

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

**Volume 5**

**Number 4**

**July 1, 2009 through September 30, 2009**

**Pages 221 - 252**

Andrew L. Cherry, DSW, ACSW  
Oklahoma Endowed Professor of Mental Health  
University of Oklahoma, School of Social Work, Tulsa Campus,  
OU OK-COSIG Project Evaluator

Mary E. Dillon, Ed.D, MSW  
Adjunct Faculty  
University of Oklahoma, School of Social Work, Tulsa Campus  
OU OK-COSIG Associate Evaluator

Joseph F. Kavanagh, MIS, MPA, MSW Student,  
University of Oklahoma, School of Social Work, Tulsa Campus  
OU OK-COSIG Assistant Evaluator

**Year:** 2009, **Quarter** 4<sup>th</sup>  
**Title of Grant:** **Oklahoma State Incentive Grant  
for Treatment of Persons with Co-occurring Substance  
Related Disorders**  
**Grant Number:** **1 KD1 SM56568**  
**State:** **OKLAHOMA**

**Project Director and Contact Information:**

June Elkins-Baker,  
Director of Provider Support Services  
ODMHSAS  
1200 N.E. 13th Street  
Oklahoma City, OK 73117-1022  
Office: (405) 522-0185  
Fax: (405)-522-3767  
jelkins-baker@odmhsas.org

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## **Acknowledgement**

With the completion of the 4<sup>th</sup> Quarter of year five the OK-COSIG project comes to the end. In this last year of the Co-occurring State Incentive Grant (COSIG), the focus of the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), OK-COSIG staff has been on efforts to sustain the gains made in the screening, assessment and treatment of people with a co-occurring disorder of mental illness and substance abuse who seek treatment in Oklahoma.

For the OU OK-COSIG evaluation team, this last year has focused on data management and organizing the separate evaluations into their component parts so as to produce a comprehensive final evaluation report.

Over the five year life of this project, I would like to acknowledge the cooperation from the Oklahoma Department of Mental Health and Substance Abuse Services, OK-COSIG staff. From day one, the cooperation was superb. The interactions and correspondence between the Evaluation team members and the OK-COSIG staff resulted in 20 comprehensive quarterly and four year-end reports. The data collected over the last five years will be used to tell the story of the OK-COSIG project and to 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 Project are based on the work of gathering documents, making observations, and analyzing both qualitative and quantitative data. The work over the five years has accomplished much at the State and local levels to provide integrated services for people with a co-occurring disorder seeking treatment in Oklahoma.

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

This is the 5<sup>th</sup> Quarterly Report for the 5<sup>th</sup> year of the OK-COSIG project. This report is in two parts. It contains the final Co-Occurring State Incentive Grants Quarterly Progress Report: SAMHSA Format and a report on the quarterly activities that is similar to past

reports. It chronicles efforts to sustain the gains made over the last five years and to continue the regional Change Agent organizations. The SAMHSA Quarterly Progress Report summarizes these efforts.

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 (July 1, 2009 through September 30, 2009). This will be followed by a list of the support activities that were carried out during the 4<sup>th</sup> Quarter of this 5<sup>th</sup> year. Next, the work accomplished on the evaluation of the project will follow. Then the goals and objectives by timeline will be described in terms of their status and the resources that were being employed to meet the objectives. Finally, additional emerging themes that were identified in the 4<sup>th</sup> Quarter of this 5<sup>th</sup> year will be described.

**Editorial note:** The Quarterly Reports produced during the 5<sup>th</sup> year of this project will be data for the final report. The Final Report will be the analysis of data collected in the previous five years. The quarterly reports will form the basis for the final report on the Project 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 Reporting Requirements**

**July 1, 2009 through September 30, 2009**

Prepared By:

Andrew L. Cherry, DSW, ACSW  
Oklahoma Endowed Professor of Mental Health  
University of Oklahoma, School of Social Work, Tulsa Campus,  
OU OK-COSIG Project Evaluator

Mary E. Dillon, Ed.D, MSW  
OU OK-COSIG Associate Evaluator  
Adjunct Faculty  
University of Oklahoma, School of Social Work, Tulsa Campus

Joseph F. Kavanagh, MIS, MPA, MSW Student,  
University of Oklahoma, School of Social Work, Tulsa Campus  
OU OK-COSIG Assistant Evaluator

<b>Year:</b> <u>2009</u>	<b>Quarter</b> 4 <sup>th</sup>
<b>Title of Grant:</b>	<b>Oklahoma State Incentive Grant for Treatment of Persons with Co- occurring Mental Health and Substance Related Disorders</b>
<b>Grant Number:</b>	<b>1 KD1 SM56568</b>
<b>State:</b>	<b>OKLAHOMA</b>

**Project Director and Contact Information:**

June Elkins-Baker,  
Director of Provider Support Services  
ODMHSAS  
1200 N.E. 13th Street  
Oklahoma City, OK 73117-1022  
Office: (405) 522-0185  
Fax: (405)-522-3767  
jelkins-baker@odmhsas.org

## I. Project Implementation

This is the 4<sup>th</sup> and last Quarterly Report for year five of the Oklahoma-Co-occurring State Incentive Grant. This report is in the *Quarterly Progress Report Format* required by SAMHSA. The documents and meeting notes on which this SAMHSA report is based can be found in the *OK-COSIG Quarterly Evaluation Report, Volume 5, Number 4* at [http://faculty-staff.ou.edu/C/Andrew.L.Cherry-1.Jr/okcosig\\_project.htm](http://faculty-staff.ou.edu/C/Andrew.L.Cherry-1.Jr/okcosig_project.htm).

The OK-COSIG project had 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, substance abuse, and trauma within Oklahoma's mental health and substance abuse treatment communities.

This is the last quarter of the fifth year and the end of the Project. As such, all personnel hired and working on the project have been reassigned or moved on to other jobs with the exception of June Elkins-Baker, Director of Provider Support Services (FTE 25%).

