Clinical Home Evaluation Report

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Direct Comments To:

Cathleen Willging, PhD
Program Director and Research Scientist
Behavioral Health Research Center of the Southwest
Pacific Institute for Research and Evaluation
612 Encino Place, NE
Albuquerque, NM 87106
Phone: 505-765-2328
Fax: 505-244-3408

cwillging@bhracs.org

Contributors Include:
Cathleen Willging, Garnett McMillan, Margaret Watson, Jill Reichman, Shannon Fluder, Nicole Kellett, and Ken Warner
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Executive Summary
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Executive Summary

Professional stakeholders* and the coaches contracted to guide them in the application of “the Milwaukee model” generally agreed on the key elements of the Clinical Home (CH) program, typically emphasizing the importance of the wraparound philosophy, case management, and client tracking. “Continuity” and “coordination of care” were identified as major features of CH, in addition to an intensive, strengths-based, individualized approach to care that actively involves clients and families in treatment planning. Professional stakeholders and coaches highlighted the inclusive nature of treatment planning and care provision under CH, commonly observing that CH encourages utilization of “natural supports,” referring to the immediate social networks of clients, in addition to “formal supports” found in the professional sector of the behavioral health system. The prominence accorded to collaboration across natural and formal support systems distinguished CH services from “care as usual.” According to professional stakeholders and coaches, CH created greater “accountability” among those charged with overseeing the implementation of treatment plans.

The majority of professional stakeholders were excited to be a part of CH, an observation confirmed by coaches. Although they were generally pleased to help develop the CH initiative, they expressed frustration with the lack of clear guidelines, expectations, and preparation for participation. Lack of preparation was tied to problems with billing and worries about future audits. While the training they received in September 2007 was deemed beneficial, professional stakeholders wished that they had received training much earlier in the CH implementation process. Moreover, not all professional stakeholders were able to participate in the training. Judges, in particular, received no guidance regarding their involvement in CH. All groups of professional stakeholders suggested that community resources and services must be considered during the preparation stages of CH and similar wraparound initiatives.

Professional stakeholders, most specifically providers, benefited from the provision of coaching, referring to it as a positive experience. The coaches were characterized as “helpful” and “flexible,” typically offering “very useful” information. Yet some providers suggested that they had received either not enough coaching or no coaching at all. Other providers found the coaching unclear and confusing, primarily because they lacked grounding in its underlying wraparound philosophy. Coaching, moreover, did not begin until long after agencies started to operate as CHs, and providers and clinical directors strongly agreed that more agency personnel needed to be involved in CH and in coaching activities. Finally, the coaching process brought up concerns for providers about how to operate effectively as CHs when faced with a lack of resources and available services.

Coaches had worked with providers in several ways, participating in team meetings, teaching providers how to facilitate these meetings, and conducting trainings with individual CHs. Coaches strove to respect “autonomy” among providers, insofar as they preferred not to “dictate” how to interact with families. Coaches contended that one should not expect providers to absorb the lessons associated with service provision

* Professional stakeholders refer to Clinical Home providers and individuals who work in the Juvenile Justice System.
under CH in a short period of time, which is especially significant as the lion’s share of training took place during a two-day session. Such absorption and subsequent changes in practice, coaches stated, took time. According to coaches, there was a need to assess how well providers comprehended these lessons as well as their overall implementation process. Nevertheless, coaches had noticed some positive changes in practice. Providers, for example, appeared to be gaining skills in coordinating and communicating with both natural and formal support systems. Professional stakeholder attitudes about the youth and their families were also changing. Coaches associated a more positive attitude towards youth and their families with increased efforts to incorporate the wraparound philosophy. Coaches reported that some providers remained resistant to change, as they did not see much difference between the coaching lessons and their actual work practice. In contrast, coaches observed that other providers appeared overconfident in their ability to integrate the lessons into “real world” action. Coaches suggested that the success of CH depended on intensive, ongoing training for professional stakeholders.

Professional stakeholders and coaches were in overwhelming agreement that CH was underfunded and that program standards, expectations, and outcomes required further explication. Key processes, such as referral, assessment, and treatment, needed to be refined.

Professional stakeholders expressed significant concern about the CH referral process. Although some mentioned that the process was family-friendly and consumer-responsive, allowing improved screening of enrollees, the process was also characterized by the majority of professional stakeholders as “complicated” and “off-putting” to potential enrollees. Wary of “telemarketers,” families did not respond well to out-of-town referral calls. Once families agreed to participate in CH, they often had difficulty in choosing a CH, as they were offered insufficient information. Professional stakeholders, in turn, expressed their frustration at not being able to give actionable feedback on the referral process.

There were professional stakeholders who did not consider CH assessments to be much different from other types of assessments, with the exception of the truncated completion timeline. Yet others believed that the quick turnaround time compromised the quality of CH assessments. Professional stakeholders were of the opinion that the assessment requirements needed further clarification and were a source of stress within agencies. Professional stakeholders noted that the CH assessment did not replace the need for additional assessments required by the court or other agencies involved in the care of CH youth.

Professional stakeholders typically argued that the treatment process under CH did not differ much from the treatment process utilized with non-CH clients. Nonetheless, professional stakeholders underscored the importance of the collaborative team meeting involving natural and formal supports, and suggested that this feature of CH was relatively new to them. They also observed that CH facilitated greater engagement in treatment processes, although participation was sometimes uneven. Room for improvement was noted in the areas of coordination, cooperation, and communication, especially with non-CH personnel and/or non-CH agencies. The interface between CH agencies and the Juvenile Justice system was sometimes marked by tension. Judges felt they had little to no voice regarding decisions impacting
youth in CH. All professional stakeholders spoke of the possible demise of residential treatment, and argued that this level of care was warranted in the treatment of some youth.

Professional stakeholders agreed that increased attention to youth, in conjunction with the focus on the family and “out of the box” thinking in the context of treatment planning would, in the long run, help reduce out-of-home placements. As in the CHs, attitudes towards youth and their families were also changing within the Juvenile Justice system, as juvenile probation officers and their colleagues became more patient, allowing time for treatment plans to be implemented as planned. However, in the minds of professional stakeholders, problematic referral processes and unclear goals and program expectations diminished possibilities for reduced out-of-home placements. Professional stakeholders also linked denials of RTC, which were independent of CH, to reductions in these placements.

In general, professional stakeholders were pleased to be part of the development of CH. Mentioned as especially rewarding was the possibility of helping at-risk youth, or youth who had already utilized many of the services available in their communities but who had yet to experience successful and sustainable outcomes. Greater tracking and intensive attention to such youth enabled professional stakeholders to locate and pursue effective solutions in consultation with the clients and their families. The role of these frontrunners in CH was seen as both “fraught with ambivalence” and “an interesting process.” Professional stakeholders believed that future CHs would benefit from their work to get the CH program off the ground.

Professional stakeholders had received limited feedback from youth and families. Some youth and families viewed the experience as “empowering” and took advantage of CH offerings, while others were reluctant to fully participate in CH. Knowledge of the CH concept and the relationship of the youth and families with specific providers shaped perceptions of the program. Professional stakeholders suggested that the enthusiasm they brought to interactions, combined with a willingness to engage clients and families in new ways of treatment planning, influenced the level of involvement of CH enrollees. There were also several reasons why families may not have wanted to participate. One factor related to the out-of-town placement call that occurred upon referral, discussed above. Other factors included lack of awareness and understanding of CH, lack of community “buy-in,” as well as skepticism over the “equal partner” philosophy.

Youth typically were told about CH by their either their case managers or their parents. Parents in turn learned about CH from ValueOptions, the Children Youth and Families Department, and/or provider agencies. For the most part, youth and family members reported waiting a couple of days to one week to partake in CH. In general, youth and families did not possess extensive knowledge regarding CH.

The majority of youth and families were unable to provide definitions of CH, although most understood its overall intention of helping at-risk youth. Indeed, despite their admitted lack of knowledge, most perceived CH as a “better option” for these youth. They also recognized that case management was an important feature of CH. The youth, in particular, spoke highly of their case managers, characterizing them as highly accessible individuals whom they could turn to in time of need. CH, they said, offered them someone with whom they could “talk,” enabled them to participate in treatment planning, imparted anger management and other coping skills, and provided
assistance with transportation, financial problems, and job seeking. Family members were also appreciative of the help provided under CH to coordinate services as well as the overall involvement of natural supports. However, they also discussed negative aspects of CH, including inadequate communication with professional stakeholders, difficulty tracking down providers for answers to specific questions, clinical meetings that were sometimes held without informing all parties, and uncertainty that CH would, in fact, "work." Youth and family members reported that CH impacted their relationships in the home setting positively, if at all. Several youth reported positive changes in the home environment, stating that they had become more “helpful” and “respectful” at home. In addition, some youth stopped hanging out with friends who were considered to be negative influences and both groups cited a decrease in legal troubles. Overall, youth and family members appeared satisfied with services provided by CH. Some suggestions for improvements included: increasing communication through more frequent updates by providers; increasing the number of CH staff; assuring that this staff was adequately trained in the concept and practice of CH; and creating a peer support system for the participating youth.
Lessons Learned and Recommendations
Clinical Home Evaluation  
Lessons Learned and Recommendations  

1. Professional stakeholders expressed frustration regarding the lack of clear guidelines for their participation in the Clinical Home program, and underscored the need for further information concerning program standards, expectations, and outcomes. **RECOMMENDATION:** Provide clear guidelines regarding participation, in addition to information on program standards, expectations, and outcomes prior to implementation of Clinical Home program.

2. Professional stakeholders expressed frustration at the lack of preparation and training to facilitate involvement in the Clinical Home program, pointing out that preparation and training for frontline service providers was not provided in a timely fashion, was insufficient, and was limited in length. **RECOMMENDATION:** Facilitate greater preparation and on-going training for professional stakeholders, especially frontline service providers.

3. Professional stakeholders and coaches unanimously voiced frustration that coaching was not provided sooner in the implementation process, its length was much too limited, and it was not accessible to all professional stakeholders. Coaches especially stressed that time was needed to understand and adapt to the Clinical Home wraparound philosophy, and recommended intensive, ongoing training for professional stakeholders. **RECOMMENDATION:** Initiate coaching as soon as possible in the implementation process, extend period of time in which coaching is provided, and offer intensive, ongoing training to all professional stakeholders.

4. Coaches expressed concern that there was no process through which to assess provider comprehension and implementation of wraparound practices under Clinical Home. **RECOMMENDATION:** Develop and put into action an assessment tool to evaluate provider comprehension and implementation of wraparound practices.

5. Judges expressed frustration at their lack preparation and training in Clinical Home. They stated that they were not really a part of the program. **RECOMMENDATION:** Provide training to judges, and educate providers on how to include judges more effectively in the program.

6. Professional stakeholders expressed concern about how to bill for Clinical Home activities, and worried that future audits would penalize them for their lack of clarity on billing issues. **RECOMMENDATION:** Prepare and disseminate clear billing guidelines and instructions on how to prepare for audits of Clinical Home caseloads.

7. Professional stakeholders, as well as coaches and judges, suggested that community resources and services must be considered during the preparation stages of Clinical Home and similar wraparound initiatives. **RECOMMENDATION:** Assess community resources and services prior to implementation, and develop strategies to maximize mobilization of these resources and services.

8. Professional stakeholders agreed that the Clinical Home program was underfunded. **RECOMMENDATION:** Enhance funding for the Clinical Home program.

9. Professional stakeholders, especially those situated outside of Albuquerque, expressed frustration at the design of the referral process. Referral calls coming from an out-of-town source were often a barrier to participation in the program.
RECOMMENDATION: Develop culturally competent outreach strategies that are responsive to diverse clienteles.

10. Professional stakeholders expressed concern that potential Clinical Home enrollees (e.g., youth and their families) were not sufficiently informed about Clinical Home sites, and thus were unable to make informed decisions. **RECOMMENDATION:** Compile information about services provided by individual Clinical Homes, to enable potential enrollees to select the Clinical Home best suited to their needs.

11. Of concern was the truncated assessment process. Most professional stakeholders agreed that the current timeline was unrealistic and could compromise the quality of assessments. Barriers beyond the control of providers made adherence to the assessment process stressful and difficult. The timely assessment process caused considerable stress for providers and possibly contributed to provider burnout. **RECOMMENDATION:** Facilitate open and honest discussion involving providers, the State, and ValueOptions to create an assessment process that is feasible.

12. Many professional stakeholders expressed confusion over what kind of assessment was to be done in the Clinical Home timely assessment process. **RECOMMENDATION:** Provide clear guidelines as to the type and content of assessment required.

13. The Clinical Home program is viewed by professional stakeholders, as well as judges, as a replacement for residential treatment. Many feel strongly that residential treatment is the best option for some youth. **RECOMMENDATION:** All parties should engage in an open and honest conversation on this subject. Greater transparency as to the intent of the program should be the goal when opening up the Clinical Home program in new areas.

14. Although the Clinical Home program is intended to reduce youth recidivism, many professional stakeholders expressed concern at the lack of clarity of what was considered to be “recidivism.” **RECOMMENDATION:** Define “recidivism.”

15. Professional stakeholders expressed concern over the high number of Clinical Home enrollees who expressed little or no understanding of the Clinical Home program. **RECOMMENDATION:** Facilitate more education and training for enrollees.

16. Professional stakeholders expressed concern that linguistically appropriate services, especially for Spanish-speaking enrollees, were in short supply under Clinical Home. **RECOMMENDATION:** The State and ValueOptions should collaborate with Clinical Homes on development of strategies to ensure the provision of linguistically appropriate services.

17. Professional stakeholders and Clinical Home enrollees stressed that the program needed more staff in order to function properly and prevent provider burnout. **RECOMMENDATION:** Assess the necessary number of Clinical Home staff and hire additional staff to ensure proper functioning of the program and to prevent provider stress and burnout.

18. Clinical Home enrollees expressed frustration over difficulties they had experienced in getting in touch with providers. **RECOMMENDATION:** Provide clear information to enrollees on how to get in touch with providers. Providers should make greater effort to update enrollees regarding all facets of the Clinical Home case.

19. Clinical Home enrollees expressed frustration that team meetings were being held without all stakeholders present. Clinical Home professionals also stated that they...
had not yet managed to have team meetings that involved all relevant stakeholders. **RECOMMENDATION:** Team meetings involving all members of the Clinical Home treatment team are the cornerstone of the wraparound philosophy. Ensure that team meetings involve all stakeholders, including Clinical Home enrollees. Develop strategies to ensure that involvement is voluntary and not coerced.
Part I: Qualitative Research Methods
I. Overview

We used a combination of qualitative research methods to understand the implementation of the Clinical Home (CH) program that was introduced to Albuquerque, Las Cruces, and Santa Fe, New Mexico in May 2007. Ten clinical sites were selected to take part in this pilot program. Initiated in September 2007, the process evaluation was designed to assess both strengths and weaknesses associated with the program from the vantage points of several stakeholder groups: (1) CH providers (representing the ten clinical sites); (2) Juvenile Justice (JJ) professionals; (3) judges; (4) coaches with expertise in wraparound care; and (5) community members (service users consisting of enrolled youth and their families). Through focus groups and semi-structured interviews carried out between October 2007 and January 2008, we documented the complex attitudes, understandings, and practices of diverse individuals and organizations involved in implementing CH, as well as those who were otherwise impacted by the new program, either as program collaborators or as service users. We chose to conduct focus groups because this methodology provides an opportunity to gain a wide range of input into issues for which relatively little information is currently known. The group process itself can be stimulating for participants, as it aids recall and leads to productive and insightful discussions that would not otherwise be possible. The semi-structured interviews, in turn, afforded the chance to examine in greater detail topics discussed in focus groups, providing us with deeper appreciation of the nuances of participation in CH from the perspectives of varied stakeholders.

II. Methods

We completed 6 focus groups, 3 with CH providers (n=22 participants) and 3 with JJ professionals (n=25 participants). Each focus group comprised 5 to 10 participants. We completed 17 semi-structured interviews with CH providers (n=9 participants), coaches (n=3), and judges (n=5 participants). In addition, 14 youth enrolled in CH and 13 of their family members also participated in semi-structured interviews. We created 5 complementary data collection guides, each tailored to a specific stakeholder group. These guides are included in the Appendix. The guides consisted of 7 to 13 stem questions and several probes. We also introduced new queries to follow-up on issues raised by the evaluation participants. The protocols covered several domains: (1) ideas about CH; (2) thoughts about taking part in CH; (3) type of preparation needed to implement CH; (4) coaching and training needs; (5) perspectives of the referral, timely assessment, and treatment processes under CH; (6) recidivism and out-of-home placement issues; (7) community member feedback concerning CH; and (8) suggested improvements to the CH model in New Mexico.

III. Analysis

The focus groups and interviews were digitally recorded, transcribed, and then entered into a qualitative analysis software package (NVivo 7®). The use of software facilitated rapid coding and the development of a coherent and consistent description of themes.
that emerged in the data. We analyzed the transcripts through a series of iterative readings, followed by a systematic line-by-line categorization of data into codes. We then identified themes and relationships between them. The data were analyzed first by "open coding" to discover themes, ideas, and issues. "Focused coding" was then used to determine which of the themes, ideas, and issues were repeated frequently in the data and which represented unusual or particular concerns. Focus group and interview data were examined in order to discover patterns and relationships relevant to how diverse stakeholders understood and experienced CH. As categories emerged from the data, a coding system was developed so that transcripts could then be indexed and systematically analyzed. This procedure allowed for the recognition of repeated, predominant themes across a range of focus groups and interviews.

The results below represent the main themes generated by our analytical process. In the presentation that follows, quotes from focus groups and interviews are often used to help exemplify a particular theme or issue. These quotes have been edited in the following ways. First, most linguistic hesitation phenomena (words such as "uh") have been deleted. Second, other common words that are not usually out of place in informal conversation, but break the flow when appearing in print, have also been deleted (words such as "okay," "you know," and "like"). Third, quotes have been corrected for grammar and syntax where necessary.
Part II: Professional Stakeholder Perspectives
I. What is Clinical Home?

Providers and Juvenile Justice (JJ) professionals generally agreed on the key elements of the Clinical Home (CH) program, typically emphasizing the importance of case management, client tracking, and the intervention’s wraparound philosophy. “Continuity” and “coordination of care” were identified as major features of CH. Providers also described the intensive, strengths-based, individualized approach to care as a defining characteristic of CH. Providers appreciated how CH broadened the focus from the individual client, or youth, to encompass their families as well. They highlighted the inclusive nature of treatment planning and care provision under CH, commonly observing that their involvement in CH encouraged them to tap into “natural supports,” referring to clients’ immediate social networks, in addition to the “formal supports” found in the professional sector of the behavioral health system. The prominence accorded to collaboration across natural and formal support systems distinguished CH services from “care as usual.” According to providers, CH also created greater “accountability” among those charged with the task of overseeing the implementation of treatment plans.

Case Management:

Definitions of CH offered by providers and JJ professionals typically cited the centrality of case management (typically referred to as “care coordination” by the coaches, see page 61). One provider described CH succinctly as “intensive, long-term case management.” Another provider stated that involvement in CH created a higher “level of commitment to whoever gets referred.” The case manager stood as a symbol of this commitment. This provider explained:

We’re in it for a longer potential duration and we’re acting as a steward even more so than we normally do. We’re almost like this big case manager—even if we’re not the ones providing the service. It’s our job to get the right services and coordinate that and make sure that they’re happening and advocate for the clients in that capacity.

One JJ professional characterized CH in similar terms:

[CH involves] a lot of heavy duty case management in that they track the family. They try to make sure that there are no breaks in services. When a kid comes out of a higher level of care, the aftercare plan isn’t implemented or even prepared and [the case managers are] supposed to help keep on top of that to make sure that it gets done, so that the aftercare services can take place without a break in service.

Providers and JJ professionals agreed that this greater ability to track clients in CH was an asset. Tracking what services have worked and what services have been less successful minimized duplication and prevented youth from “falling through the cracks.” It also lessened the stress created when at-risk individuals had to repeat their stories to
new providers. Judges also observed that tracking by the case managers represented an important feature of CH, although they did not view this element as particularly novel or innovative. One judge stated, “The advantages that have been articulated tend to do with more tracking of the child. I’m not diminishing that value, but the Clinical Home is not this new concept if that’s its primary value.”

**Coordination of Care:**

Providers emphasized the importance of coordinating a range of services for youth and families in CH. In this vein, the treatment plan for each youth and family needed to be individualized while, at the same time, increasing the availability of natural and formal supports that families could avail themselves of in order to achieve positive outcomes. One provider explained:

> We’re making sure that all the treatment components are working in a coordinated effort and that there’s consistency of flow of information, that there’s no gaps, that it’s seamless, and that the clients are just basically getting the help they need and that someone’s always aware of exactly what’s going on with them and where they’re at in the system.

In keeping with this observation, there was general consensus among providers and JJ professionals that CH facilitated greater individualized monitoring and attention to both youth and families. Both groups also understood that the long-term relationships likely to develop between the client and CH providers would result in an enduring commitment to the youth and her/his family. One JJ professional described his hopes for this relationship:

> [CH providers] have to follow through. As long as a family needs [them], they’re to continue. They can’t drop them [or] hand them off to anyone else….They’re the pivot point, and they’re to make sure everything is connected. Everybody understands what’s going on when it’s happening and so there’s no lack of communication about treatment.

Judges argued that it was the responsibility of CHs to coordinate “everything from outpatient services to intensive in-home services to residential and group home services.”

**Family-Focused Care**

The providers and JJ professionals overwhelmingly agreed that “family-focused care” was a critical defining characteristic of CH and a concept that had reshaped the way they approached their work.

In particular, providers discussed the importance and the benefit of placing the family at the center of the treatment process under CH. Rather than deciding as providers what was best for a given youth, they and their colleagues were becoming more likely to “find
out” what the family needed and wanted. This newfound appreciation for the family perspective represented a shift in conventional mental health practice for many providers. One provider stated:

You ask them, “So, what is it that you really want?” And we’ve never really asked, “What is it that you want to do, and what’s going to work for you?” That is getting away from business as usual. It’s not prescriptive. It’s more taking the recommendations from the person. They’re saying, “This is what’s going to work for me.”

Across the board, providers contended that CH allowed families to have more input and to feel more empowered in the context of the treatment process. “Family,” one provider stated, “is a real key. They’re part of the team, and it’s not that they’re less than the professional. They’re as important to this team as everybody else is in trying to figure out what is the best thing for the family. This is really getting into the meat of the family and seeing what is needed.”

Providers believed that the greater focus on the family would ultimately lead to less dependence on case managers by service users. Empowering families to take a greater role in treatment, one provider asserted, enabled families “to realize that in the end they’re going to have to rely on themselves and their external supports.” Greater family involvement also forced providers to rethink the ways they dealt with clients and families, and to be more patient in searching for solutions. One provider described this learning process as follows:

What I have learned is, working with almost all of the families and the clients, is that I’ve got to go back and ask questions again, because I’ve got to give them time to think about it. You ask them, “So, what’s going to work for you?” That totally took them down a different path, and they’re not used to thinking like that….That’s positive and it’s more rehabilitative, and I’m from a standpoint that when services aren’t as in big of a demand that people will be more resilient and maybe won’t need services again possibly, or if they do it will be a longer stint of time. So that the way that it’s presented, the way that it’s taken in by the client is more healthy, because it really puts less of a dependence upon the case manager.

According to providers, this shift away from dependence upon case management would move clients and families towards greater self-sufficiency and empowerment. This shift was not possible without the involvement of both natural and formal supports in supporting the youth and family during treatment. The involvement of natural supports allowed treatment teams to “create” individualized services, for example when an uncle or aunt would take on an after-school supervisory role.

JJ professionals and judges also considered it important that care and treatment within CH focused on the entire family, and not just on the youth. One JJ professional stated, “I tell the families that it’s an agency that coordinates all the services for the family, not
just for the child that we’re referring to the CH, but for the entire family, and that they make sure that the entire family’s getting the services that they need.” Another increasingly accepted precept of CH is that the family must consent to services. A second JJ professional felt strongly about this precept, saying, “It’s stuff that they want….It’s not something that’s imposed on them or they feel like they have to do it. I think that helps the families ease into the recommendations that anybody might have. They agreed to it and they’re asking for help, so it’s a voluntary thing.”

