

OK-COSIG
Quarterly Evaluation Report

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Acknowledgement

With the end of the second quarter of the third year of the OK-COSIG project, it is with appreciation and great pleasure that I can report that the cooperation from the OK-COSIG staff that started from day one continues to be excellent. The interactions and correspondence between the Evaluations team members and the OK-COSIG staff is very frequent and time consuming for all. This level of cooperation, however, is needed to collect data that we can use to tell the story of the OK-COSIG project and document the outcome of these integrative system components, based on what was done, and how it was done.

Additionally, the OK-COSIG project evaluation has benefited and is made possible because of the cooperation and support of Department staff and administrators at all levels. The accomplishments of this third year will be a gauge of how well we continue to work together, gathering documents, making observations and doing the initial assessments. This is the work of making integrated services for people with a co-occurring disorder a reality in Oklahoma.

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How this quarterly evaluation report is organized

This is the 2nd Quarterly report for the third year of the OK-COSIG project. This report differs from previous quarterly reports in that the executive summary has been replaced with the Co-Occurring State Incentive Grants Quarterly Progress Report: SAMHSA Format. The remainder of this Quarterly Report will be similar to past reports. It will continue to chronicle interviews, documents, and meeting notes. The SAMHSA Quarterly Progress Report will summarize these data.

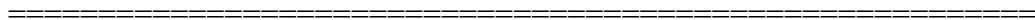
Following the SAMHSA Quarterly Progress Report, a brief overview of the work accomplished by the OK-COSIG staff and the OK-COSIG evaluation team in the last three months (January 1, 2007 through March 31, 2007). This will be followed by a list of the implementation activities that were carried out during the 2nd quarter of this third year. Next, a summary of the work completed by the ISI Advisory Group sub-committees will be described. An overview of the evaluation project will follow. Then

the goals and objectives by timeline will be described in terms of their status and the resources that are being employed to meet the objectives. Finally, additional emerging themes that were identified in the first quarter of this third year will be described.

Editorial note: The Quarterly Reports produced during the third year of this project will be data for the year-end reports. The year-end reports will be the data used for the five year report. These reports will also form the basis for the final report on the Process Evaluation. To maintain the highest level of accuracy, corrections will be made on quarterly reports as errors are identified or clarifications are needed. These changes will be issued as new pages that will replace the pages with errors. The new pages will retain the old text, but the old text will appear with a ~~striketrough~~ to indicate that it was changed. The new added text will be underlined. All revision dates will appear at the bottom of the page.

Disclaimer:

This project is supported by funding awarded by the ODMHSAS and SAMHSA. Points of view in this document are those of the author and do not necessarily represent the official position or policies of ODMHSAS.



**Co-Occurring State Incentive Grants Quarterly Progress Report:
Formatted to comply with SAMHSA 2007 Reporting Requirements**

January 1, 2007 through March 31, 2007

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**Year: 2007,
Title of Grant:**

**Quarter 2nd
Oklahoma State Incentive Grant
for Treatment of Persons with Co-
occurring Substance Related
Disorders**

**Grant Number:
State:**

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OKLAHOMA**

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I. Project Implementation

This is the Second Quarterly Report for year three of the Oklahoma-Co-occurring State Incentive Grant. This report is in the *Quarterly Progress Report Format* required in 2007 by SAMHSA. The interviews, documents, and meeting notes on which this SAMHSA report is based can be found in the *OK-COSIG Quarterly Evaluation Report, Volume 3, Number 2* at http://faculty-staff.ou.edu/C/Andrew.L.Cherry-1.Jr/okcosig_project.htm.

The OK-COSIG project has two interrelated and overarching goals.

Goal 1. Develop, implement and evaluate a standard protocol for the screening and assessment of mental health and substance abuse treatment service recipients in all State funded programs.

Goal 2. Develop, implement and evaluate an integrated treatment model for persons with co-occurring disorders that is accessible, culturally competent, and grounded in evidence-based practices.

These Goals with their objectives, activities and timelines were designed to develop within Oklahoma's mental health and substance abuse treatment communities with the capacity to identify and treat people who present with the co-occurring disorders of mental health, trauma, and substance abuse. The need to develop the capacity and expertise nationwide to identify and treat people with co-occurring problems resulted from years of neglect by both fields (MH/SA) and the Federal and State agencies responsible for providing treatment programming.

The consequence of dichotomizing these human conditions into either a mental health or an addiction problem was responsible for the high rate of treatment failure among those that did not fit into the dichotomy. Although the stories and examples of "self-medication" were told throughout the mental health field as either "urban legend" or "practice wisdom" the concept that some people with a mental health disorder used and abused substances persisted. In a similar fashion, a practice axiom among some in the addiction treatment field went something like "If the person does not get it on the third try, there is more going on than addiction." Yet, there were only two treatment options, mental health or substance abuse. The treatment landscape did not begin to change for people with co-occurring disorders until the late 1990s.

In 2002, Substance Abuse and Mental Health Services Administration (SAMHSA) released a landmark report to Congress on the Prevention and Treatment of Co-occurring Substance Abuse Disorders and Mental Disorders. This signaled a paradigm shift in the thinking about the treatment being provided to people with the co-occurring disorders of mental health and substance abuse. The report and the subsequent money appropriated by Congress set the stage for SAMHSA to provide funding, leadership, and support for state efforts to improve their service infrastructure, and their capacity to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based treatment services to persons with the co-occurring disorders of mental health and substance abuse.

Kuhn, (1962) in his seminal book, *The Structure of Scientific Revolutions* called a "paradigm shift." a phenomenon in science where there is a major change in basic assumptions. The shift in the assumptions in the field of mental health and addictionology caused by the need to explain and treat people with the co-occurring

disorders of mental health and addiction is an example of the “paradigm shift” phenomenon. These shifts have had a profound impact on other sciences. We should prepare for nothing less as the science of understanding and treating people with co-occurring disorders comes into conflict with hallowed assumptions held dear in the fields of mental health and addiction treatment.

This shift in the basic therapeutic assumptions about the best treatment approach for people with a co-occurring disorder is taking place because of studies that highlight the failure of *sequential* and *parallel treatment* to produce positive outcomes (i.e., treatment by mental health clinicians followed by or in tandem with treatment by substance abuse clinicians) (Clement, Williams, & Waters, 1993). This movement is being guided by a focus on *best practices* and varied experiences in the field ((Drake & Mueser, 1996; Hoge & Morris, 2004; Minkoff, 1991; Rosenberg & Rosenberg, 2006).

This duality was reflected in the modalities used to treat co-occurring disorders in Oklahoma before 2003. In 2002 the OK-COSIG proposal was submitted but not funded. Nevertheless, the Department began exploring and implementing plans to develop services for people with a co-occurring disorder. One outcome from this effort was a program to treat people with a co-occurring disorder at the Tulsa Community Behavioral Health Center.

In 2004 the OK-COSIG proposal was funded and this accelerated ODMHSAS efforts. The funding was used to hire personnel to focus exclusively on developing programming capacity for treating people with the co-occurring disorders of mental health, trauma, and substance abuse.

The roadmap to organizational change for any given institution is as allusive as the “holy grail.” Nevertheless that was one of SAMHSA’s plans when devising the COSIG funding mechanism. In Oklahoma, if one looks at the treatment available for a person with a co-occurring disorder before 2003 and one looks at the treatment available for a person with a co-occurring disorder in 2007 the plan is succeeding in Oklahoma.

Before 2003 there were no programs in Oklahoma designed for people with a co-occurring disorder. There were few if any plans in the treatment community to develop co-occurring services. The knowledge level of clinical staff related to co-occurring disorders was more esoteric than practical. Moreover, there were structural barriers in the form of state policy at the contractual and funding levels that gravitated against the development of programming to integrate both mental health and substance abuse treatment. On the positive side, most practitioners in Oklahoma were ready for this change. Like practitioners around the country, they had collectively come to a similar conclusion, *sequential* and *parallel treatment* for people with a co-occurring disorder was ineffective. Practitioners did not need a great deal of convincing; they wanted training and information to enhance their practice with people who presented with the co-occurring disorders of mental health, trauma, and substance abuse.

In 2007, the structural barriers are methodically being removed. State policies and contracts are continuing to be modified to include language promoting capacity building and integrated approaches for treating people with a co-occurring disorder. Local program administrators, clinicians, and staff working in the fields of mental health and substance abuse treatment in communities across Oklahoma are acutely aware of the implications for failing to treat co-occurring disorders. Network building is being used to develop the infrastructure for service coordination. Workforce and clinical competence

development issues are being addressed. Over the last three years, a large cadre of administrators and staff have attended Core-Level training on engagement and integrated treatment for people with a co-occurring disorder. Retooling by the clinical staff across the state using the resources made available by the OK-COSIG project is well underway. The number of model programs involved in capacity building over the last two years six months has increased from 7 to 28.

