

North Carolina Methamphetamine Initiative/
Appalachian State University
Partnership for Methamphetamine Treatment Program Development
and Evaluation

PROCESS EVALUATION

**Executive Summary and Final Report
June 2008**

Appalachian State University
Institute for Health and Human Services

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PROCESS EVALUATION

Executive Summary

In 2003, North Carolina, like a number of other states, experienced a rapid increase in the number of reports related to the manufacture and use of methamphetamine (meth). The Substance Abuse Services/Community Policy Management Services unit of the state Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (the Division) recognized the need for an effective response to the problems posed by the meth crisis. By Fall 2006, the Division had provided the opportunity for four Local Management Entities (LMEs) in western North Carolina to develop and implement meth treatment programs in their communities. The LMEs each selected two counties from within their service areas to participate in the project: 1) Foothills LME, Caldwell and McDowell counties; 2) New River LME, Ashe and Watauga counties; 3) Smoky Mountain LME, Haywood and Macon counties; and Western Highlands LME, Buncombe and Rutherford counties.

In February 2005, at the request of the Division, Appalachian State University (ASU) submitted a proposal to establish the NC Methamphetamine Initiative/ ASU Partnership for Methamphetamine Treatment Program Development and Evaluation. The initial proposal included development and implementation of a three-year longitudinal program evaluation and a process evaluation of the Watauga/Ashe program, but was later expanded to cover evaluation of all participating counties. The purpose of the process evaluation is to explore the process of development of the treatment programs and the actual delivery of their treatment models, in order to provide a frame of reference for program evaluation and inform the development of programs at future sites. This Process Evaluation Report precedes and will complement the final Program Evaluation Report, which is pending completion in December 2008.

Each participating county developed its own unique treatment program model, primarily utilizing one of two theoretical models, Family Solutions or Matrix, in combination with various other interventions, such as individual therapy, case management, community support, or parenting groups. The project initially began in Spring 2004, with the development of the Watauga/Ashe program model, Family Solutions (FS), designed to provide intensive treatment for the meth user and his or her whole family. Soon after the four LMEs and eight counties were identified, the Division identified and encouraged the use of the Matrix model of substance abuse treatment as a key intervention for each of the sites. The Matrix model is a cognitive-behavioral IOP (Intensive Outpatient Program) treatment intervention originally developed to treat cocaine abuse. The treatment model is highly structured and includes a manual of psycho-educational topics that are presented to groups over a 16-week period.

The process evaluation protocol included conducting in-person structured interviews of clients, clinicians, and administrators from each of the sites funded for meth treatment programs. A total of 29 interviews were completed between October 2006 and July

2007. Using content analysis, respondent comments were analyzed for common and unique themes according to respondent groups (client, clinician, or administrator) and LMEs.

In assessing themes and trends that emerged, client respondents focused more of their attention on local factors related to their respective treatment and programs. They greatly valued their gains in knowledge and skills from treatment, and especially valued the family involvement component. They were very positive about the individual characteristics of clinicians, including the relationships they had with their clinicians. They noted problems with limited staffing and limited funding. They commented on aspects related to the law and DSS (Department of Social Services), and identified a number of strengths regarding the linkages to these entities. As a rule, they did not speak to any issues related to mental health reform. The clients' responses illustrate the depth of the affirming feelings they have about their respective treatment programs and the clinicians who worked with them.

Clinicians were more likely to share observations of weaknesses than were client respondents. They, too, identified strengths in the increasing knowledge and awareness of clients and their skills acquisition, and they offered a great deal of feedback, primarily positive, regarding both the Family Solutions and Matrix models of treatment. They offered more of a detailed "picture" of the relationships and perspectives of the legal and criminal justice systems and DSS, both positive and negative. They were fairly uniform in their criticisms of mental health reform, whether addressing agency-related changes, staff changes, or paperwork changes. Clinicians also offered their perspectives regarding State involvement, noting specific strengths and weaknesses.

Like clinicians, administrators offered more criticism of different aspects of the project. They, too, were uniform in their frustration with changes related to mental health reform. They shared their perspectives of the strengths and weaknesses of State involvement and also discussed strengths and weaknesses regarding funding related to their programs. Although they had less first-hand knowledge of the progress of clients, administrators also talked about the gains in knowledge and awareness of clients and their skills development. Further, administrators provided detailed, predominantly positive comments about their respective models of treatment, Family Solutions and Matrix.

Across LMEs, it was possible to see their differences, particularly when it came to concrete resources. Respondents of all groups talked about different concrete resources as issues, depending on their particular community and program. Transportation was frequently cited as a problem. The aggregated LME site interviews revealed the same strengths across treatment programs--the treatment model (either Family Solutions or Matrix), especially the family involvement component of treatment; and the "results" of treatment (i.e., knowledge and awareness, skills acquisition). All of the sites discussed the informal collaboration among agencies, community awareness, and community resources, but only New River respondents devoted a lot of detail to discussing their formal community collaborative. All of the site-based interviews stressed the same

issues related to mental health reform—changes in agencies, changes in staff, changes in paperwork—and viewed them as negative.

The following recommendations are made based on the findings of the process evaluation:

- 1) A qualitative process evaluation should be utilized as an ongoing part of a program evaluation.
- 2) When implementing new program models and funding new sites, the more systemic stability that can be created, the better. That stability will not only benefit development and implementation of new programs, but also evaluation of those efforts.
- 3) Increased attention should be paid to the importance of clear and consistent communication among project participants. Efforts to promote stability, as in 2) above, will likely promote improved communication as well.
- 4) The ability of the State to be able to fund and support pilot efforts will continue to be important.
- 5) Respondents indicated the importance of knowledge and skills acquisition, the family component of treatment, and the characteristics of clinicians. Efforts should be made to support and encourage further development of these noted strengths of the treatment programs.
- 6) Provide support for the development of strong community collaboratives. Clinicians should be involved. Clients might also participate in community collaboratives, and can assist with advertising, education, and increasing awareness.
- 7) To effectively serve the entire community, adequate funding for transportation and service delivery in outlying sites seems imperative. Service delivery to clients in their own homes and/or providing transportation to clients so they can participate in group and other on-site treatment takes time and that time and its associated costs should be factored in when planning for funding, staffing, and service delivery.

Looking across the interviews more broadly, it appears there were some common elements in the development and implementation of each of the treatment programs. First, there was the problem of meth abuse in the community, followed by the opportunity to respond to the problem with support and funding offered by the Division. Simultaneously, key players emerged and communities coalesced to varying degrees around common goals. The creativity, energy, effort, and resources that went into the development and implementation of each unique treatment program seemed to culminate in clients, clinicians, and administrators feeling strongly and positively about their own programs, regardless of the theoretical treatment models utilized.

What also seems clear is that the increased knowledge and awareness that resulted from training and/or participation in the treatment programs was valuable to clients, clinicians, and administrators. Perhaps the most significant finding is that family involvement was perceived as a highly valued component of treatment regardless of the treatment model. Another significant finding is that clients valued the clinicians with whom they worked and were appreciative of the opportunity to engage in treatment they perceived as effective. Community collaboration and cooperation among agencies was highly valued by clients, clinicians, and administrators when it was present and desired when it was not.

All of this effort took place in the midst of significant systemic upheaval across the state and within each community. While respondents were consistently negative regarding changes in agencies, staff, and paperwork due to mental health reform, they were clearly able and willing to expend considerable effort and engage in significant change in the process of developing and providing treatment programs.

PROCESS EVALUATION

Final Report

Background

In 2003, North Carolina, like a number of other states, experienced a rapid increase in the number of reports related to the manufacture and use of methamphetamine (meth). Watauga County alone reported that 17 children were placed in Department of Social Services (DSS) custody as the result of arrests for manufacture in clandestine labs, usually found in or near homes (Thornton, 2004). Staff members from the local area mental health and substance abuse services agency, New River Behavioral HealthCare (NRBHC), and Watauga County DSS were confronted with concerns about how to best serve parents and children involved with these labs. Watauga County DSS organized a team to address Child Protective Services (CPS) issues and develop a Meth Lab Response Protocol, including decontamination procedures for children and parents, safety issues for DSS workers, protocol for urine and saliva drug screens, evidence collection, concerns related to contamination of homes, and treatment issues for children and parents. The team, many of whom were also members of the Watauga County Drug Endangered Child (DEC) Team, included representatives from DSS, NRBHC, law enforcement, criminal justice, the school system, health department, hospital, and a forensic psychologist. At the same time, staff members of the Substance Abuse Services/Community Policy Management Services unit of the state Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (Division) recognized the need for an effective response to the problems posed by the meth crisis. In Spring 2004, state staff members encouraged NRBHC and Watauga County DSS staff to submit a proposal for a meth treatment program.

The resulting proposal to provide a model Methamphetamine Family Treatment Program (MFTP) in Watauga and Ashe counties included provisions for a program evaluation and was fully funded by the Division. Staff members of NRBHC and Watauga County DSS began development and implementation of their program, and subcontracted with ASU to participate in the development efforts, provide consultation and technical assistance, and develop and implement an evaluation of the program.

In November 2004, staff members of the Division met with representatives of NRBHC, Watauga and Ashe County DSSs, and ASU to discuss the development of the Watauga/Ashe program. A member of the Division's Best Practices unit was impressed with the collaboration among community members and agencies, calling it a model for service delivery in the context of the State's mental health reform. She suggested an evaluation of the process of development of the Watauga/Ashe MFTP might be useful to inform program development efforts in other sites.

Mental health reform efforts began in North Carolina in 2000, when the legislature became concerned about finances, accountability, loss of confidence, and lack of

innovation in the DMHDDSAS (Division of Mental Health, Developmental Disabilities, and Substance Abuse Services) system. There was an interest in increasing local governance, reducing reliance on institutions, and a trend toward privatization (Mahan, 2008). Beginning with legislation enacted in 2001, the State has been undergoing reform, with its accompanying opportunities and challenges, and it is within this historical time period and context that the meth problem arose and responses to it were developed.

To address the growing meth problem in the western region of the state, the Division was interested in expanding the project and its program evaluation component. In February 2005, at the Division's request, ASU submitted a proposal to establish the NC Methamphetamine Initiative/ ASU Partnership for Methamphetamine Treatment Program Development and Evaluation. The proposal included development and implementation of a three-year longitudinal program evaluation and a process evaluation of the Watauga/Ashe MFTP.

By Fall 2006, the Division had provided the opportunity for four Local Management Entities (LMEs) in western North Carolina to develop and implement meth treatment programs in their communities. The LMEs each selected two counties from within their service areas to participate in the project, as noted below:

<u>LME</u>	<u>Participating Counties</u>
Foothills	Caldwell McDowell
New River	Ashe Watauga
Smoky Mountain	Haywood Macon
Western Highlands	Buncombe Rutherford

(Note that Smoky Mountain LME assumed administrative responsibility for all of the counties in the New River service area, including Ashe and Watauga, effective July 1, 2007.)

The program evaluation was expanded to include each of the new sites (counties). Initially, the process evaluation was to address only the Watauga/Ashe MFTP, but when a representative from Smoky Mountain LME expressed a wish for her community to have the opportunity to participate, the process evaluation was also expanded to include each of the sites. As stated in ASU's February 2005 proposal to the Division, the purpose of the process evaluation is to explore the process of development of the Watauga/Ashe MFTP and the actual delivery of its treatment model, in order to provide a frame of reference for its own program evaluation and inform the program development and

evaluation efforts of other sites. Thus, this purpose was adapted across all sites. This Process Evaluation Report precedes and will complement the final Program Evaluation Report, which is pending completion in December 2008.

In addition to this report, the Division has requested interim reports regarding specific topics related to the process evaluation. Impressions from Process Evaluations: Providing Evidence-Based Practice During Time of Mental Health Reform was submitted in July 2007. In January 2008, a Draft Summary of Matrix-Related Comments from Process Evaluation Interviews was submitted.

An overview of the treatment programs developed by each site, methods utilized in the process evaluation and analysis, results, strengths and limitations of this evaluation, summary, and recommendations are provided below.

Overview of Treatment Programs

As noted above, the project initially began with the development of the Watauga/Ashe MFTP model. This model, which eventually was named Family Solutions (FS) by the community team that developed it, was designed to provide intensive treatment for the meth user and his or her whole family. The model is characterized by a number of key elements. A Rapid Entry intake process is utilized, in which DSS and FS workers jointly conduct a home or office visit at the time services are initiated, often within 24 hours of a child abuse/neglect report filed with DSS. At this time, all family members are assessed for treatment and service needs. Urine drug screens are administered on site at the time of intake. Within two weeks the client participates in the selection of a Support Network Team, comprised of family members and/or friends of the client, FS clinicians and staff, DSS workers, and other agency, school, and community representatives. This team meets regularly with the client to provide support, engage in problem solving, overcome barriers to treatment, and provide accountability. An array of available interventions are utilized as needed, including Intensive Outpatient Treatment (IOP), individual, family, and group therapies, AA/NA (Alcoholics Anonymous/Narcotics Anonymous), and case management and support services. Other support services include transportation, child care, and meals provided at group therapy meetings. Services are delivered in the office, clients' homes, schools, and community. Clients progress through defined levels of treatment, with total length of treatment planned for one year.

Soon after the four LMEs and eight counties were identified, the Division identified and encouraged the use of the Matrix model of substance abuse treatment as a key intervention for each of the sites. The Matrix model is a cognitive-behavioral IOP treatment intervention originally developed to treat cocaine abuse. The treatment model is highly structured and includes a manual of psycho-educational topics that are presented to groups over a 16-week period. During that period, clients attend Early Recovery Skills groups, Relapse Prevention groups, Family Education groups, and Social Support groups. Use of Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and drug screens are expected. A client who is a previous graduate of the Matrix program is utilized as a peer

co-leader of group meetings. Specific topics are covered in individual sessions and are included in the manual.

The Division has provided extensive training and supervision opportunities for clinicians and administrators of each site and has now adopted the Matrix model as a Best Practice intervention for substance abuse treatment for stimulant abuse, including meth. The Division has also mandated some changes to the implementation of the Matrix model in order to adapt it to the state's Medicaid Service Definitions and other policies. For example, the number of sessions has been shortened from 16 to 14 weeks and the duration of time clients spend in group meetings has been increased.

Across sites, there has been inconsistent fidelity to the Matrix model. The Division requested that ASU conduct an informal survey of fidelity to the various structural elements of the Matrix model. A summary of this survey was provided in April 2007 and is included in Appendix A of this report. Highlights are mentioned below.

In addition, each site developed their treatment programs with varying levels of community support and collaboration, including DSS involvement, and more or less emphasis was placed on the use of additional interventions and supports, beyond the Matrix model IOP, such as individual and family therapy, contingency management, transportation, child care, meals, and case management or support. Further, although each of the models calls for a weekly family night group, the content, structure, and purpose of those groups varies across sites. Co-leaders of groups are sometimes utilized. According the Matrix model, a co-leader is a peer of the clients, someone who has successfully completed the program and now co-leads groups with the clinician. In the FS model, the co-leader is likely to be another clinician or a student intern.

In the Foothills LME, serving Caldwell and McDowell counties, there were difficulties finding a service provider and retaining clinicians who were trained in the Matrix model. On the fidelity survey, they reported no additional services were provided.

In the New River LME, FS and DSS workers attended and attempted to utilize the model in their IOP groups, individual therapy, and other service delivery, as training was provided regarding the Matrix model. Over time, their use of the Matrix model has been inconsistent and they have cited concerns over its appropriateness and utility within the family treatment model they have been developing. On the fidelity survey, they reported in-home family case management and case support, transportation, and child care were provided.

Smoky Mountain LME, serving Haywood and Macon counties, has enjoyed less staff turnover, with Haywood reporting the closest fidelity to the Matrix model of all sites. Haywood has also reported they provide transportation, child care, contingency management, videos, financial presentations, and scholarships. Macon County reported no additional services were provided.

In Western Highlands, Buncombe County was able to retain trained clinicians for the first 18 months of their program, and to provide transportation, child care, and meals. Rutherford County's program was not successfully developed due to problems related to LME divestiture of services, agency changes, and lack of available substance abuse treatment clinicians.

In addition, although the project was initially developed to provide treatment for methamphetamine abuse, the Division eventually allowed the sites to serve individuals who presented with other stimulant abuse, as long as no meth abusers were denied treatment. Across sites, there was some confusion and inconsistency regarding eligibility for services.

Methods

A process evaluation protocol was developed by members of ASU's Research Team during the 2006-2007 fiscal year. The protocol included conducting in-person structured interviews of clients, clinicians, and administrators from each of the sites funded for meth treatment programs. (As noted above, Rutherford County was not able to develop a treatment program, nor did they participate in the process evaluation.) A structured interview guide was developed, utilizing a SWOT framework. The SWOT framework utilizes questions based on the strengths, weaknesses, opportunities, and threats related to a project (Andrews, 1980). The interview guide also included contextual and content questions regarding the treatment program at each site (see Appendix B). An Informed Consent form was developed (see Appendix C) and approval to conduct the Process Evaluation was obtained from the Institutional Review Board (IRB) at ASU.

