2011

Youth 'N Action Engagement Project

Engaging Youth for a Lifetime of Success

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Report Prepared by the
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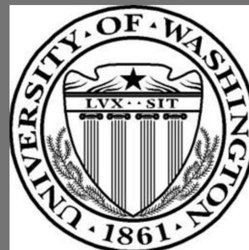

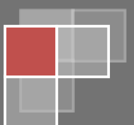

Youth 'N Action Engagement Project

Executive Summary

The intent of the Youth 'N Action Engagement Project was to assess the youth engagement practices of agencies involved in the Juvenile Drug Court Enhancement Project (JDCEP) and the Assertive Adolescent and Family Treatment-4 Project (AAFT-4). These projects are an attempt to expand the number of clinicians who are qualified in three specific evidence-based practices: the Adolescent Community Reinforcement Approach (A-CRA), Assertive Continuing Care (ACC), and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). The engagement evaluation was performed as a collaboration between staff and faculty at the University of Washington, and Youth Evaluators from Youth N' Action (YNA), a youth-led advocacy and support group. Youth Evaluators helped develop the overall research questions and the specific research protocol. The Youth Evaluators conducted focus groups with clinical providers and drug court staff, analyzed the data, and contributed to the development of this report.

Results

Definition of engagement. Providers and the juvenile drug court developed a view of youth engagement that went beyond simple attendance at treatment sessions, and included "authentic" personal engagement with the treatment process. However, aside from case notes, no agency systematically tracked clients' levels of engagement and contributors to successful engagement. Additionally, very few agencies engaged youth in roles that transcended traditional "client" status, such as youth serving on advisory boards, writing newsletters, participating in community outreach, or serving as peer-support specialists.

Barriers to engagement. The main barriers to engagement, as described by focus group participants, were:

- *Perceptual barriers:* Lack of motivation or interest in treatment;
- *Concrete barriers:* Lack of transportation; and language barriers, which was especially a problem in engaging some immigrant or refugee parents;
- *Contextual barriers:* Families and peers who are unsupportive of treatment; and cultural and racial differences between youth and providers;
- *Agency barriers:* The burden of the GAIN assessment tool, which takes 1-3 hours, and audio-recording sessions, which makes some clients uncomfortable or suspicious; and agency policies that disallow clinicians from using current forms of communication such as email and texting with clients.

Engagement strategies. Engagement strategies fell into five general categories: 1. Building trust, relationships, and rapport, 2. Developing intrinsic motivation, 3. Providing incentives and other extrinsic motivators, 4. Removing barriers to participation, and 5. Involving families in the treatment process. Most focus group participants focused on the first three categories; it was clear that providers worked hard to show youth that they respected and cared about them, and that they focused on individualizing treatment and developing intrinsic motivation. However, there were many fewer examples provided of how agencies worked to remove barriers to engagement. Additionally, while all focus groups emphasized the importance of involving families, participants struggled with how to do this successfully.

Issues specific to the JDCEP. There were several issues that were particular to the JDCEP (as opposed to the AAFT-4 or treatment as usual).

- *Inadequate communication and understanding among JDCEP clinical providers and the JDC.* Consistent with our earlier report, these remain the largest barriers to the success of the JDC. Agencies and the JDC fail to understand each other's roles, purpose, and activities in terms of the enhancement project.
- *Lack of referrals and skepticism about the appropriateness of A-CRA and ACC.* Very few youth had been referred to services through the JDCEP, which caused frustration to all clinical providers. Participants in the drug court focus group expressed a concern that A-CRA and ACC were not intense enough and were not culturally competent enough to meet the needs of the type of youth served by the King County Juvenile Drug Court. Participants from the drug court focus group also expressed concern that the agencies did not have experience working with inner city, traumatized youth. Because of these concerns, we had a discussion with the developers of A-CRA and ACC and discovered that these programs are being used with success in JDCs in other culturally diverse and urban contexts such as San Antonio, TX and Denver, CO. The developers said that the intensity of services is tailored to the youth's needs and could be quite intense, if needed. It is unclear with what level of intensity A-CRA occurs within the local context.

Recommendations

Based on these issues, this report makes several recommendations to improve the JDCEP and AAFT-4 projects.

1. *Continue to demonstrate respect and caring for the needs and desires of youth clients.* Use the terms "youth," "adolescent," or "young adult," instead of "kids." Develop policies that allow texting, email, and other modern forms of communication with youth clients. Work on the youth's goals and areas of interest, or help them identify goals. Ensure that activities are relevant to young adults.

2. *Define "engagement" more broadly to expand youth roles, focus on community engagement and outreach, and build efforts for supporting family involvement.* Youth roles can be expanded beyond "client," to possibly include youth serving on advisory boards, youth-run media, youth trained as peer supporters, and more.
3. *Use incentives as a treatment motivator strategically.*
4. *Work with Chestnut Health Systems and SAMHSA to reduce the burden of the GAIN assessment.*
5. *Build mechanisms to systematically track the youth engagement process for individual youth and for agency client loads.*
6. *Build mechanisms for communication, collaboration, and understanding among treatment providers and the JDC.* These efforts can include approaches such as: creating a contact list for all parties involved in the project; holding providers accountable for providing weekly treatment summaries; involving clinicians in team staffings; clearly defining and communicating roles to all stakeholders; holding a joint training for all stakeholders to provide an educational overview of the ACRA, ACC, and JDC; have a provider serve as a regular member of the JDC; and explore the possibility of returning Youth Advocates to the JDC to act as liaisons.

