# Bernalillo County Behavioral Health Initiative: Education and Training Program Review

**Prepared by:**

Alexander Severson, Ph.D.

**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

Education and Training (E &T) is a suite of eight behavioral health programs developed in coordination between Bernalillo County Department of Behavioral Health Services and seven different behavioral healthcare providers in Bernalillo County designed to address behavioral health professional training and community education needs in the community. The foci of the E & T programs is twofold: to use the existing social-scientific and clinical evidence-base on E & T programs to (1) increase knowledge among those in relevant professions on how to best serve the behavioral health needs of clientele using a "train-the-trainer" model and (2) increase knowledge and awareness among community members on how to interact with and offer support to individuals living with behavioral health issues in Bernalillo County (Orfaly et al. 2005).

The training dimension of these interventions broadly targets those in relevant professional fields who interact with community members living with behavioral health issues on a regular basis including first-responders, educators, peer-support workers, and licensed clinicians. The primary goal of these training sessions is to increase knowledge among training participants about a specific dimension of mental health care provision or delivery with the expectation that by providing evidence-based training opportunities to relevant professionals, client-side behavioral health outcomes such as social service utilization, rates of recidivism, homelessness, and drug usage will decline in consequence as participants become more effective at service delivery.

The educative dimension of these interventions broadly targets those in the community who are either interested in behavioral health or who interact with those living with behavioral health issues on a regular basis. The primary goal of these educative sessions centers on increasing community-level awareness of the resources available to those who are suffering with behavioral health issues and increasing public understanding of specific behavioral health challenges. The expectation of these education interventions is that by increasing the understanding of behavioral health among professionals and community members, health professionals and community members will be less likely to stigmatize mental illness and substance abuse and will be more likely to de-escalate crisis events where they occur. In the long term, the expectation is that these education interventions will increase social service utilization and treatment usage, reduce the incidence of mental health crises, and increase the quality of life for those currently living with behavioral health conditions in the community.

Across two distinct waves of funding in 2018 and 2019, Bernalillo County awarded seven behavioral health providers grant money totaling $3,000,000 to provide E & T interventions to professionals and community members in Bernalillo County. The University of New Mexico Institute for Social Research (ISR) was contracted by Bernalillo County to provide technical assistance and evaluation of programs funded through the Behavioral Health Initiative including the suite of E &T programs (BHI 2015). In what follows, we provide a brief overview of cumulative performance metrics across all providers, specific terms of each provider's contracts, a summative review of each provider's most recently provided performance measures[1], a review of provider-specific performance measures where applicable, and provider-specific barriers to, and successes with, program implementation. We conclude this report by identifying common process themes across providers, comment on some limitations of the reported performance measure data,

[1] This report contains all performance measures submitted to Bernalillo County Department of Behavioral Health Services (DBHS) by December 29, 2020. One of the providers reported performance measure data through October 2020, five of the providers reported performance measure data through November 2020, and one of the providers reported performance measure data through December 2020.

and identify some ways in which this research can progress longer term into subsequent outcome evaluations.

**General Overview of E & T Programs**

A total of 7,901 program participants attended 318 E & T sessions from March 2019 through November 2020. While all E & T sessions addressed timely behavioral health questions in the community, they varied considerably both within and across providers in terms of the specific types of behavioral health issues addressed, the specific form the E & T sessions took (e.g., one-shot webinars vs. multi-day in-person multi-hour sessions), the size of each E & T session, and the intended target population (e.g., first responders vs. community members interested in behavioral health). Table 1 below provides an overview of each provider's training goals, target populations, and total program reach – measured as number of trainings and number of training participants – through November 2020.

*Table 1. Overview of Provider Training Goals, Target Populations, and Program Reach*

| Provider | Training Goals | Target Population | # of Trainings | # of Participants |
|---|---|---|---|---|
| All Faiths | • Trauma-informed training classes for violent conflict de-escalation | • First Responders<br>• Educators | 19 | 905 |
| ARCA | • Better understanding symptoms and implications of traumatic brain injuries (TBI)<br>• Provide resources to offer support for those suffering from TBI | • Employees of DBHS<br>• Professionals and community members who interact with brain injury survivors | 23 | 206 |
| BCCHC | • Reduce the stigma associated with Opioid Use Disorder (OUD)<br>• Increase understanding of the appropriate use and availability of Medication Assisted Treatment (MAT)<br>• Provide education and awareness of OUD and MAT treatment resources through website development | • Interested community members | 37 | 547 |
| MITC - 1 | • Increase # of people trained in motivational interviewing (MI) techniques | • Behavioral health providers<br>• Community members<br>• Trainers | 27[2] | 975 |

[2] MITC-1 conducted a number of motivational interviewing coaching sessions not counted here as formal trainings.

| | | | | |
|---|---|---|---|---|
| | • Increase MI listening skills<br>• Reduce compassion burnout<br>• Increase MI proficiency through a series of trainings | | | |
| MITC - 2 | • Create Behavioral Health Training Institute<br>• Provide experiential workshops | • Healthcare providers<br>• Community members who interact with those who suffer from behavioral health issues | 24 | 1,159 |
| NAMI-NM | • Implement standardized courses and support groups for those living with behavioral health conditions | • Middle and high school students<br>• Adults who have experienced symptoms of mental health condition<br>• Veterans and caregivers of veterans | 8[3] | 969 |
| NMBLC | • Raise awareness of behavioral health issues in the Black community and of the socio-cultural factors which restrict access within the community | • Behavioral health providers and community members who interact with Bernalillo County Black residents who suffer from behavioral health issues | 33 | 1,557 |
| Serna Solutions | • Deliver a series of behavioral health trainings and continuing educational opportunities on an array of behavioral health topics | • Peer-support workers<br>• Master's-level clinicians<br>• Clinical supervisors and directors<br>• Interested community members | 52 | 1,583 |

[3] NAMI -NM conducted a series of support sessions not counted here as formal trainings.

One way to assess the potential effectiveness of E & T programs is to ask program participants how satisfied they were with different aspects of the courses they attended. A majority of providers administered surveys after each E & T session where they asked whether program participants were satisfied with program logistics and the quality of the trainer. Most providers also assessed whether program participants perceived the training materials as being either interesting or engaging and whether program participants perceived the training itself to be well organized. Providers reported the percentage of program participants who completed the training satisfaction survey who indicated they were either "Satisfied" or "Very Satisfied" with each of these program components in their monthly performance measure reports to the DBHS with all providers stipulating in their contracts a performance measure target of 80+% training satisfaction.

While all providers reported the total number of program participants each month, not all providers reported the number of program participants who completed the training satisfaction surveys each month. Whether a provider reported the sample size for the training satisfaction surveys influences the substantive interpretation of the averages and limits the comparisons we can make across providers for statistical reasons detailed in more depth in the *Conclusion* section of this report. It also limits our ability to make strong claims about whether a given provider did, in fact, meet specific contractual benchmarks.

Because the substantive interpretation of the training satisfaction averages is dependent upon whether the survey sample size is known, in what follows, we provide two visualizations of training satisfaction metrics in Figure 1 for the five provider-years [ARCA; BCCHC; MITC – 1 (Year 1); MITC -1 (Year 2); Serna (Year 2)] where we have data on the number of completed training satisfaction surveys and in Figure 2 for the five provider-years [All Faiths; MITC – 2; NAMI; NMBLC; Serna (Year 1)] where we do not have data on the number of completed training satisfaction surveys. Whether or not the sample sizes were reported, we caution that this method of aggregating satisfaction metrics across providers – which themselves are already aggregated across theoretically distinct forms of trainings – limits the interpretability and comparability of these numbers within and across providers and obscures meaningful variation both within and across providers.

Figure 1 plots the weighted-average[4] of training satisfaction metrics against the performance measure target benchmark of 80+% satisfaction for 1,925 completed training satisfaction surveys from 2,675 program participants (Response Rate[5]: 72.0%) for the five provider-years where we do have information on completed survey sample sizes. It is worth noting that some of these providers do not report data for each of these four categories: BCCHC, MITC-1 (Year 1; Year 2), and Serna (Year 2) do not report data on satisfaction with training logistics, and BCCHC does not report data on perceptions that the training materials were engaging. The weighted average technique excludes this missingness and accounts for the fact that different providers have different numbers of program participants each month.

[4] For more information on why we used a weighted average instead of a non-weighted average, see this link for more information.

[5] Response rates are calculated as the total number of completed surveys divided by the total number of training participants. Providers who did not report the former have an indeterminate numerator and thus, the response rates are incalculable.

*Figure 1. Weighted Average of Cumulative Training Satisfaction Metrics Among Providers Reporting Sample Size Information for Satisfaction Surveys*

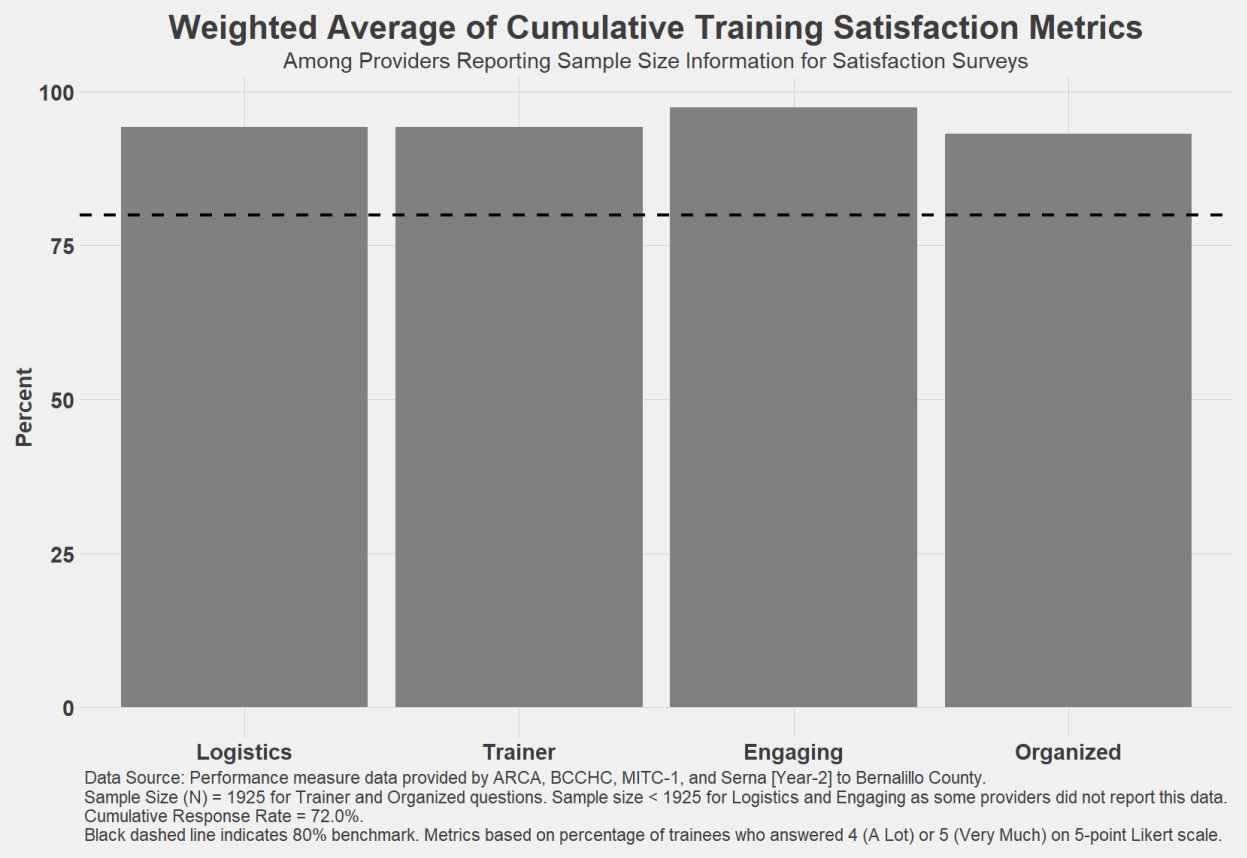
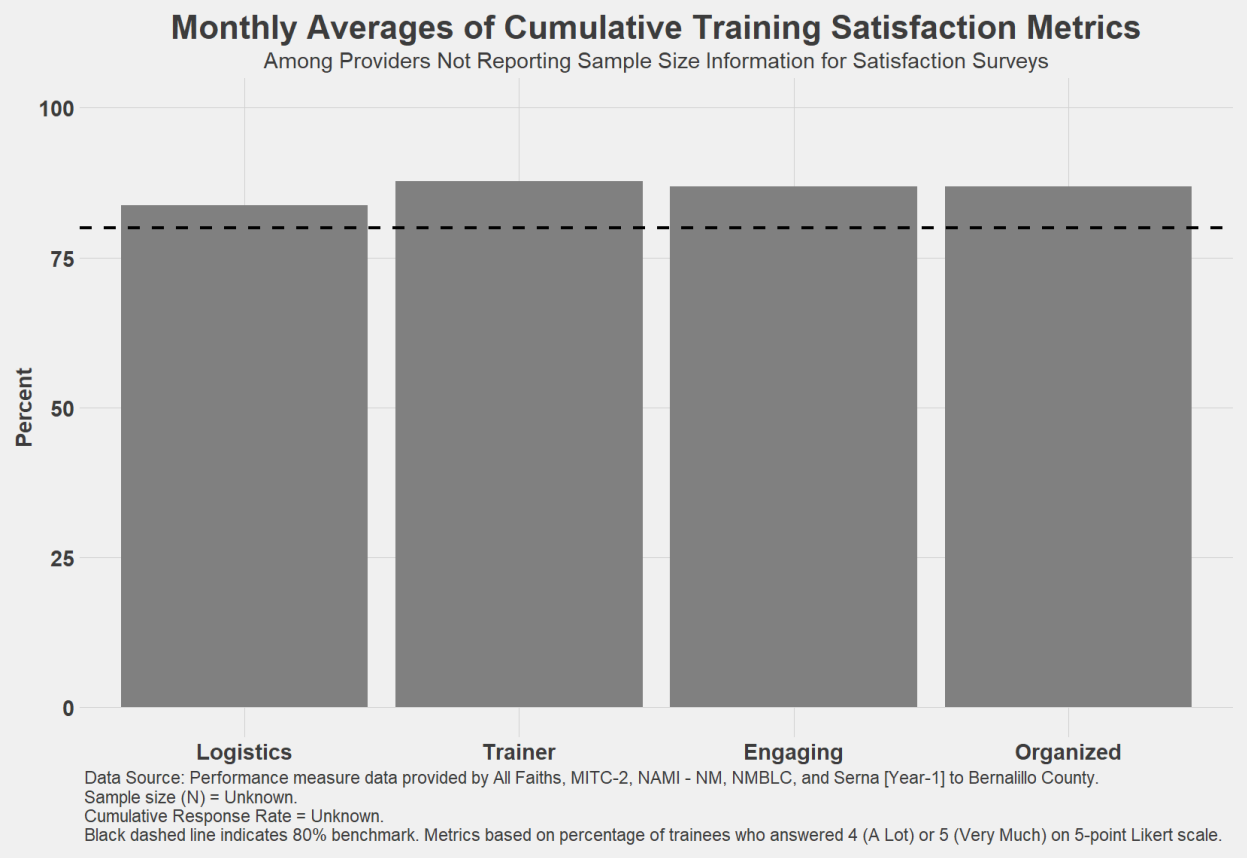



Figure 2 below plots the average of the provider-level average monthly satisfaction metrics against the performance measure target benchmark of 80+% satisfaction for the five provider-years where we do not have information on the completed survey sample sizes. It is worth noting that some of these providers do not report data for each of these four categories: MITC-2 and Serna (Year 1) do not report data on satisfaction with training logistics.

We should note one final general caveat to the interpretation of cumulative training satisfaction metrics: training satisfaction surveys were not delivered after every training session or course across providers. For instance, participants in webinar trainings often did not complete training satisfaction surveys. Because of this, it is important to be mindful of how the selection of specific training sessions to administer satisfaction surveys might artificially bias the results. For instance, if satisfaction surveys were more likely to be administered at in-person trainings instead of webinar trainings, and if it is the case that participants generally dislike webinar trainings more than in-person trainings because of the lack of in-person interaction, attempts at generalizing the results from surveys administered in one context – in-person trainings – to other contexts – such as webinar trainings – run the risk of overestimating the true degree of training satisfaction.

*Figure 2. Monthly Averages of Cumulative Training Satisfaction Metrics Among Providers Not Reporting Sample Size Information for Satisfaction Surveys*




*Training-Related Knowledge Increases*

One necessary precondition for E & T programs to successfully promote positive long-term client-side behavioral health outcomes is for the trainings to increase the amount of training-relevant knowledge program participants have. However much one prefers a specific trainer or perceives a training to be well-organized, these facets of training matter little if the relevant skills and knowledge acquired from the training are not retained and subsequently deployed in real-world client interactions.

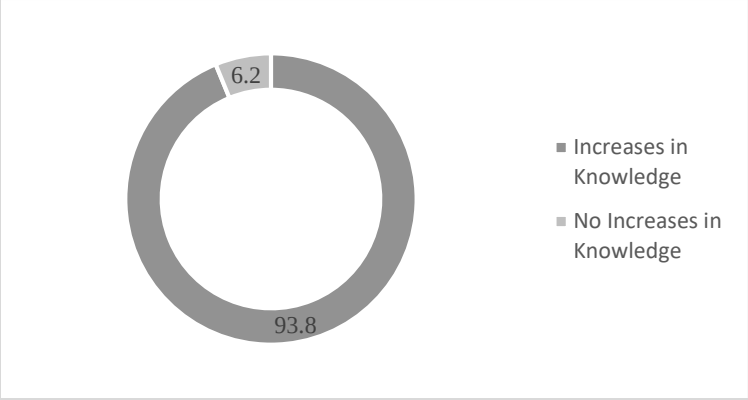
To this end, a majority of providers assessed whether their interventions increased training-relevant knowledge by giving participants a knowledge test before the training session (pre-test) and immediately after the training session (post-test) to better understand whether training-relevant knowledge increased, decreased, or stayed the same. Fewer providers reported longitudinal increases in training-relevant knowledge three-months after the initial training and still fewer at six-months after the initial training, statistics which, however imperfect, could testify to the effectiveness of the interventions if the skills and knowledge learned in training are theoretically defensible and, in turn, applied in practice.

There is more variation within and across the set of providers in how they assess knowledge gains than in how they assess satisfaction metrics given the intrinsic uniqueness of the knowledge-sets developed during each training session. For instance, Serna Solutions offers training sessions on topics as diverse as psychopharmacology, social media ethics, mental health first aid, and the social determinants of health. Assessing knowledge of psychopharmacology requires a different assessment tool with different sets of

questions than assessment of the knowledge of social media ethics. Relatedly, given the diversity of topics covered in E & T sessions both within and across providers and the limited information we can gather from the performance measure reports, it is not obvious how knowledge change is operationalized, through which sets of questions, or over how many questions. For these reasons, we cannot comment on the validity of the tests administered, the tests' other psychometric properties, or the specific within-person degree of knowledge change that occurred as a result of the trainings in the absence of more information. Additionally, some providers reported more multiple outcome measures related to training knowledge. For instance, both MITC-1 and MITC-2 assessed multiple knowledge components (e.g., Copenhagen Burnout Inventory, Motivational Interviewing Scale, and Helpful Response Questionnaire) which were not integrated into the performance measure reporting as a single statistic. The specificity reduces the comparisons we can make across providers.

Half of the providers (ARCA; All Faiths; BCCHC; NMBLC) reported information on the percent of program participants who completed the pre-tests and post-tests who saw increases in training-relevant knowledge, however operationalized, by the providers. Unlike the training satisfaction surveys, all four of the providers noted the sample size of those who completed the pre-test and post-test. However, it is worth noting that the number of program participants who completed the pre-test and post-tests across all providers is comparatively low. 816 out of the total 7,901 participants (10.3%) completed both the pre-test and post-test. Thus, inferences about the effectiveness of these trainings in producing knowledge gains should be interpreted with due caution given the potential for selection bias and outlier skew. Further, as detailed in more length in the *Conclusion* section, there are some theoretical and statistical complications associated with aggregating this information across categorically-different types of trainings and across different providers and thus, these cumulative knowledge-change statistics should be interpreted with appropriate levels of caution. Of the program participants who completed both the pre-test and post-tests, approximately 93.8% saw increases in training-relevant knowledge the day of their training (see Figure 3).

