

AN ASSESSMENT OF FOUR SUBSTANCE ABUSE TREATMENT PROGRAMS

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Section 1: Introduction

The Colorado Division of Criminal Justice (DCJ), Office of Research & Statistics (ORS) conducted an evaluation of the Federal Purpose Area 13. Federal Purpose Area 13 provides programs which identify and meet the treatment needs of adult and juvenile offenders who are drug and alcohol dependent. This purpose area encompassed Colorado Purpose Areas 3 (Therapeutic Communities) and 5 (Offender Treatment Programs).

The four programs that meet Colorado's Purpose Area 3 are:

- ❑ Boulder County Integrated Juvenile Substance Abuse Services
- ❑ CrossPoints Enhanced and Intensive Outpatient Program
- ❑ University of Colorado Health Sciences Center Marijuana Treatment Program for Adolescent Probationers
- ❑ Southern Ute-Ignacio Multi-Systemic Program

All four of these programs addressed a need for substance abuse treatment in local communities. In Boulder County, over 50 percent of juvenile probationers were violating their probation by using illegal substances. Additionally, some youth were being placed in residential treatment programs far away from their homes, which limits family involvement and supervising officer involvement. The CrossPoint program, which is located in Denver, Colorado, found that two groups of offenders were being underserved in Colorado: those assessed to need intensive outpatient substance abuse treatment and those with co-occurring disorders. According to several different studies, the University of Colorado Health Sciences Center Marijuana Treatment Program for Adolescent Probationers found that marijuana use among adolescents in Colorado ranks high when compared to national figures. Marijuana is often considered to be the "gateway drug" which can lead to more serious drug use and further risks to their physical, mental, and criminal state. Southern Ute reported that Ignacio youth have been found to have higher levels of drug and alcohol use than those in comparable communities, while substance abuse treatment is very limited in this community.

Byrne Funding

Over the last five years, Colorado's Byrne/JAG Board awarded over four million dollars towards substance abuse treatment. Three of the programs involved in this assessment are currently receiving funding for FY2006, while the Southern Ute program completed its fourth year of funding in June 2005. See the tables below for funding information.

Table 1: Byrne Funded Substance Abuse Offender Treatment Programs, FY2001-2005

Total Amount Awarded for Substance Abuse Treatment	Programs Funded
FISCAL YEAR 2001	
\$1,354,752	<ul style="list-style-type: none"> <input type="checkbox"/> City and County of Denver The Sister Project <input type="checkbox"/> Colorado Department of Human Services New Directions for Families <input type="checkbox"/> El Paso County Department of Health and Environment COSAAT <input type="checkbox"/> Southern Ute Community Action Programs New Gate Community Project <input type="checkbox"/> Southern Ute-Ignacio Multi-Systemic Therapy Treatment Program <input type="checkbox"/> El Paso County Sheriff's Department Gateway Substance Abuse Prevention Project <input type="checkbox"/> El Paso County Community Corrections Substance Abuse Treatment Program <input type="checkbox"/> University of Colorado Health Sciences Center Outpatient Therapeutic Community <input type="checkbox"/> Colorado Division of Youth Corrections Juvenile Extended Treatment and Transition
FISCAL YEAR 2002	
\$998,520	<ul style="list-style-type: none"> <input type="checkbox"/> City and County of Denver The Sister Project <input type="checkbox"/> El Paso County Department of Health and Environment COSAAT <input type="checkbox"/> Southern Ute Community Action Programs New Gate Community Project <input type="checkbox"/> Southern Ute-Ignacio Multi-Systemic Therapy Treatment Program <input type="checkbox"/> Boulder County Health Department, Impact <input type="checkbox"/> Colorado Department of Corrections, DOC Multimedia CDRom Curriculum <input type="checkbox"/> El Paso County Community Corrections Substance Abuse Treatment Program <input type="checkbox"/> University of Colorado Health Sciences Center Outpatient Therapeutic Community
FISCAL YEAR 2003	
\$189,358	<ul style="list-style-type: none"> <input type="checkbox"/> Boulder County Health Department, Impact <input type="checkbox"/> University of Colorado Health Sciences Center Outpatient Therapeutic Community
FISCAL YEAR 2004	
\$789,053	<ul style="list-style-type: none"> <input type="checkbox"/> University of Colorado Health Sciences Center Marijuana Treatment Program for Adolescent Probationers <input type="checkbox"/> Southern Ute Community Action Programs New Gate Community Project <input type="checkbox"/> Southern Ute-Ignacio Multi-Systemic Therapy Treatment Program <input type="checkbox"/> Arapahoe County Department of Social Services Multi-Systemic Therapy (MST) Team <input type="checkbox"/> Colorado Department of Human Services Intensive Female Offender Outpatient Program; <input type="checkbox"/> Probation Department, 9th Judicial District Drug/Alcohol Mental Health Project <input type="checkbox"/> University of Colorado Health Sciences Center Outpatient Therapeutic Community <input type="checkbox"/> Boulder County Integrated Juvenile Substance Abuse Services
FISCAL YEAR 2005	
\$743,806	<ul style="list-style-type: none"> <input type="checkbox"/> Probation Department, 9th Judicial District Drug/Alcohol Mental Health Project <input type="checkbox"/> Southern Ute Community Action Programs New Gate Community Project <input type="checkbox"/> Southern Ute-Ignacio Multi-Systemic Therapy Treatment Program <input type="checkbox"/> Boulder County Integrated Juvenile Substance Abuse Services <input type="checkbox"/> University of Colorado Health Sciences Center CrossPoint Enhanced & Intensive Outpatient Program <input type="checkbox"/> University of Colorado Health Sciences Center Marijuana Treatment Program for Adolescent Probationers <input type="checkbox"/> Alcohol and Drug Abuse Division Female Substance Abusing Offender Programs

Source: Drug Control System Improvement Colorado State Annual Report 2001-2004; Office of Adult and Juvenile Justice Assistance (OAJA) Colorado State Annual Report 2005.

Table 2: Funding of the Four Substance Abuse Treatment Programs

Funding Year	Time Period	Amount Awarded	Amount Spent
<i>CrossPoints Enhanced and Intensive Outpatient Program</i>			
1 st	7/1/2004-9/30/2005	\$205,702	\$205,702
<i>Boulder County Integrated Juvenile Substance Abuse Services</i>			
1 st	7/1/2003-6/30/2004	\$105,218	\$104,518.40
2 nd	7/1/2004-9/30/2005	\$124,043	\$124,043
<i>Marijuana Treatment Program for Adolescent Probationers</i>			
1 st	7/1/2003-6/30/2004	\$81,870	\$81,870
2 nd	7/1/2003-9/30/2005	\$101,799	\$101,799
<i>Southern Ute Ignacio Multi-Systemic Program</i>			
1 st	10/1/2000-9/30/2001	\$152,893	\$147,660
2 nd	10/1/2001-12/31/2002	\$201,300	\$201,300
3 rd	10/1/2003-9/30/2004	\$206,521	\$206,521
4 th	10/1/2004-6/30/2005	\$150,025	\$141,759

Source: Division of Criminal Justice (DCJ) Internal Grant Management System (GMS).

IMPORTANT LIMITATION OF THIS RESEARCH

The Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191 of the 104th Congress) limits access to client treatment records without the express permission of the client. Therefore, the ORS was not able to gain access to treatment data from the funded projects. This significantly limited our ability to evaluate these programs. The evaluation entailed a content analysis of documents pertaining to each program. Specifically, these documents included the program applications, quarterly and final reports. These documents varied in quality and completeness. In most instances, even when outcome data were provided, it was not clear what time period was represented or if data were comparable across time periods. The ORS regrets these limitations.

BACKGROUND

It is important to frame the following project descriptions in a context of what is known about effective drug and alcohol treatment. It should be noted that the project descriptions of the actual treatment delivered were extremely limited, and often the number of cases processed through the program remained the focus of project reports. Nevertheless, there is a considerable literature, based on excellent research, which provides clear direction for service delivery in the field of drug and alcohol treatment. We summarize that literature below, drawing from a publication from the National Institute of Health.

Section 2: What Works for Drug and Alcohol Treatment

The National Institute of Health presents 13 research-based principles of drug addiction treatment:

- 1. No single treatment is appropriate for all individuals.** Matching treatment settings, interventions and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.
- 2. Treatment needs to be readily available.** Because individuals who are addicted to drugs may be uncertain about entering treatment, taking advantage of opportunities when they are ready for treatment is crucial. Potential treatment applicants can be lost if treatment is not immediately available or is not readily accessible.
- 3. Effective treatment attends to multiple needs of the individual, not just his or her drug use.** To be effective, treatment must address the individual's drug use and any associated medical, psychological, social, vocational, and legal problems.
- 4. An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.** A client may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient at times may require medication, other medical services, family therapy, parenting instruction, vocational rehabilitation, and social and legal services. It is critical that the treatment approach be appropriate to the individual's age, gender, ethnicity, and culture.
- 5. Remaining in treatment for an adequate period of time is critical for treatment effectiveness.** The appropriate duration for an individual depends on his or her problems and needs. Research indicates that for most patients, the minimum time at which improvement is reached is three months in treatment. Additional treatment can produce further progress toward recovery. Programs must include strategies to engage and keep clients in treatment.
- 6. Counseling—individual and group – and other behavioral therapies are critical components of effective treatment for addiction.** In therapy, clients address issues of motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding nondrug-using activities and improve problem solving abilities. Behavioral therapy also facilitates interpersonal relationships and the individual's ability to function in the family and community.
- 7. Medications are an important element of treatment for many clients, especially when combined with counseling and other behavioral therapies.** Methadone and levo-alpha-acetylmethadol (LAAM) are very effective in helping individuals addicted to heroin or other opiates stabilize their lives and reduce their illicit drug use. Naltrexone is also an effective medication for some opiate addicts and for individuals with co-occurring alcohol dependence, for example.

- 8. Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.** Because addictive disorders and mental disorders often occur in the same individual, patients presenting for either condition should be assessed and treated for the co-occurrence of the other type of disorder.
- 9. Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.** Medical detoxification safely manages the acute physical symptoms of withdrawal associated with stopping drug use. While detoxification alone is rarely sufficient to help addicts achieve long-term abstinence, for some individuals it is a strongly indicated precursor to effective drug addiction treatment.
- 10. Treatment does not need to be voluntary to be effective.** Strong motivation can facilitate the treatment process. Sanctions or enticements in the family, employment setting, or criminal justice system can increase significantly both treatment entry and retention rates and the success of drug treatment and interventions.
- 11. Possible drug use during treatment must be monitored continuously.** Lapses to drug use can occur during treatment. The objective monitoring of a patient's drug and alcohol use during treatment, such as through urinalysis or other tests, can help the patient withstand urges to use drugs. Such monitoring also can provide early evidence of drug use so that the individual's treatment plan can be adjusted. Feedback to those who test positive for illicit drug use is an important element of monitoring.
- 12. Treatment programs should provide assessment for HIV/AIDS, Hepatitis B and C, Tuberculosis and other infectious diseases, and counseling to help clients modify or change behaviors that place themselves or others at risk of infection.** Counseling can help patients avoid high-risk behavior. Counseling also can help people who are already infected manage their illness.
- 13. Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.** As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning. Participation in self-help support programs during and following treatment often is helpful in maintaining abstinence.

Source: National Institutes of Health, October 1999, Publication No. 99- 4180.

Section 3: Colorado's N-SSAT Results

Annually the Substance Abuse and Mental Health Services Administration (SAMHSA) conducts the National Survey of Substance Abuse Treatment Services (N-SSAT). This survey is designed to collect data from facilities throughout the 50 states, the District of Columbia, and other U.S. jurisdictions, that provide substance abuse treatment.

The latest 2004 N-SSATS, reported that Colorado had a 98 percent response rate to the survey. Four hundred and twenty-five (425) substance abuse treatment facilities reported that they were serving 30,501 clients as of March 31, 2004. See the tables below for further 2004 data regarding the facilities and treatment.

Table 3: Facility Ownership/Operation

	CLIENTS IN TREATMENT ON MARCH 31, 2004					
	Facilities		All Clients		Clients Under Age 18	
	Number	%	Number	%	Number	%
Private non-profit	162	38%	11,211	37%	1,260	48%
Private for-profit	235	55%	16,088	53%	1,024	39%
Local government	7	2%	677	2%	207	8%
State government	12	3%	1,485	5%	111	4%
Federal government	7	2%	826	3%	-	-
<i>Dept of Veterans Affairs</i>	3	1%	588	2%	-	-
<i>Dept of Defense</i>	4	1%	238	1%	-	-
<i>Indian Health Service</i>	-	-	-	-	-	-
Other	-	-	-	-	-	-
Tribal government	2	1%	214	1%	30	1%
TOTAL	425	100%	30,501	100%	2,632	100%

Source: N-SSAT State Profile-Colorado 2004.

