CENTER FOR APPLIED RESEARCH & ANALYSIS

Bernalillo County Behavioral Health Initiative: Youth Transitional Living Services Process Evaluation

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Introduction

The Youth Transitional Living Services (YTLS) programs funded by the Bernalillo County Behavioral Health Initiative (BHI) began in June of 2018. Four agencies were selected to address underlying causes of homelessness and housing instability among youth 14 to 24 years old. The County provided funding to "…enhance an assortment of services, which when provided with supportive housing could lead to self-sufficiency and stable, permanent housing." (Zamora, p.3). Over 247 youth have been clients in one or more of these programs in the two and a half years this evaluation spans (May 2018 [program inception] through June 2021). This evaluation synthesizes information from multiple data sources to study the implementation of the YTLS.

Background

In February 2015, the Bernalillo County Commission (BCC) and voters approved a non-sunsetting 1/8 cent gross receipts tax (GRT) to develop a unified and coordinated behavioral health system in the County and to improve access to care throughout the region. This tax generates approximately $17 million per year. These tax monies fund the Bernalillo County Behavioral Health Initiative (BHI), a series of programs meant to improve behavioral health outcomes in the community.

In April 2015, the BCC contracted Community Partners, Inc. (CPI) to develop a business plan for a regional, cohesive system of behavioral health care. CPI assessed the behavioral health care delivery system and recommended a governing board structure and planning process that resulted in a comprehensive regional behavioral health business plan. With guidance from the community and governing board, the County began implementing the approved service components, including research and evaluation focused on the implementation and impact/outcomes of programs funded by the GRT. Bernalillo County and its Department of Behavioral Health Services (DBHS) manage the contracts and providers of those services.

The CPI report recommended youth transitional living services (YTLS) narrowly as, "Expand Transitional Living Services for female adolescents struggling with substance-use issues, providing treatment, education, life skills training, case management and employment-support services in a therapeutic setting for up to six months" (p.4). In their 2017 request for proposals (RFP), the County expanded the target population and list of services, soliciting proposals:

> To provide programs serving unaccompanied homeless and precariously housed youth age 14 – 24 with identified behavioral health needs. Services should be comprehensive in nature and may include independent living services, housing search and placement, vocational training, employment assistance, educational advancement, mental health and substance abuse treatment, financial empowerment, life skills, identity formation, and service coordination. (Zamora, p 3)

The RFP noted the County would not directly fund housing. Instead, the goal was to enhance an assortment of services, which when provided with supportive housing could lead to self-sufficiency and stable, permanent housing (Zamora, p 3). In general, youth transitional living services are designed to address the needs of youth who may lack the life skills to become independent after bouts of homelessness or years of involvement with juvenile justice or foster care systems. At the time of the RFP, the January 2017 point-in-time (PIT) count showed 39 unaccompanied children younger than 18 years old and 68 youth (ages 18-24) experiencing homelessness, (NMCHE 2017).

The County's performance-based RFP[1] resulted in four contracted providers: Youth Development, Inc. (YDI), A New Day, Serenity Mesa, and Casa Q. Each provider offered a slightly different bundle of services to address the needs of its target population: Casa Q for LGBTQ residents; Serenity Mesa for female residents dealing

[1] Wherein the RFP defines the problem and respondents provide potential solutions to achieve desired outcomes.

with substance use disorders; A New Day for systems-involved youth; and YDI for the target population broadly defined. Common among the services offered by three of the four providers were: the development of individual treatment/progress plans, case management, housing access and stabilization aid, employment and education supports, opportunities for life skills building, and access to behavioral health services. New Day's service was care coordination.

Literature

Estimating the number of youths experiencing homelessness at any given time is challenging. As part of a nationwide effort, the New Mexico Coalition to End Homelessness (NMCEH) participates in the New Mexico Point-in-Time (PIT) count in Albuquerque every two years. The result is a snapshot of sheltered and unsheltered individuals and families on a particular day, usually in January. Even given the difficulties posed by the weather, refusals, data collection errors, and many other factors, the PIT is considered by government funding agencies to be the best estimate of people experiencing homelessness. The NMCEH 2021 count results found three children (under age 18) unsheltered, 220 in emergency shelters, and 82 in transitional housing for a total of 305 minors experiencing some form of homelessness. For older youth (18 to 24 years old) there were 24 people unsheltered, 47 in emergency shelters, and 30 in transitional housing for a total of 101 youth experiencing homelessness (NMCEH 2021). Together, these two groups accounted for 25.9% of the total estimated population experiencing homelessness on January 25, 2021.

Youth homelessness is a complex social issue that is intractable for researchers, policy makers, governments, and community organizations who provide direct services to this population. Substance use disorders are not generally considered a primary causes of youth homelessness, or being precariously housed. The primary causes of youth homelessness are LGBTQ discrimination, abusive home life, aging out of the foster care system, and poverty (Slotnick 2009, Hunter 2008, Morton 2017). The top cause is consistently conflict in the home. Although drug use can be a source of family conflict, it is usually described as a consequence of experiencing homelessness.

The National Coalition for the Homeless suggests that among adults, the intersection of addiction, mental illness, and homelessness is far more complex, with addiction as both the cause and a result of homelessness (NCH, 2009). In their study of factors predicting first-time homelessness after substance use treatment, DiGuiseppi et al. (2020) analyzed Global Appraisals of Individual Needs (GAIN) scores for almost 18,000 youth in SAMHSA funded substance use treatment clinics and estimated that 5% would experience at least one day of homelessness in the 12 months post treatment. Over half of the study participants were referred from juvenile justice and for 70%, treatment was on an outpatient basis; youth with previous homeless experiences were excluded from the study. Among the 17 statistically significant risk factors the three highest ranked were being male, depression and prior treatment for substance use disorder (SUD). The substance use characteristics are noted here in order of their influence predicting homelessness: illicit drug dependence (6^{th}), family history of substance use (7^{th}), marijuana dependence (11^{th}), and alcohol dependence (15^{th}). Counter to the main body of research in youth homelessness, LGBTQ, black race, Hispanic ethnicity, school problems, and parenting did not predict risk of homelessness for this population.

Much of the YTLS literature focuses on foster youth transitioning out of care. Winiarski, et al., describe that time period as "a simultaneous breakdown of multiple supportive system in the youth's life," (2021, p.2). According to Naccarato and DeLorenzo (2008) and Rashid (2004), youth transitioning to independent living are extremely vulnerable. They experience multiple risk factors at greater rates than youth with families including: school failure, unemployment, obtaining medical care, housing, homelessness, violence, teen parenthood, involvement with the criminal justice system, substance abuse, and mental health problems. New Mexico's Children, Youth and Families Department's (CYFD) most recent estimate of children in foster care in Bernalillo

County was 681 individuals with 132 exiting the foster care system, and 14 aging out of foster care at the end of the September 2020. (CYFD 2020).

There does not appear to be a single model program for the delivery of YTLS but there are some critical components in common throughout the literature. In discussing transition age youth, Winiarski, et al mentioned risk mitigation through, "a case management response that helps youths begin the process of securing housing, education, and other social supports while they are still involved with the juvenile justice or foster care systems," (2021, p.2). They found the Housing First model (providing shelter before services) both an effective intervention and an entrée to targeted services. An independent living needs assessment in a county in Ohio found that youth transitioning to adulthood need supportive adults, basic housing, and other supportive services typically provided by birth or adoptive parents to youth throughout their late teens and twenties (Mares, 2010). After housing needs, acceptance of sexual identity, and emotional support were cited as critical needs for LGBQ youth experiencing homelessness (Choi, 2015).

Packard et al. (2008) found the most successful transitional programs are those that address the needs of the youth participants with a variety of connected services. According to Jarvis and Robertson, "A successful transitional living program (TLP) is composed of a constellation of interrelated characteristics, factors and values." (1993, p1). The major components of most programs include program structure, physical setting, geographic context, cultural aspects, theoretical/clinical base, service linkage, and training. The characteristics of each of these components are the focus of the process evaluation recognizing the differences between the residential and non-residential programs. Adherence to best practices in YTLS service delivery may increase client outcomes.

There is a lack of research into the effects of transitional living programs on individual outcomes. In their meta-analysis of participation in transitional programs and post-transitional outcomes from 19 studies, Heerde, et al, found "…a small-medium correlation for housing, education and employment…" (2016, e25). The effects of YTLS on mental health and substance abuse were inconclusive. Modest positive impacts on earnings, housing stability, economic wellbeing, health, and safety were also found in the randomized control study of Youth Villages Transitional Living program in Tennessee (Skemer and Valentine, 2016).

The remainder of this section is an overview of some specific assessment tools and program models BHI YTLS providers use. According to process maps, interviews, and document reviews, there are several providers using the same assessments (e.g., CAFAS) and there are providers using models and assessments unique to their programs (e.g., Seven Challenges). They are discussed here because these assessments have been mentioned by providers as tools used to inform treatment plans. Assessment choices can be driven by other funding agencies as well as program need (CYFD requires the GPRA). Whether and how they are implemented is a process evaluation question. They also relate to the measurement of client outcomes that are, or could be, used in evaluation research. Including them here also allows easy reference and avoids repetition in the study findings. Some text is verbatim from descriptions in articles or creator/owner websites and is cited as such.

Assessments Mentioned by Providers

Adverse Childhood Experiences Scale (ACE)

Used by: Serenity Mesa at intake.

The Adverse Childhood Experiences Scale is designed to rapidly identify individuals at high risk for toxic stress so appropriate treatment strategies can begin. Developed by the Centers for Disease Control and Kaiser Permanente, The Adverse Childhood Experience Questionnaire is 10 questions, each related to a specific domain: physical, emotional, and sexual abuse; physical and emotional neglect; and household dysfunction caused by mental illness, mother treated violently, divorce, incarcerated relative, and substance abuse. Clients

are instructed to indicate whether they experienced the event described in the question. A point is given for each affirmative answer generating scores from zero to ten. In general, adults with an ACE score of 4 or more are considered to be at greater risk for behavioral, physical, and mental health issues. (For a literature review of the acceptability, feasibility, and implications of ACEs screening, see Rarden et al, 2021.)

Child and Adolescent Functional Assessment Scale (CAFAS)

Used by: YDI's Independent Futures every 30 days. Retrieved from http://www2.fasoutcomes.com/content.aspx?contentid=1084.

The Child and Adolescent Functional Assessment Scale (CAFAS: Hodges, 2000a; 2000b) assesses the degree of impairment in youth with emotional, behavioral, psychiatric, or substance use problems. The CAFAS provides an objective, comprehensive assessment of a youth's needs that is sensitive to change to over time for eight life domains: At School, At Home, in the Community (delinquency), Behavior Toward Others, Moods/emotions, Self-Harm, Substance Use, and Thinking (assessing irrationality). A Total Score and subscale scores are generated, with higher scores indicating greater impairment in day-to-day functioning. Therefore, as treatment progresses, lower CAFAS total and subscale scores indicate improvement.

Originally developed in 1989 and supported by over 20 years of research and 80 published articles, the CAFAS is a robust, psychometrically sound measure. Reliability studies have demonstrated that the CAFAS has satisfactory internal consistency and interrater reliability (Hodges & Wong, 1996), as well as test-retest reliability (Hodges, 1995). Studies investigating the validity of the CAFAS have included evaluations of concurrent and predictive validity.

The CAFAS contains 8 scales for youth functioning:

- School/Work Role Performance
- Home Role Performance
- Community Role Performance
- Behavior Toward Others
- Moods/Emotions
- Self-Harmful Behavior
- Substance Use
- Thinking

The CAFAS is designed for children and youth between 5 years of age and 19 years of age and is used to inform decisions about levels for care, type and intensity of treatment, placement and need for referral.

Casey Life Skills (CLS)

Used by: Serenity Mesa, Casa Q, YDI at intake. Retrieved from https://www.casey.org/casey-life-skills-resources/

The Casey Life Skills assesses the behaviors and competencies youth need to achieve their long-term goals. It aims to set youth on their way toward developing healthy, productive lives. The CLS includes 6 skill areas:

- Daily Living
- Self-Care
- Relationships and Communication
- Housing and Money Management
- Work and Study
- Career and Education Planning

The CLS is designed for youth between 14 years and 21 years of age, typically requires 30-40 minutes to complete and can be used to create a learning plan with them to gain the skills they need. The CLS can be used as a post assessment to measure changes in skill or abilities in a particular area and the total progress over varying periods of time from monthly to quarterly to annually.

Global Appraisal of Individual Needs Short Screener (GAIN-SS)

Used by: Serenity Mesa at intake and repeated every 30 days and YDI's Independent Futures at intake.
Retrieved from: https://gaincc.org/instruments/

The GAIN-SS is a 20-item, self-administered questionnaire designed to quickly identify several behavioral disorders for purposes of treatment planning and program evaluation. The questions measure 20 symptoms associated with four mental health domains: internal disorders (e.g., depression, suicide, anxiety, trauma); behavioral disorders (e.g., ADHD, conduct disorder); substance use disorders (e.g., abuse, dependence); and crime/violence (e.g. interpersonal violence, drug related crime). Responses are given in a scale indicating the recency of the problem. Scores measure levels of severity and suggested clinician response: Low (0 score, unlikely to have diagnosis or need services), Moderate (1 and 2, possible diagnosis, assess and intervene), High (3+ for total screener or any sub-screen, high probability of diagnosis, formal assessment and intervention warranted).

Center for Substance Abuse Treatment (CSAT) Government Performance and Results Act (GPRA) Core Client Outcome Measures for Discretionary Services Programs

Used by: Serenity Mesa at intake, discharge and six-month post-discharge.

GPRA refers to standardized data collection and reporting for federally funded programs. Researchers collect standardized health information for program evaluation and the result are used to ensure Federal agencies are held accountable for achieving program results. SAMHSA's GPRA is an extensive, hour long interview covering: drug and alcohol use; family and living conditions; education, employment and income; crime and criminal justice status; mental and physical health problems and treatment/recovery; and social connectedness. Additional sections for program specific questions may cover follow-up status, discharge status, services received, etc. GPRA is administered at intake/baseline, at 3 months follow up (if a programmatic requirement), at 6 months follow up, and discharge.

Social Determinants of Health (SDoH)

Used by: Serenity Mesa at intake.

It is unclear which, if any, validated instruments are used to collect these data. DBHS has been in the process of moving toward requiring all providers use the WellRx, an 11-item questionnaire assessing needs in 4 domains (economic stability, education, neighborhood and physical environment, and food). While SDoH questions might be asked as part of intake, treatment planning or case management, we do not know how clients are 'assessed' for SDoH. Providers who also receive City of Albuquerque funding use their SDoH assessment instrument.

Models Guiding Service Delivery

High Fidelity Wraparound

Used by: New Day.

High-Fidelity Wraparound is an evidence-based practice designed to be used for youth with complex needs. It is a youth-guided, team supported, care coordination model for systems involved youth or youth with intractable mental health needs who receive services from multiple community providers and government programs. The California Evidence-Based Clearinghouse for Child Welfare rates Wraparound as highly relevant to child

welfare and as "3-promising research evidence" for behavioral management programs for adolescents and for placement stabilization program. (CEBC, 2021)

The HFW model is associated with a national structure of trainings, certifications, and fidelity measures that are performed independently of local funders and their requirements. (see The National Wraparound Implementation Center (NWIC) and National Wraparound Initiative (NWI) websites for more information.) In New Mexico, the training, certification and oversight of HFW is the purview of the NM Children, Youth and Families Department (CYFD).

Wraparound is sometimes used to describe case management or treatment strategies and it can be used interchangeably with Hi-Fidelity Wraparound by model adherents. Certifications of both facilitators and programs are key to determining whether people are discussing the evidence-based model or an intensive team process. Additionally, there are standardized data submission requirements for local and national oversight and evaluation of both fidelity to model and client outcomes. The backbone of their self-evaluation is the Wraparound Fidelity Assessment System (WFAS), "a multi-method approach to assessing the quality of individualized care planning and management for children and youth with complex needs and their families. The instruments that comprise the WFAS can be used individually, or to provide a more comprehensive assessment, in combination with one another." (https://nwi.pdx.edu/assessment-fidelity/)

Descriptions of the HFW model are integrated into the Program Description for New Day.

Seeking Safety

Used by: Serenity Mesa.

From the American Addiction Center: "Seeking Safety is an evidence-based model that can be used in group or individual counseling. It was specifically developed to help survivors with co-occurring trauma and SUD and, crucially, in a way that does not ask them to delve into emotionally distressing trauma narratives. Thus, "safety" is a deep concept with varied layers of meaning – safety of the client as they do the work; helping clients envision what safety would look and feel like in their lives; and helping them learn specific new ways of coping." (AAC, 2021)

The curriculum is presented in a for-purchase book comprised of 25 topics that each teach a safe coping skills while addressing addiction and trauma together. The CEBC rates its relevance to child welfare as Medium and the scientific rating is 3- Promising Research Evidence[2] in addressing adolescent substance abuse and client level trauma treatment. There are processes and materials available for ensuring fidelity to the Seeking Safety Model.

Seven Challenges

Used by: Serenity Mesa

From the CEBC: *The Seven Challenges*® program, specifically for young people with drug problems, is designed to motivate a decision and commitment to change and to support success in implementing the desired changes. The program simultaneously aims to help young people address their drug problems as well as their co-occurring life skill deficits, situational problems, and psychological problems. The challenges provide a framework for helping youth think through their own decisions about their lives and their use of alcohol and other drugs. Counselors use the program to teach youth to identify and work on the issues most relevant to them. In sessions, as youth discuss the issues that matter most, counselors seamlessly integrate The Seven Challenges® as part of the conversation.

[2] The California Evidence-Based Clearinghouse for Child Welfare (CEBC) defines "3-Promising Research Evidence" as research outcomes that have been published in a peer reviewed journal. A score of 1 represents a practice with the strongest research evidence.

The Seven Challenges is rated medium for relevance to child welfare and is a 3-Promising Research Evidence for adolescent substance abuse treatment. It can include individual, group or family therapy, substance use education, Seven Challenges journaling, and relapse prevention. Seven Challenges has not been evaluated as an approach for reducing homelessness.

Nurtured Heart Approach (NHA)

Used by: New Day, YDI Independent Futures, and Serenity Mesa.

The NHA was designed as a strategy for parents of children with behavioral disorders such as ADHD and defiant disorder. The 3 Stands of NHA are: Absolutely No, Absolutely Yes, and Absolutely Clear. Unwanted behaviors are not "energized" through undue attention to them; success and achievements, no matter how small, are to be recognized; and there is clear and consistent application of rules and the consequences of breaking them.

In their evaluation of the theoretical and empirical foundations of the NHS, Hektner et al, (2013) noted that while there was no empirical evidence of its effectiveness, "several elements of the Nurtured Heart Approach are consistent with clinical practice, developmental theory, and other empirically validated parent training programs. These elements include its focus on recognizing positive behavior with detailed, specific description and praise; creating opportunities for success; establishing clear rules, limits, and expectations; minimizing energy directed to the child in response to undesired behaviors; and providing swift, appropriate, but not harsh consequences for undesired behaviors. Thus, NHA is built on a solid foundation of empirically and theoretically valid ideas and strategies." (2013, p 434). The Nurtured Heart Approach® is considered an evidence-informed, practice based on existing research and anecdotal evidence.

In all cases, fidelity to a chosen model and/or the appropriate use of screening tools would be some of the characteristics of a high-functioning YTLS program. It would also increase the likelihood of reaching the desired outcomes for program clients.

Study Design and Methods

The scope of this evaluation has been limited as a result of the COVID-19 pandemic. On March 11, 2020, the first case of the COVID-19 virus was reported in New Mexico. In the wake of this development, public health orders and independent precautionary measures were implemented to combat the pandemic. These measures resulted in significant changes to operational procedures for most health and behavioral services, including YTLS, and for our human subjects research.

Period of Study

The time frame for this process evaluation is May 2018 (program inception) through June 2021. Near the end of their second year of operation, the YTLS providers found themselves adapting their services to meet client needs during a global pandemic. The first COVID-19 cases in New Mexico were confirmed on March 11, 2020, and on March 23, 2020, Governor Michelle Lujan Grisham issued a stay-at-home order for non-essential workers[3]. Some behavioral health providers closed their physical offices and moved to telephone and video platforms to deliver client services; others quickly put in place mask requirements and protocols for cleaning and social distancing to allow them to keep open their facilities. While the effects of the public health restrictions and service delivery challenges related to the pandemic are not yet fully understood, we consider some of these extraordinary challenges in our evaluation of these programs.

[3] From: https://www.krqe.com/health/coronavirus-resources/timeline-coronavirus-in-new-mexico/

Document Review and Provider Conversations: Generation of the Process Maps and Program Descriptions

To obtain a better understanding of each program, we created a process map for each YTLS program. These maps provide a view of the program at a point in time. After reviewing program contracts and documents, maps were generated by ISR staff while in contact with the providers and were approved by the providers upon completion. Ideally, these maps serve as an accurate visual representation of the process a client undergoes for each of these programs, from first to final contact, according to the providers. We used the process maps as tools to inform our process evaluation and guide our research questions; client level data should confirm or clarify these maps.

Performance Measure Review

BHI service providers are required to submit monthly performance measures to DBHS. Providers enter required data into a DBHS-designed MS Excel spreadsheet – originally aggregated counts or percentages. While some measures vary based on program process and goals, they are designed to capture similar information including: counts of new and continuing clients, education, employment and life skills attainment, social determinants of health, etc. They also report standardized client demographic information including: gender, age, race, ethnicity, and type of insurance. The narrative section asks the providers to report successes, learning outcomes, barriers and quality improvement for the month.

Occasionally adjustments were made to the measures to more closely reflect the work of the providers. In June 2020 DBHS changed the level of data required from program- to client-level data. Demographics and Discharge sections were expanded and new sections included: Presenting Issue, Crisis and Treatment, Type and Units of Service In-house, Treatment Planning, Referrals Outside of Agency and client self-assessments. At this time the system is still being refined, including data quality controls. We cannot match clients across the two data sets so we do not know how much overlap there is with previously reported aggregate measures.

For our purposes, the monthly performance measures were not used as primary sources of data: they were not designed to be used for program evaluation and contain errors and inconsistencies we cannot resolve. However, they are briefly summarized herein with a focus on the narrative sections of the performance measures. This program information provides insights into the basic work of the programs, programmatic changes and their potential effect on program implementation. They may also help us understand changes in the client-level data. We use the notations Y1 and Y2 for our discussion of first and second year data. Y3 data appear in Appendix A.

Administrator and Staff Interviews

To avoid delays related to the pandemic and following human subject research guidelines, interviews were carried out remotely using the Zoom videoconferencing platform. A semi-structured interview guide was used to allow for flexibility. Interviews were typically conducted via video to more closely mimic an in-person experience, with the exception of a few interviews that were switched to audio-only partway through to mitigate the effects of a poor connection.

Recruitment

Interview recruitment was conducted via email, using a standard recruitment letter. The general procedure for recruitment was to send the initial recruitment email, followed by up to three follow-up emails, spaced by at least one week. The follow-up emails served as reminders for busy potential interviewees, and included the option to decline participation in the interviews (and by extension, the continuation of follow-ups). If an individual agreed to be interviewed, they were sent an official confirmation email with a reminder of the date and time, a copy of the consent form, a Zoom link, a Zoom meeting password, and instructions for using Zoom if they didn't already have it installed on their electronic device.

Consent

A verbal consent process was used for the interviews. Prior to the interview's start, the researcher conducting the interview shared their screen and reviewed the IRB-approved consent document with the participant. The researcher read the form aloud, concluding with asking the participant if they consented to be interviewed and to be electronically recorded. Prospective interviewees were still allowed to participate in the interview if they did not wish to be recorded, although that situation did not arise.

Recording

Interviews were recorded electronically using Zoom's built-in record-to-cloud function. Recording to Zoom's cloud allows the software to record audio only instead of audio paired with video, allowing an additional layer of protection for interview participants. No video was recorded over the course of this study. Recording to the cloud also allows Zoom to automatically generate a written transcript, which was downloaded and edited for accuracy by researchers.

Security

To follow best practices for secure Zoom meetings, the waiting room and password functions were switched on. This prevented anyone from entering the meeting without a password, and allowed the researcher hosting the meeting to prevent anyone from entering the meeting without manual approval. Meeting IDs were generated automatically. Zoom recordings and transcripts were downloaded onto ISR's secure server. The original copies of the transcripts and recordings were deleted from Zoom's cloud after analysis.

Participation

Interviews were conducted from November 2020 through March 2021. There were 27 people eligible for inclusion and 15 were interviewed, a response rate of 55.5%. For each provider there were representatives from management/administration and non-supervisory employees such as case managers and clinical staff.

Client Record Review

ISR worked with each provider to obtain client-level data. Data was protected in transfer using encrypted jump drives provided by ISR, and at rest and in use using ISR's protected servers for storage. Due to the relatively short timeline and the need for providers to de-identify some of their own information, electronic data was prioritized over physical records. Data that was already stored in spreadsheets or easily extractible from databases was prioritized. There is variation in what was collected between the four providers due to differences in what the providers documented, and how it was collected stored. Details of the data collection appear before the presentation of client level results for each provider. The ability to acquire client level data was affected by the ability of the programs to extract and provide requested data.

Minor Data Compared to Adult Data

Under the HIPAA waiver granted to ISR by the UNM IRB, data originating from adults was treated differently than data originating from minors. State law NM Stat § 14-6-1 (2018) allows access to identified data for adults with the approval of an Institutional Review Board but does not allow identified data for minors. All data for minors was collected in a deidentified format to comply with state law. This was accomplished by working with the providers to ensure all data was in the appropriate format prior to collection by ISR. For the purpose of this research, a "minor" is any person who was under the age of 18 at entry to the relevant YTLS program. Names, addresses, and all elements of date save for year were removed from data originating from minors. Random identifiers were used to link service data to allow for detection of duplicate entries. Acquiring deidentified data for minors was particularly challenging and resulted in less data and delays in obtaining data.