Introduction

To be effective, substance abuse treatment must engage clients. The intent of the Youth 'N Action Engagement Project was to assess the youth engagement practices of agencies involved in the Juvenile Drug Court Enhancement Project (JDCEP) and the Assertive Adolescent and Family Treatment-4 Project (AAFT-4). This evaluation was conducted as a follow-up to a previous process evaluation report describing the development of these projects (Pullmann, Ague, Nehler, Rivers, & Trupin, 2011). The engagement evaluation was performed as a collaboration between staff and faculty at the University of Washington, and Youth Evaluators from Youth N' Action (YNA), a youth-led advocacy and support organization. Through a Community Based Participatory Research approach, these Youth Evaluators contributed to the development of the overall research questions and the specific research protocol. The Youth Evaluators conducted focus groups with clinical providers and drug court staff, analyzed the data, and contributed to the development of this report.

AAFT-4	Assertive Adolescent and Family Treatment-4 Project
ACC	Assertive Continuing Care
A-CRA	Adolescent Community Reinforcement Approach
AYR	Auburn Youth Resources
CHS	Center for Human Services
CYFS	Central Youth and Family Services
DBHR	Division of Behavioral Health and Recovery
GAIN-I	Global Appraisal of Individual Needs—Initial
GAIN M-90	Global Appraisal of Individual Needs—Monitoring 90 days
JDC	Juvenile Drug Court
JDCEP	Juvenile Drug Court Enhancement Project
KYFS	Kent Youth and Family Services
SAMHSA	Substance Abuse and Mental Health Services Administration
MHCADSD	King County Mental Health, Chemical Abuse, and Dependency Services Division
TF-CBT	Trauma Focused Cognitive Behavioral Therapy
THS	Therapeutic Health Services
WAPI	Washington Asian and Pacific Islanders Against Substance Abuse
YES	Youth Eastside Services
YNA	Youth N' Action

JDCEP and AAFT-4. The JDCEP and AAFT-4 projects are funded by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) through King County's Mental Health, Chemical Abuse, and Dependency Services Division (MHCADSD). The goal of JDCEP and AAFT-4 is to increase the capacity of providing agencies to perform three types of treatment services: (1) Adolescent Community Reinforcement Approach (A-CRA), (2) Assertive Continuing Care (ACC), and (3) Trauma-Focused CBT (TF-CBT). The JDCEP focuses on increasing the capacity of local behavioral health clinicians to provide these treatment services to youth in the King County Juvenile Drug Court (JDC), while the AAFT-4 focuses on expanding these treatment services to a more typical adolescent population within one substance use treatment agency.

A-CRA and ACC. The *Adolescent Community Reinforcement Approach* is a recovery- and abstinence-oriented, behaviorally-focused approach to treatment developed by Chestnut

Health Systems (Godley et al., 2010; Godley et al., 2001; Godley, Smith, Meyers, & Godley, 2009). It is based on the Community Reinforcement Approach, which has well established evidence of effectiveness on abstinence and recovery for substance-abusing adults (Meyers & Smith, 1995). At its core, the A-CRA works to rearrange the client's social environment so that sober behavior is more reinforcing than substance use. This includes developing positive peer activities, positive family relationships, and improved life skills. A strong therapeutic alliance is foundational to A-CRA; hence, appropriate and effective engagement practices are essential to effectiveness. Therapists build their treatment plans around a detailed clinical assessment (a 1-3 hour interview using the Global Appraisal of Individual Needs or GAIN-I) and a functional analysis developed during the first several weeks of treatment. The length and course of treatment is flexible to meet the needs and treatment progress of the adolescent. Generally, treatment in A-CRA takes place over 12- to 14 weeks, with 10 individual sessions with the adolescent and 2 sessions with the caregiver and adolescent. Others, such as romantic partners, friends, and siblings, can also be involved in sessions, when deemed appropriate.

A Youth Evaluator wrote:

"This is the first time I have ever done a focus group. When I first began the project, I thought that it was going to be very hard and that the agencies weren't going to be very friendly and open. The agencies were actually very nice and open."

Assertive Continuing Care is an approach to provide follow-up services after substance use treatment is completed (Godley, Godley, Karvinen, Slown, & Wright, 2006). By using the word "assertive," the developers mean that ACC places the responsibility for ensuring sessions occur in the hands of the clinician, encourages face-to-face sessions in natural settings that are convenient for the adolescent, and emphasize several non-traditional activities such as addressing barriers to treatment, advocacy for youth, and resource identification. The goal of ACC is to reinforce treatment success by removing barriers to participation in follow-up, especially transportation. Elements of ACC, such as the emphasis on community- or home-based services, are often incorporated into A-CRA. ACC is generally conducted for up to six months.

<u>*TF-CBT.*</u> *Trauma-focused CBT* is an evidence-based practice for children and adolescents who are experiencing significant emotional and behavioral distress as a result of traumatic life events. At the time the engagement evaluation was conducted, AAFT-4 and JDCEP clinicians had not been trained in TF-CBT as part of these projects.

<u>*King County Juvenile Drug Court.*</u> The King County JDC is one of hundreds of drug courts throughout the nation. On a case-by-case basis, juveniles who have drug or alcohol problems

are offered the opportunity to enter the drug court program. Through this program, they receive treatment, are frequently tested for drug use, and have frequent hearings and supervision from the drug court judge. By entering the program, youth waive the right to a court trial, but if they successfully complete the program, then charges are dropped. The JDC takes a team approach to treatment. Involvement typically lasts from 9 to 24 months.

