

SAMHSA/CSAT Treatment for Homeless Casa Santa Clara Project

Final Report

2010

Acknowledgments

This report was prepared by the Center for Applied Behavioral Health Policy (CABHP), of Arizona State University and was funded through the Treatment for Homeless Grant awarded by the U.S. Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services, Grant Number: 5 H79 T118543-04.

Dr. Michael Shafer, Vicki Staples, Dr. Robert Rhode and Airiqa Tibbs-Ramirez, were responsible for the content, analysis, and writing of the report.

The authors wish to thank the staff of the Old Pueblo Community Services for their ongoing commitment to the delivery of services to individuals with co-occurring disorders and assistance with this project. The success of this grant is clearly attributable to the leadership of their Chief Executive Officer and Founder, Nick Jones, and his aspiration to help men and women coming out of prison with drug and alcohol problems, to reintegrate them into the community by aiding their adjustment to freedom, and providing opportunities for them to learn the necessary skills to become productive members of society. Clients and staff exemplified Clinical Director Tom Litwicki's commitment to incorporating collaborative counseling methods and evidence-based practices to help persons struggling with change, and also by increasing the internal motivation required to achieve their goals.

Alice Strader and Lindsay Gray, former CABHP Research Assistants, worked diligently to capture evaluation findings from program participants and staff to ensure their voices and ideas were incorporated in the program design and improvement activities.

We also wish to recognize Raquel Ramirez, Clinical Director for Outpatient Services for Compass Behavioral Health, the initial treatment provider for this project.

In addition, we would like to express our appreciation to Dr. Ali Manwar, SAMHSA Project Officer, and the staff at Center for Substance Abuse Treatment for providing us with this opportunity to better serve homeless individuals on the road to recovery.

Finally, we thank the participants who took part in the project and participated in interviews and focus groups, and whose access, availability, and insights greatly contributed to the findings in this report.

Opinions expressed in this report are strictly those of the author and no endorsement by the SAMHSA is to be inferred.

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**Treatment for Homeless Program
SAMHSA/CSAT**

1. Grant Period: September 30, 2004 thru September 30, 2009
2. Grant Number: 5 H79 TI18543-04
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Summary

The Casa Santa Clara (CSC) project represents a collaborative partnership between the Center for Applied Behavioral Health Policy (CABHP) at Arizona State University and the Old Pueblo Community Services, Inc. (OPCS), formerly known as Old Pueblo Community Foundation. The goal of the Casa Santa Clara project was to infuse two evidence-based practices (EBPs) – Community Reinforcement Approach (CRA) and Motivational Interviewing (MI) – into the operations of a services-enriched transitional housing program for homeless ex-offenders. During the final year of funding, the goal has remained constant. However, the objectives and methods used to support that goal have been altered. No longer was the project focused on the implementation of these EBPs, but rather the focus shifted to that of the institutionalization of these practices within the fabric of the organization. The focus also shifted toward sustainability and dissemination, ensuring the continuation of financial resources needed to perpetuate the delivery of these EBPs, and disseminating those processes and practices to other transitional and halfway house organizations serving homeless ex-offenders.

The partnership between the OPCS and CABHP has been an effective and productive one. While CABHP served as the grantee, OPCS received the majority of the funding from the award, totaling 65%. These funds were used to support case managers and other project staff, along with purchasing clinical treatment services from Compass Healthcare, a community-based licensed behavioral health provider. Staff from CABHP maintain an active role in staff training, development, and technical assistance, and manage the evaluation of the project, including the GPRA data collection.

This project took us from 4 employees to 36 full-time and 18 part-time staff, allowing us to grow to be the largest and most diversified transitional housing organization in the state of Arizona-I know, I checked! It offered us the ability to become a credible behavioral health organization in a short amount of time. The training and guidance we received could never have happened without the solid support and encouragement. Thanks also go to Tom Litwicki and our clinical team that has allowed us to achieve these great numbers. The training and support we received from Robert Rhode was stellar. The opportunities that have come our way as a result of the CSC Project have allowed us to continue our work, without laying off any staff. MI, CRA, and Contingency Management have been engrained in our organization and we now identify with the success of the MI model.

This project is truly a sustainable one, not often achieved from a \$2,000,000 grant. I hope SAMHSA realizes this as it was a good investment of government dollars. It offered Old Pueblo Community Services the opportunity to make a difference in helping our community and our homeless clients. It also opened the door for ATR funding, DOJ funding, and four VA homeless projects.

Nick Jones, Chief Executive Officer

OPCS transformed their organization into a licensed outpatient clinic for substance abuse counseling. Services directly provided include assessment, treatment planning, outpatient group and individual counseling, discharge planning to individuals with substance use disorders, and persons with substance use and co-occurring mental health disorders. All services are guided by the use of evidence-based practices that include Motivational Interviewing,

Community Reinforcement Approach, and Contingency Management. In addition, all OPCS staff meet or exceed professional standards established by the Arizona Department of Health Services, Office of Behavioral Health Licensure, and they receive clinical supervision in evidence-based practices by subject matter experts. As a direct result of the grant, OPCS is now the largest transitional housing provider and recognized by several organizations for the quality of their services, including probation, parole, and the bureau of prisons in the state of Arizona.

Goals and Objectives

As stated in the original application to SAMHSA, the purpose of the Casa Santa Clara Project was to expand and strengthen substance abuse and mental health treatment services to homeless individuals in Tucson, Arizona released from the Arizona Department of Corrections, Federal Bureau of Prisons, and Arizona jails. This project planned to combine two evidence-based practices, Community Reinforcement Approach and Motivational Enhancement Therapy, with a promising trauma recovery component, the Trauma Recovery and Empowerment Model (TREM). The project's goal was to provide gender-sensitive and culturally appropriate treatment services to over 575 previously incarcerated and homeless individuals during the five-year grant period. The project had been developed around four key objectives:

- 1) Build motivation for and engage program participants in substance abuse and mental health treatment services through the use of **Motivational Enhancement Therapy**;
- 2) Eliminate reinforcement for substance use and enhance positive reinforcement for sobriety using the **Community Reinforcement Approach**;
- 3) Lessen the impact of trauma and facilitate trauma recovery among program participants by enhancing the **trauma awareness** of our service providers; and
- 4) **Create a consortium** of homeless providers, behavioral health services, and primary care providers, promoting cross training, inter-agency communication, and seamless systems of integrated services provision to the homeless ex-offender population.

The key partners in this project are: Old Pueblo Community Foundation, a transitional housing provider; Compass Health Care, a comprehensive behavioral health care provider; a group of current and former residents of Old Pueblo that have formed a volunteer Resident Advisory Panel for this project; and the Center for Applied Behavioral Health Policy Division (a unit originally affiliated with the University of Arizona that transferred during Year 2 of the Project to Arizona State University).

