Bringing Adolescents into Substance Abuse Treatment Through Community Outreach and Engagement: The Hartford Youth Project†

Reginald Simmons, Ph.D.*; Jane Ungemack, Dr.P.H.**; Jennifer Sussman, M.F.A.***; Robyn Anderson, M.A.****; Sandra Adorno*****; Jose Aguayo, A.A.*****; Khary Black, B.A.*****; Steven Hodge, B.A.*****; Rachel Tirnady, B.A.******

Abstract—While outreach and case management services have been shown to improve retention of at-risk youth in behavioral health treatment, these important support services are challenging to implement. The Hartford Youth Project (HYP), established by the Connecticut Department of Children and Families as a pilot for the state adolescent substance abuse treatment system, made outreach and engagement integral to its system of care. HYP brought together a network of stakeholders: referral sources (juvenile justice, schools, community agencies, child welfare, and families); community-based outreach agencies; treatment providers; and an administrative service organization responsible for project coordination. Culturally competent Engagement Specialists located in community agencies were responsible for: cultivation of referral sources; community outreach; screening and assessment; engagement of youth and families in treatment; case management; service planning; recovery support; and advocacy. This article describes HYP's approach to identifying and engaging youth in treatment, as well as its challenges. Use of family-based treatment models, expectations of referral sources, limited service capacity, youth and family problems, and staff turnover were all factors that affected the outreach and engagement process. Process, baseline assessment and case study data are used to describe the needs and issues specific to Hartford's substance-abusing Latino and African-American youth.

Keywords—adolescent, outreach, substance abuse treatment

Throughout the 1990s, substance use among adolescents increased nationwide while the age of initiation decreased, putting more youth at risk of developing long-term substance abuse and dependence (Johnston, O'Malley & Bachman 2002). While there are indications that the rates of substance use have declined in recent years, they remain high.

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*Assistant Professor, Criminology and Criminal Justice Department, Central Connecticut State University, New Britain, CT.

**Assistant Professor, Department of Community Medicine and Health Care, University of Connecticut School of Medicine, Farmington, CT.

***Research Associate, Department of Community Medicine and Health Care, University of Connecticut School of Medicine, Farmington, CT.

****Project Manager, Advanced Behavioral Health, Middletown, CT.

*****Engagement Specialist, Hispanic Health Council, Hartford, CT.

******Graduate Research Assistant, Central Connecticut State University, New Britain, CT.

Please address correspondence and reprint requests to Jane A. Ungemack, Dr.P.H., Department of Community Medicine and Health Care, School of Medicine, University of Connecticut Health Center, 263 Farmington Ave., Farmington, CT 06070-6325; email: ungemack@nso2.uchc.edu; phone: (860) 679-5403; or fax: (860) 679-5464.

In 2005, the National Household Survey of Drug Use and Health (NSDUH; SAMHSA 2006) found that 16.5% of 12- to 17-year-old youth were current alcohol users and 9.9% reported use of marijuana, the most commonly used illicit drug. This national survey also revealed that 8.0% of youth aged 12 to 17 met criteria for substance abuse or dependence. However, less than one in ten (8.6%) identified with abuse or dependence had received substance abuse treatment at a specialty facility, indicating the large gap between treatment need and service use.

According to national data, adolescents living in the Northeast and in socioeconomically disadvantaged urban centers are at particularly high risk for marijuana and other illicit drug use (SAMHSA 2006). Data from the NSDUH, as well as state-specific data, bear out this reality for Connecticut. Historically, Connecticut adolescents aged 12 to 17 have had higher rates of use than the national average for both alcohol and marijuana. A statewide school survey conducted in 2000 showed that 52% of Connecticut's tenth graders reported using alcohol compared to 41% of their peers nationwide as reported by the Monitoring the Future survey (Ungemack, Cook & Damon 2001). The rate of marijuana use among tenth graders was 26% compared to 20% nationwide for that year. It is noteworthy that marijuana and alcohol are the primary problem substances for youth entering substance abuse treatment (Dennis et al. 2002).

In Connecticut, a series of substance abuse treatment needs assessment studies, including a statewide school survey and targeted studies of at-risk youth, were conducted between 1995 and 2004 to estimate treatment needs in the state. Based on a 1995 statewide school survey, it was estimated that 9% of the state's senior high school students and 4% of junior high school students gave sufficient evidence of substance-related behaviors and problems to warrant a more detailed evaluation for substance use disorder (Ungemack, Hartwell & Babor 1997). At-risk populations, such as juvenile arrestees, incarcerated youth, alternative school students and school dropouts and chronic truants, had inflated rates of treatment need compared to youth who were captured by school surveys. One-third of juvenile arrestees met criteria for substance abuse and dependence, and most of those who were substance dependent were found to have high rates of family distress, psychiatric problems (i.e., depression, suicidal ideation), school disengagement, and risky sexual behaviors associated with contracting HIV (Schottenfeld et al. 1996). More than half (53%) of incarcerated adolescents were determined to have met criteria for substance abuse or dependence, mostly attributable to marijuana use (Ungemack, Delaronde & Blitz 1998). Need for treatment was associated not only with age, but also with gender, ethnicity (i.e., Hispanics evidenced higher rates of need than either White or Black students), and type of community. When data from both in-school and out-of-school populations were taken into account, the estimated rate of treatment need in large, socioeconomically disadvantaged urban centers such as Hartford was 11% compared to 6% statewide (Ungemack, Delaronde & Cook 2000). According to a report of the Connecticut Alcohol and Drug Policy Council (2002), approximately 15,000 youth in Connecticut were estimated to be in need of substance abuse treatment or early intervention.

There are many reasons why youth, like adults, do not receive substance abuse treatment. Lack of a perceived need for treatment is the most often cited reason for not obtaining substance abuse treatment services. According to analyses of data from the 2003 and 2004 NSDUH surveys, 90.6% of adolescents with a need for alcohol treatment and 87.4% of those meeting criteria for illicit drug abuse or dependence did not perceive a need for treatment (SAMHSA 2006). Other commonly mentioned explanations for not receiving treatment include: financial barriers; stigma concerns; embarrassment or fear about getting treatment; lack of knowledge about available programs; insufficient availability of treatment slots; and other access issues, such as lack of transportation or childcare and not being able to get time away from ongoing responsibilities to attend treatment (SAMHSA 2006). These barriers to treatment affect parents/caretakers of substance-abusing youths, if not the children themselves.