Program Service Observations

While originally part of the scope of this process evaluation, program service observations did not occur in the first two program years and were cancelled due to the COVID-19 pandemic for much of Y3. These would have been helpful in discovering how and when the assessments were given, thereby potentially improving the quality of provider data. Additionally, we have limited understanding of the processes of "Phasing Up" at Serenity Mesa and creating a family environment at Casa Q. We also cannot speak to the fidelity of HFW, 7C or NHA; these may be part of future research plans.

Program Descriptions and Study Findings

To obtain a better understanding of each program and as noted earlier, in collaboration with program staff, we created a process map for each YTLS program. Ideally, these maps serve as an accurate visual representation of the process a client undergoes for each of these programs, from first to final contact. These are simplified for inclusion in this report, for the fully articulated maps see Appendices C-F. All the programs adapted quickly to video, telephone and texts platforms for service delivery and adopted recommended safety protocols for those activities that required face-to-face contact. School and business closures diminished client opportunities for YTLS clients. For SM and CQ it also meant residents were at the facilities all day, with shorter periods of school engagement, curtailed access to friends and family, and the need for changes in scenery from their campuses. The pandemic created a series of challenges that might have changed the some of the aspects of program delivery but they appeared to be within the existing program frameworks.

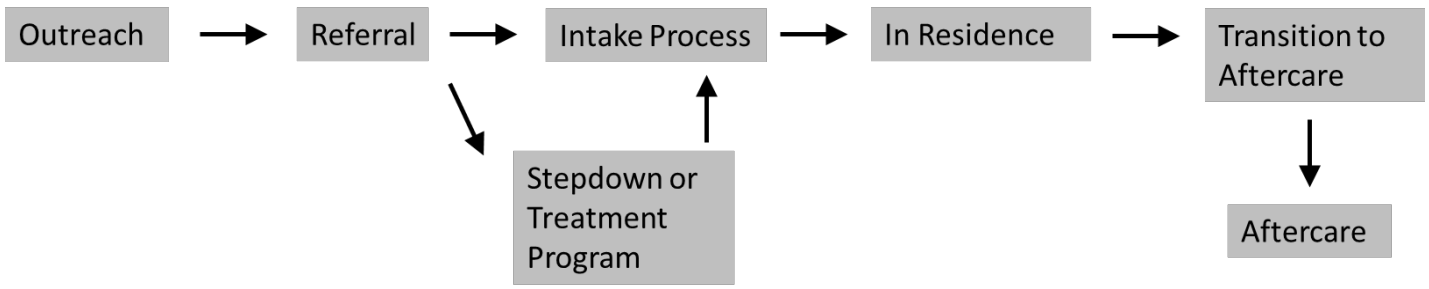
Casa Q

Process Map and Program Description

Casa Q is a residential transitional living facility with a focus on LGBTQ+ youth. This program is designed to provide an accepting, home-like environment for about eight young people. In service of providing a stable environment, Casa Q is intended to be a long-term living situation, serving youth until they age out or choose to move on rather than setting a time limit on their stay. Residential programming includes therapy, wraparound services, meetings, transition planning, and hands-on life skills training such as cooking and cleaning. According to program materials and interviews the aftercare system provides support when and where it is needed, allowing youth to retain a higher level of independence by acting as a safety net. Aftercare is handled by a specific case manager, and has served more youth at any given moment in time than there are in the residential program.

Figure 1 is a simplified version of the program process map (see Appendix C). These are visual representations of how the provider described the program to ISR CARA staff, from outreach to client discharge and aftercare. The descriptions for each element were gathered from conversations with the provider and documents reviewed in the creation of the process maps.

Figure 1. Casa Q Process Map



Outreach

Community outreach for Casa Q is conducted through schools and social services. School outreach targets two schools a month, rotating through different high schools and middle schools in the area. When possible, Casa Q conducts school outreach by attending Gay Straight Alliance meetings to speak directly to LGBTQ+ youth. Casa Q reaches out to social services with a bi-weekly flyer drop-off at various locations, including St. Martin's homeless shelter, NM Power, the Transgender Resource Center, the Truman Clinic, and SW Cares. They also participate in A New Day's Youth Blast drop-in center and Common Bond's U21 program.

Referral

After the initial referral is received, the referral packet is reviewed by Casa Q. Additional background documents are collected when possible such as school transcripts and previous behavioral health information. Casa Q uses this information to determine if the referred youth is eligible for intake into the program. Their exclusion criteria focus primarily on potential safety hazards, and includes active self-harm or suicidal ideation, active drug use, active non-compliance with taking prescribed medications, and violence against other youth or treatment staff within the last 12 months. Violent incidents are investigated on a case-by-case basis, as LGBTQ+ youth are at high risk for bullying and assault and cases of self-defense are not necessarily a basis for exclusion from the program. Once the referral packet and background documents have been reviewed, youth proceed to the intake process.

Stepdown or Treatment Program

At any point in the program, if a youth referred to Casa Q is a good fit except for an issue that has a resolution in sight, Casa Q will refer them to the appropriate program with the understanding that they are welcome to come back after the issue is resolved. This is a common approach taken for youth erroneously referred to Casa Q for stepdown from an inpatient or detention program. To mitigate the impact of moving from a highly structured system to one of high independence, Casa Q will refer youth to an appropriate step-down program and invite them to return when they are ready. Young people struggling with substance abuse but who are ready to seek treatment are another group that might take this path. If a youth is ready to seek treatment for a substance use disorder, they would be referred to another community-based provider, like Serenity Mesa, to receive that treatment and be welcomed back at Casa Q upon successful completion of the other program.

Intake

The first step of the intake process is an in-person interview of the prospective client conducted by the program director. Next is the staff screening, essentially a meeting among the staff where the client and their potential fit with the program is discussed. The final step before setting a move-in date is the house screening, normally conducted at a dinner or similar social gathering, where current residents sit down with the new youth as a final check for fit. If the potential client gets along with the current residents and decides they are ready to enter the program, a move-in date is set and they become a new resident of Casa Q.

Once a client is in residence, a "settling in" period occurs, usually about 30 days. This stage begins with intake paperwork, various needs assessments, and includes assignment of a wraparound team. Together the client and team co-create the client's Plan for Success which might include an education plan and/or employment plan, a crisis plan, medical, dental, physical and mental health plans, and therapy schedule (either once a week or bi-weekly). Wraparound meetings will continue to be conducted every 30 days.

In residence

The next stage for Casa Q residents is maintenance, where their primary goals are to maintain their day programming. If they have a C+ or better on day programming, they are allowed to get a job as well. Discussions about transitioning to independent living begin early, as soon as the client is ready to think of their next steps. The aftercare case manager is added to the client's wraparound team at the beginning of transition

planning. Once a transition plan is in place and the resident is ready to leave the program, intake into Casa Q's aftercare begins: case management is transferred to the aftercare manager and another needs assessment is conducted. The client then works with staff to co-create a Plan for Aftercare Success.

Aftercare

Aftercare is conducted through weekly or bi-weekly meetings for about 18 months, although the time can be extended if the client continues to express need for aftercare. Casa Q's aftercare system is intended to function similarly to the supports a young person would ordinarily receive from their parents after moving out of the family home. Casa Q provides advice and assists clients in fulfill immediate needs (e.g., obtaining home furnishings, transportation, etc.) and tries to help solves crises by either providing direct support or connecting them to the appropriate services.

COVID Impact

Casa Q's small size allowed their staff and residents to isolate in-house, with intakes and aftercare for non-residents conducted via telephone.

Performance Measure Review

According to the program, referrals came from 10 different agencies with the majority (73.4%) coming from four entities: shelter, CYFD protective custody, parents/family, and clients themselves. Slightly more than 40% of all referrals were declined for reasons such as parents withholding permissions, family complexities that required a higher level of whole-family care, violent behavior, or youth determining it would be a poor fit or ending engagement altogether.

According to performance measure data clients were most likely to have received mental health services, case management and substance abuse services. From April 2019 – May 2020 life skills services were also reported, some in a group format and others with one-on-one service delivery. The average number of group life skills hours deliver per month was about 13 hours, with 22 hours of individual lessons per month. All residents either had been enrolled in high school, a GED program, college classes, or had already achieved a high school diploma or GED. All residents participated in some form of job readiness and several had jobs for the duration of their stay. During this time period Casa Q reported 18 clients discharged from the program, with more than 80% successfully discharged. The aftercare program had about 7 clients per month; they received an average of 2.4 case management hours per client, per month.

Narratives show a program constantly adding capacity through partnerships, staff training, and program development. Casa Q reported partnering with: community providers for therapy; CNM and ABQ Charter Academy for education; Casa Hermosa (YDI) and New Day for housing; Serenity Mesa for an ""out of the box" case plan solution for LGBTQ youth who need substance abuse in-patient services" and for PRN staff sharing; All Faith's for clinical and wraparound services; and CYFD to expand services to youth who had been engaged in sex trafficking. Early in the program there were also several mentions of difficulties hiring qualified staff.

From June 2019 – August 2019 the program reported having a waiting list. The house census fluctuated based on referrals from other entities and, later, for adaptations for COVID-19 issues. When there were low census number among all YTLS providers in late 2019, staff increased efforts to encourage referrals from GSAs EmPower and TGRC. By December 2019 they reported being over capacity for the aftercare program. They consistently reported the lack of available TLP placement options, noting long waiting lists and the need for higher levels of care youth shelters for clients who aged out of Casa Q.

Throughout the reports to the County, there was an emphasis on the value of having a case manager and the importance of the aftercare program. Staff report working with residents on a new tiered process for earning privileges based on program goals met and created with residents and aftercare clients a new life skills curriculum.

Staff Interviews

Program Information

Six staff were eligible to participate in the interviews. Two interviews were completed with Casa Q staff, both of whom work full time and had a minimum of 10 years of experience in this field. Each held a bachelor's degree. The interviewees were united in expressing confidence in the program, and both identified housing and improving the lives of their residents through their time investment as primary goals of Casa Q.

> *I think you have to have time, time is valuable … time that we utilize every single day in the young person's life while they're with us to make their lives better…In the smallest ways, in the biggest ways.*
>
> *There's a lot of one on one adult support like you would have with a parent.*

Interviewees said their program is intended to make large time investments in each of their clients, facilitated by serving a relatively low number of youth in comparison to other housing programs, but having a significant impact in their lives. Casa Q is the smallest YTLS provider among the four, and interviewed staff emphasized what they viewed as strengths of being a smaller program.

> *Because our numbers are so low, 12 to 16 kids a year, we have this amazing opportunity to really provide a lot of support.*
>
> *We hold individual conversations with the kids, they can come to us if they have a rough day and we can immediately sit down and address whatever the problem is. There's a lot of face time involved.*

Outreach

Staff reported that Casa Q's outreach strategy focuses primarily on talking directly to LGBT organizations that serve youth, gay-straight alliances in schools, and at other programs within the community. According to the interviewees, Casa Q also reaches out to non-LGBT focused behavioral health and youth programs, like CYFD and youth shelters.

> *We have somebody out engaging with those kids [LGBT youth organizations], but I think in the last six years too we've really established ourselves within the social work community and in the educational Community. Our referrals have tripled in the last two years, in a good way.*

Referrals

The interviewees stated that the majority of their referrals come from CYFD. When asked what they believed their best source of referrals to be, answers were split; one interviewee said it was CYFD, and the other named youth shelters with the explanation that shelters more consistently gave referrals that were good fits for Casa Q. Staff report that Casa Q also receives referrals from LGBT community programs, JPOs, therapists, counselors, and other mental and behavioral health workers that engage with the age group served by Casa Q. Additionally, Casa Q's referral form is available on their website, a resource staff say was added to increase accessibility for self-referrals.

> *Just having that [referral form] accessible on our website for an aunt to download or a kid to download …by just that little tiny change we increased our intakes a lot, once people had this basic access.*

When asked whether there were any sources they wished they received referrals from but currently do not, Casa Q interviewees diverged.

> *I wish we could see more from religious organizations, like at the churches. We'll hear about it too late, like a teen is looking for help, and they're looking in a part of the church system. They need help, they're struggling with their sexuality. And they put them up in foster…I wish that they would involve us.*

I think there's an underserved population of two spirit, LGBTQ indigenous kids. And I think that as a community, as a state, we're doing those kids a big disservice.

Screening

Interviewees reported that Casa Q's screening process was primarily comprised of an initial search for "red flags," followed by a series of interviews (individual and then group), as seen in Casa Q's process map. According to the interviewed staff, red flags could be any one of a variety of different factors that indicate a youth may be unwilling or unable to safely join Casa Q. Some of these flags, such as a record of violence or sexual harassment, might be found during the initial stage of collecting and reviewing documents associated with the potential resident. Red flags can also appear during the series of interviews. Examples include potential clients showing up to interviews with Casa Q staff while intoxicated, expressing that they do not wish to attend Casa Q (and are participating in the process due to outside pressure), refusing to trade in their phones for a Casa Q-issued device[4], and stating that they have no intention of pursuing education. Staff also explained that potential clients might also need to be turned away if they lack a certain level of independence.

They have to be able to work our program, a big part of our program is independence. You have to be able to independently get up, independently do your schoolwork, go to therapy and be part of a wraparound team. We're not an intensive care facility; our staff is not equipped to handle somebody who isn't high functioning enough to be somewhat independent.

Staff also clarified that a red flag is not always an instant disqualification; if a potential resident is experiencing difficulties that may be resolved soon, Casa Q would refer them to an appropriate provider to assist them, then resume intake once the problem has been addressed.

We had a kiddo who came into here who had a recent history of drug use, so we referred (them) to Serenity Mesa and kept their bed while they finished the program, and then we allowed them in. Because they were perfect for the program, you know, this program was perfect for them, but they needed to get clean.

Intake and Assessments

Casa Q staff stated that intake consists of meeting with the prospective resident and their guardian to sign paperwork and one last "interview" that served as a chance to see how the potential resident and the current youth of Casa Q got along. Staff went on to explain that this "interview" is less formal (basically a test of fit between the prospective client and current residents), it could be a meeting, a meet-and-greet, or a house dinner. It was also used as a chance to introduce the residents to each other.

They look at our clients, that already have joined and they're like 'I see me in there. I see kiddos in the program who've been through whatever I'm going through and they're alive, they're fine, they're happy to be joking with me, I can do this, I was scared but now I'm ready to move in'.

Casa Q interviewees were united in expressing that intake is officially complete once the prospective resident has met the current residents and decided they still want to move in, and once their paperwork has been filled out. One interviewee revealed that the paperwork stage can be a barrier to some youth who wish to join Casa Q. Casa Q's residents are minors at the time of intake, so a legal guardian must sign them into the program. They explained that when a youth is estranged from their family but not in CYFD custody, the responsibility of signing them in to Casa Q can fall to the same legal guardians that originally kicked them out of their home. This was identified as a significant barrier by the staff members.

[4] Casa Q cell phones are assigned at intake. Youth are required to take their cell phones with them when they are off-site, primarily for safety reasons.

...the guardian has to sign the kid in, so one of the first questions we ask is if the guardian is gonna be willing to do that. Sometimes the kid will reach out [to us] themselves and be like 'I'm homeless because my mom don't like my lifestyle' and that's the whole problem because we need to get this guardian to sign them in. If they're not willing to, we can't take them. I've seen it a lot, we'll interview with this kiddo, they'll have a referral, and they need help. They need this so bad, and the guardian is just like 'no'. They want to just ignore the whole side of them that is gay. Like, 'you can live on your friend's couch but you can't live in a group home that caters to individuals like you,' it's so sad.

The interviewee went on to explain that Casa Q has a lawyer to advise them in situations like this, and they would also appeal to CYFD directly. They said that CYFD was sometimes able to step in if the situation was dire enough, but can only intervene if the case is an emergency.

When asked about assessments, a Casa Q staff member identified Casey Life Skills, ACES, and a psychological evaluation as assessments given at or near the time of intake. The Casey Life Skills was identified as a tool used to help build their case plans, based on identified strengths and weaknesses of the client. The interviewee said the ACES and the psychological evaluation were used more as an early estimate of what the new resident's behavioral and mental healthcare needs may be.

I think ACES really gives me an idea where [our team can say] 'Okay, we have John Doe, he's 15, here's where he's scoring on the ACES. Historically, have you worked well with kids like this?' So it really gives us kind of an idea of what to expect.

Service Delivery

Both Casa Q interviewees drew parallels to a family home in their descriptions of the services delivered by Casa Q. They listed a diverse selection of potential services, based on the individual needs of their clients.

We do provide all services that a family or parents provide. So we provide housing, we provide anything from medical to emotional to psych--I'm going to do everything. We schedule their medical evaluations, their mental health evaluations, their educational IEPS, we go to their parent-teacher conferences. We buy them clothes, we take them to prom…we literally do all the parenting functions that you would do on a daily basis, we refer them to any and every service they'll need.

We also do life skills. We do cooking, we do nutrition, we're actually doing wellness. We have a person in the community who is a physical trainer and a nutritionist and she's working with our kiddos in regards to nutrition and wellness so it's pretty awesome. We do life skills with medical, dental, med management, we make sure the kiddos have medications on site when they need them. Kind of like everything a child would need in a regular home setting, we do at Casa Q. And it's so individualized that it really works for them.

Additionally, one interviewee identified wraparound as the care-coordination approach used by Casa Q. (This appears to be a general approach modeled after High Fidelity Wraparound.)

In the last 16 months, 24 months every single one of my kids that have been accepted in Casa Q, I've also created a wraparound team for them.

Discharge

According to Casa Q employees, there are a variety of ways a successful discharge from their program could occur. They explained that these are based primarily on the goals identified by the resident during the course of Casa Q's programming, so how success is defined will vary from client to client.

This is definitely a successful discharge: a kiddo who's aging out of the system, like 17 and a half or 18 and they're transitioning to a transitional living facility or to their own apartments with their partners.

There are kiddos who will discharge and move back home, move back with their parents. All of those are successful discharges. If you've moved where you want to move, that's successful. It's your party. You know, if you've achieved the goals you set with your case worker, you've succeeded. If your case plan was just "get out of Casa Q" and you did, good job, you did it."

When asked about involuntary discharges, Casa Q interviewees mostly pointed to potential safety issues. They stated that Casa Q is not an inpatient or medical facility, so residents may need to be discharged if they require a higher level of care.

We had a kid who was doing self-harm and refused to go to counseling. And if we left them alone, they would hurt themselves. We had people checking in on them once an hour, day and night, but as soon as we turned our back they would hurt themselves. We're not equipped to keep a kid like that safe, so we had to discharge.

Residents may also be discharged for threatening staff or other residents, consistent bullying behavior, bringing drugs or alcohol into Casa Q, fighting, or consistent refusal (or inability) to engage with Casa Q programming. Casa Q interviewees also mentioned that some residents may unsuccessfully discharge themselves by running away from Casa Q and not returning. One staff member reported that residents who repeatedly run away and return may need to be discharged on the grounds that they do not wish to stay at Casa Q.

Aftercare

Casa Q's aftercare program is a separate, defined structure as opposed to an informal extension of their program.

We actually have a case manager just for our aftercare kiddos. She would meet with them once a week. Make appointments with them, help them figure out how to manage their finances, give them any needed supplies, like we had food baskets. Basically her main job was to make sure the kids stayed stable after they moved out. It was a big help to have her on that. That's kind of just case management for aftercare in a nutshell, just meeting with them once a week until they didn't need it anymore.

According to Casa Q staff, this case manager is added to the resident's team about 60 days prior to their planned discharge from the main program to ensure smooth the transition. Staff also reported that a separate case plan is made for aftercare, using the same form residents have learned during their time at Casa Q so it is familiar to them.

Casa Q's aftercare theoretically lasts eight months according to their process map, but interviewees report that this time period can be longer in practice, because transitioning youth out of the aftercare program may pose some difficulty.

I think that it's really hard to get the kids from shelter to aftercare, and out of aftercare. I think that's one of our struggles, because you have to also look at that we possibly have known this young person, been working with them, since they were 15… they're only going to become stronger humans and stronger adults, by having our support.

When asked about barriers to providing aftercare, interviewees identified a variety of issues. One stated that the biggest issues where a lack of housing availability and the difficulty of finding safe places for openly LGBT youth to work. The other brought up youth not wanting to accept help, staffing, and, in cases where a former client had moved out of reach of local services, distance.

Client Data

Casa Q does not have an electronic record management system or a formal paper record system that results in a client record. The information we were provided and that is reported below was gathered by the program from a variety of paper records and automated into two worksheets in one MS Excel file. We received data for 56 clients admitted between January 2015 and December 2020 as residents at Casa Q. Because the contract between the County and Casa Q was not signed until mid-May 2018 we removed all clients with an intake date prior to mid-May 2018. This resulted in 27 Casa Q clients who had admission dates between mid-May 2018 and December 2020. Four of these 27 clients or 14.8% were still residents of the program as of early August 2021 when we received the data. We received two sets of data from the program. "General" data included length of stay in the program, the month and year clients were admitted and discharged, the reason for leaving, the referral source, general information on their behavioral health, whether they had a history of contact with the juvenile justice system (yes or no), whether the client received mental health services and the frequency, and the number of hours of life skills training, education, therapy and case management. Demographic data included – age, gender, gender identity, sexual orientation, and race/ethnicity. These data cannot be matched to the "general" information and we did not have a way to know which of the 27 clients were in the program during the funded time period. For this reason, we do not report any demographics. As mentioned elsewhere, state law only allows de-identified data for minor clients.

Table 1 reports the referral source for the 27 clients. The most frequent sources of referral were from CYFD (48.2%). Ten clients were referred from shelters and four were referred from other sources. These included "Therapists" and from a "Receiving Center".

Table 1. Referral Source

	Count	Percent
CYFD	13	48.2
Shelter	10	37.0
Other	4	14.8

According to the data reported the large majority of clients (77.8%) were using some substance at admission into the program. Marijuana by itself or in combination with another drug was listed as the substance for 61.9% of the clients who used a substance. Substance abuse was listed as a "yes" for 7 clients, a "no" for three clients and N/A for two clients.

Table 2 reports the services received by clients while residents in the program. This table does not include the four active clients. This information does not match to the performance data that reported an average of 13 hours of group life skills hours per month and 22 hours of individual lessons per month. The data provided by Casa Q did not include individual lessons.

Table 2. Clients and Services

	Clients	Average Hours	Total Hours	Range in Hours
Life Skills	23	20.4	469	2 - 72
Education	18	772	13,897	48 – 1,780
Therapy	13	28.1	365	2 - 72
Case Management	23	43.5	1,034	4 - 256

The program reported whether clients received mental health services and how frequently (Table 3). This was not applicable for all clients. Twenty clients received mental health services weekly and two clients received services bi-weekly. The program did not provide the type or length of service.

Table 3. Mental Health Services

	Count	Percent
Weekly	20	90.9
Bi-Weekly	2	9.1

At the time we received the client data in early August 2021, 23 (85.2%) of the 27 clients had discharged from the program.

Table 4. Program Status

	Count	Percent
Active	4	12.9
Closed	23	85.2

Table 5 reports the discharge reason for closed clients and excludes the four active clients. Seven clients successfully completed the program and 14 clients did not successfully complete the program for a variety of reasons. This finding does not match to the performance measures which reported 80% of discharging clients discharged successfully. Three of the clients turned 18 years of age and were no longer eligible for the program; they were referred to other housing. Three clients ran away, three returned to their families, three needed a higher level of care, and three were discharged for unsafe behaviors (i.e. physical assault).

Table 5. Discharge Reason

	Count	Percent
Successful	7	31.7
Turned 18	3	13.6
Run Away	3	13.6
Return to Family	3	13.6
Need for Higher Level of Care	3	13.6
Unsafe Behaviors	3	13.6

Unknown 1

Table 6 reports the length of the stay in the program. On average clients spent on average 130.2 days in the program (range 5 days (2) to 575 days).

Table 6. Length of Stay in Program

	Count	Percent
30 Days	6	27.3
60 Days	1	4.5
90 Days	6	27.3
120 Days	1	4.5
150 to 180 Days	3	13.6
210 + Days	5	22.7

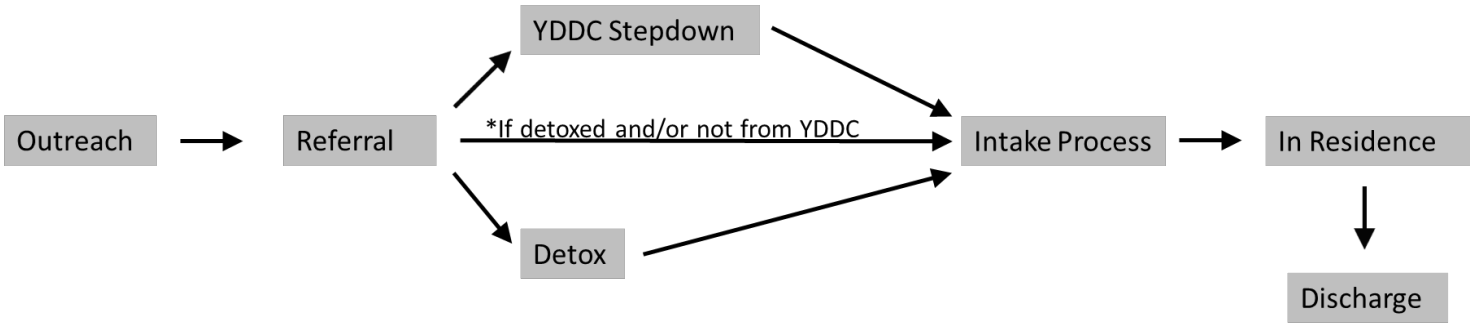
Missing 1

Serenity Mesa

Program Description

Serenity Mesa is a sober living facility for youth ages 14-21 with a primary focus on addiction recovery. While both male and female youth are served at this facility, the YTLS funding is for services for up to six females. The ideal stay at Serenity Mesa is 4-5 months long, although a discharge can still be considered successful if the young woman has finished the intensive outpatient program (IOP) portion designed to be completed within the first 3 months. In addition to substance use counseling delivered using The Seven Challenges model, youth at Serenity Mesa also move through "the Five Phases", Serenity Mesa's own system for tracking progress on daily responsibilities and programming. If all goes well, a young person at Serenity Mesa completes about one phase per month. Each completed phase allows more freedom within the program. A six-month check-in is attempted for each former client post-discharge. Serenity Mesa intends to fully implement a formal aftercare system in the future. Figure 2 is a simplified version of their process map (see Appendix D). These are visual representations of how the provider described the program to ISR CARA staff, from outreach to client discharge and aftercare. The descriptions for each element were gathered from conversations with the provider and documents reviewed in the creation of the process maps.