Table 4: Primary Focus of Facility

	CLIENTS IN TREATMENT ON MARCH 31, 2004					
	Facilities		All Clients		Clients Under Age 18	
	Number	%	Number	%	Number	%
Substance abuse treatment services	231	54%	18,953	62%	1,370	52%
Mental health services	36	9%	1,718	6%	336	13%
Mix of mental health & substance abuse treatment services	136	32%	8,519	28%	869	33%
General health care	5	32%	408	1%	4	<1%
Other/unknown	17	1%	903	13%	53	2%
TOTAL	425	4%	30,501	100%	2,632	100%

Source: N-SSAT State Profile-Colorado 2004.

Table 5: Substance Abuse Problem Treated

	CLIENTS IN TREATMENT ON MARCH 31, 2004				
	Facilities*		Clients		Clients per 100,000 Population, Aged 18+
	Number	%	Number	%	
Clients with both alcohol and drug abuse	347	95%	13,495	44%	372
Clients with drug abuse only	281	77%	5,775	19%	158
Clients with alcohol abuse only	337	92%	11,231	37%	322
TOTAL**	366	-	30,501	100%	852

*Facilities may be included in more than one category.

**Excludes 59 facilities that were not asked or do not respond to this question.

Source: N-SSAT State Profile-Colorado 2004.

Table 6: Type of Care

	Facilities*		All Clients			Clients Under Age 18	
	Number	%	Number	%	Median No. Of Clients per Facility	Number	%
OUTPATIENT	395	93%	28,602	94%	51	2,214	81%
Regular outpatient	375	88%	24,177	79%	50	-	-
Intensive outpatient	188	44%	1,879	6%	5	-	-
Day treatment/partial hospitalization	28	7%	398	1%	1	-	-
Detoxification	20	5%	125	<1%	1	-	-
Methadone	11	3%	2,023	7%	220	-	-
RESIDENTIAL	57	13%	1,762	6%	21	486	19%
Short term	19	5%	229	1%	12	-	-
Long term	41	10%	1,238	4%	14	-	-
Detoxification	18	4%	295	1%	18	-	-
HOSPITAL INPATIENT	14	3%	137	<1%	9	22	1%
Rehabilitation	9	2%	104	<1%	9	-	-
Detoxification	11	3%	33	<1%	2	-	-
TOTAL	425	-	30,501	100%	50	2,632	100%

*Facilities may be included in more than one category.
Source: N-SSAT State Profile-Colorado 2004.

Table 7: Facility Administrative and Funding Characteristics

	Facilities	
	Number of Facility Responses	% of Facility Responses
Has agreements or contracts with managed care organizations for provision of substance abuse treatment services	176	41%
Receives Federal, State, county, or local government funds for substance abuse treatment programs	186	44%

Source: N-SSAT State Profile-Colorado 2004.

Table 8: Programs for Special Groups

	Facilities	
	Number of Facility Responses	% of Facility Responses
Any program or group	403	95%
Adolescents	202	48%
Co-occurring disorders	113	27%
Criminal justice clients	22	52%
Persons with HIV or AIDS	24	6%
Gay and lesbians	25	6%
Seniors or older adults	22	5%
Women	136	32%
Pregnant or postpartum women	47	11%
Men	103	24%
DUI/DWI offenders	308	73%
Other groups	54	13%

Source: N-SSAT State Profile-Colorado 2004.

Table 9: Types of Services Offered

	Facilities	
	<i>Number of Facility Responses</i>	<i>% of Facility Responses</i>
ASSESSMENT SERVICES	397	93%
Comprehensive substance abuse assessment or diagnosis	390	92%
Comprehensive mental health assessment or diagnosis	169	40%
SUBSTANCE ABUSE THERAPY AND COUNSELING	419	99%
Family counseling	277	65%
Group therapy	407	96%
Individual therapy	396	93%
Relapse prevention	345	81%
Aftercare counseling	287	68%
PHARMACOTHERAPIES	268	63%
Antabuse	267	63%
Naltrexone	95	22%
Buprenorphine	12	3%
Methadone	17	4%
TESTING	376	88%
Breathalyzer or blood alcohol testing	327	77%
Drug or alcohol urine screening	322	76%
Screening for Hepatitis B	88	21%
Screening for Hepatitis C	91	21%
HIV testing	44	10%
STD testing	33	8%
TB screening	102	24%
Transitional Services	323	76%
Assistance with obtaining social services	122	29%
Discharge planning	311	73%
Employment counseling or training	80	19%
Assistance in locating housing	81	91%
OTHER SERVICES	349	82%
Case management services	263	62%
Child care	15	4%
Domestic violence	152	36%
HIV or AIDS education, counseling, or support	168	40%
Outcome follow-up after discharge	135	32%
Transportation assistance to treatment	51	12%
Acupuncture	7	2%
Residential beds for clients' children	8	2%

Source: N-SSAT State Profile-Colorado 2004.

Section 4: Overview of Programs and Outcomes

BOULDER COUNTY INTEGRATED JUVENILE SUBSTANCE ABUSE SERVICES

PROBLEM PROJECT ADDRESSES

Over 70 percent of the higher risk youth (youth scoring in the high medium and maximum level on the CYOLSI) violate supervision by using illegal substances.

Data from Boulder County demonstrated that over 50 percent of all youth placed on probation in Boulder County violated their probation by using illegal substances. Over 70 percent of the higher risk youth (youth scoring in the high medium and maximum level on the CYOLSI) violated their supervision by using illegal substances.

Each year, 100 Boulder County youth have been placed outside of their homes. Of those placed, 25 percent were deemed to have substance abuse issues that put them at significant risk of requiring inpatient or residential treatment. A residential placement could include anything from a 4 to 6 week of inpatient treatment program, a 45 to 60 day wilderness program, or a lengthy residential treatment center placement. Many of the adolescent inpatient and/or residential treatment programs are located outside of Boulder County. This distance limits family involvement in treatment, reduces the supervising officer's ability to be an active part of treatment planning, and serves as a barrier to the continuity of care upon the youths return to the community.

Boulder County Integrated Juvenile Substance Abuse Services sought grant funding to provide an integrated continuum of substance abuse treatment and containment services for youth between the ages of 12 and 18 with significant substance abuse problems who were also involved in the criminal justice system.

PROGRAM DESCRIPTION

This program provides graduated services that separate low-level offenders from higher risk youth in the Integrated Substance Abuse Specific Intensive Supervision (ISIS) and the Intensive Teen Outpatient Program (ITOP) programs. ITOP is designed to meet the needs of low to medium risk juveniles with substance abuse issues. Those youth with more intensive abuse treatment needs are provided treatment and supervision through ISIS.

According to program documentation, ISIS is a newly designed program using best practices, i.e., intake assessments, cognitively based treatment curriculum, and staff consisting of specially trained probation officers and counselors. ISIS addresses the individualized needs of the youth, consequently reducing the number of days spent in detention, out of home placements, revocations, and recidivism. It includes aftercare following residential treatment, a 12-step meeting once per week, and a mentor/sponsor recruited from the sober Boulder community. ISIS staff members will interact with youth and provide services that focus on the following:

- ❑ Positive reinforcement
- ❑ Modeling of pro-social styles of thinking, feeling, and acting
- ❑ Concrete skill building
- ❑ Problem solving skills

Curriculum has also been developed to address the needs of the female population. Gender-specific services are provided through female specific treatment groups for both the mid-range and high intensity female program participants.

Families are involved at the initial assessment, and are asked to participate in multi-family groups. Program staff facilitate consistent communication between family members, PO's, and treatment providers to ensure participant compliance. The family serves a critical role in emphasizing clear expectations, structure, and immediate consequences for participants. In many cases, the parents need to back away and the juveniles need to take accountability for their actions and responsibilities in all areas of life. Further, the support of other parents dealing with the same issues seems to be helpful. In the parents group, parents receive advice on the following topics:

- ❑ How to deal with a juvenile who is addicted
- ❑ How to support them getting out of the system
- ❑ Learning how to set boundaries and natural consequences

Table 10: Summary of the Program Components for Boulder County's Integrated Juvenile Substance Abuse Services

Mid-Range ITOP	ISIS
<ul style="list-style-type: none"> ▪ Probation contact 2 times monthly ▪ Group treatment 1-2 times weekly ▪ 8 week multi-family group ▪ Minimum of 2 months in the program ▪ Female specific programming 	<ul style="list-style-type: none"> ▪ Need/level driven contacts with PO (2 times/week-2 times/month) ▪ 3 level program ▪ Individual and group treatment (level driven) ▪ AA/NA meetings ▪ Minimum to 6 months program duration ▪ Link to community mentors (weekly contact) ▪ 8 week Parent Support Group ▪ Female specific programming

Source: Information obtained from the subgrantee's applications, quarterly and final reports.

PROGRAM OUTCOMES

According to program documentation, program developers expected the following outcomes:

- ❑ Reduction of out of home placements and incarceration for 60 youth by providing intensive community based treatment and team supervision that focuses on treatment compliance (so as to reduce incidents of criminal behavior and substance abuse by 20 percent and increase successful terminations to 70 percent);
- ❑ Ensure services are driven by an initial assessment process;
- ❑ Provide integration of existing services by creating an interagency team that follows the youth from intake through discharge;
- ❑ Allow youth who do go to inpatient/residential programs to transition out to a specialized probation program with an officer who has extensive knowledge of resources for substance abusing youth coupled with intensive outpatient treatment; and
- ❑ Provide additional of services for high-risk youth.

The Boulder program prepared a very specific implementation plan. This is presented below.

YEAR 1

1. Implement a two-level treatment/probation program on July 1, 2003.
2. By June 30, 2004, at least 70 percent of participants will successfully complete the program.
3. Decrease the number of probation revocations and recidivism resulting from relapse from program participants by 20 percent, by July 1, 2003.
4. Complete baseline and quarterly evaluations on all participants to measure progress and commitment to change.
5. By June 30, 2004, at least 70 percent of program participants will successfully terminate from this specialized probation program.
6. Team members will log all intermediate sanctions utilized that divert placement, detention or commitment.
7. By August 1, 2003, hire an additional full-time probation officer and a part-time ITOP counselor.
8. By November 1, 2003, cross-train all program employees to familiarize them with the curriculum and probation services.
9. Up front assessments will be completed on 100 percent of program participants.
10. Gender specific services will be provided to a minimum of 60 youth.
11. Increase parent/guardian participation by providing an eight-week parent education & support group, thus increasing parental/guardian responsibility for implementing sanctions; 80 percent of parents will complete the group.
12. The treatment team will meet a minimum of once per month to staff cases, plan treatment and complete quarterly evaluations.
13. By August 15, 2003, cross-train all partner agency staff regarding program components and requirements.

Source: Colorado Division of Criminal Justice Drug Control & Systems Improvement Program 2003 Application.

YEAR 2

1. By June 30, 2005, at least 70 percent of participants will successfully complete the program.
2. Decrease the number of probation revocations and recidivism resulting from relapse from program participants by 20 percent, by July 1, 2005.
3. Complete baseline and quarterly evaluations on all participants to measure progress.
4. By June 30, 2005, at least 70 percent of program participants will successfully terminate from this specialized probation program.
5. Team members will log all intermediate sanctions utilized that divert placement, detention or commitment.
6. Up-front assessments will be completed on 100 percent of program participants.
7. Gender specific services will be provided to a minimum of 60 youth.
8. Increase parent/guardian participation by providing an eight-week parent education & support group, thus increasing parental/guardian responsibility for implementing sanctions. 80 percent of parents will complete the group.
9. The treatment team will meet a minimum of one time per month to staff cases, plan treatment and complete quarterly evaluations.

Source: Colorado Division of Criminal Justice Drug Control & Systems Improvement Program 2004 Application.

RESEARCH FINDINGS

Program Modifications

- ❑ Based on information learned in the first year, the program properly reassessed how girls would be integrated into the program. The program served 36 adolescent girls, most of whom were classified as low risk. For this reason, the female gender-specific ISIS program was done away with, so only males were referred to ISIS; girls and low-risk boys were placed in ITOP.
- ❑ Based on information learned, an award system was added to the ISIS program to provide additional incentives to the participants. Through interagency staffing reviews, flexible funds have been allocated to reward the youth for specific accomplishments (i.e. each participant who successfully completes the program received a \$40 gift card at graduation).

Target Population

- ❑ In Year 1, the program served approximately 20 high-risk males each quarter.
- ❑ The total number of girls served cannot be determined from the data provided. It was reported, however, that at least 15 were served in the first quarter.
- ❑ Youth who completed the ISIS program spent, on average, 9 months in the program, 3 months longer than expected by the program developers.

