Bernalillo County Behavioral Health Initiative: Community Engagement Teams Evaluation

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INTRODUCTION

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

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

One of the programs funded as part of the BHI is a peer-to-peer short-term case management program for individuals who are pre- or post-behavioral health crisis. In State Fiscal Year 2023, the New Mexico Crisis and Access Line (NMCAL) received 20,569 calls, the 988 New Mexico Suicide and Crisis Lifeline 15,337 calls, and the Peer to Peer Warmline 21,080 calls (NMCAL, 2023b). The tope three reasons people call NMCAL are for suicide, substance use, and anxiety/situational stress – 62% of callers are not enrolled in behavioral health services and 58% are on Medicaid or have no insurance (NMCAL, 2023a).

In August 2021, Bernalillo County established a scope of work through Department of Behavioral Health Services Multi-award for Behavioral Health Services, for Community Engagement Teams (CET) with Youth Development, Incorporated (YID), to support crisis services. The contract sought to "*…establish Crisis Intervention/Stabilization services for children, youth, adult and families*" to –

> *…provide short-term crisis outpatient services for individuals that are experiencing behavioral health and other related challenges that without appropriate intervention could escalate to a point of requiring higher level of care such as hospitalization or incarceration. Services will focus on stabilizing clients and address their mental health issues and concerns in the least restrictive setting.* (CCN 2020-0856 2021)

The program was directed to staff a full-time master's level licensed clinical supervisor/Program Manager; one full-time MIS/Data Manager/Intake Specialist; three full-time Peer Services Specialists with "lived experience" in mental health or substance use; and one 10-hours per week clinical psychologist or psychiatrist with prescribing authority for medication management. Service delivery was to include *Referral and Screening*, *Service Coordination/Planning*, *Peer Case Management*, *Family Peer Support*, *Clinical Assessment*, and *Clinical Services*. This set-up was modified in March 2022 to include admission and exclusionary criteria. Staff model and service delivery components remained the same. Admission criteria identify exceptions for program capacity limits, new referral waitlists, and an explicit focus on triage model care (e.g., "*serving the most vulnerable and at-risk clients and families...*"). Exclusionary criteria included –

> *… individuals who are severely impaired to the point they cannot participate in decision making, those who are actively suicidal, actively using a narcotic or other illegal substance, including inhalants or alcohol at the time of intake or violent to the extent that they pose a hazard to others.* (CCN 2020-0856 2022).

Early discussions with YDI and CET staff in July 2021 indicated that the program was not yet staffed according to the contract, staff were not trained to deliver the program, and YDI CET lacked a program design or model, process map, and logic model. Additionally, no best-practice was declared in Bernalillo County's contract or expressly identified by YDI CET. For these reasons, we concluded that a process evaluation could not yet be conducted for YDI's CET program. We alternatively decided to work with staff to develop a process map for the program, review client record data, and implement a staff survey describing program processes. That is, our primary research questions are:

(1) How does the YDI CET program ideally operate?
(2) How do client records document and/or evidence CET operations?
(3) In what ways do YDI CET staff describe ideal program processes and common challenges?

The primary purpose of this report is to determine how Youth Development, Inc. (YDI)'s CET implements services and describes their declared program design. The CET program also has not been studied previously and lacks comprehensive documentation for how services operate – CARA's study will therefore primarily describe CET processes and determine to what extent client records evidence CET service provision. Our report is structured to: (1) discuss relevant program models and research to the CET program, (2) describe research methods deployed, (3) discuss results, and (4) summarize findings and recommendations.

LITERATURE REVIEW

Community Engagement Teams (CET) are more commonly referred to as Crisis Resolution Teams (CRTs) and follow a trend for behavioral health services to become more community-based and centered. A CET is a community-based crisis intervention team that provides immediate stabilization services for individuals in a behavioral health crisis (BCDBHS, 2020). CET is also a peer-to-peer support system using a recovery-focused approach to help individuals with non-emergent, non-violent mental health crises and/or substance use disorders. Teams seek to de-escalate the crisis and provide short-term case management (Behavioral Health Services, 2021). CET provides a brief intervention within 24 hours to assist individuals in identifying triggers leading to the behavioral health episode as well as aid clients in developing a plan of action and building skills related to coping, self-management, natural supports, personal recovery, and independent living strategies. The program ultimately refers individuals to ongoing community mental health or substance abuse services and provides warm handoff to these community-based service providers. Participation in CET is entirely voluntary.

Crisis Response Team (CRT) Models

Crisis response teams originate from the model of community mental health teams (CMHT)—enduringly implemented in the United Kingdom and Italy (Burns, 2004, p. 11). CMHTs were designed as

a secondary care team that can conduct assessment and care support for those with complex problems, and receive most referrals from primary care providers and medical staff, as well as social services. Treatment principles for CMHTs included: implementing evidence-based practices, training all staff in psychological/psychiatric therapies and psychosocial interventions, offering psychological therapies, provide pharmacotherapy, completing comprehensive assessment and support with substance abuse, supporting survival skills, monitoring physical health of clients, offering family and career support and education, and supporting outcome goals that "…*exceed the purely medical and include social functioning*" ((Burns, 2004, p. 13).

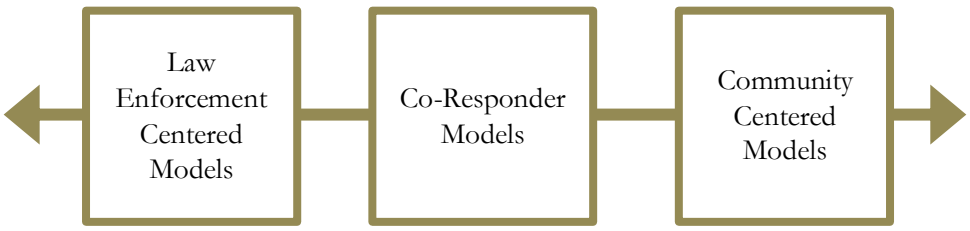
Flowing from this model of care, CRTs reflect an evolution in community engagement through rapid assessment, ability to conduct home visits, dispense medications, and help individuals solve practical problems. While providing more hands-on short-term case management, CRTs have less capacity to address a severe or a prolonged crisis compared to the CMHTs (Johnson, 2004, p. 25). Once a client's crisis has been assessed and resolved, CRTs refer patients to ongoing and longer-time care services. Therefore, CRTs provide quick intervention in the community and subsequently move treatment from in-patient, institutional care, to community care supports.

Many models for CRT exist, which has spurred calls for normative studies to assess CRT program fidelity in relation to the achievement of outcomes (Holgersen et al., 2022, p. 5). Watson, Compton, and Pope's (2019) study reviewing CRTs in the United States (US) described at least nine models and approaches. These different models and approaches offer a mix of professional and multidisciplinary compositions (e.g., various combinations of law enforcement, clinical psychologist, and mental health professionals). CRT models ultimately exist within a continuum where they can be comprised of law enforcement personnel, teams with a mix of law enforcement and mental behavioral health clinicians, or community-based teams made up of only behavioral health specialists (Beck, et. al., 2020; Watson, Compton, and Pope, 2019; Odejimi, Bagchi, and Tadros, 2020). Figure 1 illustrates.

Each CRT model encompasses different degrees of public safety and crisis intervention. Law enforcement only models can include crisis intervention teams (CIT) or case management teams where law enforcement personnel are trained in crisis de-escalation techniques. CITs are staffed by law enforcement officers who are trained to de-escalate behavioral health crises and direct individuals to mental health services and/or transport them directly to mental health care facilities (Watson et al., 2017, p. 432). One of the first CITs implemented in the U.S. found the number of arrests for individuals experiencing a behavioral health crisis decreased, while diversion to mental health services increased

Figure 1

Mental Behavioral Health Crisis Intervention Model Continuum



Note: Adapted from Beck, Reuland, and Pope (2020) Behavioral Health Alternatives

(Watson and Fuambarber 2012). However, some have called attention to the need for randomized control trial research as critical next-steps in understanding CIT outcomes (Watson & Compton, 2019, p. 4).

Another model is the co-response model. Co-response models are comprised of law enforcement paired with mental and/or behavioral health clinicians. Co-responder teams typically respond to emergency calls for emotional or behavioral disturbances and can incorporate telehealth or remote delivery during a crisis, while others serve the community outside an emergency call (Krider et al., 2020). Street triage is one type of co-response intervention which has been shown to decrease police involvement in behavioral health crises, decrease admission to emergency care, and reduce the number of persons sent to jail (Odejimi et al., 2020, p. 9). Critically, co-response and law enforcement only models necessarily maintain contact with agents of the criminal justice system when responding to behavioral health crises.

