Evaluation of Arizona Families F.I.R.S.T.

Annual Evaluation Report

Submitted on: **December 4, 2002**

Submitted to: **Arizona Department of Economic Security**
Division of Children, Youth and Families
Phoenix, Arizona

Contract #: **E4371670**

Submitted by: ***James Bell Associates***
1001 19th Street, North., Suite 1500
Arlington, VA 22209
(703) 528-3230
FAX (703) 243-3017

in collaboration with:
Westat, Inc., Rockville, MD
and
Professional Consultation Consortium, Phoenix, AZ

TABLE OF CONTENTS

Page

Executive Summary ... i

Chapter I. Introduction ... 1
- A. Background Information on the Arizona Families F.I.R.S.T. Program ... 1
- B. Data Sources Analyzed for the Annual Report ... 2
- C. Organization and Contents of Annual Report ... 3

Chapter II. Overview of Evaluation Framework ... 5

Chapter III. Description of Arizona Families F.I.R.S.T. Clients and Services Received ... 8
- A. Characteristics of Individuals Referred ... 8
- B. Characteristics of AFF Participating Clients ... 9
  1. Demographic Characteristics ... 10
  2. Family Size and Marital Status ... 12
  3. Education Level and Employment ... 13
  4. Title XIX Participants ... 15
  5. Substance Abuse ... 16
- C. Service Activity ... 19
  1. Referrals ... 19
  2. Assessments ... 21
  3. Levels of Client Engagement in Treatment ... 23
  4. Substance Abuse Treatment Services ... 25
  5. Time Spent in Treatment ... 30

Chapter IV. Perceptions of Timeliness, Availability, and Accessibility of Services ... 33
- A. Timeliness of Services to Clients ... 34
  1. Assessments ... 35
  2. Service Plans ... 36
  3. Engagement in Treatment ... 36
  4. General Factors Perceived to Affect Timeframes ... 37
  5. Perceived Changes in Timeframes and Contributing Factors ... 38
- B. Perceived Availability of Services ... 38
  1. Differences Between Rural and Urban AFF Provider Agencies ... 39
  2. Program Capacity ... 39
  3. Use of Different Terminology That May Affect Perceived Availability ... 40
  4. Perceived Changes in Availability and Contributing Factors ... 40
- C. Perceived Changes in the Accessibility of Services ... 42
  1. Transportation Issues ... 42
  2. Hours of Operation ... 43
  3. Clients' Priority to Access Services ... 43
  4. Changes in Accessibility to Services and Contributing Factors ... 43

D. Implementation of Arizona Families F.I.R.S.T. Collaborative Partnerships 43
1. Collaborative Partners: A Description 44
2. The Role of Subcontractors 48
3. Successes in Collaboration 48

Chapter V. Client Satisfaction 49
A. Clients' Participation in Services and Activities 50
B. Clients' Experiences and Satisfaction with AFF 50
C. Clients' Need for Services 51
D. Experiences With Residential Treatment 51
E. Clients' Knowledge and Understanding of the AFF Program 52

Chapter VI. Policy Activities and Systems Level Changes 53
A. Quality Improvement Site Visits 53
B. Development of Joint Protocols 53
C. ADHS Staff Liaison for AFF 54
D. Coordination Meetings 55
E. Sharing of Resources 55

Chapter VII. Summary and Conclusions 57

Appendix A: Mapping of DHS Codes to AFF Services 61
Appendix B: AFF Project Director Interview 69
Appendix C: Site Level Description of AFF Collaborative Partnerships 75
Appendix D: Lessons Learned in the Implementation of Arizona Families F.I.R.S.T. 89

EXECUTIVE SUMMARY

Arizona Families F.I.R.S.T. and Its Development in Brief

Arizona Families F.I.R.S.T. (AFF) was established by Arizona Revised Statute (ARS) 8-881 (Senate Bill 1280, passed in the 2000 legislative session) and is administered jointly by the Arizona Department of Economic Security (ADES) and the Arizona Department of Health Services (ADHS), with ADES designated as the lead agency. The legislation established a statewide program for substance abusing families entering the child welfare system as well as those families receiving cash assistance through Temporary Assistance for Needy Families (TANF). The legislation recognized that substance abuse is a major problem contributing to child abuse and neglect, and is also a significant barrier for those attempting to re-enter the job market or maintain employment.

In the Spring of 2001, nine AFF providers received contracts through ADES to implement a community substance abuse prevention and treatment program under Arizona Families F.I.R.S.T. Contract providers across the State of Arizona were funded so that all counties would be covered by AFF services. The agencies funded included: TERROS; Southeastern Arizona Behavioral Health Services (SEABHS); Community Partnership of Southern Arizona (CPSA); Arizona Partnership for Children (AZPAC) in Coconino, Yavapai, and Yuma counties; Horizon Human Services; WestCare Arizona; and Old Concho Community Assistance Center. Over the first year of the program, AFF provider agencies worked to: develop a referral process; screen, assess, and treat clients within the required AFF timeframes; develop collaborative partnerships with subcontractors and other community agencies; and coordinate treatment services with RBHA providers when the AFF client was in the Title XIX program. By March 31, 2002, 1,447 individuals had been referred to the AFF program (84% referred from CPS) and 803 individuals had participated in treatment services.

The evaluation of AFF, required by ARS 8-881, focuses on the implementation of the AFF community substance abuse prevention and treatment programs at all nine sites, the factors that contribute to their success, and the extent to which the legislature's outcome goals of increases in timeliness, availability and accessibility of services; recovery from alcohol and drug problems; child safety; permanency for children through reunification; and the achievement of self-sufficiency through employment can be obtained. The focus during the first year of the evaluation was on establishing a cross-agency, client-level data base system, documenting the implementation of AFF through quarterly data collection at each of the AFF sites, and analyzing data on clients' utilization of services.

Overview of Annual Evaluation Report

This report presents service utilization data through March 2002 and process data collected through June 2002.[1] The evaluation data have contributed to a better understanding of the characteristics of AFF participating clients; the types of drugs used by clients across the nine AFF sites, including poly-drug use patterns; referral trends during the first year and site-level factors influencing referral patterns; levels of client engagement in services and service utilization patterns; and lengths of stay in treatment.

Process data presented in this report offer an early indication of changes in the timeliness, availability, and accessibility of treatment services as perceived by AFF program directors. Data collected through interviews with AFF program directors at each of the AFF sites indicate that several AFF provider agencies have made significant progress in establishing a collaborative group to help support the goals of AFF and provide services to clients while some AFF providers still have more work to do

---

[1] The evaluation plan does not call for reporting on outcomes until the second year of the program.

in that area.[2] The majority of AFF project directors perceive that the ARS 8-881 funding has had an impact on increasing the availability of treatment and support services.

Although treatment recovery data are not yet available, the findings that AFF clients are engaged in services at a high rate and are spending several months in treatment services are positive results. Key findings of this annual report are summarized below, under the research questions that were examined in this report.

What Are the Characteristics of Participating Clients?

- Overall, 58 percent of participating clients were in the Title XIX program (i.e., enrolled in Medicaid); 34 percent were non-Title XIX.

- Seventy five percent of participating clients were female, and 25 percent were male. Twenty two percent were between 18 and 25 years old; 37 percent were between 26 and 33 years; 31 percent were from 34 to 41 years of age; and 10 percent were 42 years and older.

- Overall, 62 percent of participants were White, 14 percent were Black, 18 percent were Hispanic, and 6 percent were Native American/Alaskan Native. There was both within-site and cross-site variation with respect to race. Overall, the racial distribution of clients engaged in the program was similar to the racial distribution of clients referred.

- Participating families varied with respect to family size and the number of children in their families. Twenty seven percent of families had only one child; 27 percent had two children; 20 percent had three children; 10 percent had four children; and 16 percent had five or more children.

- Approximately 44 percent of participating clients across the AFF sites did not complete high school. This pattern was consistent across sites—for clients served by both urban and rural provider agencies.

What Do We Know About Drug Use Among AFF Clients?

- With respect to drug use reported at the time of enrollment in AFF, 62 percent of participating clients reported using alcohol; 49 percent used marijuana; 37 percent said they used cocaine; 42 percent used methamphetamines; six percent used heroin/morphine; and eight percent used other hallucinogens. There was site variation in drug usage: Use of cocaine was highest at CPSA (65% of clients); the heroin/morphine; and eight percent used other hallucinogens. There was site variation in drug usage: Use of cocaine was highest at CPSA (65% of clients); the highest rates of marijuana use were reported by CPSA (74%), AZPAC Yavapai (73%), and SEABHS (60%). The rate of methamphetamine use was over 50 percent at AZPAC Yavapai (79%), AZPAC Yuma (82%), Horizon (56%), and WestCare (71%).

- The polydrug co-morbidity patterns among participating clients indicated that for the 26 percent of participants who reported that methamphetamine was their most frequently used substance, 50 percent also used alcohol, and 47 percent also used marijuana. Twenty percent of participants reported that their most frequently used drug was cocaine. Among this group, 70 percent also used alcohol and 63 percent also used marijuana.

[2] In-depth interviews also were conducted on a quarterly basis with different informants interviewed each quarter, including treatment providers, referral agency staff, collaborative partners, and representatives of RBHAs. The implementation findings have been summarized throughout this report and are available in more detail in the Quarterly Evaluation Reports.

To What Extent are AFF Clients Engaged in Substance Abuse Treatment?

- Engagement in treatment services was one of the Steering Committee's[3] suggested performance measures. Fifty five percent of all clients referred to AFF are subsequently engaged in treatment services.[4] Engagement in treatment can be viewed as an intermediary outcome that is attained prior to observing long-term outcomes related to recovery.

- Overall, clients who receive an assessment are likely to have a service plan developed and enter treatment. Seven of the nine AFF provider agencies completed assessments on 70 percent or more of their referred clients, and overall, 80 percent of assessed clients had a service plan developed.

- At six of the nine AFF sites, there was a consistent pattern whereby 100 percent of clients with a service plan went on to receive treatment services. At all AFF sites, 91 percent or more of those with a service plan received treatment services.

To What Extent are AFF Clients Staying in Treatment Services?

- With respect to length of stay in treatment, 51 percent of clients who entered the program by September 30, 2001 remained in treatment for three months or longer, and 37 percent stayed in treatment for at least four to six months.

- Among clients who entered the program by April 1, 2001, over 55 percent stayed in treatment for six months or longer, 18 percent stayed in treatment for eight to ten months, and 20 percent remained in treatment for 10 months or longer. These utilization patterns are promising given that research on substance abuse treatment emphasizes that the longer a client stays in treatment, the more likely it is that the treatment will result in long-term behavior change.[5]

To What Extent Has AFF Increased the Timeliness, Availability, and Accessibility of Treatment Services?

- Seven of the AFF provider agencies reported a perceived increase in the timeliness of service delivery since they began implementation of AFF more than a year earlier. Factors to which they attributed these increases included AFF policies and requirements regarding the timeframes within which clients must be screened, assessed, and have service plans developed; ADES monitoring practices through quality improvement visits and corrective action plan letters; and AFF provider agencies' accountability to ADES when they fail to meet timeframe requirements.

- The outreach and engagement component of AFF allows AFF provider agencies to spend time and resources on engaging clients in the screening and assessment process (i.e., there are AFF dollars available for outreach and engagement activities). The outreach and engagement component was perceived by AFF provider agencies to contribute toward an increase in the timeliness of serving clients.

- AFF collaborative partnerships have increased the awareness of services available among the referral agency staff, which in turn has shortened the timeframes within which referrals are made

[3] The AFF Steering Committee was formed as a policy committee to provide guidance and oversight to AFF and initially took on the role of specifying policies and requirements to help shape the direction of the program and reviewing implementation procedures.

[4] This level of engagement is higher than the engagement rate for another child welfare-substance abuse partnership program run through the Connecticut Department of Children and Families – Project Safe, where only 37 percent of caregivers referred by the child welfare agency for assessment and treatment actually engaged in treatment (www.maine@aan.usm.maine.edu/nosafe/sheehan.html; accessed 10/25/02).

[5] Hubbard, R., Marsden, M., Rachal, J., Harwood, H., Cavanaugh, E., & Ginzburg, H. (1989). Drug Abuse Treatment: A National Study of Treatment Effectiveness. Chapel Hill: The University of North Carolina Press.

because referral staff know what services are available to clients who need help and they know the process for making referrals.

- Seven AFF provider agencies reported a perceived increase in the availability of treatment services over the past year. This increase was attributed to the following factors: AFF funding through ARS 8-881 to provide treatment services for non-Title XIX clients, which has increased the number of treatment slots available in Arizona for this population; and AFF funding for support services, which has increased the supply of services such as child care, housing assistance, and transportation for both Title XIX and non-Title XIX clients.

- All nine AFF provider agencies reported a perceived increase in the accessibility of treatment services. This increase was attributed to a number of factors. First, the AFF requirement that there be a coordinated, comprehensive service delivery system that includes referral agencies (CPS and Jobs) and the local RBHA has helped to increase clients' access to services provided through multiple agencies and treatment providers in their local communities. Second, the family-centered treatment model implemented under AFF includes the provision of individualized support services to clients (i.e., tailored to the particular needs of the client and his/her family), such as child care and transportation, which has increased clients' ability to gain access to core treatment services. Third, AFF provider agencies indicated that increased communication has resulted from their collaborative partnerships, which has contributed to an increase in the number of cross-agency referrals and clients' access to different services offered through various agencies that network with the AFF provider agency.

- Another important factor contributing to improvements in availability and accessibility is the larger context in which AFF was implemented during 2001. Proposition 204 had passed, allowing for an expansion of Title XIX eligibility as well as covered services under Medicaid beginning in October 2001. The higher volume in Medicaid clients has, in turn, enabled the Title XIX provider network to expand its services and build greater capacity.

What Do We Know About Clients' Satisfaction with AFF?

- Clients reported that their relationships with AFF case managers, treatment staff, and counselors were extremely beneficial to them and that they had frequent contact with these professionals. Treatment staff who were recovered addicts were especially helpful to them because these staff were knowledgeable about the recovery process from personal experience.

- Clients indicated that their substance abuse treatment therapists communicated with their CPS or Jobs case managers regarding their case plan, treatment plan, and the progress that clients were making. Clients reported that they found this information sharing to be helpful, for example, when treatment providers were able to keep their CPS case manager informed about their progress in an effort to help them regain custody of their children.

To What Extent Has There Been Increased Coordination Across Systems?

- Increased coordination between the treatment system and the child welfare system was reported after the first year of implementation. AFF provider agencies described how AFF has removed the barriers to getting CPS clients into treatment. Where previously, CPS staff provided primary caregivers with a referral for treatment but left the responsibility to the primary caregiver to follow through, increased coordination has resulted in treatment staff seeking out the clients to complete a screening and assessment and using motivational techniques to get them into treatment.

- Coordination between treatment providers and other community agencies has increased, largely through improved communication. CPS staff have become involved in treatment planning and case staffings, and treatment providers share information with CPS staff on the progress that clients are making in their treatment. In addition, some AFF provider agencies that are not Title

XIX providers (AZPAC Coconino and AZPAC Yavapai) report that their RBHAs are involved in a high level of case coordination and treatment planning and have instituted new practices to coordinate the services provided to AFF clients.

- Increased coordination at the State level, between ADES and ADHS, has occurred during the first year of the AFF program. Factors that have contributed to this coordination include: regular communication and meetings between the AFF administrator at ADES and the Bureau Chief of Substance Abuse Prevention and Treatment at ADHS; an AFF liaison from ADHS who spends time onsite at the ADES office, participates in trainings for AFF provider agencies and RBHAs, and participates in AFF quality improvement site visits; the development of joint protocols between the two agencies that have been implemented and followed by agency staff; and even the sharing of resources between agencies.

What Other Lessons Have Been Learned After the First Year of the Program?

- AFF program directors acknowledged the importance of collaborating with providers and other agencies in their local communities to enhance the services provided for clients, and they believed that continued efforts to increase collaboration was an important activity in the ongoing implementation of AFF.

- Factors cited by AFF program directors that were important facilitators to implementation of AFF treatment services were AFF's family-centered treatment philosophy, which allowed providers to address issues in the family as part of a client's treatment program; the emphasis on comprehensive and coordinated services; the adherence of AFF to "best practices" standards set forth in the substance abuse literature; perceived support from ADES administrators and staff; and the ADES program monitoring and accountability that is in place.

- Barriers noted by AFF program directors regarding implementation of AFF services included: receiving a lower number of referrals than expected; not having separate funding to carry out case management activities; in some communities, having a lack of agencies to offer aftercare and supports for clients; and dealing with agencies who had their own perspectives regarding best practices for substance abuse treatment (e.g., the perception that residential treatment is the only option for clients with substance abuse problems). AFF program directors across sites also discussed the lack of available residential treatment services as a barrier to meeting clients' treatment needs.

Conclusion

Overall, information presented in this annual report indicates that during the first year of the program, AFF provider agencies have been successful in implementing the AFF program requirements. The referral, outreach, screening, and assessment practices are in place and clients with service plans developed are entering treatment services and are remaining in treatment for several months. These findings with respect to engagement in treatment and retention in treatment can be viewed as intermediate outcomes that are expected on the pathway to ultimately achieving expected outcomes concerning recovery, permanency, and employment. The emerging findings reported through year-end process data collected across the nine AFF provider agencies indicate that provider agencies already perceive improvements in timeliness, availability and accessibility of services.

Other systems-level outcomes, such as increased service coordination and coordination at the State level also have been identified. While outcomes related to recovery, child welfare, and employment will not be reported until next year, the preliminary findings are positive with regard to improved coordination of services, increased availability, and access to services, and relatively high rates of client engagement and retention in services.

CHAPTER I
INTRODUCTION

Arizona Families F.I.R.S.T. (Families in Recovery Succeeding Together) was established as a community substance abuse prevention and treatment program by ARS 8-881 (Senate Bill 1280, which passed in 2000 legislative session). Under the requirements of the Joint Substance Abuse Treatment fund that was established under the legislation, Section 8-884 requires an evaluation of the Arizona Families F.I.R.S.T. program (AFF). The evaluation of AFF focuses on the implementation of community substance abuse prevention and treatment programs at each of the nine AFF sites across the State of Arizona, the factors that contribute to their success, and the extent to which outcome goals can be attained such as increases in timeliness, availability and accessibility of services; recovery from alcohol and drug problems, child safety, permanency for children through reunification, and the achievement of self-sufficiency through employment. The focus during the first year of the evaluation was on establishing a cross-agency, client-level data base system, documenting the implementation of AFF through quarterly data collection at each of the AFF sites, and analyzing data on clients' utilization of services.

A. Background Information on the Arizona Families F.I.R.S.T. Program

Arizona Families F.I.R.S.T. is administered jointly by the Arizona Department of Economic Security (ADES) and the Arizona Department of Health Services (ADHS), with ADES designated as the lead agency. The legislation established a statewide program for substance abusing families entering the child welfare system as well as those families receiving cash assistance through Temporary Assistance for Needy Families (TANF). The legislation recognized that substance abuse in families is a major problem contributing to child abuse and neglect, and that substance abuse can present significant barriers for those attempting to re-enter the job market or maintain employment. Federal priorities under the Adoption and Safe Families Act (ASFA) that address child welfare outcomes, such as permanency and shorter time frames for reunification, coupled with the time limits established under the TANF block grant, also were factors behind the legislation.

The purpose of AFF is to develop community partnerships and programs for families whose substance abuse is a barrier to maintaining, preserving, or reunifying the family, or is a barrier to maintaining self-sufficiency in the workplace. The Joint Substance Abuse Treatment Fund was established to coordinate efforts in providing a continuum of services that are family-centered, child focused, comprehensive, coordinated, flexible, community based, accessible, and culturally responsive. These services were to be developed through government and community partnerships with service providers (including subcontractors and Regional Behavioral Health Authorities—RBHAs), as well as through partnerships with other agencies such as faith-based organizations, domestic violence agencies, and social service organizations.

The Legislature defined in ARS 8-884 the following outcome goals to be evaluated:

- Increase the availability, timeliness, and accessibility of substance abuse treatment to improve child safety, family stability and permanency for children in foster care or other out-of-home placement, with a preference for re-unification with the child's birth family.
- Increase the availability, timeliness, and accessibility of substance abuse treatment to achieve self-sufficiency through employment.
- Increase the availability, timeliness, and accessibility of substance abuse treatment to promote recovery from alcohol and drug problems.

The AFF Steering Committee further required that the following performance measures be used to evaluate the effectiveness of the program:

- Reduction in the recurrence of child abuse and/or neglect.
- Increase in the number of families either obtaining or maintaining employment.
- Decrease in the frequency of alcohol and/or drug use.
- Decrease in the number of days in foster care per child.
- Increase in the number of children in out-of-home care who achieve permanency.

In the Spring of 2001, nine provider agencies received contracts through ADES to implement a community substance abuse prevention and treatment program under Arizona Families F.I.R.S.T. Contract providers across the State of Arizona were funded so that all counties would be covered by AFF services. The agencies funded included: TERROS; Southeastern Arizona Behavioral Health Services (SEABHS); Community Partnership of Southern Arizona (CPSA); Arizona Partnership for Children (AZPAC) in Coconino, Yavapai, and Yuma counties; Horizon Human Services; WestCare Arizona; and Old Concho Community Assistance Center. The AFF provider agencies and the geographic areas they serve are summarized in Exhibit I-1.

Exhibit I-1 AFF Provider Agencies and Counties Served

AFF Provider Agency	County
TERROS	Maricopa
Community Partnership of Southern Arizona (CPSA)	Pima
Arizona Partnership for Children (AZPAC)	Coconino
Old Concho Community Assistance Center	Apache/Navajo
AZPAC	Yavapai
AZPAC	Yuma
WestCare Arizona	La Paz/Mohave
Horizon Human Services	Pinal/Gila
Southeastern Arizona Behavioral Health Services (SEABHS)	Cochise, Graham, Greenlee, Santa Cruz

Among the nine AFF provider agencies, five are not Title XIX providers (AZPAC Coconino, AZPAC Yavapai, AZPAC Yuma, WestCare, and Old Concho) and must refer Title XIX AFF clients to a Title XIX provider/RBHA for their treatment services. The other AFF provider agencies are Title XIX providers (TERROS, CPSA, SEABHS, and Horizon) and provide treatment services for both Title XIX and non-Title XIX AFF clients.

In February 2002, ADES renewed all nine AFF provider agencies' contracts through June 30, 2003. Provider rates were increased approximately five percent for referrals and assessments, and some provider agencies received individual rate increases for specific services.

B. Data Sources Analyzed for the Annual Report

This annual report draws upon data from multiple sources. Service utilization data cover the period from March 2001 through March 31, 2002, which is the first full year of the program's operation. Service utilization data were obtained from each of the AFF provider agencies and electronically transmitted into the client-level database maintained by the evaluator. In addition, service data were obtained through ADHS for this same time period (for services utilized by Title XIX AFF clients) from the CEDARS and ENCOUNTER data systems. Data on client characteristics were supplied by AFF provider agencies using information available from the assessments completed with clients.

During the course of the first year, quarterly site visits were conducted to each of the AFF provider agencies to assess different areas of program implementation (e.g., referral process; determining levels of care; coordinating treatment services). Quarterly evaluation reports were prepared to summarize the findings with respect to implementation. Where implementation data from the quarterly reports are useful for interpreting quantitative findings that are reported, we have incorporated findings from the quarterly process data in this report.

To assess perceptions of changes in timeliness, availability, and accessibility of services after the first year of the program, in-depth interviews were conducted with AFF program directors and agency administrators during June and July 2002. The qualitative findings from these interviews were analyzed and are reported in Chapter IV.

Data on collaborative partnerships were obtained through the year-end AFF program manager interviews and through an analysis of collaboration matrices completed by each AFF program director.

Service coordination was assessed through the program director interviews conducted at the end of the first year and through process data collected during the quarterly site visits (e.g., interviews with referring agency staff and RBHA staff). State-level coordination was examined through interviews conducted with ADES and ADHS administrators and staff at the end of the first year, and through a review of policy documents made available by the program administrator.

AFF client satisfaction was assessed through focus groups and interviews conducted during site visits in February and March 2002. Focus groups were conducted with clients from TERROS, AZPAC Yuma, Horizon, and Old Concho. At the remainder of AFF sites, face-to-face individual interviews or telephone interviews were conducted with clients. The criteria for inclusion in the focus groups and interviews was that clients needed to be currently enrolled in AFF and they needed to be receiving some type of substance abuse treatment service.

More detail regarding the specific methodologies used has been included in Chapters III, IV, and V where the findings of our analyses are presented.

C. Organization and Contents of Annual Report

This report begins with a brief overview of the evaluation framework that was used to guide the evaluation of AFF (Chapter II). In Chapter III, findings with respect to characteristics of referred and participating AFF clients are presented. This chapter also reports on service activity for participating clients during the first year of the program, including levels of engagement, treatment services utilized, and lengths of stay in treatment. Data in Chapter III, in general, are presented at the AFF provider agency level as well as cross-site (i.e., statewide totals). Process data collected during the year during site visits have been reported previously in Quarterly Evaluation Reports that addressed program implementation. Some of these data have also been incorporated into Chapter III to help interpret some of the patterns of service utilization at the site level. Also, some of the State-level policies that impacted the program, overall, have been included in this chapter, as appropriate.

Chapter IV presents preliminary findings with respect to perceived changes in timeliness, availability, and accessibility of services. These were some of the legislative outcome goals and had been included in the evaluation plan. This annual report is the first time that data have been reported through a systematic qualitative analysis to address preliminary changes in these areas (as perceived by AFF program directors). The chapter also includes a discussion of the implementation of collaborative partnerships based on qualitative interview data as well as an analysis of collaborative partner matrices that each program director completed.

Chapter V presents findings on client satisfaction based on interviews and focus groups with clients at each of the nine AFF provider sites, and Chapter VI summarizes policy activities undertaken at the State level that have resulted in increased coordination across state agencies during the first year of the program.

Finally, Chapter VII provides a summary and conclusion of the major findings presented in the annual evaluation report.

CHAPTER II
OVERVIEW OF EVALUATION FRAMEWORK

The evaluation design that was developed for AFF includes both a process study and an outcome study. The process study focuses on program implementation to determine whether AFF provider agencies implemented the service model as intended by the legislation and program administrators. The process study also is useful for explaining why outcomes were achieved or not achieved. The outcome study addresses whether the AFF outcome goals and performance measures were achieved. As well, other outcomes in the areas of recovery, family stability, safety, permanency, self-sufficiency, and systems change are addressed. The outcome study addresses outcome findings at both the participant and systems levels.

The evaluation framework upon which the AFF evaluation is based includes a number of models to be used in understanding the program from multiple levels—from the conceptualization of the program by policymakers to the actual experience of clients who enter the program and utilize the substance abuse treatment services. These models include:

- **The Policy Model**: This model provides the standard description of the design of the program against which subsequent implementation of AFF is analyzed. Data to address the policy model are gathered from document reviews and interviews with policymakers. This model reflects the way in which the state administrators, legislators, and various stakeholders *envisioned* the program and how it was designed to operate. In the First Annual Evaluation Report on AFF (October 2001), an analysis of program policies, policy-level documents, the RFP, the Vision Statement, the role of the Steering Committee, and activities of ADES to help implement the program was conducted and findings were presented. In the current annual report, policy issues and changes have been included in various chapters to help interpret program models or what is occurring at the operational level. As well, a more detailed discussion of policy-level changes during the first year is provided at the end of Chapter V.

