Bernalillo County Behavioral Health Initiative: Adverse Childhood Experiences

Prepared by:

Alex Tonigan, M.A.
Paul Guerin, Ph.D.
Sara Haugaard, B.A.

Prepared for:

Bernalillo County Department of Behavioral Health Services

UNIVERSITY OF NEW MEXICO, INSTITUTE FOR SOCIAL RESEARCH
CENTER FOR APPLIED RESEARCH AND ANALYSIS
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Introduction

The Bernalillo County Department of Behavioral Health Services (DBHS) mission is to improve behavioral health outcomes in Bernalillo County through innovative, cohesive and measurable programs, treatment services and supports aimed at preventing the incidence of crisis and substance use disorder. In February 2015, the Bernalillo County Commission (BCC) and voters approved a new gross-receipts tax (GRT) expected to generate between $17 and $20 million each year, to improve access to care throughout the County and to develop a unified and coordinated behavioral health system in the County and surrounding area (CPI, 2016). In April 2015, the BCC contracted Community Partners, Inc. (CPI) to provide consultation and 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.

Among a variety of projects, the CPI report recommended the funding of a program(s) that would address adverse childhood experiences. Following a request for proposals (RFP), eight providers were funded in FY 2018 (July 2017) in what was envisioned as a four-year funding cycle. They included University of New Mexico (UNM ADOBE), University of New Mexico Office of Community Health (UNM OCH), University of New Mexico Young Children's Health Center (UNM YCHC), All Faiths, Centro Savila, CLN Kids, New Day, and PB&J. Of these, 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 more detail later. The four-year funding cycle for the ACEs program ends in June 2021.

The seven programs have been contracted to provide services to at risk children and their families across the full continuum of services including primary prevention, identification, early intervention, support and treatment, harm reduction, outreach, and services in children's homes and within the community. The funding pays for services and family supports not currently reimbursed by Medicaid or third party payers. The seven providers have been 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 have been contracted to provide can be found by visiting this site: https://www.bernco.gov/Department-Behavioral-Health-Services/reduction-of-adverse-childhood-experiences-aces-.aspx

The ability to conduct this study using client level data was delayed until June 2019 for two connected reasons. First, early in the four-year funding cycle providers expressed reservations in providing identifiable data explaining their concerns with confidentiality and using these data for research purposes even with a federally approved human subject review. 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 meant we could not use identified client level data without consent. Following this the County in collaboration with advocates, the New Mexico Sentencing Commission, and others proposed changes to the state statute that would allow a research exception following federal guidelines. The amendment to the statute (HB 267) was passed in the January 2019 New Mexico legislative session and took effect July 1, 2019 amending § 43-1-19 to include subsections (B)(6) through (B)(8). These additional subsections provide for exceptions to the requirement that a valid authorization (signed consent by an individual receiving services) be obtained prior to the disclosure. Specifically, the additional subsections allow for the disclosure of information in three instances;

1. Care which is necessary for the continuity of a client's treatment in jail or a prison facility [(B)(6)];
2. Information for continuation of care upon release from a jail or corrections facility [(B)(7)]; or
3. Information requested by a government agency, its agent or a state educational institution for the purpose of research subject to § 14-6-1 NMSA 1978.

In September 2019 we submitted a human subject review that was approved in October 2019. Following this approval, we began negotiating data collection with the seven providers. In March 2020 the County received a letter from the three UNM HSC programs, which noted the amendment to the Mental Health Code only covered adults and did not apply to minors. The County and others who helped with the amendment agreed and beginning in approximately April 2020, in coordination with County and provider staff, we began negotiating with provider staff to collect HIPAA de-identified data for minors. The three UNM HSC providers declined to participate under the UNM Main Campus Institutional Review Board (IRB) approval noting the IRB monitoring the study would need to be led by health professionals of the HSC. For this reason and as noted elsewhere the three HSC providers are not included beyond the reporting of performance measures that by contract are provided to the County and only include summarized data and so are not subject to a human subject review.

Children from birth to age five are at a particularly high risk for exposure to potentially traumatic events due to their dependence on parents and caregivers (Lieberman & Van Horn, 2009). These traumatic events are known as Adverse Childhood Experiences (ACEs). According to the Center for Disease Control and Prevention (https://www.cdc.gov/violenceprevention/acestudy/about.html), ACEs are categorized into three groups: abuse, neglect, and family/household challenges. Each category is further divided into multiple categories of 10 childhood experiences identified as risk factors for chronic disease,

mental health issues, and early death in adulthood. Under the category of *abuse* is emotional abuse, physical abuse, and sexual abuse. Under the category of *family/household challenges* is mother treated violently, household substance abuse, mental illness in household, parental separation or divorce, and incarcerated household member. Under the category of *neglec*t is emotional neglect and physical neglect. A more complete description can be found at: https://www.cdc.gov/violenceprevention/acestudy/about.html under Data and Statistics and ACEs Definitions.

Today, it is widely accepted that children have the capacity to perceive and remember traumatic events (De Young et al., 2011). From birth, the tactile and auditory senses of a child are similar to those of an adult, which suggests that a child can experience stressful events (De Young et al., 2011). At 3 months of age, a child's visual sensory development increases exponentially. 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 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).

Study Design and Methodology

This study includes several different but related components and helps complete a process evaluation of the four community-based ACE programs. As noted earlier, this process evaluation does not include the three Health Sciences Center (HSC) programs beyond a review of their performance measures. The HSC programs did not actively participate in this research and we only had access to the performance measures

each funded program is required to provide to the BHI on a monthly basis. This is described in more detail in the provider study finding section and discussion section. This study includes a review of program required performance measures for all seven providers, service data of clients and their families served by the four community based programs, and interviews with staff from the four community-based programs.

The following describes the study design and includes the target populations for the process evaluation (i.e. the ACEs providers), and the different data collection strategies such as monthly performance measures of aggregate data, client-level data extraction, and staff interviews.

Table 1 summarizes the target population and a description of the intervention that was included in each providers' contract. We also list the forms that each provider either listed in their proposal, contract, other written materials or were identified in their performance measures. This table is referenced in later parts of the report to compare the information listed in the table to information from the performance measures, client data, staff interviews, and discussion section.

Table 1. ACE Providers

Program	Target Population	Intervention Description	Listed Forms
UNM ADOBE	Youth (ages 12-17) discharged from the Youth Services Center (YSC) (With 2+ previous "bookings")	1) Provide service and treatment bridge for youth in the Bernalillo County Youth Services Center (YSC) (this is the County detention center for minors) through home & community visitation. Coordination with educational and legal services, access to ADOBE medical services if needed. Visits once every 1-4 weeks.	• Adverse Childhood Experiences Assessment (ACE)
UNM OCH	Children (ages 0-5) & families	1) Screening and education: At Pediatric Emergency Services (PES); Community Health Workers (CHW) use two screening tools to assess client risk/need 2) Service connections: CHWs use mobile app to connect client to service provider, schedule an initial appointment, & provide regular follow-up 3) Clinical Assessment & Treatment: Clinical assessment of BH needs and referral to ongoing BH treatment	• Adverse Childhood Experiences (ACE) • Social Determinants of Health (SDOH) • Weschler Preschool and Primary Scale of Intelligence (WPPSI) • Bayley Scales of Infant and Toddler Development (Bayley)
UNM YCHC	Children & adolescents (ages 0-18)	1) Screening and education: Nursing and medical staff screen all patients for ACEs 2) Crisis intervention / case management: case managers provide access to basic support services. 3) Formal BH treatment: individual, family, or group counseling to young people 4) Additional treatment: youth development groups, home visitation, parent groups, community forums, etc.	• Adverse Childhood Experiences Assessment (ACE) • Impact of Counseling Questionnaire (IOCQ) • Children's Functional Assessment Rating Scale (CFARS) • Youth Outcomes Questionnaire (YOQ) • Goal Attainment Score (GAS) • Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) • Safe Environment for Every Kid (SEEK) • Care Giver Strain Questionnaire (CGSQ) • Columbia Suicide Severity Rating Scale (C-SSRS)

All Faiths	Children, youth, & families (ages 3-21)	1) Family Wellness after Trauma: Adult therapy and psychoeducation, trauma-informed therapy services to children, case management services.	• Adult-Adolescent Parenting Inventory (AAPI-2) • Adverse Childhood Experiences Assessment (ACE) • Client Well-being Scale (CWB) • Comprehensive Psychological Assessment
Centro Savila	Youth (ages 0-18) living in the South Valley discharged from the Youth Services Center (YSC)	1) Critical Time Intervention: Case managers work with children and families from intake at LPI, to connections to supports, clinical assessments, home visits, etc.	• Adverse Childhood Experiences Assessment (ACE) • Pathways Assessment • Presumptive Eligibility Medicaid on Site Application Assistance (PE/MOSAA)
New Day	Youth (ages 12-18) experiencing homelessness	1) Life Skills Coaches meet one-on-one with youth and develop personalized service plans. These coaches will meet weekly with the youth, and help connect them to Life Skills Academy classes, community activities and other referrals. 2) Services will have three tiers of intensity, depending on client need and risk. 3) Services will be offered at New Day's Shelter as well as the Children's Court.	• Comprehensive Behavioral Health Assessment (CBHA) • Adverse Childhood Experience Assessment (ACE) • Dominance, Inducement, Submission, and Compliance Assessment (DISC) • Emotional Quotient Inventory (EQ-I) • Initial (All About You)
PB&J	Children (ages 0-5) & families	1) Home based programming: case management that coordinates clinical services and access to various basic needs (at least one home visit per month) 2) Center-based programming: group services that support health, child-parent interaction, and prevents abuse and neglect (at least one day a week for 2.5 hours per session)	• Adverse Childhood Experiences Assessment (ACE) • North Carolina Family Assessment Scale Generals Services and Reunification (NCFAS-G-R) • Adult Adolescent Parenting Inventory (AAPI-2) • Protective Factors Survey (PFS) • Comprehensive Multidisciplinary Evaluation (CME) • Ages & Stages Questionnaire Social-Emotional (ASQ-SE) • - Parenting Interactions with Children: Checklist of Observations Linked to Outcomes (PICCOLO)

Performance Measures

An important aspect of performance based contracting and the BHI funding is the ability to track the performance of service providers. Each service provider agreed upon a number of broad performance measures and provider-specific performance measures to be reported on a monthly basis. In an attempt to standardize performance measure reporting the County provided a structured and uniform reporting template in Microsoft Excel containing two sections. First, a series of tables that allowed the programs to enter counts of various thinks like the number clients and services and demographic information. Second, a performance measure narrative section designed to allow providers to describe program successes and barriers, changes or adjustments made to the program, quality improvement activities, and to provide any feedback or suggested changes to their performance measures.

In September of 2018, we completed an initial comprehensive review of the monthly performance measure reports. This review outlined the contract information, objectives and responsibilities, and the

specific performance measures. For each of the reported performance measure, ISR identified whether terminology within the measures might benefit from more specific or clear operationalization and definitions, and additional commentary. This included how providers define what it means to be a client, as most provide services to both children, adults, and family members. The reviews concluded with broad recommendations. For example, we recommended that providers differentiate between primary and secondary clients when serving children and their family members. We also recommended differentiating between new clients and continuing clients to better understand the number of new clients and continuing clients.

This report reviews performance measures by provider with a brief description of the measure. A table of performance measures is provided in each provider section based on a review of performance measures from late calendar year 2020 making them a snapshot and they not meant to be reflective of the entire length of time the providers have been contracted. We also provide brief summaries of the performance measures. The quality of performance measure reporting has varied by provider. In addition, program level performance measures have sometimes changed as well as how they have been reported.

We rely on the client data we acquired from the programs and use the performance measures as an adjunct to the client level data. We do not report the performance measures in detail. It is important to remember the performance measures were not designed or intended to be used for program evaluation and are used by the Bernalillo County Department of Behavioral Service (DBHS) staff to help monitor program performance. As mentioned earlier we only have performance measures for the three HSC programs, which are reported briefly.

Client-Level Data

In preparing to receive client-level data, ISR met with the providers on a number of occasions between their initial contract funding in 2017 through mid-2020 in order to better understand their program design, their data collection, and to discuss acquiring identifiable data for clients over the age of 18, and de-identified client-level data for minors. The meetings and discussions were important for several reasons. First, it was essential to have a shared understanding of provider and evaluator expectations, goals, and intentions. This included understanding the data we were requesting and understanding the ways we could accommodate the provider. In acknowledging the needs of the provider, we also needed to understand the capacity of the provider in terms of resources and knowledge. We anticipated providing the would require more time and technical assistance for providers who did not have specific staff devoted to data collection and management, and/or providers utilizing a system with which they were not familiar.

Second, it was important to understand each providers' electronic record system as we anticipated this would impact the length of time to extract data, what data could be provided, and the format of the data. This proved to be true. Determining whether data could be extracted from electronic record systems in a simple flat file format in which the data in various flat files could be linked using an identifier (like .csv) was important. All the providers were ultimately able to provide some data in flat files. The ability to link data among files varied and proved to be a challenge. Third, it was key to understand the types of data collected and maintained by the providers. Early on in the evaluation, we held inter-provider and provider level meetings to discuss the process evaluation and to request from providers blank copies of all data collection instruments (from recruitment through discharge and any follow up, as well as administrative,

internal, and documents that described services). Finally, it was also essential to receive only de-identified protected health information for clients under the age of 18. Protected health information is information, including demographic information, which relates to the individual's past, present, or future physical or mental health or condition, the provision of health care to the individual, or the past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual. Protected health information includes many common identifiers when they can be associated with the health information listed above. Once these meetings, discussions, and agreements were finalized, providers were able to provide electronic identifiable data for clients over the age of 18 and de-identified data for clients under the age of 18, between June 2020 and August 2020.

Overall, across the four providers, the data varied in a variety of ways that impacted our ability to compile, analyze and report the data. For example, the variables provided, the quality of those variables, (i.e. standardization and completeness), and the ways in which those variables were organized into separate data files, differed across the providers. Additionally, for clients who were minors, certain protected health information was de-identified by the providers prior to its extraction. Collectively, in some instances where minor data had been de-identified, or adult data has been split into multiple different excel workbooks, it was not possible to consistently link individuals from referral to discharge throughout the clients' program engagement.

Importantly, we received screening and assessment data from a couple of providers that included pre-test and post-test data for clients that could be matched and on which we could perform paired samples t-tests. This included the Adult Adolescent Parenting Inventory (AAPI-2), the Protective Factor Survey (PFS) and the Parenting Interactions with Children Checklist of Observations Linked to Outcomes (PICCOLO). The paired samples t test compares two means that are from the same individual. In the case of these 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 using a P-test and Cohen's d was used to measure the magnitude of the effect. These findings can be used to provide a measure of change from the pre-test period to the post-test period and so can be viewed as an outcome measure. The following four sections briefly describes client-level data for each provider.

All Faiths

All Faiths data was received in late June 2020, which consisted of client enrollment and demographic data, client assessment data, and client service and participation data. All Faiths utilizes three main instruments for collecting data on individuals once they become official clients in their Family Wellness ACEs services. This includes the *Adult Adolescent Parenting Inventory (AAPI*), the *ACEs screen*, and the *Client Well-being Scale (CWS).* For clients in the All Faiths Family Wellness ACEs program additional internal forms are completed that assist in their treatment planning and client-specific goals, which are then reported as discharge outcomes and discharge reasons. Client-level data for each of the assessments were provided to us. These are described in more detail in the client data section.

Centro Savila

Centro Savila data extraction required three different data extractions in an attempt to ensure all client records were included and these occurred in July 2020. With Centro Savila data we are able to report client enrollment, client demographics, service appointment types and counts, and discharge dates. Aggregated client data reported in monthly performance measures including from a *biopsychosocial assessment*, *Pathways Assessment, PE/MOSAA assessment*, *brief mood survey,* and a *suicide risk assessment* are reported in the performance section of this providers review. These assessments were not included in the client level data.

New Day

New Day uses an electronic data management software managed by a staff person responsible solely for the database, to collect and track clients who are enrolled in their one-on-one life skills coaching and other services. New Day data was extracted in June 2020. ISR received client-level data for clients that were enrolled and received one-on-one life skills coaching services and class-level data on the drop-in group life skills classes. New Day reported collecting client-level data, such as the *Progress Pathways Assessment*, *Emotional Intelligence Survey (EIS*), *ACEs screen,* and the *Dominance, Inducement, Submission, and Compliance Assessment (DISC)*. These assessments are discussed in detail within the analysis section.

PB&J

The data provided by PB&J included referral, intake, assessment, services, and discharge data that could be matched. In late July 2020, we were provided electronic assessment data, client demographic data, client participation data, and staffing services. The following assessments were included *Adverse Childhood Experiences (ACEs), Adult Adolescent Parenting Inventory (AAPI), Ages and Stages (ASQ), North Carolina Family Assessment Scale (NCFAS), Protective Factor Scale (PFS), and the Parenting Interactions with Children Checklist of Observations Linked to Outcomes (PICCOLO).* These assessments are described in more detail within the analysis section.

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 contained the following sections:

- 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.

The analysis consisted of direct coding and analyzing for interviews without transcriptions, and more in-depth coding for sections of the transcriptions which considered additional components not captured within non-transcribed interviews.

Table 2 reports the number of interviews completed by provider. The interview guide is provided in Appendix A. Data by provider is reported in more detail in the individual provider sections of the reports that include a review of performance measures, client data and interviews.

Table 2. Interviews

Provider	Number of Interviews
All Faiths	10
Centro Savila	7
New Day	3
PB&J	9

Table 3 reports education for the interviewees. Seventy-five percent of the respondents had a Bachelor's degree or Master's degree.

Table 3. Education

Education	Count	Percent
HS or equivalent	3	12.5%
AA	1	4.2%
BA	10	41.7%
MA	8	33.3%
Doctoral degree or equivalent	2	8.3%

Missing 5

Table 4 reports certifications held by the respondents.

Table 4. Certification Status

	Count	Percent
Yes	17	58.6%
No	12	41.4%

Table 5 documents whether respondents were clinical or administrative staff. A number of the interviewees had job titles that suggested they were administrators but a more complete review of the interviews showed while their job titles indicated they were administrators they provided direct services. In these cases, we counted these interviewees as clinical staff.

Table 5. Type of Staff

Staff Type	Count	Percent
Clinical	16	57.1%
Administrator	12	42.9%

Missing 1

Table 6 reports the years of work experience of the interviewees. On average interviewees had 11.5 years of experience with a minimum of 0.8 years and 30 years. Four (14.8%) of the interviewees had 21 years or more of work experience and 4 (14.8%) had 16 to 20 years of work experience. Almost 30% of the interviewees had 16 or more years of work experience.

Table 6. Years of Work Experience

Years	Count	Percent
0 to 2	3	11.1%
3 to 5	4	14.8%
6 to 10	7	25.9%
11 to 15	5	18.5%
16 to 20	4	14.8%
21 +	4	14.8%

Missing 2

Table 7 reports the number of years each respondent had been employed at their respective agency. On average interviewees had been employed 5.4 years with a range of .4 years to 17 years.

Table 7. Years at Provider

Years	Count	Percent
0 to 2	4	15.4%
3 to 4	10	38.5%
5 to 6	3	11.5%
7 to 8	3	11.5%
9 to 10	5	19.2%
11 +	1	3.8%

Table 8 reports the number of hours worked weekly by interviewees. The vast majority (88.5%) were full time employees.

Table 8. Hours Worked Weekly

Hours	Count	Percent
Less than 20	1	3.8%
20-30	1	3.8%
31-39	1	3.8%
40+	23	88.5%

Missing 3

Table 9 reports the number of hours worked on average that we part of the BHI project. Fourteen of the 29 interview respondents did not answer this question and so data is missing for almost half of the respondents (48.3%). While almost 90% of interviewees as shown in Table 8 were full time employees less than 50% of respondents worked full-time on the BHI funded ACE project.

Table 9. Hours Worked BHI Weekly

Hours	Count	Percent
1 to 20	6	40.0%
21 to 39	2	13.3%
40+	7	46.7%

Missing 14

Table 10 summarizes average years of experience and average years worked at the provider by provider. Staff all providers had on average more than 10 years of experience with PB&J staff having 13.9 years of experience, followed by All Faiths with 12.3 years, New Day at 10.5 years of experience, and Centro Savila at 10 years of experience. All the providers had experienced staff. Interviewees had fewer years of experience on average at the provider where they were employed than years of work experience in their work field.

Table 10. Summary Information by Provider

Provider	Interviews	Average Years of Experience	Range in Years of Experience	Average Years Worked at Provider	Range in Years Worked at Provider
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	3	13.9	4 to 30	5.6	.5 to 10
New Day	9	10.5	3.5 to 10	4.1	3.5 to 5

Study Findings

Our review of the four programs focused on a review of program materials (i.e. most current fiscal year contracts and available program descriptions), an analysis of performance measures provided to the County, interviews with staff and administrators of the four community based programs, and de-identified data for minor clients and identified data for adult clients. This section reports on these data for each of the providers, in the following order: All Faiths, Centro Savila, New Day, and PB&J.

All Faiths

Program Description

All Faiths was contracted to provide services, through their Family Wellness after Trauma program, to children and families, often involved across multiple systems, who have experienced trauma, crisis, homelessness, and/or domestic violence, to help overcome the effects of trauma. Through trauma informed therapy and case management, All Faiths provides families with healthy coping and nurturing strategies, tools for enhancing parental expectations for childhood behavior, and individualized treatment. To accomplish this, the Family Wellness in Trauma program is designed to provide adult caregiver therapy and psycho-education, children's therapy services, and early intervention services.

Adult caregiver therapy and psycho-education consisted of parenting group therapy and psycho-education sessions. Children's therapy services provide children under the age of 5 weekly one-hour trauma informed therapy services. Depending upon the needs of the client, the weekly therapy services can be accessed for up to 3 years. Additionally, case management services can be provided, which can range

from several hours of services to months of weekly sessions. According to All Faiths, case management is considered to be the "glue" that holds the whole design together—it ensures the various therapy and psycho-education services are supported and facilitated outside the All Faiths office. For example, assistance getting referrals and access to healthcare, housing, transportation, employment, social relationship services, and community participation. Intensity of case management is determined by client need, ranging from very minimal assistance to very intense and long-term support due to complex needs.

Within their scope of work, All Faiths noted the overall goal of the Family Wellness after Trauma program is to prevent future adverse childhood experiences (ACEs) and treat negative behaviors that exist due to preexisting ACEs for primary caregiver(s). In doing so, the client has an increased probability for long-term physical and emotional health and well-being. All Faiths proposed developing client-focused treatment outcomes, which included reduction in child maltreatment, reduction in juvenile justice involvement, reduction in family violence, healthy child development, linking families to community supports, creating nurturing parenting practices, and improving overall child health.

All Faiths proposed using Trauma Focused Cognitive Behavioral Therapy (TF-CBT), Attachment, Regulation, and Competency Approach (ARC) and the Neuro-sequential Model of Therapeutics (NMT) in its original scope of services. Additionally, the Nurtured Heart Approach is described as being an integral curriculum within the All Faiths program. These are broadly described in the table below (Table 11).

Table 11. Evidence-based Practices

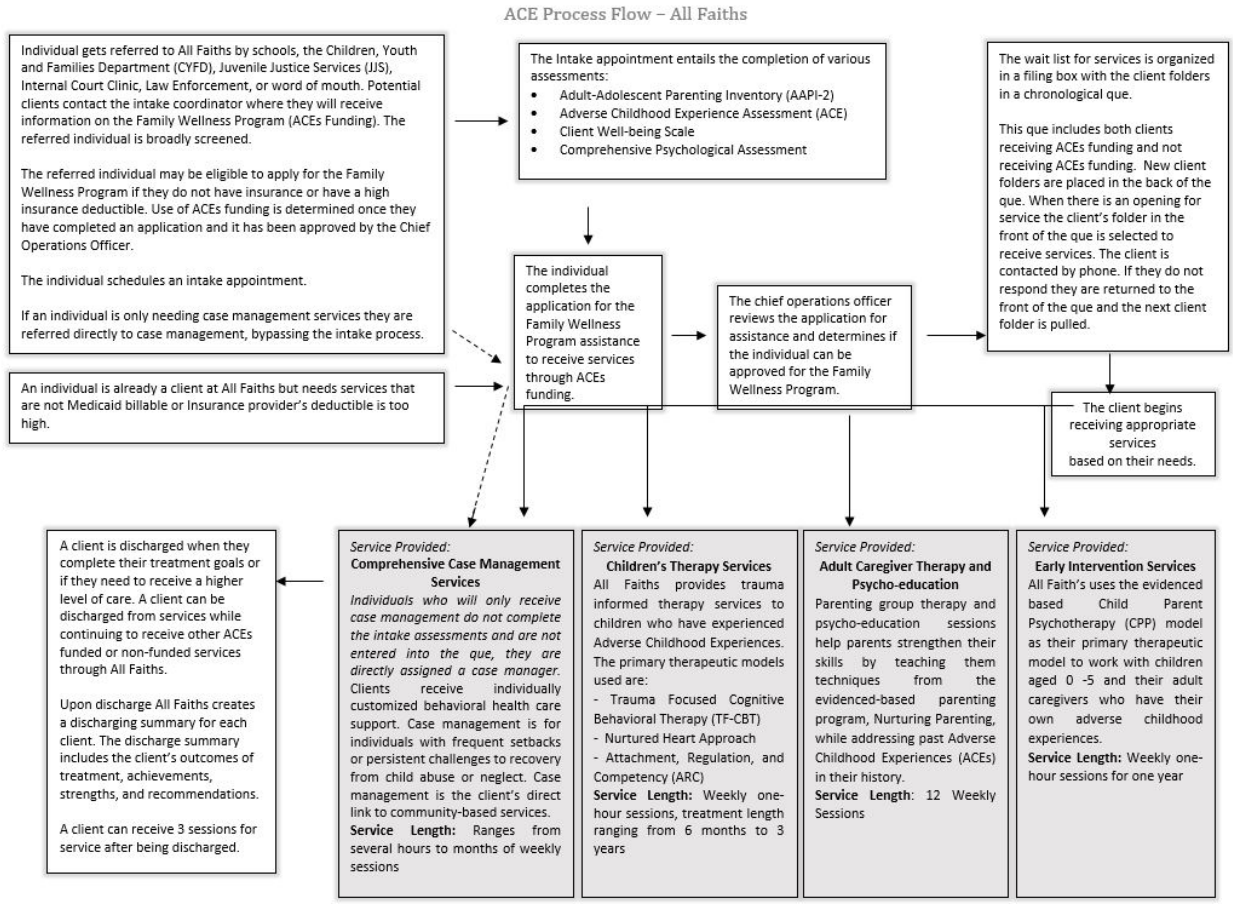
Evidence-based Practice	Description
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)	TF-CBT is a family-focused treatment in which children and caregivers both receive treatment, often in parallel individual sessions, to provide a safe place to discuss their feeling and thoughts and to gain skills to help child and caregiver regulate responses to trauma and triggers. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4476061/
Attachment, Regulation, and Competency Approach (ARC)	The ARC approach draws from four key areas, including normative childhood development, traumatic stress, attachment, and risk and resilience, to provide flexible components-based interventions for children and adolescents who've experienced complex trauma. (https://arcframework.org/what-is-arc/)
Neuro-sequential Model of Therapeutics (NMT)	NMT is not a specific intervention or therapeutic technique, but rather an approach that integrates foundational principles of traumatology and neurodevelopment. Specific therapeutic techniques can be selected and guided through the understanding of child cognitive developmental stages and neurobiological development. (https://thevillagenetwork.org/nmt/)
Nurtured Heart Approach	The Nurtured Heart Approach emphasizes the Three Stands, which includes ending the endorsement of negative behaviors, reinforcing positive behaviors, and maintaining and demonstrating clear, fair, and consistent boundaries and rules.