**Minimization of Out-of-Home Placement**

Multiple providers commented on the potential of CH to minimize residential treatment center (RTC) placements, and some stated that it was their impression that minimization of RTC use was the express intent of the program. In fact, they considered this potential to be the motivating factor underlying CH. This was a view shared by JJ professionals and judges. One provider summed up the opinion of many when he stated that “Clinical Home requires a lot of thinking outside the box on how we traditionally think to keep a child maintained in their home or in the community and not straight to a higher end service.” Creating an individualized treatment plan to fulfill both youth and family needs, mindful of the cultural background of clients, was considered essential to maintaining youth in their homes and communities.

JJ professionals also called attention to the potential of CH to decrease detention among youth. One JJ professional stated, “A lot of times, kids that are involved in the system, they’ll commit another delinquent act, be placed back in detention, then services stop, and then we have to start over again. And so [CH] helps to keep that from happening.”

While judges were supportive of “keeping kids in the community,” and were agreed with the provision of wraparound services to realize this goal, they also intimated that CH had been instituted as a “broad brush” replacement for RTC, therapeutic foster care, and other “high end” care. According to judges, out-of-home placements were being minimized because authorizations for these services had been substantially reduced when the CH intervention was first introduced.

**Increased Collaboration**

Collaboration was portrayed by all professional stakeholders as a vital component of CH. For example, providers expressed appreciation for the increased collaboration between CH providers and JJ professionals, mainly facilitated through weekly meetings. One provider noted:

> A few probation officers have mentioned that they wished they had all their kids in Clinical Home because we do work closely as a team—they don't end up having to do everything, just the same as I don't end up having to do everything, the therapist doesn't have to do everything. We all have smaller parts. And as a team, it’s been a lot easier.
This increased ability to shoulder the workload combined with the individual treatment plan increased possibilities for greater success in helping youth with intensive needs.

JJ professionals in areas with more than one CH felt “fortunate” to collaborate with multiple agencies, while those with fewer or only one CH in their area expressed the wish for more agencies to become CHs. Collaboration was facilitated in settings where collaboration between provider agencies and JJ professionals preexisted the implementation of CH. One JJ professional explained:

We had an established relationship with those providers. And that made it easier, because we were already dealing with the same kids. We knew who the key players were in those agencies, and that made this transition. We were all in it together. So, we kind of all had to find our way together as a group. I think that made it a little easier.

This group commitment or feeling of “all being in it together” fostered collaboration between provider agencies and JJ professionals, as various players took charge of the part of the workload to which they were most suited. One JJ professional stated:

We have large caseloads and they can do the stuff that we can't do. They're out there checking up on the kids, doing the intricate little things that we can't do, because we’ve got too much—like going into court—and just it's a huge process, the stuff that we have to do. And they can take care of all the treatment aspect of it, which is a good thing.

Another JJ professional said that while at first she and her colleagues felt that their work was being taken away from them, the actual effect of CH was to give them more time to spend with clients. Rather than making referrals and ensuring that clients were taking part in their designated services, JJ professionals were able “to go out into the field and be probation officers.” One JJ professional said, “I really tried to take advantage of it with my staff. We got out all summer long, and kids saw us more than they ever did. And so, not only were they getting supervised clinically and in-home services, but they were also being supervised by the JPOs [Juvenile Probation Officers].”

**Philosophy Shift**

For many professional stakeholders, CH was associated with new ways of thinking that had affected the way they performed their work. For example, the “hands on” experience in CH combined with training received in September 2007 had led to a “philosophy shift” within agencies and in the JJ system. This philosophy shift was said to impact care processes more broadly. One provider stated, “Even though a kid in our program is not identified as Clinical Home, I’m finding myself using the same process of just getting a kid in case management. It’s hard to avoid once you get used to this process. It’s hard not to make a full circle connection and pull these pieces together.” Others agreed, stating that they were implementing wraparound principles even with
youth not officially enrolled in CH. Another provider called the “on the ground” preparation for CH “retraining” that had led providers at her agency to “approach things in a totally different way.” More contact was maintained with clients, and this enabled providers to guide families to build up their own resources to deal with crises, thus lessening dependency upon formal supports.

Such shifts were taking place in the JJ system as well. JJ professionals suggested that the introduction of the wraparound concept via CH influenced how they help clients. One JJ professional noted:

The wraparound that we were always supposed to be doing for a very long time is coming into play. It's just gradual, because we don't always understand what it means. Wraparound sounds easy to understand. It means going around something. But if it's so big, you can't get around it, because some problems are too big or you can't get to the truth....What [CH] has done for me is change my viewpoint of how to assist and put services in place. And that's a lot of what my unit is working at as to how to understand what we need to do for our families and kids, because it's not about a kid on probation and these are the court orders. It's about what brought you to this place and what do we need to do to get you out of here and not come back and stay successful in your community.

Another JJ professional concurred, emphasizing how CH prompted professional stakeholders to search for new ways to think about finding solutions for the family:

As the providers, it doesn't have to always be a clinical thing to fix or help a family. Sometimes they just need to feel comfortable with who they know can help them. And if they're comfortable with their church, maybe their services need to come from their church. I think that because it's Clinical Home and we're professionals in JJ. We're looking at how to assist these families the way they're comfortable in being assisted.

As a result of their participation in CH, more providers and JJ professionals were considering new ways of helping clients. The wraparound training helped to put the focus of treatment on the family and the community, and away from clinical settings.

**Accountability**

Providers and JJ professionals associated CH with accountability. They argued that CH would cultivate greater accountability among providers, because of their long-term commitment to remain with specific clients. Providers noted that there had been the tendency in the past to assume other individuals were responsible for the oversight of a case involving multiple service providers, and that CH had called this assumption into question. One provider explained, “From the family’s point of view, there’s someone going through the process with them that knows what’s happening and where the gaps are.” The communication and coordination that takes place under the CH, providers and JJ professionals suggested, prevented families from falling through the cracks and
minimized possibilities for service duplication. To a lesser extent, professional stakeholders observed that CH fostered accountability among participating families, as they were perceived to be the driving force of treatment plans.

Other themes related to this topic included difficulties with timely assessment, lack of client and family preparation, lack of system capacity, funding concerns, barriers to collaboration including scheduling, communication, and territorialism, as well as a lack of understanding across systems. These themes are described at greater length below.

II. Preparation

Providers unanimously stated that they were happy to be a part of CH. Although providers were pleased to be able to help develop CH, they expressed frustration at the lack of clear guidelines, expectations, and preparation for participation. Although the training they received in September 2007 was deemed beneficial, providers wished that they had received training much earlier in the CH implementation process. Providers also mentioned concerns and problems that they had encountered with billing, and worries about future audits. JJ professionals expressed mixed opinions regarding the preparation they had received. Some said that they had received information in meetings and in the same September 2007 training related to the wraparound concept. This training was referred to as “very good,” and was contributing to a philosophy shift within the JJ system. Other JJ professionals stated that they had received little or no training. As will become evident in Part II of this report, JJ professionals were not participants in the coaching made available to providers. Judges made it clear that they had received no preparation to facilitate their involvement in CH. All groups of professional stakeholders suggested that community resources and services must be considered during the preparation stages of CH and similar wraparound interventions.

Lack of Preparation and Timely Training

Although the September 2007 training that providers and their agency colleagues had participated in was “helpful,” providers expressed extreme frustration that it left questions regarding CH unanswered and that they had not received more preparation earlier in the process. One provider stated that the “Clinical Home project came, and training came after. To me that’s been really weird, because the training is vague of what Clinical Home really does.” Providers said they had received “virtually no training,” and described the entire CH implementation process as having put “the cart before the horse” (this was a common refrain in focus groups and interviews). Providers were perturbed that a clear and easily understandable definition of CH had not been imparted to them, even during the September 2007 training. Several providers discussed how the conceptual model upon which CH was based had never been fully articulated, and—in their minds—still remained elusive and, at times, confusing.

While responses to the September 2007 training were overwhelmingly positive, most providers believed it had occurred too late in the implementation process. Nor did the
training necessarily enhance their confidence as CH providers. One provider discussed her frustration with the training:

It would've been helpful had they showed us how they facilitate a meeting, instead of, “Here, figure it out, because that's how you learn.” Well no, it would have been easier if you just did one and showed us how you do it, because it's starting from scratch.” I know they do it to get everybody to think outside of the box and blah, blah, blah. But if [CH] started in May and now we're doing the training….to me that's not very efficient to just [say], “Here, figure it out, and we'll have another training whenever.” It would have been more helpful to actually see some hands-on or even videos of how they do it or something like that. Because this concept is foreign to a lot of agencies, this whole meetings including people and how they're run, how they're facilitated. So I honestly didn't think the training was very good; I left, and because I didn't know anything about Clinical Home before, hadn't really done it before, was like, “What? I don’t get this.” So I didn't think it was a very good training, but I was new to Clinical Homes; maybe that's why I didn't really get it.

Another provider said the training had been useful to her only because she had already taken steps to educate herself on the wraparound concept, both personally and through coaching sessions. Without this foundation, she stated, the training would not have been as useful. In her opinion, “where that real constraint came in is the training that we did was done in two days. And it was so many different areas that were addressed just for brief moments.”

Multiple providers expressed concern that not enough individuals participated in the training. One provider said the training “was very helpful. They were pretty clear. But the information hadn’t been dispersed properly, so there’d only be two or three people showing up to these monthly meetings. Where, in reality, it’s supposed to be the entire clinical team.” This concern was echoed throughout the focus groups and individual interviews, as providers pointed to frustration at the uneven education of professional stakeholders in CH.

One provider discussed feelings of betrayal that arose from her initial exposure to CH:

I was invited to one of the first meetings. My preparation was, "They picked you to be a part of this new program. It's nothing major. It's nothing extra. It's just a bit of tracking here and there when clients leave our agency." Then so I went to this meeting and three to four people came up to me afterwards and said, "You look like a deer caught in the headlights," because I was just shocked and amazed at everything I was hearing of what you were actually supposed to do. I left the meeting crying and wanting to submit my resignation because I was picked for the program, because it wasn't explained to me. After speaking to our coach from Milwaukee—and she's been very helpful. She's always available for any type of consultation. It was in speaking with her and speaking with two of our therapists at the time that knew a little bit more of what Clinical Home meant. But, yeah,
based on what my supervisor had told me, I ran back to my office and was typing my resignation.

Although this provider ultimately decided to stay and continue as a part of CH, she stated that more appropriate preparation would have eased her transition greatly.

Some JJ professionals indicated that they too had attended the “awesome” two-day training that took place in September 2007. Before this event, however, JJ professionals had received “very little” training and quite a few JJ professionals stated that they had received no training at all. One observed, “The JPOs got even less training than the clinician people got. We basically got an overview of what it was, and for months they had to keep telling us because we were like, ‘What?’” A few JJ professionals indicated that they had attended some “VO meetings,” but frontline staff were not typically involved in those meetings.

Judges did not receive any type of formal preparation, despite the fact they were expected to play a key role in CH. Echoing the sentiments of his colleagues, one judge said he learned about CH “on my own.” He added, “Any education of the judges on how [CH] works would be helpful so that we truly can be allies rather than working at cross purposes with each other.” Judges admitted, however, that their “busy schedules” also prevented them from participating in training opportunities and other CH events (i.e., treatment team meetings).

**Unclear Expectations**

Professional stakeholders noted that expectations and outcomes for CH had never been fully articulated by the state or VO—a topic discussed at greater length on pages 51 and 55. Their input regarding these expectations and outcomes was not solicited to any great degree. The resulting lack of clarification was a source of stress for individual providers and agencies. One provider stated:

I’m not sure any of us still know what it means to operate effectively as a Clinical Home, because the outcomes are not now, and I don’t believe ever were very clearly identified. As a result, the expectations for Clinical Homes have never been very clearly defined, and frankly, in training staff working with this project, that’s one thing I’ve really struggled with in terms of how do I teach them how to do this effectively, when I’m still not real sure what everybody’s looking for.

Another provider noted that “the biggest barrier overall systemically is that there [were] no clear expectations of anybody.” These unclear expectations not only affected CH personnel, but also the families who were to participate in the project. Providers agreed that families were not sufficiently educated in how CH was supposed to work. Time spent by providers educating families lessened their ability to finish an assessment within the allotted 72 hours.
JJ professionals recognized that lack of guidance on how to operate as CHs constituted a tremendous disadvantage for providers, as well as a constant source of stress in the workplace.

**Lack of Clarity about Assessment**

This lack of clarity, providers stated, extended to the assessment process as well, described at greater length on pages 34-38. One provider said that there “never were clear guidelines about what kind of assessment to do.” Another provider observed that JJ professionals did not understand how the assessment process under CH functioned, stating, “So we freed up a couple of Master’s level therapists to do assessments. We’re going to get these assessments started in 24 hours. JPO [Juvenile Probation Office] thought they were going to be finished, have a 10-page written assessment for psychological ready to go in 24 hours. It’s like, no!” This lack of clarity placed extra stress upon providers involved in CH. Many providers requested that requirements be spelled out clearly and concretely, in writing.

**Concerns about Audits**

The overall lack of clarity regarding intended program implementation led many providers to voice worries about being audited, stating that they were unsure if they were carrying out CH correctly. One provider explained:

> It instills a fear in you, because we know that we’re on the Fed’s radar, so it’s just a matter of time before they’re going to come and take a sample and audit all this stuff. And we’re going to have Clinical Home in there. In fact, I’ll give you a good example. We just got audited for our certification by CYFD [Children, Youth, and Families Department], and they didn’t have a clue what Clinical Home was. And they went in and looked at our roster and they go, “Clinical Home?” They pulled every one of our Clinical Home cases except for one, because they wanted to find out what this was all about. So that was really surprising!

Another provider said, “The training is vague. So I’m either billing too much or not billing enough. I don’t know what’s going to happen when they get audited. But it doesn’t make sense to me that here we are so gung-ho about this project and there’s so much not figured out.”

**Lack of Provider Knowledge of Resources**

JJ professionals in particular expressed concern that many frontline service providers lacked a comprehensive knowledge of resources available in the community to help youth enrolled in CH. One JJ professional tied this particular workforce issue to a lack of funding, which forced provider agencies to hire individuals with less experience:

> One issue is the amount of moneys available for staff. This is true of all agencies. You're going to hire people that may be fresh out of programs. And that speaks
to the issue of not always knowing what the resources are, because it's something that you have to build over time. It's not something that you just get out of school knowing all that stuff.

High provider turnover exacerbated this problem, as agency newcomers took time and resources to train, both in wraparound philosophy and available community resources.

**Clinical Home Capacity**

This chicken-and-egg problem was cited many times by providers and JJ professionals: agencies do not have the money to hire new staff without taking on more clients, but cannot take on more clients without hiring new staff to deal with the caseload. Providers and JJ professionals suggested that workforce capacity was an important issue that needed to be considered during the preparation stage of CH, especially if the intervention was to be rolled out in other areas of the state. High caseloads and a low number of employees emerged as serious problems within extant CHs, which limited their CH enrollment. Connected to this concern was the need for funding to hire, train, and pay additional CH personnel.

JJ professionals discussed their concerns about CH provider caseloads. Without enough case managers, quality of the program was compromised:

One case manager that I work with said, "One of my kiddos, the family has extensive protective services history, and what we want is intensive home-based services and police." They're having to refer to one of their other programs because the case manager that's currently overseeing that case, her caseload is so high, she can't go into the home two to three times a week….She's up to 16, 17 cases, and she's the only one in the agency right now that's a case manager that's overseeing the Clinical Home cases. And they need to get another person in there, but they don't have the funding for it. They don't have the staffing.

A further concern providers voiced related to the difficulty in providing services for the high number of clients potentially eligible for CH. This was tied to a general concern about funding. Both providers and JJ professionals argued that the needed case management structure was not in place when CH began. Providers mentioned the inability of agencies to hire sufficient staff to comply with the guideline of 10-12 clients per case manager. In addition, providers generally agreed that there were simply not enough available resources to maintain youth successfully in communities. This led one provider, amongst general agreement, to deem CH as a “classic unfunded mandate.” Providers worried about the ability to sustain this “valuable project” in the face of insufficient funding, and the effect that this would have on providing a quality continuum of care. Long-term tracking of clients, providers indicated, though crucial, also led to many unbillable hours and was thus another source of stress.
III. Coaching on Wraparound Service Planning

Providers generally agreed that working with CH coaches was a positive experience. The coaches were characterized as “helpful” and “flexible,” and most providers stated that the coaching was useful. Yet some providers indicated that they had received either not enough coaching or no coaching at all. Other providers found the coaching unclear and confusing. Another commonly voiced concern was that the coaching was provided long after agencies began to operate as CHs. In general, however, the biggest concern that providers voiced was that more agency personnel needed to be involved in CH and to share as the recipients of coaching. Finally, the coaching process brought up concerns for providers about how to operate effectively as CHs when faced with a lack of resources and available services.

Coaches are Wonderful and Available

Many providers were enthusiastic about the positive qualities of their coaches. One provider called her coach “wonderful,” stating that “she really pushes us to think about things in a different way, and it’s been valuable.” Other providers mentioned how coaches worked through specific scenarios with the treatment team, helping its members to understand better the workings of the wraparound process. Coaches were available for brainstorming sessions, working through treatment plans, and staffing difficult cases.

Providers stated that their coaches were available through phone and e-mail contact. The frequency with which providers were in contact with coaches varied, but nearly all providers agreed that the coaches were available to talk and help whenever needed. One provider stated that her coach was “always available because I don't call her at her office. I call her on her personal cell number. She's that willing to help out, to give out her personal cell number and say, ‘Any time.' And there hasn't been once that I've called that she's not responded.” Another provider mentioned that the usefulness of phone and e-mail communication was such that “it feels like we have an ongoing relationship even though we only get to see her once a month.”

Utility of the Coaching

One positive quality of the coaching process was the flexibility given coaches and agencies “to really define and identify what they wanted out of the coaching.” This flexibility allowed coaches to help with weaknesses and concerns specific to each agency. One provider stated, “the coach came in and literally the first day was like, ‘Well, what do you need?’” However, this provider continued, without a clear understanding of the wraparound process, which should have been imparted during the initial preparation stage, it was difficult to tell the coach what kind of help was needed.
At times as well, the information provided by the coaches (one example was sample service plans) was overly simplistic and not implementable.

By and large, the providers rated the coaching as “very good.” One provider commented, “None of what she’s presented have I found to not be useful.” Another provider echoed this sentiment, stating that, “the coaching, for us, has been priceless.” Several others described the September 2007 training centered on “the wraparound model” as “great.” They suggested that the overall coaching experience would have been even more useful had this important training been provided to them and other professional stakeholders earlier in the CH implementation process.

Indeed, some providers described the coaching as less helpful than did their colleagues, primarily because of the lack of training that characterized the initial months of CH implementation. The coaching, moreover, did not begin until this implementation process was well underway. Thus, providers voiced their frustration at only having coaching made available to them after their agencies had begun to operate as CHs.

### Not Enough or No Coaching

A small number of providers stated that they had not received any coaching at all. Significant worry centered around the fact that the coaches were only available for a limited time, after which time providers would be on their own. When one provider received an e-mail from her coach mentioning that the coaching would soon be over, “that e-mail, that scared me, because she’s been the constant.” When this provider shared with other participants in the focus group her concern about having a limited time to work with the coaches, other providers expressed surprise and dismay at learning then for the first time that the coaches would soon no longer be available.

### More People Need to be Involved

Of all concerns voiced by providers, the greatest was that not enough people had been involved in either the coaching or the September 2007 training. Frontline service providers in particular tended to be left out of coaching and training opportunities. One provider mentioned, “At our agency I think that the case management supervisor calls for coaching when she feels a need. The direct service people don’t know anything about that. I just happened to hear that. Otherwise I wouldn’t know.” Other providers said this had also been the case at their agencies.

One provider clarified that only clinical directors and supervisors had been involved in the wraparound training. Another provider expressed “regret” that the initial training had not included more frontline service providers:

> The only regret that I have is that we didn’t open it up to a larger group of people within the case management program initially so that we had more people on board. Because we’re having to go back to do a lot of training. And so, having more people opened up to it would’ve opened up a broader discussion. We
could’ve ironed out some [issues], had some discussions around some questions we realized later and not necessarily in the training. It would’ve been healthier to do that. Because what I realize is that we are going to need to have an ongoing training program, because case managers move up or go into other agencies, and so you got new people come in that don’t have any clue what really wraparound is. And that’s one of our interview questions, “So, to you, what is wraparound?” And it’s amazing the answers you get from that. I mean, I’ve wanted to run a video, because it’d almost be comical to see some of the answers that you get when you ask that question.

If providing training or coaching solely for supervisors and clinical directors was going to be the strategy for disseminating information on how to operate as a CH, one provider suggested, then “the approach needs to be taken that you are training the trainers, because this training needs to stay alive somehow and be taken back so that’s part of that ongoing process.”

**Lack of Community Resources and Services**

The coaching, in addition to the September 2007 training, made professional stakeholders acutely aware of incongruities between the wraparound philosophy and the harsh realities of the New Mexico service delivery context. Providers and JJ professionals often expressed apprehension about the ability of New Mexico to put into practice a fully functioning wraparound program. One provider explained, “The idea of wraparound was great, but I don’t think our state is at the point that we have that support to implement those wraparound services yet.” There was pervasive concern that moving children into CH without needed community resources and services in place was setting them up for failure. Even when needed services were available, providers mentioned that they were not always billable:

The 24-hour on-call service, for example, when the kid’s acting out at midnight, they can pick up the phone and you would have a case manager respond. But there’s no way you can bill for that or put together a team. So the funding is a huge issue. But that right there, if you could go into the home and deescalate, verbally de escalate a situation, the police didn’t have to get called, the kid didn’t have to go to the hospital for an evaluation. You had maybe a couple of case managers and a therapist respond just during that initial time until you could get some of these other services in place, then we would see a greater success rate in keeping our kids in the community.

JJ professionals also expressed frustration at the lack of services needed to successfully maintain youth in their communities. One JJ professional stated:

It’s very confusing for us. We’re being told money is being taken from this higher-up pocket because it’s not good to institutionalize a child, whether it’s detention or treatment. That makes sense to me. Then give me services in the community to place kids so that they can go home at night, but they have the support they
need. So intensive outpatient for a drug user means three or four times a week—that sounds pretty reasonable to me—they said, "Oh, well, just do outpatient." Well, once or twice a month doesn't work for a drug user.

Yet a second JJ professional observed:

The main issue that I see is that there is a lack of capacity with intensive outpatient type of programs. They're supposed to reduce RTC beds, which is fine. But if you don't have the capacity in the community to absorb that with the intensive outpatient, then we have a lot of kids that sit in the detention center on waiting lists for outpatient types of services, and they're certainly not getting any better while sitting in the detention center.

Another related concern JJ professionals voiced was that CH providers were unable to hire sufficient staff to deal with the number of youth referred to their programs.

Such concerns led many providers as well as JJ professionals to question why New Mexico’s CH program was based upon the Milwaukee model of wraparound care, as this model was a highly funded, urban-oriented program. The feasibility of transferring this model to New Mexico, a resource-poor and predominantly rural state, caused a great deal of concern and discussion.

Professional stakeholders emphasized the need to evaluate existing community support services before implementing a CH program. This would decrease the stress placed upon providers and enable more children successfully to stay in their communities.

IV. Referral Process

Providers and JJ professionals expressed significant concern about the CH referral process. Although some mentioned that the process was family-friendly, consumer-responsive, and allowed for better screening of enrollees, the majority of comments addressed problems in the referral process. In short, the referral process was “complicated” and “off-putting.” Families did not respond well to referral calls coming from out of town. Once the family agreed to be part of CH, there were difficulties in choosing a CH. Once a CH was chosen, there were problems in locating the youth. Coordinating with children who were in detention centers had initially been a problem during the referral stage, but that had been resolved. The JJ professionals, in particular, expressed their frustration at not being able to give feedback on the referral process.

Judges were generally unaware of how the referral process functioned, although they suggested that it was working reasonably well. However, the judges believed that the process had not taken advantage of the “special knowledge” that they possessed about eligible youth.
Family-Friendly, Consumer-Responsive, Enables Screening

A small number of providers stated that they liked the referral process. One provider explained “The strength of the referral process is that it is very family-friendly, it is very consumer-responsive, and [the VO] group is working real hard to maintain that, to maintain family choice.” Another positive element mentioned was the ability of the referral process to screen which youth were appropriate for CH. While they harbored concerns about the referral process, providers believed that the process had improved over time, and that there was growing cooperation and coordination between key players inside agencies, across agencies, and with JJ professionals. One provider’s comment illustrated the changing attitudes about cooperation: “Before, we all just tried to take care of it ourselves and we didn’t necessarily refer out until it got really bad, and then who wanted it? So it’s really like we sit at a table and say, ‘What does this kid need and who else can do this?’ So that’s been really good.”