Defining Youth Engagement. Substance use treatment research typically defines "youth engagement" as treatment enrollment, attendance, and/or retention, which is consistent with definitions of engagement in other populations (cf. Grote, Zuckoff, Swartz, Bledsoe, & Geibel, 2007; Ingoldsby, 2010; McKay, Stoewe, McCadam, & Gonzales, 1998; Slesnick, 2001). More nuanced views of engagement see it as an ongoing, therapist-facilitated process, where quantifiable client behaviors (such as attendance) are only partial indicators of an underlying course of engagement (Both Gragg & Wilson, 2011). This view of engagement is highly consistent with the treatment approach advocated in ACC, as described above, with the burden of building the engagement process placed on the clinician. In this approach, engagement incorporates themes such as surmounting barriers to attendance, collaboration with treatment providers, attitudes toward treatment, active and authentic participation in treatment, empowerment, participant roles that transcend "client" status, and family participation and involvement in treatment (Hornberger & Smith, 2011; McKay & Bannon, 2004; Simmons et al., 2008).

A Youth Evaluator wrote:

"Before we participated in any of the focus groups, I figured that the providers and the Drug Court team would be clueless on how to engage youth and treat them. I went into the process thinking, 'All these old farts will know nothing about youth and will probably be ignorant on how to even communicate with youth.' But after listening to them I was really amazed to find a lot of them saying things that were very empowering and heartfelt."

It is important to note that during early discussions among the evaluation team about the definition of engagement, the Youth Evaluators did not believe that attendance, alone, was a good indicator of engagement. Instead, they believed that authentic engagement was better defined as collaborative and active participation in treatment. Authentically engaging youth may involve work far beyond the scope of traditional clinical services, especially in communities that have a "healthy cultural suspicion" of these services (Simmons, et al., 2008). This broader work likely includes ongoing community engagement and community outreach in order to build trust and understanding, and to reduce stigma and lack of knowledge that acts as a barrier to engagement.

Defining Elements of Engagement. While many researchers have discussed engagement in adolescent substance abuse treatment, we were unable to find any comprehensive review of elements of engagement strategies. However, recent work on family engagement in children's mental health services does provide this comprehensive view and, in many ways, is analogous to the issues surrounding engagement in adolescent substance use services.

In a review of 27 randomized controlled trials of children's mental health treatments, 62 different engagement interventions were coded and distilled down to 17 common elements of family engagement (Evangelista Brandt & Lindsey, 2011). Research is still under way to determine which of these elements are most strongly related to a positive engagement process. However, these elements may still prove useful to organizations wishing to diversify their approaches to engagement. They include the following:

- *Cultural acknowledgment*—Strategies to explore and respond to the client's culture, including matching the therapist and clients' cultural/ethnic backgrounds, considering who to involve in treatment, etc.
- *Psychoeducation*—Providing information about the etiology of substance use and the course of treatment.
- *Praise/Rewards*—Providing praise or concrete rewards for attending treatment or participating in activities.
- *Behavioral Contracting*—Signing a contract with clients on mutually agreed-upon responsibilities (attending treatment, etc.)
- *Attendance Monitoring*—Monitoring attendance and tardiness, participation, homework completion, client perceptions of therapeutic alliance, satisfaction, and relevance.
- *Accessibility Promotion*—Strategies to promote attendance such as providing food, childcare, transportation, reminder calls/letters.
- *Peer Pairing*—Matching clients with peers currently in treatment or who have successfully graduated.
- *Case Management*—Providing case management services.
- *Expectation Setting*—Clearly defining what is expected of the client in treatment.
- *Problem Solving*—Working with the client to solve ongoing problems and surmount barriers to treatment.
- *Assessment of Strengths, Needs, and/or Barriers*—Formal assessment to identify areas in need of help and personal strengths which can be used to build upon.
- *Goal Setting*—Identifying the goals of the client and helping them work toward those goals.
- *Rapport Building*—Building trust, respect, and alliance.

- *Therapist Monitoring*—Similar to Attendance Monitoring, keeping track of the clients progress.

While these elements of engagement provide a starting point for reflecting on the engagement practices of the AAFT-4 and JDCEP projects, the evaluation team took a grounded approach that allowed for practices and elements beyond those described above.

Removing barriers to engagement. Many clients do not engage due to perceived or concrete barriers. Treatment approaches such as ACC are defined as "assertive" specifically because the clinician is tasked with breaking down barriers to treatment (Godley, et al., 2006). Research in children's mental health again provides a helpful conceptual overview of barriers. Barriers have been classified into four types (McKay & Bannon, 2004): concrete/logistical barriers (lack of time and transportation), contextual barriers (community violence or community poverty), agency barriers (waiting lists, paperwork), and perceptual barriers (stigma, perceived need for treatment). In children's mental health, findings have indicated that perceptual barriers have the strongest effect on engagement. These perceptions appear to be most significantly influenced by the therapeutic alliance and the degree to which clients were involved in treatment planning (McKay & Bannon, 2004). These findings indicate that initial rapport building and early determination of the client's needs and goals are essential to engagement and retention.

Process

The evaluation team consisted of a youth empowerment consultant, three Youth Evaluators who are members of Youth N' Action (YNA), the director of YNA, and an Assistant Professor and a Research Coordinator from the University of Washington. The three Youth Evaluators were hired based on their ability to share their unique insight and personal experiences relevant to the evaluation. While none of the Youth Evaluators had been through the drug court, all of them had received publicly-funded substance use treatment or mental health services in King County, and two of them had multiple contacts with the juvenile justice system. To read a little more about two of the youth evaluators, Appendix A features their written responses to a few questions that were posed to them.

