Implementation Guide

Community-based Assessment and Treatment for Adolescents & Families to Launch Interventions for Substances & Trauma

How to Use This Guide

1 PROGRAM OVERVIEW

Offers descriptions of CATALIST's primary elements including planning factors such as training and personnel as well as evidence-based screening and assessment tools and intervention programs.

2 IMPLEMENTATION

Focuses on describing considerations within the different phases of implementing a new model within one's own community and how to thoughtfully approach making adaptations.

3 EVALUATION

Highlight key factors in building a strong program evaluation of the model from evaluation planning through to analyzing outcomes.

4 CATALIST IN ACTION

Highlights one community's experience in implementing the CATALIST model, providing details on how the five phases guided the adoption process and outcomes obtained 2 years post-implementation.

ADDITIONAL RESOURCES

For access to references used throughout this document as well as supplemental implementation materials, please use the QR code to go to our CATALIST Resources page.

For any questions, please contact lpeppard@ubalt.edu.

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Introduction

The CATALIST program enhances and expands community-based prevention, early intervention, treatment, and recovery services for adolescents ages 12-18 at risk for substance use and co-occurring disorders (SUD/COD) and their caregivers.

CATALIST leverages community infrastructures and resources to build a system of care for youth at risk of developing or struggling with SUD/CODs. Services are provided in organizations... within the community to meet the needs of program participants.

GATEWAY & REFERRALS
Prominent originating organizations or programs for identifying, screening, and referring youth into CATALIST include
1) the juvenile justice system
2) middle and high schools
3) emergency rooms

any one of several people or agencies, including: prosecuting attorney/courts, probation officers, guardian ad litem, schools, emergency departments, public health programs, child protective services, truancy officers, local coalitions, caregivers, or oneself.

NINE COMPONENTS:
CATALIST is comprised of nine core components representing a synthesis of evidence-based strategies that can be operationalized in ways that are feasible and acceptable to communities.

PROGRAM GOALS

1. Screen and identify underserved adolescents ages 12 through 18 for SUD/COD.
2. Offer early intervention services for tobacco, risky or hazardous alcohol use, other drugs, depression, and anxiety to low- and moderate-risk adolescents.
3. Increase access to age and developmentally appropriate SUD/COD treatment, recovery, and support services for moderate- to high-risk adolescents referred to the CATALIST program.
4. Provide a coordinated, multi-system, family-centered approach to SUD/COD treatment,expanding comprehensive evidence-based treatment to primary caregivers.
5. Promote intentional culture change through the synthesis of individual, family, and community level strategies.

1 Program Overview

Descriptions of CATALIST's primary elements including planning factors such as training and personnel as well as evidence-based screening and assessment tools and intervention programs.

Nine Core Components

1. Eligibility Criteria

Carefully considering eligibility is important, because the substance use and behavioral health needs of youth in many communities can be substantial while intervention resources may be more limited. All youth ages 12 to 18 are eligible for CATALIST primary prevention, identification and screening services and these services can be administered by originating organizations or programs, as well as treatment programs.

CATALIST early intervention, treatment and recovery services are reserved for youth with identified substance use or at high risk of substance use due to risk conditions present in their lives. Youth eligible for CATALIST services include those with:

IDENTIFIED SUBSTANCE USE

OR

DEPRESSION, ANXIETY, OR TRAUMA, AND one of the following risk conditions for substance use present:

- Parental substance use/ mental health issues
- Involvement in the criminal legal system
- Strong potential to be involved in the criminal legal system through truancy (a criminalcharge)

Youth with sexual charges, violent charges, or personality disorders are not currently eligible for CATALIST services but are navigated into appropriate care. Notably, a high number of youth referred to treatment have assault and battery charges and need treatment for substance use and mental health issues. These charges are considered misdemeanors in many states and not violent charges, therefore, youth with these charges are still eligible for the program.

2. Location of Services

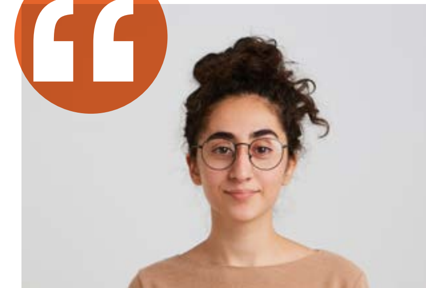
It is important to identify, with community partners, the best location for services based on several variables: community culture, availability of space and resources, interest in offering a range of services for youth and their caregivers, licensure of the facility and appropriate staff, and the role of the facility in community. CATALIST sites are established and trusted resources in the community and should have the infrastructure in place to conduct the full range of CATALIST services.

3. Primary Prevention

Primary prevention programs prevent a specific behavior or disease from occurring. Interventions are implemented with a universal population to prevent a behavior (such as vaping or other substance use) from occurring. The primary prevention program implemented in CATALIST for nicotine and vaping is *CATCH My Breath*. The following resources are also shared in both school and community settings: SAMHSA's *Keeping Youth DRUG FREE* and *Talk. They Hear You*. When possible, community resources such as school-based social workers or school resource officers are leveraged and trained to provide these primary prevention interventions.

4. Screening & Assessment

Universal and secondary screening are discussed in greater detail on page 9. Every eligible youth referred to CATALIST is screened using valid and reliable tools. Youth are universally screened for substance use, depression, anxiety, and social needs.



"I got to meet with different people that I know that have been through what I'm going through. I see that they got past it, so I'm able also to get past it."

CATALIST YOUTH

Some programs may also initially screen for trauma. Further assessment of functioning, determined by scores on the initial screen, is conducted for the following domains: resiliency, belongingness, family cohesion, externalizing and criminal/violent behaviors, and adverse childhood experiences. Caregivers of CATALIST youth entering treatment are also screened for substance use, depression, anxiety and social needs, as well as their perspective on their youth's resiliency and family's functioning.

5. Collaborative Care Model

The Collaborative Care Model (CoCM) is a specific type of integrated care model traditionally implemented in healthcare reference for collaborative care model. The five principles of CoCM include patient-centered team care, population-based care, measurement-based treatment to target, evidence-based care, and accountable care. These principles support a systematic process for identifying and treating depression, anxiety, substance use disorders and trauma. Evidence-based interventions are utilized by behavioral health professionals, and the progress of clients is formally monitored with validated screening tools. Clients are advanced to a higher level of service or care if they do not progress toward their established treatment goals. CATALIST has adopted the core principles of CoCM as a guiding framework.

6. Early Intervention

Early intervention is offered for youth in early stages of substance use. Depending on the risk-level(s) identified during screening, one or more interventions are offered including brief intervention (BI) using brief intervention (BI) and enhanced BI using Motivational Interviewing (also referred to as the Brief Negotiated Interview or BNI), Behavioral Activation, Relaxation Training, This is Quitting, and referral to community resources.

7. Treatment

CATALIST treatment staff and therapists are trained and supported to provide evidence-based individual, group, and family interventions for substance use, depression, anxiety, and trauma. Individual-level interventions include Cannabis Youth Treatment's Motivational Enhancement Therapy/Cognitive Behavior Therapy (MET/CBT), Trauma-Focused CBT (TF-CBT), Eye Movement Desensitization and Reprocessing (EMDR), and Contingency Management (CM) (see Recovery section, page 7). Brief Strategic Family Therapy is used to engage families in youth

INTERVENTIONS

INDIVIDUAL-LEVEL:

- ✓ Cannabis Youth Treatment's Motivational Enhancement Therapy/ Cognitive Behavior Therapy (MET/CBT)
- ✓ Trauma-Focused CBT (TF-CBT)
- ✓ Eye Movement Desensitization and Reprocessing (EMDR)
- ✓ Contingency Management (CM)

GROUP-LEVEL:

- ✓ Wellness Recovery Action Plan (WRAP)
- ✓ Recovery groups (See page 7)

FAMILY-LEVEL:

- ✓ Brief Strategic Family Therapy

> “It is not a one size fits all program. It is a program that touches each individual child's need. That's the beauty of the program, we can find something that is going to be for every personality type.” CATALIST STAFF

treatment. Youth who need more intensive services such as residential care are referred directly to the appropriate level of service. The Case Manager is responsible for managing all aspects of services and care navigation, including screening youth and caregivers. Frequent communication to identify and navigate challenges is essential. For example, the ways in which various components of the program are introduced to potential participants and caregivers is important. Scripts including specific language are discussed among the team and implemented by the treatment staff.

8. Recovery

Since inception, recovery coaching has been an integral part of CATALIST. Youth participating in CATALIST treatment services also have access to Individual and Group Youth Peer Recovery services supported by the CATALIST Youth Recovery Coach (YRC). Youth recovery groups play a crucial role in providing a supportive environment for young individuals overcoming challenges with substance use or mental health concerns. These groups offer a safe place for sharing experiences. The YRC checks in with the youth at the beginning of group to see if they are struggling with anything that week. At times and as appropriate, the YRC may share struggles they have had that may resonate with the youth. The group talks about goals and what they would like to work on during their time in group. The YRC uses that information to create group topics for the next week(s). Examples of discussion themes include communication, personal goals, self-esteem, wellness, stages of change, personal experiences, emotions, mental health, values, time and money management, struggles and setbacks, and relapse prevention planning.

There are times when youth may not want to talk in a group setting for various reasons. In addition to group sessions, meeting individually with the YRC offers a personalized intervention to support and guide youth in their recovery journey. This is important as the YRC has firsthand experience with recovery and personal growth. The YRC may share their story with the youth if appropriate to further build rapport and trust. Individual time with youth provides opportunities for mentorship, guidance, and a safe and confidential way to address individual concerns. In these individual interactions the youth can set goals and work towards their personal recovery millstones.

9. Engagement & Integration of Caregivers

CATALIST was created in response to a need to enhance and expand early intervention, treatment, and recovery services for underserved and at-risk adolescents ages 12-18 with substance use disorders and/or co-occurring disorders (SUD/COD) and their primary caregivers. Caregivers complete their own individual screening at the time their youth engage in treatment services. Caregivers with identified substance use, depression, anxiety, or trauma are connected with outside treatment sites.

The CATALIST Model

FOR YOUTH AND CAREGIVERS

INTENTIONAL CULTURE CHANGE

ENGAGEMENT & INTEGRATION OF CAREGIVERS

- Identification and screening for substance use, depression, anxiety, trauma and social needs
- Referral to treatment as indicated
- Family treatment with youth

YOUTH

COLLABORATIVE CARE CORE PRINCIPLES
drive each aspect of the model.