At the end of the 4<sup>th</sup> Quarter of year five of the OK-COSIG project, although the work is ongoing, many of the structural barriers to treating people with a co-occurring disorder that have existed over the years between mental health and substance abuse treatment communities have been bridged or weakened. The Infrastructure changes such as the changes in the ODHMSAS State rules governing mental health treatment (Chapter 17) and substance abuse treatment (Chapter 18) continue to stand out as one of the major accomplishments. These rules set the standards for care. The word or terms related to "co-occurring" are used at least "62" times in these two documents. These ODMHSAS Administrative Rules can be viewed at <http://www.odmhsas.org/AdminRules.htm>.

Another accomplishment was the integrated contracts that are being used for both mental health and substance abuse treatment facilities. The integrated contract establishes common standards for both mental health and substance abuse treatment facilities.

The trainings provided by the OK-COSIG staff over the last five years have been effective in alerting those in the mental health and substance abuse community to the treatment needs by those with a co-occurring disorder and the concept of integrated treatment for people with a co-occurring disorder. The core and intermediate level

curricula that was developed during this Project is available to Oklahoma providers of mental health and substance abuse treatment. Moreover, these curricula provided the foundation for workshops and trainings, including “training for trainers” to help clinicians, administrator, and staff develop a co-occurring capable program. The multitude of activities such as trainings and consensus building workshops are described in detail in the quarterly reports generated over five years.

The Advanced training manual for trainers, *Co-Occurring Capable Advanced Level of Learning* was completed and was awaiting approval from ODMHSAS leadership when this project ended.

The evaluation efforts in fiscal year five focused on identifying and verifying the changes that have been made since 2004 using data from the Individual Client Information System (ICIS) for fiscal years 2005-2006, 2006-2007, and 2007-2008. The data and follow-up interviews related to the Government Performance and Results Act (GPRA) were also completed in 2008. OK-COSIG personnel collecting the GRPA data had a follow-up rate of 89.3 %. This was above the mandatory rate of follow-up, which was 80%. The hard work of the people collecting the GRPA data is reflected in this rate. However, the GRPA data did not prove to be very helpful in answering questions about individual outcomes because of the construction of the questionnaire which resulted in a great deal of missing data. The analysis of the Oklahoma GPRA data is reported in the 2<sup>nd</sup> Quarterly Report Year 5.

**a. Description of project changes or modifications [since reapplication] in:**  
*(1) Goals and Objectives*

There have been no modifications in this quarter. The project ended on September 30, 2009. In year five, the work of the OK-COSIG staff and the regional Change Agents focused on efforts to sustain the gains made over the years of the Project and planning future efforts to make all ODMHSAS treatment programs co-occurring capable.

*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*

In an effort to sustain and continue to develop consensus among providers related to the need to become co-occurring capable, on the last day of the OK-COSIG project (9-30-2009), a daylong training and Awards Ceremony was held at Shepherd Mall in Oklahoma City. It was attended by Change Agents and program representatives. Invitations were also sent to "non-model" sites in each of the five regions in Oklahoma. Each "non-model" site was allowed to bring two people to the training. Many of those

attending were given a “Trail Blazer Award.” Deputy Commissioner of Mental Health Services, Carrie Slatton-Hodges, and Deputy Commissioner of Substance Abuse Services, Caletta McPherson were at the event to present the awards.

The workshop was conducted by Rhonda McKillip. The workshop material came from her books on treating people with a co-occurring disorder, *The Basics - Second Edition - A Curriculum for Co-Occurring Psychiatric and Substance Disorders* (2009).

At this training, the Change Agents and program representatives met in groups by region to review the *Co-occurring Capability - Vision Statement*, the latest draft of the *State of Oklahoma, Integrated Services Consensus* document. They also reviewed the draft of the *Oklahoma Co-Occurring Disorder (COD) Capability Organizational Orientation and Program Fidelity Scale*. This scale will be used to help determine if the programs are co-occurring capable (See Appendix A, B, and C in the full quarterly report. The full report will be online at [http://faculty-staff.ou.edu/C/Andrew.L.Cherry-1.Jr/okcosig\\_project.htm](http://faculty-staff.ou.edu/C/Andrew.L.Cherry-1.Jr/okcosig_project.htm)). At the end of this Project, the plans are to continue the Integrated Services Sustainability Advisory Group and the regional Change Agent meetings.

After the Awards Ceremony, the OK-COSIG local evaluator (author of this report) presented a brief overview of treatment outcomes of people with a co-occurring disorder who were treated at model programs during fiscal years two, three and four of this five year Project. The following are two highlights from the presentations.

On average, people with a co-occurring disorder were identified far more often by the Original Model programs. Table 1, reflects the percentages of people identified with a co-occurring disorder by program type over three years.

**Table 1:** The Average Percentage of people identified with a co-occurring disorder by program type over three years.

Original Model Programs (data is from three years)	New Model Programs (data is from two years)	Control Programs (data is from three years)
NO = 55%	NO = 70%	NO = 75%
YES = 45%	YES = 30%	YES = 25%

People with a co-occurring disorder also completed treatment far more often in the model programs than in the control programs. Tables 2-4 show the percentage of treatment completion.

**Table 2:** Percentage who Completed Treatment by Year and Program Type

2005-2006 Total number of Adults, 19,241

Treatment Completion

Original Model Programs data is from three years	MEN No COD	<b>MEN COD</b>	Women No COD	<b>Women COD</b>
Model	56%	68%	45%	66%
Control	20%	24%	15%	17%

**Table 3:** Percentage who Completed Treatment by Year and Program Type

2006-2007 Total number of Adults, 30,645

Treatment Completion

Original Model Programs data is from three years	MEN No COD	<b>MEN COD</b>	Women No COD	<b>Women COD</b>
Model	40%	60%	33%	54%
New	29%	30%	21%	24%
Control	41%	9%	21%	32%

**Table 4:** Percentage who Completed Treatment by Year and Program Type

2007-2008 Total number of Adults, 35,160

Treatment Completion

Original Model Programs data is from three years	MEN No COD	<b>MEN COD</b>	Women No COD	<b>Women COD</b>
Model	48%	84%	42%	80%
New	30%	17%	23%	18%
Control	47%	29%	13%	18%

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

For all intents and purposes, the work on Objective 1.2 has been completed. The vast majority of staff at the 28 model programs have been trained with the Core Level and Intermediate Level curriculum. The Advanced training manual for trainers, *Co-Occurring Capable Advanced Level of Learning* has been completed and is waiting for approval from leadership. Many Change Agents in the field have expressed interest and are looking forward to beginning the Advanced training.

