TECHNICAL ASSISTANCE REPORT FOR THE ACCESS TO RECOVERY GRANT PROGRAM

TARGETED POPULATIONS: TECHNICAL ASSISTANCE EXAMPLES

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Contents

1. Introduction

During the summer of 2007, the Center for Substance Abuse Treatment in the Substance Abuse and Mental Health Services Administration, (SAMHSA/CSAT) tasked its Access to Recovery (ATR) technical assistance contract, the Performance Management Technical Assistance Coordinating Center (PM TACC), to develop a set of resource materials for incoming second-round ATR grantees. The PM TACC prime contractor, the American Institutes for Research (AIR), and their subcontractor, JBS International, Inc., brought to this product-development task the experiential knowledge rooted in service to CSAT and the ATR Round 1 grantees throughout all phases of the first-round grants-- from the pre-application roll-out of the Presidential initiative, to early implementation and sustained operation of the grant programs, to their eventual close-out. SAMHSA/CSAT's selected topics for the resource materials target key issues, barriers, challenges, and decision points that faced the first-round grantees during each of these phases. They are written from the PM TACC contract's experiences with the 15 grantees that broke new ground for the substance abuse field by demonstrating the feasibility of using a voucher model for providing publicly-funded treatment and recovery services.

Some of the newly developed resource materials modify, update, and consolidate technical assistance (TA) reports emanating from the Round 1 grantees' TA experiences. Other products provide syntheses of the Round 1 grantees' experiences related to various topics central to effective and efficient planning, implementation and management of an ATR grant. CSAT has requested that these reports be made available to Round 2 ATR grantees so that the new cohort may benefit from the experience and work accomplished by the initial ATR grant recipients. Below are lists of the available reports.

SYNTHESES

- Access to Recovery Report: Lessons Learned from Round 1 Grantees' Implementation Experiences
- Administrative Management Models: Compilation of Approaches by Initial Access to Recovery Grantees
- Planning and Implementing a Voucher System for Substance Abuse Treatment and Recovery Support Services: *A Start-Up Guide*
- Setting Up a System for Client Follow-Up
- Recovery Support Services
- Case Management
- Summary and Analysis of Grantee Fraud, Waste, and Abuse Activities

TA CONSOLIDATED REPORTS

- Basics of Forecasting and Managing Access to Recovery Program Expenditures
- Compilation of Technical Assistance Reports on Rate Setting Procedures
- Development of a Paper-based Backup Voucher System
- Financial Management Tools and Options for Managing Expenditures in a Voucher-Based System: Round 1 Grantee Experiences
- Motivational Interviewing: A Counseling Approach for Enhancing Client Engagement, Motivation, and Change
- Outreach to Faith-Based Organizations: Strategic Planning and Implementation

- Strategies for Marketing Access to Recovery to Faith-Based Organizations
- Targeted Populations: Technical Assistance Examples

About this TA Report

This document, *Targeted Populations: Technical Assistance Examples*, addresses the topic of working with specific targeted populations (e.g., children and adolescents, pregnant women, clients involved with the criminal justice system, people with specific racial/ethnic backgrounds such as American Indians). Many ATR programs choose to focus their efforts on such target populations. This document synthesizes information from three TA events requested by Round 1 grantees with respect to work with their targeted populations.

About the ATR Program

ATR is a competitive discretionary grant program funded by SAMHSA that provides vouchers to clients for purchase of substance abuse clinical treatment and Recovery Support Services (RSS). ATR program goals include expanding capacity, supporting client choice, and increasing the array of faith-based and community-based providers for clinical treatment and recovery support services. Key among ATR's goals is providing clients with a choice among qualified providers of clinical treatment and RSS. Under the ATR program, treatment and RSS can be provided by both nonsectarian and faith-based organizations (FBOs).

2. Example 1: Increasing Client Numbers From the Criminal Justice System

- This TA effort was directed towards helping the grantee identify methods of increasing client numbers and services in relation to the criminal justice system.

- Two consultants conducted a review of ATR practices within the grantee State and other States, a review of the literature on ATR programs and client recruitment, and telephone consultation and onsite meetings with several key stakeholders.

- The consultants found that the grantee had previously obtained peer-to-peer TA and taken steps to address the problem (e.g., by modifying eligibility criteria). Nevertheless, the grantee was still experiencing difficulties due to factors such as the need for multiple agencies to coordinate efforts to implement the program and a history of judicial and probation department independence in dictating the services to their offenders.

- The consultants provided numerous recommendations. Suggestions for working within existing parameters included ways to decrease duplication of efforts, improve communication, and address specific concerns across agencies. Suggestions for changing existing parameters included modifying eligibility criteria and having more flexibility in voucher dollar allocations.