JJ professionals focused largely on their concerns about the referral process, but they did mention that referrals were taken in and assigned by VO “pretty quickly.”

There was consensus among the judges that their colleagues in the JPO usually made the referral to CH, and the judges approved it, when they deemed it appropriate. This was the extent of their knowledge regarding referrals. The judges suggested that the referral process worked reasonably well.

Referral Process Complicated

Some providers were hard pressed to describe how the CH referral process was meant to function. One provider characterized the process as “Machiavellian.” Another stated: “I couldn’t even define how it went, but the call comes in and then goes to VO, and I don’t even know, but it was very complex to me and a lot of tight control, sort of ambiguous and then all of a sudden the case would or would not drop from the sky and you’d be handed it.” Others mentioned that at times, only a name would be shared with the CH, without any other contact information, thus further complicating the process. In areas where JJ professionals worked especially closely with CH providers, probation officers would often inform providers that they had referred youth to VO for CH. In an effort to streamline the process, providers would prepare for the eventual call informing them that the family would be in their CH. Providers working in this manner reported being told they “were messing up the process.”

Initial Contact with Family

Providers discussed many problems in the referral process that centered around issues concerning the family. The first was the difficulty in getting in touch with the family within the allotted 24 hours. Problems cited included lack of contact information attached to the referral, families who did not have phones, or whose phones were disconnected, or
who did not answer calls, particularly those from potential “telemarketers.” Once families were contacted, some providers mentioned there were problems in finding the youth. At times, parents were unaware of the whereabouts of their children, complicating the timely assessment process.

Out-of-Town Contact a Problem

Providers and JJ professionals often attributed family resistance, discussed below, to the referral process. Families, they reported, were uncomfortable receiving a call from someone they did not know. One JJ professional described the process:

It is done within our office. It goes to <name>; and then from <name>, he'll call it into the VO people. And then they in turn will get with the people up in Albuquerque. They will then call the family to present the program to them and not knowing who they are, that's where the break is. See what I'm saying? If it was somebody locally that they already know, that would be so much easier for acceptance into the program.

Another JJ professional noted that including this extra non-local person or office into the referral process provided the families with "zero connection," and told about a mother who only accepted her child being admitted to CH because a JJ professional whom she trusted explained the process to her and told her what she could expect. The JJ professional shared, “If somebody would've called her from Albuquerque she would’ve flat out said, “No way.” But because she knew who we were, after we got through explaining the process to her, she said, “Okay, I'll take it. There’s no problem. It'll help my family.” Another JJ professional stated that using an out-of-town referral center slowed down the process of getting a child admitted to CH. She expressed annoyance with not being allowed to play a bigger role in the referral process:

I don’t know why they don’t just trust us to have the probation officer who knows the family and how to get in touch with them to call the family, say, “We want to offer you Clinical Home. We can explain what it is. We’re not going to move your kid out of your house. And here are the agencies. Here’s one right in your neighborhood.” They won’t budge on that.

This JJ professional echoed a commonly expressed sentiment: that JJ professionals feel that their abilities, strengths, and expertise are not being effectively used in CH.

“Clinical Home” is a Confusing Name

The observation that the name “Clinical Home” was confusing or misleading was repeated in all CH personnel and JJ professional focus groups and most individual interviews. Upon hearing the name, families frequently drew the conclusion that their children were going to be placed in an RTC or a detention center, rather than in a wraparound service program.
One JJ professional stated that this problem had been brought up with policymakers:

My big problem from the beginning is the fact that this is the VO-driven program. We, JJS [Juvenile Justice Services], we didn't have any input in it. When they had the Clinical Home dialogue, we all went back and we said the JPOs are having a hard time with this Clinical Home concept. Even when you provide the information, then they have to transfer it to the family. The family thinks it's a home. It's a place they went. My idea was that they were going to hear us. Oh, no, they didn't hear. They had already made the decision it was going to be the Clinical Home and it was the Clinical Home. And VO wouldn't change the title. Now, that is not engaging the community, in my way of looking at it.

Families were misled by the name, assuming that “Clinical Home” was an actual place, a residential treatment center or a detention center where the child would be placed. One JJ professional commented, “No matter how many times you tell them, ‘Okay, this isn’t a home that we’re sending your kid to,’ they keep perseverating over the name of it, Clinical Home, thinking that we’re trying to take the kid out of the home and put them someplace else.” Parents who could no longer deal with their children were often eager to be a part of CH, as they assumed the children would be placed in a “home” other than their own.

JJ professionals were of the opinion that families were insufficiently prepared to take part in CH. Many families had received little or no information about what participation entailed. One JJ professional suggested:

If they did an orientation for the family before we ask them, “Do you want to join this?” that would help us. That way they can explain their own thing to them, their own program. And then ask the family, “Do you want to participate?” Other than us just going up to the family and saying, “Hey, you know,” our little spiel about [what] we know. It’d be more effective if they like did maybe once a month a group orientation of families we’re considering to refer. Then the family can say, “Yeah, I do want this for my family,” or “No, I don’t.”

In sum, providers and JJ professionals suggested that a lack of understanding about the referral process and CH in general caused some families to become “nervous” and “uptight.” Both providers and JJ professionals also cited the paucity of informative CH materials to disseminate to families. Despite having great number of families in CH who were Spanish speakers, there were no Spanish language CH materials available.

Lack of Family Education and Informed Choice

Providers and JJ professionals underscored a lack of family education, clarifying that many families were unaware of what CH was. One provider said, “I had cases where parents were consulted, and we’d go out there, and they’d be like, ‘Who are you?’” Another provider added:
As I’m sitting here thinking about how it can be improved…instead of the urgency on getting the referral into the provider’s hands, that maybe a day or two could be spent meeting with the family and giving them some options of availabilities. Really putting them through a slight education process so they know that Clinical Home is not a place, that it’s really a service. And then when the referral gets to where it’s going then you wouldn’t have people that you couldn’t get a hold of, because they would actually be looking for your call. A lot of people have no clue that we’re contacting [them]….That is a barrier to overcome just to get in the front door. Because when you say, “Clinical Home,” they could be thinking you’re there to take their kid away. There’s a real education piece of what Clinical Home is, the benefits of it to the family before we get involved. Since VO is the gatekeeper, I think that is a responsibility, and initially they said they would bridge that gap. I don’t think that’s happening.

Guidance in choosing an appropriate CH to meet the family’s needs reflected another piece of missing family education. Multiple providers stated that VO was “telling the parents the names of the programs but they wouldn’t tell them what those programs did. So the parents were trying to make a decision of choosing one and had no clue.” Several providers stated that families told them they had chosen a CH based on the agency’s name, as they were uninformed of what services the agencies provided. One provider mentioned that she had suggested a solution to this problem, but her input was not heeded:

I remember sitting at some meetings, saying why don’t you at least describe some of the services that we offer, so they can make an informed decision. They would have none of it. They said we are not doing any marketing, we’re not going to market anybody. But I’m not asking you to market anybody, I’m merely asking you to give them that information so that they can make an informed consent. But that’s not going to happen.

As agencies often have a certain specialization or focus to their services, providers insisted it would be more logical to provide families with information that would allow them to find the most appropriate agency to be their CH.

JJ professionals likewise expressed frustration at their inability to counsel families as to which CHs they ought to choose. Although the process was designed to prevent the “marketing” of one agency over another, silence merely kept families in the dark and prevented them from making an educated choice. One JJ professional commented:

The family really is not informed. Somebody calls me and says, "I have five Clinical Homes, and I have no idea where they are. They want me to make a decision." I don't think it's fair for the families. As a clinical person, I feel the need to inform the people in the community what they are all about and what kind of services they provide. But we, the people working with the families, are not supposed to be influencing them either. So one of the ways that we're doing it is, we're saying, "This home, we had referred a whole bunch of kids to this home,
and the results have been positive." So the family will say, "Okay, maybe we'll go with that." It's very complicated. They're not informed.

Quite a few JJ professionals called for a more “locally-driven referral process,” as did several providers. Families in Las Cruces and Santa Fe had mentioned to them that receiving a phone call from a center in Albuquerque was a turn-off, as mentioned previously. They argued that families would be more receptive to participation in CH if they were to receive a call from someone from their local area.

Detention

One issue that had originally been a problem was the initial contact with and assessment of youth housed in a detention center, as “the detention hours were not matching the time they were coming to see the kids.” Both providers and JJ professionals reported that this issue had been successfully resolved.

Lack of Ability to Give Feedback on the Referral Process

A final concern of professional stakeholders pertained to their perceived inability to give feedback on the referral process. One JJ professional stated, “We asked if we could call the Resiliency group in Albuquerque, talk to them about how they’re progressing, and they’ve told us ‘No, we’re not allowed to talk to them.’ They refused that request.” This caused JJ professionals to feel disenfranchised and in the words of one JJ professional, “paranoid.”

V. Timely Assessment

There were providers who did not consider CH assessments to differ much from the other assessments they performed, with the exception that they had to complete CH assessments within a truncated period of time. Yet other providers believed that the quick turnaround time compromised the quality of CH assessments. Overall, providers were of the opinion that the timely assessment requirement needed further explication and that it was a significant source of stress within their agencies. Professional stakeholders, particularly the JJ professionals, noted that the CH assessment did not replace the need for additional assessments required by the court or other agencies implicated in the care of CH youth. Judges were unsure if the assessments were conducted in a timely fashion, noting that they were not always privy to follow-up from the CHs.

Responsiveness to All

Some providers felt that there was no qualitative difference between CH assessments and others and that the timely assessment process was working relatively well for now. The compressed timeline requirements were sometimes mentioned as a difference, but many providers felt they tried to be timely in their responsiveness to all their clients, not
just CH clients. There was awareness, too, that assessments were “works in progress,” and that situations with families and youth could change very rapidly. One provider explained the process: “We can get any kind of kid and do an assessment, and a week later we’re gonna have more information than we did at that assessment. So, when we have kids that are sort of emerging situations, family, self-referral, we do it in 24 hours….But we know that that’s gonna have limitations inherently, and that what we even see a month later’s gonna be different. So it has to be a living, breathing, progressive document anyway.”

**High Quality Assessment?**

Providers believed that CH held “the potential to fill some objective assessment or direction towards appropriate levels of care.” One provider stated that “at least one goal or positive that can come out of CH is a more objective assessment of the services and levels of care and resources available in the state. What is most appropriate for this kid.” This speaks also to the previously mentioned ability of the program to create individually-tailored treatment programs. Several providers, however, felt that completing a high quality assessment within 24 hours was near to impossible. It was easier if the youth was in detention, but interactions with the families could be difficult, especially if the family had not “bought in” to the process.

**Age of the Case**

One provider discussed the “disconnect” between the 24-hour requirement and the fact that the “case,” by the time they received it, might have been two weeks old. While they still responded with haste and urgency when a youth or family was in crisis, when a case was already weeks old, they felt a bit more leeway in proceeding with the family. The provider explained:

> I agree with the timely assessment philosophy, because you get out there while their need is great. You do everything you can, whether it be beginning mental health type assessment and then get your therapist a day later or whatever. But again, it was like we were using a philosophy that we use when someone calls in need, in immediate need on a stale or an older case situation. So there was a little disconnect there. I mean that it keeps you on your toes to get out there and service these families quickly. Timely assessment is an important aspect of the kind of work we do. But again, can they wait ‘til Tuesday? Yeah, they’ve already been waiting two weeks, and they don’t know.

**Unclear Assessment Requirement**

Perhaps most perplexing to providers was the lack of clarification from the state or VO about the type of assessment required. Providers indicated there had been a great deal of misunderstanding and/or miscommunication about the different levels or types of assessments required by the CH program as well as by CYFD. Most providers felt that the system was “disjointed” and evinced strong opinions about which type of
assessment was possible to complete in 24 hours and which type was really needed to move a youth forward in the treatment process. One provider explained:

We come back to what the definition of assessment is, because I could do a preliminary service type assessment. What are the general needs? When I want to produce a report in 24 hours that's going to go to court to help determine some serious things on this kid, I want to get collateral, I want to do a comprehensive assessment. And so again, that idea of if we're assessing it for the Clinical Home purpose to stabilize the family to begin to look at what the needs and resources are—but if you want something level two, level four for the court—you couldn't do that in 24 hours or even 72.

Another provider said, “So, they were expecting us to do a full blown level two with all the diagnostics, the collateral, everything. 'We'll just up it to 24 hours; just take one of your therapists off and just devote their time fully to that.' It's like, 'No, not.'”

Further problems regarding assessment stemmed from the expectations and timeline concerns of the judicial system. One JJ professional explained:

We were told at the beginning that once the referral was made that there would be a treatment plan in 72 hours. Well, the judges hold on to that, the lawyers hold on to that. And the referral may be made, but if the clinician or the Clinical Home cannot get in touch with one part of the loop that they need to get a release…it gets really sticky. So kids are sitting in detention longer than they were sitting before because of Clinical Home, because it's taking them too long get things in place. So we have this magic number of 72 hours, and they were thinking, okay, poof, everything should happen. Well, it doesn't if you don't have the releases. So what's happened with a couple of our families is that they meet the parent, they meet with the child, they come up with a plan. But then what the Clinical Home has done is they said, "Well, we want to look at TFC [Therapeutic Foster Care]." So they'll get a release from one agency, for TFC. And then if they don't have a family, then they have to start all over getting releases again. And it's creating a lot of trouble because we've got kids that have been sitting in detention going on two months—waiting for something that I think didn't have to take that long. But it is very difficult, because kids are waiting to get stuff done, and it's not fair to the child to sit in detention because we can't get our stuff together.

JJ professionals also commented on the unfairness of leaving children to wait in the detention center while treatment teams took up to 30 days to put together comprehensive treatment plans.

Judges felt “out of the loop” regarding the assessment process, and were unsure what happened with youth after they began their CH tenure. One judge discussed his confusion:
I’m not sure if their assessments are different than what is usually performed. I’m not sure if they’re more comprehensive or less comprehensive. We have different types of assessments so I’m not sure how comprehensive they are. There’s some assessments that are very general, just determine what the overall situation is with respect to a child and doesn’t do psychological testing. Other assessments are much more detailed in our psychological assessments so I’m not sure what they’re doing in Clinical Home.

Judges asserted the need for further information regarding the overall CH assessment process, as well as updates on youth who have participated in CH assessments.

**Inaccurate Information**

Several providers felt that the assessments they were seeing were not of high quality. This was said mainly in reference to the quality of work coming out of other agencies besides their own. One provider stated:

Sometimes you hope that that collaboration is accurate and correct, but it’s not. One time I had this one girl and I went over, "Okay. This is what they told me in regards to history." She goes, "That's wrong. That's the wrong sequence." So everything—I just discarded that assessment that they sent me, and I started from scratch. And it was very difficult, because these were numerous placements in a certain sequence. And they omitted a lot of stuff, added stuff that didn't even apply. You have to start from scratch if it's wrong.

**Timely Assessments as Source of Stress**

Providers all noted that the timely assessment process was causing a great deal of stress and anxiety in their agencies. One provider brought up angst associated with the timeline:

My role is to within 24 hours go do an assessment. Now, we were recently told we actually have three days instead of one day. But the assessment is supposed to include an interview with the client, with the family, with whoever else is involved. The thing’s supposed to be written up and faxed to VO within 24 hours. That’s crazy. You can't do all that. I can't do it. So, this is the plan upon which everything is based, initially anyway. And there’s not even sufficient time to do it.

A second provider described how her agency struggled to comply with timeliness requirements:

We have a protocol that when the fax comes in our receptionist grabs it and she makes copies of that fax and it goes to our department, it goes to the outpatient department, to the clinical director, and then it goes to our [case management] department….And within that, immediately we start looking for who the assessor’s going to be based on their availability. And if nobody’s available then
we start moving things around to make that happen. And when we see that fax come in it happens immediately. And then people are getting phone calls in the field, and we’re communicating very tightly, so that it doesn’t get overlooked.

Finally, a third provider characterized the timely assessment process as a nerve-racking, crisis-type situation, akin to firefighters responding to a call: “It’s like the fire alarm going off and we’ve got people pulling on their boots and running down the pole and jumping on the truck, and going out there. And then you got to get in there and overcome the barriers at the front door.”

Providers emphasized the frustration of trying to comply with the assessment requirement, which became especially difficult when families could not be reached within the allotted time. Even if a treatment plan could be put together according to the designated timeline, providers believed that it would not be one that was particularly good or useful in the long term.

This process broke down when referrals were received on Friday afternoons. This appeared to be a universal issue that agencies were contending with. One provider shared, “I keep a spreadsheet of all the referrals and it’s true, we’ve gotten more on Friday afternoons and the day before a three-day weekend.” Some agencies addressed this situation by working all weekend, while others put off the assessment until the following Monday.

**Problem of Multiple Assessments**

One JJ professional described timely assessment as a promise that “doesn’t have a lot of meaning behind it.” JJ professionals described their disappointment as assessments did not always get done in a speedy manner, which at times led to children returning to detention or the hospital when immediate intervention was not accomplished.

To JJ professionals and the judges, creating a new assessment was a redundant activity, as in many instances assessments had already been completed for the youth involved. Both parties were concerned that the emphasis placed upon the production of a new CH assessment wasted time and resources. Moreover, the judicial system often required assessments sooner than the CHs could provide them. According to one JJ professional:

The court really does determine for the most part when we can get an assessment and when we cannot get an assessment. So by the time we make a referral to Clinical Home, we already go in there with an in-depth forensic evaluation that we provide to the Clinical Home. I do not believe that the Clinical Home goes and does a full blown other…assessment. They assess the case based on the documentation that we’ve provided them. But I don’t think we’ve had a Clinical Home that has actually gone in and has assessed the kid. Not with a battery of psychological tests….They have a meeting, and they do what we call a level two, which any of our social workers can do that. It’s just eyeball the data,
look at the referral information, and come out with some kind of a plan. It’s really more of an assessment plan for what they’re gonna do. They say that they can do level four, but I don’t think there’s ever been a need for them to.

JJ professionals felt that doing another assessment was redundant. They were also concerned that “start up” time took too long, particularly in agencies where high case manager turnover was a problem. In addition, JJ professionals felt that the timely assessment requirement placed an undue burden on providers, families, and youth, who, in many instances, had already participated in numerous assessments. In these instances, timely assessment represented another “demand” placed on clients and families. JJ professionals were more inclined to offer “assistance” to youth and families rather than make more demands on them. Moreover, JJ professionals alleged that there was not much of a difference in the type and/or quality of an assessment done for CH youth versus those youth not involved in CH.

VI. Treatment Process

Providers typically argued that the treatment process under CH did not differ much from the treatment process utilized with non-CH clients. Nonetheless, providers did recognize the importance of the collaborative team meeting comprised of informal and formal supports, and suggested that this feature of CH was relatively new. JJ professionals, in particular, appreciated their involvement in these meetings, despite uneven participation. In short, professional stakeholders observed that CH facilitated greater engagement and better communication regarding treatment processes. Nonetheless, room for improvement was noted in the areas of coordination, cooperation, and communication, especially with non-CH personnel and/or non-CH agencies. The CH and JJ system interface was sometimes marked by tension, and judges felt that they had little to no voice regarding decisions impacting children in CH. All professional stakeholders spoke of the possible demise of residential treatment within New Mexico, and argued that residential treatment was warranted in the care of some CH youth.

Greater Engagement

One positive and hopeful development to come out of CH, according to providers, is that they themselves were trying harder with the CH youth and families. One provider put it this way: “Honestly, I’ve seen us—within my own agency—push a little harder to stay with kid and family and to engage with them in a way that in the past we might’ve said, ‘Okay, we’ve done what we can. And you know what? We’re here for you when you want to come back.’ And I’ve seen us push beyond that a little more in some positive ways.” Another stated, “We’ve been more proactive, too. Like when one of our kids have been in one of the psychiatric hospitals or the hospital-based RTCs, we’ve been more active in pushing our way into the treatment planning and then the discharge planning and making sure they don’t fall through the cracks.”

Better Communication and Collaboration
Related to the above was the idea that there was better communication among professional stakeholders and families, which included the concept of “family-kid participation.” Providers and JJ professionals felt that if youth and families were “at the table,” then they were participating, or “buying in,” and that was positive. Some providers felt that the training helped them cultivate better relationships with other service providers. Providers felt strongly, too, that treatment was not, and in reality should not be, different from the “regular” treatment provided to non-CH families. All clients should receive the same treatment based upon best practices.

Some JJ professionals were quite pleased with what they saw as a major benefit of the CH process: greater cooperation among professional stakeholders. One benefit of this enhanced cooperation, especially between JJ professionals and providers, was that the youth were not as able to play one professional off the other. One JJ professional explained, “We try to provide a united front….I think too that the unity between Clinical Home and probation has been good, because there hasn’t been splitting when the kid will play one on the other.”

JJ professionals appreciated their involvement in the treatment planning process, which occurred during the monthly meetings. Not only were they present at the meetings and thus kept up-to-date on the progress made by youth in the program, but they were also an integral part of discussions regarding which treatments were best for certain kids. One JJ professional explained:

Once we find out who has the kid, we often give a lot of input into what we think the treatment should be. Like one family, one of the early ones went to <program name>, and we said, “This family needs multi-systemic therapy;” and they did it. And we didn’t want them to just handle it with their resources; we wanted them to farm out what else the family needed that they couldn’t provide. Agencies have been real good about that.

Occasionally, differences in perspectives manifested themselves. One JJ professional stated:

Clinical Homes have gone into the court when we’ve asked them to explain to the judge, “This is the service the kids are going to receive.” I know we don’t always agree 100%. We may have a little bit different focus, and that’s fine, because we agree to disagree. But our collaboration is open enough where we can have these discussions to say, “Okay, we understand your perspective, you understand our perspective. Let’s come back to the table and make it fit.”

Judges were overwhelmingly in favor of collaboration, but found that collaboration did not extend to them. One judge stated, “Well, if someone was willing to collaborate with me, I’d be happy to collaborate back.” Underscoring her experience of collaboration in CH, a second judge said, “Whatever the court thinks seems to carry no weight at all.”
Lack of Coordination, Cooperation, and Communication

One problematic aspect of the CH experience for some providers was that coordination, cooperation, and communication within their own agencies were sometimes lacking. This lack of coordination among provider colleagues was in distinct contrast to increased levels of cooperation and communication between providers and JJ professionals. One provider explained:

I've talked to other supervisors and told them I've got deadlines that I have to meet. That's why treatment team meetings take place, things like that. Honestly, probation officers have dropped their schedules. When I call them—I can call a probation officer and say, "We need to meet at this time so the child doesn't miss too much school." They'll do it. I can ask somebody within our agency, "Sorry. Can't do it." They're not willing to move their schedule around sometimes. And that's very frustrating. My difficulty sometimes in scheduling a ten-person treatment team meeting is our staff.

Due to scheduling conflicts, it was difficult to get all needed individuals—not just CH personnel or JJ professionals—together in a timely fashion. Scheduling was complicated by problems of territoriality within the broader community, with one provider disclosing that it was difficult "trying to work out the logistics of who's going to do what without people feeling possessive" when interacting with non-CH sites. Another provider added:

When you are referring out services to other places, services are so used to owning that client, and it's hard to share among all and have one person being the facilitator, because everyone wants to take on that role. And, I mean, we all want to help, and if you're just doing a small part of the thing, it's hard to just do that small part.

Clinical Home and Juvenile Justice System Interface

At times, a lack of understanding one the part of JJ professionals of the CH program and of CH providers of the JJ system led to tension, especially in situations involving the judges. JJ professionals did not have a thorough knowledge of the benefits or workings of CH when the intervention was first introduced, and judges possessed even less knowledge. One judge was told that CH was on the horizon—“The phrase was used ‘this is coming to a theater near you’”—during a single lunch meeting. The judge was not given any further information until the program had been implemented. The judges were concerned that they had not been consulted during the planning stages of CH. The judges and other JJ professionals suggested that CH had been “imposed” on them. As a result, they lacked a good grasp of CH when it was first introduced, as was the case with their provider colleagues in the CH sites. The newly designated CH providers, in turn, were charged with the “on the job” training and education of JJ professionals and judges, despite the fact that the underlying concepts and expectations of CH had not been fully conveyed to them.
Providers, JJ professionals, and judges stated that their relationships with one another were often “mixed.” In particular, the JJ professionals frequently felt as though the CH providers were not utilizing their knowledge and expertise effectively. Much of this expertise, they argued, derived from their past involvement with youth now enrolled in CH. One professional stated:

The Clinical Home folks need to be doing more communication with the JPOs, because some of these kids have been with these JPOs for long periods of time. They know the kids better than anybody. The major complaint I hear from the JPOs is that "I wish they would have called me," or, "Why didn't they call, because I could have told them." That call needs to take place before the assessment is complete, because that seems to be where things go awry and maybe they don’t get what the JPO and the JPO supervisor think is appropriate.