*Figure 3. Weighted Average of Participants with Increase in Training-Relevant Knowledge Day of Training*



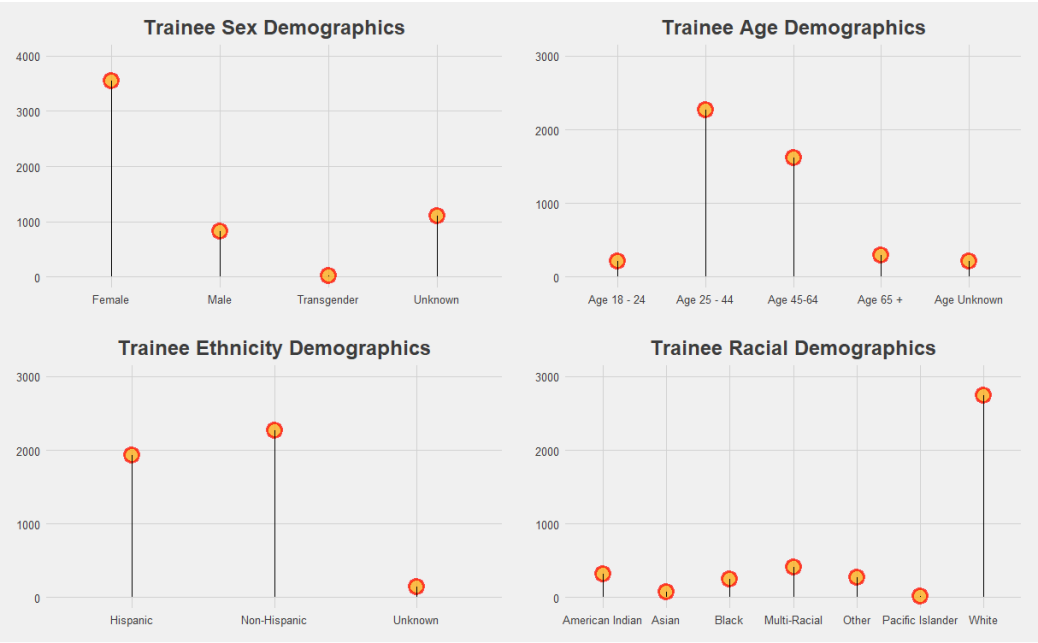

As noted, fewer providers reported longitudinal statistics on increases in, or maintenance of, training-relevant knowledge at the three- and six-month mark post-training. Thus, we do not aggregate this information here and instead present this information individually within each provider's more detailed report subsection.

*Demographics*

All providers were contractually obligated to report relevant demographic information on program participant sex, age, ethnicity, and race. Across all providers, of the 4,393 program participants who

reported their sex, 80.7% identified as female. Among the 4,594 program participants who reported their age, 51.6% of program participants indicated they were in the 25-44 age bracket. Among the 4,193 program participants who reported their ethnicity, 54.1% identified as non-Hispanic/Latino. Among the 4,063 program participants who reported their racial identity, 62.5% identified as white. Figure 4 provides an overview of cumulative program demographics.

*Figure 4. Cumulative Program Demographics*




*The Effect of Covid-19 on E & T Program Implementation*

Most E & T providers encountered some difficulties related to program implementation in response to the onset and continuation of the Covid-19 pandemic. For instance, in their narrative reports, most providers indicated they had to cancel training sessions earlier in the pandemic or re-configure service delivery from in-person training sessions to virtual training sessions. While some providers noted this process was challenging and some program participants disliked the transition, on average, most providers were able to proceed with service delivery and none experienced statistically-significant reductions in their reported survey satisfaction metrics per a series of unreported ordinary least squares regressions predicting each training satisfaction measure as a function of month.

**Provider Summaries**

*All Faiths Children's Advocacy Center*

All Faiths Children's Advocacy Center (hereafter, All Faiths) was awarded a one-year contract (CCN 2019-0922) for contracted period January 2020 – December 2020 in response to Request for Proposal (RFP) #: 10-20-JZ to deliver professional trauma-informed training classes to first responders and to ancillary school staff (Walkey and Cox 2013; Marsac et al. 2016). This dual-training is designed to help first responders and educators recognize the early signs of trauma and de-escalate potentially violent crisis situations as well as to help first-responders cope with their own personal experience of vicarious trauma on the job (Trippany, Kress, and Wilcoxon 2004).

Per their professional services agreement, All Faiths agreed to conduct 10 three-to-six-hour long trauma-informed care trainings in 2020 with first responders and 10 three-to-six-hour long trauma-informed care trainings in 2020 with ancillary school staff. Through November 2020, All Faiths conducted 12 sessions of trauma-informed training among first responders and seven sessions of trauma-informed training among ancillary-school staff (N = 905[6]). This rate of training exceeds All Faiths' performance target of 10 first-responder trainings by the end of 2020, though it is below the performance target of 10 school staff training sessions for 2020.

*Table 2. Summary of All Faiths Training Satisfaction Performance Metrics (January 2020 – November 2020)*

| Satisfaction Performance Metric | Average Monthly Satisfaction % | N (Sample Size) |
|---|---|---|
| *Training Logistics* | 98.2% | Unknown |
| *Trainer Quality* | 98.4% | Unknown |
| *Training Information Engaging* | 96.9% | Unknown |
| *Training Information Organized and Prepared* | 97.2% | Unknown |

All Faiths did not report the number of completed training satisfaction surveys. Through November 2020 and among the participants who completed the training satisfaction survey, All Faiths met their performance measure targets of 80+% satisfaction ratings for training logistics (2020 Average: 98.2%[7]) and perceptions of trainer quality (2020 Average: 98.4%). Most of the training participants who responded to the survey indicated that they found the information presented to be engaging and useful (2020 Average: 96.9%) and were satisfied that the training materials were well organized and prepared (2020 Average: 97.2%)[8]. Figure 1 in Appendix A provides a monthly visualization of All Faiths' satisfaction performance metrics through November 2020.

In terms of training knowledge retention, All Faiths encountered some technical issues administering the pre-post assessment in January 2020 noting in a subsequent monthly performance measure report that they were unable to administer the pre-post assessment to program participants in January 2020 and that they were unable to follow-up with January 2020 training participants by email. However, All Faiths indicated that after learning about this issue, staff implemented systems to force completion of pre-post assessments. Of the 308 training participants who completed the pre-post assessments from January 2020 through October 2020 (Response Rate: 39.1%), all participants saw maintenance of or increases in specific knowledge measures the day on which they received training (2020 Average: 100%; N = 308). All Faiths first reported data for the initial wave of three-month pre-post assessments in June given the inability to follow-up with January participants and the lack of February training sessions. Three months after participating in training, training-related knowledge was maintained or increased in all participants who completed the assessment (2020 Average: 100%; N = 105). Six months after initially participating in training, training-related knowledge was maintained or increased in all participants who completed the assessment (2020 Average: 100%; N = 44).

All Faiths provided demographic information for all months with the exceptions of February 2020, September 2020, and October 2020 when there were no trainings. All Faiths indicated that they generated

[6] N denotes sample size (e.g., # of program participants).
[7] Yearly averages reported absent sample sizes should be interpreted as monthly satisfaction training averages and not as overall participant averages.
[8] Satisfaction is operationalized as 4 or 5 response on 5-point Likert scale indicating "Agree" or "Strongly Agree". This operationalization holds across the set of providers.

demographic estimates for the month of January 2020 because of the compound issues of unit and item non-response among training participants for the month given the technical issues associated with data collection, though it is unclear how they generated these estimates from the performance measure reports. We present the cumulative demographic information of program participation across gender, age, ethnicity, and race in Figure 1 of Appendix B and by certification count in Figure 1 of Appendix C. Though November 2020, All Faiths partnered with 16 community partners including recent partnerships with the Transition Age Youth ECHO project and the Public Safety ECHO project with the City of Albuquerque. All Faiths did not report any additional program-specific performance measures.

Despite some of the challenges associated with converting social programs online during Covid-19, All Faiths did not experience a sharp discontinuity in service delivery in March 2020 associated with the onset of Covid-19 and the implementation of mandatory organizational social distancing policies. In their March 2020 narrative statement, All Faiths indicated that they collaborated with community partner MITC to prepare for the transition to Zoom-training sessions and converted training materials and training sessions to online platforms.

In sum, through November 2020, All Faiths met their annual performance measure targets of ten first-responder trainings (N = 12) but had not yet met their annual performance measure target of ten school staff training sessions for 2020 (N = 7). All Faiths did not specify a performance target for number of program participants (N = 905). All Faiths met their annual performance measure targets of 80% or more of program participants satisfied with (a) training logistics (98.2%), (b) trainer quality (98.4%), (c) interestingness of training materials (96.9%), and (d) organization of training materials (97.2%). All Faiths did not specify a performance target for knowledge retention. However, 100% of 308 program participants increased training-relevant knowledge the day of the training, 100% of 105 program participants maintained initial knowledge gains at the three-month mark post-training, and 100% of 44 participants maintained initial knowledge gains at the six-month mark post-training. All Faiths did not specify demographic performance measure targets. Most of All Faiths' program participants were female (83.1%) and ranged in age from 25 - 44 (70.9%). A majority ethnically identified as Non-Hispanic/Latino (62.8%) and racially identified as Caucasian/White (70.6%). The most commonly reported certification among All Faiths program participants was the Licensed Professional Clinical Counselor (LPCC).

*ARCA*

ARCA was awarded a one-year contract (CCN 2019-0921) for contracted period January 2020 – December 2020 in response to Request for Proposal (RFP) #: 10-20-JZ to provide Acquired Brain Injury Training (ABIT) and Education classes to employees of the Department of Behavioral Health, professionals, and community members who interact with brain injury survivors. The goal of ACRA's E & T program is to train relevant professionals and community members about the unique dynamics of working with brain injury survivors and to provide information on how to support those with traumatic brain injuries (Togher et al. 2004).

Per their professional services agreement, ARCA agreed to conduct 24 four-hour trainings for the contracted time period. Through November 2020, ARCA conducted 16 sessions of ABIT classes across four different healthcare providers and seven CBIS classes for a total of 23 trainings to date (N = 206). ARCA did not conduct any ABIT or CBIS training classes in January, February, March, June, or September 2020. The current level of training is slightly below the performance target of 24 training sessions for the total period.

*Table 3. Summary of ARCA Training Satisfaction Performance Metrics (January 2020 – November 2020)*

| Satisfaction Performance Metric | Percent of Satisfied Participants | N (Sample Size) |
|---|---|---|
| *Training Logistics* | 94.2% | 132/140 |
| *Trainer Quality* | 98.4% | 138/140 |
| *Training Information Engaging* | 88.6% | 124/140 |
| *Training Information Organized and Prepared* | 94.2% | 132/140 |

Through November 2020, ARCA received 140 completed training satisfaction surveys (Response Rate: 70.0%). Among the 140 participants who responded to the survey, ARCA met their performance measure goals of 80+% satisfaction with training logistics (2020 Average: 94.2%; N = 132) and perceptions of trainer quality (2020 Average: 98.4%; N = 138). Most of the training participants who responded to the survey indicated that they found the information presented to be engaging and useful (2020 Average: 88.6%; N = 124) and were satisfied that the training materials were well organized and prepared (2020 Average: 94.2%; N = 132). Figure 2 in Appendix A provides a monthly visualization of these satisfaction-specific performance metrics.

Through November 2020, ARCA noted that 175 participants completed the knowledge retention survey (Response Rate: 85.0%). Most of the participants who completed pre-post assessments at the time of the training saw maintenance of or increases in knowledge related to awareness of traumatic brain injuries (2020 Average: 88.6%; N = 155). Through November 2020, ARCA reported limited information about the persistence of knowledge retention over time among program participants. For instance, ARCA reported that 25% of participants saw maintenance of or increases in training knowledge three months after the initial training (N = 4) and that 100% of participants saw maintenance of or increases in training knowledge six months after the initial training (N = 2).

ARCA provided demographic information for April 2020 through November 2020. We present the cumulative demographic information of program participation across gender, age, ethnicity, and race in Figure 2 of Appendix B and by certification count in Figure 2 of Appendix C. Through November 2020, ARCA partnered with 29 community partners – 11 new and 17 existing -, including recent collaborations with First Choice Community Healthcare, Bernalillo County Youth Services Center, Albuquerque Fire & Rescue H.E.A.R.T., New Mexico Coalition to End Homelessness, and UNMH Case Management. ARCA did not report any additional program-specific performance metrics.

In their November 2020 performance measure narrative, ARCA indicated that they incorporated an "Every 21 Seconds" video into their training, showcasing New Mexicans living with brain injury, and noted that they have four planned training sessions scheduled for December 2020 for UNM Case Management and ARCA specialized foster care providers and social workers.

In sum, through November 2020, ARCA had not yet met their annual performance target of 24 four-hour trainings for the contracted time period (N =23). ARCA did not specify a performance measure target for number of program participants (N = 206). ARCA met their annual performance measure targets of 80% or more of program participants satisfied with (a) training logistics (94.2%), (b) trainer quality (98.4%), (c) interestingness of training materials (88.6%), and (d) organization of training materials (94.2%). ARCA did not specify a performance target for knowledge retention. However, 88.6% of 155 program participants increased training-relevant knowledge the day of the training, 25% of four program participants maintained initial knowledge gains at the three-month mark post-training, and 100% of two participants maintained initial knowledge gains at the six-month mark post-training. ARCA did not specify demographic

performance measure targets. Most off ARCA's program participants were female (60.2%) and ranged in age from 25 - 44 (53.9%). A majority ethnically identified as Hispanic/Latino (61.7%) and racially identified as Caucasian/White (70.6%). The most commonly reported certification among ARCA program participants was the Bachelors of Social Work (BSW).

*Bernalillo County Community Health Council*

The Bernalillo County Community Health Council (hereafter, BCCHC) was awarded a two-year contract (CCN: 2019-0146) in March 2019 for contracted period March 15, 2019 – March 31, 2021 in response to Request for Proposal (RFP) #: 35-18-JZ develop a set of E & T modules and Continuing Education Units (CEUs) designed to reduce the stigma associated with Opioid Use Disorder (OUD), to increase the community's understanding of the appropriate use and availability of Medication Assisted Treatment (MAT) in Bernalillo County, and to provide education and awareness of OUD and MAT treatment resources through the development of a new, updated, user-friendly web-based resource directory. In June 2020, BCCHC launched the website, Elivehealth.com, alongside a companion mobile-application and as part of their program collaborated with a variety of stakeholders, including prospective providers and patients, to solicit website and app design feedback using individual and group key informant interviews.

BCCHC's performance measure target for program participation consisted of 300 new participants in Year-1 of their contract from March 2019 - February 2020 and specifically, the recruitment of 50 participants within the first six months of the first year of the contract and 250 in the second six months of the first year of the contract. In Year-1 of the program (March 2019 – February 2020), BCCHC conducted 13 Anti-Stigma and Refresher trainings though they did not conduct any trainings within the first six months of the contracted period and did not meet their performance target for program participation (N = 226). In Year-2 of the program (March 2020 – March 2021) through November 2020, BCCHC conducted 24 Community Resilience and Healing training sessions (N = 321). As BCCHC's annual performance target for Year-2 was to reach between 240-360 new participants per year, BCCHC met their target benchmark for program participation for Year-2.

*Table 4. Summary of BCCHC Training Satisfaction Performance Metrics (March 2019 – February 2020)*

| **Satisfaction Performance Metric** | **Percent of Satisfied Participants** | **N (Sample Size)** |
|---|---|---|
| *Training Logistics* | N/A | N/A |
| *Trainer Quality* | 73.2% | 94/133 |
| *Training Information Engaging* | N/A | N/A |
| *Training Information Organized and Prepared* | 84.9% | 101/133 |
| *Satisfaction with OUD Training* | 37.6% | 50/133 |
| *Satisfaction with MAT Training* | 12.0% | 16/133 |

In Year-1 of the program, BCCHC received 133 completed training satisfaction surveys (Response Rate: 58.9%). In Year-1 of the program, of the 133 participants who completed the training satisfaction survey, BCCHC did not achieve their performance measure goal of 80+% satisfaction with the trainer (Year-1 Average: 73.2%; N = 94). Training participants generally indicated the training materials were well-organized and prepared (2020 Average: 84.9%, N = 101). However, a minority of training participants who completed the training satisfaction survey indicated they were satisfied with the OUD training (Year-1 Average: 37.6%; N = 50) and the MAT training (Year-1 Average: 12%; N = 16). BCCHC did not report statistics on participant satisfaction with logistics or perceptions of training material engagingness. Figure 3 in Appendix A provides a monthly visualization of these satisfaction performance metrics for 2019.

*Table 5. Summary of BCCHC Training Satisfaction Performance Metrics (March 2020 – November 2020)*

| Satisfaction Performance Metric | Percent of Satisfied Participants | N (Sample Size) |
|---|---|---|
| *Training Logistics* | N/A | N/A |
| *Trainer Quality* | 67.1% | 55/82 |
| *Training Information Engaging* | N/A | N/A |
| *Training Information Organized and Prepared* | 0% | 0/82 |
| *Satisfaction with OUD Training* | 21.7% | 35/82 |
| *Satisfaction with MAT Training* | 20.1% | 25/82 |

In Year-2 of the program (March 2020 - March 2021) through November 2020, BCCHC received 82 total training satisfaction surveys (Response Rate: 25.6%). In Year-2 of the program, BCCHC has not met their performance measure goals of 80+% satisfaction with the trainer (Year-2 Average: 67.1%; N = 55). Of the 82 participants who completed the training satisfaction portion of the survey, training participants did not perceive the training materials to be well organized or prepared (Year-2 Average: 0%; N = 0) and a minority were satisfied with OUD training (Year-2 Average: 21.7%; N = 35) and MAT training (Year-2 Average: 20.1%%; N = 25). Figure 4 in Appendix A provides a monthly visualization of these satisfaction performance metrics for 2020.

In Year-1 of the program, 95 participants completed both the pre-tests and post-tests for the knowledge retention survey. Of the 95 participants who completed both the pre-test and post-test, 86.3% (N = 82) experienced increases in knowledge retention the day of the training. In Year-1 of the program, BCCHC did not report data on the persistence of knowledge retention at the three or six-month mark following training completion. In Year-2 of the program through November 2020, 55 program participants completed both the pre-test and post-test. Of the participants who completed both the pre-test and post-test, 50.9% (N = 28) saw increases in knowledge retention the day of the training. BCCHC did not report data on knowledge-retention at the three- or six-month marks. In the narrative statements, BCCHC noted that there were some inefficiencies in data collection for the knowledge assessments and that they modified their data collection procedures (e.g., transitioning to the use of Survey Monkey) in an effort to increase assessment response rates.

BCCHC provided partial demographic information for October – December 2019 and for January – November 2020. The provider noted in their performance review that they encountered difficulties collecting survey data on some of the participant demographic questions on ethnicity and race and indicated that they were exploring potential options for better collecting this data going forward, though it is unclear from the reporting on the performance measure narrative what the specific difficulties were. We present the cumulative demographic information of program participation across gender, age, ethnicity, and race in Figure 3 of Appendix B and by certification count in Figure 3 of Appendix C. In Year-2 of their program through November 2020, BCCHC partnered with 25 community partners including recent collaborations with St. Joes Children, Opioid ECHO, ASAP Clinic, and Presbyterian Care Coordinators.

Per their professional services agreement, BCCHC indicated they would report a series of additional performance measures including outcome data on the number of buprenorphine-waivered providers, the number of patients who engaged in medication-assisted treatment in Bernalillo County, and website analytics for Elivehealth.com to include clicks on resources, website visits, repeat visits and surveys about use. BCCHC has not reported these outcomes in their monthly performance measure reports to date, noting

that the website has not formally been launched due to complications in securing agreement with their providers. In their meetings with the County, BCCHC indicated that they plan to launch the website in early 2021.

BCCHC encountered some disruptions to service delivery in March 2020 associated with the onset of Covid-19 and the implementation of mandatory organization-wide social distancing policies specifically with respect to outreach and recruitment in the months of March and April. Despite this, the provider was able to meet their performance target for number of program participants for Year-2 by December 2020 (N = 329).

In sum, BCCHC did not meet their annual performance target for program participation (240-360 participants) in Year 1 of their contract (N = 226) but did meet their annual performance target for program participation in Year 2 of their contract through November 2020 (N = 321). BCCHC did not specify a performance measure target for the total number of trainings (N = 37). BCCHC did not meet their annual performance measure targets of 80% or more of program participants satisfied with (a) trainer quality (Year 1 Average: 73.2%; Year 2 Average: 67.1%) or (b) overall satisfaction with OUD training (Year 1 Average: 37.6%; Year 2 Average: 21.7%) or (c) MAT training (Year 1 Average: 12.0%; Year 2 Average: 20.1%). BCCHC met their annual performance target of 80% or more of program participants satisfied with the organization and preparedness of training materials in Year 1 of program implementation (Year 1 Average: 84.9%), but not in Year 2 through November 2020 (0%). BCCHC did not specify a performance target for knowledge retention. However, majorities of participants who completed the post-tests the day of the trainings reported increases in training relevant knowledge (Year 1 Average: 86.3%; Year 2 Average: 50.9%). BCCHC did not report data on longitudinal maintenance of, or increases in, training related knowledge at the three- or six-month marks. BCCHC did not specify demographic performance measure targets. Most of BCCHC's program participants were female (78.7%) and a plurality ranged in age from 25 - 44 (43.9%). A majority ethnically identified as Hispanic/Latino (79.4%) and racially identified as Caucasian/White (68.5%). The most commonly reported certification among BCCHC program participants was the Bachelors of Social Work (BSW).

*MITC - 1*

Motivational Interviewing (hereafter, MITC-1 for this contract) was awarded a two-year contract (CCN #: 2018 – 0864) for contracted period January 2019 – December 2020 in response to Request for Proposal (RFP) #: 35-18-JZ to increase the number of behavioral health providers, community members, and trainers trained in motivational interviewing (MI) techniques, to increase MI listening skills, reduce compassion burnout, and increase MI proficiency through a series of trainings (Hettema, Steele, and Miller 2005).

In Year-1 of the program (January 2019 – December 2019), MITC-1 conducted 15 introductory two-day motivational interviewing trainings totaling 190 hours (N = 473). MITC-1 thus marginally undershot their performance target to provide MI training to 480 community members. Similarly, average participant training per class (2019 Average: 29.13 participants/training session) was below the performance target of 40 participants per class. In Year-1 of the program, MITC-1 conducted 17 Level-1 Coaching Sessions (N = 111), eight Level 2 coaching sessions (N = 46), and one Level-3 coaching session (N= 8) and thus exceeded their performance target of 150 total coaching attendees (N = 165).