Through the course of five years of SAMHSA funding, the core objectives of the project were achieved. Most significantly, the Old Pueblo Community Foundation was transformed from a relatively small (described by CEO Nick Jones as a "mom and pop" operation) to a larger, robust and clinically enhanced provider of transitional housing services using evidence-based practices

that specialize in meeting the unique needs of ex-offenders with substance use disorders. Key achievements of this program during the five year period included:

- 522 individuals (representing 90.8% of the originally proposed coverage target) were enrolled and served by the program.
- Substantial improvements in client's housing stability, abstinence, employment/school attendance, and health/behavioral/social consequences related to alcohol or illegal drug use were documented.
- Client progress was also reported on the number of arrests, crimes committed, and probation status.
- The number of residences operated by OPCS increased by 44% from the 4 available at the time this project was proposed to its current slate of 9 transitional housing facilities.
- The static capacity of OPCS grew by more than 34%, from the 65 slots at the time this grant was awarded to 190 at the time of the grant completion.
- Two evidence-based practices, Community Reinforcement and Motivational Interviewing, were fully integrated into the operations and program philosophy of the agency. Staff and client handbooks were revised multiple times to reflect this change in philosophy; program forms were adapted to align with MI/CRA program philosophy; staff are now selected on the basis of their skill and/or willingness to adapt to these program philosophies and are regularly evaluated by their peers and clinical supervisors on their proficiency with, and adherence to these evidence-based practices.
- A fully operational electronic health record/clinic chart program was developed and then enhanced, eliminating paper files. The development of this system was supported in part by SAMHSA funding and has now been disseminated, free of charge to three other local agencies that provide transitional housing and other support services to ex-offenders.
- OPCS applied for and received licensure from the Arizona Department of Health Services, Office of Behavioral Health Licensure. This recognition has opened the door for additional funding sources for the agency through the state's Single State Authority (SSA), county probation departments, and others, as well as broadening their eService delivery base to include outpatient treatment services.
- A new statewide organization, the Arizona Recovery Housing Organization (AZRHA) was formed as a direct result of this program. Represented by 16 founding agencies from Pima, Maricopa, and Yavapai counties and stakeholders representing the Mesa City Council, parole, probation, police department, and Department of Corrections, the state purpose of the AZRHA is to "act as a voice for recovery housing providers, residential providers, and programs in Arizona that promote recovery from addiction....by promoting the development and quality operation of recovery based residential services" (e.g., recovery homes, halfway houses, sober living housing, transitional housing, recovery-facilitative housing).
- Additional funding was secured to sustain the full program and no staff layoffs resulted when the current funding ended.

Slippages and Variations in Originally Stated Goals and Objectives

Overall, little variation or slippage was experienced in the originally stated program goals and objectives. While slippage was encountered in the ability to capture follow-up GPRAs from program participants, all other critical program objectives were met, and in most cases exceeded, our original proposal. With regard to the issue of trauma-informed care, we originally proposed to incorporate an evidence-based practice, the Trauma Recovery Empowerment Model (TREM) into the clinical operations of OPCS. Toward that end, we did engage the purveyors of TREM in staff in-services and program consultations during the first year of the project. Periodic staff in-services were provided on the topic of trauma. Although all participants are screened for a history of trauma, the project did not fully incorporate trauma-based programming as a core component of services. We would describe our orientation toward trauma and being “trauma informed”, but not “trauma focused”. The reasons for this slippage are numerous.

The extent to which we concentrated on the incorporation of motivational enhancement therapy into our clinical practice was significant. At the time this project was proposed, OPCS operated with a zero tolerance policy with regard to substance abuse. Residents were routinely discharged from the program if they were found to be using. Today, this program embraces a “harm reduction” orientation that utilizes a variety of practices aligned with motivational enhancement to address continued substance use and/or resident relapses. The pervasiveness of our efforts in systems change, with regard to the institutionalization of practices and procedures in alignment with motivational enhancement, left little room for the incorporation of other evidence-based practices. While our project team never explicitly stated or made a strategic decision, the project evolved into a commitment to make sure that motivational enhancement practices had become institutionalized within the fabric of the program, ensuring the continued application of these practices after project funding had been eliminated. Among the examples of the institutionalization of these practices are the following major milestones:

- The client application form has altered to included open-ended questions, consistent with a MI style;
- Clinical staff counseling sessions are regularly audio taped and reviewed;
- UA testing has shifted from a “suspected use” basis to a random basis and tied to contingent rewards; and
- The CRA ‘happiness scale’ was incorporated into client intake forms.

In summary, the trauma informed component was not fully incorporated into the program in the interest of institutionalizing motivational enhancement and contingency management practices, ensuring sustainment beyond SAMHSA funding despite inevitable staff changes. In hindsight, it was an overly ambitious expectation to fully implement three evidence-based practices within the time frame of the grant.

Additional Accomplishments

Resident Advisory Groups

Resident Advisory Program (RAP) groups were initiated in the spring of 2007 to provide client input into the CSC program and ongoing service delivery. A formal feedback process was developed to ensure management received the recommendations and suggestions in a timely manner, and follow-up actions were completed. Initially the group met monthly during the first years, evolving overtime to quarterly meetings. Participation varied and eventually stabilized to approximately 8 residents plus 2 staff. Program changes that were initiated based on recommendation from the RAP groups included modifications to curfews and eliminating restrictions on cell phones.

Continuing Care (Aftercare) Program

It was apparent that the needs of program participants extended beyond the time they were residing at OPCS. OPCS hired a new case manager/outreach coordinator during the first quarter of 2008 in order to support participants continued success. This individual was instrumental in establishing a continuing care program for discharged residents. CSC now employ a Case Manager and a Case Aide to assist with paperwork and provide additional outreach and engagement with clients. A Peer Recovery Support Specialist was also hired to provide individual supportive services, facilitate peer groups as well as coordinate recreational and social events. Calls to CSC residents are conducted two weeks after their discharge to provide continued support and engage in ongoing support services. Key program components to support participants in receipt of ongoing services include:

- *Outreach, engagement and continuing care activities*- a protocol was developed for contacting residents after discharge to encourage them to participate in ongoing supportive services and ensure that they receive services based on their discharge plan. Information to link them with additional community services and resources (e.g. housing, sobriety, work) is frequently provided;
- *Alumni Group*-organizes holiday parties, social events and graduation ceremonies;
- *Allowance*-for clients to participate in the recovery community of their choice, including SMART Recovery and Alcoholic Anonymous Meetings;
- *Social Events*-organized events in the community such as bowling, coffee house outings and karaoke; and
- *Transportation*-to assist former and current participants to attend 12 Step Recovery Social Events/Dances.

Motivational Interviewing Training Program

The central goal of this project was to enhance the Motivational Interviewing (MI) skills and increase the frequency with which the staff used the Community Reinforcement Approach (CRA). The initial trainings involved all of the staff, including the administrators and program

creators, and were intended to increase their openness to a MI style. This training approach used a guiding style to train MI rather than directing them to use it or just teaching them how to do it. That is, their motivation to learn MI was solicited and nurtured. Doing the training this way respected that the staff had been working with these clients and in the field for many years. It also side stepped the obvious resistance to doing something different than directing the clients to what they needed to do. It was probably a year before some of the staff started to value a guiding style. This is not uncommon, unless a health care provider believes the outcome research or finds the style consistent with how they already work, it takes a year or more to become good enough at MI with clients so that the work with clients goes better for both the client and health care provider. Part of the learning of MI included modifying paperwork that the staff used and clients were given. Other forms and paperwork were modified to be consistent with a motivational interviewing approach.

Below are examples of the modifications and rationale for the changes needed to fully implement MI into the CSC program.

At the beginning of the project, the clients signed a contract that included statements like these:

I will not use drugs or alcohol, or any mind-altering substances. I will make a commitment to stay clean and sober for 90 days, knowing that my life will get better in that time. ____ initial

As part of my commitment to live at Casa Santa Clara I agree to procure gainful employment within two weeks, understanding that if I'm working I will be able to be self-sufficient in a short period of time. I will work day jobs so I can attend my therapeutic program in the evening. ____ initial

These are accurate and well intended directions or advice given to the client. Having the client initial each statement was intended to increase the client's compliance with each healthy behavior. On one hand the staff believed that telling the clients these program requirements was necessary. They also recognized that clients would agree to anything at the beginning of the program in order to gain entry. Staff members were often arguing with these same clients weeks later when the clients were not following the program rules despite this initialed document. To move from this telling style to one consistent with MI, the initial paperwork given to the client was changed to:

You might or might not have used drugs or alcohol in the past. Think about the kind of life you want to create for yourself starting now with the Casa Santa Clara program. Given those goals, what do you plan to do about drugs or alcohol while you are at Casa Santa Clara?

