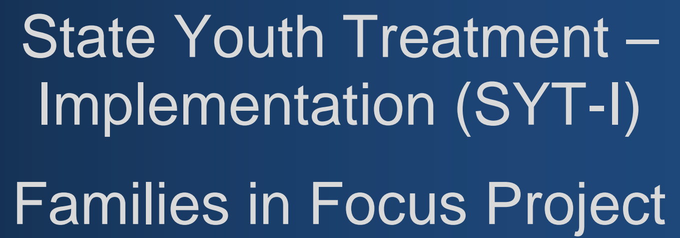

THE IOWA CONSORTIUM FOR SUBSTANCE ABUSE RESEARCH AND EVALUATION

Annual Report
Year One
October 2016

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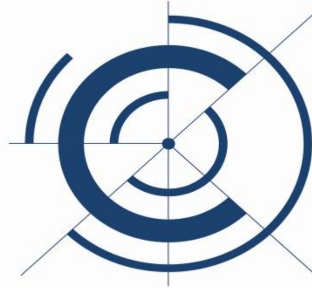

State Youth Treatment – Implementation (SYT-I) Families in Focus Project

Year One Annual Evaluation Report

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EXCUTIVE SUMMARY

In October 2015, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded the Iowa Department of Public Health (IDPH) a three-year grant to implement the State Youth Treatment – Implementation (SYT-I) Families in Focus project. The purpose of SYT-I is to expand and enhance evidence-based treatment and recovery support services for substance use disorders and/or co-occurring disorders among adolescents (ages 12 to 17) and transitional aged youth (ages 18 to 25), and their families. The SYT-I Families in Focus project expands on the efforts of the State Adolescent Treatment Enhancement Dissemination (SAT-ED) Families in Focus project in Iowa, also funded by SAMHSA from October 2012 through March 2016.

The four SAT-ED Families in Focus providers will continue participating in the SYT-I Families in Focus project: Heartland Family Services (Heartland) in Council Bluffs; Prairie Ridge Integrated Behavioral Healthcare (Prairie Ridge) in Mason City; Prelude Behavioral Services (Prelude) in Iowa City; and Youth and Shelter Services (YSS), Inc. in Ames.

The SYT-I Families in Focus project has three goals:

- To advance the state in further establishing a coordinated effort to serve adolescents and their families.
- To expand and enhance youth and family treatment for an additional 240 adolescents and transitional aged youth (TAY). Iowa will serve 60 adolescents/TAY in Year One, 80 adolescents/TAY in Year Two, and 100 adolescents/TAY in Year Three.
- To improve outcomes for adolescents, transitional aged youth, and their families.

The project will expand evidence-based treatment options and enhance treatment service delivery by assuring greater access to recovery support services for adolescents, transitional aged youth, and their families. Treatment providers will continue to offer multi-dimensional family therapy (MDFT) to high-risk youth and their families. Motivational enhancement therapy/cognitive behavioral therapy (MET/CBT) was added as a treatment option to serve a greater number of adolescents and TAY who need more flexible treatment options or for those who do not meet the MDFT eligibility requirements for family involvement. Prior to treatment, providers administer an assessment tool to identify whether a client is suitable for treatment. Potential clients ages 12 to 17 receive the Comprehensive Adolescent Severity Indicator (CASI). Providers can use any approved IDPH assessment tool for clients ages 18 to 25.

Treatment providers have exceeded their Year One goal of admitting 60 clients into the grant by 30 clients. The follow-up rate is above the minimal threshold as defined by SAMHSA. At the end of data collection for Year One there were 56 discharges, 64.3% successfully completed treatment.

Admissions by Treatment Type and Agency

Treatment Type	Totals	Heartland Family Services	Prairie Ridge	Prelude Behavioral Services	Youth & Shelter Services
MDFT	34	21	0	0	13
MET/CBT	56	10	23	21	2
Totals	90	31	23	21	15

GPRA Follow-up Interviews by Treatment Provider

GPRA Follow-up Interviews	Grant Totals	Heartland Family Services	Prairie Ridge	Prelude Behavioral Services	Youth & Shelter Services
Due	31	21	3	0	7
Completed	26	19	2	0	5
Rate	83.9%	90.5%	66.7%	NA*	71.4%

*As of August 31, 2016, Prelude Behavioral Services did not have any clients due for follow-up.

Discharge Status by Treatment Provider

Discharge Status	Totals	Heartland Family Services	Prairie Ridge	Prelude Behavioral Services	Youth & Shelter Services
Completion/Graduation	36	8	12	14	2
Termination	20	8	4	4	4
Total Discharges	56	16	16	18	6
Success Rate	64.3%	50.0%	75.0%	77.8	33.3%

The Iowa Consortium for Substance Abuse Research and Evaluation (Consortium) conducts the evaluation for the SYT-I Families in Focus project. This report presents results from September 30, 2015 through August 31, 2016.

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BACKGROUND

In October 2015, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded the Iowa Department of Public Health (IDPH) a three-year grant to implement the State Youth Treatment – Implementation (SYT-I) Families in Focus project. The purpose of SYT-I is to expand and enhance evidence-based treatment and recovery support services for substance use disorders (SUD) and/or co-occurring disorders among adolescents (ages 12 to 17) and transitional aged youth (ages 18 to 25), and their families. The SYT-I Families in Focus project expands on the efforts of the State Adolescent Treatment Enhancement Dissemination (SAT-ED) Families in Focus project in Iowa, also funded by SAMHSA from October 2012 through March 2016.

The four SAT-ED Families in Focus providers will continue participating in the SYT-I Families in Focus project: Heartland Family Services (Heartland) in Council Bluffs; Prairie Ridge Integrated Behavioral Healthcare (Prairie Ridge) in Mason City; Prelude Behavioral Services (Prelude) in Iowa City; and Youth and Shelter Services (YSS), Inc. in Ames.

The SYT-I Families in Focus project has three goals:

1. To advance the state in further establishing a coordinated effort to serve adolescents and their families:
    - Hiring a state adolescent treatment/youth coordinator to develop state infrastructure to support youth or family members of youth with SUD at either the policy or program levels.
    - Strengthening the Interagency Council by recruiting representatives from various organizations in the community to serve on the council, developing financial maps, implementing a state-wide workforce development plan, and participating in infrastructure reform.
    - Developing the Substance Abuse Financial subcommittee and identifying new financial resources and coordinating finance sources through financial mapping.
    - Developing new or modifying at least two existing state policies and procedures which affect the population of focus, this includes: 1) developing state standards for licensure/certification/credentialing of professionals and paraprofessionals who serve the adolescent population; and 2) developing a Financial subcommittee and collaborating with managed care organizations (MCO's) to work towards reimbursement of EBP; identifying new financial resources and coordinating finance sources through financial mapping; and finding ways to use existing resources more efficiently and effectively.
    - Strengthening and enhancing the provider collaborative. This includes a monthly provider call to identify and address administrative challenges, as well as continuing to certifying staff in MDFT, MET/CBT, and use of the CASI and the GPRA.
2. To expand and enhance youth and family treatment for an additional 240 adolescents and TAY:
    - Increasing evidence-based youth, family, assessment and treatment by continuing to provide MDFT and adding the MET/CBT treatment option as well as recovery support service options. The goal is to serve 60 adolescents/TAY by the end of the first year, 80 by the end of the second year, and a 100 by the end of the first year.
    - Increasing minority referral and treatment by expanding outreach and community support services.

- Improving workforce development by training 18 MDFT therapists each year (54 total), two MDFT trainers (6 total), 30 MET/CBT therapists (90 total), 10 MET/CBT trainers, and 30 CASI therapists (90 total).
- Using the workforce map to recruit, prepare, and retain a qualified workforce to serve adolescents. Activities include working with local colleges to prepare faculty in appropriate college and education settings to deliver curricula that focuses on adolescents and TAY specific SUD evidence-based practices (EBP); improving state licensure standards; offering online training for CASI; and implementing Feedback Informed Treatment (FIT).

3. To improve outcomes for adolescents, TAY, and families:
   - Participants will maintain program completion rates at a minimum of 75%.
   - A minimum of 80% of adolescents and TAY will report increased rates of abstinence, enrollment in education, vocational training or employment, social connectedness, and decreased criminal and juvenile justice involvement.
   - Six-months post-discharge, 75% of adolescents, TAY and participating family members will report improved family functioning in family interactions, mental health, peer relations, and reduced substance use (SU).
   - In partnership with the Consortium, IDPH and providers will strengthen outcome measurements by developing tracking forms in order to track specific, meaningful outcomes for all MDFT and MET/CBT clients and their families.
   - Continuing to share the outcomes of this project each year at the Annual Governor's Conference on Substance Abuse and as requested by other groups.

The project will expand evidence-based practices (EBP) and enhance treatment service delivery by assuring greater access to recovery support services for adolescents, transitional aged youth and their families. Treatment providers will continue to offer multi-dimensional family therapy (MDFT) to high-risk youth and their families. MDFT is widely recognized in the United States and abroad as an effective science-based treatment for adolescent SUD, delinquency, and school problems.[1] Iowa originally selected MDFT because it has been shown to be an effective treatment for 12 to 18-year-old youth with co-occurring SU and mental health problems, thereby addressing Iowa's gap in service for this population. Furthermore, MDFT has validated success with different genders, ethnic minorities, and youth involved in the criminal justice system.

MDFT is a family centered treatment approach that addresses substance abuse, delinquency, antisocial and aggressive behaviors, school and family problems, and emotional difficulties. The objectives of MDFT are to engage adolescents and their families and motivate them to enter and complete treatment, enhance family functioning, employ methods that focus on adolescent drug use and dependence, improve school performance and relationships with school personnel, promote prosocial alternatives to delinquent behavior, strengthen family stability, and reduce mental health symptoms.[2] Treatment can last anywhere from three to six months and the intensity of the sessions are determined by the adolescent and the family; successful completion of MDFT can be delivered across a flexible series of 12 to 16 weekly or twice weekly 60 to 90 minute sessions.

Motivational enhancement therapy/cognitive behavioral therapy (MET/CBT) was added as a treatment option to serve a greater number of adolescents and TAY who need more flexible treatment options or for those who do not meet the MDFT eligibility requirements for family

[1] Brannigan, R., Schackman, B.R., Falco, M., & Millman, R.B. (2004). The quality of highly regarded adolescent substance abuse treatment programs. Archives of Pediatrics and Adolescent Medicine, 158, 904-909.
[2] http://www.mdft.org/MDFT-Program/What-is-MDFT

involvement. The MET sessions focus on factors that motivate clients to change while the CBT sessions teach clients the skills to cope with problems and meet their needs in ways that do not involve turning to SU. MET/CBT is a brief but effective treatment option and can be provided in a variety of treatment settings to adolescents that may not have a family member that is able to participate in treatment, however, family members are welcome to participate. MET/CBT can be delivered in either five sessions or 12 sessions, which include both individual and group sessions for teens and young adults. The initial two sessions are individual sessions and focus on Motivational Enhancement Therapy (MET) while the remaining sessions are group sessions and incorporate Cognitive-Behavioral Therapy (CBT).

In Year 1, SAMHSA approved the provision of MET/CBT in residential treatment. Therapists agree both residential and outpatient clients receiving MET/CBT follow the same curriculum regardless of the level of care. However, residential sessions are often completed at a quicker pace. If the client is discharged before the clinician is able to complete the curriculum, the opportunity to continue with MET/CBT on an outpatient basis is available. While the curriculum remains the same in residential treatment, there are more opportunities to engage than on an outpatient basis. Therapists are able to encourage, challenge, and educate clients further in residential treatment. Therapists are also able to collaborate with a client's counselor, inform them on their engagement in the sessions so they can use the information and apply it to their individual sessions and treatment plans, which can aid in the success of goal setting. Motivational Interviewing (MI) is a collaborative conversation style for strengthening a person's own motivation and commitment. During MI, clients can recognize the difference between where they are on their treatment path and where they would like to be. It is particularly helpful in the early stages of treatment when determining the individuals' functional level and goals. The principles of MI are consistent with strongly held values of recovery, cultural competency, and self-determination. MI was selected as an additional level of support because it is both shown to achieve good outcomes for adolescents and TAY and it can used regardless of family participation in therapy.

Prior to treatment, providers administer an assessment tool to identify whether a client is suitable for treatment. Potential clients ages 12 to 17 receive the Comprehensive Adolescent Severity Indicator (CASI), which is a semi-structured clinical assessment and outcomes interview. The CASI was selected because of its completeness and ease of delivery. It is comprised of independent modules, each incorporating objective, focused, and concrete questions. Questions are formatted to identify whether certain behaviors have ever occurred, whether they occur regularly, how old the adolescent was when they occurred, and whether they occurred regularly during the past year (past month and other 11 months). Interview questions include health, family, stressful life events, legal status, sexual behavior, alcohol and other drug use, mental health functioning, peer relationships, education, and use of free time. In addition to collecting information on risk factors and maladaptive behaviors, the CASI also includes questions designed to assess the strengths of the youth. Providers can use any approved IDPH assessment tool for clients ages 18 to 25.

Recovery Support Services (RSS) are a way to enhance treatment delivery and are available to adolescents, TAY, and their families. Services available during Year One include:

- Behavioral Health Assessment/Consultation – to help clients and family members cope with immediate stressors, identify and utilize available resources and strengths, and return the client/family to their usual functioning level
- Celebrating/Strengthening Families
- Child Care

- Crisis Respite
- Drug Testing
- Drug Testing Incentive Gift Card – based on the number of consecutive negative drug test screens
- Education/Vocational Training
- Electronic Recovery Support Messaging – messaging in the form of text messages
- In-Home Services – designed to assist clients in their recovery by having a therapist come into their home to provide support
- Life Skills Coaching – to help clients make informed decisions, communicate effectively, and develop self-management skills to assist in their recovery
- Pharmacological Interventions
- Sober Living Activities – e.g. organized community recovery events, fitness memberships, recreational activities and educational supports
- Supplemental Needs – gas cards
- Transportation – bus cards

DATA COLLECTION PROCESS

Evaluators obtained data from several sources for this report:

- Government Performance and Results Act (GPRA) instrument at admission, discharge, and six-months post-admission (follow-up);
- Treatment admission data from IDPH's Central Data Repository (CDR);
- Various additional forms from treatment providers and IDPH to the Consortium;
- Meeting notes and agendas;
- Key informant interviews;
- Site visit reports;
- MDFT web-based clinical management system.

Client level data across the GPRA, CDR, and forms provided to the Consortium are linked by a unique client number. Grant admissions began on October 22, 2015. Data presented here are through August 31, 2016. Unless otherwise noted, client level data are from the GPRA interviews conducted at admission, follow-up, and discharge.

Government Performance and Results Act (GPRA)

Client Level

Treatment providers administer the Government Performance and Results Act (GPRA) services instrument to clients at grant admission, six-months post-admission (follow-up), and at grant discharge. They enter the GPRA data into the Iowa-Service Management and Reporting Tool, Web Infrastructure for Treatment Services (I-SMART WITS). These records are batch uploaded into the United States Department of Health and Human Services CSAT – GPRA Services Accountability Improvement System (SAIS). Admissions data from October 22, 2015 to August 31, 2016 were retrieved from SAIS on September 9, 2016.

Agency Level

Additionally, treatment providers attending EBP training also submit GPRA best practice satisfaction surveys to the Consortium. The trainees submit a baseline survey immediately following a training and 30 days following the training. The Consortium enters these surveys into SAIS.

Central Data Repository (CDR)

The Consortium used treatment admission data from IDPH's Central Data Repository (CDR). The treatment providers report these data directly to the CDR. The CDR contains all of the state required SUD treatment and admission data in Iowa. For this report, the evaluators retrieved data from the CDR on September 29, 2016 for clients admitted into the grant during Year 1.

Data Supplied to the Consortium

Client Level

Treatment providers furnish several forms about the client to the Consortium. At grant admission, providers send an intake notification form. This form provides additional information about the client including GPRA information, intake date, the treatment option selected, and information regarding family members or other adults anticipated to participate in treatment with the client.

At discharge from grant services, treatment providers submit a discharge notification form to the evaluators. The discharge notification form provides information about completion of treatment, confirmation of the treatment option(s) provided, screening information for a co-occurring diagnosis, the number of sessions completed by the client, and participating family member or other relevant adult.

Approximately six months following grant discharge, treatment providers administer the Client Global Outcomes Measures (GOM) to SYT-I clients. Providers also administer a Family GOM to family members participating in MDFT. Treatment providers have two weeks before the six-month post-discharge date and 28 days after that date to complete the GOM. The questions on the survey ask about changes in the client related to general behavior, family interactions, SU, mental health, and peer relations to determine if there is improvement. Questions about the convenience of attending treatment sessions, satisfaction, and consideration of cultural needs are also included.

Each month treatment providers report the previous month's use of RSS for their clients. RSS are vouchers provided to clients to reduce barriers to treatment and aid in recovery.

Organizational Level

In addition to client level forms, the Consortium obtains organization level data from treatment providers and IDPH about staff trainings, meetings, and presentations. Each quarter treatment providers update staff EBP training records. Data concerning staff training are current through June 2016. Each month, both treatment providers and IDPH, provide information to the

Consortium concerning grant activities, such as meetings and presentations. These data are through August 31, 2016.

The evaluators use their and IDPH's meeting notes and agendas to aid in the evaluation of grant goals. Depending on the committee, meeting frequency varies between monthly and quarterly. Moreover, IDPH furnished the SAMHSA site visit report and provider site visit reports to the evaluators. The SAMHSA site visit occurred in June 2016. Provider site visits were in May and June of 2016. In particular, these documents aid in the evaluation of grant infrastructure.

Key Informant Interviews

The evaluators conducted key informant interviews over the phone during the month of August 2016. Interviews were conducted among all four designated SYT-I project treatment providers, Adolescent Steering Committee, and Workforce Committee members. Interview participants were selected using purposeful sampling based on the EBP used most often and the amount of clients they have served. Eight therapists and five executive directors/clinical directors from the four treatment providers were selected for provider-level interviews. For committee interviews, four members were selected based on their degree of involvement as well as four treatment provider directors who serve on the committees.

