THE IOWA
CONSORTIUM
FOR SUBSTANCE ABUSE RESEARCH AND EVALUATION

CULTURALLY COMPETENT — SUBSTANCE ABUSE TREATMENT— PILOT PROJECT

FINAL EVALUATION REPORT

NOVEMBER 1, 2007 – JUNE 30, 2008

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Culturally Competent Substance Abuse Treatment Pilot Project

Background and Objectives

On July 1, 2007, The Iowa Department of Public Health (IDPH) received an appropriation from the general fund of the Iowa Legislature (House File 909a) to provide culturally competent substance abuse treatment. Through a competitive process, the Iowa Department of Public Health awarded three licensed substance abuse treatment providers funds to implement culturally competent substance abuse treatment pilot projects. The pilot projects were implemented in November 2007 and continued through June 30, 2008.

The objectives of the Culturally Competent Substance Abuse Treatment Pilot Projects (CCTP) are to:

- increase substance abuse treatment options for racially and ethnically diverse populations;
- provide best practices or tried treatment methods and document program outcomes so Iowa treatment providers may adopt culturally competent treatment methods;
- identify barriers to participants accessing treatment and work with community wrap around services to assist clients with barriers in order to participate in and complete treatment services;
- maintain contact and support services with clients for six months;
- document and provide program outcomes by working with the Iowa Consortium for Substance Abuse Research and Evaluation;
- disseminate information about the pilot project including but not limited to: programming, lessons learned, community involvement, and outcomes as requested; and
- train substance abuse treatment staff to work more effectively with the target population.

The three agencies selected to pilot these services were: Center for Alcohol and Drug Services (CADS), Employee and Family Resources (EFR), which provides case management services and subcontracts with Urban Dreams to provide substance abuse treatment services, and Jackson Recovery Centers.

Evaluation Process and Methods

The Iowa Consortium for Substance Abuse Research and Evaluation (Consortium) was selected to provide evaluation of the Culturally Competent Substance Abuse Treatment Pilot Projects. The Consortium's evaluation responsibilities include the following:

- develop, administer and collect client surveys on perceived cultural competence of the programs;
- develop, administer and collect cultural competency surveys for clinical staff and staff that are in contact with clients in some direct or indirect capacity, to be given at the beginning and toward the end of project activities;
- compile survey results and provide analysis of information collected;

- compile and report progress information gathered from reports submitted by the three designated agencies; and
- provide outcome measure analyses, i.e., length of stay and discharge status for clients served in this project.

The Consortium also provided training and technical assistance to grantees in administering the evaluation.

Agency evaluation responsibilities include:
- disseminate and collect client and staff surveys;
- mail completed surveys to the Consortium;
- utilize the Iowa Service Management and Reporting Tool/Substance Abuse Reporting System (I-SMART/SARS) to record client data;
- provide client admission data to the Consortium; and
- submit Tri-Annual Progress Reports and a Year End Report to IDPH and the Consortium.

Client and Staff Survey Instruments

Client Survey

The client survey instrument used in this study was the Iowa Cultural Understanding Assessment – Client Form, adapted from the Assessment Tool for Cultural Competence developed by the Maryland Mental Hygiene Administration of Maryland Health Partners. The Maryland Assessment Tool for Cultural Competence is a fifty-two-item tool designed to assess client perceptions of the cultural competence of mental health service systems. The Consortium wish to acknowledge the work of the Maryland Health Partners on the instrument that formed the basis of the Iowa tool.

Consortium staff reviewed published materials regarding The Maryland Assessment Tool for Cultural Competence in order to determine the most appropriate questions for this project. The original developers performed psychometric analyses on the survey items (Arthur et al, 2005; Cornelius et al. 2004). These published reports were used as a basis for selecting questions. The Consortium selected relevant items with an item-total correlation of 0.5 or greater to create the instrument for this study. Two items with slightly lower correlations that appeared relevant to this study were also included in the instrument. This resulted in a significant modification to the original instrument. The number of questions in the instrument was reduced by more than half and the wording of some items was modified for appropriateness to the substance abuse field. The resulting Iowa instrument is a twenty-five-item questionnaire designed to assess client perceptions of the cultural competency of the treatment agency and staff. The instrument includes questions regarding client perceptions of staff cultural competency (e.g., “The staff here understand some of the ideas that I, my family, and others from my cultural, racial, or ethnic group may have”), evidence of cultural sensitivity in the physical environment of the agency (e.g., “The waiting room and/or facility has pictures or reading material that show people from my racial or ethnic group”), and use of culturally appropriate collateral services (e.g., “If I want, the staff will help me get services from clergy or spiritual leaders”).

The Iowa Cultural Understanding Assessment – Client Form was translated into a Spanish language version by the University of Iowa Cultural and Linguistic Services. This instrument is entitled, “Evaluación del Entendimiento Cultural de la Gente de Iowa – Formulario para Clientes.”

Staff Survey

The staff survey instrument used in this study was a modified version of the California Brief Multicultural Competence Scale (CBMCS) developed by Richard Dana, Glenn Gamst, and Aghop Der-Karabetian (2004) at the University of LaVerne, California. The CBMCS is a twenty-one-item self-report questionnaire designed to measure multicultural competence of mental health service providers. With the permission of the developers of the instrument, the Consortium modified the instrument for use with substance abuse treatment providers. This modification consisted of changing the words "mental health" to "substance abuse treatment" on nine of the twenty-one items. This instrument contains questions regarding sensitivity to gender minorities, the aged, and individuals with disabilities, as well as cultural/ethnic minorities. The instrument includes items such as: "I am aware of institutional barriers that may inhibit minorities from using substance abuse treatment services" and "I can identify my reactions that are based on stereotypical beliefs about different ethnic groups."

The developers of the CBMCS have created a cultural competency training program for providers based on the contents of the instrument. The CBMCS Multicultural Training Program provides up to thirty-two hours of continuing education credits. The training kit is available through SAGE Publications (contact information appears in the References section).

Survey Protocols

The Consortium provided copies of staff and client surveys to participating agencies at the beginning and near the end of the project. Agencies returned the completed surveys to the Consortium for data entry and analysis. Consortium staff double-entered these data and cross-checked the records for data entry errors. Data on the number of surveys returned during this reporting period and survey results are provided in the "Survey Results" section. Demographic information on participants completing these surveys is also provided. Copies of the client and staff survey instruments appear in the appendix.

Client Surveys

Counselors at CADS administered surveys to clients individually. Clients returned completed surveys to the Counselor or Program Manager, who sent them to the Consortium. The Program Manager maintained a list of clients who were given surveys and clients who returned surveys. Survey responses were kept confidential.

At EFR, Urban Dreams counselors distributed client surveys in a group format. Counselors were present, but clients were allowed to take the surveys with them to complete if they preferred. Clients were informed that their responses are confidential, and staff members did not read their responses. The counselors gave one client in each group an envelope, and that client collected the completed surveys, which were stored in a secured cabinet until the EFR counselor retrieved them and sent them to the Consortium.

At Jackson Recovery, two therapists distributed client surveys: one distributed surveys individually, and one distributed them in a group format. Therapists were present while clients completed the surveys and indicated that clients often asked questions about the survey and the meaning of some survey questions. Clients were informed that their responses are confidential. Clients gave completed surveys to the therapist, who sent them to the Consortium.

Staff Surveys

The project manager at CADS distributed staff surveys to staff members during an all-staff meeting. Some staff completed the survey prior to leaving the staff meeting; others took the survey with them to complete. Some staff members returned completed surveys to the program manager to mail to the Consortium, and others sent their survey directly to the Consortium via return envelope.

Program managers at EFR and Jackson Recovery distributed surveys individually to staff to complete on their own. Some staff members returned completed surveys to the program manager to mail to the Consortium, and others sent their survey directly to the Consortium via return envelope.

Agency Progress Reports

Agencies submitted Tri-Annual Progress Reports to IDPH and the Consortium which include the following information pertaining to both the process and outcome evaluation for the project:

- additions to or changes in key personnel;
- staff training efforts and number of staff trained;
- organizations to which clients were referred by grantee for additional treatment or ancillary services;
- efforts (other than initial trainings) to expand project's capacity to serve the target population;
- information disseminated to others about project (e.g., newspaper article; T.V. or radio coverage, public presentations);
- changes in or concerns about grantees financial status that may affect the implementation or operations of the grant;
- changes in local conditions that may affect continued project success (i.e. changes in target population, funding for services);
- project successes on progress toward goals outlined in the application;
- project challenges grantee encountered and strategies implemented for overcoming them;
- technical assistance needs;
- number of clients served;
- number of clients screened;
- number of clients discharged prior to completion; and
- number of clients successfully completing program.

The Consortium provided initial and final project reports to IDPH that integrate agency process data, survey results, and client outcome data.

Client Participation Data

The Consortium created an electronic data management system to manage survey and client participation data for this project. Agencies submitted data on client admissions to the Consortium via fax on a weekly basis. Consortium staff entered client admission data into the data management system. Additionally, agencies submitted client data to IDPH via the I-SMART/SARS reporting system. The Consortium accessed the I-SMART/SARS system to track client participation and obtain data on client length of stay, level of care, and discharge status.

Process Evaluation

Program implementation information compiled from agency tri-annual reports has been summarized below to provide insight into progress of the pilot project. Process evaluation data include:

- additions to or changes in key personnel;
- staff training efforts and number of staff trained;
- organizations to which clients were referred by grantee for additional treatment or ancillary services;
- efforts (other than initial trainings) to expand project's capacity to serve the target population;
- information disseminated to others about project (e.g., newspaper article; T.V. or radio coverage, public presentations);
- changes in or concerns about grantees financial status that may affect the implementation or operations of the grant;
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- project successes on progress toward goals outlined in the application;
- project challenges grantee encountered and strategies implemented for overcoming them; and
- technical assistance needs.

Personnel and Program Overview

Center for Alcohol and Drug Services (CADS)
Kara Harland NCC/LPC
Program Manager, Cultural Diversity Program
4230 11th St.
Rock Island, IL 61201
309-788-4571

Additional clinical project staff includes one counselor, one case manager hired for this project, and one clerical staff person hired for this project. The project was fully staffed in January, 2008. CADS' goal for the pilot project was to serve forty Latino and African American clients (with approximately ten clients being Latino, thirty being African American) using the Matrix Model. At CADS, culturally competent treatment services primarily involve faith-based counseling and peer mentoring. The agency has monthly contact with clients who remain engaged in aftercare services following successful completion of treatment. The agency does not maintain follow-up contact with clients discharged unsuccessfully.

Employee & Family Resources (EFR)
Harry Teel, LMHC, CEAP
Director, Substance Abuse Services
505 5th Ave, Suite 6000
Des Moines, IA 50309
(515) 471-2344; (888) 251-4610

Additional clinical project staff includes two Urban Dreams counselors, one of whom was hired for this project, one EFR assessment counselor/case manager, and the EFR Clinical

Supervisor. This project was fully staffed in February, 2008. Employee and Family Resources' goal for the pilot project was to serve seventy-five African American clients using Motivational Enhancement. EFR continues case management services for six months after the completion of treatment with clients who remain engaged with them. Clients who do not attend continuing care sessions or return a phone call from the project counselors or case manager are discharged as unsuccessful after thirty days of no response.

Jackson Recovery Centers
Amy Bloch, LISW, CADC
Program Director of Outpatient Services
800 5th Street
Sioux City, IA 51101
712-234-2300

Additional clinical project staff includes two Spanish speaking counselors hired for this project, the Clinical Supervisor, and the Vice President/Chief Clinical Officer. The project was fully staffed in January, 2008. Jackson Recovery's goal was to serve one-hundred fifty Hispanic clients using the Matrix Model and the Community Reinforcement Approach. Jackson Recovery offers continuing care services, consisting of weekly group sessions and monthly individual sessions, for three to six months following completion of primary treatment. Efforts are made to keep clients engaged in some level of care for twelve months.

Training

CADS
CADS project staff attended trainings on cultural diversity, sexual harassment, group treatment, mandatory child abuse reporting, and ethics. Project staff members attended the Annual Governor's Conference on Substance Abuse and were trained within the agency on record keeping and completing service activity logs.