Two initial evaluation team meetings focused on describing the overall goals of the project, discussing the various meanings of engagement, and describing the agencies who would participate. Later meetings focused on brainstorming specific research questions and specific focus group questions, and on training the youth to conduct focus groups. The research and focus group questions were formulated over a period of four weeks. To develop the questions, Youth Evaluators combined theories of youth engagement, best practices for engagement, evidence-based practices, and their own life experiences.

Each member of the focus group team was trained to conduct focus groups, including skills for appropriate responding, active listening, ethics, and the basics of focus group facilitation. Youth evaluators received this training over a series of weekly meetings, telephone conference calls, and multiple practice sessions. During these trainings, the evaluation team continued to develop and solidify the focus group questions. As the team practiced, questions were modified, deleted, and added based on their experiences in previous focus groups. Appendices B and C feature the final versions of the focus group questions and administration protocol (Appendix B is for the clinical providers, Appendix C is for the Juvenile Drug Court Team). The focus group administration protocol is consistent with standard practice, beginning with broad "grand tour" questions and narrowing to more specific and sensitive questions as the group progressed.

The questions primarily focused on seven key elements:

1) What was the initial process of engagement?
2) What were the most effective tools used to engage youth?
3) How was youth engagement tracked and reported?
4) Why did youth disengage?
5) What were the barriers to youth engagement?
6) How did agencies empower youth?
7) What could King County Juvenile Drug Court do to assist providers in the engagement process of clients involved in the Juvenile Drug Court Enhancement Project?

There were five focus groups conducted with six clinical agencies and the Juvenile Drug Court. These were conducted in August and September of 2011. Overall, there were 31 participants in the focus groups. The agencies that participated in the evaluation and the number of participants in the groups are as follows:

- Auburn Youth Services (AYS; 3 focus group participants)
- Center for Human Services (CHS; 7 focus group participants)
- Juvenile Drug Court (JDC; 12 focus group participants)
- Kent Youth and Family Services (KYFS; 3 focus group participants)
- Therapeutic Health Services/Central Youth and Family Services (THS; 2 focus group participants)
- Washington Asian and Pacific Islanders Against Substance Abuse (WAPI; 1 focus group participant)
- Youth Eastside Services (YES; 3 focus group participants)

CHS is the only clinical provider for AAFT-4, and is also a clinical provider for JDCEP. AYS, CHS, KYFS, THS, and YES are clinical providers for adolescents through the JDCEP. WAPI provides

management of GAIN intake and follow-up interviews. The Juvenile Drug Court includes staff of the drug court and participating stakeholders such as attorneys and probation officers. Agency directors or lead staff at each agency were sent a letter of invitation from the managers of the projects at MHCADSD describing the logistics of the project. The University of Washington contacted the agencies to describe the project in more detail and schedule focus group sessions. The focus groups lasted between one to two hours and were held at a time convenient for the participants. Most agencies participated in separate groups, but two agencies, CHS and THS, did a joint focus group. Meals or snacks were provided at each focus group, and each participant received a $30 gift cards to a department store. The staff member could keep this for him or herself or to use with youth as the agency's policies allowed. Each participant was told that participation in this evaluation was voluntary and confidential, and each focus group participant signed a form indicating their consent to participate.

The focus groups were facilitated by youth and supervised by University of Washington research staff. The Youth Evaluators took turns reading the questions and asking follow-up questions. Each evaluator participated in active listening and building rapport with the participants.

During the first focus group, the team found that participants had difficulty tracking the questions being asked. A recommendation, which was put into place for future focus groups, was to have a set of the questions available to each participant. For all future focus groups we provided participants with a notebook listing the questions and allowing space for participants to express concerns confidentially, should they choose. Only a few participants chose to use this option.

A Youth Evaluator described one focus group like this:

"Man, it was like shaking a can of pop. We asked one question and that built on another and pretty soon we were getting answers all over the place… they didn't want to stop talking!"

The Youth Evaluators also developed a written satisfaction survey to allow focus group participants to provide information about their focus group experience and ways to improve the focus group. Responses were from 1 to 5, with 1 meaning "not at all effective" and 5 meaning "super effective." Most focus group participants completed a satisfaction survey (24 individuals or 77%). Results, depicted in the table below, indicated very high levels of satisfaction. No question received a lower rating than 4 out of 5.

	Mean	Standard Deviation
The questions were clear and precise	4.6	.49
The facilitators presented the questions in a clear and focused manner	4.9	.34
The facilitators created a welcoming and comfortable environment	5.0	.00
The facilitators were professional	5.0	.00
There was enough allotted time for the whole group to speak	4.8	.44

Approach to Analysis. We took a "grounded theory" (Strauss & Corbin, 1998) approach to analysis. In grounded theory, theory is inductively derived from data and data is systematically analyzed in an ongoing interplay between researchers and data. In this case, data are the words and interactions that occurred during focus groups. The systematic analysis occurred during team discussions about the data and their interpretation. The evaluation team met immediately after every focus group to debrief, and met at least once before every focus group to prepare for the next group. During these meetings, we discussed the findings, formulated general themes, and built interpretive categories. We would sometimes modify the focus group approach or specific questions based on themes and other areas of interest that arose in our analysis from previous groups. The Youth Evaluators each wrote individual reports of their experiences and their impressions of the most important findings from the groups. Wording from those reports appears throughout this current report. All focus groups were transcribed. Our final analysis meetings reviewed these Youth Evaluator reports, transcripts, notes from the focus groups, and all other data artifacts, and attempted to classify and categorize our findings into several coherent themes. In this way, the analysis of the data and our approach to collecting data was dynamic yet grounded through an evolving understanding of youth engagement.

Results

Several themes emerged during the evaluation process.

