FOLLOW-UP EVALUATION TO:

A DESCRIPTION AND ASSESSMENT OF THE IOWA JUVENILE INSTITUTION'S SUBSTANCE ABUSE SERVICES PROJECT

Division of Criminal and Juvenile Justice Planning
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A Description And Assessment Of The Iowa Juvenile Institutions' Substance Abuse Services Project

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INTRODUCTION:

In April, 1991, The Department of Human Rights, Division of Criminal and Juvenile Justice Planning (CJJP) published a report titled, "A Description and Assessment of the Iowa Juvenile Institutions' Substance Abuse Services Project". The report was the product of a research effort undertaken at the request of the Governor's Alliance on Substance Abuse to evaluate the substance abuse services at the state juvenile institutions. Included in the report were a number of specific recommendations regarding the provision of substance abuse services at the institutions.

At the time of the first report, the Department of Human Services, which operates the two state juvenile institutions, was contracting with the Substance Abuse Treatment Unit of Central Iowa (SATUCI) to provide substance abuse evaluations and counseling services. SATUCI chose not to renew their contract for the state fiscal year 1992.

Through a competitive grant application process, DHS chose Addiction Management Services (AMS) as the new service provider. AMS currently provides assessments of all juveniles who enter the institutions, a comprehensive evaluation for students with identified or potential substance abuse problems, and two levels, or types, of treatment intervention. As resources allow, AMS is also involved in arranging post institutional substance abuse services, and they have sporadically been conducting follow-up telephone contacts with past clientele to evaluate their progress, and to offer support toward continuing sobriety.

Many of the research activities utilized in the initial evaluation were duplicated in this follow-up study. Time and resources, however, did not allow for as comprehensive an examination of the project or the clientele which it serves. Interviews were conducted with a variety of institutional and AMS staff as well as post institutional case managers. Surveys were distributed to AMS and institutional staff, information was provided by the juvenile institutions on students admitted during our study time frame, and AMS client case files were examined.

The peer review panel utilized in the first evaluation was reconvened for this evaluation. They conducted staff interviews, reviewed AMS client records, and were kept apprised of all related evaluation activities undertaken independently by CJJP staff.

The main thrust of this follow-up evaluation was to assess the extent to which the substance abuse provider and DHS have implemented the recommendations from the earlier evaluation. Efforts were also made to evaluate the overall treatment approach, its appropriateness given the environment in which it is operating, and the program's overall potential to impact the juveniles which it is designed to serve.

This report is comprised of two sections. The first section presents a description of the research activities undertaken by CJJP staff, a description of services provided by AMS, staff and system official's perception of the substance abuse project, and a discussion of the recommendations from the 1991 study. The second section is comprised of a report from the peer review panel and includes observations on the quality of substance abuse programming at the institutions.

OVERVIEW OF SERVICES

Assessments

AMS is currently providing two levels of substance abuse evaluations. An "initial assessment" is conducted on all admission and court evaluation guests at both juvenile institutions. Juveniles who are re-admitted to the institutions are re-assessed only if they have been out of the institution for more than three months, or upon special request from a parent, institutional staff, or other concerned official.

The initial assessment consists of interviews with students and the completion of two substance abuse inventories. The inventories include the Children of Alcoholics Screening Test (C.A.S.T.) and the Substance Abuse Involvement Scale (S.A.I.S.). The purpose of the initial assessment is to assess the student's involvement with mood altering chemical substances and to determine if the student is appropriate for further involvement in the AMS program. As a matter of AMS policy, all initial assessments are conducted within seventy-two hours of arriving at the State Training School or Iowa Juvenile home.

The second type of evaluation provided in the juvenile institutions is the "comprehensive evaluation". All students whose life has been found to be affected by drugs or alcohol and who are determined to be appropriate for AMS services are given a comprehensive evaluation. The comprehensive evaluation is a prerequisite for involvement in any organized clinical interventions provided by AMS counselors. The comprehensive evaluation consists of additional interviews with AMS counselors and, as circumstances warrant, additional screening tests. The general purpose of this evaluation is to assist in the identification of individuals in need of AMS services and to gain further insight into their family background, legal history, history of chemical use, etc.

Treatment

Two different levels of treatment are available at the Juvenile Home/Training School. Students are separated into the two levels based on the degree to which mood altering chemical substances have affected their lives. Individuals who have been identified through the initial assessment and comprehensive evaluation as being dependent upon drugs/alcohol are involved in the "primary treatment" track, and individuals who are identified as drug/alcohol abusers or who come from families which have been disrupted by drug/alcohol abuse are involved in the "low intensity" program.

The low intensity program includes an hour long group session per week, and one individual session per month with an AMS counselor. At the Juvenile Home, AMS is providing a specialized low intensity service designed specifically to meet the needs of children of alcoholics/drug abusers. The Children of Alcoholics (COA) group is being provided almost to the exclusion of regular low intensity programming in the Juvenile Home.

Primary treatment consists of one individual session per month with an AMS counselor, and five two hour group sessions per week at the Training School/four sessions per week at the Juvenile Home. Students progress through the AMS treatment program at their own pace. AMS requires that students be available for programming for a minimum of 45 days.

Continuing Care

AMS provides a continuing care group for students who have reached maximum benefits in primary or low intensity treatment prior to being released from the institutions. Students are discharged from treatment but continue to meet with AMS counselors in a group setting until they are released from the institution.

Discharge Planning & Aftercare

For individuals involved in the AMS program at the institutions, AMS assists in arranging continued substance abuse treatment or support services for juveniles after their release from the institutions. These services range from arranging for AA or NA sponsors, to assisting in arranging admission to an in-patient substance abuse treatment facility.

Case Planning/Case Management

AMS counselors are assigned to specific institutional cottages and are responsible for various case planning and case monitoring functions for the residents of those cottages receiving services. AMS staff are involved in developing an institution-wide case plan for the residents of their cottages.

AMS staff are assigned as the lead substance abuse counselor and develop an individualized substance abuse treatment plan for each student referred to AMS from the cottage. The AMS staff assigned to a specific cottage is expected to keep cottage staff informed of their students' involvement with AMS.

SUBSTANCE ABUSE SERVICES TREATMENT REFERRAL PROCESS

The substance abuse assessment is one of many assessments conducted for all students placed at the Training School and Juvenile Home. Assessments are conducted by each of the clinical and educational departments on campus during the first few days of every student's institutionalization. Within thirty days of placement at the institution, an Individual Case Plan (ICP) meeting is held. At this meeting representatives from the student's cottage, the school, the institution's psychologist, the student's guardian, and AMS develop a service intervention plan for his/her stay in the institution.

With input from this group, the institutional clinical director prioritizes the multiple needs of the student, as documented through the multiple assessments, and develops an individualized treatment plan which identifies the services with which each student will participate.

This case planning process provides an opportunity for all service providers on campus to share the results of their assessments with each other and with the institutional staff who also will be working directly with students in their living units. The decision making process is designed to provide each member of the group with input.

The prior substance abuse provider was not involved in this case planning process to any great extent. Previously, the referral of a student to substance abuse counseling was dependent upon the recommendation of the institutional staff in the cottage. In the past, SATUCI recommended particular interventions to the clinical director, who, through the ICP, was then responsible for referring students back to SATUCI for services. SATUCI staff were typically not present at the ICP meeting unless specifically asked to attend.

DESCRIPTION OF SERVICE ACTIVITIES

CJJP used the juvenile institutions' admission records to identify all juveniles admitted from April 1st through September 30, 1992. This time period was chosen because AMS staff indicated that the program was not fully operational prior to April, 1992, and it was expected that by the time the case files were read, AMS would have had ample time to conduct evaluations and initiate services on those in the sample.

Through the institution's records, CJJP identified 175 admissions and re-admissions to the institutions during the previously mentioned time frame. Three of these individuals were admitted, released, and re-admitted to an institution during our time period. To prevent double counting, they were removed from the original sample leaving 172 admissions/re-admissions. Of these admissions/re-admissions, 129 case files were randomly chosen to be read.

Because of the limited amount of time which AMS had been fully operational at the institutions, it was recognized that a relatively large percentage of the individuals in the sample, who were involved with AMS would not yet be released from the institutions or from AMS services, and therefore, CJJP would be unable to examine the full continuum of case activity from initial assessment to discharge. Further, it was recognized that because a small number of the case records were read as early as 30-45 days from admission to the institution, AMS treatment interventions may not have been initiated.

It is reasonable to assume, that even though few of the cases will have reached completion, all should have progressed past the initial assessment and comprehensive evaluation; AMS policy

requires that the initial assessment be completed within seventy two hours and the comprehensive evaluation within thirty days of placement.

There were a number of juveniles from the sample who were re-admissions and had been involved in substance abuse counseling with AMS or SATUCI during a prior admission. The information collected on these individuals was limited to services provided during the time frame of April 1 to September 30, 1992.

How Many Residents Receive Services?

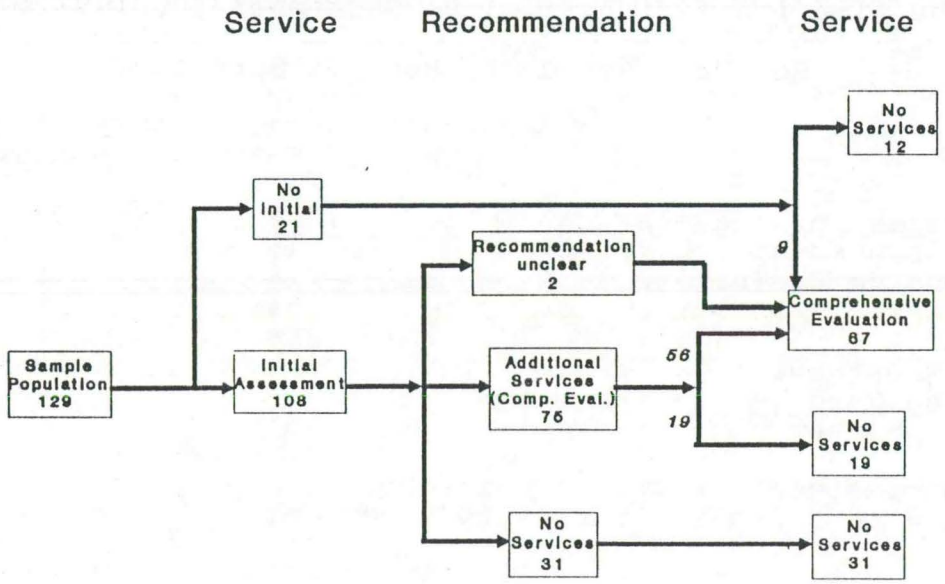
	Juvenile Home		Training School	
	Number	%	Number	%
Total Admission/Re-admission	43	100%	86	100%
Initial Assessment	39	91%	69	80%
Comprehensive Evaluation	31	72%	36	41%
Low Intensity Treatment	4	9%	9	10%
COA	12	28%	0	0%
Primary Treatment	4	9%	18	21%
Continuing Care	2	5%	0	0%
Follow-up Survey	2	5%	0	0%

Note: One resident at the Juvenile Home received both primary treatment and low intensity treatment.