In Year-2 of the program through November 2020, MITC-1 conducted 12 introductory training sessions totaling 152 hours (N = 502). Through November 2020, MITC-1 conducted 23 Level-1 Coaching Sessions (N = 152), 21 Level 2 coaching sessions (N = 129), and 14 Level-3 coaching session (N= 118). MITC-1 exceeded their Year-2 performance target of 240 coaching attendees (N = 391) and performance target of 16 coaching groups (N = 58).

*Table 6. Summary of MITC-1 Training Satisfaction Performance Metrics (Year-1)*[9]

| Satisfaction Performance Metric | Percent of Satisfied Participants | N (Sample Size) |
|---|---|---|
| *Training Logistics* | N/A | N/A |
| *Trainer Quality* | 98.3% | 415/423 |
| *Training Information Engaging* | 98.4% | 417/423 |
| *Training Information Organized and Prepared* | 99.5% | 422/423 |

In Year-1 of the program (January 2019 – December 2019), MITC-1 received 423 completed training satisfaction surveys (Response Rate: 89.4%). In Year-1 of the program, MITC-1 did not report data on satisfaction with training logistics. Of the 423 participants who completed the training satisfaction survey, MITC-1 met their performance measure goals of 80+% satisfaction with the trainer (2019 Average: 98.3%; N = 415). Of the participants who completed the training satisfaction portion of the survey, training participants generally perceived that the training information was presented in an engaging and interesting way (2019 Average: 98.4%) and indicated that the training materials were well organized and prepared (2019 Average: 99.5%) Figure 5 in Appendix A provides a monthly visualization of these satisfaction performance metrics for 2019.

*Table 7. Summary of MITC-1 Training Satisfaction Performance Metrics (Year-2)*[10]

| Satisfaction Performance Metric | Percent of Satisfied Participants | N (Sample Size) |
|---|---|---|
| *Training Logistics* | N/A | N/A |
| *Trainer Quality* | 97.4% | 285/293 |
| *Training Information Engaging* | 98.1% | 287/293 |
| *Training Information Organized and Prepared* | 96.4% | 282/293 |

In Year-2 of the program through November 2020 (January 2020 – November 2020), MITC-1 received 293 completed training satisfaction surveys (Response Rate: 58.4%). In Year-2 of the program, MITC-1 did not report data on perceptions of training logistics. Of the 293 participants who completed the training satisfaction survey, MITC-1 met their performance measure goal of 80+% satisfaction with the trainer (2020 Average: 97.4%). Of the participants who completed the training satisfaction portion of the survey, training participants generally perceived that the training information was presented in an engaging and interesting way (2019 Average: 98.1%) and indicated that the training materials were well organized and prepared (2020 Average: 96.4%). Figure 6 in Appendix A provides a monthly visualization of these satisfaction performance metrics for 2020.

In Year-1 of the program, MITC-1 did not report statistics on the degree of knowledge retention. However, MITC - 1 did report the number of pre- and post-surveys and follow-up assessments completed. For instance, in Year-1 of the program, 419 of 441 (95.0%) of participants who completed the Motivational Interviewing (MI) Questionnaire Pre-Survey completed the Post-Survey. 409 of 428 participants (95.6%) who completed the Pre-Helpful Response Questionnaire (HRQ) assessment completed the Post-HRQ assessment. In Year-1 of the program, 113 participants completed HRQ assessments at the one-month mark

[9] Specific numbers of participants in the sample size column are estimates based on percentages provided by MITC projected from the percentages provided and total sample size of survey respondents.
[10] Specific numbers of participants in the sample size column are estimates based on percentages provided by MITC projected from the percentages provided and total sample size of survey respondents.

and 21 participants completed HRQ assessments at the six-month mark. 444 participants completed the Pre-Copenhagen Burnout Inventory (CBI) assessment (Kristensen et al. 2005), 126 participants completed the 1-month CBI assessment, and 18 completed the six-month CBI assessment.

In Year-2 of the program, MITC-1 reported the same set of assessment metrics as in Year-1. In Year-2 of the program through November 2020, 276 of 381 participants (72.4%) who completed the MI Questionnaire Pre-Survey completed the Post-Survey and 208 of 347 participants (59.9%) who completed the Pre-HRQ assessment completed the Post-HRQ assessment. In Year-2 of the program through November 2020, 160 participants completed HRQ assessments at the one-month mark and 102 participants completed HRQ assessments at the six-month mark. 383 participants completed Pre-CBI assessments, 198 participants completed the one-month CBI assessment, and 84 participants completed the six-month CBI assessment.

Per their professional services agreement, MITC-1 agreed to report outcome data for CBI, MI, and HRQ scales. MITC-1 reported aggregated data on these outcomes for Year-1 in their December 2019 performance measure report, reporting percent reductions in burnout at the one-month mark in the Personal Life (-11% of burnout), Work Life (-3% of burnout), and Client Contact (-5% of burnout) dimensions of the CBI-scale and reductions in burnout at the six-month mark in the Personal Life (-11%), Work Life (-13%), and Client Contact (-5%) dimensions of the CBI-scale. MITC-1 reported increases in understanding of MI principles (+30%), proficiency (+26%), and utilization of motivational interviewing (+20%) using the MI scale. MITC-1 reported increases in empathy scores immediately after training (+0.90 immediately following training; +0.49 at the one-month mark; 0.69 at the six-month mark) and increases in percent reflections (+28% immediately following training; +25% at the one-month mark; +28% at the six-month mark) using the HRQ scale. MITC-1 had not reported this set of outcome data for Year-2 to date.

MITC-1 did not report demographic information for January 2019, February 2019, April 2020, and August 2020 as they did not offer trainings these months. We present the cumulative demographic information of program participation across gender, age, ethnicity, and race in Figure 4 of Appendix B and by certification count in Figure 4 of Appendix C. MITC-1 partnered with 21 community partners in 2019 and 19 community partners in 2020 including recent partnerships with the Albuquerque Fire Department and Rescue Heart Program, the Eating Disorder Treatment Center, University of New Mexico College Enrichment Program, and the Family Connection.

In their November 2020 performance measure reports, MITC-1 indicated that they were taking steps to increase the quality of training provided by conducting Zoom practice sessions prior to all trainings to support the needs of training participants and by continuing to conduct data reviews using RedCap.

In sum, in Year 1 of their contract, MITC-1 did not meet their annual performance target (480 participants) for program participation (N = 473) or their performance target (40 participants per session) for average number of participants per session (N = 29.1). In Year 1 of their contract, MITC-1 met their annual performance target (N = 150) of number of coaching attendees (N = 165). In Year 2 of their contract, through November 2020, MITC-1 met their annual performance target (480 participants) for program participation (N = 502) and their performance target (40 participants per session) for average number of participants per session (N = 41.8). In Year 2 of their contract through November 2020, MITC-1 met their annual performance target (N = 240) for number of coaching class attendees (N = 391). MITC-1 met their annual performance measure targets of 80% or more of program participants satisfied with (a) trainer quality (Year 1 Average: 98.3%; Year 2 Average: 97.4%), (b) engagingness of training materials (Year 1 Average: 98.4%; Year 2 Average: 98.1%), and (c) organization and preparedness of training materials (Year 1 Average: 99.5%%; Year 2 Average: 96.4%). In Year 1 and Year 2 of the program, MITC-1 did not report statistics on the degree of knowledge retention. However, MITC-1 did report outcome data for CBI,

MI, and HRQ scales, generally finding reductions in burnout, increased understanding of MI principles, and increases in empathy scores in Year 1 of the program. Most of MITC-1's program participants were female (80.7%) and a majority ranged in age from 25 - 44 (52.4%). A majority ethnically identified as Non-Hispanic/Latino (55.1%) and racially identified as Caucasian/White (69.3%). The most commonly reported certification among MITC-1 program participants was a Bachelors of Social Work (BSW).

*MITC-2*

MITC was awarded an additional one-year contract (CCN #: 2020-0013) in January 2020 for period January 2020 - December 2020 in response to Request for Proposal (RFP) #: 10-20-JZ to create a Behavioral Health Training Institute which would provide coaching, supervision, and support as well as a series of experiential workshops to healthcare providers and community members who interact with those who are suffering from behavioral health issues. The suite of E & T modules covered by MITC-2 address a number of the Leading Health Indicators (LHI) identified in the Healthy People 2020 Initiative of the U.S Department of Health and Human Services (Office of Disease Prevention and Health Promotion 2020). Specifically, the training offered through the Behavioral Health Training Institute included a series of trainings on Mental Health First Aid, Empathic Listening, Addressing Suicide, Question, Persuade, or Refer (QPR), Applied Suicide Intervention Skills Training (ASIST), and Screening for Suicide Risk. MITC-2 partnered with the Hilton Adolescent SBIRT Project through NORC at the University of Chicago alongside other community providers.

Per their professional services agreement, MITC-2 agreed to conduct 12 two-hour Brief Empathic Listening Classes in 2020, four of which would have online options, with populations which may not typically access such training. Other performance target goals included providing four six-and-a-half-hour Empathic Listening Workshops, four two-hour long Engaging Others in Treatment classes, four six-and-a-half-hour Vicarious Trauma classes, two 15-hour DBT group facilitation classes, one 40-hour MBRT class, two-20-hour coaching terms for those who completed DBT, and one 20-hour term of coaching for those who completed MBRT.

Through November 2020, MITC-2 conducted 13 two-hour Empathic Listening classes (N = 574), two 6.5-hour Empathic Listening classes (N = 62), four Vicarious Trauma classes (N = 147), three Engaging-Others in Treatment classes (N = 174), three Dialectical Behavioral Therapy Introduction and Coaching classes (N = 122), and two MBRP Introduction and Coaching classes (N = 78). In sum, MITC-2 conducted 24 total trainings on 1,159 participants through November 2020.

*Table 8. Summary of MITC-2 Training Satisfaction Performance Metrics (January 2020 – November 2020)*

| **Satisfaction Performance Metric** | **Average Monthly Satisfaction %** | **N (Sample Size)** |
|---|---|---|
| *Training Logistics* | N/A | N/A |
| *Trainer Quality* | 96.0% | Unknown |
| *Training Information Engaging* | 94.9% | Unknown |
| *Training Information Organized and Prepared* | 97.4% | Unknown |

MITC-2 did not report the number of participants who completed their training satisfaction survey. MITC-2 did not report statistics on satisfaction with training logistics. Through November 2020, among participants who completed the training satisfaction survey, MITC-2 met their performance measure goal of 80+% satisfaction with perceptions of trainer quality (2020 Average: 96.0. Most training participants believed that the training information was presented in an engaging and useful way (2020 Average: 94.9%)

and indicated that the training materials were well organized and prepared (2020 Average: 97.4%). Figure 7 in Appendix A provides a monthly visualization of these satisfaction performance metrics for 2020.

Through November 2020, MITC-2 did not report statistics on knowledge increases. However, MITC-2 did report the number of pre-surveys, post-surveys, and follow-up assessments completed. For instance, 246 of 461 (53.4%) of participants who completed the Empathic Listening Pre-Test completed the corresponding one-month Post-Test, 83 of 137 participants (60.6%) who completed the Vicarious Trauma Pre-Test completed the corresponding one-month Post-Test assessment, 111 of 146 participants (76.0%) who completed the Engaging Others Pre-Test completed the corresponding one-month Post-Test, 35 of 38 participants (92.1%) who completed the MPQ Pre-test completed the corresponding one-month post-test, and 21 of 57 participants (36.8%) who completed the DBT Pre-Test completed the corresponding one-month post-test.

In terms of program-specific performance measures, MITC-2 indicated they would report outcome data for the CBI as well as the Professional Quality of Life Scale (ProQOL) (Hudnall 2009). MITC-2 hypothesized that burnout and compassion fatigue would decrease as a result of program participation. While MITC-2 reported the number of CBI and ProQOL scales completed by program participants, they had not reported specific outcome data using these metrics through November 2020.

MITC-2 did not report demographic information for January 2020 as they did not offer any training sessions in January 2020. We present the cumulative demographic information of program participation across gender, age, ethnicity, and race in Figure 5 of Appendix B and by certification count in Figure 5 of Appendix C. Through November 2020, MITC-2 partnered with 47 total community partners including a recent collaboration with Turning Point Recovery. Their performance target was to average of 4 partnerships quarterly. MITC-2 exceeded their performance target with by averaging 15.6 collaborative community partners per quarter excluding the month of December 2020.

In their November 2020 performance measure reports, MITC-2 indicated that they were taking steps to increase the quality of training provided by conducting Zoom practice sessions prior to all trainings to support the needs of training participants and by continuing to conduct data reviews using RedCap.

Per their professional services agreement, MITC-2 agreed to conduct 12 two-hour Brief Empathic Listening Classes in 2020, four of which would have online options, with populations which may not typically access such training. Other performance target goals included providing four six-and-a-half-hour Empathic Listening Workshops, four two-hour long Engaging Others in Treatment classes, four six-and-a-half-hour Vicarious Trauma classes, two 15-hour DBT group facilitation classes, one 40-hour MBRT class, two-20-hour coaching terms for those who completed DBT, and one 20-hour term of coaching for those who completed MBRT.

Through November 2020, MITC-2 conducted 13 two-hour Empathic Listening classes (N = 574), two 6.5-hour Empathic Listening classes (N = 62), four Vicarious Trauma classes (N = 147), three Engaging-Others in Treatment classes (N = 174), three Dialectical Behavioral Therapy Introduction and Coaching classes (N = 122), and two MBRP Introduction and Coaching classes (N = 78). In sum, MITC-2 conducted 24 total trainings on 1,159 participants through November 2020.

In sum, through November 2020, MITC-2 met their annual performance targets for number of Brief Empathic Listening classes (Target = 12; N = 13), Vicarious Trauma classes (Target = 4; N = 4), DBT classes (Target = 2; N = 3), and MBRP classes (Target = 2; N = 3). However, through November 2020, MITC – 2 had not yet met their annual performance targets for number of 6.5-hour Empathic Listening Classes (Target = 4; N = 2) or for their Engaging Others in Treatment classes (Target = 4; N = 3). MITC-2

met their annual performance measure targets of 80% or more of program participants satisfied with (a) trainer quality (2020 Average: 96.0%), (b) engagingness of training materials (2020 Average: 94.9%), and (c) organization and preparedness of training materials (2020 Average: 97.4%). MITC-2 did not report statistics on the degree of knowledge retention. Most of MITC-2's program participants were female (85.4%) and a majority ranged in age from 25 - 44 (50.7%). A majority ethnically identified as Non-Hispanic/Latino (52.7%%) and racially identified as Caucasian/White (74.3%). The most commonly reported certification among MITC-2 program participants was a Licensed Professional Clinical Counselor (LPCC).

*National Alliance on Mental Illness – New Mexico*

The National Alliance on Mental Illness – New Mexico (hereafter, NAMI – NM) was awarded a one-year contract (CCN: 2020-0030) in January 2020 for period January 15, 2020 – December 31, 2020 in response to Request for Proposal (RFP) #: 10-20-JZ to implement standardized courses and support groups for those living with a mental health condition.

Per their professional services agreement, NAMI - NM agreed to provide four Peer-to-Peer eight-week courses, four Family-to-Family eight-week courses, six Family-and-Friends training courses, 24 Family Support Groups, 24 Connection Support Groups, and 20 CIT panel presentations. Through November 2020, NAMI-NM had conducted four Peer-to-Peer eight-week courses, four Family-to-Family eight-week courses, zero Family-and-Friends training courses, 22 Family Support Groups, 65 Connection Support Groups, and zero CIT panel presentations (N = 969).

*Table 9. Summary of NAMI - NM Training Satisfaction Performance Metrics (January 2020 – November 2020)*

| **Satisfaction Performance Metric** | **Average Monthly Satisfaction %** | **N (Sample Size)** |
|---|---|---|
| *Training Logistics* | 90.7% | Not Reported |
| *Trainer Quality* | 94.7% | Not Reported |
| *Training Information Engaging* | 94.2% | Not Reported |
| *Training Information Organized and Prepared* | 90.7% | Not Reported |

NAMI – NM did not report the number of participants who completed the training satisfaction surveys. Through November 2020 and of those who completed the training satisfaction surveys, NAMI - NM met their performance measure goals of 80+% satisfaction with training logistics (2020 Average: 90.7%) and perceptions of trainer quality (2020 Average: 94.7%). Of those who completed the training satisfaction surveys, most participants believed that the training information was presented in an engaging and useful way (2020 Average: 94.2%) and perceived the training materials have been well organized and prepared (2020 Average: 90.7%). Figure 8 of Appendix A provides a monthly visualization of these satisfaction-specific performance metrics.

Through November 2020, NAMI – NM did not report statistics on training knowledge increases or belief change. To this point, in their performance measure reports, NAMI- NM indicated that, "These metrics don't apply to presentations or support groups (Connection & IOOV), but we will collect these metrics at the conclusion of the Family to Family class (an 8-week course)." Through November 2020, NAMI – NM had not reported training knowledge retention metrics for the Family-to-Family class.

There were some data quality issues with respect to the reporting of demographic information for this provider as they only reported demographic breakdown for training participants in the month of May,

August, and October and even then, only for one class – Family to Family. NAMI - NM noted that the completion of this information was optional so not everyone who attended a training completed these forms and noted that they are working on ways of improving this going forward. The recording of demographic information was also conditioned by training type: some trainings – such as webinars – complicated the provider's ability to collect relevant demographic information given the training type selected and given provider choices surrounding when to collect such data. We present the cumulative demographic information of program participation across gender, age, ethnicity, and race in Figure 6 of Appendix B and by certification count in Figure 6 of Appendix C. Through November 2020, NAMI - NM partnered with 6 total community partners.

While NAMI – NM experienced some service delivery shifts in response to Covid-19, NAMI – NM consulted with the national office and coordinated with the NAMI Albuquerque affiliate leadership on how to implement E & T trainings via Zoom, indicated that they have implemented some techniques (e.g., sign-up pages) designed to reduce the costs associated with Zoom participation, and have implemented strategies to increase survey completion.

In sum, through November 2020, NAMI-NM met their annual performance target of four Peer-to-Peer eight-week courses (N = 4), four Family-to-Family eight-week courses (N = 4), and 24 Connection Support Groups (N = 65). Through November 2020, NAMI – NM had not yet met their annual performance target of six Family-and-Friends training courses (N = 0), 24 Family Support Groups (N = 22), or 20 CIT panel presentations (N = 0). NAMI – NM did not specify a performance measure target for the total number of program participants (N = 969). NAMI – NM met their annual performance measure targets of 80% or more of program participants satisfied with (a) training logistics (90.7%), (b) trainer quality (94.7%), (c) engagingness of training materials (94.2%), and (d) organization of training materials (90.7%). NAMI - NM did not specify a performance target for knowledge retention and did not report data on maintenance of or increases in training related knowledge the day of the training or data on longitudinal maintenance of or increases in training related knowledge at the three - or six-month marks. NAMI-NM did not specify demographic performance measure targets. Most of NAMI – NM's program participants were female (56.3%) and a plurality ranged in age from 45 - 64 (46.6%). A majority ethnically identified as Non-Hispanic/Latino (57.3%) and racially identified as Caucasian/White (68.5%). The most commonly reported certification among NAMI - NM program participants were the Certified Peer Support Worker (CPSW).

*New Mexico Black Leadership Council*

The New Mexico Black Leadership Council (hereafter, NMBLC) was awarded a one-year contract for period January 2020 – December 2020 in response to Request for Proposal #: 10-20-JZ to raise awareness of behavioral health issues in the Black community and of the socio-cultural factors which restrict access within the community among mental health providers and community members who interact with Bernalillo County Black residents who suffer from behavioral health issues.

Per their professional services agreement, NMBLC agreed to offer 12 two-to-four-hour courses per year for licensed health professionals, offer 12 two-to-four-hour classes per year for community members and stakeholders, develop and offer six classes tailored to the needs of the community and six classes with community service providers. Through December 2020, NMBLC conducted 33 total courses (N = 1557). Based on the level of description provided in the performance measure reports, we were unable to assess which of the specific trainings were provided to which groups (e.g., health professionals versus community members) and thus cannot provide more granular information on the achievement of specific target training goals. However, NMBLC did not meet their overall implicit performance target of 36 total courses for the year (N = 33).

*Table 10. Summary of NMBLC Training Satisfaction Performance Metrics (January 2020 – November 2020)*

| Satisfaction Performance Metric | Average Monthly Satisfaction % | N (Sample Size) |
|---|---|---|
| *Training Logistics* | 98.6% | Not Reported |
| *Trainer Quality* | 99.4% | Not Reported |
| *Training Information Engaging* | 99.5% | Not Reported |
| *Training Information Organized and Prepared* | 99.5% | Not Reported |

NMBLC did not report the number of participants who completed the training satisfaction survey. Of participants who completed the training satisfaction survey, NMBLC met their performance measure goals of 80+% satisfaction with training logistics (2020 Average: 98.6%) and perceptions of trainer quality (2020 Average: 99.4%). Most of the training participants who responded to the survey indicated they found the information presented to be engaging and useful (2020 Average: 99.5%) and were satisfied that the materials have been well organized and prepared (2020 Average: 99.5%). Figure 9 of Appendix A provides a monthly visualization of these satisfaction-specific performance metrics.

