CT STRONG

Final Evaluation Report

November 18, 2019

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Research for Positive Change

CT STRONG
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I. PROGRAM OVERVIEW

This study was an evaluation of a youth and young adult program called CT Strong (Connecticut Seamless Transition and Recovery Opportunities through Network Growth). CT Strong was federally funded through a five-year Now Is the Time -- Healthy Transitions grant from SAMHSA, the Substance Abuse and Mental Health Services Administration, to the Connecticut Department of Mental Health and Addiction Services (DMHAS) who partnered with the Department of Children and Families (DCF). The Healthy Transitions program was designed to improve access to treatment and support services for youth and young adults ages 16 – 25 that had or were at risk of developing a serious mental health condition.

Connecticut was one of sixteen states who received this Healthy Transitions grant. All Healthy Transitions awarded programs utilized a wraparound approach, family advocacy, and peer support components, but in different ways. One primary distinguishing feature of the CT program was that it focused on the youth and young adult population in three metropolitan areas, instead of two cities or towns as other grantees did.

The CT Strong program was implemented in Milford, Middletown, and New London. Participating agencies serving these towns were Bridges, Community Health Center, and Child and Family Agency of Southeastern Connecticut, respectively. Each team included a wraparound facilitator, a peer support specialist, and a family advocate. The overall CT STRONG program goals were to increase the rate at which transition age youths (age 16-25) were engaged and connected to appropriate treatment and support services, and to improve existing services to obtain better outcomes.

In addition to DMHAS and DCF, several other agencies were responsible for different components of the project. DMHAS contracted with ABH to provide project management, coordinate with the project sites, and to lead state-wide peer recovery support initiatives. In addition, there were multiple other state agencies and state-level initiatives that were involved as part of CT Strong. Partnerships included multiple family and peer-driven organizations such as NAMI, FAVOR CT, and Youth M.O.V.E. A state-level transition team, functioning as a steering committee, was established early on and met regularly throughout the project.

The evaluators for this project were from the UCONN School of Social Work. The evaluation of the CT Strong project was primarily the responsibility of Eleni Rodis, M.S., Acting Director of Research for DMHAS, and Research Associate in the School of Social Work at the University of Connecticut (UConn). In addition to Ms. Rodis, several research assistants and data personnel were involved in the project. Research assistants successively took on the daily evaluation management (e.g. communicating with program sites, assigning and conducting interviews,

helping in report preparation, etc.), and a data manager/analyst took responsibility for data oversight and reporting. Jennifer Willett was the evaluation coordinator for years 1 and 2, while Jenn Donnelly was the evaluation coordinator for years 3 through 5. Other RAs were involved in interviewing and data entry.

II. EVALUATION OVERVIEW

In order to try to capture a full picture of a complex program, data collection included both quantitative and qualitative methods. We used a mixed methods research design, including multiple time-point, cross-sectional comparisons, and pre-post comparisons. Data was used for continuous quality improvement in that data on clients served early in the project informed us about the effectiveness of our treatment model in time to make changes as needed. We generated reports on the status of program participants over time for review by the program staff. This feedback was used to consider which areas may have needed improvement. Later in the program, we reviewed outcomes of program participants so that the staff were able to see the impact of their service provision. Using client reports of services received, staff reports of services provided and administrative data, we were able to examine service provision and utilization.

As the evaluation team collected process observations and client-level data, this information was shared with the DMHAS project director, project manager, program sites, and other relevant stakeholders in order to guide project implementation. Preliminary data from the interviews, focus groups and weekly logs were shared with project leadership, program staff, and the state level committee. In addition, the evaluation staff contributed sections to the annual reports that were sent to SAMHSA, and participated in the federal-level site visits, conference calls, and meetings.

We participated fully in all aspects of the national evaluation. We achieved a high recruitment rate for the supplemental client interviews, and reached the baseline supplemental interview goals. Nearly all of our youth and young adults who completed a NOMS client interview in this timeframe completed the SYAI. We participated in a site visit from the National Evaluation Team in February 2019.

Along with DMHAS and ABH leadership, we presented on CT STRONG at the 32nd Annual Research & Policy Conference on Child, Adolescent, and Young Adult Behavioral Health (Rodis et al., 2019). We published an article in Focal Point titled "Preliminary Outcomes in CT STRONG: A Youth and Young Adult Wraparound Program" (Rodis et al., 2019).

DATA COLLECTION METHODS:

The evaluation of CT STRONG involved both quantitative and qualitative components, including:

1) Collection of administrative data from CT Strong and ABH staff;
2) Weekly program activity logs;

3) Focus groups and qualitative observations;
4) Interviews with program participants.

1. Administrative Data: Secondary data on service utilization was received from ABH and the CT Strong program sites. Over the course of the project, forms were created with information on client characteristics, types of contact, service referrals made, services provided, discharge dates, discharge reasons, etc. An interview contact sheet and tracking database were also developed to track follow-up attempts.

2. Weekly Program Activity Logs: For elements that could not be obtained from administrative data, logs of CT Strong staff activities were used to record client-related contacts and types of assistance offered, including referrals to other treatment and service programs. There were expected differences from traditional programs in services provided, and the activity log captured the different program components for clients. This information allowed us to describe the services most often provided by different staff, and to analyze which activities and referral mechanisms were most useful and most frequent.

3. Focus Groups and Qualitative Observations: On an on-going basis, the researchers monitored general project development, including meeting notes, emails, decisions that were made by the oversight committee, etc. At least one person from the evaluation team attended all project meetings, conference calls and webinars with stakeholders, the federal funders and program staff for purposes of project development, documentation, and process evaluation. Evaluators participated in regular project and state-level Transition Team meetings. In these meetings, program staff and leaders discussed issues such as difficulties with engagement, interagency barriers and logistical problems. These meetings helped us write a narrative of the project and to explain successes and barriers. The lead evaluator participated in decision-making, and provided data to help with this process.

Several focus groups with both clients and program staff were held over the course of the project. In total, the evaluators conducted nine focus groups, five with young adult clients, two with CT Strong program staff, one with peer young adult support group participants, and one with peer young adult support group facilitators. Focus groups helped us to better understand the program and the nature of services. We used focus group data to describe the program and the relationships between the program and the clients, to identify key components of the program, to identify barriers and facilitators to implementation, and to better interpret the quantitative findings. Information from client focus groups were used to provide feedback to staff about the aspects of the program that participants found helpful or not, and any areas where changes in approach were warranted.

4. Program Participant Interviews: Recruitment for the study occurred through the CT Strong program staff at the three sites in Milford, Middletown, and New London. Participating agencies in these areas included Bridges, Community Health Center, and Child and Family Agency of Southeastern Connecticut, respectively. CT Strong program staff invited all youth and young adult program participants (16-25 year olds) to hear about the evaluation from a

member of the research staff. There were several meetings and calls with the local site staff to reaffirm engagement procedures and to review referrals. Baseline interviewing began in August 2015. We stopped interviewing at the end of June, 2019 to allow enough time to conduct final analyses and reports by the end of the grant.

The interviews were conducted by trained research interviewers. CT Strong clients were interviewed at baseline, 6 months and 12 months after intake. Initially, 18-month interviews were also conducted if participants were still in the program, but this resulted in insufficient numbers to be able to analyze, so this interval was dropped. The evaluation interviews were separate from program involvement. That is to say, even people who dropped out of the program were interviewed if they consented. Conversely, they could still receive services from the program even if they did not want to participate in the evaluation. If a client initially agreed to meet with the evaluation interviewer (asked by the CT Strong program staff), a signed referral form was faxed to the research office. After receiving permission to contact the clients, a research interviewer described the evaluation and conducted informed consent with willing participants. Participants received $10 for each completed interview, and were eligible for $5 bonuses for keeping their first scheduled appointments.

The structured interviews consisted primarily of the required SAMHSA measures that make up the GPRA/NOMS tool. Participants were asked about their personal characteristics, employment, educational status, substance use, social support, living conditions, legal involvement and mental health, including trauma symptoms and overall functioning. We felt that there were some variables missing from the GPRA/NOMS that could be important in affecting clients' lives as well as program outcomes, so we added a few background questions: what languages the participants speak, if they were expecting children or pregnant, how many children they had, and some questions about their children (sex, age, biological or other relationship, legal guardianship, and whether living with children). We also added some brief measures that would capture important information more specific to our intervention with the young adult population: the Youth Empowerment Scale (Walker et al., 2010) and the Hemingway Measure of Late Adolescent Connectedness (Karcher & Sass, 2010). The instruments selected for the local evaluation had sound psychometric properties and had been used with similar populations. We also created a Stigma Scale since this was of particular interest to the project. We wanted to see whether the program clients had experienced stigma, either internal or external, related to having emotional difficulties. The scale was developed by Beth Flanagan (a co-investigator from Yale who also works with DMHAS) and Eleni Rodis, mainly by selecting items from previously existing stigma measures. A literature review was conducted on internal and external stigma perception, and appropriate scales were selected, including the Self Stigma of Mental Illness (Filianos 10 Item Short Form) Scale and the Body Barriers to Seeking Help Scale. Some of the items were adapted to be more young adult friendly, such as changing "mental illness" to "emotional difficulties" and changing "professional help" to "counselor." Items from all of the 3 added scales are included in Appendix A.

Reports on the progress of recruitment were regularly prepared and shared with project leadership and program staff. Interview data was entered into SAMHSA's data platform (SPARS), and CT-specific interview responses were entered into a local Access database. The interviewers and evaluation manager used a tracking database in order to monitor interview participation, interview due dates, and other tracking details.

The research interviewers experienced some difficulties connecting with the youth and young adult population, both for intakes and follow-ups. Many efforts were made to try to engage with each participant. Tracking activities used by interviewers included phone calls, texts, emails, and mailed letters to study participants and their contacts, as well as phone calls and meetings with program staff to locate participants. Youth and young adult participants could experience difficulties with keeping a phone turned on with monthly phone bills, and some participants also had frequent changes in where they were staying. For sixteen and seventeen year olds (who needed parent/guardian consent for the study), interviewers may have been only able to reach and get consent from either the minor or the guardian, but both were needed, so the interview couldn't take place. If interviewers were unable to reach participants after many repeated attempts, demographic and program service information were collected and the cases were entered in the SPARS system.

III. RESULTS

Participant Interviews

Study Referrals and Refusals: The number of participants enrolled was lower than originally expected. This seemed to be largely due to the programs serving fewer clients than expected in the core services model, as well as not all of the clients agreeing to participate in the study interviews. The project leadership reduced the goal from 720 to 630, and later to 510, to reflect changing expectations for CT Strong program enrollment. We decided to include people in the evaluation that the program sites served in non-core ways, that is to say that the CT Strong staff provided services for them but they didn't become full CTS clients, in order to more accurately reflect the work being done by the teams.

In total, there were 470 CT Strong cases included in the evaluation; 200 interview cases and 272 non-interview cases. The non-interview cases represented clients served by CT Strong but who did not agree to be interviewed, either because they refused to the program staff, they declined to be contacted by the evaluators, or the interviewers weren't able to reach them for a baseline interview. Demographics for administrative GPRAs were collected for these cases and entered into SPARS. By the end of the project, the evaluation team had received a total of 265 study referrals and 28 refusals to be contacted by evaluation staff from the program sites. There were numerous clients where the evaluators never received a referral or a refusal from the program staff despite frequent on-going contacts between evaluation and program staff. Demographic and service information were also collected for these clients. The final recruitment numbers can be seen below.

Recruitment Table:

Location	Baselines completed	Demographics collected	**Total people per site**
Middletown	87	60	**147**
Milford	56	92	**148**
New London	54	93	**147**
Total	**197**	**218**	**415**

The average baseline interview took 35 minutes to complete. The follow-up interviews took an average of 30 minutes to complete. Most interviews were conducted at a fast food restaurant, home of the participant or a relative, program site, library, or over the phone – whatever was most convenient for the client. A few interviews took place outdoors, at a drop-in center, or at another convenient location for the participant.

A total of 197 baseline, 118 6-month, and 82 12-month interviews were completed. Some significant limitations to the completeness of the interview data included a higher than expected refusal rate. In our observation, most adult populations we've worked with, including those that were homeless, had serious mental illness and/or substance use diagnoses, demonstrated lower refusal rates than the YYA population. The final 6-month follow-up rate was 66% and 12-month was 51%. Due to the generally low participation rate and follow-up rate, we were unsure whether the interview data was representative of the CT Strong participant population overall and also whether those who completed follow-up interviews were consistently different from those who didn't. Please see the table below for details of the follow-up analysis, but results indicated that there were not significant differences between those who completed follow-ups or and those who didn't. Results indicating changes over time should still be viewed with caution, though, due to the low follow-up rate.

However, there were significant differences revealed in terms of program clients who agreed to complete the interview component (including consent and baseline interview) vs those who didn't. Details can be seen below in the Demographics section, but generally the interview participants were more likely to be female and older, resulting in what seems to be underrepresentation of males and younger clients in the interview data.

Because of a relatively low number of 12-month interviews, and the very low follow-up rate at 12 months, most of the analyses reported below focus on the baseline and 6-month data.

Demographics: Baseline interview data indicated that the interview participants were 62.2% female, 36.2% male, and 1.5% transgender. Race and ethnicity of participants was self-reported as 31.0% white, 26.9% black, 34.7% Hispanic, and 6.9% multiracial. Sexual orientation was reported as 80.7% heterosexual, 5.9% gay or lesbian, and 13.4% bisexual. Compared to census data of the CT general population, CT Strong participants were more likely to be LGBT, black or Hispanic, and female (United States Census Bureau, 2018). There were no statistically

significant differences in race and ethnicity between interview and non-interview cases, which are shown below.

Race and Ethnicity	Interview		Non-Interview Cases	
	n	%	n	%
White	67	31.0%	97	37.6%
Black	58	26.9%	66	25.6%
Hispanic	75	34.7%	84	32.6%
Multi-racial	15	6.9%	10	3.9%
Refused or missing	1	0.5%	1	0.4%
Total	216	100.0%	258	100%

More female participants agreed to participate in the interviews than males. 62.2% of interview participants and 45.5% of non-interview cases were females. There were a few people who identified as transgender or other gender in both the interview and non-interview cases. When the third gender choice was excluded, to make numbers high enough for conclusive chi-square significance testing, significantly more females than males chose to participate in the interviews. The females were divided about 50/50 in participate/not participate, while the males participated only about 1/3 of the time ($p < .001$). Additionally, the mean age of participants interviewed (19.5) was significantly higher than the mean age of non-interview participants (18.9; $p < .05$). This significant difference reflects that minors were more likely to be non-interview cases. It was much more difficult to interview minor participants because both parental and youth participant consent were needed.

Gender	Interview		Non-Interview Cases	
	n	%	n	%
Male	71	36.2%	140	53.0%
Female	122	62.2%	120	45.5%
Transgender or Other Gender	3	1.5%	4	1.5%
Total	196	100.0%	264	100.0%

A statistical comparison was completed of participants who only did baseline interviews and those who completed baseline and follow-up interviews. Chi-square tests revealed that there were no statistically significant differences except for one trending difference for education level. There were no statistically significant differences in terms of gender, race, ethnicity, age,

or employment status. People with higher educational levels (at least high school diploma or some college) were more likely to complete follow-up interviews than those in lower grades or without a high school diploma. This difference between the two groups was trending as significant (p=.094).

Participants by Location	N of respondents				% of total respondents			
	Baseline	6-month	12-month	**Total**	Baseline	6-month	12-month	**Total**
Middletown	87	51	36	**174**	44.2%	43.2%	43.9%	**43.8%**
New London	56	36	25	**117**	28.4%	30.5%	30.5%	**29.5%**
Milford	54	31	21	**106**	27.4%	26.3%	25.6%	**26.7%**
Total	**197**	**118**	**82**	**397**	**100%**	**100%**	**100%**	**100%**

Language: Almost 30% of participants spoke a language other than English at home, with 80.4% of this group speaking Spanish. Other languages spoken by CT Strong clients included French, Creole, American Sign Language, Portuguese, Chinese, Creole, Hindi, Jamaican Patois, Polish, and Thai.

Participants with Children: Baseline interview data indicated that 22.4% of participants (n=37) had at least one child, and 6.8% of participants (n=11) were pregnant or expecting a child at baseline. Of the group with children, 24 participants had 1 child and 13 participants had 2 or more children. Approximately 54% of the participants' children were female, and the children were mostly in the age range from 1 to 6 years old, with the oldest child being 13. Approximately 94% of the participants were legal guardians of their children and were their biological parent, and approximately 84% of the participants' children lived with them.

Military: Only 1 participant served in the military. 28 participants (14.2%) had immediate family members in the military, such as partners, parents, siblings, and other family members.