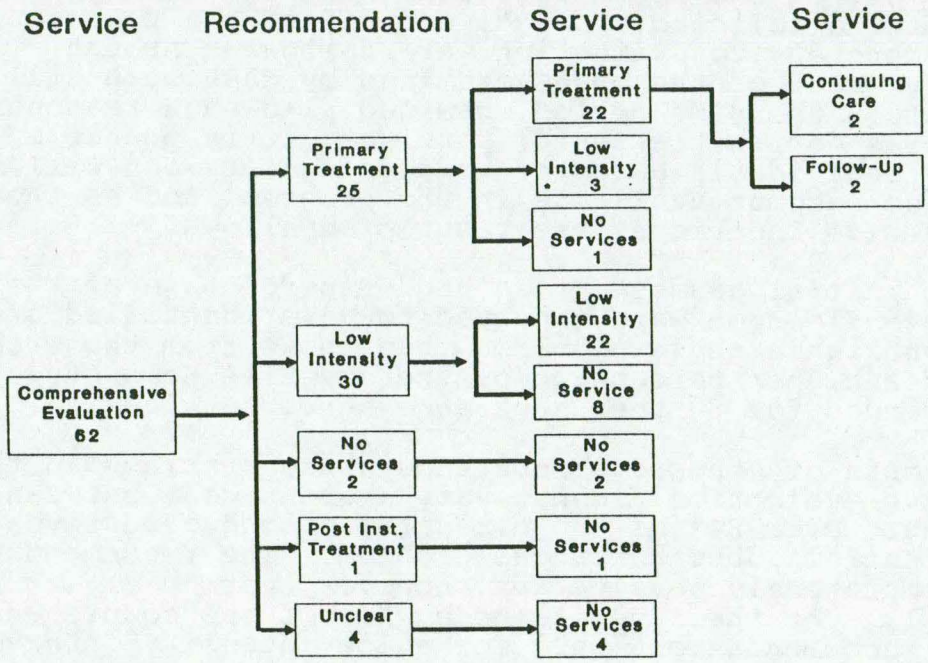
Eighty four percent of the juveniles in the representative sample were provided an initial substance abuse assessment upon admission or re-admission to the juvenile institutions. AMS' goal is to assess all admissions and all re-admissions who have been out of the institution for over three months. During the sample time period, twenty one of the individuals in the sample did not receive an initial assessment. Nine of those who were not provided an initial assessment were recommitments with prior involvement with AMS or SATUCI, and were provided a comprehensive evaluation without first receiving an initial assessment.

The remaining twelve individuals who were not provided an initial evaluation did not have any AMS interventions recorded in their case files. One of these was a re-commitment but was out of the institution for less than three months and subsequently not re-evaluated. Six were re-admissions but out of the institution for more than ninety days, which according to AMS policy requires a new assessment. Two individuals were not involved with AMS due to short lengths of stay, two were assessed prior to their admission on a court ordered evaluation at the State Training School and were found not to be in need of further services, and one juvenile was a new admission and for unknown reasons not assessed.

Follow Through On Recommendations From Initial Assessments



Follow Through On Recommendations From Comprehensive Evaluations



•One Person Received Both Low And Primary Tx.

Of the 108 juveniles provided an initial assessment by AMS, eighty-one or 75% were assessed as having an identified or potential substance abuse problem. Seventy-five individuals were recommended for a comprehensive evaluation, thirty-one were recommended to receive no further services, and two recommendations were unclear to researchers.

At the time that AMS case records were examined, sixty-two individuals from the sample had received a comprehensive evaluation, and another five were in progress. Fifty-four (87%)

of the students receiving a comprehensive evaluation, were assessed as having an identified or potential substance abuse problem, three were identified as having no problem, and five assessments were unclear. Of the comprehensive evaluations completed, two recommended no further substance abuse service, thirty low intensity services, twenty-five primary treatment, one post institutional in-patient treatment, and four recommendations were unclear.

Forty-six individuals from the sample were involved in either low intensity or primary treatment services provided by AMS during the time period studied. These individuals represented 36% of the sample population and 57% of the individuals assessed to have

at least a potential substance abuse problem in the initial assessment, and 85% of those assessed as having at least a potential problem in the comprehensive evaluation.

It should be emphasized that, at the time of our review of AMS case files, 82% of the recommendations from the initial assessments were followed through, and 81% of the recommendations from the comprehensive evaluation were followed through. Additionally, most of the cases examined by CJJP were still open. Although the time period examined allowed a reasonable length of time for initiation of services, it is possible that more of the individuals assessed as needing services will receive them as space becomes available in the program, and as their institution-wide individual treatment plan allows.

Through the initial assessment, a higher percentage of the kids from the Juvenile Home were reported to have identified or potential substance abuse problems than those from the Training School, and a higher percentage of the Juvenile Home students were recommended for further substance abuse services.

The assessments of student's substance abuse problems in the comprehensive evaluation did not vary a great deal between the institutions. Over 84% of the evaluations conducted revealed at least a potential substance abuse problem. The recommendations from the comprehensive evaluation, however, varied significantly. At the Juvenile home, 74% of the comprehensive evaluation recommendations were for a low intensity intervention, and most of those were specifically for COA group. Only 16% of the comprehensive evaluations recommended primary treatment at the Juvenile Home. At the State Training School, 65% of the recommendations from the comprehensive evaluation, were for primary treatment and 23% were for low intensity treatment, none of which specifically identified a need for COA services.

These recommendations were echoed in the services provided at the institutions, as most of those involved in AMS treatment at IJH were admitted to low intensity treatment, and at the State Training School, the majority of the admissions were for primary treatment.

<u>Minority Representation In Substance Abuse Services</u>
Minorities represented approximately 25% of the sample population, and 24% of the individuals provided with an initial substance abuse assessment by AMS. Through the initial assessment, minority students represented 17% of the individuals recommended for a comprehensive evaluation and 42% of the individuals recommended for no further substance abuse services.

Thirteen percent of the individuals receiving a comprehensive evaluation were minorities and 87% were non-minorities. For those individuals receiving a comprehensive evaluation, minority

students represented 8% of the students recommended for primary treatment and 13% of those recommended for low intensity treatment.

Minority students in the sample represented 9% of the individuals involved in primary treatment and 16% of the students involved in low intensity treatment. Overall, minorities represented 13% of the individuals from our sample who were involved in any substance abuse treatment service provided by AMS.

Racial Make-up Of The Sample Population

Black	N=27	21%
Caucasian	N=97	75%
Hispanic	N= 3	2%
Indian	N= 1	1%
Unknown	N= 1	1%
	N=129	100%

Initial Assessment Recommendations By Race

	Comprehensive Evaluation	No Services	Unclear
Black (N=22)	11	11	0
Caucasian (N=82)	62	18	2
Hispanic (N= 3)	2	1	0
Indian (N= 0)	0	0	0
Unknown (N= 1)	0	1	0
N=108	75	31	2

Comprehensive Evaluation Recommendations By Race

	COA	Low Int.	Primary Treatment	In-Patient Treatment	No Serv.	Unclear
Black (N= 7)	1	3	2	0	0	1
Caucasian (N=55)	16	10	23	1	2	3
Hispanic (N= 0)	0	0	0	0	0	0
Indian (N= 0)	0	0	0	0	0	0
Unknown (N= 0)	0	0	0	0	0	0
N=62	17	13	25	1	2	4

Service By Race

	COA	Low Int.	Primary Treatment
Black	1	3	2
Caucasian	11	10	20
Hispanic	1	0	0
Indian	0	0	0
Unknown	0	0	0
	12	13	22

Fifty percent of the minority students and 76% of the non-minority students who received an initial assessment were recommended for a comprehensive evaluation.

Sixty-nine percent of the minority students and 94% of the non-minority students for whom a comprehensive evaluation was recommended, went on to received a comprehensive evaluation. Thirty-five percent of the minority students and 70% of the non-minority students received a comprehensive evaluation.

Twenty-ninety percent of the minority students and 42% of the non-minority students who received a comprehensive evaluation were recommended for primary treatment; 57% of the minority students and 47% of the non-minority students were recommended for low intensity treatment.

Eight percent of the minority students and 24% of the non-minority students were involved in primary treatment; 15% of the minority students and 26% if the non-minority students were involved in low intensity treatment. Overall, 19% of the minorities in the sample were involved in AMS treatment services compared to 42% of the non-minority students.

The Length And Intensity Of Service Interventions

The short period of time for which case records were selected, limited our ability to describe the length of treatment interventions and their intensity throughout their involvement in substance abuse counseling. We are restricted to describing the time periods involved in initiating a particular service and describing the intensity of services through the time period for which case records were examined.