Figure 2. Serenity Mesa Process Map



Outreach

Serenity Mesa conducts provider outreach using the email blast platform Constant Contact, as well as brochure drop-offs at treatment providers such as Turquoise Lodge, UNM, and DBHS's Comprehensive Assessment and Resiliency through Excellence (CARE) campus. Community outreach is conducted via Facebook, Instagram and Twitter, as well as at event tables at health fairs. Outreach can also be conducted in-person by representatives of Serenity Mesa speaking to school assemblies or directly to leaders in the community.

Referral

The majority of Serenity Mesa's referrals come from inpatient treatment providers and corrections facilities, followed by parents and family members. In descending order, the remainder of their referrals are self-referred, referred by another YTLS provider, or referred by Juvenile Justice. Their referral process is a multi-step procedure that begins with Serenity Mesa receiving the referral packet. After all relevant background documents are collected and reviewed, a clinician assessment is conducted either in person or over the phone to determine the SUD status of the applicant. Serenity Mesa's program is only intended for youth who have a substance use disorder; those who do not meet this criterion are assisted in finding alternative placement instead of moving on to the next step of the intake process. If the interview indicates they are suited to enter the program, a prospective move-in date is set.

Transition to Intake (only for YDDC or non-detoxed youth)

At this point, there is more than one path a potential client could take to intake. If the client has not yet gone through the process of detoxification (detox), they must first detox for the minimum required number of days (3) before intake. Serenity Mesa has a detox requirement for safety reasons. While they are able to dispense Suboxone and other maintenance drugs, Serenity Mesa is not intended to be a detox facility and is not equipped

to handle life-threatening withdrawal symptoms. Therefore, potential residents must be detoxed for a minimum of three days before entering the facility; ideally for 5-7 days. Efforts are made to assist youth in this process when necessary. Serenity Mesa will connect youth with Suboxone providers such as UNM Adobe and Sage Neuroscience. Youth requiring detox may also be directed to Mesilla Valley Hospital or The Peak for inpatient detox programs. One exception to the three-day detox rule is marijuana: the withdrawal from marijuana is non-life threatening and the length of time THC can remain in the system for regular users makes it difficult to verify whether or not the detox requirement has been fulfilled. Instead of being part of the detox requirement, THC levels are monitored throughout the program for fluctuations that could indicate current use.

Intake

The on-site intake process includes a urine drug screen. The presence of drugs (other than marijuana) in this test is considered a failure point in the process. Youth who screen positive for drugs cannot proceed to the next step of intake, although spots may be briefly held for them on a case-by-case basis while they attempt to meet this requirement.

Youth who screen negative see a case manager who assists them in filling the intake paperwork packet. Their belongings are searched and all contraband is taken. Additionally, all clothing is washed by a staff member. The youth is then turned over to another staff member who goes through the resident handbook with them and orients them to Serenity Mesa with a tour and introductions. Following these steps the client officially moves in to Serenity Mesa.

In Residence

The first 30 days in residence is considered a settling in period. A behavioral health assessment is conducted within 10 working days of entry to gauge the client's current status. The client begins intensive outpatient therapy (minimum 9 hours a week), life skills programming (minimum 5 hours a week), and has the first of their monthly treatment team meetings. If the client does not have a high school diploma, they will also enroll in a high school equivalent or GED prep program. At the end of 30 days they should have completed Phase I, for which the completion incentive is an 8-hour off-campus pass.

The next step in residency is the 31-90 day period. Clients continue with 9 hours per week of outpatient therapy, Clients at this stage are issued one 8-hour pass a week to leave Serenity Mesa's campus and upon completion of Phase II, an overnight pass. Completion of Phase III should coincide with 90 days in the program. At this point they may petition for a cell phone and are provided greater opportunities for off-campus travel. If they have a high school diploma, they begin a job readiness program. From 91 to 180+ days, clients are considered to be in the final stage of the residential program and continue with outpatient therapy and case management for a minimum of 2 hours per week. Intensive outpatient therapy will have been ideally completed by the end of the first 90 days. During this stage, clients are allowed significantly more freedom: up to three days a week off campus, not including passes given for meetings, community service, and one free day. There are still assignments to complete Phases IV and V in the last two program months. If the client is still in residence after 181+ days, obtaining a high school diploma or GED and/or a job are program goals.

Discharge

While residents are eligible for successful discharge after completing the intensive outpatient therapy in the first 90 days, the suggested length of stay is 3-4 months, with the ideally successful client having completed all five phases. Discharge Planning, which includes relapse prevention, a continued education plan, continued individual and group therapy, living arrangements, and transportation options, is finalized in this phase. There are several scenarios that are considered unsuccessful discharges. Some clients leave the program early, with or without staff involvement. Residents may be discharged early upon their request, or for rule violations. It is also possible for a client to be discharged when a condition that Serenity Mesa is not equipped to safely handle

either develops or is revealed. In these cases, Serenity Mesa will make efforts to help the client get into another facility with the appropriate level of care. The final way residents leave is by absconding, simply leaving the facility with no notice.

Serenity Mesa has a three-day grace period for residents who abscond, allowing them to return to the program if they pass a urine screen. There is some flexibility on this requirement on a case-by-case basis. (e.g., Serenity Mesa may choose to work with a client who used a drug on the first day they left if they are committed to returning and resuming their programming.) Serenity Mesa's aftercare program is not yet evaluable.

Performance Measures

For the first two program years, Serenity Mesa reported all assessments were completed in less than 10 days and reported providing an average of 116 hours of IOP per month and 15.5 hours of case management per month. On average, by month clients received 21 hours of life skills activities, participated in an average of 29.4 hours per month of health and wellness activities and 21.1 hours of experiential learning activities. In an average month, the program reported, about 2 residents were either enrolled in high school, GED program, or college classes. An average of 3 clients per month "phased up" as they worked through their programming.

In the first 21 months of the program, 7 residents were successfully discharged into housing including permanent housing, family/guardian/friends/foster care or TLP. Of the 20 residents who discharged unsuccessfully 40% returned to homelessness, 20% disengaged from services and 15% exited to an in-patient program. For most of the remaining 25%, their location and status were unknown. At the end of June 2021 Serenity Mesa reported having discharged 28 residents since June of 2020. The majority of residents (60%) had housing at discharge, most with family or a guardian. About 18% returned to homelessness and the remaining 22% were unknown or in the corrections system.

Early narratives show a program transitioning from serving males to serving females, including adjustments in policies, procedures, programming, and activities. There were challenges associated with the staff's unfamiliarity with female adolescent behavior, these were met with continuous staff training and policy adjustments. Staff recognized that female clients were more likely to abscond than male clients so they looked for patterns to discover issues they could address early enough to deter flight. The increased use of Fentanyl among youth posed another challenge resulting in a procedural revision for residents returning from a day pass under the influence of drugs and requiring detox. At drop-off, family members were requested to wait for the results of an instant UA so they could take the resident to a hospital or detox.

Securing an educational partner for GED/high school enrollment was also a theme in the early narratives with the eventual resolution by a partnership with RFK Charter School. Collaborations with New Day's hi-fidelity wraparound services and TLP, and CYFD continued to generate referrals and additional efforts were made to market services to other provider who worked with SUD youth. Staff attended meetings and trainings monthly for a variety of subjects including Nurtured Heart, NARCAN, and Motivational Interviewing.

Staff hiring and retention was a challenge throughout the program. One potential remedy was to partner with Casa Q for PRN staff sharing. SM reported housing options for discharging youth as a continuous struggle. The stay at home order for COVID-19 precautions introduced additional challenges for staff and residents requiring rapid adjustments to house activities, service delivery (tele-health), school attendance (remote learning), and access to family members (via virtual platforms). The number of residents and staff on site were both lower than usual. Normal operations resumed in May 2020 and SM addressed their waitlist.

Staff Interviews

Program Information

Interviews were completed with Serenity Mesa staff in a variety of positions, from upper management to peer support workers. Eleven staff were eligible for the interview: two declined to participate, five completed, and the remainder did not respond to our requests. Most of those interviewed had worked at Serenity Mesa for 3-6 years. The majority of interview participants had completed some college, with a minority holding masters' degrees. All of the staff interviewed shared certifications they considered relevant to their work at Serenity Mesa, including peer support worker, NARCAN, Nurtured Heart, and Crisis Prevention (CPI) certifications. The majority of staff worked full-time on YTLS, with a few working half-time or less.

Outreach

Interviewees asserted that Serenity Mesa's outreach efforts cover a broad scope of activities. Interview participants highlighted tables at health fairs and other events as a primary focus for Serenity Mesa's outreach efforts.

> *If there's anything local where we can have a table, we participate in that type of outreach. We also participate in community events, so Albuquerque Celebrates Recovery, some of the Office of the Peer Resource and Engagement area events. We do have a website, we have a Facebook page, we have a newsletter that we send out through Constant Contact and we also do face to face meetings with juvenile probation officers, judges…really anybody any anybody that we could potentially get a referral from.*

Additionally, multiple Serenity Mesa staff mentioned traveling around New Mexico to reach out to institutions and judges in other communities, such as Raton and Las Cruces. They stated that Serenity Mesa does not have a marketing department, so most of this outreach is conducted by the administrators and other staff members. More than one employee also spoke about conducting NARCAN trainings as a form of educational outreach for Serenity Mesa.

Referrals

Most of the Serenity Mesa employees interviewed were not responsible for processing referrals, but those that were gave very consistent answers for this section of the interview.

> *The majority is from other caseworkers or JPOs, POs. Those are our biggest referral sources, then the other part would be family or guardians and self.*

When asked what they believed their best source of referrals to be, interviewees were unanimous in asserting that JPO's and PO's were the best sources of referrals for Serenity Mesa. One interviewee explained that this was because about half of the time, young people referred by their parents or self-referral do not actually show up at the facility, or may arrive in a state of intoxication. They consider referrals from JPO's and PO's to be significantly more reliable, as the probation officer will ensure that the youth is detoxed, and will often personally transport them to Serenity Mesa.

Perceived gaps in referrals included the county jail, which once referred young adults (18-21 years old) to Serenity Mesa but stopped after the staff person who did so left. Also highlighted was Bernalillo County's CARES Campus, which does serve young adults who fit the demographics targeted by Serenity Mesa but has never given them a referral, according to an interviewee.

Screening

According to staff, the first step in screening a referral is collecting background documents. They explained that the biggest things they look for are potential threats to the safety of their residents, such as any history of sexual assault or extreme violence. Some cases of violence may be looked at more closely if they involved drug use, as one interviewee described, violence related to active intoxication may be taken under special consideration.

So say if they were high on meth and they acted out aggressively, we may look at that differently then somebody who, you know, has robbed and beaten up people just for the heck of it.

Interviewees also stated that Serenity Mesa may direct referrals elsewhere if they are a danger to themselves or are otherwise experiencing a condition that Serenity Mesa is not equipped to handle. Examples included youth that are actively experiencing suicidal ideation, psychosis, or severe eating disorders. Staff reported that a youth who receives treatment for one of these issues elsewhere and successfully stabilizes may be accepted back at Serenity Mesa with priority.

Serenity Mesa staff reported that if the referral passes the initial screening, the next step will be an interview to determine their substance use disorder status. They stated that this interview would be conducted by a therapist or clinical director, and based on their recommendation the referral will either be accepted or directed to other resources.

A lot of times, people will just try to send somebody in and they smoked weed once in their life, they don't really have a substance abuse disorder. They just have a management issue with their kids and they want them to go into treatment. So we have to filter those kinds of things out."

Intake and Assessments

According to the interviewees, a urine analysis (UA) is conducted when a prospective resident first arrives at Serenity Mesa to ensure that their detox requirement has been fulfilled.

They have to be detoxed so when they come in if they test positive for illicit substances, then we know that they're probably under the influence or they've used within the last three days. We tell them that ahead of time, "you cannot test positive for heroin, meth, opiates, cocaine," things like that, or you won't be able to stay, you have to go off to the detox first.

Serenity Mesa staff said that if the youth passes the UA, they will then go on to the process of filling out the intake paperwork, which takes 1½ to 2 hours and includes a set of assessments. The assessments listed as being given at or near the time of intake were the GPRA (Government Performance and Results Act Client Outcome Measures for SAMHSA-related projects), the GAIN-SS, ACES, and a social determinates of health questionnaire. They stated that the AESQ and the GAIN-SS are repeated every 30 days, and that the GPRA and social determinants of health assessment are repeated at discharge.

After filling out their paperwork, interviewees said a frontline staff person would search all the belongings of the new resident, confiscate any drugs or drug paraphernalia, and then wash all of their clothes. They stated that valuable items such as jewelry and electronics would be locked up for safekeeping, to be returned when the resident exists the facility. Staff report that intake also includes a tour of Serenity Mesa's campus.

The whole process takes about four hours. Once that process is completed, then they go into the lodge and if everybody is in life skills for the afternoon, then they just kind of jump in wherever they're at."

Service Delivery

Serenity Mesa staff reported that the primary service offered is substance abuse treatment. According to interviewees, the core of their program is 90 days of IOP, consisting of nine hours a week of individual and group therapy conducted under the Seven Challenges and Seeking Safety models. Interviewees also stated that at least five hours a week of life skills classes are delivered to Serenity Mesa's residents. When asked what kind of life skills their residents receive, employees listed a wide variety of offerings.

Everything from, cooking, cleaning, personal hygiene, leasing apartments, changing tires, staying sober, coping skills, personal development, writing resumes, budgeting…and interviewing for jobs.

Interviewees reported that in addition to the minimum five hours of life skills there is Serenity Mesa's job readiness program, and seven hours a week of health and wellness, or about one hour a day of some form of physical activity, be it going to their on-site gym, playing basketball, or taking a walk outside.

Serenity Mesa staff also said that education was a significant component of their program, with high school classes and GED preparation facilitated by RFK Charter School. They said that residents without high school diplomas have the choice of classes or GED prep, and that those with diplomas would continue to work on their education or choose to focus solely on job readiness. One interviewee noted, "A lot of kids come in and they get their GEDs, which is a big step for them."

Additional services were also reported to be delivered based on individual needs of Serenity Mesa residents, as determined by their case managers.

> *A lot of them with substance abuse problems also have neglectful parents. A lot of things are neglected medically, like dental needs. A lot of them need glasses, doctors' appointments, med management. So those are things that [staff] help with, depending on the kid and their needs. Helping them get a driver's license, helping them get an ID, helping them replace vital documents like birth certificates, Social Security cards, just anything that they need to get their feet on the ground.*

Staff also said that residents who arrive at the facility without basic necessities such as clothing will have those things provided to them by Serenity Mesa.

Discharge

Interviewees noted that completing 90 days was considered a successful discharge. During that time:

> *They've completed all of the IOP requirements, case management requirements and therapeutic requirements. Some children are eligible to stay longer, depending on their home situations. That way they can start working saving money or for waiting for placement, things like that. But typically it's 90 days.*

Other reasons for discharge include behavioral issues, physical violence, and bringing drugs on campus.

> *So sometimes you'll just get a kid who just is completely and constantly defiant. They'll get multiple chances and opportunities but if they're just not putting any effort into the program, then at that point. we have to find different placement. And again, it has to be constant and extreme negligence of programming.*

Discharge planning begins early in a client's stay at Serenity Mesa based on where the individual would like to be when they finish the program. They develop a discharge plan, an aftercare plan, and a discharge summary noting everything they accomplished while in the program. Staff also try to facilitate a smooth transition to post-program life.

> *For those who want, we do provide after care by therapy and our services. That's one of the discharge planning things we do. Then it's finding placement for them, that's a big one. Getting them into other services if they're out of town or if they didn't get their diploma, making sure they transition in to another school or GED program….It just depends on the kid but making sure that they have a safe place to go is a priority.*

Aftercare/Rapid Re-housing

Serenity Mesa had recently expanded their program to include formalized aftercare. This new component was not funded through the BHI but appeared to be an important component to supporting program graduates in their recovery from substance abuse.

We have a rental assistance program that we just started where our clients can graduate our program and move into an apartment and for a year they'll get rental assistance from us, in addition to a stipend. We also do continued therapy with them, so they'll get an individual therapy session once a week and a case management session once a week. They'll still be drug tested and they'll get face-to-face on-site support.

COVID Impact

According to program staff, as a result of being a housing facility, Serenity Mesa was heavily affected by COVID-19. Staff report that the majority of youth chose to leave the facility due to the pandemic risk. Intakes were halted and the facility was manned by a skeleton crew of two. The remaining the staff worked from home in compliance with the governor's orders. Serenity Mesa continued to delivery IOP, life skills, individual therapy, and case management services over the phone or via video conferencing.

Client Data

We received data for 62 unique female clients admitted between September 2018 and June 2021 as residents in the Serenity Mesa female housing unit. Four females were admitted twice which means the program served 66 duplicated clients. We received services for one client who was not included in the demographic data. We do not know why this happened. As mentioned elsewhere state law allows us access to identified data for adults with the approval of an Institutional Review Board but does not allow identified data for minors. Serenity Mesa served both minors and adults. We largely received de-identified data for adults and only de-identified data for minors. We did not receive intake dates or discharge dates or dates of services.

We received data from Serenity Mesa in two forms. First, we received electronic data that consisted of a listing of all clients with some intake and demographic data. This included age, race/ethnicity, education, drug of choice, living situation at intake, whether the client was on probation or not, discharge status, length of stay in the program, and placement at discharge. Second, in mid July 2021 we received paper copies of a form unique to this program called a "Phase Form". The program includes five phases that are designed to take a month to complete and which is mentioned in the program description. Activities and services are recorded weekly using this paper-based Phase Form. The paper Phase Form is provided to each client and each resident receives signatures for completing required phase tasks. After successfully completing a phase residents are moved to the next phase. The program provided paper copies of these forms with the names redacted for minor clients.

We were also provided discharge summaries and treatment summaries for some clients who had left the program. The discharge summary contained information summarizing the client's performance while in the program and the discharge reason. The treatment summary form contained a summary of the client's treatment to date by phase. The phase forms, discharge summaries, and treatment summaries came in a bound packet for each client and contained unique identification numbers developed by the program solely for the purposes of this study. These forms were not used in the analysis for two reasons. First, discharge information was included in the electronic data and second, and importantly, the discharge and treatment forms primarily consisted of notes summarizing treatment and discharge and the treatment summary notes could not be converted to a count of services.

Table 7 reports the "living situation" for the 66 clients prior to becoming a client. Because the living situation for the four duplicate clients differed between admissions they are reported twice. This information appears to be a combination of the living situation of each client and the referral source. For example, the Detention Facility/Criminal Justice System category includes detention facilities (i.e. living situation) and the juvenile probation office (i.e. which suggests a referral source and not a living situation). This information should be collected as two variables – living situation and referral source. Slightly more than 25% of clients were living

at a treatment facility prior to being a resident. Only 21.2% were living with family prior to being admitted to the program, 15.2% were homeless and 15.2% were involved with the criminal justice system.

Table 7. Situation Prior to Becoming a Resident

	Count	Percent
Family	14	21.2
Homeless	10	15.2
Treatment Facility	18	27.3
Shelter	5	7.6
Detention Facility/Criminal Justice System	10	15.2
Self	7	10.6
Other	2	3.0

Table 8 reports race and ethnicity. Almost 60% of clients were Hispanic, 27.6% identified as White, 12.1% were American Indian, and 3.4% were African Americans. Race/ethnicity information was missing for 4 clients.

Table 8. Race/Ethnicity

	Count	Percent
American Indian/Alaskan Native	7	12.1
African American	2	3.4
Hispanic	33	56.9
White	16	27.6
Total	58	100.0

Missing 4

Table 9 reports age by age group for all 66 clients. Because 3 of the 4 client who were in the program twice were different ages at each admission all duplicate clients are included. The average age of all clients was 17.6 years of age. The youngest clients were 14 years old and the oldest client was 23 years old at intake. Thirty-six clients (55.3%) were minors.

Table 9. Age

	Count	Percent
14 to 15	9	13.8
16 to 17	27	41.5
18 to 19	15	23.1
20+	14	21.5
Total	65	100

Missing 1

Table 10 reports education while in the program. Thirty clients (46.2%) were working on their GED while in the program. Twenty-four clients (36.9%) either had their High-School diploma or GED or were not in the program long enough to enroll in school. Eleven or 16.9% of the clients were enrolled in high-school.

Table 10. Education

	Count	Percent
GED	9	13.8
High School	27	41.5
Not Enrolled	15	23.1
Total	65	100.

Drug of choice information was provided and is reported in Table 11. Methamphetamine use accounted for 25%, followed by Other (17.2%), and then Heroin (15.6%). Other included multiple drugs and benzodiazepines.

Table 11. Drug of Choice

	Count	Percent
Alcohol	9	14.1
Cocaine	5	7.8
Fentanyl	8	12.5
Heroin	10	15.6
Marijuana	5	7.8
Methamphetamine	16	25.0
Other	11	17.2

Missing 2

Table 12 reports services for clients based on the Phase Forms. We received Phase Forms for 27 clients who had discharged from the program and Phase Forms for 4 of the 6 active clients. We do not report services for the 4 active clients and only report on the services received for the 27 discharged clients. It is not completely clear why we did not receive Phase Forms for 31 discharged clients, but it appears this is primarily because these clients did not remain in the program a minimum of 30 days and so did not have a completed Phase Form. We were told clients keep their phase forms and these clients may not have provided them to staff when they left. We received discharge summaries and/or treatment summaries for some clients that indicated they had discharged and/or received services beyond Phase 1 but there were no Phase Forms for them. For this reason, services are not reported for clients who received services but did not remain in the program for at least one month, and did not submit a Phase Form, and for clients for whom we did not receive Phase Forms.

It is important to point out the program was extremely cooperative in responding to our requests for client level data. CARA staff met with Serenity Mesa staff several times face to face and exchanged a number of phone calls and emails over the course of data collection. As noted elsewhere, we could only accept deidentified minor data. We agreed the Phase Forms were a solution to this issue for this study. This solution still required the provider to pull these forms, make copies and deidentify them. The pandemic exacerbated this issue because we could not review electronic files and work more closely with the provider to figure out how to extract data from the electronic record system. The program was clear more data was available in the electronic record system than what we would be provided using the Phase Forms. Time and circumstances did not allow us to acquire electronic data.

Twenty-seven clients received 2,470 services in an average of 56.5 days with an average of 95 services and a range of 27 to 221 services. Importantly, we were not able to differentiate the time periods for the 4 clients who were residents in the program twice. This occurred because we did not receive intake and discharge dates for the clients.

Clients received a mix of services that were collapsed by the program into the five categories listed below. Therapy was the most frequently provided service (42.2% of all services and 40.2 on average per client), followed by life skills, and case management. Twenty-three clients received an average of 3.6 career/job services.

Table 12. Services and Contacts

Service Received	Clients	Services	Percent Receiving Service	Percent of All Services	Mean	Range
Total	27	2,470	100%	100%	95	27to 221
Therapy Services	26	1,044	96.2	42.2%	40.2	7 to 90
Case Management	26	322	96.2	13.0%	12.4	4 to 24
Life Skills	26	964	96.2%	39.0%	37.1	13 to 95
Career/Job	23	82	85.2%	3.3%	3.6	1 to 14
Discharge Planning	25	47	92.3%	1.9%	1.9	1 to 6
Other	6	11	22.2%	0.4%	1.8	1 to 3

Table 13 reports the last phase completed for the 26 clients for which this information was available from the phase forms[5]. Almost equal numbers of clients completed Phase 1, Phase 2, and Phase 3. One client completed Phase 4.

Table 13. Client's Final Phase

	Count	Percent	Services	Percent
Phase 1	8	30.7	1,100	44.8
Phase 2	9	34.6	866	35.2
Phase 3	8	30.7	457	18.6
Phase 4	1	3.8	34	1.4

Table 14 reports services provided by phase for all clients.

Table 14. Services by Phase

	Phase 1		Phase 2		Phase 3		Phase 4	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Career/Job	15	1.4	23	2.7	36	7.9	8	23.5
Case Management	157	14.3	121	14.0	40	8.7	4	11.8
Discharge Planning	8	0.7	3	0.3	17	3.7	0	0.0
Life Skills	447	40.7	350	40.4	153	33.4	14	41.2
Therapeutic	459	41.8	365	42.1	212	46.3	8	23.5
Other	11	1.0	2	0.2	0		0	0.0
Total	1,097	100	866	100	458	100	34	100

Eighteen clients (30.5%) successfully completed the program and 41 clients did not discharge successfully (Table 15). Nineteen clients absconded from the program, 11 were expelled for various reasons, and 11 were left the program for other reasons including needing a higher level of care, not wishing to fully participate, and death in the family. Clients were expelled for fighting, drug use, or other violations of program rules.