Community-based teams therefore limit law enforcement involvement with mental and behavioral health crises. CRTs under this scheme pair crisis resolution with home- or community-based treatment approaches, making them more accessible and flexible to those in crisis, while simultaneously decreasing barriers to care (Winness et al., 2010). As Winess and colleagues note in their review of community-based CRT literature, community-based CRTs provide services in the home or other safe settings and are more likely to promote a person-centric view of crisis, as opposed to viewing these individuals as a risk to general public safety. Community-based crisis resolution teams aim to promote a partnership of equality between providers of services and user-clients, which also emphasize a philosophy of recovery. Community-based CRTs may therefore be better situated in crisis simply because they avoid direct law enforcement involvement, and instead incorporate multidisciplinary teams comprised of professionally trained clinicians, specialists, and other personnel who have lived experiences (i.e., peer support) and are more capable of relating personally to those in crisis (Beck et al., 2020). 'Peer workers' – those with lived experience similar to the people they support – are identified by the Substance Abuse and Mental Health Services Administration (SAMHSA) as a best practice component of behavioral health support programs (SAMHSA, 2020).

Peer Support

Peer workers provide a unique perspective and relatability in the delivery of supportive services which primarily supports improving engagement from clients by building on personal experiences that allow peer workers to relate better with those they serve. Peer support has demonstrated improved outcomes for reduced re-hospitalizations, cost of services, behavioral health symptoms, and increased service utilization, treatment engagement, quality of life, and functioning (Philadelphia Dept. of Behavioral, 2017; SAMHSA, 2017, 2022). Ideally, this allows peers workers to promote a recovery-focused approach to service provision, as well as better identification and referral to relevant mental and behavioral health services (Bravata et al., 2023; Repper & Carter, 2011). One study of peer support effectiveness by Harrison and colleagues (2017), involved a seven-year evaluation of 20 integrated treatment for dual disorders (e.g., mental issue and substance use) teams. They found that compared to teams with a part-time or no certified peer support worker, teams with one or more full-time certified peer workers had significantly higher fidelity to integration of co-occurring disorder service treatment compliance. Higher fidelity was also associated with decreased number of days spent in the hospital (J. Harrison et al., 2017).

A notable post-crisis CRT program called REAL – Respond, Empower, Advocated, and Listen – was also implemented in Lincoln, NE in 2011. The program is a collaboration between local law enforcement officials, community corrections officers, and mental health providers, which deploys trained peer specialists following an individual's contact with law enforcement (post-crisis). Peer specialist's follow-up with individuals post-crisis and ask if they would like to participate in the REAL program. If they do, peer specialists provide assistance in accessing programs or services. One analysis of REAL program data for one-, two-, and three-years after police-abated mental health crisis found that *"…compared with nonreferred individuals, referred participants generated fewer calls for service and were less likely to be taken into emergency protective custody 24 and 36 months after a crisis*" (Bonkiewicz et al., 2018). However, the authors note there were no significant differences among the two groups in terms of number of arrests.

Despite promising research, more robust analyses have been performed which find more mixed and uncertain evidence for peer support (Lloyd-Evans et al., 2014; Wheeler et al., 2015). A metanalysis of randomized control trials of peer support for people with severe mental illness by Lloyd-Evans et al. (2014) ultimately found "…*little evidence from current trials about the effects of peer support for people with severe mental illness*", and that despite some positive findings, "…*current evidence does not support recommendations or mandatory requirements from policy makers for mental health services to provide peer support programmes*" (Lloyd-Evans et al., 2014, p. 10). The authors emphasize that peer support programs often lack comprehensive data collection and management, which undermine the evidence base. They recommend that peer support programs be implemented in high quality projects whenever feasible, as "…*deficiencies in the conduct and reporting of existing trials exemplify difficulties in the evaluation of complex interventions*."

Implementing CRT

Resources exist for guiding systems of care for behavioral health crisis responses. The behavioral health crisis care best practices toolkit developed by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2020) is emblematic. Their document outlines how crisis systems should reflect coordinated care that occurs along a continuum of services. Those services similarly exist on a continuum of integration with one another, as illustrated in Figure 2.

Integrating crisis services is paramount since existing infrastructure for crisis response is largely fragmented and frequently duplicates or isolates supports. As a result, developing ideal programs or models to follow, especially for evaluation of fidelity or outcomes, is difficult as programs attempt to address gaps in care for clients by essentially duplicating care or reducing availability of services to scale programs appropriately. In a sense, model drift occurs because of poorly defined program goals and

Figure 2

Continuum of Crisis Services Coordination and Collaboration

Minimal	Basic I	Basic II	Close I	Close II
Agency Relationships	Shared MOU Protocols	Formal Partnerships	Data Sharing (Not Real-Time)	"Air Traffic Control" (ATC) Connectivity

Note. Adapted from SAMHSA (2020) Behavioral Health Crisis Care Best Practices Toolkit.

coordinated systems. A paper by the National Association of State Mental Health Program Directors (NASMHPD) describes the current state of crisis services programs clearly –

> *To date, there is no single federal definition for specific crisis services. For example, the Centers for Medicare and Medicaid Services, in its 115 Serious Mental Illness Availability of Services template offers some broad language in its definition of terms for "crisis stabilization units" and "coordinated community crisis response", but leaves details up to states to define. It also leaves the term "crisis call centers" up to states to define. State by state definitions and programmatic nuances therefore can make comparisons challenging.* (Pinals, 2020, p. 8).

Pinals (2020, pp. 9–11) alternatively calls for defining crisis services within 16 unique types, to guide conceptualizing program implementation. All 16 categories, Pinals argues, should be integrated within *pathways* of care that transition clients from higher service levels to lower – e.g., a call to medical

- Warm/Peer Warm Lines
- 24-Hour Crisis Lines
- Mobile Crisis Teams
- Crisis Intervention Teams
- Co-Response Teams
- Crisis Hubs/ Crisis Centers/ Coordinated Community Crisis Response Centers
- Psychiatric Urgent Care
- Transition or Bridge Clinics
- Crisis Stabilization Units &
- Extended Observation Units
- Crisis Residential Services
- Living Room/Peer Run Crisis Centers
- In-Home Supports/Family Based Crisis Home-Based Support/Respite Services
- Emergency Rooms with or without dedicated behavioral health sections
- Partial or Day Hospitals
- Acute Psychiatric Hospital Units

response services should transition clients (based on need) to an ER or crisis hub, then from a crisis hub to medications or a Crisis Stabilization Unit (CSU), inpatient care, etc. (Pinals, 2020, p. 12).

At the very least, SAMHSA's 2020 best practices toolkit emphasizes a system of behavioral health crisis care involves careful, real-time coordination between three core services (SAMHSA, 2020, p. 12):

(1) **Regional Crisis Call Center** - a 24/7 clinically staffed hub that offers crisis intervention through telephone, text, and chat and meet national standards for suicide risk assessment and prevention.
(2) **Crisis Mobile Team** – Mobile Crisis Teams who are able to respond and assist individuals in crisis "where they are at", whether at home, the office, or any community location.
(3) **Crisis Receiving and Stabilization Facilities** – Facilities that offer short term observation and stabilization for all referrals they receive in a home-like non-hospital context.

In terms of Community Engagement Teams (CET), the scope of work defined for CET services most resembles those captured by *Crisis Receiving and Stabilization Facilities*, which accept all referrals and prevent escalation of crises. Such facilities are described by SAMHSA as broadly serving those with varying mental illness severity and clinical presentation, age, and should include substance abuse

referral. Critically, SAMHSA recommends not relying on law enforcement to conduct triage or assessment for this core crisis service area.

To be effective, SAMHSA (2020, pp. 22–23) recommends that stabilization facilities should, at minimum:

(1) Accept all referrals
(2) Assess and support medical stability while in the program
(3) Support mental health and substance abuse issues
(4) Assess physical health and deliver care for minor physical health needs prior to transition to any other more appropriate medically staffed facility/service provider
(5) Be staffed 24/7/365 with multidisciplinary teams, including psychiatrists, nurses, licensed and credentialed clinicians to conduct assessments, and peer support workers with lived experiences similar to the population served
(6) Offer walk-in and first-responder drop-off
(7) Reject 10% or less of referrals
(8) Screen and complete comprehensive assessments for suicide risk
(9) Screen and complete comprehensive assessments for violence risk

Identified best practices also include: (1) 24 hour or less crisis receiving and stabilizing, (2) offer dedicated first responder areas, (3) incorporate intensive support beds into a partner program, (4) support real-time bed registry system with crisis call center cub, and (5) coordinate connection to ongoing care). SAMHSA additionally recommends key monitoring and performance metrics for crisis receiving and stabilization programs:

- Number served
- Percentage of referrals from law enforcement
- Percentage of referrals from all first responders
- Percentage discharge to the community
- Percentage not referred to emergency department for medical care
- Percentage completing an outpatient follow-up visit after discharge
- Guest service satisfaction
- Percentage of referrals accepted
- Law enforcement drop-off time
- Average length of stay
- Percentage of involuntary commitment referrals converted to voluntary
- Readmission rate
- Total cost of care for crisis episode
- Percentage reporting improvement in ability to manage future crisis

A unique measure for CRT model fidelity was also developed in 2014, as a result of the Crisis Resolution Team Optomisation and Relapse Prevention (CORE) study through the University College London (University College London (UCL), 2019), that aimed to improve the functioning of CRTs. Stage 1 of the CORE study involved a national survey of CRT implementation and practices. Stage 2 developed a model for CRT best practices based on in-depth review of 75 CRTs. The final stage of the CORE study ultimately explored whether greater adherence to CRT model fidelity was associated with better outcomes. Overall, higher fidelity by CRTs to their CORE Fidelity Score tool resulted in fewer in-patient admissions, lower in-patient bed use, and better staff psychological health, but did not improve the primary outcome for the study, patient satisfaction (Lloyd-Evans et al., 2020).