Disability: Almost half of the participants (49.5%) reported one or more disability issues. The most frequent disability reported was experiencing serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition (45.4%). This was much higher than any other reported disability, with the second most frequent being blind or having serious difficulty seeing, even when wearing glasses, at 9.2%. CT Strong participants were much more likely to have a disability compared to the CT general population (7.3%) (United States Census Bureau, 2018).

Program Involvement: Program involvement in the past 30 days decreased from 81.7% at baseline to 51.7% at 6 months and 36.6% at 12 month follow-up. Family advocate support (36.5% to 29.7% to 22.0%) and CT Strong peer support (38.6% to 33.1% to 23.2%) also decreased steadily over the three intervals. Program involvement numbers suggest that there were some youth & young adults who needed continued support beyond the original 6-month duration of the program, and this was often discussed by CT Strong program staff at staff

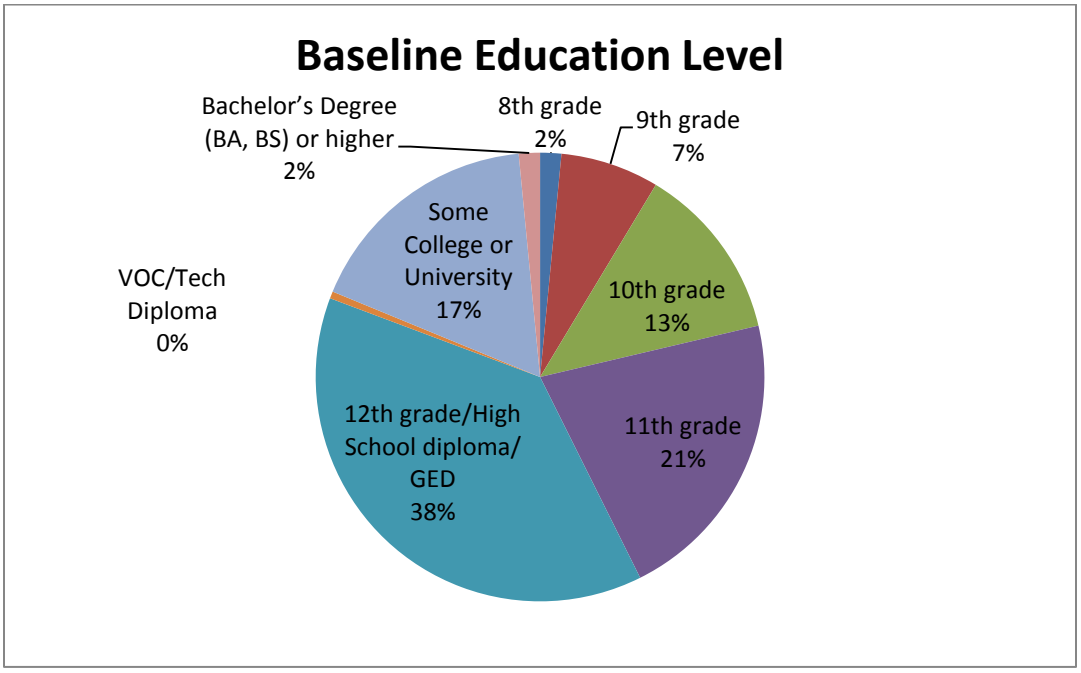
meetings and focus groups. Peer support through other avenues, such as NAMI, in the past 30 days increased from 16.8% to 28.0% to 29.3% over time. This 74.4% percent change increase from baseline to 12 month suggests that CT Strong helped participants get better connected with other peers or peer groups in their community.

Program Perceptions: CT Strong participants reported a positive perception of the program in the interviews. Over 90% of participants agreed with the following at 6 months after intake: staff believed in their ability to grow, change, and recover; staff respected their wishes about who was given information about their treatments; they liked the CT Strong services they received; they would choose services from CT Strong over other agencies; and they would recommend the CT Strong agency to a friend or family member. There were no statistically significant changes between program perception items between 6 month and 12-month intervals. The only statement with agreement below 75% was "Staff told me what side effects to watch out for" at 64.7%. 27.5% of participants responded as undecided for this question and 7.8% responded as disagree or strongly disagree, sometimes remarking to the interviewers that this was not an applicable question for them. The questions in this program perceptions section were only asked at follow-up in for participants who were still using services at 6 or 12-month interviews. Interviewers would ask these questions if participants answered yes to a question ("have you participated in the CT Strong program in last 30 days"), so not every participant answered it.

Program Perceptions	6 month (N=58)	12 month (N=47)	% Agree or Strongly Agree at 6 Month*
	Mean	Mean	
Staff here believe that I can grow, change, and recover.	4.47	4.43	96.6
I feel free to complain.	4.12	3.94	84.5
I was given information about my rights.	4.34	4.23	91.4
Staff encouraged me to take responsibility for how I live my life.	4.33	4.26	87.9
Staff told me what side effects to watch out for.	3.82	3.78	64.7
Staff respected my wishes about who is and who is not to be given information about my treatment.	4.49	4.30	96.5
Staff were sensitive to my cultural background (race, religion, language, etc.)	4.4	4.26	89.5
Staff helped me obtain the information I needed so that I	4.32	4.16	90.6

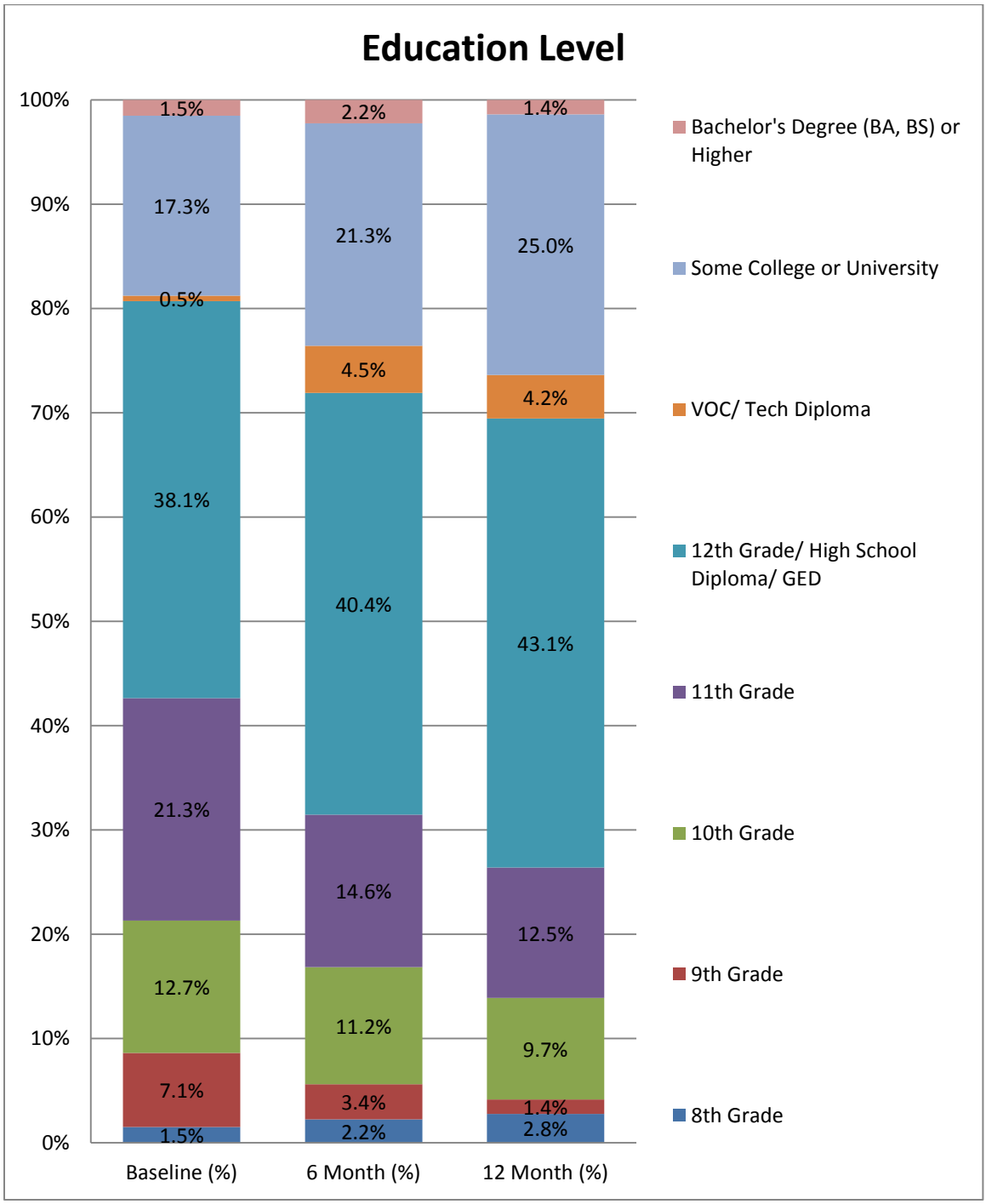
could take charge of my illness.			
I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.)	3.75	3.85	75
I felt comfortable asking questions about my treatment and medication.	4.26	4.15	86.8
I, not staff, decided my treatment goals.	4.3	3.96	86
I like the services I received here.	4.47	4.28	93.1
If I had other choices, I would get services from this agency.	4.36	4.04	91.4
I would recommend this agency to a friend or family member.	4.5	4.17	93.1
Average (means)	**4.281**	**4.129**	
*no statistically significant changes in program perception items between 6 month and 12 month intervals.			

Education, Employment and Income: Over half of the participants had a 12th grade education level, GED or some college at baseline. Less than 9% of participants had an 8th or 9th grade level education and 34.0% had completed 10th or 11th grades at baseline.



The interview data suggests some positive outcomes on several measures. Increases in education level were statistically significant (p=.001) from baseline to 6 and to 12-month

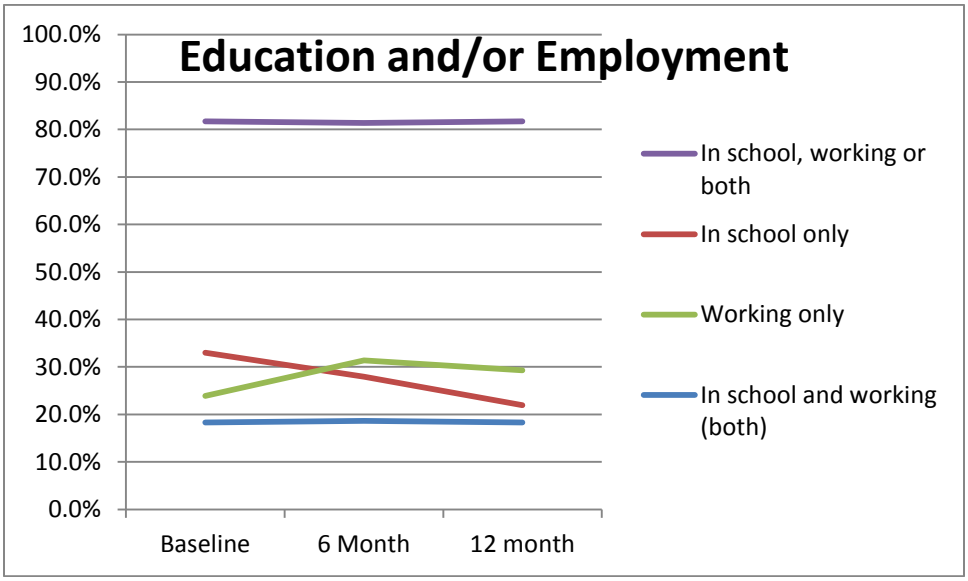
intervals. There was a steady increase in those with some college or university education and in those with a high school diploma or GED.



In terms of employment, those employed (either full or part time) at baseline made up 42.1 %, 50.0% at 6-month and 47.6% at 12-month. Those enrolled in school started higher at baseline (51.3%) and decreased at subsequent time points – 46.6% at 6 months and 40.2% at 12 months. Given the increased education levels shown above, this finding of decreased school enrollments suggests that some participants completed their high school or vocational diplomas during the CT Strong program.

Of those enrolled in school, we saw an increase in school attendance from baseline to 6 months. There was a 29.2% percent change increase of participants with zero unexcused absences from baseline (51.1%) to 6 months (66.0%).

When employment and school rates were combined, the rates were fairly steady across the time intervals, indicating that most were either working, in school or both.



Participants felt less financial security between baseline ($\bar{x}$ = 3.28) and 6 months ($\bar{x}$ = 2.89), although this change was not statistically significant. At the 6-month interval, more participants reported “not at all” or “a little” in terms of having enough money in the last 4 weeks, and less likely to report “moderately” or “mostly.”

Substance Use

Alcohol: Alcohol was the most frequently used substance reported. At baseline, 29.4% reported any alcohol use and 9.6% reporting using until intoxicated in the last 30 days. Use of alcohol in the past 30 days increased non-significantly at 6 months to 36.4%, and slightly decreased to 35.4% at 12 months. However, 12.7% of respondents at 6 months and 17.1% of respondents at 12 months reported using alcohol to intoxication.

Illegal drugs: Use of illegal drugs decreased overall; 25.4% of participants reported using illegal drugs in the past 30 days at baseline, 23.3% at 6 months, and 19.5% at 12 months. Marijuana

use, following federal guidelines, is considered illegal even if participant reported having a prescription. The most commonly reported substance used was marijuana, with 100% of participants who reported using an illegal drug reporting marijuana use. The only other illegal drugs or drugs taken other than prescribed reported were sedatives or sleeping pills (8%) and prescription opioids (2%), reported only at baseline with 8% and 2%, respectively, and hallucinogens, reported at baseline, 6 months, and 12 months at 6.0%, 7.4%, and 6.3%, respectively.

Perception of risk from high alcohol use: At all three time points, a great majority of participants perceived at least moderate risk when people have 5 or more alcoholic drinks once or twice a week. A small percentage of the youth and young adult participants perceived no risk from this amount of drinking, as seen in the table below.

How much do people risk harming themselves physically or in other ways when they have 5 or more alcoholic drinks once or twice a week?			
	baseline $\bar{x} = 3.16$	6 month $\bar{x} = 3.28$	12 month $\bar{x} = 3.28$
(1) No risk	7.2%	3.6%	5.3%
(2) Slight risk	16.9%	15.5%	11.8%
(3) Moderate risk	28.9%	30.0%	32.9%
(4) Great risk	47.0%	50.9%	50.0%

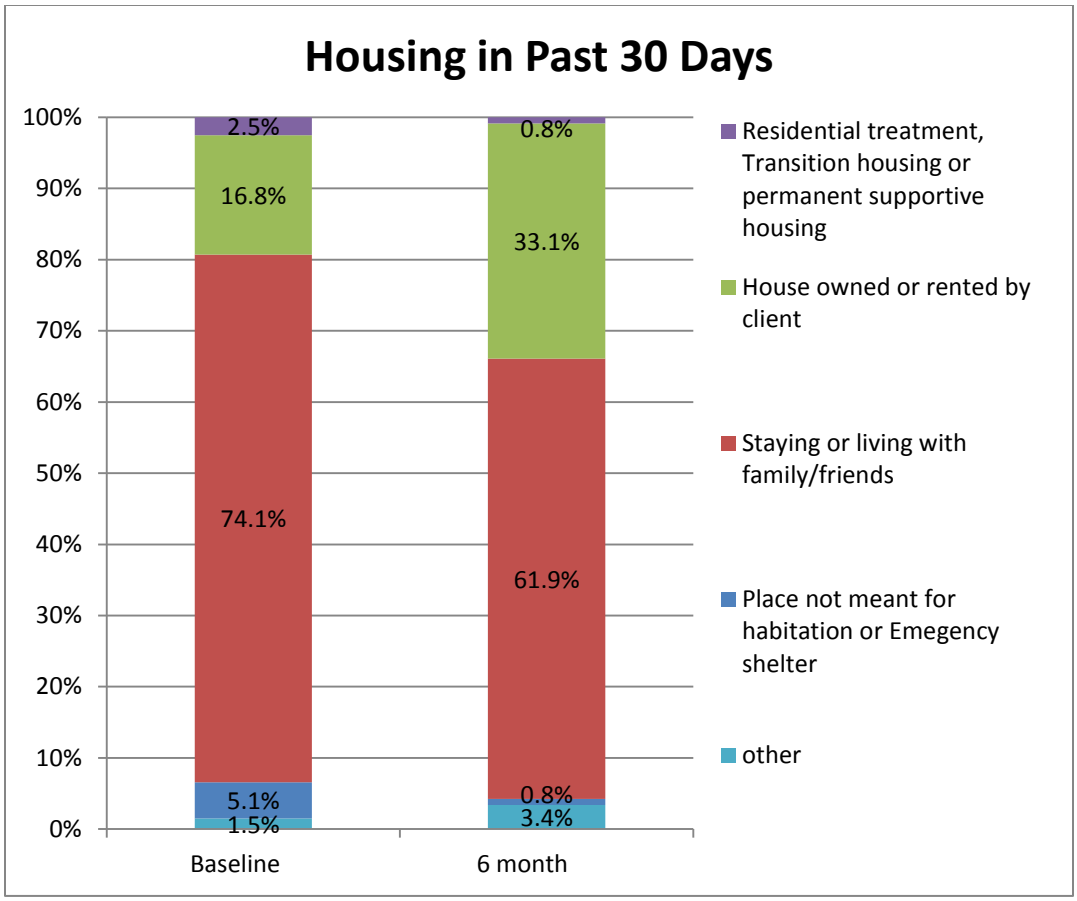
Tobacco Use: Tobacco use stayed relatively steady across the time periods, with 28.1% of participants reported using tobacco in the past 30 days at baseline, 25.9% at 6 months, and 29.3% at 12 months. The most common tobacco product was cigarettes, with 78.2% of tobacco users reporting cigarette use at baseline, 83.3% at 6 months, and 79.2% at 12 months. The next most common tobacco product was electronic cigarettes, with 29.1% using at baseline, 26.7% at 6 months, and 25.0% at 12 months. No chewing tobacco use was reported, and some cigar use was reported (between 4% and 7% at all intervals).