Table 15. Discharge Status

	Count	Percent
Successful	18	30.5
Absconded	19	32.2
Expelled	11	18.6
Other	11	18.6

Missing 1

[5] According to the provider, the numbers from the phase forms do not match the numbers in their EMR system: they undercount the number of clients who discharged at Phase 4.

On average clients spent 56 days in the program with a median of 42 days. Four clients were in the program for over 121 days and 6 clients were in the program 1 day.

Table 16. Total Days in Program

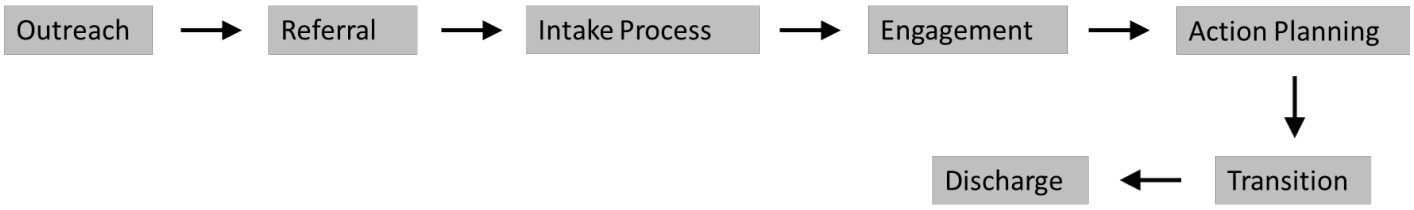
Less than 10 days	12	21.4
11 to 31 days	12	21.4
32 to 60 days	8	14.3
61 to 90 days	8	14.3
91 to 120 days	12	21.4
121 -176 days	4	7.1

Missing 4

New Day

Program Description

New Day is an organization that provides a wide variety of services to youth and their families. Their YTLS program is a small slice of these services and uses the High-Fidelity Wraparound (HFW) model to serve youth ages 15.5-25 with multi-system involvement (e.g., CYFD or courts and corrections) and/or are diagnosed with a severe emotional disorder or mental illness. High-Fidelity Wraparound is an evidence-based practice designed to be used for youth with complex needs. It focuses on building and employing a wraparound team to help the needs of the struggling youth. Wraparound teams may consist of the youth's family, close friends, probation officer, or other community supports in addition to healthcare professionals. New Day's program is not residential, although youth from residential programs may participate in HFW. At the time of evaluation, New Day has no formal aftercare system but youth are allowed stay in communication with New Day staff after discharge to receive additional guidance if they so choose. Figure 3 is a simplified version of their process map (see Appendix E). These are visual representations of how the provider described the program to ISR CARA staff, from outreach to client discharge and aftercare. The descriptions for each element were gathered from conversations with the provider and documents reviewed in the creation of the process maps.



Outreach

New Day outreach is primarily aimed at other YTLS providers and community organizations. This list includes the New Mexico Transgender Resource Center, UNM LGBTQ Resource Center, APS Title I Project, Equality New Mexico, Common Bond, PFLAG, Engender Inc., and Bernalillo County Juvenile Detention Alternative.

Referrals

New Day's referrals come from the Young Adult Court, other transitional living programs, life skills programs, Juvenile Justice, CYFD Protective Services, and the behavioral health and housing provider communities. Their criteria for intake begins with age and geographical requirements: potential clients must be 15.5 to 24 years old and a resident of Bernalillo County. They must also be involved in at least one system (such as CYFD or juvenile justice), and have a functional impairment of some kind (such as homelessness or difficulty in school).

Intake

After eligibility has been determined, New Day's first attempt to contact the youth/their family should occur within 24 hours of the referral. If successful contact is made and the youth/family is willing to participate, they are considered a client. From this point forward, everything proceeds according to the four phases of the High-Fidelity Wraparound model.

Engagement

There is an initial meeting with the youth and/or family during which the wraparound and evaluation process is explained, HFW guides are shared, and required forms are signed. The facilitator "gathers the family story" to identify any immediate concrete needs so that they may be addressed quickly. The family story serves as a needs assessment for everyone in the group, illustrates the complexity of the family needs and supports, and identifies others from the community as potential helpers. When possible, additional information on the new client is also collected, such as an IEP or past clinical assessments. This process lays the groundwork for the first family team meeting, which should occur within 30 days of the first in person visit with the client.

At the team meeting, the vision, needs, and strengths of the youth are discussed with the family. Potential team members from systems partners, the family, and peers are identified in this meeting. The resulting team meeting preparation form is reviewed and approved by the Wraparound coach, after which the first official Wraparound Team Meeting is scheduled.

Action Planning

The Action Plan is a youth-centered, individualized plan for the client success that is formulated during the first official Wraparound Team Meeting. It is based on the goals and vision of the youth, and includes benchmarks for measuring progress. A Safety and Stability plan is also formulated to address adverse events that may affect the youth. Both the Action and Safety and Stability Plans should be distributed to all team members within 48 hours of the official Wraparound Team Meeting that produced them. At this point, the action planning process is implemented and will continue until the youth is ready to leave the program.

During the continued action planning phase (Implementation), Wraparound Team Meetings are held biweekly for the first two months and at least once a month after that point. The frequency of the meetings should reflect the needs of the individual youth, so in practice the meetings may be more frequent than the minimums described. These meetings focus on measuring the progress the youth is making toward their Action Plan benchmarks, and review their strategies, vision, strengths, and needs. The Wraparound coach facilitates the meetings and coordinates the delegation of tasks to team members who support the youth and holds them responsible for their commitments as well.

Transition

When the Wraparound coach and other professional staff determine that the youth is ready to move on form Wraparound, they initiate the discharge preparation phase. Discharge preparation is a controlled process that involves the formation by the team of a transition plan of care that includes what formal services will continue, a funding strategy for those services, identifying which informal/natural supports will continue to carry out the transition plan, determining who can take over the transitional role, and creating a post transition crisis plan. The Wraparound facilitator identifies and transfers responsibilities to parties who can continue to support the youth after they are discharged from New Day's program.

Discharge

Official discharge from HFW is initiated by the Wraparound coach and New Day staff, and involves a letter sent to the family or individual youth. For planned discharges, the letter is usually a summary of the youth's successes within the program. If discharge occurred as a result of loss of contact or lack of engagement, the

letter serves as a notification of discharge and includes the reasons for said discharge. The family/youth must be discharged from Wraparound within 7 days of the decision to discharge them is made by New Day staff.

Performance Measures

New Day received referrals from 10 agencies over the course of 24 months. Housing status at the time of referral was 36.4% housed (family, friends, independently) and 27.3% homeless, 18.2% from detention or incarceration, 9.1% with another YTLS provider. Educational institutions, group homes and RTC/treatment facilities accounted for the remaining 9.1% of clients. For 20 months New Day also tracked clients referred from the Youth Services Center (juvenile detention center): 69 clients were referred, 58.0% were accepted, 7.2% were denied, and 34.8% had unknown dispositions.

Overall, the number of clients in HFW increased from a monthly Y1 average of 10.3 to 16.4 in Y2. Therapy services were offered for 12 months, from October 2018 through August 2019, with an average of 3.6 sessions/meetings per client per month for a subset of HFW clients. Resource navigation was offered from October 2018 through May 2020 serving an average of 4.1 clients per month in Y1 and 11.3 in Y2. Clients received an average of 4.1 consultations in Y1 and 5.4 in Y2.

Narratives show a program navigating the challenges of offering HFW in a detention setting and the difficulty of hiring and retaining staff. In this case, there would sometimes be a moratorium on new clients while existing staff were at their maximum caseloads. The lengths of the process for HFW certification by CYFD also affected caseloads. ND added capacity through partnerships, staff training, and strengthening internal supports for HFW staff. Their suite of services were offered to, and used by, the other YTLS providers.

Staff Interviews

Program Information

The majority of New Day interviews were conducted with management and administrative staff. The interviewees' overall levels of education reflect this: the majority held master's degrees while a small minority held associates degrees. New Day's interviewees were also quite experienced, ranging from 10+ to over 40 years of experience in their fields with 2-3 of those years spent working on New Day's YTLS program. All interviewees worked full-time overall, although hours put into New Day's YTLS branch ranged more widely, from 1-2 hours a week up to 40. Each interviewee mentioned at least two certifications or licenses they considered relevant to their work at New Day. Certifications/licenses listed include ARC Trainor, Licensed Clinical Counselor (LPCC), Licensed Clinical Social Worker, Nurtured Heart Trainer, certified Wraparound Provider, endorsed Wraparound facilitator, endorsed Wraparound coach, and Licensed Master Social Worker (LMSW).

Outreach

New Day employees reported using a variety of outreach strategies, although they most emphasized going to other organizations and giving talks about High-fidelity Wraparound, either 30 minute "snapshots" or more in-depth "101" trainings that ran for two hours. Organizations they targeted with this type of outreach include CYFD, Casa Q, YDDC, and various other behavioral health agencies. Interviewees also mentioned attending state and community development meetings to give talks.

> *We go through the 11 values of Wraparound, how to be team members, how do you participate, what do we expect to see, and what are these fidelity tools and how can you expect to see them if you are doing this, and what that looks like.*

Other outreach strategies listed include cold-calling and word of mouth from individuals who participate in HFW meetings.

Referrals and Screening

According to New Day interviewees, their referrals come from a variety of sources with no clear frontrunner. When asked about potential referral gaps, they said that they would like to see more referrals coming from CYFD. They reported that self and community referrals were encouraged by allowing them to drop off physical copies of their referral/application forms at drop-in centers and other organizations that provide resources for the community. These forms were described as being intentionally "low-barrier," ideally making it as easy as possible for a person to refer themselves or someone they know who might need HFW services. When asked who is eligible for HFW, one interviewee explained,

> *Anybody…as long as you met the criteria that you were a resident of Bernalillo county, in the age group, and had one or more system involvement, then really you could qualify. So we've gotten referrals from schools, from counselors, from Title One, from young people themselves…really from all over the place.*

New Day interviewees described the screening process itself as something that is undertaken twice a week by sitting down with applications and their formal referral review form to see if the applicants meet their criteria and if they can determine their immediate needs. As mentioned above, the screening requirements for New Day are fairly minimal. Staff explained that as a non-residential program, New Day is able to take on more intense cases without the safety concerns that may accompany taking on the full-time care of the youth.

> *There is nothing that is too intense for wraparound. Honestly, the more intense the young person is, the better fit. The only thing that we say no to is if they don't want to do it…they fly the ship, they create the vision, they're really in control. So if it's not something they want to do, then it won't work.*

Intake and Assessments

New Day staff reported that official intakes, or "enrollments" occur after a period of engagement that can vary from client to client. They explained that this variation exists because some clients need to get further into the engagement phase than others to feel comfortable before officially entering their program. Staff clarified that "engagement" is the first stage of the Wraparound program; it simply begins rapidly enough that the earliest part can precede a client's official enrollment. Once the client is enrolled, the engagement phase will continue. Engagement is not limited to the young person alone, as staff clarified that this phase often included meeting with the prospective HFW team as a whole. New Day would not move forward with the process if the prospective client and their care team did not think their program was a good fit.

> *We do try to do a pre-meeting with teams because it's really not just about the person being referred, it's the entire team. It really is a coordination process, so we need them to be on board with it...we want to have one unified plan.*

Not everyone has a team when they enter the program. So while all of New Day's clients pass through this first phase, the amount of time spent here is more individualized to the client.

> *Typically you won't start team meetings until 1 to 3 months into that engagement phase, so you can really work on gathering the family story and finding team members or building out a team if there isn't one already developed.*

Service Delivery

Interviewees reported that New Day's main YTLS service is High Fidelity Wraparound, an evidence-based approach to care coordination; most of the services a youth in their HFW program receives come from other places. They explained that because HFW is primarily a facilitation of other services and New Day does not

consider the services obtained through referrals made in the process of conducting HFW to be counted as part of the services they deliver.

> *It's a facilitation of services it's, an intense care coordination is how it's described…we're not going to help you ride the bus. We're going to help you find people to help you ride the bus. Especially with our age group. We do some referrals, but we really try to help the young person do it, and so we don't necessarily count those."*

A couple of other in-house services were mentioned as being offered in connection to HFW. Interviewees stated that they have life skills coaches who sit on HFW teams and deliver those services. Staff also said that New Day offers in-house psychotherapy as an optional service to youth participating in their HFW program, although most youth do not choose to use this option. So while some of these services can come from additional programs within New Day (such as housing, job training, and their life skills academy), many of them are delivered by other resources in the community. This results in a wide variety of potential service connections. New Day staff explained that the Action Plan created by the youth and their HFW team is used to guide this access to community resources.

> *The majority of the other services are just whatever the young person has identified they need, or that the team has identified and built into the Action Plan. Those are often utilized at other places. We work on finding the connections and making referrals, then helping make sure that they're in communication and it's flowing well and they're on the same page.*

The other main service offered through New Day's YTLS programming was the resource navigator. Staff stated that unlike their HFW program, the resource navigator is not attached to an individual program that requires enrollment, but was open to both New Day's youth and the community as a general resource. New Day interviewees went on to explain that although a person is legally considered an adult at 18, treating them as one without additional considerations for where they are developmentally as a young-adult and as an individual person can leave them without the support they need to access services.

> *The transition from youth service provider to adult service provider is huge…if you add a trauma informed [lens], plus a developmental lens, we're talking about young people who might be 22 but are experiencing the world more like they're 16, and you really do need to be different…This program is designed for transition-age young people…After this, most of them are going to be solidly in the in the adult world, and if we don't make some of those bridges with them and for them they're going to kind of just be like 'what do I do now?'"*

New Day staff stated that, in addition to young people being unfamiliar with adult services, the providers themselves often run into the same problems. According to interviewed staff, youth service providers tend to be specialized in their knowledge of the youth service world, and the same effect is present in adult service providers being specialized to care networks in the adult service world.

> *We developed this resource navigator position because we wanted somebody out there to be bridging, you know learning about the adult services. A lot of youth providers know nothing about the adult world…they (the resource navigator) don't actually work as much with young people, specifically they work with service providers.*

Discharge

According to the New Day interviewees, successful discharge from their program usually occurs when a youth has met the goals identified in their Action Plan and is meeting benchmarks along the path to completing their long-term vision. They also said that a youth may be discharged if it is determined they no longer need HFW.

Some people don't need that high-level service anymore, and just having a case manager they meet with once a month and do a few things with, that might be the level of service they need. So that's the other part, even if they haven't maybe completed all their things, it really is kind of seeing that they don't need this level of intensity, then connecting them with other resources.

While interviewees asserted that it was extremely rare for a youth to be discharged from HFW to a higher level of care, it is possible for a youth to be removed if they are unwilling or unable to engage with the program. According to interviewed staff, New Day's HFW is designed to be a voluntary program, but judges will still occasionally order youth to attend it. So if a young person reveals that they are attending meetings against their will, they are discharged. Consistently missing meetings and not responding to New Day's contact attempts was also listed as reasons participants may be removed. One interviewee explained that HFW is supposed to be a "high-touch" program, so if a youth chooses not to engage, the model cannot function as intended.

Rather than have discharge planning as a distinct phase of the program, it is incorporated from the beginning. When a youth completes a planned discharge, staff report that they do so with a plan in place that has been developed over the course of their time in HFW.

Throughout the process of doing wraparound we are constantly talking about when will we know Wraparound is done, when will you be ready to leave our service of care-coordination and be ready to do it on your own? We do not have a document or a form called our discharge plan, but the purpose of wraparound is to start at point A and end at point B, which is an agreed upon point.

While staff asserted that this is a very individualized process, they did say that successful discharge usually follows the completion of specific goals identified early in the process by the youth and their team. So, "point B" is reached, and the youth moves on.

Aftercare

At the time of this evaluation, New Day did not offer a formal aftercare program or have a process for systematic client follow-up. Staff reported that young people were welcome to call back and check in, but they were limited in what services they could provide because the youth is no longer part of their program. The exception to this appears to be when a HFW team builds in a meeting intended to occur after formal discharge, but this is less a standard aftercare procedure and more an attenuated process of exiting the program.

Some teams might build in like an emergency meeting. Like if in the next six months, we have an emergency, we might call you for like a little support to get us back on track.

Client Data

We received data for 30 adult clients admitted between August 2018 and January 2021 and 18 minor clients. Because state law does not allow the use of identified minor data without consent and does for adults we received identified data for adult clients and de-identified data for minor clients and so we received two sets of data from New Day. The data for minor clients did not include service data or intake or discharge dates. As noted elsewhere we negotiated data separately with each provider and for a variety of reasons received data for different time frames and that contained different data. This was based on a number of factors including our understanding of what data each provider collected, how these data were stored, their ability to provide the data in an agreed upon time frame, and subsequent negotiations to obtain additional or enhanced data. Adult data included service data and intake and discharge dates. For minors we agreed that demographic, referral and discharge data would be sufficient. The following tables report variously data for both adults and minors and adults only. This is noted in the description of the tables. Only adult data is described in the tables reporting services.

Table 17 reports the referral source for the 48 clients. The largest number of clients were referred from the criminal justice system (27.3%), followed by community organizations (18.2%), and referrals from New Day (15.9%). Together these three sources accounted for slightly more than 60% of all referrals. The referral source was missing for four clients.

Table 17. Referral Source

	Count	Percent
CYFD Protective Services	5	11.4%
School	2	4.5%
New Day	7	15.9%
Family/Guardian	3	6.8%
Self	5	11.4%
Community Organization	8	18.2%
Criminal Justice System	12	27.3%
Other	2	4.5%

Missing 4

Table 18 reports race and shows that 45.8% of the clients identified as White, 20.8% identified as American Indian, 16.7% were American Indian, and 14.6% refused (4) or did not know (3).

Table 18. Race

	Count	Percent
American Indian/Alaskan Native	10	20.8
African American	8	16.7
Native Hawaiian or Pacific Islander	1	2.1
White	22	45.8
Refused/Don't Know	7	14.6

Table 19 reports gender, this information was not provided for minors. A majority of clients were male (70%), 23.3% were female, and 2 adult clients did not identify as male, female, or transgender. Ten clients did not identify as "straight" and identified as gay (1), bisexual (7), asexual (1), or queer (1). One client refused to identify and this information was missing for three clients.

Table 19. Gender

	Count	Percent
Female	7	23.3
Male	21	70.0
Does not identify as Male, Female or Transgender	2	6.7

Table 20 reports ages for all clients. The average age of all clients was 18.5 years old. The youngest clients were 15 years old and the oldest clients were 23 years old (three clients). Twenty-five percent of the clients were 17 years old and 20.8% were 18 years old.

Table 20. Age

	Count	Percent
15	3	6.3
16	3	6.3
17	12	25.0
18	10	20.8
19	6	12.5
20	6	12.5
21 +	8	16.7

We were also provided school status (i.e. attending school regularly/irregularly, graduated/GED, and dropped out) and last grade attended including college/trade school, GED, and the actual grade level (i.e. 9th grade). Table 21 reports school status.

Table 21. Education

	Count	Percent
Attending school irregularly	8	20.5
Attending school regularly	15	38.5
Dropped out	7	17.9
HS graduate	4	10.3
GED	2	5.1
Does not know	3	7.7

Missing 9

The next set of tables reports services provided to adult clients. This includes the number, type and length of services, types of contacts, total services by client and length of service, discharge status and discharge reason. From New Day we received service level data for adult clients only. We received the date of each appointment, the type of appointment, and length of appointment among a number of other variables.

Table 22 reports adult clients and services. On average these 30 clients had 52.7 services scheduled and received 44.2 services with 8.5 canceled services (this includes no shows and canceled).

Table 22. Clients and Services

	Clients	Average	Median	Total
Services Provided	30	44.2	31	1,327
Services Cancelled	30	8.5	7	255
Total Services	30	52.7	44.5	1,582

Almost all services provided were WRAP or Team Meetings (99.7%)

Table 23. Type of Service

	Count	Percent
WRAP or Team Meeting	1,296	99.7
Care Coordination	4	.03
Total	1,327	100

Missing 27

Almost 30% of all services did not include the client in the WRAP or team meeting service.

Table 24. Collateral Contact

	Count	Percent
Collateral with Young Person	931	70.7
Collateral without Young Person	385	29.3
Total	1,316	100

Missing 11

The majority of services and contacts were via phone (50.3%) or text (21.3%) and slightly more than 20% were face to face. The large majority of the face to face contacts were collateral contacts with the client.

Table 25. Type of Contact

	Count	Percent
Email	15	1.2
Face to Face	283	21.8
Virtual	68	5.2
One on One	2	0.2
Phone	652	50.3
Text	276	21.3
Total	1,296	100.0

Missing 31

Table 26 reports the length of services described in Table 9 in minutes and only appointments in which a service was provided. On average services lasted 34 minutes and a median of 15 minutes, meaning half the services lasted longer than 15 minutes and half lasted less than 15 minutes. The range in the length of services was 0 minutes (26 services) to 300 minutes or 5 hours (1 service). Slightly more that 28% of all services were between 0 minutes and 10 minutes and 14.6% were 61 minutes or longer.

Table 26. Length of Service in Minutes per Service

	Count	Percent
0 to 10	380	28.6
11 to 15	299	22.5
16 to 30	232	17.5
31 to 45	88	6.6
46 to 60	138	10.4
61 to 90	94	7.1
91 +	99	7.5

Missing 61

Table 27 reports the number and percent of total services provided to the 30 adult clients who received at least one service. Each client received an average of 44.4 services. Five clients (16.7%) received 81 or more services and 5 clients (16.7%) received between 1 and 10 services with one client receiving 172 services. In addition to services provided there were an additional 252 scheduled services for which a client either was a no show (204 services and on average 6.8 services) or was canceled by the client or staff person (48 services and on average 1.6 services).

Table 27. Total Services Provided per Client

	Count	Percent
1 to 10	5	16.7
11 to 20	7	23.3
21 to 50	6	20.0
51 to 80	7	23.3
81 +	5	16.7

Table 28 reports length of service in hours per adult client. On average clients received 25.1 hours of services with one client receiving 91.1 hours and 50% of clients receiving more than 17.2 hours of service and 50% receiving less than 17.2 hours of services. In total, adult clients received 754.7 hours of service.

Table 28. Length of Service in Hours per Client

	Count	Percent
0 to 9 hours	8	26.7
10 to 15 hours	5	16.7
16 to 30 hours	8	26.7
31 + hours	9	30.0

Missing 5

We received discharge information for all clients. At the time we received the data 12 clients were active and 36 had been discharged or closed. On average clients remained in the program 265.1 days with a median of 201.5 days and a range of 49 days to 864 days.

Table 29. Program Status

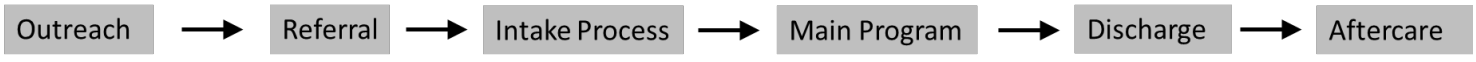
	Count	Percent
Active	12	25.0
Closed	36	75

YDI's Independent Futures

Program Description

Independent Futures (IF) is a non-residential YTLS provider serving youth ages 16-21, specifically those with substance use and/or mental health needs. IF is intended to help youth develop the necessary life skills for independent living by making and following an individualized Service Plan with a focus on the areas of education, housing, and employment. YDI also offers therapy, although this is an optional part of the program based on the choice of the youth in question. IF does not have a formal aftercare system within their own program, but they do attempt a six-month checkup on youth after discharge. Like New Day, former clients of YDI's program may continue to stay in contact with YDI staff after discharge. On a case-by-case basis, YDI can arrange for former clients to receive youth support services and/or case management from other providers. Figure 4 is a simplified version of their process map (see Appendix 1). These are visual representations of how the provider described the program to ISR CARA staff, from outreach to client discharge and aftercare. The descriptions for each element were gathered from conversations with the provider and documents reviewed in the creation of the process maps.

Figure 4. YDI Independent Futures Process Map



Outreach

YDI conducts two basic types of outreach. The first type targets providers of community services directly, such as crisis shelters, healthcare facilities, the police department, schools, and social service organizations. The second type is street outreach, a newer form of outreach that YDI indicates is notably impactful. To directly contact potential clients, YDI staff travel to shelters and homeless encampments, or walk the streets where youth are likely to congregate.

Referral

IF receives referrals from CYFD, schools, other YTLS providers, the Young Adult Court, the Youth Services Center, the behavioral health and housing provider communities, and internal referrals from YDI's other programs such as Amistad and Casa Hermosa.

Intake Process

The intake process begins with a review of the referral packet. To be eligible for YDI's program, potential clients must be 16-21 years old and precariously housed or homeless. A potential client would be rejected if their current level of impairment renders them unable to engage with the program, although they may be allowed in later after completing a more intensive program or if their status has improved. Potential clients are assigned to a case worker, after which the next step is an in-person interview. If the interview results indicate that IF is a good fit, intake paperwork may be completed immediately. The youth is officially a client upon completing the paperwork.

Main Program

In their first three sessions with IF, the youth will work with staff to make a Crisis Plan and Service Plan (also called a Youth Individualized Plan). A short battery of assessments are also given during this time. All clients take the Casey Life Skills assessment (CLSA), client who are 16-18 years old take the Child and Adolescent Functional Scale (CAFAS), and clients who are 19-21 years old take the Global Assessment of Individual Need (GAINS SS). From their fourth session through discharge, IF clients focus on executing their Service Plan, which is updated every 90 days.