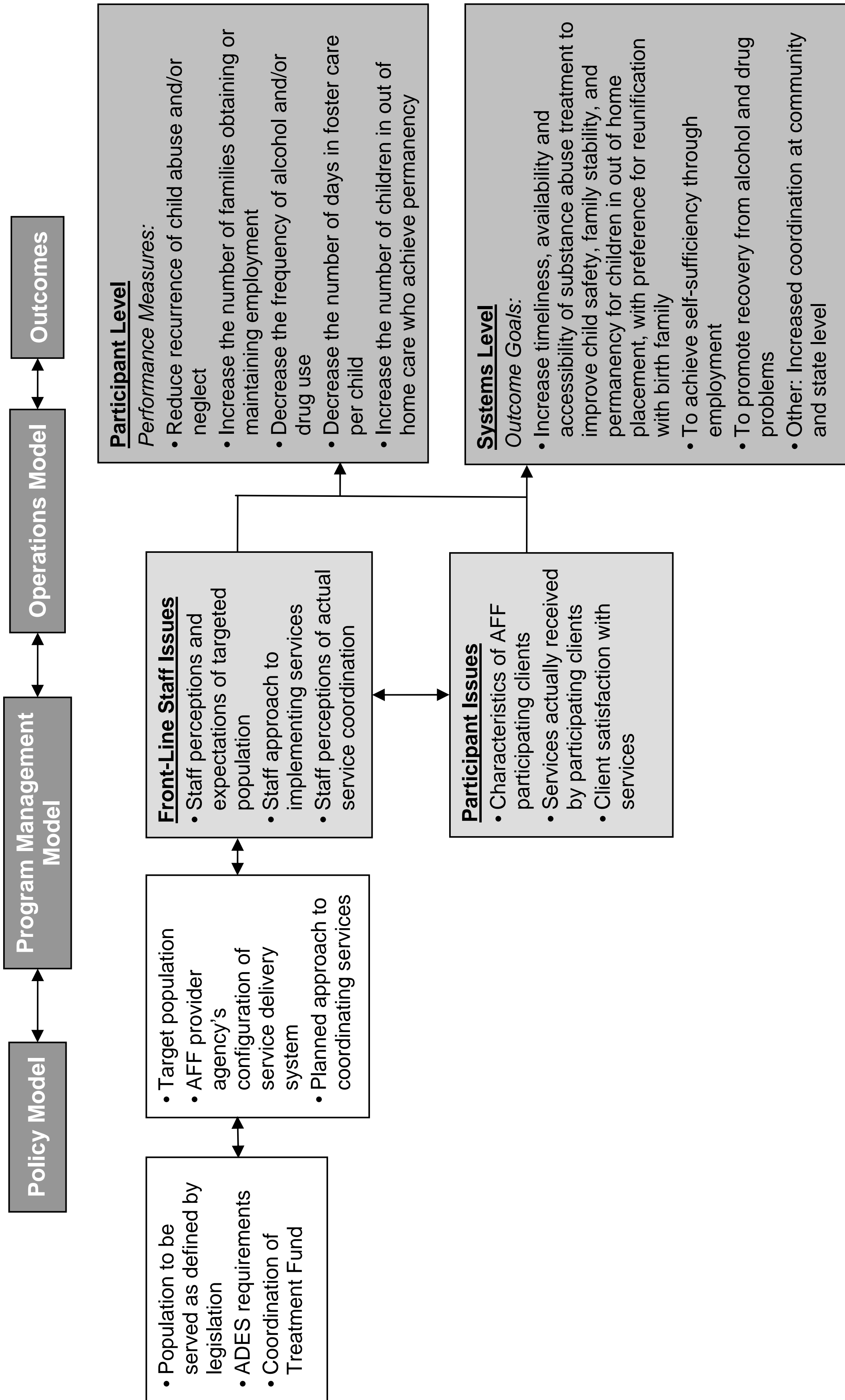
- **The Program Management Model**: This model describes the way in which each AFF provider agency *operationalized* the policy guidelines, designed their initiative to meet State requirements, and responded to the unique characteristics of their locality and the needs of their program participants. In the First Annual Evaluation Report, findings from site visits that assessed the program management models of the nine AFF provider agencies were reported, including the administrative structure of the AFF provider agencies; compensation for services and provider rates; staff qualifications and training issues; and linkages to provide supportive services for clients. Subsequent Quarterly Evaluation Reports throughout the first year of the program reported on different aspects of the Program Management Model being implemented by AFF provider agencies.

- **The Operations Model**: This model consists of the dual perspectives of frontline staff and program participants in describing program operations. Key questions of the frontline staff sub-component of the model concern whether staff are *implementing* the program according to the Program Management Model, and, if not, "Why not?" The participant issues sub-component of the model identifies participant perspectives and descriptive data on participant needs and actual receipt of services. It also identifies how satisfied participants are with services, how well the vision statement is operationalized in terms of the participants' experiences (e.g., are services available to them, accessible, and can they receive them in a timely manner?), and whether or not there are unmet needs.

- **Outcomes:** The evaluation framework developed to study AFF provides an examination of the program effectiveness at the participant level as well as the systems level. Participant-level outcomes include changes that occur after utilization of program services, specified in Chapter I as performance measures (e.g., reduced re-allegations of child abuse and neglect, attainment of employment, decrease in alcohol/drug use, reduced time in foster care, increase in reunifications from foster care). System-level outcomes include changes in the service delivery systems in communities (e.g., availability, timeliness, and accessibility of substance abuse treatment services) which in turn can influence participant-level outcomes such as child safety, family stability, permanency for children in foster care, the achievement of self-sufficiency through employment, and recovery from alcohol and drug problems. Other systems-level outcomes can include systems change at the local as well as state level (e.g., increased coordination between agencies).

Exhibit II-1 provides an overview of the Evaluation Framework. This framework summarizes the models described above, upon which the evaluation is built. The framework provides a description of the system components at various points in time and from the perceptions of different stakeholders. It serves as a map or guide for how the major activities of the AFF process and outcome studies fit together into an overall program evaluation. For the current annual report, much of the data presented addresses the Operations Model with some information (i.e., preliminary findings on systems-level changes) addressing the Outcomes component of the evaluation framework.

Exhibit II-1
Arizona Families F.I.R.S.T.
Evaluation Framework



CHAPTER III
DESCRIPTION OF ARIZONA FAMILIES F.I.R.S.T. CLIENTS AND SERVICES RECEIVED

In this section of the annual report, we present available data on the characteristics of individuals referred to Arizona Families F.I.R.S.T. (AFF) during the first year of the program; characteristics of clients who actually enrolled in the program; service activity data, including referrals, assessments, service plans, engagement in treatment services, types of treatment services utilized; and length of time that participating clients spent in treatment. This section also includes implementation findings from data collected onsite with respect to referrals, assessments, service planning, and treatment in order to better understand the service trends that emerged from the client data. Findings are summarized using tables, charts and summary bullet points. The section pertaining to service activity includes more detailed narrative discussion because of the qualitative research findings that have been incorporated into the chapter.

In the exhibits that follow, percentages are reported in the body of the tables to allow for comparisons across the AFF provider agencies, and Statewide percentages are reported in the column labeled “All Sites.” In a few exceptions, frequency data are reported instead of percentages to more effectively convey findings. The exhibits presented in this chapter on descriptive information pertaining to age, sex, and race report percentages with adjustments for unknown/missing data so that the percentages for referred and participating clients can be compared.[1]

A. Characteristics of Individuals Referred

In this section, data are presented on characteristics of individuals referred to AFF, for all individuals referred since the program’s inception in March 2001 through March 31, 2002.[2] The information available on referred individuals is more limited than the data available on participating clients. The key findings from the exhibits are summarized in bullet form following each exhibit.

Exhibit III-1
Age of Individuals Referred: Project Inception - March 31, 2002 (n = 1447)

Age	Provider Site									All Sites
	AZPAC Coconino	AZPAC Yavapai	AZPAC Yuma	CPSA	Horizon	Old Concho	SEABHS	TERROS	West Care	
Under 18 years	0%	0%	0%	1%	0%	0%	0%	1%	0%	n=5 (0.4%)
18-25 years	26%	28%	17%	26%	30%	19%	17%	27%	23%	n=354 (26%)
26-33 years	19%	28%	39%	38%	37%	30%	42%	37%	18%	n=489 (36%
34-41 years	33%	30%	39%	27%	29%	37%	30%	27%	31%	n=388 (28%)
42+ years	22%	14%	6%	9%	5%	14%	11%	8%	28%	n=137 (10%)
Total	n=27	n=81	n=18	n=380	n=84	n=91	n=53	n=600	n=39	N=1,373

Note: For 74 individuals, data were missing on age. Percentages are based on adjustments for unknown age.

- 26 percent of the individuals referred were between the ages of 18 and 25 years, 36 percent were between 26 and 33 years old, 28 percent were from 34 to 41 years of age, and 10 percent of persons referred were age 42 or older.

[1] The percent of unknown/missing data for each variable is presented so that readers can understand the extent to which data were not available. For exhibits that report data other than age, sex, and race, the total N’s remain constant and we present the percent of unknown/missing data, where relevant.

[2] While the majority of AFF provider agencies began implementation of their programs in March 2001, data on referrals indicate that some referrals were received prior to March 2001. Thus, tables that present referral data for the overall year-to-date were labeled “project inception – March 31, 2002”)

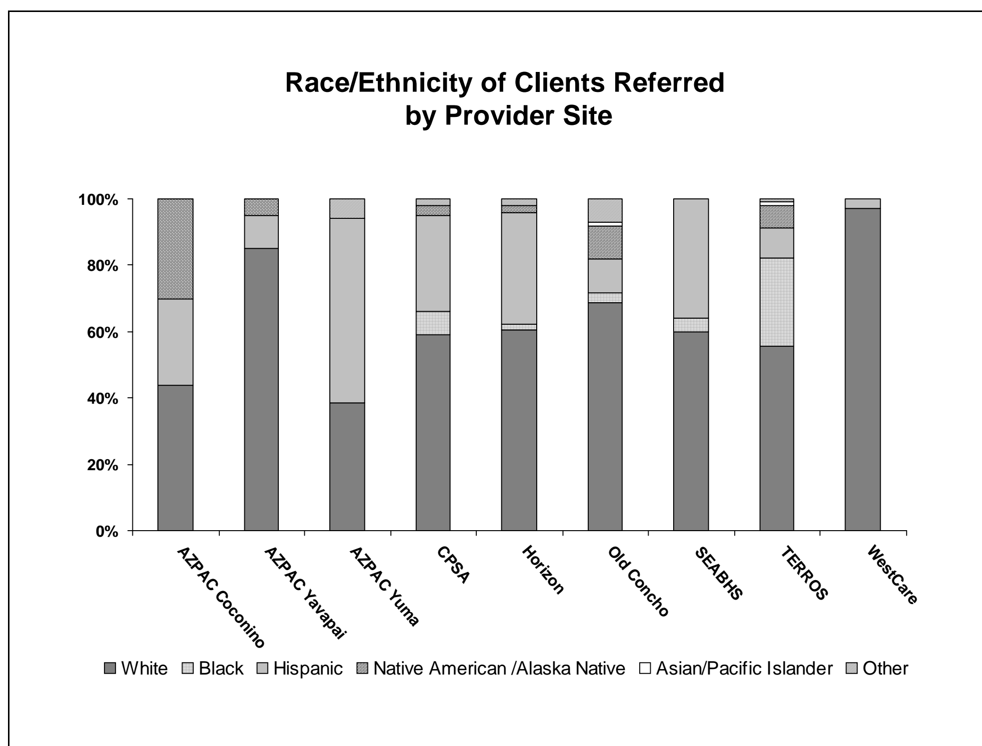
Exhibit III-2
Sex of Individuals Referred: Project Inception – March 31, 2002 (n = 1447)

Gender	Provider Site									All Sites
	AZPAC Coconino	AZPAC Yavapai	AZPAC Yuma	CPSA	Horizon	Old Concho	SEABHS	TERROS	WestCare	
Male	30%	31%	33%	29%	19%	27%	28%	22%	26%	n=354 (26%)
Female	70%	69%	67%	71%	81%	73%	72%	78%	74%	n=1,028 (74%)
Total	n=27	n=85	n=18	n=401	n=63	n=91	n=53	n=605	n=39	N=1,382

Note: For 65 individuals, data were missing on sex. Percentages are based on adjustments for unknown sex.

- Seventy four percent of persons referred were female, 26 percent were male.

Exhibit III-3
Race of Individuals Referred: Project Inception - March 31, 2002
(n = 1447)



- Statewide, 60 percent of individuals referred to AFF were White, 14 percent were Black, 18 percent were Hispanic, and Native American/Alaska Natives accounted for 5 percent of referrals.
- For 104 individuals referred, data was missing on their race.

B. Characteristics of AFF Participating Clients

Clients were considered to be *participating clients* if they had a service plan developed. This definition was developed in the analysis plan for the evaluation to ensure that the clients followed in the outcome study were individuals who had actually enrolled in the program. Hence, enrollment is indicated when a service plan has been developed. The following data on characteristics of AFF participating clients includes those individuals who had a service

plan developed during the first year of the program (i.e., any time between March 2001 and March 31, 2002).

1. Demographic Characteristics

The first set of exhibits in this section report on descriptive information about participating clients, including their age, sex, race, number of children, education level, employment status and marital status. Each exhibit is followed by a summary of the information reported using summary bullet points.

a. Age and Sex

The following data report on age and sex of clients participating in AFF.

Exhibit III-4
Age of Participating Clients: March 2001 - March 31, 2002
(n=803 participating clients)

Age	Provider Site									All Sites
	AZPAC Coconino	AZPAC Yavapai	AZPAC Yuma	CPSA	Horizon	Old Concho	SEABHS	TERROS	WestCare	
Under 18 years	0%	0%	0%	0.4%	0%	0%	0%	0.3%	0%	n=2 (0.3%)
18-25 years	21%	24%	9%	23%	27%	18%	15%	22%	7%	n=174 (22%)
26-33 years	21%	30%	36%	38%	29%	32%	43%	40%	7%	n=293 (37%)
34-41 years	32%	30%	45%	28%	34%	43%	30%	29%	71%	n=244 (31%)
42+ years	26%	15%	9%	10%	10%	7%	13%	9%	14%	n=83 (10%)
Total	n=19	n=66	n=11	n=252	n=41	n=28	n=47	n=318	n=14	N=796

Note: For 7 individuals, data were missing on age.

- Of the participating clients (i.e., those with a service plan by March 31, 2002) 22 percent were between 18 and 25 years old; 37 percent were between 26 and 33 years; 31 percent were from 34 to 41 years of age; and 10 percent were 42 years and older.

- The patterns with respect to age of participating clients were similar to the ages of individuals referred to the program. Within AFF sites, age of participants showed a similar pattern to the age of referred individuals. The exception was WestCare, where referred clients were distributed across age categories but among participating clients, 71 percent were from 34 to 41 years old (the overall number of participants at WestCare, however, is only 14).

Exhibit III-5
Sex of Participating Clients: March 2001 – March 31, 2002
(n=803 participating clients)

Gender	Provider Site									All Sites
	AZPAC Coconino	AZPAC Yavapai	AZPAC Yuma	CPSA	Horizon	Old Concho	SEABHS	TERROS	WestCare	
Male	21%	29%	18%	32%	19%	18%	26%	20%	21%	n=197 (25%)
Female	79%	71%	82%	68%	81%	82%	74%	80%	79%	n=602 (75%)
Total	n=19	n=66	n=11	n=257	n=37	n=28	n=47	n=320	n=14	N=799

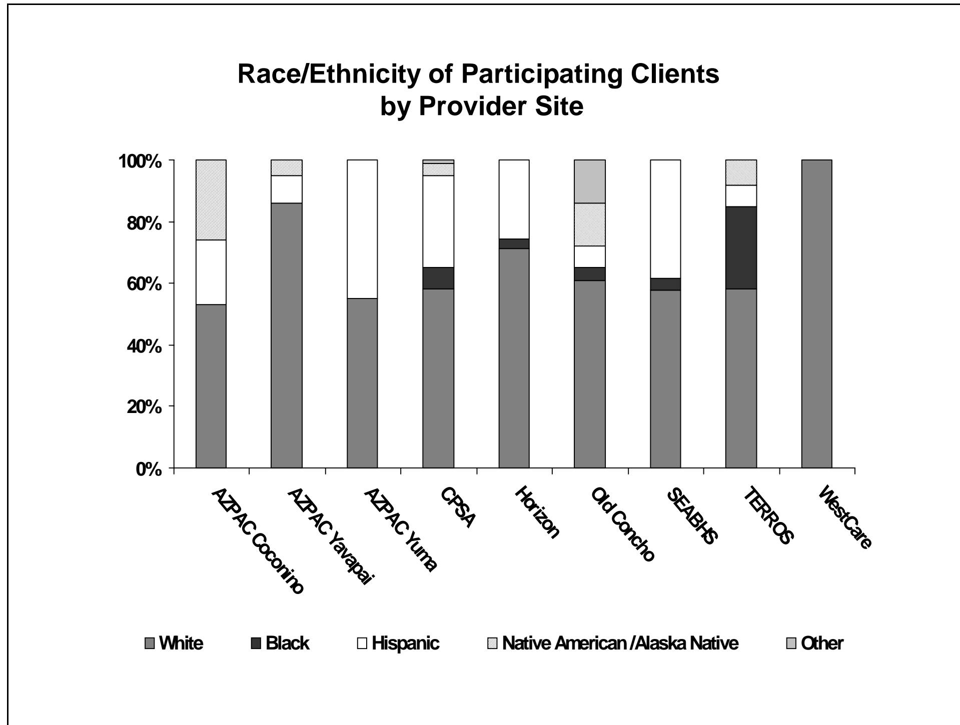
Note: For47 individuals, data were missing on sex.

- Seventy five percent of participating clients were female, and 25 percent were male, reflecting a pattern that was similar to those who were referred to AFF.

b. Race

The exhibit that follows presents information on race of AFF participating clients.

Exhibit III-6
Race of Participating Clients: March 2001 – March 31, 2002
(n=803 participating clients)



- With respect to race/ethnicity of participating clients, overall, 62 percent of participants were White, 14 percent were Black, 18 percent were Hispanic, and 6 percent were Native American/Alaskan Native.[3] There was both within-site and cross-site variation regarding the race of participating clients.

- In general, the racial distribution of clients engaged in AFF was similar to the racial distribution of clients referred to the program (e.g., 27 percent of TERROS' referrals were Black, and 27 percent of TERROS' participants were Black; 29 percent of the referrals at CPSA were Hispanic, and approximately 30 percent of CPSA's participants were Hispanic).

- *Hispanics:* Almost one-half of AZPAC Yuma's participants were Hispanic (45%). However, due to the low number of referrals at AZPAC Yuma, this site accounted for only three percent of Hispanic participants cross-site. CPSA accounted for more than half (52%) of Hispanic participants cross-site.

- *Blacks:* Over one-quarter (27%) of the participating clients served by TERROS wee Black, which accounted for almost 80 percent of all Black participants across sites.

[3] According to 1999 ADES data, the overall racial composition of Arizona's general child welfare population is 55.7 percent White, 3.4 percent Black, 31.8 percent Hispanic, 7.1 percent Native American/Alaskan Native, and two percent Asian/Pacific Islander.

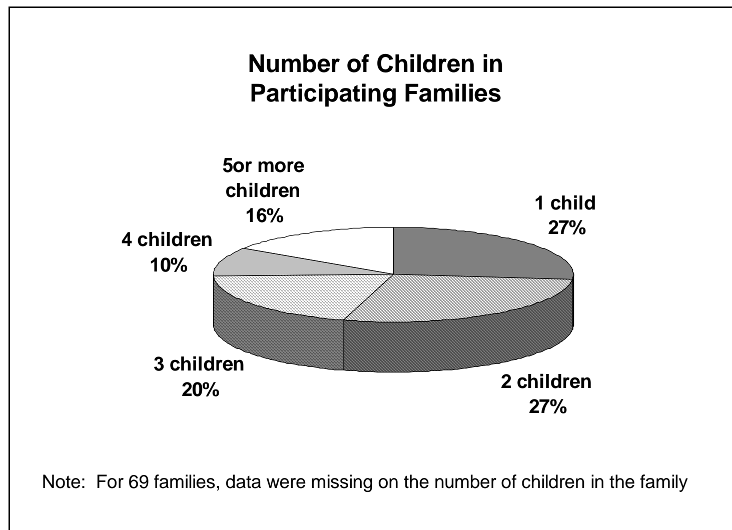
- *Whites:* More than one-half of the participants at each of the nine AFF provider sites were White. One hundred percent of the participating clients served by WestCare were White. However, this provider agency serves a small number of clients and it accounted for only three percent of the total Whites participating in AFF.

- *Native Americans:* Over one-quarter of the participating clients served by AZPAC Coconino were Native American (26%), accounting for 11 percent of Native Americans cross-site. CPSA and TERROS accounted for three-quarters of all Native Americans served by the AFF program. However, come of the other AFF provider agencies that served smaller numbers of clients, such as Old Concho, also had a large proportion of participating clients who were Native American (14% of Old Concho's participating clients were native American, accounting for 9% of Native Americans across sites.

2. Family Size and Marital Status

The following exhibits report on family size and marital status among participating clients. Family size is presented in terms of the number of children in participating families.

Exhibit III-7
Number of Children in Participating Families: March 2001 – March 31, 2002 (n=636 participating families)



- Overall, among the 636 participating families, there was variation in family size with respect to the number of children in families.

- Twenty seven percent of participating families had only one child; another 27 percent of families had two children; 20 percent had three children; and 10 percent of participating families had four children.

- Statewide, 16 percent of families accounted for those with five or more children**.**

Exhibit III-8
Marital Status of Participating Clients: March 1, 2001 - March 2002

Marital Status	Provider Site									All Sites
	AZPAC Coconino	AZPAC Yavapai	AZPAC Yuma	CPSA	Horizon	Old Concho	SEABHS	TERROS	West Care	
Married	32%	20%	27%	12%	27%	11%	32%	19%	29%	n=146 (18%)
Consensual	5%	3%	0%	4%	0%	7%	0%	2%	0%	N=22 (3%)
Never Married	37%	45%	64%	35%	32%	7%	34%	56%	29%	n=346 (43%)
Separated/ Divorced/ Widowed	16%	24%	9%	14%	32%	18%	32%	16%	36%	n=145 (18%)
Unknown/ Missing	11%	8%	0%	35%	10%	57%	2%	8%	7%	n=144 (18%)
Total	n=19	n=66	n=11	n=257	n=41	n=28	n=47	n=320	n=14	N=803

- Overall, 18 percent of participating clients were married.
- Sixty one percent of participants were not married. In specific, 43 percent of the participating clients overall had never been married, and 18 percent of clients across sites were separated, divorced, or widowed.
- Marital status was not known for 18 percent of the participating clients.

3. Education Level and Employment

The following two exhibits report on the highest education level attained by participating clients and the employment status of participating clients.

Exhibit III-9
Highest Education Level Attained by Participating Clients:
March 2001 - March 31, 2002

Education Level Attained	Provider Site									All Sites
	AZPAC Coconino	AZPAC Yavapai	AZPAC Yuma	CPSA	Horizon	Old Concho	SEABHS	TERROS	West Care	
Less than High School Diploma/Certificate	32%	38%	36%	43%	54%	25%	26%	51%	21%	n=352 (44%)
GED	0%	11%	36%	11%	10%	0%	17%	0%	0%	n=52 (6%)
High School Diploma	63%	30%	27%	26%	17%	18%	40%	20%	57%	n=206 (26%)
Vocational Education Certificate	5%	3%	0%	0%	5%	0%	0%	0%	0%	n=5 (1%)
College Associate Degree	0%	5%	0%	9%	5%	0%	2%	10%	7%	n=63 (8%)
College Bachelor Degree	0%	5%	0%	0.4%	0%	0%	0%	1%	0%	n=7 (1%)
College Advanced Degree	0%	3%	0%	1%	0%	0%	0%	3%	0%	n=13 (2%)
Unknown	0%	6%	0%	9%	10%	57%	15%	15%	14%	n=105 (13%)
Total	n=19	n=66	n=11	n=257	n=41	n=28	n=47	n=320	n=14	N=803

- Overall, 44 percent of total participating clients across AFF sites did not complete high school. This pattern was consistent across sites—for clients served by both urban and rural provider agencies.

- For 32 percent of participating clients, a high school diploma or GED was the highest education level attained.

- TERROS and CPSA accounted for almost 90 percent of the participating clients with an Associate's degree.

- TERROS and AZPAC Yavapai accounted for 86 percent of all clients whose highest education was a Bachelor's degree.

- For 13 percent of the participating clients, information was not available on their education level.

Exhibit III-10
Employment Status of Participating Clients: March 2001 - March 31, 2002

Employment Status	Provider Site									All Sites
	AZPAC Coconino	AZPAC Yavapai	AZPAC Yuma	CPSA	Horizon	Old Concho	SEABHS	TERROS	West Care	
Employed Full Time	21%	23%	27%	41%	15%	14%	28%	17%	21%	n=209 (26%)
Employed Part Time	21%	12%	0%	11%	7%	0%	9%	4%	0%	n=60 (7%)
Work Activity*	0%	0%	0%	4%	2%	0%	0%	3%	0%	n=20 (2%)
Educational/ Training Activities**	0%	0%	9%	2%	0%	0%	4%	2%	0%	n=13 (2%)
Not Employed	53%	59%	64%	31%	66%	29%	57%	58%	50%	n=391 (49%)
Unknown	5%	6%	0%	12%	10%	57%	2%	15%	29%	n=110 (14%)
Total	n=19	n=66	n=11	n=257	n=41	n=28	n=47	n=320	n=14	N=803

* Work activities include transitional employment, community-based work, facilities-based work activities, and sheltered employment.

** Educational/training activities include education/training, social drop-in/recreational activities, and volunteer.

- Across AFF sites, 26 percent of participating clients were employed full-time; 7 percent were employed part-time; and 49 percent of clients were not employed.

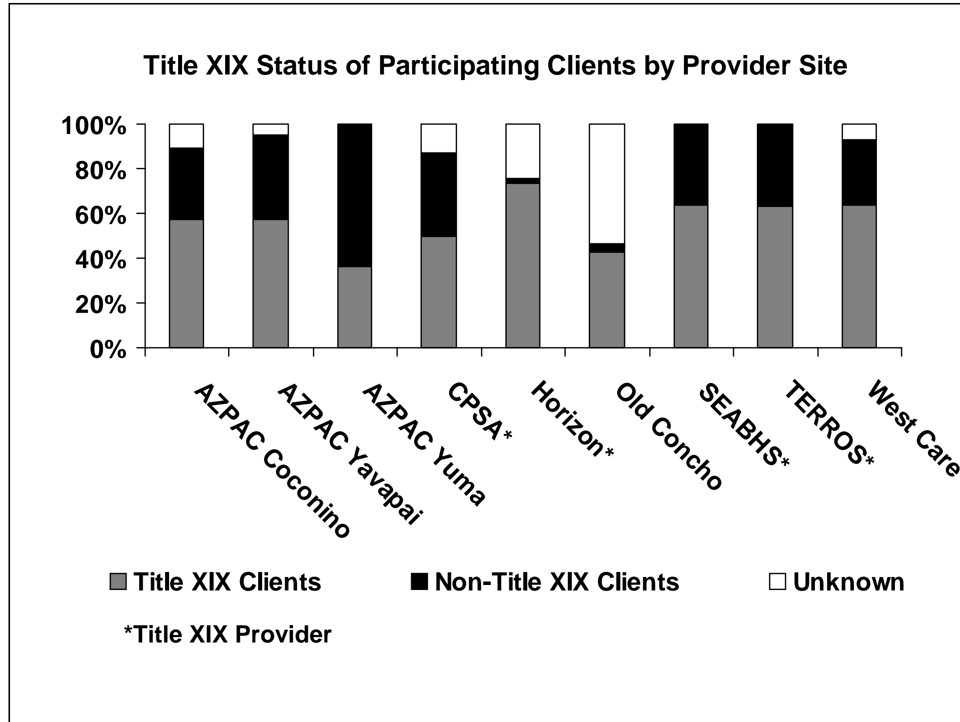
- Four percent of clients were involved in a work activity or educational training.

- For the participating clients served at the two largest urban AFF sites (CPSA and TERROS), 41 percent of the CPSA clients were employed full-time but only 17 percent of the TERROS clients worked full-time.

4. **Title XIX Participants**

Exhibit III-11 presents data on the Title XIX status (i.e., enrollment in Medicaid) for AFF participating clients.

Exhibit III-11
Title XIX Status of Participating Clients: March 2001 - March 31, 2002
(n=803 participating clients)



- Overall, 58 percent of participating clients were Title XIX (i.e., enrolled in Medicaid); 34 percent were non-Title XIX.
- For eight percent of participating clients, Title XIX status was not known.
- With respect to site variation, AZPAC Yuma had the lowest percentage of Title XIX participating clients (36%) compared to the other AFF provider agencies. AZPAC Yuma is not a Title XIX provider and therefore must refer Title XIX clients to a RBHA subcontractor for services.
- Horizon had the highest percentage of Title XIX clients (73%) compared to the other provider agencies. Horizon is a RBHA subcontractor.
- For the other AFF provider agencies, the percentage of Title XIX participating clients ranged from 58 percent to 64 percent.