The ACEs contract provided funds to help bridge the gap in paying for needed services not covered by Medicaid and for clients without the means to pay for the services. The funds are available for new client(s) who are unable to pay for services, or existing clients who require services not covered by Medicaid.

The All Faiths program design is illustrated in the following process flow, Figure 1, which provides insight on how clients engage in the program, beginning with the client referral, screening and eligibility criteria determination, intake process, assessment and service delivery, and discharge process. This is discussed in more detail in the staff interview section. As demonstrated in the process flow below, new clients enter the All Faiths program through an intake appointment. All Faiths is an open referral agency, meaning they will accept a referral for services from other agencies as well as the clients themselves. New clients are able to call the main number Front desk and request an intake, in which the personnel have been trained to gather basic demographic and insurance information, and also have access to intake therapists' schedule to make the initial appointment.

During scheduled intake appointments, clients are asked to complete forms that gather information about: family structure (e.g., demographics, who lives in the home), prior treatment history, medical conditions, and child development information (e.g., any developmental delays). This information is reviewed by program staff before meeting with the client and family to complete the Comprehensive Psychosocial Assessment, which is a detailed interview that includes the presenting problem (what brought the client to All Faiths), education and vocational problems, social functioning issues, problems with age appropriate independent living skills, functional strengths, legal history, substance abuse history, abuse and neglect history, sexual health history, and high-risk behaviors. Following this, a crisis plan is developed. Clients are also asked to complete the Adverse Childhood Experiences (ACEs) screen, the Client Wellbeing Scale (CWB), and adults and/or primary caregivers are administered an Adult Adolescent Parenting Inventory (AAPI-2), if appropriate.

Staff create the initial treatment plan, which has SMART goals (Specific, Measurable, Achievable, Relevant, and Timely) for the client. Clients with the highest need (e.g., imminent danger to self or others) are assigned to therapists first. Otherwise, clients are assigned to therapists on a first-come–first-serve basis when therapists and case managers have openings in their schedules. For existing clients, if additional case management services that are not Medicaid billable are needed, they can complete an application to receive those services, which would then be paid for through the ACE funding. Clients are successfully discharged once they have achieved their treatment plan goals. Clients can also be disengaged from services through lack of engagement and missing appointments. Figure 1. All Faiths Process Flow



Performance Measures

Provider monthly performance measures consist of two types of data, first, a series of tables that were intended to track a variety of meaningful measures for each month over the span of a fiscal year. These broadly entail incoming referrals, assessments completed, ACEs scores, number of services provided by hour, number of clients served, client outcomes, number of BHI meetings, and client demographics. Second narrative, which was intended to further describe performance.

Narrative data was generally organized into the following sections: 1) Goal achievement, successes, and targets met, including notable data points, 2) Changes and adjustments made that address barriers, unmet targets, and/or opportunities for greater success, 3) Continuous quality improvement and training activities performed this month to enhance programming and achieve positive outcomes, 4) Collaborative relationships with schools or educational partners, 5) Suggested changes to performance measures and targets, outcomes, notable trends, outliers, and any other qualitative or quantitative items

Over the last several years, both the measures and the narrative have evolved with the intention of better operationalizing measures and to include measures for new activities. The performance measure data is limited in many ways and is not discussed at length.

Table 12 lists the performance measures with a brief description. All Faiths began receiving client referrals in July 2017, not all referred individuals became clients. The client data did not include referral information and so referral sources are reported here. All Faiths reported receiving 5,467 referrals, with the majority occurring in the first year and the fewest occurring in the third. Law enforcement provided the largest number of referrals (3,421), followed by self-referrals (567), while shelters provided the fewest (2). In the third year, All Faiths reported serving 2,347 unique clients while the client data includes data for 1,621 unique clients. We do not know what caused this large discrepancy and when reporting on clients we relied on client level data.

Table 12. Performance Measures

Performance Measure	Defined
Number of referrals received	This measure reports the number of unduplicated referrals by month by referral source. The measure includes a total by referral source and month.
ACE scores	ACE scores are provided by month and count by low score (0-3), high score (4-10), and declined. The measure includes a total by month and by score level.
Number of assessments completed	This measure includes the number of unduplicated assessments by month by assessment tool and total assessments by month and total for each assessment.
Number of services provided by hour	The number of services by hour is reported by service including therapy services and case management services by month and total hours of service by month and total by type of service.
Number of clients served	This measure is reported by unduplicated number of clients by type of client (therapy and case management). The measure also appears to report "continuing" clients. This measure includes total by month and type of client and whether they are unduplicated or continuing.
Client Outcomes	This measure reports client outcomes and goals by quarter year and total.
Number of meetings with BHI providers	This measure reports meetings by month
Client demographics	Reported monthly demographics include gender, age by category, race/ethnicity, annual income, and client insurance source.

Client Data

Between July 2017 and June 2020, All Faiths enrolled 1,621 clients. We were not provided referral data so we do not know the in-referral source for clients. This section describes the clients using available information including age, gender, and race and ethnicity. We also report the number, type, and length of services provided to clients as well as length of stay in the program and whether clients were active or had been discharged from the program. We also report available screening and assessment information. All Faiths provided Adverse Childhood Experience (ACEs) screening data, the Adult Adolescent Parenting Inventory (AAPI), and the Child Well-Being scale (CWB).

Females comprised 57% of the clients and males made up 43% of the clients.

Table 13. Gender

	Count	Percent
Female	924	57%
Male	697	43%

Table 14 reports the ages of clients. The average age of clients was 18.1 years of age with a median of 14 years of age, meaning 50% were older than 15 years of age and 50% of younger than 15 years of age.

Clients' ages ranged between 1 year old and 72 years old. Slightly more than 50% of all clients were between 6 years of age and 15 years of age.

Table 14. Age

	Count	Percent
1-5	72	4.4%
6-10	370	22.8%
11-15	479	29.5%
16-17	204	12.6%
18-20	143	8.8%
21-30	72	4.4%
31-40	134	8.3%
41-50	90	5.6%
51-60	42	2.6%
61+	15	0.9%

Table 15 reports the race/ethnicity of clients. Four clients declined to report either race or ethnicity and this information was missing for 183 clients. A slight majority of clients (53.3%) were Hispanic, followed by Whites 33.3%, American Indians (5.6%), and African Americans (4.9%).

Table 15. Race/Ethnicity

	Count	Percent
American Indian/Alaskan Native	80	5.6%
Asian	10	0.7%
African American	70	4.9%
Native Hawaiian or Pacific Islander	5	0.3%
Hispanic	764	53.3%
White	478	33.3%
Other	27	1.9%

Missing 183

The next set of tables reports on services provided to clients. This includes the number, type and length of services, types of contacts, total services by client and length of service, and discharge status.

Table 16 reports the services received by clients. On average clients received 7.6 services. Slightly more than 33% of all clients received one service followed by 37% that received between 2 and 5 services. Forty-six clients received 51 or more services, 11 clients received 100 or more services with one client received 256 services.

Table 16. Count of Services

	Count	Percent
1	565	34.9%
2-5	599	37.0%
6-10	189	11.7%
11-20	136	8.4%
21-50	86	5.3%
51+	46	2.8%

Table 17 describes the types of services clients received. Most frequently (72.4%) clients received case management services followed by individual therapy (12.7%). Together these two services accounted for 85.1% of all services. An intake service was the third most provided service with 756 intakes or 5.7% of all services. The fact that case management services account for the large majority of services matches to the programs design in which case management is considered to be the "glue" that binds the program and ensures the various therapy and psycho-education services that make up the largest portion of the other services provided (18.4%).

Table 17. Service Type

	Count	Percent
Caregiver Therapy	255	1.9%
Case Management	9,650	72.4%
CCSS Service	175	1.3%
Family Therapy	415	3.1%
Group Therapy	98	0.7%
Individual Therapy	1,698	12.7%
Intake	756	5.7%
Reassessment	142	1.1%
Wrap Case Coordination	102	0.8%
Other	42	0.3%

Table 18 provides additional information on the type of service by reporting information on how the service was recorded. The large majority of services were recorded as progress notes (91.4%), with a smaller percent listed as assessments (3.4%), treatment plans (2.2%), and diagnostic forms (1.2%).

Table 18. Service Type Detailed

	Count	Percent
Assessment	453	3.4%
Diagnostic Form	159	1.2%
Discharge Summary	13	.1%
Progress Note	12,190	91.4%
Safety Plan	111	.8%
Service Plan	41	.3%
Treatment Plan	294	2.2%
Other	70	.5%

Table 19 reports length of stay in the program for clients 18 years of age and older, as noted earlier there were 496 clients 18 years of age and older. Data to calculate length of stay was not available for minors. The average length of stay was 275.1 days with a median of 220.5 days and a range of 1 day to 984 days. The largest number (55) and percent (15.6%) of clients were in the program 501 days or more.

Table 19. Length of Stay in Days

Days	Count	Percent
1 to 50	22	6.3%
51 to 100	49	13.9%
101 to 150	52	14.8%
151 to 200	40	11.4%
201 to 250	40	11.4%
251 to 300	29	8.2%
301 to 350	23	6.5%
351 to 500	42	11.9%
501+	55	15.6%

Table 20 reports total hours of service by client. On average clients received 9.7 hours of service with a range of .8 of an hour to 450 hours. The median number of hours was 2.5 hours meaning half the clients received more than 2.5 hours of service and half received less than 2.5 hours of service. In total, during the reporting period 15,693.85 hours of services were provided. This translates to 7.54 years of service. As expected a quick review of clients found those with the largest number of services and largest number of hours of service were the same clients and they typically had the longest lengths of stay.

Table 20. Hours of Service

Category	Count	Percent
Less than 1 hour	297	18.3
1 to 2 hours	571	35.2
3 to 5 hours	260	16.0
6 to 9 hours	152	9.4
10 to 15 hours	141	8.7
16 to 24 hours	62	3.8
25 to 99 hours	112	6.9
100 + hours	26	1.6

All Faiths provided data on the following 3 screenings and assessments:

- Adult-Adolescent Parenting Inventory (AAPI-2)
- Child Well-Being Scale (CWB)
- Adverse Childhood Experiences (ACE)

Enough information was provided on all three of the tools to report the count of screens/assessments administered and the average score associated with the measure(s). The AAPI-2 includes a small number

of pre-tests and post-tests, compared to all the AAPI-2s administered, which allowed us to conduct paired sample t-tests. The paired samples *t* test compares two means that are from the same individual, object, or related units. 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 significantly different and Cohen's D was used measure the magnitude of the effect. The CWB is reported below as Table 21 as the average score for each of the scale concepts. ACE scores are reported, including the average score and range of scores.

Adult-Adolescent Parenting Inventory (AAPI-2)

The Adult-Adolescent Parenting Inventory (AAPI-2) is an inventory designed to assess the parenting and child rearing attitudes of adult and adolescent parent and pre-parent populations. Based on the known parenting and child rearing behaviors of abusive parents, responses to the inventory provide an index of risk for practicing behaviors known to be attributable to child abuse and neglect. The AAPI-2 includes five constructs in which a score is derived to provide an index of risk in five specific parenting and child-rearing behaviors:

- Construct A - Expectations of Children
- Construct B - Empathy Towards Children's Needs
- Construct C - Use of Corporal Punishment as a Means of Discipline
- Construct D - Parent-Child Role Responsibilities
- Construct E - Children's Power and Independence

The AAPI-2 includes two form and each has 40 items. Form A is designed as the pre-form and Form B is the post-form. The AAPI-2 is a validated and reliable tool used to assess parenting attitudes.
Staff administered 227 AAPI-2s that resulted in 22 pairs. For some reason 7 clients had three AAPI-2s. Twenty-three clients had two AAPI-2 of which 22 matched. There were 198 clients with an AAPI-2 Form A who did not have a matching AAPI-2 Form 2. We do not know why the large majority (87.2%) of AAPI-2s did not result in matched pairs.

Having matching AAPI-2s allowed us to conduct a paired sample t-test. The paired samples *t* test compares two means that are from the same individual, object, or related units. In the case of the AAPI-2 the means from the pre-test and post-test can be used to determine whether there is statistical evidence that the means between the paired observations are significantly different.

In Table 21 the first column lists the domain being test, 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 size of the difference between two variables. The larger the effect size the stronger the relationship between two variables. It is important to measure 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.

Table 21 reports on the results of the 22 matched pairs of AAPI-2 assessments. Three of the 5 constructs showed statistically significant changes in scores, two with medium effect sizes and one with a large effect size. Two of these showed improvement from the pre-test to the post-test. Construct B - Empathy Towards Children's Needs showed a small statistically significant improvement with a medium effect size and Construct D - Parent-Child Role Responsibilities showed a large statistically significant improvement with a corresponding large effect size. Construct E - Children's Power and Independence showed a statistically significant change with a large effect size showing a worsening in this construct between the pre-AAPI-2 and post-AAPI-2. There were no improvements with Construct A - Expectations of Children and Construct C- Use of Corporal Punishment as a Means of Discipline.

Table 21. AAPI-2 Paired Sample T-Test

Scale	Variable	Mean	Standard Deviation	T	sig.	Effect Size Cohen's d
Construct A	Pre-test	6.18	1.436	-1.93	0.067	0.32
	Post-test	6.77				
	Difference	-0.59				
Construct B	Pre-test	5.64	2.031	-1.995	0.059	0.42
	Post-test	6.5				
	Difference	-0.86				
Construct C	Pre-test	6.05	2.937	0.581	0.568	0.17
	Post-test	5.68				
	Difference	0.37				
Construct D	Pre-test	5.68	1.552	-5.632	0.000	0.98
	Post-test	7.55				
	Difference	-1.87				
Construct E	Pre-test	6.73	2.479	2.58	0.017	0.68
	Post-test	5.36				
	Difference	1.37				

Child Well-Being Scale (CWB)

Table 22 reports average scores for the Child Well-Being (CWB) scale. All Faiths staff administered 1,427 forms. The form asks individuals to "think about today, your past month, and the many feelings you had about different parts of your life". The CWB form uses a six-point scale designed to measure very unsatisfied (1) to very satisfied (6) using a series of faces with expressions that appear move from very happy to very sad. The scale is not clear that what is being measured is the degree of satisfaction. The scores in Table 22 show the respondents were generally satisfied about how they feel when they think about the concepts.

Table 22. Child Well-Being Scale

Topic	Mean
Me: Self-esteem/Well being	4.7
My Identity: Cultural/Ethnic, Sexual, Spiritual	5.0
My Family	4.8
My Friends	4.9
My School or Work	4.4
My Home or Housing	5.1
My Safety	5.2
My Health	5

Adverse Childhood Experiences (ACEs)

The ACEs is a 10-item screen intended to determine whether a client has experienced various traumatic events. Each item is a binary question, asking for either a "Yes" or "No". The All Faiths ACE screen includes four additional items: children, rejection, assault, and public assistance.

Table 23 reports ACE scores and the ACE enhanced score that includes the additional four items added by the program. This information was available for 662 clients and missing for 959 clients. On average clients had a 4.2 on the ACE screen and 5.8 on the All Faiths ACE enhanced screen.

Table 23. ACE Screen

	ACE		ACE Enhanced	
ACE Score	Count	Percent	Count	Percent
0	23	3.5%	23	3.5%
1	42	6.3%	42	6.3%
2	56	8.5%	56	8.5%
3	65	9.8%	65	9.8%
4	76	11.5%	76	11.5%
5	72	10.9%	72	10.9%
6	65	9.8%	65	9.8%
7	54	8.2%	54	8.2%
8	62	9.4%	62	9.4%
9	33	5.0%	33	5.0%
10	45	6.8%	45	6.8%
11			29	4.4%
12			23	3.5%
13			12	1.8%
14			5	.8%

Clients were discharged for two main reasons. First, if a client disengaged in the program, missed appointments, and/or did not return calls, they were considered 'Disengaged from services'. Clients were also discharged as 'Completed treatment successfully'.

In addition to discharge status, All Faiths also tracked client progress outcomes. Table 24 reports program status for adult clients because we did not receive program status information for minor clients. At the time we received the data, 29% of the clients were still active in the program and 71% had been closed.

Table 24. Program Status

	Count	Percent
Active	144	29.0
Closed	352	71.0

Staff Interviews

Ten interviews were completed with All Faiths staff. One interview was completed with an administrator and 9 interviews were conducted with direct service staff. Six of the 9 direct service staff reported at least one certification. Table 25 through Table 27 report education, years of work experience, and years working at All Faiths.

According to Table 25, All Faiths staff reported on average working 7.8 years at the agency and an average of 12.3 years of work experience with one staff member reporting 28 years of work experience and 17 years working at All Faiths. Eight of 10 staff reported their education with all reporting staff having at least a Bachelor's degree.

Table 25. Years Worked at Provider

Years	Count	Percent
0 to 2	0	0.0%
3 to 4	4	50.0%
5 to 6	1	12.5%
7 to 8	1	12.5%
9 to 10	1	12.5%
11 +	2	25.0%

Table 26. Education

Education	Count	Percent
HS	0	0.0%
Some College	0	0.0%
BA	1	12.5%
MA	6	75.0%
PhD	1	12.5%

Missing 2

Table 27. Years of Work Experience

Years	Count	Percent
0 to 2	1	11.1%
3 to 5	2	22.2%
6 to 10	1	11.1%
11 to 15	3	33.3%
16 to 20	1	11.1%
21 +	1	11.1%

Table 28. Type of Staff and Certified Staff

Staff Type	Number of Staff
Clinical	8
Administrator	1
	Yes
Certification	4

The interviews were useful for gaining an understanding of the program processes from the perspective of staff. This included hearing how clients engage and move through program. This provided clarity on what really occurs as opposed to what the program planned. This is discussed below.

According to the interviews, individuals learn about the All Faiths program services through public and community outreach. Outreach for the program involved providing education and awareness at the leadership level to partnering and neighboring providers. This mostly entailed letting partners know the qualification criteria for receiving free program services, and getting the word out about their program and services. Staff indicated that this outreach was typically completed by one individual.

Individuals could also be referred to All Faiths through direct referrals from agencies like the N.M. Children, Youth Family (CYFD) Department and local law enforcement (i.e. APD and BCSO) from schools, and from All Faiths programs. The referral process assisted in determining if an individual was appropriate for services through All Faiths. Information from interviews also indicate that hospitals were an appropriate referral source when youth were discharged from an inpatient setting and noted noted hospitals typically referred to a psychiatrist instead.

When clients receiving case management services at All Faiths, who might benefit from additional services not covered through Medicaid, can complete an application for assistance using the Family Wellness ACEs fund. When this happens the client's case manager helps the client complete an application. Services they might receive can include a therapist attending a court hearing with the client and attending student-teacher meetings to assist in completing Individualized Education Plans (IEP). The purpose is to provide support to the client(s) in a way that was previously limited due to Medicaid's billing restrictions. When an individual or family is referred to All Faiths by an external agency, a basic screen is completed that includes a number of questions, including the referral source, their primary issues, and the types of supportive services needed and if eligible a full intake and assessment

appointment is scheduled or the client is provided case management. Staff were able to reiterate that this aspect of their program design is what made it most unique and most helpful to their clients. One interviewee noted:

> *"… we work with clients who've experienced trauma. A lot of times, what they need is not actually covered by insurance. So, we use the family wellness funds to pick up where insurance leaves off."*

Moreover, the majority of staff agreed that their program was successful in retaining clients and that they felt their clients were well served. For example, one staff explained:

> *"We are able to do things that perhaps other agencies who don't have this kind of funding. We're able to do more follow-up and kind of all-encompassing work that is necessary to do this work really and make changes within the families and it everything much more successful. I think we are successful at it because of that."*

Staff reported it was difficult to say for certain if clients were a "better fit" or "worse fit" for their program. Staff said that clients that appeared to do best in their program are clients that voluntarily participate and who are motivated and are not forced into the program. This was a consistent finding across the programs.

If prospective client(s) did not have insurance or had a high deductible or co-pay, the prospective clients were provided information on the County funded Family Wellness program, a flier with the Family Wellness program information, and instructions on how to fill out the application for the program. When case management and therapy were needed, the prospective client scheduled an intake appointment that included the completion of various assessments. The Psychosocial Comprehensive Assessment is administered at the intake appointment, which typically required 2 hours to administer and gathered historical information across multiple life domains of life (i.e. life history, education, physical health, and mental health). It is then administered on an annual basis and referred to as the Re-assessment by a separate staff member to avoid any potential biases. Additional assessments are completed at intake, including the Client Well-being Scale (CWB) and the Adult Adolescent Parenting Index (AAPI-2) if appropriate.

After the completion of the intake appointment, individuals are considered clients. Once the application is approved, they are also considered clients served through the Family Wellness for ACEs grant funding. If there is a waitlist they are put in a queue for services, unless they are an imminent danger to themselves or others, then they are moved to the top of the list. This is done by the supervisor of case managers, who reviews all the intakes to determine which have the highest needs. When there is a client with immediate high needs but no case managers have openings, the case manager supervisor might carry a temporary caseload until there is an opening with the regular case managers. If there is a case manager that's available, the client is assigned a case manager and then a therapist if necessary.

Clients are assigned to therapists as current clients are discharged from their caseload, through what All Faiths refers to as the box process, which is the physical location of the client files, which are organized

chronologically. When a client is discharged from therapy services, that therapist goes to the "box" and pulls the next client file to set up their first appointment based on the therapists' schedule. If the client is unable to attend the appointment, the file is put back in the "box" at the front, and the next client file is pulled to schedule an appointment. When a client only needs case management, they schedule their first appointment and they are immediately assigned a case manager. Additional screening and intake appointments are not needed, nor is it necessary to be put on a waitlist.

Like any other client served at All Faiths, clients served through the Family Wellness grant funding are able to be enrolled in more than one program, including Adult Behavioral Health, Case Management, Child Behavioral Health, Comprehensive Community Support Services (CCSS), Intake, Assessment, and Collateral, Safe House, and Wrap Around services. Regardless of the program, clients oftentimes receiving more than one service during the appointment.

All Faiths staff reported providing services using a variety of different curriculum and evidence based practices. These include Trauma Focused Cognitive Behavioral Therapy (TF-CBT), Nurtured Heart Approach, and even Eye Movement De-Sensitization and Reprocessing (EMDR) Therapy. Staff agreed that client needs drive the approach utilized, though all the approaches are centered on addressing both child and caregiver trauma, emphasizing treatment at the family level. Per interviews, All Faiths staff reported they provide therapy weekly for up to two years for clients. Group therapy is provided for men and women weekly for 12 weeks for 120 minutes per session, and also separately for children. Intensive case management is provided to clients internally. All Faiths staff also reported they refer out other services such as dental care, vision, family planning, medication management, child support, legal services, reentry and transition plans, identity-acquisition documents, childcare, education/GED, financial literacy, food security, heat and utilities, transportation, and housing.

A formal discharge process exists for clients. Client(s) can be discharged from the program when they successfully complete the services. According to the interviews with All Faiths staff and administrators, individuals leave the program when they have met their goals, are stabilized, and a treatment plan is completed. Individuals can also be discharged due to disengagement from services. Individuals are removed from services if they need more substance use treatment and are referred to a different provider, if they have higher needs, or there are safety concerns with the individual. Infrequently when safety concerns arise (i.e. if a client or caregiver of a client exhibits threatening or dangerous behavior) clients may be discharged.

For successful completions, a discharge summary is completed, which is attached to their discharge and aftercare plans, and safety plans, all stored within their electronic database. The discharge summary includes follow up assessments, like the Adult Adolescent Parenting Inventory (AAPI-2) Form B. Following a successful completion, former clients may return to All Faiths services and do not need to go through the entire intake process if it is within 6 months of their discharge, and if their case manager and/or therapist has openings. If not, former clients are required to go through the intake process again. Similar to interviewees from other programs, the majority of staff agreed that individual client stories were the best indicators of client success. For instance, having a client call months after successfully discharging to let them know how well they are doing. Though the providers recognized the importance

and use of outcomes measure for determining client success, they emphasized the importance of more qualitative measures.

Discussion

In reviewing the three different sources of data, each source offered insight into the program design and implementation. For All Faiths, we relied on staff interviews for understanding the intended implementation of the program. Discussing the ways in which clients engaged in their program was useful because it allowed us to understand the complex roles and responsibilities within the All Faiths program. Staff interviews were an integral component in understanding how the program was supposed to be implemented versus how it was actually implemented. Overall, staff and administrators were able to sufficiently describe their program design and subsequent implementation. Staff were not always able to describe certain processes in rich detail, particularly for processes for which they were not responsible. For processes that staff were responsible for, staff were all able to adequately describe what the process was supposed to look like, and the ways in which it was implemented and, in some instances, deviated from the proposed design. Staff that were not directly responsible for the intake processes had a limited understanding of specifically how clients were referred and triaged within the All Faiths Family Wellness program. Staff that were more directly involved were able to provide a more in-depth description and explanation of how the process worked. Of all the processes within the program, the intake and triaging processes were the most complex, as they are implemented in a manner that is client-centered and individualized. The triaging of clients and services are based upon the immediate needs of clients, and for those who are in highest crisis. Unfortunately, the intake and triaging processes were not well described or illustrated within the providers' documentation of their program design and scope of services. It also was not well captured within the performance measures or the client data we received. Certain aspects within that process may provide relevant and interesting information for the provider and the County in performance measure reporting, such as the number of clients who directly bypass the triaging process due to needing only case management services, or the length of time clients wait in cue before receiving therapy services. Illustrating a process flow within the performance measure reporting would also prove useful, and it could include supplemental narrative describing the differences between the proposed designs versus the actual design. In sum, because the intake and triaging process designs were proposed and described with little detail, it's not possible to determine the extent to which they were adhered to. We can broadly say that All Faiths adhered to the general intake and triaging design they proposed.

Pertaining to the service delivery, performance measure data and client data provided support for their adherence to the program design and implementation. As noted in the performance measure section, there were some discrepancies between the counts reported in the performance measures and the counts we found from the client data. Despite this, the performance measure data did provide overall support that those services were being provided to clients as they had proposed. They client data further confirmed that those services were provided to their clients. The staff interviews provided more contextual information pertaining to service delivery. Staff were fluent and knowledgeable of the particular services and curricula they utilized within the Family Wellness program design as it pertained to their specific roles. Interestingly, there was no way for us to verify which curricula was utilized and how it was utilized. As discussed previously, All Faiths program design proposed the use of several different evidence based practices and curricula, including Trauma Focused Cognitive Behavioral Therapy (TF-CBT), Attachment, Regulation, and Competency Approach (ARC), Neuro-sequential Model of Therapeutics (NMT), and the

Nurtured Heart Approach, though this aspect of the program is not reported in performance measure data or client data. Thus, we can't definitely say that All Faiths adhered to their proposed evidence based practices, such as implementing curricula as it was designed, though we can say that the provider did provide services to their clients as they described in their design.

Staff interviews were useful for understanding the program from the perspective and opinions about program effectiveness and outcomes. The majority of staff were able to discuss the data they collected and how it was used at a relatively superficial level, and it was not clear whether the data collection component of the program design was emphasized or well understood by staff. Because All Faiths has staff specifically devoted to data management, this would align with that conclusion. Staff provided a variety of responses such as recidivism or program graduation. Many times, staff described the moment they felt a client and their family was improving as an "ah-ha" moment, where it was clear to them that the clients had absorbed everything they learned, was applying it to everyday life, had developed healthy coping and parenting skills, and secure attachment relationships. These responses were focused to individual clients and not the program. Performance measures included counts of services and changes in the number and mix of services, but are not outcome measures. All Faiths used the AAPI-2 and CWB data to assess clients and as a measure of client change. The AAPI-2 was used to measure changes in parenting and child rearing attitudes of parents and so provided a measure of pre and post parenting for parents who completed the assessments particularly both the pre- and post-assessment. Based on the client data and the limited number of pre- and post-AAPI-2s that could be matched the use of the AAPI-2 was not consistent. The CWB was used to measure children's well-being. While we were able to report clients reported. they were generally satisfied about how they felt when they thought about concepts like family, friends, school or work, home or housing, their safety, and their health. Having de-identified data did not allow us to match this measure to clients to measure change of multiple administrations of the scale.