Inpatient and ER Treatment: There were a few participants who used inpatient and emergency room treatment within 30 days of their interviews at different intervals. A total of 8, 3, and 4 participants had been to a hospital for mental health care at baseline, 6 months, and 12 months, respectively. Two participants at baseline and 6 months, and none at 12 months, received inpatient or residential substance use treatment. Finally, a total of 8, 2, and 5 participants at respective intervals used the emergency room for psychiatric problems within 30 days of their interview.

Criminal Justice Involvement: Criminal justice involvement showed a similar pattern as inpatient and ER treatment, with only a few participants reporting involvement at any time point. See table below for these numbers.

Criminal Justice Involvement	Baseline (N = 197)	6 month (N = 118)	12 month (N = 82)
	N	N	N
Arrested in past 30 days	7	2	5
Arrested for drug-related offenses in past 30 days	2	0	0
Currently awaiting charges, trial or sentencing	16	6	6
Currently on parole or probation	13	9	9

Housing: There were changes in housing status across time, especially between baseline and 6 months, although they were not statistically significant. The majority of participants reported staying or living with friends or family, 74.1% at baseline and 61.9% at 6 months. Living with family or friends is a broad category that could include high schoolers living with their parents, young adults couch-surfing with friends, and other types of housing situations, so there is some difficulty interpreting whether this category reflects a positive living situation or not. Second most frequently, participants reported renting or owning their own place: 16.7% at baseline and 33.1% at 6 months. (This change almost reached statistical significance.) The percentage of participants who reported living in an emergency shelter or a place not meant for habitation decreased from baseline to 6 months at 5.0% and 0.8% respectively. There was a trend toward significance in a decrease of nights spent homeless (p=.075). Participants' perception about their housing improved over time. From baseline to 6-month intervals, there was a statistically significant increase for the statement "My housing situation is satisfactory" (p=.021).



Health: Overall health perception remained stable over time (baseline mean = 3.29 and 6 month mean = 3.25 out of 5 from "poor" to "excellent" range). People spending nights in hospital in past 30 days for mental health or substance use remained low and stable over time as well (all times under 5%.). There were no significant changes over time.

The following questions ask about how you have been feeling during the last 4 weeks.	Baseline (N= 197)	6 month (N = 118)	12 month (N= 82)
	Mean	**Mean**	**Mean**
How would you rate your quality of life? (1 - 5: Very Poor, Poor, Neither Good Nor Poor, Good, Very Good)	2.60	3.84	3.7
Do you have enough energy for everyday life? (1 - 5: Not at all, A little, Moderately, Mostly, Completely)	2.70	3.46	3.59
How satisfied are you with your ability to perform your daily living activities? (1 - 5: VD, D, NSND, S, VS)	3.86	3.78	3.91
How satisfied are you with your health? (1 - 5: VD, D, NSND, S, VS)	3.63	3.66	3.74

How satisfied are you with yourself? (1 - 5: VD, D, NSND, S, VS)	3.51	3.81	3.91
How satisfied are you with your personal relationships? (1 - 5: VD, D, NSND, S, VS)	3.66	3.63	3.89
Average (Means)	**3.33**	**3.70**	**3.79**

Dealing with Everyday Life: There were minor to moderate improvements in each everyday life question from baseline to 6 months, although they did not all reach statistical significance. The following are the three largest percent change increases in the people who agree or strongly agree with the statements, which were also statistically significant:

26.0% My housing situation is satisfactory
17.1% I am getting along with my family members
11.2% I am able to control my life

Everyday life during the last 30 days. Mean (1 - 5: Strongly Disagree to Strongly Agree)	Baseline (N= 197)	6 Month (N = 118)	Statistical Significance
I do well in school and/or work.	4.13	4.24	-
I am getting along with my family members.	3.71	3.89	-
I deal effectively with my daily problems.	3.77	3.90	-
I am able to control my life.	3.78	3.94	$p < .05$
I am able to deal with crisis.	3.76	3.89	$p < .05$
I do well in social situations.	3.81	3.89	-
My housing situation is satisfactory.	3.53	3.88	$p < .05$
My symptoms are not bothering me.	3.38	3.52	-
Average (Means)	**3.73**	**3.89**	-

Emotional Health: Ratings of emotional health symptoms remained stable over time from baseline to 6 months, such as the frequency of feeling nervous, hopeless, depressed and that everything was an effort. The two largest percent changes from baseline to 6 months are a 21.3% change increase in feeling restless or fidgety and a 23.1% change decrease in feeling worthless (for participants that reported emotion some, most or all of the time.) The changes noted are not statistically significant.

The following six questions ask about how you have been feeling during the past 30 days. For each question, please indicate how often you had this feeling. (0-4: All, Most, Some, A Little, None)	Baseline (N= 197)	6 Month (N = 117)	12 Month (N= 82)
	Mean	**Mean**	**Mean**
a. Nervous	2.26	2.22	2.33
b. Hopeless	2.94	2.91	2.77
c. Restless or fidgety	2.37	2.11	2.3
d. So depressed that nothing could cheer you up	3.05	3.11	2.9
e. Everything was an effort	2.43	2.50	2.46

f. Worthless	3.13	3.26	3.2
Average (Means)	**2.82**	**2.82**	**2.83**

Trauma & PTSD Symptoms: Of note, 61.6% of the interview participants reported having experienced trauma in their lifetimes at baseline. Of the group of respondents who experienced trauma, 93.2% reported experiencing at least one PTSD symptom in their lifetime.

Types of trauma: The most frequent category of trauma experienced was interpersonal violence, with 72.6% of respondents selecting this type of event at baseline. 19.7% of respondents indicated experiencing community or school violence, 11.1% reported experiencing other trauma, and 10.3% experienced a natural or man-made disaster. No respondents reported military trauma.

Types of PTSD symptoms: Each PTSD symptom was reported at a similar rate, with the exception of feeling numb or detached from others, activities, or surroundings reported the least at 61.5%. The most frequently reported symptom was trying hard not to think about the experience(s) or going out of their way to avoid situations that were reminiscent of them, at 76.9%. 72.6% had nightmares about the experience(s) or thought about them when the participant did not want to. Finally, 71.8% of respondents who experienced trauma reported being constantly on guard, watchful, or easily startled.

Suicide Attempts: 27.0% of respondents reported ever trying to kill themselves in their lifetime at baseline. Early in the study, the percentage of participants reporting suicide attempts was even higher, resulting in the DMHAS project leadership requiring that the CT Strong teams conduct Columbia Suicide Severity Scale screenings for all their current and future CT Strong clients.

Overall Life Satisfaction: There were a couple significant improvements in satisfaction with ability to perform daily activities. Overall quality of life reported as good or very good had a 126.8% change increase from baseline to 6 months ($p<.05$ statistically significant from baseline to 6 months, and the mean increased 2.60 to 3.84 out of 5.) Enough energy for everyday life (moderately, mostly or completely had a 44.6% change increase from BL to 6M ($p<.01$ statistically significant, and the mean increased from 2.70 to 3.46 out of 5.) Participants reporting being satisfied or very satisfied with themselves had a 19.2% change increase from BL to 6M ($p=.075$ trending significant over three time periods, and the means increased from 3.51 to 3.81 out of 5.) The other items about overall life satisfaction did not have significant changes over time, including satisfaction with health, personal relationships, and ability to perform daily living activities.

Support for Recovery: Recovery supports remained relatively stable over time. 13.2% of participants attended self-help groups at baseline and 15.3% at 6 months. 72.6% of participants at baseline and 81.4% at 6 months reported having interaction of family and/or friends that are supportive of their recovery, a 12.1% change increase. Over 50% of participants said they needed support managing health care needs at all three interview times. In terms of managing their health care needs at baseline, 38.2% responded “On my own most of the time,” 42.9%

responded “On my own some of the time and with support from others some of the time,” 11.5% responded “With support from others most of the time,” and 7.3% responded “Rarely or never.” From baseline to 6 months, improvements in independently managing health care needs was trending as statistically significant (p=.083).

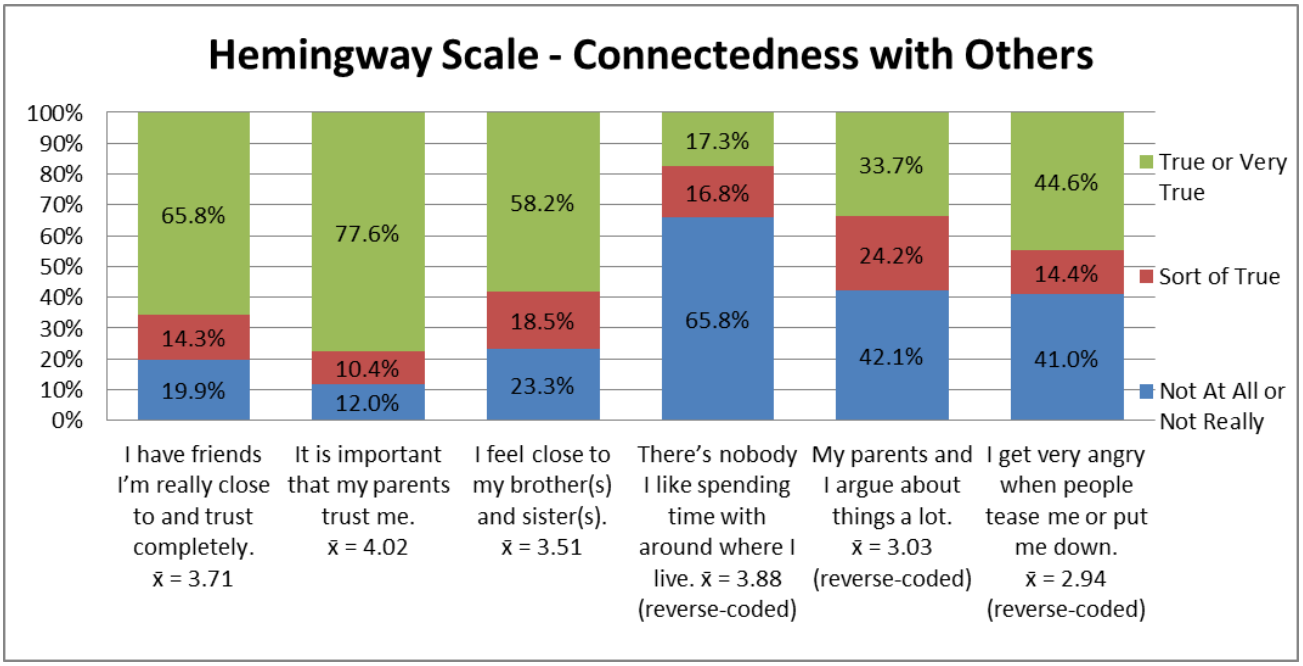
Social Connectedness: The social connectedness section indicated small improvements from baseline to 6 months for all questions asked. All but one of the questions started out as a high percent of agreement, and the question “I feel like I belong in their community” showed the most growth (13.7% change increase). The improvement over time suggests that their time in CT Strong had an impact on their feeling of belonging.

	% Agree or Strongly Agree w/ Statement		Percent Change from BL to 6M	Means 1 = Strongly Disagree 5 = Strongly Agree		Statistical Significance from Baseline to 6 Months
Social Connectedness	Baseline	6 Month		Baseline	6 Month	
I had people with whom I did enjoyable things.	90.3	94.9	5.1%	4.22	4.36	p < .01
In a crisis, I would have the support I need from friends or family.	81	83.8	3.5%	4.11	4.20	-
I am happy with the friendships I had.	76.2	81.9	7.5%	3.96	4.07	-
I feel like I belong in my community.	59.1	67.2	13.7%	3.66	3.78	-
I knew people who would listen and understand me when I needed to talk.	83.6	87.6	4.8%	4.10	4.20	-
I had people that I was comfortable talking with about my problems.	85	86.5	1.8%	4.12	4.19	-
I have family or friends that are supportive of my recovery.	84.9	90.2	6.2%	4.15	4.25	p < .05
I generally accomplish what I set out to do.	75.0	82.3	9.7%	3.91	4.13	-
Average (Means)	-	-	-	4.03	4.15	-

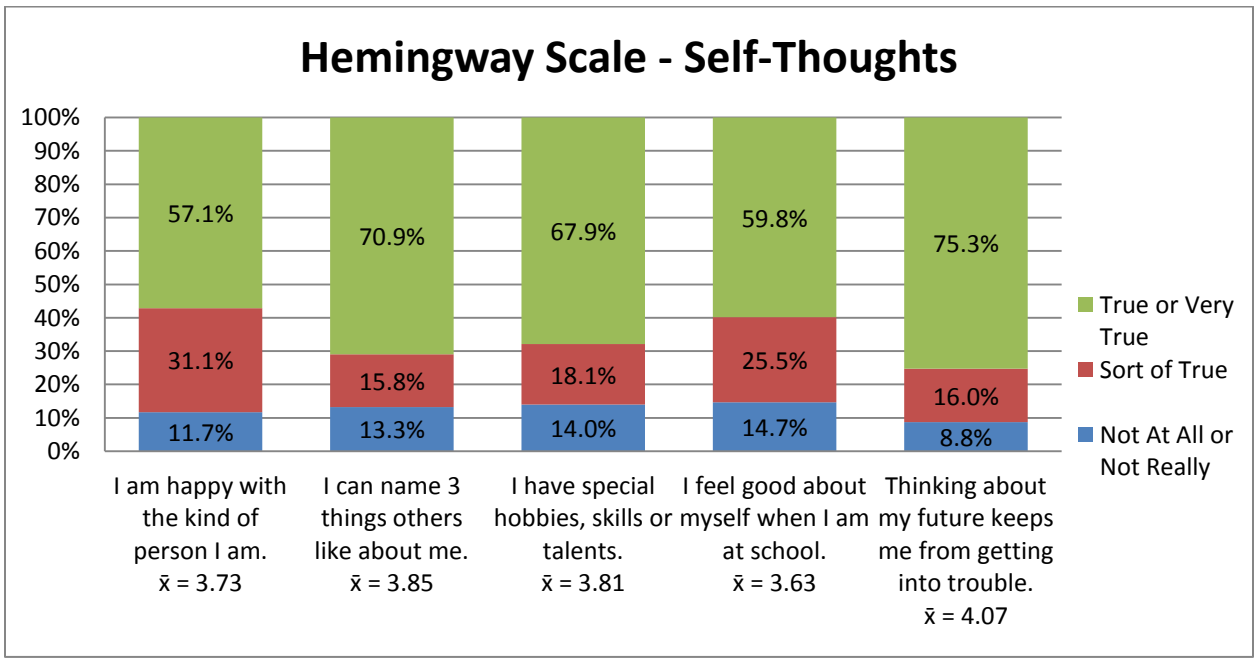
Hemingway Measure of Late Adolescent Connectedness: The table below reports the means for the Hemingway Measure of Late Adolescent Connectedness at the three time intervals. Reverse-coded questions are in red. Analyses indicated in subsequent tables suggested some improvement over time in connectedness.

Hemingway Measure of Late Adolescent Connectedness (How True?; 1-5: Not at all, Not really, Sort of true, True, Very True)	Baseline (N = 197)	6 Month (N = 117)	12 Month (N = 82)
	Mean	**Mean**	**Mean**
1. There's nobody I like spending time with around where I live.	3.88	3.77	4.01
2. I have friends I'm really close to and trust completely.	3.71	3.79	3.75
3. I am happy with the kind of person I am.	3.73	3.93	3.90
4. It is important that my parents trust me.	4.02	4.21	4.15
5. I feel close to my brother(s) and sister(s).	3.51	3.58	3.68
6. I can name 3 things others like about me.	3.85	3.96	3.91
7. My parents and I argue about things a lot.	3.03	3.12	3.13
8. I have special hobbies, skills or talents.	3.81	4.00	3.86
9. I feel good about myself when I am at school	3.63	3.68	3.68
10. I get very angry when people tease me or put me down.	2.94	3.24	2.76
11. Thinking about my future keeps me from getting into trouble.	4.07	4.11	4.25
Mean	**3.65**	**3.76**	**3.73**

Below are two bar graphs displaying the Hemingway Scale responses at baseline. We grouped this scale's questions into two sections. The first group of responses is about relationships with other people and the second group of responses is about their self-thoughts. In the first group of questions, there was a 24.1% change increase from baseline to 6 months in "not really" or "not at all" responses for the statement "I get very angry when people tease me or put me down." Responses for this question were statistically significant from baseline to 6 months ($p<.05$). There was a 13.0% change increase in "true" or "very true" responses for the statement "It is important that my parents trust me." The remaining four statements remained relatively consistent over time.