The service plans focus on three main areas to develop the necessary skills for independent living: education, housing, and employment. There are also two types of services provided to some youth that are not part of the core program: therapy, which may be started and stopped at any time during the program based on the youth's choice; and Comprehensive Community Support Services (CCSS), which are available to youth who qualify (by having insurance), and are essentially the same set of services in the core program but billable to insurance.

Discharge

If the youth has completed their goals and has a stable housing placement along with the skills to maintain it, they can be successfully discharged. The amount of time it takes to reach those goals differs based on the needs of the client so there is no set length of program for IF. Early or unsuccessful discharge is another a way youth leave the program. A youth may be discharged early by YDI if they are unable or unwilling to engage with the program, or if contact is lost. Youth are also discharged by default if they move out of Bernalillo County as that is YDI's service area, although if the youth moves for the purpose of getting into a stable housing situation, this is still considered a successful discharge.

Aftercare

YDI does not have a defined aftercare program, although a 6 month follow-up is attempted after discharge. Some youth remain in closer contact with YDI based on needs, relationships with staff, and their individual choice. Additionally, YDI will connect youth to life coaching and case management services conducted by other organizations upon discharge if they deem it necessary for the individual. This is an indirect form of aftercare; the services exist but YDI directs the former client to them instead of delivering them personally.

COVID Impact

YDI's YTLS program lacks a residential component, which allowed them to continue service delivery electronically with little interruption due to COVID-19 restrictions.

Performance Measures

From June 2018 to May 2020 YDI reported data on 121 clients. YDI reported hours of service data from March 2019 through May 2020, and numbers of assessments and life skills from July 2018 to May 2020. Overall, the average number of hours delivered for clinical supervision and case management increased from Y1 to Y2 and counseling and assessment hours decreased. For the 15 months these measures were tracked, the average hours of clinical supervision per month was 9.3, with 13.4 hours for counseling and assessments, and 137 hours for case management. Case management accounted for 86.3% of all hours reported, followed by 8.4% for counseling and assessments and 5.8% for clinical supervision. Within life skills services, IF offered a monthly average of 1.6 hours to groups and 66.9 hours to individuals. Among the assessments and plans tracked, IF reported an average of 7.8 Casey Life Skills Assessments, 8.0 CAFAS, and 6.4 transitional living plans per month.

From July2018 to May 2020 IF reported the number of clients who had a GED or high school diploma or who were pursuing an educational goal and the number participating in job readiness programs. The monthly average number of clients who were enrolled in high school was 9.9; 2.7 were enrolled in a GED program and 4.4 were pursing post-secondary education. The monthly average of clients who had a GED or high school diploma was 7. On average, 12 clients every month had a job. The average for successfully discharged clients was 2.8 per month.

Narratives show a program adapting general YDI procedures, forms and electronic medical records system to fit the needs of IF. Lagging referrals early in the program resulted in increased outreach efforts with community providers who also served youth/young adults; they began to pick up in November 2018. Turnover in staff was also an early challenge for this new program. Implementation of the life skills services met with scheduling and transportation difficulties with clients resulting in referrals to New Day's Life Skills Academy as a temporary solution. Reports noted the difficulties in finding placements for youth in CYFD custody: limited options, wait lists, and lack of a good fit for these clients with available programs. Staff recruitment was completed in January 2019. In March 2019 internal referral issues were resolved.

In Y2, IF continued to build institutional capacity and worked to resolve lower than desirable referral numbers. IF explored additional contact methods when COVID-19 restrictions began and moved all contacts to the telephone or a virtual platform. Improved relationships among YDI programs resulted in increased access for homeless youth.

Staff Interviews

Four interviews were completed with YDI employees, at a response rate of 100%, with representatives from case management and the supervisory staff. All employees interviewed had at least eleven years of experience in the field, with a maximum of over 30 years.

Program Information

When asked about the goals of YDI's YTLS program, interviewees were united in defining their first priority as finding safe placement for their clients, followed by education and life skills.

> *My first [priority], it would always be safe placement. I mean, that's what we work really, really hard for each client is to find them safe placement.*
>
> *Once that [safe housing] is established, learn the skills to be independent, such as budgeting, money management, daily living skills, how to keep an apartment clean, how to maintain their daily hygiene,*

how to properly prepare for interviews… So mostly stabilizing with housing and all the things that trickle down from that.

While housing is not an area of services paid for by the YTLS contract, it is a fundamental strategy in their case management. YDI as an organization does have housing (Amistad Crisis Shelter and Casa Hermosa), and that housing plays a vital role in their YTLS services. These programs serve youth in roughly the same age group and are both referral sources and potential housing resources for IF youth.

Finding their clients safe housing is one of three main areas of focus identified by the interviewees. These categories are used by YDI as both as a measurement of their success with clients and as a benchmark necessary for successful discharge from the program.

…all of our clients, they will not be discharged unless we find them safe placement and job stability. Educational needs, housing placement needs, and independent living skills. Those are the top three that we go by.

Rather than following an existing YTLS service model, the emphasis on these three areas came from the evolution of their IF program over the last 3 years. Originally, their strategy involved entirely client-identified goals, similar to the strategy used in High Fidelity Wraparound. In their process of self-evaluation, IF staff discovered that the client-defined goals were consistently not being met. As a result, their new strategy still allows clients to choose their own goals, but now involves them doing so from a series of choices within the frameworks of education, housing, and employment. Staff report that this strategy has produced better results for IF, and attribute its formation to close working relationships between clinical supervisors and case managers.

Outreach

Interviewees confirmed that outreach involves a variety of community organizations contacted through several different strategies.

We make contacts with whoever we can…Sometimes we make connections when we're doing street outreach with our other programs… Our clients have brought in people as well. 'I know so and so, who needs help.' We work a lot with the CYFD. We get a lot of referrals from them. Our shelters are aware of us, so we get referrals from our shelters. So pretty much, word of mouth, flyers, brochures, emails go out, meetings that happen. We get invited to different types of meetings to share about our programs… We have other staff who sit on other boards and other calls and meetings and so forth, and they'll share the information as well. You name it, we do it."

Street outreach was also mentioned by the interviewees. This is a relatively new strategy for YDI that involves walking the streets to search for youth in need.

I like to do that because that's where you get your referrals, you go into the parks, you go to the skate parks, you go downtown. It's amazing how much Albuquerque has grown with homelessness. It's a lot of hide and seek.

Referrals

Interviewees noted that Independent Futures receives referrals from CYFD, school counselors, and shelters. Staff reported Amistad as a frequent internal source of referrals and New Day as a frequent source of community referrals. IF interviewees also mentioned Casa Hermosa as both a source and a destination for internal referrals.

We had a client that was staying (at a friend's house without permission for several weeks). So it got really intense when the parents did find out, it didn't work out so well. So we had to immediately remove

him from the house, and we made a referral to Casa Hermosa. They did an interview with him and they ended up taking him in.

When asked to identify potential gaps in referrals, YDI staff listed youth residential treatment programs (RTCs) and detention centers as being potential sources of youth in need of the services YDI provides. They explained that residential treatment centers target youth with serious behavioral and mental health needs, but services can drop off abruptly after the youth turns 18. According to the interviewee, detention centers used to be a source of referrals, but there have not been any for some time. As with RTC youth, perceived need was the main reason staff wanted to see more referrals from detention centers.

> *I mean, it could be a very scary situation for the youth that are there at the detention center, but I would like to see more referrals from there. Because they're the ones that really need it; they're troubled. They're… basically, they screwed up and they don't know when they're allowed back home."*

Screening

According to interviewed staff, YDI's IF program is intended to serve transition-aged youth who are homeless or precariously housed.

> *What we look for when we get a referral is, is the youth currently: at risk of being homeless, homeless, displaced, precariously housed, and are they in the age range. Right now we are serving 16 to 24 so we definitely look at the age range and we look at what is going on currently in their circumstances. What is their situation? What do they need the most assistance and help with? So when we get the referrals, we look for those things.*

Intake and Assessments

Intakes can take place in a multitude of locations, depending on what is most accessible to the client. Interviewees report that the process involves a case manager or supervisor from IF meeting with the client to introduce them to the program and guide them through the required paperwork.

> *Our youth are not always stable in a safe housing environment, so we make sure that we can meet them where they are. So we go to them. We review all of our forms with them. We have…eight to twelve intake forms. We go over all the consents, all the HIPAA forms. Make sure that they understand the forums that they're signing, they sign each form as a consent to services, as well as a lot of the forms ask for our signature as well. So we go over that. We let them know a little bit more about the program, give them time to ask questions, get familiar with us, with what the expectations are of the program.*

Staff report that the Casey Life Skills Assessment and the Child and Adolescent Functional Assessment Scale or the Global Assessment of Individual Need are given at the time of admission and the play a role in on-going client interactions. *"Those [CAFAS and CLS] are given at intake and then every 90 days. And that demonstrates the progress or lack thereof."* In addition to those evidence-based tools, YDI also completes two other documents near the time of intake, an individualized service plan and a crisis safety plan. As part of the individualized service plan, a case manager works with the youth to choose goals within the framework of education, safe placement, and life skills. Staff reported that this plan is updated every three months to mark progress and continue adding new goals as necessary.

> *We have to update it [the crisis plan], and the service plan every three months…So if the client found job stability, has been working, I will note that on their service plan 'client has been successful at work and is consistent daily as scheduled.' And then if they successfully reach that goal, well they could pick another goal from the list.*

The crisis safety plans are a tool the client creates with their case manager. Interviewees gave multiple uses for this document, which appears to serve as both a contingency plan for the client and a potential way for case managers to find them in case of loss-of-contact.

> *The crisis safety plan is designed for the youth to identify to us, 'These are things that may trigger me' if they're aware of them. And then we always have them identify natural supports. Okay you're starting to have a bad day, or if you're starting to lose your temper, or if you're feeling like you might want to cause harm to yourself. How can we help? Who is the person you turn to in a crisis, who is your safety net?*

> *We ask our youth for three contact numbers; someone that you talk to, it doesn't matter if it's a friend, neighbor. Anyone that you talk to you on a weekly basis, is there a way that I can contact them and see if we could find you.*

Service Delivery

YDI's primary service is case management, delivered through individual meetings between clients and case managers. These meetings can take place in a variety of locations, depending on where and when the client is available. Case managers expressed pride in their ability to be mobile and "meet clients where they're at." Mobility and flexibility were common themes in the service descriptions given by all of the YDI interviewees.

> *A lot of my youth, they work during the day, or they go to school and then work and then they're only available at eight o'clock at night. So I adjust my schedule to where I go in late and I meet them and I work until about 10 o'clock at night because I meet them at eight o'clock in the evening at Casa Hermosa."*

Interviewees stated that other services, particularly life skills and referrals to other programs, are identified in the individual service plans and delivered on an as-needed basis. YDI staff reported that a myriad of life skills classes can be arranged to serve clients, in a variety of locations, prepared and delivered by YDI staff.

> *If it was cooking, we would borrow the Three Sisters kitchen…If they didn't know how to cook, we would reserve the kitchen and we would do a cooking class for them. If it was a budgeting class, money management, we would go to the different schools, set up different classrooms…my coworker [and I], we would go to teach them a money management class on different days, or we would do it after school or at the library. If it was, how to fill out FAFSA, or any of those, we would just take different groups and check out a room at the library… go pick them up and take them to a meeting room at Starbucks, McDonald's, whatever and just teach them a course. Pull out our little white boards or little flip papers and teach them whatever it was that we're going to do, or we could do a PowerPoint presentation in our conference room."*

Interviewees said that life skills not provided by Independent Futures are referred out.

> *They [New Day] are a very good program, they assist clients with getting a job. And they have Life Skills classes. So it's a really big help to us. As far as Casa Hermosa, they also do life skills classes. So we, we work a lot with New Day, Casa Hermosa and Amistad. We basically refer them to those three."*

When asked about services they referred out, interviewees identified a particularly close working relationship with New Day. New Day is a provider of High-Fidelity Wraparound, and YDI's case managers reported sitting on HFW teams organized by New Day. "*We're involved in team meetings or wraparound meetings. That involves a team of eight besides the client, so the client has a big team to assist them with their needs.* YDI interviewees were quick to highlight coordination with other programs as a strategy they use to fill potential service gaps and gave an example of New Day referring out to IF.

We don't do what the state calls high fidelity wraparound. But All Faiths Family Services does, so we refer to them. New Day youth and family services does that as well, so we'll refer to them. And then similarly we provide CCSS, Comprehensive Community Support Services, but New Day does not do that. So they may have youth that they refer to us for that service. So there's, yeah, there's a collaboration there.

Interviewees reported that YDI also provided therapy and counseling as optional services. They said that these would not be included as part of the service plan unless the client opted to use them, and they can be added or removed at the client's request. These can include, but are not limited to, specific forms of therapy, medical services, education programs, and vocational training.

Discharge

According to an IF case manager, discharge planning begins in earnest about two weeks out from the planned discharge date. Interviewees stated that once the client completes their goals and/or reaches the benchmarks identified in their service plan for discharge, they qualify to be successfully discharged from YDI's Independent Futures. Safe and stable housing placement is always one of these goals, and IF interviewees confirmed that clients are not discharged from the program unless this goal has been met. Staff said that clients can also be discharged for moving out of the service area, loss of contact, or a lack of willingness/capacity to engage with the program. These are part of YDI's stated process, and were for the most part confirmed by interviewees. However, there were some examples of staff going beyond the stated process.

If I don't have contact within a week, I will go and start looking for them. Say if it was somebody that was at a shelter, and they're no longer at that shelter…within the time that I've got to know them, I've gotten to know where they hang out, or where they used to use or whatnot. So I will go to Coronado park or I will go to the back areas of UNM or Frontier, or to the Walmart or to behind wherever, and I will literally go and walk and look for these kids, and I've found most of them. And I'm like, 'hey, what's up, I got your EBT card, just come to the office' and, 'oh Miss,' you know, and I reconnect, and I bring them in. I would say there's like a handful, that I never saw again, sadly.

Aftercare

YDI interviewees confirmed that aftercare is provided on an as-needed basis. They stated that at least one six-month follow-up is attempted for all clients, but more frequent follow-ups can be performed if a case manager deems it necessary or the client asks for it. Some clients may continue meeting with their YDI therapist after discharge.

It's their choice to continue, and we ask them, the therapist does ask them, 'do you still want to continue with therapy or do you feel that you're comfortable enough to be without therapy?' So that's when they will let us know, yes or no.

Others may disengage from services entirely, or contact their case manager independently asking for services months later.

As an agency we offer it [aftercare] for-forever, as long as we have something that can provide services to them. If they're needing to get back into our program, we can readmit them as long as they still meet the qualifications to get in. So our aftercare can be, in my opinion, it's never ending. It's a revolving door. We'll see the youth come back and check in with us, or all of a sudden, they're in another program within YDI as an agency. So we follow up with them there too. So it's always open to them for whenever if they want to follow up with us. They're more than welcome to, we follow up with them at least one time.

The primary barrier to providing aftercare was identified as "loss of contact." Once a youth is discharged, a change in address or cell number can potentially eliminate YDI's ability to check on them. YDI has no formal aftercare program, but case managers do informally maintain relationships with some clients based on those clients reaching out to them after discharge. It may be most accurate to characterize this type of fairly informal aftercare as an open-door policy, a path back to services within the program rather than a defined structure existing outside of it.

The only deviations from YDI's stated process found during these interviews involved case managers going above and beyond the call of duty to re-establish contact with AWOL clients. These deviations should not be considered negative, and these efforts are commendable from a moral perspective. This is not an outcome study, so no data on how this strategy may impact outcomes is currently available. However, any research team doing an outcome study on YDI in the future should note the possibility of individuals going beyond stated practice, as this could lead to higher retention rates and better outcomes than the originally defined process alone.

Some youth who are discharged for "loss of contact" may also return to the program after contact is re-established. This is not a deviation from YDI's stated process, but it is notable as a potential weakness in the BHI's current data collection strategy.

> *We've had youth who have discharged because they didn't have the means to contact or reach the case manager or their therapist any longer, and months down the road we make that contact again and they say, 'Hey, I didn't have a phone. I want to start services again.' What we mark off is what the county has on our reports, which is very vague, in my opinion, but that's what we have. So that's how we get to choose what they discharged as.*

Additional Observations

YDI prides itself on crafting individualized service and treatment plans based on the unique needs of each client, a common sentiment among the YTLS providers. They appear to have a strong organizational culture supported by frequent oversight meetings. All interview participants were consistent in emphasizing the need to focus on education, housing, and employment as pathways to long-term stability for the young people they serve. From a theoretical perspective, this is similar to Maslow's hierarchy of needs: safe and stable placement is emphasized first as a foundation for future stability, followed by educational and vocational needs. The only deviations from the procedures described in their process map were those borne of case managers doing more than initially described, such as making a serious effort to track down a client who has lost contact before discharging them. These deviations are not considered negative, they are most likely the result of an incomplete understanding on the part of researchers rather than an actual departure from YDI protocol.

Client Data

We received data for 60 adult clients and 50 minor clients admitted between August 2018 and mid-March 2020. As mentioned elsewhere state law does not allow the use of identified data for minors and for that reason, we received slightly different data for adults and minors and we cannot always combine the data to report together. For example, we are unable to have complete dates for minors (mm/dd/yyyy), including admission dates, discharge dates, and service dates; we could only have year (yyyy). This means we cannot calculate length of service for clients who have been discharged by comparing the admission date to the discharge date. Rather, for minors this information was provided to us as the number of months in the program rather than days. This information is useful but less precise than calculating the length of stay in days. Keeping to this example of dates, we cannot combine the length of stay for adults and minors because of the differences in the method used to create length of stay. For this reason, when this occurs, we use the more precise data for adults.

Service Data

Between August 2018 and March 2020 31 of 59 clients (50.9%) had been discharged from the program. Because we cannot have full dates for minor clients we are not able to accurately report program length of stay or discharge status for minor clients. This section describes the clients served by the program and the services they received.

Table 30 reports the referral source for the 110 clients. The large majority of clients were self-referred 76.4%. Five clients were internal referrals, four were from CYFD, five from schools and nine referrals were from a shelter. The referral source was missing for three clients and unknown for one client.

Table 30. Referral Source

	Count	Percent
CYFD Protective Services	4	3.8
School	5	4.7
YDI	5	4.7
Shelter	9	8.5
Self	81	76.4
Other	2	1.9

Missing 3

Table 31 reports race and ethnicity and shows that 54.2% of adult clients identified as Hispanic, 20.3% identified as White, 8.5% were American Indian, and 15.2% were African Americans.

Table 31. Race/Ethnicity

	Count	Percent
American Indian/Alaskan Native	5	8.5
African American	8	15.2
Other	1	1.7
Hispanic	32	54.2
White	12	20.3

Missing 2

Table 32 reports gender, this information was not provided for minors. A slight majority of adult clients were female. Gender was missing for two clients.

Table 32. Gender

	Count	Percent
Female	31	53.4
Male	27	46.6

Missing 2

Table 33 reports age by age group. The average age of all clients was 17.8 years of age. The youngest clients were 16 years old and the oldest client was 21 years old. Almost 30% of the clients were 17 years old followed by 18-year-old clients (23.1%).

Table 33. Age

	Count	Percent
16	19	17.6
17	31	28.7
18	25	23.1
19	21	19.4
20	11	10.2
21	1	0.9

Missing 2

Table 34 reports education.

Table 34. Education

	Count	Percent
GED	36	34.0
High School	29	27.4
HS Graduate	30	28.3
Dropped Out	8	7.5
Vocational/College	3	2.8

The next set of tables reports services provided to clients. In discussions with YDI staff we discovered the program provided services that were not billable under the BHI funding and were paid by other funding streams and primarily Medicaid. Table 34 reports total services and total BHI funded services.

We do not have detailed information for services (i.e. service date and type of service) that were not funded by BHI. BHI funded service data includes the number, type and length of services, types of contacts, total services by client and length of service, discharge status and discharge reason.

Table 35 reports Total Services and Total BHI Funded Services. Clients received an average of 29.8 services of which an average of 19.8 were funded by BHI. In total 3,219 services were provided of which 2,148 or 66.7% were funded by BHI.

Table 35. Clients and Services

	Minimum	Maximum	Average	Median	Total
Total BHI Funded Services	1	107	19.8	15.5	2,148
Total Services	2	144	29.8	24.5	3,219

The remaining YDI tables (Table 36 – Table 40) report BHI funded services. For the 19 months for which we have data, IF delivered 2,148 services across 10 different activities (Table 37). IF provided some services that are not billable to the BHI funding and were paid by other funding streams, primarily Medicaid. These services were not included in the encounter level data provided by the program. We do not know how often this occurred. Case Management and Life Skills account for 71% of all services.

Table 36. Number of Services

	Count	Percent
Case Management Note	710	33.1
Life Skill Note	819	38.1
CCSS Note	113	5.3
CCSS Plan	11	0.5
Service Plan	68	3.2
Individual Therapy	285	13.3
Group Therapy	1	0.0
Enhanced Assessment	13	0.6
Discharge	73	3.4
Non Billable Crisis/Safety Plan	55	2.6

Missing 2

Table 37 reports services clients received after removing the two clients who had no services listed in the appointment data. Table 8 reports the number of clients, the number of services, the mean number of services received by those who received the service, and the range received by clients for each service. A total of 2,141 services were provided to 108 clients at an average of 19.8 services per client and a range of 1 service to a maximum of 107 services.

Table 37. Services and Contacts

	Clients	Services	Percent	Mean	Range
Case Management Note	91	709	33.1	7.8	1 to 29
Life Skill Note	83	814	38.0	9.8	1 to 48
CCSS Note	7	113	5.3	16.1	1 to 43
CCSS Plan	3	11	0.5	3.7	1 to 8
Service Plan	52	67	3.1	1.3	1 to 3
Individual Therapy	37	285	13.3	7.7	1 to 42
Group Therapy	1	1	0.0	1.0	1
Enhanced Assessment	13	13	0.6	1.0	1
Discharge	60	73	3.4	1.2	1 to 4
Non Billable Crisis/Safety Plan	49	55	2.6	1.1	1 to 2
Total	108	2,141	100	19.8	1 to 107

Table 38 reports the length in minutes of services described in Table 37. On average services lasted 41.9 minutes and a median of 30 minutes, meaning half the services lasted longer than 30 minutes and half lasted less than 30 minutes. The range in the length of services was 10 minutes (1 service) to 420 minutes or 7 hours (1 service). Almost 38% of all services were between 30 minutes and 35.5% were between 46 and 60 minutes, and 16.9% were between 1 and 15 minutes.

Table 38. Length of Service in Minutes per Service

	Count	Percent
1 to 15	363	16.9
16 to 29	16	0.7
30	813	37.8
31 to 45	104	4.8
46 to 60	762	35.5
61 to 90	53	2.5
91 +	37	1.7
Total	2,148	99.9

Table 39 reports the number and percent of total services provided to the 108 clients who received at least one service. Each client received an average of 19.7 services. Seven clients (16.9%) received 51 or more services and 24 clients (22.2%) received between 21 and 35 services with one client receiving 107 services.

Table 39. Total Services Provided per Client

	Count	Percent
1 to 5	28	25.9
6 to 10	13	12.0
11 to 20	27	25.0
21 to 35	24	22.2
36 to 50	9	8.3
51 +	7	6.5
Total	108	99.9

Table 40 reports length of service in hours per client. On average clients received 13.7 hours of services with one client receiving 92 hours and 50% of clients receiving more than 10.25 hours of service and 50% receiving less than 10.25 hours of services. In total clients received 1,499.7 hours of service.

Table 40. Ranges for Hours of Service Received per Client

	Count	Percent
0 to 5 hours	41	38.0
6 to 10 hours	17	15.7
11 to 20 hours	29	26.9
21 + hours	21	19.4
Total	108	100

Assessment Data

YDI provided data on two assessments: Casey Life Skills (CLS) and Child and Adolescent Functional Assessment Scale (CAFAS). Enough information was provided to report beyond the count of assessments administered. The CLS and CAFAS include pre-tests and post-tests which allowed us to conduct paired sample t-tests. This test compares two means that are from the same individual, object, or related units. In the case of three instruments, the means from the pre-test and post-test were used to determine whether there was statistical evidence that the means between the paired observations were statistically significantly different (p-value ≤ 0.05) and Cohen's D was used measure the magnitude of the effect. This information is presented in the next section. The information for each assessment is presented in identical table formats.

In each table (Table 41 and Table 42) the first column lists the domain being tested, column two reports the mean of the pre-test and post-test and the average difference between the pre-test and post-test domain, the next

column reports the standard deviation (a measure of the spread between numbers), followed by t (the test statistic for the paired t-test), then whether there is a statistically significant difference shown as sig., and finally Cohen's d that measures the effect size. An effect size is a measure of magnitude of the difference between two variables. The larger the effect size the stronger the relationship between two variables. It is important to consider both statistical significance and effect size. Cohen d's effect size suggests that $d = 0.2$ is considered a 'small' effect size, 0.5 represents a 'medium' effect size and 0.8 a 'large' effect size.

There are limitations to these two assessments. First, the use of the CLS and CAFAS was sporadic. For the 60 adult clients we received CAFAS data for 21 clients (35%) and had an initial and exit CAFAS for 8 clients (13.3% of total and 38.1% of clients with a CAFAS). We received CLS data for 36 of 60 adult clients and had a pre-test and post-test for 19 clients (60.0% of total and 52.8% of clients with a CLS).