Finally, the three sources of data adequately supported All Faiths adherence to their proposed discharge design, though more detailed performance measure data would have proved useful. Performance measure data allowed for our determination that All Faiths had discharged clients as proposed, with clients being designated as successfully discharged ('discharged') or 'disengaged,' in the instance that they lost contact or unsuccessfully discharged. The process in how that was determined was not adequately captured within the performance measure data or the client data, however, it was well described within the staff interviews. Collectively, the three sources of data indicate that All Faiths adhered to their proposed discharge design.

Centro Savila

Program Description

Centro Savila's Adverse Childhood Experiences – Critical Time Intervention (ACEs-CTI) program is designed to prevent future ACE experiences focused to institutionally involved youth and their families. Centro Savila proposed wrap around intensive case management services to reduce juvenile justice involvement for at risk youth. These wrap around intensive case management services are intended to assist in the transition of youth from institutions to the community, with staff first addressing personal and family crisis, such as addiction or housing barriers.

As such, a key aspect of the Centro Savila design is providing intensive case management and psychosocial support to clients and their families *immediately post-release* from environments such as jails, shelters, behavioral or mental health treatment centers or prisons, thus helping them develop and strengthen community-based networks of support so that they are less likely to return to these settings. The CTI model is designed to last roughly 9 months following institutional discharge, and involves two components: (1) strengthening the individual's long-term ties to services, family, and friends and (2) providing emotional and practical support during the transition.

While the CTI model is originally designed to engage clients before releasing from institutions, Centro Savila proposed an adaptation in which they engaged youth as soon as they arrived at the Youth Reporting Center at La Plazita Institute (LPI). Once at LPI, Centro Savila noted youth receive a risk assessment and based upon those results, are assigned a CTI specialist and have family members contacted and engaged for services. Services include positive youth development activities, including organic gardening, ceramics and screen-printing, and People Making a Change (P-MAC), for approximately a month, which is the length of time anticipated needed to complete the intake process. Throughout that time, clients would continue to participate in the array of services available through Centro Sávila and other partnering organizations. The CTI model is designed for the gradual removal of CTI Specialist support once strong networks of support and services are developed, established and reviewed to assure they are maintained by the client.

Centro Savila noted each CTI Specialist would have a caseload of 10-15 families and specializes in particular issues reflective of their agency. ACE-CTI Specialists from partner organizations would also have access to youth to complete an intake during the 30-day youth period when they report to LPI as an alternative sentence to incarceration. LPI also offers complementary services for youth that include group PMAC and Community Supported Agriculture (CSA) participation, tutoring and educational support through their Barrio Youth Corps program, as well as job and entrepreneurial preparedness and activities centered on community and cultural reintegration.

Within the program design, Centro Savila's identified several short-term outcomes and long-term outcomes. Short-term outcomes included: 1) Families reaching transfer of care within nine months of program initiation, 2) Reduced criminal justice system involvement of participating families, 3) Reduction in behavioral and mental health problems among participants, and 4) Improvements in ACEs-related SIH (Social Indicators of Health) indicators among participating families. Long-term outcomes included 1) Reduced accumulation of ACEs in participating families especially related to abuse and incarceration, economic hardship, mental illness and substance abuse, 2) Improved coordination and communication for ACEs- informed work especially for criminal justice involved families in Bernalillo County, and 3). Sustained reductions of criminal justice involvement of youth and their family members with reduction in County cost of managing adjudicated youth.

As part of the design, Centro Savila proposed using various approaches including critical time intervention, the progress pathways model, strength-based approaches, attachment-based theory, life skills, seeking safety, complex trauma inventory, slowdown, medically assisted treatment (MAT), and an array of holistic healing services including Reiki, Acupuncture, and Acudetox. These are broadly described in Table 29 below.

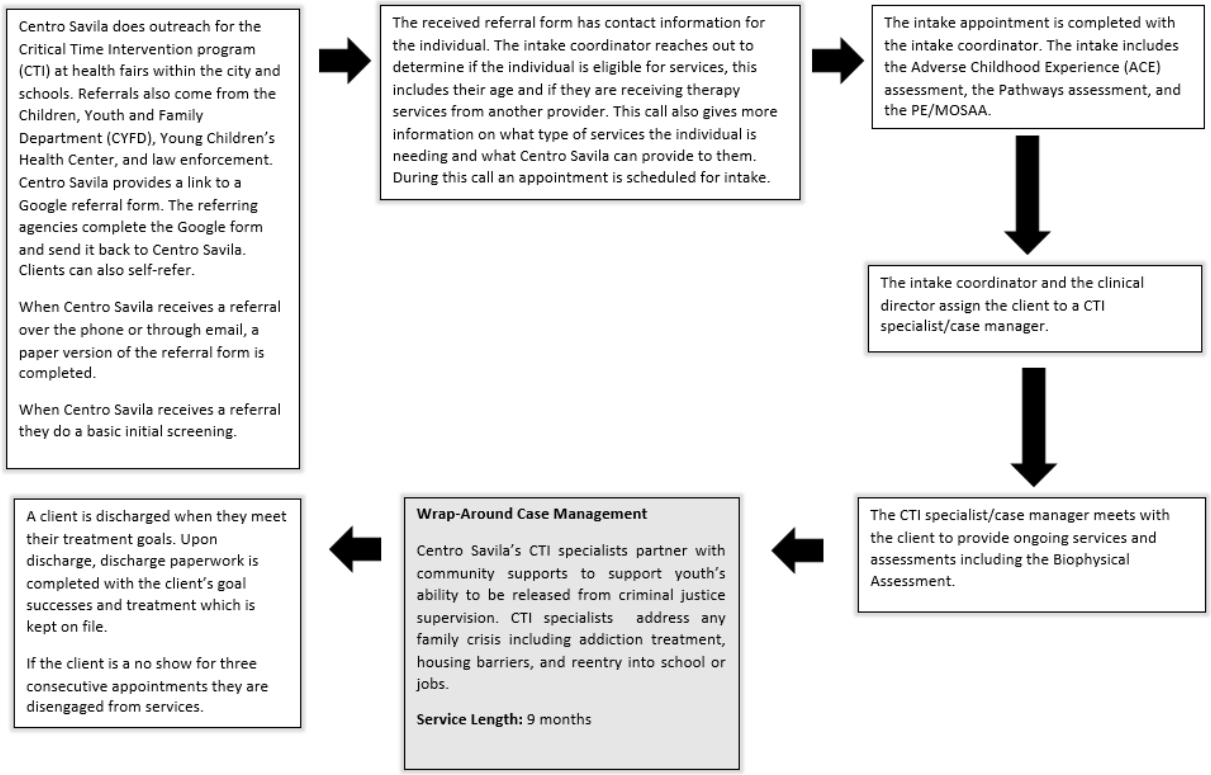
Table 29. Evidence-based Practices

Evidence-based Practice	Description
Critical Time Intervention (CTI)	The CTI model is designed to mobilize support for very vulnerable populations during times of transition. The time-limited model has several core components including a phased approach, community based, decreased intensity over time, small caseloads, no early discharge, harm reduction approach, and weekly team supervision. https://www.criticaltime.org/cti-model/
Progress Pathways	Pathways Program assists clients by connecting them with resources within the community. Pathways Program uses a Pathway Navigator to work with clients with multiple unmet needs. The Pathways Program address issues such as homelessness, hunger, limited healthcare access, and barriers in trying to navigate different systems. https://sharenm.org/the-savila-collaborative-dba-centro-savila/pathways-program-centro-savila
Life Skills	Life skills assist youth in developing key skills to improve their emotional intelligence, social intelligence, social capital, and functional intelligence. https://www.ndnm.org/
Seeking Safety	Seeking Safety is a therapeutic evidence-based model for women suffering from trauma, substance abuse, and/or PTSD. Seeking Safety treats both PTSD and substance use disorder at the same time by the same clinician. Depending on the client's needs Seeking Safety can be conducted as a single session or over multiple sessions.
Complex Trauma Inventory	The CTI is not an intervention or model but a measure of posttraumatic stress disorder and complex posttraumatic stress disorder. The CTI assists clinicians with diagnosis, symptom tracking, treatment planning, and assessing outcomes. https://pubmed.ncbi.nlm.nih.gov/29160557/
Medically Assisted Treatment (MAT)	MAT is used to treat substance use disorders with medication, counseling, and behavioral therapies. MAT is primarily used for the treatment of addiction to opioids. MAT improves patient survival, increases retention in treatment, decreases illicit opiate use, increases ability to gain and maintain employment, and improves birth outcomes among pregnant women. https://www.samhsa.gov/medication-assisted-treatment

The Centro Savila program design is illustrated in Figure 2, which provides insight on how clients engage in the program, beginning with the client referral, screening and eligibility criteria determination, intake process, assessment and service delivery, and discharge process. As indicated in the process flow, Centro Savila receives referrals from a variety of different sources, mainly through their partnering agency La Plazita Institute (LPI). Once a referral is received by the intake coordinator at Centro Savila, preliminary eligibility is determined and an intake appointment is scheduled and completed.

During the intake appointment, several assessments, such as the Adverse Childhood Experiences (ACEs) Assessment, the Progress Pathways Assessment, and the PE/MOSSA are completed, along with consent paperwork. Following, a Critical Time Intervention (CTI) Specialist case manager is assigned to the client to provide core services, such as home visitation, community navigation services, and facilitation of peer, institutional, and familial supports. Over the span of 7-9 months, the CTI specialist case manager provides ongoing services, while encouraging greater client independence and reliance on sustainable support systems, thus tapering off clinical work. Once treatment goals have been met, or if the client has been disengaged for a period of time, and informal discharge summary is completed. This process is discussed in more detail within the final section, staff interviews.

Figure 2. Centro Savila Process Flow



Performance Measures

Monthly performance measures contain two types of data, first, a series of tables that were intended to track a variety of measures for each month over the span of a fiscal year. These broadly entail incoming

referrals, assessments completed, ACEs scores, number of services provided by hour, number of clients served, number of outgoing referrals, client outcomes, number of BHI meetings, and client demographics. Secondly, narrative, which was intended to capture qualitative level data.

Narrative data was generally organized into: 1) Goal achievement, successes, and targets met, including notable data points, 2) Changes and adjustments made that address barriers, unmet targets, and/or opportunities for greater success, 3) Continuous quality improvement and training activities performed this month to enhance programming and achieve positive outcomes, 4) Collaborative relationships with schools or educational partners, 5) Suggested changes to performance measures and targets, outcomes, notable trends, outliers, and any other qualitative or quantitative items. Over the last several years, both the measures and the narrative have evolved with the intention of better operationalizing measures and to include measures for new activities.

Table 30 lists and defines the performance measures reported by Centro Savila. As noted elsewhere performance measure data is limited and is not discussed in detail. Because Centro Savila provided a limited set of client data some performance measures are reported in more depth than for the other three community-based providers. Within the monthly performance measures, Centro Savila reported administering the Adverse Childhood Experiences (ACEs) screen, an unidentified clinical assessment, the PE/MOSAA, the Pathways Assessment, and an unidentified suicide risk assessment. Centro Savila reported administering the Adverse Childhood Experiences (ACEs) screen to 800 clients, with 336 scoring between 0 and 3 and 464 scoring between 4 and 10. This is inconsistent with the client data, which includes information on 279 unique clients. Moreover, client-level ACE screen data was provided for 187 clients, with 110 missing ACEs scores.

Additionally, across the three years, Centro Savila reported providing 9,434 hours of services to 1,414 total primary clients and to 317 total secondary clients. We identified 279 unique clients within the client data and it is not clear why such large differences exist between the client data and performance measures. It is also unclear how Centro Savila defines and counts a ‘returning client’, and how this proves to be a useful measure. It is assumed that the measure attempts to measure the number of times new clients returned to services, though this makes little sense. Another difficulty, also found in our review of other providers, is measuring and reporting the different types of clients, referred to as primary and secondary clients. The main difference between primary and secondary clients is the primary client is individual referred to the program, and the secondary client is typically a family member of the primary client. The difference between primary and secondary clients is not always clear. For example, a secondary client might initially have become aware of Centro Savila services through their relationship to the primary client, but they may also require additional supports and could become a primary client.

In summary, eight performance measures were reported. Based upon a review of these measures the use of the measures for the evaluation was limited. It was difficult to differentiate new clients from continuing clients and to use the performance measures to supplement the client data.

Table 30. Performance Measures

Performance Measure	Defined
Number of referrals received	This measure reports the number of referrals by month by referral source. The measure includes a total by referral source and month.
ACE scores	ACE scores are provided by month and count by low score (0-3) and high score (4-10). The measure includes a total by month and by score level.
Number of assessments completed	This measure includes the number of unduplicated assessments by month by assessment tool and total assessments by month and total for each assessment.
Number of services provided by hour	The number of services by hour is reported by service including therapy services and case management services by month and total hours of service by month and total by type of service.
Number of clients served	This measure is reported by unduplicated number of clients by type of client (therapy and case management). The measure also appears to report "continuing" clients. This measure includes total by month and type of client and whether they are unduplicated or continuing.
Number of outgoing referrals to other programs	The number of unduplicated referrals is reported by a couple of sources and by referrals sent and completed.
Client outcomes	This measure reports client outcomes and goals by quarter year and total.
Number of meetings with BHI providers	This measure reports meetings by month
Client demographics	Reported monthly demographics include gender, age by category, race/ethnicity, annual income, client insurance source, and housing.

Client Data

From the data received by Centro Savila we were able to identify 279 clients. Because of the way the data was provided by Centro Savila identifying clients was a challenge. The provided data included client identification numbers with duplicated services so that we could not always determine if they were, in fact, the same or different clients and services. Referral and admission dates were sometimes missing and/or dates did not match making it impossible, at times, to determine what services had been provided. Other variables also had issues. For example, age was calculated in more than one way, a large percent of clients were missing race and ethnicity information, there were missing ACE scores, and missing education data. In addition to missing information in the financial category, the values were not mutually exclusive and could not be categorized in a consistent manner. We believe some these issues may have been a result of only being able to received de-identified data for minors and the capacity of the program to provide these data.

Table 31 reports the ACE screen score for the 187 clients for whom this information was available. ACE screen data was missing for 92 (33%) clients. The average ACE score was 4.1 indicating clients were at risk.

Table 31. ACE Screen

ACE Score	Count	Percent
0	12	6.4%
1	22	11.8%
2	21	11.2%
3	23	12.3%
4	36	19.3%
5	25	13.4%
6	14	7.5%
7	13	7.0%
8	11	5.9%
9	5	2.7%
10	5	2.7%

Table 32 reports the age of clients. The average age of clients was 17.6 years of age. The youngest clients were 12 years of age and the oldest client was 69 years of age.

Table 32. Age

	Count	Percent
12	4	1.4%
13	22	7.9%
14	28	10.0%
15	25	9.0%
16	37	13.3%
17	43	15.4%
18	45	16.1%
19	41	14.7%
20	20	7.2%
21+	14	5.0%

Table 33 shows the education level of the clients. This information was missing for 38.7% of the sample. As expected, based on the age of the clients, a small majority of the clients were in middle-school or high-school and 36.6% had graduated from high-school or earned a GED. This information was missing for 115 clients or 41.2% of the 279 clients.

Table 33. Education

	Count	Percent
Middle School or less	36	22.0%
Some High School	64	39.0%
HS or GED	60	36.6%
Some College	4	2.4%

Missing 115

The count of services is reported in Table 34. On average clients received 8.5 services with half receiving more than 4 services and half receiving less than 4 services. A total of 2,381 services were provided with a range of 1 service to a maximum of 64 services. Slightly more than 25% of clients receive 1 service and 29% received 2-5 services. Slightly more than 26% of clients received 11 or more services with 2 clients receiving 51 or more services.

Table 34. Count of Services

	Count	Percent
1	72	25.8%
2-5	81	29.0%
6-10	51	18.3%
11-20	40	14.3%
21-50	33	11.8%
51+	2	0.7%

Table 35 shows individual therapy accounted for 53.5% of all services followed by collateral therapy (10.2%), intakes (9.7%), and family therapy (8.4%)

Table 35. Service Type

Service	Count	Percent
Assessment	143	6.0%
Case Management	187	7.9%
Collateral Therapy Session	244	10.2%
Family Therapy Sessions	199	8.4%
Group	63	2.6%
Individual Therapy	1,273	53.5%
Intake	231	9.7%
Other	41	1.7%

Table 36 reports services with additional detail. Almost 60% of the clients received an average of 7.7 individual therapy sessions. Interestingly, only 228 or 81.7% of the clients had a documented intake in the data we received. Clients also commonly received assessments (119 or 42.6%) and smaller numbers received collateral or family therapy and group treatment.

Table 36. Services and Contacts

	Clients	Services	Percent	Mean	Range
Total	279	2,381	100%	8.5	1 to 64
Assessment	119	143	6.0%	1.2	1 to 12
Case Management	56	187	7.9%	3.3	1 to 23
Collateral Therapy Session	55	244	10.2%	4.4	1 to 39
Family Therapy Sessions	49	199	8.4%	4.1	1 to 22
Group	21	63	2.6%	3.0	1 to 17
Individual Therapy Session	166	1,273	53.5%	7.7	1 to 38
Intake	228	231	9.7%	1.0	1 to 2
Other	24	41	1.7%	1.7	1 to 8

Staff Interviews

Seven interviews were completed with Centro Savila staff. On average staff had 7.8 years of work experience with the provider and 12.3 years of total work experience.

Table 37. Years at Centro Savila

Years	Count	Percent
0 to 2	2	28.6%
3 to 4	3	42.9%
5 to 6	1	14.3%
7 to 8	0	0.0%
9 to 10	1	14.3%

Table 38. Years of Work Experience

Years	Count	Percent
0 to 2	2	28.6%
3 to 5	0	0.0%
6 to 10	2	28.6%
11 to 15	2	28.6%
16 to 20	0	0.0%
21 +	1	14.3%

Table 39. Years of Education

Education	Count	Percent
HS	1	16.7%
Some College	1	16.7%
BA	2	33.3%
MA	1	16.7%
PhD	1	16.7%

Missing 1

Table 40. Staff Type and Certifications

Staff Type	Number of Staff
Clinical	6
Administrator	1
	Yes
Certification	4

The interviews were useful for gaining an understanding of how the program works from the perspective of the interviewees. This included hearing from staff and administrators how clients engage and 'move' through the program. This provided clarity on how the program operates compared to the program design. This is discussed below.

The interview asked how clients learned about the program. Staff reported that clients learned about Centro Savila from schools as well as through outreach. Outreach presentations were reportedly done for various community-based providers and at various health fairs. Originally, Centro Savila reported needing to conduct outreach to various agencies to inform them of the services offered in order to generate referrals, however, this lessened overtime and as knowledge of the program spread. Based on the interviews, one particular staff was responsible for community outreach.

Similarly, one staff was also responsible for the intake process. The intake process begins when at referral. Referrals and initial screening were completed through a Google link. Referrals typically came from the Juvenile Probation Office, schools, and internally from Centro Savila, which are considered a good fit for Centro Savila. Interviewees noted historically there have been limited internal referrals across the other Behavioral Health Initiative funded programs, specifically those funded through the ACEs funding. Individuals who are eligible based on the initial screening are given an intake appointment. Staff reported eligibility is further confirmed at the intake appointment and is limited to individuals between the 12 and 24 years of age. Individuals who are not eligible are referred to another agency. The contract with the County notes that this intake must be completed within 10 days of receiving the referral for eligible clients.

At the intake appointment, parents and youth are asked to attend, and paperwork is completed by both the parents and the youth. The intake process includes completion of various consent forms, release of information forms, and assessments, which are done with the parent and youth. For demographic information and the consenting process, both the parents and youth stay in the room. For other

information and assessments, the parents are asked to step out of the room or vice-versa for privacy. The program design reports a variety of screening tools and assessments, such as the ACE screen and the Progress Pathways assessment are completed at the first intake appointment and re-administered at subsequent appointments if needed. Staff also reported completing different assessments at the intake, including the ACEs assessment, Progress Pathways assessment, and a suicide risk assessment. Some staff also mentioned completing a Presumptive Eligibility Medicaid on Site Application Assistance (PE/MOSAA) form, though none were able to describe the assessment or provide the full name of the assessment. As with the other providers, Centro Savila staff described the ACE as a very invasive screen, however the decision to train one particular staff to be responsible for the administration of the screen was an apparent attempt to reduce inconsistencies in staff rapport building abilities. Administrators discussed intentional and deliberate selection and training of a particular staff to be responsible for administering the ACE because of the specific skills and traits of that staff. One staff noted that because of the trauma that their youth have experienced, supervisors even considered the tone of voice that their staff used when speaking with the youth clients, noting:

> *"they just needed a lighter presence and somebody who could take it slow and in a certain way that they have. So yeah, I was cognizant of that and that's why maybe…you know, I had to work with him too because I think his feelings were hurt. But it wasn't like…they just have different strengths. But that was something that I was aware of. So, that's why I wanted to put [redacted name] there."*

After the intake is completed, the intake coordinator lets the family know that a therapist will contact them to schedule their next appointment. The first and second appointments with the therapist often focus on completing the extensive biopsychosocial assessment.

Staff discussed the various services provided to clients and their families, as well as the different curriculums used by Centro Savila. Centro Savila staff reported using a variety of curriculum and evidence based practices, including critical time intervention, the progress pathways model, strength-based approaches, attachment-based theory, life skills, seeking safety, complex trauma inventory, slowdown, medically assisted treatment (MAT), and an array of holistic healing services including Reiki, Acupuncture, and Acudetox. Staff listed the above curricula and evidence-based practices inconsistently, with some staff listing all and other staff only mentioning a few.

Services can be provided in house, referred out, or both. While general case management might provide services to their clients on a weekly basis, intensive case management might entail up to 4 weekly visits with their clients. Staff agreed that individual therapy is both referred out as well as provided by Centro Savila in house, and is provided weekly for 50-60 minutes. Family therapy is either referred out or provided by Centro Savila once a week for 50-90 minutes. Group therapy is referred out for services related to substance use disorder, parent and child bonding time, and therapeutic cooking classes.

Administrators spent a substantial amount of time during the interviews discussing the intentional cultivation of staff skills and training, which they discussed to be important components of service provision. Specifically, Administrators noted that staff had options to pursue specific areas, curricula, and/or concentrations based upon their interests and where that staff "showed promise". Based upon one

particular interview, it was apparent that substantial time and thought was put into developing an internal process for clinical supervision and for debriefings of case summaries. For instance, an interviewee noted:

> *"But also, I've really advocated that everybody seeks out their own therapy because I felt like that was really important if we are going to be working with them, we have to know ourselves first. And so, that's always a journey. So, everybody in some way, has taken that on as a way of taking care of themselves."*

Furthermore, clinical supervision was discussed during the interviews with administrators. The process was described as follows:

> *"I wanted to start sharing info in meetings. So, we have…part of that day is admin meetings. So, we are just looking at like what's going on in our calendar. Where do people need help in terms of just is there anything in the office that we need? Any outreach opportunities? Let's talk about all of that. So, everybody is on the same page. So, those are just admin tasks. Then, the other side was more let's talk about our cases. Have I had anything that I wanted to share? Any information about a certain modality or interventions that I have heard in supervision might be needed. And so, I just felt like that was needed. But it's been shifting because I've wanted us to come together as a team and speak clinically on a case that there was a case manager and maybe a few other therapists treating other family members."*

According to the staff and administrator interviews, clients can be successfully discharged or administratively discharged. According to staff and administrators, an individual is successfully discharged when they have met their treatment goals. On the other hand, individuals can be administratively discharged if they are a repeat 'no show' or if they are no longer interested in receiving services. When an individual is discharged, a discharge summary or plan is created for them. The discharge plan includes the previously identified goals that they've achieved. Staff agreed that many previously administratively discharged clients do come back and re-engage when they're better able to commit, and clients who've successfully discharged also check in to let them know how they're doing. According to staff, Centro Savila does not have a formalized follow up procedure.

As noted in the introduction of the interview section, staff and administrator interviews were very helpful in gaining a clearer understanding of the Centro Savila program implementation. Our review of interviews found it was clear Centro Savila did not have a clear program design and so the implementation process was not consistent. Certain aspects of the program design like case management were implemented to a degree. It was not clear how the case management and individual therapy were coordinated and how they related to each other. Further, client data suggests that the majority of appointments and subsequent services consisted and resulted from individual therapy, not case management services. It is thus unclear what the planned and actual role of the critical time intervention specialists (CTI) were.

Discussion

In considering the quality and quantity of the three data sources we received for the evaluation of Centro Savila, our ability to determine whether and how well the provider adhered to their program design is

limited. As with the other providers, we relied primarily on the client data and the staff interview data to help us understand, document, and report the program processes. The performance measure data reported by Centro Savila provided a very broad overview of the various measures deemed important by the provider and the County, and were only discussed briefly in this report. Performance measures conflicted with client data and interview data and could not be confirmed with these data.

According to performance measures the majority of referrals were from schools or self-referrals, which differed from staff interviews that suggested the majority of referrals came from the Juvenile Probation Office (JPO). Unfortunately, we were not able to resolve this difference and the client data was not able to provide additional information. Another example deals with the number of clients served. Based on performance measure data Centro Savila reported 34 clients successfully completed the program and 194 disengaged from services, a total of 228 unique clients that is less than the 279 clients reported in the client data. It is not clear why these numbers do not match. Despite these discrepancies, the performance measure data broadly indicated Centro Savila the services their program was designed to provide, though it does not describe or support evidence for *how* those services were provided or for whom. It is important to note the performance measures were not designed to be used for the evaluation and were for the County to monitor performance. In addition, it is important to repeat that additional information may have been available from this provider that could have provided more insight and detail into the implementation of the program. In the future more effort should be placed on working with programs to determine if additional information is available.

Client data was limited in describing who the program served and provide limited information on services. Client data provided to our office was limited and provided only minimal information useful for reporting adherence to the program design. The client data was most useful for reporting service delivery, specifically, counts and types of services that were provided to unique and duplicate clients. Other processes within the Centro Savila program design were not well confirmed by the client data, including referrals, screening, assessment, discharge, and aftercare processes. We did not have intakes and discharge information and lacked screening and assessment data beyond the ACE screen.

Staff interviews were helpful in understanding the day to day operations at Centro Savila. The number of staff interviews provided diversity and proved useful in understanding the program.

Considering the different sources of data available, it is difficult to definitively report Centro Savila adhered to their program design. Services were provided to youth, but we cannot describe the processes in which those services were provided. Specifically, we are unable to say with certainty that the clients served were indeed the clients with high needs based upon high ACEs scores. Though performance measure data provided counts of clients who scored low and who scored high on the ACEs screen, we could not confirm this using available client data. The staff interviews provided helpful information about who administers the ACEs screen, though there was no confirmation about how that information, along with other assessment data, was used to guide treatment and services. We know ACEs screens were administered, and likely the clients were high needs, though the specifics of what services were provided based on need level, was limited.

New Day

Program Description

New Day's *Social Emotional Education and Asset Development* (SEED) program was designed to serve youth by increasing permanent connections, increasing emotional intelligence, and increasing competency in skills. New Day proposed prospective clients would be able to engage in two main ways through their program, first by attending drop-in life skills group classes, and second by enrolling in one-on-one life skills coaching.

Drop-in life skills group classes were intended to focus on financial literacy, job preparation, cooking, art, and gardening, with classes being held 3-4 evenings a week and occasionally on the weekends. The life skills group classes are accessible through the Life Skills Academy (LSA) and the Albuquerque Life Skills Collaborative. By participating in the LSA, youth could identify interests and aptitude for careers and hobbies; increase subject area knowledge; develop positive relationships with caring adults and peers; gain experiences of being connected to their community; and develop a future orientation.