Below are Hemingway question responses about self-thoughts and self-confidence. Improvements from baseline to 6 and 12 months were trending as statically significant (p=.064) for the statement "I can name 3 things others like about me." The four other statements had small though insignificant changes over time. There were statistically significant improvements from baseline to 6 months for the statements "I am happy with the kind of person I am (p<.05) and "I have special hobbies, skills or talents" (p<.05). The remaining two statements in the chart below were not statistically significant over time.



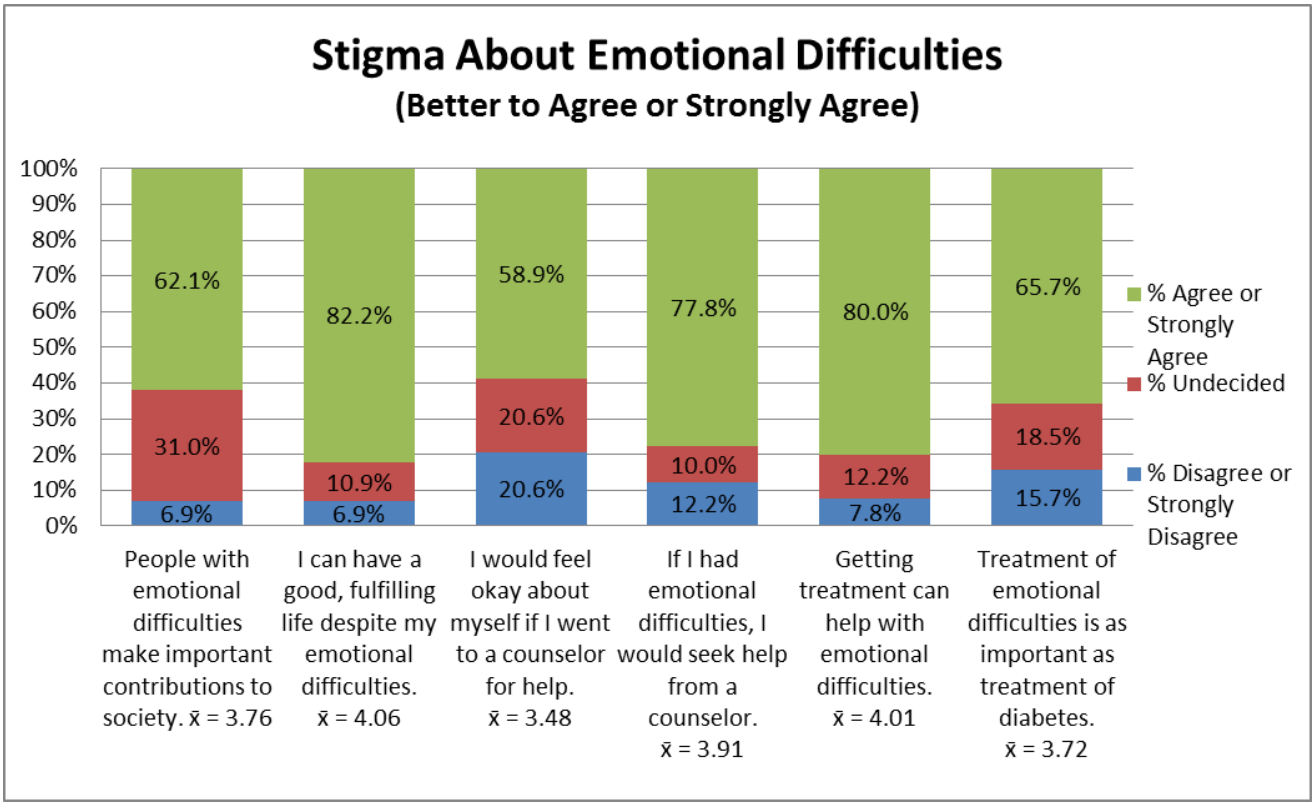
Stigma: Data from the combined stigma items can be seen as remaining fairly steady over time. The means for the stigma section are reported in the table below for the baseline, 6-month, and 12-month intervals. Reverse coded items are in red. The questions were asked on a 5-point scale from 1- Strongly Disagree to 5- Strongly Agree.

Stigma (1-5: SD, D, U, A, SA) **Reverse coded questions in red ink**	Baseline (N = 197)	6 Month (N = 117)	12 Month (N = 82)
	Mean	**Mean**	**Mean**
1. People with emotional difficulties make important contributions to society.	3.76	3.78	3.78
2. I don't socialize as much as I used to because my emotional difficulties might make me look or behave "weird".	3.21	3.31	3.03
3. Having emotional difficulties has ruined my life.	3.49	3.79	3.76
4. I stay away from social situations in order to protect my family or friends from embarrassment.	3.46	3.54	3.33
5. People without emotional difficulties could not possibly understand me.	3.29	3.37	3.23
6. People ignore me or take me less seriously just because I have emotional difficulties.	3.47	3.60	3.61
7. I can't contribute anything to society because I have emotional difficulties.	4.08	4.19	4.11
8. I can have a good, fulfilling life despite my emotional difficulties.	4.06	4.07	4.13
9. Others think that I can't achieve much in life because I have emotional difficulties.	3.46	3.50	3.39
10. I would feel okay about myself if I went to a counselor for help.	3.48	3.62	3.59
11. If I had emotional difficulties, I would seek help from a counselor.	3.91	3.87	3.98
12. Getting treatment can help with emotional difficulties.	4.01	4.09	4.15
13. People with emotional difficulties tend to be violent.	3.19	3.28	3.28
14. Treatment of emotional difficulties is as important as treatment of diabetes.	3.72	3.98	3.86
15. I often think about the fact that I am a person with emotional difficulties.	3.01	2.97	2.89
Average (Means)	**3.57**	**3.66**	**3.61**

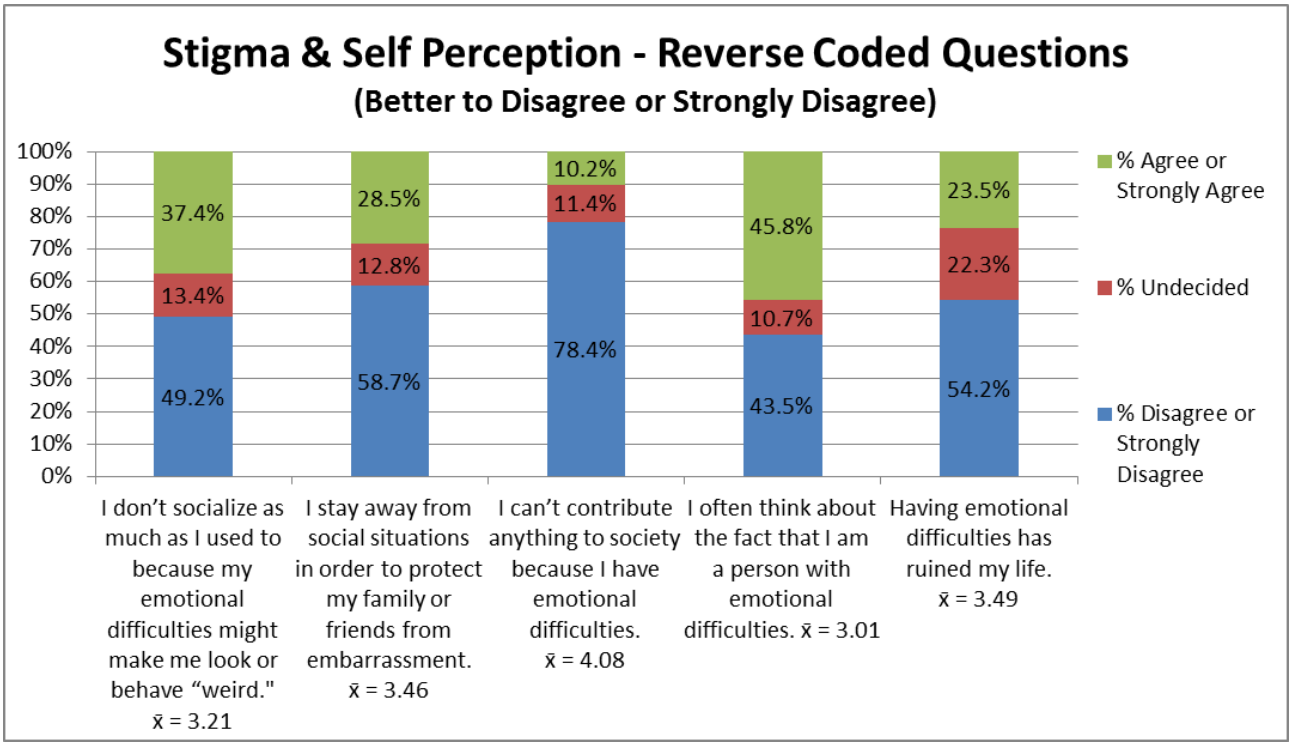
The fifteen baseline responses about stigma are organized into the three graphs below. Only one response in the second graph was statistically significant over time. The means at baseline can be found below each item description. Items are grouped in the graphs, with blue as disagreement (1 or 2), red as undecided (3), and green as agreement (4 or 5) to show the

general baseline stigma of the participants. The first two graphs are about internalized stigma. The third graph has external stigma questions that were all reverse coded, so the blue areas were the preferred outcome and represented less stigma.

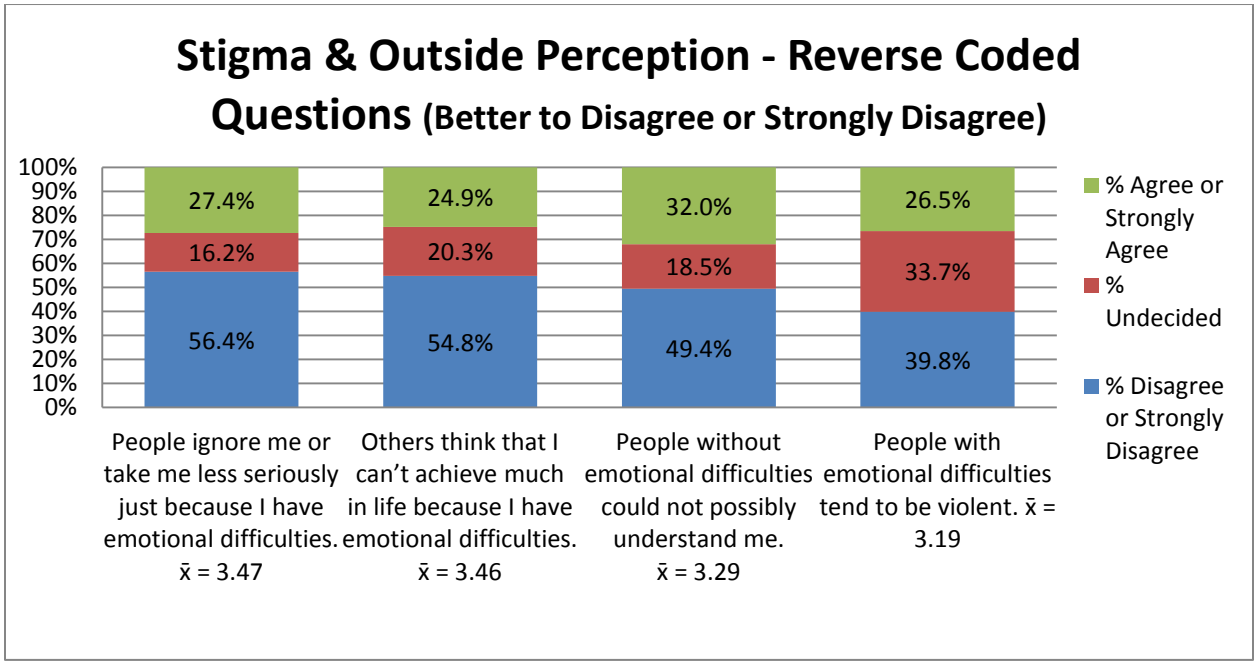
77.8% of participants reported that they would seek help if they had emotional difficulties, but only 58.9% would feel okay about themselves if they went to a counselor for help. 80% of participants believed that getting treatment can help with emotional difficulties. Most participants believed that people with emotional difficulties make important contributions to society. One of the stigma responses was statistically significant from baseline to 6 months. Participants were more likely to believe that treatment of emotional difficulties was as important as treatment of diabetes after 6 months in the program ($p<.05$).



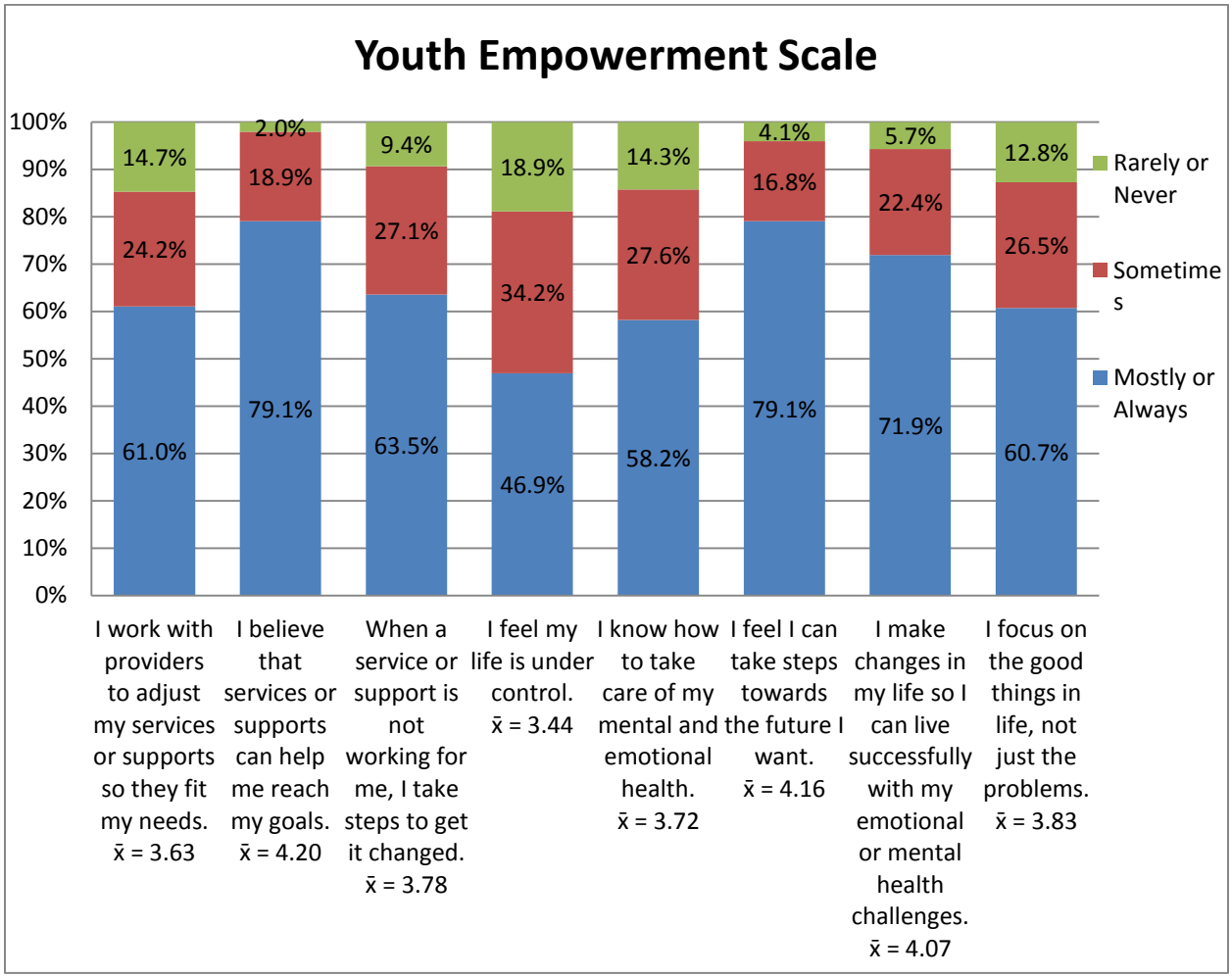
Below are self-perception stigma questions that are reverse-coded questions, meaning that it is better to disagree or strongly disagree. Almost a quarter of participants believed emotional difficulties had ruined their lives, and about 10% believed they couldn't contribute anything to society because they had emotional difficulties. 37.4% of participants reported that they didn't socialize as much as they used to because of fear that emotional difficulties might make them look or behave weird. There were statistically significant improvements from baseline to 6 and 12-month intervals in the participants believing emotional difficulties had ruined their lives ($p<.05$). Participants were significantly more like to disagree or strongly disagree with the statement at 6 and 12 months than at baseline.



