

***OK-COSIG***  
***Quarterly Evaluation Report***

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## **Acknowledgement**

In the 3<sup>rd</sup> Quarter, the OK-COSIG team continued to focus on providing core training and workshops, consensus building with the three Executive Committees of Model Site Directors, working to recruit the next cohort of programs to be model programs in year three of the OK-COSIG project, and coordination and collaboration with other TSIG initiatives.

The flow of information between the Evaluation team members and the OK-COSIG staff continues to be open and supportive. This level of cooperation between the Evaluation team and the OK-COSIG team is needed to be able to collect data that will describe the outcomes of the consumers and the program components that produced the outcome.

The OK-COSIG Evaluation Team was very busy this last quarter. The work over the past year and nine months is taking shape. Additionally, the framework for the Macro, Mezzo, and Micro evaluations (the Institutional Review Board (IRB) approvals) has been received from the OU IRB. The ODMHSAS IRB has approved all but the Micro study which is expected by mid July. Both IRB's have been enormously helpful to the Evaluation Team.

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### **How this quarterly evaluation report is organized**

This 3<sup>rd</sup> Quarterly report for the second year of this project begins with 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, 2006 through June 30, 2006). This will be followed by a list of the implementation activities that were carried out during the 3<sup>rd</sup> Quarter. Next a summary of the work completed by the ISI Advisory Group sub-committee 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 last quarter will be described.

**Editorial note:** The Quarterly Reports produced during the second 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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## **Executive Summary**

*With only three (3) months left in this Second year of the OK-COSIG project, the preparation work to begin the task of gathering a major portion of the data that will be used to determine the Fidelity and Outcome of the O K-COSIG project is almost complete.* In the final quarter of this second year, the OK-COSIG evaluation team will finish gathering the baseline data for all three levels of the evaluation (MACRO, MEZZO, and MICRO). The data collected is the raw data that consist of: observations at the State Department level, observations of the work of the pilot programs, and both qualitative and quantitative data from consumers who used the services for people with a co-occurring disorder provided by the 15 model programs.

In the first year there was a great deal of work accomplished in terms of identifying an integrative model and developing a consensus to support the integrative system model to treat people with co-occurring disorders. The Change Agent concept was adopted and initial training provided. A Change Agent is a clinical person with additional training related to providing integrated services to people with a co-occurring disorder who advocates and acts as a consultant to staff and professionals at his or her agency. The training needs, competencies, and curricula were identified. The OK-COD Integrative Treatment Screen was developed. It is online as a part of the ICIS system. It will be tested for reliability, validity, and sensitivity and specificity this year. The OK-COSIG staff have been working collaboratively with the three Executive Committees of Model Site Directors on how the Memorandum of Understanding can improve cooperation and treatment outcomes. OK-COSIG staff has also joined in the work and support the overall ODMHSAS transformation initiative. As the other ODMHSAS initiatives come online and take their place in the infrastructure, the OK-COSIG staff can and will be able to provide helpful information given their experience developing integrative services for people with a co-occurring disorder.

In the second year, consensus building among the shareholders, workshops and core trainings, identifying agencies for the second cohort of pilot programs, and participating in the overall transition under the TSIG initiative has been a major focus of the OK-COSIG staff. The OU Evaluation team received OU IRB approval for the



April 3, 2006. L. D. Barney, Co-Occurring Program Specialist attended discussion at a mental health court in Oklahoma City. Most people who are in the mental health court are in quadrant two and have co-occurring issues.

April 3, 2006. Dr. Khepra Khem worked on the OK-COSIG training manual, designing and editing it most of the month. He also helped plan for the conference held on April 25<sup>th</sup>. On April 26, 2006 he went on medical leave for four weeks.

April 4-7, 2006. Todd Crawford and L. D. Barney, and others in the Department attended a methamphetamine treatment conference in Los Angeles.

April 5-7, 2006. Todd Crawford attended a SAMHSA sponsored Conference. The conference focused on the Matrix model. This model is the only evidence-based treatment strategy for people with methamphetamine dependency. It is developed from a combination of cognitive behavioral therapy, contingency management, relapse prevention, and motivational interviewing.

April 10, 2006. Todd Crawford attended the weekly leadership meeting.

April 11, 2006. Todd Crawford sat in on a focus group in Woodward related to the adult recovery collaborative and answered questions about co-occurring services.

April 11, 2006. L. D. Barney attended the Tulsa Executive Committee meeting.

April 12, 2006. Todd Crawford attended a focus group in Lawton where the need for integrated services for people with co-occurring disorders in rural areas of southwestern Oklahoma was addressed.

April 12, 2006. L. D. Barney attended the screening and assessment committee meeting.

April 14, 2006. Todd Crawford attended a meeting at central office with staff from both the mental health and substance abuse divisions. They shared information on progress and direction.

April 17, 2006. Todd Crawford attended the weekly leadership meeting.

April 18, 2006. Todd Crawford attended a Behavioral Health Team meeting, which is a subcommittee for the partnership of children's behavioral health.

April 19, 2006. Todd Crawford and L. D. Barney attended the ISI Advisory Group that met at Central Office. They finalized the training manual and forwarded it up to leadership.



health centers used during intake and treatment. Currently they are recruiting substance abuse providers so that both groups of providers will be using a common screening and assessment intake format.

Randy Tate, executive director of North Care, a community mental health center in OKC signed on as a participating provider for the grant and also agreed to be a model site in year three of the OK-COSIG project.

May 15-17, 2006. Todd Crawford and L. D. Barney attended the Pennsylvania Co-occurring Disorders Conference and they made a presentation on the Oklahoma Screening instrument. They had a large turnout for their presentation.

May 15-16, 2006. Dr. Khepra Khem attended the Start Training for trainers.

May 18-19, 2006. Todd Crawford attended the Start Training for trainers.

May 19, 2006. Todd Crawford met with the Change Agents from the Norman model sites about using the new training manual and how they are going to set up their trainings for the core curriculum.

May 22, 2006. Todd Crawford attended a day long training conducted by the substance abuse management team to develop a strategic plan for next year with an emphasis on integrated services.

May 22-29, 2006. Dr. Khepra Khem worked on the training manual.

May 24, 2006. Todd Crawford and L. D. Barney attended the first Change Agent meeting in Pryor. They addressed issues related to core training, explaining the new manual, and discussing logistical pieces.