5. Substance Abuse

The remaining three exhibits in this section address the probability of substance dependence[4], reported use of various drugs at AFF enrollment, and poly-drug co morbidity patterns among AFF participating clients. Similar to the presentation format used in this chapter, key findings from each of the exhibits are discussed in summary bullets.

Exhibit III-12
Probability of Substance Dependence
Among Participating Clients: March 2001 – March 31, 2002

Probability of Substance Dependence	Provider Site									All Sites
	AZPAC Coconino	AZPAC Yavapai	AZPAC Yuma	CPSA	Horizon	Old Concho	SEABHS	TERROS	West Care	
High Probability	5%	42%	91%	58%	51%	93%	36%	43%	43%	n=394 (49%)
Low Probability	21%	12%	9%	25%	7%	4%	28%	22%	0%	n=163 (20%)
Missing	74%	45%	0%	18%	41%	4%	36%	36%	57%	n=246 (31%)
Total	n=19	n=66	n=11	n=257	n=41	n=28	n=47	n=320	n=14	n=803

Note: Based on data from the Substance Abuse Subtle Screening Inventory, administered during the first year of the program to screen for presence of a substance abuse disorder. The SASSI-3 screens for substance dependence even if individuals do not acknowledge misuse of substances or symptoms associated with it.

- Data from the SASSI-3 indicates that, overall, 49 percent of participating clients had a high probability of substance dependence. The SASSI-3 is only one part of a comprehensive assessment that is completed with clients; the full assessment also includes a biopsychosocial assessment and a family centered interview.

- Data were missing from almost one-third of participants, which limits the ability to draw further conclusions or interpretations regarding the probability of substance dependence among clients.[5]

[4] Substance dependence, according to the SASSI Institute, is a primary, pervasive, progressive disorder that has a negative impact on individuals, significant others, and society.
[5] Beginning in March 2002, ADES replaced the SASSI-3 screening measure with the Addiction Severity Index-Lite version, an assessment tool which can be used to assess change in clients over time on several dimensions related to recovery and which has been used widely in the field of substance abuse research.

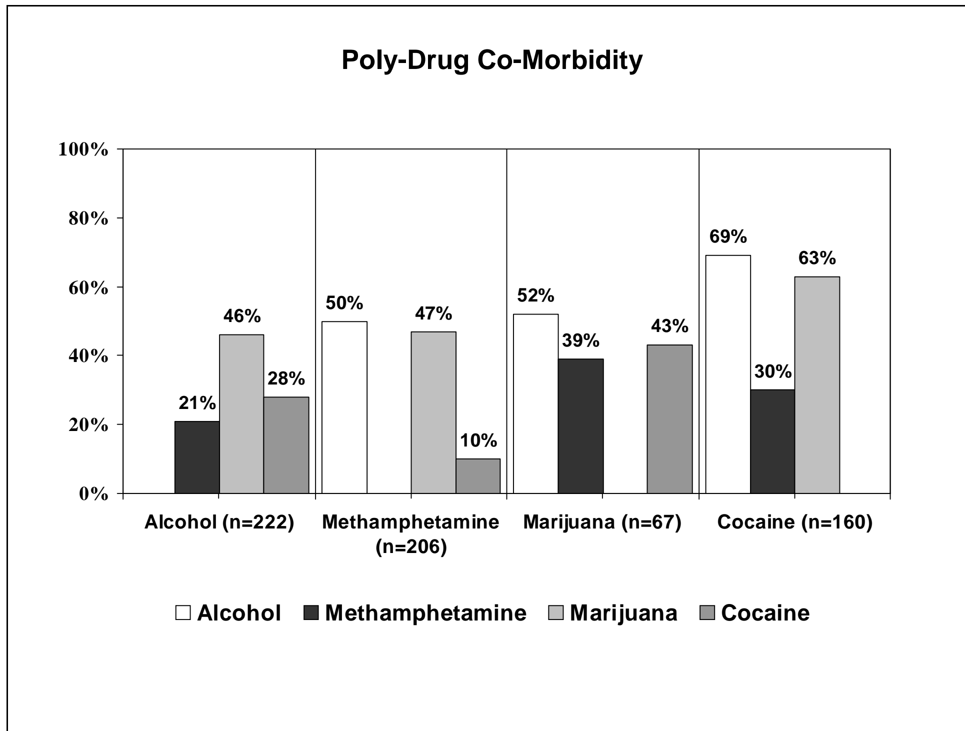
Exhibit III-13
Percent of Participating Clients Using Drugs at Enrollment: March 2001 – March 31, 2002

	Provider Site									
	AZPAC Coconino	AZPAC Yavapai	AZPAC Yuma	CPSA	Horizon	Old Concho	SEABHS	TERROS	West Care	All Sites
Alcohol	84%	64%	55%	78%	41%	82%	79%	48%	43%	n=499 62%
Tobacco	5%	9%	0%	6%	5%	43%	0%	3%	7%	n= 47 6%
Cocaine	5%	23%	0%	65%	10%	4%	21%	30%	0%	n=296 37%
Marijuana	32%	73%	9%	74%	20%	7%	60%	33%	36%	n=391 49%
Heroin/ Morphine	0%	11%	0%	11%	0%	0%	0%	3%	0%	n=47 6%
Methamphetamine	16%	79%	82%	34%	56%	43%	47%	38%	71%	n=338 42%
Total	n=19	n=66	n=11	n=257	n=41	n=28	n=47	n=320	n=14	n=803

Note: This table includes drugs that clients were actively using at the time of their enrollment in AFF. If a client had not used a drug in the past 30 days, this was not included. Percentages reported are not based on mutually exclusive categories (i.e., the same client, if using multiple drugs, was reported in more than one category). Information on type of drug(s) being used was available for 87% of participating clients.

- Overall, 62 percent of participating clients reportedly used alcohol.
- Forty nine percent of clients reportedly used marijuana.
- Thirty seven percent of participants indicated that they used cocaine.
- Methamphetamine use was reported by 42 percent of participating clients.
- Six percent of clients used heroin/morphine.
- Eight percent of clients used other hallucinogens; for other drug types, including inhalants, barbiturates, other stimulants, and other narcotics, the rate was approximately two percent.
- The data substantiate the pervasive alcohol and methamphetamine problem that AFF provider agencies discussed during site visits.
- With respect to site variation, use of cocaine was highest at CPSA, where 65 percent of participating clients reportedly used cocaine. Since CPSA is one of the largest provider sites, it accounts for most of the statewide cocaine use.
- The highest rates of marijuana use were reported by CPSA (74%), AZPAC Yavapai (73%), and SEABHS (60%).
- Four AFF provider agencies (AZPAC Coconino, CPSA, Old Concho, and SEABHS) reported that 78 percent or more of their participating clients used alcohol.
- The rate of methamphetamine use was over 50 percent at four of the AFF sites: AZPAC Yavapai (79%); AZPAC Yuma (82%); Horizon (56%); and WestCare (71%).

Exhibit III-14
Poly-Drug Co-Morbidity Patterns Among Participating Clients:
March 2001 – March 31, 2002
(n = 803 participating clients)



Poly-drug co-morbidity was examined for clients who reported usage of more than one drug type. On the basis of either exclusive use of one drug type or most frequent usage of a particular drug, "frequent drug type" categories were identified. The four most frequently used substances were alcohol, methamphetamine, marijuana, and cocaine. Within each of these frequent drug use categories, multiple drug use patterns were examined with respect to other types of drugs that clients reported using in addition to their most frequently used substance.

- Twenty eight percent of participating clients reported that alcohol was their exclusive or most frequently used substance. Among this group, 46 percent also reported using marijuana.
- Twenty six percent of participants reported that methamphetamine was their most frequently used substance, and among this group, 50 percent also used alcohol and 47 percent also used marijuana.
- Among the eight percent of clients whose most frequently used drug was marijuana, 43 percent also reported use of cocaine.
- Twenty percent of participating clients reported that their most frequently used drug was cocaine. Among these clients, 70 percent also used alcohol and 63 percent also used marijuana.

One potential interpretation of the drug combination patterns observed is that clients may be using additional drugs as the effects of their most frequently used drug recede. For example, the effects of methamphetamine typically last more than 10 hours and the half-life[6] is 12 hours, while cocaine's high lasts about 20 to 30 minutes, with a half-life of approximately one hour.[7] It is possible that alcohol and marijuana may be used as transition substances by the AFF clients who are frequent methamphetamine and cocaine users.

C. Service Activity

The information on service activity includes referral and assessment trends over the first year of the program; levels of engagement in treatment services; definitions of primary treatment level groups and the types of treatment received by participating clients; and length of time that participating clients spent in treatment.

1. Referrals

Exhibit III-15 presents data on the number of referrals to AFF during the first year of the program. The data indicate that Statewide, the number of referrals was generally constant across quarters, averaging about 345 referrals per quarter.

Exhibit III-15
Number of Referrals by Quarter: Project inception through March 31, 2002

	Provider Site									
Quarter	**AZPAC Coconino**	**AZPAC Yavapai**	**AZPAC Yuma**	**CPSA**	**Horizon**	**Old Concho**	**SEABHS**	**TERROS**	**West Care**	**All Sites**
<Mar 2001	1	1	0	18	3	7	0	31	2	63
Mar - Jun 2001	1	21	4	102	31	22	13	145	17	356
Jul - Sep 2001	1	14	4	114	31	16	17	119	6	322
Oct - Dec 2001	15	31	3	104	17	27	6	150	4	357
Jan - Mar 2002	9	18	7	104	4	19	17	161	10	349
Total	27	85	18	442	86	91	53	606	39	1,447

There was site variation with respect to the number of referrals received. In specific:

- About half of the AFF provider agencies showed fluctuation in the number of referrals received over the quarters, but ended the year with an increase in referrals during the fourth quarter (January – March 2002). These agencies included WestCare, TERROS, SEABHS, and AZPAC Yuma (although Yuma, in general, received very few referrals during the entire year).

- CPSA generally showed a consistent rate of referrals from quarter to quarter.

- AZPAC Coconino, AZPAC Yavapai, and Old Concho showed fluctuating referral rates during the first year and then a decrease by the fourth quarter.

- Horizon had a constant rate of referrals but then a decrease by the fourth quarter, receiving less than 44 percent of the referrals that had been received during the previous quarter.

In the quarterly AFF evaluation reports submitted in January 2002 and April 2002, it was noted that all AFF provider agencies have communication procedures in place with their referral

[6] Half-life refers to the time it takes for the body to remove 50 percent of a drug.

[7] National Institute on Drug Abuse (NIDA) (2001). Methamphetamine, Cocaine Abusers have Different Patterns of Drug Use, Suffer Different Cognitive Impairments. NIDA Notes: Research Findings. Volume 16, Number 5, December. (link referenced on 10-21-02; www.nih.gov/NIDA_Notes/NNVol16N5/Meth-Coc.html)

agencies. TERROS and CPSA, which showed an increased or sustained level of referrals from the third to fourth quarters, reported during site visits that they had been meeting with CPS case managers and supervisors on a monthly basis to discuss the referral process and the cases being referred. ADES initially conducted a Level I training for referral agency staff on the AFF program, and four provider agencies (AZPAC Yavapai, Old Concho, TERROS, and WestCare) held their own, additional trainings with the referral agencies to clarify referral practices. Some of the sites that experienced a drop in the number of referrals during the fourth quarter discussed with the evaluators during the winter 2002 site visits that they were concerned over the decrease in referrals they were experiencing that quarter. Some questioned whether the decline in referrals might be related to the possibility of ADES reductions in the AFF budgets and community perceptions that the program might no longer be able to continue at its current level. In particular, interviews conducted with CPS supervisors in Yavapai County revealed that following ADES budget cuts to the Family Builders program across the State, CPS staff were worried that similar budget reductions might occur with AFF and they wondered what would happen to services for clients whom they were continuing to refer to the program.

With respect to the outreach and engagement that occurs with a client once a referral is received, the majority of AFF provider agencies have used their own staff to perform outreach rather than use subcontractor staff. Only three of the AFF provider agencies made changes during the course of the year in how they performed outreach. TERROS, after experiencing success using the agency's HIV outreach teams to locate clients in neighborhoods during the early evening hours, implemented a change in November 2001 and expanded the capacity of their three subcontractors to perform outreach to AFF clients using this approach. WestCare also made a change in their approach during the spring of 2002 and began making home visits to referred clients in order to conduct an initial screening and attempt to engage them in AFF. In addition, SEABHS made changes to its outreach procedures following budget reductions to the Family Builders program. These budget cuts resulted in the loss of outreach staff provided by the subcontractor in Cochise County's three locations, who previously had been conducting outreach for AFF. In response, the SEABHS staff were trained on outreach procedures by the subcontractor staff and took over these activities.

Exhibit III-16 presents information on the source of referrals to AFF over the course of the first year of the program. These data are consistent with information that has been reported previously in quarterly evaluation reports. The majority of referrals to AFF are made by CPS. Statewide, 84 percent of referrals were from CPS, six percent were from Jobs, and three percent were from Family Builders. For six percent of the referrals, information was not available on the source of the referral. Of all AFF provider agencies, Horizon had the highest percentage of referrals from Jobs (19%).

Exhibit III-16 Percent of Clients Referred by Referral Source: Project Inception through March 31, 2002

Referral Source	Provider Site									All Sites
	AZPAC Coconino	AZPAC Yavapai	AZPAC Yuma	CPSA	Horizon	Old Concho	SEABHS	TERROS	West Care	
CPS	70%	79%	100%	90%	79%	84%	66%	83%	97%	n=1,220 (84%)
Family Builders	26%	6%	0%	1%	0%	2%	2%	4%	0%	n=46 (3%)
JOBS	4%	0%	0%	7%	19%	14%	4%	5%	0%	n=90 (6%)
Unknown	0%	15%	0%	2%	2%	0%	28%	9%	3%	n=91 (6%)
Total	n=27	n=85	n=18	n=442	n=86	n=91	n=53	n=606	n=39	N=1,447

In focus groups conducted mid-way through the first year of the program, referral agency staff, including CPS and Jobs staff, highlighted some possible reasons for why an overwhelming proportion of referrals to AFF come from CPS rather than Jobs. First, there clearly were differences in the identification methods used by CPS and Jobs staff prior to making a referral. CPS staff at each of the nine AFF provider sites mentioned similar ways in which they identified substance abuse issues with their clients, including the use of existing court reports, CPS investigations, in-home assessments, psychological evaluations, crime reports, observational information, and risk assessments. Jobs staff from across the nine AFF sites do not have the same sources available to them in identifying substance abuse, and their approach is more limited—in specific, they rely on self-administered surveys and observations of clients. It is clear that CPS staff have more resources available and more opportunities to identify substance abuse problems among their clients than do Jobs staff. Further, CPS workers have more legal authority to do so, than do Jobs staff.

A general perception that emerged from the Jobs staff during onsite interviews and focus groups was that AFF is a program for CPS clients. Focus groups with Jobs staff at some sites (CPSA and SEABHS) revealed that the Jobs staff perceive their referrals to be less important to the AFF provider agencies than the referrals they receive from CPS. Jobs staff at one AFF site noted that CPS case examples were used predominantly during the initial training conducted by State ADES administrative staff.[8] Many Jobs workers indicated during focus groups that they were hesitant to take a confrontational stance with a client whom they suspected of having a substance abuse problem because they did not believe they had the authority to delve into this area. They stated that CPS has a broader scope of concern than Jobs as well as the legal authority to investigate whether clients (i.e., parents) are abusing substances. At two of the AFF sites (AZPAC Yuma and WestCare), Jobs staff noted the problems they had experienced in trying to get their clients to accept referrals to AFF. Some Jobs staff, for example, described how they had clients who refused to accept the AFF referral because they feared they might be reported to CPS due to their substance abuse problem, and consequently, could lose their children. Other Jobs staff discussed the fear among Jobs clients that they would lose their cash assistance benefits if they participated in AFF.

2. Assessments

AFF provider agencies are expected to make efforts to complete the substance abuse assessments of clients referred to AFF within five days following outreach and screening. The five AFF provider agencies that do not directly provide Title XIX services (AZPAC Coconino, AZPAC Yavapai, AZPAC Yuma, WestCare, and Old Concho) work with RBHA providers to facilitate the assessment of Title XIX clients. AZPAC Coconino and AZPAC Yavapai also use local subcontractors to conduct the assessments of their non-Title XIX AFF clients. For CPSA, TERROS, SEABHS, and Horizon, the assessments are administered by the agency staff or through coordinating activities within their provider networks (e.g., sharing assessment duties with subcontractors). Two of the AFF provider agencies (WestCare and Horizon) conduct the assessments at the same time as the screening due to the constraints posed by large geographic distances. The other AFF provider agencies conduct the assessments during a second meeting that follows the outreach and screening.

In general, the assessments typically take from one and a half to three hours to complete, and sometimes longer when dealing with issues such as learning disabilities and illiteracy. AFF provider agencies are required by program policy to conduct a comprehensive assessment that includes a biopsychosocial assessment; a family-centered interview; the use of any collateral information available from the referring agency, the court, or other agencies that

[8] During the Level II trainings conducted by ADES in FY 2002, an effort has been made to include more training to benefit Jobs workers on how to identify substance abuse problems and make referrals.

have had involvement with the client; and an assessment tool prescribed by ADES.[9] Until March 2002, AFF provider agencies were required to use the Substance Abuse Subtle Screening Inventory (SASSI-3). The March 1, 2002 contract amendments for AFF provider agencies specified a change with respect to the screening and assessment instruments to be used. In order to collect assessment data for the evaluation that would allow for repeated follow-up measurements, ADES required that AFF provider agencies begin using the Addiction Severity Index-Lite instead of the SASSI-3 during the assessment process. The SOCRATES, previously used for screening, was eliminated, and in its place the SASSI-3 was specified as the tool to be administered during the screening process. The ASI-lite is administered at all AFF sites as part of the initial assessment, then again at six month and 12 month follow-up points. Interviews with all AFF program directors at the end of FY 2002 revealed that all of the provider agencies had obtained the ASI training materials and were implementing the ASI-Lite as their assessment tool.

Exhibit III-17 presents data on assessments completed[10] during the first year of the program. Information is presented by quarter for each of the AFF providers and Statewide.

Exhibit III-17
Number of Assessments by Quarter: Project Inception through March 31, 2002

	Provider Site									
	AZPAC Coconino	**AZPAC Yavapai**	**AZPAC Yuma**	**CPSA**	**Horizon**	**Old Concho**	**SEABHS**	**TERROS**	**West Care**	**All Sites**
<Mar 2001	1	1	0	18	3	7	0	23	1	54
Mar - Jun 2001	1	19	4	82	26	17	13	103	14	279
Jul - Sep 2001	1	12	4	93	27	13	17	83	4	254
Oct - Dec 2001	15	29	3	75	15	19	5	92	4	257
Jan - Mar 2002	6	10	2	57	4	3	15	59	6	162
Total	24	71	13	325	75	59	50	360	29	1,006

These data indicate the following:

- Overall, the number of assessments completed statewide was constant during the first three quarters (average of 263 per quarter); this number dropped in the fourth quarter to only 162 assessments (63% of the previous quarter's assessments).
- All AFF provider agencies except for SEABHS and WestCare experienced a drop in the number of assessments from the third to the fourth quarters.
- SEABHS experienced a marked decrease in assessments in the third quarter, which corresponds to their decreased number of referrals during that quarter. This can be explained by loss of subcontractor outreach staff at that time who were no longer available to conduct outreach for SEABHS due to budget cuts.
- Data for other AFF provider agencies that completed fewer assessments in the fourth quarter are congruent with their decreased number of referrals during the quarter. It is

[9] Four AFF provider agencies were using other assessment instruments in addition to those required by ADES. For example, TERROS used the EUREKA because it is required by the RBHA; AZPAC Yuma, WestCare, and Horizon used the CAGE and the MAST.
[10] The term "completed assessment," used throughout this report, refers to when clients referred to AFF follow through with having a substance abuse assessment completed.

possible that the data are reflections of concerns voiced by program directors and referral agencies during the site visits, that fears of proposed AFF budget cuts may have created some hesitancy in communities with respect to continuing to refer new clients to AFF.

3. Levels of Client Engagement in Treatment

Engagement in treatment services was one of the suggested performance measures specified by the AFF Steering Committee at the inception of the program. **Exhibit III-18** presents data, by site, on levels of engagement for the nine AFF provider agencies for the year-to date (March 1, 2001 through March 31, 2002). The data indicate the following:

- Statewide, 70 percent of referrals received assessments, 80 percent of completed assessments had service plans developed, and 99 percent of service plans resulted in receipt of treatment services.
- Seven of the nine AFF provider agencies completed assessments on 70 percent or more of their referred clients. AZPAC Coconino (89%), AZPAC Yavapai (84%), Horizon (87%), and SEABHS (94%) show the highest percentage of referrals that resulted in completed assessments.
- A comparison between the two large urban AFF sites with high numbers of referrals (TERROS and CPSA) indicates that TERROS completed assessments on 59 percent of referred clients compared to the 74 percent of referrals that were assessed at CPSA. CPSA's streamlined system of using only one subcontractor to conduct assessments may be a possible explanation for their success in comparison to TERROS. Another factor could be that referred clients at TERROS may be less willing to follow through with the assessment if CPS has closed their case and is no longer involved (CPS workers in District I reported that they close protective services cases upon referral to AFF if they determine that the child is safe and no longer at risk for maltreatment).
- Overall, 80 percent of assessed clients had a service plan developed. AZPAC Yavapai (93%), AZPAC Yuma (85%), SEABHS (94%), and TERROS (89%) show the highest percentage of assessed clients with a service plan developed.
- A comparison between TERROS and CPSA shows that TERROS developed service plans for 89 percent of its assessed clients whereas at CPSA, service plans were developed for 79 percent of clients that were assessed. At TERROS, the service planning takes place at the end of the assessment meeting, and at CPSA, service plans are developed at a separate meeting scheduled after the assessment. This difference might partially account for TERROS' slightly higher rate of developing service plans.
- A consistent pattern was that at six of the nine AFF sites, 100 percent of clients with a service plan went on to receive treatment services (i.e., received at least one treatment service). At all AFF sites, 91 percent or more of those with a service plan received treatment services.

Exhibit III-18
Levels of Client Engagement by Provider: March 1, 2001 - March 2002

	Provider Site									All Sites
	AZPAC Coconino	AZPAC Yavapai	AZPAC Yuma	CPSA	Horizon	Old Concho	SEABHS	TERROS	West Care	
Total Clients Referred	27	85	18	442	86	91	53	606	39	n=1,447
Number of Referrals that Received Assessment	24	71	13	325	75	59	50	360	29	n=1,006
Number of Assessments Where Service Plans were Developed	19	66	11	257	41	28	47	320	14	n=803
Number of Service Plans that Resulted in Services Received	19	65	10	247	41	28	12	320	14	n=756

In **Exhibit III-19,** Statewide levels of engagement rates are summarized for the first year of the program. This chart highlights the following:

- Fifty five percent of the total clients referred to AFF are subsequently engaged in treatment services.[11] This engagement rate is very encouraging with respect to clients identified as needing treatment who are receiving services.

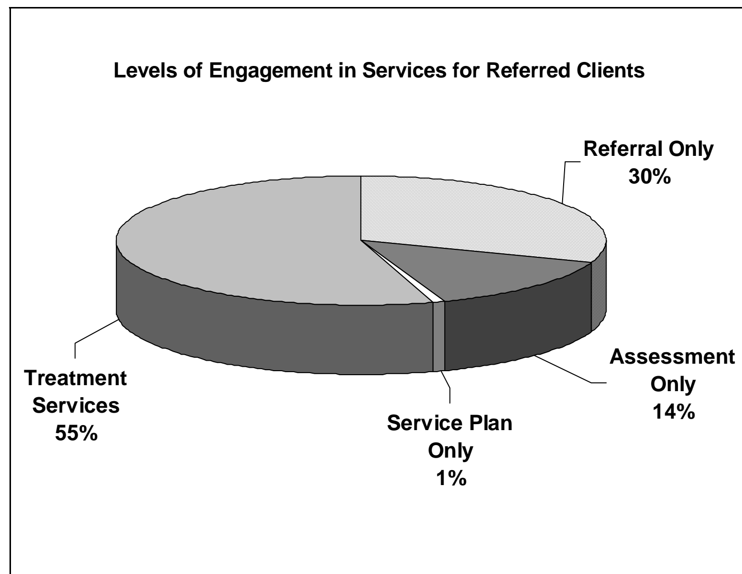
- Thirty percent of clients did not receive any services beyond the referral. An additional 14 percent drop out after the assessment.

- Once a client receives an assessment, the data indicate that the client is likely to have a service plan developed and enter treatment.

- Of those clients who have a service plan developed, only one percent drop out before receiving services.

[11] Project Safe, operated through the Connecticut Department of Children and Families, reported that over a four and a half year period, only 37 percent of caregivers referred by the child welfare agency for assessment and treatment services actually engaged in treatment (www.maine@aan.usm.edu/nosafe/sheehan.html; accessed on 10/25/02).

Exhibit III-19
Statewide Levels of Engagement in Arizona Families F.I.R.S.T.
For Clients Referred through March 31, 2002
(n = 1,447 clients)



4. Substance Abuse Treatment Services

As specified in the AFF program requirements, provider agencies were expected to develop a comprehensive continuum of treatment services to support clients in their recovery. These *treatment modalities* include the following services:

***Substance Abuse Education*:** These services are short term in duration and are appropriate for clients who are unwilling to commit to more intensive services. Attendance at substance abuse awareness groups and individual counseling to consider the effect of substance abuse on one's life would be included under substance abuse education. While clients who are eligible for Title XIX services wait for their approval and enrollment in the Arizona Health Care Cost Containment System (AHCCCS), substance abuse education services are available to these clients.

***Outpatient Treatment Services*:** Outpatient treatment services are intended for clients who can benefit from therapy, are highly motivated, and have a strong support system. These clients need a minimum level of intervention and other supports. Service providers are required to provide a minimum of three hours per week of individual or group treatment (or a combination of both).

Intensive Outpatient Treatment Services: Intensive outpatient services are intended for clients who can benefit from structured therapeutic interventions, are motivated, and have some social supports. This continuum of services is appropriate for clients who need a moderate amount of therapy and supports. At a minimum, service providers are expected to provide nine hours per week of therapy for a minimum of eight weeks. This therapeutic involvement can include individual, group, and family therapy; substance abuse awareness; and social skills training.

Residential Treatment: Residential treatment services are intended for clients who need an intensive amount of therapeutic and other supports to gain sobriety. These services include 24-hour care and supervision. And similar to intensive outpatient treatment, residential

treatment can include individual counseling, group therapy, family therapy, substance abuse awareness, and social skills training. Residential treatment may include children residing with parents while the parents are in treatment.

Aftercare Services: Aftercare services are to be provided for all clients. At a minimum, the aftercare plan should include a relapse prevention program, identification and linkage with supports in the community that encourage sobriety, and available interventions to assist clients in the event that relapse occurs. Development of the aftercare plan is expected to begin while the client is in treatment.