Despite modest outcomes resulting from the study, the CORE Crisis Resolution Team Fidelity Scale is the only systematically developed instrument for assessing CRT model fidelity. The CORE CRT Fidelity Scale contains 39-items with several sub-items that are determined to be "met" or "unmet", based on review of evidence from case notes, paperwork review, manager interview, staff interview, service use interview, family/carer interview, and/or interviews with staff from other mental health services. Each item is scored 1 - 5 based on the number of met or unmet best practices. Importantly, the CORE CRT Fidelity Scale should not be used or adapted without permission from the developers.

In sum, CRTs exist within a continuum of model designs and service integration infrastructure. While promising studies and evidence exists, rigorous randomized control trial and metanalysis evidence does not offer consensus on the effectiveness of these programs. Still, clear best practices and guidelines have been developed by SAMHSA which highlight the importance of integrating crisis services within first responder infrastructure, and within other mental health services and systems care. SAMHSA recommends a behavioral health crisis system should involve clear lines of referral and continuity, centralization of information and services, and integration with technology to support real-time and any-time crisis care. Clear process documentation and policies, combined with high-quality performance and program data collection are vital for understanding whether CRT programs achieve outcomes, which center around (1) referral acceptance, (2) screening and assessment, and (3) referral to appropriate ongoing medical and/or supportive care.

METHODOLOGY

Our report is intended as a descriptive account of the CET program and aims to document how CET ideally operates and to what degree program data and staff surveys confirm ideal processes. Three sources of data were collected: (1) program documents and forms, (2) client records, and (3) staff surveys.

Program Documents

In August 2022 we collected all relevant program documents and forms the CET program uses. This included: Service plans, release of information form (2109), referral source form, PCP information form, insurance billing form, HIPPA notice of privacy practices form (2019), GAIN-SS assessment, crisis & safety plan, confidentiality and informed consent, client grievance form (2017), client discharge summary, client demographics survey, and after-hours client acknowledgement form. Lastly, we collected and reviewed Bernalillo County's contracts with YDI from 2020 to 2022.

Client Records

We obtained adult client records for YDI's CET program between May 2021 through August 31st, 2023. This reflects the period YDI CET has collected data on clients for. In total, we received records for 1,597 unique referrals; 418 unique intake records; and 431 unique service records. Many of these records were missing information, so not all data we review in this report reflect the total number of clients CET has been referred or supported. Importantly, while we received data for Global Appraisal of Individual Needs – Short Screener (GAIN-SS) outcome data, those documents were received as paper forms and must be digitally entered, scored, and analyzed. We did not expect to receive this data in paper format, and therefore were not able to include this data in the present report.

Staff Survey

We administered an online survey to current CET administrators and staff who were directly involved with the program. The survey was open from August 17th – 31st, 2022. Anonymous invitations were e-mailed to nine staff and administrators and eight (89%) completed the survey. CARA's survey collected qualitative and quantitative data across six categories: (1) Participant professional experiences, (2) CET program design, (3) General client characteristics, (4) Program services & process, (5) CET program outcomes, and (6) Program effectiveness, challenges, and success. Quantitative survey data were analyzed using SPSS 28, and qualitative data have been coded and analyzed using ATLAS.ti 22 software. Eight YDI staff responded to our survey who had, on average, 7.5 years of experience with YDI. The least experienced respondent had half a year of experience and the most experienced had 20 or more years of experience. All respondents worked full-time for YDI.

RESULTS/DISCUSSION

We worked with YDI staff to develop a map of current CET program processes (as of June 2022). Figure 1 illustrates that final document. In general, CET receives a call for CET services. CET staff then determine whether services are appropriate. If potential clients are minors CET staff speak with their parents or guardian. If the potential client declines services, then contact ends. Alternatively, if a client accepts services then a client profile is made within CET's information management system (MIS), EMR-Bear, and is assigned a Peer Support Worker (PSW). PSWs are overseen by the Clinician Supervisor. The bulk of services for CET occur with Peer Sessions, which occur 1 to 6 times depending on client goals and need for referral to resources. CET clients ultimately complete CET discharge which includes warm hand-off to services. Alternatively, clients may disengage from the program prior to warm handoff. Finally, CET attempts to follow-up with clients one-month after program discharge.

Data are intended to be collected at each step in CET. We now review each process outlined in the ideal CET process map and analyze how data describe who comes to CET and how CET provides services to those individuals. As we refer to services, we make a distinction between individuals referred to CET, and those who had completed intake records. This is important as client records tended to be more complete records (with a few exceptions) and contained client demographic data, desired help, and contained service data (e.g., service and safety plan, prescriber visits, services, and outcome). We received additional service records separately, which distinguished other services YDI CET provides. Throughout this report we also integrate information collected from eight full-time staff at YDI who responded to a staff survey in August 2022. Those survey data are presented to describe the program as it operated in August 2022.

Call for CET Services

Staff indicated in our 2022 survey that the first process – client referral to CET – involves first receiving a phone call, e-mail, inquiry through website, self-referral, or referral by a community member, and is followed-up on within the first 24 hours of contact. According to client records, since 2021 CET has received 1,597 adult referrals. Table 1 summarizes referrals – data are divided between clients that could be matched to an intake record (*Clients* column) and *all* referrals, for cases where the call type could be determined. CET received most referrals by phone, with a little over a quarter received in-person (28.9%). For referrals who ultimately completed an initial intake record (418 individuals), 307

Table 1

Summary of call types for referrals, adult YDI CET clients 2021 - 2023

	Clients		All Referrals	
Call Type	Count	Percent	Count	Percent
Phone	239	77.9%	849	58.6%
E-Mail*	32	10.4%	182	12.6%
In-Person**	36	11.7%	419	28.9%
Total	307	100.0%	1450	100.0%

Note. Clients column reflects clients with an intake record where call type could be determined. *All referrals* column encompass referrals where a call type could be determined. *Two entries were recorded as *BHI Online Referral* and were therefore categorized as *e-mail* type calls for service. **Entries for *Brief Encounter*, *Walk-up* or *Walk-In* were categorized as *In-Person*. Missing data are for records which included no description of the call type that would be captured by *Phone*, *E-mail*, or *In-person* (e.g., *Informational* and *Repeat referral*).

noted referral call type. A little over three quarters of clients (77.9%) with intake records were referred by phone. About 1/5th of remaining clients (22.1%) were referred either by e-mail or in-person.

With the same distinction between CET clients with intake records and all referrals received, Table 2 summarizes referral *sources*. Overall, referral source was similarly distributed between all referrals and clients with intake records. Roughly half of all referrals were self-referrals, and about a quarter of referrals came from Albuquerque Community Safety (ACS). About one quarter of remaining referrals came from internal YDI programs, external programs (e.g., schools, rehab centers, homeless support, etc.), Mobile Crisis Teams (MCT), and Albuquerque Police Department (APD) (28.9% for clients; 23.2% for all referrals). Less than 6% of referrals came from Adult Protective Services (APS), Behavioral Health Initiative (BHI) programs, criminal justice system sources, Children, Youth & Family Department (CYFD), or family members (5.9% for clients; 3.4% for all referrals). Referral source was missing for roughly 1/5th of client records (18.9%), and for 2.9% of all referral records.