Staff Training

- ❑ All team members received ADAD training from the State Court Administrators Office and from JSAT clinicians.

Collaboration

- ❑ The treatment team met once per month, as planned, for planning and complete evaluations.
- ❑ The quarterly reports stated an increase in communication and collaboration among staff working in this program.
 - Probation officers talked to JSAT and ITOP clinicians weekly as well as received weekly progress notes.
 - The parent group facilitator sent weekly updates on the parents to probation, so the probation officers knew how the parents were progressing.
 - ISIS worked with the SMART team (Substance-abuse Multi Agency Review Team). SMART provides weekly case planning and evaluation services; written recommendations and evaluations to the court guide treatment and sentencing recommendations. It is the responsibility of the SMART team to staff cases to ensure the integration of services and interventions.

Parents Program

- ❑ During the first year of funding, parental participation was 50 percent in the first quarter, but in quarters 3 and 4 there was 100 percent participation.
- ❑ During the second year of funding, there was a breakdown of parent participation at the beginning of the funding year. Some parents felt that they did not have to participate because their children had absconded. Others just refused to attend, causing the Probation Officer to take them back to court for contempt of court orders.
- ❑ The courts and families of the youth voiced their satisfaction with the staff and the programming.

Program Outcomes

- ❑ In the first year of funding, ISIS served 64 youth, with 10 graduating.
- ❑ In the final report from the second year of funding, the following ISIS outcomes were provided:
 - In Year Two, 115 youth received services.
 - 44% of them terminated successfully.
 - 44% were terminated unsuccessfully.
 - 12% were unclassified:
 - Reasons included moving out of state, family decisions to place them in high level residential programs, placements outside of the county, etc.
- ❑ In the final report from the second year of funding, the following ITOP outcomes were provided:
 - 103 youth were enrolled in ITOP
 - 18% of those cases are still active
 - 42% were successful terminations
 - 38% were unsuccessful terminations
 - 2% transferred
- ❑ Regarding revocations, 14 youth in the ISIS program received probation revocations during the first year. Seventy-one percent of these revocations were related to relapse issues. This number increased during the second year of funding to 19 youth. These second-year revocations were for:
 - 37% (7) were for substance use
 - 26% (5) were for receiving a new charge
 - 21% (4) were for running away from home
 - 11% (2) were for technical violations
 - 5% (1) were for other reasons

Additional Programmatic Impacts

- ❑ Boulder County Department of Social Services reported that a total of 20 youth were placed in inpatient substance abuse programs during this first grant period (9 during the first 6 months and 11 during the last 6 months).
- ❑ Data indicated that youth who had participated in the intensive ISIS program none of them have been committed to DYC.
- ❑ The continuum of care enabled clients to be maintained in the community for longer periods of time, subsequently receiving more services and guidance regarding abstinence and relapse prevention.
- ❑ Services provided by IJ/SAS ranged from education to cognitive restructuring while maintaining clients in the community based setting.

ORS COMMENTARY

The program components were inconsistent with the 13 principles of drug addiction treatment listed by the National Institute of Health. Particularly important in the Boulder program was the focus on the family, an important part of the youth's social world, and the integration with probation, referred to by the Institute of Health as "legal problems." The program's focus on assessment was important to "meet the person's changing needs." These program components were consistent with Principles 3 and 4. Although there was an emphasis on continuity of care and intensity of services when needed, it was not clear how this would take place.

Researchers found only one outcome with pre- and post-program data, but the time periods may not be comparable. With that caveat, it was noteworthy that in the problem statement of the grant, the applicant noted “each year 100 Boulder County youth were placed outside of their homes. Of those placed, 25 percent were deemed to have a substance abuse issues that puts them at significant risk requiring inpatient or residential treatment.” During the 12-month grant period for which data were provided, 20 youth were placed in inpatient substance abuse programs. This suggests that the program may have a small impact on the number of youth placed outside the home for drug abuse.

According to project documentation, the continuum of care enabled clients to remain in the community for longer periods of time, subsequently receiving more services and guidance regarding abstinence and relapse prevention. However, no data was provided to substantiate this assertion.

Documents stated that IJ/SAS promoted a shared philosophy and ensured integrated case plans and consistent responses to relapse of substance abusing youth, but data to this effect were not provided.

In terms of objectives, the applicant planned for a success rate of 70 percent but it appeared the rate in fact ranged between 45 and 60 percent. The actual success rate might be reasonable given the risk level and seriousness of the youth, however, information about the population served was not provided.

Finally, at certain times during the grant period, 100 percent of the families were participating in services. This exceeded the program developers' original expectations. The courts and families of the youth voiced their satisfaction with the staff and the programming.

CROSSPOINT ENHANCED AND INTENSIVE OUTPATIENT PROGRAM

PROGRAM PROBLEM STATEMENT

According to N-SSAT (2001), two groups of offender populations seem to be under-served in Colorado: those assessed as needing Intensive Outpatient (IOP) substance abuse treatment and those with co-occurring disorders. The 2001 N-SSAT report stated that 27 percent of those with substance abuse problems also have mental illnesses. Colorado has identified a seven level substance abuse treatment needs index, based on the American Society of Addiction Medicine protocols, that classify offenders into different categories following a series of assessments. These seven levels range from level 1 (no treatment) to level 4 (intensive outpatient treatment) to level 7 (no treatment, assess for psychopathy).

- ❑ Level 1: No Treatment
- ❑ Level 2: Drug and Alcohol Education and Increased Urinalysis
- ❑ Level 3: Weekly Outpatient Therapy
- ❑ Level 4: Intensive Outpatient Therapy
- ❑ Level 5: Intensive Residential Treatment
- ❑ Level 6: Therapeutic Community
- ❑ Level 7: Assess for Psychopathy-No Treatment

The 2001 report, *Analysis of Offender Substance Abuse Treatment Needs and the Availability of Treatment Services* prepared by Colorado's Interagency Advisory Committee on Adult and Juvenile Correctional Treatment, found that many offenders in need of higher or more intensive levels of substance abuse treatment did not receive the needed treatment. In one year, 5,443 community based offenders were assessed to need intensive outpatient treatment (IOP) but only 878 received it because only 16 percent of the needed treatment slots (state licensed and funded) were available to this group. Clearly there was a shortage of licensed programs providing these services, perhaps because of the higher costs and time commitments required for clients who need IOP services. As a result, the Alcohol Drug Abuse Division (ADAD) proposed a new level of care: Enhanced Outpatient Program (EOP), which was adopted in July 1, 2004. EOP calls for 3-8 hours of treatment weekly, and is offered exclusively to offenders. With this grant, CrossPoint intended to provide an intensive and enhanced outpatient treatment program for adult offenders, serve as an intermediate sanction, and be a less expensive alternative to residential treatment.

DCJ reported that offenders with substance abuse treatment needs failed 32 percent of the time after release from community correction facilities, compared to 23.4 percent of offenders without documented substance abuse treatment needs.

Offenders with co-occurring disorders of substance abuse and mental illness constitute another under-served population in Colorado. According to a 2002 issue of *Elements of Change*,¹ it was reported that offenders with substance abuse treatment needs failed 32 percent of the time after release from community correction facilities, compared to 23.4 percent of offenders without documented substance abuse treatment needs. Also noted was nearly 38 percent of recidivating events were for drug and alcohol offenses; and 23.6 percent of new charges filed were for drug felonies. Also in a 1999 report to the Colorado Task Force on Mental Illness and Offenders Subcommittee on Prevention and

¹ *Elements of Change* is a quarterly newsletter that is distributed by the Office of Research and Statistics, Division of Criminal Justice. This newsletter highlights trends and issues in the criminal justice system such as alcohol and drug use, special correctional populations, crime prevention, sentencing patterns, and new laws.

Intervention, the report estimated that the prevalence of co-occurring disorders within the Colorado criminal justice system ranged from 7 percent in the jails to 3-11 percent in the prisons.

Offenders with co-occurring disorders have traditionally been referred to separate treatment programs (mental health and substance abuse treatment), but this created challenges for the criminal justice system. First, very few programs serve this population. Next, multiple referrals constitute a burden in time and money expenditures for the offender, who may already be struggling with their basic responsibilities of working and paying rent, restitution and fines. Finally, the coordination and tracking of services at multiple sites is difficult for the supervising authority and treatment personnel.

Offering both treatments in one location would serve as an effective and relatively inexpensive intermediate sanction that would produce better compliance and outcomes for offenders with co-occurring disorders.

PROGRAM DESCRIPTION

This program was designed to move participants gradually from more intensive to less intensive treatment. Program developers believed the ideal progression would consist of two months in intensive outpatient (IOP), then 4 months in enhanced outpatient (EOP), ending with 6 months in standard outpatient care, for a total of one year in treatment.

All offenders are intended to undergo an assessment to see if the client is appropriate for Levels 3 or 4 treatment (based on the 7 levels of treatment described above). Those deemed appropriate for Level 4 drug and alcohol treatment will be enrolled initially in IOP. However, if the assessments find that the client's current commitment or their level of functioning precludes them from successful participation in IOP, they will be placed in EOP. Those with a history of treatment of mental illness and/or have been diagnosed with mental health disorder will undergo a mini mental status exam. Those who score 10 or above on the Beck Depression Inventory (DPI) or who have elevated scores on certain scales like the LSI and/or the Adult Substance Survey may be referred for a psychiatric evaluation or mental health treatment.

Clients undergoing the psychiatric evaluation will be placed in IOP or EOP. Upon completion of their psychiatric evaluation, they maybe placed in special groups or mental health counseling.

IOP consists of nine hours of treatment a week for 2 months. The program includes relapse prevention, family education/therapy, strategies for self-improvement and change, and medical/psychological education and therapy. Those offenders with co-occurring disorders will also attend a dual-diagnosis group and have weekly individual therapy. After successfully completing IOP, offenders will step down to EOP.

EOP ranges from 3-6 hours of treatment a week for 4 months. Treatment consists of strategies for self-improvement and change, family counseling, monthly individual sessions with a therapy, and group therapy that will be decided by the therapist. Dual-diagnosis clients will also attend a dual-diagnosis group and individual counseling twice a month.

Outpatient Treatment is 1.5-2 hours of treatment weekly. Treatment consists of individual counseling and strategies for self-improvement and change. For those with co-occurring problems, group and individual therapy will be customized for the individual.

TREATMENT INTERVENTIONS

Strategies for Self Improvement and Change (SSC)

Strategies for Self Improvement and Change (SSC) is a cognitive behavioral intervention developed for adult offender populations. This model targets criminogenic risk factors and has been found effective in reducing recidivism.²

Relapse Prevention

The relapse prevention curriculum facilitates understanding and systematically addresses needs for lifestyle change and relapse prevention following cessation of D&A use.

12 Step Facilitation Therapy

12 Step Facilitation Therapy is used to introduce the clients to Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) and to encourage participation in the current treatment program.

Family Education/Therapy

Family education/therapy looks at family dynamics, codependency issues, anger issues, and DV issues as they apply to the client's family and extended peer support system. Family participation is encouraged, but the main focus is on the client reestablishing connections with family and understanding family dynamics.

Solution-Focused Therapy Group

Solution-Focused Therapy Group is a process group that examines individual client problems and issues and utilizes solutions-focused therapy techniques to seek resolution. This therapy group is ideally suited for the offender population, incorporating reintegration into society, problem solving, and dealing with anger management in real life situations.

UA/BA

All clients are required to do urinalysis and/or blood analysis in accordance with the requirements of their individual probation or parole officers and with the requirements of the program.

Pharmacological Interventions

Pharmacological interventions are an effective treatment of those with co-occurring problems. Success of clients with dual diagnoses is often compromised by a client's failure to consistently take medications. Drugs available for the abstinence of alcohol and drugs include antabuse, naltrexone, methadone, and buprenorphine.

² Edward J. Latessa, Ph.D., What Works & What Doesn't in Reducing Recidivism: The Principles of Effective Intervention at http://www.dsgonline.com/Program_Logic_Model/San_Diego_TM/Day%201-Lunch-Latessa.ppt

Table 11: CrossPoint Program Description

	IOP	EOP	Outpatient Treatment
Treatment sessions...	9 hours a week for 2 months	3-6 hours of treatment weekly for 4 months.	1.5-2 hours of treatment weekly
Treatment consists of...	Relapse Prevention Group (8 Sessions) Family Education/Therapy (8 Sessions) Strategies for Self Improvement and Change (SSC), Module 1 (8 Sessions) Strategies for Self Improvement and Change (SSC), Module 2 (8 Sessions) Medical/psychological education and therapy	Attend at least one individual session per month Strategies for Self Improvement and Change (SSC) (24 Sessions) Group therapy (24 Sessions); type of group therapy will be decided to the therapist Family counseling or multi – family group	Strategies for Self Improvement and Change (SSC) (14 Sessions) Individual counseling (1 hour a month)
Dual diagnosis clients ...	Will also attend 8 sessions of a dual-diagnosis group and have weekly individual therapy.	Will attend a dual diagnosis group and individual counseling twice monthly.	Individual and group therapy will be individualized for those with co-occurring problems.