One-on-one life skills coaching was designed to include at least bi-weekly meetings with a life skills coach to assess progress and provide additional services. Coaches use elements of the Fostering Success Coaching Model, Nurtured Heart Approach, and High Fidelity Wraparound. Coaches work with youth to co-create their individual goals and objectives and meet individually once every other week or more, if needed. Individual coaching focuses on exploring with youth their interests and help them build specific and relevant goals. Coaches have the opportunity to reflect the young person's strengths and abilities to them so they could begin to see more of these qualities in themselves.

In addition to the drop-in life skills group classes and the one-on-one life skills coaching, New Day sought to provide a comprehensive social-emotional education that included community engagement and youth leadership opportunities. The SEED design is based upon the theory that having life skills competency coaches would allow for intensive one-on-one interaction to help them build the social, emotional and functional competencies necessary for building healthy attachment and moving toward independence and leadership. Participation in the Youth Action group also give youth a safe practice space to use their newly learned skills, deepen relationships with peers and adults, and ultimately increase their self-esteem and inner wealth.

Across the drop-in life skills group classes, one-on-one life skills coaching, and leadership classes, the SEED program is designed to focus on coping mechanisms, level of awareness, resiliencies, and acquisition of new skills. Specifically:

- Coping Mechanisms: Exposure to new types of activities such as art, gardening and yoga provide opportunities to develop new ways to cope with difficult times and increase awareness on ways to let out steam, fill up when they are depleted and move through challenging times.
- Level of Awareness: Their awareness around the connections they have, the impact of those connections and ability to alter or shift relationships as needed. Increased awareness around their own feelings, emotions and responses to particular situations and ways to deal with hard feelings and interactions are also likely. Increased awareness of their talents, goals and overall inner wealth.
- Resiliencies: Social competence, problem solving, autonomy/independence, and sense of purpose and future.

- New Skills: cooking, gardening, budgeting, financial planning, employment readiness, anger management, frustration tolerance, communication skills, healthy relationships, setting boundaries, creative and critical thinking, cleaning, yoga, dealing with law enforcement and other systems and so many more.

The SEED program design consisted of three levels of participation. Level 1 consisted of youth who attend LSA classes and related activities, Level 2 consisted of youth who participated in classes and received one-on-one competency coaching, and Level 3 consisted of youth who utilized the full array of services—coaching, classes, leadership opportunities, and community engagement. The design also prioritized youth with highest ACE scores, though the scope of services described most of all their clients would likely have high ACEs regardless. Prioritization occurs for the one-on-one competency coaching (Level 2 and 3) is given to youth with the fewest natural supports—an added risk factor makes them particularly vulnerable to negative outcomes.

As part of the design, the program proposed using the Fostering Success Coaching Model, the Nurtured Heart Approach, and High Fidelity Wraparound. These are broadly described in Table 41 below.

Table 41. Evidence-based Practices

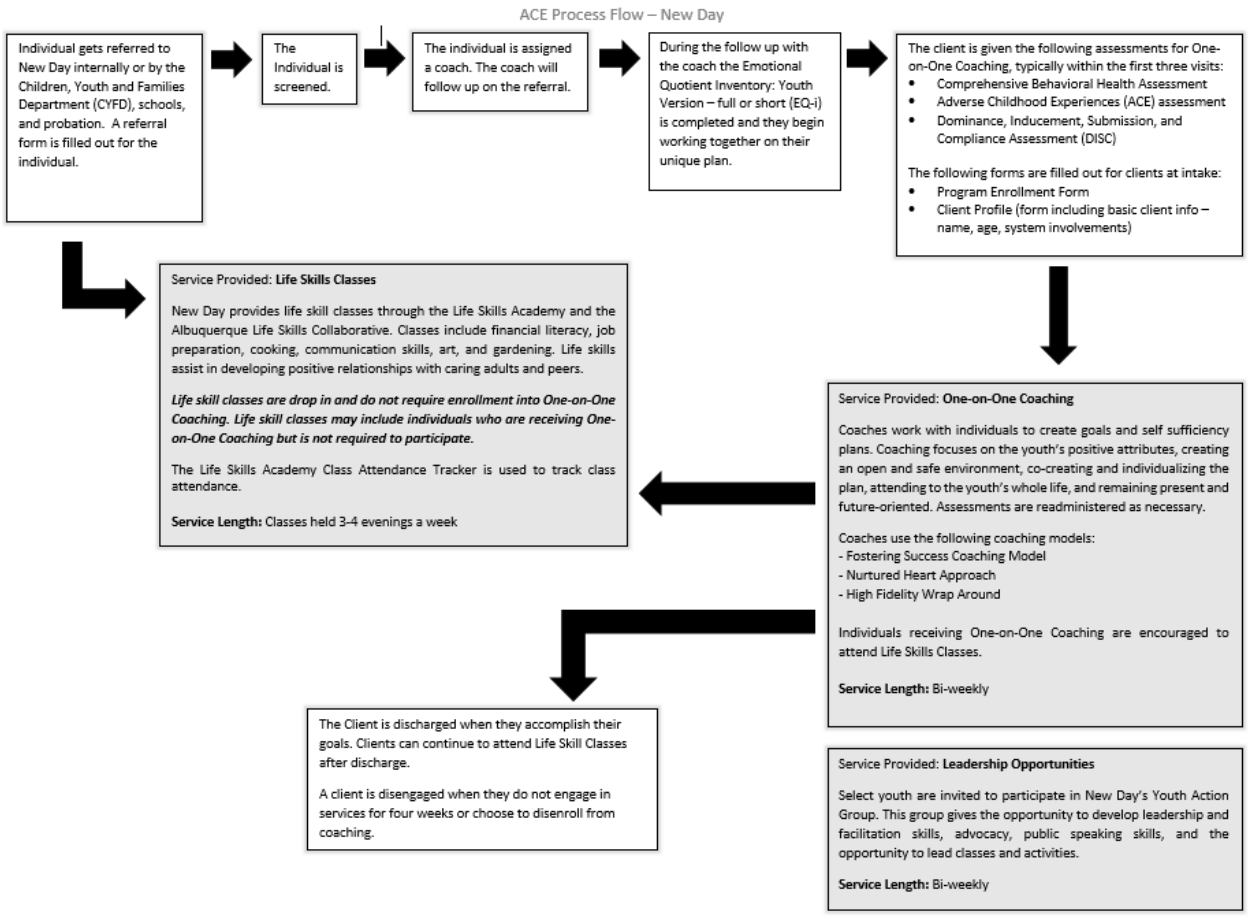
Evidence-based Practice	Description
Fostering Success Coaching Model	Fostering Success (FS) Coach model of practice provides framework and support to professionals who work with students from the foster care system and are enrolled in secondary education. The coaching model can be used either as a full program of support or as a skill set for educational advisors. FS Coaches provide support to students who experienced ACEs and or who have experienced foster care. (https://www.fosteringsuccesscoaching.com/)
Nurtured Heart Approach	The Nurtured Heart Approach emphasizes the Three Stands, which includes ending the endorsement of negative behaviors, reinforcing positive behaviors, and maintaining and demonstrating clear, fair, and consistent boundaries and rules.
High-Fidelity Wraparound	HFW is a youth and family guided planning process that brings together providers and supports from different parts of the youth's life. HFW helps identify and achieve goals with assistance from these supports. The goal of HFW is to have youth live in their homes and communities successfully.

The New Day program design is illustrated in Figure 3, which provides insight on how clients engage in the program, beginning with the client referral, screening and eligibility criteria determination, intake process, assessment and service delivery, and discharge process. This is further discussed in more detail within the final section, staff interviews. As demonstrated in the process flow, New Days' SEED program was designed to receive referrals from three different sources, including New Day's shelter, Life Skills Academy (LSA), and the juvenile justice system. Within the New Day Shelter, staff identify and refer youth who might benefit from program services through examining the comprehensive assessments completed when they entered the shelter. The Life Skills Academy provides referrals through their self-hosted website, where information regarding the program is supposed to be posted. New Day identified

the Juvenile Detention Alternatives Initiative (JDAI) as a partnering agency, and proposed they would provide referrals for young people in the juvenile justice system that may benefit from the program. Community outreach is conducted through the Life Skills Collaborative, Community Service Agencies, and schools within the area.

Per the SEED design, once a referral is made, a coach meets one-on-one with the young person to complete the Emotional Intelligence Survey (EIS) and they begin working together on their unique plan. Coaches apply the central elements of coaching, including focusing on a youth's positive attributes, creating a safe and open environment, co-creating and individualizing the plan, remaining youth-centered, attending to the youth's whole life, and remaining present and future-oriented. Also, coaches connect youth with LSA classes, community activities and any other necessary referrals to further develop their competencies and skills. Additionally, coaches encourage youth to participate in leadership opportunities. As such, youth are invited to participate in the Youth Action group, which is designed to meet bi-weekly, and to give youth a forum to develop leadership and facilitation skills, advocate on behalf of youth issues, practice public speaking, and lead classes and activities. Throughout engagement, life skills coaches administer assessments as deemed appropriate, specifically in determining the client needs, areas to focus on, and goal setting. When a youth has successfully achieved their goals and feels ready for independence, they are discharged. Youth who miss multiple appointments or lack consistent engagement can be discharged.

Figure 3. New Day Process Flow



Performance Measures

Provider monthly performance measures consist of two types of data, first, a series of tables that were intended to track a variety of measures by month by fiscal year. These broadly entail incoming referrals, assessments completed, ACEs scores, number of clients served and number of meetings, client outcomes, number of BHI meetings, and client demographics. Second, a narrative section designed to collect qualitative level data on the measures.

Narrative data was generally organized into: 1) Goal achievement, successes, and targets met, including notable data points, 2) Changes and adjustments made that address barriers, unmet targets, and/or opportunities for greater success, 3) Continuous quality improvement and training activities performed this month to enhance programming and achieve positive outcomes, 4) Collaborative relationships with schools or educational partners, 5) Suggested changes to performance measures and targets, outcomes, notable trends, outliers, and any other qualitative or quantitative items

Table 42 lists and describes the performance measures reported by New Day. Over the last several years, both the measures and the narrative have evolved with the intention of better operationalizing measures and to include measures for new activities. As with the other providers performance measure data is limited and is not discussed at length.

New Day reported administering the Adverse Childhood Experiences (ACEs) screen, Initial (All About You), the Emotional Quotient Inventory (EQ-I)/Emotional Intelligence Survey (EIS), and the Dominance, Inducement, Submission, and Compliance Assessment (DISC) beginning in the second half of the first contract year (January 2018-June 2018). Because neither ACE assessment data nor EQ-I data was provided in the client data, it is briefly described here.

New Day administered the Adverse Childhood Experiences (ACEs) screen to 57 clients, with 15 scoring between 0 and 3 and 42 scoring between 4 and 10 (74%). New Day did not begin administering the EQ-I until January 2018, and from that period through June 2020, administered 32 EQ-I's. The number of unique clients was not identified.

New Day began accepting clients in July 2017. Because the measure used to count clients changed over the three year period, we are unable to use the performance measure data to count clients and supplement the client data. Specifically, in the first year of the contracted time period (July 2017-June 2018), New Day reported the number of new and continuing clients served with one-on-one coaching. New and continuing life skills classes, new participation and continuing participation in leadership class, number of leadership meetings, and number of clients served by Youth Blast were not reported until the second and third year of the contract (July 2018-current).

While record review data showed other New Day programs accounted for 15 of the referrals, the performance measures reported their Safe Home accounted for 52 referrals and the Peer Drop in Center (Youth Blast) accounted for an additional 28 referrals.

Table 42. Performance Measures

Performance Measure	Defined
Number of referrals received	This measure reports the number of unduplicated referrals by month by referral source. The measure includes a total by referral source and month.
ACE scores	ACE scores are provided by month and count by low score (0-3), high score (4-10), and declined. The measure includes a total by month and by score level.
Number of assessments completed	This measure includes the number of unduplicated number of assessments by month by assessment tool and total assessments by month and total for each assessment.
Number of clients served and meetings	This measure is reported by unduplicated number of clients by type of client (therapy and case management). The measure also appears to report "continuing" clients. This measure includes total by month and type of client and whether they are unduplicated or continuing.
Client Outcomes	This measure reports client outcomes and goals by quarter year and total.
Number of collaborative community partners	This measure reports established new partnerships by and total by month and total by type of partnership
Client demographics	Reported monthly demographics include gender, age by category, race/ethnicity, annual income, client insurance source, and housing.

Client Data

This section reports client-level data which includes referrals, enrollment and intake, screening, assessment, services, and discharges. Information on the classes provided by New Day are reported separately.

During the time of this study, between July 2017 and June 2020, the program enrolled 78 individuals. Three of these clients (2 adults and 1 minor) did not have any services recorded. The analysis is limited in some ways because, as reported elsewhere, while we were able to received identified data for adults we were only able to receive de-identified data for minors. New Day enrolled 17 adult clients (18 years of age and older) and 61 minor clients (younger than 18 years of age). The following set of tables reports on these individuals. This includes demographic information and services received.

Table 43 reports the referral source. Nine clients were missing this information. The largest number of referrals (35.3%) were self-referrals, followed by other New Day programs (22.1%) and Community Organizations (20.6%). Together these three sources accounted for 78% of all referrals. Juvenile Probations and Guardians each accounted for 5 referrals (7.4%).

Table 43. Referral Source

	Count	Percent
Community Organization	14	20.6%
Juvenile Probation Office	5	7.4%
Other New Day Program	15	22.1%
Self	24	35.3%
Community Support Worker	1	1.5%
Family Member	3	4.4%
Guardian	5	7.4%
School Counselor/Social Worker	1	1.5%

Missing 10

Table 44 reports the race/ethnicity of enrolled individuals as extracted from the record review data. Respondents were asked to separately report their race and ethnicity and this table combines race and ethnicity. Slightly more than 50% of the clients self-reported being White with 16 of these individuals reporting they were Hispanic. Fourteen clients (19.2%) reported they were Hispanic, 9 reported they were American Indian, 8 reported being African-American, two Asian, and one reported being Native Hawaiian or Other Pacific Islander. Four African Americans also identified as Hispanic, the Native Hawaiian or Other Pacific Islander also identified as Hispanic/Latino, and three American Indians identified their ethnicity as Hispanic/Latino. In total 38 clients (51.3%) reported being Hispanic/Latino. Four clients either refused (2) or did not know (2) their race or ethnicity.

Table 44. Race Ethnicity

	Count	Percent
American Indian or Alaska Native	9	12.3%
Asian	2	2.7%
African American	8	11.0%
Native Hawaiian or Other Pacific Islander	1	1.4%
White	39	53.4%
Hispanic/Latino	14	19.2%
Total	73	

Missing 5

Equal numbers of clients reported being female or male (48.7%) and two clients reported being transgender.

Table 45. Gender

	Count	Percent
Transgender	2	2.6%
Female	37	48.7%
Male	37	48.7%
Total	76	

Missing 2

Table 46 reports school attendance. The majority of clients reported attending school regularly (52.9%) and a small minority reported attending school irregularly. Almost 20% reported they had dropped out of school, five reported they graduated from high-school, and five reported they had completed their GED. In total slightly more than two-thirds (67.7%) reported attending school regularly or having finished high-school. Of the 13 that had dropped out of school 3 dropped out in the 11th grade, 5 in the 10th grade, three in the 9th grade, one in the 8th grade, and one in the 7th grade.

Table 46. School Attendance

	Count	Percent
Attending School Irregularly	9	13.2%
Attending School Regularly	36	52.9%
Dropped Out	13	19.1%
Graduated from High School	5	7.4%
Obtained GED	5	7.4%
Total	68	

Missing 10

Table 47 reports clients' ages as detailed in the record review data. The average age of all clients was 16.2 years of age. The youngest clients were 12 years old and the oldest client was 24 years old. The large majority of clients were between 16 years and 18 years of age, accounting for 77% of all clients.

Table 47. Age

	Count	Percent
12	3	4.1%
13	3	4.1%
14	2	2.7%
15	6	8.1%
16	19	25.7%
17	26	35.1%
18	12	16.2%
20	1	1.4%
21	1	1.4%
24	1	1.4%
Total	74	

Missing 4

Table 48 reports the clients living status at the time they were enrolled, which was extracted in the record review data. Slightly more than 33% lived with a guardian and 29% lived in a crisis shelter. Living status is a measure that is also reported within the providers' monthly performance measures, which is discussed in the performance measure data section below. During staff interviews, the New Day Safe Home shelter was discussed in relation to referral sources and other activities.

Table 48. Current Living Status

	Count	Percent
Crisis Shelter	19	29.2%
Friends	2	3.1%
Guardian	22	33.8%
Relatives	8	12.3%
Rents an Apartment	1	1.5%
Foster Care	2	3.1%
Transitional Living Program	6	9.2%
Other	5	7.7%
Total	65	

Missing 13

One-time screening and on-going assessment for adult and minor clients was difficult to clearly understand through information gathered in the record review data. This is because only a few assessment-related variables were included in the data, which conflicted with the information we gathered through the staff interviews and in the performance measure reporting. Specifically, within the record review data obtained, variables regarding self-sufficiency development and focus areas were included. These were consistent with values belonging to what New Day refers to as an informal version of *Progress Pathways.* As noted in the performance measure section, the EQ-I, sometimes referred to as the EIS, was not provided in the client data. The following section provides a discussion of the data collection tools, and two tables with counts of the self-sufficiency development and the focus areas. Conflicting data reported in the monthly performance measures are discussed in the performance measure section following.

ACE screening data was not included with the client data provided by the program. As described elsewhere, the ACE's screen calculates the number of adversities, toxic stress, and/or traumas that client has experienced. Monthly performance measures reported the counts of ACEs screens administered and the count of screens scoring low and those scoring high. New Day refers to this particular assessment as both the EQ-I and the EIS. These data were not provided by New Day in the client data and was outlined in the performance measure section.

Table 49 reports the number of clients in which emotional intelligence, functional intelligence, and social capital were identified as areas of improvement. Fifty-four clients indicated wanting to work on emotional intelligence, 65 identified functional intelligence, and 50 identified social capital. The second column includes the average times a given client selected that type of self-sufficiency to focus on.

Table 49. Self-Sufficiency Development

	Number of Clients	
Emotional Intelligence	54	
Functional Intelligence	65	
Social Capital	50	

Progress Pathways

Progress Pathways assessment measures seven domains of life and specific areas of focus. The domains include 1) Basic Needs, 2) Daily Living Skills (Focus Areas: Safety, Cleanliness, Nutrition, Health, Community, Goal Setting, Having Fun, and Sobriety), 3) Education (Focus Areas: General, High School/GED, College), 4) Employment & Career Planning (Focus Areas: Skills, Explorations), 5) Housing & Money Management (Focus Areas: Money Feelings, Banking, Budgeting, Credit/Loans, Housing/Tenant Assistance), 6) Emotional Awareness & Identity (Focus Areas: Emotional Awareness, Identity), and 7) Relationships & Communication (Focus Areas: Advocacy, Relationships, Communication). These domains are scored through the use of the scoring rubric that categorizes the client status, including thinking, planning, initiating, doing, and excelling.

Table 50 reports clients focus areas and how many individual clients focused in each area. Seventy-five clients had focus areas. Clients commonly identified a certain area to focus on more than one time during their engagement in services. The second column includes the average times any given client selected that focus area. This means, for instance, on average, clients identified financial literacy twice during their engagement in services, whereas clients identified employment and career readiness an average of 4 times during the engagement in services. The most common focus area was employment and career readiness with 51 individual clients identifying the area, followed by community engagement and education, both with 46 individual clients. 17 individuals identified 'other' focus areas services, which included 22 unique services including; drivers permit, EBT and bus pass, meeting TLP expectations, program enrollment, room cleanliness, transportation and self-care, crisis support/problem solving, domestic skills, functionality, social distancing plan, socializing, community resources-mental health, independence through emancipation, gaining independence, and inner wealth/emotional preparedness.

Table 50. Focus Areas

	Number of Clients	Average per Client
Community Engagement	46	3
Creativity and Self-Expression	42	3
Education	46	3
Employment and Career Readiness	51	4
Financial Literacy	32	2
Health and Nutrition	37	3
Healthy Relationships	43	3
Housing	33	3
Identity/Self Awareness	41	3
Time Management	2	1
Transportation	2	2
Other	17	1

Table 51 reports services clients received and the type of contact in which those services were provided. As noted earlier 75 clients had at least one service recorded in the New Day electronic management system. The table reports the number of clients, the number of services, the mean number of services or

contact types received by those who received the service or contact, and the range received by clients. Table 52 reports service data in slightly more detail and Table 53 does the same for contact types.

Table 51 reports this information by the total services recorded and the completed services. The database was used to record all scheduled services and included whether the service was "completed". For a variety of reasons scheduled services were not always completed. Most frequently this occurred because the client did not attend the scheduled service for a variety of reasons including they had to work, they had other obligations, and often they just did not show or contact the program noting they were not going to be able to complete the service. On rare occasions the staff member was unable to attend the service because they were ill. A total of 673 scheduled services were recorded in the database and 492 or 73.1% of all services were completed. Importantly 26.9% of all scheduled services were not completed. On average, clients had 9 scheduled services and attended 6.6 services with one client having one scheduled serviced they did not complete and a range of 1 -45 scheduled services and 0 – 35 completed services.

The program also recorded how these services were provided and in Table 53 these are listed as contact types and listed in more detail in Table 52. Most frequently these services were provided face to face (59.8%) and on average clients who received a face to face service (71 or 96.6% of all clients who received at least one service) received 4.1 face to face services. Clients who receive a text/phone contact (63) or one on one (61) service received an average of 1.5 and 1.6 services respectively.

Table 51. Services and Contacts

	Clients	Services	Mean	Range
Total services	75	673	9.0	1 - 45
Completed services	74	493	6.7	0 - 35
Life skills	74	477	6.4	1 - 35
Contact Type				
Face to Face	71	294	4.1	0 - 28
Text/Phone	63	92	1.5	0 - 15
One on One	61	98	1.6	1 - 5
Other	3	8	2.7	0 - 4

As noted 3 clients did not have any services recorded in the database and one client had one service scheduled they did not complete. 51 services were scheduled but not completed. As shown in Table 52, almost all the completed services were listed as Life Skills (97%). There were 492 completed services and 477 of these services were Life Skills.

Table 52. Services

	Count	Percent
Life Skills Coaching	477	97.0%
One on One	1	0.2%
Transitional Living	1	0.2%
Youth Centered Meeting	1	0.2%
Housing	6	1.2%
Community Education	2	0.4%
Aftercare	1	0.2%
Care Coordination	1	0.2%
Prevention	1	0.2%
Outreach	1	0.2%

Missing 123

Table 53. Contact Type

	Count	Percent
Face to Face	294	59.8%
One on One	98	19.9%
Phone	29	5.9%
Text	63	12.8%
With Client and other	3	0.6%
Zoom	1	0.2%
Group	4	0.8%

Missing 130

Life Skills Classes

Life skill class information is reported at the class level. Data on the group-level life skill classes included the class topics, number of attendees, names of life coaches who led the classes, and the date classes were held. Importantly, because client-level rosters were not provided for the class attendance, it is not possible to determine whether the total count of participants includes duplicates, or only unique clients. Thus, the total counts of clients served is provided, with the cautionary that it likely includes duplicates. Total minutes of services provided, however, can be adequately summed and reported.

Table 54 includes a collapsed list of classes. Between 2017 and 2020, 52 life skills coaching classes were held. Thirty-three of the 52 classes were hosted at the Life Skills Academy Building and 19 were hosted at the Life Skills Academy Community. Data we were provided showed 7 life skills classes were held in 2017, translating to 630 minutes of class, or 10.5 hours. In 2018, one cooking class was held, providing a total of 240 minutes to 9 clients. In 2019, 31 classes were held, providing a sum of 4,225 minutes, or 70.42 hours, of services. In 2020, 13 classes were held, providing approximately 90 minutes of services.

Table 54. Life Skills Classes

Class Name	Client Count Range	Minutes
What's Up Bro, 7-part series	2-8	630
I'd Eat That! Kitchen-Continued Training #15	9	240
Life Skills Academy (LSA) Social, 3-part series	14-16	255
Six String Heart Guitar Class, 9-part series	1-5	460
Hoop it Up! 2-part series	6-7	180
Job Readiness, 3-part series	3-5	180
Resume Workshops, 4-part series	2-9	345
Interviewing Workshops, 4-part series	2-8	240
Cesar Chavez Life Skills Lunch Group, 2-part	14	80
Fun in the Land of Enchantment Summer Camp, 6-part	7-11	2,520
Other One-Time Classes:		
Sara and Val's Class	1	0
Coping Skills to Thrive	8	60
Los Puentes Spring Break Class #1	11	240
Arcade Night	17	90
Code and CREATE Your Opportunity!	3	60
Field Trip to the Harbour	5	150
Budgeting Basics	6	40
Learn about You! DISC Assessments	2	90
Zoom 101	1	60
Pride Celebration	8	90

Table 55 reports client enrollment status on the date the data was extracted. Six clients were enrolled in the program on the date we received the data (as of June 2020) and 72 or 92.3% had been closed to services. Using data for clients 18 years and older we were able to calculate the average length of stay in days in the program.by counting the number of days between service start date and date of discharge. Two clients with a date of discharge received no services. One client had the same start date and discharge date, had one life skills face to face service, and 0 days in the program. Two adult clients were still active. On average discharged clients were in the program an average of 174.7 days with a maximum of 382 days and a minimum of 0 days as noted earlier. The data did not contain a discharge reason.

Table 55. Enrollment Status

	Count	Percent
Active	6	7.7%
Closed	72	92.3%

Staff Interviews

Three interviews were completed with New Day staff. On average respondents had worked 3.7 years at New Day and had an average of 10 years of work experience in their job field. Two respondents had a Bachelor degree (one respondent did not answer this question) and neither of the clinical staff listed a license or certification in their field.

The interviews were useful for gaining an understanding of the program from the perspective of staff. This included how clients move through and engage in the All Faiths program.

Staff reported that a large number of referrals to the Life Skills program originate from internal programs, such as the Safe Home. While individuals living at the New Day Safe Home were not required to participate in the Life Skills, interviewees noted it could be made to be mandatory in the future.

It is not clear how individuals are referred to the drop-in group life skills classes. Individuals who are enrolled in the one-on-one Life Skills Coaching services are able to also participate in the drop-in group Life Skills classes, but drop-in individuals must be enrolled in the New Day program to receive the one-on-one Life Skills Coaching. The specific steps for external referrals getting to New Day for Life Skills coaching is somewhat unclear, and it appears as though it is more informal and on a case by case basis. It is known that when a referral, in whatever format, is received, it is sent to the New Day manager and director. Staff then review and screen the referral and if eligible the individual is assigned to a coach. The coach then meets with the individual to complete an intake in a manner similar to internal referrals from the Safe Home. Client eligibility was discussed during the interviews and staff suggested that the youth must be under the age of 18 and must not already be receiving services elsewhere to be considered eligible for the program, noting:

> *I'll just ask the basic questions. How old are they? You know, are they getting services outside of anywhere else? So, I think there's been some confusion around young people who are getting CSW services and what would they necessarily need coaching for if they are already getting a service? And so, just asking that question as well. Like what are their interests? Are they wanting them to be in coaching just because they need more help in their professional capacity? Like maybe this young person is too much for them to deal with. What is it that you need help with? And so, those are basic screening questions that I would ask. But just knowing what the funding requires and what goes into the grant and what's around that…"*

Yet, when probed whether the potential client could or could not be receiving services elsewhere, staff said youth could, and clarified that:

> *"Just you know, they might be getting like mental health services or they might be getting something else with their family. But there has been some overlap when someone is getting CSW services and like where are we kind of doing the same thing? Like both of us might be doing the same exact thing…"*

At the first check-in, coaches and clients set goals, benchmarks, and things to work on for the following week. A coaching action plan is also completed, though it is not clear if this is completed at the intake or during the weekly check-ins. One-on-one coaching services are designed to bridge the gap between case management services and certain services not billable to Medicaid. This can include providing a referral for an identified need, and connecting the client to the referral. Interviewees reported New Day is working

on implementing an adjusted version of the progress pathways. The progress pathways may replace the coaching action plans and is meant to help measure progress throughout coaching services. Again, this was not described in detail with one staff noting:

> *"We have a coaching action plan that we complete in the beginning. We kind of work off of that. I know and I think Katie will probably talk about this but I think they are rolling out something called progress pathways, which will take over the coaching action plan. That will show…it's supposed to show the progress or their progress throughout coaching. So, that will be a more formal way of seeing the progress or lack of progress…"*

Staff interviews revealed that first time and new youth attending a Life Skills Academy (LSA) class were asked to fill out a "first time visitor form" which collected various demographic and client-level information. Interviewees noted LSA class attendance signup forms were completed for continuing clients participating in LSA classes, which helps track client levels of engagement. We received a list of classes that included the class name and count of total attendees, but not a list of individual attendees. It would have been helpful to be able to describe attendance at the client level for this study, however, because we could not have identified data, this was not possible.