Two members of the Research Team and a graduate student research assistant conducted the interviews. According to Eisenhardt (cited in Huberman & Miles, 2002), the use of multiple investigators enhances the "creative potential" of the study and provides complementary as well as different perspectives of the data collected (p. 14). Respondents for the evaluation were selected by staff of the respective sites and the ASU Research Team based on their perceived familiarity and knowledge of the treatment program development efforts. Some of the respondents were no longer working with the programs. Three pilot interviews were conducted between October and December 2006. After minor revisions to the interview guide, the remainder of the interviews were completed by July 2007. A total of 29 interviews were completed, including seven clients, seven clinicians, and fifteen administrators. More administrators were interviewed in order to ensure that respondents would represent the types of agencies involved in the program--Department of Social Services (DSS) program administrators, supervisors and social workers; Methamphetamine Initiative program coordinators, a substance abuse specialist, provider agency administrators, and local management entity administrators. While the interviews were being conducted, the interviewers wrote notes and quotes of the respondents' answers. The responses were then typed, and content analyses of these interviews were conducted to learn what each of these projects entail; how each of these projects evolved within their respective sites from the participants'

perspectives; and the strengths, weaknesses, opportunities, and threats to the projects perceived by the participants.

To conduct the content analyses, a grounded theory approach was undertaken. According to Huberman and Miles (2002), with a grounded theory approach, the researcher conceptualizes the data by analyzing written interviews line by line (p. 374). To strengthen this type of analysis, two members of the Research Team were used to analyze the data from the interviews. One had conducted interviews; the other had not. Based on their analysis, 38 unique codes emerged from the data (see Appendix D). These codes were then conceptualized into seven higher order categories, which included community-based codes, staff-related codes, client-related codes, concrete resources, treatment-oriented codes, legal-related aspects, and codes related to mental health reform.

To analyze the interview data, every line of text from each interview was analyzed by the two researchers to determine which codes best applied. Lines of text often received multiple codes. In addition, the coded data were further coded by one of the researchers according to whether the respondents' comments were positive, negative or descriptive in nature. The second researcher randomly selected two client, two clinician, and three administrator interviews to also analyze the nature of the comments. This approach can best be described as a check of "interrater reliability," which is a characteristic of quantitative research (Thyer, 2001). The two researchers were found to be in agreement on the nature of the comments from 71% to 93% of the time. As Eisenhardt states, "the convergence of observations from multiple investigators enhances confidence in the findings" (cited in Huberman & Miles, 2002, p. 14). Lincoln and Guba (1985) suggest that "analyst triangulation" (i.e., use of multiple analysts) of the analyses further provides credibility for the findings from qualitative research. With the strong agreement between the two researchers, the initial coding was supported and used for further analysis.

Following these reviews, the data were analyzed for common and unique themes according to respondent groups (client, clinician, or administrator) and LMEs. To analyze the data, positive and negative comments from each respondent group or LME were totaled. The decision was made to leave out descriptive comments for this part of the analysis, since descriptions were merely informative and did not represent subjectivity on the part of the respondent. Thus, the numbers provided in the discussion of results, below, represent the total number of positive or negative comments across the respondent group for that particular code, and the percentages provided are based on the aggregated number of positive and negative comments for that same code. Positive or negative comments might also be referred to as strengths or weaknesses, respectively, in this report.

Results

Although it is not appropriate to generalize the findings based on these non-representative interviews, it is possible to assess these interviews for similar themes regarding the unique aspects of the meth treatment programs in each community, and to determine if

the knowledge gained is transferable, contributing to better understanding, support, and development of these and future programs in other sites.

Client Findings

A total of seven clients were interviewed—one from each of the seven participating counties. The clients provided feedback regarding their observations and experiences with their respective meth treatment projects. In particular, clients offered a great deal of feedback regarding their respective communities' involvement with the meth initiatives, staff-related factors, client-based factors, and aspects of treatment. Clients reported more rarely on factors pertaining to concrete resources, legal aspects, and mental health reform.

While some clients cited community awareness of the meth initiative as a strength, a common theme was the need for greater awareness of the program and more community resources. A total of 23 client comments (74%) focused on the need to increase awareness. One client simply stated, "The program needs to be promoted more." Another client said, "[There] needs to be more advertising to let the public know what the [program's name] is." Similarly, 16 clients' comments (40%) noted community resources that also assisted their recovery, but 24 of their comments (60%) focused on the lack of other community resources. Reporting on one strength, a client said, "I have been in individual therapy, and I am attending family therapy with my parents and children... We are learning Love & Logic." More often, clients noted the need for additional community resources to assist the meth program and their recovery. One client said, "More NA meetings... people in treatment take advantage of what there is, but there isn't too much." Another client suggested, "Work related programs for addicts... I can't find a job. I'm a convicted felon." A third client stated, "There is a need for more meth programs... [there are] not enough agencies to provide it [meth treatment]." Only one client appeared to be knowledgeable about the formal and informal collaborative effort within her community.

Staff characteristics, availability, training and education, and staff members' relationships with participants were discussed and overwhelmingly viewed as strengths across the different meth sites. A total of 18 comments regarding specific characteristics of staff (100%) were positive. "People are ready to help you and they are eager to help," said one client. Another client observed, "They are kinda like family through the good times and bad," while a third client stated, "Staff are real encouraging. They are really on top of things like drug testing and attendance." Regarding availability, one client noted, "Staff are stretched pretty thin. It doesn't hamper their dedication. For an emergency, they are there 24 hours a day." Another client further noted, "Transportation could get in the way, but [staff member's name] comes to my house when I can't come to the office." A third client said, "[We] can see the clinician whenever we need to."

A number of client comments focused on the strengths of the specific training and education (TE) of the staff members' as well as the relationship that the staff members developed with the clients as positive themes. A total of 9 comments (90%) identified training and education as a strength. One client reported, "[It] feels good to have

someone who knows about addiction.” Another client stated, “[Staff member’s name] is a very good counselor.” The only negative observation or need observed by a client was the following statement, “Hiring needs to allow for certified substance abuse counselors, not just master’s prepared clinicians.” The relationships that staff members establish with clients also were highlighted. “[Individual program’s staff] are awesome in working with you to get better...we would go on strike if there was no program,” said a client. Similarly, a second client stated, “[Individual program’s name] stuck with me no matter what.” Clients noted limited staff (LS) as the primary staff-related issue. One client referred to the number of people needing meth treatment. “[There are] lots of people, but not enough staff.” Another said, “There are not enough employees.”

Characteristics related to clients also were a focus of clients. One client in particular views the negative impact of meth as a positive impetus for the program and for treatment. “I signed over my parental rights to my parents. But now, we all live together. I was busted with meth when someone called to DSS to investigate. DSS felt like I was worth saving. It is not like this for everyone.” The same client observed, “Meth use and labs being so high helped the program get started.” Four of the seven clients talked about the negative aspects of meth. One client simply stated, “When you start up it is hard to stop.” Another client shared, “I lost everything, home, and every possession. I had to put my cats to sleep due to them being contaminated. One was my kid’s cat, one was 12 years old. If I didn’t, I would have had three charges of animal endangerment.” Another client observed, “Just arresting people doesn’t take care of the problem—it didn’t bother me and didn’t stop me as a drug addict. Meth is so addictive—[I] did it for my depression and it becomes what is important.”

Other client-related strengths included gaining personal knowledge and awareness (n=37, 100%), and being able to apply newly-developed skills (n=32, 97%). “Matrix gave me a better understanding of how to abstain, how the limbic system works, how serotonin works in the brain, what to expect and the stages including the honeymoon stage and the wall,” stated a client. Another client said, “The information we learn is awesome. The program helps me to explain to others about my addiction.” A third client said, “This program is teaching us about recovery, relapse, and goals.”

Clients also identified the acquisition and application of skills as a major theme or strength derived from their meth treatment. A client explained, “[We] lived so long in active addiction that we need a recovery routine like brushing our teeth or eating. When we stop, we can’t be with the same people or do the same things.” “[The meth program] helped us to stop using...I got off of drugs and I seen where I was. Some clients have gotten their kids back or custody back,” said another client. Interestingly, clients almost equally cited the personal commitment of clients to their own recovery as a strength (n=7, 47%) and the lack thereof, as a weakness (n=8, 53%). A client said that one of the barriers to getting treatment is “[a] person not wanting the help.” She further states, “I am a lot more motivated, have a lot more strengths.” An additional client shared, “I saw people and myself change across time from not wanting to be there to contributing to discussions.” A third client explained, “It [meth treatment] helps people who want to get

the help.” Another client observed, “Some people don’t come because they don’t want to...retention is hard. I’d like to see more people complete.”

Clients also reported on common strengths of the aspects of treatment. Group dynamics (n=18, 90%) and family involvement (n=15, 88%) were referred to by clients as positive themes from the treatment models, regardless of the treatment modality (i.e., Matrix or Family Solutions). One client shared, “[Group] is the only place I have to spill my guts...I receive support in class.” Another client said, “[The program] helped families learn how to communicate with each other.” When discussing the respective programs themselves (i.e., Matrix or Family Solutions), clients were overwhelmingly positive about each. A total of 59 out of 63 comments (94%) were positive about the Matrix model, and 23 out of 24 comments (96%) were positive about the Family Solutions model.

Clients rarely commented on concrete resources as a strength or barrier. A few clients identified funding of the meth programs as an issue. “You need money to expand. Money from foundations,” stated a client. A potential barrier, “if funding was taken,” observed a client. Another client reported a specific weakness related to funding. “[There is] a lack of funding for programs in jail and on the street.” A unique theme mentioned by only one client was employment problems. This client referenced the issue numerous times. “[We] need a job program for addicts. We can’t move on without it. Without a job I feel like I am not progressing, I worked at [name of a fast food restaurant] as an hourly manager and the salaried position was given to someone else. My record prevented me from getting the job.”

Legal-related aspects were rarely addressed by clients, although a few clients discussed some strengths and barriers related to the law. One client explained how she believed these meth programs were related to changes in the law and overwhelmed court systems. “The number of labs increased...state laws changed...court was overwhelmed with cases and needed to refer to treatment.” She further stated, “Between the program and the changes in the law, use has been cut down.” A second client said, “I was court ordered to [program’s name]. It shouldn’t be a punishment. I requested this program.” She also observed that due to involvement in the meth program, “for nine hours a week, I am sure not to do anything illegal.” The issue of punishment also was cited by another client. “[I] wish it wasn’t mandatory.” This client also pointed out that “sentencing to jail time not to treatment,” gets in the way of providing meth treatment. A third client emphasized the issue of punishment. “Law enforcement—it may deter for some—they treat you like you weren’t human; [they] lost sight of people being involved in this. They arrested and busted labs, but there’s no treatment in jail.” Clients’ comments (n=8, 89%) reflected positively on DSS’ involvement in the meth programs. “The initial reason I started the program had some to do with looking good to DSS and the courts, but then my goal became to better myself.” Finally, clients as a whole did not mention mental health reform as a strength or barrier, except that one client generally observed, “Local and state changes may create opportunities.” A second client stated, “The State needs to be more aware. [They] need to fund more programs. The State needs to come up with new solutions.”

Clinician Findings

A total of seven clinicians were interviewed—one from each of the seven participating counties. The clinicians were licensed professionals, with previous experience in mental health and substance abuse treatment. As a group, the clinicians identified both strengths and barriers related to community characteristics and to the treatment model (i.e. Matrix or Family Solutions). The clinicians primarily highlighted client-related factors such as acquisition of knowledge and skills as strengths of the treatment and funding issues as a barrier. Legal-related issues were identified more frequently by the clinician respondents in comparison to the client respondents. Finally, the clinician respondents discussed mental health reform, frequently citing negative factors.

Clinicians often discussed community awareness. A few clinicians identified community awareness as a strength. One clinician explained, “Referrals come from DSS, [mental health], and probation officers.” Another clinician explained, “The [meth] problem had the attention of law enforcement from the Attorney General to the sheriffs.” More frequently, clinicians discussed the lack of community awareness or understanding. One clinician elaborated, “There is still so much that people do not know or understand about substance abuse. There are attitudes which represent radical extremes. On the one hand, some think it is okay if the client is “just” using pot as long as it is not cocaine or meth, while others think that any relapse is an indication of treatment failure instead of part of the process...some people still have a “slash and burn” attitude about relapse and do not understand what a powerful drug meth is.” Clinicians also were critical of the lack of promotion of the program. “More outreach to the community...[there is] a lack of promotion in the community, with DSS and judges,” said one clinician. Another clinician said that “educating the community, publicity about the program,” were opportunities related to the meth program, while a third clinician said, “Low referrals and a high dropout rate are a problem.”

Interestingly, nearly half of the comments of clinicians (n=28, 53%) addressed community resources as a strength, and 25 comments (47%) referred to the lack of resources within the community as a barrier. Speaking of resources within one community, a clinician observed, “There are caring people in the community who desire to help people get treatment.” The same clinician cited resources including “Christian 12-Step...other faith-based agencies, Recovery Education Center...sleep problems, parenting skills, infant massage through the CDSA, methadone clinic...life counseling, gateway clinics, peer support specialists” within her community. Another clinician talked about the relationship of the meth program to Narcotics Anonymous (NA). “It (meth program) has been a feeder for NA and NA holds a once per month panel on family education, which has been a good interaction.” However, clinicians also cited problems related to community resources. “Not being involved with the judicial system...politics in the county were a barrier, turf oriented,” were comments mentioned by one clinician. A second clinician talked about the lack of NA in her community. “No NA meetings in the area is a problem. There also is no supervised detox available in the area.” Another clinician said, “The lack of other services after 14 weeks—it is a community support group or nothing.”

The majority of clinicians talked about the formal community collaborative (n=15, 75%) and the informal community collaborative (n=17, 68%) as strengths. Regarding the formal collaborative, a clinician observed, “The diversity of the task force included the [the local management entity’s name, private provider’s name], fire department, the newspaper, non profit agencies, the sheriff’s department, the police department, and DSS.” She viewed this diversity positively. “The community collaborative and the relationships we have with other agencies,” were reported as strengths by another clinician. However, a couple of clinicians identified issues with their collaborative. One clinician said, “More community collaborative [involvement]. The clinician was never invited to the collaborative.” The informal collaboration among agencies also was highlighted by clinicians as a positive theme. Of her community, one clinician said, “The community mobilized itself around the meth issue. There were strong interagency relationships including with the sheriff. Everybody in the community supported it.” Another clinician said, “Relationships with DSS and probation [are a strength]...also the interagency cooperation.” Still another clinician observed, “The number of agencies involved at the ground level and the different ideas coupled with the opportunity for discussion [were strengths]. Decisions were made and then implemented.” Nonetheless, a few clinicians cited problems with the informal collaboration. “[We] tried to get schools, doctors, and mental health services involved,” said a clinician. Another clinician said, “DSS was weak in their participation.” A third clinician observed, “[The relationship] took awhile to develop mutual respect with DSS.”

Although clinicians did not refer to staff characteristics as often as the clients, nonetheless, they particularly viewed characteristics of colleagues and administrators as positive. “Dedication to the program with [two staff members’ names],” said a clinician; “[staff member’s name] was determined to meet client’s needs.” Another clinician said, “[Administrator’s name]. He gave me the opportunity to run with it. [Staff member’s name], also gave me the opportunity and the support.” A third clinician observed, “[Administrator’s name] vision did not allow things to get in the way.” A few of the overall comments about staff characteristics were negative and specific (n=4, 17%). For example, one clinician reported, “The coordinator wasn’t generating clients—no advertising.” Clinicians pointed to the training and education of existing staff as a strength (n=11, 39%), but also viewed the lack of specific training and education as problematic (n=17, 61%). “[Staff member’s name] background in mental health and substance abuse,” was voiced by a clinician as a strength. Another clinician observed, “Clinicians [were] brilliant in their own way, specific to modality, population, working together to identify and address problems.” But problems also were voiced. “Workers’ lack of substance abuse and family therapy knowledge,” was expressed by a clinician. “Nobody bought into the Matrix training and issues were not being addressed.” Another clinician suggested, “If the State wants results, it needs to take action. The State could step in and mandate training. The State overlooked this part.” Still another clinician reported, “The current context of state and local policies, resources and staff had an incredible negative impact. People were not trained, there were new treatment plans without training and the volume of the plan [was a problem].”