Source: Information obtained from the subgrantee’s application, quarterly and final reports.

PROGRAM OUTCOMES

According to program documents, program developers expected the following outcomes from the IOP and EOP programs:

- ❑ Reduced admissions and returns to the Department of Corrections;
- ❑ Avoided costs and reduced dockets in the judicial system;
- ❑ The freeing-up of valuable treatment beds at Peer I and Community Correction beds at other facilities;
- ❑ Cost savings because the treatment, though longer in duration, is less expensive than residential treatment.

For their first year of funding, CrossPoint prepared a very specific implementation plan, which can be found below.

YEAR 1:

1. Provide substance abuse or substance abuse and mental health treatment services for up to 80 offenders in the first year.
2. Provide 9 hours a week or treatment activities for clients enrolled in IOP.
3. Provide 3-6 hours of treatment activities for each client enrolled in IOP.
4. Provide 1.5 to 2 hours a week of treatment activities for clients enrolled in standard outpatient care.

5. Provide psychiatric evaluations and treatment for all clients needing treatment of co-occurring disorders and prescription of appropriate medications as needed.
6. Serve as an intermediate sanction/alternative placement to offenders under community supervision.
7. Perform random urine and breath tests on 100 percent of enrolled clients to measure abstinence.
8. Assess each client and place in the levels of care, which meets his/her needs with which the client can reasonably comply.
9. Develop a special sliding-fee scale, which does not exceed client co-pays for standard outpatient treatment.
10. Utilize existing resources to facilitate clients' purchase of psychiatric medications.
11. Eighty percent of clients admitted will complete at least 3 months of treatment.
12. Seventy five percent of clients will achieve at least moderate achievement of treatment goals.
13. Forty percent of clients will remain in treatment at least one year, or until completion of their legal supervision.
14. Ninety percent of actively enrolled clients will remain substance free while engaged in treatment.
15. Ninety five percent of enrolled clients will not commit a new crime while in treatment.
16. Maintain a recidivism rate of less than 30 percent at one year from admission.
17. Eighty five percent of those referred as an alternative to incarceration will remain crime-free and not recidivate while in treatment.

Source: Colorado Division of Criminal Justice Drug Control & Systems Improvement Program 2004 Application.

RESEARCH FINDINGS

Mental Health Assessments

- During the first year of funding, 83 mental health assessments were done. On average there were 21 assessments done each quarter.

Services Provided

- The goal for the first year was to provide substance abuse or substance abuse and mental health treatment services for up to 80 offenders. CrossPoint exceeded this goal by serving 148 clients in year one.

Table 12: Substance Abuse and Mental Health Counseling at CrossPoint

	Substance Abuse and Mental Health Counseling Provided To		
	<i>IOP</i>	<i>EOP</i>	<i>Outpatient</i>
<i>1st Quarter</i>	8	10	*
<i>2nd Quarter</i>	13	13	7
<i>3rd Quarter</i>	10	28	7
<i>4th Quarter</i>	11	34	7

*At this point, there were no traditional outpatient clients.

Source: Data obtained from the subgrantee's application, quarterly and final reports.

Program Costs

- One of the program goals was to provide treatment at a reasonable cost.
 - CrossPoints has been able to fulfill this goal. They have developed a sliding fee scale that makes this program affordable for all their clients. See payment scale below.
 - \$10 per group session

- o \$15 per individual session
- o \$15 psychiatric evaluation and report
- o \$10 psychiatric follow up
- o \$5 Urinalysis (UA)
- o \$3 Breathalyzer (BA)
- An assistance program was developed for clients who are in need of psychiatric medications. The clients apply for prescription assistance to the individual drug companies for discounted or free medications.

Psychiatric Medication

- Since the implementation of the psychiatric services, clients have been taking advantage of the service as well as the assistance program.
- Found that the medication regimes have increased program success as well as reduced recidivism. Clients are consistently taking their antabuse to help them maintain their sobriety.

Table 13: CrossPoint Psychiatric Medication Services

	Used the Psychiatric Services Available	Taking Psychiatric Medication	Using the Prescription Assistance Program
<i>1st Quarter</i>	Data not available	Data not available	Data not available
<i>2nd Quarter</i>	8	7	Data not available
<i>3rd Quarter</i>	11	8	5
<i>4th Quarter</i>	10	8	5

Source: Data obtained from the subgrantee's application, quarterly and final reports.

Length of Stay

- The goal for this first year of funding was to have 80 percent of the clients admitted complete at least 3 months of treatment. The program exceeded this goal with 90 percent of the clients were completing a minimum of treatment.
- More than half (57%) of the clients remained in treatment for at least one year, or until completion of their legal supervision vs. the original goal of 40 percent.

Substance Free:

- The goal of having 90 percent of their clients substance free while in treatment was not met, with only 79 percent of the clients remaining substance free. This shortfall was attributed to the high number of high-risk individuals who were enrolled during the first year of funding as well as to an increase in seasonal "lapses."

Recidivism:

- One hundred percent of the clients did not commit a new crime while in treatment.

Additional Programmatic Impacts

- The program subsequently started to take on clients that may have been better suited in an inpatient or residential facility, but due to lack of funds ended up at CrossPoint EIOP program. These offenders were lucky that CrossPoint was able to accommodate them, or they would have fallen through the cracks and possibly become another recidivism statistic.
- During the program's first year of funding, the program served chronically mentally ill clients with severe alcohol and/or drug dependence with very little recent sobriety. According to program documents, this population was a little more difficult to work with.

But after time in the program, these difficult cases demonstrated a reduction in substance use.

- According to program documentation, the program was selective with admitting clients. Priority was given to the high needs cases with co-occurring disorders, but the need for the enhanced level of treatment remained high. Despite services provided by CrossPoint, this level of treatment remained in demand.

ORS COMMENTARY

CrossPoint Enhanced and Intensive Outpatient Program did well in their first year of Byrne funding. According to program documentation, they addressed many of their program goals and objectives, and exceeded a few of them. Ninety percent of the clients admitted to the program completed at least three months of treatment, compared to the 80 percent originally predicted. One goal was to have 40 percent of clients remain in treatment for at least one year, or until completion of their legal supervision. By year-end, 57 percent of the clients remained in treatment for a year or until completion of their legal supervision. Ninety-three percent of clients achieved at least moderate progress on their treatment goals versus the 75 percent originally predicted. One hundred percent of the clients remained crime free while undergoing treatment, again exceeding the original program predictions.

In addition to exceeding their goals, CrossPoint addressed four of the *What Works* principles from the National Institute of Health (NIH). Principle 5 indicates that, for most patients, the minimum time at which improvement is reached is three months in treatment. Most of the clients stayed in treatment for at least three months and over half remained in treatment for a year or until their supervision ends. NIH Principle 7 states that medication is an important element of treatment, especially when combined with counseling and other behavioral therapies. Several clients at CrossPoint took psychiatric medications in addition to their group and individual sessions. The program reported that the medication regimes increased program success and reduced recidivism. NIH Principle 8 addresses the need for treating addicted or drug-abusing individuals with co-existing mental disorders in an integrated way. At CrossPoint, offenders are able to receive the different treatments in one location. However, data regarding the number offenders served with co-occurring disorders was never provided. Separating out this population would provide more insight to determine if the offenders with co-occurring disorders were getting their needs met. Finally, NIH Principle 11 states the need to continuously monitor drug use, and CrossPoints use of UAs and breathalyzers supports this principle.

The program also fell short of achieving their goal of having 90 percent of their clients substance free while in treatment. At the end of the funding year, only 79 percent of the clients remained sober. They attribute this shortfall to the high number of high-risk individuals who were enrolled during this first year of funding as well as to an increase in seasonal “lapses.”

The program also intended to serve as an intermediate sanction or as an alternative placement for offenders under community supervision and for those referred as an alternative to incarceration. It is not clear from the data provided if these offenders would otherwise have been sentenced to prison.

Finally, 100 percent of the clients served remained crime free while in treatment.

UNIVERSITY OF COLORADO HEALTH SCIENCES CENTER MARIJUANA TREATMENT PROGRAM FOR ADOLESCENT PROBATIONERS

PROGRAM PROBLEM STATEMENT

According to a 2002 study by the Colorado Substance Abuse Study Group, Colorado ranked the highest in the nation for marijuana use among high school students. The number of Colorado students reporting recent marijuana use exceeded the national sample for all grade levels. Additionally, the 2001 National Household Study reported that Colorado ranked 5th in the nation for marijuana use in the past month by 12-17 year olds.

The average age of first use of marijuana has significantly decreased in the past 20 years (Johnson & Gerstein, 1998) and the rate of daily marijuana use has exceeded that of daily alcohol use for adolescents (Monitoring the Future, 1999). Marijuana is usually one of the first substances with which an individual experiments before progressing to more serious drugs such as heroin and cocaine. In a study of adult treatment referrals, 90 percent of all the adult clients reported that their first marijuana use occurred before they were 18 years old (Brace, CWEG, 2005).

The potency of cannabis has increased an estimated 300 percent since the 1970s making it a more harmful drug. According to emergency rooms and autopsy reports, marijuana use is believed to be one of the major contributors to violent death and accidents: marijuana was found to be involved in 30 percent of adolescent vehicle crashes, 20 percent of homicides, 13 percent of suicides, and 10 percent of other unintentional injuries (CDC, 1997; McKweon, Jackson, Valios, 1997; Office of Applied Studies, 1995). Marijuana use is also correlated with numerous risks to physical and mental health, school drop-outs, fighting, and criminal behaviors. In Colorado, 85 percent of the children and adolescents committed to juvenile corrections are in need of drug and alcohol treatment (Colorado Substance Study Group, 2002).

Adolescent substance abuse intervention should be a priority, but it is not. Resources and funding are limited. Nationally, fewer than one in ten youth with dependence symptoms receive treatment.

Since marijuana is a problem with adolescents who are involved in the Colorado justice system, several requests have been made to Synergy Outpatient Services to provide treatment to adolescent probationers. Synergy/ARTS is one of the largest licensed substance abuse treatment providers for adolescents in the state of Colorado, serving approximately 160 adolescents at a time with more than 80 percent of the youth having current involvement in the criminal justice system. In collaboration with the 18th Judicial District Probation Department, Synergy Outpatient Services proposed the provision of accessible, brief, cost-effective substance abuse treatment for marijuana abusing probationers and their families.

PROGRAM DESCRIPTION

This marijuana treatment program was designed for juveniles 13-18 years old involved in the juvenile justice system. The program utilizes the Cannabis Youth Treatment (CYT) Series manual based on Motivational Enhancement Therapy (MET) and Cognitive Behavioral Therapy (CBT). This treatment approach is considered to be “best practice” for treatment of cannabis abuse by the Substance Abuse and Mental Health Services Administration (SAMHSA).

To be accepted into the program, the youth must have used marijuana at least once per week for three months and their primary drug of choice must be marijuana. Those clients excluded from the program include: those who are in substance abuse treatment elsewhere; those who are unable to participate in group-based therapy due to significant or severe psychological issues; and those who require a higher level of care due to severe behavior, violence, or substance abuse with substances other than marijuana (and alcohol) and/or to an extreme extent requiring a higher level of care.

New groups are started every month, which allow for continuous referrals by the probation department. The program is offered at two different probation locations within the 18th Judicial District: Aurora and Littleton. The groups are offered during the early evening hours to accommodate the school and work schedules of both the parents and the youth. A smaller group is run at the Foote Detention Center. However, numerous modifications have been made to the Foote program in order for it to operate at the detention center. These modifications include: the program runs in a shorter time frame, the groups are run in consecutive days, family sessions are not done because the offenders are under the custody of the state, and UAs are not done since the clients are incarcerated.

PROGRAM COMPONENTS

Intake

Intake is the start of the treatment process. During the intake process consent forms are signed, program parameters are reviewed, assessments of the clients' substance abuse are done, and the clinical interview is conducted with the client and the parent to gather information about the extent of their substance abuse, criminal history, and mental health history.

Cognitive Behavioral Therapy (CBT)

The youth will undergo five group sessions. In these groups the youth are trained in interpersonal and self-management skills. The focus of these groups is on behavioral rehearsals and practicing functional behaviors. These groups help correct deficits in the clients' coping skills related to avoiding marijuana use, increase the recognition of risk cues, and expand the repertoire for managing stresses and risky situations. Group size is usually limited to 8-10 youths.