EFR
The Director of Substance Abuse Treatment at EFR and a treatment counselor at Urban Dreams attended "Community Based Treatment of Methamphetamine Addiction." The EFR treatment director, EFR assessment counselor/case manager, and two Urban Dreams counselors attended "Motivational Interviewing" training held at EFR. All project staff attended the Annual Governor's Conference on Substance Abuse. The two Urban Dreams counselors and the EFR assessment counselor reviewed "Enhancing Motivation for Change in Substance Use Disorder Treatment" (SAMHSA Treatment Improvement Protocol # 35). The Urban Dreams counselor hired for this project and the EFR Clinical Supervisor discuss the application of this protocol to culturally diverse clients during supervision meetings.

Jackson Recovery Centers
Jackson Recovery Center's two Spanish-speaking therapists attended Spanish Command Training, Motivational Interviewing Training-Part II, Stages of Change training, Rethinking Substance Abuse & Gambling Disorders training, and the Annual Governor's Conference on Substance Abuse. Agency staff trained the two new project counselors on site through agency orientation, case management training, and workshops on Motivational Interviewing and ethics. Both counselors meet on a regular basis with the Program Director for clinical supervision and

client staffing. Both participate in an ongoing mentoring program with senior therapy staff. The Marketing Director trained the project counselors on marketing and community outreach in order to effectively provide the community with information about the program, services, and addiction in Hispanic culture. Project staff also read *Evidence-Based Treatment for Alcohol and Drug Abuse* by Emmelkamp and Vedel, and discussed its content with staff mentors.

Service Coordination, Capacity Expansion, and Community Outreach/Education

CADS

CADS referred clients to the Family Resources, Inc. Rape/Sexual Assault Program, Vera French Community Health Care, and Employment Services. The case manager also referred clients to several faith-based organizations and spiritual leaders in the community.

CADS worked during the pilot project period to establish a referral system for faith-based services. The Cultural Competency Team, led by the Case Manager, met with several area pastors, elders, and priests to discuss the Culturally Competent Treatment Project and create a bridge for clients to faith-based counseling services. A training session for faith leaders is scheduled for the week of July 14, 2008. Several interested faith leaders are bilingual (Spanish and English). Cultural Competency Team members met with representatives from Scott County Kids to provide program information and discuss services offered by that agency. The Spanish language interpreters for Scott County Kids and the Community Health Center expressed interest in trainings that may be provided by CADS' project team. Additional outreach activities included translating the program counselor's business cards into Spanish and creating and disseminating a brochure to generate referrals and educate community members about program services.

EFR

EFR referred clients to the Mid-Eastern Council on Chemical Abuse (MECCA), Eyerly Ball Community Mental Health Services, Department of Human Services (DHS), Visiting Nurse Services, and Family Drug Court. These services included higher levels of substance abuse treatment after relapse, outpatient mental health therapy and medication management for co-occurring disorders, and family involvement in drug court process as an adjunct to DHS involvement. In addition, Urban Dreams provided ancillary services to project clients, including ex-offender program services, parenting program, Healthy Start program, pre-employment training classes, job placement & retention, and spiritual counseling. Urban Dreams is providing services under the Access to Recovery (ATR) project, which allows clients to receive ancillary services that support their recovery efforts during and after formal substance abuse treatment.

EFR presented project information to the Polk County Board of Health Advisory Committee and provided project information to the YMCA, Hearts and Hands Clinic, Central Iowa Shelter Services, Bethel Mission, Hope Ministries, and Door of Faith. Staff gave project brochures to the Des Moines Area Community College, Grand View College, the Black Ministerial Alliance, and Oakridge Neighborhood Association for dissemination. EFR program staff wrote a press release regarding the Culturally Competent Substance Abuse Treatment Pilot Project, though the press release was not picked up by the local media. Information and a contact number for the project was posted on the EFR website (www.efr.org).

Jackson Recovery Centers

Jackson Recovery Centers referred clients to Siouxland Community Health, the Department of Human Services, and Boys and Girls Home.

Jackson Recovery Centers developed and implemented a community outreach/education plan targeting several community agencies, employers, and media outlets, with the focus of providing information to the community about culturally competent program services and addiction in the Hispanic culture. Jackson Recovery's Marketing Director met with project staff monthly to assist them in making contacts and meeting with community providers. Radio ads aired regularly and articles were published monthly in three Spanish-speaking newspapers.

Progress and Challenges

CADS

CADS surpassed its goal of serving forty [40] clients, with more than ten being Hispanic clients and more than thirty being African American clients, during the pilot project period. Sixty-two clients were admitted to the Culturally Competent Treatment Program. CADS implemented an agency-wide needs assessment which aided counselors in identifying clients appropriate for the culturally competent treatment program and services needed by those clients. The agency used all-staff meetings as the venue to distribute program overview materials, administer staff surveys, and discuss project progress and changes. The program counselor translated agency documents, forms, and signage into the Spanish language and interpreted DUI/OWI evaluations for Spanish speaking clients throughout the agency. In addition, the counselor was personally contacted by several clients in neighboring communities who are in need of substance abuse treatment services in Spanish. In response to that need, he established a weekly treatment group conducted in Spanish. The Case Manager assisted many program clients in finishing their education, attaining driving privileges, and securing employment.

CADS established a referral system for faith-based services, as described in the *Service Coordination, Capacity Expansion, and Community Outreach/Education* section. CADS also established a peer mentoring program, engaging clients in continuing care with six to twelve months of sobriety as mentors. Four mentors were selected through endorsements from counselors and program managers of their respective programs and were trained in active listening, receiving and giving feedback, basic counseling skills, boundaries, and effective confrontation. The Peer Mentors established a weekly support group with current CCTP clients, called the Cultural Diversity Group. Peer Mentors co-facilitate the group and select topics directly related to recovery issues with which group members appear to be having difficulty. At the end of the pilot period, CADS had begun selecting additional mentors and planned to establish a second Cultural Diversity Group.

CADS did not report any changes in or concerns about their financial status or local conditions that may affect the implementation or success of the project. They did not identify any technical assistance needs for project implementation.

EFR

Employee & Family Resources and Urban Dreams collaborated to identify and refer clients to the Culturally Competent Treatment Program. EFR's assessment counselor spent one day each week at Urban Dreams to assess potential clients and communicate with Urban Dreams' counselor about assessment results. Sixty-nine clients were admitted to the program during the pilot project period. Jail-based assessment counselors referred eleven clients to the program.

Project staff reported two challenges to program implementation, both of which involve client retention. First, staff lost contact with some clients between the assessment and the time they were to enter the program. Staff attempted to address this problem by asking clients during the assessment interview for multiple contact persons and numbers to increase chances of locating the client. However, loss of contact with clients remained an issue throughout the pilot project. The second challenge was the inability of clients to remain involved in the program due to incarceration. The agency identified a consultant to assist them in addressing this barrier; however, due to communication and scheduling problems this plan was not realized. Near the end of the pilot project period, EFR requested technical assistance from IDPH in finding another consultant to help address this issue.

EFR reported that there were no changes in or concerns about their financial status or local conditions that may affect the implementation or success of the project.

Jackson Recovery Centers

Jackson Recovery Centers initially faced a significant barrier to program implementation: that of finding trained substance abuse therapists fluent in Spanish. Jackson Recovery hired two Spanish speaking therapists in December, 2007 who had minimal substance abuse counseling experience but were dedicated to serving the Hispanic community. The agency provided the therapists with extensive training and ongoing mentoring from senior staff. The first clients were admitted to the CCTP in February 2008.

Jackson Recovery Centers implemented the program in two communities: Sioux City and Denison. Client admissions were consistently higher in Sioux City than in Denison, and staff enlisted the assistance of Jackson Recovery's Marketing Director to assist in increasing communication about the program to the Denison community. Jackson Recovery received negative feedback from some community members following a press release about the program. Callers expressed disagreement with the agency and the State of Iowa providing services free of charge to Spanish-speaking individuals. Jackson Recovery used this feedback as an opportunity to emphasize the importance of the program in increasing cultural awareness and understanding. Jackson Recovery did not report any changes in or concerns about their financial status or local conditions that may affect the implementation or success of the project.

Forty-seven clients were admitted to the program during the pilot project period. Jackson Recovery submitted a corrective action plan to IDPH in May to address their inability to reach their targeted number of clients for the pilot project. The plan included expanding services to other Hispanic clients within the agency, increasing awareness in the communities the agency serves, and building a strong referral base. Specific activities outlined in the plan include:

- Using Spanish speaking staff as consultants within the agency's English speaking programs to better meet the need of the Hispanic populations in those programs through reduction of cultural barriers. This will result in additional admissions to the project and improve the cultural competence of existing programs.
- Having Cultural Competency staff members meet with various teams across the agency to increase awareness of the issues facing the target population and encourage identification and referral to the CCTP.
- Sending Cultural Competency therapy staff out to various organizations to discuss programming at Jackson Recovery, provide information on working with people of Hispanic ethnicity, and offer consultation on developing cultural competency.

Overall, each agency participating in the pilot project has developed, staffed, and implemented culturally specific services for their respective target populations. All agencies have identified and addressed barriers to treatment and increased efforts to provide access to culturally competent treatment services through outreach to minority communities, as well as directly provide or link clients to additional ancillary services. Agency staff are receiving training to continue to increase their knowledge and skills in providing services to these populations.

Outcome Evaluation

Data for the outcome evaluation was gathered from agency tri-annual reports, weekly agency reports to the consortium and ISMART/SARS data received on a monthly basis.

Number of Clients Served

The Center for Alcohol and Drug Services (CADS) targeted forty Latino and African American clients for this pilot project (with an estimated ten clients being Latino and thirty being African American). Employee and Family Resources (EFR) targeted 75 African American clients. Jackson Recovery targeted one-hundred fifty Hispanic clients. Three sources of data exist on the number of clients served in this project. One source is the tri-annual progress reports grantee agencies submit to IDPH and the Consortium. The other sources are lists of clients admitted to the Culturally Competent Substance Abuse Treatment Program, which are sent to the Consortium weekly, and client admission forms agencies enter into the I-SMART/SARS state substance abuse electronic reporting system. Table 1 on page 10 provides information summarized from the tri-annual reports. Tri-annual report forms ask agencies to report the number of clients served in the project, which may include clients evaluated for treatment but not admitted as well as clients admitted to treatment; the number of clients evaluated/screened through project funds; the number of clients discharged, for any reason, before completing treatment; and the number of clients graduating from the program. Agencies have different criteria for graduation: some agencies graduate clients at the end of primary treatment, while others graduate clients only after completion of continuing care. In the latter case, clients who complete primary treatment but do not require continuing care are considered successful discharges, although not graduates, and therefore would not be included in the graduate totals in this table.

Table 1. Clients Served from November, 2007 through June, 2008 (Tri-Annual Report Data) and Discharge Status, by Agency

	Participating Agency			
	CADS	EFR	Jackson Recovery	TOTAL
Target Number of Clients	40	75	150	265
Number of Clients Served	62	68	47	177
Number of Evaluations Conducted with Project Funds	17	68	40	125
Number of Clients Graduated	5	12	1	18
Number of Clients Discharged Prior to Treatment Completion	4	18	3	25

Table 2 presents admission data from the weekly admission lists agencies sent to the Consortium, as well as admission and discharge data from I-SMART/SARS system records. Admission figures reflect the number of clients admitted for treatment services under this project. Discharge figures reflect the number of clients discharged after successfully completing treatment and the number of clients discharged for any reason without having successfully completed treatment.

Table 2. Client Admissions and Discharges (I-SMART/SARS Data), by Agency

	Participating Agency			
	CADS	EFR	Jackson Recovery	TOTAL
Target Number of Clients	40	75	150	265
Number of Client Admissions (Agency Data)	57	67	31	155
Number of Admissions (I-SMART/SARS)	55	30	27	112
Number of Clients with Successful Discharge (I-SMART/SARS)	16	5	1	22
Number of Clients Discharged Incomplete (I-SMART/SARS)	12	6	3	21
Number of Clients Remaining in Program on June 30, 2008 (I-SMART/SARS)	27	19	23	69

Agencies reported to the Consortium, via weekly lists, one-hundred fifty-five Culturally Competent Treatment Project (CCTP) client admissions during the pilot project period. One-hundred twelve admission records were found in the I-SMART/SARS system. Employee and

Family Resources reported difficulties with their web-based application relaying data to IDPH via the SARS system. These problems were not resolved at the time the data was accessed for this report, which may account for the low numbers of admissions and discharges from I-SMART/SARS data compared to numbers from the tri-annual report. Differences for the other agencies may have occurred because the I-SMART/SARS data was retrieved before agencies entered their records into the system.