Executive directors from each provider were automatically selected for committee interviews, along with four additional committee members selected based on their degree of involvement within the committees. Interview participants were provided the list of questions before their scheduled appointment. Interviews lasted between 15 and 70 minutes. Participation was voluntary and responses were kept confidential using the following methods: 1) data collected from the interviews is reported in aggregate form, without any identifying information; and 2) electronic interview notes were maintained on secure database and all data will be destroyed after the grant ends. Interview participants were cooperative and provided constructive feedback regarding the project. Respondents were allowed to provide multiple responses to questions, so the numbers referenced in the appendix will not always add up to the total number of respondents. Specific responses to each question appear in the appendix as well as being synthesized and provided in later sections of this report regarding infrastructure.

MDFT web-based clinical management system

The MDFT originators developed a web-based clinical management system (MDFT Clinical Portal). This system is designed to facilitate therapist, supervisor, and therapist assistant fidelity to MDFT, enhance implementation of MDFT, provide a system of monitoring and accountability, and allow MDFT International to provide technical assistance and support. Data from the MDFT Clinical Portal are used to provide MDFT implementation reports at the request of the evaluators.

ADMISSIONS

Grant Admissions

Treatment providers admitted 90 clients into the grant from October 1, 2015 through August 31, 2016. These data are from records submitted to the Consortium. The sample of clients used in this report are based on complete GPRA admission data. As shown in Table 1, this project intends to serve 60 unduplicated clients during Year One. During the first year of the grant, providers exceeded this goal by 30 clients, 150% of the intended target for Year One. A little under two-thirds of the clients are in MDFT. Table 1 displays grant admissions by treatment provider and therapy type.

Table 1. Grant Admissions by Provider and Treatment Type

Treatment Type	Totals	Heartland Family Services	Prairie Ridge	Prelude Behavioral Services	Youth & Shelter Services
MDFT	34	21	0	0	13
MET/CBT	56	10	23	21	2
Totals	90	31	23	21	15

Client Demographics

There are five key demographic variables presented in this section: gender, race, ethnicity, urbanicity, and age. Unless otherwise noted data presented are from the GPRA instrument. Fifty-nine clients (65.6%) are male and 31 clients (34.4%) are female. As detailed in Table 2, 91.1% of the clients identified as Caucasian, 5.6% as African American, 1.1% as Hawaiian/Pacifica Islander, and 2.2% as Multi-racial. Almost 6.0% of the clients reported Latino or Hispanic ethnicity. Clients report their county of residence when admitted to the grant. Of the 99 counties in Iowa, 38 counties are identified as urban counties and 61 are rural counties.[3] Seventy-seven clients (89.5%) reside in urban counties and nine clients (10.5%) reside in a rural county in Iowa. County of residence was taken from the state treatment admission records and matched with GPRA data. Table 2 delineates the frequencies for client demographics at grant admission.

[3] As defined by U.S. Census Bureau, Population Division, Office of Management and Budget, February 2013 delineations.

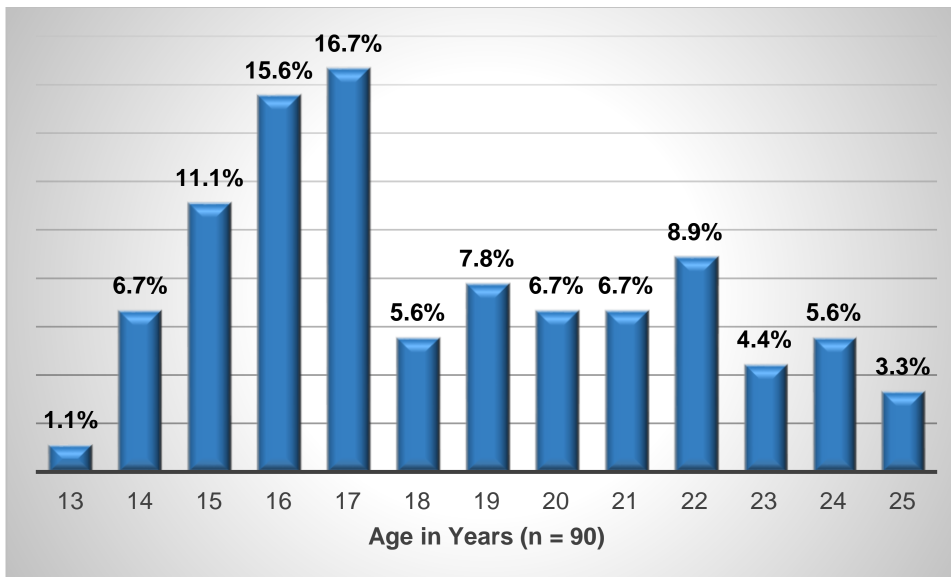
Table 2. Client Demographics

Gender	All Clients % (n = 90)
Female	34.4 (31)
Male	65.6 (59)
Race	**All Clients % (n = 90)**
Caucasian	91.1 (82)
African American	5.6 (5)
Hawaiian/Pacific Islander	1.1 (1)
Multi-Racial	2.2 (2)
Ethnicity	**All Clients % (n = 90)**
Hispanic/Latino	5.6 (5)
Not Hispanic/Latino	94.4 (85)
Urbanicity*	**at Admission % (n = 86)**
Rural	10.5 (9)
Urban	89.5 (77)

*There were four records in the GPRA data that could not be matched to statement records; thus, there are different sample sizes.

SYT-I grant admissions range from 13 to 25 years old with a median age of 17 years. At the close of Year One, 51.1% of the clients are in the adolescent age group (12-17) with a median age of 16.0 years. The 48.9% of the clients are in the transitional age youth group (18-25). Their median age was 21 years. Figure 1 displays the frequencies of clients' age at admission.

Figure 1. Age at Admission



Housing

The majority (60.0%) of SYT-I clients at admission lived in someone else's residence. The next most frequent form of housing (21.1%) was own/rent apartment, room, or house. One client lived in an "other" type of housing, which the client indicated he stayed with his mother. Table 2 displays the breakdown of housing types.

Table 2. Housing

Housing	% (n = 90)
Own/Rent Apartment, Room, or House	21.1 (19)
Someone Else's Apartment, Room, or House	60.0 (54)
Halfway House	2.2 (2)
Residential Treatment	2.2 (2)
Shelter	3.3 (3)
Street/Outdoors	2.2 (2)
Institution	7.8 (7)
Other: Stayed with Mom	1.1 (1)

*Percentages may not total 100.0 because of rounding.

Education and Employment

The most frequently occurring highest level of education finished is 12th grade/high school diploma/equivalent (32.2%). The range of education is seventh grade through bachelor's degree or higher with a median of 11th grade. Thirty-eight of the clients (42.2%) are unemployed and not looking for work. Two clients indicated their current work status as "other." One client stated they would begin working full-time shortly after his intake interview. Another client reported he was working for his grandparents. The majority of clients (53.3%) said they were currently enrolled full-time in school or job training. Two clients specified they were enrolled part-time in school. None of the clients specified a training program. Table 3 contains frequencies for all the response categories for highest level of education, employment, and enrollment in school or job training program.

Table 3. Education, Employment, and Training

Highest Level of Education	% (n = 90)
7th Grade	4.4 (4)
8th Grade	4.4 (4)
9th Grade	15.6 (14)
10th Grade	21.1 (19)
11th Grade	16.7 (15)
12th Grade, High School Diploma, GED	32.2 (29)
1st Year of College or University Completed	2.2 (2)
2nd Year of College or University Completed	2.2 (2)
Bachelor's Degree or higher	1.1 (1)
Employment Status	**% (n = 90)**
Employed Full-time	10.0 (9)
Employed Part-time	16.7 (15)
Unemployed Looking for Work	28.9 (26)
Unemployed Not Looking for Work	42.2 (38)
Other	2.2 (2)
Enrolled in School or Job Training Program	**% (n = 90)**
Enrolled Full-time	53.3 (48)
Enrolled Part-time	2.2 (2)
Not Enrolled	44.4 (40)

*Percentages may not total 100.0 because of rounding.

Substance Use at Admission

At admission, clients are asked about their SU in the past 30 days. The most frequently used substance was marijuana (48.3%) and alcohol was second (36.0%). Marijuana use ranged from one day to everyday in the past 30 days with a median of six days. Alcohol use ranged from one in the past 30 days, to 20 days of the last 30 with a median of two days. Of the clients who drank alcohol in the past 30 days, 11 clients drank five or more drinks in one sitting. Of those who drank alcohol or used illegal drugs in the past 30 days, 12 clients used both alcohol and drugs on the same day. Six clients injected drugs in the last 30 days. One of those six clients replied that more than half of the time they injected drugs in the past 30 days, they had used a syringe/needle, cooker, cotton, or water someone else had used. Two clients reported using other drugs than those listed in the GPRA instrument. One client used non-prescribed drugs (Vyvanse and Adderall). The other client used Vicodin in the last 30 days. Table 4 displays the breakdown SU in the past 30 days.

Table 4. Substance Use in the Past 30 Days

Alcohol and Drugs	% (n)	Total # of Respondents
Binge Drinking (Five or More Drinks in One[a] Sitting)	35.5 (11)	31
Used Alcohol and Drugs on the Same Day[b]	63.2 (12)	19
Injection Drug Use	**% (n)**	**Total # of Respondents**
Injected Drugs in Past 30 Days	6.7 (6)	90
Substance Use	**% (n)**	**Total # of Respondents**
Marijuana/Hashish	48.3 (43)	89
Alcohol	36.0 (32)	89
Methamphetamine	12.2 (11)	90
Heroin	7.9 (7)	89
Other Opiates[c]	4.4 (4)	90
Cocaine/Crack	3.3 (3)	90
Hallucinogens/Psychedelics	3.3 (3)	90
Benzodiazepines	13.5 (12)	89
Tranquilizers	1.1 (1)	90
Inhalants	2.2 (2)	90
Other Illegal Drugs	2.2 (2)	90

Note: Column totals are not equal to the number of records since people report multiple substances and some respondents replied “Don’t Know” or “Refused.”
[a]Only respondents who answered that they drank alcohol at least one day in the past 30 days respond to this question.
[b]Only respondents who answered that they drank alcohol or used illegal drugs at least one day in the past 30 days respond to this question.
[c]Other opiates is a category containing client use of Codeine, Darvon, Demerol, Diluadid, Morphine, Non-Prescription Methadone, OxyContin/ Oxycodone, Percocet, or Tylenol 2, 3, or 4.

Mental and Physical Health

An important aspect of this grant is to better serve clients with co-occurring SUD and mental health disorders. One way the grant intends to provide better services for this population is by screening clients for mental health disorders. During Year One of the grant, all but one client was screened. Seventy-two of the clients screened positive for a mental health disorder. Over half of the clients, have experienced serious depression, anxiety, and were troubled by their mental health issues in the past 30 days not because of their SU. Those encountering depression did so for at least one day to 30 days with a median of 15 days. The range of those facing anxiety was one day to 30 days with median of 14 days. The range of occurrence that clients were bothered by mental health issues was one day to five days with a median of three days. Table 5 gives the frequencies of co-occurring mental health screening and mental issues experienced in the past 30 days not due to SU.

Table 5. Mental Health

Co-occurring Mental Health Screening	at Admission % (n = 90)	
Not Screened	1.1 (1)	
Negative	18.9 (17)	
Positive	80.0 (72)	
Mental Health Issues Experienced In Past 30 Days Not Due to Substance Use	**at Admission % (n)**	**Total # of Respondents**
Serious Depression	53.3 (48)	90
Anxiety or Tension	65.2 (58)	89
Hallucinations	4.4 (4)	90
Trouble Understanding, Concentrating, or Remembering	41.6 (37)	89
Trouble Controlling Violent Behavior	22.2 (20)	90
Attempted Suicide	6.7 (6)	90
Prescribed Medication for Psychological/Emotional Problems	32.2 (29)	90
Bothered by Mental Health Issues*	81.4 (57)	70

Note: Some respondents replied “Don’t Know” or “Refused,” and these responses are treated as missing data.
*Only clients who experienced the mental health issues above for at least one day answered responded to this survey question.

Over 75.0% of the clients rated their overall health as good to excellent. In the last 30 days, 26 clients stated they received inpatient treatment for substance use. The range staying overnight was from one night to 30 nights with a median stay of 6.5 nights. Thirty-five clients disclosed they received outpatient treatment for substance use. The minimum number of times this occurred was one and the maximum was 13 with a median of one time in the last 30 days. Seven clients indicated they received treatment in the emergency room for mental or emotional difficulties. Six of these clients went the ER once and one client went to the ER three times. Table 6 itemizes clients’ overall health rating and receipt of treatment for physical complaints, mental health issues, and substance use in inpatient, outpatient, and ER facilities.

Table 6. Health and Treatment Services

Overall Health	% (n = 89)
Excellent	14.6 (13)
Very Good	18.0 (16)
Good	46.1 (41)
Fair	19.1 (17)
Poor	2.3 (2)
Received Inpatient Treatment for	**% (n = 89)**
Physical Complaint	1.1 (1)
Mental Health	11.2 (10)
Alcohol or Substance Use	29.2 (26)
Received Outpatient Treatment for	**% (n = 89)**
Physical Complaint	2.3 (2)
Mental Health	12.4 (11)
Alcohol or Substance Use	39.3 (35)
Received Treatment at Emergency Room for	**% (n = 89)**
Physical Complaint	2.3 (2)
Mental Health	7.9 (7)
Alcohol or Substance Use	4.5 (4)

Note: Some respondents replied “Don’t Know” or “Refused,” and these responses are treated as missing data. Clients may answer affirmatively to more than one question (i.e. the rows in the above table, except for “overall health”); therefore, column totals do not equal the number of clients (i.e. “n=”).
*Percentages may not total 100.0 because of rounding.

Of the clients using substances in the past 30 days at admission, 62.9% felt stress because of their SU. Twenty-four clients said their substance use caused them to reduce or give up important activities. For 62.9% of the clients who used in the past 30 days, they attributed emotional problems to their substance use. Table 7 displays the frequencies for the effects of substance use on the clients. The data only includes clients who acknowledged SU in the past 30 days.

Table 7. Effects of Substance Use

Stress, Activities, Emotional Problems Due to Alcohol and Drug Use	% (n = 62)
Experienced Stress Due to Use of Alcohol or Other Drugs in Past 30 Days	62.9 (39)
Use of Alcohol or Other Drugs Caused Reduction or Giving Up Important Activities	39.3 (24)
Use of Alcohol or Other Drugs Caused Emotional Problems in Past 30 Days	54.8 (34)

Note: Clients may answer affirmatively to more than one question (i.e. the rows in the above table); therefore, column totals do not equal the number of clients (i.e. "n=").

Pregnancy and Children

Of the females at admission, none of them were currently pregnant. Thirteen of SYT-I clients have children. Most of those have one child, two clients have two children, and one has three children. Two of the 13 parents in the grant have children living with someone else because of a child protection order and one parent has lost their parental rights. Table 8 displays information about pregnancy and children at grant admission.

Table 8. Pregnancy and Children

Currently Pregnant[a]	% (n = 31)
Yes	0.0 (0)
Have Children	**% (n = 90)**
Yes	14.4 (13)
Children and Protection Orders[b]	**% (n)**
Children Living with Someone	16.7 (2)
Lost Parental Rights	7.7 (1)

[a]This question is only asked of females.
[b]Twelve of the clients responded to having children living with someone and 13 answered the question about losing their parental rights.

Violence and Trauma

Over half of the clients admitted during the first year of the grant to have experienced violence or trauma in any setting.[4] Twenty-eight clients had nightmares or thought about the violence or

[4] Types of violence can include, but are not limited to community or school violence, domestic violence, physical, psychological, or sexual maltreatment/assault within or outside of the family, or terrorism. Types of trauma can include, but are not limited to trauma from a natural disaster, neglect, or grief.

traumatic event. Table 9 displays the frequencies of clients encountering violence and trauma, and the effects of those life experiences.

Table 9. Experience of Violence and Trauma

Violence and Trauma	% (n = 90)
Ever experienced violence or trauma in any setting	51.1 (46)
Ever experience nightmares because of violence	31.1 (28)
Tried hard not to think about violence	30.0 (27)
Constantly on guard, watchful, or easily startled	27.8 (25)
Felt numb and detached from others, activities, or surroundings	28.9 (26)
Ever been hit, kicked, slapped, or otherwise physically hurt	7.8 (7)

Note: Clients may answer affirmatively to more than one question (i.e. the rows in the above table); therefore, column totals do not equal the number of clients (i.e. “n=”).

Criminal and Juvenile Justice Activity

Six clients were arrested in the 30 days before admission. All these clients were arrested only once and four of them were arrested for drugs. Fourteen of the clients spent at least one night in jail in the past 30 days. Of those clients jailed, time spent in jail ranged from one day to 30 days with a median stay of 16 days. Over half the clients are on probation or parole. Table 10 specifies criminal and juvenile justice activity.

Table 10. Criminal Justice Activity

Arrested in the last 30 days	% (n = 90)
Zero	93.3 (84)
One	6.7 (6)
In the last 30 days	**% (n = 90)**
Spent at least one night in jail	15.6 (14)
Awaiting charges, trial, or sentencing*	18.0 (16)
On probation or parole	57.8 (52)

Note: Some respondents replied “Don’t Know” or “Refused,” and these responses are treated as missing data. Clients may answer affirmatively to more than one question (i.e. the rows in the above table); therefore, column totals do not equal the number of clients (i.e. “n=”).
*The number of respondents is 89.

Social Connectedness

At admission, the overwhelming majority of SYT-I clients (93.3%) were interacting with significant others who support recovery. Sixty-one clients turned to family members when in trouble. Seventeen clients attended voluntary self-help recovery groups. Nine of these clients attended other self-help recovery groups, and two of 17 clients attended religious self-help recovery groups. The number of times those 17 clients attended groups ranged from one time to 15 times with a median attendance of four times. Table 11 enumerates the number of clients interacting with people who support recovery.