Motivational Enhancement Therapy (MET)

This portion of the program includes a guided discussion and evaluation process between the therapist and the client that allows for discussion of personal concerns and goals, pros and cons of substance abuse, and motivations related to substance use. It emphasizes personal responsibility for change and direct advice to change, direct feedback regarding personal risk/harm; an empathetic therapist and a menu of alternatives. These individual sessions are followed by personalized feedback reports. The clinician that they work with in the group and family sessions is the same one who conducts these individual therapy sessions.

Family Support Sessions

Families are asked to participate in two individual family sessions. The first family session explores the individual family dynamics related to the youth's substance abuse problem. The second session offers education and clinical focus for the particular issues identified from the previous session. The goals of these sessions are to engage the family in their adolescent's recovery, provide them with training and support to build their competence and effectiveness in parenting their teens with substance abusing issues. Also information is provided to the families that cover additional topic areas: adolescent development, qualities/activities of functional

families, drugs/alcohol and adolescents, signs of use, relapse prevention and elements of recovery, boundaries, roles, discipline, communication and conflict resolution, and community resources/supports.

Urinalysis (UA)

Clients are required to provide UAs. The UAs are screened for marijuana and eight other drug types. Probation Officers or the referring agency send clients to an external agency for random UAs. Synergy clinicians have access to this data directly from that agency. Besides the random UAs, clients are asked to provide a UA at intake and at their last treatment session.

Level I Counseling

This group was added during the second year of funding. It is offered to the youth who are leaving the program and assessed for needing Level I treatment, and who would benefit from some additional individual and/or family support to provide some further individualized treatment and enhance the clients ability to maintain changes that have been achieved. They will undergo four individual sessions that are still grounded in Motivational Interviewing and Cognitive Behavioral Therapy. And the youth will continue to work with the same clinician who has worked with them in past.

Reporting and Recommendations to Probation or Referring Agency

Since Synergy is collaborating with the 18th Judicial District, they have created a release of information form for the referring agency, which allows Synergy to provide reports to officers and case managers about clients' attendance/participation and any other important information. A final report that summarizes client compliance, participation, UA results, and treatment recommendations is also submitted to the probation officer or referring agency.

PROGRAM OUTCOMES

According to program documents, program developers expected the following outcomes:

- ❑ Develop and implement a quality treatment program that allows access for increased numbers of clients with significant marijuana use who otherwise would not;
- ❑ Reduce marijuana use and thus the potential for family, physical and mental health, academic, social and behavioral problems;
- ❑ Reduce criminal recidivism;
- ❑ Identify the appropriate clients for this treatment modality, assess the nature of each youth's substance abuse problem and provide recommendation for further substance abuse treatment and other relevant services such as health care and family therapy.

This program prepared a very specific implementation plan. This is presented below.

YEAR 1:

1. Hire two therapists by August 15, 2003.
2. Provide training in the therapy model by September 1, 2003.
3. By July 31, 2003, purchase and/or develop training session materials.
4. By July 31, 2003, develop, negotiate and sign memorandum of understanding with the 18th Judicial District probation department regarding roles, expected service provision, protocols, confidentiality, reporting/tracking urinalysis, and criminal behavior.
5. By August 30, 2003, conduct stakeholder orientation sessions; provide referral protocols.

6. By September 1, 2003, begin screening and accepting admissions, contact clients/families, begin session series.
7. Starting by September 30 and throughout the first year, each of the two therapists will conduct, ongoing, two separate weekly groups of therapy with the adolescents (staggered to have a new sessions starting at the beginning of every month to accommodate new admissions). Each group will last for eight weeks at a time and each group will be preceded by 2-3 individual evaluation/motivational sessions with each participant.
8. Starting by September 30 and throughout the first year, each therapist will consistently conduct two separate parents groups, with staggered starts for eight weeks (parallel to the adolescents groups). Each session is one time per week for eight weeks.
9. Admit 100 clients to the treatment during the first year.
10. Demonstrate a rate of 80 percent client attendance at the 8 sessions during the first year.
11. Demonstrate parent participation at a rate of 80 percent attendance at 8 sessions aimed at improving family communication, during the first year.
12. Reduce marijuana use as demonstrated by “clean” urinalysis at last session for 80 of the clients and also criminal behavior as indicated by the juvenile justice information system (ICON), during the first year.
13. Quarterly progress reports will be submitted to the Division of Criminal Justice.
14. An evaluation report addressing those components specified in the evaluation section of this grant application will be submitted to the Division of Criminal Justice by September 30, 2003.

Source: Colorado Division of Criminal Justice Drug Control & Systems Improvement Program 2003 Application.

YEAR 2:

1. During the second year, July 1, 2004-June 30, 2005, a new eight week treatment course will begin every month. Treatment begins with an intake session that is attended by the adolescent and at least one parent, followed by 2 MET individual sessions, and then 5 weekly CBT group therapy sessions.
2. During the second year, each therapist will consistently conduct two individual, one and one half hour family sessions for each family.
3. Admit another 96 clients to the treatment during the first year.
4. Demonstrate a rate of 80 percent client attendance at the eight sessions during the first year.
5. Demonstrate parent participation at a rate of 80 percent attendance at eight sessions aimed at improving family communication, during the first year.
6. Reduce marijuana use as demonstrated by “clean” urinalysis at last session for 80 of the clients and also criminal behavior as indicated by the juvenile justice information system (ICON), during the first year.
7. Quarterly progress reports will be submitted to the Division of Criminal Justice.
8. An evaluation report addressing those components specified in the evaluation section of this grant application will be submitted to the Division of Criminal Justice by September 30, 2005.

Source: Colorado Division of Criminal Justice Drug Control & Systems Improvement Program 2004 Application.

RESEARCH FINDINGS

Referrals

- ❑ In the 1st year of funding, 97 clients were referred to the program, and 91 clients enrolled in treatment.

- After intake, 5 individuals were no longer available to start the program due to arrest and placement in day treatment, having their case dropped, or an unexpected move out of state.
- Intake data were available on 91 clients, and outcome data on 89 clients (as two clients enrolled at the end of the year, no outcome data were available for them yet).
- For the 2nd year, 139 clients were referred and 125 clients enrolled. Most of the clients were served at the Aurora location, and 40 were served in Littleton.
 - Twelve clients dropped out of the program before they began their treatment sessions.
 - Four people were admitted into the aftercare component of the program, Level I.
 - Intake data are available on 117 clients, and outcome data on 107 clients.

Table 14: Referrals/Enrollment for the Marijuana Treatment Program for Adolescent Probationers

	Year 1	Year 2
Referred Clients	97	91
Enrolled Clients	139	125

Source: Data obtained from the subgrantee's application, quarterly and final reports.

Table 15: Referral Sources for the Clients at the Marijuana Treatment Program for Adolescent Probationers

Referral Sources	Year 1	Year 2
18 th JD Juvenile Probation Department	72%	75%
17 th JD Juvenile Probation Department	-	1%
Pre-trial Services	17%	18%
Foote Detention Center	11%	6%
TOTAL	100%	100%

Source: Data obtained from the subgrantee's application, quarterly and final reports.

Staff

- Clinicians were extensively trained in MET/CBT therapy as well as in the Cannabis Youth Treatment Series.
- Clinicians were available for two full days a week at the two probation sites.
- Each case was discussed during weekly supervision sessions and careful consideration was given to the formal treatment recommendations.
- The supervisor reviewed all the clinical documentation.
- Monthly project meetings were held with probation.

Age

- During both years of funding, the average age of clients was 16 years old.

Table 16: Age of the Clients at the Marijuana Treatment Program for Adolescent Probationers

	Year 1		Year 2	
	Frequency	%	Frequency	%
12	-	-	2	1.6
13	2	2.2	1	0.8
14	9	10.1	12	9.6
15	17	19.1	20	16.0
16	22	24.7	34	27.2
17	21	23.6	36	28.8
18	18	20.2	20	16.0
TOTAL	89	100	125	100

Source: Data obtained from the subgrantee's application, quarterly and final reports.

Gender

- During the first year of funding, 90 percent of the clients were male. In the 2nd year of funding, the female population increased slightly from 10 to 15 percent. Commensurately, males decreased from 90 to 85 percent.

Table 17: Gender of the Clients at the Marijuana Treatment Program for Adolescent Probationers

	Year 1		Year 2	
	<i>Frequency</i>	<i>%</i>	<i>Frequency</i>	<i>%</i>
Male	80	89.9	106	84.8
Female	9	10.1	19	15.2
TOTAL	89	100	125	100

Source: Data obtained from the subgrantee's application, quarterly and final reports.

Race/Ethnicity

- During both years of funding, Caucasians made up over 50 percent of the client population. During the 2nd year, the Hispanic population slightly decreased, while the African American population almost doubled.

Table 18: Race/Ethnicity of the Clients at the Marijuana Treatment Program for Adolescent Probationers

	Year 1		Year 2	
	<i>Frequency</i>	<i>%</i>	<i>Frequency</i>	<i>%</i>
Caucasian	47	52.8	61	48.8
Hispanic	19	21.3	19	15.2
African American	17	19.1	44	35.2
Asian	2	2.2	1	0.8
Other	4	4.5	-	-
TOTAL	89	100	125	100

Source: Data obtained from the subgrantee's application, quarterly and final reports.

Attendance/Retention

- In order for clients to meet the attendance/retention goal, they needed to attend 6 out of 8 sessions required (intake and functional analysis session, 2 individual MET sessions, and 5 CBT sessions).
 - During the first year of funding, 80 percent of the clients attended intake plus the five out of the seven sessions. Sixty percent of the clients had perfect attendance.
 - Over three-quarters of the clients completed the necessary 6 out of 8 sessions in the second year, and just over half of the clients had perfect attendance.

Table 19: Attendance of the Clients at the Marijuana Treatment Program for Adolescent Probationers

	Year 1	Year 2
Attended 6 out of the 8 Sessions	79.7%	77.6%
Perfect Attendance	60.7%	55.1%

Source: Data obtained from the subgrantee's application, quarterly and final reports.

Table 20: Discharge Information of the Clients at the Marijuana Treatment Program for Adolescent Probationers

	Year 1	Year 2
Successful	67%	77.6%
Unsuccessful	33%	22.4%
TOTAL	100%	100%

Source: Data obtained from the subgrantee's application, quarterly and final reports.

- For both years, the most frequent reason for discharge other than program completion was treatment non-compliance.

Table 21: Reasons for Discharge of the Clients at the Marijuana Treatment Program for Adolescent Probationers

	Year 1	Year 2
Completed the Program	67%	68.1%
Non-Compliance	23%	20.2%
Re-Arrest	7%	3.4%
Severe Substance Abuse	-	5.0%
Severe Mental Health	3%	0.8%
Behavioral Problems	-	1.7%
Family Relocated	-	0.8%
TOTAL	100%	100%

Source: Data obtained from the subgrantee's application, quarterly and final reports.

Average Number of Days in Treatment

- The average number of days in treatment for the first year was 40 days. This number increased to 54 days in treatment for the second year of funding.
 - The program run at the Foote Detention Center was completed in a shorter time frame of 23 days in order to reach everyone before their status changed, they were released, or they were moved to another facility.

Family Involvement

- For those clients at the Foote Center, there was no family involvement as the clients were in the custody of the state. However, information packets were sent to their families, and families were invited to contact the client's therapist for further information.
- Parents of clients that were 18 years old and participating in the program did not have to participate in the family sessions since they were considered to be legal adults. However, 2 out of the 18 such clients in the first year did have family involvement.
- During the first year of funding, 79 percent of the parents of non-Foote clients between the ages of 13 and 17 participated in the educational family counseling sessions. Parental participation decreased the following year, with two-thirds of clients' parents attending the family sessions.
- The program found that many families participate only in the first family session, so combining the entire program content into one long family session was considered.
- The program found that parental involvement was crucial to successful treatment. During the second year 84 percent of the clients who successfully completed the program had parental participation in the family sessions. This validated the emphasis placed on family involvement.

Table 22: Parental Participation of the Clients at the Marijuana Treatment Program for Adolescent Probationers

	Year 1	Year 2
0 Sessions	21.0%	32.7%
1 Session	58.0%	30.8%
2+ Sessions	21.0%	35.5%
TOTAL	100%	100%

Source: Data obtained from the subgrantee's application, quarterly and final reports.

UAs

- Clients who participated at the Foote Center were not required to give UAs since they were incarcerated.

- ❑ In the first year, 169 UAs were collected from the non-Foote participants. Seventy-three percent were negative for all substances, 22 percent were positive for marijuana only, 2 percent were positive for marijuana and another substance, and 3 percent were positive for a substance other than marijuana.
- ❑ During the second year, 217 UAs were collected from the non-Foote participants, resulting in 51 percent negative for all substances, 34 percent positive for marijuana only, 3 percent positive for marijuana and another substance, and 1 percent positive for a substance other than marijuana.