After CET receives referrals, YDI staff make calls to schedule a time to meet with individuals and meet them 'where they are at' – e.g., at home, in the community, etc. Client records document the number of call attempts made to reach referrals. Table 3 summarizes the average number of call attempts, distinguishing between clients with intake records and those from all referral records. Just 24 clients with intake records contained data on call attempts. The average number of call attempts completed for those with intake records was 1.8 per person, and 50% of these clients had 2 or more call attempts. The minimum number of call attempts for clients was 1, with the maximum being 4. Referral records contained data for call attempts made to 396 individuals. The average number of call attempts made for all referrals received was 2.57 per person, with 50% of all clients receiving 3 or more calls. The minimum

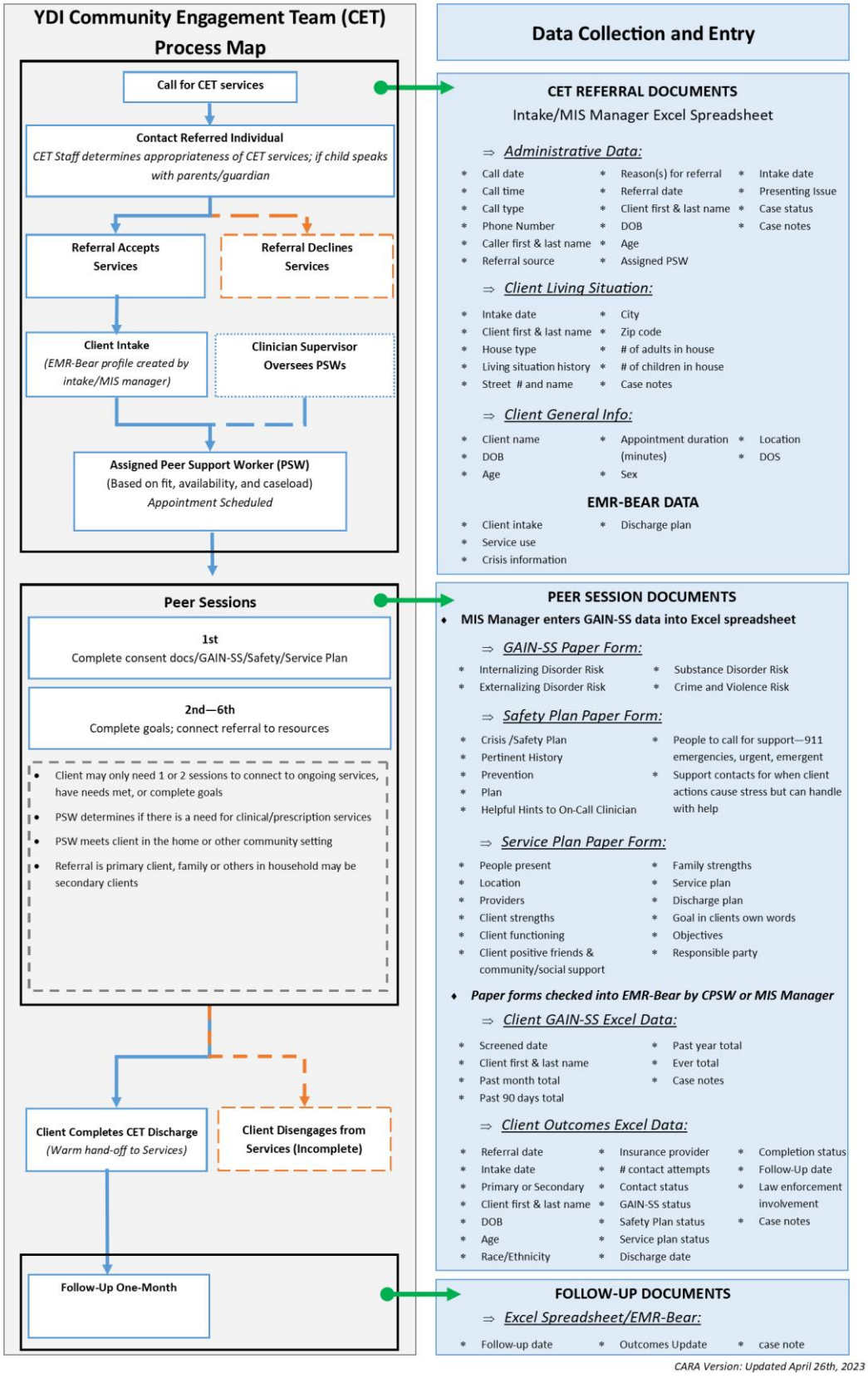

YDI Community Engagement Team (CET) Process Map
Call for CET services
Contact Referred Individual
CET Staff determines appropriateness of CET services; if child speaks with parents/guardian
Referral Accepts Services
Referral Declines Services
Client Intake
(EMR-Bear profile created by intake/MIS manager)
Clinician Supervisor Oversees PSWs
Assigned Peer Support Worker (PSW)
(Based on fit, availability, and caseload)
Appointment Scheduled
Peer Sessions
1st
Complete consent docs/GAIN-SS/Safety/Service Plan
2nd—6th
Complete goals; connect referral to resources
Client may only need 1 or 2 sessions to connect to ongoing services, have needs met, or complete goals
PSW determines if there is a need for clinical/prescription services
PSW meets client in the home or other community setting
Referral is primary client, family or others in household may be secondary clients
Client Completes CET Discharge
(Warm hand-off to Services)
Client Disengages from Services (Incomplete)
Follow-Up One-Month
Data Collection and Entry
CET REFERRAL DOCUMENTS
Intake/MIS Manager Excel Spreadsheet
⇒ Administrative Data:
Call date
Call time
Call type
Phone Number
Caller first & last name
Referral source
Reason(s) for referral
Referral date
Client first & last name
DOB
Age
Assigned PSW
Intake date
Presenting Issue
Case status
Case notes
⇒ Client Living Situation:
Intake date
Client first & last name
House type
Living situation history
Street # and name
City
Zip code
# of adults in house
# of children in house
Case notes
⇒ Client General Info:
Client name
DOB
Age
Appointment duration (minutes)
Sex
Location
DOS
EMR-BEAR DATA
Client intake
Service use
Crisis information
Discharge plan
PEER SESSION DOCUMENTS
MIS Manager enters GAIN-SS data into Excel spreadsheet
⇒ GAIN-SS Paper Form:
Internalizing Disorder Risk
Externalizing Disorder Risk
Substance Disorder Risk
Crime and Violence Risk
⇒ Safety Plan Paper Form:
Crisis /Safety Plan
Pertinent History
Prevention
Plan
Helpful Hints to On-Call Clinician
People to call for support—911 emergencies, urgent, emergent
Support contacts for when client actions cause stress but can handle with help
⇒ Service Plan Paper Form:
People present
Location
Providers
Client strengths
Client functioning
Client positive friends & community/social support
Family strengths
Service plan
Discharge plan
Goal in clients own words
Objectives
Responsible party
Paper forms checked into EMR-Bear by CPSW or MIS Manager
⇒ Client GAIN-SS Excel Data:
Screened date
Client first & last name
Past month total
Past 90 days total
Past year total
Ever total
Case notes
⇒ Client Outcomes Excel Data:
Referral date
Intake date
Primary or Secondary
Client first & last name
DOB
Age
Race/Ethnicity
Insurance provider
contact attempts
Contact status
GAIN-SS status
Safety Plan status
Service plan status
Discharge date
Completion status
Follow-Up date
Law enforcement involvement
Case notes
FOLLOW-UP DOCUMENTS
⇒ Excel Spreadsheet/EMR-Bear:
Follow-up date
Outcomes Update
case note
CARA Version: Updated April 26th, 2023

Table 2

YDI CET adult client referral sources, 2021 - 2023

	Clients		All Referrals	
Organization	Count	Percent	Count	Percent
Self	140	41.3%	742	47.9%
Albuquerque Community Safety (ACS)	81	23.9%	396	25.5%
Bernalillo County Sherrif's Office (BCSO)	24	7.1%	81	5.2%
Internal Program	24	7.1%	64	4.1%
External Program	24	7.1%	72	4.6%
Mobile Crisis Teams (MCT))	17	5.0%	76	4.9%
Albuquerque Police Department (APD)	9	2.7%	67	4.3%
Adult Protective Services (APS)	7	2.1%	12	0.8%
Behavioral Health Initiative (BHI)	6	1.8%	25	1.6%
Criminal justice system	5	1.5%	9	0.6%
Children, Youth, & Family Department (CYFD)	2	0.6%	4	0.3%
Family Member	0	0.0%	2	0.1%
Total	339	100.0%	1,550	100.0%
Missing	79	18.9%	47	2.9%

Note. Some intake records lacked a matched referral record and/or were missing referral source data.

call attempt was 0, with the maximum being 11 call attempts. Three referrals documented 0 call attempts and 19.4% (77) recorded one call attempt.

Client Issue(s) at Intake

Surveyed YDI staff explained that the target population for YDI CET is broad. As one respondent said emblematically, YDI CET helps "*Everyone in need." (*CPSW 1*)* Other YDI staff explained that target clients included "*someone with a behavior or mental health condition or in a crisis" (*ADMIN 3) or "*Any*

Table 3

Summary statistics of call attempts for adult YDI CET clients, 2021 - 2023

	Clients	All Referrals
Mean	1.88	2.57
Median	2.00	3.00
Std. Deviation	0.900	1.157
Minimum	1	0
Maximum	4	11
Total	24	396
Missing	394	1201

Note.