In communities of color, a variety of additional factors affect both the perception of service need and access to those services. Research has shown that perception of mental health treatment need can vary by race or ethnic background, suggesting that different criteria are being used to identify problem behaviors among different cultural groups (Slade 2003). Research by McMiller and Weisz (1996) found that African-American and Hispanic parents of children with identified emotional and behavioral problems were less likely than non-Hispanic White parents to perceive the need for or to seek professional help for their children's behavioral health problems. Many in communities of color question the cultural appropriateness of existing services or express preferences for nontraditional interventions more in keeping with their cultural values and institutions (Sue & Torino 2005). Access to health services can be impeded by the actual and perceived cultural sensitivity of available services, including linguistic compatibility or fit of the intervention services with the health beliefs and values of the community. Another potential barrier to services is a lack of conviction about the efficacy of mental health or substance abuse treatment, which has also been shown to vary by racial/ethnic background (Bussing et al. 2003). Further, many in minority communities have a "healthy cultural suspicion" of mainstream institutions due to personal experiences or awareness of prejudice and maltreatment towards minority groups (Boyd-Franklin 2003). Whaley (2001) suggests that cultural mistrust can especially impact the attitudes and behaviors of African-Americans when it comes to accessing mental health services. Indeed, some evidence seems to justify this wariness. In their study of service placement

patterns by racial background, Sheppard and Benjamin-Coleman (2001) found that Black youth were three times more likely to be remanded to detention centers compared to White youth who were more frequently hospitalized for comparable emotional and behavioral disturbances. The perceived consequences of admitting to use of illicit drugs or alcohol abuse, especially with respect to criminal justice or child welfare, may also influence individuals' willingness to seek treatment for themselves or family members (Anderson et al. 2006).

Community outreach and engagement has been identified as an effective strategy to increase the identification and utilization of mental health and substance abuse services by high-risk populations with treatment needs (Rowe et al. 2002; Gottheil, Sterling & Weinstein 1997). According to Lerner (1995) and Vera and colleagues (2005), relationship-building, collaboration and needs assessment are essential components of effective outreach and engagement in underserved communities of color. Vera and her colleagues (2005) suggested that members of the majority culture, including service agencies, are often strangers to non-White communities and may not be greeted with open arms initially. They recommended that "outsiders" establish relationships with trusted members and/or institutions in the community when attempting to offer services. Outreach workers who are part of the community have been shown to be effective in identifying and accessing persons in need of behavioral and medical services (NIDA 2000). In an integrated system of care, outreach workers play a key role in problem identification, helping substance abusers access treatment and support services, skill-building, reinforcement of behavioral change, and community education (Jansson et al. 2005; NIDA 2000).

Substance-abusing adolescents typically present with a number of related issues, including: legal entanglements due to criminal activity and arrest, co-occurring mental health problems, poor academic performance, sexual risk, histories of abuse, parental substance abuse and/or mental health disorders, chaotic family life, and unstable housing situations, among others (Dennis et al. 2002). Research shows that persons from historically underserved racial and ethnic groups often need supportive services in addition to therapy to maximize the effectiveness of interventions (Vera et al. 2005). Case management to encourage engagement, retention and access to needed support services as part of an integrated treatment approach has been shown to enhance the benefits of substance abuse treatment (Marsh 2000; McLellan et al. 1998).

THE HARTFORD YOUTH PROJECT

In 2002, the Connecticut Department of Children and Families (DCF) implemented the Hartford Youth Project (HYP) with funding from the Center for Substance Abuse Treatment (CSAT) under the Strengthening Communities for Youth (SCY) Initiative. As the state agency with legislated responsibilities for child welfare, mental health and substance abuse services, DCF designed HYP as a pilot for the State's adolescent substance abuse treatment system using a system of care approach to identify substance abusing adolescents and to bring them into appropriate community-based treatment, especially as an alternative to residential care or incarceration in the juvenile justice system.

Hartford was chosen as the site of the SCY project because of the high perceived need for age-appropriate substance abuse treatment services for the city's youth. The residents of Hartford, a population of approximately 122,000, are primarily of persons of color, including 41% who identify themselves as Hispanic (mostly Puerto Rican) and 38% who are African American or Black (U.S. Census Bureau 2000). The median household income of Hartford's residents in 1999 ($24,820) was less than half the state average of $53,935, with almost one-third living below poverty level. Despite Connecticut's ranking as one of the richest states, Hartford, its capitol, is one of the nation's poorest cities.

HYP's target population was Hartford residents aged 10 to 17 who were identified as either having a substance use disorder or substantial risks for developing one. One of the goals of HYP was to reach youth in the community before they became involved with the criminal justice system, historically the primary source of referrals for adolescents entering behavioral health treatment. By targeting community youth, DCF hoped to intervene early before the youth became more deeply involved with substance abuse.

HYP brought together a network of stakeholders in adolescent substance abuse treatment including: referral sources (DCF, juvenile justice, community agencies, schools, and families); community-based outreach agencies; treatment providers; and an administrative service organization responsible for project coordination and implementation of a management information system. HYP was designed to provide a continuum of substance abuse treatment and aftercare services. One of the distinctive characteristics of HYP was its commitment to family-focused services and family involvement in children's treatment. In particular, DCF worked to develop and implement in-home treatment services based on evidence-based models, including Multi-Systemic Therapy (MST; Henggeler, Pickrel & Brondino 1999) and Multi-Dimensional Family Therapy (MDFT; Liddle 1999). HYP also offered the evidence-based programs of Motivational Enhancement Therapy/Cognitive Behavioral Therapy (MET/CBT; Sampl & Kadden 2000) and Family Support Networks (FSN), which added a family component to MET/CBT. Given the demographic profile of the clientele HYP served, the provision of culturally appropriate services was a priority in planning and implementing HYP.

As depicted in Figure 1, outreach and engagement were integral to the HYP model. Culturally responsive

Engagement Specialists (ES), hired by and located in two community-based agencies (Urban League of Greater Hartford and Hispanic Health Council), obtained referrals from juvenile justice agencies, schools and other community sources, and then linked the youth and families to treatment offered by several different provider agencies, as well as wrap-around support services available in the community. The ESs were responsible for a wide array of tasks designed to bolster and maintain engagement of substance-abusing youth and their families so that they could receive needed services. These responsibilities included: cultivation of referral sources; community outreach to youth, schools, providers, and youth-serving agencies; screening and assessment; engagement of youth and families; case management; service planning; treatment and recovery support; and advocacy. The ESs, who worked with the adolescents and their families throughout treatment and up to one year after their initial assessment, also conducted follow-up interviews.

This article describes HYP's approach to identifying and engaging youth in treatment through the use of Engagement Specialists (ES). It discusses the successes and challenges HYP experienced in implementing this part of the initiative.