1. Youth Engagement: What is it and what does it look like?

Providers described several indicators of youth engagement. Most commonly cited was *attendance* in treatment sessions. They also frequently mentioned several behaviors which indicated the youth was *making an effort* in treatment, such as unprompted participation, speaking honestly "especially about the bad things," calling the provider if they were going to be late or have to miss a session, asking the provider for help with needs such as

transportation, and checking-in. Other indicators included *non-verbal cues* such as smiling, making eye contact, and using an open body posture.

Providers and Youth Evaluators alike defined engagement as an *active process*, and not simply attending treatment. It was described as *ongoing, authentic personal engagement* with the treatment process, where youth had *buy-in* to treatment and felt like treatment was *collaboration* between youth and provider.

At least one agency felt that *attendance was not necessarily a good indicator of treatment engagement*, because sometimes youth did not attend services because they were engaged in more positive activities such as band, sports, or academic activities, or sometimes youth "needed a break" from treatment.

Participants felt that attendance and/or active engagement was essential to treatment success. However, aside from individual treatment and progress notes, *no agency systematically tracked engagement*. All providers said that they attempt to find out the reasons for disengagement when a youth stopped attending sessions, but these reasons were never collected and aggregated in order to analyze and improve practice. Progress notes were not treated systematically as a way to measure and track youth engagement across client loads. No participants used any standardized measures of engagement, such as the Vanderbilt Therapeutic Alliance Scale (Shelef & Diamond, 2008), with their clients. No agencies had any tracking system that could detail the numbers of and reasons for youth disengagement or lack of attendance. Agencies were unable to provide us with information about the rates of treatment disengagement.

A Youth Evaluator wrote:

"When we asked them 'How do you track the reasons why youth stop going to therapy, and is there a system for reporting it?' they seemed to struggle with that question and didn't really have any real way of tracking why youth stopped going to their program."

As described earlier, more expansive views of engagement can include empowerment through roles that transcend traditional "client" status. Examples in other settings throughout the nation include youth clients or program graduates serving on boards of directors or advisory boards, youth-run media such as agency newsletters or websites, youth peer support specialists, youth review of new materials or treatment approaches, youth liaisons hired to re-engage clients, youth-led community outreach efforts, and youth-run activity groups. However, with one exception (one agency said that they had a former client serving on their advisory

board), *participants were unable to provide any examples of youth involved in these types of roles* through their agency or program.

2. **<u>What are the main barriers to engagement?</u>**

As described earlier, providers generally try to ask youth why they do not engage or why they disengage. These reasons may be tracked in case notes, the GAIN-M90, and in attendance records. However, none of the agencies systematically tracked these reasons in order to provide an overall examination of client engagement in their agency. However, during our focus groups providers were still willing to talk about common barriers to engagement. These are broken down into four categories.

<u>Perceptual barriers.</u> Perceptual barriers have the strongest effect on engagement The most frequently endorsed barrier to treatment from focus group participants is *lack of motivation/boredom*—clients do not feel that they have a problem, and drugs and their drug-using peers are more interesting than counselors and sobriety. As one participant said, "[Clients feel that] treatment is wack."

<u>Concrete barriers.</u> The most common concrete barrier was *lack of transportation*. This was often correlated with a lack of parent support for treatment. *Language barriers* were also mentioned as a serious problem for immigrant and refugee families.

<u>Contextual barriers.</u> Unsupportive families and peers was stated as a contextual barrier in all but one of the provider groups involved in the Youth 'N Action Engagement Project. A few agencies described some success at parent partnering. Most or all agreed it was vital for youth engagement and sustaining treatment. Some agencies struggled with engaging parents in their child's treatment. Those who were successful simply made it a mandatory part of treatment. One agency said that parent involvement was mandatory, if indicated. This agency told parents that they would not treat their child unless the parent had some involvement.

A Youth Evaluator wrote:

"Another thing I observed is that there was a lack of parent partnership. As a youth, I think that parent partnership is one of the most important things when getting the youth to recovery… drug court and treatment providers should try hard to engage the parents so parents can show the youth that they really do care about their wellness."

Cultural differences between clients and clinical staff, including race, ethnicity, and poverty, were also mentioned as contextual barriers. *Co-occurring mental health* issues such as anxiety and depression, and particularly *trauma* were often mentioned as barriers to working through

treatment. A history of trauma and abuse contributes to a lack of trust in adults, and conflict-related trauma in refugees presents problems that clinicians may not be experienced in working with.

Agency barriers. The *GAIN assessment tool* was mentioned several times as a barrier to engagement due to its length; providers stated that it generally took more than two hours to complete, and could take up to four. Providers were also concerned about asking the *GAIN's intrusive questions* prior to building rapport and trust with the client. One provider described the GAIN assessment as "just something we [providers and youth] have to overcome together" rather than as a beneficial tool for assessing the client's needs and strengths. Also, Chestnut Health Systems requires audio-recordings of therapy sessions so that providers can earn ACRA/ACC certification status. Youths' mistrust toward being recorded was mentioned as a difficult barrier, especially during the first sessions. Finally, agencies have *policies that restrict the use of modern forms of communication* (i.e. the use of email, texting, and social networking sites). While these policies are well-intentioned to protect client confidentiality and address possible legal issues, policies are inconsistent among agencies. Agencies that allow texting or emails find it a very helpful way to stay in touch and remind youth of their sessions, and clinicians report that *clients are particularly enthusiastic about texting as a means of communication* but several agencies do not permit texting. At least one agency uses texting but not email, and one agency uses email but not texting.

