

***OK-COSIG
End of Year 3 Evaluation
Report***

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Table of Content

Acknowledgement	175
How this Year-End Report is Organized	177
Executive Summary	178
Third Year Overview	181
Progress on Project Goals and Objectives	182
Goal 1.....	182
Objective 1.1 –.....	182
Summary of Objective 1.1 – over the first three years (10-1-5 though 9-30-7)	182
Objective 1.2 –.....	184
Summary of Objective 1.2 – over the first three years (10-1-5 though 9-30-7)	184
Goal 2.....	185
Objective 2.1-.....	186
Summary of Objective 2.1 – over the first three years (10-1-5 though 9-30-7)	186
Objective 2.2 –.....	187
Summary of Objective 2.2 – over the first three years (10-1-5 though 9-30-7)	187
Objective 2.3 –.....	188
Summary of Objective 2.3 – over the first three years (10-1-5 though 9-30-7)	188
Objective 2.4 –.....	189
Summary of Objective 2.4 – over the first three years (10-1-5 though 9-30-7)	189
Evaluation Activities and Accomplishments	190
The MACRO Evaluation	193
The MEZZO Evaluation	194
Major Themes from the Key Informant Interviews in Year Three.....	194
Analysis of the OK-COSIG Process Evaluation Data	196
Abstract.....	196
Introduction.....	196
Mythology.....	199

Sources of Data.....	199
Data Analysis.....	200
Findings.....	201
Complexity Theory.....	204
The Pattern of Complex Adaptive Systems Change.....	208
Stages of Organizational Change in Complex Systems.....	209
Tools and skill sets for managing change in complex systems.....	209
Tools and skill sets employed by the OK-COSIG team.....	213
The following tools were used in Stage 1:.....	214
Additional tools that could have been used in Stage 1.....	215
The following tools were used in Stage 2:.....	217
Additional tools that could have been used in Stage 2.....	219
The following tools were used in Stage 3:.....	220
Additional tools that could be used in Stage 3.....	222
Discussion.....	223
References used in the Analysis of the OK-COSIG Process Evaluation Data.....	224
Postscript.....	224

Acknowledgement

This is the third year-end evaluation report related to the work on the Oklahoma Co-Occurring State Incentive Grant (OK-COSIG). This report will focus on the analysis of the Process Evaluation data collected over three years. This is a beginning draft of the analyses. The deductions that are presented in this report may be modified as more data becomes available over the last two years of this evaluation. Even so, the observations collected over the last three years strongly support the conclusions in these reports.

A Process Evaluation (or formative evaluation) provides an overall analysis of the factors that contributed to or impeded successful implementation by the programs. The process evaluation over time will show the difficulties and problems of implementing the services for people with a co-occurring disorder (a specific group of people with a specific diagnosis) and the best approaches for delivering those services.

A process evaluation documents and analyzes the early development and actual implementation strategy. This is done by assessing whether strategies were implemented as planned and whether expected outcome was achieved.

A process evaluation focuses on what services were provided to whom and how. It is used to monitor program implementation, for identifying changes made to the implementation plan, and for determining the outcome of the implementation process. It consists of quantitative and qualitative data and assessments that provide complementary data on the strengths and weaknesses of the components of the program. The process evaluation methods traditionally include data from focus groups, surveys, participation in activities, and the analysis of documents.

Examples of process evaluation questions are:

- Was the program implemented as planned?
- What aspects of the program are strong?
- What aspects of the program are weak?
- What can be done to continue to strengthen the program?
- Can efficiency be improved?
- Are there unexpected effects?
- What problems arose?
- What actions are needed to support the change that has taken place?

The collection of qualitative data has involved both the Department of Mental Health and Substance Abuse and the model programs, and the administrators and staff at these agencies. Without their contributions and cooperation this process evaluation would have been impossible to complete.

The ODMHSAS leadership, the OK-COSIG team, and the Change Agents both those designated as change agents and those professionals who are the indigenous change agents who have been actively involved in program development over the last three years have driven the organizational change at all levels.

The OK-COSIG project began after a sustained effort over two years that went into producing a winning COSIG proposal. This first year of the OK-COSIG project was designed to be the planning year. Over this planning year, the OK-COSIG staff worked extremely hard to identify the components of a model of integrated services to better provide care and treatment for people with co-occurring disorders that will be a good fit for Oklahoma.

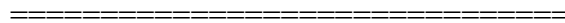
In the second year a model was designed that would guide the assessment and treatment of people with a co-occurring disorder. A Core Training was developed and evaluated. Training of all staff began. Consultants were brought in at regular intervals to supplement the training and as technical support. Rules and statutes were changed to include providing treatment to people with co-occurring disorders.

In the third year, all staff at the participating agencies was trained using the Core Level curriculum. The Intermediate Curriculum was developed and tested. Thirteen new agencies were recruited to be mentored by the 15 pilot programs. Several Change Agents groups began to function and take on the role of advocate and resource in their agencies.

These events and their activities were documented and data collected about these events as material for the process evaluation. The analyses of this data, the Process Evaluation analysis is presented in two reports in this year-end report.

According to the original proposal, year three was the last year of full operation for the OK-COSIG project. The final two years are for rolling out the co-occurring treatment approaches developed over the last three years to the rest of the state. And for the collecting

of follow-up data to determine the outcome of the OK-COSIG project. As such, this was a particularly busy year for the evaluation team. In addition to attending numerous committee meetings, workshops, and presentations, the work involved program visits, individual interviews, focus groups, and the management of large databases. This work accomplished by our team of four exceeds expectation because of the extra effort of Mary Dillon, Lisa Byers, Tiffany Adamson, and Lesa Barnett. Without their professionalism and their willingness to work beyond expectations this year-end report would be sorely disadvantaged. As an evaluation team, we drew our inspiration from people in the community who are suffering with a co-occurring disorder but continue to struggle to find recovery. Consumer participation on the ISI Committee and its subcommittees and their desire to promote, support, and to be involved in self-help groups contributed to the overall accomplishment of the OK COSIG project.



How this Year-End Report is Organized

This end of the year report for ‘Year 3’ is not meant to be a detailed report on the activities and events sponsored or participated in to further the goals of the OK-COSIG project. The activities and events are reported in a great deal of detail in each of the quarterly reports.

The primary purpose of the year-end report is to analyze the data collected over the year to determine the progress made on the two goals and six objectives of the OK-COSIG project. In this year-end report, however, the analysis of data collected over the last three years for the Process Evaluation will be presented after a brief overview of the work, challenges, and progress made in Year 3. The two qualitative reports that are the products of the process evaluation analysis look more closely at what brought about the change, how the change occurred, and how much of the change can be expected to be retained after the project ends.

The bulk of this report will be on the information derived from observations attending OK-COSIG related subcommittee meetings, attending OK-COSIG related trainings, attending COSIG related conferences, attending other OK-COSIG related functions, from

minutes of OK-COSIG subcommittee meetings, from quarterly interviews with the three primary members of the OK-COSIG Project team, interviews with the chairs of the OK-COSIG subcommittees, key informant interviews, documents developed by the OK-COSIG subcommittees and the OK-COSIG team, and from 16 focus groups over the last three years.

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

Disclaimer:

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

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Executive Summary

The end of the year report last year was for the most part a statistical analysis of the ICIS database collected on the participating agencies. This baseline analysis will become very important when it is compared to data collected on the same agencies over the next two years.

This year-end report focuses less on the quantitative and more on the qualitative analysis. Qualitative data was collected to provide observations to be analyzed for the

process evaluation. Two reports on the qualitative analysis of the data are presented as case studies in *change management* and *organizational change*.

As I suggested last year, the OK-COSIG project is a study in change management. Change management is the process and tools for managing the “people” side of change. In this case study, these are the changes needed to introduce new and altered approaches to integrate mental health practices with knowledge of substance abuse practices. Changing approaches and relationships in two fields that have been in separate camps and at times oppositional for over half century, however is challenging, but not impossible. To change an organization such as ODMHSAS and the agencies that provide services to individuals seeking mental health and substance abuse treatment, strategies must be developed that are based on sound organizational change principles that also help all shareholders understand, accept, and facilitate the changes.

The evaluator’s part in this process is to identify and track the implementation of these organizational principles. One such principal is “shareholder ownership or at least involvement and tacit approval.” A great deal depends on the degree that the shareholders are committed to the change. Another such principal is the provision of “training and support for the transformation process.” Training raises awareness and provides the skill to meet the new required tasks.

As complicated as change is to implement, manage and evaluate, the change process occurs in an organizational environment. This adds layers and nested levels of complexity to what is and can be observed by the evaluation team. In this case, there are many entities having an impact on the outcome of the OK-COSIG project. Two such entities are: SAMHSA (mostly through COCE and a yearly conference) and ODMHSAS (leadership, rules, yearly conference). Within these organizations, however, there are groups that support the COSIG effort and groups that want to move to other service issues (nested levels that complicate the process).

In addition to studying *change management* (the tools employed to change the system of treatment and the outcome of that work), the OK-COSIG project can also be studied as a model of organizational change. In this view, by using a model, we can provide another

analysis of what brought about the change, how the change occurred, and how much of the change can be expected to become a part of the organizational framework in the future.

In any organizational change effort, *advocates for change* will almost never meet their expectations in the aftermath of the change process. *Advocates against change* have a similarly disappointing experience; they feel, if there has to be change, the less change the better. The reality is that some things change, others do not, and some may almost be unchangeable in this environment. So, how do we know if the OK-COSIG is succeeding? In addition, to measuring the impact of the activities and programs implemented by the OK-COSIG team and ODMHSAS leadership, we also have to step back and look at the whole picture.