In terms of knowledge retention metrics, most of the training participants who completed the pre-post assessments from January 2020 through December 2020 (2020 Average: 98.8%; N = 192) saw increases in specific knowledge measures the day on which they received training. Through December 2020, NMBLC did not report data on longitudinal knowledge retention at three or six months out.

In terms of participant demographics, NMBLC did not report demographic information for May – August of 2020. We present the cumulative demographic information of program participation across gender, age, ethnicity, and race in Figure 7 of Appendix B and by certification count in Figure 7 of Appendix C. Through December 2020, NMBLC partnered with 26 total community partners including recent partnerships with the New Mexico Black Voters Collaborative and the UNM Athletics Program to offer mental health and wellness drop-in evening sessions for UNM student athletes.

While NMBLC experienced some service delivery shifts in response to Covid-19, NMBLC indicated that they were working on strategies to routinize their internal workflows (e.g., developing presenter toolkits, templates, and setting up calendars and scheduling) and brainstorming ideas about how to adapt their course offerings based on their expected audience (i.e., behavioral health providers or community members).

In sum, through December 2020, NMBLC had not yet met their annual performance target of 36 total trainings (N = 33) though it is unclear, given the lack of specificity in the performance measure reporting, which specific courses it provided and to whom. NMBLC did not specify a performance measure target for the total number of program participants (N = 1557). NMBLC met their annual performance measure targets of 80% or more of program participants satisfied with (a) training logistics (98.6%), (b) trainer quality (99.4%), (c) engagingness of training materials (99.5%), and (d) organization of training materials (99.5%). NMBLC did not specify a performance target for knowledge retention. 98.8% of program participants who completed the saw increases in knowledge the day of the training. NMBLC did not report data on longitudinal maintenance of or increases in training-related knowledge at the three- or six-month marks. NMBLC did not specify demographic performance measure targets. Most of NMBLC's program participants did not specify a sex (82.1%); however, of those who did report their sex, a majority of program participants were female (78.5%). A plurality of NMBLC's program participants ranged in age from 24 – 44 (49.3%). A majority of NMBLC's program participants identified ethnically as Non-Hispanic/Latino

(66.8%) and a plurality as Caucasian/White (31.2%). The most common reported certification among NMBLC program participants was the Licensed Professional Clinical Counselor (LPCC).

*Serna Solutions LLC*

Serna Solutions LLC (hereafter, Serna) was awarded a one-year contract over period January 1, 2019 – December 31, 2019, renewed in 2020, to deliver a series of behavioral health trainings and continuing educational opportunities to peer-support workers, Master's-level clinicians, clinical supervisors and directors, and interested community members. Examples of their training opportunities and CEUs included: Community Reinforcement Approach for Adolescents and Adults, Community Reinforcement and Family Training, Assessing and Treating Co-Occurring Disorders, Psychopharmacology for Behavioral Health Professionals, Clinical Supervision, Cultural Competency: Humility and Fluency, Social Determinants of Health, Trauma Informed Care, and Introduction to Medically Assisted Treatment (MAT). Their set of community education opportunities include classes on Ethics: Navigating Social Media, Telehealth, and Other Technological Trends, Youth Mental Health First Aid (Y-MHFA), Supporting Someone with an Addiction using the CRAFT Approach, and The Opioid Epidemic.

Specific training performance measure targets were not included in the Serna professional service agreement – in terms of desired number of trainings or desired number of participants – for Year-1 of their program. In Year-1 of the program (January 2019 – December 2019), Serna offered 20 total courses (N = 638). Through October in Year 2 of the program (January 2020 –December 2020), Serna offered 32 total courses (N = 945).

*Table 11. Summary of Serna Training Satisfaction Performance Metrics (Year-1)*

| **Satisfaction Performance Metric** | **Percent of Satisfied Participants** | **N (Sample Size)** |
|---|---|---|
| *Training Logistics* | N/A | Not Reported |
| *Trainer Quality* | N/A | Not Reported |
| *Training Information Engaging* | N/A | Not Reported |
| *Training Information Organized and Prepared* | N/A | Not Reported |

*Table 12. Summary of Serna Training Satisfaction Performance Metrics (Year-2)*

| **Satisfaction Performance Metric** | **Percent of Satisfied Participants** | **N (Sample Size)** |
|---|---|---|
| *Training Logistics* | N/A | Not Reported |
| *Trainer Quality* | 96.4% | 821/854 |
| *Training Information Engaging* | 98.0% | 835/854 |
| *Training Information Organized and Prepared* | 98.1% | 838/854 |

In Year-1 of the program, Serna did not record performance measure data accurately in their performance measure reports, and it is unclear what specific numbers they entered into their Excel spreadsheets for the training satisfaction survey metrics. Thus, we cannot comment on Serna's training satisfaction performance measure data for Year-1 of their contract.

In Year-2 of the program, Serna received 854 completed training satisfaction surveys (Response Rate: 90.2%). Serna did not record data on satisfaction with training logistics. Through October 2020 in Year-2 of the program (January 2020 – December 2020), of the 854 participants who completed the training satisfaction survey, Serna met their performance measure target of 80+% satisfaction perceptions of trainer

quality (2020 Average: 96.4%; N = 821). Most of the training participants who responded to the survey indicated they found the training information presented to be engaging and useful (2020 Average: 98.0%; N = 835) and were satisfied that the materials have been well organized and prepared (2020 Average: 98.1%; N = 838). Serna did not report any data on knowledge retention for Year-1 or Year-2 of the contract to date.

Serna did not report demographic information for January 2019, February 2019, and April 2019 as they did not offer trainings these months. We present the cumulative demographic information of program participation across gender, age, ethnicity, and race in Figure 8 of Appendix B and by certification count in Figure 8 of Appendix C. Through November 2020, Serna partnered with 372 total community partners.

In their November 2020 performance measure report, Serna indicated that their training on leadership development was pushed back into 2021 with a tentative start date in February 2021 and noted that they aimed to host two events in December 2020.

In sum, Serna did not specify performance measure targets for training volume or program participation for Year 1 or Year 2 of their contract. Serna did not report training satisfaction data for Year 1 of their program. Serna met their annual performance measure targets of 80% or more of program participants satisfied with (a) trainer quality (Year-2 Average: 96.4%), (b) training information engagingness (Year 2 Average: 98.0%), and (c) training material organization (Year 2 Average: 98.1%). Serna did not specify a performance target for knowledge retention and did not report data on knowledge retention in Year 1 or Year 2 of the contract. Serna did not specify demographic performance measure targets. Most of Serna's program participants were female (80.2%) and a majority ranged in age from 25-44 (50.0%). A majority identified ethnically as Hispanic/Latino (50.8%) and racially as Caucasian/White (63.5%). The most commonly reported certification among Serna program participants was the Licensed Independent Social Worker (LISW).

**Conclusion and Recommendations**

Most E & T providers encountered some difficulties related to program implementation in response to the onset and continuation of the Covid-19 pandemic. For instance, in their narrative reports, most providers indicated they had to cancel training sessions earlier in the pandemic or re-configure service delivery from in-person training sessions to virtual training sessions. While some providers noted this process was challenging and some program participants disliked the transition, on average, most providers were able to proceed with service delivery and none experienced statistically-significant reductions in their reported survey satisfaction metrics per a series of unreported ordinary least squares regressions predicting each training satisfaction measure as a function of month.

Having noted the general successes in program continuity, however, there are some limitations to the performance measure data which limit the strength of conclusions we can make at the provider-level or in general across the set of E & T programs. From Table 12 below, only 50% of the providers reported sample sizes for their training satisfaction surveys and of the 50% of providers who reported the sample size for the training satisfaction surveys, response rates varied from a minimum of 25.6% to a maximum of 90.2%.

*Table 13. Response Rates[11] to Training Satisfaction Surveys by Providers*

| Provider | Response Rate for Satisfaction Surveys |
|---|---|
| All Faiths | Unknown |
| ARCA | 70.0% |
| BCCHC (Year 1) | 58.9% |
| BCCHC (Year 2) | 25.6% |
| MITC-1 (Year 1) | 89.4% |
| MITC-1 (Year 2) | 58.4% |
| MITC-2 | Unknown |
| NAMI - NM | Unknown |
| NMBLC | Unknown |
| Serna (Year 1) | Unknown |
| Serna (Year 2) | 90.2% |

The unknowability of the sample sizes for five of 11 of the provider-program years coupled with the low response rates of some of the others providers' satisfaction surveys make it difficult to accurately assess true perceptions of training quality, a problem particularly pronounced in small sample sizes (Fink 2003; Groves and Peytcheva 2008). Absent individual-level data on survey participants, we cannot discern whether participants who completed the satisfaction surveys or knowledge assessments were systematically different from those who did not take the survey on dimensions which correlate with either outcome (e.g., training satisfaction; training-relevant knowledge or attitudes) which, in consequence, could bias the data. Because survey and assessment participation were optional and at the discretion of training participants across all providers, self-selection into these assessments could inflate estimates of training satisfaction or degree of knowledge retention if those who enjoyed the training the most were more motivated to take the survey relative to those who had less satisfactory experiences. Alternatively, self-selection into these assessments could deflate estimates of training satisfaction or degree of knowledge retention if those most critical of the training were more motivated to take the survey relative to those who had more satisfactory training experiences (Groves and Peytcheva 2008). Further, the unknowability of the sample size for some of the providers and the small sample sizes of others raise the possibility that unidentified outlier respondents skew the distribution of reported opinion when these satisfaction and knowledge measures are dichotomized and collapsed together.

A related point – footnoted earlier – is that the substantive interpretation of the annual satisfaction measures across providers is conditional on whether the provider reports the sample sizes. For providers who report survey and assessment sample sizes, the annual average should be interpreted as the weighted average of training satisfaction across all participants who completed the survey or assessment: the weighted average accounts for disparities in reported sample sizes across different months. For providers who do not report survey or assessment sample sizes, the annual average should be interpreted as the monthly average of training satisfaction, though this is less informative. To illustrate, suppose that a hypothetical provider reports the results of ten total surveys, eight of which are completed in the month of November and two of which are completed in the month of December. Suppose ten of the November survey participants are satisfied with the training (100%; 10/10) whereas only one of the survey takers in December is satisfied with the training (50%; 1/2). If we only examine monthly satisfaction averages without information about

[11] Response rates are calculated as the total number of completed surveys divided by the total number of training participants. Providers who did not report the former have an indeterminate numerator and thus, the response rates are incalculable.

the monthly sample sizes, we may be tempted to conclude – if simply averaging monthly satisfaction percentages together – that 75% of participants were satisfied, when in reality, this estimate grossly understates the true degree of satisfaction. Thus, the average yearly satisfaction figures given by the providers which were not accompanied by information on the total number of completed surveys run the risk of such bias – assuming there were non-equivalent numbers of survey takers across months – and should only be interpreted as average monthly satisfaction levels rather than as the overall percent of program participants who completed the survey who were satisfied. In the future, to hedge against this complication in interpretation, we encourage providers to, at minimum, directly report both the total number of participants who scored a certain way on a specific measure (e.g., number who answered with a 4 or 5 on 5 point-Likert scale) and the total number of participants who answered specific questions on both surveys and pre-post assessments and encourage the County to enforce this collection going forward.

In a similar vein, we caution against making any causal inferences on the effectiveness of these programs on the basis of the data reported here (Matthay et al., 2020). By design, most providers offered training on an array of substantively distinct behavioral health topics, offered these trainings using different service delivery modes, and offered training and classes of variable duration. By aggregating training satisfaction and knowledge retention metrics into single percentages across multiple training sessions, however, we lose substantively interesting information about how participants evaluate different types of training sessions. Collapsing satisfaction scores or knowledge metrics without conditioning by the specific training or class offered obscures theoretically and practically interesting potential heterogeneity in program treatment effects across subgroups which could be informative for program design purposes downstream. For instance, it might be helpful to know that Training A is evaluated more highly by Group A than Group B and that Training A is overall better received than Training B across both groups. Knowing such information can aid in the development of culturally-adaptive programming, can help signal the need for program modification if necessary, and could be beneficial from a cost-effectiveness perspective as well.

Relatedly, another potential challenge to causal inference is the possibility of client duplication. Theoretically, given the overlap in some of the providers' target populations, it is possible that the same participant attends multiple trainings from multiple providers. While we may be tempted to assume the hypothesized positive effects of multiple training sessions will compound as more trainings are attended, we cannot empirically assess this assumption on the basis of the data provided. One possibility might be that participants who participate in multiple trainings across multiple providers are cognitively burdened by excessive information and thus may be less likely to retain the information learned in training. An alternative possibility might be that participants who participate in multiple trainings have higher levels of intrinsic motivation which explains why they attended in the first place and which may, in turn, correlate with more positive longitudinal client behavioral health outcomes. It is unclear from the data how many duplicate participants, if any, exist. Thus, the scale of this potential confound is unknown.

Additionally, there were some data quality concerns across multiple providers. One provider, for instance, mistakenly recorded the number of attendees for the number of trainings. One provider indicated they double-counted the same training across two months, making it unclear how to interpret the monthly figures for those two months. One provider submitted multiple performance measure reports as .pdf files instead of Excel worksheets which, on the back-end, delays data analysis. Another provider used an inaccurate denominator to compute their monthly satisfaction metrics. One provider inserted the number of training participants into the column for percent satisfaction for a years' worth of training satisfaction data and provided uninterpretable numbers exceeding the number of trainees for a given month in the incorrect column. Multiple providers did not report contracted performance measure data such as psychometric scales or website analytics, and most providers did not report longitudinal knowledge retention or belief change

for three or six-month follow-up periods. There were some delays in accessing performance measure data with reports submitted after the fifteenth of each month. These issues – paired with the possibility of mentioned response biases and questions surrounding sample sizes – limit the interpretability of the data in this report. While we recognize the potential organizational costs, we recommend standardizing reporting practices across providers, that providers develop a psychometrically-valid universal training satisfaction questionnaire to be delivered across all providers to increase comparability and the standardization of questions used, and to increase provider-level staff training on data reporting and quality to mitigate some of these problems.

Further, it may be worth considering which metrics are useful to report going forward. Knowing the number of pre-assessments and post-assessments completed, while helpful, does not tell one much if this information is not paired with complementary information about increases or decreases in knowledge. Relatedly, in the absence of access to individual-level data on recorded outcome measures and in the absence of more information about the specific questions providers are asking, it is unclear what precisely is being assessed from an outcome-oriented perspective (e.g., how exactly is each provider measuring knowledge gains or maintenance?). Further, the phrasing of some of the existing performance measures – at least in the context of how they are reported in the monthly performance measure reports - complicates interpretation at times (e.g., In the context of the collaborative partnership metric, it is unclear what the distinction is between "Developing a new partnership, coordination and shared information" and "Establishing a new partnership, cooperation and relationship".). Relatedly, while it is helpful to know the degree to which training-related knowledge increased the day of the training, it is arguably more important to track training-relevant knowledge increases over a longer period of time and to gather survey data on the extent to which clinicians and other training participants integrate aspects of their training into their own practice instead of assuming such practices and techniques will necessarily be deployed. Resolving some of these conceptual ambiguities and including more data on specific outcome measures – and not primarily self-reported training satisfaction – will optimize the utility of such reports going forward.

Finally, the evaluation of most of these programs occurred in the broader context of the Covid-19 pandemic (Sastry, McGonagle, and Fomby 2020). The pandemic influenced a number of program operations, staffing procedures, hours, and morale. While there do not appear to be any statistically-significant discontinuities in training satisfaction metrics across all providers, it is worth being mindful of the ways in which the specific service delivery changes engendered by Covid-19 mid-intervention – most prominently, the transition away from in-person to virtual trainings – may influence outcomes, differentially bias who self-selects into programs, and complicates the ability to make causal inferences about specific providers' program efficacy.

Some of these limitations, however, present opportunities for future research for outcome evaluation, conditional on data availability. For instance, one possibility for outcome evaluation could compare participants who complete specific training programs with matched colleagues – similar on most other background covariates – who did not attend such training and, pending the availability of particular client-side outcome records we could link to specific program participants and non-participants (e.g., case report follow-ups; re-arrest data) and sufficient sample sizes of participants and non-participants, we could use matching techniques to approximate the causal effect of training on client-side outcomes (Dehejia and Wahba 1999).

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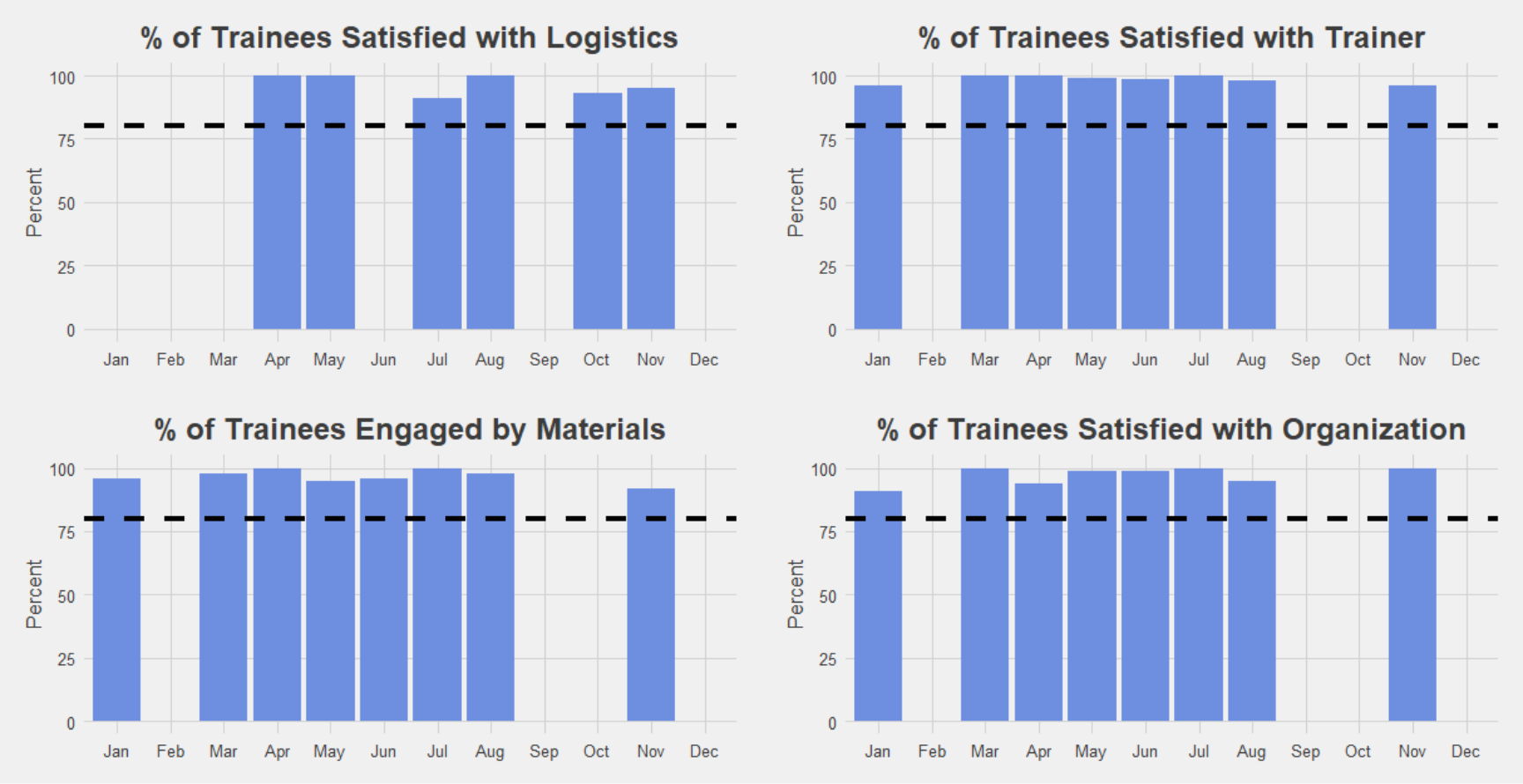
## Appendix A – Training Satisfaction

*Figure 1. Training Satisfaction Metrics for All Faiths Participants (January 2020 – November 2020)*

