Bernalillo County Behavioral Health Initiative Adverse Childhood Experiences Process Evaluation: Report in Brief

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In this brief: This brief summarizes the process evaluation of the 4 community-based programs funded under the ACE project.

This process evaluation aims to capture fidelity (whether the intervention was delivered as intended) and the quantity of the intervention implemented.

Highlights

- Client data and staff interviews showed programs generally served their target populations.
- ACE screen scores showed programs served a population with higher needs.
- There was a general consensus across providers that clients were high-risk and high-need. This was not entirely confirmed by client data partly because we lacked screening and assessment information.
- HSC providers did not actively participate in the evaluation and only their BHI required monthly performance reports are included in the full report.
- The study findings suggests the providers designed best practice programs but we lacked detail to show how these were implemented.

(Continued on page 2)

Background

Eight providers were funded in FY 2018 (July 2017) for a four-year funding cycle. Five were community-based providers, and three were associated with the UNM Health Sciences Center (HSC). In FY 2019, seven providers renewed their contracts, leaving four community-based providers and three HSC providers. HSC providers did not actively participate in the evaluation and only their BHI required monthly performance reports are included in this report. This is discussed in detail in the full report. The four-year funding cycle for the ACEs program ended June 2021.

The seven providers were funded for:

- Screening and assessment, provision of therapeutic parent/child groups, and home-based comprehensive case management;
- Provision of clinical and community supports through wrap-around case management for adolescents and their families involved in institutions;
- Provision of therapy, psycho-education, intervention services, and case management services to adult caregivers and their children;
- Provision of one-on-one coaching services, life skills classes, and leadership opportunities to at-risk youth.

The funded providers and the services they were contracted to provide can be found at: https://www.bernco.gov/Department-Behavioral-Health-Services/reduction-of-adverse-childhood-experiences-aces-.aspx.

It is widely accepted that children have the capacity to perceive and remember traumatic events (De Young et al., 2011). A study by Gaensbauer (2002) suggested that infants as young as 7 months of age can remember and reenact traumatic events for up to 7 years. By 18 months of age, children begin to develop autobiographical memory (Howe, Toth, & Cicchetti, 2006). Autobiographic memory is a memory system consisting of episodes recollected from an individual's life, based on a combination of episodic (personal experiences and specific objects, people and events experienced at particular time and place) and semantic (general knowledge and facts about the world) memory (Williams et al. 2008). Researchers have demonstrated that infants and young children have the perceptual ability and memory to be impacted by traumatic events (De Young et al., 2011 and Howe et al., 2006).

Researchers have focused on how trauma during early childhood affects mental and physical health later in life. Symptoms of mental illness can manifest immediately after a trauma, but in some cases, symptoms do not emerge until years later. PTSD, anxiety disorders, behavior disorders and substance abuse have all been linked to traumatic events experienced during early childhood (Kanel, 2015). The types and frequencies of traumatic events and whether they were directly or indirectly experienced can also have various effects on physical and mental health later in adulthood. In a review of literature, Read, Fosse, Moskowitz and Perry (2014) described support for the traumagenic neurodevelopmental model. This model proposes that brain functioning changes following exposure to trauma during

(Continued from page 1)

- The community based providers served different target populations and have different programs that resulted in large differences in the number of clients referred, admitted, and served.
- For two providers we were able to report information from referral at least one outcome measure for one provider (All Faiths) and three for another provider (PB&J). Clients in both programs showed improvements on these measures. These are important findings.
- The four-year funding cycle for ACEs ended June 30, 2021.

childhood. These biological factors often lead to psychological issues and physical and mental health concerns in adulthood.

The original and most widely cited study on ACEs was conducted at Kaiser Permanente from 1995 to 1997 with two waves of data collection. Over 17,000 Health Maintenance Organization members from Southern California receiving physical exams completed confidential surveys regarding their childhood experiences and current health status and behaviors. Study findings found a strong graded dose-response relationship between ACEs and the negative health and well-being outcomes across the course of life in the study participants. This means that the higher number of ACEs a participant experienced, the higher the risk for negative health and well-being in adulthood (Felitti et al., 1998).