Table 23: UA Results of the Clients at the Marijuana Treatment Program for Adolescent Probationers

	Year 1	Year 2
Negative for All Substances	73.0%	50.5%
Positive for Marijuana Only	22.0%	34.0%
Positive for Marijuana & Another Substance	2.0	2.8%
Positive for Another Substance Other than Marijuana	3.0%	1.1%
TOTAL	100%	100%

Source: Data obtained from the subgrantee's application, quarterly and final reports.

Recidivism:

- ❑ The Integrated Colorado Online Network (ICON) was used to gather some recidivism data. However, recidivism data was available for only 87 percent of the clients served in the first year and 60 percent of the clients for the following year.
 - Seventy seven percent of the clients whose data regarding re-offense was available in the first year had no further charges. The other 23 percent did have new charges, the majority of which were for non-violent crimes. No comparison group data were provided.
 - In the second year, 86 percent of the clients who had data regarding re-offense available had no further legal charges in the 2 months after discharge from the program. Only 14 percent did have further charges, mainly for non-violent or drug offenses. No comparison group data were provided.

Table 24: Recidivism of Clients at the Marijuana Treatment Program for Adolescent Probationers Two Months Post-Discharge.

	Year 1		Year 2	
	<i>Frequency</i>	<i>%</i>	<i>Frequency</i>	<i>%</i>
No offense	59	76.6	61	85.9
Drug/Alcohol Ticket	2	2.6	2	2.8
Possession Charge	-	-	2	2.8
Drug & Non-Violent	1	1.3	-	-
Non-Violent	15	19.5	4	5.6
Violent	-	-	2	2.8
TOTAL	77	100	71	100

Source: Data obtained from the subgrantee's application, quarterly and final reports.

Additional Services

- ❑ Clients who were enrolled in this program benefited from professional assessments that determined additional needs and services that go beyond the scope of what this program provides. Given the prevalence of co-occurring psychosocial factors in correlation to substance abuse, it was not surprising that 55 percent in the first year and 75.5 percent of the clients in the second year were referred for additional services upon discharge.
- ❑ After the first year of program implementation, stakeholders gave the feedback that one of the most valuable aspects of the program was the professional assessment of the

severity of the substance abuse problem of each client as well as assessment of and recommendation for other types of needed services.

Table 25: Additional Services for the Clients at the Marijuana Treatment Program for Adolescent Probationers

	Year 1		Year 2	
	<i>Frequency</i>	<i>%</i>	<i>Frequency</i>	<i>%</i>
Substance Abuse	35	71.4	43	47.8
Mental Health	5	10.2	6	6.7
Family Therapy	1	2.0	2	2.2
Substance Abuse & Mental Health	5	10.2	18	20.0
Substance Abuse & Family Therapy	3	6.1	21	23.3
TOTAL	49	99.9	90	100

Source: Data obtained from the subgrantee's application, quarterly and final reports.

Level I Aftercare

- This group was added during the second year of funding. It was offered to those who were leaving the program and were assessed for needing Level I treatment, and who would also benefit from some additional individual treatment and/or family support.
 - Four individuals participated in the Level I aftercare component.
 - Two participated at the Aurora probation site while the other two participated at the Littleton probation site.
 - Three of these clients were initially referred to this program by the 18th JD Juvenile Probation Department and the other was from a diversion program.
 - Half of these participants were males.
 - All four of the youth showed signs of depression on the CARROLL, which was given to them at intake. This demonstrated their need for individual support.
 - Two of the youth were clean at discharge, another was clean and then relapsed, and the final youth continued to use at a high frequency throughout the duration of treatment and was referred for a higher level of substance abuse treatment.

Program Modifications

- At the end of the first year, the program found that they were prepared to serve more clients than were being referred. Program administrators determined that low enrollment was due to transportation. The program was then made available at two additional sites: Aurora Probation and the Foote Detention Center.
- Transportation was again identified as an obstacle for treatment participation during the second year of funding, this time for probationers in Centennial. As a result, the program started providing services at the Justice Center in Centennial.
- In the second half of the second year of funding, families were required to pay a small co-payment, moving the program towards self-sufficiency.

Additional Programmatic Impacts

- After two years, the program brought together the restorative justice program and the treatment programs. These programs are now aligned toward the same goal, providing clients with treatment that works in order to prevent them from being further involved in the juvenile justice system.
- This program costs the same per week as a regular outpatient program (approximately \$600/mth) but it is shorter and thus the entire treatment episode costs less and the program can accommodate more clients over time.

- This program can use money from Synergy Signal Behavioral Health/Alcohol and Drug Abuse Division and Offender Services fund in cases where more intensive levels of substance abuse treatment is needed.

ORS COMMENTARY

The University of Colorado Health Sciences Center Marijuana Treatment Program for Adolescent Probationers was utilizing “best practice” treatment methods for cannabis abuse in adopting the Cannabis Youth Treatment Series. This program is based on Motivational Enhancement Therapy (MET)/Cognitive Behavioral Therapy (CBT).

As originally intended, the program worked in collaboration with the 18th judicial district. This relationship proved to be beneficial, with over 70 percent of the referrals to treatment coming from this judicial district. Additionally, groups were offered at two of the district’s probation offices, which has been accommodating to the youth and their parents. Recidivism data was available for more than half of the clients through the use of the Judicial Department’s Integrated Colorado Online Network (ICON). The available data regarding reoffense indicated that over 75 percent of the clients had no further legal charges.

For the first year of funding, the program’s goal was to admit 100 clients to treatment. Ninety-one clients entered treatment that year. The next year the program lowered this goal with the hope of admitting 96 new clients. That year they surpassed the goal by enrolling 125 new clients. During those two years, over 80 percent of the clients in the program were male. According to program documentation, the services provided to the youth were the same regardless of their gender. There was no evidence of gender-specific services being offered to the female population at this program. All clients were required to attend the same treatment sessions.

In order to discharge successfully from the program, a client needed to attend 6 out of 8 sessions. In the first year, 80 percent of the clients met the goal of attending the 6 out of the 8 sessions, but this percent fell slightly in the second year. There was no explanation for the decrease in the second year.

A new treatment component, Level I Aftercare, was added in the second year of funding. This new service was developed for youth who are leaving the program but need additional individual and family support. After reviewing all the program documentation, there was no explanation regarding why this group was added. However, there was outcome data regarding the four clients who participated in this group in its first year of implementation.

Parental participation was an important treatment component of this program. Parents were asked to participate in two family sessions. The program hoped to have an attendance rate of 80 percent. According to the data provided by the program, in the first year 79 percent of the parents attend one or more of the educational family counseling sessions. Parental participation decreased the following year, with only two thirds of the client’s parents attending the family sessions. In year two, 84 percent of the clients who successfully completed the program had parental participation in the family sessions. This validated the emphasis placed on family involvement by the program.

One of the programmatic goals was to reduce marijuana use as demonstrated by a “clean” urinalysis at the last session for 80 of the clients. Data regarding the client’s last session was not available in the program documentation. However, the data provided indicated 169 UAs were collected, which 73 percent negative for all substances in the first year. The next year more UAs

were collected, but the percentage of clean UAs dropped to 50 percent, while the number of positive UAs for marijuana rose. Again, there was no explanation for these changes.

The University of Colorado Health Sciences Center Marijuana Treatment Program for Adolescent Probationers did a very good job with their quarterly and final reports. In these reports, the program provided a level of detail and data that has not been seen in the other three substance abuse treatment programs assessed. These reports should be used as an example of what type of information should be included in the quarterly and final reports.

SOUTHERN UTE-IGNACIO MULTI-SYSTEMATIC TREATMENT PROGRAM

PROGRAM PROBLEM STATEMENT

Ignacio, Colorado is a relatively small tribal community that was experiencing drug and alcohol problems with their adolescent population.

Levels of binge drinking among Ignacio youth are significantly above those in other surveyed communities: 18.3 percent of students statewide vs. 28.3 percent of Ignacio students.

According to the 1999 Colorado Youth Survey, Ignacio youth had higher levels of alcohol and substance abuse than comparable communities. For example, 28.3 percent of students (grades 6-12) in all surveyed communities had used alcohol in the previous 30 days, while the rate in Ignacio was 38.7 percent. Across the state, 12.5 percent of students reported marijuana use within the last 30 days, compared with 27.7 percent of Ignacio students. Levels of binge drinking among Ignacio youth were significantly above those in other surveyed communities: 18.3 percent of students statewide vs. 28.3 percent of Ignacio students.

In 1998, the Southern Ute Police Department reported that 49 youth were referred to protective custody for underage drinking, three cases went to juvenile court for liquor law violations, three for underage consumption, five for assaults, and six arrests were made for disorderly conduct related to underage drinking. Also, the Southern Ute Tribal Court reported that of the 107 juvenile charges filed, 59 percent were for drug and alcohol offenses while the other 41 percent were for violent offenses.

The Colorado Youth Survey demonstrated that family members with a history of substance abuse and anti-social behaviors influence youth in the home. However, family also plays an important role in getting these youth help. Unfortunately, if they see their parents or family members using drugs or drinking heavily this will defeat the message for substance abuse counseling.

Substance abuse treatment availability in Ignacio has been very limited. Outpatient counseling has always been available to the Indian teens, but at a relatively low intensity, only one to two counseling sessions per week. In the case of the non-Indian teens, they have to travel 24 miles to Durango for intensive outpatient treatment.

This community identified two important issues: alcohol/alcoholism and family dysfunction as suggested by domestic violence and drug and alcohol abuse. For this reason, the applicants intended to implement a Multi-Systemic Therapy (MST) program.

PROGRAM DESCRIPTION

MST is an intensive family and community based treatment that addresses multiple determinants of serious antisocial behavior in juvenile offenders.³ The MST approach views youth as individuals living and acting within a complex network of interconnected systems: family, peer, school, neighborhoods, etc. Intervention may be necessary in any one or a combination of these interconnected systems. Interventions are intended to improve caregiver discipline practices, enhance family affective relations, decrease youth association with deviant peers, increase youth association with prosocial peers, improve youth school or vocational performance, engage youth

³ Multisystemic Therapy available at <http://www.mstservices.com/>.

in prosocial recreational outlets, and develop an indigenous support network of extended family, neighbors, and friends to help caregivers achieve and maintain.⁴

The MST program takes approximately four months to complete, and during this time there are multiple therapist family contacts each week. Participants will undergo some cognitive behavioral, behavioral, and pragmatic family therapies. Also, a treatment plan is designed in collaboration with the youth and their family. All of these services are delivered in the youth's natural environment (i.e. home, school, community).

The Southern Ute program has established a MST treatment modality for adolescent substance abuse. This MST program, unlike traditional MST programming, will take five months rather than four to complete. This is the first application of MST with a Native American population. Clients that are seen as inappropriate for this program include adolescents who are actively suicidal, homicidal, or psychotic, or have been referred for a sex offense.

PROGRAM OUTCOMES

According to program documentation, the program is expecting the following outcomes:

- ❑ Improved parenting skills in caregiver family members;
- ❑ Increased cohesion and involvement with the teen among family members;
- ❑ Reduced contact among deviant peers;
- ❑ Increased contact among pro social peers;
- ❑ Increased attendance and improve achievement at school/work;
- ❑ Increased participation in positive leisure activities;
- ❑ Improved relations between family, the social environment, and the community; and
- ❑ Increased capacity for problem solving among family members.

Although the outcomes are very specific, the applicant did not indicate what they would use for measures.

Although they are very specific, the applicant did not indicate what would be used to measure these outcomes.

This program prepared a very specific implementation plan that is presented below.

YEAR 1:

1. Secure at least six collaborative memoranda of agreement with organizations and agencies that will have some significant responsibility or jurisdiction for adjudicated youth by the end of July 2000. These agreements would confirm that Peaceful Spirit would "take the lead" in clinical decisions in cases assigned to the MST program.
2. Establish on-call procedures and criteria by July 31, 2000. Purchase cell phones by July 31.
3. Hire two MST therapists (M.A. level) and hire or assign clinical supervision and administrative assistant duties by August 31, 2000.
4. Staff (MST therapists and clinical supervisor) receive, complete and are certified in the MST program (5-day program) by September 15, 2000.

⁴ Multisystemic Therapy available at <http://www.mstservices.com/>.