May 25, 2006. Todd Crawford met with Donna Hyde, the lead Change Agent for the crisis center and worked with her on them setting up their trainings.

May 30, 2006. L. D. Barney attended an Investigations Training.

May 26, 2006. Todd Crawford met with the trauma group, chaired by Julie Young and talked about coordinating trainings and coordinating efforts.

Todd also met with Bill Pyatt, who represents an organization that is an association for private behavioral health care providers in Oklahoma. They discussed linking private providers into the ISI process.

May 29, 2006. Todd Crawford attended the weekly leadership meeting.



June 9, 2006. L. D. Barney tested three Change Agents on the OK-COSIG CORE training curricular. This allows them to test other staff.

June 12, 2006. Todd Crawford attended the weekly leadership meeting. At this meeting it was decided that the heads of the major initiatives need to be meeting weekly to become better organized.

June 12-15, 2006. L. D. Barney worked with David Mee-Lee, M.D. who conducted a two day workshop in Oklahoma City and in Tulsa. His workshop focused on “How to Make Integrated Services Really Work.”

June 12-16, 2006. Dr. Khepra Khem worked on the training manual.

June 13, 2006. Todd Crawford attended the first meeting of the Collaborative Leadership group (those heading the major initiatives). They will meet every Tuesday from 7:30 to 8:30 A.M. The focus will be on utilizing resources more proactively. This group met for lunch with the evaluation team from the Center for Substance Abuse Prevention.

June 14, 2006. Todd Crawford attended the electronic medical records meeting in Norman. The focus is to help develop an electronic record for the state. Todd spoke on behalf of integrated mental health, substance abuse, and trauma information.

June 15, 2006. Todd Crawford participated in the COCE conference call, which discussed Double Trouble in Recovery (DTR).

June 16, 2006. Todd Crawford attended a workshop with professionals in mental health and substance abuse in El Reno and was involved in a panel discussion about utilizing drug testing with consumers.

June 19, 2006. Todd Crawford attended the weekly leadership meeting.

June 20, 2006. Todd Crawford attended the weekly Collaborative Leadership group meeting.

June 19, 2006. L. D. Barney went to the Northeast Oklahoma Executive Committee meeting. He met with administrators and clinicians from the Northeast including Tahlequah. They worked on the memorandum of understanding.

June 21, 2006. L. D. Barney attended the Screening and Assessment Subcommittee and the ISI Advisory Committee Meeting.

June 21, 2006. Dr. Khepra Khem attended the ISI Advisory Committee Meeting and made a presentation on the newly published OK-COSIG training manuals. They printed 350 black and white manuals and 100 color copies for the Change Agents.

June 21-24, Todd Crawford attended the National Drug Court Conference in Seattle and attended workshops on co-occurring disorders.

June 22, 2006. L. D. Barney worked on the COCE technical assistance conference that will be presented August 9, 2006. COCE is bringing in consultants to assist the team as they begin to focus on expansion in Northwestern Oklahoma (by Federal definition this is a Frontier area). This area has very few people and they are spread out.

June 26, 2006. Todd Crawford attended the weekly leadership meeting.

June 27, 2006. Todd Crawford attended the weekly Collaborative Leadership group meeting.

June 26-30, 2006. Dr. Khepra Khem helped organize Change Agent workshops within the individual agencies. The agencies are responsible for training 25% of their staff by September 1, 2006. There were 10 workshops scheduled by the end of this quarter.

June 28, 2006. Todd Crawford and L. D. Barney attended the regional Change Agent meeting in Norman.

June 29-30, 2006. Todd Crawford and L. D. Barney conducted a workshop of substance abuse providers at the Postal Training Center in Norman.

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### ***Summary of the work of the ISI Advisory Group and Subcommittees***

The ISI Advisory group met two times this quarter on April 19, 2006 and on June 21, 2006 in OKC from 1:00 PM-3:00 PM. The work reported by the subcommittees in the third quarter of the second year was reviewed.

A summary of the work completed by the ISI Advisory Group subcommittees during this 3<sup>rd</sup> Quarter is presented in this section. There are five ISI Advisory Group subcommittees:



Requirements: The contractual requirements were reiterated that specify for agencies to complete the COMPASS by 6/30/06. Additionally, there are requirements for 25% of the staff to be trained by 9/30/06 with a minimum score of 70 on the final competency test.

Content: The first Regional Change Agent meeting on June 2<sup>nd</sup> also included the unveiling of a modified training manual. The modified manual was noted by meeting members to make it easier to follow. This manual will be used by the lead Change Agents when they train their own agency personnel regarding the Welcoming Environment, Cultural Competency, CCISC Model, and the Person-centered, strengths-based approach. This manual will be utilized by the Lead Change Agents to facilitate trainings at their individual agencies.

The development of the Advanced Case Management Generalist Training was another content area of focus. Walter Kisthardt was contacted to schedule a planning meeting related to this topic. The meeting date was set for July 14<sup>th</sup> at the ODMHSAS central office in OKC.

#### ***Screening and Assessment Subcommittee Work Summary***

The subcommittee met each month during this quarter. Work was devoted to the completion of the welcoming policy and a first draft of a screening policy. Members demonstrated an integrated committee with members from other groups present at meetings. Representatives from the Paperwork Reduction Workgroup/Clinician's Workgroup and the Finance Subcommittee were present and shared updates on their work. Meetings will rotate to different agencies on the 2<sup>nd</sup> Wednesday of each month with each sponsoring facility to offer a brief tour and summary of services. This meeting was held at Northcare. The next meeting will be at Gateway. The accessibility of minutes and new events for CO-SIG/ISI was emphasized to support integration of information and activities.

The screening policies from agencies were reviewed to provide a starting point for the subcommittee to draft a new screening policy. Tip 42 and other national level resources were utilized to inform Oklahoma's screening policy. A highlight from the work was the presence of 6 consumers to better inform this task. A draft of the

screening policy was completed by the June 21<sup>st</sup> meeting and made available to the Advisory Committee at their afternoon meeting that same day.

The status of the screening form was shared. Initially 200 screens were reported as completed. By the end of June the number had risen to 655. The welcoming policy was reworked to submit to the Advisory Committee by April 19<sup>th</sup> with approval reported at the June 21, 2006 meeting.

