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Bernalillo County Behavioral Health Initiative: Adverse Childhood Experiences Process Evaluation

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INTRODUCTION

The Bernalillo County Behavioral Health Initiative (BHI) seeks to provide a "strong continuum of care for individuals living with behavioral health conditions, along with their families" (Bernalillo County, 2023). Behavioral health conditions can refer to "mental health and substance use disorders, life stressors and crises, and stress-related physical symptoms" (AMA, 2022). The Behavioral Health Initiative began in February 2015 when the Bernalillo County Commission (BCC) and voters approved a new gross-receipts tax expected to generate between $17 and $20 million each year to develop a unified and coordinated behavioral health system in the County and surrounding areas (CPI, 2015). The initial structure of BHI's continuum of care programming took form in April 2015, when the Bernalillo County Commission contracted Community Partners, Inc. (CPI) to develop a business plan for a regional, cohesive system of behavioral health care. CPI proposed behavioral health programs in several categories, which were then vetted and approved for funding by the Albuquerque Bernalillo County Government Commission. One of these categories is "Prevention, Intervention, Treatment and Harm Reduction Services," which includes programs to address adverse childhood experiences (ACEs).

ACEs refer to traumatic events experienced as a child or youth (less than 18 years old), such as being the victim of physical, emotional, and/or sexual abuse. Through complex and not fully understood psychological processes, these adverse experiences often produce behavioral health problems that can manifest throughout the lifetime. These behavioral health problems include psychological conditions like depression and anxiety and risky behaviors like smoking, drug and alcohol use, risky sexual activities, self-harm, and interpersonal violence (Felitti et al., 1998). These behavioral issues, in turn, often lead to negative life outcomes, like low income, unemployment, lower educational achievement, a range of physical health problems, and heightened mortality (Brown et al., 2009; Metzler et al., 2017). Perhaps most tragically, these behavioral health outcomes increase the risk of ACEs for one's children, thus creating a cycle of intergenerational behavioral health issues. ACEs are prevalent in the United States, with an estimated 64% of adults having experienced one or more ACEs as minors (Swedo, 2023). Due to their prevalence and negative effects, preventing and treating ACEs is a critical public health concern.

BHI initially funded eight providers to address the problem of ACEs in Bernalillo County beginning in July 2017 for a four-year funding cycle. Funds were to be used for "the full continuum of services including primary prevention, identification, early intervention, support and treatment, harm reduction, outreach, and services in children's homes and within the community" (Bernalillo County, 2021). Additionally, BHI contracted with the Institute for Social Research (ISR) at the University of New Mexico (UNM) to conduct process evaluations that focused on evaluating these programs in terms of their design and implementation. This report was completed in March 2021.

For the subsequent 4-year funding cycle beginning in July 2021, BHI re-contracted with four providers from the prior funding cycle (Peanut Butter and Jelly, All Faiths, Centro Savila, and New Day) and 4 new, community-based providers: AMIkids, Youth Development Incorporated

(YDI), Cuidando los Niños (CLN), and Enlace Comunitario). BHI contracted with the ISR to conduct outcome evaluations of the four continuing providers and process evaluations of the four new ACE programs. This report concerns the four new ACE programs. A separate study was conducted of the four continuing ACE programs that focused on program outcomes.

This process evaluation is focused on evaluating these programs in terms of their design and implementation.

The report includes process evaluations for AMIkids and Youth Development Incorporated. It was not possible to complete process evaluations of Cuidando los Niños or Enlace Comuntario. While Cuidando los Niños was funded in July 2021 the program was not fully implemented in time to be included in this study. The program experienced challenges in becoming fully staffed and retaining staff. Enlace Comuntario was funded in November of 2022 and their schedule of services is reliant on the school calendar. At the time of this study the program had not fully implemented and could not be included in this study. Enlace Comunitario and CLN will be included in a subsequent and future study.

The remainder of this report is organized into 4 sections:

1. A Literature Review section, which provides important background on the problem of ACEs and evidence-based strategies for addressing the problem,
2. A Study Design and Methodology section, which describes what data we collected and how we analyzed it to evaluate each program,
3. A Study Findings section, which presents the results of our analyses for each program,
4. A Conclusions section, which summarizes our main findings.

LITERATURE REVIEW

The Problem of ACEs

Adverse Childhood Experiences (ACEs) refer to traumatic events experienced from birth to the age of 18, which place one at higher risk for a range of negative outcomes later in life. ACEs encompass multiple categories of traumatic events, including experiencing physical abuse, psychological abuse, sexual abuse, neglect, financial problems, food insecurity, and homelessness; witnessing domestic violence, drug and alcohol abuse, or mental illness in the home; having a household member die; having divorced or incarcerated parents; and witnessing or experiencing violent crime in the community (Choi et al., 2020; Felitti et al., 1998; Reidy et al., 2021).

ACEs are widespread among the United States population. The Centers for Disease Control and Prevention (CDC) estimates that around 64% of adults experienced one or more ACEs as minors and around 17% experienced four or more (Swedo, 2023). The most prevalent categories of ACEs reported were emotional abuse, parental divorce, and substance abuse in the home. ACEs are more prevalent among women than men and among American Indian/Alaskan Natives and multiracial individuals than other racial groups.

ACEs are associated with negative health outcomes and diminished economic and social prospects later in life. This relationship is “grade-dosed”, meaning the more ACEs someone has,

the more negative outcomes they are likely to suffer. Many of these negative outcomes pertain to behavioral health, like suffering from psychological problems (e.g., anxiety and depression) and engaging in risky behaviors like substance use, smoking, physical inactivity, self-harm and suicide, interpersonal violence, and sexual risk taking (Felitti et al., 1998; Hughes et al., 2017; Merrick et al., 2019). These behaviors, in turn, lead to a heightened risk for various physical health problems, including obesity, diabetes, heart disease, cancer, chronic lung disease, liver disease, bone fractures, and sexually transmitted diseases. Brown et al., (2009) found that, in a sample of 17,337 adults, those with 6 or more ACEs died on average around 20 years earlier than those with no ACEs. Regarding socio-economic outcomes, individuals with more ACEs statistically have lower lifetime academic achievement, employment, and income (Metzler et al., 2017).

The costs of these negative outcomes are significant, both for individuals and society at large. Peterson et al., (2018) estimate that child maltreatment alone (physical abuse, sexual abuse, psychological abuse, and neglect), which represents only a subset of all ACEs categories, imposes a lifetime economic cost of $830,928 per victim (in 2015 USD), which amounts to a total of around $2 trillion dollars for the United States. Among a sample of European countries, Hughes et al., (2021) estimated the costs of ACEs totaled between 1.1-6% of a country's gross domestic product. Given the costs on individuals and society, it is in the public interest to develop and implement interventions to address the problem of ACEs.

Interventions to Address ACEs

Interventions to address ACEs can be divided conceptually into prevention and mitigation approaches. Prevention approaches target the causes of ACEs to reduce their future incidence. Treatment interventions focus on mitigating the impact of existing ACEs on individuals' life outcomes.

Preventing ACEs

As with any social-behavioral phenomenon, the causes of ACEs are complex and where or when they will occur cannot be predicted with certainty. However, it is possible to identify risk factors that increase the likelihood of experiencing ACEs. The CDC lists a range of family and community level risk factors for ACEs (CDC, 2023).

Many ACE risk factors deal with economic stressors, such as having low household income and educational attainment, or living in a community with high levels of poverty, unemployment, food insecurity, and limited economic opportunity (CDC, 2023; Swedo, 2023). Closely related are factors associated with a lack of parental supports, as well as factors that place greater demands on parents' resources. For example, families who are isolated from others who could provide support and who live in neighborhoods with diminished social support networks are at higher risk for ACEs, as are young caregivers, single parents, and families who have children with special needs. The CDC recommends a range of interventions to prevent ACEs by strengthening economic and social supports to parents and communities. These include things like subsidized childcare, subsidized housing, tax credits for families, SNAP, child support

payments, and family friendly work-places (e.g., paid leave, flexible work schedules, livable wages) (Fortson et al., 2016, pp. 13–14).

Other risk factors for ACEs pertain to insufficient knowledge and/or inappropriate cultural attitudes around healthy parenting practices. Families with parents who use spanking and other forms of corporal punishment for discipline, who view violence as an appropriate means of settling disputes, and who engage in minimal monitoring and supervision of children are at higher risk of ACEs (CDC, 2023). Many of these attitudes and practices are likely learned behaviors, as having parents who were themselves abused or neglected as children is a key risk factor for ACEs. Evidence-based preventative interventions targeting parenting attitudes include parenting skills classes, which teach parents about developmentally appropriate child behavior, techniques for communicating with children, managing problematic behaviors, and appropriate methods of discipline (CDC, 2019, p. 17; Gubbels et al., 2019). The CDC also recommends community scale approaches targeting parenting norms and attitudes, such as educational campaigns and laws to prevent corporal punishment (CDC, 2019, p. 13).

Lastly, several family level risk factors deal with the behavior of the child and the environment outside the home. For example, children who engage in delinquent behavior and early sexual activity are at higher risk for ACEs, as are children who live in areas with low levels of public order, high levels of violent crime, high drug and alcohol availability, and limited community activities for youths (e.g., sports leagues). Interventions to target these risk factors include mentoring and after-school programs, which seek to connect youth with adults who can serve as role models and provide guidance to promote academic and employment success (CDC, 2019, p. 19).

Treating ACEs

Treatment interventions seek to mitigate the negative effects of ACEs that people have already experienced. As highlighted previously, ACEs have a grade-dose, or cumulative association with a range of negative life outcomes (Felitti et al., 1998). However, knowing this association exists doesn't offer guidance about how to treat ACEs once they occur. To effectively treat ACEs, a causal model of *how* ACEs produce negative life outcomes is required.

Scientists broadly agree that children can remember ACEs (Coates, 2016) and that these memories affect neurological and cognitive development (Cross et al., 2017; Read et al., 2014). This may even have an adaptive explanation, as traumatic experiences early in life could signal that the world is hostile, thereby altering the developmental trajectory "toward faster and more reactive responses to threat, less delay of gratification, and other stress adapted traits" (Ellis et al., 2017, p. 564). This produces *internalizing* and *externalizing* behaviors. Internalizing refers to withdrawing into oneself and dissociating from one's emotions, whereas externalizing refers to engaging in aggressive and destructive anti-social behaviors (Sheffler et al., 2019; Zhang & Mersky, 2022). These behavioral issues can persist into adulthood, leading to diminished life possibilities and negative health outcomes (Jones et al., 2018; Morgan et al., 2021). Tragically, these negative adult outcomes place their children at heightened risk of ACEs, thus creating an intergenerational cycle.

There are several approaches to interrupting and reversing the process that leads from ACEs to negative life outcomes. A classic approach is to help individuals process and overcome trauma by talking about it with therapists, often referred to as "talk" therapy, or psychotherapy. One such therapy technique is Trauma Focused Cognitive Behavioral Therapy (TF-CBT). TF-CBT is based on the theory that psychological problems stemming from trauma are reinforced by unhelpful patterns of thought and behavior. Therefore, TF-CBT teaches people to engage in alternative patterns of thought and behavior in order to overcome trauma (APA, 2017; Lorenzo-Luaces et al., 2016). TF-CBT has been shown effective in improving outcomes for children with ACEs and their non-abusive caregivers (Cohen & Mannarino, 2015; Ramirez de Arellano et al., 2014). Motivational interviewing is another evidence-based technique, which has been shown effective in helping individuals to recognize and change problematic behaviors that can be self-reinforcing (Apodaca & Longabaugh, 2009; Bischof et al., 2021).

An alternative treatment to therapy is so-called *strength-based approaches*. While there is a strong statistical correlation between ACEs and negative life outcomes, some individuals are outliers who have positive life outcomes despite suffering from ACEs. These people are described as having "resiliency," which is defined technically as a set of factors that lead individuals to have positive outcomes despite exposure to risk (Masten, 2001). These resiliency factors are usefully grouped into two categories: "assets" which are internal characteristics of the individual, and "resources," which are external features of one's environment and social relations. "Assets" associated with resiliency include things like intelligence and effective emotion regulation. External resources include things like adult support, low parental discord, high socio-economic status, effective schools, and safe neighborhoods (Fergus & Zimmerman, 2005; Vanderbilt-Adriance & Shaw, 2008). Strength-based approaches to treating ACEs seek to build these internal and external resiliency factors in individuals exposed to ACEs.

Programs to increase resiliency for young children generally seek to provide a safe, nurturing, and stimulating environment where natural development can hopefully return to a normal trajectory, thanks to the intrinsic resiliency of child development. Interventions to promote such a home environment include early childhood home visiting, parenting skills and family relationship classes (Fortson et al., 2016, p. 25), and parent-child psychotherapy, which aims at improving the relationship between an abusive or neglectful parent and their child (Lieberman & Van Horn, 2009).

Approaches to build resiliency in older children and adolescents may also seek to actively instill specific assets and resources by teaching life skills and providing opportunities to form healthy relationships and become involved in the community. For example, the Positive Youth Development (PYD) program seeks to provide youth with opportunities for leadership, skill building, and sustained connections between youth and adults (Edwards et al., 2007). There is some preliminary evidence that PYD and similar approaches are effective in improving subjective sense of knowledge, skills, autonomy, and social connection, however, evidence for their effectiveness in shaping behavior in desired ways is mixed (Bettinger & Baker, 2014; Chandler et al., 2015; Maslow & Chung, 2013).

In sum, ACEs interventions can be broadly divided into prevention and treatment, with prevention focusing on protecting children and youths from exposure to future ACEs and

treatment seeking to mitigate the effects of existing ACEs on life outcomes. In practice, these lines are often blurred by the fact the same intervention can be seen to perform both functions. For instance, interventions to strengthen family functioning can both prevent future ACEs and treat existing ACEs by creating a nurturing home environment. Moreover, due to the intergenerational dynamics around ACEs, effective treatment of individuals with ACEs in the present can help prevent ACEs in their future children.

STUDY DESIGN & METHODOLOGY

To complete the evaluation of the ACE programs, we completed a review of program documents, a review of client level data, and conducted a staff survey. This section describes the study.

Program Materials

Program documents included contracts between the programs and Bernalillo County that provided an overview of the program, described the staffing model, outlined the service delivery model, presented data and metrics for tracking client performance, detailed a timeline and provided the budget. We also reviewed program audits with the County, program forms (i.e., referral, intake, and discharge forms) and assessment instruments. We reviewed these documents to document and report the program's design and implementation plan.

Client Level Data

Service data included client level data and monthly performance reports. We reviewed these data to assess whether each program was following their program design outlined in their program documents. Using available client level data, we were chiefly interested in assessing whether each program was providing services of the planned type, intensity, and duration to the intended target population. We relied primarily on client level service data, which allowed us to match individuals across different datasets. This is important for tracking how individual clients move through the program and for assessing the variability in client experiences. Due to state law dealing with human subject research and minors, we could only receive de-identified data for minors (i.e., no names, addresses, birth dates or similar data which could identify clients). We coordinated with providers prior to receiving data to ensure all such identifiers had been removed and replaced with a confidential client ID number. Monthly performance measures, by contrast, report on a program's clients in the aggregate, or summary form. Fewer inferences can be drawn from this data, as individual clients cannot be matched across datasets and because these reports typically report on a smaller set of client variables. Due to these limitations, we used the monthly performance reports to help resolve ambiguities in the interpretation of client level data. When monthly performance reports differed from client level data, we relied on the client level data.

Staff Survey

The purpose of the survey was to explore how staff perceive the program. The survey included questions which were intended to assess beliefs respondents may have about the ACE program, goals of family support services, job stress and satisfaction, what respondents thought about the program, and a set of demographic questions. The survey was confidential and respondents were

eligible because they were current or recent staff with the programs. The online survey was designed to take no more than 15 minutes to complete.

STUDY FINDINGS

All providers provided a range of program documents that we reviewed to help us understand their programs. Subsequent communications and meetings with program staff were necessary to understand what service data was available to request and the format in which it could be provided. This task was complicated by the need to de-identify data, which had to be performed by providers prior to providing the data. ISR applied for and received approval from the UNM Institutional Review Board (IRB) to collect and analyze human subjects' data prior to receiving any client level data.

The results of these analyses are presented below by provider.

AMIKIDS

Program Description

Program documents we reviewed included the contract with Bernalillo County, the BHI FY 2023 annual audit, program forms (i.e., referral, intake, and discharge forms) and assessment instruments (i.e., the Youth Self-Report (YSR), the ACEs survey, the Social Determinants of Health survey, the Youth Outcomes Survey (YOS), and the Family Assessment Device (FAD). The YSR, FAD and YOS are to be used as pre- post-test measures to measure change among clients. We reviewed these documents to document and report the program's design and implementation plan as well as report client level outcomes.

In the program's contract with the County AMIkids was contracted to include a Family Centric Team (FCT). The Family Centric Model (FCM) was developed by AMIkids and focuses on children with behavioral health issues related to Adverse Childhood Experiences. Primary clients are intended to be children 11 to 18 years of age with family and siblings as secondary clients. To be eligible children are required to have a permanent living situation.

AMIkids utilizes a whole family treatment approach, which means the primary client's parent(s)/guardian(s) and siblings also participate and are considered secondary clients. A Family Support Specialist (FSS) is connected to each family, who then utilizes the Family Centric Model (FCM): a 3 stage model created for service coordination and planning. The services in each phase are provided in the client's homes, school, community center, or other predetermined agreed upon locations. The phases are:

1. Family bonding and assessment: In a minimum of 30 days, the Family Support Specialist focuses on building connections with the client and their family, completing assesments, and documentation. During this phase a set of client-specific goals and a care plan are created.
2. Family development: This phase lasts 4-8 weeks and focuses on building skills and utilizing psychoeducation tailored to the client's care plan objectives.
3. Family preservation: This end phase lasts 2-4 weeks. An exit plan is created by evaluating how the client utilizes the tools and skills they have learned. If additional help is needed referrals are made to outside partners. Before discharge, each family is given a Family

Maintenance Plan that defines individualized competencies that have been achieved, available resources in case of future needs, and techniques to preserve the family bond.

The program provides case management services that includes developing a care plan for each primary client based on their assessment, risk factors and needs. When necessary the program refers primary clients to other community based providers if the client requires services outside the scope of the Family Centric Model.

The program serves clients in various locations including their homes, in schools, community centers, or other agreed upon locations. The program is designed to receive referrals from various sources including the state Children, Youth and Families Department (CYFD), Albuquerque Public Schools (APS), and community based organizations. No more than 30% of referrals were to come from other AMIkids programs.

All BHI funded Adverse Childhood Experiences (ACE) programs are required to complete the ACE survey which is used to measure childhood trauma. The survey assesses 10 types of childhood trauma. Five are personal: physical abuse, verbal abuse, sexual abuse, physical neglect, and emotional neglect and five are related to other family members: a parent who's an alcoholic, a mother who's a victim of domestic violence, a family member in jail, a family member diagnosed with a mental illness, and the disappearance of a parent through divorce, death or abandonment. Contractually the ACE survey is supposed to be administered within 45 days of intake.

Each ACE progam is also contractually obligated to administer the BHI Social Determinants of Health (SDOH) survey within 45 days of program intake. The SDOH survey is an 8 question survey designed to gather information that can be used to assess and monitor social needs and risk factors of those assessed.

The Youth Self Report (YSR) is a child-report measure that assesses emotional and behavioral problems among children 11 years to 18 years of age. Behaviors are based on the preceding 6-months and rated on a 3-point scale: 0-Not true, 1-Somewhat or sometimes true and 2-Very true or often true. The questionnaire provides scores for 8 syndrome scales: anxious/depressed, withdrawn/depressed, somatic complaints, social problems, thought problems, rule-breaking behavior, and aggressive behavior. The questionnaire also provides scores for 6 DSM-oriented scales: affective problems, anxiety problems, somatic problems, attention deficit/hyperactivity problems, oppositional defiant problems, and conduct problems. There are 20 social competency items that measure the child's participation in hobbies, games, sports, jobs, chores, friendship, and activities.

The McMaster Family Assessment Device (FAD) measures structural, organizational, and transactional characteristics of families. The FAD includes 7 scales: affective involvement, affective responsiveness, behavioral control, communication, problem solving, roles, and general family functioning. Respondents (typically, all family members ages 12+) are asked to rate how well each of the 60 statements describes their own family. Higher scores indicate worse levels of family functioning. The FAD has been widely used in research and clinical practice. Uses

include: (1) screening to identify families experiencing problems, (2) identifying domains in which families are experiencing problems, and (3) assessing change following treatment.

The AMIkids Youth Outcomes Survey (YOS) has 6 measures and is designed to measure change among clients. These measures include emotional regulation, goal setting, school connectedness, education expectations, resilience/coping skills, and helping alliances.

Staff Survey

A staff survey was used to gather information from program staff with four sections. The first section asked about the related work experience and education of respondents. The second section asked for respondent's opinions relating to ACE programs followed by a third section on job stress and job satisfaction. The fourth section included questions about the assessments used by the program, family support services, and training. There was also a set of demographic questions.

All staff has a college degree, with the highest level of education being a Master's degree. On average, staff had 8 years of experience working with at-risk youth, and 5 years working with families. As this is a new program, staff had a maximum of two years working in their current position and for AMIkids.

Table 1 reports respondents' opinions on factors contributing to ACEs and their effect on the lives of children and adults. Respondents agreed treating ACEs in children is important and programs designed to target ACEs help improve life outcomes.

Table 1 ACEs

ACE Program Questions	Average	Level of Agreement
Trying to prevent ACEs in children is a waste of time.	2	Disagree
Most children with ACEs won't be able to break the cycle of their family.	2.7	Slightly disagree
Children should not be punished for their parents' decisions.	5	Strongly agree
Families in ACEs programs will not change after they leave the program.	3	Neither agree nor disagree
Parents are often just victims of their circumstances.	3	Neither agree nor disagree
Most children are victims of their parents' choices.	3.7	Almost Agree
Children can be motivation for parents to change.	4.7	Almost strongly agree
ACE programs help improve the life outcome of children and their families.	4	Agree

Table 2 reports opinions toward counseling. AMIkids treats/mitigates ACEs through providing various methods of family counseling. The questions are specific to the type of counseling AMIkids provides and the type of behavior they aim to address. Responses indicate that staff believes strong communication within a family can help prevent children from engaging in antisocial behavior and have a positive mental health outcome. This belief aligns with the goals of AMIkids in mitigating the harm caused by ACEs and preventing future involvement in the criminal justice system by improving communication within the family unit.

Table 2 Counseling

AMIkids ACE program Questions	Average	Level of Agreement
On average, each family member is dedicated to improving their communication with each other.	3.3	Neither agree nor disagree
I do not take it personally if the primary client's behavior does not improve.	2.7	Slightly disagree
I think it is the responsibility of the parents to establish strong and effective communication	4.7	Almost strongly agree
Children/adolescents in a family with strong communication/support are less likely to engage in antisocial behavior	4.3	Agree
A parent's opinion of mental health impacts their child's own mental health.	4.3	Agree
I think a preventative approach toward behavioral issues is much more important than treating them after they're presented.	4.7	Almost strongly agree

Table 3 reports opinions of family dynamics, or the functioning of the relationship between parents and their child(ren). These questions are specific to the program's provided treatments. Responses show that staff believe family dynamics are important in the prevention of ACEs and are important when considering treatment options. Staff believe that parents' education of risk factors are important in preventing delinquent behavior in their children. They had a neutral response to family-based treatment models being more effective than an individualized treatment model. All the responses align with the goals of AMIkids.

Table 3 Family Dynamics

Family Dynamic Questions	Average	Level of Agreement
Family based treatment models are more effective than individualized treatment models.	3.3	Neither agree nor disagree
All family service specialists should consider the family dynamics when treating anti-social behaviors in youth.	4.7	Almost strongly agree
Every family should have access to family counseling services.	5	Strongly agree
Family dynamics has an important influence on the prevention of ACEs.	4.3	Agree
Parents being educated in risk factors of delinquent behavior is just as important as children being educated in risk factors of delinquent behaviors.	4.3	Agree

Table 4 reports the respondent's opinions of community-based programs. All respondents strongly agree that community-based programs are important in preventing ACEs and preventing youth involvement in the criminal justice system. They believe the role of community-based programs are important in helping families and providing access to necessary resources. They also agree that the programs should collaborate with other community providers and resources. All the responses align with the beliefs of AMIkids as they function as a community-based program.

Table 4 Community Based Programs

Community-Based Program Opinion Questions	Average	Level of Agreement
Community based programs should play a role in ensuring families have access to necessary resources.	5	Strongly agree
Helping families get on their feet and remaining stable should be a priority.	5	Strongly agree
Community based programs should play a role in assisting those who struggle with poor mental health.	5	Strongly agree
Programs should be expected to collaborate with multiple community providers and resources.	5	Strongly agree
One goal of community-based programs should be to prevent involvement with the criminal justice system.	4.7	Almost strongly agree

Table 5 and Table 6 include questions that are specific to the respondent's personal experiences while providing services for AMIkids. The first two sections are the job stress and satisfaction as measured by the Public Attitudes Towards Offenders with Mental Illness Scale (PATOMI).

Responses to these questions indicate staff are satisfied in their positions and experience low levels of stress. There were neutral responses to experiencing pressure when at work and changing jobs if they had the chance.

Table 5 Job Stress

Job Stress Questions	Average	Level of Agreement
When I'm at work, I often feel tense or uptight.	2	Disagree
A lot of times, my job makes me very frustrated or angry.	1.7	Mostly strongly disagree
I am usually calm and at ease when I am working.	3.7	Slightly Agree
I usually feel that I am under a lot of pressure when I am at work.	3.3	Neither agree nor disagree

Table 6 Job Satisfaction

Job Satisfaction Questions	Average	Level of Agreement
I like the duties I perform in my job.	4.3	Agree
I enjoy most of the work I do here.	4.3	Agree
My job suits me very well.	4.7	Almost strongly agree
If I had the chance, I would get a job in something other than what I am doing now.	3	Neither agree nor disagree
I don't think my job is worthwhile.	1.3	Strongly disagree

The next section evaluates the staff's perceptions of the assessment tools used by AMIkids. Each assessment measures various factors that can contribute to ACEs. Respondents were asked about their opinions of each assessment and if they believe the assessments to be effective. The responses from staff toward individual assessments were neutral, they neither agreed or disagreed that the assessments were an accurate or useful tool to measure what they were designed to measure, except for the Social Determinants of Health screening tool where staff agreed that it pinpoints the risks of the clients and their families. They agreed the assessments provided an accurate depiction of the work AMIkids conducts. In evaluating the individual responses, respondents did not agree on the intention of the assessments. One staff disagreed that the YSR and the ACEs assessments were useful to their respective evaluations, while other respondents agreed or remained neutral. AMIkids indicates the use of assessment to be an accurate tool in assessing the level of care a client needs both upon intake and discharge. AMIkids uses outcome measurements to determine effective treatment options within the program and if any additional resources need to be recommended upon discharge.

Table 7 Assessments

Assessment Opinion Questions	Average	Level of Agreement
The Youth Self-Report is an accurate indicator of psychiatric symptoms in our clients.	3	Neither agree nor disagree
The McMaster's Family Assessment Device provides useful information of the primary clients' risk based on their family functioning.	3.3	Neither agree nor disagree
Using the Adverse Childhood Experiences assessment has been helpful in providing an understanding of the primary client and family's risks while creating an action plan for them.	3.7	Almost agree
The Social Determinants of Health is helpful to understand the risks associated with the primary client and their family.	4	Agree
The assessments we use provide an accurate depiction of the work AMIkids conducts.	4.7	Almost strongly agree

The employee training section asked respondents of their personal experiences and opinions of the training they received. Staff agreed the training they received is applicable to their job.

Table 8 Training

Training Opinion Questions	Average	Level of Agreement
Overall, the on-the-job training I receive is applicable to my job	4.7	Almost strongly agree
Overall, the training I receive on the job meets my needs	3.7	Almost agree
Overall, I am satisfied with the amount of training I receive on the job.	3.7	Almost agree
I am generally able to use what I learn in on-the-job training in my job.	4.3	Agree

Table 9 reports on personal work experience focused on personal feelings respondents feel while conducting their job. Each statement includes an item listed on the AMIkids website of the family services they provide. All respondents reported positive feelings of their work experiences, confidence in their ability to perform their job duties, and believed they were positively influencing the lives of their clients.

Table 9 Personal Work Experience

Personal Work Experience Feelings Questions	Average	Level
Confidence in my ability to recognize risk factors contributing to delinquent behavior in adolescents.	4	Sometimes
A feeling that you are positively influencing other people's lives through your work.	4.7	Almost all the time
A feeling of accomplishment after working closely with children and their family.	4.7	Almost all the time
Confidence in my ability to use communication strategies to improve family dynamics that mitigate delinquent behavior	4.7	Almost all the time
A feeling that you can easily create a safe and relaxed atmosphere for children and their family.	4.3	Most the time
Confidence in my ability to teach families about risk and protective factors that impact their children and their environment.	4.7	Almost all the time

The job opinions sections report the respondents' opinions based on their experience working for AMIkids as well as their opinions of the job duties and organization itself. Responses indicated confidence in their ability related to the ACEs program and its procedures. They enjoy working for AMIkids and with their team. Responses suggest understaffing is not an issue.

Table 10 Job Duties and Opinions

Job Duties and Opinion Questions	Average	Level of agreement
I am familiar with the ACE procedure.	5	Strongly agree
In general, I agree with the goals of the ACE program.	4.7	Almost strongly agree
I am committed to the success of the ACE program.	5	Strongly agree
In general, I agree with AMIkids' policies regarding ACEs.	4.7	Almost strongly agree
I have access to all the resources I need to do my job.	4.3	Agree
The people I work with cooperate and work as a team.	5	Strongly agree
We are prepared to handle an emergency.	4.7	Almost strongly agree
I often perform outside of my normal job duties due to understaffing.	3.7	Almost agree
AMIkids is a great place to work.	5	Strongly agree
I am aware of AMIkids emergency preparedness policies and procedures.	5	Strongly agree

The last set of questions reports the preparedness of respondents and if they understand AMIkids treatment model. Respondents indicated they are prepared to work with clients and their families

to provide the treatment and resources they need. They are confident in creating a comfortable and safe environment for the clients and their families experiencing trauma, assessing their levels of risk, and creating effective individual treatment plans. Respondents' preparedness to provide these treatments align with AMIkids' expectations of the services provided.

Table 11 Job Ready

Job Preparedness Questions	Average	Level
When a family is exhibiting risk factors that contribute to delinquent behavior	4.3	Often
Work with families to decrease environmental risks that impact the child's behavior	4.7	Almost all the time
Creation of a safe and consistent environment capable of meeting sensory needs	4.7	Almost all the time
Giving families the necessary tools and methods that will make them effective at reducing negative communication patterns	4.7	Almost all the time
Offering extra support during difficult times or transitions.	4.7	Almost all the time
Selecting and using the most effective behavior modification tools (i.e., token economy, positive reinforcement, rank system, etc.) for each family	4.7	Almost all the time
Use communication strategies to help increase intrafamilial support and promote prosocial behavior	4.7	Almost all the time
Remaining composed and offering emotional support during outbursts or emotional struggles.	5	All the time
Assessing the effectiveness of the individual treatment plans for each client	5	All the time
Work with adolescents who have mental health issues that negatively contribute to their behavior	4	Almost all the time

The remaining three questions gathered the respondents' perceptions of the work conducted by AMIkids. The questions and their relative answers are as follows:

1. On a scale of 1 (Not at all important) to 5 (Very important) "Overall, how important do you believe the role of this program is in impacting the prevention of ACEs in children and families?"
   Average Response: Very Important
2. Yes/No "Do you feel the program has succeeded in enhancing children and families' capacity to function in the community? (i.e., reduced contact with the criminal justice system, education, job skills, employment, housing, and health.)"
   All Responses: Yes
3. Explain why they selected yes.

One respondent indicated that families they worked with had expressed that the respondent has helped families improve their communication and decision-making skills.

Another respondent witnessed children they worked with improve their behavior by engaging in extracurricular activities, improved confidence, and inspiration to apply to jobs after participating in the family centered model AMIkids uses to treat ACEs.

Client Level Data Review

Data reported in this section comes from two sources. First, the program provided us a limited set of deidentified individual level data that included ACE, SDOH, and assessment data. Second, we had access to monthly performance reports the program provides to the County. This includes limited aggregated demographic information, referral information, and discharge information. In this section we note the data source.

Table 12 through Table 17 report performance measure data that is reported monthly to the County. These performance measures include total number of assessments, referrals, services, and demographics. The demographic section is particularly important since the primary clients of AMIkids are minors and we could not collect any identifiable information, such as gender, race, etc., on minors. The period of the performance measures is from July 2022 to August 2023.

Table 12 reports referrals to the program by source. Ninety-nine referrals were received from July 2022 to September 2023. Almost 50% were Juvenile Justice sources and from CYFD Protective Services. Slightly more than 27% of referrals were self-referrals.

Table 12 Referrals

Type	Count	Percent
Self	27	27.3
APS or other school	9	9.1%
Shelter	0	0.0%
BHI Provider	1	1.0%
Law Enforcement	1	1.0%
Juvenile Justice	24	24.2%
CYFD Protective Services	24	24.2%
Safe Home	0	0.0%
UNM	4	4.0%
Other	9	9.1%
Total	99	

Table 13 compares the assessments listed in the performance measure report with the client level data we received in November 2023 and reports for July 2022 through August 2023. The client level data we received included a termination or completion status list and assessment scores for the ACE survey, SDOH screen, the Youth Outcomes Survey (YOS), the YSR and FAD. The pre- and post-YSR are reported to allow comparison between the reported assessments and the

received assessments. There were 22 more assessments recorded in the performance reports compared to the count of assessments provided by AMIkids.

The count of ACE survey, SDOH screens and YSR were similar when compared to the performance measure counts. There were larger variations with the number of YOSs and FADs reported in the performance measure reports compared to the number of each we received from the program. We do not know why this occurred. According to the program it may be the case that a FAD was submitted electronically but the submission was not received through the server, or that a YOS was completed on paper and then never data entered into the system.

Table 13 Assessment Variance

Types of Assessments	Number of Assessments (Performance Report)	Number of Assessments (Received)	Difference
ACEs	43	44	1
SDOH	43	45	2
YOS	69	55	-14
YSR	47	51	4
FAD	55	40	-15
Totals	257	235	-22

As described earlier the program administers a variety of assessments. The ACEs and SDOH are administered near intake and the YSR, YOS, and FAD were to be completed at intake, quarterly, and at discharge.

Table 14 reports the number of assessments completed, the percent completed for all clients, and the average number of days between the admission date and the date the assessment was administered.

The pre-YSR assessments were completed on average almost 25 days after admission and were completed for 64.3% of clients. Most clients who did not receive the post-YSR were discharged due to attendance violations. The FAD assessment was described in the program's contract as being administered at intake and discharge. We only received FAD intake assessments.

Table 14 Assessment Totals

Assessment	Completed	% of Administration	# of Days from Intake to Assessment
ACEs	44	78.6%	N/A
SDOH	45	80.4%	-10.2
Pre YSR	36	64.3%	24.7
Post YSR	15	26.8%	N/A
FAD	40	71.4%	21.9
Pre-YOS	34	60.7%	1.3
Post-YOS (1)	17	30.4%	N/A
Post-YOS (2)	4	7.1%	N/A

Demographics

Based on the unique assessments report in Table 14 the program served 56 unique clients. Information reported in this section relies on information from the performance reports. As described below the counts provided in the performance reports do not always match to the assessment counts. We do not know why this occurred but in evaluations of other BHI funded programs we have often found that the performance measures do not match to data provided by the programs.

As shown in Table 15 the majority of clients (55.3%) were 12-15 years of age and 40.4% were 16-18 years of age and 2 clients were 6-11 years of age.

Table 15 Age

Age Range	Count	Percent
6-11 Years	2	4.3%
12-15 Years	26	55.3%
16-18 Years	19	40.4%

Table 16 reports client gender. Almost 64% of clients were male, 34% were female and one client reported as transgender/non-binary.

Table 16 Gender

Gender	Count	Percent
Male	30	63.8%
Female	16	34.0%
Transgender/Non-Binary	1	2.2%

The performance reports included some demographic information. The performance measures reports were missing information for 9 clients based on the number of clients with assessments we received described earlier. Slightly more than 75% of clients identified as Hispanic/Latino.

Table 15 Ethnicity

Ethnicity	Total	Percent
Hispanic/Latino	36	76.6%
Non-Hispanic/Latino	11	23.4%

Race of the clients is reported in Table 16. The largest portion of clients identified as White (66%). No clients identified as Asian or Native Hawaiian or Pacific Islander.

Table 16 Race

Race	Count	Percent
Black or African American	4	8.5%
Asian, Native Hawaiian, Pacific Islander	0	0%
White	31	66.0%
American Indian/Alaska Native	1	2.1%
Multiracial	1	2.1%
Other	10	21.3%

Table 17 reports type of insurance that originates from the performance reports. Sixty percent of clients reported having Medicaid, 34.3% reported having commercial insurance and 5.7% reported having no insurance.

Table 17 Insurance

Type of Insurance	Count	Percent
Medicaid	21	60%
Commercial Insurance	12	34.3%
No Insurance	2	5.7%

ACE Screening

AMIkids provided data on ACEs screening for 46 of 56 clients. Table 18 reports the scores from section one of the ACEs screening assessment. Almost 40% received a high score between 4 and 10.

Table 18 ACE Screening

ACEs Score	Count	Percent
0	5	10.9%
1	7	15.2%
2	11	23.9%
3	5	10.9%
4	6	13.0%
5	5	10.9%
6	3	6.5%
7	1	2.2%
8	2	4.3%
9	0	0%
10	1	2.2%
Total Low Score (0-3)	28	60.9%
Total High Score (4-10)	18	39.1%

SDOH

The SDOH screening tool contains 8 categories: Food, Housing, Utility, Transportation, Substance Abuse, Mental Health, Safety, and Medical. Table 19 reports screening results by category and indicates the number of times clients responded "Yes" to a category and received a referral for the need. The "Decline Referral" column reports the number of times clients responded yes to a category but declined a referral. Five clients declined referrals and 9 of the 45 clients who received the SDOH assessment received referrals for one or more of the listed categories. Food, housing, utilities, transportation, and mental health all received three referrals, with medical receiving one referral.

Table 19 SDOH Number of Referrals Requests

Category	Yes	Declined Referral
Food	3	2
Housing	3	0
Utility	3	3
Transportation	3	0
Substance Abuse	0	0
Mental Health	3	0
Safety	0	0
Medical	1	0

Youth Self-Report

The YSR is a 112-question assessment designed as a pre and post-test scored on a three-point scale of how often each item is true. The assessment evaluates psychiatric symptoms that youth may be exhibiting that are categorized by syndromes and behavioral or emotional problems. These problems and behaviors correspond to various behavioral and emotional disorders noted by the DSM-V, such as depression, anxiety, attention deficit/hyperactivity disorder (ADHD), oppositional defiant disorder, and conduct disorder. These symptoms are also divided into internalizing and externalizing behaviors. Once the items are scored, they are calculated into a t-score and percentile. Since symptoms contributing to disorders vary in terms of severity, number, and types of symptoms, the t-score creates a consistent scale across the categories. A total score is also calculated combining each of the disorder categories. ACEs has been found to play an important part in the development of emotional and behavioral disorders throughout the affected individual's life (Zhang 2022) and the YSR has been validated as a useful tool to evaluate mental health in young people (Lacalle et al. 2014).

Table 20 reports the results of the 15 matched pre and post-tests. The first column lists the scale being tested, column two reports the mean of the pre-test and post-test and the average difference between the pre-test and post-test domain, the next column reports the standard deviation (a measure of the spread between numbers), followed by t (the test statistic for the paired T test), then whether there is a statistically significant difference shown as sig., and finally Cohen's d that measures the effect size. We report statistically significant differences for p values less than p=.05. This provides evidence that this relationship is unlikely due to chance. An effect size is a measure of size of the difference between two variables. The larger the effect size the stronger the relationship between two variables. It is important to measure statistical significance and effect size. Cohen d's effect size suggests that $d = 0.2$ is considered a 'small' effect size, 0.5 represents a 'medium' effect size and 0.8 a 'large' effect size.

Two scales showed statistically significant changes in scores. Both the Anxiety and Stress sub-scale scores showed statistically significant improvements with medium-sized effects. There were no improvements in the other scales or the Total score.

Table 20 YSR Pre-Post T-score Comparison

Scale	Variable	Mean	Standard Deviation	T	Sig (P-value)	Effect Size Cohen's d
Total	Pre-test	61.13	8.50	1.81	0.092	0.47
	Post-test	55.53	10.39			
	Difference	-5.6	1.89			
Depressive	Pre-test	60.47	9.86	1.06	0.305	0.28
	Post-test	57.6	7.11			
	Difference	-2.87	-2.75			
Anxiety	Pre-test	59.47	9.4	2.22	0.044	0.57
	Post-test	53.73	5.66			
	Difference	-5.74	-3.73			
Somatic	Pre-test	56.47	7.72	1.81	0.092	0.47
	Post-test	52.27	4.37			
	Difference	-4.2	-3.35			
ADHD	Pre-test	59.67	6.66	1.38	0.190	0.35
	Post-test	56.93	5.26			
	Difference	-2.74	-0.60			
Pre-Oppositional Defiant	Pre-test	58	7.58	1.64	0.123	0.42
	Post-test	54.93	5.26			
	Difference	-3.07	-2.32			
Conduct	Pre-test	61.2	9.28	1.50	0.157	0.39
	Post-test	57.73	8.69			
	Difference	-3.47	-0.59			
OCD	Pre-test	56.13	17.42	0.38	0.709	0.10
	Post-test	54.47	5.73			
	Difference	-1.66	-11.69			
Stress	Pre-test	61.87	8.24	2.42	0.030	0.63
	Post-test	55.27	5.04			
	Difference	-6.60	-3.23			

McMaster's FAD

The McMaster's FAD is a self-reported measure of family functioning. The FAD contains 60 items scored on a 4-point scale (strongly agree, agree, disagree, and strongly disagree) based on the extent to which the statement describes the respondent's family. Higher scores indicate a worse level of family functioning. The FAD contains 6 dimensions or domains (Problem Solving, Communication, Roles, Affective Responsiveness, Affective Involvement, Behavior Control) and a seventh scale measuring global family functioning.

Affective involvement (7 items) shows the interest and value family members have toward each other's activities and concerns. Affective responsiveness (6 items) reflects the family member's ability to show concern and emotions regarding their family's welfare and emergency situations. Behavior Control (9 items) refers to the family's standards for behavior and Communication (9

items) reflects the family's ability to exchange information verbally in a clear manner. Problem Solving (6 items) reflects the family's ability to resolve issues and Roles (11 items) reflects the extent to which the family has established patterns of behavior to handle family functions such as providing resources and support. Global family functioning combines the other scales to assess the overall health of the family.

The program provided scores for each client by domain using a method developed by AMIkids external evaluator. These scores were then used to calculate a percent that was used to determine a "risk level". AMIkids categorizes risk into four levels:

- High Risk that indicates poor family functioning - 76% - 100%
- Moderate-High Risk that indicates low family functioning – 51% - 75%
- Moderate Risk that indicates moderate family functioning – 26% - 50%
- Low Risk that indicates good family functioning – 0% - 25%

Table 21 reports family functioning by risk level near intake when the FAD was administered. The mean score of the 40 assessments we received was 67.5% indicating an average Moderate-High Risk family functioning score. No clients scored at low risk or at moderate risk. The vast majority of clients scored at Moderate-High Risk (92.5%) and 3 clients scored at High Risk (7.5%).

Table 21 FAD Frequency Distribution

Scores (%)	Frequency	Percent
50.01 - 55.00	1	2.5
55.01 - 60.00	3	7.5
60.01 - 65.00	9	22.5
65.01 - 70.00	15	37.5
70.01 - 75.00	9	22.5
75.01 - 80.00	2	5.0
80.01+	1	2.5

Program Completion

AMIkids provided client level data that consisted of admission dates, discharge (or termination) dates and type, reason for discharge/termination, completion status (such as successful, never started, violation of attendance requirements, etc.), times and dates for each support session and the people in attendance (such as family support specialist, mother, youth, sibling, etc.). On average clients attended 11 support sessions from admission to discharge. This included clients who were discharged early for various reasons such as violation of attendance requirements, agency termination, and violation of probation. On average clients who completed the program attended 14 sessions, which aligns with the 12-14 week treatment model. The average length of time clients spent in the program was almost 23 weeks, with a minimum of 9 days and a maximum of 41 weeks.

Table 22 details the completion status of clients and Table 23 reports additional detail on clients who were reported as unsuccessful completions. Almost two-thirds of the clients who discharged from the program completed successfully. Of the 36.4% of clients who did not successfully complete the program the largest percent of clients were unsuccessfully discharged for violating attendance requirements (56.3%). Discharge information was not available for 11 clients, and it appears these clients were still active in the program at the time we received these data.

Table 22 Client Completion Status

Completion Status	Count	Percent
Successful Completion	28	63.6%
Unsuccessful Completion	16	36.4%

Table 23 Unsuccessful Completion Reason

Unsuccessful Completion Reason	Count	Percent
Violation Attendance Requirements	9	56.3%
Agency Termination (DJJ/PO/Parent decision)	3	18.8%
Never Began	1	6.3%
Violation of Probation	1	6.3%
Inappropriate Program Placement	1	6.3%
Lost Contact/Moved	1	6.3%

Youth Outcomes Survey

The Youth Outcomes Survey consists of 51 questions in four sections. The survey is designed to measures resilience, school engagement, and other intermediate measures. Tables 24-27 report the responses by section. The first assessment was taken on average within 1.8 days of admission for 34 clients. The second assessment was conducted for 17 clients after an average of 125.1 days, or about 4 months, after admission. A third assessment was conducted for 4 clients after an average of 169 days of admission, or about 5.5 months. When reporting the differences between assessments we used the first or intake assessment and the last or discharge assessment which in 4 instances was the third assessment.

The first 15 questions are answered on a scale of Not at all True (1) to Totally True (4) and focuses on the individual's personal achievements in relation to school performance, goal management, and emotional regulation. Table 26 summarizes the average response, the corresponding average response from the pre- and post-tests, and the difference between responses.

Post responses improved from the pre-assessment on 6 of the 15 questions and stayed the same on the remaining 9 questions. Importantly, respondents reported their personal achievements improved.

Table 24 YOS Questions 1-15: Personal Achievements Related to School Performance

Question	Pre Response	Post-Response	Numerical Difference
I work hard at school	Mostly True	Mostly True	0
I set goals for myself	Mostly True	Mostly True	0
I can relax when I feel tense	A Little True	Mostly True	1
I enjoy being at school	A Little True	Mostly True	1
I can keep my feelings from getting out of control	Mostly True	Mostly True	0
I develop step-by-step plans to reach my goals	Mostly True	Mostly True	0
I can make myself feel better when I am worried	A Little True	Mostly True	1
I get bored in school a lot	Mostly True	Mostly True	0
I can control myself when I get angry	A Little True	Mostly True	1
If I set goals, I take action to reach them	Mostly True	Mostly True	0
I do well in school	Mostly True	Mostly True	0
It is important to me that I reach my goals	Mostly True	Mostly True	0
I feel good about myself when I am at school	A Little True	Mostly True	1
I am good at figuring out how to reach my goals	Mostly True	Mostly True	0
Doing well in school is important to me	Mostly True	Totally True	1

Table 25 reports the YOS questions 16-18 that asks clients about their future plans. Questions 16 and 17 are formatted differently as: “Do you think you will finish high school or earn your GED” and “Do you plan on going to college at some point?” with responses falling on a scale of Definitely Yes to Definitely Not. The remaining questions (18-24) are yes/no questions titled: “I don’t know yet”, “Get a job and work”, “Go to college”, “Join the military”, “Go to a technical school or community college for a special trade”, “Participate in an apprenticeship”, and “Something else”. Clients can respond as often as they need to, depending on their future goals. The percentage of “yes” responses was used to report the next steps clients planned to take as they approached adulthood, and if they changed throughout the course of the program.

The first two questions ask clients about their future academic goals. The first question asked if the client planned to graduate high school or get their GED. 97.1% of clients answered yes at the intake YOS assessment and 100% of clients answered yes upon discharge. The next question asks if the client was considering going to college, clients who answered yes increased 11.7% from intake to discharge. The following categories indicate specific life plans, such as going to college, getting a job, joining the military, etc. Responses decreased for each category, except for tech-school/community college which increased 8.9%.

Table 25 YOS Questions 16-18: Future Life Goals

Are you planning to…	Pre Yes %	Post Yes %	Difference %
Graduate Highschool/GED	97.1%	100.0%	2.9%
Go to college at some point	76.5%	88.2%	11.7%
I don't know yet	32.4%	29.4%	-3.0%
Job	82.4%	76.5%	-5.9%
College	58.8%	35.3%	-23.5%
Military	14.7%	5.9%	-8.8%
Tech School/Community College	38.2%	47.1%	8.9%
Apprenticeship	32.4%	23.5%	-8.9%
Something else	20.6%	5.9%	-14.7%

Table 26 reports the next set of 14 questions which concern how clients deal with problems. Respondents were first asked to answer “yes” or “no” as to whether they handled a recent problem that came up with each listed coping mechanism. They were next asked how much it helped with the recent problem. The questions with the highest increase were clients doing something like watching TV or playing a game to deal with a problem that arose with clients finding it to be very helpful to coping with the problem. We do not report the percent change in how many clients responded yes to each coping mechanism but do report how much each coping mechanism helped in dealing with the problem. It is not clear what the changes in how much it helped from the pre to post assessment means or measures. In general, there was little change from the pre to the post assessment and for both the pre and post outcome survey the coping mechanisms helped a little.

Table 26 YOS Questions 19-32: Coping Mechanisms

How client handled a recent problem that came up	How much it helped (Pre)	How much it helped (Post)
I just tried to forget it	A little	A little
I did something like watch TV or played a game	A little	A lot
I stayed by myself	A lot	A little
I kept quiet about the problem	A little	A little
I tried to see the good side of things	A little	A lot
I blamed myself for causing the problem	A little	A little
I blamed someone else for causing the problem	A little	A little
I tried to fix the problem by doing something or talking to someone	A little	A little
I yelled, screamed, or got mad	A little	A little
I tried to calm myself down	A little	A little
I wished the problem had never happened	A little	A little
I wish I could make things different	A little	A little
I tried to feel better by spending time with others like family, grownups, or friends	A lot	A lot
I did not do anything because the problem could not be fixed	A little	A little

Table 27 reports the last set of 19 questions that focus on the client's opinion of and experience with the AMIkids staff. The questions are on a 6-point scale of Strongly Disagree (1) to Strongly Agree (6). Because clients could not form opinions of staff at the time of first survey that occurs near the time clients are admitted to the program, we do not report those results and we do not compare the pre and post survey results. Table 27 reports the results of the post survey. Generally, clients slightly agreed that program staff were helpful.

Table 27 YOS Questions 33-51: Opinions of Staff

Question	Post-Assessment Response
I feel I can depend upon an AMIkids staff member	Slightly Agree
I feel an AMIkids staff member understands me	Slightly Agree
I feel that there is an AMIkids staff member that wants me to achieve my goals	Slightly Agree
At times, I don't trust an AMIkids staff member's judgement	Disagree
I feel I am working together with AMIkids staff in a joint effort	Slightly Agree
I believe we have similar ideas about my needs	Slightly Agree
I generally respect how AMIkids staff members view me as a person	Slightly Agree
The services I receive are well suited to my needs	Slightly Agree
I like AMIkids staff as people	Slightly Agree
In most conversations, AMIkids staff and I find a way to work on my problems together	Slightly Agree
Some AMIkids staff slow the progress in the program	Disagree
A good relationship has formed with an AMIkids staff member	Slightly Agree
AMIkids staff members appear to be experienced in helping people	Slightly Agree
I want very much to work out my problems	Slightly Agree
AMIkids staff and I have good conversations	Slightly Agree
AMIkids staff and I sometimes have negative interactions	Slightly Disagree
AMIkids staff and I talk about important events in my life	Slightly Agree
I believe an AMIkids staff member likes me as a person	Slightly Agree
At times, AMIkids staff members seem distant	Slightly Disagree

Discussion and Conclusion

Based on the staff survey the program has an experienced staff. All respondents had a college degree, with the majority having a Master's degree. On average, staff had 8 years of experience working with at-risk youth, and 5 years working with families.

The staff survey provided information on how staff perceived the program and how their personal beliefs aligned with the program design. We found staff beliefs aligned with the program design. We also found staff felt positive about their work and liked working for AMIkids. Staff also did not feel overworked and felt positive about their work with their clients. Additionally, the staff positively impact their clients as reported by clients in the Youth Outcomes Survey.

The performance measure reports and the assessment data helped us understand how the program works and provided preliminary information regarding program results. The limitations that exist because we cannot have identified minor information limits our ability to describe and report how the program operates. This is described elsewhere in this report and has been documented in other reports that involve programs that serve minors. Performance reports provided useful information but they primarily report on aggregated information and at times information appears to be missing when compared to the client level data we were able to obtain

and report on. It would be useful in the future to consider methods to acquire and use more detailed deidentified data to describe the program and how it operates.

Ninety-nine referrals were received from July 2022 to September 2023. Almost 50% were Juvenile Justice sources and from CYFD Protective Services. Slightly more than 27% of referrals were self-referrals. The majority of clients (55.3%) were 12-15 years of age, 40.4% were 16-18 years of age and 2 clients were 6-11 years of age. Almost 64% of clients were male, 34% were female and one client reported as transgender/non-binary. The program primarily served minority clients and 60% of clients reported having Medicaid, 34.3% reported having commercial insurance, and 5.7% reported having no insurance.

Almost 40% of the clients received a high ACE score between 4 and 10. Sixteen of 45 clients screened using the SDOH received referrals. Five clients declined referrals and 9 clients who received the SDOH assessment received one or more referrals. The FAD that measures family functioning also provided some insight into the circumstances of clients. On average, clients received a score of 67.5% indicating an average low family functioning score. No clients scored at low risk or at moderate risk. The large majority of clients scored at Moderate-High Risk (92.5%) and 3 clients scored at High Risk (7.5%).

On average clients attended 11 support sessions from admission to discharge. This included clients who were discharged early for various reasons such as violation of attendance requirements, agency termination, and violation of probation. On average clients who completed the program attended 14 sessions, which aligns with the 12-14 week treatment model. The average length of time clients spent in the program was almost 23 weeks, with a minimum of 9 days and a maximum of 41 weeks.

Almost two-thirds of the clients who discharged from the program completed successfully. Of the 36.4% of clients who did not successfully complete the program the largest percent of clients were unsuccessfully discharged for violating attendance requirements (56.3%). Discharge information was not available for 11 clients, and it appears these clients were still active in the program when we received these data.

The Youth Outcomes Survey measures resilience, school engagement, and other intermediate measures. The first set of questions focus on the individual's personal achievements in relation to school performance, goal management, and emotional regulation. Post responses improved from the pre-assessment on 6 of the 15 questions and stayed the same on the remaining 9 questions. Importantly, respondents reported their personal achievements improved.

The next set of 14 questions concern how clients deal with problems. It is not clear what the changes in how much a particular coping mechanism helped from the pre to post assessment means or what it measures. In general, there was little change from the pre to the post assessment and for both the pre and post outcomes survey the coping mechanisms helped a little.

The last set of 19 questions focus on the client's opinion of and experience with the AMIkids staff. Because clients could not form opinions of staff at the time of first survey that occurs near the time clients are admitted to the program we do not report those results and we do not

compare the pre and post survey results. Generally, clients slightly agreed that program staff were helpful.

The program administered the YSR as a pre and post-test. The assessment evaluates psychiatric symptoms that youth may be exhibiting that are categorized by syndromes and behavioral or emotional problems. This study reports the results of a small sample of 15 matched pre and post-tests. Two of 8 scales showed statistically significant changes in scores. Both the Anxiety and Stress sub-scale scores showed statistically significant improvements with medium-sized effects. There were no improvements in the other scales or the Total score. The YSR provides preliminary information regarding the effectiveness of the program.

YOUTH DEVELOPMENT INCORPORATED

Program Description

YDI's ACE program collaboratively involves their Prevention, Intervention and Behavioral Health (PIBH) and Early Childhood Education (ECE) Departments to provide ACEs prevention services for infants and children aged 0-12 and their families. YDI proposed to serve a universal target population and to accept referrals from any entity. Program services include assessment, case management, therapy, and medication management. Staff include a parttime program manager, parttime clinical supervisor, a full-time therapist, three full time case managers, a part time prescriber, and a part time data manager. The program contract with the County also noted the proposed program staff would be supported by other YDI staff including case managers, community support workers, therapists, and intervention specialists. The contract also noted services would be provided in agreed upon locations including family homes, school settings, and community settings.

The program uses three assessments, two to screen the client's level of need and one to evaluate their progress in the program. The screening assessments are the ACEs and SDOH assessments and the outcome assessment is the Child and Adolescent or Preschool and Early Childhood Functional Assessment Scales.

The ACEs score contains ten questions falling within three categories: abuse (emotional, physical, and sexual), household challenges (mother treated violently, substance abuse in household, mental illness in household, parental separation, and incarcerated household member), and neglect (emotional and physical).

Staff Survey

A staff survey was used to gather information from program staff that included four sections. The first section concerned the experience and education of respondents. The second section asked for respondent's opinions relating to ACE programs followed by a section on job stress and job satisfaction. The third section included questions about the assessments used by the program, family support services, and training. The last section is a set of demographic questions. Most questions asked staff to respond using a 5-point Likert scale of 'strongly

disagree to strongly agree,' 'never to all the time,' and 'not at all important to extremely important' depending on the topic and question. Four of seven staff responded to the survey.

Table 28 reports average years of staff education and experience. All respondents had at least a Bachelor's degree with the majority having a Master's degree. All staff had a background in behavioral health and case management. The minimum number of years staff has worked in behavioral health services and with ACEs was 1 year.

Table 28: Staff Education & Experience

Type of experience	Average Years
Years providing behavioral health services	7
Years providing case management	2.8
Years working with youth with Adverse Childhood Experiences (ACEs)	5.6
Years working with families	8.8
Years working for YDI	3.8
Years in current position	1.6
Respondents' highest level of education	80% Master's20% Bachelor's

Table 29 reports on respondents' opinions regarding ACEs and are reported on a 5-point Likert scale of 1 (Strongly Disagree) to 5 (Strongly Agree). This section includes questions on staff's opinions of Adverse Childhood Experiences and the relationship they have to the individual, their family, and their community. There are also specific questions that relate to the services YDI provides to address adverse childhood experiences. Staff reported ACEs as important to treat in children and families, and that YDI helps improve life outcomes in families with ACEs.

Table 29 ACEs Questions

ACEs Program Question	Average	Level of Agreement
Trying to prevent ACEs in children is a waste of time.	1	Strongly disagree
Most children with ACEs won't be able to break the cycle of their family.	1.3	Almost strongly disagree
Children should not be punished for their parents' decisions.	3	Neither agree nor disagree
Families in ACEs programs will not change after they leave the program.	1.3	Almost strongly disagree
Parents are often just victim of their circumstances.	3.5	Almost agree
Most children are victims their parents' choices.	3.3	Neither agree nor disagree
Children can be motivation for parents to change.	4.5	Almost strongly agree
ACE programs help improve the life outcome of children and their families.	3.7	Almost agree

Table 30 reports staff's opinions of family dynamics, or the relationship between parents and children, and how those dynamics can impact the child/adolescent. Part of the work conducted by the ACEs program at YDI is to work with the individuals and their families to mitigate and prevent the harm of adverse childhood experiences. The questions and their average response are included in the table below. Responses are also on a scale of 1 (Strongly disagree) to 5 (Strongly agree). Half of the questions in this section received a neutral response, though respondents agreed parents have a strong role in their child's behavior and indicated preventative approaches toward behavioral issues is more important than treatment. This finding aligns with the goals of the YDI ACEs program.

Table 30 Family Behavior

Family Behavior Questions	Average	Level of agreement
On average, each family member is dedicated to improving their communication with each other.	3	Neither agree nor disagree
I do not take it personally if the client's behavior does not improve.	3.3	Neither agree nor disagree
I think it is the responsibility of the parents to establish strong and effective communication	4.3	Agree
Children/adolescents in a family with strong communication/support are less likely to engage in antisocial behavior	3.3	Neither agree nor disagree
A parent's opinion of mental health impacts their child's own mental health.	4.3	Agree
I think a preventative approach toward behavioral issues is much more important than treating them after they're presented.	4	Agree

Table 31 reports on staff's perception of the relationships between individuals with ACEs and the community. Respondents strongly agreed that community-based programs, such as YDI, are very important in preventing criminal activity and helping families receive necessary resources, especially mental health resources. Additionally, respondents agreed that community-based programs should collaborate with other community providers and resources. This aligns with the goals of YDI as a community-based program designed to prevent the criminal involvement of youth by addressing mental health.

Table 31 Community Programs

Community Programs Question	Average	Level of Agreement
Community based programs should play a role in ensuring families have access to necessary resources.	4.8	Almost strongly agree
Helping families get on their feet and remaining stable should be a priority.	5	Strongly agree
Community based programs should play a role in assisting those who struggle with poor mental health.	5	Strongly agree
Programs should be expected to collaborate with multiple community providers and resources.	5	Strongly agree
One goal of community-based programs should be to prevent involvement with the criminal justice system.	4	Agree

Table 32 through Table 35 report staff experiences on the job. They incorporate job stress, satisfaction, use of assessments, and employee training. Respondents were generally happy with their role in the program. They believe their work to be important, they enjoy what they do, and have confidence in their positions. There was one neutral response referring to feeling pressure while at work.

Table 32 Job Stress

Job Stress Questions	Average	Level of Agreement
When I'm at work, I often feel tense or uptight.	2.3	Disagree
A lot of times, my job makes me very frustrated or angry.	2.3	Disagree
I am usually calm and at ease when I am working.	4.3	Agree
I usually feel that I am under a lot of pressure when I am at work.	3.3	Neither agree nor disagree

Table 33 Job Satisfaction

Job Satisfaction Questions	Average Numerical Response	Level of Agreement
I like the duties I perform in my job.	5	Strongly Agree
I enjoy most of the work I do here.	5	Strongly Agree
My job suits me very well.	5	Strongly Agree
If I had the chance, I would get a job in something other than what I am doing now.	1.5	Almost strongly disagree
I don't think my job is worthwhile.	1	Strongly disagree

Table 34 reports opinions and perceptions of the effectiveness of the assessments used to evaluate client progress. The Childhood and Adolescent Functional Assessment Scale (CAFAS) and the Preschool and Early Childhood Functional Assessment Scale (PECFAS) are used as a pre and post assessment to measure client progress. The responses show that staff have a favorable opinion of all the assessments used by YDI. They agreed the assessments are helpful in creating their treatment plans and in understanding the risks of the individuals and families in their program.

Table 34 Assessments

Question	Average	Level of Agreement
The Childhood and Adolescent Functional Assessment Scale (CAFAS) is effective at determining indicators of a young person's [child or adolescent] functioning.	4.8	Almost strongly agree
The Preschool and Early Childhood Functional Assessment Scale (PECAFAS) is effective at determining indicators of a child's functioning.	4.8	Almost strongly agree
The CAFAS or PECAFAS assessments provide important information when creating an individualized treatment plan.	4.8	Almost strongly agree
Using the Adverse Childhood Experiences assessment has been helpful in providing an understanding of the primary client and family's risks while creating an action plan for them.	5	Strongly agree
The Social Determinants of Health is helpful to understand the risks associated with the primary client and their family.	4.5	Almost strongly agree
The assessments we use provide an accurate depiction of the work YDI conducts.	4.8	Almost strongly agree

Table 35 reports respondents' satisfaction with their training. Respondents were satisfied with training they received.

Table 35 Job Training

Question	Average	Level of agreement
Overall, the on-the-job training I receive is applicable to my job.	4.8	Almost strongly agree
Overall, the training I receive on the job meets my needs.	4.8	Almost strongly agree
Overall, I am satisfied with the amount of training I receive on the job.	4.8	Almost strongly agree
I am generally able to use what I learn in on-the-job training in my job.	5	Strongly Agree

Table 36 reports respondents' experience with their work including their feelings toward work, their opinions of the program, and their work preparedness. The questions for the staff's feelings

toward work were formed using the goals and objectives found on YDI's website and in their contract. The responses follow a scale of 1 (Never) to 5 (All the Time). All respondents had confidence in their ability to provide quality and effective care to their clients and their families.

Table 36 Job Experience

Questions	Average	Level of agreement
Confidence in my ability to recognize when trauma has affected the lives of clients and their families	4.3	Often
Confidence in my ability to recognize when risk factors contribute to behavioral issues in adolescents	4.5	Almost all the time
A feeling that I am positively influencing other people's lives through my work.	4	Often
A feeling of accomplishment after working closely with children and their family.	4.3	Often
Confidence in my ability to form effective individualized treatment	4	Often
A feeling I can create a safe and relaxed atmosphere for children and their family.	4.5	Most the time
A feeling that my work with children and their families is positively impacting the community	3.8	Sometimes
Confidence in my ability to be understanding and empathetic with clients and to put them at ease	4.3	Often

The next table (Table 37) reports on questions designed to evaluate perceptions and opinions of their job duties within YDI's ACEs program. The questions include how the staff feels about the workplace and the work itself. The responses follow a scale of 1 (Strongly Disagree) to 5 (Strongly Agree) and are detailed below. The responses indicate that respondents understand and agree with the program's procedures and goals. Respondents also agreed they enjoy working at YDI and the people with whom they work.

Table 37 Job Duties

Question	Average	Level of agreement
I am familiar with the ACEs procedure.	5	Strongly agree
In general, I agree with the goals of the ACEs program.	5	Strongly agree
I am committed to the success of the ACEs program.	5	Strongly agree
In general, I agree with YDI's policies regarding ACEs.	5	Strongly agree
I have access to all the resources I need to do my job.	5	Strongly agree
The people I work with cooperate and work as a team.	4.8	Almost strongly agree
We are prepared to handle an emergency.	4.3	Agree
I often perform outside of my normal job duties due to understaffing.	4.3	Agree
YDI is a great place to work.	4.5	Almost strongly agree
I am aware of YDI emergency preparedness policies and procedures.	4.3	Agree

Table 38 reports on how prepared staff feel they are to do their work. Responses showed that respondents feel well prepared to work with children and adolescents with high ACEs scores and are comfortable providing treatment. All responses align with the purpose of the CAFAS and PECFAS assessments and the principles for effective case management, indicating respondents felt they are prepared to work effectively and to positively impact the children and families they serve.

Table 38 Work Preparedness

Please indicate your preparedness to:	Average	Level of Agreement
Work with children and adolescents who have experienced trauma	4.8	Almost strongly agree
Using the ACEs screening tool to appropriately provide services to the needs of the family and/or child	5	Strongly agree
Work with children and adolescents who have experienced trauma	5	Strongly agree
Assess changes in clinical outcomes for youths receiving services	4.5	Almost strongly agree
Giving families the necessary tools and methods that will make them effective at reducing negative communication patterns	4.3	Agree
Offering extra support during difficult times or transitions.	4.8	Almost strongly agree
Utilize case management to implement treatment more proactively and improve clients' outcomes	4.8	Almost strongly agree
Convey empathy to focus on the client and their treatment	5	Strongly agree
Remaining composed and offering emotional support during outbursts or emotional struggles.	4.8	Almost strongly agree
Assessing the effectiveness of the individual treatment plans for each client	5	Strongly agree
Work with children and adolescents who have mental health issues that negatively contribute to their behavior	5	Strongly agree
Use the best available research when creating individualized treatment plans	4.3	Agree

The last set of questions summarize the staff's opinion regarding the purpose of the ACEs program at YDI. For the question "Overall, how important do you believe the role of this program is in impacting the prevention of ACEs in children and families?" respondents reported on a scale of 1 (Not at all important) to 5 (Extremely important) the program was very important (4.8) in the prevention of ACEs.

The last question included two parts. First, a yes or no question of "Do you feel the program has succeeded in enhancing children and families' capacity to function in the community? (i.e., reduced contact with the criminal justice system, education, job skills, employment, housing, and health.)" followed by asking the respondent to elaborate on their answer. Every respondent

answered “yes” to the first part. Staff responses indicated they helped families receive education, support, and resources that have helped mitigate the harm from ACEs. Based on the responses from the staff, the services and assistance provided to the families is valuable to improving the lives of family members as well as to improve community outcomes by providing resources and assistance to decrease criminal behavior and activity.

Client Level Data Review

YDI provided client data through late July 2023 that included intake and discharge dates, if a safety and service plan were completed, and program completion status.

YDI administers the Adverse Childhood Experiences (ACEs) screening tool and the Social Determinants of Health (SDOH) screening tool at intake and provides clinical therapy services and case management for both families and individuals.

Depending on the age of the client the Childhood and Adolescent Functional Assessment scale (CAFAS) or the Preschool and Early Childhood Functional Assessment Scale (PECAFAS) is administered at intake and exit. The assessments are designed “to assess degree of impairment in functioning secondary to emotional, behavioral, or substance use problems” (Hodges et al. 1999). The CAFAS evaluates 8 life domain areas, focusing on older children and adolescents and the PECAFAS focuses on children aged 7 and younger on 7 life domain areas. The life domain areas are school, home, community, behavior toward others, moods, self-harm, substance use (CAFAS only), thinking, caregiver for material needs, and caregiver for social support.

YDI also provides monthly performance reports to the County that includes some aggregated demographic information (gender, age groups, ethnicity, race, annual income, and health insurance) and performance metrics including number of referrals received, assessments completed by type (ACE, SDOH and CAFAS/PECFAS), ACE scores, clinical services, and case management services. Some of this information is reported in this section.

The table below (Table 39) details the total number of referrals by source listed in the performance measure reports. The program received 199 referrals. Almost 60% were external referrals and 40.7% were internal referrals from YDI’s other programs. Self-referrals comprised the largest portion of external referral types at 33.7% followed by APS (21.1%). These along with internal referrals accounted for 95.5% of all referrals.

Table 39 Referrals

Referral Type	Count	Percent
Self	67	33.7%
APS or other school	42	21.1%
Shelter	3	1.5%
BHI Provider	0	0%
Law Enforcement	1	0.5%
Juvenile Justice	0	0%
CYFD Protective Services	3	1.5%
Safe Home	0	0%
UNM	0	0%
Other	12	6%
Internal Referrals	71	40.7%

During the time of our study the program admitted 139 primary clients and 34 secondary clients for a total of 173 clients.

Table 40 Clients

Client Type	Count	Percent
Primary	139	80.3%
Secondary	34	19.7%
Total	173	

Table 41 reports the number and percent of safety plans and service plans compared to the total number of primary clients. More than 75% of primary clients had a safety and service plan.

Table 41 Safety and Service Plans

Plan Type	Count	Percent
Safety Plan	107	77.0%
Service Plan	106	76.3%

The performance measure reports documented the number of assessments completed. There were 94 ACEs screening assessments completed, 106 Social Determinants of Health assessments completed, and 199 CAFAS/PECFAS assessments completed. The count reported in the performance measure reports did not match with the assessment data we received from the program. We do not know why this occurred, but it may be because the performance reports included secondary clients' (parents/guardians and siblings) assessments.

The performance reports also included detail for the clinical services provided by YDI and are reported in Table 40.

Table 40 Services

Clinical Services	Count
Clinical Assessments Completed	45
Individual therapy hours	610
Family therapy hours	89

The next table (Table 41) reports case management services. This includes the number of service plans and the number of case management hours for primary clients and the parents/guardians and siblings of primary clients.

Table 41 Case Management Service Hours

Case Management Service	Count
Treatment/service plans made	171
New primary client hours	278
Continuing primary client hours	901
New secondary client hours	74
Continuing secondary client hours	258
Total number case management hours	1,511

Program services included medication management provided by a part time prescriber. Table 42 reports on clients who received medication management in terms of the number of medication management visits they received. According to program records medication management was provided to 34 clients. Nine clients were adults over the age of 19 who were likely secondary clients. On average clients had 3 visits, with one client having a total of 6 visits. There was a total of 112 visits totaling 125 hours (7,500 minutes). The visits range from 45 minutes to 1.5 hours (120 minutes), with one visit lasting 45 minutes, and 4 lasting 1.5 hours. The average visit lasted 1.1 hours.

Table 42 Visits

Number of Visits	Count	Percent
1	5	14.7%
2	3	8.8%
3	10	29.4%
4+	16	47.1%

Slightly more than 50% of all clients were female and males were 46.2% of clients. No clients reported as transgender/non-binary.

Table 43 Gender

Gender	Count	Percent
Male	66	46.2%
Female	77	53.8%

Age range was excluded due to an inconsistency with the performance measure counts when compared to the number of primary clients.

Table 44 reports ethnicity. A large majority of clients identified as Hispanic (76.2%).

Table 44 Ethnicity

Ethnicity	Count	Percent
Hispanic/Latino	109	76.2%
Non-Hispanic/Latino	34	23.8%

Client race is reported in Table 45. Most clients were White (74.8%), followed by African American (14.7%).

Table 45 Race

Race	Count	Percent
Black/African American	21	14.7%
Asian	1	0.7%
White	107	74.8%
American Indian and Alaska Native	7	4.9%
Native Hawaiian/Pacific Islander	2	1.4%
Multiracial	5	3.5%

Table 46 reports family income. Approximately 40% of clients' families had incomes less than $20,000 and 32.9% had incomes between $20,001 and $40,000. No clients had incomes greater than $65,000 and income information was missing for 27 clients (18.9%).

Table 46 Income

Income Level Annually	Count	Percent
$0-$20,000	58	40.6%
$20,001-$40,000	47	32.9%
$40,001-$65,000	11	7.7%

Type of insurance was also reported as a performance measure. The majority of clients had Medicaid (76.3%) and 20% reported no insurance.

Table 47 Insurance

Type of Insurance	Count	Percent
Medicaid	122	76.3%
Private Insurance	6	3.8%
No Insurance	32	20.0%

ACEs screening

We received 130 ACE screenings which were completed between February 2022 and June 2023 at intake. Table 48 reports the scores. The average ACE score mean was 3.7 which is close to a high score of 4. Four clients had a score of 0 and one client had a score of 10. Almost 61% of the clients did not have a high ACE score.

Table 48 ACEs Scores

Score	Count	Percent
0	9	6.9%
1	19	14.6%
2	19	14.6%
3	23	17.7%
4	18	13.8%
5	16	12.3%
6	6	4.6%
7	8	6.2%
8	6	4.6%
9	4	3.1%
10	2	1.5%
Total Low Score (0-3)	28	60.9%
Total High Score (4-10)	18	39.1%

Note. The total number of assessments and percentages do not include the missing assessments.

SDOH

The social determinants of health screening assessment was completed at intake. The assessment contains 12 or 13 questions, to evaluate the level of unmet needs in 13 categories: food, behavioral health, transportation, housing, legal, safety, income, daycare, utilities, education, hospitalization, emergency department visit, and substance use. Responses to these questions are typically used to determine if clients need referrals to resources. Table 49 details the percentage of clients who indicated a need for a referral for each category, with the highest percentage

indicating 31.8% having unmet needs with food, and the lowest area of need being substance abuse with one client (0.6%).

Table 49 SDOH Count

SDOH Area	Count	Percent
Food	49	31.8%
Behavioral Health	42	27.3%
Transportation	36	23.4%
Housing	35	22.0%
Legal	29	18.8%
Safety	27	17.5%
Income	26	16.9%
Daycare	28	18.1%
Utilities	19	12.3%
Education	15	9.7%
Hospitalization	10	6.5%
ED Visit	8	5.2%
Substance Abuse	1	0.6%

Table 50 reports program completion status. At the time we completed data collection 39 primary clients were still active. Of the 100 clients that were discharged 60 clients (60%) completed the program successfully, 23 (23%) were unsuccessful and 17 (17%) completed partially.

Table 50 Program Completion

Completion Status	Count	Percent
Successful	60	60%
Unsuccessful	23	23%
Partial Success	17	17%

CAFAS/PECFAS:

The Childhood and Adolescent Functional Assessment Scale and the Preschool and Early Childhood Functional Assessment Scale assesses the extent of interference in day to day functioning and can be used overtime to measure change in 8 domains. The domains are At School, At Home, in the Community (delinquency), Behavior Toward Others, Moods/emotions, Self-Harm, Substance Use, and Thinking (assessing irrationality). A total score and subscale scores are provided, with higher scores indicating greater impairment in day-to-day functioning. Table 49 reports total scores only because we did not receive domain score data.

The CAFAS was used at multiple points by the program. We received assessment data for 145 clients that included 99 intake assessments, 52 1st quarter assessments, 16 2nd quarter

assessments, 2 3rd quarter assessments, and 61 Exit assessments. Of these assessments we have 59 paired intake and exit assessments that are reported in Table 49.

The items are scored on the level of severity for each impairment, or item the client has experienced. The impairments are used to evaluate the level of risk of emotional, behavioral, and/or psychological problems. The impairments are scored as severe with a score of 30, moderate with a score of 20, mild with a score of 10, and minimal/no with a score of 0.

Column two reports the mean of the pre-test and post-test and the average difference between the pre-test and post-test, the next column reports the standard deviation (a measure of the spread between numbers), followed by t (the test statistic for the paired T test), then whether there is a statistically significant difference shown as sig., and finally Cohen's d that measures the effect size. We report statistically significant differences for p values less than p=.05. This provides evidence that the measured difference between pre-test and post-test is unlikely due to chance. An effect size measures the magnitude of this difference. The larger the effect size the greater the change clients experienced from pre- to post-test. It is important to measure statistical significance and effect size. Cohen d's effect size suggests that d = 0.2 is considered a 'small' effect size, 0.5 represents a 'medium' effect size and 0.8 a 'large' effect size.

Table 51 reports the total score. The total score had a large statistically significant change with a large effect size of 1.02.

Table 51 CAFAS Total Score Paired Samples T-Test

Variable	Mean	Standard Deviation	T	Sig	Effect Size Cohen's d
Pre-test	58.47	35.14	7.83	<0.001	1.02
Post-test	19.49	26.55			
Difference	38.98	38.27			

Discussion and Conclusion

The review of program documents, performance measures, the staff survey, and review of client level data that included the CAFAS/PECFAS that was administered at intake and near discharge provided insight regarding the implementation of the program and short-term outcomes. Through the staff survey we confirmed the program has trained and experienced staff with expertise in providing mental health services to youth. Respondents' personal beliefs also aligned with the program goals. Surveys also provided further understanding about how respondents viewed their role, their job, and their position within the program. Survey respondents reported a positive work experience, their beliefs aligned with the program, and they enjoyed their work.

Performance measures provided referral information and some demographic information on clients served by the program. Almost 60% were external referrals and 40.7% were internal referrals from within YDI. Self-referrals comprised the largest portion of external referral types at 33.7% followed by APS (21.1%). These three sources accounted for 95.5% of all referrals.

Performance measures also included information on the services provided such as number of hours dedicated to clients as well as the time it takes to conduct various services (i.e., assessments and therapy). Performance measures provided aggregated counts of services but does not provide insight into the effectiveness and quality of the services provided. Because the performance measure data did not always match to the client data there may have been some errors either in the reporting of the performance measures to the County and/or in the client level data. This data also showed the frequency of clients who were unable to successfully complete the program due to attendance issues, or a loss of contact.

The assessments and pre/post tests provided some preliminary information regarding the effectiveness of the program. The ACEs and SDOH results showed the program is providing services to youths living with adverse childhood experiences. The Childhood and Adolescent Functional Assessment Scale and the Preschool and Early Childhood Functional Assessment Scale which assesses the extent of interference in day to day functioning and can be used over time to measure change in 8 domains allowed us to report preliminary outcomes for the program. The domains are At School, At Home, in the Community (delinquency), Behavior Toward Others, Moods/emotions, Self Harm, Substance Use, and Thinking (assessing irrationality). A total score and subscale scores are provided, with higher scores indicating greater impairment in day-to-day functioning. We were only able to report total scores because we did not receive domain score data. Results indicated a positive effect for clients in reductions in interference in day-to-day functioning from when they began the program to when they were discharged (the total score showed a statistically significant improvement with a large effect size of d=1.02).

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