Reversed stigma questions about outside perception are below. Less than a third of participants believed people without emotional difficulties cannot understand them. About a quarter of participants believed that people with emotional difficulties tend to be violent. There were no statistically significant changes over time for these questions.



Youth Empowerment Scale: There were a number of statistically significant changes related to feeling more empowered over time for the CT Strong participants. A majority of participants believed that services and supports could help them reach their goals (79.1%) and that they could take steps towards the future they wanted (also 79.1%). While the statement about believing in services and supports to help reach goals started off high, there was a trend of statistical significance from baseline to 6 months (p=.066). There was a 21.5% change increase in participants who reported mostly or always knowing how to take care of their mental health from baseline (58.4%) to 6 month (70.7%), which was statistically significant (p<.05). There was a statistically significant change (p<.01) in this section for the statement "I focus on the good things in life, not just the problems" from baseline to 6 and 12-month intervals. The means for this question (1 - Never or almost never to 5 - Always or almost always) increased from 3.83 to 4.04 to 4.33 over the three time periods. Making changes to live successfully with mental health challenges was also statistically significant p<.05) from baseline to 6-month intervals.



Youth Empowerment Scale (5-Always or almost always, 4-Mostly, 3-Sometimes, 2-Rarely, 1-Never or almost never)	Baseline (N = 197)	6 Month (N = 117)	12 Month (N = 82)
	Mean	**Mean**	**Mean**
1. I work with providers to adjust my services or supports so they fit my needs	3.63	3.55	3.50
2. I believe that services or supports can help me reach my goals	4.2	4.18	4.10
3. When a service or support is not working for me, I take steps to get it changed.	3.78	3.86	4.05
4. I feel my life is under control	3.44	3.5	3.54
5. I know how to take care of my mental and emotional health	3.72	3.97	3.89
6. I feel I can take steps towards the future I want	4.16	4.16	4.31
7. I make changes in my life so I can live successfully with my emotional or mental health challenges	4.07	4.22	4.23
8. I focus on the good things in life, not just the problems.	3.83	4.04	4.33
Average (means)	**3.85**	**3.94**	**3.99**

Interviewer Observations: Following each interview, the interviewers rated their perception of the accuracy and reliability of each section of the interview. Approximately 99% of interviews had all of the sections marked as mostly or very reliable. When interviewers thought certain responses were not reliable, the interviewer and evaluation manager discussed these responses. If the responses were in fact found to be not at all reliable, those specific responses would be coded as missing so they didn't skew the results.

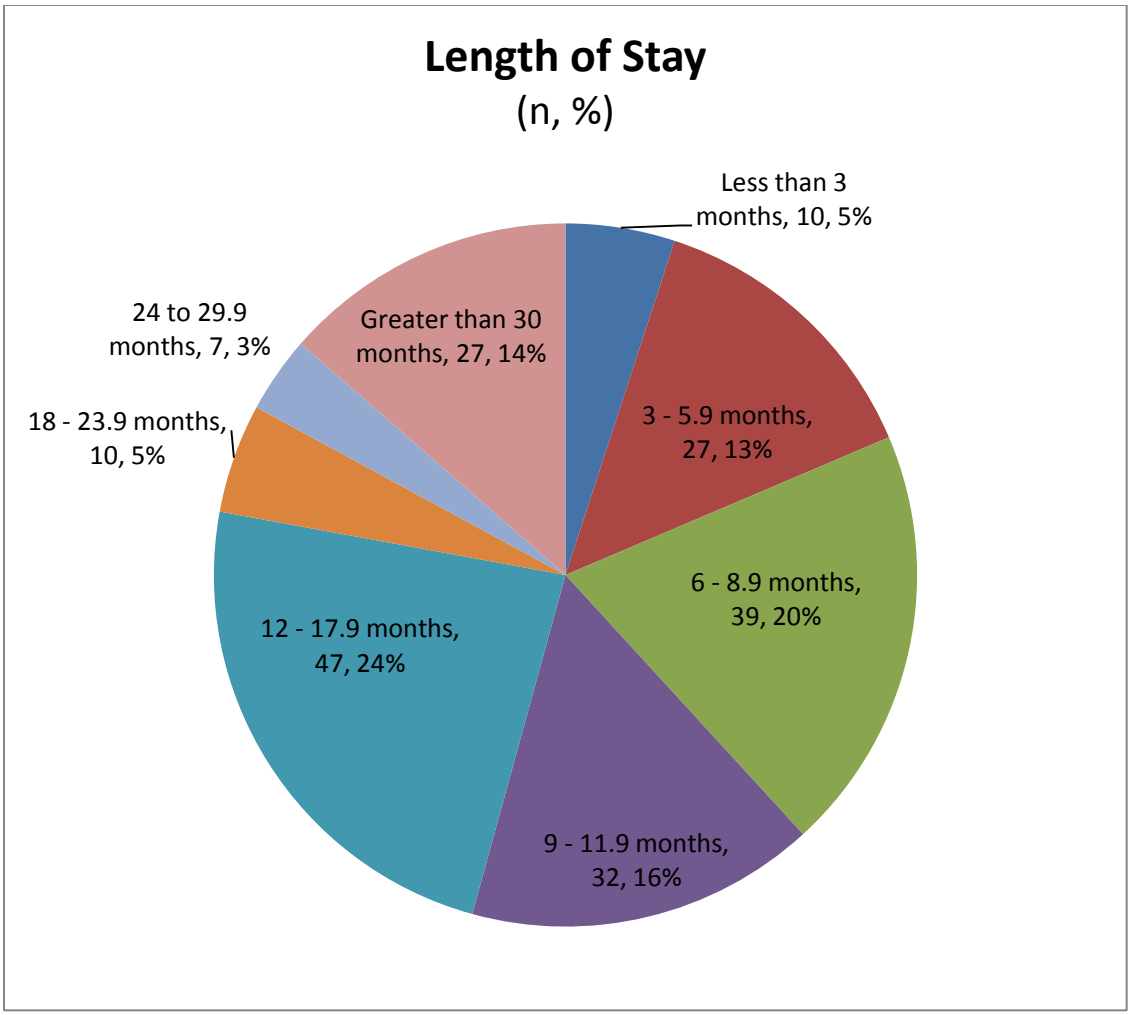
Interviewer Observations (1 - 4: Not at all reliable, a little reliable, mostly reliable, very reliable)	baseline (N = 197)	6 month (N = 117)	12 month (N = 82)
	Mean	**Mean**	**Mean**
1. Demographics	3.99	3.97	3.99
2. CT STRONG Program Questions	3.95	3.96	3.95
3. Education/Employment	3.99	3.95	3.94
4. Military Family and Deployment	3.99	3.97	3.98
5. Disability Measures	3.97	3.96	3.91
6. Mental and Physical Health	3.89	3.94	3.94
7. Recovery	3.93	3.96	3.98
8. Sexual Orientation	3.97	3.82	3.75
9. Family and Housing	3.99	3.82	3.79
10. Drug and Alcohol Use	3.72	3.84	3.81

11. Crime/CJ Involvement	3.75	3.82	3.81
12. Violence and Trauma	3.93	3.91	3.90
13. Social Connectedness	3.93	3.91	3.91
14. Stigma	3.92	3.9	3.91
15. Hemingway Measure of Late Adolescent Connectedness	3.95	3.92	3.95
16. Youth Empowerment	3.96	3.92	3.95
Average Mean and SD of responses	**3.93**	**3.91**	**3.91**

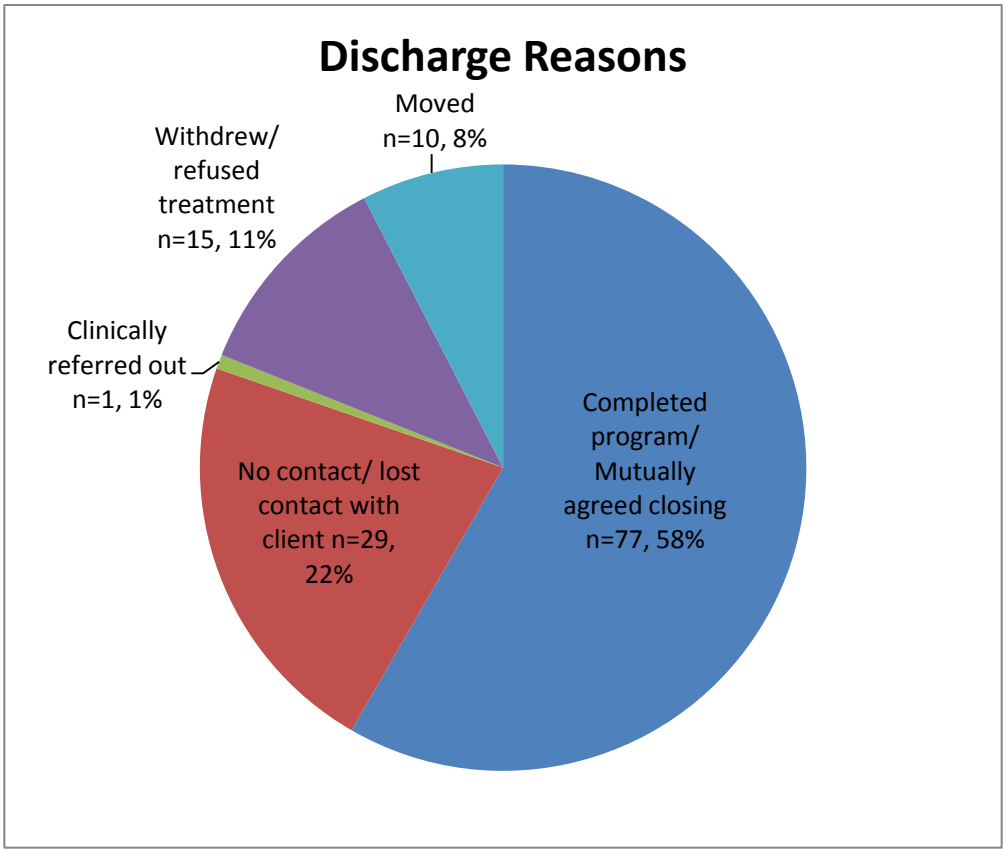
Administrative Data

Service forms were used to determine length of stay in the CT Strong program and the reasons for discharge. These forms were basically required service items for the GPRA/NOMS that the evaluation team sent to the program staff, since they knew the types of services provided and referred for each client, as well as exact intake and exit dates. The service form is included in Appendix A. (We created and used weekly activity forms that were more detailed and collected more frequently than the requirement for every 6 months, and information on service provision will be described in the next section using the weekly log data.) SAMHSA asked for program information every 6 months about (1) if the client was still receiving services, (2) discharge reasons, and (3) specific service use info: Screening, Assessment, Treatment Planning or Review/Plan of Care, Psychopharmacological Services, Co-Occurring Services, Case Management, Trauma-specific Services, Medical Care, Employment Services, Family Services/Advocate, Child Care, Transportation, Education Services, Housing Support, Social Recreational Activities, Consumer Operated Services, HIV Testing, and Mental Health Services.

We calculated client length of stay in the program and discharge reasons using client intake information and the client service forms. The length of stay was calculated based on 199 clients, and discharge reasons for 132 people at the time of data collection. A majority of clients were in the program less than 12 months (55% total), and about 45% of clients were in the program for a year or longer. While CT Strong was originally planned to be a 6-month program, the clients often needed services beyond that timeframe. Program staff reported that it could take weeks or months to build rapport with the youth or young adults before getting the clients to really engage with the program. The average length of stay was 15.24 months. The pie chart below shows client length of stay broken in different time intervals: using 3-month intervals under a year, 6-month intervals over a year up to 30 months, and everyone greater than 30 months combined. The client with the longest length of stay was 48 months, meaning they participated in the program in some capacity for 4 years. The youth and young adults' intensity and frequency of involvement in the program likely changed over time.



The most frequent reason for discharge from CT Strong was due to the client completing the program, or there being a mutually agreed closing with both client and staff. A few clients moved out of the area or out-of-state and could no longer participate. There were also many clients that withdrew from the program, or that the program staff lost contact with. There were several service forms where the discharge reason was not specified, which are not included in the chart below.



Weekly Activity Logs

Weekly activity logs were created for this project, reflecting the types of activities in which the staff were expected to engage with the clients or on their behalf. A copy of the form can be seen in the Appendix. Weekly activity log data was used to describe the frequency, intensity and types of services provided by staff. The staff completed a total of 4,118 logs for 381 clients. There was an average of 127 clients per site with at least one activity log submitted (range of 120 to 136 clients per site). The total number of logs per client ranged from 1 to 83, with a mean of 11 weekly logs per client. The average amount of staff time reported with or on behalf of a client was 1 hour and 35 minutes per week. Staff reported spending anywhere from 5 minutes to 45 hours working with or on behalf of a client in a week.

Program Site	Total # of clients with at least one log	Minimum # of logs per client	Maximum # of logs per client	Mean # of logs per client	**Total logs per site**	**Mean Amount of time per log (hours: minutes)**
Milford	120	1	66	10	**1199**	2:04
New London	125	1	42	8.93	**1116**	1:21
Middletown	136	1	83	13.26	**1803**	1:20
Total	381	1	83	10.73	**4118**	**1:33**

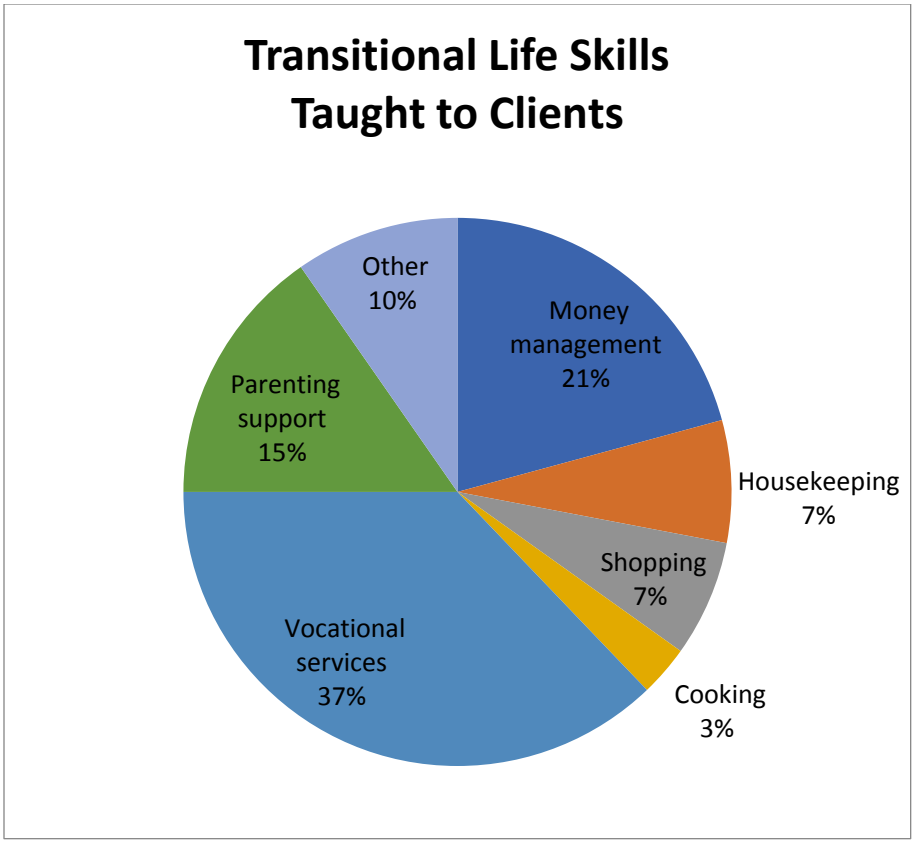
Top 15 Overall Activities: The top weekly log activities reflected the work most often provided by staff from all categories. Seeing the most common services together can demonstrate the greatest needs of clients and the greatest impacts of the program. These top activities can be found in the table below. The four most frequently reported activities included emotional support or counseling (n=273; 71.7%), educational support (n=242; 63.5%), engagement in treatment planning/ case conferencing (n=240; 63.0%), and vocational services (n=211; 55.4%). As the fifth most common activity, program staff provided and helped arrange transportation for 53.0% of clients (n=202).. Additional commonly provided activities are listed in order of frequency below.

