



# **CULTURALLY COMPETENT SUBSTANCE ABUSE TREATMENT PROJECT**

## **ANNUAL REPORT**

**JULY 1, 2008 – JUNE 30, 2009**

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## **Executive Summary**

### **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. Three agencies were selected through a competitive process to provide services under the Culturally Competent Substance Abuse Treatment Project: 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. The agencies implemented pilot treatment projects from November 2007 through June 30, 2008, and these projects were awarded funding to provide a second year of services, from July 1, 2008 through June 30, 2009. The Iowa Consortium for Substance Abuse Research and Evaluation (Consortium) was selected to conduct an evaluation of the Culturally Competent Substance Abuse Treatment Project.

The objectives of the Culturally Competent Substance Abuse Treatment Project (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.

### **Training**

The Culturally Competent Treatment Project provided two training seminars to increase the cultural sensitivity and competency of agency staff overall. One-hundred seventy-four treatment staff and other helping professionals participated in those training seminars. As a result of those trainings and additional efforts on the part of the grantee agencies, one-hundred percent of CADS staff, eighty-eight percent of EFR staff, and seventy-five percent of Jackson Recovery Centers staff received training in cultural competency during this project year.

### **Client Outcomes**

#### *Clients Served*

One-hundred eighty-four clients were admitted to substance abuse treatment through the Culturally Competent Substance Abuse Treatment Project (CCTP) between July 1, 2008 and June 30, 2009. Three-hundred sixteen clients underwent placement screenings and were referred to CCTP treatment. One-hundred sixty non-CCTP clients also were served by this project through participation in CCTP programming. Fifty-nine percent of clients admitted to the project were African American, forty percent were Hispanic or Latino, and two percent were another race/ethnicity. Eighty-two percent of clients were male and eighteen percent were female. The median age of clients admitted to the project was thirty-four.

## Cultural Competency and Comparison Group Outcomes

Evaluators conducted an analysis comparing outcomes for clients in the Culturally Competent Treatment Project to outcomes for minority clients in other treatment programs in Iowa. The two groups were similar in race/ethnicity and age. The groups differed in the percentage of males and females, with relatively fewer females among the Cultural Competency clients. Alcohol was the most frequently cited substance for both groups. Statistically significant differences were found between the two groups when alcohol was not the primary substance: cocaine/crack was more frequently mentioned and marijuana was less frequently mentioned in the Cultural Competency group than in the Comparison group.

There was no significant difference between the two groups in regard to discharge status: successful completions occurred at approximately the same frequency. However, the Cultural Competency group had significantly more admissions later in the analysis time window and more clients still in treatment. It is possible that many of the CCTP clients still in treatment may have a greater chance to successfully complete treatment, as the programs have solidified in recent months.

Discharge Status	Comparison Group	Cultural Competency
<b>Discharge Category (All Clients)</b>	(n = 4,497)	(n = 279)
Successful	46.0%	39.8%
Neutral	7.3%	7.5%
Unsuccessful	27.7%	18.3%
Still in Treatment	19.0%	34.4%
<b>Discharge Category (Discharged Clients)</b>	(n = 3,643)	(n = 185)
Successful	56.8%	60.3%
Neutral	9.0%	11.4%
Unsuccessful	34.2%	28.3%

Days in Treatment (Median)		
Discharge Reason	Comparison Group	Cultural Competency
Successful	65.5 days	92 days
Neutral	30 days	73 days
Unsuccessful	29 days	46 days

Clients in the Cultural Competency group stayed in treatment significantly longer than those in the statewide Comparison group, regardless of their discharge status. The median length of stay for clients in the Cultural Competency group was one-hundred twelve days while

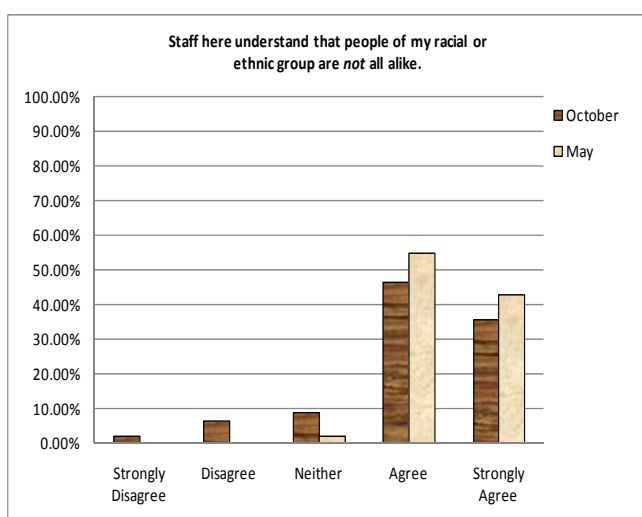
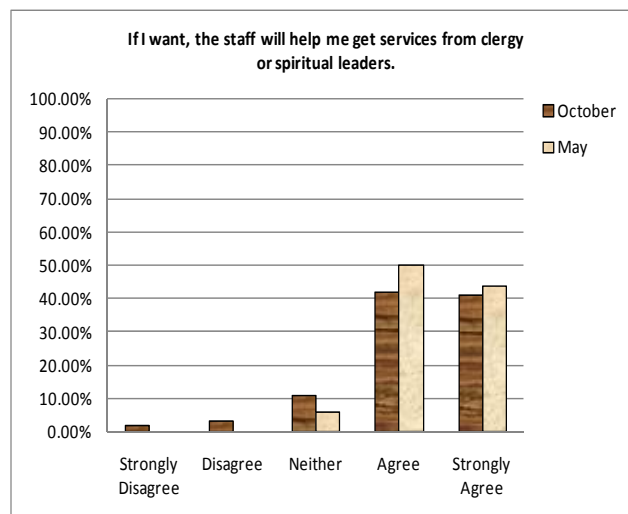
the median length of stay for clients in the Comparison group was sixty-four. The Cultural Competency programs increased the "Unsuccessful" clients' treatment exposure (length of stay) by one-and-a-half times.

Individual CCTP programs also were analyzed separately. Each program had a significantly greater length of stay than the comparison group, and CCTP programs did not differ from each other in length of stay.

### Client Survey Results

Client survey results are positive, with at least eighty-six percent of respondents agreeing or strongly agreeing with all but three statements indicating cultural competency of the staff and agency. The three exceptions had at least eighty-two percent agree or strongly agree, and were: "The waiting room and/or facility has pictures or reading material that show people from my racial or ethnic group;" "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;" and, "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."

Some statements had ninety-eight percent of respondents agree or strongly agree, most notably: “If I want, the staff will help me get services from clergy or spiritual leaders;” and, “Staff here understand that people of my racial or ethnic group are *not* all alike.” Those two statements also showed a notable increase from the October, 2008 survey period to the May, 2009 survey period in percentage of clients agreeing or strongly agreeing. The percentage increases for those statements were 10.7% and 15.7%, respectively (surpassing the statistical confidence interval).

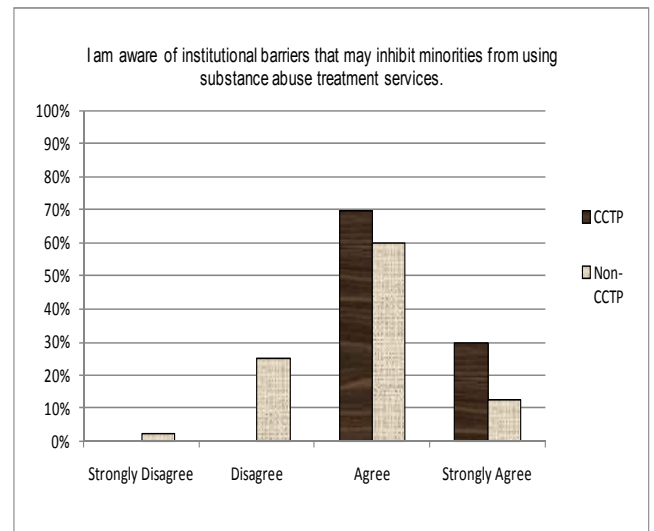
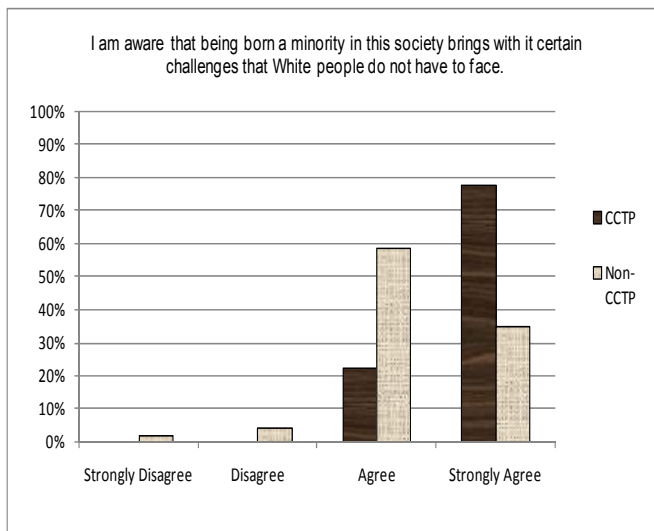


However, because only half of the eligible clients in the project completed the survey, the results should be viewed with caution. Clients who did not complete the survey may have different views than those represented here.

## Staff Survey Results

Survey results indicate staff members feel competent with most aspects of culturally sensitive treatment provision. There were statistically significant differences in race/ethnicity and ability to speak a foreign language between CCTP staff and non-CCTP staff, with a greater percentage of CCTP staff being racial/ethnic minorities and being able to speak a foreign language well enough to provide treatment services in that language.

Statistically significant differences also were found between CCTP staff and non-CCTP staff on eight survey items, most notably: “I am aware that being born a minority in this society brings with it certain challenges that White people do not have to face;” and, “I am aware of institutional barriers that may inhibit minorities from using substance abuse treatment services.”



The percentage of staff agreeing with some items decreased from the December, 2008 survey period to the May, 2009 survey period. The greatest decreases in agreement were with: “I am aware of how my cultural background and experiences have influenced my attitudes about psychological processes;” and, “I am aware of institutional barriers that may inhibit minorities from using substance abuse treatment services.” It may be that as agency staff were exposed to additional information on cultural issues, they became more aware of gaps in their own knowledge of issues affecting minorities.

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## **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. These projects were again awarded funding to provide a second year of services, July 1, 2008 through June 30, 2009.

The three agencies providing services under the Culturally Competent Substance Abuse Treatment Project are: 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.

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

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- 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.

## **Evaluation Process and Methods**

The Iowa Consortium for Substance Abuse Research and Evaluation (Consortium) was selected to conduct an evaluation of the Culturally Competent Substance Abuse Treatment Project. 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 project evaluation includes surveying clients and agency staff regarding perceived cultural competency of the staff and the agency, gathering process data through agency quarterly reports, and gathering outcomes data through agency admission reports and the state substance abuse reporting system (I-SMART/SARS).

Agency evaluation responsibilities include:

- disseminating and collecting client and staff surveys;
- mailing completed surveys to the Consortium;
- utilizing the Iowa Service Management and Reporting Tool/Substance Abuse Reporting System (I-SMART/SARS) to record client data;
- providing client admission data to the Consortium; and
- submitting Quarterly Progress Reports and a Year End Report to IDPH and the Consortium.

### *Agency Progress Reports*

Agencies submit Quarterly 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 the number of staff trained in cultural competency and other areas;
- organizations to which grantees referred clients for additional treatment or ancillary services;
- progress toward goals agencies submitted in continuation applications;
- efforts to expand the project's capacity to serve the target population;
- changes in or concerns about the grantee's 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);
- information disseminated to others about the project (e.g., newspaper article; T.V. or radio coverage, public presentations);
- project challenges the grantee encountered and strategies implemented for overcoming them;
- technical assistance needs;
- program marketing;
- number of clients screened;
- number of clients admitted;
- number of clients discharged prior to completion; and
- number of clients successfully completing program.

### *Client and Staff Survey Instruments and Survey Protocol*

#### Client Survey

The client survey instrument used in this study is 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 Consortium wishes to acknowledge the work of the Maryland Health Partners on the instrument that formed the basis of the Iowa tool. The Iowa instrument is a twenty-five item questionnaire designed to assess client perceptions of the cultural competency of the treatment agency and

staff. 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 is 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.

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

#### Client Surveys

The Consortium and the Iowa Department of Public Health (IDPH) instituted a change in survey protocol this year. During the pilot period, agencies administered surveys to clients upon entry into the program and again just prior to transferring to continuing care. The protocol was changed to surveying all clients in the program every three months. This protocol allows for:

- inclusion of clients participating in all phases of treatment, with varying attitudes toward treatment, and varying levels of success/failure;
- increasing survey return rates and reducing agency staff burden;
- focusing on what is and is not working about the program at any given time; and
- assessing change over time by comparing responses at successive survey points.

The Consortium provided survey instruments, return envelopes, and a written survey administration protocol to agencies to ensure survey uniformity and client confidentiality. Agencies returned completed surveys to the Consortium for data entry and analysis. Consortium staff double-entered the survey data and cross-checked the results for data entry errors.

At CADS, counselors administered surveys to clients individually or in small groups. 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. 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. Jackson Recovery staff distributed surveys in a group format, and staff returned surveys to the Consortium. Completed surveys were collected in a manner that maintained respondent confidentiality. Staff members also gave the survey individually to

clients who were not in the group that day. In most cases, staff members return the surveys to the Consortium; a few clients took the survey home to complete and return on their own.

#### **Staff Surveys**

Agencies administered surveys at approximately six month intervals to clinical staff and non-clinical staff having direct contact with clients. The Consortium provided survey instruments, return envelopes, and a written survey administration protocol to agencies to ensure survey uniformity and staff participant confidentiality.

The program manager at CADS distributed staff surveys during an all-staff meeting to CCTP staff and to other program managers/supervisors to distribute to their staff members. Most staff completed the survey prior to leaving the staff meeting; others were given the survey later if not part of the meeting that day. Respective facilities/programs were each given a return envelope in which to send surveys to the Consortium. A few surveys were returned directly to the project manager for mailing. 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. At Jackson Recovery's Woodbury facility, staff completed surveys in a team meeting and sent them together in one mailing to the Consortium. At the Crawford facility, each staff person completed the survey individually and either returned the survey individually or took them to a central location where a designated staff person sent them to the Consortium.

Client and staff survey instruments and administration protocols appear in Appendix A.

### **Process Reporting**

The information provided in the Process Reporting section is summarized from agency quarterly reports.

#### *Personnel and Program Overview*

##### Center for Alcohol and Drug Services (CADS), Davenport, Iowa

Krystle Krauss, Program Manager, Cultural Diversity and Family Services

Additional project staff includes one counselor, one case manager, and one clerical staff person. One clinical staff person is African-American and one is Hispanic. A new Program Manager assumed responsibility for CADS' CCTP program (titled, "Cultural Diversity Program") at the beginning of this project year.

CADS' goal for the project year is to serve forty Latino and African American clients, with approximately ten clients being Latino, thirty being African American. CADS' Program Manager describes their best practice treatment model as follows: "The Evidence-Based Practice (EBP) used for this initiative is the Matrix Model for treatment. Its methodology supports proven treatment interventions, ongoing recovery, and wellness that comprise SAMHSA's central support areas: Emotional, Informational, Instrumental, and Affiliation. The Matrix Model includes the following components, all of which are used in the Cultural Diversity Program: Cognitive Behavioral Therapy, Conjoint Sessions, Family Education Lectures, Motivational Interviewing, Neurobehavioral Education, Recovery Support Services, Relapse Analysis, Self-Help Initiation, and Urine Testing. Challenges for the use of the Matrix model in a more rural

setting have been addressed and are resolved on an ongoing basis as needed.” CADS’ culturally competent treatment services also involve faith-based counseling and peer mentoring.

CADS’ CCTP staff implements three strategies to keep clients engaged in services and follow-up contacts for six months. First, with clients who have disengaged from the program before treatment completion, staff attempt to contact, via phone, letter, and/or residential visit, clients and existing collateral contacts in attempt to reengage clients. Second, Cultural Diversity clients are considered a priority population for Access to Recovery and other supplemental services. Utilizing such services aids client retention and assists in removing financial barriers that the Cultural Diversity Program is unable to directly alleviate. Third, all clients are staffed on at least a weekly basis to identify their needs early and determine the most appropriate interventions to use. Individualized treatment and interventions allow for staff to intervene in clients’ dysfunctional thought and behavior patterns, break the negative cycle, and begin creating a lifestyle of healthier decision making. Project staff has monthly contact with clients who remain engaged in continuing care services following successful completion of treatment. The agency does not maintain follow-up contact with clients discharged unsuccessfully.

#### Employee & Family Resources (EFR), Des Moines, Iowa

Harry Teel, Director, Substance Abuse Services

Additional project staff includes two Urban Dreams counselors, one of whom was hired for the project during the pilot period, one EFR assessment counselor/case manager, and the EFR Clinical Supervisor. EFR’s newest CCTP case manager and all Urban Dreams clinical staff working with Culturally Competent Substance Abuse Treatment Project clients are African American. EFR experienced a turnover in CCTP case managers the second half of this project year. The first case manager left the project in February, 2009 and was temporarily replaced by the Clinical Supervisor. In June, the position was filled with a staff person from Urban Dreams, who was in training under the Clinical Supervisor at the end of the reporting period. The counselor at Urban Dreams who was hired for this project earned his Certified Alcohol and Drug Counselor (CADC) credential from the Iowa Board of Certification in May 2009.

Employee and Family Resources’ goal for the project year is to serve seventy-five African American clients using Motivational Enhancement in case management and treatment services. For EFR’s best practice model, all project staff members incorporate the practices outlined in “Enhancing Motivation for Change in Substance Use Disorder Treatment” (SAMHSA Treatment Improvement Protocol # 35).

EFR endeavors to continue case management services with clients for six months after the completion of treatment. Urban Dreams and EFR CCTP staff ask clients for multiple phone numbers during initial contact, including (with signed consent) the phone number(s) of significant others that may be able to help the agencies retain contact with clients after discharge. Clients who do not attend continuing care sessions or return phone calls from the project counselors or case manager are discharged as unsuccessful after thirty days of no contact.

#### Jackson Recovery Centers (JRC), Sioux City, Iowa

Amy Bloch, Program Director, Outpatient Services

Additional clinical project staff includes two Spanish speaking counselors hired for this project during the pilot period, the Clinical Supervisor, and the Vice President/Chief Clinical Officer.

Both project counselors are Hispanic. No staffing changes have occurred in Jackson Recovery's program this project year.

Jackson Recovery Centers' goal for the project year is to serve one-hundred fifty Hispanic clients using the Matrix Model and the Community Reinforcement Approach. Jackson Recovery's Program Manager describes their best practice treatment model as follows: "The Matrix Institute on Addictions established The Matrix Model in 1984, an empirically supported chemical dependency treatment program which incorporates a set of clinical protocols that have been documented for their success by NIDA, CSAT and NIAAA. This model integrates treatment elements from a number of specific strategies including relapse prevention, Motivational Interviewing, psycho-education, family therapy, and twelve-step program involvement. The Matrix Model: Intensive Outpatient Alcohol and Drug Treatment is a curriculum developed by Hazelden that is based on the foundation of the Matrix research. This program has been continuously adapted and revised over the last two decades to give chemically dependent persons and their families' education, structure and support so they can achieve long-term recovery from alcohol/drug dependence. The structured program addresses core clinical areas within 5 different weekly treatment sessions: Early Recovery Skills group; Family Education group; Relapse Prevention group; Social Support group, and individual/conjoint therapy sessions.

"Patients who participate in the MATRIX program attend more clinical sessions, have longer lengths of stay, provide more drug-free urine samples during the treatment period, and have longer periods of abstinence than those who are assigned to receive treatment as usual."

"Reasons for selecting the MATRIX Model for the target population: In several research studies, the Hispanic population was specifically identified in their outcomes. In the initial study of Matrix clinics in Southern California comparing the Matrix Model to Treatment-As-Usual (TAU), the race/ethnicity representation was approximately 18% Hispanic. In follow-up evaluations of the Matrix model, 2 different studies document the effectiveness of this approach with Spanish-speaking individuals. In a study conducted with 23% of the population being Hispanic, there was a strong correlation between the amount of treatment received and the percent of negative urinalysis results for the Matrix subjects but not for the TAU clients. Similarly, Matrix clients showed significant improvement on the ASI employment and family scales. In another study, with Matrix clients representing 18% of the sample, Matrix clients showed significantly higher rates of retention and showed a completion rate of 40.9% compared to TAU clients who had a 34.2% completion rate.

"Jackson Recovery's experience with implementing MATRIX with the Hispanic population has been very favorable. We have implemented the MATRIX treatment program which runs group therapy 3 days per week with weekly individual therapy sessions. The feedback from patients has been very positive: they identify they like the curriculum/program and believe that they are learning a great deal of useful information and concepts. Staff members report that it is easy to facilitate and that they also learn from it. We continue to work with our staff on developing their therapy skills by providing them with clinical supervision and peer mentorship."

Jackson Recovery Centers offers continuing care services, consisting of weekly group sessions and monthly individual sessions, for three to six months following completion of primary treatment.

## *Case Coordination*

Grantee agencies referred clients to outside organizations this project year for additional treatment or ancillary services. Referral organizations and services were as follows:

### CADS

- Area Education Agency
- Community Health Care and other dental/medical providers
- Department of Transportation
- Edgerton Women's Health Clinic
- Education Services (Scott Community College and others)
- Employment Services (Blackhawk College, Workforce Development Center and temporary employment agencies)
- Faith-based organizations
- Family Resources Inc. Domestic Violence and Rape Sexual Assault Program
- Housing Assistance (Humility of Mary, Recovery Homes United, 723 Step House, Unity House)
- Income Maintenance
- Legal Aid
- Psychology Associates
- Salvation Army
- Social Security Administration
- Technology Now (employment counseling/skill development)
- Vera French Community Health Care

### EFR

- Transportation (Des Moines Area Rapid Transit bus passes and gas cards)
- Outpatient mental health evaluation (Eyerly-Ball)
- GED program (DMAACC)
- Job readiness services (Iowa Workforce Development)
- Alcoholics Anonymous and Narcotics Anonymous
- Smoking cessation (American Lung Association)
- Dietician consultation
- 

In addition, Urban Dreams provided the following ancillary services and referrals:

- Job readiness preparation, including resume writing
- Spiritual counseling
- Parenting education
- HERO (Habilitation and Empowerment for Returning Offenders)
- Job counseling and pre-employment job training
- Transportation for job search
- Ex-offender program

Urban Dreams and EFR are providing services under the Access to Recovery (ATR) project, which allows for clients to receive ancillary services that support their recovery efforts during and after formal substance abuse treatment.

### Jackson Recovery Centers

- Council on Sexual Assault and Domestic Violence
- Department of Human Services
- Public Defender's Office

- Siouxland Community Health Center for physical and psychiatric assessments, medication management
- Consultation with Jackson Recovery's gambling addiction therapist

### *Staff Training and Efforts to Increase Cultural Competency of Agency Staff Overall*

The Iowa Department of Public Health provided two statewide cultural competency trainings in June, 2009 with Culturally Competent Substance Abuse Treatment Project funds. One training session was held at Jackson Recovery Centers in Sioux City, for Jackson Recovery staff and selected professionals in the community. Eighty-seven people, eighty of whom were Jackson Recovery staff, attended that training. The other training was held in West Des Moines, and was open to helping professionals across the state. Eighty-seven people also attended this training. Both sessions were conducted by Dr. Tameka Taylor and Ruth Ramos of Compass Consulting Services, LLC.

