

OK-COSIG
Quarterly Evaluation Report

Volume 3

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April 1, 2007 through June 30, 2007

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Acknowledgement

With the end of the third 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.

How this quarterly evaluation report is organized

This is the 3rd 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 (April 1, 2007 through June 30, 2007). This will be followed by a list of the implementation activities that were carried out during the 3rd 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.

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

April 1, 2007 through June 30, 2007

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

**Quarter 3rd
Oklahoma State Incentive Grant
for Treatment of Persons with Co-
occurring Substance Related
Disorders**

**Grant Number:
State:**

**1 KD1 SM56568
OKLAHOMA**

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I. Project Implementation

This is the Third 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 3* 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 the capacity to identify and treat people who present with the co-occurring disorders of mental health, trauma, and substance abuse within Oklahoma's mental health and substance abuse treatment communities.

The OK-COSIG project continues to be supported enthusiastically by practitioners, agency and program personnel who work in the mental health and substance abuse treatment communities in Oklahoma. Like practitioners around the country, clinicians in Oklahoma have collectively come to the conclusion that *sequential* and *parallel treatment* for people with a co-occurring disorder is not effective. As a result practitioners did not need a great deal of persuading that a new approach was needed to successfully treat people with a co-occurring disorder. When it became available, they welcomed the training and information to enhance their practice with people who present with the co-occurring disorders of mental health, trauma, and substance abuse.

In 2007, as the end of the third year of the OK-COSIG program is coming to a close, the structural barriers that have existed since the inception of mental health and substance treatment, are methodically being weakened or removed. State policies and contracts are continuing to be modified to include language that requires agencies to provide integrated approaches for treating people with a co-occurring disorder. In fact, with the changes in the ODHMSAS State rules governing mental health treatment (Chapter 17) and substance abuse treatment (Chapter 18) we are starting to see barriers erected that will make *business as usual* more difficult at all three levels of the organizational structure that supports treatment for people in Oklahoma with a co-occurring disorder. The orientation and training over the last three years has been effective in setting the standard for best practices when providing services and treatment to people with a co-occurring disorder. This will be enduring. Helping professionals will

use the best tools available to them in their practice when they know of them and they are open to new ideas and research findings.

Changes at the middle management level have been effected by the project as well. This group was tasked with implementing the contract changes and the “standard protocol for the screening and assessment” of people who seek either mental health treatment or substance abuse treatment. It takes a great deal of effort and is costly when agencies have to change forms and provide new services (i.e. screening and if needed, assessing for mental health, trauma, and a substance disorder).

At the State Department level, the focus on integrating the mental health and substance abuse communities extends beyond the OK-COSIG project. ODMHSAS will not have separate SA and MH conferences this year nor in the future. The Integrated Conference will be held in January 2008. Plans are in the works to begin pilot programs that will provide enhanced co-occurring services on an outpatient basis in a CMHC and a SA treatment center. The pilot will help identify the cost of providing these services. There is also an on going effort to integrate the two departments of mental health and substance abuse within the Department.

Making the changes necessary to provide services to all of the people with a co-occurring disorder who seek services is a work in progress. Especially the provision of treatment that is “accessible, culturally competent, and grounded in evidence-based practices.” At this point, local program administrators, clinicians, and staff working in the communities across Oklahoma are acutely aware of the implications for failing to treat people with co-occurring disorders. The orientation and core-level training to retool the treatment staff has been supplemented with network and capacity building strategies to assist program administrators in sharing ideas, skills, and resources. To accomplish the ‘accessible’ goal an infrastructure for service coordination is slowly developing. The primary barrier to interagency cooperation and collaboration is related to financial issues and contracting.

Workforce and clinical competence issues related to providing services for people with a co-occurring disorder are being addressed. Over the last three years, a large cadre of administrators and staff from 15 model programs has attended orientation meetings, consensus building workshops, and committee meetings. They have also attended the Core-Level training on engagement and integrated treatment for people with a co-occurring disorder. Change Agents, clinicians who are advocates and trainers that focused on co-occurring disorders in their respective agencies have been identified and are working together and providing trainings at their agency. Retooling by the clinical staff in the 15 model programs is well underway. The orientation and training in the 13 new programs has begun.

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 and his team have concentrated on developing a Core-Level and an Intermediate Level of training, and the methods needed for delivering those trainings.

In the third 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 to move forward. 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.

Over the last three quarters the OK-COSIG staff have provided basic ongoing support and technical assistance for the original pilot program staff. They are providing the 13 new model programs, the initial orientation and Core Level trainings.

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 moving forward.

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.

The work to implement a standard practice for screening and assessment for people with a co-occurring disorder has been codified. New language in the rules in Chapters 17 and 18 will help sustain the use of the screening and assessment protocol.

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 and in the Intermediate level training that has just been developed and pilot tested. A cadre of staff, at the 15 model sites, has received the Core Level training. All of the model programs have a Change Agent that has received the Core-Level training. The Change Agents will now be trained at the Intermediate Level and expected to go back to their respective agencies and train the clinical staff with the Intermediate Level Curriculum. Next, Core-Level trainings are being provided to the 13 programs added to the original 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.

Over the last quarter, several consultants and speakers (Dr. Kenneth Minkoff, Dr. Christy Cline and Dr. David Mee-Lee were brought in to orient the new model programs and energize the 15 original model programs.

The greatest portion of the work on Objective 2.1 has been accomplished. The implementation ideas, philosophies, and presentations by consultants Dr. Minkoff and Dr. Christy Cline of ZiaLogic, Dr. Walter Kristhardt, Dr. 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 continues to receive a great deal of attention and progress on this objective is being made. The licensing bodies have joined together as a committee to meet monthly to discuss their role as regulators of clinical practice in the treatment of people with a co-occurring disorder. The group is made up of representatives from: the Licensed Behavior Practitioner (LBP) (practitioners with a graduate degree in clinical psychology), Licensed Clinical Social Workers (LCSW), Licensed Professional Counselors (LPC), Licensed Marriage and Family Therapist (LMFT), Licensed Alcohol and Drug Counselors (LADC), and Certified Alcohol and Drug Counselors (CADC). The board that licenses Alcohol and Drug Counselors added language to their statute that changed statutes that were extremely narrow in defining who their practitioners could counsel. Their statutes now include a client group identified as having a co-occurring disorder. This committee is also working on a definition of professional training that is needed by professionals they license to work with people with a co-occurring disorder.

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 (Title 450:17, Chapter 17) and substance abuse treatment (Title 450:18, Chapter 18) include changes that relate to treatment for co-occurring disorders. These rules, along with other structural changes within the Department, are removing barriers that have kept the fields of mental health and substance abuse treatment separate and left people with a co-occurring disorder without an effective treatment option. Moreover, these changes in the rules will make it more difficult for agencies to continue business as usual. With these changes, all mental health agencies and programs must address the question of how they are going to deal with people who present with a co-occurring disorder. Is the agency going to provide co-occurring services (by becoming co-occurring, clinically capable) to

the person requesting services or is the agency going to refer the person to a co-occurring, clinically capable program? It appears that the vast majority of agencies are looking for ways to develop co-occurring, clinically capable programs.

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 next phase is training Change Agents with the Intermediate-Level training and then for the Change Agents to go back to their agencies and train the staff at their respective agency. Ten Core-Level trainings and two piloted Intermediate-Level trainings were conducted in the third quarter. All of the 15 model programs have been provided Core-Level training. Over the last quarter and in the next quarter, two Core-Level trainings will be provided to the 13 programs added to the 15 original model OK-COSIG programs.

(2) Project timeline for project implementation

Over the last 33 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.”* Work on this objective is being accomplished. The reason this objective was not completed 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. Given the movement in the last quarter, the structure and components needed to support a call for credentialing are in place. The work on this objective is making progress.

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 third quarter of the third year the broad focus of the OK-COSIG staff was on: 1) incorporating and sustaining the provision of co-occurring programming at the State policy level during the transformation process, 2) engaging and orientating the new 13 model programs, 3) continuing to provide statewide training of clinicians and staff, 4) developing credentialing standards for clinicians who treat people with a co-occurring disorder, and 5) increasing the participation of consumers in the committees process and increasing participation among Native American groups in the project.

b. Status of Project

(1) Description of activities during this quarter regarding:

- screening and assessment,

Members of the subcommittee completed their work on the protocol for screenings, assessments, and integrated treatment plans. Currently they are working on developing a collection of screening and assessment tools that can be used by all agencies. This will be a compendium of scales and measures used for screening and assessing mental health, substance abuse, and trauma. The philosophy behind developing a collection of scales and measures related to screening and assessment is that they should be individualized and based on consumer need.

- workforce development/curriculum development workgroup,

The development and evaluation of the Intermediate Level training for change agents was completed and evaluated. The curriculum was approved by leadership and will be printed by August 2007. The advanced level curriculum outline is complete. The content is now being gathered. The advanced curriculum goals are: Goal 1-provide clear expectation regarding co-occurring capable versus enhanced treatment, Goal 2-introduce motivational interviewing and matching treatment to stages of change, Goal 3-education regarding mental health and substance abuse, and Goal 4-will define the parallel process.

