

CALIFORNIA ACCESS TO RECOVERY EFFORT (CARE)

A Retrospective Analysis of CARE 1



November 2008

Prepared by the California Department of Alcohol and Drug Programs and the University of California, Los Angeles, Integrated Substance Abuse Programs



University of California Los Angeles,
Integrated Substance Abuse Programs



Department of Alcohol and Drug Programs

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California Access to Recovery Effort (CARE) Program

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Executive Summary

Background and Purpose

In 2004, the California Department of Alcohol and Drug Programs (ADP) was awarded a three-year, \$22.8 million, Access to Recovery (ATR) grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). The ATR grant was to be used to establish a voucher program to allow people in need of alcohol and other drug (AOD) treatment to access services from a variety of providers, including faith-based and other nontraditional organizations. ADP chose to focus its ATR program—the California Access to Recovery Effort (CARE)—on youth, ages 12 through 20, in the counties of Los Angeles and Sacramento.

The CARE program represented a new way of doing business for ADP and the AOD field. In the prevailing system, ADP allocates state and federal funds to county AOD program offices to contract with agencies in their county. With CARE, funds were given to eligible youth in the form of an electronic voucher. CARE clients were able to choose from a wide range of services and provider organizations in their community that are not typically part of the traditional publicly-funded AOD treatment system. For example, in addition to the limited services normally available to youth (primarily individual and group counseling in an outpatient setting), CARE service options included family therapy, residential treatment, and recovery support services.¹ CARE services were available from nontraditional providers (such as faith-based, grass-roots, and other community organizations who do not typically receive government funds), in addition to traditional AOD treatment providers.

This report is a retrospective analysis of the goals, activities, services, and client outcomes for the CARE program. Data for the report were from the Government Performance Results Act (GPRA) dataset for CARE clients; and from surveys, interviews, and focus groups with stakeholders, conducted by the University of California, Los Angeles Integrated Substance Abuse Programs.

Summary of Findings

- The CARE program significantly increased access to, and the capacity of, treatment and recovery support services in the target counties. Over 12,000 racially and ethnically diverse youth were served by the CARE program (69 percent in Los Angeles and 31 percent in Sacramento), many of whom would not have otherwise received needed services.
- CARE clients received many services that were not previously available through public funding (such as case management, family therapy, residential treatment, and recovery support). The average cost of services per client was \$1,570.

¹ CARE recovery support services were activities and services designed to assist youth in treatment and help them maintain their recovery. Services available included a wide range of educational and employment services, mentoring, spiritual coaching, transportation, and childcare.

- Clients were satisfied with the services they received, and most said they would recommend the program to a friend if he or she needed similar help.
- Most clients had the opportunity to choose their service provider. However, it appeared that assessors employed by, or strongly associated with, treatment or recovery support providers gave clients less choice than did independent assessors.
- A client's participation in the CARE program resulted in substantial reduction in their use of AOD, as well as other positive outcomes:
 - ✓ Clients' use of any alcohol or illegal drug use decreased from 64 percent at admission to 18 percent at discharge.
 - ✓ Arrests and jail time decreased from 9 to 3 percent, and 10 to 4 percent, respectively.
 - ✓ Average retention in the CARE program was 120 days, well above the 90-day threshold for predicting treatment success.
- Clients who received recovery support services, in addition to treatment services, were more likely to successfully complete treatment than clients who received treatment services only. In addition, clients who received services from both a faith-based and a secular organization were slightly more likely to successfully complete treatment than those who received services from only one type of organization (faith-based or secular).
- A voucher management system was designed and implemented that issued vouchers and tracked associated services, costs, and client outcomes.
- CARE vouchers were redeemed by many organizations that had not been part of the traditional county-funded youth treatment system. In addition, the program afforded opportunities for dialogue, collaboration, and increased networking among youth service organizations, many of whom were not known to each other previously.

Conclusions/Lessons Learned

- There is a large unmet need for treatment and recovery support services for substance-using youth.
- Youth and their parents value the opportunity to choose their service provider(s) and be involved in decisions related to their treatment and recovery.
- Care coordination (case management) is critical for AOD-involved youth. It provides a bridge between a youth's assessment/referral and service access, and results in a broader and more integrated array of services to meet youth needs.
- Two to three month vouchers do not provide enough time to adequately address most youth's AOD treatment needs.

- While not fully developed during the grant period, collaboration and partnerships between traditional and nontraditional providers, including faith-based organizations, are feasible and result in positive client outcomes. The marketing and outreach function is critical to recruiting nontraditional providers and developing these positive relationships.
- Many youth treatment providers need training and/or technical assistance on cultural competency and evidence-based practices, and many nontraditional providers need assistance in developing the infrastructure to participate in government programs.
- Consistent monitoring of providers is necessary to ensure compliance with policies and procedures and guard against fraud, waste, and abuse.
- Involvement from all stakeholder groups at various stages of the program is essential.
- Initiation of a thorough project evaluation must occur at the outset of a project. The CARE project evaluation was not initiated until very late in the project, precluding the completion of an adequate evaluation.
- The administrative rate cap on the grant, intended to preserve funds for services, limited resources available for provider oversight, marketing, and outreach.

Background

Access to Recovery – A New Approach to Substance Abuse Treatment

In March 2004, SAMHSA disseminated a Request for Applications for the ATR voucher program. ATR, a Presidential initiative, made available \$100 million through a competitive grant, for which state substance abuse agencies and tribal organizations were eligible to apply.

SAMHSA recognized that the recovery process is a personal one and that there are many pathways to recovery. By providing vouchers to clients, ATR allowed individuals in need of substance abuse treatment and recovery support the ability to choose the services and programs that best met their personal needs and preferences, including faith-based programs and services.

Key requirements of the ATR grant were to:

- Provide all services pursuant to a voucher(s) given to the consumer (no contracts with providers were allowed).
- Ensure that each consumer received an assessment to determine the appropriate level of services and was provided a genuine, independent, choice of appropriate providers.
- Involve a broad network of eligible providers, particularly organizations that had not previously received public funding, including faith-based and other community organizations.
- Make available both clinical and non-clinical (recovery support) services.
- Maintain accountability and take active steps to prevent fraud and abuse.
- Expand service capacity.
- Produce cost-effective, successful, outcomes for the largest number of people. Life domains measured to determine success were drug and alcohol use, employment, school, criminal justice, housing, social support, and retention in services.

California's ATR Grant Development

ADP collaborated with a diverse stakeholder workgroup to develop California's ATR application. ADP chose to focus its ATR application on a critical treatment need in California—services for substance-abusing youth. The application requested \$15 million per year to serve 9,280 youth ages 12 to 20 in four counties—Los Angeles, Sacramento, San Diego, and San Francisco. These counties included the four California cities that were part of the President's 25-Cities Initiative and which, collectively, possessed the greatest youth treatment gap in the State. The application proposed to expand access to a comprehensive array of clinical treatment and recovery support options and increase the number of service providers specializing in substance-abusing youth, while ensuring the safety and efficacy of treatment for youth served.

Program Development

In August 2004, SAMHSA announced that California was among the 14 states and one tribal organization awarded an ATR grant. However, the grant amount ADP requested was reduced by 50 percent (to \$7.6 million annually), while the number of clients SAMHSA expected to be served (5,950) was not proportionately reduced. ADP worked with the Steering Committee identified in the grant application to revise the grant scope of work and budget in response to the award reduction. This required difficult decisions about changes that would have the least negative impact on service provision and program integrity. One of the decisions made was to limit the target areas to Los Angeles and Sacramento counties.

ADP partnered with the California Rural Indian Health Board (CRIHB), another ATR grantee, to maximize resources, since both agencies were utilizing the same voucher management contractor (MAXIMUS). ADP and CRIHB were able to share costs related to the development and maintenance of the voucher management system and customer call center.

The implementation of the CARE program was a considerable undertaking and involved a tremendous amount of planning, organization, outreach and marketing, and systems design and development. By the end of May 2005, the following systems were in place:

- A network of approved and trained providers, including faith-based and other nontraditional providers, to provide assessments and an array of treatment and recovery support services. Recovery support service categories were defined as educational and employment services, mentoring, spiritual coaching, transportation, and childcare.
- A web-based voucher management system to issue vouchers to clients; track clients, outcomes, voucher services, and associated costs; and generate provider reimbursement data.
- A toll-free customer service number and central call center to assist youth, parents, and referral sources access voucher services, and to assist providers with the voucher management system.
- A comprehensive policies and procedures manual, including the CARE voucher structure and process, allowable services, and reimbursement rates.
- A CARE website with general program information, promotional materials, forms, and provider directories.

Program Implementation

On May 30, 2005, 10 months after the grant award, the first CARE vouchers were issued to clients. Following is an overview of the voucher process implemented:

- Local referral sources, in addition to the website and call center, referred potential clients to an assessment provider for eligibility determination.

- Assessment providers were the “gatekeepers.” They conducted assessments, determined level and types of services needed, offered clients choice of appropriate programs from the network of approved providers, and electronically requested vouchers for those services. Assessment providers also assigned a care coordinator (case manager) who collected required client data.
- The central call center reviewed and approved voucher requests and provided technical assistance with the voucher management system.
- Clients, with assistance from their care coordinator, accessed treatment and/or recovery support services from their provider(s) of choice.
- Treatment and/or recovery support provider(s) provided appropriate and allowable services as authorized by the voucher and billed electronically for those services.
- The voucher value was decreased as services were billed. When the voucher expired, or when its value was depleted (whichever came first), the client’s CARE service episode was closed.

The first few months of operation were somewhat slow since referral sources and providers did not know exactly what to expect with this new approach to providing AOD services. In addition, there was a steep learning curve with the voucher mechanism and use of the web-based system. A few large provider organizations were the primary referral sources for the first CARE clients, while some providers admitted to taking a “wait and see” approach. Soon, however, youth, parents, and providers realized the benefits of the CARE program. Following are some of the comments from providers and parents:

- “It really allowed us to offer a whole lot more services to youth that just weren’t possible before...and it allowed a lot of kids to get services.”
- “It was an opportunity to work with families because we had parents who didn’t know where to turn. CARE was a valuable asset because [without it] we always exceeded capacity.”
- “If it weren’t for those vouchers, we wouldn’t be able to give treatment.”
- “What I like about the program is it’s not complicated and there wasn’t a lot of restrictions. It gives you much more hope that it’s going to work [for your child] because you don’t have to stress about the financial part. You can focus on everything else.”
- “I just can’t express the need for such a service. It gives us multiple ways in which we can help young people. It looks at it from a whole new point of view, from faith to recovery support to just your traditional treatment.”

The increased awareness of the CARE program and its benefits resulted in a dramatic increase in client enrollment, provider participation, and expenditures. Between program start-up and the end of the first year of operations, the number of enrolled providers rose from 86 to 297. Client enrollment jumped from 800 youth in November 2005 to over 3,600 youth by May 2006, at which time overall expenditures (provider redemptions of client vouchers) had reached \$7.7 million.

Figure 1: Trends in Clients Served in First Year

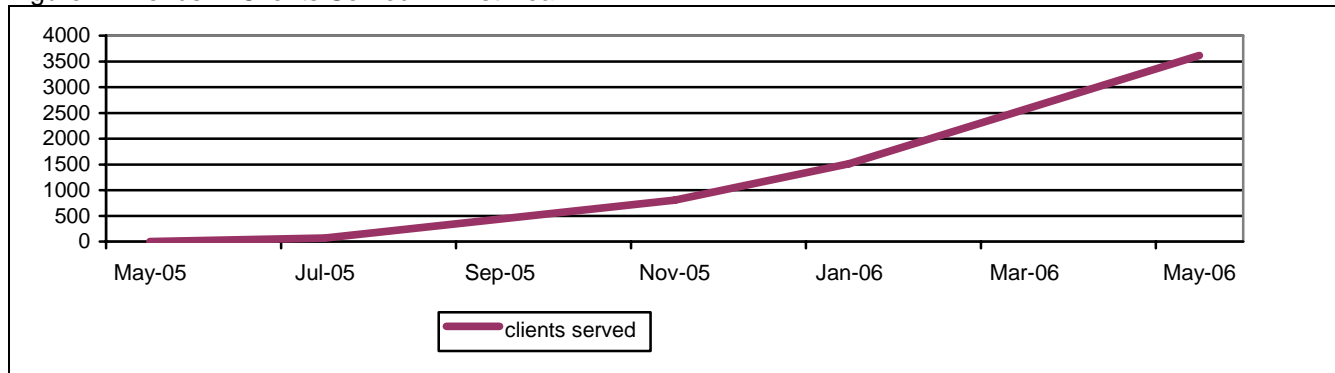
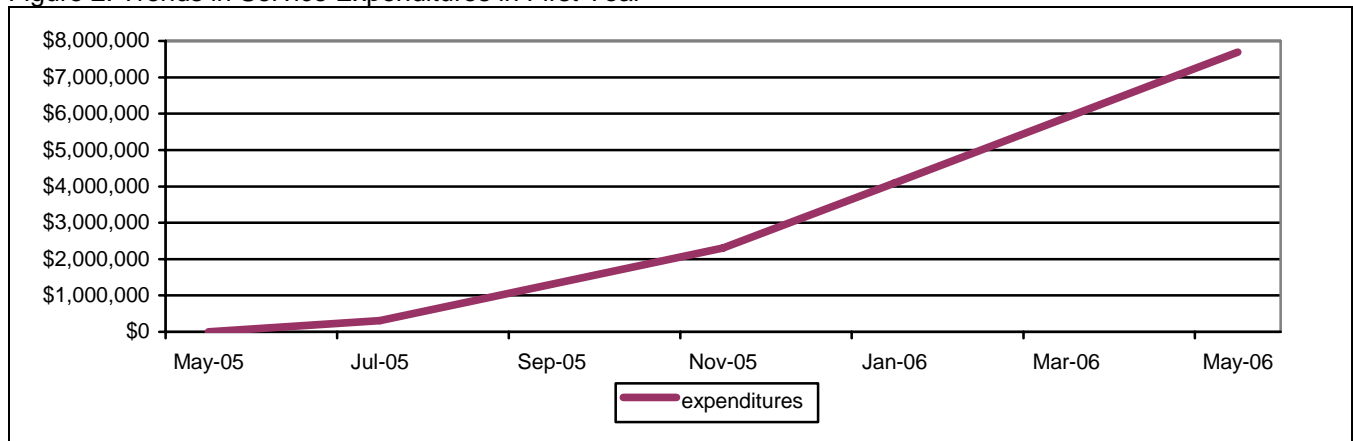


Figure 2: Trends in Service Expenditures in First Year



ADP and the Steering Committee needed to make mid-course modifications to respond to these rapidly increasing numbers. Some of the adjustments made and their outcomes are described below.

Program Adjustments

The escalation of services under CARE during the first year exceeded expectations, and the voucher funds were obligated (issued) more quickly than anticipated. As a result, the CARE management team had to stop issuing vouchers in December 2006 to allow unused funds to be returned to the voucher pool.² Vouchers were issued again in April 2007 and new policies went into effect to slow down expenditures and manage the voucher funds. Voucher timeframes were shortened from 90 days to 60 days, and their maximum value was reduced by one-third.

Even with the new policies implemented to slow down voucher issuance, the amount of obligated funds rose quickly when vouchers were issued again in April 2007. Therefore, additional adjustments were instituted over the next few months. Enrollment was limited to one new client per day, per assessment provider/location. The client caseload per provider was frozen so that in order to admit another client, the provider had to discharge a client.

² Each voucher had a value that was “obligated” upon issuance; however, often clients did not utilize the entire voucher amount but the remaining unused funds were not available to issue to another client until the voucher expired or the client was formally discharged in the voucher management system.

Also, two of the more costly types of vouchers were discontinued: residential treatment for adults (18-20 years old) and intensive outpatient treatment. These actions helped stabilize the obligation and redemption of voucher funds to enable the CARE management team to reliably forecast and manage the voucher expenditure rate.

Program Close-Out

ADP requested two no-cost extensions to fully spend the voucher funds carried over from year one due to implementation delays, which extended the grant period to April 30, 2008. The last vouchers under CARE were issued on January 31, 2008, and all clients were completed with CARE services by April 14, 2008.

In June 2008, the University of California, Los Angeles' Integrated Substance Abuse Program, completed an analysis of data from interviews, surveys and focus groups conducted with CARE stakeholders, including providers, youth and their parents. UCLA also analyzed the GPRA data submitted for clients served by CARE. The following chapters summarize key findings from these data.

Summary of Findings

The CARE program allowed for increased treatment and recovery support opportunities for youth, their families in the target communities. The program exceeded its goals in terms of the number of clients served and the quantity and type of service providers from which youth could choose. Overall, clients were satisfied with the services they received, and the follow-up interviews revealed positive life changes. These and other key findings from the program are described below.

Service Accessibility and Capacity

Perhaps the most significant accomplishment of the CARE program was its success in expanding the number of youth served in Los Angeles and Sacramento counties. Over 12,000 youth and their parents were provided substantial amounts of treatment and recovery services via funding from the CARE program. Slightly more than two-thirds of the clients were served in Los Angeles County and the remainder was served in Sacramento County. In both Los Angeles and Sacramento counties, the average stay in services was more than 100 days.

Stakeholders were virtually unanimous in their praise for the added AOD treatment and recovery support services provided by CARE. There was a widely-held perception that many, if not most, of the youth who received services under CARE would not have been able to receive services without CARE funding. Although the funding from CARE could not meet all the youth AOD treatment and recovery service needs in Los Angeles and Sacramento counties, it was a major step in the right direction in expanding service capacity.

The number of programs available to serve youth increased as a result of CARE. Some new youth programs opened, and programs that had previously focused on adults expanded their services to serve youth. In addition, many stakeholders and providers felt that as a result of the inclusion of faith-based and other nontraditional providers, services for substance-involved youth became accessible in some communities where previously none had been available.

Some clients who normally would have had to await eligibility approval to receive Drug Medi-Cal (DMC) services were served without delay by CARE during the DMC waiting period. CARE also supplemented some clients' DMC treatment by providing case management, residential treatment, family therapy, or additional individual counseling—services that were not reimbursable under DMC.

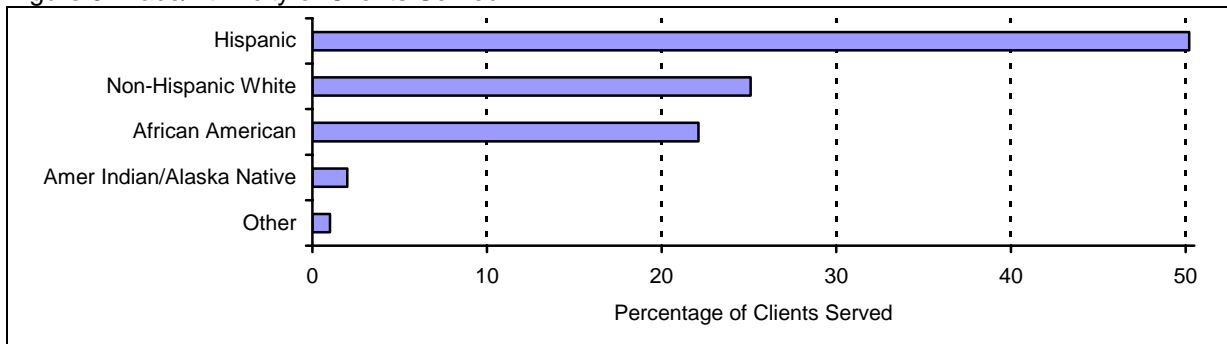
Diverse Youth Served by Diverse Service System

The youth served by CARE were a cross-section of the overall population in the target areas. Likewise, the organizations and individuals providing CARE services reflected the diverse needs and preferences of the target population.

- Race/Ethnicity

The race/ethnicity of the CARE client population was very much in line with the demographics of Los Angeles and Sacramento counties. Half the clients were Hispanic, 25 percent were non-Hispanic White, 22 percent were African American, two percent were American Indian/Alaskan Native, and less than one percent were another race/ethnicity.

Figure 3: Race/Ethnicity of Clients Served



- Age and Gender

CARE served individuals aged 12 through 20 years old. Eighty percent of clients were between 12 and 17 years of age, and the average age was 16 years. The percentage of young women served by CARE (34 percent) was consistent with treatment access by adolescent females statewide and nationally. Females were more likely to use methamphetamines than males. Male clients were more likely to be Hispanic and use only alcohol and/or marijuana.