In short, JJ professionals were concerned that their own unique abilities and contributions were not being fully recognized and incorporated into the CH. Because they were typically left out of the loop with regard to the nuts and bolts of intervention implementation, the judges did not always understand the perspectives of other professional stakeholders in CH.

In spite of such issues, CH providers and JJ professionals often benefited from past working relationships that enabled them to navigate new terrain together. Members of both groups found themselves bringing others within their organizations up to speed on CH. One JJ professional shared:

We’re trying to get the JPOs to buy in and tell them, “This is the benefits of doing this,” and we don’t even really know what this Clinical Home was. It was tough for the first few months. I’m going to say there’s still certain staff that believe, “Why make referral to Clinical Home? What am I getting out of Clinical Home that I’m not already getting from other providers?” But a lot of staff are working really closely with Clinical Home.

JJ professionals discussed the difficulty of explaining CH to clients when they did not have a full knowledge of CH themselves. One JJ professional asked, “If we don’t know, how is the family going to feel comfortable about participating in something we can’t explain?” This JJ professional attributed the lack of understanding to inadequate formal training on CH.

JJ professionals also noted that CH providers did not always have an understanding of the JJ system, especially regarding their own work roles and responsibilities, and the general culture of the judicial system. This lack of knowledge occasionally led to problems in terms of coordination and cooperation. In addition, whereas some JJ professionals felt that they were integral to the treatment planning process, others felt that they were not. Specifically, they would like to be included earlier on in the treatment planning process, during the first stages, when treatment plans were being formulated.
A JJ professional explained, “So if we were part of the initial treatment plan, it would probably help moving down the road, because most of the time we’ve had those kids at least a few months, if not a few years.” Another JJ professional noted, “Or the Clinical Home doesn’t—isn’t even aware of the extensive Child Protective Services [CPS] history that the family has or that CPS is even involved, ‘cause the family doesn’t disclose that information. So then there's—there's a whole bunch of issues with that as well.”

Other JJ professionals were desirous of receiving any treatment plan, at any stage of the process. They felt in the dark about where their “kids” were in the CH process. One JJ professional noted, “We don’t get a treatment plan, do we?” Another replied, “No, I haven’t gotten one treatment plan, and I have five or six kids in Clinical Home.” A third stated, “I've seen a couple because I have seven JPOs. But based on how many referrals we make to Clinical Home, that's probably I've seen a handful and that's it….They should be meeting with us and giving us a copy of the assessment and the treatment plan so that we can know what we're doing with them, because otherwise we're working against them.” A fourth added, “Yeah, the JPO should really be a part of that process…..JPOs know much more about those kids.” In addition, to aid the providers in treatment planning, some JJ professionals think that they would benefit from further training in wraparound service planning.

There seemed to be widespread agreement that communication among providers and JJ professionals needed improvement, although it had certainly improved since the initiation of CH. There was a feeling that providers did not always understand or respect what JJ professionals did, and vice versa. This lack of understanding had caused problems in communication. JJ professionals argued that better communication among professional stakeholders would result in better treatment planning. Both groups spoke of the need to acknowledge cultural differences between the behavioral health service delivery and JJ systems.

**Demise of Residential Treatment**

Providers, JJ professionals, and judges all believed that RTC was fast becoming a thing of the past. Quite a few providers felt, based on their many years of clinical experience, that RTC was warranted in a handful of cases. One provider explained:

One significant barrier to working with the families has been, especially because the families are being told this is an alternative to residential treatment, is that we do not, in many cases, have alternative treatments to offer….That affects everyone whether they’re Clinical Home or not if there’s a push down in TFC or RTC. We’re like, “Great. Where to?”

JJ professionals expressed similar opinions. As discussed below in the context of recidivism, judges were vehement in vocalizing their concern that RTC had become increasingly inaccessible since CH was introduced. They argued that RTC denials were not in the best interest of some adjudicated youth.
VII. Involvement of Youth and Families in Treatment Process

Professional stakeholders suggested that the enthusiasm they brought to interactions, combined with a willingness to engage clients and families in new ways of treatment planning, influenced the level of involvement of CH enrollees. Nonetheless, some families were resistant to the program. Providers and JJ providers attributed this resistance to several factors. One factor related to the out-of-town placement call that occurs upon referral, which sometimes was interpreted with suspicion. Other factors included a lack of awareness and understanding of CH, lack of community “buy-in,” and CH program requirements, in addition to skepticism over the “equal partner” philosophy. Finally, while this last point did not pertain to the direct service provision context per se, providers did note that requirements for consumer representation in higher level meetings sponsored by the state and/or VO were problematic.

Provider Enthusiasm and Engagement

Several providers felt that their enthusiasm for and openness to CH communicated itself to the youth and families involved. The intensive involvement of case managers was also integrally connected to the level of involvement of youth and their families. One provider explained:

The extent to which they are equal partners depends on the case manager or the care coordinator...It requires additional work on our part. When we’re willing to do that then they become an equal partner. They need to be the leader of their team. Our job needs to be to prepare them to do that. We just become the scribe that really writes down what their needs are, and it becomes our job to help them figure out again on a partnership level what it’s going to take to make that happen. That’s the challenge.

Providers explained that it was their experience that the more “heard” the families felt within the context of the CH intervention, the more involved in the treatment and healing process they became. The providers communicated clearly their commitment to this aspect of CH.

Out-of-Town Referral Call

As noted on page 31, providers and JJ professionals were consistent in their view that the out-of-town referral call constituted a major barrier to family involvement. Some families had only agreed to take part after a local provider or JJ professional with whom they were familiar had explained the CH program, an apparent violation of CH protocol. Families also encountered difficulties understanding the information presented to them. One provider explained:

There’s been at least a dozen families that they have no idea what Clinical Home is. So we go in with the expectation that they know why we’re there, and what the
Clinical Home project is about, and we are caught a little off guard. And now we know to ask before and explain if we need to, but initially we were going in not thinking we needed to explain what the project was about, why they were chosen, who selected them.

**Family Resistance**

Both providers and JJ professionals commented that some family members resisted participation in CH. Whether due to a lack of awareness of existing problems, or simply a lack of desire to have strangers in the home “telling them what to do,” some families who might have benefited most resisted taking part in the new program. Reasons that family members disclosed to providers and JJ professionals regarding their non-participation included “I don't have any issues” and “I don't have time.” Some families simply lacked sufficient understanding of what CH comprised. One JJ professional noted that “at first they thought the home was a place—you took the kid away from the family and place them in this home.”

There were some families who were adamant that they did not want to be involved. One JJ professional recalled, “I've had quite a bit of my families—probably about four out of five of them call me and they say, ‘Nope, we don't want that. Is that something additional to do? You know, we don't want that.’ Because to some families it may sound kind of threatening…” Families were often concerned that the extra time and effort required to be a part of CH would create more of a burden than a relief.

One provider suspected that some families might not embrace the idea of being involved in the CH program because they perceived it as intimidating. One provider said, “The whole accountability thing for the families might be a little intimidating, maybe that there's gonna be such a big team, that there's gonna be so many people involved.”

**Community “Buy-In”**

The JJ professionals expressed specific concern that lack of community “buy-in” had adversely affected family participation in CH. Until the concept of CH and the actual program gained widespread acceptance within the broader community, families would be reluctant to participate. One JJ professional stated:

If you don't have that whole concept that the village is the one who's going to raise the child and help the child, then you're not going to be able to fix things. I was in a meeting yesterday for a client, and the mother said, “You know what? I appreciate what you do, lady. You're a nice lady. You're good at what you do. But I don't want you to come in my house and tell me what to do.” So you have the concept of all of us thinking that we need to fix everybody, when we're not the experts of their families. And we have to have a perception and a concept that we are there to assist them, not impose our values and our ways of doing things on them, because we're the supposed professionals. So if you don't have the buy-in from the community of what they're going to do to assist the child and then
you don’t have the buy-in of the community, which are the clients and the
consumers, which are the parents and the kids saying that we want this, then it’s
just not going to always work.

Initial CH Program Requirements

Providers identified several CH program requirements as barriers to youth and family
involvement. In particular, the requirement of a timely assessment could prove
“onerous” and “off-putting” to families. The guidelines that governed the timely
assessment process were also characterized as “disjointed” and “confusing,” and
sometimes families might be asked to participate in multiple intakes and assessments
depending on the level of care they were endeavoring to access. Providers made it
clear, however, that these additional intakes and assessments were often required by
the institution they were referring to rather than by the CH. One provider explained,
“Well they have to do an intake process with several agencies sometimes. Like we have
a kid who’s doing JCC [GET], family youth shelters, [and] therapy with us, and they still
have had to do a lot of repeating of the CYFD version of the assessment.”

Families “Don’t See” Options

Both providers and JJ professionals mentioned that some families were disappointed
when they became involved in CH, primarily because they initially perceived CH as a
means to access residential treatment. One provider explained, “Still some of the
parents have been sold on that they need residential by JPOs [and] other providers. It’s
always what they want, they don’t see options.”

Providers and JJ professionals speculated that the past experience of families in the JJ
system led them to believe that they did not have options. When options were now
presented to families, in spite of assurances that they had freedom to choose among
them, families found that they did not know how to navigate the new terrain. One
provider explained:

Historically the families haven’t really been as involved as they should’ve been.
It’s the role of the case manager to involve them and constantly go back and
remind them of their role and make them accountable. If a case manager is good
at doing that then the family is a lot more involved. Because historically or
traditionally they haven’t been as involved as they should’ve been—it [was]
easier to just have the case manager do it.

Echoing this concern, one JJ professional explained that the families often felt “stuck,”
believing that they had no control over the treatment circumstances and thus, “they
don’t always take advantage of the options of choice.”
Skepticism Over “Equal Partner” Philosophy

Providers experienced communication problems with some parents involved in the CH program. While these providers believed strongly in the “equal partner” philosophy underpinning CH, they had problems communicating to parents that “equal partner” did not necessarily mean that they could refuse treatment. A provider explained:

One of the things I have had to push with families is being an equal partner does not mean that you can refuse everything that your probation officer tells you they want you to do. We even went over it in our training in September, because I did talk to the coach and said, "Okay. Just so you know, side conversations, I'm hearing that the families are saying, 'See. See. I lead this team. So, therefore, I don't have to do what the PO tells me.'"

Coaches have been helpful in this regard, giving advice to the providers that has helped them address this novel problem.

Consumer Representation

Although this barrier did not pertain to the direct service provision context per se, providers did note that requirements for consumer representation at higher-level meetings sponsored by the state and/or VO were problematic. They noted that such requirements were often satisfied by consumers who were employed by VO, while other, non-VO consumers rarely attended such meetings. Some providers admitted that they felt protective of the families with which they worked. Although the providers were pleased to have them “at the table,” they were unsure whether the families had been appropriately prepared to be there. One provider explained, “It’s a shift to have families at the table with us. I don’t think any of us in this room are against it. It’s just very different.” Another provider shared:

Well, part of it [is] we want to protect some of the consumers from those meetings, which are upsetting for us…much less them. I’m sorry—I sometimes feel a little protective. But man, they don’t see it as, I mean, if my eyes are glassing over and I’m spacing out, they are too, even more. Is the system ready for the consumer? Is the consumer ready for the system?

VIII. Feedback from Youth and Families

The feedback from youth and families that professional stakeholders were privy to was generally limited. Some youth and families found the CH experience to be empowering and had taken advantage of CH offerings. Other youth and families were resistant to full participation in CH. Knowledge of the CH concept and the relationships of youth and families with specific providers influenced their perceptions of the program.
Limited Feedback

Feedback from families had been somewhat limited, according to both providers and JJ professionals. The judges uniformly claimed that they had not received feedback from youth and families about CH. As one judge put it, “I don’t get many thank you cards!”

Positive Feedback

Some providers had heard from families, and had witnessed in family demeanor that participating in CH had proved itself to be an empowering experience. One provider spoke of a youth who was enthusiastic over the prospect of being able to convene a meeting of her treatment team whenever she wanted (although she had yet to do so). Parents were also described as “more verbal” and “friendly” towards their children’s providers now that they had come to understand the CH process through first-hand experience.

JJ professional had also heard that families in CH felt “empowered.” One JJ professional said:

And I talked to two moms, and both said the same thing. They feel empowered. They feel like they have control over their family, instead of the system. And they like that. They liked being the ultimate person to say, ‘You know what? I do want this.’ Or ‘No, I don’t want that.’ Or ‘This isn’t working for me, so let’s change this.’ And they were listened to. They liked being able to be in charge of their family. And also it helped them to identify support groups besides Social Service agencies. They were able to ask their neighbor, “Can you watch my kid for two hours?” And that’s something that they didn’t even know was available to them, because they’ve never had a support system.

A few JJ professionals stated that families appreciated the ability they were afforded in CH to choose their own service providers. One JJ professional said, “I just remember that the parent contacted the JPO and said, ‘We really need to choose another Clinical Home,’ because they weren’t happy with the situation. They were allowed to do that. That's one good thing.”

Another JJ professional suggested that many families wanted to take advantage of CH offerings. He said, “Families that really want help and need help, they’re taking advantage of everything Clinical Home has to offer. I have one family that I’m thinking of that has engaged not only their child, the child has not only engaged, but the entire family is going to parenting support groups. They’re really trying to take advantage of the services that are being offered.”

Negative Feedback

While providers and JJ professionals were able to recount stories of families who had benefited from CH, they also discussed families that purposefully “elude” CH. On the
purely negative side, one provider speculated that the heavy-handedness of some JJ professionals could cause families either to decide not to participate in or to want to withdraw from CH. This provider explained:

There [are] a couple of families that really don’t want anyone in their business that have kind of pulled out or not shown up. And some have wanted to withdraw, and partially it’s been the Juvenile Justice of, “I’m not gonna let your kid move. You know, he’s 17. You can’t, you know, we don’t want you to leave town because there’s still this. He hasn’t finished probation.” Really, it’s the hammer stuff that have made them like, “I want to withdraw from this whole process.”

Feedback Dependent on Provider-Client/Family Relationship

Many providers felt that the type of feedback they had heard, whether negative or positive, was dependent upon whether the family liked specific services or a particular caregiver, typically a case manager. They found that the personal relationships forged between families and individual providers—and the quality and texture of those relationships—affect ed how the families perceived their experience in CH, as well as decisions to remain in the program.

Feedback Affected by Client and Family Understanding

Providers maintained that feedback, whether positive or negative, was dependent upon whether or not the family understood the CH concept to begin with. One provider said:

It’s kind of specific to each family. [With] some of them really, you’re able to explain it well to them and you’re just trying to provide them wraparound support for them. They’re all for it. Some of them are completely on board and they understand that. They’re just getting support and I guess some consistency and stability from somebody who’s gonna be there for an extended period of time.

IX. Recidivism

Professional stakeholders agreed that the concept of “recidivism” as related to CH required further articulation. They believed that increased attention to youth, in conjunction with the focus on the family and “out of the box” thinking in the context of treatment planning would ultimately help reduce out-of-home placements. Attitudes towards youth and their families were also changing under CH, as JJ professionals became more patient, allowing time for treatment plans to be implemented. In the minds of professional stakeholders, problematic referral processes and unclear goals and program expectations diminished possibilities for reduced recidivism. Professional stakeholders linked denials of RTC to reductions in out-of-home placements.
**Increased Attention**

According to providers and JJ professionals, the increased attention to youth, and the way in which this attention was spread out among stakeholders could decrease the likelihood of youth returning to the JJ system. Attention to youth was increased and maintained by better communication among professional stakeholders. One provider mentioned a case in which she credited the attentiveness and cooperation of the clinical team to the client’s success: “With everybody being on the same page and keeping tabs on her treatment….She was at risk at one point. But now she’s doing well. She’s attending school. She's totally turned around. I think with the Clinical Home team, that has really made a difference.”

**Focus on the Family**

One positive aspect of CH that providers believed could help reduce recidivism concerned the focus on the family and not just the “offender.” A commonly accepted premise of CH was that treatment needs must be focused on the family system. The whole family would need support in order to help the youth extricate him- or herself from the JJ system. One provider explained:

> It’s addressing not just one person, but it’s trying to address the problems in the whole family, and trying to get them to look at, “Look, you guys are a family.” And how can you work on your family [and] not just see this kid as the problem. That’s gonna be helpful, because that’s where so many of these issues come from is that we always just look at the kid as the offender or just the one problem. Well if you look deep, there’s a lot of problems in a lot of these families.

JJ professionals were also supportive of the focus on families. Echoing a common sentiment among his colleagues, one JJ professional explained, “Clinical Home has the potential to greatly affect recidivism because providers and services are targeting the families as well as the youth.” However, he cautioned that the program needed to be even more effective: “What’s going to make it more effective is that they be prepared with all the tools, the staff, [and] the services.”

**“Out of the Box” Thinking**

Providers felt that there was more “out of the box” thinking than prior to CH. Rather than just sending youth to detention, a common practice in the past, providers and JJ professionals were rethinking their treatment approaches to repeat offenders. One provider remarked:

> With the recidivism, instead of looking at detention and just incarcerating and detaining kids to punish them, we're looking more at interventions. Probation officers are more receptive to that as well. And even the therapist. It's the
therapist [who] sometimes really relied upon that too, like [the clients are] just not getting it, so detain them. That's the only way they're going to get it. But, no, if what we're doing on this level of care is not working, what can we do differently? We're not getting to those worst case scenarios where we're like, “Okay. He definitely needs a higher level of care or he needs intensive home-based services.” Those conversations are happening a lot earlier in the process to actually try working with the families in different ways.

Quite a few JJ professionals were positive and hopeful that the type of thinking encouraged under CH could help reduce recidivism among New Mexico youth. In general, there was enthusiastic support for “the Milwaukee model,” and JJ professionals were hopeful that once the program was implemented according to this specific model, the state would see an improvement in rates of recidivism among youth offenders. More services offered at existing CHs as well as “lots of involvement from stakeholders” would aid in reducing recidivism as well. Nonetheless, JJ providers also called attention to the limitations of this model within the New Mexico context.

**Changes in Attitudes toward Youth**

One aspect of CH that JJ professionals referred to quite often related to the increased patience fellow JJ professionals currently had with youth. They felt they were more patient with probation violations than before because they were working closely and well with the providers who were trying to help the youth under their charge.

**Referral Processes**

Ways in which the providers felt that CH as it was currently operating would not make inroads toward reducing recidivism had to do with when the referrals were made (see pages 29-34).

**Unclear Goals and Program Expectations**

All professional stakeholders felt that the goals of CH were not clearly stated from the outset. This included the goal of recidivism, which emerged as an ambiguous concept at best. A philosophical discussion ensued about how exactly one was to understand the meaning of a reduction in recidivism. One provider asked, “I mean, what is recidivism? Is it a kid getting put into a residential treatment center, or is it a kid committing a new crime? Is it a probation violation? And we shouldn’t be defining that six months in.”

Another provider stated:

I like that we could all make up stories about recidivism. True. Because we haven’t defined anything! It’s program development 101. What are your goals? How you gonna get there? How are you going to pay for it? What are the things you need to make it happen? What’s the theoretical model that’s driving it and what’s the evidence behind the theoretical model?
The provider continued:

I was excited to hear about the research that has been done on wraparound. Other people have been researching wraparound for the last 10 years while we were jumping around different models. So it’s nice to know that we can stand behind wraparound as an evidence-based model and begin to refine it more. But again, we don’t know. We still have disagreement on what the model was and has become in Clinical Home.

Alternative to Residential Treatment

Some JJ professionals felt that CH was working better than the alternative of residential treatment. It was understood among JJ professionals and judges that “some kids did well in RTC,” while others did not. In either case, youth returned to problematic home environments and often experienced problems with the law again. Not able to “treat” or “fix” the home context, JJ professionals and judges had few resources to target the larger community settings in which the youth lived. One JJ professional explained:

We used to be able to send our kids to RTCs and they’d come back the same. We couldn’t see the difference or the change. What we have seen now with Clinical Home is that they’re working with the families intensively. And for a kid, you have to work on mom and dad to be able to fix the kid, because if mom and dad are not fixed it’ll never work….They’ll still be drinking, the domestic violence, and now, because RTCs are phasing out, the Clinical Home is forcing everybody at the lower end to work with the families, the whole family, not just that one kid.

Several JJ professionals and judges were adamant that RTCs were needed for certain youth offenders. No other community based option would address the needs of these youth, they argued. Liability was also a concern for the JJ professionals. One JJ professional explained:

I can think of one case. This kid has so many problems, but we got denied RTC. Clinical Home rolled out. We put him in Clinical Home, we worked with the kid. We really tried to exhaust almost every option we could in the community, and the kid just continued to escalate, escalate, [and] escalate. We still knew he needed residential treatment. We knew we weren’t gonna get it. He continued to escalate in the meantime.”

The JJ professional added that he and his colleagues arranged for a 15-day diagnostic evaluation. The evaluation recommended commitment to an RTC program. They were unable to get this service authorized for the youth in question, despite their repeated attempts to do so.

The judges were angry that youth in their courts had been unable to access RTC services in recent months. Underscoring the perception of his colleagues, one judge
observed, “Residential treatment—intensive residential treatment—is an appropriate service for certain clients that are otherwise being referred to Clinical Home.” A second judge also defended residential treatment:

Out-of-home placement is not necessarily a negative for many kids. It means giving them a safe and secure environment in which to rehabilitate themselves. In my view there’s a misunderstanding of the initial perception about out-of-home placements. We look at the strengths of the families and the communities first and foremost and we would leave children in the home with support services, which is what the Clinical Home is designed to facilitate and that’s why it’s so good, but unless the causes and conditions in the home can be changed that adversely affect that child’s safety and behavior, then Clinical Home is not going to be very effective unless they can really get into the family and deal with the underlying issues in the home which many, they can. But for a certain population they can’t. It’s too destructive and harmful so in that regard I think that in some ways it’s good and in some ways it is effective and in some ways it’s not.

Similar concerns about the need for residential treatment were expressed by all judges.

**Do Not Expect Effect on Recidivism**

Some providers and JJ professionals were unconvinced that CH would reduce recidivism. “Clinical Home won’t help recidivism” one JJ professional suggested, “Because of the child and family, the recidivism just doesn’t stop, where the child just continues to get in trouble because of lack of support or lack of parents following through. Sometimes it's that. I don't know that we can say that it has anything to do with Clinical Home.”

Another JJ professional suggested that the focus of CH needed to change. Focusing on the older kids, who had already been in and out of trouble for years was misguided because these kids were de facto harder to treat. In contrast, CH needed to focus more on the younger offenders because there was still time to help them. He stated:

This is something that needs to start a lot sooner. ....Basically they concentrated on kids that were in detention, kids that were at risk of out-of-home placement or commitment, that was the first, the first target. But I think that we needed to be looking at our kids that are coming in at 8, 9, 10, 11 years old, and those are the kids we need to be targeting. And over time, I see definitely that Clinical Home would help to reduce the number of kids in the system. But starting with a kid that’s 15, 16, 17 years old, I don't think so.

**X. Improving the Clinical Home Model**

In general, providers were pleased and excited to be part of the development of the CH program. To a certain extent, JJ professionals shared this excitement. Mentioned as especially rewarding was the possibility to be able to help at-risk youth, or youth who
had already utilized many of the available services but had not experienced successful outcomes. Greater tracking and intensive attention to such youth enabled providers to locate and pursue effective solutions in consultation with the clients and their families. The role of these CH frontrunners in CH was seen as both “fraught with ambivalence” and “an interesting process.” One provider noted that newcomers to CH would benefit from the work that had been done by those who had participated in the pilot program.

Professional stakeholders offered several suggestions to improve CH. These included: 1) institute a transparent selection process for future CHs; 2) create clear definitions of key CH concepts and expectations of CH processes; 3) engage in evaluation; increase education and training for professional stakeholders; 4) enhance funding for CH agencies; 5) institute name change; 6) revamp referral system; 7) specify timely assessment policy; 8) foster communication and collaboration across professional stakeholder groups; 9) expand CH partners and agencies; and 10) encourage linguistic and cultural competency. Professional stakeholders also expressed concern regarding the long-term viability of the program.