- Plans for the next quarter are to continue to do Core-Level trainings for any state agency or community organization that requests it. Additionally, a manual for the Intermediate Training Curriculum will be printed by August. This material will provide the material the Change Agents will need to begin training the staff at their agency at the intermediate level. Another future plan is to disseminate trainings on TIP 42 designed by Regional ATTC. systems integration,

A draft of the COD statement of work (SOW) that operationalizes enhanced co-occurring services was written. The SOW is related to an outpatient contract that would host mental health and substance abuse services under one roof.

The incentive contracts and their established timelines have been proposed. Incentives are typically very helpful to the model agencies. Incentives can be earned by model programs that meet specific objectives and goals. The objectives and goals are related to work to become co-occurring capable (i.e., completing the COMPAS, training of staff, and sending staff members to the OK-COSIG Committee meetings. Model programs can earn approximately \$15,000 in the first year and \$5,000 in the second year for meeting identified goals. The incentives are funded from the OK-COSIG grant and their use was approved by the funder, SAMHSA.

Work over two years paid off when Chapters 17 (Title 450, the Standards and Criteria for Community Mental Health Centers) and Chapter 18 (the Standards and Criteria for Alcohol and Drug Treatment Programs) related to co-occurring became law. The language relates to ODMHSAS funded agencies and the provision of services to identify and link people with a co-occurring disorder (See Appendix C: 2007Changes in Chapter 17 and 18—Standards and Criteria in the full report at http://faculty-staff.ou.edu/C/Andrew.L.Cherry-1.Jr/okcosig_project.htm)

- financing,

The Finance Subcommittee did not meet during this quarter. 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 (an integrated contract) for mental health and substance abuse service providers. The work of the committee will continue to be difficult, no new funding was provided to enhance programs this year. Existing dollars must be used to provide any COD enhancements. ODMHSAS continues to request additional funding.

Barriers to work related to the ability to obligate monies for co-occurring services when new funds are not available.

- management information and data systems,

Work to make changes to the FY 2008 ICIS was completed. Alert fields have been changed for mental health, substance abuse, and trauma screens with a positive, negative, or did not screen as the three response categories. How to conduct the screens have been added to the manual and potential screens are listed.

The plan to collect the data required under the Government Performance and Results Act (GPRA) and the data that needs to be collected for the COSIG initiative is complete. The start date for collecting the data is July 1, 2007.

- evaluation,

The data collected on the screen has been analyzed and a final revision has been produced. The statistical analysis of the AC-OK Screen has shown that this screen is highly reliable, valid, very **sensitive, and has high levels of specificity**. A report to the ODMHSAS leadership has been submitted (see Appendix A).

- the change agent regional committees.

There are three 'change agent regional committees' that are meeting regularly and others are in different stages of development. The two operating committees volunteered to mentor other 'change agent regional committees' that are forming. At the 2nd Change Agents Conference on the 24th of May, Dr. Minkoff challenged the change agents "to take the ball and run with integration." The Change Agents have begun expressing feelings of being overwhelmed by the work involved. ODMHSAS leadership is aware of the situation. The Project staff are working on developing other supports.

(2) Accomplishments

Over the last three quarters the major accomplishments have been adding 13 new programs to the 15 original 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.

A formal recommendation related to the Screen was sent to the ODMHSAS. The report recommends using the screen as revised. The report can be found in the appendix of the full report on this quarter's activities at http://faculty-staff.ou.edu/C/Andrew.L.Cherry-1.Jr/okcosig_project.htm.

In May OK-COSIG staff brought in Dr. Minkoff and Dr. Christy Cline to meet with the Department of Corrections (DOC) mental health and substance staff for a half

day of planning on how to integrate care for people with a co-occurring disorder and who are incarcerated. Later, DOC brought Dr. Cline back for a full day planning meeting and discussion on what integrated services would look like. The DOC is planning to empanel a “change” committee tasked with implementing an integrated system of services for people with a co-occurring disorder who are incarcerated. The OK-COSIG staff has offered their help. The State legislature increased the DOC appropriations to hire six employees to assist with discharge planning and connecting people with community resources that are being released from confinement with complex conditions, such as co-occurring disorders.

(3) Other significant project activities

- The Recovery Support Specialist Program Grant was submitted to provide peer support (RSS) in traditional substance abuse treatment facilities. RSS are currently in community mental health centers. ODMHSAS has also applied for the Access to Recovery Grant to fund service delivery by voucher system.
- A revised format will be used for the program reports based on the fidelity and ICIS data has been developed. A draft has been distributed for comment and suggestions in the last quarter. Changes resulting from the feedback are being incorporated into the draft program report.
- The OK-COSIG staff was also involved in the preparation to begin gathering data for the Government Performance and Results Act (GPRA). The co-occurring data that needs to be collected for the COSIG initiative will come from the existing ODMHSAS client data core thru the ICIS system.
- This quarter, the OK-COSIG staff entered into discussions with a company to develop a treatment journal for persons with co-occurring disorders called “Successful Living with Co-occurring Disorders.”

c. Difficulties/Problems Encountered

(1) Barriers to accomplishment

- There was no new funding to enhance programming for treating people with a co-occurring disorder added to the budget. This means that enhanced services for people with a co-occurring disorder will be funded out of current funds. Given the circumstances, it will be important to guard against mental health and substance abuse programs getting hurt financially in a situation where we are “robbing Peter to pay Paul.”
- Change agents have clearly expressed feelings of being overwhelmed. They talk about trying to balance being a Change Agent and carrying a full caseload of clients/consumers. To address this issue, technical assistance will be provided in the next quarter. Dr. Minkoff and Dr. Cline will provide technical assistance August 20th. ODMHSAS leadership is aware of the situation. They plan to

address this issue on September 25th at the at the retreat for executive and clinical directors.

- The Project staff are working on developing other supports.
- There is movement in the effort to identify ways to involve the Native American Tribes. The Choctaw Nation has applied for a grant thru SAMHSA to attend the COD Policy Academy.
- Consumer and Advocate involvement continues to be 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

- To improve the chances that the standards developed to enhanced services for people with a co-occurring disorder, language has been added to the rules in Chapter 17 and 18 to require that these services be provided to people who are assessed as having 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.

Not Applicable.

OK-COSIG Quarterly Evaluation Report

Third Quarter of Year 3

(Note: The data for the SAMHSA report on the OK-COSIG Project has been developed from Interviews, Documents, Meetings Minutes, Committee Chair Reports, and Notes that are summarized in the following sections.)

This is the 3rd 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 3rd Quarterly Report of Year 3 will delineate the work toward accomplishing these two objectives.

Activities and Events

April 1, 2007 through June 30, 2007

This section lists the activities associated with the OK-COSIG project staff for the 3rd 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 3rd quarter of year three, but it is a good representation of the work that was accomplished.

by Dr. Alex Stalcup, who used to work at the free clinic in San Francisco, on why treatment works.

Dr. Khem conducted a Core Level training at UCO for students enrolled in the substance abuse program. Later that week, Dr. Khem conducted a Core Level training for Project Boys to Men, a community agency.

April 23-27.

L. D. Barney met with some folks from Drug Recovery, Inc about their participation in the model programs. Later that week he met with the Norman area change agents and provided technical assistance at Griffin Hospital.

Todd Crawford and Dr. Khem participated in a national COCE state led conference call on consumer engagement.

April 30 - May 4.

L.D. Barney met with the RSS group and later that week with the credentialing/licensing committees at the Health Care Authority in Tulsa.

Dr. Khem conducted a Core Level training for DHS child welfare workers in OKC. On the 2nd and 3rd Dr. Khem led a Change Agent training in Tulsa.

May 7-11.

Todd Crawford and L.D. Barney met with the Mental Health consumer council. L.D. Barney facilitated a meeting with Dr. David Mee-Lee and a group reviewing detox policy. He also met to continue planning related to the RSS. Later he was involved with Case Management training based on Dr. Walter Kristhardt's model. Later that week, he also met with North Care Center and attended a 'screening meeting' with Health Care Authority later that day.

May 14-18.

Dr. Khem facilitated the first Intermediate curricular training in Norman. L.D. Barney presented at the Intermediate curricular training in Norman.

Dr. Khem facilitated a Core Level training at 12 & 12 in Tulsa, OK. And, a Core Level training in Norman for the regional area (44 people attended). Another Core Level training was completed at ACT in Tulsa by their change agent.

May 21-25.

L.D. Barney met with Choctaw Nation, which is applying for a grant thru the Bureau of Indian Affairs that is very similar to the OK-COSIG grant. Todd Crawford and L.D. Barney met with the Oklahoma Department of Corrections where Dr. Minkoff and Dr. Cline facilitated a discussion about integrated treatment for people with co-occurring disorders who are incarcerated. L.D. Barney provided technical assistance in Lawton.