- ✓ Youth/Family-Centered Team Care
- ✓ Population-Based Care
- ✓ Measurement-Based Treatment to Target
- ✓ Evidence-Based Care
- ✓ Accountable Care

5 RECOVERY

Youth Peer Recovery Group, CATALIST Youth Peer Recovery Coach

4 TREATMENT

Individual: Cannabis Youth Treatment MET/CBT, TF-CBT, EMDR, CM
Group: Youth recovery, WRAP
Family: BSFT
Other: Drug testing, Case management

TARGETED ASSESSMENT

Resiliency, Belongingness, Family Cohesion, Externalizing and Criminal/Violent Behaviors, and Adverse Childhood Experiences

3 EARLY INTERVENTION

BI and BNI using Motivational Interviewing, Behavioral ActivationBehavioral Activation, Relaxation Training, This is Quitting, Referrals to other resources as indicated

2 UNIVERSAL & SECONDARY SCREENING

Substance Use, Depression and Anxiety, Trauma (depending on where screening takes place and staff expertise), Social Needs

1 ORIGINATING ORGANIZATIONS

JUVENILE JUSTICE, MIDDLE & HIGH SCHOOLS, EMERGENCY DEPARTMENTS

RISK LEVEL: MODERATE TO SEVERE — LOW TO MODERATE

PRIMARY PREVENTION

Catch My Breath
Talk. They Hear You.
Keeping Youth Drug Free

PROVIDED BY ANY PROGRAM OR ORGANIZATION AT ANY POINT.

Screening & Assessment: Rationale & Specific Tools

Screening can occur in referral or "originating" organizations or programs such as the courts, schools or emergency departments. Screening can also occur within treatment centers.

Screening can include two phases: Universal and Secondary (defined below). Often, universal and secondary screening are done sequentially at the same time as is the case in CATALIST.

The screening tools used in CATALIST are valid and reliable measures of substance use, depression, anxiety, trauma and social needs. If youth have moderate to severe risk in these areas and treatment is indicated, additional assessment measures are administered to measure strengths such as resiliency and belonging as well as other factors including externalizing and criminal or violent behaviors, family cohesion, and adverse childhood experiences. The measures selected can be utilized for risk stratification to help identify the recommended level of services for youth and their families. Youth enrolled in CATALIST treatment and recovery interventions are assessed using these same measures at intake, at three-months after intake, and again at six-months after intake to measure progress.

For youth enrolled in treatment and recovery services, providers engage caregivers and ask them to complete their own screening. Because we know caregivers are an important factor in their youth's wellbeing, it is critical to screen caregivers for substance use, mental health issues and other factors that can impact their functioning and family. As described earlier, caregivers are asked to complete measures of substance use, depression, anxiety, and social needs as well as share their perspective on their youth's resilience and their family's functioning. Results of the caregiver screening are shared only with the caregiver and additional services and supports are initiated if indicated.

DEFINING TERMS

Universal screening: a brief set of screening items that are given to an entire group or population.

Secondary screening: screening that takes place when an individual is positive for initial risk on the universal screening.

TABLE 1

Youth Screening & Assessment Tools

Table 1 details each tool used for youth and Table 2 details each screening tool used for caregivers. The columns labeled "Universal" and "Secondary" refer to the initial screening that can occur at originating organizations or at treatment programs.

The CATALIST Assessment expands to additional domains to gain a more comprehensive picture of the youth's life.

PLEASE NOTE

Please note that:

1) administration of screening tools is slightly adapted for CATALIST implementation.

2) only those trained in trauma-informed care should administer the Child PTSD Symptom Scale for the DSM-V. References for the published tools can be found in the Appendices.

NAME OF TOOL	UNIVERSAL SCREENING	SECONDARY SCREENING	ASSESSMENT
Strengths	2 items on sources of pride and ways of coping		
Social Determinants of Health	8 items on social needs factors		
Familial substance use (not published)	Single item: Does anyone you live with have smoking, drinking or drug use habits that concern you?		
Familial mental health (not published)	Single item: Does anyone you live with experience depression, suicide or other mental illness that concerns you?		
Screen 2 Brief Intervention for substance use (S2BI)	5 items on past year use of nicotine, alcohol, marijuana, prescription drug misuse, and other illegal drugs	2 items on past year use of synthetics and inhalants	
CRAFFT (symptoms/ behaviors for substance use)	1 item about riding in a car with others under influence	5 items on impact of any substance use; asked if youth endorse ANY past year use on S2BI	
Patient Health Questionnaire-9 (PHQ-9 for depression)	3 items on feeling no pleasure, little interest, and suicidal ideation	6 items on symptoms of depression	
Generalized Anxiety Disorder-7 (GAD-7)	2 items on feeling nervous and experiencing worry	5 items on symptoms of anxiety	
THE CHILD PTSD SYMPTOM SCALE FOR DSM-V (CPSS-V-SR)	8 items on traumatic events and related symptoms. *Note: Schools and Emergency Departments do NOT ask*	21 items on symptoms of trauma	
Child & Youth Resiliency Measure (CYRM)			17 items on resilience
General Belongingness Scale			12 items on belonging
Family Adaptation and Cohesion Evaluation Scales (FACES-III)			20 items on family functioning
Global Appraisal of Individual Needs Short Screener (GAIN SS) Externalizing and Criminal/ Violence behavior scales			10 items on adolescent externalizing and criminal/ violent behaviors
Adverse Childhood Experiences Questionnaire (ACE-Q for trauma)			2 items on number of traumatic events youths have experienced

> I started paying more attention and trying to find out really what I was experiencing instead of just accepting it as normality.”

TABLE 2

Caregiver Screening & Assessment Tools

MEASURES	UNIVERSAL	SECONDARY
Social Determinants of Health	8 items measuring social needs factors	
Familial substance use	Single question: Does anyone you live with have smoking, drinking or drug use habits that concern you other than your youth who is receiving services here through the CATALIST program?	
Familial mental health	Single question: Does anyone you live with experience depression, suicide or other mental illness that concerns you other than your youth who is receiving services here through the CATALIST program?	
Tobacco use	1 item on past year use of nicotine	
U.S. Alcohol Use Disorders Identification Test (US AUDIT for alcohol use)	3 items on past year use of alcohol	7 items on impact of alcohol use
Modified Drug Abuse Screening Test (DAST-10 for other substance use)	4 items on past year use of cannabis, prescription opioid misuse, prescription drug misuse, and other illegal drugs	9 items on impact of cannabis use, prescription opioid misuse, prescription drug misuse, and other illegal drug use
Patient Health Questionnaire-9 (PHQ-9 for depression)	3 items on feeling no pleasure, little interest, and suicidal ideation	6 items on symptoms of depression
Generalized Anxiety Disorder-7 (GAD-7)	2 items on feeling nervous and experiencing worry	5 items on symptoms of anxiety
Child and Youth Resiliency Measure (CYRM) Caregiver Resilience	17 items measuring resilience	
Family Adaptation and Cohesion Evaluation Scales (FACES-III)	20 items measuring family functioning	

Evidence-Based Strategies

CATALIST uses evidence-based practices (EBPs) that have been found effective for preventing substance use and treating youth for substance use and co-occurring mental health disorders. Collectively, the proposed EBPs can support communities in providing a full continuum of services from primary prevention through to recovery so that youth receive effective intervention targeted to the level appropriate based on their presenting risk as determined by the screening and assessment process. Here is a brief description of each of the interventions utilized.

PLEASE NOTE

This is not an exhaustive list of EPBs for youth but rather, the EBPs described here have been identified within the CATALIST model as optimal when considering a range of youth population factors (e.g. accounting for diverse demographic factors, ease of EBP implementation in community settings, ease of sustainability, etc.).

PRIMARY PREVENTION INTERVENTIONS

Catch My Breath (CMB) is an e-cigarette and vaping education-based prevention program for grades 5-12. CMB aims to increase awareness in students, teachers, parents, health professionals, and concerned citizens about youth vaping and its consequences. Students are introduced to skills in self-awareness, self-management, social awareness, relationships, and responsible decision making. Caregivers are provided with resources to assess their child's vaping and support them in reducing vaping risk. CMB outcomes include increased vaping knowledge, increased perception of positive outcomes for not vaping, and reduced likelihood of vaping in the year following program implementation (Baker et al., 2022; Kelder et al., 2020).

Talk. They Hear You. is a primary prevention program designed to engage parents and caregivers, educators, and community members in having and continuing conversations about underage drinking and substance use, including looking for signs for when a youth may need more support. **Talk. They Hear You.** provides resources to increase awareness of the prevalence and risks of underage drinking and substance use and provides caregivers and others with opportunities to learn and practice different skill-building techniques and use helpful resources and tools. The ultimate goal of the program is to increase caregivers' and others' actions to prevent underage drinking and substance use by frequently talking with youth about the risks and dangers of substance use (SAMHSA, 2020; https://www.samhsa.gov/talk-they-hear-you).

Keeping Youth Drug Free is a resource guide for parents offering advice on keeping youth substance free. The guide reviews statistics about adolescent substance use and offers tips on good communication for caregivers and other caring adults to use when talking with youth about substances. The guide also features case studies for additional insight (SAMHSA, 2020; https://store.samhsa.gov/sites/default/files/sma17-3772.pdf).

EARLY INTERVENTIONS

Motivational Interviewing (MI) is widely recognized for facilitating decision-making and behavior change with a robust literature showing it leads to greater rapport, desire and commitment to change, actual behavior change, and treatment engagement/ engagement/retention, including with adolescents (Miller & Rollnick, 2023; Naar & Suarez, 2021; Carroll et al., 2006). MI skills are foundational to many brief intervention models including those used to activate behavior change that reduces substance use and co-occurring mental health risk. Delivery of many EBPs are influenced by this intentionally respectful way of being to empower personal choice regardless of ethno-racial, sexual, gender, economic, or other diversity. MI also serves as one of the foundations for addressing attitudinal barriers and obstacles while engaging leaders, stakeholders, staff, and community partners throughout the project implementation process.

For youth who score positive for low to moderate risk and could benefit from early intervention an enhanced Brief Intervention, the **Brief Negotiated Interview (BNI)**, a 5-15 minute semi-structured conversation designed to facilitate positive health behavior change, may be used. The BNI utilizes MI to build rapport, explore pros and cons of use, provide information, elicit feedback, and collaboratively create a plan for change. The BNI has an extensive literature base supporting reductions in substance risk for adolescents and adults (Bernstein et al., 1997; Saitz et al., 2014; Bernstein et al., 2009).

TEXT-TO-QUIT

Another brief intervention for depression risk is a single-session of **Behavioral Activation (BA)**. BA is a therapeutic intervention (Lejuez et al., 2011) to decrease depression by promoting activation towards value-based activities. It has demonstrated effectiveness as a BI for adolescents and adults (McCauley et al., 2016; Gawrysiak et al., 2009). The BA for anxiety risk is a single-session **Relaxation Training** which may include autogenic training, progressive muscle relaxation, diaphragmatic breathing, and guided imagery. Relaxation training is a firmly established intervention for reducing anxiety across age groups (Manzoni et al., 2008)

This is Quitting (TIQ) is a text-to-quit vaping program for adolescents and young adults designed to provide youth access to daily evidenced-based tips and strategies to quit vaping products. Youth receive strategies targeted to their level of readiness to quit and can request additional support during times of increased need (e.g., elevated stress). Youth also receive messaging from peers who have attempted or successfully quit vaping to normalize the various motivational stages during the quit process. Parents can enroll to receive strategies for how to support their children as well as pursue quitting themselves. TIQ program outcomes have demonstrated over 50% reduction or abstinence from vaping after two weeks of program use with 30-day abstinence rates at 16% (Graham et al., 2020; Noar et al., 2019).