**Strong Enthusiasm**

The great majority of providers and JJ professionals emphasized their support for the program. One provider said, “It's been a privilege. It's been exhilarating. It's been challenging. Really, for me it kind of turned the soil and kind of shook the ground that I stood on and made me think a lot differently about how I provide services.”

Another provider spoke of hurdles with CH and his decision to ultimately support the new program, stating that “It's been a difficult process all the way around because with any pilot project, anything new is going to be difficult. Now, I'm 100% invested in this program, and I'm hoping it'll succeed, because it's something that's very beneficial to the families that are involved in it.”

Similar sentiments were shared by JJ professionals. Many had been at first skeptical of CH, but eventually emerged as firm supporters of the program.

The judges were more lukewarm with regard to their level of enthusiasm, primarily because they had not been engaged as full partners in the implementation process. However, they did appear in general to be positively disposed toward CH.

**No Changes Necessary**

A small contingent of providers felt that everything was good “as is” with CH. They claimed they would not change anything about the way CH had been designed or implemented.

**Institute Transparent Selection Process**

Several providers discussed the unclear nature of the selection process for CHs. The process of selecting CHs was opaque to many providers, and there was unease among
them because of it. Moreover, there was questioning as to the model that was selected to underpin CH (most commonly referred to as “the wraparound model” or “the Milwaukee model”). Some providers suggested that other models might have better suited New Mexico’s unique circumstances. One provider explained, “One of the very front end things would have been a more objective and fair selection of providers. It’s still a great mystery. We all said, “Gee, there are providers not sitting at the table that should be. What’s that about?” And an RFP process or something…”

Create Clear Definitions and Expectations

Several suggestions were made by the providers and JJ professionals—suggestions they felt would, if implemented, help improve the current CH model. The first suggestion was for the state and VO to take the time to create better definitions of terms, standards, and expectations—from outlining the intent and internal operations of CH to basic staff responsibilities. Once created, these definitions needed to be communicated clearly to all professional stakeholders. One provider explained:

I would like to see some standards come through the state as to what defines a Clinical Home. What are the expectations in terms of getting [families] in, getting them seen, timelines for assessments, timelines for monthly meetings, qualifications of personnel? If we’re ever gonna be subjected to an audit, we need to know exactly how to prepare for it. My understanding is at some point that Clinical Homes are only supposed to be with Core Service Agencies. But the state still hasn't defined what a Core Service Agency is yet. So, I mean, we're bringing up a program that eventually is gonna help us get to a designation for the state, but we don't even know exactly what those criteria are yet.

There was widespread agreement among providers and JJ professionals that the concept of CH required further articulation by both the state and VO before the program was rolled out in other parts of New Mexico. Moreover, attempts needed to be made to relate this concept to other initiatives on the horizon, most specifically Comprehensive Community Support Services (CCSS) and Core Service Agency (CSA). Providers were particularly interested in learning how the three programs—CH, CCSS, and CSA—converge, so that they would be able to stay one step ahead by shaping their own policies to facilitate the hiring and training of new staff.

Up-Front Evaluation

Providers suggested that the evaluation component of CH should have been created before the actual program was implemented. Importantly, the articulation of an evaluation strategy prior to program implementation would have provided professional stakeholders with a more solid understanding of expected outcomes.
Increase Education and Training

Improved education about CH—education aimed at all stakeholders in natural and formal support systems—was seen as essential to the continuing success of the program, as it would allow for smoother start-up of the program elsewhere in the state.

Providers and JJ professionals were adament that judges needed to be better educated about CH and how CH is supposed to work. One JJ professional noted:

To my knowledge nobody sat down with the judges in the three pilot sites and said, “Okay, this is what Clinical Home is. This is what it’s gonna look like. This is how it’s gonna affect you making the decisions on the kid, from the bench on a kid’s case.” I mean, we’re rolling this baby out as we go day to day, and we’re rolling it out to <name’s> staff and we’re rolling it out to the judiciary. And that makes for a tough acceptance. We need the judge’s blessing.

Judges also underscored that there had been little or no outreach or education provided to the judiciary branch on the topic of CH.

Enhance Funding for Clinical Home Agencies

Professional stakeholders felt that insufficient funding prevented implementation of the “full model,” referring again to the wraparound model or the Milwaukee model upon which CH is based. One provider drew a vivid picture of how the system could not truly begin to affect clients—particularly recidivism among clients—in its present form:

It’s kind of like getting software on the Internet, you know, when you can get the trial version, but you got to pay $19.95 to get the full version. So, we’ve got the trial version right now, and so we have not got the key to unlock it all and use all the bells and whistles. So presently it’s not doing real well. Potentially it has a tremendous ability to keep kids out of the judicial system and keep them from going back into it.”

Another provider communicated the same message: “This model [is] designed to put that person in the community with services and support. And it’s not comprehensive enough at this point with the availability of services to be successful.”

Above all, professional stakeholders expressed concern about inadequate reimbursement and payment problems experienced by CHs. Underscoring an opinion shared by his colleagues, one judge observed that CH providers had yet to be compensated “at a level or for the service that they should be compensated, and that is putting a strain on an otherwise good model.”

JJ professionals were particularly adament that insufficient funding prevented providers from delivering “true” wraparound care. One JJ professional noted, “VO is doing a disservice to the community and to the youth. They’re driving this program, but they’re
not providing the funding for the service providers to provide the wraparound services or to work with a family and be flexible with what the family needs.”

On a practical level, providers and JJ professionals uniformly felt that CH required more funding to prove successful in the long run. Some providers were not being paid well for their services under CH, or even being paid at all. Judges offered similar observations. One judge explained:

[Providers] cannot do [Clinical Home] if they’re not paid. So while you have commitment and support and expertise and collaboration...people do need to keep their doors open and pay salaries and that’s a huge frustration. [Capacity is limited] by lack of payment and lack of follow-through by ValueOptions to fulfill the promises that they have made to the field about this program. Many treatment providers were told to do this on an experimental basis for a number of months. Well that’s a very huge commitment for a small treatment provider to make and they did so. They went ahead and embarked on it and following that initial test period are still having the challenges of being paid under contract. It’s a good model but you need that critical component of resources to be used to support it and if you don’t have that no matter how well-intentioned people are and how good the model is it’s not going to work.

**Address Service Limitations and Insufficient Staffing Capacity**

There was ubiquitous agreement on the part of providers and JJ professionals that case managers, in particular, tended to shoulder the burden of work responsibilities under CH. However, most agencies had trouble keeping up with the demand for CH, as they lacked sufficient staff and funds to hire new employees. This situation further increased the work demands of case managers. Providers are particularly concerned about the potential for “burnout” among some staff, including therapists, and they suggested that their own personnel be able to switch job duties on occasion. One provider said, “It's kind of good to have instead of two people doing it, several people doing it, because it stops burnout. If you had to write a bunch of level two assessments all at one time that might be a little much.”

**Institute Name Change**

Providers and JJ professionals advised that the name “Clinical Home” should be changed. The current name confused families, as well as non-CH personnel working in the professional sector of the behavioral health system. They argued that “more concrete” and “descriptive” terms should be considered when renaming the program. Problems with the name “Clinical Home” were very frequently the first concern voiced by both providers and JJ professionals.
Revamp Referral System

Several providers and JJ professionals suggested that a better referral system was needed because the current system did not work. Presently, not enough information was given to families for them to make an informed choice as to which services or which agencies they wanted to or would work well with. Buy-in among the families could be improved through greater education in general about the overall CH process. Such education needed to begin at the point of referral.

Specify Timely Assessment Policy

Simply put, providers were unsure of exactly what type of assessment was required of them under CH and when it was due. The expectations of JJ professionals and judges regarding these assessments did not necessarily mesh with the expectations of providers. Judges, in particular, were “out of the loop” regarding the intended assessment expectations. Some providers believed that all CH agencies should be held accountable for performing the same type of assessment.

Foster Communication and Collaboration

Providers and JJ professionals mentioned several areas in which communication and collaboration could be enhanced. On the one hand, CH providers highlighted the need to foster communication about CH and CH clients within agencies, as in many cases non-CH personnel were not up to speed regarding the new model of service delivery that their colleagues were attempting to implement. This lack of knowledge strained communication efforts within agencies. On the other hand, providers experienced problems reaching out to non-CH agencies. The benefits of collaboration had yet to be clearly conveyed to these agencies.

While some of the JJ professionals thought that compared to before the implementation of CH, communication among professional stakeholders—especially service providers and JJ professionals—was much improved, other JJ professionals felt strongly that communication could be improved even more. In particular, efforts needed to be made to open communication with judges.

Judges in turn also called for better communication among all the stakeholders involved in a youth’s “case.” Because they were often concerned that they might missing a crucial piece of information that could affect a youth’s case, judges wanted to have as much information as possible in order to adjudicate the case fairly and well. One judge suggested:

…some means of communicating in this high tech world that allows input, even initial input—“Do you have any specific knowledge on this child based on your prior involvement with him?” An email could be sent out, a text message or
something or another to the folks that have been involved. If so, “Do you feel comfortable with appropriate releases providing us input in this assessment process?” And as judges we’re guilty all the time of excluding people unintentionally that have information that would be helpful to us as we make decisions about kids for the rest of their lives or things that could affect them for the rest of their lives.

In short, all professional stakeholders were in general agreement that work still needed to be done to improve channels of communication.

Expand Clinical Home Agencies and Partners

Providers and JJ professionals agreed the CH program should be expanded to other agencies and to other settings. However, they did not believe that such expansion should take place without careful consideration of their experiences in the pilot program. They felt that attention to their experiences would serve to strengthen program design and implementation processes. They also expressed the need to engage in intensive outreach to community “partners” outside of the JJ system, such as schools.

Encourage Linguistic and Cultural Competency

Linguistic and cultural competence were qualities that providers and JJ professionals recognized as needed in CH. One JJ professional, for example, highlighted the need for providers who can work with families illiterate in English or composed of monolingual Spanish speakers. He said:

> It's important to look at the diversity of the population that you're working with and the income, education. All those pieces factor into getting the community to buy in to whatever. Some of the families are illiterate; they do not know how to read, some of the parents. Some of them don't speak English. You have to take those into consideration. You can't get them to buy in if there's nobody that can communicate with them.

Another JJ professional stated, “I mean, we're talking about Native Americans and Hispanics and being able to be culturally sensitive. But we've got more cultures in this community right now we're having to represent.” The judges, in particular, were of the opinion that Clinical Home did not adequately address the needs and circumstances of the immigrant population.

Concern with Long-Term Viability of Program

Professional stakeholders expressed concern about the long-term viability of CH. One provider stated, “Some people view this program as just another thing from the state that's not going to be here next year, so why even bother.” The lack of concrete definitions, expectations, and guidelines indicated to some a lack of seriousness from the state in standing by this project.
Part III: Coach Perspectives
I. What is Clinical Home?

According to the coaches who contracted to train providers and other stakeholders in New Mexico on their service delivery modality, a CH could be defined by its core set of values. Fundamentally, the core values that held the program together and facilitated change focused on keeping youth and their families together. One coach described his perspective on CH, adding in a few additional components to the definition: “So we’re strength-based, we’re community-based, we’re needs-driven, we’re culturally competent. So it’s a matter of hooking families up with a team of people that stick to those values and help them reach their vision.”

Wraparound Services

More practically, the purpose of the CH was viewed as preventing youth and families from shifting from agency to agency in their quest for services, by offering wraparound care instead. The wraparound concept was considered central to New Mexico’s model of CH. Although families might at times need to seek services from other agencies, there would be one agency responsible for coordinating services and overall care provision for clients and their families. One coach said:

What I understand it to be is that New Mexico is defining CH as an agency that will follow kids up until adulthood by providing them with coordinated care, having responsibility for making sure that the care is as seamless as possible, that their needs are met, and that they will get whatever services, supports, strategies in place for those kids and families that are needed, but that they ultimately would be the primary responsibility for that youth.

Coaches agreed that the care coordinator (typically referred to as the case manager in discussions with providers) was to be assigned to a youth and in turn would be responsible for “opening the file, doing the assessment, doing the strengths discovery, setting up the plan, figuring out what’s needed, and making sure that the strategies and services get put into place.”

Accountability

CHs were to be held accountable in ways that traditional service agencies are not. One coach stated:

What you’re hoping with Clinical Home is that there’s an accountability factor that holds agencies responsible for being somewhat of an umbrella agency but also being open to figuring out what kids and families truly need and not necessarily just what they have to offer. The advantage of a Clinical Home model is that you could hold that agency responsible for as seamless of care as possible; that they are now going to be the primary agency responsible for that kid’s care throughout their development stages.
Informal Supports

The coaches cited several concepts that distinguished CH from “business-as-usual,” including a “family-driven” approach to services that incorporated what the coaches referred to as “informal” supports. These were persons in the home or the community who worked with the families and aided them in reaching their self-generated goals. One coach explained:

That’s what really makes the difference, yeah. It’s really family-driven. Although we might have some of those formal supports on board, ultimately you really want to make sure that you get those informals to the table too. That’s how it’s gonna work. Cause if you have a bunch of formal people at the table, it’s not proven very effective.

The coach suggested that clients and families were less likely to “connect,” “share,” or to feel “comfortable” if professional stakeholders dominated the table.

Strengths-Based Approach

CH stakeholders saw holding team meetings in the family home and focusing on family strengths to be additional important components of CH. One coach suggested, “Team meeting is run very different. It’s opened with strengths and its focus is on strengths throughout the whole meeting. We don’t talk about problems or deficits. We really focus on the needs and what the child needs help with. So it can take a different tone than it would in let’s say a therapeutic setting….”

II. Description of the Coaching Process

For the coaches, a large part of their work focused on training, communication, problem solving, helping the providers create strategies that would aid them in maintaining fidelity to the “Milwaukee model,” and program evaluation. The coaching process, according to the coaches, prepared providers by teaching them about the core values of the Milwaukee model, which encompassed wrap-around services, in addition to a strengths-driven, community-based, and collaborative approach. The coaching also prepared providers to write treatment plans in the spirit of the Milwaukee model, facilitate meetings, and improve rapport with youth and families.

Consumer-Driven Services and Teamwork

One coach explained that the main role of coaches was to help the providers understand and put into practice the concept of consumer-driven services:

As a coach I’m trying to help them see that the families really need to be the decision makers and that it’s okay for them to say, “No.” It’s okay for them not to like something. It’s really gonna be driven by them. So part of my role in the
coaching is helping them see that too. That no matter how passionate you are about this therapeutic approach working, if the family doesn’t want to try it, they don’t want to try it. It’s a different mindset for some. Not for all of them.

Another coach emphasized team building and the importance of teaching CH providers to facilitate meetings with providers, JJ professionals, clients, and families. The coaches also discussed the need to educate the providers on the right tone to set in meetings so as not to alienate but rather empower youth and the families. To this end, coaches observed the providers facilitating meetings among stakeholder groups and commented afterwards. They also trained and observed judges and other JJ professionals on the teamwork approach, offering feedback when appropriate.

In response to the question about the coaching process, coaches voiced concern about how CH was implemented. Specifically, they expressed uncertainty about the providers being “coached” five months before they actually received training in the Milwaukee model. One coach stated that the lack of basic training up front could explain why some of the participating provider agencies were still conducting “business-as-usual,” engaging in conventional case management. The coach stated:

We were told to really meet them where they’re at. We’ve had some good starts but also some stops around general consensus about what they all need. So that’s tough when you’re coaching before you’ve actually been trained. So the training didn’t occur until September so then there was just coaching in October since that. While the training was very well received—it’s hard to say how much implementation is going on. Then there’s a couple of agencies out there who have been very much on the periphery that I suspect are just doing business as they’ve always done under a more case management model.

III. Family-Focused Care

The main lesson that coaches wanted to impress on the providers is that the family was the center of the CH universe. The focus needed to be on family “voice” and “ownership” of the process. Coaches conveyed the importance of never having meetings which concerned the family without the family being present. CH needed not to be about doing something to the families, but rather was about involving them in their own service planning from the beginning. The provider agencies had been exposed to what the coaches called a “consultation model” in which the providers were instructed in helping families without pushing services on them. According to one coach:

They’ve experienced a consultation model that is much different than they’ve ever experienced in terms of the way we help them work through challenges. We’ve worked hard and talked a lot about the need to use community resources to help kids and families stay together. And that means really looking at the family’s culture and who surrounds them and where they’re going to be living and what their real needs are so that they’re a little less traditional, less services-driven. That they recognize that most kids and families have not done that well
with traditional services. I think that, I hope, I believe that’s [something] that we’ve done some pretty heavy emphasis on.

Another coach discussed this theme further:

Establishing family vision, identifying strengths, identifying needs, and coming up with strategies, and crisis planning—five areas that they focus on. In a meeting that takes an hour and a half to cover these things and then the family can walk away with a tangible plan that someone’s going to be implementing with them. The other thing [we teach them] would be just how do you ask the right questions to get those points addressed.

IV. Preparation of the Workforce

Coaches asserted that preparation was primarily linked to funding, training, workforce capacity, leadership, and quality assurance. One coach summed up the consensus view of the others:

There’s a combination of a lot of things related to training, coaching, quality assurance, feedback loops, funding strategies that are more flexible and a little bit more unique. And starting with good leadership and a very tight program design where people clearly know what’s expected of them. Then obviously you need some training and coaching on the model that you’ve designed. And then you need workforce development, because maybe your current workforce is capable but needs some additional training and coaching, or you may have to expand your workforce. Then they need some quality assurance in place that actually speaks to the values and principles of the model. And then the quality assurance really needs to be the feedback loop. More than just satisfaction surveys but actually quality assurance measures that actually hold people accountable for what’s being expected from the model. And then obviously some outcome studies that where a group of stakeholders have clearly defined what outcomes you’re hoping for from this model and how are you doing so far.

Provider Readiness - Positives

The coaches were asked how the provider agencies (and their staff) were and were not prepared to operate effectively as CHs. On the positive side, when speaking about workforce issues, coaches often spoke about the obvious degree of enthusiasm evinced by the providers as they learned about the CH process.

Provider Enthusiasm

According to the coaches, many providers were eager and willing to begin their careers as members of a CH. One coach stated, “I think they’re ready. I feel good energy. They all have the energy and they want to do it and they’re excited about it, but I don’t know if they’re ready to fly yet.”
Provider Readiness – Negatives

On the other hand, coaches also cited several reasons why some provider agencies were not yet ready to fully and competently implement CH. The main reason related to the scarcity of training opportunities for providers.

Lack of Training

Coaches cited the lack of appropriate and timely training given to providers as well as the short amount of time allowed for the agencies to begin operation. One coach described the situation that providers experienced early on in the process:

They were forced to start taking in families without any basic training so they were just doing what they’d known to do, which was the old way of doing business. They just received their basic training last month (September 2007) and even with that, that’s a two-day training and for our care coordinators in Milwaukee it’s like a 40-hour, 50-hour module, except they’re different modules that they go through plus they get ongoing training, so we just introduced them to the process.

Not only did the providers need more time to train, the coaches suggested that others at CH agencies needed training as well. One coach said:

They have only just begun their training in terms of what it would mean to be strengths-driven, needs-driven, using the wraparound principles and process of wraparound….And that needs to be pretty extensive across the whole agency, and so far we’ve really just been working with those that are considered to be care coordinators or supervisors of care coordinators. I mean, it’s a good start, but we have a long ways to go.

It was felt that the two-day training in September 2007 was barely enough to get CH agencies off the ground, yet alone operate effectively on their own at the end of 2007. One coach stated:

It just started and what we’re being told is that the Clinical Homes that are up now, their time so to speak is up in December and they’re going to be taking up with another group so that’s gonna be hard because with this model you can go for the two-day training but it takes a while for you to understand practice. Once you have a foundation now we can start doing some of the other stuff but by no means are you ready to facilitate this on your own after a two-day training.

Too Many Provider Responsibilities

Another concern expressed by the coaches impacting provider readiness was related to the tremendous caseloads that the CH providers had to manage. Some case managers had to divide their time between doing “business-as-usual” case management and
learning how to provide service coordination for their CH clients. This was not an ideal mixing of responsibilities, according to the coaches, as the Milwaukee model demanded a tremendous amount of time from the care coordinators. Moreover, coaches suggested that a therapeutic background wasn’t necessary to fulfill the role of care supervisor: “It’s really not a case management position. And when I interview, I interview for facilitators. I interview for someone who can facilitate a team meeting. There’s confusion about the educational background. There’s a lot of therapists. And you don’t necessarily have to have the therapist.”

One coach commented on CH staffing issues:

Some case managers have other cases and then they have the Clinical Home, which can be very hard. And I’m just going to be honest. In order to be able to do this, you really just need to be doing Clinical Home. It’s pretty extensive. It’s time consuming. 8 to 10 families is probably what they can handle.

The number of meetings that providers must attend can be overwhelming. The same coach went on to state:

The care coordinator has to facilitate monthly team meetings [and] plans of care… I think they’re 90 days here. But if there’s a crisis, you have to facilitate meetings more often… So there also is a weekly face-to-face. And that’s just in, our expectations. I believe there’s some similarity here. So it’s very time consuming—the documenting, the preparing for the meeting, the being able to facilitate the meeting. That’s a lot of time. So it’s hard because the other families that you have, it’s a lot different.

V. Working with Clinical Home Providers

Coaches reported having worked with providers in several ways, participating in team meetings, teaching providers how to facilitate team meetings, and conducting trainings with individual agencies. Coaches indicated that they strove to respect “autonomy” among providers, insofar as they preferred not to “dictate” how providers interacted with families.

Team Meetings and the Facilitator Review Tool

Besides coaching and training in a group setting, the coaches interacted with CH agencies in other ways. One coach spoke about participating in team meetings, commenting on how that context had helped providers both learn to facilitate meetings and to engage families. The coaches had also taught the providers about the “Facilitator Review” tool, which aided in teaching the skills needed to facilitate team meetings. According to one coach, the tool “helps them learn some of the skills that it takes to facilitate a meeting. It’s got some basic criteria on there and it rates them on a scale of one to five. You give it to them before the meeting so that they know. They can make sure that they cover all the areas, and it helps them prepare for a good meeting.”
Frequency of Contact and Common Provider Questions

Coaches had shared materials on the Milwaukee model and on wraparound services with provider agencies. They spoke about how they had scheduled independent trainings with specific agencies that were struggling with certain topic areas, for example, crisis planning. On several occasions, they had referred providers to their colleagues in Wisconsin, who helped agencies with “management information systems” and evaluations. Coaches also stated that they were available by email and phone in the event that providers needed to contact them with problems or questions on how to handle specific situations with youth and families.

Frequency of contact with the provider agencies varied among the coaches. Some were in weekly phone or email contact, while others had a regularly scheduled phone conference once a month. According to the coaches, high turnover within agencies could make remaining in contact difficult. One coach explained, “I try to reach out to them at least twice a month just to check in. Actually maybe three of the agencies that I work with have had a problem with turnover in terms of the person who’s actually doing the work, so it’s hard to pin down an individual.”

Coaches discussed several kinds of issues that they had assisted providers in overcoming: barriers presented by the JJ system, issues related to engagement with the family, and missed planning opportunities. At times, providers, as yet inexperienced with fully implementing the wraparound philosophy, were unable to figure out the best ways in which to aid youth and families. Coaches reported being summoned by agencies to help them in these situations. One coach explained:

Generally it’s either a system barrier that they’re not sure how to get through, whether it be a disagreement with child welfare probation or another system that’s involved in the families. Or it will be an engagement issue where they haven’t figured out how to engage with this particular family in a way that keeps them involved and on the right track. Thirdly I would say it ends up being things, misses in terms of the planning process—an oversight where they missed some piece. They either don’t have the right support at the table [or] they haven’t figured out the right resource or the right fit.

Respecting Autonomy

It should be noted that coaches stated their awareness of the need to be careful when assisting providers, so as not to dictate to them what needed to be done for families. Coaches expressed their cognizance of the need for families to feel a part of the team. One coach explained the delicate dance they had to do while helping the provider agencies, but not taking over the process:

One thing about coaching is, it truly is coaching. We’re not one to just hand out answers. Especially if we haven’t even met the family. So unless we’re sitting on their team, we’re very careful. I even have a structure that I use in terms of the
questions that we ask and how we ask them, because we really need them to take it back to the child and family team. So it’s, it really is coaching around, “Well, go back to this piece of the process and the answer is probably there.” Coaching’s invaluable when done right…I don’t believe in the traditional, “I’m the expert when I haven’t even met the family.”