Clinicians noted lack of availability of staff (n=10, 80%) and limited staffing (n=35, 100%) as recurrent negative themes. One clinician discussed some of the issues related to availability. “Clinicians need more supervision...time availability—[having your] own family life.” Explaining some of the changes to mental health, one clinician said, “After July 1st there was no longer 40 hours a week dedicated to Meth IOP; [Name of staff member] was doing other assessments. It changed availability [of staff] for meth clients.” Similarly, clinicians saw limited staffing as an issue. Referring to weaknesses, one clinician said, “Lack of enough clinical and administrative staff.” The same clinician said, “The structure of the project requires more than any one person can do and with no administrative help.” Another clinician said, “Lack of staff, we never had enough staff. This really hurts the program and burns out clinicians.” This clinician also said, “[We] need more staffing—better staffing patterns.” Describing weaknesses, another clinician said, “Not being able to do sufficient follow-up with people who drop out because there is not any money for community support to track people down and find out what happened.” Clinicians also highlighted communication (n=22, 96%) at all levels of the project as an issue. One clinician commented on the communication within the project: “[You] must rely on your own interpretation of the program, and don’t know limits of how far to go.” Of state and local communications, she also said, “[There are] inconsistent messages about what is okay and what is not okay...often feels like there is a lack of clear expectations. No feedback except negative from the [LME’s name]—“guess we’re stuck with you.” Another clinician observed within her program, “[Name of coordinator] was saying one thing and the LME was saying another.” A third clinician also reported, “The coordinator did not communicate with the clinician, which resulted in the clinician not knowing enough about the client.” She also added, “[I] question who is treating the children of addicts. Sent lots [of children] to providers. Lack of communication to child providers.”

Clinicians, like clients, occasionally observed the impact of meth as a positive impetus for the development of the program. One clinician said, “The program has filled a void to address the disaster meth poses to the community.” However, clinicians more often observed the negative consequences of meth. “The threat clients felt was the label...clients had no problem admitting to being a crack addict. If labeled [a meth addict], then they were concerned about [their] meth use getting out in the community, then possible legal consequences. There was a stigma attached to children getting treatment, if DSS was not involved, then they may get involved. [This] stopped some children from getting counseling.” Another clinician said, “It’s hard to catch the “meth mamas.”

Clinicians, like clients, overwhelmingly noted gains in knowledge of meth and skills acquisition as positive results from the meth treatment, and like clients, they noted the commitment of clients as a strength and lack thereof, as a barrier. All ten of the comments (100%) from the clinicians about increases in knowledge related to meth treatment were positive, including families’ growing awareness. “The family education program with an emphasis on educating the family about the process of change in a family,” was a strength viewed by a clinician. She further noted, “The cycle of substance abuse, understanding genetics, effects on children. This gave family members a chance

to ask questions... Families are [now] knowledgeable about drugs, meth and others, about the pleasure center, and how one drug can lead to another.” Talking about the sobriety process, another clinician observed, “[It] shifts from external to internal motivation. This is significant for the client and for the client’s family.” Clinicians commented more (n=13, 93%) on the positive gains in skills experienced by clients. One clinician stated, “Clients said ‘I didn’t realize how good life could be’ as they began recovery. Another clinician shared, “One clinician had a client who was a meth addict was up for a life sentence. [She] may still do some time, but [she] is now attending college as a counselor.” “Clients are making significant changes from not being able to hold a job and care for children to the ability to do these things,” noted a third clinician. The only negative comment was the following observation by a clinician. “Prevention is working with us [the meth program], but parents are hesitant to put children into prevention programs.”

The commitment of the clients also was highlighted as a strength. “Built ins—client wanted to prove sobriety—tangible result,” said one clinician. Another clinician stated, “The results are mostly anecdotal. I am impressed that most clients, maybe 80%, have gotten off meth, but only a few are off of all substances.” “Clients could really ‘sink their teeth into it [the meth program]’—clients responded,” observed a different clinician. However, like the client respondents, the clinician group also noted that lack of commitment on the part of clients, possibly due to other factors, was a barrier. One problem a clinician observed, “Clients are doing group, but go to prison anyway. Other clients drop out when they see that.” Another clinician suggested, “Because it was free, some had no investment, some dropped out...clients had a hard time coming in so often.”

Clinician respondents viewed specific transportation issues and lack of knowledge of transportation resources as a barrier. A total of nine comments (69%) were negative. “The lack of resources for transportation and child care are still a big weakness... [We] have a van, but need money for the driver,” reported a clinician. A second clinician responded, “Transportation is a huge barrier,” while another clinician said, “Transportation problems—no buses. Clinicians transport using their own cars.” A fourth clinician questioned, “Where is the money for transportation and child care supposed to come from? As far as transportation, who wants to work from 4-6 and 9-11?” Even though transportation was more often viewed as a problem, a few clinicians observed funding for transportation as a strength. One clinician observed that “federal funding for everything, food, gas vouchers, and child care,” was a strength of the program. Another clinician referred to the same support. “The fact that there is money available for transportation and refreshments,” she said.

Other concrete resources were mentioned less often than transportation by the clinician group. Housing was mentioned as both a strength (n=5, 71%) in terms of other community resources and as a weakness (n=2, 29%). One clinician said a local housing resource was a community strength. “[Name of local housing program], a faith-based organization that provides housing placement and wrap-around case management,” was a strength. She also noted as a weakness in the community, “[There are] no halfway houses.”

The cost of the meth program to clients was viewed by the majority of the comments from clinicians as a positive theme (n=9, 82%). Viewing the lack of a charge to clients as a positive, one clinician said, “The fact that it [the meth program] is free, most clients are unemployed, on their way to prison,” “No cost,” observed a second clinician, and a third clinician stated, “Services are free to clients.” A few comments from clinicians expressed reservations about the lack of a fee associated with services. “It’s free,” said one clinician; “anything worth having costs money.”

Funding was mentioned as both a strength (n=12, 32%) and as a weakness (n=26, 68%) by clinician respondents. One clinician observed, “The national/state crisis and attention on meth made the money available.” Other clinicians observed some specific problems with funding. A clinician noted, “There was confusion in some counties about Matrix money and Matrix IOP.” Another clinician said, “There was not money designated for administrative and infrastructure costs. The providers had to subsume the administrative costs.” A third clinician reported, “Meth users have unique problems. Individual therapy not reimbursed for all the client may need.” She also said, “There was a question about how social support was going to be paid for. It started changing, getting dollars not as easy as in the past.” “Not being able to do sufficient follow-up with people who drop out because there is not any money for community support to track people down and find out what happened. Not funding any services for people in jail—we need to have IOP in jail! It is sickening,” responded a clinician. Further, a clinician identified “ongoing uncertainty of funding” as a problem.

Clinicians noted the family component of the meth treatment as a major strength, and the majority of the specific comments about the treatment modality (i.e., Matrix and Family Solutions) also were positive. Family involvement (n=10, 83%) was the treatment component most often mentioned by clinicians as a positive. A clinician stated, “Matrix is a positive recovery process of the clients and family. [We] initially wondered how will we get families in, then the group grew when families saw other families.” Another clinician said, “[We] connected with families of the clients. They got to understand addiction.” Clinicians also viewed the treatment modality, either Matrix (n=64, 61%) or Family Solutions (n=44, 64%) as a strength. Of the Matrix model, a clinician stated, “The Matrix model itself was one of the strengths. A cognitive behavioral therapy approach to therapeutic process and emphasis on family involvement were strengths.” Another clinician listed strengths of the Matrix model. “Empowering for a client to be a peer co-leader. It’s availability; it’s non-discrimination about meth or other stimulants. No cost. Family involved on family night—feed them on family night...materials, hand-outs, books.” A third clinician responded, “The structure of the program is excellent and the Matrix materials are excellent.” The negative comments about Matrix appeared to be specific and varied. One clinician said, “The lengthened program caused burnout of clients. If [they] stayed with 16 weeks of Matrix, could have more [of a] focus on community resources, AA and NA...The program needs to be standardized. [The] two day training [was] not that fantastic.” Another clinician remarked, “Not allowing clinicians to do the project as intended,” was a weakness. Yet another clinician said, “The lack of rapid access...need to have 42 sessions of IOP. The program is not

individualized enough—people need different amounts of treatment—gives a false idea of what treatment is supposed to be.”

Similarly, most comments were positive about the Family Solutions model. “Treatment for the whole family, flexibility for home visits, rapid entry, relationships with DSS and probation, flexibility to respond right away and get started immediately, working as a team within Family Solutions, also the interagency cooperation, working with kids,” were aspects mentioned by a clinician. Another clinician responded to strengths of Family Solutions noting “how the team formulated the goals and how clients meet the goals that are logical, measurable, and attainable. The goals are easy to understand for the clients. The team itself is a strength, including the larger team that includes ASU.” “The changes some families make is such a huge leap after living in generations of hell,” observed a clinician. Like the Matrix model, specific weaknesses were noted with Family Solutions. “The program is not as well coordinated as preferable. Clinicians need more supervision...issue of chasing/enabling versus supporting...limited to stimulant use instead of all substance abuse,” were concerns mentioned by one clinician. She also expressed, “It turned into a focus on the Matrix program, when, in reality, Matrix is a small part of the overall program.” Another clinician made similar observations. “The State has keyed in on Matrix, which can be counterproductive to Family Solution goals. [We] set up the Family Solutions program, were given free reign and then had to change...clinicians are busy testing the weaknesses of the system, and can’t test the weaknesses of the program.”

Clinicians were more likely than clients to discuss some legal-related factors. They viewed these aspects as both strengths and weaknesses, including drug court, the law, jail, DSS involvement, and a punishment orientation. One clinician talked about the desire to have a drug court in her community--“having a drug treatment court here would help.” However, in a community where a drug court existed, another clinician observed, “The [name of the LME] included drug court in the IOP which threatened the integrity of the program. There were different expectations of each program. Drug court clients, if they missed five times, then they had to go to jail. Clients were able to see consequences this way, but it was hard for the clinician. Drug court clients had 6 pm curfew, if a positive UDS (urine drug screen) or missed appointment, went to jail. This caused friction between the groups.”

Clinicians also viewed the legal environment as both a strength and a weakness. Explaining the development of the meth program, one clinician reported, “It started out as trying to find a way to address the problems of meth labs. Eighty percent of local arrests involved meth.” Another clinician observed, “The liaison with probation has been great” within her community. She also said, “There were strong interagency relationships, including the sheriff.” One clinician linked legal consequences to treatment. “At the beginning, there is motivation outside of themselves (clients) through DSS or legal consequences [to change].” Clinicians identified awareness of the legal system as a problem. “[The] court is not aware, no drug court; not telling attorneys about the program,” were comments made by one clinician. Similarly, another clinician said, “Lack of promotion in the community, DSS, judges... [the] program is not appreciated

by the legal system--[makes it] difficult for the client to stay hopeful.” Still a third clinician observed, “Judicial knowledge and involvement in the process. If they knew the parameters, [we] would have alternatives. Would be helpful if they were more aware of the Matrix model.”

Jail and/or prison were viewed by clinicians as a strength if related to treatment. One clinician noted, “There is one jail supported by [name of mental health program.] [They] provided Matrix in jail.” Another clinician stated, “I would like to be able to offer the treatment program in jails and prisons. Law enforcement would love it and it could then feed into IOP.” More often (n=9, 60%), jail and/or prison was viewed as a barrier. “The community is pleased with the IOP, but lots of people are incarcerated, so [they] are not able to finish the program,” observed a clinician. Another clinician said, “the fact that it [meth treatment] is not offered in the jails,” is a problem. In a related fashion, clinicians discussed the orientation towards punishment of the legal system as a barrier. “The legal system has a particular view of punitive action, which is diametrically opposed to treatment, i.e., more prisons/laws vs. better treatment,” responded a clinician.

The different meth sites were unique in their involvement with local departments of social services (DSS). This involvement was viewed by clinicians as positive (n=16, 52%) and negative (n=15, 48%). One clinician observed, “Children remaining in the home is up. [It’s been] a positive impact on the community, like families staying together.” Another clinician noted, “Kids being taken from homes due to the meth lab situation was a huge issue for DSS.” A third clinician viewed DSS involvement as a strength, and she said, “Involvement with DSS. [We] attended meetings with DSS, [had] team meetings. DSS is aware of the program, used the program.” But in some cases, DSS lacked involvement according to some clinicians. “DSS was missing in the picture. DSS failed to refer to the program,” stated a clinician. She also said, “I’d like to see DSS get more involved with Matrix.” Another clinician noted, “Not getting referrals from the police department, DSS... [it took] a long time for DSS to catch on.” “DSS was weak in their participation,” observed a third clinician, “the threat of termination of parental rights is not enough of a stick.”

Unlike clients, clinicians referred to mental health reform often with negative comments. Clinicians viewed mental health reform related to agencies (n=13, 100%), staff (n=8, 100%), paperwork (n=22, 100%), and divestiture (n=5, 100%) as problematic. A clinician reported, “because of the chaos in the system, many agencies are reluctant to make referrals.” She also said that a weakness was, “the relationship with the LME changed, and the computer software changed... The paperwork and the administration was a fiasco. [The] lack of focus and confusion was wearing and caused loss of credibility with clients.” When asked what “gets in the way of providing meth treatments, another clinician said, “agency changes, staff changes.” Regarding staffing changes related to reform, a clinician observed, “[A] weakness was the lack of knowledge and follow-through with DSS, some related to the large turnover in mental health.” A second clinician identified staff changes as a problem. “Major loss and attrition of clinicians.” Paperwork changes related to mental health reform also were identified as a problem. “Amount of paperwork and red tape to obtain treatment stands in

the way of treatment of client...paperwork alienates the client and makes clinicians spend time away from the client,” stated a clinician. The same clinician later said, “The experience of public mental health is that paperwork requirements are taxing on the client. The first edition of the PCP (Person Centered Plan) was 30 pages long, blank. Completed fully, [it] took a half day. This is a waste of client time.” Another clinician stated, “the paperwork is time consuming and insane.” Still another clinician said, “The paperwork is a huge burden—the meth grant, the State, insurance—all have separate processes and forms.”

The State was viewed positively via some comments (n=7, 25%) and negatively via a number of comments (n=21, 75%) by the clinician respondents. One clinician responded, “Under mental health reform, this has been the only group treatment funded by State money and all the rest is community support.” More of the comments revolved around problems related to State involvement, particularly timeliness. One clinician said, “The length of time to get the program implemented lost clients and interest.” Another clinician reported, “The program was real slow in starting due to the bureaucracy the LME has created, and is faced with from the State. It took forever to get going.” A third clinician said, “The State’s policies related to paperwork, reports and reimbursement gets in the way [of providing meth treatment].”

Administrator Findings

A total of fifteen administrators were interviewed as a part of the process evaluation. They identified a variety of strengths and barriers. Administrators discussed community-related factors often. Most of the observations were very positive. A total of 70 comments that could be classified as positive (79%) were made by this group regarding community awareness of the meth programs. In providing a foundation for their meth program, one administrator stated, “people were open and ready. [It was] a massive effort.” She further said, “the local and national climate was a strength—with all the meth hype, here is some treatment.” Another administrator explained that to begin the effort in their community, “there was an initial meeting in [local town], which 200 people attended.” Another administrator shared, “the community really wanted it [the meth program].” Some administrator respondents discussed issues with community awareness and need (n=19, 21%). One observed, “[It’s] hard to know the real need. There was a crisis, but the demand does not match the perceived need.” A second administrator made a similar observation. “[There were] not as many cases as we anticipated.” This administrator also said that one of the opportunities was to “tell the community what is available.”

Administrators also discussed other resources within their communities as primarily a strength (n=75, 66%), but also as a barrier (n=38, 34%). In listing community strengths, one administrator said, “local communities, interagency cooperation, [and an] interdisciplinary approach.” Another administrator specifically stated, “the LME has made the commitment to the project.” In another community, an administrator pointed out “NA meetings” within the community as a community resource and strength. A fourth administrator stated, “[a local] substance abuse provider was willing to get on

board.” Administrators also discussed problems with additional community resources, or the lack thereof. One administrator said, “other treatment providers [have services] not based on evidence-based programs, not Matrix.” Another administrator pointed out, “no other IOP,” within the community. A different administrator said, “Clinicians in the community hold on to clients that would be more appropriate in IOP.”

Administrator respondents discussed the formal and informal community collaboratives that developed and supported each meth program, and they were overwhelmingly positive. Approximately three quarters of the comments about the formal community collaborative (n=47, 77%) and 75 of the comments about the informal community collaborative (87%) viewed these as strengths. Discussing their formal community collaborative, one administrator said, “We evolved into an ongoing partnership to engage all CPS substance abuse visits. We’ve become a model for partnering DSS and treatment to reduce child problems regarding substance abuse.” This respondent further explained that the informal community collaborative which led to the formal community collaborative, “was initiated in the community when [the local DSS] requested a treatment program be developed to better meet their needs, specifically a program that did not segment families. It was presented at a large community meeting to address substance abuse...” Another administrator explained that in her community, “[the local county] had a history of task forces...the community coalition formed.” Another administrator stated, “community-based, stakeholder driven” to highlight the primary strengths of her formal and informal community collaborative. Fewer comments were directed towards problems with the collaboratives, but they were focused concerns when voiced. For example, one administrator said of the informal collaboration of agencies in her community, “[there is] discouragement of community players who encounter pressure from the State that keeps them from feeling in charge, especially DSS, the GAL (Guardian ad Litem), the schools.” Another administrator observed, “Turf issues of agencies, including the faith community, mental health, and law enforcement,” interfered with treatment. In another community, the administrator said, “...Everyone was told to come to the table, but the ongoing collaboration never came about. It has been disappointing.”