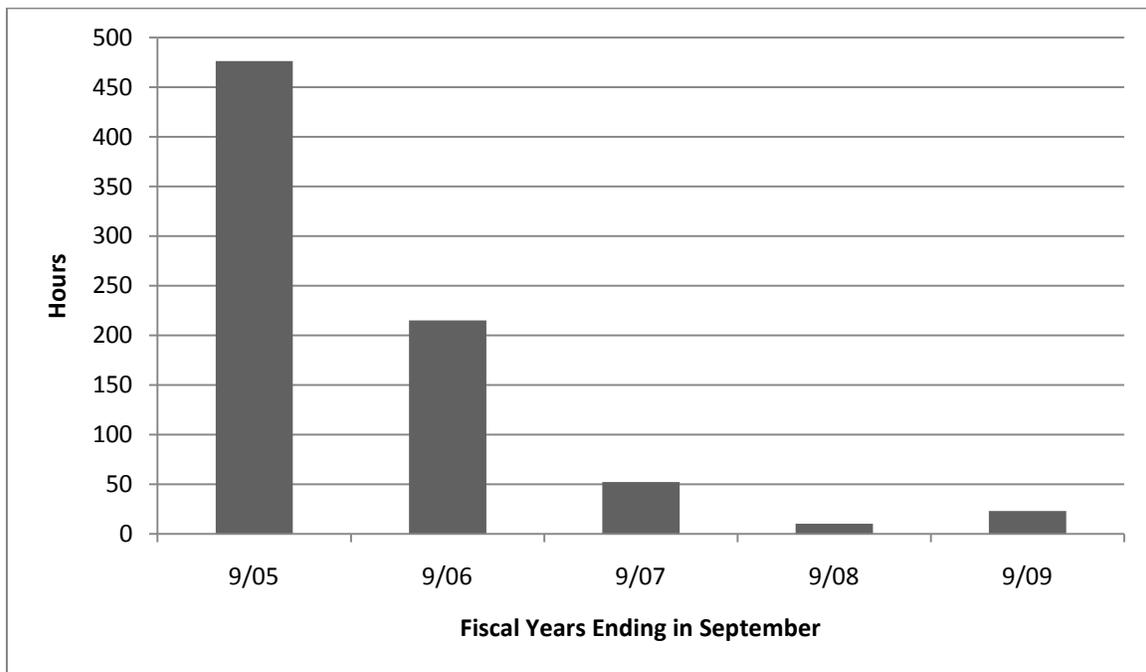
Some people like to work and others do not. What disadvantages and advantages would there be for you to work a day job, 8 hours a day, 5 days a week?

These statements ask the client to do more than initial and comply. They ask the client to start advocating for change by moving away from substance use and illegal activities. In the language of MI, these questions are "pulling for change talk".

The counselors who conducted the group sessions preferred, like many counselors in the field, to explore the client’s recent experiences and to give advice. Using CRA activities required the counselor to engage the clients in something for which the clients may have limited interest. This was compounded by counseling sessions occurring in the evening after many of the clients had been working all day in the hot Arizona sun. Some of the counselors’ supervisors started demonstrating in the evening groups how CRA might work in these groups, and the counselors moved away from a process-oriented group. Without some regular observation the counselors would often return to checking in with clients at the beginning of group and following whatever events were presented.

More training hours occurred in the beginning of the project than at the end. As noted in Figure 1 below.

Figure 1: Motivational Interviewing Training Hours



This was a function of helping the staff make the transition from a directing style to a guiding style and increasing the competency of supervisors who then took over the training with case managers and counselors. After two years, Casa Santa Clara was able to attract several excellent staff who valued using MI and were quite skilled in helping other staff use this approach with clients. MI and the CRA became valued within the organization and new employees having these skills were desirable.

In addition, training during the early years used examples from the trainer. Training in later years used excerpts from audiotapes that case managers and counselors had recorded with their actual clients. These recordings were initially difficult to obtain. As with most counselors, there is an aversion to being directly observed. Establishing a safe environment in which to receive feedback helped CSC staff learn how a MI style might sound with the clients with whom they were currently working. The supervisors and staff learned to use the Motivational Interviewing Treatment Integrity Scale (MITI) to structure the review of tapes and enhance their skills. Many of the supervisors' own client recordings were at near expert levels as measured by this instrument.

MI Training Program

- *Peer coaching and mentoring*
- *Audio-recordings reviewed in a group setting*
- *Cash Incentives based on skill level*

In order to build internal expertise, OPCS institutionalized a number of core processes to ensure that MI and CRA were integrated at all aspects of their program, including personnel development. The training program was initially a "top-down approach"; whereas the supervisor had the staff submit a baseline recording and then provided individual coaching to the employee. Staff were reluctant to expose themselves to this level of intense

scrutiny and the supervisors had a great amount of difficulty getting audio recordings from staff. Approximately a year ago, the program moved to a "bottom up" orientation wherein the training is delivered primarily through a series of successive iterations or approximations are presented within the context of clinical consultation. This model of peer coaching helped to build the staff's knowledge and self-efficacy. Audio-recordings of individual counseling and intake sessions conducted by staff are reviewed in a group setting. Moving away from an individual supervision model to a group coaching and mentoring process reduced the impression that staff were judged and strengthened the team's relationship. The peer coaching program also includes cash incentives based on submission of audio-recordings and bonus opportunities for achieving specific scores on the MITI. Individuals who achieve the proficiency level receive a \$100 bonus and those who are determined to be competent receive a \$200 bonus.

In addition to the focus on MI, training was provided to staff on Cultural Competency. This training was provided by Mr. Victor Flores, Cultural Diversity Manager at CABHP. This initial training was designed as an introduction to the concepts, values, and approaches to cultural diversity and strategies for enhancing cultural awareness at the individual and organizational level. OPCS piloted the *Organizational Cultural Competency Self-Assessment*, a tool being developed by CABHP. The results from the self-assessments were incorporated into OPCS' Cultural Competency that was submitted as a part of their licensure application.

Lessons Learned

GPRA Intake and Follow-Up Rates

It is critical to monitor both the intake and follow-up rates as low quarterly intake or follow-up percentages early in the program will negatively impact subsequent rates for the remainder of the grant period. It is extremely difficult to achieve a cumulative rate of 100% for intakes and 80% for follow-ups when quarterly rates are not achieved or maintained. The program had a 0% intake rate in two quarters (second and last quarter) which significantly impacted the overall intake rate. The initial start-up of the program took longer than anticipated. Prior to the last quarter we received approval to stop intakes, although the target numbers for the quarter were not adjusted accordingly in the GPRA system.

Problems achieving the quarterly follow-up rates also occurred, especially early in the program. Despite multiple verbal agreements, CABHP evaluation staff were unable to gain access into the criminal justice institutions to conduct interviews with program participants. As the CSC program targeted individuals reentering the community from a criminal justice setting, there was a high rate of participants that returned to criminal justice settings which was a significant barrier to meeting the 80% follow-up rate. Formal memorandums of understanding should have been established to collect participant data within the various criminal justice settings (i.e. jail and prison).

Alterations to the program had to be made in the way that clients were defined, enrolled, and discharged to attain GRPA collection requirements including the 80% follow-up rate. Due to the intrinsic difficulty in engaging this population, individuals were not enrolled (i.e. initial intake GPRA completed) until they had been receiving services for approximately 14 days to allow time for engagement thereby increasing the likelihood that they could be located for the exit and 6-month follow-up interviews and avoid possibly being penalized for not achieving the 80% follow-up rate. This inherently modified the target population and program results as data would not be captured on the clients who initially dropped out of service. The discharge process was also changed so that case managers could notify the research assistant prior to a client being involuntarily discharged or if they were fearful that the person was going to flee to allow time for the GPRA information to be collected and/or contact information updated.

Recruitment

Initially, one of the challenges was recruiting and retraining employees who would use the evidence-based practices. Over the years, OPCS found that “the best employees come from within” and from “word of mouth referral.” Key attributes sought in new employees are passion, attitude and energy. OPCS was able to quickly identify those who did not fit into the culture or were unwilling to adapt to their approach. If a staff person did not buy into the philosophy and approach then OPCS did not hesitate to “let them go.” OPCS management realized that they needed to change their interview process for potential staff to examine individual power orientation and approach through the exploration of case examples. For

example, candidates are now asked questions such as “What would you do to try and get a person to floss his teeth?”