VI. Application of Coaching Lessons

Coaches shared the opinion that one should not expect providers to absorb the lessons associated with service provision under CH in a short period of time. Such absorption and subsequent changes in behavioral health practice, coaches emphasized, take time. Coaches also discussed the need to assess provider comprehension and overall implementation of these lessons. Nonetheless, coaches noticed some positive changes in practice. Providers, for example, appeared to be gaining skills in coordinating diverse stakeholders and communicating among them. Provider attitudes about youth and their families were also changing in some agencies. Several agencies also seemed to be integrating what they had learned from coaches in their treatment planning activities, although such activities could yet benefit from ongoing improvement efforts. Coaches associated positive attitude change towards youth and their families with increased efforts to apply lessons in providers’ work. Coaches had the impression that some providers remained resistant to the lessons, as they did not see much difference between information taught and their own day-to-day work practice. Other providers appeared overconfident in their ability to integrate the lessons into “real world” action.

One Step at a Time

The coaches mentioned several ways they could tell when providers understood and were applying the lessons they had learned about the Milwaukee model. Coaches explained that they did not really expect the agencies to understand and apply all of their training right away. Usually, providers began to show their understanding and application of one of the values they had been taught. One coach explained:

It’s just certain parts of the process that they’re getting. It’s not the whole process, because it’s difficult. But it’s usually one of the values that they’re really getting. And so if they really are right on about, let’s say, family centered approach, then I’ll say, “They’re getting that.” They might not be so good on the culturally competent part…but they’re getting that part. So it’s evaluating the values and how they interpret them and how they’re using them in their teams.

Assessing Comprehension

A different coach shared that she listened carefully to whether and how the providers talked about the concepts they had learned, how they posed questions, and how they used the coaches’ time when they were on site. The coach described the process:
What I do see, what I do get to see is the way, when you do know you’ve had an impact is when staff are asking you questions in a different way and they’re using a different language and they’re taking a different approach. It’s not so negative. It’s not so deficit-driven. Then you do see that you’ve had an impact when they begin to change their language and change the way they ask questions and change the way they think. Even the agenda for the day when I come to coach has been growing and expanding and getting more sophisticated. Then you know you’ve had an impact.

Assessing Implementation

When asked if there were any specific ways in which provider agencies were applying some of the coaching and training they had received, the coaches were able to list several. For example, coaches discussed how the providers were holding team meetings in the community, and writing strengths-based and family-focused treatment plans. One coach explained:

I’ve seen them developing teams and inviting natural informal supports. I’ve seen them hold team meetings in the community. I’ve seen them really working to collaborate with their system partners, the school system and the probation department, more specifically cause they’re at the meetings and represented. Some of them have also even developed, we sent out some of our written plans in terms of format some of them have developed a plan, a written plan that would capture this process as well, which I think is huge if an agency shifts from their typical treatment plan to trying to find something that meets this model that they’re invested in making sure. And a lot of the agencies have told us that regardless of where this goes, even the kids who aren’t in Clinical Home, this is the model that they’re using with all the families that come in. It does take time to learn that there’s a lot of things that need to be worked on but for the most part they’re attempting to do what they can with the training that they’ve gotten so far.

Another way in which coaches said they evaluated if providers were "getting it," was by observing if families were engaged. One coach shared, “The families are feeling their success with their plans. They feel like the care coordinator’s helping them establish a team that’s going to be there once the care coordinator’s gone. So it’s really based on the families and their satisfaction with it.” A different coach suggested that the concepts that she and her colleagues taught worked, yet she still felt it was too early to tell in New Mexico whether the families were feeling the positive effects of the CH program:

As far as at the family level, one can only hope. I’ve been doing it long enough to know that certain things really do have an impact even when I don’t get to see them directly. But that’s been fairly data-driven; just by the years of experience and the collection of data here where there’s just certain things you know you have to do. But it’s too soon in New Mexico for me to honestly say that families have felt a difference.
Coaches also discussed the frustrations they felt with trying to evaluate if the provider agencies were applying their training to their work with the CH families. Because coaches could not collect the data they would need to evaluate the provider agencies’ performance, they felt in the dark about how well the agencies were doing. One coach expressed the following frustration:

If there’s anything that’s a bit of a challenge for me it is I don’t get to impose the same level of QA [Quality Assurance] that I can do at home. I sometimes feel like I can’t tell for sure, because I can’t do the same level of data collection. I have to depend on asking the right questions and going back to where we started the last time to find out if they’ve progressed with the family. And the biggest challenge is that generally I’m only hearing it from their perspective. So that worries me.

**Enhanced Communication and Collaboration**

An area where the coaches had noticed a positive difference in the way providers were interacting with youth and families was in a greater coordination between stakeholders and community members. One coach stated:

A lot of team meetings that I’ve gone to had pretty good-sized teams and a lot of people working with the family. Whether they’re on a phone conference or sitting at the table, their teams look pretty good. More people get involved and the various systems that they come from. I see the POs there. I see school reps there. I see the service providers there. Some agencies are doing a better job than others in terms of reaching out to not only their agency to provide services but other agencies and they’re having collaborative meetings with those agencies about what they could provide for their families.

Another coach put it this way:

There has been an increase in communication among system people and among agencies. I have seen that happen, which is really a positive thing. There’s agencies who are talking to each other more. More than they ever have. I know this sounds strange, because you would’ve hoped that it would’ve always occurred, but now when a referral comes from an agency they’re actually picking up the phone and talking to each other about what’s worked, what hasn’t, and this is what the family is really asking for. And unfortunately, you didn’t see that before. They knew who each other were, because they might’ve seen each other at a conference or at a meeting, but now the agencies are actually talking to each other and talking about what’s in the best interest of families. So there’s much more communication than there used to be.

Coaches had also noticed that more team meetings were being held in families’ homes. They had witnessed the provider agencies beginning to focus on the strengths of youth and families, rather than on deficits or weaknesses. They cited the enthusiasm that many providers were displaying about CH as a positive development. One coach said:
There's excitement about what this could look like and what this could mean for families. Some people are excited about being able to do work differently with their families, using this model as opposed to being locked into what they've traditionally done, and they expressed that in training.

**Evolution of Attitudes**

Coaches had noticed that some agencies were really working hard to train their employees to cultivate different attitudes toward youth and families. Rather than treat them like criminals, agencies were working hard to make youth and families feel comfortable. One coach stated:

I've noticed some active work at changing the attitudes of their employees at the agency around families. [They are] working hard on making their agency more welcoming to families. And taking a hard look at the fact that some things that they were doing that they may not have even been aware of was not all that welcoming to families.

A related issue coaches mentioned was a change in provider attitudes towards youth. The same coach commented, “There is an increase of an awareness that the kids that have been referred are really not that different or not that, I don't believe, that challenging. They're seeing that these kids are kids and the families are families.”

**Area for Improvement - Treatment Planning**

One coach in particular felt that several of the agencies did not appear to be trying very hard to understand and implement the training on wraparound services and CH tenets. An area where provider agencies needed improvement was in documenting the treatment plans that they created with (or in some cases without) the families. The coaches would have liked the provider agencies to learn to create treatment plans that were “friendly to the family and workable,” because, as one coach pointed out, “You can’t really function without the road map. You can get lost.” Another coach articulated that it would be helpful if all the agencies agreed to a format for the treatment plan. This innovation would reduce redundancy and save time:

There needs to be a mechanism for a unified plan of care or uniform plan of care. They’re all doing their own thing as it related to what they probably call a treatment plan. We call a plan of care. And for the sake of families, it would be really good if the agencies got together and said, “Here’s what it’s gonna look like.” At least keep it as close as possible so that when families do touch other agencies they don’t have to start all over again or it doesn’t look like a foreign language to them.
VII. Provider Response to Training

When asked how providers were responding to the training, coaches suggested that there was variation among the agencies. Some were embracing the new directives and concepts espoused by the Milwaukee model and the CH program, while others were less enthusiastic or having more difficulty in implementing the wraparound philosophy:

It’s very different depending on the agency. There’s some that are stars that have really been trying to work in this way for awhile. They needed some structure and just are eating it up. So there’s a couple agencies that you could identify as stars. There’s a lot in the middle, and then there’s a couple that I don’t think have really employed much at all or really practiced much at all.

Positive Provider Response

Coaches offered several responses as to why some agencies had an easier time than others in applying their training. First, what made it easier for some agencies, coaches believed, was that their personnel had a positive attitude toward and embraced change. These agencies, especially at the leadership level, were especially willing to try out new methods that could help their clients improve. This sort of positive disposition was described by one coach:

Those agencies that have said, “Hey, I’ve worked in a lot of places. I’ve been with a lot of families, and I get that there’s always room to improve and that we’re not doing things as culturally sensitive as we could be.” There’s a couple stars out there that have just said, “We want to be different. We want to have families embrace our agency. We want to be part of the community. We want to do things better for kids and families.” And that attitude allows them to be much more open to the learning. And those are the agencies that are clearly exceeding in terms of what’s been asked of them. And they’re also the same agencies that have also been around the block who say, “Yeah, things do come and go, but it’s not all about the money, and we’ll figure out a way to make the money, and this is just the right thing to do.” It is a lot to do with attitude and leadership.

Provider Resistance

For the most part the coaches felt that the providers were open to the idea of CH, but there had been some resistance in terms of the provider agencies thinking they were already “doing” CH with their other clients. One coach stated:

There was resistance in that “we’re already doing it.” A lot of providers like to feel like this is just common sense and this is what we’ve always done, but when you get in there and you start peeling back the layers of what their business practice really is, they’re not doing it, it’s really the old traditional medical model of providing services. Now most of the agencies are at the place where they do see,
where they could change some things internally to get to what this process really should be. I still think that there’s some confusion about how to effectively do this with the number of families they’ll be serving.

Coaches noted that there were agencies that displayed an even less positive attitude about the changes required of them to participate in CH. The coaches suggested that a few negative beliefs about CH were present in these provider agencies. First, some agencies felt that CH was only the most recent behavioral health requirement put forth by the state, and that it would not be the last. It was thus taken less seriously than it might otherwise be, with some providers adopting a “wait and see” attitude. Another concern on the part of provider agencies was that they would not be paid for doing the extra work, and so were reluctant to embrace the model without proper compensation. Yet another point of resistance on the part of providers was their conviction that they were already providing CH-like wraparound service planning, so they had nothing to learn or to change about “the way they do business.”

One coach described the various types of resistance evidenced by some providers:

It’s really their attitude. It has everything to do with whether they handle change well, whether they embrace the idea that there’s always a way for all of us to improve versus getting defensive. Those agencies that are struggling, there’s been two or three reasons why. Either they are so convinced that the money’s not going to be there and the only reason they’ll do it is for the money. So that’s the most negative scenario which does exist. Therefore, “If I’m not gonna get paid for this, why should I do it?” Then there’s another level of resistance that has to do with, “Oh, things come and go. This will just be another thing to come and go.” I understand that. And then that third level of resistance would be around, “We’ve been doing this all along. What do you mean; we’re really not doing it?” So if you take a defensive posture that you think you were the best thing since sliced bread, and then someone comes in and says, “Perhaps there are some things we could be doing better,” and your leadership is not open to that, then you’re gonna struggle. So we have those levels of resistance, which makes it hard to do this.

Last, Coaches reported confronting providers’ convictions about the appropriateness of out-of-home placements for some youth. Finding providers “passionate” about out-of-home placements as a “need” of certain youth, the coaches worked to educate them that much can be accomplished for these youth by adhering to the tenets of the Milwaukee model. One coach explained:

It can be challenging though, because when you hear somebody who’s so passionate about an approach they think it’s got to work, and it’s the end-all if it doesn’t work. That can be challenging when you hear that. Like, “Wow, they really think that that’s the only solution to that problem.” Then they get really frustrated when you don’t think, for instance, “This child needs to be out of the home. He needs residential care.” As a coach I would challenge and say, “First of
all I don’t think placement is really a need. Placement is a strategy. What is the need that you think is going to be met by that placement?" Most of the time we can strategize and come up with ideas that could be taken care of in the home. But they don’t want to hear it. “Oh they tried. All that’s in the chart. All that’s in the chart. It didn’t work.” But it’s interesting because then you’ll come back and you’ll see them later on and they’ll say, “We tried this, and it worked.”

In general, however, coaches emphasized that provider reluctance or difficulties with adopting the wraparound philosophy could be traced at least in part to a lack of communication about CH and the lack of training providers had received.

**VIII. Coaches Suggestions for the Future**

Coaches offered several suggestions to enhance future implementation of CH in New Mexico. First, the overall design and goals of CH needed to be clearly stipulated. Second, communication among the state, VO, providers, and coaches about intended implementation processes needed to be improved. Third, quality assurance procedures needed to be implemented and accountability links needed to be strengthened. Fourth, all professional stakeholders—not simply providers—needed to be educated on the CH intervention. Fifth, efforts needed to be made to increase funding in order to cultivate application of the Milwaukee model. Finally, resource development within communities needed to be seen as an essential component of the CH intervention.

**Design and Goals of Clinical Home**

The coaches made it clear that their job had been made more difficult by the lack of a clearly communicated design and set of goals for the New Mexico CH program. One coach expressed dismay at the extent to which communication had broken down between the state, VO, and the providers about the New Mexico CH design. According to this coach:

> The folks that hired me obviously knew I would be coming from a wraparound perspective, and they are quite aware of what we’ve done here in Milwaukee and what I do in other states. So they definitely knew, they knew what they wanted, and they knew what I had to offer, and they knew what the coaches I would bring had to offer. But there was a communication breakdown from there—lots of barriers in terms of VO versus state, versus who we are. I’m amazed at how well we’ve been received; the agencies have really embraced the model, have embraced us, and seem to just eat up any information you’ll give them. So that’s not been the challenge. It’s just been lack of design, or at least a lack of communication about a model and what that means to everyone and lots of looseness around it.
Better Communication

The coaches understood the problems with communication among stakeholders to be inextricably related to the murky design and goals of the CH program as it stood. They felt there needed to be better communication between the state, VO, and providers about the design of CH and what the coaches could offer in terms of training and assistance. If the provider agencies had been better prepared before the coaches arrived, the program would have gotten off to a stronger start and the coaches could have hit the ground running in terms of training and coaching. Their jobs would have been easier and they would have been more effective. For example, providers needed to know which training modules were being taught when, and who was required to go to the trainings. One coach clarified:

From the beginning there needs to be a clear understanding of agencies about what we can do. I think that because people just didn’t know what this was or what to do with us that they underutilized us. We could have done a lot more out of the gate. I think to start with the training first thing you know as soon as possible would have helped. I also think that if the agencies knew what we could provide in terms of helping them to structure, first of all they would need to have staff hired so that we can assist in training the staff which didn’t happen for most of the agencies and I get why, but…those are things that probably would have really helped. And then what that would have done would’ve allowed us to structure our visits a little bit better because we could set up, make sure we have a person who can set up team meetings and would come and are actually in the meetings with and helping and learn the process as opposed to kind of troubleshooting and things that we can do over the phone usually.

The coaches also suggested that there needed to be better communication both internally within provider agencies and among them.

Several coaches wanted to make it clear that they did not necessarily blame agencies or the providers that work for them for their perceived deficits. In fact, one coach pointed to the lack of transparent communication among stakeholders as one reason why some of the agencies might not be as far along in implementing the CH precepts as expected. The coach said:

What’s hard is when you have been in the different roles that I’ve worked in. You begin to understand that sometimes agencies are held accountable for things that have never been clearly articulated. So sometimes it’s hard to say that it’s their fault. You know, that they need to do this, this, and this, because maybe they heard it at one meeting, but there was never anything, never other real teeth put into anything. So they’re allowed to go and do what they’re gonna do.
Lack of Quality Control and Lack of Leadership

Coaches stated that the model, as it was being implemented by New Mexico, was not adequately designed for quality control. Indeed, they felt that the model was not a good fit for the environmental idiosyncrasies they discovered in the state. One problem they cited was that there were few mechanisms by which stakeholders could simultaneously hold others accountable and be held accountable themselves. Implicit in these remarks was the idea that better leadership was needed. One coach commented:

There’s not a lot of people who can hold other people accountable the way it’s currently designed. There’s not even quality assurance to hold people accountable for what they’re supposedly learning or not learning. There’s not a lot of teeth in this, and there’s not a clear expectation of, “Here’s what you need to have in order to do this. Here’s what we’re gonna coach on after you’ve learned this.” So I’d like to see a more thought-out model that fits for New Mexico and what they’re trying to do. Having said that, in some ways I know why, I understand why it didn’t happen, because it’s a bit like putting the cart before the horse. They have to be pretty clear top down. “This is what we’re looking for and this is why. This is why we would have this kind of training and coaching model in place, because this is workforce development work we’re going to do. This is what we want the agencies to be doing. This is what we want the model to look like for kids and families involved in systems. And here’s the leadership that’s gonna roll it out and make sure that it’s happening.” So when all is said and done, I’m always amazed—not just in New Mexico but other places—I think people do want to do the right thing for the most part. People want to learn what they can learn. So in many ways there’s a lot of great things that have happened, but there’s a lack of clear leadership and accountability.

Coaches also explained there needed to be a clear and distinct system for monitoring children and families for progress. They asserted that a means for collecting data and evaluating the performance of the providers as well as the families was fundamental to the success of CH. One coach explained, “It would be nice to see more consistency around agency quality assurance; you know, that they would somehow come together to say, ‘What are we shooting for kids and families? And how will we hold ourselves accountable for that?’”

Stakeholder Education and Training

The coaches underscored the importance of educating judges and JJ professionals about how CH functioned. Basic skills development was also an area coaches mentioned was in need of attention. One coach explained:

I still think there’s a great deal of skill set improvement that’s needed. I’m really surprised at the lack of awareness and skill around good crisis safety planning.
That’s just one example. But in general there’s still a pretty big need for some focused training and skill set development if they’re gonna continue using a wraparound model. It’s a lot harder than people think. You read it and you see it and it sounds so simple and it sounds so common sense. It’s really not that easy for providers. So the biggest need is probably a continuation of skill set training in order to do the work in a variety of areas.

Coaches also felt provider agencies needed more time to get used to the idea of collaborating with families. Many of them were still operating by means of a therapeutic model that placed the therapist at the top of the hierarchy. Families and communities, too, needed education because frequently people thought that the safest place for youth was juvenile detention. Communities, too, would rather have youth offenders in jail than at home in their midst.

**Funding Challenges**

According to coaches, one barrier preventing CH agencies from nurturing the Milwaukee model in New Mexico was funding. Agencies simply could not afford to assign the recommended eight to ten families to one care coordinator. Rather, they had to load their case managers/care coordinators with many more families than was recommended by the model and the coaches.

Coaches indicated that providers had communicated their frustration at not having enough money to operate effectively. Coaches responded to these concerns by encouraging the provider agencies to be creative in getting the needs of the youth and families met in cost-effective ways. One coach said:

> If they want to be creative about providing an intervention whether that’s in a family’s home or something innovative that maybe they haven’t tried before, they still get stuck on how do we get this done if they shut us down or can’t give us the money to fund it. So I try to help them find creative ways of soliciting the community to get what they need.

**Resource Development**

The coaches argued that work still remained in the area of community resource development. One coach explained:

> There needs to be some resource development in terms of families. I haven’t gotten a really good sense of the communities here in terms of do they have available foster families if kids don’t have families or can’t go to families. They really shouldn’t be sitting in detention or in institutions. First and foremost we’d want to identify that family and see if they work. But if not, there needs to be something else for them and that your community needs to start building those resources because [there is] not a lot out there.
Part IV: Community Member Perspectives

(Youth and Families)
I. What is Clinical Home?

In general, participating youth could not provide a clear definition of CH or elaborate on the functions of CH or services provided other than case management. When asked for a definition of the CH, most youth responded with statements such as, “I don’t know.” In some instances, youth remained unaware that they were enrolled in a program called, “Clinical Home.”

For the few youth able to elaborate on CH functions or services provided under CH, responses generally centered on the centrality of case management. The experience of CH was dependent on the relationship that the youth had forged with her/his case manager. Youth often mentioned that that case managers assigned through CH spent more time with them and provided “better” services than previous case managers with whom they had worked. One youth said, “The case managers like Clinical Home, they’re more there to help you than what the regular case management is like. They’ll help you find a job better and they’re there for you whenever you need them and stuff like that.” Another youth appreciated the advocacy role assumed by case managers, saying, “If we need help with something, they’re there to help us. Like sometimes if my mom has a question, she’ll take it to one of the people that are from Clinical Home, and then they bring it up to the judge and my PO. They advocate for us.”

While most family members were unable to provide a concrete definition of CH, they all understood its overall intention of helping youth. One family member stated, “I don’t understand all of it, but my understanding is that they help—a new way to attempt to help the children get back on the correct path.”

One family member was able to give a detailed description of CH:

It’s a comprehensive program to provide services for children with special needs, high needs. It’s supposed to follow the child wherever they go up until the age of 21, providing them services, case management, whatever they need. I don’t know if it’s called kind of like wraparound services, extra case management. It’s a team approach. I mean, it’s an all-around—it’s everything that this child needs. And it’s handled by one agency versus several agencies.

Many family members understood that CH involved a greater number of providers who were involved in the child’s life, including doctors, counselors, case managers, and people from the JJ system.

II. Learning about Clinical Home

Youth learned about CH from family, law enforcement officials—in particular juvenile probation officers—and case managers. In general, youth reported that they had not been provided with much, if any, upfront information on the CH and what to expect other than receipt of case management services. One youth said, “[I was told] that I’ll keep
case management through the whole time, that I’ll have somebody there that will help me with anything—like if I need to go do stuff for school or whatever—they’ll help me. They just find everything out and reiterate it to me. They just help me as much as I need and that makes things move faster.” The source of information in this instance was the youth’s case manager. This youth, along with numerous others, mentioned that the information provided by the case manager was clear and understandable.

Family members learned about CH through the legal system, CYFD, VO, and provider agencies. Most family members were not provided with much upfront information on CH, but understood that it was a “better option” in most cases, for youth. However, one family member did appear to have received some in-depth information from CYFD regarding CH. She said:

Well, through CYFD, because they were just finding out about this as well, it was just that it was an intensive program that kind of follows the child no matter where they are, you know, whether they’re residential, whether they’re home, wherever. But it follows them and provides the wraparound services.

Family members reported several reasons for taking part in CH. One parent reported being forced to take part in CH, while most other family members participated in CH because they understood it to be the best option for the youth involved. One family member claimed that she desperately needed help because she was unable to make the proper connections to agencies for services on her own:

I had a case worker at ValueOptions, and all of a sudden I found out that person was no longer there, and they assigned me a new one, and then when I called her I found out that she was no longer my case worker through ValueOptions and so it was kind of like where do I go now? But she provided me then with a phone number of, I assumed he was a supervisor.

The family member continued:

Well, at first I didn’t understand what was going on. I kind of got the feeling that ValueOptions was just dumping us. And that upset me because it had been kind of nice being able to deal directly with somebody from there to alert them to the things that were going on. And seems we couldn’t get the extra help that my grandchild needs and, of course, now I don’t have that option anymore because now they don’t even answer my phone calls…. I was placing several phone calls to several different people and not getting responses back to my phone calls. And, you know, where do I, as a layperson, who doesn’t know that system that well, where do we turn to next? And so, having somebody who is better acquainted with the system, who’s worked in it for a little while—hopefully that person could make the connections that I obviously could not make.

Length of wait to get in the CH varied immensely according to family members. One family member reported an immediate response with an assessment within 24 hours
taking place. For the most part, however, both youth and family members reported a wait ranging from a couple days to one week.

III. Thoughts about Being Part of Clinical Home

Youth commented on the positive aspects of CH, including having someone there to talk to, learning to control anger, learning coping skills, assistance with transportation, and having someone there to help navigate the system. Very few youth reported anything negative. On this front, one youth complained about “mixed messages.” She said, “There’s too many mixed messages that go around. It’s not just all the same thing. It doesn’t move at the pace that they tell you it’s going to and a lot of times you don’t have answers for a while and they don’t know what’s going on.” One other youth complained that the CH treatment team was “always in his business,” a comment which, though meant negatively, spoke positively to the attention of CH personnel to youth in the program.

All family members were happy to be involved in CH and had positive experiences to report. They believed that help with coordination of services and the overall involvement of other family members were extremely important aspects of CH. Yet, they also discussed negative aspects of CH, including inadequate communication, uncertainty that CH would work, difficulty tracking down providers for answers to questions, and clinical meetings that were sometimes held without informing other participating family members. One family member also expressed the grievance that though CH had originally helped her through financial difficulties, this type of support had since ceased, “leaving her hanging” in terms of rent and car repairs.