- Referral Sources

CARE promoted a “no wrong door” policy for service access, meaning that youth could be referred to CARE by any government office, community agency, or individual. Based on information collected at intake, youth were referred from a wide range of sources including schools, criminal justice, mental health, faith-based organizations, AOD programs, and family members (see figure 4).

Figure 4: Client Referral Sources



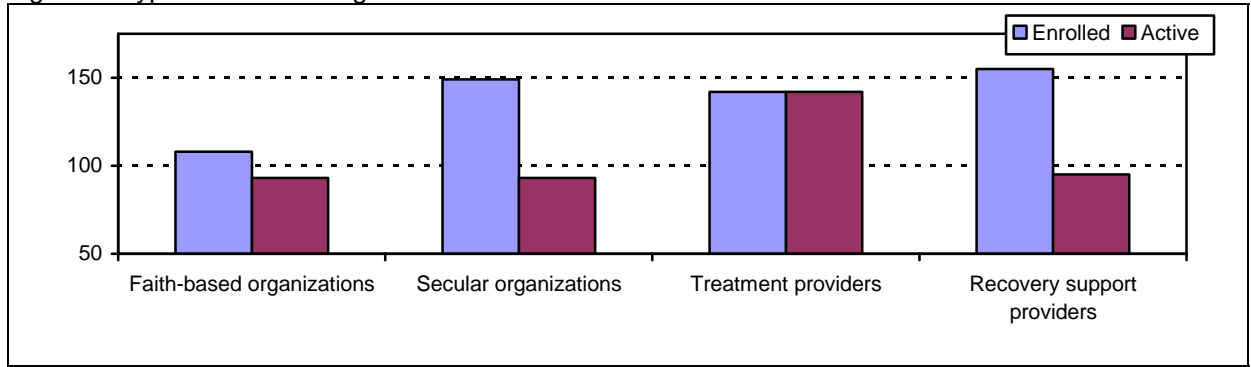
Only two percent of the total youth said they had been referred by the CARE website. Most of the youth and their parents participating in focus groups were not aware that the CARE website and call center were available for referral assistance. A call center activity study in 2006 found that only nine percent of calls were from a potential client or non-CARE provider referral source.

- Variety of Service Providers

Including both recovery support service providers and faith-based organizations (FBOs) were key requirements of the ATR grant. As a result of aggressive outreach and marketing by the CARE management team, the service delivery system consisted of a wide variety of treatment and recovery support service providers (see figure 5). One-half of the active providers were faith-based and one-half were secular (non-faith-based). Treatment services were provided by 142 organizations and recovery support services were provided by 95 organizations (some organizations provided both types of services). Eight percent of clients received services from faith-based providers only, and 39 percent received services from both faith-based and non-faith-based providers.

Many of the recovery support providers, both faith-based and secular, had not previously accessed government funds and the CARE program was a new experience for them. For many of these providers, CARE presented an opportunity to be reimbursed for the services they had already been providing in the community for years. Some providers were able to expand their services or programs, and move towards becoming state-certified. However, some providers were not prepared for the infrastructure necessary to participate in the program, such as required recordkeeping and billing processes. CARE did not provide funds for program start-up—it operated on a fee-for-service payment system which required that programs be solvent enough to wait 60 to 90 days for reimbursement. This was an extreme hardship for some small, grass-roots, organizations. Thus, many of the nontraditional organizations that enrolled were never active (did not serve any CARE clients).

Figure 5: Types of CARE Programs

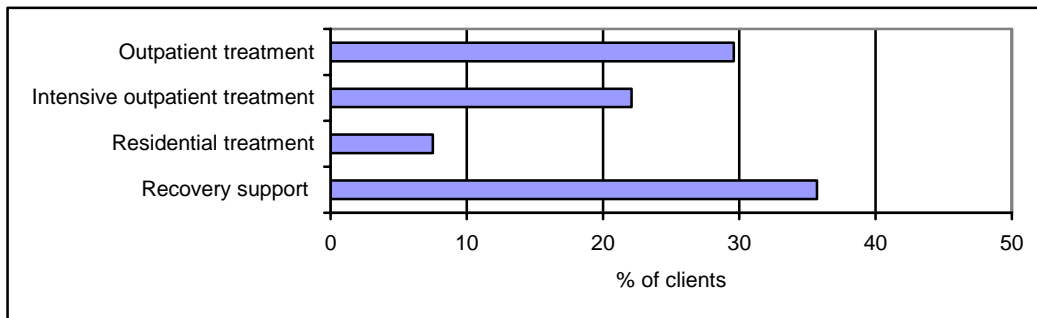


Service Quality and Quantity

- Service settings

Outpatient treatment was the most widely utilized modality followed by recovery support. More than 28 percent of clients received services in multiple modalities, including 17 percent who received both treatment and recovery support services.

Figure 6: Percentage of clients served by modality



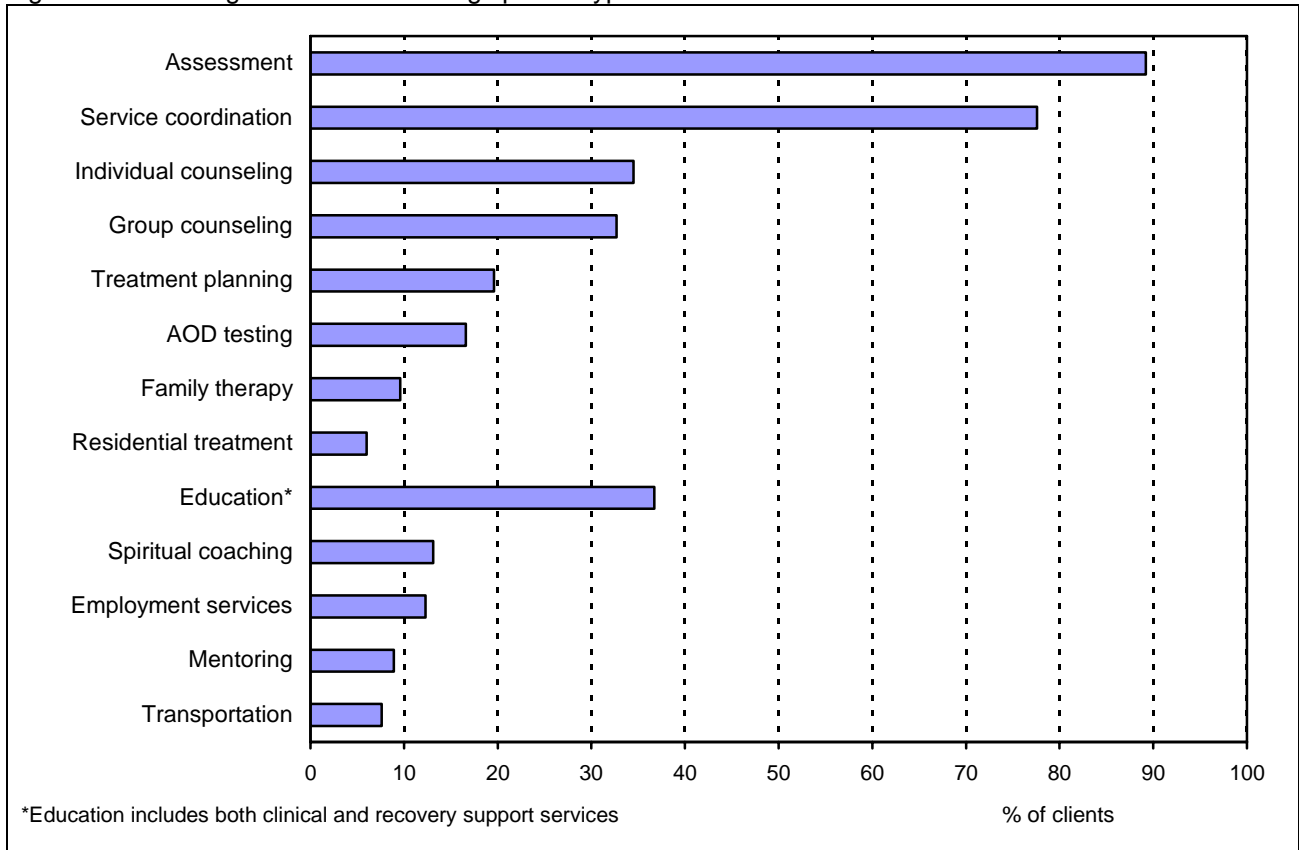
- Service types

Each client received a large amount of treatment and recovery support services over the course of their participation. Individual and group counseling and AOD education services were the most widely used treatment services. Educational services were the most widely used recovery support service.

Youth and parent participants were specifically impressed with family services offered by CARE. Parents reported satisfaction with the services and the desire to receive more. They felt it was important to increase the time spent with their children and improve the connection and understanding between them, as well as address any family problems. Providers also felt the opportunity to provide family services was a strong aspect of the CARE program. Ten percent of clients received family therapy provided by a licensed therapist, as shown in figure 7. Additional youth and their parents received family counseling provided by a non-licensed staff (such as a certified AOD counselor) and they are included in the group counseling and education categories in figure 7.

CARE provided many recovery support services (including spiritual services) that had not previously been delivered in the traditional AOD treatment system. Thirty-six percent of clients received recovery support services either as an adjunct to clinical treatment or as a stand-alone service. Initially, not many clients were issued recovery support vouchers. Providers reported that some clients were not open to accessing recovery support. Other clients, especially those who were mandated to treatment, did not want to attend any service that was not absolutely required. In addition, ADP found that some assessment providers were initially unfamiliar with, or untrusting of, the recovery support providers in their area and did not make the availability of such services known to the clients.

Figure 7: Percentage of clients receiving specific types of services



- Cost of services

Approximately \$19 million was spent on CARE services during the grant period, of which 44 percent was used for outpatient treatment, 25 percent for residential treatment, 14 percent for recovery support, and 17 percent for assessment and care coordination. The cost of a service unit of recovery support ranged from \$.34 per mile of transportation to \$42 for an individual educational or employment service. The cost of a service unit of treatment ranged from \$20 for a drug test to \$175 for a residential bed day. The average cost of CARE services per client was \$1,570.

- Length of services

Initially, vouchers were issued for three months and could be extended if there was money left on the voucher after the three-month period. During the last year of the program, voucher timeframes were reduced to two months and two-thirds of their initial value. Almost all providers felt that the biggest shortcoming of the CARE program was that the voucher timeframes were not long enough to effectively treat youth. Youth and their parents also cited the lack of more/longer services, particularly residential services, to be the greatest drawback. While ADP realized that even a three-month stay in treatment would not be sufficient for some clients, issuing longer (and thus more costly) vouchers would not have allowed the program to stay within the grant requirements issued by SAMHSA.

- Service provider qualifications

ADP established eligibility criteria for CARE providers to promote effective and safe services but not impose such burdensome requirements that provider participation was discouraged. Treatment providers participating in CARE were required to be certified by ADP as meeting AOD program standards. In addition, they had to have a minimum of three years experience providing AOD treatment to adolescents, or have one year experience providing AOD treatment/recovery, mental health, or other behavioral health services, and employ a program director or clinical supervisor who was a substance abuse counselor certified by a recognized body with at least three years experience in providing AOD treatment/recovery services for youth.

Recovery support providers were required to be accredited, certified, or approved by a nationally-recognized accrediting organization or State approval agency for the specific program service authorized; and/or meet the following criteria:

- ✓ Be registered with the California Secretary of State's Office;
- ✓ Meet all required federal, state, and/or local zoning codes and other regulations;
- ✓ Have an ethical framework for guiding employee, volunteer, and client interactions that addresses roles, boundaries, supervision, training, and client rights/grievance procedures;
- ✓ Have a risk management strategy including adequate insurance to cover risks; and
- ✓ Have at least one year of experience providing the same type of recovery support services to youth in the community.

In addition, treatment providers were required to comply with the evidence-based practices for youth outlined in California's *Youth Treatment Guidelines*, and recovery support providers were required to comply with the non-treatment-related components of the *Guidelines* (such as youth development principles and cultural competency).

Many CARE providers utilized the services of ADP's youth treatment technical assistance contractor to improve their knowledge and expertise in areas related to AOD-using adolescents. However, there was no systematic effort to measure the extent to which providers used evidence-based practices, and it was not clear if there was widespread use of evidence-based practices. During interviews with providers, none used the phrase "evidence-based practices" to describe their CARE services, although many mentioned service components that are evidence-based, such as strength-based care and family-based interventions.

Some provider organizations were not compliant with policies and procedures or misrepresented their qualifications in their application. ADP needed to implement corrective actions with some providers and a few were removed from the CARE network.

Client Satisfaction

Fifty-two CARE clients completed a client satisfaction survey in which they were asked whether they received specific services and whether they received "too much," "too little," or the "right amount of this service."

The vast majority of the youth who volunteered to participate in the study had received or were receiving outpatient services from traditional treatment providers. The full survey questionnaires (youth and parent) appear in the appendices.

Overall Satisfaction with Services and Treatment Outcomes

Figure 8. Services received by youth and satisfaction with amount of service received

Services Received	Number of youth (n) who received the service N=52	% of youth who received the service	Of those who received the service, % of youth who responded they received the "right amount of service"
Treatment and Ancillary Services			
Inpatient detoxification services	8	15.4	50.0
Residential substance abuse treatment	14	26.9	50.0
Outpatient substance abuse counseling/groups	29	55.8	58.6
Individual substance abuse counseling	32	61.5	46.9
Family counseling	31	59.6	71.0
12-step groups	27	51.9	48.1
Urinanalysis/ drug screening	14	71.2	43.2
Other substance abuse services	10	19.2	40.0
Education and Employment			
College courses	3	5.8	100.0
Employment assistance	9	17.3	55.6
Educational testing/assessment	22	42.3	50.0

Services Received	Number of youth (n) who received the service N=52	% of youth who received the service	Of those who received the service, % of youth who responded they received the "right amount of service"
GED classes/literacy classes	4	7.7	25.0
Other education or vocational services	10	19.2	30.0
Help with legal problems	16	30.8	25.0
Transportation assistance	14	26.9	64.3
Help with living/social skills	14	26.9	35.7
Money management	9	17.3	44.4
Recreational/social activities	19	36.5	63.2
Afterschool sober recreational programs	15	28.8	46.7
Childcare	4	7.7	100.0
Mentoring	13	25.0	46.2
Housing	6	11.5	100.0
Other Activities of Daily Living	3	5.8	66.7
Help with entitlements	3	5.8	66.7
Religious			
Individual pastoral, spiritual, or religious counseling	7	13.5	57.1
Religious/spiritual youth group	7	13.5	57.1
Meditation/prayer	10	19.2	60.0
Other spiritual/religious services	5	9.6	80.0

The majority of clients reported positive outcomes due to the treatment they received through the CARE voucher. Taken as a whole, they reported decreases in drug use and other problems, and improvement in life overall.

Figure 9. Youth satisfaction with services (N=52)

Quality of Services	Number of youth (n) and % answering...	
	"Well to Excellent"	
How well did you get along with...	n	%
The person in charge of treatment?	49	94.2
Other staff?	48	92.3
Other participants?	43	82.7
	"Somewhat to Very Helpful"	
How helpful was treatment on your relationship(s) with...	n	%
Other clients in program?	38	73.1
Your primary counselor?	45	86.5
Other staff in program?	44	84.6
	"Somewhat to Very Helpful"	
How helpful was/were...	n	%
The substance abuse recovery groups	39	75.0

Quality of Services	Number of youth (<i>n</i>) and % answering... “Well to Excellent”	
	<i>n</i>	%
Employment assistance	19	36.5
Health care/medical referrals	16	30.8
Services with mental health/emotional problems	25	48.1
Services for family issues/parenting assistance	32	61.5
Services for legal problems	22	42.3
Services for financial problems	12	23.1
Services for spiritual or religious concerns	11	21.2
	“Somewhat to Strongly Agree”	
	<i>n</i>	%
The person in charge of my treatment and I agreed on my treatment goals	42	80.8
The person in charge of my treatment looked out for my best interests	46	88.5
The person in charge of my treatment worked well with me	48	92.3
The treatment I received matched my expectations	41	78.8
I was satisfied with the treatment I received	46	88.5
I received services in a timely way	42	80.8
I would recommend the CARE program to other youth	48	92.3

Overall, clients who participated in the CARE surveys were satisfied with the services they received from CARE providers. The highest ratings were given to the primary counselors as individuals and the treatment program staff as a group.

Service Coordination

Service coordination was a significant component of the CARE experience. In the traditional system, AOD treatment is frequently isolated from other needed services, but CARE reimbursed for care coordination (case management), which resulted in a broader and more integrated array of services being provided to youth. Care coordinators also functioned as an important bridge between a youth’s assessment and receipt of services by motivating and assisting clients to follow through with service access, thus minimizing no shows and early drop outs.

Care coordinators were responsible for tracking client progress and collecting the required client data, which was an area that was challenging for many providers. Care coordination was provided by the assessment provider, who was often not the treatment or recovery support provider. Lack of communication between the care coordinator and the client’s service provider was often cited as problematic, as well as the travel time/distance between the care coordinator and the location where the client was receiving services. Some providers felt that having care coordination as a function of the assessment provider, rather than the treatment provider, created a fragmentation of services that was difficult to manage and, ultimately, was a disservice to clients. However, others felt that having a case coordinator housed in an participating treatment agency influenced the participants’ ability to freely choose where they would get their services.

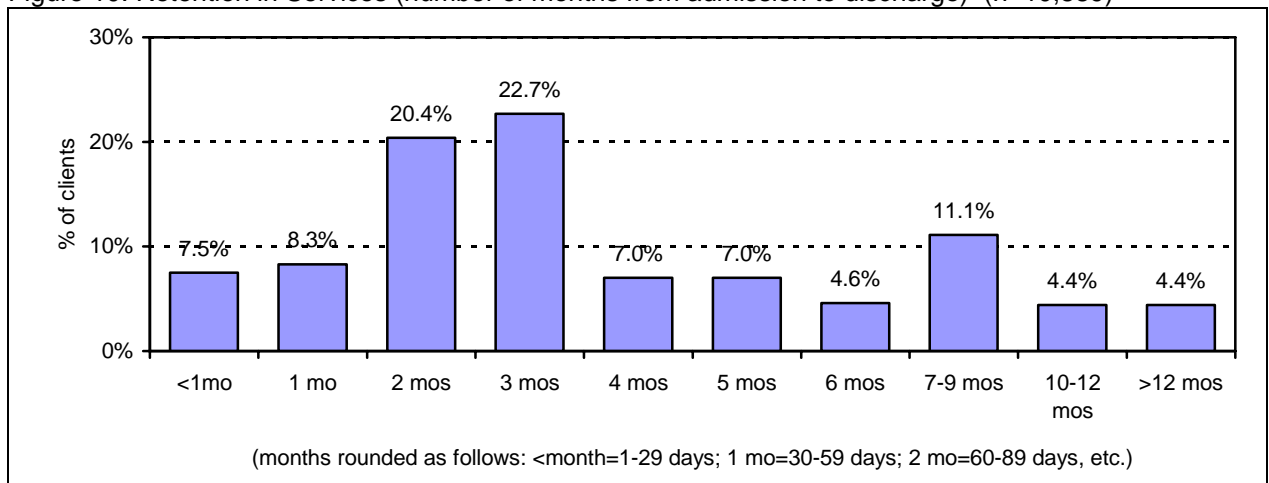
Client Outcomes

A youth's participation in the CARE program resulted in a substantial reduction in their AOD use, as well as other positive outcomes. The average retention in services, which is an indicator of positive client outcomes, was 120 days (see Figure 10). All categories of AOD use were reduced to one-quarter to one-third of their admission levels (see Figure 11). Arrests and days in jail were also significantly reduced over the course of the treatment and follow-up period (see Figure 12), and positive social connections increased (see Figure 13). In short, all measures of treatment reflected that youth in CARE received significant episodes of treatment and that these episodes of treatment were associated with positive behavior change.

- Retention in Services

Research funded by the National Institute on Drug Abuse has shown that 90 days is the threshold for predicting treatment success, and 54 percent of CARE clients had retention of 90 days or more. Higher percentages of clients with retention of 90 days or more were observed for Sacramento County (61 percent) versus Los Angeles County (50 percent); for females (56 percent) versus males (53 percent); and for clients utilizing multiple modalities (68 percent) versus those receiving services in only one modality (39-52 percent).