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

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

The Change Agent Lunch and Awards Ceremony was part of the ongoing effort to maintain and continue to develop consensus. The support from the model agencies and Change Agents, while the other agencies develop a co-occurring capability, is important. As this Project ends, there are 28 model agencies. At these agencies, there exists a good size cadre of people to do trainings and promote the need for agencies to become and stay co-occurring capable.

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

The integrated contract establishes common standards for both mental health and substance abuse treatment facilities. As well, statutory changes that became effective in year four set educational standards required for Licensed Alcohol and Drug Counselors (LADC) to clinically address co-occurring issues and to counsel people with a co-occurring disorder. The other professional license statutes have not changed; they were already able to address co-occurring issues in treatment.

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

The new contract for both mental health and substance abuse has been implemented. In the past, this contract was used for mental health agencies. This infrastructure change will go a long way toward improving the quality of care for people with co-occurring disorders and people receiving services for substance misuse. This ‘universal contract’ will also set the standard of care across the state for both mental health and substance abuse treatment agencies.

In year three, State rules governing mental health treatment (Title 450:17, Chapter 17) and substance abuse treatment (Title 450:18, Chapter 18) were changed to include the treatment of co-occurring disorders. The rules will make it much more likely that agencies will address the needs of people with a co-occurring disorder.

*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.*

The work on this Objective has been completed. The Core-Level training and the Intermediate-Level training was delivered to the model agencies and others in the state over the last five years. The Advanced training manual for trainers, *Co-Occurring Capable Advanced Level of Learning* has been completed. It will be available to agencies in the future as a part of an ongoing effort to sustain the changes and to continue to improve treatment for people in Oklahoma who present with the co-occurring disorders of mental illness and substance abuse. The plan is for the Change Agents to conduct co-occurring trainings in the future.

#### *Project timeline for project implementation*

The Project ended on September 30, 2009. The objectives and activities are chronicled in the quarterly reports, year-end reports, and the final project report that will be produced by December 31, 2009. The final report will cover the five years of the project. All reports are available online at [http://faculty-staff.ou.edu/C/Andrew.L.Cherry-1.Jr/okcosig\\_project.htm](http://faculty-staff.ou.edu/C/Andrew.L.Cherry-1.Jr/okcosig_project.htm).

#### *(2) Approach and strategies proposed*

A full report on the accomplishments and findings from the five year OK-COSIG project will be completed by December 31, 2009. This will be submitted to ODMHSAS and it will be available online at [http://faculty-staff.ou.edu/C/Andrew.L.Cherry-1.Jr/okcosig\\_project.htm](http://faculty-staff.ou.edu/C/Andrew.L.Cherry-1.Jr/okcosig_project.htm).

#### **Status of Project**

(1) Description of activities during this quarter regarding:

- screening and assessment,

Screening and Assessment protocols are included in the State of Oklahoma, Integrated Services Consensus document and in the Oklahoma Co-Occurring Disorder (COD) Capability Organizational Orientation and Program Fidelity Scale.

- workforce development/curriculum development workgroup,

The Core-Level curriculum and the Intermediate Level curricula are available. *Co-Occurring Capable Advanced Level of Learning* has been completed. It will be available to agencies in the future as a part of an ongoing effort to sustain the changes and to continue to improve treatment for people in Oklahoma who present with the co-

occurring disorders of mental illness and substance abuse. The plan is for the Change Agents to conduct co-occurring trainings in the future.

- financing,

A standardized contract is now being used for both Mental Health and Substance Abuse agencies.

- the change agent regional committees,

The plan is for the Regional Change Agent meetings to continue after the end of the OK-COSIG project.

- evaluation,

The focus this quarter has been on continuing to analyze and organize the data collected over the five years of the OK-COSIG Project. The comparison of the quantitative data from the Model and Control programs shows that there are positive differences between people being treated at the Model programs and people treated at the Control programs.

A full report on the accomplishments and findings from the five year evaluation of the OK-COSIG project will be completed by December 31, 2009. This report will be submitted to ODMHSAS and it will be available online at [http://faculty-staff.ou.edu/C/Andrew.L.Cherry-1.Jr/okcosig\\_project.htm](http://faculty-staff.ou.edu/C/Andrew.L.Cherry-1.Jr/okcosig_project.htm).

## (2) Accomplishments

- Over the five years of this Project, the Goals and Objectives set out in the proposal in 2004 for the most part have been accomplished. However, in the broader sense the work clearly succeeded in the overarching goal of facilitating an infrastructure change at the State level that supports integrated treatment for people with co-occurring disorders. This Goal has been accomplished. The major infrastructure changes were: 1) changes made in the rules and contracts to include people with a co-occurring disorder, 2) instituting screening and assessment for people with co-occurring disorders, 3) developing a curricula on treating people with co-occurring disorders, 4) providing training for mental health and substance abuse clinical, administrative, and support staff, 5) developing a uniform contract for both mental health and substance abuse programs, and 6) raising awareness and support for changing treatment protocol to better provide for people with co-occurring disorders.
- At the agency level, the number of model agencies expanded from the originally proposed 7 to 28 model programs that became co-occurring capable during this project or were in the process of becoming co-occurring capable at the end of the project.
- The Oklahoma Department of Mental Health and Substance Abuse Services has completed five year of successful work on the OK-COSIG project.
- The veracity of data collected for this evaluation is another success story. The freedom of access to ODMHSAS data and the help in obtaining data for this evaluation has been extraordinary. Cooperation at all levels made data gathering possible. ODMHSAS staff, treatment program administrators, clinicians, and support staff were supportive and helpful.