This poses challenges for analyzing the data and making comparisons, especially over time, as very few clients were given re-assessments and even then, re-assessments were not administered at consistent intervals. This limited the statistical power to detect effects and the inconsistent re-administration of such tools may result in a survivorship and selection biases favoring longer-term clients who are doing better in the program versus clients who disengage and withdraw from active program participation.

Casey Life Skills Assessment (CLS)

Table 41 presents the results of a paired sample t-test for the initial CLS compared to the follow-up assessment. A paired t-test is an appropriate test when it is possible to compare two population means where you have two samples in which there are matched before-and-after observations on the same subjects.

The Daily Living, Relationships and Communication, Housing and Money Management, Work and Study, and Career and Education Planning scales were statistically significantly different between the pre-test and post-test and on average scores on these scales were statistically significantly higher at the post-test period compared to the pre-test period, ***with higher scores indicating improvement with all five domains showing large effect sizes***. The Self-Care scale did not show a statistically significant difference and the effect size was small.

Table 41. CLS Paired Sample T-Test

Scale	Variable	Mean	Standard Deviation	t	sig. (2 tailed)	Cohen's d
Daily Living	Pre-test	73.1				
	Post-test	81.7				
	Difference	8.6	6.8	-5.4	0.000	1.27
Self-Care	Pre-test	72.3				
	Post-test	77.5				
	Difference	5.2	20.8	-1.1	0.285	0.38
Relationships and Communication	Pre-test	74.9				
	Post-test	84.5				
	Difference	9.6	12.8	-3.3	0.004	1.18
Housing and Money Management	Pre-test	77.3				
	Post-test	101.6				
	Difference	24.3	21.4	-4.9	0.000	1.37
Work and Study	Pre-test	78.9				
	Post-test	90.8				
	Difference	11.9	12.0	-4.3	0.000	0.89
Career and Education Planning	Pre-test	31.4				
	Post-test	40.1				
	Difference	8.7	8.9	-4.3	0.000	1.06

Child and Adolescent Functional Assessment Scale (CAFAS)

Independent Futures staff administered at least one CAFAS to 21 adults that resulted in 8 matched pairs. There were 13 initial assessments that did not have a matching exit assessment. We do not know why more adult clients did not have a CAFAS and why there were not more matched pairs. IF uses CAFAS with clients through age 18. Clients who enter the program at the age of 18 or younger may age into the next functional assessment age category where clients 19 years old and older receive the GAINS-SS. This might account for some of the disparity in the availability of pre- and post-CAFAS assessments.

Table 42 reports the results of the 8 matched pairs of CAFAS assessments. None of the scales showed statistically significant changes in scores. It appears three of the scales – Community and Role Performance, Self-Harmful Behavior and Thinking were not asked.

Table 42. CAFAS Paired Sample T-Test

Scale	Variable	Mean	Standard Deviation	T	sig. (2 tailed)	Cohen's d
Total	Pre-test	42.8				
	Post-test	30.0				
	Difference	12.8	26.3	1.295	.243	0.41
School/Work Role Performance	Pre-test	12.5				
	Post-test	7.5				
	Difference	5.0	10.7	1.323	.227	0.35
Home Role Performance	Pre-test	7.5				
	Post-test	2.5				
	Difference	5.0	7.5	1.871	.104	0.56
Community Role Performance	Pre-test	0				
	Post-test	0				
	Difference					
Behavior Towards Others	Pre-test	6.2				
	Post-test	5.5				
	Difference	0.7	8,3	.424	.695	0.19
Moods/Emotions	Pre-test	8.7				
	Post-test	7.5				
	Difference	1.2	9.9	.357	.732	0.18
Self-Harmful Behavior	Pre-test	0				
	Post-test	0				
	Difference					
Substance Use	Pre-test	5.0				
	Post-test	5.0				
	Difference	0	5.3	0.000	1.000	0.00
Thinking	Pre-test	0				
	Post-test	0				
	Difference					

Table 43 reports the program status for adult clients through March 2020. Thirty-one of the 59 adult clients with information (49.1%) had been discharged from the program and 29 were active. Adult discharged clients were in the program an average of 160.1 days with a maximum of 404 days and a minimum of 38 days. The large majority were successfully closed (24, 77.4%), 6 were closed as unsuccessful (19.4%) and one only received an intake. Table 15 reports discharge reasons.

Table 43. Program Status

	Count	Percent
Active	29	48.3
Discharged	31	51.6

Table 44 reports the discharge reason for closed clients and excludes the client who only received an intake. The largest number and percent of clients who discharged and completed the program received a safe placement (27 and 87.2%).

Table 44. Discharge Reason

	Count	Percent
Safe Placement Arranged	27	87.2
Declined Further Services	2	6.4
No Contact	2	6.4

Discussion and Summary

This section discusses and summarizes the interviews and client data informed, in part, by the process maps, performance measures and County contracts. This is not a comparison of services by provider, per se, we juxtapose them to illustrate the YTLS initiative as a whole. A direct comparison is not possible because the programs vary in their designs, target population, and services. Performance measure (PM) data cannot be compared to the client data and is not, in itself, a reliable data source for our evaluation; it is used here in a limited manner to provide some information not available in the client data.

Program Structures

Transition Living Programs combine housing with services, providing homeless youth with stable, safe living accommodations for up to 21 months. They seek to build skills necessary for clients to achieve and maintain independent living. The combination of housing and services varies across the YTLS providers. Although the County did not fund 'heads in beds,' all four providers' YTLS services were associated with some form of youth housing either directly (Casa Q and Serenity Mesa,) or indirectly (New Day and YDI.) For the two residential programs, the ability to offer additional services under the YTLS umbrella enhanced their capacity to serve their residents or increase the number of clients they could serve. New Day and YDI have housing programs *within their organizations,* but their YTLS services were not tied to those programs. For all intents and purposes, CQ and SM function similarly to a TLP so the total number and hours of service were dependent on the house census. This became especially important during the initial months of the pandemic when stay-at-home orders and concerns for staff and resident welfare impacted the number of referrals, intakes, and hence the number of residents.

The four YTLS agencies were well-established in the community as youth service providers before they received BHI funding. With the exception of YDI's new Independent Futures program (which is specifically named in their promotion materials), the other YTLS "programs" expanded already existing services within their home agencies' operational models. Serenity Mesa added staff to facilitate extending their residential addiction recovery services to females. New Day's High-Fidelity Wraparound for justice involved youth was partially funded; they asked for help covering pre-clinical and consulting services not reimbursed by Medicaid to fully implement the program. Casa Q formalized and staffed their case management services and according to staff interview the aftercare program as well. We did not receive client data on aftercare clients. The aftercare program is not part of this evaluation and may be evaluable in the future after it is fully implemented and documented. Also, because Bernalillo County is a "payer of last resort," funds were to be used for non-

Medicaid reimbursable services. This means we may not have had all the services provided to clients. The YDI client data review reported the number of services that were provided and not part of the BHI funding.

This was particularly challenging from an evaluation perspective: for three of the four YTLS "programs," any attribution of client progress potentially goes beyond the penumbra of YTLS funded services to the organizations' core programs (New Day) and/or the agencies themselves (Casa Q and Serenity Mesa) when the services are nearly inextricable from the process it supports. We must then determine the added value of an unknown portion of YTLS-funded services identified without the benefit of evaluating the institutional context in which they occur. The residential programs provide the best example: part of any improvements in the status of clients may be attributable to the provision of stable, safe housing, an evaluation of which would be, de facto, an evaluation of Casa Q or Serenity Mesa's program as a whole. (Which was not the focus of the evaluation.)

It then follows that the service agency mission statements are for *organizations* and provide general context and guidance for YTLS service implementation. Some of the plans for operationalizing those ideals for the YTLS services can be found in goals and objectives.

Physical Setting & Geographic Context

The Casa Q house is in a near-northeast heights residential neighborhood, close to services, employment, education opportunities, and public transportation. Their small LGBTQ+ staff provides support for youth in an environment similar to an extended family with single and shared rooms and common spaces. Serenity Mesa's campus is surrounded by desert on Albuquerque's southwest mesa with limited access to the facility. The campus includes: sex segregated lodges with shared kitchens; common meeting spaces within the lodges, in multi-function buildings and in outside locations; administrative buildings; and extensive lands. SM is meant to be mostly self-contained with visitation and client travel closely monitored. This location helps increase the safety for residents, minimizes distractions while residents go through the program, and is a deterrent to absconding. It appears that Casa Q and Serenity Mesa have developed their residential facilities to meet the specific needs of their populations. New Day and YDI IF's services are conducted in close proximity to the other programs in their organizations facilitates internal referrals both to and from YTLS services.

YDI and ND also have campuses, YDI's in the south valley and New Day's in southeast Albuquerque near USS Bullhead Memorial Park, with some services delivered at their administrative offices near the Sunport. New Day's Safe Home shelter is co-located with administrative buildings and common classrooms. YDI's campus includes Casa Hermosa (transitional living program), the Amistad Crisis Shelter, and several administrative buildings with easy access to public transportation.

Cultural Aspects

The principal standard for culturally and linguistically appropriate services (CLAS) in health and health care is: provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. People with substance use disorder, African Americans, Hispanics, the LGBTQ community are mentioned as populations with historical health disparities for whom CLAS is important. Native Americans, undocumented immigrants, systems involved youth, and sex trafficked youth are additional populations to consider in Bernalillo County.

Along these lines, Casa Q offers LGBTQ+ youth an accepting family environment, providing a safe place for youth who are struggling with their identities and or the consequences of others' perspectives about them. Those cultural ties extend beyond their residential stays. Structuring a housing program like a family home is a deceptively simple approach that rapidly multiplies in complexity as services and care networks are gathered for the young people involved. Nowhere is this more apparent than in Casa Q's aftercare, or in other words, what it means to be a family after a youth has moved out.

There was a meeting recently and we challenged the people there: we have a young person who we've had since [early teen] and now they got accepted in college with a full ride at [out of state college]. [This person] is in our aftercare program…I think that we need to help them buy a [mode of transportation]. You know, just like a parent would. And the group was instantly was like 'yeah! Like, of course we need to do that.'

Familial support does not necessarily end at 18, nor does it end 8 months after that point. Family support continues until it is no longer needed. Parents can be more than a source of reassurance and advice, they can be a very real safety net in a society where such nets are distressingly easy to fall through.

Some kids only need [aftercare] for one month, some of them need it for years, some of them don't want it at all. It's just like a little less on their shoulders, knowing we're there to follow them and help them if they need it, to be their support. Also, as LGBT people we tend to make our own families. A lot of our families are trash. So we make our own. And to a lot of them we ***are*** *family. So them seeing us even after they graduate the program, them seeing their case manager, knowing they're still a part of it helps them be successful.*

Casa Q seems to be replicating that to an extent in their aftercare program, which might explain why it is so difficult to discharge clients from aftercare within a set time period. Just as a family's investment in their child continues after they have "left the nest", so too does Casa Q's. Offering respect and "meeting them where they are," were other ways YTLS staff talked about recognizing and adapting to the needs of the client.

Specific to the implementation of CLAS in behavioral health care settings, The U.S. Department of Health and Human Services Office of Minority Health recommends behavioral health care providers, "incorporate cultural humility and linguistic competency into the delivery of quality behavioral healthcare and services." (HHS, *nd,* p.4). They further recommend providers, "build community trust and engagement by hiring highly qualified education and mental health professionals who are more reflective of local residents (p.9).

Staff

We did not ask providers for their staff demographics and limited our demographic questions in the interviews. Race, ethnicity, gender identification, and languages spoken can also impact client/clinician relationships, which may be related to client outcomes. Meyer and Zane (2013) found that "ethnic minority clients generally felt that issues regarding race and ethnicity were more important than did White clients. When these elements were considered important but were not included in their care, clients were less satisfied with treatment."

As noted in the discussion of the interview section for each provider, staff appear to have the expected and necessary credentials for their positions. In their original budgets: Casa Q proposed funding for about 2.3 FTE for 3 staff; Serenity Mesa proposed 5.8 FTE for 14 positions, including house managers, residential aids, clinicians and administrative oversite staff; New Day originally proposed 4 FTE for 7 positions including a therapist, resources specialist, program manager, two 2-1 FTE Wraparound facilitators, and clinical and administrative oversight personnel; YDI IF requested about 3.5 FTE for 5 staff including case managers, clinical managers, a clinical supervisor, a Youth Care Worker and administrative oversight staff.

We do not have access to data that would allow us to make observations about changes in staffing needs as the programs matured. An important process evaluation question is, "Did they have the staff they needed to implement their program as designed or adapted over time?" Staff numbers are directly related to service delivery and program capacity. Anecdotally, hiring and retaining quality staff for these positions was challenging and a constant concern that was exacerbated by the pandemic. Other than billing records (to which we do not have access), we are not aware of a systematic collection of these data by the county or reported by providers. At this time, we cannot address this question.

Another aspect of staffing is the relationships among clinicians, case managers, and supervisors. Independent Futures appears to be characterized by a strong organizational culture and a supportive structure of oversight. Their interviews showed consistency in goals, approaches toward youth, and program knowledge among the staff. Supervisors spoke proudly of their case managers, and the case managers expressed appreciation for the support provided by their supervisors.

> *There's one on ones, it's virtual now but it's weekly supervision that (clinical supervisor) does with each of the case managers individually. And then as a team. And then once a month, they all participate in group supervision and then (clinical supervisor) meets for her own clinical supervision with the clinical director weekly. So we have layers of supervision. And it's meant to support our staff."*

Goals and Objectives

Jarvis and Robertson suggest goals and objectives should be: clear, specific, and measurable; created before program implementation; and should serve as outcome measures. "They should describe what the program believes it should and can accomplish," (1993, p.2). YTLS goals and objectives are enumerated in *Appendix A: Scope of Services* of the contracts for each provider. The contracts were prepared by DBHS with feedback from providers. Aside from some minor variations in style, level of detail, and service type, they are very similar. Services in common include case management, systems navigation, assessments, program plans, therapy, and, for YDI IF and New Day, crisis stabilization. From the contracts, performance measures were derived making clear the expected levels of service delivery and some short-term outcomes. Taken all together, they are a representation of what the YTLS providers would like their services to achieve.

Goals and objectives from the contracts are presented below, followed by a brief summary of client data for each provider. The objectives describing acquisition of consent, cooperation in the UNM ISR evaluation, and YTLS service provider collaboration are common to all contracts and have been omitted here. The proposed activities to meet stated objectives have been edited for brevity.

Casa Q

The goal of the Contractor's services was to provide assessment, case management and navigation services to LGBTQ and/or LGBTQ friendly youth age 14-18 who are potential clients, current residents at the Casa Q house and former residents who can benefit from after care services, in Bernalillo County. These youth were to homeless, precariously housed or at risk of homelessness and have a behavioral health need.

To achieve this goal, the program focus was on accomplishing the following objectives with the young people served:

- Increase case management services
- Increase navigation services
- Increase access to behavioral health services
- Increase access to after care services

To realize those objectives, the Contractor was to use BHI funding to:

- Provide case management and navigation supports to at least twelve (12) potential clients
- Conduct comprehensive needs assessments within the first 30 days after first engagement.
- Create for each client a comprehensive client service plan based on identified needs.
- To serve a minimum of eighteen (18) individuals per year and maintain an average daily census of a minimum eight (8) of residents with an average stay of roughly five months.
- Ensure that former clients who successfully complete their goals at Casa Q and are transitioned to a safe, stable and supportive option, continue to access needed services.
- Provide case management and navigation services for a minimum of (8) former residents per contract year.

Based on the client data we received from Casa Q, they served 27 clients from July 2018 to December 2020. Approximately 85% of referrals came from CYFD or a shelter. The average length of stay was 154 days, or slightly over 5 months. About 57% of the clients received a behavioral health service; 78% participated in education services; and all residents received life skills training and case management services. About 27% of clients either ran away or were discharged for unsafe behavior and 31.7% clients successfully discharged. The remaining categories of aged out of service (at 18 years old), return to family, and referred to a higher level of care accounted for 13.6% each. We did not receive data on any clients who received aftercare services and overall received limited client level data.

Serenity Mesa

The goal of the program was to provide transitional living services to at least 25 homeless and precariously housed female young people ages 14-21 who had a substance-use and/or mental health disorder.

To achieve this goal, the program was to focus on accomplishing the listed objectives with the young people they served:

- Provide substance abuse treatment including assessments, individual, group and family therapy, trauma informed care, monthly treatment plans, relapse prevention planning and aftercare services
- Provide life skill classes, high school education. health and wellness classes and education, individualized case management, and job readiness.
- Provide services and supports that help youth realize an increased community connection and an increased sense of belonging and purpose, and that increase social and emotional well- being and coping skills.
- Case managers will work with clients to develop a comprehensive discharge plan including: after care, community support systems, housing, and employment.

To realize those objectives, the Contractor was to:

- Conduct a behavioral health assessment within 10 working days of client's admission intothe program
- Provide intensive therapy programming at a minimum of 9 hours of individual, group and family therapy per week.
- Provide life skills programming for a minimum of 5 hours of life skill classes perweek.
- Provide case management services specific to each client's need.
- Conduct monthly treatment team meetings with the client and support staff to identify short term and long term goals and monitor the progress of goal attainment.
- Assist clients in systems navigation from child to adult servicesystems.
- Provide diverse therapeutic interventions specific to client needs.
- Provide comprehensive discharge planning for all clients discharging from the program
- Provide after care appropriate to the needs of the client with connections to community supports and services prior to discharge.

Client data from September 2018 to June 2021 showed Serenity Mesa admitted 62 unduplicated female clients, four of whom were admitted twice, for a total of 66 clients. In the information for housing status prior to in-take, the family and self-categories combined are 31.8%; the remainder are homeless, precariously housed or justice-involved (68.2%). Education data show 55.3% of clients in GED or high school enrollment. Of those unenrolled (23.1%), there is no reason given (e.g. has a full time job, etc.).

Of the 27 discharged clients for whom there was service data, 96% received therapy, 96% received case management; 96% received life skills; 85.5% worked on career readiness; 92% received discharge planning; and 22% had other services listed. Program phase forms showed 69.4% of clients had progressed past Phase 1 at

the time of their discharge. Life skills and therapeutic services accounted for 83% of all services delivered in Phase 1 and were the majority services delivered through all Phases.

Eighteen clients (30.5%) successfully completed the program. Nineteen clients absconded from the program, 11 were expelled, and 11 left the program for other reasons including needing a higher level of care and not wishing to fully participate. Clients were expelled for reasons like fighting, drug use, and other violations of program rules. On average clients spent 56 days in the program with a median of 42 days. Four clients were in the program for over 121 days and 6 clients were in the program 1 day.

New Day

The goal of the Contractor's services will be to provide intensive care coordination, crisisstabilization, system navigation, diverse therapeutic interventions, and after care services for homeless and precariously housed young people ages 16-24 with substance use and/or mental health needs in Bernalillo County.

To achieve this goal, the Contractor will focus on accomplishing the following objectives with the young people served:

- Increase community connection
- Increase sense of belonging and purpose
- Increase social and emotional well-being and coping skills
- Increase access and sustainability in maintaining stable housing

To realize those objectives, the Contractor will:

- Provide intensive care coordination using high fidelity wrap around individualized service to meet the specific needs of each client.
- Provide crisis stabilization with individualized crisis plans specific to the needs of each client.
- Provide diverse therapeutic interventions specific to client needs.
- Provide after care appropriate to the needs of the client.
- Provide emergent, overnight stabilization and case management services for youth in need from the Youth Services Center.
- Assist clients in systems navigation to bridge the gap between child and adultservice systems.

New Day's service profile changed over time and it appears direct delivery of navigation and therapeutic services were provided outside of the BHI-funded services reported to us. We received information only for the High Fidelity Wraparound Program. HFW had 48 clients between August 2018 and January 2021; 37.5% were minors (for whom we received partial data). CYFD Protective Services and the criminal justice system provided 38.5% of referrals. This may be an undercount of systems-involved youth since they could have come from any of the other referral sources and we did not receive information designating either the number or type of systems in which each person was involved. Internal referrals from New Day accounted for 15.9% of referrals.

Adults received an average of 44.2 services, 99.7% of which were "WRAP or Team Meeting" and .03% were care coordination. Almost 30% of collateral contact occurred without the young person in attendance; they were present at 70.7% of WRAP or team meetings. Service provision averaged 34 minutes per event with half the services lasting less than 15 minutes. The total hours of services received averaged 25.1 hours.

YDI Independent Futures

The goal of the YDI program was to provide intensive care coordination, crisis stabilization, system navigation, diverse therapeutic interventions and after care services for homeless and precariously housed young people ages 16-21 with substance use and/or mental health disorders in Bernalillo County.

To achieve this goal, the program focused on accomplishing:

- Increase community connection
- Increase sense of belonging and purpose
- Increase social and emotional well-being and coping skills
- Increase access and sustainability in maintaining stable housing

YDI Services to be provided to achieve these objectives:

- Assessments: Casey Life Skills Assessment (CLS); Child and Adolescent Functional Assessment Scale (CAFAS) for youth age 16-18; Global Assessment of Individual Need (GAIN) for youth 19-21 will be administered.
- Youth Individualized Plan: Each youth will develop a service plan with individualized goals.
- Life Skills Training Program: Provide individual and group sessions focusing on skills to teach and enhance independent living skills.
- Behavioral Health and Related Services: Counseling (individual and group) provided to address needs identified through the assessment process.
- Employment/Educational/Volunteer Opportunities/Training: Service provided directly and through referral to YDI's Workforce Training Division to teach youth employability skills.
- Case Management and Support Services: Case coordination to assist youth in accessing needed resources, especially focusing on stabilizing their living environment.
- Crisis Stabilization and Shelter Placement: Referrals from YSC will be provided crisis intervention/stabilization services and foster family reunification. In cases where reunification is not immediately possible, emergency shelter placement through Amistad Crisis Shelter will be provided.

To realize those objectives, YDI was to:

- Provide intensive care coordination using high fidelity wrap around individualized services to meet the specific needs of each client. YDI Staff Responsible: Case Managers.
- Provide crisis stabilization with individualized crisis plans specific to the needs of each client. YDI Staff Responsible: Case Managers, Clinician and Youth Care Worker for YSC youth.
- Crisis Stabilization and Shelter Placement: Referrals from YSC will be provided crisis intervention/stabilization services and foster family reunification. In cases where reunification is not immediately possible, emergency shelter placement through Amistad Crisis Shelter will be provided.
- Assist clients in systems navigation to bridge the gap between child and adult service systems. YDI Staff Responsible: Case Managers.
- Provide diverse therapeutic interventions specific to client needs. YDI Staff Responsible: Clinical Supervisor
- Provide after care appropriate to the needs of the client. YDI Staff Responsible: All program staff.
- Provide after care appropriate to the needs of the client. YDI Staff Responsible: All program staff.
- Provide emergent, overnight stabilization and case management services for youth in need from the Youth Services Center. YDI Staff Responsible: Youth Care Worker, and Case Managers with assistance from Amistad shelter staff.

YDI Independent Futures admitted 110 clients between August 2018 and mid-March 2020, 45.5% of whom were minors. The majority of IF clients were self-referred (76.4%); internal YDI referrals accounted for 4.7% of all referrals. Client received an average of 23.5 individual sessions. Case management notes and life skill notes accounted for 71.2% of services and individual therapy, 13.3%. The average service lasted about 42 minutes with half of all services lasting no longer than 30 minutes. Clients received an average of 19.7 services and an average 13.7 hours of service.

YDI supplied the only assessment data for this evaluation: Casey Life Skills (CLS) and Child and Adolescent Functional Assessment Scale (CAFAS). As discussed earlier, there were important limitations associated with the data but they provide an important example of the power of using validated instruments, as designed, and the need for tracking the resulting information. The CLS data showed improvements in CLS scores, with large effect sizes, in five domains: Daily Living, Self-Care, Relationships and Communications, Housing and Money Management, Work and Study, and Career and Education Planning. CAFAS did not show statistically significant changes in any domain and there was no data for three domains.

Population Served

The target population described in the County's RFP for YTLS was, "unaccompanied homeless and precariously housed youth age 14-24 with identified behavioral health needs." (Zamora, p.3). Within that broad description, providers proposed to serve several sub-populations experiencing housing instability and requiring behavioral health service: resident LGBTQ youth ages 14-18 years old (Casa Q); resident females with substance use disorders ages 14-21 years old (Serenity Mesa); and systems-involved youth ages 16-24 years old (New Day). YDI's service population was generally 16-24 years old, Hispanic or other minority, male, homeless or precariously housed, and exhibiting behavioral health needs. The target population for Independent Futures was not expected to differ from other YDI programs. Another eligibility requirement for all clients was to be a resident of Bernalillo County.

We expected to see client data that confirmed both the service eligibility criteria (age, housing instability, identified behavioral health need, county of residence) and the target population demographics for all providers. Table 45 summarizes the eligibility criteria and demographic information from the client data we received. Casa Q demographic data could not be reported. The client level data for all providers captured one eligibility criteria: age. Two providers collected a measure of housing insecurity.

Based on the data we received we cannot *completely confirm* eligibility and target population markers. Some information may not have been reported because it is expected or assumed to be 100% or was not in the data we received. This could have occurred because we did request the data, it was not provided because it was not available, or perhaps it was not easily extracted. Housing insecurity and system involvement in this table have been derived from referral source (so they are less reliable); they should be collected as two mutually exclusive variables (housing status at entry and referral source). Identified behavioral health and substance use disorder could be gathered at intake or as present/absent or as a presenting behavioral health issue variable. Those determinations, however, should be made using an evidence-based instrument specifically for these purposes.