In staff interviews New Day reported administering the Adverse Childhood Experiences (ACEs) screen, the Dominance, Inducement, Submission, and Compliance Assessment (DISC), the Initial (All About You), and the Coaching Action Plan. With the exception of the Coaching Action Plan, the three assessments are reported in both the monthly performance measures and staff interviews, but the Coaching Action Plan is only broadly discussed in staff interviews. Moreover, the ways in which the screens and assessment results and scores were used, such as informing treatment, were described broadly as staff were unable to provide additional details when probed during interviews. According to the interviews, while the EIS/Emotional Quotient Inventory (EQ-I), the Initial (All About You), and the Dominance, Inducement, Submission, and Compliance Assessment (DISC) were used to help inform how the life skills coaches interacted and communicated with youth, the way in which the information was used differed among staff. While the Dominance, Inducement, Submission, and Compliance Assessment *(*DISC) assessment was not included in the record review data, it is included in the performance measure data and was discussed during the staff interviews. According to interviews, similarly to the EIS assessment, the DISC is not a mandatory assessment, though it is useful to complete because it *'says a lot about who they [the client] are'.* The Initial (All About You) assessment was briefly discussed during the staffing interviews and interviewees noted, this assessment is used similarly to the DISC and the EIS. It is administered during the intake process by the life skills coach and, according to the interviews, it can be helpful in understanding ways in which to relate and communicate with the client. These data were not part of the client data.

Based on the interviews it was not clear how frequently the various assessments were being administered or whether the results were being used to identify goals and areas of focus across the domains of life. One interviewee reported this assessment was administered a little differently depending upon the life skills coach, the client, and the overall circumstances, whereas another indicated it was being implemented in the future. For instance, one staff noted *"That's just my personal thing that I'll do. So, it's just like because I kind of just have…whenever I meet someone for the first time, I'll do the intake paperwork and then we'll get into goals…"*

Staff interviews indicated that the ACE screen was administered to clients at the beginning of services, usually within the first few initial appointments. Yet, how those ACEs scores were used was unknown to staff. It also appeared that staff had only been recently notified that a specialist would be administering the ACEs screen, and that Life Skills Coaches had been administering the ACEs screen up until that point. It was noted:

> *"So, we have and we do use the ACE assessment. I just…we just found out that our therapist at the safe home does that. So, I don't need to do it anymore. I can just get it from her. She's like trained to do that. So, she does it. So, that's pretty cool."*

Another important parallel seen across the staff within New Day and also across the other three community based providers is the struggle with administering the ACEs screen without first building rapport and trust. Because the ACEs screen is so invasive, staff noted they have suspected youth have not always honestly reported their experiences when asked to complete the screen at the first intake appointment. This can be problematic if at another time, once the youth perhaps has had more time to build trust and a relationship with the Life Skills Coach, then discloses having experienced a particular trauma that was not previously disclosed. During the interview, one staff noted:

> *"I think like with the ACES grant, you know they fill out the ACES survey and then you kind of get a better idea of what kinds of trauma we are actually dealing with. And then, you know for instance, there was a person who completed the survey and everything was 0 but we know their story and we know their history and they just weren't willing to talk about it. They didn't want to talk about it. So, that was where we had to…I had to talk to Katie. I was like well, this is what she put. I can't change the answers even though I know this thing she was dealing with. But like it's not going to disqualify her from getting services…"*

Easing into a relationship with clients first is prioritized over completing the ACEs screen at the first appointment. A staff described this further in saying:

> *"So, the way that I see it is it's kind of backwards in that you have to build that relationship first. You can't just dive in because the ones who just did the referral and we try to reach out, they are like no, I don't want to do this. And so, they kind of disappear"*

Similar to the administration of screening and assessments, services to youth are provided based upon the preferences of the life skills coach and on the needs and preferences of the youth. One staff described their process as:

> *"And then, basically, it's like a check-in each week to see where their progress is and how I can help them reach their specific goal. Maybe getting a driver's license or getting a job or something like that. Sometimes, they are just super unstructured and super informal if they are having a bad day and they are just not feeling it. It's more of like I guess we work on coping mechanisms. It really just depends on the young person and kind of what they are going through that day, I guess…"*

Staff reported similarly to each other that youth whom seemed to do best within their program were there on their own accord and were personally motivated and seeking help. Youth who were ready to build healthy relationships and to acquire the necessary tolls and resources they needed to be successful were also described as most successful in the program. Youth that did not often do well, either due to poor participation or engagement, were described as being forced to participate or as not emotionally ready or prepared to fully participate. One staff mentioned that in such instances, sometimes the youth will disengage and then re-engage when they are ready, noting:

> *"I've had a few that have left and re-engaged. They just needed a break. So, that's pretty cool too. And then when they come back on their own terms, it's better for them and me"*

Discussion

Using performance measure data, client data, and staff interview data, we gained an understanding of the program New Day program. These measures broadly reported service types and counts, screening counts, and discharge counts. Thus, while we were able to determine that New Day reported completing certain activities and administering certain screens and assessments, we are not able to always confirm how these things were actually done and how they were completed. The client data provided us with some support for adherence to the program design and implementation, such as service delivery. We depended on staff interview data to help fill in the gaps of the performance measure data and the client data, as well as to provide contextual information, we only interviewed three New Day staff. With three staff interviews we lacked some variety and depth in content we had with other programs with more interviews. It would have been useful to have interviewed staff who led leadership classes and life skills group drop in classes. During the scheduling process with administrative staff at New Day, we requested interviews with all staff who had a role within the ACEs program, including staff that provide direct and indirect services.

We found that as planned and proposed, a large number of incoming referrals originated from within the New Day program such as the New Day Safe Home. We also found the collection of client information, such as goals, was not standardized, and staff did not describe a uniform data collection procedure. Furthermore, based on the interviews, performance measures, and client data, it was not clear how frequently assessments were being administered or whether the results were used to identify goals and areas of focus. According to the New Day performance measures, the Adverse Childhood Experiences (ACEs), the Dominance, Inducement, Submission, and Compliance Assessment (DISC), the Initial (All About You), and the Coaching Action Plan were administered to clients and counts were reported. We did not find consistent evidence these tools were administered in a standardized manner across the performance measure data, client data, or staff interview data. For example, the performance measures reported New Day administered the ACE screen to 57 clients. Fifteen of the clients scored between 0 and 3 and 42 scored between 4 and 10. However, based upon the client data, New Day served 78 unique clients, so it is unclear whether the remaining 21 clients completed an ACE screen. Performance measures reported 134 assessments, 60 consisting of the Initial All About You tool. In the client data we did not receive assessment data. Because the Initial All about You tool is administered at the intake, it is not clear why only 60 of the 78 clients completed the assessment. As with other providers, we found a limited connection between the service delivery and the proposed evidence-based practices and curricula described in client data and the interviews. In the performance measure narrative, New Day reported engaging in various staff training activities, which often pertained to the curriculum. More explicit measures of curricula adherence and implementation were not reported..

New Day's Social Emotional Education and Asset Development (SEED) program was designed to serve youth by increasing permanent connections, increasing emotional intelligence, and increasing competency in skills. New Day sought to provide a comprehensive social-emotional education that also included community engagement and youth leadership opportunities. New Day also proposed that one-on-one life skills coaching would include at least bi-weekly meetings with a life skills coach to assess progress and provide client services. According to the client data, on average, clients had 9 scheduled services, attended 6.6 services with a range of 1-45 scheduled services and 0-35 completed services. Because dates of services could not be provided for minor clients, we are not able to report frequency of services.

Because of limited client data available for the drop-in life skills group classes and youth leadership engagement, we were not able to determine the extent of adherence to that component of the program design. We were able to determine that drop in life skills class were provided, but we were not able to report how they were provided and the characteristics of attendess. As described in the program description, drop-in life skills group classes were intended to focus on financial literacy, job preparation, cooking, art, and gardening, with classes being held 3-4 evenings a week and occasionally on the weekends. According to client data, New Day provided 20 classes, some of which were one-time classes and others that ranged from 2 to 9 sessions. Topics of the group classes were aligned with what was proposed, including "I'd Eat That! Kitchen-Continued Training", "Job Readiness" (3 classes), and "Interviewing Workshops (4 classes), and "Life Skills Academy (LSA) Social (3 classes). We received the count of individuals who attended each class and were unable to attach engagement in these life skills classes to any one client.

PB&J

Program Description

The PB&J program is designed to provide trauma-informed parenting programs and integrated case management. This included comprehensive case management services to prevent and mitigate adverse childhood experiences, parenting and primary caregiver(s) groups, and access to basic needs and healthcare supports. As part of the Behavioral Health Initiative (BHI) ACEs funding, PB&J sought to provide closed psycho-educational, trauma informed, interactive parenting groups, each operating with a 16 or 28 week program curriculum, which is based on family involvement and the intensity and duration of services needed as identified during the intake and enrollment process. Group services can be provided to both the parent and child who attend together one day a week for 2.5 hours per session. The sessions are designed to include a combination of psycho-educational adult groups, developmentally appropriate children's groups, and parent/child interactive facilitated time. Several sessions are held throughout the week to best meet the needs and schedules of the clients and include morning, afternoon, evening, and weekend options, and bilingual staff are available and utilized for Spanish speaking families. A clinician and developmental specialist attend and facilitate sessions for content delivery and to attend to the emotional needs in the group.

Additionally, PB&J's program provides participating clients and families with basic needs assistance, access to nursing and nutritional services, as well as individual and group counseling. Basic needs assistance can include transportation assistance and access to healthy meals and snacks. Access to nursing includes health screenings, immunizations, and basic primary care. PB&J's program design provides

home visiting and comprehensive case management support services, as well. This includes providing home visits that support and complement e group sessions.

Case management (service coordination) services are provided to identify and address family safety barriers, including past or ongoing trauma, while also coordinating clinical services such as counseling. Families are also offered the opportunity to attend group outings, such as trips to the zoo, a museum, park, and hiking to help build peer relationships with other families, social skills, joy and satisfaction in the parent/child relationship, and a sense of community.

PB&J program goals include: 1) Child is healthy, 2) prevention of child maltreatment, 3) child is on healthy developmental trajectory and ready for school, 4) family is connected to a supportive social network, receives needed health services, is enrolled in income support programs and can access educational and employment opportunities, 5) parents have developmentally accurate expectations for their child's behavior, interact with their children in positive and nurturing ways and provide appropriate structure, and 6) prevention of intimate partner violence and reduced recidivism for incarcerated parents.

Table 56. Evidence-based Practices

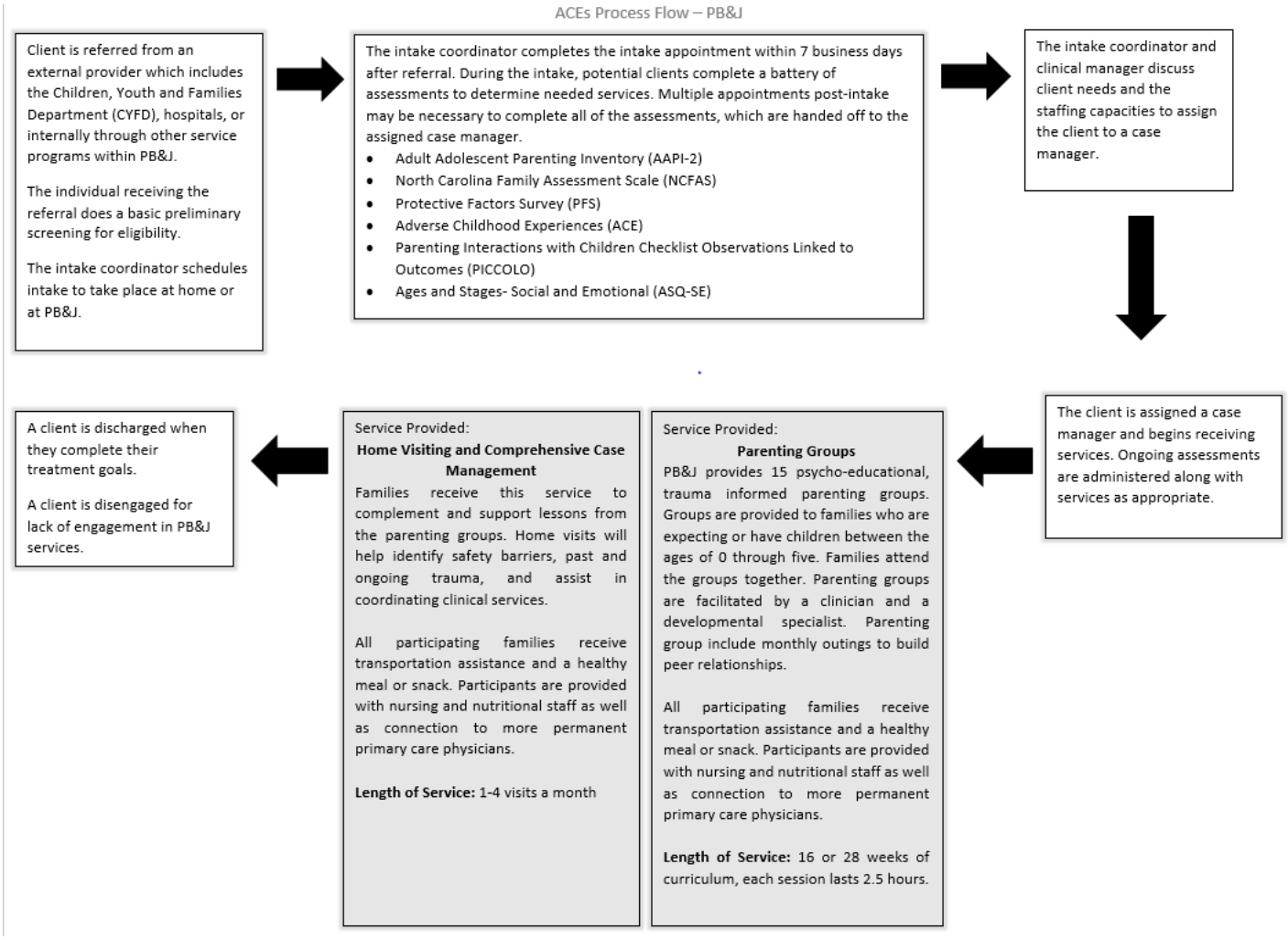
Evidence-based Practice	Description
Circle of Security	The Circle of Security model focuses on helping primary caregivers develop a healthy and secure attachment with their child. https://www.circleofsecurityinternational.com/circle-of-security-model/what-is-the-circle-of-security/
Nurtured Heart Approach	The Nurtured Heart Approach emphasizes the Three Stands, which includes ending the endorsement of negative behaviors, reinforcing positive behaviors, and maintaining and demonstrating clear, fair, and consistent boundaries and rules.

The PB&J program design is illustrated in Figure 4, which provides insight on how clients engage in the program, beginning with the client referral, screening and eligibility criteria determination, intake process, assessment and service delivery, and discharge process. As indicated in Figure 4, when a referral is received by PB&J, the intake coordinator contacts the family to describe the program, collect basic family information and determine eligibility, and schedule an appointment with interested families for a full intake assessment. The intake appointment includes a full developmental evaluation of the child, known as the Comprehensive Multidisciplinary Evaluation and determines eligibility of the family for services. Eligibility criteria includes: established condition, developmental delays, biological and environmental at risk factors. Once the intake has been completed, the families' needs are identified and a case manager is assigned. The family is encouraged to engage in e interactive parenting groups in addition to home visits and case management services.

During service engagement, the following assessments/screening tools are administered based on age of the child: Ages and Stages -Social Emotional Screening (ASQ-SE), vision, hearing, and health screening. PB&J also completes the following assessments/screening tools over several visits and after establishing rapport with the family, and as appropriate to each family's needs: Adult Adolescent Parenting Inventory

(AAPI-2), Adverse Childhood Experiences (ACE) screen, the North Carolina Family Assessment Scale for General Service & Reunification (NCFAS-G-R), Parenting Interactions with Children: Checklist of Observations Linked to Outcomes (PICCOLO), and the Protective Factors Survey (PFS). Once a family has achieved their goals and/or finished their interactive parenting groups, they are successfully discharged. Families can also be discharged from the program due to disengagement from services and/or lack of contact.

Figure 4. PB&J Process Flow



Performance Measures

Similar to the other three providers monthly performance measures consist of two types of data, first, a series of tables that were intended to keep count of various meaningful measures for each month over the span of a fiscal year. These report incoming referrals, assessments completed, ACEs scores, number of services provided by hour, number of clients served, number of outgoing referrals, client outcomes, number of BHI meetings, and client demographics. Secondly, narrative, which was intended to capture qualitative level data. Narrative data was generally organized into the following sections: 1) Goal achievement, successes, and targets met, including notable data points, 2) Changes and adjustments made that address barriers, unmet targets, and/or opportunities for greater success, 3) Continuous quality improvement and training activities performed this month to enhance programming and achieve positive outcomes, 4) Collaborative relationships with schools or educational partners, 5) Suggested changes to performance measures and targets, outcomes, notable trends, outliers, and any other qualitative or quantitative items.

Over the last several years, both the measures and the narrative have evolved to better report measures and to include measures for new activities. Due to the amount and quality of of client data PB&J we do not report performance measures. Table 57 reports the PB&J performance measures.

Table 57. Performance Measures

Performance Measure	Defined
Number of referrals received	This measure reports the number of unduplicated referrals by month by referral source. The measure includes a total by referral source and month.
ACE scores	ACE scores are provided by month and count by low score (0-3), high score (4-10), and declined. The measure includes a total by month and by score level.
Number of assessments completed	This measure includes the number of unduplicated assessments by month by assessment tool and total assessments by month and total for each assessment.
Number of families served	The number of services by hour is reported by service including therapy services and case management services by month and total hours of service by month and total by type of service.
Number of home visiting services provided	This measures reports the number of home visiting hours, number of families, and average number of hours per family by month.
Number and hours of intensive case management services provided	This measures reports the number of intensive case management hours, number of families, and average number of hours per family by month.
Number and hours of social work services provided	This measure reports the number of social work hours, number of families, and average number of hours per family by month.
Number and hours of nursing services provided	This measure reports the number of nursing hours, number of families, and average number of nursing hours per family by month.

Client Outcomes	This measure reports client outcomes and goals by quarter year and total.
Number of meetings with BHI providers	This measure reports meetings by month.
Client demographics	Reported monthly demographics include gender, age by category, race/ethnicity, annual income, housing, and client insurance source.

Client Data

Between June 2017 and June 2020 the program enrolled 545 clients. Almost half (49.7%) of these individuals also had a family identification (family id) number indicating these 271 clients were part of a family that enrolled for services. One family id included four clients, 6 family ids included three clients, and 55 family ids had two clients. Interestingly, 139 clients with a family id included only one client. We do not know why this happened and additional review of the data might shed light on the reason(s) this was found in the data. In addition, 107 of the 545 clients or 19.6% did not have any services recorded and 32 clients had only cancelled services recorded. The review of services focuses on the 406 clients who had at least one completed service. Forty-six of these clients also had a family id suggesting they may not have had services and the other family member may have been the client. This deserves further study.

Table 58 reports the referral source of the 545 clients. The largest percent of clients were referred by CYFD (41.7%) followed by PB&J itself (19.2%), and then self-referrals (18.8%). These three sources accounted for 79.7% of all referrals. The referral source was missing for 274 clients which were those clients with a family id, we do not know why this happened.

Table 58. Referral Source

	Count	Percent
Community Provider/Clinic	21	7.7%
Court	11	4.1%
CYFD	113	41.7%
Family	6	2.2%
School	8	3.0%
Other	6	2.2%
PB&J	52	19.2%
Probation and Parole	3	1.1%
Self	51	18.8%

Missing 274

PB&J separately collects race and ethnicity. Table 59 reports race and Table 60 reports ethnicity and Table 61 combines race and ethnicity. When reported by race Whites make up 77.5% of the population and by ethnicity Hispanics are 77.7% of the clients. Table 61, which is the combination of race and ethnicity shows that 74.3% of the clients identified as Hispanic, 9.9% identified as White, 9% were Native American, and 6% were African Americans. This suggests the large majority of clients who

identified their race as White identified their ethnicity as Hispanic. Sixteen clients declined to state their race and 8 clients declined to provide their ethnicity.

Table 59. Race

	Count	Percent
American Indian/Alaskan Native	64	12.1%
Asian	5	0.9%
African American	47	8.9%
Native Hawaiian or Pacific Islander	3	0.6%
White	410	77.5%

Missing 16

Table 60. Ethnicity

	Count	Percent
Hispanic	417	77.7%
Not Hispanic	120	22.3%

Missing 8

Table 61. Race/Ethnicity

	Count	Percent
American Indian/Alaskan Native	44	9.0%
Asian	1	0.2%
African American	29	6.0%
Native Hawaiian or Pacific Islander	3	0.6%
Hispanic	362	74.3%
White	48	9.9%

Missing 16

Table 62 reports gender and the majority of clients were female.

Table 62. Gender

	Count	Percent
Female	309	56.7%
Male	236	43.3%

Table 63 reports age by age group. The average age of all clients was 15.6 years of age. The youngest clients were 0 years old and the oldest client was 59 years old. Fifty percent of the clients were minors between the ages of 0 and 17 years of age with 47.3% being between 0 and 5 years of age.

Table 63. Age

	Count	Percent
0	65	15.2%
1	47	11.0%
2	35	8.2%
3	31	7.3%
4	19	4.4%
5	5	1.2%
15-17	12	2.8%
18-20	28	6.6%
21-30	107	25.1%
31-39	57	13.3%
40+	21	4.9%

Table 64 reports education. Education is only reported for clients 15 years of age and older.

Table 64. Education

	Count	Percent
Less than High School	95	37.5%
GED	26	10.3%
High School	59	23.3%
College Credit no degree	46	18.2%
Vocational/Technical or AA	21	8.3%
Bachelor's Degree	5	2.0%
Master's Degree	1	0.4%

This table reports employment status for clients 18 years of age and older. Almost two-thirds of clients 18 years of age and older were unemployed and 35.5% were employed.

Table 65. Employment Status

	Count	Percent
Employed	89	35.5%
Unemployed	162	64.5%

Missing 6

Table 66 is related to Table 65 and reports the reason the 162 clients were unemployed. Thirty-three percent were unemployed because they were homemakers, one client was retired, 11 were students, 5 were incorporated, and 26 were on SSDI (social security disability insurance). A small minority of those employed were actively looking for work (15.6%). The majority of those who were unemployed we would not expect to be looking for work or to become part of the workforce

Table 66. Unemployed Reason

	Count	Percent
Actively looking	24	15.6%
Not looking	1	0.6%
SSDI	26	16.9%
Homemaker	51	33.1%
Incarcerated	5	3.2%
Retired	1	0.6%
Student	11	7.1%
Other	35	22.7%

Missing 8

Income is reported for those with a family id because this information was not available for individuals who did not have a family id. Income is reported for 179 family ids with this information missing for 21 family ids. More than 60% of the family ids had incomes of $10,000 or less. Only 3.1% of the family ids had incomes of $30,000 or more.

Table 67. Income

	Count	Percent
$0 - $10,000	119	66.48%
$10,001 - $20,000	41	22.91%
$20,001 - $30,000	16	8.94%
$30,001 - $40,000	0	0.00%
$40,001 - $50,000	2	1.12%
$50,000 +	1	0.56%

Missing 21

Table 68 reports the spoken language of clients. Thirty-five clients are not included in this analysis including 32 clients who were pre-verbal and three for whom this information is missing. More than 90% of clients' language was English, Spanish was the language for 7.8% of clients, and 0.4% clients language was Native American.

Table 68. Language

	Count	Percent
English	468	91.8%
Spanish	40	7.8%
Navajo	1	0.2%
Other Native American	1	0.2%

Missing 3

The next set of tables reports on services provided to 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.

Table 69 reports the type of contact. The large majority of services (76.7%) were face to face and 15.5% or 1,030 services were cancelled with another 101 (1.5%) listed as attempted contacts. In the tables reporting services cancelled services are removed from the analyses and tables.

Table 69. Contact Type

	Count	Percent
Face to Face	5,084	76.7%
Phone Contact	286	4.3%
Attempt Contact	101	1.5%
Cancelled	1,030	15.5%
Other	127	1.9%

Table 70 reports services clients received after removing clients who received no services and any clients who only showed cancelled services. As noted earlier 107 clients did not have any services recorded in the PB&J electronic management system and 32 had only cancelled services. Table 70 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 5,598 services were provided to 406 clients at an average of 15.5 services per client and a range of 1 service to a maximum of 74 services.

Table 70. Services and Contacts

	Clients	Services	Percent	Mean	Range
Total	406	5,598	100%	13.8	1 to 74
Case Management	127	656	11.7%	5.2	1 to 52
Child Group	151	886	15.8%	5.9	1 to 32
Consultation	2	7	0.1%	3.5	3 to 4
DI Services	15	34	0.6%	2.3	1 to 6
Evaluation	15	17	0.3%	1.1	1 to 32
Home Visit	84	236	4.2%	2.8	1 to 12
Nursing	2	3	0.1%	1.5	1 to 2
Parent Child Group	245	1,237	22.1%	5.0	1 to 21
Parent Group	102	730	13.0%	7.2	1 to 23
Service Coordination	3	6	0.1%	2.0	1 to 4
Transportation	1	8	0.1%	8.0	8
Other	171	1,769	31.6%	10.3	1 to 42

Table 71 reports the length of services described in Table 70 in minutes. On average services lasted 103.3 minutes and a median of 105 minutes, meaning half the services lasted longer than 105 minutes and half lasted less than 105 minutes. The range in the length of services was 0 minutes (152 services and 2.1%) to 810 minutes or 13.5 hours. Three services were recorded at 810 minutes and all three services were listed as face to face parent groups. Almost 38% of all services were between 121 minutes and 150

minutes and 24.6% were between 31 minutes and 60 minutes. A quick review of cancelled services indicated that 947 or 86.2% of these services were most frequently a Parent Child Group (45.1%), Parent Group (20.2%) and Child Group (25.6%). These three services accounted for 90.9% of all cancelled services.

Table 71. Length of Service in Minutes per Service

	Count	Percent
0	152	2.7
1 to 30	701	12.5
31 to 60	1,407	25.2
61 to 90	492	8.8
91 to 120	222	4.0
121 to 150	2,103	37.6
151 to 180	178	3.2
181 +	339	6.1

Missing 4

Table 72 reports the number and percent of total services provided to the 406 clients who received at least one service. Each client received an average of 12.6 services. Nineteen clients (4.7%) received one service and 36 clients (8.9%) received 35 or more services with one client receiving 74 services.