The work of the individual staff members of the OK-COSIG project cover the Macro, Mezzo, and Micro levels of the organizational structure. Todd Crawford, Co-occurring Clinical Director works a great deal at the Macro level. In addition to his other responsibilities he attends the ODMHSAS Central Administration Team meetings and Transformation meetings representing the OK-COSIG initiative. L. D. Barney, Co-Occurring Program Specialist focuses on the Mezzo level. He concentrates on developing and maintaining the local consensus for the increase of integrated, quality co-occurring services using an inclusion process that promotes committees made of up of mental health and substance abuse administrators and staff, consumers, and advocates from local communities to identify and give direction to policy development. The approach used is task-focused, structured, and involves interaction in small groups as part of the change process. Dr. Khepra Khem, Co-Occurring Training Specialist, is more focused on the Micro level. For the most part, he has concentrated on developing a Core-Level training and the methods for delivering that training. In year three he and his committees will produce and begin an Intermediate Level of training for clinicians who will be working with people who have co-occurring disorders related to mental health, trauma, and substance abuse.

In the second quarter of this third year, the OK-COSIG project has met many of the objectives laid out in 2004 toward accomplishing the two Goals of the initiative. The work toward developing statewide capability to identify, refer and/or treat people with a co-occurring disorder continues at an accelerated pace. The integration of treatment for people with a co-occurring disorder into the fabric of behavioral health across departments is evolving. Changes in State law and contracting procedures support this capacity building effort. And, in areas where additional work is needed to accomplish the Goals of the initiative (additional inclusions of consumers and advocates, Native Americans, African Americans, and Hispanics; credentialing; and advanced training) efforts are underway and new stratagems are being undertaken.

a. Description of project changes or modifications [since reapplication] in:

(1) Goals and Objectives

Goal 1. Develop, implement and evaluate a standard protocol for the screening and assessment of mental health and substance abuse treatment service recipients in all State funded programs.

Objective 1.1 – Develop consensus among providers, service recipients, consumer advocates and other interested parties on a standard screening and assessment protocol for use in mental health and substance abuse treatment settings.

A great deal of work has been done along the way to accomplishing Goal 1, Objective 1. The work yet to be completed, on developing a standard screening and assessment protocol for use in mental health and substance abuse treatment settings in Oklahoma, continues and is making progress at both the MACRO, MEZZO, and MICRO levels. At the state department level, committees are resolving issues about the differences related to the screening protocol that ODMHSAS will adopt and the screening process that the State Health Care Authority is going to adopt. At the MEZZO levels,

consensus building continues. The Screening and Assessment committee has been instrumental in this consensus building effort, in screening instrument development, in the identification of assessment tools, in screening and assessment protocol development, in the “welcoming” and “no wrong door” policy, and at the MICRO level giving clinicians a voice in the process. One strategy developed last year that has shown good results is holding the Screening and Assessment committee meetings at different agencies around the state where agency staff, clinicians, and service recipients participate.

Objective 1.2 – Train all mental health and substance abuse treatment providers in the screening and assessment protocol.

The second Objective of Goal 1 is being accomplished using a training module on Screening and Assessment in the Core-Training Curricula developed over the last two years by the Training-Workforce Development Subcommittee, and its work groups: the Curricula Development Workgroup, the Data Reporting Committee, and the On-Line Course Workgroup. All of the model programs have been provided Core-Level training. Over the last quarter and in the next quarter, or two Core-Level trainings will be provided to the 13 programs added to the cadre of 15 model COSIG programs.

Goal 2. Develop, implement and evaluate an integrated treatment model for persons with co-occurring disorders that is accessible, culturally competent, and grounded in evidence-based practices.

Objective 2.1 - Develop consensus among providers, service recipients, consumer advocates and other interested parties on the elements of an integrated treatment model for persons with co-occurring disorders.

The greatest portion of the work on Objective 2.1 has been accomplished. The implementation ideas, philosophies, and presentations by consultants Dr. Kenneth Minkoff and Dr. Christy Cline of ZiaLogic, Dr. Walter Kristhardt, Dr. David Mee-Lee and the technical assistance provided by COCE transformed the organizational change process from being a state mandated change to being a clinical change driven by evidence-based practice. Currently, most of the remaining work is in the rural and frontier communities.

Objective 2.2 - Establish joint licensure/certification and funding processes for both mental health and substance abuse staff.

This Objective has received a great deal of attention over the last two quarters. Several of the licensure Boards meet to hear about the need for credentialing co-occurring competence within the law that governs their Board. The plan is to encourage and help the licensure boards focus on language changes and developing a strategic plan around credentialing co-occurring competence. The OK-COSIG staff are working with the Board of Licensed Professional Counselor, the Board of Licensed Alcohol and Drug Counselors, the Board that licenses Psychologist, the Social Work Licensure Board, and the Board that licenses Behavioral Health parishesioners.

Objective 2.3 – Develop contracting procedures that create strategic incentives for the implementation of integrated treatment systems at the provider level.

Over the last year a great deal of time and energy has gone into accomplishing this Objective. The ODHMSAS State rules governing mental health treatment (Chapter 17) and substance abuse treatment (Chapter 18) include changes that relate to treatment for co-occurring disorders.

Objective 2.4 – Train all mental health and substance abuse treatment providers in the use of a comprehensive, integrated system of care model for persons with co-occurring disorders.

Much of the work has been completed on this Objective. The Core-Level training presents the rationale and science behind integrated treatment for people with a co-occurring disorder and the components for a welcoming and recovery oriented environment. Eight Core-Level trainings were provided in the second quarter. All of the 15 model programs have been provided Core-Level training. Over the last quarter and in the next quarter, or two Core-Level trainings will be provided to the 13 programs added to the cadre of 15 model OK-COSIG programs.

(2) Project timeline for project implementation

Over the last 30 months of the OK-COSIG project most of the objectives and activities met their targeted timelines and have been completed. These activities are chronicled in the quarterly reports produced over the last two years. They are available online at http://faculty-staff.ou.edu/C/Andrew.L.Cherry-1.Jr/okcosig_project.htm. The exception is *Objective 2.2 “credentialing.”* This objective is being addressed. The reason this objective was not accomplished in the first six months is that the timeline was unrealistic. There were too many components, such as consensus among the shareholders about the competencies needed to treat people with a co-occurring disorder that had to be developed first. Currently, the structure and components needed to support a call for credentialing are in place or are nearly in place. The work on this objective has begun.

The work to train 80% of staff at all State funded mental health and substance abuse treatment facilities in the screening and assessment protocol within 60 months is ongoing.

The work of the ISI Advisory Group and its subcommittees to help develop, implement and evaluate an integrated treatment model that conforms to evidenced-based practice for people with co-occurring disorder is ongoing.

(3) Approach and strategies proposed

In this second quarter of the third year the broad focus of the OK-COSIG staff is on: 1) incorporating and sustaining the provision of co-occurring programming at the State policy level during the transformation process, 2) continuing to provide statewide training of clinicians and staff, 3) credentialing standards for clinicians who treat people with a co-occurring disorder, and 4) increasing the participation among consumers and Native American groups in the COSIG initiative.

b. Status of Project

(1) Description of activities during this quarter regarding:

- screening and assessment,

Screening and Assessment reports involved the availability of recommended instruments or tools, which became available during the quarter (see Appendix C). The OK-COSIG Screen will also be included. The major work revolved around the completion of the Welcoming, Screening, Assessment, and Recovery Planning Practice Guidelines. This process took longer than anticipated, but was commendable given its achieved goal of consumer input at every step of development. Each individual agency from this point has the flexibility of incorporating their own agency, certifying body, or funding source into these guidelines.

- workforce development/licensure and credentialing,

Training was a continued focus. Comments from the completed core level trainings indicated that some who attended felt lost and not connection to the consumer. A possible reason offered was that the Core Level training involves all staff from the agencies versus just clinicians. The role of the trainer in facilitating the trainees' sense of connection despite their agency role will be emphasized.

- services integration,

A major rewrite of the Project's Consensus Document was completed and two policy approvals describe the achievements for the Advisory Group's second quarter this year. The Welcoming, Screening, Assessment, and Recovery Planning Practice Guidelines were approved (See Appendix B). The advisory group provided guidance to the Training and Workforce Development Subcommittee's Curriculum Workgroup regarding the development of its Intermediate and Advanced curriculum. Leadership approved the Intermediate curriculum at the end of the quarter. Technical assistance was sought to find better ways to involve the American Indian Tribes in providing co-occurring services. These events represent significant accomplishments that will continue through 2007.