### (3) Other significant project activities

- At the end of this Project, the Integrated Services Sustainability Advisory Group made up of Change Agents (advocates and trainers) planned to continue to meet. They were working on policy and financial issues related to providing treatment for people with a co-occurring disorder.
- The Change Agents have the potential to develop as a cadre of trainers and advocates of “best practices.” They could help fill the need for more training on “best practices,” as well as developing an integrated treatment program for treating people with a co-occurring mental health and substance abuse disorder. They are a major asset that could help to improve and maintain treatment services.

#### **c. Difficulties/Problems Encountered**

##### (1) Barriers to accomplishment

- A formal plan is needed that delineates how the remaining mental health and substance abuse treatment programs in the state will become co-occurring capable programs. This would give the effort a goal and an outcome that can be measured. One of the lessons ‘relearned’ from the OK-COSIG Project is that trainings in “best practices” in one clinical area can have an overall positive clinical impact on a treatment program. Among the 15 original model programs, treatment outcomes were better for both client groups (those with a co-occurring disorder as well as those with no co-occurring disorder). And, those gains were sustained over three years as compared to the control programs during the same period.
- Another barrier to sustaining the gains made over the last five years is *the lack of leadership at the federal level* on issues related to treatment for people with co-occurring disorders. The science is clear, at least a third of people with a mental health disorder or a substance misuse issue have a co-occurring disorder that would benefit from integrated treatment. Yet, leadership at the Federal level continues to support and maintain artificial silos for mental health and substance abuse funding, policy, and research. This division impedes progress in the development of new treatment models and in developing knowledge about the similarities and differences among the three primary groups we studied: people with a mental illness, people with a substance abuse problem, and people with a co-occurring disorder. *Leadership at the federal level is needed to reap the benefits and gains made by the COSIG funding project.*

##### (2) Strategies to overcome barriers

- Sustaining the gains made over the life of the project will need state level leadership.  
At the State level, the plan (when this Project ended) was to include as a part of the regular ODMHSAS program review, a ‘program fidelity inventory’ used to assess *integrated co-occurring treatment and services* for people with co-occurring disorders. This plan will help sustain the changes (better identification and treatment completion for people with co-occurring disorders). It would also

continue to motivate programs to become co-occurring capable and to maintain their co-occurring treatment and services.

2. Personnel

- a. List all current positions supported by the grant, including any vacancies, with percent of time on the project.
- June Elkins-Baker, Director of Provider Support Services, ODMHSAS is working with the Regional Change Agent groups and chairing the Integrated Services Sustainability Advisory Group meetings (FTE = .25).
- b. List staff changes, including contractors/consultants, within the reporting period.

September 30, 2009 was the last day of the OK-COSIG project.

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

The plan is for June Elkins-Baker, Director of Provider Support Services to continue to be the liaison person for the Regional Change Agent groups. This will include continuing the COSIG Advisory meetings.

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## **The Structure of the Final Report on the Oklahoma Co-Occurring State Incentive Grant 2004 through 2009**

This report will be completed by December 31, 2009.

### **Executive Summary**

#### **I. MACRO Evaluation**

- A. The Context: History and Background**
- B. Changes in Organizational Structure of ODMHSAS: change in law, changes in policy, changes in procedure, and changes in clinical licensure.**
  - 1. Results of the qualitative evaluation of advisory committees work and the work of the COSIG staff.**
  - 2. Results of the qualitative evaluation of changes made in policy and procedures related to co-occurring disorders.**
  - 3. Results of focus groups.**
- C. Changes in State trainings and curricula development related to treating people with a co-occurring disorder.**
  - 1. Results of the evaluation of developed co-occurring curricula,**
  - 2. Results of the evaluation of trainings, and**

3. **Results of surveys of trainee attitude.**
- II. **Mezzo Evaluation**
  - A. **Changes at the programming and treatment levels.**
    1. **Results of the Fidelity Evaluation of each of the 15 original model programs.**
    2. **Results of the qualitative analysis of the work of the Change Agent development and contributions.**
  - B. **Changes in Program Treatment Outcomes**
    1. **Results of the Analysis of ICIS data from fiscal years 2005-2006, 2006-2007, and 2008-2009. Effects of implementing an integrated treatment approach to improve clinical services for people with a co-occurring.**
    2. **Results of the analysis of the differential effect among the 15 original programs that implemented an integrated treatment approach.**
- III. **Micro Evaluation**
  - A. **Changes in Individual Client Treatment Outcomes**
    1. **Putting a Face on People with a Co-occurring Disorder.**
    2. **Gender and ethnic differences.**
  - B. **Contribution of GRIPRA data.**
    1. **Problems with using the GRIPRA data.**
    2. **Results of analysis of the Oklahoma GRIPA Data.**
- IV. **Other Issues of Interest.**
- V. **Conclusion**

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

### **Fourth Quarter of Year 5**

(Note: The data for this last SAMHSA report in this five year project on the OK-COSIG Project has been developed from Documents and Meeting Minutes that are summarized in the following sections.)

This is the 4<sup>th</sup> Quarterly report and the last report on the five year project referred to in these reports as the OK-COSIG project to improve treatment of persons with Co-Occurring Mental Health and Substance Abuse related disorders in Oklahoma. The preceding report, “Co-Occurring State Incentive Grants Quarterly Progress Report: Formatted to comply with SAMHSA Reporting Requirements” broadly sums up the five year long evaluation study. The data and analysis that led to these conclusions in this summary will be delineated in great detail in the final report called the, *Final Report on the Effect of the Oklahoma Co-Occurring State Incentive Grant (2004 through 2009)*. The Project used two interventions to promote systemic infrastructure change: 1) it developed a standard protocol for screening and assessment of people with a mental health and substance abuse problem, and field tested and evaluated a co-occurring screen; 2) a model was developed to provide integrated treatment that is accessible, culturally competent, and grounded in evidence-based practices. The following sections of the 4<sup>th</sup> Quarterly Report of this last year will describe the work conducted in the 4<sup>th</sup> quarter of year 5.