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

That was then. A description of that same treatment environment at the end of September, 2007, is in a good way, surprisingly different. One example of the change that has taken place was elicited by a series of questions used in the focus groups that were designed to pinpoint any changes and the reasons for those changes. The following questions and answers are instructive. They tend to sum up the belief of the clinicians who participated in the OK-COSIG Project.

Question: What would you say was most responsible for the services that have been developed for people with a co-occurring disorder?

Answer: The answer was unanimous, “The OK-COSIG Project.”

Question: How long would it have taken to reach this same point without the OK-COSIG Project?

Answer: “Somewhere between 10 and 20 years.”

Third Year Overview

The planning that took place during the first year came to fruition in years two and three. Change agents continue to advocate, act as a resource, and train staff on the Core Level curriculum at their agencies. The OK-COSIG staff continued to work at the administrative, agency, community, and consumer levels to promote integrated treatment across the state for people with co-occurring disorders. The implementation of policies that indicate an organizational shift in the service structure moved forward.

The ISI vision statement

A Healthy Oklahoma: All people with or at risk for co-occurring disorders have access to a recovery-oriented, consumer-driven system of care.

The ISI statement of expected outcome:

We embrace recovery-oriented, consumer-driven, trauma-informed, and culturally competent systems transformation.

The COSIG project is responsible for accomplishing two primary goals that are intended to promote systemic infrastructure integration 1) a standard protocol for the screening and assessment of mental health and substance abuse problems will be developed, evaluated, and field tested, and 2) a model of integrated treatment that is accessible, culturally competent, and grounded in evidence-based practices.

The following sections of the Year-End Report for Year 3 will explicate the work toward accomplishing these two objectives in year 3 of the OK-COSIG project.

Progress on Project Goals and Objectives

Goal 1.

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

Objective 1.1 –

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.

Summary of Objective 1.1 – over the first three years (10-1-5 through 9-30-7)

The task of operationalizing Objective 1.1 was assigned to the Integrated Services Initiative (ISI), Welcoming, Screening, Assessment, and Recovery Planning Subcommittee. Over the last three years it met monthly. The subcommittee began its work by reviewing screening and assessment tools that could be used to identify people with a co-occurring disorder.

The Welcoming, Screening, Assessment, and Recovery Planning Subcommittee studied numerous screening and assessment tools and approaches over the first six months. In addition to reviewing and discussing the assessment process at various agencies, and considering assessment tools being tested at several agencies, the subcommittee recommended a standard of 72 hours after intake in which to complete the initial assessment at inpatient facilities, with the caveat that clients are assessed for initial placement in treatment with the ASAM PPC-2R. It was recognized that it will be challenging for Providers to complete a full assessment at time of admission. The Screening and Assessment

subcommittee proposed to continue to use the CAR for the mental health assessment, and the ASI for substance abuse assessments.

Based on the observations at meetings and workshops with agency administrators and staff, and committee meetings, there was a clear understanding and acceptance that a standard screening and assessment protocol would be used in mental health and substance abuse treatment agencies that contract with ODMHSAS. The major concern expressed by administrators in the first year related to screening and assessment was that there were at least two assessment protocols currently being used in mental health. This was an area that needs clarification and policy realignment.

Year two focused on developing a standard screening and assessment protocol for use in mental health and substance abuse treatment settings. Work continued at the MACRO, MEZZO, and MICRO levels. At the state department level, committees were resolving issues about the differences related to the screening protocol that ODMHSAS will adopt and the screening process that the State Health Care Authority was going to adopt. At the MEZZO levels, consensus building continued. The Welcoming, Screening, Assessment, and Recovery Planning Subcommittee was instrumental in building consensus for the “welcoming” and “no wrong door” policy. At the MICRO level, one strategy developed in year one that showed good results and continued to be used in year three was holding Welcoming, Screening, Assessment, and Recovery Planning Subcommittee meetings at different agencies around the state where agency staff, clinicians, and service recipients participated.

One of the products of the Welcoming, Screening, Assessment, and Recovery Planning Subcommittee was the *Integrated Assessment and Recovery Process Protocol*. This protocol covered: Welcoming Practice Guidelines, Screening Practice Guidelines, Assessment Practice Guideline, and Integrated Recovery Plan Practice Guidelines.

At the end of year 3, the implementation of a standard practice for screening and assessment for people with a co-occurring disorder became new language in the rules in Chapters 17 and 18. How well this protocol will be implemented will be determined in years four and five.

In year four, an assessment pilot group from five state operated residential facilities will conduct an Assessment Pilot to determine the feasibility of using assessment tools such as the CAAPE, DAPS, and SA-45 instead of the ASI and CAR.

Objective 1.2 –

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

Summary of Objective 1.2 – over the first three years (10-1-5 through 9-30-7)

The task of operationalizing Objective 1.2 was assigned to the Integrated Services Initiative (ISI), Welcoming, Screening, Assessment, and Recovery Planning Subcommittee. The work on Objective 1.2 centered on the development of a rapid screen to identify people who need to be assessed for a co-occurring disorder and developing policy

During year one, the first version of a rapid screen was formally approved by the ODMHSAS leadership. The original screen, the *OK-Co-occurring Disorder Screen*, consisted of 17 common behavioral health questions used in the fields of mental health, addiction, domestic violence, and trauma. The screen was designed to be easy to use and easy to interpret. To pilot test the screen, it was administered to 234 people who called either a mental health or addiction treatment program. Statistical analysis of the screen subscales included Principal Components Analysis (PCA) of the items, calculating Cronbach's Alpha (α) coefficients, and a beginning examination of sensitivity and specificity. The data analysis suggests that the three subscales had acceptable internal consistency (MH $\alpha = .70$, SA $\alpha = .89$, DV $\alpha = .72$).

In year two the online version of the screen was added to the Integrated Client Information System (ICIS) data collection system. This was the third version of the screen, the *OK-COD Online Screen*. In this version, the domestic violence items were dropped because the Domestic Violence Department was moved from the ODMHSAS and became a department in the Oklahoma Attorney General's office. Added to the scale were questions that would be used to screen for trauma. This version consisted of 15 items. The screen was piloted during the second quarter of year two. By the end of the 4th quarter of year two,

3,071 screens were completed. The report on the computerized version of the screen called, *Report on the Reliability, Validity, Sensitivity, and Specificity of the OK-COD Online Screen* was completed 2-20-2007. The OK-COD Online screen was tested between June and December of 2006. The computer version of the screen was administered to 3,608 people who called for help or went to one of nine participating mental health and substance abuse treatment facilities seeking help. The group *not* admitted for treatment (n = 1,894) was slightly larger than the admitted group (n = 1,714). Of these, there were 1,191 (62.9%) screens completed at mental health agencies, 344 (18.2%) screens were completed at the substance abuse treatment centers and 359 (19%) screens were completed at the two agencies that treated people for a co-occurring disorder. The analysis determined that three subscales (MH, SA, and TA) existed within the screen. The factor analytical solution accounted for 57.25% of the variance among those being screened. The Cronbach Alpha coefficients were used as a statistical measure of the internal consistency for each of the three subscales. The Cronbach Alpha for the Mental Health screen was .74. The Cronbach Alpha for the Substance Abuse Screen was .89. The Cronbach Alpha for the Trauma Screen was .60. Based on this analysis a fourth version of the screen was developed called: *The AC-OK Co-occurring Screen*. The 15 item screen had a Cronbach Alpha of .89 on the Substance Abuse subscale and a Cronbach Alpha of .79 on the mental health subscale. For more detail and a copy of *The AC-OK Co-occurring Screen*, go to <http://faculty-staff.ou.edu/C/Andrew.L.Cherry-1.Jr/AC-CODScreenPg.htm>.

All staff working for the model agencies was trained in the screening and assessment protocol by the end of year three. The work to train 80% of staff at all State funded mental health and substance abuse treatment facilities in the screening and assessment protocol within 60 months is ongoing.

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.

Summary of Objective 2.1 – over the first three years (10-1-5 through 9-30-7)

In year one, to build a consensus among providers, service recipients, consumer advocates, and other interested parties, the ISI Advisory committee and its subcommittees were organized. Membership consisted of ODMHSAS staff, other State agencies, administrators and staff from mental health and substance abuse agencies, advocates, and consumers from around the state of Oklahoma. During year one, there were at least 39 ISI committee and subcommittee meetings and at least 23 trainings and workshops. Dr. Kenneth Minkoff and Dr. Christie Cline were able to attract a great deal of attention to the need for treatment of those with a co-occurring disorder. They brought in a model, the CCISC model and provided training on how to implement it. They also provided trainings both at the pilot sites and in other State locations during year one.

The OK-COSIG team devoted a great deal of time and work to form a consensus among providers, service recipients, consumers, advocates, and other interested parties on the concept of integrated treatment for people with a co-occurring disorder. The Comprehensive Continuous Integrated System of Care (CCISC) was selected as the model that would be supported by the implementation team. A State of Oklahoma *Consensus Document* based on the philosophy of the CCISC delineated the expectation among and between providers.