A. Overview and Purpose of the Technical Assistance

This ATR program grantee targeted the criminal justice population. The program requested TA to identify methods of increasing client numbers and services in relation to the criminal justice system because its numbers were not meeting the Center for Substance Abuse Treatment (CSAT) targets for the number of clients to be served and the number of services to be provided.

Earlier attempts to increase the number of participants led to the expansion of the program from initially serving drug courts (each very independent and focusing on different populations and services) to also serving probation departments. The expansion of the eligible population to include probationers was viewed as consistent with the grantee's goal of keeping the services dedicated to those in the early stages of criminal justice involvement. Although probationers may have been involved with the criminal justice system in the past, those on probation are typically thought of as being in the front end of the system because, if they fulfill the terms of their probation, they exit the system. However, if they violate the terms, they could end up in prison (i.e., the back end of the criminal justice system). The grantee was geared toward providing services to prevent offenders from going to prison.

Earlier grantee efforts to increase client numbers also included receiving peer-to-peer TA from two other ATR programs. One of these peers was also targeting drug court programs, but was in the early stages of doing so and did not yet have a large population from drug courts. Most of its clients were from the general population. Those coming into the ATR program who were involved with the criminal justice system were coming through treatment programs funded through the Substance Abuse Prevention and Treatment Block Grant, and they received recovery support services through an ATR voucher. The second peer had designed its program around

referrals from a Treatment Alternatives for Safe Communities program, but that referral process had some challenges. Therefore, this peer revised its ATR program to allow providers to identify their own clients who were on probation. This increased the client numbers substantially. The second peer also expanded its service population to include parolees. Finally, the second peer had program coordinators who worked exclusively with those who enroll clients to make sure enrollments were occurring and clients were getting to services. As a result of the peer-to-peer TA, the ATR grantee (1) continued discussions with executive leadership about target client populations and (2) modified existing contracts with assessment providers to add a staff position to serve as a liaison to probation departments, drug courts, and child protective services (CPS) offices to recruit clients.

Despite its prior efforts, the grantee still was not meeting its CSAT targets for the number of clients to be served and the number of services to be provided. Thus, this TA was requested to further assist the grantee in attempting to achieve these goals.

B. Technical Assistance Methodology

The TA involved having two consultants gather information about the grantee's ATR program and provide recommendations for how CSAT targets might be achieved. The consultants conducted a fact-finding review of current ATR practices (within the grantee State as well as other States), a review of the literature on ATR programs and client recruitment, and telephone consultation and onsite meetings with several key stakeholders. Based on this information, the consultants developed recommendations for the grantee.

C. Consultant Assessment

On the basis of the background readings, it was clear that other ATR sites had experienced similar problems, particularly in recruiting clients to participate. Program modifications that led to increased participation in these instances were noted and included as part of discussions during preliminary phone calls and the site visit.

Some of the relevant ATR program conditions identified for the grantee included: (1) a delayed start-up, (2) multiple agencies having to coordinate on many fronts, (3) the inherent problems of coordinating services in a system of strong judiciary control and influence in the county-based system of care, and (4) only 15 months of funding remaining at the time of the TA, with the potential for a 4-month extension.

The inherent strengths of the grantee's ATR program included:

- Competent staff dedicated to seeing the program carried out to the best of their ability.
- Agency directors willing to meet and discuss ongoing and new challenges.
- Leadership committed to implementing and coordinating the ATR program to improve the broad system of care.

Inherent struggles of the grantee's ATR program included the following:

- Multiple agencies (i.e., drug courts, various State health and justice agencies) needed to coordinate efforts to implement the program.
- There was a history of judicial and probation department independence in dictating the services provided to the offenders overseen by their agencies.
- Program sustainability appeared to be lacking. No mechanism appeared to be in place to embed the ATR program into the existing service delivery system or to continue the funding of the program. Therefore, providers were less inclined to hire new staff for the ATR program or to expand the service delivery system.
- Transportation needs were a prominent obstacle for clients to access ATR services. The ATR program did not provide vouchers for transportation, and some communities had little or no public transportation.
- Given the need to start "ramping down," providers were going to need to stop admitting new clients when approximately 6 months remained in the ATR program.
- Assessing and providing medication to clients who had co-occurring addiction disorders and mental illness was difficult.

D. Consultant Recommendations

Recommendations were presented according to two possible frameworks—working within existing parameters versus changing existing parameters.

Working Within Existing Parameters

Within the existing parameters, an increase in the number of ATR program participants would need to be achieved through the current system, which was designed to offer services to those who were participating in a drug court or who were on probation.