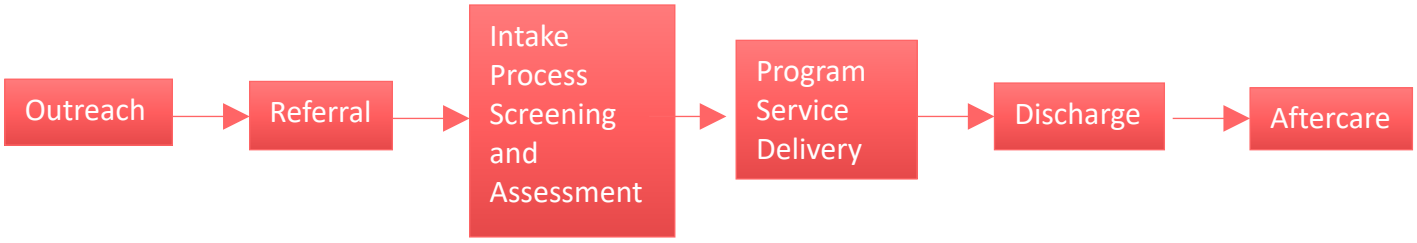
Table 45. Eligibility Criteria and Select Demographics Reported in Client Data by Provider

Eligibility Criteria	Casa Q	Serenity Mesa	New Day	YDI IF
Age Range, Years Old	13-17	14-23	15-23	16-21
Housing Insecurity	Missing	23%	Not included	9%
Identified Mental Health Need	Incomplete	Not included	Not included	Not included
Resident of Bernalillo County				
Target Population Characteristics				
Substance Use Disorder	Yes	Yes	Not included	Not included
LGBTQ status	Yes	Not included	Yes	Not included
Systems involved youth/CYFD or YSC referral	48%	68%	39%	4%

Program Process

Throughout this evaluation a guiding framework for the performance measure review, interviews, and data analysis has been a chronological progression what happens to get a prospective client into and through a program (Figure 5). This orders our summary and recommendation for YTLS, in general, and for each provider.

Figure 5. Generic Process Map for YTLS Delivery



Outreach

The YTLS providers have similar strategies for outreach including: presentations to youth or behavioral health service organizations, professional contacts with detention and child welfare personnel, and collaboration with other YTLS agencies. Other agencies might find the providers by word of mouth or through web-sites and social media. Agencies do not always have a clear idea of what the YTLS providers offer, sometimes leading to time, travel and other resources being spent for a very low return. Most recently, some YTLS providers have started doing direct recruiting themselves via street outreach rather than waiting for contacts to move through the referral process.

Referrals

Referrals came from many of the same sources, including other YTLS providers. Quality referrals depend on the referring party understanding the program: neither Casa Q nor Serenity Mesa is equipped to handle individuals with acute behavioral health needs or who are actively in the process of detoxing, as examples. Another source leading to a lack of fit between prospective residents and providers was the pressure for Casa Q and Serenity Mesa to change their intake procedures as a solution to increasing their census. Both were asked to shorten their in-take processes and accept higher risk cases. Whether this has affected the number of patients absconding or being expelled from the programs remains to be seen. These disruptions to a carefully curated LGBTQ household or highly structured addiction recovery program can divert organizational resources and decrease the safety and comfort of current residents. Census counts fluctuate for a variety of uncontrollable reasons, perhaps a low census count could be seen as an opportunity to conduct client follow-ups and aftercare and develop or formalize policies and procedures to guide those services.

New Day and YDI Independent Futures offer services that might overlap somewhat with their TLPs. This is less true for HFW than Independent Futures. For all the YTLS providers, development of an easy-to-follow decision tree depicting who is right for each program (YTLS and other ND and YDI IF programs) might aid other organizations in making referrals. This idea might have been discussed at one of the early YTLS provider collaboration meetings, we encourage the group to revisit the development of this potentially useful resource.

When asked about what referral sources they would like to add to their partnerships, Casa Q mentioned churches and people who work with Two Spirit indigenous youth. Serenity Mesa noted the county jail would be a good source, as would the DBHS CARE campus. New Day would like to see referrals from CYFD and YDI IF indicated RTCs (residential treatment centers) and detention centers would be good sources of referrals for them.

Intake, Screening and Assessments

Intake processes vary based on the needs and goals of the program. New Day's 'low-barrier' applications are reviewed bi-weekly and Casa Q's process includes a thorough review of client backgrounds and a series of interviews with staff culminating in a meeting with current house residents. Because Casa Q and Serenity Mesa serve *in loco parentis* to varying degrees, intakes may be more comprehensive and the referral time to intake time would be expected to be longer than those of New Day and YDI IF. Not all YTLS providers need the same screening tools or assessments to ascertain client fit for a program or to create their case management or treatment plans. Screening and assessments ranges from functional (CAFAS AND CLS for YDI IF) to drug screening and behavioral health assessments (Serenity Mesa).

However, one of the eligibility criteria for all BHI funded programs is the presence of an *identified behavioral health need*. SAMHSA defines behavioral health as promotion of mental health, resilience and wellbeing; the treatment of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions. (*nd,* p.1). How that is determined is unclear for all the providers. Often assessments are included in referral packages and rather than assess again, providers accept the outside assessment if it's within a time frame they find acceptable. Providers also indicated there are sources whose assessments they find unreliable and in those cases they will re-assess to verify a diagnosis.

As seen in the earlier section describing the population served, there was very limited client level data addressing this criteria. *Presenting Issue* is reported to the County in the Y3 performance measures (Table A3); how these are determined is unclear but providers appear to be collecting this information. Earlier in the literature review we discussed eight assessments mentioned by providers either in documents provided for our review, the creation of their process maps, or in interviews. Again, these data might be collected but for the most part they were not in the client data we received. We recognize that screenings and assessments are primarily for the benefit of the client and should only be used when deemed appropriate by the provider. They are useful for both provider and evaluator appraisal of the impact of YTLS. We recommend that providers use evidence-based and validated instruments, implement them as intended, and record results in a way that is accessible for tracking progress over time. This is discussed more fully in the general recommendations section.

Service delivery

Casa Q is designed to be a long-term housing solution for LGBTQ+ youth up to when they turn 18 years of age, with staff and residents stepping into the role that a family would normally serve for young people growing up in stable and supportive homes. The primary service provided by Casa Q is housing (for which the County does not pay) with transitional living services secondary. This is consistent with idea of "housing first." Looking only at services, Casa Q is raising young people either rejected by their biological families or for whom family housing is not an option. Because Casa Q is modeled after a supportive home, some of these services they offered were: academic supports such as: homework assistance, transportation to and from school, helping youth select the school and programs that are the best fit for their need; life skills including cooking, cleaning, driving, basic house upkeep skills; psychiatric services arranged on an as-needed basis and medication was dispensed by the staff; doctor's visits, dental care, and other medical needs are also addressed on as-needed basis. Upon moving out, clients still receive some of those services along with household goods, help obtaining an apartment; grocery shopping, etc.

Serenity Mesa is not a housing provider, per se, or a program that necessarily targets homeless or precariously-housed youth. It is a sober-living facility providing addiction recovery supports based on The Seven Challenges model, and includes IOP, life skills, and a supportive peer environment, all elements of a good residential addiction recovery facility. For some systems-involved youth, it is also a "step-down" from more restrictive environments (e.g., detention) to help ease them into an environment where there are daily challenges to their

sobriety as they move toward full independence. Their primary goal is facilitating relapse prevention and resiliency; all their services support that goal.

The Seven Challenges model is designated as an evidence-based practice for use with the demographic served by Serenity Mesa. It is the only Medicaid approved model for this population in New Mexico. However, this evidence-based designation is based on the implementation of the model as designed. Avoiding "the mad rush for abstinence" (defined by the Seven Challenges manual as the intense pressure put on youth by adults to immediately quit using substances) is a fundamental component of this model. Serenity Mesa is a sober-living facility that requires abstinence *while clients are in the program* and enforces it with drug screening. This does not mean that the Seven Challenges model cannot work in an environment where abstinence is enforced—it simply means that it has yet to be studied in that context. At Serenity Mesa a positive drug test does not necessarily result in expulsion from the program; the client's decisions that led to usage are supposed to become object lessons in IOP.

To insure fidelity to their model, the program reported Seven Challenges conducts annual audits with Serenity Mesa and requires clinicians to meet quarterly with their clinical director. Access to those audits and pre-post interviews with clients would illuminate the core messages received and their potential impact on client decision-making in the short and long term. Because SM is not a typical YTLS program, clear articulation of expected program outcomes is critical. A theory of change for how the concepts and activities of 7C are related to housing stability would be beneficial.

New Day differs from the other providers in that instead of incorporating multiple models into one program, they focus primarily on maintaining one evidence-based model. Their primary service is high-fidelity wraparound, a nationally-regulated evidence-based approach to care-coordination. To be considered true high-fidelity wraparound, a provider is required to be certified. This can create goal conflict between funders and the HFW staff: New Day cannot implement changes that threaten the program's fidelity. For example, in order to correctly follow the HFW model, new facilitators are only allowed a caseload of three clients and are not permitted to take on more until they have had additional experience and trainings. This best practice is at odds with the contractual need to serve a greater volume of clients while program staff are being trained. More generally, for programs that were understaffed or impacted otherwise due to the pandemic the number of clients served may have been reduced.

Additionally, this program essentially comes pre-packaged with its own system of oversight. The High Fidelity Wraparound model is associated with a national structure of trainings, certifications, and fidelity measures that are performed independently of local funders and their requirements.

> *You have to be certified as an agency, as well as having the individuals certified. In order to maintain our certification as an agency to provide wraparound, we have to do it to fidelity and we have to share all of our data with a centralized database…we're basically tracked that way…to be a facilitator, you have to have an outsider come watch a couple of your meetings every year. You have to complete the wraparound fidelity index, and the family does that you're working with, and you have to have your files audited.*

New Day's HFW is evaluated for fidelity and outcomes by NMCYFD and the NWIC. Their direct data entry into the national Wraparound Fidelity Assessment System (WFAS) aids with local and national research on HFW. WFAS is, "a multi-method approach to assessing the quality of individualized care planning and coordination for children and youth with complex needs and their families." Additionally, WRAPSTAT is for "collecting and using wraparound fidelity, satisfaction, and outcomes data." With all the support from NWIC and NWI, there is no reason to try to replicate their findings. We recommend the County, New Day, and CYFD broker a data sharing agreement and access to past New Day HFW reports. This is not in lieu of continued

evaluation by UNM ISR but a recognition that the data for most rigorous evaluation of HFW resides with NWIC.

What is not covered by NWIC is New Day's use of the Nurtured Heart Approach. Fidelity to this model can be determined through structured observation, although relating it to HFW outcomes without data internal to that process would not result in a sufficiently robust evaluation of either component. We note, too, that NHA is an evidence-informed practice specifically for children exhibiting attention-deficit/ hyperactivity disorder (ADHD) behaviors. Its usefulness in the YTLS context has not been documented.

The **YDI Independent Futures** program provides a variety of services including life skills, social skills, case management, behavioral health, education assistance, and workforce training. All of this is delivered through the lens of case management. YDI case managers make and execute treatment plans with the client. Some services appear to be ad hoc (budget lessons at a coffee shop) while others are delivered in more formalized situations (budget lessons at local schools). This is a demonstration of one of the principles underlying all YDI IF services, "meet them where they're at," in this case, literally. Structured observations would lend insight into YDI IF service delivery.

Confusingly, service providers often talk about "WRAP" meetings, meaning client meetings with affiliated staff in attendance. These are neither certified HFW activities nor are they part of the NWI data collection systems. However, YDI IF staff do participate as team members for clients they share with New Day's HFW program. Similarly, wraparound is care coordination and the HFW staff do not deliver direct services so they might contact YDI IF for case management, Serenity Mesa for client recovery supports or Casa Q for LGBTQ resources, including placement.

Discharge

Most providers mentioned that discharge planning begins very early in the program so there are goals and benchmarks to work toward, a shared understanding of what success looks like to the client, and it sets expectations. Not all YTLS participants discharge in a way that allows planning, much less an end-of-program assessment or satisfaction survey. Casa Q and Serenity Mesa reported (respectively) 31.7% and 30.5% of clients successfully discharged. The majority of the remaining clients absconded or were expelled, neither of which is an ideal situation for an exit interview. YDI IF reported 60 discharge services and reasons for discharge for 31 clients, 87% for whom a safe place was arranged. For New Day date of discharge for adults and days of service for all clients but not discharge status was provided. In the current DBHS monthly reporting for individual clients, reason for discharge does not include "absconded" or "expelled," they appear to be aggregated into a "disengaged from services" or "other" category (Table A16) that makes it difficult to track and potentially address improving client retention.

YTLS providers documented discharged clients in four different ways. Casa Q and Serenity Mesa reported similar information but different categorizations cover success, absconding, expulsion, etc. New Day reported only whether a case was closed or active and YDI reported "safe place arranged" or not. This highlights the issue of conflating *housing placement* with *program success*. The underlying assumption is, housing placement is equivalent to program success. We looked for variations in client engagement within a program to help understand what lead to a good housing placement. People who received more services may be more likely to have an acceptable housing outcome than those who received few or no services (was not successfully engaged). One is an explanatory variable for the other: what did the client do in the program (service receipt) that made it more or less likely they would get a good housing placement?

Aftercare

During the study time period Casa Q was the only provider with a dedicated aftercare case manager. Nowhere in their client data or performance measures was there clear indication of whether services received were case

management for aftercare or as part of their residential services. For the informal aftercare services there was no information for clients who received aftercare. Without client level aftercare data it will be difficult to attribute the impact of aftercare on housing stability over time.

YDI had no formal aftercare system in place at the time of this evaluation, which was identified as an area they would like to improve in the future. Despite having no formal aftercare system in place, they do have informal aftercare, and their clients appear to use it. This seems to have come about not as a result of intentional planning, but rather as a natural consequence of how clients and case managers bond and communicate with one other. Case managers and clients often use cell phones or social media to contact each other, forms of communication that can persist after a client is formally discharged. Clients may continue to update their case manager on successes or crises in their lives after they have left the program. Likewise, a case manager might frequently check on a former client they were worried about. YDI's process map states they do a 6-month follow-up at minimum, but this could occur more or less frequent depending on the client's situation. Whether this system is intentionally constructed or formed naturally, the result is the same—a safety net to catch youth where they might have fallen, providing support and a path back to any needed services.

Recommendations

General

BHI is one of possibly or potentially many funding streams providers engage to improve and expand their services. The ultimate goal of the BHI YTLS funding is preparing youth to deal with the challenges of obtaining and maintaining stable housing, whether that housing is a long-term shelter, supported housing, an apartment or a house. They might be housed with families of origin or families of choice, roommates or by themselves. To varying degrees, all YTLS providers are *in loco parentis*, doing the job of helping youth transition to independence. They do it, in part, because they believe they make a difference for a moment or a lifetime. Understanding what approaches or techniques are most successful is critical to expanding the ability of all providers to aid these transitioning youth.

Funded programs should more completely document the status of clients at intake into programs, *particularly if programs are doing something to affect a change in client's status.* This status should, to the extent possible and practicable, be documented at discharge and some follow up point as well. For YTLS programs this could include housing status; education status, employment status, substance use, and behavioral health. This concept seems fairly straight forward and apparent but is often not implemented. This may not be done for a variety of reasons including funding, the staff time required, training, and need. Measuring change in client status could partly be accomplished by adopting a screening or assessment tool that fits with the program's goals and intent.

Providers collect data for their program needs and report other data monthly to DBHS for contract management. Currently, these data are insufficient, separately and together, for robust outcome evaluation. There are screening and assessment tools used (sometimes without fidelity to their best practices for use), but not easily shared, and there is key programmatic information that is not being collected. Other data issues have been noted through this report.

We recommend the County work with YTLS providers and perhaps consult with UNM ISR CARA to improve and streamline the data collected for program management, oversight and evaluation. Discussions could include a basic overview of measuring goals and objectives, an inventory of screening and assessment tools used and those that might be potentially useful, leveraging existing assets for data collection (CARA access for Casey Life Skills, CAFAS, GPRA and others; potential data collection through audits), maximizing the usefulness for providers of collected data, and developing a strategy to work with EMRs.

Outreach and Referrals

Chronically low residential or program engagement numbers suggest, as a first step, a review of outreach practices including target audiences, message content and communication platforms. Providers mentioned several agencies from whom they currently do not receive referrals but might be a good source. A way to jump-start the relationship (and strengthen existing relationships) is to intentionally reframe it through the lens of building mutually beneficial partnerships. Having some awareness of the organizational culture of the potential partner can illuminate common ground, potential sticking points, and new possibilities for collaboration. Although developed by the *Partnership and Community Collaboration Academy* for use by federal land and conservation agencies, the processes for achieving competency in Partner Cultural Awareness are nearly universally applicable and may be applicable to the BHI.

Partner Cultural Awareness is understanding your partner's culture and sharing the culture of your agency, it, "Acknowledges, understands, respects and communicates respective partners' cultures that are based upon missions, practices, people, governance, traditions, financial structure and capacity, and institutional histories. [it] Finds ways that partners' cultures can contribute to *strengthen the mutual endeavor*; values the difference and finds ways to integrate these differences into a workable operating culture for the overall partnership," (PCCS, 2020; emphasis added). The video/podcast linked above outlines a short exercise to move the conversation from getting referrals to improving the outcomes for the clients both organizations serve. Building partnerships from this base should also improve *the quality* of referrals, saving time and resources otherwise lost in the pursuit of potential clients who do not meet provider program criteria. It also provides a framework for overcoming barriers based in organizational or personal histories.

The collaborative nature of the YTLS providers is apparent in their referrals to one another, clearly recognizing the value each program adds to the goal of improving the lives of youth through the provision of individualized services. The DBHS-sponsored monthly provider meetings were valued as a forum for sharing information about bed availability, the status of clients in common, additional funding opportunities, news about legislation, and updates about other agencies in the constellation of youth program providers. These meetings also served a strategic function by facilitating preparation for the influx of clients expected from the closure of Desert Hills (April 2019) and discussions about establishing a common PRN pool. Meeting participants included program directors, case managers, clinicians, and occasional guest speakers. Acknowledging the time commitment for these monthly meetings, participants were asked if they would prefer to meet less frequently: they chose to continue meeting monthly (pre-pandemic). We recommend the monthly meetings continue, subject to the preferences of the providers.

Revisit Screening and Assessments

As noted in *Assessments Mentioned by Providers*, and in discussions about the data provided for this evaluation, a number of programs used standardized screening and assessment tools. This includes the CAFAS (or GAINS-SS) and CLS, which can be used by programs operationally to design and provide services to clients as well as be used to document their success. These tools or others like them might be universally useful for YTLS programs.

There are other assessments that might be helpful for providers (and benefit program evaluation) as well. Based on the goals and objectives listed for the providers, we recommend exploring adding assessments for: perceived social supports, closeness of relationships, self-efficacy, family relationships, and well-being. At this point we would not require any particular tools but urge providers to choose validated instruments and use them as they are designed to be used. It takes time and resources to administer an assessment for a funder or for programmatic reasons, revising these vital functions for each of the providers and for the YTLS initiative as a whole could help streamline these processes, improve program services and help with the evaluability of the programs.

Discharge and Aftercare

We recognize that not all YTLS participants discharge in a way that allows planning, much less an end-of-program assessment. At minimum, reason for discharge and discharge status of housing status, employment, and education should be collected, along with any of the data programs believe are critical to indicating program success. When there is an opportunity, we recommend conducting final assessments such as CLS or GAINS. Incorporating validated screenings and assessments at baseline and re-administering them at or near discharge creates an understanding of how clients are doing, and their status as clients move into aftercare. Aftercare may include a new set of services under new circumstances for the client. This passage should be delineated in the data, a documented exit procedure (including assessments, client feedback on the program, etc.), and new intake package and assessments are recommended.

Future Research

There are gaps in our understanding of several of the YTLS delivery *processes* that could potentially be addressed through structured observations. This includes observing The Seven Challenges program to measure implementation with the intent of determining measures appropriate for an outcome evaluation. Observations of both male and female residential programs could provide useful insights based on their experience of adapting the Serenity Mesa program to young women. Casa Q's aftercare program has a dedicated aftercare case manager, closer study of how this program was integrated into the house and how it functions may result in findings beneficial to all providers as they develop their aftercare programs. Observations of YDI IF staff may generate knowledge useful for other providers' data collection and record management. For all providers, we could focus on understanding their particular needs for improving data collection and reporting. Continued evaluation of New Day's High Fidelity Wrap Around services could focus on the program's participation in the national evaluation, including accessing reports generated under those auspices.

With the cooperation of the YTLS providers and using information from this process evaluation we can conduct Outcome Evaluability Assessments to determine whether an outcome evaluation can be conducted with any of the programs and under what conditions. This includes how the results of the process evaluation and recommendations could be used to prepare programs for outcome evaluations, the type of outcome evaluation and proposed research methods.

Conclusion

Over 247 youth have been clients in one or more YTLS programs in the last two and a half years. Although interviews suggest programs are mostly conducted as described in the process maps, the client level data only partially supported the program designs and implementation. This gap is at least partly the result of how information is collected and stored by providers, client records we could not access in our time frame, state law limiting access to identified client data for minors, and the on-going pandemic. Without robust indicators for program eligibility, status at intake and discharge, and clarity about program services and those received by clients, the study of short- and long-term program impacts will require an Outcome Evaluability Assessment. ISR CARA technical assistance staff may work with providers and DBHS to assist in preparing for the next evaluation phase.

It is our position that policy makers and practitioners have a professional responsibility to seek out research evidence and to use this evidence to inform their decisions. The administration of the taxpayer-funded Behavioral Health Initiative should be an example of evidence-based public health, with decisions made, *"…*on the basis of the best available scientific evidence, using data and information systems systematically, applying program-planning frameworks, engaging the community in decision making, conducting sound evaluation, and disseminating what is learned." (HPIO, p.1). Furthermore, "When done well, evidence-based practice increases

the effectiveness, efficiency and accountability of public health interventions by steering resources toward "what really works" based on expert evidence, while also providing space for innovative development and evaluation of new strategies informed by the experiences of community members and front-linepractitioners." (*ibid*) BHI providers should be encouraged to adopt programs and strategies that have been evaluated as effective for the specific issues being addressed and to employ empirically validated screening and assessment tools in ways that allow internal and external program evaluation.

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Appendices

Appendix A – Year 3 Performance Measures

In June 2020 DBHS changes data collection instruments for all YTLS providers. Reporting went from slightly program-specific performance measures reported in aggregate to standardized individual level client data. This gave DBHS staff more flexibility to derive aggregate measures and have far more analytic flexibility. However, there are errors, e.g., use of date enrollment vs. date entered appears to be inconsistent across providers (rendering calculations of length of stay unreliable), and there are incongruities in client active/inactive and discharged/in program status. The following tables include all providers so it is easier to see the variations in client populations, service delivery and short-term outcomes for clients. We present these tables without discussion, for your information.