In year 2, the OK-COSIG team continued to build a consensus for providing services for people with a co-occurring disorder. They attended meetings with administrators of other state initiatives (Children's Behavioral Health, Cross Training Initiative 2, Recovery Collaboration, and Transformation State Incentive). They attended meetings and trainings with law enforcement representatives. Expansion to Northwest Oklahoma or Frontier areas was also a topic of the fourth quarter that was bolstered by COCE assistance. The Team did presentations and trainings at the Inter-Tribal Substance Abuse Prevention and Treatment

Center Northeast, Indian Health Service, and the Choctaw Nation. Additionally, they recruited 10 new model programs

The decision to develop a cadre of advocates called Change Agents resulted in a conference that both trained and promoted networking among the Change Agents. Two regional groups began to meet on a monthly basis.

Members of the various subcommittees began to express the difficulty they were having maintaining consumer and substance abuse provider involvement. Although, outreach efforts were instituted, the attendance of those shareholders not associated with the model programs continued to decline.

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

Objective 2.2 –

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

Summary of Objective 2.2 – over the first three years (10-1-5 through 9-30-7)

The work to establish joint licensure/certification for a co-occurring specialist did not begin until the first quarter of the third year. The initial meetings with members of the various licensure bodies took place in the second quarter. Over the next two quarters, several of the licensure boards met to hear about the need for credentialing co-occurring competence within the law that governs their Board. The plan was to encourage and help Oklahoma licensure boards focus on language changes and developing a strategic plan around credentialing co-occurring competence. Changes in the licensure provisions by the Licensed Behavior Practitioner (LBP) (practitioners with a graduate degree in clinical psychology),

Licensed Clinical Social Workers (LCSW), Licensed Professional Counselors (LPC), Licensed Marriage and Family Therapist (LMFT), Licensed Alcohol and Drug Counselors (LADC), and Certified Alcohol and Drug Counselors (CADC) is an important next step and is being facilitated by the OK-COSIG team. Changes by the licensure and credentialing boards to include language related to treating people with a co-occurring disorder will support both the training and continued education of clinicians in Oklahoma.

Objective 2.3 –

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

Summary of Objective 2.3 – over the first three years (10-1-5 through 9-30-7)

In year one, the Finance subcommittee was tasked with developing contracting procedures that would create strategic incentives for the implementation of the integrated treatment systems at the provider level. The report highlighted important issues that are related to providing an integrated system of service. One challenge was the anticipated increase in the number of people who were eligible for mental health funding and reimbursement via Medicaid, (e.g., the disability classification, inability to work, etc.). Services provided to a person with a co-occurring disorder, if treated by a Licensed Mental Health Professional (LMHP) at a Mental Health center could be reimbursable via the ODMHSAS contract for mental health services, or Medicaid. If medications were prescribed by the mental health facility's physician, the psychotropic medications could be paid for by the mental health facility or reimbursed through Medicaid. Many people with a co-occurring disorder are currently being treated for their substance abuse disorder by unlicensed Certified Alcohol and Drug Counselors (CADC). The Oklahoma Health Care Authority does not reimburse for services provided by CADCs. However, if the substance abuse facility utilizes a licensed mental health professional, the facility would be able to bill Medicaid (assuming the consumer is TXIX eligible) but would bill under a mental health code. ODMHSAS encouraged community mental health treatment providers to become certified to provide

substance abuse treatment. Substance abuse treatment facilities were encouraged to hire licensed counselors that had substance abuse experience. Both types of service providers need to develop a network with other providers. A future goal was to develop an enhanced Medicaid rate specifically for co-occurring treatment services. This rate would reflect the additional cost involved in assessment and treatment for both mental health and substance abuse.

In year two an OK-COSIG budget revision was approved that dropped two personnel lines so that the money could be used as incentives to compensate agencies for completing the COMPASS and for sending their staff to be trained in the Core-level Curricula. The Finance Subcommittee secured COCE technical assistance on funding opportunities for providing services for people with a co-occurring disorder. A discussion regarding the need to develop funding mechanisms for “enhanced COD services.” The committee recommended developing a type of braided funding for Mental Health and Substance Abuse services and piloting those strategies in one or several model sites. In the budget approved during year three, no new money was provided for co-occurring services.

The Systems Integration subcommittee was tasked with pulling together the work of the other ISI subcommittees. The most important product of this committee was the changes in the ODHMSAS State rules governing mental health treatment (Title 450:17, Chapter 17) and substance abuse treatment (Title 450:18, Chapter 18) include changes that relate to treatment for co-occurring disorders.

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.

Summary of Objective 2.4 – over the first three years (10-1-5 through 9-30-7)

During year one, more than 460 staff members from the substance abuse treatment and mental health treatment communities participated in training on the elements of the

CCISC Model. Some attended several events and trainings. Trainings were conducted by Dr. Kenneth Minkoff and Dr. Christie Cline, Dr. Kisthardt, and Howard Vogel. With the primary focus on Dr. Minkoff and Dr. Cline's trainings on the CCISC, training for trainers, and change agent training. The *Training-Workforce Development Subcommittee* was tasked with developing the educational training component that would be used to provide training related to integrated services for people with a co-occurring disorder to clinicians, staff, and administrators both within and outside of the model sites.

In year two, trainings from national level representatives continued. Dr. Minkoff and Dr. Cline emphasized an integrated treatment approach. Dr. Kisthardt emphasized strengths-based assessment and treatment approach. The Core-level training covered the Welcoming Environment, Cultural Competency, the CCISC Model, and the Person-centered, strengths-based approach. Dr. David Mee-Lee provided integrated treatment planning. A modified Core-Level training manual was released in the third quarter. The manual was used by the lead Change Agents when they train their own agency personnel.

In year three, Core-Level trainings were provided at treatment agencies and to community groups. All of the 15 model programs were provided Core-Level training. Core-Level trainings were provided to the 13 programs added to the cadre of 15 model OK-COSIG programs. In year four, Intermediate-Level training will be provided by OK-COSIG staff and the Change Agents in their respective agencies. As well, the development of the Advanced-Level curricula is well underway and will be completed in year four.

Evaluation Activities and Accomplishments

In year 1 the Evaluator worked with Decision Support Services Division to determine the data that would be needed from the ICIS computer system to help determine outcomes of the Project. The agreement between the ODMHSAS and the evaluator was completed. Under the agreement, de-identified extracts of data (data that cannot be linked to the individual service per HIPPA requirements) from the pilot sites would be made available to the evaluators on an annual basis for each year of funding. Data from the first planning year is being used as the baseline against which data from the pilot sites over the years can be assessed.

The evaluators began work on developing a Screen (a hot button screen that was simple to use and easy to score) to identify people with a co-occurring disorder seeking treatment. With the help of the Screening and Assessment Subcommittee members, the first version of the screen, the OK Screen, was designed and tested. The first version of the screen was formally approved by the ODMHSAS leadership. The original screen, the *OK-Co-occurring Disorder Screen*, consisted of 17 common behavioral health questions used in the fields of mental health, addiction, domestic violence, and trauma. To test the screen, it was administered to 234 people who called either a mental health or addiction treatment program.

The evaluators also produced a semi-structured interview guide to assess the impact of change in recipients of service. The questions on the interview guide came from data gathered from direct observation, the literature on program evaluation, literature on integrated treatment models, and the subcommittees, specifically, the Screening and Assessment Subcommittee, the Education and Training Subcommittee, and the Research and Evaluation Subcommittee.

In year two the piloting of the online version of the screen was completed. Some 3,071 screens were completed by the model programs.

An evaluation of agency knowledge about self help groups for consumers experiencing co-occurring disorders was assessed. The results led to suggestions related to relevant information to communicate to consumers over the phone. A major achievement within this year was the development of a Double Trouble in Recovery (DTR) Directory that lists 21 DTR resources. The directory lists the name of the group, meeting location, date and time. A contact person's name, number, and email were also included. This list is available on the ODMHSAS website under Integrated Services Initiative.

Immense time and effort went into the development of an evaluation that would assess the administrator, provider, and consumer experiences of the OK-COSIG implementation. Three separate Institutional Review Board applications utilizing qualitative and quantitative methods to assess the macro, mezzo, and micro level data were developed and submitted to the University of Oklahoma and the ODMHSAS. All three Institutional Review Board (IRB) proposals were approved by the University of Oklahoma IRB committee. The ODMHSAS IRB approved the macro and mezzo level proposals. The micro

level evaluation that involved consumers was not approved by the ODMHSAS IRB. The macro and mezzo level data was obtained in year two.

The macro level ODMHSAS ICIS data was received in the fourth quarter of year two. The data set contained 21,879 cases with 115 variables. Data management took a great deal of time. Several months were needed to review the data set and transform the data into SPSS. This data is being used as the baseline. The data file contains ICIS data from the fifteen pilot sites and five control agencies.

Telephone interviews with key informants (administrators and providers at the state and agency level) over the year were analyzed for themes that were then re-submitted to a focus group of administrators and providers to rank them in terms of the areas that needed the least and most amount of work. These themes appear in the Mezzo Evaluation section in the End of Year 2 Evaluation Report.

The Core-Level trainings were evaluated by the evaluation team members with a pre test, post test, and a focus group. The findings were used to make changes in the content and presentation.

Fidelity interviews required extensive time and work related to scheduling of interviews and travel across the state to model sites to conduct face to face interviews with two agency representatives. In addition to the model sites, agencies that functioned as controls were interviewed using the same format and questionnaire. The completed interviews which included a Likert type response assessed a number of areas related to fidelity.

In year three, the analysis of the *OK-COD Online Screen* was completed. Based on this analysis, a final version of the screen, the *AC-OK Co-occurring Screen* was completed. The *Third Quarterly Report* described the *AC-OK Co-occurring Screen* as valid, highly reliable with high sensitivity and specificity. The preliminary results on the screen highlighted the need for ICIS training. This spurred the creation of the Data Reporting Subcommittee in the last quarter of Year two that is devoted to training in this area to enhance the integrity of the data within the ODMHSAS system.