Client Demographics and Level of Care

Information on client demographics and level of care were obtained from I-SMART/SARS records. Therefore, demographic and level of care data include only clients for whom admission records existed in I-SMART/SARS.

The I-SMART/SARS system contains separate information on race and ethnicity of clients admitted to substance abuse treatment. Race data were available for one-hundred six of the one-hundred twelve CCTP clients in the I-SMART/SARS system. Sixty-five (58%) were African American, forty-one (37%) were Caucasian, and a race was not reported for six (5%) of the clients, but they were identified as having Mexican or Hispanic ethnicity. Ethnicity data were available for all one-hundred twelve CCTP clients in the system. Ethnicity breakdowns were as follows: seventy-three (65%) non-Hispanic/Latino; thirty-one (28%) Mexican; seven (6%) other Hispanic or Latino; and one (0.9%) Puerto Rican. Ninety-two clients (82%) were male; twenty (18%) were female. The median age of clients admitted was 31.5 years (minimum = 18, maximum = 59).

The Consortium also retrieved information on the level of care or treatment modality into which clients were admitted. Some clients were admitted to treatment prior to the start of the Culturally Competent Treatment Project, so the level of care into which they were originally admitted may not be the same as the level of care they received upon entry into the project. Sixty-five (58%) of clients were originally admitted to extended outpatient treatment, nineteen (17%) were admitted to intensive outpatient treatment, fourteen (13%) were admitted to medically monitored detoxification, ten (9%) were admitted to residential treatment, three (3%) were admitted to day treatment, and one (0.9%) was admitted to outpatient detoxification.

Outcome Measures

Information on client outcomes (length of stay and discharge status) were obtained from I-SMART/SARS records.

Length of Stay in Project

Length of stay (LOS) in the project was calculated for project clients who were discharged during the pilot project period and for clients remaining in the project as of June 30, 2008. Length of stay data for discharged clients include only clients for whom both admission and discharge records existed in I-SMART/SARS. Length of stay data for clients remaining in the project include clients for whom admission records existed in I-SMART/SARS and for whom a discharge record did not exist in the system. The first date of service billed to the Culturally Competent Treatment Project was used as the start date to calculate length of stay; therefore these figures may not reflect the client's total time in treatment, as clients may have already been receiving treatment prior to admission to the project. The median length of stay in the project for clients successfully completing treatment was sixty days (minimum = 7, maximum = 132). The median length of stay for clients discharged without completing treatment was forty-seven days (minimum = 1, maximum = 106). The estimated median length of stay for all clients

who have been discharged or remain in the program based on a survival analysis is one-hundred thirty-two days.

Discharge Status

Discharge information was found for forty-three clients. Twenty-two (51%) successfully completed treatment. The most recent national statistics published by SAMHSA (SAMHSA, 2008) indicated that forty-one percent of clients discharged nationwide in 2005 successfully completed treatment. Twelve (28%) of the CCTP clients left treatment on their own prior to completion, four (9%) were discharged for lack of progress or non-compliance, three (7%) were incarcerated, one (2%) was referred to a different program or agency, and one (3%) was discharged after completing detoxification.

Survey Findings

Client Surveys Returned

Agencies administered the Iowa Cultural Understanding Assessment to clients within two weeks following admission to the Culturally Competent Substance Abuse Treatment Program (entry point), and again when clients completed primary treatment, prior to entering continuing care (exit point). Agencies returned ninety entry point surveys and twenty-four exit point surveys. Nearly forty-one percent (40.6%) of clients receiving treatment completed and returned an entry point survey. Table 3 provides breakdowns of client surveys returned by type and by agency.

Table 3. Number of Client Surveys Returned

Survey Type	Participating Agency			
	CADS	EFR	Jackson Recovery	TOTAL
Entry Point Client Survey (English)	29	34	NA	63
Exit Point Client Survey (English)	5	2	NA	7
Entry Point Client Survey (Spanish)	3	NA	24	27
Exit Point Client Survey (Spanish)	1	NA	16	17
Key: NA = Not Applicable				

Client Survey Demographics

Seventy-two percent of clients completing the survey at entry point were male, twenty-four percent were female, and three percent did not answer the question regarding their sex. Sixty-one percent of respondents were African American, three percent Caucasian, and two percent American Indian. Thirty-six percent were Hispanic or Latino ethnicity, forty-six percent other ethnicity, and nineteen percent did not answer the ethnicity question.

Ninety-six percent of clients completing the survey at exit point were male, and four percent did not answer the question regarding their sex. Twenty-five percent were African American; the remainder of participants did not indicate a race. Seventy-five percent of respondents were

Hispanic or Latino ethnicity, twenty percent were other ethnicity, and four percent did not answer the ethnicity question.

Client Survey Results

Client entry and exit surveys were not matched by participant, therefore survey results do not reflect individual change in attitude or perception over time. Rather, entry survey results reflect perceptions of clients who were at the beginning of their treatment experience, and exit survey results reflect perceptions of clients who were at the end of their treatment experience. To protect the confidentiality of participants, survey results are not broken down by agency. Table 4 displays results for each survey question at entry and exit point.

Table 4. Client Survey Results: Iowa Cultural Understanding Assessment (continued on page 16)

Statement	Strongly Disagree		Disagree		Neither Agree Nor Disagree		Agree		Strongly Agree	
	Entry	Exit	Entry	Exit	Entry	Exit	Entry	Exit	Entry	Exit
1. The staff here understand some of the ideas that I, my family, and others from my cultural, racial, or ethnic group may have.	2.2%	4.2%	1.1%	4.2%	11.1%	12.5%	42.2%	45.8%	43.3%	33.3%
2. Staff here understand the importance of my cultural beliefs in my treatment process.	2.2%	0%	0%	4.2%	12.2%	8.3%	40.4%	50.0%	45.6%	37.5%
3. The staff here listen to me and my family when we talk to them.	1.1%	4.2%	2.2%	4.2%	5.6%	4.2%	36.0%	45.8%	55.1%	41.7%
4. If I want, the staff will help me get services from clergy or spiritual leaders.	1.1%	0%	3.4%	4.2%	16.9%	12.5%	38.2%	41.7%	40.4%	41.7%
5. The services I get here really help me work toward things like getting a job, taking care of my family, going to school, and being active with my friends, family, and community.	1.15	0%	1.1%	0%	6.7%	8.3%	40.0%	41.7%	51.1%	50.0%
6. The staff here seem to understand the experiences and problems I have in my past life.	3.4%	0%	2.3%	4.2%	3.4%	0%	31.8%	50.0%	59.1%	45.8%
7. The waiting room and/or facility has pictures or reading material that show people from my racial or ethnic group.	6.7%	0%	6.7%	20.8%	17.8%	8.3%	33.3%	37.5%	35.6%	33.3%
8. The staff here know how to use their knowledge of my culture to help me address my current day-to- day needs.	3.3%	0%	0%	4.2%	13.3%	4.2%	38.9%	45.8%	44.4%	45.8%
9. The staff here understand that I might want to talk to a person from my own racial or ethnic group about getting the help I want.	3.3%	8.7%	1.1%	4.3%	11.1%	0%	36.7%	47.8%	47.8%	39.1%
10. The staff here respect my religious or spiritual beliefs.	3.3%	0%	0%	0%	8.9%	4.3%	34.4%	47.8%	53.3%	47.8%
11. Staff from this program come to my community to let people like me and others know about the services they offer and how to get them.	4.5%	0%	3.4%	4.2%	21.3%	16.7%	36.0%	41.7%	34.8%	37.5%
12. The staff here ask me, my family or others close to me to fill out forms that tell them what we think of the place and services.	3.4%	4.2%	5.6%	4.2%	20.2%	16.7%	37.1%	41.7%	33.7%	33.3%

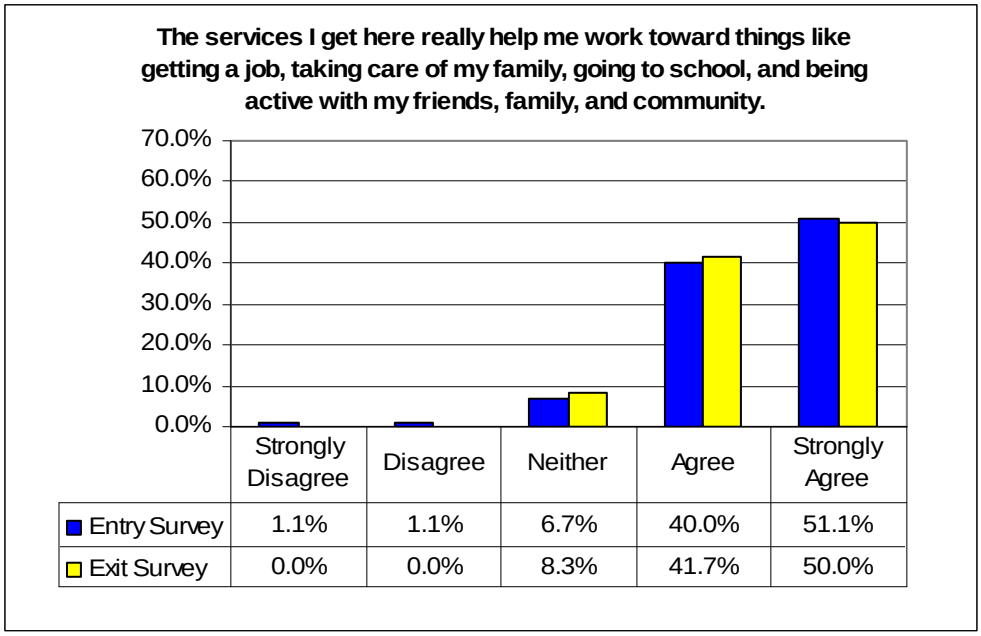
(continued)

Table 4. Client Survey Results: Iowa Cultural Understanding Assessment (continued from page 15)

Statement	Strongly Disagree		Disagree		Neither Agree Nor Disagree		Agree		Strongly Agree	
	Entry	Exit	Entry	Exit	Entry	Exit	Entry	Exit	Entry	Exit
13. Staff here understand that people of my racial or ethnic group are *not* all alike.	1.3%	0%	5.3%	13.0%	15.8%	0%	34.2%	47.8%	43.4%	39.1%
14. It was easy to get information I needed about housing, food, clothing, child care, and other social services from this place.	1.2%	4.2%	7.0%	4.2%	18.6%	29.2%	37.2%	16.7%	36.0%	45.8%
15. The staff here talk to me about the treatment they will give me to help me.	1.1%	0%	1.1%	0%	2.2%	0%	34.8%	45.8%	60.7%	54.2%
16. The staff here treat me with respect.	1.1%	0%	1.1%	0%	3.4%	4.2%	25.0%	41.7%	69.3%	54.2%
17. The staff seem to understand that I might feel more comfortable working with someone who is the same sex as me.	3.4%	12.5%	10.1%	0%	27.0%	29.2%	27.0%	37.5%	32.6%	20.8%
18. Most of the time, I feel I can trust the staff here who work with me.	2.2%	0%	3.4%	0%	12.4%	4.2%	32.6%	50.0%	49.4%	45.8%
19. The waiting room has brochures or handouts that I can easily understand that tell me about services I can get here.	4.5%	0%	10.1%	0%	16.9%	12.5%	41.6%	45.8%	27.0%	41.7%
20. If I want, my family or friends are included in discussions about the help I need.	3.4%	0%	5.6%	0%	12.4%	8.3%	43.8%	54.2%	34.8%	37.5%
21. The services I get here deal with the problems that affect my day-to-day life such as family, work, money, relationships, etc.	2.3%	0%	5.7%	4.2%	5.7%	20.8%	40.9%	29.2%	45.5%	45.8%
22. Some of the staff here understand the difference between their culture and mine.	3.4%	4.2%	1.1%	0%	15.9%	8.3%	44.3%	41.7%	35.2%	45.8%
23. Some of the counselors are from my racial or ethnic group.	3.4%	8.3%	3.4%	4.2%	7.9%	0%	38.2%	41.7%	47.2%	45.8%
24. Staff are willing to be flexible and provide alternative approaches or services to meet my cultural/ethnic treatment needs.	2.2%	0%	0%	0%	11.2%	16.7%	39.3%	33.3%	47.2%	50.0%
25. If I need it, there are translators or interpreters easily available to assist me and/or my family.	1.1%	0%	2.2%	0%	25.8%	16.7%	32.6%	33.3%	38.2%	50.0%