Service Interventions -- Time Frames

	Juvenile Home AVG. # OF DAYS		Training School AVG. # OF DAYS	
AVG. NO. DAYS FROM ADMISSION UNTIL THE INITIAL EVALUATION:	6	(N=39)	3	(N=69)
AVG. NO. OF DAYS FROM INITIAL EVALUATION UNTIL BEGINNING OF THE COMPREHENSIVE EVALUATION:	20	(N=31)	14	(N=37)
AVG. NO. OF DAYS TO COMPLETE THE IN-DEPTH EVALUATION:	4	(N=31)	18	(N=31)
AVE. NO. OF DAYS FROM COMPREHENSIVE EVALUATION TO LOW INTENSITY TREATMENT:	13	(N=4)	13	(N=9)
AVE. NO. OF DAYS FROM COMPREHENSIVE EVALUATION TO LOW INTENSITY (COA) TREATMENT:	45	(N=12)	N/A	(N=0)
AVE. NO OF DAYS FROM COMPREHENSIVE EVALUATION TO PRIMARY TREATMENT:	18	(N=4)	11	(N=18)
AVE. NO. OF DAYS FROM COMPREHENSIVE EVALUATION TO START OF ANY SERVICES:	34	(N=20)	12	(N=27)
AVE. NO. OF DAYS BETWEEN ADMISSION AND START OF SERVICES:	61	(N=20)	63	(N=27)

In comparison to the first evaluation, substantial reductions were made at the Juvenile Home in the time required to initiate evaluations and begin providing substance abuse services. The length of time between admission to the institution and the beginning of treatment at the Juvenile Home was reduced from 129 days to an average of only about sixty-one days. The number of days between admission to the institution and the initial assessment was reduced from 18 days to only six days, the average number of days between the initial and comprehensive evaluation was reduced from eighty-one days to twenty days, and comprehensive evaluations took only four days to complete as compared to fifteen days when previously evaluated.

Reduction in the time required to assess and treat residents can also be seen at the Training School. The time required to conduct initial assessments was reduced from eleven days to three days, the first session of the comprehensive evaluation was being

conducted within an average of fourteen days which compares to fifty-five days identified in the previous study. However, it took an average of nineteen days to complete the comprehensive evaluation, which is double what it took in the previous evaluation. All things considered, the amount of time required to evaluate and initiate substance abuse services at the Training School, was reduced from an average of seventy-four days to only sixty-three days.

Previously, students were not becoming involved in substance abuse programming until about midway through their stay at the institutions. Students in the current sample were involved in treatment in around two months, which is approximately one fourth of their stay in the institutions. Much of this reduction can be attributed to a reduction in the amount of time taken to conduct evaluations. Previously, the evaluation and assessment process took approximately one third of the average student's stay at the institution; more recently, it took just over a month, which accounts for less than one fifth of their placement.

It should be noted that most of the individuals involved in our sample were still in the institution at the time of our review of case records, and technically could still be referred to AMS for substance abuse services. Such referrals would increase the average time required to evaluate and initiate substance abuse services as outlined above.

Average Number Of Service Interventions Per Month

	Juvenile Home	Training School
Low Intensity		
Group	2.1 (N=15)	1.9 (N=6)
Individual	1.1 (N=8)	.4 (N=4)
Primary		
Group	13.0 (N=4)	14.8 (N=18)
Individual	1.6 (N=4)	1.2 (N=17)
Continuing Care		
Group	0 (N=0)	.7 (N=2)
Individual	0 (N=0)	.7 (N=2)

The above table displays a calculation of the average monthly number of services which were provided to the students in our sample based on the number of months between their date of admission to AMS services to the time at which case files were read and the number of interventions. Student involvement in the program ranged from one day to several months.

As previously discussed, AMS is providing two levels of treatment at the institutions. Primary treatment is intended to provide one individual session per month and group services five days a week at the training school - four days a week at the Juvenile Home. Low intensity treatment is designed to provide one group service per week and one individual session per month.

As demonstrated in the above table, students targeted for low intensity treatment were not receiving the level of service for which the program was designed. On the average, individuals in our sample population participated in just over 1 group session every other week at the Juvenile Home, and slightly less at the Training School. Students involved in low intensity treatment at the Juvenile Home participated in more individual sessions on the average than was designed, and students at the Training School participated in slightly less than one individual session every other month, which is less than half of what the intervention design anticipated.

Student's participation in primary treatment groups were also less intensive than planned. According to AMS' original projections, students could be expected to have participated in an average of 17-18 primary group counseling sessions per month at the Juvenile Home, and 21-22 group sessions at the Training School. Students from our sample at the Juvenile Home actually participated in an average of only 13.0 groups and students at the Training School 14.8 groups.

On the average, students from our sample participated in a higher number of individual primary treatment sessions than the intervention was designed to provide. Primary treatment was designed to provide one individual session per month. At the training School students were involved in an average of 1.2 sessions per month, while students at the Juvenile home were involved in 1.6 sessions per month.

STAFF AND SYSTEM OFFICIAL'S PERCEPTIONS OF THE PROGRAM

Research Methods

As in the first evaluation, CJJP surveyed staff at both institutions who work directly with juveniles involved in the AMS program or who are often involved with the AMS project. Sixty-five surveys were distributed at the Juvenile Home, eighty-four at the Training School, and eight to AMS. Overall, 120 surveys were returned, which is a 76% return rate; forty-four (68%) surveys were returned from the Juvenile Home, sixty-nine (82%) from the Training School, and six (75%) from AMS. For comparison reasons, many questions on this survey were identical to those asked of respondents in the first evaluation. See appendix B for a copy of the survey instrument used.

Each chief juvenile court officer (JCO) and DHS district supervisor was contacted by mail and asked to discuss the AMS project with their line staff. A specific set of questions were presented to them for this purpose and a telephone interview was conducted to collect information describing their knowledge of, and involvement in, the AMS program. Four of the five DHS supervisors responded to the telephone interview as did six of the eight chief JCOs.

Communication

80% of the individuals surveyed indicated that adequate communication exists between AMS and institutional staff in dealing with substance abusing juveniles. This compares to only 34% of the respondents surveyed during the last evaluation.

A significantly higher percentage of the respondents in this survey indicated that "institutional staff have a good understanding of services provided by AMS, and of the treatment approach utilized by them". 85% of the AMS staff agreed with the above statement as compared to only 45% of the SATUCI staff surveyed last time. The percentage of youth service workers who reported having a good understanding of the AMS substance abuse program increased; however, over half still indicated that they were unsure or did not have a good understanding of the program and its service approach.

The majority of communications between the institutions and the substance abuse service provider is initiated by AMS. Only 55% of the respondents indicated that institutional staff consistently inform AMS counselors of student progress in the cottage, and 63% indicated that they consistently inform AMS of behavioral, emotional, and mental issues, which are affecting AMS clients' progress in the cottage. This compares to 74% and 73% respectively of the individuals responding to the same questions for AMS informing institutional staff.

Interestingly enough, AMS staff were the most satisfied group concerning AMS and institutional staff's communication. AMS staff indicated in interviews with CJJP that communication is much improved with cottage staff, but there is room for improvement.

Scheduling for Substance Abuse Treatment

A lower percentage of the respondents from both institutions indicated that student participation in the substance abuse program is affected by scheduling conflicts within the institution and a resulting need to choose among competing programs/services to meet student needs. Fewer participants indicated that participation in substance abuse programming is limited by the time at which AMS staff are available, participation is limited by institutional staff choosing other activities for youth at the times counseling is available, and participation is limited by students choosing other activities during available AMS counseling times.

The percentage of respondents indicating that "counselors were not spending enough time each week with students to effectively impact their substance abuse problems" decreased from 48% to less than 10% in the follow-up survey. This may be in part due to the reduction in scheduling conflicts within the institutions and between the institutions and AMS.

Institutional Staff's Commitment To Substance Abuse Programming

In the more recent survey, institutional staff have demonstrated a stronger commitment to the substance abuse program, as evident by nearly 90% of the respondents indicating that students are adequately encouraged by cottage staff to participate in AMS activities. This compares to only 60% of the respondents from the last survey. Further, 100% of the AMS counselors indicated that students are encouraged compared to only about a quarter of the SATUCI respondents in the last survey.

Additionally, a higher percentage of the respondents on the more current survey indicated that substance abuse counseling should be among the institution's top priorities and that AMS' assessment of each student's need for substance abuse counseling should be given top priority in determining which programs/services the student will participate in.

Confidence In The Substance Abuse Program

Over half of the respondents on the more recent survey indicated that the substance abuse service provider is capable of dealing with behavioral problems and severe substance abuse problems, as compared to only 27% and 16% respectively in the previous survey.

Over 83% of the respondents in the most recent survey indicated that AMS does a good job of assessing student's involvement with drugs and alcohol, and recommending appropriate levels of substance abuse interventions at the juvenile institutions. This question was not asked on the first survey, so no comparison is available.

Youth Service Workers

Throughout the survey, youth service workers consistently responded in a less favorable manner regarding the services provided by AMS and their interaction with AMS than did institutional administrators and AMS staff. Youth service workers were less confident in AMS' ability to handle students with severe substance abuse issues and students with behavior problems than institutional and cottage administrators. It should be noted also that not all AMS counselors were confident in their ability to handle these special issues.

Youth service workers were also more critical of their own role in the substance abuse project. Youth service worker's responses indicated they were less familiar with the AMS project than any other group; a higher percentage of the youth service workers responded that institutional staff do not communicate student's

progress and potential treatment problems to AMS staff, and they were most critical of AMS' communication with institutional staff.

Awareness Of The Substance Abuse Program Outside Of The Institutions.

By and large, the Chief JCOs and DHS regional service supervisors, spoke highly of the AMS program. Most indicated that the level of communication between the substance abuse treatment provider and field DHS workers and JCOs was much improved. Most indicated that AMS regularly contacts JCOs or social workers regarding substance abuse evaluations results or with specific concerns regarding their treatment approach. Those commenting on AMS communications also indicated that the communications were concise and efficient and that AMS posed relevant questions.

Court officials and DHS field service workers in the 1991 study were unfamiliar with the SATUCI project. With few exceptions, JCOs and DHS field service workers were not aware that SATUCI provided substance abuse services in the institutions, and communication between field workers and SATUCI was almost non-existent.

Respondents to the more recent survey, indicated that AMS staff regularly attend institutional ICPs and that they provide helpful information which assists in developing treatment plans while in the institutions and upon release from the institutions.

DHS supervisors indicated that their staff would like AMS to routinely provide written evaluation and progress reports on their clients. They indicated that the reports which they have received have been above average.

Those interviewed had mixed reactions regarding the follow-up planning services provided by AMS. Some of the individuals interviewed were not aware that AMS was involved in assisting with post institutional service preparation, some indicated AMS should be doing more to follow through with getting kids into the appropriate level of services after leaving the institutions, and others were quite impressed with AMS in this regard. It appeared, that none of those interviewed were aware of exactly what AMS does to arrange post institutional services for their clients.