Key informants were again interviewed in year three. When possible, the individuals that had completed the key informant interviews during year two were asked to complete the

same interview in year three. If the person was not available because they were no longer in the same position or would not return telephone calls, the names of change agents were utilized. In addition, 10 new agencies were added to the initiative the third year, change agents were utilized as key informants in those agencies. The responses were submitted to a focus group of providers and administrators to rank them in terms of the areas that were important to sustaining the changes made by the OK-COSIG Project.

Macro level data was received in its raw form in the last quarter of year two. Year three involved massive amounts of time transforming the data and variables into an SPSS data file. Initial analysis of the dataset revealed interesting relationships among demographic and service use variables that will inform future analyses of ICIS data from years FY 2006-2007 and FY 2007-2008. Site specific reports will continue in years four and five.

In year three, follow up data collected by CSAT Discretionary Services Client Level GPRA (Government Performance and Results Act) Tool became a requirement. GRPA data is being collected at select OK-COSIG pilot sights. This data gathering tool tracks the clients and collects follow-up information six months after discharge. This follow-up information is an essential component on client outcome that is available from no other source. The evaluators will work with the ODMHSAS Decision Support Services Division to workout a data sharing agreement. The IRB applications to the University of Oklahoma IRB and the ODMHSAS IRB will be amended if needed. This will provide a micro level perspective.

Intermediate level trainings were evaluated by the evaluation team members with a pre test, post test, and a focus group. One was conducted in the Tulsa area. Another took place in Norman. The team provided the results of the first training before the second training took place. This allowed the trainers to incorporate the feedback into curricula before the Norman training.

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The MACRO Evaluation

The MACRO evaluation is based on a subset of data from the ICIS database. This database is used by mental health and substance abuse agencies in Oklahoma that have contracts with

ODMHSAS. The Baseline data for FY 2005-2006 has been analyzed and reported in the *End of Year 2 Evaluation Report*. Data for FY 2006-2007 will be compared to the baseline data in year four.

The MEZZO Evaluation

The Mezzo evaluation presented in this year-end report consists of two sections. The first section is an analysis of the Key Informant and Focus Group data. The second section is an analysis of the data gathered for the Process Evaluation in relationship to organizational change that took place over the last three years at the agency level.

At the end of year three the evaluation of the *Service Coordination and Networking* identified seven primary themes. In year three, the information collected from the 11 key informants was analyzed. Again in year three, using a slightly modified Delphi methodology to obtain a multi-level perspective, the seven focus group members (clinicians from participating agencies) were also asked to rank the themes identified from the key informant interviews.

The unmistakable air that permeated the focus group meeting was a sense of mild sadness. Members expressed the belief that the COSIG Project was coming to an end. They acknowledged the work that had been accomplished but expressed concern about the work that was left undone. The seven themes and the perspective of the focus group members reflect this state of mind.

Major Themes from the Key Informant Interviews in Year Three

1) Assessment:

In the majority of agencies, although the staff continues to work on assessment process, screening and assessment has improved. The process of integrating the screening and assessment for people with a co-occurring disorder with the standardized assessment procedure required by an individual “accrediting body” is continuing. Trauma identification has improved, but staff still needs more training. Nevertheless, at some agencies, the assessment process has stayed pretty much the same as before the COSIG Project.

2) Training:

Training has been effective in educating the treatment community about people with a co-occurring disorder. Training must be ongoing because of the staff “turnover” at the agency level because of the low pay. Agencies need to incorporate the Core-Level training in the new staff orientation.

3) Services Provided:

There is a continuing problem among people who request treatment for an addiction problem but do not want treatment for their mental health disorder.

The waiting list for outpatient treatment services is still very long. There may be as many as 70 people on a waiting list at any given time. Transportation to and from treatment is still a problem.

4. Service Barriers:

Some of the “barriers” have come down. There is less reluctance among agencies and staff to treat people with a co-occurring disorder. Cultural competency continues to be a concern (i.e., sensitivity to Native American, African American, and Hispanic cultures that may view mental health and substance abuse differently from others). The trainings developed instructed staff as to “what” to do but do not explain “why” they should do it in that way.

5) Self-Help Groups:

Several agencies are running DTR groups. Some agencies had difficulties with the initial start-up of groups. RSS staff have been instrumental starting and maintaining Double Trouble Recovery (DTR) groups within some agencies and in various communities.

6) Funding:

Agency administrators have expressed concern about the amount of staff time required for OK-COSIG training and program development, especially since no additional monies were allocated. Paperwork has increased when the agencies became co-occurring capable providers.

7) Next Step:

There will be an on-going need at agencies for staff training related to people with a co-occurring disorder. If ODMHSAS wants agencies to continue to comply with co-

occurring capacity standards, the Department will need to provide funding for continued trainings.

One approach suggested by the focus group members was for the Department to develop a staff position at the State level that would be responsible for continued education and trainings related to co-occurring disorders.

Another suggestion was for the Department to establish a budget line at each agency to support the work of the Change Agents.

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Analysis of the OK-COSIG Process Evaluation Data

Abstract

This is an analysis of how a large complex organization changed so that it could provide an integrated system of treatment to better serve people with the co-occurring disorders of mental illness and substance abuse. This analysis is based on the work completed to this point by the Oklahoma Co-occurring State Infrastructure Grant (OK-COSIG) project implementation team. The data used in this analysis was gathered over three years as part of the Process Evaluation of that project. Complexity theory is used to build a model of change, to organize the data, and to explain why the changes took place. Additionally, using this simulation model, a first attempt at identifying the tools employed by the OK-COSIG team to produce specific change and the effectiveness of those tools to facilitate specific changes is presented.

Introduction

The analysis of the Process Evaluation data from the Oklahoma Co-occurring State Infrastructure Grant (OK-COSIG) makes one thing abundantly clear. Unlike Lewin's (1951) construct of organizational change, organizational change among mental health and addiction treatment agencies is not about *unfreezing* to change and *refreezing* to sustain the change, it is about learning to deal with and adapting to change. It is about developing an organizational culture that is flexible and one that continues to function and provide first-rate

treatment even when the organization is changing. Mental health and substance abuse treatment agencies flourish when they are learning organizations that can make needed change. Learning is one of the strengths shared by professionals in these agencies.

“A road map indicating how and why planned change unfolds and what paths are likely to lead to success or failure is vital in today’s changing world” (Prochaska, 2000, p.76). The following is a description of changes that occurred at the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) and at mental health and addiction treatment agencies with which it contracts for services. These changes occurred in conjunction with the events, activities, and initiatives carried out by the OK-COSIG implementation team. The OK-COSIG team used events, activities, and initiatives that they believed would result in specific changes. The changes were needed to improve the effectiveness of treatment provided to people with the co-occurring disorders of mental illness and substance abuse.

To begin to conceptualize the *why* and *how* changes occur in the Project (the dynamics involved in organizational change), first we took the hypothetical position that the purpose of SAMHSA’s COSIG program was to reduce the lag time between scientific discoveries related to mental illness and substance use disorders and the provision of services at the client level. This allows for a broader view of the outcome—going beyond goals and objectives. Designing and funding programs to move “science to service” is a logical role for a federal agency like SAMHSA and is sorely needed. The Annapolis Coalition on the Behavioral Health Workforce in the Executive Summary of their report (published by SAMHSAS) titled, *An Action Plan for Behavioral Health Workforce Development* delineated the problems caused by the lag time between the validation of an intervention and its use in the field.

Most critically, there are significant concerns about the capability of the workforce to provide quality care. The majority of the workforce is uninformed about and unengaged in health promotion and prevention activities. Too many in the workforce also lack familiarity with resilience and recovery-oriented practices and are generally reluctant to engage children, youth, and adults, and their families, in collaborative relationships that involve shared decision-making about treatment options. **It takes**

well over a decade for proven interventions to make their way into practice, since prevention and treatment services are driven more by tradition than by science. The workforce lacks the racial diversity of the populations it serves and is far too often insensitive to the needs of individuals, as these are affected by ethnicity, culture, and language. In large sections of rural America, there simply is no mental health or addictions workforce (Hoge, Morris, Daniels, Stuart, Huey, & Adams, 2007: 1).

Secondly, we started with the knowledge that the OK-COSIG Project was designed as an intentional change effort with specific goals and objectives. These goals and objectives are linked to measures and preferred outcomes that can be used and compared to observed changes. Moreover, using this approach, it is also possible to identify the tools (events, activities, and initiatives) used by the implementation team in their attempt to make changes in this complex, large organizational system (ODMHSAS and the agencies that contract with it to provide mental health and addiction treatment services). Parenthetically, even though the Process Evaluation data collected over the last three years strongly supports the following inferences, the conclusions presented in this report are tentative. The conclusions will likely be modified as more data becomes available over the next two years. Moreover, in this first draft, the list of changes made and the tools used is not inclusive. Rather, examples are provided to illustrate the tools employed and changes made in each stage.

This change effort began at SAMHSA with the recognition that there was a high prevalence of people with the co-occurring disorders of substance abuse and mental illness. These numbers were supported by findings from the 2002 National Survey on Drug Use and Health in the United States. The survey found over 23% of adults suffering from serious mental illness abused alcohol or other drugs. In the population without a serious mental illness only 8.2% abused alcohol or other drugs. Among adults who abused alcohol or other drugs, 20.4% had a serious mental illness.