Todd Crawford, L.D. Barney, and Dr. Khem attended the 2nd Change Agent conference on the 24th of May. Dr. Khem presented training tips for change agents.

May 28 – June 1.

Todd Crawford, L.D. Barney, and Dr. Khem attended the Annual Provider meeting on the 30th and 31st of May. It was the first meeting where mental health and substance abuse treatment providers met together. Dr. Khem presented on the Intermediate curriculum.

June 4-8.

L. D. Barney met with change agents from Griffin and Central Oklahoma Community Mental Health Center. He also arranged for Dr. Mee-Lee to return to talk to staff from the substance abuse division about detox. They are putting together a committee to look at the detox process and policy..

Dr. Khem facilitated a Core Level training for SOS, Specialized Outpatient Services. On June 6-7th four ISI Committee trainers attended a conference in Kansas City on “train the trainers” conducted by The Addiction Technology Center (ATTC).

June 11-15.

Todd Crawford and L. D. Barney met with a work group to plan the integrated Mental Health and Substance Abuse treatment conferences. Later that week, L. D. Barney provided technical support at the Bill Willis Center in Tahlequah. And, Todd Crawford, L. D. Barney, and Dr. Khem attended the Systems Integration and Advisory Committee, and the Curriculum Workgroup meeting and the Training Workforce Subcommittee meeting.

Dr. Khem facilitated a Core Level training at Sugar Mountain, a residential mental health facility.

June 18-22.

L. D. Barney met with the area health coalition group at Bill Willis Community Mental Health Center. He addressed the group about the COSIG Change Agent Group and several agencies agreed to participate in the Northeast Regional Change Agent group. He also met with the credentialing/licensing committee.

Dr. Khem attended the Providers Certification Training on the rules (mental health, gambling, alcohol and drug, and on residential care).

June 25-29.

L. D. Barney met with the new Detox Review Committee. The chair is Dr. Ardwin, who runs the residential program at Griffin Hospital. Dr. Khem facilitated a regional Core Level training for 57 people at Red Rock in OKC.

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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, and Screening & Assessment subcommittees. A summary of the work completed by the ISI Advisory Group subcommittees during the 3rd quarter of year three is presented in this section.

There are six ISI Advisory Group subcommittees:

1. The Training-Workforce Development Subcommittee,
Curricula Development 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 Subcommittee Summary

The Advisory Group met on April 12, 2007 and was scheduled to meet June 14, 2007. The minutes for the second meeting were not completed by the time this report was prepared. Twenty-three people attended the April meeting at Central Office. Numerous subcommittee updates were given.

The Training and Workforce Development subcommittee chair began the meeting by presenting Intermediate Level Training curriculum. Rand Baker and Dr. Steve Davis made only minor modifications before it was approved. Dr. Khem and Cindy Schultz identified change agents in the Tulsa and Norman area as the initial target audience for the two trainings this quarter. Change agent's evaluation of the training was gathered immediately after the training by written survey and focus groups conducted by Dr. Cherry and his evaluation team. The feedback was incorporated into the second change agent training with the Intermediate Training curriculum.

Tami Box provided a review of the primary work of the Screening and Assessment Subcommittee as the generation of a screening and assessment tool collection. The philosophy behind a collection is that screening and assessment must be individualized based on the consumer. Practical issues were then addressed in the advisory meeting regarding copyright and the cost of instruments. L. D. Barney advised that the subcommittee request a sample copy at no cost. If this was not possible then list the title of the tool only.

Janie Hogue initiated a discussion of the ASI, its redundancy, and how it is a burden to consumers. There appears to be many that do not like the ASI, but it is a contractual requirement at this time. This initiated a discussion of who requires the ASI, the Oklahoma Health Care Authority or ODMHSAS. An OHCA representative stated that they defer to ODMHSAS. The use of the ASI will now be put on the Executive

Director's agenda with the Screening and Assessment committee being the logical body to make a formal recommendation. Krista Rhoades stated that she participates with that committee to help coordinate the requirements for data reporting if the ASI is not used.

Krista Rhoades reported for the Outcomes and Evaluation Subcommittee. This group has worked on the FY 2008 changes to ICIS. Alert fields have been changed for mental health, substance abuse, and trauma screens with a positive, negative, or did not screen as the three responses categories. How to conduct the screens have been added to the manual and potential screens are listed. It will take another calendar year to change the screen. The committee has asked for actual screens to be on ICIS. On another issue, 'service focus' is now explained in the manual.

The subcommittee chair stated that it is ready to begin reporting SAMHSA's co-occurring measures (screen, assessment, admission, and treatment type). Eventually every agency will receive this information. The ASI is now the only way to provide assessment results which can be compared to the screen results.

The Systems Integration chair spoke to the Chapter 17 and 18 changes and the single provider contract.

Dr. Cherry updated members on SAMHSA's new quarterly report format. He also explained the program report has content which includes two components. One is findings from the quantitative analysis of the over 23,000 cases from 2005. The second part is findings from the fidelity interviews conducted in the previous year. Dr. Cherry also shared some initial findings. Individuals with co-occurring disorders are in treatment half as long. They tend to be younger, but present at co-occurring agencies at an older age (indicating that they become aware of their co-occurring disorder after being in the system multiple times).

Janie Hogue presented a new training opportunity that uses a DVD with Scott Miller, a trainer that is consumer focused. She will be attending a training of his and requested any available funds be directed toward bringing him to Oklahoma.

Grant submissions were presented. The Recovery Support Specialist Program Grant was submitted to provide peer support (RSS) in traditional substance abuse treatment facilities. RSS are currently in community mental health centers. ODMHSAS will also be applying for the Access to Recovery Grant to fund service delivery by

voucher system. Oklahoma has been asked to participate in the ATTC TIP 42 training that may turn into a larger research project.

Todd Crawford discussed GPRA data reporting requirements as federal law. He discussed three new positions that would be filled to accommodate this requirement.

Advisory Subcommittee Chair Report

The chair was ill and not able to complete the chair report.

Training and Workforce Development Subcommittee

The main subcommittee did not meet this quarter. Work was carried out under the Curriculum Development Workgroup.

Chair Report

The chair reports the accomplishments related to the trainings and curriculum development that has been undertaken by the Curriculum Development Workgroup. Intermediate training was developed, approved, and delivered to the 15 model site programs. Advanced level curriculum is in development and is detailed below in the Curriculum Development section. In addition core level trainings were provided to the new 17 model site programs. Kansas City, Missouri's ATTC Tip 42 "Train the Trainer" training was provided to four participants this quarter. ATTC provides ongoing non-formal technical assistance to the staff.

Difficulties encountered this quarter were the change agent's expressions of feeling overwhelmed that were shared during the May Intermediate trainings. Technical assistance will be utilized in the next quarter to help with this situation.

Plans for the next quarter related to the finalization of the trainer-trainee manual for the Intermediate Curriculum, training all the model sites at the Intermediate level, continue core level training for any state agency or community organization that requests it, and work on formalizing the advanced curriculum. Another future plan is to disseminate trainings on TIP 42 designed by Regional ATTC.

Curriculum Development Workgroup

The workgroup met two times this quarter. Sixteen individuals were present during the April meeting. At the time this report was prepared, the June 14th meeting minutes were not ready. Smaller groups of subcommittee members have volunteered to

work on advanced curriculum goals. Progress on the four goals was discussed. Goal 1 involves providing clear expectations regarding co-occurring capable versus enhanced treatment. The second goal will introduce motivational interviewing and how to match treatment to stages of change. This represents a combination of previously defined goals 2 and 4. Education regarding mental health and substance abuse will be Goal 3. Goal 4 will define the parallel process. Deadline for completion is September 30th. Training locations are being coordinated.

Curriculum Development Workgroup Chair Report

The intensity of last quarter in terms of the creation of the Intermediate curriculum came to fruition in the conduction of two change agent trainings in Tulsa and Norman in May. Work continues on the development of the advanced level training with the subcommittee breaking down into smaller workgroups to gather information for each goal. Discussed issues related to the screening tool that will be used in the curriculum. More work remains before the manual is trainer friendly. Difficulties remain in terms of equitable distribution of the work. There are only a few people contributing consistently. This leads to another main concern of the chair which is the sustainability of trainings once the grant is over. The strategy to address this difficulty is to streamline the work into workgroups, provide encouragement to present members, and seek new participants. Plans for the next quarter are the finalization of the Intermediate level of learning and develop advanced training.

Data Reporting Workgroup

The Data Reporting Workgroup completed its tasks and was folded back into the Training and Workforce Development Subcommittee.