Table 11. Social Connectedness with People Whom Support Recovery

Social Connectedness	% (n = 89)
Attended Voluntary Self-help Recovery Groups	19.1 (17)
Attended Voluntary Religious Self-help Recovery Groups	2.3 (2)
Attended Other Self-help Recovery Groups	10.1 (9)
Interacted with Significant Others Who Support Recovery	93.3 (83)

Note: Some respondents replied “Don’t Know” or “Refused,” and these responses are treated as missing data. Clients may answer affirmatively to more than one question (i.e. the rows in the above table); therefore, column totals do not equal the number of clients (i.e. “n=”).

Use of Recovery Support Services

Each month treatment providers submit information on client use of RSS to the Consortium. These data reflect services used through August 31, 2016. During Year One of the grant, 53 clients have received RSS. The most money spent on a service was sober living activities, which totaled $2,707.00. The amount spent on sober living activities ranged from zero dollars to $492.00 with median of zero dollars. The money spent on sober living activities on average for a client was $30.08 with a standard deviation of $82.79. Given the wide range, a mean larger than the median, and a standard deviation larger than the mean, the distribution of sober Living activities across clients is highly skewed, which suggests the receipt of this kind service is not normally distributed across all SYT-I clients. There are several factors playing into this unequal distribution, one is length of stay in the grant. The longer a client is in the grant, the more opportunities they have to receive services. The next service agencies spent the most money on was drug testing, which totaled $2,400.00. Per client, this service ranged from zero dollars to $320.00 dollars with a median of zero dollars spent. The average money spent on drug testing per client was $26.67 with a standard deviation of $68.56. Again distribution of this service across clients is skewed. The third highest spending on a service was life skills coaching, which totaled $1,540.00. The service ranged from zero dollars to $640.00 with median of zero dollars. On average, $17.11 was spent on a client for life skills coaching with a standard deviation of $76.24. The fourth highest spending on a service was gas cards, which totaled $1,229.00. Per client, this service ranged from zero dollars to $180.00 with median of zero dollars. On average, $13.66 was spent on gas cards per client with a standard deviation of $32.83. Table 12 displays all the RSS used by SYT-I clients in Year One of the grant.

Table 12. Recovery Support Services

Total Recovery Supposed Services Received	Units Received	Dollars Spent on RSS	Number of Clients Served
Sober Living Activities	2707	2707	14
Drug Testing	75	2400	18
Life Skills Coaching	77	1540	16
Supplemental Needs - Gas cards	1229	1229	34
Behavioral Health Assessment/Consultation	26	780	8
In-Home Services	9	540	2
Drug testing Incentive Gift Card	37	370	8
Transportation – Bus	228	228	5
Electronic Recovery Support Messaging	222	222	6
Education/Vocational Training	75	75	1
Celebrating/Strengthening Families	0	0	0
Child Care	0	0	0
Crisis Respite	0	0	0
Pharmacological Interventions	0	0	0

Note: The Number of Clients Served column total is not equal to the number of clients since clients can utilize multiple recovery support services.

GPRA FOLLOW-UP INTERVIEWS

GPRA Follow-up Interviews

The treatment providers administer the Government Performance and Results Act Client Outcome Measures Instrument (GPRA) to all clients at grant admission and when possible approximately six months following grant admission (follow-up interview). Adhering to GPRA guidelines, providers may conduct follow-up interviews with clients within a time frame of 30 days before and up to 60 days after the six-month post-admission date. The GPRA follow-up interviews due are for those clients that have reached six-months post-admission as of August 31, 2016. The GPRA follow-up rate is calculated by dividing the number of completed follow-up interviews by the number of interviews due. SAMHSA guidelines require grants maintain a follow-up rate of 80.0% or higher, which SYT-I is. In two instances, follow-ups were not completed because one client could not be located (moved) and the other was located, but the treatment provider could not gain institutional access. Table 13 displays the GPRA follow-up counts and rates by treatment provider.

Table 13. GPRA Follow-up Interviews by Treatment Provider

GPRA Follow-up Interviews	Grant Totals	Heartland Family Services	Prairie Ridge	Prelude Behavioral Services	Youth & Shelter Services
Due	31	21	3	0	7
Completed	26	19	2	0	5
Rate	83.9%	90.5%	66.7%	NA*	71.4%

*At data cutoff, 8/31/2016, Prelude Behavioral Services did not have any clients due for follow-up.

Client Demographics with Completed GPRA Follow-up Interviews

At follow-up, there were 11 females interviewed and 15 males. All identified as Caucasian and 88.5% as not Latino. One client was from a rural locale. Table 14 contains the breakdown of demographic information.

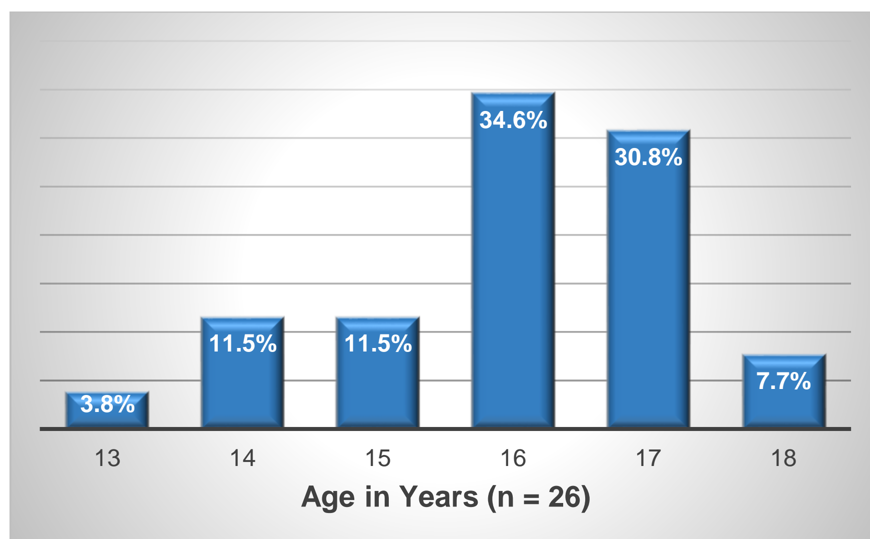
Table 14. Demographics of Clients with Completed Follow-up Interviews

Gender	at Follow-up % (n = 26)
Female	42.3 (11)
Male	57.7 (15)
Race	**at Follow-up % (n = 26)**
Caucasian	100.0 (26)
Ethnicity	**at Follow-up % (n = 26)**
Hispanic/Latino	11.5 (3)
Not Hispanic/Latino	88.5 (23)
Urbanicity*	**at Follow-up % (n = 26)**
Rural	3.8 (1)
Urban	96.2 (25)

*These data are from state treatment records, but match those clients with completed GPRA follow-ups.

Clients at follow-up ranged in age from 13 years to 18 years with median of 16 years. Figure 2 on the following page depicts age at follow-up.

Figure 2. Age at Follow-up



Housing at Follow-up

At follow-up, 61.5% of those interviewed lived in their own apartment, room, or house. Nine of the clients living in someone else's residence at admission live in their own residence at follow-up. The client at follow-up who lives in a halfway house lived in their own domicile at grant admission; whereas the client living in an institution at follow-up, lived in someone else's residence at admission. Table 15 delineates housing at admission and follow-up for those with completed GPRA follow-up interviews.

Table 15. Housing at Follow-up

Housing	at Admission % (n = 26)	at Follow-up % (n = 26)
Own/Rent Apartment, Room, or House	34.6 (9)	61.5 (16)
Someone Else's Apartment, Room, or House	65.4 (17)	30.8 (8)
Halfway House	0.0 (0)	3.8 (1)
Institution	0.0 (0)	3.8 (1)

Education and Employment at Follow-up

The most frequently occurring highest level of education at follow-up was 10th grade (38.5%). The three clients working full-time at follow-up did not work full-time at admission. One of the three was employed part-time. Another was unemployed but looking for work. The third was unemployed and not looking for work. At follow-up, 88.5% of the clients were enrolled full-time in school or job training. One client at admission was not enrolled in school or a training program, but at follow-up they were enrolled part time. Table 16 contains frequencies for all the response categories for highest level of education, employment, and enrollment in school or job training programs at admission and follow-up.

Table 16. Education, Employment, and Training at Follow-up

Highest Level of Education	at Admission % (n = 26)	at Follow-up % (n = 26)
7th Grade	3.8 (1)	3.8 (1)
8th Grade	11.5 (3)	7.7 (2)
9th Grade	26.9 (7)	11.5 (3)
10th Grade	26.9 (7)	38.5 (10)
11th Grade	23.1 (6)	23.1 (6)
12th Grade, High School Diploma, GED	7.7 (2)	15.4 (4)
Employment Status	**at Admission % (n = 26)**	**at Follow-up % (n = 26)**
Employed Full time	0.0 (0)	11.5 (3)
Employed Part time	15.4 (4)	30.8 (8)
Unemployed Looking for Work	34.6 (9)	15.4 (4)
Unemployed Not Looking for Work	50.0 (13)	42.3 (11)
Enrolled in School or Job Training Program	**at Admission % (n = 26)**	**at Follow-up % (n = 26)**
Enrolled Full time	92.3 (24)	88.5 (23)
Enrolled Part time	3.8 (1)	7.7 (2)
Not Enrolled	3.8 (1)	3.8 (1)

Substance Use at Admission and Follow-up

At follow-up, 18 clients (69.2%) reported abstinence of SU in last 30 days. Twelve of those 18 clients were using substances in the 30 days prior to grant admission.[5] Of the clients using substances at follow-up, marijuana was the most frequently used drug. While 26.9% of the clients used marijuana in the month before their follow-up interview, there was still a 30.8 percentage point decrease in marijuana use from admission to follow-up.[6] Those having used marijuana in the past month, their use ranged from one to ten days with a median of three days. Table 17 on the following page shows the clients with completed GPRA follow-up interviews SU at admission and follow-up.

[5] McNemar's $\chi^2 = 7.14$, df = 1, p =.008
[6] McNemar's $\chi^2 = 5.33$, df = 1, p =.021

Table 17. Substance Use in the Last 30 Days at Follow-up

Alcohol and Drugs	at Admission % (n)	at Follow-up % (n)
Binge Drinking (Five or More Drinks in One Sitting[a]	33.3 (2)	25.0 (1)
Used Alcohol and Drugs on the Same Day[b]	33.3 (1)	66.7 (2)
Injection Drug Use	**at Admission % (n = 26)**	**at Follow-up % (n = 26)**
Injected Drugs in Past 30 Days	0.0 (0)	0.0 (0)
Substance Use	**at Admission % (n = 26)**	**at Follow-up % (n = 26)**
Marijuana/Hashish	57.7 (15)	26.9 (7)
Alcohol	23.1 (6)	15.4 (4)
Other Opiates[c]	3.8 (1)	0.0 (0)
Benzodiazepines	11.5 (3)	0.0 (0)
Inhalants	3.8 (1)	0.0 (0)

Note: Column totals are not equal to the number of records since people report multiple substances.
[a]Only respondents who answered that they drank alcohol at least one day in the past 30 days respond to this question. Those with a completed follow-up, six clients responded at admission, and four replied at follow-up.
[b] Only respondents who answered that they drank alcohol or used illegal drugs at least one day in the past 30 days respond to this question. Three clients responded at admission and follow-up.
[c]Other opiates is a category containing client use of Codeine, Darvon, Demerol, Diluadid, Morphine, Non-Prescription Methadone, OxyContin/ Oxycodone, Percocet, and/or Tylenol 2, 3, or 4.

Mental and Physical Health at Follow-up

While clients were still experiencing mental health issues at follow-up, there was a decrease across depression and cognitive issues from admission to follow-up.[7] The other mental health issues experienced in the past 30 days may show a decrease in the table, but it is not a statistically significant decrease. Of the 13 clients experiencing serious depression at admission, only five still reported depressive days 30 days prior to follow-up. There was one client who did not report occurrences of serious depression at admission, but did at follow-up. Those experiencing depressive feelings reported episodes occurring twice to every day in the month before the follow-up interview with a median experience of seven days. Table 18 on the following page displays the breakdown of clients' (with complete GPRA follow-up interviews) co-occurring mental health screenings and experience of mental health issues at admission and follow-up.

[7] Depression: McNemar's $\chi^2 = 5.44$, df = 1, p =.020
Anxiety: McNemar's $\chi^2 = 0.69$, df = 1, p =.405
Cognitive Issues: McNemar's $\chi^2 = 6.00$, df = 1, p =.014
Violent Behavior: McNemar's $\chi^2 = 3.00$, df = 1, p =.083
Suicide: McNemar's $\chi^2 = 2.00$, df = 1, p =.157
Bothered by Mental Health Issues: McNemar's $\chi^2 = 0.20$, df = 1, p =.655

Table 18. Mental Health at Follow-up

Co-occurring Mental Health Screening	at Admission % (n = 26)		
Not Screened	3.8 (1)		
Negative	19.2 (5)		
Positive	76.9 (20)		
Mental Health Issues Experienced In Past 30 Days	**at Admission % (n)**	**at Follow-up % (n)**	**Total # of Respondents**
Serious Depression	50.0 (13)	23.1 (6)	26
Anxiety or Tension	46.2 (12)	34.6 (9)	26
Hallucinations	0.0 (0)	0.0 (0)	26
Trouble Understanding, Concentrating, or Remembering	42.3 (11)	19.2 (5)	26
Trouble Controlling Violent Behavior	23.1 (6)	11.5 (3)	26
Attempted Suicide	7.7 (2)	0.0 (0)	26
Prescribed Medication for Psychological/Emotional Problems	19.2 (5)	19.2 (5)	26
Bothered by Mental Health Issues*	81.8 (9)	72.7 (8)	11

Note: Clients may answer affirmatively to more than one question (i.e. the rows in the above table, except "co-occurring"); therefore, column totals do not equal the number of clients (i.e. "n=").
*Only clients who experienced the mental health issues above for at least one day answered responded to this survey question.

Over 90.0% of the clients at follow-up rated their overall health as good to excellent. Table 19 displays overall health rating and treatment received at inpatient, outpatient, and ER facilities at admission and follow-up.

Table 19. Health and Treatment Services at Follow-up

Overall Health	at Admission % (n = 26)	at Follow-up % (n = 26)
Excellent	15.4 (4)	26.9 (7)
Very Good	15.4 (4)	26.9 (7)
Good	57.7 (15)	38.5 (10)
Fair	7.7 (2)	7.7 (2)
Poor	3.8 (1)	0.0 (0)
Received Inpatient Treatment for	**at Admission % (n = 26)**	**at Follow-up % (n = 26)**
Physical Complaint	3.8 (1)	0.0 (0)
Mental Health	11.5 (3)	0.0 (0)
Alcohol or Substance Use	11.5 (3)	3.8 (1)
Received Outpatient Treatment for	**at Admission % (n = 26)**	**at Follow-up % (n = 26)**
Physical Complaint	3.8 (1)	3.8 (1)
Mental Health	23.1 (6)	7.7 (2)
Alcohol or Substance Use	53.9 (14)	26.9 (7)
Received Treatment at Emergency Room for	**at Admission % (n = 26)**	**at Follow-up % (n = 26)**
Physical Complaint	0.0 (0)	0.0 (0)
Mental Health	3.8 (1)	0.0 (0)
Alcohol or Substance Use	0.0 (0)	0.0 (0)

Note: Clients may answer affirmatively to more than one question (i.e. the rows in the above table, except “overall health”); therefore, column totals do not equal the number of clients (i.e. “n=”).

Of clients using substances at follow-up, none of the clients reported any effects because of their use. Table 20 shows the effects of substance use at admission for those six clients.

Table 20. Effects of Substance Use at Follow-up

Stress, Activities, Emotional Problems Due to Alcohol and Drug Use	at Admission % (n = 6)	at Follow-up % (n = 6)
Experienced Stress Due to Use of Alcohol or Other Drugs in Past 30 Days	16.7 (1)	0.0 (0)
Use of Alcohol or Other Drugs Caused Reduction or Giving Up Important Activities	33.3 (2)	0.0 (0)
Use of Alcohol or Other Drugs Caused Emotional Problems in Past 30 Days	33.3 (2)	0.0 (0)

Note: Clients may answer affirmatively to more than one question (i.e. the rows in the above table); therefore, column totals do not equal the number of clients (i.e. “n=”).

Pregnancy and Children at Follow-up

None of the clients with a completed GPRA follow-up interview were pregnant or had children at admission or at the time of the follow-up interview.

Violence and Trauma at Follow-up

Almost 70.0% of the clients at follow-up experienced no change in violent or traumatic occurrences since admission. A little over 7.0% who experienced violence or trauma at follow-up had not experienced it at the admission GPRA interview. In terms of change from admission to follow-up, one client who reported nightmares at admission no longer reported them at follow-up. One client reported at follow-up that they no longer felt constantly on guard compared to how they felt at admission. Two clients no longer had to try hard not to think about violence at follow-up. Four clients are no longer feeling numb at follow-up compared to admission. Two clients reported being physically hurt at follow-up, but they had not at admission. Table 21 delineates the frequencies of violence/trauma, some negative consequences of those experiences, and if they have been physically hurt for clients who have completed a follow-up GPRA.

Table 21. Experience of Violence and Trauma at Follow-up

Violence and Trauma	at Admission % (n = 26)	at Follow-up % (n = 26)
Ever experienced violence or trauma in any setting	46.2 (12)	30.8 (8)
Ever experience nightmares because of violence	23.1 (6)	19.2 (5)
Tried hard not to think about violence	19.2 (5)	11.5 (3)
Constantly on guard, watchful, or easily startled	11.5 (3)	3.8 (1)
Felt numb and detached from others, activities, or surroundings	19.2 (5)	3.8 (1)
Ever been hit, kicked, slapped, or otherwise physically hurt	3.8 (1)	11.5 (3)

Note: Clients may answer affirmatively to more than one question (i.e. the rows in the above table); therefore, column totals do not equal the number of clients (i.e. "n=").