As well in 2002, SAMHSA released a landmark report to Congress on Co-occurring Disorders that suggested a model of *integrated services and treatment* was showing unprecedented success in the treatment of people with co-occurring disorders. The report and the subsequent money appropriated by Congress set the stage for the SAMHSA program

called COSIG. The Congressional appropriation was used to provide funding, leadership, and support for state efforts to improve their service infrastructure, and their capacity to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based treatment services to persons with co-occurring substance abuse and mental health disorders. The OK-COSIG project began when SAMHSA funded the proposal—October, 2004.

Mythology

This analysis is based on data obtained from observation of the OK-COSIG project from the perspective of a local evaluator. This means that the observations of federal activity are from a distance. There were few direct observations at the federal level. Information is from secondary sources. The observations of state agencies are more indirect than direct. They came from agency clinicians, key informants, and others involved in the OK-COSIG project. They reported what they saw changing and not changing. Observations of the clients who were treated at these agencies also took the form of individual client data collected on the ICIS system. The observations of the ODMHSAS and the implementation team activities were more direct. These observations consisted of data collected while: attending OK-COSIG related subcommittee meetings, attending OK-COSIG related trainings, attending COSIG related conferences, attending other OK-COSIG related functions.

Sources of Data

This analysis is based on qualitative and quantitative primary data collected from numerous sources. Data came from minutes of OK-COSIG subcommittee meetings, from quarterly interviews with the three principal members of the OK-COSIG Project team, interviews with the chairs of the OK-COSIG subcommittees, key informant interviews, documents developed by the OK-COSIG subcommittees and the OK-COSIG team, and from focus groups, fidelity evaluations, and surveys. Interviews were conducted with people both inside and outside of ODMHSAS.

Secondary data sources consisted of the ODMHSAS website, other related websites, grant applications, newspaper articles, and informal observations. Initially, data was also

gathered at events to develop awareness and support for making changes to better provide services for people with a co-occurring disorder. When sites visits were conducted, evaluators kept a low profile. To minimize the setting effects on evaluators (elite bias), the spectrum of participants were interviewed, both supporters and skeptics (Miles & Huberman, 1994).

In carrying out the evaluation study, we were sensitive to the fact that the presence of evaluators “creates social behavior in others that would not have occurred ordinarily” (Miles & Huberman, 1994: 265) and bias observations and deductions. To minimize the impact of the evaluation on the data collected; we clearly identified ourselves as independent evaluators to participants and informants in our study. We explained the intentions of our evaluation and the data collection process to the participants. Furthermore a letter approved by the University and State Department IRBs was read before each interview or focus group. Additionally, to better understand the impact of the evaluation on the project, data was gathered on the effect the evaluation had on the OK-COSIG team and the project.

Data Analysis

The analysis presented here was informed by Eisenhardt’s rule. “It is the connection with empirical reality that permits the development of a testable, relevant, and valid theory” (1989: 532).

To increase the reliability and validity of the data, findings were triangulated; events, activities, and initiatives that took place were verified from multiple sources. As a result, the reports generated over the last three years only include events, activities, and initiatives that were substantiated over multiple information sources. The data that was collected, the findings, and the conclusions were distributed quarterly to all involved as well as posted on a public web page. The reliability and validity of the quarterly reports is supported by the public nature of the reports. They were open to public scrutiny and changes were made based on feedback from participants. These reports are available at http://faculty-staff.ou.edu/C/Andrew.L.Cherry-1.Jr/okcosig_project.htm.

Interview questions. The interviews questions were semistructured and open-ended. The same interview guide for key informants was used over the last two years. The

comparison of the themes related to concerns and issues identified from key-informants and focus group participants over the last two years is informative and the issues are supported by other data.

Theme list. A theme was defined as a recurring topic of discussion that captured a central idea (Dutton & Dukerich, 1991). The process used to identify themes, Grounded Theory, resulted in a list of unique themes. Grounded theory methodology was the primary method that guided the qualitative data gathering efforts and the analysis of the qualitative data. Similar qualitative stakeholder analyses have been successfully used to understand new emerging and evolving systems in the past. Grounded theory emphasizes what respondents perceive as important as opposed to what is found as important in the quantitative data. (Salzer, & Shear, 2002; Widra, & Fottler, 1992).

Narrative analysis. The evaluators have used a number of narrative accounts of the OK-COSIG Project activities and the changes that were observed in an attempt to find a model that best captures the change efforts. Narrative analysis is used for organizing longitudinal data and the plenteous information that is accumulated (Langley, 1999).

Coding interview. Quarterly interviews with the OK-COSIG implementation team were recorded, transcribed and reviewed for themes related to organizational change and/or contextual elements. Informant interviews were used to identify themes and focus groups were used to validate and refine those themes.

Findings

To begin to understand and explain the changes that have occurred over the last three years, as a result of the OK-COSIG project, data collected using a mixed methods approach has been accumulated and descriptive reports generated. In this analysis, we go beyond simply describing the events, activities, and initiatives of the OK-COSIG project. In this analysis, we attempt to explain why some things changed and others did not.

One approach to understanding organization change is to live through it. Another approach is to review the scientific literature. The literature suggests that since the mid 1980s, researchers have described organizational change as either episodic or continuous (Weick & Quinn, 1999), and convergent or radical (Greenwood & Hinings, 1996; Tushman

& Romanelli, 1985). Among mental health and substance abuse treatment centers most often change seems to be continuous and convergent. In the case of the OK-COSIG project, however, the change was more *episodic* than continuous and more *radical* than convergent.

Another characteristic that quickly became evident in the study of this project was that the intended changes were not following a linear course. This highlighted several contextual problems. The project had to be completed in three years (plus two years of collecting follow-up data), and the implementation plan (based on the grant proposal) was designed from a linear perspective. During the first two years, positive changes did occur but they were disjointed and at times even chaotic. Over time it became clear that the changes were emerging from nonlinear events. Changes that emerge from nonlinear events are impossible to accurately explain using the traditional linear analytical models (Meyer, Gaba, & Colwell, 2005). A different model was needed to understand how the changes came about.

There are a number of theories and constructs that are used to explain change management. Until recently successful change management was thought of as a strategy for overcoming resistance to change. More recently, however, change management is thought of as a strategy that builds energy and engagement around the change. It is viewed as a leadership issue.

Kurt Lewin developed an early model of change and described it in three-stages. The first stage was "unfreezing." This was a period when inertia was overcome and the existing "mind set" was dismantled. The second stage is where the change occurs. This is typically a period of confusion for those involved in the change. The third stage is called "refreezing." This is where a new mindset develops and the comfort level of the employees is at previous levels.

The Gleicher's Formula for changing organizations suggests that change occurs when a combination of circumstances comes together to overcome resistance: organizational dissatisfaction, the vision for the future, and the possibility of immediate, tactical action. The formula can be expressed as $D \times V \times F > R$ (D = Dissatisfaction with how things are; V = Vision of what is possible; F = First, concrete steps that can be taken towards the vision; and R = Resistance) (Smith, 1998).

Another model to change organizations was developed at Prosci Research. This theory suggests that people must achieve five building blocks to successfully change. These building blocks are called the ADKAR Model. A = **Awareness** of why the change is needed, D = **Desire** to support and participate in the change, K = **Knowledge** of how to change, A = **Ability** to implement new skills and behaviors, and R = **Reinforcements** to sustain the change (Hiatt, 2006).

Arnold Mindell (1995) applies Process Oriented Psychology to organizational change. In this model, systems are transformed by shifting roles that people unconsciously hold in a system. Otto Scharmer's (2007) Theory U is another construct that describes a process in which change strategies are based on the emerging future rather than on lessons learned from the past. And, of course there is Paskett, Masten, Phillips, and Case (1992) concept that the stage model of behavior change can be applied to the organizational level in terms of identifying readiness to change. Intervention programs are then tailored to correspond to the stage of change.

Among these organizational change theories that help explain nonlinear change, the changes observed over the first three years of the OK-COSIG project fits most persuasively into a model developed from *complexity theory*. Although complexity theory has not been used extensively to explain organizational change (e.g., Baker, et al., 2007; Chiles, Meyer, & Hench, 2004; Lichtenstein, 2000; Lichtenstein, Carter, Dooley, & Gartner, 2007) when examining the changes that occurred as a result of the OK-COSIG project, the major tenets of this theory provide a representation of organizational change that can help us understand this most complicated interface between human behavior and organizational dynamics.

This evaluation did not begin in 2004 with the assumption that *complexity theory* would guide our understanding of how services would change or did it provide a paradigm within which to evaluate events. Nevertheless at the end of three years, *complexity theory* seems to explain the changes that took place, as a result of this project, better than other organizational change theories.

The OK-COSIG project implementation team started out the change process by holding a series of linear meetings and events that were thought or hoped would be followed

by a series of linear changes at the agency level. Linear changes did not occur. What did occur can best be explained using complexity theory.

Complexity Theory

From the complexity science paradigm, an organization is viewed as a complex system that is comprised of numerous interacting entities. The entities in this case, mental health and substance abuse treatment agencies, are semiautonomous entities and make decisions and act in relationship to changes or anticipated changes in ODMHSAS policy. Their actions and the changes they make are based on local knowledge. In this case, local knowledge is comprised of previous experiences with ODMHSAS. This history includes the impact on local agencies when previous ODMHSAS policy changes were made, formal and informal relationships with peer and competing agencies, and formal and informal rules that govern the relationships among all of the entities.