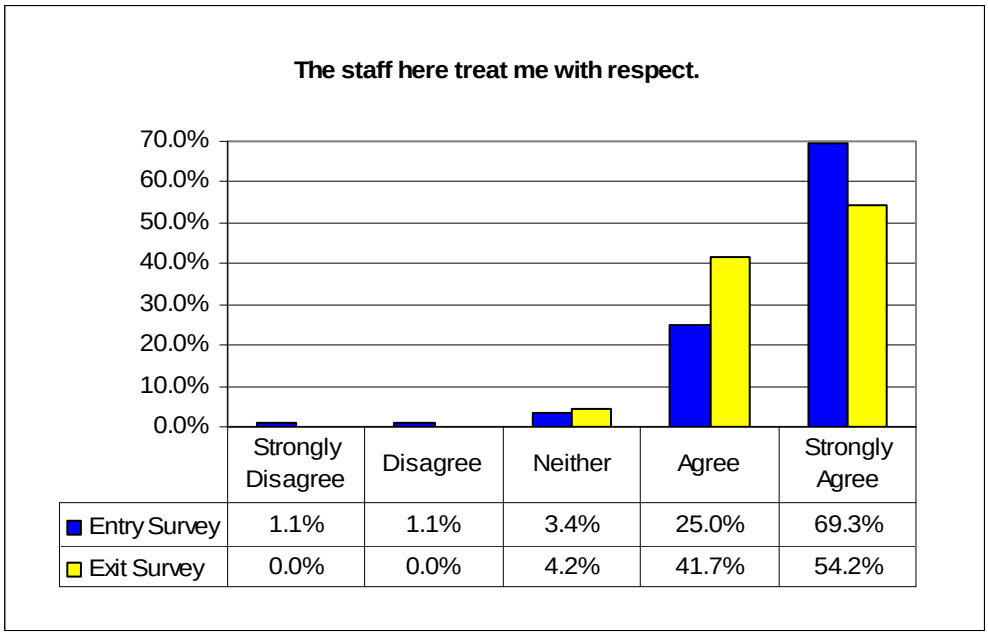
Seventy-five to ninety percent of respondents either agreed or strongly agreed with most statements indicating cultural competency of the agency and staff at entry point and exit point. Using a numerical scoring method where 1 = Strongly Disagree, 2 = Disagree, 3 = Neither Agree nor Disagree, 4 = Agree, and 5 = Strongly Agree, the median score for most survey items was 4. Two items had median scores higher than 4 at both the entry point and the exit point. Those are item 5, regarding services being helpful in obtaining employment, taking care of family, and being socially active (median = 5 at entry, 4.5 at exit); and item 16, regarding staff treating them with respect (median = 5 at entry and exit). Graphs 1 and 2 present a visual display of the responses to items 5 and 16, respectively.

Graph 1. Client Survey Item 5 Results



	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
Entry Survey	1.1%	1.1%	6.7%	40.0%	51.1%
Exit Survey	0.0%	0.0%	8.3%	41.7%	50.0%

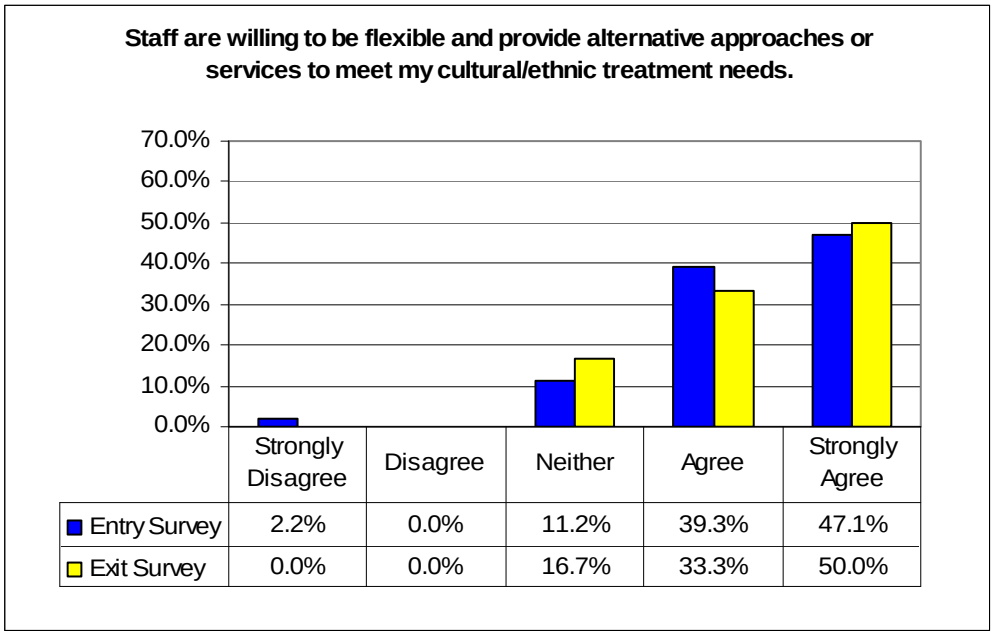
Graph 2. Client Survey Item 16 Results



	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
Entry Survey	1.1%	1.1%	3.4%	25.0%	69.3%
Exit Survey	0.0%	0.0%	4.2%	41.7%	54.2%

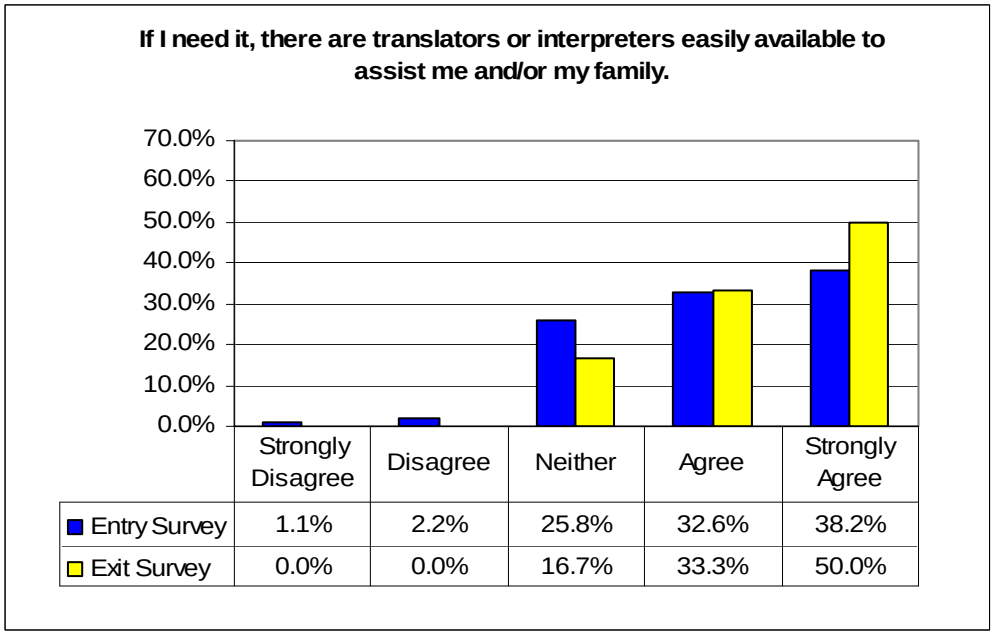
Two items had median scores higher than 4 at the exit point (median = 4.5 for both). Those were item 24, regarding ability of staff to adapt approaches to clients' cultural needs, and item 25, regarding the availability of translators or interpreters. Graphs 3 and 4 provide a visual display of the responses to items 24 and 25, respectively.

Graph 3. Client Survey Item 24 Results



	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
Entry Survey	2.2%	0.0%	11.2%	39.3%	47.1%
Exit Survey	0.0%	0.0%	16.7%	33.3%	50.0%

Graph 4. Client Survey Item 25 Results

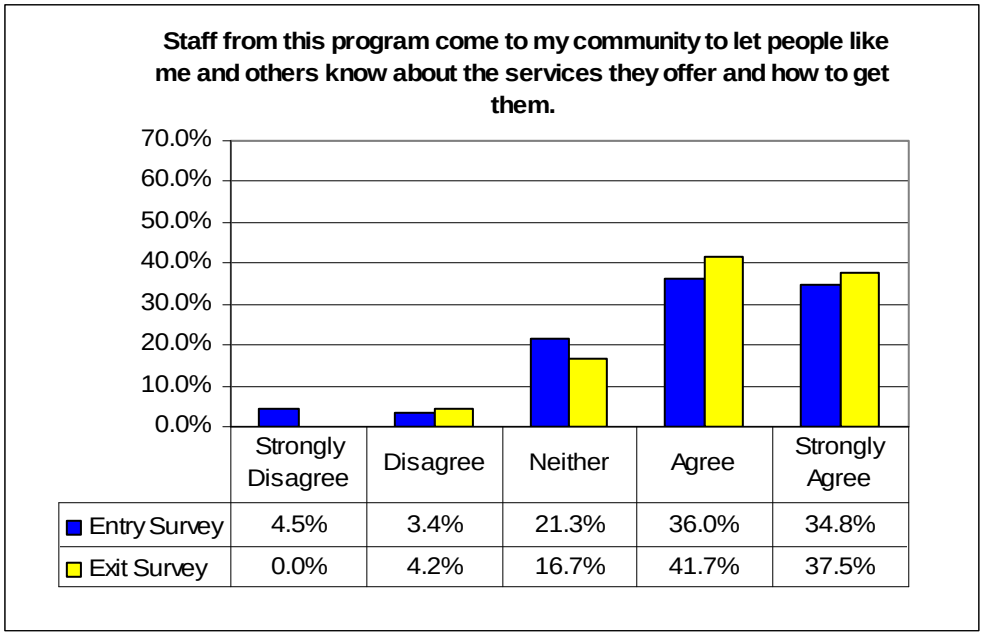


	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
Entry Survey	1.1%	2.2%	25.8%	32.6%	38.2%
Exit Survey	0.0%	0.0%	16.7%	33.3%	50.0%

One other item had a median score of 5 at entry and exit. This was item 15: "The staff here talk to me about the treatment they will give me to help me." While this result is not surprising, it serves as an indicator that agency staffs are doing well in this area.

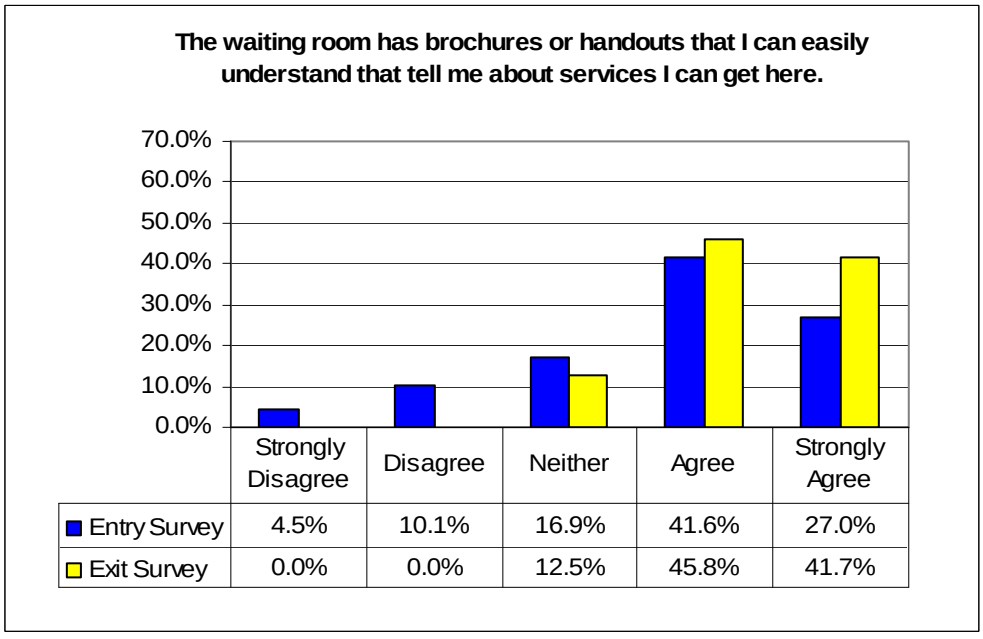
Two items showed fewer than 75% of respondents indicating agreement or strong agreement at entry but more than 75% indicating agreement or strong agreement at exit. Those were item 11, regarding staff outreach to the client's community, and item 19, regarding the waiting room having easily readable brochures. The difference between the entry and exit responses for item 19 was statistically significant (Wilcoxon, $p < .05$). The higher percentage in agreement at exit on these items may be reflective of progress agencies made through this project in outreach to cultural minorities in the community and in efforts to translate materials into other languages. Graphs 5 and 6 provide a visual display of the responses to items 11 and 19, respectively.