THE HYP MODEL

Relationship-building, collaboration, needs assessment, and individualized family-focused treatment were the guiding principles underlying HYP's system of care, and they were demonstrated at the agency, staff and practice levels.

Agency Stakeholders

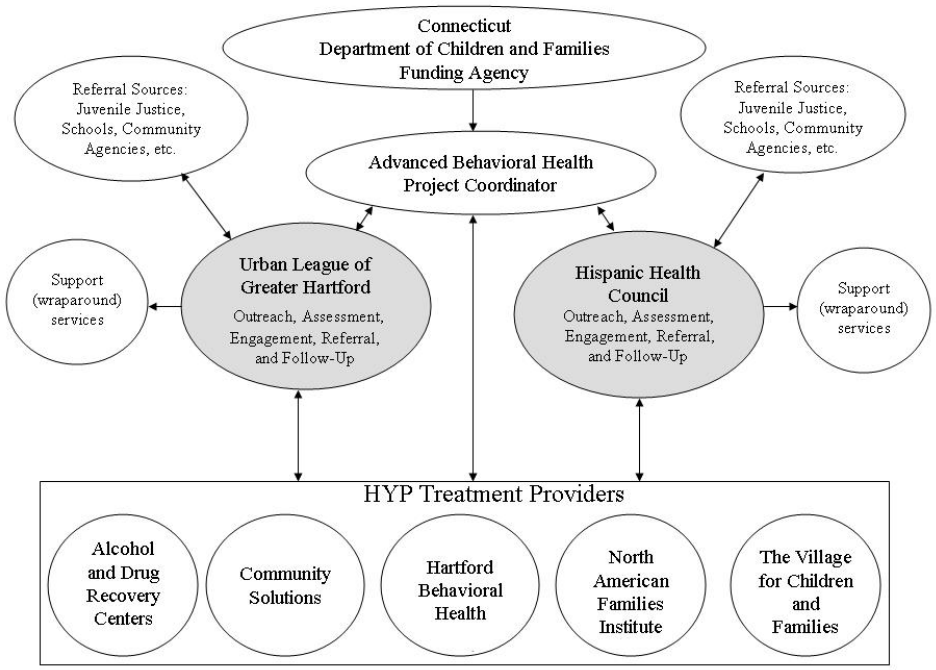
Community-based outreach agencies. Because its central mandate is child welfare, DCF is often mistrusted by members of the state's communities of color even though the agency is responsible for funding and providing a myriad of services benefiting children and youth. To help neutralize its negative public image and to ensure that the two major population groups—Hispanics and Blacks—were reached by HYP, DCF collaborated with two community-based agencies with long histories of service to the Hartford community, the Hispanic Health Council and the Urban League of Greater Hartford. Both are based in or near the communities they serve, enhancing geographic accessibility as well as the comfort level of their clients. Both agencies are multiservice organizations that are trusted and well-utilized by community members for social, educational, vocational and prevention services. Based on the agencies' histories of providing outreach services to Hartford families, DCF worked collaboratively with management staff from the community agencies before and during the project to develop and refine the HYP outreach and engagement model. The community agencies' input helped ensure that the service-delivery model was culturally responsive, a key aspect of effective collaboration. The community agencies were also responsible for staffing the outreach component of HYP and providing on-site daily supervision of the ESs.

DCF and its community collaborators designed HYP so that youth and their families would be quickly and continuously linked to supportive services as needed as part of the intervention to facilitate treatment gains. These ancillary support services included: assistance with housing, medical care, mental health care and financial crises; legal counseling; vocational counseling; educational support; transportation; and childcare. These supportive services were considered to be as important to treatment success as the treatment services themselves. The two outreach agencies either directly offered services or had relationships with other community-based organizations that offered a variety of supportive services for families. The ESs developed, and regularly updated, a comprehensive inventory of community-based organizations and resources available to HYP clients as supportive services.

Referral source linkages. For HYP to be successful, it was critical for the ESs to establish relationships with agencies with access to the target population. Without these relationships, reaching substantial numbers of youth in need of treatment would have been difficult. Beginning in the first year of the project, the HYP Project Coordinator and the ESs developed and implemented a strategy to market HYP to the leadership and staff of these community organizations and groups, including: school social workers; principals; Board of Education members; Hartford's juvenile probation department; parole officers; DCF caseworkers; and task forces and grassroots organizations serving the city's youth and families. Through formal presentations and informal personal contacts, the HYP staff described the project and the treatment and support services available to substance-abusing youth and their families. The HYP staff engaged potential referral sources in discussions about how they could work together to benefit the youth and their families. These discussions enhanced the referral sources' buy-in regarding the value of adolescent treatment services and helped build successful relationships between HYP and the community. The ESs regularly made repeat presentations to established referral sources in order to brief new staff, answer questions, or update key referral personnel. In order to build trust and foster dialogue, the ESs provided status updates on referred youth and their families, as appropriate within client confidentiality constraints. Due to the success of these sustained efforts, the ESs eventually had to do less street outreach and direct solicitation of referrals in order to obtain clients. Referrals began to flow in via phone-calls, emails, and faxes, which allowed the ESs to focus their time and efforts in other areas.

Project coordination. As described above, DCF had brought together a network of stakeholders to build HYP's system of care. The ES and the treatment staff, the stakeholders with the most client contact, were employees of their independent host agencies, including the two outreach agencies and five Hartford-based substance abuse treatment

FIGURE 1
Hartford Youth Project System of Care for Substance Abusing Youth



agencies: The Village for Families and Children (The Village); Hartford Behavioral Health (HBH); Community Solutions, Inc. (CSI); Alcohol and Drug Rehabilitation Clinic (ADRC); and North American Families Institute (NAFI). DCF contracted with each agency to provide services for HYP youth and their families. The ESs worked only on HYP, but most treatment providers served HYP clients via dedicated treatment slots while providing clinical services to other non-HYP clients.

It was an added complication that the evidence-based and manualized family-based models used by agencies serving HYP clients (particularly MST and MDFT) called for providing comprehensive case management similar to that of the ESs. Early in the project, DCF convened the treatment providers and the model developers to define how best to include the ES in the intervention without sacrificing the fidelity of the clinical treatment protocols. DCF, as the lead entity, brokered these discussions to determine the appropriate level and type of ES involvement to maximize positive treatment outcomes without undermining the integrity of the treatment model. The ES case management component was designed as true wrap-around service, active before, during and after treatment. During treatment, the ESs functioned as a key resource as needed to address problems in keeping the youth and family in treatment, allowing the clinical program's own case manager to assume more of a therapist assistant role to directly support treatment.