### ***Outcome and Evaluation Subcommittee Work Summary***

The committee met on May 24, 2006. The meeting included updates regarding the Change Agent training and HR evaluations from the previous period. The committee also discussed the overall evaluation plan pertaining to the macro, mezzo, and micro levels. The May 24<sup>th</sup> meeting was very productive and led to a report on April 19, 2006 that presented detailed information on the FY05 co-occurring clients by categories of admission. A screening policy was circulated on June 16, 2006 that addressed issues related to the completion of the ASI, CAR, and Screen to yield the best data for co-occurring clients and to assess the reliability and validity of the screen.

Analysis of Co-Occurring Admissions: Category I specifies presenting problems or diagnosis only. This means that the clients have substance abuse presenting problems or DSM-IV diagnoses and mental health presenting problems or a DSM-IV diagnosis. Category I represented 25% (13,166 clients) admitted. Category II is distinguished by the service focus versus a diagnosis. Service focus can include: 1) mental health, substance abuse, and domestic violence, or 2) mental health and substance abuse, or 3) co-occurring. This category captured an additional 5% (2,071 clients). Category III represents presenting problem/diagnosis with ASI/CAR score. This category identified 14% (7,356 clients). Category II adds few additional clients not captured by Categories I and III. Category III captures an additional 3% of clients not identified by Category I. This information provided information for the subsequent screening policy memo dated June 16, 2006. Data: The work in this area revolved around the completion of data among the agencies related to the ICIS system and the screen. ICIS allows the entry of two diagnoses, but some are not aware of this capability. Requiring ICIS training in provider contracts was suggested to alleviate this problem. Recommendations to the workforce and training subcommittee to include ICIS as a component of training were

also discussed. Information related to the screen was shared. The number of screens completed to date was offered, which led to a discussion of why some agencies are not completing screens. Through an analysis of FY05 it was discovered that unless a client is admitted, assessment results cannot be obtained.

Recommendations: The committee developed recommendations to address this problem, which was circulated by a memo dated 6/16/06. The memo noted that a field had been added to the Integrated Screen module that allowed for assessment results to be entered. The need for agencies to complete an ASI, CAR, and the Screen was also requested. Linking the screen to ICIS was also addressed. Work will continue in the next quarter with other committees to gain agency compliance in gathering information that will best inform the services for consumers with co-occurring disorders.

#### ***Systems Integration Subcommittee Work Summary***

This committee is made up of one or two representatives from each subcommittee. The purpose of the meetings is to integrate information from the work within the Integrated Services Initiative. Updates from the Screening and Assessment, Outcomes and Evaluation, Training/Workforce Development, and the Financial Subcommittees were shared.

The Outcomes/Evaluation Subcommittee agreed that there was a need for ICIS training for data entry personnel and providers related to the ability to enter more than one diagnosis on the CDS and ICIS. There is confidence that the ICIS system is capable of tracking the necessary outcomes for COD. There must be assurance that AVITAR has the capacity to use the integrated screen once it is normed and found valid.

An update on training was provided with model site staff training beginning in mid June. Requirements are for 25% of direct care staff to pass the core level with a score of 70% or better by September 30, 2006. The need to develop an intermediate, advanced, new employee training, and the ICIS training previously mentioned was announced.

Screening/Assessment subcommittee provided updates on the near completion of the Welcoming Policy, the focus on the development of a screening policy with the input of a consumer panel.

The first order of business for the SIS was contract language for FY 07. Contracts were reviewed in order to discuss the inclusion of co-occurring specific expectations that used the same terms across mental health and substance abuse contracts. The need for language that communicates the same expectations for all providers was reiterated and will be brought up in the future Systems Integration meetings as they have the responsibility for language adjustments for FY 08 contracts. An addendum of “promising practices” was also suggested. Easier access to information was discussed with the recommended addition of a COSIG icon at the top of the ODMHSAS website.

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### ***OK-COSIG Evaluation Team Activities***

The work this quarter was primarily focused on the IRB process, attending subcommittee meetings, gathering data about subcommittees, piloting the Fidelity Scale that will be used to measure the fidelity of co-occurring service and programming. The team also began planning and determining the logistics of conducting the consumer survey for the Outcome portion of the OK-COSIG evaluation.

#### ***Evaluation Team Activities April through June 2006***

##### **April**

April 2-4, 2006. The four members of the OU Evaluation team presented at the Oklahoma National Association of Social Workers Annual Conference, Norman. The evaluation team did a conference presentation that outlined a model for social work with people with a co-occurring disorder. Andrew Cherry did the introduction and wrap-up of the presentation, *Services Integration for People with Co-Occurring Disorders, Social Work's Role*. Lisa Byers presented issues related to *Understand the Cultural and Ethnic Challenges*. Mary Dillon presented on, *Mutual Aid & Self-Help Groups*, and Tiffany Adamson presented on, *A Students Perspective*. Approximately 75 people attended and the attendees were very active in the discussion that followed the presentations.

April 4, 2006. OU Evaluation Team, Schusterman Campus, Tulsa  
Meeting's purpose was the preparation of material for the quarterly report.

April 21, 2006. OU Evaluation Team, Schusterman Campus, Tulsa

There was an update on ongoing work, and new tasks were assigned. The finalization of the interviews with Change Agents that attended the Vinita and Norman trainings is ongoing. Quarterly report preparation was the next topic. Contact with subcommittee chairs for ongoing reports of activities is in progress. The first new task involved a mailing list for the 15 sites as a first step in organizing the administrator interviews and clinician focus groups. The second task involved coordination of the fidelity assessment with the first site to be the Tulsa Center for Behavioral Health in June, 2006. The utilization of consumers to inform fidelity assessment will be attempted from consumer comments obtained 4-12-06. Obtaining a list of variables from Mark Reynolds was identified as needed. The preparation of the third IRB application was also discussed.

April 26, 2006. OU Evaluation Team, Schusterman Campus, Tulsa

The consumer/micro level of the IRB application was discussed with Dr. Cherry taking the lead. Themes from 4-12-06 consumer comments were presented by Dr. Byers. Tiffany Adamson updated the team on the results of support groups in the area. The training regarding referencing with Endnotes proceeded. The team's attendance at the April 27<sup>th</sup> training with Dr. Cline and Minkoff was coordinated. The fidelity assessment was discussed. The first site to be assessed will be the Tulsa Center for Behavioral Health in June 2006.

## **May**

May 2, 2006. OU Evaluation Team, Schusterman Campus, Tulsa

The following topics were discussed: IRB micro level application, literature searches for exemplars related to planned change, program development, instruments for micro level application, and need for filing organization.