In the case of the OK-COSIG project, the agencies changed, adapted, and transformed themselves to be able to meet new policies and programming rules based on their history with ODMHSAS. These changes did not occur linearly (step 1 change followed by step 2 change). They did not occur because of specific coordination efforts (such as the coordination needed to install a new computer system). Nor were they the result of central communication (the changes to be made were clearly delineated to the agencies, for example, a change in data collection) (Maguire & McKelvey, 1999). As Anderson (1999) suggests, organizational change in complex systems (such as ODMHSAS and its contracting agencies) are characterized by nonlinear decision making that are driven by feedback loops, not linear events.

Pelz (1982) tested phase theory (a theory from complexity science) and found that change occurred in phases rather than as a linear procedure. The research also showed that intentional change (such as the OK-COSIG efforts) was easier to document and evaluate than unintentional change.

Plowman and associates (2007) suggested that there are four constructs from complexity theory that can be used to understand nonlinear organizational changes brought

about by the OK-COSIG project. They are: (1) initiating conditions, (2) the state of equilibrium, (3) deviation amplification, and (4) fractals and scalability.

An initiating condition. Complexity theory has its roots in the physical and biological sciences. The theory underscores the sensitivity and impact of an initiating event on complex systems. The euphemism for “chaos theory” (Lorenz, 1963) is the story that first became popular in the physical science community of the flap of a butterfly’s wings in one part of the world creating a storm in another part of the world. This was a phenomenon already understood by mathematicians; a small fluctuation in one variable can have a major impact including unanticipated consequences in other variables. As such, Stacey (1995) suggests that organizations are not predictable and that changes in them are *often more emergent* than intentional.

In the case of the OK-COSIG project, the initiating condition was the SAMHSA COSIG funding in 2004. Over the next three years, the form of organizational change followed emergent ideas by the participating agencies about changes that were possible. Rather than hold up or slow down change opportunities so that goals could proceed unilaterally as planned, ODMHSAS leadership and the implementation team moved goals and their objectives forward that met with the least resistance such as: *consultant activities* (used to legitimize the need for change), *shareholder committees activities* (primarily made up of participating agencies), *staff training activities* (promoted by small monetary incentives), and *changes in legislative rules* (rules related to services that must be provided by agencies contracting with ODMHSAS). If resistance was encountered trying to implement one of the components of an objective, resources and attention to that component was reduced. Some examples are: *licensure changes among clinician groups*, *development of self help groups*, and *the development of a cadre of Recovery Support Specialists (RSS)* (consumers in recovery working as peer counselors). Using consumers in recovery working as peer counselors on treatment teams was clearly a recognized concept and an accepted practice. Nevertheless, the difficulty encountered in the development of a department to provide consumer counselors to agencies providing direct treatment was not as successful as was hoped. Its development did not meet expectation.

These changes and lack of changes occurred because some of the goals and their objectives were ancillary to providing services to people with a co-occurring disorder. The “welcoming policy,” for instance, is an excellent concept on which to base the intake process on. Nevertheless, it is only loosely connected to providing services to people with a co-occurring disorder. What stands out is that it can be taken as a general censure of perceived agency practice. The “no wrong door” concept, on the other hand, helps explain to clinicians and administrators why people with a co-occurring disorder are often turned away from treatment at a mental health or substance abuse treatment center.

The state of equilibrium. Based on complexity theory, the change or lack of change can be explained by a series of OK-COSIG events that caused disequilibrium within the participating agencies. Chemical systems are good examples of change occurring from a nonlinear process (Nicolis & Prigogine, 1989; Prigogine & Stengers, 1984). In these processes, change occurs when the chemical is forced out of its state of equilibrium. As the chemical loses existing symmetries, disorder results. In the midst of this chaos, irregular and unpredictable patterns called *dissipative structures* form and lead to spontaneous self-reorganization (Kauffman, 1993).

Change occurs in organizations in much the same way. When organizations experience instability, for instance, when there are threats to the organization’s operating procedures (their state of equilibrium) forces emerge within the organization that are contradictory, operate simultaneously, and pull the organizations in different directions (Stacey, 1992). For example in the case of the OK-COSIG project, the SAMHSA grant was a force calling for innovation and experimentation in the treatment approaches used to service and treat people with a co-occurring disorder. It was clear to all shareholders that these activities would create a need for change at the agency level. This is the type of outside pressure that causes disequilibrium within an organization. Although viewed as a positive change by all involved, at the same time, it was an impediment and interfered with the need of agency administrators to develop yearly operational plans, budget and allocate resources, and meet contractual obligations to funders and clients. This was a formidable counterforce. Maguire and McKelvey (1999) described this phase of change as adaptive tension. From this pull and push period a compromise emerges. This occurs among members who know they

must make changes and have the freedom to change in ways that tend to meet the goals of the innovation and do the least damage (caused by the change) to their agency operations as a whole.

Network theorists often use a concept called Bose-Einstein Condensate to explain this phenomenon of change. The theory, from physics, explains that when molecules in systems are pushed into disequilibrium, they become highly interconnected and a new form of matter emerges (Bianconi & Barabási, 2001). In a similar way, when organizational systems reach a state of disequilibrium (a critical state requiring adaptation), entities that were independent become more interdependent (McKelvey, 2001). The same phenomenon can be observed in social systems. When people in a social system experience stress (a crisis or a need to make changes) people that were independent become highly interdependent. In highly interconnected systems, positive feedback can reinforce the direction of a change. In this case study, making available incentives to train staff reinforced the direction of the transformation.

Deviation amplification. The study of cybernetics has been referred to as a science of self regulating and equilibrating systems (Maruyama, 1963). Relevant to this case is the role that feedback plays in a transformation process. This construct proposes that positive feedback can amplify deviations and move systems away from the stable equilibrium—business as usual—toward a new configuration. Conversely, negative feedback in the change process can reduce the effect of the change process and move the organization back to the previous state of equilibrium.

Fractal patterns and scalability. The concept of fractal patterns and scalability describes configurations in organizations that repeat themselves with differing levels of complexity. Fractal patterns are similar but are not exactly the same. These patterns repeat themselves in finer and finer detail (Mandelbrot, 1977). Applied to organizational dynamics, fractal patterns are observable at nested levels and will also be observed in the whole. McKelvey and Lichtenstein (2005) propose that emergence change occurs in the same pattern across levels in an organization, the individual, group, and organizational levels.

The Pattern of Complex Adaptive Systems Change

The Pattern of Complex Adaptive Systems Change (Lichtenstein, 2000) pulls together these constructs from complexity theory and provides an illustration of the dynamics involved in organizational change and the reestablishment of equilibrium. The beginning assumption is that there are existing limits on the work that any organization can accomplish.

In stage 1: Increased Organization. There is an increase in work activity; this is the initiating condition.

In stage 2: Tension and a threshold change. As work activity increases beyond system limits, stress and tension increase. At some point, because of the lack of capacity to accomplish the additional work using the current organizational configuration and the associated increasing tension, disequilibrium occurs.

In stage 3: Newly Emerging Configuration. In the final stage, forces converge to act as a catalyst and transform the organization into a new configuration that can accomplish the expected work. At this stage, complex systems stabilize and establish equilibrium. In this construct, there are stages of change but no linear steps that can be followed to achieve change. Even so, there are tools and skill sets that can be used to move organizations through the change process.

The analysis presented here uses a variation of a model based on *complexity theory*, and Lichtenstein's (2000) model, it is called the *Stages of Organizational Change in Complex Systems* (this model is designed to simulate mental health and substance abuse treatment agencies). Using this model to organize events, what at first appears to be chaos (the change process) is transformed into an observable set of tools used to move the organization through the three stages of change. By comparing the tools, and skill sets that are available to accomplish change with the tools and skill sets used by the OK-COSIG project implementation team, changes that did take place, changes that did not take place, and changes that have not occurred will be examined (the outcome brought about by the OK-COSIG project).

Stages of Organizational Change in Complex Systems

- Stage 1: “Unfreezing.” An initiating condition is needed that creates stress related to current operating procedures.
- Stage 2: Disequilibrium. The initiating condition increased stress to the point that the level of stress exceeds the capacity of the System to absorb the stress; disequilibrium occurred.
- Stage 3: Reestablishing equilibrium. Forces converge and the organization is transformed into a new configuration that can accomplish the additional work. Equilibrium is reestablished.

Tools and skill sets for managing change in complex systems

Using Complexity Theory as a model to organize activities initiated by the OK-COSIG team, it also provides us with the opportunity to identify events and activities as tools and skill sets that were used to manage change in each stage. Accordingly, after the presentation of the complexity model, a description of the tools and skill sets used by the OK-COSIG implementation team will be discussed.

Stage 1: “Unfreezing.” An initiating condition is needed that creates stress related to current operating procedures. The initiating condition used by the OK-COSIG implementation team was the introduction of new knowledge about treatments for people with a co-occurring disorder, and information on best practices. This increased the stress experienced by clinicians and administrators.

To “unfreeze” an organization raise awareness and develop support for the needed change.

- A. Raise awareness that a change is needed. This is a good way to start the change process. Awareness of the need for a change is another way of saying, change is coming. The more often the events, the more intense the pressure to meet perceived needs of the clients (interest in needs expressed by the leadership, consumers, other shareholders, etc.). The stronger the evidence

for the need to make changes, the more it creates tension and increases the expectation of an increase in work activity.

Tools and skill sets for raising awareness?