Another strategy the HYP Project Coordinator used to foster collaboration and coordinate care was to establish monthly meetings between the ESs and treatment providers. They would discuss shared cases and troubleshoot barriers to their clients' treatment. These meetings helped the ESs and treatment providers formulate a better understanding of their youth and families' needs and develop coordinated intervention strategies. Over the course of the project, the treatment providers and ESs began to see each other as valuable assets to their work through their mutual involvement with families.

Quarterly meetings were held with the entire HYP network, including the ESs, treatment providers, evaluators and DCF management staff. In addition to sharing of project data and updates, these meetings provided an opportunity for network members to have input in key decisions regarding the project and to raise issues requiring group discussion and problem-solving. These meetings led to a network identity that went beyond each member's individual agency, fostering rapport among network members and mutual investment in HYP.

Practice Characteristics

The Engagement Specialist role in HYP was multifaceted, involving more than simply identifying and engaging potential clients who are traditionally difficult to reach. HYP ESs were also responsible for assessment, service planning,

pretreatment motivation building, promoting family involvement, facilitating entry to treatment, retention, and client tracking and follow-up. The following describes these roles and how the ESs engaged and retained often challenging, multi-need youth and their families.

Screening and assessment. After receiving a referral, the ES contacted the youth and his/her parents to discuss HYP services. If the youth and parent/caretaker consented, the ES began the process with a brief screening of the youth to determine appropriateness for HYP services by administering a semistructured pre-assessment tool, the Global Assessment for Individualized Needs—Quick (GAIN-Q; Dennis et al. 2002), to assess potential problems in substance use, physical health, mental health, criminal activity and risk behaviors. Because HYP targeted youth at risk of substance use problems as well as those with substance use disorders, very few youth were found ineligible for further assessment. Any substance-abusing youth or youth at risk for substance abuse was eligible as long as the youth had the capacity (i.e., was over 10 years old with no cognitive impairments) to complete the full GAIN assessment and participate in substance abuse treatment. Early in the project, the community-based agencies advised DCF to link all referred youth to some services regardless of HYP eligibility because it would help build a positive reputation in the community. Thus, the intervention protocol allowed ESs to refer HYP-ineligible clients to appropriate community resources, such as primary mental health care.

The ES administered the GAIN-Q upon first contact with the client or, if necessary, at a later time, often at the outreach agency or in the youth's own home. The ESs were a logical choice to conduct the GAIN-Q given their expertise in engaging youth, as well as the trust these community-based, culturally matched staff engendered. At the urging of the outreach agencies, and in consultation with Chestnut Health Systems, probes and alternative wording suggestions were added to the GAIN assessment tools to increase cultural sensitivity for use with Hartford's Hispanic and Black clients. Adaptations included expansion of race and ethnicity categories to better capture Hartford's West Indian and Puerto Rican populations, and the addition of probes to highlight other needs pertinent to Hartford's low-income families, such as lack of food or housing. These minor yet important adaptations facilitated greater understanding on the part of the youth and thus improved the quality of the data gathered.

The SCY-recommended Global Assessment of Individual Needs Interview (GAIN-I) was used to conduct a full baseline assessment of the HYP youth, providing data for treatment recommendation and service provision, as well as for the project evaluation. The GAIN-I interviews were usually conducted in the outreach agency, but some interviews were conducted in detention or lock-up, at school, or in the youth's home, based on the youth's situation.

Initially, DCF had wanted to use independent interviewers to conduct the GAIN-I assessments. However, there were challenges in identifying, training, and certifying a corps of independent GAIN interviewers who were available during key client access times. Frustrated by the assessment delays that resulted, the ESs suggested that they would be best equipped to administer the GAIN-I. Given the sensitive nature of many GAIN items, some youth were reluctant to share information with outside staff, even though they were clearly informed of their rights to confidentiality. Based on their role and the trust they engendered, it was thought that the ESs could obtain the most honest, accurate, and complete data from their clients. Moreover, the time spent in assessment also facilitated relationship-building between ESs and clients. Very few ESs had prior experience administering a comprehensive semistructured assessment such as the GAIN-I. However, with the training and support of the evaluation team, a core group of ESs became proficient GAIN interviewers.

Fostering family involvement. The literature suggests that the active involvement of family members in the assessment and treatment-planning process facilitates positive treatment outcomes with clients of color (Liddle et al. 2006). The ESs set the tone for family involvement early in the engagement process to promote treatment initiation and retention. They scheduled and convened a service planning meeting shortly after a treatment recommendation was made and the client referral was accepted by a treatment provider. The planning meeting included the client, the parent(s) or other primary caregivers, the ES, the treatment provider, and any other person that the youth or family identified as having a significant role in the client's life. These key "others" included: school representatives; social workers; probation officers; extended family; friends; or preexisting providers, such as mental health providers or mentors. The involvement of family and key others in the planning process with the treatment provider and ES facilitated family investment in the treatment process from the beginning.

The ES led the service planning meeting as the primary contact with the family. The meeting was usually held at the outreach agency because it was more likely to be known to the youth and family. Many families had previously received services at that agency or knew others who received services and had been "treated well" by the agency. During the service planning meeting, the family and HYP staff together developed the goals and objectives of treatment, along with timeframes and responsibilities for each stakeholder, including the treatment provider. The goals and objectives addressed the holistic needs of the family, such as educational, vocational, financial, housing, health, recreational or spiritual needs, in addition to the youth's substance abuse treatment needs.

Engagement. Engagement in HYP was a dynamic, ongoing process that varied in intensity throughout the

course of each adolescent's treatment. In the beginning the ESs were typically heavily involved with the family to help them recognize the need for treatment and services available to them; they decreased their involvement once treatment started. At a minimum, the ES stayed involved with the youth in a mentoring role and through planned monthly recreational and educational events. At times, when a client ceased being available for treatment or the family experienced a crisis interfering with their ability to participate, the treatment provider or the family would ask the ES to assist in reengagement efforts or crisis intervention. The ESs also stepped in when the family's case-management needs extended beyond those the adolescent substance abuse treatment provider could address. In those instances where the treatment model did not have a case management component, such as MET/CBT or FSN, the ES served as the case manager for the family, working to refer the family to needed services as the client received treatment.

On occasion, the ES served as liaison between the family and the clinician when a provider had problems engaging a client or family member or a misunderstanding arose between the provider and client and/or the family. Usually, the ES was able to help clarify issues for one or both parties and facilitate relationship-building between the provider and client.