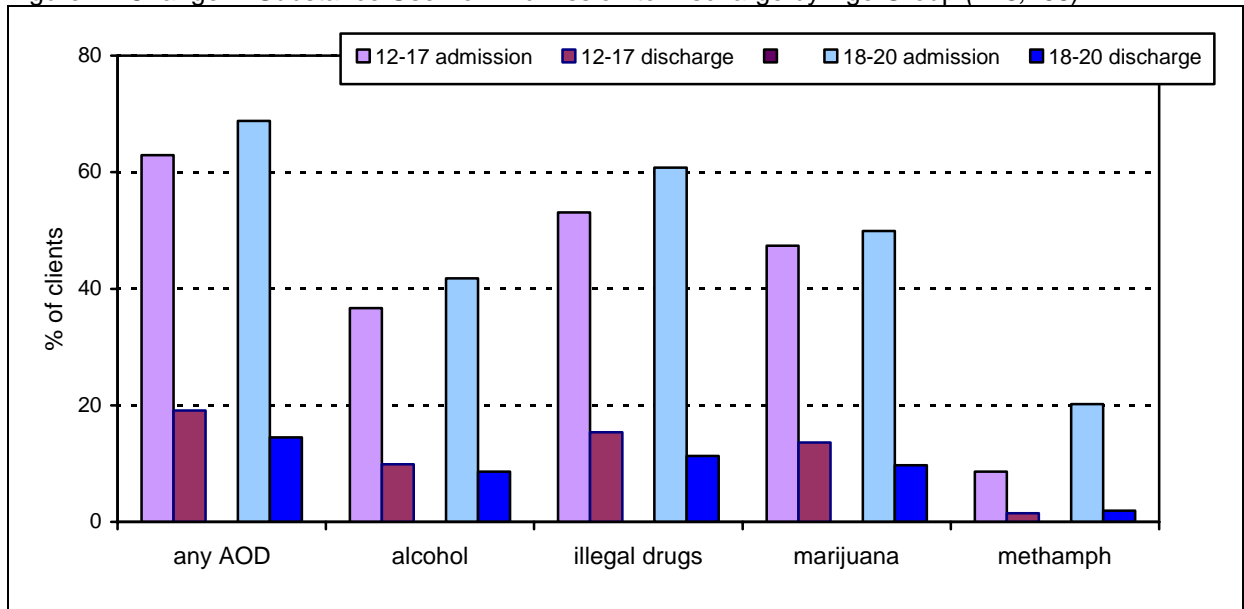
Figure 10: Retention in Services (number of months from admission to discharge) ($n=10,889$)



- Reduction in AOD Use

The percentage of clients reporting any alcohol or illegal drug use decreased from 64 percent at admission to 18 percent at discharge. The use of alcohol decreased from 38 to 10 percent; and any illegal drug use decreased from 55 to 15 percent. Marijuana use decreased from 48 to 13 percent and methamphetamine use decreased from 11 to two percent. Slightly greater decreases were seen for the older group (18 to 20) for each of the five substance use categories considered.

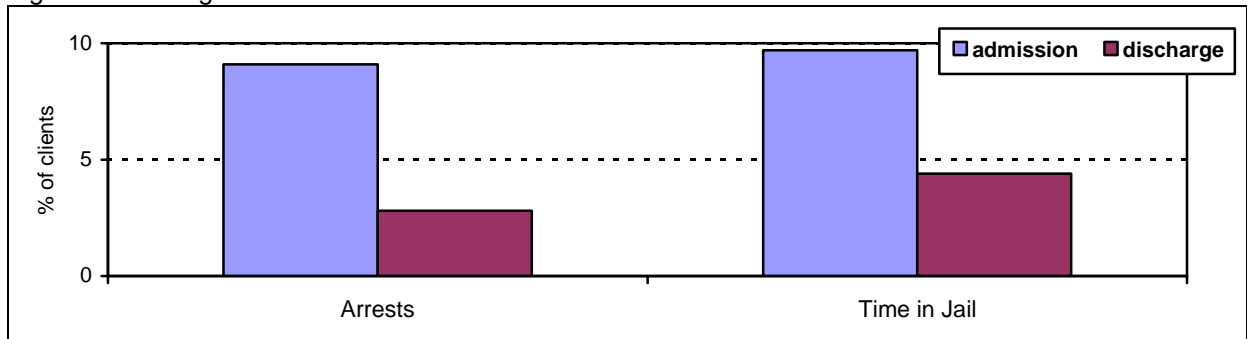
Figure 11: Change in Substance Use from Admission to Discharge by Age Group (n=8,468)³



- Reduction in Arrests and Jail Time

The percentage of clients reporting an arrest in the 30 days prior to admission and discharge dropped from nine percent to three percent. The percentage of those reporting any jail time dropped from 10 percent to four percent.

Figure 12: Changes in Arrests and Time in Jail

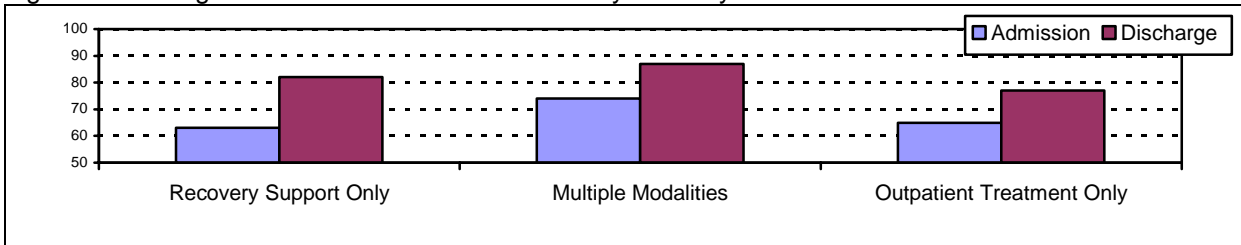


- Improved Positive Social Connections

The percentage of clients reporting interaction with family and friends that were supportive of their recovery increased from 68 at admission to 81 percent at discharge. Improvements were greater among clients who received recovery support services only (63 to 82 percent), than those who received combinations of modalities (74 to 87 percent) or outpatient treatment-only (65 to 77 percent).

³ From the sample of 10,889 clients in the retention analysis, 2,421 were omitted from analyses of substance use outcomes because they had no substance-use frequency recorded at discharge, resulting in an outcome sample of 8,468.

Figure 13: Change in Positive Social Connections by Modality of Service Received



- Treatment Completion

In measuring successful treatment completion, there were no significant differences between clients receiving services only from secular providers in comparison to clients receiving services only from FBO providers. However, clients receiving services from both FBO and secular providers had a slightly higher rate of successful treatment completion than the two groups receiving one type of service (FBO or secular). FBO and secular providers may have contributed unique treatment components, which are more effective when applied in combination. Clients receiving recovery support services, in addition to clinical services, successfully completed treatment at higher rate (28.2 percent) than those receiving only clinical services (17.6 percent successful completion).

Assessments and Client Choice

Under CARE, a network of clinical and non-clinical (recovery support only) assessors was established. These assessors determined client eligibility, conducted the initial assessment, informed youth of their treatment and recovery support options, and facilitated service referrals. Assessment providers were either a licensed clinician with at least two years experience conducting assessments for youth and at least one year experience working with clients with AOD problems; or they were an established (at least five years) youth treatment organization and utilized staff with the necessary clinical qualifications, training, and knowledge to administer assessments and determine level of care.

In general, the assessor network provided an entry point that offered youth choice and placed them in appropriate services. However, the areas of assessment and client choice resulted in some of the most passionate comments from stakeholders. Early in the project, many of the assessors were directly linked to specific treatment organizations who were required to address and implement practices to prevent conflict of interest (e.g., having a separate assessment unit and multidisciplinary review of assessment and placement decisions). Nevertheless, there were many concerns among providers about the objectivity of placement and referral decisions.

ADP investigated all complaints of potential bias and conducted routine site visits of assessment providers to verify compliance. ADP regularly monitored data to determine where clients chose to receive services in relation to where they were assessed, as well as what type of services were being recommended by assessors. In addition, ADP recruited independent assessors (not directly associated with a treatment or recovery support provider) to further guard against potential bias. A total of 12,559 assessments were

conducted under CARE, and there were 25,482 client referrals made for post-assessment services (not including care coordination). Of those referrals, 15,758 (61.8 percent) were to providers other than the assessor.

In addition, there were concerns about provider competition for clients and proprietary attitudes towards the youth. Some providers felt “their kids” were “stolen” if they referred a potential client for an assessment and the client received services elsewhere. Another common concern was the length of time it took an assessor to contact a potential client when referred, although many providers and youth/parents felt youth received an assessment relatively easily and quickly. Some stakeholders indicated that some assessors may not have had the skills needed to screen and refer youth out for psychiatric services when indicated. The various stakeholder comments related to assessments and client choice are more fully discussed in Chapter 4 of this report.

Voucher Mechanism

A voucher management system (VMS) was implemented as the mechanism for issuing vouchers to clients and reimbursing providers for services provided to clients who redeemed vouchers at their organization. All VMS transactions were linked at the client and provider levels by unique identifiers. The VMS issued vouchers with the specified allowable services and timeframe as determined by ADP, and deducted value as services were billed. Through the VMS, assessors entered GPRA data, which was uploaded to SAMHSA monthly.

The CARE voucher model was a new concept to the provider community. Considerable effort was made to educate providers on how to request and redeem vouchers, and use the VMS. Between July 2005 and July 2006, the CARE management team provided 42 days of training, which were attended by over 1,000 individuals. In addition, there were substantial modifications made to the VMS to make it more user-friendly, which resulted in a greater understanding and acceptance among providers.

Interagency Collaboration

The CARE management team spent significant efforts to increase coordination and networking between participating CARE providers. These included hosting resource-sharing events where providers could network, facilitating trust-building between various agencies previously unknown to each other, and educating clinical providers on the effectiveness of recovery support services. While some providers were never aware of these opportunities to network and collaborate with other agencies, for those who attended, these efforts were seen as helpful in breaking down barriers between secular and faith-based entities, and traditional and nontraditional providers. Sixty-two percent of providers interviewed felt that CARE increased local networking and collaboration.

Stakeholder Perspectives

This chapter summarizes the observations and feedback from written surveys and face-to-face interviews with three stakeholder groups: 1) key informants; 2) service providers; and 3) participating youth and their families.

- Eighteen “key informants” involved in the planning, implementation, operation and oversight of the CARE program at the federal, state, and county level were individually interviewed. They included staff from SAMHSA, ADP, and MAXIMUS; and members of the Steering Committee.
- Sixty-one providers were individually interviewed and 70 providers completed a written survey.
- Fifty-two youth and 47 parents and/or guardians who participated in the CARE program completed a written survey and participated in focus groups or one-on-one interviews.

The survey instruments and interview/focus group questions are included in Appendix 3 of this report.

Overview

Overall, stakeholders applauded the CARE program for successfully providing AOD treatment and recovery support services to a historically underserved population. The majority of stakeholders felt that CARE offered youth choice in terms of the number and type of service options available, including family therapy, residential treatment, and recovery support services. The following quotations from stakeholders highlight some of the perceived benefits of the CARE program:

- “There was an expansion of services that would not normally be available to those youth [especially] nontraditional kinds of programs.”
- “There was a group of kids that we never had before from the churches and the private sector.... They had too much pride to use county services or they thought they wouldn’t have qualified because they’re working-class.”
- “Youth were more likely to receive treatment or recovery support services than being placed on a waiting list because the funds were available.”
- “A lot of the faith-based providers and a lot of ...ethnic communities...that have also been kept out of the loop of county funding; they were able to provide services to a greater degree under these programs.”
- “The shift in having a holistic approach to providing treatment and recovery support services [was good]... giving these kids the support they need for the rest of their lives.”
- “They [clients] like the fact that the recovery support services are there...and they wouldn’t have been able to get the services without CARE.”
- “Kids for the first time...had access to funded residential treatment—that was the biggest difference—secondarily the [recovery support] services to go along with treatment.”

- “Vouchers were paying for things where there was a gap in services, like ...residential treatment...I saw many treatment providers work with youth in the residential environment when they otherwise wouldn't have been able to.”

Stakeholders identified specific areas in need of examination and improvement, including the voucher system, the payment system, the quality and accountability of providers, and the true promotion of choice for service recipients. The benefits and limitations in various program areas are described in more detail below.

Outreach and Referral of Youth

To market the program to youth, the CARE management team developed brochures, pamphlets, posters, and referral cards all branded with the CARE logo that was field-tested with youth. Materials were mass-mailed to youth-specific organizations, including all school districts in Los Angeles and Sacramento counties. Providers were also welcome to add their contact data to these materials or create their own materials, which some did (e.g., brochures, business cards).

Stakeholders reported a variety of pathways to CARE and service providers tailored outreach efforts to their local youth communities since they already knew them well. In both counties, CARE helped to establish, or strengthen, linkages with schools. The additional funds available through CARE enabled providers to provide services inside the schools and, in turn, schools were very receptive to the program. Teachers, school nurses, and school counselors were a primary referral source.

Stakeholders also reported a strong criminal justice system link. Many youth and parents responded that they were referred to CARE by a court, drug court, judge, probation officer, or public defender. Some said that enrollment in treatment was mandated by the court and that youth were given a list of programs from which to choose, or were told to call a specific treatment program to make an appointment. However, stakeholders also mentioned that while probation officers and judges were eager to partner with CARE to get treatment for the youth they served, they were frustrated that they were unable to mandate the type of treatment the youth would receive and the specific provider from which they should receive those services.

In addition to juvenile justice and schools, referrals to CARE came from churches, working-class families, and parents who preferred to access services through private agencies rather than county agencies. For some youth who were already enrolled in treatment, the service provider where they were receiving services referred them to the CARE program when their initial funding source ran out. A few youth and parents indicated that they were referred by a relative or family member who had a good experience using the CARE voucher or with a particular provider.

Youth were also meant to self-refer to CARE by utilizing the website and/or the call center. Some key informants perceived that the call center was underutilized as a referral process. Lack of awareness of the call center was mentioned by a vast majority of youth and their parents. However, the few who did use the call center had favorable comments. In addition, when a few parents found out about the call center, they indicated disappointment that they

were unaware of it earlier because it would have been useful to them to communicate their appreciation of the program or to confirm what services were offered when conflicting information was being provided in the field.

Expansion of Service Accessibility and Capacity

The overwhelming majority of stakeholders believed CARE increased the number and types of services offered, and allowed youth access to needed treatment and recovery support services easily and often in a timely manner. CARE provided increased funding for youth services overall funding for nontraditional providers, in particular, and expanded treatment capacity.

Stakeholders noted that CARE provided services to many youth who would not have been able to access services without the program, and their gratitude was expressed. CARE participants included those who preferred to obtain services through private, rather than county, agencies due to perceived stigma associated with receiving county services, and those who preferred to receive services from faith-based or other non-traditional organizations instead of traditional treatment providers due to religious beliefs. One interviewee explained that through the CARE program, private treatment providers were able to provide services in geographic areas that were not being served by the county-contracted providers.

Some providers served youth under CARE while the client's eligibility for Drug Medi-Cal services was being determined. Once the client's eligibility was complete, the provider would bill DMC and use CARE funds to pay for needed services not covered by DMC. In this way, CARE successfully filled funding gaps and shortened the wait time to treatment. However, it was also suggested that some providers may have utilized CARE funds without fully investigating and/or exhausting other sources of funding.

Many youth and parents emphasized that without CARE, they would not have been able to afford treatment. A few were not certain if their insurance would have covered the services or said they did not have insurance and would have had to pay for treatment themselves and could not have afforded it. Many of the parents with insurance said that they could not have afforded the co-payments, or partial payment, required for treatment for their children.

Assessment Process

The assessment process was a topic of much interest and concern to key informants and providers as it had the potential to greatly impact client choice (either positively or negatively) and the services that youth received. CARE assessment providers were the "gateway into the network," because youth were required to receive an assessment and be offered a choice of providers prior to being referred for treatment or recovery support services.

Since CARE voucher funds were readily available for eligible youth, one of the strengths of the program mentioned by all stakeholders was that youth could receive an assessment relatively easily and quickly. Some parents mentioned that they were able to get an assessment appointment the next day after calling, and a few said it occurred the same day.

Many parents commented positively about the assessment process. However, a parent whose child was facing complications in his AOD treatment, due to a co-occurring mental disorder, felt that his special needs were not appropriately addressed. This parent stated that for youth in treatment for the first time, the CARE program was their first chance to get a psychiatric screen and referral for a mental health assessment and treatment, which, in their case, had not occurred. A few key informants also felt that some assessors may not have had the skills or expertise to appropriately identify and address any mental health issues among the youth they assessed.

Some youth were comfortable with the assessment process; however, most were not, commenting that it was too long, boring and draining, and there was too much paperwork. Some youth indicated that the nature of some of the questions made them feel uncomfortable or angry. While some youth did not appear to understand why they were asked so many questions, and the questions seemed repetitive or made them feel weird or awkward, others found the questioning during the assessment to be useful for the provider or funder, or considered it important to receiving the appropriate treatment for their problems.

Client Choice

Most youth expressed that they had a choice of service providers and services from which to select after having completed the assessment. Similarly, many parents agreed that their children were given choices. Although the majority of youth and their parents interviewed were given a choice, some complained that they were given either only one option, or unsuitable options, and could not negotiate for another place to receive their services. Some youth were frustrated because their treatment provider was too far away, even with a subsidy of bus tokens provided through the voucher.

Youth and their parents expressed that choice was important to them because they wanted to have options to fall back on in case one provider was a bad fit. Although a few youth and parents said that they did not care whether they were given a choice, most commented that it was important to have the option of selecting the treatment program and services. One parent said that as long as his/her child was receiving appropriate services and things were going well, s/he was not concerned about not being given treatment provider options.

Eighty-one percent of providers interviewed said that clients were given a choice of provider during the assessment process. The majority of providers clearly stated that the CARE protocol was implemented appropriately—that clients were offered a choice of providers.

“The concept behind the CARE program is fantastic. Encouraging choice and finding referrals for our clients have always been an obstacle in our field. CARE did a great job of bringing together a high number of treatment and recovery support providers, both faith-based and non-faith-based, which allowed youth the option of choice.”

Not all providers, however, felt that clients were truly given a choice. Some perceived that in cases where CARE assessment providers were affiliated with a specific treatment or recovery support agency there was a bias towards assessors' programs. Although assessment providers who also provided treatment and/or recovery support were required to implement practices to prevent conflict of interest in the placement/referral process, some providers felt that assessors influenced client choice by promoting their own program and downplaying other choices. However, other stakeholders felt that when a youth chose the assessor's agency, it was a natural result due to the rapport built with the person conducting the assessment.

Key informants and providers felt self-referral presented both positive and negative aspects for youth. On the positive side, referrals by assessment providers to their own program contributed to minimizing wait-time and facilitating rapport between youth and provider, thereby increasing engagement and retention in treatment. The negative side was the possibility that youth were not given the opportunity to make an independent choice among service providers. The following quotations are provided as examples:

- "A lot of times the [assessment] provider [was the one] that the youth chose to stay with because that's the person that she or he had initial contact with."
- "One could argue that there is more value to [a youth receiving treatment from the assessment provider] because [the youth] has established a rapport with your program which may be a good thing. If I don't know you, I may not be going for treatment at all."

In some instances, CARE assessment providers felt pressure to refer youth back to the CARE treatment or recovery support provider who had referred the youth for assessment, which violated the philosophy of choice. Some providers felt there was competition between providers to get clients and their vouchers referred to themselves. Some indicated that while treatment became more available, there was no increase in choice. "Folks, for the most part, went to where they wanted to get services. And it was just a matter of the providers getting the [clients'] vouchers in order to get reimbursed for providing those services." A few parents mentioned that they went to a specific assessment location having already decided that they wanted their children to receive treatment services there.

Youth who were given several service providers from which to choose expressed that they based their provider decision on many different factors, but geographic location was the most critical. Most clients sought services that were close to their home or school. Other important factors in both youth and parent decisions in selecting a provider were feeling comfortable with the assessor/counselor at the program, the program schedule and service intensity, and similar faith/spiritual beliefs. Parents appeared to consider the reputation of the program more often than the youth. Many youth and parents reported feeling more comfortable with counselors who had AOD use histories themselves.

Supporting Informed Choice

To support client choice, ADP had originally proposed a report card system that would indicate the quality of providers based on treatment outcomes and client satisfaction. The report cards were to be posted on the CARE web site and available from the call center. However, due to the complexity, the report card was not implemented as originally proposed. Instead, assessment providers were expected to present clients with information about the program options to assist them with informed choice based on information available on the provider directories, and by attending networking sessions hosted by the CARE management team.