- systems integration,

A scheduled meeting for March 14th was rescheduled to take place at the beginning of the next quarter, April 11, 2007. Although the subcommittee did not meet this quarter, the work of identifying a fidelity scale that would function as an agency administered audit is the main focus of committee members. The Central Office could then utilize the same fidelity scale to complete an independent audit that would be compared to the agency generated score. The IDDT and the DDCAT were deemed as not practical for the Oklahoma system when COCE questioned the subcommittee member's desire to find or develop a new fidelity scale. This topic will continue to drive the work of the committee in the following quarters.

- financing,

Members of the Finance Subcommittee met once during this quarter on February 7, 2007. Five people attended. The goals of the committee are: 1) Identify how co-occurring services are currently provided and funded, and 2) Identify how co-occurring services should be provided and funded in the future. The major accomplishment over the last quarter was the production of a combined ODMHSAS contract for mental health and substance abuse services. Barriers to work related to the ability to obligate monies for co-occurring services when new funds are not available. Future work will focus upon the review of examples of integrated contracts from Georgia, Ohio, and Value Options for financing services for co-occurring services that may have relevance to Oklahoma.

- management information and data systems,

The development of a plan to collect the data required under the Government Performance and Results Act (GPRA) was a major focus. The co-occurring data that needs to be collected for the COSIG initiative and how it will be derived from the existing ODMHSAS client data core thru the ICIS system was also worked out.

- evaluation,

The OK-Online Screen data was analyzed and a report generated on the analysis. A brief report on the Screen analysis (See Appendix A) and the brief report on preliminary analysis of the ICIS FY 2005 data found in the Year two Year-End Report

were prepared and distributed at the Annual COSIG Grantee meeting held in Baltimore, Maryland in March.

- program pilot studies,

A draft format that will be used for the individual model program reports based on the fidelity data and ICIS data is being developed. A draft will be distributed for comment and suggestions in the third quarter.

- project-specific goals and objectives.

Work continued on the policy related to the transition/discharge practice guidelines. Sustaining consumer involvement remained a challenge this quarter. This difficulty along with the struggles in attaining the involvement of several stakeholder groups needed to be over before the OK-COSIG can “walk out” the project to all providers of mental health and substance abuse services. The strategy to overcoming both these barriers is identifying and tapping the stakeholder networks of the people working within the initiative. These accomplishments, identified barriers, and strategies will support the future goals for the next quarter, year, and after the formal initiative which is to create a co-occurring capable service system in Oklahoma.

(2) Accomplishments

Over the last two quarters the major accomplishments have been adding 13 new programs to the 15 pilot programs that are developing as co-occurring capable. Key elements of infrastructure development are also addressed, including credentialing, and services coordination.

At this point OK-COSIG staff feel that they are ready to provide the training and technical assistance to all program staff who asks for training or programs operated by the State. They feel confident that by the end of the Grant period that every mental health and substance abuse program in Oklahoma will become co-occurring capable.

(3) Other significant project activities

The OK-Online Screen data was analyzed and a report generated in the second quarter. One of the major barriers has been the cost involved in identifying people with a co-occurring disorder. This process has typically required two assessments. One assessment focused on mental health disorders. The second focused on substance abuse disorders. To eliminate part of this burden, a rapid psychometric screen was developed, the Oklahoma Co-Occurring Disorders Online Screen (the OK-COD Online Screen). This screen was intended to help determine if the person requesting help needed a professional assessment for a mental health or a substance abuse problem. The OK-COD Online screen was developed and tested as a part of the OK-COSIG initiative between June and December of 2006. This computer version of the screen was administered to 3,608 people who called or went to one of nine participating mental health and substance abuse treatment facilities. The results of the Principal Component Analysis (PCA) factorial analytic procedure suggested that the number of items in the three scales could not be reduced. The factor solution also accounted for 57.25% of the variance among those being screened. The Cronbach Alpha coefficients were used as a statistical measure of the internal consistency of each of the three subscales. The Cronbach Alpha for the Mental Health screen was .74. The Cronbach Alpha for the Substance Abuse Screen was .89. The Cronbach Alpha for the Trauma Screen was .60.

Additionally, a draft format that will be used for the program reports based on the fidelity and ICIS data is being developed. A draft will be distributed for comment and suggestions in the third quarter.

A major focus and effort was around the collecting of the data required under the Government Performance and Results Act (GPRA). Meetings to plan the implementation of the data gathering process have been productive. The co-occurring data that needs to be collected for the COSIG initiative come from the existing ODMHSAS client data core thru the ICIS system.

The Change Agent Regional Committees have been organized and offer a great deal of promise for promoting integrated services for people with a co-occurring disorder and for sustaining the services developed.

c. Difficulties/Problems Encountered

(1) Barriers to accomplishment

Because of a number of contract problems, efforts are still underway to identify ways to involve the Native American Tribes. There is interest among the tribes and the Indian Health Organization. The Tribal health organizations provide a great deal of the behavioral health services in Oklahoma.

Consumer and Advocate involvement has been difficult because of the lack of transportation for consumers and the burden of time and effort experienced by consumers and advocates who have participated.

(2) Strategies to overcome barriers

Technical assistance from COCE has been helpful. Additional outreach efforts to engage the Tribes are underway. Meetings with Consumer Affairs will be used to identify other approaches to engage consumers and advocates in the development of an infrastructure to provide integrated services for people with a co-occurring disorder.

2. Personnel

- a. List all current positions supported by the grant, including any vacancies, with percent of time on the project.

- Todd Crawford – Co-Occurring Clinical Director and Project Manager
 - LD Barney – Co-Occurring Program Specialist
 - Dr. Khepra Khem – Co-Occurring Training Specialist
 - Renea Butler-King – Coordinator of Field Services
 - Amber Rentaria-Hulme – COD Field Representative
 - Suzan Esley – Co-Occurring Recovery Coordinator
 - Krista Rhodes – Decision Support Services (DSS) Data Analyst
 - Brenda Pitts – Administrative Assistant

- b. List staff changes, including contractors/consultants, within the reporting period.

No staff changes were made over the last quarter.

- c. Describe the impact of the personnel vacancies/changes on project progress and strategies for minimizing negative impact.

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Second Quarter of Year 3 — Overview

This is the 2nd Quarterly report of Year 3 on the OK-COSIG project to improve Treatment of persons with Co-Occurring Mental Health and Substance Abuse related disorders in Oklahoma. The overarching goal of the OK-COSIG project is to improve the delivery of state-funded services for people in Oklahoma with a co-occurring disorder. The project will contribute two interventions to promote systemic infrastructure change: 1) it will develop a standard protocol for screening and assessment of people with a mental health and substance abuse problem, and field test and evaluate a screen; 2) a model will be developed to provide integrated treatment that is accessible, culturally competent, and grounded in evidence-based practices. The following sections of the 2nd Quarterly Report of Year 3 will delineate the work toward accomplishing these two objectives.

Activities and Events

January 1, 2007 through March 31, 2007

This section lists the activities associated with the OK-COSIG project staff for the 2nd quarter of the third year. There was a major change in leadership at ODMHSAS. The Oklahoma State Board of Mental Health and Substance Abuse Services named Terri White commissioner of the Oklahoma Department of Mental Health and Substance Abuse Services.

The following is a week by week summary of the major activities of the OK-COSIG project staff from which data was collected and analyzed. The work behind the scenes, efforts involved in organizing and coordinating the events is not fully reflected here. This list does not constitute the entire body of the OK-COSIG project staff work and activities during the 2nd quarter of year three, but it is a good representation of the work that was accomplished.

teleconference meeting to help plan for the Annual COSIG Grantee meeting to be held in Baltimore, MD.

Dr. Khepra Khem Co-Occurring Training Specialist was involved in meetings with the Curricula Workgroup and the Training Workforce Development subcommittee.

January 15-19. Todd Crawford attended the initial meeting with all of the different licensing boards across the state to begin the discussion about developing a credentialing process for a scope of practice for co-occurring disorders.

L. D. Barney met with the Northwest Center for Behavioral Health in Woodward, OK. He facilitated the Advisory group meeting. He met with the new Director of a new model program to develop a new Executive committee for the Oklahoma City area. He met with several Executive Directors of new model programs to outline what is expected from them. He participated in another COSIG teleconference meeting to help plan for the Annual COSIG Grantee meeting to be held in Baltimore, MD.

January 22-26. The OK-COSIG staff attended the Substance Abuse Conference in Tulsa. Among the presentations, there was a major track on co-occurring disorders. Todd Crawford also met the psychiatrist in charge of the residential programs at Griffin about providing some technical assistance to their residents related co-occurring disorders.