Advocacy. Advocacy is especially appropriate for underserved populations who are disproportionately affected by systemic problems that present barriers to their access to needed services and resources (Vera et al. 2005). Problems faced by HYP families included, but were not limited to: legal entanglements, health problems, lack of income, educational placement and support issues, and housing instability. The ESs often advocated alone or in collaboration with the treatment provider to address these issues on behalf of the families of clients. It was not unusual for ESs to testify on behalf of clients at court hearings, help family members access necessary medical treatment, or assist families in obtaining rent assistance or disability services. These types of problems often either contributed to the client's behavioral health issues or threatened treatment progress.

Engagement specialist training. In order for the ESs to effectively handle their multifaceted role within HYP, training and ongoing supervision were essential. Upon hire, all ESs completed a two-day training that introduced them to the goals and objectives of the project, as well as their roles and responsibilities. The training curriculum covered: the supervisory process; management of referrals; referral response; conduct of service planning meetings; treatment models; community resources; mandated reporting requirements; ethics and confidentiality; crisis-management; and strategies for engaging youth and families. The ESs were trained in expectations regarding the support they would provide to each of the therapy models, as well as in their responsibilities in tracking youth and administering three, six and 12-month post-test measures (CSAT's Government Performance and Results Act reporting and GAIN M-90). In a separate three-day session, the evaluation team provided the ESs with training on administration of the GAIN instruments and then oversaw their subsequent certification in the GAIN. DCF also provided training to the ESs in Motivational Enhancement Therapy and Seven Challenges (Schwebel 2000) to further enhance their engagement and intervention skills and effectiveness.

Supervision. The demands of the outreach and engagement role in HYP required a supervision structure that afforded ongoing support. The outreach agency supervisors were responsible for the on-site daily supervision of their resident ESs. The Senior ES, the first outreach staff hired by HYP who had demonstrated experience and skill in implementing the HYP model, served as a mentor for her coworkers and assisted with their ongoing training. She reported to the HYP Project Coordinator, as well as to her agency supervisor. The Senior ES was the primary gatekeeper for all referrals and the first point of contact for other ESs in need of guidance and direction. She also acted as the key contact for scheduling of HYP-wide outreach efforts, meetings, and prosocial activities for HYP youth.

The HYP Project Coordinator, an experienced clinician, was responsible for the overall supervision of the project and reported to the DCF Director of Substance Abuse Services. The Project Coordinator was responsible for making treatment recommendations, using the GAIN data and the ESs' qualitative input to determine the most appropriate treatment model for each youth. At the weekly case review meetings, the Project Coordinator reviewed and made recommendations for treatment and engagement. The Project Coordinator also provided crisis intervention recommendations to the ESs and morale and administrative support as needed.

The evaluation team worked closely with the Project Coordinator, ESs and their supervisors, meeting with them weekly to ensure that the evaluation and intervention were closely linked and that project data were collected and disseminated in a timely manner. The Evaluation Project Director was responsible for supervising the ESs' tracking and GAIN administration activities.

Engagement Specialist Characteristics

While they varied in education, experience and skills, the most effective ESs had certain key characteristics that were associated with successful outreach and engagement.

Knowledge of the community. Both informal and formal knowledge of the community were important qualifications for the ESs. Knowledge of formal institutions and supports, such as social services, vocational and educational services, was essential, but only a beginning point. Armed with an inventory of community resources that they had created and that were fostered through personal contacts and use,

the ESs were able to connect their clients and families with community assets, such as the faith-based organizations, family advocacy, recreational and sports programs, and grassroots neighborhood organizations or groups working to improve their community. These resources provided support for recovery and were avenues to alternatives to substance use and other problem behaviors.

Familiarity with community statistics was another tool that helped the ESs understand their clients and the challenges they faced. These publicly available social indicators included rates of high school graduation, truancy and dropout, employment, home ownership, poverty, crime, arrest and incarceration. These data were also a resource for engaging community stakeholders and referral sources.

An awareness and understanding of the informal structures and dynamics in the community, not easily discernible to outsiders, was critical for establishing relationships with youth and their families. Examples of such structures are the drug culture, neighborhood turf, and gang affiliations. The ESs were trained to identify community barriers to meetings or involvement with the client and family in order to develop ways of circumventing those barriers and to facilitate program entry and retention. For instance, there were times when an adolescent or caregiver was uncomfortable with the idea of the adolescent coming to the ES's office on their own because it meant traversing a neighborhood that wasn't their turf and could put the youth at risk of physical harm. More commonly, the youth and his/her family lacked transportation to get to meetings or treatment. The ESs were able to provide safe transportation when needed through the use of bus tokens, taxi services, and agency-owned vans.

All of the ESs were racially, linguistically, and ethnically representative of the communities they served. Many grew up or lived in Hartford. Being part of the neighborhood culture, ethnically as well as geographically, afforded ESs access to their clients that would have been more challenging to obtain as "outsiders." Their ongoing presence and participation in the community, through residence, personal ties, work and recreation, increased their accessibility and effectiveness as ESs. Each ES had a cell phone that made it possible to reach them evenings and weekends, as well as during the days. The ESs could respond quickly either in person or via phone when a youth or family was in crisis. This "on call" availability helped build trust in the ESs' commitment to help improve the lives of their clients. Because they were part of the communities they served, they were regarded as insiders by community members.

Commitment and persistence. The ESs who were most effective in engaging and retaining families in treatment were those who did not give up if their initial engagement efforts were unsuccessful. Often, clients who seemed unresponsive were actually wrestling with a treatment barrier that, once identified, could be addressed by the ES. Effective engagement and communication strategies involved persistence, creativity, flexibility and a willingness to seek input from colleagues and those knowledgeable of the youth, including their parent(s). Many of these components have been documented by others as crucial when working with at-risk adolescents of color and their families (Boyd-Franklin, Morris & Bry 1997). The ESs used a variety of strategies to engage reluctant youth and their families, such as:

- Making repeated visits or calls to the client's home at various times of day or on weekends;
- Asking family members about how to best engage the adolescent, which helped reinforce the importance of the family's input and involvement;
- Meeting where the client was most comfortable, whether at home, at school (with family and school permission), at the ES's office or another safe, neutral location;
- Being sensitive to the child and family's previous experiences with treatment or other services to overcome any lingering negative feelings or expectations;
- Finding out about the youth's interests and building those activities into shared time between the ES and adolescent, which provided opportunities to explore alternative outlets for the adolescent and strengthen the relationship between them;
- Planning youth or family-focused activities that were not treatment-focused, such as special event fairs, sports events, campus visits, or holiday parties.