All of the Chief JCOs interviewed were at least familiar with the AMS project in the juvenile institutions. This was due to the fact that AMS provided an overview of their program at a meeting in which all of the chief JCOs were present.

Not all of the DHS supervisors interviewed had any personal interactions with AMS but indicated that their staff were, by and large, pleased with the level and quality of communication. Most of the interactions between DHS workers or JCOs and AMS

counselors appears to be initiated by AMS staff. As a matter of policy, AMS attempts to contact the JCO or DHS field worker for each client which is evaluated.

Several of the individuals interviewed indicated that the recent cap placed on group home placements could increase the number of juveniles placed in the juvenile institutions specifically to obtain substance abuse counseling or other similar types of specialized services. The lack of more appropriate placements make the juvenile institutions more attractive and kids that were previously considered inappropriate for the institutions may be placed there because of a lack of better options.

ADDRESSING THE RECOMMENDATIONS FROM THE 1991 STUDY

The majority of the activities undertaken in this follow-up evaluation were intended to assess the extent to which AMS and the juvenile institutions have implemented the recommendations provided in the evaluation in 1991. The following section is intended to address each of these recommendations and describe the extent to which they have been implemented by AMS and or the institutions.

Substance abuse services should continue to be available at both juvenile institutions.

It is widely accepted by DHS administrators, institutional line staff, and other system officials that the substance abuse services in the juvenile institutions are an essential component in the institutions' efforts to make a significant and lasting impact on the lives of juveniles in the institutions.

The degree to which the services are needed has been demonstrated by the fact that over 75% of the juveniles evaluated by AMS in our sample population were assessed to have at least a potential substance abuse problem, and over 70% of the students were recommended for further substance abuse services. Of the sixty-two students from the study sample who were provided with a comprehensive evaluation, twenty-five were recommended for primary treatment which is designed to serve chemically dependent students, and thirty students were recommended for low intensity treatment, which is provided to substance abusers and children of alcoholics/drug abusers. As of the time case records were reviewed, over one third of the students in our study were involved in substance abuse treatment.

The Department of Human Services should develop measurable goals and objectives for its substance abuse services program at each institution; clearly stated agreements regarding the services and expectations of its contractual services provider should be formally adopted and publicized throughout both institutions, district DHS offices and juvenile court offices.

This recommendation is multifaceted and has been partially implemented in a number of ways. Administrators from both institutions provided direction to AMS regarding the institutions' wants, needs, and expectations, and otherwise were active in the development of AMS' service delivery model.

The institution's substance abuse treatment objectives may not have been communicated on a wide scale basis to all institutional employees. Based on survey results and interviews, it appeared that youth service workers were only marginally familiar with AMS's specific types of services and treatment methodologies. Their knowledge was limited, in most cases to "AMS provides evaluations and two types of treatment".

CJJP contacted Chief JCOs and DHS regional supervisors to discuss their knowledge and opinions of the substance abuse services project. Most were familiar with the project although few could discuss any specifics about AMS programming. Very few of the officials interviewed from outside the institutions were aware of the range of services offered or the intensity or longevity of services provided. Further, very few were aware of the criteria and procedures for enrolling students in AMS programming. AMS staff have made efforts to familiarize themselves with institutional policies, personnel, and operations. AMS staff appear to be respectful of institutional protocol and work well with institutional administrators and line staff.

Although most of the discussion on the implementation of this particular recommendation has outlined problems which still exist, institutional staff at both institutions have a much better understanding of AMS' programming than they did of the past substance abuse service provider. Much of this can be attributed to assigning AMS counselors to cottages and the more frequent interaction between AMS and cottage staff. Additionally, AMS has simplified the structure of services and the terminology which it uses to refer to substance abuse services.

Consideration should be given to the development of one or more models of residential service delivery that are designed to acknowledge and take advantage of the institutions' closed, isolated, and highly structured service and supervision-oriented environments.

It seems clear that DHS and AMS have taken a number of steps consistent with the intent of this recommendation. However, AMS continues to operate from what is basically an outpatient treatment framework. What seems to distinguish their approach from past efforts is the extent to which their activities are considered more of an integrated part of other institutional services, rather than as a supplemental service to the broader institution service plan.

Evidence of such integration can be seen in the assignment of AMS counselors to specific cottages, AMS participation in students' institution-wide treatment planning, and in the institution staff's efforts to assist AMS gain the participation and cooperation of student service recipients. Another major change from past practices related to this recommendation is the design of AMS's service interventions for those students receiving primary services, and the frequency of student contact with AMS in these cases.

It was not clear, however, that the exchange of information between AMS and institution staff is formally structured to take full advantage of the closed, isolated and highly structured service and supervision-oriented environment of the state institutions. While communication about student participation in substance abuse services has improved, interviews and case readings did not indicate the type of coordinated monitoring and tracking of specific treatment goals that would seem possible and that might be desired in the institutional setting.

Institution staff seem to know whether students are participating with AMS, and they seem to be working to track, monitor and impact positively on such participation. Institution staffs' knowledge and involvement, however, seem more limited to attendance and cooperation levels and less inclusive of the nature of specific treatment goals and the level of progress a student is achieving through their treatment plan. This may be , In part, due to the nature of AMS treatment planning and the extent to which treatment plans do, or do not, clearly specify outcome goals with measurable and observable action steps.

There also were indications that AMS staff were not routinely made aware of students' progress with non-substance abuse services at the institution, nor were AMS staff typically given a role to play in the monitoring and tracking of student progress with services other than AMS services.

The above recommendation was not meant to suggest that a service approach designed like AMS's is either inappropriate or ineffective. Rather, it was meant to suggest that the institutions offer an environment that is potentially supportive of other than an outpatient service model for the delivery of substance abuse services; and it was offered to encourage an examination of how to maximize the potential benefits of targeting the institutions' high levels of supervision and behavior monitoring to substance abuse treatment progress in addition to substance abuse treatment participation.

Specific target groups from the larger institutional populations should be identified to receive project services; for at least some targeted residents, substance abuse treatment should be the primary focus of the institutions' service interventions. It is further recommended that unmotivated youth should not be excluded from this project's service

AMS's written referral criteria and case reading findings seem to indicate that unmotivated youth are indeed being referred to, and are receiving, substance abuse services. Previously, such students were considered inappropriate referrals. It appears that both institutions have made it clear to motivated and unmotivated youth that substance abuse programming is as important in their treatment plan as any of the other services with which they are involved. Students understand that "making their week" is partially dependent upon their progress and behavior in substance abuse programming. This support from institutional staff reportedly has been of great help to AMS staff in motivating youth who would otherwise not cooperate or make little progress in treatment.

The development of the primary treatment component seems to have facilitated the identification of a specific target group that is more easily distinguished from other students than was previously the case. AMS recommendations for both primary and low intensity treatment were routinely followed, which may also indicate a sense of understanding and agreement between AMS and the institutions regarding the target populations of these services.

Both the Juvenile Home and the State Training School have demonstrated a strong commitment towards the implementation of a targeted approach to substance abuse programming within the overall treatment environment of the institutions. The administration at both institutions, in cooperation with AMS and school staff, have assured that students are available for substance abuse counseling during a part of the day which was previously set aside for school or vocational training, and the time spent with AMS counselors can now be applied toward educational credits.

Despite these developments, it is not clear whether substance abuse treatment is the primary focus of the institutions' service intervention for any identifiable segment of the student

population. The overall intervention experienced by students receiving primary treatment from AMS while at the institution includes a variety of other services provided by persons who have little contact with AMS staff and who may not be aware of AMS-developed case-specific treatment goals or specific treatment activities.

Written service referral criteria (not just exclusionary criteria) defining the target populations should be developed to guide the selection of the substance abuse service recipients.

As previously mentioned, AMS has developed referral criteria which it uses to identify individuals appropriate for substance abuse services. Although not all institution staff appeared to be familiar with this criteria, its existence and use by AMS to develop service recommendations was apparent. That their recommendations were typically implemented by institution staff would seem to indicate general agreement with the AMS criteria.

Policies and procedures should be developed, implemented and monitored to: a) assure that all institution and substance abuse provider staff are aware of the program's goals; b) facilitate appropriate referrals; and c) provide for the shared and coordinated monitoring of client progress among provider staff, institution counselors and cottage personnel.

AMS staff have provided in-service training on their project at both institutions. The in-services were intended to provide institutional staff with an overview of the services being provided by AMS staff and of the treatment approach utilized by them. Few of the staff interviewed by CJJP attended this training, and few line staff were more than moderately familiar with AMS treatment approaches. Neither institutional nor AMS administrators have developed and implemented written policies to ensure that cottage line staff are well informed about the AMS project, its goals, and its operation.

While referral criteria and resulting service recommendations seemed to be agreed upon and useful to both AMS and institution staff, it did appear that the timing of the actual initiation of the recommended services is not being addressed with clear policies or institution-wide practices. Particularly at the Juvenile Home, the timing of service initiation varied among cottages and specific cases, and AMS staff are not necessarily made aware of how the institution's service referrals are determined. It seems likely that the initiation of recommended substance abuse services is affected by assessment findings and judgements from other than AMS and involve multiple presenting problems and decisions regarding which of a student's problems should be addressed "first". The extent to which this situation is problematic was not clear; nor was it clear to what extent it is due to conflicting opinions about AMS recommendations or because AMS assessments may not be as holistic as is possible or desired.

AMS clearly is more involved in the institution-wide case planning and substance abuse service referral process than was their predecessor when CJJP first evaluated the program. This increased involvement was likely due to the availability of AMS counselors to attend ICPs and the positive rapport established between institution and AMS staff. However, the institutions have not developed any written policies requiring the involvement of AMS counselors in individual case plans. AMS does have a written policy which requires their counselors to provide a recommendation for each student's involvement in AMS programming, and encourages participation in the ICP of students for which substance abuse counseling is being recommended.

At both institutions, informal lines of communication have developed which are utilized to exchange information on student's progress and problems in their cottages and in substance abuse programming. These informal lines of communication have been supported at the Juvenile Home by an AMS policy requiring AMS counselors to provide cottage staff with weekly written feedback on all students. Cottage staff at both institutions are not required, as a matter of policy, to communicate student's progress in cottage programming to AMS staff.