Graph 5. Client Survey Item 11 Results



	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
Entry Survey	4.5%	3.4%	21.3%	36.0%	34.8%
Exit Survey	0.0%	4.2%	16.7%	41.7%	37.5%

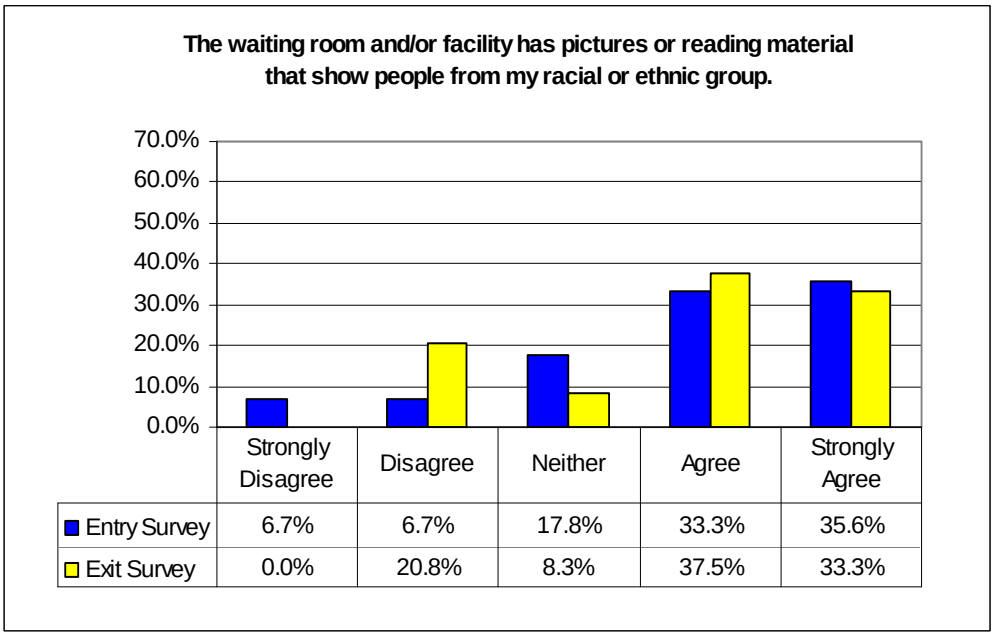
Graph 6. Client Survey Item 19 Results



	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
Entry Survey	4.5%	10.1%	16.9%	41.6%	27.0%
Exit Survey	0.0%	0.0%	12.5%	45.8%	41.7%

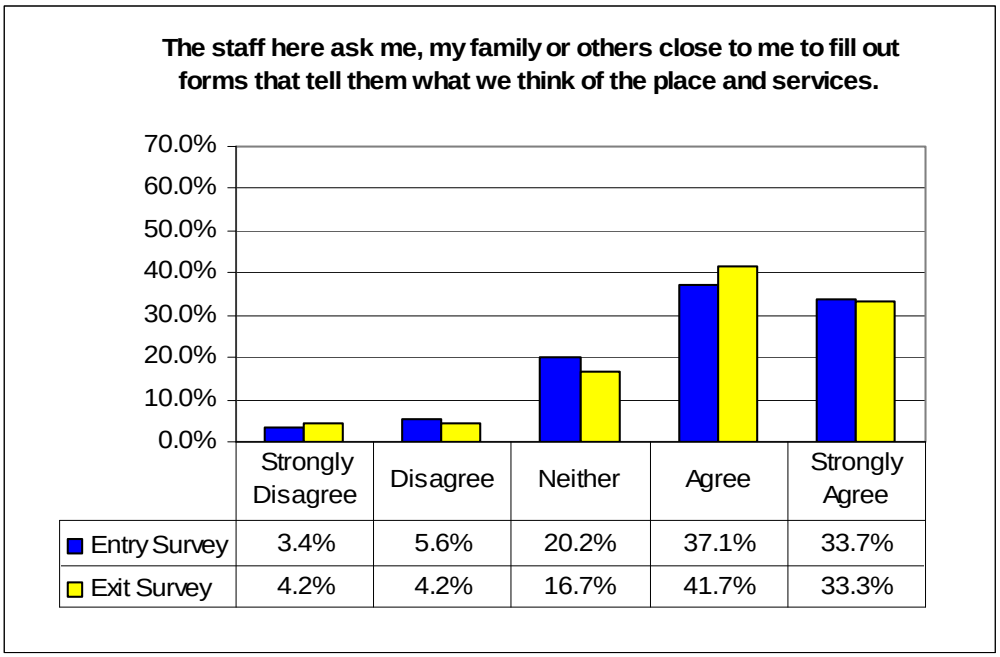
Fewer than 75% of respondents indicated agreement or strong agreement at both entry and exit on four survey items. Those were item 7, regarding pictures at the agency of people from minority racial/ethnic groups; item 12, regarding opportunities to give feedback regarding services; item 14, regarding information about outside social services; and item 17, regarding staff understanding of clients' desire to have a counselor of the same sex as the client. While the median scores of these items were 4 for each at entry and exit, these areas may warrant additional attention and efforts on the part of the agencies. Graphs 7 through 10 provide a visual display of the responses to items 7, 12, 14, and 17, respectively.

Graph 7. Client Survey Item 7 Results



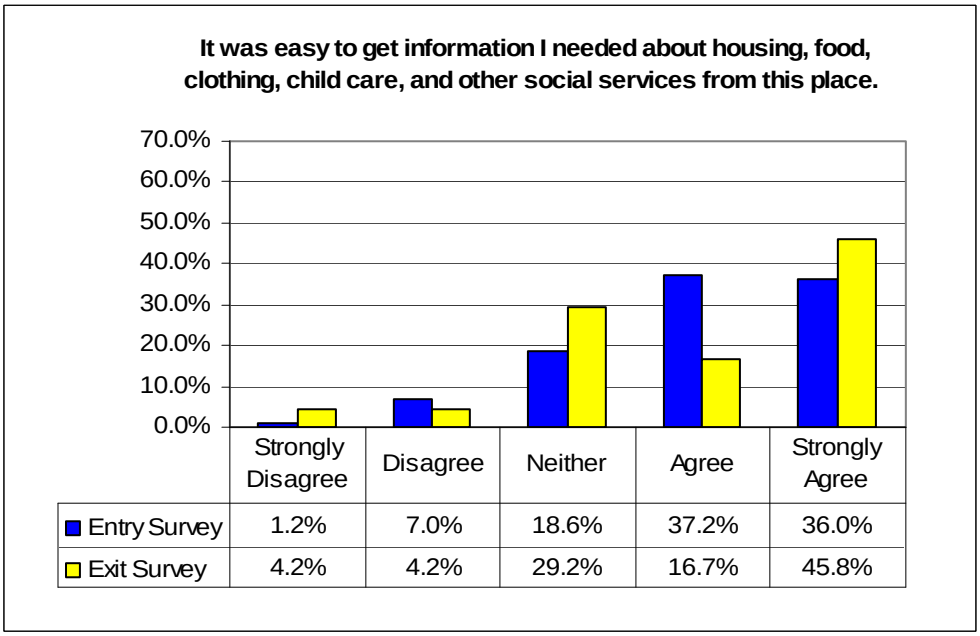
	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
Entry Survey	6.7%	6.7%	17.8%	33.3%	35.6%
Exit Survey	0.0%	20.8%	8.3%	37.5%	33.3%

Graph 8. Client Survey Item 12 Results



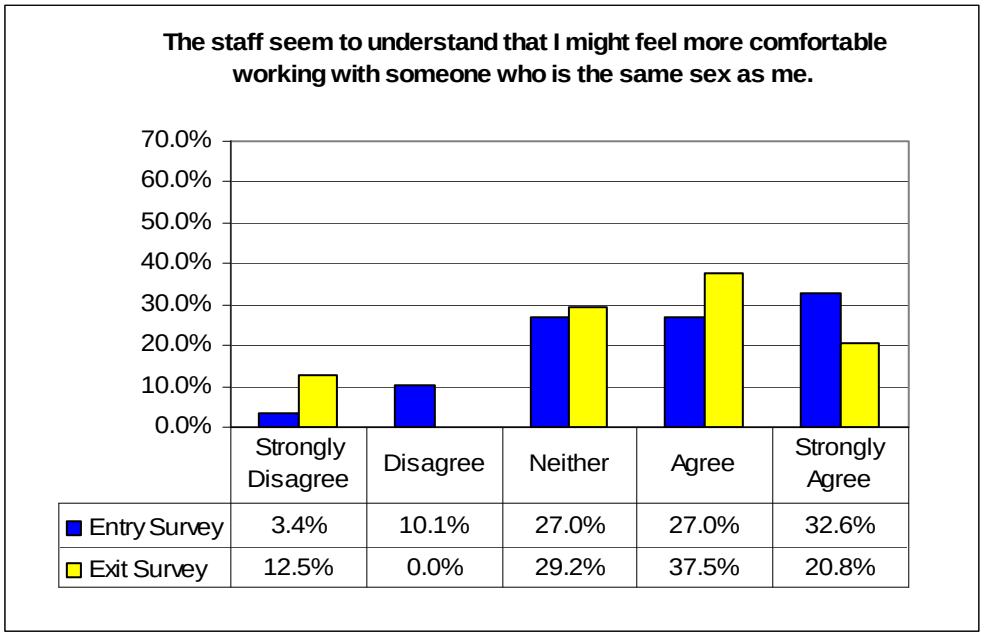
	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
Entry Survey	3.4%	5.6%	20.2%	37.1%	33.7%
Exit Survey	4.2%	4.2%	16.7%	41.7%	33.3%

Graph 9. Client Survey Item 14 Results



	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
Entry Survey	1.2%	7.0%	18.6%	37.2%	36.0%
Exit Survey	4.2%	4.2%	29.2%	16.7%	45.8%

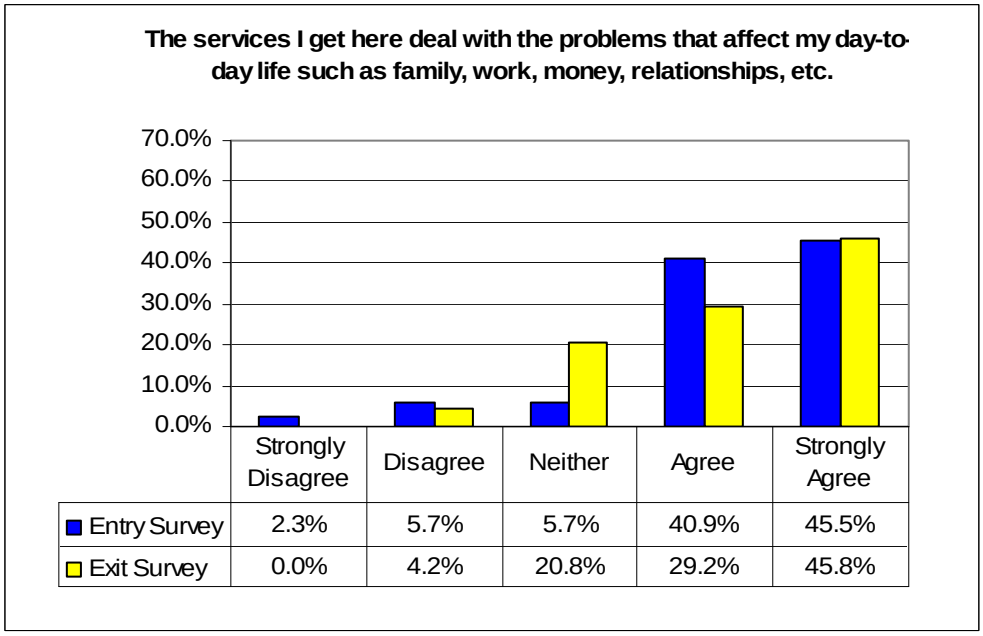
Graph 10. Client Survey Item 17 Results



	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
Entry Survey	3.4%	10.1%	27.0%	27.0%	32.6%
Exit Survey	12.5%	0.0%	29.2%	37.5%	20.8%

One item had fewer than 75% of respondents indicate agreement or strong agreement at the exit point. This was item 21, regarding whether services help clients with issues in their day to day lives. While the median score was 4 at entry and exit, this issue may warrant additional attention and efforts on the part of the agencies, as the percent indicating agreement or strong agreement decreased from 86.4% at entry to 75% at exit. Graph 11 provides a visual display of the responses to item 21.