Welcoming, Screening, and Assessment

The subcommittee met once each month during this quarter. Discharge guidelines and protocol occupied the group's work. Much discussion throughout this period was on the different screening and assessment tools each facility uses and will use in the future. Members reviewed a list of optional tools. The list will hopefully be posted on the ODMHSAS website in September, 2007. Discharge guidelines and protocol were also reviewed. Final approval by the Advisory Committee will take place by email. The

members then discussed Dr. Mee-Lee's upcoming training on Co-occurring focused ASAM on July 9th.

Welcoming, Screening, and Assessment Chair Report

The accomplishment of the subcommittee was the establishment of protocol for screenings, assessments, and integrated treatment plans. Another activity of mention is the building of a data base of screening and assessment tools. A problem that was discussed was the mandatory use of the ASI. Individualized assessment as a goal does not mandate the use of any one instrument for all consumers. Staff turnover and the investment of time to bring them up to speed is a barrier to achieving the committee's work. An approach for dealing with this issue is the creation of an orientation book for change agents that would provide history. No technical assistance was sought, no issues from last quarter were carried over into this session, and no other concerns are present at the end of this quarter. The quarter will begin with continued work on the data base of screening and assessment tools.

Outcomes and Evaluations Subcommittee

The chair reported that the subcommittee has been included in a bigger evaluation committee within ODMHSAS that includes other agencies, but it did not meet.

Systems Integration Subcommittee

Eight people attended the meeting held on June 14th. Three topics were discussed before subcommittees shared their reports. The three topics included work that was in various stages. A draft of the COD enhanced statement of work (SOW) was presented. SOW is an outpatient contract that would host mental health and substance abuse services under one roof. Committee members were receptive. Todd Crawford provided an update on the incentive contracts and their established timelines. A highlight of the presentation was the congruency between the COD contract language and the committee recommendations. Members received copies of Chapters 17 and 18. Without any questions, the next meeting will move to a discussion of standards and necessary adjustments. A draft of a tool to measure COD capability on the organizational and program level was presented. The tool will provide more operational information and is to be self administered. The tool will yield a baseline and provide a measure for

improvement. Janie Hogue's agency has been piloting the tool and gave positive feedback regarding its use.

Subcommittee reports ensued. The Screening and Assessment Subcommittee reported on the finalization of the screening tool which will be ready for use by July 1st. The possibility of a residential pilot test of an integrated assessment process with recommended tools was presented with a potential to begin July 1, 2007 with five residential facilities.

The Training and Workforce Subcommittee indicated that the Intermediate level training of change agents was completed with the curriculum finalized and ready to print by August 2007. The advanced level curriculum outline is complete. The content is now being gathered. ISI trainers (Amber Hulme, Cindy Schultz, Joe Yosten, and Lance Dickinson) attended a May TIP 42 Training of Trainers (TOT) training in Kansas City. That information will be shared with change agents by summer 2008.

The Outcomes Subcommittee report included information about the GRPA and COD measures collection that is due to begin. The CDC has been changed with all model sites expected to screen and complete this section. Three new staff positions are posted to collect GRPA data in seven pilot sites with the plan to have the positions filled by August 2007.

Finance updates revolved around the completion of the integrated contract for CMHC's. Unfortunately, no new funding was offered to enhance programs this year. Existing dollars must be used to provide any COD enhancements as ODMHSAS continues to request funding.

The chair of Systems Integration, Billy Ray has too many work commitments to continue in the position. The focus in the next quarter will be on finding a new chair and working to see that the new drafts of the SOW and the measurement tools move toward finalization stages.

Systems Integration Subcommittee Chair Report

The chair indicated that the modification of the mental health and substance abuse contracts to include co-occurring language as the major accomplishment. In addition the development of statement of work for facilities to provide both mental health and substance abuse was undertaken this quarter. Overseeing the development and approval

of the screening tool and the Intermediate curriculum completion were activities carried over from last quarter. The inability to secure new legislative funding for integrated services is the major problem. Another issue is that the Integration Subcommittee is dependent on the other subcommittee's fulfillment of their mandate. Continuing to push for integrated policy and funding from the state to service delivery is the strategy for overcoming barriers. Work within the next quarter will be targeted toward program evaluation of integrated services and data collection for new measures.

Finance Subcommittee

The subcommittee did not meet during this quarter. The chair's report shares the development of a single provider contract to reflect the consolidated treatment of mental health and substance abuse services. Inclusion of co-occurring language related to awareness, training, and treatment is also a new addition. More state appropriated substance abuse funding is now utilized for co-occurring treatment. A continuing activity is the review of other state's funding agreements. The most promising state plan has not been shared which represents one problem encountered by the subcommittee. Another problem identified by the subcommittee chair is that the financial duties appear to be the last step in the process of implementation.

A significant barrier to the subcommittee's mandate is the lack of new monies for the initiative. The chair provides the example that all mental health funds are obligated; it would be problematic to take mental health funds from community mental health agencies to fund substance abuse agencies, which may not use the funds. The involvement of mental health and substance abuse agencies is needed to address this barrier. This will undoubtedly occupy next quarter's work along with the continued evaluation of other state plans.

The Regional Change Agent committees

Regional Change Agents: Norman

Seven members gathered for the first quarter meeting on April 28th. Nine people met for the last meeting on June 27th. The April meeting began with an update on relevant business from other subcommittees. The Training and Workforce subcommittee approved the Intermediate Training, the Welcoming, Screening, and Assessment

subcommittee is compiling a list of screening and assessment tools and a list of state funded and unfunded treatment facilities. Performance Improvement will meet every quarter and bring action plans for the Fidelity Scale. Dr. Khem will provide training to physicians. Brenda Pitts of ODMHSAS has a list of current change agents.

Kathy Otis-Davis is making revisions to letters of invitation for future collaborating agencies. A list of agencies to invite was generated. The letters were originally suggested by ODMHSAS. The group then worked on purposes for continuing the Regional Chang Agents meeting. Potential purposes were networking, identifying barriers, educating new programs and service providers, and training support. The meeting may be scheduled on a quarterly basis. Cindy Schultz will make a technical assistance request for Dr. Minkoff and Dr. Cline to attend a meeting prior to the end of September based on member's suggestion. It was suggested that executive directors' mandate trainings for physicians.

In June, people continued the work generated in April. The letter of invitation was revised, members were asked to bring the contact information for five agencies that they would like to receive the invitation letter to the September 2007 monthly change agent meetings. Dr. Minkoff and Dr. Cline will provide technical assistance August 20th. New ideas for the initiative were brought (lunch and learn, brochures, newsletters, posters in facility, policy/language change, survey of consumers in terms of defining recovery, purchase of resources in co-occurring area that you are weak in, honor past efforts to get us to this point, add co-occurring questions, and utilize grant team).

Chair Report Norman Regional Change Agents

The chair identified two major accomplishments this quarter: 1) establishment of ongoing regional core level trainings and 2) development of a network that provides support and encouragement to change agents that has led to increased confidence in the trainer role. Another significant activity has been the realization of the plan to involve other community agencies.

Ongoing issues from the previous quarters are the lack of clear communication from the grant staff and feeling overwhelmed with the dual obligations of being a change agent and a provider. The website is not updated frequently. Critical meetings, required trainings, deadlines are not always posted. Change agent duties require a lot of time that

takes away from current positions. In addition the absence of consistent involvement across agencies places the burden on a few representatives from a small number of agencies which increases the load on their individual work load and agency hours. The chairperson has become responsible for 90% of the committee work. This represents the main barrier to completion of the group mandate and the main concern of the chairperson. The approach to this inequity is to continue to work, provide encouragement, and offer to assist others in finding ways to increase involvement. Adding agencies is the planned activity for the next quarter. It is also suggested that ODMHSAS fund a position to work full-time on the initiative to ensure sustainability.

Regional Change Agents: Tulsa

The Tulsa Regional Change Agents met once during each month this quarter. The April meeting had seven members. Thirteen and twelve people representing a variety of agencies attended the May and June gathering respectively. The April meeting focused on networking and referrals, ISI subcommittee work, DTR training, DTR group leader list, and a review of the Fidelity Scale.

Members continued the discussion of networking, DTR, and subcommittees in May. The Fidelity Scale review also continued with the added emphasis that this scale will be replacing the COMPASS as a self evaluation tool for facilities. The 3rd COMPASS is due by July 1st. The need for a licensed professional to lead the core level and Intermediate trainings was reiterated in order for CEUs to be issued. Joe Yosten provided a selection of books and videos that he has used ISI dollars to purchase. He invited all change agents to keep a list of possible materials to buy and do the same. The annual change agent meeting was May 24th in OKC.

Networking and referrals was once again a theme for the final quarter meeting. Members were encouraged to become informed by reading notes from all the ISI subcommittee meetings on the ODMHSAS website. Clinical assessment and placement summary with a list of different agencies that provide each level of care was offered as a referral source. Change agents spoke about the beginning of Intermediate level training in July and the start of advanced level training in September.