Use of a Non-confrontation Positive Therapeutic Alliance

Findings from focus groups showed marked improvement, as well as support for the power of establishing a non-confrontational positive therapeutic alliance and the positive benefits of implementing MI and CRA. Administrative staff described the extensiveness of the implementation of the principles and concepts of MI and CRA into the CSC program as an “overall umbrella” that is now institutionalized and “will not go away as it is in the DNA”. The approach has worked so well with program participants and is also embedded into the staff supervision model.

Consumer Involvement in the Organization

A turning point for the organization was the incorporation of consumer involvement in the organization. As a result of feedback from participants, Alumni and RAP groups were developed. One of the challenges of the initial coaching and support staff was to establish the consumer run aspects program. Initially, funding for these activities was provided through a grant and staff took the lead in facilitating the activities. One of the lessons learned very quickly was that the staff was “doing too much”. In order to sustain these aspects of the program the participants needed to “run it” by taking ownership. Participants did not just want to volunteer and staff needed to let them experience this responsibility, even if that meant “stumbling a bit” in the beginning. Now the activities are completely self-sustained and participants have developed mechanisms for funding activities (e.g. car washes). Additional tangible results of the feedback received from program participants included changes to the policy and procedures, expansion of employment services through partnerships with community providers, and the need to reexamine the process for collecting program fees.

Separating the Collection of Financial Fees from Program Staff

Originally case managers were responsible for the collection of program fees from participants who reported that this created the perception that program staff were more interested in recovering fees than helping the clients. This dichotomy seemed to distract clients from working on their own recovery, and therefore, OPCS needed to separate financial elements (i.e., paying fees and making and enforcing payment plans) from case management. Results from this change in policy were instantaneous and highly beneficial to the relationship between clients and case managers. Case managers are now focused on helping participants seek out funding sources that will assist clients with housing fees and obtaining employment.

Employment

The inability of participants to obtain and maintain employment has been a critical barrier for client success. Employment is a primary requirement for individuals on probation and parole. OPCS has made concerted efforts to prepare participants to return to work and establish relationships with community organizations that provide employment opportunities and

services. However, given the current economy, this issue will continue to be a barrier as unemployment rates continue to grow.

Ongoing Collaboration and Establishment of Formal Feedback Mechanisms

Consistent ongoing meetings between the program and evaluation staff are critical to ensuring that swift decisions, including any needed program adjustments, are made based on information collected. Having a continuous quality improvement process is invaluable to successful implementation and program evaluation. Initially, staff from CABHP had a significant role in steering the clinical practices and directly influencing the program transformation through regular meetings with management and ongoing trainings and technical assistance to staff. It is recognized that this “hands on” approach shifted when there were changes in both CABHP’s management staff and the location of the Center. OPCS and CABHP acknowledged that when this level of direct support and routine oversight was reduced, OPCS staff were no longer “challenged” and emerging issues were not identified or responded to in a timely manner. Reestablishment of regular Implementation and Evaluation Meetings facilitated many new program enhancements; however, it was too late to resolve other issues (e.g. GPRA follow-up rates).

Evidence-based Practices and Training

Motivational interviewing takes longer to learn than most agencies estimate. Fully implementing MI and CRA took several years and hundreds of hours of training. CRA was easier to adopt when the concepts were translated into forms and procedures that fit easily with what the staff were already doing. For example, urinalysis (UA) was initially conducted on a regularly or fixed schedule. Implementation of CRA principles by applying a random schedule using a “fishbowl” and incorporating a reward program for negative UAs, decreased both program costs and positive test results. Direct observation of staff working with clients is necessary to enhance, as well as maintain, skills in both of these approaches. The development of a peer coaching program, including cash incentives based on submission of tapes and bonus opportunities for achieving MITI scores, reinforced the importance of MI, as well as assisted staff in overcoming their aversion to submitting audio recordings. Having a concrete method of measuring staff’s skill level and verifying the use of MI was a critical component to implementing MI.

You’re not doing Motivational Interviewing if you’re not tape scoring. We can prove we are really doing it!

-Tom Litwicki,
CSC Director of Program

Access to Additional SAMHSA Resources

Both the OPCS Chief Executive Officer and the Director of Programs acknowledged their involvement in the SAMHSA Addiction Technology Transfer Center's Leadership Academy. The 360 evaluation process and networking aspects of the program were identified as particularly helpful. Goals that were identified and achieved included building agency infrastructure and expanding funding. In addition, the Director of Programs conducted a Lean Plan Systems Review of OPCS' services that examined participant interactions that did not add value. As a result of this review process, case managers were moved from the administrative office into the resident houses. Adjustments were made in the program and additional training was provided to staff as "85% of time working with people who won't do well instead of the other way around."

The CSAT audit process and the technical assistance provided afterwards were very helpful and assisted OPCS to identify areas where they could not only improve the program, but also the organization as a whole. As a result of the audit, OPCS hired a financial manager and created their first Policy and Procedures Manual that laid the foundation for obtaining their behavioral health license.

Collection of Participant Data

Attending the CSAT sponsored GRPA trainings was very helpful, as was the ability to collaborate with other SAMHSA grantees. For example, our SAMSHA Project Officer assisted us in reaching out to other programs that were working with individuals involved in the criminal justice system to gather strategies on improving follow-up rates, including how to gain access to correctional settings.

Initially, CABHP Research Technician was located off-site and would only be able to conduct data collection activities, participate in meetings, or attend events. During the last two years of the program CABHP Research Technician was co-located at the program. This change had a positive and dramatic impact on the follow-up rates. By being at the program each day, coordination with OPCS to secure interviews with missing participants improved and the Research Technician was able to establish a relationship with program participants. As a result, they began to contact her when it was time for the six-month interview. Looking back, collection of the GPRA data should have been integrated into clinical service, especially the follow-up interviews, as program staff developed strong relationships with participants and would encounter prior residents while providing continuing care services.

Closeout and Future of the Project

The CSC program will remain active providing the same services using the evidenced-based program model that was implemented during this grant to the same targeted population. Even though an explicit sustainability plan was not developed, successful strategies were executed to broaden OPCS' funding array. Over the years, the cost per client reduced with the growth of the organization, as well as improvements in staff professionalism and retention. Additional

sources secured included a new contract with the Veteran's Administration that absorbed the costs of 5.5 employees who were previously funded under this grant.

Although plans were developed to expand peer delivered services and target new populations, funding for these proposals was unable to be secured. In 2009, OPCS and CABHP collaboratively submitted two SAMHSA grant applications. Unfortunately, neither application was awarded.

Development/Dissemination of Products/Information

Program Manuals

OPCS developed two detailed program and operational manuals, the *Casa Santa Clara for Men & Oasis House for Women Transitional Housing House Manager*, and *Casa Santa Clara and Oasis House Transitional Housing Staff Manual*, to provide guidance to staff responsible for various elements of service delivery within the organization. These program manuals provide staff with an orientation to the treatment philosophy underpinning OPCS's clinical orientation, detailed guidance regarding the nature and scope of services delivered to clients at varying stages of their stay at OPCS, and specific, concrete, actionable, and operational details regarding the desired course of actions, interactions, behaviors, and reporting requirements of staff to support these services.

Client Management Data Base

Resources from this grant were used to create and later enhance OPCS' *Client Management* data base. This investment provides an avenue for OPCS to manage their program and track outcomes. The data management system has also been shared, at no cost, with other programs in the community in WINR and Safe House Ministries.

Poster Sessions and Presentations

Disseminating information on the processes, practices, key findings and lessons learned for implementing and delivering evidence-based practices to other transitional and halfway house organizations serving homeless ex-offenders has occurred through formal poster sessions and presentations at key conferences. Below is a list of the venues that staff from CABHP and/or OPCS has presented:

- *Opening Doors: Strengthening Recovery-Facilitative Housing 2nd Annual Symposium* held in November of 2009. This conference is sponsored by Women In New Recovery/Our Common Welfare, another Arizona SAMHSA funded organization with whom we have collaborated over the past several years.
- *10th Annual Summer Institute* held in July of 2009. Presented with Women In New Recovery/Our Common Welfare and highlighted the creation of AZHRA.