Graph 11. Client Survey Item 21 Results



	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
Entry Survey	2.3%	5.7%	5.7%	40.9%	45.5%
Exit Survey	0.0%	4.2%	20.8%	29.2%	45.8%

Staff Surveys Returned

Agency staff completed the Modified California Brief Multicultural Competence Scale at the beginning of the CCTP or upon their entry into the project (first round), and again in the last month of the pilot project (second round). CADS provided surveys to all staff; EFR provided surveys to staff working on the project; and Jackson Recovery provided surveys to all staff at locations in Sioux City and Denison.

Table 5 provides the number of staff first and second round surveys returned by each agency.

Table 5. Number of Staff Surveys Returned

Survey Type	Participating Agency			
	CADS	EFR	Jackson Recovery	TOTAL
1st Round Staff Surveys	35	3	10	48
2nd Round Staff Surveys	26	3	1	30

Staff Survey Demographics

The median age of staff completing the first round survey was 44; the median age of staff completing the second round survey was 32. The majority of staff members at both survey points were female counselor/therapists. Race and ethnicity were not asked on the first round survey. Seventy-three percent of the staff completing the second round survey were White, twenty percent were African American, and seven percent were Hispanic or Latino. More than half of first and second round survey respondents had taken coursework in multicultural counseling. More than two-thirds of first round respondents had attended workshops on multicultural issues and more than one-third had attended multiple workshops. More than half of second round respondents had attended workshops on multicultural issues and nearly half had attended multiple workshops. Less than one-fourth of first round respondents had attended such workshops since the start of the CCTP project, and one-third of second round respondents had attended such workshops since the start of the project. Table 6 displays data on staff survey respondent demographics and experience/training in multicultural issues.

Table 6: Staff Survey Demographics (continued on page 24)

Staff Survey Demographics		
	1st Round Survey (N=48) Median Minimum/Maximum	**2nd Round Survey (N=30) Median Minimum/Maximum**
Age	**44** 23 / 66	**32** 23 / 63
Years of Experience in the Substance Abuse Treatment Field	**3.5** <1 / 26	**3.0** <1 / 26

Table 6: Staff Survey Demographics (continued from page 23)

	1st Round Survey Percent	2nd Round Survey Percent
Gender		
Female	**75%**	**70%**
Male	**25%**	**30%**
Race		
White	(Not asked	**73%**
Black or African American	on 1st round survey)	**20%**
Missing		**7%**
Hispanic or Latino Ethnicity		
Yes	(Not asked	**7%**
No	on 1st round survey)	**93%**
Highest Level of Education Completed		
High School Diploma	**13%**	**20%**
Two-Year Degree	**23%**	**13%**
Undergraduate Degree	**44%**	**47%**
Masters Degree	**19%**	**17%**
Doctoral Degree	**2%**	**3%**
Job Title		
Counselor/Therapist/Case Manager	**74%**	**69%**
Medical Staff	**9%**	**10%**
Program Manager/Director	**6%**	**10%**
Office Staff	**6%**	**7%**
Coordinator/Supervisor	**4%**	**3%**
Years of Experience in the Substance Abuse Treatment Field		
Less than 2 years	**41%**	**40%**
2-5 years	**19%**	**23%**
6-10 years	**10%**	**20%**
11-15 years	**4%**	**3%**
16-20 years	**19%**	**6%**
More than 20 years	**6%**	**6%**
Had Coursework on Multicultural Counseling in School		
Yes	**54%**	**57%**
No	**44%**	**40%**
Currently Taking	**2%**	**3%**
Attended Workshops on Multicultural Issues in Substance Abuse Treatment		
Yes	**69%**	**57%**
No	**31%**	**40%**
Missing	**0%**	**3%**
Attended Workshops Since CCTP Began		
Yes	**23%**	**33%**
No	**75%**	**67%**
Missing	**2%**	**0%**
Number of Workshops Attended Since CCTP Began		
1	**8%**	**7%**
2	**4%**	**17%**
3	**2%**	**7%**
Missing	**85%**	**70%**
Speak a Foreign Language Well Enough to Provide Substance Abuse Treatment in that Language		
Yes	**10%**	**7%**
No	**90%**	**93%**

Staff Survey Results

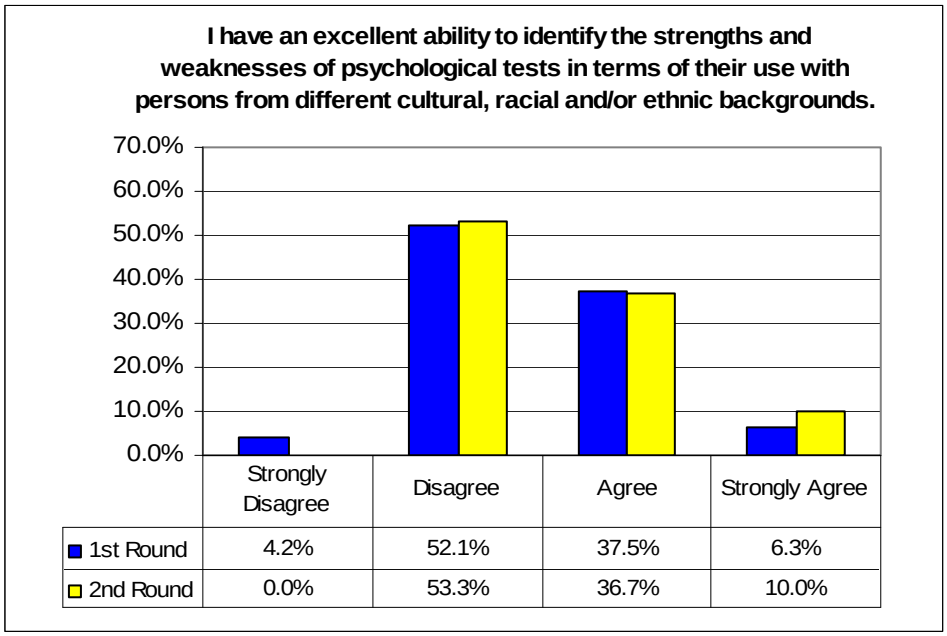
As with client entry and exit surveys, staff first and second round surveys were not matched by participant, therefore survey results do not reflect individual change in attitude or perception over time. Rather, first round survey results reflect perceptions of staff who are beginning work in the Culturally Competent Treatment Program, and second round surveys reflect perceptions of staff who have worked for a period of time in the Culturally Competent Treatment Program (in this case, a few to several months). To protect the anonymity of participants, survey results are not broken down by agency. Table 7 on page 26 displays results for each survey question at entry and exit point.

Table 7. Staff Survey Results: Modified California Brief Multicultural Competence Scale

Statement	Strongly Disagree		Disagree		Agree		Strongly Agree	
	1st Round	2nd Round	1st Round	2nd Round	1st Round	2nd Round	1st Round	2nd Round
1. I am aware that being born a minority in this society brings with it certain challenges that White people do not have to face.	2.1%	3.3%	2.1%	3.3%	52.1%	53.3%	43.8%	40.0%
2. I am aware of how my own values might affect my client.	2.1%	0%	4.2%	3.3%	54.2%	60.0%	39.6%	36.7%
3. I have an excellent ability to assess, accurately, the substance abuse treatment needs of persons with disabilities.	0%	0%	27.7%	30.0%	63.8%	63.3%	8.5%	6.7%
4. I am aware of institutional barriers that affect the client.	0%	0%	10.4%	16.7%	60.4%	56.7%	29.2%	26.7%
5. I have an excellent ability to assess, accurately, the substance abuse treatment needs of lesbians.	0%	0%	29.2%	33.3%	62.5%	60.0%	8.3%	6.7%
6. I have an excellent ability to assess, accurately, the substance abuse treatment needs of older adults.	0%	0%	27.7%	26.7%	63.8%	70.0%	8.5%	3.3%
7. I have an excellent ability to identify the strengths and weaknesses of psychological tests in terms of their use with persons from different cultural, racial and/or ethnic backgrounds.	4.2%	0%	52.1%	53.3%	37.5%	36.7%	6.3%	10.0%
8. I am aware that counselors frequently impose their own cultural values upon minority clients.	4.2%	3.3%	29.2%	20.0%	45.8%	56.7%	20.8%	20.0%
9. My communication skills are appropriate for my clients.	0%	0%	2.1%	0%	59.6%	76.7%	38.3%	23.3%
10. I am aware that being born a White person in this society carries with it certain advantages.	0%	6.7%	17.0%	23.3%	57.4%	50.0%	25.5%	20.0%
11. I am aware of how my cultural background and experiences have influenced my attitudes about psychological processes.	0%	0%	8.3%	6.9%	64.6%	75.9%	27.1%	17.2%
12. I have an excellent ability to critique multicultural research.	4.3%	0%	45.7%	60.0%	43.5%	30.0%	6.5%	10.0%
13. I have an excellent ability to assess, accurately, the substance abuse treatment needs of men.	2.1%	0%	22.9%	36.7%	54.2%	40.0%	20.8%	23.3%
14. I am aware of institutional barriers that may inhibit minorities from using substance abuse treatment services.	0%	0%	8.3%	10.0%	62.5%	66.7%	29.2%	23.3%
15. I can discuss, within a group, the differences among ethnic groups (e.g. low socioeconomic status (SES) Latino client vs. high SES Latino client).	4.2%	6.7%	31.3%	43.3%	50.0%	43.3%	14.6%	6.7%
16. I can identify my reactions that are based on stereotypical beliefs about different ethnic groups.	0%	0%	17.0%	23.3%	68.1%	66.7%	14.9%	10.0%
17. I can discuss research regarding substance abuse issues and culturally different populations.	2.1%	0%	34.0%	36.7%	53.2%	56.7%	10.6%	6.7%
18. I have an excellent ability to assess, accurately, the substance abuse treatment needs of gay men.	2.1%	3.3%	34.0%	46.7%	51.1%	43.3%	12.8%	6.7%
19. I am knowledgeable of acculturation models for various ethnic minority groups.	6.3%	3.3%	45.8%	50.0%	39.6%	46.7%	8.3%	0%
20. I have an excellent ability to assess, accurately, the substance abuse treatment needs of women.	2.1%	0%	20.8%	16.7%	58.3%	63.3%	18.8%	20.0%
21. I have an excellent ability to assess, accurately, the substance abuse treatment needs of persons who come from very poor socioeconomic backgrounds.	0%	0%	23.4%	26.7%	53.2%	53.3%	23.4%	20.0%

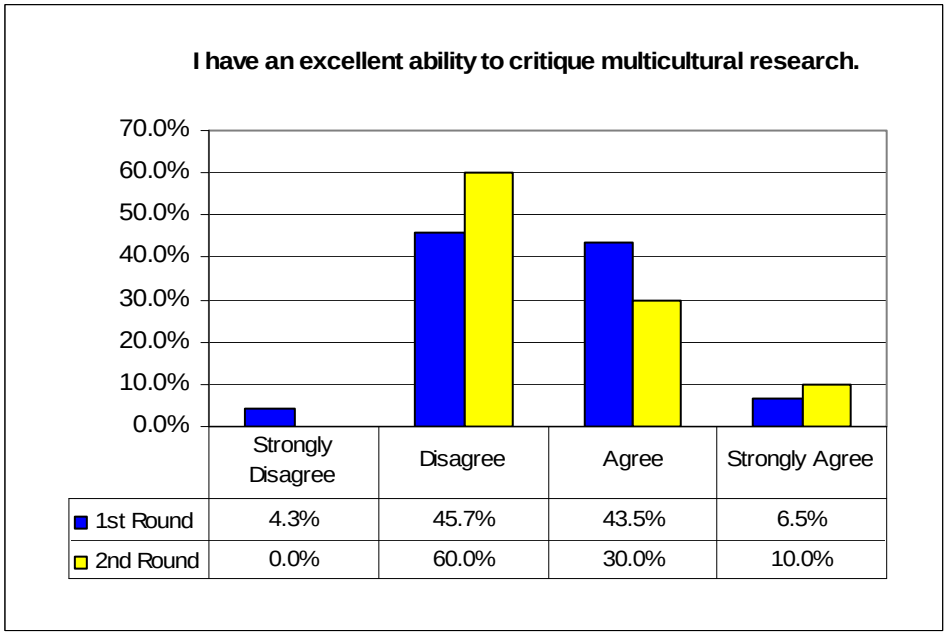
Using a numerical scoring method where 1 = Strongly Disagree, 2 = Disagree, 3 = Agree, and 4 = Strongly Agree, the median score for most survey items was 3. Three items had median scores lower than 3 at both survey points. Those are item 7, regarding the respondent's knowledge of the use of psychological tests with various ethnic groups (median = 2); item 12, regarding the ability to critique multicultural research (median = 2.5 at first round and 2 at second round); and item 19, regarding knowledge of acculturation models for ethnic groups (median = 2). Graphs 12, 13, and 14 present responses to items 7, 12, and 19, respectively.