January 29 - February 2. Todd Crawford presented information on co-occurring disorders to the Licensing Drug and Alcohol Board with the hope that they will create a credential for co-occurring disorders. He worked on the screening and assessment, formulating the screening protocol that the State is going to adopt and the more formal screening process that the State Health Care Authority is going to adopt. Todd and L. D. Barney worked with Dr. Kenneth Minkoff and Dr. Christy Cline of ZiaLogic that week providing technical assistance to new model programs. Dr. Kenneth Minkoff and Dr. Christy Cline provided technical assistance to programs in the OKC and Tulsa areas, and worked some with the adolescent programs.

Dr. Khepra Khem worked with the Curricula Workgroup putting the intermediate curriculum together.

February 5-9. Todd Crawford worked on the Recovery Community Support Program grant (RCSP) grant making sure that the grant integrates with the COSIG grant and the Transformation grant and other major initiatives. He continued to work with the Health Care Authority. He attended the Behavioral Health Development team meeting, which is the guiding committee for the partnership for children's behavioral health. He was also involved in a budget discussion for FY 08 and what is going to be necessary to provide programming for children, for systems of care, and other programs. He was also involved in the Robert Wood Johnson Star-SI (Strengthening Treatment Access and Retention-State Incentive) grantee meeting in Norman. The STAR-SI is a program to help agencies and programs improve their performance improvement processes, simplify and remove barriers to access and retention for persons seeking substance abuse services.

L. D. Barney worked on contracts, met with community mental health center directors, and participated in another COSIG teleconference meeting to help plan for the Annual COSIG Grantee meeting to be held in Baltimore, MD.

Dr. Khepra Khem met with the Curricula Workgroup and the work on the advanced curriculum was begun.

February 12-16. Todd Crawford attended another meeting with the licensing bodies around the co-occurring credential. The group at this meeting agreed on some language changes. The language changes broadened the Oklahoma Board of Licensed Alcohol and Drug Counselors (LADC) rules to serve folks with co-occurring disorders. The plan is to get the language drafted over the following weeks. He facilitated a meeting to develop a day long planning session for all of the programs involved to learn more about the TSIG grant. Dr. David Mee-Lee was in town for three days and Todd and L.D. worked with him on improving detox. On the 13th & 14th, L. D. Barney worked with Dr. Mee-Lee who did training for trainers on integrated ASAM training. On the 15th, L. D. provided technical assistance at Bill Willis Center in Tahlequah, OK. He also participated in

another COSIG teleconference meeting to help plan for the Annual COSIG Grantee meeting to be held in Baltimore, MD.

February 19-23. Todd Crawford facilitated a TSIG meeting related to the mental health transformation plans and goals. He worked with Workforce Development addressing needs for co-occurring disorder training and other kinds of educational needs. He also met with the representatives from Dept. of Corrections to discuss their desire to move towards providing integrated services for people with a co-occurring disorder and about including them the OK-COSIG trainings. He also was involved in a conference call with Advocates for Human Potential (AHP). They talked about finalizing the AHP report on the OK-COSIG project.

L. D. Barney attended a Screening and Assessment meeting on the 21st and attended a Department wide meeting to discuss how they could support the transformation grant. He participated in another COSIG teleconference meeting to help plan for the Annual COSIG Grantee meeting to be held in Baltimore, MD.

Dr. Khepra Khem continued to work with the Curricula Workgroup on the advanced curriculum. He also attended a Core-Level Training at the Red Rock treatment center.

February 26 – March 2. The OK-COSIG staff attended the ISI advisory committee meeting. Todd also attended the Change Agent subcommittee meeting, and he and L. D. attended the Screening and Assessment subcommittee meeting. The Screening and Assessment subcommittee finalized the screening process and began working on the assessment process the ODMHSAS and the Health Care Authority will use.

Dr. Khepra Khem attended a Core-Level training for TLC (Total Life Counseling) which is a new model site. Another Core-Level training was also conducted at Copes, which is a new model site.

March 5-9. Todd Crawford, L. D. Barney, David Wright, and Andrew Cherry attended the 3 day Annual COSIG Grantee meeting held in Baltimore, MD.

March 12-16. Todd Crawford met with ODMHSAS leadership to bring them up to speed on what will be required in terms of the data collection reporting for COSIG. He also met with leadership and decision support services to start the work of planning for data collection. Todd met with providers and talked to them about the data collection. He also attended another statewide screening and assessment meeting.

L. D. Barney met with staff from one of the licensing boards with regards to co-occurring certification and different licensures. Later, that week he attended a documentation committee meeting, involving a number of different agencies to talk about the screening and assessment. He also attended a meeting to plan for next year's substance abuse conference.

Dr. Khepra Khem met with the Curricula Workgroup to continue the work on the advanced curriculum. He also conducted a Core Level training for Central Oklahoma Community Mental Health and at the Carl Albert Community Mental Health Center in McAlester, OK. He also went to New York for a Motivational Interviewing training which was conducted by a company called Sciacca.

March 19-23. L. D. Barney went to Pryor, OK and met with the Northeastern Executive Council. They discussed the Fidelity scale that is being reviewed. He attended a screening and assessment committee meeting in Lawton, OK. He also was involved in a COCE conference call.

March 26-30. Todd Crawford finalized the data reporting and collection plan, which will be sent off this spring with a timeline of what will be collected for SAMSA. He also worked with the ODMHSAS legal department on drafting the language for the LADC statutes. The staff is also working with the Board of Licensed Professional Counselor, the Board that licenses Psychologist, the Social Work Licensure Board, and the Board that licenses Behavioral Health parishioners. He attended an initial meeting exploring recovery and peer support services in the state. The group will explore the kind of services provided, who's going to provide the services, and what kind of credentialing is

needed. He also attended Workforce Development meeting. He has also begun working with the Infectious Disease Institute at the OU Health Science Center in OKC. The effort will be to share training curricula. They would provide training on working with people who are HIV positive and with people who have other infectious diseases. The Infectious Disease Institute is already integrated with MH and SA services, as well as prevention, early intervention, and treatment. A contract is being developed for next year. He also presented on the screening tool at the clergy conference called Caring for Your Congregation in Tulsa sponsored by the Mental Health Association.

L. D. Barney worked on the ASAM, Training for Trainer, conference certification. He attended a Recovery Management Conference in Chicago conducted by the ATTC. The focus of the conference was on recovery management and how recovery is viewed. He also attended a conference on Veterans and how ODMHSAS is going to handle the influx of veterans from the Iraqi and Afghanistan wars.

Dr. Khepra Khem conducted a Core-Level training in Ada, for the mental health and substance abuse centers of southern OK and did a presentation for the Tri City substance abuse centers and mental health drug court.

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Summary of the work of the ISI Advisory Group and Subcommittees

The Advisory Group met two times during this quarter. Updates came from the Finance, Outcomes and Evaluations, Systems Integration, Training and Workforce, Performance Improvement, and Screening and Assessment subcommittees. A summary of the work completed by the ISI Advisory Group subcommittees during the 1st quarter of year three is presented in this section.

There are five ISI Advisory Group subcommittees:

1. The Training-Workforce Development Subcommittee,
 - Curricula Development Workgroup
 - Data Reporting Workgroup
 - On-Line Course Workgroup
2. The Screening and Assessment Subcommittee,

3. The Outcome and Evaluation Subcommittee,
4. The Financial Subcommittee,
5. The Systems Integration Subcommittee, and
6. The Regional Change Agent committees

Advisory Group

The Advisory Group met two times during this quarter. Updates came from the Finance, Outcomes and Evaluations, Systems Integration, Training and Workforce, Performance Improvement, and Screening and Assessment subcommittees.

The major work reported to the Advisory Group regarding Finance was in relation to the examples of integrated contracts from Georgia, Ohio, and Value Options. The need to get a group together to read the lengthy contracts and pull the Oklahoma relevant elements is in discussion. Data collection occupied the agenda of the Outcomes and Evaluation Subcommittee as it discussed the outside evaluation, screening, and the ability of the existing data system to accurately capture co-occurring clients. The Data Reporting Workgroup (Training and Workforce Development Subcommittee) also focused on data and its inclusion in the intermediate level curriculum training.

Training was a continued focus of the meeting with comments from the completed core level trainings shared by one of the change agents present. Some trainee comments of feeling lost and not feeling a connection to the consumer were shared by the meeting member. A possible reason was offered for those comments given that the core training involves all levels of staff from the agencies versus just clinicians. The role of the trainer in facilitating the trainees' sense of connection despite their agency role was emphasized.

Professional policy additions were another important topic of the quarter. Charter changes to allow a co-occurring certification is on the legislative agenda of the LADC. Similar changes in the charters of the other licensure board to allow credentialing for clinicians trained to treat people with a co-occurring disorder without requiring dual certification or licensure is also on the agenda.