3. Youth Engagement: How do we get there?

Engagement strategies appeared to fall into five general categories: 1. Building trust, relationships, and rapport, 2. Developing intrinsic motivation, 3. Providing incentives and other extrinsic motivators, 4. Removing barriers to participation, and 5. Involving families in the treatment process.

Building trust, relationships, and rapport. Most providers described the initial intake process as important to client engagement in treatment; providers and the JDC staff emphasized initial efforts to *make the client feel comfortable and respected*. Several providers and the drug court staff said that it was important, especially during the early phases of building relationships, to let the clients talk about themselves, their interests, and the things they enjoyed doing. This helped to build relationships, but it also proves useful for appeals to internal motivators. *Fun activities* such as recovery-oriented games, sports, and trips to the park or sporting events were used as motivators and as learning tools to build life skills. One clinician—who, we believe not coincidentally, reported having more clients from the drug court than any other clinician—claimed to *visit the drug court regularly*. This clinician credited these visits for building initial trust with clients because of familiarity and recognition. This clinician also believed this helped build trust from the drug court staff. Only the drug court mentioned the importance of

providing a "culturally relevant setting" in order to build motivation and encourage engagement.

Developing intrinsic motivation. Several—though not all— stressed the need to *individualize treatment* to the needs and wishes of each client, which includes *meeting youth were they are at* (in recovery) and a process of *identifying youth's goals and helping them work toward those goals.* Data from providers and the drug court indicate agreement on a priority focus on internal motivators. For instance, staff described the importance of conveying that treatment was a partnership: "I make it clear we work together to overcome their obstacles, not to set them back, but if they are struggling then we work on how to get around that." The focus on helping the youth understand and develop their goals was also used as an internal motivator for recovery, as substance abuse was framed as a barrier to achieving their goals. Several clinicians said they used *motivational interviewing* techniques to enhance and help develop clients' intrinsic motivation.

Providing incentives and other extrinsic motivators. Providers varied widely on their use of *incentives for participation* such as using gift cards to reward treatment attendance. We heard little to no structure or consistency to the use of incentives, both across and within agencies. Some agencies heavily used incentives while others did not use incentives at all. Motivation often came through verbal praise and support for small successes. Agencies also talked about ways to award clients for participation, including *youth awards ceremonies* and *graduation ceremonies*. Seeing other youth graduate from treatment was cited as a valuable way to build motivation. Other forms of extrinsic motivation came from appealing to the *youth's desire to avoid negative consequences*. These included avoiding minor annoyances ("sometimes it comes down to pestering the youth to come to treatment"), simply being done with having to attend treatment (by successfully competing it), and completing the requirements of the drug court (and, consequently, having criminal charges dropped).

Removing barriers to engagement. Focus group participants described a few approaches they have taken to removing barriers to participation. These included *facilitating transportation* through providing bus passes, *facilitating communication* through providing a cell phone, and *providing food at meetings* (which is also an external motivator and a way to build rapport). However, we were surprised at the relative rarity of barrier removal as a voiced strategy for increasing engagement. While many agencies and the drug court were engaged in activities which could be construed as addressing the four barriers to engagement described earlier (concrete, contextual, agency, and perceptual barriers), they rarely described these activities in this way. The JDC mentioned a few times that they *once employed youth advocate positions, who focused on removing barriers to treatment by connecting the JDC to the clinicians,* but due

to budget issues those positions are now gone. Participants in the JDC focus group stated that the youth advocate position was a strong piece of the program which is now missing.

Involving families in the treatment process. Nearly all agencies described *family involvement as vital*. Family involvement ranged from general family encouragement of treatment to family members participating in the treatment process. Most agencies felt that families were vital and that parents could be empowered as the "experts" in their child's life. However, *lack of family support or encouragement was frequently mentioned as a major barrier to treatment.* Agencies expressed high levels of frustration with their attempts to involve families. Challenges with parent engagement are described in more detail in sections

below.

A Youth Evaluator wrote:

"I think it was very cool that this agency held events in the community and made an effort to get their name out and show that they are youth-friendly. I think they care about youth's recovery."

Engagement strategies rarely mentioned. There were a few engagement strategies which were rarely mentioned. Only one agency explicitly mentioned *community engagement strategies* such as having booths at community fairs and making presentations to community groups in order to make sure the community was aware of their services and to reduce stigma. As described above, community engagement is considered very important, especially when working with communities of color or marginalized communities who may be more likely to mistrust systems and services. Only one agency described using funds to purchase a cell phone for a youth to improve communication (and they reported success with this approach). Most agencies were able to provide only a few examples of providing treatment services in the community or other non-clinic setting.

4. What do agencies do when youth prematurely disengage from treatment?

All agencies said that they attempt to follow-up with clients who disengage and try to address their reasons for not coming to treatment. Reasons for disengagement are documented in case notes. Because there had not been many referrals specific to the JDCEP, agencies in this program were unsure of the role the JDC could play in helping them re-engage clients. Two agencies have specific staff members who had the specific role of finding and attempting to re-engage clients. These staff members go to youths' homes, talk with friends and families, and look for them at their usual hangout locations. Agency staff described these efforts as helpful, but they are fraught with challenges. Other agencies stated that they did not have the resources to make these more intensive efforts. One said "We can't go chasing them down if

we cannot find them, if we can't get a hold of them or their families, then there is really nothing we can do…. I feel we are stuck, we do not have the policy to go out there [and find them]."

5. **Not enough money for clinicians**

On numerous occasions, the focus group participants said that they felt that clinicians did not get paid enough for their work.