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The work in the 4<sup>th</sup> and last quarter of this five year Project focused on finding ways to sustain the gains made over the last five years. During this quarter, the Integrated Services Sustainability Advisory Group made up of Change Agents from regional groups of Change Agents met three times and held a COSIG Closeout Training on September 30, 2009.

### **Accomplishments in the 4<sup>th</sup> Quarter of Year Five**

A Change Agent Lunch, Awards Ceremony and all day training was held on 9-30-2009. The daylong training and Awards Ceremony was held at Shepherd Mall in Oklahoma City. It was attended by Change Agents and program representatives.

Invitations were also sent to "non-model" sites in each of the five regions in Oklahoma. Each "non-model" site was allowed to bring two people to the training. Many of those attending were given a "Trail Blazer Award." Deputy Commissioner of Mental Health Services, Carrie Slatton-Hodges, and Deputy Commissioner of Substance Abuse Services, Caletta McPherson were at the event to present the awards.

The workshop was conducted by Rhonda McKillip. The workshop material came from her books on treating people with a co-occurring disorder, *The Basics - Second Edition - A Curriculum for Co-Occurring Psychiatric and Substance Disorders* (2009).

At this training, the Change Agents and program representatives met in groups by region to review the *Co-occurring Capability - Vision Statement*, the latest draft of the *State of Oklahoma, Integrated Services Consensus* document. They also reviewed the draft of the *Oklahoma Co-Occurring Disorder (COD) Capability Organizational Orientation and Program Fidelity Scale* (See Appendix A, B, and C). This scale will be used to help determine if the programs are co-occurring capable.

### **The Plan for the Final Report on the Effect of the Oklahoma Co-Occurring State Incentive Grant (2004 through 2009)**

The full report on the accomplishments of the OK-COSIG project based on the findings from the five year evaluation study will be completed by December 31, 2009. This report will be submitted to ODMHSAS and it will be available online at [http://faculty-staff.ou.edu/C/Andrew.L.Cherry-1.Jr/okcosig\\_project.htm](http://faculty-staff.ou.edu/C/Andrew.L.Cherry-1.Jr/okcosig_project.htm).

**Appendix A:**

**Co-occurring Capability - Vision Statement**

## **Co-occurring Capability - Vision Statement BY THE COMMISSIONER**

### **VISION**

The Oklahoma behavioral health system will be welcoming, recovery-oriented, trauma-informed and co-occurring capable in order to most effectively meet the needs of the individuals and families with complex co-occurring conditions who are the expectation in all service settings.

### **POLICY**

All ODMHSAS state operated and contracted provider agencies will engage in an organized process, in partnership with ODMHSAS leadership, and with other providers in their region, to become welcoming, recovery oriented, trauma-informed, and co-occurring capable. This process will be overseen by the Integrated Services Advisory Committee, which will be constituted to represent ODMHSAS divisions, state operated and contracted providers from each region, and regional change agent teams, consumer/family advocates, and other key stakeholders

### **BACKGROUND**

For the past five years, ODMHSAS has been working on the Integrated Services Initiative (ISI), funded through a SAMHSA COSIG grant. The purpose of this grant was to help Oklahoma develop a sustainable process for building a welcoming, recovery oriented, integrated system of care in order to help achieve the vision described above. During the past five years, 28 model programs have participated formally in the Integrated Services Initiative, in which each agency learned how to engage in a process to become more welcoming, accessible, recovery oriented, and co-occurring capable. During this time, not only have individual agencies made progress, but the consensus that the vision of universal co-occurring capability is a valuable goal has increased, even in (especially in) a time when resources are becoming scarcer, and the people we serve are becoming more complex. In addition, there have been a number of accomplishments of the ISI that promote the sustainability of this process, even as the COSIG grant is coming to an end.

Some of the accomplishments include:

- Formation of an Integrated Services advisory committee
- Creation of a consensus document signaling agency commitment to implementing and sustain co-occurring capability
- Creation of a website to access co-occurring resources
- Creation and expansion of collaborative networks of providers across the state through Regional Change Agent groups
- Development of a valid and reliable integrated screening tool that is being utilized in several states
- Development of a fidelity tool for agency self-assessment
- Incorporation of co-occurring capability requirements into standards and contracts
- Training of field service representatives to provide technical assistance in the field
- Development of co-occurring training materials at core, intermediate, and advanced levels

### **NEXT STEPS:**

ODMHSAS is committed to building upon the success of the Integrated Services Initiative to continue the process of universal development of welcoming, recovery

oriented, trauma-informed co-occurring capable services. Much has been accomplished, but we know much more work needs to be done. Working in partnership across the state, building on our strengths in small steps, we can make progress toward this goal.

Therefore, ODMHSAS is committed to sustaining and expanding services to consumers with co-occurring disorders throughout the state with the understanding that co-occurring capability is the expectation not the exception for all agencies.

All providers and stakeholders are invited to join ODMHSAS leadership, the Integrated Services Committee, the 28 model programs, and the regional change agents, in continuing to sustain and expand our journey toward state-wide co-occurring capability. ODMHSAS Leadership is committed to providing resources, training, and technical assistance to enable each agency in making successful and sustainable progress toward the goal of every program become welcoming, recovery oriented, trauma informed and co-occurring capable. During the coming months, each provider will receive information about how to join the process, and how to make progress during the coming year.

## **Appendix B**

### **State Of Oklahoma Integrated Services Consensus Document**

**DRAFT**  
**STATE OF OKLAHOMA**  
**INTEGRATED SERVICES CONSENSUS DOCUMENT**

**PURPOSE**

This document was developed in partnership with providers, the Integrated Services Advisory Committee, and ODMHSAS to ensure every program throughout the state joins in the process of becoming co-occurring capable. It articulates the commitment of the signers to specific policy, principles, and practices toward sustaining and expanding co-occurring capability at all levels of care.