In addition, project staff from all grantee agencies, the Consortium, and IDPH participated in a roundtable discussion/technical assistance session facilitated by Dr. Tameka Taylor and Ruth Ramos in June. Participants identified challenges, barriers, and strengths of the CCTP project, within each participating agency and in terms of processes involving the agencies, the Consortium, and IDPH. Data issues were a common theme among all participants. The facilitators assisted participants in outlining strategies to address data problems, overcome other identified barriers, and facilitate problem-solving and resource sharing across organizations. A copy of Compass Consulting's summary report of this session appears in Appendix B.

### CADS

CADS' Culturally Competent Treatment Project staff participated in the following trainings:

- ABCs of Hepatitis
- Annual Governor's Conference on Substance Abuse
- ASAM Training
- Criminal Thinking
- Cultural Competency
- Dependent Adult Abuse
- Depression, Suicidality, Crisis Calls
- Diversity in the Workplace
- Documentation
- Endangered Children
- Ethics
- Family Drug Court
- From Intake to Discharge: A Discussion on Effective Treatment Planning
- Insurance
- Insurance Calls
- Leadership Training for Supervisors
- Mandatory Child Abuse Training
- Methadone Treatment
- Motivational Interviewing
- National Center on Substance Abuse and Child Welfare
- Nurturing Families Training Program
- OWI/DUI
- Prescription and Over the Counter Drugs
- Sexual Harassment in the Workplace

- Spirituality in Perspective
- Statewide project staff meeting/consultation with Cultural Diversity trainers
- Understanding Child Welfare and the Dependency Court

CADS has implemented four main strategies to increase the cultural competency of the entire agency staff:

- Cultural competency related materials purchased via the CCTP grant were shared with staff
- Staff members discuss cultural issues at regular client review staffings
- Agency staff members participated in available training opportunities
- CCTP Program staff members work to create an atmosphere throughout the agency that reminds employees to be accepting towards and sensitive to cultural differences

One-hundred percent of CADS' staff received training in cultural competency/cultural diversity this project year.

#### EFR

EFR and Urban Dreams Culturally Competent Treatment Project staff participated in the following trainings this project year:

- Annual Governor's Conference on Substance Abuse
- Cultural Competency Training sponsored by the Iowa Department of Public Health
- Multicultural Counseling: Working With Diverse Populations, conducted by Dr. Derald Wing Sue
- The Ethics of Cultural Competence
- Statewide project staff meeting/consultation with Cultural Diversity trainers
- Undoing Racism

In addition to project staff attending the trainings mentioned above, EFR contracted with a consultant, Jonathan Lofgren, L-ADC, to provide technical assistance on increasing the effectiveness of their CCTP program. Resources and materials recommended as a result of this consultation will be used to increase the awareness of other EFR staff regarding African-American culture and substance abuse treatment.

EFR has an ongoing initiative regarding cultural diversity and inclusivity. Although not all activities that EFR staff participate in related to this initiative are formal trainings, all are intended to increase staff awareness of, sensitivity to, and ability to embrace diversity. Approximately eighty-eight percent of EFR's and six percent of Urban Dreams' staff received training in cultural competency/cultural diversity this project year.

#### Jackson Recovery Centers

Jackson Recovery's Culturally Competent Treatment Project staff participated in the following trainings this project year:

- Addiction and the Brain
- Advanced Motivational Interviewing
- Advanced Motivational Interviewing II
- Annual Governor's Conference on Substance Abuse
- Annual Summer School for Helping Professionals
- Child Sexual Abuse
- Clinical Approaches to Trauma & Addiction
- Diversity Training, hosted by Jackson Recovery Centers

- Drug-Endangered Children
- Enhancing Your Group Therapy Skills
- Ethics and Drug Endangered Children
- Local community workshop on Cultural Competency
- In-service trainings on clinical care and clinical documentation.
- Sex & Addiction
- Statewide project staff meeting/consultation with Cultural Diversity trainers
- Treating Mood Disorders

To increase the cultural competency of the agency staff, Jackson Recovery hosted a cultural diversity training workshop. Eighty Jackson Recovery staff participated in this workshop in June, 2009. Seventy-five percent of Jackson Recovery Centers' staff received training in cultural competency/cultural diversity this project year.

### *Progress Toward Project Goals*

#### CADS

One of CADS' goals for the project was to establish a faith-based referral system. CADS staff and community spiritual leaders solidified the outreach and referral process to connect interested clients to faith-based services this project year, and increased the number of linkages with faith-based community resources. CADS' Cultural Diversity staff offered a training for spiritual leaders that addressed entering treatment, the disease concept of chemical dependency, symptoms and phases of chemical dependency, and the importance of spirituality in treatment. Spiritual leaders from five different churches participated in the training: Christ the King Lutheran Church, Mount Sinai Christian Fellowship, Progressive Baptist Church, Rock of Ages Missionary Baptist Church, and Saint Mary's Catholic Church. Most clients interested in connecting with spiritual support in the community are referred to leaders in the churches that participated in the training. Program staff also maintains contact with the Native American Coalition and the Metropolitan Community Church of the Quad Cities for client spiritual support. CADS has also included spiritual leaders in treatment programming and events. Spiritual leaders celebrated recovery with clients and the public at CADS' Annual Alumni September Fest, where some attending spiritual leaders provided the opening prayer in English and Spanish. In addition, an elder from a local church shares his life story with clients each quarter and expressed willingness to be part of clients' spiritual path in recovery.

Another program goal was to find and implement a treatment curriculum that was available in English and Spanish languages. CADS selected a curriculum from New Freedom Programs called, "A New Freedom." The curriculum is a comprehensive workbook-based change program which addresses behavioral health issues, substance abuse, and other dependencies, and includes the evidence-based approaches of cognitive-behavioral therapy, motivational enhancement, social learning model, risk/protective factors management, asset/strength building, and develops key coping and problem-solving skills for positive social development and relapse prevention. Program staff is currently using the curriculum with clients on an individual basis and as a supplement to the Spanish Speaking Group's discussions and recovery assignments.

A third goal was to implement a relapse prevention group for CCTP clients. Project staff explored two possibilities: 1) starting a Cultural Diversity Relapse Prevention Group; and 2) incorporating more culturally relevant information into the existing Relapse Prevention Group until a sufficient number of CCTP clients is reached to form a separate group. After conducting an assessment of client needs, CADS decided to utilize current Relapse Prevention and

Relapse Prevention Training Groups. The Cultural Diversity Program shared culturally relevant information and materials with the group facilitators/therapists to utilize in the group process. Cultural Diversity Program peer mentors also assist in co-facilitating these groups. Also as a result of the needs assessment, one case manager reinstated the Spanish Speaking (therapy) Group in March. This group meets weekly in the evening to accommodate clients' day time work hours. The Cultural Diversity program also has begun to use cultural medallions as a recognition tool for clients' major achievements and progress.

A fourth goal for the project was to establish a peer mentoring program. During this project year, project staff continued efforts begun last year to identify, train, and connect peer mentors with clients. The Program Manager, with feedback from peer mentors and staff, updated and implemented a revised training support component for peer mentors. The Program Manager monitors the training and the program on an ongoing basis to ensure that the most appropriate and best services are provided. At the end of the reporting period, the program had three active peer mentors who serve as peer leaders in the group setting and as individual sober social supports outside the treatment setting. These mentors meet with the Program Manager for ongoing skills training and program planning as needed. Peer mentors have increased their involvement by offering mentoring services throughout all levels of care and to family groups in effort to create greater awareness of cultural influences and needs in recovery. Additional potential mentors are being identified on an ongoing basis.

The Program Manager also used input from program clients to create a "Cultural Diversity Satisfaction Form for Clients." This form provides CCTP clients an anonymous outlet for giving feedback directly to CADS about the program. The form will be available to clients on an ongoing basis, but staff will request clients fill out the form during intervals when surveys are not being requested by the Consortium. CADS has established a new goal for State Project Year 2010 (FY10) to allow clients to become more active participants in the change, development, and growth of the Cultural Diversity Program.

#### EFR

EFR's primary goal for the project is to provide culturally relevant substance abuse assessment and treatment to the African American population in their area. EFR and Urban Dreams have implemented strategies to reach the target population. Through their involvement with the African American community, Urban Dreams staff identifies clients who may benefit from project involvement and refers them to EFR for comprehensive substance abuse assessment. An EFR case manager spends one day each week at Urban Dreams to conduct placement screenings on-site, helping to accommodate clients' schedules and transportation limitations, and to facilitate communication with Urban Dreams staff regarding assessment results. The agencies have developed and implemented a client referral form and client information sheet for use with prospective clients to further facilitate communication regarding assessment results.

Significant progress was made this year in identifying strategies to provide the most appropriate substance abuse assessment, outpatient treatment, and case management services to African-American clients. Since the start of the project, CCTP staff has incorporated the practices outlined in "Enhancing Motivation for Change in Substance Use Disorder Treatment" (SAMHSA Treatment Improvement Protocol # 35) in their services to clients. However, staff identified a need for an expert consultant to provide technical assistance regarding ways to best serve the targeted population. EFR worked with IDPH to identify specific unmet project needs (e.g., service delivery model; best practice curriculum), and IDPH provided suggestions regarding expert consultants who could provide such technical assistance. In June 2009, Jonathan

Lofgren, L-ADC, conducted onsite observation, consultation, client interviews, and curriculum review, and provided recommendations regarding areas for program improvements. Recommended improvements addressed the areas of physical space, client engagement, and best practice curricula. At the end of the reporting period, EFR and Urban Dreams had begun developing plans to implement the recommended improvements, including purchasing curriculum materials and moving the treatment program into a larger, available building.

An additional goal for EFR and Urban Dreams was better identification of client wrap-around service needs and communication of such to the case manager. To accomplish this goal, staff developed a wrap-around service intake form that Urban Dreams uses with all CCTP clients and shares with EFR as soon as possible upon completion.

### Jackson Recovery Centers

Jackson Recovery's primary goal was to provide effective treatment services to Spanish-speaking clients. During this project year, Jackson Recovery conducted client focus groups at both program locations (Denison and Sioux City) to assess client satisfaction and identify unmet needs. Clients were asked about the assessment process, treatment, their therapist, staff's sensitivity to cultural issues, and clients' overall satisfaction with the program. Clients reported feeling respected by their therapists and shared they liked the MATRIX treatment program and found it educational. Some clients referred by other entities indicated that they did not completely understand why they were in treatment, which staff addressed with those clients. Facilitators indicated that the feedback was very positive overall. Feedback from the focus groups was shared with therapist to assist them in continuing to improve their skills and provide the most effective services.

### *Client Case Studies*

Full case study reports submitted by each agency appear in Appendix C.

### CADS

CADS submitted four case studies over the course of the year. One client was discharged shortly before treatment completion due to moving out of state, but reported having a positive experience in treatment and the Cultural Diversity Program. The second client also moved out of state and was discharged having successfully completed treatment. This client identified her Case Manager as someone she knew that she could contact if she needed guidance or help. The third client was discharged prior to treatment completion after indicating he/she was no longer interested in treatment services. The fourth client remained engaged in treatment at the end of the reporting period. The CCTP case manager was instrumental in connecting all clients with several needed services, and appeared instrumental in keeping three of the clients engaged in treatment.

### EFR

EFR/Urban Dreams submitted eight case studies over the course of the year. Several of those clients were homeless and jobless upon entry into treatment. Those clients all obtained gainful employment and housing with the assistance of CCTP project staff. Four clients were discharged successfully, having fully or substantially completed their treatment plans. One client was discharged unsuccessfully as he was required to serve jail time on previous charges, prior to completing treatment. One client remained in the program at the end of the reporting period. The other two clients maintained periodic contact with Urban Dreams, although the case studies did not indicate the discharge status of those clients.

### Jackson Recovery Centers

Jackson Recovery Centers submitted success stories for two clients, both of whom were successfully discharged. Both clients had lost custody of their children prior to entering treatment. At last contact, one client regained shared custody and the other had regained full visitation privileges as a result of addressing emotional, relationship, and legal issues while in the CCTP program.

### *Capacity Expansion Efforts*

#### CADS

CADS has taken several steps to expand the project's capacity to serve the target population. The three CCTP staff members were trained on Access to Recovery Services (ATR) through IDPH. This allows for the continuation of care to remain with the primary case manager, and the client is more readily informed of other available resources. CADS Cultural Diversity Program has built new partnerships with community agencies through the community partnerships and referral process of ATR.

CADS established a collaborative relationship with the Scott County Family Drug Court (FDC) team, which consists of a primary judge, substitute judge, several attorneys, Department of Human Services staff, Family Resources staff, and other community partners. CADS educated the FDC team on the services of the Cultural Diversity Program and the team has begun incorporating the Cultural Diversity Program into FDC case planning. FDC team members have also extended willingness to help clients with recovery; for example, taking clients to church with them.

The program manager exchanged information, including pamphlets for interested customers, with the Healing Heart Center. This Center provides an array of clinical and holistic services. The Healing Heart Center Director expressed willingness to provide pro-bono services to Cultural Diversity Program clients who may not otherwise be able to afford such services. The program manager corresponded and/or met with managers and/or directors of three local housing facilities frequently used by clients: Humility of Mary, offering housing to women and children; Recovery Homes United, providing  $\frac{3}{4}$  houses for females or males; and Unity House, providing  $\frac{3}{4}$  house for males. The program manager shared information about the Cultural Diversity Program and care coordination services with those individuals so that the organizations can work most effectively and efficiently together to provide services to shared clients. The program manager also made contact with the BeeGlobal Club of Saint Ambrose University, which works to promote diversity and unity on campus and beyond. The CCTP has advertised and shared with clients and their families a variety of family friendly, sober activities BeeGlobal hosts, such as the Diversity Fest. Cultural Diversity Program staff is seeking opportunities through this collaboration to increase awareness of the CCTP among educational departments and students preparing for the workforce, particularly in the Criminal Justice and Social Services fields.

Cultural Diversity Program staff also assisted clients in addressing/removing stressful barriers associated with holidays and with the economic downturn. Staff connected clients with such programs as Toys for Tots drives, Holiday basket giveaways, holiday support group meetings, food programs, and employment fairs, particularly those for individuals with a criminal background.

### EFR

EFR reported no capacity expansion efforts this project year, indicating that the number of clients participating in the program each quarter was ahead of pace for the target goal of 75 clients.

### Jackson Recovery Centers

Project staff meets with the local provider group on a monthly basis to provide information about the CCTP program as well as identify additional resources in the community for clients in this program. Jackson Recovery's Sioux City based CCTP therapist also collaborated with a bilingual mental health therapist from another agency to examine the "Love & Logic" parenting program. At the end of the reporting period, Jackson Recovery was planning to have the CCTP therapist become trained to utilize this program with CCTP patients and Hispanic family members at Jackson Recovery.

### *Financial Status*

CADS and EFR indicated no changes in or concerns about their financial status this year that may affect implementation of the grant. Jackson Recovery reported concerns about patients who enter the program but drop out and are re-admitted later: Jackson Recovery provides treatment for these individuals but is unable to bill the project for them, creating a financial burden on the agency.

### *Changes in Local Conditions*

During the first quarter, a homeless shelter and transitional housing complex in CADS' catchment area announced that they were closing due to financial reasons, which would significantly affect program clients. However, that shelter was taken over by another local organization and another shelter from a different organization opened in January of 2009, providing additional housing services for project clients.

EFR and Jackson Recovery Centers indicated no changes in local conditions during this year that may affect project success.

### *Dissemination of Project Information*

#### CADS

CADS Cultural Diversity staff shared information about the program (verbal discussion, brochures, and pamphlets) with numerous individuals at a CADS booth at the annual Take Back the Night event. This event was sponsored by local domestic violence counseling and advocacy programs. The Cultural Diversity Program also was represented at the Annual CADS Alumni September Fest, which is open to the public. Program clients, mentors, staff, and their family members assisted in food planning and preparation for the Fest, and various ethnic foods were prepared and served.

CADS CCTP staff shared program information with clients and staff at the Family Resources Domestic Violence Shelter, and Humility of Mary housing program. Information was shared with staff from Psychology Associates and Technology Now. Information is shared on an ongoing basis with collateral and wraparound agencies mentioned in the "Case Coordination" section

above. CADS has also developed plans to disseminate information via new venues beginning in the first quarter of State Project Year 2010, including the 4<sup>th</sup> of July parade, Junior Bix Race, Family Fun Day parade and booth at the Martin Luther King Center, September Fest, and through the radio station KALA.

CADS also reported that information also is disseminated informally by mentors, clients, and staff, as evidenced by an increased amount of individuals and community agencies contacting the CADS Program Manager to learn more about the Cultural Diversity Program.

#### EFR

EFR and Urban Dreams post project information their respective websites: [www.efr.org](http://www.efr.org) and [www.urbandreams.org](http://www.urbandreams.org). No additional program information was disseminated directly this year.

#### Jackson Recovery Centers

Jackson Recovery advertises the CCTP program in local Spanish newspapers in order to inform the community about CCTP services. Jackson Recovery also produced a TV commercial in June that will begin running in August, 2009. The commercial targets Spanish-speaking families who may not otherwise hear of the services. The agency submitted program information, written in Spanish, to the local 'Parents Guide' that goes out to all school-age children in Sioux City. The agency sent out brochures to approximately a dozen community providers who serve Spanish-speaking individuals, and produced a new brochure targeting physicians and attorneys.

Project staff met with a local Catholic church and provided program marketing materials for them to distribute to the congregation. CCTP staff members also have been asked to speak in services at several churches, which will expand the program's outreach.

Finally, the CCTP therapist in Woodbury County was asked to serve on a community board that works with providers on outreach to the Hispanic community. Jackson Recovery anticipates this will help increase community awareness of the CCTP program and services.

#### *Challenges and Strategies*

#### CADS

One of the challenges CADS' Cultural Diversity Program encountered was the transition to a new program manager at the beginning of the project year. To ensure that the connections built with clients and with community agencies were not lost in the transition, the former program manager assisted the current program manager with the initial transition process and remained available for a few months for any questions pertaining to program development. The current program manager also introduced herself to clients in the program individually and to the Cultural Diversity treatment group. In addition, the current program manager made contact with most outside referral sources and ancillary service agencies to inform them of the change and to maintain positive working relationships.

During the holidays, project staff addressed the challenge of client vulnerability due to holiday stress. Clients expressed a wide range of concerns ranging from grief/loss issues to financial stressors of gift buying. Program staff responded several different ways including, but not limited to: discussing these issues in individual and group settings, providing transportation to referral sources and holiday programs, and providing information on sober community events.

Another challenge faced was clients having difficulty gaining and/or maintaining employment. Many clients have been laid off, forced to take reduced hours, or been unable to secure stable employment. The CCTP staff has assisted clients in a variety of efforts toward gaining and maintaining employment. This has included skill-building in the areas of presentation, interview preparation and training, basic math, resume writing and application completion, coping with difficult people and situations, basic computer training, and appropriate attire. This has also included identification of and transportation to job fairs, hiring employers, and temporary employment agencies. CADS has identified a need to have stronger employer-based connections to assist clients in finding reliable employment, and has established a Project Year 2010 goal for the Cultural Diversity Program to expand community contacts of potential employers.

CADS also saw an increase within the program in the number of clients with untreated mental health concerns. The staff referred clients to a mental health care professional that provides contract services at CADS' Country Oaks facility.

#### EFR

One significant challenge the project encountered was remaining in communication with clients following initial assessment as they transitioned to treatment and case management services. Staff frequently found that phone numbers clients initially provided had been disconnected. Staff implemented a strategy of asking clients for multiple contact numbers and contact information for supportive family members and friends (if applicable). However, staff continued to find that many clients were not reached during the weekly case management calls. A second strategy was then implemented: Urban Dreams now asks clients to provide updated phone information each week during group, and this updated information is shared with EFR project staff.

A second significant challenge encountered was inefficient data management and administrative reporting procedures between EFR and Urban Dreams. Project staff at EFR, Urban Dreams, IDPH, and the Consortium held a conference call to clarify data management expectations and deadlines. Project Director Harry Teel provided direct supervision of I-SMART data entry by Urban Dreams staff in December, 2008. Iowa Department of Public Health data management staff also provided technical assistance to identify the source of data errors and correct erroneous procedures.

Third, staffing changes necessitated a temporary reassignment of initial assessment and case management responsibilities to other EFR staff, which decreased the number of potential CCTP clients assessed at Urban Dreams by EFR staff. EFR anticipates that the addition of the new case manager to the project will eliminate this problem during FY10.

#### Jackson Recovery Centers

Jackson Recovery's primary challenge this year was to reach an increased number of the target population in their catchment areas. Staff implemented strategies to increase client retention in the Denison office, which the staff indicated were showing some efficacy. The CCTP program recruited the agency's marketing director to assist in more effective dissemination of project information to the Hispanic community. A multi-faceted marketing/outreach plan was created and implemented during the fourth quarter (see the 'Dissemination of Project Information' section above, and 'Program Marketing' below) that project staff anticipates will draw in more clients and increase community awareness of the program.

## *Program Marketing*

### CADS

The Cultural Diversity Program (“Program”) currently uses a tri-fold brochure as a marketing tool, which covers information about CADS and its mission, Cultural Diversity Program staff, benefits of the program corresponding to chemical dependency and to what research indicates benefits the target population, the purpose of the program, and services offered by the Program.

Proposed items for inclusion in the complete marketing package still under development include information pertaining to English/Spanish curriculum and to the training curriculum for mentors.

### EFR

EFR’s marketing package currently includes a single page project information sheet for the general public, community agencies, and service providers, and a one-third page flyer targeting potential African American clients. The project information sheet covers community outreach, collaborating agencies, services provided, and benefits of the program to African American clients.

### Jackson Recovery Centers

Jackson Recovery’s marketing package currently includes a brochure in Spanish and English, advertising in the area Spanish newspaper and on the Spanish radio station, and letters/mailings to local physicians and attorneys about the program. Jackson Recovery also (as mentioned above) produced a TV commercial in June 2009 that will begin running in August 2009, targeting Spanish-speaking families.

Copies of each agency’s marketing materials appear in Appendix D.

## *Technical Assistance Needs*

### CADS

CADS and Jackson Recovery Centers reported no technical assistance needs this project year.

### EFR

As noted above, EFR requested technical assistance this year in finding an expert consultant to provide project guidance on improving the treatment program. Through suggestions provided by IDPH, EFR hired Jonathan Lofgren, L-ADC, who performed the requested assessment and provided recommendations on implementing a more structured, robust treatment curriculum.

## *Sustainability*

### CADS

CADS has established communication with individual and organizational networks at the grassroots level to advance strategies for ongoing support for the programs and services. CADS is reviewing local, state, and federal funding streams which may assist the CCTP.

### EFR

EFR reported that while they are licensed as an assessment and referral provider and are unable to apply for treatment-specific funding beyond this grant, they support and encourage Urban Dreams in their efforts to sustain the program beyond CCTP funding.

### Jackson Recovery Centers

Jackson is committed to serving Hispanic patients and their families. After the CCTP grant period ends, Jackson Recovery anticipates continuing the program with some modifications. For instance, the agency would need to charge patients for their treatment services based on their standard sliding fee scale, and would have CCTP staff also treat English-speaking clients.

### *Additional Information*

### CADS

CADS program staff reported a re-engagement of Cultural Diversity clients who had been discharged unsuccessfully, frequently due to leaving against clinical advice. Upon return, many of those clients expressed a desire to re-engage in the Cultural Diversity Program. The Cultural Diversity Program expressed appreciation for the additional funding for materials and technical assistance that will assist them with their endeavors to reach more African American and Hispanic clients in the upcoming year.

### EFR

Based on Jonathan Lofgren's recommendations and made possible by IDPH funding, EFR purchased curriculum materials in June 2009 including cognitive-behavioral treatment manuals, client workbooks, and DVDs and provided copies to Urban Dreams for use with CCTP clients. Many of these materials are specific to African-American clients, and others focus on increasing overall professional knowledge and competence regarding working with clients who have a history of PTSD or other co-occurring disorders. EFR expressed appreciation for the opportunity to provide services to African-American clients through the Culturally Competent Treatment Project, and look forward to continued project success during FY10.