Like the other groups of respondents, administrators noted the characteristics of staff members’ (n=45, 85%) as well as training and education of staff (n=31, 70%) as strengths. They cited limited staffing (n=26, 100%) as a problem. Of her staff members, one administrator observed, “[name of staff member] is a good clinician, [who] worked hard to put something together. [Name of other staff member] is an excellent clinician, highly committed to the model and client priority above herself. She has good boundaries, is not enmeshed, has integrity, very professional, great connection with the clients, and runs a good program.” Of another staff member in another site, an administrator noted, “[this program] is [local staff member’s name] child. She puts so much into the project, fought to maintain it and wants to maintain the fidelity to the family treatment model.” Similarly, the training, education, and experience of staff members, both previous training and training associated with the project, were viewed to be positive themes. Discussing strengths, an administrator said, “[the] clinical skills, specifically of the clinicians,” is a strength. “Solid team—quality people working with

[name of staff member],” said another administrator. At still another program, the administrator observed that the leadership are, “dedicated to keeping good clinical team members.” She also observed, “Clinicians were trained in Matrix six months, and adapted style to Matrix.” A third administrator said, “wonderful training—motivational interviewing/Matrix.”

However, limited staff was viewed unanimously as a barrier. An administrator observed, “[there are] only five substance abuse professionals in the area.” A second administrator pointed out in her community, “[we] do not have a case manager in [name of county], or interns to help out.” Another administrator said, “it is a demanding service. [It’s a] recipe for burnout—lots of front-end work.”

Some administrators identified communication of staff (n=7, 23%) as a strength, but most comments (n=24, 77%) were negative regarding communication. Communication was viewed as a strength in the development process. An administrator noted, “[the project] opened up doors to communicate with other agencies, seek out resources.” However, communication was viewed more often as an issue. Another administrator said, “Mixed messages—[we] needed more consistency...lack of communication—unreturned calls from the State to the meth coordinator.” A second administrator stated, “[we] need better communication with those in charge of Matrix.” She also said, “lots of communication difficulties.” “We are not sure of the criteria to get into the meth program. I have referred but they say the case is not appropriate—may be referred to a 20 to 90 hour program,” shared a third administrator.

Administrators cited the impact of meth as a strength (n=28, 61%) and as a weakness (n=18, 39%). Meth was viewed as an impetus for the development of the program. “It originated from the crisis of meth and meth labs tearing up families in the local community...Agencies worked together and nobody was concerned about turf and stepping on the toes. Rather, they all wanted to build a program to meet the needs of the people in the community,” said an administrator. The same administrator said meth created an opportunity--“the emergency due to the meth labs and children being endangered and removed for safety.” In another community, an administrator made similar observations. “[An LME and a substance abuse provider] put in the grant application. DSS was interested in supporting the effort. Assembling community partners made certain of the need and helped with support and collaboration. The meth lab situation also helped create support.” The impact of meth also was viewed as a problem. “Easily accessible to get drugs here—pills, meth, pot...meth use is prevalent,” said an administrator. Another administrator stated, “many don’t understand substance abuse as a disease. There is stigma attached.” “DSS and mental health often have different views. DSS approves more of jail time, especially if a person has been mass producing meth and has been trafficking. That affects the whole community,” observed a third administrator.

A handful of positive comments (n=9, 75%) were mentioned regarding the gains in awareness experienced by clients and many positive comments (n=48, 100%) regarding the acquisition of skills experienced by clients were voiced by administrators. One

administrator explained the strengths of the program as “education about how the drug affects the person, especially the change in how clients process information.” She also elaborated, “Matrix helped us understand what is happening with the client and how he/she could make changes. It gave us an invaluable awareness of paranoia. In the past, the client may have been suspicious of the change...It was thought at the beginning that meth users were impossible to change. Matrix gave us and them hope.” Regarding skills development, another administrator said, “people have become productive members of society when they were just using drugs and wasting their lives away.” Another administrator observed that her program, “dramatically stabilized clients...has gotten people off drugs with family involvement—helped addicts get satisfaction—solved a lot of problems beyond substance abuse for families, including child well-being, family relationships, and housing.”

The most frequently mentioned concrete resources from administrators were transportation problems (n=17, 71%), funding issues (n=89, 71%), and location (n=23, 79%). In explaining what can get in the way of treatment, one administrator said, “transportation and the hours it would take to transport clients...[we] could do a better job marketing the service including childcare and transportation.” Another administrator stated, “[there are] tremendous logistical and geographical problems. Families live in the most remote areas.” A third administrator observed, “the county is large and it is hard to have intensive treatment when most of the time is spent on transportation between clients’ homes.” Funding barriers also were cited by administrators as a problem. “[There are] still existing barriers to billing and drawing down the money. This discourages programs to start. Twelve month draw-down was to change to UCR (Usual and Customary Rate), but if the clients don’t show, the staff are still there.” This administrator also recommended, “need more potential for drawing down the monies...revolutionize how programs get reimbursed.” When asked what gets in the way of treatment, another administrator said, “funding, lack of, strings attached, the whole authorization process...the money was a small amount. Should have funded two programs more fully or even one program.” The same administrator observed, “The Division folks [are] committed to funding.” A third administrator said, “The weakness of both counties [was] limited State funds [which] derailed the process in both counties.” This administrator observed funding issues related to rural communities. “[There are] limitations on categories of money especially in the rural locations. [I] understand that block grant funding does not pay attention to limits of the rural community. [You] may have two for-profits and no other providers. What do we do if we need to have a not-for-profit [to draw down the grant]?”

Location often was cited as a barrier. “[We’re] overextended trying to cover two counties,” shared an administrator. Another administrator observed, “people in rural areas [are] not close to groups...[it’s a] small community—hard to break relationships with other users.” Another administrator explained, “How to serve and provide transportation would be a six hour loop. Geography and transportation are past and current barriers.”

Only the specific treatment component of family involvement was mentioned as a strength by administrators (n=13, 100%). However, administrator respondents offered numerous comments, mainly positive, regarding the Family Solutions (n=104, 84%) and Matrix (n=138, 69%) treatment models. One administrator said, “Families [are] preserved, retention of families in treatment, and relationships [are] improved.” Another administrator observed, “Families enjoyed participation, fellowship, and group interaction.” A final administrator said their meth program, “gave hope to families.”

Administrator respondents offered more positive comments about the specific treatment model (i.e., Family Solutions, Matrix) than the other two respondent groups. In describing the strengths of the Family Solutions model, one administrator shared, “assertively engage[s] in treatment, [the] entire family involved in treatment, families are directly engaged to increase function, children are assessed and treated, [the] community really wanted it, designed by the community around community needs. Since the community desires [the program], children benefit and families are kept together.” Another administrator observed, “Family Solutions works with the entire family. It is an outpatient service that goes out to their homes.” A third administrator observed, “The program [Family Solutions] treats addiction by addressing the family as a whole with special attention given to the children.” Similar, positive comments were offered about the Matrix model. “More DSS involvement, more children’s involvement, meth treatment for persons in jail, move into an adolescent Matrix-style model, retain [the] family and individual in treatment with more aggressive follow-up,” shared an administrator. Describing strengths of Matrix, another administrator said, “families being treated together rather than treatment as usual. Recognizing the family illness rather than just the client illness. Matrix was overseen and held to task through the research component with the coordinator able to more fully implement the IOP.” Yet another administrator observed, [Matrix has had] a positive impact on client. [It] changes attitudes and the ability to reason.”

Negative comments about Family Solutions primarily revolved around concerns about support from the State for the model. One administrator, “[I] question if grantors will value the model.” She further states that a weakness is, “securing enough funds to support the Family Solutions model...[there is] ongoing pressure for Family Solutions to conform to other models.” When asked about what does or could get in the way of treatment, another administrator said, “if we cannot pay our way, the organization will stop the program, and return to treatment as usual with a trickle-down approach to child well-being.” Concerns about paying for the service also surfaced with the Matrix model. “[We] need more money to cover the 12 additional parts that the Matrix requires, including weekly random UDS. Where is the money going to come from after the grant? It is an unrealistic, unfundable program, [which] takes \$7000 per year per client to serve. Add children’s, contingency management, and it is over \$10,000 to serve the client.” Regarding Matrix, another administrator observed, “difficulty for the providers to provide fidelity. [We] struggle with comprehensive services. For [the] client, there needs to be decreased dosing.” A third administrator stated, “Ours [Matrix] was not as integrated of a system as we would have liked.”

Positive involvement with the law and with DSS were legal factors referred to most often by administrators. One administrator said, “meth manufacturing is down in large part to the Governor’s initiative, which makes it harder to get ingredients. This administrator also said, “law officers are exposed to another way of looking at the issue.” Another administrator observed, “judges are understanding and give more opportunities to clients than jail. Judges understand addiction here.” “[The meth program] was a way of wrapping law enforcement in the community dialogue at the table, not [being seen] as a barrier,” said a different administrator. The different focus of the legal system as well as the lack of supportive services were the few negative themes. “Law enforcement not prioritizing treatment like the other agencies...[We] need to get services to those in jail.” Another administrator noted, “Law enforcement was not on board, we need their support.”

Many of the comments mentioned DSS involvement as a major strength in the meth programs. One administrator observed, “[the meth program] made it possible for more children to remain in the home. More families did not have children removed due to this program...[it] kept children from losing entire extended family support networks.” “Weekly staffing of DSS/[the meth program], which is not available through the traditional style of treatment,” was a strength according to another administrator. An administrator also shared, “I know of three kids with a mom that worked with [the meth program] and DSS to get her kids back home who were in custody.” Like the legal arena, the problems that were mentioned regarding DSS often revolved around differing levels of investment and a different focus from the meth programs. An administrator at one site said, “both counties lack significant DSS involvement.” In a program with DSS involvement, an administrator acknowledged, “some frustrations with DSS, [such] as DSS not calling for a CPS visit,” were problematic. A different administrator stated, “complete investment of DSS is needed...DSS did not help to build the services.”

In addition, administrators also expressed primarily negative observations about the impact of mental health reform on the meth programs. A total of 17 comments about changes in agencies related to mental health reform (94%), changes in staff (n=19, 100%), and changes in paperwork (n=13, 100%) were provided. One administrator said of agency changes, “[We had] trouble finding providers...the agencies were put in place with no real leaders.” Another administrator said, “shifting roles of LME, the Division, and clinicians,” was problematic. Describing what gets in the way of treatment, a third administrator shared, “agency changeover—changing of the guard.” Similarly, staff changes related to mental health reform were viewed negatively. “[There was] huge staff changeover,” said an administrator. “Change in clinicians,” was a problem cited by another administrator. She went on to say, “changing people was confusing. We were one year into it, and then a series of people stayed briefly.” Changes in required paperwork were also mentioned as a barrier. An administrator cited, “paperwork. Seventy pages to get into IOP. [There was a] lack of unified vision about paperwork.”

Finally, administrators identified strengths (n=30, 41%) and weaknesses (n=44, 59%) regarding State involvement. They also identified primarily strengths with the university/research component (n=10, 91%). One administrator stated, “Using a

community collaborative to develop a treatment program for the only time in the state.” The same administrator shared, “State-level willingness to give funding dollars that are not subject to drawdown by UCR service definitions,” was a strength. Another strength exhibited by the State was the support for start-up, “[Name of staff member] spoke on a radio show and [Division Chief] heard. She then called and offered to help find funding,” explained an administrator. Another administrator observed, “[the] commitment between the Division, the LME, and the providers—collaboration between meth coordinators,” also are strengths. Yet another administrator said, “The State as a funder has a commitment to making this happen.”

Problems also were identified regarding State involvement or lack of involvement. “The State had no standards. Landlords were without standards—children were living in toxic environments. What were acceptable toxic levels?” said an administrator. “Challenges with organizing and getting an organized response and process,” were some problems cited by an administrator regarding State involvement. The same administrator said, “the Division makes the rules. There’s some confusion about the rules.” Another administrator said, “[there is] disagreement between the local community and the State about the best model for treatment...I would like the State, in managing the grant money, to show more responsiveness to the local community.” A different administrator stated, “State requirements and State service definitions are at odds with best practice.” The same administrator later shared concern about “having to fit the service definitions of the State. State licensure changes complicated things—this added another layer of angst, which was bad timing.”

The university/research component was primarily viewed as positive. When discussing opportunities or strengths, one administrator commented, “Also, the research piece was a plus and helped to make the work more intentional.” Another administrator observed, “Helps to ‘sell’ locally if connected to research—state and federal. Helps enforce the details/specifics to programs/communities—gives “backbone.” A third administrator said, “and it gets to be evaluated.” The only negative comment involved the lack of outcomes to date. “[We] don’t have outcomes to support [the] model and treatment,” remarked an administrator.

Site Based Findings

As noted above, four different LMEs (Foothills, New River, Smoky Mountain, and Western Highlands) received funding to develop meth treatment programs in two of each of their counties. Each of the LMEs had different experiences regarding the development and implementation of their programs. The following are some of the primary themes shared by respondents within a site.

Foothills LME. A total of two clients, two clinicians, and four administrators were interviewed from Caldwell and McDowell counties.

The Foothills respondents provided a number of comments regarding their community and their meth treatment program. They shared both positive and negative comments

about the community's "awareness" of the program and other community resources, and some positive comments about the informal community collaboration. Few comments were provided regarding the formal community collaborative that was developed to facilitate the program.

Foothills respondents offered a number of comments about their community's awareness of the program. A total of 21 comments (38%) could be viewed as positive, while 34 of the comments were negative (62%). Positive comments included the increase in meth labs helping to "create" the program. One client remarked, "[the Matrix program] started here when McDowell County found out about the increased number of meth labs in the county." An administrator observed, "word of mouth is happening—clients are sharing about the program here." However, the majority of the comments focused on problems with community awareness. "Community awareness [has] not taken hold—not having a great impact. [There's a] lack of community excitement. The provider could have done more promotion. There was no coordinator of these efforts," shared an administrator. A clinician stated, "[there's a] lack of promotion in the community—DSS—judges...[we] need a coordinator position in the courtroom consistently handing out flyers. I never saw a flyer;" while a client said, "if the community saw how many people [were] in the program, then the community would know the extent of the problem. You don't hear about it in the community. [You] need to advertise more."

Strengths (n=13, 35%) and barriers (n=24, 65%) also were highlighted by respondents regarding additional community resources. One of the administrators noted in one of the target counties, "[the] community coalition—different stakeholders—was easy to pull together due to previous history of working with each other." A client shared that she has benefited from other community resources while in the program. "I have been in individual therapy. I am attending family therapy now with my parents and my children." Respondents also noted a number of barriers. One client observed, "[there are] not enough clinicians or psychiatrists in the community." A clinician shared her observation of one of the target counties, "politics in the county were a barrier, turf-oriented," and an administrator noted, "There is not a child/family team with mental health."

Although only two Foothills respondents talked about the formal community collaborative, a total of four of the respondents (n=9, 56%) reported strengths in the informal community collaboration surrounding the meth program and three discussed barriers (n=7, 44%). One client simply said, "I have a great support team." A clinician talked about strengths of prior collaborations in one of the target counties. "Caldwell had a history of previous task forces." Discussing barriers to the informal community collaboration, an administrator noted, "all partners were not in place [and] couldn't develop the program fully." A second administrator observed the lack of a history of collaboration as a problem in one of the counties. "McDowell does not have the history of stakeholder agencies having prior relationships." She later noted, "now that the meth coordinator has been hired, the stakeholders and general community will be educated."

Foothills respondents noted strengths in individual staff characteristics (n=27, 87%), staff availability (n=10, 63%), and training and education of staff (n=12, 67%), while noting weaknesses regarding limited staffing (n=12, 100%) and communication (n=18, 95%). One clinician noted two particular staff people as supportive. “[Name of staff member]. He gave me the opportunity to run with it. [Second staff member] gave me the opportunity and the support.” Similarly, a client referred to strengths of two staff people. “[Name of two staff people] are intelligent.” Discussing the availability of staff for different purposes, an administrator highlighted the following strengths of her program. “[Program administrators] are dedicated to keeping good clinical team members.” She also observed that the program, “allowed hiring of [a] person who does not have to meet productivity, [and] can market, educate, train, attend treatment meetings—things clinicians cannot get paid for.” A client observed, “[we] can see [a] clinician whenever we need to.” Training and education of staff also were highlighted positively by Foothills respondents. One administrator said, “[In] McDowell, [the] clinical team had a combined total of over 30 years in the field.” A clinician simply stated, “[we] had staff—had the knowledge,” when asked about strengths for providing meth treatment.