1. It appeared that some drug court and probation systems were reluctant to participate actively in the ATR program because of perceived duplication of efforts. For example, at the time of the TA, the State criminal justice department probation division required that probationers who were participating in a State-funded program for chemically dependent offenders (which provided screening, assessment, referral, and treatment placement services) be administered an evaluation instrument developed by the criminal justice department, which was a revised version of the Addiction Severity Index. For probationers in this program who also were eligible for ATR, ATR required that the Government Performance and Results Act (GPRA) baseline assessment be administered. Given the overlap between the two instruments, the perception was that clients were asked the same questions twice in many cases and that this was overly burdensome. The TA consultants offered two possible solutions that could reduce this redundancy. First, the local probation departments and the ATR providers could work

together to develop a single instrument that meets the requirements of both oversight agencies. Second, the two oversight agencies could accept either instrument for their screening purposes, or one agency could accept the other's instrument.

Grantee Response/Status of Recommendation: The ATR program's oversight agency liked the idea of asking the criminal justice department to accept the ATR assessment instrument in lieu of their own. The ATR program's oversight agency also noted that the perceived duplication could be eliminated by having courts and the criminal justice department only refer ATR clients who had not had the criminal justice department's assessment. In addition, this agency noted that many clients who were referred to the ATR program had outdated criminal justice department assessments due to the length of time they had been on the waiting list for that program's services. Therefore, in many cases, a new assessment with the GPRA instrument was clinically indicated for entrance into the ATR program. The ATR oversight agency presented a list of implementation options to the criminal justice department and was anticipating a response at the time of the TA report. Options that received joint concurrence would be implemented.

2. Some judges and probation departments appeared to be reluctant to use the ATR program because of the requirement that ATR clients have a choice over which services and service providers they received via the issued voucher. Judges and probation officers are accustomed to mandating specific services and dictating the level of care, and they expect to be able to continue to do these things. In these situations, it would be helpful if the ATR program director could meet with the appropriate criminal justice department or drug court official and develop a list of ATR service providers that the drug court or probation departments believe are acceptable services for their clients to choose.

   Grantee Response/Status of Recommendation: The ATR program oversight agency concurred with the recommendation to seek court and criminal justice department input on providers, and noted that this practice was already incorporated within its ATR model and local procedures. The agency requested that all drug courts and local probation offices provide a list of preferred providers, and all identified providers were invited to participate in ATR. As new providers are identified, the agency will continue to invite them to participate in ATR. However, the agency did not limit participation to only those providers identified by the courts or the criminal justice department. ATR staff requested clarification from CSAT on whether it would be in compliance with the grant requirements to include and allow client choice among community and faith-based providers, many of whom were not participating as court or probation department providers. ATR program staff noted that, if a potential client's choice was not agreeable to the judge or probation department, the client could be removed from the ATR program and provided services through other State programs.

3. Access to the ATR screening location appeared to be difficult for some potential ATR program participants. One solution that was offered was to have the screening take place within the probation department or drug court location. It was noted that agreements could be modified with assessment providers to serve as liaisons to the

probation department, drug courts, and CPS and to conduct screenings within the county judicial system.

Grantee Response/Status of Recommendation: The grantee concurred with the recommendation to create positions to serve as liaisons to the probation department, drug courts, and CPS and to conduct screenings within the county judicial system where possible. This modification was occurring at the time of the TA report, and the consultants believed it needed to continue. For example, one large urban county was working with its local assessment and referral provider to provide space within its probation location to allow for the screening to occur there. In this way, the probation and ATR functions could be seamless and more transparent to the offenders who participate in the ATR program. At the time of the TA report, agreements had already been executed, and in most counties the liaison position had already been filled. Although the grantee encouraged the assessment provider to conduct assessments on site, not all courts or probation offices were able to provide sufficient space or technological support for this activity.

4. Another way suggested to increase the number of ATR program participants was for the grantee and probation department/drug court staff to continue to improve their collaborative working relationship. The directors of these agencies had already met and begun this process; in addition, support for the ATR program appeared to be gaining momentum at the grassroots level within the probation departments and drug courts. However, some barriers still existed and needed to be overcome, such as apparent misunderstandings as to which ATR providers were available in specific counties.

   Grantee Response/Status of Recommendation: The grantee acknowledged that some courts and probation departments still struggled with how the required components of ATR could be integrated within their existing systems and protocols. Thus, the grantee concurred with the recommendation to continue to work on specific processes, county-by-county, with each court and probation department.

5. Probation departments and drug courts should be encouraged to expand their list of "approved" providers. Some probation departments and drug courts did not appear to want to consider several ATR-approved providers for their clients because the service providers had not received (or applied for) probation department approval. Issues such as reporting treatment compliance back to the courts could be negotiated at the county level.

   Grantee Response/Status of Recommendation: The grantee concurred. Courts and probation departments were being informed that ATR would not limit client choice to only those providers "approved" by the court or the probation department. Reporting treatment compliance back to the courts was required and included as care coordination by the assessment providers.