**BACKGROUND**

For the past five years, ODMHSAS has partnered with individual agencies making progress on co-occurring capability statewide. With the Integrated Services Initiative (ISI), funded through a SAMHSA Co-Occurring Disorder State Incentive Grant (COSIG), Oklahoma developed the infrastructure for implementing and sustaining Co-occurring Capability. During the past five years, model programs learned how to be more welcoming, accessible, trauma informed, recovery oriented, and collaborative. In addition, there have been a number of accomplishments that promote the sustainability of this process, even as the COSIG grant has come to an end:

Formation of an Integrated Services Advisory Committee

Creation of a consensus document delineating agency commitment to implementing and sustaining co-occurring capability

Creation of a website to access co-occurring capability resources

Creation and expansion of collaborative networks of providers across the state through Regional Change Agent Groups

Development of a valid and reliable integrated screening tool that is being utilized in several states

Development of a co-occurring capability fidelity tool for agency self-assessment

Incorporation of co-occurring capability requirements into standards and contracts

Training of Field Service Coordinators to provide training and technical assistance on-site

Development of co-occurring training materials at core, intermediate, and advanced levels

We are committed to building upon the success of the Integrated Services Initiative by continuing the process of sustaining and expanding welcoming, recovery oriented, trauma-informed co-occurring capable services throughout the state with the understanding that co-occurring capability is the expectation not the exception for all agencies.

Integrated Services utilizes the Comprehensive Continuous Integrated System of Care (CCISC) model, which is based on the following points taken from clinical consensus about best practices (Minkoff, 1998, 2000). Its focus is an integrated treatment philosophy from the perspective of both the mental health and the addictive disorder treatment system. The model has been adapted in Oklahoma to include trauma and to incorporate the expectation that individuals who have experienced trauma are likely to have mental health and/or substance abuse issues themselves, or in their families:

Co-occurring disorders are an expectation, not an exception.

All individuals with co-occurring psychiatric and substance use disorders are not the same - The national consensus four quadrant model for categorizing co-occurring disorders shall be used as a guide in service planning.

Empathic, hopeful, and integrated treatment relationships are one of the most important contributors to treatment success in any setting

Case management and care must be balanced with empathic detachment, expectation, contracting, consequences, and contingent learning for each participant, and in each service setting.

When psychiatric, trauma, and substance disorders coexist, each disorders shall be considered primary. Addiction, mental illness, and trauma can be treated within the philosophical framework of a recovery model in which interventions are not only diagnosis-specific, but also specific to phase of recovery and stage of change.

There is no single correct intervention - Each intervention must be individualized according to diagnoses, level of functioning, external constraints or supports, phase of recovery/stage of change, and multidimensional assessment of level of care requirements.

Clinical outcomes must be individualized - Abstinence and full recovery are usually long term goals, but short term clinical outcomes must be individualized, and may include reduction in symptoms or use of substances, increases in level of functioning, increases in life management skills, movement through stages of change, reduction in harm, reduction in service utilization, and/or movement to a lower level of care.

## OUTCOMES

By using these principles and practices, the model sites showed an increase in identification of individuals with co-occurring disorders, improved access to services, increased retention in services, and improved staff/consumer understanding of how unresolved trauma can impact service outcomes at all levels of the system of care.

## WORKING IN PARTNERSHIP

ODMHSAS, providers, consumers, advocacy groups, and other state agencies commit to collaboratively work in partnership toward sustaining and expanding co-occurring capability throughout the state in a manner that supports, integrated service delivery in line with CCISC principles and expansion of state/regional collaboration. We shall assist all programs in being successful over time by creating learning partnerships and sharing knowledge, innovations, resources, and materials. Each part is essential to the process and defined as follows:

**ODMHSAS State Leadership:** The decision making entity within the single state authority on mental health, trauma, and addictive disorders.

**Integrated Services Advisory Group:** Responsible to investigate, develop, and submit recommendations to the ODMHSAS State Leadership about sustaining and expanding the co-occurring capability with regional participation that is representative of the providers, consumers, advocacy groups, and other agency collaborators in the state.

**Regional Executive Committees:** Quarterly meetings of executive directors involved in the continuum of care in their region with the purpose of fostering cooperation, collaboration, and problem solving.

**Regional Change Agent Groups:** Regional groups responsible for sustaining and expanding co-occurring capability, as well as providing support and collaboration to one another in the areas they serve. The regional areas are Northwest, Southwest, Northeast, Southeast, and Central.

**Internal Change Agent Groups:** Staff from each program in the agency working together to develop, sustain, and expand co-occurring capability within their own agency by teaching, coaching, and supporting agency staff in the process.

## SUSTAINABILITY AND EXPANSION PLAN

### ODMHSAS:

ODMHSAS will adopt this consensus document as an official policy statement, disseminate it in official material to providers and incorporate its elements into official planning documents and other publications. ODMHSAS will maintain fundamental policies and procedures that support sustaining and expanding Co-Occurring Capability across all its divisions and providers.

ODMHSAS, along with its provider organizations, will support and encourage collaborative and cooperative processes to sustain and expand a comprehensive system of care that fosters regional interagency coordination of care for both adults and children.

ODMHSAS will maintain a webpage for listing resources, communicating about Co-Occurring Capability activities/events, and for receiving feedback regularly from around the state.

ODMHSAS will support all participating providers, in utilizing the Co-Occurring Capability Fidelity Tool as part of their Performance Improvement process toward proficiency in sustaining co-occurring capability. ODMHSAS will support sustaining and expanding Double Trouble in Recovery and other co-occurring self-help groups throughout the state to ensure availability of peer support for persons with co-occurring needs.

ODMHSAS will provide training and technical assistance through Field Service Coordinators for sustaining and expanding co-occurring capability such as: core level training, assistance with completing the agency self assessment, polity development, access to resources, co-facilitation of regional change agent group meetings, and coordinating care with other area providers.

#### STATE OPERATED PROGRAMS AND PROVIDER AGENCIES

Participating agencies agree to *adopt this consensus document as an official policy statement*, disseminate it in official material to staff and board members, incorporate its elements into official planning documents and other publications, and engage in planning efforts relative to the overall system of care to sustain and expand co-occurring capability throughout the state.

Participating agencies in each region agree to *collaborate and cooperate to develop a comprehensive system of care* that fosters regional interagency care coordination to meet regional/local needs and support the overall State-wide system of care.