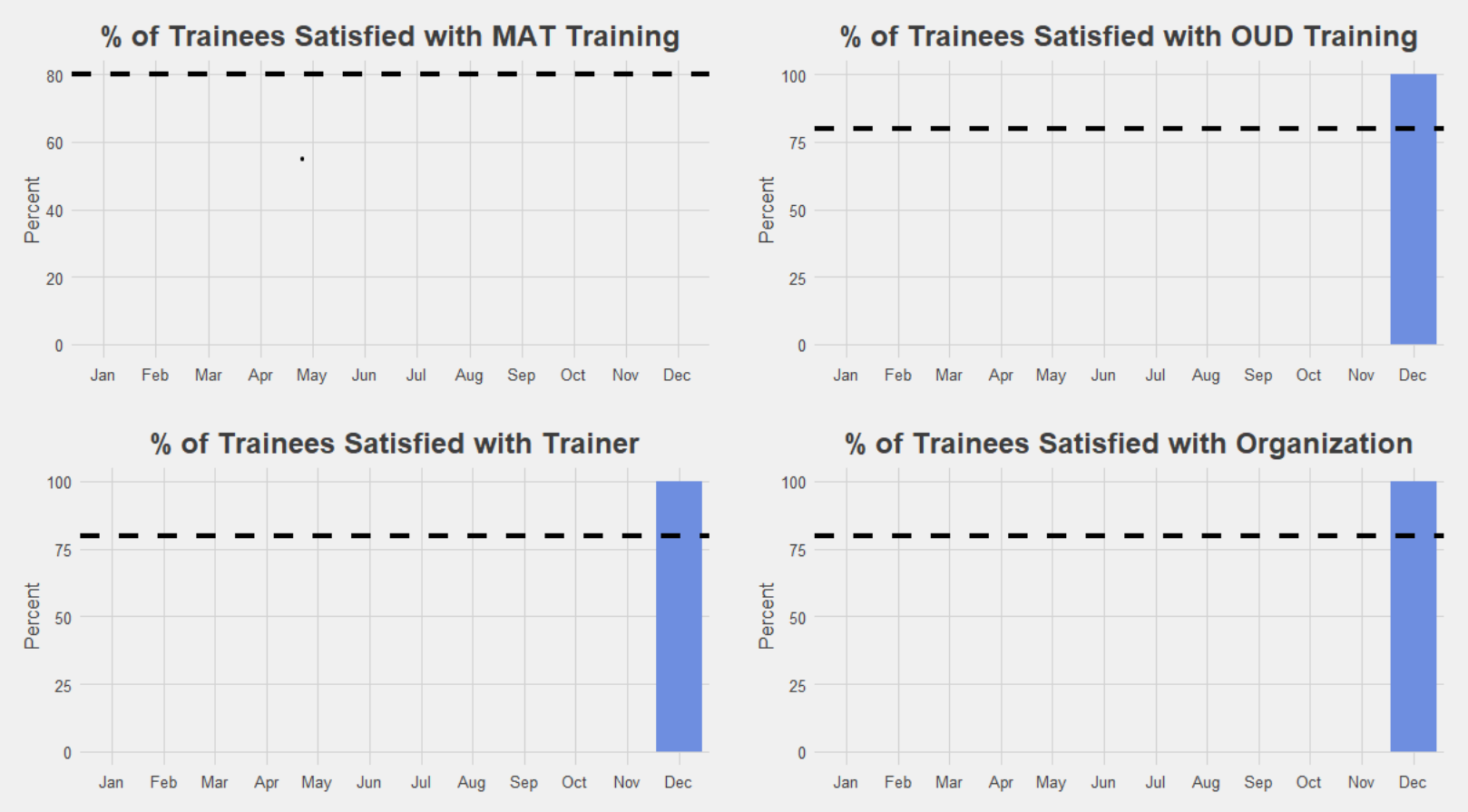

*Data Source: Performance measure data provided by All Faiths to Bernalillo County.*
*Sample size (N) for surveys unknown as provider did not report this data.*
*Black dashed line indicates 80% benchmark. Metrics based on percentage of trainees who answered 4 (A Lot) or 5 (Very Much) on 5-point Likert scale.*

*Figure 2. Training Satisfaction Metrics for ARCA Participants (January 2020 – November 2020)*



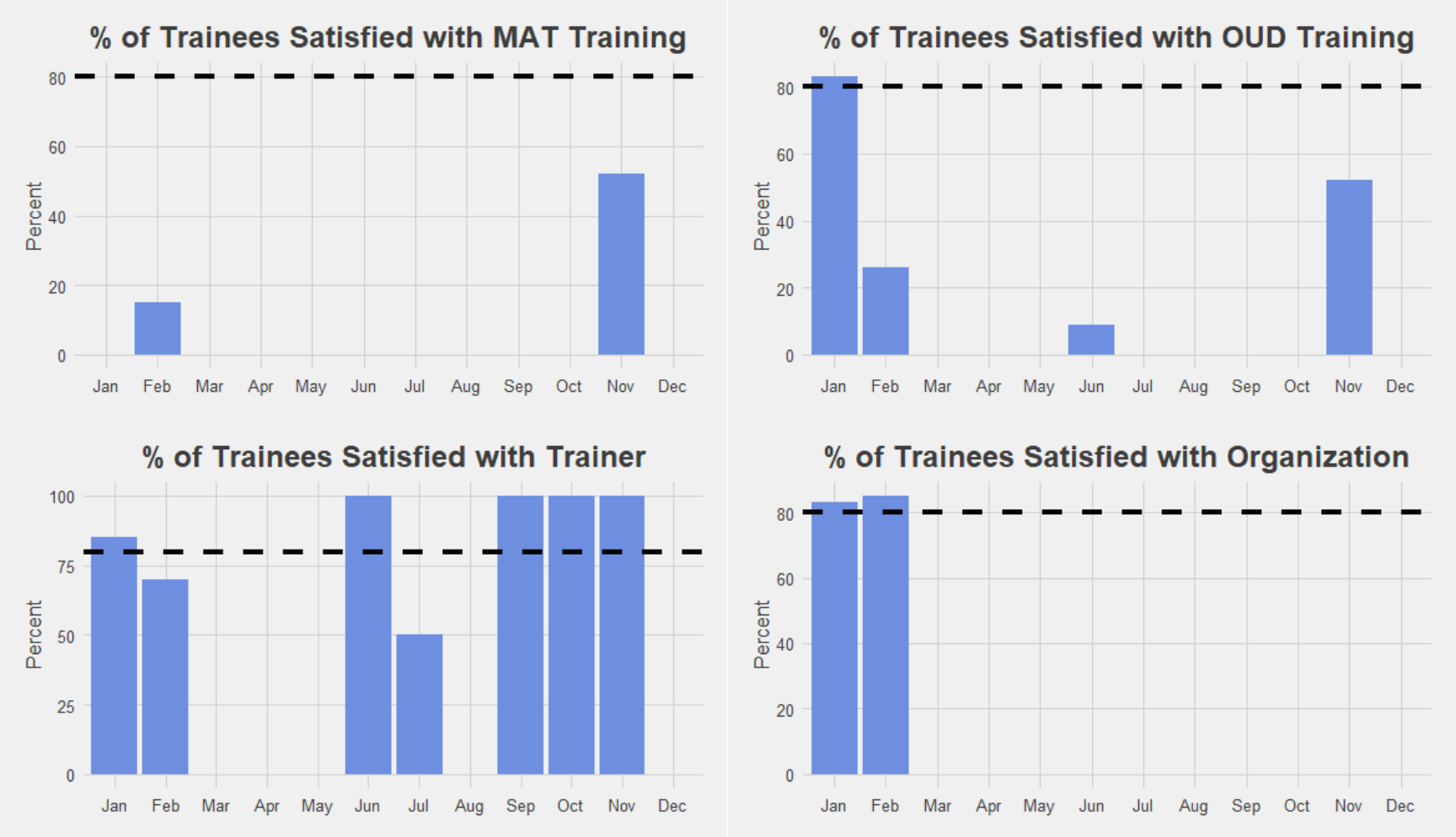

*Data Source: Performance measure data provided by ARCA to Bernalillo County.*
*Sample size (N) = 140.*
*Black dashed line indicates 80% benchmark. Metrics based on percentage of trainees who answered 4 or 5 on 5-point Likert scale.*

*Figure 3. Training Satisfaction Metrics for BCCHC Participants (January 2019 – December 2019)*



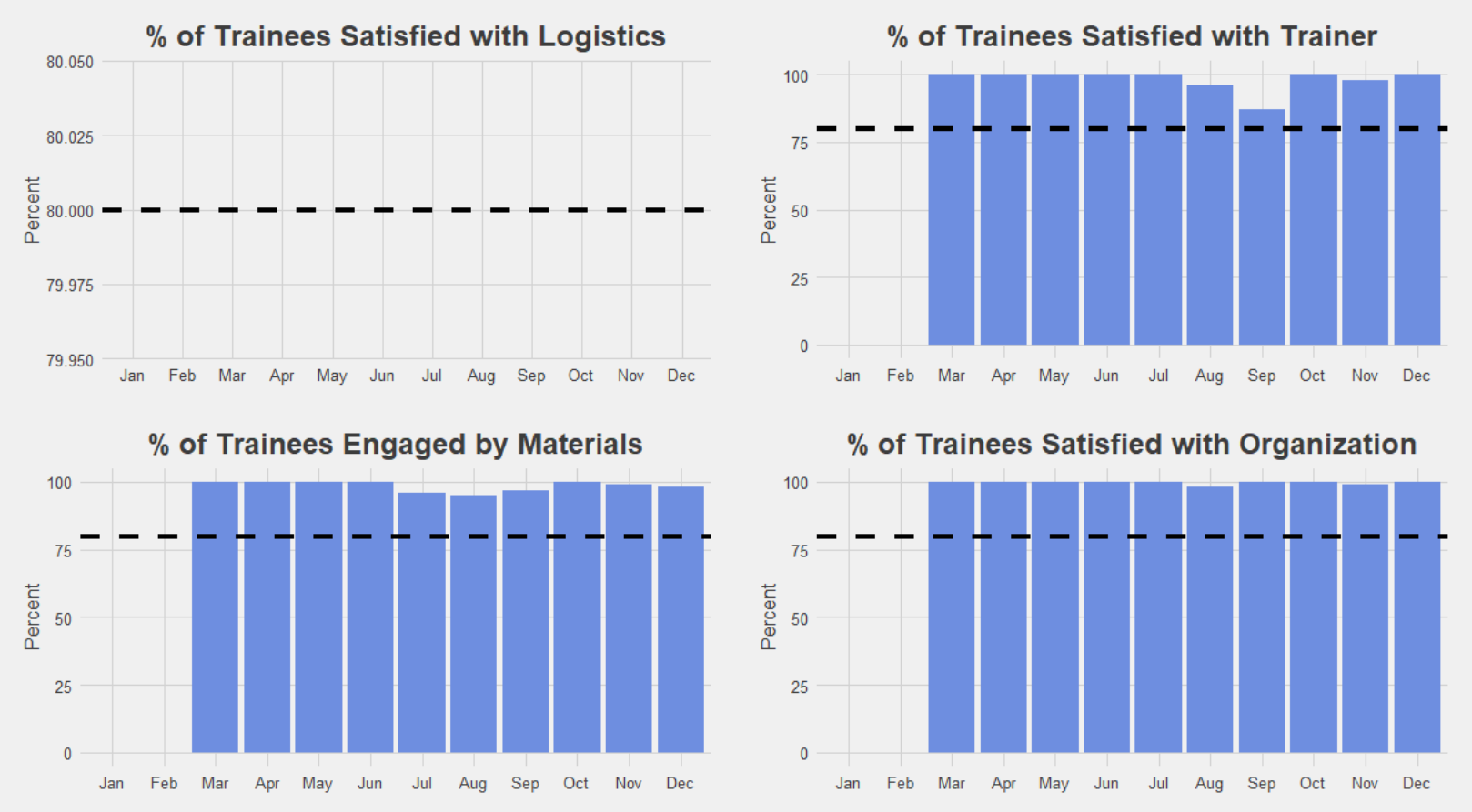

*Data Source: Performance measure data provided by BCCHC to Bernalillo County.*
*Sample size (N) = 2.*
*Black dashed line indicates 80% benchmark. Metrics based on percentage of trainees who answered 4 or 5 on 5-point Likert scale.*
*Some months reported 0% satisfaction, not visible in this visualization.*

*Figure 4. Training Satisfaction Metrics for BCCHC Participants (January 2020 – November 2020)*




*Data Source: Performance measure data provided by BCCHC to Bernalillo County.*
*Sample size (N) = 213.*
*Black dashed line indicates 80% benchmark. Metrics based on percentage of trainees who answered 4 or 5 on 5-point Likert scale.*
*Some months reported 0% satisfaction, not visible in this visualization.*

*Figure 5. Training Satisfaction Metrics for MITC-1 Participants (January 2019 – December 2019)*

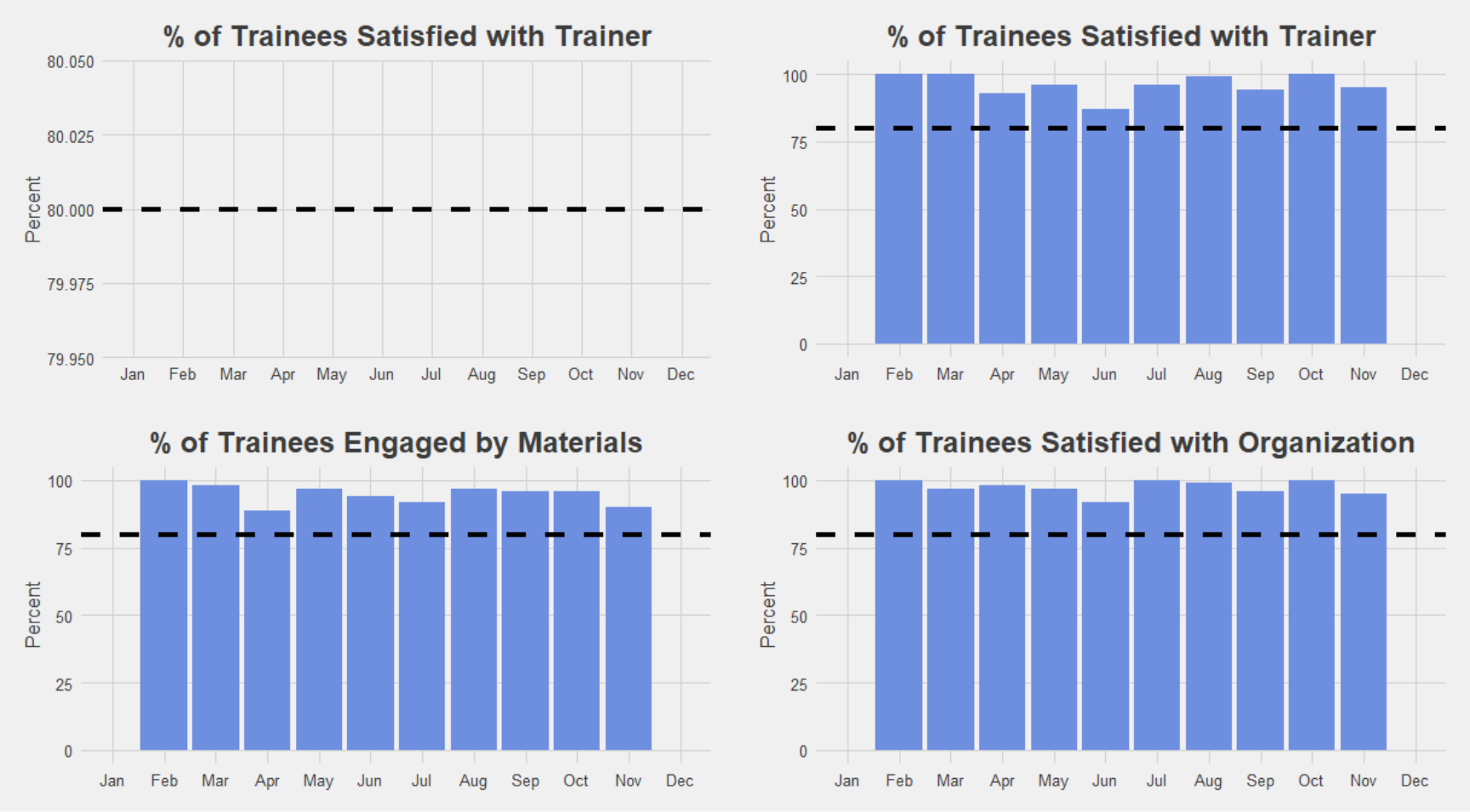



*Data Source: Performance measure data provided by MITC-1 to Bernalillo County.*
*Sample size (N) = 423.*
*Black dashed line indicates 80% benchmark. Metrics based on percentage of trainees who answered 4 or 5 on 5-point Likert scale.*
*MITC-1 did not report data on satisfaction with training logistics.*

*Figure 6. Training Satisfaction Metrics for MITC-1 Participants (January 2020 – November 2020)*


*Data Source: Performance measure data provided by MITC-1 to Bernalillo County.*
*Sample size (N) = 293.*
*Black dashed line indicates 80% benchmark. Metrics based on percentage of trainees who answered 4 or 5 on 5-point Likert scale.*

*Figure 7. Training Satisfaction Metrics for MITC-2 Participants (January 2020 – November 2020)*

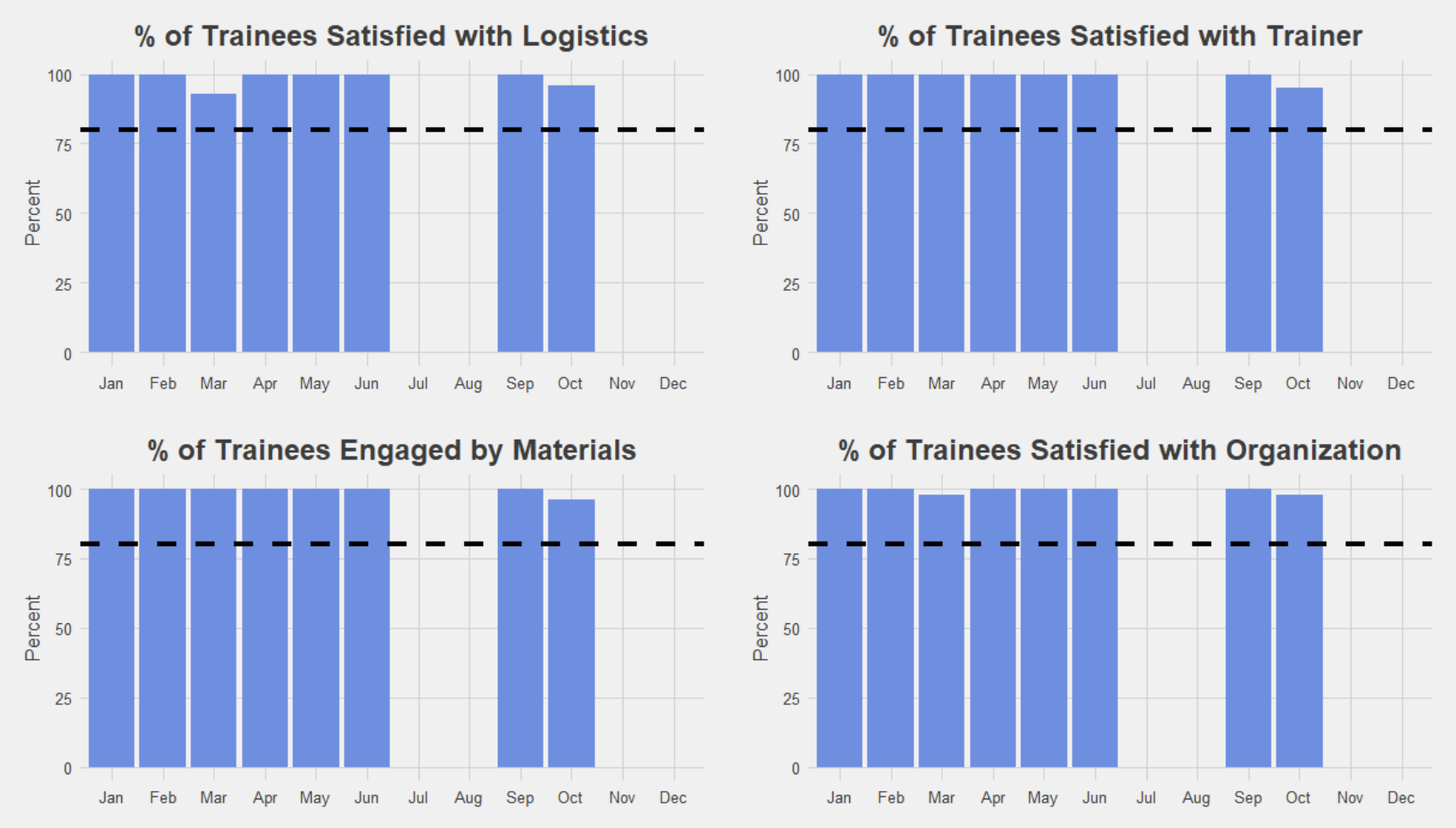



*Data Source: Performance measure data provided by MITC-2 to Bernalillo County.*
*Sample size (N) for surveys unknown as provider did not report this data.*
*MITC-2 did not report data on satisfaction with training logistics.*
*Black dashed line indicates 80% benchmark. Metrics based on percentage of trainees who answered 4 or 5 on 5-point Likert scale.*

*Figure 8. Training Satisfaction Metrics for NAMI - NM Participants (January 2020 – November 2020)*


*Data Source: Performance measure data provided by NAMI - NM to Bernalillo County.*
*Sample size (N) for surveys unknown as provider did not report this data.*
*Black dashed line indicates 80% benchmark. Metrics based on percentage of trainees who answered 4 or 5 on 5-point Likert scale.*

*Figure 9. Training Satisfaction Metrics for NMBLC Participants (January 2020 – November 2020)*