May 4, 2006. OU Evaluation Team, Schusterman Campus, Tulsa

The micro level application was discussed again. Areas for further work were the need for consumer follow-up questions, instrumentation, realms of functioning to assess (social, vocational, community integration, and service involvement). The

fidelity assessment was discussed and the need for a cultural competence question was asked.

May 8, 2006. OU Evaluation Team, Schusterman Campus, Tulsa

Topics included the micro level application in relation to the use of a control group, the inclusion of a quality of life measure. The remainder of the meeting focused on the preparation of the fidelity assessment. The CCISC, IDDT, the Illness Management Recovery Scale (IMRS), were utilized in the preparation. The GOI will also be used.

May 11, 2006. OU Evaluation Team, Schusterman Campus, Tulsa

Discussed upcoming dates: June 2<sup>nd</sup> Change Agent training in Tulsa, June 7<sup>th</sup> Change Agent training in Norman, June 21<sup>st</sup> two committee meetings in Norman (back to back), and June 24<sup>th</sup> evaluations and outcomes committee meeting in Norman. The process to be used during the Fidelity Program Evaluations was outlined. We decided to go ahead and order the BSI. The representation of consumer participants from each site was established.

For the Pilot Sites:

Ethnicity/Race	Male	Female
Caucasian	40	40
Native American	10	10
African American	10	10

For the Control Group:

Ethnicity/Race	Male	Female
Caucasian	10	10
Native American	5	5
African American	5	5

May 16, 2006. OU Evaluation Team, Schusterman Campus, Tulsa

Updates on the micro level IRB were shared. The quarterly report was discussed in terms of the information needed from the subcommittees.

May 18, 2006. OU Evaluation Team, Schusterman Campus, Tulsa

We used this time to work on the cultural competency questions and questions asking about medication usage and adherence for the fidelity and interview questions (1<sup>st</sup>, 4<sup>th</sup> month, and 1 year). We took a look at the revised clinician consent form (mezzo) and the Consumer Survey Information sheet. The IRB application was organized with regards to the appendices.

May 23, 2006. OU Evaluation Team, Schusterman Campus, Tulsa

The meeting focused on the finalization of the fidelity interview which included copying the materials for the evaluation team and for TCBH, the first agency to participate. Materials and a summary of the fidelity evaluation were prepared to update the Outcome and Evaluations Subcommittee at their May 24, 2006 meeting. Copies of the satisfaction survey for the micro level OU-IRB application were sent. A modification form to increase the key informants from 9 to 15 was submitted to the OU-IRB for the mezzo level study. A discussion of the typologies for the macro level study was begun.

May 25, 2006. OU Evaluation Team, Schusterman Campus, Tulsa

Micro level study – agency completion of the CAR, ASI, and screen was discussed. Accessing data by case record was another topic.

May 31, 2006. OU Evaluation Team, Schusterman Campus, Tulsa

Fidelity – final questions regarding the conduction of the evaluation were addressed. Quarterly report – discussion of the materials needed to complete this report. The integration of information that will result from all levels of the study was discussed.

## **June**

June 6, 2006. OU Evaluation Team, Schusterman Campus, Tulsa

Fidelity – sharing regarding the process of future fidelity interviews including probes related to increase differentiation of 1-10 responses. Scoring was discussed in terms of high and low scores. Micro level – sampling frame by agency and ethnicity was decided. A memo was sent to offer agencies related to responses to calls for consumers seeking information about self help groups.

June 12 & 13, 2006. OU Evaluation Team, 12 and 12, Tulsa

Members attended the David Mee-Lee training.

June 13, 2006. OU Evaluation Team, Schusterman Campus, Tulsa

Fidelity – need to draft a thank you letter to TCBH director for their time. Mezzo – need for a list of 30 names for agency administrator key informant interviews. Random selection of 6 state level administrators was performed. These 6 key informant interviews were ready to be conducted. The micro level study is waiting on agency characteristics related to ethnicity. The inclusion of agencies that are not involved in COSIG was decided in order for those agencies to function as a control group. The discussion of data entry and NVIVO was another topic.

June 19, 2006. OU Evaluation Team, Schusterman Campus, Tulsa

An update of the research process was prepared for the June 21, 2006 meeting of ISI at the Central Office.

June 22, 2006. OU Evaluation Team, Schusterman Campus, Tulsa

Updates from the Screening and Assessment Subcommittee and the ISI Subcommittee meeting on 6/21 were shared. The completion of a CAR and ASI and a screen was one of the topics shared. If a person is not admitted or referred to an agency then there are no instruments completed. A brief discussion of a youth screen took place with the possibility of a parental check off list. State level key informant interviews were begun. The questions proved to be understandable with no changes recommended. Approximate time for completion was 15 to 20 minutes.

June 27, 2006. OU Evaluation Team, Schusterman Campus, Tulsa

An update on the state administrator key informant interviews was provided. The potential need for an expanded list of names was discussed. Names of agency administrators that could function as key informants were randomized. The completion of this interview for one agency will be completed and the process will be shared. The preparation of activities and summaries for the quarterly report was the major topic.

June 29, 2006. OU Evaluation Team, Schusterman Campus, Tulsa

There was an update regarding the mezzo level interviews in terms of the number to be completed for the state administrators and the first attempt to schedule interviews for the agency administrators. Areas of quarterly report were assigned in order to meet the July 10<sup>th</sup> deadline.

### ***Summary of OK-COSIG Evaluation Team***

The evaluation team met 18 times during this quarter in order to coordinate the work necessary for data gathering. This quarter saw the intensification of work by the evaluation team as OU-IRB approval for all three levels of study was achieved. Work continued on the agency fidelity evaluations, and continued assessment work related to training and services. April of 2006 was the month of continued work to assist the project with training assessments. The last Change Agent training related to the Welcoming Environment, Cultural Competency, and Strengths-based content was performed at the end of the last quarter on March 28, 2006. The beginning of this quarter involved the conduction of individual interviews with five participants in that March 28<sup>th</sup> training. Themes were analyzed and provided to the Workforce and Training Subcommittee Chair, Dr. Khepra Khem. The major and consistent theme was to tailor the trainings to the audience (staff or clinician) to enhance the use of the training time.