Participating agencies agree to formally *adopt the goal of achieving and/or sustaining co-occurring capability* for the entire agency.

Participating agencies agree to *conduct an agency self-assessment* for all agency programs using the Co-occurring Capability Fidelity tool at twelve-month intervals to evaluate the agencies' status regarding co-occurring disorder service capabilities and use the findings to develop an action plan for achieving/sustaining co-occurring capability.

Participating agencies agree to *improve /sustain welcoming, access, and retention* for individuals with co-occurring disorders

Participating agencies agree to *identify internal change agents* to work within each program toward developing and sustaining agency wide co-occurring capability.

Participating agencies agree to *assign appropriate clinical leadership and internal change agents* working as partners in the change process to engage in regional change agent meetings to sustain and expand organized mechanisms for interagency collaboration and support.

Participating agencies agree to *support staff members, consumers, and families* to participate in system-wide efforts to sustain and expand co-occurring capability standards, policies, and procedures.

Participating agencies agree to *utilize an integrated screening tool and Performance Improvement process* to support accurate identification of co-occurring disorder consumers and ensure they receive an appropriate integrated assessment and treatment plan.

Participating agencies agree to *develop/sustain integrated billing and documentation of integrated services* within each single funding stream and type of service offered at their agency.

Participating programs agree to *provide input into the development of co-occurring treatment scopes of practice* for single licensed clinicians, and adapt those scopes of practice into human resource policy and clinical practice instructions for their clinicians.

Participating programs serving adults *agree to initiate a process to develop at least one Double Trouble in Recovery* meeting as appropriate for their setting and population.

#### PARTICIPATING CONSUMERS AND FAMILIES

Consumers in different stages of recovery will be offered the opportunity to participate as change agents and engage in the sustainability and expansion of co-occurring capable services.

Participating consumers and families will be encouraged to identify consumer participants in dual recovery who are interested in partnering in the sustainability and expansion of Double Trouble in Recovery meetings in their communities.

ADVOCACY ORGANIZATIONS:

Participating advocacy organizations will be encouraged to engage in sustaining and expanding co-occurring capable services throughout the state.

Participating advocacy organizations will be encouraged to develop official materials recognizing individuals with co-occurring disorders as an expectation within the population for which they are advocating, and supporting statewide sustainability and expansion of co-occurring capable services as a formal advocacy goal.

OTHER STATE AGENCIES:

Other participating state agencies will be encouraged to engage in sustaining and expanding co-occurring capable services throughout the state. These agencies will be requested to also encourage representatives of their agency delivery systems to participate in developing co-occurring capability for their service programs (DOC, Indian Health Services, DHS, etc.).

ODMHSAS will continue to engage with OHCA to define allowable services and UR criteria that support the principles of integrated treatment so that funding and reimbursement policies are aligned with service delivery expectations, and to train APS and SURS (or any medical quality audit staff) to use the allowable service definitions and UR criteria in the way that funding reviews are conducted in order to support this alignment.

In agreement with the above, I commit my agency as a partner in sustaining and expanding Co-occurring Capability throughout Oklahoma:

_____	_____	_____
Name	Title	Agency
_____	_____	_____
Signature		Date

=====

Break out Questions – Consensus Document

What was your initial reaction to the tone of the document? What suggestions do you have to improve the tone if needed?

After reading the 12 items providers are committing to in the document, please discuss and report back the following:

Barriers

Training/resources needed to be successful

One step we as an agency are willing to take in the next 30 days toward beginning, continuing, or sustaining co-occurring capability

**Appendix C**

**Oklahoma Co-Occurring Disorder (COD) Capability: Organizational Orientation  
and Program Fidelity Scale**

**DRAFT**

**Oklahoma Co-Occurring Disorder (COD) Capability**

**ORGANIZATIONAL ORIENTATION AND PROGRAM FIDELITY SCALE**

<b>Organization Name:</b>	<b>Date:</b>				
Please rate each item by circling the appropriate number indicating how your organization is operating today.					
	<b>Never</b>	<b>Rarely</b>	<b>At times</b>	<b>Mostly</b>	<b>Always</b>
<b>1. Organizational Philosophy</b>					
The organization is clearly committed to a philosophy that supports the practice of COD capability as evidenced by:					
• COD language in program description/brochure	1	2	3	4	5
• Leadership and staff are knowledgeable regarding COD	1	2	3	4	5
• Utilization of COD-oriented materials in the treatment process	1	2	3	4	5
• Consumers are knowledgeable of COD issues/resources	1	2	3	4	5
• Copy of current consensus document on file	1	2	3	4	5
• The agency is engaged in a local or regional network of service providers who regularly meet to address collaborative relationships.	1	2	3	4	5
Comments:					
<b>2. Consumer Eligibility/Identification</b>					
• The organization has formal processes in place which allow for rapid engagement, screening, and identification of COD.	1	2	3	4	5
• The organization tracks the number of consumers seeking services and those who have been identified as COD in a systematic fashion.	1	2	3	4	5
• The organization shows evidence of referring/linking consumers to appropriate services not provided on-site.	1	2	3	4	5
Comments:					
<b>3. Welcoming/Screening/Assessment</b>					