Criminal and Juvenile Justice Activity at Follow-up

The clients arrested in the month before follow-up were not the same clients that were arrested in the 30 days prior to their follow-up interview. Moreover, the clients awaiting charges, trial, or sentencing at admission were not still waiting at follow-up. Only one client who was awaiting charges at admission was on probation or parole at follow-up. Five of the 12 clients on probation/parole at follow-up were on probation/parole at admission. Table 22 specifies criminal and juvenile justice activity in past 30 days before admission and follow-up GPRA interviews.

Table 22. Criminal Justice Activity

Arrested in the last 30 days	at Admission % (n = 26)	at Follow-up % (n = 26)
Zero	92.3 (24)	96.2 (25)
One	7.7 (2)	3.8 (1)
In the last 30 days,	**at Admission % (n = 26)**	**at Follow-up % (n = 26)**
Spent at least one night in jail	0.0 (0)	0.0 (0)
Awaiting charges, trail, or sentencing	11.5 (3)	7.7 (2)
On probation or parole	42.3 (11)	46.2 (12)

Note: Clients may answer affirmatively to more than one question (i.e. the rows in the above table, except "arrests"); therefore, column totals do not equal the number of clients (i.e. "n=").

Social Connectedness at Follow-up

Four clients had attended voluntary self-help recovery groups 30 days prior to follow-up, but had not 30 days before admission. Three of these clients attended religious affiliated groups. The

one client who attended an "other" self-help recovery group, had not attended any recovery groups at admission. All the clients with completed GPRA follow-up interviews reported they have interacted with significant others who support recovery the month before the follow-up. Two of three clients who reported having no one to turn to at admission, said at follow-up they have friend that they can turn to when they are having trouble. Table 23 displays the frequencies for clients interacting with people who support recovery.

Table 23. Social Connectedness with People Whom Support Recovery at Follow-up

Social Connectedness	at Admission % (n = 26)	at Follow-up % (n = 26)
Attended Voluntary Self-help Recovery Groups	0.0 (0)	3.8 (1)
Attended Voluntary Religious Self-help Recovery Groups	0.0 (0)	11.5 (3)
Attended Other Self-help Recovery Groups	7.7 (2)	3.8 (1)
Interacted with Significant Others Who Support Recovery	84.6 (22)	100.0 (26)

Note: Clients may answer affirmatively to more than one question (i.e. the rows in the above table); therefore, column totals do not equal the number of clients (i.e. "n=").

DISCHARGE GPRA INTERVIEWS AND OUTCOMES ANALYSES

SYT-I treatment providers discharged 56 clients during Year One. While there were 56 discharge notification forms, there were only 44 completed GPRA discharge interviews.

Client Demographics with Completed GPRA Discharge Interviews

The demographic profile of clients with completed GPRA discharge interviews is similar to the profile of clients at admission. In terms of percentages, there were more males discharged than the percentage of males at admission. At discharge, five clients lived in a rural county. Table 24 displays the frequencies of demographic characteristics.

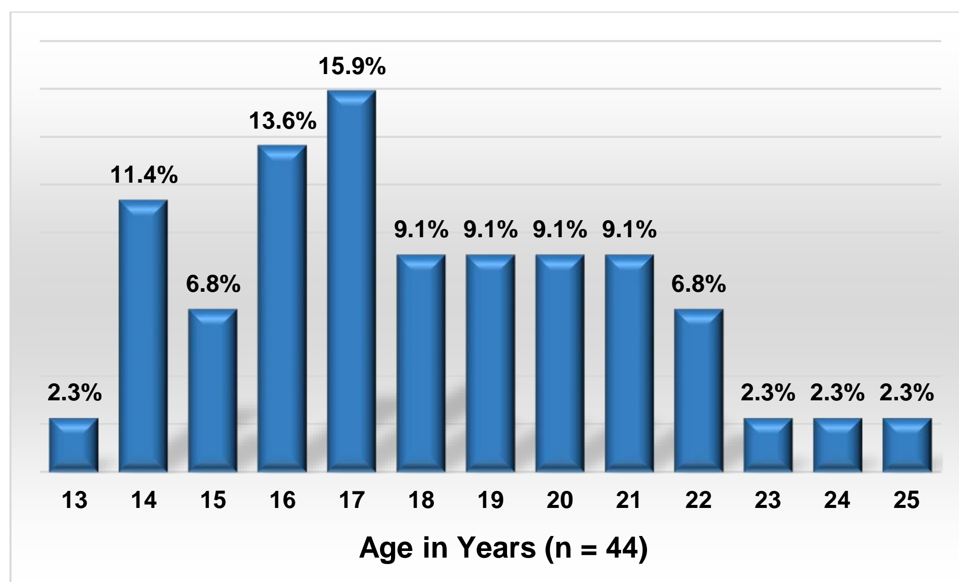
Table 24. Demographics of Clients with Completed GPRA Discharge Interviews

Gender	at Discharge % (n = 44)
Female	29.5 (13)
Male	70.5 (31)
Race	**at Discharge % (n = 44)**
Caucasian	90.9 (40)
African American	2.3 (1)
Hawaiian/Pacific Islander	2.3 (1)
Multi-Racial	4.6 (2)
Ethnicity	**at Discharge % (n = 44)**
Hispanic/Latino	4.6 (2)
Not Hispanic/Latino	95.5 (42)
Urbanicity[a]	**at Discharge % (n = 42)**
Rural	11.9 (5)
Urban	88.1 (37)

*Percentages may not total 100.0 because of rounding.
[a]There were two records in the GPRA data that could not be matched to statement records; thus, there are different sample sizes.

The age range of clients with completed GPRA discharge interviews is from 13 years to 25 years with a median of 17.5 years. This group has slightly older clients than at admission. At admission, the range is the same, but the median was 17 years. There are 22 adolescents ranging in age from 13 years to 17 years with a median of 16 years. For TAY, there were 22 clients with an age range of 18 to 25 years with a median of 20 years. Figure 3 depicts age of clients with complete discharge interviews.

Figure 3. Age at Discharge



Housing at Discharge

At the time of the GPRA discharge interview, 16 clients (36.4%) lived in someone else's apartment, room, or house. At grant admission, 14 of these clients were living in someone else's residence, one was living in a shelter, and another was residing in an institution. Table 25 provides the breakdown of housing at admission and discharge for those clients with completed GPRA discharge interviews.

Table 25. Housing at Discharge

Housing	at Admission % (n = 44)	at Discharge % (n = 44)
Own/Rent Apartment, Room, or House	15.9 (7)	25.0 (11)
Someone Else's Apartment, Room, or House	61.4 (27)	36.4 (16)
Halfway House	0.0 (0)	0.0 (0)
Residential Treatment	4.6 (2)	34.1 (15)
Shelter	2.3 (1)	0.0 (0)
Street/Outdoors	2.3 (1)	0.0 (0)
Institution	13.6 (6)	4.6 (2)
Other: Stayed with Mom	0.0 (0)	0.0 (0)

Education and Employment at Discharge

The most frequently occurring highest level of education of clients with completed GPRA discharge interviews was 12th grade/high school diploma/equivalent (36.4%). At discharge, there were an equal number of clients (8) working full-time as working part-time. Additionally,

there was an equal number of clients (14) that were unemployed and looking for work as there were clients who were unemployed and not looking for work. The client who listed he was working for his grandparents at admission responded he was unemployed but looking for work at discharge. Over half of the clients were enrolled in school or a training program at discharge. Eighteen of these clients replied they were unemployed too (5 clients looking for work and 13 not looking for work). One client indicated he was enrolled in Iowa Works – WIOA training program and the other said she was recently accepted into a technical school. Table 26 lists the frequencies for highest level of education, employment, and enrollment in school/training program at admission and discharge for clients with completed GPRA discharge interviews.

Table 26. Education, Employment, and Training at Follow-up

Highest Level of Education	at Admission % (n = 44)	at Discharge % (n = 44)
7th Grade	6.8 (3)	6.8 (3)
8th Grade	6.8 (3)	6.8 (3)
9th Grade	9.1 (4)	6.8 (3)
10th Grade	22.7 (10)	20.5 (9)
11th Grade	11.4 (5)	18.2 (8)
12th Grade, High School Diploma, GED	38.6 (17)	36.4 (16)
1st Year of College or University Completed	0.0 (0)	0.0 (0)
2nd Year of College or University Completed	4.6 (2)	4.6 (2)
Bachelor's Degree or higher	0.0 (0)	0.0 (0)
Employment Status	**at Admission % (n = 44)**	**at Discharge % (n = 44)**
Employed Full time	6.8 (3)	18.2 (8)
Employed Part time	15.9 (7)	18.2 (8)
Unemployed Looking for Work	29.6 (13)	31.8 (14)
Unemployed Not Looking for Work	45.5 (20)	31.8 (14)
Other	2.3 (1)	0.0 (0)
Training Program	**at Admission % (n = 44)**	**at Discharge % (n = 44)**
Enrolled Full time	56.8 (25)	54.6 (24)
Enrolled Part time	0.0 (0)	0.0 (0)
Not Enrolled	43.2 (19)	40.9 (18)
Other	0.0 (0)	4.6 (2)

*Percentages may not total 100.0 because of rounding.

Substance Use at Discharge

At discharge, 32 clients (72.7%) reported abstinence of substance use in last 30 days prior to GPRA discharge interview. Sixteen of those 32 clients were using substances in the 30 days

prior to grant admission.[8] Of the clients using substances at discharge, alcohol was the most frequently used substance. In the month prior to their discharge interview, the clients' alcohol use ranged from one day to three days with a median of two days. There was a 66.7% decrease in marijuana use from admission to discharge.[9] Table 27 displays the frequencies of client substance use at admission and discharge for clients with a completed GPRA discharge interview.

Table 27. Substance Use in the Past 30 Days at Discharge

Alcohol and Drugs	at Admission % (n)	at Discharge % (n)
Binge Drinking (Five or More Drinks in One Sitting)[a]	28.6 (4)	42.9 (3)
Used Alcohol and Drugs on the Same Day[b]	62.5 (5)	100.0 (2)
Injection Drug Use	**at Admission % (n = 44)**	**at Discharge % (n = 44)**
Injected Drugs in Past 30 Days	6.8 (3)	4.6 (2)
Substance Use	**at Admission % (n = 44)**	**at Discharge % (n = 44)**
Marijuana/Hashish	40.9 (18)	13.6 (6)
Alcohol	31.8 (14)	15.9 (7)
Methamphetamine	11.4 (5)	2.3 (1)
Heroin	6.8 (3)	4.6 (2)
Other Opiates[c]	2.3 (1)	2.3 (1)
Cocaine/Crack	6.8 (3)	0.0 (0)
Hallucinogens/Psychedelics	2.3 (1)	0.0 (0)
Benzodiazepines	15.9 (7)	0.0 (0)
Tranquilizers	2.3 (1)	0.0 (0)
Inhalants	4.6 (2)	0.0 (0)

Note: Column totals are not equal to the number of records since people report multiple substances.
[a]Only respondents who answered that they drank alcohol at least one in the past 30 days responded to this question. Of those with a completed discharge interview, 14 clients responded at admission, and seven replied at discharge.
[b]Only respondents who answered that they drank alcohol or used illegal drugs at least one day in the past 30 days respond to this question. Eight clients responded at admission and two at discharge.
[c]Other opiates is a category containing client use of Codeine, Darvon, Demerol, Diluadid, Morphine, Non-Prescription Methadone, OxyContin/ Oxycodone, Percocet, and/or Tylenol 2, 3, or 4.

Mental and Physical Health at Discharge

The month prior to discharge, some clients were still experiencing mental health issues. While the frequency of serious depression 30 days prior to admission did not change at discharge, there was change in who experienced it and who did not. Four of the 20 clients at admission, did not report depressive episodes at discharge. The range of days encountering depression was one day to 30 days with a median of 8.5 days. Table 28 shows the breakdown of clients'

[8] McNemar's χ^2 = 13.24, df = 1, p =.0003
[9] McNemar's χ^2 = 10.29, df = 1, p =.0013

(with complete GPRA discharge interviews) co-occurring mental health screenings and experience of mental health issues at admission and follow-up.

Table 28. Mental Health at Discharge

Co-occurring Mental Health Screening*	at Admission % (n = 44)		
Not Screened	2.3 (1)		
Negative	18.2 (8)		
Positive	79.6 (35)		
Mental Health Issues Experienced In Past 30 Days	**at Admission % (n)**	**at Discharge % (n)**	**Total # of Respondents**
Serious Depression	45.5 (20)	45.5 (20)	44
Anxiety or Tension	58.1 (25)	44.2 (19)	43
Hallucinations	0.0 (0)	4.6 (2)	44
Trouble Understanding, Concentrating, or Remembering	34.9 (15)	32.6 (14)	43
Trouble Controlling Violent Behavior	25.0 (11)	15.9 (7)	44
Attempted Suicide	2.3 (1)	2.3 (1)	44
Prescribed Medication for Psychological/Emotional Problems	27.3 (12)	18.2 (8)	44
Bothered by Mental Health Issues[a]	87.5 (21)	83.3 (20)	24

Note: Clients may answer affirmatively to more than one question (i.e. the rows in the above table, except "co-occurring"); therefore, column totals do not equal the number of clients (i.e. "n=").
*Percentages may not total 100.0 because of rounding.
[a]Only clients who experienced the mental health issues above for at least one day answered responded to this survey question.

Over 90.0% of the clients at discharge rated their overall health as good to excellent. Of the 44 clients, 18 (40.9%) reported a higher health rating at discharge than they did at admission.[10] Nineteen clients experienced no change and seven clients indicated a decrease in their overall health from admission to discharge. Table 29 displays overall health rating and treatment received at inpatient, outpatient, and ER facilities at admission and follow-up.

[10] Wilcoxon Z = 18, p =.043

Table 29. Health and Treatment Services at Discharge

Overall Health	at Admission % (n = 44)	at Discharge % (n = 44)
Excellent	13.6 (6)	20.5 (9)
Very Good	20.5 (9)	38.6 (17)
Good	52.3 (23)	31.8 (14)
Fair	13.6 (6)	9.1 (4)
Poor	0.0 (0)	0.0 (0)
Received Inpatient Treatment for	**at Admission % (n= 44)**	**at Discharge % (n= 44)**
Physical Complaint	0.0 (0)	2.3 (1)
Mental Health	6.8 (3)	2.3 (1)
Alcohol or Substance Use	36.4 (16)	36.4 (16)
Received Outpatient Treatment for	**at Admission % (n= 44)**	**at Discharge % (n= 44)**
Physical Complaint	2.3 (1)	6.8 (3)
Mental Health	4.6 (2)	20.5 (9)
Alcohol or Substance Use	45.5 (20)	47.7 (21)
Received Treatment at Emergency Room for	**at Admission % (n= 44)**	**at Discharge % (n= 44)**
Physical Complaint	2.3 (1)	15.9 (7)
Mental Health	6.8 (3)	2.3 (1)
Alcohol or Substance Use	4.6 (2)	0.0 (0)

Note: Clients may answer affirmatively to more than one question (i.e. the rows in the above table); therefore, column totals do not equal the number of clients (i.e. "n=").
*Percentages may not total 100.0 because of rounding.

Of the 10 clients using substances at discharge, one less client reported experiencing stress because of their SU 30 days prior to their GPRA discharge interview compared to admission. Two clients at admission responded that their SU did not affect their activities or create emotional problems, but at discharge, these clients did attribute their SU to affecting activities and emotions. One experienced the exact opposite from admission to discharge. At admission, she replied her SU did affect her activities and emotional problems, but not a discharge. Table 30 shows the frequencies of the effects of SU at admission for those 10 clients.

Table 30. Effects of Substance Use at Discharge

Stress, Activities, Emotional Problems Due to Alcohol and Drug Use	at Admission % (n = 10)	at Discharge % (n = 10)
Experienced Stress Due to Use of Alcohol or Other Drugs in Past 30 Days	70.0 (7)	60.0 (6)
Use of Alcohol or Other Drugs Caused Reduction or Giving Up Important Activities*	44.4 (4)	55.6 (5)
Use of Alcohol or Other Drugs Caused Emotional Problems in Past 30 Days	50.0 (5)	60.0 (6)

Note: Clients may answer affirmatively to more than one question (i.e. the rows in the above table); therefore, column totals do not equal the number of clients (i.e. "n=").
*The number of respondents for this question was nine.

Pregnancy and Children at Discharge

At the time of the GPRA discharge interview, one client was pregnant. Six clients have children. Of those six parents, one client's child is living with someone else because of a protective order and has lost parental rights. Table 31 shows the frequencies of clients who are pregnant, have children, and protective orders at admission and discharge.

Table 31. Pregnancy and Children at Discharge

Currently Pregnant[a]	at Admission % (n = 13)	at Discharge % (n = 13)
Yes	0.0 (0)	7.7 (1)
Have Children	**at Admission % (n = 44)**	**at Discharge % (n = 44)**
Yes	13.6 (6)	13.6 (6)
Children and Protection Orders[b]	**at Admission % (n = 6)**	**at Discharge % (n = 6)**
Children Living with Someone	16.7 (1)	16.7 (1)
Lost Parental Rights	16.7 (1)	16.7 (1)

[a]This question is only asked of females.
[b]Six clients that have children responded to having children living with someone and the question about losing their parental rights.

Violence and Trauma at Discharge

Over 86.0% of the clients at discharge experienced no change in violent or traumatic occurrences since admission. Thirty days before their GPRA discharge interview, four clients reported experiencing violence or trauma, but did not at admission. At discharge, two clients who had previously reported a traumatic event did not report such an event ever happened later. This reporting pattern occurred with nightmares and trying not to think about violence. While frequency of feeling constantly on guard did not change from admission to discharge, one

client did experience a decrease, in that, he no longer had occurrences of those feelings. A similar pattern occurred with feeling numb and detached, 92.1% reported no change in these feelings from admission to discharge, but three clients at discharge responded they did experience these emotions. Over 90.0% of clients at discharge reported no change in being physically hurt. A little under 10.0% did confirm experiencing physical harm at discharge, but had not at admission. Table 32 delineates the frequencies of violence/trauma, some negative consequences of those experiences, and if they have been physically hurt for clients who have completed a discharge GPRA.