HYP was designed to have two ES staff stationed at each agency (i.e., Urban League, Hispanic Health Council) at any one time. Over the five years of the project, 11 ESs were hired. Seven ES staff had to be replaced when they left for other employment opportunities. Reasons for leaving included: being hired by other agencies that had come to appreciate their competencies; need for better pay; and the realization for a few that being an ES was not a good fit for them. With each change in staff, HYP lost a wealth of informal knowledge of clients that was not well documented in client files or in the MIS system (e.g., client hangouts, aliases, friends, additional collaterals, beeper numbers). Given the personal nature of the relationships each ES established with the youth and families, staff turnover led to discontinuities in some clients' transitions from initial contact to treatment engagement and entry.

Client Profile

The HYP initiative was designed to serve the entire Hartford community, especially the large Hispanic and Black neighborhoods in the city. Between March 2003 and June 2007, the ESs received 360 referrals to HYP. In 21 cases, the ESs were either unable to contact the referred youth or family or they refused to participate in HYP at the initial meeting with an ES. Three hundred thirty-nine adolescents completed the baseline GAIN assessment, including 209 who went on to receive a treatment recommendation. One hundred ninety (91%) of those referred to an HYP clinical service entered the treatment program. The remaining 19

TABLE 1
Hartford Youth Project Client Characteristics by Racial/Ethnic Background

Client Characteristics	African American (N = 117)	Hispanic (N = 190)*	Total (N = 63)
Demographic			
Mean Age (SD)	14.5 yrs. (1.2)	14.7 yrs. (1.2)	14.7 yrs. (1.2)
Male Gender	69.8%	76.7%	74.6%
Single parent	60.3%	72.6%	68.9%
Substance Use			
Past Year Substance Severity:			
No Use	4.2%	0.0%	1.4%
Use	64.6%	63.6%	62.2%
Abuse	22.9%	17.0%	19.6%
Dependence	8.3%	19.3%	16.8%
Current Weekly Marijuana Use	80.6%	81.0%	81.4%
Current Weekly Alcohol Use	49.2%	57.3%	55.8%
Comorbidity			
Past Year Mental Health Problems:			
Internalizing Problems Only	6.3%	7.7%	7.4%
Externalizing Problems Only	42.9%	35.0%	37.4%
Both Internal And Externalizing	20.6%	24.8%	23.2%
Neither	30.2%	32.5%	32.1%
Ever Victimized	55.6%	43.2%	47.4%
Weekly School Absences in Past 90 Days	49.2%	53.8%	51.6%
Sexually Active in Past 90 Days	77.6%	75.4%	76.9%
Multiple Sex Partners in Past 90 Days	41.4%	43.9%	42.9%
Violent in the Past Year	77.8%	74.4%	76.3%
Illegal Activity in the Past Year	61.9%	54.7%	56.8%
Lifetime Juvenile Justice Involvement	95.2%	86.3%	89.5%
Spent 13+ Days in Controlled Environment in Past 90 Days	25.8%	34.5%	30.9%

*Includes 10 cases who were not classified as either African American or Hispanic.

adolescents failed to participate in the treatment program to which they had been referred, although they did receive ongoing follow-up by the ESs.

According to ES reports at weekly case review meetings, youth and their families did not engage in treatment for a variety of reasons. Given the family-focused nature of HYP treatment, both the client and his or her family had to be motivated to participate in treatment. However, it was often a challenge to obtain parental buy-in. Some parent/caregivers did not think that their child had a substance abuse problem. Others felt that the youth's substance use problem was not the family's problem and that the youth should be solely responsible for attending treatment. Some parents did not want therapists to come to their home, especially in cases where there was a coexisting parental substance abuse problem or where the family was already involved with DCF. The adolescent's own resistance to treatment, of course, was another barrier that often could not be overcome. Delays caused by waiting lists for limited treatment slots or treatment providers' need to conduct their own comprehensive eligibility assessments contributed especially to dropout of families between assessment and treatment admission. While the ESs worked hard to keep families engaged in the interim, some clients became incarcerated between assessment and admission or during treatment, or families simply lost interest. In a few instances, the court decided to place youth involved in the juvenile justice system into non-HYP treatment via juvenile justice slots if the HYP treatment admission process was delayed too long.

Of the 190 youth who entered treatment, the majority (59%) were referred by the juvenile justice system, mostly parole and probation officers. The remaining referrals were from DCF's child welfare office (13%), schools, (10%), self or family (10%), and other sources, including treatment providers and social service agencies (8%). Fifty-six percent of the youth entered MDFT, 34% MST, and 9% FSN. Only 1% received MET/CBT with direct services to the youth alone. One hundred seventeen (62%) self-identified as Hispanic or Latino, 63 (33%) identified themselves as African American or Black, and 10 (5%) were from another racial/ethnic group, including White, Asian and Native American. Table 1 shows the demographic and psychosocial profiles of the Hispanic and Black clients served by HYP. Overall, the average adolescent was 14.7 years of age. Three out of four clients

were males and the majority (60% of African Americans and 73% of Hispanics) lived in single-parent households. The substance use and environmental risk profiles of these youth were consistent with the target population HYP had been designed to serve. Most of the adolescents who received treatment services through HYP did not meet substance use disorder criteria at their initial assessment; slightly more than a third (36%) reported sufficient substance-related symptoms to meet diagnostic criteria for substance abuse or dependence prior to treatment admission. Marijuana was the primary problem substance. Despite the relatively low substance abuse severity, almost all youth reported either co-occurring disorders or severe environmental risks that justified intervention. Approximately seven out of ten clients reported symptoms of internalizing and/or externalizing disorders, and almost half admitted that they had ever been victimized, whether physically, emotionally or sexually. Most (95% of Blacks and 86% of Latinos) had a history of juvenile justice involvement, and majorities of youth in both groups admitted engaging in violent or illegal activity in the past year. More than half (52%) of clients reported being absent from school on a weekly basis. Finally, despite their young age, 77% were sexually active and 43% reported having multiple sex partners within the past 90 days. None of the differences in risk according to the race/ethnicity were statistically significant.

Prior to HYP, the treatment completion rate for DCF-funded outpatient substance abuse treatment services was approximately 30%. The treatment completion rate for HYP was 48% overall, including 12% who were transferred to another level of care.

Case Studies

The two case studies below are composites representative of the youth and families served by the ESs from each agency. These cases, written in first person in the voices of the ESs who composed them, illustrate the range of needs and issues in this population and the strategies ESs used to bring and keep these youth in treatment.

Case study #1. A fourteen-year-old Puerto Rican male, "Raul," lived in a small apartment in Hartford with his mother, "Josie", his sister, brother and two nephews (his sister's children). Raul was referred to HYP by a probation officer following charges of marijuana possession, burglary and criminal trespass. An appointment was made to assess the teen at my office at the Hispanic Health Council, with his mother present in an adjacent room.