6. ATR staff members were exerting significant effort to overcome obstacles presented by a few probation departments and drug courts. The consultants suggested that these

efforts might be better invested in expanding efforts where the ATR program was successfully being implemented. For example, it was suggested that, rather than trying to figure out how to increase the use of ATR services by a drug court that rarely uses ATR, staff time might be better spent developing strategies to expand services within drug courts that were actively participating in ATR.

Grantee Response/Status of Recommendation: The grantee noted that courts had an opportunity to reevaluate their participation in ATR when agreement memoranda came due for renewal. The grantee indicated that it would honor commitments made to participating drug courts that wanted to continue their involvement.

7. The TA consultants recommended that the ATR program and oversight agency staff participate in a State-level criminal justice-related advisory council to increase support for the program.

   Grantee Response/Status of Recommendation: ATR staff planned to participate in an upcoming meeting of a State-level criminal justice-related advisory council to discuss the ATR program.

8. It was suggested that providers contract for staff services rather than hire new staff, because only 15 months of funding remained.

   Grantee Response/Status of Recommendation: The grantee concurred that this was an effective strategy and recognized it was a business decision already being made by several assessment providers.

9. The ATR program had begun hiring full-time recruitment coordinators to work at the county level to: (1) assist in the assessment process, (2) work with problem cases, (3) educate the judiciary about the ATR program, and (4) recruit both clients and service providers.

   Grantee Response/Status of Recommendation: The grantee amended agreements with assessment providers to hire a full-time coordinator to work with local courts, probation departments, and CPS offices to recruit new clients. But coordinators were not to assist in the assessment process or work with problem cases.

Changing Existing Parameters

The consultants noted that changes to some of the ATR program's existing parameters might need to be considered.

1. The consultants indicated that, realistically, the only conceivable way the grantee's ATR program could come close to meeting its target numbers was to expand the population being served. While maintaining the intent of providing services to those involved in the front end of the criminal justice system, the ATR program might expand eligibility to those "at risk" for entering or reentering the criminal justice system. For example, individuals who participate in State-funded treatment programs and who have

been involved previously in the criminal justice system and are at risk for reentering the system because of active drug use might be ideal candidates to receive ATR services. In many cases, these individuals meet all of the other eligibility criteria and constitute a large proportion of clients in community-based programs. Changing eligibility in this manner also would allow individuals involved with CPS not currently under court instruction to participate.

Grantee Response/Status of Recommendation: The grantee concurred with expansion consistent with its original intent of serving civil and criminal justice-involved clients. At the time of the TA report, the grantee had a start date in place for modifying its eligibility criteria so that all CPS clients would be eligible to participate in ATR.

2. The consultants suggested that the ATR program consider providing additional flexibility in allocating the dollar amount of vouchers for specific levels of care. It appeared that some clients might not be considered for the ATR program because they would require more services than the ATR program would fund. Given that the program is designed to match level of service to level of need, this design would be more closely achieved if clients who had more severe problems were able to receive more services than clients who present with less severe problems. A fairly simplistic way to achieve this would be to develop criteria from the existing screening instrument that would allow identification of clients who have low, moderate, or high severity of problems. The ATR guidelines could then recommend the level of service to be provided within each severity level (e.g., equating to something like $1,500 per client in the low severity level, $2,500 per client in the moderate severity level, and $3,500 per client in the high severity level). This also would provide an increased likelihood that those who have more severe problems would receive residential services. Control of expenditures could be maintained by having the changes in levels of care monitored by ATR management.

   Grantee Response/Status of Recommendation: The grantee concurred. At the time of the TA report, the ATR program clinical director was going to review the treatment costs for regular State-funded services and recommend revisions to the voucher limits.

E. Consultants' Perceived Outcomes

The problems associated with increasing referrals to the ATR program needed to be addressed at both the State and county levels. For example, the independence of the judiciary in each of the counties involved in the ATR program and its history of unilaterally determining the most appropriate client services often were in conflict with the ATR policy of allowing client choice in selecting services. Staff from both entities needed to continue efforts toward developing lists of approved providers that were mutually acceptable. Also, because ATR staff needed to work closely with the criminal justice department staff in setting policy and resolving philosophical differences in program implementation and oversight, establishing a problem-solving team from both agencies was indicated to assist in addressing program barriers.

In short, the ATR, judicial, and probation department guidelines needed to be a little more flexible, and all of these entities needed to continue their efforts toward improving coordination with each other. By forming "partnerships" with each of these entities, local support for the ATR program was much more likely and obstacles were more likely to be overcome.

During the TA meetings, a number of issues were discussed that appeared to be helpful and, in some cases, represent new information. For example, the criminal justice department indicated that it would be willing to consider waiving use of its assessment instrument in cases where the ATR assessment was being used. This was clearly new information and needed to be followed up on by the ATR staff.