Table 32. Experience of Violence and Trauma at Discharge

Violence and Trauma	at Admission % (n = 44)	at Discharge % (n = 44)
Ever experienced violence or trauma in any setting	45.5 (20)	50.0 (22)
Ever experience nightmares because of violence	27.3 (12)	20.5 (9)
Tried hard not to think about violence	25.0 (11)	20.5 (9)
Constantly on guard, watchful, or easily startled	22.7 (10)	22.7 (10)
Felt numb and detached from others, activities, or surroundings	22.7 (10)	22.7 (10)
Ever been hit, kicked, slapped, or otherwise physically hurt in the past 30 days	6.8 (3)	15.9 (7)

Note: Clients may answer affirmatively to more than one question (i.e. the rows in the above table); therefore, column totals do not equal the number of clients (i.e. “n=”).

Criminal and Juvenile Justice Activity at Discharge

All the clients were arrest free during the month prior to their GPRA discharge interview. At discharge, eight clients were awaiting charges, trial, or sentencing, six of which had the same status at admission. At discharge, 30 clients experienced no change in their probation/parole status from admission. Specifically, 20 were still on probation or parole and ten were not. Some clients’ probation/parole status changed from admission to discharge. Six clients who were on probation/parole at admission were not at discharge, and eight went from not being on probation/parole to being on probation. Table 33 displays criminal and juvenile justice activity the 30 days prior to GPRA discharge interview.

Table 33. Criminal Justice Activity at Discharge

Arrested in the last 30 days	at Admission % (n = 44)	at Discharge % (n = 44)
Zero Times	93.2 (41)	100 (44)
One Time	6.8 (3)	0.0 (0)
In the last 30 days,	**at Admission % (n = 44)**	**at Discharge % (n = 44)**
Spent at least one night in jail	18.2 (8)	0.0 (0)
Awaiting charges, trail, or sentencing*	27.9 (12)	18.2 (8)
On probation or parole	59.1 (26)	63.6 (28)

Note: Clients may answer affirmatively to more than one question (i.e. the rows in the above table, except "arrests"); therefore, column totals do not equal the number of clients (i.e. "n=").
*At admission, only 43 responded to this question, one client did not know.

Social Connectedness at Discharge

Overall, 24 clients at discharge had attended some kind of voluntary self-help recovery group. Six of the 16 clients attending voluntary self-help groups at discharge did not attend these kinds of groups at admission. None of the clients attending religious affiliated self-help recovery groups at discharge attended these kinds of groups at admission. Almost all the clients (97.7%) said they interacted with someone who supported recovery. Additionally, at discharge, all the clients reported having someone to turn to when they are having trouble. One client responded she could turn to Drug Court when she is having trouble; at admission, she said she had her friends. The client who said they did not have anyone to turn to at admission, reports at discharge he can turn to his friends. Table 34 displays the counts of social connectedness measures at discharge and admission for those clients with a completed GPRA discharge.

Table 34. Social Connectedness with People Whom Support Recovery at Discharge

Social Connectedness	at Admission % (n = 44)	at Discharge % (n = 44)
Attended Voluntary Self-help Recovery Groups	22.7 (10)	36.4 (16)
Attended Voluntary Religious Self-help Recovery Groups	2.3 (1)	13.6 (6)
Attended Other Self-help Recovery Groups	6.8 (3)	4.6 (2)
Interacted with Significant Others Who Support Recovery	93.2 (41)	97.7 (43)

Note: Clients may answer affirmatively to more than one question (i.e. the rows in the above table); therefore, column totals do not equal the number of clients (i.e. "n=").

Discharge Status and Treatment Outcomes

Fifty-six clients were discharged from the SYT-I grant prior to September 1, 2016. Of the 56 clients, 64.3 completed/graduated from the grant. Table 35 displays grant discharges by

treatment provider and discharge status. These data are from notification forms submitted by treatment providers to the Consortium.

Table 35. Discharge Status by Provider

Discharge Status	Totals	Heartland Family Services	Prairie Ridge	Prelude Behavioral Services	Youth & Shelter Services
Completion/Graduation	36	8	12	14	2
Termination	20	8	4	4	4
Total Discharges	56	16	16	18	6
Success Rate	64.3%	50.0%	75.0%	77.8	33.3%

Clients in SYT-I participated in one of two EBP, MDFT or MET/CBT. Thirteen clients discharged in Year One were engaged in MDFT and 43 clients were engaged in MET/CBT. Six of the seven MDFT clients successfully completed their treatment. Seventeen more clients successfully completed MET/CBT. Although the sample size is small, when examining the frequencies of both treatment types by both discharge statuses, there is no statistically significant difference between these treatment types.[11] Table 36 breaks down discharge status by therapy type.

Table 36. Therapy Type by Discharge Status

Discharge Status	Therapy Type		
	MDFT % (n = 13)	MET/CBT % (n = 43)	Total Discharges
Completion/Graduation	46.1 (6)	69.8% (30)	64.3% (36)
Termination	53.9 (7)	30.2% (13)	35.7% (20)

Length of Stay in Grant

Length of stay in SYT-I is calculated from the intake and discharge dates of the GPRA. Treatment providers submitted these dates to the Consortium via intake and discharge notification forms. For both successful and terminated discharge clients, the median length of stay in the grant was 57 days ranging from one day to 231 days. Examining length of stay in the grant by discharge status, yields no statistical difference between median length of stay of complete/graduated and terminated clients.[12] Table 37 provides descriptive statistics for the length of stay in the grant by discharge status.

Table 37. Descriptive Statistics for Length of Stay in the Grant

Discharge Status	# of Discharged Clients	Median	Minimum	Maximum	Mean (standard deviation)
Completion/Graduation	36	27.5	1	231	62.3 (62.1)
Termination	21	89	1	191	90.1 (63.0)
Total Discharges	57	57	1	231	72.6 (63.3)

[11] Pearson $\chi^2 = 2.42$, df = 1, p = .119
[12] Mann-Whitney z = -1.51, p = 0.130

Minority Groups

At discharge, there are 8 clients identifying as a racial or ethnic minority. There is not a statistical difference in discharge status if one is a part of a minority group.[13]

Mental Health at Admission

At each GPRA interview, clients are asked a multitude of questions about their mental health: co-occurring mental health disorder, experience of depression, anxiety, hallucinations, problems with cognitive functions and controlling violent behavior, suicide, if they are bothered by their mental issues, if their SU was stressful, and if SU caused emotional problems. None of these variables at admission were statistically related to discharge status.[14]

Social Connectedness

The GPRA instrument assesses the extent of client social connectedness at admission, follow-up, and discharge. Focusing on the attendance of any type of voluntary self-help recovery group at admission and discharge status from the discharge notification form, there is no association between attendance and discharge status.[15] Table 38 shows attendance at any type of voluntary self-help recovery group and discharge status.

Table 38. Attendance at Voluntary Self-help Recovery Groups by Discharge Status

Voluntary Self-help Recovery Group Attendance at Admission	Completion/Graduation % (n = 36)	Termination % (n = 20)
No	63.9% (23)	65.0% (13)
Yes	36.1% (13)	35.0% (7)

Significant Others Participation in Treatment

Part of the treatment plan in MDFT consists of significant others participating in the clients' therapy. There were 11 clients who engaged in MDFT at discharge and had significant others participate in treatment. The minimum number of session attended by significant others was two and the maximum was 14 sessions with a median number of six sessions There was no statistically significant association between discharge status and significant other involvement in therapy.[16]

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[13] Pearson χ^2 = 0.002, df = 1, p = 0.967
[14] Co-occurring mental health disorder – Pearson χ^2 = 1.36., df = 1, p = 0.244;
Experience of depression – Pearson χ^2 = 0.311, df = 1, p = 0.577;
Anxiety – Pearson χ^2 = 1.52, df = 1, p = 0.218;
Hallucinations – Pearson χ^2 = 0.008, df = 1, p = 0.930;
Problems with cognitive functions – Pearson χ^2 = 0.01, df = 1, p = 0.919;
Controlling violent behavior – Pearson χ^2 =3.40, df = 1, p = 0.065;
Suicide – Pearson χ^2 = 1.32, df = 1, p = 0.250;
Bothered by their mental issues – Pearson χ^2 = 0.886, df = 1, p = 0.347;
If their SU was stressful – Pearson χ^2 = 0.61, df = 1, p = 0.435;
If SU caused emotional problems – Pearson χ^2 =1.43, df = 1, p = 0.232;
[15] Pearson χ^2 = 0.007, df = 1, p = 0.934
[16] Mann-Whitney z = 1.48, p = .139

Use of RSS

Providing recovery support services is one way to aid clients during their time in treatment. Simply examining whether or not there is an association between receiving RSS and client discharge status yields no statistically significant relationship.[17] Upon disaggregation of RSS and analyzing the relationship between the four services, agencies spent the most on – sober living activities, Life Skills Coaching, Drug Card, and Gas Card, there is some support for an association between receipt of some services and discharge status. There was a statistically significant association between receipt of Sober living activities and discharge status.[18] There was also a statistically significant relationship between the amount of sober living activities and successful grant completion.[19] Use of Life Skills Coaching[20], Drug Card[21], and Gas Card[22] showed no statistically significant relationships with discharge status. Table 39 provides use of recovery support services by discharge status.

Table 39. Use of Recovery Support Services by Discharge Status

Use of Recovery Support Services	Completion/Graduation % (n = 36)	Termination % (n = 21)
No	47.2% (17)	57.1% (12)
Yes	52.8% (19)	42.9% (9)
Sober living activities	**Completion/Graduation % (n = 36)**	**Termination % (n = 20)**
No	75.0% (27)	100% (20)
Yes	25.0 % (9)	0.0% (0)
Life Skills Coaching	**Completion/Graduation % (n = 36)**	**Termination % (n = 20)**
No	83.3% (30)	100% (20)
Yes	17.7% (6)	0.0% (0)
Drug testing	**Completion/Graduation % (n = 36)**	**Termination % (n = 20)**
No	75.0% (27)	95.0% (19)
Yes	25.0% (9)	5.0% (1)
Supplemental Needs - Gas Card	**Completion/Graduation % (n = 36)**	**Termination % (n = 20)**
No	58.3% (21)	70.0% (14)
Yes	41.7 % (15)	30.0% (6)

GLOBAL OUTCOME MEASURES

Treatment providers implement the Family Global Outcome Measure (GOM) and the Adolescent GOM. The agency therapist or therapist assistant administered this measure to clients and family members via the telephone approximately six months after discharge from the grant. Staff had two weeks before the six-month post-discharge date and 28 days after that date to complete these Global Outcome Measures. The GOM's ask both the adolescent and

[17] Pearson $\chi^2 = 0.522$, df = 1, p = 0.470
[18] Pearson $\chi^2 = 5.96$, df = 1, p = 0.015
[19] Mann-Whitney z = -2.41, p = .016
[20] Pearson $\chi^2 = 3.73$, df = 1, p = 0.053
[21] Pearson $\chi^2 = 3.51$, df = 1, p = 0.061
[22] Pearson $\chi^2 = .747$, df = 1, p = 0.388

family member to indicate if they believe the adolescent improved, is the same, or worse regarding the adolescent's in general, their family interactions, substance use, mental health, and peer relations.

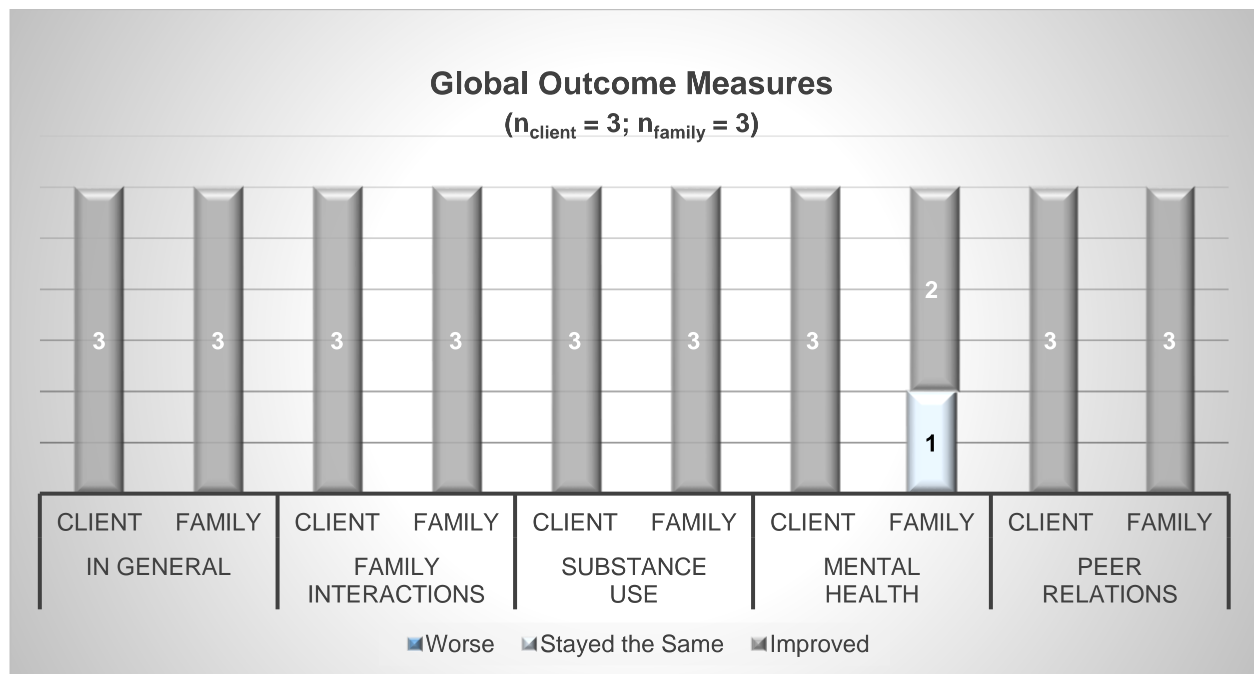
Since implementation, three Adolescent Global Outcome Measures were completed and three Family Global Outcome Measures were completed. Forms were not completed for several reasons, including: staff unable to reach clients or family members, staff unable to locate clients or family members, no forwarding address or phone number, and clients or family members declining to answer the questions. Both GOM's (adolescent and family member) were completed for three clients. Because of the small sample size analyses to assess agreement between client and family have been omitted. In future reports, these analyses may be conducted if the same size warrants.

Clients and family members were asked to rate their total improvement (ranging from improved – no change – worse) was due entirely to the treatment program:

- In general, would you say you are… (In General)
- Would you say your family interactions are… (Family Interactions)
- Would you say your substance use is… (Substance Use)
- Would you say your mental health is… (Mental Health)
- Would you say your peer relations are… (Peer Relations)

All of the clients and two of the family respondents rated improvements for these measures. Figure 4 depicts the distribution of client and family responses to the GOM outlined above.

Figure 4. Global Outcome Measures – Client and Family



Clients and family members are also asked about convenience and satisfaction of services, and if the client's cultural needs were met. Again, the clients rated these measures highly. Figures 5 through 7 displays the distribution of client and family responses to these other GOM.

Figure 5. Convenience of Services

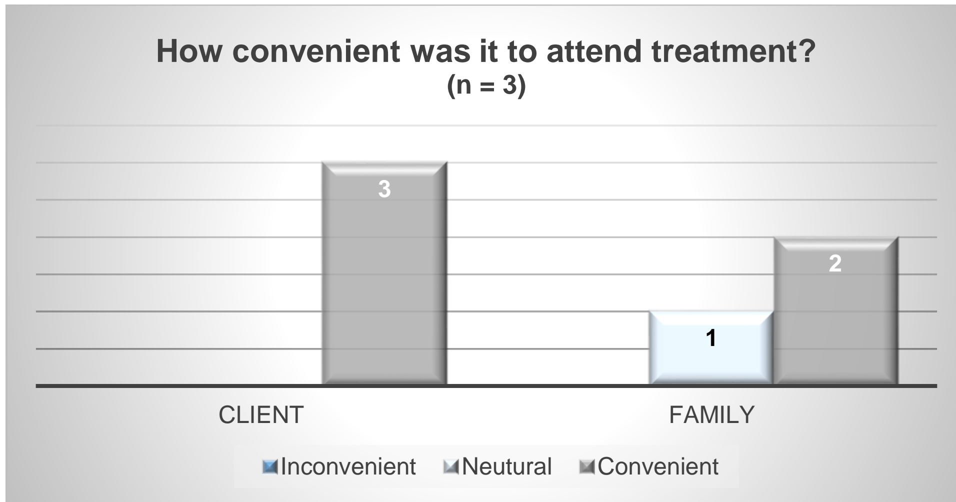
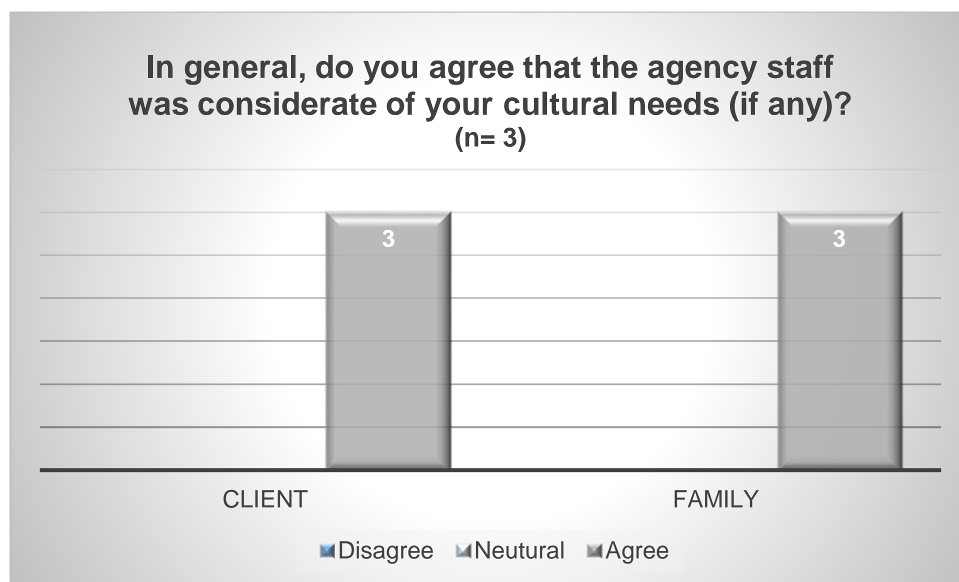


Figure 6. Satisfaction with Services

Figure 7. Cultural Needs Met



WORK FORCE DEVELOPMENT

Staff Training

MDFT certification requires six months of intensive training, which includes several on-site trainings, weekly and biweekly phone calls with MDFT trainers to review cases and assist with case planning, DVD supervisions and live supervisions at site visits by MDFT trainers, written examinations, and work samples. Follow-up MDFT trainings are held at treatment provider sites to complete the training process. During the follow-up trainings, the MDFT trainers and therapists participate in two days of case review, consultation, and live supervision. Live supervision sessions consist of one-hour preparation and planning for the session, an actual family therapy session, and a half hour post session debriefing. Provider therapists and trainers watch the sessions live and MDFT trainers communicate directly to the therapist in sessions to provide guidance or direction if necessary. All of these requirements are completed through the MDFT Clinical Portal in order to provide feedback reports on the fidelity of MDFT certification.