Weekly Log Activities -- Top 15	**N (Number of Clients Who Received this Service)**				**% (Percent of Clients Who Received this Service)**			
Program Site	Milford	New London	Middletown	Total	Milford	New London	Middletown	Total
Emotional support or counseling	87	96	90	273	31.9%	35.2%	33.0%	71.7%
Educational support	79	96	67	242	32.6%	39.7%	27.7%	63.5%
Engaged in treatment planning and/or case conferencing.	65	71	104	240	27.1%	29.6%	43.3%	63.0%
Vocational services	53	91	67	211	25.1%	43.1%	31.8%	55.4%
Transportation	79	75	48	202	39.1%	37.1%	23.8%	53.0%
Connection to peer support	81	53	62	196	41.3%	27.0%	31.6%	51.4%
Completed intake, orientation, program introduction and/or screening.	81	63	49	193	42.0%	32.6%	25.4%	50.7%
Community activities	86	56	50	192	44.8%	29.2%	26.0%	50.4%
Advocacy	34	111	44	189	18.0%	58.7%	23.3%	49.6%
Connection to family advocate	87	28	51	166	52.4%	16.9%	30.7%	43.6%

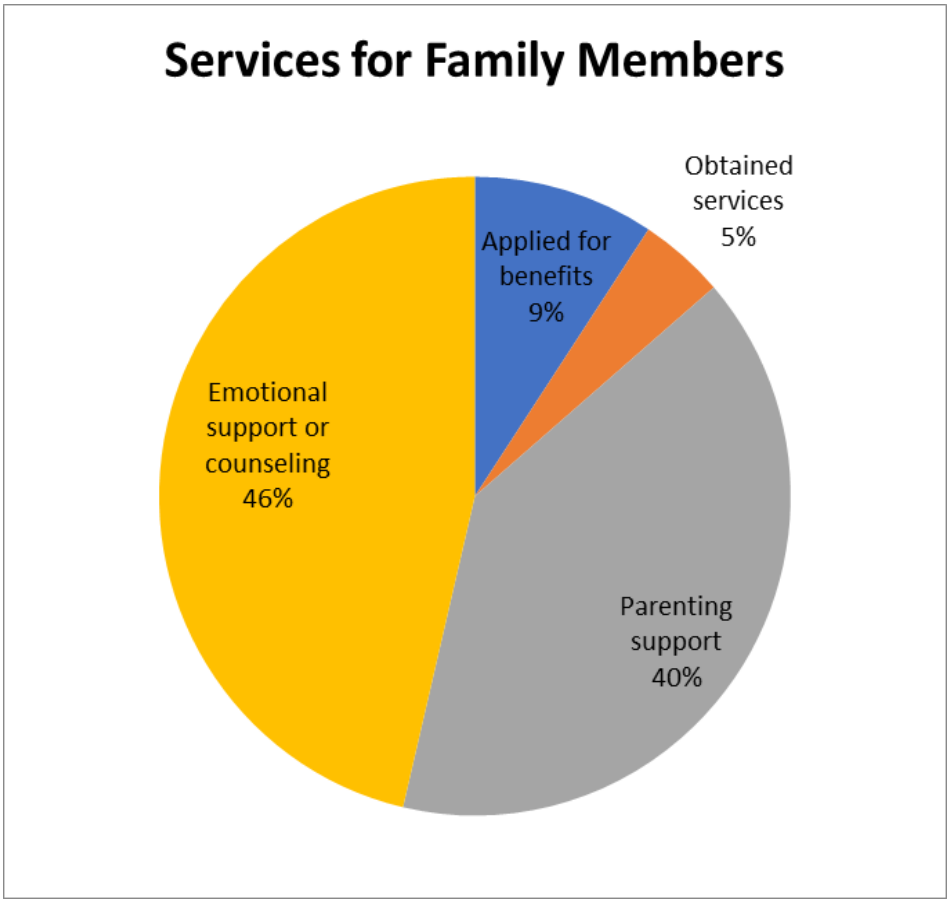
Mental health services	26	28	74	128	20.3%	21.9%	57.8%	33.6%
Attempted to re-engage client in services.	64	14	48	126	50.8%	11.1%	38.1%	33.1%
Money management	11	43	64	118	9.3%	36.4%	54.2%	31.0%
Housing subsidy	22	28	53	103	21.4%	27.2%	51.5%	27.0%

Provided Services: CT Strong staff provided a variety of services and supports for clients. The most frequently provided service was ***emotional support or counseling***. Emotional support/counseling was provided to a total of 273 clients (72%), reflected in 1753 weekly logs. ***Educational support*** was the second most provided service, with 242 total clients (64%) who received support in 1492 total logs. ***Transportation, advocacy, and community activities*** were other highly provided services, with 53%, 50%, and 50% of the CT Strong clients receiving support in these areas. When CT Strong staff provided ***crisis management*** for clients (n = 94, 25%), we often saw an increase of overall hours with the clients for those weeks. CT Strong staff provided or organized connections to ***peer support*** (n=196) or connections to a ***family advocate*** (n=166) frequently as well. These connections were provided or organized for 51% and 44% of clients, respectively. Less frequently, staff provided or organized ***legal support*** (n=76, 20%), natural supports for wraparound process (n=88, 23%), specialized classes for the clients and their family members (n=42, 11%), and family psychoeducation (7%).

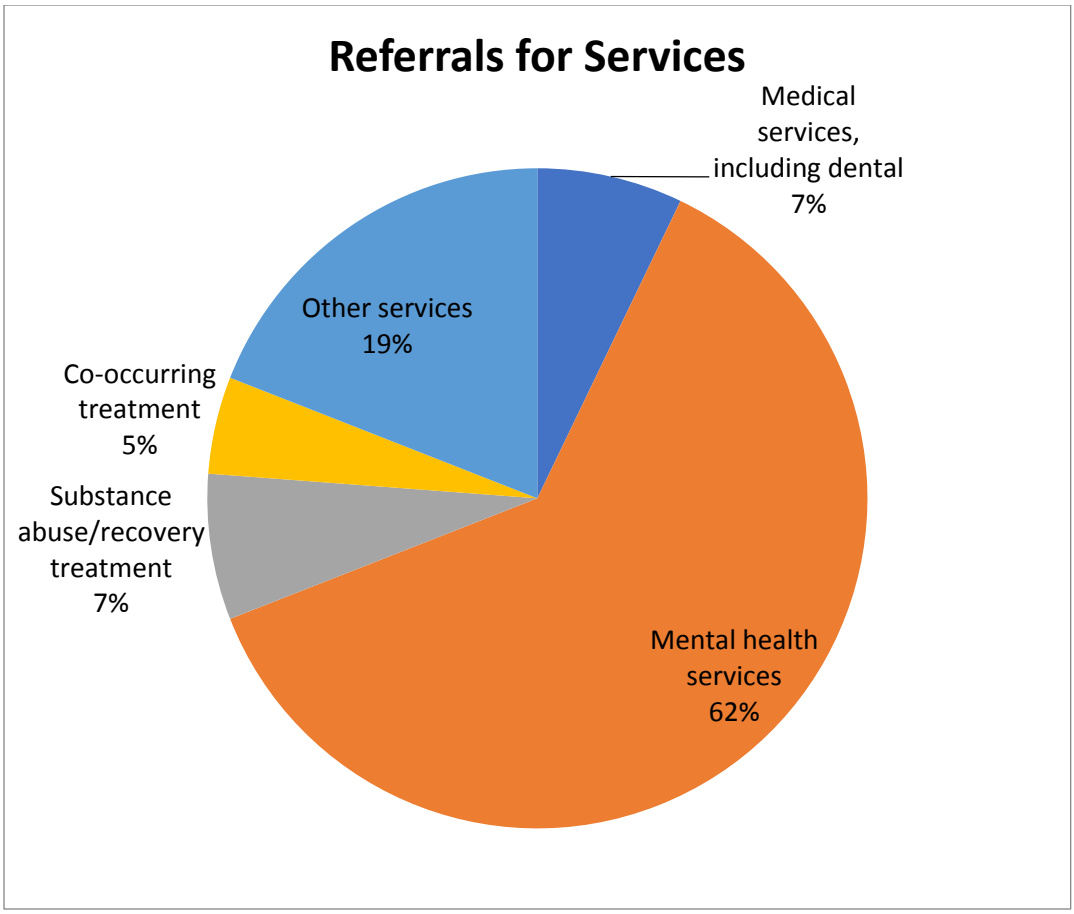
Transitional Life Skills: Of the various life skills, ***vocational*** (n=211) and ***money management*** (n=118) life skills were the most frequently taught to clients. ***Parenting support*** was next, with 87 clients receiving this support. Some clients also received help with housekeeping (n=41), shopping (n=39), cooking (n=17) and other life skills (n=55). CT Strong staff taught transitional life skills to clients in a variety of approaches, including cooking classes at drop-in centers, practice job interviews, "Dress for Success" events that provided professional clothes and resume help, peer support groups, and through regular meetings with program staff. The pie chart below compares the proportion of each life skill taught out of the total transitional life skills taught. For example, 37% of all life skills taught to clients were vocational skills.



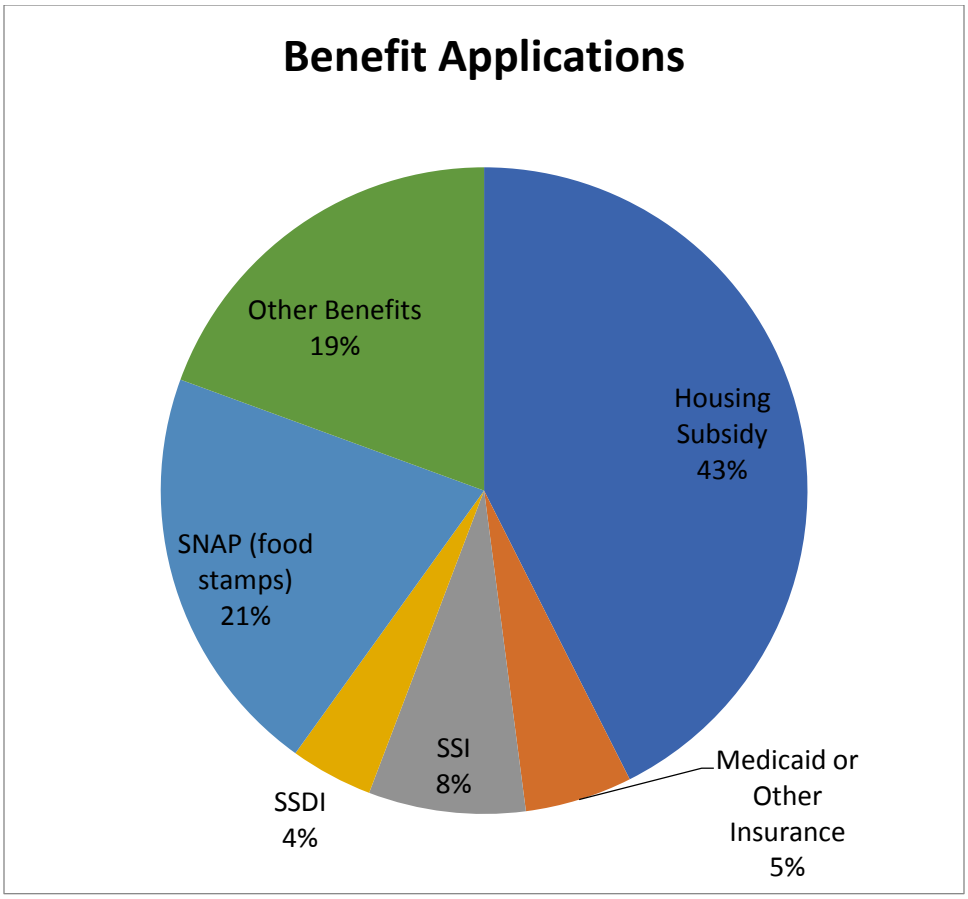
Services Provided for Family Members: The family advocate at each site primarily worked with family members of clients. Peer support specialists and wraparound coordinators also met with clients' families. CT Strong staff provided emotional support or counseling to 95 family members, and parenting support was provided for 82 family members of CT Strong clients. Less frequently, the program staff also helped family members apply for benefits (n=19) or obtain services (n=9). Staff worked with clients' parents, guardians, siblings, and other family members. As demonstrated in the pie chart below, 45% of all services provided for family members were emotional support or counseling, 40% were parenting support, and a total of 14% were assistance in obtaining benefits and services.



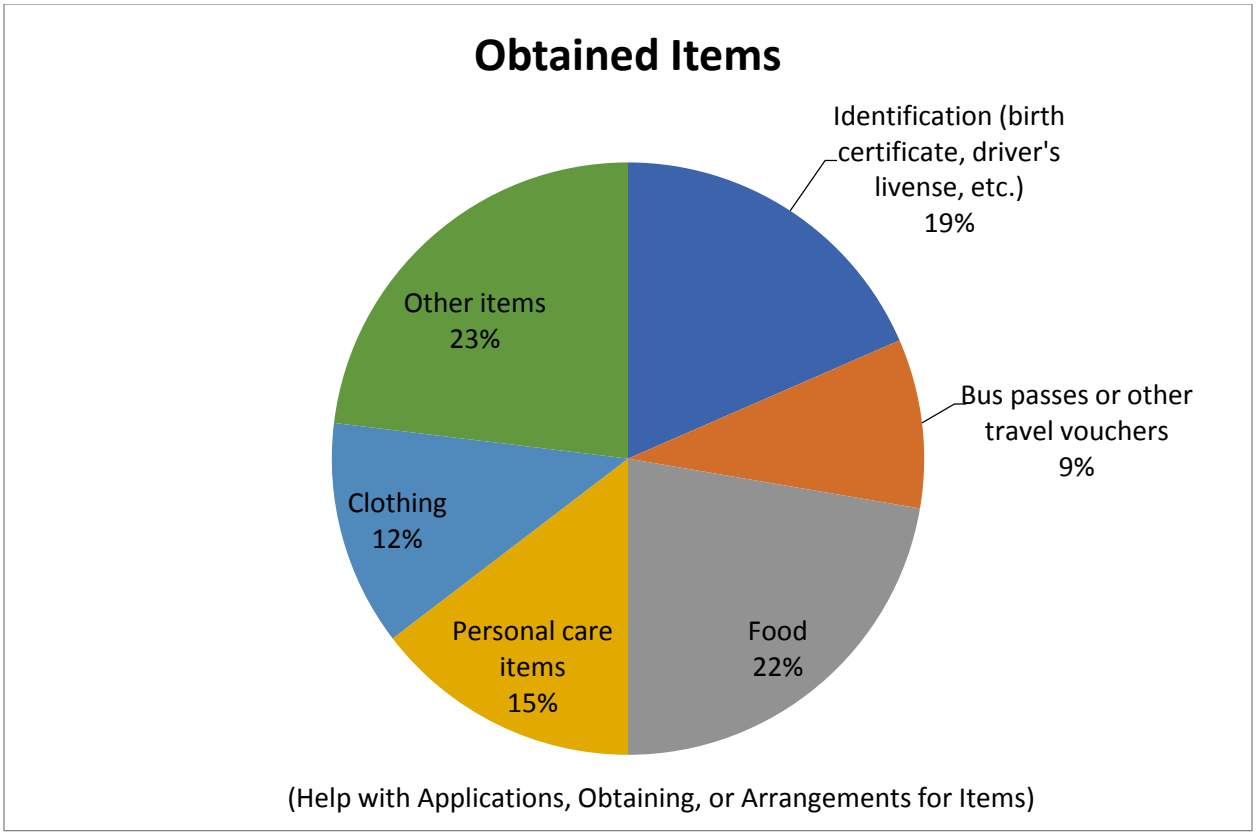
Obtaining and Applying for Services: As part of its wraparound approach, connecting youth and young adults to other services was one of the main goals of the CT Strong program. CT Strong staff helped 128 clients (34%) obtain, apply for, or arrange mental health services. They also connected 46 clients to medical services, 28 clients to substance abuse/recovery treatment, 9 clients to co-occurring treatment, and 33 clients to other services. As seen in the pie chart below, a majority of service referrals were for mental health services.



Benefit Applications: Program staff also assisted clients with applying for benefits. Out of all the benefit types, clients needed the most help with housing. There were 380 weekly logs with housing application marked off, and a total of 103 clients who received help with a housing subsidy application. Assistance with SNAP benefits (50 clients) was also commonly reported and reflected a high need for clients. Less frequently, CT Strong staff helped clients with SSI (n=19), SSDI (n=10), Medicaid (n=13), and other benefit applications (n=47).



Obtaining Services and Basic Needs: CT Strong staff helped clients obtain and apply for a variety of basic need items, including identification (e.g. driver's licenses), bus passes, travel vouchers, personal care items, clothing and food. 23% of CT Strong clients (n=88) received help obtaining personal care items, and 24% received help obtaining bus passes or other travel vouchers (n=90). Driver's licenses and other forms of identification (n = 90) were also highly sought after, as 24% of CT Strong clients received help obtaining identification. CT Strong helped 78 clients receive food (n=78), clothing (n=55) and other items (n=62). The pie chart below depicts that the percentage of items obtained out of the total items, ranging from 9% to 23%.