Chair's Report Regional Change Agents: Tulsa

The subcommittee enjoyed five major accomplishments this quarter. Members established a system that informs all participants of ISI subcommittee business, broke down barriers that has denied access to different Tulsa programs, recruitment of new partners (Women and Children's, and ACE DUI School), the inter agency sharing of training and new program information, discussion on how to assist facilities and executive directors with the COSIG Initiative. Another notable achievement has been the inclusion of external partners such as the Oxford House, the leasing management and other staff from the Mental Health Association.

Ongoing issues are how to sustain the accomplishments, motivate staff for change, and balance being a change agent with the full case load of clients/consumers. Problems encountered are that some programs lack the full support of their organization. Barriers that prevent the realization of the committee mandate is the ability to sustain the process after the grant runs out, executive director support, staff turnover and helping new staff catch up. The subcommittee created two strategies to overcome the barriers. One is to gather input from leadership on how to sustain the process from the top down. The second is to establish more standards so the changes will be required policy that will be sustained. The plan for the next quarter is to change meeting locations to foster familiarity with different programs.

OK-COSIG Evaluation Team Activities

OU Evaluation Team Activities

The team met four times during the month of April. The beginning of the month was focused as always on completing the quarterly report from the previous period with the change of orienting individuals to the new SAMHSA reporting format. April work revolved around the arduous production of program reports which involved discussion of variables, analysis, and the write up of program fidelities. The end of the month the team also fulfilled the request of the Training and Workforce Subcommittee to conduct focus groups of the Intermediate level change agent training participants.

Five meetings took place in May. The team's time was consumed with data analysis and program report preparation. The evaluation of the two Intermediate Trainings was also a major project that was completed over the weekends following the two trainings. Three team members conducted two focus groups after change agents completed the initial Intermediate Trainings. Results were analyzed and immediately provided to the trainers. Fidelities and key informant interviews for 2007 were planned this month as well. Preparation of the quarterly report was discussed.

The evaluation team members submitted a proposal to the Hawaii International Conference on Social Sciences, (May 30 through June 2, 2007) to do a presentation on the value of screening for a co-occurring disorder. It was accepted as a paper presentation and it was delivered by the team on May 31st.

The team met in person three times in the month of June regarding the progress on the key informant interview and fidelity completion, data analysis, and program reports. Members will continue to focus on these jobs in the next quarter.

OU Evaluation Team Chair Report

The completion of the testing, analyses and revise the screen has been an arduous and trying task. And, although many of the barriers to universal screening for a co-occurring disorder are still intact (training, time involved, cost, and an infrastructure where everyone seeking mental health or substance abuse services is screened), the *lack of a rapid response, co-occurring screen* that is accurate, takes little training, and is easy to administer—*has been eliminated*. The statistical analysis of the AC-OK Screen has shown that this screen is highly reliable, valid, very **sensitive, and has high levels of specificity**.

MACRO Evaluation

One of the efforts over the last year has been to develop a structure between the evaluation team and the ISI committee chairs and key informants so that data can be collected in a consistent way. The system we are using seems to finally be working quite well. Part of this effort was relationship building. It required developing a formal structure for reporting activities and developing a system of personal contact near the end of each quarter. This achievement is very important because the evaluation budgets in years four and five are very small and will not allow for much more than reviewing

Outcome Evaluation for the 3rd Quarter — Year 3

Service Coordination and Networking: The analysis of the FY 05 data needed to construct a base line for the Model and Control programs is underway. The analysis of the qualitative data will continue during the next quarter.

Service Recipient Outcomes for Services Pilot: The methodology for doing the micro level evaluation has changed because of the micro level data that will be collected for SAMHSA. This data will be used to report on Service Recipient Outcomes.

Cultural Appropriateness of Evaluation: The evaluators are sensitive to the importance of agency staff and services to people with a co-occurring disorder being culturally and gender sensitive and competent. As the work of consensus building among the Tribal Nations continues, evaluation team members hope to become better informed about the process and report on the cultural fit and other related issues.

Plans for Using the Findings of the Evaluation. The quarterly reports and evaluation findings are distributed to the Governor's liaison and oversight committee and the COSIG Advisory Group.

Involvement of Members of the Target Population in the Design and Implementation of the Evaluation. The OK-COSIG Advisory Group will have a primary role in examining and approving all training and evaluation protocols being planned for use in the project. Although it has been difficult to maintain consumer participation, the 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 3rd 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:

A great deal of progress has been made on this Objective.

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 since the beginning of the Project. 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 is moving forward at a good pace. The draft language for the LADC statutes to treat people with a co-occurring disorder was supported by the other licensure boards and has become law. The staff is also working with the Board of Licensed Professional Counselor, the Social Work Licensure Board, and the Board that licenses Behavioral Health practitioners on similar language.

Objective 2.3 –

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

Status:

- Incentives that reward model programs for reaching objectives related to co-occurring capable programming has been developed and will be funded out of the OK-COSIG grant.
- The changes in language in Chapters 17 (the Standards and Criteria for Community Mental Health Centers) and in Chapter 18 (the Standards and Criteria for Alcohol and Drug Treatment Programs) is a major strategic change that will motivate the implementation of integrated treatment systems at the provider level.

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 data collected on the screen has been analyzed and a final revision has been produced. The statistical analysis of the AC-OK Screen has shown that this screen is highly reliable, valid, very **sensitive, and has high levels of specificity.** A report to the ODMHSAS leadership has been submitted (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 15 Model Programs and Program Fidelity data will be collected on the 13 additional model programs this year. 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 and we have started collecting the second round of data.

- 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 and we have started collecting data for year 3.

- 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*

Emerging Themes

In the 3rd quarter of this third year, a number of themes identified in year one and two have been addressed or are being addressed. With the addition of 13 new model programs, new themes and variations on old themes are evolving that are important to the process of providing integrated services for people with a co-occurring disorder in Oklahoma.

Training Development

The three groups under the Training and Workforce Subcommittee finished the development and evaluated the Intermediate Training curricular. The staff are continuing to deliver Core-Level trainings. Ten were conducted in the last quarter. They will be working on the advanced curriculum in the next quarter. Orientation and Core Level trainings are being delivered to the new model programs.

Change Agents Feeling Overwhelmed

Change agents have clearly expressed feelings of being overwhelmed. They talk about trying to balance being a Change Agent and carrying a full caseload of clients/consumers. To address this issue, technical assistance will be provided in the next quarter. Dr. Minkoff and Dr. Cline will provide technical assistance August 20th. ODMHSAS leadership is aware of the situation. The Project staff are working on developing other supports.

Sustainability

There is the realization among clinicians and staff that have been involved in the OK-COSIG project over the last three years that the project will be coming to an end in the near future. They are concerned about sustainability and are interested in strategies to maintain the changes that have been made over the last three years. The discussion about sustainability needs to begin. The education and training provided by this grant, the

efforts to integrate mental health and substance abuse services at the Department level, and the changes in Chapters 17 and 18 will go a long way in sustaining these changes.

The ASI as a Redundant Assessment Tool

A discussion about the weaknesses of the ASI and it being the mandatory assessment tool required of agencies providing substance abuse treatment has come up several times. Steps are being taken to allow several agencies to try different approaches.

Engage the Tribal Nations of Oklahoma

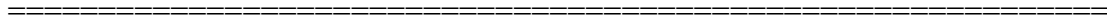
The inclusion of the Tribal Nations is receiving more attention and this effort will need to be sustained. The work and support of the Choctaw Nation and their application for a grant thru the Bureau of Indian Affairs (that is very similar to the OK-COSIG grant) is a partial response to this need.

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 staff is aware of the situation and the Access to Recovery Grant application was a partial response to this concern.



Postscript

Work since the beginning of the Project in 2004 is beginning to show a great deal of results. Curriculum development and training has been ongoing, engaging new programs is succeeding, the work on credentialing is making progress. Most importantly, Chapter 17 and Chapter 18 will go a long way to sustain the changes made and changes still needing to be made so that all mental health and substance abuse treatment programs funded by ODMHSAS will be co-occurring disorder capable programs.

APPENDIX

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

Appendix A: Report to the ODMHSAS Leadership on the development of the co-occurring screen.

Appendix B: Report on the Intermediate Training focus groups responses.

Appendix C: Changes in Chapter 17 and 18—Standards and Criteria

Appendix A: Report to the ODMHSAS Leadership on the development of the co-occurring screen.

Recommendation to ODMHSAS leadership on a screen to identify people with co-occurring disorders

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Friday, May 18, 2007

These studies were conducted in conjunction with a SAMHSA COSIG Project. My thanks for the cooperation on this screen development project go to the Oklahoma Department of Mental Health and Substance Abuse Services and the nine agencies that participated in piloting the Screens from which the AC/OK Screen was developed. They are: Bill Willis CMHC, Family and Children's Services, Gateway to Prevention and Recovery, Grand Lake M.H.C., Norman Alcohol Center, Norman Alcohol Information Center, OK County Crisis Intervention Center, Tulsa Center for Behavioral Health, and 12 & 12.