During the initial assessment, Raul admitted he had a history of school suspensions due to reckless behavior. He had been using alcohol and marijuana since he was about 11. In the past 90 days he had been smoking marijuana on a daily basis to reduce his boredom and to fit in and have fun. He reported that his father lived in Arizona and was basically absent from the family. Raul's mother reported, and Raul confirmed, that he was having problems at home as well as at school, including frequent missed curfews, school absences and truancy, and arguments with his mother and sister. Raul admitted he had a problem with authority figures like teachers, school counselors, and his probation officer because he believed he was mature enough to do what he pleased. He knew that there were consequences of substance abuse and that he was headed for incarceration if he did not improve his behavior. He was concerned that his mother could be arrested and the other children placed in DCF custody if his mother was found to have drugs in her house.

Throughout the assessment, I listened to Raul without condoning his behavior or being judgmental. I told him that his personal information and feelings would be shared only with those assigned to his service within the Hartford Youth Project. In the end, I gained his trust. I told him that it would take one or two weeks to receive his treatment recommendation, but that I would be in regular contact throughout that time. I shared my office and cell phone numbers with him and encouraged him to call me if any situation arose or if he needed to talk.

I also offered my services to his mother, who spoke limited English. Two days later, Josie called to advise me that her heat had been turned off for repeated nonpayment. Josie admitted she was having trouble paying her bills due to a decrease in her scheduled hours at the fast food restaurant where she worked. She did not own a car and so relied heavily on public transportation, but lacked money for bus fare. I brought the utility assistance paperwork to Josie and helped her write a request for funds to the "Starfish Fund," my agency's discretionary fund. I also brought her a week's worth of bus tokens so she could get to work. Within five days, my agency was able to provide fuel assistance of $250, which got Josie's heat turned on. I contacted the gas company on her behalf to arrange a payment plan, due to her limited English skills.

Within a week I received a treatment recommendation for MDFT at the Village for Families and Children. I contacted the family and an appointment was set to have a service planning meeting at the Village with MDFT therapist "Marta." We developed a number of goals to help Raul decrease his marijuana use and improve his behavior at home and school. The meeting was conducted primarily in English, so I acted as translator for Josie, which helped her comprehension and increased her comfort level.

Raul and his family completed treatment with Marta at the Village. Marta reported several improvements upon discharge, including: drastically decreased marijuana use; a decrease in school incidents; improvement in grades; better communication between Raul and both his mother and older sister; and more time spent at home, especially in the evenings. At discharge, Raul was involved in a basketball team through the Boys and Girls Club and had weekly contact with a mentor and ongoing probation monitoring (with no incidents).

Case study #2. Tamara, a fifteen-year-old African American female, was referred to the Hartford Youth Project as result of truancy and suspected substance use. According to the family's DCF worker, Tamara was skipping school to get high. I met with her to administer the GAIN-Q to determine her eligibility for HYP. Tamara was dressed in sweatpants and an oversized t-shirt. She appeared sullen and uncommunicative, and possibly depressed. In response to the GAIN-Q items, she denied skipping school as well as substance use and any other problem behaviors. Based on her answers to the GAIN-Q, Tamara was not eligible for HYP. But I suspected that she was not being honest with me. I spoke with her mother, "Lucille," who reported that, in addition to skipping school, Tamara had been spending time with friends who smoked weed and had come home with eyes red, smelling of marijuana. Her mother also reported that Tamara had been sexually abused by a male cousin at the age of 12. Even if Tamara was not currently using, she was at risk for substance use because of her peer group and other issues. I asked my female colleague to conduct the full GAIN assessment with Tamara to increase Tamara's comfort level. To my colleague, Tamara admitted skipping school and having used marijuana weekly, making her eligible for HYP. Tamara disclosed that she skipped school not to get high but because she "has nothing to wear."

I went to the family's home to meet with Lucille. The family lived in a rental apartment in a three-family house located in a dangerous neighborhood known for drug sales and gang activity. Seeing the condition of the home, and the lack of furniture, I knew that the family had needs beyond substance abuse treatment. Tamara, her siblings (two boys and two girls under the age of 10), and Lucille all needed clothing. There was also an insufficient food supply in the house. Lucille had recently lost her job, and the family was not receiving any benefits.

I worked with the DCF worker to get the children new clothes for school. I contacted Center City Churches to obtain some clothing for the client's mother as well. I transported Lucille back to the Urban League so that she could fill out the paperwork to obtain food stamps. In the meantime, I worked with the local food bank to get the family some food. Based on the Tamara's reported weekly substance abuse, she was referred to Multisystemic Therapy (MST). Lucille also needed support in her daughter's school meetings, including transportation and advocacy. Based on the days she missed, Tamara would need to repeat ninth grade. Based on behavior when she did attend school, and the gang-related activity of her social group, Tamara faced possible expulsion. I asked Tamara to sign an attendance and behavior contract with me. I also accompanied Tamara and Lucille to meetings with school officials, made plans for her to enroll in summer school to help her make up the educational ground she had lost, and advocated for and linked Tamara with a tutor from the Urban League.

As Tamara continued with HYP, it became clear that her behavior was influenced by her surroundings. Her friends were youth from the neighborhood, many of whom were gang and substance-involved. Living in such a dangerous neighborhood was also stressful for Tamara, who was now smoking marijuana regularly. Lucille expressed a strong desire to move from the current neighborhood to ensure her family's safety and Tamara's well-being. I referred the family to the Urban League Housing Department, and they helped the family locate and obtain a two-family house in a much better neighborhood. Without transportation or money for movers, the family needed help moving. I packed and loaded boxes and drove the family back and forth between the old and new house.

The MST team began work with the family, but the family expressed dissatisfaction with the therapist and asked to discontinue treatment. The family felt the therapist could not relate to their situation. I assured the family that the therapist was "on their side" and wanted to help them, and I set up a meeting with the MST team and family in the family's home to discuss barriers to treatment. In the meantime, I contacted the MST therapist for a treatment status on this family. The therapist reported difficulty engaging the family. Because of my various efforts to meet the family's needs, the family trusted that I had their best interests in mind, and I was able to help the treatment provider gain the family's trust so they could continue treatment.