Across the nine AFF provider agencies, the majority of AFF providers use subcontractors to provide a range of direct clinical services to clients, as well as drug testing. Five AFF providers (AZPAC Coconino, AZPAC Yavapai, AZPAC Yuma, CPSA, Old Concho, and SEABHS) use subcontractors to provide counseling, outpatient, and intensive outpatient services. Four AFF providers (AZPAC Coconino, AZPAC Yavapai, AZPAC Yuma, and TERROS) use subcontractors to perform drug screening and testing. Only three providers (AZPAC Coconino, Old Concho, and TERROS) use subcontractors to conduct assessments. Subcontractors also are utilized by some AFF provider agencies, such as Old Concho, TERROS, and SEABHS, to provide residential treatment services. Subcontractor agencies also are employed for other types of services, such as outreach and engagement and a wide range of supportive services. For example, subcontractors working with AZPAC Yuma provide job placement and childcare services. Subcontractors to Old Concho provide domestic violence services, emergency housing assistance, and aftercare services. SEAHBS utilizes subcontractor agencies to provide parenting skills training, peer support and mentoring, self help groups, and employment counseling.

a. Determining Levels of Care

At all nine AFF sites, substance abuse treatment providers who were interviewed during site visits indicated that they used multifaceted processes to determine the level of care and the specific treatment modalities for AFF clients. The primary factors are taken into consideration when planning the most suitable treatment for clients include information gathered through the assessment, the client's substance abuse history, prior treatment history, the particular circumstances and environment surrounding the client, and the client's willingness and motivation to address the substance abuse problem. Interviews conducted with referral agency staff indicated that the referral agencies also submit background information when it is available in order to assist treatment providers in deciding upon the type of treatment that is appropriate for a client. Treatment staff explained that client input is a factor in determining the level of care that a client receives because clients sometimes are unwilling to participate in the recommended treatment program but will agree to an alternative form of treatment. For example, a treatment provider may recommend residential treatment if the client's history and assessment information warrants this level of care. However, if such clients cannot be convinced to enroll in a residential treatment program, treatment providers often will attempt to engage clients in the next level of treatment, which is intensive outpatient treatment. Another factor that can influence the level of care is a court decision, whereby judges sometimes make recommendations for a specific type of substance abuse treatment or level of care in CPS cases. In addition, level of care can be influenced, to some extent, by treatment availability and accessibility, as is the case with residential treatment for clients living in rural areas. In this example, there may be clients for whom residential treatment is recommended but the clients do not wish to relocate to Phoenix or Tucson for their treatment. Some of the providers and treatment staff interviewed (TERROS, Horizon, CPSA, and SEABHS) reported that they also utilize criteria from the American Society of

Addiction Medicine (ASAM) as a clinical standard to determine recommended levels of care.

Data presented in this chapter on treatment services utilized by participating clients includes information reported for AFF non-Title XIX clients (who received ARS 8-881 funded services) as well as AFF Title XIX clients (who received Medicaid funded services)[12]. Service data for non-Title XIX clients was submitted to the evaluator by the AFF provider agencies. Data for Title XIX clients was obtained from the ADHS data systems. For all clients, any services received by clients through March 31, 2002 were included. ADHS staff assisted the evaluator in mapping ADHS services to the corresponding AFF treatment modalities and services, where possible. A copy of the mapping document used in tabulating treatment services is included in Appendix A. Sometimes, there were services that could not be matched across the two systems. For example, for non-Title XIX clients, the modality called Aftercare is different for the Title XIX clients, who receive an array of different services following their formal treatment but these are not specifically called aftercare services. In our presentation of data on treatment services for Title XIX and non-Title XIX clients, we have used the major treatment modality categories developed for the AFF program by ADES.

b. Definitions of Primary Treatment Level Groups

In an effort to utilize client-level data to understand the combinations of treatment services utilized by AFF clients, our initial review of utilization data revealed that there was no particular sequence of services that characterized a participating client's experience. Rather, most clients fell into a range of different combinations of treatment services. In order to better understand the patterns of service utilization and variation in treatment services, different "primary treatment level groups" were identified. These groups were based on a hierarchical continuum of most intensive treatment type to least intensive treatment. The groups correspond to the AFF treatment modalities. However, participating clients were counted in only one group so that these represent mutually exclusive categories. The specific definitions of each primary treatment level group follow:

- **Residential Treatment Group:** This group includes any participating clients who received residential treatment services. Hence, even if these clients received other kinds of treatment, their most intensive treatment received was residential treatment.

- **Intensive Outpatient Group (IOP):** This group includes any participating clients who received intensive outpatient services and did not receive any residential treatment. Thus, the most intensive treatment received by this group was intensive outpatient treatment.

- **Outpatient Group (OP):** This group includes any participating clients who received outpatient services and received neither residential treatment nor intensive outpatient treatment services. Hence, the most intensive treatment that this group received was outpatient treatment.

Of the 803 participating clients, there were 137 clients who fell into the residential treatment group, 79 clients in the IOP group, and 434 clients in the OP group. There were 153 participating clients who did not fall into one of these three groups. In other words, these clients did not receive residential, IOP, or OP services but instead received some other type(s) of services, such as substance abuse education, support services, psychological evaluations, and case management.

[12] Some Title XIX AFF clients received services funded by ARS 8-881, such as supportive services and substance abuse education.

c. Treatment Services Data

Exhibit III-20 presents information for participating clients in the primary treatment level groups and the secondary treatment services that they received. Percentages are reported to provide a general understanding of the types of secondary services received in relation to primary treatment.

Exhibit III-20
Client's Primary Substance Abuse Treatment Level Group and Secondary Services: March 2001 - March 31, 2002
(n = 803 participating clients)

	Residential Treatment	Intensive Outpatient Services	Outpatient Services	None of the Above
Number in Treatment Level	N = 137	N = 79	N = 434	N = 153
Percent that also received these Secondary Services:				
Intensive Outpatient Services	26%			
Outpatient Services	58%	67%		
Aftercare	4%	5%	8%	
Social Supports	39%	61%	30%	29%
Education	7%	11%	15%	33%
Detoxification	1%	1%	2%	1%
Medication	18%	5%	9%	5%
Other Services	55%	65%	60%	49%

Note: Aftercare is a term used by AFF providers to describe a range of services such as relapse prevention programs, identification and linkage with supports in the community that encourage sobriety, and interventions to assist clients in the event that relapse occurs. This category is reported when AFF providers bill ADES for aftercare services. RBHA providers would not call these services “aftercare” but still provide a range of continuing services to clients. Examples of “other services” include case management, psychological exams, and urinalysis.

- Among clients in the residential treatment group, 58 percent also received OP services, 26 percent received IOP services, and 39 percent received social supports.

- Clients in the IOP group also received OP services (67%) and social supports (61%). The high level of social supports associated with IOP services may relate to the intensity of this service, where clients are expected to attend treatment for at least nine hours per week for a minimum of eight weeks. The demands on clients may create other needs for supportive services such as child care, transportation, and emergency financial assistance.

- Thirty percent of clients in the OP group also received social supports, 15 percent received substance abuse education, and 60 percent received other services. These other services included case management (60%), psychological exams (15%) and urinalysis (11%).

- One possible explanation of the finding that clients are accessing outpatient services at a much higher rate than intensive outpatient services may be a reflection of the reality of what clients are able to handle in terms of the demands of an intensive treatment program. It is possible that the 434 clients in the OP treatment group include some individuals who were unable to attend the nine hours per week required for IOP, and consequently, these clients fall into the OP treatment group because outpatient services were billed for these clients. Another explanation may be that clients did not need

intensive outpatient services and that outpatient services were sufficient to address their needs.

- Treatment combination patterns reflect the treatment philosophy of AFF where clients are offered a range of intensive service options. For example, the finding that 61 percent of clients in the IOP group also receive social supports suggests that AFF is working with those families to help them stay in their homes and provides them with supports while they are in treatment (instead of trying to place all clients needing an intensive treatment experience in residential treatment).

As reported in the April 2002 quarterly evaluation report, interviews with substance abuse treatment providers indicated that substance abuse education was one of the frequent services utilized by AFF clients. Substance abuse education services are reflected in Exhibit III-20 under "education." Also, many of the clients who did not receive residential treatment, intensive outpatient treatment, or outpatient services may have received substance abuse education (n = 153 clients). Substance abuse education was described by treatment providers as an activity frequently offered in group settings following a client's assessment. This education is intended as a means to further engage the client in treatment. In many of the rural AFF sites, clients begin to participate in a substance abuse education group immediately following their assessment and then enter an intensive outpatient services program within a few weeks.

Treatment providers also indicated during onsite interviews that intensive outpatient service is one of the other types of service utilized most often by clients. Although the service data do not reflect this trend (i.e., a majority of participating clients fall into the outpatient services treatment level group), it is possible that from a service planning perspective, treatment providers had planned IOP services for a majority of clients. However, as discussed above, the reality may have been that clients were not able to participate in treatment at the level required for IOP services, and, consequently, the treatment they received could instead reflect that they utilized OP services. Intensive outpatient programs are frequently utilized as a treatment modality by the AFF and RBHA providers for AFF clients who require a more intensive level of treatment. According to treatment providers interviewed, most of the clients enrolled in intensive outpatient services have serious substance abuse problems and have experienced a serious family crisis (e.g., family breakup, children removed by Child Protective Services, criminal justice involvement). These clients are typically offered an intensive outpatient program that consists of participation in a group meeting three times a week for eight to 12 weeks. According to ADES AFF billing guidelines, clients must attend a minimum of nine hours of treatment per week if enrolled in intensive outpatient services in order for the AFF provider agency to receive reimbursement at the intensive outpatient services rates. If AFF clients attend fewer than nine hours of treatment per week, AFF provider agencies may bill ADES at the lesser outpatient services rate, which requires only three hours of service per week. Some of the intensive outpatient services programs that are provided to Title XIX clients through RBHA providers consist of fewer than nine hours per week of services because these programs operate under RBHA and ADHS guidelines rather than under AFF policies.

Several of the RBHA providers offer programs for clients with co-occurring conditions, designed to ensure that clients with mental health issues that co-exist with substance abuse problem can receive treatment that is integrated to address both problems. ADHS has encouraged the development of these programs through grants and technical assistance to CPSA, TERROS, SEABHS, and Mohave Mental Health Clinic.

The reduction of client attrition is a primary challenge for all of the AFF provider agencies. When clients miss treatment sessions, AFF program staff follow up with the client by making home visits alternatively, telephone calls in an effort to re-engage them. Each of the AFF provider agencies has designated staff (usually case managers or assistants) who make the follow-up telephone calls and conduct home visits. For example, SEABHS utilizes transportation aides to make home visits because many of their clients do not have telephones. The AZPAC Yavapai AFF case managers make telephone calls or home visits, as well, to follow up with clients who have missed their treatment appointments. Treatment providers at all AFF sites rely on CPS or JOBS case managers to help them determine why clients are missing appointments. They also rely on CPS and JOBS staff to help encourage the clients' participation in treatment. AFF provider agencies indicated that working with the CPS or JOBS case manager has proved to be effective in keeping the client engaged, except in cases where the referring agency has closed the case once the client has been referred to AFF.

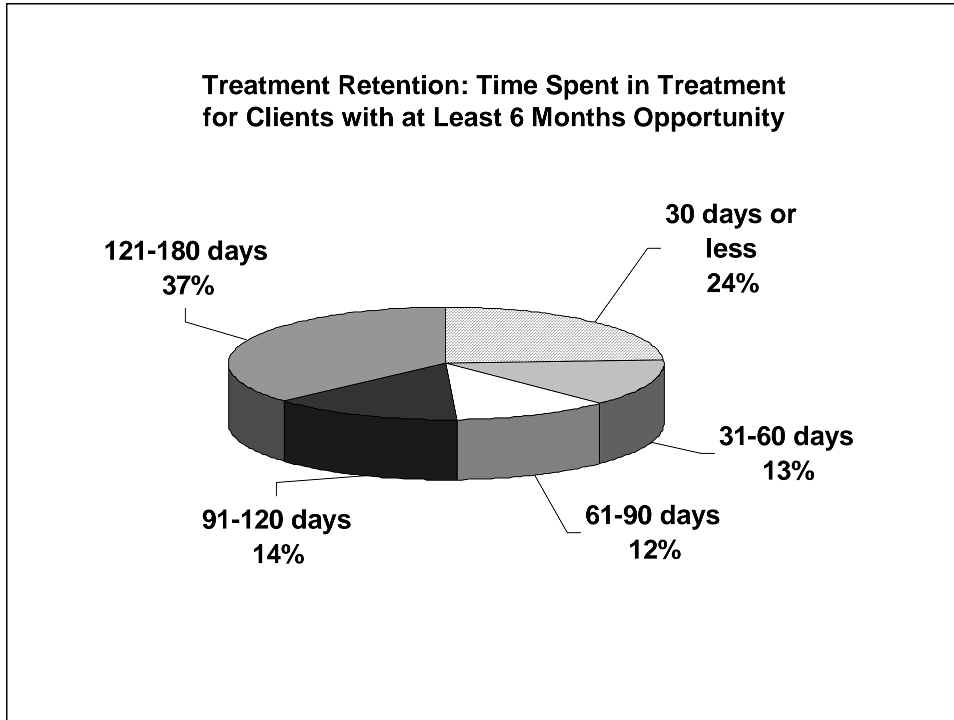
Several AFF program directors indicated that they were concerned that CPS clients without court involvement were less likely to follow through with treatment than those who had court involvement and children in foster care, which can serve as a strong motivating factor. Treatment providers interviewed during the site visits indicated that, in their experience, individuals are more likely to attend group sessions regularly and to complete treatment if they have been ordered to do so by the court, because they will face major consequences for failure to comply (e.g., loss of a driver's license, loss of child custody, jail time).

As AFF program directors reflected back over their first year of providing AFF services to clients, all nine program directors reported that their agencies' service delivery systems have changed since the implementation of AFF. Program directors consistently reported that services are delivered differently now than compared to before AFF program implementation with regards to the theoretical approach, as well as the actual service delivery. Program directors described the service approach to be more holistic, family-centered, and empowerment-focused. Services delivery was described to be more individualized, coordinated, strength-based, and comprehensive with the implementation of AFF. Data from client focus groups echoed these sentiments as clients described their services as individualized. Clients also described their satisfaction with support services such as rent and access to housing and parenting classes. The wrap-around service model, which has allowed for greater flexibility in the types of services offered to clients (e.g., support services such as transportation and child care), coupled with the funding of services not previously funded (e.g., outreach and engagement of clients) has also made it easier for clients to access the services they need, as voiced by both clients and AFF program directors.

5. Time Spent in Treatment

Exhibits III-21 and **III-22** display findings with respect to lengths of stay in treatment services for clients that had an opportunity to spend at least six months in treatment (i.e., enrolled in AFF by September 30, 2001) and for clients that had a 12 month opportunity to receive treatment services (i.e., enrolled in AFF by April 1, 2001).

Exhibit III-21
Length of Stay in Treatment for Clients with 6-Month Opportunity: March 2001 - March 31, 2002
(n = 238)

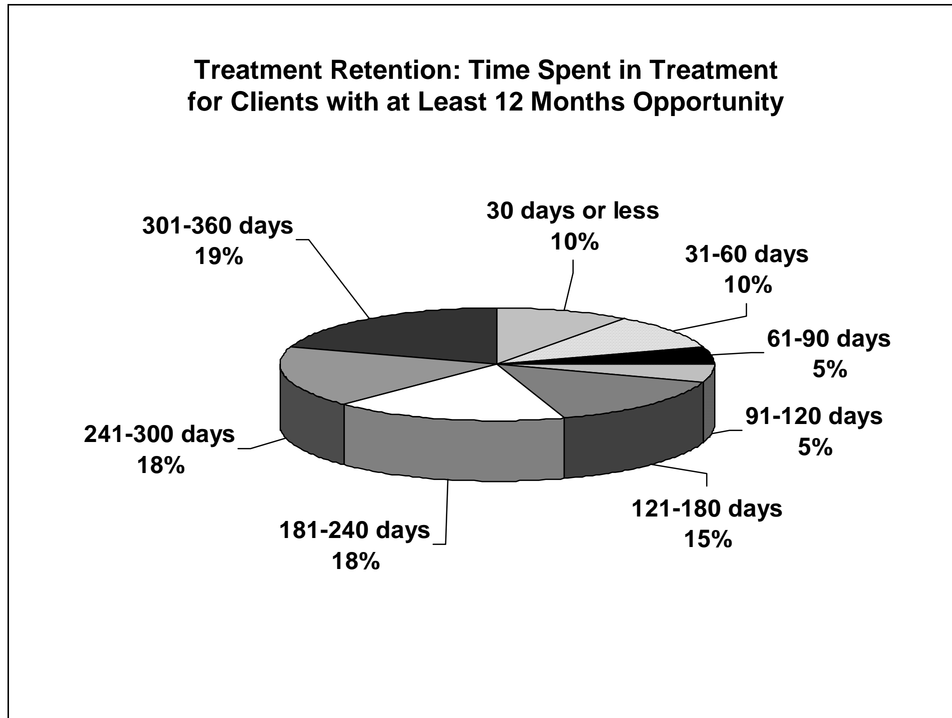


Note: Includes clients enrolled by September 30, 2001.

- For participating clients enrolled in the program by September 30, 2001, over half (51%) remained in treatment for three months or longer.

- Thirty seven percent of clients remained in treatment for at least four to six months.

Exhibit III-22
Length of Stay in Treatment for Clients with 12-Month Opportunity: March 2001 - March 31, 2002 (n = 40)



Note: Includes clients enrolled by April 1, 2001.

- Among the clients referred to AFF by April 1, 2001 (who had an opportunity to spend 12 months in treatment), over 55 percent stayed in treatment for six months or longer.
- Eighteen percent of clients remained in treatment for eight months to ten months.
- Almost 20 percent of participating clients stayed in treatment for 10 months or longer.

Research on the effectiveness of substance abuse treatment programs has documented that a client's length of stay in treatment is an important factor. The length of time spent in treatment is a predictor of successful outcomes with the typical result being that the longer a client stays in treatment, the better the outcome (e.g., the more likely it is that treatment will result in long-term behavior change).[13] Overall, the findings on length of stay in treatment are indicative of intermediary outcomes that show how AFF participating clients who are engaged in treatment, are in fact, remaining in treatment for several months.

[13] Hubbard, R. Marsden, M., Rachal, J., Harwood, H. Cavanaugh, E., & Ginzburg, H. (1989). Drug Abuse Treatment: A National Study of Treatment Effectiveness. Chapel Hill: The University of North Carolina Press.

CHAPTER IV
PERCEPTIONS OF TIMELINESS, AVAILABILITY, AND ACCESSIBILITY OF SERVICES

Throughout the first year of the program, the evaluation of AFF included the collection of process data and reporting on program implementation in quarterly evaluation reports. Each quarter, the focus of reports shifted to different topics in order to assess the progress that AFF provider agencies had made in those areas. In this chapter, process findings from data collected at the end of fiscal year 2002 are presented. In specific, process data were focused on addressing preliminary changes with respect to the timeliness, availability, and accessibility of services, which were among the legislative outcome goals established for AFF. In addition, emerging findings on the implementation of collaborative partnerships across the nine AFF sites are presented.

Program directors from each of the nine AFF provider agencies were interviewed using a semi-structured interview protocol designed to systematically assess their perceptions regarding changes in the timeliness, availability, and accessibility of treatment services since the implementation of AFF in March 2001 **(see Appendix B)**. Interviews were completed during the fourth quarter, which allowed for providers to reflect on AFF service delivery after the first year of program implementation. Three interviews were conducted on-site (CPSA, TERROS, and SEABHS) in June 2002, and the remaining six interviews (AZPAC Yavapai, AZPAC Yuma, AZPAC Coconino, Horizon, Old Concho, and WestCare) were conducted via telephone in July 2002. The evaluator did not have an opportunity to assess timeliness, availability, and accessibility at the end of the fiscal year with other informants such as the RBHAs and local treatment providers, so it is important to emphasize that the information presented is based upon the perceptions of AFF providers.[1]

Several indicators were used to assess timeliness, including: days (maximum and average) between screening, assessment, and completion of service delivery plan; perceived wait time (maximum and average) for appointments; the role of collaborative partnerships in increasing timeliness of services; and perceived changes in timeliness since program implementation. Availability was gauged by the following indicators: perceived program capacity; service gaps; service additions and service deletions; service reductions; services covered by the programs; minimum program requirements for substance abuse services; the role of collaborative partnerships in increasing the availability of services; and changes in availability since program implementation. Finally, accessibility was assessed using the following indicators: service utilization; wait lists; hours of operation; transportation; the role of collaborative partnerships in increasing the accessibility of services; and changes in service accessibility since program implementation

Interviews and focus groups conducted with clients during the third quarter focused on their level of satisfaction with treatment services, and obtained some limited information with respect to their early perceptions of the timeliness, availability, and accessibility of the treatment services they received. Finally, data collected from providers regarding the dates of clients' assessments and first treatment services allowed for a quantitative analysis of AFF provider agencies' level of compliance with the policy requirements regarding service timeframes.

The findings discussed in this chapter with respect to timeliness, availability, and accessibility of treatment services, and some of the different perceptions reported by AFF provider agencies, can be better understood when placed in the context of some basic structural differences among the AFF provider agencies. **Exhibit IV-1** provides information regarding each AFF provider agency in terms of

---

[1] Since the time these interviews were conducted in early summer 2002, staff from the Division of Behavioral Health Services, ADHS, have convened several meetings in local communities with RBHAs and AFF provider agency staff to address issues regarding coordination of services for Title XIX AFF clients and to improve communication systems.

whether the agency is located in an urban or rural area, the percent of overall (Statewide) AFF participants served by the provider agency, and whether the AFF provider agency has direct experience providing Title XIX services.

A. Timeliness of Services to Clients

The RFP for AFF mandates several different timeframes that AFF provider agencies must adhere to when serving AFF clients. With respect to outreach and engagement, AFF provider agencies are required to make the first outreach attempt with clients within 24 hours of their referral to the program. AFF provider agencies are also required to make at least three attempts to contact the client during the outreach phase. After the client has been contacted and an initial substance abuse screening has taken place, AFF provider agencies are required to assess the client within five working days (one week) of the screening and to subsequently develop a service plan within five working days (one week) of the assessment. The RFP does not mandate the timeframe from service plan development to engagement in treatment services, but a theoretical model included in the RFP provides a timeframe that clients should receive their first therapeutic service within 14 days of their referral.

Prior to conducting an assessment, the AFF provider agency checks on the client's Title XIX status.[2] If AFF clients are Title XIX eligible (enrolled in Title XIX), the client is sent to the RBHA or the local RBHA provider for the assessment. Otherwise, the AFF provider conducts the assessment. If the client is likely to be eligible for Title XIX, the client is referred to the RBHA. However, services are to be provided by AFF until Title XIX eligibility is determined.

In general, AFF provider agencies conduct the assessment for non-Title XIX AFF clients, or use subcontractors, and the agencies that provide the treatment services typically develop the treatment plan for clients. AFF provider agencies are still responsible for developing the overall service plan, regardless of whether they serve the client directly or whether a subcontractor provides the treatment service.

Program directors from each of the nine AFF provider sites were asked about their perceptions regarding the timeframes within which clients referred to AFF receive assessments, have service plans developed, and are engaged in at least one treatment service. Program directors were asked to report their perceptions of the average, as well as the maximum, number of days for each timeframe specified. In general, program directors reported average timeframes within the requirements of the program.

[2] Title XIX eligibility status (i.e., whether the client is already enrolled in Title XIX) should be determined by the AFF provider agency. Title XIX status is usually checked using the Medifax system. AFF provider agencies that are Title XIX providers are able to determine eligibility status quickly, whereas some of the AFF provider agencies that are not Title XIX providers have required training regarding the determination of a client's Title XIX eligibility status. ADHS staff have addressed local issues pertaining to the determination of eligibility status as they arise by working closely with AFF provider agencies to help them identify whether an AFF client is already enrolled in Title XIX. Both ADHS and the RBHA believe that Title XIX eligibility is currently identified as quickly as possible.

Exhibit IV-1
Characteristics of AFF Provider Agencies

AFF Provider Agency	District Served	Counties Served	Urban / Rural	Percent of AFF Participants Served by Provider Agency (n=803 participants statewide)	Experience as a Title XIX Provider*
TERROS	I	Maricopa	Urban	40%	Title XIX Provider
CPSA	II	Pima	Urban	32%	Title XIX Provider (RBHA Agency for District II)
AZPAC Yavapai	III	Yavapai	Rural	8%	Non-Title XIX Provider
Old Concho	III	Navajo and Apache	Rural	3%	Non-Title XIX Provider
AZPAC Coconino	III	Coconino	Rural	2%	Non-Title XIX Provider
WestCare	IV	LaPaz and Mohave	Rural	2%	Non-Title XIX Provider
AZPAC Yuma	IV	Yuma	Rural	1%	Non-Title XIX Provider
Horizon	V	Pinal and Gila	Rural	5%	Title XIX Provider
SEABHS	VI	Graham, Greenlee, Cochise, and Santa Cruz	Rural	6%	Title XIX Provider

* Title XIX providers are able to serve both Title XIX AFF clients and non-Title XIX AFF clients. Non-Title XIX providers must send their Title XIX AFF clients to a Title XIX provider (i.e., RBHA subcontractor) for assessment and treatment services. The non-Title XIX AFF provider agencies are reimbursed by AFF for some services provided to Title XIX AFF clients; these include outreach and screening, education, aftercare, and support services.

1. Assessments

As discussed previously in Chapter III, WestCare and Horizon conduct assessments at the same time of the screening, while the remaining AFF provider agencies conduct the assessments at a second meeting that follows the outreach and screening. Program directors from eight of the nine AFF provider agencies reported conducting assessments within the required one week of client screenings. TERROS reported an average timeframe of seven to ten days, slightly longer than the required one week. TERROS reported that the average timeframe for conducting assessments includes many clients who were difficult to find or who did not show up for their assessment appointment, and that average timeframes are much shorter when those clients are not included. AZPAC Coconino reported that the development of a strong collaborative relationship with their local RBHA has helped them meet the AFF timeframes. In specific, the RBHA and AFF provider agency worked together to address what AFF providers perceived as a two-step process for conducting screenings and assessments at the local RBHA. The RBHA designated a liaison to work with AFF clients, allowing AFF clients to bypass the process of conducting screening and assessments on different days in order to complete their assessments in a timely manner in compliance with AFF program requirements.

Two of the rural AFF provider agencies that are non-Title XIX providers (AZPAC Yuma and WestCare) reported that they were unaware of the length of time it takes AFF Title XIX clients

to be assessed by the local RBHA agency. This could be due to the fact that both agencies had new program directors who had been working on the project for less than three months, and both agencies had referred relatively few Title XIX AFF clients to the RBHA. This suggests that there is a need for increased communication and coordination between these AFF providers and their local RBHAs. Other non-Title XIX AFF provider agencies have established effective working relationships with their RBHAs and know when the Title XIX AFF clients are assessed, the findings of the assessment, the recommended treatment plan, etc. Such coordination was not yet in place at AZPAC Yuma and WestCare at the time of data collection during June and July 2002. However, as indicated earlier in this chapter, meetings between the AFF providers, local RBHAs, and ADHS have taken place in recent months to help institute improved communication at the local level.

2. Service Plans

Six of the AFF providers reported timeframes for developing service plans were typically completed within the one week requirement. In fact, five providers reported average timeframes of one to two days, much less than the one week requirement. AZPAC Coconino reported slightly longer timeframes (5-10 days) for service plan development and cited uncooperative clients as the reason for this. AZPAC Yuma and WestCare, for the reasons discussed earlier, did not have information about timeframes for service plan development for their AFF Title XIX clients. Since AFF provider agencies are expected to develop service plans, more follow-up may be necessary with these AFF provider agencies to ensure that they understand the difference between a service plan and treatment plan (which the RBHA develops). Follow-up also may be necessary to ensure that these AFF providers are developing overall service plans for the Title XIX clients they refer to the RBHA.

Data submitted by AFF providers regarding the dates of assessments and service plans confirmed the reports of program directors. The median number of days between the completion of an assessment and the completion of service plan across the nine AFF providers agencies is four days, much shorter than the one-week time frame.

3. Engagement in Treatment

Six of the AFF providers reported that clients are engaged in treatment services within one week, on average, of the development of their service plans; one AFF provider reported that timeframes for engagement were sometimes longer than one week (Old Concho), and two AFF providers were unable to report timeframes for engagement in treatment for all their AFF clients (AZPAC Yuma and WestCare). Most of the providers who reported meeting the one week timeframe for engagement indicated that AFF clients begin treatment on the same day that their service plan is developed. Old Concho's program director perceived that there are extra steps involved with assessing and engaging Title XIX AFF clients at the local RBHA, which may extend the timeframe. However, this program director did not indicate an awareness of any interim services (e.g., pre IOP) that may have been provided by the RBHA to these clients. AZPAC Yuma and WestCare were unable to report the average number of days between service plan development and engagement in treatment services for AFF Title XIX clients for the reasons previously mentioned.[3]

Data submitted by AFF providers regarding the date of service plan completion and the date of a client's first treatment service confirmed the reports of program directors. The median number of days between the completion of the service plan and the date of engagement in treatment services across the nine AFF provider agencies is zero days, which confirms that clients are beginning treatment on the same day that their service plan is completed.