The MDFT therapists training certification is completed on average within six months of the initial training. Some therapists complete the process over longer periods due to timing of cases and case review submissions. Once certified in MDFT, the client caseload can increase up to eight adolescents for full-time therapists. MDFT supervisors and trainers undergo a process similar to regular certification with regular contact with the trainer and review of techniques. MDFT supervisor training took place on January 27, 2016 at YSS. MDFT therapist training took place at YSS on February 9-11 and Heartland on February 25-26, 2016. MDFT booster training for recertification took place at YSS on June 29, 2016 and Heartland Family Services on July 26, 2016.

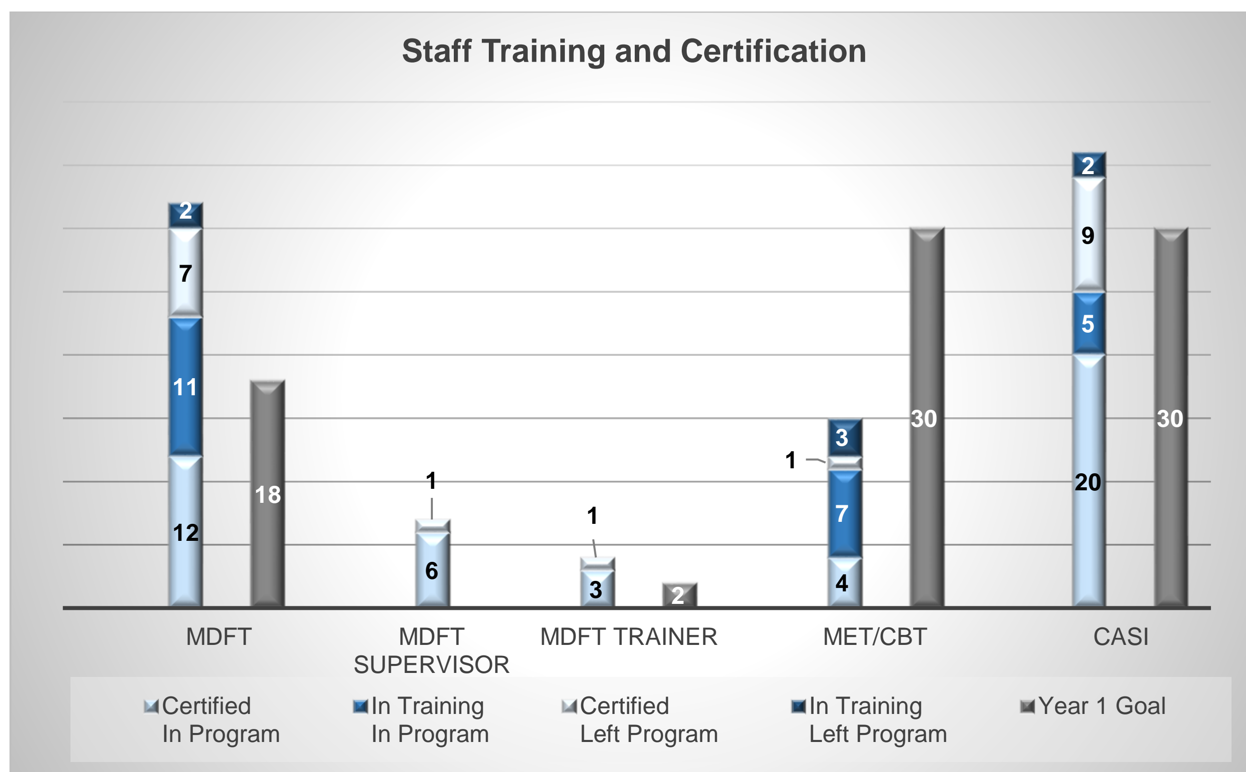
The MET/CBT certification process includes submitting taped video sessions of MET Session One and Two, and CBT Session Three, Four, and Five. Supervisor level certification includes passing the therapist level certification and submitting a review of another staff's session of MET

Session One and Two and CBT Session Three, Four, and Five. Review criteria looks at how a therapist builds rapport with the client by discussing client's lifestyle, strengths, interests; whether the therapist gives rationale for MET/CBT; whether they orient the client to the MET/CBT sessions; and whether or not they communicate their understanding of the client's concerns through reflective listening and comments. Two MET/CBT two-day trainings occurred in Year One on December 9-10, 2015 and September 20-21, 2016.

CASI training consists of a combination of on-line training and direct contact with one of the four Iowa Statewide experts during follow-up trainings. The CASI follow-up training includes a two-day training session, passing a post-training proficiency measure and passing a follow-up proficiency measure. In order to assist statewide experts in Iowa in training new CASI clinician's, an on-line training program was developed and given as another option for therapists. Trainees who become CASI certified for the first time through online training must complete the online training and then have two site visits with an Iowa trainer. The first site visit occurs immediately following the on-line training and the second a few months later, which allows the clinician to practice. There have been two CASI trainings during Year One. YSS statewide experts conducted a CASI training on February 25-26, 2016 and a CASI follow-up training on April 8, 2016. Statewide experts from Heartland conducted a CASI training on September 18-19, 2016. The four Iowa statewide experts also participated in re-certification on September 28-28, 2016.

Figure 8 depicts staff training efforts during Year One. It includes both current and staff that have left the program. Both MDFT Training and CASI training goals were met. These data are current as of August 2016.

Figure 8. Staff Training



Key Informant Interview Training Discussions

Overall, therapists believe both MDFT and MET/CBT have had a positive effect on their agencies. Therapists and directors feel more competent and are able to offer additional services to clients. Therapists reported their agencies were more competitive because of the training they could offer for MDFT and MET/CBT, especially when they could do in-house training. Overall, therapists thought they learned much by breaking down the curriculum for both EBP's and receiving feedback through fidelity checks. They also enjoyed the less intensive training and feedback portion of MET/CBT. The therapists thought the MDFT fidelity checks were an important part of the certification process and helped them grow as a therapist. Therapists also indicated they needed more MI training as they felt like the MET/CBT training did not adequately address this.

Reimbursement was reported as being one of the biggest barriers associated with training, therapists are not reimbursed for this time or supervision tasks to certify staff members within agencies. Directors continually worry about these evidence-based practices and their dependence on training because of attrition. Trying to fill the gap in service when therapists leave has been difficult since trainings are generally only done once a year. Directors also think it is difficult to find willingness on the part of the therapists to get trained in addition to all the other obligations they have. Moving forward with the grant, directors believe the best model is to over train therapists and trainers so they are not so reliant on yearly EBP trainings.

Fidelity Monitoring

The six-month MDFT fidelity reports requested by the evaluator from Cindy Rowe at MDFT International are used to give indicators to agencies of areas that need more attention so that full year data can be improved. It has been a difficult six months to report on fidelity with accuracy because of new therapists being trained, supervisors being pulled away for many competing demands (including training), and transitions within the agencies. The supervision availability for fidelity assessment has been uncharacteristically low because of these factors.

These data reflect the six-month period from January 1, 2016 to June 30, 2016 for Heartland Family Services and Youth and Shelter Services. During this six-month period, Heartland served 18 cases and closed 14 of those cases while Youth and Shelter Services served 21 cases and closed eight of those cases.

Case Duration

Heartland: Case duration is well within the target of 90-180 days; this program is averaging 162-day case duration or 5.4 months per case on average. Engagement, or cases closed with eight sessions or more completed was 57.1%, which is lower than the expected 80% target. Twenty-one percent of clients dropped out of treatment before the treatment goals were met.

YSS: Case duration is well within the target of 90-180 days; this program is averaging 135-days case duration or 4.5 months per case on average. Engagement, or cases closed with eight sessions or more completed was 62.5%, which is lower than the expected 80% target. Sixty-two percent of clients dropped out of treatment before the treatment goals were met.

Session Dose

Heartland: Average weekly session dose is lower than expected for this level of treatment. Cases averaged 28 minutes of treatment per week and the average per week would be expected to be about 1.5 hours. Therapists averaged 10.8 minutes of family sessions per week, which is also less than the target of 30 minutes.

YSS: Average weekly session dose is lower than expected for this level of treatment. Cases averaged 46.9 minutes of treatment per week and the average per week would be expected to be about 1.5 hours. Therapists averaged 20.8 minutes of family sessions per week, which is also less than the target of 30 minutes.

Session Locations

MDFT recommends sessions be delivered both on site and in the home. Sessions held in the office can reduce therapist burnout, increase the opportunity for live sessions, and can facilitate productive and efficient sessions. However, in-home work is also recommended by MDFT as it may increase retention rates, overall contact time, and family session time but is considered to be the more intensive version of MDFT with several sessions a week.

Heartland: More than 98% of sessions are in the clinic.

YSS: Seventy-three percent of sessions are in the clinic.

Clinical Supervision

Heartland: Case review supervision is low, the benchmark is three per month and therapists have an average of 1.22 per month. The monthly report for Live Supervision is zero and the suggestion is 0.42 sessions or higher per month or five to six per year. DVD Review Supervision is 0.17 and the suggestion is 0.42 or higher or five to six per year. Supervisors have ensured therapists video record 26% of their therapy sessions and document it in the portal; the suggestion is at least 25%.

YSS: Case review supervision is low, the benchmark is 3 per month and therapist have an average of 1.82. The monthly report for Live Supervision is .08 and the suggestion is .42 or higher. DVD Review Supervision is 0.33 and the suggestion is 0.42 or higher. Supervisors have ensured therapists video record 28% of their therapy sessions and document it in the portal; the suggestion is at least 25%.

Barriers and Solutions to Widen the Use of Effective EBP: Key Informant Interview Discussion

Therapists believe a major barrier in this project is the requirement they have to complete 12 sessions of MDFT to receive the full amount of funding. In several cases, clients have been successfully discharged at eight sessions and therapists felt it was not best practice to continue providing services when the client did not need it. They reported much of the grant funding was going unused because the funds were not needed for additional services. Therapists also thought the unbillable time in the grant was a barrier, for example, only being reimbursed on a case rate and not until they get their first case, so time spent training or supervising other therapists was not reimbursed. They believe having reimbursement based on hours towards the grant or a combination of hours and output would be better than just output alone. Therapists report time constraints of paperwork, forms, and data entry systems was also a barrier. Therapists also pointed out how invaluable a therapist assistant is to this project because of the paperwork and data entry process. This position is better able to connect clients to community resources in addition to being a point of contact for local agencies like schools and juvenile courts, and they are able to explain recovery support services to clients and find the best services for them.

Therapists reported staffing in rural areas was a barrier to expanding access to those areas. Therapists who have both rural and non-rural clients have to divide time between satellite offices and the main offices, which takes away from all clients. Suggested solutions to widen the use of effective EBP in rural counties were:

- Increasing trained therapists and staffing those therapists part-time in satellite offices, taking the service to the client and their family when possible;
- Marketing, outreach, and word of mouth;
- Integrating themselves into rural communities.

Overall, agency directors believed funding was the biggest barrier to widen the use of effective EBP programs. They reported when a grant partially supports programs, providers will have to eventually rely on a fee for service when the grant ends, which is not built around paying for extra services that programs like MDFT and MET/CBT provide (e.g. RSS). In addition, working with managed care organizations to increase rates for evidence-based practices is an ongoing battle, so these programs are at risk once funding goes away. Directors think if reimbursement

from managed care organizations eventually matches the services they are providing, then it is easily sustainable. These potential funding issues have caused providers frustration considering the time and effort to establish an EBP. They would like to be able to offer these EBP's indefinitely as part of their repertoire of therapeutic practices. Agency directors thought funding would be a larger issue for MDFT because it is a higher intensity program, however, they believe they could sustain MET/CBT without grant funding and with the current reimbursement rates.

Directors thought a barrier to the effectiveness of these evidence-based practices was a lack of communication within the treatment agency. The failure of the treatment agency to adequately roll out the grant and explain very specifically what the requirements were and all of its elements. Requirements should have been covered before staff members were assigned duties and for some provider's implementation was more confusing than it should have been. However, they did believe that the Project Director was helpful and worked with them to answer their questions. Training and workforce shortages were discussed as the largest barriers for agencies. These types of programs are heavily dependent on training so there is a delay in service due to the training process. There are not enough therapists getting trained and therapists are taking on more clients because trained staff members leave. Therapists with EBP training are more marketable so keeping them after they are trained can be difficult. Suggested solutions are:

- Training a higher number of therapists to combat attrition;
- Training a therapist to become an in-house trainer so providers do not have to rely on once a year trainings;
- Convincing managed care organizations to cover the reimbursement costs for all evidence-based practices;
- Implementing policies require therapists to pay back a portion of their training costs if they leave the agency within a specified amount of time after completion of training.

Effective communication was mentioned several times as a barrier. Providers thought there was not enough communication in regards to grant specifics before the contracts were finalized. They believed SYT-I would be similar to SAT-ED in many ways but there were many differences. Overall, providers felt there was not enough communication until something went wrong.

Providers discussed the value of integrated health and the need to use it as soon as a client is admitted to the grant. Clients are supposed to complete paperwork for integrated health before therapy starts, but often times they put it off and lose those valuable resources. Providers think it needs to be protocol to complete the paperwork at the beginning of treatment.

Providers reported the use of the CASI was often times a barrier due to the time constraints of administering the CASI. They felt the amount of time it takes to get through the questions is often unreasonable when working with the adolescent population, especially when it can take two to three sessions to complete.

AGENCY ACTIVITIES

Meetings and Presentations

Each month agencies submit documentation to the Consortium about past month meetings and presentations related to SYT-I. These data began in April 2016 and continued through August 2016. Over these five months, the agencies have engaged in 70 meetings and three presentations related to SYT-I. The average was 14.6 activities each month, ranging from 11 to 16 activities in a month. Prairie Ridge had the most activities across the five months, 32 meetings and one presentation.[23] These activities were conducted across a variety of different media. Fifty of the meetings were face-to-face. Three meetings were via the telephone. Three were listed as a conference. Seventeen were facilitated through visual conferencing. The data presented in this section are not representative of all the activities agencies engage in for SYT-I such as the inclusion of monthly provider calls and Adolescent Steering Committee meetings vary by one agency and not the others.

Heartland Family Services

Heartland reported seven meetings during the past five months. This number is not reflective of provider calls or SYT-I committee meetings. They have had four meetings about billing associated with SYT-I, specifically, the EBP. Two meetings concerned recertification of MDFT. One meeting concerned grant management within Heartland.

Prairie Ridge Integrated Behavioral Healthcare

Prairie Ridge had 40 meetings (see footnote 19) and one presentation. They had three meetings about grant management about the GPRA and RSS. Two staff helped with a booth at a symposium related to TAY. They also conducted 11 meetings to plan a symposium on TAY. Other meetings related to the grant included site visit follow-up and progress report discussions.

Prairie Ridge facilitated a symposium geared to issues of TAY and dissemination of MET/CBT. The first speaker of the day was Travis Loyd, an inspiration speaker and consultant. The focus of his presentation was to share stories of overcoming and inspiring others. Two Prairie Ridge staff, Breanna Johnson and Kate Weiner, presented information about barriers to serving TAY and creative solutions for this population. Another speaker, Michael Ferkack of the Iowa Department of Justice, presented information on Human Trafficking specific to youth and Iowa. The day ended with a brainstorming session that would provide attendees two action steps to implement their workplace and was led by Kelly Grunhovd of Prairie Ridge.

Prelude Behavior Health Services

Prelude conducted 15 meetings during data collection time frame discussed above. Eleven of their meetings were dedicated to MET/CBT – focusing on client admission and discharge, certification and training, ISMART and GPRA. Two meetings were to discuss ways to improve performance and efficiency. During one meeting, Prelude staff trained a patient account specialist. One meeting was a training session on the GPRA entry system in ISMART.

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[23] Eight meetings were excluded because they were for activities that all the other agencies were engaged in as well – Monthly Provider Calls, Steering Committee Meetings, and the SAMSA Site Visit.

In April, Prelude conducted two presentations with staff. These presentations were to inform the staff of EBP services – MDFT and MET/CBT.

Youth Shelter & Services

YSS reported eight meetings during the five months of data collection. Their first meeting was about MDFT sustainability. The other seven meetings were centered around MDFT. One of these meetings were with MDFT clinicians and another was with Mercy Hospital Staff. Another meeting was with the Story Country Board of Supervisors. Four of the MDFT meetings were with criminal and juvenile justice representatives.

Provider Monthly Meetings

The project director meets with all the agencies and the evaluators once a month. These meetings provide an opportunity for open dialogue between IDPH and treatment providers. Meetings entail discussions about training needs, contracts, grant expectations, data entry of state treatment records and the GPRA, and site visits. During one call, there was a brainstorming session for RSS with a specific focus on sober living activities for clients in rural areas. Kevin Gabbert of IDPH, the project director for Access to Recovery, facilitated the session.