- *National Association of Halfway House Alcoholism Programs Annual Meeting and Opening Doors: Strengthening Recovery-Facilitative Housing 1st Annual Symposium* held in November of 2008. Two presentations were facilitated on implementing evidence-based practices in a transitional housing setting, including one highlighting strategies for implementing motivational interviewing.
- *9th Annual Summer Institute* held in July of 2008. OPSC and CABHP completed a presentation highlighting key findings and implementation strategies to a wide range of service providers and funding organizations (e.g. Arizona Department of Health Service, Regional Behavioral Health Authorities, and the Arizona Department of Corrections).
- *The Faith-Based Training coordinated by the African American Alcohol & Other Drug Council of LA County*, and the Los Angeles Metropolitan Churches in August of 2008.
- Two poster presentations were conducted in June of 2008 at the national *College on Problems of Drug Dependency* and *SAMSHA Homeless Grantee Meetings*.
- The combined CABHP and OPSC team made a presentation at the *8th Annual Summer Institute* in July of 2007. The state-wide conference focused on providing the best available tools to individuals and agencies who deliver behavioral health services to those in need.

OPCS management staff plans to continue mentoring other organizations by sharing their success and lessons learned at AZRA meetings and trainings. CABHP staff will also present information on this program at upcoming events, distribution of this final report, and highlighting program outcomes on CABHP Website.

Other

The CABHP Evaluation Manager participated in a phone interview and follow-up survey with the Boston University Study of Evidence-Based Practices in Community-Based Substance Abuse Programs Boston in August of 2009. The aim of the study was to understand the experiences of community organizations in implementing evidence-based treatments or services through SAMHSA funded grants, with the hope that the data might help oversight bodies to better understand the realities of providing services under real-life circumstances.

Case Examples

Lenny came to CSC after approximately 10 years in prison. He was very motivated to succeed, having been released and re-incarcerated three times. He was raised in generational poverty in the South Tucson area, and most of his siblings were involved in criminal activity or currently incarcerated. Lenny started using methamphetamine during his early twenties, prior to his third incarceration. He reported that methamphetamine helped him cope with life and gave him the energy he thought he needed. He quickly became addicted to methamphetamine and was eventually incarcerated for sales of dangerous drugs. Towards the end of his sentence he enrolled in an outpatient substance abuse program and started working closely with a counselor. Upon release he chose to come to the CSC program instead of living with family, believing that if he returned to his family he would likely return to drug usage.

Lenny graduated from the CSC program after 90 days and joined the Resident Advisory Panel (RAP) and Alumni group. It was in these groups that he met Maria. Maria had also been released from prison and had completed the CSC program. She also had a history of methamphetamine dependence. Maria reported that initially she did not plan on staying off of methamphetamine, and did not intend to take the program seriously. However, during the sessions she began to rethink this position. Through her relationship with other clients and her counselor, she began to think that she would be able to live a sober life. She attributed this change to the nature of the therapy, a non-confrontational style, in which counselors didn't tell her what to do, but let her explore possible solutions to her problems. With her newfound confidence Maria maintained her abstinence from drugs and alcohol and became deeply involved in her groups and aftercare services.

Although OPCS discourages clients from initiating romantic relationships during early sobriety, it became increasingly obvious that Lenny and Maria had become smitten with each other. After approximately 12 months they were married and Maria was pregnant. It was around this same time that Maria found out she had an outstanding warrant for a drug offense from approximately eight years prior. Hoping to resolve the warrant, she turned herself in and was released pending a trial. During the time of her offense, Maria was involved with a man who was manufacturing and selling methamphetamine.

Maria remained sober during the pre-trial period and stayed involved in the OPCS RAP and Alumni groups, as well as community peer-based support groups. Her pre-trial investigator stated that she believed Maria had really changed her life for the better and was now a productive member of society. In addition, staff from OPCS went with Maria to her sentencing and offered support for community resources if Maria was allowed to complete her sentence on probation. Even the judge stated that Maria seemed to have made a sincere change in her

life and that he could not see the benefit to incarceration. However, he also recognized that the law was clear and that the minimum sentence for her offense was two years in the State Prison. Maria was sentenced and led out of court in handcuffs, leaving behind her husband, newborn, and extended family. Although it seemed as though this was a devastating blow to

her and Lenny, they vowed to remain sober and crime free. Lenny continued to work and lived in subsidized housing while raising his son as a single father. However, more difficulty was on the way.

After about nine months, Lenny and Maria's child passed away from sudden infant death syndrome. Lenny was in Phoenix visiting Maria's family at the time. They were sleeping on the floor of Maria's mother's small home, when Lenny woke up, checked on his son, and found that he was cold and not breathing. He made attempts to revive his son, but it was too late. OPCS staff rallied around Lenny and Maria, with the Alumni group sponsoring a car wash to raise funds to cover burial costs. Lenny and Maria were not allowed to visit each other in prison to help cope with their grief due to their prior criminal history. Instead they were only allowed to communicate by mail. Maria was allowed to see her son for an hour prior to the funeral only after funds were provided to cover the costs of her prison transport. Lenny was offered grief counseling at no charge through the CSC program; he declined and became more and more isolated. Unable to express his deep grief, Lenny started using alcohol again. However, due to his involvement with twelve step groups and SMART Recovery, he was able to admit this use and gain support from his peers. He stopped drinking, sold his furniture and household goods, and reentered transitional housing. He is now back on track, attending counseling for his grief and loss, and participating in peer groups to support his sobriety. In another year Maria will be out of prison and they look forward to reuniting. In letters to the CSC staff and counselors, Maria says she is sober and staying focused on reentering society again, proving that she can be successful and lead a positive and drug free life.

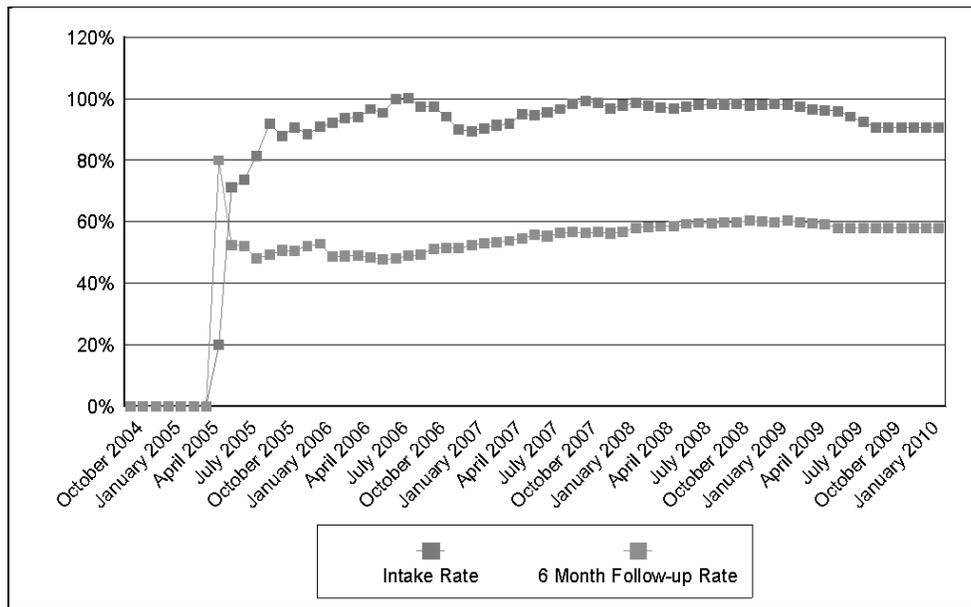
This may seem like an unlikely case study to demonstrate the success of the CSC project. Lenny relapsed, Maria was back in prison, and their only child died. However, this case well represents the extreme difficulties faced by persons released from incarceration. The stigma associated with labels such as "ex-con", "addict", and "mentally ill", collide with limited access to affordable housing, employment, and medical services. When a newly released person decides to take control of his or her destiny, rejecting an often generational history of crime and addiction, that individual is usually in need of support from family and community. The CSC project was designed to be part of that support team. Through the use of motivational interviewing, these clients were encouraged to take steps to improve their lives, and through contingency management they were rewarded for positive actions, allowing for natural consequences when they faltered. If we had not received the support of this SAMHSA project, with training, consulting, and evaluative feedback provided by the Center for Applied Behavioral Health Policy, OPCS would have most likely continued to deliver more traditional substance abuse services. This would include highly directive services and zero tolerance for relapse. Under this treatment system Maria and Lenny would most likely have been discharged during difficult times, labeled as non-compliant with program rules, and defiant toward change (in the case of Maria's statements at intake). Instead, they were allowed to explore their own recovery needs and supports, and were welcomed into the program when their need was highest. The fact that Lenny is sober today, and Maria is only serving two years, instead of a possible thirteen, testifies to the success of this project.