IV. Services Utilized under Clinical Home

Services reportedly used by youth included: therapy, assistance with finding a job, assistance with school registration, family counseling, transportation, keeping track of appointments, and advocating on their behalf during court meetings. Youth all agreed that the services were “really useful” and did not have any ideas for improvement other than “just getting things done properly and more accurately.”

Services reportedly used by family members represented a relatively small and narrow list. These services included: assistance with filling out forms (e.g., Medicaid enrollment), help locating the “right” treatment, financial assistance, and counseling or therapy.

V. What is Positive about Clinical Home Providers?

Youth generally spoke very highly of their case managers, observing that they were always there for them when they needed to talk. One youth asserted that the case managers at her CH were there because “they want to help” and were not working merely for financial benefit. She explained, “They’re just really there to help you. They’re
Family members appeared very satisfied with their providers. They described providers as knowledgeable, caring, good listeners, understanding, willing to work around schedules, and willing to bend over backwards to help.

**VI. What is Negative about Clinical Home Providers?**

The only negative aspect discussed was that providers were not always “on the same page,” otherwise youth had little negative to report. One youth explained, “Like there’s something that the doctor might know but my case manager doesn’t know or my therapist knows but my case manager doesn’t know that it’s not getting, you know calls aren’t being made through everybody. It’s just kind of they don’t always know what’s going on.” Several youth also reported that they did not think the multi-systemic therapy they were receiving to be helpful.

Overall, family members did not have much negative to share about CH providers. The only negative comments implicated lack of communication and an inappropriate facility placement for one youth. One parent did comment that the success of Clinical Home depended largely on adequately trained providers and the importance of them being open to the CH model.

**VII. Involvement in Treatment Planning**

Most youth claimed to be involved in treatment planning, observing that they had participated in stating what goals or problems they wanted to focus on, and what they believed they needed help with. Case managers responded to those goals and then formed their plans around them. One youth explained, “My case manager asks me what do I want and what do I need. And she tries to give me ways for me to choose what I want to get from the program and not let just my mom choose—I can help choose, too.”

The youth seemed to feel that they were treated well by their providers, and as equal partners. For example, when asked if he felt he was treated as an equal partner one youth responded, “Yes, very much so actually.”

Family members appeared to play some role in treatment planning processes, although in some cases it was limited. One family member mentioned, “The only part that we’ve been involved in is when we had the big meeting and they had all the different people there that could talk about what services are available for her. That’s the only thing we’ve been involved in.” Another family member described the positive experience of being involved in the primary meeting, but noted the lack of follow up and feeling like the family was left hanging ever since. A third family member found the process to be somewhat overwhelming due to the large number of participants, “There were so many
people involved that I don’t even know, at this point in time, who they all were or where they were from. They were introduced to me and I understood at the time, but everybody worked really hard to get my granddaughter in the appropriate school.” At the same time, there were family members who considered themselves to be fully involved in the planning process. One family member said, “Oh my gosh. I mean, I’ve been on top of everything, making sure everything’s done. I mean, I’m still around. I mean I’ve done everything, so I don’t know what I’m lacking on, you know?”

VIII. Impact of Clinical Home

Youth suggested that involvement in CH had impacted their relationships in the home setting positively, if at all. Several youth reported positive changes in the home environment, stating that they had become more “helpful” and “respectful” at home. Similarly, family members did not find that the CH had exerted much of an effect on the home other than creating a less stressful environment. One family member did discuss a positive impact on her relationships with others outside of the home as she has less to complain about since becoming involved with CH.

Some youth suggested that CH had exerted a positive effect on their experience of school. One youth observed:

At school, if I get in trouble, my case manager is right there beside me to say, “Well, you know?” Like to figure out what’s going on. And to try to help me make the best decisions than what I did make. Like when I got suspended from school my case manager—I called her right away and she was right there for me. She was telling me, “You know this?” You know, try to help me make better decisions than that I did.

One youth said CH affected her relationships with others. Since becoming CH, she stopped communicating with friends with whom she had done drugs. She said this was a positive change. Similarly, family members did not report much effect on these relationships, with the exception of one youth no longer hanging out with friends who were perceived as negative influences.

IX. Legal Issues

Involvement in CH deterred some youth from further legal infractions. One youth said that her legal issues had “gotten better” since she became part of CH. She clarified, “They helped me stay out of trouble and not to steal cars, not to steal….I look up to one of the staff, they just tell me why it’s bad and then I’m just gonna be on probation forever and I don’t want to be on probation.” A second youth commented, “I’d say it has made a difference, ‘cause like right now me and my family are at the point where we don’t need any more problems, ‘cause we’re already in enough ‘cause of me.” A third youth added, “We don’t even have freedom to go shopping or anything after 7:00. And so right now they do help us if we do need time after 7:00 or anything for any reason they will help
me by contacting my PO and stuff. But yeah, right now we haven’t got in any more trouble or nothing.”

Family members likewise noted that youth in CH experienced a decrease in legal troubles.

**X. Out-of-Home Placement**

Some youth mentioned specific residential treatment and inpatient programs that they would have accessed if it were not for CH. They said that CH enabled them to stay out of such places.

Family members reported that some youth in CH had utilized residential treatment and group home services.

**XI. Designing a Clinical Home**

Overall most youth were satisfied with services provided by CH. One youth wanted to increase the number of team meetings. She suggested having “more meetings to make sure everybody’s on the same page and meet with the client, their family, the therapist, everybody that’s involved that’s on the team to help more often to get everything to know exactly everything that’s going on so they’ll be all on the same page.”

Overall most family members were also satisfied with services provided by CH. Some suggestions for improvements included: increasing communication through more frequent updates by providers; increasing the number of CH staff; making sure the CH staff was adequately trained in the concept and practice of CH; and creating a peer support system for the CH youth. In terms of communication, family members wanted more information about what was going on with youth through more frequent meetings, phone calls or written reports. When asked how services could be improved, one family member responded, “Just by communicating with us and kind of letting us know what’s actually being used, because they have lots of things available to them but because they’ve kind of taken over coordinating all that we’re not necessarily in a regular contact, other than that initial meeting.” In terms of peer support, one family member explained:

> Okay. I think that—and don’t laugh at me—but I’ve thought about this with <name> before. Big Brothers and Big Sisters. I think to have a role model that says you know, not one like mom, you know, one that’s more his own age, a peer that is good and say, “You know, we can go and have fun and do this instead of doing this.” You know?

One family member suggested that it was important to raise awareness within the state legislature of the challenges confronting youth in CH, as well as in the broader behavioral health system. She explained:
There needs to be people appointed who will deal with our legislatures, so that they can see that mental health care in New Mexico is sadly lacking. And they're the only ones who can really change this. They've cut back funding so, therefore, the facilities are really careful about who they will accept. And we just need better response from the people in Santa Fe to the care of people who through no fault of their own, or even through fault of their own, you know, because of some cases that's the case, have mental health issues. I think that responsibility lies with them. I've contacted <name's> office and I've got nothing in return. And so I'm a little, little disenchanted with him right now. So, because I think those are the people who make a difference for the rest of us.

Contact was an ongoing problem, this participant reported:

I don’t really know how to go about contacting these people. Maybe that is something that could be added to the program. That if we want to do some contacting on our own that we be given information as to how we could do that in a positive way, so that our senators, our legislatures, are more responsive to us.
Part V: Quantitative Analysis
Quantitative Data Analysis Overview:

The scope of work for the Clinical Home (CH) evaluation included several quantitative data analysis objectives. These objectives included an evaluation of

1) Utilization of Behavioral Health Services
2) Interactions with the Juvenile Justice System (JJS)
3) Timely assessment
4) Successful engagement
5) Reduced recidivism

Objectives #2 and #5 were combined into a single analysis of recidivism and interactions with the JJS after assessment in CH. In addition, the evaluation of out-of-home clinical care under objective #5 was incorporated into objective #1 since each is an evaluation of behavioral health services utilization. Each objective includes a set of analyses that are more fully described under each objective section.

Data Sources:

Three data sources were used for the quantitative evaluation of CH: The Value Options Claims Database (VOCD), the Value Options Clinical Home Referral Database (VOCHR), and the CYFD FACTS Database (FACTS).

Value Options Claims Database (VOCD): The VOCD was provided to BHRCS evaluators in an Excel spreadsheet. Data included all claims from each youth’s first contact with behavioral health services administered by ValueOptions (VO) up until December 1, 2007. Each entry records a distinct claim, including a description, category, provider, date, and claim amount (in dollars paid by VO) for each service provided to each subject. Each entry identifies primary, secondary, and tertiary diagnosis based on the International Classification of Diseases, version 9 (ICD-9) at the time of service. Records for each subject also include date of birth, gender, race/ethnicity, primary, secondary, and tertiary ICD-9 diagnoses at the time of enrollment into the VO database. The VOCD constitutes the primary database for evaluating behavioral health services utilization of subjects enrolled in CH.

Value Options Clinical Home Referral Database (VOCHR): The VOCHR included the date of referral to CH, the date of first contact, and the date of assessment in CH. The VOCHR was provided to BHRCS evaluators in hard copy format, and was subsequently data entered into an Excel spreadsheet. The VOCHR was used primarily to identify the start date, defined as the assessment date, of participation in CH.

CYFD FACTS Database (FACTS): The FACTS is a record of charges filed against each subject that resulted in a petition. Data include identifiers, incident dates, and charges, along with administrative details used by the JJS. The FACTS is used to collect data on CYFD Protective Services and JJS clients, including all contact with the JJS.
Data Limitations: Data for this evaluation were extensive; every claim for every behavioral health service encounter paid by VO during the observation period was recorded in the VOCD, as was every criminal incident leading to a petition for each subject. However, it is not clear if there was ever a lag between the service encounters, incident dates, and entry into each database. For example, a recent encounter may not have been processed and entered into the VOCD by the time the VOCD was pulled for the BHRCS evaluators. Thus, behavioral health services utilization rates may be underestimated towards the end of 2007. This was also a problem with the VOCHR database. There may have been a lag between the assessment date and the date that it was recorded in the paper forms. Accordingly, it may appear that more recent enrollees in CH were never assessed. This is simply because the assessment date had not yet been entered into the VOCHR paper forms that had been ultimately given to BHRCS. Similarly, there may be a lag between an incident that would lead to a petition, and entry of that record in the FACTS. As such, however, if the date is missing in the database, it is interpreted as never having occurred.

Several fields in the claims database had frequent missing values. These are summarized in Table 1, below. Of particular concern were the Ethnicity and Primary Enrollment ICD-9 codes. The abundant missing data obviated any opportunity to conduct more detailed analyses of utilization or recidivism by diagnosis or race/ethnic categories.

Table 1: Missing Data summary for the VOCD. Counts refer to entries in the VOCD.

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<th>VARIABLE</th>
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<th>% Missing</th>
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</tr>
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<td>&lt;1%</td>
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<td>Secondary Enrollment ICD-9</td>
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<td>Service Description</td>
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</tr>
<tr>
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</table>
Data were provided by Value Options on 259 youths identified as having been referred to CH between April 16, 2007 and December 1, 2007. Identifiers, claims data, or referral dates were missing for 138 youths, leaving a total of 121 subjects providing valid data for this analysis.

**Objective #1: Utilization of Behavioral Health Services.**

A) Create a descriptive profile for intervention enrollees.
B) Analyze/write-up data on enrollee utilization of behavioral health services 2 years prior to intervention.
C) Analyze/write-up comparison of enrollee utilization of behavioral health services 6 months prior to and 6 months after enrollment.

**Measures and Definitions:**

The intervention start date is defined as the date that assessment occurred. Subjects who were referred but never assessed never received the CH intervention, and thus do not contribute to the pre/post analysis. Of the 121 subjects providing valid data, 96 had valid assessment dates and were used for parts (B) and (C) of this objective.

The assessment date separates pre-CH from post-CH periods for each subject. The length of the pre-CH period is defined as the number of months between first appearance in the VOCD and the assessment date. The post-CH period is defined as the number of months between the assessment date and December 1, 2007.

For analysis (C), the six month pre-CH was defined as the minimum of the pre-CH period and six months. Likewise, for analysis (C), the six month post-CH period was defined as the minimum of the post-CH period and six months. These definitions ensured that valid behavioral health services utilization rates would be computed for each period.

The age of each subject was defined as the number of years between the date of birth and the date of referral to CH. The baseline ICD-9 code was defined as the most specific diagnosis for each patient extracted from the primary, secondary, and tertiary ICD-9 codes identified for each patient in the VO enrollment forms.

Behavioral health services were classified into one of six categories by the evaluation principal investigator in collaboration with a CYFD representative. These categories are out-of-home placement, case management, intensive treatment (including day treatment, psychosocial rehabilitation, home-based treatment, and BMS/Skills training), psychiatry services, outpatient therapy services, and screening/excluded/unlisted services. Service descriptions within each category are listed in Appendix 1.

Behavioral health services “Utilization” is defined on two scales: encounters and dollars paid by VO on a claim. Each claim in the VOCD defined a separate behavioral health service encounter. For example, ten claims for ten services delivered on the same day
are recorded as ten separate encounters. The amount paid by VO for each encounter was specified in the VOCD. Utilization was computed separately for each category of service. Total utilization was also computed as the sum of all encounters or dollars paid in all categories.

Statistical Methods: Baseline summaries statistics were generated for the 121 subjects providing valid data for this analysis to construct a descriptive profile of the CH population. Separate summaries for males and females were generated.

The rate of behavioral health services utilization was computed as the sum encounters (or dollars paid by VO) divided by the sum of the person-months during which services were accumulated for either the pre-CH or post-CH periods. When computed for an individual, these statistics identify the average monthly utilization for that individual. Similarly, the sum encounters over the entire population divided by the sum person-months over the entire population defines the average monthly utilization for a member of the CH population.

Utilization up to two years prior to entry into CH was computed for the entire sample and separately by six-month period prior to enrollment. The goal of the latter analysis is to estimate changes in utilization leading up to enrollment into CH.

Utilization rates were compared between the pre-CH and post-CH periods. The Sign test was used to test the null hypothesis of no difference in encounter rate or expenditure rate after enrollment in CH. Tests were conducted for all service types and separately for each category of service.

The pre-CH and post-CH utilization rates were statistically modeled using generalized linear models. The encounter rates were modeled using Poisson regression. The log(expenditures+1) were modeled using normal errors regression. The log length of the pre-CH or post-CH period was included in each model as an offset term. Generalized estimating equations (GEE) were used to adjust the fitted regression coefficients, and associated standard errors, for the intra-subject correlation in behavioral health services utilization. Each model included a gender and a period indicator as predictors. The exponentiated regression coefficient for the period effect expresses the relative increase (or decrease) in the behavioral health services utilization rate after enrollment in CH. The GEE methodology requires that these relative rates be interpreted as population averaged effects.

RESULTS:
Objective #1: Utilization of Behavioral Health Services.

A) Create a descriptive profile for intervention enrollees.

Table 2 summarizes the age distribution and months between entry into CH and the database extraction date, but gender for all subjects referred. Overall, males referred to
CH are younger than females. However, the most represented age group for either gender is 16-17 years old (females = 43.1%; males = 38.6%). Table 2 also shows the mean, minimum, and maximum number of months observed in CH. The average was 4.0 months for females and 4.1 months for males. These short observation periods require that one interpret any evaluation of the impacts of CH with considerable caution.

Baseline ICD-9 diagnoses by gender are shown in Table 2a. The majority of subjects did not have a baseline ICD-9 code entered in the enrollment data. 29.4% of females and 40% of males had unknown psychiatric disorders. Otherwise, the most highly represented diagnosis in the sample was (313.81) Oppositional defiant disorder of childhood or adolescence (14.9% of the sample), followed by ill-specified disorders associated with conduct (e.g. 309.3 & 312.89) or for encounters with health services (e.g., V61.20). 4.1% of subjects had a baseline diagnosis of Attention deficit disorder of childhood with hyperactivity (314.01). The excessive missing data and low resolution of individual diagnoses restrict the utility of the analysis of baseline diagnoses for referrals to CH.

<table>
<thead>
<tr>
<th>Table 2: Characteristics of 121 subjects referred to Clinical Home</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F (N=51)</td>
</tr>
<tr>
<td>Age at referral</td>
<td></td>
</tr>
<tr>
<td>11-13</td>
<td>N</td>
</tr>
<tr>
<td>%</td>
<td>5.9</td>
</tr>
<tr>
<td>14-15</td>
<td>N</td>
</tr>
<tr>
<td>%</td>
<td>27.5</td>
</tr>
<tr>
<td>16-17</td>
<td>N</td>
</tr>
<tr>
<td>%</td>
<td>43.1</td>
</tr>
<tr>
<td>18-20</td>
<td>N</td>
</tr>
<tr>
<td>%</td>
<td>23.5</td>
</tr>
<tr>
<td>Months in Clinical Home</td>
<td>Mean</td>
</tr>
<tr>
<td></td>
<td>Min</td>
</tr>
<tr>
<td></td>
<td>Max</td>
</tr>
<tr>
<td>ICD-9 code</td>
<td>N</td>
</tr>
<tr>
<td>------------</td>
<td>---</td>
</tr>
<tr>
<td>(296.2) Major Depressive Disorder Single Episode</td>
<td>0</td>
</tr>
<tr>
<td>(296.22) Major depressive affective disorder single episode moderate degree</td>
<td>0</td>
</tr>
<tr>
<td>(296.31) Major depressive affective disorder recurrent episode mild degree</td>
<td>1</td>
</tr>
<tr>
<td>(300.4) Dysthymic disorder</td>
<td>1</td>
</tr>
<tr>
<td>(304.3) Cannabis dependence</td>
<td>0</td>
</tr>
<tr>
<td>(305.00) Nondependent alcohol abuse unspecified drinking behavior</td>
<td>1</td>
</tr>
<tr>
<td>(305.2) Nondependent cannabis abuse</td>
<td>1</td>
</tr>
<tr>
<td>(309.3) Adjustment disorder with disturbance of conduct</td>
<td>2</td>
</tr>
<tr>
<td>(309.81) Posttraumatic stress disorder</td>
<td>2</td>
</tr>
<tr>
<td>(309.9) Unspecified adjustment reaction</td>
<td>0</td>
</tr>
<tr>
<td>(311) Depressive disorder not elsewhere classified</td>
<td>3</td>
</tr>
<tr>
<td>(312.30) Impulse control disorder unspecified</td>
<td>0</td>
</tr>
<tr>
<td>(312.8) Other specified disturbances of conduct not elsewhere classified</td>
<td>0</td>
</tr>
<tr>
<td>(312.81) Conduct disorder childhood onset type</td>
<td>0</td>
</tr>
<tr>
<td>(312.82) Conduct disorder adolescent onset type</td>
<td>3</td>
</tr>
<tr>
<td>(312.89) Other specified conduct disorder not elsewhere classified</td>
<td>1</td>
</tr>
<tr>
<td>(312.9) Unspecified disturbance of conduct</td>
<td>1</td>
</tr>
<tr>
<td>(313.81) Oppositional defiant disorder of childhood or adolescence</td>
<td>9</td>
</tr>
<tr>
<td>(314) Attention Deficit Disorder of Childhood</td>
<td>0</td>
</tr>
<tr>
<td>(314.01) Attention deficit disorder of childhood with hyperactivity</td>
<td>0</td>
</tr>
<tr>
<td>(315.9) Unspecified delay in development</td>
<td>0</td>
</tr>
<tr>
<td>(799.9) Other unknown and unspecified cause of morbidity or mortality</td>
<td>1</td>
</tr>
<tr>
<td>(V60.8) Other specified housing or economic circumstances</td>
<td>1</td>
</tr>
<tr>
<td>(V61.20) Counseling for parent-child problem unspecified</td>
<td>4</td>
</tr>
<tr>
<td>(V61.21) Counseling for victim of child abuse</td>
<td>1</td>
</tr>
</tbody>
</table>
Table 2a: ICD-9 diagnoses by gender.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>F</th>
<th>M</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N  %</td>
<td>N  %</td>
<td>N  %</td>
</tr>
<tr>
<td>(V62.3) Educational circumstances</td>
<td>0  0%</td>
<td>2  2.9%</td>
<td>2  1.7%</td>
</tr>
<tr>
<td>(V71.09) Observation of other suspected mental condition</td>
<td>4  7.8%</td>
<td>1  1.4%</td>
<td>5  4.1%</td>
</tr>
<tr>
<td>Unknown</td>
<td>15 29.4</td>
<td>28 40.0</td>
<td>43 35.5</td>
</tr>
<tr>
<td>All</td>
<td>51 100.0</td>
<td>70 100.0</td>
<td>121 100.0</td>
</tr>
</tbody>
</table>

Objective #1: Utilization of Behavioral Health Services.

B) Analyze/write-up data on enrollee utilization of behavioral health services 2 years prior to intervention.

Table 3 shows average per-capita behavioral health services utilization up to two years prior to assessment in CH. Results are shown separately for males and females. Overall, each subject experienced on average 4 (females) and 4.9 (males) behavioral health service encounters per month prior to assessment in CH. Per-capita average dollars paid by VO during that time was $1,321 (females) and $1,705 (males). The most frequently used services fell into the intensive outpatient category. The highest average per-capita expenditures were paid for out-of-home placement ($986 for females and $1,248 for males).

<table>
<thead>
<tr>
<th>Table 3: Behavioral health services utilization up to 2 years prior to assessment in the Clinical Home.</th>
<th>Females</th>
<th>Males</th>
</tr>
</thead>
<tbody>
<tr>
<td>All services</td>
<td>4.0</td>
<td>$1,321</td>
</tr>
<tr>
<td>Out-of-home placement</td>
<td>0.8</td>
<td>$986</td>
</tr>
<tr>
<td>Case management</td>
<td>0.6</td>
<td>$41</td>
</tr>
<tr>
<td>Intensive tx (day treatment, psycho-social rehabilitation, home based, BMS/Skills training)</td>
<td>1.7</td>
<td>$221</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>0.4</td>
<td>$34</td>
</tr>
<tr>
<td>Outpatient therapy services</td>
<td>0.4</td>
<td>$27</td>
</tr>
<tr>
<td>Excluded/Unlisted/Screening</td>
<td>0.1</td>
<td>$14</td>
</tr>
</tbody>
</table>

Table 4 shows the number and percent of subjects with at least one behavioral health service encounter during four six-month periods prior to assessment in CH. For example the “N Claiming” column in the “0-6 months pre-assessment” category identifies the number of subjects who had at least one behavioral health service encounter during the six months prior to assessment. In general, Table 4 indicates that
the number of subjects with behavioral health service encounters increased over time up until assessment in CH.

Table 4: Subjects with one or more encounters over time before referral to Clinical Home.

<table>
<thead>
<tr>
<th></th>
<th>0-6 Months pre-referral</th>
<th>6-12 Months pre-referral</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N Claiming</td>
<td>% Claiming</td>
</tr>
<tr>
<td>All services</td>
<td>76</td>
<td>63%</td>
</tr>
<tr>
<td>Out-of-home placement</td>
<td>35</td>
<td>29%</td>
</tr>
<tr>
<td>Case management</td>
<td>40</td>
<td>33%</td>
</tr>
<tr>
<td>Intensive tx (day treatment, psycho-social rehabilitation, home based, BMS/Skills training)</td>
<td>31</td>
<td>26%</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>56</td>
<td>46%</td>
</tr>
<tr>
<td>Outpatient therapy services</td>
<td>45</td>
<td>37%</td>
</tr>
<tr>
<td>Excluded/Unlisted/Screening</td>
<td>33</td>
<td>27%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>12-18 Months pre-referral</th>
<th>18-24 Months pre-referral</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N Claiming</td>
<td>% Claiming</td>
</tr>
<tr>
<td>All services</td>
<td>52</td>
<td>43%</td>
</tr>
<tr>
<td>Out-of-home placement</td>
<td>19</td>
<td>16%</td>
</tr>
<tr>
<td>Case management</td>
<td>19</td>
<td>16%</td>
</tr>
<tr>
<td>Intensive tx (day treatment, psycho-social rehabilitation, home based, BMS/Skills training)</td>
<td>25</td>
<td>21%</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>37</td>
<td>31%</td>
</tr>
<tr>
<td>Outpatient therapy services</td>
<td>31</td>
<td>26%</td>
</tr>
<tr>
<td>Excluded/Unlisted/Screening</td>
<td>22</td>
<td>18%</td>
</tr>
</tbody>
</table>

Objective #1: Utilization of Behavioral Health Services.

C) Analyze/write-up comparison of enrollee utilization of behavioral health services 6 months prior to and 6 months after enrollment.