Foothills respondents discussed limited staff and communication as weaknesses regarding their meth program. One clinician explained, “This IOP alone is a full-time job. [It’s] hard to do this plus a full time schedule.” An administrator commented, “ARP-Phoenix couldn’t bring [a] licensed person to provide services, then ARP Phoenix pulled out.” Likewise, respondents cited communication problems within their program as barriers. Discussing weaknesses, one administrator said, “communication about the program and clients from the program [are] lacking.” She later added, “[we] need better communication with those in charge of Matrix...[we also] need more communication with the federal government. For example, once someone is convicted, they are allowed to stay in their homes until they are assigned to a prison. We need to know for custody purposes, when the person is leaving. Also, [it] may be unsafe for the children while the person is waiting for prison assignment.” Responding to the same question about weaknesses, a different administrator noted, “communication—[there were] mixed messages during the change from ARP Phoenix and Catawba Valley Behavioral Health Care.” Similarly, a clinician said, “communication in combining Matrix and IOP,” was a weakness in providing meth treatment.

Client-related factors also were mentioned by Foothills respondents. They spoke positively (n=21, 64%) and negatively (n=12, 36%) about the impact of meth on the program and the community, and they spoke in strength-based terms about the increases in knowledge and awareness (n=27, 100%) and skills’ acquisition (n=13, 100%) among clients. When discussing the impact of meth, one client shared in her group, “we give each other advice. [For] example, there is a woman who lives in the ‘middle of the hill.’ There is meth and crack there. We recommended to her that she find ways to schedule her time.” An administrator said, “[the] communities met due to the meth crisis.” She later added, “[the] community wanted an immediate fix to the problem. [There was] community awareness and outrage.” A clinician also noted, “Meth manufacturing is down in large part to the Governor’s initiative, which makes it harder to get ingredients.” Nonetheless, respondents also recognized the negative impact of meth. In describing the

network of meth producers, one administrator observed, “meth cooks are like a club—they all know each other.” A client said, “living in this community, it is hard to be away from drugs. [You] don’t know where to go.” Another administrator explained problems that get in the way of meth treatment in the following manner. “[We’re] still seeing articles about meth super labs in Mexico, articles showing negative living environments, [it] gets in the way of viewing meth addiction as a treatable disease.”

All of the comments about increases in knowledge awareness among clients were positive. “Matrix gave me a better understanding of how to abstain, how the limbic system works, how serotonin works in the brain, what to expect, and the stages, including the “honeymoon” and the “wall,” stated a client. Another client said, “[I] learned about the brain. I had no clue until I took the class. I learned what different drugs do to people.” Administrators voiced comparable gains. “Matrix helped us understand what is happening with the client, and how he/she could make changes.” Increases in skills also was seen by respondents as positive. Stated one client, “this program has taught us how to schedule our time to prevent relapse and to do “thought stopping.” A clinician shared, “people in church would see differences, [a] minister saw clients changing, [he] would see them at the grocery store, on the street.”

Cost of the program to the client and overall funding of the program were the only “concrete resources” mentioned across respondents. The cost of the program to clients was more frequently cited as a strength (n=8, 73%). When asked about strengths, one clinician said, “the fact that it is free, most clients [are] unemployed, on their way to prison.” An administrator simply answered that one of the strengths, “[It’s] free.” Overall funding for the program was viewed as both a strength (n=19, 38%) and as a weakness (n=31, 62%) by respondents. An administrator explained that one of the strengths of the program, “having money above substance abuse monies.” Another administrator stated, “the meth money was pertinent to Caldwell and McDowell.” She also later added, “funding [was] in place—not an obstacle.” A clinician said, “[we] needed childcare. The funding was there but not the service.” Nonetheless, funding also was a barrier. An administrator observed, “[there are] still existing barriers to billing and drawing down the money. This discourages programs to start...need more potential for drawing down the monies, [and an] opportunity to lobby so resources can continue.” Another administrator responded, “limitations on categories of money, especially in the rural locations. [I] understand that block grant funding does not pay attention to limits of [a] rural community. [You] may have two for-profits and no other providers. What do we do if we need to have a not-for-profit?” A client noted one weakness as, “lack of funding for programs in jail and on the street.” A clinician said, “[there’s a] question about who is controlling Matrix money, no knowing where the money is going,” is an issue.

Foothills respondents cited group dynamics (n=12, 86%) and family involvement (n=12, 80%) as key strengths regarding treatment, and they offered numerous observations about the Matrix treatment model used in their program, primarily positive (n=92, 79%). One client said, “group members are bonded with each other.” She later said, “if someone in the group relapses, we don’t down them.” Another client shared, “it’s a good place to

meet people.” Comments also were positive about the family involvement component. A client said, “family members don’t realize that they are in recovery also. At family night, they explain that recovery needs to be a top priority.” A clinician observed, “[we] connected with families of the clients. They got to understand addiction.”

The Matrix model also received strong support from respondents. “[Matrix] helped me to stay clean and organized, [to] realize what is going on inside my head, my brain, my addiction. I learned to create islands (part of the Matrix curriculum), doing things you like to do, trying new things clean.” A clinician echoed these comments. “In my career as a substance abuse clinician, [Matrix is] the best intervention for treatment, [it’s] consistent, structured, accessible, easy to understand for clients and the community, easy to promote. Another clinician noted the following strengths of Matrix: “empowering for a client to be a peer co-leader; its availability; its nondiscrimination about meth or other stimulants, no cost, family involved in family night, feed them on family night...” In noting negatives, one administrator observed, “[it’s] too soon to tell if the program reduces relapse or has an ongoing impact.” A clinician also said, “not allowing the clinicians to do the project as intended,” is a problem.

Strengths and barriers related to legal factors, jail or prison, and DSS were mentioned by all of the Foothills respondents. Respondents discussed positive and negative aspects related to the law equally (n=16, 50% positive; n=16, 50% negative). One client said, “between changes in the program and the law, use has been cut down.” An administrator commented, “law officers are exposed to another way of looking at the problem.” Another administrator observed, “[when] the law signed off on the protocol, we were surprised.” Again, the respondents cited equal problems with the legal system. One clinician commented, “[there] could be better community support from the legal system.” An administrator echoed the comment, “law enforcement not on board—we need their support.” Further, a client observed, “not enough information is given to court system about the program.” Relationships with jail and prison were viewed as a strength and a barrier. “There is one [Matrix program] in jail supported by the [name of mental health program],” reported a clinician. An administrator acknowledged that one opportunity created by their program, “it changes our perspective that all meth users should go to jail. Some children are even able to go back into the home.” But problems also were mentioned in the relationships with jail or prison. “Police are aware of other options, but once they get you into the system, they won’t let you out,” stated one client. A clinician observed another problem. “A lot of clients [are] going through the [meth] program, but still went to jail, often long-term.”

In addition, DSS involvement in the meth program was seen equally as a strength (n=16, 50%) and as a problem (n=16, 50%). A client said, “DSS felt like I was worth saving. It is not like this for everyone.” A clinician stated, “DSS really liked the meth group,” in their community. An administrator explained in their program, “participants [are] eligible to access other services like family and individual sessions. DSS was the primary portal. Clients began to gain access through them.” However, there were barriers mentioned. “I have a problem with how DSS investigates allegations. The DSS workers here are hard, they have seen lots of abuse,” replied a client. A clinician

commented, “[it] took a long time for DSS to catch on.” Another clinician observed, “[there was a] lack of communication with DSS, not maintaining relationships.”

Finally, changes related to mental health reform in agencies (n=11, 100%) and in staff (n=9, 100%) were negative themes, and state involvement was viewed mainly as a problem (n=12, 66% of the comments), although a third of these types of comments were supportive (n=6, 33%). When asked what gets in the way of treatment, one administrator said, “there have been so many changes...changes in clinicians, delayed services...trouble finding providers... We continued to operate despite these changes.” A different administrator noted, “[we had] difficulty with starting due to the change from for-profit to not-for-profit. Universal was private, but had the momentum going, then had to change...change mid-stream to ARP-Phoenix—hopefully, they’ll keep the same players.” Changes in staff also were problematic. “Changing people was confusing. We were one year into it, and then a series of people stayed briefly... The agencies were put in place with no real leaders.” A client provided a similar perspective, “changes in providers was hard, when it went from a laid-back person to a hard person.”

A third of the comments about State involvement were positive. “[The] State as a funder has a commitment to making this happen,” said an administrator. She further added, “at the state level, the funded additional money [for the program]” is a strength. Another administrator identified specific State staff and a State group as helpful. “[Matrix trainer], [a] tech advisor; [State Meth Initiative Program Administrator], [who] coordinated the whole community thing from the State; [and the] networking group with other LMEs [were helpful].” There were a number of negative comments about the State’s involvement. “The State needs to be more aware—needs to fund more programs,” said a client. A clinician said that one weakness of the State involvement, “not allowing the clinicians to do the project as intended.”

New River LME. As noted above, New River developed and implemented a methamphetamine family treatment model that eventually became known as Family Solutions. At the time the Watauga/Ashe effort was being developed, the New River LME had not divested its services. A total of two clients, two clinicians, and four administrators from Ashe and Watauga counties were interviewed.

As the “oldest” of the meth programs, community-related factors were cited by all respondents. Community awareness was mentioned numerous times by New River respondents as both a strength (n=27, 68%) and sometimes as a barrier (n=13, 33%). When initially dealing with the issue of meth in their community, one administrator said, “the main issue was that nobody knew what to do about the labs. What to do about the toxic environment—how to keep EMS (Emergency Management Services) and FD (Fire Department) workers safe? What decontamination protocol to follow.” She later added, “the community considered and still does [see] the program as belonging to them.” A clinician noted, “The national/state crisis and attention on meth made money available.” A client observed, “Before the sheriff was voted in, he said he would change the community and he has.” Still, lack of community awareness also was cited by respondents as an issue. The same client recommended the following changes. She said,

“get out and involved with the public more—more community outreach. Work with jail to get list of names. While I was in jail, there were four to five dealers in there...post Family Solutions numbers with pull out numbers on the bottom [of a flyer].” An administrator observed, “There’s not much publicity about the program.”

Community resources was primarily viewed as a strength by respondents (n=28, 78%), although eight comments were negative (22%). A client specifically identified supportive resources. “TASC (Treatment Alternatives to Street Crime), Family Solutions, and [my] probation officer have all been supportive.” An administrator observed, “[the meth program] opened up doors to communicate with other agencies—seek out resources.” Another administrator stated, “NA meetings,” as a strength. “It was a good process to learn what other agencies are using,” she further stated. Some negative comments also were cited. “We need more inpatient closer to this community,” said a client. An administrator observed, “Discouragement of community players who encounter pressure from the State that keeps them from feeling in charge, especially DSS, GAL, schools,” is a barrier.

New River respondents spoke positively and often of their formal community collaborative (n=42, 84%) and of the informal community collaboration (n=46, 90%). Speaking of her formal community collaborative, one administrator said, “[the community collaborative was] designed by the community around community needs.” She further explained, “it [the meth program] was initiated in the community when Watauga DSS requested a treatment program be developed to better meet their needs, specifically a program that did not segment families. It was presented at a large community meeting to address substance abuse without State knowledge; the community on its own requested a modification in the structure of treatment. Agencies involved included DSS, substance abuse, law enforcement, the health department, the fire department, environmental specialists, forensic toxicologists, and Guardian ad Litem.” Another administrator commented, “Different committees worked together on outcomes and measures. It was a good process to find out what other agencies were using.” When asked about strengths of their meth program, the same administrator said, “Community collaboration working on a common goal.” A clinician said of their formal collaborative, “Working closely with other agencies,” is a strength. “The community collaborative, which, especially in Watauga, is more established,” was reported as a strength by another clinician.

Similarly, respondents also had very positive comments about their informal collaboration. A strength noted by one clinician was, “community collaboratives and the relationships we have with other agencies.” She further observed that one of the opportunities for such a program is, “the number of agencies involved at the ground level and different ideas coupled with discussion.” An administrator, also talking about opportunities within her community, noted the following strength: “Weekly staffing of DSS/Family Solutions, which is not available through the traditional style of treatment.” She later observed, “It could not have been done by any one entity. It took the knowledge and understanding of multiple agencies. It was understood that each agency had an area of expertise to bring to the table, and that it was necessary to integrate that

into an overall program.” From the client perspective, one observed, “TASC, Family Solutions, and [my] probation officer have all been supportive.”

Like the previous site, characteristics about the staff (n=24, 92%) and training and education of the staff (n=8, 80%) were strengths of their meth program. Speaking of the staff, a client said, “they keep you on your toes. Help you keep yourself in line.” A clinician specifically referenced one of the administrators as a strength of their meth program. “Because of [staff member’s name] creativity and willingness to do something completely different as opposed to following the box of the State and New River.” An administrator also noted specific staff people as strengths, “the people I have worked with at Family Solutions, primarily [two staff members’ names], and some with [two staff members’ names].”

While the respondents commented less on the training and education of staff, they saw it as a strength of their program. One clinician said, “Clinicians [are] brilliant in their own way specific to modality, population, [and] working together to identify and address problems.” A client said, “It feels good to have someone who knows about addiction.”

Availability of staff was viewed both positively and negatively by the New River respondents and limited staffing was noted as a problem. A total of seven comments (41%) addressed the availability of staff as a positive factor in their meth program. One client said, “transportation could get in the way, but [staff member’s name] comes to my house when I can’t come to the office.” She further said, “Family Solutions is just a phone call away.” A different client said, “[a different staff member’s name] came to my house to meet with family/help [my] family.” She also observed, “staff is stretched pretty thin. It doesn’t hamper their dedication. For an emergency, they are there; 24 hours/day line.”

The negative comments about availability (n=10, 59%) appeared to relate to limited staffing (n=12, 100%). One clinician said, “Clinicians need more supervision.” She later stated that what gets in the way of treatment, “time limitations...burn-out by clinicians—clinicians are spread too thin.” An administrator noted, “[we’re] overextended trying to cover two counties. Having half the team working in Ashe reduced the responsiveness in Watauga.” Describing weaknesses, another administrator observed, “[we] do not have [a] case manager in Ashe county, or interns to help out in Ashe.”

The impact of meth was viewed as an asset (n=13, 62%) and a barrier (n=8, 38% of the comments), while the acquisition of skills (n=44, 100%) was viewed as uniformly positive. One client explained the impact of meth in her life. “I was using meth earlier than other drugs. After my father died, I had grief issues. In my short time using meth, I made lots of mistakes. I misused meds to get off of meth. I got four DUIs...[I] lost my kids due to the DUI, and [I’m] attempting to get custody back.” Another client explained the pervasiveness of meth in her situation. “Just arresting people doesn’t take care of the problem—it didn’t bother me and didn’t stop me as a drug addict. Meth is so addictive—[I] did it for my depression and it becomes what is important.” Clinicians and administrators discussed how the meth “crisis” led to start-up of the program. One of the

clinicians said, “Kids being taken from homes due to the meth lab situation was a huge issue for DSS...[the] DSS crisis with children being removed made it possible to do something innovative.” An administrator noted, “meth use is prevalent...it’s easily accessible to get the drug here...pills, meth, pot.”

All of the comments of respondents were positive regarding the acquisition of skills experienced by clients who participated in their meth program. One administrator said, “[the meth program has] gotten people off drugs with family involvement. Helped addicts get satisfaction. [It’s] solved a lot of problems beyond substance abuse for families, including child well-being, family relationships, and housing.” A client reported, “For the goal, “improve parenting skills,” I have taken parenting classes. I have supervised visits with my children, and next month I will get unsupervised visits.” She further said that the project has affected her and other clients, “helped them kick their drug habit. [It] made me a lot better, drug-free with a good job. I am pregnant, getting my custody back, getting married.” A clinician similarly observed, “Clients are making significant changes from not being able to hold a job and care for children to being able to do these things.”

Respondents often commented negatively about concrete resources, transportation and location, while strengths and weaknesses of the funding of the program were cited, and strengths of the free charge to clients were mentioned. A total of 10 comments (77%) were directed at the issue of transportation and 16 comments (89%) were made about location. One administrator observed, “[we] cannot run IOP in Ashe, because the area is too large and it creates transportation problems. If [we] were able to buy two more vans and hire two drivers, maybe it would work.” Another administrator said, “the county is large, and it is hard to have intensive treatment when most of the time is spent on transportation to clients’ homes.” A clinician stated, “transportation is a huge barrier... geography is too spread out and too expansive.” A client also observed, “We need more inpatient treatment closer to the community.”