Social Determinants of Health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life risks and outcomes. As stated earlier, routine screening is done to identify risks among SDOHs including food security, utilities, housing, child-care, healthcare costs, transportation, literacy, safety in the home, substance use in the home, and depression/suicide/mental illness in the home (Meyer et al., 2020). As needs are identified, the provider partners with the family to assertively refer them to resources in the community to address those needs.

Relaxation training is a firmly established intervention for reducing anxiety across age groups

TREATMENT INTERVENTIONS

Cannabis Youth Treatment's Motivational Enhancement Therapy (MET)/Cognitive Behavioral Therapy (CBT). MET and CBT are gold standard therapeutic interventions with robust evidentiary support for treating adolescent and adult substance use disorders/co-occurring mental health disorders (SUD/COD) when used alone (Lenz et al., 2016; Hofmann et al., 2012); or combined (Dennis et al., 2004). CATALIST uses the Cannabis Youth Treatment series volumes 1 and 2, an integrated 5 to 12 session MET/CBT model to effectively and efficiently enhance and sustain motivation while teaching intrapersonal, interpersonal, and social support skills to youth with SUD/COD.

Trauma Focused CBT (TF-CBT) is an evidence-based, trauma focused treatment for children and teens between the ages of 3 and 17. TF-CBT is a short-term treatment model ranging from 8 to 25 sessions. TF-CBT is a skills-based treatment model that effectively addresses trauma and trauma impacts including affective (e.g. depressive, anxiety), cognitive, and behavioral problems, as well as improving participating caregiver's personal distress about the adolescent's traumatic experience, effective caregiver skills, and supportive interactions with the adolescent (de Arellano et al., 2014).

Eye Movement Desensitization and Reprocessing (EMDR) is a treatment that enables people to heal from the symptoms and emotional distress that are the result of traumatic experiences. EMDR focuses on directly altering the emotions, thoughts, and responses resulting from traumatic experiences. The technique used in EMDR is intended to change the way a traumatic memory is stored in the brain, thus reducing, and eliminating the problematic symptoms (Rodenburg et al., 2009; Racco & Vis, 2015; Olaghere et al., 2021).

Contingency Management (CM) is among the most effective treatments for addressing SUD in adults (Prendergast et al., 2006). The model uses immediate and desirable rewards to reinforce abstinence and increase treatment retention. CATALIST programs employ the fishbowl CM method which provides treatment participants an opportunity to randomly select a reward from a fishbowl with rewards varying in size and monetary value. CM, including the use of the fishbowl, has been found to increase engagement, retention, and improve outcomes (Petry et al., 2000; Stanger et al., 2009; Stanger et al., 2015; Kamon et al., 2005).

Brief Strategic Family Therapy (BSFT). BSFT seeks to change maladaptive family interaction patterns by coaching family interactions as they occur in session to create the opportunity for more functional interactions to emerge (Robbins et al., 2009). The major techniques used are joining (engaging and entering the family system), diagnosing (identifying maladaptive interactions and family strengths), and restructuring (transforming maladaptive interactions) (Valdez et al., 2013). BSFT is a short-term, problem-oriented intervention. A typical session lasts 60 to 90 minutes. The average length of treatment is 12 to 15 sessions. For more severe cases, such as substance-using adolescents, the average number of sessions and length of treatment may be doubled, perhaps to 24 weeks. BSFT effectively integrates with other models such as Motivational Interviewing, TF-CBT, Seven Challenges and CBT (part of BSFT draws heavily from Cognitive Behavioral Theory).

RECOVERY INTERVENTIONS

Youth Peer Recovery Groups are facilitated by a Youth Peer Recovery Coach. These groups provide pro-recovery peer and adult role models, structured activities and a positive social climate that promotes fun, a sense of belonging, and accountability. Such elements are likely to help adolescents resolve their ambivalence about SUD recovery and increase their motivation to engage in the hard work of recovery (Paquette et al., 2019; Oser et al., 2012).

Youth Peer Recovery Coaching is provided individually to youth via a Youth Peer Recovery Coach. Recovery coaching has been found to contribute to decreased substance use and increased remission for both adolescents (Godley et al., 2019) and adults (Bassuk et al., 2016).

Personnel

How your community decides to implement the CATALIST model in addition to the size of your community will determine which types of and how many personnel you will need.

For example, if organizations such as courts, schools and emergency departments will be doing the universal screening and possibly the secondary screening and early intervention, it may be that existing personnel within those organizations adopt those responsibilities. If, as in the case of our community example (described later), a local outpatient treatment services provider adopts all aspects of the model from prevention through to recovery, you may need to hire or ensure a current staff person can fulfill the role of the CATALIST Services Coordinator. Critical factors that must be considered is if, within any given role, they can fulfill the range of responsibilities listed and they have the necessary credentials given the tasks they will be overseeing.

CATALIST Services Coordinator (CSC)

The full-time CSC engages in the following activities: manages all aspects of care navigation for CATALIST youth, delivers early interventions for youth, connects youth and primary caregivers with additional recommended services, schedules weekly team meetings. and assists with treatment data collection to measure individual youth and programmatic progress over time. Desired qualifications include having a Bachelor's degree in social work or behavioral health discipline and two years of experience working with adolescents and families experiencing substance use and behavioral health conditions.

Clinical Therapists

Therapists provide direct therapeutic support and interventions to identified adolescents struggling with or at risk of developing substance use disorders. The clinical therapist is someone who understands substance use, co-occurring/co- existing disorders and the varying manifestations associated with such disorders.

Therapists promote recovery by addressing the often-complex needs of youth and their caregivers and are responsible for providing screenings, assessments and conducting individual, group, and family therapy, completing treatment planning, participate in multi-disciplinary treatment team meetings, and collaborate with all available community resources while preparing reports, correspondence, and documents. Desired qualifications include having a Master's degree from an accredited institution in Professional Counseling, Social Work or related field required, a professional license to practice therapy within the state in which the program is located, and two years previous experience.

Youth Recovery Coach (YRC)

The CATALIST YRC leads Youth Recovery Groups; provides individual support services to youth as needed, and meets weekly with the CSC and therapists to discuss the status of youth. Qualifications include being a person with lived experience in recovery and having completed the peer recovery coaching certification.

JOB DESCRIPTIONS INCLUDED IN RESOURCES

2 Implementation Guidance

The 5-phase process and key elements presented in this section supports communities in thinking through the process of assessing the need for, developing, and implementing the CATALIST model.

Five Phase Approach

Whenever one sets out to consider starting something new, to build a program or a continuum of services in this case, it is critical to consider how to go about such efforts in the most effective way possible. Drawing from several frameworks and systems, the five-phase process presented below supports communities in thinking through the steps of assessing the need for, developing and implementing the CATALIST model.

> “Sometimes people need a little help. Trust me, when I tell you there's no heroin addict out there, cocaine addict or alcoholic out there that likes their condition, they want to be free from it. They just do not know how to do that alone. They need the right type of treatment, the right type of support, the right opportunity. They want to be people who feel like they are connected with other people and have people that care about them and people they can talk to and socialize with. It takes more than just a good leader to run this program. It takes people in the community that support programs like this too.” CATALIST CHAMPION

Phase 1: Mobilize

Building a community team of relevant stakeholders who are willing to work together to pursue implementation of the CATALIST model is critical. Thus, the first phase focuses on identifying and mobilizing community members. Common activities in the mobilization phase include determining roles and responsibilities of the implementation team, identifying a team leader to oversee and manage the process, building knowledge among the implementation team, defining the goals and scope of the effort, and building community awareness and support for the model.

CATALIST “champions” may or may not be members of the implementation team. A champion is someone who believes in the model and its ability to achieve the community’s goals for promoting intentional culture change by supporting wellbeing through the prevention and reduction of adolescent substance use and co-occurring mental health disorders. Thus, part of mobilizing involves identifying model champions and determining how they will partner with the CATALIST implementation team.

Phase 2: Assess

Community assessment is the process of identifying the strengths, assets, needs and challenges of a specified community. Given the purpose of the CATALIST model, a community assessment focuses on strengths, assets, needs, and challenges within a specific community as it pertains to addressing adolescent substance use and co-occurring mental health challenges. Community assessments are essential to the development of a sustainable and comprehensive infrastructure. These assessments reveal the most pressing needs and available resources to inform the selection of interventions. Community assessments typically measure the following:

- Prevalence of substance use (who is using what)
- Gaps in evidence-based programming
- Gaps in implementation resources
- Opportunities for implementation support
- Community strengths and assets

Typically, this information is collected using both quantitative and qualitative data. Sources of data may include archival data (e.g., past records of substance-related problems such as number of school-identified youth of concern or number of youth requesting treatment services in the community, number of emergency room visits for overdose, etc.), survey data (e.g., national and local assessments of youth substance use), key informant interviews (e.g., interviewing youth or school personnel), and focus groups.

The idea of collecting data as part of a community assessment may feel overwhelming to community teams. Team leaders can maintain the momentum developed during the mobilization phase by providing the rationale for the assessment content, identifying existing data sources, developing an assessment approach that fills gaps between what data exist and are needed, and taking lead on organizing the data and drawing meaningful conclusions.

Team leaders are also encouraged to develop a summary report highlighting the key findings from the assessment and to share and elicit feedback from the community. Assessment findings and community feedback will propel the team toward agreed upon priorities that have community support and help garner resources to allocate to the development of a prevention infrastructure and implementation of selected interventions.

Phase 3: Plan

The planning phase includes several key activities that will support implementation teams in working together to build the CATALIST model. These activities include transforming identified needs into goals and SMARTIE (Specific, Measurable, Achievable, Relevant, Time-Bound, Inclusive, and Equitable) objectives, possibly developing a logic model for the community-level prevention, early intervention and treatment, identifying and selecting effective strategies such as the ones described in this implementation guide, and developing an evaluation plan to measure implementation efforts and outcomes. It is essential that the planning team intentionally elicit and integrate stakeholder perspectives throughout this phase.

Teams need to ensure that the selection of interventions are supported by high-quality research to achieve the prevention outcomes specified in the logic model. Outcomes may include enhanced protective and reduced risk conditions, and/or delayed or reduced substance use and other problem behaviors. Substance use intervention strategies with a strong evidence base can often be found on public registries that provide a

"I graduated high school, and that's a big step because I know I couldn't have done it if I wasn't sober."