Tables 5a and 5b summarize mean utilization six months pre-CH and six months post-CH for females and males, respectively. Among females, there were no statistically significant changes pre- to post-assessment in any category of service other than case management. These jumped from an average of 0.63 per month to 2.9 per month (p<0.01). This change in the claim rate is also reflected in the change in dollars paid by VO, which increased per-capita from $53 per month to $158 per month (p<0.01).
Results are fairly consistent between males and females in the sample: there was a significant increase in the rate of case management utilization after versus before entry into CH (0.54 to 2.23 claims per month; p<0.01), which resulted in more expenditure by VO ($32 to $116; p<0.01). Additionally, claims rates among males over all services were statistically higher after assessment in CH (3.46 to 5.34; p<0.05). Rates of utilization for most service categories increased over time among males and females, with the exception of intensive outpatient treatment, which generally decreased after entry into CH. None of these, other than case management, were significantly different pre- to post-assessment in CH.

### Table 5a: Female claims rates 6 months pre- and post-assessment in the Clinical Home.

<table>
<thead>
<tr>
<th></th>
<th>Pre-Assessment Avg. Monthly Claims</th>
<th>Post-Assessment Avg. Monthly Claims</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>All services</td>
<td>3.67</td>
<td>6.45</td>
<td>0.11</td>
</tr>
<tr>
<td>Out-of-home placement</td>
<td>0.77</td>
<td>0.94</td>
<td>0.68</td>
</tr>
<tr>
<td>Case management</td>
<td>0.63</td>
<td>2.90</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Intensive tx (day treatment, psycho-social rehabilitation, home based, BMS/Skills training)</td>
<td>1.34</td>
<td>0.82</td>
<td>0.31</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>0.49</td>
<td>0.67</td>
<td>0.62</td>
</tr>
<tr>
<td>Outpatient therapy services</td>
<td>0.31</td>
<td>0.73</td>
<td>0.72</td>
</tr>
<tr>
<td>Excluded/Unlisted/Screening</td>
<td>0.12</td>
<td>0.38</td>
<td>0.54</td>
</tr>
</tbody>
</table>

### Table 5a: Female VO payment rates 6 months pre- and post-assessment in the Clinical Home.

<table>
<thead>
<tr>
<th></th>
<th>Pre-Assessment Avg. Monthly $ Paid</th>
<th>Post-Assessment Avg. Monthly $ Paid</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>All services</td>
<td>$1,211</td>
<td>$1,070</td>
<td>1.00</td>
</tr>
<tr>
<td>Out-of-home placement</td>
<td>$842</td>
<td>$609</td>
<td>0.68</td>
</tr>
<tr>
<td>Case management</td>
<td>$53</td>
<td>$158</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Intensive tx (day treatment, psycho-social rehabilitation, home based, BMS/Skills training)</td>
<td>$241</td>
<td>$185</td>
<td>0.31</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>$47</td>
<td>$53</td>
<td>0.24</td>
</tr>
<tr>
<td>Outpatient therapy services</td>
<td>$19</td>
<td>$43</td>
<td>0.72</td>
</tr>
<tr>
<td>Excluded/Unlisted/Screening</td>
<td>$10</td>
<td>$23</td>
<td>0.84</td>
</tr>
</tbody>
</table>

### Table 5b: Male claims rates 6 months pre- and post-assessment in the Clinical Home.

<table>
<thead>
<tr>
<th></th>
<th>Pre-Assessment Avg. Monthly Claims</th>
<th>Post-Assessment Avg. Monthly Claims</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>All services</td>
<td>3.46</td>
<td>5.34</td>
<td>0.05</td>
</tr>
<tr>
<td>Out-of-home placement</td>
<td>0.59</td>
<td>0.68</td>
<td>1.00</td>
</tr>
<tr>
<td>Case management</td>
<td>0.54</td>
<td>2.23</td>
<td>&lt;.01</td>
</tr>
</tbody>
</table>
Table 5b: **Male** claims rates 6 months pre- and post-assessment in the Clinical Home.

<table>
<thead>
<tr>
<th>Service</th>
<th>Pre-Assessment Avg. Monthly Claims</th>
<th>Post-Assessment Avg. Monthly Claims</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intensive tx (day treatment, psycho-social rehabilitation, home based, BMS/Skills training)</td>
<td>1.10</td>
<td>0.95</td>
<td>0.81</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>0.43</td>
<td>0.46</td>
<td>1.00</td>
</tr>
<tr>
<td>Outpatient therapy services</td>
<td>0.51</td>
<td>0.52</td>
<td>0.09</td>
</tr>
<tr>
<td>Excluded/Unlisted/Screening</td>
<td>0.29</td>
<td>0.50</td>
<td>0.44</td>
</tr>
</tbody>
</table>

Table 5b: **Male** VO payment rates 6 months pre- and post-assessment in the Clinical Home.

<table>
<thead>
<tr>
<th>Service</th>
<th>Pre-Assessment Avg. Monthly $ Paid</th>
<th>Post-Assessment Avg. Monthly $ Paid</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>All services</td>
<td>$1,296</td>
<td>$1,573</td>
<td>0.45</td>
</tr>
<tr>
<td>Out-of-home placement</td>
<td>$978</td>
<td>$1,184</td>
<td>0.69</td>
</tr>
<tr>
<td>Case management</td>
<td>$32</td>
<td>$116</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Intensive tx (day treatment, psycho-social rehabilitation, home based, BMS/Skills training)</td>
<td>$171</td>
<td>$135</td>
<td>0.48</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>$40</td>
<td>$38</td>
<td>0.74</td>
</tr>
<tr>
<td>Outpatient therapy services</td>
<td>$28</td>
<td>$33</td>
<td>0.09</td>
</tr>
<tr>
<td>Excluded/Unlisted/Screening</td>
<td>$47</td>
<td>$66</td>
<td>0.70</td>
</tr>
</tbody>
</table>

Summaries of pre- and post-CH utilization combining both males and females are shown in Table 5C. Results show a clear increase in both the number of claims (0.58 to 2.51 per month) and dollars paid by VO ($41 to $134) for case management services once assessment in CH occurs (p<0.01). Results indicate that the overall claim rate increase from 3.56 to 5.81 per month (p<0.01).

Table 5c: VO encounter rates 6 months pre- and post-assessment combining males and females.

<table>
<thead>
<tr>
<th>Service</th>
<th>Pre-Assessment Avg. Monthly Claims</th>
<th>Post-Assessment Avg. Monthly Claims</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>All services</td>
<td>3.56</td>
<td>5.81</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Out-of-home placement</td>
<td>0.67</td>
<td>0.79</td>
<td>0.67</td>
</tr>
<tr>
<td>Case management</td>
<td>0.58</td>
<td>2.51</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Intensive tx (day treatment, psycho-social rehabilitation, home based, BMS/Skills training)</td>
<td>1.21</td>
<td>0.90</td>
<td>0.28</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>0.46</td>
<td>0.55</td>
<td>0.82</td>
</tr>
<tr>
<td>Outpatient therapy services</td>
<td>0.42</td>
<td>0.61</td>
<td>0.43</td>
</tr>
<tr>
<td>Excluded/Unlisted/Screening</td>
<td>0.21</td>
<td>0.45</td>
<td>1.00</td>
</tr>
</tbody>
</table>
Table 5c: VO dollars paid 6 months pre- and post-assessment combining males and females.

<table>
<thead>
<tr>
<th>Service</th>
<th>Pre-Assessment Avg. Monthly $ Paid</th>
<th>Post-Assessment Avg. Monthly $ Paid</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>All services</td>
<td>$1,256</td>
<td>$1,362</td>
<td>0.51</td>
</tr>
<tr>
<td>Out-of-home placement</td>
<td>$915</td>
<td>$943</td>
<td>1.00</td>
</tr>
<tr>
<td>Case management</td>
<td>$41</td>
<td>$134</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Intensive tx (day treatment, psycho-social rehabilitation, home based, BMS/Skills training)</td>
<td>$203</td>
<td>$156</td>
<td>0.16</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>$43</td>
<td>$44</td>
<td>0.64</td>
</tr>
<tr>
<td>Outpatient therapy services</td>
<td>$24</td>
<td>$37</td>
<td>0.43</td>
</tr>
<tr>
<td>Excluded/Unlisted/Screening</td>
<td>$30</td>
<td>$48</td>
<td>1.00</td>
</tr>
</tbody>
</table>

Table 6 shows results of the regression analysis of the encounter and expenditure rates. Quantities express the relative rate of encounter (column 1) or dollars paid (column 3) for each category of behavioral health service. After adjusting for gender, there was an estimated 1.7-fold increase in the overall monthly rate of encounters (p<0.0001), though there was no apparent change in the average monthly dollars expended over all service types (relative dollars paid = 1.6; p=0.21). Among specific service categories, the only statistically significant difference was in the utilization of case management services. Monthly utilization of these services saw a large increase after assessment in CH in both average monthly encounters (relative rate = 4.6; p<0.0001) and expenditures (relative rate = 11.3; p<0.0001).

Table 6: Regression results for utilization rate analysis.

<table>
<thead>
<tr>
<th>Service</th>
<th>Relative Encounter Rate (Pre- vs. Post-Clinical Home)</th>
<th>Relative $ Paid (Pre- vs. Post-Clinical Home)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All services</td>
<td>1.7</td>
<td>1.6</td>
</tr>
<tr>
<td>Out-of-home placement</td>
<td>1.2</td>
<td>1.4</td>
</tr>
<tr>
<td>Case management</td>
<td>4.6</td>
<td>11.3</td>
</tr>
<tr>
<td>Intensive tx (day treatment, psycho-social rehabilitation, home based, BMS/Skills training)</td>
<td>0.8</td>
<td>0.5</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>1.3</td>
<td>0.9</td>
</tr>
<tr>
<td>Outpatient therapy services</td>
<td>1.4</td>
<td>1.1</td>
</tr>
<tr>
<td>Excluded/Unlisted/Screening</td>
<td>2.2</td>
<td>0.8</td>
</tr>
</tbody>
</table>
Objective #2: Interactions with the Juvenile Justice System; Objective #5: Reduced recidivism.

Recidivism is defined as an incident that results in a petition and that occurs after assessment in CH. Incident dates were extracted from the FACTS and merged with the subject data in the VOCD. The number and percent of subjects recidivating were computed from the resulting database. Kaplan-Meier estimates of the percent recidivating after assessment in CH were also computed. The log-rank test of the null hypothesis of no difference in the recidivism curves of males and females was computed. Subjects who did not recidivate by December 1, 2007 were defined as censored on that date.

Results:

Eleven females (26%) and 13 males (24%) recidivated after assessment in CH. Among these, there were 46 distinct charges cited in petitions against these subjects. Seven were felonies (15%), 13 were misdemeanors (28%), and 24 (52%) were probation violations. Two citations had unknown charges (5%). Figure 1 shows recidivism curves for males and females. These curves identify the fairly high rate of recidivism for this population, though fewer than half recidivated by 180 days after assessment. There was no statistically significant difference in the recidivism curves of males and females.

Figure 1: Recidivism curves for males and females enrolled in CH.
**Objective #3: Timely Assessment.**

This objective evaluates the extent to which subjects referred to CH are being assessed in a timely manner. The assessment process in CH is divided by three dates. In chronological order these are: referral date, first contact date, and assessment date. Three intervals of time are analyzed for the purposes of this objective: a) the number of days between referral and assessment; b) the days from referral to first contact; and c) the days from first contact to assessment. Dates were extracted from the VOCHR.

For each interval the number and percent who did not achieve the endpoint are computed by quarter of 2007. Additionally, Kaplan-Meier estimates of the median length of each interval are computed, along with 95% confidence intervals. Subjects who did not meet the endpoint of each interval were defined as censored on December 1, 2007.

**Results:**

**A) Referral to Assessment.**

The number and percent of subjects who were not assessed after referral is shown by quarter of 2007 in Table 7. The higher percentage of subjects who were not assessed in more recent months are likely a result of a lag time between updating the VOCHR and the date that it was provided to the evaluation team. Thus, the 66% of referred subjects who went un-assessed between October and December, 2007 includes many subjects who were assessed but not entered in the VOCHR, as well as subjects who were not yet assessed as of the pull date of the VOCHR. The median time from referral to assessment was 9 days (95% confidence interval = 8 – 16 days).

<table>
<thead>
<tr>
<th>Quarter of 2007</th>
<th>No Assessment</th>
<th>Assessed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-Jun</td>
<td>2 (3.1%)</td>
<td>63 (96.9%)</td>
<td>65</td>
</tr>
<tr>
<td>Jul-Sep</td>
<td>9 (25.7%)</td>
<td>26 (74.3%)</td>
<td>35</td>
</tr>
<tr>
<td>Oct-Dec</td>
<td>14 (66.7%)</td>
<td>7 (33.3%)</td>
<td>21</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
<td><strong>96</strong></td>
<td><strong>121</strong></td>
</tr>
</tbody>
</table>

**B) Referral to First Contact.**

The number and percent of subjects who were not contacted after referral are shown in Table 8. This table clearly indicates that very few subjects were not contacted (a total of
only 2 were not contacted), and that this rate did not change since the inception of CH. The median time from referral to first contact was 2 days (95% CI = 2-3 days).

<table>
<thead>
<tr>
<th>Quarter of 2007</th>
<th>No Contact</th>
<th>Contact Made</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-Jun</td>
<td>0 (0%)</td>
<td>65 (100%)</td>
<td>65</td>
</tr>
<tr>
<td>Jul-Sep</td>
<td>1 (2.9%)</td>
<td>34 (97.1%)</td>
<td>35</td>
</tr>
<tr>
<td>Oct-Dec</td>
<td>1 (4.8%)</td>
<td>20 (95.2%)</td>
<td>21</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2</strong></td>
<td><strong>119</strong></td>
<td><strong>121</strong></td>
</tr>
</tbody>
</table>

**C) First Contact to Assessment.**

The number and percent of subjects who were not assessed after contact are shown in Table 9. There is a marked increase in the percent of subjects who went un-assessed since the inception of CH (3.1% in April to June, 2007 up to 65% in October to December, 2007). The reasons for this are listed in section (A). The median time from first contact to assessment was 6 days (95% CI = 4-11 days).

<table>
<thead>
<tr>
<th>No Assessment</th>
<th>Assessed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-Jun</td>
<td>2 (3.1%)</td>
<td>63 (96.9%)</td>
</tr>
<tr>
<td>Jul-Sep</td>
<td>8 (23.5%)</td>
<td>26 (76.5%)</td>
</tr>
<tr>
<td>Oct-Dec</td>
<td>13 (65.0%)</td>
<td>7 (35.0%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>23</strong></td>
<td><strong>96</strong></td>
</tr>
</tbody>
</table>

**Objective #5: Reduced Recidivism (Out-of-home placement)**

A. Analyze/write-up data on admittance to out-of-home clinical care for each individual 6 months prior to and 6 months after enrollment.
Measures and Analysis:

Analysis of this objective follows the procedures outlined for objective #1. In addition, the percent of subjects with at least one out-of-home placement claim in the VOPD is computed.

Results:

Rate of out-of-home utilization and claims amounts separated by gender are shown in tables 5a and 5b. Table 10 shows summaries of monthly per capita out-of-home placement claims and dollars paid, as well as the percent of subjects with one or more claims 6-months pre- and post-CH assessment. Results indicate an increase in the claims rate, dollars paid, and percent of subjects with one or more claims after assessment in CH. However, none of these changes were statistically significant at the 0.05 test level.

Table 10: Out-of-home services utilization. 6-months Pre-Assessment | 6-months Post-Assessment
--- | ---
Per-capita monthly claims | 0.67 | 0.79
Per-capita monthly dollars paid by VO | $915 | $943
% of subjects with one or more out-of-home service claim | 34% | 40%
Appendix: Data Collection Protocols
Clinical Home Personnel

1. What is a clinical home?
   a. How is a clinical home supposed to work?
   b. What types of services should a clinical home offer?
   c. What distinguishes these services from care as usual?

2. What are your thoughts about being part of a clinical home?
   a. What is positive about being part of a clinical home?
   b. What is negative about being part of a clinical home?

3. What type of preparation is needed for an agency or staff to operate effectively as a clinical home?
   a. What type of preparation did you and your co-workers receive?
   b. How useful was this type of preparation?
   c. What else do you and your co-workers need to operate effectively as a clinical home?

4. Can you comment specifically on the coaching on wraparound service planning that you and your co-workers were supposed to receive?
   a. In what ways was this coaching useful?
   b. In what ways was this coaching not useful?
   c. How have you applied lessons from the coaching process in your own work?
   d. How could the coaching process be improved?

5. How is the clinical home pilot project going?
   a. What has been positive about the pilot project experience?
   b. What has been negative about the pilot project experience?
   c. What lessons have been learned as a result of this experience?
6. What’s your take on the referral process? How would you describe the overall process?
   a. In what ways does this process work well?
   b. In what ways does it not work so well?
   c. How could the process be improved?

7. What’s your take on the timely assessment process? How would you describe the overall process?
   a. In what ways does this process work well?
   b. In what ways does it not work so well?
   c. How could the process be improved?
   d. How is assessment in the pilot project different than for your other clients?

8. What’s your take on the treatment process? How would you describe the overall process?
   a. In what ways does this process work well?
   b. In what ways does it not work so well?
   c. How could the process be improved?

9. To what extent are youth and families involved in the treatment process.
   a. In what ways are youth and families involved as “equal partners” in this process?
   b. In what ways are they not involved as “equal partners” in the treatment process?
   c. How does the level and type of involvement differ for youth and families who are not part of a clinical home?

10. What feedback have you received from youth and families about the clinical home program?
    a. In what ways have youth and families responded favorably to the clinical home program?
b. In what ways have youth and families not responded favorably to the clinical home program?

c. Why is it that some youth and families agree to receive services from the clinical home program, while others refuse services?

11. In what ways are the clinical homes designed to address issues of recidivism among youth?

a. How would you describe the capacity of the current clinical homes to decrease youth involvement in the juvenile justice system? How might this capacity be enhanced?

b. How would you describe the capacity of the current clinical homes to decrease out of home placements for mental health and/or substance abuse treatment for participating youth? How might this capacity be enhanced?

12. If you were to design a clinical home from scratch, what would you do differently?

a. What would you keep in the clinical home model? Why?

b. What would you get rid of? Why?

c. How else would you alter or improve upon the clinical home model?

13. Is there anything else you’d like to share about your own or your agency’s experiences in the clinical home pilot project?
Coaches

1. What is a clinical home?
   a. How is a clinical home supposed to work?
   b. What types of services should a clinical home offer?
   c. What distinguishes these services from care as usual?

2. What type of preparation is needed for an agency or staff to operate effectively as a clinical home?
   a. In what ways were the providers who are now receiving coaching from you prepared to operate effectively as a clinical home?
   b. In what ways were the providers who are now receiving coaching from you not prepared to operate effectively as a clinical home?

3. Tell me about the coaching that you offer to providers involved in the clinical home pilot project?
   a. Describe the coaching process. How does it work?
   b. In what ways were you involved in designing the coaching process?
   c. How does the coaching process prepare providers to operate effectively as a clinical home?
   d. How are providers responding to the coaching process?
   e. How might the coaching process be improved?

4. Can you comment specifically on how you’ve coached providers in wraparound service planning?
   a. What are the three main lessons that you attempt to impart on wraparound service planning?
   b. To the best of your knowledge, how have providers applied these lessons in their work with youth released from detention centers?
   c. What makes it easy for providers to apply these lessons?
   d. What makes it hard for providers to apply these lessons?
5. How else do you work with providers involved in the clinical home pilot project?
   a. Besides coaching in a group setting, what types of interactions do you typically have with these providers?
   b. Besides coaching in a group setting, how often do you interact with these providers?
   c. In what ways do you work with the providers on individual cases?
   d. What types of issues arise when you are working with providers on individual cases?
   e. How do you work with providers to resolve these issues?

6. How do you determine whether providers are applying lessons from the coaching process?
   a. On what basis do you determine whether improvements have been made?
   b. Can you describe three areas where you’ve noticed improvement among providers?
   c. Can you describe three areas where providers still need to improve?

7. Is there anything else you’d like to share about your experience in the coaching process?
Juvenile Justice Professionals and Judges

1. What is a clinical home?
   a. How is a clinical home supposed to work?
   b. What types of services should a clinical home offer?
   c. What distinguishes these services from care as usual?

2. What are your thoughts about collaborating with the clinical homes in your area?
   a. What is positive about collaborating with the clinical homes?
   b. What is negative about collaborating with the clinical homes?

3. What type of preparation is needed for juvenile justice professionals to collaborate effectively with the clinical homes in your area?
   a. What type of preparation did you and your co-workers receive?
   b. How useful was this type of preparation?
   c. What else do you and your co-workers need to collaborate effectively with the clinical homes?

4. How is the clinical home pilot project going?
   a. What has been positive about the pilot project experience?
   b. What has been negative about the pilot project experience?
   c. What lessons have been learned as a result of this experience?

5. Please describe the referral process.
   a. In what ways does this process work well?
   b. In what ways does it not work so well?
   c. How could the process be improved?

6. What’s your take on the timely assessment process? How would you describe the overall process?
   a. In what ways does this process work well? Why?
b. In what ways does it not work so well? Why?

c. How could the process be improved?

d. How is assessment different for pilot project participants than for your other clients?

7. What’s your take on the treatment process? How would you describe the overall process?

a. How are juvenile justice professionals involved in this process?

b. In what ways does this process work well?

c. In what ways does it not work so well?

d. How could the process be improved?

8. What feedback have you received from youth and families about the clinical home program?

a. In what ways have youth and families responded favorably to the clinical home program?

b. In what ways have youth and families not responded favorably to the clinical home program?

c. Why is it that some youth and families agree to receive services from the clinical home program, while others refuse services?

9. In what ways is the clinical home designed to address issues of recidivism among youth?

a. How would you describe the capacity of the current clinical homes to decrease youth involvement in the juvenile justice system? How might this capacity be enhanced?

b. How would you describe the capacity of the current clinical homes to decrease out of home placements for mental health and/or substance abuse treatment for participating youth? How might this capacity be enhanced?

10. If you were to design a clinical home from scratch, what would you do differently?

a. What would you keep in the clinical home model?
b. What would you get rid of?

c. How else would you alter or improve upon the clinical home model?

11. Is there anything else you’d like to share about your own or your colleagues’ experiences in the clinical home pilot project?
Community Participants

1. Tell me about this new program called Clinical Home that you and your family are now involved in?
   a. How is this new program supposed to work?
   b. What types of services does this new program offer to you and your family?
   c. How is this new program different from other services/programs that you and your family may have been involved in?

2. How did you first learn about this new program?
   a. What were you told about this new program?
   b. Who provided you with this information? Was the information understandable?
   c. What made you decide to take part in this new program?
   d. How long did you have to wait to get into this new program?

3. What are your thoughts about being part of this new program?
   a. What is positive about being part of this new program?
   b. What is negative about being part of this new program?

4. What services have you used since taking part in the new program?
   a. In what ways are these services helpful or useful to you and your family?
   b. In what ways are these services not helpful or useful to you and your family?
   c. How could these services be improved?

5. What do you like about the providers involved in this new program? By “providers,” I mean the case manager, therapists, counselors, and doctors.

6. What don’t you like about the providers involved in this new program? By “providers,” I mean the case manager, therapists, counselors, and doctors

7. How have you been involved in planning your own services or the services of your family member?
a. How did the providers who participated in the service planning treat you?

b. Did you feel that you and your family were treated as “equal partners?” Why or why not?

c. Have you been satisfied with the treatment plan? Why or why not?

d. Were you referred to other services and how did those providers treat you?

8. In what ways has this **new program** affected the lives of you and your family?

   a. At home?

   b. At school?

   c. In the community?

   d. How has it affected your relationships with friends?

   e. How has it affected the legal issues that you’ve recently experienced?

9. Has this **new program** made any difference in whether you and/or your family members get into trouble with the law? Why or why not? (**Probe:** Have you had any contact with the police since becoming involved with this new program.)

10. Has this **new program** made any difference in whether you and/or your family must go to a hospital, residential treatment center, or group home to get mental health and/or substance abuse services? Why or why not? (**Probe:** Have you had any contact with a hospital, residential treatment center, or group home since becoming involved with this new program?)

11. If you were to design a program like this from scratch, what would you do differently?

   a. Would you keep the program as it is? Why?

   b. What would you get rid of? Why?

   c. What new things would you add to improve the program?

12. Is there anything else you’d like to share about your own or your family’s experiences in this **new program**?