Screening and Assessment reports involved the availability of recommended instruments or tools, which became available during the quarter (see Appendix C). The

OK-COSIG Screen will also be included. The major work revolved around the completion of the Welcoming, Screening, Assessment, and Recovery Planning Practice Guidelines. This process took longer than anticipated, but was commendable given its achieved goal of consumer input at every step of development. Each individual agency from this point has the flexibility of incorporating their own agency, certifying body, or funding source into these guidelines.

A major rewrite of the Project's Consensus Document was completed and two policy approvals describe the achievements for the Advisory Group's second quarter this year. The Welcoming, Screening, Assessment, and Recovery Planning Practice Guidelines were approved (See Appendix B). The advisory group provided guidance to the Training and Workforce Development Subcommittee's Curriculum Workgroup regarding the development of its Intermediate and Advanced curriculum. Leadership approved the Intermediate curriculum at the end of the quarter. Technical assistance was sought to find better ways to involve the American Indian Tribes in providing co-occurring services. These events represent significant accomplishments that will continue through 2007.

Work continued on the policy related to the transition/discharge practice guidelines. Sustaining consumer involvement remained a challenge this quarter. This difficulty along with the struggles in attaining the involvement of several stakeholder groups needed to be over before the OK-COSIG can "walk out" the project to all providers of mental health and substance abuse services. The strategy to overcoming both these barriers is identifying and tapping the stakeholder networks of the people working within the initiative. These accomplishments, identified barriers, and strategies will support the future goals for the next quarter, year, and after the formal initiative which is to create a co-occurring capable service system in Oklahoma.

Training and Workforce Development Subcommittee Work Summary

The completion of the intermediate level training was the major work finished during this quarter. It was approved by the leadership committee. This accomplishment represents the hard labor of the Curriculum Development Workgroup under the direction of Cindy Schultz with integration of content from the Data Reporting Workgroup. Both

of these smaller groups were created under the larger Training and Workforce Development Subcommittee last year. In particular the chair noted the strong leadership of Cindy Schultz in curriculum development was instrumental because of the difficulty of maintaining full committee participation from members that have multiple commitments. A strategy utilized to deal with the participation problem was to utilize email communication as much as possible and firm decision making. Now the workgroup will turn their attention to the advanced level training, begin to train the model sites in this curriculum, and evaluate those trainings.

The completion and approval of the intermediate training curriculum was the major accomplishment noted by Cindy Schultz, the leader of the workgroup. The work required for the development of the advanced training has begun and will be the focus on the next quarter. A continued issue that has carried over from the previous quarter is the need to develop web based learning for ongoing training. Difficulties include the majority of the actual work of information gathering for curriculum content falling on a few members and the coordination and completion of meeting minutes in time for the next meetings. This affects not only the individual practitioner, but the productivity of the entire agency. In order to avoid the over working of a few members in the next level of curriculum development, large subcommittee meetings will be held that are open to anyone that has ever attended a subcommittee meeting, smaller workgroups will be developed to address the task.

Toward the end of the last year the Training and Workforce Development Subcommittee developed the Curriculum Development Workgroup and the Data Reporting Workgroup. The purpose of these workgroups was to facilitate the completion of intermediate and advanced training and infuse that training with knowledge of the importance of accurate data reporting and the skills to do so. This organizational creation has resulted in the work that is detailed in the following workgroups. The chair of the Training and Workforce and Development Subcommittee has been integral in sustaining communication and knowledge building from the national level to the state and within the subcommittee. The sharing of COD training for adolescent providers, the South Florida COD manual, and the dissemination of an online training from Lori Franklin of FCS was accomplished in this quarter.

The Curricula Development Workgroup

It is hard to describe the intensity of work that the workgroup completed during this quarter. They met officially four times as a workgroup with the first two meetings in January drawing 20 and 19 attendees from across numerous agencies with two consumers at the first meeting and one consumer at the second meeting. The last two meetings saw attendance drop to half with nine people attending both gatherings. One consumer attended the third meeting. No consumers were present at the last quarter gathering.

These meetings do not include the time spent outside in attaining curriculum information, preparing it for the workgroup review, editing, presenting it to the members of the larger committees for further changes, and maintaining meticulous minutes.

The first of the meetings (January 10, 2007) revolved around the development of objectives for the goals of the intermediate curriculum. This process involved a review of ASAM and ASI criteria, discerning differences between the two, strengths perspective, stages of change, evaluation of environmental influence, peer support, motivation, and high risk situations. In addition to actual content the method of learning was discussed (didactic lecture, small group, use of case scenarios) and the need for a glossary.

The second meeting on January 11, 2007 focused on a variety of topics that affect curriculum and training. Curriculum goals 1-5 were a main topic. The need for members to provide case scenarios for the training examples was reiterated. Handouts for the manual were designated. Completion of the test bank was announced. The glossary was tabled. An aspect of trauma was a topic of discussion in relation to debriefing and source of care. Times were added to the objectives for Goals 3 and 5. The need for more time for trainers to grasp information was voiced.

A number of decisions exemplified the February 1, 2007 meeting that solidified the intermediate curriculum. A trauma video gained approval for use with one member noting that it brought a personal touch. The trauma parallel process was moved to the advanced training due to its length. Placement of all approved scenarios in the appendix was approved with additions to the instructions to clarify their use. The inclusion of the screen and its link to CEUs is dependent on its validation by Dr. Cherry. Joe Yosten will

create a list of screening tools to place in the appendix. The glossary and test bank was also edited.

A February 8, 2007 meeting represented the first gathering devoted to the advanced curriculum development with nine people attending. The first order of business was to develop goals and objectives. Four Goals were written and approved by the workgroup. A meeting scheduled for March 8th was intended to focus on defining goal objectives. This work will continue into the next quarter.

Goal 1: Introduce seminar participants to the definitions of co-occurring capable/enhanced treatment.

Goal 2: Introduce seminar participants to the therapeutic technique: motivational interviewing.

Goal 3: Provide education on substance use disorders and/or mental health disorders.

Goals 4: Seminar participants will learn and demonstrate how to match treatment to stages of change.

Data Reporting Workgroup

Ten members of this workgroup met once during the quarter. The main message of the meeting was the need to show data based outcomes. Congress has articulated this requirement to SAMHSA. The Data Reporting Workgroup will now communicate the need to the ISI Subcommittees and carry forward this requirement. The remainder of the meeting was spent in review of the Program Assessment Rating Tool (PART). The PART was designed to assess program performance through the identification of strengths and weaknesses. Once assessed funding and management decisions can be made to enhance program functioning. Another informative point was the January 1st availability of a free searchable online database for government spending such as block grants, formula grants, cooperative agreements, and indirect financial assistance (per S.2590 now a law). Available in October 1, 2007 will contain subcontracts and sub grants information such as the amount of federal funding over past 10 years, list of each transaction, location of recipient, primary performance location, and unique identifier for each recipient. The accessibility of this information brings a new level of awareness to researchers, service providers, the general public regarding funding.

The completion of the intermediate level training was the major work completed during this quarter was accepted by the leadership committee. This accomplishment represents the hard labor of the Curriculum Development Workgroup under the direction of Cindy Schultz with integration of content from the Data Reporting Workgroup. Both of these smaller groups were created under the larger Training and Workforce Development Subcommittee last year. In particular the chair noted the strong leadership of Cindy Schultz in curriculum completion as all the workgroups faced the difficulty of keeping full committee participation from members that have multiple commitments. A strategy utilized to deal with the before listed problem was to utilize the medium of email communication as much as possible and firm decision making. Now the workgroup will turn to the advanced level training, begin to train the model sites in this curriculum, and evaluate those trainings.

The completion and approval of the intermediate training curriculum was the major accomplishment noted by Cindy Schultz, the leader of the workgroup. The work required for the development of the advanced training has begun and will be the focus on the next quarter. A continued issue that has carried over from the previous quarter is the need to develop web based learning for ongoing training. Difficulties included the majority of the actual work of information gathering for curriculum content falling to just a few members and the coordination and completion of meeting minutes in time for the next meetings. This affects not only the individual practitioner, but the productivity of the entire agency. In order to avoid the over working of a few members in the next level of curriculum development, large subcommittee meetings will be held that are open to anyone that has ever attended a subcommittee meeting, smaller work groups will be developed to address the task.

The development of a plan to collect the data required under the Government Performance and Results Act (GPRA) was a major focus. The co-occurring data that needs to be collected for the COSIG initiative and how it will be derived from the existing ODMHSAS client data core thru the ICIS system was also worked out.

Screening and Assessment Subcommittee Work Summary

Screening and Assessment activities and meetings involved the availability of recommended instruments or tools, which became available during the quarter (see Appendix C). The OK-COSIG Screen will also be included. The major work revolved around the completion of the Welcoming, Screening, Assessment, and Recovery Planning Practice Guidelines. This process took longer than anticipated, but was commendable given its achieved goal of consumer input at every step of development. Each individual agency from this point has the flexibility of incorporating their own agency, certifying body, or funding source into these guidelines.