### Jackson Recovery Centers

Jackson Recovery reported that they are in the process of developing a culturally sound 'Cultural Assessment' for clients that would be used to assist the primary therapist in identifying cultural barriers or areas to address in treatment.

## **Outcomes Evaluation**

### *Clients Served*

This section includes data only on clients served during Project Year 2009 (July 1, 2008 through June 30, 2009).

### Screenings and Admissions

Three-hundred sixteen clients received placement screenings through Culturally Competent Treatment Project funds in Project Year 2009. One-hundred eighty-four clients were admitted to treatment. Table 1 presents Culturally Competent Treatment Project (CCTP) placement screening and admission totals by agency, based on records agencies submitted to IDPH via I-SMART/SARS. These figures differ from figures reported by agencies in their quarterly and annual reports. "New Clients Admitted to CCTP Treatment" includes only clients who were not previously admitted to CCTP. In the event that a client was admitted more than once during the reporting period, only the first admission is counted.

**Table 1. Client Screenings and Admissions: July 1, 2008–June 30, 2009**

	CADS	EFR/UD	JRC	TOTAL
CCTP Placement Screenings	0 <sup>1</sup>	225 <sup>2</sup>	91	316
New Clients Admitted to CCTP Treatment	60	63	61	184
Annual Target for Admissions	40	75	150	265

<sup>1</sup>CADS does not bill placement screenings to the Culturally Competent Treatment Project.

<sup>2</sup>EFR submitted one-hundred thirty-six placement screening records and Urban Dreams submitted eighty-nine.

#### Additional Clients Served

Agencies also provide Culturally Competent Treatment Project services to some clients who are not counted as CCTP clients (i.e., clients whose treatment is paid by another source). One-hundred sixty non-CCTP clients also received CCTP services this year. Table 2 presents the number of these additional clients involved in CCTP services at each agency.

**Table 2. Non-CCTP Clients Involved in Culturally Competent Treatment Program Services**

	CADS	EFR/UD	JRC	TOTAL
Non-CCTP Clients Involved in CCTP Services	35	119	6	160

#### Client Demographics

Demographic data are based on the one-hundred eighty-four admission records found in I-SMART/SARS for the timeframe of July 1, 2008 through June 30, 2009. Fifty-nine percent (58.70%) of clients were African American, forty percent (39.67%) were Hispanic or Latino, and two percent (1.63%) were another race/ethnicity. Eighty-two percent (82.07%) of clients were male and eighteen percent (17.93%) were female. The median age of clients admitted to the project was thirty-four (34.0 years). The youngest was eighteen; the oldest, seventy-three.

#### Client Discharges

Two-hundred two Culturally Competent Treatment Project (CCTP) clients were discharged from treatment this year. One-hundred two of these had been admitted during this project year. Fifty-eight percent of clients admitted and discharged this project year successfully completed treatment. Table 3 on page 20 presents Culturally Competent Treatment Project (CCTP) client discharge numbers and discharge status information by agency for all clients discharged this project year and for clients admitted and discharged within this project year.

**Table 3. Numbers of Clients Discharged and Discharge Status – Total Discharges in Project Year 2009 and Discharges for Clients Admitted in Project Year 2009**

	CADS		EFR		JRC		TOTALS	
	Total	Admitted FY2009	Total	Admitted FY2009	Total	Admitted FY2009	Total	Admitted FY2009
Number of Clients with Successful Discharge	41	28	50	17	32	14	<b>123</b>	<b>59</b>
Number of Clients Discharged Prior to Treatment Completion	21	17	42	13	16	13	<b>79</b>	<b>43</b>
Total Number of Clients Discharged	62	45	92	30	48	27	<b>202</b>	<b>102</b>

#### Duration of CCTP Services for Clients in Current Project Year

Data presented in this section are based on the one-hundred two clients admitted to the Culturally Competent Treatment Project this project year (on or after July 1, 2008) for whom there was a corresponding discharge record found in I-SMART/SARS. A different starting point for each agency was used for this analysis, due to differences in the point at which the agencies begin providing CCTP services to clients. CADS clients are admitted by staff decision into their Cultural Diversity Program after they are admitted to treatment. For CADS clients, the date the client was admitted to the Cultural Diversity Program was used as the start date. For Jackson Recovery, the admission to treatment date was used, as clients begin CCTP programming upon admission to treatment. For EFR/Urban Dreams, the placement screening date for clients admitted to CCTP treatment at Urban Dreams was used, as CCTP case management services begin at the time of the placement screening/referral to CCTP treatment. The date of discharge from treatment was used for all agencies as the end-of-service date. The median length of CCTP services for clients successfully completing treatment this project year was eighty-nine (88.5) days. The median length of CCTP services for clients discharged before completing treatment was fifty-four (54.0) days. More comprehensive treatment length of stay and survival analysis results (including clients admitted during the pilot project year and clients remaining in treatment on June 30, 2009) are presented in the "Survival Analysis" section beginning on page 24.

#### *Cultural Competency and Comparison Group Outcomes*

This section includes data on a sample of clients served through the Culturally Competent Treatment Project to-date, November 1, 2007 through June 30, 2009.

Evaluators conducted an analysis comparing outcomes for Culturally Competent Treatment Project clients (Cultural Competency group) to outcomes for minority clients in other treatment agencies in Iowa (Comparison group). For the Cultural Competency group, Evaluators selected CCTP clients who had both admission and discharge data submitted to the state. Clients were also eligible to be included without discharge data if they remained in treatment on June 30, 2009, reported their race as African American/Black, or their ethnicity as Hispanic. Clients who indicated their race as African American/Black, regardless of ethnicity, were regarded as African

American/Black. Clients who indicated any other race and listed their ethnicity as any Hispanic or Latino group were regarded as Hispanic/Latino. There were too few clients (n = 5) in the other race/ethnic groupings to reliably analyze. If clients were admitted more than once into the program, only one of their admissions was randomly included. This resulted in 279 clients for analysis in the Cultural Competency group. (Note: This includes clients from both the pilot and 2009 project years, whereas the client figures in Table 1 include only clients in the 2009 project year.)

A comparison group of minority clients who were not involved with the Culturally Competent Treatment Project was drawn from the state's SARS and I-SMART systems. To improve comparability, evaluators selected those minority clients (Black or Hispanic) with an admission date between the earliest (December 18, 2006) and latest (June 23, 2009) dates found for the CCTP clients. The Comparison group was also restricted to represent the age range of Cultural Competency group clients, eighteen to sixty-three years of age. Clients admitted for detoxification services only were excluded. Methadone clients also were excluded from both groups because of their usually atypical (extremely long) lengths of stay. When clients had multiple admissions during the period, one admission was randomly selected. These criteria produced 4497 comparison client admissions. For every admission record, the relevant databases were searched for a corresponding discharge record.

#### Demographic and Clinical Composition

The evaluators performed analyses to compare the Cultural Competency group clients to the Comparison group on basic demographics and clinical variables. Comparisons are shown in Table 4. The ratio of African Americans to Hispanics in CCTP clients was not different from the ratio in the rest of the state during this time period. The clients were also similar in age. The two groups differed in the percentage of males and females, with relatively fewer females among the Cultural Competency group when compared to minority clients statewide.

**Table 4: Basic Demographic and Clinical Composition of the Comparison and Cultural Competency Groups**

	Comparison Group (n = 4,497)	Cultural Competency Group (n = 279)
<b>Mean Age at Admission (years)</b>	<b>32.7</b> (sd = 10.4)	<b>33.9</b> (sd = 10.5)
<b>Race/Ethnicity %</b>		
African American	64.1	60.2
Hispanic	35.9	39.8
<b>Sex %<sup>1</sup></b>		
Male	76.2	84.2
Female	23.8	15.8
<b>Primary Substance, Admission %<sup>2</sup></b>		
None	< 0.1	2.2
Alcohol	49.1	50.5
Cocaine/Crack	13.9	19.9
Marijuana	30.8	25.6
Other/Miscellaneous	6.3	1.8
<b>Referral Source %<sup>3</sup></b>		
Self	9.2	14.3
Health Care Provider	4.3	3.9
SA Provider	7.8	1.8
Other Individual	3.8	1.4
OWI	16.9	15.4
Criminal Justice	33.6	31.2
Civil Commitment	1.1	1.8
Other Community	2.3	25.5
Miscellaneous	20.8	4.7

<sup>1</sup>  $p < 0.003$ ,  $\chi^2 = 9.455$ ,  $df = 1$ .

<sup>2</sup>  $p < 0.0001$ ,  $\chi^2 = 86.739$ ,  $df = 4$ .

<sup>3</sup>  $p < 0.0001$ ,  $\chi^2 = 441.461$ ,  $df = 8$ .

There were statistically significant differences between the groups in the primary substance reported. Many types of primary substance at admission appeared too infrequently in the Cultural Competency group to allow for a statistical comparison (e.g., heroin, opiates and synthetics, PCP, hallucinogens, methamphetamine or other stimulants, barbiturates). These substances were collapsed into the Other/Miscellaneous group. Alcohol was the most frequently cited substance, with both groups reporting alcohol as the primary substance approximately fifty percent of the time. Cocaine/Crack was more frequently reported in the Cultural Competency group than in the Comparison group. Clients in the Cultural Competency group reported Marijuana less frequently than clients in the Comparison group.

Referral source percentages also differed between Cultural Competency and Comparison groups. The referral "Other Community" was much more frequently noted in the Cultural Competency group than in the statewide Comparison group. Referral sources in the miscellaneous category (e.g., community mental health, school, employer/EAP) were

consistently more frequent in the statewide Comparison group than in the Cultural Competency group.

#### Discharge Status

Of the two-hundred seventy-nine Culturally Competent Treatment Project clients in this analysis group, over one third were still in treatment as of June 30, 2009. In the Comparison group, less than twenty percent were still in treatment. Discharge status was collapsed into three categories. A discharge was considered "Successful" when discharge status was coded as Completed Treatment - Treatment Plan Completed or Completed Treatment - Treatment Plan Substantially Completed. A discharge was coded "Unsuccessful" when discharge status was coded as Program Decision Due to Lack of Progress/Compliance or Client Left before completing treatment. A "Neutral" category was created that consisted of the codes: Referred Outside, Incarceration, Death, Other, and Managed Care Decision. Table 5 presents discharge status of the Comparison group and Cultural Competency group clients. The first category, "All Clients," includes clients who were discharged and clients who were still in treatment as of June 30, 2009. The second category, "Discharged Clients," includes only clients who have completed treatment.

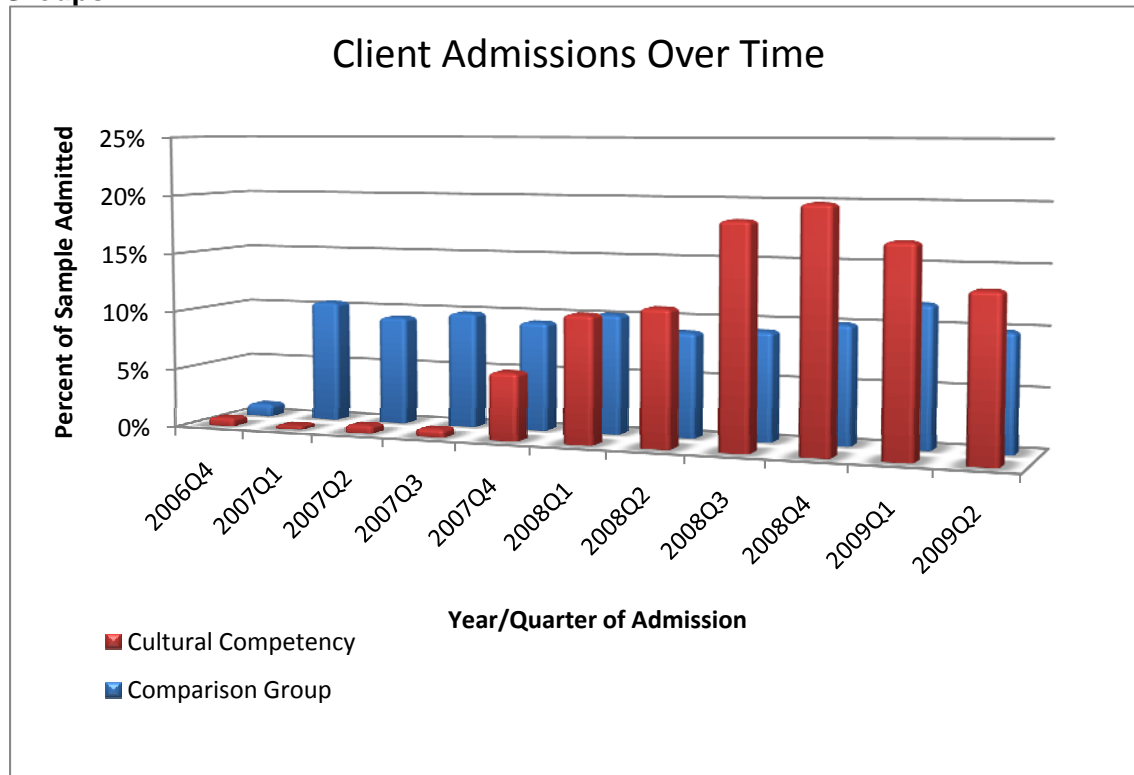
**Table 5: Client Discharges - Comparison and Cultural Competency Groups**

<b>Discharge Status</b>	<b>Comparison Group</b>	<b>Cultural Competency Group</b>
<b>All Clients<sup>1</sup></b>	(n = 4,497)	(n = 279)
Successful	46.0%	39.8%
Neutral	7.3%	7.5%
Unsuccessful	27.7%	18.3%
Still in Treatment	19.0%	34.4%
<b>Discharged Clients</b>	(n = 3,643)	(n = 185)
Successful	56.8%	60.3%
Neutral	9.0%	11.4%
Unsuccessful	34.2%	28.3%

<sup>1</sup>  $p < 0.0001$ ,  $\chi^2 = 42.26$ ,  $df = 3$ .

The Cultural Competency group had significantly more clients still in treatment when compared to the statewide Comparison group. When considering only discharged clients (removing clients still in treatment), there was no significant difference between the two groups. Successful completions occurred at approximately the same frequency for discharged clients. However, it is possible that a later follow up of these data may indicate more successful completions among the Cultural Competency group, as the programs have become more established. To complicate matters, there are significant differences in the pattern of admission dates, as shown in Figure 1. The Cultural Competency group has many more admissions later in the analysis time window ( $p < 0.0001$ , Mann-Whitney  $t = 10.00$ ,  $df = 4774$ ) whereas the Comparison group admissions appear more evenly distributed over the entire time period. This is likely due to lower admissions in the beginning of the Culturally Competent Treatment Project.

**Figure 1: Admission Patterns for Clients in the Cultural Competency and Comparison Groups**



### Survival Analysis

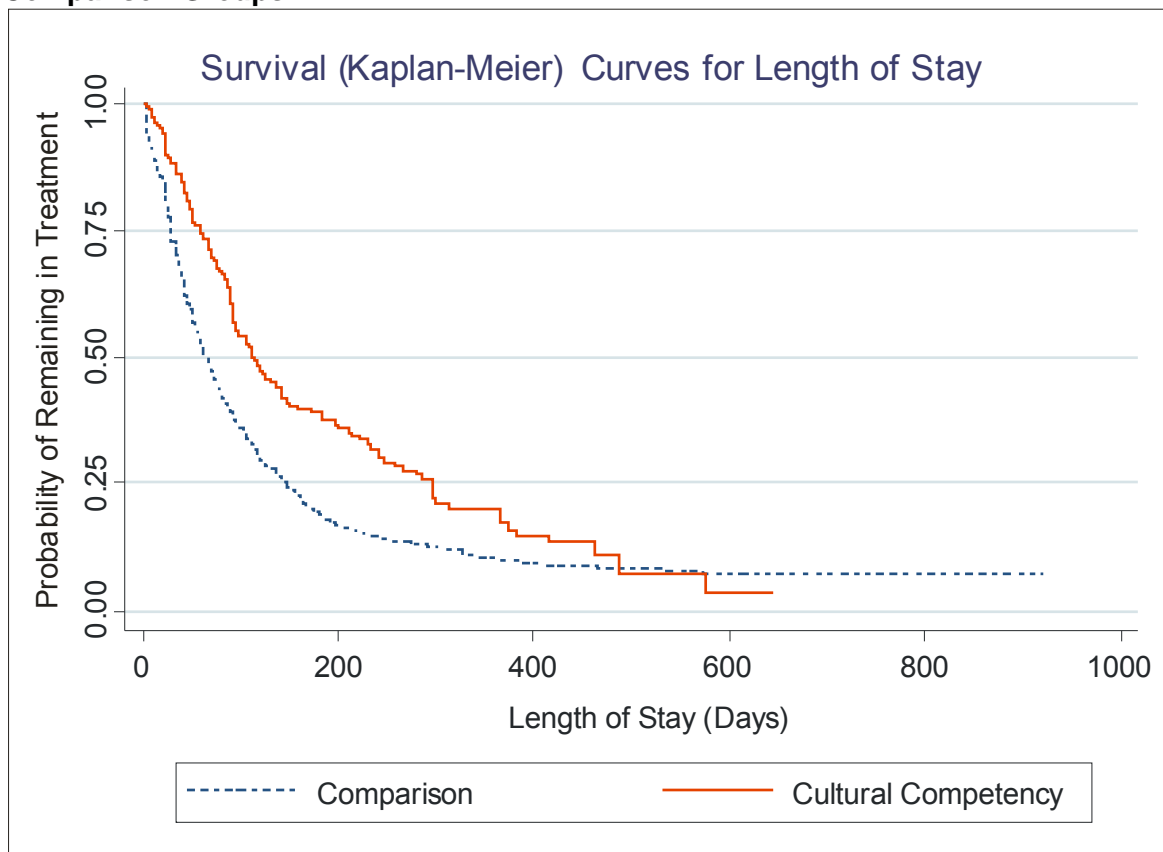
Several analyses are presented regarding length of time in treatment. These analyses use survival methods to account for the fact that some clients have not yet completed treatment, thus, clients who were discharged and clients who remained in treatment on June 30, 2009 are included in the analyses. The survival analysis also considers that the two groups are not equivalent in admission patterns. For most of the analyses, methods used make the least statistical assumptions and most conservative assessments (e.g., the log-rank test).

Clients in the Cultural Competency group stayed in treatment significantly longer than those in the statewide Comparison group. The median length of stay for clients in the Cultural Competency group was one-hundred twelve days (95% confidence interval: 96 – 139 days) while the median length of stay for clients in the Comparison group was sixty-four (95% confidence interval: 61 – 67 days). The survivor (i.e., staying in treatment) curves from the analysis are shown in Figure 2.

In Figure 2, the solid red line represents the proportion of the 279 Cultural Competency clients ending treatment over time. The dotted blue line represents the same information for the 4497 Comparison clients. The more jagged appearance of the Cultural Competency curve is a result of the much smaller number of clients in this group. The sharp drop at the end (around five-hundred days in treatment) is likely due to the duration that this program has been offered. The curve for the Cultural Competency group clearly indicates longer lengths of stay (the solid red line is offset to the right of the dotted line) with an immediately obvious effect early in the

program which becomes even more pronounced up until about one year (365 days) of treatment, where the advantage begins to taper off.

**Figure 2: Length of Stay Survival Curves for Clients in the Cultural Competency and Comparison Groups**



Note: Log-rank test = 42.98, df = 1,  $p < 0.0001$ .

To verify that this significant increase in length of stay was consistent for all clients regardless of discharge status, the survival analysis was repeated for those clients who had successful, neutral, and unsuccessful discharges from treatment. The median days in treatment are shown in Table 6 on page 25. All discharge categories showed a significantly increased length of stay for the Cultural Competency group.

**Table 6. Median Days in Treatment for Clients in the Comparison and Cultural Competency Groups by Discharge Status**

Days in Treatment	Comparison Group	Cultural Competency Group
<b>Discharge Status (Median)</b>		
Successful <sup>1</sup>	65.5 days	92 days
Neutral <sup>2</sup>	30 days	73 days
Unsuccessful <sup>3</sup>	29 days	46 days

<sup>1</sup>Log-rank test = 10.34, df = 1, p < 0.002.

<sup>2</sup>Log-rank test = 4.07, df = 1, p < 0.05.

<sup>3</sup>Log-rank test = 5.15, df = 1, p < 0.03.

The Cultural Competency and Comparison groups were similar in that of the three categories, successful discharges occurred the most often, and unsuccessful discharges the least. The fact that the unsuccessful clients in the Cultural Competency programs remained in treatment longer than the Comparison clients is particularly impressive. The Cultural Competency programs increased the "Unsuccessful" clients' treatment exposure (length of stay) by one-and-a-half times.

To verify that the significant increase in length of stay was consistent for the Cultural Competency programs in all three agencies, evaluators repeated the survival analyses three times. Each analysis contrasted clients from a CCTP agency to the statewide Comparison group. All three individual agency program analyses showed significant increases in length of stay. Furthermore, an additional analysis compared the three agencies among themselves. The agencies did not differ from each other in length of stay. The increased length of stay of Cultural Competency group appears to be consistent across agencies and consistently longer than the Comparison group length of stay.

The Cultural Competency group differed from the statewide Comparison group on a few demographic and clinical variables. The previous analyses (Table 4) indicated that the Cultural Competency group diverged somewhat from the Comparison group in the percentage of males, primary substance of abuse, and referral source. To assure that these differences did not artificially produce the favorable increase in length of stay, evaluators used methods to statistically control for the possible confounders (Cox proportional hazards regression). While primary substance at admission and referral source did affect the length of stay, these variables did not moderate the differences between the Cultural Competency and Comparison groups. Clients in the Cultural Competency group stayed significantly longer in treatment than those in the Comparison group once the other effects were removed (Wald  $\chi^2 = 52.30$ , df = 1, p < 0.0001). Thus, demographic and clinical differences in the two groups did not explain the increased length of stay seen in the Cultural Competency programs.

## *Client Survey Results*

### Client Surveys Returned

Clients completed the Iowa Cultural Understanding Assessment during each quarter of the project year. The fourth quarter client survey was implemented from May 11<sup>th</sup> through May 25<sup>th</sup>, 2009. Agencies were instructed to provide surveys to all clients participating in CCTP programming, regardless of their length of time in treatment. Staff was instructed to inform clients that the survey is voluntary and that results will be kept confidential.

The three participating agencies returned a total of fifty-one client surveys to the Consortium for the May survey round. Table 7 presents the number of client surveys the Consortium received from each agency, the total number of CCTP clients in treatment at the start of the survey period, and the percentage of surveys returned. (For information on demographics and number of clients completing the other quarterly surveys, please see the Culturally Competent Substance Abuse Treatment Project FY09 Progress Reports for quarters 1 through 3.)

**Table 7. Number and Percentage of Client Surveys Returned**

	Participating Agency			
	CADS	EFR/Urban Dreams <sup>1</sup>	Jackson Recovery	TOTAL
Client Surveys Returned (Number Returned / Number of Clients in Treatment at Survey Point)	13 / 40	14 / 14	24 / 48	51 / 102
Percentage of Total	32.5%	100%	50.0%	50.0%

<sup>1</sup>EFR administers surveys to clients in the CCTP treatment program at Urban Dreams.

Because only half of the eligible clients in the CCTP project completed the survey, the results must be viewed with caution. Clients who did not complete the survey may have different views than those represented here.

### Client Survey Participant Demographics

Eighty percent (80.4%) of survey participants were male; twenty (19.6%) percent were female. Thirty-nine percent (39.2%) indicated they were African-American; sixty-one percent (60.8%) indicated they were Hispanic or Latino.

