists peers in developing advance directives and other crisis prevention tools | ☐ | Click or tap here to enter text. |
| **Category IX:** Values Communication | **1.** Uses respectful, person-centered, recovery-oriented language in written and verbal interactions with peers, family members, community members, and others | ☐ | Click or tap here to enter text. |
| | **2.** Uses active listening skills | ☐ | Click or tap here to enter text. |
| | **3.** Clarifies their understanding of information when in doubt of the meaning | ☐ | Click or tap here to enter text. |
| | **4.** Conveys their point of view when working with colleagues | ☐ | Click or tap here to enter text. |
| | **5.** Documents information as required by program policies and procedures | ☐ | Click or tap here to enter text. |
| | **6.** Follows laws and rules concerning confidentiality and respects others' rights for privacy | ☐ | Click or tap here to enter text. |
| **Category X:** Supports Collaboration and Teamwork | **1.** Works together with other colleagues to enhance the provision of services and supports | ☐ | Click or tap here to enter text. |
| | **2.** Assertively engages providers from mental health services, addiction services, and physical medicine to meet the needs of peers | ☐ | Click or tap here to enter text. |
| | **3.** Coordinates efforts with health care providers to enhance the health and wellness of peers | ☐ | Click or tap here to enter text. |
| | **4.** Coordinates efforts with peers' family members and other natural supports | ☐ | Click or tap here to enter text. |
| | **5.** Partners with community members and organizations to strengthen opportunities for peers | ☐ | Click or tap here to enter text. |
| | **6.** Strives to resolve conflicts in relationships with peers and others in their support network | ☐ | Click or tap here to enter text. |
| **Category XI:** Promoted Leadership and Advocacy | **1.** Uses knowledge of relevant rights and laws (ADA, HIPAA, Olmstead, etc.) to ensure that peer's rights are respected | ☐ | Click or tap here to enter text. |
| | **2.** Advocates for the needs and desires of peers in treatment team meetings, community services, living situations, and with family | ☐ | Click or tap here to enter text. |
| | **3.** Uses knowledge of legal resources and advocacy organization to build an advocacy plan | ☐ | Click or tap here to enter text. |
| | **4.** Participates in efforts to eliminate prejudice and discrimination of people who have behavioral health conditions and their families | ☐ | Click or tap here to enter text. |
| | **5.** Educates colleagues about the process of recovery and the use of recovery support services | ☐ | Click or tap here to enter text. |
| | **6.** Actively participates in efforts to improve the organization | ☐ | Click or tap here to enter text. |
| | **7.** Maintains a positive reputation in peer/professional communities | ☐ | Click or tap here to enter text. |
| **Category XII:** Promotes Growth and Development | **1.** Recognizes the limits of their knowledge and seeks assistance from others when needed | ☐ | Click or tap here to enter text. |
| | **2.** Uses supervision (mentoring, reflection) effectively by monitoring self and relationships, preparing for meetings and engaging in problem-solving strategies with the supervisor (mentor, peer) | ☐ | Click or tap here to enter text. |
| | **3.** Reflects and examines own personal motivations, judgments, and feelings that may be activated by the peer work, recognizing signs of distress, and knowing when to seek support | ☐ | Click or tap here to enter text. |
| | **4.** Seeks opportunities to increase knowledge and skills of peer support | ☐ | Click or tap here to enter text. |

# Nurtured Heart Approach Checklist

| Nurtured Heart Approach (NHA) Strand | Frequency | Field Notes |
|---|---|---|
| **Absolutely No!**<br>• Staff clearly identify negative behaviors<br>• Staff demonstrate measured and calm reactions when responding to negative behaviors | ☐ Not observable<br>☐ Rarely, less than 10% of opportunities<br>☐ Occasionally, about 30% of opportunities<br>☐ Sometimes, about 50% of opportunities<br>☐ Frequently, about 70% of opportunities<br>☐ Usually, about 90% of opportunities<br>☐ Every opportunity | |
| **Absolutely Yes!**<br>• Staff reinforce positive behaviors | ☐ Not observable<br>☐ Rarely, less than 10% of opportunities<br>☐ Occasionally, about 30% of opportunities<br>☐ Sometimes, about 50% of opportunities<br>☐ Frequently, about 70% of opportunities<br>☐ Usually, about 90% of opportunities<br>☐ Every opportunity | |
| **Absolutely Clear!**<br>• Staff clearly identify expectations and consequences of negative behaviors | ☐ Not observable<br>☐ Rarely, less than 10% of opportunities<br>☐ Occasionally, about 30% of opportunities<br>☐ Sometimes, about 50% of opportunities<br>☐ Frequently, about 70% of opportunities<br>☐ Usually, about 90% of opportunities<br>☐ Every opportunity | |