1. Use documents and experts to raise awareness:
 - a) Documents that justify needs,
 - b) Literature from the field that justify need,
 - c) Consultants/Experts.
 2. Use events and meetings to raise awareness
 - a) Workshops,
 - b) Conferences,
 - c) Opportunities for shareholder feedback,
 - d) Town Hall Meetings.
- B. Develop support for the needed change.

Tools available to increase support for change?

1. Consensus building activities. Skills to engage stakeholders in dialogue about needs (shareholders representing all interested groups). Skills to develop and maintain Shareholder committees.
2. Knowledge that supports the needed changes:
 - a) New best practices that can be presented as the reason to change,
 - b) Presentations on how changes will improve treatment outcomes,
 - c) Presentations on how the changes will reduce cost and workload.
3. Motivational activities to promote the need for change.

Stage 2: Disequilibrium. The initiating condition increases stress to the point that the level of stress exceeds the capacity of the System to absorb the stress; disequilibrium occurred.

Planning, training, and support that can be used to manage organizational stress and confusion that results from disequilibrium.

- A. Provide knowledge on how to change; how to provide the new services and treatment for people with co-occurring disorders.

Tools available to provide knowledge and skill training on how to change.

1. Collaboration
 - a) An implementation plan that was developed by shareholders or that the shareholders agree on,
 - b) Network building activities to develop statewide capability.
 2. Training
 - a) Skills training to provide the new services,
 - b) Training on ways to make the administrative changes needed to support the new services,
 3. Changes in rules, regulations, and policy.
 4. Expand base of support.
- B. Support the implementation of the planned change.

Tools available to support the implementation of the planned change.

1. Motivational activities:
 - a) Agency based advocates for the needed change. The OK-COSIG team called these people Change Agents.
 - b) Recognition of effort and success.
 - c) Leadership support for the plan,
2. Resources:
 - a) Incentives,
 - b) Technical Assistance.

Stage 3: Reestablishing equilibrium. Forces converge and the organization is transformed into a new configuration. The changes have actually been made. The extent of the changes, however, will vary on a continuum from *little or no change* to *successful change*. This depends on how effectively and how often the tools to promote organizational

change were employed. The primary tasks are to sustain the change, set standards, and change the culture and philosophy.

The OK-COSIG team needs to continue to refine a set of measures and rewards for compliance and improved client outcomes.

A. Establish performance measures and rewards,

Tools available to establish performance measures and rewards.

1. Monitor client outcomes.
2. Monitor policy compliance.
3. Monitor program fidelity.

B. Continue to reorient the organizational culture.

Tools available to sustain a new organizational culture.

1. Ongoing workshops, events, and initiatives to sustain the changes made.
2. Ongoing initiative to expand the base of support for the change,
3. Ongoing initiative to realign rules, regulations, and policies,
4. Ongoing Collaboration
5. Redesign orientation for new employees to sustain cultural changes made within the organizations.
6. Redesign published materials from the state and local agencies to include information for people with co-occurring disorders.
7. Leadership show of support for successful changes that were accomplished.

Tools and skill sets employed by the OK-COSIG team

In this section, the tools and skill sets available to promote change at mental health and substance abuse treatment agencies will be compared to the tools and skill sets used by the OK-COSIG project implementation team. Using this approach, changes that did take place, changes that did not take place, and changes that have not occurred will be examined. **Note:** In this section the tools that are presented are roughly ordered by the degree to which they were used. All events are not listed that occurred in each stage. What are listed are examples of the tools used by the team.

Stage 1: “Unfreezing” (Lewin, 1951). To “unfreeze” an organization raise awareness and develop support for the needed change.

Tools and skill sets for raising awareness?

1. Use documents and experts to raise awareness:
 - a) Documents that justify needs,
 - b) Literature from the field that justify need,
 - c) Consultants/Experts.
2. Use events and meetings to raise awareness
 - a) Workshops,
 - b) Conferences,
 - c) Opportunities for shareholder feedback,
 - d) Town Hall Meetings.
- B. Develop support for the needed change.

Tools available to increase support for change?

1. Consensus building activities. Skills to engage stakeholders in dialogue about needs (shareholders representing all interested groups). Skills to develop and maintain Shareholder committees.
2. Knowledge that supports the needed changes:
 - a) New best practices that can be presented as the reason to change,
 - b) Presentations on how changes will improve treatment outcomes,
 - c) Presentations on how the changes will reduce cost and workload.
3. Motivational activities to promote the need for change.

The easiest part of organizational change is raising awareness. The second easiest part of organizational change is finding support (at least verbal support) for making the

needed changes. The OK-COSIG project implementation team used many if not all of the tools in the model successfully.

The following tools were used in Stage 1:

These are tools that can be used to “unfreeze” a human service system.

Note: The name of the *tool* is in *italics*. The tools can be used to increase awareness and support. The capital “A” stands of “Awareness” and the “S” stands for “Support” for the change.

1. *Documents that justify needs, A:* Distributed TIPs 42 and other material.
2. *Consultants/Experts, A/S:* Used consultants/experts to raise awareness and build support for the needed changes and implementation plan. Implementation ideas, philosophies, and presentations by consultants Dr. Kenneth Minkoff and Dr. Christy Cline of ZiaLogic, Dr. Walter Kristhardt, Dr. David Mee-Lee and the technical assistance provided by COCE raise awareness and build support for the needed changes. These experts helped provide knowledge on how to change and what to change. The use of these tools raised awareness and produced enthusiastic support from most clinicians and administrators.
3. *Consensus building, A:* OK-COSIG staff presenting at major state initiative meetings.
4. *Consultants/Experts, A/S:* COCE: The technical assistance.
5. *Consensus building, S:* Developing an implementation plan. Engaging administrators, clinicians, and consumers on the subcommittees (stakeholders) in dialogue about needs.
6. *Training, A/S:* Core level training: Development and delivery. Training provided to all participating agency staff. The focus of training is on recovery, resilience, and trauma.
7. *Consensus building, A/S:* Shareholder participation among participating agencies was strong. Shareholders from Native Americans, African Americans, and Hispanics would have extended the support base. Consumer and Advocate shareholders was difficult because of the lack of transportation for consumers and the burden of time and effort experienced by consumers and advocates who did participate. These shareholders would have extended the support and would have been a source to sustain the changes. The goal to provide treatment

that is “accessible, culturally competent, and grounded in evidence-based practices,” has not yet been attained. Of this troika, cultural competency lags behind the other two.

8. *Consensus building, A/S:* Consultants and speakers (Dr. Kenneth Minkoff, Dr. Christy Cline and Dr. David Mee-Lee) were brought in to orient and motivate the new model programs and energize the 15 original model programs.

Additional tools that could have been used in Stage 1

- Collect data on opinions,
- Committing to shared responsibility and accountability
- Planning contingencies/scenarios
- Anticipating results—asking, “What would happen if we did X?”

Comments on Stage 1: Some agency shareholders needed to be convinced that services and treatment for people with a co-occurring disorder needed to be different than the services provided for people with a mental illness or a substance use disorder. Some agency shareholders had to be persuaded that the numbers of people with a co-occurring problem was large enough to be considered a separate treatment group. The tools used to develop a consensus among the shareholders, for the most part agency shareholders, were the consultants, workshops, and conferences. The shareholder subcommittee meetings (mostly agency clinicians in the second year) were also useful in raising awareness among the participants about the commitment of ODMHSAS leadership and SAMHSA.

To develop support for the needed change, subcommittees were formed and given assignments to develop the implementation plan. The assignments were based, for the most part, on the Goals and Objectives stated in the OK-COSIG grant proposal. This provided the agency shareholders the opportunity to operationalize the Goals and Objectives.

The subcommittee meetings were also where the OK-COSIG project implementation team began to develop a cadre of supporters for providing best practice treatment for people with a co-occurring disorder. During these meetings documents that supported integrated treatment were circulated and discussed. As the subcommittee invested labor and expertise in the project, their support grew. This development will also be helpful when new agencies begin to make the change in that the “Hawthorne effect” will have already begun to raise

awareness and support. Or, the “Hawthorne effect” could raise the lack of support if the original agencies found that the changes required some action such as, taking currently committed scarce resources to make the change).

A high level of empowerment was reached by the subcommittee members. This sense of empowerment, however, was reduced when the ODMHSAS leadership vetoed a subcommittee proposal that had been accepted unanimously by the larger project implementation committee. From that point on, the subcommittee members were less challenging. They saw the OK-COSIG project implementation team as being less powerful as previously believed. Even so, subcommittee members continued to press their points. It took several months for the process to get back on track. Shareholder participation dropped but picked back up as the OK-COSIG project implementation team continued to use consultant presentations and workshops to encourage shareholder participation.

At the end of the first year, the OK-COSIG project implementation plan began to take form. The stress level on the participating agencies had risen to the point that action on their part was required. What change or changes would look like was still being discussed in the OK-COSIG subcommittees. The agencies were entering the early phases of Stage 2.

Stage 2: Disequilibrium. Planning, training, and support can be used to manage organizational stress and confusion that results from disequilibrium.

Tools available to provide knowledge and skill training on how to change.

1. Collaboration
 - a) An implementation plan that was developed by shareholders or that the shareholders agree on,
 - b) Network building activities to develop statewide capability.
 2. Training
 - a) Skills training to provide the new services,
 - b) Training on ways to make the administrative changes needed to support the new services,
 3. Changes in rules, regulations, and policy.
 4. Expand base of support.
- B. Support the implementation of the planned change.

Tools available to support the implementation of the planned change.

1. Motivational activities:
 - a) Agency based advocates for the needed change. The OK-COSIG team called these people Change Agents.
 - b) Recognition of effort and success.
 - c) Leadership support for the plan,
2. Resources:
 - a) Incentives,
 - b) Technical Assistance.