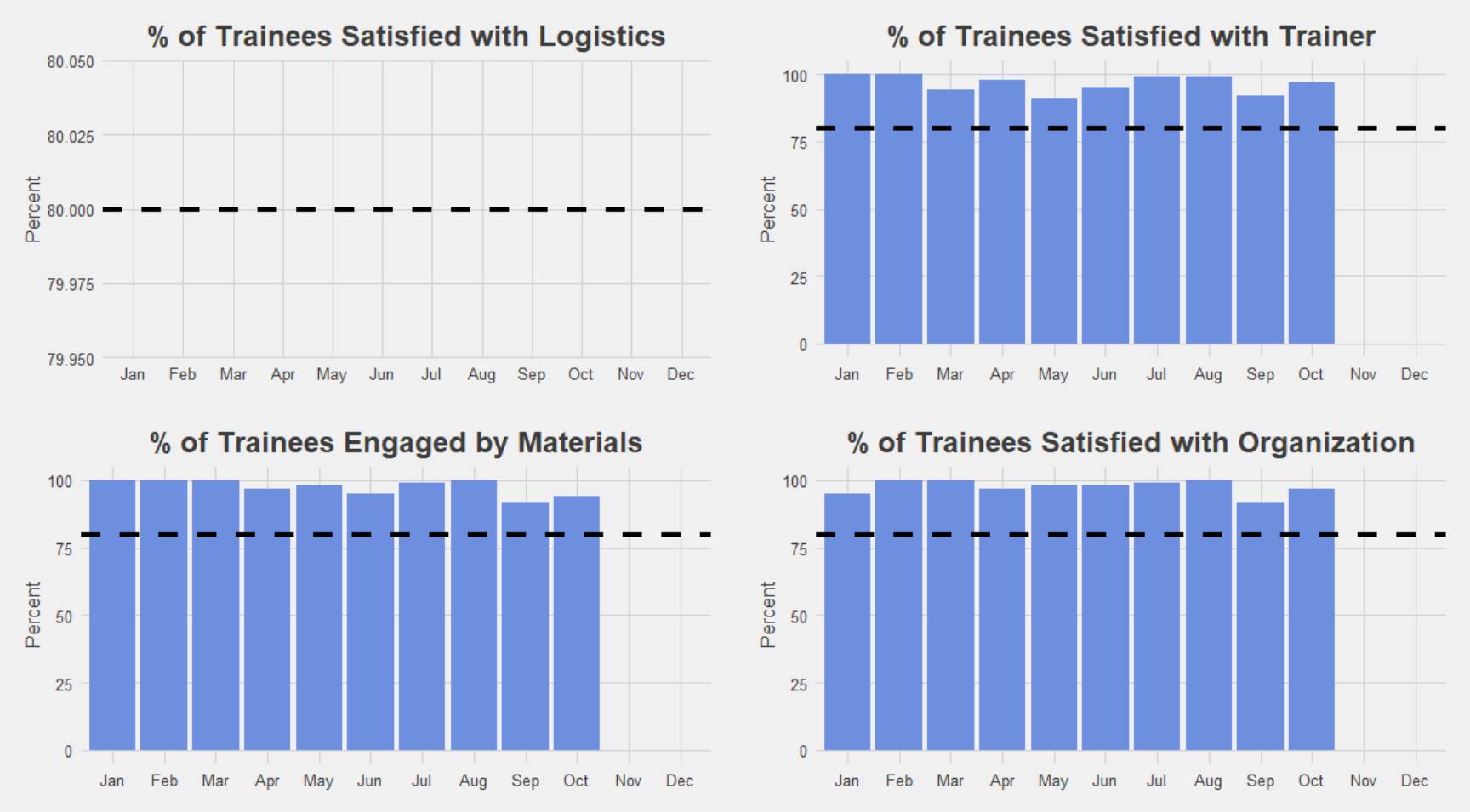



*Data Source: Performance measure data provided by NMBLC to Bernalillo County.*
*Sample size (N) for surveys unknown as provider did not report this data.*
*Black dashed line indicates 80% benchmark. Metrics based on percentage of trainees who answered 4 or 5 on 5-point Likert scale.*

*Figure 10. Training Satisfaction Metrics for Serna Participants (January 2019 – December 2019)*


*Data Source: Performance measure data provided by Serna to Bernalillo County.*
*Sample size (N) for surveys unknown as provider did not report this data.*
*Black dashed line indicates 80% benchmark. Metrics based on percentage of trainees who answered 4 or 5 on 5-point Likert scale.*

*Figure 11. Training Satisfaction Metrics for Serna Participants (January 2020 – November 2020)*




*Data Source: Performance measure data provided by Serna to Bernalillo County.*
*Sample size (N) = 854.*
*Serna did not report data on satisfaction with training logistics.*
*Black dashed line indicates 80% benchmark. Metrics based on percentage of trainees who answered 4 or 5 on 5-point Likert scale.*

## Appendix B – Demographics of Participants

*Figure 1. Demographics of All Faiths Participants (January 2020 – November 2020)*

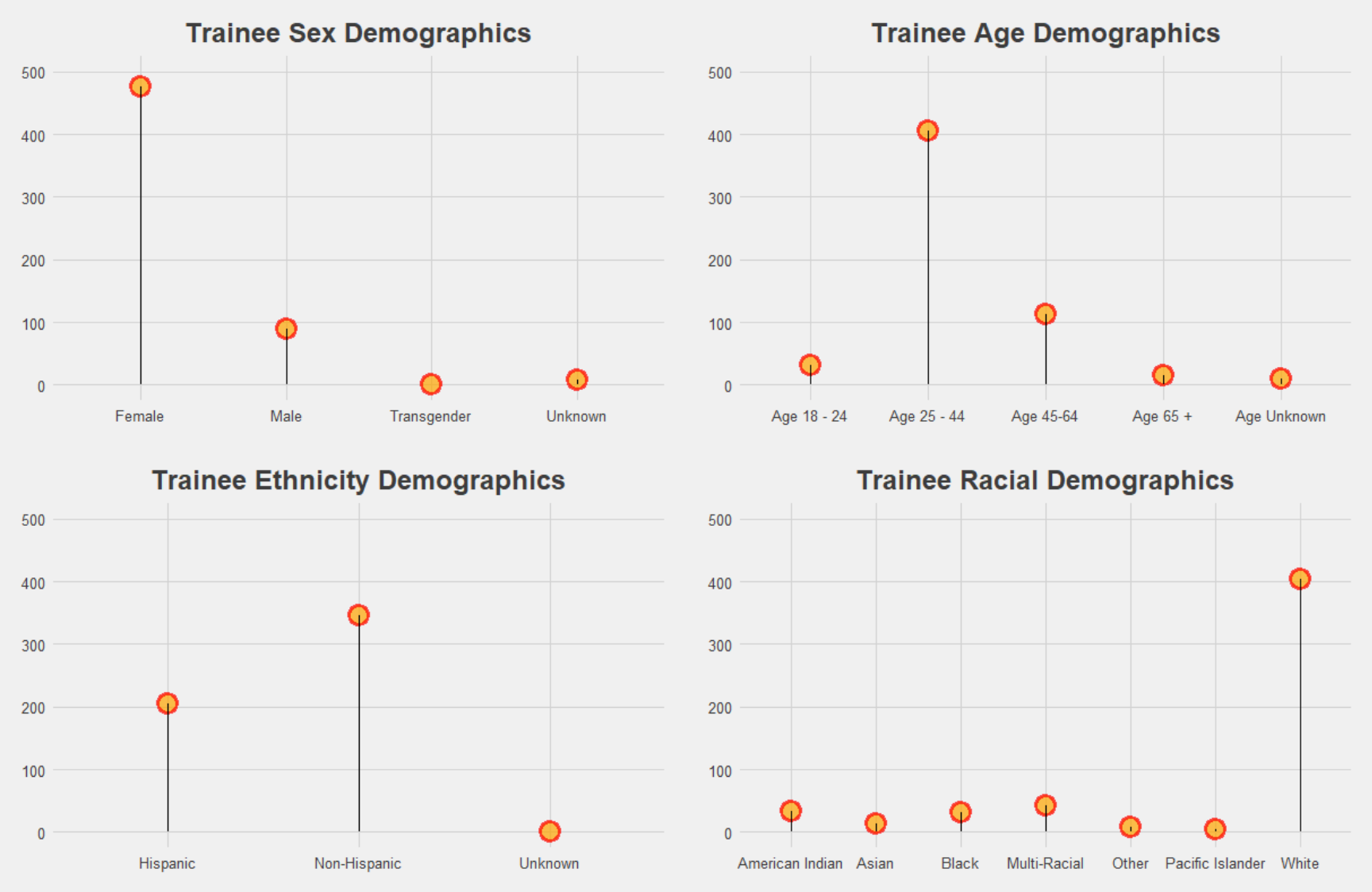


*Figure 2. Demographics of ARCA Participants (January 2020 – November 2020)*

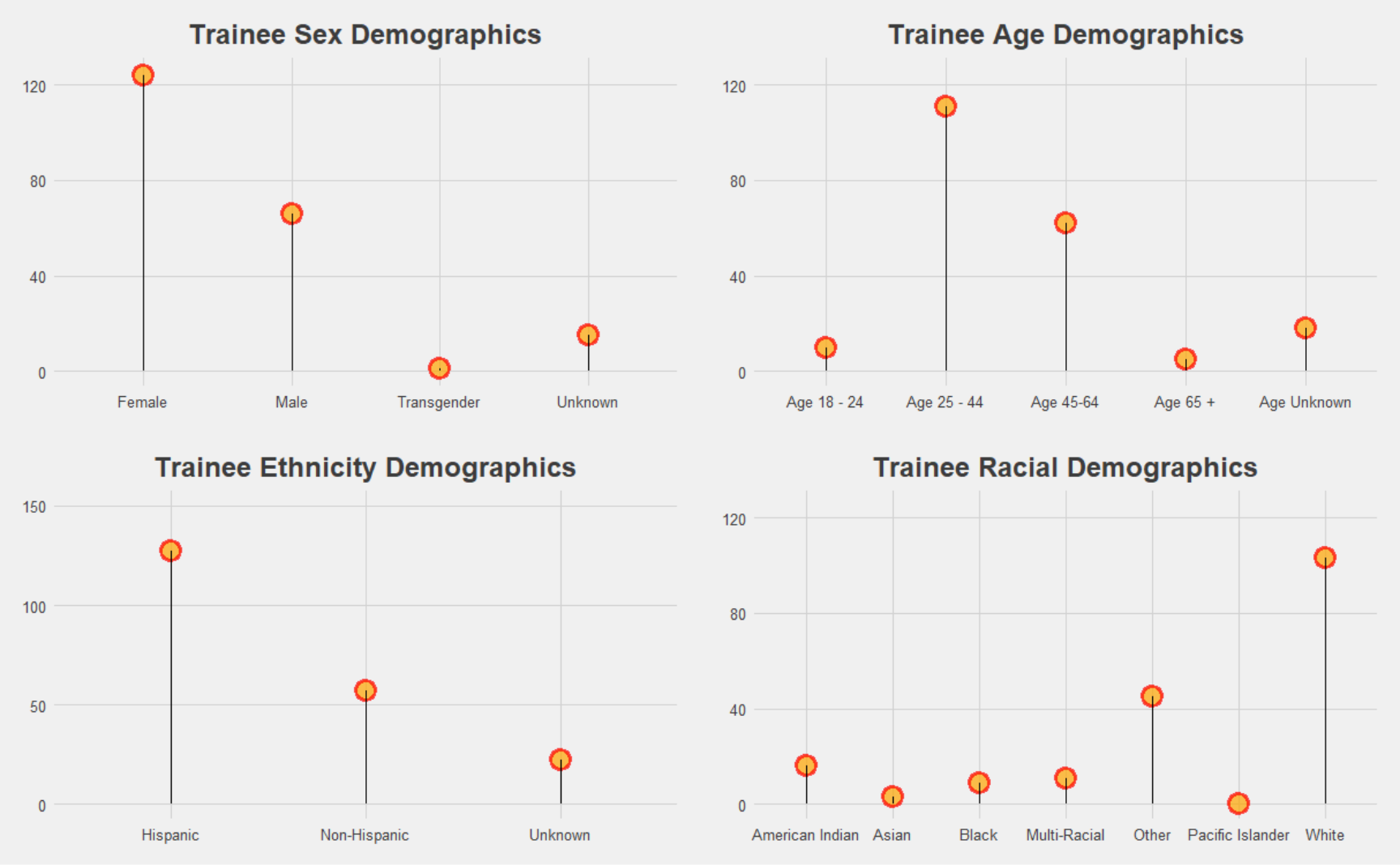



*Figure 3. Demographics of BCCHC Participants (January 2019 – November 2020)*

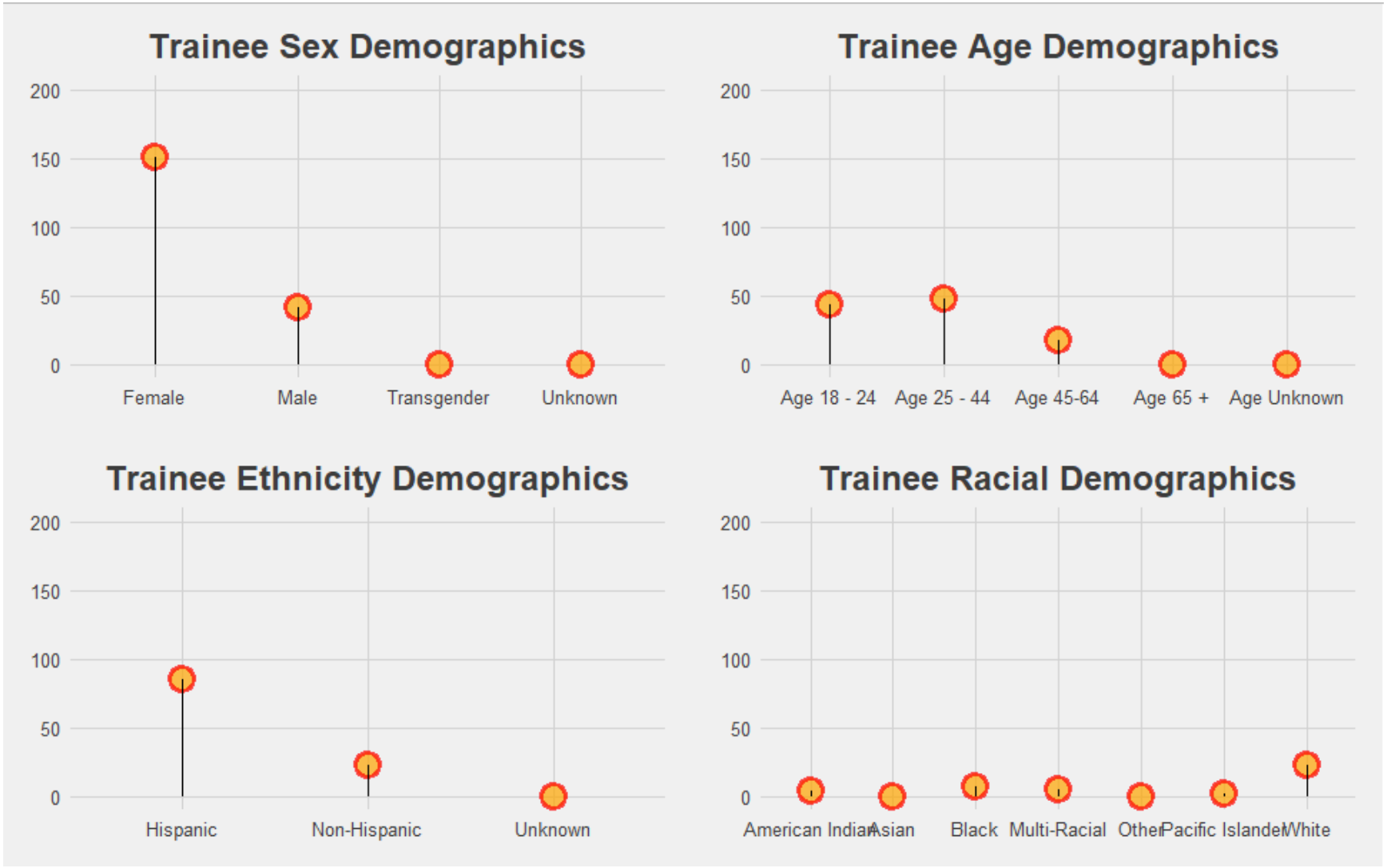



*Figure 4. Demographics of MITC-1 Participants (January 2019 – November 2020)*

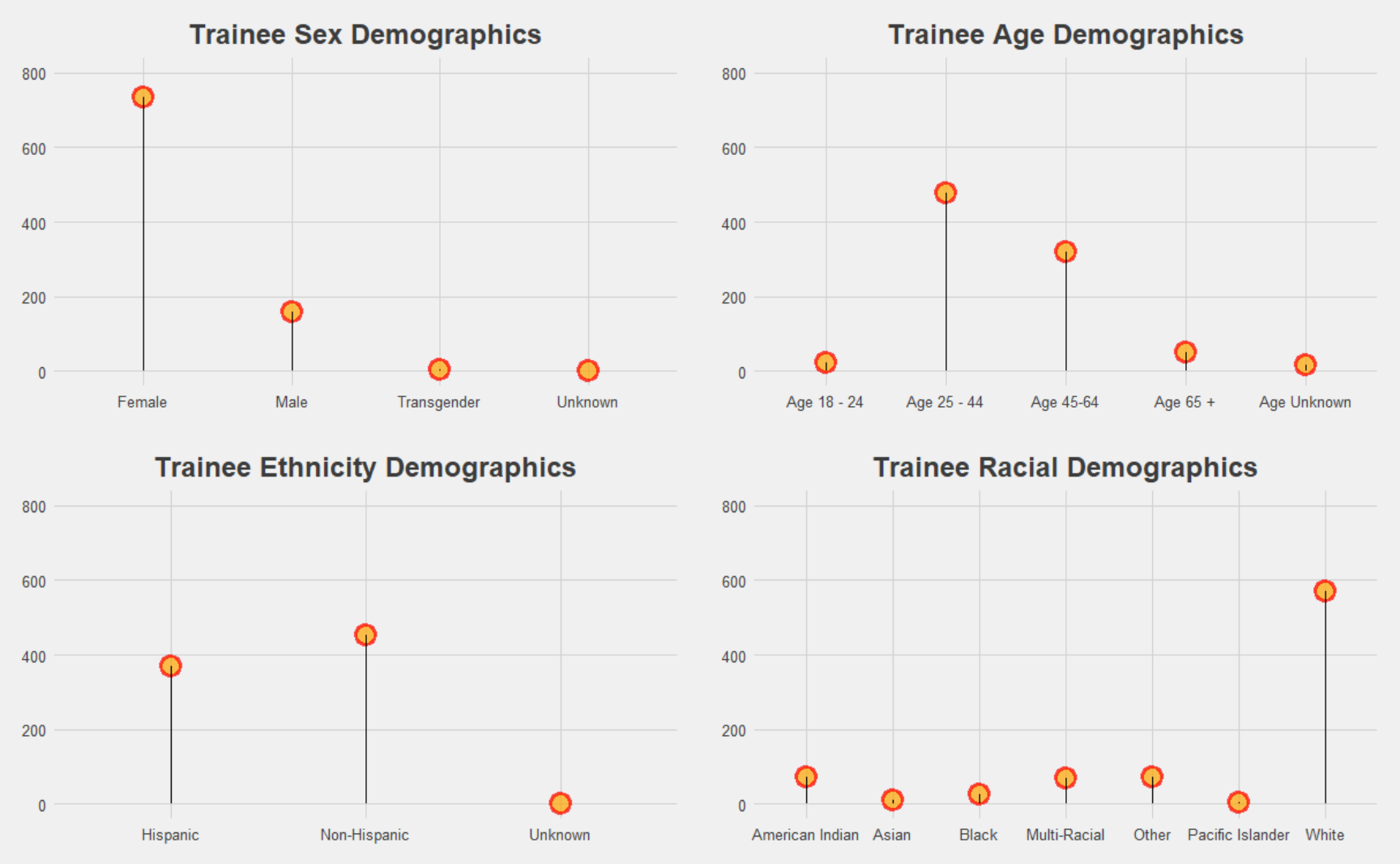



*Figure 5. Demographics of MITC-2 Participants (January 2020 – November 2020)*

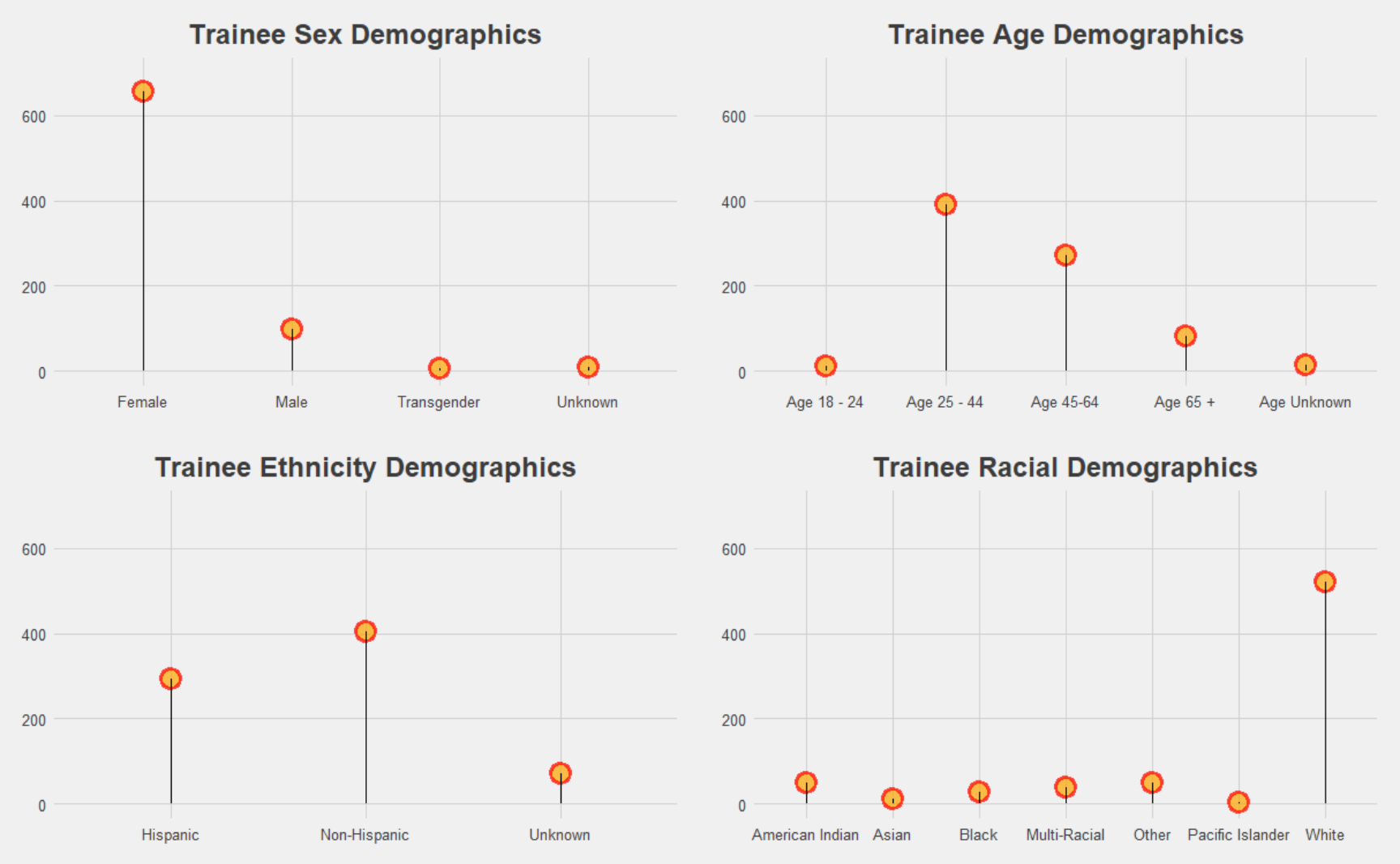



*Figure 6. Demographics of NAMI - NM Participants (January 2020 – November 2020)*