# General Observation Guide

*Fill-Out section below prior to attending service/activity:*

**Observer Name(s):** Click or tap here to enter text.
**Date (**mm/dd/yyyy**):** Click or tap here to enter text.
**Service/Activity:** Click or tap here to enter text.
**Provider Organization:** Click or tap here to enter text.

---

*Fill-Out section below during observation of service/activity:*

**Time Started ([**12-hr**]** hh:mm am/pm**):** Click or tap here to enter text.
**Time Ended ([**12-hr**]** hh:mm am/pm**):** Click or tap here to enter text.
**Location:** Click or tap here to enter text.
**Number of People already present (excluding observer and staff):** Click or tap here to enter text.
**Number of Drop-Ins([**12-hr**]** hh:mm am/pm**):**

| | | |
|---|---|---|
| 1. | Time Arrived: | Click or tap here to enter text. |
| | Time Left: | Click or tap here to enter text. |
| 2. | Time Arrived: | Click or tap here to enter text. |
| | Time Left: | Click or tap here to enter text. |
| 3. | Time Arrived: | Click or tap here to enter text. |
| | Time Left: | Click or tap here to enter text. |
| 4. | Time Arrived: | Click or tap here to enter text. |
| | Time Left: | Click or tap here to enter text. |
| 5. | Time Arrived: | Click or tap here to enter text. |
| | Time Left: | Click or tap here to enter text. |
| 6. | Time Arrived: | Click or tap here to enter text. |
| | Time Left: | Click or tap here to enter text. |
| 7. | Time Arrived: | Click or tap here to enter text. |
| | Time Left: | Click or tap here to enter text. |
| 8. | Time Arrived: | Click or tap here to enter text. |
| | Time Left: | Click or tap here to enter text. |
| 9. | Time Arrived: | |
| | Time Left: | Click or tap here to enter text. |
| 10. | Time Arrived: | Click or tap here to enter text. |
| | Time Left: | Click or tap here to enter text. |
| 11. | Time Arrived: | Click or tap here to enter text. |
| | Time Left: | Click or tap here to enter text. |
| 12. | Time Arrived: | Click or tap here to enter text. |
| | Time Left: | Click or tap here to enter text. |
| 13. | Time Arrived: | Click or tap here to enter text. |
| | Time Left: | Click or tap here to enter text. |
| 14. | Time Arrived: | Click or tap here to enter text. |
| | Time Left: | Click or tap here to enter text. |
| 15. | Time Arrived: | Click or tap here to enter text. |
| | Time Left: | Click or tap here to enter text. |
| 16. | Time Arrived: | Click or tap here to enter text. |
| | Time Left: | Click or tap here to enter text. |
| 17. | Time Arrived: | Click or tap here to enter text. |
| | Time Left: | Click or tap here to enter text. |
| 18. | Time Arrived: | Click or tap here to enter text. |
| | Time Left: | Click or tap here to enter text. |
| 19. | Time Arrived: | Click or tap here to enter text. |
| | Time Left: | Click or tap here to enter text. |
| 20. | Time Arrived: | Click or tap here to enter text. |
| | Time Left: | Click or tap here to enter text. |
| 21. | Time Arrived: | Click or tap here to enter text. |
| | Time Left: | Click or tap here to enter text. |
| 22. | Time Arrived: | |
| | Time Left: | Click or tap here to enter text. |
| 23. | Time Arrived: | Click or tap here to enter text. |
| | Time Left: | Click or tap here to enter text. |
| 24. | Time Arrived: | Click or tap here to enter text. |
| | Time Left: | Click or tap here to enter text. |
| 25. | Time Arrived: | Click or tap here to enter text. |
| | Time Left: | Click or tap here to enter text. |
| 26. | Time Arrived: | Click or tap here to enter text. |
| | Time Left: | Click or tap here to enter text. |
| 27. | Time Arrived: | |
| | Time Left: | Click or tap here to enter text. |
| 28. | Time Arrived: | Click or tap here to enter text. |
| | Time Left: | Click or tap here to enter text. |
| 29. | Time Arrived: | Click or tap here to enter text. |
| | Time Left: | |