### Client Survey Results

Overall, survey results are positive, with at least eighty-two percent of respondents agreeing or strongly agreeing with all statements indicating cultural competency of the staff and agency. And, only three statements had fewer than eighty-six percent of respondents agree or strongly agree. Those statements were Item 7: "The waiting room and/or facility has pictures or reading material that show people from my racial or ethnic group" (82.4% agreed or strongly agreed); Item 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" (82.4% agreed or strongly agreed); and Item 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" (82.0% agreed or strongly agreed).

Four items had ninety-eight percent of respondents agree or strongly agree. Those were Item 4: "If I want, the staff will help me get services from clergy or spiritual leaders;" Item 13: "Staff here understand that people of my racial or ethnic group are *not* all alike;" Item 15: "The staff here talk to me about the treatment they will give me to help me;" and Item 20: "If I want, my family or friends are included in discussions about the help I need." Table 8 on pages 21 and 22 presents client survey responses from all agencies combined. The table follows the order of the client survey instrument, listing each question and response option in order and providing the percentage of participants who selected each response option.

Results of the October, 2008 client survey are also provided for comparison purposes. However, many different clients completed the May survey than completed the October survey. Therefore, survey results do not reflect change in individual client attitudes or perceptions over time; rather, the data reflect client perceptions of the CCTP program in October and client perceptions of the program in May.

**Table 8. Client Survey Results: Iowa Cultural Understanding Assessment** (continued on page 30)

Statement	Strongly Disagree		Disagree		Neither Agree Nor Disagree		Agree		Strongly Agree	
	October 2008	May 2009	October 2008	May 2009	October 2008	May 2009	October 2008	May 2009	October 2008	May 2009
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%	0.0%	1.1%	0.0%	6.7%	3.9%	45.6%	47.1%	44.4%	49.0%
2. Staff here understand the importance of my cultural beliefs in my treatment process.	3.3%	0.0%	2.2%	0.0%	6.5%	5.9%	42.4%	35.3%	45.7%	58.8%
3. The staff here listen to me and my family when we talk to them.	3.3%	0.0%	2.2%	0.0%	1.1%	2.0%	46.2%	45.1%	47.3%	52.9%
4. If I want, the staff will help me get services from clergy or spiritual leaders.	2.2%	0.0%	3.3%	0.0%	11.1%	6.0%	42.2%	50.0%	41.1%	44.0%
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.	2.2%	0.0%	4.4%	0.0%	6.6%	6.0%	37.4%	34.0%	49.5%	60.0%
6. The staff here seem to understand the experiences and problems I have in my past life.	2.2%	0.0%	2.2%	0.0%	5.5%	3.9%	40.7%	51.0%	49.5%	45.1%
7. The waiting room and/or facility has pictures or reading material that show people from my racial or ethnic group.	2.2%	2.0%	4.4%	3.9%	14.3%	11.8%	37.4%	45.1%	41.8%	37.3%
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%	2.2%	0.0%	8.8%	8.0%	40.7%	38.0%	45.1%	54.0%
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.	2.2%	0.0%	3.3%	2.0%	11.1%	6.0%	41.1%	46.0%	42.2%	46.0%
10. The staff here respect my religious or spiritual beliefs.	3.3%	0.0%	0.0%	0.0%	8.8%	4.0%	35.2%	36.0%	52.8%	60.0%
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.	3.3%	2.0%	1.1%	0.0%	23.3%	15.7%	43.3%	45.1%	28.9%	37.3%
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.	2.2%	0.0%	3.3%	2.0%	21.1%	16.0%	43.3%	44.0%	30.0%	38.0%

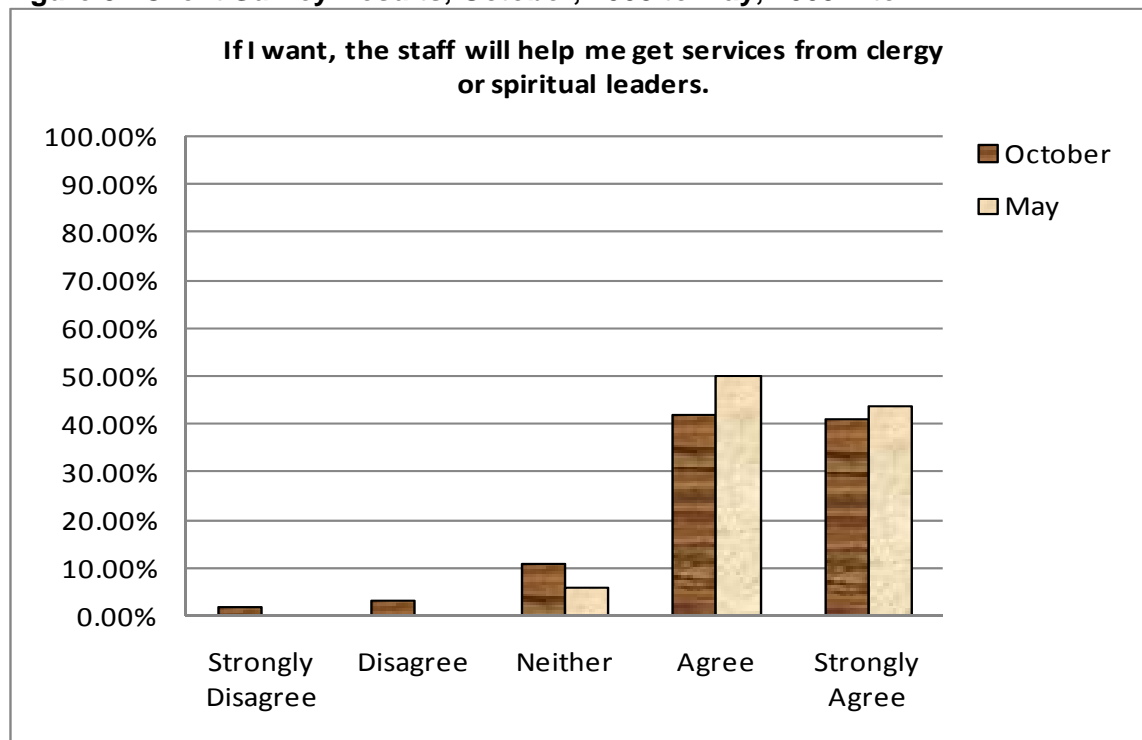
**Table 8. Client Survey Results: Iowa Cultural Understanding Assessment** (continued from page 29)

Statement	Strongly Disagree		Disagree		Neither Agree Nor Disagree		Agree		Strongly Agree	
	October 2008	May 2009	October 2008	May 2009	October 2008	May 2009	October 2008	May 2009	October 2008	May 2009
13. Staff here understand that people of my racial or ethnic group are <i>not</i> all alike.	2.2%	0.0%	6.7%	0.0%	8.9%	2.0%	46.7%	54.9%	35.6%	43.1%
14. It was easy to get information I needed about housing, food, clothing, child care, and other social services from this place.	2.2%	2.0%	4.4%	0.0%	15.6%	12.0%	43.3%	48.0%	34.4%	38.0%
15. The staff here talk to me about the treatment they will give me to help me.	2.2%	0.0%	2.2%	0.0%	2.2%	2.0%	41.1%	49.0%	52.2%	49.0%
16. The staff here treat me with respect.	3.3%	0.0%	0.0%	0.0%	1.1%	3.9%	36.7%	43.1%	58.9%	52.9%
17. The staff seem to understand that I might feel more comfortable working with someone who is the same sex as me.	3.3%	4.0%	2.2%	6.0%	19.8%	4.0%	42.9%	34.0%	31.9%	52.0%
18. Most of the time, I feel I can trust the staff here who work with me.	2.2%	0.0%	1.1%	2.0%	6.6%	3.9%	47.3%	49.0%	42.9%	45.1%
19. The waiting room has brochures or handouts that I can easily understand that tell me about services I can get here.	2.2%	0.0%	1.1%	0.0%	8.8%	13.7%	50.6%	49.0%	37.4%	37.3%
20. If I want, my family or friends are included in discussions about the help I need.	2.2%	0.0%	0.0%	0.0%	11.1%	2.0%	47.8%	58.8%	38.9%	39.2%
21. The services I get here deal with the problems that affect my day-to-day life such as family, work, money, relationships, etc.	4.4%	0.0%	1.1%	0.0%	1.1%	5.9%	50.6%	47.1%	42.9%	47.1%
22. Some of the staff here understand the difference between their culture and mine.	2.2%	0.0%	1.1%	2.0%	7.7%	3.9%	51.7%	49.0%	37.4%	45.1%
23. Some of the counselors are from my racial or ethnic group.	1.1%	0.0%	2.2%	0.0%	7.7%	6.0%	49.5%	48.0%	39.6%	46.0%
24. Staff are willing to be flexible and provide alternative approaches or services to meet my cultural/ethnic treatment needs.	2.2%	0.0%	1.1%	0.0%	8.8%	8.0%	45.1%	44.0%	42.9%	48.0%
25. If I need it, there are translators or interpreters easily available to assist me and/or my family.	2.2%	2.0%	1.1%	0.0%	14.3%	11.8%	39.6%	37.3%	42.9%	49.0%

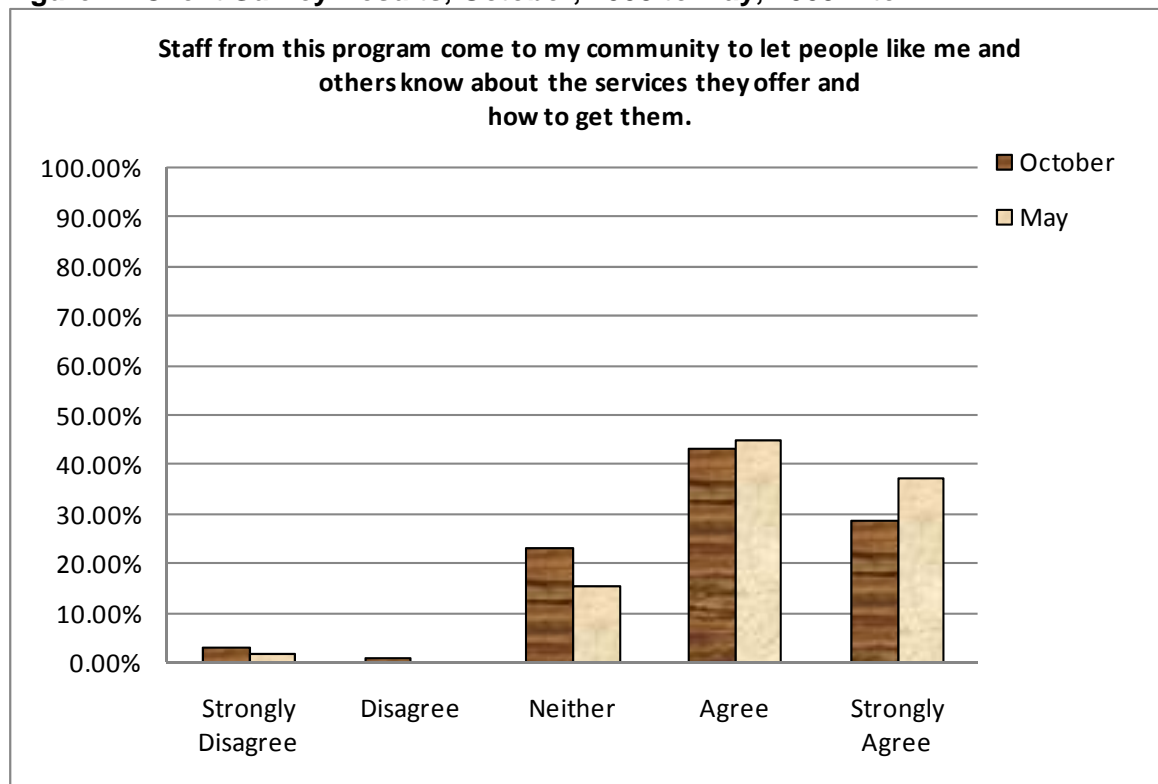
### October-to-May Client Survey Results Comparisons

Several items showed substantial improvement between October, 2008 and May, 2009. There were no notable decreases in client agreement with any statements. Five survey items showed an increase of ten percent or more: Item 4 (10.7% increase); Item 11 (10.2% increase); Item 13 (15.7% increase); Item 17 (11.2% increase); and Item 20 (11.3% increase). Figures 3 through 7 provide a visual display of the responses to those items, respectively, by survey period.

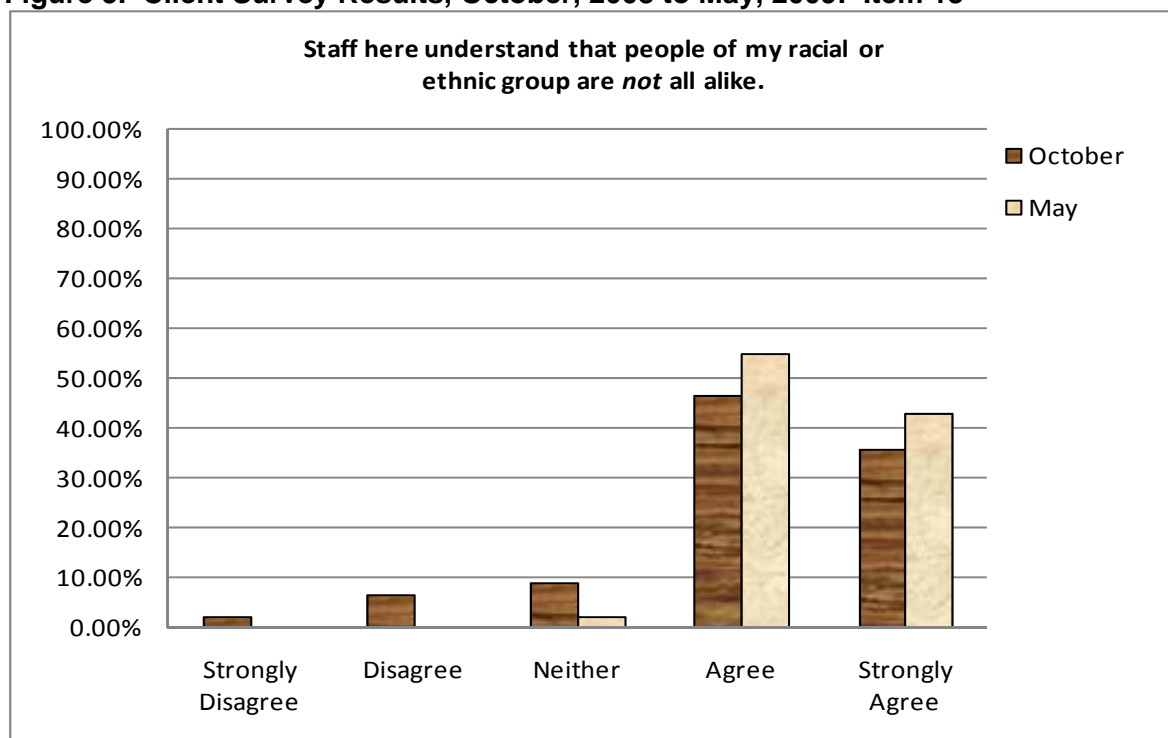
**Figure 3. Client Survey Results, October, 2008 to May, 2009: Item 4**



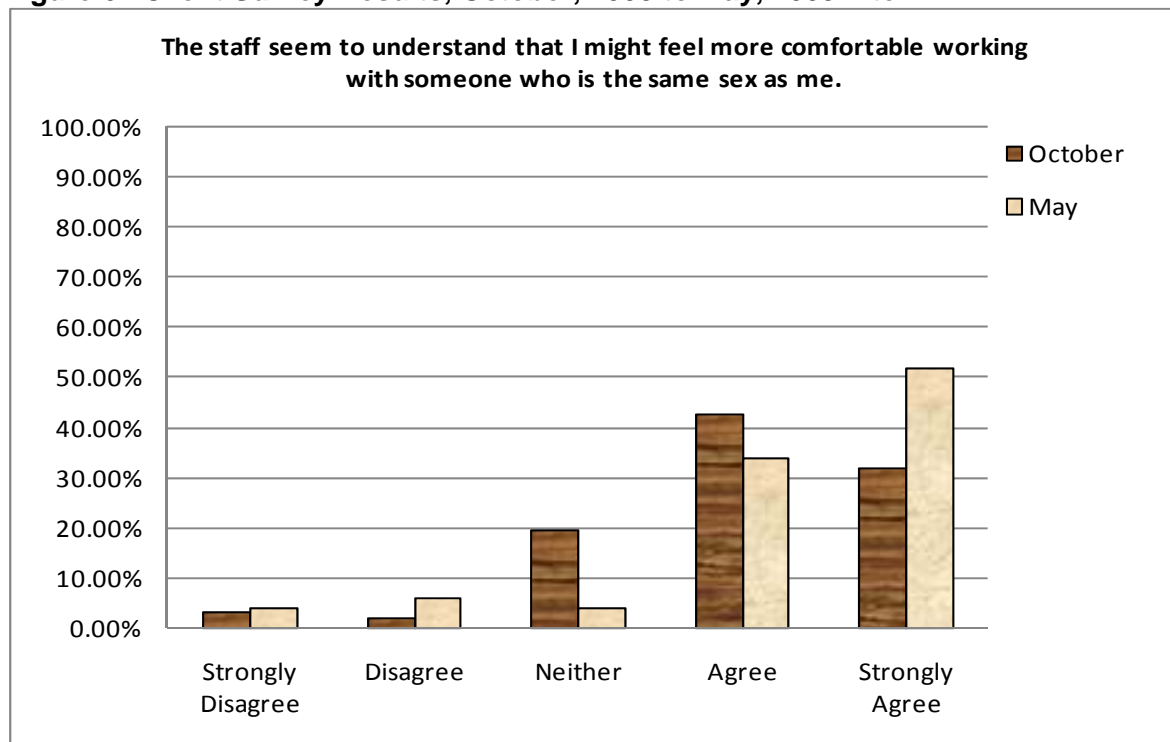
**Figure 4. Client Survey Results, October, 2008 to May, 2009: Item 11**



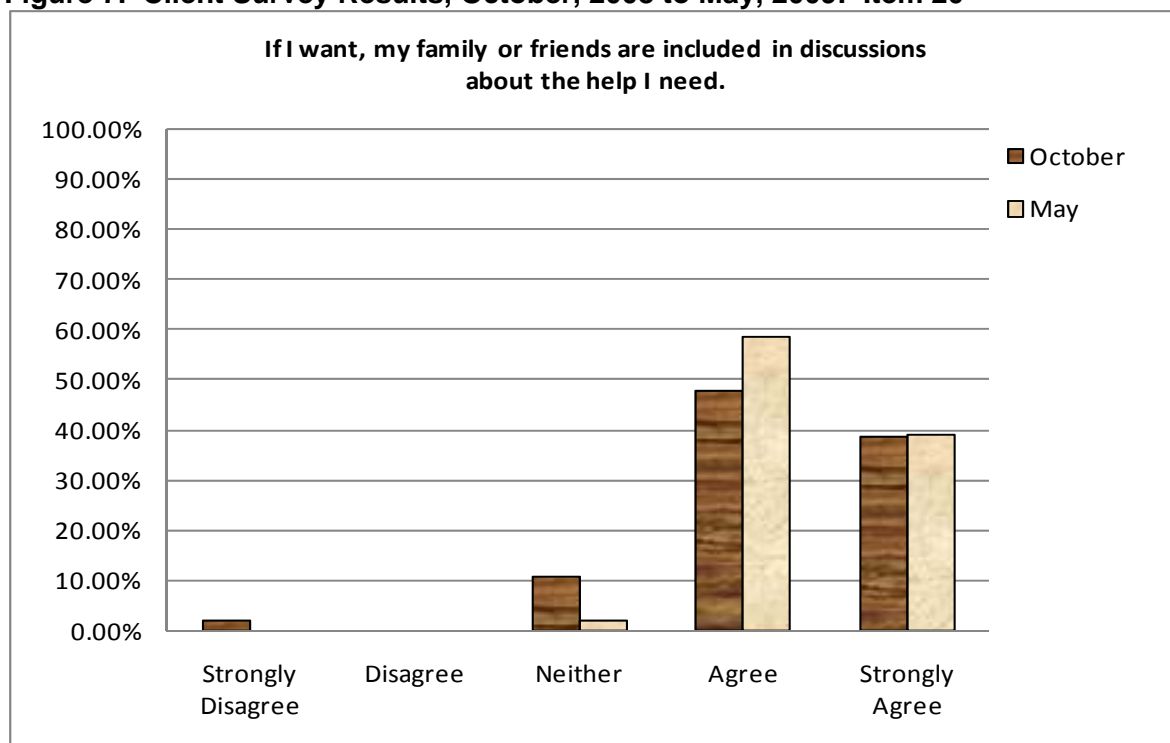
**Figure 5. Client Survey Results, October, 2008 to May, 2009: Item 13**



**Figure 6. Client Survey Results, October, 2008 to May, 2009: Item 17**



**Figure 7. Client Survey Results, October, 2008 to May, 2009: Item 20**



## Staff Survey Results

### Staff Surveys Returned

Agency staff completed the Modified California Brief Multicultural Competence Scale during the second and fourth quarters of this project year (December, 2008 and May, 2009). All agency clinical and non-clinical staff members who have contact with clients were invited to complete the survey. One-hundred nine staff members completed surveys during the May survey period. Table 9 presents the number of staff surveys the Consortium received, the number of eligible staff at each agency, and the percentage of surveys returned. To protect the anonymity of participants, survey results are not presented by agency. (For information on demographics and number of staff completing the survey in December, 2008, please see the Culturally Competent Substance Abuse Treatment Project FY09 Q2 Progress Report.)

**Table 9. Number and Percent of Staff Surveys Returned – May 2009 Survey**

	Participating Agency				
	CADS <sup>2</sup>	EFR	Urban Dreams	Jackson Recovery	TOTAL
Staff Surveys Returned (Number Returned / Number of Eligible Agency Staff <sup>1</sup> )	71 / 125	10 / 13	7 / 7	21 / 30	109 / 174
Percentage of Total Eligible	56.8%	76.9%	100%	70.0%	62.6%
<sup>1</sup> Eligible staff includes any staff who have direct contact with clients. <sup>2</sup> CADS staff who have not had recent contact with clients do not complete the survey.					

### Staff Survey Demographics

Eighty-one percent of staff completing the May survey were White, seventeen percent were African American, and two percent were Hispanic or Latino. The median age of staff completing the survey was forty-four and the median years of experience in the substance abuse field was four (see Table 10 for additional data). More than two-thirds (71%) of staff members were female. Forty-eight percent of survey respondents had taken coursework in multicultural counseling while in school. Sixty-six percent had attended workshops on multicultural issues and thirty-nine percent had attended such workshops between July 1, 2008 and the date they completed the survey in May, 2009.

Differences in race/ethnicity and ability to speak a foreign language between CCTP staff and non-CCTP staff were statistically significant. Forty percent of CCTP staff were White, whereas eighty-five percent of non-CCTP staff were White. Thirty percent of CCTP staff speak a foreign language well enough to provide treatment services in that language (fifty percent indicated that language was Spanish and fifty percent did not specify the language), whereas six percent of non-CCTP staff are able to do so (thirty-three percent indicated that language was Spanish, seventeen percent indicated Greek, seventeen percent indicated both Bosnian and German, and thirty-three percent did not specify the language).

Table 10 presents data on staff survey respondent demographics, experience, and training in multicultural issues.