Multiple weekly meetings began in May and continued through June to accommodate the planning needed for the conduction of interviews for the fidelity evaluation and key informants. Instruments to assess fidelity were developed based on existing measures. The process for the conduction of the interviews was finalized in order to conduct the first fidelity site visit at the beginning of June. During this same time, preparation for the key informant interviews of state level administrators began which included the attainment of a list of names that would then go through the process of random selection. The names of the randomly selected individuals would then be telephoned in June and asked to volunteer as key informants.

The fidelity of the Integrated Services Initiative was evaluated through anonymous calls to the agencies to request information related to self help groups. A few agencies provided information. Other agencies were not aware of any groups. A process for handling these calls was recommended that emphasized the welcoming approach, and provision of concrete information and encouragement as it relates to programs.

June can be considered the month of increased data gathering. The first fidelity interviews were completed with one agency. The mezzo level of data gathering was also initiated with telephone interviews of administrators as key informants. The informants were asked open-ended questions about co-occurring services. As the evaluation team began to listen to administrators and clinicians involved in mental health and substance abuse services, the picture of coordination and networking of co-occurring services begins to take form. The next quarter will allow consumers the opportunity to share their unique perspectives. As these multi-level responses flow in, another major step will be toward the ultimate goal of service enhancement for people experiencing co-occurring disorders.

### **MACRO EVALUATION**

The previous quarterly report contained information related to the number of people (28%) served by the ODMHSAS that could be considered co-occurring in the fiscal year 2005. This quarter was spent gaining more in-depth information regarding how these consumers were designated once they contacted the ODMHSAS.

Krista Rhoades provided a report on how co-occurring consumers were identified in the past. A classification of three categories emerged. Category I specifies presenting problem or diagnosis only. This means that the clients have substance abuse presenting problems or DSM-IV diagnoses and mental health presenting problems or a DSM-IV diagnosis. Category I represented 25% (13,166 clients) admitted. Category II is distinguished by the service focus versus a diagnosis. Service focus can include: 1) mental health, substance abuse, and domestic violence, or 2) mental health and substance abuse, or 3) co-occurring. This category captured an additional 5% (2,071 clients). Category III represents presenting problem/diagnosis with ASI/CAR score. This category identified 14% (7,356 clients). Category II adds few additional clients not captured by Categories I and III. Category III captures an additional 3% of clients not identified by Category I.

A factor related to the macro level data was the misconception by some that only one diagnosis can be entered into the ICIS system per person. ICIS does allow for two diagnoses to be entered for one person. The inclusion of ICIS training in future agency contracts was suggested to correct this. Involving the Workforce and Training

Subcommittee was another suggestion to enfold ICIS training into the ISI Change Agent trainings.

The Integrated Services Screen was the additional macro level piece of data that was addressed. The number of screens completed to date is 200. Agencies were encouraged to contact the program coordinator to receive a code to access the web based screening tool. Questions regarding which agencies were utilizing the screen and why certain agencies were not yet utilizing the screen on a consistent basis were asked. The need for completion of an ASI, CAR, and Screen by agencies to pilot the screen and test the reliability and validity was formally requested in a memo by the ISI Screening and Assessment Committee. The completion of these three pieces of information is necessary even if the client is not admitted. The development of a screen protocol was discussed. The need for an adolescent or child screen was discussed and tabled.

This quarter can be viewed as a natural unfolding of the Integrated Services initiative with the introduction of change into an existing statewide system of data gathering. The creation and introduction of the co-occurring screen is bringing awareness of the current status of data entry and tracking of two previously separate systems (mental health and substance abuse). Completion of screens to date is promising. Questions regarding why certain agencies are completing the screen and why other agencies are not will inform the initiatives efforts to create a viable co-occurring service system.

### **MEZZO EVALUATION**

A fidelity measure based on the IDDT, CCISC, IMRS, and the GOI was created with particular attention to cultural content for age, culture, disability, gender, and sexual orientation. The scheduling and completion of the first fidelity interview took place on June 6, 2006 with one administrator and one senior level clinician with references to case records. From the perspective of the evaluation team the interview process went smoothly. Additional themes were discussed related to the interview and decisions related to scoring were made.

With OU-IRB and ODMHSAS IRB approval obtained in the last quarter, the data gathering process began. A list of state level administrators was obtained from the program coordinator with the random selection of a smaller number to volunteer for an



and collaboration with other TSIG initiatives. The collection and reporting of information and data about the work and activities of OK-COSIG team, the ISI Advisory Group and its subcommittees, and the pilot program activities and services related to the implementation of integrated services to people in Oklahoma with a co-occurring disorder continues to be a one of the major tasks for the OK-COSIG Evaluation team.

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### **Outcome Evaluation for the 3<sup>rd</sup> Quarter – Year 2**

*Service Coordination and Networking:* Data gathering to assess coordination and networking at the state and local administration levels began in this quarter. The evaluators are using a qualitative approach based on the information from key informant interviews with program administrators at the State, regional, and local levels to determine the degree of *Service Coordination and Networking*.

Later, focus group data with provider staff at the pilot sites will also be collected and used as another view of the level of coordination and networking among agencies. A random sample of seventeen regional provider sites, half at mental health facilities and half at substance abuse facilities, will be used as a sample during the fourth and fifth funding years to determine the level of coordination and networking statewide. Sites for this assessment will be selected to provide equal coverage of all service areas within the State. The semi-structured interview guide to be used in this assessment was developed during the first funding year.

*Service Recipient Outcomes for Services Pilot:* Service recipients who volunteer to participate in this study will be interviewed at three points in time over a one year time period. The participants will be interviewed shortly after their admission, around 4 months after admission, and again at approximately a year after admission. This will require that we track consumers who volunteer for the two follow-up interviews. First a random sample of consumers will be recruited from the pilot co-occurring treatment programs and the control programs. Standard and long standing procedures for tracking participants in longitudinal studies will be employed. The Consumer Survey Information Sheet (CSIS) will be completed only during the first interview for each service recipient.

The CSIS requests information on their current residence, any plans to move, and the name of a family member and/or friend who will likely know their whereabouts over the next year. The research team will maintain monthly contact by telephone, email, or mail. The volunteer participants will not be compensated but a token \$20 will be given to each person for each of the three interviews.