As was discussed previously, the extent to which client progress with substance abuse services is jointly monitored seems typically to be limited to student participation compliance; efforts to mutually coordinate the monitoring of specific treatment goal attainment were significantly less noticeable from the study interviews or in case record documentation. No specific written policies regarding shared and coordinated monitoring of client progress were identified.

Steps should be taken to assure that substance abuse education and prevention services provided in the institution by non-substance abuse provider staff are compatible with the substance abuse provider's service approaches.

Currently, there is no education and prevention service component being provided by or with the assistance of AMS at the Iowa Juvenile Home or State Training School. In the 1991 evaluation, SATUCI had developed a prevention/education curriculum specifically intended to be presented in the cottages by cottage staff. The curriculum was being used sporadically at the Training School and not at all at the Juvenile home. This curriculum is currently not being used by either institution, however a component of the "law related education" programming which all students are exposed to at the Training School, deals with education and prevention, though it is much less intensive.

Staff at the Iowa Juvenile Home have indicated that the curriculum developed by SATUCI was sent to the Department of Health, Division of Substance Abuse to be revised and re-implemented among the cottages at IJH. The Division of

Substance Abuse was forced to lay off the staff person assigned to revising the curriculum, and no further progress has been made in this area.

It should be noted, that in their contract, AMS did not agree to provide prevention and education services at the juvenile institutions. The director of AMS indicated that prevention and education services would not be an efficient use of their limited resources, due to the fact that most of the juveniles in the institutions have progressed in their drug/alcohol usage past the point of effective prevention and education. Officials at the State Training School were in agreement; however, their counter-parts at the Iowa Juvenile Home indicated that substance abuse prevention and education service would be worthwhile if provided to 100% of the clientele or, at a minimum, to those students not involved in other AMS programming, and further that it would be most beneficial if provided or co-facilitated by AMS staff.

Monitoring procedures should be implemented to further examine the usefulness of providing initial evaluations to all admissions to the institutions. Such monitoring should be structured to establish the extent to which institutional and post institutional service responses are, in fact, responding to the evaluation's recommendations. Efforts should be made to verify self-reported assessment information with institution records and other sources.

As discussed elsewhere in this report, the recommendations from the initial assessment and comprehensive evaluations were being followed through in the majority of cases. As is demonstrated by the flow of services chart in the "Overview of Services" section of this report, 75% of the individuals recommended for additional services progressed to the comprehensive evaluation which is a pre-requisite to admission to AMS treatment services. Further, over 80% of the individuals recommended for treatment services in the comprehensive evaluation were involved in treatment.

Institutional staff indicated, through interviews and the open comment section of the survey, that AMS is doing a good job of verifying the self reported information from the initial assessment and comprehensive evaluation. This was confirmed by discussions with JCOs and DHS workers. Further, eighty-four (65%) of the 129 AMS case files reviewed by CJJP documented discussions with a parent, guardian, case worker, institutional staff, or other individual to verify assessment information.

Any plans developed to target the project's client population should address the extent to which aftercare preparation is viable as a separate service delivery model component.

AMS has indicated that they feel aftercare preparation is important but that providing evaluations and treatment services to students at the institutions is their highest priority. Given

the institutions' role in specifying expectations for the AMS services, it seems that they agree with this prioritizing. As a result, AMS is not providing aftercare preparation as a separate service component, but to some degree has incorporated it into their overall treatment program. AMS is providing these services, as resources allow, to students involved in low intensity and primary treatment as well as to students involved in continuing care group.

DHS supervisors indicated that AMS counselors did not always involve the DHS worker in aftercare preparation, but that the aftercare services which were arranged through the assistance of AMS counselors was for an appropriate level of services and with an appropriate service provider. DHS supervisors also indicated that they felt students benefited from AMS aftercare preparation, but that it was not provided for all AMS clientele. DHS supervisors indicated that they were uncertain why some clientele were assisted with post institutional services, while others were not.

It seems that there is no AMS, institution or other DHS policy that targets AMS aftercare preparation services to either a certain type of student or as a typical component of any of the different types of AMS treatment interventions.

Discharge reports summarizing assessment findings, service progress, and service recommendations should be required for all residents receiving any of the substance abuse provider's services.

Very few of the individual case files which were reviewed by CJJP staff were discharged from AMS services. Of the nine cases discharged, only three discharge summaries were in the files. It is possible that discharge summaries for these students were not yet completed but would be prior to the student's discharge from the institution.

AMS has a policy in place which requires staff to write a discharge summary for all individuals completing AMS services. According to interviews with JCO and DHS supervisors, the discharge summaries have not consistently been distributed to post institutional case managers. This is reportedly due in part to concerns regarding client confidentiality.

Efforts should be made to assure an awareness by the courts and post institution case managers/supervisors of the substance abuse assessment findings, service progress, and service recommendations developed while youth are in the institutions.

AMS' documented correspondence with the juvenile court and DHS case workers is post institution case managers/supervisors is, for the most part, limited to the evaluation process. Sixty-six case files reviewed by CJJP staff included documented case consultations with DHS workers or juvenile court officers.

Eighty-eight percent of these case consultations were to verify information provided in the initial assessment or comprehensive evaluation. Only two case files contained documentation of case consultation directly with a juvenile court judge.

The required case permanency plans, developed for all youth under the court's jurisdiction, should be updated when a youth leaves the institution to include a specific response to substance abuse service recommendations that stem from interventions experienced by youth while in the institutions.

It does not appear that case permanency plans are being routinely altered to indicate a post institution response to substance abuse service recommendations that is directly related to interventions experienced by youth while in the institutions.

Most DHS supervisors indicated that DHS workers do not always consult AMS in regards to updating the case permanency plan when a youth leaves the institutions. The supervisors did, however, indicate that most DHS workers who have had kids involved in AMS programming have had some interaction with AMS, either through telephone contacts or case review meetings. According to DHS supervisors, DHS workers should have a good feel for the extent of their client's substance abuse problem as identified by AMS and of the services the client were involved in.

DHS supervisors indicated that DHS workers would be greatly assisted in addressing substance abuse issues in the case permanency plan if they routinely received copies of their clients' substance abuse evaluation reports, progress reports, and AMS discharge summary. Most DHS supervisors acknowledged that this information is available to DHS workers but that they often need to make specific requests for the information and confidentiality regulations can be cumbersome.

Consideration should be given to recruitment of minority substance abuse service provider staff and the inclusion of culturally specific intervention components or techniques as an integral part of the project's service delivery model.

It did not appear that AMS had made any significant efforts to develop a curriculum specifically designed to provide specialized counseling to ethnic or racial minority students. Some of AMS' staff have attend a training session on substance abuse counseling for American Indian clientele. During the time period that CJJP was on campus reading AMS case records, AMS did not have any minority staff.

Regular, project-wide oversight meetings between the institutions, the substance abuse provider, and other system officials should take place with mutually agreed upon and consistent agenda items and procedures to assure project-wide performance monitoring.

This recommendation was originally intended to facilitate regular communication between the institutions and the substance abuse provider. It was thought that such an advisory committee could assist in overcoming some of the organizational barriers which had affected communication between SATUCI and the institutions. It was envisioned that the committee would be utilized by both entities to develop joint goals and expectations for the project and to strategize for the most efficient and effective use of the substance abuse provider.

The lines of communication between the institutions and AMS is much improved over that of SATUCI and the institutions. The need for formalized meetings to assist in resolving operational and programmatic problems may have been reduced by the increased level of informal communication.

AMS has assembled an advisory committee which consists of DHS and institutional officials as well as substance abuse counseling professionals, CJJP, the Division of Substance Abuse, and Juvenile Court officials. The committee meets on a quarterly basis, and to date has been utilized to report project performance, with little done by way of brain storming potential directions for the project or trouble shooting existing problems which exist in the delivery of services.

CONCLUSIONS AND RECOMMENDATIONS

With few exceptions, the substance abuse services at the state juvenile institutions have undergone significant changes over the last two years. There has been substantial progress toward implementing the recommendations from the 1991 study, "A Description and Assessment of the Iowa Juvenile Institutions' Substance Abuse Services Project". The primary goal of this follow-up study was to revisit the project and assess the extent to which these recommendations have been implemented.

The extent to which each of the past recommendations has been addressed was discussed in the previous section from the perspective of CJJP staff; the findings and opinions offered by CJJP in that section were developed using information from data collection activities conducted by CJJP staff (surveys, case readings and interviews) and from the findings and assessments of the peer review panel, as presented in a separate document authored by the panel and attached to and made a part of this report.

The "Peer Review Panel Report II" is submitted in its entirety as a part of the larger report to allow DHS, AMS and others the opportunity to hear directly from this panel. In effect, the report submitted by CJJP contains two separate reports, although CJJP's goal in discussing past recommendations was to incorporate the findings from all information gathered by either CJJP staff or the peer review panel.

The "Peer Review Panel Report II" contains a variety of recommendations developed by the peer review panel independently from CJJP. With no significant departures, CJJP agrees with and supports these recommendations. In addition, the recommendations that follow in this section also are offered to suggest where attention could be focused as DHS continues its efforts to improve the delivery of substance abuse services in the state's juvenile institutions.

* Consideration should be given to the development of formal DHS and AMS policies and procedures that assure a monitoring of substance abuse treatment goal attainment involving both AMS and institution staff. The current joint monitoring and supervision of student participation and cooperation with substance abuse treatment activities should continue and be made a part of the recommended treatment progress monitoring.

  To implement these recommended policies and procedures, it may first be necessary to assess the content of AMS treatment plans and alter them, if necessary, to include specific, individualized treatment goals with attainable and measurable outcome measures.

* Consideration should be given to the development of formal DHS policies to assure that AMS staff receive information about student progress and treatment issues from other institution service providers. Such policies should be designed to facilitate necessary adjustments in the substance abuse treatment plan and to provide AMS staff with the opportunity and responsibility to assist in the monitoring of student progress in institution services other than substance abuse treatment.

* AMS and institution administrators should continue to take steps to assure that all institution staff are familiar with the goals and expectations of the institutions' substance abuse services and with the specific evaluation techniques and treatment methodologies practiced by AMS.

* AMS and institution administrators should develop ongoing procedures to provide information about the institution's substance abuse services to juvenile court officers and DHS workers responsible for providing case management and supervision prior to and following a student's stay at the institution.