The easiest way to measure the outcomes of this TA would be to see whether any of the recommended changes were implemented and if they resulted in an increase in the number of ATR participants and services. Increases in client referrals might be seen in a relatively short time (within a month); however, it was not reasonable to expect that the increase in referrals would be sufficient to bring the ATR up to its target numbers for Years 1 and 2.

The only conceivable way the grantee's ATR program could realize the targeted numbers was through a substantial change in the eligibility of the population pool. Even if this were to occur, extending eligibility to populations that were not involved in the criminal justice system would require a whole new array of start-up activities, and that change was unlikely to occur within the remaining timeframe of the program funding.

3. Example 2: Increasing Client Numbers Among American Indians

- This TA effort was directed towards helping the program, which targets the American Indian population in a large State, with marketing strategies to help meet its service-activity targets.

- Two consultants engaged in three teleconferences with staff from the ATR program and PM-TACC, reviewed program materials, and conducted a 2-day site visit at the ATR program's headquarters.

- The consultants found that the grantee had been engaging in a multi-pronged effort to expand provider and client enrollment (by contacting all FBOs and transitional housing associations in the State, revising a marketing campaign geared towards family decision-makers, etc.) and appeared to be relatively close to meeting or exceeding its service targets. Nevertheless, they believed new and refined marketing efforts were needed to ensure a continuation of the program's favorable enrollment trend. This was because ATR was not yet firmly established and only a handful of tribes accounted for most program activity.

- The consultants recommended that the grantee continue the various marketing efforts it had initiated. They also suggested that an information campaign aimed at Indian Health Organization (IHO) substance abuse counselors be undertaken, and provided an overview of principles to follow when conducting such a campaign. The consultants did not support the grantee's plan to expand the use of retail cards as a way to provide RSS.

A. Overview and Purpose of the Technical Assistance

This ATR program targeted the American Indian population in a large State. The goal of the program was to increase the capacity to address alcohol and other drug dependency issues within the American Indian communities in the State by expanding resources for treatment and facilitating client access to care. The goal of this TA request was to help ATR program staff and stakeholders explore, evaluate, and refine marketing strategies for the ATR program to help it meet its service-activity targets.

The grantee's efforts to extend ATR services to American Indian tribes in the State were consistent with its mission: to create resources for the tribes so they could provide quality health care services to American Indians within the State, and to ensure that the tribes that endorsed the ATR proposal were allowed the opportunity to participate. The grantee, via a multi-tribe advisory council, has an extensive reach to the State's American Indian population. Multiple IHOs in the State actively participate in the ATR program. Some IHOs have a greater fiscal and clinical infrastructure and therefore are able to participate more vigorously than the smaller programs; all tribal providers, however, are guaranteed equal access.

The grantee's relationships with tribes, IHOs, and substance-abuse providers, for a number of reasons, are not especially conducive to the rapid rollout of new services and purchasing methods. The grantee does not have the formal authority to make public policy, enforce regulations, purchase services, or mandate service participation. Its influence is derived from

its ability to meet the tribes' needs and preferences and depends on it being inclusive, supportive, and facilitative, which takes finesse and time.

The grantee reported start-up problems and pressure to meet its projected goals, which seemed to have created a skewed picture of the actual success that was occurring. The start-up delays that were reported included the funding award being made in August of one year, but funds not becoming available until November of that year. This was combined with delays in the start of the grantee's contract with the firm that was going to manage its ATR program, which had to be delayed to coincide with the ATR award gaining approval from the State's legislature. This combined course of events delayed actual service delivery rollout until late May of the following year. This positioned the grantee to start the project in a deficit mode that would cause it to fall short of its projected goal of persons to be served within the agreed-upon timeline. The TA consultants noted that this grantee's start-up difficulties were not unusual for the typical rollout of new service types and the design of the necessary payment mechanisms.

Trend data at the time of the TA suggested that since full implementation of the project (the prior 10 months), the number of clients was steadily increasing toward meeting or exceeding the projected goals. It also was determined that an inaccurate count of new participants had added to the low enrollment picture. Corrective action related to this inaccurate accounting indicated that the pace for enrolling active clients in the project was only slightly lower than the per-month target that was needed to meet utilization goals. If the increasing utilization trend continues at the same pace, it is possible that the grantee could meet and even exceed the requirements of the grant within a few months of the TA.

B. Technical Assistance Methodology

Two consultants engaged in three pre-site visit telephone conferences with ATR program staff members and staff members from the Performance Management Technical Assistance Coordinating Center. ATR program staff sent the consultants information for their pre-site visit review, including descriptions of the program, marketing materials, and a 2-year client satisfaction survey of service recipients.