Final Evaluation

CSAT/Government Performance and Results Act (GPRA)

In the original application it was anticipated that there would be 575 program participants served during the five (5) years of the grant. Five hundred and twenty-two (522) individuals actually consented to the study for a 90.8% intake coverage rate. The intake coverage rate ranged from 0 during the first two quarters while the program was being started, to over 98% throughout the five (5) years of the project (Figure 2). Approval was granted during the final quarter of the last year of the project to cease accepting new participants as there would not be funding for individuals to complete their treatment. However, the client target number was not adjusted accordingly in the GPRA Data Base, negatively impacting the overall intake rate for the program. The mean number of new participants entering the program each month was 29 (excluding the first and last quarter) with intakes ranging each month from 0 to 42. As noted in the “Lessons Learned” section, it is extremely difficult to achieve a cumulative rate of 100% for intakes and 80% follow-ups when programs do not achieve the quarterly target rates.

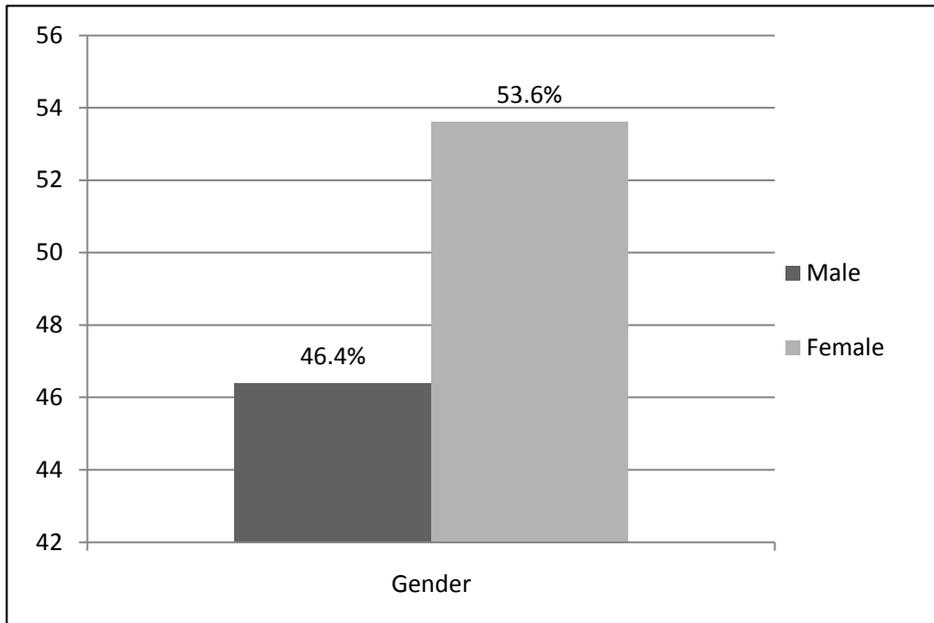
Figure 2: Intake and 6 Month Follow-up Rates



During the five (5) years of the grant 522 individuals received services from the CSC project at a cost-per-client of \$1,712¹. As noted in Figure 3, 242 participants were male (46.4%) and 280 were female (53.6%).

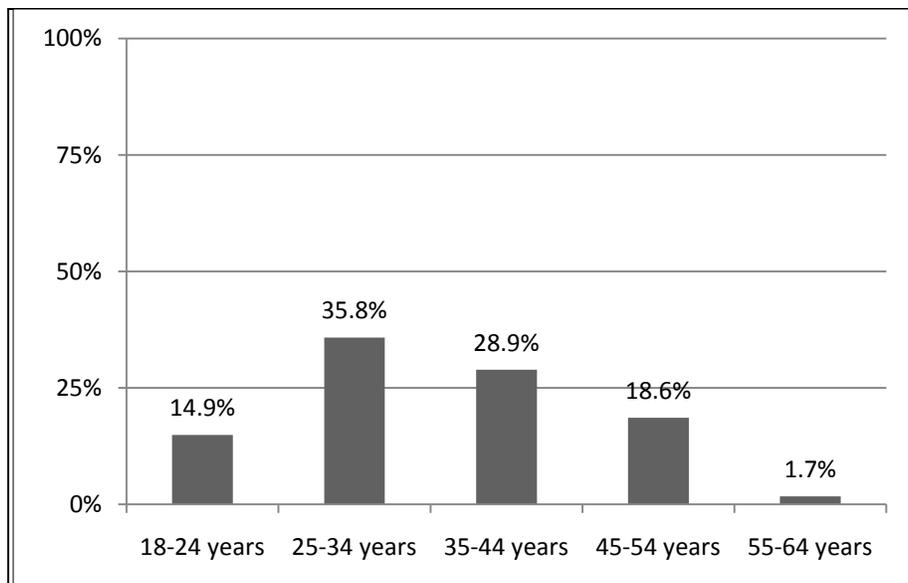
¹ GPRA Cost Per Participant is equal to: Rate of Adjusted Budget (.9, .8, .6 or .5) * ((Total Budget / # of months in grant) * # of elapsed months) / (# of Intakes * 1.6).

Figure 3: Participants Gender



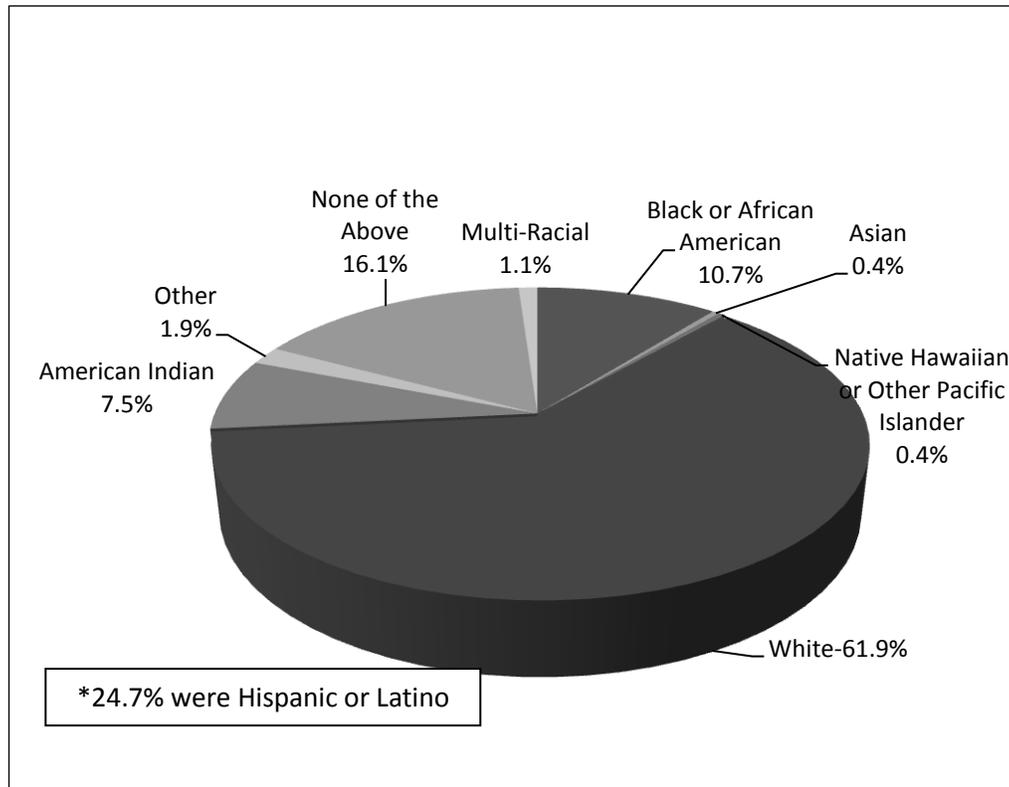
A number of age groups participated in the program (see Figure 4) with approximately 80% of the participants under the age of 45 and very few (1.7%) over 55 years of age. Less than 20% of the participants were young adults between the ages of 18-24.