Focus Groups

Qualitative data was collected throughout the course of the project, both in terms of process observations and directly through focus groups and meetings with key staff. Process observations revealed that the program sites utilized the strengths and resources of their communities. They made connections with school-based health clinics, young adult drop-in centers, technical high schools, and NAMI drop-in centers, depending on the services that were available in their town. Program staff also built their programs and services around the needs of the youth and young adults in their town, organizing groups and events focused on homelessness outreach, young fathers, masculinity and gender socialization, criminal justice diversion, peer connectedness, and other topics.

An additional qualitative process observation related to the communication between program supervisors at the three sites and the rest of the team. At times, the program staff brought up questions and complaints that had been communicated about with supervisors and seemed not to have been passed on to the line staff. Some activities were completed by the supervisors and the rest of the team may not have been aware of what had been done. For instance, a sustainability work group had been established with membership from DMHAS, ABH and the three team supervisors, but after a few meetings, the site members requested that it disband. The line staff later brought up not having a sustainability planning group as a problem.

Sample focus group questions were developed and approved by the DMHAS Institutional Review Board (IRB) prior to implementing the groups (along with all the other measures), but the facilitators were flexible in asking follow-up questions to clarify responses and to pick up on topics initiated by participants. All groups were led by the lead evaluator and/or the evaluation coordinator with another research staff to take notes as needed. No program staff or other non-participant was present during the focus groups. The facilitators read and gave out copies of the information sheet prior to beginning each group. Most of the focus group participants were young adults ages 18 to 25. A few participants were 17 years old, and we obtained parental consent prior to the focus group. With the consent of all participants, a digital recording pen was used to record notes and an RA wrote up transcripts. Thematic analysis was conducted after each set of groups. General feedback from the groups was presented after each set of groups to DMHAS leadership, program staff and the state level transition team.

In the second through fifth years of the CT Strong program, several focus groups were held with representatives of different populations involved in the study. In total, there were 5 focus groups with CT Strong clients (n = 42) across the 3 program sites, 2 focus groups with CT Strong program staff (n = 10 at the first group; n = 7 at the second group, with some overlap in staff at both), 1 focus group with young adult support group participants (n = 13), and 2 focus groups with young adult peer group facilitators (n= 7).

Focus Groups with CT Strong Clients

Program Benefits: The clients were very enthusiastic about the program, wanted more people to know about it, and wanted more programs like it to be set up. Almost all participants also referred their friends to the program. The young adults appreciated the program flexibility to focus on their goals. They identified their main goals and needs as jobs, education, support while in school/college, independent housing, advocacy, knowledge of rights, and help getting into services. CT Strong assisted them with finding jobs and completing job applications, getting driving permits, and looking into colleges and financial aid, and getting connected to other services. Many participants felt they benefitted from the non-clinical focus of the program, stating that traditional counseling did not work for them or it was not what they needed.

> "It's not clinical. It feels good to get life advice. It's not just like 'here's some medication to make your life better.' What's a bottle a pills going to do for you? What's a bottle of pills going to do for you to get your license… to get you a job… to get you out of your home? I think this program works for people who don't think counseling works."

> "Clinical feels like something I have to do. Like, 'You have to do this. It's mandatory.' This is something I want to do. They ask me 'What do you want to check in on?' It's like a family vibe or atmosphere."

Perceptions of CT Strong Staff: Participants spoke very positively about the relationships and bonds they had formed with CT Strong staff members. They felt that these relationships were comfortable, reliable, and helpful whenever they needed support, resources or advice. The participants felt that the program staff were receptive to their needs. The staff provided an environment where they could comfortably share information about themselves. The young adults had a consensus that they trusted the staff, saying, "They keep your personal stuff personal," and "They respect you 100%." They felt the staff were real with them and gave helpful life advice. The young adults also discussed having no or few adults in their life outside of this program that they trusted.

At a couple groups, participants who had children noted that the staff were parents themselves, which made it easier for them to relate. Participants appreciated that staff were members of the community who they often already knew, and it made their connection feel much more natural. Additionally, the young adults noticed the dedication of the staff and how much time and energy that staff put into helping them succeed.

> "They are all part of the community. It made me more comfortable knowing them."

> "And they are all parents; they all understand what it is like to have children. They want to do everything for their child, and they put the same amount of love and energy in us as they do their own children."

Family Relationships: There were multiple accounts from participants of difficulty dealing with their families. The young adults wanted their parents to respect personal space and privacy, and they reported having had outbursts with their parents at times. Some participants desired to improve their family interactions, while some were more geared towards separation and independence. One participant shared that they stopped arguing as much with family due to what they learned in the program. They learned from the program and their teachers to give a little bit of time before answering, which helped them in reacting to stressful family interactions.

> "It's very hard to live with most of my family, especially my mother. We don't always see eye to eye. We don't get along. I want my mother to respect me as a person."

> "Sometimes me and my parents go on and off a lot. But now, starting a couple months ago, I don't argue much with my parents. I realize trouble always gets me in trouble. I want to be good. You get more privileges; you have more fun."

Many of the participants at one site agreed that they do not have father figures in their lives. Being able to hear advice from both male and female CT Strong staff members was especially helpful. They reported that it gave them a different perspective on issues. Male participants felt

it was important to be shown different ways to be a successful man by male role models within the program, while female participants felt it was important to understand the male perspective in relationships.

> "I had my kids and I didn't know what I was doing, and they didn't have their dad. This program taught me how to be their mom without having their dad."

> "So having two males [staff] in the program … it really helps a lot. You don't realize how important it is to have both perspectives in your life until you are missing one."

Physical & Mental Health and Associated Stigma: Many of the participants reported how stigma or stereotypes about their mental or physical health had affected them. Multiple participants at one program site reported dealing with bullying in the schools, but they did not report any of these incidents to any authority. Participants reported a general uneasiness with trusting peers, family, or teachers with information about their life; worrying that the information could be used against them. Some participants reported receiving general criticism from their family members, peers and teachers.

> "Most of the kids at school pick on me. I don't really do anything. My teacher asks me about it, if I am upset. She asks if my classmates have said anything to me or told me anything. I say no. She asks a lot but I say no."

> "I have been bullied in high school. There are a lot of kids that pick on me… They didn't apologize for it. Or get in trouble."

Employment and Future Goals: Participants reported varying levels of employment, ranging between unemployed but in school, employed part-time, unemployed but actively applying, unemployed due to medical issues, and working full-time. Participants reported their current and past difficulties with submitting job applications, mostly with never hearing back. Many participants received help from the program staff, who sat down to do applications with them. Other participants reported struggles with finding, applying, and staying in college, mainly due to financial struggles.

> "I might change it [my major], but it might be for a financial reason. I might go back [to school], but it's expensive. I was only able to do a semester because I couldn't afford it. I didn't have anyone to sit down with me and explain costs."

Improving Services: Participants suggested increasing the hours of the drop-in center, improving transportation to the program, and incorporating outreach and programming at the drop-in specifically for people with mental health or substance use issues. Participants agreed that getting more young adults and community members involved would be beneficial. When

asked how the program could better identify or reach people who are unsure about joining, the participants stated that word of mouth and having a trusted person make the introduction was crucial. Fear of asking for help often prevents young adults from participating in programs like CT Strong.

> "I know there are a lot of kids just like me or worse who don't know about the program or resources, and they are just sitting at home wondering about how to fix their problems. There are resources out there that could help them."

Participants at one site reiterated how the program staff being from the community makes the program what it is:

> "There is nothing to make it better, because they make everything better."

> "You don't have to worry about building rapport with the person 'cause you already have it. Sometimes rapport can take a month or a week, or any other amount of time. You can just skip all that. This answers the question about making the program better. It makes it easier skipping all that, getting more people from the community helps. Grabbing people from the community makes it better."

Program Take-Aways and the Future: Overall, the participants were very sad to know the program was ending and wished more people could have gotten involved when they had the chance. The young adults at one site all committed to sharing what they learned from the program with their peers and others in their lives. They mentioned that some of the best things they learned from the program were to never give up, when you fall you must always get back up, not to blame other people, how to be a parent, and how to stand on their own.

> "I am not going to stop just 'cause it ended. I mentor kids now. I take what I learn and run with it. Everything they teach me, I teach someone, and they can teach their friends."

> "I am coaching now; I want to make an impact on kids now like they did for me."

> "Everyone is different but we have similarities. They can learn from us and apply it to others. I know I can pass on to people the skills I learn, things that worked for me or others... It can help the community."

> "That's one of the best things to learn – I will never give up. Stop worrying about what people think or what could happen. I'll keep going and help others as much as I can."

Focus Groups with Young Adult Peer Groups

One focus group was conducted with young adult peer group participants (n=13) and two with young adult peer group facilitators (n=7) who had lived experience with mental illness. These participants were not necessarily CT Strong participants, but could have been. The peer group participants generally described having had many mental health problems since childhood, especially as related to trauma. Most had a history of mental health services and were currently still involved in these services. Referral sources for the peer groups included websites, community agencies, parents, friends, flyers, therapists or other mental health staff. The main needs of the participants were jobs, education, support while in school/college, independent housing, advocacy, knowledge of rights, and help getting in door to services.

Generally, the peer group format for the grant (through NAMI) started out with a more structured protocol but became less formal in response to participant preference and facilitator experience. They usually started the groups with a check-in with all members about their week. The facilitators utilized many creative activities, such as art projects, games, taking walks, journal writing, yoga, and meditation. While engaging in these activities, free-flowing conversation often followed. Participants described feeling less alone, feeling that the group was like a family and that they supported each other. The young adults attending the peer support groups found the experience to be very positive:

> "We do have deep conversations about what we're going through… And we'll give words of encouragement to everybody… It's a very nice environment and it's safe for a lot of people. So I like it a lot."
>
> "It's like we just poured our hearts out to everybody and we're family, and you're coming back to us next week."
>
> Many participants discussed making friends in the group. "Some of us hang out outside of group. I would say that a lot of people I'm pretty close with, I met in this group."

Barriers to Accessing Services: The young adults identified stigma as a barrier to receiving mental health services. They mentioned that the fear of stigma often prevented young people from getting help or talking about what is happening. They noticed that there was less stigma in younger generations and reported that their parents often did not understand mental illness.

> "For me, I consider my [mental illness] experience as one small chapter of my whole book."
>
> "It's just a diagnosis. It doesn't mean you are that person; you just live with it."

Experiences with Other Services: Participants described a range of experiences with mental health providers and different treatment modalities. All seemed to have had experiences with services they disliked and with ones they liked, including having found mental health professionals they both trusted and those they did not trust. Many expressed appreciation for receiving trauma-specific services. Generally, the young adults wanted their preferences to be

heard and solicited. They did not want assumptions to be made about them, and they did not want cookie-cutter recommendations used for their treatment (e.g. based solely on diagnosis). They did not want medication to be assumed to be the best course of treatment, although some found relief for their symptoms with medication. There was a strong preference for non-traditional and non-medical approaches such as yoga and meditation.

Recommendations: Participants recommended the following: There should be more young adult support groups and parent education/training across the state. Mental health providers should not judge youths' or young adults' capabilities based on their worst days.

> "It's definitely something I look forward to in the week… it's definitely something I'd rather have more often than just once a week."

Don't assume peer staff are always ready to disclose & delve into personal issues.

> "Whenever we are ready for treatment, providers should be sure to make that a safe place and considering all available options, including other avenues aside from taking medication."

Regarding schools/the education system, they wanted mental health education and training for all staff and all children, such as teaching emotional intelligence.

> "At school we can get all of the kids in one place, and this is something we have to take advantage of… And that is really such a great opportunity; I don't think that can be stressed enough. Because it's going to create a wave of difference, and that's really gonna have an effect."

Focus Groups with CT Strong Program Staff

CT Strong staff from all three program sites participated in two program staff focus groups, with ten staff in 2017 and seven staff in 2019. Feedback about the program was generally positive, with appreciation expressed for certain model aspects including flexibility, relationships, client-driven model, prevention and increased awareness. Staff also brought up concerns about services for young adults, data reporting, and lack of sustainability.

Positive Aspects of Program:

<u>Flexible and Client-Driven:</u> Staff spoke positively of the flexibility of the CT Strong Program, especially compared to more traditional programs. Their clients could express what they needed, what they hoped to get out of the program, and how they would like the program to function. Staff created individualized program plans based on client goals and ideas. This flexibility made CT Strong stand apart from the traditional wraparound model. Staff had the flexibility to meet with the youth, young adults and their parents at the school, home or in the

community. Staff were able to be involved in all aspects of the young adults lives, being there for them and standing up for them even if no one else would or was able to. Staff noted that other professionals, like counselors, therapists, and school-based health clinics would refer young adults to the staff at CT Strong because they were much less restricted in what they were able to do with them.

> "I think because of that flexibility we were able to engage more people in this age range."
>
> "There aren't a lot of programs where you have the luxury of being able to invite the participants into the program and say 'what do you need, what should this look like?'"
>
> "It seems like we can do everything. That's how I felt."
>
> "Not everybody needs therapy, and therapy looks different for this age group."

Staff were able to provide almost any services the young people identified as needing, from getting an apartment, transportation, how to do laundry, etc. Staff discussed how having the young adult as the client, rather than the family system or parents, shifted the narrative and put them in the driver's seat of their experience in the program. Program staff "met the clients where they are" by working first on what clients identify as their immediate needs and goals.

> "It's really client-driven, not the other way around. I think it's a philosophy but also a practice in the grant, and that's one of the most unique things about this grant."

<u>Trusting Relationships:</u> Because staff members had the flexibility of working on the goals the young adults identified, this led to the development of trusting and close relationships. This seemed to be one of the most valuable outcomes of the program, as staff discussed how it gave the young adults stability, predictability, hope, and a sense of empowerment. Building relationships and trust also allowed the CT Strong staff to teach the young adults how to advocate for themselves and learn accountability without fear of judgment.

The staff also formed relationships within the communities and schools, as evidenced by clinicians and school staff reaching out to them and referring their students to CT Strong. Program staff created positive rapport within the entire school community to the point that other students who were not part of CT Strong would recognize them in the hallways and sit with them during lunch periods.

> "They looked at us as 'we are people in your community that are supportive of you, care about you, and want you to be successful.'"

> "At times we're the only ones that believe in them at that time, we're the only ones that push them to do better. They might not be getting that from friends, family members, they're getting all that from us."
>
> "When you have a trusted adult that can come into your space and you learn to trust them, the opportunities are endless with them."
>
> "It's like having their own person that can advocate for them and teach them how to advocate for themselves. It helps create safe spaces."
>
> "You walk into the school of 1,300 kids; people don't know who you are. But when we walked in that building, they knew exactly who we were because of word of mouth. Because we're coming in, we're doing something positive. Not just for the young adults we're working with, but for the entire community. They all benefitted in ways they didn't realize."

Proactive Prevention Model: The program staff spoke positively of the CT Strong model being more prevention-focused. Staff stated how the CT Strong program was more proactive than reactive because it aimed to work through struggles young adults were currently facing, which could save money from reduced hospitalizations and DOC involvement down the line. Staff gave an example of a new prison that was built in the past year, and they discussed that working with youth now could lessen the need for prisons and emergency room services in the future. Staff thought the state should do more proactive work like this with the younger population.

Mental Health Awareness: Staff noted the importance of engaging young adults in discussions about mental health and how that positively impacted their communities and relationships. Creating safe spaces of discussion and recognition of mental health issues moved the youth from joking about mental health to talking openly about it without fear, shame or judgment.

> "I know that when we started with our kids in the schools, we would talk about mental health and they would make jokes and stuff. And I remember just yesterday we had a little get-together and there were kids who were just like 'yeah, sometimes my depression gets the best of me, my anxiety gets the best of me…' I think it's beneficial in them just recognizing that the issues they're having are not just 'oh I'm a teenager I'm dealing with this.' They're able to be in a space and talk about their mental health openly without feeling judged, or even going out into public and saying 'okay I have anxiety, I have depression' and not feeling bad or scared about it, or ashamed."

Program End and Sustainability:

Ending of Program: Overall, the staff members were frustrated and upset by the ending of the CT Strong program. They felt that taking away this program, and the services their clients were receiving, would be doing a disservice to the young people and their communities, as well as leaving people without supports. There were also concerns raised about the individuals who would not be able to benefit from these services in the future, despite the need for them not going away.

> "The way it has ended is almost overshadowing all of the great work that has happened. It's ending in a way where I feel like we're leaving people hanging."

> "There's a transition plan in terms of 'okay, you're going to be connected to Nurturing Families because you're pregnant.' So that is there, but that overall support, that relationship and the time it takes to build a relationship, it is just left."