Members of the Screening and Assessment Subcommittee met monthly over the quarter. The meeting of January 9, 2007 was attended by 10 subcommittee members and took place at the Norman Alcohol and Drug Treatment Center. This meeting consisted of discussion involved proofing and making changes to the Integrated Assessment and Recovery Process Protocol before submitting it to the Advisory group for recommendations and approval.

The second Screening and Assessment Subcommittee meeting took place at Total Life Counseling on February 21, 2007, with 9 people present for this subcommittee meeting. The subcommittee made a few revisions to the Integrated Assessment and Recovery Process Protocol to include ASAM and clearer guidelines for consumer's transitioning thru levels of care.

The last Screening and Assessment Subcommittee meeting of the quarter took place Jim Taliaferro Community Mental Health Center on March 21, 2007, with 7 people in attendance. During this subcommittee meeting three main topics were discussed; the consumer panel, the Integrated Assessment and Recovery Process Protocol, and screening and assessment tools. The subcommittee identified that highlights from the consumers suggestions and concerns would be added to the document of consumer feedback. The Integrated Assessment and Recovery Process Protocol draft was under review by leadership. A goal set by the subcommittee was to have its members submit recommended screening tools and assessment tools to the subcommittee, which would be comprised into a binder that would be made available to all state agencies.

The Screening and Assessment Subcommittee Chair has identified the subcommittee's greatest achievement as holding meetings at different facilities each month and having a panel of consumers to give input at each of these facilities. The only barrier that this subcommittee has experienced is travel time, with some members having to drive up to two hours to subcommittee meetings. However, the subcommittee has taken the approach of carpooling and asking the state to set up teleconferencing capabilities. The subcommittee was encountering problems of using language in their documents that was too clinical, but input from consumers helped to put the wording in terms that was easier to understand. The subcommittee did not ask for or use technical assistance over the last quarter. The Screening and Assessment Subcommittee plans to continue working on developing the database of resources that they plan to make available to all of the state's agencies. The main concern of subcommittee members is that financial roadblocks within agencies will hinder the implementation of many of the subcommittee's recommendations.

Outcome and Evaluations Subcommittee Work Summary

This committee did not meeting during the quarter. Baseline data has been provided to Dr. Cherry, the outside evaluator. This data will be used to give a picture of co-occurring clients and to develop individual reports for each model program. The committee members reported discussion regarding the inclusion of screen results on the CDC form for FY 2008. The results would indicate mental health negative, mental health positive, substance abuse negative, substance abuse positive, or did not screen. If the screen is not included, data will have to be obtained by going back to each agency.

Systems Integration Subcommittee Work Summary

A scheduled meeting for March 14th was rescheduled to take place at the beginning of the next quarter, April 11, 2007. Although the subcommittee did not meet this quarter, the work of identifying a fidelity scale that would function as an agency administered audit is the main focus of committee members. The Central Office could then utilize the same fidelity scale to complete an independent audit that would be compared to the agency generated score. The IDDT and the DDCAT were deemed as not practical for the Oklahoma system when COCE questioned the subcommittee

member's desire to find or develop a new fidelity scale. This topic will continue to drive the work of the committee in the following quarters.

Finance Subcommittee

Members of the Finance Subcommittee met once during the middle of this quarter to discuss a variety of topics. The meeting of February 7, 2007 was attended by five people. These individuals began their time by re-visiting the subcommittee's original goals in order to ground their work. The goals are 1) Identify how co-occurring services are currently provided and funded and 2) Identify how co-occurring services should be provided and funded in the future. In the pursuit of these goals, Krista Rhoades presented data for FY 05 – FY 06 for a number of different areas including: number of COD clients, COD clients by agency, location of services, type of paid services, total dollars charged to ODMHSAS for COD clients for each agency, number of COD clients served, dollars per client, and all services received at each agency by contract source. The next report will be the number of clients receiving services under more than one contract source which will be available in the next quarter.

The individuals then discussed if the current data system provided sufficient information for COD clients. Potential issues related to data entry were brought up such as the need to do data entry training, consistency among providers in data entry, changing ICIS rules to adequately gather COD data, the consumer downplay of mental health or substance abuse symptoms dependent on the agency they present at. The future action to be taken at the subcommittee level is a combined meeting of the Finance and Outcomes subcommittees with a number of providers present to offer perspectives on current practices of gathering COD client data in order to identify any difference among agencies and ideas for enhancing COD data collection.

Barriers to becoming COD capable were the final item of discussion. According to the members of the subcommittee, mental health and substance abuse agencies have the same five struggles: 1) finding personnel that have experience in the other field, 2) training existing personnel in the other field's issues, 3) acquiring adequate funding for the other field's services, 4) ability to make proper referrals, 5) funding for services besides TXIX. The substance abuse facilities have the additional barriers of access to a physician, availability and funding for medications.

The chair of the *Finance Subcommittee* reported that in addition to the areas identified within the meeting the major accomplishment of the subcommittee was the production of a combined contract for mental health and substance abuse. Cross national information sharing continued in this quarter with the addition of other states' funding plans for co-occurring programs. Barriers to work on were the ability to obligate monies when new funds are not available. The approach to overcome this barrier is to have leadership involved in mental health and substance abuse levels. Future work will focus upon the review of state plans for relevancy to Oklahoma with acknowledgment of the barriers and the awareness that the timing of the finance function appears to follow the work of the other committees.

The Regional Change Agent committees

Regional Change Agents: Norman

Two meetings were held during this quarter. The first Norman Regional Change Agent meeting focused on a variety of issues with the main theme across all the areas centering on creating a co-occurring service system when the OK-COSIG grant comes to an end. Twelve people met at Griffin Memorial Hospital on February 28, 2007 to discuss a variety of issues and the end of the grant funding. By 2008, 80% of all clinicians need to be trained at the core-level. Training for trainers will be offered quarterly at the Central Office. Members suggested that quarterly regional core-level trainings be offered to deal with needs related to employee turnover. SOS established three credit hours of CEUs that will accompany one hour clinical staff trainings. It will be conducted on the fourth Wednesday of each month. Dual certification acceptance is proceeding with LCSWs and LADCs.

The need for physician training was discussed. Dr. Mee Lee and Dr. Minkoff will lead this effort. Government level education has been gained with the attendance of Oxford House state coordinators at core training. The need to expand the COD service structure was met with the reminder that the group is still working on a letter of invitation for agencies that have MOUs in the area. Recognizing that an employee may have a period of time before they can attend regional core-level training, members suggested that the training and workforce subcommittee develop a condensed core-level training (60-90 minutes) that the individual can take immediately.

Communication among providers, facilitation of referrals across agencies, a discussion of overcoming barriers to involvement, the strengths and weaknesses of the core level training, and a meeting place to promote agency change were the major accomplishments. Another significant achievement was work done on an inclusion plan for other service agencies in the regional meetings. Issues from the last quarter are the completion of core-level trainings and the need for physician involvement. Technical assistance is being sought to gain doctor participation. Struggles that the group faced included the sharing of meeting notes in order to prepare minutes and the work of a few carrying the group. Members indicated that they are at a loss in terms of how to engage other service agencies and how to affect their own agencies other than offering the core-level training. The members are proactive in their request of a letter of invitation developed by the grant staff to engage agencies. The chair will meet the Tulsa Regional Change Agent Chair regarding their process of agency outreach. A future agenda item is to consider requesting a central core-level training for the whole region rather than individual agencies providing ongoing training. Concerns for the chair are leadership for meetings and how to put skills to use after the core-level training is complete.

Regional Change Agents: Tulsa

Two meetings were held for the Regional Change Agents in Tulsa. The January 5, 2007 meeting had eleven people in attendance. Networking was discussed with the suggestion that a list of each agency's admission and exclusion criteria would be helpful. Coordination of the initiative and the service structure was a topic with the announcement of other subcommittee meetings, DTR training for support groups, the development of the Tulsa Mental Health Court, a monthly newsletter, bulletin board, and possibility of a COD fair. The need to shorten the core-level training was also a discussed. Ten members attended the March 2, 2007 meeting at TCBH in Tulsa where networking and ISI subcommittees were themes from the January gathering. DTR training was another ongoing topic. Suzan Easley wants to post a list of group leaders that are available to run DTR. DVIS needs help with a leader for their DTR group. The next DTR training was announced for April 26th. Members were informed of ODMHSAS standards changes and online access for proposed rules that will be in place July 2007.