CATALIST YOUTH

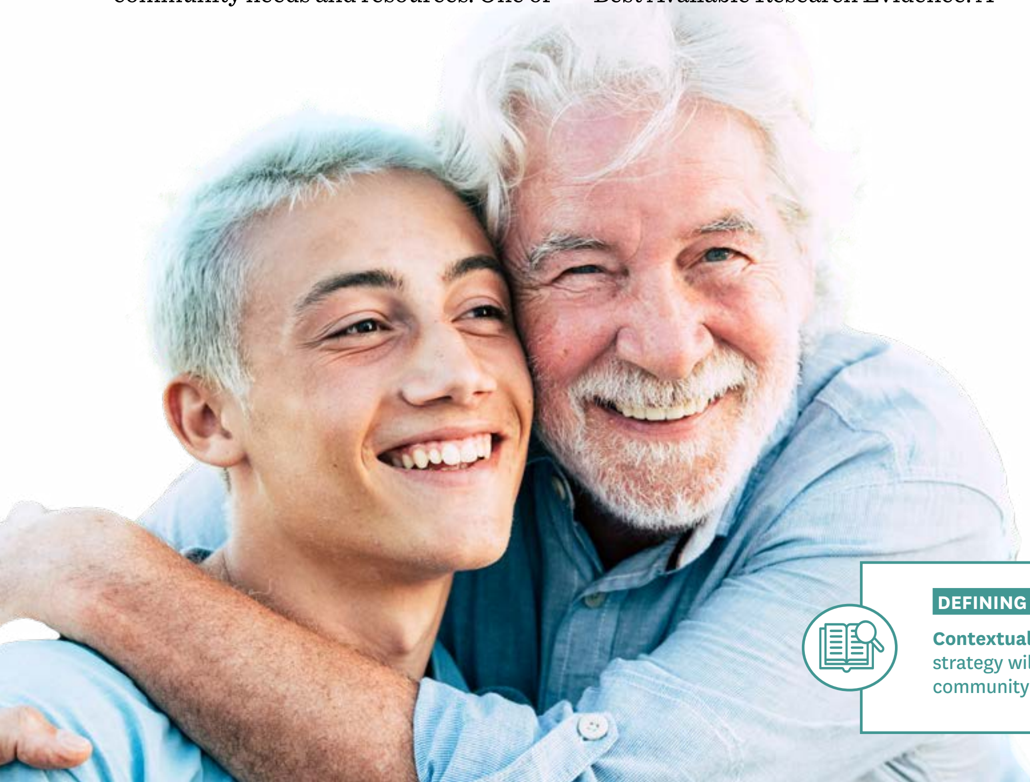
"A lot of things got brought up in therapy that some of us struggled with that we didn't know that each other struggled with. Our therapist would give an example of what somebody could do to make them feel better. It would happen at my house, and it would improve the living environment." CATALIST YOUTH

summary of available data and offer a rating based on the strength of the evidence and effectiveness of the strategy.

It is also important to attend to the fit between the selected strategy and community needs and resources. One of the limitations of current science is that not all evidence-based interventions have been tested within varied demographic groups. The Center for Disease Control's "Understanding Evidence Part 1: Best Available Research Evidence. A Guide to the Continuum of Evidence of Effectiveness" offers guidance on how to consider fit based not only on the best available research evidence, but also contextual and experiential evidence.

Contextual evidence informs how likely effective implementation will be by assessing the necessary resources to implement an identified program or strategy with high fidelity or as intended; whether a program or strategy will be useful and is appropriate for that community or setting; whether it will be feasible and successful given the economic, social, geographic, and historical aspects of the community or setting; and finally, the likelihood it will be accepted by the people and decision makers in the community or setting.

Experiential evidence refers to the collective experience and expertise of those who have practiced or lived in a particular setting. Experiential evidence can inform the decisionmaking process by answering questions about what has and has not previously worked in a community, whether the program or strategy would appeal to stakeholders and participants, and importantly, whether it would meet the needs and goals of its target population.



Phase 4: Implement

In this phase, communities implement community-level and/or selected activities. Key activities in this phase include:

- creating any needed policies or operating procedures including any agreements across community programs
- defining workflows for how primary prevention programs will be delivered and how youth will be identified, screened, and provided with targeted interventions based on risk
- ensuring adequate resources and training are delivered
- preparing for implementation by developing community-level and program/strategy- specific evaluation plans initiating sustainability planning

When adopting and implementing a new model or series of programs on a community level, it is critical for each organization to identify how current policies and operating procedures impact the implementation of the model. Across each involved organization, key staff will need to consider if any changes are needed to such policies and operating procedures in order to facilitate successful use of the model. In addition, given the CATALIST model is a community-based model involving multiple youth-serving organizations along a continuum of services, ensuring agreements

DEFINING TERMS

Contextual evidence: whether a program or strategy will be useful and is appropriate for that community or setting.

Experiential evidence: the collective experience and expertise of those who have practiced or lived in a particular setting.

"I think you must have a passion for helping people and wanting to meet them right where they are at. I think you must be very flexible and open. I think kind and caring and empathetic are the characteristics that were needed within these positions." CATALIST STAFF

or memoranda of understanding exist that foster communication across organizations is essential. Defining workflows will further help identify the types of changes in policies, operating procedures and agreements across organizations. Workflows are detailed maps of the pathways by which youth and caregivers take part in the CATALIST model. Such maps include points of entry into the model, where and who will deliver the range of services within the continuum, as well as eligibility criteria and where youth who are not eligible can be referred. Developing workflows can help the CATALIST implementation team to consider facilitators and barriers to employing the CATALIST model.

Workforce training is an often-overlooked element, yet essential for success. CATALIST implementation teams can develop a training plan that specifies which professionals will be trained, the training they need to receive, the process for ongoing support and professional development, and funding required for training-related activities. Training plans should be grounded in the goal of helping the identified professionals achieve the knowledge, skills, and competencies needed to deliver the identified evidence-based interventions.

Sustainability planning begins during mobilization and continues throughout all five phases. However, during implementation, implementation teams firm up community-level and selected intervention-specific sustainability plans. High quality implementation resulting in intended outcomes and satisfaction with the prevention or intervention activity help to ensure the continuation of that activity. At the community level, factors that support sustainability include having a high functioning implementation team, developing the CATALIST infrastructure, securing ongoing financial supports and resource allocation including considering reimbursement models, ensuring ongoing training and technical assistance, demonstrating intended outcomes, and disseminating those outcomes to engender community support.

"A lot of people in this program has shown me that no matter what it is I'm going through, they can make time to help me. That was a big struggle of mine, not feeling like I mattered and that's definitely helped." CATALIST YOUTH

DEFINING TERMS

Process evaluation: The evaluation of the types and quantities of services delivered.

Outcome evaluation: The measure of change in key indicators over time.

Phase 5: Monitor & Evaluate

Monitoring and evaluation processes begin during the community assessment phase and continue throughout all phases. **There are two main types of evaluation: process and outcome.** Both are important in determining the effectiveness of prevention and intervention activities.

Process evaluation gives information about how, and how well, a program or strategy was implemented. The focus of process evaluation includes the types and quantities of services delivered, beneficiaries of those services, resources used to deliver the services, practical problems encountered and ways such problems were resolved. This type of evaluation data includes tracking core planning and ongoing implementation activities (e.g., implementation fidelity, intervention dose, process for adaptations, continuous quality improvement) along with other program inputs and outputs. Process evaluation helps increase understanding of how program impact and outcome were achieved, key elements for program replication and true costs of implementing the program.

Outcome evaluation demonstrates whether the program or strategy had the intended impact and includes short, intermediate, and longer-term program outcomes. The focus of outcome evaluation includes measuring change in key indicators over time including increases in protective factors such as youth resiliency, youth sense of belonging, and family functioning as well as decreases in risk factors including substance use and mental health symptoms. This type of evaluation often includes repeated data collection over time starting when participants, in this case youth, begin to receive services.

Documenting what and how much was accomplished (i.e., process) and whether it made any difference (i.e., outcome) is important in determining what needs to change to improve or justify continuation of a specific program. When thinking about how to monitor and evaluate the CATALIST model, comparable processes are followed. Process and outcome evaluations are informed by the community-level logic model and used to determine whether the synthesized set of activities achieved their intended outcome(s). Factors that influence how well the CATALIST model is working include the effectiveness of the implementation team, impact of the implemented programs and/or strategies, and progress made toward development and sustainability of a supportive infrastructure. It is generally recommended that program-level evaluations be implemented at least annually, and community-level assessments be implemented every two years as these time points allow opportunities to measure the impact of the intervention, program, or model.

Balancing Fidelity & Making Thoughtful Adaptations

It is important to implement selected programs or strategies using techniques that ensure high fidelity as fidelity has been found to impact program effectiveness.

The process of assessing program fit will uncover where CATALIST characteristics differ from the local context. At times adaptations may be needed to best suit a community's organization setting context, preferences, needs, values and customs. For example, a program that has only been evaluated as effective in a legal setting (e.g. drug court), will need to be adapted to increase the fit within an outpatient treatment program in a health system. Adaptations may include additions, deletions, modifications, and reordering.

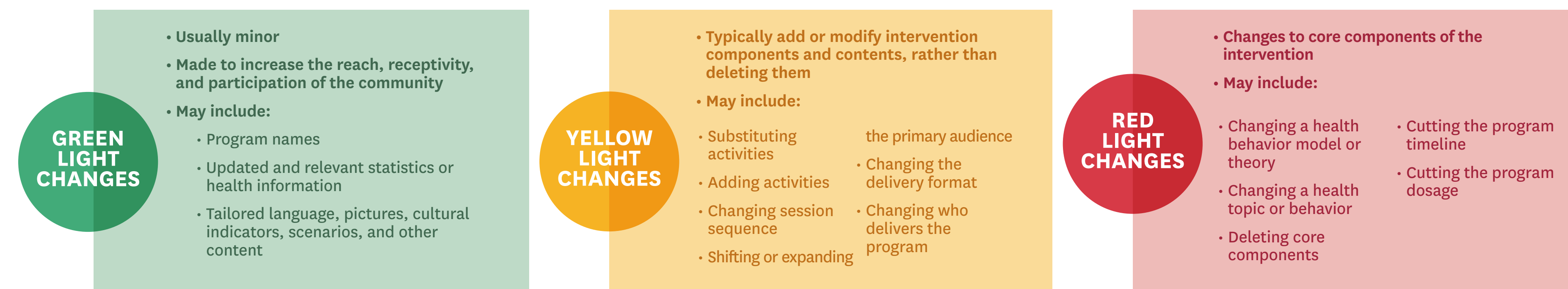
Program developers will sometimes speak to the adaptation process in their intervention materials, specifying which adaptations are allowed (green light), which require consultation with the developers as they could diminish program effectiveness (yellow light), or which cannot be adapted (red light). Figure 2 provides a summary of common green, yellow, and red light adaptations (Balis et al., 2021). Each of the evidence-based interventions chosen for CATALIST have core components that have demonstrated efficacy when used as described. Alterations to these may not result in the desired outcomes.

When the need for adaptation arises, it is recommended to review adaptation information and recommendations provided by the program developers. There will be times when a program developer does not intentionally address an adaptation under consideration or when there is no guidance on what adaptations can be made. In both circumstances, it is recommended to seek guidance directly from the program developers before implementing an adaptation. When consultation with the intervention developers is not an available or feasible option, it is recommended to follow best practices for how to effectively maintain fidelity to the core complements of a program while making thoughtful adaptations to meet the needs of the target population. One such resource is Balancing Fidelity and Adaptation: A Guide for Evidence-Based Program Implementation (Cooper et al., 2019). Where possible, it is ideal to plan adaptations ahead of time while recognizing that adjustments may need to be made during the implementation process in response to new information or circumstances.