Agency and Youth Successes: Key Informant Interview Discussion

Overall, therapists thought their biggest successes were the changes they had seen in both clients and families. They discussed clients who had completely turned their lives around with MET/CBT by identifying goals and inconsistencies in their thinking. They discussed families who returned to MDFT voluntarily after leaving for personal reasons and how they had not returned to substance use. According to therapists, clients believe that both MDFT and MET/CBT are unlike any other programs they have ever been a part of; for example, one client had gone through multiple providers and multiple therapies and thought MDFT was different and better. According to therapists, clients thought MET/CBT was specifically tailored to them, they felt like it had value and was applicable to several different areas of their life, they liked the worksheets and that each session had a goal, and they liked the small group settings and felt as though they could express themselves better. One client thought MET/CBT was so beneficial that they referred a family member to the program. Therapists discussed how much parents thought MDFT helped their children and they were better able to understand them and help them communicate better. They also discussed how their clients had both immediate family and extended family participating and they saw the change in the family members in addition to the client. Therapists thought that the success of MDFT was that family participation had increased, not only because of the family component of MDFT but because they wanted to be a part of the change and the solution. Therapists thought the changes happening in families because of these EBP's would have a generational, community affect, and that these small ripples would affect society as a whole.

Therapists also discussed the changes and successes they had experienced because of SYT-I and SAT-ED. Overall, they thought one of their biggest accomplishment thus far had been the change they had seen for themselves and their colleagues using these EBP's. They began to think differently about their general approach to treatment and they thought that led to a better level of client care. Therapists also felt as though they had a better understanding and perspective of TAY and were much more attuned to that population now. They also thought that it was nice to be able to have these options for their clients and that being able to train other

staff members on an EBP was a success because providers were now expected to be able to offer EBP's.

Agency Steps toward Achieving Goals: Key Informant Interview Discussion

Providers are demonstrating a coordinated effort to increase the number of trained staff in each EBP; they are working diligently to increase all intakes, including rural and minority adolescents, and they are taking the necessary steps to become more culturally competent.

Providers continue to work towards increasing the total number of trained staff in MDFT, MET/CBT, and the CASI. All providers have surpassed their first-year training goal for MDFT trained therapists, supervisors, trainers, and CASI trained therapists. Providers are over halfway to meeting their first-year goal for the total number of MET/CBT therapists trained and have plans to send additional staff members to the next training. In addition to staff using the CASI assessment for MDFT, two providers have adopted the CASI agency wide for all clients under 18 who have a SUD. By increasing the use of the CASI they are screening more adolescents for both SUD and mental health problems and increasing evidence-based services for adolescents with co-occurring disorders.

In an effort to increase rural intakes providers are increasing outreach in rural areas and staffing MDFT and MET/CBT trained therapists in rural satellite offices to make it easier for those adolescents and their families to receive treatment. One therapist, working in a satellite office, has a great relationship within the community, has integrated themselves with the public health department, schools, and providers in order to bring awareness to MDFT. However, it has been difficult to staff rural offices as services are driven by the request for service and if providers cannot justify the added clinician hours they are unable to increase staff.

For one provider, many of their MDFT referrals come from juvenile court and that is where they have done the most outreach. Another provider tries to recruit and maintain a diverse workforce in the hopes this might also draw in minority clients. One agency indicated that being able to work in client's homes helps them adapt to their culture, the client feels more comfortable, and they are more likely to continue with treatment. However, therapists thought regardless of their efforts to increase minority clients, there will always be a struggle because of Iowa's homogenous population.

Providers are using marketing and outreach with other state agencies to increase intakes and referrals as well as bring awareness to MDFT and MET/CBT. One provider facilitated a symposium geared toward issues of TAY and dissemination of MET/CBT in an effort to bring new perspective to professionals treating this population. Another agency is planning to use MDFT materials to market to physicians in an attempt to increase awareness of treatment options for adolescents who test positive for SU in blood or urine analysis tests. For one provider, many of their MDFT referrals come from juvenile court, which is where they have done the most outreach. Over the course of two years, this outreach has resulted in three additional contracts to provide MDFT services, these contracts include the Polk County Juvenile Court, the Fifth District Juvenile Court, and the Eldora State Training School.

Providers are also working towards becoming more culturally competent; one agency has a diversity officer dedicated to competency issues, they have forms translated into Spanish and an interpreter, and they are recruiting and maintaining a diverse workforce. Another provider has a cultural plan in place to look at sensitivity to religion and race and have completed trainings on topics such as cultural humanity and stigma. One provider is addressing cultural

competency by providing training in Safe Zone, Culture of Poverty, topics related to disability, and Islamic diversity. They also have an LGBT subcommittee, they bring the service to the client in their home when possible to address any cultural barriers, and they have bi-lingual staff.

Recovery Support Services: Discussion from Key Informant Interviews

Overall, therapists believe recovery support services (RSS) provide incentives to engage in therapy and find them very beneficial. Clients are grateful for the gesture and they feel as though it is above and beyond what they have been offered in other treatment settings. These services have been most beneficial to clients who are struggling financially and in some situations, they make it possible for the client to continue with treatment.

Although RSS have been very beneficial for clients, therapists have had difficulty with the definitions being vague or unclear as to the full spectrum of activities that qualify for each RSS. Without clear definitions, they find it difficult to explain the benefits to adolescents when they enroll them in the grant and it makes it harder for clients to buy into this part of therapy. For example, agencies find it hard to explain the full range of sober living activities when they are not sure of the possibilities. Therapists think a list of all possible services or open communication between providers as to the services they are using would be helpful. Therapists are frustrated with having to contact IDPH staff each time they are unsure of RSS coverage since it takes time to receive answers to these requests. Therapists also reported that using services with rural clients poses an issue due to accessibility. Many of the community activities that are covered are less available if at all in rural areas and finding creative ways to make these funds more accessible is important. In addition, rural clients often do not have transportation to get them to these activities in areas where they are accessible.

Therapists reported some services cannot benefit every client even with the best intentions. Services like behavioral health assessments are not always beneficial because a doctor is not always available to make it to each client who would benefit. Many of the sober living activities require family participation and often times clients do not have the support of family members or transportation to get them to these activities. Residential clients or clients who live out of town may not know where they are going to end up when they leave treatment, so RSS like gym memberships can be difficult to offer. Additionally, therapists reported many residential clients have insurance, which covers some of the RSS, however, these clients cannot use services from two different payer sources so it appears as though some of the grant funded RSS are not being used.

Therapists also reported the need to expand on some RSS, specifically, they thought celebrating/strengthening families was difficult to translate to clients. They believe that being able to provide family dinner as a service for families would be extremely beneficial as valuable interactions and change within the family dynamic happen around the dinner table. Therapists also think there are unclear limits to services that are supposed to be covered. For example, one client needed a tool belt as part of his apprenticeship but this was not something covered even though apprenticeship costs are often covered. In addition, therapists also think there are a lack services that are beneficial to adolescents. Therapists mentioned hygiene products and clothing as being more beneficial services for adolescent clients and something they actually need. Clothing and hygiene products have been added as an available RSS for Year Two.

COMMITTEES

SYT-I Committees

SYT-I has established three committees, the Adolescent Steering Committee (Steering Committee), the Workforce Development Committee, and the Financial Subcommittee to help achieve the goals of the grant.

Adolescent Steering Committee

The Steering Committee is scheduled to meet quarterly and has met three times during the first year of the grant. The first committee meeting convened in January. During this committee, the project director reviewed goals of the grant. There was a discussion of state infrastructure and the other grant committees – Workforce Development and Finance Subcommittee. They also went over the EBP's and current counts of trained workforce. One goal of the grant concerns modification of two state policies. At this meeting, the conversation centered around reimbursement rates with state Medicaid. As Iowa has recently privatized Medicaid through three companies, this conversation is extremely important to begin coordination efforts with the three managed care organizations. The other policy discussed was licensure standards. The first step is to review the standards and treatment competencies to build into licensure standards.

The Steering Committee met again in April. The agenda was similar to the first meeting and extended many of the topics discussed. A main thrust of this meeting was to create action plans for moving forward. Members discussed workforce development focusing on additional members for the Workforce Development Committee, the connection between competencies and reimbursement rates, training methods and the use of technology (such as distance supervision). The committee continued discussion of reimbursement rates and state licensure regulations.

The Steering Committee met a third time in July. An aspect of the infrastructure, development or use of existing family and youth services, was discussed. As the state does not currently have a structure for supporting recovery for youth, it has been decided to create a staff position to help create this needed structure. At the time of the meeting, the members talked about how to organize the youth while filling this staff position. It was suggested to look to Achieving Maximum Potential (AMP) in the State Training School for organizing youth. It was discussed that the committee is in need of more members to represent the managed care organizations, parent and youth, as well as, individuals with expertise or contacts for workforce and housing for youth. The project director reviewed the Workforce Committee meeting from June. This spurred a discussion of potential contacts at area educational institutions for this committee. The Steering Committee discussed technology and distance supervision for clinicians. Lastly, the committee discussed reimbursement. They reviewed the work SAT-ED had done with Magellan (the previous Medicaid provider in Iowa) to get MDFT approved for reimbursement. The committee agreed that the next steps are to get the details used with Magellan and then schedule meetings with the three managed care organizations. The project director reviewed the financial map, which is the main objective of the Financial Subcommittee. The work of this committee has been a barrier to the grant because of the complicated nature of the financial map. Working towards a solution, the first step discussed is getting the old Medicaid codes and

the new Medicaid codes, which will help identify what resources are currently in use and aid in identifying the pre- and post-use of Medicaid for SUD treatment.

Workforce Development

To achieve the policy goal of licensure standards in the state Iowa for SUD treatment for youth, the Workforce Development Committee was created. This committee met in June. The majority of the committee members are professionals in the area of SUD treatment. They decided their first step is to gather data on graduates with advanced degrees. They also discussed adding to current curriculum, addressing treatment options, and figuring out where gaps in curriculum exist.

Financial Subcommittee

The Financial Subcommittee met in April. The committee members reviewed the financial map template, which contains the categories of the information the committee needs to supply to fulfill the grant goal. As mentioned above, this financial map is complicated and information is needed from several sources and is needed yearly. The committee discussed potential members to add to the committee who would have the needed information or access to the information. As discussed at the Steering Committee meeting in July this committee has stalled. One suggestion was to contract experts to develop the financial map.

Coordinated Effort to Serve the Population: Discussion from Key Informant Interviews

Committee members are currently working on licensure regulations to enhance services for the adolescent population. Currently the only guidelines that exist in Iowa are for inpatient adolescent treatment, there are no formal best practices for any EBP for adolescents with SUD who are out of residential treatment. The committee is working towards re-writing the guidelines for outpatient treatment and credentialing staff who work with the adolescent population. In addition, the committee is also trying to bring awareness to the issue. Iowa clinicians are typically not trained to understand adolescent developmental issues in their coursework. There needs to be additional certifications or an endorsement to prepare clinicians for adolescent substance use issues. Currently, clinicians receive on the job training for the most part, the committee is hoping to work with colleges and universities so future clinicians have more preparation on how young adults and children are different from adults in terms of substance use.

Other successful efforts include engaging managed care organizations and having ongoing discussions around the use of EBP and long-term sustainability. If programs like MDFT are reimbursed, then the service is sustainable when grant funding ends. Current reimbursement rates do not come close to reimbursing all of the services SYT-I provides, especially the recovery support services.

Committee members are also working to implement or enhance the process for juvenile re-entry adolescents to receive MDFT and transition back home as seamlessly as possible. Members are making sure the juvenile court knows the program exists and how successful it has been so the success of the program can grow within juvenile court. Members are also working on a pilot project for MDFT for youth that are currently in the State Training School with the hope to expand MDFT to adolescents who are in group care.

In addition, members are working to ensure the eligibility requirements of these programs are known around the state; Iowa struggles with family engagement and services for family engagement. Members are also working to change the mindset from serving just the adolescents with MDFT to also serving the family and working with the entire system. Committee members believe the only way to see change is a systematic change, with family involved, the Department of Human Services, the criminal justice system, and schools.

RECOMMENDATIONS

Client Level

Therapists consistently mentioned the need for clarity of the recovery support services during the key informant interviews. They feel as though they are not using the full range of services because the definitions are vague. They also think it is difficult to explain the benefits of some of the services to clients, which may create resistance in the client to treatment. We have several recommendations to aid in the use of recovery support services.

First, we recommend providers create a list of services they have used during this project year, or for other grants, such as participation in the Access to Recovery grant. This information can be the first step in a brain storming session during a monthly provider call. We also suggest holding focus groups with clients and asking them what do they need to help with their recovery. Given client age, these individuals are at the prime point for intervention, and possibly having assistance with other areas of their lives – housing, employment/education, criminal/juvenile justice, could translate to more successful outcomes.

In this vein, there are several current RSS services that could help – life coach and education/vocational training. To use the life coach services, providers may want to partner with other specialists, for example, an employment specialist. In Iowa, there are several Drug Courts with federal grants that have an employment specialist.[24] This individual or others in the Drug Court grant could serve as connections to others in the community. These connections could help, holistically, with the needs of the SYT-I population. Moreover, the life coach RSS could also help with probation/parole requirements as many of the clients in SYT-I are on probation/parole.

Some clients not finished their high school degree, and completing their education may improve their quality of life in general. Area community colleges offer high school equivalency tests.[25] Additionally, Kirkwood Community College offers courses for individuals whom need to complete a high school course.[26] These are just a few examples of educational resources available and RSS may be used to augment some or all of the costs.

While the state is in the process of hiring a youth and family coordinator to aid in grant goals, it might be helpful to use social capital and to create community networks to connect clients with their community or help to create a community. These networks may provide sources for employment, housing, and sober living activities (such as client volunteering). Furthermore, any

[24] The Consortium is providing the evaluation for two Drug Court grants.
[25] Des Moines Area Community College: https://go.dmacc.edu/hiset/Pages/welcome.aspx or Kirkwood Community College http://www.kirkwood.edu/site/index.php?p=35772
[26] Kirkwood Community College – Need a class to finish high school: http://www.kirkwood.edu/site/index.php?p=35763

connections made, would help the coordinator transition into their role once hired. Additionally, providers may want to do outreach with educational institutions to aid clients in their schooling or vocational training.

Although not presented in this report, but asked in the GPRA interview, some clients are engaging in risky sexual behavior. Twenty-two out the 32 clients at admission had unprotected sexual contact in the last 30 days. Four of these people who engaged in unprotected sexual contact, also used a syringe/needle, cooker, cotton or water that someone else used. As integrated behavioral health is at the forefront of treatment, providers may want to include sexual health as part of services. Providing sex education may require the creation of a new RSS, or partnering with other community agencies, that focus on physical/sexual health.

Organizational Level

Providers indicated they were frustrated with the case rate per client model of reimbursement, where reimbursement is directly correlated to output with clients from start to finish versus reimbursement based on total hours toward the grant. Therapists also found the unbillable time associated with training in an EBP or training other staff members to be frustrating. In addition, providers thought it was not best practice to continue with MDFT treatment to 12 sessions if a client is ready to be discharged after eight sessions, as providers expressed this is still considered successful completion of treatment within the model. We recommend providers engage in an open discussion about these issues with IDPH staff and their SAMHSA GPO in an effort to evoke change or find solutions. Also, due to NREPP guidelines indicating that MDFT can be "delivered across a flexible series of 12-16 weekly or twice weekly 60-90 minute sessions," IDPH recommended providers speak with MDFT International trainers regarding these requirements.

During the key informant interview process, some committee members were unclear as to the role they played within the committee, or how their inclusion on the committee would help achieve grant goals. Some members were unclear of when meetings occurred and were unaware of important grant projects other committee members were involved with. We recommend clearer communication with members about their role on the committee. Moreover, periodic updates about committee work, barriers, and achievements with committee projects would be beneficial, for example, a bi-monthly SYT-I committee newsletter.

APPENDIX

First Year Key Informant Interviews

Responses from Therapists at the Treatment Provider Sites

What effect do you think SYT-I has had on your agency and how you provide treatment services?

- All respondents thought the project had a positive effect on their agencies. Staff from each agency thought being able to provide incentives like recovery support services to engage adolescents and clients in therapy was extremely helpful.
- MDFT providers believed it had completely changed how they provide services both in this project and in general; therapists thought they have a much wider skill set to offer clients now.
- Two therapists thought the project reinforced the need for evidence-based practices and the need to stay competitive as an agency by offering training and services on EBP. One therapist discussed how MDFT allowed their agency to increase their referral base as they now have multiple funders for MDFT.
- Another therapist reported MET/CBT allowed them to focus more on transitional aged youth by outlining the needs they have. By offering MET/CBT they have provided opportunities to the TAY population that were not available in the past. Another therapist realized through the project they were not using motivational interviewing skills as often as they could be.
- One staff member thought MET/CBT filled a piece of the puzzle that was not there before.
- Two respondents felt MDFT was helpful but limiting to the providers because it limits some of the services they can provide. They thought only being reimbursed for 12 sessions was challenging because often times they discharged clients at eight sessions.

What is your opinion about MDFT and or MET/CBT?

- Overall, therapists thought MET/CBT was a great program. They thought it helped both the therapist and the client stay focused and on track with a goal at the end of every session, but they also liked how it was flexible and can be adjusted to each client. In addition, therapists thought the worksheets were helpful, they kept clients accountable and clients see the value in them.
- Two therapists thought MET/CBT could be applied to many different life skills in addition to aiding substance use recovery and they thought clients really appreciated that.
- One therapist thought their feedback in regards to certification for MET/CBT was harsh at certain points and forced them to reconsider their therapeutic approach. They also thought that while MET/CBT works in a group dynamic, it doesn't work very well in individual sessions because the therapist has to play different roles, while in a group setting the group takes on those roles.
- All MDFT therapists felt it was a wonderful program, which has produced amazing results. Although it is extremely timely to be trained, they believed they have grown immensely as therapists because of it. One therapist thought the theoretical model really helped them connect the emotional side to the overall wellbeing of the client. They liked that it focused on the emotional distress that families go through and forces them to

talk about those things that are unspeakable. Another therapist has seen intense changes in the family experiences while another therapist thought it was the best thing that has happened to their agency.
- Another staff member thought the theoretical concept of MDFT was vague in that they wanted to know the reasoning for some of the treatment principals. They felt like those principals were not explained very well.