Running header: The AC-OK Screen for Co-Occurring Disorders

Do Not Copy any part of this document without permission from Dr. Andrew L. Cherry, The Oklahoma Endowed Professor of Mental Health, School of Social Work, University of Oklahoma, Tulsa.

Recommendation to ODMHSAS leadership on a screen to identify people with co-occurring disorders

Based on the two studies to develop a screen to identify people with co-occurring disorders, that has taken over 2 ½ years, the attached third iteration of the original screen items is the version that I am recommending. The number of items has been reduced to the bare minimum. The phraseology is succinct and clear. It has good reliability and it has high levels of specificity and sensitivity.

As important as these psychometric properties are to the screen, I recommend the AC-OK Screen for Co-Occurring Disorders because it can be administered and scored in less than 5 minutes. This is important considering that an estimated 35% or 1 in 3 people who present at an Oklahoma mental health or substance abuse agency (with ODMHSAS contract) will have a co-occurring disorder. Although many of the barriers to universal screening for a co-occurring disorder are still intact (training, time involved, cost, and an infrastructure where everyone seeking mental health or substance abuse services is screened), the *lack of a rapid response, co-occurring screen* that is accurate, takes little training, and is easy to administer—*has been eliminated*.

Brief Overview

Screening for the co-occurring disorders of mental health and substance abuse has been recognized as a best practice (SAMHSA, 2005). Universal screening, however, is far from being a reality.

To provide increased and upgraded treatment options for people with a co-occurring disorder, one of the first steps is to identify people at risk. *Screening* is defined as a brief process that collects only enough detailed information to determine if the person needs a full, more sophisticated assessment. The screening process can also provide important information to potential consumers that can assist them in clarifying their own position regarding treatment (Health-Canada, 2002; Rosenberg, et al. 1998).

This summary is based on two previous studies designed to test the reliability, sensitivity, and specificity of three screening subscales (mental health, substance abuse, and trauma). The analysis of the AC COD Screen was based on 234 respondents who were screened with the instrument. The analysis of the OK Online Screen is based on the responses of 3,608 people who were screened between February and November of 2006.

Given these two studies, there are several critical changes that need to be made to the OK Online COD Screen. The Substance Abuse subscale continues to be strong but it has a problem with terminology that introduces a validity issue referred to as “social desirability.” Rather than being grammatically correct, natural language is often used in psychometric scales to avoid responses to “emotionally laden words.” In this case the word “drunk” is used in two items in the OK Online COD Screen. Based on the reliability of these items compared to the first version indicates that the word needs to be dropped. In the AC-OK Screen for Co-Occurring Disorders these two items have been rephrased to avoid the influence of “social desirability.”

A more serious problem is with the Trauma subscale. This scale has an unacceptably low reliability coefficient ($\alpha = .60$). A coefficient of .70 out of a 100 is the low end scores that are considered acceptable. As a stand alone subscale, the Trauma scale is unacceptable.

Based on the results of several Factor Analyses, the problem is that the items in the Trauma subscale are mental health related. This is appropriate because it is a screen designed to be used by behavioral health treatment centers and clinicians. However, these items are picking up trauma related mental health issues.

This is a serious problem because we would not want people to think this was a good Trauma scale when it is not very reliable. As a stand alone subscale, the results of using the OK Online COD Screen Trauma scale would be slightly better than flipping a coin where “heads” indicates Trauma and “tails” indicates no Trauma indicated.

To avoid this hazard, the items have been incorporated into the mental health subscale and one item is not included as a trauma item. In the final version, the items are identified as “Trauma Related Mental Health Issues.” These changes increased the reliability coefficient of the mental health subscale from a .74 to a .79.

The following is a standard description used to report the properties of a psychometric scale. This is followed by a short bibliography and a Screen Form with instructions.

Instrument Description & Properties

- Name:** AC-OK Screen for Co-Occurring Disorders (Mental Health, Trauma & Substance Abuse)
- Purpose:** The AC-OK Screen for Co-Occurring Disorders (Mental Health, Trauma & Substance Abuse) was designed to determine if a person who asks for help from either a mental health agency or a substance abuse treatment agency needs to be assessed for the possible co-occurring disorders of Mental Health, Trauma and Substance Abuse.
- Background:** AC-OK Screen for Co-Occurring Disorders is based on two previous studies designed to test the reliability, sensitivity, and specificity of a screen designed encompass three domains (mental health, substance abuse, and trauma). The pilot study analysis was based on screens completed on 234 people seeking treatment from either a mental health or substance abuse treatment agency. The analysis of the second study was based on responses from 3,608 people seeking treatment from either a mental health or substance abuse treatment agency.
- Scoring:** One (1) “Yes” answer on any of the three (3) domains (Mental Health, Trauma and Substance Abuse) indicates that an additional assessment(s) is needed in that domain. The items associated with each scale domains are:
Mental Health Issues: 7 , 8 , 9 , 10 , 11 , 12 , 13
Trauma Related Mental Health Issues: 14 , 15
Substance Abuse Issues: 1 , 2 , 3 , 4 , 5 , 6
- Reliability:** Reliability of the Screen scales:
Mental Health scale ($\alpha = .79$).
Substance Abuse scale ($\alpha = .89$)
- Validity:** The items used in this instrument are similar to items used in familiar assessments instruments such as the CAR, the ASI, ASAM, the BSI, the MMPI, etc.
- Specificity and Sensitivity:**
To determine specificity, the findings of the screen were compared to the CAR-psy, the ASI-psy, and the DSM-IV diagnosis. In this comparison the screen matched the assessment in over 90% of the cases on which assessment information was available.
- Reading level of Screen:**
Flesch Reading ease: .61
Flesch-Kincaid Grade Level: 6.5
- Primary References:**
Detailed reports are available on each of these studies at http://faculty-staff.ou.edu/C/Andrew.L.Cherry-1.Jr/AC-OK_CODScreenPg.htm
- Availability:** A copy of the AC/OK Screen for Co-Occurring Disorders can be downloaded from <http://faculty-staff.ou.edu/C/Andrew.L.Cherry-1.Jr/AC-CODScreenPg.htm>

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**AC-OK Screen for Co-Occurring Disorders
(Mental Health, Trauma & Substance Abuse)**

First Name: _____ Last Name: _____
 Gender: _____ Date of Birth: _____ Date of Screening: _____

During the past year:

1. Have you been preoccupied with drinking alcohol and/or using other drugs? Yes No
 2. Have you experienced problems caused by drinking alcohol and/or using other drugs, and you kept using? Yes No
 3. Do you, at times, drink alcohol and/or used other drugs more than you intended? Yes No
 4. Have you needed to drink more alcohol and/or use more drugs to get the same effect you used to get with less? Yes No
 5. Do you, at times, drink alcohol and/or used other drugs to alter the way you feel? Yes No
 6. Have you tried to stop drinking alcohol and/or using other drugs, but couldn't? Yes No
 7. Have you experienced serious depression (felt sadness, hopelessness, loss of interest, change of appetite or sleep pattern, difficulty going about your daily activities)? Yes No
 8. Have you experienced thoughts of harming yourself? Yes No
 9. Have you experienced a period of time when your thinking speeds up and you have trouble keeping up with your thoughts? Yes No
 10. Have you attempted suicide? Yes No
 11. Have you had periods of time where you felt that you could not trust family or friends. Yes No
 12. Have you been prescribed medication for any psychological or emotional problem? Yes No
 13. Have you experienced hallucinations (heard or seen things others do not hear or see)? Yes No
 14. Have you ever been hit, slapped, kicked, emotionally or sexually hurt, or threatened by someone? Yes No
 15. Have you experienced a traumatic event and since had repeated nightmares/dreams and/or anxiety which interferes with you leading a normal life? Yes No
-
-

Instructions: For the **AC-OK Screen for Co-Occurring Disorders (Mental Health, Trauma & Substance Abuse)**

“I’m glad you called; let’s see how I can help. In your own words, what is going on, OR can you tell me a little about why you called (today)?”

“In order to find the best services for you, I’d like to ask you a few short yes or no questions to see if there is anything we may have missed. There are no ‘right’ or ‘wrong’ answers and these questions may or may not apply to your situation. Is this okay with you?”

- This screen should be used when a person first contacts the agency for services.
- This screen is only a tool to help identify potential areas that may need further assessment. Please note: **This is NOT a diagnostic tool and should not be used as an assessment.**
- Please read each question *exactly* as written in the *order* provided.
- If a potential crisis is identified during the screening, please follow your agency protocols immediately to assess for lethality and provide appropriate intervention.
- Positive indicators (one “YES” answers), in any three (3) domains indicates that an assessment(s) is needed in that domain.

Scoring: Remember, one (1) “Yes” answer on any of the three (3) domains (Mental Health, Trauma and Substance Abuse) indicates that an additional assessment(s) is needed in that domain.