Graph 12. Staff Survey Item 7 Results



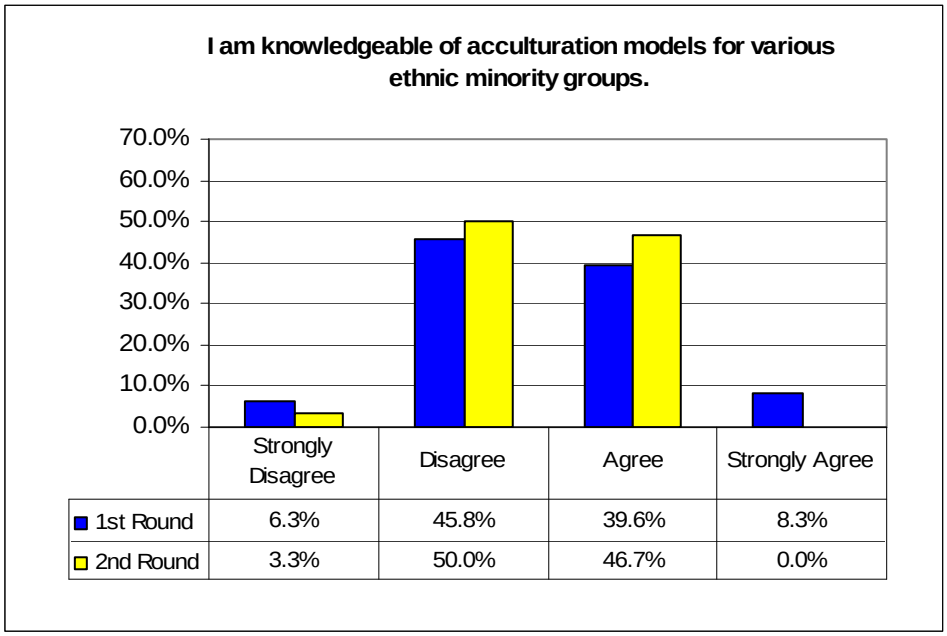
	Strongly Disagree	Disagree	Agree	Strongly Agree
1st Round	4.2%	52.1%	37.5%	6.3%
2nd Round	0.0%	53.3%	36.7%	10.0%

Graph 13. Staff Survey Item 12 Results



	Strongly Disagree	Disagree	Agree	Strongly Agree
1st Round	4.3%	45.7%	43.5%	6.5%
2nd Round	0.0%	60.0%	30.0%	10.0%

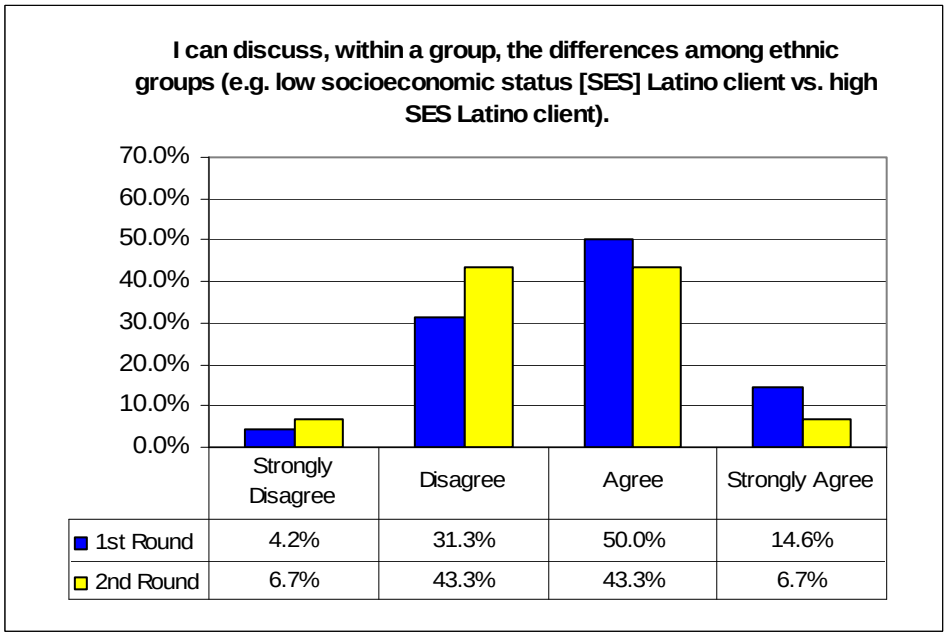
Graph 14. Staff Survey Item 19 Results



	Strongly Disagree	Disagree	Agree	Strongly Agree
1st Round	6.3%	45.8%	39.6%	8.3%
2nd Round	3.3%	50.0%	46.7%	0.0%

Item 15 had a median score lower than 3 at the second round survey point. That survey item addresses the ability to discuss differences among ethnic groups (median = 2). Graph 15 provides a visual display of the responses to item 15 .

Graph 15. Staff Survey Item 15 Results



	Strongly Disagree	Disagree	Agree	Strongly Agree
1st Round	4.2%	31.3%	50.0%	14.6%
2nd Round	6.7%	43.3%	43.3%	6.7%

These results highlight the areas in which staff members may tend to perceive themselves as less competent. These areas include the strengths and weaknesses of using psychological tests with racial and ethnic minorities, critiquing multicultural research, knowledge of acculturation models, and ability to articulate differences within various racial/ethnic groups.

Conclusion

The Iowa Department of Public Health funded three agencies, Center for Alcohol and Drug Services (CADS), Employee and Family Resources (EFR), and Jackson Recovery Centers, to implement pilot programs to provide culturally competent substance abuse treatment from November 2007 through June 2008. The objectives of the Culturally Competent Substance Abuse Treatment Pilot Projects (CCTP) were to:

- increase substance abuse treatment options for racially and ethnically diverse populations;
- provide best practices or tried treatment methods and document program outcomes so Iowa treatment providers may adopt culturally competent treatment methods;
- identify barriers to participants accessing treatment and work with community wrap around services to assist clients with barriers in order to participate in and complete treatment services;
- maintain contact and support services with clients for six months;
- document and provide program outcomes by working with the Iowa Consortium for Substance Abuse Research and Evaluation;
- disseminate information about the pilot project including but not limited to: programming, lessons learned, community involvement, and outcomes as requested; and
- train substance abuse treatment staff to work more effectively with the target population.

Agencies reported serving one-hundred seventy-seven clients through the CCTP project, and admitting one-hundred fifty-five clients to substance abuse treatment. I-SMART/SARS admission records were found for one-hundred twelve of those clients. EFR reported experiencing technical difficulties with data submissions to IDPH, which may account for most of the missing records. Fifty-eight percent (58%) of clients for whom records existed in I-SMART/SARS were African American; thirty-eight were of Hispanic or Latino ethnicity. Eighty-two percent (82%) were male and eighteen (18%) percent were female. The median age was thirty-two years, and all were at least eighteen years old.

Outcome data from I-SMART/SARS show that twenty-two project clients successfully completed treatment and twenty-one clients were discharged from treatment prior to completion. The median length of stay for clients who successfully completed treatment was sixty days. The median length of stay for clients discharged before completing treatment was forty-seven days. Sixty-nine CCTP clients remained in treatment at the end of the pilot project period.

All three grantee agencies increased their capacity to serve culturally diverse populations through training current staff or hiring and training additional staff persons in cultural sensitivity and culturally competent treatment practices. All grantee agencies implemented evidence-

based substance abuse treatment approaches for this project. All agencies identified and addressed barriers to treatment for these populations and increased their efforts to provide access to culturally competent treatment services through outreach to minority communities, collaborating with community agencies and faith-based groups to increase referrals and provide ancillary services, and creating or translating program materials into the native language of their target populations. Agencies linked clients with outside support services and made efforts to engage project clients in continuing care services for a minimum of six months following treatment. Agencies complied with process and outcome data reporting requirements and collaborated with the Consortium to resolve omissions and discrepancies in the data. Agencies disseminated information on their CCTP programs to Iowa providers through presentations at the Annual Governor's Conference on Substance Abuse. All agencies provided project staff with training on working with the target populations through formal training seminars or regular supervision and mentoring meetings.

The Consortium found multiple discrepancies between admission dates reported directly versus admission dates in the I-SMART/SARS data. Some discrepancies were caused by differences in agencies' processes for screening and admitting clients to the project and how admissions were defined. Some were caused by problems transferring data electronically to the I-SMART/SARS system. The Consortium and grantee agencies have resolved some of the discrepancies and are taking steps to resolve those remaining. The Consortium will work with IDPH within the first two months of the next project year to establish a unified reporting protocol for client admission. Data will be monitored for completeness (e.g., race, ethnicity), and consistency. When a discrepancy is identified, every attempt will be made to resolve the discrepancy within 48 hours. In addition, survey return rates were markedly lower for the second administration than for the first administration, yielding limited data from which to draw conclusions. The Consortium will discuss possible recommendations with IDPH to modify the survey administration protocol to increase survey submissions for the next grant year.

Jackson Recovery Centers reported that clients often asked questions about the survey and the meaning of some survey questions. Jackson Recovery is targeting Spanish speaking clients and administering the Spanish language survey. The Consortium will assess the need for training on the instrument and the possibility of issues with translation.

Client survey data indicate that clients generally perceive agencies and staff as competent in most aspects of culturally-sensitive substance abuse treatment. The areas receiving the highest ratings at both entry and exit were treating clients with respect, and services being helpful in obtaining employment, taking care of family, and being socially engaged. Four areas showed higher levels of agreement at exit than at entry, indicating that agencies may have improved in these areas during the pilot project period: the ability of staff to adapt approaches to clients' cultural needs, the availability of translators or interpreters, staff outreach to the client's community, and the availability of easily readable brochures in the waiting room. The difference between entry and exit scores on the availability of brochures was statistically significant (Wilcoxon, $p < .05$).

Four client survey items showed the lowest levels of agreement at both entry and exit. So, these areas may warrant additional attention and efforts on the part of the agencies: having pictures at the agency of people from minority racial/ethnic groups; opportunities to give feedback regarding services; availability of information about outside social services; and understanding of clients' desire to have a counselor of the same sex. Fewer respondents agreed or strongly agreed with one area at exit than at entry: that services helped clients with

issues in their day to day lives. This area also may warrant additional attention and efforts by agencies.

Staff survey data indicate that staff members feel competent with most aspects of culturally sensitive treatment provision. Four items had lower median scores than the others. These results highlight the areas in which staff members tend to perceive themselves as less competent. These areas include the strengths and weaknesses of using psychological tests with racial and ethnic minorities, critiquing multicultural research, knowledge of acculturation models, and ability to articulate differences within various racial/ethnic groups. It may be beneficial for cultural competency training programs to touch on these areas. However, these areas do not correspond to the areas that the clients felt were most lacking.

Client and staff survey data show areas of strength and areas for potential improvement in providing culturally competent treatment. The survey participant numbers were small, however, and additional survey data will help further illuminate these areas.

The Culturally Competent Substance Abuse Treatment Pilot Project has allowed agencies to increase their capacity to provide culturally sensitive substance abuse treatment and to identify and begin to address barriers to racial/ethnic minorities obtaining substance abuse treatment. Continuation of this project will provide additional opportunities to further these efforts. Lessons learned through this pilot project and successive years of implementation will benefit agencies across the state to adopt best practices for providing culturally competent treatment to Iowa's culturally and ethnically diverse clients.

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For further information on the CBMCS Multicultural Training Program, contact Kassie Graves at SAGE Publications (Kassie.Graves@sagepub.com).