One key informant reported that youth were given a “pretty good” overview of the providers with which to make their decision. However, another key informant wondered how much information youth actually received, and whether they were truly able to make informed choices. One interviewee commented that, since there were no statewide standards for recovery support services, it would be difficult for clients (or providers) to objectively judge the quality of those types of services. Additionally, concerns were voiced about the capacity of youth to make an appropriate choice if their judgment might be impaired by substance abuse.

Engaging Nontraditional Providers

A requirement of the ATR grant was to involve both FBOs and recovery support providers, neither of which were typically part of California’s AOD service system. Traditional providers came on quickly, but there was considerable work done by the CARE management team to build trust and willingness for nontraditional providers to participate, and then develop and enhance partnerships between all providers participating in CARE.

Key informants repeatedly credited the CARE marketing and outreach manager with successfully recruiting and involving faith-based and other nontraditional organizations. It was evident that this individual was a good fit for the role, and had the skills, expertise, and personality to break down barriers and connect with the individuals and organizations that CARE was targeting.

Many of the nontraditional organizations had never received government funding, and the CARE program represented a new experience for them. The main challenges to recruitment were building their trust and allaying their concerns about traditional restriction on the use of government funds for faith-based services. Technical assistance was also needed for nontraditional organizations to assist them with the application or develop the infrastructure necessary to be eligible to apply. The CARE marketing and outreach manager met with agencies individually, and in groups, to explain how the program worked and how it benefited them, such as payment for services they were already providing and the ability to expand their programs. Many stakeholders thought that FBOs had not previously accessed government funding because of perceived bureaucratic requirements, or because they might be required to relinquish their faith-based activities as a condition of funding. A few FBOs already on board with the CARE program were asked to speak to other such providers to offer their own positive experience with the program and confirm that “they can trust ADP, that they will not let you lose your personal identification or philosophy as a FBO.”

Key informants recounted that some nontraditional providers were able to adapt while others struggled. Some required a substantial amount of technical assistance to develop their infrastructures (e.g., recordkeeping and billing), which licensed and certified treatment providers already had in place. Even with technical assistance, some providers were unable to successfully build the needed infrastructure and/or did not have the financial stability necessary to wait for post-service reimbursement. As noted in the prior chapter, some of these providers enrolled but were never active (did not accept or redeem any client vouchers).

Once nontraditional providers were recruited into the CARE network, the CARE marketing and outreach manager endeavored to build positive relationships between these agencies and the assessment providers, which were primarily traditional treatment providers. However, client referrals to nontraditional organizations were slow to come. The key factors influencing the development of new partnerships were lack of familiarity, trust, and openness to change. Quotations from interviewees are presented below:

- “Some loved the opportunity to work with the faith community side-by-side. Others struggled with it. They hadn’t done it before and weren’t open to doing it. It was hard to shift that paradigm for some, especially for larger, more sophisticated treatment providers because they believed they had everything in-house.”
- “[Treatment providers] didn’t want to turn someone over to recovery support until they had a grip on them first. Their whole process was, and it’s a recovery belief, let them get into treatment, let them work their program and then add things.”
- “You have the relationship-building and trust issues. And not having worked with one another before, people were a little hesitant to make referrals to someone. Even with three years I think [the county] is really just embarking on this thing.”
- “With the FBOs, it was hard to mingle with. I went to meetings [but] didn’t see providers from that arena. Something we could improve [is] getting FBO recovery support providers to [have] a little bit more exposure.”

Over time, trust was built (albeit to varying extents) between traditional and nontraditional programs. Fifty-five percent of the providers surveyed made new relationships within the CARE service provider network, and almost two thirds (62 percent) of providers interviewed felt that the program increased local networking and collaboration, particularly among the Sacramento providers. A few providers felt that collaboration was forced but had positive results.

Approximately one-third of all providers surveyed and interviewed indicated that CARE did not increase collaboration. Some felt that collaboration was ineffective, minimal, or only occurred with some agencies. Many of the providers who did not feel that collaboration was enhanced wished that it had been, or that it could be in the future. While some key informants reported that networking sessions broke down barriers between faith-based and secular organizations, they reported that the frequency and length of the sessions were insufficient.

The stakeholder comments below illustrate the diverse perspectives and observations regarding the local networks.

- “There were a lot of cross-referrals and networking that occurred. I was really surprised that it worked.”
- “Unique partnerships evolved.”
- “There is a lot more communication occurring, but how deep, how strong, or how intense that is, I really don’t know.”
- “[Assessment providers] weren’t referring to the recovery support [providers]. And a lot of them weren’t referring them out to the religious community...at all.”
- “Treatment providers did not necessarily endorse sending their kids to...the faith-based providers. So there definitely was a separation.”
- “It has given us a tool to really access additional resources. It has allowed us to work together.”
- “All of a sudden...we get to know them through the CARE program, like other FBO and other providers that provide services but may have not been known as a substance abuse provider.”
- “We have become more aware of the many program and service providers in the region.”
- “Those that understood the benefits of collaboration and partnerships got the most out of the CARE program. Those who wanted to operate in silos and maintain their individuality struggled with the program.”
- “FBOs have been great partners overall—some treatment, some recovery support. They have a lot to offer. The relationships between the faith-based and traditional groups have been positive...I think those relationships that were built created dialogue.”

Voucher System

The ATR grant required that all services be provided to a client via a voucher. The CARE program developed and implemented a voucher management system (VMS) for issuing, tracking, and redeeming vouchers. Initially, some of the VMS functions were not accessible to providers, requiring a fax process between providers and the call center that was time-consuming and frustrating. However, within a few months, these electronic functions were made available to the providers. Additional enhancements to make the VMS more user-friendly were added over the next year. All possible voucher functions, including extension requests, were automated, default fields were added to streamline data entry, and a notification alert/bulletin board was added. Some providers noted that improvements made in the VMS during the course of the program made a big difference in their satisfaction with the program.

However, some providers continued to experience challenges related to the time it took to get clients’ vouchers approved in the VMS after they had been assessed. “It starts with the assessor, since we can’t start to provide services to a youth until they have been entered into the VMS system. Some assessors have taken up to three weeks while others take only three days.” Some providers found the voucher system to be cumbersome to use. One key informant explained, “The population that generally works within AOD circles, they’re not usually computer nerds. The VMS was overwhelming for many.... People [were] calling [the

call center] everyday.” The individual added that assessment providers eventually became used to the system and the need for technical assistance dramatically decreased.

One of the major challenges with the voucher system was related to tracking funds. After approximately one year of operations, the amount of obligated funds shown in the VMS rose to the amount of the entire grant amount. It was unclear how much of the substantial obligated funds were actually unobligated since clients who had dropped out or were not accessing services were not being discharged in the VMS by assessment providers, which would have freed up the funds. Without assessment provider compliance in this area, it was difficult to determine how much of each open voucher was going to be redeemed. It became necessary to stop enrollments of new clients for a 90-day period to let all the pending vouchers run out to accurately account for all funds.

Service Quality

Ensuring quality and accountability among service providers was a concern for some stakeholders. A few parents and youth felt that ADP was not aware of some of the practices of their service providers that they felt were inappropriate. Some stakeholders expressed concern regarding whether there was enough oversight of the CARE providers.

While noting that there are no data to substantiate this, one key informant had the impression that assessors may have enrolled youth who did not formally meet the criteria for having a substance abuse disorder currently, or in the past. Other key informants were concerned about program standards for recovery support providers, since they were not certified by ADP in the traditional manner.

Cultural Competence

Providers mentioned being able to serve diverse populations, including Spanish-speaking individuals, but for the most part, they defined cultural competence as being able to speak the same language as the client and/or client’s family. Several providers did not know what was meant by the term “cultural competence.” Some providers felt that cultural competence was expressed more in terms of how clients were treated versus use of specific culturally competent tools, which most providers felt did not exist. Some providers did not feel that the GPRA data collection tool was culturally sensitive. While parents and youth reported feeling a sense of commonality with providers in terms of background or experience with addiction issues, they did not report receiving special services other than some special language services.

Multilingual services are an important indicator of cultural competency. All the CARE materials were available in both English and Spanish. The call center had bilingual staff (English and Spanish), and immediate access to an interpreting service when needed. One key informant suggested that the materials be made available in some of the Asian languages. According to one key informant, because most CARE clients are in school, they are fluent in English and language options are not as critical for them, but that language options might be crucial for many parents, for whom English is not their first language.

Participants also felt that gay, lesbian, and transgender or gender-specific outreach and services were not generally offered by CARE providers and that such services would be beneficial in addressing the unique issues faced by these populations.

CARE Services

Virtually all stakeholders perceived CARE to have increased the number and/or types of service options offered. In particular, stakeholders were appreciative of the funds available to provide family therapy, residential treatment, and recovery support services. The issue of enhanced services was especially pronounced in Sacramento where the changes seemed to be fairly dramatic, especially the addition of residential treatment which had not been available previously. However, several parents and youth were disappointed that the choices for residential treatment were so limited and felt that the residential placement they received did not address their needs.

A large majority of youth and parents appreciated the individual counseling received. Several parents reported that drug testing was an important component of the services their child received, although several youth commented that everything in the program was positive except the drug testing. Many parents felt that the family counseling and family nights were two of the most important components of the youth's treatment, and younger youth felt they benefited from having their parents involved (although older youth specifically did not want their parents involved).

Many providers also felt that the ability to provide family services was a positive aspect of the CARE program. "When we had the funding to provide [family] services... we were able to make a significant impact on the adolescents, especially in working with their families." Some providers had explicit ways in which they involved parents in their clients' care. But family/parental involvement was not always a straightforward or easy component to incorporate into programming, according to providers. This was often due to the logistical challenge of getting all relevant parties together in the same location at the same time.

There was considerable positive feedback from stakeholders, providers, youth, and families about the recovery support services made available under CARE.

- "[Recovery support] was a real novel part. I thought it was a really good thing; the whole recovery support concept."
- "The shift in having a holistic approach to providing treatment and recovery support, [is] giving these kids the support they need for the rest of their lives."
- "They [clients] like the fact that the recovery support services are there and that they are unique and they wouldn't have been able to get the services without CARE."

Some providers felt that CARE funds did not increase the number of recovery support services available to youth, only that CARE allowed providers to be compensated for a broader range of services than previously allowed.

Providers also discussed the flexibility they were allowed with CARE in order to meet clients' needs. Providers were able to determine service mixes for clients individually without some of the restrictions on other fund sources such as DMC. "You can get away from all the bureaucracy and [have] more one-on-one with the client."

The majority of parents and youth reported positive outcomes due to the treatment they received through CARE. In general, they reported decreases in drug use and other problems, and improvement in life overall. However, many parents and youth felt that the time window for services allowed by CARE vouchers was too short and they desired or felt they needed longer-term care. This was emphasized by providers as well. More than one-third of the providers (39 percent) discussed length of time in treatment and were unanimous that youth did not have enough time in CARE services.

Program Sustainability

Some key Informants noted that providers, especially smaller agencies, may have been inhibited from building capacity (e.g., hiring staff) for fear that, based only on CARE funds, their program would not be sustainable. Key informants from a county expressed concern about what would happen to the agencies, communities, and youth when the money from CARE ended. One said, "[The county] approached [CARE] somewhat apprehensively because we knew this was a time-limited grant project. ...We already know we're only serving the tip of the iceberg as far as the real level of need is. And we're kind of concerned about hyping this program too much, and then the grant goes away and we're left holding the bag..."

GPRA Data Collection

Assessment providers were responsible for collecting and submitting intake GPRA data, and care coordinators (staff of the assessment provider) were responsible for collecting and submitting status and discharge GPRA data. While the majority of providers felt that the reasons to do GPRA data collection were clear, they mentioned difficulties with tracking clients to collect the data. One challenge mentioned was that clients often chose to receive services from a provider located some distance from the care coordinator, and the care coordinator's cost to travel to these other locations was not reimbursable. Later in the program, SAMHSA allowed the status and discharge data to be obtained over the phone (with proper consent), which assisted with locating clients. Another challenge was that treatment and recovery support providers did not always notify the care coordinator when clients were to be discharged. Care coordinators reported showing up to conduct GPRA interviews and the clients had been gone from the program for some time.

- "The focus must be on supporting care coordinators and educating treatment providers about the importance of working with care coordinators in providing continuity of care. We struggle daily to follow clients' progress and maintain current GPRA [data], primarily due to lack of communication by treatment providers."
- "The care coordinators are the integral building blocks to the CARE system... Providers have neglected [this] and, therefore, tracking becomes problematic... It becomes exceedingly difficult [to collect GPRA data] when [care coordinators] have not been advised that the client has already been terminated or discharged."

Key informants reported that even though policies clearly stated that assessors/care coordinators were required to collect and submit GPRA data, compliance initially was incomplete. The CARE management team was able to improve compliance with intake GPRAs by requiring that it be submitted prior to requesting a treatment or recovery support voucher for the client. However, compliance with status and discharge GPRAs remained incomplete, which affected reliability of data.

In addition to collecting outcome data, the discharge GPRA was important because it served to disencumber a client's remaining voucher funds. Since care coordinators were not consistently compliant in entering such data, this led to difficulties in monitoring available voucher funds. A key informant explained that when a client was issued a voucher that encumbered a set amount of funds, but that client never accessed services and the care coordinator never submitted a discharge GPRA, the voucher money remained tied up. When this occurred with many clients, the problem was compounded.

ADP instituted new policies to address this problem, including limits on client enrollments and provider caseloads. According to key informants, this policy increased compliance with the discharge GPRA requirement because to add one client, assessment providers had to discharge another. One key informant suggested that the enrollment limits may have also encouraged assessment providers to more selectively prescreen potential clients.

Grant Administration

While they were regularly meeting, the Steering Committee was effective in providing guidance in the implementation and operation of the CARE program, since many issues arose that required discussion and modification. A number of key informants commented that although they felt the committee was a very useful forum for discussing a broad range of issues concerning the design and implementation of the CARE program, they were disappointed that after the first 18 months, the Steering Committee met less often and members had less input. Others commented that, as the program became established, members were updated regularly but meetings were only held as necessary to discuss specific issues or problems.

Informants reported a sense that the ATR grants, at least initially, overwhelmed the grantees across the country. There was inadequate time to build the infrastructure before grantees were expected to begin issuing vouchers. In addition, the administrative rate cap on the grant, intended to preserve funds for services, limited resources available for provider oversight, marketing, and outreach.

Limitations

The CARE evaluation, which is the basis of this retrospective analysis, attempted to use all available information and data that could be compiled that provided meaningful perspective on the CARE program. However, the observations and conclusions of the findings have significant limitations. The scope and accuracy of the analysis were seriously restricted by a number of parameters of the evaluation design and timetable. All findings included in this report have to be considered within these constraints and limitations.

The CARE program was a large and relatively complex undertaking that had many “moving parts.” The program had to get many things done on a very rapid schedule, involving many referents, service providers, assessors, fiscal intermediaries, and, ultimately, youth and their parents. The CARE program evolved over time, and the people and activities involved changed over time. In order to conduct an optimal evaluation for a project of this type, it is important to have the evaluation designed as part of the project and in place as the project is implemented.

UCLA Integrated Substance Abuse Programs (ISAP) was contacted about the possibility of conducting the CARE evaluation in May 2007, two months prior to the scheduled end of the project. Work began on the evaluation in July 2007. This late initiation of the evaluation process resulted in a number of significant limitations, including the following:

- All youth in the CARE program were admitted for assessment and services without consenting to participate in evaluation activities. As a result, the evaluation team had to design a methodology for contacting the youth and their parents after they had already received the services (or were still receiving them) and have this methodology approved by the three Institutional Review Boards (IRBs) that had oversight over the evaluation (State of California IRB, UCLA IRB, Friends Research, Inc., IRB).
- Acquiring retroactive consent to speak with youth about their involvement in CARE was extremely challenging and resulted in an eight-month process to get all three IRB approvals. The IRBs were reluctant to allow contact with youth for data collection and interviews (many of the youth were criminal justice referrals and hence were considered highly vulnerable populations). This eight-month IRB approval process resulted in less than a two-month period to collect provider, youth, and parent data; analyze these data; and write the report.
- The youth who were available for contact at the late date of the evaluation received services during the last months of the CARE program. Since there were many modifications in the program over the course of the three-year period, information from these last participants may or may not have been representative of services provided throughout the entire project period.
- Because the only youth and parents who were interviewed/surveyed were those currently in CARE at the time of the evaluation, it was not possible to contact youth who dropped out of CARE prematurely. These individuals may have had a different treatment experience with CARE, but it was impossible to reach these youth and parents for input due to the time constraints of the evaluation.

Recommendations

These recommendations are drawn from stakeholder perspectives. Some address components of the CARE program that worked well and stakeholders felt were important to continue. Other recommendations address limitations in the CARE program or problematic areas that stakeholders felt should be considered to enhance future youth treatment efforts in the State.

Program Implementation

Stakeholder involvement

- Frequent and ongoing monitoring and modification of the program may be needed as circumstances change, but not without first understanding the potential effects of such changes on the various stakeholder groups. Thus, the involvement of representatives from all of the stakeholder groups at the various stages of the program is crucial.
- Schedule regular meetings that are convenient for stakeholders to attend and involve representatives of all key stakeholder groups early on and continuously throughout the grant period.
- Consider county differences in the implementation and operation of programs to leverage the strengths of the local systems and develop other areas, as needed.

Assessment

- Clearly define the requirements for assessors to ensure that they have the necessary qualifications/credentials to assess youths' multiple needs, including mental health issues.
- Include independent, licensed clinicians as assessment providers to help guard against potential bias toward referring clients to one's own agency.
- Clarify the roles and responsibilities of the assessment provider, care coordinator, and treatment and recovery support providers. Monitor and conduct site visits with providers and follow-up with clients to ensure that roles are clear and responsibilities are being met.
- Maintain a reasonable limit on the number of client enrollments per day to keep caseloads to a manageable level and ensure timely follow-up with clients.
- Identify why youth may not follow through with obtaining services, or drop out of the program after receiving an assessment, and develop strategies to minimize the no-show and/or drop out rate.

GPRA data

- Maintain a reasonable limit on the number of treatment and recovery support service vouchers to help facilitate submission of discharge data and to control expenditures.
- Allow treatment and recovery support providers to collect status and discharge GPRA data from clients rather than requiring that such data be collected by assessment providers. In addition, allow these data to be collected by phone instead of in-person.
- Investigate and/or close cases where there has not been any activity in the system for 14 days to disencumber funds being held for clients who have dropped out of CARE.
- Monitor providers for compliance with the GPRA data requirements.

Service Accessibility and Capacity

Client choice

- Monitor assessors to ensure that youth are being provided with a selection of providers from which to choose and are receiving sufficient information with which to make informed and independent choices.
- Offer clients a choice of receiving services from traditional and faith-based/other nontraditional organizations to better serve the diverse needs of clients and their families.

Service options

- Ensure that enough residential treatment capacity exists for youth who need it. Whenever possible, ensure that these services are easily accessible and available locally.
- Increase voucher timeframes beyond 60-90 days.

Traditional and nontraditional partnerships and networks

- Strengthen information-sharing and relationships among traditional, faith-based, and other nontraditional organizations. Referrals to recovery support service providers should be an area of focus.
- Involve faith-based organizations and recovery support service providers early on in the planning and implementation of youth treatment efforts.

Voucher Management System (VMS)

- Design the VMS to be user-friendly and non-cumbersome.
- Monitor and ensure that providers are not entering duplicate clients into the system.

Outreach to Diverse Communities

Youth

- Conduct outreach to youth, especially underserved populations, at schools and faith-based and other nontraditional organizations, in geographic areas of the county not served by county-contracted providers, and within the juvenile and criminal justice systems.
- Translate materials into other languages besides Spanish, which may be especially important for the parents of the youth.

Service providers

- Thoroughly review applications to ensure that treatment providers have expertise in providing youth services, even though they may be long-term-certified by ADP. With respect to nontraditional organizations that have not previously contracted with the State or county, ensure that they have the administrative and fiscal infrastructure required to participate in a program such as CARE, or can develop their infrastructures given technical assistance. Conduct site visits as an integral part of the application review process.
- Rather than openly soliciting applications for recovery support providers, identify and

invite those that have excellent reputations in the community to submit applications. For smaller counties, limit the number of providers in the various categories in each region of the county to facilitate coordination, networking, and relationship building.