Figure 4: Percent Distribution of Clients by Age Group



CSC clients were predominantly Caucasian (61.9%), followed by 16.1% of the individuals who did not identify with any of the ethnicities listed. African-Americans and Native American Indians made up a majority of the remaining clients with 10.7% and 7.5% participation, respectively, from each group. Multi-racial clients accounted for 1.1% of the sample, while both Asians and Native Hawaiian or other Pacific Islander individuals each accounted for 0.4% of CSC clients. Figure 5 illustrates a detailed breakdown of participants by Race. There were 129 of the 522 clients (24.7%) who self-identified as being Hispanic or Latino.

Figure 5: Percent Distribution of Clients by Race/Ethnicity



Intake information was collected on 100% of the 522 participants, 239 individuals completed the exit interview (45.8%) and 219 individuals (58.0%) completed the 6-month follow-up interview.

As the majority of individuals who were entering the program came from correctional institutions, jail or prison, the reported substance use at intake was relatively low. Regarding drug and alcohol use at intake, 58 of the 522 participants reportedly used alcohol in the past 30 days (11.1%); 29 out of 522 used cocaine/crack in the past 30 days (5.6%) and 27 of the 522 participants used marijuana/hashish in the past 30 days (5.2%). Less than one percent of the participants reported using any of the remaining substance use categories (e.g. Heroin, Benzodiazepines, Morphine, and Hallucinogens) captured in GPRA.

At the conclusion of the clients' program completion period, CSC consistently saw a significant increase in the number of clients who had sought out and obtained stability in their housing situations. Approximately 39.7% of CSC assisted clients had found a permanent place to live in the community. This data illustrates a vast difference from the 3% of clients who had begun the project reporting to have had no housing stability. Furthermore, approximately 83.3% reported that they were currently employed or attending school, and the number of clients who had experienced no alcohol or illegal drug related health, behavioral, or social consequences increased from 69.3% to 96.3%. Figure 6 displays the change in national outcome measures over the three different time periods (intake, discharge, and 30 day follow-up) in which data from the six investigated client behaviors/community outcomes was taken.

Figure 6: GPRM Outcomes

GPRM Measures	Intake n=522	Discharge n=239	6-Month Follow-up n=303
Abstinence: Did not use alcohol or illegal drugs	84.7%	88.7%	84.7%
Crime and Criminal Justice: Had no past 30 day arrests	97.7%	97.5%	97.0%
Employment/ Education: Were currently employed or attending school	81.7%	89.5%	83.3%
Health/ Behavioral/Social Consequences: Experienced no alcohol or illegal drug related health, behavioral, social consequences	69.3%	98.3%	96.3%
Social Connectedness: Were socially connected	97.5%	99.6%	97.5%
Stability in Housing: Had a permanent place to live in the community	2.5%	8.4%	39.7%

Among the improvements reported were abstinence, housing stability, employment/education, and health/behavioral/social consequences. The rate of change was highest (233.3%) for individuals reporting that they had a permanent place to live, increasing from 2.5% at intake to 8.4 % during the discharge interview. There was a moderate increase observed in employment

(5.9%) and slight improvements in abstinence from alcohol and/or illegal drugs (2.9%) and social connectedness (0.9%). The number of individuals reporting no alcohol or illegal drug related health, behavioral, or social consequence(s) increased significantly from 69.3% at intake to 98.3% at discharge.

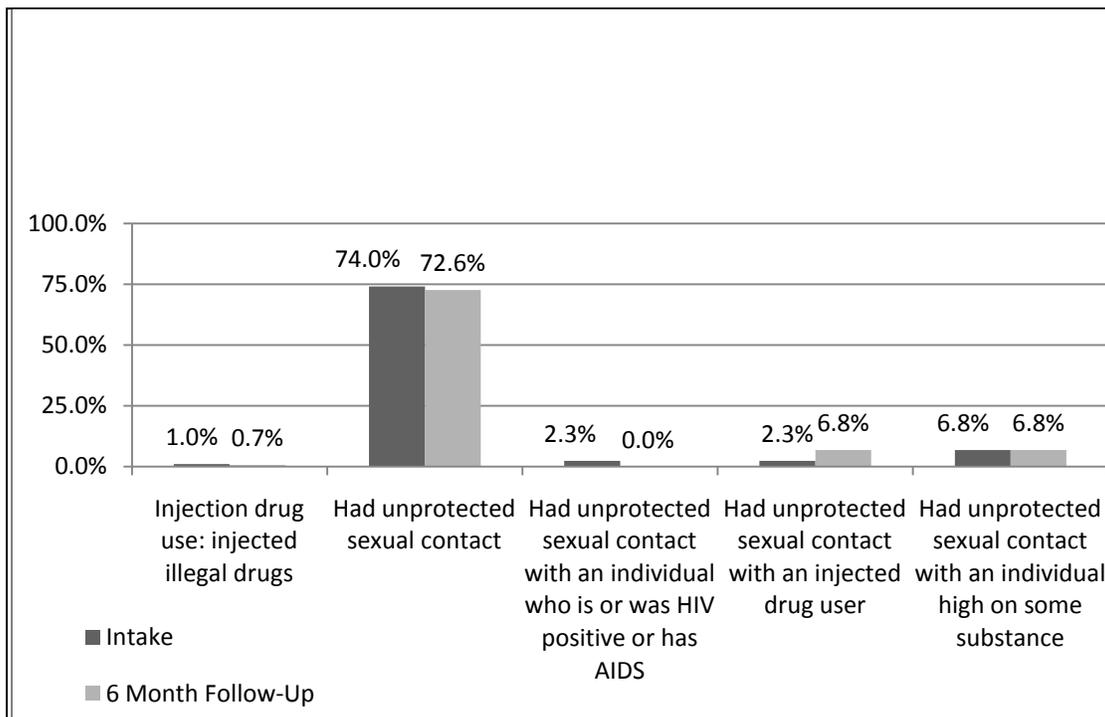
There were 407 (84.4%) of the 522 participants who reported that they were on parole or probation at the time of their intake compared to 193 (80.8%) at discharge and 211 (70.6%) at 6-month follow-up. The percentage of individuals who reported that they had not committed a crime in the past 30 days increased from intake (87.1%) to discharge (91.6%) and the 6-month follow-up (92.3%).