[3] It is important to place the reports from AZPAC Yuma and WestCare in the context of the overall program, and in specific, how these two provider agencies combined account for only 3 percent of all AFF participating clients.

4. General Factors Perceived to Affect Timeframes

While AFF providers reported that they had, in general, been successful in meeting required timeframes, they discussed various factors that resulted in deviations from timeframes, including individual client issues, program operations, types of services needed, and knowledge of the Title XIX service system. These are discussed in this section.

With respect to individual client issues, AFF provider agencies reported that common reasons for failing to meet timeframes include clients who do not show up for appointments or are uncooperative during the assessment or service planning period. Other reasons included difficulty finding or contacting clients due to incorrect addresses, lack of addresses, or lack of telephone service at the clients' homes. Finally, some providers reported incidents where clients were incarcerated or moved back to the Reservation.

Two AFF provider agencies reported deviations in timeframes that were related to program operations. For example, program directors at TERROS reported that some delays may be due to clinical staff who are not able to conduct the assessments or develop the service plans within the required timeframes because of the overwhelming amount of paperwork involved for each client. TERROS staff are currently addressing this issue through the formation of a paperwork reduction committee that is revising the assessment and service plan forms into shorter, more user friendly tools. Once the new forms are completed, TERROS will seek approval from ADES and begin to train their staff. TERROS believe that paperwork reduction will enhance the agency's capacity to respond to the AFF program's timeframe requirements.[4]

WestCare also reported staff-related delays in assessments due to the length of time it was taking to engage clients. WestCare has changed their outreach and engagement process by implementing a home visit component, rather than only telephone contact. Home visits and the delivery of home-based services are central components to WestCare's service delivery system, and the program director believes that these recent changes (made in the last four months) will increase the overall timeliness of service delivery for AFF clients.

With respect to the types of services needed, in general, all AFF providers reported differences in timeliness of services (i.e., wait times after development of a service plan) depending on the type of treatment that was needed for the client. Seven AFF provider agencies reported long wait times of up to four to six weeks for a client to be placed in residential treatment. CPSA, the only AFF provider agency that is also a RBHA, reported longer wait times for residential treatment and methadone treatment for non-Title XIX AFF clients because more treatment slots are available for Title XIX clients. AZPAC Yavapai and AZPAC Yuma also reported wait times for intensive outpatient services that can take up to four weeks. All providers reported no wait times for outpatient services and substance abuse education, and only one AFF provider (WestCare), which has not yet developed a strong collaborative relationship with their local RBHA, perceived that the RBHA does not provide the supportive services necessary for the timely delivery of services (e.g., transportation). This perception suggests that the AFF provider agency needs to work more closely with their RBHA to understand what services can and cannot be covered through Title XIX.

Providers described services such as outpatient treatment and substance abuse education as having open-ended capacity and the ability to increase the number of treatment slots as the demand increases. Residential treatment, however, is limited in capacity with many provider agencies competing for beds in one residential treatment center that has only 12 to 15 beds.

[4] At the writing of this report, ADES reports that in recent months, the paperwork reduction plan has been implemented at TERROS.

Finally, perceptions in the overall timeliness of services varied with respect to knowledge of the Title XIX service system. In general, the five AFF providers that are not Title XIX providers (AZPAC Yavapai, AZPAC Yuma, AZPAC Coconino, Old Concho, and WestCare) reported longer wait times for Title XIX clients than for non-Title XIX clients for both intensive outpatient or residential treatment services. [5] AZPAC Yavapai reported that the extra steps involved with the assessment of Title XIX clients at the RBHA (screenings and assessments on different days) can delay the development of a service plan and engagement in treatment services. However, interim services may be provided by the RBHA without the provider's knowledge. Also, AFF pays for substance abuse education (e.g., therapeutic groups) to be provided to Title XIX clients while they are waiting to engage in their treatment program. In contrast, Horizon, which is a Title XIX provider, reported that there sometimes are more treatment slots available for Title XIX clients, which can result in more timely access to some services for Title XIX AFF clients than for non-Title XIX AFF clients.

5. Perceived Changes in Timeframes and Contributing Factors

All AFF program directors, with the exception of directors from AZPAC Yavapai and AZPAC Yuma, reported perceived changes in the timeliness of service delivery since the implementation of AFF. All seven of these AFF program directors reported that timeframes in which clients were referred, assessed and began treatment services have improved since the implementation of AFF and that clients are now engaged in services more quickly than they were before the AFF program. AFF program directors reported several factors which they believed contributed to the changes in timeliness of service delivery. Exhibit IV-2 reports the common cross-site reasons, which included: 1) AFF policies and requirements as outlined in the RFP; 2) monitoring of the AFF program by ADES staff through site visits and follow-up; 3) accountability to ADES for failure to meet requirements; 4) the outreach and engagement component of AFF that allows AFF provider agencies to bill ADES for time and resources spent conducting initial outreach and attempting to engage the referred client in the program; and 5) the AFF collaborative partnerships formed at each AFF provider site that has increased communication and awareness of services among referring agencies, RBHAs, and other substance abuse treatment providers in the community.

B. Perceived Availability of Services

In order to address the current availability of services, as well as changes in the availability of services since the implementation of AFF, program directors at each provider site were asked questions regarding their perceptions of the service gaps in their agencies and communities, their agencies' capacity to serve clients, and the level of service utilization.

In general, there were several reported gaps in services that were consistent among all AFF provider agencies. For example, all nine AFF program directors described a lack of residential treatment services available in their communities. CPSA also emphasized that a lack of residential treatment services for families, especially for fathers and their children, was a problem in all areas of the State. Four AFF provider agencies (CPSA, Old Concho, SEABHS, and WestCare) reported a lack of detoxification services or methadone clinics. Finally, several sites described the unavailability of aftercare services. With respect to having sufficient services available for particular types of treatment, all nine AFF providers reported adequate outpatient treatment and substance abuse education services.

When availability of services for Title XIX AFF clients and non-Title XIX AFF clients is examined from the perspective of AFF provider agencies, different responses emerged. Six AFF provider agencies (AZPAC Yuma, AZPAC Coconino, Horizon, Old Concho, TERROS, and WestCare) reported greater availability of services for non-Title XIX AFF clients, one agency (CPSA) reported

[5] These five AFF provider agencies, combined, serve only 16 percent of all AFF clients statewide.

greater availability for Title XIX clients, and two provider agencies (AZPAC Yavapai and SEABHS) reported that the availability of services was similar for Title XIX AFF clients and non-Title XIX AFF clients. At AZPAC Yavapai, where the program director reported no difference in the availability of treatment services for Title XIX and non-Title XIX AFF clients, there had been a high level of case coordination that had been implemented between AFF and the local RBHA during the past year, which was perceived to have contributed to increased availability of treatment services for all AFF clients.

Other factors that related to perceptions of the availability of services include urban and rural differences, program capacity, and the lack of a common terminology among Title XIX and non-Title XIX providers. These factors are discussed below.

1. Differences Between Rural and Urban AFF Provider Agencies

Program directors at other rural sites (AZPAC Yavapai, AZPAC Coconino, Horizon, SEABHS, and WestCare) conveyed difficulties in developing and sustaining an array of services in small, remote areas. These program directors in rural areas discussed how the small number of referrals in many remote areas does not warrant the expansion of service delivery into those areas. Instead, clients in these areas must access services in the nearest town or city, which could be more than 50 miles away (e.g., AZPAC Yavapai clients who live in East Yavapai receive services in Prescott, which is 50 miles away). An example is residential treatment, where provider agencies serving clients in rural areas do not have local residential treatment services and are forced to utilize residential treatment services several hours away in cities such as Tucson, Phoenix, and Flagstaff. Further, some provider agencies reported that due to the location of residential treatment, some clients with families or jobs prefer to stay in the local area and receive outpatient treatment instead. One provider agency (AZPAC Coconino) reported that clients choose to receive services in the local area rather than travel to an urban area that may have a slot (i.e., residential bed) open immediately, which increases the wait time for those clients.

AZPAC Yuma and AZPAC Yavapai described general deficits in support services such as child care and transportation to some parts of their service areas. Program directors pointed out that without the availability of support services in their communities, some of their clients are not able to access treatment services. These program directors believe that the AFF resources for support services had enabled them to begin addressing this problem.

Program directors also discussed issues of staff-shortage in rural areas. These same concerns were echoed by RBHA staff, who reported that there were problems with having sufficient staff in rural areas to meet the service needs, particularly with respect to a shortage of licensed therapists with substance abuse treatment credentials.

2. Program Capacity

All nine provider agencies reported that, at present, their programs have not had any problems meeting the outpatient service needs of their clients, and they did not foresee problems in the future with respect to meeting the need for outpatient services. Therefore, all nine AFF provider agencies presently have the capacity to keep pace with the current rate of referrals through outpatient treatment. However, the program directors described residential treatment, and in some cases intensive outpatient, as having a limited number of treatment slots available.

Five program directors reported that, overall, they perceived that the treatment services at their agencies are currently being fully utilized. Four program directors (AZPAC Yuma, TERROS, CPSA, and Old Concho) described some of their treatment services (or services offered through their agencies' subcontractors in particular service areas) as not being fully

utilized. TERROS reported that there are empty treatment slots for intensive outpatient, which is due in part to drop-out rates once clients begin treatment. If group treatment is involved, new clients must wait for a new cycle of treatment to being. Therefore, if clients drop out midway through treatment, those treatment slots remain empty until the beginning of a new treatment group.

Some of the AFF provider agencies reported that there are non-Title XIX providers in their local communities with open slots to provide outpatient treatment services to AFF clients but these slots are not being used. There are several reasons for this, including the fact that these providers are not approved as Title XIX providers and therefore cannot deliver services to Title XIX AFF clients; some AFF providers (e.g., CPSA) prefer to utilize Title XIX subcontractors in order to provide a seamless service system;[6] and the low number of overall referrals from CPS and Jobs at some AFF sites (e.g., AZPAC Yuma).

3. **Use of Different Terminology that May Affect Perceived Availability**
   It is possible that some of the different perceptions by AFF providers about service availability for Title XIX clients is the result of different terminology used to describe services. Interviews with ADHS administrators revealed that RBHA staff and AFF provider agency staff use different terms when describing the types of services available. Therefore, staff from the AFF provider agency may not understand that a service is available through the RBHA and vice versa. For example, the AFF program refers to all services provided to a client upon completion of the core substance abuse treatment services as "aftercare." The RBHA, however, does not refer to these services as "aftercare," but, instead, defines each type of aftercare service separately (e.g., job training). Therefore, AFF provider staff may need training on specifying the precise services needed (i.e., aftercare is a term that designates when services are provided; it does not define the specific service needs of clients).

   Another example is the availability of gender specific services. The RBHA does not use the term "gender-specific" to describe a particular type of service. Rather, gender specific treatment is considered an approach to service. Some AFF provider staff who view "gender specific" as a particular kind of service may not realize that gender-specific treatment guidelines are supported in the RBHA's overall approach to treatment. ADHS recognizes this problem with different language among Title XIX and non-Title XIX providers and is working on a service matrix that cross walks the services offered by the RBHA and AFF provider agency. This matrix, when completed, will be distributed to local RBHA and AFF provider agencies in order to deepen their understanding of the types of services available through each system.

4. **Perceived Changes in Availability and Contributing Factors**
   In general, seven AFF provider agencies perceived that there had been an increase in the overall availability of treatment services in their communities since the implementation of AFF. **Exhibit IV-2** reports the common cross-site reasons, which included: 1) AFF funding, especially for substance abuse treatment services for non-Title XIX clients and support services for both Title XIX and non-Title XIX clients; and 2) the AFF collaborative partnerships formed at each AFF provider site, which have increased the availability of treatment services (e.g., relationships with subcontractors to provide services has expanded) and increased the awareness of services among referring agencies (e.g., CPS), RBHAs, and other substance abuse treatment providers in the community.

[6] Administratively, it is easier for non-Title XIX AFF clients to begin treatment services with a Title XIX provider because the clients' Title XIX status may change during their service period. In specific, if non-Title XIX clients begin treatment with a Title XIX provider and eventually become Title XIX eligible, they would not have to change treatment providers.

Exhibit IV-2
Changes in Timeliness, Availability, and Accessibility of Services and Contributing Factors: Perceptions of AFF Program Directors

AFF Provider	Timeliness		Availability		Accessibility	
	Changes since March, 2001	Contributing Factors	Changes since March, 2001	Contributing Factors	Changes since March, 2001	Contributing Factors
AZPAC Yavapai	No changes	• Program director did not perceive an identifiable change in service delivery.	No changes	• Program director did not perceive an identifiable change in service delivery.	***Increased accessibility***	• Increased awareness of services through AFF collaboration • Increased support services (e.g., transportation) due to AFF
AZPAC Yuma	No changes	• There have never been waitlists in Yuma County (before or after the implementation of AFF	***Increased availability***	• AFF funding	***Increased accessibility***	• Increased accessibility for CPS clients offered through AFF
AZPAC Coconino	***Increased timeliness***	• AFF collaboration with RBHA	No changes	• Program director did not perceive an identifiable change in service delivery.	***Increased accessibility***	• Increased awareness of services through AFF collaboration • Increased support services (e.g... domestic violence services) due to AFF.
CPSA	***Increased timeliness***	• ADES policies • ADES monitoring • Outreach component of AFF	***Increased availability***	• Increased coordination of services due to AFF	***Increased accessibility***	• Increased coordination and awareness of services for CPS due to AFF collaboration
Horizon	***Increased timeliness***	• AFF funding • AFF flexibility of services • AFF collaboration	***Increased availability***	• Increased communication with referral sources (CPS and JOBS) due to AFF	***Increased accessibility***	• Increased coordination of services with referral sources (CPS and JOBS) through AFF collaboration
Old Concho	***Increased timeliness***	• AFF funding • Flexibility of services • AFF collaboration	***Increased availability***	• Increased coordination and awareness of services due to AFF	***Increased accessibility***	• Increased coordination an awareness of services through AFF collaboration • Increased access to individualized services due to AFF treatment philosophy

AFF Provider	Timeliness		Availability		Accessibility	
	Changes since March, 2001	Contributing Factors	Changes since March, 2001	Contributing Factors	Changes since March, 2001	Contributing Factors
SEABHS	***Increased timeliness***	• AFF funding • Increased capacity • ADES monitoring • AFF collaboration	***Increased availability***	• Increased coordination and awareness of services through AFF collaboration	***Increased accessibility***	• Outreach component of AFF
TERROS	***Increased timeliness***	• AFF funding • AFF program requirements • ADES monitoring • ADES accountability	***Increased availability***	• Increased network of services through AFF collaborative partnership	***Increased accessibility***	• Outreach and engagement component of AFF • Supportive services (e.g., child care and transportation) offered through AFF
WestCare	***Increased timeliness***	• AFF collaborative meetings with CPS, JOBS, and RBHA	***Increased availability***	• AFF resources • Increased awareness of services for CPS and JOBS through AFF collaboration	***Increased accessibility***	• Outreach and engagement component of AFF • Provision of home-based services • Increased awareness of services for CPS and JOBS through AFF collaboration

C. Perceived Changes in the Accessibility of Services

In order to address the current accessibility of services, as well as changes in the accessibility of services since the implementation of AFF, program directors at each provider site were asked about factors that affected clients' access to treatment services. These factors included transportation issues, the hours of operation for the AFF provider agencies, and priority to access services.

1. Transportation Issues

All nine AFF provider agencies provide transportation support services. The most common forms of transportation provided include taxi, bus, and fuel vouchers. Three AFF provider agencies (AZPAC Yuma, Horizon, and SEABHS) have subcontracts to provide transportation through a van service (e.g., Safe Ride). As reported earlier, AZPAC Yuma and AZPAC Yavapai perceive, in general, that there is insufficient transportation in their communities and that the transportation they provide through AFF is making an important contribution to their local areas.

About half of the AFF providers (TERROS, WestCare, CPSA, and SEAHBS) reported that transportation was not considered a barrier to any client accessing services. TERROS and WestCare both provide home-based services if needed, Horizon provides individual transportation and a van service, CPSA relies on their public transportation system with bus and taxi vouchers, and SEABHS provides van shuttle service and has a contract with Safe Ride.

For all other AFF provider agencies where lack of transportation was reported to be a possible barrier to accessing services, transportation services such as taxi and bus vouchers or van services are offered, but the distance (e.g., 50 miles) that some rurally based clients must

travel is too far for accessing these services or other forms of public transportation. Focus groups with program participants from these rural areas revealed similar concerns. AFF clients that live in remote areas reported that, while transportation was available to access services, it was difficult for them to participate in IOP services because the amount of time and travel, on a daily basis, was too burdensome (e.g., traveling more than one hour to attend a therapy session). Some distances also are too far for provider agencies to offer home based services on a regular basis. AFF provider agencies have been successful in developing an array of transportation options, but when individuals reside far away from communities where service providers are located, and the distances are too far for provider staff to make home visits, there may be no way to avoid lengthy travel times.

2. **Hours of Operation**
   Almost all AFF providers reported flexible hours of operation, which included the standard 9 am to 5 pm, Monday through Friday, hours along with evening and weekend hours. Some sites offer evening and weekend hours on an as needed basis (e.g., Old Concho), while other sites offer standard evening hours as late as 8 or 10 pm (e.g., AZPAC Coconino, CPSA, Horizon, SEABHS, and TERROS). CPSA and TERROS, the only two AFF provider agencies serving predominately well-populated, urban areas, were also the only sites that reported standard Saturday hours. AZPAC Yavapai and WestCare reported the most limited hours, 8 am to 5 pm, Monday through Friday, but staff do respond to pagers after hours (i.e., crisis hours).

3. **Clients' Priority to Access Services**
   Six of the nine AFF provider agencies service other clients in addition to their AFF clients, but only two of the AFF providers (CPSA and Horizon) have a priority system for accessing services. At these agencies, Title XIX AFF clients are the first priority, other Title XIX clients are the second priority, and all other clients are third. Although AZPAC Yavapai's program director indicated that AFF clients should have priority access over the other clients that their agency serves, there was no clear system for assuring that they did. The remaining three providers that serve other clients in addition to AFF clients reported that there is no priority system for accessing services.

4. **Changes in Accessibility to Services and Contributing Factors**
   All nine AFF program directors reported perceived changes in the accessibility of services since the implementation of AFF. All program directors perceived an increase accessibility to treatment services. AFF program directors reported several factors which they believed contributed to the changes in the accessibility of services. Exhibit IV-2 reports the common cross-site reasons, which included: 1) the family-centered treatment model implemented by AFF; 2) AFF programmatic components of the service delivery system that focus on family-centered, client-centered, comprehensive, coordinated services; 3) the funding and provision of support services, such as child care, transportation and housing; 4) the outreach and engagement component of AFF that allows AFF provider agencies to bill ADES for time and resources spent conducting initial outreach and attempting to engage the referred client in the program; 5) the AFF collaborative partnerships formed at each AFF provider site; and 6) the increased communication and awareness of services among referring agencies (e.g., CPS), RBHAs, and other substance abuse treatment providers in the community.

D. Implementation of Arizona Families F.I.R.S.T. Collaborative Partnerships

The requirements that each of the AFF provider agencies establish collaborative partnerships for AFF, or use existing collaborative partnerships, were specified in the initial program Request for Proposals (RFP). Collaborative partnerships are to provide guidance to AFF provider agencies and to ensure that provider agencies are delivering services to AFF clients in a comprehensive and integrated manner that responds to the cultural, demographic, and geographic diversity of the

community. AFF providers are encouraged to use collaborative partnerships as a way to address service gaps in their local communities and to enhance their overall service delivery system. Under the definition of a collaborative partnership in the RFP, a subcontractor that receives funding through ARS 8-881 may be a collaborative partner, but collaborative partners also should include State agencies, public and private community agencies, the RBHAs, faith based organizations, CPS, JOBS, service providers, domestic violence programs, housing, the juvenile court, treatment programs, and grass-roots organizations in local communities. The requirements include a provision that members of local collaborative structures should meet, at a minimum, on a quarterly basis. Quarterly meetings and minutes of those meetings are to be included as part of AFF provider agencies' contract requirements.

According to the ADES Substance Abuse Program Administrator, the requirement with respect to collaboration partnerships was based on knowledge about best practices and on the philosophy that a coordinated, community-based approach to substance abuse treatment and recovery can be particularly effective in addressing the treatment needs of clients as well as in helping to sustain their recovery and prevent relapse. In designing this AFF program component, ADES built upon its history of helping to establish collaborative community-based projects through funding from the Federal Family Preservation and Support Initiative.

As part of measuring systems change during the first year, the evaluation assessed the types of collaborative partnerships formed by each AFF provider agency (e.g., the agencies and organizations represented). Information was collected from AFF program directors regarding the collaborative partnerships their agencies had established in response to the AFF requirements.

The purpose of collecting this information was to gain an understanding of the structure of the interagency relationships and obtain insight into the motivation and level of commitment among the collaborating agencies and their local AFF providers. The types of information collected from all nine AFF sites included the following: 1) the name of each collaborating agency; 2) the type of service or function provided by each collaborating agency (e.g., referral source, treatment provider); 3) the type of link between the AFF provider agency and the collaborating agency (e.g., formal or informal); 4) the history of the collaborative relationship (e.g., the number of years the agencies have worked together); and 5) the collaborating agencies' level of participation in the AFF collaborative partnership meetings. This information can be found for each AFF provider agency in Appendix C.

1. Collaborative Partners: A Description

Exhibit IV-3 describes the collaborative partnerships at each of the nine AFF provider sites. This table includes the total number of collaborative partners working with each AFF provider agency, including the types of agencies and organizations represented, the type of interagency relationship that links the agencies with the AFF provider agency, (subcontractor vs. informal), the representatives who attend the quarterly AFF collaboration meetings, and the history of these collaborative relationships.

Collaborative partnerships varied across the nine AFF provider sites in terms of membership size, representation, and the history of the working relationships. The total number of collaborative members at a given AFF site ranged from four to 45 members, with CPSA and Horizon reporting the largest membership (25 and 45 partners respectively), and AZPAC Yuma and WestCare reporting the fewest members (four each). The number of years of collaboration ranged from one to 30 years, with the majority of AFF providers (AZPAC Coconino, AZPAC Yavapai, AZPAC Yuma, Horizon and WestCare) reporting only one to two year relationships with their collaborative partners. TERROS and SEAHBS, however, reported that they had worked with the majority of their collaborative partners for more than 10 years.

Exhibit IV-3
AFF Program Directors' Description of the AFF Collaborative Partnerships: Number of Partners Represented From the Community, Participation at Quarterly Meetings, and History of Collaboration

AFF Provider Agency	CPS	JOBS	Courts	RBHA	Subcontractors[A]	Community Agencies[B]	Number that Attend Meetings	History of Collaborative Relationship
AZPAC Coconino (n=9 partners)	0	0	0	1 *provides treatment for Title XIX and residential treatment*	6 *provide assessments, OP, IOP, and drug testing*	2 *provide education and respite*	7 *referring agencies, RBHA, subcontractors, and community agency attend*	1 year
AZPAC Yavapai (n=10 partners)	1	0	1	1 *provides treatment for Title XIX*	2 *provide counseling and drug testing*	4 *provide parent skills training, transitional housing, and legal advocacy, domestic violence*	6 *referring agencies, RBHA, subcontractors, and community agencies attend*	1 year
AZPAC Yuma (n=4 partners)	0	0	0	1 *provides treatment for Title XIX*	3 *provide counseling, job placement services, and child care*	0	4 *RBHA and subcontractors attend*	1-2 years
CPSA (n=25 partners)	1	1	1	N/A[C]	16 *provide clinical services and drug testing*	4 *provide domestic violence, medical, and housing services*	21 *CPS, JOBS, RHBA, subcontractors and community agencies attend*	7 years
Horizon (n=45 partners)	8	1	1	1	34 *provide supportive services*	0	12 *CPS, JOBS, RHBA and subcontractors attend*	1 year

[A] Subcontractors include agencies that have a formal agreement with an agency, such as a signed inter-agency agreement that specifies services the agency will provide for AFF clients in return for payment.

[B] Community agencies include agencies that have only an informal arrangement with the AFF provider agency to provide services or materials for AF clients.

[C] CPSA is the PBHA and provides treatment to Title XIX clients.

AFF Provider Agency	CPS	JOBS	Courts	RBHA	Subcontractors[A]	Community Agencies[B]	Number that Attend Meetings	History of Collaborative Relationship
Old Concho (n=10 partners)	0	0	0	0	10 *provide assessment, OP, IOP, family counseling, outreach, aftercare, domestic violence services, education, and emergency housing services*	0	9 *RBHA and subcontractors attend*	2-4 years
TERROS (n=9 partners)	0	0	0	0	9 *provide residential treatment, aftercare, outreach, assessment, incentives, and drug screening*	0	5 *Subcontractors attend*	3-30 years *(the majority have worked together for 10+ years)*
SEABHS (n=33 partners)	1	2	1	1	17 *provide residential treatment, OP, IOP, parenting skills training, outreach, peer support, employment counseling, mentoring, and self help*	9 *provide housing supports, faith-based mentoring and supports, recreation, and transportation*	12 *Subcontractors and community agencies attend. RBHA, CPS, JOBS, and the courts do not attend.*	2-12 years *(more than half have worked together for 10+ years)*
WestCare (n=4 partners)	1	1	0	2	0	0	4 *CPS, JOBS, and RBHA attend*	1-7 years *(RBHA has 7 year working relationship)*

[A] Subcontractors include agencies that have a formal agreement with an agency, such as a signed inter-agency agreement that specifies services the agency will provide for AFF clients in return for payment.

[B] Community agencies include agencies that have only an informal arrangement with the AFF provider agency to provide services or materials for AF clients.

a. Referral Sources

Approximately half of the AFF providers reported that CPS or JOBS were members of their collaborative partnerships. Of the five AFF provider agencies (AZPAC Yavapai, CPSA, Horizon, SEABHS, and WestCare) who reported that CPS was a member of their collaborative partnerships, all reported that CPS actively attended the quarterly collaborative partnership meetings. Four AFF providers (CPSA, Horizon, SEABHS, and WestCare) reported that JOBS staff were members of their collaborative partnerships and actively attended their quarterly meetings.

Although CPS is the primary referral source for the AFF program, four AFF providers (AZPAC Coconino, AZPAC Yuma, Old Concho, and TERROS) did not report that CPS was a member of their collaborative partnership. Several reasons may explain why these

agencies did not describe CPS as a collaborative partner. First, in interviews conducted with AFF program directors, TERROS reported that building a relationship with CPS had been difficult due differing treatment philosophies (CPS case managers perceived residential treatment to be the only treatment option in most cases). Second, AZPAC Yuma's program directors reported that their collaborative partnership was still taking shape and they had not yet actively pursued a collaborative partnership with their referral sources. Third, interviews with CPS staff who refer clients to Old Concho revealed that while case coordination and collaboration exist between CPS and Old Concho, the location of Old Concho's main office makes it difficult to access AFF provider staff. CPS staff suggested that Old Concho open a satellite office in Winslow, Arizona, which would make provider staff more accessible to CPS staff. The distance between Old Concho's main office and local CPS offices may explain why CPS staff do not regularly attend the collaborative partnership meetings at Old Concho. Since the two counties served by Old Concho cover a large geographic area and meetings often require individuals to travel more than 100 miles to a central location, the program director uses individual meetings with collaborative partners to maintain communication or meets with them in small groups.