Mental Health Issues: 7 , 8 , 9 , 10 , 11 , 12 , 13

Trauma Related Mental Health Issues: 14 , 15

Substance Abuse Issues: 1 , 2 , 3 , 4 , 5 , 6

Reliability of the Screen scales:

Mental Health scale ($\alpha = .79$).

Substance Abuse scale ($\alpha = .89$)

Reading level of Screen:

Flesch Reading ease: .61

Flesch-Kincaid Grade Level: 6.5

Appendix B: Report on the Intermediate Training focus groups responses.

Evaluation Report on the first Co-Occurring Capable Intermediate Level Training

This report is based on the Focus Group responses to the Co-Occurring Capable Intermediate Level Training May 2 & 3, 2007 held at TCBH on Wednesday and 12 & 12 on Thursday.

Nine of the 17 participants change agents who participated in the two day training were selected randomly to participate in the focus group. They all volunteered to stay after the training. A letter outlining confidentiality as related to their comments about the training was read to the group. After hearing the terms of confidentiality and the expectations as participants in the focus group, they agreed to volunteer to be participants in the focus group. The following is a summary of the 1 hour and 30 minute focus group session.

- I. There were a number of positive statements about the training.
 - A. A real positive is that the participants recognized that they need this type of training.
 - B. The exercises were very helpful. The participants suggested adding more exercises.
 - 1) The participants pointed out that the Fundamentals of Recovery was a key content area that they felt was necessary and effective.
 - 2) They noted the role play in the screening and welcoming component was also effective.
 - C. The group as a whole agreed that Katie Henson was an excellent presenter.
 - D. The amount of material given to the participants was overwhelming; however, the mood among the focus group participants was sober and realistic.
 - 1) The group members were very realistic in that they expect they will have to work hard to prepare to do similar trainings in their agencies.
 - 2) They expect the people they will train will react much as they did to the training. There will be many questions about the material and concepts.
- II. There are areas where improvements can be made.
 - A. The workshop was "too chaotic." More structure was needed.
 - 1) The constant question's from participants was the main cause for the feeling of chaos.
 - 2) Presenters need to control the flow of the presentation, not the participants.
 - 3) There were two suggestions. Have participants hold all questions until the end of the presentation. Or, have participants turn in written questions.
 - B. Presenters need to stay on topic and follow their power point presentations.
 - C. Two examples used in the presentation drew criticism. The suggestion was to alter them slightly. The reason these changes were suggested is that the examples seriously disrupted the presentations and the flow of information.
 - 1) One was the Bi-polar example. It needs to be presented in such a way as not to imply that "stealing" is a symptom of a Bi-polar disorder.
 - 2) Two, the cigarette example needs to be dropped, and a secondary drug needs to be used as the example.
 - D. The CDC presentation was too long and could have been shortened.
 - E. Participants suggested shortening the "Welcoming" part of the "Welcoming and Screening" presentation and spend more time on the "Screening" part. They observed that much of the material about "Welcoming" had been presented in the core level training.
 - F. The participants wanted more skills training in how to do trainings.
 - G. Presenters need to avoid "talking down" to participants.
 - H. The July deadline for implementing the changes created a great deal of expressed anxiety.
 - I. On a scale of 1 to 10, the participants gave the workshop a score of "8" on the question about the training relating to data reporting. However, the participants gave the training a "6" when asked how would they score the training as a whole.

Conclusion:

The majority of the discussion was concerning technical issues related to the presentation of the materials and the way in which the presentations were conducted. These should be very easy to change before the training on May 16 and 17.

We appreciate the focus group participant's insight and willingness to actively participate in the focus group process. As evaluators, we could not have asked for a better group.

Submitted on: 5-7-7

Submitted by: The OU Evaluation Team

Evaluation Report on the second Co-Occurring Capable Intermediate Level Training

This report is based on the Focus Group responses to the Co-Occurring Capable Intermediate Level Training May 23 & 24, 2007 held at Sarkeys Foundation, Norman.

Nine of the 20 Change Agents who participated in the two day training were selected randomly to participate in the focus group. They all volunteered to stay after the training. A letter outlining confidentiality as related to their comments about the training was read to the group. After hearing the terms of confidentiality and the expectations as participants in the focus group, they agreed to volunteer to be participants in the focus group. The following is a summary of the 1 hour and 30 minute focus group session.

A. Themes

1. The participants take very seriously their role as Change Agents. They accept the fact that it requires time above and beyond their job description. They view their work as a contribution to improving services to people with a co-occurring disorder in Oklahoma. They attended the training to learn how to provide training to their agency staff on the Co-Occurring Capable Intermediate Level curriculum.
2. After the training the participants did not feel prepared to conduct the Intermediate Level training. This theme was shared by the first group. Participants were also unsure if the materials provided were the actual training manual that they should use. They expressed concern that some sections were missing and the materials would change.
3. The lack of a method for answering questions during the presentations (verbal or written) was frustrating to participants.
4. They were concerned that some of the material was covered in the Core Level training. It seemed redundant. Additionally, although they admired the enthusiasm that the presenter had for the statistics from the ISIC data, the consensus was that some of the information was not pertinent for all of their staff and four hours was far too long to spend on this section.
5. The trauma portion of the training was well received and for these participants it represented new information or content. The participants speculated that when doing trainings at their agency, it might go over better if they used the trauma training as a platform to deliver the rest of the intermediate training to the staff at their agencies. Significant to this project and the process of collaboration among mental health and substance abuse treatment practitioners, the trauma piece appears to be an issue which both groups realize their clients share.
6. It was pointed out that there was a lack of the consumer voice in the training.
7. A related concern was the lack of content of diversity and cultural competency. It was pointed out that there was a lack of racial and ethnic diversity among the Change Agents at the training. The point was that the population being served is much more diverse.
8. It was also clear at this focus group that it takes an immense amount of time to prepare and conduct the trainings. This is time when they and those being trained cannot provide services to consumers. They and the staff at their agencies are compensating for this situation by working 10 and 11 hour days.

The Change Agents are obviously under a great deal of pressure. The concern is that the extra hours of work will increase turnover of staff and cause other problems such as “burn out.” This, we believe is why they wanted more of a curriculum that would be easy to deliver. They expressed a uniform concern that they would need to do a great deal of work before they could do the training themselves. The July deadline for having their staff trained in the Core Level and the Intermediate Level by the July deadline is creating a great deal of expressed anxiety. There may be some agencies that have not finished training all of their staff on the Core Level.

9. The participants’ verbalized that the focus group was a good debriefing exercise. They recognized that trainings must be tailored to each agency. They also began the process of identifying the expertise and weaknesses of personnel at their agencies needed to deliver the training. But most importantly, they talked to each other and did some problem solving.

They talked of sharing resources. They discussed the potential of cross agency collaboration relating to training on sections like the ASAM, ASI, and the CAR. This situation offers a real opportunity for collaboration between mental health and substance abuse treatment practitioners. It needs to be nurtured by COSIG staff.

10. In the past, the Regional Change Agent meetings were used to share ideas about doing the Core Level Trainings. The participants reported that these meetings were very useful and facilitated the adjustments they made to accommodate their specific agency environment. Given the feedback from the participants, the meetings should continue to be a forum where they can share ideas about conducting the Intermediate Level Training.

B. Recommendations

1. Consider developing more skills training on how to train. The participants need more exercises and examples they can use when doing the training.
2. Consider cutting down on the section with the statistics. There are some of us that do enjoy statistics but it could be shortened. The Change Agents were concerned that they had to deliver all of that content.
3. Adding content to the Intermediate Level Training curriculum about diversity and culture that is relevant to practice.
4. Add the “consumer’s voice” in the training material.
5. In future trainings, develop a method for participants to ask questions, either at the end of the sessions for individual questions and answers, have participants write questions that will be answered within the training period, by email, or other method.
6. In future trainings, try to begin the training with the trauma content and have trauma frame the remaining elements or reference back (for example in terms of “Welcoming”).
7. To facilitate the work of the Change Agents in preparing to do the Intermediate Level Training, the OK-COSIG staff could help by attending regional Change Agent meetings and providing technical assistance on how to best adapt the training to the needs of their agencies.

We wish to acknowledge again our appreciation for the focus group participant’s insight and willingness to actively participate in the focus group process. As evaluators, we could not have asked for a better group of professionals.

Appendix C: 2007 Changes in Chapter 17 and 18—Standards and Criteria

The following are the changes in language in ODMHSAS's Administrative code Chapters 17 (the Standards and Criteria for Community Mental Health Centers). The changes in and Chapter 18 (the Standards and Criteria for Alcohol and Drug Treatment Programs) related to co-occurring are as comprehensive.

These Administrative Rules can be viewed at:

<http://www.odmhsas.org/AdminRules.htm>

Chapter 17:

450:17-1-2. Definitions

The following words or terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Abuse" means the causing or permitting of harm or threatened harm to the health, safety, or welfare of a resident by a staff responsible for the resident's health, safety, or welfare, including but not limited to: non-accidental physical injury or mental anguish; sexual abuse; sexual exploitation; use of mechanical restraints without proper authority; the intentional use of excessive or unauthorized force aimed at hurting or injuring the resident; or deprivation of food, clothing, shelter, or healthcare by a staff responsible for providing these services to a resident.