Clients

The four community-based providers served different target populations and have different programs that resulted in large differences in the number of clients referred, admitted, and served. This also resulted in different lengths of stay, types of services, and number of services. Table 1 summarizes selected client level data variables including the number of clients, the average age of clients, the total number of services, the most frequently offered service and percent each represented of all services, the average number of services provided to each client, the total number of hours of service provided, and the average length of stay of clients.

The four providers served clients who were on average minors and the providers served from 78 clients at New Day to 1,621 clients at All Faiths with Centro Savila serving 279 clients and PB&J serving 545 clients. The total number of services varied considerably and this was partly a function of the number of clients. For example, All Faiths enrolled the largest number of clients and also provided the largest number of services but did not provide the largest average number of services per client. PB&J with the second largest number of clients provided the largest average number of services.

Total hours of service were not available for Centro Savila or New Day. During the approximate 3 years of data All Faiths provided 15,693.8 hours or 7.5 years of service and PB&J provided 9,522.5 hours or 4.6 years of service. All Faiths and New Day also reported the length of stay for clients for a subset of clients. All Faiths reported 275.1 days as the average length of service and New Day reported 174.7 days.

For two providers we were able to report information from referral to intake and

Table 1—Program Client Summary

Provider	Target Population	Clients	Average Age	Total Services	Most frequently used service and percent	Average number of services per client	Total hours of Service	Length of Stay in Days per client
All Faiths	Children, youth, & families (ages 3-21)	1,621	18.1	13,333	Case Management (72.4%)	9.7	15,693.8	275.1
Centro Savila	Youth (ages 0-18) living in the South Valley discharged from the Youth Services Center (YSC)	279	17.6	2,381	Individual Therapy (53.5%)	8.5		
New Day	Youth (ages 12-18) experiencing homelessness	78	16.2	492	Life Skills Coaching (97%)	6.7		174.7
PB&J	Children (ages 0-5) & families	545	15.6	5,598	Parent/Child, Child, or Parent Group (50.9%)	23.4	9.522.5	

enrollment and through service delivery with at least one outcome measure for one provider (All Faiths) and three for another provider (PB&J). Clients in both programs showed improvements on these measures from the initial measure to the follow up measure. These are important findings. Table 2 reports the findings from the Adult Adolescent Parenting Inventory (AAPI) with medium effect sizes shown in red and large effect sizes in green. For PB&J three of the 5 constructs showed highly statistically significant changes in scores with medium effect sizes all of which showed improvement between the pre-AAPI-2 and post-AAPI-2. These included Expectations of Children, Empathy Towards Children's Needs, and Parent-Child Role Responsibilities. There were no improvements with Use of Corporal Punishment as a Means of Discipline and Children's Power and Independence. The All Faiths analysis showed statistically significant changes in scores with medium effect sizes for one of the 5 constructs and a large effect size for one of the constructs showing improvement from the pre– to the post-assessment. The Children's Power and Independence construct showing a worsening medium effect size.

Table 2—Paired Sample T-Test

Scale	All Faiths		PB&J	
	p-value	Effect Size Cohen's d	p-value	Effect Size Cohen's d
Construct A – Expectations of Children	0.067	0.32	**0.002**	**0.44**
Construct B – Empathy Towards Children's Needs	**0.059**	**0.42**	**0.000**	**0.54**
Construct C – Use of Corporal Punishment as a Means of Discipline	0.568	0.17	0.355	0.14
Construct D – Parent-Child Role Responsibilities	**0.000**	**0.98**	**0.000**	**0.54**
Construct E – Children's Power and Independence	**0.017**	**0.68**	0.895	0.01

METHODOLOGY

This study employs a mixed-methods approach – using both qualitative and quantitative data to assess the implementation of the ACE funded programs. The study includes a review of program materials (i.e. required performance measures, process maps, and contracts), service data of clients and their families, and interviews with staff. A human subject approval was obtained from the University of New Mexico Main Campus Institutional Review Board (IRB). The three HSC programs did not actively participate in the study and only their performance measures are reviewed in the full report.

Program Materials

Required performance measures were reviewed to help understand how programs were implemented and provide additional context to client level data when appropriate. Contracts and program approved process maps that describe how a program enrolls and serves clients were reviewed and used to help describe how the programs were designed.