The service recipients will be asked to participate in a maximum of 3 interviews about their experiences in co-occurring treatment and during a one year follow up. They will be interviewed shortly after admission, again at approximately four months after admission, and again at approximately one year after admission. The semi-structured interviews will focus on the individual's experiences as a recipient of service (for a co-occurring, an addiction, or a mental health disorder). The volunteers will also be asked to complete standardized questionnaires: the Brief Symptom Inventory, the Life Satisfaction Survey, and a set of open-ended questions. The sheet will contain demographics and contact information. This information will be coded and kept secure from the interview data. The approximate time for the entire interview session is estimated to be between 1 and 2 hours. The interviews will take place at the agency of service, the participant's home, or a mutually agreed upon place. The participants will be asked to answer one telephone call a month so that we can maintain contact with him or her.

*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 begins, evaluation team members will observe the process and report on the cultural fit and other related issues.

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*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.

The OK-COSIG Advisory Group will have both service recipients and advocacy groups, forming approximately 40% of the membership, from the service pilot sites and other service regions within the State. All training materials, data collection protocols, including informed consent processes, will be piloted with the OK-COSIG Advisory Group and, based on this experience, will either be approved for use in the project or recommended for modification.

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### **Methodology Used to Develop the 3<sup>rd</sup> Quarter Report – Year 2**

The methodology that was used to produce this quarterly report continues to be largely qualitative. The data consists of collected materials and observations by evaluation team members. Relevant documents were collected from committee meetings, trainings and workshops. The minutes from each ISI Advisory Group subcommittee meeting were cataloged with dates and times and those in attendance. Direct observation by the evaluators for the project consisted of attending 18 meetings and workshops to collect primary data. 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.

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### **Progress on Project Goals and Objectives by Timeline for Year Two**

#### ***Goal 1.***

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

#### ***Objective 1.2 –***

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

**Status:**

This work is in progress. A computer version has been placed on the ICIS data system and over 600 screens were entered into the system. Work to determine the reliability and validity continues.

**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 has been a major part of the work of the OK-COSIG team this quarter. Based on the number of agencies that are participating in the project, consensus building has been 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:**

Establishing joint licensure/certification has ostensibly been tabled for the present.

*Objective 2.3 –*

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

**Status:**

The ISI Finance subcommittee will be bringing in technical support to facilitate the work on this objective.

*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:**

Four core-level trainings have been provided at the pilot sites. The trainers have been trained. The pilot programs are responsible for training 25% of their staff by September 1, 2006.

**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 Fidelity Scale has been developed and piloted at TCBH. The Fidelity scale had only minor problems that were worked out by the evaluators (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: *In progress***

- 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:** *In progress*

- 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:**

The data gathering visits will begin in the next quarter.

- 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:**

This was completed for year one and a great deal of work has been completed for year 2.

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

provider sites, half at mental health facilities and half at substance abuse facilities, during the fourth and fifth funding years.

**Status:** *In progress*

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### **Emerging Themes**

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

#### *Subcommittee Integration.*

A major effort was made this quarter to integrate the ISI subcommittees with members from other subcommittees. This is an effort to improve communication and knowledge across committees.

#### *Increased Coordination of Change Agent Trainings.*

There was a discernable increase in the coordination of activities related to Change Agent Trainings. This was enhanced by the creation of a Regional Change Agent Subcommittee.

#### *Consumer Involvement in the Screening and Assessment Subcommittee work.*

Two consumer panels worked with the Screening and Assessment Subcommittee on the “welcoming policy” and on the “screening and assessment” policies.

#### *Self-help groups for people with a co-occurring disorder.*

During this quarter the evaluation team checked the availability of DTR/Self help group information provided to callers at the pilot programs. Staff from two of the programs were helpful. Staff from the remaining programs were unaware of self help groups for people with a co-occurring disorder. The evaluation team has suggested to the OK-COSIG team a Quick Reference Information Sheet to help program staff respond to future calls.

## Suggestions for Handling Calls on DTR

Emphasize:

1. We are glad that you called. (Welcoming Environment)
2. Concrete Information: (Give them something concrete to take with them). Prepare a Quick reference to DTR groups through the ODMHSAS/COSIG:

Names of the groups available,

Where the groups meet,

When the groups meet,

Times that the groups meet,

Contact name and number for person/s running groups, and

Eligibility to attend (specify if only open to people in treatment at that agency).

3. Future: Let the caller know that we are expanding support to people that are dealing with both mental health issues and addiction because there are many that would benefit. (They are not alone)

### *Engage the Tribal Nations of Oklahoma*

A concerted effort to engage the Tribal Nations of Oklahoma into the Integrative Service System will begin in the next quarter.

### *Treatment Practices Related to Families*

Explore Developing Curriculum for working with families of people who are being treated for a co-occurring disorder.

### *A Drop Off in Consumer Involvement*

There continues to be too few consumers attending the subcommittee meetings. One suggestion is to set up an ISI Consumer Subcommittee to help maintain higher levels of consumer involvement.

*Pilot site program issues*

Work on the MOU moved forward this quarter. There is still a lot to do to make it a living document that impacts practice.

*Inclusion of the substance abuse treatment agencies*

Substantial work to include substance abuse agencies in the Integrative Service Initiative was carried out this quarter. There is still a lot of work to do in the effort to make sure the substance abuse agencies are full partners in the integrated system of services. A large percentage of people with a co-occurring disorder present for services at substance abuse treatment centers.

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**Postscript**

This has been another busy quarter. Even so, the preparation and work to implement a multi level evaluation of the OK-COSIG project is in place. Over the next quarter, a great deal of scientific data will be collected to be used as baseline data for the OK-COSIG program evaluation. By the end of the last quarter in year two, we will have a solid baseline to compare services and outcomes of people receiving ODMHSAS integrated services for people with a co-occurring disorder.

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## **APPENDIX**

The documents in this Appendix are products of work completed in the third quarter.

**Appendix A: OU Fidelity Measure for Co-occurring Programs**

**Appendix B: The OK-COSIG Evaluation Table of Events**

## Appendix A

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### OU Fidelity Measure for Co-occurring Programs

This measure is designed to determine program fidelity based on the Comprehensive Continuous Integrated Systems of Care (CCISC) model (Minkoff, 2001). It also incorporates competency areas from the Integrated Dual Disorder Treatment (IDDT) model, and the General Organizational Index for Evidence-Based Practice (GOI) model.

Prior to the evaluation team's visit, there are documents that can be collected and organized to facilitate the work of the visit. We need the program staff to have all written policies and procedures related to the provision of services and treatment of people with a co-occurring disorder so that we can review them. We will also need staff to pull 10 randomly selected case records of people with a co-occurring disorder currently in treatment.