The funding of the program was viewed positively (n=10, 30%) and negatively (n=23, 70%), while the free charge to clients, while mentioned less often, was seen as a major asset (n=7, 88%). A clinician viewed one of the strengths, “funding was made available—we were allowed to do the program.” An administrator noted a specific strength, “State level willingness to give funding dollars that are not subject to drawdown by UCR definitions.” More of the comments about funding appeared to be negative. One administrator observed, “Unequal distribution of funds and resources—most of the time and energy went to Watauga County, and the resources and staff went there as well.” Another administrator noted, “I would like the State, in managing the grant money, to show more responsiveness to the local community.” A clinician said that some of the barriers included “[the time it took] for the grant to come through and [there’s] ongoing uncertainty of funding.” Nonetheless, the free cost of the program to clients was viewed primarily as a strength of the program. A clinician said that one of the strengths is “services are free to clients.” Another clinician said, [the] logistics include breaking down barriers, grant funded free service, flexible in scheduling—“we come to you.” An

administrator also said of their program, “it is invaluable to us, to go out right at the beginning with Family Solutions, no worry about costs, seeing families in their homes.”

All of the respondents shared numerous observations about the Family Solutions treatment model. While most of the comments were about the strengths of the program (n=166, 76%), 51 of the comments (24%) addressed issues. The Matrix model of treatment also was discussed. Eleven of the comments (73%) discussed some of the problems associated with this model. Finally, the family involvement component was most often mentioned by respondents as one of the assets of the meth program (n=13, 100%).

One of the administrators described the detailed strengths she viewed of the Family Solutions model. “Family Solutions is an assertive collaboration engaged with clients. DSS and Family Solutions are concurrently engaged in triage with the entire family from the first encounter to handle emergency and urgent needs. It is different from most past substance abuse programs, which are passive programs (they make an appointment and either “show” or “no-show” with no follow-up). Rather, with Family Solutions, the client and family are assertively engaged and attempt to decrease the barriers such as child care and transportation. They work to solve problems to get them in treatment and immediately establish a network team with all of the stakeholders—the extended family and the treatment team. All children are assessed for strengths and needs, and infants for a developmental evaluation prior to IOP. Special needs and community support are addressed before IOP.” A clinician noted the following strengths of the Family Solutions model: “treatment for the whole family, flexibility for home visits, rapid entry” and “[it’s] an opportunity to see recovery in [the] larger context [of the] goals.” Another clinician commented on strengths that she viewed as a result of the program, “arrests are down, meth lab numbers down. Children remaining in the home is up. [There’s been a] positive impact on the community, like families staying together.” Clients similarly, spoke of the strengths of the program. “Frequent drug screens (initially only abstained because of the test—then [I] thought more clearly and had other reasons); involvement of family as they are associated with addiction; IOP classes—Monday, Wednesday, Friday; [the] frequency of treatment kept me in treatment...program structures and levels...individual therapy for personal things.”

Problems with Family Solutions also were noted. When describing weaknesses of the program, a clinician explained, “the program is not as well coordinated as preferable...don’t know limits of how far to go—the issue of chasing/enabling versus supporting.” She later said, “the goals are good, but it is hard to see the forest for the trees.” An administrator stated, “[I have a] concern that this model [Family Solutions] will be forced to operate as a fee for service.” A clinician also stated, “Clinicians are busy testing the weaknesses of the system, [they] can’t test the weaknesses of the program.”

Most of the negative comments about Matrix were related to the issue of conforming the Family Solutions model to Matrix. One clinician said, “It [the meth program] turned into a focus on the Matrix program when, in reality, Matrix is a small part of the overall

program.” An administrator echoed a similar concern. “The impression that the State sees Matrix as the primary focus is a problem, because it is designed for individuals, but not for addressing family dynamics.” In describing weaknesses related to providing treatment, another administrator noted, “[there’s a] disagreement between the local community and the State about the best model for treatment program (i.e., the Matrix model).” She later added, “to have reporting involve more of the goals of the project. Only two of the nine goals are supported by Matrix reporting.”

Involvement of DSS in the meth program was predominantly seen as an asset by all of the respondents. A total of 38 comments (83%) focused on this involvement as a strength. One administrator noted, “we evolved into an ongoing partnership to engage all CPS substance abuse visits. We’ve become a model for partnering [with] DSS and treatment to reduce child problems regarding substance abuse...[we’re] pioneering a new approach and DSS [is] the leader in the state as far as developing responses to the meth problem.” She also commented on one of the DSS staff members as a strength. “[Name of DSS staff member] is a powerful force in forging the treatment and community collaboratives.” A clinician referred to DSS involvement as a strength, “relationships with DSS and probation...referrals come from DSS, New River, probation officers.” Another clinician observed, “[the meth program] is similar in Ashe—relationship with Ashe DSS is exemplary.” She also noted, “at the beginning, there is motivation [on the part of clients] to change outside of themselves through DSS or legal consequences.”

Paperwork related to mental health reform was viewed negatively (n=14, 100%). Describing problems with paperwork, one clinician said, “[the] amount of paperwork and red tape to obtain treatment stands in the way of treatment of client. The Person Centered Plan’s first form [was] labor intensive, bores the client and lulls the client into quitting treatment. Then, [the] paperwork changed, may change again—why should the clinician learn new paperwork? Paperwork alienates the client and makes clinicians spend time away from the client.” Another clinician observed, “Paperwork is time-consuming and insane.” She later explained some of the weaknesses related to treatment, “the current context of state and local policies, resources and staff had an incredible negative impact. People were not trained; there were new treatment plans without training, and the volume of the plan.”

State involvement was viewed more positively (n=15, 38%), although there were a number of concerns highlighted by New River respondents (n=24, 62%). One administrator noted, “The Division [is] invested in finding [the] best practice—evidence-based treatment...The Division is willing to fund pilot projects.” Another administrator said, “[The] State level willingness to give funding dollars that are not subject to drawdown by UCR service definitions” is a strength. In discussing possible opportunities for better coordination with the State, another administrator said, “community reps—DSS/MH/CJ(Criminal Justice)/GAL/schools—could meet with State people to advocate regarding what State can and cannot do to facilitate [the] program.” A clinician said of weaknesses, “the Division, the State, has keyed in on Matrix, which can be counterproductive to Family Solution goals...the Division is a threat due to Family Solutions not supporting particular treatment model.” A client observed that one of the

opportunities related to meth treatment might be problematic with State involvement. “Team up with religious organizations. It can help refocus—need to replace addiction with something; but, with a state agency, this may be difficult.”

Smoky Mountain LME. In Haywood and Macon counties, a total of two clients, two clinicians and four administrators were interviewed. For their programs, both counties primarily based their treatment on the Matrix model. Like the previous two LMEs, respondents cited positive and negative themes associated with community awareness of their program (n=21, 60%; n=14, 40% respectively) and other community resources (n=48, 50%; n=48, 50% respectively). While they did not discuss the formal community collaborative, respondents primarily spoke positively about the informal community collaboration (n=27; 87%) within their catchment area. One administrator identified the start of the effort and community awareness. “There was an initial meeting in Cherokee which 200 people attended...there was an openness to learn.” She later shared, “Lots of time [was] spent on presenting and educating. [This] heightened community awareness.” A clinician observed, “The Meth Initiative served as a springboard for educating the community regarding the problems of methamphetamine addiction and treatment and prevention.” Issues also were noted regarding community awareness. “There is still so much that people do not know or understand about substance abuse. There are attitudes which represent radical extremes. On the one hand, some think it is okay if a client is “just” using pot, as long as it is not cocaine or meth, while others think that any relapse is an indication of a treatment failure, instead of part of the process,” remarked a clinician. A client suggested, “events to promote the program,” as an opportunity to increase awareness.

Community resources represented both an asset and a problem according to respondents. A clinician observed, “There are caring people in the community who desire to help people get treatment.” She also mentioned some unique resources in their community, “Restoration House—a faith-based organization that provides housing placement and wrap-around case management. CASA-Works—a one year program.” Another clinician noted, “[we have] a wonderful NA community—meetings four times per week.” She also said, “there were strong interagency relationships including the sheriff.” An administrator said, “There are several programs including [name of staff member’s] program at Mountain Youth Resources, and two separate faith-based programs [are] having good results.”

Yet the lack of other resources also was highlighted. One client suggested, “activities [within the community] to show people how to do things sober, like a picnic or a movie, a bar without alcohol. Something to take our minds off of the drugs.” She also discussed other weaknesses. “Meetings are few and far between. There are a few more AA meetings. People in treatment take advantage of what there is, but there isn’t too much.” Another client offered, “work-related programs to assist addicts. [Name of staff member] has resources but still I need ongoing assistance.” An administrator noted that what may have gotten in the way of treatment was “choosing between seven counties—how to meet all of the needs. Many counties unserved.” Another administrator observed potential

opportunities for additional resources, “[we need to] get into the school system. We need a male Oxford House...there are not enough resources.”

The informal community collaboration was referred to as a strength. A clinician noted, “the community mobilized itself around the meth issue...everybody supported it.” She also said, “[the] liaison with probation has been great.” An administrator noted the relationship with another site. “There were start up meetings with various agencies...there was a meeting with ASU and Smoky LME.” In discussing strengths with other agencies, she said, “we support each other and cooperate with each other.” A different administrator remarked succinctly, “fabulous community commitment and interest...each county had great stakeholders—great community. [We] had to pick among these—the strongest and best substance abuse programs.”

Like the other sites, staff characteristics were a positive theme cited by Smoky respondents, while training and education were viewed both positively (n=15, 50%) and negatively (n=15, 50%), and limited staffing (n=29, 100%) was a barrier. One administrator discussed the personal strengths of some of her staff members. “[Name of staff member] is committed to treating the substance abusing individual including meth to the best of her ability...she is a good clinician—worked hard to put something together. “[Name of other staff member] is an excellent clinician, highly committed to the model and consumer priority above herself. She has good boundaries, is not enmeshed, has integrity, very professional, great connection with the consumers, runs a good program.” Another administrator commented, “[name of staff member] and her staff have been very positive.” The same administrator noted problems with limited staffing. “It [the meth program] is a demanding service. [It’s] a recipe for burnout—lots of front-end work.” She also said, “[there is] a lack of qualified staff.” A clinician echoed similar comments: “Lack of enough clinical and administrative staff.”

Smoky Mountain LME respondents commented on the positive gains achieved by clients in terms of increasing knowledge and awareness (n=10, 100%) and skill acquisition (n=17, 94%). One client said, “It [the meth program] gives people hope. It helps individuals to get things out and identify where the substance abuse started...the information we learn is awesome. The program helps me explain my addiction.” Another client said, “You can never learn enough coping skills. I know I need to hear it more than once—learning to deal with life triggers.” In addition, the acquisition of skills was highlighted by different respondents. A client reported, “[the meth program] saved my husband’s life...I know it has made me better with my family, made me a better parent. For nine hours a week, I am sure not to do anything illegal!” An administrator observed, “anecdotally, people graduate—become peer specialists.” A second client said, “it [the meth program] helps keep me clean. Helps me “pick up in the right direction.” She further shared, “[I] lived so long in active addiction that we need a recovery routine like brushing our teeth or eating. When we stop, we can’t be with the same people or do the same things.”

Concrete resources, including transportation (n=12, 71%), funding (n=43, 84%) and location (n=9, 69%) were seen as barriers. One clinician described the following

weaknesses: “lack of resources for transportation and child care are still a big weakness.” She also said later, “[we] have a van but need money for a driver.” An administrator discussed both transportation and location problems. When asked what gets in the way of treatment, she said, “How to serve and provide transportation would be a six hour loop. Geography and transportation are past and current barriers.” Another administrator provided a similar response. “Transportation and the hours it would take to transport clients. Probation wants the program but transportation is an issue and so is child care.” Another administrator wondered aloud, “[I] wonder if [the] model is ideally suited for a rural population. There is not an in-between step.”

The Smoky Mountain LME respondents viewed the Matrix model primarily positively (n=88, 71%). There were some negative comments (n=36, 29%), but all of the comments (n=13, 100%) about the family involvement component were positive. One client said of Matrix, “this program is an opportunity to make a choice in the right direction...[it] teaches us recovery skills.” Another client said, “[the Matrix program] helped many of our families. Wednesday night is family night. We are getting help.” A clinician reported on the strengths of their Matrix model. “The number of hours we are able to offer service...the structure of the program is excellent and the Matrix materials are excellent.” An administrator noted one of the strengths of Matrix was, “commitment between the Division, the LME, and the providers.” She also referred to the Matrix model as an “increase in substance abuse treatment—reasonable, effective treatment.” Another administrator observed, “Meridian is invested in seeing it continue and thrive. [The Matrix program] serves the underserved.” She also discussed the commitment of a staff member to the model. [Name of the staff member] is passionate about the service, attempting to do the model with fidelity, well-versed in the field, and has the commitment and skill. The program works with individual and families.” Negative observations also were made. One clinician said of weaknesses, “not being able to get the children’s portion off the ground, so that we have not been able to do the children, and the parenting skills improvement part of the program.” She added, “not funding any services for people in jail—we need to have IOP in jail! It is sickening! Another clinician stated, ‘we need to have 42 sessions of IOP. In addition, an administrator said a problem was “putting [the] Matrix model into NC service definitions like an unfunded mandate. [It] would have made sense to work out compensation prior to service provision. Instead, meth coordinators had to figure it out.” In addition, she said, “detail of [the] model needed to be worked out prior to service provision.”

Legal factors, including a positive impact related to the law (n=16, 70%), a positive (n=11, 61%) and negative (n=7, 39%) impact related to DSS, and negative views of a punishment-oriented perspective (n=9, 82%) were common themes across respondents. One of the administrators talked about the strong, prior relationship with the sheriff’s department. “I have worked with the sheriff for 18 years. We knew everybody in the community, especially the schools. She later said, “judges are more understanding and give more opportunities to clients than jail. Judges understand addiction here.” Another administrator stated, “[the meth program] is a way of wrapping law enforcement in[to] the community dialogue at the table, not as a barrier.” The relationship with DSS and its impact were considered both negative and positive. An administrator noted, “the

collaboration of agencies, including probation, parole, DSS, mental health, and substance abuse is a real strength.” In describing the development of the program, the administrator further explained, “Smoky and Meridian put in the grant application. DSS was interested in supporting the effort. Assembling community partners made certain of the need, and helped with support and collaboration.” Nonetheless, problems with DSS also were highlighted. “Both counties lack significant DSS involvement,” said an administrator. A different administrator observed problems with DSS rules. In describing weaknesses, she said, “the DSS time frames involved. We must be done with a case within one year.”

A punishment orientation also was cited by a number of respondents. One client said, “[I] wish it [the meth program] wasn’t mandatory.” She further said that what gets in the way of treatment is “sentencing to jail time, not to treatment.” Another client expressed frustration due to the legal issues. “Without a job, I feel like I am not progressing. I worked at [place of employment] as an hourly manager, and the salaried position was given to someone else. My record prevented me from getting a job...I was court ordered to [name of treatment]. [It] shouldn’t be a punishment. I requested the program.”

Finally, Smoky Mountain LME respondents reported that paperwork changes (n=11, 100%) and State involvement (n=16, 73%) were often viewed as barriers. One clinician observed, “The paperwork and the administration was a fiasco.” An administrator said, “the program was real slow in starting due to the bureaucracy the LME has created, and is faced with from the State. It took forever to get going.”

Western Highlands LME. One client, one clinician, and three administrators were interviewed from Buncombe County. As noted above, the Rutherford County meth treatment program was not successfully established. However, at least one of the participating respondents did have knowledge of the efforts expended to develop a Rutherford County program.

As in other LMEs, community-related factors, including community awareness, community resources, and the informal community collaboration were mentioned by a number of Western Highlands’ respondents. The majority of comments about awareness of the community (n=25, 68%) could be considered positive. One administrator explained, “[the] local and national climate was a strength—with the meth hype, here is some treatment.” She also said there was “high motivation for support in the community.” A client shared, “I found out about the program through my PO (probation officer).” Similarly, 30 comments (81%) were positive concerning other community resources. In describing strengths within her community, one administrator said, “[the meth program] is provided by an agency with experience with substance abuse.” She also said, “I hope it will build a stronger recovery continuum.” Another administrator said, “[the] coordinator was a big help in coordinating community resources.”

While the formal community collaborative was not highlighted, the informal community collaboration surrounding this program was mentioned by a number of respondents. An administrator said, “ARP could assume the program and had the infrastructure to expand—[they] also had a prior good relationship with the community.” Another

administrator identified the following strengths that led to the development of the program. “[We] looked regionally for a provider, [a] group of folks came together and discussed provider capacity. People showed enthusiasm, innovation, and strengths in seeking grants. [There was] strong collaboration, the human services community was not territorial.”