The themes interpreted from the Chair's report indicate that substantial communication and knowledge sharing has taken place among the model sites and within the central office. Becoming co-occurring capable, trauma informed, barriers to screening and referring, motivational strategies for staff have been shared by all the members as representatives of their respective agencies. Members have shared about their organizations and service provision. This cross agency discussion and knowledge building has provided coordination and a sense of direction regarding the concrete items that need to be achieved: MOUs, consensus documents, COMPASS, and contract objectives.

Old and new issues center on time and money. Meetings across the state involve travel costs productivity losses which is an issue that was voiced in previous quarters. There is the lag in making the financial changes necessary to reimburse for co-occurring services. Additionally, some facilities have difficulty supporting change agents and the goals of the initiative. Change agents are not given any release time to perform any of the responsibilities they need to for the trainings and committee meetings. Staff turnover is a barrier to the committee's mandate if the agency loses someone that functioned as a change agent. Assistance was sought from Todd Crawford, L.D. Barney, and Dr. Khem. A request for leadership to focus on financial issues was another strategy sought to deal with barriers. Concern for the co-occurring service system was expressed once the initiative ends. Future plans include expanding the committee meetings to other agencies and preparing for the administration of a Co-Occurring Fidelity Scale.

OK-COSIG Evaluation Team Activities

The Evaluation Team met on January 3rd, 2007 to discuss and prepare the First Quarterly Report and the Year End Report. At a January 9th, 2007 meeting, the team members reviewed the new lists of control and pilot sites and finalized the First Quarterly and Year End reports and emailed those reports to the OK-COSIG team. At a January 23rd, 2007 meeting, the Evaluation Team discussed the reapplication process for continuing OU IRB approval. The Evaluation team acknowledged that the team members would all need to renew their Citi Training certifications. In February, the Evaluation Team met on the 8th,

OK-COSIG team is aware of it and continues to look for ways to increase service recipients and advocacy group participation.

Methodology Used to Develop the 2nd Quarter Report – Year 3

The methodology that was used to produce this quarterly report is both qualitative and quantitative. The qualitative data consists of interviews, collected materials, and observations by evaluation team members. Relevant documents were collected from committee meetings, trainings, and workshops. The minutes from ISI Advisory Group subcommittee meetings were cataloged. These documents and data as a whole provide a description of events, activities, accomplishments, and tasks that have been completed, or are still being worked on. The quantitative data consists of the ICIS admission data on the 15 Model and 5 Control programs. This data file is made up of 196 variables on 21, 879 people admitted for treatment.

Progress on Project Goals and Objectives

Goal 1.

Develop, implement, and evaluate a standard protocol for the screening and assessment of mental health and substance abuse treatment service recipients in all State funded programs.

Objective 1.2 –

Train all mental health and substance abuse treatment providers in the screening and assessment protocol.

Status:

This work is in progress.

Goal 2.

Develop, implement, and evaluate an integrated treatment model for persons with co-occurring disorders that is accessible, culturally competent, and grounded in evidence-based practices.

Objective 2.1 –

Develop consensus among providers, service recipients, consumer advocates, and other interested parties on the elements of an integrated treatment model for persons with co-occurring disorders.

Status:

Consensus building and infrastructure building has been a major part of the work of the OK-COSIG team this quarter. Based on the number of agencies that are participating in the project (recently increased by 13), consensus building continues to be successful. The OK-COSIG team continues to be fully engaged in consensus building among the shareholders.

Objective 2.2 –

Establish joint licensure/certification and funding processes for both mental health and substance abuse staff.

Status:

The work to establish credentialing for a co-occurring specialist moved forward last quarter. Draft language for the LADC statutes has been proposed. The staff is also working with the Board of Licensed Professional Counselor, the Board that licenses Psychologist, the Social Work Licensure Board, and the Board that licenses Behavioral Health parashioners.

Objective 2.3 –

Develop contracting procedures that create strategic incentives for the implementation of integrated treatment systems at the provider level.

Status:

The ISI Finance subcommittee has received technical assistance and is moving forward on developing a plan and a mechanism for funding co-occurring treatment. The committee members are reviewing other state plans for financing services for people with co-occurring disorders that may have relevancy to Oklahoma

Objective 2.4 –

Train all mental health and substance abuse treatment providers in the use of a comprehensive, integrated system of care model for persons with co-occurring disorders.

15 Months

- Fifteen months after the award date, the co-occurring disorders training specialist, under the guidance of the national consultants, will have trained all staff in the pilot sites in the integrated treatment model (Activity 2.4.2).

Status: Accomplished.

24 Months

- Within 24 months, the evaluator will produce a report assessing the implementation fidelity of the screening protocol at the pilot sites (Activity 1.2.4).

Status:

The screen has been piloted and the Assessment Practice Guidelines have been written by the Screening and Assessment Subcommittee and approved by the Leadership Committee. The screen has been piloted and the evaluation report has been completed (see Appendix A).

- End of the second year after the award date, the evaluator will have conducted an assessment of treatment fidelity and clinical outcomes on a sample of persons with co-occurring disorders and will provide a report to the OK COSIG Advisory Group (Activities 2.4.3 to 2.4.5). The services pilot will be implemented in two urban settings in the second year, Tulsa (Service Areas 3 & 5) and Norman (Service Area 15).

Status:

Program Fidelity data has been collected from the Model Programs. A preliminary report was produced and is found in the Year-End Report, Year 2. A Program report based on the Fidelity and ICIS data is being developed.

- Implementation of the screening and assessment protocol will be assessed at the service pilot sites during years two and three and statewide in years four and five.

Status: The first round of Fidelity data has been collected.

- A two person team under the direction of the Program Evaluator will visit each of the 15 pilot programs involved in the services pilot sites at the end of year two and three (The number of pilot programs has increased from 8 to 15).

Status:

Program Fidelity data has been collected for year 2.

- The Project Evaluator will produce a site specific report based on the three sources of information that will examine the relationship between organizational factors and implementation fidelity, and changes in implementation fidelity from year two to year three for the two urban sites and from year three to year four for the rural sites.

Status: *In progress*

- The Evaluator will work with Decision Support Services Division to extract this information for each of the service pilot sites on an annual basis for each year of funding. Data from the first planning year will provide a baseline against which data from the pilot sites at years two and three can be assessed.

Status:

A preliminary MACRO evaluation for FY05 has been compiled and can be found in the Year-End Report, Year 2. A Program report based on the Fidelity and ICIS data is being developed.

- *Service Coordination and Networking.* The assessment of coordination and networking will be strictly qualitative and based on a combination of key informant interviews with program administrators at the state, regional, and local levels and focus groups with provider staff at the services pilot sites during the second and third years of funding, and at a random sample of seventeen regional provider sites, half at mental health facilities and half at substance abuse facilities, during the fourth and fifth funding years.

Status: *In progress*

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Emerging Themes

In the 2nd quarter of this third year, a number of themes identified in year one and two have been addressed or are being addressed. New themes and variations on old themes, however, are developing and are important to both the short term and long term success of the OK-COSIG project.

Training Development

The development and work of three groups under the Training and Workforce Subcommittee has made great deal of progress this quarter. They will be working on the advanced curriculum in the next quarter. Core level training are being delivered to the new model programs and other groups that are interested in the training. .

Engage the Tribal Nations of Oklahoma

The inclusion of the Tribal Nations is receiving more attention and this effort will need to be sustained. The engagement of additional tribal governments will be evaluated in the following quarters.

Treatment Practices Related to Families

The need to explore and develop curriculum for working with families of people who are being treated for a co-occurring disorder remains a theme of the project.

Low Service Recipients and Consumer Advocates Involvement

There is a continuing need for involvement from Service Recipients and Consumer Advocate groups. The OK-COSIG is aware of the situation and exploring ways to increase their participation.

Postscript

Work in this second quarter of the third year of the OK-COSIG project has been focused on training and curriculum development, engaging new programs, working on credentialing, and for the evaluation team, data analysis. There has been observable progress related to the OK-COSIG goals and objectives during the quarter.

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APPENDIX

The documents in this Appendix are products of work completed in the 2nd quarter of the 3rd year.

Appendix A: Report on the Reliability, Validity, Sensitivity, and Specificity of the OK-COD Online Screen

Appendix B: The Welcoming Policy statement approved by ODMHSAS Leadership.

Appendix C: Suggested List of Tools from the Screening and Assessment Subcommittee

Appendix A
Report on the Reliability, Validity, Sensitivity, and Specificity of the OK-COD
Online Screen

Prepared by the OU OK-COSIG Evaluation Team:
Andrew L. Cherry, DSW, ACSW
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Mary E. Dillon, MSW, ABD
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3-1-2007

In Oklahoma, an important component of the COSIG initiative is focused on screening people to determine if they have a co-occurring problem with mental illness and substance abuse. To improve treatment, first people with a co-occurring disorder must be identified by behavioral health providers. One of the major barriers has been the cost involved in identifying people with a co-occurring disorder. This process has typically required two assessments. One assessment focused on mental health disorders. The second focused on substance abuse disorders. To eliminate part of this burden, a rapid psychometric screen was developed and pilot tested in 2005 (N = 234). In 2006, between June and December, an online version of the screen called the Oklahoma Co-Occurring Disorders Online Screen (the OK-COD Online Screen) was tested (N = 3,608).