DEFINING TERMS

Program fidelity refers to the degree of adherence and competence to core components that make an evidence-based practice effective and the actual implementation of that program in a new setting or community (SAMHSA, 2002).

FIGURE: NAME OF FIGURE?

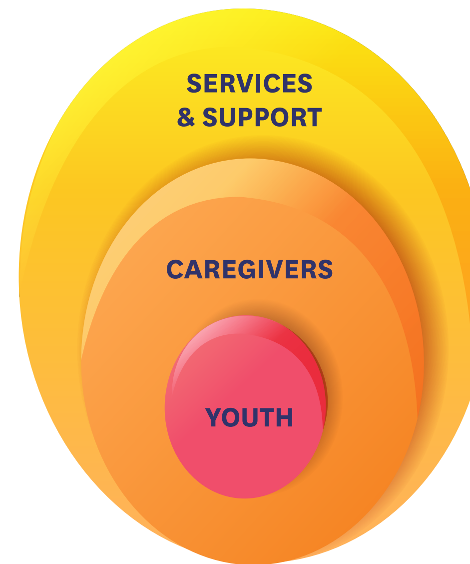


3 Evaluation

A general overview of the importance, types, and timing of evaluation efforts when implementing the CATALIST model. This next section provides additional details and guidance on how the initial implementation of the CATALIST model was evaluated.

Evaluation Goals & Plan

Whenever embarking on an effort to achieve specific goals, it is critical to develop an evaluation plan. Developing an evaluation plan involves the following steps: clarifying the program goals and objectives, developing evaluation questions, developing evaluation methods, and setting up a timeline for evaluation activities. The CATALIST goals are shown below.



PLEASE NOTE

Note: The steps described in this section may or may not match your exact implementation of the CATALIST model and evaluation aims although should provide helpful direction as you plan your own community's evaluation.

FIGURE 2
CATALIST GOALS

Goal 01

Screen and identify underserved adolescents ages 12 through 18 for substance use disorders (SUD) and/or co-occurring mental health disorders (COD).

Goal 02

Offer early intervention services for tobacco use, alcohol use, use of other drugs, depression and anxiety to adolescents with low- to moderate risk.

Goal 03

Increase access to age and developmentally appropriate SUD/COD treatment, recovery, and support services for moderate- to high-risk adolescents referred to the CATALIST program.

Goal 04

Provide a coordinated multi-system family centered model for SUD/COD treatment, expanding comprehensive evidence-based treatment to primary caregivers.

TABLE 3 EVALUATION PLAN
FOR YOUTH WITH NO TO LOW RISK; BROAD PREVENTION EFFORTS

Table 3 details the evaluation plan we developed based on the goals in Table 3. Primary measures include initiation of and engagement in services, outcomes, and satisfaction with services. Depending on your implementation team's goals, needs and available resources, you might opt for a simpler evaluation plan that focuses on tier one indicators including initiation and engagement. The other option would be to focus on a tier two evaluation that includes tier one and also focuses on measuring outcomes over time as show on the second page of Table 4.

PLEASE NOTE

When reviewing the evaluation plan, it is important to note that for goals 3 and 4, evaluation methods include collecting data at multiple timepoints for youth and caregivers engaged in treatment. The following outlines the procedures utilized to obtain informed consent in addition to when and how data are collected.

ACTIVITIES	MEASURES	DATA COLLECTION	OUTCOMES
Prevention services: • CATCH My Breath • Talk. They hear you • Keeping Youth Drug Free • CATALIST Resource Guide	• # of youth exposed to information • # of parents exposed to information • Community-level (Youth Risk Behavior Survey (YRBS)) data on nicotine and other substance use indicators	• Community Services Tracking Form to be completed weekly by CSC and submitted to data team • YRBS school-level data indicators on nicotine and other substance use as well as perceptions of risk	• Increase in consistent delivery of prevention programming within the two counties • Reductions in nicotine and substance use a Outcomes
Goal 1: Identification & Screening • Universal and secondary screening	• # of youth screened • # of youth eligible but not screened • Reasons why youth not screened	• Web-based screening link (captures all completed screenings)	• Sites demonstrate universal screening rates of 80% or greater of eligible youth.
Goal 2: Early Intervention • SUD Brief Intervention • MH Behavioral Activation • This is Quitting	• # of youth positive for substance use and/or mental health risk • # of youth positive who received early intervention • Reasons why youth did not receive BI	• Web-based screening link for screening results • Web-based intervention tracking link	• Over 80% of youth who are positive for low risk substance use and/or mental health receive early intervention
Goal 3: Increase access to Treatment Referrals to CATALIST	• # of youth referred to CATALIST • # of youth eligible but not referred • Reasons why youth not referred	• For baseline, TEDS-A dataset for youth receiving treatment. • Weekly referral and engagement • Tracking by CSC using tracking form.	• Increase in number of youths receiving treatment within catchment area(s)

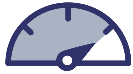


TABLE 3 EVALUATION PLAN
FOR YOUTH WITH MODERATE TO SEVERE RISK CONTINUED

ACTIVITIES	MEASURES	DATA COLLECTION	OUTCOMES
Goals 3 & 4: Moderate to Severe service initiation and engagement • Care Navigation • Connection to Services • Caregiver Engagement • Monitoring • Screening & Connection for Caregivers	**Services received (ongoing)** • CATALIST Enrollment Tracking form	• CSC completed weekly for each youth	**Increased access and engagement into family-based treatment:** • Youth initiate services • Youth engage in services defined as attending a minimum of 2 treatment sessions within first month post-enrollment
• **Goal 4: Treatment** • Motivational Enhancement Therapy/ Cognitive Behavioral Therapy • Cannabis Youth Treatment's MET/CBT (there already) • Trauma Focused-CBT • Eye Movement Desensitization Reprocessing • Contingency Management • Brief Strategic Family Therapy	**Resiliency/Belonging:** • Child and Youth Resilience Measure (youth; caregiver) • General Belongingness Scale (youth) • Family Adaptation Cohesion and Evaluation Scale III (youth; caregiver)	• CSC complete as part of clinical intake and follow up. Universal screening would not include resiliency or belonging measures. These would be conducted at initial appointment with CSC or therapist as youth initiate treatment services	• **Increased prosociality including:** • Resilience • Belonging • Family cohesion **Reduced risk including:** • Decreased mental health symptoms • Decreased youth substance use • Decreased parental mental health symptoms • Decreased parental substance use
• **Goal 4: Recovery** • Youth Recovery Group • CATALIST Youth Recovery Coach • Feedback Loop back to CSC	**Mental health:** • PHQ – 9 (youth; caregiver) • GAD – 7 (youth; caregiver) **Substance use:** • S2BI + CRAFFT (youth) • AUDIT (caregiver) • DAST10 (parents) • Drug testing **Social Determinants of Health** SDoH screening measure (youth; caregiver) **Satisfaction with services** (youth, caregiver at 6 months)	• Web-based screening and assessment link at administered at intake, 3- and 6-months. • At the 6 month follow up point, conduct qualitative interviews with each CATALIST youth (and caregiver) focused on eliciting their perspective of how CATALIST impacted their lives and their satisfaction with CATALIST services and overall experience.	**Social Determinant of Health needs are addressed:** • Number of SDoH needs identified • Number of SDoH needs addressed by connecting with resources **Understanding key components of the CATALIST model that contributed to successes as identified by youth and families**

Participant Enrollment

Whenever engaged in program evaluation, it is important to consider the impact of your evaluation on participants. It is critical that evaluation efforts respect the rights of participants and recognize the vulnerability of individuals, particularly youth, in being asked to take part in a program evaluation while seeking treatment services.

Thus, it is critical to ensure your program obtains the participants' consent to take part in the evaluation. The Office of Human Research Protections has resources on this topic including a flow chart to help you determine whether your program qualifies as research or quality improvement (https://www.hhs.gov/ohrp/index.html) as in some cases, the use of an Institutional Review Board may be required or recommended.

At the time of intake into the treatment program, youth and their parents or guardians also receive information about the evaluation and are asked to sign a consent to take part in the evaluation. Sample consent forms are included in the Appendix. The consent explains the purpose of the evaluation, what is involved, confidentiality including data security, their rights as an evaluation participant, and compensation. The consent also has space for the participant to include their contact information with the understanding that this information will be released to the external evaluation team should they leave services during the course of the evaluation. It is emphasized to participants that should they choose not to take part in the evaluation, it will not impact their receipt of services in any way and that it is their right to withdraw from participating at any time as well.

MORE RESOURCES

www.hhs.gov/ohrp/index.html

"CATALIST helps both the juveniles I work with in Juvenile Drug Court but also the children I represent in abuse and neglect cases who have been exposed to substance abuse by family members but came into the court system through no fault of their own."

CATALIST provides these children an opportunity to address their substance abuse in a program that keeps them out of the juvenile system and allows them to learn healthy coping skills while learning how the generational issues they were exposed to are unhealthy and developing more appropriate coping skills."

EMILY R. MOWRY
Managing Attorney, ChildLaw Services, Inc.
Eastern Panhandle Office

Data Collection, Analyses and Reporting

Client outcome data are collected at three time points:

1. Intake into services
2. Three months post-intake
3. Six months post-intake.

Client outcome data include the screening and assessment measures described earlier in Part I. At 6-months, youth are also asked to participate in a brief, qualitative interview about their experience in services (described later). Client outcome data are collected via a HIPAA-compliant web-based data capture system. Examples of such systems include REDCap and Qualtrics. Collecting the data via a platform such as REDCap or Qualtrics facilitates data validation, completeness and security, as well as eases the burden on the clinical staff. These platforms allow for branching logic and measurement scoring which helps clinical staff administer the tools more easily and obtain valuable clinical information at the end of administration that can inform treatment planning. If utilizing a web-based data capture system, your team will need to plan to program your selected measures into the platform. In addition, it is important to ensure CATALIST clinical staff receive training on how to utilize the platform, are provided with a user guide to navigate the platform, and have a resource they can contact on an as-needed basis should issues arise.

For the initial CATALIST model evaluation, youth receive a gift card to one of several local establishments for completing the 3- and 6-month assessments Youth also receive an additional $10 at the 6-month assessment for completing the qualitative interview (described later). As stated earlier, we try to interview youth at 3- and 6-months even if they are no longer engaged in services.

As part of the clinical treatment program, youth often take part in toxicological substance use testing or urine drug testing. For youth who are enrolled in the evaluation, it is important to obtain whether the youth was positive or negative for any substances in addition to the date of each test. Urine drug test results serve as a primary objective indicator of substance use when measuring client outcomes.