"Adults who have a serious mental illness" are persons eighteen (18) years of age or older who meet the following criteria:

(A) Currently or at any time during the past year have had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet criteria specified within DSM-IV with the exception of "V" codes, substance abuse disorders, and developmental disorders, unless they co-occur with another diagnosable serious mental illness; and

"Chronic Homelessness" refers to an individual with a disabling condition who has either: (a) been continuously homeless for a year or more, or (b) has had at least 4 episodes of homelessness in the past 3 years. For this condition, the individual must have been on the streets or in an emergency shelter (i.e. not transitional housing) during these episodes. Chronic homelessness only includes single individuals, not families. A disabling condition is a diagnosable substance abuse disorder, serious mental illness, or developmental disability, including the co-occurrence of two or more of these conditions.

Defined in Chapter 17 as:

"Consumer committee" or **"consumer government"** means any established group within the facility comprised of consumers, led by consumers and meets regularly to address consumer concerns to support the overall operations of the facility.

"Co-occurring disorder" means any combination of mental health and substance abuse symptoms or diagnoses in a consumer.

"Co-occurring disorder capability" means the organized capacity within any type of program to routinely screen, identify, assess, and provide properly matched interventions to individuals with co-occurring disorders.

"Co-occurring disorder enhanced" means that the program (or subunit of the program) provides a specialized service designed for individuals with co-occurring disorders, usually with a higher level of available service capacity or intensity for the co-occurring

substance use disorder than would be the case in a comparable co-occurring disorder capable program.

SUBCHAPTER 3. REQUIRED SERVICES

PART 1. REQUIRED SERVICES

450:17-3-1. Required core services

The services in this subchapter are core services, are required of each CMHC, and are required to be provided in a co-occurring capable manner.

PART 3. SCREENING, INTAKE, ASSESSMENT AND REFERRAL

450:17-3-21. Integrated screening, intake, and assessment services

(a) CMHC policy and procedure shall require that a screening of each consumer's service needs is completed in a timely manner. An integrated screening should be welcoming and culturally appropriate, as well as maximize recognition of the prevalence of co-occurring disorders among those who typically present for services at a Community Mental Health Center.

PART 5. EMERGENCY SERVICES

450:17-3-41. Emergency services

(a) CMHCs shall provide, on a twenty-four (24) hour basis, accessible co-occurring disorder capable services for substance abuse and/or psychiatric emergencies.

450:17-3-43. Emergency examinations, staffing

(a) Staff providing emergency examinations shall be an LMHP as defined in 43A O.S. § 1-103 and meet the CMHC's privileging requirements for the provision of emergency services, which shall include core competency in emergency evaluation of co-occurring disorders.

PART 7. OUTPATIENT COUNSELING SERVICES

450:17-3-61. Outpatient counseling services

(a) Facilities that provide outpatient services shall offer a range of co-occurring disorder capable services to consumers based on their needs regarding emotional, social and behavioral problems. These outpatient counseling services shall be provided or arranged for, and shall include, but not be limited to the following:

450:17-3-62. Outpatient counseling services, substance abuse

(a) Facilities shall provide co-occurring disorder capable outpatient substance abuse counseling services.

PART 9. MEDICATION CLINIC SERVICES

450:17-3-81. Medication clinic services

- (a) Medication clinic services shall include an assessment of each individual's condition and needs; and an assessment of the effectiveness of those services.
- (b) Medication clinic services shall be co-occurring capable and shall utilize accepted practice guidelines for psychopharmacologic management of co-occurring disorders.
- (c) CMHCs shall offer comprehensive medication clinic services to consumers in need of this service, including, but not limited to:

PART 9. MEDICATION CLINIC SERVICES

450:17-3-81. Medication clinic services

- (a) Medication clinic services shall include an assessment of each individual's condition and needs; and an assessment of the effectiveness of those services.
- (b) Medication clinic services shall be co-occurring capable and shall utilize accepted practice guidelines for psychopharmacologic management of co-occurring disorders.
- (c) CMHCs shall offer comprehensive medication clinic services to consumers in need of this service, including, but not limited to:

PART 11. CASE MANAGEMENT

450:17-3-101. Case management services, adult

- (a) Case management efforts shall empower consumers to access and use needed services and meet self-determined goals. These services include resource skills development and consumer advocacy provided in various settings based on consumer need.
- (b) Case management services shall be co-occurring disorder capable and made available to all adults who have a serious mental illness, and shall provide the following:
- (1) Screening to determine their need for case management services, which shall include evidence the following were evaluated:

450:17-3-101.1. Case management services, child, adolescent and family

- (a) Case management services shall be co-occurring disorder capable and offered to children and their families to assure access to needed services. This includes referral, linkage and advocacy. These services may be offered to any child or family who presents for service at a community mental health center but must be offered to a child identified as Seriously Emotionally Disturbed. Services should be offered in a manner that engages families in intervention strategies which promote healthy decisions regarding substance use in order to promote healthy support for the presenting child.
- (c) Psychiatric rehabilitation programs recognize that co-occurring substance abuse disorders will be common place among many of the participants in these programs. As such, the program shall be co-occurring disorder capable and facilitate processes for dual recovery for these individuals.
- (D) Provision of integrated interventions to address co-occurring issues in the child and/or family.

PART 7. DAY TREATMENT SERVICES, CHILDREN AND ADOLESCENTS

450:17-5-34. Day treatment services for children and adolescents

- (a) Day treatment services are designed for non-residential consumers who spend only a part of a twenty-four (24) hour period in the program.
- (1) Hours of operation shall be held during periods which make it possible for consumers to receive a minimum of three (3) hours of treatment and services each day in the program, excluding time spent in fulfillment of academic educational activities as required by law; days and hours of operation shall be regularly scheduled and conspicuously displayed so as to communicate the schedule to the public; and
- (2) Services provided shall be co-occurring disorders capable and include, at a minimum, the following:
- (b) If offered by a CMHC, vocational employment services should be co-occurring disorder capable and be available to individuals with co-occurring disorders who are interested in work as a goal, even if they are not yet abstinent.

PART 11. COMMUNITY LIVING PROGRAMS

450:17-5-56. Community living programs

- (a) Community living programs shall be co-occurring disorders capable and include at least one of the following two types of supportive housing options for persons not in crisis who need assistance with obtaining and maintaining an independent living situation:

PART 15. INPATIENT SERVICES

450:17-5-95. Inpatient services within the community mental health setting

- (a) Inpatient services are intended to meet the needs of consumers through evaluation, treatment, and stabilization.
- (b) Inpatient services shall be co-occurring disorders capable and include:

(5) A multidisciplinary co-occurring disorder competent treatment team, including twenty-four (24) hour psychiatric nursing, and a medical staff, shall be employed to meet the broad clinical needs of consumers.

SUBCHAPTER 13. ORGANIZATIONAL MANAGEMENT

450:17-13-1. Organizational and facility description

(a) The CMHC shall have a written organizational description which is reviewed annually and minimally includes:

- (1) The overall target population specifically including welcoming those individuals with co-occurring disorders, for whom services will be provided;
- (2) The overall mission statement; and
- (3) The annual facility goals and objectives, including the goal of continued progress for the agency in providing recovery oriented, culturally competent, trauma informed and co-occurring capable services.

(b) The CMHC's governing authority shall review and approve the mission statement and annual goals and objectives and document their approval.

((4) Goals and objectives, including making progress toward co-occurring capable, trauma informed, and culturally competent service delivery; and

(5) Delineation of processes to assure welcoming accessible, integrated, and co-occurring capable services and a plan for how each program component will address the needs of individuals with co-occurring disorders.

(f) The CMHC shall have written statement of the quality improvement processes, procedures and plans for attaining the organization's goals and objectives. These procedures and plans shall define specific tasks, including actions regarding the organization's co-occurring capability set target dates and designate staff responsible for carrying out the procedures and plans.

(7) Self-assessment tools to determine progress toward co-occurring, recovery oriented, trauma informed and consumer driven capability.

(5) Improvement in the following:

(A) co-occurring capability, including the utilization of self-assessment tools as determined or recommended by ODMHSAS;

450:17-19-2. Job descriptions

(a) There shall be job descriptions for all positions setting forth minimum qualifications and duties of each position.

(b) All job descriptions shall include an expectation of core competencies in relation to individuals with co-occurring disorders.

(c) Compliance with 450:17-19-2 shall be determined by a review of written job descriptions for all facility positions, and other supporting documentation provided.

(d) Staff competency development shall be aligned with the organization's goals related to co-occurring capability, and incorporate a training plan, training activities, and supervision designed to improve co-occurring core competencies of all staff.

(8) Co-occurring disorder competency and treatment principles.