**Table 10. Staff Survey Participant Demographics (continued on page 36)**

<b>Staff Survey Demographics</b>	
	<b>Survey Results (N=109) Median Minimum/Maximum</b>
<b>Age</b>	<b>44</b> 22 / 67
<b>Years of Experience in the Substance Abuse Treatment Field</b>	<b>4.0</b> <1 / 35
	<b>Survey Results: Percent</b>
<b>Gender</b>	(Number Missing = 1)
Female	<b>71%</b>
Male	<b>29%</b>
<b>Race/Ethnicity</b>	(Number Missing = 3)
White	<b>81%</b>
Black or African American	<b>17%</b>
Hispanic/Latino	<b>2%</b>
<b>Highest Level of Education Completed</b>	(Number Missing = 1)
High School Diploma	<b>25%</b>
Two-Year Degree	<b>16%</b>
Undergraduate Degree	<b>42%</b>
Masters Degree	<b>15%</b>
Doctoral Degree	<b>2%</b>
<b>Job Title</b>	(Number Missing = 2)
Counselor/Therapist/Case Manager	<b>53%</b>
Office/Support Staff	<b>25%</b>
Coordinator/Supervisor	<b>10%</b>
Medical Staff	<b>6%</b>
Program Manager/Director	<b>5%</b>
<b>Years of Experience in the Substance Abuse Treatment Field</b>	(Number Missing = 7)
Less than 2 years	<b>28%</b>
2-5 years	<b>26%</b>
6-10 years	<b>11%</b>
11-15 years	<b>12%</b>
16-20 years	<b>8%</b>
More than 20 years	<b>8%</b>
<b>Had Coursework on Multicultural Counseling in School</b>	(Number Missing = 1)
Yes	<b>48%</b>
No	<b>52%</b>
Currently Taking	<b>0%</b>
<b>Attended Workshops on Multicultural Issues in Substance Abuse Treatment</b>	(Number Missing = 0)
Yes	<b>66%</b>
No	<b>34%</b>
<b>Attended Multicultural Workshops in Project Year 2009</b>	(Number Missing = 1)
Yes	<b>39%</b>
No	<b>61%</b>

**Table 10. Staff Survey Participant Demographics (continued from page 35)**

<b>Staff Survey Demographics</b>	
	<b>Survey Results: Percent</b>
<b>Number of Workshops Attended in Project Year 2009</b>	(Number Missing = 7)
0	<b>65%</b>
1	<b>19%</b>
2	<b>6%</b>
3 or more	<b>9%</b>
<b>Speak a Foreign Language Well Enough to Provide Substance Abuse Treatment in that Language</b>	(Number Missing = 0)
Yes	<b>8%</b>
No	<b>92%</b>

**Staff Survey Results**

Survey results reflect agency staff members' perceptions of their own cultural competency. Results indicate staff members feel competent with most aspects of culturally sensitive treatment provision. More than ninety percent of staff indicated agreement or strong agreement with three statements: "I am aware that being born a minority in this society brings with it certain challenges that White people do not have to face." (Item 1; 94.4%); "I am aware of how my own values might affect my client." (Item 2; 91.5%); and "My communication skills are appropriate for my clients." (Item 9; 99.0%).

However, less than half of respondents indicated feeling competent in critiquing multicultural research (Item 12; 45.1%). Just over half reported having excellent ability to identify the strengths and weaknesses of psychological tests when used with racial and ethnic minorities (Item 7; 52.4%), feeling competent discussing differences among ethnic groups (Item 15; 55.3%), and being knowledgeable about acculturation models for ethnic minority groups (Item 19; 56.3%).

Table 11 on page 37 displays results for each survey item. Results of the December 2008 staff survey are also provided for comparison purposes. However, December and May surveys were not matched by respondent. The composition of staff completing the December survey may have been different from that completing the May survey, therefore survey results do not reflect individual change in attitude or perception over time. Rather, the data reflect perceptions of staff who completed the survey during those time periods.

**Table 11. Staff Survey Results: Modified California Brief Multicultural Competence Scale**

Statement	Strongly Disagree		Disagree		Agree		Strongly Agree	
	Decem-ber 2008	May 2009	Decem-ber 2008	May 2009	Decem-ber 2008	May 2009	Decem-ber 2008	May 2009
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.	0.0%	1.9%	3.7%	3.8%	60.7%	55.7%	35.5%	38.7%
2. I am aware of how my own values might affect my client.	0.0%	1.9%	8.3%	6.6%	58.3%	56.6%	33.3%	34.9%
3. I have an excellent ability to assess, accurately, the substance abuse treatment needs of persons with disabilities.	2.0%	1.9%	22.5%	25.2%	64.7%	59.2%	10.8%	13.6%
4. I am aware of institutional barriers that affect the client.	0.0%	0.9%	7.6%	10.4%	75.2%	66.0%	17.1%	22.6%
5. I have an excellent ability to assess, accurately, the substance abuse treatment needs of lesbians.	6.9%	3.9%	23.8%	27.2%	61.4%	58.3%	7.9%	10.7%
6. I have an excellent ability to assess, accurately, the substance abuse treatment needs of older adults.	2.9%	2.9%	20.4%	23.5%	64.1%	53.9%	12.6%	19.6%
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.	7.7%	2.9%	37.5%	44.7%	45.2%	38.8%	9.6%	13.6%
8. I am aware that counselors frequently impose their own cultural values upon minority clients.	4.7%	3.9%	25.2%	28.2%	53.3%	52.4%	16.8%	15.5%
9. My communication skills are appropriate for my clients.	0.0%	0.0%	1.9%	1.0%	65.7%	65.7%	32.4%	33.3%
10. I am aware that being born a White person in this society carries with it certain advantages.	1.9%	3.7%	15.0%	15.9%	58.9%	50.5%	24.3%	29.9%
11. I am aware of how my cultural background and experiences have influenced my attitudes about psychological processes.	0.0%	0.0%	8.5%	13.3%	72.6%	63.8%	18.9%	22.9%
12. I have an excellent ability to critique multicultural research.	6.9%	2.9%	51.0%	52.0%	39.2%	36.3%	2.9%	8.8%
13. I have an excellent ability to assess, accurately, the substance abuse treatment needs of men.	2.9%	2.0%	21.4%	20.6%	53.4%	55.9%	22.3%	21.6%
14. I am aware of institutional barriers that may inhibit minorities from using substance abuse treatment services.	0.0%	1.9%	17.3%	22.9%	68.3%	61.0%	14.4%	14.3%
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).	7.9%	3.9%	39.6%	40.8%	43.6%	45.6%	8.9%	9.7%
16. I can identify my reactions that are based on stereotypical beliefs about different ethnic groups.	0.0%	0.9%	10.2%	13.2%	79.6%	70.8%	10.2%	15.1%
17. I can discuss research regarding substance abuse issues and culturally different populations.	2.8%	0.0%	33.0%	26.9%	55.7%	58.7%	8.5%	14.4%
18. I have an excellent ability to assess, accurately, the substance abuse treatment needs of gay men.	9.9%	6.9%	30.7%	31.4%	51.5%	47.1%	7.9%	14.7%
19. I am knowledgeable of acculturation models for various ethnic minority groups.	6.9%	2.9%	51.0%	40.8%	35.3%	47.6%	6.9%	8.7%
20. I have an excellent ability to assess, accurately, the substance abuse treatment needs of women.	2.9%	3.9%	16.5%	17.5%	64.1%	50.5%	16.5%	28.2%
21. I have an excellent ability to assess, accurately, the substance abuse treatment needs of persons who come from very poor socioeconomic backgrounds.	1.9%	1.9%	18.4%	19.4%	60.2%	54.4%	19.4%	24.3%

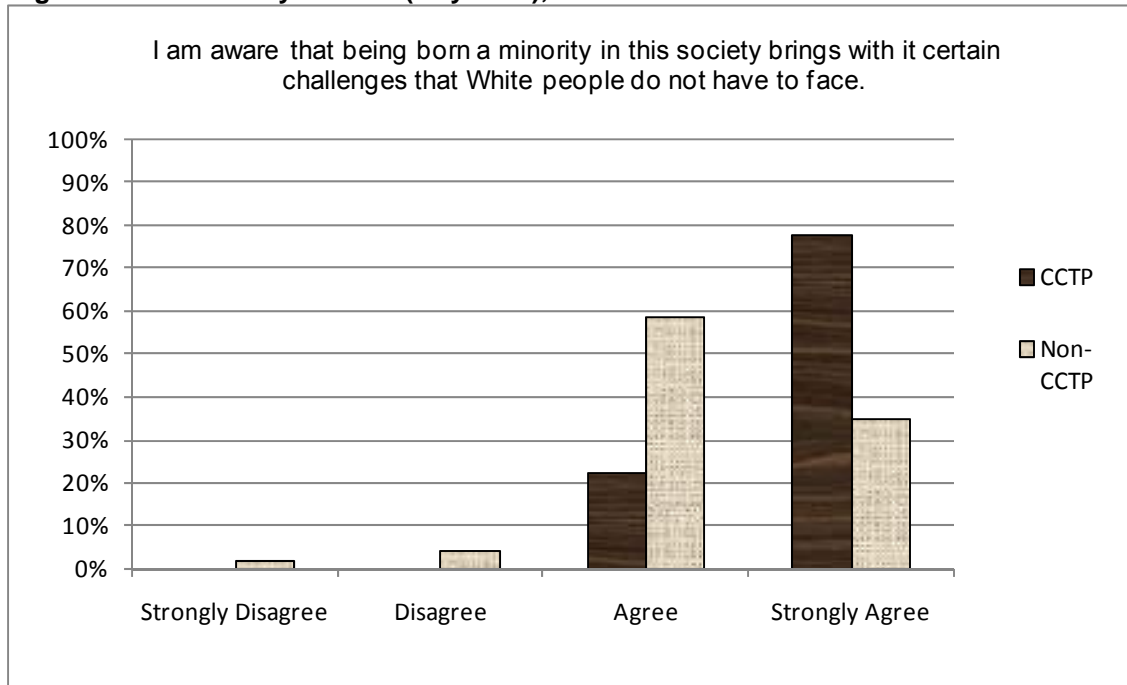
### Staff Results Comparisons

May staff survey data were analyzed for differences between White and non-White staff. There were no statistically significant differences between White and non-White staff members' responses to Items 1 through 21. Staff survey data were also analyzed for differences between designated CCTP staff and non-CCTP staff. Statistically significant differences were found between CCTP staff and non-CCTP staff on eight items. Designated Culturally Competent Treatment Project staff indicated significantly stronger agreement than did non-CCTP staff with the following:

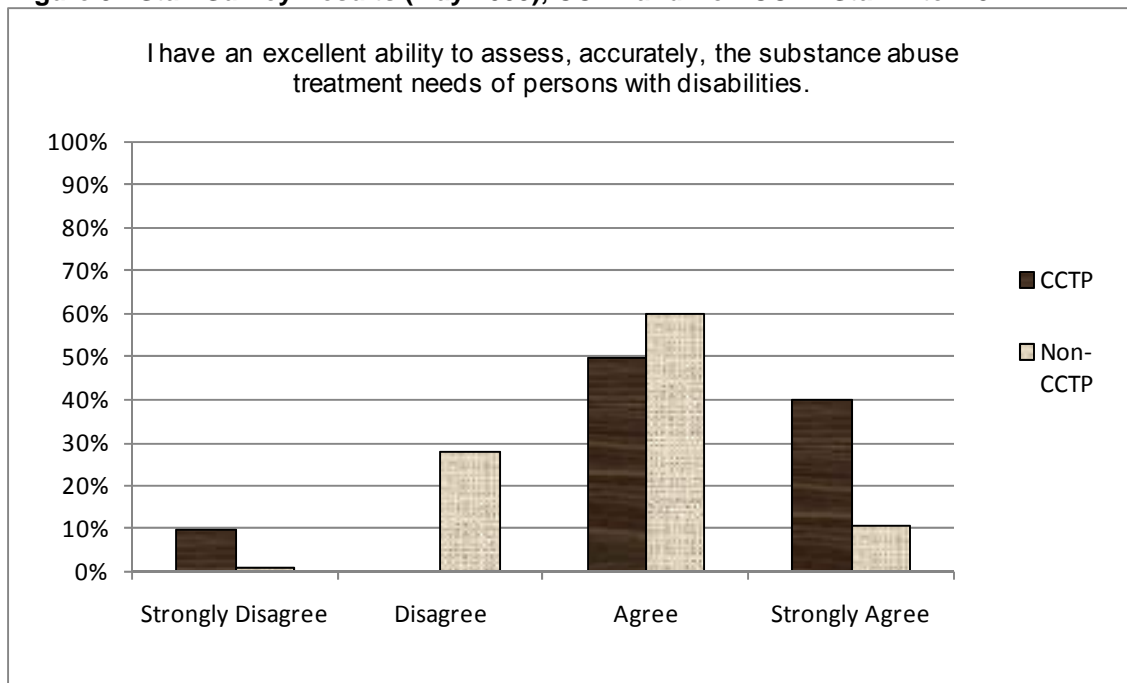
- Item 1: "I am aware that being born a minority in this society brings with it certain challenges that White people do not have to face." (Wilcoxon Two-Sample Test  $z = 2.48$ ,  $p < 0.05$ )
- Item 3: "I have an excellent ability to assess, accurately, the substance abuse treatment needs of persons with disabilities." (Wilcoxon Two-Sample Test  $z = 2.05$ ,  $p < 0.05$ )
- Item 4: "I am aware of institutional barriers that affect the client." (Wilcoxon Two-Sample Test  $z = 2.26$ ,  $p < 0.05$ )
- Item 9: "My communication skills are appropriate for my clients." (Wilcoxon Two-Sample Test  $z = 2.56$ ,  $p < 0.05$ )
- Item 10: "I am aware that being born a White person in this society carries with it certain advantages." (Wilcoxon Two-Sample Test  $z = 2.55$ ,  $p < 0.05$ )
- Item 14: "I am aware of institutional barriers that may inhibit minorities from using substance abuse treatment services." (Wilcoxon Two-Sample Test  $z = 2.17$ ,  $p < 0.05$ )
- Item 19: "I am knowledgeable of acculturation models for various ethnic minority groups." (Wilcoxon Two-Sample Test  $z = 2.00$ ,  $p < 0.05$ )
- Item 21: "I have an excellent ability to assess, accurately, the substance abuse treatment needs of persons who come from very poor socioeconomic backgrounds." (Wilcoxon Two-Sample Test  $z = 2.20$ ,  $p < 0.05$ )

Figures 8 through 15 on pages thirty-nine through forty-two present survey responses by staff category for these items.

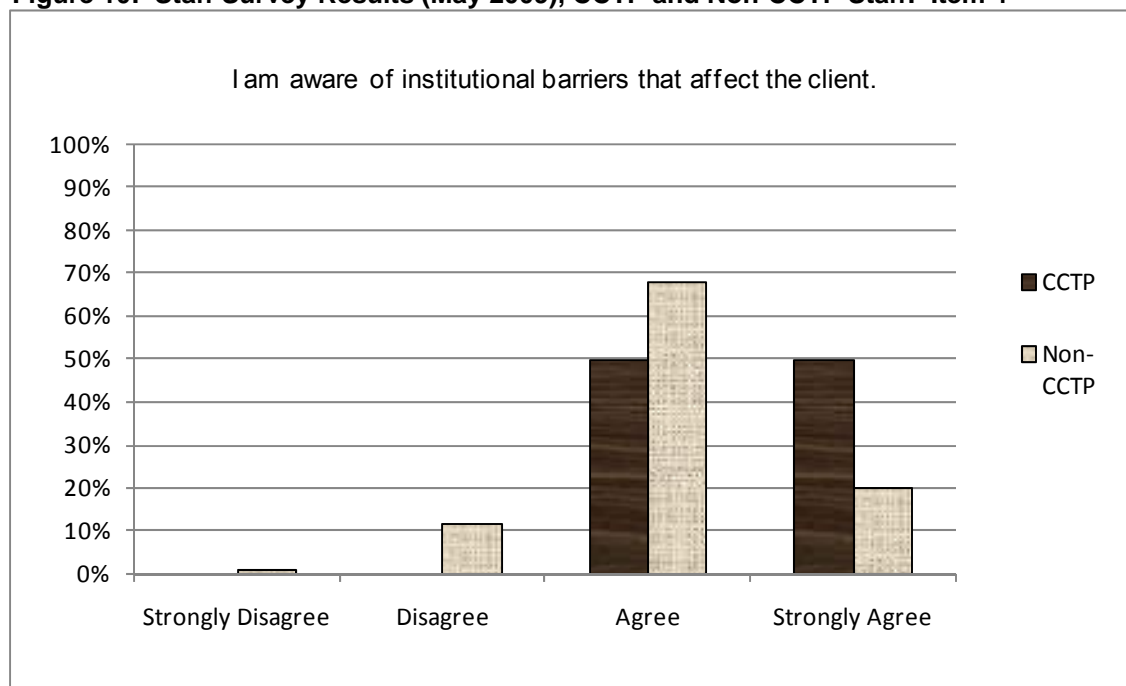
**Figure 8: Staff Survey Results (May 2009), CCTP and Non-CCTP Staff: Item 1**



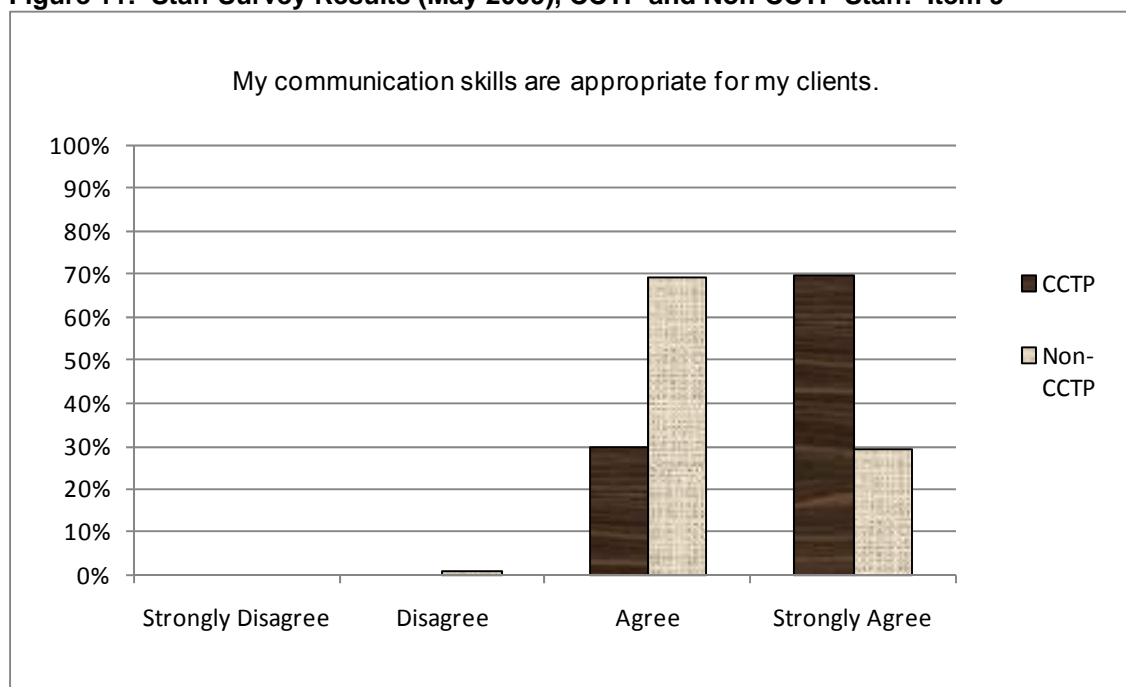
**Figure 9: Staff Survey Results (May 2009), CCTP and Non-CCTP Staff: Item 3**



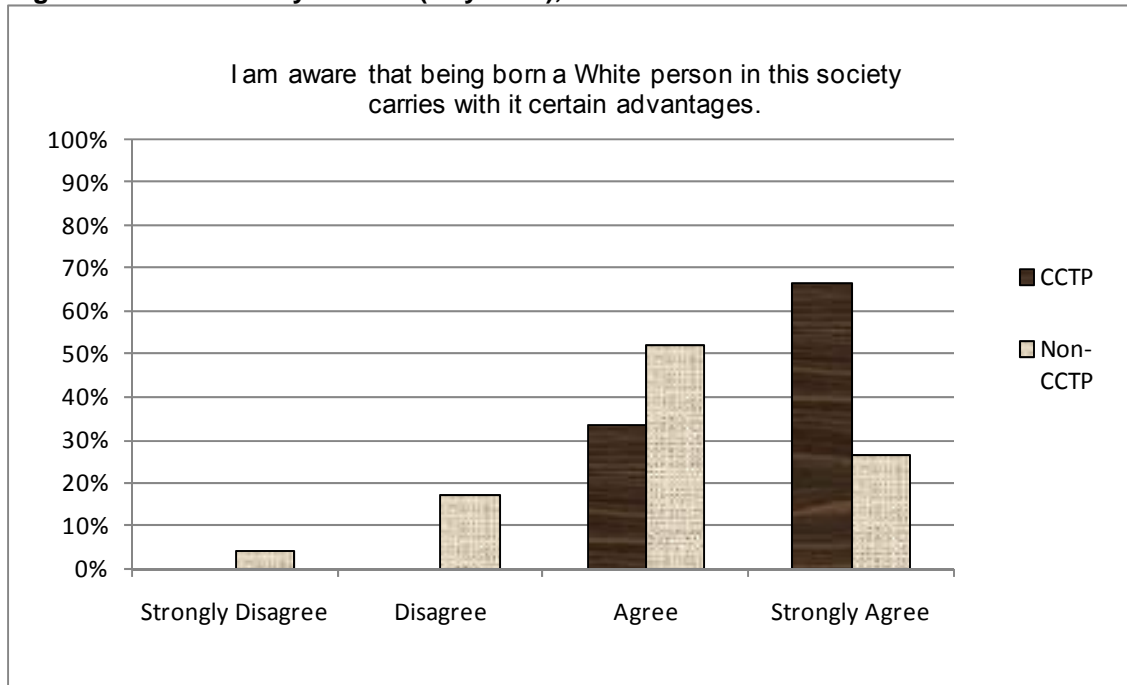
**Figure 10: Staff Survey Results (May 2009), CCTP and Non-CCTP Staff: Item 4**



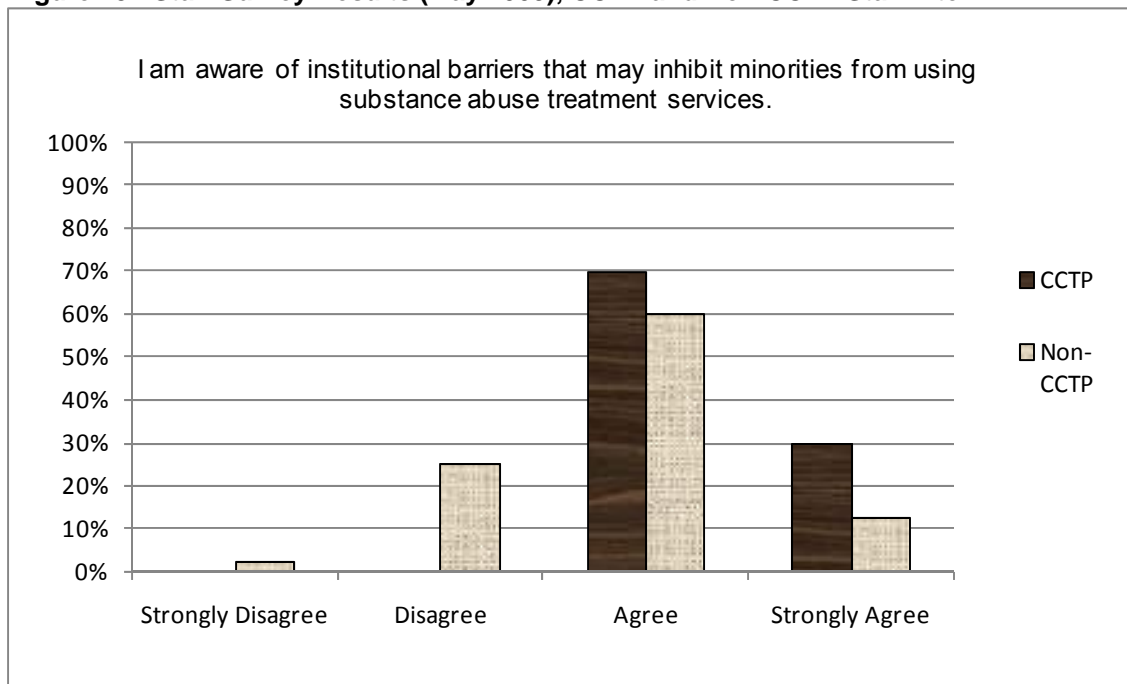
**Figure 11: Staff Survey Results (May 2009), CCTP and Non-CCTP Staff: Item 9**