Table 72. Total Services Provided per Client

	Count	Percent
1	19	4.7%
2 to 5	48	11.8%
6 to 10	91	22.4%
11 to 15	79	19.5%
16 to 20	61	15.0%
21 to 25	29	7.1%
26 to 34	43	10.6%
35 +	36	8.9%

Table 73 reports length of service in hours per client. On average clients received 23.4 hour of services with one client receiving 106.6 hours and 50% of clients receiving more than 19.4 hours of service and 50% receiving less than 19.4 hours of services. In total clients received 9,522.5 hours of service.

Table 73. Length of Service in Hours per Client

	Count	Percent
0 to 2 hours	54	13.3%
3 to 10 hours	81	20.0%
11 to 15 hours	39	9.6%
16 to 25 hours	63	15.5%
26 to 35 hours	70	17.2%
36 to 50 hours	65	16.0%
51 + hours	34	8.4%

Table 74 reports the type of contact for the 5,598 services. Skills coaching accounted for 43.2% of all types of contacts followed by transportation (25.8%). Other included 10 categories including Center, Evaluation, Therapy, Psychosocial, Assessments, and Consultation.

Table 74. Type of Contact

	Count	Percent
Case Management	707	12.6%
Classroom	720	12.9%
Home Visit	226	4.0%
Skills	2,142	38.3%
Transportation	1,707	30.5%
Other	96	1.7%

Table 75 reports whether the service was provided individually or in a group. The vast majority of services were offered in groups (84.8%).

Table 75. Group or Individual

	Count	Percent
Group	4,624	82.6%
Individual	974	17.4%

Table 76 combines reporting services by the type of contact (face to face, phone, and other). Attempted contacts are not included. Face to face contacts accounted for 90.8% of all contacts types and phone contacts accounted for 5.1% of all contact types. Together they accounted for 95.9% of all contacts.

Table 76. Service by Type of Contact

	Face to Face		Phone		Other	
	Count	Percent	Count	Percent	Count	Percent
Case Management	218	4.3%	256	89.5%	102	80.3%
Children Group	883	17.4%	3	1.0%	0	0.0%
Consultation	7	0.1%	0	0.0%	0	0.0%
DI Services	34	0.7%	0	0.0%	0	0.0%
Evaluation	15	0.3%	1	0.3%	1	0.8%
Home Visit	219	4.3%	5	1.7%	1	0.8%
Nursing	1	0.0%	0	0.0%	0	0.0%
Parent Child Group	1,196	23.5%	14	4.9%	20	15.7%
Parent Group	726	14.3%	0	0.0%	3	2.4%
Service Coordination	4	0.1%	2	0.7%	0	0.0%
Therapy	8	0.2%	0	0.0%	0	0.0%
Transportation	1,769	34.8%	0	0.0%	0	0.0%
Other	4	0.1%	5	1.7%	0	0.0%

Table 77 reports the type of service by group and individual delivery. As expected services listed as being provided in groups like children groups, parent child groups and parent groups were typically provided in a group. A few parent child groups were listed as individual. We do not know why this occurred and could be an error in the data. All but 4 of the 1,769 transportation services were listed as group services, we do not know why this occurred.

Table 77. Service Type by Group or Individual

	Group		Individual	
	Count	Percent	Count	Percent
Case Management	0	0.0%	656	67.4%
Children Group	886	19.2%	0	0.0%
Consultation	0	0.0%	7	0.7%
DI Services	28	0.6%	6	0.6%
Evaluation	0	0.0%	17	1.7%
Home Visit	1	0.0%	235	24.1%
Nursing	0	0.0%	3	0.3%
Parent Child Group	1,205	26.1%	32	3.3%
Parent Group	730	15.8%	0	0.0%
Service Coordination	0	0.0%	6	0.6%
Therapy	0	0.0%	8	0.8%
Transportation	1,765	38.2%	4	0.4%
Other	9	0.2%	0	0.0%

Table 78 shows the contact type by group and individual. Almost all the group contacts were face to face while only 50.3% of all individual contacts were face to face, 28.4% were by phone, 9.7% were attempted contacts and 11.6% were other. Other included Collaborative Communication, Collateral Communication, and Paperwork Connected with Family.

Table 78. Contact Type by Group/Individual

	Group		Individual	
	Count	Percent	Count	Percent
Face to Face	4,594	99.4%	490	50.3%
Phone Contact	9	0.2%	277	28.4%
Attempted Contact	7	0.2%	94	9.7%
Other	14	0.3%	113	11.6%

PB&J provided data on the following 6 screenings and assessments:

- North Carolina Family Assessment Scale (NCFAS)
- Adverse Childhood Experiences (ACE)
- Ages and Stages Questionnaire – Social Emotional (ASQ-SE)
- Parenting Interactions with Children: Checklist of Observations Linked to Outcomes (PICCOLO)
- Adult-Adolescent Parenting Inventory (AAPI-2)
- Protective Factor Survey (PFS)

Enough information on five of the six instruments was provided to report beyond the count of assessments administered. Sufficient data was not provided for the NCFAS to conduct any analyses beyond a count of the forms completed. ACE screening scores are reported including the average score and range of scores. The ASQ-SE is reported by the number of questionnaires administered, the count by administration period, the number per client, and the results. The remaining three instruments (PICCOLO, AAPI-2, and PFS) include pre-tests and post-tests which allowed us to conduct paired sample t-tests. The paired samples *t* 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 significantly different and Cohen's D was used measure the magnitude of the effect. This information is presented in the next section for the PICCOLO, AAPI-2, and PFS. The information for each is presented in identical table formats described next.

In each table (Table 79 thru Table 81) the first column lists the domain being test, 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 size of the difference between two variables. The larger the effect size the stronger the relationship between two variables. It is important to measure 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.

Parenting Interactions with Children: Checklist of Observations Linked to Outcomes (PICCOLO)

The Parenting Interactions with Children: Checklist of Observations Linked to Outcomes (PICCOLO) is a checklist of 29 observable developmentally supportive parenting behaviors in four domains (affection, responsiveness, encouragement, and teaching). A PICCOLO observation can be completed with children who are at least 4 months old with follow-up observations at 6-month increments. The PICCOLO measures developmental parenting (Roggman, Boyce, Innocenti, 2008) that includes when parents clap their hands for their child's first step, soothe their frustrated child and read and sing with their preschool child. Positive parenting values support children's development leading to healthy outcomes.

Table 79 presents the results of a paired sample t-test for the initial observation of the PICCOLO compared to the follow-up observation. 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 Affection (51 matched pairs), Responsive (50 matched pairs), and Teaching (49 matched pairs) domains were statistically significantly different between the pre-test and post-test and on average scores on these domains were higher at the post-test period compared to the pre-test period, with higher scores indicating improvement with all three showing medium effect sizes. While the Encourage (51 matched pairs) domain shows a statistically significant difference the effect size was small.

Table 79. PICCOLO Paired Sample T-Test

Scale	Variable	Mean	Standard Deviation	T	sig.	Cohen's d
Affection	Pre-test	7.780	3.214	-3.79	0.000	0.41
	Post-test	9.490				
	Difference	-1.71				
Responsive	Pre-test	6.160	3.531	-3.885	0.000	0.50
	Post-test	8.100				
	Difference	-1.94				
Teaching	Pre-test	5.430	4.257	-3.356	0.002	0.43
	Post-test	7.470				
	Difference	-2.04				
Encourage	Pre-test	7.290	3.716	-3.014	0.004	0.16
	Post-test	8.860				
	Difference	-1.57				

Adult-Adolescent Parenting Inventory (AAPI-2)

The Adult-Adolescent Parenting Inventory (AAPI-2) is an inventory designed to assess the parenting and child rearing attitudes of adult and adolescent parent and pre-parent populations. Based on the known parenting and child rearing behaviors of abusive parents, responses to the inventory provide an index of risk for practicing behaviors known to be attributable to child abuse and neglect. The AAPI-2 includes

five constructs in which a score is derived to provide an index of risk in five specific parenting and child-rearing behaviors:

- Construct A - Expectations of Children
- Construct B - Empathy Towards Children's Needs
- Construct C - Use of Corporal Punishment as a Means of Discipline
- Construct D - Parent-Child Role Responsibilities
- Construct E - Children's Power and Independence

The AAPI-2 includes two form and each has 40 items. Form A is designed as the pre-form and Form B is the post-form. The AAPI-2 is a validated and reliable tool used to assess parenting attitudes.

Staff administered 153 AAPI-2s and this resulted in 56 pairs. There were 41 AAPI-2s that did not have a pair, three were post-AAPI-2s and 38 were pre-AAPI-2s. We do not know why more AAPI-2s did not result in matched pairs.

Table 80 reports the results of the 56 matched pairs of AAPI-2 assessments. Three of the 5 constructs showed statistically significant changes in scores with medium effect sizes all of which showed improvement between the pre-AAPI-2 and post-AAPI-2. This 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.

Table 80. AAPI-2 Construct Paired Sample T-Test Results

Scale	Variable	Mean	Standard Deviation	T	sig.	Effect Size Cohen's d
Construct A	Pre-test	4.91	1.708	-3.285	0.002	0.44
	Post-test	5.66				
	Difference	-0.75				
Construct B	Pre-test	4.52	2.286	-3.975	0.000	0.54
	Post-test	5.73				
	Difference	-1.21				
Construct C	Pre-test	6.09	1.577	-0.932	0.355	0.14
	Post-test	6.29				
	Difference	-0.20				
Construct D	Pre-test	4.63	2.001	-4.208	0.000	0.54
	Post-test	5.75				
	Difference	-1.13				
Construct E	Pre-test	5.44	2.036	-0.132	0.895	0.01
	Post-test	5.47				
	Difference	-0.04				

Protective Factor Survey (PFS)

The Protective Factor Survey (PFS) is a validated pre-post evaluation tool for use with caregivers receiving child maltreatment prevention services. It is a self-administered survey that measures protective factors in five areas: family functioning/resiliency, social support, concrete support, nurturing and attachment, and knowledge of parenting/child development. Table 81 reports the results of a paired sample t-test of the sample of PFS screening tools in which there was a pre and post-PFS. In total the program administered 242 PFS assessments of which 153 were a pre-test and 89 were a post-test. A total of 78 clients had both a pre-test and post-test and Table 81 reports these 78 clients with a matching pre- and post-test.

The interpretation of the paired sample t-test table format and the definition of the various terms was provided earlier and is not repeated here. This includes the importance of the measure of statistical significance and effect size.

Statistically significant changes were found from the per- to post-test period for Concrete Support with a Cohen's d small effect size of .28 indicating improvement in concrete support. There were also small effect sizes that were not statistically significant for Nurturing and Attachment (.20) and Knowledge of Parenting/Child Development (.20) showing small improvements in nurturing and attachment and knowledge of parenting/child development.

Table 81. Protective Factor Survey Paired Sample T-Test

Scale	Variable	Mean	Standard Deviation	T	sig.	Cohen's d
Part 1 – Family Functioning/Resiliency	Pre-test	4.933	1.410	0.723	0.472	0.08
	Post-test	4.818				
	Difference	0.12				
Part 2 – Social Support	Pre-test	4.513	0.997	1.514	0.134	0.15
	Post-test	4.342				
	Difference	0.17				
Part 3 – Concrete Support	Pre-test	2.816	0.952	2.339	0.022	0.28
	Post-test	2.564				
	Difference	0.25				
Part 4 – Nurturing and Attachment	Pre-test	3.632	1.207	1.595	0.115	0.20
	Post-test	3.415				
	Difference	0.22				
Part 5 – Knowledge of Parenting/Child Development	Pre-test	5.410	1.434	1.526	0.131	0.20
	Post-test	5.162				
	Difference	0.25				

Ages and Stages Questionnaire Social-Emotional (ASQ SE)

The Ages and Stages Questionnaire Social-Emotional (ASQ SE) screening is designed to identify social-emotional difficulties in young children, to help guide decisions for further assessment, help determine information/support services families may need, and bridge communication between parents and professionals about child's behavior. The ASQ SE is designed to be administered at intervals and these intervals are listed in Table 82 with the number of ASQ SEs administered. PB&J staff administered 164 ASQ SE screenings. The fewest were administered at 2-months (11 and 6.7%) 6-months (19 and 11.6%), and 30-months (19 and 11.6%) and relatively similar numbers and percent were administered at 12-months, 18-months, and 24-months.

Table. 82 ASQ SEs Administered

	Count	Percent
2-month	11	6.7%
6-month	19	11.6%
12-month	27	16.5%
18-month	29	17.7%
24-month	29	17.7%
30-month	19	11.6%
36 month	12	7.3%
48 month	14	8.5%
60 month	4	2.4%

Table 83 reports the number of ASQ SEs per client. Four clients had 3 ASQ SEs, 24 had two ASQ SEs, and 100 clients had a single ASQ SE administered. This means 32 clients had 2 or 3 ASQ SEs and the large majority had a single ASQ SE.

%

Table. 83 Number of ASQ SE per Client

Number of Screenings	Count	Percent
1	96	75.0%
2	28	21.9%
3	4	3.1%

Table 84 reports whether or not the ASQ SE score was within expectations. The large majority of all individuals screened were within expectations, which means the children were within the expected range of social emotional development and their development appeared to be on schedule. The 27 children who were not within expectations suggests further assessment may be needed.

Table. 84 ASQ SE Within Expectations

	Count	Percent
No	27	16.5%
Yes	137	83.5%

Adverse Childhood Experiences (ACEs)

PB&J administered 137 ACE screens. For each screen the option existed to score a child and two parents. Table 85 collapses the scores to the family by reporting one score. This was done because the data did not adequately indicate who was screened. For example, on any given screen, because of the way the data was provided it was not possible to know if a score of zero was an individual who was screened and scored a zero or if that individual was not screened and for that reason the score was a zero. For this reason we developed a simple rule - if two parents had a score the score of first parent is reported. The vast majority of forms included a score for parent one (129 or 94.2%) and this tended to be the highest score. Two scores are from parent two and 6 scores are from a child where there was no score for parent one or parent two.

The mean or average score was 4.1 indicating that on average screened families, using the method describe above, were at a higher risk for health problems.

Table 85. ACE Screen

	Family	
ACE Score	Count	Percent
0	2	1.5%
1	23	16.8%
2	22	16.1%
3	14	10.2%
4	13	9.5%
5	23	16.8%
6	11	8.0%
7	11	8.0%
8	7	5.1%
9	10	7.3%
10	1	0.7%
Mean	4.2	
Median	4.0	

Table 86 reports client status on the date the data was extracted. The 118 clients with an intake date but no services are not included in this table. On the date we received the data, 154 clients were active in the program and 252 or 62.1% had been closed to services. On average discharged clients were in the program an average of 133 days with a maximum of 517 days and a minimum of 13 days. Table 87 reports discharge reasons.

Table 86. Program Status

	Count	Percent
Active	154	37.9%
Closed	252	62.1%

Table 87 reports the discharge reason for adult clients for whom we were provided this information. The largest number and percent of clients (116 and 38.8%) completed the program. Other common reasons included parent withdrew (18.6%), lost contact (10.4%), clients dropped without placement (9.4%), and family non-compliant (7.8%). Together these 5 reasons accounted for 85% of all discharges.

Table 87. Discharge Reason

	Count	Percent
Family not eligible	1	0.3%
Completed	116	38.8%
Dropped without placement	20	9.4%
Dropped with placement	1	0.3%
Family non-compliant	15	7.8%
Family refused services	14	9.1%
Incarcerated	2	0.7%
Lost Contact	22	10.4%
Parent Withdrew	47	18.6%
Program no longer appropriate	14	4.6%

Staff Interviews

Nine interviews were completed with PB&J staff. On average staff had 4.1 years of work experience with the provider and 10.5 years of total work experience.

Table 88. Year of Experience with PB&J

Years	Count	Percent
0 to 2	2	28.6%
3 to 4	1	14.3%
5 to 6	0	0.0%
7 to 8	2	28.6%
9 to 10	2	28.6%
11 +	0	0.0%

Table 89. Year of Work Experience

Years	Count	Percent
0 to 2	0	0.0%
3 to 5	1	12.5%
6 to 10	4	50.0%
11 to 15	0	0.0%
16 to 20	1	12.5%
21 +	2	25.0%

Two of the interviewees had a high-school education, 5 reported having a B.A. and one a masters' degree.

Table 90. Education

Education	Count	Percent
HS	2	25.0%
Some College	0	0.0%
BA	5	62.5%
MA	1	12.5%
PhD	0	0.0%

Missing 1

Five of the staff interviewed reported clinical staff titles and four reported they were administrators. One clinical staff member reported having a certification.

Table 91. Staff Type and Certifications

Staff Type	Number of Staff
Clinical	5
Administrator	4
	Yes
Clinical Certification	1

The interviews were useful for helping us understand how the program works from the perspective of staff. This included how clients 'move' through and engage in the All Faiths program.

According to the interviews, potential clients and others learn about PB&J services from different sources, including Lovelace case management, Presbyterian, Children Youth and Families Department, schools, and through word of mouth. Staff reported community outreach is used to spread word about the program, and this has been going on for many years. Interviewees agreed the program has deep roots in the community and is well known. Because they've developed solid and trusting relationships within the community, they are able to focus on providing services rather than on outreach.

When a prospective client referral is received, either through walk-ins to the office, or by phone calls, the front office is responsible for starting the preliminary screening. This appears to be a brief informal screening, where the front office staff confirm some broad eligibility criteria and disqualifiers, like being currently incarcerated. The front office documents the referral using the referral form, if it appears that the prospective client is eligible, and passes this information to the intake coordinator staff. Because PB&J provides a wide array of different services, staff are also able to provide internal referrals to various services in which the client can participate in simultaneously.

An intake coordinator then contacts the source of the referral and obtains the prospective client's information, including contact information. They then contact the referred individual/family, and schedule an intake appointment. At this point the referred individual/family is considered a client. During the intake appointment, which can be done as a home visit or completed at the PB&J offices, intake paperwork is completed and the client needs are discussed.

While one interviewee reported there was no eligibility criteria to receive PB&J services under the ACE funding, the remainder of the interviewees noted the child and/or primary caregiver(s) of the child client needed to have experienced an adverse childhood event. Staff explained the majority of their clients had all experienced some form of trauma, whether or not the clients felt comfortable sharing the details of those experiences with staff at PB&J. Completion of the ACE screen was also discussed in more detail with the staff. It was noted that it is usually done during the intake appointment with the intake coordinator, however, it can be very intrusive and clients may not always feel comfortable reporting every experience. In such instances, if the data appears inaccurate in some way, the screen is sometimes re-administered by the case manager.

Following intake and within a short period of time, the intake coordinator and the clinical manager discuss client needs and case manager/staffing capacities, and assign the client to a case manager. The case manager is responsible for providing home visits and additional case management services, which occur as needed, often on a weekly basis. Various assessments are administered including the North Carolina Family Assessment Scale (NCFAS), the Ages and Stages Questionnaire Social Emotional (ASQ-SE) form, the Individualized Family Service Plan (IFSP), the Protective Factor Survey (PFS), the Parenting Interactions with Children: Checklist of Observations Linked to Outcomes (PICCOLO), and the Adult Adolescent Parenting Inventory (AAPI-2).

PB&J staff reported using the Nurturing Heart Approach and the Circle of Security curriculum. The Nurtured Heart Approach emphasizes the Three Stands, which includes ending the endorsement of negative behaviors, reinforcing positive behaviors, and maintaining and demonstrating clear, fair, and consistent boundaries and rules. The Circle of Security is an attachment-based model that focuses on enhancing the relationship between the primary caregiver and child.

According to the interviews, group, family, and individual therapy are provided internally and are referred out to external providers, while intensive case management was reported to be provided internally. A wide variety of other services were described as being provided including vision and dental checks, meal assistance and meal boxes, assistance in emergency utility payment, and consistent transportation to the PB&J campus on a regular basis, which is scheduled around the needs of the families.

Across the interviews, staff reiterated the importance of serving their clients "where they're at," and as holistically as possible. Specifically, staff described the importance of understanding what the clients' needs were, but also their particular barriers that prevented them from receiving those services. They agreed that the clients that they served were often the most marginalized and hardest to reach because they often not only needed case management and therapy, but also needed assistance with their utilities, transportation, and food assistance. The staff emphasized that primary caretakers are forced to prioritize the most important needs, like food insecurity, that they can't access treatment or food if they are physically unable to access those services due to a lack of transportation. Across the staff interviews, every single person expressed some sentiment of pride that they were able to provide transportation, utility assistance, and food assistance. One interviewee noted:

> *"…we've always thought of PB&J as if you are not hungry and you have a full stomach, it just makes for a better environment. It really does. When we bring the families here and we have the groups, we help them. We know they are here and we feed everybody… We provide transportation. Yes. We are part of a program with the city where we buy the monthly bus pass*

for 10 dollars. So, we buy a stack of them, you know? That comes from donations. But also, we have our own PB&J bus transportation. That's one thing that the county does participate in and we're so very grateful. Because part of our buses, they pay for some drivers and they pay for some of the utilities. I mean, the gas and the oil and the maintenance. That is so crucial to the program. It really is."

Interviews described the discharge process. Clients either disengage from services due to a lack of engagement or lack of responsiveness, or they successfully complete the program. A successful discharge includes discussion of future plans. Individuals may still qualify for services after they are discharged, and many families remain in touch by calling and chatting, even years after they've discharged.

Discussion

PB&J focus was on family based services, including child and caregiver therapy, group therapy and psycho-educational parenting groups, and case management. PB&J provided the most complete set of client level data, including the largest variety and most complete set of demographic variables, the most complete service data, and a variety of screening and assessment forms including matching pre- and post-tests. The nine staff interviews were useful in understanding the program design and various roles within the program.

Clear operationalization and definitions of primary and secondary clients as well as differentiating individual clients from family units, was only partially clear in the PB&J program design. PB&J provided clear client data which allowed us to definitively know the number of families and unique clients they served.

Performance data and interview data showed that PB&J proposed a relatively clear referral process design, and both sources found that process is implemented consistently. Staff interviews suggested most staff and administrators, even those not directly responsible for the incoming referral process, were relatively knowledgeable of the process and agreed upon their adherence to the implementation. Performance measure data were helpful in documenting the number and sources of the incoming referrals.

Further, client data and staff interviews suggested staff were knowledgeable of the screening and assessments administered, the services provided, as well as the discharge process. Client data reported the counts and outcomes for screening and assessment tools, types and counts of services, and the length of time for services. The performance measures thus provide some general support for their program design and implementation, but not the processes. Staff interviews provided the most insight and information for understanding the processes of screening and assessment, service delivery, and discharge. Because the staff interviewed were diverse and had varying responsibilities, some administrators were not always knowledgeable about clinical services, and some clinical staff were not knowledgeable about the administrative processes. This was to be expected. Despite this, most staff had a broad understanding of their program design and intended implementation. They also were able to describe when certain screens and assessments were administered, for whom they were administered, and how that information was used to guide treatment and services. As with the other three providers, it would be beneficial to collect and report data to support the use and implementation of evidence-based practices and the utilized curricula. PB&J reported utilizing the Nurtured Heart curricula and the Circle of Security curricula, though there is no explicit data measure to serve as support. Within the performance measure narrative,

PB&J did describe various training efforts for staff in the use of different curricula, though it was not directly connected to the services provided to the families.

PB&J also collected and reported various outcome measures within the performance measure reports and also provided several of those assessments in the client data. Because that data consists of raw scores for pre and post assessments, we were able to also determine some preliminary outcomes of their program design and services.

PB&J provided a solid example of how the particulars of a program design and its actual implementation might change and shift over the course of time, yet the actual provision of services, treatment, and subsequent data collected, remained constant. The curricula in which PB&J sought to provide as well as the actual services (parenting groups, case management, etc.) were implemented as proposed and designed.

Health Sciences Center (HSC) Programs

Because the three HSC programs did not participate in the full evaluation we provide a brief program description and review monthly performance measure data, which were reported to DBHSand provided to our office.

The Adverting Disparities in Outcomes by Building Engagement (ADOBE) Project

Program Description

The ADOBE project design includes four components:

1) a comprehensive medical and legal home for youth released from the Bernalillo County Youth Services Center (YSC),
2) home-based navigation,
3) school liaison services, and
4) evaluation activities and report generation.

The program design focuses on youth who reside in Bernalillo County and who were incarcerated in the Bernalillo County Youth Services Center (YSC). Prior to being released from YSC, youth receive information from the YSC medical and nursing team, the Community Services Worker staff, and home navigators about the ADOBE Project. The youth enter the ADOBE project by agreeing to receive navigation services from ADOBE, coupled with primary medical care, psychiatric care, or care coordination with the young person's primary medical provider and/or psychiatrist. Other youth with juvenile justice system involvement may enter ADOBE services via referrals from Juvenile Probation, Juvenile Court Judges, pre-adjudication programs, other programs such as the Protecting and Empowering Girls program at YSC, the UNM Law Clinic, and community providers.

Youth and families who accept ADOBE services receive appointments made by the navigators with the administrative assistant to the ADOBE Clinic at the North Valley Family Medicine Center (FMC) in 3 to 10 days after discharge. Each young person has an assigned navigator who conducts outreach to the family of youth on their caseload. Family members who have difficulties accessing mental health, primary health, or substance use disorder treatment services may also enter clinical services in the ADOBE Project.

Upon entering the YSC, youth are asked to complete a short screening questionnaire covering demographic information, medical needs, and legal needs. And upon entering the ADOBE project, youth complete more detailed legal needs and medical and behavioral health questionnaires at time of discharge from YSC to improve the warm handoff from services in YSC to the ADOBE Project.

After enrollment, youth and their family sign agreements for services and releases of. The navigators meet with youth after discharge from YSC and work with them and family members to complete assessments such as the self-sufficiency instrument (www.selfsufficiencystandard.org/), the conflict tactics scale (http://www.icpsr.umich.edu/files/PHDCN/wave-3-instruments/13689-ctss.pdf), the Alabama Parenting Questionnaire (https://cyfar.org/sites/default/files/PsychometricsFiles/Parenting%20Questionnaire-Alabama%20(parents%20of%20children%206-18)_0.pdf), and the SEEK Life Stressors Checklist and the Personal Supports Questionnaire. In addition, navigators present the youth and family members with the short version of the Brief ACE Instrument 2017 (Helitzer, Graeber) to evaluate the history of ACEs.

Performance Measures

Table 92 reports ADOBE performance measures. We review ADOBE reported performance measures between July 2017 and June 2020. Most of the reported measures are consistent across the three reporting years with a few slight differences. For example, ADOBE did not always report differentiations between new and continuing clients making it difficult to determine the unique number of clients served. Additionally, the number of new and continuing client visits to psychiatry are counted within the number of new and continuing Family Medicine Center (FMC) visits from July 2018 through June 2019. Beginning in July 2019 through June 2020, new and continuing client visits to psychiatry are counted as a unique measure.

Referring to the Table 92 below, the first measure reported by ADOBE includes the sources of incoming referrals. As proposed, the majority of incoming referrals to the ADOBE program originated from within the juvenile justice, with 524 of the 624 total incoming referrals identified as 'Juvenile Justice' The specific juvenile justice source was not listed.

Between July 2017 and June 2020, ADOBE reported 117 ACE assessments. Of the 117 assessments, 31 had low scores of 0-3 and 86 scored high, between 4 and 10. The ACE assessment was the only assessment data reported in the performance measures. Other assessments listed in their contract were not reported in the performance measures including the Conflict Tactics Scale, the Alabama Parenting Questionnaire, the SEEK Life Stressors Checklist, and the Personal Supports Questionnaire.

On average ADOBE reported 12 days between discharge from YSC and the youth receiving their initial screening and assessments, which was close to the 3-10 proposed days.