In addition to clinical outcome data, it is important to track service utilization data. A key staff member at each program should be identified to maintain a tracking log. For the initial CATALIST model evaluation, the tracking log included multiple sheets of data. One sheet tracked all referrals and the outcome of those referrals. If youth are enrolled into the CATALIST program, staff continue to track their activities each week on a separate sheet. Activities can include in which evidence-based therapy model they are taking part each week, their

"The CATALIST Team provides just the right balance of compassion and accountability. They have already provided so many participants a path forward without the impediment of substance abuse in their lives."

BRIDGET M. COHEE
Circuit Court Judge, 23rd Judicial Circuit

participation in the recovery groups, whether their caregiver(s) is taking part in services, and other similar types of information. These data help track participant engagement over time as well as service utilization. The tracking sheet is sent to the evaluation team weekly and once a month, a member(s) from the clinical team and the evaluator meet to review cases due for 3- and 6-month reassessments.

As a complement to the quantitative client outcome data collected, qualitative interviews are conducted with youth six months post-intake into services. The purpose of these interviews is to elicit youths' experience in CATALIST including how they feel CATALIST impacted their lives and their overall satisfaction with the program. When a caregiver(s) is engaged in family-based treatment, the evaluation team tries to ensure they are present for the interview to share their perspective as well. Interviews are approximately 15 minutes in duration, conducted virtually via a HIPAA-compliant, virtual platform, recorded with consent and audio recordings are transcribed for analysis. The interview guide includes questions exploring the following domains: reasons why youth were referred, youths' goals for participating in the program, what was helpful or not helpful about the program, how the team showed they cared about them, self-identified changes in their thoughts and actions relative to their substance use and mental health, changes in their sense of self-efficacy and their goals, changes in their family culture, and advice they would give a friend starting in the program. Interview transcripts are analyzed in progressive annual cycles of coding and categorizing to generate themes and subthemes. The Qualitative Interview Guide is provided in the Appendix.

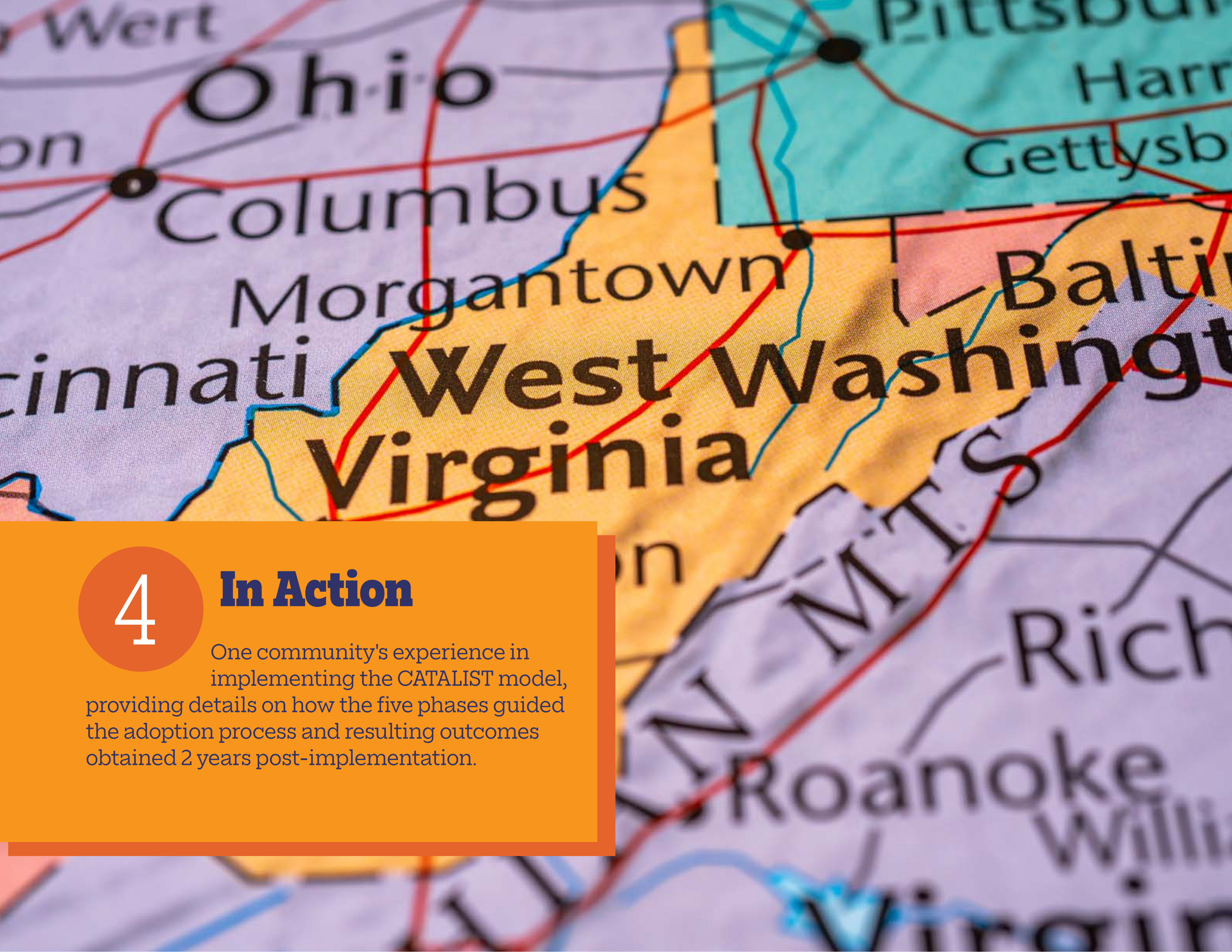
So, what do you do with all these data?

Data can be utilized to facilitate continuous quality improvement (CQI) as well as to understand the effectiveness of your program. CQI is a progressive incremental improvement of processes, safety and consumer related care. In presenting the team with key data indicators in real time, we can identify if changes are needed in how the program is administered. In addition, annually, data can be analyzed to determine whether implementation of the model is effective in improving the symptoms of youth and their caregivers. Results of analyses can be shared with the implementation team, community partners, and other key stakeholders in the form of presentations, infographics, annual reports and more.

We recognize that for community programs to embark on this level of evaluation may be difficult due to constrained resources. As stated earlier, implementation teams may opt for a simpler, focused, tier 1 level of evaluation aimed at tracking implementation as well as initiation and engagement across the various levels of the model. Other programs may elect to utilize an approach that incorporates both tiers 1 and 2 so as to also measure longer term outcome indicators. Some level of evaluation is critical to determine the success of your implementation of the CATALIST model within your community. Demonstrating such success will serve to generate ongoing support, increasing the likelihood of sustainability. It will be important for programs to determine which key outcomes need to be prioritized within the evaluation and focus resources on obtaining, analyzing and communicating those outcomes specifically.

MORE RESOURCES

info here about where to find the Qualitative Interview Guide among other things



4 In Action

One community's experience in implementing the CATALIST model, providing details on how the five phases guided the adoption process and resulting outcomes obtained 2 years post-implementation.

Berkeley County, WV

Within Berkeley County, key leaders of youth-serving organizations and systems had growing concerns. They were witnessing that youth in their community were being raised, in part, by biological parents who were actively struggling with substance use disorders or youth who had been removed from the care of their biological parents to live with other family members or within the foster care system.

Concerns grew regarding how the trauma youth endured placed them at risk for engaging in their own maladaptive behaviors. There was not a strong relationship between the juvenile legal system and the treatment community. Accessing treatment might result in being placed on a waitlist for up to six months. Thus, concerned leaders came together to **mobilize** and address the lack of treatment and related services for youth. Leaders included the Director of the Berkeley Day Report Center (Berkeley County, WV, n.d.), a local Judge and other members of the juvenile legal system, the head of the Martinsburg Initiative (a comprehensive community prevention effort), members of the Berkeley County school system, members of the Emergency Department at West Virginia University Health, members of the local child protective services office, and the Berkeley County Council. These efforts were supported by the Washington Baltimore High Intensity Drug Trafficking Area (W/B HIDTA).

As these groups mobilized to identify a solution, the W/B HIDTA provided initial funding to the Berkeley Day Report Center (BDRC) to implement the CATALIST model as the BDRC had an established, trusted relationship with the legal system and existing infrastructure for referrals for the adult legal system. In addition, the BDRC was already providing a continuum of care for adults involved with the legal system and worked to obtain their license as a behavioral health center (licensed as of 2022). An implementation team was formed comprised of the BRDC Director, a BRDC Clinical Supervisor, a Principal Lead and a Program Manager from the W/B HIDTA, and an outside evaluator, contracted to support program evaluation.

A community **assessment** was conducted in collaboration with the Martinsburg Initiative, a primary and secondary prevention effort to break the cycle of substance use disorders and mitigate risk factors for substsance misuse. The community assessment highlighted that West Virginia consistently leads the nation in fatal overdoses with Berkeley County ranked as one of the top eight counties for fatal overdoses with a rate of 94/100,000. Berkeley County has a median household income less than the U.S. average, 10% live in poverty, and 11% of residents

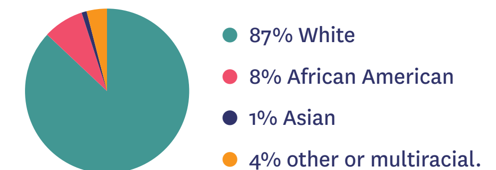
Berkeley County, WV

COMMUNITY PROFILE

Top 8 Berkeley County ranked as one of the top eight counties for fatal overdoses with a rate of 94/100,000.

10% live in poverty

11% of residents under age 65 have a disability



KEY ELEMENTS FOR SUCCESS

AS DESCRIBED BY CURRENT CATALIST CHAMPIONS AND STAFF

- Ensuring program flexibility to tailor to specific needs of youth and their caregivers
- Using interventions that you know work for youth and their caregivers
- Cultivating trusting relationships with youth
- Focusing on reducing physical barriers to accessing services by providing transportation or providing services where youth are naturally located such as schools
- Embracing a positive, caring, supportive, and hopeful attitude towards youth
- Being consistent and dependable while maintaining professional boundaries
- Addressing underlying trauma and other mental health issues as key in promoting abstinence and recovery from substance misuse
- Offering youth-focused peer recovery supports
- Fostering an "open door" policy so youth feel they are welcome anytime
- Creating a youth-friendly, trauma-informed, safe environment
- Building positive relationships with other community organizations

under age 65 have a disability. Racial makeup is 87% White, 8% African American, 1% Asian, and 4% other or multiracial. When considering resources available for youth, the community assessment further confirmed gaps in accessing quality treatment including a lack of healthcare professionals offering substance use treatment to youth, no existing recovery groups for youth, and a lack of transportation. In addition, Berkeley County's juvenile legal system was struggling to identify risk and match risk to appropriate resources that could help manage those risks.