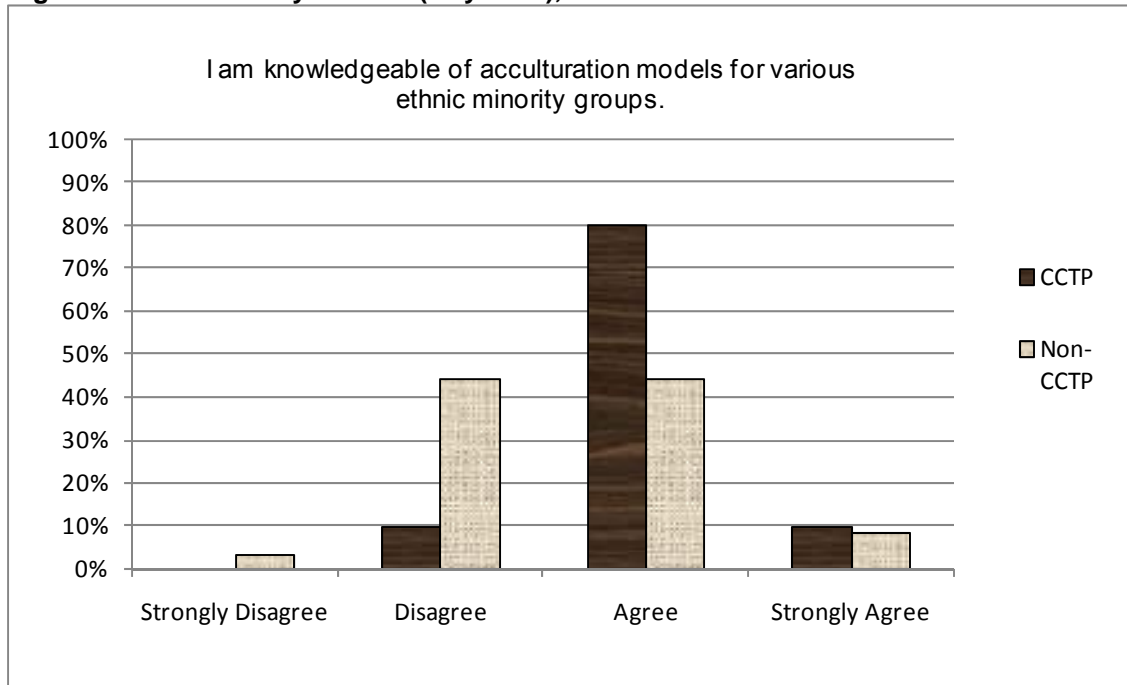
**Figure 12: Staff Survey Results (May 2009), CCTP and Non-CCTP Staff: Item 10**



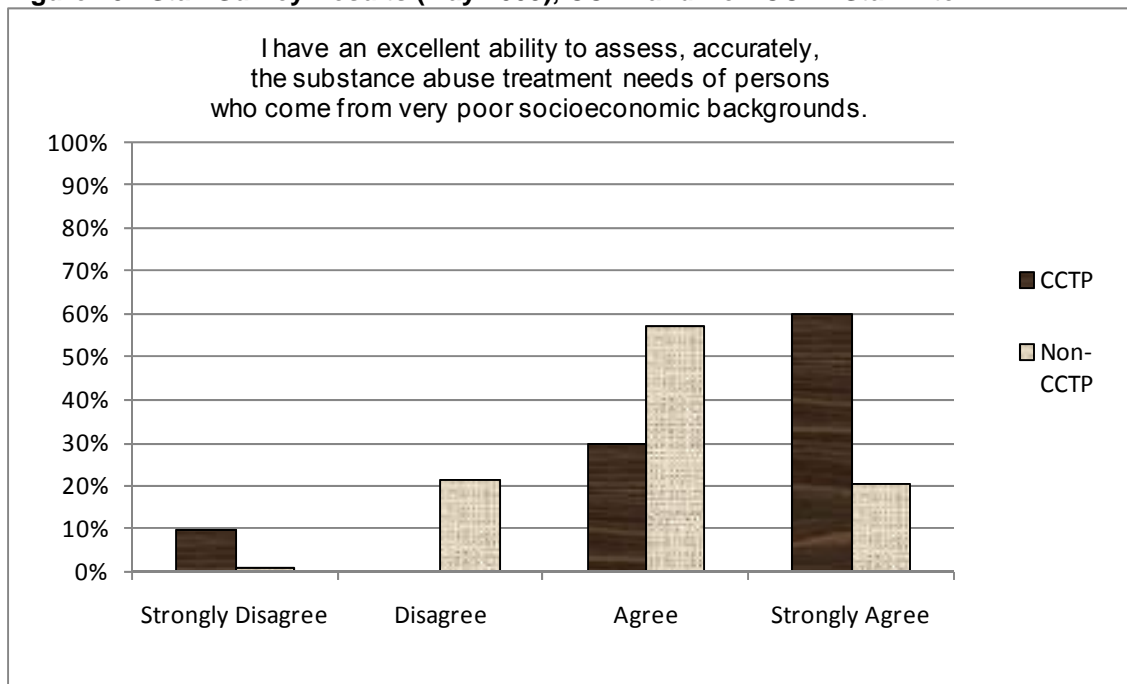
**Figure 13: Staff Survey Results (May 2009), CCTP and Non-CCTP Staff: Item 14**



**Figure 14: Staff Survey Results (May 2009), CCTP and Non-CCTP Staff: Item 19**



**Figure 15: Staff Survey Results (May 2009), CCTP and Non-CCTP Staff: Item 21**

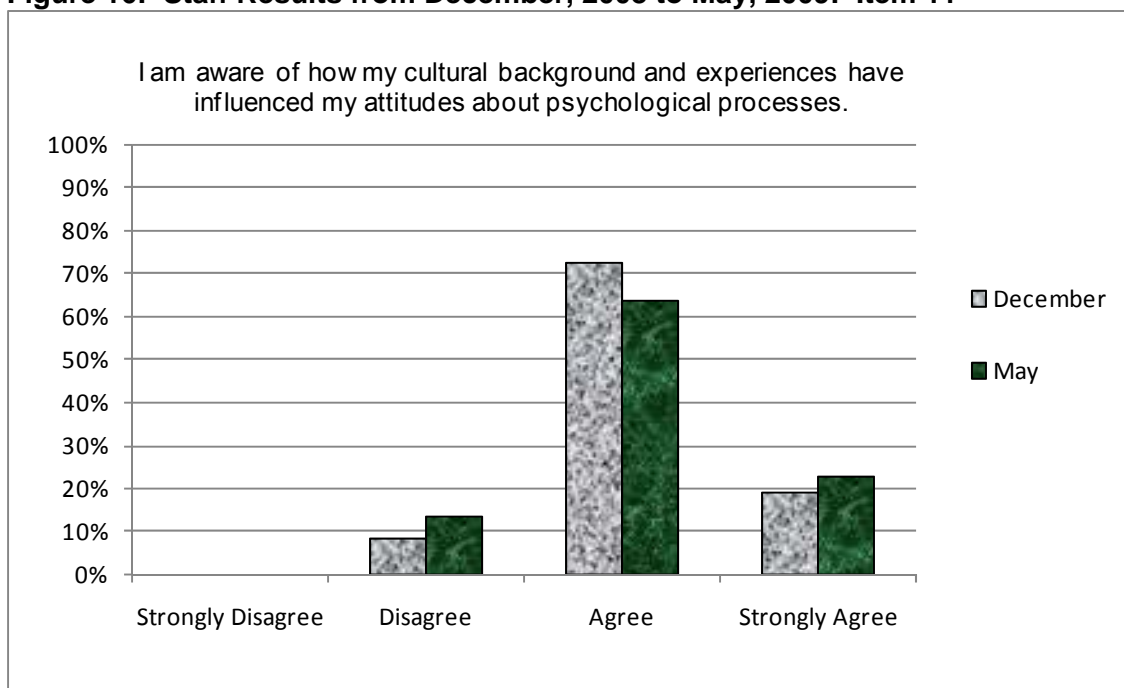


### December-to-May Staff Survey Results Comparisons

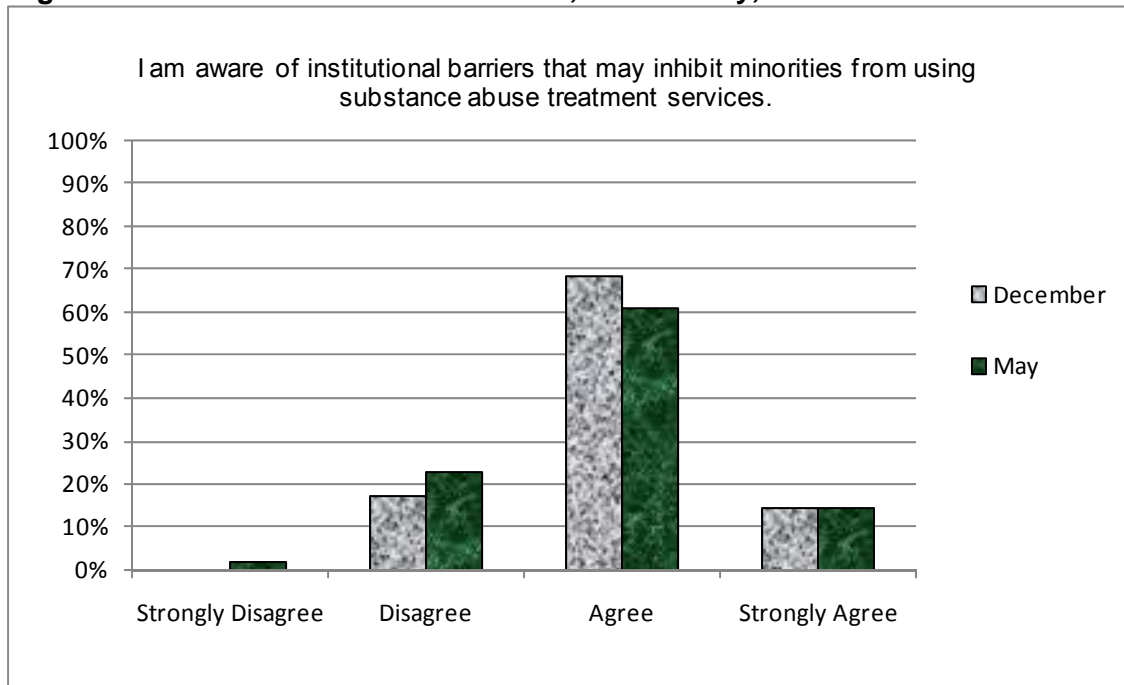
The direction of change in overall staff responses between the December, 2008 and May, 2009 surveys varied by agency and question/item. However, staff members completing the survey in May were less likely to agree with two-thirds of the survey items than those completing it in December. The greatest decreases in agreement were on Item 11: "I am aware of how my cultural background and experiences have influenced my attitudes about psychological processes" (4.8% fewer staff agreed or strongly agreed) and Item 14: "I am aware of institutional barriers that may inhibit minorities from using substance abuse treatment services" (7.4% fewer staff agreed or strongly agreed).

Figures 16 through 19 present December, 2008 and May, 2009 staff surveys responses for Items 11, 14, 17, and 19, respectively.

**Figure 16: Staff Results from December, 2008 to May, 2009: Item 11**

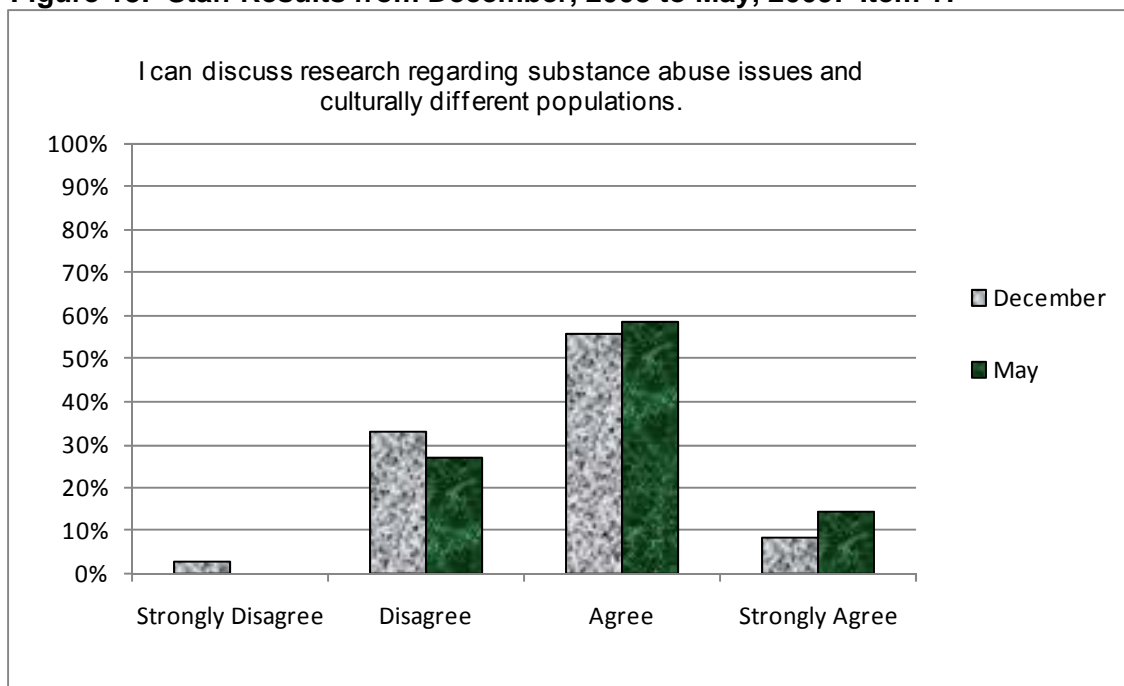


**Figure 17: Staff Results from December, 2008 to May, 2009: Item 14**

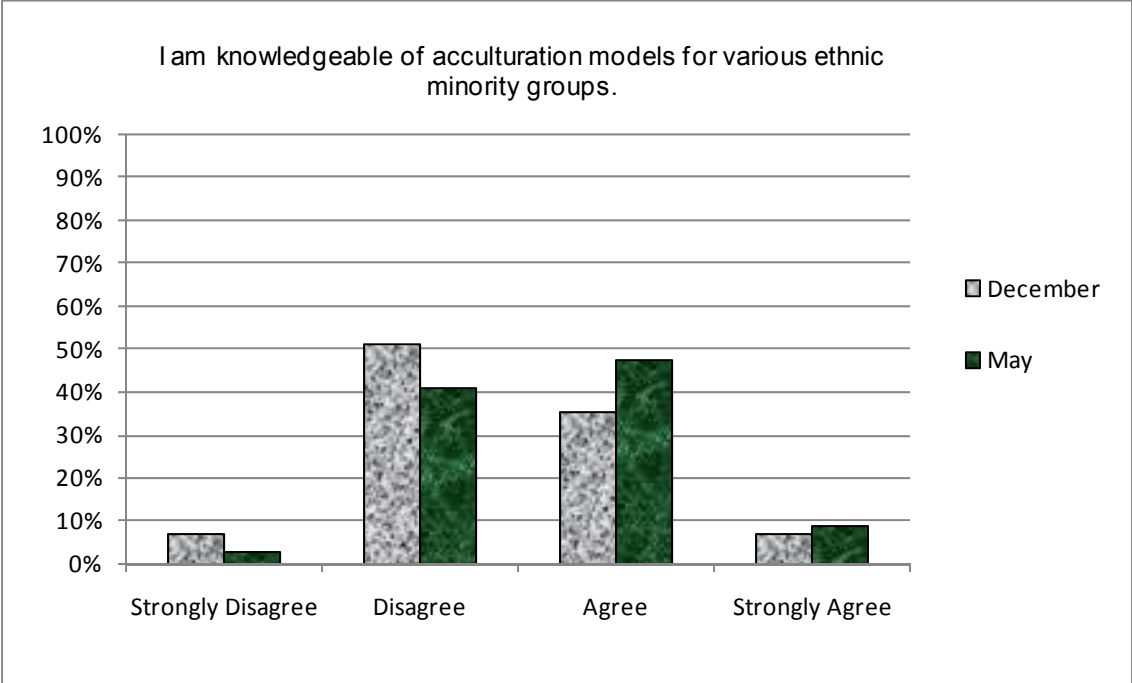


The greatest increases in agreement from December to May were on Item 17: “I can discuss research regarding substance abuse issues and culturally different populations” (8.9% more staff agreed or strongly agreed) and Item 19: “I am knowledgeable of acculturation models for various ethnic minority groups” (14.1% more staff agreed or strongly agreed).

**Figure 18: Staff Results from December, 2008 to May, 2009: Item 17**



**Figure 19: Staff Results from December, 2008 to May, 2009: Item 19**



## Summary and Impressions

The Center for Alcohol and Drug Services (CADS); Employee and Family Resources (EFR) and subcontractor, Urban Dreams; and Jackson Recovery Centers each implemented strategies for providing more culturally relevant treatment programming and services during this project year. CADS selected a research supported treatment curriculum available in Spanish and English languages to utilize in conjunction with the Matrix Model implemented in the pilot project period. CADS also strengthened and solidified the faith-based referral system and integrated peer mentoring into their Cultural Diversity Program. CADS trained staff from five churches and collaborated with other faith-based organizations to provide spiritual support to project clients, and have three active, trained peer mentors providing sober support to clients. CADS reported that several clients who had left the program against medical advice or were otherwise discharged against medical advice were returning for services and requested to be readmitted to the Cultural Diversity Program. EFR hired a consultant to assess the program and recommend ways to increase effectiveness in serving African American clients. EFR purchased recommended materials and shared them with Urban Dreams to use in conjunction with the Motivational Enhancement approach staff members already use. Both agencies were developing specific plans to implement additional recommendations, such as relocating to a different building, at the end of the project period. Jackson Recovery continues to implement the Matrix Model and Community Reinforcement approaches, but also conducted focus groups to obtain feedback from clients about unmet needs and suggestions for improving the program. Group facilitators indicated that client feedback about the program and staff was positive. The Culturally Competent Treatment Project (CCTP) also provided trainings to increase the cultural sensitivity and competency of agency staff overall. As a result of those trainings and additional efforts on the part of the grantee agencies, one-hundred percent of CADS staff, eighty-eight percent of EFR staff, and seventy-five percent of Jackson Recovery Centers staff received training in cultural competency.

Participating agencies also conducted activities designed to increase awareness among the target populations and the larger community of the project and available services. CADS developed collaborative relationships with a wide range of community based organizations and service providers, and participated in numerous community activities and events. EFR and Urban Dreams developed relationships with additional community service providers through the Access to Recovery program. Some Urban Dreams staff persons are active members of the minority community and disseminate project information there both formally and informally. Jackson Recovery project staff participates in monthly community service provider meetings to exchange program and service information. Jackson Recovery also makes good use of various local media outlets in addition to program brochures to reach members of the target population and inform the community.

Agencies reported conducting three-hundred sixteen placement screenings and admitting one-hundred eighty-four clients to substance abuse treatment through the Culturally Competent Substance Abuse Treatment Project (CCTP) between July 1, 2008 and March 31, 2009. One-hundred sixty non-CCTP clients also were served by this project through participation in CCTP services. Fifty-nine percent of clients admitted to the project were African American, forty percent were Hispanic or Latino, and two percent were another race/ethnicity. Eighty-two percent of clients were male and eighteen percent were female. The median age of clients admitted to the project was thirty-four.

Based on records agencies submitted to the Iowa Department of Public Health via the I-SMART/SARS system, one-hundred twenty-three CCTP clients successfully completed

treatment between July 1, 2008 and June 30, 2009, and seventy-nine clients were discharged prior to completion of treatment. These figures include clients who were admitted to the project during the 2007-2008 pilot year but remained in treatment at the start of the 2009 project year. Of clients admitted to the project this year, fifty-nine (58%) completed treatment successfully and forty-three (42%) were discharged or left treatment prior to completion. The median duration of CCTP services for clients admitted this project year who successfully completed treatment was eighty-nine days. The median duration of CCTP services for clients admitted this project year but discharged before completing treatment (neutral and unsuccessful discharges combined) was fifty-four days.

Evaluators conducted an analysis comparing outcomes for clients in the Culturally Competent Treatment Project to outcomes for minority clients receiving treatment at other agencies in Iowa. Clients included in the analysis were restricted to those who reported their race as African American/Black or their ethnicity as Hispanic, and who had an admission date between the earliest (December 18, 2006) and latest (June 23, 2009) dates found for the CCTP clients. This yielded 279 CCTP clients and 4497 comparison group clients for the analysis. The ratio of African Americans to Hispanics in CCTP clients was the same in both groups. The clients were also similar in age. The two groups differed in the percentage of males and females, with relatively fewer females among the Cultural Competency clients when compared to the minority clients statewide.

Alcohol was the most frequently cited substance, with both groups reporting alcohol as the primary substance about fifty percent of the time. Statistically significant differences were found between the two groups when alcohol was not the primary substance: cocaine/crack was more frequently mentioned in the Cultural Competency group than in the Comparison group, and clients in the Cultural Competency group mentioned marijuana less frequently than clients in the Comparison group. Referral source percentages also differed between Cultural Competency and Comparison groups. The category "Other Community" referral was much more frequently noted in the Cultural Competency group than in the statewide Comparison group.

There was no significant difference between the two groups in regard to discharge status: successful completions have occurred at about the same frequency. However, the Cultural Competency group had significantly more clients still in treatment and more admissions later in the analysis time window. It could be that many of the CCTP clients still in treatment may have a higher chance to successfully complete treatment, as the programs have solidified in recent months.

Clients in the Cultural Competency group stayed in treatment significantly longer than those in the statewide Comparison group. The median length of stay for clients in the Cultural Competency group was one-hundred twelve days while the median length of stay for clients in the Comparison group was sixty-four. (Note: Length of stay for the Cultural Competency group referred to here includes clients from both project years and is based on the date of treatment admission, whereas the duration of CCTP services figures provided previously in this section include only clients admitted and discharged during Project Year 2009, and are based on the date the client began receiving CCTP services.) This significant increase in length of stay for the Cultural Competency group was consistent for all clients regardless of their discharge status. The Cultural Competency programs increased the "Unsuccessful" clients' treatment exposure (length of stay) by one-and-a-half times. The individual programs implemented in the Culturally Competent Treatment Project also were analyzed separately. Each program had a significantly greater length of stay than the comparison group, and CCTP programs did not differ among themselves in length of stay.