AZPAC Coconino, AZPAC Yuma, AZPAC Yavapai, Old Concho, and TERROS did not include JOBS as a collaborator. JOBS referrals accounted for only six percent of the total referrals during year one, and focus groups with JOBS staff revealed, overall, that they perceived AFF to be a program solely for CPS clients. It is not clear why JOBS staff were not aware they could and should refer clients to AFF. However, in the Level II training conducted by ADES, additional efforts were made to include Jobs staff in training sessions.

b. RBHA Representatives

Collaboration with the RBHA is applicable for eight of the nine AFF providers (CPSA is a RBHA). Of these eight AFF providers, six reported RBHAs were collaborative partners and that RBHA staff regularly attend the AFF collaborative partnership meetings. TERROS and Old Concho were the two AFF providers that did not report RBHAs as collaborative partners. TERROS is a RBHA subcontractor and provides services to Title XIX clients, which may explain why they did not report their RBHA as a collaborative partner. Old Concho is not a RBHA subcontractor, but the proximity from their local RBHA agency makes it difficult for RBHA staff to regularly attend the AFF collaborative partnership meetings at the Old Concho site. The program director at Old Concho, as indicated above, uses individual meetings to maintain contact with the RBHA.

c. Community Agencies

Almost half of the AFF provider agencies (four out of nine) reported that they have developed informal arrangements (i.e., a working agreement not involving a formal agreement or subcontract) with local community agencies to provide services or materials to AFF clients. The number of community agency partners ranged from two to nine at the four AFF provider agencies who reported collaborating informally with local agencies. Each of these AFF provider agencies also reported that representatives from local community agencies attend the AFF collaborative partnership quarterly meetings.

AZPAC Coconino works with community agencies to ensure that education and respite care are provided for their AFF clients. AZPAC Yavapai collaborates with local agencies who provide parent skills training, transitional housing, domestic violence services, and legal advocacy. Community agencies provide domestic violence, medical, and housing services for CPSA's AFF clients. Finally, SEABHS works with local agencies in order to access housing supports, faith-based mentoring, recreation, and transportation for their AFF clients.

2. The Role of Subcontractors

Subcontractors include agencies that have signed a formal inter-agency agreement with the AFF provider agency that specifies services to be provided to AFF clients in return for payment or some other formal arrangement. The fiduciary relationship between the AFF provider agency and the service subcontractor may affect their level of involvement in the AFF collaborative partnership (e.g., the number of meetings attended). Therefore, subcontractors should be viewed differently than collaborative partnerships formed with community agencies where no payment system is in place.

All but one AFF provider agency (WestCare) included their subcontractors as collaborative partners when describing the members of their collaborative partnerships. The number of subcontractors reported by the other AFF provider agencies ranged from two to 34. CPSA, SEABHS, and Horizon reported the highest number of subcontractors with 16, 17, and 34 respectively. All AFF providers sites that reported subcontractors as collaborative partners, also reported that subcontractor staff attended the AFF collaborative partnership meetings. However, the number of subcontractor staff that attended collaborative meetings compared to the overall number of subcontractor staff at each AFF provider agency varied greatly. For example, 13 of CPSA's 16 subcontractors regularly attend the collaborative partnership meetings, while only 11 of Horizon's 34 subcontractors attend the collaborative meetings (see Appendix for more detail).

3. Successes in Collaboration

The majority of AFF providers (seven of nine) perceived collaboration as a facilitator to program implementation. Program directors described how collaboration involved regular opportunities for informal contact and exchanges among different agencies and organizations, allowing agencies in the community to see how others could provide valuable resources for their clients. In particular, AFF provider agencies discussed how the collaborative partnerships increased awareness among referral agency staff, RBHA staff, and other service providers in their communities with respect to the services that were available. According to program directors, increased awareness of services among agencies has, in turn, increased the timeliness of referrals from referring agencies such as CPS. It also has increased the number of cross-agency referrals, enabling clients to receive a wide array of supportive services offered through multiple agencies.

Findings from survey data collected from referral sources, subcontractors, RBHA representatives, and AFF provider staff supported these perceptions of collaboration. While methodological constraints of the survey (e.g., unequal representation of the collaborative partners at each AFF provider site) inhibit us from presenting specific results, it should be noted that respondents to the survey reported a high level of communication with other agencies and knowledge of what other agencies do.

CHAPTER V
CLIENT SATISFACTION

In order to assess client satisfaction and experiences with AFF services, data were gathered from clients at each of the nine AFF sites during site visits conducted in February and March 2002. Forty eight clients were interviewed, including 43 females and five males. Thirty-four of these clients were currently enrolled in either AFF intensive outpatient treatment or outpatient services, and 14 clients were currently enrolled in residential treatment services. The interview methods utilized to query clients included face-to-face individual interviews (n = 9 clients), telephone interviews (n = 17 clients), and focus groups (n = 22 clients). Focus groups were conducted with clients served by TERROS, AZPAC Yuma, Horizon, and Old Concho. Focus groups were held with clients receiving their treatment through outpatient services, intensive outpatient treatment, and with clients residing in a residential treatment program. Interviews with individual clients were conducted at the remainder of the AFF sites.

AFF provider agencies assisted the evaluator with arranging the meetings with clients. The criteria for inclusion was that clients needed to be currently enrolled in AFF and they needed to be receiving some type of substance abuse treatment. For the focus groups, the evaluator met with clients who already were attending a group treatment meeting scheduled on the day of the site visit.[1] Clients were informed about the focus groups in advance and they provided consent for their participation prior to the meeting with the evaluator. Only those clients who provided consent attended the focus group meetings (information is not available for those clients who were enrolled in group treatment but chose not to participate in the focus groups).

With respect to the individual client interviews, AFF program directors provided the evaluator with a list of client names and telephone numbers after the clients provided clearance that it was alright for the evaluator to contact them. The individual client interviews took place both in face-to-face settings as well as by telephone. There were a total of 11 clients who did not show up for their scheduled interviews.

Clients who met in person with the evaluator were each provided with a $20 incentive, in the form of cash or a Wal-Mart gift certificate, for their participation. Clients who were interviewed by telephone received a $10 money order for their participation. Questions posed to clients were focused on their experiences with AFF, their level of satisfaction with the program and the services provided, perceptions about the services they found to be most helpful, and areas in which they continued to have needs.

In reviewing the findings on client satisfaction that follow, it is important to recognize that there clearly are some biases in the data on client perceptions, including the fact that different methodologies were used for gathering information from clients; clients were "selected" for participation in focus groups and interviews by the AFF program directors and thus may have been their more "successful" clients; and at some of the AFF sites, only a few clients were interviewed. These limitations underscore that caution should be applied in not generalizing these responses to the overall population of AFF clients that received substance abuse treatment services. The information is useful for generating some early impressions of a selected group of clients with respect to program satisfaction and their experiences with the program to date.

[1] An important factor in convening focus groups was addressing the issue of confidentiality among individuals receiving treatment for substance abuse problems. It was necessary to conduct focus groups with "already established groups" rather than bring together clients in a group meeting for the first time (which would violate their confidentiality and disclose to others that they were at the meeting because they had a substance abuse problem).

A. Clients' Participation in Services and Activities

Clients interviewed during focus groups, face-to-face individual interviews, and telephone interviews revealed some common goals that motivated them to participate in AFF services and activities. These goals included the desire to remain "clean" and sober as well as the intention to seek reunification with their children who had been removed from home and placed in the custody of CPS. With respect to the specific program activities that clients participated in, clients frequently reported that they were participating in NA or AA support groups, which they perceived as beneficial. Clients also indicated that parenting classes were valuable to them, as was the individual counseling they received. Other clients reported that they had received valuable assistance with immediate needs such as housing, food, transportation, and clothing. Some clients participating in outpatient services said they currently were residing in transitional living facilities and found that the stable and structured housing program in which they were residing was instrumental in the success of their substance abuse treatment.

In some areas of the state, clients participating in intensive outpatient services or outpatient services also were receiving services from other CPS-related programs such as Family Preservation, Intensive Family Services, or counseling. According to clients involved in these additional services and programs, the time commitments required when participating in multiple programs were perceived as extensive. There were a number of clients interviewed who appeared to be overwhelmed with their current situation and the level of treatment (i.e., time, commitment that were involved). For example, some of the clients who were being treated for co-occurring disorders were struggling to attend all of their appointments during the week. One mother noted that her AFF case manager came to her home at least once per week to remind her of treatment appointments that had been scheduled. The case manager also had checked to see if she needed any assistance with clothing or food for her children.

AFF program participants indicated that they had played a role in the development of their treatment plans. However, many also were participating in the program as part of a case plan or court order to satisfy conditions of probation or dependency matters (i.e., their treatment plan and level of care had been determined by others and the clients were "complying" with what had been specified).

B. Clients' Experiences and Satisfaction with AFF

The majority of the clients who were interviewed rated their overall satisfaction with the AFF program's substance abuse treatment services as very high. Specific services that were mentioned as most helpful included counseling sessions with therapists, group meetings, assistance with rent or access to halfway house programs, support groups such as NA and AA, and parenting classes. Clients reported that their relationships with AFF case managers and treatment staff, particularly their counselors, were extremely beneficial to them. Clients said they were well acquainted with and had frequent contact with these professionals. A number of clients indicated that substance abuse treatment staff who were recovered addicts were especially helpful to them because these staff members had first-hand knowledge about the recovery process based on their personal experience. Because these staff knew of the potential problems that were part of the recovery process, they were perceived by clients as better able to relate to them and the problems they were experiencing.

With respect to case coordination and communication, clients stated that they found it helpful when their substance abuse treatment therapist communicated directly with their CPS or Jobs case manager regarding their case plan, treatment plan, and the progress that clients had been making in their treatment. Several clients reported that their treatment therapists were keeping their CPS case managers up-to-date on their progress in an effort to help them regain custody of their children.

C. Clients' Need for Services

The interviews and focus groups with clients also addressed their current needs for services and some of the service they wanted to see expanded. Some of the clients interviewed indicated that they would like to receive more assistance with transportation, such as access to bus passes in Tucson. Other clients spoke about how they wanted an alternative to bus transportation and to the *Safe Ride* transportation services provided through TERROS.[2] There were some clients who said there was a need for more gender-specific groups to address substance abuse and domestic violence, as well as a need for groups that included parents and children.

Program clients from rural areas reported that they had experienced some difficulties participating in intensive outpatient treatment due to the time and travel involved as well as some transportation problems. One participant without a car traveled more than one hour to attend therapy appointments. Other clients said they had to arrive at their treatment sessions an hour or more before the session was scheduled to begin. In some situations, clients said they could not be transported with their children if the transportation provider had only one child car seat. Another client who lacked a telephone was having difficulty complying with the urine testing required by DES-CPS because she had to travel to a pay telephone every day in order to learn whether her number had been selected for urinalysis.

With respect to services offered to meet the cultural needs of clients, one of the Spanish-speaking female clients said that she preferred specialized outpatient treatment groups that were conducted in Spanish only. These groups previously had been offered by AZPAC Yuma, but the provider agency had shifted to offering bilingual groups. The client indicated that an excessive amount of time was being spent in the bilingual group translating information between English and Spanish. This client also recommended the inclusion of gender-specific groups. At the time of the interview, she was the only woman in an intensive outpatient services group composed of 17 males, which made her feel uncomfortable about participating in the sessions.

D. Experiences With Residential Treatment

Several of the clients who were receiving residential treatment services indicated that they had agreed to the placement in a residential treatment facility because there were few other alternatives available to them. This was due to the court's involvement in dependency cases involving their children, or in probation cases, which resulted in the treatment assignment being "decided for them." In general, clients in residential treatment said their initial motivation and engagement in a residential substance abuse treatment program came from their experience with CPS and the courts. In specific, they feared losing custody of their children or going to prison.

Half of the 14 clients who participated in the focus group at the Amity residential program in Tucson had plans to return home to their local communities following the completion of their treatment. The other half intended to relocate to other areas because they had established new goals and relationships. As a result, they wanted to live in communities that offered greater opportunities and resources in areas of employment and education for their children. Clients who were receiving treatment through Amity indicated an interest in job training, especially computer skills. Other clients who were planning to relocate said they wanted a "fresh start" with new friends and relationships, and they feared that they could face a potential relapse if they returned home to their communities (e.g., smaller communities where they might begin to associate with former friends who still were involved in abusing alcohol or drugs).

Some of the clients interviewed were living with their children while in treatment at Amity. These clients emphasized the emotional benefits they had experienced by having their children with them

[2] These clients reported that the bus is not always reliable in getting them to appointments on time, and that Safe Ride drivers make mistakes and mark clients as not there when they stop (called a "dry run"), which can result in transportation services being cancelled if a client receives three "dry runs."

while they were in treatment. At the same time, they underscored that while there were many advantages to this arrangement, there are additional responsibilities that clients carry when simultaneously participating in an intensive treatment program and continuing to care for children.

E. Clients' Knowledge and Understanding of the AFF Program

Overall, the clients interviewed seemed knowledgeable about AFF based on their particular level of personal experience with the program. Most clients were aware of the particular AFF services that they had participated in or had been offered, but they were generally unaware of the broader range of services available to them through AFF. For the most part, clients associated their treatment with the specific agency providing them with services (such as Amity, TERROS, Catholic Social Services, etc.). A few of the clients knew of the Arizona Families F.I.R.S.T. Statewide program and mentioned that they were participants in this initiative.

Clients, in general, were aware of the individualized nature of the services provided through AFF. The services that were available and planned took into account the individualized needs of clients. This meant that when necessary, clients were able to enter residential treatment with their children residing with them. For other clients who did not want to enter residential treatment and relocate to another area such as Tucson, it meant that intensive outpatient services were available to them so that they could remain at home with their children while in treatment. Although clients did not articulate the term "family-focused" in their interviews, their descriptions of the way in which providers individualized their treatment services reflects that treatment services incorporated attention to both the individual's needs and the overall needs of the family while the individual client received treatment.

CHAPTER VI
POLICY ACTIVITIES AND SYSTEMS LEVEL CHANGES

During the first year of the program, interviews were conducted with State-level administrators and staff from ADES and ADHS to understand the various activities that were underway at the State level to support implementation of the program at the nine AFF provider sites. Increased coordination across the ADES and ADHS systems, which was one of the Steering Committee's performance measures, was evident through a number of joint activities between the two agencies that supported AFF. These activities included quality improvement site visits that include staff from both agencies, the development of joint protocols to guide program policies, the creation of a staff liaison for AFF from ADHS, coordination meetings, and when necessary, even the sharing of resources. These elements that reflect the level of coordination in the ADES/ADHS partnership are described below.

A. Quality Improvement Site Visits

The site visits to AFF provider agencies are called quality improvement site visits because they were designed to not only monitor program activities, but to serve as a learning opportunity for AFF provider agencies to receive feedback on what is working well and what program areas are not proceeding as well as they should be. The quality improvement site visits are conducted on a quarterly basis by ADES staff. During the site visits, AFF provider staff are interviewed in order to assess their understanding of the program, whether they are incorporating the essential elements (i.e., best practices) into the treatment services they deliver, and whether they are meeting the required timeframes established for AFF. Case files also are reviewed during the site visits to assess contract compliance (e.g., fingerprinting, training, billing, reporting).

Following the site visits, ADES prepares a letter to the AFF provider agency to summarize what was learned during the visit and to identify any areas of deficiency. Depending on the issues found, AFF provider agencies sometimes are asked to submit a corrective action plan to ADES to describe how they intend to address any problems or concerns. A review of letters sent from ADES to AFF provider agencies following the site visits indicates that, in addition to reporting on the positive accomplishments that were achieved, ADES provides specific recommendations in the letters (e.g., making specific additions to local monitoring tools for assessing contract compliance; improving collaboration between AFF and local CPS and Jobs offices to increase the number of referrals; training local staff on time frames required; reviewing with staff the AFF forms and when these should be used). Further, the letters provide a summary of whom the site visitors interviewed during their visit and provide a summary of each client case file that was reviewed, including the materials that were missing or incomplete, and factors that appear to be effective (called "What's Working") with respect to service delivery and documentation of information on the client.

In addition to the AFF quality improvement site visits, ADES personnel conduct an annual operational and financial review (OPFIN) of the RBHAs across the State. In that context, a subcomponent of the review examines ARS 8-881 activities, which means that ADHS staff are also helping to monitor the activities of AFF and share this information with ADES.

B. Development of Joint Protocols

During the first program year, five separate protocols were developed jointly between ADES and ADHS. The protocols reflect agreements reached between the two agencies that involved extensive coordination of efforts and a mutual understanding of how the issues involved would affect each agency as well as larger systems, such as the RBHAs. Since the legislation for AFF requires the joint administration of the Treatment Fund by ADES and ADHS, the first protocol developed was an Intergovernmental agreement (IGA) between the two agencies which includes

their shared vision and goals of the program, specific responsibilities of each agency under the "Partnership," and financing issues and payment mechanisms.

The additional protocols that were developed over the course of the first year included: Non-Supplantation of Funds; Confidentiality/Communication; Management and Coordination of the Substance Abuse Treatment Fund; and Coordination Between the Substance Abuse Treatment Partnership/ADHS Title XIX and Title XXI Programs. The development of the protocol on coordination between the Partnership and Title XIX and Title XXI programs involved extensive communication and exchange of ideas and feedback between ADHS, ADES, and the RBHAs on how to implement the AFF requirements for clients receiving treatment through the Title XIX program. According to the AFF State administrator, the coordination protocol was able to be developed because of the strong team effort that went into the process, the close partnership between ADES and ADHS, and the fact that there was support from higher levels within both agencies to develop a protocol to address the coordination of services for Title XIX clients (since many clients in AFF were Title XIX and would receive their treatment services through a Title XIX provider).

The context in which the coordination protocol was developed involved all parties coming together to try and understand each other's system and how these operated (including the differences), so that a seamless service system could be implemented for Title XIX clients. This protocol also was developed under the context that Proposition 204 had passed in the State legislature, which not only expanded eligibility for Title XIX but also changed covered services for Title XIX clients so that the RBHA system would be able to provide more flexible services than before and they could provide more family-centered work. According to the Bureau Chief of Substance Abuse Prevention and Treatment at ADHS, the expansion of services and expanded eligibility under Proposition 204 meant that the RBHA system would now be able to handle the increasing demand placed on the system with the volume of new clients in AFF who were Title XIX. If Proposition 204 had not been implemented at the same time that AFF was initiated, it is possible that ADES might have had to work with providers to build their own treatment systems since the AFF program could have placed excessive demands for services on the RBHAs, which they would have been unable to meet given their limited resources.

C. ADHS Staff Liaison for AFF

One of the contributing factors to a coordinated, cross-agency working relationship between ADES and ADHS has been the assignment of an ADHS staff person to serve as liaison to ADES. The AFF liaison from ADHS works onsite at the ADES offices approximately two to three days per week. The day-to-day management of AFF, at a policy level, has benefited from her presence on location with the AFF administrator and other ADES staff. According to interviews with both ADES and ADHS staff, the AFF liaison from ADHS has helped to ensure that Title XIX issues that arise among the AFF provider agencies receive the necessary attention at the State level so that the issues can be resolved. In addition, the AFF liaison from the health department has played an important role in educating ADES staff and AFF provider agencies about Title XIX issues. In situations where AFF provider agencies face challenges in getting clients served through their RBHAs or in obtaining needed information from the RBHA, the AFF liaison is made aware of the problem by ADES and then follows up directly with the RBHA to address the situation.

During the first year of the program, the ADHS AFF liaison worked with the local RBHAs across Arizona to clarify what was expected of them regarding the provision of behavioral health services to AFF clients who were enrolled in AHCCCS. She also provided training and education with the AFF provider agencies regarding the Title XIX system, including basic rules and regulations, which was beneficial since five of the nine AFF provider agencies are not Title XIX providers. The ADHS AFF liaison also participates in site visits to AFF provider agencies and supports ADES in the State-sponsored provider trainings.

D. Coordination Meetings

The coordination between ADES and ADHS also was evident through reports of their joint participation in meetings for AFF. Based on interviews conducted with ADES and ADHS staff, regular meetings take place between the agencies which help to maintain a high level of communication regarding the program and have contributed to timely problem solving and issue resolution when topics arise. The ADHS AFF liaison meets with weekly with her colleagues at ADHS to keep them informed about AFF. A joint meeting also is held every other week that includes the ADES and ADHS administrators, the Jobs supervisor, and other staff in order to discuss the progress of the program. The AFF administrator at ADES and the ADHS Bureau Chief of Substance Abuse Prevention and Treatment also meet informally each month to discuss the progress of AFF, to review emerging findings from the evaluation, to discuss any problems that require resolution or TA that may be necessary, and in general, to plan next steps for the program.

Other coordination meetings take place that include both ADES and ADHS. For example, AFF provider agencies convene quarterly collaboration meetings in their local communities and ADES and ADHS staff often attend these, when feasible. In addition, ADES convenes monthly AFF provider agency teleconferences and the ADES AFF liaison participates in these calls, and as necessary, the ADHS Bureau Chief will participate also. The ADHS AFF liaison also attends the RBHA coordinator meetings that are held regularly across the State, as well as regular conference calls, in which the ADES AFF administrator has been invited to participate. ADHS also convenes scheduled meetings, when necessary, to work with a RBHA on addressing any specific issues that create challenges in serving Title XIX AFF clients or sharing information with AFF provider agencies that are not Title XIX providers. In addition, the

RBHAs were invited to the AFF Level II trainings that were sponsored and led by ADES. Several RBHAs also were invited to the ADES-sponsored technical assistance conference on AFF collaboration in June 2002, at which the ADES AFF liaison served as a discussant during a plenary panel discussion.

E. Sharing of Resources

The protocol on coordination between the Partnership and Title XIX programs includes a section on funds coordination, whereby supplemental monies from the Substance Abuse Treatment Partnership (i.e., ARS 8-881 dollars) can be made available to Title XIX clients. These supplemental dollars are intended to support AFF Title XIX clients with respect to substance abuse prevention, treatment, and recovery support services to achieve the legislative goals of child safety, family stability, permanency, self-sufficiency, and alcohol/drug recovery. AFF provider agencies indicated that this policy enabled them to offer specific support services to Title XIX clients that could not be provided through a RBHA (e.g., certain types of transportation services). AFF provider agencies also stated that this policy enabled them to extend a client's stay in residential treatment when the length of stay covered under Title XIX had been exceeded. Further, the protocol on coordination clarifies that all program participants identified as potentially eligible for Title XIX services may receive substance abuse education services through the AFF provider agencies until the determination of a client's eligibility and enrollment in the Title XIX program is complete.

Resource sharing also has worked in the other direction, whereby ADHS monies have been used to help support ADES with respect to AFF services. In one instance during the past year when the State was dealing with budget cuts and possible reductions in AFF funding, ADHS funded AFF with $50,000 from their block grant for substance abuse treatment.

In general, the degree of coordination that is in place at the policy level appears to be consistent with the expectations of the legislature in forming a partnership between ADES and ADHS. At the operations level, the majority of AFF providers that are not Title XIX providers have established effective working relationships with their local RBHAs to coordinate services for the Title XIX AFF clients. Two provider agencies, as noted in this report, have not implemented this level of coordination to the extent accomplished by other non-Title XIX AFF providers and their RBHAs, and have identified this as an important task for the coming year.

CHAPTER VII
SUMMARY AND CONCLUSIONS

The first year of the Arizona Families F.I.R.S.T. program (AFF) was examined in this report through service utilization data from March 2001 through the end of March 2002, and through process data collected during the first year of the program and at the end of FY 2002. The evaluation data have contributed to a better understanding of the characteristics of AFF participating clients; the types of drugs used by clients across the nine AFF sites in Arizona, including poly-drug use patterns; referral trends during the first year and site-level factors influencing referral patterns; levels of client engagement in services and service utilization patterns; and lengths of stay in treatment.

Process data presented in this report offer an early indication of changes in the timeliness, availability, and accessibility of treatment services as perceived by AFF program directors. Data collected through interviews with AFF program directors indicates that several AFF provider agencies have made significant progress in establishing a collaborative group to help support the goals of AFF while other providers still have more work to do in that area.

Although treatment recovery data are not yet available, the findings that AFF clients are engaged in services at a high rate and are spending several months in treatment services are positive results. Key findings of this annual report are summarized below.

AFF Clients Are Engaged in Substance Abuse Treatment and are Staying in Treatment

- Engagement in treatment services was one of the Steering Committee's suggested performance measures. Fifty five percent of all clients referred to AFF are subsequently engaged in treatment services.[1] Engagement in treatment can be viewed as an intermediary outcome that is attained prior to observing long-term outcomes related to recovery.

- Overall, once a client receives an assessment, the data indicate that the client is likely to have a service plan developed and enter treatment. Seven of the nine AFF provider agencies completed assessments on 70 percent or more of their referred clients, and overall, 80 percent of assessed clients had a service plan developed.

- At six of the nine AFF sites, there was a consistent pattern whereby 100 percent of clients with a service plan went on to receive treatment services. At all AFF sites, 91 percent or more of those with a service plan received treatment services.

- With respect to length of stay in treatment, 51 percent of clients with an opportunity to spend at least six months in treatment services remained in treatment for three months or longer, and 37 percent stayed in treatment for at least four to six months.

- Among clients who had an opportunity to spend at least 12 months in treatment, over 55 percent stayed in treatment for six months or longer, 18 percent stayed in treatment for eight to ten months, and 20 percent remained in treatment for 10 months or longer. These utilization patterns are promising given that research on substance abuse treatment emphasizes that the longer a client stays in treatment, the more likely it is that the treatment will result in long-term behavior change.

Increases in Timeliness, Availability, and Accessibility of Treatment Services

- Seven of the AFF provider agencies reported an increase in the timeliness of service delivery since they began implementation of AFF more than a year earlier. Factors to which they attributed these

[1] This rate of engagement is higher than the engagement rate of 37 percent, reported by Connecticut's Project SAFE (see Chapter III).

increases included AFF policies and requirements regarding the timeframes within which clients must be screened, assessed, and have service plans developed; ADES monitoring practices through quality improvement visits and corrective action plan letters; and AFF provider agencies' accountability to ADES when they fail to meet timeframe requirements.

- The outreach and engagement component of AFF allows AFF provider agencies to spend time and resources on engaging clients in the screening and assessment process (i.e., there are AFF dollars available for outreach and engagement activities). The outreach and engagement component was perceived by AFF provider agencies to contribute toward an increase in the timeliness of serving clients.

- AFF collaborative partnerships have increased the awareness of services available among the referral agency staff, which in turn has shortened the timeframes within which referrals are made. Referral staff know what services are available to clients who need help and they know the process for making referrals.

- Seven AFF provider agencies reported an increase in the availability of treatment services over the past year. This increase was attributed to the following factors: AFF funding through ARS 8-881 to provide treatment services for non-Title XIX clients, which has increased the number of treatment slots available in Arizona for this population; and AFF funding for support services, which has increased the supply of services such as child care, housing assistance, and transportation for both Title XIX and non-Title XIX clients.

- All nine AFF provider agencies reported an increase in the accessibility of treatment services. This increase was attributed to a number of factors. First, the AFF requirement that there be a coordinated, comprehensive service delivery system that includes referral agencies (CPS and Jobs) and the local RBHA has helped to increase clients' access to services provided through multiple agencies and treatment providers in their local communities. Second, family-centered treatment model implemented under AFF includes the provision of individualized support services to clients (i.e., tailored to the particular needs of the client and his/her family), such as child care and transportation, which has increased clients' ability to gain access to core treatment services. Third, AFF provider agencies indicated that increased communication has resulted from their collaborative partnerships, which has contributed to an increase in the number of cross-agency referrals and clients' access to different services offered through various agencies that network with the AFF provider agency.

- Another important factor contributing to improvements in availability and accessibility is the larger context in which AFF was implemented during 2001. Proposition 204 had passed, allowing for an expansion of Title XIX eligibility as well as covered services under Medicaid beginning in October 2001. The higher volume in Medicaid clients has, in turn, enabled the Title XIX provider network to expand its services and build greater capacity.

Increased Coordination Across Systems

- Increased coordination between the treatment system and the child welfare system was reported after the first year of implementation. AFF provider agencies described how AFF has removed the barriers to getting CPS clients into treatment. Where previously, CPS staff provided primary caregivers with a referral for treatment but left the responsibility to the primary caregiver to follow through, increased coordination has resulted in treatment staff seeking out the clients to complete a screening and assessment and using motivational techniques to get them into treatment.

- Coordination between treatment providers and other community agencies has increased, largely through improved communication. According to both providers and CPS, the CPS staff have become involved in treatment planning and case staffings, and treatment providers share

information with CPS staff on the progress that clients are making in their treatment. In addition, at AFF provider agencies that are not Title XIX providers, such as AZPAC Coconino and AZPAC Yavapai, the RBHAs are involved in a high level of case coordination and have instituted new practices to coordinate the services provided to AFF clients (e.g., creating a liaison position to work with AFF Title XIX clients on completing their assessments within the ADES timeframes).