- Expand outreach efforts to target non-Protestant organizations and “invisible” youth populations (e.g., homeless, those in the foster care system about to emancipate, gay, lesbian, trans-sexual, and transgender youth).
- Have faith-based providers already on board speak to others who have concerns about becoming involved with government agencies.
- Carefully consider the qualities and skills of the individual(s) responsible for the marketing and recruitment for the youth treatment effort, as they appear to be crucial. In particular, pay close attention to the “fit” of the individual’s qualities and skills with the target counties (e.g., urban), the service providers, and the youth populations.

Technical Assistance

- Enhance training and education for providers, particularly new nontraditional organizations. Topics should include:
 - ✓ how to use the voucher management system;
 - ✓ record keeping and billing;
 - ✓ developing administrative and financial infrastructures;
 - ✓ how to actively market services offered to other providers and promote one’s organization;
 - ✓ benefits of collaboration.
- Consider assisting faith-based organizations in the writing of grant proposals to fund increases in service capacity and/or sustain the capacity built.
- Educate providers on what each has to offer.
- Review referral sources and develop strategies to increase referrals through underutilized referral pathways.
- Assess CARE service provider needs for diversity and cultural competency training, and monitor use of, and satisfaction with, the training offered.

Service Quality

- Focus on both the quantity and quality of the services provided under the CARE program.
- Conduct frequent site visits to monitor providers and ensure that (a) youth are being provided with several service providers from which to choose, (b) youth are receiving services for which providers are billing and being reimbursed, and (c) providers are abiding by policies and procedures.
- Consider developing standards for recovery support services and providers of those services.
- Systemically address evidence-based practices
- Implement a mechanism for performance measurement.

Resources

- Revisit allocation of resources (e.g., staff), and, where feasible and needed, consider increasing allocation to:
 - ✓ enhance the VMS;
 - ✓ conduct additional marketing and recruitment of providers (especially faith-based and non-traditional organizations), youth and families;
 - ✓ conduct provider site visits as part of the application process;
 - ✓ increase the number of provider site visits for auditing purposes;
 - ✓ expand technical assistance for service providers, especially nontraditional organizations.
- Ensure funds to sustain the provision of treatment and recovery support services to qualified youth in California.

Evaluation Plan

- Establish an evaluation plan as the program is developed and have the evaluation team collect ongoing information as the program is implemented. This is important in order to get the full benefit of evaluation feedback early in implementation and on an ongoing basis.
- If the evaluation plan includes the use of identifying information from participants (youth or parents) by the evaluators, have consent forms signed at the time of assessment.
- Enter participants into the California Outcomes Measurement System (CalOMS) in order to better understand and measure treatment effects.

Appendix 1: CARE Timeline

Year 1

Period up to, and including, the First Quarter of Year 1 (March 2004 through October 2004)

In March 2004, ADP, in collaboration with a diverse stakeholder workgroup, began to develop California's application for the ATR program, a \$100 million competitive grant released by SAMHSA. ADP chose to focus its ATR application on a critical treatment need in California—services for substance-abusing youth.

In June 2004, ADP submitted California's ATR proposal, which requested \$15 million per year to serve 9,280 youth ages 12-20 in four counties—Los Angeles, Sacramento, San Diego, and San Francisco. These counties included the four California cities that were part of the President's 25-Cities Initiative and which, collectively, possessed the greatest youth treatment gap in the State. The application proposed to expand access to a comprehensive array of clinical treatment and recovery support options (including faith-based programmatic options), and increase the number of service providers specializing in substance-abusing youth, while also ensuring the safety and efficacy of treatment for youth served.

On August 3, 2004, SAMHSA announced that California was among the 14 states and one tribal organization awarded an ATR grant. However, while the grant amount ADP requested was reduced by 50 percent (to \$7.6 million annually), the number of clients SAMHSA expected to be served (5,950) was not proportionately reduced.

In September 2004, ADP worked with the Steering Committee identified in the grant application to revise the grant scope of work and budget in response to the award reduction. This required difficult decisions about changes that would have the least negative impact on service provision and program integrity. One of the decisions made was to limit the target areas to Los Angeles and Sacramento counties.

ADP also partnered with CRIHB, another ATR grantee, to maximize resources, since both agencies were utilizing the same voucher management contractor (MAXIMUS). ADP and CRIHB were able to share some costs related to the development and maintenance of the call center and voucher management system (VMS) that would issue vouchers to clients; track clients, services, associated costs, and outcomes; and reimburse providers.

Second Quarter of Year 1 (November 2004 through January 2005)

By January 2005, ADP developed a comprehensive policies and procedures manual, which included the CARE voucher structure, allowable services, and reimbursement rates. Under the MAXIMUS contract, the CARE website was completed, a call center was established, and a customer service manager was hired to facilitate the anticipated calls from youth, parents, providers, referral sources, and the general public.

Third Quarter of Year 1 (February 2005 through April 2005)

By March 2005, the CARE toll-free number was installed and customer service representatives were hired and trained to respond to calls and process voucher requests.

In April 2005, ADP sent letters and enrollment applications to treatment and recovery support organizations within the two counties, encouraging them to participate in the CARE program. Immediately after the letter was sent, the CARE Management Team⁴ identified dates and locations in each county for the first provider orientation. Approximately 125 organizations participated in the orientation which provided an overview of the CARE program, as well as more specific information on program requirements and provider responsibilities, client eligibility, the roles of ADP and MAXIMUS, performance objectives, billing and reimbursement processes, data collection, and reporting requirements. Additional information was provided by a consultant for the Center for Substance Abuse Treatment (CSAT) on the GPRA data-collection reporting tool, which is used to evaluate the effectiveness of the ATR program.

Also in April 2005, MAXIMUS hired a CARE marketing and outreach manager to implement the marketing and outreach plan. Provider expansion focused on engaging and involving faith-based and other nontraditional organizations, educating referral sources on the services available under CARE, and outreach to potential youth clients. A promotional brochure was produced in both English and Spanish and distributed to youth, their families, and referral sources in the two target counties.

Fourth Quarter of Year 1 (May 2005 through July 2005)

On May 31, 2005, the call center began issuing the first vouchers to clients to redeem for services from eligible CARE providers. At that time, ADP had approved over 50 treatment providers (many with multiple locations) and five recovery support providers to participate in CARE. Initially, vouchers were requested by providers, and approved by the call center, via faxed documentation.

On June 30, 2005, the web-based VMS was fully operational, allowing providers to request vouchers, submit GPRA reports, and bill for services via the VMS. On July 6, 2005, the CARE Management Team held a webcast to train providers on how to use the VMS.

At the time of program startup, providers could bill for voucher-funded services via the VMS, but the automated process to reimburse providers was not operational, posing a temporary delay in providing payment to providers. The CARE Management Team initiated a paper invoice process to pay service providers in the interim.

⁴ The CARE Management Team consisted of ADP, MAXIMUS, and the Steering Committee.

In July 2005, ADP distributed client satisfaction materials to all care coordinators (case managers) to prepare them to distribute surveys to clients. Client satisfaction surveys and business reply envelopes were provided to clients by care coordinators during status interviews, beginning with the first status interview at one month into treatment and repeated every two months thereafter until discharge. Clients completed the surveys independently, sealed them in the business reply envelope, and mailed them directly to ADP (postage was prepaid).

By the end of the grant, approximately 600 clients had completed the ADP-administered client satisfaction survey in which they were asked to answer questions on a scale of 1 to 5 (1= Strongly Disagree; 2=Disagree; 3=Not Sure; 4=Agree; and 5=Strongly Agree). The surveys indicated a high degree of satisfaction with CARE services as shown below:

Figure 8: Client Satisfaction with CARE (ADP-administered tool)

Question	Average Rating
Overall, I am satisfied with the services I received.	4.3
I helped to choose my services.	3.9
I received the services that were right for me.	4.2
The location of the services was convenient.	4.1
Services were available at times that were convenient for me.	4.1
I got the help I wanted.	4.2
Staff respected my religious/spiritual beliefs.	4.3
Staff was sensitive to my cultural/ethnic background.	4.2
I would recommend the CARE program to a friend if he or she needed similar help.	4.3

By the end of Year 1, the CARE Management Team had accomplished the following:

- Recruited, approved, and trained 124 providers, of whom 20 were faith-based organizations and 36 provided recovery support services.
- Developed a web-based VMS, established a call center, and issued over 600 vouchers to clients.
- Developed and distributed a client satisfaction survey.
- Established a CARE website that included a current list of approved providers, downloadable provider applications, updated policies and procedures, frequently asked questions, and master forms.

Year 2

First Quarter of Year 2 (August 2005 through October 2005)

At the ATR grantee meeting in September 2005, SAMHSA expressed concern that California might not meet its client and provider expansion goals. In response to these concerns, the CARE Management Team developed a corrective action plan to increase the number of FBOs participating in CARE, increase client access to recovery support services, and improve administrative functions.

In October 2005, the CARE Management Team implemented many of the corrective actions, including: 1) educating providers on the effectiveness of recovery support services as well as the mandate that faith-based providers be offered as choices to clients; 2) broadening and clarifying the eligibility criteria for youth who could receive recovery support services without treatment; 3) developing an assessment application for qualified licensed practitioners who have ties with faith-based organizations; and 4) increasing the maximum value of the recovery support voucher.

Also, as part of the corrective action plan, the CARE Management Team stepped up its outreach to faith-based and nontraditional service providers, providing orientation and training to 27 providers and at two large resource sharing events with more than 100 attendees. There were multiple recruitment events where program information and assistance in completing the provider application was offered to FBOs. By the end of the quarter, a total of 37 FBOs were approved to accept vouchers.

Activities related to promoting and building strong relationships between secular and faith-based, traditional and nontraditional providers, continued throughout year two in the form of training, technical assistance, and resource-sharing events. In this quarter, three community outreach recruitment events were held to encourage youth participation in the CARE program, and a process was instituted to connect youth in juvenile hall to recovery support services during, and after, incarceration.

The first upload of voucher and client data, collected via the GPRA tool, was submitted on October 31, 2005; however, it was not accepted by SAMHSA until November 2007 because of provider errors on the GPRA reports. This compelled the CARE Management Team to provide ongoing GPRA trainings to improve providers' accuracy, as well as ensure compliance with GPRA reporting.

By the end of the quarter, the CARE program had served 808 clients.

Second Quarter of Year 2 (November 2005 through January 2006)

In December 2005, ADP first summarized responses from the client satisfaction survey. An overwhelming majority of clients chose "strongly agree" as the response option to the statement "the CARE program was a positive service to youth. The CARE program also reached its 1,000-clients-served mark by the end of this month.

As of January 31, 2006 (eight months into service provision), the CARE program had over 200 approved providers and had served 1,529 clients.

Third Quarter of Year 2 (February 2006 through April 2006)

In February 2006, the CARE Management Team, with the support of a technical assistance consultant, developed report card indices based on the GPRA domains and measures from the client satisfaction survey. The plan was that results of the report cards were to be made available to CARE program clients to assist them in choosing among available providers. However, by mid-2006, ADP decided not to move forward with the CARE report card due to complexities connecting one set of GPRA outcomes or client satisfaction ratings to a unique service set.

In April 2006, the CARE Management Team began issuing new residential recovery support vouchers developed with assistance from SAMHSA. With these vouchers, providers were reimbursed at a daily rate for “bundled” recovery support services provided to clients in a residential setting.

Due to continued delays in implementing the automated payment system, ADP hired a part-time staff in their accounting office to manually process provider invoices, thus reducing the risk of service providers dropping out of the CARE program because of late payments.

Fourth Quarter of Year 2 (May 2006 through July 2006)

By May 2006, California’s ATR program had exceeded its provider expansion goals. The CARE network represented a diverse set of providers, including faith-based and nontraditional organizations, who reflected the needs and preferences of the target population. Thus, recruitment for providers ended and no provider applications were accepted after June 1, 2006.

Limiting provider enrollment enabled ADP to redirect limited resources to quality assurance and technical assistance activities to maintain and improve the integrity of the program. In July 2006, ADP developed and distributed to providers a site visit review tool, and began conducting site visits utilizing this tool. Between July 2006 and December 31, 2007, ADP conducted approximately 75 on-site provider reviews as part of its quality assurance plan to identify performance and accountability concerns and improve the quality of services and competence of providers.

Beginning in July 2006, the CARE Management Team began issuing a monthly newsletter that included client success stories submitted by CARE providers or their clients.

Year 3

First Quarter of Year 3 (August 2006 through October 2006)

In September 2006, the CARE Management Team instituted new policies to improve GPRA compliance, including a maximum caseload for care coordinators, required monthly client contact by care coordinators, and mandatory cooperation by providers with care coordinators to assist in collecting GPRA data from their clients. In response to a policy change from SAMHSA, the CARE Management Team also revised the window for GPRA status interviews and allowed telephone interviews under specific instances.

Also in September 2006, CARE had exhibits at ADP's Treatment Conference in Sacramento and the Rally for Recovery at the State Capital, where they distributed materials for outreach and awareness.

By the end of September 2006, California's ATR program had served over 6,500 clients, exceeding its goals for the target number of clients to be served (5,960).

Second Quarter of Year 3 (November 2006 through January 2007)

An escalation of services during the previous quarter exceeded expectations and voucher funds were utilized more quickly than anticipated. As a result, the CARE Management Team had to stop issuing vouchers as of December 1, 2006, to allow unused funds to be returned to the voucher pool. In an effort to "flush out" the unused voucher funds, providers were required to notify care coordinators immediately if a client was discharged, and payment was withheld from assessment providers until they submitted any overdue discharge GPRAs.

Third Quarter of Year 3 (February 2007 through April 2007)

In March 2007, the CARE Management Team worked with SAMHSA to provide sustainability training to faith- and community-based CARE providers. SAMSHA and the CARE team encouraged organizations to diversify their resources and seek other funding sources so as not to rely on CARE funding, a time-limited fund source.

On April 2, 2007, the CARE Management Team began issuing vouchers after a three-month hiatus. New policies went into effect to manage voucher funds and ramp down the grant. Voucher timeframes were shortened from 90 days to 60 days, and their maximum value was reduced by one-third. Providers were required to bill for a service within 14 days of providing the service, and if a voucher was not billed within 14 days of issuance, it was cancelled.

Fourth Quarter of Year 3 (May 2007 through July 2007)

Even with the new policies implemented to slow down voucher issuance, the amount of obligated funds skyrocketed when vouchers were issued again in April 2008. Therefore, in May and June 2007, additional policies were instituted. Enrollment was limited to one new client per day per assessment provider/location. The client caseload per provider was frozen so that in order to admit another client, the provider had to discharge a client (which helped with GPRA compliance because the discharge process includes a discharge GPRA). Also, two types of vouchers were discontinued: residential treatment for adults (18-20 years old) and intensive outpatient vouchers. These actions helped stabilize the obligation and redemption of voucher funds to enable the CARE management team to reliably forecast and manage the voucher expenditure rate.

In June 2007, ADP did a preliminary analysis of CARE outcome data and found that clients receiving recovery support services, in addition to clinical services, completed treatment successfully at a higher rate in comparison to those receiving only clinical services, and that clients receiving services from both FBO and secular providers had a slightly higher rate of successful treatment completion than the two groups receiving one type of service (FBO or secular).

Also in June 2007, ADP developed and submitted an application for ATR 2, in which ADP proposed to continue and expand the CARE program.

In July 2007, ADP received approval from SAMHSA for a no-cost extension of the ATR grant through December 31, 2007.

In July 2007, ADP contracted with the Integrated Substance Abuse Programs (ISAP) at the University of California at Los Angeles (UCLA) to conduct a retrospective analysis of the CARE program. After extensive efforts to have the study approved by the Institutional Review Boards of UCLA, Friends Research Institute, and the Committee for Protection of Human Subjects of the State of California, UCLA received an endorsement to begin their study in April 2008.

In August 2007, the limit on new enrollments was increased from one to four clients per day, per assessment provider, and adult residential treatment vouchers, which were discontinued in June 2007, were again made available, but were limited to 30 days instead of 60 days.

In September 2007, CARE was awarded a second, three-year ATR grant from SAMHSA. Although the award was reduced to \$14.5 million for a 3-year period (from \$22.6 million for the first grant), the program will be expanded to Butte, Shasta, and Tehama counties, as required by the grant, to target methamphetamine-using youth.

Appendix 2: Study Methodology

Study Design Overview

Data were collected from respondents using both qualitative and quantitative methods. Youth and parents completed a survey and/or participated in separate focus groups. Service providers completed a self-administered survey questionnaire and a semi-structured individual interview. Key informants participated in a semi-structured individual interview.

All evaluation procedures were reviewed and approved by the Institutional Review Boards of the University of California, Los Angeles, Friends Research Institute, and the Committee for Protection of Human Subjects of the State of California. In addition, a Certificate of Confidentiality was obtained from the U.S. Department of Health and Human Services for the study. For youth aged 12 to 17, parents were asked for permission for their child's participation in the study. Participants received a copy of the informed consent form.

GPRA Data Analysis

All available admission and discharge records, or most recent status records, for CARE participants from the GPRA (Government Performance and Results Act) data files were used to assess program outcomes. There were 13,145 admission records representing 11,910 unique clients. The number of days of services and different types of services were accumulated across multiple records for each client to represent the total services received.

Descriptive statistics (e.g., percentages or averages) provided an overall picture of CARE participants in terms of demographics (gender, race/ethnicity, age at admission), substance use during the 30 days prior to admission, socio-demographic characteristics (including family and living conditions, education, and employment), health, and criminal justice status. Percentages were used for client characteristics and outcomes measured as categories (e.g., male/female or substance use/no substance use); averages were used to summarize continuous variables (e.g., number of sessions or number of days of substance use).

Outcomes were assessed in terms of change from admission to discharge, using the repeated measures approach of generalized linear models, with generalized estimating equations (GEE) for binary outcomes.⁵ The analysis approach allowed assessment of change from admission to discharge, as well as differential change by selected county and demographic characteristics. Analysis was done using Statistical Analysis System (SAS) 9.1.3.

⁵ Hedeker, D., & Gibbons, R. (2006). *Applied Longitudinal Analysis*. New York: Wiley.

Youth and Parent Surveys and Focus Groups

Overview

A convenience sampling approach was used to recruit 52 current or former CARE clients and 47 of their parents to participate in a survey and/or focus group. The sample size was predetermined based on feasibility and the necessity to acquire a sample that included the diversity of youth during the brief contract period. Recruitment methods included a direct mailing to 500 of the most recent youth to enroll in CARE, flyers posted by service providers at their facilities, and the UCLA-CARE website. Recruitment flyers were mailed to every eligible CARE provider and, when possible, flyers were also delivered in person. Clients or former clients who were interested in participating in the study called, e-mailed, or mailed the response mailer enclosed in the direct mailing to UCLA staff. In some cases, participants heard about focus groups by word-of-mouth or flyers and attended the focus group without prior contact with the UCLA team. Eligible participants were continuously recruited until May 9, 2008. Data collection from surveys, interviews, and focus groups occurred between April 1, 2008, and May 5, 2008.

Surveys

Surveys were administered at the participant's home (when requested by participant), provider locations, or UCLA offices. A UCLA staff member met in private rooms with participants to review the informed consent form, answer questions, and obtain their signature if they wished to participate in the study (either the survey or focus group, or both). If the respondent was aged 17 or younger, the individual's parent or guardian was also asked to review and sign the informed consent form.

Fifty-three youth participated in the survey during April and May 2008, which represents less than one percent of CARE clients as of December 2007. Forty-seven parents of those youth also participated in the survey. Respondent data were entered by participants onto paper and pencil questionnaires and later entered into laptop computers by UCLA staff. For Spanish-speaking participants, surveys were translated and administered by UCLA staff. The survey took approximately 25 minutes to complete. Participants received a gift card valued at \$10 for completing the surveys.

The survey instrument (included in Appendix 3) was developed by UCLA to address the CARE goals and objectives. There were five separate measures in each survey:

- Brief demographics: 12 questions to collect descriptive data such as ethnicity, highest grade completed, drug use history, etc.
- Religion and Spirituality: 21 questions regarding the role of religion and spirituality in their, or their child's, substance abuse recovery.
- Services Received: 34 questions about the type and amount of services the youth received.
- Feedback: 34 questions about the perceived usefulness of services and satisfaction with the services received.
- Outcomes: 9 questions about specific positive outcomes youth or parents may have seen in the youth's life.