JDCEP specific issues

Unless otherwise specified, the sections above apply to "usual practice" in youth engagement in treatment services and broadly applicable to both the AAFT-4 and JDCEP projects. However, much of the data was specific to the JDCEP.

6. **Lack of referrals and skepticism about the appropriateness of A-CRA and ACC**

At the time of the focus groups, very few referrals had been made as part of the JDCEP. Two agencies reported only having received one referral by that time. Participants in the drug court focus group expressed a concern that A-CRA and ACC were not intense enough and were not culturally competent enough to meet the needs of youth served by the King County juvenile drug court, which they described as disproportionately African American males with severe needs. Participants from the drug court focus group also expressed concern that the agencies did not have experience working with inner city, traumatized youth. These concerns were directly related to the fact that very few referrals had been made to the clinical providers as part of the JDCEP.

To follow up on this concern, the evaluation team had a conversation with Dr. Mark Godley, one of the developers of ACC/A-CRA at Chestnut Health Systems. Dr. Godley indicated that ACC/A-CRA were highly flexible programs and designed to be responsive to the needs of individual youth and communities. Additionally, he said that the program was being successfully implemented in 5-10 juvenile drug courts nationwide, and that some of these courts worked with inner city and culturally diverse youth. For instance, a juvenile drug court in San Antonio, Texas, has implemented the programs in a primarily Latino(a) population. It should be pointed out that most jurisdictions using the model in drug courts were smaller and less racially diverse than

A Youth Evaluator wrote:

"My experience has grown throughout this project. I learned about the different practices that agencies use to help youth to recovery. I learned how to act, dress, and approach the professional world. I also learned how to conduct a focus group and track down and analyze data."

King County. Hence, it appears possible that these programs can be successfully applied with youth from a diverse range of needs in large cities.

However, because very few youth have been referred to the JDCEP, this evaluation was unable to explore whether the King County treatment providers who are involved in this project are applying the model with the flexibility and intensity felt appropriate by the drug court. For their part, *all treatment providers repeatedly expressed confusion about the reasons why they had received so few referrals.* This confusion was related to high levels of frustration with the lack of referrals. Additionally, during our focus groups many of the agencies described having years of experience working with youth who had severe and complex needs. And, conversely, one provider said they had experienced trouble engaging JDCEP youth because the treatment requirement was too intense and required too much involvement from the youth.

The JDC expressed concerns that they had been led to believe the providers would be delivering treatment in the community, with less focus on clinical treatment. Dr. Godley indicated that this is an emphasis of ACC, and some providers incorporate these elements of ACC into A-CRA. It is true that very few providers talked about meeting youth in the community; however, as mentioned earlier, few providers had received a significant number of referrals, which would be necessary in order to practice these approaches.

7. **Inadequate communication and understanding among clinical providers involved in the JDCEP and the JDC staff**

While the specific concerns related to lack of referrals which are described above are important, of the most importance is what they illustrate: *inadequate communication and understanding between the drug court and clinical providers* which leads to these concerns.

Consistent with our earlier report (Pullmann, et al., 2011), *communication and cross-system understanding remains the largest barrier to the success of the JDCEP*. Several clinical agencies continue to report a lack of understanding about how drug court works. *Several participants expressed a desire to meet with a drug court representative, or to have an opportunity to visit the drug court.* Similarly*, there remains little practical knowledge in the JDC about A-CRA, ACC, or the clinical approach being taken by the agencies.*

Similarly, and consistent with our previous report (Pullmann, et al., 2011), the JDC team expressed a *strong desire for weekly reports, prior to team staffing, from providers about treatment progress for individual youth*. They expressed that they use this information for decision making, and that problems occurred when it arrived late or was missing. For instance, they make decisions about sanctions with information from these reports, and when the reports have been late then inappropriate decisions have been made. Some members of the

JDC team expressed frustration with having to monitor providers to send this information regularly, while others said this had not been an issue.

8. **Lack of a sense of partnership between the JDC and the JDCEP clinical providers**

With a few rare exceptions, there was *little sense of partnership between the providers and the JDC.* This is consistent with our previous report (Pullmann, et al., 2011). Clinicians expressed the desire to be more involved in the JDC team, perhaps by attending team staffings. Clinicians noted that their current involvement was generally limited to filing weekly reports for each participant in the drug court stating if they are in compliance, attending appointments, and abstaining from drugs and alcohol. The JDC team has been reticent to allow clinicians to attend team staffings. The clinical providers on the JDCEP reported very little communication, collaboration, or a sense of partnership with the JDC team, with the exception of JDC Probation Officers. When asked to provide examples of effective communication in the project, more than one agency described regular face-to-face contact between a provider and JDC Probation Officers. Each agency reported having very positive relationships with the King County Probation Officers in general, and specifically the PO's at JDC. One agency stated how impressed they were that the JDC Probation Officer traveled an extraordinarily long way to meet with an A-CRA client. Agencies said that they receive excellent help from PO's in locating and re-engaging clients. However, as mentioned earlier, only one clinician reported visiting the JDC on a regular (almost weekly) basis, and this provider reported a very good working relationship with the JDC.

9. **Concerns about racial and cultural match between JDCEP providers and clients**

As described in our previous report (Pullmann, et al., 2011), there continues to be concern from the JDC about the racial and cultural match between the clinical providers involved in the JDCEP and drug court clients. They felt that some agencies did not have providers trained in A-CRA and ACC who could serve African American youth, in particular. While our focus groups did not include all JDCEP clinicians involved in the project, nearly all who attended were white.