DISCUSSION

The Hartford Youth Project was a system of care model that demonstrated how a diverse group of stakeholders with different agency cultures and service goals could effectively collaborate to meet the complex needs of its hard-to-reach treatment population. To accomplish its aims, HYP placed outreach and engagement at its center. Engagement Specialists were involved in every phase of the client-focused process, from pretreatment and assessment to treatment and then to follow-up, to sustain treatment gains. In order to increase access to and use of adolescent substance abuse treatment services by Hartford's primarily Latino and African American residents, HYP elevated the role of the ES from simply outreach or case management to that of a key intervention agent. The ESs served as a bridge between the youth and family and a network of treatment and support services.

Certain conditions had to be in place to enable the outreach and engagement component to function and thrive in HYP. Consistent with best-practice recommendations for wrap-around services (Walker & Schutte 2004), the state agency, DCF, worked to foster cohesiveness among team members by building commitment to common goals, respect and collaboration. This was challenging to do, especially in the face of differences in skills, professional orientations, and perspectives of the staff and agencies involved in HYP.

The state agency was responsible for oversight and project management, but it actively collaborated with community-based agencies, treatment providers, and other stakeholders in the project's development and implementation, building system-wide buy-in by all stakeholders. With so many agencies involved, role delineation and project coordination were crucial for integrating outreach and engagement and treatment service lines of responsibilities. The resulting infrastructure was complex but well-developed and supported the ESs' success.

Individual characteristics and training are crucial considerations for outreach and engagement. The ES staff had a number of personal characteristics that were considered important for their role, including knowledge of and comfort in the communities they served, strong interpersonal skills, flexibility, persistence and commitment to improving the well-being of youth and families. To help prepare them for their role, the ESs received intensive training in substance use issues, treatment models, assessment, engagement and motivation strategies, community services and advocacy. At all times they had the guidance and support of the HYP leadership. They also had opportunities to guide adaptations to the outreach and engagement model to enhance its cultural appropriateness and effectiveness. The ESs, who had minimal or no higher education, became skilled in identifying client needs, planning for services, leveraging and utilizing community resources for clients, and interfacing with service providers.

Overcoming treatment provider reluctance to integrate nonclinical, nonagency outreach and engagement workers who were employees of another agency into the treatment intervention was a significant challenge. However, through ongoing dialogue between treatment providers, engagement staff, and project management, a collaborative approach was developed in which ESs became instrumental liaisons between the providers and the families, providing crucial case management and other services as a family-oriented wraparound to the evidence-based models.

The family focus of HYP was both an asset and a challenge for engaging and maintaining adolescents in treatment. A family-focused treatment approach for adolescents with substance abuse problems is considered a best practice, especially when used with families of color (Liddle et al. 2006; Boyd-Franklin, Morris & Bry 1997). According to Walker and Schutte (2004), for a family-driven process to be successful in a system of care, structures and supports must be in place that are responsive to client needs but also open to family participation and preferences, incorporate and encourage family strengths, and allow adjustments due to changing family situations. HYP's approach addressed the needs of the whole family rather than just those of the adolescent, but it also depended on the active participation of parents/caretakers as well as the youth. There were numerous barriers to obtaining family buy-in and participation in treatment, including reluctance to participate in the "child's" treatment, resistance to having strangers come into the home, concerns about vulnerability to legal or child welfare problems, and insufficient concern about the child's substance use. Given these types of challenges to implementing HYP's family-oriented services, it is important for future research, as well as policymakers and program developers, to systematically assess the barriers to family-focused models for adolescent substance abuse treatment and how the delivery system can overcome them.

Another initial challenge was the cultivation of community-based referral sources. Schools in particular were reluctant to make referrals to adolescent substance abuse treatment due to concerns about the effectiveness and costs of the HYP approach, student confidentiality, and the stigma associated with substance abuse treatment. Referral sources also hesitated because HYP was new and it had an assertive approach to getting substance-abusing youth into treatment, even though they welcomed its family-focused services. The ESs had to work hard to cultivate relationships with and build the trust of referral sources, using presentations, printed materials, media interviews and ongoing contacts, as well as the HYP's increasingly positive reputation in the community, to convince school and community personnel of its value.

Other challenges were inherent in the ESs' role within the system of care, which included marketing, outreach, assessment, treatment planning, advocacy, case management and data collection. Because of the pressures and time demands of these multiple responsibilities and a large caseload, the ESs required close supervision, crisis management and daily support. The nonhierarchical supervisory structures and the multi-agency design of HYP sometimes made accountability and support functions disjointed and inefficient. Strategies that maximized the ESs' access to ongoing supports and clear direction included integrating agency-level supervisors into regular project meetings and establishing benchmarks that were reported regularly to keep everyone apprised of the ESs' accomplishments and any problems they encountered in the field.

These job-related pressures, the intense nature of the work, and the limited monetary compensation allocated to outreach and engagement contributed to staff turnover among ESs. Given the comprehensive and intimate nature of the ES role and its dependence on building trusting relationships with clients and families, staff turnover threatened continuity of contact and care for the clients. Incoming ESs had to work hard to reconstruct informal client information and rebuild relationships. More systematic documentation of qualitative client information and case sharing were identified as two ways of promoting continuity of both information and client care in the face of staff turnover.

Sustainability of the outreach and engagement component of HYP was a particular concern for DCF. Based on the HYP experience, DCF was able to justify allocation of state resources to expand intensive in-home family-based

models like MST and MDFT statewide. However, finding stable financial support for outreach and engagement was more problematic. Because the ESs were unlicensed, most of the services they provided through HYP were not eligible for cost reimbursement by public or private insurance as most clinical services were, or they were duplicative to case management services the treatment program offered. DCF did have success in sustaining the ESs via state-level funding for the project's post-grant year due to documented evidence of HYP's positive client outcomes, concerted advocacy efforts by HYP youth, families and staff, and the active support of community and agency leaders who realized the value of outreach and engagement for adolescent substance abuse treatment. However, the long-term sustainability prospects in the absence of insurance reimbursement remain uncertain, and support via customary funding options will require development of a well-articulated evidence-based outreach and engagement model.

HYP's goals were to increase access and engagement in adolescent substance abuse treatment. The project exceeded its service objectives in both the number served and in improving treatment discharge outcomes from historical state levels. The rate of successful discharges (clients who either completed treatment or were transferred to another level of care) for HYP was not different from the national rate of positive treatment discharges (48% in HYP compared to 47% found in the national Treatment Episode Dataset; OAS 2005). Future research is needed to quantitatively demonstrate the contribution that this service model makes to treatment access and effectiveness over standard practices, and the conditions under which outreach and engagement is most likely to be needed or succeed. It is possible that outreach and engagement services are more critical to treatment effectiveness with modalities that do not include intensive case management or in-home services, or are more appropriate for minority and/or socioeconomically disadvantaged populations who have multiple needs but limited access to supportive resources.

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