Focus Groups

Focus groups to obtain youth and parents' perspectives and experiences were conducted immediately after the survey and at the same facility to make it as convenient as possible for participants to take part in both components. All youth and parents who completed the survey also participated in a focus group or a one-on-one interview. Focus groups were held in private rooms and moderated by trained and experienced researchers. Most focus groups included approximately eight people; however, in one case, all but one member of a scheduled focus group did not show up, resulting in an individual interview, and, in another, word-of-mouth communications led to an unexpectedly high show-rate resulting in a group of 17. In a few cases, participants asked for individual interviews in their homes. For Spanish-only speaking participants, translation was provided by UCLA staff and on one occasion by a bilingual parent participant.

Figure 14: Youth focus group and interview participants

County	Number of Participants			
	Youth		Parents	
	1:1 Interview	Focus Group	1:1 Interview	Focus Group
Los Angeles	3	26	3	32
Sacramento	2	21	1	11
Totals	5	47	4	43
	Total Youth: 52		Total Parents: 47	

The focus group session began with the moderator and assistant introducing themselves and welcoming the participants. Ground rules for the session were presented (e.g., no right or wrong answers, respect each other's answers and opinions, maintain confidentiality) and individuals were given an alias to use during the session. On average, youth focus group discussions lasted 25 minutes; the shortest being seven minutes (for an individual) and the longest being 50 minutes. The majority of the parent focus groups lasted approximately 33 minutes; the shortest being six minutes (with an individual) and the longest being 58 minutes. Participants were each paid \$40 in gift cards for their participation. (The youth and parent focus group scripts are included in Appendix 3.)

The focus group discussions were digitally audio-recorded, and an assistant took written notes. The digital voice recordings were transcribed verbatim and transcripts were reviewed and edited by UCLA staff. The qualitative data analysis process followed generally accepted procedures.⁶ A preliminary code list was developed from predetermined topics of interest to ADP and themes and patterns that emerged from reading and rereading the transcripts. Initially, several transcripts were independently coded by at least two UCLA staff, codes and reasons for coding decisions were discussed, and consensus was reached among coders. Adjustments were subsequently made to the code list. Transcript data were coded using Atlas.ti, a qualitative data analysis software package. The coding of each transcript was reviewed by a second staff member and adjustments were made. A constant comparative method of analysis was used, whereby narratives were compared both within and across focus groups in order to achieve thorough representation of the primary cross-cutting

⁶ Marshall, C., & Rossman, G.B. (1995). *Designing Qualitative Research* (2nd ed.). Thousand Oaks, CA: Sage Publications.

themes. After coding was completed, the codes representing the primary themes were summarized and individual differences were highlighted. Findings were discussed among the UCLA team members (analyst triangulation) as a way to assess face validity of the data.⁷ Representative quotations were selected to illustrate the findings.

Service Provider and Assessor Survey and Semi-Structured Interviews

CARE service providers and assessors were recruited for the study using a convenience sampling approach. All CARE providers were given a survey questionnaire along with a recruitment letter and informed consent form by mail, e-mail, fax, or in person, and were given the option of completing a web-based version of the survey. Providers were recruited continuously until 70 providers agreed to complete the survey and 61 providers agreed to participate in interviews.

UCLA developed two survey instruments for providers—one for service providers and one for assessors—to obtain providers’ perspectives on how well the goals of the CARE program had been addressed. The survey instruments (included in Appendix 3) were pilot tested and feedback was incorporated. The survey took providers approximately 30 minutes to complete. Once the completed questionnaire and consents were received by UCLA, a gift card valued at \$10 was sent to the respondent.

Semi-structured interviews were conducted with 61 service providers, including 14 assessors who consented to having their feedback incorporated into this report. The interviews ranged from 15 to 48 minutes (the majority lasted 30 minutes) and were conducted by UCLA staff. Topics were developed and pilot tested to receive feedback on how well the goals of the CARE program had been addressed (the interview questions are included in Appendix 3). Fifty-eight interviews were digitally audio-recorded and later transcribed verbatim. Four interviews were not recorded at the request of participants, but summarized in interviewer notes. Participants were sent gift cards valued at \$20 for completing the interview.

Figure 15: Provider and assessor types interviewed (N=61)

County	Faith-based providers/assessors	Traditional clinical providers/assessors	Faith-based clinical providers/assessors
Los Angeles	9	26	12
Sacramento	0	9	5
Total	9 providers/assessors	35 providers/assessors	17 providers/assessors

Digital voice recordings of the interviews were transcribed verbatim, and the same methods for review and analysis were utilized as described above for the youth focus groups.

⁷ Patton, M.Q. (1990). *Qualitative Research and Evaluation Methods* (2nd ed.). Newbury Park, CA: Sage Publications.

Key Informant Interviews

A combination of purposeful and snowball sampling approaches⁸ was used to recruit 18 participants for the key informant interviews from stakeholders involved in the design and implementation of CARE. During the semi-structured interview, respondents were asked to recommend other stakeholders whom interviewers should contact.

Interviews using open-ended questions (included in Appendix 3) were conducted in-person at the respondents' offices or by phone, and lasted between 17 and 80 minutes (the majority lasted 39 minutes). Each interview was conducted by one or more UCLA staff member and was digitally audio-recorded and later transcribed verbatim. Key informants were not paid for their participation. Procedures for analyzing the key informant interview qualitative data were similar to those used for the focus groups and provider interviews.

⁸ Patton, M.Q. (1990). *Qualitative Research and Evaluation Methods* (2nd ed.). Newbury Park, CA: Sage Publications.

Appendix 3: Interview Questions and Survey Questionnaires

Key Informant Semi-Structured Interview Guide

1. How did you see the CARE program implemented in your county?
2. Could you describe the marketing of CARE to youth/parents/providers?
3. What is your role, if any, with regard to CARE?
4. When did you become involved with CARE activities?
5. Who benefited most/least from CARE? How?
6. How did you see CARE funds allocated/spent?
7. What did you see as the primary pathways into the program? Criminal justice, education, foster-care? Other referral sources?
8. Did you see or use GPRA data?
9. (If you are not ADP staff) What was your interaction/communication with ADP re: the CARE project? When/how did you communicate with ADP?
10. What do you know about the screening/eligibility process for CARE? Do you know about the recovery support/spiritual assessment process?
11. What was the collaboration like between traditional and non-traditional providers? Other people to contact? Could you characterize it?
12. Can you tell us about the referral agencies to CARE? How were they involved? How were they recruited as referral agencies?
13. What worked well overall in CARE? What didn't?
14. In the grant there was an emphasis on youth receiving at least two choices for every type of program; how did that go? Feasible? Effective? Worthwhile?
15. How is the type of choice offered by CARE different than standard operating procedure?
16. Can you tell us about unforeseen or unintended consequences of CARE?
17. What were the service gaps CARE tried to remedy in your area?
18. How well did the voucher system work from your point of view?
19. CARE was refunded for Phase 2. What do you see they you could do differently or change?
20. Can you tell us about any specific struggles/weaknesses you saw with CARE?
21. Can you tell us about any specific successes/strengths with CARE?
22. Is there anything that we have not asked you about that you feel is important for us to know?
23. Who else do you think we should talk to about CARE?

Some key informants were asked:

24. Were there any special efforts made to address the needs of diverse communities? For example, language-minority groups, foster, homeless, or other underserved groups?
25. Tell me about the Steering Committee. When was it convened? How often did it meet? When did it stop meeting? What type of decisions/recommendations did the Steering Committee make?
26. How would you describe the youth that participated in CARE in terms of their characteristics (e.g., age, drug use severity, service needs)?
27. In your opinion, how easy or difficult was it for youth who qualified under CARE to get vouchers?
28. Tell me performance management under CARE (e.g., reports, client satisfaction survey).
29. From your perspective, were youth given enough information with which to make informed and independent choices for services? Please explain or provide examples.
30. Tell me about the training in diversity and cultural competence that was available to service providers?
31. To what extent were CARE services and marketing materials available in languages other than English?
32. What's your impression of the types of services youth received under CARE, especially recovery support and non-traditional services, including gender-specific approaches?
33. Tell me about any efforts to provide and/or support the use of evidence-based practices (e.g., California's Youth Treatment Guidelines) for substance abuse treatment for youth.
34. In your opinion, to what extent, if at all, did cost-shifting occur?

Service Provider Survey

This study is being conducted by the UCLA Integrated Substance Abuse Programs under the sponsorship of the California Alcohol and Drug Programs (ADP). Its purpose is to better understand the impact of the California Access to Recover Effort (CARE) throughout Los Angeles and Sacramento counties.

Your participation is **voluntary** and **confidential**. All results will be reported only in aggregated form. Your participation will not affect current or future relationship with CARE or ADP.

Instructions

Please answer all questions in this survey unless you are instructed to skip questions.

Unless indicated, the questions in this survey pertain to the past year.

Please make a copy of your completed survey and keep it for your records.
You may attach additional pages if you wish to comment on your responses.

Please mail your completed survey along with your consent forms to Ana Ceci Mel, MS, Research Associate, using the postage paid envelop enclosed.

**If you have any questions, please do not hesitate to contact
Richard Rawson, Principal Investigator (310) 267-5311 or
Anne Bellows, Project Director at (310) 267-5232.**

1. Please place a check mark beside the degree or credential that best describes your training and background:
 PhD or PsyD Psychologist
 MFT Therapist
 MD Psychiatrist
 MD Other specialty
 RN Psychiatric Nurse or Nurse Practitioner
 MSW Social Worker
 BS Social Worker
 CAADAC Certified Alcohol and Drug counselor
 Certified Criminal Justice Addiction Professional
 Religious degree: (circle one) Bachelor or equivalent, Masters, Doctorate
 Other please describe: _____
2. How many years have you worked with substance abusing youth? _____
3. What is the name of the service provider where you are employed?

4. In which county does this service provider operate?
 Sacramento Los Angeles Other: _____

Service Provider Survey (2 of 6)

5. To the best of your knowledge, please rank the 5 most serious substance abuse problems in your clinic or agency (ranking the worst problem as 1, next worst as 2, etc.) over the past year.

_____ Alcohol
_____ Heroin
_____ Cocaine/Crack
_____ Methamphetamine
_____ Marijuana
_____ Barbiturates
_____ Hallucinogens
_____ Benzodiazepine or other Tranquilizers
_____ Non-prescription methadone
_____ Oxycodone/Oxycontin
_____ Inhalants
_____ Over-the-counter
_____ Other prescription drugs
_____ Ecstasy or other club drugs
_____ Other (Please Specify: _____)

6. Please place a check mark beside the best descriptor of your treatment program at the address indicated above. If you have more than one type of program at this address, please fill out this survey as it pertains to the program with the largest number of client admissions in the past 12 months:

_____ Faith-Based counseling
_____ Recovery Support Services (Describe): _____
_____ Non-Residential Outpatient
_____ Intensive Day Treatment
_____ Outpatient Drug Free _____ Outpatient (medication)
_____ NTP Maintenance
_____ Day Care Rehabilitative
_____ Outpatient Detoxification (non-medical)
_____ Outpatient Detoxification (medical)
_____ NTP Detoxification
_____ Detoxification (hospital) _____ Detoxification (non-hospital)
_____ Residential (30 days or less) _____ Residential (30 days or more)
_____ Other, Please Describe: _____
_____ Methadone maintenance (facility may also use buprenorphine in maintenance)
_____ Methadone detoxification (facility may also use buprenorphine in detoxification)
_____ Halfway Houses
_____ Buprenorphine services
_____ Outpatient
_____ Partial hospitalization/Day treatment
_____ Residential short-term treatment (30 days or less)
_____ Residential long-term treatment (more than 30 days)
_____ Hospitalization inpatient

Special Programs/Groups:

_____ Persons with co-occurring mental and substance abuse disorders
_____ Persons with HIV/AIDS
_____ Gays and Lesbians
_____ Women/girls
_____ Residential beds for clients' children
_____ Men/boys
_____ DUI/DWI offenders
_____ Criminal justice clients

Service Provider Survey (3 of 6)

Special Language Services:

- ASL or other assistance for hearing impaired
 American Indian and Alaska Native languages
 Spanish
 Foreign languages other than Spanish

Forms of Payment Accepted:

- Medicaid
 State financed insurance (other than Medicaid)
 Medicare
 Private health insurance
 Military insurance (e.g., AV, TRICARE)
 Self payment
 Access to Recovery (ATR) voucher

Payment Assistance:

- Sliding fee scale (fee based on income and other factors)
 Payment assistance (check with facility for details)

7-23. The next set of questions ask you about your opinions of the CARE program. Please circle the number that corresponds to your answer for the questions below:

To what extent do you, as a service provider, agree with the following statements?

	Strongly Disagree	Moderately Disagree	Neither Agree nor Disagree	Moderately Agree	Strongly Agree
7. The goals of CARE are clear to treatment program staff in my agency.	1	2	3	4	5
8. CARE is <u>not</u> useful in my agency.	1	2	3	4	5
9. Program staff in my agency often experience technical problems with CARE vouchers.	1	2	3	4	5
10. In my opinion, CARE-related operations are running smoothly in my agency.	1	2	3	4	5
11. Treatment program staff in my agency are made aware when changes occur in CARE vouchers, administration, and /or service provision.	1	2	3	4	5
12. CARE vouchers are being used to facilitate performance and outcomes improvement in my agency.	1	2	3	4	5
13. Treatment program staff in my agency are adequately trained in CARE policies and procedures.	1	2	3	4	5

Service Provider Survey (4 of 6)

14. With CARE, clients are receiving more effective treatment than before this system was used in my agency.	1	2	3	4	5
15. Treatment program staff in my agency have <u>not</u> been adequately trained on which clients have vouchers or may be eligible for CARE vouchers.	1	2	3	4	5
16. CARE intake assessments are useful for treatment planning with programs in my agency.	1	2	3	4	5
17. Treatment programs in my agency are paid for CARE invoices in a satisfactory and timely manner.	1	2	3	4	5
18. CARE intake assessments have been useful in my agency for measuring client treatment and ancillary service needs at <u>admission</u> .	1	2	3	4	5
19. I communicate with other service providers on a regular basis about CARE services in my agency.	1	2	3	4	5
20. CARE assessors provide useful client assessment information for this agency.	1	2	3	4	5
21. CARE GPRA data has been useful in my agency for measuring treatment/ ancillary service needs at <u>discharge</u> .	1	2	3	4	5
22. CARE GPRA data has been useful in my agency for documenting changes in clients' levels of functioning between admission and discharge.	1	2	3	4	5
23. ADP Management staff communicate with staff in my agency on a regular basis with respect to CARE policies and procedures, data collection and reporting requirements.	1	2	3	4	5

24. Please describe your agency's process for collecting and inputting CARE GPRA data at intake, discharge, and follow-up: (Please indicate the name of the person or agency who does the GPRAs for your clients if you do not do these GPRA assessments)

Service Provider Survey (5 of 6)

25. In the past year, did you contact ADP staff to ask questions about CARE?
YES ____ NO ____ If so, how many times? _____
26. Why did your agency staff typically contact ADP for CARE assistance (check all that apply)?
____ potential CARE clients assessment
____ CARE Inclusion/exclusion criteria
____ GPRA Data collection questions and issues
____ GPRA Data submission problems
____ Technical issues
____ Training needs
____ Other (Please Specify: _____)
____ I did not contact ADP for CARE assistance
27. Are you aware of the CARE website? <http://www.californiacares4youth.com/>
YES ____ NO ____
28. If so, have you accessed it within the past year? YES ____ NO ____
29. Do you think this website is useful? YES ____ NO ____
30. Is program or provider-specific feedback provided to you from ADP or Maximus or another source?
YES ____ NO ____
31. If YES, please describe the process:

32. How are providers typically communicated with about CARE?
____ E-mail
____ Site Monitors
____ Monthly Meetings
____ Site Visits
____ Newsletter/Memos
____ Other (Please Specify: _____)
____ Not Applicable
33. Have you made new relationships within the CARE service provider Network of Traditional and Non-traditional services? ____ Yes ____ No
34. List the names of the agencies with which you have new relationships:

35. Is there a deadline that providers have to submit CARE data (invoices, GPRAs) to ADP or Maximus each month? YES ____ NO ____
36. If YES, please describe the submission process:

37. Do you think CARE coordinators and Assessors understand why they are collecting GPRA data?
YES ____ NO ____

Service Provider Survey (6 of 6)

38. If no, please explain why not:

39. In your opinion, is training needed in your agency for assessment procedures, CARE eligibility, and GPRA data collection and/or use? YES _____ NO _____

40. If YES, please check off the type(s) of training that is most needed?

- Substance abuse assessment
- Psychiatric assessment
- CARE eligibility criteria
- Data Collection
- Data Reporting
- Data Utilization for treatment improvement
- Information re: services that are available to clients from other CARE agencies.
- Other (Please Specify: _____)

41. Please check off the type(s) of training that would be most useful in your county?

- Workshop/Classes
- Training of trainers
- On-call help desk
- Online tutorial
- Other (Please Specify: _____)

42. If additional funding became available at the state level for improving or expanding CARE, how would you suggest spending it?

43. Is there anything else you would like to tell us regarding the implementation/operation of CARE?

THANK YOU VERY MUCH FOR TAKING THE TIME TO COMPLETE THIS SURVEY.

Please send your survey and survey consent form by U.S. mail, please use the postage paid envelop enclosed addressed to:

Ana Ceci Mel, Research Associate
UCLA Integrated Substance Abuse Programs
1640 S. Sepulveda Blvd., Suite 200, Los Angeles, CA 90025
Fax: (310) 312-0538

If you prefer to email the completed survey please address it to Ana Ceci Mel at acmel@mednet.ucla.edu.

Service Provider Semi-Structured Interview

1. What was your role in your agency prior to CARE? Did it change after CARE?
2. What was your role in CARE service provision?
3. How did your agency become involved in CARE?
4. What were the typical pathways CARE participants took to get to your agency?
5. In your opinion did CARE impact your agency's service capacity? In what ways?
6. How did the program work to serve the needs of youth substance users?
7. What was the impact of vouchers? For example what was the impact on faith based/non-traditional Recovery Support services for youth? Your agency? Parents of youth? Communities?
8. What were the most and least beneficial aspects of the program? for providers, youth, parents, and communities?
9. Were there any unanticipated consequences of CARE? Please describe them.
10. Would you continue to take CARE vouchers? How might you do it again differently?
11. How has implementation of CARE impacted collaboration between you and local administrators across the treatment continuum?
12. How important is it to be able to get into treatment services right away? And how did vouchers impact time to treatment?
13. How do clients respond to the offer of a choice in selecting a treatment/recovery provider? How do clients choose?
14. Did your assessment program involve the client's family/caregiver(s)? How? If not, why?
15. Did your youth assessments consider strengths and abilities, as well as problems or needs?
16. Did your assessments use culturally competent or appropriate assessment tools? Please describe them.

Assessor Survey

This study is being conducted by the UCLA Integrated Substance Abuse Programs under the sponsorship of the California Alcohol and Drug Programs (ADP). Its purpose is to better understand the impact of the California Access to Recover Effort (CARE) throughout Los Angeles and Sacramento counties.

You are being asked to participate because you served as a CARE assessor in your county. Your participation is **voluntary** and **confidential**. All results will be reported only in aggregated form. Your participation will not effect current or future relationship with CARE or ADP.

Instructions

Please answer all questions in this survey unless you are instructed to skip questions.

Unless indicated, the questions in this survey pertain to the past year.

Please make a copy of your completed survey and keep it for your records.
You may attach additional pages if you wish to comment on your responses.

Please mail or fax your completed survey along with your consent forms to Ana Ceci Mel, Research Associate using the postage paid envelop enclosed.

If you have any questions, please do not hesitate to contact Richard Rawson, Principal Investigator (310) 267-5311 or Anne Bellows, Project Director at (310) 267-5232.