**Desired Services (observable—do *NOT* ask clients):**

Coffee:

Notes:

Programming (e.g. Craft Night, Bonfire, Art is Life!, etc.):

Notes:

Restroom:

Notes:

Basic Necessities

Notes:

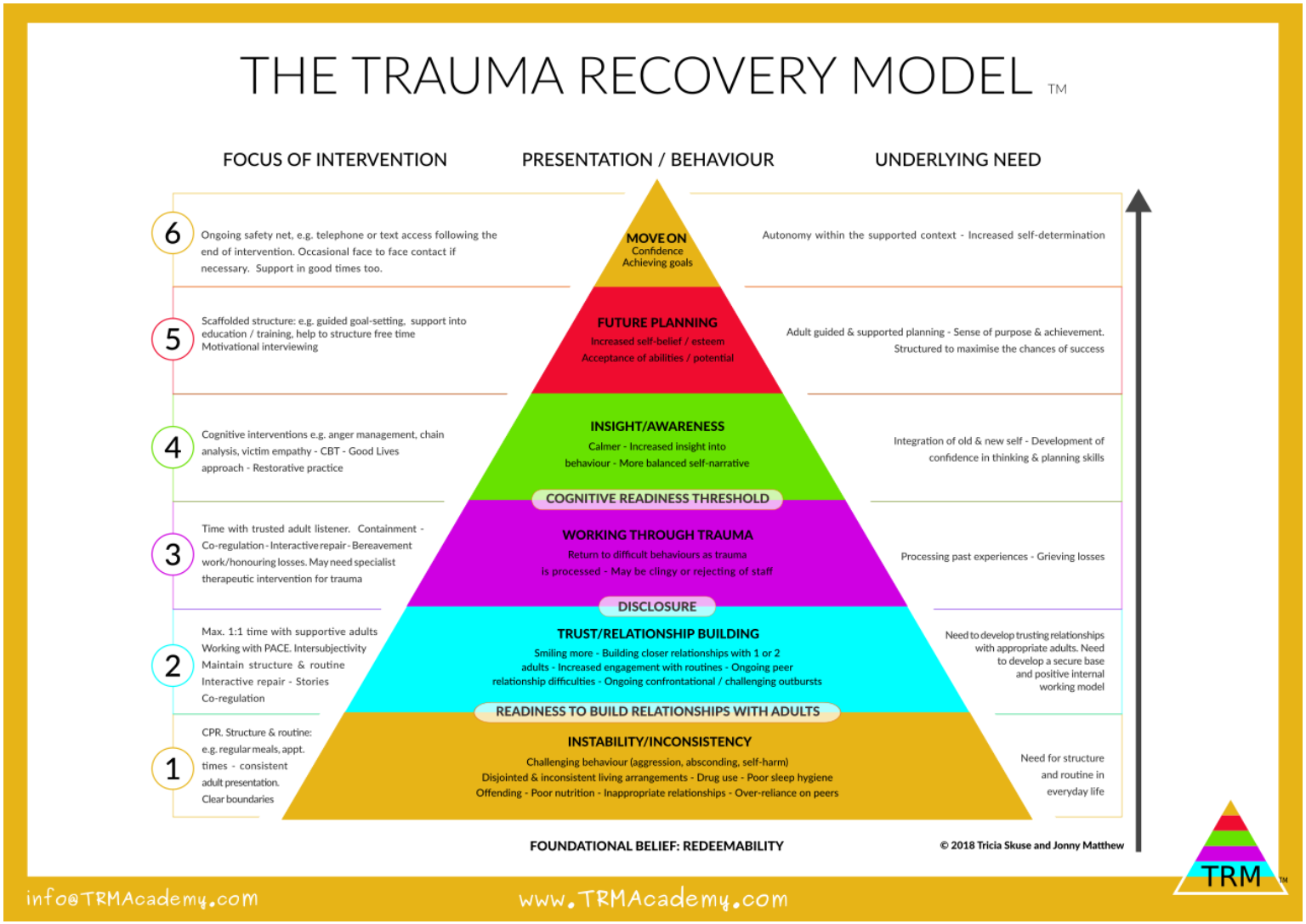
Socialize/Lounge:

Notes:

Other:

Notes:

## APPENDIX F


THE TRAUMA RECOVERY MODEL TM
FOCUS OF INTERVENTION
PRESENTATION / BEHAVIOUR
UNDERLYING NEED
6
Ongoing safety net, e.g. telephone or text access following the end of intervention. Occasional face to face contact if necessary. Support in good times too.
MOVE ON
Confidence
Achieving goals
Autonomy within the supported context - Increased self-determination
5
Scaffolded structure: e.g. guided goal-setting, support into education / training, help to structure free time
Motivational interviewing
FUTURE PLANNING
Increased self-belief / esteem
Acceptance of abilities / potential
Adult guided & supported planning - Sense of purpose & achievement. Structured to maximise the chances of success
4
Cognitive interventions e.g. anger management, chain analysis, victim empathy - CBT - Good Lives approach - Restorative practice
INSIGHT/AWARENESS
Calmer - Increased insight into behaviour - More balanced self-narrative
Integration of old & new self - Development of confidence in thinking & planning skills
COGNITIVE READINESS THRESHOLD
3
Time with trusted adult listener. Containment - Co-regulation - Interactive repair - Bereavement work/honouring losses. May need specialist therapeutic intervention for trauma
WORKING THROUGH TRAUMA
Return to difficult behaviours as trauma is processed - May be clingy or rejecting of staff
Processing past experiences - Grieving losses
DISCLOSURE
2
Max. 1:1 time with supportive adults
Working with PACE. Intersubjectivity
Maintain structure & routine
Interactive repair - Stories
Co-regulation
TRUST/RELATIONSHIP BUILDING
Smiling more - Building closer relationships with 1 or 2 adults - Increased engagement with routines - Ongoing peer relationship difficulties - Ongoing confrontational / challenging outbursts
Need to develop trusting relationships with appropriate adults. Need to develop a secure base and positive internal working model
READINESS TO BUILD RELATIONSHIPS WITH ADULTS
1
CPR. Structure & routine: e.g. regular meals, appt. times - consistent adult presentation. Clear boundaries
INSTABILITY/INCONSISTENCY
Challenging behaviour (aggression, absconding, self-harm)
Disjointed & inconsistent living arrangements - Drug use - Poor sleep hygiene
Offending - Poor nutrition - Inappropriate relationships - Over-reliance on peers
Need for structure and routine in everyday life
FOUNDATIONAL BELIEF: REDEEMABILITY
© 2018 Tricia Skuse and Jonny Matthew
info@TRMAcademy.com
www.TRMAcademy.com
TRM TM

## APPENDIX G

| Youth Blast<br>Jan. 2019-Feb. 2020<br>Wells Park Community Center | Virtual/Pop-up Drop In Center<br>April 2020-November 2020<br>Online/Various Parks around the City | The Space-Phase 1<br>December 2020-Present<br>142 Truman St NE | The Space-Fully Operational<br>Grand Opening: July 2021<br>142 Truman St NE |
|---|---|---|---|
| Safe Space | Intentional time for young people to connect | Safe Space | Safe Space |
| Connection with other young people | Deliveries of Clothing/Hygiene Donations | Connection with other young people | Connection with other young people |
| Clothing/Hygiene Donations | Deliveries of Snacks/Meals on Occasion | Clothing/Hygiene Donations | Clothing/Hygiene Donations |
| Food | Access to Resources connection through staff | Food | Full Kitchen for Food Prep |
| Access to Wi-Fi/computers | Activities focused on young people's request | Access to Wi-Fi/computers | Access to Wi-Fi/computers |
| Access to showers | | Access to Classes/Activities | Access to laundry facilities |
| Access to Classes/Activities | | Hosting New Day Staff for meetings | Access to showers |
| Hosted Community Partners | | Access to Resources | Access to Classes/Activities |
| Access to Resources | | | Community Partners using office space |
| | | | Access to resources/supports |