Table 4

Summary of presenting issues for adult YDI CET clients, 2021 - 2023

	Clients		All Referrals	
Issue	Count	Percent	Count	Percent
Homelessness	221	64.4%	725	45.4%
Mental Health	131	38.2%	545	34.1%
Other	83	24.2%	281	17.6%
Employment	26	7.6%	64	4.0%
Substance use	18	5.2%	112	7.0%
Unique clients	343		1597	

Note. Total count and percent do not add to 343 or 1,597 unique clients. Clients could present multiple issues in need of support.

individual residing the Bernalillo County area that needs resources to stabilize a non acute crisis" (ADMIN 4). Client intake records and referral records document the kinds of needs clients (or those who refer the primary client) identify as an issue or crisis area to receive services for. Five areas are identified in records: homelessness, mental health, employment, substance use, and other. Table 4 summarizes presenting issue categories. For clients with intake records, the top category of support was for homelessness (64.4%). Over a third of clients with intake records (38.2%) wanted help with mental health issues. One-quarter (24.2%) desired support in some other category of assistance (e.g., medication management, school enrollment, legal aid, case management, Medicaid, medication, resources, daycare, vital documents, etc.). Similarly, for all referrals received, top identified issues were for homelessness (45.4%), with a little over a third (34.1%) desiring support with mental health, and the remaining 17.6% indicating some other category of need.

We also were able to identify unique combinations of needs since clients could identify more than one area of support. For clients with intake records, the top five issues – which encompass 61.5% of all issues or crisis support needed – were for (1) strictly homelessness (28.7%); (2) mental health & homelessness (22.7%), (3) strictly mental health (10.5%); (4) strictly some *other* category of issue and support (6.5%); (5) homelessness and some *other* category of issue or support. The top five categories were for all referrals received were exactly the same, and with roughly the same distribution. With homelessness being a top issue for most clients, it follows that adult client record data on living situation at intake indicate that nearly half of all clients with intake records were either homeless (41.8%), or living in a hotel (5.6%) or shelter (1.7%). Of those who were homeless or unstably housed, about 7% (29 clients) indicated they had 1 or more children living with them. About the same amount (6.2%) of clients indicated another adult was living with them.

Client Attrition

As potential YDI CET clients are assessed, clients ultimately choose to accept or decline services. The process map we developed with YDI staff illustrates that some clients disengage or refuse services. However, survey data suggest other circumstances also occur in which clients are inappropriate for CET

Table 5

Summary of client statuses, adult YDI CET clients 2021 - 2023

Status	All Referrals	
	Count	Percent
Loss of contact	602	71.4%
Declined services	139	16.5%
Located outside Bernalillo County	26	3.1%
Other outcome	20	2.4%
Provided resources	16	1.9%
Discharged	13	1.5%
Brief encounter	7	0.8%
Too acute	7	0.8%
Referred to external program	6	0.7%
Institutionalized	5	0.6%
Inappropriate for program	2	0.2%
Total	843	100.0%
Missing	754	47.2%

Note.

or cause removal. We asked YDI staff in our 2022 survey under what circumstances a client is removed from the CET program. Staff explained that the top reasons for removal included: (1) non-compliance, (2) if the client was too acute for service (e.g., suicidal, required hospitalization, etc.), (3) clients are prohibitively violent, (4) client resides outside Bernalillo County, and (5) client is non-responsive after three outreach attempts. One administrator emphasized though that "*CET doesn't typically remove clients from care but does seek out more appropriate resources for clients*" (ADMIN 4). Client records generally support this through client "statuses" which are summarized in Table 5. Most referrals that document client status indicate over two-thirds of clients (71.4%) result in loss of contact. About 16.5% of clients ultimately decline YDI services and a minority of clients (3.1%) were located outside of Bernalillo County. Nearly half of all client statuses for referral records were missing (47.2%).

Client Intake

Demographic data suggest some trends exist in *who* YDI CET supports. As noted, we received intake records for 418 adult YDI CET clients. Table 6 summarizes their demographic characteristics and insurance coverages. Most clients were between the ages of 18 and 47 (67.3%), and, on average, were 40.4 years old. Fifty percent of clients were 38 years old or younger. The oldest client was 90 years old. Most clients were also white (84.2%). A little over 1/10th of clients (11.2%) identified as Native American or African American. As noted in the Table 6, respondents could identify up to two racial categories because race and ethnicity recorded the same data interchangeably. In terms of ethnicity, most clients (56.5%) identified as Hispanic; 4.5% of clients indicated they identified as Hispanic alone; 51.9% of those who identified as Hispanic also identified as White. Most clients were also Female (58.4%), with a minority identifying as non-binary (0.5%). Finally, most adult YDI CET clients had insurance coverage

through Medicaid (74.8%) at intake and roughly 5% had coverage through private insurance, Medicare, or a combination of Medicaid and private insurance. Nearly 1/5th of adult clients (19.9%) had no insurance coverage at intake.

Client intake records additionally capture date of referral and date of intake, which allowed us to track the length of time between referral to intake. The average number of days between referral to intake for adult YDI CET clients was 5.7 days, and 50% of all clients completed intake in four days or less. The minimum number of days from referral to intake was 0 (26.8% of clients), and the maximum was 86

Table 6

Summary of demographic characteristics and insurance status, adult YDI CET clients 2021 - 2023

Characteristic	Count	Percent
Age		
18 - 32	135	33.4%
33 - 47	137	33.9%
48 - 63	99	24.5%
64 or older	33	8.2%
Race		
White	352	84.2%
Native American	24	5.7%
African American	23	5.5%
Asian	6	1.4%
Ethnicity		
Hispanic alone	19	4.5%
Hispanic and white	217	51.9%
Non-Hispanic	182	43.5%
Gender		
Female	244	58.4%
Male	172	41.1%
Non-binary	2	0.5%
Insurance		
Medicaid	305	74.8%
Private insurance	15	3.7%
Medicare	5	1.2%
Medicaid/Private insurance	1	0.2%
VA	1	0.2%
None	81	19.9%

Note. n = 418 for all categories. Race and ethnicity interchangeably recorded either option, therefore up to two racial categories were allowable. Race counts therefore do not add to total clients (418).

Table 7

Summary of public assistance received by adult YDI CET clients, 2021 - 2023

Assistance type	Count	Percent
SNAP	84	20.1%
TANF	29	6.9%
WIC	16	3.8%
SSI	2	0.5%
Two or more public assistance programs received	24	5.7%
Any assistance	102	24.4%
No assistance noted	316	75.6%

Note. n = 418. Clients could receive multiple public assistances so counts and percentages do not add to 418 or 100%.

days (a single client). Ninety percent of clients completed intake within 14 days of referral. Thirty-seven percent (37.1%) of adult YDI CET clients completed intake within 24 hours of referral.

Client records also track whether individuals are receiving public assistance at intake. Table 7 summarizes those data which indicate about three-quarters of clients (75.6%) were not documented receiving any kind of public assistance at intake. If clients received assistance at intake, the most commonly received assistance was for food stamps (20.1%) and Temporary Assistance for Needy Families (TANF) (6.9%). Very few clients (5.7%) received two or more public assistance programs at intake.

Peer Sessions

Peer sessions are the critical services that YDI CET supports clients with and overlap with intake processes. YDI staff respondents from our 2022 survey explained that peer sessions involve "*Navigat*[ing] *through the service plan to work on crisis at hand and make any referrals necessary for continued services*" (ADMIN 1), such as "*…referrals to therapy, behavioral health services, housing assessments, finding a job, referrals to our prescriber, etc."* (ADMIN 3). PSWs in our survey emphasized the importance of client goals identified in service plans. In peer sessions PSWs "*assist clients with their goals and needs with what was discussed during the service plan"* (CPSW 3). The 1st peer session that YDI CET staff complete involves completion of consent documentation, GAIN-SS assessments, crisis & safety plans, and service plans. YDI CET's process map (Page 10) illustrates how clients may only need 1 to 2 sessions to receive warm handoff to services, have their needs met, or complete goals. YDI staff survey responses suggested this happens, explaining that "*sessions 2 – 3 are putting referrals to different agencies and trying to get appointments scheduled"* (CPSW 4).

PSWs also determine need for clinical or prescription services and meet with clients in the home or community setting. Referrals are made for primary clients, while the primary client's family or significant others may become secondary clients. Table 8 summarizes descriptive statistics from client intake records for completion of documentation that occurs in the 1st peer session. Safety & crisis plans and service plans were completed for about three-quarters of adult YDI CET clients – 74.6% and 73.7% of

Table 8

Summary of completed plans and initial assessments for adult YDI CET clients, 2021 - 2023

	Complete		Incomplete	
	Count	Percent	Count	Percent
Service plan	308	73.7%	86	20.6%
Safety & crisis plan	312	74.6%	82	19.6%
GAIN-SS	312	74.6%	71	17.0%
GAIN-SS scanned	377	90.2%	34	8.1%

Note. n = 418.

clients, respectively. While 90.2% of client records document a GAIN-SS assessment was scanned into YDI's MIS (GAIN-SS scanned, *Yes* or *No*), other data which recorded the date GAIN-SS assessments were administered suggested only 74.6% of clients were administered the assessment. Because GAIN-SS scores were not documented in client records, it was not possible to determine which field was more accurate. YDI staff explained that GAIN-SS assessments are not always scored, and therefore not always entered into the MIS. We requested paper copies of GAIN-SS assessments and received 395 scanned paper records. We were unable to enter and score these digital files in time for this report. These data would provide information about clients' risk of internalizing, externalizing, or substance disorders, as well as crime and violence risk. It is presently unclear if these GAIN-SS records are complete for all individuals or if any were administered twice to clients (indicating a possible outcome measure).

In terms of other services provided, we received data for seven types of support hours clients receive: (1) progress notes, (2) discharge plans or summaries, (3) crisis & safety plans, (4) service plan notes, (5) consent and intake, (6) aftercare support, and (7) individual therapy. Table 9 summarizes the descriptive statistics for service data. The most common services provided were for progress note and discharge summary support – 96.5% and 90.0% of clients, respectively. The second most common supports

Table 9

Summary of total service time received (minutes) for all adult clients in YDI CET, 2021 - 2023

Service	Unique Clients	Missing	Mean	Median	Std. Dev.	Min.	Max.
Progress Note	416	15	187.4	150.0	146.0	15.0	985.0
Discharge Summary	388	43	28.9	30.0	22.8	0.0	340.0
Crisis & Safety Plan	328	103	31.1	30.0	11.7	0.0	180.0
Service Plan Note	324	107	30.6	30.0	9.8	0.0	150.0
Consent & Intake	32	399	43.1	30.0	24.0	30.0	120.0
Aftercare	3	428	5.0	0.0	8.7	0.0	15.0
Individual Therapy 30-min	1	430	20.0	20.0		20.0	20.0

Note. n = 431. Service data provided to UNM CARA captured more unique clients than intake records documented. Std. Dev. = Standard Deviation.

Table 10

Summary statistics for time spent (minutes) at prescriber visits, adult YDI CET clients 2021 - 2023

	Unique Clients	Mean	Median	Std. Dev.	Min.	Max.
1st visit	30	69.0	60.0	17.4	60.0	120.0
2nd visit	21	64.3	60.0	14.3	30.0	90.0
3rd visit	13	64.6	60.0	20.7	30.0	120.0
4th visit	10	60.0	60.0	0.0	60.0	60.0
5th visit	3	60.0	60.0	0.0	60.0	60.0
6th visit	1	60.0	60.0	-	60.0	60.0

Note. n = 30. Std. Dev. = Standard Deviation.

provided to clients were for crisis & safety and service plans – 76.1% and 75.2% of clients, respectively. Consent and intake support was provided to very few clients (7.4%), and only one client received individual therapy services according to service data.

Additionally, PSWs can decide whether clients would benefit from prescription services. This was also tracked by intake records and are summarized in Table 10. Overall, 30 unique clients have received prescriber support since 2021. For all visits, the average time spent with a prescriber was about one hour (60 – 69 minutes), and half of all visits last about one hour too. The shortest time for any visit with prescribers was 30 minutes and the longest time spent with prescribers was for two hours. Table 11 summarizes descriptive statistics for the number of days between intake dates and prescriber visits. On average, clients who visited with a prescriber for the first time, met with them 16.5 days after intake. The average number of days from intake to a second prescriber visit was a little over a month, at 36.7 days. The maximum number of days from intake to a subsequent prescriber visit was 276 days – roughly 9 months. Only 10 clients visited a prescriber 4 or more times. The average time between intake and the 4th and 5th visit was about 3-months (91.7) and 5-months (159.7 days), respectively.

Table 11

Summary statistics for days from intake to prescriber visits, adult YDI CET clients 2021 - 2023

Visit	Unique Clients	Mean	Median	Std. Dev.	Min.	Max.
1st	30	16.5	13.0	13.6	1.0	69.0
2nd	21	36.7	30.0	21.1	12.0	92.0
3rd	13	61.5	53.0	30.1	17.0	115.0
4th	10	91.7	91.0	36.8	37.0	161.0
5th	3	159.7	120.0	102.4	83.0	276.0
6th	1	155.0	155.0	-	155.0	155.0

Note. n = 30. Std. Dev. = Standard Deviation.

Discharge

YDI CET's process map indicates CET discharge occurs with warm handoff to other ongoing services, or when a client disengages from CET services/support. One respondent in our YDI staff survey explained "*Once services are connected the CPSW is able to discharge the client. The warm handoff is difficult when referring out of agency as many are just put on waitlists and no contact is made until their turn"* (ADMIN 1). To this point, one PSW noted the discharge process could vary depending on a client's unique needs, which could involve "*Locat*[ing] *services for clients and make*[ing] *sure they are enrolled or on a waiting list…*" (CPSW 2). It could include "*Accompanying clients to appointments/intakes with services that fit their needs*" (ADMIN 2), or even to "*…check and see if they* [client] *need anything else while waiting for other agencies to reach out*" (CPSW 4). Importantly, discharge could also happen if the maximum number of sessions are reached – "*After four session* [sic] *or less discharge client or link client with other services that client is needing*" (CPSW 3). Adult YDI CET client records indicate the vast majority receive *Discharge Summary* services (90.0%). However, YDI staff noted that discharge summary services can be completed with or without the client. Client records we received do not contain any other measures for discharge outcome except for minutes of *Discharge Summary* services and discharge date.

Supplementing client records, we asked surveyed YDI CET staff to rate their level of agreement with the following statement: *The CET program is successful in retaining clients from intake to discharge/ warm hand-off to services*. Five out of eight surveyed staff answered this question, with most responding with *somewhat agree* (60%), one with *neither agree nor disagree* (20%), and one with *somewhat disagree* (20%). While most agreed to the statement, all expressed caveats in their explanation for why they choose their response–

> **Somewhat Agree**
>
> *Due to clients and such sometimes client lose contact with CPSW. Not to mention a lot of hand off services have giant waiting lists depending on the client need. We can referred out most of the time but due not see if it follows through due to programs requirements.* [sic] (CPSW 3)
>
> *If a client is willing to engage in the beginning they are able to see services through the end. Many also come in and once they feel supported and offered help they no longer feel they are in crisis and chose to not continue services.* (ADMIN 1)
>
> **Neither Agree nor Disagree**
>
> *Due to short-term sessions PSW is unable to make sure warm handoffs are completed due to the waiting list or other circumstances.* (CPSW 4)

Similarly, we asked survey respondents if certain client profiles were more successful in the program. Most YDI CET staff respondents indicated *No* (62.5%), while three indicated *Yes* (37.5%). For those who said yes, they echoed the sentiments in the comments above. Staff explained that those who do best are –

> *…clients who are seeking services and willing to participate at their own free will* [sic] (ADMIN 1)

> *A person that is willing to follow through with the program goals* (ADMIN 3)
>
> *Those that engage with the Peer Support Worker and agree to the 4 meeting sessions* (ADMIN 4).

We also asked respondents whether there was a client profile which appeared to do worst in the program. Most YDI CET staff respondents said *Yes* (62.5%), with three indicating *No* (37.5%). Two respondents essentially echoed the same sentiment from previous responses, noting that those who are not willing to participate do worst –

> *Those that feel forced to participate by law enforcement* (ADMIN 1)
>
> *Adults who are referred by other adults and don't make a self referral* (ADMIN 2)

One respondent similarly explained that "*Those that set up an intake then don't show and avoid further contact*" (ADMIN 4) are most likely to do worse. Clients experiencing homelessness were also identified by two participants as most likely to do worse in the program, particularly because of limited resources for these issues despite YDI CET staff support.

> *Homeless. Due to the client's living status and the arise of the homeless and population and demanding housing. We have been left short of resources to solve this and also due to lack of communication at times people living on the street struggle so much daily that it can interfere with our scheduled appointment due to not reaching the client or the client missing an appointment. The phone is not charging or simply not having one, Having to relocate, and such.* (CPSW 3)
>
> *Homeless population due to location issues and also communication issues. The client tends to move around and having no phone is also a struggle to locate client and find client*. (CPSW 2)

It is important to highlight that if clients who experience homelessness do indeed have greater difficulty accessing needed resources and supports within the community as a result of availability, this is particularly problematic since most of the adult clients CET receives need help with homelessness (Table 4), and nearly half of clients (49.1%) are either experiencing homelessness or are unstably housed at intake (page 13).

Aftercare

After discharge, one-month (30 days) follow-up is conducted to ensure that clients ultimately received ongoing services they were handed-off to, and/or understand "…*where client is and provide additional resources at that time if needed*" (ADMIN 1). Adult YDI CET client records document dates for individuals where aftercare follow-up was completed, but no other information we reviewed was available for aftercare service results. For those where aftercare dates were available (n =53), follow-up occurred on average 44.4 days post-discharge. Half of all follow-ups occurred 36 days or less after discharge, with the earliest follow-up occurring 7 days after discharge, and the latest occurring 146 days (roughly 4.5 months) post-discharge. We should note that while service records we received document hours of aftercare provided, those records suggest only three individuals received aftercare for, on average, 5-minutes.

Outcomes

Records we received for adult YDI CET clients did not include any outcome measures. We did receive GAIN-SS assessment dates and records about whether GAIN-SS were scanned into YDI's MIS. We ultimately received 395 digitally scanned copies of GAIN-SS assessments but were unable to digitally copy and score these in time for this report. If GAIN-SS assessments are not always scored and systematically recorded, this begs the question *how* GAIN-SS are useful to service provision. If GAIN-SS are not useful for providing services, an alternative crisis assessment tool should be implemented. According to best practices recommended by SMAHSA's 2020 toolkit for behavioral health crisis care, crisis receiving and stabilization services should monitor the "percentage of individuals reporting improvement in the ability to manage future crisis," as well as "guest service satisfaction" (SAMHSA 2020; 51). Further, if warm handoff to services is a central component of CET services, it is critical to systematically document (1) which ongoing services are referred *out* to, (2) whether warm hand-off occurs with a client, and (3) whether follow-up indicates intended services and/or resources were ultimately received by the client.

To this point, we asked survey respondents what the primary goals of the CET program were. Half of surveyed YDI CET staff indicated the primary goals of the program were to provide general assistance or help, and/or guidance and mentorship.

> *Help the community the best way we can. Supply support, an ear, some mentorship, and hope for our clients. The goal is to assist anyone in need and get connected to their needs the best way possible.* (CPSW 2)

> *The primary goals are to offer short-term case management services led by a peer that has a similar experience, provide the individual with stabilizing them in the crisis and guiding them to the proper support and help, and finally provide a warm handoff to other services.* (ADMIN 3)

> *To respond to non acute crisis referrals and assist with accessing resources to stabilize the individual and prevent further harm to self or others.* (ADMIN 4)

Since YDI CET staff intend to primarily connect individuals to resources and help through warm hand-off and stabilize an individual to prevent physical harm to self and others, it is useful to measure these outcomes with standardized and/or validated tools and/or instruments.

We also asked survey respondents what they thought the most accurate measure of effectiveness for the CET program is, and respondents overhwlemingly explained that "*warm hand-offs to longer term services*" (ADMIN 2), being "*…able to help people know where to go when they are ready*" (CPSW 2), and "*helping clients become stable in their crisis*" (ADMIN 3). Some respondents also explained that the most accurate measure of effectiveness was "*communication and consistency*" (CPSW 3) and "*…being out in the field and talking to people who need help*" (CPSW 4).

Additional outcome metrics (not presently collected) were articulated by surveyed CET staff when we asked whether CET program performance measures collected by Bernalillo County (e.g., calls for services, referrals, Social Determinants of Health (SDOH), quality of life, etc.) were related to explicitly identified CET outcome measures (e.g., reduce crisis events, prevent hospitalizations and/or law enforcement and first responder interventions). Surveyed YDI CET staff overwhelmingly agreed that they

did (87.5%), with just one respondent expressing neutrality. One respondent explained performance measures "…*allows us to see pre and post scores to compare if an improvement or lack thereof exists*"(ADMIN 1), and that they have "…*been able to help people get reconnected into there medications and also locate housing options and many more things*..." (CPSW 2). While YDI CET collects systematic data on prescriber visits and living situation at intake, client records we received do not measure whether prescriber visits reconnect clients to medication, or what a clients' living situation is upon discharge. Since surveyed CET staff indicated many clients are waitlisted for housing support, those metrics would be useful to document.

Without measures for program outcomes it is difficult to understand whether CET achieves its primary goals. However, we collected anecdotal evidence from surveyed CET staff about whether the program: (1) reduces crisis events, (2) prevents first responder events, (3) prevents hospitalization, and (4) prevents law enforcement interventions. Chart 1 illustrates the responses. Eighty-percent (80%) of staff agreed the CET program increases a client's access to care, especially community-based care. Most also felt neutral (60.0%) about whether the CET program prevents law enforcement interventions or hospitalizations. Finally, most agreed (80%) the CET program reduces crisis events.

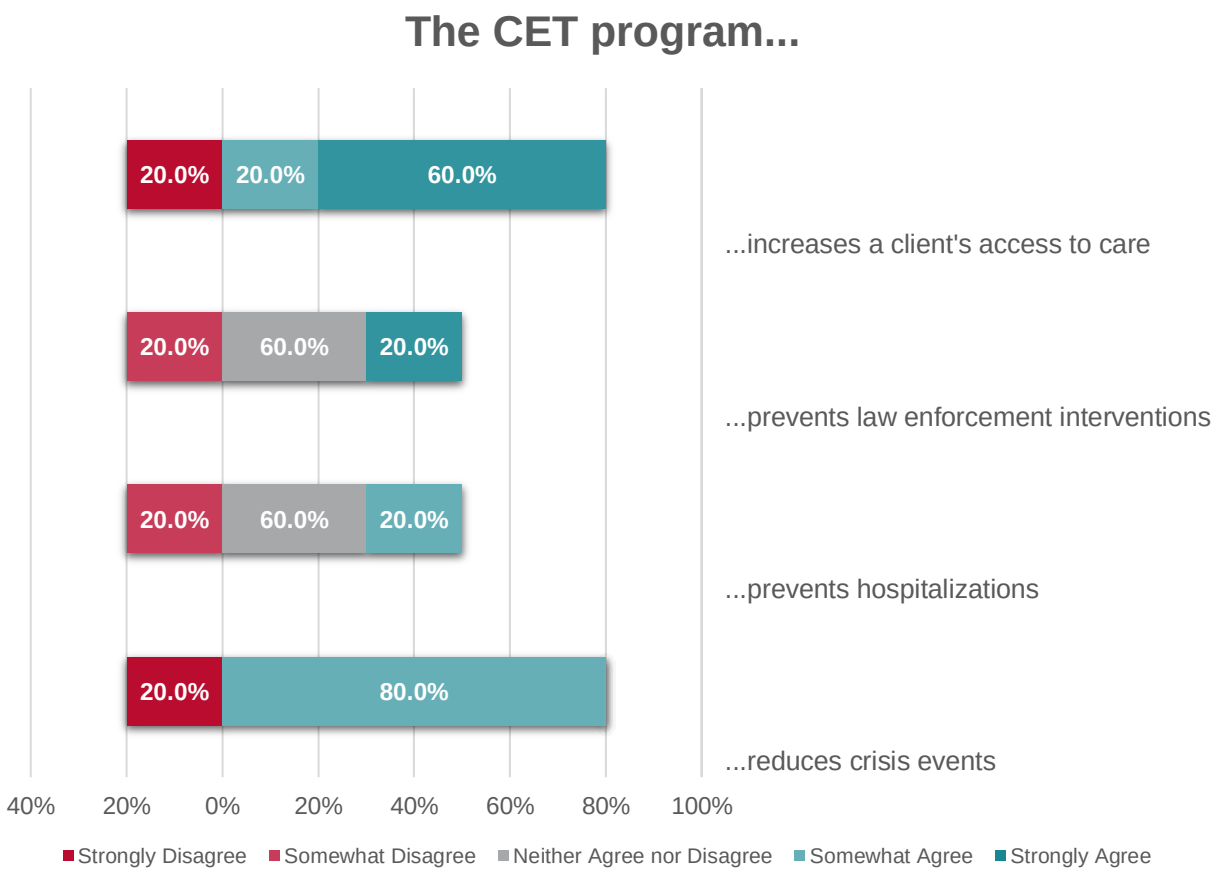
The survey responses we received – Chart 1 – are not proof that the program achieves its intended outcomes. But those data do highlight the importance of collecting measures which would illuminate outcome achievement, particularly for connections made for clients to a broader continuum of care, and whether crises are stabilized. Ostenisbly, two of the outcomes we surveyed YDI CET staff about – preventing law enforcement interventions and hospitalizations – are metrics that evaluators can assess through an outcome evaluation by matching YDI clients to statewide data on arrests and hospitalizations. It is first critical to understand whether program outputs – e.g., warm hand-off to referrals, type of referral made, housing situation at intake vs. exit, re-connection to medication, etc. – are completed, so that a subsequent outcome evaluation could determine whether program outputs are associated with long-term positive outcomes (e.g., decreased arrest, fewer hospitalizations, etc.). We therefore strongly recommend fertive discussion about (1) improving data collection practices to capture more clients, and (2) identifying outcome measures best suited to the CET program. Our discussion (above) identifies some specific measures for consideration.

Challenges

Our survey of YDI CET staff included some final questions about unanticipated issues and top challenges with achieving program goals and outcomes. Surveyed CET staff described four unanticipated issues: (1) CET support is too short-lived, (2) lack of immediately available resources, (3) undefined target population, and (4) referral pipeline issues. One respondent explained an unanticipated issue included "*Having a limited amount of sessions provided to be sure that a warm hand-off and connection is made for next level of care*" (ADMIN 1). The same respondent also described that a "*Lack of immediate resource and long waitlists for services*" were an issue, including "*locating housing and shelter care appropriate for individuals*." *Another respondent noted "Many of the clients we* [CET] *are receiving are unsheltered individuals, and not all have behavioral health needs."* (CPSW 2). Another respondent noted that issues included "*Having a clear idea of what our target population is*" (ADMIN 1). Lastly, one respondent identified that referrals were "*…not coming from the original referral source, the Crisis Mobile Team*" (ADMIN 2). We also asked surveyed YDI CET staff to rank which challenges were top

Chart 1

Summary of YDI CET staff agreement with statements on program outcomes



Note. n = 8. Suvery responses reflect 89% of YDI CET staff in August 2022.

issues for the CET program. At the time of the survey, top challenges included: (1) Referral source definition, (2) housing and resource waitlists, (3) short-term care, (4) lack of 24 hours/365 coverage with four staff to cover, (5) referral sources not providing enough information, (6) changing administration at Bernalillo County without clear instructions about the program, and (7) locating or finding clients.

In terms of resolving issues and challenges, multiple respondents indicated housing and resource (un)availability was a systemic issue within Bernalillo County, which waitlists evidenced. Several respondents emphasized the need for increasing the number of peer sessions and providing longer-term support to clients. It is important to note that at the time of the survey (August 2022) CET was limited to a maximum of four peer sessions, which were subsequently increased by Bernalillo County to six peer sessions for the most recent contract period. Regarding CET target populations, one respondent explained YDI CET continues "*…to seek understanding of what our* [CET's] *identified target population is to streamline their definition of* ***any individual residing in Bernalillo County***" (ADMIN 1 – emphasis added).

Despite these challenges and issues, YDI CET staff consistently highlighted their work offered a "glimpse of hope" to clients, and, as one respondent described, "M*any also come in and once they feel supported and offered help they no longer feel they are in crisis*." When asked to rate their level of agreement with "*Clients benefit from the CET program,"* surveyed staff unanimously agreed they did. They explained benefits included –

> *Being connected to resources and having someone mentor you and also be by your side to make sure your goal is completed.* (CPSW 3)
>
> *When clients work with a peer support worker, I believe they have already made the right decision to answer the call and accept help. Also, many of the clients have a crisis plan and service plan to understand their next steps.* (ADMIN 3)

Many YDI CET staff noted throughout our survey they felt program benefits could be increased if CET was *"…a long-term engagement program because we don't have enough time to make sure they are getting everything they are needing*" (CPSW 4).

CONCLUSION

Our analysis of YDI CET client records for adults in tandem with staff surveys suggest the program has received over 1,597 referrals between May 21st, 2021, and August 31st, 2023. This is an undercount as we did not review records for minors. Adult client records document that, out of all referrals received, 418 completed intake and 431 have received services and/or support. Thirty unique adult YDI CET clients also completed visits with a CET prescriber, and on average, visited with prescribers for roughly one-hour during each visit. Most adult clients received progress note, discharge summary, crisis safety plan, and service plan services. Three clients received aftercare support and one client received individual therapy, according to client records.

Client records also suggest adult YDI CET clients are mostly between the ages of 18 and 47, female, Hispanic, and White. Data collected on client need indicate CET is receiving vulnerable clients, who primarily need support with homelessness (45.4%) and/or mental health (34.1%). Clients who ultimately complete CET intake overwhelmingly want help with homelessness (64.4%) and/or mental health (38.2%). Records for adult YDI CET clients also revealed nearly half of all clients at intake were homeless or unstably housed. About three-quarters of clients were not receiving public assistance (SNAP, TANF, or WIC).

Importantly, client records lack measures for key program outputs and outcomes. Data we received did not systematically collect information on whether warm hand-off to services were successful, or document what kinds of services clients were ultimately referred to. Anecdotally, surveyed YDI CET staff overwhelmingly agreed CET was successful in retaining clients from intake to discharge. The majority also agreed CET led to reductions in crises and increased clients' access to care. Still, it would be useful to understand (1) how successfully clients are referred to other programs, (2) what kinds of support they are ultimately connected to, and (3) if warm hand-off is successful for most. This is critical considering that surveyed staff emphasized how waitlists and immediate resources were sometimes unavailable, and that warm hand-offs were challenging since waitlists often extended beyond the maximum number of sessions CET staff were able to complete with clients.

We also highlighted additional challenges identified by CET staff relating to unclear target populations and referral pipelines. Bernalillo County's contract with CET states that –

> *YDI will provide short-term services for individuals that are experiencing behavioral health needs that without appropriate intervention could escalate to a higher level of care such as hospitalization or incarceration…YDI will collaborate with all identified community partners in securing referrals for CET to include City and County Mobile Crisis Teams*. (CCN 2020-0856)

Some surveyed staff explained such a mandate is broad, and effectively means the CET target population is anyone. Bernalillo County's 2022 contract does outline exclusionary criteria now though, which includes "*…individuals who are severely impaired to the point they cannot participate in decision making, those who are actively suicidal, actively using a narcotic or other illegal substance, including inhalants or alcohol at the time of intake or violent to the extent that they pose a hazard to others. Individuals in these categories must be referred to an appropriate agency.*"

Systematic data are needed to understand *who* CET receives, in terms of mental and behavioral health populations. YDI CET data on client referral status indicates a substantial number of referrals result in loss of contact or refusal of service which does make this challenging. Ideally, GAIN-SS assessments would describe clients' behavioral health disorder severity clients, but those data are not systematically scored and collected. It would be interesting to compare behavioral health needs by referral source and/or presenting issue to understand how CET's target population might be constrained to provide clarity about who they attempt to support. If YDI CET client records are accurate, then nearly half of all referrals and clients who complete an intake need housing support, rather than behavioral health support. Some surveyed YDI CET staff suggested this is the case. The best practice toolkit developed by SAMHSA succinctly states that at minimum, crisis receiving and stabilization services should accept all referrals with low rejection rates (less than 10%), but also specifically notes they must "*design their services to address mental health and substance use crisis issues*" (SAMHSA 2020; 22), as well as be staffed at all times (24/7/365). To that end, crisis and stabilization services should also screen for suicide risk and violence risk. And while not explicitly a housing support, best practices also include incorporating "*some form of intensive support beds into a partner program*" and "*include beds within the real-time regional bed registry system operated by the crisis call center hub…*" (SAMHSA 2020; 23).

Bernalillo County notes in their 2020 contract with YDI that CET should collaborate with community partners to secure referrals from Mobile Crisis Teams (MCT). Some surveyed staff explained that such a referral pipeline has never truly occurred. Table 2 summarizes referral source data from adult YDI CET client records, which indicates a minority of all referrals received have been from MCT (5.0% of clients; 4.9% of all referrals). While we cannot speak to whether MCT referrals have operated as originally intended, client records support that few overall persons have been referred to YDI CET and just 17 of the 76 total referrals YDI CET received from MCT completed initial intake. It may be useful for subsequent analyses to reconcile MCT program referral records and YDI CET client referral records to understand the dynamics involved in referring from MCT to CET. SAMHSA specifically describes how "*Crisis services should not be viewed as stand-alone resources operating independent of the local community health and hospital systems but rather an integrated part of a coordinated continuum of care*" (SAMHSA 2020; 25). Such a care system at its most integrated "*…requires shared protocols for coordination and care management that are supported in real time by electronic process.*"

In sum, our report highlights the critical need for more complete data collection on key outputs and outcomes for YDI's CET program. While data suggest services and supports are being provided, it is unclear whether positive outcomes could be expected from the CET intervention since data collection does not include measures that would allow evaluators to determine achievement of outcomes. There are also internal YDI CET staff concerns, as noted in our 2022 survey, about a clear target population to serve and referral pipeline. If an initial CET design was to include referrals directly from MCT, then most referrals are not received by that source. We have identified in this report several categories of measures that might be collected by CET to begin to document key outputs and outcomes though. However, that enterprise should be considered by Bernalillo County in the context of the logistical, financial, and personnel demands that high-quality data collection require of providers. More complete data collection and identification of appropriate output and outcome measures should occur prior to any future process or outcome evaluation.

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