1. Please place a check mark beside the degree or credential that best describes your training and background:

PhD or PsyD Psychologist
 MFT Therapist
 MD Psychiatrist
 MD Other specialty
 RN Psychiatric Nurse or Nurse Practitioner
 MSW Social Worker
 BS Social Worker
 CAADAC Certified Alcohol and Drug counselor
 Certified Criminal Justice Addiction Professional
 Religious degree: (circle one) Bachelor or equivalent, Masters, Doctorate
 Other please describe: _____

2. How many years have you worked with substance abusing youth? _____

3. Do you work for a CARE Service Provider site? yes no (if yes, go to question 3, if not, skip to questions 5)

4. What is the name of the service provider where you are employed?

5. In which county does this service provider operate?

Sacramento Los Angeles Other: _____

Assessor Survey (2 of 6)

6. Please place a check mark beside the most common treatment you recommended for the clients you assess for CARE in the past 12 months:

- Faith-Based counseling
- Recovery Support Services (Describe): _____
- Non-Residential Outpatient
- Intensive Day Treatment
- Outpatient Drug Free Outpatient (medication)
- NTP Maintenance
- Day Care Rehabilitative
- Outpatient Detoxification (non-medical)
- Outpatient Detoxification (medical)
- NTP Detoxification
- Detoxification (hospital) Detoxification (non-hospital)
- Residential (30 days or less) Residential (30 days or more)
- Other, Please Describe: _____

-
- Methadone maintenance (facility may also use buprenorphine in maintenance)
 - Methadone detoxification (facility may also use buprenorphine in detoxification)
 - Halfway Houses
 - Buprenorphine services
 - Outpatient
 - Partial hospitalization/Day treatment
 - Residential short-term treatment (30 days or less)
 - Residential long-term treatment (more than 30 days)
 - Hospitalization inpatient

Special Programs/Groups:

- Persons with co-occurring mental and substance abuse disorders
- Persons with HIV/AIDS
- Gays and Lesbians
- Women/girls
- Residential beds for clients' children
- Men/boys
- DUI/DWI offenders
- Criminal justice clients

Special Language Services:

- ASL or other assistance for hearing impaired
- American Indian and Alaska Native languages
- Spanish
- Foreign languages other than Spanish

Forms of Payment Accepted:

- Medicaid
- State financed insurance (other than Medicaid)
- Medicare
- Private health insurance
- Military insurance (e.g., AV, TRICARE)
- Self payment
- Access to Recovery (ATR) voucher

Payment Assistance:

- Sliding fee scale (fee based on income and other factors)
- Payment assistance (check with facility for details)

Assessor Survey (3 of 6)

7-22. The next set of questions ask you about your opinions of the CARE program. Please circle the number that corresponds to your answer for the questions below:

To what extent do you, as a CARE Assessor, agree with the following statements?

	Strongly Disagree	Moderately Disagree	Neither Agree nor Disagree	Moderately Agree	Strongly Agree	Decline to answer
7. The goals of CARE are clear to me and other Assessment staff.	1	2	3	4	5	-7
8. Program staff where I refer clients often experience technical problems with CARE vouchers.	1	2	3	4	5	-7
9. In my opinion, CARE-related assessment and referral operations are running smoothly.	1	2	3	4	5	-7
10. CARE Assessment staff are made aware when changes occur in CARE vouchers, administration, and /or service provision.	1	2	3	4	5	-7
11. CARE vouchers are being used to facilitate performance and outcomes improvement.	1	2	3	4	5	-7
12. CARE Assessment staff are adequately trained in CARE policies and procedures.	1	2	3	4	5	-7
13. With CARE, clients are receiving more effective treatment than before this system was used.	1	2	3	4	5	-7
14. CARE Assessment staff have <u>not</u> been adequately trained on which clients have vouchers or may be eligible for CARE vouchers.	1	2	3	4	5	-7
15. CARE intake assessments are useful for treatment planning with programs.	1	2	3	4	5	-7

	Strongly Disagree	Moderately Disagree	Neither Agree nor Disagree	Moderately Agree	Strongly Agree	Decline to answer
16. CARE Assessment staff are paid for CARE invoices in a satisfactory and timely manner.	1	2	3	4	5	-7
17. CARE intake assessments are useful for measuring client treatment and ancillary service needs at <u>admission</u> .	1	2	3	4	5	-7
18. I communicate with many traditional and non-traditional service providers on a regular basis about CARE services.	1	2	3	4	5	-7
19. CARE assessments provide useful client assessment information for service providers.	1	2	3	4	5	-7
20. CARE GPRA data has been useful for measuring treatment/ ancillary service needs at <u>discharge</u> .	1	2	3	4	5	-7
21. CARE GPRA data has been useful for documenting changes in clients' levels of functioning between admission and discharge.	1	2	3	4	5	-7
22. ADP Management staff communicate with CARE Assessment staff on a regular basis with respect to CARE policies and procedures, data collection and reporting requirements.	1	2	3	4	5	-7

Assessor Survey (5 of 6)

23. Please describe your process for collecting and inputting CARE GPRA data at intake, discharge, and follow-up:

24. In the past year, did you contact ADP staff to ask questions about CARE?
NO ____ YES ____ How many times? _____

25. Why did you typically contact ADP for CARE assistance (check all that apply)?

- potential CARE clients assessment
- CARE Inclusion/exclusion criteria
- GPRA Data collection questions and issues
- GPRA Data submission problems
- Referral questions
- Technical issues
- Training needs
- Other (Please Specify: _____)
- I did not contact ADP for CARE assistance

26. Are you aware of the CARE website? <http://www.californiacares4youth.com/>
YES ____ NO ____ (SKIP to Question 36)

27. If so, have you accessed it within the past year?
YES ____ NO ____

28. Do you think this website is useful?
YES ____ NO ____

29. Is CARE Assessment or provider-specific feedback provided to you from ADP or Maximus or another source?
YES ____ NO ____

30. If YES, please describe the process:

31. How are CARE Assessment providers typically communicated with about CARE?

- Monitors
- Monthly Meetings
- Site Visits
- Newsletter/Memos
- Other (Please Specify: _____)

32. Is there a deadline that CARE Assessment providers have to submit CARE data (invoices GPRAs) to ADP or Maximus each month?
YES ____ NO ____

33. If YES, please describe the submission process:

Assessor Survey (6 of 6)

34. Do you think CARE coordinators understand why they are collecting GPRA data?

YES _____

NO _____

35. If NO, please explain why not:

36. In your opinion, is training needed for assessment procedures, CARE eligibility, and GPRA data collection and/or use?

YES _____

NO _____

37. If YES, please check off the type(s) of training that is most needed?

_____ Substance abuse assessment

_____ Psychiatric assessment

_____ Religious/Spiritual Assessment

_____ CARE eligibility criteria

_____ Data Collection

_____ Data Reporting

_____ Type, number, and location of Service Providers available through CARE

_____ Data Utilization for treatment improvement

_____ Other (Please Specify: _____)

38. Please check off the type(s) of training that would be most useful to you?

_____ Workshop/Classes

_____ Training of trainers

_____ On-call help desk

_____ Online tutorial

_____ Other (Please Specify: _____)

39. If additional funding became available at the state level for improving or expanding CARE, how would you suggest spending it?

40. Is there anything else you would like to tell us regarding the implementation/operation of CARE?

THANK YOU VERY MUCH FOR TAKING THE TIME TO COMPLETE THIS SURVEY.

Please send your survey and survey consent form by U.S. mail, please use the postage paid envelop enclosed addressed to:

Ana Ceci Mel MS, Research Associate
UCLA Integrated Substance Abuse Programs
1640 S. Sepulveda Blvd., Suite 200
Los Angeles, CA 90025
Fax: (310) 312-0538

If you prefer to email the completed survey please address it to Ana Ceci Mel at acmel@mednet.ucla.edu.

Assessor Semi-Structured Interview

1. What was your primary job prior to CARE? Did it change after CARE?
2. Did you have a role in CARE service provision in addition to your role as CARE Assessor? Can you describe it?
3. How did you become involved in CARE?
4. What were the typical pathways CARE participants took to get to you as an Assessor?
5. How important is it to be able to get into treatment services right away? And how did vouchers impact time to treatment?
6. In your opinion did CARE impact agencies service capacity? In what ways?
7. How did the program work to serve the needs of youth substance users?
8. What was the impact of vouchers? For example on faith-based/non-traditional Recovery Support Services for youth? Your agency? Parents of youth? communities?
9. What were the most and least beneficial aspects of the program for providers, youth, parents and communities?
10. Were there any unanticipated consequences of CARE? Please describe them.
11. Would you continue to do CARE Assessments? How might you do it again differently?
12. How has implementation of CARE impacted collaboration between local administrators across the treatment continuum? Please describe them.
13. How do clients respond to the offer of a choice in selecting a treatment/recovery provider? How do clients choose?
14. Did your assessment program involve the client's family/caregiver(s)? How? If not, why?
15. Did your youth assessments consider strengths and abilities, as well as problems or needs?
16. Did your assessments use culturally competent or appropriate assessment tools? Please describe them.

Youth Survey

INTRODUCTION: You have been asked to participate in this research study because you've received services through the CARE voucher funded by California State Department of Alcohol and Drug Programs (ADP). Your participation in this research study is completely voluntary and confidential.

This survey asks questions about your experience in the CARE Program. If you do not feel comfortable giving an answer to a particular statement, you may skip it and move on to the next statement.

This survey begins with a short demographic section that is for descriptive purposes only.

Question	(Response option/range)
1. Today's date	(date)
2. What is your gender?	M F Transgender Other Don't know/ Not sure Refused
3. What is your age?	12-24 Refused
4. How would you describe your ethnicity?	Hispanic/Latino Black or African American Asian Native Hawaiian or other Pacific Islander Alaska Native White American Indian Other Mixed Race Don't know/ Not sure Refused
5. When you started treatment, what was the main drug you used?	Alcohol Cocaine Heroin Inhalants LSD (Acide) Marijuana MDMA (Ecstasy) Methamphetamine PCP/Phencyclidine Prescription Medicine Smoking/Nicotine Steroids (Anabolic) Other (describe): _____ Don't know / Not sure Refused

Youth Survey (2 of 11)

Question	(Response option/range)
6. Which of the following substances had you used during the six months before you entered treatment at CARE? (check all that apply)	Alcohol Cocaine Heroin Inhalants LSD (Acid) Marijuana MDMA (Ecstasy) PCP/Phencyclidine Prescription Medicine Smoking/Nicotine Steroids (Anabolic) Other (describe): _____ Don't know / Not sure Refused
7. What is your highest grade completed?	Elementary school 7 8 9 10 11 12 Some vocational/vocational school completed Some college/college completed Don't know / Not sure Refused
8. Were you enrolled at school at the time you entered CARE treatment?	Yes/no Don't know / not sure Refused
9. Are you currently in school?	Yes/no Don't know / not sure Refused
10. What is your employment status?	0 paid hours. 20 or less paid hours, 21 or more paid hours per week) Don't know / not sure Refused
11. How did you hear about CARE?	Website Treatment Provider Friend Parent/Family Religious Organization Teacher/School staff Your Healthcare Provider/Doctor Parole Officer/Judge/Court Other (describe): _____ Don't know/ not sure Refused

Religion and Spirituality in Recovery (Form 2)

Please state either:
1= "I strongly disagree"
2= "I disagree somewhat"
3= "I neither agree nor disagree"
4= "I agree somewhat"
5= "I strongly agree"

How much do you agree with the following statements?	STRONGLY DISAGREE	SOMEWHAT DISAGREE	NEITHER AGREE NOR DISAGREE	SOMEWHAT AGREE	STRONGLY AGREE	REFUSED TO ANSWER	DON'T KNOW
12. I am a religious person.	1	2	3	4	5	-7	-8
13. I regularly spend private time in prayer.	1	2	3	4	5	-7	-8
14. Discussion of forgiveness in treatment is important to my recovery.	1	2	3	4	5	-7	-8
15. I am a spiritual person.	1	2	3	4	5	-7	-8
16. I need guidance in treatment to get in touch with my religious or spiritual self.	1	2	3	4	5	-7	-8
17. I regularly spend time reading spiritual or Biblical passages at least once a day.	1	2	3	4	5	-7	-8
18. I have forgiven those who hurt me in the past.	1	2	3	4	5	-7	-8
19. I trust that God will help me overcome my substance abuse problems.	1	2	3	4	5	-7	-8
20. I can overcome this substance abuse problem on my own without any religious or spiritual guidance.	1	2	3	4	5	-7	-8
21. Having people pray for me without my knowledge would be helpful to my recovery.	1	2	3	4	5	-7	-8

Youth Survey (5 of 11)

Services Received: Mental Health & Substance Abuse (Form 3)

INSTRUCTIONS: I would like to know if you have received any of the services listed. I will read you a list of services. Please tell me if you received the following services by saying either yes or no. If you answer “yes” to any of the services listed, I will ask you to please use the following scale to make your rating:

1 = “Some service, but not enough”

2 = “The right amount of services”

3 = “Too much of this service”

Mental Health:	Received?	If yes, how much?	Refused to answer	Don't know
1. Psychosocial assessment	Y N	1 2 3	-7	-8
2. Inpatient mental health services	Y N	1 2 3	-7	-8
3. Individual counseling	Y N	1 2 3	-7	-8
4. Group counseling	Y N	1 2 3	-7	-8
5. Family counseling	Y N	1 2 3	-7	-8
6. Prescription medications for psychological problems	Y N	1 2 3	-7	-8
7. Other mental health services:	Y N	1 2 3	-7	-8
Substance abuse:	Received?	If yes, how much?	Refused to answer	Don't know
8. Urinalysis/drug screening	Y N	1 2 3	-7	-8
9. 12 Step Groups	Y N	1 2 3	-7	-8
10. Inpatient detoxification services (medical)	Y N	1 2 3	-7	-8
11. Residential substance abuse treatment	Y N	1 2 3	-7	-8
12. Outpatient substance abuse counseling and groups	Y N	1 2 3	-7	-8
13. Individual substance abuse counseling	Y N	1 2 3	-7	-8
14. Other substance abuse services:	Y N	1 2 3	-7	-8

Youth Survey (6 of 11)

Services Received: Educational/Vocational & Legal (Form 3)

Please use the following scale to make your rating:

1 = "Some service, but not enough"

2 = "The right amount of services"

3 = "Too much of this service"

Educational/Vocational:	Received?	If yes, how much?	Refused to answer	Don't know
15. College courses	Y N	1 2 3	-7	-8
16. Employment assistance	Y N	1 2 3	-7	-8
17. Educational testing/assessment	Y N	1 2 3	-7	-8
18. GED classes/ literacy classes	Y N	1 2 3	-7	-8
19. Other education or vocational services	Y N	1 2 3	-7	-8
Legal:				
20. Help with legal problems (for example, someone to write a letter for you to the court, attend a legal hearing or trial, or meet with a lawyer on your behalf)	Y N	1 2 3	-7	-8
Activities of Daily Living (ADLs):	Received?	If yes, how much?	Refused to answer	Don't know
21. Transportation assistance	Y N	1 2 3	-7	-8
22. Help with living or social skills (for example, how to shop, cook, rent an apartment, maintain a household)	Y N	1 2 3	-7	-8
23. Money management	Y N	1 2 3	-7	-8
24. Recreational/social activities (for example picnic, trip, or other outing, sports)	Y N	1 2 3	-7	-8
25. Afterschool sober recreational programs	Y N	1 2 3	-7	-8
26. Childcare	Y N	1 2 3	-7	-8
27. Mentoring	Y N	1 2 3	-7	-8

Youth Survey (7 of 11)

Services Received: Benefits assistance & Spiritual services (Form 3)

Please use the following scale to make your rating:
1 = "Some service, but not enough"
2 = "The right amount of services"
3 = "Too much of this service"

Benefits/entitlements assistance:	Received?	If yes, how much?	Refused to answer	Don't know
28. Help with Entitlements (e.g. CAL-WORKS, SSI, GR)	Y N	1 2 3	-7	-8
Spiritual/religious:				
29. Individual pastoral, spiritual, or religious counseling	Y N	1 2 3	-7	-8
30. Religious/Spiritual youth group	Y N	1 2 3	-7	-8
31. Meditation/prayer	Y N	1 2 3	-7	-8
32. Other spiritual/religious services	Y N	1 2 3	-7	-8

Feedback Survey (Form 4)

INSTRUCTIONS: Please tell me how well you got along with the following people by responding either:

1 = "Poorly"

2 = "Fair"

3 = "Well/Good"

4 = "Very Well/Very Good"

5 = "Excellently"

Use the word or number that best describes your feelings and experiences while receiving CARE voucher services.

How well did you get along with:	POORLY	FAIRLY	WELL/ GOOD	VERY WELL/ VERY GOOD	EXCELLENTLY	REFUSED TO ANSWER	DON'T KNOW
Other participants	1	2	3	4	5	-7	-8
Other staff	1	2	3	4	5	-7	-8
The person in charge of your treatment	1	2	3	4	5	-7	-8

Please state either:

1 = "I strongly disagree"

2 = "I disagree somewhat"

3 = "I neither agree or disagree"

4 = "I agree somewhat"

5 = "I strongly agree"

Please tell me how much you agree or disagree with the following statements:	STRONGLY DISAGREE	SOMEWHAT DISAGREE	NEITHER AGREE NOR DISAGREE	SOMEWHAT AGREE	STRONGLY AGREE	REFUSED TO ANSWER	DON'T KNOW
Staff were there for themselves more than for the clients.	1	2	3	4	5	-7	-8
Staff were sensitive to my cultural and gender needs.	1	2	3	4	5	-7	-8
Staff were sensitive to my spiritual or religious needs.	1	2	3	4	5	-7	-8
The rules and regulations were too strict.	1	2	3	4	5	-7	-8
It was hard to figure out what the rules were.	1	2	3	4	5	-7	-8
It was the best kind of program for people like me.	1	2	3	4	5	-7	-8
I trusted the staff/counselors.	1	2	3	4	5	-7	-8
I would have liked more assistance with employment issues.	1	2	3	4	5	-7	-8
I would have liked more assistance with educational issues.	1	2	3	4	5	-7	-8

Youth Survey (9 of 11)

Feedback Survey (Form 4)

How would you rate the following? Please respond either:
1 = "Poor" **3 = "Good"** **5 = "Excellent"**
2 = "Fair" **4 = "Very Good"**

How would you rate the following?	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT	REFUSED TO ANSWER	DON'T KNOW
The physical environment/facilities	1	2	3	4	5	-7	-8
Staff qualifications, experience, and fairness	1	2	3	4	5	-7	-8
The expected length/duration of treatment	1	2	3	4	5	-7	-8
The community environment	1	2	3	4	5	-7	-8

Please respond either: 1 = "Not at all helpful" 2 = "Somewhat unhelpful" 3 = "Neither" 4 = "Somewhat helpful" 5 = "Very helpful" or "Not applicable" if you did not experience that specific aspect of the program

How helpful were the following aspects of treatment provided by CARE vouchers?	NOT AT ALL HELPFUL	SOMEWHAT UNHELPFUL	NEITHER	SOMEWHAT HELPFUL	VERY HELPFUL	REFUSED TO ANSWER	DON'T KNOW	N/A
Substance abuse recovery groups	1	2	3	4	5	-7	-8	-9
Your relationships with other clients in the program	1	2	3	4	5	-7	-8	-9
Your relationship with your primary counselor in the program	1	2	3	4	5	-7	-8	-9
Your relationship with other staff in the program	1	2	3	4	5	-7	-8	-9
Employment assistance	1	2	3	4	5	-7	-8	-9
Health care/medical referrals	1	2	3	4	5	-7	-8	-9
Mental health/emotional problems	1	2	3	4	5	-7	-8	-9
Family issues/parenting assistance	1	2	3	4	5	-7	-8	-9
Legal problems	1	2	3	4	5	-7	-8	-9
Financial problems	1	2	3	4	5	-7	-8	-9
Spiritual or religious concerns	1	2	3	4	5	-7	-8	-9

Youth Survey (10 of 11)

Feedback Survey (Form 4)

INSTRUCTIONS: I am going to ask you “How much do you agree or disagree with the following statements about your treatment through CARE?” Please state either:

- 1 = “I strongly disagree”
- 2 = “I disagree somewhat”
- 3 = “I neither agree nor disagree”
- 4 = “I agree somewhat”
- 5 = “I strongly agree”

	STRONGLY AGREE	DISAGREE SOMEWHAT	NEITHER AGREE NOR DISAGREE	AGREE SOMEWHAT	STRONGLY AGREE	REFUSED TO ANSWER	DON'T KNOW
The person in charge of my treatment and I agreed on my treatment goals.	1	2	3	4	5	-7	
The person in charge of my treatment looked out for my best interests.	1	2	3	4	5	-7	
The person in charge of my treatment and I worked well together.	1	2	3	4	5	-7	
The treatment/services that I received matched my expectations.	1	2	3	4	5	-7	
Overall, I was satisfied with the treatment/services that I received.	1	2	3	4	5	-7	
I received services in a timely way.	1	2	3	4	5	-7	
I would recommend the CARE program to other youth.	1	2	3	4	5	-7	

Outcomes Survey (Form 5)

INSTRUCTIONS: Please tell me how much you were helped by the services you received through the CARE program by responding:
1 = “Strongly disagree”
2 = “Somewhat disagree”
3 = “Neither agree nor disagree”
4 = “Somewhat agree”
5 = “Strongly agree”

The services I received:	STRONGLY DISAGREE	SOMEWHAT DISAGREE	NEITHER AGREE NOR DISAGREE	SOMEWHAT DISAGREE	STRONGLY AGREE	REFUSED TO ANSWER	DON'T KNOW
1. Helped me reduce my drug and alcohol use.	1	2	3	4	5	-7	-8
2. Helped me with problems with my parents.	1	2	3	4	5	-7	-8
3. Helped me with problems with school or work.	1	2	3	4	5	-7	-8
4. Helped me with my friends.	1	2	3	4	5	-7	-8
5. Improved my life overall.	1	2	3	4	5	-7	-8
6. Helped me with my psychological condition (e.g. depression, anxiety, etc.).	1	2	3	4	5	-7	-8
7. Helped me with how I feel about myself.	1	2	3	4	5	-7	-8
8. Helped me to better solve problems.	1	2	3	4	5	-7	-8
9. Helped me to get along better with others.	1	2	3	4	5	-7	-8

Other Outcome Notes:

Thank you for your participation!