What is your opinion of the Comprehensive Adolescent Severity Inventory (CASI)?

- All respondents who have used the CASI thought it was a lengthy assessment and took up more time than other assessments. One therapist thought that it was difficult to keep adolescents engaged during the assessment and that those administering it need to be mindful of how edgy or anxious adolescents may become while taking it.
- One staff member has struggled with the continuous questions that have to be asked of adolescents. They also said it usually takes them one to two hours with just the assessment, and does not include meeting the parents or any other additional paperwork that must be completed; traditional assessments generally take half the amount of time. However, this respondent indicated they see the value in this tool.
- One therapist mentioned there were several positive things about the CASI but there are areas that are missing, more specifically, gambling questions. They also thought the other screening tool they use was a better option for some mental health and trauma as CASI only lightly touches on trauma.
- Two therapists thought the CASI was very thorough. One respondent liked that they were able to assess all domains of adolescent life from family to mental health to peer relationships. They believed it had good conceptualization about where they will go when they finish it. Another respondent thought the CASI helped them streamline the process to better assess their clients and get them connected to the services they need.

Have any of your clients provided feedback about MDFT, MET/CBT or CASI? If you have received client feedback what did they think?

- Therapists who have received feedback on MET/CBT said their clients believed it was a positive experience. They felt like it had value and that it was applicable to several different areas of their life, especially anger management. Clients really appreciated the skill transfer of MET/CBT.
- One staff member indicated clients liked that the program was tailored to them specifically and they like the worksheets and homework because it was a challenge and a good way to reinforce the practice and what they were learning. They also liked that there was a goal at the end of every session.
- Another therapist reported clients liked the structured system to this approach because it was unlike any other experience they have had in the past.
- Clients have also reported they liked the smaller groups and they enjoyed having other clients in their age groups in this setting. They felt like they could express themselves more in those small groups.
- Overall, therapists reported clients thought MDFT was very beneficial. Parents thought it really helped their children and they were able to understand them and help them communicate better.
- One staff member said clients described it as being different and better than anything they have done before. One client had been to multiple providers, went through multiple therapies, and thought MDFT was different from any of those.

- All therapists reported clients consistently said the CASI was long, but they did not have a lot of productive feedback.

Has MDFT and or MET/CBT enhanced your ability to provide therapy? How so or how not?

- Each respondent agreed MET/CBT or MDFT enhanced their ability to provide therapy.
- One therapist thought MET/CBT gave them one more approach or method. As an individual they thought it built up skills they already had and pushed them to do something better.
- Another therapist felt MDFT helped them dig deeper not only with their adolescent clients but also with their adult clients who are not in MDFT.
- One staff member believed MDFT enhanced their ability to provide therapy because it was more supervised and had more structure than any other EBP.
- One respondent discussed how MDFT had overreaching goals each session and small goals to reach those goals. They believe these small goals helped therapists focus on the next shift and develop their interventions.
- Another therapist thought the structured curriculum of MET/CBT has helped them to stay focused. It has enhanced their ability to provide therapy, they try to see things from the client's perspective more often and they are always developing new and better ways to explain concepts or worksheets to clients so that they are able to fully understand what is being said.

Do you think MDFT has increased family participation in treatment?

- All respondents thought family participation had increased not only because of the family component of MDFT, but because family wanted to be a part of the change and the solution, which is part of the success of MDFT.

Have there been any barriers to RSS? If so, solutions?

- Three respondents thought the biggest barrier to RSS were the fact that they were vague as to what qualifies as an RSS. Without a concrete list of the full spectrum of possibilities, they felt clients could be missing out on a service which would benefit them. Respondents thought it was difficult for clients to buy into this benefit without knowing exactly what services they could benefit from. One therapist thought it would be helpful to have open communication with other agencies as to how they are using each RSS or to have a running list of services have been used or can be used.
- Another therapist thought the celebrating/strengthening families service was difficult service to translate to clients. Family dinners are not a covered service and this staff member believed being able to provide family dinner as a service for families would be extremely beneficial as a lot of valuable interactions and change within the family dynamic happen around the dinner table. Two respondents discussed how difficult it was for rural clients to benefit from RSS due to accessibility, many of the community activities are covered are less available if at all in rural areas.
- Another therapist reported that using RSS with residential treatment or out of town clients was not always possible or it was difficult. These clients may not have cars so they cannot use gas cards, they are unable to drive themselves to activities, or they might not know where they will end up after treatment so they are not able to use services like gym memberships. In addition, these clients often do not have family support so some sober living activities that require family participation are inaccessible.

This staff member also discussed how behavioral health assessments are not always accessible because a doctor does not always have the time to see every client. Another therapist reported that some residential clients have insurance, which covers several of the services covered under the grant. However, they cannot use both insurance and grant funds for services that are covered under both, so it looks as though many services are going unused.

- One respondent did not think there were any barriers, they thought RSS were a positive addition and clients really appreciated the gesture.

How well do you think the SYT-I project addresses your clients' cultural needs?

- Two respondents believed RSS did a great job of addressing clients' cultural needs; one respondent thought that they were a huge benefit for those who are struggling financially because of the array of services that are covered. The other respondent thought RSS offered an overall holistic approach in that some RSS have family involvement and RSS like gym memberships help clients get their physical needs met.
- Another staff member thought there was not a lot of cultural diversity among clients and therefore not a lot of cultural needs.
- One therapist thought MET/CBT did not do a great job of addressing cultural components while another respondent liked that the MET/CBT curriculum did not appear to cater towards one group or another. They thought it was good that the curriculum did not favor one group over another.
- One respondent thought both MDFT and MET/CBT inherently addressed client's cultural needs as it pertains to their age because both EBP's are directed toward certain age groups. Another therapist thought MDFT addressed cultural needs because the curriculum allows them to make it as individualized as possible to any population.
- Another staff member felt like the project did not do a great job of addressing rural clients' cultural needs, such as funding for activities like 4-H or other farming or specialized training/supplies for work.
- One staff member thought the ability to do in-home treatment addressed clients' cultural needs because some clients are more comfortable at home rather than in an office setting and they are able to get more out of treatment. However, they reported a barrier to in-home treatment were billing issues due to the differences in billing between the home and office or switching from one to the other when necessary.

What has been the biggest success and accomplishment as a result of the project?

- Four respondents thought the biggest success was the change they had seen in both clients and their families. One therapist spoke about a client who had completely turned their life around with MET/CBT and were able to identify goals and inconsistencies with their thinking. Another therapist had a couple of families who needed to stop MDFT because of personal reasons and both came back voluntarily and have not returned to substance use. One respondent thought the changes happening in families would have a generational and community affect; they believed these small ripples would affect society as a whole and within families. Another respondent saw changes happening with their client, participating family members, and the extended family as well. Another therapist had a client refer their cousin to MET/CBT treatment after they heard how beneficial the program was.
- One staff member felt the biggest accomplishment was the change that happened for therapists. They began to think differently about their general approach to treatment and that led to a better level of client care. Another therapist reported their understanding and perspective of TAY was their biggest accomplishment because they felt like they were much more attuned to this population now.
- One respondent thought a success was being able to train other staff members on an EBP because insurance companies were now expecting providers have EBP's, so it was nice to have this option for their clients.

What barriers and challenges do you encounter with the project?

- Two respondents thought paperwork was the biggest barrier. They thought the time constraints of paperwork and keeping track of everything they needed to complete in addition to treating clients was difficult.
- One therapist reported the unbillable time associated with the project was a barrier. They discussed issues with being reimbursed on a case rate per client and not for total hours toward the project, they also thought it was frustrating they were not reimbursed at all for training or supervising other staff members in training.
- Another therapist thought it was a challenge that reimbursement was correlated to output with clients from start to finish. The spoke about being frustrated when they were not reimbursed for follow-ups and discharge interviews despite their best attempts to complete them.
- One agency discussed how not having a therapist assistant during the first part of the grant was challenging. They thought this role was invaluable in that they are able to connect to community resources, they have a point of contact in schools, and they are able to connect clients to other resources the therapists do not necessarily have the time to seek out.
- Two therapists faced challenges with the EBP curriculums. For MET/CBT, they found it hard to apply the curriculum because it assumes the client is past the pre-contemplation stage and they want to make changes. The curriculum does not take into account that they may have been court ordered or have other external reasons for being there. For MDFT, they thought most interventions were harder depending on what clients were going through compared to the intervention guidelines in the manual. They also thought clients often felt overwhelmed by all of the goals so the simpler the goals the better.

If there anything else that would be helpful for the evaluation team to know?

- One therapist really enjoyed the MET/CBT curriculum and had positive feedback but they thought more specific dialogue regarding the rationalization for the skills was necessary. They thought it was a challenge to come up with the right wording so the script does not sound overly scripted but that it also covers the main points.
- Another therapist thought communication could have been better between the Iowa Department of Public Health and their agency. It was not until their agency received the contract that they found out SYT-I was completely different from SAT-ED; they had assumed it would be more similar. There were many assumptions from their treatment agency about the grant and not any fact finding before receiving the contract. They felt there also was not enough communication within their agency until something went wrong.
- One respondent thought it was much less chaotic than SAT-ED and another staff member discussed the possibility of having a list of possible RSS in circulation between treatment providers.

Are there any resources you feel weren't being utilized?

- One therapist mentioned they would be able to use more RSS if they were more clear as to everything was covered.
- Another treatment provider discussed the issue of grant money not being used when therapists do not reach 12 sessions with their clients.
- One respondent expressed frustration with the case rate SYT-I implements and thought because of all the training that needs to be completed, they would not be able to meet their intake numbers and grant funds would go unused.

Responses from Directors at the Treatment Provider Sites

What have been some of the challenges (or barriers) with instituting the EBP's and RSS in your agency? Any solutions?

- One director thought the biggest challenge was the cultural shift of doing something to fidelity that has been a barrier because of increased time and increased cost.
- Another director discussed the internal failure of their treatment agency to adequately roll out the grant. They would have liked to have had all the requirements and expectations explained very specifically to all staff members before they assigned duties within the agency.
- Funding and employee turnover was mentioned by two directors as a barrier because they do not get reimbursed for the amount of time and training put into implementation. Workforce shortage is also a huge barrier for them because they often get a therapist fully trained only to have some turnover, which causes delays in services. One treatment agency has implemented a performance bonus plan to help with employee engagement and turnover.
- One director thought administering the CASI was a barrier given the time constraints, they thought the amount of time to complete an assessment was unreasonable. They also believed finding the time to get the CASI online training done in addition to other obligations was very challenging.

- Another director thought the RSS guidelines were too restrictive in how they could be used and they did not think they always matched with the needs of the clients, especially in rural counties.
- The dependency on training and staff turnover was a barrier for two directors. They reported they often lose therapists once they get them trained and this has created major workforce issues. The solution for one agency is to over-train therapists when training occurs in order to diminish attrition issues while a solution for the other agency is to increase staff trainers.

What have been some of the challenges (or barriers) with sustaining EBP in your agency? Any solutions?

- All treatment providers thought sustainability was the biggest barrier with EBP and all of them thought MET/CBT was much more sustainable than MDFT.
- One director discussed how difficult MDFT was to sustain even though it was a good approach, they felt like it was hard to keep family involved and difficult for therapists to keep up with documentation.
- Another director spoke about how difficult it was to continue funding a program that was partially supported by a grant. Once the grant goes away they have to rely on a fee for service system which is not built around paying for additional services that programs like MDFT provides. One provider thought if they could get the reimbursement rates from managed care companies to match the service they provide, it would be sustainable, but not until this happens. However, they thought MET/CBT was much more sustainable without grant funding with the current reimbursement rates.

What are some of the successes that have been encountered in an effort to increase intakes of rural adolescents? How about struggles that have been encountered in an effort to increase intakes of rural adolescents?

- Being able to go to the community of one rural client to provide services was seen as a success, especially because the intake could not have occurred otherwise. A struggle for them is not being able to staff the rural office as much as they would like. Availability of therapists is driven by request and they are not able to justify increased therapist hours in the rural office yet.
- One treatment provider thought a success was the amount of outreach they have done in rural areas and the awareness they have brought to MDFT through marketing and making sure people in the community know it is available. Another success for them has been thinking outside of the box to deliver the best care; if all else fails, they always take the service to the client and family where they are located.
- Word of mouth about MDFT has been the biggest success for one agency. In addition, the therapist who is staffed in the rural office has a great relationship in the community and has integrated themselves with the public health department and providers there. This therapist has marketed the model and increased referrals. A struggle with having a therapist in the rural office once a week is it takes time away from clients at the main office.
- One agency's biggest barrier was their inability to plan well for having the therapist at their rural office trained in an EBP, they thought more planning was necessary to make this happen.

What are some of the successes that have been encountered in an effort to increase intakes of minority adolescents? How about struggles that have been encountered in an effort to increase intakes of minority adolescents?

- Overall, the only success reported was increased outreach to juvenile court services that resulted in increased minority referrals as their minority population often comes from juvenile court services.
- Directors reported that increasing minority adolescents had been an ongoing struggle in Iowa as the state population is not very diverse. One provider works to recruit and retain a diverse workforce and hopes this will increase minority intakes. This provider also connects with other agencies in the community and is serving those populations to inform them of the services that are provided.

Responses from the Adolescent and Workforce Steering Committees

What is your understanding of the purpose of the adolescent steering/workforce committee?

- One member thought the purpose was to increase dissemination of treatment and improve the support network for adolescents and their families by improving communication so adolescents know their options for treatment.
- Two members thought the purpose was to put together stakeholders to better understand the unmet needs for adolescents and TAY and to find ways to enhance treatment services.
- Two committee members believed the purpose of the committee was to place individuals at the table who have the capabilities to alter the funding environment and increase sustainability. They also thought the purpose was to provide guidance and oversite to the project and to make sure they were implementing the work plan.
- Two members understood the purpose as providing guidance and helping to establish guidelines around the licensure standard and how those standards could be enhanced to support the grants efforts.
- One member thought their purpose in the committee was to have influence at their university in an effort to strengthening students' understanding of public health concerns like SUD.

How long have you been on the committee? What is your role on the committee?

- Five members have been on the committee for over four years since the beginning of SAT-ED, others have been on the committee between four and eight months.
- Three members reported they are provider representatives and help other members understand EBP and the family systems approach.
- Another member reported they provide insight from the licensure perspective on establishing guidelines for specific staff credentials to work with the adolescent population.
- One member has experience working in juvenile reentry and their role is to provide input on transitioning adolescents back home as seamlessly as possible after receiving treatment. They also felt as though not enough agencies know MDFT exists and given its success rate they thought they could provide insight into how to expand MDFT within juvenile court.

What are you currently working on because of committee involvement?

- Overall, committee members reported they were focusing on new state licensure standards for credentialing staff who work with the adolescent and young adult population in outpatient treatment.
- Another member discussed working with universities on an additional certification, endorsement, or coursework specifically for therapists working with the adolescent and young adult population with SUD. They reported that therapists have psychology or social work backgrounds but their coursework does not cover substance use with this population, it is only on the job training.
- One member is currently working on a pilot for MDFT for youth who are currently in the State Training School with the hope to expand to adolescents in-group care.
- Two committee members are working on committee recruitment – one who has been working on recruiting families who have been through treatment or have a family member in treatment - believe their presence on the committee would be invaluable. The other member has been working on recruiting advanced practice nurses who have clinical practice in adolescent work and special expertise in adolescents with SUD. This member believes healthcare workers need to be educated across the lifespan and involving healthcare workers in this grant could help make a difference not only in the grant but also in the nursing profession.

What are some of the accomplishments of the project? What are some of the biggest barriers experienced by the project?

- Two members discussed how the participation of the managed care organization and the addition of getting one doctor in particular to the committee table were both accomplishments. They believed that being able to engage these organizations in the use of MDFT and MET/CBT is the first step in reimbursement.
- One member thought a success was the progress state agencies have made in understanding more about what kids need; it is starting to be understood that kids need more than just being sent to residential treatment programs for true change to occur. The only way to see change is a systematic change with family involved, the Department of Human Services, the criminal justice system, and schools.
- Another member spoke about their success in finding a family member with lived experience willing to participate on the committee.
- Most respondents felt as though there were not a lot of barriers as of yet but they believed they would run into several barriers during the course of the grant. Committee members all mentioned the difficulty in accomplishing the goals they have set out to attain.
- One member thought the process of financial mapping would be a barrier given its complexity.

Are there any persons or community sectors you recommend for inclusion on the committee?

- One member discussed the benefits of including a pediatrician or another doctor that works with families with substance use issues. Another member thought it was important to include a nurse or healthcare professional and someone from the school system, they thought there needed to be a link between the two.
- Another member thought it was crucial to include high-level personnel from the Department of Human Services.

- One person mentioned including someone from the criminal justice system, attorneys who work with adolescents or probation officers. Another member mentioned the need for more diversity on the committee. Someone else thought it would be helpful to find youth with SUD to participate but they recognized it had been a struggle to find someone.

Are there any policy changes that have been accomplished as a result of the Interagency Council or the project?

- One member reported their treatment agency had a successful policy change by becoming an adult only agency when Youth and Shelter Services merged with Francis Lauer. They reported that during SAT-ED they became aware of that fact that the kids needed to be treated in a program that is just for kids and when agencies focus on both kids and adults, kids are often seen as an afterthought because there are not as many therapists specializing in this population.
- Another respondent believed a change in mindset among treatment providers and state agencies as it relates to adolescents in treatment was a success. These entities are starting to understand when you work with kids you have to work with the entire system, there needs to be a systematic change and not just a change with the adolescent.
- One member has thought this grant provided the vehicle for increased networking and collaboration among state agencies on the needs of adolescents in the state. This level of collaboration had been difficult to organize without the grant because of funding barriers.