<ul style="list-style-type: none"> <li>• Copy of current COD practice guidelines for welcoming, screening, and assessment on file</li> </ul>	1	2	3	4	5
<ul style="list-style-type: none"> <li>• The organization has written policies and procedures in place which support welcoming, integrated screening, and integrated assessment (MH, SA, &amp; Trauma) either on-site or by collaboration</li> </ul>	1	2	3	4	5
<ul style="list-style-type: none"> <li>• Agency policy describes assessment as an ongoing process which determines or rules out COD and is used as the basis for the recovery plan</li> </ul>	1	2	3	4	5
Comments:					
<b>4. Individualized Recovery Planning/Treatment</b>					
<ul style="list-style-type: none"> <li>• The organization has written policies and procedures in place which support the development of integrated, individualized recovery plans based on assessment results.</li> </ul>	1	2	3	4	5
<ul style="list-style-type: none"> <li>• The recovery plan addresses COD needs and services on-site or by collaboration with other agencies to meet the stated goals.</li> </ul>	1	2	3	4	5
<ul style="list-style-type: none"> <li>• The consumer has access to all services identified on the recovery plan either on-site or through collaboration with other agencies.</li> </ul>	1	2	3	4	5
<ul style="list-style-type: none"> <li>• Services are designed and delivered for each identified treatment area (MH, SA, &amp; Trauma) taking into account the consumer's stage of change.</li> </ul>	1	2	3	4	5
<ul style="list-style-type: none"> <li>• The consumer sits at the head of the recovery team and is involved in fostering clear communication among practitioners within and outside of the program.</li> </ul>	1	2	3	4	5
<ul style="list-style-type: none"> <li>• Case Management services are offered to all consumers and referrals/linkages to community resources are clearly documented</li> </ul>	1	2	3	4	5
<ul style="list-style-type: none"> <li>• Consumers have access to group treatment opportunities specifically designed to address mental health and substance abuse issues in a trauma-informed manner.</li> </ul>	1	2	3	4	5
Comments:					
<b>5. Training</b>					
<ul style="list-style-type: none"> <li>• The organization ensures that all staff is oriented to COD capability within the first 30 days of employment.</li> </ul>	1	2	3	4	5
<ul style="list-style-type: none"> <li>• The organization ensures that all staff completes the core level COD training and demonstrate understanding of COD-capable services within 90 days of employment.</li> </ul>	1	2	3	4	5
<ul style="list-style-type: none"> <li>• The organization ensures that all staff members complete</li> </ul>	1	2	3	4	5

annual booster training on COD capability.					
<ul style="list-style-type: none"> <li>Each program clinician operates within his/her scope of practice and receives training to address the multiple issues that may intersect with his/her current scope of practice.</li> </ul>	1	2	3	4	5
Comments:					
<b>6. Supervision</b>					
<ul style="list-style-type: none"> <li>The organization conducts structured supervision for all staff involved in COD-capable service delivery</li> </ul>	1	2	3	4	5
<ul style="list-style-type: none"> <li>The supervision is provided by an individual experienced in the delivery of COD-capable services.</li> </ul>	1	2	3	4	5
<ul style="list-style-type: none"> <li>At least one performance indicator on COD capability is included on each employee's annual job evaluation</li> </ul>	1	2	3	4	5
Comments:					
<b>7. Performance Improvement/Outcomes</b>					
<ul style="list-style-type: none"> <li>The organization has written policies and procedures that outline their performance improvement goals including, at a minimum, one goal on COD capability</li> </ul>	1	2	3	4	5
<ul style="list-style-type: none"> <li>The organization's PI plan outlines objectives to completing the COD-capable goal(s), monitoring techniques, and who is responsible for the process</li> </ul>	1	2	3	4	5
<ul style="list-style-type: none"> <li>This process is regularly reviewed and updated by a defined group or committee responsible for the development of COD capability.</li> </ul>	1	2	3	4	5
<ul style="list-style-type: none"> <li>The results of the PI process are shared with staff and consumers</li> </ul>	1	2	3	4	5
Comments:					
<b>8. Consumer Choice/Consumer-Driven Services</b>					
<ul style="list-style-type: none"> <li>Service type, duration, and frequency are designed with input from consumers.</li> </ul>	1	2	3	4	5
<ul style="list-style-type: none"> <li>Consumers report they have access to COD-capable services.</li> </ul>	1	2	3	4	5
<ul style="list-style-type: none"> <li>Consumers report benefits from the services delivered.</li> </ul>	1	2	3	4	5
<ul style="list-style-type: none"> <li>All clinicians providing COD-capable treatment services understand and utilize motivational interventions.</li> </ul>	1	2	3	4	5
<ul style="list-style-type: none"> <li>Consumers are provided information and have access,</li> </ul>	1	2	3	4	5

wherever possible, to community based self-help groups designed specifically for individuals with COD.					
<ul style="list-style-type: none"> <li>The program has a protocol for identifying and responding to consumers who are struggling to fully engage in treatment services.</li> </ul>	1	2	3	4	5
Comments:					
<b>9. Family Engagement and Education</b>					
<ul style="list-style-type: none"> <li>The program design and curriculum supports family member (significant other) engagement in the recovery process.</li> </ul>	1	2	3	4	5
<ul style="list-style-type: none"> <li>The program offers specific educational and counseling opportunities directly related to COD for family members or significant others as a routine part of the treatment program.</li> </ul>	1	2	3	4	5
Comments:					
<b>10. Pharmacological Treatment</b>					
<ul style="list-style-type: none"> <li>The program policies eliminate barriers for admission into, continued stay, or transition out of treatment based solely on prescribed psychotropic medications and/or active substance use.</li> </ul>	1	2	3	4	5
<ul style="list-style-type: none"> <li>The program has specific interventions in place to educate consumers concerning the benefits and risks of psychotropic medications.</li> </ul>	1	2	3	4	5
<ul style="list-style-type: none"> <li>At a minimum, the program has in place consultative and/or collaborative relationships which allow for access to psychotropic medication evaluation, administration, and follow-up.</li> </ul>	1	2	3	4	5
<ul style="list-style-type: none"> <li>If psychotropic medication is prescribed, the treatment plan clearly indicates this intervention is occurring and who is providing the service.</li> </ul>	1	2	3	4	5
<ul style="list-style-type: none"> <li>Clear and routine communication occurs between the treatment program and the entity providing the medication services.</li> </ul>	1	2	3	4	5
Comments:					
<b>11. Interventions to Promote Health</b>					
<ul style="list-style-type: none"> <li>The program design and curriculum includes interventions to promote the overall health of consumers (i.e.: nutrition, exercise, stress management, etc.)</li> </ul>	1	2	3	4	5

<ul style="list-style-type: none"> <li>The program design provides consumer access to referral and case management services for health related issues (i.e.: dental, vision, medical, etc.)</li> </ul>	1	2	3	4	5
Comments:					
<b>Additional Comments:</b>					