5. Establish record-keeping system that includes MST approved “instrument” to track case histories, assure program quality, measure outcomes and make decisions by August 31, 2000.
6. Establish regular schedule of clinical supervision by September 15, 2000.
7. Maintain referral agreements with Southern Ute Tribal Court, Ignacio Municipal Court, and the 6th Judicial District probation department. These agreements will include mechanisms for accountability. On-going.
8. Enroll 10 juveniles and their families as the initial caseload by September 30, 2000.
9. Maintain an average caseload of 10 through June 30, 2001.
10. Maintain requirements that all MST therapists and staff participate in initial 5-day training, weekly clinical consultation with MST services, quarterly booster training.
11. Hold weekly supervision sessions that guide MST therapists in conceptualizing cases in multi-systemic terms, setting treatment priorities, identifying obstacles to success, and designing interventions to navigate those obstacles. On-going.
12. Ensure that MST therapists are accessible at times convenient to clients and in times of crisis, very quickly. On-going.
13. Hold weekly telephone consultations with MST treatment services. On-going.
14. Maintain caseloads not exceeding 6 families per therapist. On-going.
15. Track progress and outcomes on all cases, complete all case paperwork weekly.
16. Maintain 24 hours a day, 7 days a week an on-call system to provide coverage when MST therapists are on vacation or taking personal time, staffed by therapists who know the details of each case and understand MST. On-going.
17. Maintain collaborative relationships with other allied organizations and agencies through the Community Treatment Team which allow MST therapists to “take the lead” for clinical decisions on each case. On-going.
18. Screen out inappropriate referrals to the MST program (actively suicidal, homicidal or psychotic and youth referred for sex offenses).
19. Maintain program discharge criteria based on outcomes and which ameliorate the referral problem/behavior. On-going.
20. Employ outcome-focused personnel evaluation methods. On-going.
21. Utilize MST treatment session logs to track direct contact by MST therapists with youth and family, and indirect contact (school, employer, peer). These logs specify frequency and duration of contact, system addressed (e.g., marital, family, peer, etc.), problem areas within each system addressed, homework assigned and completed. On-going.
22. Utilize audio-taped treatment sessions with youth and families as a supervisory/quality control tool. On-going.
23. Utilize the MST Services Therapist Adherence Measure quarterly with all cases.
24. Utilize Family Information form. On-going.
25. Utilize the MST Supervisor Adherence Measure quarterly (a questionnaire completed by MST therapists)
26. Utilize the Family Information Follow-Up Questionnaire with all families at discharge.
27. Of 30 cases enrolled, 24 will complete treatment by September 30, 2002.
28. Of 30 cases, 75 percent will meet performance standards in the following areas at completion of treatment and at follow-up intervals (6,12,18 months): safety (abuse and neglect reports; at home (placements out of home; out of trouble with the law (arrests); and in school (truancy and expulsion records)
29. Case outcomes will meet MST standards. On-going.

Source: Colorado Division of Criminal Justice Drug Control & Systems Improvement Program 2000 Application.

YEAR 2:

1. Maintain referral agreements with Southern Ute Tribal Court, Ignacio Municipal Court, and the 6th Judicial District probation department. These agreements will include mechanisms for accountability. On-going.
2. Enroll 2-3 new clients per month (on the average) for the total of 30 by September 30, 2002.
3. Maintain an average caseload of 10 through September 30, 2002.
4. Maintain requirements that all MST therapists and staff participate in initial 5-day training, weekly clinical consultation with MST services, quarterly booster training.
5. Hold weekly supervision sessions which guide MST therapist in conceptualizing cases in multi-systemic terms, setting treatment priorities, identifying obstacles to success, and designing interventions to navigate those obstacles. On-going.
6. Ensure that MST therapists are accessible at times convenient to clients and in times of crisis, very quickly. On-going.
7. Hold weekly telephone consultations with MST treatment services. (52 sessions, on-going).
8. Maintain caseloads not exceeding 6 families per therapist. On-going.
9. Track progress and outcomes on all cases, complete all case paperwork weekly. Paperwork completion is monitored by MST supervisor with assistance from the Administrative Assistant. On-going.
10. Maintain 24 hours a day, 7 days a week an on-call system to provide coverage when MST therapist are on vacation or taking personal time, staffed by therapists who know the details of each case and understand MST. On-going.
11. Maintain collaborative relationships with other allied organizations and agencies through the Community Treatment Team which allow MST therapists to “take the lead” for clinical decisions on each case. On-going.
12. Screen out inappropriate referrals to the MST program (actively suicidal, homicidal or psychotic and youth referred for sex offenses).
13. Maintain program discharge criteria based on outcomes and which ameliorate the referral problem/behavior. On-going.
14. Employ outcome-focused personnel evaluation methods. On-going.
15. Utilize MST treatment session logs to track direct contact by MST therapists with youth and family, and indirect contact (school, employer, peer). These logs specify frequency and duration of contact, system addressed (e.g., marital, family, peer, etc.), problem areas within each system addressed, homework assigned and completed. On-going.
16. Utilize audiotaped treatment sessions with youth and families as a supervisory/quality control tool. On-going.
17. Utilize the MST Services Therapist Adherence Measure quarterly with all cases.
18. Utilize Family Information form. On-going.
19. Utilize the MST Supervisor Adherence Measure quarterly (a questionnaire completed by MST therapists).
20. Utilize the Family Information Follow-Up Questionnaire with all families at discharge.
21. Of 30 cases enrolled, 24 will complete treatment by September 30, 2002.
22. Of 30 cases, 75 percent will meet performance standards in the following areas at completion of treatment and at follow-up intervals (6,12,18 months): safety (abuse and neglect reports; at home (placements out of home; out of trouble with the law (arrests); and in school (truancy and expulsion records)
23. Case outcomes will meet MST standards. On-going.

Source: Colorado Division of Criminal Justice Drug Control & Systems Improvement Program 2001 Application.

YEAR 3:

1. Maintain referral agreements with Southern Ute Tribal Court, Ignacio Municipal Court, and the 6th Judicial District probation department. These agreements will include mechanisms for accountability. On-going.
2. Enroll 2-3 new clients per month (on the average) for the total of 30 by June 30, 2004.
3. Maintain an average caseload of 10 through June 30, 2004. On-going.
4. Maintain requirements that all MST therapists and staff participate in initial 5-day training, weekly clinical consultation with MST services, quarterly booster training. (Current MST therapist have completed initial training and maintained booster training.)
5. Hold weekly supervision sessions which guide MST therapist in conceptualizing cases in multi-systemic terms, setting treatment priorities, identifying obstacles to success, and designing interventions to navigate those obstacles. (52 sessions, on-going time frames).
6. Ensure that MST therapists are accessible at times convenient to clients and in times of crisis, very quickly. On-going.
7. Hold weekly telephone consultations with MST treatment services. (52 sessions, on-going).
8. Maintain caseloads not exceeding 6 families per therapist. On-going.
9. Track progress and outcomes on all cases, complete all case paperwork weekly. Paperwork completion is monitored by MST supervisor with assistance from the Administrative Assistant. On-going.
10. Maintain 24 hours a day, 7 days a week an on-call system to provide coverage when MST therapist are on vacation or taking personal time, staffed by therapists who know the details of each case and understand MST. On-going.
11. Maintain collaborative relationships with other allied organizations and agencies through the Community Treatment Team which allow MST therapists to "take the lead" for clinical decisions on each case. On-going.
12. Screen out inappropriate referrals to the MST program (actively suicidal, homicidal or psychotic and youth referred for sex offenses).
13. Maintain program discharge criteria based on outcomes and which ameliorate the referral problem/behavior. On-going.
14. Employ outcome-focused personnel evaluation methods. On-going.
15. Utilize MST treatment session logs to track direct contact by MST therapists with youth and family, and indirect contact (school, employer, peer). These logs specify frequency and duration of contact, system addressed (e.g., marital, family, peer, etc.), problem areas within each system addressed, homework assigned and completed. (Weekly.)
16. Utilize audio-taped treatment sessions with youth and families as a supervisory/quality control tool. On-going. (A sample session is reviewed every two months.)
17. Utilize the MST Services Therapist Adherence Measure quarterly with all cases.
18. Utilize Family Information form. (30 times during the program year).
19. Utilize the MST Supervisor Adherence Measure quarterly (a questionnaire completed by MST therapists) every two months.
20. Utilize the Family Information Follow-Up Questionnaire with all families at discharge. (At least six per quarter, plus additional times for follow-up at 6,12, and 18 months after client discharge for past clients)
21. Of 30 cases enrolled, 24 will complete treatment by June 30, 2004 (six per quarter).
22. Of 30 cases, 75 percent will meet performance standards in the following areas at completion of treatment and at follow-up intervals (6,12,18 months): safety (no abuse/neglect reports); youth are still at home (reduction in placements out of home); out of trouble with the law (reduction in re-arrests); and in school (reduced truancy and expulsion). This involves verifying information for new clients enrolled in the program year (5 to 6 per quarter), plus additional verification for past clients.

23. Of the 30 cases, 75 percent will show reduction in problem behaviors identified at intake, and meeting overarching goals of the treatment plan developed shortly after intake. Seventy-five percent is a national MST standard.

Source: Colorado Division of Criminal Justice Drug Control & Systems Improvement Program 2003 Application.

YEAR 4:

1. Maintain referral agreements with Southern Ute Tribal Court, Ignacio Municipal Court, and the 6th Judicial District probation department. These agreements will include mechanisms for accountability. On-going.
2. Enroll 2-3 new clients per month (on the average) for the total of 22 new clients between October 1, 2004 and by June 30, 2005.
3. Maintain an average caseload of 10 through June 30, 2005. On-going.
4. Maintain requirements that all MST therapists and staff participate in initial 5-day training, weekly clinical consultation with MST services, quarterly booster training. (Current MST therapist have completed initial training and maintained booster training.)
5. Hold weekly supervision sessions which guide MST therapist in conceptualizing cases in multi-systemic terms, setting treatment priorities, identifying obstacles to success, and designing interventions to navigate those obstacles. (39 sessions, on-going time frames).
6. Ensure that MST therapists are accessible at times convenient to clients and in times of crisis, very quickly. On-going.
7. Hold weekly telephone consultations with MST treatment services. (39 sessions, on-going).
8. Maintain case loads not exceeding 6 families per therapist. On-going.
9. Track progress and outcomes on all cases, complete all case paperwork weekly. Paperwork completion is monitored by MST supervisor with assistance from the Administrative Assistant. On-going.
10. Maintain 24 hours a day, 7 days a week an on-call system to provide coverage when MST therapist are on vacation or taking personal time, staffed by therapists who know the details of each case and understand MST. On-going.
11. Maintain collaborative relationships with other allied organizations and agencies through the Community Treatment Team which allow MST therapists to "take the lead" for clinical decisions on each case. On-going.
12. Screen out inappropriate referrals to the MST program (actively suicidal, homicidal or psychotic and youth referred for sex offenses).
13. Maintain program discharge criteria based on outcomes and which ameliorate the referral problem/behavior. On-going.
14. Employ outcome-focused personnel evaluation methods. On-going.
15. Utilize MST treatment session logs to track direct contact by MST therapists with youth and family, and indirect contact (school, employer, peer). These logs specify frequency and duration of contact, system addressed (e.g., marital, family, peer, etc.), problem areas within each system addressed, homework assigned and completed. (Weekly.)
16. Utilize audio-taped treatment sessions with youth and families as a supervisory/quality control tool. On-going. (A sample session is reviewed every two months.)
17. Utilize the MST Services Therapist Adherence Measure quarterly with all cases.
18. Utilize Family Information form. (22 times during the program year).
19. Utilize the MST Supervisor Adherence Measure quarterly (a questionnaire completed by MST therapists) every two months.
20. Utilize the Family Information Follow-Up Questionnaire with all families at discharge. (At least six per quarter, plus additional times for follow-up at 6,12, and 18 months after client discharge for past clients)

21. Of 22 new cases enrolled, 16 will complete treatment by September 30, 2004 (six per quarter).
22. Of 22 cases, 75 percent will meet performance standards in the following areas at completion of treatment and at follow-up intervals (6,12,18 months): safety (no abuse/neglect reports); youth are still at home (reduction in placements out of home); out of trouble with the law (reduction in re-arrests); and in school (reduced truancy and expulsion). This involves verifying information for new clients enrolled in the program year (5 to 6 per quarter), plus additional verification for past clients.
23. Of the 22 cases, 75 percent will show reduction in problem behaviors identified at intake, and meeting overarching goals of the treatment plan developed shortly after intake. Seventy-five percent is a national MST standard.

Source: Colorado Division of Criminal Justice Drug Control & Systems Improvement Program 2004 Application.

RESEARCH FINDINGS

Caseloads

- The goal was to have caseloads that did not exceed six families per therapist.
 - Over the four years of funding, full time therapists averaged 4-6 families on their caseload. The number of families on each therapist's caseload depended upon which phase of the program each family was in and the number of referrals to the program.