Recommendations

1. **Continue to demonstrate respect and caring for the needs and desires of youth clients.**
    a. **Use the terms "youth," "adolescent," or "young adult" rather than "kids".** Youth Evaluators felt that the word "kid" was disrespectful, though it was frequently used by adults during the focus groups.
    b. **Develop policies that allow texting, email, and other current forms of communication with youth clients.**
    c. **Work on the youth's goals and interests, or help them identify their goals.**
    d. **Ensure that activities are relevant to young adults.**

2. Define engagement more broadly.

a. Expand the roles of youth in the JDCEP, AAFT-4, JDC, and clinical services beyond that of "client."

A Youth Evaluator wrote:

"I would suggest that they use as many empowerment strategies as possible, look into having youth on their board of directors and encourage more self-expression through youth-produced media. Continuing to support the role of peers in their engagement and treatment process would help engage youth and help in their recovery."

Over the last thirty years, the field of behavioral health services has been moving towards more inclusive and participatory approaches. This seems especially appropriate for youth during their transition to adulthood, as they earn increasing independence and control over their development. There are several options for including youth in larger roles in these projects or at agencies or the JDC. These approaches help create a "culture of engagement." They can include: youth serving on advisory boards or boards of directors; youth-run newsletters, websites, or blogs; youth who provide formal peer support; youth-led art projects such as murals, digital storytelling, photovoice, and more. However, *successfully developing these approaches takes time, effort, and thoughtfulness.* For instance, a single, unprepared youth on a board of directors is likely to fail. Groups such as Youth N' Action are experienced in providing consultation and support to efforts to engage and empower youth.

b. Use community engagement strategies.

For the reasons discussed earlier, community engagement can often be essential to building a context of trust, understanding, and respect. Outreach at community fairs, churches, schools, and locally owned businesses can be surprisingly effective at reducing stigma, garnering parent involvement, and increasing retention in services. The Hartford Youth Project has an excellent report on effective strategies for community engagement for substance use treatment providers: http://www.thefreelibrary.com/Bringing+adolescents+into+substance+abuse+treatment+through+community...-a0195755752.

c. Provide assistance to agencies on effective techniques for supporting parent and family involvement. Every focus group described their struggles with engaging parents and other family members in the treatment process. However, research has clearly indicated that family involvement strongly facilitates

successful substance use treatment. Agencies may need support such as reimbursement systems which encourage clinical time spent engaging families, and expert consultation on how to encourage and support family engagment

3. **Carefully consider the strategic use of incentives as a treatment motivator.**

The evaluation team had a lot of discussion about the appropriateness of using incentives to encourage participation, with the Youth Evaluators being especially concerned about the possibility of their overuse and/or their use as a substitute for developing internal motivation. While there is no doubt that incentives can be useful in many situations, the Youth Evaluators felt that youth might be better served through a primary emphasis on encouraging internal motivators by:

- identifying the unique goals of each individual youth and helping them work towards those goals;
- identifying barriers (concrete, contextual, agency , or perceptual) to engagement and actively working to reduce or remove those barriers;
- using motivational interviewing techniques;
- demonstrating respect for youth;
- meeting the youth were they are at, both psychologically and physically, and
- using peer-to-peer support delivered by clients who were successfully in recovery in order to demonstrate to youth that recovery is possible and positive.

A Youth Evaluator wrote:

"I would suggest that the providers be wary of overusing incentives as an engagement tool, to make sure that is well-balanced with personal motivation and only used for rewarding good behavior and recovery."

4. **Work with Chestnut Health Systems and SAMHSA to address the challenges of the GAIN assessment instrument.**

The GAIN assessment tool was frequently mentioned as a barrier to building trust and rapport, and (because of its length and excessive administration time) as an added burden for clinicians and clients. After learning about the GAIN, the Youth Evaluators agreed that they would also be irritated and deterred were they to have to go through an assessment. However, SAMHSA requires the use of the GAIN for

A Youth Evaluator wrote:

"I felt like none of the agencies [and the JDC] really knew too much about each other. I think the JDC and their partnering agencies should have a meeting together to figure out what they can do to help each other out."

youth in order to determine eligibility, clinical need, and salient contextual issues. The evaluation team felt that additional work should be done to examine the unintended consequences of the GAIN administration and possible solutions.

5. **Build mechanisms to systematically track the youth engagement process for individual youth and for agency client loads.** This will help agencies uncover successful strategies and highlight areas that need attention.

6. **Consciously build mechanisms for communication, collaboration, and understanding among treatment providers and the JDC.**

A Youth Evaluator wrote:

"I would suggest that the providers and the drug court work out communication at the least, but it might also benefit them if they directly partnered as a recovery team, and had pre-court briefings with the providers present to participate as team members. That might help the providers get more referrals and understand their role in the process, and also help the drug court with report deadlines and prevent harmful miscommunication."

Consistent with our recommendations from our previous report, and as a result of suggestions from focus group participants, *we strongly encourage the JDCEP to continue to build specific mechanisms to support partnerships among stakeholders.* These can possibly include one or more of the following suggestions:

a. **Create a contact list and email listserv for all individuals involved in the JDCEP**
b. **Hold providers accountable for providing weekly individual treatment summaries prior to JDC team staffings**
c. **Involve clinicians in team staffings, when appropriate.**
d. **Clearly define roles, and communicate these roles to all stakeholders.**
e. **Hold a joint training with all staff to provide an educational overview on the process and functioning of the JDC, A-CRA, and ACC.** Allowing staff to directly communicate with each other and ask questions of each other's work would be the most efficient way to dispel the many misconceptions held by both groups.
f. **Have a provider serve as a regular member of the drug court team.**
g. **Explore the effectiveness of returning Youth Advocates to the drug court team as formal liaisons with treatment providers**

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