- Increased coordination at the State level, between ADES and ADHS, has occurred during the first year of the AFF program. Factors that have contributed to this coordination include: regular communication and meetings between the AFF administrator at ADES and the Bureau Chief of Behavioral Health Services at ADHS; an AFF liaison from ADHS who spends time onsite at the ADES office, participates in trainings for AFF provider agencies and RBHAs, and participates in AFF quality improvement site visits; the development of joint protocols between the two agencies that have been implemented and followed by agency staff; and even the sharing of resources between agencies.

Other Lessons Learned During the First Year of AFF

- Program directors described specific lessons learned with respect to implementation of AFF, including facilitating factors as well as barriers **(see Appendix D)**. Overall, program directors acknowledged that they had gained an appreciation of the importance of collaborating with providers and other agencies in their local communities in order to enhance the services provided for clients. The majority of program directors described the formation of their AFF collaborative partnership as one of the program's greatest accomplishments, and several believed that continued efforts to increase collaboration was an important activity in the ongoing implementation of AFF.

- AFF program directors cited other factors that they learned were important with respect to facilitating implementation of AFF treatment services. Common factors included AFF's family-centered treatment philosophy, which allowed providers to address issues in the family as part of a client's treatment program; AFF's wrap-around service model that emphasizes comprehensive and coordinated treatment services; the adherence of AFF to "best practices" standards set forth in the substance abuse literature; perceived support from ADES administrators and staff, and the sense of "partnership" that exists between AFF providers and the State administration; and the ADES program monitoring and accountability that is in place.

- Some of the particular accomplishments that AFF provider agencies noted after their first year of implementation included: Strides in building relationships and coordinating activities with CPS agencies; hiring the necessary staff to deliver AFF services; graduating clients from treatment and reunifying parents with their children; expanding the services offered to clients and using "flex funds" to offer services that previously could not be provided; and providing services through a home-based model for families with transportation barriers.

- AFF provider agencies learned that there also are barriers to implementing AFF that must be addressed. Some providers received lower referral numbers than expected, others found the lack of separate funding for case management activities posed challenges, and two provider agencies (TERROS and Old Concho) expressed how their communities lacked agencies that could offer aftercare and supports for clients. Another barrier experienced by AFF provider agencies was dealing with agencies who had their own perspectives regarding best practices for substance abuse treatment (e.g., the perception that residential treatment is the only option for clients with substance abuse problems).

- AFF program directors described some of the next steps they would be undertaking in working toward overcoming various barriers encountered with respect to implementation . These included continued efforts to educate collaborators (including CPS) about best practices in substance abuse and appropriate treatment, building relationships with judges from the juvenile courts, increasing

collaboration with faith-based groups and other local agencies, building better relationships with referral agencies, strengthening the coordination between the AFF provider agency and their local RBHA, and building a shared vision among collaborative partners so that everyone is operating out of a common mission and understanding of what they are trying to accomplish for AFF clients.

- Overall, information presented in this annual report indicates that during the first year of the program, AFF provider agencies have been successful in implementing the AFF program requirements. The referral, outreach, screening and assessment practices are in place and clients with service plans developed are entering treatment services and are remaining in treatment for several months. These findings with respect to engagement in treatment and retention in treatment can be viewed as intermediate outcomes that are expected on the pathway to recovery. The emerging findings reported through year-end process data collected across the nine AFF provider agencies indicate that provider agencies already perceive improvements in timeliness, availability and accessibility of services.

- Other systems-level outcomes, such as increased service coordination and coordination at the State level also have been identified. While outcomes related to recovery, child welfare, and employment will not be reported until next year, the preliminary findings are positive with regard to improved coordination of services, increased availability, and access to services, and relatively high rates of client engagement and retention in services.

This service was funded through a contract with the Arizona Department of Economic Security (ADES) Division of Children, Youth and Families in partnership with the Arizona Department of Health Services (ADHS) through the Joint Substance Abuse Treatment Fund. Points of view are those of the author and do not necessarily represent the official position or policies of either ADES or ADHS.

APPENDIX A
MAPPING OF DHS CODES TO AFF SERVICES

DHS PROCEDURE CODES	DHS SERVICE DESCRIPTION	AFF SERVICE CODE	AFF SERVICE DESCRIPTION	UNITS
D1000	*Medication*	31	*Medication*	per prescription
S1004	*Case Management*	32	*Case Management*	15 minutes
S1005	*Case Management*	32	*Case Management*	15 minutes
S2001	*Detoxification*	18	*Detoxification (XIX)*	per day
S2007	*Psychiatric Health Facility (Level 1 Subacute)*	36	*Psychiatric Health Facility (Level 1 Subacute)*	per day
S2009	*Psychiatric Health Facility (Level 1 Subacute)*	36	*Psychiatric Health Facility (Level 1 Subacute)*	per day
S2013	*Housing Support*	7c	*Housing*	per day
S4001	*Level II BH Residential (room and board)*	27	*Level II BH Residential (room and board)*	per day
S4002	*Level II BH Residential (room and board)*	27	*Level II BH Residential (room and board)*	per day
S6008	*Other Professional*	23	*Other Medical Professional consult*	15 minutes
W2000	*Medical Day Program*	37	*Medical Day Program*	(3-6 hrs)
W2002	*Therapeutic Day Program*	6	*Intensive outpatient services*	(3-6 hrs)
W2003	*Therapeutic Day Program*	6	*Intensive outpatient services*	(6-8 hrs)
W2020	*Crisis Stabilization (face to face)*	38	*Crisis Stabilization*	(15 mns)
W2021	*Crisis Stabilization (mobile unit)*	38	*Crisis Stabilization*	(15 mns)
W2030	*Case Management*	32	*case management*	(15 mns)
W2050	*Consultation, Assess., Special Testing (Eval & Diagnosis)*	15	*Title XIX Assessment*	(per hour)
W2052	*Consultation, Assess., Special Testing (Screening)*	23	*Medical Professional Services and Consultation*	(per screen)
W2200	*Personal Assistance*	7l	*Support services*	(30 mns)
W2201	*Beha. Managt. In Level II BH Residential*	27	*Adult or Child Residential Treatment Title XIX age dependent*	(4 hours)
W2202	*Beha. Managt. In Level II BH Residential*	27	*Adult or Child Residential Treatment Title XIX age dependent*	(6 hrs)
W2210	*Living Skills Training*	7i	*Living Skills Training*	(30 mns)`
90899	Category A = Treatment Services, Subcategory 05 = Other Professional: Unlisted psychiatric service or procedure	23	Outpatient Services Title XIX -- (number of hours determine intensity).	(15 mns)
W2300	Category A = Treatment Services, Subcategory 01 = Counseling, Individual: Individual Counseling - Office	24b	Outpatient Services Title XIX -- Individual Counseling (number of hours determine intensity)	hours
W2151	Category A = Treatment Services, Subcategory 01 = Counseling, Individual: Individual Counseling - Out-of-Office	24b	Outpatient Services Title XIX -- Individual Counseling (number of hours determine intensity)	hours

DHS PROCEDURE CODES	DHS SERVICE DESCRIPTION	AFF SERVICE CODE	AFF SERVICE DESCRIPTION	UNITS
90804	Category A = Treatment Services, Subcategory 01 = Counseling, Individual: Individual Psychotherapy, insight oriented, behavior modifying and /or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with patient	24b	Outpatient Services Title XIX -- Individual Counseling (number of hours determine intensity)	hours
90806	Category A = Treatment Services, Subcategory 01 = Counseling, Individual: Individual Psychotherapy, insight oriented, behavior modifying and /or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with patient	24b	Outpatient Services Title XIX -- Individual Counseling (number of hours determine intensity)	hours
90853	Category A = Treatment Services, Subcategory 02 = Counseling Group: Group Psychotherapy (other than of a multiple-family group)	24a	Outpatient Services Title XIX -- Group Counseling (number of hours determine intensity).	hours
W2351	Category A = Treatment Services, Subcategory 02 = Counseling, Group: Group Counseling	24a	Outpatient Services Title XIX -- Group Counseling (number of hours determine intensity).	per member rate
W2350	Category A = Treatment Services, Subcategory 03 = Counseling, Family: Family Counseling - Office	24c	Outpatient Services Title XIX -- Family Counseling (number of hours determine intensity).	(15 mns)
W2152	Category A = Treatment Services, Subcategory 03 = Counseling, Family: Family Counseling - Out-of-Office	24c	Outpatient Services Title XIX -- Family Counseling (number of hours determine intensity).	(15 mns)
90885	Category A = Treatment Services, Subcategory 04 = Consultation, Assessment & Specialized Training: Psychiatric Evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes.	30	Psychiatric Evaluation Title XIX	per evaluation
99244	Category A = Treatment Services, Subcategory 04 = Consultation, Assessment, & Specialized Training: Office consultation for a new or established patient, which requires 3 key components: a comprehensive history; a comprehensive examination; and, medical decision-making of moderate complexity for problems of a moderate/high severity. (Approx. 60 minutes)	30	Assessment Title XIX	per assessment

DHS PROCEDURE CODES	DHS SERVICE DESCRIPTION	AFF SERVICE CODE	AFF SERVICE DESCRIPTION	UNITS
90801	Category A = Treatment Services, Subcategory 04 = Consultation, Assessment, & Specialized Training: Psychiatric diagnostic interview examination. Unit unspecified.	30	Psychiatric Evaluation Title XIX	per evaluation
W4005	Category A = Treatment Services, Subcategory 04 = Consultation, Assessment, & Specialty Training: Assessment, Comprehensive	20b	Assessment Title XIX	per assessment
W4001	Category A = Treatment Services, Subcategory 04 = Consultation, Assessment, & Specialty Training: Assessment, General	20b	Assessment Title XIX	per assessment
W4003	Category A = Treatment Services, Subcategory 04 = Consultation, Assessment, & Specialty Training: Screening	23	Outreach/Engagement/Screening	per screening
J2680	Category C = Medical Services, Subcategory 11 = Medication Services: Injection: fluphenazine decanoate, up to 25 mg.	31	Medication Title XIX	These are for crisis resolution
J1631	Category C = Medical Services, Subcategory 11 = Medication Services: Injection: haloperidol decanoate, per 50 mg.	31	Medication Title XIX	per prescription
W2101	Category C = Medical Services, Subcategory 11 = Medication Services: Opioid Agonist Administration -- Office	31	Medication Title XIX	methadone, per day
W2102	Category C = Medical Services, Subcategory 11 = Medication Services: Opioid Agonist Administration -- Take-Home	31	Medication Title XIX	methadone, per day
85025	Category C = Medical Services, Subcategory 12 = Laboratory, Radiology, and Medical Imaging: Blood count; hemogram and platelet count, automated, and automated complete differential WBC count (CBC)	23	Medical Professional Services and Consultation	per test
80053	Category C = Medical Services, Subcategory 12 = Laboratory, Radiology, and Medical Imaging: Comprehensive metabolic panel	23	Medical Professional Services and Consultation	per test
80100	Category C = Medical Services, Subcategory 12 = Laboratory, Radiology, and Medical Imaging: Drug Screen; single drug class, each drug class	20a	Urinalysis	per test
82977	Category C = Medical Services, Subcategory 12 = Laboratory, Radiology, and Medical Imaging: Glutamyltransferase (GGT)	23	Medical Professional Services and Consultation	per test

DHS PROCEDURE CODES	DHS SERVICE DESCRIPTION	AFF SERVICE CODE	AFF SERVICE DESCRIPTION	UNITS
G0001	Category C = Medical Services, Subcategory 12 = Laboratory, Radiology, and Medical Imaging: Routine venipuncture or finger/heel/ear stick for collection of specimen(s)	23	Medical Professional Services and Consultation	per test
84443	Category C = Medical Services, Subcategory 12 = Laboratory, Radiology, and Medical Imaging: Thyroid stimulating hormone (TSH), RIA or EIA	23	Medical Professional Services and Consultation	per test
90805	Category C = Medical Services, Subcategory 13 = Medical Management: Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services.	24b	Outpatient Services Title XIX -- Individual Counseling (number of hours determine intensity)	hours
99211	Category C = Medical Services, Subcategory 13 = Medical Management: Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician, or pharmacological management by nurse practitioner or physician's assistant (approximately 5 to 10 minutes)	23	Case Management Title XIX	5 - 10 minutes
99215	Category C = Medical Services, Subcategory 13 = Medical Management: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed history; a detailed examination; and, medical decision-making of high complexity.	23	Medical Professional Services and Consultation	per session
99214	Category C = Medical Services, Subcategory 13 = Medical Management: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed history; a detailed examination; and, medical decision-making.	23	Medical Professional Services and Consultation	per session

DHS PROCEDURE CODES	DHS SERVICE DESCRIPTION	AFF SERVICE CODE	AFF SERVICE DESCRIPTION	UNITS
99205	Category C = Medical Services, Subcategory 13 = Medical Management: Office or other outpatient visit for the evaluation and management of new patient, which requires these 3 key components: a detailed history; a detailed examination; and, medical decision-making of high complexity.	23	Medical Professional Services and Consultation	per session
99203	Category C = Medical Services, Subcategory 13 = Medical Management: Office or other outpatient visit for the evaluation and management of new patient, which requires these 3 key components: a detailed history; a detailed examination; and, medical decision-making of low complexity.	23	Medical Professional Services and Consultation	per session
W2100	Category C = Medical Services, Subcategory 13 = Medical Management: Nursing Services	23	Medical Professional Services and Consultation	per session
90862	Category C = Medical Services, Subcategory 13 = Medical Management: Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy.	23	Medical Professional Services and Consultation	per session
99361	Category D = Support Services, Subcategory 18 = Case Management: Medical team conference with an interdisciplinary team of health professionals or community agency representatives to coordinate client care. Approximately 30 minutes. (Client not present)	32	Service coordination -- Case Management Title XIX	per session
90889	Category D = Support Services, Subcategory 18 = Case Management: Preparation of report of patient's psychiatric status, history, treatment, or progress (other than legal or consultative purposes) for other physicians, agencies, or insurance carriers.	32	Service coordination -- Case Management Title XIX	per time

DHS PROCEDURE CODES	DHS SERVICE DESCRIPTION	AFF SERVICE CODE	AFF SERVICE DESCRIPTION	UNITS
99371	Category D = Support Services, Subcategory 18 = Case Management: Telephone call by a physician or for consultation or medical management or for coordinating medical management with other health care professionals (e.g., nurses, therapists, social workers, nutritionists, physicians, pharmacists).	32	Service coordination -- Case Management Title XIX	per time
W4042	Category D = Support Services, Subcategory 18 = Case Management: Case Management	32	Service coordination -- Case Management Title XIX	per time
W4043	Category D = Support Services, Subcategory 18 = Case Management: Case Management	32	Service coordination -- Case Management Title XIX	per time
W4040	Category D = Support Services, Subcategory 18 = Case Management: Case Management -- Behavioral Health Professional -- Office	32	Service coordination -- Case Management Title XIX	per time
W4041	Category D = Support Services, Subcategory 18 = Case Management: Case Management -- Behavioral Health Professional -- Out-of-Office	32	Service coordination -- Case Management Title XIX	per time
S7001	Category D = Support Services, Subcategory 25 = Interpreter Services: Interpreter services to assist clients who are deaf or do not understand English or language use by the counselor during counseling or other treatment activities in obtaining maximum benefit form treatment services.	33	Supportive Services Title XIX	per time
S6000	Category D = Support Services, Subcategory 26 = Flex Fund Services: Flex Fund Services	33	Supportive Services Title XIX	per time
A0428	Category D = Support Services, Subcategory 27 = Transportation: Ambulance service; basic life support, non-emergency.	7a	Transportation	trip
Z3648	Category D = Support Services, Subcategory 27 = Transportation: Ambulatory van, base rate, rural.	7a	Transportation	trip
Z3621	Category D = Support Services, Subcategory 27 = Transportation: Ambulatory van, base rate, urban.	7a	Transportation	trip
Z3643	Category D = Support Services, Subcategory 27 = Transportation: Ambulatory van, per mile, rural.	7a	Transportation	trip

DHS PROCEDURE CODES	DHS SERVICE DESCRIPTION	AFF SERVICE CODE	AFF SERVICE DESCRIPTION	UNITS
A0425	Category D = Support Services, Subcategory 27 = Transportation: Ground mileage, per statute mile.	7a	Transportation	trip
A0160	Category D = Support Services, Subcategory 27 = Transportation: Non-emergency transport; mile-caseworker or social worker	7a	Transportation	trip
A0100	Category D = Support Services, Subcategory 27 = Transportation: Non-emergency transport; taxi, intra-city, base rate	7a	Transportation	trip
A0130	Category D = Support Services, Subcategory 27 = Transportation: Non-emergency transport; wheel-chair van, base rate.	7a	Transportation	trip
Z3620	Category D = Support Services, Subcategory 27 = Transportation: Urban, non-emergency transport, coach van	7a	Transportation	trip
99262	Category F = Inpatient Services, Subcategory 37 = Inpatient Services, Professional: Follow-up inpatient consultation for an established patient, which requires at least 2 of these 3 components: an expanded problem-focused interval history; an expanded problem-focused examination; and, medical decision-making of moderate complexity.	35	Medical Evaluation and Management of a Patient in a Residential or Hospital Title XIX	per session
90817	Category F = Inpatient Services, Subcategory 37 = Inpatient Services, Professional: Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management.	35	Medical Evaluation and Management of a Patient in a Residential or Hospital Title XIX	per session (20 - 30 minutes per)
99223	Category F = Inpatient Services, Subcategory 37 = Inpatient Services, Professional: Initial hospital care, per day, for the evaluation and management of a patient which requires these 3 components: a comprehensive history; a comprehensive examination; and, medical decision-making for a problem of high severity.	35	Medical Evaluation and Management of a Patient in a Residential or Hospital Title XIX	per day

DHS PROCEDURE CODES	DHS SERVICE DESCRIPTION	AFF SERVICE CODE	AFF SERVICE DESCRIPTION	UNITS
99222	Category F = Inpatient Services, Subcategory 37 = Inpatient Services, Professional: Initial hospital care, per day, for the evaluation and management of a patient which requires these 3 components: a comprehensive history; a comprehensive examination; and, medical decision-making for a problem of moderate severity.	35	Medical Evaluation and Management of a Patient in a Residential or Hospital Title XIX	per day
99233	Category F = Inpatient Services, Subcategory 37 = Inpatient Services, Professional: Subsequent hospital care, per day, for the evaluation and management of a patient which requires at least 2 of these 3 components: a comprehensive history; a comprehensive examination; and, medical decision-making for a problem of high complexity.	35	Medical Evaluation and Management of a Patient in a Residential or Hospital Title XIX	per day
99231	Category F = Inpatient Services, Subcategory 37 = Inpatient Services, Professional: Subsequent hospital care, per day, for the evaluation and management of a patient which requires at least 2 of these 3 components: a comprehensive history; a comprehensive examination; and, medical decision-making for a problem of low complexity.	35	Medical Evaluation and Management of a Patient in a Residential or Hospital Title XIX	per day
99232	Category F = Inpatient Services, Subcategory 37 = Inpatient Services, Professional: Subsequent hospital care, per day, for the evaluation and management of a patient which requires at least 2 of these 3 components: a comprehensive history; a comprehensive examination; and, medical decision-making for a problem of moderate complexity.	35	Medical Evaluation and Management of a Patient in a Residential or Hospital Title XIX	per day
W4051	Category G = Residential Services, Subcategory 38 = Level II Behavioral Health Resident: Level II Behavioral Health Residential	27	Adult or Child Residential Treatment Title XIX age dependent	per day
S2000	Category G = Residential Services, Subcategory 40 = Room and Board	27	Adult or Child Residential Treatment Title XIX age dependent	per day

APPENDIX B
AFF PROJECT DIRECTOR INTERVIEW

ARIZONA FAMILIES F.I.R.S.T.
PROGRAM DIRECTOR INTERVIEW GUIDE

Respondent-- ***AFF Program Director***

Date: ____

Specific AFF Site: ____

Name of Director/others interviewed: ____

____

A. Context

[I'd like to start by getting some information about your background and your role and involvement in the project]

1. Briefly describe your roles and responsibilities with respect to Arizona Families F.I.R.S.T. How long have you been working with Arizona Families F.I.R.S.T.? Were you involved in preparation of the original contract proposal?

2. How was the decision made to apply for a contract through the Community Substance Abuse Prevention and Treatment Fund?

3. Prior to receiving the AFF contract, what were your greatest concerns with regard to the availability of services in your District/community at that time?

4. What were your greatest concerns with respect to the timeliness in which clients received their treatment services in your District/community?

5 What concerns did you have at that time regarding clients' access to those services in this District/community?

[I'm now going to ask you some questions about your perceptions of the availability, timeliness and accessibility of substance abuse treatment services in this community since the implementation of the Arizona Families F.I.R.S.T. program.]

B. Questions Pertaining to Timeliness

1. Typically, what is your sense of the maximum number of days that it takes, at this project, for a substance abuse assessment to be completed after a screening indicates that further follow-up is necessary?

2. What is the average number of days after the screening before a substance abuse assessment is typically completed?

3. When would a case deviate from the average number of days?

4. Do you think that this time frame for completion of substance abuse assessments is different from the time frame that was in place before the Arizona Families F.I.R.S.T. project? How is it different? Have the AFF policies or requirements for the timing of substance abuse assessments made a difference? What other factors do you think may have contributed to the difference?

5. Typically, what is your sense of the maximum number of days that it takes, at this project, for a service plan or treatment plan to be developed following the completion of a substance abuse assessment?

6. What is the average number of days after the assessment that the service plan / treatment plan is developed?

7. When would a case deviate from the average number of days?

8. Do you think that this time frame for developing a service plan /treatment plan is different from the time frame that was in place before the Arizona Families F.I.R.S.T. project? How is it different? Have the AFF policies or requirements made a difference? What other factors do you think may have contributed to the difference?

9. Typically, what is your sense of the maximum number of days that it takes, at this project, between the signing off the service plan or treatment plan and the beginning of treatment services?

10. What is the average number of days between the signing off of the service plan / treatment plan and the beginning of treatment services?

11. When would a case deviate from the average number of days?

12. Do you think that this time frame between signing off on the service plan and the client beginning treatment services is different from the time frame that was in place before the Arizona Families F.I.R.S.T. project? How is it different? Have the AFF policies or requirements made a difference? What other factors do you think may have contributed to the difference?

13. What is your sense of the maximum waiting time for a client to get into treatment services? (e.g., how many days). How does the waiting time vary by the specific type of treatment services? Please explain.

14. What is the average waiting time for a client to get into treatment services [Probe: for specific types of treatment]

15. When would a case deviate from the average waiting time? How would payment of the services/funding source affect the average time a client waits to get into treatment services?

16. What is your sense of how often maximum wait times for appointments are exceeded (e.g., where client needs to wait longer before she/he can receive treatment)? What are the reasons for why this would happen?

17. Do you think that these current wait times are any different from the wait times before Arizona Families F.I.R.S.T. was in place? If so, how are they different? Have AFF policies or requirements made a difference with respect to these waiting times? What other factors do you think may have contributed to the difference?

18. Is transportation scheduled for clients when needed, so that they can get to their treatment appointments? What kinds of transportation services do you provide?

19. Are there limited wait times for clients with respect to departure from their home or following their appointments? (in other words, do they have to wait when they are dropped off for their appointments, and do they have to wait after completing their appointment for their transportation home?)

20. How often are these typical wait times for transportation exceeded?

21. Do you think that these current wait times for transportation are any different from the wait times for transportation before Arizona Families F.I.R.S.T. was in place? If so, how are they different? Has the transportation provided through AFF made a difference with respect to these waiting times (i.e., before and after appointments)? What other factors do you think may have contributed to the difference?

22. Are there differences in the timeliness of services depending upon whether a client is Title XIX or non Title XIX enrolled? Explain.

23. In general, what role, if any, has the AFF collaborative partnership had in increasing the timeliness in which substance abuse services are provided to clients in this community?

C. Questions Pertaining to Availability

1. What is your overall perception about whether this community has sufficient substance abuse treatment services to meet clients' needs? Do you think your agency/program's capacity is sufficient to meet the needs of clients?

2. As a service provider, do you think your agency's capacity to meet the needs of clients through substance abuse services has changed since the implementation of Arizona Families F.I.R.S.T.? In what ways?

3. Have there been changes in the community's capacity to meet clients' needs through services? Explain.

4. Do you think AFF has contributed to these changes in capacity? If so, how? What other factors do you think may have contributed to the changes?

5. Currently, where are the gaps in services? (probe: different types of substance abuse services) Did these gaps exist prior to implementation of Arizona Families F.I.R.S.T.?

6. Have there been any recent deletions in services? (in other words, are there substance abuse services that had been available for clients in this community but currently are no longer available?) What accounted for the deletions in these services?

7. Have there been any recent additions in services? (in other words, are there any new substance abuse services available in the community?). Did these additions in services take place after the implementation of Arizona Families F.I.R.S.T.? What accounted for the addition(s) of these services?

8. Have there been any recent reduction in services? (in other words, are there substance abuse services that are no longer available at the same level (frequency, intensity) as before? Did these changes occur after the implementation of Arizona Families F.I.R.S.T.? What accounted for the changes in delivery of these services?

9. How do the covered services available for Title XIX clients differ from the Arizona Families F.I.R.S.T. program services available that are paid for by ADES? Do the services available to Title XIX AFF clients differ from services available to non Title XIX AFF clients?

10. Do Arizona Families F.I.R.S.T. clients pay for any of their substance abuse treatment services? Explain. [Probe: resources available for services]. Are substance abuse services affordable for clients?

11. Are there minimum requirements that must be met in order for clients to receive specialized substance abuse services (e.g., residential treatment)? If so, what are the requirements for determining whether clients can receive the service?

12. When would your agency deviate from these requirements (probe: what circumstances)?

13. Overall, do you think the availability of substance abuse services today in this community differs from what was available prior to implementation of Arizona Families F.I.R.S.T.? If so, how? What factors do you think have contributed to the change?

14. In general, what role, if any, has the AFF collaborative partnership had in increasing the availability of substance abuse services in this community? Are there any services currently available through the formation of collaborative partnerships that were not available prior to implementation of AFF?

D. Questions Pertaining to Accessibility

1. Do have a sense of the number of available treatment slots (for new clients) in your service network (either within this agency or through your subcontracts, etc.). In general, how many slots are available for new clients needing: outpatient services, intensive outpatient, residential treatment, residential treatment with child, substance abuse education groups?

2. Are the services available being utilized, overall? Do you know of service providers that have "empty slots" for certain services (e.g., slots/served ratio?). Are there specific services that clients are not accessing? Why?

3. Do you know the average number of AFF clients waitlisted for substance abuse treatment services? What is the average length of time clients spend on a wait list? Does this differ by the type of service? Does this differ depending upon whether a client is Title XIX or non Title XIX?

4. Are the clients served by your agency who are not enrolled in AFF any more or less likely to be waitlisted for substance abuse treatment services?

5. What are the general hours of operation for services [Probe: by service type]

6. What are your policies with respect to clients' use of your transportation services? How many clients can you accommodate with transportation? How many clients are using transportation services? What is the process for applying for transportation? What are the hours, frequency that transportation is provided?

7. Are there some clients who are unable to utilize a treatment service due to lack of transportation? Explain. (probe- distance not covered by transportation service)

8. What is the payment process for services? (e.g., co-pay, look for insurance first, Medicaid eligible, etc.). Are services withheld until a payment source is identified, or payment is received?

9. Are clients made aware of how much treatment services are going to cost, and whether they need to pay any service fees? Are they made aware of the required payment processes?

10. Have there been any changes in the process of how clients get referred for services since the implementation of Arizona Families F.I.R.S.T.? If so, what changes? If a client needs a particular treatment service, do you have the client call the service provider directly to schedule an appointment or does an AFF staff person call the treatment provider or accompany the client?

11. Do you think that, since the implementation of Arizona Families F.I.R.S.T., there have been any changes in how clients receive their services (e.g., are the services more efficient, customer-friendly, comprehensive, family-based, etc or are they overall delivered in the same way?)

12. Do you think that there have been any changes, since the implementation of Arizona Families F.I.R.S.T., in how the cultural needs of clients are addressed through treatment services? What culturally relevant services are available to clients and how many clients participate in these services?