Youth Focus Group Script

1. How were you referred to CARE?
2. What was it like to use the CARE call center (for those who used it)?
3. What was the assessment center like? In your opinion, was the assessment thorough and useful?
4. Did you have a choice of services and providers?
5. What services provider did you choose?
6. How did you choose this provider?
7. Was your faith or spiritual beliefs a factor in choosing this provider?
8. Did your parents know about your treatment? How did having your parents involved or not involved impact you and your treatment?
9. What were the best aspects of the program?
10. What were the worst aspects of the program?
11. Was there anything about the program that you did not expect?
12. What was it like to change providers (for those who changed)?

Parent Survey

INTRODUCTION: You have been asked to participate in this research study because your child received services through the CARE voucher funded by California State Department of Alcohol and Drug Programs (ADP). Your participation in this research study is completely voluntary and confidential.

This survey asks questions about your child's experience in the CARE Program. If you do not feel comfortable giving an answer to a particular statement, you may skip it and move on to the next statement.

This survey begins with a short demographic section that is for descriptive purposes only.

Please answer the following questions about **yourself**:

Question	(Response option/range)
1. Today's date	(date)
2. What is your gender?	M F Transgender Other Don't know/ Not sure Refused
3. What is your age?	18-99 Refused
4. How do you describe your race or ethnicity?	Hispanic/Latino Black or African American Asian Native Hawaiian or other Pacific Islander Alaska Native White American Indian Other Mixed Race Don't know/ Not sure Refused
5. What is your employment status?	0 paid hours, 20 or less paid hours, 21 or more paid hours per week Don't know/ Not sure Refused
6. What is your highest grade completed?	Elementary school 7 8 9 10 11 12 Some vocational/ vocational school completed Some college/ college completed Don't know/ not sure Refused

Parent Survey (2 of 11)

Please answer the following questions about your **child**:

Question	(Response option/range)
7. What is your child's gender?	M F Transgender Other Don't know/ Not sure Refused
8. What is your child's age?	12-21 Refused
9. What is your child's highest grade completed?	Elementary school 7 8 9 10 11 12 Some vocational/ vocational school completed Some college/ college completed Don't know/ Not sure Refused
10. Is your child currently in school?	yes/no Don't know/ Not sure Refused
11. What is your child's employment status?	0 paid hours, 20 or less paid hours, 21 or more paid hours per week Don't know/ Not sure Refused
12. How did you or your child hear about CARE?	Website Treatment Provider Friend Parent/Family Religious Organization Teacher/School staff Your Healthcare Provider/Doctor Parole Officer/Judge/Court Other (describe): _____ Don't know/ Not sure Refused

Parent Survey (4 of 11)

Religion and Spirituality in Recovery (Form 2)

Please state either:
1= "I strongly disagree" **3 = "I neither agree or disagree"** **5 = "I strongly agree"**
2= "I disagree somewhat" **4 = "I agree somewhat"**

How much do you agree with the following statements?	STRONGLY DISAGREE	SOMEWHAT DISAGREE	NEITHER AGREE NOR DISAGREE	SOMEWHAT AGREE	STRONGLY AGREE	REFUSED TO ANSWER	DON'T KNOW
13. My child regularly spends private time in prayer.	1	2	3	4	5	-7	-8
14. Discussion of forgiveness in treatment is important to my child's recovery.	1	2	3	4	5	-7	-8
15. My child is a spiritual person.	1	2	3	4	5	-7	-8
16. My child needs guidance in treatment to get in touch with his/her religious or spiritual self.	1	2	3	4	5	-7	-8
17. My child regularly spends time reading spiritual or Biblical passages at least once a day.	1	2	3	4	5	-7	-8
18. My child has forgiven those who hurt him/her in the past.	1	2	3	4	5	-7	-8
19. I trust that God will help my child overcome his/her substance abuse problems.	1	2	3	4	5	-7	-8
20. My child can overcome his/her substance abuse problem on his/her own without any religious or spiritual guidance.	1	2	3	4	5	-7	-8
21. Having people pray for my child without my knowledge would be helpful to my child's recovery.	1	2	3	4	5	-7	-8

Parent Survey (5 of 11)

Services Received: Mental Health & Substance Abuse (Form 3)

INSTRUCTIONS: We would like to know what kind of services your child has received. I will read you a list of services. Please tell us if your child received the following services by saying either yes or no. If your child did receive one of the services listed we will ask you if your child received an adequate amount of the services. If you answer “yes” to any of the services listed I will ask you to please use the following scale to make your rating:

1 = “Some service, but not enough”

2 = “The right amount of services”

3 = “Too much of this service”

Mental Health:	Received?	If yes, how much?	Refused to answer	Don't know
1. Psychosocial assessment	Y N	1 2 3	-7	-8
2. Inpatient mental health services	Y N	1 2 3	-7	-8
3. Individual counseling	Y N	1 2 3	-7	-8
4. Group counseling	Y N	1 2 3	-7	-8
5. Family counseling	Y N	1 2 3	-7	-8
6. Prescription medications for psychological problems	Y N	1 2 3	-7	-8
7. Other mental health services:	Y N	1 2 3 4	-7	-8
Substance Abuse:	Received?	If yes, how much?	Refused to answer	Don't know
8. Urinalysis/drug screening	Y N	1 2 3	-7	-8
9. 12 Step Groups	Y N	1 2 3	-7	-8
10. Inpatient detoxification services (medical)	Y N	1 2 3	-7	-8
11. Residential substance abuse treatment	Y N	1 2 3	-7	-8
12. Outpatient substance abuse counseling and groups	Y N	1 2 3	-7	-8
13. Individual substance abuse counseling	Y N	1 2 3	-7	-8
14. Other substance abuse services	Y N	1 2 3	-7	-8

Parent Survey (6 of 11)

Services Received: Educational/Vocational, Legal & Activities of Daily Living (Form 3)

Please use the following scale to make your rating:

1 = "Some service, but not enough"

2 = "The right amount of services"

3 = "Too much of this service"

Educational/Vocational:	Received?	If yes, how much?	Refused to answer	Don't know
15. College courses	Y N	1 2 3	-7	-8
16. Employment assistance	Y N	1 2 3	-7	-8
17. Educational testing/assessment	Y N	1 2 3	-7	-8
18. GED classes/ literacy classes	Y N	1 2 3	-7	-8
19. Other educational or vocational services	Y N	1 2 3	-7	-8
Legal:				
20. Any help with legal problems (for example, someone to write a letter for your child to the court, attend a legal hearing or trial, or meet with a lawyer on your child's behalf)	Y N	1 2 3	-7	-8
Activities of Daily Living (ADLs):				
21. Transportation assistance	Y N	1 2 3	-7	-8
22. Help with living or social skills (for example, how to shop, cook, rent an apartment, maintain a household)	Y N	1 2 3	-7	-8
23. Money management	Y N	1 2 3	-7	-8
24. Recreational/social activities (for example picnic, trip, or other outing, sports)	Y N	1 2 3	-7	-8
25. Afterschool sober recreational programs	Y N	1 2 3	-7	-8
26. Childcare	Y N	1 2 3	-7	-8
27. Mentoring	Y N	1 2 3	-7	-8
28. Housing	Y N	1 2 3	-7	-8
29. Other ADLs	Y N	1 2 3	-7	-8

Parent Survey (7 of 11)

Services Received: Benefits Assistance & Spiritual Services (Form 3)

Please use the following scale to make your rating:
1 = "Some service, but not enough"
2 = "The right amount of services"
3 = "Too much of this service"

Benefits/entitlements assistance:	Received?	If yes, how much?	Refused to answer	Don't know
30. Help with Entitlements (CAL-WORKS, SSI, GR)	Y N	1 2 3	-7	-8
Spiritual/religious:				
31. Individual Pastoral, Spiritual, or religious counseling	Y N	1 2 3	-7	-8
32. Religious/Spiritual youth group	Y N	1 2 3	-7	-8
33. Meditation/prayer	Y N	1 2 3	-7	-8
34. Other spiritual/religious services	Y N	1 2 3	-7	-8

Parent Survey (8 of 11)

Feedback Survey (Form 4)

INSTRUCTIONS: Please tell me how well your child got along with the following people by responding either:
1 = "Poorly" **3 = "Well/Good"** **5 = "Excellent"**
2 = "Fair" **4 = Very Well/Very Good"**
 Use the word or number that best describes your feelings and experiences while receiving CARE voucher services.

How well did your child get along with:	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT	REFUSED TO ANSWER	DON'T KNOW
Other participants	1	2	3	4	5	-7	-8
Other staff	1	2	3	4	5	-7	-8
The person in charge of my child's treatment	1	2	3	4	5	-7	-8

Please tell me how much you agree or disagree with the following statements:	STRONGLY DISAGREE	SOMEWHAT DISAGREE	NEITHER AGREE NOR DISAGREE	SOMEWHAT AGREE	STRONGLY AGREE	REFUSED TO ANSWER	DON'T KNOW
Staff were there for themselves more than for my child	1	2	3	4	5	-7	-8
Staff were sensitive to my child's cultural and gender needs	1	2	3	4	5	-7	-8
Staff were sensitive to my child's spiritual or religious needs	1	2	3	4	5	-7	-8
The rules and regulations were too strict	1	2	3	4	5	-7	-8
It was hard to figure out what the rules were	1	2	3	4	5	-7	-8
It was the best kind of program for people like my child.	1	2	3	4	5	-7	-8
I trusted the staff/counselors for my child.	1	2	3	4	5	-7	-8
I would have liked more assistance with employment issues for my child.	1	2	3	4	5	-7	-8
I would have liked more assistance with educational issues for my child.	1	2	3	4	5	-7	-8

Parent Survey (9 of 11)

Feedback Survey (Form 4)

Please respond either: 1 = "Poor" 2 = "Fair" 3 = "Good" 4 = "Very Good" 5 = "Excellent"

How would you rate the following?	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT	REFUSED TO ANSWER	DON'T KNOW
The physical environment/facilities	1	2	3	4	5	-7	-8
Staff qualifications, experience, and fairness	1	2	3	4	5	-7	-8
The expected length/duration of treatment	1	2	3	4	5	-7	-8
The community environment	1	2	3	4	5	-7	-8

Please respond either: 1 = "Not at all helpful" 2 = "Somewhat unhelpful" 3 = "Neither" 4 = "Somewhat helpful" 5 = "Very helpful" or "Not applicable" if you did not experience that specific aspect of the program

How helpful were the following aspects of treatment for your child?	NOT AT ALL HELPFUL	SOMEWHAT UNHELPFUL	NEITHER	SOMEWHAT HELPFUL	VERY HELPFUL	REFUSED TO ANSWER	DON'T KNOW	N/A
Substance abuse recovery groups	1	2	3	4	5	-7	-8	-9
Your child's relationships with other clients in the program	1	2	3	4	5	-7	-8	-9
Your child's relationship with your primary counselor in the program	1	2	3	4	5	-7	-8	-9
Your child's relationship with other staff in the program	1	2	3	4	5	-7	-8	-9
Employment assistance	1	2	3	4	5	-7	-8	-9
Health care/medical referrals	1	2	3	4	5	-7	-8	-9
Mental health/emotional problems	1	2	3	4	5	-7	-8	-9
Family issues/parenting assistance	1	2	3	4	5	-7	-8	-9
Legal problems	1	2	3	4	5	-7	-8	-9
Financial problems	1	2	3	4	5	-7	-8	-9
Spiritual or religious concerns	1	2	3	4	5	-7	-8	-9

Feedback Survey (Form 4)

INSTRUCTIONS: I am going to ask you “How much do you agree or disagree with the following statements about your child’s treatment through CARE?” Please state either:
1 = “I strongly disagree”
2 = “I disagree somewhat”
3 = “I neither agree or disagree”
4 = “I agree somewhat”
5 = “I strongly agree”

	STRONGLY DISAGREE	SOMEWHAT DISAGREE	NEITHER AGREE NOR DISAGREE	SOMEWHAT AGREE	STRONGLY AGREE	REFUSED TO ANSWER	DON'T KNOW
The person in charge of my child’s treatment and I agreed on my child’s treatment goals.	1	2	3	4	5	-7	-8
The person in charge of my child’s treatment looked out for my child’s best interests.	1	2	3	4	5	-7	-8
The person in charge of my child’s treatment worked well with us.	1	2	3	4	5	-7	-8
The treatment/services that my child received matched my expectations.	1	2	3	4	5	-7	-8
Overall, I was satisfied with the treatment/services that my child received.	1	2	3	4	5	-7	-8
My child received services in a timely way.	1	2	3	4	5	-7	-8
I would recommend the CARE program to other youth and parents.	1	2	3	4	5	-7	-8

Parent Survey (11 of 11)

Outcome Survey (Form 5)

INSTRUCTIONS: Please tell me how much your child was helped by the services your child received through the CARE program by responding:
1 = “Strongly disagree”
2 = “Somewhat disagree”
3 = “Neither agree nor disagree”
4 = “Somewhat agree”
5 = “Strongly agree”

The services my child received:	STRONGLY DISAGREE	SOMEWHAT DISAGREE	NEITHER AGREE NOR DISAGREE	SOMEWHAT AGREE	STRONGLY AGREE	REFUSED TO ANSWER	DON'T KNOW
1. Helped my child reduce his/her drug and alcohol use.	1	2	3	4	5	-7	-8
2. Helped my child with problems he/she had with me.	1	2	3	4	5	-7	-8
3. Helped my child with problems with school or job.	1	2	3	4	5	-7	-8
4. Helped my child with his/her friends.	1	2	3	4	5	-7	-8
5. Improved my child’s life overall.	1	2	3	4	5	-7	-8
6. Helped my child with his/her psychological condition (e.g. depression, anxiety, etc).	1	2	3	4	5	-7	-8
7. Helped my child with how he/she feels about him/herself.	1	2	3	4	5	-7	-8
8. Helped my child to better solve problems.	1	2	3	4	5	-7	-8
9. Helped my child to get along better with others.	1	2	3	4	5	-7	-8

Other Outcome Notes:

Thank you for your participation!

Parent Focus Group Script

1. How were you or your child referred to CARE?
2. What was it like to use the CARE call center (for those who used it)?
3. What was the assessment center like? In your opinion, was the assessment of your child thorough and useful?
4. Did your child have a choice of services and providers?
5. What services provider did you and your child choose?
6. How did you choose this provider?
7. Were your faith or spiritual beliefs a factor in choosing this provider?
8. What were the best aspects of the program?
9. What were the worst aspects of the program?
10. Was there anything about the program that you did not expect?
11. What was it like to change providers (for those who changed)?

Appendix 4: Tabulated Results of Youth and Parent Surveys

Figure 16: Services received by youth and their satisfaction with amount of service received

Services Received	Number of youth (n) who received the service N=52	% of youth who received the service	Of those who received the service, % of youth who responded they received the "right amount of service"
Treatment and Ancillary Services			
Inpatient detoxification services	8	15.4	50.0
Residential substance abuse treatment	14	26.9	50.0
Outpatient substance abuse counseling/groups	29	55.8	58.6
Individual substance abuse counseling	32	61.5	46.9
Family counseling	31	59.6	71.0
12-step groups	27	51.9	48.1
Urinanalysis/ drug screening	14	71.2	43.2
Other substance abuse services	10	19.2	40.0
Education and Employment			
College courses	3	5.8	100.0
Employment assistance	9	17.3	55.6
Educational testing/assessment	22	42.3	50.0
GED classes/literacy classes	4	7.7	25.0
Other education or vocational services	10	19.2	30.0
Help with legal problems	16	30.8	25.0
Transportation assistance	14	26.9	64.3
Help with living/social skills	14	26.9	35.7
Money management	9	17.3	44.4
Recreational/social activities	19	36.5	63.2
Afterschool sober recreational programs	15	28.8	46.7
Childcare	4	7.7	100.0
Mentoring	13	25.0	46.2
Housing	6	11.5	100.0
Other Activities of Daily Living	3	5.8	66.7
Help with entitlements	3	5.8	66.7
Religious			
Individual pastoral, spiritual, or religious counseling	7	13.5	57.1
Religious/spiritual youth group	7	13.5	57.1
Meditation/prayer	10	19.2	60.0
Other spiritual/religious services	5	9.6	80.0

Figure 17: Youth reports of service quality (N=52)

	Number of youth (n) and % answering... “Well to Excellent”	
How well did you get along with...	n	%
The person in charge of treatment?	49	94.2
Other staff?	48	92.3
Other participants?	43	82.7
	“Somewhat to Very Helpful”	
How helpful was treatment on your relationship(s) with...	n	%
Other clients in program?	38	73.1
Your primary counselor?	45	86.5
Other staff in program?	44	84.6
	“Somewhat to Very Helpful”	
How helpful was/were...	n	%
The substance abuse recovery groups	39	75.0
Employment assistance	19	36.5
Health care/medical referrals	16	30.8
Services with mental health/emotional problems	25	48.1
Services for family issues/parenting assistance	32	61.5
Services for legal problems	22	42.3
Services for financial problems	12	23.1
Services for spiritual or religious concerns	11	21.2
	“Somewhat to Strongly Agree”	
	n	%
The person in charge of my treatment and I agreed on my treatment goals	42	80.8
The person in charge of my treatment looked out for my best interests	46	88.5
The person in charge of my treatment worked well with me	48	92.3
The treatment I received matched my expectations	41	78.8
I was satisfied with the treatment I received	46	88.5
I received services in a timely way	42	80.8
I would recommend the CARE program to other youth	48	92.3

Figure 18: Parent reports of service quality (N=47 surveyed)

	Number (n) and % of parents of those answering "Well to Excellent"	
How well did <i>your child</i> get along with...	n	%
The person in charge of treatment?	39	83.0
Other staff?	39	83.0
Other participants?	36	76.6
	Number (n) and % of parents of those answering "Somewhat to Very Helpful"	
How helpful was treatment for <i>your child's</i> relationship with...	n	%
Other clients in program?	33	70.2
Your primary counselor?	33	70.2
Other staff in program?	33	70.2
	Number (n) and % of parents of those answering "Somewhat to Very Helpful"	
How helpful was/were...for your child	n	%
The substance abuse recovery groups?	33	70.2
Employment assistance?	9	19.1
Health care/medical referrals?	15	31.9
Services with mental health/emotional problems?	25	53.2
Services with family issues/parenting assistance?	32	68.1
Services with legal problems?	9	19.1
Services with financial problems?	8	17.0
Services with spiritual or religious concerns?	10	21.3
	Number (n) and % of parents answering "Somewhat to Strongly Agree"	
	n	%
The person in charge of child's treatment and I agreed on my child's treatment goals	33	70.2
The person in charge of child's treatment looked out for my child's best interests	34	72.3
The person in charge of child's treatment worked well with us	35	74.5
The treatment that my child received matched my expectations	32	68.1
I was satisfied with the treatment that my child received	33	70.2
My child received services in a timely way	34	72.3

[†] N is number of parents surveyed, which may differ from the number of parents who responded to this question.