Upon review of information collected on the participants who completed both intakes and 6-month follow-up interviews, improvements were reported in housing stability, employment, and health/behavioral/social consequences. The rate of change was highest for individuals reporting that they had a permanent place to live, increasing from 3.0% at intake to 39.7% during the 6-month follow-up interview. There was a 0.0% rate of change for abstinence from alcohol and/or illegal drugs as well as for social connectedness. As noted previously, the number of individuals reporting abstinence at intake was high as they were entering the program directly from a correctional institution. Reported attendance at school or work also increased from 81.7% at intake to 83.3% at 6-month follow-up, a 2.0% rate of change. Although there appears to be relatively small gain in employment and no gain in social connectedness, it is believed that since the majority of the individuals had been in the program for over 14 days when they completed their intake, and the program requirement was to have a job or be attending school, this rate of change does not accurately reflect the number of individuals who achieved employment outcomes. In addition, participants were rapidly connected to supports upon entry to the program, both formal within the program, and informal community supports; this again would have diminished the number of individuals reporting this as an achievement. The number of individuals who reported that they had experienced no alcohol or illegal drug related health, behavioral, or social consequence(s) increased significantly from 69.3% at intake to 96.3% for a rate of change of 38.9%. There was not a significant decrease in the percentage of individuals who reported they had no arrests in the past 30 days between intake (97.7%) and 6-month follow (97.0) up as the rate of change was -0.7%. Approximately 16.1% of the 522 participants reported that they were on parole or probation at the time of their intake compared to 11.7% at the 6-month follow-up, and 47.2% reported that they had committed a crime in the past 30 days compared to 26.5% at the 6-month follow-up. At intake 7.1% had been arrested compared to 6.8% at the 6-month follow-up. Most of the participants had not spent time in jail or prison during the past 30 days (92.9% at intake and 90.1% at follow-up).

Figure 7 summarizes the percentage changes of risky behaviors that CSC clients identified they were practicing from the start of the program to the 6 month follow-up assessment. A slightly lower proportion of the program's participants reported having had unprotected sexual contact and injecting illegal drugs. A greater change was noted in the 2.3% of clients who reported

having had unprotected sexual contact with HIV-positive or AIDS infected individuals at intake. No clients reported practicing this behavior when completing the 6-month follow-up evaluation. In addition, comparison of the rates of clients who reported having unprotected sexual contact with an injected drug user or with an individual high on some substance did not appear to be impacted by the program as the number of clients participating in these behaviors either increased or remained static during the 6 months post-assistance.

Figure 7: Changes in Risky Behaviors from Intake to 6-Month Follow-up for Clients



Process Evaluation

Over the course of the program, a total of 15 focus groups were conducted in an attempt to elicit information about the CSC project from clients and program staff. It was critical at the beginning of the program to collect information from staff on their experience with Motivational Interviewing (MI) and the Community Reinforcement Approach (CRA), how their clients responded to their use of each approach, and comments or concerns about the CSC project as a whole. All program staff of OPCS participated in the initial focus group including case managers, housing coordinators, the office manager, receptionist, and intake specialist. Members of the group vocalized that, as a result of MI and CRA training, they now listened to their client’s needs more often instead of trying to lead them and telling them the necessary steps to take. Allowing the client to decide what they want or need was said to be an “eye

opening” experience and one that worked to the client’s benefit because it forced them to become proactive about their recovery. It was also said that communication with clients had been increased as a result of MI and CRA use. Finally, the staff offered several suggestions about how to improve the CSC Project by voicing their concerns about an employment program not respecting client’s wishes, simplifying the process of admission to OPCS, the training schedule, the pay rate, providing more transportation, and House Managers needing more flexibility with their schedules so that they would be able to attend more training sessions.

Focus groups with program participants focused on their perceptions of the services they were receiving and opportunities for improvement. Consistent feedback from participants indicated that although it was important for them to interact with people in similar situations, group counseling was not effective for them. Many people voiced that they would have liked to participate in more one-on-one sessions with their counselors. Clients stressed that it would be more beneficial to them to communicate personally with a specialist immediately after prison in order to deal with the drastic change of location. Others were frustrated by time restraints and felt as if they were not able to communicate their feelings as openly due to an inability to relax and be open about some of their more personal experiences.

In contrast, those in favor of group counseling sessions noted that it was a place for them to learn to be more open with others and enhance their communication skills upon being released from prison. Counselors proved to play a significant role in this advancement. The 2007 focus groups expressed that the counselors seemed to be working to monitor the group rather than direct it, and this was something they appreciated. It allowed some of them to change their thinking behaviors, and in turn, modify their past abusive actions by learning how to deal with difficult situations. It was also noted that when counselors were very personable, friendly, and seemed to genuinely have an interest in each client’s recovery process, it assisted them in learning to be more open and honest about their issues.

Recognition for good behavior was also a desired element that the clients wanted implemented into the program. As a result of these concerns, it was recommended that OPCS consider developing a reward system to acknowledge client’s progress and review the structure of the counseling component to include more one-on-one sessions. In addition, some of the positive outcomes for the women were that they were receiving assistance to stay sober, as well as create better lives for themselves by obtaining housing and financial assistance.

Although counselors were heavily praised for their guidance and rehabilitation efforts, criticisms about these staff members were also voiced during many of the client focus groups. In 2007, when asked about suggestions for the programs, it was mentioned by a number of women that they felt some of the staff’s focus was on the financial gain of the program rather than assisting them. This issue proved to be particularly detrimental to clients’ progress as they began to lose focus on their recovery processes and instead began to direct their attention to what they felt was a major cause of tension between themselves and their appointed help. They requested a more efficient screening of house manager applicants and described how

they felt a lack of effective communication between staff and clients. This concern, combined with a lack of resources for finding employment, a desire for more intensive classes, and meeting schedule conflicts that prohibited some clients from obtaining employment, left clients feeling as if they were not receiving enough support from the program despite their efforts and desire to get help for their issues.

The issues concerning the OPCS staff appeared to be addressed and resolved upon the evaluation of the groups in July 2009. The praise for these employees was universal as clients articulated that the strong efforts of everyone, especially house managers, case managers, and clinical staff, were greatly appreciated and contributed to the success of their transition from prison to the community. The most appreciated and utilized services provided by the staff were financial and employment assistance. The Jackson Employment Center (JEC), in correlation with OPCS, aided clients with job searches, as well as obtaining and maintaining employment. Another partner services group, Access to Recovery, was used by a number of clients to assist them in paying for their housing costs for the duration of their participation in the program. This assistance lightened the burden of their financial stresses and allowed clients to apply more focus and effort to their recovery process.

Clients reported that they looked to one another for support in stressful times. There appeared to be strong bonds among the clients in each focus group who indicated that they were receiving a great amount of support from one another and making friends in the house. Having a sense of structure in their lives and having the opportunity to learn from others were indicated by the men and women to be positive results of the program.

Review of the focus group evaluations indicates that the CSC Project has improved greatly over the years. Issues that once seemed to prohibit clients from making progress in the program were eliminated by modifications of the structure, as well as an increase of participation by staff members. Clients appear to be pleased with the program and explained that it has been successful in assisting them with their transition from prison into the community. The CSC program administration staff also reported that feedback received from focus groups was extremely helpful as participants felt comfortable telling the CABHP facilitator things that they would not tell program staff. Conducting debriefing meetings following the focus groups, and the tracking recommendations through the Implementation and Evaluation Team, established formal feedback mechanisms to track the timely response and resolution of issues identified.

Suggestions and Recommendations

1. OPCS and CABHP staff concur that GPRA measures are not adequate to evaluate an organization's transformation (such as the one described in this report). In addition, clinical process measures, in addition to qualitative data collected, are needed. For example, preliminary testing on a tool that CABHP developed to measure staff fidelity with CRA principles and practices was conducted with OPCS program staff. However, after review of the initial results and feedback from OPCS program staff, it was the consensus of the Implementation and Evaluation Team that the tool did not adequately measure CRA and, due to limited resources, testing was discontinued. CABHP should explore potential funding avenues to continue testing and finalize the tool as efforts to locate appropriate tools failed.
2. Additional feedback from the SAMHSA and the assigned Project Manager would have been welcomed as it appeared communication focused primarily on intake and follow-up rates. A sufficient amount of program and evaluation staff time and resources are needed to produce quarterly and annual reports; however, minimal feedback or direction was received following submission.