Staff characteristics were mentioned as a recurring positive theme among respondents (n=12, 92%). Further, training and education of staff were mentioned both positively (n=16, 67%) and negatively (n=8, 33%) by respondents. A client spoke directly about the strengths of a staff member. “[name of staff member] has taught us a lot. When asked about strengths of the program, a clinician said, “[name of staff member’s] background in mental health and substance abuse; Buncombe’s willingness to have [Matrix trainer] return for training.” Ad administrator stated that one of the strengths she observed, “Matrix training—everybody on board.” She later added, “[a] knowledgeable LME and substance abuse person, [name of staff member] at the table,” also was a strength. Some negative comments also were mentioned. Another administrator stated, “lack of qualified, trained staff,” was a problem. A clinician said, “[the] two day training [was] not that fantastic...[I] wished there was a complete overview to workers.”

The impact of meth was viewed negatively (n=9, 75%) according to a number of comments by Western Highlands’ respondents. An administrator talked about the stigma of meth. “[the] threat clients felt was the label...clients had no problem admitting to being a crack addict. If labeled, [they were] concerned about client meth use getting [known] out in the community, then possible legal consequences. Stigma attached to children getting treatment, if DSS [was] not involved, then [there was fear] they may get involved. [It] stopped some children from getting counseling.” Another administrator reported similar comments. “many don’t understand substance abuse as a disease. There is stigma attached.” She also observed there were “not as many cases as we anticipated.”

Increases in the knowledge and awareness of clients (n=21, 95%) and skill acquisition (n=27, 96%) also were considered key strengths. A client reported, “this program is teaching us about recovery, relapse, and goals. [We’re] learning about drug addiction.” An administrator talked about the following knowledge as a strength. “[The program discusses] the cycle of substance abuse, understanding genetics, effect on children, etc. This [information] gave family members a chance to ask questions.” In addition, skill acquisition was an asset of the program. Talking about the effects of the program, a client said the program “taught us a lot about our addiction...I got off of drugs and I seen where I was. Some clients have gotten their kids back or custody back.” An administrator working with the program observed, “Any person participating in a substance abuse treatment regimen makes a huge commitment, yet at the same time needs to work.” Discussing effects of the program, she later added, “Hopefully [the program] impacted lives, strengthened recovery.”

Funding was the only concrete resource highlighted by Western Highlands LME respondents with regularity. A total of 18 comments (69%) were provided about the funding barriers. A clinician observed, “Meth users have unique problems. Individual

therapy [is] not reimbursed for clients, [but they] may need [it].” She added later, “there was a question about how social support was going to be paid for. It started changing—getting dollars [was] not as easy as in the past.” An administrator stated, “funding took a year to come. Agencies were providing services with no funds.”

Most of the comments from respondents about the Matrix model were positive (n=77, 69%) and approximately a third of the comments were negative (n=34, 31%). All of the comments provided about the family component of the model were positive, although there were fewer overall (n=9, 100%). When asked about what she would like to say about the meth program, a client said, “I like everything about it.” A clinician said, “[the] Matrix model itself was one of the strengths. [It’s] cognitive behavioral therapy approach to therapeutic process, and emphasis on family involvement were strengths...clients could really “sink their teeth into it,” clients responded.” An administrator observed the following strengths. “Families being treated together rather than treatment as usual. Recognizing the family illness rather than just the client illness. Matrix was overseen and held to task through the research component, with the coordinator able to more fully implement the IOP.” Negative comments about the model also were made, and they usually focused on implementation issues. A clinician mentioned these issues. “North Carolina’s arbitrary decision to meet SA IOP definitions. [The] lengthened program caused burnout of clients. If [we] stayed with 16 weeks of Matrix, could have more focus on community resources—AA and NA...[the] program needed to be more standardized.” Another administrator stated, “there was a lot of back and forth about whether the program treated just meth or other drugs. [We had] difficulty getting timely drug screens, and may have missed clients who really needed the program...clients may be in jail and not able to access treatment.”

The impact of the law and the relationships with DSS were noted by respondents. A total of nine comments (53%) could be considered positive regarding the impact on the legal system, while eight comments (47%) could be considered negative. In discussing opportunities, an administrator said, “[a] closer working relationship with criminal justice” would be beneficial.” One of the clinicians pointed out the diversity of their task force which developed the effort as a strength. The task force included criminal justice representatives. “Diversity of the task force, which included Western Highlands, New Vistas, fire department, the newspaper, ARP Phoenix, Families Together, the sheriff’s department, the police department, and [two staff members].” Nonetheless, the legal system also was viewed as a barrier at times. “Law enforcement not prioritizing treatment like other agencies,” was a weakness identified by an administrator. She also said, “we need to get treatment to people in jail.” Another administrator made a similar observation. “[there was a] lag of criminal justice to get them to treatment.” A clinician suggested the following: “judicial knowledge and involvement in the process. If they knew the parameters, [they] would have alternatives. [It] would be helpful if they were more aware of the Matrix model.”

DSS involvement was more often considered a problem (n=13, 59%), although some comments about DSS (n=9, 41%) were positive. A clinician stated, “[a] major weakness was the lack of knowledge and follow-through with DSS, some related to the large turn-

over in mental health.” She further observed, “DSS [was] missing in the picture. DSS failed to refer to the program.” When asked how DSS and law enforcement work together in the community, an administrator observed, “[they have] a good working relationship.”

The final comments revolved around staff changes related to mental health reform and State involvement. Regarding staff changes, all 15 comments (100%) were negative. When asked what gets in the way of treatment, a clinician said, “agency changes, staff changes.” Responding to the same question, an administrator stated, “huge staff changeover.” She also shared, “ARP’s top three administrators left the agency. Clinical support staff left the agency. [A] counselor left the agency. All new staff as of 01/01/07. Changes in staff had a huge impact, including the lost history of the project.” Some of the comments about State involvement were positive (n=9, 31%), although a number were negative (n=20, 69%). Different barriers were cited regarding State involvement. A clinician said, “[the] only weakness was that the State seemed to change the program after it started.” An administrator observed, “We started on a roll with a full implementation plan, but the State put us on hold for four months. Therefore, we lost staff, momentum, and credibility. It was an example of how not to implement.” The administrator later added, “Having to fit the service definitions of the State—State licensure changes complicated things. This added another level of angst, which was bad timing. When asked about strengths of the program, an administrator said, “State level support—[State Meth Initiative Program Administrator] and [Assistant Section Chief/Director of Operations and Clinical Services].” The administrator also reported, “The training on Motivational Interviewing and Matrix and tech support were excellent.” A clinician succinctly said, “[Name of staff member] and State dollars.” “It is a bonus in the midst of current cutback and changes to have a program designated for substance abuse treatment. It is a carrot. With the other cuts, it is a blessing to have the funded money for the program here,” replied an administrator.

Strengths and Limitations of the Process Evaluation

This process evaluation can be described as “multi-method,” although it is primarily qualitative in nature. The sample size was small (n=29) and non-representative (i.e., not randomly selected). Respondents were selected by staff of their sites and the Research Team to participate in this evaluation for their perceived familiarity and knowledge of their programs. This was intentional, because the stated purpose of the process evaluation was to explore the process of development of the treatment programs and the actual delivery of their treatment models, in order to provide a frame of reference for program evaluation. Although random selection might have had the effect of reducing bias, it might also mean that respondents were less informed about the programs they were being asked to comment on. All respondents participated on a voluntary basis. Only one declined to be interviewed--a respondent from Rutherford County. This was unfortunate, as useful information related to that county’s efforts might have been gained. As previously noted, respondents included clients, clinicians, and administrators from all seven participating counties, resulting in the opportunity to gain knowledge from various perspectives.

Use of the structured interview guide provided consistency and uniformity across interviews. All respondents were asked and able to discuss strengths, weaknesses, opportunities, and threats associated with the development and implementation of their respective programs. In addition, all respondents were given the opportunity to add additional comments at the end of the interview. Their willingness to participate in the process evaluation and their responses demonstrate their support of and investment in their programs, and may reflect their individual and collective commitment to improving the programs.

As addressed in the Overview of Treatment Programs, above, there were variations across programs in treatment models and service delivery. For example, when respondents spoke of treatment components such as “family involvement,” the phrase had different meanings across sites. It is recommended that responses be carefully examined in their respective contexts. The pending quantitative program evaluation will be useful in assessing the effectiveness of various treatment components on outcomes. As previously noted, it is not possible to generalize from these findings. However, it is possible to assess the transferability and utility of information and knowledge gained from this evaluation to inform the future development of these and other programs.

Summary

The purpose the process evaluation—to explore the process of development of the treatment programs and the actual delivery of their treatment models, in order to provide a frame of reference for program evaluation—was achieved.

In assessing themes and trends that emerged, client respondents focused more of their attention on local factors related to their respective treatment and programs. They greatly valued their gains in knowledge and skills from treatment, and especially valued the family involvement component. They were very positive about the individual characteristics of clinicians, including the relationships they had with their clinicians. They noted problems with limited staffing and limited funding. They commented on aspects related to the law and DSS, and identified a number of strengths regarding the linkages to these entities. As a rule, they did not speak to any issues related to mental health reform. The clients’ responses illustrate the depth of the affirming feelings they have about their respective treatment programs and the clinicians who worked with them.

Clinicians were more likely to share observations of weaknesses than were client respondents. They, too, identified strengths in the increasing knowledge and awareness of clients and their skills acquisition, and they offered a great deal of feedback, primarily positive, regarding both the Family Solutions and Matrix models of treatment. They offered more of a detailed “picture” of the relationships and perspectives of the legal and criminal justice systems and DSS, both positive and negative. They were fairly uniform in their criticisms of mental health reform, whether addressing agency-related changes, staff changes, or paperwork changes. Clinicians also offered their perspectives regarding State involvement, noting specific strengths and weaknesses.

Like clinicians, administrators offered more criticism of different aspects of the project. They, too, were uniform in their frustration with changes related to mental health reform. They shared their perspectives of the strengths and weaknesses of State involvement and also discussed strengths and weaknesses regarding funding related to their programs. Although they had less first-hand knowledge of the progress of clients, administrators also talked about the gains in knowledge and awareness of clients and their skills development. Further, administrators provided detailed, predominantly positive comments about their respective models of treatment, Matrix and Family Solutions.

Across LMEs, it was possible to see their differences, particularly when it came to concrete resources. For instance, respondents of all groups talked about different concrete resources as issues, depending on their particular community and program. Transportation was frequently cited as a problem. The aggregated LME site interviews revealed the same strengths of their treatment programs--the treatment model (either Family Solutions or Matrix), especially the family involvement component of treatment; and the “results” of treatment (i.e., knowledge and awareness, skills acquisition) were all favorably described. One of the most interesting differences that emerged was in discussion of the community. All of the sites discussed the informal collaboration among agencies, community awareness, and community resources, but only New River respondents devoted a lot of detail to discussing their formal community collaborative. This could have been due to the fact that the community collaborative team was well-established and had a substantial role and stake in the development of their treatment program; it may also reflect the strength of this particular collaborative. Again, all of the site-based interviews stressed the same issues related to mental health reform—changes in agencies, changes in staff, changes in paperwork—and viewed them as negative.

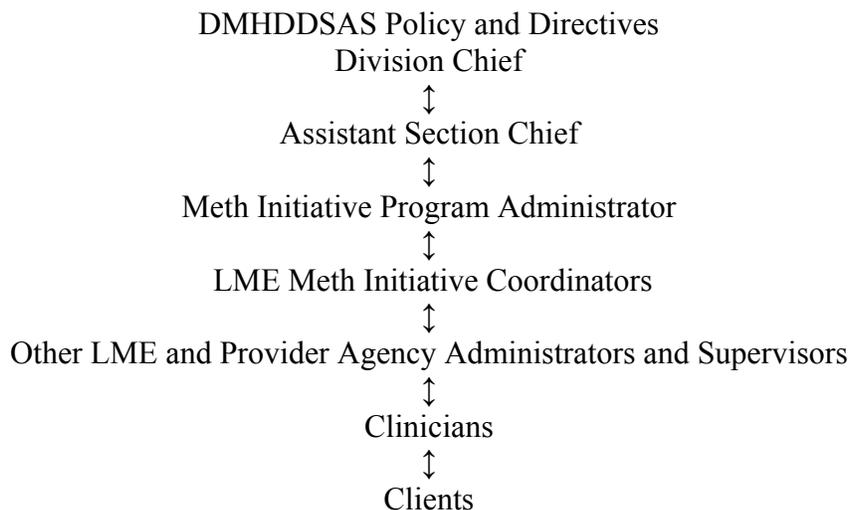
Recommendations

As noted above, this Process Evaluation Report precedes and will complement the final Program Evaluation Report, which is pending completion in December 2008. As such, all recommendations are tentative, pending completion of the quantitative program evaluation, which together will provide a more complete picture of this project.

- 1) Already, there seems to be some merit to the utility of having a qualitative evaluation component as an ongoing part of a program evaluation. While wide-ranging policy and funding decisions may best be decided on quantitative criteria, it is not possible to fully assess the “depth” of an individual client’s experience or her outcomes without the “richness” of qualitative data.
- 2) On the ground, at the administrative, clinical, and direct service levels, mental health reform was often characterized by too much provider turnover, staff turnover, and paperwork. This created a difficult and complex environment, often resulting in staff trying to provide services in spite of those characteristics of the system, rather than with full support of the system. When implementing new program models and funding new sites, the more systemic stability that can be created, the better. That stability will not

only benefit development and implementation of new programs, but also evaluation of those efforts. Stability at the administrative level might be promoted by consistency in structure, policies, procedures, funding, staffing, and supervision. Suggestions for improving stability at the clinical/direct service level include: a) overlap of employment of outgoing/incoming staff to orient and train; b) increased training opportunities; c) mentoring of new staff by other programs' treatment providers; d) utilizing clients as resources to provide ongoing co-leadership of groups, enhancing continuity; and e) development of orientation and other materials for new staff.

3) Respondents frequently mentioned concerns about ambiguous and confusing communication. The flow of communication among individuals participating in the project itself is simplistically illustrated below. Add to this the influence, needs, and recommendations of the community collaboratives, Matrix trainer, and research component. To that, add the evolving nature of the Meth Initiative in the context of mental health reform and it is obvious there were numerous opportunities for miscommunication.



Increased attention should be paid to the importance of clear and consistent communication among participants, perhaps by: a) ensuring regular meetings among participant groups; b) following meetings with written documentation, disseminated to all relevant parties; c) when appropriate, communicating solely in written form, disseminated to all relevant parties; d) ensuring a communication flow pattern that provides feedback and information to those “up the chain,” as well as “down;” and e) more in-depth study of communication patterns to determine those that are most effective. Efforts to promote stability, as in 2) above, will likely promote improved communication as well.

4) These models of treatment are innovative. Some of the respondents discussed the importance of the State funding pilot projects. In the ever evolving reform environment, this may be extremely difficult. However, given the “crisis” that meth posed during the past few years, it is inevitable that other mental health/substance abuse “crises” will

occur. The ability of the State to be able to fund and support pilot efforts will continue to be important.

5) Respondents indicated the importance of knowledge and skills acquisition, the family component of treatment, and the characteristics of their clinicians. Efforts should be made to support and encourage further development of these noted strengths of the treatment programs.

6) Informal and formal community collaboratives were valued and seen as positive when they were characterized by good working relationships and active participation of representatives of various community agencies, e.g. law enforcement, criminal justice and courts, schools, health departments, DSS. The collaboratives influenced community awareness, program development, referrals, and client satisfaction. Strong community collaboratives can be vehicles for educating other community representatives. Likewise, education and awareness can lead to stronger community collaboratives. The need to advertise more, promote awareness, and educate the community (citizens, law enforcement, and criminal justice, in particular) were frequently mentioned by respondents as important and may be useful in overcoming the stigma still attached to mental health/substance abuse treatment. Clinicians should be included in the collaborative meetings. Clients might also participate in community collaboratives, and assist with advertising, education, and increasing awareness.

7) Transportation difficulties presented problems in these primarily rural communities. To effectively serve the entire community, adequate funding for transportation and service delivery in outlying sites seems imperative. Service delivery to clients in their own homes and/or providing transportation to clients so they can participate in group and other on-site treatment takes time and that time and its associated costs should be factored in when planning for funding, staffing, and service delivery.

Conclusion

Looking across the interviews more broadly, it appears there were some common elements in the development and implementation of each of the treatment programs. First, there was the problem of meth abuse in the community, followed by the opportunity to respond to the problem with support and funding offered by the Division. Simultaneously, key players emerged and communities coalesced to varying degrees around common goals. The creativity, energy, effort, and resources that went into the development and implementation of each unique treatment program seemed to culminate in clients, clinicians, and administrators feeling strongly and positively about their own programs, regardless of the theoretical treatment models utilized.