* Steps should be taken by AMS and institution staff to assure that evaluation findings, progress reports, discharge summaries and other pertinent information related to students' substance abuse services are provided to juvenile court officials and DHS workers responsible for post-institution case management services.

* The required case permanency plans, developed for all youth under the court's jurisdiction, should be updated when a youth leaves the institution to include a specific response to service recommendations that stem from interventions experienced by youth receiving the institutions' substance abuse services.

* Consideration should be given to all recommendations offered by the peer review panel in the attached report.

PEER REVIEW PANEL REPORT II

Method

The assessment of the substance abuse programs at the institutions was made through interviews with involved persons and review of client records. Persons interviewed included: administrators and supervisors; cottage directors; counselors; and youth services workers .... a broad range of institutional and Addiction Management Services (AMS) staff. Institutional staff interviewed included those directly involved with the AMS programs, as well as those with indirect involvement.

It should be noted that the staffs of AMS, the State Training School (STS), and the Iowa Juvenile Home (IJH) were cooperative and helpful in their interactions with the peer review panel. We in general continue to be impressed with their dedication and genuine concern for the young people with whom they work.

Summary

The substance abuse services at the two institutions are provided by AMS on an outpatient model. The substance abuse prevention curriculum previously utilized by the STS on a regular basis and the IJH irregularly has been discontinued. A curriculum (Law Related Education) is integrated into the cottage program (at STS only); this curriculum is not substance abuse specific. While the previous substance abuse provider's (SATUCI) evaluation and treatment activities were largely segregated, the current provider's (AMS) services are more integrated and more frequently involve staff in living units. AMS has managed the creative integration of substance abuse services into the institutional programs. The treatment provided by AMS is not substantially different in form than that provided by SATUCI, in some cases the same materials and staff are being employed. The upper management of both juvenile institutions is clearly supportive of AMS's programming. There is accurate, effective communications between all involved organizations, particularly at a service delivery level. The AMS programming appears to be much more integrated into the overall institutional operations.

While relationships between the institutions and the treatment provider have improved significantly, there are some difficulties with the quality of AMS programming, in particular, clinical supervision, as well as a lack of sensitivity to ethical issues.

Accomplishments Summary

* In general, the adequacy of communication between the institutions and AMS is generally accurate and effective, particularly at a service delivery level. It is a vast improvement over the previous review.

* There obviously is a positive leadership position which has been taken by highest management at both institutions to remove organizational barriers to communication and to initiating joint problem solving. One no longer has the sense of a great chasm between the institutions and the substance abuse provider.

* The administrations of both institutions have worked with AMS to give the substance abuse provider "equal footing" in the institution. The upper management of both juvenile institutions is clearly supportive of AMS's programming.

* AMS has managed the creative integration of substance abuse services into the institutional programs. There is a substantial positive change in the degree to which the substance abuse program is accepted and integrated into the programs of the institutions.

* There is shared and coordinated monitoring of client progress among substance abuse provider staff and institution personnel. There is a sense of shared purpose and mission.

* The current provider obviously makes an effort to contact corroborating sources of information and obtain data from them regarding clients, rather than rely solely upon client self-report.

* It should be noted that recommendations from the AMS evaluations are followed through in the institutions' programming on a regular basis.

* There is no doubt that substantial positive changes have taken place with regard to the provision of substance abuse treatment to "unmotivated youth". These changes have occurred with the joint participation of the substance abuse provider and the institutions in a cooperative venture.

* AMS has developed and uses written inclusion criteria, which also include appropriate exclusion criteria. The criteria are utilized on a consistent basis and an individualized copy is placed in each student's record.

* There is evidence that AMS has many more contacts with post-institutional placements than the previous provider.

There were consistent attempts to assist clients in receiving continued substance abuse services following their discharge from AMS.

Recommendations Summary

* AMS needs to have clear differential diagnosis to distinguish primary chemical dependency from substance abuse secondary to other issues (e.g., primary anti-social with substance use).

* In general, there is a lack of sensitivity at AMS regarding cultural diversity. As of the peer review site visit, AMS had made no efforts to recruit minority staff. This is unacceptable given the number of minority students. It appears that minority students received proportionately less primary treatment than non-minority students. AMS should be required to develop an affirmative action plan with clear goals and objectives to recruit minority staff roughly proportional to the service population. This plan should be in place so that it can guide recruitment and selection at the time of the next job opening.

* AMS has not incorporated culturally specific intervention components or techniques into their service delivery model. Culturally specific programming should be provided given the high percentage of minority students (compared to the general Iowa population) and the high incidence of substance abuse reported among minority populations. Both minority staff and the intentional incorporation of culturally specific interventions are necessary.

* AMS does not provide substance abuse specific prevention and education services and is not funded to do so. The institutions do not provide such services. Given the pervasive nature of substance use and abuse among this population, and that juveniles at both institutions fit anyone's definition of "high-risk", "high-risk" substance abuse specific prevention programming should be provided routinely.

* Resources currently used for COA/low intensity treatment should be reallocated to provide more intense primary treatment and more extensive community placement follow-up. There needs to be much more emphasis upon aftercare or continuing care services. It should be noted this will require more adequate differential diagnosis than is currently employed to clearly distinguish those who can benefit from primary treatment.

* The COA/low intensity treatment for chaotic families really should not be part of substance abuse treatment, rather it

should be part of the cottage program. One has the sense that almost all of the institutions' populations are perceived to exhibit a need for COA/low intensity treatment. The COA/low intensity treatment might be one strategy for high-risk prevention programming for all students coming from chaotic families.

* Previously an AA group was available at IJH. AMS took responsibility for this AA group and it is no longer reliably available. This should be corrected.

* There are some difficulties with the quality of programming, and in particular, clinical supervision. The methods used to evaluate students are generally clinically adequate and the recommendations resulting from the evaluation are generally reasonable. The use of "McAuliffe's Essential Symptoms" (1975) is outdated.

* There could be substantial benefit in having the evaluation include an assessment of client cognitive functioning (including consideration of I.Q. test results with allowance for cultural differences), learning disabilities, learning perceptual sets, et cetera, and their impact on substance abuse treatment planning and subsequent treatment.

* The substance abuse evaluations would have greater value if they articulated longer term goals and planning for students' discharge and subsequent continuing care.

* There is really little individual treatment available. Areas of need identified in the assessment process are frequently not addressed in the master treatment plan. There is a need for clear outcome goal development. It appeared there was little group counseling or treatment, that group sessions were largely lecture and discussion.

* The mixing of younger and older students (12 and 17 years old) in the same treatment group may not be appropriate. Low functioning, immature boys, and minority students are not receiving services appropriate to their needs. Those students with special needs should be identified and provided services appropriate to their needs. Serious consideration should be given to gender specific groups.

* AMS staff need assistance with students with behavior disorders, attention deficit disorders, and learning disabilities. This appears to be a training deficit, as well as deficiency of adequate supervision, both of which should be open to easy remedy.

* There were several broad issues regarding the operation of AMS which were of concern in addition to the lack of

sensitivity regarding cultural diversity. As operated, there appeared to have been few opportunities for legitimate inservices and professional training. There was a lack of clinical supervision. Monitoring of policies and procedures within AMS is poor. Clinical supervision, other than peer review, is poor or non-existent. This is a major deficit of the provider. The communication between director and line staff within AMS itself is highly variable in quality and needs to improve. Overall there seemed to be a lack of sensitivity regarding ethical considerations at AMS.

Discussion

AMS does not provide prevention and education services and is not funded to do so. Given the pervasive nature of substance use and abuse among this population, substance abuse prevention and education should be provided as a matter of course by the institutions or included in the contract with AMS. Previously an AA group was available at the institution. AMS took responsibility for this AA group and it appears the availability of the group has decreased and/or ceased since then. The group is no longer reliably available. In addition, while treatment services are available to juveniles in general, it appears that minority students received proportionately less primary treatment than non-minority students.

DHS institutional staff including YSW are much more aware of AMS's role as a participant than during the last review. This awareness appears to be directly tied to the relationships developed between AMS staff and institution staff. Institution staff make more frequent positive comments about AMS than they did concerning the prior contractor. It should be noted that institution staff are no more knowledgeable regarding program content than previously.

In general, there is greater awareness on the part of both the provider and the institutions regarding each other's general mode of operation, procedures for working with each other, as well as general policies. There is a lack of awareness regarding specific criteria, as well as specific programming. The increased awareness is obviously due to the assignment of individual AMS counselors to particular cottages. This assignment of counselors has provided the opportunity for working relationships to blossom between provider and institution staff. The assignment of counselors to cottages is the action which has had the most significant impact upon the relationship of the provider and institutions. It has been key to integrating the substance abuse program into the institutions, as has the actions of institutional management to make the substance abuse programming a priority.

There remains a slight difficulty in communication between AMS and the institutions .... a difficulty common to substance abuse and other institutions, particularly those of a correctional nature ...

there is a lack of common meaning ascribed to a variety of jointly used terms, most importantly "treatment". Each system means something different by the term "treatment" and each system is not always aware that the other means something different when using the same term.

There is improvement in how the substance abuse services provider and institutions are utilizing the institutions' closed, isolated, and highly structured service and supervision-oriented environment to deliver substance abuse services. One no longer has the sense of a great chasm between the institutions and the substance abuse provider. There is a sense of shared purpose and mission; the adversarial relationship has diminished. There is clear evidence of direct and substantial communication between AMS and the cottages. There is provider participation in grading students and "making weeks". There is the administration of consequences by cottage staff to students for behavior during participation with AMS. The administration of consequences is both formal and informal and includes acknowledgement on positive as well as negative student actions. The designation of one substance abuse counselor to provide services to a given cottage has facilitated integration of the substance abuse services into the institution. Provider counselors spend time in cottages on a regular basis; there appear to be more services provided in cottages than was the case previously.

The commitment of the institutions to providing substance abuse services is more evident. A concrete example of this is the provision of school credit for participation with AMS and the concomitant permitting students afternoon time away from school for AMS activities. This has changed the difficulty the previous provider had encountered accessing students for services.