The people screened in 2006 were on average about 36 years of age. They ranged in age from 18 to 75. About 50% were between 18 and 35 years of age. Of those who completed the screen, 56.3% were female and 43.7% were males. Those *not* admitted to treatment (n = 1,894) were the same average age as those admitted to treatment (n = 1,714). There were 1,191 (62.9%) screens completed at mental health agencies, 344 (18.2%) screens were completed at the substance abuse treatment centers and 359 (19%) screens were completed at the agencies that treated people with a co-occurring disorder.

To determine the psychometric properties of the three scales (mental health, substance abuse, and trauma) the Principal Component Analysis (PCA) factorial analytic procedure and the Cronbach Alpha analysis were used. The factor solution suggested that the number of items in the three scales could not be reduced. The factor solution also accounted for 57.25% of the variance among those being screened. Second, Cronbach Alpha coefficients were used as a statistical measure of the internal consistency of each of the three subscales. The Cronbach Alpha for the Mental Health screen was .74. The Cronbach Alpha for the Substance Abuse Screen was .89. The Cronbach Alpha for the Trauma Screen was .60.

Because of the lack of data on those individuals who were screened but *not* admitted to a treatment facility that provided data to the ODMHSAS, only data on individuals admitted to treatment were used to determine the Screen's *sensitivity* and *specificity*.

Of the 1,509 adults admitted to a treatment program and who were given a DSM-IV Axis I diagnosis, 1,066 adults were given both a primary and secondary Axis I diagnosis. Of this number, 496 (47%) were diagnosed with a co-occurring disorder. Based on the DSM-IV Axis I primary and secondary diagnosis, the OK-COD Online

Screen identified 452 (91%) of those people as needing to be screened for a co-occurring disorder before they were given the diagnosis. The OK-COD Online Screen missed 44 people who were later diagnosed with a co-occurring disorder.

Based on the CAR and ASI assessments, the OK-COD Online Screen agreed with the CAR_sa in 90.5% of cases that the individual needed to be fully assessed for a co-occurring disorder. The OK-COD Online Screen agreement with the ASI_psy was even more impressive. The Screen agreed with the ASI_psy in 96% of the cases that were later identified by the ASI_psy as needing a full assessment for a co-occurring disorder

The Mental Health Screen suggests that there were very little difference between the two groups in terms of needing to be assessed for a mental health problem (Admitted = 49.2; Not Admitted = 50.8%). The Substance abuse Screen, however, screened-in considerably more people not admitted than admitted who needed to be assessed for a substance abuse problem (Admitted = 44.5%, Not Admitted = 55.5%). Based on the OK-COD Online Screen, 71.8% of the 1,714 admitted to treatment needed to be assessed for a co-occurring disorder. Another 21.5% needed to be assessed for a mental health problem, and 4.1% needed to be assessed for a substance abuse problem.

Identifying this many people requesting treatment that needed to be screened for a co-occurring disorder will have a significant impact on the number of people that will need to be assessed for both a mental health and substance abuse disorder. Currently, in Oklahoma everyone admitted for treatment is being assessed by a CAR or ASI. If the OK-COD Screen becomes part of an intake protocol, 70% of those seeking services will need to be assessed using both the CAR and ASI.

Table 1
OK-COD Online Screen by Agency Screening

Agency Service Type that Administered Screen			
OK-COD Online Screen IDed Problem Area	Mental Health Prog.	Substance Abuse Prog.	COD Prog.
Mental Health	Identified 95.6%	Identified 68%	Identified 95.2%
Substance Abuse	Identified 78%	Identified 78%	Identified 96%
Trauma	Identified 87.4%	Identified 68%	Identified 89%

Table 2
Specificity and Sensitivity

Specificity: OK-COD Online Screen Agreement with the CAR sa, the ASI-psy, and the DSM-IV DX			
OK-COD Screen	DSM-IV DX	CAR-sa	ASI-psy
Correct	452 / 91%	459 / 90.5%	170 / 96%
Missed	44 / 8%	48 / 9.5%	7 / 4%
Sensitivity: OK-COD Online Screen numbers compared to the estimated number of people in treatment with a co-occurring disorder			
The OK-COD Online Screen identified approximately 72% of all people screened as needing a full assessment to determine if the person has a co-occurring disorder. This is estimated to be twice the number of people who will be diagnosed with a co-occurring disorder after a full clinical assessment for both a mental health and substance abuse problem.			

Screening for the single disorders of substance abuse problems, mental health problems, domestic violence, child abuse, etc. has a rich history of success. The OK-COD Online Screen is a screening tool that can be used during the intake process at many different types of human service agencies that takes less than 5 minutes to administer.

The major barriers to universal screening for a co-occurring disorder are training, time, cost, and an infrastructure where everyone seeking mental health or substance abuse services is screened. Although many of the barriers to universal screening are still intact, the barrier related to the lack of a co-occurring screen that is effective and can be administered in a cost efficient way to detect people who need to be assessed for a co-occurring disorder has been removed. The analysis of the OK-COD Online Screen has shown that this screen is reliable, valid, **sensitive, and has high levels of specificity.**

For a copy of the full report go to http://faculty-staff.ou.edu/C/Andrew.L.Cherry-1.Jr/okcosig_project.htm

Appendix B

This is the Welcoming Policy statement that was approved by ODMHSAS Leadership.

Welcoming Policy Statement

Mission Statement (Purpose) was recommended:

Committee reviewed proposed mission statement and reopened section for discussion. The two below statements will be presented to larger ISI meeting for recommendation/approval.

- To welcome individuals with either mental health or substance abuse issues or co-occurring and provide integrated mental health and substance abuse services and supports.
- To welcome all individuals who would benefit from integrated mental health and substance abuse services and supports.
- Motion passed, committee approved.

Purpose was recommended:

- Those individuals who are identified, as having one or both, a mental health disorder and substance abuse disorder shall be welcomed at every ODMHSAS operated or contracted program. The welcome shall be documented in program brochures that describe services at the site or in any other way the program broadcasts its array of services.
- The welcoming response shall convey a no wrong door philosophy to address treatment of any co-occurring disorders simultaneously in order to affect the most successful and desirable treatment outcomes.
- Appropriate plans and arrangements for the integrated treatment of co-occurring conditions shall be evident in clients' medical records at any ODMHSAS operated or contracted program site and available to clients, per agency accessibility policy.
- Henceforward, language reflecting the ODMHSAS commitment to a continuous, comprehensive, and integrated system of care shall be incorporate into every ODMHSAS agency policy and procedure.
- Motion passed and committee approved.

Now that the welcome policy has been approved, each agency will need to incorporate in to their agency policy.

Appendix C

Suggested List of Tools from the Screening and Assessment Subcommittee

Screening (Substance Abuse)

Name of Tool	Person Responsible
Brown Two-Item	
CAGE/CAGE-AID	Kelli
TWEAK	
T-ACE	
ADS	
MAST	Tami
DAST (10,20,28)	Tami-28
DALI	
AUDIT	Kelli
ASSIST	
UNCOPE	
CRAFFT	
CIWA-Ar	Kelli
SASSI	Jill

Screening (Mental Health)

Mental Status Exam	Jill
Mini-Mental Status Exam	Jill
BSI-Brief Symptom Inventory	Jill/ Dr. Cherry?
Brief Psychiatric Rating Scale (BPRS)	
Mental Health Screening Form III	

Assessments (combined)

ILSA interview Guidelines	
WRAP	Dave
PRISM	
ASI	Edwin
CAAPE	Dave
MAPP	Tami

Assessment (Substance Use)

Clinician' Alcohol/Drug Use Scale	
Stage of Treatment SATS	
SUDDS-IV	Edwin

Assessment/Diagnosis (mental health)

Structured Clinical Interview for DSM IV (SCID-IV)	
GAF	Dave

Readiness to Change Assessment

SOCRATES v8	Kelli
URICA	Kelli
RTCQ	Kelli
Readiness Ruler	Kelli
MAGIC	Kelli

Trauma

PAR	Edwin

Adolescent Tools

SA screen	SASSI-A	
SA assess.	ASI-A	
MH assess.	PADDI	Edwin
Trauma assess.	UCLA PTSD Parnt/chd/spanish	
Trauma assess.	CBCL	Jenny
Trauma assess.	TSCC	Jenny
Trauma/anxiety	RCMMAS	Jenny
Depression	CDI	Jenny
Family adaptability	FACES III	Jenny