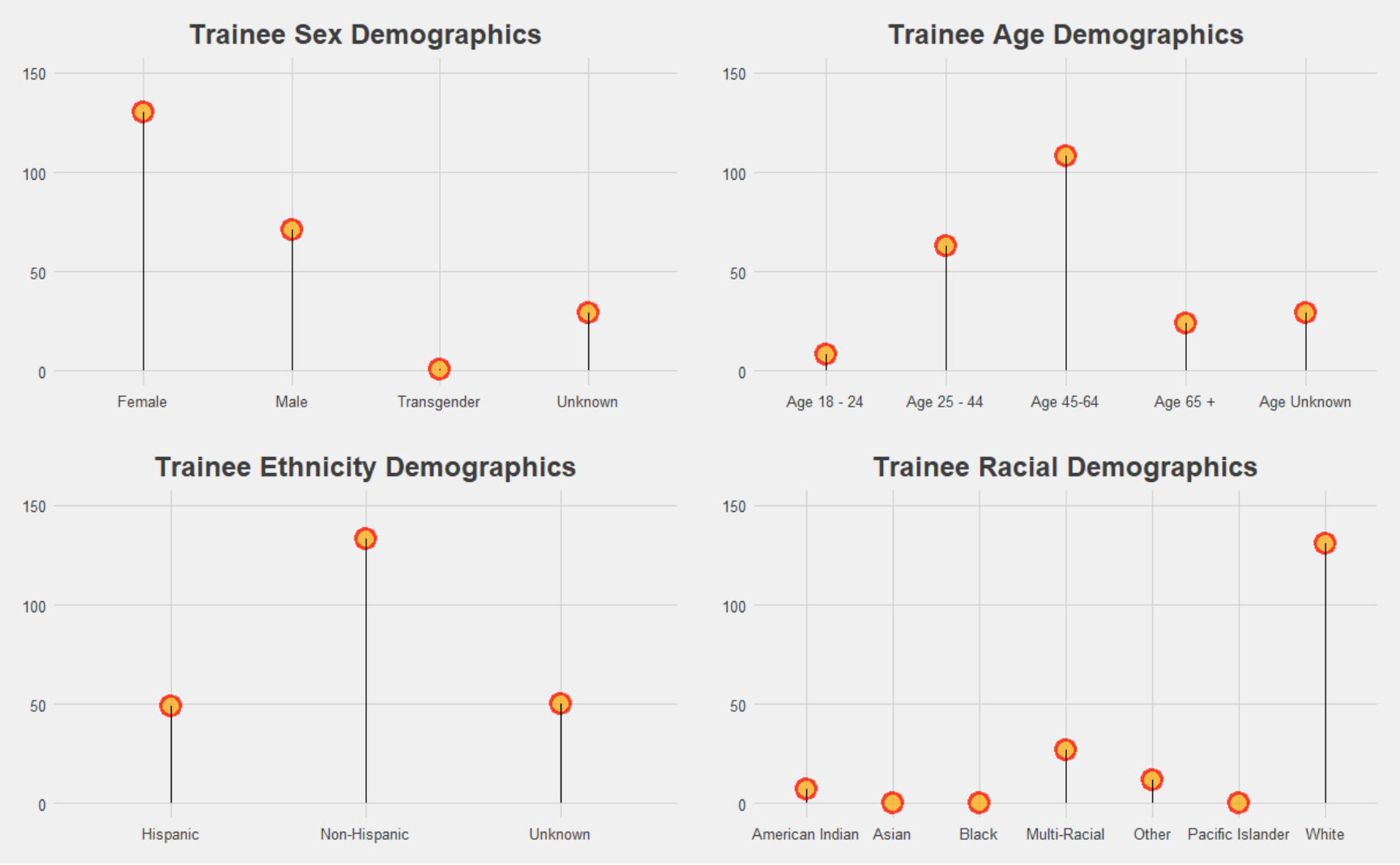

Trainee Sex Demographics
150
100
50
0
Female
Male
Transgender
Unknown
Trainee Age Demographics
150
100
50
0
Age 18 - 24
Age 25 - 44
Age 45-64
Age 65 +
Age Unknown
Trainee Ethnicity Demographics
150
100
50
0
Hispanic
Non-Hispanic
Unknown
Trainee Racial Demographics
150
100
50
0
American Indian
Asian
Black
Multi-Racial
Other
Pacific Islander
White

*Figure 7. Demographics of NMBLC Participants (January 2020 – November 2020)*

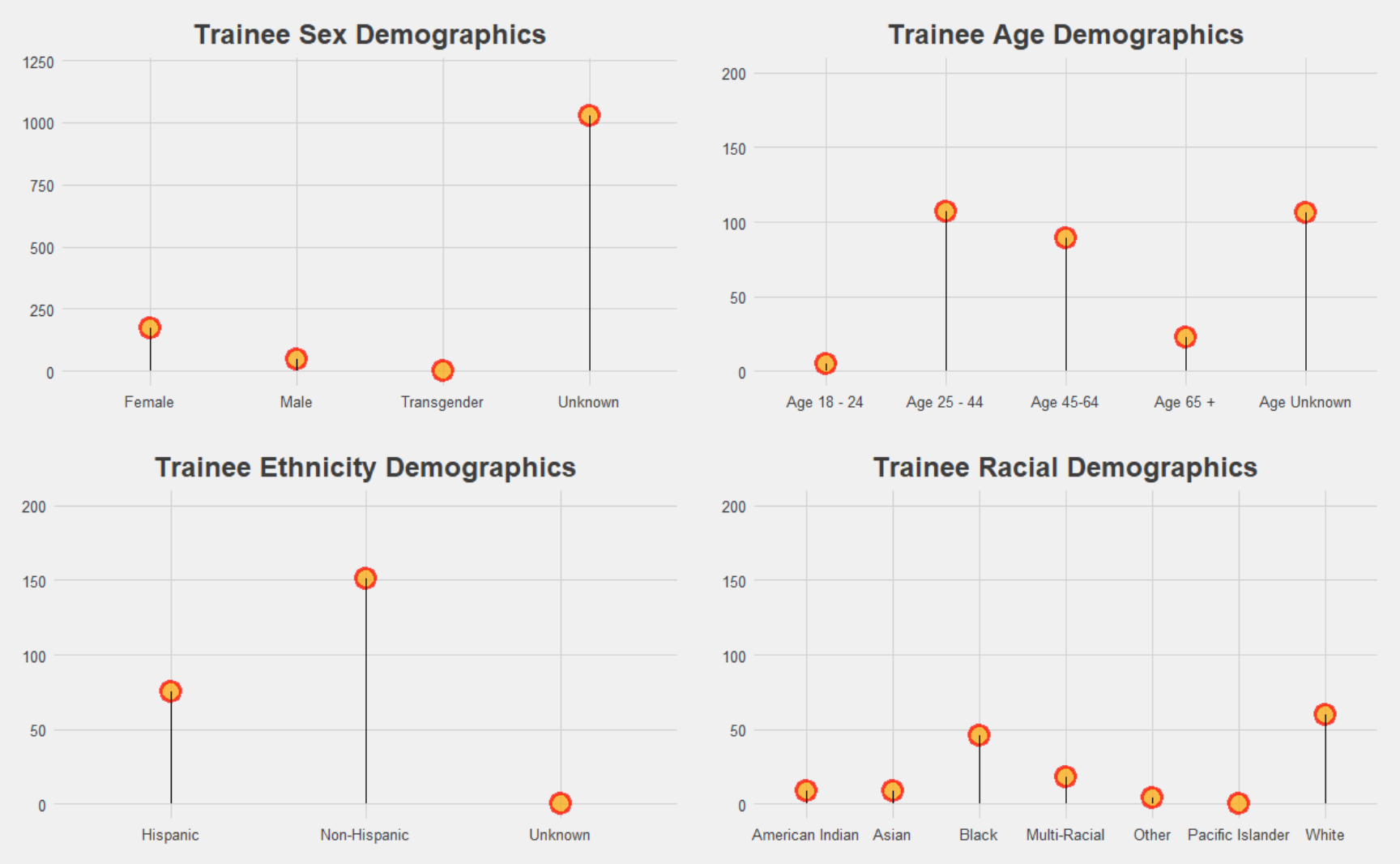
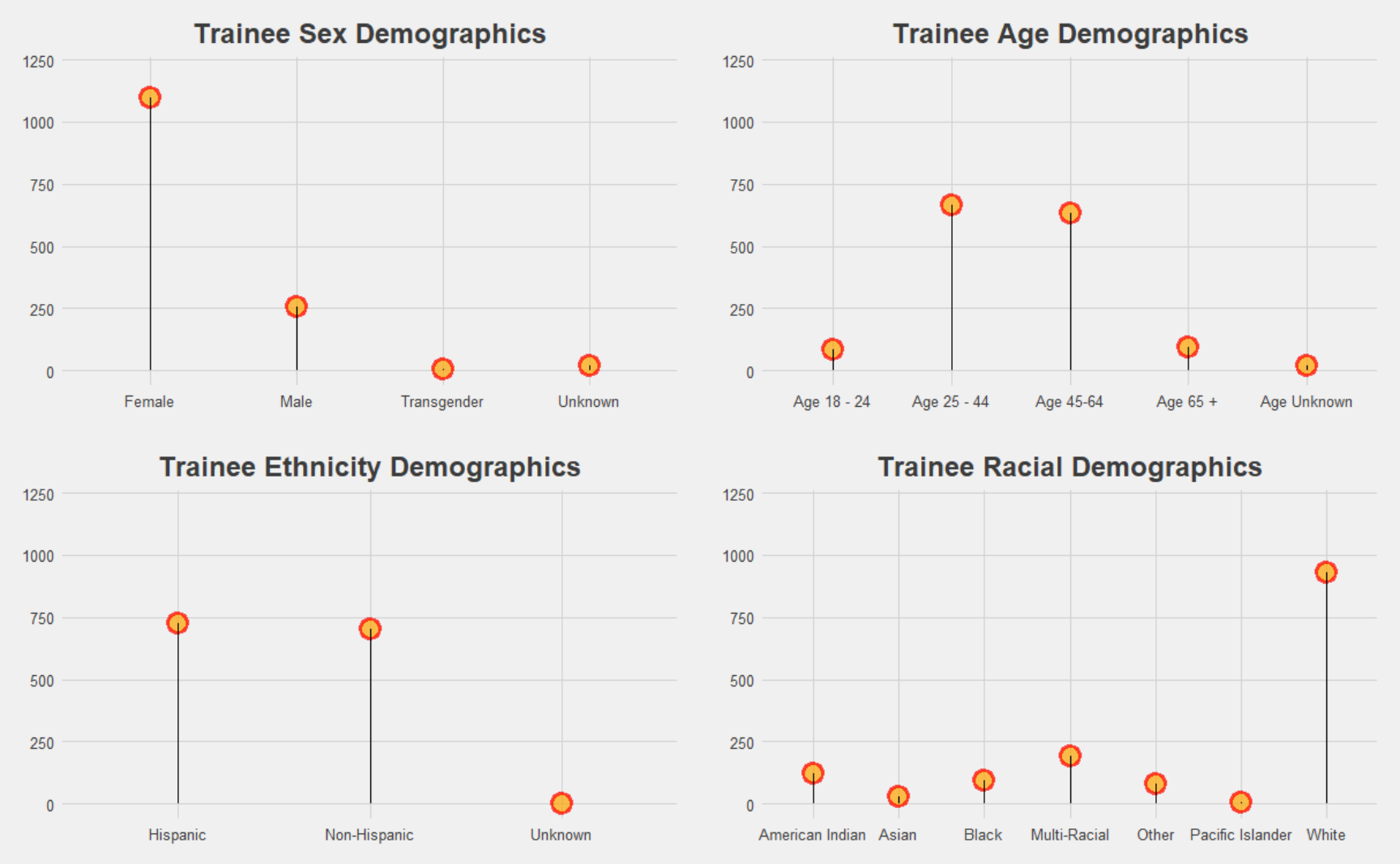


*Figure 8. Demographics of Serna Participants (January 2019 – November 2020)*



## Appendix C: Most Common Trainee Certifications by Provider[12]

*Figure 1. All Faiths Participants' Most Common Certifications*

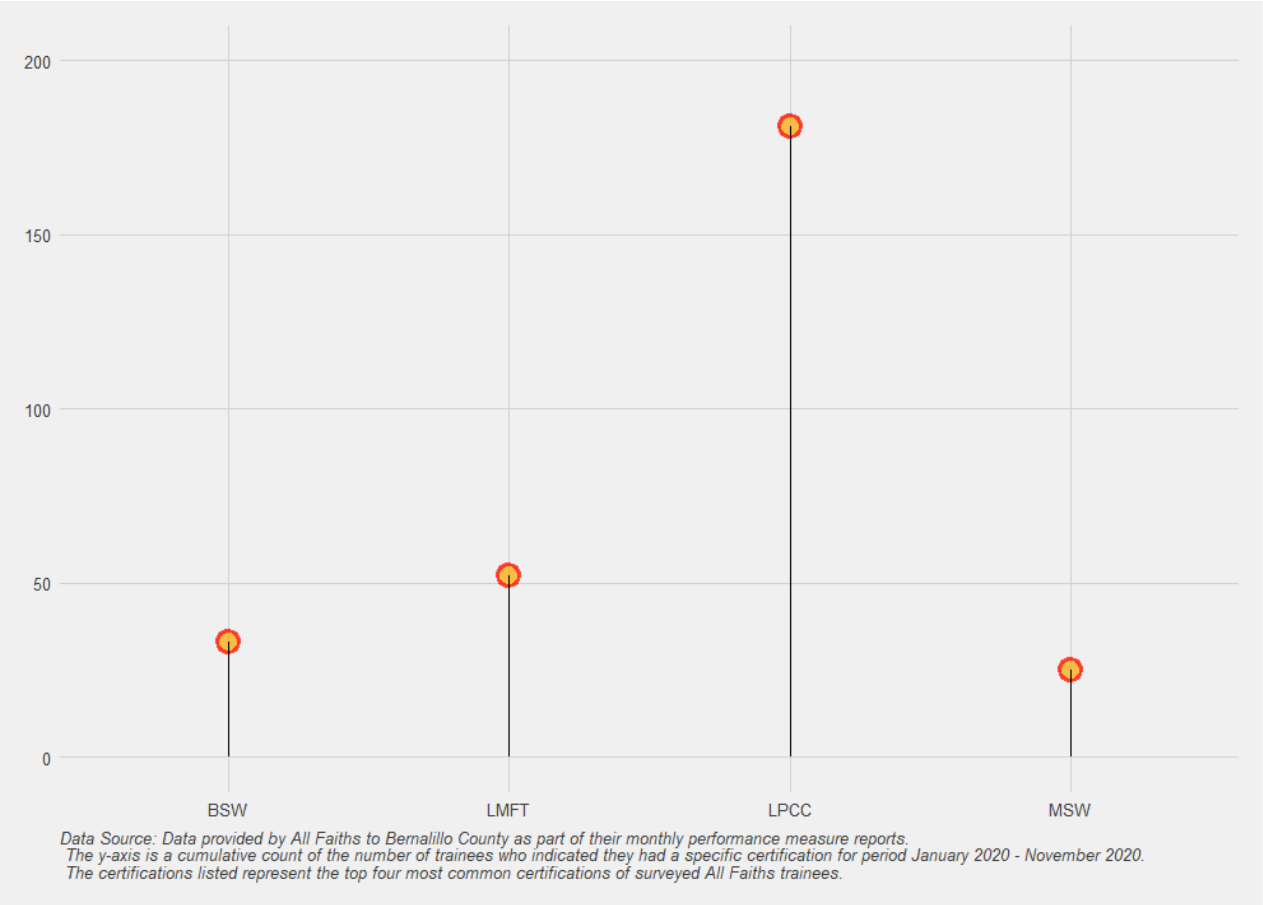
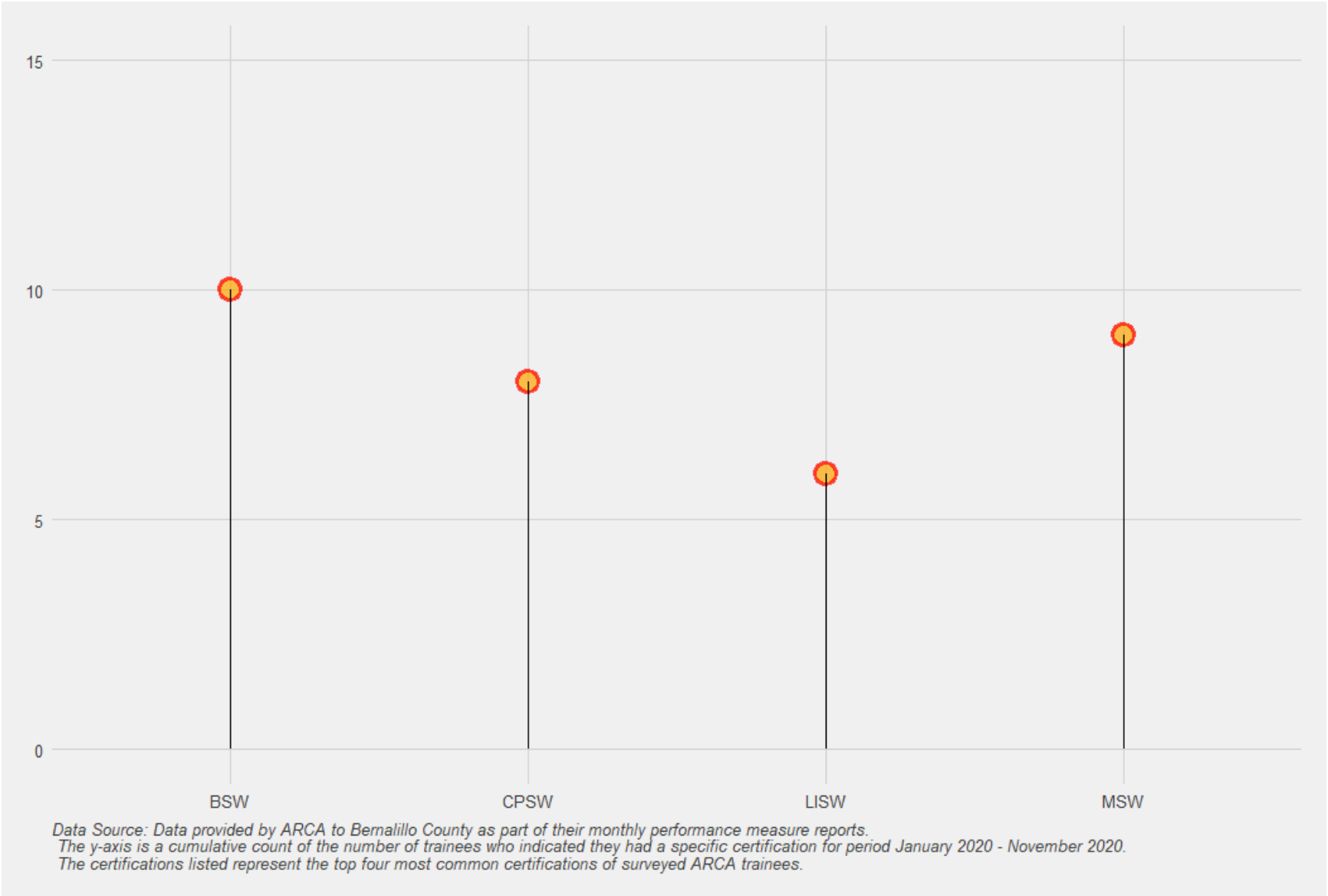