Three performance measures pertained to services provided, by type and time, and clients served. As part of their program description, ADOBE provided comprehensive medical and legal services, school liaison services, and home-based navigation. Service activities reported within the performance measures included visits to case management, psychiatric visits, primary care physician (PCP) visits, school liaison visits, behavioral health provider visits, Family Medical Center (FMC) visits, and law clinic visits. Further, performance measures included the counts of clients served and minutes/hours of services provided for case management and for school liaison services. Between September 2017 and June of 2020, ADOBE reported 5,961 visits for new and continuing clients. ADOBE reported providing 5,166.83

hours (2.48 years) of case management services and school liaison meetings. Length of time of services were not provided for the other four activities.

Of the 5,961 visits, 700 were reported as new client visits. This included 114 visits to FMC, 94 visits to PCP Medical, 50 visits to psychiatry, 218 case management visits, 147 school liaison meetings, 43 behavioral health visits, and 34 law clinic visits. Overall, the mix of reported services in performance measures match those services described in the program design.

Client outcome measures were reported in the performance measures. Within the performance measures, ADOBE reported successful discharge, disengagement from services, number of clients who returned to YSC, and number actively participating in educational goals. These measures generally reflect the broader goals for the program design, which includes successful discharge from the ADOBE program and reduced recidivism, defined as a return to YSC. Between October 2017 and June 2020 ADOBE reported 11 individuals had successfully discharged from services, 165 individuals had disengaged from services, and 1,088 individuals had actively participated in educational goals. ADOBE reported 80 clients returned to YSC, 15 returned to YSC after 0-1 appointments with ADOBE, and 66 returned to YSC after 1 or more appointments at ADOBE.

Table 92. ADOBE Performance Measures

Number of Referrals Received	This measure reports the number of referrals by month by referral source. This includes the number of youths referred to the program including self-referral and other BHI providers.
ACEs Scores	ACE scores are provided by month and count by low score (0-3) and high score (4-10). The measure also includes the percent of high scoring clients.
Average Number of Days Following Discharge from YSC a Youth Receives Initial Screening and Assessment	This measure reports the average number of days between a youth being discharged from YSC to when they received their initial screening and assessment. This measure is the monthly average number of days.
Visit Type	This measure reports the number of client visits by month and the type of visit they received. This measure represents duplicate individuals within the month.
Client Service by Time	This measure reports the number of hours provided for case management and school liaison by month. This measure includes duplicate individuals.
Number of Clients Served	This measure reports the number of clients served by month. This measure reports the number of youths' contacted, new clients, continuing clients, new secondary clients, and continuing secondary clients.
Client Outcomes	Client outcomes report client outcomes by month. Client outcomes include discharge, disengaged, and returning.
Collaboration with BHI Providers	This measure reports monthly collaboration with BHI providers. This measure counts the number of newly establish partnerships.
Type of Insurance	This measure reports the number of individuals monthly with Medicaid, commercial insurance, and no insurance.
Client Demographics	Reported monthly demographics include gender, age by category, race, ethnicity, income level by category, and number of referrals.

Office of Community Health (OCH)

Program Description

The OCH program provides core service using community health workers (CHW) within the UNM Pediatric Emergency Room to children (aged 0-5) and their parents or primary caregivers. The services include initial screening using the WellRx, the ACEs, and client stratification, which identify adverse childhood experiences, risk factors for child abuse, social determinants of health, and to identify client needs and subsequent referrals. CHWs funded through this project were trained to administer the WellRx screening tool comprised of eleven questions. The WellRx tool was created by the Office of Community Health (OCH) to identify social determinants of health (SDOH) such as food insecurity, homelessness, and unemployment, and identify current client service needs.

Additional services included health education, general information about community resources, assistance with enrollment in public benefits, referrals/assistance with community agencies and follow up, in-depth clinical assessment of children and parents, and systems advocacy to remove institutional barriers. This process begins at the time pregnant women and parents of children (ages 0-5) seek health care services at the UNM Pediatric Emergency Room, as they are screened for ACEs and SDOH. Between 11:00 am and 11:00 pm, a UNM Pediatric Emergency Room Triage provider identifies families for screening, and alerts the community health workers of the family if that family is not in a critical crisis. Client characteristics include being an adult parent who has multiple or complex unmet needs and reports feeling unhealthy; have had a minimum of one Emergency Room visit within the last year; are currently experiencing homelessness and disconnected from services; are undocumented and/or limited-English proficient (LEP) immigrant who does not understand how to access existing resources and/or have run into barriers trying to navigate the system. The program focuses on low-income children in homes currently experiencing ACEs and the impact of the toxic stressors listed above.

Individuals with an ACE score of four or more are referred to the UNM Department of Psychiatry and Behavioral Sciences where more in-depth assessments can be conducted with parents and their children, which can be followed with appropriate treatment services

Performance Measures

Table 93 reports the OCH performance measures from August 2017 through June 2020. Some of the measures were not collected in the same manner over the span of the three years. For example, the number of baseline screenings, which included parents screened, children screened, and families screened, were not all collected for the entire reporting period. Parents screened were reported between August 2017 and June 2018 and beginning July 2018 primary patients and siblings screened were added to the measure. Between July 2019 and June 2020, OCH added screened families to the measure. OCH did not differentiate between new and continuing clients making it difficult to determine the unique number of clients served.

OCH reported screening 2,902 parents between July 2017 and July 2018 and did not list screenings for siblings. During the second and third year, OCH reported screening 2,496 parents, 132,544 siblings under the age of 18, and 175,730 siblings aged 0-5. The number of siblings screened is suspiciously high and was largely driven by the count of screenings listed in 4 months with 40,000 screenings or more. Most other months listed fewer than 200 screenings.

Over the reporting period, 4,943 ACE assessments were administered, with 247 individuals declining or refusing to complete the ACE assessment, 463 (9.9%) clients scoring high between 4 and 10, and 4,233 (90.1%) clients scoring low of 0-3. Additionally, the program reported administering 2,951 WellRx screens.

Performance measures also included various intervention services, including health education and referral services, in-depth behavioral health assessments and clinical assessments, and early childhood education participation. Of these measures, OCH reported providing 3,000 clients face to face interventions with community health workers, providers, and partners, with the time spent per client per intervention appointment reported as 443 minutes or 7.4 hours. Additionally, OCH reported providing 2,296 families with health education, 1,209 families with referrals to social services, 1,511 families were provided referrals to primary care physicians (PCP's), and 402 families were provided referrals to home visiting. OCH did not report the results of the referrals. A total of 116 patients were reported as having participated in the early childhood education program. A total of 25 in-depth psychological clinical tests were completed and 118 community health workers were trained to provide assessments,

Collectively, the performance measures reported by OCH reflected the services and activities provided within the program design.

Table 93. OCH Performance Measures

Unduplicated Number of Screenings	This Measure reports the number of unduplicated parents who were screened and partially screened. This measure includes ACEs and Social Determinants of Health.
Number of Individuals Screened at Baseline	This measure reports the number of individuals screened by month. This includes parents, siblings, and families.
Interventions	This measure reports the number of clients who received face to face intervention with CHW, a provider, or a partner. This measure also reports the average time spent on the intervention per person or per event by month.
Number of Individuals Scored as High or Low Risk	This measure reports the unduplicated number of high risk and low risk scores.
ACEs Scores	ACE scores are provided by month and count by low score (0-3) and high score (4-10). This measure also reports the average high score by month.
Social Determinates of Health (SDH)	This measure provides by month the number of families screened and the average SDH score. This measure also breaks down the SDH by question but it is unclear how those are calculated.
Number of Families Provided Health Education, Information and Referral	This measure provides by month the type of referrals, education, and information that was provided to families. This measure is broken into three categories family services, intensive interventions, and comprehensive interviews.
In-depth Behavioral Health and Clinical Assessment	This measure provides the monthly total of individuals who received health and clinical assessments by provider as well as training.
In-depth Clinical Assessment	This measure reports the number of psychological tests completed and the number of CHW's trained to provide assessments by month.

Collaboration with BHI providers	This measure reports by month the number of clients referred to other BHI programs.
Early Childhood Education Program Participation	This measure reports by month the number of primary patients and additional children in the family participating in the early childhood education program.
Number of Collaborative Community Partners	This measure reports the number of new partnerships by month with other community providers
Client Insurance and PCP	This measure reports the type of insurance clients are using by month. This includes SSDI Medicare, commercial insurance, and self-pay.
Emergency Department and Hospitalization Frequency	This measure reports the number of individuals who had more than two emergency department visits, average times they visited the emergency department, as well as the average number of times hospitalized.
Client Demographics	Reported monthly demographics include gender, age by category, race, ethnicity, pregnancy status, income level by category, and housing.

Young Children's Health Center (YCHC)

Program Description

YCHC was funded to increase their capacity for screening, assessing, and serving parents and children who are vulnerable and require support services, including youth transitioning from within systems of juvenile justice or foster care, those with behavioral health/mental health needs, persons with physical and or developmental disabilities, veteran families, single parent families, victims of domestic violence, and other marginalized populations. As part of the funding YCHC provided screening and identification, short-term counseling and service coordination services, formal behavioral health services, parenting groups, community forums/meetings, and community engagement and parenting support.

The program design is flexible and responsive in its service delivery and accepts families and children referrals from a variety of sources. Referral sources include self-referrals and from other family members, neighbors, local schools, and friends. Additionally, clients were also referred by insurance carriers, the UNMH newborn nursery, medical and/or nursing staff based on information obtained via screening and triage processes, and public school Health and Wellness Teams. Once identified, a member of YCHC's Family Services Program contacts and meets with the child/family to develop rapport as well as gather information about the family and assess the child and family's needs and strengths. YCHC staff assist the family in accessing the appropriate service either internally or via referral to another community agency.

All clients seen for medical services are screened for ACE's during the nursing triage process and/or during well child visits via the use of the SEEK and a set of surveillance questions. Clients referred for social work services are initially screened for immediate safety risks and then given assistance with developing a safety or crisis prevention plan if needed. YCHC staff work collaboratively with the family to assist them in developing goals and a plan for services. The plan for services is individualized and is based upon family members' unique strengths, needs, culture, history, developmental phases, circumstances, and ability to participate in service related activities. Clients referred for formal behavioral health services receive a formal intake and diagnostic assessment, and have a formal treatment plan to guide the delivery of services.

Through these core services, YCHC sought to achieve the following goals: 1) identify children who have been impacted by ACEs, trauma, and toxic stress, 2) Parents, children, and families report feeling safer, better supported, and more stable, 3) Improved mental health and behavior, 4) Improved parenting and family support through home visitation services and parenting groups, 5) Increased community awareness, engagement, and collaboration, and 6) Decreased social isolation and increased positive parent child interaction.

Performance Measures

Table 94 reports YCHC performance measures beginning in July 2017. The collection and reporting of some of the measures varied over the three-year time frame. For example, between July 2017 and June 2018, YCHC reported the number of clients served by month and continuing clients for short-term counseling and service coordination, however, that measure was not continued through the second and third year. Beginning in July 2018 through June 2019, YCHC reported the number of clients served for the current month and the number of clients who were provided a brief intervention and service coordination. Beginning in July 2019 through June 2020, YCHC reported the number of clients served by month, the number of client brief intervention year to date, the number of hours of service by month, and the number of hour's year to date.

Two of the performance measures described in the table below, included counts of outside referrals and internal referrals. According to the performance measures, YCHC received 970 provider referrals from YCHC internally, and 238 from outside agencies. Beginning in July 2018 through June 2020, YCHC reported 20 referrals from other ACE programs.

As part of the program design, YCHC administered screenings during well child and acute visits Since July 2017, YCHC reported completing 34,005 screenings of duplicated children during acute and well child medical appointments using the ACE screen and the SEEK questionnaire.

Intervention services provided by YCHC included formal behavioral health therapy and counseling, short-term counseling and service coordination, psycho-educational parenting group sessions and quarterly community forums. Similar to ADOBE and OCH, YCHC reported services, which aligned with the program design. For example, YCHC provided 205 psycho-educational parenting group sessions with 247 participants and 791 clients were reported to have received 866 service hour of behavioral health therapy and counseling.

YCHC also reported 81 individuals participated in 14 community forums between September 2017 and March 2020. YCHC reported offering neighboring program activities to promote community engagement to 11,675 families, though it was not specified whether these were duplicate families or unique.

The performance measure reviews are fairly reflective of the proposed design and processes.

Table 94. YCHC Performance Measures

Number of Outside Referrals	This measure reports the number of unduplicated internal and external referrals by month.
Internal Referrals	This measure reports the number of unduplicated internal referrals by month.
Screenings	This measure reports the number of screenings provided by month. The reporting was not consistent reporting both duplicated and unduplicated numbers over the reporting period.
Provide Brief Intervention	This measure reports by month the number of unduplicated clients served. This measure also reports the number of clients who received brief intervention by the total year to date.
Provide Formal Behavioral Health Therapy and Counseling	This measure reports the monthly unduplicated number of clients who were served for therapy and counseling.
Psycho-Educational Parenting Group Sessions	This measure reports the number of parenting sessions provided and the number of parents receiving services by month.
Quarterly Community Forums	This measure reports the number of community forums and the number of participants at the forums by month.
Neighboring Program Activities	This measure reports by month the number of children and the number of adults participating in neighboring activities. Individuals are duplicated within the monthly reports.
Work Collaboratively Between all Providers	This measure reports the number of meetings, collaborative sessions and new established partnerships by month.
Client Outcomes	This measure reports by month the number of cases reviewed client's assessment scores. It is unclear how the assessment scores are being reported.
Client Demographics	Reported monthly demographics include gender, age by category, race, ethnicity, income by category, and housing.

Discussion and Conclusion

This report documents the evaluation of the four community based ACE providers using a mixed method approach that included a review of program materials including proposals, contracts, program logic models, and process maps developed with the providers; a limited review of performance measures; the analysis of primarily deidentified client data provided by the programs; and staff interviews. We also briefly review performance measures for the three HSC programs that did not actively participate in the evaluation, which is described elsewhere.

Discussion

Our evaluation relied on program materials along with staff interviews to describe the four community based providers. It is important to remember program materials provide information that span approximately four years and do not document how these programs were implemented and changed during the course of the funding period. The program materials should adequately describe what the community based providers were contracted to do and how.

Performance measures submitted to the County by the programs on a monthly basis were intended to help the County monitor the performance of the programs. We used these measures to help describe the programs and broadly their performance. The performance measures often did not correlate to the client

data as expected. Because of this finding we seldom used the performance measures in combination with the client data to report how the programs were implemented and functioned. Further review of the performance measures in comparison to program materials could help describe the programs but this was not the primary goal of using these measures. As noted in the introduction the performance measures were intended to assist with program monitoring and they were not designed to be part of the evaluation. With that in mind, we had hoped to use the performance measures to enhance and expand on the client data. In general, we found this was not possible and often times the performance measures conflicted with the client data.

The collection and analysis of primarily deidentified client data helped us understand how clients were referred, screened and assessed, how they became clients, how they were served and discharged. As described earlier, in a variety of places, providers experienced challenges providing data and we experienced challenges in organizing, compiling, cleaning and reporting these data. We expected this to happen and did not understand at the outset how large of a problem this would become. Because the performance measures and client data often did not correlate and complement each other we relied on client level data. This is the first time these types of data have been available for an evaluation and he had hoped to use this to a greater degree for the evaluation. More effort should be made to understand the connection between the performance measures and client data. With the experiences gained from this evaluation future research with the ACE providers and other funded BHI projects should go more easily concerning the collection and use of performance measures and client data. The results from this study can be used to help with the design of measures, implementing the collection and reporting of measures, and using these measures to document performance.

We also completed a large number of interviews with staff, including administrators, with topics including referral sources, the intake process, evidence based practices, case management, service delivery, discharge, and aftercare and follow up. These interviews were helpful in describing from the viewpoint of staff how programs were implemented and operate.

We have found that using data from multiple of sources allows us to better and more completely understand how programs are implemented and operate than any single source of data.

Performance Measures

While it varied by program, in general, we found programs had some difficulties and challenges reporting performance measures. This is partly a result of this being a new experience for providers and a relatively new practice for the DBHS and DBHS staff. DBHS administrators and staff are still learning about this practice and how best to monitor performance. Providers have not yet adjusted to collecting, compiling and reporting this information reliably. In our evaluation it was apparent the ability to track and report performance measures is a challenge for providers and the size of the challenge and quality of data varied by provider.

Performance measures should be reviewed and where possible revised to more closely measure program performance. For example, it may useful to adjust how clients are counted by requiring the reporting separately of new clients and discharged clients and making the distinction clear regarding what defines an intake and discharge. At the end of any given reporting period, subtracting discharged clients from new clients should provide the count of current clients. This will require that providers more clearly define what is a client and when an individual becomes a client and when a client is discharged and that

this information more carefully and clearly be collected and reported by programs. It is also important to define how families are reported.

There were also challenges reporting screening and assessments. Providers proposed to use a variety of screenings and assessments and frequently it was not possible to match what providers proposed to client level data and performance measures. We are convinced some of this disconnect is related to changes in the contracted time period from what was proposed to changes in what was used. It is also apparent some of the screening and assessment data may not have been provided because it may have been in a paper form, another automated format like a MS Excel or another database, or in a scanned format. It was also difficult to know when a particular screening and assessment or other form was being used and if was being used for a segment of clients. We could not track these changes using the performance measures and/or client data. This finding was not unexpected. As programs become implemented and work through the process in how they operate this happens. A method should be developed to more clearly document why, when and how this occurs. Two of the four providers provided screening and assessment data that were used as pre- and post-tests. Unexpectedly we found a large number of pre-tests without matching post-tests and at times and more surprising found post-tests with no matching pre-tests. The results of matching pre- and post-tests is described later along with the implications of the results.

Screening, assessments and other forms reported in the performance measures should have been available in the electronic data. It is not clear whether these screenings, assessment and other forms were not used, were in a paper format, or were in an electronic format and we were not provided the data. It would be useful for contracted providers and for the County to ensure these types of data are automated. Further the County should consider developing a process that ensures providers adequately describe the purpose and use of screening, assessments, and other forms and that they are being used for the stated purpose.

We recommend that the County provide on-going training for providers in performance based contracting that includes the philosophy and purpose as well as the practical aspects of accurately collecting and reporting. The County should also train their staff on how performance based contracting works, how measures should be constructed, how they should be reported, and how they should be used to monitor performance.

Client Data

Client data is typically a primary source of information for program evaluations. These data help us understand how individuals process through a program from referral to intake to discharge and follow up. The more completely these data exist from beginning to end the better researchers are able to conduct evaluations. These data should include demographic information to describe the population from referral to discharge; service data to describe the number, type, length, and provider of services; discharge information, and screenings and assessments using standardized instruments that describe individuals needs and risks and that can be administered at intake and at some period of follow up to provide a measure of change.

Client data was a challenge for a couple of reasons. First, because we could only receive de-identified data for minors it was a challenge for programs to provide these data. Providers and our staff typically had a series of conversations about providing data that led to the data we were provided. An amendment to the New Mexico Children's Act, that would have allowed for identified data, was not passed in the most recent legislative session (55th Legislative Session January 2021 – March 2021). This amendment

would have added a research exception and would have removed the challenge directly related to deidentified data. Community based providers often do not have the resources and expertise and their electronic management systems are typically not designed with this purpose in mind and are primarily focused to business operations. Second, our ability to assist was limited because we were unable to review identified data to make suggestions on how best the data might be provided. Third, we were unable to collect the data either directly from paper records, from provider electronic management systems or design a study that might have systematically sampled client records. Fourth, evaluation studies impose a burden on programs that are the subject of the evaluation for which they are often unprepared.

While we received client level data from all four community based providers the amount of data, the type of data, and quality varied. Under different circumstances it may have been possible to incorporate on-going conversations with providers to clarify what was received and request additional information. In our review of client data, even considering the challenge of acquiring, compiling, cleaning, and reporting deidentified data, it was clear some of the data was incomplete and unreliable. It is not clear why this happened and it would be useful to understand this in more detail. This could be done by following up with providers.

Generally, client data did not match with performance measures and further more detailed reviews of the data combined with conversations with providers could help us understand why this happened. Very importantly this included the number of individuals referred, the number of clients admitted and discharged, services provided, and the number of screenings and assessment completed.

The ACE screen was commonly used to measure client risk. PB&J screened families with the ACEs and the average score for PB&J families was 4.1 indicating that on average screened families, using the method describe earlier in the PB&J section to compile scores, were at a higher risk for health problems. On average the ACE score for All Faiths clients screened was 4.2 again showing a higher risk. The average ACE screen score for screened Centro Savila clients was 4.1 indicating clients were at higher risk. While the ACE screen was listed as a form used by New Day, ACE screen data was not provided in the client data. ACE screen data was reported in the performance measures as counts of scores between 1 and 3 and 4 and 10. New Day administered the ACE screen to 57 clients, with 15 scoring between 0 and 3 and 42 scoring between 4 and 10 (74%).

For the three providers using the ACE screen, and from whom we received client level data, clients screened were at higher risk. The New Day performance data, reported by score level, showed that almost 75% of the screened clients had a score between 4 and 10 which placed them at higher risk. The ACE screen was the only form used by all four providers that provided a measure of client need or risk.

Other measures were used including by New Day that used an inventory/survey to measure emotional intelligence referred to as the Emotional Quotient Inventory (EQ-I) and Emotional Intelligence Survey (EIS). The results of this tool provide a measure of emotional intelligence, functional intelligence and social capital. These data were only available in the performance data and generally showed the majority of clients on each measure were high functioning. PB&J used the Ages and Stages Questionnaire Social-Emotional (ASQ-SE) screening that is designed to identify social-emotional difficulties in young children. PB&J and All Faiths used the AAPI-2 to assess parenting and child rearing attitudes. PB&J also

used North Carolina Family Assessment Scale Generals Services and Reunification (NCFAS-G-R), the Protective Factors Survey (PFS), and the Parenting Interactions with Children: Checklist of Observations Linked to Outcomes (PICCOLO). Data from the AAPI-2, PFS, and PICCOLO were described and discussed in the related provider section and again below.

When the services provided by a program are conducive to the use of screenings and/or assessments that are designed to be administered at two time periods or more the County should consider requiring providers to screen and assess their clients at intake and at a follow up time period using appropriate instruments. This would allow the programs and the County to have a measure(s) of change that would provide some outcome information. Two of the four community based providers proposed to use such instruments and provided enough data for us to match paired samples and use a paired sample t test to provide a measure of statistical significance and Cohen's d which provides a measure of the magnitude of the effect.

Both All Faith's and PB&J used the Adult-Adolescent Parenting Inventory (AAPI-2) which as described earlier is a validated, reliable, and well-studied inventory designed to assess the parenting and child rearing attitudes of adult and adolescent parent and pre-parent populations. Based on the known parenting and child rearing behaviors of abusive parents, responses to the inventory provide an index of risk for practicing behaviors known to be attributable to child abuse and neglect. The AAPI-2 includes five constructs in which a score is derived to provide an index of risk in five specific parenting and child-rearing behaviors:

- Construct A - Expectations of Children
- Construct B - Empathy Towards Children's Needs
- Construct C - Use of Corporal Punishment as a Means of Discipline
- Construct D - Parent-Child Role Responsibilities
- Construct E - Children's Power and Independence

All Faiths administered at least one AAPI-2 to 197 clients. Of these 174 (88.3% were) administered one AAPI-2, 16 had 2 AAPI-2s, and 7 clients had 3 AAPI-2s. We were able to create 22 matched pairs. We do not know why the large majority (88.3%) of clients did not have a second AAPI-2.

PB&J staff administered 153 AAPI-2s that resulted in 56 matched pairs. There were 41 AAPI-2s that did not have a pair, three were post-AAPI-2s and 38 were pre-AAPI-2s. Of 97 individuals who were administered an AAPI-2 there were 41 (42.3%) individuals who did not have a matching AAPI-2. PB&J had a much higher percent of clients (56.7%) who had a matching AAPI-2 compared to All Faiths (11.7%). We do not know why more AAPI-2s did not result in matched pairs.

Having matching AAPI-2s allowed us to conduct a paired sample t-test. The paired samples t test compares two means that are from the same individual. In the case of the AAPI-2 the means differences from the pre-test and post-test can be used to determine whether there is statistical evidence that the means between the paired observations are significantly different.

Table 95 combines the results of the All Faiths and PB&J analysis. 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. In Table 95 medium effect sizes are shown in red and large effect sizes in green. 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 two of the three of the 5 constructs and a large effect size for one of the constructs with one construct with a medium effect size showing a worsening in the construct. Empathy Towards Children's Needs showed a small statistically significant improvement with a medium effect size and Parent-Child Role Responsibilities showed a large statistically significant improvement with a corresponding large effect size. Children's Power and Independence showed a statistically significant change with a large effect size showing a worsening in this construct between the pre-AAPI-2 and post-AAPI-2.

Table 95 AAPI-2 Results

	All Faiths		PB&J	
Scale	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

For PB&J two other pre- post-tests were available one of which showed improvement from the baseline to the follow up.

The Parenting Interactions with Children: Checklist of Observations Linked to Outcomes (PICCOLO) is a checklist of 29 observable developmentally supportive parenting behaviors in four domains (affection, responsiveness, encouragement, and teaching). The Affection, Responsive, and Teaching domains were statistically significantly different between the pre-test and post-test with higher scores indicating improvement with all three showing medium effect sizes. The Encourage domain showed a statistically significant difference with a small effect size.

The Protective Factor Survey (PFS) is a pre-post evaluation tool for use with caregivers that measures protective factors in five areas: family functioning/resiliency, social support, concrete support, nurturing and attachment, and knowledge of parenting/child development. There was a small statistically significant change in the Concrete Support measure with a small effect size that showed a worsening in the measure. There were no statistically significant changes in the other four measures.

Service Data and Discharge

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 96 summarizes selected client level data variables we received and were able to compile and report. These data can be used to generally summarize the services provided by the programs. This includes 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. As a reminder the number of clients served are reported using client data as are all the other data types listed in Table 96. Earlier we reported we focused on client level data because of the large differences between client level data and the performance measures that we could not reconcile. For example, New Day reported 60 Life Skill Coaching clients and 60 Leadership Class clients or 120 total clients. This is 42 or 53.8% more clients than were found in the client data. The majority of clients New Day reported were attendees in life skill classes (670 clients). The data we received from New Day reported the number of attendees by class (Table 54) and did not identify individual attendees that we could have used to count the number of individuals served.

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 or a subset of clients. All Faiths reported 275.1 days as the average length of service and New Day reported 174.7 days.

As noted elsewhere if we would have been able to have identified data we would have had more complete data to report.

Table 96 Provider Client Data 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	

Staff Interviews

As noted earlier 29 staff interviews were completed and the number varied by provider based on BHI funded staff and those who consented to participate in the interviews. Providers with more interviews provided a larger sample for analysis and generally more information.

Table 97 which was reported earlier summarizes the interviewees 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 97 Interviews

Provider	Interviews	Average Years of Work Experience	Range in Years of Work Experience	Average Years Worked at Provider	Range in Years Worked at Provider
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

The interview included a number of sections that helped us document the design and implementation of the programs from the viewpoint of staff in a fairly linear process. The interview was used as a guide for a conversation to elicit more detailed information. Interview sections included program information (i.e.

program goals), the intake process (i.e. use of screenings and assessments and how the intake process works), service delivery (i.e. types of services provided), discharge (how the discharge process works and how success is defined), and after care (i.e. is after care part of the program).

Program Design and Implementation

Staff interviews provided support for the program designs as well as for program implementation.

Interviews with staff reported on the design of the programs. For example, All Faiths staff interviews provided key information about the design of the program, specifically how clients enter the program, which elaborated on the client data. Because all of the clients served by All Faiths are eligible to receive services, it was not clear when a referral became a client. During the interviews it was clarified that All Faiths referred to their clients who received services through ACEs funds as those participating in the Family Wellness services. Clients who were identified as needing additional services and support were entered into their data systems, along with every other client, and a service code was billed when the client had received a service funded through the ACEs funding. Understanding the internal process of identifying clients and providing services through ACEs funds was integral to understanding how clients entered the program. Interviews with All Faith staff also provided support for the emphasized importance of expanded case management services, especially for activities not typically Medicaid billable, such as attending counseling or individualized education plans (IEP) at the clients' school. As described in the program description, All Faith said expanded and individualized case management services were the glue to their services. This was iterated across the staff interviews in different ways, but was best evidenced through their program design in which their target population was all their clients.