The implementation team utilized the community assessment results and the existing literature on effective community-based approaches for addressing behavioral health risk among youth to **plan** how the CATALIST model would be implemented. The team identified key clinical staffing positions needed, developed those job descriptions and consequently hired the CATALIST Services Coordinator (CSC), a therapist, and a Youth Recovery Coach (YRC). To address the transportation needs, a van was purchased. Initial planning discussions further included devising workflows for each of the community partners that would refer youth to CATALIST, developing the evaluation plan and related data collection procedures, and identifying a training plan for the clinical team. Community partners included a local community coalition that had been providing social work support in the schools and community, the hospital's emergency department, and the juvenile court system. Other conversations focused on creating a marketing brochure and press release to announce CATALIST to the community, defining protocols for meeting youth's transportation needs and employing toxicological screening to further measure progress in treatment.

To **implement** the CATALIST model, the BDRC staff and therapists received an orientation to the model, including eligibility criteria, and formal training on selected evidence-based interventions. The CSC role was further defined as the person responsible for managing all aspects of services and care navigation, screening youth and caregivers, coordinating the contingency management process, and collecting data for the external evaluator and sharing it in a way so the data are de-identified. The YRC provides individual and group peer recovery support services and the therapist provides individual and family therapy sessions for youth.

As part of the sustainability plan, additional strategies were considered concurrently including applying to be a licensed and accredited youth treatment site and implementing an electronic health record that allows for Medicaid billing for reimbursement of services. For those without Medicaid, CATALIST services are free. CATALIST began accepting referrals at the Berkeley Day Report Center (BDRC) in October 2021.

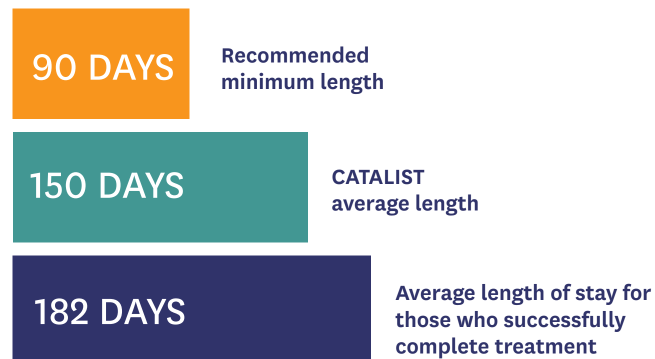
The implementation team devised processes to **monitor** and **evaluate** the degree to which the CATALIST model was being implemented with fidelity and its overall effectiveness. For monitoring, the implementation team met with the BRDC clinical team bi-weekly initially and then shifted to monthly post-early implementation. During these Continuous Quality Improvement meetings, the evaluator would provide summary data related to implementation of the model. These data included referral numbers, treatment initiation and engagement numbers, risk profiles of the population being served, and the types of services and treatment practices delivered. In addition, the clinical team often prepared a case presentation

to review on a more micro-level, how the CATALIST model was being implemented. As data were shared, the team was able to identifiy what was working well and what might need to be modified or even reinforced to increase fidelity to the model and to potential outcomes.

To evaluate outcomes, we utilized the approach and methodology described in Part III of this guide. The results presented below include data collected through December of 2023. It is important to note that data collection as part of the outcome evaluation continue to be collected.

At the time of analyses, 61 (51%) of 119 eligible youth had completed intake, 3-month and 6-month assessments. Sample demographics are shown in Figure 3. The average length of time in services was 150 days which is two months longer than the recommended minimum timeframe. The National Institute on Drug Abuse has stated as one of their principles of effective treatment that it is critical for individuals to remain in treatment for a minimum of three months. In addition, most research has demonstrated that better outcomes are associated with longer periods in treatment. Of note, those who successfully complete treatment remained in services for an average of 182 days.

FIGURE 3: TIME IN SERVICES



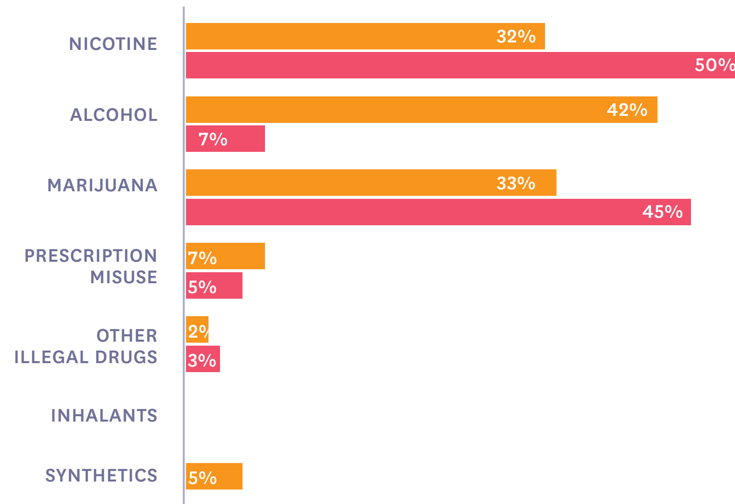
Substance Use

At the time of intake into CATALIST treatment, 82% of youth endorsed using nicotine, 51% endorsed using alcohol, 78% endorsed using marijuana, and 12% endorsed using other drugs in the past year. Over time, youth decreased their use of substances as is shown in Figure X. From intake to 6 months later, use of nicotine decreased from 82% to 48%, alcohol decreased from 48% to 20%, and use of marijuana decreased from 78% to 37%. Importantly, 6 months after entering the CATALIST program, 48% had no risk or had decreased their risk level from their initial intake into the CATALIST program. The CRAFFT is a health screening tool designed to identify substance use, substance-related riding/driving risk, and substance use disorder among youth ages 12-21. Scores on the CRAFFT can range from 0 to 6 with scores of 2 or over indicative of the likelihood of the presence of a substance use disorder. Mean scores on the CRAFFT decreased significantly from 2.8 to 1.5 (F=7.97, p<.001).

Toxicological screening results further support these self-reported decreases over time. Youth completed an average of 21.4 tests (SD= 17.5) during treatment. Of the 52 youth who participated in testing, 75% were negative on their last screen with 52% testing consistently negative for all substances while an additional 23% initially tested positive but were negative by the end of treatment.

TABLE 4: SUBSTANCE USE FREQUENCY AT INTAKE (N=61)

● Monthly or less ● Weekly to daily use



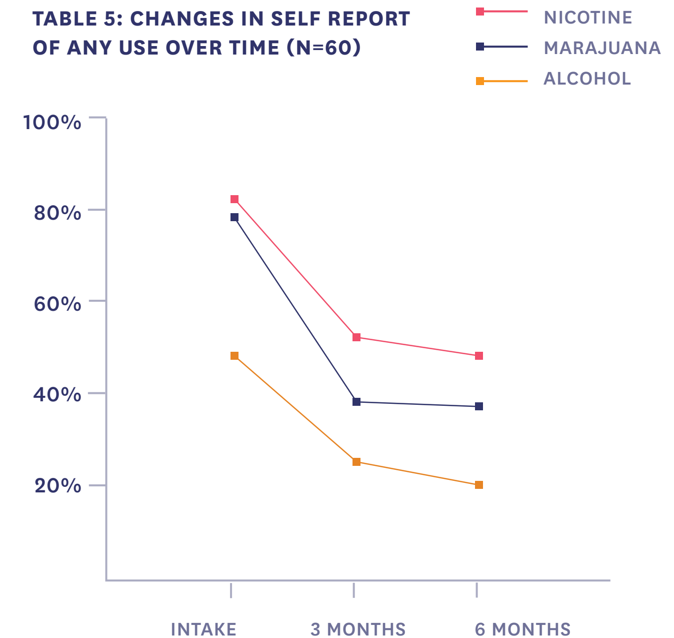
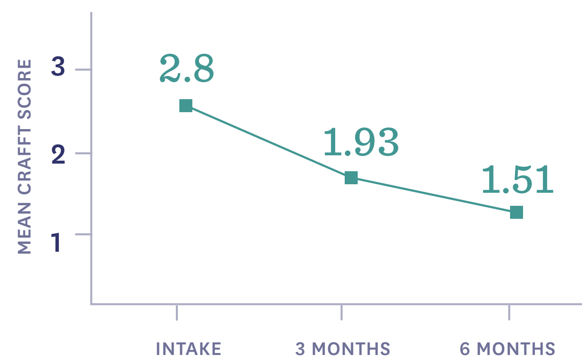


TABLE 6: YOUTH REPORTED FEWER IMPACTS FROM SUBSTANCE USE BASED ON CRAFFT



"My anxiety levels still sometimes fluctuate, and sometimes I have periods of time where it gets worse, but I've been taught new ways to handle it and other ways to calm myself down."

CATALIST YOUTH

TABLE 7: YOUTH EXPERIENCED SIGNIFICANT DECREASES IN DEPRESSION

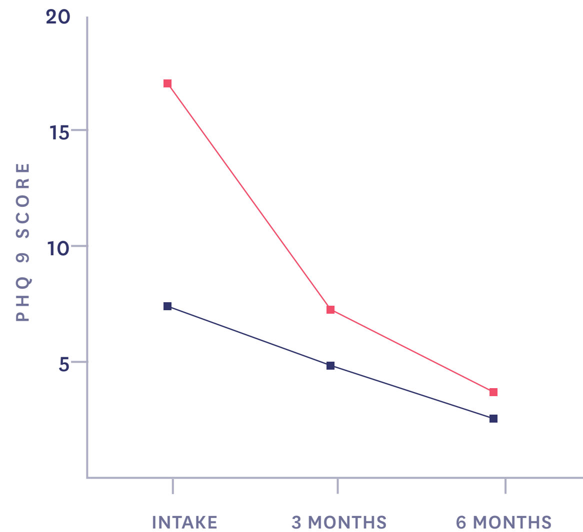


TABLE 8: YOUTH EXPERIENCED SIGNIFICANT DECREASES IN ANXIETY

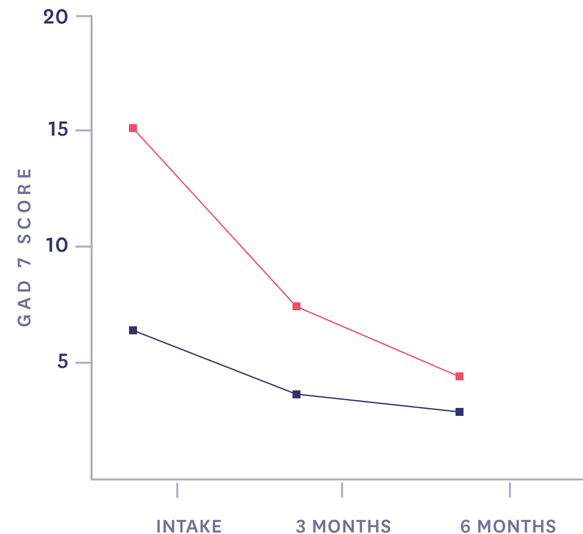
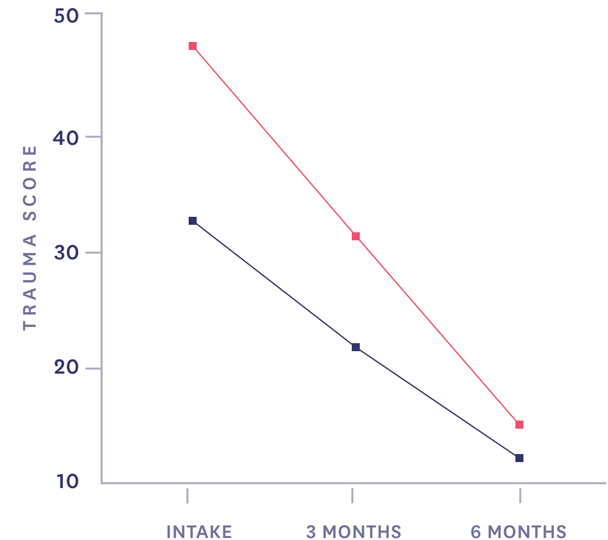