APPENDIX

Survey Instruments

Iowa Cultural Understanding Assessment – Client Form

Please indicate your level of agreement with the statements below by circling the number to the right of the statement that best fits your opinion. All responses are confidential. When you have completed the survey, please either use the pre-addressed, stamped envelope to return the survey by mail or place it in the drop box at the facility. **Thank you very much for your participation!**

Demographic Information

What is your sex? ____Male ____Female

What is your race? ____Alaskan Native ____American Indian ____Asian ____Black or African American
____Native Hawaiian or other Pacific Islander ____White

Are you Hispanic or Latino? ____Yes ____No

Statement	Response				
	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
1. The staff here understand some of the ideas that I, my family, and others from my cultural, racial, or ethnic group may have.	1	2	3	4	5
2. Staff here understand the importance of my cultural beliefs in my treatment process.	1	2	3	4	5
3. The staff here listen to me and my family when we talk to them.	1	2	3	4	5
4. If I want, the staff will help me get services from clergy or spiritual leaders.	1	2	3	4	5
5. The services I get here really help me work toward things like getting a job, taking care of my family, going to school, and being active with my friends, family, and community.	1	2	3	4	5
6. The staff here seem to understand the experiences and problems I have in my past life.	1	2	3	4	5
7. The waiting room and/or facility has pictures or reading material that show people from my racial or ethnic group.	1	2	3	4	5
8. The staff here know how to use their knowledge of my culture to help me address my current day-to- day needs.	1	2	3	4	5
9. The staff here understand that I might want to talk to a person from my own racial or ethnic group about getting the help I want.	1	2	3	4	5
10. The staff here respect my religious or spiritual beliefs.	1	2	3	4	5

Iowa Cultural Understanding Assessment – Client Form

Statement	Response				
	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
11. Staff from this program come to my community to let people like me and others know about the services they offer and how to get them.	1	2	3	4	5
12. The staff here ask me, my family or others close to me to fill out forms that tell them what we think of the place and services.	1	2	3	4	5
13. Staff here understand that people of my racial or ethnic group are *not* all alike.	1	2	3	4	5
14. It was easy to get information I needed about housing, food, clothing, child care, and other social services from this place.	1	2	3	4	5
15. The staff here talk to me about the treatment they will give me to help me.	1	2	3	4	5
16. The staff here treat me with respect.	1	2	3	4	5
17. The staff seem to understand that I might feel more comfortable working with someone who is the same sex as me.	1	2	3	4	5
18. Most of the time, I feel I can trust the staff here who work with me.	1	2	3	4	5
19. The waiting room has brochures or handouts that I can easily understand that tell me about services I can get here.	1	2	3	4	5
20. If I want, my family or friends are included in discussions about the help I need.	1	2	3	4	5
21. The services I get here deal with the problems that affect my day-to-day life such as family, work, money, relationships, etc.	1	2	3	4	5
22. Some of the staff here understand the difference between their culture and mine.	1	2	3	4	5
23. Some of the counselors are from my racial or ethnic group.	1	2	3	4	5
24. Staff are willing to be flexible and provide alternative approaches or services to meet my cultural/ethnic treatment needs.	1	2	3	4	5
25. If I need it, there are translators or interpreters easily available to assist me and/or my family.	1	2	3	4	5

* Adapted from the Assessment Tool for Cultural Competence, Maryland Mental Hygiene Administration of Maryland Health Partners. 1/2008

Evaluación del Entendimiento Cultural de la Gente de Iowa—Formulario para Clientes

Por favor indíquenos a que nivel está de acuerdo con las frases a continuación por poner un círculo alrededor del número a la derecha de la declaración que es más semejante a su opinión. Todas las respuestas son confidenciales. Cuando ha llenado el cuestionario, por favor use el sobre que ya tiene dirección y sello para devolverlo por correo o póngalo en el buzón en el edificio.
¡Muchas gracias por su participación!

Información personal

¿Cuál es su sexo? ☐ Hombre ☐ Mujer

¿Cuál es su raza? ☐ Nativo de Alaska ☐ Amerindia ☐ Asiática ☐ Negra o afroamericana ☐ Nativo de Hawaii u otra isla del Pacífico ☐ Blanca

¿Es Ud. Hispano o Latino? ☐ Sí ☐ No

Frase	Respuesta				
	Muy en desacuerdo	En desacuerdo	Ni de acuerdo ni en desacuerdo	De acuerdo	Totalmente de acuerdo
1. Los empleados aquí entienden algunas de las ideas que yo, mi familia, y otros de mi grupo cultural, racial, o étnico posiblemente tengan.	1	2	3	4	5
2. Los empleados aquí comprenden como mis creencias culturales son importantes en el proceso de tratamiento.	1	2	3	4	5
3. Los empleados aquí escuchan a mí y mi familia cuando hablamos con ellos.	1	2	3	4	5
4. Si lo quiero, los empleados me ayudarán a conseguir los servicios del clero o líderes espirituales.	1	2	3	4	5
5. Los servicios que recibo aquí verdaderamente me ayudan a trabajar para cosas como conseguir un puesto, cuidar a mi familia, asistir a la escuela, y estar activo con mis amigos, familia, y comunidad.	1	2	3	4	5
6. Me parece que los empleados aquí entienden las experiencias y problemas que tengo en mi vida pasada.	1	2	3	4	5
7. La sala de espera y/o el edificio tienen imágenes o materiales de leer que muestran gente de mi grupo racial o étnico.	1	2	3	4	5
8. Los empleados aquí entienden como usar su conocimiento de mi cultura para ayudarme a responder a las necesidades diarias actuales.	1	2	3	4	5
9. Los empleados aquí comprenden que tal vez quiera hablar con alguien de mi propio grupo racial o étnico sobre como conseguir la ayuda que quiero.	1	2	3	4	5
10. Los empleados aquí respetan a mis creencias religiosas o espirituales.	1	2	3	4	5

Evaluación del Entendimiento Cultural de la Gente de Iowa—Formulario para Clientes

Frase	Respuesta				
	Muy en desacuerdo	En desacuerdo	Ni de acuerdo ni en desacuerdo	De acuerdo	Totalmente de acuerdo
11. Los empleados de este programa vienen a mi comunidad para informar a gente como yo y otros de los servicios que ofrecen y como conseguirlos.	1	2	3	4	5
12. Los empleados aquí piden que yo, mi familia, y otros que conozco bien llenen formularios que les dicen lo que pensamos del lugar y sus servicios.	1	2	3	4	5
13. Los empleados aquí entienden que la gente de mi grupo racial o étnico no son todo lo mismo.	1	2	3	4	5
14. Era fácil obtener la información que necesitaba sobre la vivienda, comida, ropa, cuidado de niños, y otros servicios sociales de este lugar.	1	2	3	4	5
15. Los empleados aquí hablan conmigo del tratamiento que me darán para ayudarme.	1	2	3	4	5
16. Los empleados aquí me tratan con respeto.	1	2	3	4	5
17. Me parece que los empleados aquí entienden que tal vez me sienta más cómodo si pueda trabajar con alguien del mismo sexo que yo.	1	2	3	4	5
18. La mayor parte del tiempo, me siento como puedo confiar en los empleados aquí quienes trabajan conmigo.	1	2	3	4	5
19. La sala de espera tiene folletos o publicaciones que puedo entender fácilmente y que me informan sobre los servicios que puedo obtener aquí.	1	2	3	4	5
20. Si lo quiero, se incluyen a mi familia y amigos en las conversaciones sobre la ayuda que necesito.	1	2	3	4	5
21. Los servicios que recibo aquí tienen que ver con los problemas que afectan mi vida diaria como la familia, trabajo, dinero, relaciones, etc.	1	2	3	4	5
22. Algunos de los empleados aquí entienden la diferencia entre su cultura y la mía.	1	2	3	4	5
23. Algunos de los consejeros son de mi grupo racial o étnico.	1	2	3	4	5
24. Los empleados están dispuestos a ser flexibles y proponer métodos o servicios alternativos para satisfacer lo que necesito de mi tratamiento a causa de mis raices culturales o étnicas.	1	2	3	4	5
25. Si lo necesito, hay traductores o intérpretes fácilmente disponibles para ayudar a mí y/o mi familia.	1	2	3	4	5

* Adaptado de la Herramienta para Evaluar la Competencia Cultural, Administración de Higiene Mental de Maryland, parte del Socio de Salud de Maryland.

**Traducido en enero de 2008. Si tiene algún comentario en cuanto a la traducción, por favor póngase en contacto con la traductora Jane Gressang, jane-gressang@uiowa.edu, 319-335-5822. Muchas gracias.

Culturally Competent Treatment – Staff Survey

We are interested in learning about your knowledge, skills, and awareness in providing services to people from diverse backgrounds and ethnic groups. The information you provide is confidential. After completing the questions below, remember to turn the page over and complete the other side. Please either use the pre-addressed, stamped envelope to return the survey by mail or place it in the designated collection area at your agency. Thank you very much for your participation!

Demographic Information

1. What is your age? _____

2. What is your sex? _____Female _____Male

3. What is your current job title? _____

4. What is your highest level of education completed?
   - _____Less than high school diploma
   - _____HS diploma or GED
   - _____Completed two-year degree program (e.g. Associate's degree)
   - _____Completed Bachelor's degree
   - _____Completed Master's degree
   - _____Completed Doctorate degree

5. How many years of experience do you have in the field of substance abuse treatment since earning your highest degree?_____

6. Have you had course work on multicultural counseling while in school?
   - ___Yes
   - ___No
   - ___Currently taking

7. Have you attended special workshops and/or training seminars on multicultural issues in substance abuse treatment?
   - ___Yes Number of workshops/trainings:_____
   - ___No

8. Have you attended special workshops and/or training seminars on multicultural issues in substance abuse treatment since November, 2007?
   - ___Yes Number of workshops/trainings:_____
   - ___No

9. Do your speak a language other than English well enough to provide substance abuse services in that language?
   - ___Yes Please specify language:_____
   - ___No

10. Were you born in the United States?
   - ___Yes
   - ___No

OVER ⇨

Modified California Brief Multicultural Competence Scale (CBMCS)

Below is a list of statements dealing with multicultural issues within a substance abuse treatment context. Please indicate the degree to which you agree with each statement by circling the appropriate number.

Statement	Strongly Disagree	Disagree	Agree	Strongly Agree
1. I am aware that being born a minority in this society brings with it certain challenges that White people do not have to face.	1	2	3	4
2. I am aware of how my own values might affect my client.	1	2	3	4
3. I have an excellent ability to assess, accurately, the substance abuse treatment needs of persons with disabilities.	1	2	3	4
4. I am aware of institutional barriers that affect the client.	1	2	3	4
5. I have an excellent ability to assess, accurately, the substance abuse treatment needs of lesbians.	1	2	3	4
6. I have an excellent ability to assess, accurately, the substance abuse treatment needs of older adults.	1	2	3	4
7. I have an excellent ability to identify the strengths and weaknesses of psychological tests in terms of their use with persons from different cultural, racial and/or ethnic backgrounds.	1	2	3	4
8. I am aware that counselors frequently impose their own cultural values upon minority clients.	1	2	3	4
9. My communication skills are appropriate for my clients.	1	2	3	4
10. I am aware that being born a White person in this society carries with it certain advantages.	1	2	3	4
11. I am aware of how my cultural background and experiences have influenced my attitudes about psychological processes.	1	2	3	4
12. I have an excellent ability to critique multicultural research.	1	2	3	4
13. I have an excellent ability to assess, accurately, the substance abuse treatment needs of men.	1	2	3	4
14. I am aware of institutional barriers that may inhibit minorities from using substance abuse treatment services.	1	2	3	4
15. I can discuss, within a group, the differences among ethnic groups (e.g. low socioeconomic status (SES) Latino client vs. high SES Latino client).	1	2	3	4
16. I can identify my reactions that are based on stereotypical beliefs about different ethnic groups.	1	2	3	4
17. I can discuss research regarding substance abuse issues and culturally different populations.	1	2	3	4
18. I have an excellent ability to assess, accurately, the substance abuse treatment needs of gay men.	1	2	3	4
19. I am knowledgeable of acculturation models for various ethnic minority groups.	1	2	3	4
20. I have an excellent ability to assess, accurately, the substance abuse treatment needs of women.	1	2	3	4
21. I have an excellent ability to assess, accurately, the substance abuse treatment needs of persons who come from very poor socioeconomic backgrounds.	1	2	3	4

Modified from Gamst, G., Dana, R. H., Der-Karabetian, A., Aragon, M., Arellano, L., Morrow, G., & Martenson, L. (2004). Cultural competency Revised: The California Brief Multicultural Competency Scale. *Measurement and Evaluation in Counseling and Development, 37, 3,163-187.*