On the other hand, other program intake processes were less clear, and staff interviews did not significantly contribute to understanding how the program worked. For example, how New Day clients moved from different services, such as the Safe House and one-on-one life skills coaching or through drop-in life skills group classes was not clear. Having the opportunity to interview only three staff at New Day limited the diversity of information we were able to gather. The number of interviews influenced the variety and depth of data collected by provider. More interviews provided a broader perspective. New Day had the fewest number of interviews and so we had less information compared to All Faiths, Centro Savila, and PB&J for which there were more interviews. This provided more detailed information and more depth into how the program were designed and implemented, including outreach, incoming referrals, intake and screening, assessment, service provision, discharge, and aftercare or follow up services.

Program Outreach

All of the programs reported outreach activities being part of their program. Generally, the interviews did not provide detailed information on outreach activities, and outreach activities appeared to be less formalized as part of each program's design, and to be a less formal activity. Generally, interviewees who reported participating in outreach activities described activities that fit within each program's design.

Incoming Referrals

Most providers reported having staff devoted to working with referred clients. Of the remaining staff who did not report having any referral responsibilities, another small portion reported they still knew the

processes. Staff with responsibilities for incoming referrals were knowledgeable about the processes and procedures.

All Faith staff interviews were useful in confirming whether their program adhered to their proposed program design, specifically in relation to how incoming referrals were handled. Generally, the staff confirmed they adhered to the program design's regarding incoming referrals.

One of 7 Centro Savila staff reported handling incoming client referrals. Of the six staff who indicated having no responsibilities within the incoming referral process, one reported feeling knowledgeable about how the incoming process worked, but was not able to full describe the process. The Centro Savila staff person responsible for handling incoming referrals was knowledgeable about the process and was able to describe the process in detail. Though a process was in place at the time of the interviews, it was apparent this process had been developed overtime. The process involving incoming referrals was effective and worked for the program.

Two New Day staff indicated they were responsible for handling incoming referrals. One staff member was responsible for receiving them internally within the Safe House program, whereas the other staff member was responsible for the life skills academy incoming referrals and broad oversight of the process. Through the staff interviews, it was apparent the incoming referral process had evolved over time as the program became implemented. As new services were added to the programming at New Day, it became possible to make more internal referrals. Similarly, as new staff joined the team, new responsibilities arose. Overall, the staff interviews indicated that they had adhered to the program designs' handling of incoming referrals, though they had been experiencing some growing pains requiring the processes to be tweaked over time.

Staff interviews indicated the incoming referral process had been adhered to as proposed in their program design. As described in the process flow, PB&J handles incoming referrals in a relatively standardized manner, but also allows for personalization for individual clients. Having a multi-step process of confirming eligibility and determining needed services was standard practice, however, they also offer an initial home visit or office visit depending upon the clients' needs and preferences.

Intake Process

While only a couple of All Faiths staff reported part of their job duties included the intake process most interviewees could describe aspects of the process. The intake process was not well described in the program design and so we lack details of the design. And this makes it difficult to determine the extent to which All Faiths practice matched the designed intake process. Based on the proposed broad and general program design All Faiths adhered to the intake process. The process flow illustrates the many various avenues in which clients can enter the program, which is designed specifically to be individualized and based upon clients' needs. All Faiths also utilizing a triaging process, which is described in the process flow, because of the high demand of services and the capacity of the program. This was anticipated in the program design, though the details of how clients were triaged was not described in the program design.

As described in the incoming referral section, Centro Savila utilized one staff to handle the incoming referrals and subsequent client intakes. Though this was not part of the original program design, this

process was used because it was decided to be more efficient and productive. Having one staff in charge of completing the intakes made the process more reliable. According to client data approximately 20% of clients who received services did not receive an intake. Centro Savila adjusted their intake process and for reasons we do not know approximately 20% of all clients did not receive an intake.

All three New Day staff interviewed indicated having a role in the intake process, with all three agreeing they were knowledgeable about that process. One interviewee described a process that matched with the process described in the scope of services, performance measures, and process flow. The other interviewees described a more limited roles in the intake process that also the program description. The interviews suggest some adherence to the intake process that was part of the program design.

Two of three PB&J staff who indicated having a role within the intake process said they were knowledgeable of the process. The other interviewee had a more limited knowledge. Four staff who did not have active responsibilities within the intake process still indicated they had knowledge of the process and were able to describe various aspects. Two staff reported they did not have a role in the intake process, nor did they have knowledge of that process. As noted in the incoming referral section above, PB&J staff interviews suggested clear adherence to their program design. The incoming referrals and intake processes were proposed to be standardized in some manners, such as the receiving of the referral, the reaching out to the client and confirming their information, and the scheduling of an intial appointment. The other component of the intake process was tailored to the clients' needs and preferences, for example, having the appointment held at the client home or at the PB&J office. Staff also consistently and uniformly described the types of information that was provided to the clients at the intake appointment and the various documentation, forms, and assessments completed at the intake appointment.

Service Delivery

All Faith's staff that reported providing services to clients were all able to adequately describe the ways in which those services were provided in detail. Staff agreed that service provision was designed in the program to be client-centered and individualized with a focus on providing case management and therapy services to clients in instances that those services were not paid for through Medicaid. This required tailoring the service approach to client needs. Based upon the staff interviews and the client data, All Faiths adhered to their service delivery.

Centro Savila adjusted service delivery processes and procedures from the initially planned service delivery design. Staff interviews indicated these changes were minor and did not impact the overall case management program design. Client data showed individual therapy, family therapy, and collateral therapy accounted for more than 71% of reported client services and case management services accounted for 7.9% of services. While staff reported utilizing different instruments to assess clients on an on-going basis in the interviews, staff did not uniformly report which instruments were utilized, or when they were administered. Assessment data beyond the ACE screen was not available in the client data..

One New Day interviewee reported providing services to Safe Home clients and another interviewee reported providing one on one life skills coaching. We did not interview staff that led drop-in life skills coaching classes. Interview findings and client data collectively showed one-on-one life skills coaching services were provided as proposed in their program design. We also found drop-in life skills classes were implemented. Generally, based we found the classes were aligned with the content proposed in their program design. New Day proposed ongoing assessment as a component of their service delivery in the

program design. Based upon staff interviews and client data, the extent to which New Day adhered to their proposed program design as it related to the types of assessments administered and when those assessments were administered, is unclear. Staff reported administering different assessments, including the Progress Pathways, EQi, and the All About You, though this was not described by staff uniformly. How and when the previously listed assessments were administered were also not well reflected within the client data. For example, counts of identified 'pathways' or areas to work on were included in the client data, but it was not clear if those were needed pathways or completed pathways. Furthermore, within the client data, 'self-sufficiency' items were listed, which included emotional intelligence, functional intelligence, and social capitol, though which assessment they belonged to remained unclear. Subsequently, it is not apparent that New Day was able to adhere to the assessment administration as originally proposed.

PB&J staff interviews found staff had varying roles and responsibilities within the program, and an overall strong understanding of their own roles and responsibilities as well as some understanding of other program processes and procedures for which they were not directly responsible or in which they were involved. As proposed in their program design, PB&J staff provided a wide array of services including case management, parenting classes, parent and child group classes, child classes, consultations, evaluation, nursing, and transportation. Staff were able to describe how services were delivered in their program, specifically as it pertained to case management, group classes, and assessments. Data further confirmed not only that staff knew which services were supposed to be provided, but also that they were provided. Specifically, client data supported the primary services included of child group classes, parent group classes, and case management services. Moreover, PB&J proposed administered ongoing assessment of clients, which entailed a large battery of tools, including the North Carolina Family Assessment Scale (NCFAS), Ages and Stages Questionnaire – Social Emotional (ASQ-SE), Parenting Interactions with Children: Checklist of Observations Linked to Outcomes (PICCOLO), Adult-Adolescent Parenting Inventory (AAPI-2), and the Protective Factor Survey (PFS). Staff interviews and client data provided support that PB&J had administered the listed instruments to their clients as they had originally proposed. Overall, based upon staff interviews and client data, it is apparent that PB&J adhered to their original program design as it pertained to all aspects of their service delivery, including case management, parenting and child group classes, and assessment.

Discharge and Follow-up

All Faiths proposed a relatively non-descript discharge and follow-up process in their program design. Despite this, staff interviews provided insight on the more specific details of the discharge and follow up process. Based upon that information, as well as through client data, it appears that All Faiths was able to adhere to their program design in client discharges and follow up processes. Specifically, this included the completion of a discharge form, designation that the client was being discharged successfully, due to their completion of treatment goals, or disengaged, indicating they had missed several appointments or disengaged from services. Unfortunately, follow up data is not collected in client data or performance measures, though it was described in the staff interviews. Moreover, All Faiths did not propose an in-depth process for follow-up procedures. Despite this, All Faith staff were able to describe the follow-up process relatively uniformly across staff. Staff noted that after a period of time after being discharged, former clients would need to go through the full intake process again to begin receiving services again. However, if the former client desired to receive services again within the specified window of time, they would be able to bypass the full intake process and be able to receive some of those services again. Moreover, clients often called or emailed staff when they were successful in a particular endeavor, such as obtaining a job, just to share the good news with that staff.

Centro Savila staff interviews described a relatively unstandardized client discharge process. As with the other three providers, Centro Savila reported discharges as either successful discharges, meaning they were successful in completing their treatment goals, or as a disengagement, meaning they lost contact and/or disengaged from services. Centro Savila staff reported that after 3 cancellations or no-shows to appointments, they were supposed to discharge the client, though staff also noted they considered other important factors, such as whether that client was normally very good about being on time to appointments and such. Client data can't be referred to for confirmation as discharge data, such as dates or designation were not provided consistently across clients.

Similar to the other providers, New Day did not propose a detailed discharge and follow up process. Broadly, the discharge process consisted of the designation of a discharge as either successful in the instance that the client completed all their treatment goals, or as disengaged, in the case that the client no-showed or disappeared from services. As with All Faiths, staff noted that clients did sometimes disengage and that often happened when the client was not yet ready to engage in services but that they did often come back. In many instances, staff took into consideration other factors before discharging the client. Client data included some discharge dates for clients but not specific reasons or differentiate whether the client was 'discharged' or 'disengaged' and so we could not determine discharge status. Because staff interviews suggested those differentiations were made, even though it was not evidenced in the client data, we note New Day adhered to their proposed discharge process.

PB&J staff interviews indicated all staff reportinged they provided services to client also reported having client discharge responsibilities. All of the staff reporting having those responsibilities were knowledgeable of the process and were able to describe it. Importantly, as with the other providers, PB&J did not propose a detailed process for discharging clients, though a procedure was generally followed. Clients were designated as successfully discharged once they completed all their treatment goals. Clients could also be discharged if they disengaged from services or no-showed appointments a certain number of times, which they were then designated as 'disengaged'. Client data supported the staff interview reports that PB&J followed and implemented a discharge process as broadly proposed within their program design.

Conclusion

Eight providers were funded in FY 2018 (July 2017) in a four-year funding cycle. They included University of New Mexico (UNM ADOBE), University of New Mexico Office of Community Health (UNM OCH), University of New Mexico Young Children's Health Center (UNM YCHC), All Faiths, Centro Savila, CLN Kids, New Day, and PB&J. In FY 2019, seven providers renewed their contracts, leaving four community-based providers and three UNM providers. UNM Health Science Center (HS) providers did not actively participate in the evaluation and only their BHI required monthly performance reports are included in this report. The four-year funding cycle for the ACEs program ends in June 2021.

The seven programs, as reported in Table 1, were contracted to provide services to at risk children and their families and the funding pays 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. Following that we found the New Mexico Children's Act also did not include an exception for research and so our study largely relies on deidentified data, which as noted in a number of places posed a variety of challenges for the programs providing the data and for us in organizing, compiling, and reporting these data. We were not able to overcome some of these challenges.

Changes to the Mental Health Code, beginning July 2019, allows for the use of identified data for research with programs serving adult clients follow federal guidelines and state law. Proposed changes to the Children's Act that would have allowed for identified data for minors following the changes to the Mental Health Code and result in the resolution to some of the challenges described in this report dealing with deidentified data did not occur in the most recent legislative session (NM 55th Legislature January 2021 – March 2021). Some of these challenges will remain as long as we are only allowed deidentified data for minors for research. Currently we are able to acquire identified data for adults following federal guidelines and state law that rely on a human subject approval from a federally approved Institutional Review Board (IRB)

We had hoped to use performance measure data to supplement client data and to compare across the two data sources. This was not possible primarily because there was often a large disconnect between the two sources and what we had expected would be comparable data including referrals, admissions and discharges, clients served and services, and screenings and assessments. For this reason, we broadly reported performance measures and focused on client level data. We used performance measures to supplement client data when this was possible and relevant. Our time frame to complete this report did not allow for multiple and detailed meetings with program provider staff that may have led to clarification of some of these differences.

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 suggests the providers designed best practice programs but we lacked detail to show how these 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.

References

Center for Disease Control and Prevention (2016). Injury Prevention & Control: Division of Violence Prevention. Retrieved from: https://www.cdc.gov/violenceprevention/ACEstudy/about.html

Community Partners, INC. (2015). Behavioral Health Business Plan (pp. 1-99) (Bernalillo County Behavioral Health Initiative, Bernalillo County Board of County Commissioners). Community Partners, INC.

De Young, A. C., Kenardy, J. A., & Cobham, V. E. (2011). Trauma in early childhood: A neglected population. Clinical Child & Family Psychology Review, 14, 231–250. doi:10.1007/s10567-011-0094-3

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M.P., Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. American Journal of Preventive Medicine, 14, 245–258.

Gaensbauer, T. J. (2002). Representations of trauma in infancy: Clinical and theoretical implications for the understanding of early memory. Infant Mental Health Journal, 23, 259–277. doi:10.1002/imhj.10020

Howe, M. L., Toth, S. L., & Cicchetti, D. (2006). Memory and developmental psychopathology. In D. Cicchetti & D. J. Cohen (Eds.), Developmental psychopathology, Vol. 2: Developmental neuroscience (pp. 629–655). Hoboken, NJ: Wiley.

Kanel, K. (2015). A guide to crisis intervention (5th ed.). Belmont, CA: Brooks/Cole.

Lieberman, A., Chu, A., Van Horn, P., & Harris, W. (2011). Trauma in early childhood: Empirical evidence and clinical implications. Development and Psychopathology, 23, 397–410.

Read, J., van Os, J., Morrison, A. P., & Ross, C. A. (2005). Childhood trauma, psychosis and schizophrenia: A literature review with theoretical and clinical implications. Acta Psychiatrica Scandinavica, 112, 330–350. doi:10.1111/j.1600-0447.2005.00634.x

Williams, H. L., Conway, M. A., & Cohen, G. (2008). Autobiographical memory. In G. Cohen & M. A. Conway (Eds.), Memory in the Real World (3rd ed., pp. 21-90). Hove, UK: Psychology Press.

Appendix A.

Base BHI Provider Interview Guide

General Interviewer Instructions

This interview guide is designed for the BHI and is to be used with most funded programs. Separate addendums, to be used in conjunction with this interview guide, may be used for specific funded projects (i.e. ACEs) and/or specific funded providers (i.e. Hope Works). This interview guide is intended to help direct the conversation toward topics and issues we want to learn more about. The topics have separate headings.

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 you must note this as appropriate. All scale questions have a line to record the numeric answer, please use this instead of circling, x'ing or checking the appropriate response.

- *The interviewer's attitude can strongly affect the quality of the participant's answer, so it is important to **not** administer the interview in a hurried manner and ensure the participant fully understands the instructions. Remain accessible for questions.*
- *Remind participant that all answers are confidential.*
- *At the end, make sure participant answered ALL questions.*

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.

This is meant as a guide to introducing the study and yourself. Prior to beginning the interview, you must describe the study and have the interviewee sign the consent. They may choose to not be audio recorded and the interviewee must initial the appropriate section. The interviewee must print their full name and sign the consent prior to beginning and the interviewer must also print and sign the consent. The interviewee must be offered a copy of the consent so be sure to have two copies.

You can paraphrase the following which comes from the introduction to the consent:

You are being asked to participate in a research study that is being done by the Institute for Social Research at the University of New Mexico. This research is studying the public benefit of the Bernalillo County Behavioral Health Initiatives (BHI) in Bernalillo County, New Mexico. You are being asked to participate in this study because you are currently an administrative person of a public benefit program funded by the Bernalillo County Behavioral Health Initiative using funds from the BHI gross receipts tax and/or City of Albuquerque funds. The Bernalillo County Department of Behavioral Health Services (DBHS) using BHI funds is funding this study.

Introduction

Administrative Information

First, I need to take a few minutes to ask a few administrative questions. Is it all right if we begin? *(Answer any questions the interviewee might have prior to beginning the interview)*

1. Interview Date: _____/_____/_____

2. ISR Interviewer: _____

3. BHI Program Name: _____

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

5. Interviewee Name: _____

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:
(*please list any certification and/or licenses you have and provide a short description, if necessary*)

A. _____/_____

B. _____/_____

C. _____/_____

9. How many total years of work experience in this field do you have? _____
(*The answer can include fractions of a year*)

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. How many hours per week do you work? _____

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

14. Briefly describe your role in the agency/program (i.e. what is your job):_____

_____

_____

_____

Program Information

Now I'm going to ask you a few questions about the program.

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

_____

_____

2. How does your program define 'consumer' or 'client'? _____

_____

3. Within your organization, how is information about clients shared? (*Probe: in staff meetings, by electronic records, informally, etc.*)

_____

_____

4. If you work with partners or other providers outside your agency, how is information about clients shared with them _____

_____

5. Do you feel this program is successful in retaining participants? _____

1. Strongly disagree 2. Disagree 3. No opinion or uncertain 4. Agree 5. Strongly agree

6. Can you explain your response: _____

_____

_____

7. What do you feel is the most accurate measure of the effectiveness of the program? _____

_____

_____

8. Does your program have an electronic client management information system? : Yes_____ No____ Don't Know_____

9. If no, how do you track clients?_____

10. If yes, which system do you use? _____

11. How useful is your client management system for you in your job? _____

1. Very useful 2. Somewhat useful 3. Somewhat useless 4. Very useless

Can you explain your response:_____

_____

Outreach

Next, I have a few questions about outreach and how potential clients and other providers learn about the program. *(If the interviewee says outreach is not part of their job function but they express an interest in answering the questions or knowledge about outreach ask the questions. If not skip to the Incoming Referrals.)*

1. Is outreach one of your job functions? Yes_____ No_____

2. Do you have knowledge of the outreach process, even if it is not part of your job function? Yes_____ No_____

3. How do potential clients learn about your program? (*Probe: Where do you go to let people know about your services? On which outreach method do you spend the most energy/resources*?) _____

_____

4. How do other providers learn about your program? (*Probe: Where do you go to let people know about your services?*)

_____

_____

Incoming Referrals

Next, I have a few questions about incoming referrals to the program. *(If the interviewee says this is not part of their job function but they express an interest in answering the questions or knowledge about outreach ask the questions. If not skip to the next section.)*

Directions to interviewer: Ask questions below and fill out table as appropriate and directed.

1. Are handling referrals one of your job functions? Yes_____ No_____

2. Do you have knowledge of the referral process, even if it is not part of your job function? Yes_____ No_____

If no, skip to next section, if yes,
3. Briefly describe how potential clients are referred to this program? (*Record name of referral source in table. 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], other BHI funded providers in other funded programs, etc.*) _____

_____

_____

Then ask,
4. You mentioned [referral type], how do referrals from this referral source typically come?" (*Probe: calls, discuss client, etc.*)**.**

5. When you get referrals from [program name], how would you describe the fit of the potential client to your program?

3. Referral Type	4. Method of Referral	5. Fit of Referral (*i.e. appropriate in likely meeting eligibility criteria*)

6. Are there other appropriate referral sources from which you would like to see referrals come from? : Yes_____ No_____

If no, skip to Intake Process.

7. If yes, what difference would it make to your program to get referrals from this source? _____

_____

8. Why do you think you are not receiving referrals from them? _____

_____

Intake process

Screening

Next, I have a few questions about how individuals are screened for the program.

1. Is screening a person for program eligibility one of your job functions? Yes_____ No_____

2. Do you have knowledge of the screening process, even if it is not part of your job function? Yes_____ No_____

If interviewee indicates they do not perform this task nor do they have knowledge of the process, then skip to General Intake section. If interviewee indicates having knowledge of the process and can describe it, proceed to the next question.

3. Could you briefly describe how screening works? _____

4. To the best of your knowledge, what are the major characteristics of this program's target population (*i.e. age range, gender, school grade, other demographic characteristics, criminal history, family history, etc.*)? _____

_____

_____

_____

5. What are the eligibility criteria for this program?_____

_____

_____

_____

6. How do you verify that those criteria have been met? _____

_____

7. What type of client appears to do well in this program? _____

_____

8. What type of client does not appear to do well in this program? _____

_____

9. Are there exclusionary criteria for this program? : Yes_____ No_____

10. If yes, what are they? _____

11. When people are ineligible for this program, what happens to them next? *(Prompt, if applicable, how do they help them to the next step?)* _____

_____

General Intake Process

We are about half way through the interview and I appreciate your help. I'm going to move to the next sections and ask you a few questions about the general intake process for the program.

1. Is the intake process one of your job functions? Yes_____ No_____

2. Do you have knowledge of the intake process, even if it is not part of your job function? Yes_____ No_____

If interviewee indicates they do not perform this task nor do they have knowledge of the process, skip to Assessments. If interviewee indicates having knowledge of the process and can describe it, proceed to the next question.

3. Would you please describe how your intake process works (once potential client has been screened)? (*This should include asking about the use of intake tools/forms and their names, the length of process, when it takes place, who performs this task, is this done formally, etc.*)

_____

_____

_____

Assessments

Thanks and 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.

1. Is assessment one of your job functions? Yes_____ No_____

2. Do you have knowledge of the assessment process, even if it is not part of your job function? Yes_____ No_____

If interviewee indicates they do not perform this task nor do they have knowledge of the process, ***then skip to Service Delivery****. If interviewee indicates having knowledge of the process and can describe it, proceed to the next question.*

Use the table below to record responses to questions 3-5. Write the name of the assessment (3a) and check the box if the assessment is conducted at intake (3b).

3. When you have a new client, what assessments are administered at or near the time of intake? *List each assessment in 3a.*

4. At what other times is this administered? *If an assessment is given more than once, record the general timing (this may be in days, months or some other frequency) in (4a) and check the box in 4b if the assessment is administered at discharge (4b).*

5. How is this information used? *Record answer in (5) Use. Ask about the period of first administration (i.e. intake or some other period) and if there is a time frame in which the assessment must be completed.*

3a. Assessment Name	3b. At Intake	4a. Frequency (in days	4b. At Discharge	5. Use
	☐		☐	
	☐		☐	
	☐		☐	
	☐		☐	
	☐		☐	
	☐		☐	
	☐		☐	
	☐		☐	
	☐		☐	
	☐		☐	

Service Delivery

This is one of the last sections and may take a few minutes to complete and some discussion. We'll get through this as quickly as possible. We are interested in how services are delivered or provided to clients in the program. Ok, if I begin?

1. Do you know if the program uses an evidenced based best practice and/or curriculum? _____
   1. Yes 2. No 3. Don't know or unsure
2. Can you describe the evidence based practice and/or curriculum and how it is used? _____

_____

_____

_____

3. Is service provision one of your job functions? Yes_____ No_____

4. Do you have knowledge of the services provided, even if it is not part of your job function? Yes_____ No_____

If interviewee indicates they do not perform this task nor do they have knowledge of the process, then skip to Discharge. If interviewee indicates having knowledge of the process and can describe it, proceed to the next question. Please indicate in the second column with a "K" if the interviewee is only describing a service process based upon their knowledge of it, and not as a function of their job.

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

- **What services your program provides.**
- **Whether the service is provided in-house, by referring out, or both;**
- **The way in which your program provides the components of a service (frequency, intensity, duration, etc.);**
- **Whether the service is intended to serve individuals with mental health diagnoses, substance use disorders, dual diagnosis; or something else.**
- **And, whether the services are intended for children, adolescents, adults, and/or families"**

So, we will begin with a broad set of services, by category, and if that service is relevant to your program, we can talk about it in more detail. As we talk, it may become clear that your program provides a service I don't mention (*and not in the table*) or provides a particular service in a different manner than we've described. We want to make sure the information we collect is an accurate representation of your programs' services.

Services

Service	**K**nowledge of (K), **Not provided(0), Provided In House (1), Referred Out (2), Both (3)**	*Describe (should include intensity/dosage, any follow-up, and identify whether it is for:* **1. MENTAL HEALTH ONLY, 2. SUBSTANCE USE DISORDERS, or 3. DUAL DIAGNOSIS**
Individual Therapy One-on-one therapy		
Family therapy Therapy which involves all (relevant) members at the same time within a family to discuss and resolve past and/or ongoing problems		
Group therapy Group of patients meet to discuss problems and solutions together under the supervision of one or more therapist		
CASE MANAGEMENT		
Intensive case management		
Strength based case management		
Clinical case management		
Generalist case management		
OTHER SERVICES		
Crisis intervention		
Peer support		
Individualized treatment plan		

Services	**K**nowledge of (K), **Not provided (0), In House (1), Referral Out (2), Both (3)?**	**Describe (should include intensity/dosage, any follow-up, etc.**
MEDICAL SERVICES		
Dental care		_____
Vision		_____
Hearing		_____
Pregnancy and family planning		_____
Health care home		_____
Medication management		_____
LEGAL SERVICES		
Child Support		_____
Legal Services		_____
Re-entry transition plans		_____
Identity Document Acquisition		_____
SOCIAL SUPPORTS		_____
Child care		_____
Education/GED		_____
Employment		_____
Financial Literacy		_____
Food Security		_____
Heat & utilities		_____
Housing		_____
Transportation		_____
OTHER, SPECIFY:		
		_____
		_____

Discharge from Program

We're almost done and I would like to ask a few questions about how clients leave the program.

1. Is discharge one of your job functions? Yes_____ No_____

2. Do you have knowledge of the discharge process, even if it is not part of your job function? Yes_____ No_____

If interviewee indicates they do not perform this task nor do they have knowledge of the process, ***then skip to After Care****. If interviewee indicates having knowledge of the process and can describe it, proceed to the next question.*

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

_____

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

_____

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

_____

6. Do you create discharge OR transition plans? Yes_____ No_____

7. Please describe what a typical discharge plan includes _____

_____

After Care/Follow-up

This is the last topic. I have a few questions about after care or follow up with clients.

1 Does your program offer after care or any follow-up for your clients? Yes_____ No_____

2 Is aftercare or any follow-up one of your job functions? Yes_____ No_____

3 Do you have knowledge of the aftercare/follow-up process, even if it is not part of your job function? Yes_____ No_____

If interviewee indicates they do not perform this task nor do they have knowledge of the process, ***then skip to next section****. If interviewee indicates having knowledge of the process and can describe it, proceed to the next question****.***

4. What does it entail? _____

_____

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

_____

6. For how long do you offer this service? _____

_____

Conclude the Interview.

Well this is the end of the interview, I appreciate your time. Is there anything I missed or that you would like to add?

Interviewer Notes: Observations made by interviewer

- *Describe the location of the interview.*
- *Any important observations about interview location? (*
- *Did participant have questions about interview, how the information will be used, or other questions?*
- *Did participant have any issues with interview or questions?*
- *Were there any distractions during interview?*

Interviewer Notes: