Bernalillo County Behavioral Health Initiative: Community Engagement Teams (CET)

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Introduction

In February 2015, the Bernalillo County Commission (BCC) and voters approved a new gross-receipts tax (GRT) expected to generate between $17 and $20 million each year, to improve access to care and to develop a unified and coordinated behavioral health system in the County and surrounding area (CPI, 2016). In April 2015, the BCC contracted Community Partners, Inc. (CPI) to provide consultation and develop a business plan for a regional, cohesive system of behavioral health care. CPI assessed the behavioral health care delivery system and recommended a governing board structure and planning process that resulted in a comprehensive behavioral health business plan. With guidance from the community and governing board, the County began implementing the approved service components, including research and evaluation focused on the implementation and impact/outcomes of programs funded by the GRT. Bernalillo County and its Department of Behavioral Health Services (DBHS) manage the contracts and providers of those services.

The CPI report recommended Community Engagement Teams (CET), a model not widely researched or reported on, as it is described within the CPI report. Within the CPI, CET's are described as teams consisting of professionals and quasi-professionals, including certified peer support specialists/community health workers, licensed behavioral health providers, and independently licensed behavioral health partners, capable of assisting people who voluntarily want mental health assistance, are not in an acute crisis, and do not require immediate hospitalization. Thus, CET is designed to target people who are having a sub-acute mental health episode. Sub-acute mental health care refers to care for a person who is either becoming acutely psychiatrically unwell (whether or not they have previously been acutely mentally ill) or who is recovering from an episode of acute psychiatric illness (MHCH, 2011). CET offers clients, and family members of clients', peer support and short-term clinical intervention services within 24 hours of initial contact or referral. Clients have opportunities to talk through current problems with peer support workers, in addition to brief interventions aimed at increasing the persons' problem solving abilities and activities of daily living skills. The team refers clients and follows up to see if clients connect with referrals. In addition, CET provides clients and interested people with education about mental health problems for clients and their social network. These services are provided with the objective of decreasing the number of emergency room visits and hospitalizations for those experiencing sub-acute behavioral health crisis, reducing recidivism and interaction with the criminal justice systems, and increasing the number of community and social services clients are connected with once served by CET. CET's uniqueness is partially attributed to the flexibility allowed for its structuring and implementation—as a hybrid model of various evidence-based models, it is intended to be tailored to the community needs by design. Due to the limited amount of literature and research for the CET model specified by the CPI, two similar models are described below.

Crisis Resolution Teams (CRT) are separate multidisciplinary teams that work to deliver a full range of emergency psychiatric interventions. The primary objectives of CRTs are: assess patients being considered for emergency admission, provide intensive home treatment for eligible patients, continue home treatment until the crisis has been resolved, refer patients to other agencies for further care that may be needed, and reduce length of stay by early discharge from hospital to intensive home treatment when feasible. According to Minghella, CRT's have reduced admissions to hospitals by between 20% and 40%, and have also reduced the length of stay for patients who are admitted (Minghella et al., 1998). Thus, CRT's differ from CET services in that they are designed to serve individuals' currently in crisis rather than sub-acute crisis, and might be considered more akin to the APD COAST teams.

Peer Support Service is an individualized, recovery focused approach that promotes the development of wellness self-management, personal recovery, natural supports, coping skills, self-advocacy skills, and

development of independent living skills for housing, and employment (Min et al., 2007). Peer supporters are individuals who use their experience of recovery from mental health disorders to support others in recovery. Combined with skills often learned in formal training, their experience and institutional knowledge put them in a unique position to offer support (Mental Health America). In both mutual support groups and consumer-run programs, the relationships that peers have with each other are valued for their reciprocity; they give an opportunity for sharing experiences, both giving and receiving support and for building up a mutual and synergistic understanding that benefits both parties (Mead, Hilton, & Curtis, 2001). In contrast, where peers are employed to provide support in services, the peer employed in the support role is generally considered to be further along their road to recovery (Davidson, Chinman, Sells, & Rowe, 2006). Peers use their own experience of overcoming mental distress to support others who are currently in crisis or struggling. The literature demonstrates that peer support workers can lead to a reduction in psychiatric hospital admissions among those with whom they work (Repper, 2011). According to the literature, some benefits for consumers from Peer Support services are reduced admission rates to psychiatric hospitals and community tenure, reduced stigma, increased empowerment, social support and social functioning, and empathy and acceptance. Additionally, peer supported services can be respite-based. Peer-run crisis respites are usually located in a house in a residential neighborhood. They provide a safe, homelike environment for people to overcome crisis. The intended outcomes are diverting hospitalization by building mutual, trusting relationships between staff members and users of services, which facilitate resilience and personal growth (Ostrow, 2011).

Important differences between the CET design and the aforementioned models should be noted. While CET and CRT models are aligned in their provision of services within the community, the CRT model is designed for acute crisis intervention, whereas CET aims to serve those whom have the potential for acute crisis and/or decompensation, or for individuals in post-acute crisis and require follow-up. The use of peer support services also aligns with the CET model, however, CET services are intended to be much more short term, providing up to 6 hours of services to individuals, as recommended by the CPI. As previously noted, the CET program, though lacking in direct evidentiary support for the model as a whole, is *based upon* evidence-based models and practices. Additional evidence-based practices and promising practices that were purportedly used include Seeking Safety, Teamlet approach, Matrix Model, Stages of Change, Maslow's Hierarchy of Need Pyramid, and clinical supervision, which are described in further detail on page 4.

This report is intended to broadly review the CET services provided by the NM Hope program, which was funded to provide behavioral health services to Bernalillo County residents in sub-acute crisis and/or pre/post crisis. Following this introduction, we include a description of the program including the program flow chart and the evidence-based practices and model employed, a timeline of the program implementation, contracted objectives, and performance measures. We then include a section that describes the technical assistance we provided to the program in the initial implementation phase of the program, which consists of a preliminary review and recommendations. This was done to help the program with implementing the CET services according to best practices and contracted design. Finally, we report the findings from our evaluation of the program, which is more limited in scope due to the premature discontinuation of the funding contract. Using the limited data that was available during the one-year period this program was in operation, we describe the implementation of the program. Because the program was never fully implemented and discontinued by the County, our evaluation was limited. While limited, the findings and resulting recommendations are important because they indicate a path forward for the CET program.

CET Program Description

New Mexico Hope was approved by the State of New Mexico as a credentialed Intensive Outpatient Program, and in March 2017 became Medicaid approved. NM Hope designed the CET program to receive referrals informally and through more formalized partnerships, such as the Mobile Crisis Teams, the New Mexico Crisis Access Line (NMCAL), St. Martin's Hospitality Center (now known as HopeWorks), Albuquerque Health Care for the Homeless, the Bernalillo County Sheriffs' Office, and the Albuquerque Police Department. Informally, community members could 'self-refer' themselves or individuals' believed to be in need of CET services, by calling the program office line.

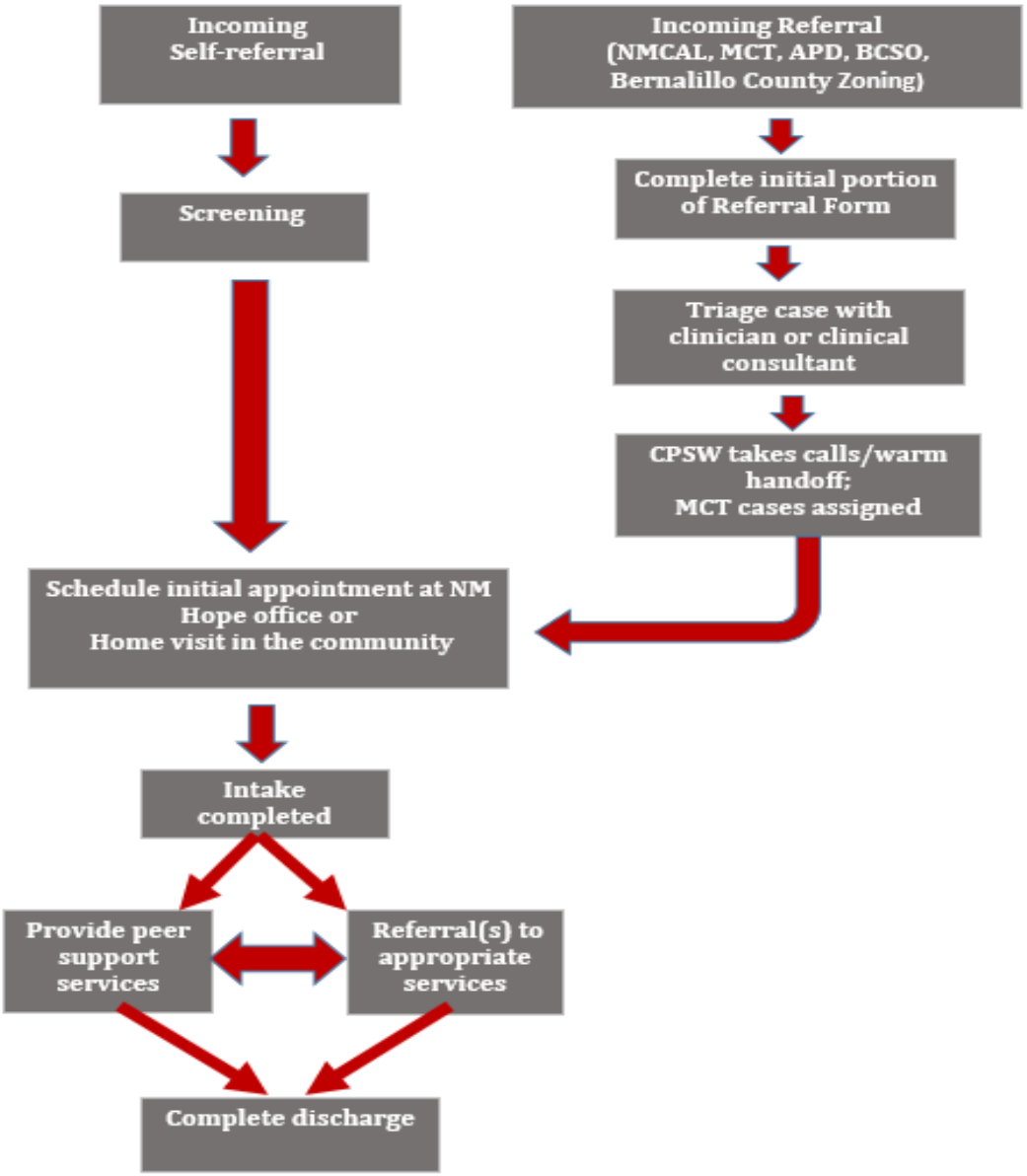
Contract and Performance Measures

NM Hope was contracted by Bernalillo County to provide a CET program, with the contract executed on January 8, 2018, set to extend for a two-year period (January 2020). Within the contract, in the personnel services budget, the program proposed needing four peer support workers, one program coordinator, two full-time clinical consultants, 1 part-time clinician, and two administrative assistants, and predicted full implementation of their program no later than February of 2018. The contract posits that the CET program provides full intake and referral services to all clients encountered by CET, provide Community Health Worker and/or Peer Case Management, provide mental and behavioral health services and referrals as needed to clients and family, and provide assistance with basic needs, and health-care supports.

These contracted services were agreed to be measured through attainable objectives and goals, and tracked utilizing the following performance metrics:

1. Number of referrals received—includes the referral sources, by time of day and day of week, assessment and screening of the referral results, the number of referrals not appropriate for CET and the outcome of such referrals;
2. Number of CET contacts—includes the amount of time between receipt of the referral and the CET contact, the length of each contact, and the result of each contact;
3. Number of CET contacts that result in referrals and/or on-going case-management by CET staff;
4. Number of CET contacts that do not result in referrals, on-going case management by CET staff or other services;
5. The results of CET contacts that result in referrals—includes the number of referred individuals that make contact with the referral source by that referral source.
6. The results of CET contacts that result in a referral back to NM Hope

Figure 1. CET Flow Chart



Services and Delivery Model

The following sections describe the proposed evidence-based practices, curriculum, and models reported to be utilized in the CET program. Per PowerPoint presentation and program materials provided by the program, the CET program delivered their services using certified peer support specialists (CPSS), and reportedly utilized evidence-based models such as Seeking Safety, Teamlet, Matrix Model, Stages of Change, Maslow's Hierarchy of Need Pyramid, and clinical supervision. Importantly, two points are to be noted, first, little documentation was identified to confirm the following models were implemented or monitored. Secondly, evidence-based practices and models are conditional, meaning their effectiveness is contingent upon their appropriate use and implementation. As such, with the exception of clinical

supervision, it is not known whether the following models and practices have been shown to produce good outcomes when utilized in community engagement team settings by CPSS's.

Certified peer support specialists (CPSS)—Certified Peer Support Specialist (CPSS) is an individual who has self-identified as having received behavioral health services and has received formal training in order to share their lived experiences to benefit others. Under clinical supervision, CPSS's are able to provide varying levels of supports and guidance in demonstrating and sharing their personal recovery skills. Broadly, successful CPSS's are able to:

- Willingly disclose their personal mental illness diagnosis;
- Describe in detail things that have helped them in their recovery and things that have been barriers to their recovery;
- Describe what they have learned about themselves and others during their process of recovery;
- Describe the clinical treatment received, including medications and/or therapies, and how they felt about the benefits and drawbacks of each respective treatment;
- Describe beliefs and values developed in order to strengthen progress to recovery;
- Describe personal community supports that helped with recovery;
- Describe and openly discuss dealing with personal crisis, triggers, and relapses;
- Understand the limitations of their lived experiences and training, and identify individuals in crisis and/or with more immediate or acute needs;

There was little information to support or refute the appropriateness of CPSS being used as the main service provider to CET clients. What can be gleaned from the comments and notes within the Progress Notes of a client file, is that in many respects, CET referrals may benefit from having a peer assist them, and that in hearing about the peer's past experience may have helped the potential CET client speak openly about their needs. In other respects, CET referrals were uninterested in hearing about the peers' experiences and were internally focused on seeking help for themselves or somebody else. In such instances, having a peer speak of their experiences may have had the opposite effect. In the instances in which the CPSS staff identified individuals as appropriate clients and provided the appropriate level of services, their level of experience and certification appeared sufficient. However, in the instances whereby individuals' required a higher level of services and subsequent clinical experiences, the CPSS certification was not sufficient. This could likely be remedied through the appropriate application of the teamlet approach, which is described below.

Seeking Safety is a trauma-informed therapeutic approach for individuals suffering from posttraumatic stress disorder (PTSD), substance abuse, and trauma. This present-focused approach is flexible and can be conducted in group or individual formats, across genders, and age groups, and doesn't require any sort of certification or licensure to provide it. Seeking Safety addresses 25 topics which fall within the following domains: 1) interpersonal; 2) cognitive; 3) behavioral; and 4) case management. Broadly, it follows the harm-reduction approach, focuses on empowerment and personal choices, achieving safety and ideals to instill hope. Of all the listed EVP in this report, Seeking Safety is most likely to be most appropriate for use for the CET program, as it can be used by CPSS staff, and offers a wide array of potentially useful topics. Despite this, there was no evidence to support that this had been implemented and used in serving the CET clients.

Teamlet models are typically small multidisciplinary teams that consist of a clinician and peer support workers, or some combination of team members qualified at varying levels of service provision. A teamlet approach allows clients to receive the appropriate level of care in an individualized and high quality manner, while leveraging the staffing capacity. If properly implemented, it can be an effective way of handling a wide array of clients with varying levels of needs. Close clinical supervision is necessary, however, to ensure less qualified support staff are not providing higher levels of care than

appropriate. Clinical supervision is an important component of any case management program, and especially so in peer-related behavioral health service provision. It entails a review of caseloads and confirmation of handling the issues for each of the cases. Documentation of clinical supervision can be useful in promoting accountability, as well as tracking professional growth and opportunities for improvement. Documented elements of supervision could include:

1. Duties and expectations-reflective listening, collateral information, decision making, problem solving, initiative, flexibility, accountability, self-awareness;
2. Intake and Assessment-high risk issues, progress notes, goals and objectives, service planning, intervention skills, evidence-based practices;
3. Resourcefulness-evaluation, discharge or term, diversity issues, ethical issues, communication outreach, ethical issues, transference;
4. Strengths and growth areas.

Similar to the Seeking Safety model, the teamlet approach offered the potential to be useful for the CET program, as it depended on mostly non-licensed staff and few licensed clinicians. Despite this, documentation does not support that this model was properly implemented. Though our review of records revealed a form for tracking clinical supervision existed, no evidence was found that the form had been used and implemented. No clinical supervision documentation was provided or analyzed.

The Matrix model is an evidence-based program (EBP) most commonly used in intensive outpatient treatment programs for cocaine and methamphetamine addicts, and is recognized by the Center for Substance Abuse Treatment (CSAT) and the National Institute on Drug Abuse (NIDA). The matrix model promotes individual/group therapy, early recovery, relapse prevention, family education, social support, and urine testing. It is an integrated approach utilizing cognitive behavioral therapy, motivational enhancement, psychotherapy and psychoeducation, and twelve step facilitation. Though an EBP in proper settings, it is not clear how this model was utilized in the context of CET services. As a very specific treatment model designed for individuals' with specific behavioral health needs, it would not likely be appropriate for many of the CET clients. Moreover, specific training and curricula are important components of the model, as is its implementation by a licensed clinician. Because there was no evidence or documentation of curricula materials, training, or forms, it might be assumed that this EBP was never formally utilized before the programs discontinuation.

Stages of Change (Prochaska & Diclemente) was reportedly utilized by CPSS staff, though there were no documents to demonstrate how the model was implemented and/or monitored. The model posits the following six stages are part of recovery: 1) Pre-contemplation—No intention of changing behavior; 2) Contemplation—Aware a problem exists, but no commitment to action; 3) Preparation—Intent upon taking action; 4) Action—Active modification of behavior; 5) Maintenance—Sustained change new behavior replaces old behavior; and 6) Relapse—Fall back into old patterns of behavior. It is not clear how the Stages of Change were utilized or embedded within the CET program, as clinical services were not provided by the CPSS staff, and there are no materials or documentations of it being applied programmatically.

Additionally, we were told the program was based on Maslow's Hierarchy of Needs Pyramid, which posits basic human needs need to be met before needs lower in the hierarchy are addressed. The hierarchy of needs includes, in the following order: 1) Physiological—Breathing, food, water, sex, sleep, homeostasis, excretion; 2) Safety-Security of body, of employment, of resources, of morality, of the family, of the health, of property; 3) Love/Belonging-Friendship, family, sexual intimacy; 4) Esteem-Self-esteem, confidence, achievement, respect of others, respect by others; and 5) Self-actualization—Morality, creativity, spontaneity, problem solving, lack of prejudice, acceptance of facts. This is often a model utilized in Housing First sorts of programs, which serve clients who are homeless, but also likely

have additional behavioral health needs. The basis of the model argues that the housing of an individual should come before the other additional behavioral health and social services, as shelter is one of the most fundamental needs for humans. As such, in the context of CET services, it can be assumed that the CPSS likely prioritized providing services intended to address physiological and safety needs before addressing lower hierarchical needs. This might have entailed linking CET clients to housing and food assistance programs before offering employment assistance, though the program did not document the order or prioritization of services given to their clients, so this can't be confirmed.

Technical Assistance

The following section describes the technical assistance provided by the ISR to the CET program in order to help the program in its implementation of providing CET services. The technical assistance that was provided during the first year entailed a preliminary review, which included discussions with the various CET staff, informal service delivery observations, acquisition of all program materials, instruments to be utilized, and development of process flow charts. Based upon these activities, ISR provided the CET program with feedback and recommendations for improving the implementation and documentation of CET services.

Technical Assistance: Preliminary Review

At the end of March through April of 2018, after the CET program had been contracted to provide CET services for several months, the ISR began working with the provider in preparation for the process evaluation. In April through August of 2018, ISR provided technical assistance to the program in developing their data collection instruments and operationalization of key variables. During this period of time, the CET program struggled with implementing the program—this includes difficulty coordinating and collaborating with outside referral sources, and internal implementation of procedures and processes. During the fall of 2018, program staff continued to provide services in the community and were in the process of entering the data collected using the newly developed battery of forms and tools. During this time, ISR prepared to begin the process evaluation, which entailed developing the research questions, design, and instruments to be utilized to capture the data. As with other BHI program evaluations, it was intended to conduct a record review of identifiable client-level data, staff and administrator interviews, and service delivery observations. In preparation for these research tasks and to again determine the program evaluability, informal reviews of the current program state were completed. Despite the substantial joint efforts in those developments, the provider remained inconsistent in its programmatic implementation. This included minimal training in the collection of client data and management of client records, as well as limited adherence to program procedures. Based upon these determinations from the preliminary review for technical assistance, several recommendations were provided.

Technical Assistance: Recommendations

First, the CET program should focus attention on solidifying program policies and procedures as quickly and efficiently as possible. Once documentation was complete, it would be recommended that it be provided to staff, and to mandate a meeting to discuss questions, expectations and offer training resources. It was imperative that all employees adhere to the formalized policies and procedures, and that the data reflect this.

Second, the program needed to more clearly and definitively understand and define the core peer support services being provided. This entailed better understanding the length of time clients are "active" within the program, the length of time it takes to discharge clients, the range of client caseloads by peer staff, range of time spent for a given caseload size, type of services provided while active within the program, and frequency and/or types of referrals given when discharged. Third, problems with data collection

needed to be addressed swiftly and consistently. Between the first and second year of implementation, all data collection forms, instruments, and processes had changed. Additionally, all of the data had been collected in hardcopy format and had not been entered electronically. While a new database had been developed for the revised forms and processes developed in the second year, it would not be able to accommodate the data that had been collected the previous year. In reviewing the hardcopy data several issues had become apparent:

- A large amount of data appeared to be missing from hard-copy intake/screen forms and client progress notes forms. Because these fields were left empty, with no explanation, it was unclear whether the questions were asked by the CET staff and the client declined, if the question was not even asked and thus not answered by the client, or if the client was asked, but did not know the answer.
- Exclusionary criteria was often blank in observed files, believed to be due to the sensitive nature of the questions. It was determined that the exclusionary questions were not explicitly asked, especially not sensitive ones pertaining the violent behavior or gang involvement. Thus, the majority of individuals' whom called and/or were referred, were never excluded and were considered eligible to become clients.
- For discharge dates, clients appeared to be actively receiving services for prolonged periods of time, and caseloads were very large. It was discovered that there was not a clear process or policy for discharging clients, so clients were not being discharged consistently across staff.

Unfortunately, meaningful changes stemming from ISR's preliminary review and recommendations were not made prior to the termination of the pilot program contract. Consequently, a review of all the data is provided below. The various components to be addressed next relate back to the performance measures and metrics outlined on page 4, as well as encompass higher order aspects of program outputs and outcomes. The closeout findings are based upon the completed monthly performance measures reports, as well as a full record review of client files.

Evaluation Findings

The record review of client files entailed ISR's full data entry of all hardcopy client files that had been filled out by CET program staff. The forms were scanned digitally and provided to ISR on encrypted thumb drives. Finally, the PDF client files were entered into an electronic database for analysis by ISR staff.

As a preface to the following presented findings, because the CET program was unable to develop and consistently implement formal program policies and procedures, it is very difficult to definitively identify program clients.

CET Program Data Collection Forms

Table 1 lists the client data collection forms utilized by the CET program and the type of information each form was designed to collect.

Table 1. CET Program Data Collection Forms

Form Name	Variables within Form
Referral (Revised May 2018)	Date; Client Name; DOB; Gender; SSN; Phone; Address; Medicaid/Insurance Policy #; Source of Payment; Referral Source/Agency; Self-Referral; Primary Language Preferred; Primary Care Physician/Psychiatrist; Reason for Referral; Current Treatment; Current Medication; Previous Treatment
Screening/ Intake	Client name; NM Hope staff name; Date of screening/intake; Time received; Birth date; Client phone; Address; Referral source; Gender identity; Race/ethnicity; Active duty; VA benefits; Medical insurance; Name of medical insurance; Exclusionary criteria (Yes/No): Violent Behavior/Extensive Violent Criminal History, Juvenile, Actively Suicidal, Active Gang Member/History of Gang Activity, Other (describe); Screen Appropriate (Yes/No); Screened Notes
Intake Form (May 2018)	Client Name; Date of Referral; DOB; Assigned Peer; Address; Current Provider/Psych.; Gender Identity; Date of Evaluation; Phone Number; Time of Call/Referral/Shift; SSN; Referral Type; Documentation Evaluated Elements: ER Visits past Year, Prescribed Psychotropic Medication, Prescribed anti-anxiety/anti-depressant medications, Prescribed Other Medications, MDC Bookings or Interaction with LE past Year, Adverse Experiences with LE, Received Community/Social Services Past Year, History of Domestic Violence, History of Sexual Assault, History of PTSD/Experienced Trauma, Primary Language other than English, Veteran, Disparity Group & Risk Factors: Chronically Ill and At High Risk, Pregnant and/or with Children, Seriously Mentally Ill, Substance Use Disorder, Co-occurring Disorder, Co-morbid (Psychological and Physical), Identifies as LGBTQ, Homeless, Immigrant/Refugee/Undocumented, Victim of Domestic Violence; Exclusionary criteria (Yes/No): Violent Behavior/Extensive Violent Criminal History, Juvenile, Actively Suicidal, Active Gang Member/History of Gang Activity, Other (describe); Screen Appropriate (Yes/No); Screened Notes
Progress Notes (Original)	Client Name; Client SSN; Client ID; Report Date; Date; Type of Session; Time of Session; Note
Progress Notes	Client Name; Client SSN; Method of Contact; Date; Start Time; End Time; Total Time of Contact; Name of Assigned Peer; Left Voicemail; Voicemail not Available: Full/Not Set Up; Notes
Discharge	Client Name; Assigned Peer; Date of Discharge; Time of Call/Referral; Shift; Outcome; Appointment Date; Type of Referral To; Total Contact Time with Client; Narrative Summary; Client Follow Through with Referral Sources, Reasons, Date/Contact; Client Declined CET Services; Peer/Clinician Have reached out to Client (Insert dates here); Client is a Relative of individual in need of low level behavioral health, refused services for self; Peer Signature and Date; Supervisor Signature and Date

Referrals

As a preface to the following presented findings, because the program was unable to develop and consistently implement formal program policies and procedures, it is very difficult to definitively identify program clients, as all individuals' referred to the CET program were treated immediately as CET clients. This is problematic for many reasons, but especially in considering the importance and purpose of having program eligibility criteria. Referring agencies did not appear to always understand and/or follow the established CET program eligibility criteria, many times referring individuals whom were likely ineligible due to active suicidal ideation and being under the age of 18 years. Consistent use of eligibility criteria is discussed in more depth in the following sections, and is an important issue with the program implementation.

Over the two-year period of time, CET received a large number of referrals, approximately 596. Of these referrals, 172 were missing date of birth. Individuals ranged from 9 years of age to 88 years of age, with an average of 41 years of age. Approximately 287 (48%) of the individuals identified as female, 221 (37%) identified as male, and 88 (15%) were missing gender. The majority of these referrals were provided by the APD Crisis Intervention Team (CIT), as well as NMCAL, and the Mobile Crisis Teams

(MCT). Of importance, data suggests that all referrals were treated as clients, though not all clients had referral paperwork.

Table 2. Referral Source

Agency	2018	2019	Undated	Total
AFD	1	1	0	2
NMCAL	103	32	31	166
MCT	121	19	19	159
BCSO	2	1	1	4
Bernalillo County Zoning	6	0	0	6
UNM Children's Hospital	1	0	0	1
APD COAST	1	0	0	1
APD-CIT	93	39	21	153
Davita	0	0	1	1
RRC	6	0	1	7
Pre-Trial and Probation	2	0	0	2
Self-Referral	24	10	5	39
NM Hope Outreach	2	2	1	5
Other	1	0	0	1
Unknown	22	12	15	46
Total Referrals	**384**	**117**	**95**	**596**

CET Response Time

Unfortunately, the length of time from initial referral to CET initial contact could not be reliably determined. This occurred because the screening/intake forms, which were to be completed with the potential client and during the initial contact, were often completed without the potential client, after receiving a referral for that client. In referring to the Progress Notes, the dates in which the initial progress note was completed could indicate the length of time, though these were completed inconsistently. Using this calculation method suggested a response time from referral to initial contact attempts ranging from 1-8 days.

For individuals referred to CET through APD-CIT and COAST, incident reports were provided and used to gauge the length of time it took for CET to engage individuals. Approximately 154 clients were referred to the CET program from APD CIT and COAST. From these referral sources, CET completed intakes within an average of 18 days and a median of 11 days, ranging from the same day to 36 days later. Of the 596 clients, a small proportion, approximately 70 (12%), were never initially engaged in services. In such instances, this appears to be related to invalid contact information, or a delay in the outreach of 7 or more days.

Screening and Intake

One of the most noteworthy findings of this review relates to the lacking adherence to screening and eligibility criteria. It remains unclear whether staff were provided a procedure in the completion of the screening/intake paperwork, as it is inconsistently completed over the time period and across different staff.

First, our review found that the referral paperwork was at times used as a replacement for the screening/intake form. In such cases, referral paperwork, consent forms, progress notes, and sometimes discharge paperwork was completed, but the screening/intake form was not. This suggests that CET might have assumed client eligibility had been determined previous to the referral, otherwise that client would

not have been referred in the first place. Second, data suggests that the screening/intake form was completed prior to making initial contact with the referred individual. In such instances, the screening/intake form has been filled out, with the eligibility criteria missing, one progress note completed indicating attempting to make contact, either through telephone calls or home visits, without any success, and the completion of discharge paperwork noting the client was never reached. Collectively, this points to the conclusion that all referred individuals are considered clients, that screening/intake paperwork was completed prior to making initial contact with the referred individual, and that individuals were admitted into the program without determining eligibility. It is not clear which information staff had used to complete the intake form and determine eligibility.

In total, eligibility criteria was documented and confirmed for 54 of the clients (9%), with 53 (98%) found to be eligible and only 1 found to be ineligible. Of the 54 accurately screened, 15 (28%) were completed in 2018 and 38 (70%) in 2019, 47 (87%) were attributed solely to one of the CPSS's. Many times within the eligibility criteria comments section, staff noted the individual presented with more severe mental health needs, such as active suicidal ideation, but still completed an intake and provided services. In such instances, these clients required much more intensive time and care by the program staff. Approximately 145 (24%) clients reported being actively suicidal, or had recently experienced acute suicidal ideation. Additionally, 11 individuals identified as minors under the age of 18, who therefore didn't meet eligibility criteria, were still admitted to CET and provided services. Of the 11 minors, 5 had histories of and reported active suicidal ideation.

Caseloads

Three certified peer support specialists (CPSS) provided services over the two-year span. Across the CPSS's, clients generally remained "active" on a case load for an average of 58.25 days, or just shy of two months. Caseload size and service time provided to clients varied greatly across the CPSS staff, with one staff carrying almost three times the clients as another CPSS.

Table 3. Total Time of Direct Service Provision by CPSS

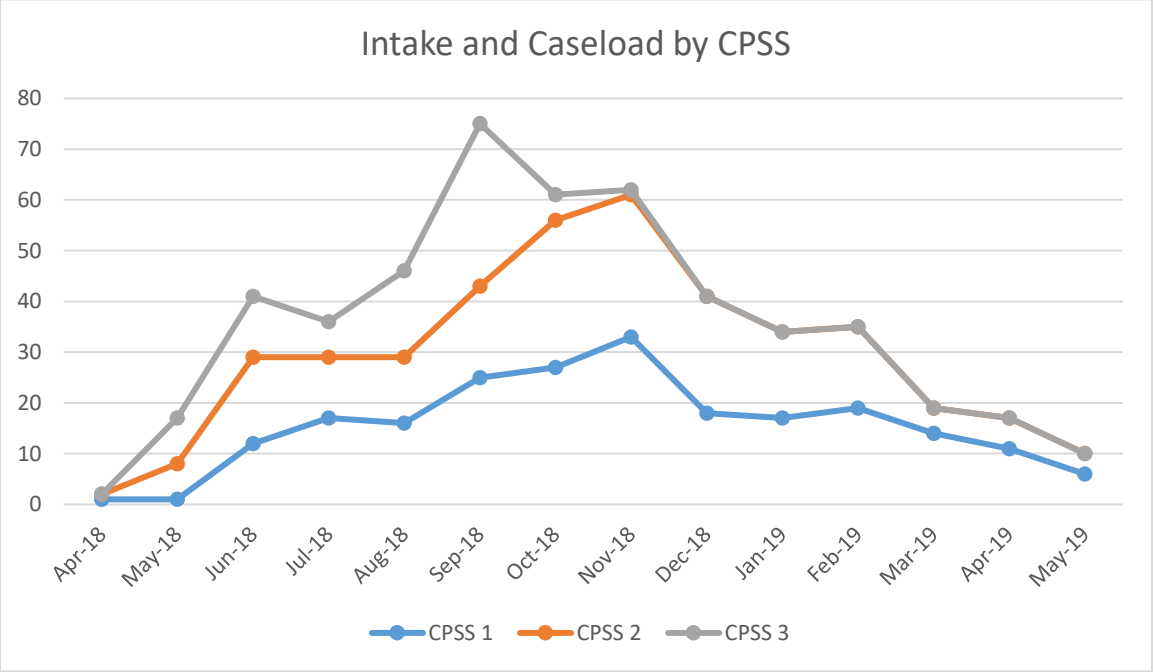
Staff	Total Clients	Total Minutes	Total Hours	Average Days Clients Engaged
CPSS 1	256	14,984	249.73	51
CPSS 2	239	10,050	167.5	39
CPSS 3	94	2,425	40.42	47
Unidentified	7	84	1.4	96
Total	596	27,543	459.05	58.25 Average

Table 4 demonstrates the rate of intake completion, which also is comparable to the caseload because all referrals were treated as clients. There was a steady increase in clients the first five months of operation, with the peak occurring between September 2018 and November 2018 and then a steady decrease.

Table 4. Intake completion and case load by month

	CPSS1	CPSS2	CPSS3	Unknown	Total	Percentage
April 2018	1	1	0		2	0%
May 2018	1	7	9		17	3%
June 2018	12	17	12		41	7%
July 2018	17	12	7		36	6%
August 2018	16	13	17	1	47	8%
September 2018	25	18	32		75	13%
October 2018	27	29	5		61	10%
November 2018	33	28	1		62	10%
December 2018	18	23	0		41	7%
January 2019	17	17	0		33	6%
February 2019	19	16	0		35	6%
March 2019	14	5	0		19	3%
April 2019	11	6	0	1	18	3%
May 2019	6	4	0		10	2%
Missing Dates	39	43	11	5	98	16%
Total	256	239	94	7	596	100%

Figure 2. Graph of intake completion by case manager



Service Engagement

A total of 596 individuals engaged with CET services between 2018 and 2019. In 2018, 384 individuals had contact with CET services, as measured by the completion of the intake paperwork. Similarly, 117

individuals had intake paperwork completed in 2019. Approximately 95 individuals were missing intake forms.

Interestingly, staff were able to meet clients and provide services in a variety of formats and modalities, such as telephone calls, home visits, office visits, visits in the community, and even email. Based upon a sample of all contacts made, as documented through the progress notes, CCPS relied mostly on phone calls, approximately between 79%-81% of the time. Around 12-14% of the contacts were made through home visits with the client. A sample was deemed sufficient for understanding the distribution of types of services.

Another consideration entails the measurement of services provided for primary versus secondary clients. The operationalization of primary versus secondary clients was not determined until the second year, and even then, was not consistently documented. Unfortunately, it is very difficult to retroactively identify these differences. It also complicates the documentation of services provided, and can result in under or over-counting services provided if attention is not closely paid.

Additionally, between two of the three CPSS's there were 11 instances in which clients received a higher than normal amount of time in services. Specifically, clients received between 6.7 and 19.92 hours of services (with a total of 110.3 hours), and required a range of 4-40 progress notes to be completed.

Thus, across the 11 clients, CPSS's completed an average of 23 progress report notes and spent an average of 10 hours per client. These clients were reportedly "active" between 48 days and 197 days, averaging approximately 118 days or 3.9 months. This high-need population consisted of mostly females (73%), ranging from 21 years of age to 76 years of age, with an average of 51 years of age. The referral sources were varied, with 4 resulting from NMCAL, 3 from APD-CIT, 2 were missing the source, 1 from MCT, and 1 was identified as a self-referral. While 3 of the individuals were identified as eligible for the CET program, the remaining clients were not screened with the set criteria, and all clients had been identified in the comments section as having active suicidal ideation and attempts. Ultimately, 6 of the clients were discharged as having 'Received Services', while 2 were categorized as 'Lost contact', 1 'Declined Services', and 2 were missing their discharge outcomes. Interestingly, the amount of time spent on the clients was underreported within the discharge paperwork, and was only determined after manual calculation of time across client progress reports. It is unclear why the time was underreported.

Approximately 22 clients received between 3 and 6.25 hours, 101 clients received between 1 and 2.91 hours, 78 clients received between 30 and 59 minutes, and 311 clients received between 1-29 minutes. Contact was never made for the remaining 70 clients, who received 0 minutes of services. Excluding the 11 outliers, the remaining 585 clients received a collective average of approximately 36.21 minutes of services.

Length of Time in CET Services and Discharge Outcomes

Approximately 39 clients were missing either the intake date, discharge date, or both dates, and length of time engaged or "active" could not be calculated. On average, for the remaining 557 individuals, clients remained "active" or engaged for 45.59 days, with a range of 0 days to 378 days.

Interestingly, those identified as having received services may not be truly reflective of how many clients actually did receive some level of services. This is due to the fact that individuals identified as having lost contact or declining services still received some amount of services. In fact, approximately 413 clients with a discharge category of 'lost contact,' and 'declined services' still engaged in services. Specifically, individuals discharged as 'declined services' still received an average of 28 minutes of services, and individuals discharged as 'lost contact' received an average of 39 minutes of services. Individuals who

were discharged as having 'received services', however, averaged much more than the former two categories, at approximately 96 minutes average.

Table 5. Types of Discharge Categories by Year

Discharge Outcome	2018	2019	Undated	Total
Received Services	52	49	0	101
Declined Services	104	31	5	140
Lost Contact	206	68	5	279
Closed file	16	2	1	19
Missing Data	33	6	18	57
Total Discharges	411	156	29	596

Outgoing Referrals

As noted in Table 1, the discharge form also included a means of documenting out-going referrals provided by CPSS when discharging the clients. This included documenting the outgoing referral agency name, reason for the outgoing referral, and whether it was confirmed that the discharged client had successfully 'connected' with that outgoing referred agency. Thus, confirming the 'connection' was in essence determining whether any follow-up had been made on the discharged client. Many times, unfortunately, these sections of the form were left blank or noted the outcome was 'unknown'. In reviewing potential barriers for documenting the outcomes, it did not appear that those follow-ups were prevented due to missing and lacking consents and MOU's. In fact, most clients signed and consented to communication with external agencies in regards to their engagement and outcomes.

Table 6. Outgoing Referrals and Follow-up by CPSS

Staff	Outgoing Referral Given at Discharge	Follow-up's on Connection Made	Percentage of Outgoing Referrals Followed Up
CPSS 1	61	10	16.4%
CPSS 2	90	30	33.3%
CPSS 3	38	11	29%
Unidentified	2	1	50%
Total	191	52	

Clinical Supervision

CET leadership provided templates of the forms they reported utilizing to document their clinical supervision activities, which included regularly scheduled group case reviews and one-on-one clinical case reviews. Additionally, some client forms, such as the client discharge paperwork, required supervisory approval indicated through their signatures. An important consideration is the length of time that lapsed from the discharge completion and the clinical supervision approval. On average, clinical supervision and approval of the discharge completion ranged from 1 week to 8 weeks, with an overall median of 5 weeks.

Conclusion and Summary

In reviewing the format and inconsistent conditions of the two previous years of data, it remained highly unlikely that the provider, County, and ISR truly understood the services being provided. The manners in

which data had been collected did not align with the contracted performance measures and thus prohibited the ability to determine whether the program was achieving their contracted objectives and goals. The intention of the report was to identify areas for improvement, highlight program successes, and utilize that information collectively to provide general and specific recommendations for future programs. As noted in the previous sections, recommended areas of focus include:

1) **Clear program processes and procedures**—Development of a program handbook that includes its mission, goals, and internal policies, as well as its treatment curriculum, templates of all data collection tools, how those should be used and when they should be used. This also includes designing processes and documentation methods that align with any potential situations that are likely to arise. For example, when a client referral is received, staff should document the referral and attempt the first initial contact to then complete the intake form with the potential client. In doing so, if contact can't be made, intakes are not unnecessarily completed for non-clients. If a potential client is reached and their intake is completed, the staff should be comfortable and trained to determine program eligibility. If the person is not eligible, there should be a clear process for the staff to take and to document that given process. Building in supervisory activities within specific data forms might also be useful, for instance, requiring supervisory approval for new client intakes within 7 days of completion.
   Loss of contact was a large contributor for client discharges, and though this is to be anticipated, it is recommended that a secondary method of contact be established. This includes collateral contact information from family and/or friends.
   In reviewing the statistics between the first and second year of operation, the data suggests two different tactics were employed (intentionally or unintentionally). In 2018, the CET staff engaged a higher number of clients, with lower needs, and provided those clients a shorter duration of services. In 2019, fewer overall clients, with reportedly higher needs, were engaged, and for longer durations of time.
2) **Specialized roles and responsibilities within the program—**The evidence-based models and curricula described in previous sections, such as the CPSS training and the Teamlet approach, provide unique avenues in which providers can leverage peer and staff of varying qualifications to provide the best possible quality of services, while being efficient and cognizant of staff shortages. These models are most effective when implemented consistently and in alignment with its design. Specifically, CPSS staff should only provide peer support services, and within the CET program, should only provide those short-term services (up to 6 hours) for clients determined to be eligible. Clinical supervision should be provided regularly, if not daily, and is best when provided in multiple different manners, including routine group meetings, routine individual meetings, documentation of client-related issues, and documentation of staff development and supervision, and supervisory confirmation procedures for various decisions and paperwork.
3) **Operationalization of key variables**—Clear definitions of key variables, such as primary versus secondary clients, should be determined, as well as ways to differentiate such variables in varying situations. Moreover, formal processes and tools to document, measure, and track those variables should be developed and implemented. It is also useful to develop the data collection instruments intended to collect client information and to map the different variables across those instruments. This ensures duplicate information is not collected, increases the likelihood for overall data consistency, and is a useful means for confirming the correct information is being collected in order to answer the research questions and determine important outcomes.

4) **Identification of meaningful program outputs**—Upon reflection of the previously discussed close-out report, many different numbers jump out and illustrate the services provided by the CET program. While the contracted performance measures provide a foundation with which we are able to better understand the basic counts of services, they may not be able to capture more meaningful ways of measuring the progress of the program. For example, the CET program utilized certified peer support specialists (CPSS) to provide non-acute supportive services, reportedly following several different evidence-based models, including Stages of Change (Proscheka and DiClemente) and Maslow's Hierarchy of Needs, yet this was not truly tracked or documented. Future programs intending to utilize and implement services following specific evidence-based practices should have ways of measuring and documenting those elements. Despite this, even more simplistic metrics to be tracked can be meaningful if they are collected and utilized appropriately. This might include reviewing the measures on a regular basis to ensure quality assurance and adherence to the models. In regards to CET, specific data points were collected and documented irregularly, and were unhelpful in the end in determining contract adherence and overall program success. For example, the length of time between referrals and intakes, the number of individuals screened eligible and ineligible for CET services, and the outcome results of clients who received CET services (i.e. how many outgoing referrals provided and how many of those outgoing referrals resulted in a successful connection).
5) **On-going training and quality improvement practices—**It is important to review/audit the implementation of the formal program procedures and processes on a regular basis. In doing so, adherence to those procedures can be determined, as well as potential reasons why they may or may not be adhered to. Additionally, it is important to determine the usefulness of those procedures, processes, and policies and whether they still serve the staff and clients; if not, they can then be revised and amended.

In conclusion, formal and concrete program procedures and processes were not developed prior to program commencement, which led to inconsistent service provision and inconsistent documentation of such provisions. These inconsistencies were confirmed through informal meetings and program observations, as well as through more formal data record reviews. While important and interesting program outputs can be gleaned from the data sources, the pattern of inconsistencies emergent across all aspects of the program heeds warning of conclusions that are drawn from such data.
As such, data revealed that CPSS staff did provide substantial time in peer support services to clients, though it also indicated they were provided in a manner that did not adhere to the CET program model nor evidence-based practices. Future programming should consider adapting and implementing the five described recommendations above.

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