> "If this program or something like this should ever come on somebody's desk, please take it. These young adults need this... And the service is no longer there."

The staff appreciated that CT Strong was inclusive for anyone who needed it. They discussed many concerns with other programs, such as high criteria for entry, separation of child and adult services, and an overall lack of services for this age group. Staff used DDS, YAS, Nurturing Families, and Care Coordination as examples of programs that have strict criteria for who is eligible to receive those services. Similarly, because DCF and DMHAS services are separated and the agencies may not always communicate with each other, they leave gaps in services for these young adults. The staff also discussed challenges for young adults with a history of trauma, learning issues or autism to get into these services.

> "So what happens in the community now? If you don't fit in these other existing siloes, you're basically back out there with nothing."

> "It's hard to now link services. We were the service."

> "The whole premise of this grant was to be able to connect to community resources and to give the young adults the tools to do that, and figure out as transition-aged youth and young adults, what is missing? And we identified what was missing. This was missing."

Data Reporting: The program staff spoke specifically about systemic issues with data collection and reporting for CT Strong and other programs, especially regarding using numbers to tell stories rather than words. One staff raised concerns that administrators and other government workers are only looking at numerical data rather than qualitative when assessing programs' strengths and weaknesses, and the outcome priorities may be incorrect (i.e. increasing high

school graduation rates as the goal to determine significant progress, rather than smaller steps and attitude changes along the way).

> "You're not listening to these kids' stories. There are so many different stories that folks didn't get to hear because it wasn't documented in numbers."

> "I want [the government] to know who these kids are. Spend time understanding their needs and what they've been through. They are worthy."

Lack of Sustainability: The staff discussed being frustrated by the lack of sustainability for the CT Strong program, as they believe their communities and individuals would benefit from continued efforts beyond the five-year grant. They also raised concerns about the allocation of funds on both state and national levels, with speculations on why the government would not continue to fund a program that was working so well from the ground level. Some staff noted that had state legislators become aware of the program or publicly supported it, it may have been allotted more continued funding. Staff also felt that there was little follow up from concerns expressed at the quarterly State Level Transition Team meetings.

> "What did the state do? None of the criteria have changed or expanded to include this population, and it was one of the main goals of the grant and it did not happen."

> "There was supposed to be a sustainability workgroup that never materialized. So what happened? If we had started the sustainability plan four years ago we might have been in a different place."

Ongoing Work: One CT Strong site had plans to continue doing some of the work that began through the grant, including drop-in center programming and clinical services offered at a technical high school. They would not be receiving funding through schools, but instead billing directly through insurance by utilizing a licensed clinician. All three sites worked to transition their youth and young adult clients into other community and school services at the end of the grant.

IV. DISCUSSION

SAMHSA's Now Is the Time -- Healthy Transitions funding provided the opportunity for Connecticut to implement the CT Strong program, which assisted transition-age individuals, 16-25 years old, at risk of or with behavioral health problems, in obtaining and maintaining services and supports. Gathered through varied evaluation methods, results suggested a highly significant impact of Healthy Transitions- CT Strong. The initiative seemed to successfully reach its target population, which can often fall through the cracks between the child and adult mental health systems. There were limitations to the completeness of the interview data, but the interview results were consistent with the qualitative data gathered from program staff and

participants. We were also able to include program data reported by the program staff on a much larger sample of the CT Strong population than just those that completed the interviews. The flexible program components, including flexibility in the length of the program and in the wraparound model, and strengthening the peer support model, seem to have been very effective, and to have contributed to success in connecting the youth and young adults to services and supports. Not having a comparison group was also a limitation of the study, but many improvements over time were observed for those who participated in the program. Positive outcomes for the CT Strong clients included: lower illegal drug use, increased educational level, increased employment status, improved housing satisfaction, a trend to improved housing status, improved quality of life and daily functioning, and a greater sense of social connectedness and empowerment.

This project shed light on how flexibility with the wraparound model is necessary to engage with the youth and young adult population. In CT Strong, the wraparound model was implemented in a way that best suited the needs and preferences of the clients. The program staff involved family members, schools, and other service providers in a less formal approach, and the clients appreciated the less clinical aspects of the program. It also provided information on the interaction between the child and adult mental health systems. Although the Connecticut mental health system has always been on the forefront of best practice, the last few years have led to a reduction in resources, both in terms of staffing and programming, due to state budget reductions. Although there are many ways in which DMHAS and DCF work together, there is still a separation between the adult and child mental health system, which is still a problem which greatly affects the transition-age population.

Both the program staff and the young adults noted what seems to be a lack of availability of non-clinical services outside of CT Strong. Clinical services often didn't provide services they felt were most needed, such as help with jobs, housing, and peer and family relationships. The participants repeated many times that, through this program, their lives were improved in many areas. It helped them with housing, parenting skills, jobs, better relationships, completing high school, and continuing their education. The participants were able to pursue self-actualizing activities such as reconnecting with families and communities, working, hobbies, advocating for others, creating art, and more. The main concern of all involved was, with CT Strong funding ending and state budget difficulties continuing, whether there would be enough other supportive services to continue these improvements. One of the main focuses and strengths of the CT Strong project was being able to serve people who were at risk of serious behavioral health issues, providing the opportunity to prevent more serious problems from developing. Most other existing services in both the adult and child systems are limited to those who are already diagnosed with serious disorders, due to limited resources.

Despite the fact that the CT Strong program will not be sustained as such, there are many aspects of the program at local and state levels that were initiated under the grant that will continue. Additional peer support groups have been set up across the state, and NAMI will continue to train and support facilitators. A young adult coordinator position was established at DMHAS' Young Adult Services Unit. DCF will continue to fund several youth-oriented drop-in

centers. The website partially funded by the grant continues to provide information and a way to connect for young people with behavioral health concerns. CT Strong helped establish a clinician at a school based health clinic, who will continue to provide services to students. The local agencies were able to retain some of the CT Strong program staff in different roles and programs, and the program staff also discussed their continued commitment to serve youth and young adults as coaches for local youth sports teams and through other roles in their communities.

V. RECOMMENDATIONS

In a time of limited resources, the dedicated people at DMHAS and its collaborating agencies must come up with creative ideas to help both their clients and their staff to serve them. Existing resources should be leveraged by coordination across program sites within DMHAS, and also across agencies and systems. For instance, further strengthening of the coordination between the adult and child mental health systems and the education system holds promise for better service provision and reducing the likelihood of people in need falling through the cracks between systems.

Based on feedback from the focus groups and the process evaluation, one recommendation is for greater peer involvement. DMHAS has already been utilizing peers to a great extent and is pushing for more. Although there are challenges with this, this seems to be the best way to engage these populations. They would like to see many more young-adult peer groups to be available across the state. As eloquently expressed in the young adult focus groups, there is a need for further training and awareness of mental health issues in many settings. They recommended that emotional coping strategies be taught to all school children and for all parents to be educated about mental illness and mental health. If these types of trainings could be broadly instituted, it's likely that many community improvements would follow. The young adults would also like mental health professionals to see them holistically rather than just as their diagnoses, and to review all treatment options with them rather than automatically offering medication.

Both clinicians and young adults involved in the project strongly recommended having non-clinical alternatives to help young adults in CT. The need for more drop-in centers was expressed multiple times, where young adults can engage in various activities and get some basic supports, including just a safe place to hang out. Feedback from the staff and clients indicates that young adults tend not to respond well to a direct approach of offering mental health services, but are more likely to engage if they can get involved in other less threatening activities that are valuable to them, like housing support, job help, fun peer activities, etc. The young adults liked that the CT Strong program staff were well-known people in their community, and this familiarity made it easier to get involved.

In terms of research, it is recommended that the young adult population be further explored, especially as it relates to mental health, complementary approaches, and peer involvement. In terms of regular data collected and reported by various state and other agencies, oftentimes,

data on the age group of interest (16-25) is not available as such. Although some agencies do have age data, they don't tend to report on the young adult or transition-age clients as a separate group. Doing so would be an invaluable first step in further exploring the needs of this population.

Methods for increasing engagement in research of the youth and young adult population, especially males, also need to be examined. It is likely that if we could have offered greater monetary compensation, we may have received higher levels of participation in interviews, but this should be tested. It may also help to have peers do outreach and invite the clients to participate in the interviews. If given the opportunity to study this population again, we will explore the literature and try to use evidence-based strategies to increase research participation.

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Appendix A

Stigma Scale (Flanagan & Rodis, 2015)

These questions are about your thoughts about having emotional difficulties. Using this scale, please indicate the response that is closest to how you feel about the statements.

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	DK	RF
1. People with emotional difficulties make important contributions to society.	1	2	3	4	5	77	98
2. I don't socialize as much as I used to because my emotional difficulties might make me look or behave "weird."	1	2	3	4	5	77	98
3. Having emotional difficulties has ruined my life.	1	2	3	4	5	77	98
4. I stay away from social situations in order to protect my family or friends from embarrassment.	1	2	3	4	5	77	98
5. People without emotional difficulties could not possibly understand me.	1	2	3	4	5	77	98
6. People ignore me or take me less seriously just because I have emotional difficulties.	1	2	3	4	5	77	98
7. I can't contribute anything to society because I have emotional difficulties.	1	2	3	4	5	77	98
8. I can have a good, fulfilling life	1	2	3	4	5	77	98

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	DK	RF
despite my emotional difficulties.							
9. Others think that I can't achieve much in life because I have emotional difficulties.	1	2	3	4	5	77	98
10. I would feel okay about myself if I went to a counselor for help.	1	2	3	4	5	77	98
11. If I had emotional difficulties, I would seek help from a counselor.	1	2	3	4	5	77	98
12. Getting treatment can help with emotional difficulties.	1	2	3	4	5	77	98
13. People with emotional difficulties tend to be violent.	1	2	3	4	5	77	98
14. Treatment of emotional difficulties is as important as treatment of diabetes.	1	2	3	4	5	77	98
15. I often think about the fact that I am a person with emotional difficulties.	1	2	3	4	5	77	98

Hemingway Measure of Late Adolescent Connectedness (Karcher & Sass, 2010).

Please indicate the number that best describes how true that statement is for you or how much you agree with it.

How TRUE about you is each sentence?	Not at all	Not really	Sort of true	True	Very true	DK	RF	N/A
1. There's nobody I like spending time with around where I live.	1	2	3	4	5	77	98	88
2. I have friends I'm really close to and trust completely.	1	2	3	4	5	77	98	88
3. I am happy with the kind of person I am.	1	2	3	4	5	77	98	88
4. It is important that my parents trust me.	1	2	3	4	5	77	98	88
5. I feel close to my brother(s) and sister(s).	1	2	3	4	5	77	98	88
6. I can name 3 things others like about me.	1	2	3	4	5	77	98	88
7. My parents and I argue about things a lot.	1	2	3	4	5	77	98	88
8. I have special hobbies, skills, or talents.	1	2	3	4	5	77	98	88
9. I feel good about myself when I am at school.	1	2	3	4	5	77	98	88
10. I get very angry when people tease me or put me down.	1	2	3	4	5	77	98	88
11. Thinking about my future keeps me from getting into trouble.	1	2	3	4	5	77	98	88

[1]Karcher, M. J. & Sass, D. (2010). A multicultural assessment of adolescent connectedness: Testing measurement invariance across gender and ethnicity. *Journal of Counseling Psychology, 57*, 274-289.

Youth Empowerment Scale (Walker et al, 2010)

This section asks you about how you manage your emotions and mental health, how you manage services and supports, and how you help change or improve service systems. There are no right or wrong answers.

Please indicate how often you feel or do the following statements:	Always or almost always	Mostly	Sometimes	Rarely	Never or almost never	DK	RF	N/A
1. I work with providers to adjust my services or supports so they fit my needs.	1	2	3	4	5	77	98	88
2. I believe that services or supports can help me reach my goals.	1	2	3	4	5	77	98	88
3. When a service or support is not working for me, I take steps to get it changed.	1	2	3	4	5	77	98	88
4. I feel my life is under control.	1	2	3	4	5	77	98	88
5. I know how to take care of my mental and emotional health.	1	2	3	4	5	77	98	88
6. I feel I can take steps toward the future I want.	1	2	3	4	5	77	98	88
7. I make changes in my life so I can live successfully with my emotional or mental health challenges.	1	2	3	4	5	77	98	88
8. I focus on the good things in life, not just the problems.	1	2	3	4	5	77	98	88

[2]Walker, J. S. & Powers, L. E. (2007). Introduction to the Youth Self-Efficacy Scale/Mental Health and the Youth Participation in Planning Scale. Portland, OR: Research and Training Center on Family Support and Children s Mental Health, Portland State University.

CT STRONG SAMHSA Services Form

Client name: _____ ***Site:*** _____

CT STRONG Staff Member: _____ ***Date:*** _____

1. Is the client still receiving services from your program? ○Yes ○No

2. On what date did the client last receive services? |____|____| / |____|____|____|____|
MONTH YEAR

3. What is the client's discharge status?

○ Mutually agreed cessation of treatment
○ Withdrew from/refused treatment
○ Not discharged
○ Clinically referred out
○ No contact within 90 days of last encounter
○ Death
○ Other: _____

4. If applicable, on what date was the client discharged? |____|____| / |____|____|____|____|
○ Not applicable
MONTH YEAR

5. Have you had contact with the client within 90 days? ○Yes ○No

Services:	Did you/your agency provide the following service to the client:		Did you refer the client to another agency for:		Don't Know	Service Not Available
	Yes	No	Yes	No		
1. Screening	○	○	○	○	○	○
2. Assessment	○	○	○	○	○	○
3. Treatment Planning or Review/Plan of Care	○	○	○	○	○	○
4. Psychopharmacological Services	○	○	○	○	○	○
5. Co-Occurring Services	○	○	○	○	○	○
6. Case Management	○	○	○	○	○	○
7. Trauma-specific Services	○	○	○	○	○	○
8. Medical Care	○	○	○	○	○	○
9. Employment Services	○	○	○	○	○	○
10. Family Services/Advocate	○	○	○	○	○	○
11. Child Care	○	○	○	○	○	○
12. Transportation (bus pass, $ for D.L., transport, etc.)	○	○	○	○	○	○
13. Education Services	○	○	○	○	○	○
14. Housing Support	○	○	○	○	○	○
15. Social Recreational Activities	○	○	○	○	○	○

16. Consumer Operated Services	○	○	○	○	○	○
17. HIV Testing	○	○	○	○	○	○
18. Other: _____	○	○	○	○	○	○
19. Mental Health Services*	○	○	○	○	○	○

***If Mental Health Services were provided by your agency, please estimate how frequently these services were delivered**:*

# of times _____ per □Day □Week □Month □Year □UNKNOWN

CT STRONG -- Weekly Activity Log

Client Code _____ CT STRONG Staff Name _____ Week Ending:_____

Total time spent with and/or on behalf of client in week: _____ Hours _____ Minutes

Please use the boxes below to record all of the activities you performed this week on behalf of this client. Check all boxes that apply.

1. ☐ Completed intake, orientation, program introduction and/or screening.
2. ☐ Engaged in treatment planning and/or case conferencing.
3. ☐ Attempted to re-engage client in services.
4. Applied for (or followed-up on):
   - ☐ Housing subsidy
   - ☐ Medicaid or other insurance
   - ☐ SSI
   - ☐ SSDI
   - ☐ SNAP (food stamps)
   - ☐ Other benefits (specify): _____
5. Obtained (or applied or arranged for):
   - ☐ Identification (birth certificate, driver's license, etc.)
   - ☐ Bus passes or other travel vouchers
   - ☐ Food
   - ☐ Personal care items
   - ☐ Clothing
   - ☐ Other (specify): _____
6. Provided (or arranged for):
   - ☐ Emotional support or counseling
   - ☐ Transportation
   - ☐ Advocacy
   - ☐ Community activities
   - ☐ Crisis management
   - ☐ Legal support
   - ☐ Educational support
7. Obtained services (or applied or arranged for):
   - ☐ Medical, including dental
   - ☐ Mental health services
   - ☐ Substance abuse/recovery treatment
   - ☐ Co-occurring treatment
   - ☐ Other (specify): _____
8. Provided or organized (or attempted to do so):
   - ☐ Family psychoeducation
   - ☐ Natural supports for the Wraparound process
   - ☐ Connection to peer support
   - ☐ Connection to family advocate
   - ☐ Specialized classes to group of clients or family members
9. Provided habilitation services/taught transitional life skills:
   - ☐ Money management
   - ☐ Housekeeping
   - ☐ Shopping
   - ☐ Cooking
   - ☐ Vocational services
   - ☐ Parenting support
   - ☐ Other (specify): _____
10. Provided for family members
    - ☐ Applied for benefits (specify): _____
    - ☐ Obtained services (specify): _____
    - ☐ Parenting support
    - ☐ Emotional support or counseling

Other (specify): _____

_____