We will need two (2) agency staff members who are knowledgeable about the agencies co-occurring program to assist the evaluation team members in answering the following fidelity questions about the agency's co-occurring programming.

- a) We would like to interview one (1) staff person who is at the administrator/supervisor level and who is knowledgeable about the agency's co-occurring program.
- b) We would also like the second person to be a senior level practitioner, who is knowledgeable about the agency's co-occurring program.

The abbreviation CR = Case Record

The abbreviation PP = Program Policy written

We anticipate the process to take approximately one hour.

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### PHILOSOPHY

*What are the critical ingredients or principles of your services?*

*What is the goal of your program?*

Does staff training include information on co-occurring disorders?

1	2	3	4	5	6	7	8	9	10
None		A little			A fair amount			A great deal	

Does the program emphasize a welcoming, empathic approach to the treatment of individuals with co-occurring disorders?

1	2	3	4	5	6	7	8	9	10
None		A little			A fair amount			A great deal	

Does the program display literature and other materials that emphasize recovery of the individual from both the mental illness and the substance disorder?

1      2      3      4      5      6      7      8      9      10  
None              A little              A fair amount              A great deal

Does the program distribute literature and other materials that emphasize recovery of the individual from both the mental illness and the substance disorder?

1      2      3      4      5      6      7      8      9      10  
None              A little              A fair amount              A great deal

### MANAGEMENT STRUCTURE

The management systems facilitate oversight of the needs of clients with co-occurring disorders?

1      2      3      4      5      6      7      8      9      10  
None              A little              A fair amount              A great deal

Quality improvement and outcome evaluation systems facilitate the outcomes assessment for clients with co-occurring disorders?

1      2      3      4      5      6      7      8      9      10  
None              A little              A fair amount              A great deal

### ACCESS

*Describe the eligibility criteria for your program.*

*How are clients referred to your program?*

*How does the agency identify clients who would benefit from your program?*

The agency uses a pre-admission screen with everyone who calls for treatment and service?

1      2      3      4      5      6      7      8      9      10  
None              A little              A fair amount              A great deal

Are there admission barriers for people with a co-occurring disorder?

1      2      3      4      5      6      7      8      9      10  
None              A little              A fair amount              A great deal

Is there any evidence of arbitrary exclusion criteria being used (alcohol level, urine toxicology screen, psychiatric diagnosis)?

1      2      3      4      5      6      7      8      9      10  
None              A little              A fair amount              A great deal

### IDENTIFICATION/DETECTION OF CO-OCCURRING DISORDERS

(PP) Is there a policy and procedure for using a screen to determine the assessment?

1      2      3      4      5      6      7      8      9      10  
None              A little              A fair amount              A great deal

(CR) There is evidence of screening documented in the case record?  
 1 2 3 4 5 6 7 8 9 10  
 None A little A fair amount A great deal

ASSESSMENT/DIAGNOSIS

(PP) There is a policy on doing assessments for co-occurring disorders?  
 1 2 3 4 5 6 7 8 9 10  
 None A little A fair amount A great deal

(CR) The diagnosis of a comorbid disorder is documented in the chart when identified in the assessment?  
 1 2 3 4 5 6 7 8 9 10  
 None A little A fair amount A great deal

*How often do you re-assess clients?*

TREATMENT PLANNING

*Please describe the process of developing a treatment plan.*

*What are the critical components of a typical treatment plan?*

*How are they documented?*

(CR) Is there evidence that clients were involved in developing the treatment plan?  
 1 2 3 4 5 6 7 8 9 10  
 None A little A fair amount A great deal

(CR) Do treatment plans identify a co-occurring disorder as a primary problem?  
 1 2 3 4 5 6 7 8 9 10  
 None A little A fair amount A great deal

(CR) Are specific goals, objectives, and interventions identified for a co-occurring disorder?  
 1 2 3 4 5 6 7 8 9 10  
 None A little A fair amount A great deal

How many members are on the interdisciplinary treatment team? \_\_\_\_\_

TREATMENT CONTENT AND TREATMENT PROGRAMMING

Do clients have access to dual recovery programs?  
 1 2 3 4 5 6 7 8 9 10  
 None A little A fair amount A great deal

Do clients have access to peer counselors, peer leaders, or peers as role models for dual recovery as part of program content or design?  
 1 2 3 4 5 6 7 8 9 10  
 None A little A fair amount A great deal

Do clients in (substance disorder treatment programs or mental health treatment programs) receive education about psychotropic medication adherence?

1      2      3      4      5      6      7      8      9      10  
None                      A little                      A fair amount                      A great deal

Are clients provided support for taking medication while in treatment?

1      2      3      4      5      6      7      8      9      10  
None                      A little                      A fair amount                      A great deal

What is the average number of people in a treatment group? \_\_\_\_\_

How long is the treatment program? \_\_\_\_\_

Is the curriculum comprehensive (medication management, recovery, self help, etc.)?

1      2      3      4      5      6      7      8      9      10  
None                      A little                      A fair amount                      A great deal

Are Motivational strategies used?

1      2      3      4      5      6      7      8      9      10  
None                      A little                      A fair amount                      A great deal

Are Cognitive-Behavioral techniques used?

1      2      3      4      5      6      7      8      9      10  
None                      A little                      A fair amount                      A great deal

Is the concept of Recovery incorporated into the treatment model?

1      2      3      4      5      6      7      8      9      10  
None                      A little                      A fair amount                      A great deal

Are clients receiving Relapse Prevention training?

1      2      3      4      5      6      7      8      9      10  
None                      A little                      A fair amount                      A great deal

### INTEGRATED TREATMENT RELATIONSHIPS

Do all clients have access to a primary, individual clinician?

1      2      3      4      5      6      7      8      9      10  
None                      A little                      A fair amount                      A great deal

Does the clinician or a case manager stay with the client regardless of treatment compliance?

1      2      3      4      5      6      7      8      9      10  
None                      A little                      A fair amount                      A great deal

Does an interdisciplinary treatment team share responsibility for both disorders?

1      2      3      4      5      6      7      8      9      10  
None                      A little                      A fair amount                      A great deal

## TREATMENT PROGRAM POLICIES

*Please tell us what your program philosophy is regarding client choice.*

*How do you incorporate their preferences in the services you provide?*

(PP) Does the program have a specific set of policies regarding co-occurring disorders?

1      2      3      4      5      6      7      8      9      10  
None              A little              A fair amount              A great deal

(PP) Are policies and procedures flexible regarding group participation in dual diagnosis treatment (treatment refusal)?