What also seems clear is that the increased knowledge and awareness that resulted from training and/or participation in the treatment programs was valuable to clients, clinicians, and administrators. Perhaps the most significant finding is that family involvement was seen as a highly valued component of treatment regardless of the treatment model. Another significant finding is that clients valued the clinicians with whom they worked

and were appreciative of the opportunity to engage in treatment they perceived as effective. Community collaboration and cooperation among agencies was highly valued by clients, clinicians, and administrators when it was present and desired when it was not.

All of this effort took place in the midst of significant systemic upheaval across the state and within each community. While respondents were consistently negative regarding changes in agencies, staff, and paperwork due to mental health reform, they were clearly able and willing to expend considerable effort and engage in significant change in the process of developing and providing treatment programs.

References

- Andrews, K.R. (1980). *The concept of corporate strategy*. Second Edition. Homewood, IL: Irwin.
- Lincoln, Y.S. & Guba, E.G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.
- Huberman, A.M. & Miles, M.B. (2002). *The qualitative researcher's companion*. Thousand Oaks, CA: Sage.
- Mahan, J. (2008). *Mental Health, Developmental Disability, and Substance Abuse Services System Reform in North Carolina*. Session presented by the Mental Health Association of North Carolina at the National Association of Social Workers 2008 Legislative Conference, Chapel Hill, NC.
- Thornton, J. (2004). *Proposal for a family treatment program for methamphetamine dependence*. Boone, NC: New River Behavioral HealthCare.
- Thyer, B. (Ed.) (2001). *The handbook of social work research methods*. Thousand Oaks, CA: Sage.

APPENDIX A

MATRIX MODEL FIDELITY SCALE
STRUCTURAL ELEMENTS

SUMMARY
April 11, 2007

SITE County	Relapse Prev Groups	Family Educ Group	Early Recovery Skills Groups	Social Support Groups	Drug Screens	Individual Sessions	Clients use Matrix notebook	Group Size	Co-Leader	No-Show Follow Up	Group sessions ≤ 3 day break	On-call	Turnover Rate	Other Services Provided/ Comments	Total Score
FOOTHILLS Caldwell	8 in 4 weeks	4 in 4 weeks	8 in 4 weeks	2 in 4 weeks	70-89% clts tested in 4 week period	70-89% of clts	45-89% of clts use ≥50% of the time***	5-6	25-44% of groups had co-leader	45-69% of the time	≥90% of the time	Always	≥75%	No add'l services provided ***There is a type error in the original model checklist on this item; should be 45-69%.	49
FOOTHILLS McDowell	8 in 4 weeks	4 in 4 weeks	8 in 4 weeks	2 in 4 weeks	70-89% clts tested in 4 week period	45-69% of clts	45-89% of clts use ≥50% of the time***	3-4	45-69% of groups had co-leader	45-69% of the time	≥90% of the time	Rarely	≥75%	No add'l services provided ***There is a type error in the original model checklist on this item; should be 45-69%.	45
NEW RIVER Ashe	*	*	*	*	*	*	*	*	*	*	*	*	*	*No IOP	
NEW RIVER Watauga	≤ 4 in 4 weeks	4 in 4 weeks	≤ 4 in 4 weeks	None in 4 weeks	≥90% clts tested in 4 week period	45-69% of clts	45-89% of clts use ≥50% of the time***	7-15 clts	0-24% of groups had co-leader	≥90% of the time	≥90% of the time	Always	≤10%	In-home family case management/ case support, transportation, child care ***There is a type error in the original model checklist on this item; should be 45-69%.	45

SITE County	Relapse Prev Groups	Family Educ Group	Early Recovery Skills Groups	Social Support Groups	Drug Screens	Individual Sessions	Clients use Matrix notebook	Group Size	Co-Leader	No-Show Follow Up	Group sessions ≤ 3 day break	On-call	Turnover Rate	Other Services Provided/ Comments	Total Score
SMOKY Haywood	8 in 4 weeks	4 in 4 weeks	8 in 4 weeks	4 in 4 weeks	≥90% clts tested in 4 week period	≥90% clts	≥90% clts use ≥50% of the time	7-15 clts	≥90% of groups had co-leader	≥90% of the time	≥90% of the time	Always	≤10%	Transportation, child care, contingency mgmt, videos, financial presentations, scholarships (see checklist for more detail)	65
SMOKY Macon	8 in 4 weeks	4 in 4 weeks	8 in 4 weeks	4 in 4 weeks	70-89% clts tested in 4 week period	≥90% clts	≥90% clts use ≥50% of the time	7-15 clts	25-44% of groups had co-leader	0-24% of the time	≥90% of the time	Always	30-54%	No add'l services provided	55
WESTERN HIGHLANDS Buncombe	8 in 4 weeks	4 in 4 weeks	8 in 4 weeks	None in 4 weeks**	≥90% clts tested in 4 week period	≥90% clts**	≥90% clts use ≥50% of the time	7-15 clts	0-24% of groups had co-leader	≥90% of the time	≥90% of the time	Always	3 clinicians since 10/05**	Transportation, child care, food (**see checklist)	57
WESTERN HIGHLANDS Rutherford	*	*	*	*	*	*	*	*	*	*	*	*	*	*No IOP	

APPENDIX B

Process Evaluation Interview Guide
North Carolina Methamphetamine Initiative/
Appalachian State University
Partnership for Methamphetamine Treatment
Program Development
and Evaluation

CONFIDENTIAL

Revised January 2007

Instruction to the Interviewer Summary:

1. Arrange for accommodations in advance.
2. Note the participant name, contact information, date and location of interview.
3. Make sure you have a separate sheet with the Methamphetamine Treatment Initiative Program Evaluation goals to give the participant.
4. Have a copy of the IRB approval letter.
5. Have a copy of the Consent to Participate for yourself and for the participant.
6. Make sure the IRB is reviewed and the consent signed before beginning the interview.
7. Bring the following:
A copy of the interview guide for each interview planned and two extra copies for impromptu interviews
8. Make short field notes on the interview guide during the interview. Continue on back as needed. Immediately after the interview, expand your notes. The longer you wait the more you will forget.
9. Attached additional pages for notes as needed.
10. Make notation in your field notes of your reactions and thoughts (labeling as such).
11. Do not share information across interviews.
12. It is sometimes helpful to summarize what the participant has said to make sure you understand them. This process can bring out more information. Use the prompts indicated as needed but they are not necessary if you are getting adequate information.
13. Be aware of the process of fostering a relationship, which can lower the participant's guard but also your own. Be friendly but make sure to keep clear professional boundaries and keep information from other sources confidential.
14. Patience, giving people time to think, can bring out good information. Don't rush it.
15. Avoid closed ended questions (yes, no, one word response questions). Better prompts are "how", "can you help me to understand", and "please tell me more" questions.

Instruction to the Interviewer:

Interviewer signature (print initials on each page):

When scheduling your interviews ask each person, “Are there any accommodations you will need with regard to our interview?”

Note needed accommodations below:

Make appropriate arrangements. Arrangements made: yes ___ no ___

Notes regarding arrangements made:

Interview is with: Name _____ Date _____

Time _____

Title/Role/Agency _____

Location _____

Review the enclosed IRB and Consent for Participation and give the participant a copy of each.

IRB reviewed: yes ___ no ___ (interviewer check)

Consent reviewed and signed with copy given: yes ___ no ___ (interviewer check)

I. Begin the interview by thanking the participant for their time and thoughtful input.

First I'd like to understand your perspective on this project. When I say
"Methamphetamine Treatment Initiative," whom/what do you associate with this? "

Prompts: What people? What organizations?

Now I would like to ask a series of questions related to the Methamphetamine Treatment Initiative and Program Evaluation.

II. Methamphetamine Treatment in Your Community

1. Please describe the methamphetamine treatment programs currently being offered in your community.

Prompts if needed:

Could you give me an example of that?

Could you help me understand that a little bit better?

Please elaborate.

Further Prompt:

If respondent identifies any other meth treatment program(s) in addition to the Meth Treatment Initiative please ask them to clarify and then elaborate.

Further Prompt:

If respondent does not identify meth treatment programs other than the Meth Treatment Initiative, ask if they are aware of other programs.

(BE SURE THE INTERVIEWEE KNOWS WHAT ACCURATELY CONSTITUTES THE METH TREATMENT INITIATIVE IN THEIR COMMUNITY.)

Read: The focus of the remainder of the interview will be related to the meth treatment programs provided under the Methamphetamine Treatment Initiative. When answering the following questions please refer only to these programs.

Say: I'd like to review the goals of the Meth Treatment Initiative with you.

Note: Give interviewee a copy of the goals to reference during the interview (see handouts).

Say: I would like to read these out loud. (**Read the goals out loud.** Allow them time to review/reflect on the goals and ask about their familiarity with them.)

The goals of the Methamphetamine Treatment Initiative and Program Evaluation for clients and families are:

- *To abstain from AOD use*
- *Reduce relapse*
- *Reunify family, if applicable*
- *Preserve family, if applicable*
- *Improve interpersonal relationships*
- *Improve parenting skills*
- *Improve wellbeing and functioning of children*
- *Retain family and individual in treatment*
- *Reduce criminal activity*

Make appropriate notation regarding their comments about familiarity with the program evaluation goals and proceed with the interview beginning with the question below.

2. Please describe strengths of the meth treatment program in your community. Please keep the goals in mind.

Prompts if needed:

Could you give me an example of that?

Could you help me understand that a little bit better?

Please elaborate.

3. Please describe weaknesses related to the meth treatment program in your community. Please keep the goals in mind.

Prompts if needed:

Could you give me an example of that?

Could you help me understand that a little bit better?

Please elaborate.

4. Please describe opportunities related to the meth treatment program in your community. Please keep the goals in mind.

Prompts if needed:

Could you give me an example of that?

Could you help me understand that a little bit better?

Please elaborate.

“Opportunities” refers to possibilities beyond the treatment and/or community response that are currently happening.

5. Please describe what gets in the way or could get in the way of providing the meth treatment program in your community. Please keep the goals in mind.

Prompts if needed:

Could you give me an example of that?

Could you help me understand that a little bit better?

Please elaborate.

6. Is there anything else you would like say about the goals and the meth treatment program in your community?

III. Methamphetamine Treatment Program Development

1. Do you know anything about how the meth treatment program started (or is starting) in your community? (If answer is “yes,” continue. If answer is “no,” skip to section IV.)
What were (are) the strengths of starting this program in your community?

Prompts if needed:

Could you give me an example of that?

Could you help me understand that a little bit better?

Please elaborate.

2. What were (are) the weaknesses of starting the meth treatment program in your community?

Prompts if needed:

Could you give me an example of that?

Could you help me understand that a little bit better?

Please elaborate.

3. What were the opportunities that helped (or may help) in starting the meth treatment program in your community?

Prompts if needed:

Could you give me an example of that?

Could you help me understand that a little bit better?

Please elaborate.

“Opportunities” refers to possibilities beyond the treatment and/or community response that are currently happening.

4. What may have gotten in the way (or might get in the way) of starting the meth treatment program in your community?

Prompts if needed:

Could you give me an example of that?

Could you help me understand that a little bit better?

Please elaborate.

5. Is there anything else you would like to add about starting the methamphetamine treatment program in your community?

IV. Methamphetamine Treatment Provision in Current Context

Read: Each meth treatment program is formed and provided in agencies that are influenced by state and local policies, resources, and staff. These can support or get in the way of programs. As policies, resources, and staff change, programs may need to change. In the next few questions keep in mind how this may affect treatment in your community.

1. Considering the current state and local policies, resources, and staff, what are the strengths related to providing meth treatment?

Prompts if needed:

Could you give me an example of that?

Could you help me understand that a little bit better?

Please elaborate.

2. Considering the current state and local policies, resources, and staff, what are the weaknesses related to providing meth treatment?

Prompts if needed:

Could you give me an example of that?

Could you help me understand that a little bit better?

Please elaborate.

3. Considering the current state and local policies, resources, and staff, what are the opportunities related to providing meth treatment?

Prompts if needed:

Could you give me an example of that?

Could you help me understand that a little bit better?

Please elaborate.

“Opportunities” refers to possibilities beyond the treatment and/or community response that are currently happening.

4. Considering the current state and local policies, resources, and staff, what gets in the way of providing meth treatment?

Prompts if needed:

Could you give me an example of that?

Could you help me understand that a little bit better?

Please elaborate.

5. Is there anything else you would like to say about the current state and local policies, resources, and staff related to providing meth treatment?

V. Effects of Methamphetamine Treatment and Community Response on the Community

What are the effects of the meth treatment initiative project on your community?

Prompts if needed:

Could you give me an example of that?

Could you help me understand that a little bit better?

Please elaborate.

VI. Effects of Methamphetamine Treatment and Community Response on Clients

Note: If interviewee is a client ask the following:

How has this project affected you or other clients?

Prompts if needed:

Could you give me an example of that?

Could you help me understand that a little bit better?

Please elaborate.

Note: If interviewee is not a client ask the following:

How has this project affected clients in your community?

Final Question:

Is there any thing else you would like to say before we end the interview?

Thank them for their time and mention that the research team may have follow up questions at a later date.

APPENDIX C

Appalachian State University

Informed Consent for Participants in Research Projects Involving Human Subjects

Title of Project: Process Evaluation for the North Carolina Methamphetamine Initiative/
Appalachian State University Partnership for Methamphetamine Treatment, Program
Development and Evaluation

Principal Investigator: Lauren Renkert

I. Purpose of this Research/Project

Your community is participating in the NC Methamphetamine Treatment Initiative. The purpose of this part of the project is to conduct a process evaluation of the development, implementation and impact of methamphetamine treatment in your community. The process evaluation will identify community and agency factors which support or interfere with methamphetamine treatment. The information obtained will subsequently be used to inform stakeholders interested in expansion of statewide services for substance abuse treatment.

II. Procedures

You have been identified as associated with the efforts of the NC Methamphetamine Treatment Initiative. We would like to interview you about your perception of the strengths, weaknesses, opportunities and threats of this project. One or two members of the research team will interview you individually. We plan to record your answers on an individual interview guide which will only be seen by members of the research team.

III. Risks

Given the limited number of participants, your role and the nature of perceptions you may share, it is possible that others may identify you as a participant. It is also possible that you may experience some distress discussing the methamphetamine problem and/or discussing negative aspects of issues related to treatment program development and implementation. We are unaware of any other risks to you based on your participation.

IV. Benefits

The purpose of the interview is to provide the NC Methamphetamine Initiative with feedback to assist in informing the field of substance abuse treatment in general and methamphetamine treatment specifically. It is possible that this evaluation will help focus or improve the efforts of the NC Methamphetamine Initiative and improve the lives of individuals and their families who are affected by methamphetamine abuse and dependence.

V. Extent of Anonymity and Confidentiality

The interview guides will be stored under lock and key in the offices of the investigators. Information collected will not be linked to your name in any published format.

VI. Compensation

There is no monetary compensation for participation in this process evaluation.

VII. Freedom to Withdraw

You are free to withdraw from this evaluation at any time without penalty.

VIII. Approval of Research

This research project has been approved, as required, by the Institutional Review Board of Appalachian State University.

IRB Approval Date

Approval Expiration Date

IX. Subject's Responsibilities

I voluntarily agree to participate in this study. To participate, I will:

- 1) provide honest answers to all questions I choose to answer.
- 2) not speak to other individuals about the content of the interview

X. Participant's Permission

I have read, or have had someone read, and understand the Informed Consent and conditions of this project. I have had all my questions answered. I hereby acknowledge the above, that I am 18 years of age or older, and give my voluntary consent:

_____ Date _____
Participant signature

Verbal consent given for telephone interview: _____ yes _____ no

Should I have any questions about this research or its conduct, I may contact:

Lauren Renkert 828-262-7907/renkertle@appstate.edu
Principal Investigator Telephone/e-mail

Robert L. Johnson 828-262-2692/johnsonrl@appstate.edu
Administrator, IRB Telephone/e-mail
Graduate Studies and Research
Appalachian State University
Boone, NC 26608

APPENDIX D

Master Code List for Process Evaluation

Community

CA-community awareness
 CR-community resources
 CCF-community collaborative formal
 CCI-community collaborative informal

Mental Health Reform

A-agency change
 S-staff change
 P-paperwork change
 ST-state
 D-divestiture

Staff

CS-characteristics of staff
 AS-availability of staff
 TE-training/education of staff
 LS-limited staff
 RP-relationship of staff
 COM-communication

Client

IM-impact of meth
 KA-knowledge awareness
 SA-skill application
 COC-commitment of client

Concrete Resources

T-transportation
 H-housing
 CCA-childcare
 C-cost
 M-money
 F-food
 LO-location
 E-employment

Treatment

GD-group dynamics
 FI-family involvement
 FS-Family Solutions
 MA--Matrix
 CC-case consultation

Legal Aspects

DC-drug court
 L-law
 J-jail/prison
 PU-punishment
 DSS-Department of Social Services