Number of Families Served

- The program was implemented in October 2000, but the first family was not seen until December 2000. For the first year, the program goal was to enroll 10 juveniles and their families. At the end of the first year, 10 families were served, however, one family did not complete treatment.
- Over the next three years, the program was never able to reach their desired goal of serving 30 families each year. This was partly due to referrals.
 - During the second year of funding, the program experienced some funding uncertainty, which prevented the enrollment of additional families. Because of this, the program was not able to reach their desired goal of serving 30 families this year.
 - Referrals were down again during the third year. This time it was due to a therapist leaving during the first quarter. Referrals were put on hold until a new therapist could be hired and trained. Twenty-five families were served this year. Twenty-two of the 25 families were treated successfully. Two were unsuccessful (one was placed in detention and in the other the parent was arrested and contact was lost between the youth and the program). Another youth completed his goals but the parent gave up custody and the youth was placed with a foster parent.
 - In the final year of funding, there were fewer referrals for Ignacio because one therapist resigned and another therapist was gone for a while due to their spouse passing away. Nevertheless, 22 new cases were enrolled in the program. The program hoped to have 16 completed by the end of the grant period.
 - There were always fewer referrals in the summer because school was out.

Table 26: Number of MST Families Served

	Number of Families Served
Year 1	10
Year 2	27
Year 3	25
Year 4	22*

*This number represented the number of families that were enrolled in the program.

Source: Data obtained from the subgrantee's application, quarterly and final reports.

Referral Agreements

- ❑ Referral agreements were created and maintained with the Ignacio Municipal Court, the Southern Ute Tribal Court specifically the Wellness Court component, and the 6th Judicial District Court System mainly Social Services and the Probation Department.

Staff

- ❑ MST therapists were readily available to their clients. They all carry cell phones, so that they can respond to their client within minutes of a call. On-call procedures were always in place. The therapists were familiar with all the families so they could provide on-call coverage whenever needed.
- ❑ The MST program had a longer than average stay for therapists, averaging one year and ranging up to 5 years.

Staff Training

- ❑ All MST staff were trained on the MST modality.
 - New staff attended five days of initial training. In the five day training, they:
 - Familiarized participants with the scope, correlates, and causes of the serious behavior problems addressed with MST;
 - Described the theoretical and empirical underpinnings of the treatment model;
 - Described the family, peer, school, and individual intervention strategies used;
 - Trained participants to conceptualize cases and interventions in terms of the principles of MST; and,
 - Provided participants with practice in designing Multisystemic interventions.
 - The MST team had weekly clinical consultations with MST Services. Here the MST therapists learned to adhere to MST treatment principles, developed solutions to difficult problems, set treatment priorities, identified obstacles to success, and designed interventions for those obstacles.
 - Staff also attended quarterly booster trainings. These boosters provided additional training in identified areas and helped problem-solve difficult cases.

Tracking Treatment Adherence

- ❑ Treatment adherence was tracked through the use of adherence instruments.
 - **Session Logs.** Therapists turned in weekly session logs. These logs were used to track direct contact between the therapist and the youth and their family, indirect contact (school, employers, peers, etc), progress or lack of progress, problem areas, homework assignments, etc.
 - **Audio Tape Treatment Session.** During the second year of the grant, they began to audiotape the treatment sessions with the youth and their families. This was used as a supervisory/quality control tool.

- ***MST Services Therapist Adherence Measures.*** Therapists were asked to complete these forms with the families quarterly. Therapists tried to get the forms done as best they could, but experienced problems such as: unavailability of clients, clients not having phones or their phones being shut off, or families not wanting to talk to the therapist when they called. When these problems arose, the therapist had to track down the client in order to get the form filled out.
- ***MST Supervisor Adherence Measures.*** Therapists were asked to fill out this form every two months.
- ***Family Information Forms.*** These forms were implemented during the second year, and then they were replaced the next year by the new online data tracking system.
- ***Family Information Follow-Up Questionnaire.*** This questionnaire was completed with families at discharge. Then additional follow-ups were done at 6 and 12 months. Forms were done away with during the third year, because the new online data tracking system was able to replace it.

MST Team Taking the Lead

- There have been some challenges along the way, but toward the end of the fourth year of funding MST therapists were allowed to take the lead when making clinical decisions.

Drug of Choice

- Over the four years of funding, the drug of choice for MST families changed from alcohol to methamphetamines. A reduction in drug use was noted in the third year of funding.

Table 27: Primary Drug of Choice for MST Families

	Youth	Parents	Families
Year 1	Alcohol	Cocaine	Unknown
Year 2	Alcohol	Unknown	Alcohol
Year 3	Marijuana	Unknown	Unknown
Year 4	Methamphetamines	Unknown	Unknown

Source: Data obtained from the subgrantee's application, quarterly and final reports.

Record Keeping

- A program goal was to establish a record keeping system that would track case histories, provide quality assurance, and measure program outcomes.
- During the third year of funding, an online system was created to track outcomes. Data were collected at admission and at discharge. The discharge data would be used to determine if the clients' overarching goals had been met.

Success Rate:

- MST programs defined success as attaining and sustaining the overarching goals identified at the onset of treatment by the family and other stakeholders and measured again at the end of treatment. The program goal was to have a 75 percent success rate.
 - The program fell short of this goal during the first year of funding, with a success rate of less than 50 percent. Reasons for this shortfall include:
 - Families were identified as the most challenging families in the community;
 - Parents had multiple issues surrounding drugs and alcohol;
 - Parents were seriously lacking parental skills;

- o Unresolved grief due to the loss of a parent or close relative from drug and alcohol use;
- o Generational historical trauma;
- o The time it took to have a full team of three therapists on board;
- o An MST learning curve;
- o This was the first time that MST was used with a Native American population;
- o Funding issues;
- o Working with families beyond the desired time frame;
- o Lapse in direction from the MST headquarters in Charleston, South Carolina; and
- o Youth were sent to treatment and/or detention before completing the program, due to systems not grasping how the MST model works.
- In the second year of funding, the program surpassed their goal with a 78 percent success rate. They credit this improvement to:
 - o Knowledge and experience;
 - o Collaboration; and
 - o Per agreement, the MST program was allotted the full 5-6 months to work with individuals at risk of out of home placement, which resulted in fewer out of home placements.
- Surpassing the desired program success rate continued in the last two years of funding.

Family Changes

- In the first year of funding, the program found trust was being developed within the families.
- The next year, parents were reporting improvements within the home. However, there was no documentation about how the program measured these improvements.
- Family members and peer support networks were now empowered to guide and support client youth in avoiding involvement in illegal activities, including drug use and to maintain a life orientation to positive activities.

Out of Home Placements

- From the third year, the program reported a reduction in out of home placements.
- MST gained recognition as a viable alternative to sending youth out of the community.

Probation Compliance

- With the implementation of the MST program, probation has reported more compliance with youths' probation requirements and fewer unlawful activities.

Increase in Graduation

- Over the four years of funding, there was an increase in the number of youth completing 12th grade that also participated in the MST program. Data were never provided in the program documentation to demonstrate this increase.

Program Modifications:

- During the 3rd year of funding the MST program expanded into two additional neighboring communities: Durango and Pagosa Springs.

Additional Impacts that MST had on Other Agencies:

- ❑ Southern Ute Social Services Division entered into a contractual agreement with Peaceful Spirit to provide some funding through Core Services (a state program which provides funds which must be requested through social services).
- ❑ The Community Treatment Team was established and continues to meet monthly to conduct multi-agency staffings. Initially, these staffings were held for MST clients only. Other entities, such as Southern Ute Probation, Tribal Court Family Services, and the Housing Authority have initiated their own multi-agency staffings.
- ❑ The agencies in the “system” and others had recently established a community-wide Suicide Prevention Coalition, which focused on specific youth at risk and developed a community awareness campaign.
- ❑ The Southern Ute Justice Center, primarily Southern Ute Police Department officers, asked for MST assistance in coaching Anglo officers in talking to Native American youth over such issues like when to act like a “buddy” and when not to.
- ❑ There have been substantial attitude changes toward the MST approach among court officers, including judges and probation officers. However, no documentation regarding how these changes were measured was provided.

Plans for Future Funding

- ❑ Byrne grants allow for four years of funding, and this was the last year of funding for the Southern Ute-Ignacio MST Program. In order to keep this program going, the Southern Ute needed to secure future non-DCSIP funding. Efforts to do so include:
 - SUCAP, as the delegate agency operating treatment programs for the Southern Ute Indian Tribe, has held numerous dialogues about long-term adolescent treatment program development with the Southern Ute Tribal Council over the past two years. As a result, the MST program is now included in the annual IHS-funded treatment plans approved by Southern Ute Tribal Council.
 - SUCAP has partnered with the 6th Judicial District and two local Social Services departments (La Plata and Archuleta Counties) to share the costs of MST clinical supervision, reducing the cost of Ignacio services.
 - SUCAP will renew efforts to seek Southern Ute Social Services Core Services support for the MST program. This was actually committed in 2002, though set aside with a change in Social Services directors. Given that out-of-home placement can cost as much as \$24,000 and that MST costs about a third of that, with the entire family, peer and community system of the subject adolescent participating in treatment. The original commitment has a good chance of being restored.
 - SUCAP has sought and received Southern Ute Gaming Funds support for MST services related to Southern Ute Tribal Court
 - SUCAP will continue to pursue billing Medicaid for treatment services. Given the current state budget climate, this is somewhat problematic, but not impossible, since in 2002 the Colorado legislature approved and the Governor signed HB 1263, which alters the state Medicaid plan to 100 percent of the cost for treatment services for Native Americans.
 - Working with the new Southern Ute Tribal Health Services Department, which was to take over operations of the Southern Ute Health clinic in 2004, SUCAP will negotiate protocols to bill the department and the tribal resource pool.
 - SUCAP will continue discussions so that MST can be included in tribal department budgets for the 2004-2005 tribal fiscal year and beyond.
 - SUCAP will seek some foundation funding, though it is anticipated that this would comprise only a small portion of the program funding.

- SUCAP will work to generate additional fee-for-service revenue from adult residential treatment programs which can be used for local programs including MST.

ORS COMMENTARY

Southern Ute adopted an established treatment which they adapted for use with a Native American population. As was the first time MST was used with a Native American population, the Byrne funding was used in an important, innovative way.

Over the four years of Byrne funding, the Southern Ute MST program was able to accomplish many of their programmatic goals and objectives. According to program documentation, the correct population of youth was referred to the program. Many of the referrals came from the collaborative agreement that had been worked out with Ignacio Municipal Court, Southern Ute Tribal Court, and the 6th Judicial District. Therapists on average work with 4-6 families at a time. The number of families participating in the program depended upon which phase of the program a family was in or the number of referrals to the program.

The MST therapists were readily available to their clients. All of them carried cell phones so they could respond to their clients within minutes of a call and on-call procedures were always in place. MST therapists remained with the program longer than average, compared to past efforts to deliver programming to Southern Ute youth. They remained with the program an average of one year, and some had been with the agency up to five years. Treatment adherence was initially tracked through the use of several paper instruments. This process changed during the third year when an online system was created. And the program expanded from its original location in Ignacio to include the neighboring communities of Durango and Pagosa Springs. This resulted in the program being able to serve more youth within the 6th Judicial District.

MST is one of the few outcome-based programs that is committed to reaching a 75 percent success rate. The program fell short of this goal during the first year of funding, but program staff were able to point out the many reasons why this occurred. Over the next three years the program surpassed this goal, crediting the increase to knowledge, collaboration, and improved family and individual outcomes. The program observed improvements among families due to better communication between the youth and their families. In addition, the program reported a reduction in out of home placements, probation officers reported better probation compliance, and there has been an increase in the number of youth who have participated in the MST program who are graduating from the 12th grade.

With the Byrne funding terminating at the end of the grant year, the program is currently searching for future funding to continue operating. This program has filled a gap within the community.

Section 5: Summary

Program documentation allowed for a generally positive assessment of these four treatment programs. Many of the projects' objectives were accomplished. For example, Boulder County Integrated Juvenile Substance Abuse Services treatment team has been working collaboratively with external partner agencies: Probation, SMART, JSAT, etc.; 100 percent of the clients at CrossPoints Enhanced and Intensive Outpatient Program remained crime free while in treatment; the University of Colorado Health Sciences Center Marijuana Treatment enrolled 125 new clients during their second year of funding; and the Southern Ute-Ignacio Multi-Systemic Program surpassed the 75 percent success rate during each of their last three years of funding.

Given the substantial substance abuse treatment needs of youth in Colorado, the use of \$1,315,172 to address this specific program area was clearly an excellent use of funding. Specifically, the use of MST with the Southern Ute youth is an example of Byrne funding supporting groundbreaking efforts to improve public safety and the quality of life in Colorado's communities.