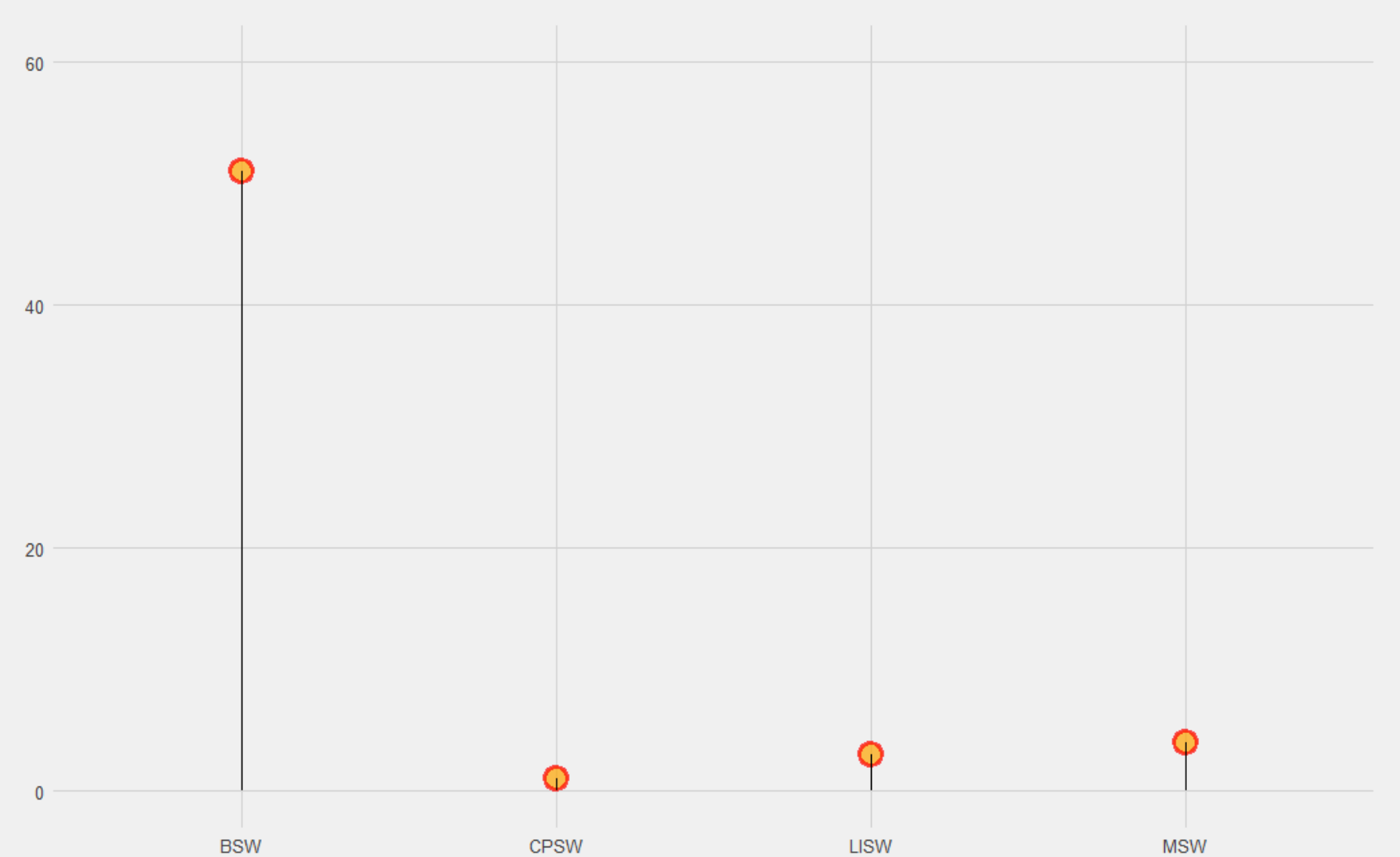

*Figure 2. ARCA Participants' Most Common Certifications*

[12] Most providers reported additional qualifications under the professional certification list. For instance, some providers included certification rows for "Professional" or "Community Member", both of which are not formal certifications or degrees. We did not include these types of qualifications for these reasons in our summation.



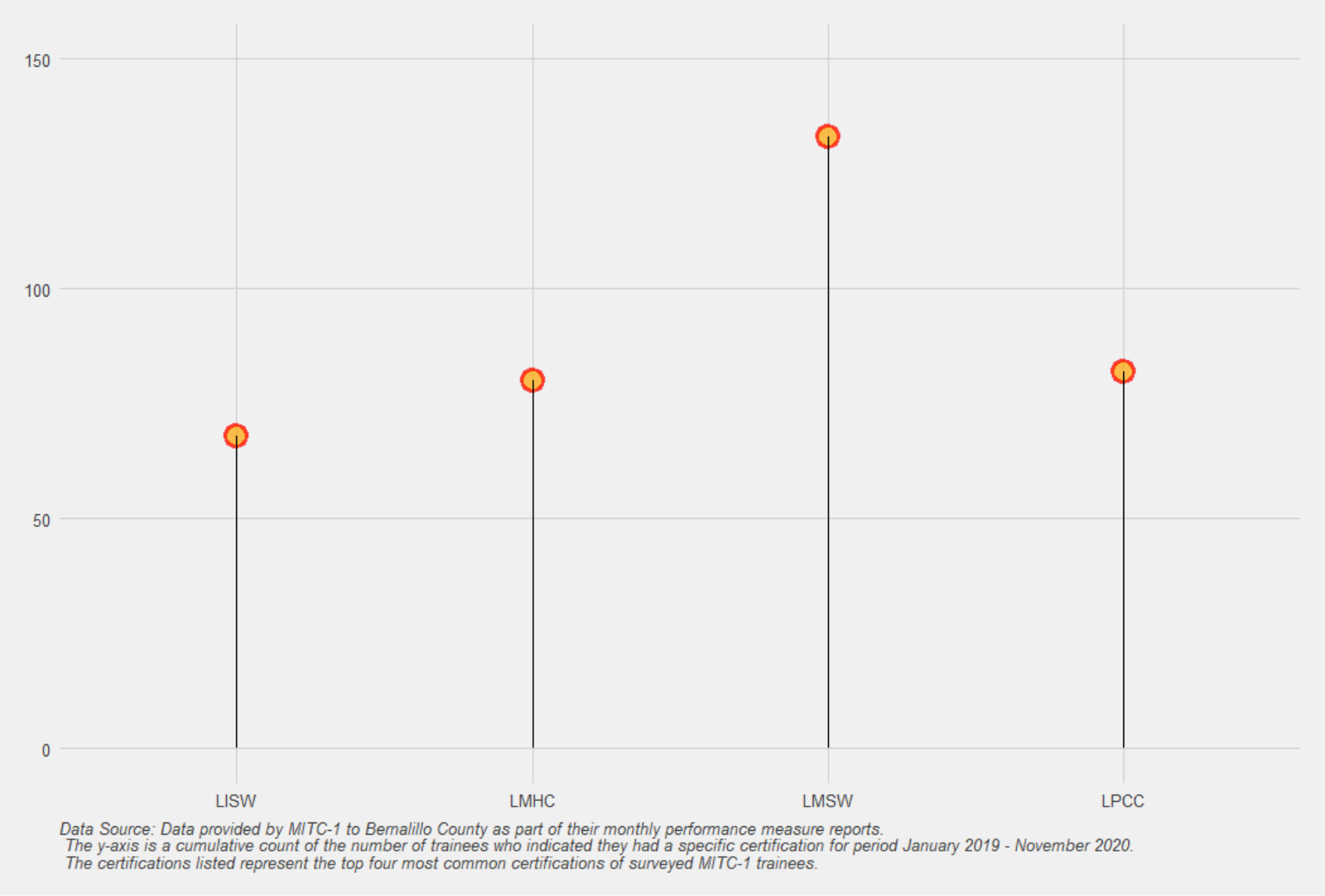

*Data Source: Data provided by ARCA to Bernalillo County as part of their monthly performance measure reports.*
*The y-axis is a cumulative count of the number of trainees who indicated they had a specific certification for period January 2020 - November 2020.*
*The certifications listed represent the top four most common certifications of surveyed ARCA trainees.*

*Figure 3. BCCHC Participants' Most Common Certifications*



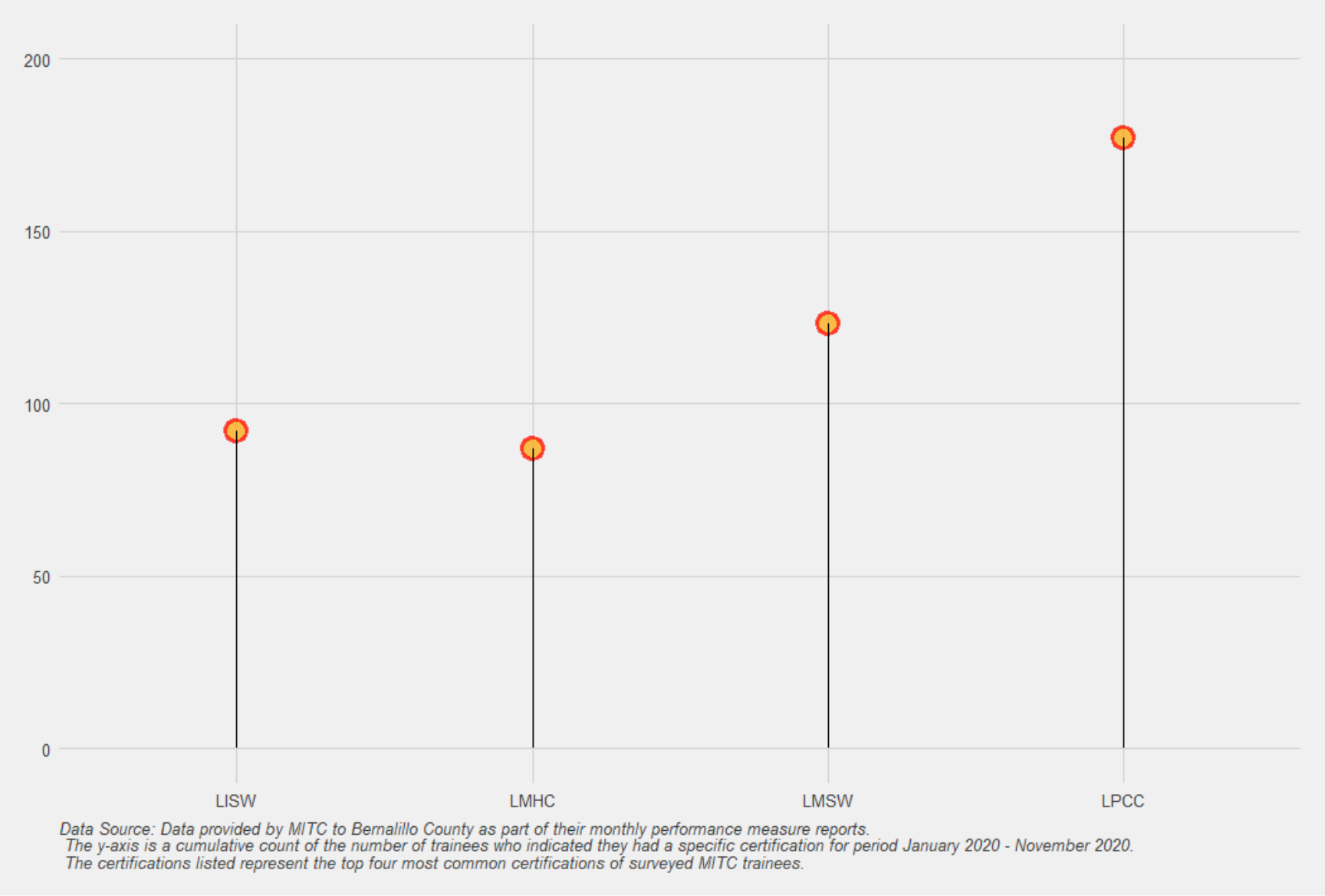

*Data Source: Data provided by BCCHC to Bernalillo County as part of their monthly performance measure reports.*
*The y-axis is a cumulative count of the number of trainees who indicated they had a specific certification for period January 2020 - November 2020.*
*The certifications listed represent the top four most common certifications of surveyed BCCHC trainees.*

*Figure 4. MITC-1 Participants' Most Common Certifications*



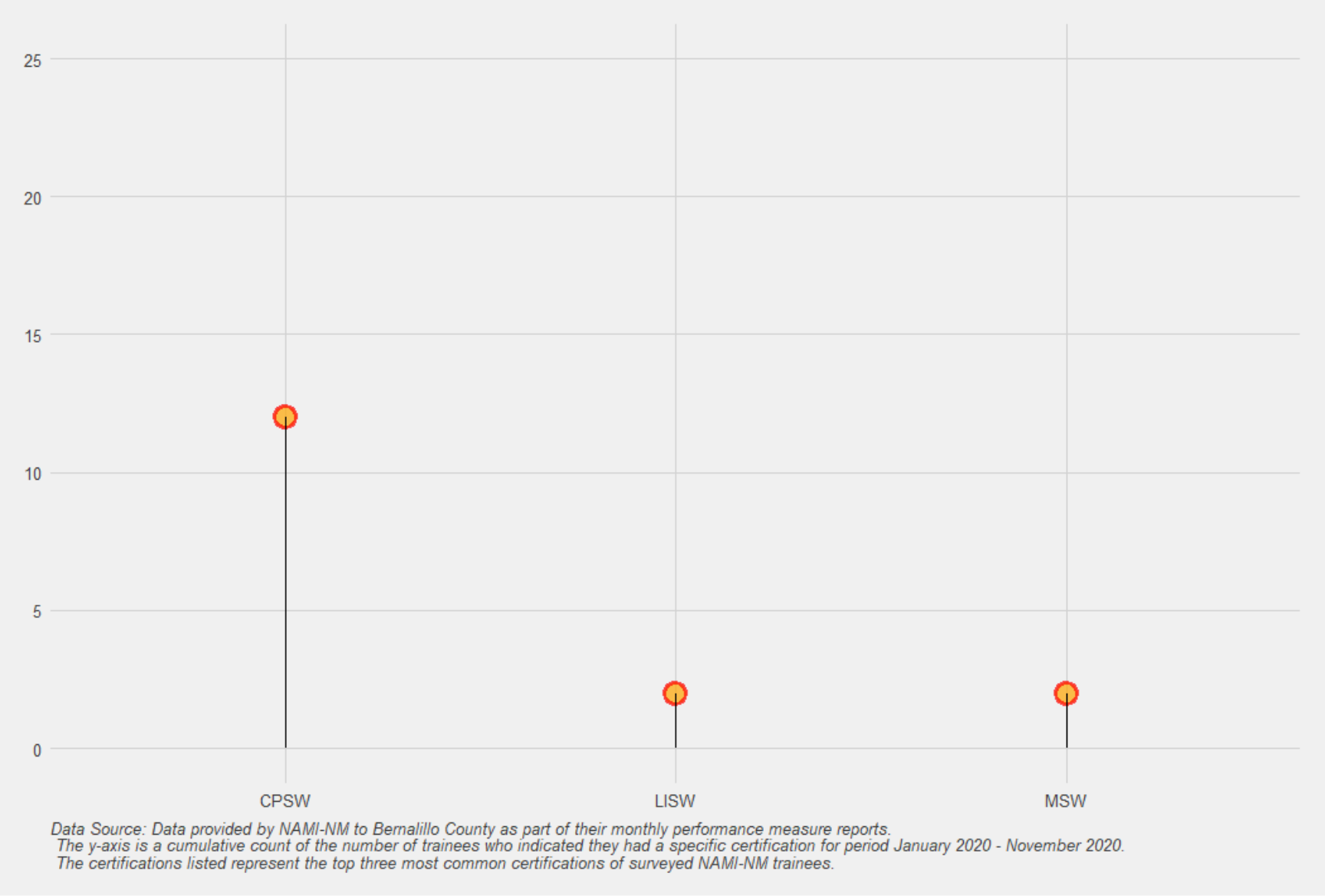

*Data Source: Data provided by MITC-1 to Bernalillo County as part of their monthly performance measure reports.*
*The y-axis is a cumulative count of the number of trainees who indicated they had a specific certification for period January 2019 - November 2020.*
*The certifications listed represent the top four most common certifications of surveyed MITC-1 trainees.*

*Figure 5. MITC-2 Participants' Most Common Certifications*



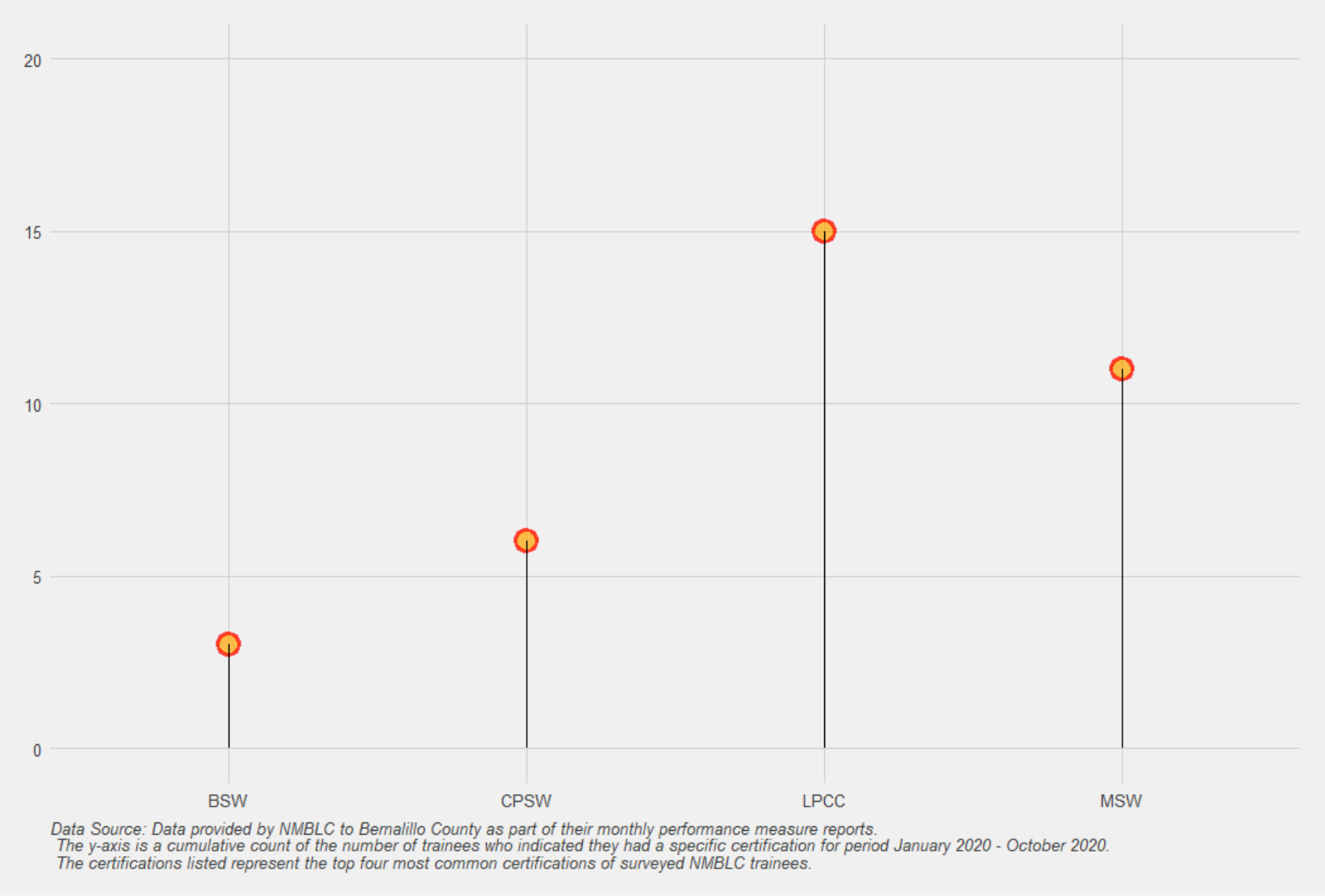

*Data Source: Data provided by MITC to Bernalillo County as part of their monthly performance measure reports.*
*The y-axis is a cumulative count of the number of trainees who indicated they had a specific certification for period January 2020 - November 2020.*
*The certifications listed represent the top four most common certifications of surveyed MITC trainees.*

*Figure 6. NAMI Participants' Most Common Certifications*




*Data Source: Data provided by NAMI-NM to Bernalillo County as part of their monthly performance measure reports.*
*The y-axis is a cumulative count of the number of trainees who indicated they had a specific certification for period January 2020 - November 2020.*
*The certifications listed represent the top three most common certifications of surveyed NAMI-NM trainees.*

*Figure 7. NMBLC Participants' Most Common Certifications*




*Data Source: Data provided by NMBLC to Bernalillo County as part of their monthly performance measure reports.*
*The y-axis is a cumulative count of the number of trainees who indicated they had a specific certification for period January 2020 - October 2020.*
*The certifications listed represent the top four most common certifications of surveyed NMBLC trainees.*

*Figure 8. Serna Participants' Most Common Certifications*


*Data Source: Data provided by Serna to Bernalillo County as part of their monthly performance measure reports.*
*The y-axis is a cumulative count of the number of trainees who indicated they had a specific certification for period January 2019 - November 2020.*
*The certifications listed represent the top four most common certifications of surveyed Serna trainees.*