13. Overall, do you think the accessibility of substance abuse services today in this community has changed since implementation of Arizona Families F.I.R.S.T.? What services are now more accessible? What factors do you think have contributed to the change?

14. In general, what role, if any, has the AFF collaborative partnership had in increasing the accessibility of substance abuse services in this community? Are there specific services that are now more accessible through the formation of collaborative partnerships that were not accessible prior to implementation of AFF?

E. Overall Impressions

1. Since the last site visit conducted by Jane Irvine this past winter, have there been any changes in your procedures for: outreach and engagement; screenings; assessments; service plans; determining levels of care.

2. Have there been any changes since the last site visit in how you provide treatment services, or changes in the providers you use for delivering treatment to clients?

3. Overall, what is your impression of the Arizona Families F.I.R.S.T. program thus far?

4. As an AFF site, what do you see as your greatest accomplishments over the past year?

5. What have been the biggest challenges/barriers faced?

6. What do you see as important next steps?

APPENDIX C
DESCRIPTION OF ARIZONA FAMILIES F.I.R.S.T. COLLABORATIVES

AZPAC Coconino

Name of Local Collaborative Partner	Type of Service or Role/Function Provided by Local Agency	Type of Link Between AFF Provider Agency and Local Agency*	History of Collaborative Relationship *(Number of years working together)*	Local Agency Representative Attends Quarterly AFF Collaboration Meetings
Northern Arizona Substance Abuse Services (NASAS)	Assessment Education Outpatient Intensive Outpatient Aftercare	4	1 year	Yes
Flagstaff Child and Family Counseling Center	Assessment Outpatient	4	1 year	Yes
Native Americans for Community Action (NACA)	Assessment Outpatient Education Aftercare	4	1 year	Yes
Northland Family Help Center (NFHC)	Respite Counseling (DV)	1, 4	1 year	Yes
Treatment Assessment Screening Center (TASC)	Drug Testing	4	5 months	No
Flagstaff Medical Center	Intensive Outpatient	4	1 year	Yes
The Guidance Center (RBHA)	Assessment Outpatient Education Intensive Outpatient Aftercare Residential	1	1 year	Yes
Alternative Center (AC)	Respite	1	On-going	No
Catholic Social Services	Education	2	5 months	Yes

*** Type of Link**

1. **No formal agreement necessary**. AFF provider agency refers clients to an existing local agency for services and/or materials. This local agency provided services to community members prior to AFF and continues to do so.
2. **Informal arrangement or agreement**. AFF provider agency works out an agreement with a local agency to provide services to AFF clients. This is usually an oral agreement between agency staff, rather than a signed contract or agreement.
3. **Written inter-agency agreement or memoranda of understanding.** There is a written, signed document between AFF provider agency and local agency that specifies the services/materials the local agency will provide for AFF clients.
4. **Subcontract with local agency.** AFF agency signs agreement with a local agency that specifies payment for services provided to AFF clients by this local agency.

DESCRIPTION OF ARIZONA FAMILIES F.I.R.S.T. COLLABORATIVES

AZPAC Yavapai

Name of Local Collaborative Partner	Type of Service or Role/Function Provided by Local Agency	Type of Link Between AFF Provider Agency and Local Agency*	History of Collaborative Relationship *(Number of years working together)*	Local Agency Representative Attends Quarterly AFF Collaboration Meetings
Stepping Stones	Domestic Violence Shelter	1	1	No
Family Drug Court	Legal Oversight	2	1	Yes
WYGC and VVGC	RBHA Treatment for Title XIX Clients	3	1	Yes
TASC	UAs, education	4	1	Yes
Parents Anonymous	Parenting Skills Training	2	1	Yes
DES ACYF	Child Protective Services	1	1	Yes
Gurley St. House	Half Way House	2	1	No
A Solutions House	Half Way House	2	1	Yes
High Country Health	Counseling	4	1	No
Family Advocacy Center	Legal Advocacy	2	1	No

*** Type of Link**

1. **No formal agreement necessary**. AFF provider agency refers clients to an existing local agency for services and/or materials. This local agency provided services to community members prior to AFF and continues to do so.
2. **Informal arrangement or agreement**. AFF provider agency works out an agreement with a local agency to provide services to AFF clients. This is usually an oral agreement between agency staff, rather than a signed contract or agreement.
3. **Written inter-agency agreement or memoranda of understanding.** There is a written, signed document between AFF provider agency and local agency that specifies the services/materials the local agency will provide for AFF clients.
4. **Subcontract with local agency.** AFF agency signs agreement with a local agency that specifies payment for services provided to AFF clients by this local agency.

DESCRIPTION OF ARIZONA FAMILIES F.I.R.S.T. COLLABORATIVES

AZPAC Yuma

Name of Local Collaborative Partner	Type of Service or Role/Function Provided by Local Agency	Type of Link Between AFF Provider Agency and Local Agency*	History of Collaborative Relationship *(Number of years working together)*	Local Agency Representative Attends Quarterly AFF Collaboration Meetings
Arizona Baptist Children's Services	Mental Health/ Counseling Agency	3	1 year	Yes
Yuma Private Industry Counsel	Job Placement Services	3	1 year	Yes
Juniper Tree Academy	Child Day Care	3	1 year	Yes
The Excel Group	Mental Health/ Counseling Agency Title 19 Provider	3	2 years	Yes

*** Type of Link**

1. **No formal agreement necessary**. AFF provider agency refers clients to an existing local agency for services and/or materials. This local agency provided services to community members prior to AFF and continues to do so.
2. **Informal arrangement or agreement**. AFF provider agency works out an agreement with a local agency to provide services to AFF clients. This is usually an oral agreement between agency staff, rather than a signed contract or agreement.
3. **Written inter-agency agreement or memoranda of understanding.** There is a written, signed document between AFF provider agency and local agency that specifies the services/materials the local agency will provide for AFF clients.
4. **Subcontract with local agency.** AFF agency signs agreement with a local agency that specifies payment for services provided to AFF clients by this local agency.

DESCRIPTION OF ARIZONA FAMILIES F.I.R.S.T. COLLABORATIVES

CPSA

Name of Local Collaborative Partner	Type of Service or Role/Function Provided by Local Agency	Type of Link Between AFF Provider Agency and Local Agency*	History of Collaborative Relationship *(Number of years working together)*	Local Agency Representative Attends Quarterly AFF Collaboration Meetings
Devereux Arizona (AzPAC)	Provides direct clinical services to AFF families	4	7	Y
DES-CPS	Referral source for CPSA AFF program	N/A	7	Y
COPE Behavioral Services, Inc.	Provides direct clinical services to AFF families	4	7	Y
Pima County Juvenile Court Center	Serves AFF families; Advisory Board Member	N/A	7	Y
Brewster Center	AFF Advisory Board Member	1	7	Y
Traveler's Aide	AFF Advisory Board Member	1	7	Y
Casa Santa Clara	AFF Advisory Board Member	1	7	Y
DES-JOBS	Referral source for CPSA AFF program	N/A	7	Y
DES-DDD	Referral source for CPSA AFF program	N/A	7	Y
CODAC Behavioral Health Services, Inc.	Provides direct clinical services to AFF families	4	7	N
Compass Health Care	Provides direct clinical services to AFF families	4	7	Y
La Frontera	Provides direct clinical services to AFF families	4	7	Y
Pima Prevention Partnership	Provides direct clinical services to AFF families	4	7	N
Jewish Family and Children Services	Provides direct clinical services to AFF families	4	7	Y
The Haven	Provides direct clinical services to AFF families	4		Y

DESCRIPTION OF ARIZONA FAMILIES F.I.R.S.T. COLLABORATIVES

CPSA

Counseling and Consulting Services	Provides direct clinical services to AFF families	4	7	Y
Catholic Social Services (AzPAC)	Provides direct clinical services to AFF families	4	7	Y
Southern Arizona Mental Health Center	Provides direct clinical services to AFF families	4	7	Y
Our Town Family Center	Provides direct clinical services to AFF families	4	7	Y
Marana Health Center	Provides direct clinical services to AFF families	4	7	Y
Project PPEP	Provides direct clinical services to AFF families	4	7	Y
Arizona Children Association	Provides direct clinical services to AFF families	4	7	N
TASC	Provides UA collection and testing to AFF families	4	7	Y
El Rio Health Center	AFF Advisory Board Member	1	7	Y
Seaney Clinical Consulting	Provides clinical consulting services to CPSA AFF program	Does not provide direct clinical services to AFF families	7	N

*** Type of Link**

1. **No formal agreement necessary**. AFF provider agency refers clients to an existing local agency for services and/or materials. This local agency provided services to community members prior to AFF and continues to do so.
2. **Informal arrangement or agreement**. AFF provider agency works out an agreement with a local agency to provide services to AFF clients. This is usually an oral agreement between agency staff, rather than a signed contract or agreement.
3. **Written inter-agency agreement or memoranda of understanding.** There is a written, signed document between AFF provider agency and local agency that specifies the services/materials the local agency will provide for AFF clients.
4. **Subcontract with local agency.** AFF agency signs agreement with a local agency that specifies payment for services provided to AFF clients by this local agency.

DESCRIPTION OF ARIZONA FAMILIES F.I.R.S.T. COLLABORATIVES

Horizon

Name of Local Collaborative Partner	Type of Service or Role/Function Provided by Local Agency	Type of Link Between AFF Provider Agency and Local Agency*	History of Collaborative Relationship *(Number of years working together)*	Local Agency Representative Attends Quarterly AFF Collaboration Meetings
A.C.E.S.	Potential Subcontractor	1	1	Y
AZ Children's Associate Globe	Supportive Services	3	1	N
AZ Children's Associate Phoenix	Supportive Services	3	1	N
ADES/DCYF – Phoenix	DES Provider	4	1	Y
ADES/DCYF- Casa Grande	Referral Source	3	1	N
Alice's Wonderland	Subcontractor	4	1	Y
Amity	Subcontractor	4	1	Y
Brubaker & Assoc.	Subcontractor	3	1	N
St. Michael & All Angels Liberal Catholic Church	Supportive Services	3	1	N
St. Anthony of Padua Catholic Church	Supportive Services	3	1	N
Divine Grace Presbyterian Church	Supportive Services	3	3	N
Pinal Juvenile Court	Referral Source	3	1	N
Central AZ Assoc of Governments	Supportive Services	3	1	N
CAHRA	Supportive Services	3	1	N
CCRD	Subcontractor	4	1	N
DES – JOBS Casa Grande	Referral Source	4	1	Y
DES – CPS Apache Junction	Referral Source	4	1	N
DES – CPS Casa Grande	Referral Source	4	1	N
DES – CPS Coolidge	Referral Source	4	1	N
DES – CPS Globe	Referral Source	4	1	N

DESCRIPTION OF ARIZONA FAMILIES F.I.R.S.T. COLLABORATIVES

Horizon

Name of Local Collaborative Partner	Type of Service or Role/Function Provided by Local Agency	Type of Link Between AFF Provider Agency and Local Agency*	History of Collaborative Relationship *(Number of years working together)*	Local Agency Representative Attends Quarterly AFF Collaboration Meetings
DES – CPS Kearney	Referral Source	4	1	N
DES – CPS Mammoth	Referral Source	4	1	N
DES – CPS Payson	Referral Source	3	1	N
St. Anthony of Padua Catholic Church	Supportive Services	4	1	N
Donna Davis, CISW	Supportive Services	4	1	Y
Governor's Division of Community Outreach	Supportive Services	3	1	Y
Horizon Human Services Globe	Provider	4	1	N
Pinal Hispanic Council Casa Grande	Subcontractor	4	1	Y
Pinal Hispanic Council Elroy	Subcontractor	4	1	Y
Pinal Gila Behavioral Health Assoc.	RHBA	4	1	Y
Supervising U.S. Probation Officer	Referral Source	3	1	N
Pinal County Adult Probation	Referral Source	3	1	N
Round the Clock Daycare	Supportive Services	4	1	N
Rachel Goodman-Yates CISW	Subcontractor	4	1	N
Rim Guidance	Subcontractor	4	1	Y
Liberty School	Supportive Services Referral Source	3	1	N
Villa Oasis School	Supportive Services	3	1	N
Globe High School	Supportive Services	3	1	N
Miami High School	Supportive Services	3	1	N

DESCRIPTION OF ARIZONA FAMILIES F.I.R.S.T. COLLABORATIVES

Horizon

Name of Local Collaborative Partner	Type of Service or Role/Function Provided by Local Agency	Type of Link Between AFF Provider Agency and Local Agency*	History of Collaborative Relationship *(Number of years working together)*	Local Agency Representative Attends Quarterly AFF Collaboration Meetings
Saguaro Elementary	Supportive Services	3	1	N
Destiny School	Supportive Services	3	1	N
Miami Headstart	Supportive Services	3	1	N
Superstition Mountain Mental Health	Subcontractor	4	1	Y
Pinal County Cities in Schools	Supportive Services	3	1	N
San Pedro Valley Behavioral Health Assoc.	Subcontractor	4	1	N
Against Abuse, Inc.	Supportive Services	3	1	N

*** Type of Link**

1. **No formal agreement necessary**. AFF provider agency refers clients to an existing local agency for services and/or materials. This local agency provided services to community members prior to AFF and continues to do so.
2. **Informal arrangement or agreement**. AFF provider agency works out an agreement with a local agency to provide services to AFF clients. This is usually an oral agreement between agency staff, rather than a signed contract or agreement.
3. **Written inter-agency agreement or memoranda of understanding.** There is a written, signed document between AFF provider agency and local agency that specifies the services/materials the local agency will provide for AFF clients.
4. **Subcontract with local agency.** AFF agency signs agreement with a local agency that specifies payment for services provided to AFF clients by this local agency.

DESCRIPTION OF ARIZONA FAMILIES F.I.R.S.T. COLLABORATIVES

Old Concho

Name of Local Collaborative Partner	Type of Service or Role/Function Provided by Local Agency	Type of Link Between AFF Provider Agency and Local Agency*	History of Collaborative Relationship *(Number of years working together)*	Local Agency Representative Attends Quarterly AFF Collaboration Meetings
Arizona Baptist Children's Services	Assessment, outpatient, intensive OP and family counseling	Contracted services	A 4 year history with more than one program.	Sometimes
Community Counseling Centers	All services	Contracted services	2 year history	Yes
Independent counseling services	Outpatient and family and Aftercare	Contracted service	2 year history	No
Little Colorado Behavioral Health Center	All services	Contracted service	3 year history	Yes
New Hope Ranch	Domestic Violence Services	Contracted service	4 year history	Yes
Donna Daniel	Outreach assessment and education	Contracted service	4 year history	Yes
Round Valley Senior Center	Emergency Housing and Emergency Services	Contracted service	4 year history	Yes
White Mountain Community Counseling	Assessment, OP, and Aftercare	Contracted Service	2 year history	Yes
Winslow Guidance Associates	All services	Contracted Service	2 year history	Yes
White Mountain Catholic Charities	Emergency Housing and Emergency Services	Contracted Service	4 year history	Yes

*** Type of Link**

1. **No formal agreement necessary**. AFF provider agency refers clients to an existing local agency for services and/or materials. This local agency provided services to community members prior to AFF and continues to do so.
2. **Informal arrangement or agreement**. AFF provider agency works out an agreement with a local agency to provide services to AFF clients. This is usually an oral agreement between agency staff, rather than a signed contract or agreement.
3. **Written inter-agency agreement or memoranda of understanding.** There is a written, signed document between AFF provider agency and local agency that specifies the services/materials the local agency will provide for AFF clients.
4. **Subcontract with local agency.** AFF agency signs agreement with a local agency that specifies payment for services provided to AFF clients by this local agency.

DESCRIPTION OF ARIZONA FAMILIES F.I.R.S.T. COLLABORATIVES

TERROS

Name of Local Collaborative Partner	Type of Service or Role/Function Provided by Local Agency	Type of Link Between AFF Provider Agency and Local Agency*	History of Collaborative Relationship *(Number of years working together)*	Local Agency Representative Attends Quarterly AFF Collaboration Meetings
AMITY	Residential (Adult, Child); After Care; Incentives	3	3 Yrs	Yes
Chicanos Por La Causa	Outreach; Assessment; OP; IOP, Residential (Adult, Child); Aftercare; Incentives	3	20 Yrs	No
Ebony House, Inc.	Outreach; Assessment; OP; IOP, Residential (Adult); Aftercare; Incentives	3	15 Yrs	Yes
Family Service Agency	Outreach; Assessment; OP; IOP, Aftercare; Incentives	3	30 Yrs	No, have indicated they plan to attend in future
Native American Connections	OP; IOP; Residential (Adult, Child); Aftercare; Incentives	3	15 Yrs	No
National Council on Alcoholism & Drug Dependence	Outreach; Assessment; OP; IOP; Aftercare; Incentives	3	10 Yrs	Yes
NOVA	Outreach; Assessment; OP; IOP, Residential (Adult, Child); Aftercare; Incentives; Pre-residential treatment group	3	30 Yrs	Yes
SAGE Counseling	Outreach; Assessment; OP; IOP; Aftercare; Incentives	3	4 Yrs	Yes
TASC	Drug Screening	3	20 Yrs	No

*** Type of Link**

1. **No formal agreement necessary**. AFF provider agency refers clients to an existing local agency for services and/or materials. This local agency provided services to community members prior to AFF and continues to do so.
2. **Informal arrangement or agreement**. AFF provider agency works out an agreement with a local agency to provide services to AFF clients. This is usually an oral agreement between agency staff, rather than a signed contract or agreement.
3. **Written inter-agency agreement or memoranda of understanding.** There is a written, signed document between AFF provider agency and local agency that specifies the services/materials the local agency will provide for AFF clients.
4. **Subcontract with local agency.** AFF agency signs agreement with a local agency that specifies payment for services provided to AFF clients by this local agency.

DESCRIPTION OF ARIZONA FAMILIES F.I.R.S.T. COLLABORATIVES

SEABHS

Name of Local Collaborative Partner	Type of Service or Role/Function Provided by Local Agency	Type of Link Between AFF Provider Agency and Local Agency*	History of Collaborative Relationship *(Number of years working together)*	Local Agency Representative Attends Quarterly AFF Collaboration Meetings
Amity – Becka Perry	Residential Treatment	4	12	Y
Arizona Children's Association – Cindy Hansen	OP Counseling Int. OP Counseling	4	12	Y
Arts for Recovery – Cristi Luna	Mentoring Supportive Services	2	2	Y
Bisbee Community Y –Joan Ruane	Housing supports support services	1	12	N
Bisbee Interfaith Council –Rev. Caryl L. Larkins	Faith based mentoring connections	1	5	N
Blake Foundation – Annabel Rose	Parenting skills training	4	8	N
Boys & Girls Club of Santa Cruz – Vicky Barden	Social/recreation	2**	10	N
Catholic Community Services – Charles Fisher	Transportation DV Shelters OP Counseling	1	12	N
Child & Family Resources – Priscilla Whitlock-Coates	Outreach/engagement parenting skills peer self help employment counseling	4	8	Y
Child Protective Services – Lisa Watkins	Key stakeholder	IGA (via RBHA)	12	N
Cochise County Adult Probation – Livingston Sutro	Key collaborator	IGA (via RBHA)	12	N
Cochise County Health & Social Services – Betty King	Health care public health services	1	10	N
Cochise County Workforce Development – Vada Phelps	Employment related services	1	10	N
Cochise Transportation Network – Rie Walker	Transportation referral services	2	3	N
CODAC – Mark Clark	Residential Treatment	4	12	N

DESCRIPTION OF ARIZONA FAMILIES F.I.R.S.T. COLLABORATIVES

SEABHS

Name of Local Collaborative Partner	Type of Service or Role/Function Provided by Local Agency	Type of Link Between AFF Provider Agency and Local Agency*	History of Collaborative Relationship *(Number of years working together)*	Local Agency Representative Attends Quarterly AFF Collaboration Meetings
Compass Health Care – Joan McNamara	Social Detox. (non-medical)	4	10	N
Community Church of Warren – Jack McCann	Faith-based support services	1	10	N
CPSA Southeastern Regional Office – Gwen Calhoun	Key Collaborator/ stakeholder	4 – RBHA contracts with SEABHS	7	N
DES Jobs Administration – Sylvia Hurtado	Key stakeholder	IGA(?) or N/H	1+	N
DES Jobs Program – Peggy Feenan	Key stakeholder	N/A	1+	N
Graham County Health Department – Neil Karnes	Health care public/health services	1	10	N
Ken Bowles	OP counseling	4	12	N
Mary's Mission – LaDonna Jackson	Parenting skills mentoring (youth)	4	5	Y
Parents Anonymous – Erica Wagner	Parenting skills support services	2**	12	Y
Parents Anonymous – Kim Hill-Olsen	Parenting skills mentoring (youth)	2**	12	Y
PPEP – John Arnold	Support services Charter school	1	10	N
Professional Counseling Assoc. – Christine Hartzler	OP Counseling	4	1+	N
Southeastern Ariz. Human Resources Council – Librado Ramirez	Community action agency/support services	3	12	N
The Haven –Sharon Lashinger	Residential TX	4	10	Y
Women's Transition Project – Lou Anne Sterbick-Nelson	Residential/transitional hsg; mentoring supporting services	2**	3	Y

DESCRIPTION OF ARIZONA FAMILIES F.I.R.S.T. COLLABORATIVES

SEABHS

Name of Local Collaborative Partner	Type of Service or Role/Function Provided by Local Agency	Type of Link Between AFF Provider Agency and Local Agency*	History of Collaborative Relationship *(Number of years working together)*	Local Agency Representative Attends Quarterly AFF Collaboration Meetings
Women's Transition Project – Jessica Simms	Residential/transitional hsg; mentoring supporting services	2**	3	Y

*** Type of Link**

1. **No formal agreement necessary**. AFF provider agency refers clients to an existing local agency for services and/or materials. This local agency provided services to community members prior to AFF and continues to do so.
2. **Informal arrangement or agreement**. AFF provider agency works out an agreement with a local agency to provide services to AFF clients. This is usually an oral agreement between agency staff, rather than a signed contract or agreement.
3. **Written inter-agency agreement or memoranda of understanding.** There is a written, signed document between AFF provider agency and local agency that specifies the services/materials the local agency will provide for AFF clients.
4. **Subcontract with local agency.** AFF agency signs agreement with a local agency that specifies payment for services provided to AFF clients by this local agency.

**Formal contract planned when agencies' received CSA certification from BHS.

DESCRIPTION OF ARIZONA FAMILIES F.I.R.S.T. COLLABORATIVES

WestCare

Name of Local Collaborative Partner	Type of Service or Role/Function Provided by Local Agency	Type of Link Between AFF Provider Agency and Local Agency*	History of Collaborative Relationship *(Number of years working together)*	Local Agency Representative Attends Quarterly AFF Collaboration Meetings
Jobs Program	Referral Source	1	1	Y
Child Protective Services	Referral Source	1	7	Y
Mohouse Mental ?	Title IX/ ? Co.	1	7	Y
ACCML	Title/IX LaPaz Co.	1	1	Y
Safehouse	Domestic violence homeless shelter	In-house	WestCare	Y
CRRYS	Youth shelter	In-house	WestCare	Y

*** Type of Link**

1. **No formal agreement necessary**. AFF provider agency refers clients to an existing local agency for services and/or materials. This local agency provided services to community members prior to AFF and continues to do so.
2. **Informal arrangement or agreement**. AFF provider agency works out an agreement with a local agency to provide services to AFF clients. This is usually an oral agreement between agency staff, rather than a signed contract or agreement.
3. **Written inter-agency agreement or memoranda of understanding.** There is a written, signed document between AFF provider agency and local agency that specifies the services/materials the local agency will provide for AFF clients.
4. **Subcontract with local agency.** AFF agency signs agreement with a local agency that specifies payment for services provided to AFF clients by this local agency.

APPENDIX D
LESSONS LEARNED IN THE IMPLEMENTATION OF ARIZONA FAMILIES F.I.R.S.T.
EMERGING THEMES FROM INTERVIEWS WITH PROGRAM DIRECTORS

AFF Provider Agency	Facilitators to the Implementation of Arizona Families F.I.R.S.T.	Barriers to Implementation	Anticipated Challenges and Next Steps
AZPAC Yavapai	• Holistic, family-centered service delivery system • Increases in accessibility of services • Collaborative partnerships have increased the awareness of treatment services available in the community	• Newness of the program • Implementation of AFF program in a rural area • The uncertainty of future funding	• Implement the ASI-Lite as the assessment tool • Use evaluation database • Rally local community around the need for public transportation
AZPAC Yuma	• Comprehensive, family-centered service delivery system • Increases in timeliness, availability and accessibility of services • Partnership and support from ADES	• Difficult to implement due to complicated billing procedures and service units • Difficult to build collaborative partnerships	• Develop better collaborative partnerships and case coordination
AZPAC Coconino	• Coordinated service delivery system • Ability to do outreach and follow-up with NT19 and T19 population • Increases in accessibility of services	• Difficult to keep clients engaged in services	• Continue to build relationships with collaborative partners
CPSA	• Coordinated, client-centered service delivery system • Ability to do outreach • Flexibility with support services for NT19 and T19 populations • Increases in timeliness, availability and accessibility of services • AFF sets an example for other substance abuse treatment programs • Clients complete treatment and are reunified with their children • Collaborative partnerships have increased awareness of services among CPS case managers	• Difficult to form collaborative relationships with CPS and providers	• Pull in more collaborators --- next focus will be building relationship with juvenile courts • Develop housing project • Protect future AFF funding
Horizon	• Holistic, family-centered service delivery system • Increases in timeliness, availability and accessibility of services • AFF focuses on mission and philosophy first and leads the way for RBHA's treatment philosophy to change • Collaborative partnerships have increased communication among service providers	• Low number of referrals to AFF program • Multiple perspectives of best substance abuse treatment practices among collaborative partners	• Increase number of AFF referrals • Increase collaboration with JOBS and CPS • Create better advocacy with the legislature

AFF Provider Agency	Facilitators to the Implementation of Arizona Families F.I.R.S.T.	Barriers to Implementation	Anticipated Challenges and Next Steps
Old Concho	• Family-centered, client-centered, empowering service delivery system • Increases in timeliness, availability and accessibility of services • Collaborative partnerships have helped to increase the accessibility of services	• Difficulty in achieving accountability at every level • Lack of funding for case management	• Address the larger treatment picture and the needs of clients with dual diagnosis
SEABHS	• Family-centered, wrap-around service delivery system • Increases in timeliness, availability and accessibility of services • AFF is a very organized program and well monitored by ADES • AFF goals are consistent with “best practices” for substance abuse treatment • Collaborative partnerships have helped to build the relationship between ADES and treatment providers	• Low number of referrals to AFF at the local level • Lack of funding for case management • Difficult to change the preconceived notion held by referral sources regarding the best type of treatment for individual clients (e.g., some CPS case managers believe that residential treatment is the only option for substance abuse treatment)	• Increase collaboration with CPS by bringing all local CPS supervisors to the table • Train treatment staff to understand the constraints and perspectives of referring agencies (CPS)
TERROS	• Family-centered, coordinated service delivery system • Increases in timeliness, availability and accessibility of services • AFF goals are consistent with “best practices” for substance abuse treatment • ADES and ADHS are committed to serving families • Collaborative partnerships help to increase availability and accessibility of services	• Difficult to build relationship with CPS • Difficult to build collaborative partnership where partners share the same vision • Difficult to change staff philosophy to family-centered and individualized treatment approach	• Build and expand collaborative partnerships by including treatment partners and community partners • Build staff competency for family-focused treatment • Analyze issues of treatment capacity • Assess outcome measures at their own sites • Conduct motivational training with staff • Develop and implement more home-based services

AFF Provider Agency	Facilitators to the Implementation of Arizona Families F.I.R.S.T.	Barriers to Implementation	Anticipated Challenges and Next Steps
WestCare	• Comprehensive and motivational service delivery system • Ability to do outreach and engagement with NT19 and T19 clients • Flexibility with support services for T19 and NT19 populations • Increases in timeliness, availability and accessibility of services • Provides services to NT19 clients from CPS or JOBS • Collaborative partnerships increase awareness of services among referral sources (CPS and JOBS)	• Lack of aftercare and supports for clients in recovery	• Increase community collaboration and include faith-based groups and other grass-roots organizations