The consultants conducted a 2-day site visit at the ATR program's headquarters. On the first day, the consultants met with ATR program staff and stakeholders, including clinical staff and individuals from a consulting firm that was hired by the grantee to design the ATR program, write the initial ATR proposal, develop a marketing plan for the ATR program, and design strategies to help the program meet its numerical service targets. The first day of consultation was devoted to a review of the situation from the grantee's perspective, an explanation by the consulting firm of new marketing strategies and service plans it had developed to help meet the ATR targets, and exploration and discussion of these strategies and plans. On the evening of the first day, the TA consultants met to discuss the potential advantages and disadvantages of these strategies and plans.

On the second day of the site visit, the consultants met with ATR program staff to review ATR service reports and participant trend data, to provide feedback about the advantages and disadvantages of the strategies and plans proposed and discussed on the first day of the TA, and to discuss additional plans and strategies from the consultants' perspective.

C. Grantee Strategies and Consultant Responses

The grantee's position of deficient enrollment activity and subsequent pressure to improve performance had prompted the grantee to create new/revised strategies to rapidly increase the number of participants enrolled in the project.

Option A: Continue with a renewed effort of the original strategies, plans, and activities to expand current enrollment of ATR activities

Prior to the TA, the grantee had begun to revise its provider enrollment policy manual, and this was being followed by TA to all tribes and tribal organizations wishing to participate. The grantee was refreshing its marketing brochures to target families, direct service providers, and leaders within the service organizations. The grantee had developed an "easy to follow" PowerPoint instruction tool and was hoping to commit it to CD if there was sufficient time left in the project. The grantee had formally contacted all faith-based organizations in the State to encourage their involvement. The grantee also had planned to conduct a face-to-face follow-up with associations representing all involved organizations. The ATR project manager was drafting a letter to be used to contact transitional housing associations in the State to encourage them to become a part of the recovery support network, specifically to provide safe, secure, chemically free living environments. The grantee was continuing with monthly/quarterly communications that seemed to be a very effective method for encouraging service organizations to stay abreast of the progress being made with the ATR project.

Consultant Response. It was evident that the grantee had given considerable thought and effort to how to increase enrollment without sacrificing the quality of services offered. This was evidenced in multiple ways, including the following: a recent client satisfaction survey report, a best practices survey that was being completed, implementation of a new communication tool, presentations at State American Indian service provider conferences, expansion of the grantee's advisory committee, recent contact with all faith-based organizations in the State, a plan to add the transitional housing associations in the State, a revision of the provider enrollment manual combined with a renewed effort to invite additional participation and provide TA on how to become active in the project, a refreshed marketing campaign designed to reach family decision-makers and steer them to service providers, counselors in service provider groups detailing for them an easy 1–800 and e-mail contact person to assist with accessing the resources available through the project, and continuing personalized communication with the executive directors of participating organizations along with a report card of the extent of their involvement.

The potential for success of this option was viewed as very positive. The thoughtful evaluation of lessons learned, employing these lessons in more detailed strategic planning, and renewing its efforts as the grantee moves forward with the project appear to be very practical. If consideration for the late start is calculated in, the overall trend line for enrollment of participants and service activity deployed will most definitely meet the stated goals of the project.

Option B: Expanded use of the vouchers and retail cards already used by some IHOs

The grantee reported that some of the more successful programs had employed small denomination ($25) retail cards with local vendors to provide for recovery support needs.

These cards were being tracked by direct service providers via scheduled face-to-face sessions, in which they collected receipts before issuing any additional cards. The grantee reported that this was quite effective and clients were getting necessary support. The downside of this option is that it is very "labor intensive." This option and protocol could be expanded with new and existing programs as a standard of practice; however, the increase in enrollment needed to meet the CSAT target will likely be much slower than desired, given the time left in the project.

Consultant Response. By use of a client satisfaction survey, the grantee had ascertained that the services most requested or utilized were recovery support services. Therefore, the grantee had focused a considerable amount of effort on opening portals of access to these services, which would increase the recovery support options and numbers of clients being enrolled in the project. This appeared to be an effective method for increasing enrollment to accessing recovery support services; as stated earlier, however, it may not be the most effective way to build volume/momentum in the short period of time left in the project. Nevertheless, this option would address the greatest/most pressing relapse stressors that participants were reporting.

D. Suggested Improvements, Refinements, and a Media Campaign

Even though the grantee's penetration trend is encouraging, staff believed that new and refined marketing efforts were needed. The consultants concurred. ATR services were new and not firmly established, and only a handful of tribes accounted for most of the activity. It was possible that these tribes would continue to identify ATR service recipients at increasing rates. On the other hand, it also was possible that ATR activity would level off. Consequently, without expanded efforts, the grantee's encouraging trend line could flatten. Apart from concerns about meeting overall numerical goals, ATR would be a valuable resource for all tribes, and this alone justifies the grantee's expanded efforts to increase utilization across its network. Also, regardless of the eventual fate of ATR funding, such marketing efforts are valuable in their own right because they strengthen the grantee's referral relationships, a benefit that transcends ATR. In addition to those items described in Option A above, the TA consultants reviewed additional ATR marketing strategies presented by grantee staff. The opportunities are outlined below.