TABLE 9 : YOUTH EXPERIENCED SIGNIFICANT DECREASES IN TRAUMA SYMPTOMS



Unpublished data from CATALIST | CLINICAL ALL

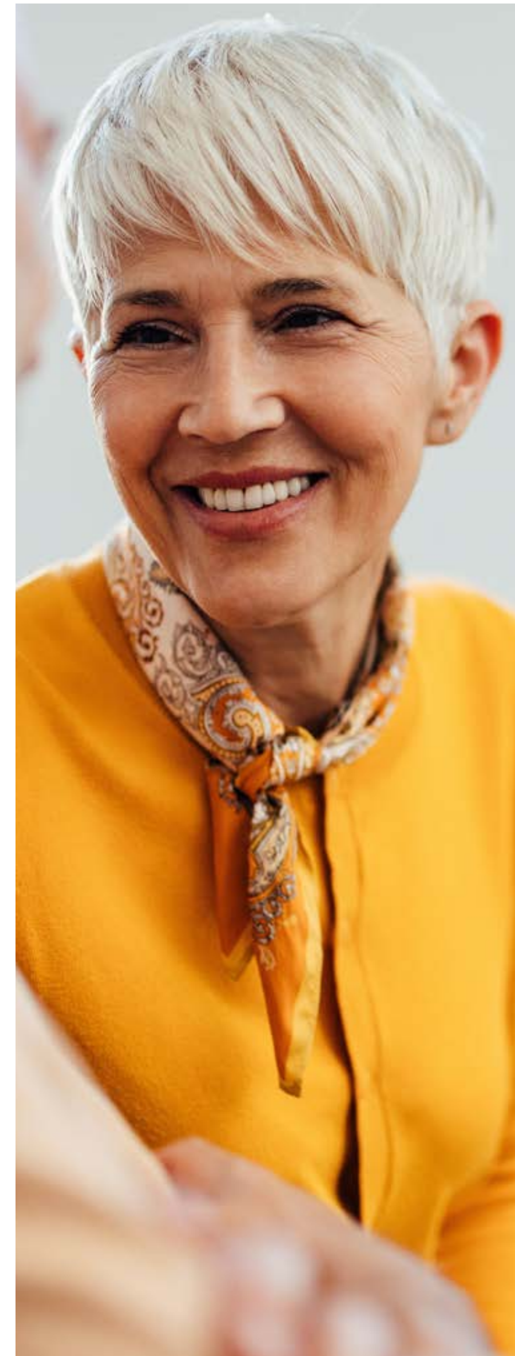
Mental Health

The Patient Health Questionnaire (PHQ-9) is a tool that measures depressive symptoms and scores are stratified for risk ranging from no risk to severe risk. From intake to 6 months later, 54% of youth consistently had no risk and an additional 34% had decreased their Depression risk level from their initial intake into the CATALIST program. Average scores on the PHQ-9 significantly decreased from 7.4 to 2.5 ($F = 12.53$; $p<.001$; see Figure X). Of the 61 youth, 22 scored in the Moderate to Severe risk range at intake which indicates the need for treatment. Importantly, among those 22 youth, average scores on the PHQ-9 decreased from 17.1 to 3.6 ($F = 59.9$; $p<.001$).

The Generalized Anxiety Disorder 7-item tool is used to measure anxiety symptoms and scores are stratified for risk ranging from no risk to severe risk. For anxiety, 48% consistently had no risk and an additional 37% had decreased their Anxiety risk level from their initial intake into the CATALIST program. Average scores on the GAD-7 decreased from 6.5 to 3.0 ($F = 7.86$; $p<.001$). However, it is important to note that 21 of the 61 youth scored in the Moderate to Severe risk range at intake which, indicates the need for treatment. Importantly, among those 21 youth, average scores on the GAD-7 decreased from 15.2 to 4.5 ($F = 27.31$; $p<.001$).

Trauma symptoms were assessed using the Child PTSD Symptom Scale Self Report measure. Trauma symptom questions are only asked of those who endorse experiencing at least one traumatic event. It is important to note that 65% of youth reported experiencing some form of trauma at the time of intake (n=39). Types of traumatic experiences reported include physical and/or sexual abuse/assault, witnessing domestic violence, and witnessing or experiencing the loss of a loved one. Average scores of trauma symptoms decreased significantly across all youth who had reported experiencing trauma ($F = 13.09$; $p<.001$). These decreases become more pronounced when considering youth who scored in the moderated to very severe symptoms range at intake ($n=24$; $F = 21.86$, $p<.001$).

"I love working with the teens. I feel like it is a gift to be able to do this. Not everybody gets to do a job that they are investing in the future, and that is what I feel like I do. I am changing the generational dysfunction that was created when this opioid epidemic hit our area, it kind of ransacked the lives of so many people....but those people have children and now those children are being raised in homes where drug use is normal. It is a normalized thing, and they need help too." CATALIST STAFF

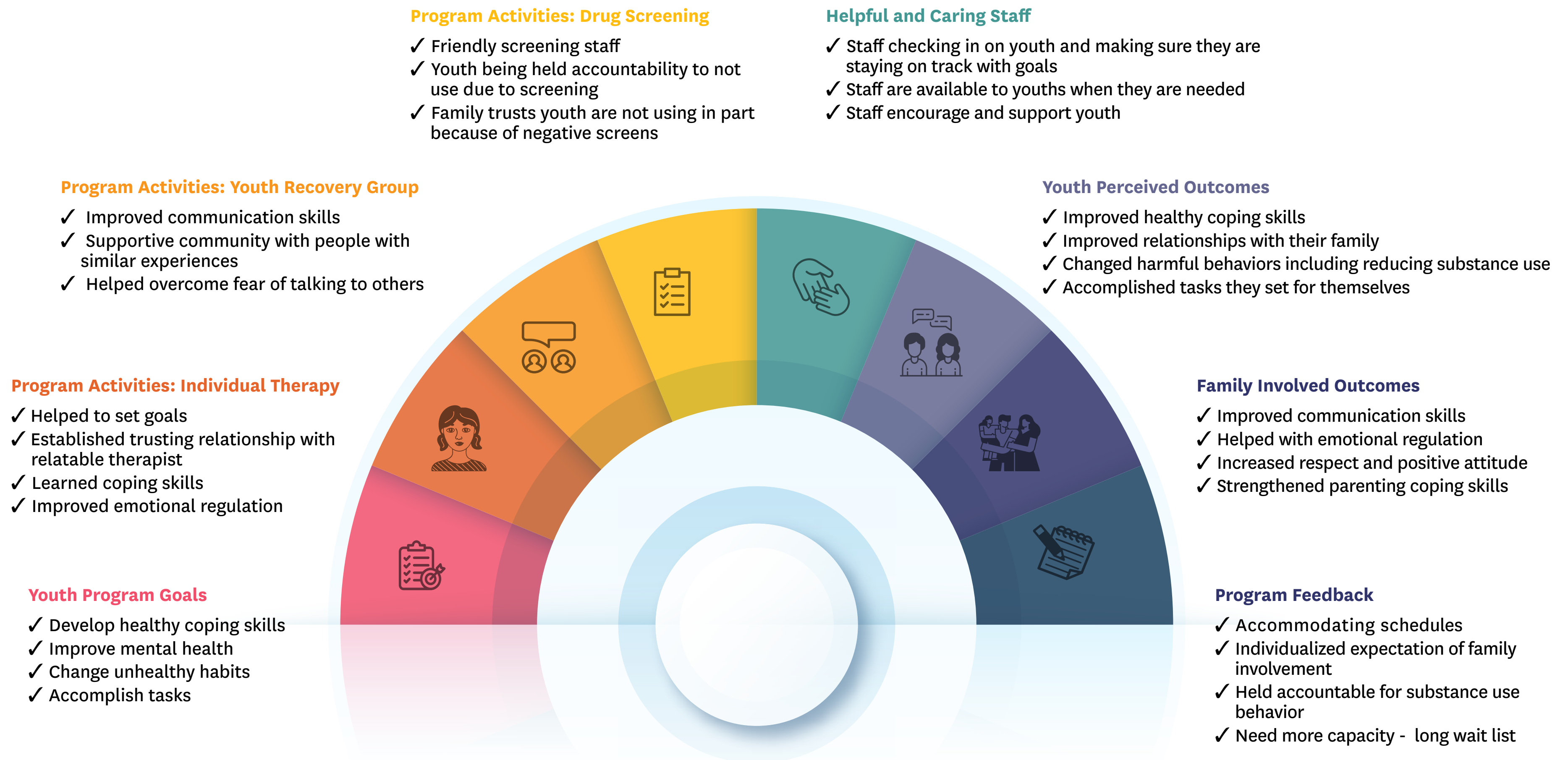


Qualitative Findings.

Sixty-one youth also completed the qualitative interviews described in Part III. Eight themes frame the findings from analyses of interview transcripts. The themes include youth program goals, program activities - individualized therapy, program activities - youth recovery group, program activities - drug screening, helpful and caring staff, youth perceived outcomes, family involvement outcomes, and program feedback. Figure X visually displays the themes and key takeaways or findings within those themes. For example, for the theme of program activities – individualized therapy, key takeaways youth shared about their experience in individual therapy include that they were able to set goals, establish a trusting relationship with their therapist, learn coping skills to help manage their substance use and/or mental health symptoms, and improve in their ability to regulate their emotions. Also note that key statements from youth during these interviews are integrated throughout this manual. A more in-depth write up of the qualitative findings can be provided upon request.

As with any evaluation effort, there are always limitations. While we tried to recruit all youths who took part in the CATALIST program, there is selection bias based on who was willing to be interviewed. Youths who were discharged from the program for noncompliance or other negative behaviors or who terminated services early did not respond to requests to interview them. We did compare intake scores among those who completed the follow ups and those who did not. Out of 17 variables measured, only the initial scores on the CRAFFT measure differed. Those who did not complete the follow up had a mean CRAFFT score of 3.5 and those who completed had a mean CRAFFT score of 2.8 out of a possible 6. Being conservative, the findings are generalizable to those who successfully engage and remain in the CATALIST program for at least six months.

FIGURE 12: OVERVIEW OF THEMES FROM THE CATALIST PROGRAM INTERVIEWS



CATALIST

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