Client and staff survey results support noted improvements in programming and services to clients, and increased cultural competency of staff. Fifty-one clients completed the Iowa Cultural Understanding Assessment in May, for an overall survey return rate of fifty percent. Project staff (evaluator, IDPH project coordinator, and agency staff) discussed strategies for increasing survey participation and return rates, such as allowing time at the end of group therapy sessions for survey administration and agencies creating systems for tracking which clients received the survey and which clients have returned them. Agencies plan to implement these strategies beginning with the first survey round of the next project year. Year-end client survey results are positive, with at least eighty-two percent of respondents agreeing or strongly agreeing with all statements indicating cultural competency of the staff and the agencies. Five items showed substantial increases from October to May in the percent of clients agreeing or strongly agreeing: staff providing clients with assistance connecting to clergy or spiritual leaders; staff coming to clients' communities to let them know about available services; staff understanding that members of the client's racial group are not all alike; staff understanding that clients may feel more comfortable with a counselor of the same sex as them; and staff including clients' family or friends in discussions about the client's treatment needs. The highest percentage of agreement for the May survey, ninety-eight percent, was seen on four items: staff providing clients with assistance connecting to clergy or spiritual leaders; staff understanding that members of the client's racial group are not all alike; staff discussing with clients how the treatment program will help them; and staff including clients' family or friends in discussions about the client's treatment needs.

One-hundred nine staff members completed Modified California Brief Multicultural Competence Scale in May. Staff survey results also are positive; results indicate staff members feel competent with most aspects of culturally sensitive treatment provision. More than ninety percent of staff indicated that they are aware that minorities face unique challenges in our society, that they are aware of how their own values may affect their clients, and that their communication skills are appropriate for their clients. However, less than half of respondents indicated feeling competent in critiquing multicultural research. And, just over half reported having excellent ability to identify the strengths and weaknesses of psychological tests when used with racial and ethnic minorities, being able to discuss differences among ethnic groups, and being knowledgeable about acculturation models for ethnic minority groups. CCTP staff felt more confident than non-CCTP staff on several items, such as, "I am aware of institutional barriers that may inhibit minorities from using substance abuse treatment services" and, "I have an excellent ability to assess, accurately, the substance abuse treatment needs of persons who come from very poor socioeconomic backgrounds." The percentage of staff agreeing with some items decreased from the December, 2008 survey period to the May, 2009 survey period. The greatest decreases in agreement were on: "I am aware of how my cultural background and experiences have influenced my attitudes about psychological processes;" and, "I am aware of institutional barriers that may inhibit minorities from using substance abuse treatment services." It may be that as agency staff were exposed to more information on cultural issues, they became more aware of gaps in their own knowledge of issues affecting minorities.

The Culturally Competent Substance Abuse Treatment Project appears to be having a positive effect on the targeted minority clients. Strategies agencies have employed to address the unique treatment needs of minority clients appear to be increasing client engagement while in treatment: client satisfaction is high and clients are remaining in treatment longer. While current data indicate that the rate of successful treatment completions is not significantly higher among Cultural Competency clients than among minority clients in other treatment programs across the state, this data is preliminary. The CCTP programs are relatively new and the

Cultural Competency group had significantly more clients still in treatment than the Comparison group at the time of the analysis. With high client satisfaction and increased length of stay, it is quite possible that the percentage of successful completions will increase.

While client and staff survey results and client outcomes indicate agencies are providing culturally competent treatment and case management services, results also highlight areas of capacity expansion and training that may further improve services to the target populations. These areas include:

- increasing direct outreach to minority communities (agency staff going to those communities to share information about CCTP services and how to access them)
- asking clients for feedback about the program and services
- adding pictures and reading materials to the lobby and facility that show members of the targeted ethnic groups, and using brochures/handouts clients can easily understand
- matching clients with therapists of the same gender
- providing information about available resources and social services in the community
- increasing the use of interpreters or translators with clients and significant others
- increasing staff knowledge of acculturation models for minority groups
- training staff to evaluate multicultural research
- training staff on intra-group differences of minority populations
- training staff in the use and limitations of psychological tests with minorities.

In addition, participating agencies should more closely examine the barriers that exist between placement screening and treatment admission for their target populations. Additional interventions and strategies may be identified that will reduce the number of clients dropping out between screening and admission.

Statewide cultural competency trainings were held during the last month of the project year; therefore, effects of those trainings will be more fully realized during the project year beginning July 1, 2009.

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Arthur, T. E., Reeves, I., Morgan, O., Cornelius, L. J., Booker, N. C., Brathwaite, J., Tufano, T., Allen, K. & Donato, I. (2005). Developing a cultural competence assessment tool for people in recovery from racial, ethnic and cultural backgrounds: the journey, challenges and lessons learned. *Psychiatric Rehabilitation Journal*. 28(3), 243-250.

Cornelius, L. J., Booker, N. C., Arthur, T. E., Reeves, I., & Morgan, O. (2004). The validity and reliability testing of a consumer-based cultural competency inventory. *Research on Social Work Practice*. 14; 201-209.

Gamst, G., Dana, R. H., Der-Karabetian, A., Aragon, M., Arellano, L., Morrow, G. & Martenson, L. (2004). Cultural Competency Revised: The California Brief Multicultural Competence Scale. *Measurement and Evaluation in Counseling and Development*, 37, 3,163-183.

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

## **APPENDIX A: Survey Instruments and Survey Administration Protocols**

Iowa Cultural Understanding Assessment (Client Survey Instrument)	42-43
Evaluación del Entendimiento Cultural de la Gente de Iowa (Spanish Client Survey)	44-45
Client Survey Administration Protocol	46
Modified California Brief Multicultural Competence Scale	47-48
Staff Survey Administration Protocol	49

## Client Form : Iowa Cultural Understanding Assessment (continued on next page)

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

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

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 <i>not</i> 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.

## Formulario para Clientes

### Evaluación del Entendimiento Cultural de la Gente de Iowa

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

## Formulario para Clientes

### Evaluación del Entendimiento Cultural de la Gente de Iowa

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 raíces 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](mailto:jane-gressang@uiowa.edu), 319-335-5822. Muchas gracias.

## **Culturally Competent Treatment Project Client Survey Administration Protocol**

Surveys are to be anonymous. If your agency does not have an outgoing mail box clients can access, designate a central location and staff person (non-counselor) to be responsible for receiving and mailing completed surveys. You may want to set up a drop box in which clients can place completed surveys.

### **If administering the survey to a group:**

Assign one client to be responsible for survey collection.

Give that client a Consortium return envelope, or place it somewhere away from staff persons.

Distribute one survey to each client. Read the statement below to clients before they fill out the survey.

Instruct the clients to place the survey in the envelope when they are finished.

When all surveys have been turned in, have the client assigned to survey collection seal the envelope in view of the other clients.

Have that client place the envelope in the outgoing mail location, or give it to the staff person designated to mail surveys, after the group is dismissed.

### **If administering the survey to an individual client:**

Give the survey to the client. Read the statement below to the client before he/she fills out the survey.

Have the client submit the completed survey for mailing to the Consortium, using one of the following options:

- 1) Give the client an individual return envelope to mail directly; or
- 2) Have the client place the survey in the designated drop box or give it to the designated non-counselor staff to mail.

**‘Purpose of Survey’ statement to be read to clients** (feel free to replace the word “client” in the statement if your agency refers to them as something else):

“The Iowa Department of Public Health is asking for clients’ feedback about how our agency and staff are doing in understanding the issues and meeting the needs of minority clients. The survey is voluntary and results are to be kept confidential. Please do not write your name or ID number on the survey form. There are two questions on the survey that often confuse people. “What is your race?” is about which race you most closely identify with, and “Are you Hispanic or Latino?” is about whether you belong to one of those ethnic groups. Race and ethnicity are separate things, so even if you are Hispanic or Latino, you are also part of some race. So, please answer both questions. If you have questions about that or anything else on the survey, please ask me.” (You may give them information below right away, or wait to see if they ask questions about race/ethnicity.)

**NOTE for survey administrators:** This information is from the federal census bureau (<http://www.census.gov/population/www/socdemo/race/racefactcb.html> and [http://quickfacts.census.gov/qfd/meta/long\\_68178.htm](http://quickfacts.census.gov/qfd/meta/long_68178.htm)). Hispanics/Latinos can be of any race, depending on their ancestral origins. For instance, people whose ancestry is from the original peoples of Europe (including Italy and Spain), the Middle East, or North Africa are considered White; those whose ancestry is from the native peoples of North, Central, or South America are considered Native American or American Indian; those whose ancestry is from Central or Sub-Saharan Africa are considered African-American.

## Modified California Brief Multicultural Competence Scale – 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? \_\_\_\_\_ Today's Date \_\_\_\_\_
2. What is your sex? \_\_\_\_\_ Female \_\_\_\_\_ Male
3. What is your race? \_\_\_\_\_ Alaskan Native \_\_\_\_\_ American Indian \_\_\_\_\_ Asian  
\_\_\_\_\_ Black or African American \_\_\_\_\_ Native Hawaiian or other Pacific Islander \_\_\_\_\_ White
4. Are you Hispanic or Latino? \_\_\_\_\_ Yes \_\_\_\_\_ No
5. What is your current job title? \_\_\_\_\_
6. What is your highest level of education completed?  
\_\_\_\_\_ Less than high school diploma \_\_\_\_\_ Completed Bachelor's degree  
\_\_\_\_\_ HS diploma or GED \_\_\_\_\_ Completed Master's degree  
\_\_\_\_\_ Completed two-year degree program \_\_\_\_\_ Completed Doctorate degree  
(e.g. Associate's degree)
7. How many years of experience do you have in the field of substance abuse treatment since earning your highest degree? \_\_\_\_\_
8. Have you had course work on multicultural counseling while in school?  
\_\_\_\_\_ Yes  
\_\_\_\_\_ No  
\_\_\_\_\_ Currently taking
9. Have you ever attended special workshops and/or training seminars on multicultural issues in substance abuse treatment?  
\_\_\_\_\_ Yes: **Number of workshops/trainings ever attended (estimate if unsure):** \_\_\_\_\_  
\_\_\_\_\_ No
10. Have you attended special workshops and/or training seminars on multicultural issues in substance abuse treatment since July 1, 2008?  
\_\_\_\_\_ Yes: **Number of workshops/trainings attended since 7/1/08 (estimate if unsure):** \_\_\_\_\_  
\_\_\_\_\_ No
11. Do you speak a language other than English well enough to provide substance abuse services in that language?  
\_\_\_\_\_ Yes: Please specify language: \_\_\_\_\_  
\_\_\_\_\_ No
12. Were you born in the United States?  
\_\_\_\_\_ Yes  
\_\_\_\_\_ No
13. Are you a designated staff person on the Culturally Competent Treatment Project?  
\_\_\_\_\_ Yes  
\_\_\_\_\_ No

## 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.

## **Culturally Competent Treatment Project Staff Survey Administration Protocol**

Culturally Competent Substance Abuse Treatment Project (CCTP) program managers should designate a central location where staff can drop off completed surveys in a confidential manner (e.g. a drop box). The program manager or a designated staff person will be responsible for mailing those surveys to the Consortium. Program managers may also provide postage-paid return envelopes for staff persons to return their completed surveys directly to the Consortium.

Distribute surveys to all clinical and non-clinical agency staff persons who are in contact with clients in some direct or indirect capacity.

It may be easiest to allot 5-10 minutes of an all-staff meeting in which to have staff complete and turn in the survey.

**Be sure to read or communicate the following purpose statement to all staff taking the survey:**

**PURPOSE OF SURVEY:** This survey is administered through the Culturally Competent Substance Abuse Treatment Project (CCTP) funded by the Iowa Department of Public Health through the Iowa legislature. Its purpose is to assess the overall level of cultural competency of the agencies involved in the project, not of individual staff members. This survey is voluntary, and survey responses are to be kept confidential. Please do not write your name on the survey form. Completed surveys will be sent directly to the Iowa Consortium for Substance Abuse Research and Evaluation for compilation and data analysis.

**NOTE:** Race and ethnicity are considered to be different concepts, therefore, please answer *both* the race question, selecting the race you most closely identify with, *and* the ethnicity question (Answer “What is your race” *and* “Are you Hispanic or Latino?”).

**Survey administrators may also provide this information to those completing the survey:**

The following information is from the Federal Census Bureau:

(<http://www.census.gov/population/www/socdemo/race/racefactcb.html> and

[http://quickfacts.census.gov/qfd/meta/long\\_68178.htm](http://quickfacts.census.gov/qfd/meta/long_68178.htm)). Hispanics/Latinos can be of any race, depending on their ancestral origins. For instance, people whose ancestry is from the original peoples of Europe (including Italy and Spain), the Middle East, or North Africa are considered White; those whose ancestry is from the native peoples of North, Central, or South America are considered Native American or American Indian; those whose ancestry is from Central or Sub-Saharan Africa are considered African-American.

## **APPENDIX B: Compass Consulting Report**

Compass Consulting Report

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## **CULTURAL COMPETENT TREATMENT PROJECT ROUNDTABLE DISCUSSION**

On June 25, 2009, Tameka L. Taylor, Ph.D. and Ruth E. Ramos facilitated a discussion with the participants of the Cultural Competent Treatment Project. The purpose of this meeting was to assess how the project was going, changes that were going to be made in the final year of the project and any future recommendations for the project.

As part of the meeting, Dr. Taylor and Ms. Ramos asked the following questions:

1. Reflections of the Culturally Competent Treatment Project to date.
  - Overall experience with setting up the project
  - Strengths
  - Barriers, Weaknesses, and Challenges keeping the project moving forward
2. What needs to be considered/implemented in order to improve access and retention of your target population in substance abuse treatment services?
3. What will you/your agencies do different in year 3?
4. Community
  - a. How has your project improved awareness in your community about the needs of your targeted population?
  - b. How have you involved the community into your CCTP?
  - c. How has this project improved your community's culture?
5. What are three things you'd want to tell another SA Treatment Provider that could help their agency/services become cultural competent?

Following are the group's responses to the above questions in hopes that this information can be helpful as the project moves forward.

## **REFLECTIONS OF THE CULTURALLY COMPETENT TREATMENT PROJECT TO DATE**

### **OVERALL**

#### **Diversity**

- Teaches cultural pride
- Allowed increased treatment opportunities for African-American and Latino clients
- I believe in agency's policies towards working with diverse clients

#### **Bridging Gaps**

- Keep building client involvement and development
- Break the curse
- Deal with family
- Prioritize bridging gaps first

#### **Increase Comfort Level**

- Clients seem to stay around longer in treatment
- It is a great experience with the patients

#### **Challenges/Challenging**

- Since this is a pilot project, things change and can be confusing

#### **Client-Focused**

- Overall, very helpful!

- Program is excellent for target population
- More holistic approach in clients' lives

## **STRENGTHS**

### **Rapport**

- Ability to relate
- About 90% of the matrix made the clients feel that it was about them
- Credibility of counselors with clients
- Clients served

### **Engagement**

- The service and duration of the program is good; three times per week gives clients attention
- Client learns coping skills to deal with everyday situations
- Client comments on benefits of weekly calls and to touch base

### **Collaboration**

- Staff willingness to help clear up discrepancies in data for the evaluation
- All staff on the project have worked well together

### **Leaders in the Field/Commitment**

- The staff at each program are positive and client-focused
- Staff commitment to reaching target populations – more and better
- Compassionate counselors and project coordinator

### **Celebrating Diversity**

- Decrease in assumptions
- Program has diversity
- Counselors have knowledge of culture
- Want to see all programs continue to celebrate culture – very good in some - could still be stepped up in others

### **Trust**

- Clients satisfaction with program
- Clients experiencing positive changes in recovery
- More opportunities for clients to ask for help outside of traditional services
- Clients come back to us after “struggle” – know that there is help
- Clients find it easier to ask for help once they establish a bonding with their case manager
- Client establish a bonding and trust relationship with their counselor

### **Professional Development**

- Looking for competent and knowledgeable counselors
- Staff development

### **Communication**

- Projects like this one are very much needed
- Positive client, staff, and community feedback
- Communication
- Honest/Open

### **Community Awareness**

- Community

### **State's Commitment to Project**

- Gena and Kris are helpful and willing to assist
- Would have liked to had more specific information at the start of the project, but understand as with all pilots focus can change
- Like having the site visits, helpful

## **BARRIERS, WEAKNESSES, CHALLENGES**

### **Data**

- Not everyone is proficient in entering data. In some cases, they dodge learning it.
- Need to coordinate data systems and report data that is accurate
- Two systems but only one is looked at for the data; causes conflict with data
- INTEGRITY “training issues”

### **Mentors**

- Finding mentors that are stable in recovery; “in it” for the right reason
- Finding mentors willing to stay and participate in project
- Getting female mentors for the program

### **Politics**

- Red tape is still a barrier to programs getting started
- House File 909a was very vague
- Did not enjoy not being able to charge patients on a second visit

### **Communication**

- There is a lack of communication between agencies

### **Changes**

- Staff retention/staff changes (3)

### **Funding**

- Since this is state appropriations, we never know if the funding will continue (puts fear in some staff)
- Budget cuts
- Facing upcoming project year budget

### **Resources**

- Supplies
- Lack of best practices
- Weak health of patients
- More robust treatment curriculum (EBPs)
- Economy – difficult to connect clients to resources – things are scarce and clients' background
- Spanish-speaking in-patient agencies /counselors lacking
- Assisting with clients in finding employment
- Problems with helping clients find housing (2)
- Getting clients connected with spiritual leaders
- Space

### **Engagement**

- Gather more community support in public – more than our usual connections
- Lack of incentives for clients to stay engaged

- Difficulty in staying in contact – phone numbers change, disconnected, etc
- Continuing to call despite low contact rates each week

### **Evaluation**

- My clients were upset because “their” nationality was not listed on the survey
- Low survey return rates make it impossible to know how the majority of clients feel about the program
- Differences in when each agency starts a client in the project. One starts at screening, one at admission and one after admission (sometimes months or years) when they are staffed. This makes it very difficult and in some cases impossible to track them through the state’s electronic reporting system.

**Immigration** (Nothing specific came up but it was discussed)

**Consistency** (Nothing specific came up but it was discussed)

## **NEEDS TO BE IMPLEMENTED TO IMPROVE ACCESS AND RETENTION OF TARGET POPULATION**

### **ACCESS**

- Staffing on-site (EFR/UD)
- Doing off-site evaluations – willingness to go to other agencies (CADS)
- Confidentiality (UD)
- Purchase bus tickets for clients (UD)
- Pick clients up and take them to AA meetings (UD)

### **RETENTION**

- Prioritize cultural competency clients among other resources/agencies (CADS)
- Male population wanting male counselors (UD)
- Continuing to foster a safe environment (EFR/UD)
- Less “lost in the shuffle” clients (EFR/UD)
- Clients are incarcerated or leave the country
- Incentives and rewards (UD)
- Use matrix model (JRC)

## **WHAT YOUR AGENCY WILL DO DIFFERENT IN YEAR 3**

- Getting space and more staff(UD)
- Alumni Committee (JRC)
- Annual banquet (UD)
- Better tracking system – getting clients in system and discharging clients in a timely manner
- Data entry – entered accurately and timely (UD)
- All clients need to be billed as “other government” #18 for funding Source and “under special initiatives”, marked as CCPT #7
- Client engagement – focus groups, evaluations (CADS)
- Assisting clients with finding employment – workforce development (JRC and CADS)
- New curriculum (EFR/UD)
- Love and Logic Training (JRC)

- Case management transition (EFR)
- More marketing (JRC, EFR/UD)
- Establish collaborations with agencies and community members (CADS)

## **WAYS TO IMPROVE AWARENESS, IMPROVE AND INVOLVE COMMUNITY**

### **IMPROVE AWARENESS**

- Talk about services
  - English/Spanish
  - Daycare/Schools (JRC)
- Flyers in community and Black ministerial alliance (EFR)
- Churches (UD)
- Local festivities/celebrations (ALL)

### **INVOLVE THE COMMUNITY**

- Peer groups (UD)
- Bring AA facilitators to clients (JRC)

### **IMPROVE COMMUNITY CULTURE**

- Intertwined more with community – agencies supporting each other (CADS)

## **ADVICE TO OTHER AGENCIES**

- Get involved with family drug court – support and collaboration
- Communication – clients, constituents, stakeholders
- Can't give up on people/clients
- Follow-up and follow-through
- Committed to clients and going the extra mile
- Flexibility
- Being accessible
- Know your own limitations
- Boundaries
- Assessing staff skills and abilities – getting trained/educated
- Creating inclusive environments – brochures, posters, bilingual
- Meet the client where the client is
- Having a direct line for clients
- Assessing literacy level
- Know the resources

## **APPENDIX C: Case Studies**

Center for Alcohol and Drug Services Case Studies	57-59
Employee and Family Resources/Urban Dreams Case Studies	60-62
Jackson Recovery Centers Case Studies	63-65

## **CADS Case Studies**

### **Client A**

Quarter 1: Client A was admitted to Level III.1 Halfway House on 07/18/2008 and the Cultural Diversity Program on 07/23/2008. Client A was referred by the Jail Based Program. Client A reports a positive experience in treatment and the Cultural Diversity Program. As a child, Client A was a victim of sexual abuse. Through the Cultural Diversity Program, the client was referred to Family Resources' Counseling and Advocacy Program where he worked on these unresolved issues by meeting with a therapist and completing assignments given to him. Client A also has some significant medical health issues and was transported and supported by a Cultural Diversity Case Manager to specialty clinics in Iowa City in August and September to receive medical follow-up/treatment. Client A experienced one relapse in the middle of August. However, Client A has maintained sobriety since then. Client A was successfully discharged from the Halfway House in latter September and transitioned into a local three-quarter house. Client A still engages in CADS Continuing Care clinical services consisting of Dual Diagnosis, Skills Development, 12 Step Group and Cultural Diversity group, in addition to contact with his primary Case Manager. Recently, Client A's Case Manager assisted him in applying for a rent assistance voucher for the three-quarter house.

Quarter 2: During the past quarter, Client A has continued to make positive strides in his recovery program. Client A continues to receive services from Family Resources Counseling and Advocacy Program and specialty clinics in Iowa City as needed. Client A maintains a sober residence. The client remains engaged in CADS Continuing Care clinical services consisting of Skills Development and Cultural Diversity Group, in addition to sessions with his primary Case Manager. The Program Manager and primary Case Manager have assisted the client in utilizing Access to Recovery Services. With a fixed income, the client has greatly benefitted from receiving monthly bus passes to get to and from recovery related activities and obtaining winter apparel.

Quarter 3: During the past quarter, Client A has continued to make positive strides in his recovery program and maintain sobriety. Client A continues to receive services from Family Resources Counseling and Advocacy Program and specialty clinics in Iowa City as needed. Client A maintains a sober residence. Client engages in CADS Continuing Care clinical services consisting of Cultural Diversity Group and sessions with his primary Case Manager. His primary Case Manager has assisted him in utilizing Access to Recovery Services including bus passes, clothing, and Employment Counseling, along with other community resources.

Quarter 4: During this past quarter, Client A was discharged from the Cultural Diversity Program due to moving out of state.

### **Client B**

Quarter 1: Client B was admitted to CADS treatment services and the Cultural Diversity Program in February 2008. Client B began services in Detox, followed by Residential treatment and the Halfway House. Client B currently resides at the Residential Correctional facility. Client B's primary Cultural Diversity Case Manager has been extensively involved in her treatment episode consisting of individual sessions and assistance with needs outside of treatment. Such assistance has included but is not limited to: shopping for personal care items and job required attire, searching for and applying for jobs, arranging transportation for dental appointments at the University of Iowa, communicating with a Lutheran Services worker for visitation time for the client and her children, getting a local bus schedule, connecting the client to Vera French Mental

Health Services, connecting the client to Career Assistance Center to obtain her GED, teaching the client how to use local resources such as Social Security office to obtain another card, budgeting financial expenses, supporting the client with probation involvement and appointments, explaining court orders, and connecting the client to Edgerton Women's Health Clinic. Client B's most recent involvement with CADS has included sessions with her primary Case Manager and participation in the Thursday evening Cultural Diversity group. Client B has utilized services to address personal issues. However, client has also regressed on several occasions by not attending groups, struggling with substance using thoughts, being afraid to ask for help, and not following some of the rules at the Residential Correctional Facility (RCF). Most recently, Client B's Case Manager has met with the RCF Counselor to address the client's lack of responsibility and motivation. Client B's Case Manager continues to actively support sobriety, positive decision making, and establishment of constructive connections to community partners and resources.