Client Data

Identified data was available and provided by the four-community based programs for adult clients. State law, which is more restrictive than federal regulations does not allow the use of minor identified data for research without consent. Client data included referral, intake, admission, demographic, service, and discharge information.

Staff Interviews

In January and February 2020, 29 staff and administrator interviews were conducted with staff from the four community-based providers. The interviews were semi-structured and 19 (65.5%) were audio recorded. Audio recordings were professionally transcribed. The interviews took an average 54.4 minutes to complete and asked about incoming referral sources and quality; intake processes including assessments for mental health, substance use, and previous traumas; evidence based practices; case management; treatment plan development; delivery of behavioral health services; delivery of services that address the social determinants of health; discharge policies; and aftercare and follow up practices.

Program materials were used to help describe the design of each program. Client data and staff interviews were used in tandem to measure how the programs followed the best practice program they proposed to implement. Performance measures were used as an adjunct data source when the measures were able to provide additional insight into program implementation. Together these data sources were used to complete the process evaluations of the programs.

Staff Interviews

Table 3 summarizes the interviews by agency and in total by reporting the number interviews, average years of work experience in their field, the range in the years of work experience in their field, the average number of years worked at their agency, and the range in years worked at their agency. Interviewed staff were experienced (average 11.5 years) and on average had worked at their agency 5.4 years.

Table 3—Staff Interview Summary

Provider	Inter-views	Aver-age Years of Work Experi-	Range in Years of Work Experi-ence	Average Years Worked at Pro-vider	Range in Years Worked at Pro-vider
All Faiths	10	12.3	.8 to 28	7.8	3 to 17
Centro Savila	7	10.0	1.25 to 26	3.7	.4 to 9
PB&J	9	13.9	4 to 30	5.6	.5 to 10
New Day	3	10.5	3.5 to 10	4.1	3.5 to 5
Total	29	11.5	.8 to 30	5.4	.4 to 17

Staff interviews provided support for the program design as well as for program implementation for all four programs. The level of program implementation varied by provider by program process (i.e. intake and service provision).

Conclusion

The seven programs were contracted to provide services to at risk children and their families and the funding was designed to pay for services and family supports not currently reimbursed by Medicaid or third-party payers.

The evaluation of the community based providers was delayed until June 2019 for two reasons. First, early on providers expressed reservations in providing identifiable data based on their concerns with confidentiality and using these data for research. Second, and closely in time following this concern, we found the New Mexico Mental Health and Developmental Disabilities Code ("Mental Health Code"), Chapter 43, Article 1 NMSA 1978 did not allow for a research exception for the use of identified data without a signed consent by an individual receiving services. This law was amended in July 2019 allowing a research exception for adults. Following that we found the New Mexico Children's Act did not include an exception for research for minors. Because the ACE project primarily serves minors our study largely relies on deidentified data. The full report describes the variety of challenges for the programs providing data and for us in organizing, compiling, and reporting these data. We were not able to overcome some of these challenges .

Client data and staff interviews showed programs generally served their target populations and through the ACE screen scores showed the programs served a population with higher needs. Within the interviews, staff often described the ACEs assessment as being administered after several initial sessions, and usually after rapport had been built between the client and the staff as opposed to being used as a means for screening and identifying high-risk clients for their program services. There was a general consensus across providers that clients were high-risk and high-need, though this was not entirely confirmed through the client data partly because we lacked screening and assessment information. The available ACE screen data showed the average client scoring high. Interview data reported the use of screen and assessments but we lacked more detailed data to make this claim in more depth and detail. The review of program level data found providers designed best practice programs but we lacked detail to show how they were implemented. Interviews also provided support for the use of best practices based on the design of the programs. The client level data shows programs enrolled clients and provided services and this generally followed the program design based upon the type and number of services provided. Our ability to report client data varied by program because of the amount and quality of client data. We were also limited by the use of deidentified client data. We were not able to complete more sophisticated analyses that might have allowed us to conduct multivariate analyses to report which types of clients benefited more.

For two providers we were able to report information from referral to intake and enrollment and through service delivery with at least one outcome measure for one provider (All Faiths) and three for another provider (PB&J). Clients in both programs showed improvements on these measures from the initial measure to the follow up measure. These are important findings. It should be the goal in the future to ensure this type of information is available in more detail and more completely.