Two Elements of Best Practice. The IHOs with the greatest ATR utilization had two common elements: involvement of the executive directors and assignment of a lead staff member coordinating ATR efforts. The grantee will communicate these best practices to other IHOs.

Criminal Justice Referrals. The grantee's ATR director has met with criminal justice officials who identified post-incarceration transitional/recovery housing as a critical need for the ATR program's target population, which is transitioning from incarceration to the community. In addition, other ATR-funded services would be helpful to this group. Continued efforts with criminal justice gatekeepers could open important access points for the grantee.

Transitional/Recovery Housing Providers. The grantee's ATR funds could be important to State providers of transitional/recovery housing as a source of funding accompanying ATR clients. The grantee intends to approach these providers, perhaps through their association.

Substance Abuse Counselors Within the State's American Indian Provider Network. These substance abuse counselors may be the largest single group capable of referring clients for

ATR. It is reasonable to assume that many of the clients of these counselors could benefit from recovery support services, and ATR can provide access to these services without the counselors losing these clients.

Using a Carefully Coordinated Information Campaign and Technical Assistance. The grantee has already used information campaigns successfully, as evidenced by its successful utilization trend. By expanding its scope and narrowing its messages to its target audiences, the grantee could achieve even greater results. The TA consultants presented some of the principles of such campaigns for marketing. This led to grantee staff indicating a need for specialized, additional TA along these lines, and the consultants concur that such assistance may be helpful. However, the availability and timeliness of such support is uncertain, and the grantee's commendable action orientation and urgency is such that it will not await TA to move forward. Consequently, the grantee asked the consultants to outline the principles of such a campaign for immediate application. The bullet points below present these principles.

- Identify the dynamics of the purchasing decision(s) and identify a single call to action that solves the problem of the referral agent.

  An effective call to action presents a single step that is clear, easy, and solves a problem of the person who is called upon to take the action. The call to action must appeal to the needs and preferences of those receiving it. Consequently, if time and resources permit, focus groups and similar methods of obtaining a better understanding of the frame of reference of target groups can help.

  From the discussions during the onsite TA and ATR's experience in other States, it seems that substance abuse counselors within the American Indian provider network could play a part in helping clients obtain ATR services. These counselors could do so by calling the ATR program's 1–800 number to initiate a referral, a simple call to action. The call to action solves the counselors' problem of arranging for funded recovery support services without the counselors giving up their clients. As noted above, it would be better to talk about these issues with counselors themselves before developing the message and call to action.

- Provide a simple, attractive message with a single call to action.

  Information campaigns tend to load up on too much information and an unclear call to action. However, information pieces that attempt to reach everybody with everything reach no one. A simple, carefully thought out piece with a single call to action—call the 1–800 number—could be appropriate for counselors. Those designing the material would need to keep verbiage to a minimum and the call to action and its benefits in solving the counselor's problem clear.

- A format that the user can retrieve easily.

  Letters, business cards, and brochures clutter spaces and are promptly lost. Counselors and referral agents normally have filing drawers for the information they need to retrieve frequently. It may be that a manila folder, with the heading

already printed and calls to action on the folder and an insert, might be appropriate and easily stored and retrieved.

- A way past the clutter gatekeepers.

  Anyone reading all of their communications as intended by the sender would do nothing else. Consequently, the sender must find ways that will reach the person in a way that commands their attention, such as passed with a sticky note attached from the CEO.

- Frequency and intensity.

  One message is rarely enough. Optimally, the person would receive at least three calls to action within a 2-week period. The calls to action can be in different formats, such as a mailing that gets past the gatekeepers and a conference handout. It can also be another copy of the same material. In any case, the "burst" of information over a short time is important. For example, three calls to action over 2 weeks are far more powerful that three calls to action in 1 year.

- Use graphics that present the solution, not the problem.

  Graphic artists love substance abuse because it gives them an opportunity to design poignant, artistic products of the many troubles possible with addictions. However, effective messages do the opposite. They present the solution. Unlike the pictures in a currently used brochure, which portrays a sad-looking young man alone, effective graphics show people together, never alone, and if not deliriously happy, then at least hopeful and content.

- The copy.

  Words should be spare, clear, appealing to the frame of reference of the reader, and present a clear, simple, unmistakable, and simple call to action. After the reader acts and has a favorable experience, then the ATR program might present more information and calls to action. One message leading to a single call to action is the maximum. Like the graphic, the copy must present a hopeful solution and not dwell on the problem. For example, a currently used brochure presents a mission statement that pairs the word "impossible" with the problem. An organization mired in the "impossible" does not inspire action.