The methods used to evaluate students are generally clinically adequate and the recommendations resulting from the evaluation are generally reasonable. In general, the criteria used in the assessment process are clear and explicit. The use of "McAuliffe's Essential Symptoms" (1975) lends some structure to the criteria, but is frankly outdated. The current provider obviously makes an effort to contact field social workers (FSWs) or juvenile court officers (JCOs) and obtain data from them regarding clients. It is clear that AMS has persisted at contacting FSWs/JCOs and made contact where another provider might not have persisted. The substance abuse evaluations produced suffer somewhat from "tunnel vision", they tend to be narrowly defined and not as holistic as they might be. There could be substantial benefit in having the evaluation include an assessment of client cognitive functioning (including consideration of I.Q. test results with allowance for cultural differences), learning disabilities, learning perceptual sets, et cetera, and their impact on substance abuse treatment planning and subsequent treatment. In addition, it would be a professional delight to have access to urinalysis of samples taken

at the time of the young person's original entry into custody, as well as consistent corroboration by community sources; it is recognized these latter two items are a logistical improbability at this time.

The evaluation content tends to be adequate. The evaluation recommendations are appropriate to the institutional setting, although they suffer from a nearsightedness, generally encompassing only the limited options available at the institutions. The evaluations would have greater value if they articulated longer term goals and planning for students' discharge and subsequent continuing care. It should be noted that recommendations from the AMS evaluations are followed through in the institutions' programming on a regular basis.

The quality and appropriateness of the services provided at the juvenile institutions varies. Substance abuse specific prevention and education services are not provided at the institutions. There is some inclusion of substance abuse in the Law Related Education program. The population of juveniles at both institutions fits anyone's definition of "high-risk". As such there should be "high-risk" substance abuse specific prevention programming. It is important to note that during the previous review there was observed the inclusion of more specific substance abuse prevention programming in some cottages and through the school. The previous prevention programming appeared to be of the type normally effective with low-risk adolescents, rather than high-risk. The absence of alcohol and other drug education and prevention services in the cottages is a major deficit. Prevention services should be implemented by the institutions and should be a normal part of their overall services. Such services when developed need to be compatible with AMS's service approach.

Treatment services are basically provided in two (2) options: a) primary treatment; b) low intensity treatment (also called COA - children of alcoholics). No matter what the diagnosis only these two options are available. There is really little individual treatment available. Areas of need identified in the assessment process are frequently not addressed in the master treatment plan. Treatment plan reviews do not deal with goal progress, they deal with process issues. There is a need for clear outcome goal development. It appeared there was little group counseling or treatment, that group sessions were largely lecture and discussion.

Progress notes use idiosyncratic language at times, and generally do not adequately track progress on treatment goals. Progress notes need to identify by title or function persons discussed. There were progress notes where the entire note had been photocopied with only the clients' names changed. The client's "life story" and "journal" do not become part of the client's record.

There was observed some difficulty with the inclusion of all students in the same group. In particular, the mixing of younger and older students (12 and 17 years old) in the same treatment group may not be appropriate. Serious consideration should be given to gender specific groups. Those students with special needs should be identified and provided services appropriate to their needs. Low functioning, immature boys, and minority students are not receiving services appropriate to their needs.

Operating at IJH is more difficult than STS for any substance abuse provider, because at the Juvenile home there are major differences in philosophies of treatment between cottages. The Eldora program has more consistence in treatment approach from cottage to cottage. The AMS services at IJH seem to be more clinically focused than those at STS.

It appears that "COA" (Children Of Alcoholics) treatment and "Low Intensity" treatment are for all practical purposes indistinguishable. It would be the recommendation of the peer review panel to place more focus upon primary treatment, to the exclusion of low intensity treatment. The COA/low intensity treatment might be one strategy for high-risk prevention programming for all students coming from chaotic families. Given limited resources, the substance abuse provider should place available resources in primary treatment and arranging and facilitating transition to community substance abuse placement. Resources currently used for COA/low intensity treatment should be reallocated to more intense primary treatment and more extensive community placement follow-up. It should be noted this will require more adequate differential diagnosis than is currently employed to clearly distinguish those who can benefit from primary treatment.

Given the setting and client population, COA/low intensity treatment for chaotic families really should not be part of substance abuse treatment, rather it should be part of the cottage program. One has the sense that almost all of the institutions' populations are perceived to exhibit a need for COA/low intensity treatment. If this is in fact the case, then such should be an integral part of the institutions services. In general substance abuse primary treatment should deal with primary substance abuse and provide consultation to cottages for students where substance abuse is one feature of what is happening with the adolescent rather than primary. It should be noted that there is a greater recognition on the part of the institutions that a portion of their population's presenting problem is primary substance abuse. As such they also recognize that COA/low intensity treatment does not really address that portion of the population.

There is no doubt that substantial changes have taken place with regard to the provision of substance abuse treatment to "unmotivated youth". These changes have occurred with the joint

participation of the substance abuse provider and the institutions in a cooperative venture. It is as if all involved have joined together to each do their part. As a result, students are referred at more appropriate times with regard to their "motivation" and cottage staff appear to enhance the motivation of the students in a variety of ways. AMS staff seem to be willing to work with students who have less than optimal motivation.

AMS staff does seem to have some difficulty working with youths who act out and are disruptive in groups. They need assistance with students with behavior disorders, attention deficit disorders, and learning disabilities. This appears to be a training deficit, as well as due to a deficiency of adequate supervision, both of which should be open to easy remedy.

AMS has developed and uses written inclusion criteria, which also include appropriate exclusion criteria. The criteria are utilized on a consistent basis and an individualized copy is placed in each student's record. A number of DHS staff had a good understanding of the criteria. In particular, youth service workers, cottage counselors and directors seemed to have a working sense of the criteria. This seems related to the positive contact they have with the counselors assigned to their cottage. The criteria do not account for cultural differences. There were a number of records reviewed where the student met the inclusion criteria but was excluded for reasons not documented in the record. It appeared this exclusion without documentation occurred much more frequently with minority students. There exists a deficit with regard to knowledge regarding cultural differences. At a basic level this deficit has a negative impact upon obviously minority students. In addition, it impacts negatively students with a divergent cultural heritage but who appear to be of the majority.

There is obviously much greater awareness on the part of both provider and institution staffs with regard to the program's goals and role within the institutions. There is also a substantial change in the degree to which the substance abuse program is accepted and integrated into the programs of the institutions. There obviously is a positive leadership position which has been taken by highest management at both institutions. It is clear that the institutions are committed to providing substance abuse treatment services. This is a commitment that was not obvious previously and its implementation is a compliment to the competence of upper management at both institutions. There is a much higher degree of familiarity with each other than ever existed with SATUCI. It is very clear that AMS has done a masterful job of integrating itself into the institutional team at both IJH and STS. AMS is perceived to be part of the team. Institution staff feel very strongly that AMS gave the institutions what the institutions wanted, whereas SATUCI attempted to impose what SATUCI wanted without regard for the needs of the institutions. Institution staff feel SATUCI was rigid and resisted participation in

institution systems, while AMS has been flexible and responsive. It should be noted that a number of DHS staff felt SATUCI had broken barriers which had made for a warmer institutional reception for AMS.

Policies and procedures have been developed and implemented to facilitate appropriate referrals for substance abuse services. Primary communication occurs within levels of the hierarchy (e.g., director to director, counselor to counselor) rather than across levels (director to counselor or youth service worker). This seems to function fairly effectively most of the time, although there appear to be times when counselors are not aware of issues discussed by directors which may effect service delivery. Communication from director to counselor is at times not very thorough, particularly within AMS.

Monitoring of policies and procedures within AMS is poor. Clinical supervision, other than peer review, is poor or non-existent. Peer review occurs by default rather than design .... largely due to the lack of hierarchical supervision.

The issue, of a student recommended for services not being made available by the institution, has become a "non-issue". There now exists a procedure for dealing with such circumstances, but it is largely unnecessary due to the positive level of communication between substance abuse counselors and cottage staff. There appears to be participation by all key personnel in the decision to exclude students from participation.

There is shared and coordinated monitoring of client progress among provider staff, institution counselors, and cottage personnel. This appears to be primarily a result of assignment of provider counseling staff to specific cottages, increased positive relationships, and the resulting increased quantity and quality of communication. It is not clear under which circumstances which staff are required to, <u>as a matter of policy</u>, communicate or coordinate with each other. Although it is obvious, as a matter of practice, that coordination and communication occur. It was clear that AMS counselors review the student's master file when possible, consult with institution staff, are on living units more frequently, are considered to be more a part of the treatment team. There is AMS participation in the student grading system and participation at case staffings.

AMS staff participate in the original case review, as well as on-going case reviews. There was the sense that AMS could be present more frequently at AMS client ICPs. In particular, the substance abuse portion of the comprehensive evaluation needs to be ready for the ICP and in writing. It appears there commonly is a "clerical" delay in producing the comprehensive evaluation. This "clerical" delay seems to be due to a gap in time between the performance of the evaluation and its dictation, as opposed to an actual delay in

typing. The delay in reports was much worse at Eldora than Toledo.

There apparently was active involvement of the AMS director with DHS administrators, including cottage directors, during the beginning of the project. This mutual involvement had a very positive impact upon the development of the project. After a delightful honeymoon, the AMS director apparently was increasingly absent to the point where it was beginning to negatively affect the relationship.

The recommendations provided by AMS through their Initial Assessment and Comprehensive Evaluation appear to be usually followed through with substance abuse counseling. There were times when global recommendations (e.g., needs treatment) were obviously not followed, although there was no explanation for the differences. Reasons why recommendations are not followed need to be documented in client records, and there needs to be a mechanism for following up with clients in such circumstances.

There is evidence that AMS has many more contacts with post-institutional placements than the previous provider. There were consistent attempts to assist clients in receiving continued substance abuse services following their discharge from AMS. What exists is a good beginning. There needs to be much more emphasis upon aftercare or continuing care services. This should include more thorough planning, and more extensive follow up with receiving agencies. This could be accomplished within existing resources by shifting efforts away from COA/low intensity treatment.

In general, there is a lack of sensitivity regarding cultural diversity. AMS has made no efforts to recruit minority staff. This is unacceptable given the number of minority students. AMS should be required to develop an affirmative action plan with clear goals and objectives to recruit minority staff. This plan should be in place so that it can guide recruitment and selection at the time of the next job opening.