Quarter 2: During the past quarter, Client B's Case Manager continued to actively support sobriety, positive decision making, and establishment of constructive connections to community partners and resources. Client B's Case Manager observed some visible regression by the client during the reporting period, but the client appears to be resuming more responsibility once again. Client B has resumed regular individual sessions with the assigned Case Manager. Client B's drug testing indicates that she has remained clean. Client B was laid off from her employer and is currently job seeking. She has been assisted in job leads and transportation by Program staff. Client B has followed through with mental health appointments with encouragement and transportation assistance by the assigned Case Manager.

Quarter 3: During the past quarter, Client B was successfully discharged from the Center and CCTP. Client B chose to discontinue services due to relocating out of the area. In her last group, Client B identified her Case Manager as someone she knows she can contact if she needs guidance or help.

### **Client C**

Client C began Detoxification at CADS in January 2009, and was self-referred. He completed the Short-term Residential Program in February 2009, was discharged from Country Oaks Residential Treatment and began attending four Continuing Care Groups weekly at the Fairmount Outpatient facility. Based on his non-verbal and verbal behaviors, Client C appears to be refraining from the use of substances and working on his recovery. Overall, Client C remained an active participant in Continuing Care; however, he relapsed in the spring of 2009, with Detoxification stays in April and May 2009. During this client's treatment, the primary case manager provided numerous interventions and services to the client. Client C was assessed for Access to Recovery Services and with these funds has received eye care assistance, clothing, housing assistance, and bus transportation. In addition, the client was assisted with the services including, but not limited to: obtaining his photo ID and social security card, transportation for IQ and mental health testing for social security, accessing food pantries, finding missionary dinners, locating suitable housing, and transportation to appointments. Client C was discharged on 07/01/2009 due to no longer being interested in services at this time.

**Client D**

Client D began Outpatient Services at CADS in January 2009, referred due to legal charges. Client D successfully completed Outpatient Treatment in February 2009 and was transferred to Continuing Care. Overall, Client D remained an active participant in Continuing Care, however she began spiraling downward in recovery with temptations surrounding interactions with a former using acquaintance. The client struggled being forthcoming about dynamics in her life and relapsed in April-May 2009. Client eventually identified willingness to enter Detoxification in May 2009 and successfully completed the Short-Term Residential Program. The client entered the Halfway House in June where residency currently continues. During Client D's treatment, the primary case manager provided numerous interventions and services to her. Client D was assessed for Access to Recovery Services and with these funds has received employment counseling services through Technology Now, eye care assistance, clothing, and bus transportation, all of which was coordinated and/or provided through her case manager. In addition, the client has received van transportation assistance, life skills coaching, and emotional support related to various community appointments for needs ranging from health care to employment. Client D and the case manager have also been working on anger management and grief issues, utilizing various exercises from curricula obtained.

## **EFR/Urban Dreams Case Studies**

### **Client A**

Client A came into the program on July 11, 2008 after 30 days in the Polk County jail. He completed his treatment plan with goals such as: identifying relapse triggers; having healthy relationships; and regaining his spirituality. He successfully completed his treatment plan, appears to be much happier, and has remained substance free. He graduated from the program and is currently scheduled to get married in November 2008. This young man worked very hard while in treatment. He returns and visits two times a week and noted that he will continue to attend group. He has completed his after-care plan and will start that on October 21, 2008.

**1/15/09 update:** Client A continues to remain sober and is now in continuing care. He has gotten married and attends his after-care sessions on a regular basis. He is still involved with the Access to Recovery (ATR) program and is doing well.

### **Client B**

Client B came into the program on July 16, 2008 with his initial evaluation at EFR, and had his initial treatment orientation at Urban Dreams on August 11, 2008. He is now nearing his graduation from the program. This young man came in with a lot of issues that he wanted to address. In his treatment plan he indicated that he wanted to work on Family Relationships/Healthy Relationships and getting his driver's license, as well as staying substance free. He talked about needing someone to listen and to understand how he felt and what he was going through. Since Client B has been involved in treatment he talked about not knowing his father, and wanting to find him just so that he could ask why. During the time he talked about this he had started working on getting his license back. He came in one day just to stop by to let me know that he had taken his written test. He came in very happy and shared the paper that informed me that he had a passing score on the written test. He called me the next day and noted that he could take the driver's test if he had a vehicle that he could use to drive. We found him a ride and a car that he could use.

During his next session he came in smiling; very happy. He reached in his pocket and brought out his new driver's license. Then he noted that he had thought about his father because when he went to get his license they thought he was his father (client is Jr., and his father is Sr.). As a result, he was able to get the city that his father lives in. This young man had not seen his father for 17 years. He wrote a letter and sent it to the Illinois police department and they delivered the letter to his father. In the letter he gave his phone number, and the day that the letter was delivered, his father contacted him by phone.

This young man has done a lot of work toward his recovery. He noted that he when heard from his father he felt "anger, sadness, frustration, and worry". After he got his driver's license he and his family drove to Illinois to meet his father, and, when he finally met him, he could not get angry. Instead, the anger, frustration, and other negative feelings vanished. He now talks to his father 2-3 times a week as he continues to do well in his recovery. His graduation is scheduled for November 11, 2008.

**1/15/09 update:** Client B was unsuccessfully discharged on November 5, 2008, and is currently incarcerated. This is not on new charges but old charges for which he still had to serve time.

### **Client C**

Client C just recently graduated successfully. He came in with a very high level of cocaine in his system (above 54,000ng). He used again during the time that he was here and his blood level increased to 68,000ng. After letting him know that it is his choice but this is a drug free program and from other means of motivation, he seemed to begin to understand how using has caused many problems in his life. He was able to watch the levels decrease and he reported feeling much better without using. He was facing five years in prison. I was able to attend his sentencing and was called as a witness as to how he was doing in the treatment process. I explained the motivational therapy that is being used and how his levels decreased over a period of time and how he has been clean for over two months. This young man received probation. He continues to attend group even though he has graduated and he is now in after-care at Urban Dreams.

### **Client D**

Client D was referred to the program and graduated successfully. When he came in he was unemployed and homeless, living in a box behind the Wilke House. He attended treatment as scheduled and was on time for each of his sessions. He reported that he at first didn't think that he was going to get anything out of the program, but he kept coming. He worked hard while in the program and remained clean and sober during treatment. Today he is still clean, sober, working at Bridgestone and in his own apartment. He checks in with his counselor at least once a week to let him know that he is doing well.

### **Client E**

Client E has had very good success. She came into the program and was not sure if she could remain clean from "crack" cocaine. She entered the program with goals established, but did not know how she was going to reach those goals. As she worked through the program, she began to follow through with recommendations and her treatment plan. She began attending meetings and reaching out to others. She struggled with helping others and not taking care of herself. It was explained to her that this is a selfish program and if she did not begin to take care of herself, there was a possibility of her returning to her old way of thinking as well as her old way of living. She did a very good job. She completed her treatment plan substantially.

Client E was living with her daughter and she saw that if she did not get a place of her own that she could possibly be back to using due to things that were going on within the home. She moved out of her daughter's house and moved into her son's house temporarily. This appeared to be good for her. She was now away from things that could have led her back to where she was with her using. She got in touch with her spirituality and began going to church on Wednesday and Sunday. She found employment, is currently employed, and is a part time student at DMACC.

### **Client F**

Client F is the second client that is having good success. She came into the program just recently for using and other activities that she was involved in. She completed her treatment plan and included in her treatment plan was a goal for her to go back to school. She has completed that goal and is now enrolled in DMACC. She is gainfully employed and is attending school.

### **Client G**

Client G came into the program on his own. He seemed very sincere about wanting to get and remain sober. At the time Client G came into

the program he was homeless and unemployed, living at Bethel Mission. We knew he was sincere because he attended every session that he was scheduled for. Client G came in in the contemplation phase. After being in the program for approximately six weeks, Client G came in and let us know that he had accomplished two of his goals. Those two goals were to get a job and get himself a home. He began working at Goodwill, working for minimum wage. He reported that the manager there also gave him a home. Client G worked hard to maintain his sobriety. He attended meetings (AA/NA) on a regular basis. He came back to Urban Dreams on the 13th of July to let us know that he is still clean and sober and is doing well. He continues to grow in leaps and bounds. He was recently in the Register in an article that was about the jobless rate. He was purchasing a shirt so that he could go to another job interview that would pay him more than his current job. Client G has come a long way, and he continues to take care of himself and his sobriety.

### **Client H**

Client H came into the program due to his alcohol use. Client H came in in the pre-contemplation phase. He was adamant about not having a problem with alcohol. He came in faithfully for his appointments and listened attentively in group. One day Client H spoke up and acknowledged that he could not drink, because drinking always causes him problems. This was when Client H entered the contemplation phase. As he went through this phase he worked hard on his treatment plan. He was unemployed and one of his goals was to obtain gainful employment. He was referred to Urban Dreams' Ex-Offender program. Through this program he was able to apply for a job at Firestone. Client H was also referred to the ATR program. Client H got the job and was able to get work boots and other clothing to start the job. In the interim, Client H was staying with a friend, but was able to get his own home while completing the treatment program. Client H was in the maintenance phase when he completed the program. He continues to do well and he remains substance free. He contacts Urban Dream occasionally to let us know that he is still clean and sober.

## **Jackson Recovery Centers Case Studies**

### **Client A**

Quarter 1: R.G. is a 48-year-old Hispanic, Spanish-Speaking male from Mexico. He presented for an evaluation following an OWI Charge 2<sup>nd</sup> offense, for which he is currently on probation. At the time of his evaluation he reported that the very first time he drank alcohol was at the age of 37, and that his alcohol intake was minimal. He denied any physical or mental health issues or concerns; although he did mention having feelings of guilt because when he was pulled over by the police and charged with DUI he had his 3 year old son with him and was charged with child endangerment. He reported a willingness to comply with treatment recommendations if treatment was necessary. It appeared that his potential for continued use was high at this time. RG also reported that at the time of the evaluation he was living with his wife but their relationship was not a good one. He identified his treatment goals as wanting to pay his fines and finish all the requirements to get his driver's license back.

On February 28, 2008 RG completed an update of the assessment done on October 21. At this time he reported that he had been unable to follow through with the recommendations of the original assessment due to lack of communication. He also reported that everything was the same except at this time he identified his treatment goals as wanting to be done with his legal charges and stop drinking.

RG began his treatment episode at the Extended Outpatient level of care on March 4, 2008. It was recommended that individual sessions on a weekly basis would be most beneficial for this patient, and the patient was in agreement. While at this level of care, he helped developed his treatment plan and identified his problem as "drinking and driving," and identified his long term goal as "stop drinking and complete his treatment successfully." He has done well with addressing various concerns, including minimal knowledge of triggers and coping skills, chemical dependency, reasons behind his alcohol use and relapse prevention. His attitude in treatment has been positive and his attendance has been excellent. He has worked on the "My Personal Journal" workbook which has helped him learn and understand the 12 steps and also address other issues like his feelings, his triggers and his coping skills. RG has gained much insight into his alcohol abuse and has developed very good coping skills. He is currently working on his relapse prevention packet and life management packet.

Currently RG is employed full time, is paying off his legal fines and has done everything that his probation officer and the law required him to do. He has completed the drinking and driving course as well as the victims of drunk drivers course. He is doing a fantastic job working his program to his benefit.

Quarter 2: RG continues to make excellent progress and since November 2008 has completed his relapse prevention packet. In doing so, he has successfully completed his primary treatment. On December 3, 2008 his level of care was changed from Extended to Continuing Care to reflect his progress in treatment. RG has now gained his driving privileges back, has paid his fines and continues to be employed full time. RG is now in the maintenance stage of change and is working on preventing going back to his old attitudes and actions as well as continuing to change and positively evolve. He reports that he wants to move on with his life and be a productive person so that he can be an example for his kids

Quarter 3: RG's attitude in treatment continued to be a positive one with excellent attendance. RG continued to work on the "My Personal Journal" workbook, which helped him gain further understanding of the 12 steps and address other issues.

Quarter 4: RG was successfully discharged on March 17, 2009. He participated in his discharge planning and also completed his transitional care plan. RG continues to be involved with DHS and is now starting parenting classes as his social worker is working towards unsupervised visitation with his kids. RG continues to be employed full time, has paid off his legal fines and has done everything that his probation officer and the law required him to do. RG has also regained his driving privileges and is doing fantastic.

On or about July 23, 2009, RG reported that he was doing well. He completed his parenting classes, is able to see his kids unsupervised and is no longer involved with DHS. He reported that he continues to work full time and that he was looking forward to spending more time with his kids during the summer. He did mention that he and his wife were in the process of getting a divorce but was in agreement with her that this was the best for all. RG overall reported being sober and well.

### **Client B**

Quarter 1: HF is a 22-year-old, Hispanic, Spanish and English speaking male from Mexico. He was referred for an evaluation by his Social Worker as his kids were removed from his care and home due to suspicions of him using illicit drugs. He presented for his evaluation on October 18, 2008. He reported that he started using marijuana at the age of 15 and used 2-3 times on the weekends and at times during the week as well. He also reported alcohol use starting at the age of 15 and drinking on the weekends about three beers. At the time of the evaluation he did test positive for THC. He denied any physical or mental health concerns but did report being sad at the time due to his kids being put in foster care because of his using. HF also reported that he and his wife did have a history of marriage counseling as their relationship was not working out. He felt that he did not need treatment but was willing to follow recommendations. He identified his treatment goals as "get my children back."

HF was admitted to Connections Group on October 22, 2008. He completed connections group and was admitted to Extended Outpatient services on February 4, 2008. It was recommended that individual session on a weekly basis would be most beneficial for this patient. While at this level of care, he was involved in developing his treatment plan and goals. He identified that the problem was "I don't have my kids because I smoked marijuana" and his long term goal was to "get my kids back." He has done well addressing various issues and concerns, including the nature of his substance abuse, relapse prevention, coping skills and the reasons behind his substance use. He also explored in detail his relationship with his wife and the feelings that went along with that and how that contributed to his use. He learned how to cope with those feelings and how to process them to benefit him and his kids. He completed assignments on spirituality, feelings, relapse prevention, and life management skills. He had excellent attendance and completed his assignments on a timely manner and his attitude towards treatment was a positive one.

On June 6, 2008 HF successfully completed his primary treatment and was moved to Continuing Care Services. He successfully met his long-term goal and was able to get his kids back from foster care and is currently living with them. He continues to do very well and continues to be clean and sober. He comes for an individual session once every 2-3 weeks for support as he continues to deal with his legal issues.

Quarter 2: HF continues in the Continuing Care level of care comes for individual sessions on a monthly basis. HF is in the maintenance stage of change, continues to do well and is keeping clean and sober. HF continues to live with his kids and is doing well in this area. HF continues to keep in touch with his social worker and all the people that are working on his legal/immigration situation. HF continues to keep a very positive outlook and attitude.

Quarter 3: HF has completed assignments on spirituality, feelings, relapse prevention, and life management skills. HF had excellent attendance and completed his assignments in a timely manner. His attitude towards treatment was a positive one.

Quarter 4: On March 12, 2009, HF was successfully discharged from treatment. He participated in his discharge planning and also in formulating his transitional care plan. HF successfully met his long-term goal and was able to get his kids back from foster care and is currently living with them. HF is doing very well.

On or about July 8, 2009, HF called briefly to report how he was doing. He reported that he was doing really well. He was in the process of getting his GED and was doing his final test on August 7<sup>th</sup>. He reported that now he and his wife now have joint custody of the kids and that he was okay with that. Overall, he reported being clean and sober and moving forward with his future plans.

## **APPENDIX D: Program Marketing Materials**

Center for Alcohol and Drug Services Program Brochure	67-68
Employee and Family Resources Program Flyer	69
Employee and Family Resources Program Information Sheet	70

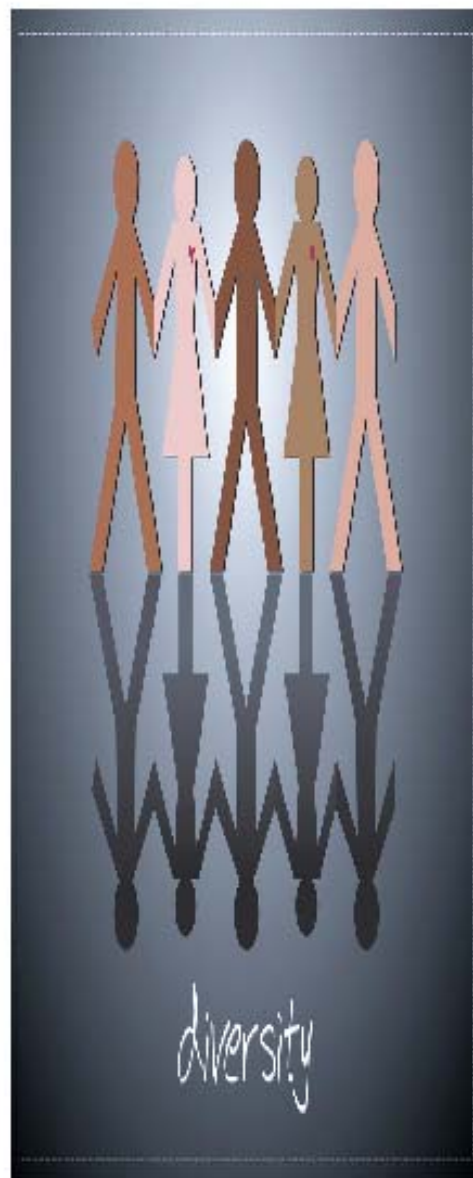
NOTE: Jackson Recovery Centers' advertising brochure is available in hard copy from the agency.

## Cultural Diversity Program

**Our Purpose:** To sustain treatment involvement of underserved and diverse populations. We are specifically targeting the African American and Hispanic populations in our Iowa based treatment programs. These populations have specific needs that can best be served in a culturally competent environment. Services we offer include but are not limited to the following:

- ♦ Culturally specific substance abuse treatment
- ♦ Interpretation services
- ♦ Education
- ♦ Access to childcare
- ♦ Access to housing
- ♦ Transportation
- ♦ Immigration Assistance
- ♦ Mentoring
- ♦ Daily Living Skills
- ♦ Employment Assistance
- ♦ And referral to an array of other counseling services.

**Our Focus:** To help clients build trust and fully engage in the benefits offered by our treatment services. We are committed to helping clients find suitable housing and will follow our clients for at least six months to continue to address their needs and concerns. This program will continually promote a positive support network through referrals to community based resources and by training Peer Mentors to better integrate clients into drug and alcohol free lifestyles.



Center for Alcohol &  
Drug Services, Inc.

## Cultural Diversity Program



*Fairmount*  
1523 S. Fairmount  
Street  
Davenport, IA 52802  
563-322-2667

*Country Oaks*  
12160 S. Utah



**The Center for Alcohol & Drug Services, Inc.** believes that chemical dependency is a disease which affects individuals emotionally, physically, and spiritually. It can happen to anyone



regardless of age, race, gender, or economic background. Rules for acceptance and participation in the program are the same for everyone

without regard for race, creed, color, national origin, age, sex, disability, religion, political affiliation or ability to pay.

#### **Our Staff**

The Program's staff is comprised of seasoned counselors sharing the similar racial and ethnic backgrounds of the clients we serve. Therefore, this staff has the unique advantage of understanding substance abuse as not only a community issue but also a cultural phenomenon.

#### **Our Mission:**

The CENTER is a private, non-profit corporation established to provide substance abuse prevention, assessment, treatment, referral services for individuals, groups and organizations in Eastern Iowa and Western Illinois, through a combination of private and public funds.

## **Benefits of the Program**

**Research indicates** that Hispanics and African Americans access fewer health care services and are more likely to disengage from treatment services prior to discharge. Barriers these clients have identified include past treatment failures, negative experiences with treatment providers, feelings or perceptions of not belonging, language, and feelings of being intimidated and/or discriminated against by large service systems. Our goal is not only to serve the identified populations but to become active in their communities and raise awareness about substance abuse related issues.

**Chemical dependency** is a disease which affects individuals emotionally, physically and spiritually. It can happen to anyone regardless of age, race, families, gender or economic background. We at the CENTER are intimately aware of the nuances and demands of those seeking recovery. Striving to serve those in need and to maintain involvement in recovery related activities will be our aim.



*Recovery is not a destination.  
It is a journey.*



For help today, Please call

563-326-1150

or

563-322-2667



### **SUBSTANCE ABUSE TREATMENT SERVICES**

Employee and Family Resources, in collaboration with Urban Dreams, is providing substance abuse assessments, treatment, and case management services to African American clients.

These services are provided by culturally sensitive, professional staff at no cost to the client. Funding is provided by the Iowa Department of Public Health.

For more information or to schedule an appointment, please call:

**(515) 243-4200**



**EFR EMPLOYEE & FAMILY RESOURCES**



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**EFR EMPLOYEE & FAMILY RESOURCES**

Employee & Family Resources' Culturally Competent Treatment Project (CCTP) is designed to serve African-American clients who are in need of and meet ASAM criteria for Extended Outpatient level of substance abuse treatment.

Incorporating Motivational Enhancement and Stages of Change principles, the project includes:

- location in the Enterprise community with extended hours
- community outreach to promote the availability of services
- substance abuse assessment and referral
- identification of wraparound (ancillary) service needs and referral to same treatment provided by
- African-American staff trained in culturally competent approaches to the engagement and treatment of clients
- 12 weeks of Extended Outpatient substance abuse treatment (group and individual)
  - group modules using cognitive behavioral therapy evidence-based interventions
  - individual sessions with substance abuse counselor
- weekly case management phone contact with a supportive case manager for 6 months, starting at initial assessment and continuing through successful discharge and thereafter

### Community Outreach

The Black Ministerial Alliance and the Polk County Board of Health Advisory Committee were made aware of the availability of culturally competent services to African-American clients in Des Moines. Client flyers were developed for distribution in waiting rooms or other common areas where potential clients might see them.

### Substance Abuse Assessment and Referral

Professional substance abuse assessment services are provided by African-American substance abuse counselors who have been trained in culturally competent approaches to the engagement and treatment of clients. These assessment services are located in the Enterprise Community to help potential clients access services. The initial assessment is conducted by the same counselor who will continue to have weekly phone contact throughout the client's treatment and program involvement.

### Wraparound Needs Assessment

A thorough assessment of ancillary service needs (transportation, housing, medical, parenting, recovery support system, etc.) is made when clients begin treatment, and appropriate referrals to community resources are facilitated. By helping clients get assistance in other life areas, potential obstacles to full engagement in the treatment process are eliminated, and clients' likelihood of successful treatment completion increases.

### Extended Outpatient Treatment

Primary treatment is 12 weeks long and includes both group and individual components. Treatment goals are established at the beginning of treatment, and individualized to best meets each client's unique needs.

Structured group modules incorporate evidence-based cognitive behavioral interventions, and are designed for group sessions 1 – 1½ hours long. Individual weekly sessions with primary treatment counselor are also scheduled, and may include further exploration of group work if appropriate, or other work in support of individualized treatment plan.

### Weekly Case Management

Starting at the time of initial assessment and continuing for six months thereafter, this weekly phone contact is conducted by the same counselor who welcomed the client into the Culturally Competent Treatment Project (CCTP). This counselor provides supportive weekly phone contact in addition to and separate from the primary treatment counselor.

Combined with 12-Step group involvement and continuing care/aftercare activities, this weekly contact is a useful adjunct to primary treatment.