E. Consultant Recommendations

By using Option A above, the grantee has delivered valuable services, and utilization of these services is slowly increasing. Although the small denomination retail cards employed for Option B involve some risk of inappropriate purchases, these risks are minimized by the relatively low values of the cards, the use of receipts to verify appropriate purchases, the use of specific retailers to narrow purchasing and redemption options, and local tribal use rather than program-wide use of the cards. In addition, the retail cards are distributed in a way that

reinforces continuing involvement in treatment, and in doing so appear to be offering a variation of the community-reinforcement model, an evidence-based practice.

- The consultants suggest that the grantee consider the risks of Option B in light of its particular situation. Other systems have devised ways of delivering recovery support services and community reinforcers without using retail cards. The grantee could reduce its risks by doing the same.

- As noted above, the grantee intends to continue to focus on marketing its services. Not doing so could result in a reversal of the favorable enrollment trend line. In particular, the TA consultants urge the continued use of engaging and reinforcing the support of IHO directors through telephone contacts and monthly comparative reports and informing these directors of the benefits of appointing an IHO ATR coordinator.

- The grantee's plans to reach out to criminal justice systems and transitional housing providers are well considered and merit action.

- An information campaign aimed at encouraging IHO substance abuse counselors to refer their clients for ATR services could help. The consultants recommend that the grantee follow through with such a campaign and do so following the guidelines above.

4. Example 3: Implementing a Best Practice—Motivational Interviewing—With an American Indian Population

- This TA effort was directed towards helping two American Indian tribes implement an evidenced-based practice (EBP) -- motivational interviewing (MI).
- One consultant provided onsite two-day trainings to each of the two tribes.
- The consultant found that training session participants expressed some concerns about implementing MI in their communities, but that demand for the training was high and participants were quite satisfied with the effort to adapt MI to Indian clients and programs.
- The consultant recommended additional support be provided (e.g., equipment, consultation) to enable Indian communities to receive more ongoing training and supervision in MI and other EBPs.

A. Overview and Purpose of the Technical Assistance

This ATR program requested assistance to provide culturally competent, onsite MI training to two American Indian tribes. MI is a client-centered, directive counseling approach for enhancing motivation to change by helping clients to explore and resolve ambivalence. The trainings were to help counselors and other health care providers meet the EBP for Indian clients. MI was identified as a best practice that could be adapted easily to serve the unique cultural needs of the reservation.

B. Technical Assistance Methodology

The consultant prepared training materials, communicated with and traveled to reservations to deliver MI training, conducted the trainings, and distributed training materials (agenda, slides, etc.) at the sessions. Two-day trainings were delivered to each of two different tribes. The materials were adapted to the needs of American Indian counselors and health care providers. The consultant tailored the MI training to meet the needs of the participants, such as local corrections staff working in drug courts and probation. The consultant's MI training was based on a previously developed learner's manual for counselors who work with American Indian/Alaska Native populations, which can be found in the appendix.

C. Technical Assistance Observations

Some training participants expressed concerns related to implementing MI in their communities. Many participants commented that EBPs need to be tailored to the needs of Indian providers, since MI was seen as important to meet the cultural needs of the people. Some indicated that MI should be a standard practice across tribes as Indian programs try to respond to the research to improve client care and meet individual Federal and State requirements. Generally, participants expressed a desire to build upon relationships with trusted consultants to assist with making ongoing improvements as EBPs emerge. Much satisfaction was voiced from both sites at the

effort to adapt MI to Indian clients and programs. The community of helpers would like this effort to continue.

The ideal group size for MI training is approximately 25–30 people. As a testament to the demand for this training in the Indian community, the group size far exceeded this range at one site. In fact, this site could have benefited from an additional trainer.

D. Consultant Recommendations

The consultant recommended the following, in no particular order:

- Continue to support Indian communities, reservations, and urban programs to standardize and implement MI as a best practice for Indian clients. One idea is to use e-learning services, such as EDNET, via the Indian Health Service (IHS) or an alternative location to facilitate additional training without the need for travel. This would allow for more frequent consultation and training to advance MI skills.

- Provide equipment for implementation, such as digital tape recorders or EDNET.

- To complement the implementation of MI and increase the use of EBPs, both tribal communities requested American Society of Addiction Medicine (ASAM) patient placement training and co-occurring disorder trainings in the next year to maximize the use of the available funding opportunity.

- Provide assistance to develop MI supervisors within Indian communities to provide ongoing assistance to staff once funding through ATR ends.

- Set up a series of 12 sessions with the consultant devoted to implementing MI at the counselor/health care provider level to improve fidelity to MI.

- Collaborate with partners who serve Indian clients in local communities as part of the effort to increase proficiency of EBPs and improve the care options within local communities.

- Identify other training and supervisory issues and create a plan for addressing Indian providers' needs.