AMS has not incorporated culturally specific intervention components or techniques into their service delivery model; this is a real weakness of the programming. The recruitment of minority staff will not in itself necessarily result in the incorporation of culturally specific aspects into the services. Both minority staff and the intentional incorporation of culturally specific interventions are necessary.

There were several broad issues regarding the operation of AMS which were of concern in addition to the lack of sensitivity regarding cultural diversity. As operated, there appeared to have been few opportunities for legitimate inservices and professional training. Staff meetings regarding forms, agency procedures, program development, and other like discussions were labeled as inservice training. Professional training to which the staff had

sanctioned access appeared to be almost exclusively that operated by AMS for profit. Counselors professional qualifications seemed minimal, the majority are not certified. There was a lack of clinical supervision. What appeared in records to be documentation of supervisory review, frequently was a signature stamp apparently applied during review by peers rather than the clinical supervisor. In fact it seems that actual clinical supervision was most frequently provided by the senior counselor, rather than the clinical supervisor, despite the appearance of the records. There were client records with correction fluid applied to change dates. The application of the correction fluid gave the impression that the dates on certain events were changed in order to bring the record into compliance with required deadline dates. One would assume this is not the kind of impression AMS would desire to communicate, therefore correction fluid should not be used in the future. We were distressed by what seemed to be an overall lack of sensitivity regarding ethical considerations at AMS.

Appendix A

Peer Review Panel

Peer Review Panel

Art Schut, Mid-Eastern Council
on Chemical Abuse
Iowa City, Iowa

Virgil Gooding, Sixth Judicial District
Department of Correctional Services
Cedar apids, Iowa

Linda Ruble, Polk County
Broadlawns Hospital
Des Moines, Iowa

Appendix B

DHS Supervisors/Chief Juvenile Court Officer Interview Schedule

DHS SUPERVISORS/CHIEF JUVENILE COURT OFFICER
INTERVIEW SCHEDULE

Are you familiar with the substance abuse services being provided by Addiction Management Services (AMS) in the state juvenile institutions?

_____

Describe the communication and cooperation which exists between your staff and AMS.

_____

_____

_____

Do AMS staff participate in developing the overall treatment plan for juveniles at the juvenile institutions?

_____

_____

Do they contribute to the case permanency plan developed by DHS case workers?

_____

_____

Are the services provided at the institutions adequate to meet the needs of students?

_____

_____

Is your staff familiar with the types of services being provided at the institutions?

_____

_____

Is your staff familiar with the procedures in place at the juvenile institutions to refer students to substance abuse counseling?

_____

_____

Have your staff had students released from the institutions who were involved in the AMS program?

_____

Did AMS assist in arranging appropriate substance abuse services in the students placement community?

_____

_____

_____

Is there anything which I did not ask you about the substance abuse services which you would like to share with me.

_____

_____

_____

_____

_____

Appendix C

Survey of Institution and AMS Staff

Unless Otherwise Directed, Respond To The Single Best Answer By Placing An "X" In The Corresponding Blank.

For All Questions In Which Your Response Is "Other", Please Elaborate On Your Answer In The Space Provided.

At Which Institution Do You Work?

_____ Eldora

_____ Toledo

Current Position:

_____ Cottage Director

_____ Cottage Counselor

_____ Youth Service Supervisor

_____ Youth Service Worker

_____ Administrator (Superintendent, Clinical Director, Principal, Vice Principal)

_____ Other (Please specify)_____

How Long Have You Been Employed At The Institution?

_____ Less Than Six Months

_____ 6-12 Months

_____ 13-18 Months

_____ 19-24 Months

_____ Over Two Years

PLEASE INDICATE IF YOU STRONGLY AGREE (SA), AGREE (A), ARE UNSURE (?), DISAGREE (D), OR STRONGLY DISAGREE (SD), WITH EACH QUESTION.

1) Adequate communication exists between AMS and institutional staff in dealing with substance abusing juveniles.
_____SA _____A _____? _____D _____SD

2) The level of student participation in AMS' program is affected by scheduling conflicts within the institution and a resulting need to choose from among competing programs/services to meet student needs.
_____SA _____A _____? _____D _____SD

3) Substance abuse counseling should be among the State Training School/Iowa Juvenile Home's top priorities.
_____SA _____A _____? _____D _____SD

4) Institutional staff have a good understanding of the services provided by AMS, and of the treatment approach utilized by them.
_____SA _____A _____? _____D _____SD

5) AMS counselors are familiar with the institutions policies, personnel, and operation.
_____SA _____A _____? _____D _____SD

6) The Iowa Juvenile Home/State Training School has made clear its expectations of AMS and communicated the expectations to all institutional personnel, and other system officials such as DHS field workers, and juvenile court officials.
_____SA _____A _____? _____D _____SD

7) AMS' assessment of each student's need for substance abuse treatment should be given top priority in determining which programs/services the student will participate in.
_____SA _____A _____? _____D _____SD

8) Institutional staff consistently inform AMS counselors, of student's progress toward meeting their treatment objectives in the cottage.
_____SA _____A _____? _____D _____SD

9) Institutional staff consistently inform AMS counselors of any behavioral, emotional, and mental, issues which are affecting AMS clients' progress in cottage programming.
_____SA _____A _____? _____D _____SD

10) The level of student participation in AMS's program is affected by institutional staff's choosing other activities for the students during the times AMS staff are available.
_____SA _____A _____? _____D _____SD

11) AMS counselors typically do not spend enough time each week with students to effectively impact their substance abuse problems.
_____SA _____A _____? _____D _____SD

12) AMS is capable of dealing with juveniles who have behavioral problems in addition to their substance abuse problems.
_____SA _____A _____? _____D _____SD

13) Students with any substance abuse related need should receive counseling from AMS during their stay at the institution.
_____SA _____A _____? _____D _____SD

14) Students in need of substance abuse counseling are adequately encouraged by cottage staff to participate in AMS activities.
_____SA _____A _____? _____D _____SD

15) The level of student participation in AMS's program would increase if AMS staff were available at different times than current schedules allow.
_____SA _____A _____? _____D _____SD

16) AMS does a good job of assessing student's involvement with drugs and alcohol, and recommending appropriate levels of substance abuse intervention while at the juvenile institutions.
_____SA _____A _____? _____D _____SD

17) AMS is capable of dealing with juveniles who have even the most severe substance abuse problems.
_____SA _____A _____? _____D _____SD

18) The Level of student participation in AMS's program is affected by student' choosing other activities during the times AMS staff are available to them.
_____SA _____A _____? _____D _____SD

19) AMS counselors consistently inform institutional staff, of student's progress toward meeting their treatment objectives in substance abuse programming.
_____SA _____A _____? _____D _____SD

20) AMS counselors consistently inform institutional staff of any behavioral, emotional, and mental, issues which are affecting their client's progress in substance abuse programming.
_____SA _____A _____? _____D _____SD

21) Please take this opportunity to make any comments regarding the substance abuse services offered in Iowa's juvenile institutions._____

_____

_____

_____

_____

_____

_____

Appendix D

AMS Case Reading Instrument

AMS Case Reading Instrument

NAME _____ ID# _____

1 Is this an open or closed case file?
1 Ongoing case file (client is currently receiving AMS services)
2 Closed (client is not receiving AMS services at this time)

2 If this is a closed file, is there a discharge summary present?
1 Yes
2 No

3 Type of services provided by AMS. (check all that apply)
1 Initial Evaluation 2 Comp. Evaluation
3 Group Counseling 4 Individual counseling
5 Post institution coord. 6 Follow-up survey

4 Date of initial assessment
1: __/__/__ 2: No initial evaluation

5 First date of comprehensive evaluation
1: __/__/__ 2: No comprehensive evaluation

6 Date of last comprehensive evaluation
1: __/__/__ 2: No comprehensive evaluation

7 Number of comprehensive evaluation sessions
1: _____

8 Date of admission to low intensity ___/___/___

9 Date of low Intensity discharge ___/___/___

10 Number of low intensity group sessions _____

11 Number of low intensity ind. sessions _____

12 Date of admission to primary treatment ___/___/___

13 Date of discharge from primary treat. ___/___/___

14 Number of primary treatment groups(PTX) _____

15 Number of primary treatment individual sessions _____

16 Date of fist continuing care group ___/___/___

17 Date of last continuing care group ___/___/___

18 Number of continuing care group _____

19 Date of fist continuing care ind. ___/___/___

20 Date of last continuing care ind. ___/___/___

21 Number of continuing care ind. _____

22 Date of first follow-up survey ___/___/___

23 Number of case consultations with the following:
* Cottage personnel _____
* DSH field worker _____
* JCO _____
* Courts _____
* IJH/STS psychologist _____
* Other Substance Abuse Agency _____
* Parents _____
* Other _____

24 Subject matter of case consultations:
* Post institution substance abuse services coordination _____
* Coordination of services with other system officials, i.e. courts, cottage, DHS, JCO _____
* Verify self reported information from substance abuse assessment _____
* Coordination with cottage _____
* Other - (Describe subject matter)_____
_____
_____
_____

25 Evaluation results:

1. Clinical assessments; (from Initial Assessment)
   a) Substance abuse problem identified
   b) Substance abuse problem potential
   c) No substance abuse problem identified
   d) Opinion unclear

2 Programming recommendations (from Initial Assessment)
   a) Comprehensive evaluation
   b) Low intensity programming
   c) Primary treatment
   d) Post institution (Follow-up) services recommended
   e) No services needed
   f) Recommendation unclear

3. Clinical assessments; (from Comp. Eval. if available)
   a) Substance abuse problem identified
   b) Substance abuse problem potential
   c) No substance abuse problem identified
   d) Opinion unclear

4. Programming recommendations (from Comp. Eval if available
   a) Low intensity programming
   b) Primary treatment
   c) Post institution (Follow-up) services recommended
   d) No services needed
   e) Recommendation unclear

26 Presenting Problems (from Master Treatment Plan)

a) Chemical dependency	h) Sexuality
b) Parental	i) Spirituality
c) Family of origin	j) Abuse history
d) Personal relationships	k) Grief and loss
e) Education	l) Legal
f) Financial	m) Medical/nutritional
g) Employment/Vocational	n) Psychological

o) not enclosed

27 Referrals to other agencies for post institution substance abuse services: (look in discharge summary and face sheet for case consultations)

agency type of service

_____

_____

_____

_____