1      2      3      4      5      6      7      8      9      10  
None              A little              A fair amount              A great deal

## PSYCHOPHARMACOLOGY

(CR) Is there evidence that clients are involved in deciding the psychopharmacology plan?

1      2      3      4      5      6      7      8      9      10  
None              A little              A fair amount              A great deal

(PP) Does the program have defined policies or practice guidelines for psychopharmacologic treatment of co-occurring disorders?

1      2      3      4      5      6      7      8      9      10  
None              A little              A fair amount              A great deal

(CR) Is there documentation of early access to psychopharmacologic assessment and intervention?

1      2      3      4      5      6      7      8      9      10  
None              A little              A fair amount              A great deal

(CR) Is there documentation that psychopharmacology for either mental illness or addiction is identified as specific to the primary disorder being treated?

1      2      3      4      5      6      7      8      9      10  
None              A little              A fair amount              A great deal

Psychopharmacology providers have documented certification?

1      2      3      4      5      6      7      8      9      10  
None              A little              A fair amount              A great deal

## DISCHARGE PLANNING

(CR) Is there evidence that the client was involved in developing the discharge plan?

1      2      3      4      5      6      7      8      9      10  
None              A little              A fair amount              A great deal

(CR) Does discharge planning specify co-occurring treatment (e.g., dual recovery groups, specific medications, and appointment dates, etc.)?

1      2      3      4      5      6      7      8      9      10  
None              A little              A fair amount              A great deal

(CR) Do client records document the use of a full range of referral resources for both disorders?

1      2      3      4      5      6      7      8      9      10  
None              A little                      A fair amount                      A great deal

(CR) Do discharge plans for both disorders involve documented communication with family members and significant others?

1      2      3      4      5      6      7      8      9      10  
None              A little                      A fair amount                      A great deal

(CR) Is discharge planning conducted with the same degree of intensity for both disorders?

1      2      3      4      5      6      7      8      9      10  
None              A little                      A fair amount                      A great deal

(CR) Are vocational issues addressed in the discharge plan?

1      2      3      4      5      6      7      8      9      10  
None              A little                      A fair amount                      A great deal

*Does your program have a systematic method for tracking outcome data?  
If 'Yes,' ask: Describe the process.*

#### INTEGRATED EXTERNAL CARE MANAGEMENT

The program has document established procedures for crisis intervention?

1      2      3      4      5      6      7      8      9      10  
None              A little                      A fair amount                      A great deal

#### STAFF COMPETENCY/TRAINING

What is the staff to client ratio? \_\_\_\_\_

Is there policy identifying staff competencies needed for working with people with a co-occurring disorder?

1      2      3      4      5      6      7      8      9      10  
None              A little                      A fair amount                      A great deal

#### SPECIFIC COMPETENCIES:

##### **Culture**

The agency designates resources specific to cultural competence?

1      2      3      4      5      6      7      8      9      10  
None              A little                      A fair amount                      A great deal

The program has standards of care related to culture?

1      2      3      4      5      6      7      8      9      10  
None              A little                      A fair amount                      A great deal

##### **Gender**

The program makes accommodations for the needs of pregnant and/or parenting women?

1      2      3      4      5      6      7      8      9      10  
None                  A little                  A fair amount                  A great deal

**Age**

There is specific programming for geriatric clients?

1      2      3      4      5      6      7      8      9      10  
None                  A little                  A fair amount                  A great deal

**Developmental Disability**

The program demonstrates specific programming for the developmentally disabled?

1      2      3      4      5      6      7      8      9      10  
None                  A little                  A fair amount                  A great deal

**Sexual Orientation**

The program personnel are aware of the impact of sexual orientation on life experiences?

1      2      3      4      5      6      7      8      9      10  
None                  A little                  A fair amount                  A great deal

**Trauma**

The program personnel recognize the high prevalence of trauma histories among individuals with co-occurring disorders?

1      2      3      4      5      6      7      8      9      10  
None                  A little                  A fair amount                  A great deal

**Family Competency**

Are families and significant others involved in treatment?

1      2      3      4      5      6      7      8      9      10  
None                  A little                  A fair amount                  A great deal

**Comments:**

Last Revised: 6-1-6

## APPENDIX B

### The OK-COSIG Evaluation Table of Events

	Fidelity	State Administrators	Agency Administrators	Clinician Focus Group	Consumer
OU-IRB	No	Yes <u>  X  </u>	Yes <u>  X  </u>	Yes <u>  X  </u>	Yes <u>  X  </u>
State-IRB	No	Yes <u>  X  </u>	Yes <u>  X  </u>	Yes <u>  X  </u>	Yes <u>      </u>
Participants	15 model sites (all) No random selection 2 Interviews per agency Administrator & Senior Clinician *Schedule on same day	1) 12 Names <u>  X  </u> 2) Randomly Select 6 <u>  X  </u>	30 Names (2 from each model agency) <u>  X  </u> 15 Randomly Selected 1 from each model agency) <u>  X  </u> *by phone or in person	48 Names (from LD) Have to be from Tulsa, Norman, Vinita? <u>      </u> 24 Randomly Selected <u>      </u> 3 Focus Groups of 8 people *in person	Agency Demographics From Krista <u>      </u> Control Agencies  *in person
Interview Materials Checklist	Fidelity Measure In person interview		1. Recruitment Script* <i>reference when schedule interview</i> 2. IFC-read 3. Interview ?s	1. Recruitment Script* <i>reference when schedule interview</i> 2. IFC-read 3. Interview ?s	1. Recruitment Script 2. IFC signed 3. Provide IFC info to them 4. Instruments
Schedule Interview					
Conduct Interview					
Code Names					
Post Interview	1) Mail thank you letter (no IFC) <u>      </u> 2) Maintain contact information for follow up interview	1) Mail thank you letter (with IFC) <u>      </u> 2) Maintain coded contact information for follow up interview	1) Mail thank you letter (with IFC) <u>      </u> 2) Maintain coded contact information for follow up interview	1) Mail thank you letter (with IFC) <u>      </u> 2) Maintain coded contact information for follow up focus group	Folder 1 Consumer Survey Information Sheet Folder 2 Contact Information (coded for name) Folder 3 Interview Data (coded for name) Post Tx Satisfaction Survey (coded for name) BSIs (coded for name) Begin tracking monthly contact
Input Data					
Analysis Report					