Table A1. Client Status by Agency Service Provider

	Agency Service Provider								Total	
	Casa Q		New Day		Serenity Mesa		YDI			
Client Status	N	%	N	%	N	%	N	%	N	%
Inactive	10	50.0	25	62.5	26	83.9	8	26.7	69	57.0
Active	10	50.0	15	37.5	5	16.1	22	73.3	52	43.0
Total	20	100.0	40	100.0	31	100.0	30	100.0	121	100.0
Average clients per month	1.5		3.1		2.4		2.3		9.3	

Table A2: Living Situation by Agency Service Provider

	Agency Service Provider								Total	
	Casa Q		New Day		Serenity Mesa		YDI			
	N	%	N	%	N	%	N	%	N	%
Precariously Housed	6	30.0	4	10.0	11	35.5	14	46.7	35	28.9
Housed	3	15.0	34	85.0	6	19.4	9	30.0	52	43.0
Homeless	11	55.0	2	5.0	14	45.2	7	23.3	34	28.1
Total	20	100.0	40	100.0	31	100.0	30	100.0	121	100.0

Table A3. Percentage of Clients' Presenting Issue by Agency Service Provider

	Agency Service Provider								Total	
	Casa Q		New Day		Serenity Mesa		YDI			
	N	%	N	%	N	%	N	%	N	%
Alcohol Abuse	8	40.0	1	2.5	20	64.5	5	16.7	34	28.1
Developmental Disability	2	10.0	6	15.0	1	3.2	3	10.0	12	9.9
Domestic Violence	11	55.0	1	2.5	11	35.5	1	3.3	24	19.8
Drug Abuse	7	35.0	14	35.0	31	100.0	7	23.3	59	48.8
Medical Needs	13	65.0	2	5.0	9	29.0	0	0.0	24	19.8
Mental Illness	19	95.0	15	37.5	20	64.5	0	0.0	54	44.6
Physical Disability	2	10.0	3	7.5	1	3.2	0	0.0	6	5.0
Sex Trafficked	8	40.0	2	5.0	8	25.8	0	0.0	18	14.9
SMI/SED	2	10.0	16	40.0	2	6.5	8	26.7	28	23.1
Traumatic Brain Injury	0	0.0	0	0.0	1	3.2	0	0.0	1	0.8

Table A4. YDC Clients by Agency Service Provider

	Agency Service Provider								Total	
	Casa Q		New Day		Serenity Mesa		YDI			
	N	%	N	%	N	%	N	%	N	%
YCD Clients	0	0.0	4	10.0	5	16.1	2	6.7	11	9.1
Non YDC	20	100.0	36	90.0	26	83.9	28	93.3	110	90.9
Total	20	100.0	40	100.0	31	100.0	30	100.0	121	100.0

Table A5 Age Reported 6/30/2021 by Agency Service Provider

	Agency Service Provider								Total	
	Casa Q		New Day		Serenity Mesa		YDI			
	N	%	N	%	N	%	N	%	N	%
Under 18	12	67	10	25.0	8	25.8	8	26.7	38	31.9
18-20	6	33	19	47.5	13	41.9	14	46.7	52	43.7
21-22	0	0	7	17.5	7	22.6	5	16.7	19	16.0
23-24	0	0	4	10.0	3	9.7	3	10.0	10	8.4
Total	18	100	40	100.0	31	100.0	30	100.0	119	100.0
Average Age		17.0		19.0		18.9		19.0		19.1
Standard Deviation		1.3		2.3		2.4		2.2		2.3
Age Range		15-19		15-24		15-23		16-24		15-24

Table A6 Client Gender by Agency Service Provider

	Agency Service Provider								Total	
	Casa Q		New Day		Serenity Mesa		YDI			
	N	%	N	%	N	%	N	%	N	%
Transgender	6	30.0	2	5.0	0	0.0	1	3.3	9	7.4
Male	3	15.0	18	45.0	0	0.0	10	33.3	31	25.6
Genderqueer / Gender nonconforming	6	30.0	4	10.0	0	0.0	1	3.3	11	9.1
Female	5	25.0	16	40.0	31	100.0	18	60.0	70	57.9
	20	100.0	40	100.0	31	100.0	30	100.0	121	100.0

Table A7 Ethnicity by Agency Service Provider

	Agency Service Provider								Total	
	Casa Q		New Day		Serenity Mesa		YDI			
	N	%	N	%	N	%	N	%	N	%
Non-Hispanic / Non-Latino	14	70.0	19	47.5	11	35.5	8	26.7	52	43.0
Hispanic / Latino	6	30.0	21	52.5	20	64.5	22	73.3	69	57.0
	20	100.0	40	100.0	31	100.0	30	100.0	121	100.0

Table A8 Race by Agency Service Provider

	Agency Service Provider								Total	
	Casa Q		New Day		Serenity Mesa		YDI			
	N	%	N	%	N	%	N	%	N	%
White	14	70.0	22	55.0	22	71.0	22	73.3	80	66.1
Other	0	0.0	2	5.0	0	0.0	0	0.0	2	1.7
Native Hawaiian or Pacific Islander	0	0.0	2	5.0	1	3.2	1	3.3	4	3.3
Multiracial	1	5.0	5	12.5	6	19.4	4	13.3	16	13.2
Black or African American	0	0.0	4	10.0	1	3.2	2	6.7	7	5.8
American Indian or Alaska Native	5	25.0	5	12.5	1	3.2	1	3.3	12	9.9
	20	100.0	40	100.0	31	100.0	30	100.0	121	100.0

Table A9 Percentage of Client Receiving Listed Service by Agency Provider

	Agency Service Provider								Total	
	Casa Q		New Day		Serenity Mesa		YDI			
	N	%	N	%	N	%	N	%	N	%
Case management	17	85.0	36	90.0	29	93.5	28	93.3	110	90.9
Education	11	55.0	14	35.0	26	83.9	18	60.0	69	57.0
Family/Natural Supports	11	55.0	24	60.0	24	77.4	2	6.7	61	50.4
IOP	3	15.0	0	0.0	28	90.3	0	0.0	31	25.6
Life Skills	12	60.0	24	60.0	28	90.3	21	70.0	85	70.2
Therapy	11	55.0	16	40.0	28	90.3	1	3.3	56	46.3

Table A10 Percentage of Clients Experiencing Crisis and Treatment Events

	Agency Service Provider								Total	
	Casa Q		New Day		Serenity Mesa		YDI			
	N	%	N	%	N	%	N	%	N	%
Arrested	0	0.0	0	0.0	7	22.6	0	0.0	7	5.8
CYFD Referral	4	20.0	0	0.0	5	16.1	0	0.0	9	7.4
ER or Psych ER Visit	1	5.0	0	0.0	4	12.9	1	3.3	6	5.0
Emergency Support	1	5.0	0	0.0	1	3.2	0	0.0	2	1.7
Hospital Visit	1	5.0	0	0.0	5	16.1	0	0.0	6	5.0
Team Addressed	0	0.0	2	5.0	5	16.1	2	6.7	9	7.4
SA Treatment In	0	0.0	0	0.0	31	100.0	0	0.0	31	25.6

Table A11 Percentage of Clients Referred Outside of Agency for Services by Agency Provider

	Agency Service Provider								Total	
	Casa Q		New Day		Serenity Mesa		YDI			
Referred Out for…	N		N		N		N		N	
Benefits Access	9	45.0	1	2.5	13	41.9	10	33.3	33	27.3
Dental	2	10.0	0	0.0	0	0.0	2	6.7	4	3.3
Educational	10	50.0	0	0.0	17	54.8	12	40.0	39	32.2
Legal and Housing	9	45.0	6	15.0	11	35.5	21	70.0	47	38.8
Life Skills	12	60.0	27	67.5	28	90.3	17	56.7	84	69.4
Other groups	4	20.0	1	2.5	23	74.2	1	3.3	29	24.0
Parenting	0	0.0	1	2.5	3	9.7	2	6.7	6	5.0
Peer support	1	5.0	0	0.0	28	90.3	0	0.0	29	24.0
Primary Care provider	5	25.0	0	0.0	3	9.7	2	6.7	10	8.3
Psychiatry	5	25.0	0	0.0	1	3.2	0	0.0	6	5.0
Behavioral Health Provider	6	30.0	0	0.0	28	90.3	1	3.3	35	28.9
Recreational	10	50.0	10	25.0	15	48.4	0	0.0	35	28.9
Vocational	7	35.0	8	20.0	18	58.1	11	36.7	44	36.4

Table A12. verbatim question

Community Connections	EXACT QUESTION				
	Casa Q	ND	SM	YDI	All YTLS Programs
Number of Responses	19	39	28	30	116
Range of Scores	1-9	1-10	1-10	3-10	1-10
Average Score	6.3	5.4	3.8	6.8	5.5
Standard Deviation	2.3	2.3	2.1	1.9	2.4
Mode	8	6	na	6	6
Median	7	5	4	7	6

Table A13. verbatim question

New Strengths and Successes	EXACT QUESTION				
	Casa Q	ND	SM	YDI	All YTLS Programs
Number of Responses	19	39	28	30	116
Range of Scores	1-8	0-10	2-10	3-10	0-10
Average Score	5.2	4.3	4.5	6.9	5.2
Standard Deviation	1.9	4.6	2.2	1.5	3.3
Mode	6	1	3	7	1 and 10
Median	6	1	4	7	5

Table A14. verbatim question

Connections to Positive Adult or Peer	EXACT QUESTION				
	Casa Q	ND	SM	YDI	All YTLS Programs
Number of Responses	19	39	28	30	116
Range of Scores	1-9	2-10	1-10	3-9	1-10
Average Score	6.6	6.0	5.0	7.0	6.1
Standard Deviation	2.5	2.1	26	1.5	2.3
Mode	8	5	5	7	5
Median	8	6	5	7	6

Table A15. verbatim question

Positive Outlook for Future	EXACT QUESTION				
	Casa Q	ND	SM	YDI	All YTLS Programs
Number of Responses	19	39	28	30	116
Range of Scores	2-10	1-10	0-10	4-10	0-10
Average Score	6.5	3.0	4.6	7.3	6.1
Standard Deviation	2.5	2.4	2.6	1.7	2.5
Mode	9	6	5	9	9
Median	8	6	5	7.5	6

Table A16. Reason for Discharge

	Agency Service Provider								Total	
	CasaQ		New Day		Serenity Mesa		YDI			
	N		N		N		N		N	
Other	3	15.0	18	45.0	14	45.2	3	10.0	38	31.4
Obtained employment	1	5.0	0	0.0	1	3.2	2	6.7	4	3.3
moved into TLP	1	5.0	0	0.0	0	0.0	0	0.0	1	0.8
Exit to inpatient program	0	0.0	1	2.5	1	3.2	0	0.0	2	1.7
Exit to adult detention	0	0.0	1	2.5	0	0.0	0	0.0	1	0.8
Disengaged from services	0	0.0	8	20.0	12	38.7	3	10.0	23	19.0
	15	75.0	12	30.0	3	9.7	22	73.3	52	43.0
Total	20	100.0	40	100.0	31	100.0	30	100.0	121	100.0

Table A17. Proportion of Clients with Listed Education and Employment Status at Discharge

	Agency Service Provider								Total	
	CasaQ		New Day		Serenity Mesa		YDI			
	N	%	N	%	N	%	N	%	N	%
number discharged	5		28		28		8		69	
Post Secondary	2	40.0	4	14.3	2	7.1	3	37.5	7	5.8
Job/Vocational	3	60.0	1	3.6	8	28.6	0	0.0	9	7.4
HS/GED	1	20.0	4	14.3	4	14.3	0	0.0	6	5.0
Employment	2	40.0	7	25.0	5	17.9	4	50.0	2	1.7

Table A18. Housing placement at discharge

	Agency Service Provider								Total	
	CasaQ		New Day		Serenity Mesa		YDI			
	N	%	N	%	N	%	N	%	N	%
Unknown	0	0.0	3	11.1	5	17.9	2	25.0	10	14.7
Transitional Housing	3	60.0	2	7.4	1	3.6	0	0.0	6	8.8
Placed with family or guardian	2	40.0	13	48.1	15	53.6	0	0.0	30	44.1
Permanent housing	0	0.0	4	14.8	1	3.6	5	62.5	10	14.7
Long-term detention	0	0.0	1	3.7	1	3.6	0	0.0	2	2.9
Homeless	0	0.0	4	14.8	5	17.9	1	12.5	10	14.7
still in program	15	75.0	13	32.5	3	9.7	22	73.3	53	43.8
Total	20	100.0	40	100.0	31	100.0	30	100.0	121	100.0

Appendix B – BHI Interview Guide

Base BHI Provider Interview Guide

General Interviewer Instructions

Instructions and guidance for interviewers are in italics. You should not skip any questions or sections unless directed to by the instructions. If the interviewee declines to answer any questions please note this. Some questions have a line to record a numeric answer, please use this instead of circling, x'ing or checking the appropriate response.

- *Remember to speak slowly and remain accessible for questions.*
- *Remind participant that all answers are confidential and they can skip any question they are not comfortable answering.*
- *At the end, review the interview to make sure you did not miss any relevant questions.*
- *If the participant is a former employee of the provider, please note "Former on the "Current Job Title" line and change all relevant language to past tense.*
- *The topics have separate headings. Do not read the headings as part of the interview, they are for your benefit.*
- *Be sure to read through the entire guide before beginning the interview; there are instructions at the end for interviewer observations.*

Text in **Bold** is meant to be read to the interviewee.
Text in ***Bolded Italics*** notes skip patterns.
Text in *Italics* is instructions for the interviewer.

If there is a project specific and/or provider specific addendum, please make sure you have a copy.

Administrative Information *(prefilled by interviewer)*

1. Interview Date: _____/_____/_____

2. ISR Interviewer: _____

3. BHI Program Name: _____

4. BHI Program Provider (if more than one provider):_____

5. Interviewee Name: _____

Introduction

Before we begin, do you have any questions about the project or the interview?

Thank you for participating in our research. Just to let you know, this interview should take about an hour to an hour and a half depending on the length of your answers. Also, because of recent events we would like to focus on the functioning of your program prior to the COVID-19 pandemic.

First, I need to ask a few administrative questions.

6. Current Job Title: _____

7. What is the highest level of education you have completed? _____
(*high school/GED = 12, list years of college [BA = 16, MA= 18, PhD = 20]; declined 99*)

8. Please tell me about any certifications and/or licenses you have that are relevant to (*program*):

A. _____

B. _____

C. _____

9. How many total years of work experience in this field do you have? _____
(*Answer should be converted to years and months*)
10. How long have you worked for this program? _____
(*Answer should be converted to years and months*)

11. Are you employed:_____
1. Full-time 2. Part-time 3. Or, Something else?; Please specify: _____

12. About how many hours per week do you work? _____

13. How many hours per week do you work on this BHI program: _____

14. Briefly describe what you do in your role as a (*fill in from Job Title above*).

_____

_____

_____

Program Information

Now I'm going to ask you a few questions about your Youth Transitional Living Services Program, or YTLS.

15. In your own words what is the main goal of this program?

_____

_____

_____

16. What do you feel is the most accurate measure of this program's success? _____

_____

_____

17. How successful do you feel this program is based on that measure?

_____

_____

_____

18. Does this program use evidenced-based practices and/or curricula? _____
1. Yes ___2. No ___ 3. Don't know ___
(If No or Don't Know, skip next question.)

19. Would you tell me a little about them and how they are used?

_____

_____

_____

_____

Next, I have a few questions about how potential clients and other providers learn about your YTLS program.
20. Are you involved in OUTREACH for this program? Yes ____ No ____ if no, **Okay, we'll go to the next set of questions…**

If no, skip to next section, if yes,

21. How do potential clients or other agencies learn about your program? (*Probe: Where do you go to let people know about your services?*)

22. On which of those do you focus most?

Incoming Referrals

Next, I have a few questions about incoming referrals to the program.

23. Is handling referrals one of your job functions? Yes_____ No_____ **Okay, we'll go to the next set of questions…**

If no, skip to the screening section, if yes,

24. Briefly describe how potential clients are referred to this program? (*Probe: phone calls, word of mouth, from family, criminal justice system [ask for specifics – i.e. courts, police, jail, probation, pre-trial], from within your agency [ask some detail about this], are there formalized procedures or paperwork for this?*)

25. Which of those is the best source of referrals? (*Probe: Is there a top three? What about other providers within the BHI funding initiative?)*

26. Is there a source that you wish you received referrals from?

Next, I have a few questions about how individuals are screened for eligibility in your program.

27. Is screening a person for program eligibility one of your job functions? Yes_____ No_____ **Okay, we'll go to the next set of questions…**

If No, then skip to General Intake section. If Yes,

29. What are the eligibility criteria for this program? *(Be sure to ask for both inclusion and exclusion criteria.)*

28. Could you briefly describe how the screening works? *(Probe: how are those criteria determined?)*

Next, I have a few questions about what happens to an individual once they are screened and deemed eligible for the program.

30. Is intake one of your job functions? Yes_____ No_____ **Okay, we'll go to the next set of questions…**

(If no, skip to the assessment section.)

31. Would you please describe how your intake process works? *Prompt: is there anything else that is part of the process.*

_____

_____

_____

_____

_____

_____

Assessments

Now I'm going to ask you a few questions about the assessment process for the program and any assessment instruments/tools you might use.

32. Is giving or facilitating assessments one of your job functions? Yes_____ No_____

(If No, skip to service delivery section.)

33. When you have a new client, what assessments are administered at or near the time of intake? *List each assessment in the table below. If this interview is audio recorded, make sure to write down the list so you can ask the follow-up questions for each assessment.)*

For each assessment, ask the following questions to complete the table information.

34. At what other times is this administered?

35. How is this information used?

Assessment Name	At Intake	Additional Time points (#)	At Discharge	Use
	☐		☐	
	☐		☐	
	☐		☐	
	☐		☐	
	☐		☐	
	☐		☐	
	☐		☐	
	☐		☐	
	☐		☐	
	☐		☐	

Service Delivery

Services

Now we would like to talk about the services you or your program provides, either directly or by referring out to other providers.

35a. Could you please describe the services associated with your YTLS program? (*How do your clients receive this service? Frequency?) [prompts added later]*

35b. What services do you refer clients to that aren't provided in-house? (*if provider of service isn't mentioned, ask who provides the service).*

Service	In house	Referred out	Notes for prompts: how service is delivered; recipient type, etc.
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

Discharge from Program

Next we have a few questions about how clients are discharged from your program.

36. Would you describe the different ways a person leaves your program?

37. What does it mean for a person to successfully discharge from your program?

38. Under what circumstances can a participant be removed from the program?

39. Do you create some sort of discharge OR transition plans for your clients? Yes_____ No_____ Don't Know_____ ***(If No or Don't Know, skip to Aftercare)***

40. Could you please describe those?

_____

_____

_____

_____

After Care/Follow-up

I have a few questions about aftercare or follow up with clients.

41. Does your program offer after care or any follow-up for your clients? Yes_____ No_____***(If no, go to Q44.)***

43. What does it entail?

_____

_____

45. For how long do you offer this service?

_____

44. What kinds of barriers are there to providing aftercare for clients?

_____

_____

Conclude the Interview.

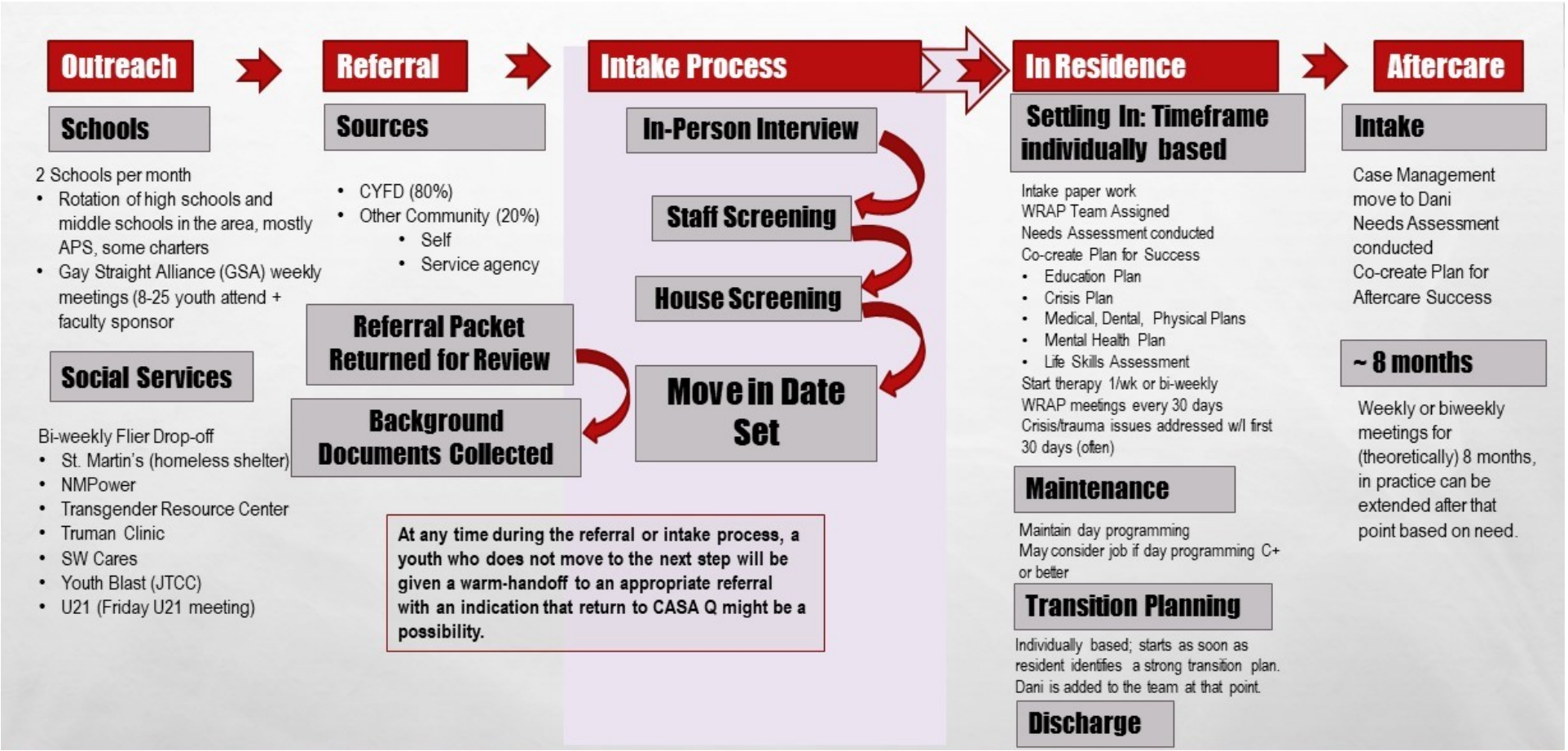
This concludes the interview questions; thank you for your time. Is there anything I missed or that you would like to add?

Additional thoughts…

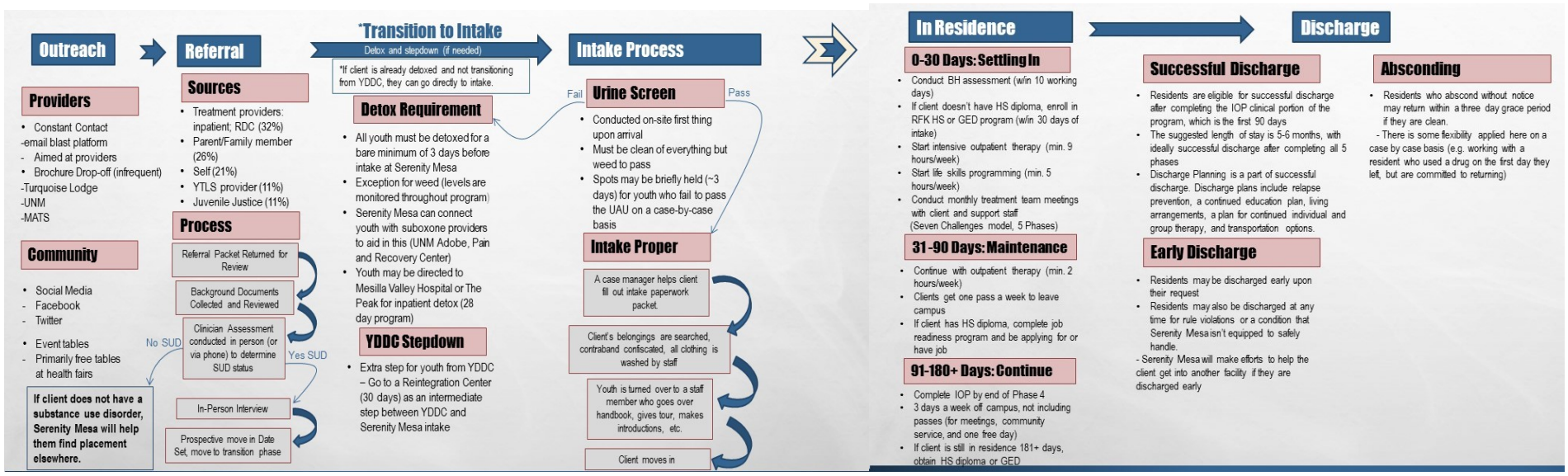
- *How was the interview conducted? (ex: Skype video, audio only, telephone)*
- *Did participant seem comfortable answering questions in this format? Were there any positive or negative comments you could note here?*
- *Did you experience any technical difficulties during this interview? If so, do you think these had any impact on data quality?*
- *Were there any other distractions during the interview? If so, do you think these had any impact on data quality?*
- *Did participant have questions about interview, how the information will be used, or other questions? If so, what were their inquiries?*
- *Did participant have any issues with interview or questions? If so, what were their concerns?*

Interviewer Notes: *Observations made by interviewer*

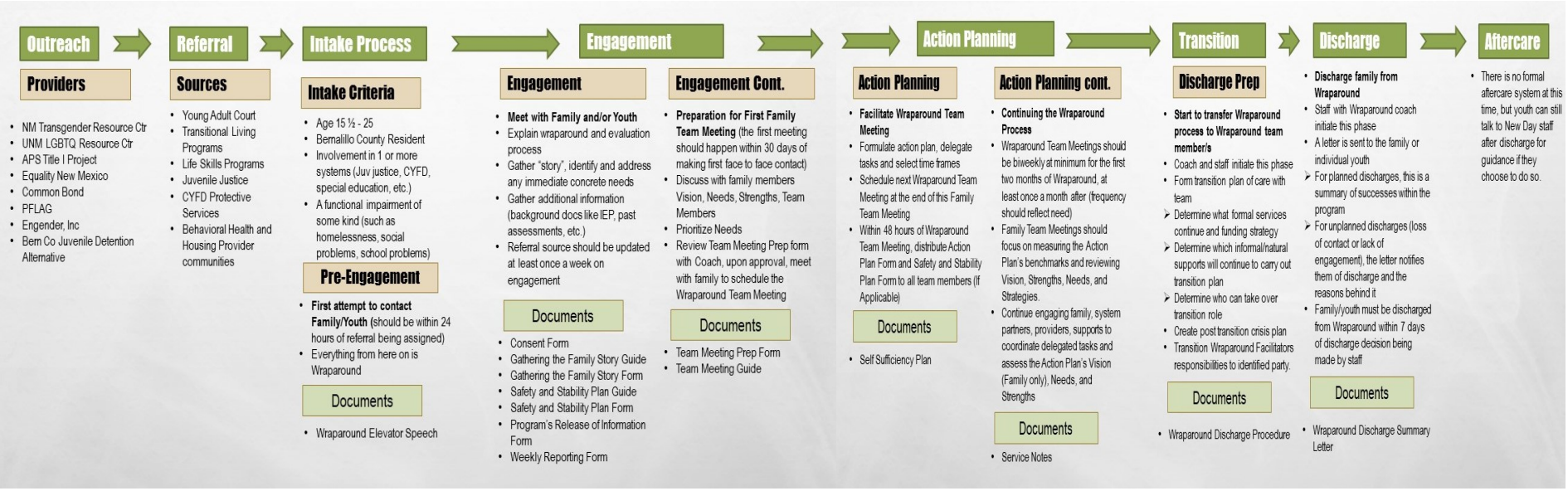
Appendix C – Casa Q Process Map



Appendix D – Serenity Mesa Process Map



Appendix E – New Day Process Map



Appendix F – YDI Independent Futures Process Map