Stage 2 is the most difficult Stage in which to manage change in the organization and one of the most important to the outcome of the change process. The major tools to use during the Stage 2 process are changing rules, regulations, and policies, technical assistance on designing the agency structure to support the delivery of the new services, and training the staff on how to provide the new service.

The tools that are the easiest to use are trainings that show staff how to provide the new service. Technical assistance on designing the agency structure to support the delivery of the new services is often more difficult in social services agencies because of the lack of money to offset the cost of new services. That was the case with the OK-COSIG project. Although, most the participants thought or hoped there would be additional dollars to offset the cost of the new services, this did not occur.

The OK-COSIG project implementation team used many if not all of the tools in the model successfully.

The following tools were used in Stage 2:

These are tools that are useful during implementation.

Note: The name of the *tool* is in *italics*. The tools can be used to increase awareness and support. The capital “**K**” stands of “Knowledge” on how to change” and the “**S**” stands for “Supports” that facilitate the change.

1. *Training, K:* Knowledge on how to change. The COMPAS helped by giving administrators and clinicians direction on what changes were needed in relationship to their program services.

2. *Training, K:* COCE—The technical assistance provided by COCE transformed the organizational change process from being a state mandated change to being a clinical change driven by evidence-based practice.
3. *Training-administrators, K:* Financial consulting regarding single contracts,
4. *Training, K:* Intermediate training to increase skills development.
5. *Training, K:* Developing an online curriculum with the video taping of modules by Dr. Khem and Dr. Minkoff. Candance Shelton (an Osage, Native American) provided technical assistance regarding tribal involvement.
6. *Collaboration, S:* Work with Certification bodies,
7. *Expand Base, S:* New model site development,
8. *Expand Base, S:* Focus on substance abuse involvement.
9. *Training, K:* The technical assistance provided by COCE transformed the organizational change process from being a state mandated change to being a clinical change driven by evidence-based practice.
10. *Change in rules, regulations, and policies, K:* The SFY-2008 contracts combined mental health and substance abuse services.
11. *Change in rules, regulations, and policies, K:* Development of a standard screening and assessment protocol for use in mental health and substance abuse treatment settings in Oklahoma. State policies and contracts were modified to include language promoting capacity building and integrated approaches. The changes in the ODMHSAS State rules governing mental health treatment (Title 450:17, Chapter 17) and substance abuse treatment (Title 450:18, Chapter 18) sent the clear signal that *business as usual* had ended. The contract requiring agencies to use a “standard protocol for the screening and assessment” was a component that informed administrators and clinicians the knowledge of what and how to change. A draft of the COD statement of work (SOW) that operationalizes enhanced co-occurring services was written. The SOW is related to an outpatient contract that would host mental health and substance abuse services under one roof.
12. *Change in rules, regulations, and policies, K:* A great deal of effort and cost is involved when agencies have to change forms used in record keeping and provide new services (i.e., screening and if needed, assessing for mental health, trauma, and a substance

disorder). Once these procedures have been changed, the cost of changing them again sustains the last changes made, in this case providing new services to people with a co-occurring disorder.

13. *Expand Base, S*: Network and capacity building strategies were used to assist program administrators in sharing ideas, skills, and resources, to accomplish the goal of ‘accessibility’ to treatment. A *consensus document* was produced that explicated the relationship between agencies on issues such as referrals.

14. *Collaboration, S*: Activities to Maintaining Consensus.

15. *Incentives, S*: Incentives were used to provide resources to encourage model programs to meet specific objectives and goals: completing the COMPAS, train staff, and send staff members to the OK-COSIG Committee meetings. Model programs can earn approximately \$15,000 in the first year and \$5,000 in the second year for meeting identified goals. The incentives are funded from the OK-COSIG grant and their use was approved by the funder, SAMHSA.

Additional tools that could have been used in Stage 2

- Maintaining focus
- Reallocation of resources (people, money, materials)
- Acknowledging adjustments to environmental issues and changes
- Acknowledging course corrections

Stage 3: Reestablishing equilibrium. The primary tasks are to sustain the change, set standards, and change the culture and philosophy. The OK-COSIG team could establish a set of measures and rewards for compliance and improved client outcomes.

Tools available to establish performance measures and rewards.

1. Monitor client outcomes.
2. Monitor policy compliance.
3. Monitor program fidelity.

B. Continue to reorient the organizational culture.

Tools available to sustain a new organizational culture.

1. Ongoing workshops, events, and initiatives to sustain the changes made.
2. Ongoing initiative to expand the base of support for the change,
3. Ongoing initiative to realign rules, regulations, and policies,
4. Ongoing Collaboration
5. Redesign orientation for new employees to sustain cultural changes made within the organizations.
6. Redesign published materials from the state and local agencies to include information for people with co-occurring disorders.
7. Leadership show of support for successful changes that were accomplished.

Once the changes have been made, the focus needs to turn to activities that support the changes made and establish the changes as a part of the organization/agency culture (Buchanan, et al., 2005). The NHS Modernization Agency (2002, p. 12) defines sustainability as follows:

Sustainability is when new ways of working and improved outcomes become the norm. Not only have the process and outcome changed, but the thinking and attitudes behind them are fundamentally altered and the systems surrounding them are transformed in support. In other words it has become an integrated or mainstream way of working rather than something ‘added on’. As a result, when you look at the process or outcome one year from now or longer, you can see that at a minimum it has not reverted to the old way or old level of performance. Further, it has been able to withstand challenge and variation; it has evolved alongside other changes in the context, and perhaps has actually continued to improve over time.

To meet this definition of change that is sustained, the OK-COSIG team needs to continue to refine a set of measures and rewards for compliance and improved client outcomes for the participating agencies.

The following tools were used in Stage 3:

These tools are useful during the reestablishment of equilibrium.

Note: The name of the *tool* is in *italics*. The tools can be used to increase awareness and support. The capital “*M*” stands of “Monitoring” change” and the “*S*” stands for “Supports” that sustains the change.

1. *Ongoing initiative to realign rules, regulations, and policies, S:* State policies and contracts are continuing to be modified to include language promoting capacity building and integrated approaches
2. *Ongoing initiative to expand base, S:* Network building to develop statewide capability to identify, refer and/or treat
3. *Ongoing initiative to realign rules, regulations, and policies, S:* Incorporating and sustaining the provision of co-occurring programming at the State policy level.
4. *Ongoing workshops, events and initiatives, S:* Provide statewide training of clinicians and staff to continue skills development.
5. *Ongoing Collaboration, S:* Realign credentialing standards used by clinical licensure boards. The OK-COSIG team and project cannot create disequilibrium or stress among the licensure boards. Overtime, however, the changes taking place in the state and in the science on co-occurring disorders will create an environment that will destabilize enough to effect change in the credentialing standards. Changes in the licensure provisions by the Licensed Behavior Practitioner (LBP) (practitioners with a graduate degree in clinical psychology), Licensed Clinical Social Workers (LCSW), Licensed Professional Counselors (LPC), Licensed Marriage and Family Therapist (LMFT), Licensed Alcohol and Drug Counselors (LADC), and Certified Alcohol and Drug Counselors (CADC) is an important next step and is being facilitated by the OK-COSIG team. Changes by the licensure and credentialing boards to include language related to treating people with a co-occurring disorder will support both the training and continued education of clinicians in Oklahoma.
7. *Monitor client outcomes, M:* Data required under the Government Performance and Results Act (GPRA).
8. *Ongoing Collaboration, S:* Change Agent Regional Committees
9. *Ongoing initiative to expand base, S:* ODMHSAS will not have separate SA and MH conferences this year nor in the future.
10. *Ongoing workshops, events and initiatives, S:* Development of a treatment journal for persons with co-occurring disorders called “Successful Living with Co-occurring Disorders.”

11. *Ongoing initiative to expand base, S:* Integrating treatment for people with a co-occurring disorder into the fabric of behavioral health across departments at the ODMHSAS and the state human service departments will help sustain the changes made.
12. *Ongoing initiative to expand base, S:* Provide presentations to community groups who are not clinical such as churches, service groups.
13. *Leadership show of support, S:* An Integrative Systems Initiative (ISI) Executive Leadership Retreat on September 25, 2007. Executive Directors and their Clinical Directors met in Norman, Oklahoma.
14. *Ongoing Collaboration, S:* ODMHSAS was awarded one of the *Access to Recovery Grants*.
15. *Ongoing initiative to expand base, S:* Signed a contract with Oklahoma University Health Science Center (The Infectious Disease Institute) to provide training and Technique Assistance in the area of improving ODMHSAS's response to individuals with HIV/AIDS and other infectious diseases.
16. *Dissipative Event:* No new funding to enhance programming. This sends a message that the change is not as important as it was presented to be. The resource burden will have a "pushback" effect. Agency staff will have to realign and change services until all services can be provided within current budgetary constraints. The tendency will be to implement as few new services as is allowed and to find other services to cut back on to balance the budget. Change agents have clearly expressed feelings of being overwhelmed and overworked.

Additional tools that could be used in Stage 3

- Use data and other feedback to make decisions regarding the value of the activities and related outcomes.
- Determine if the accomplishments are those targeted and expected.
- Determine if the accomplishments are resulting in progress toward attaining the desired outcome.
- Determine if the accomplishments were worth the costs.
- Disseminating information to the public.

- Activities to sustain the outcome within the larger organization.

Discussion

This conceptualization is a nonlinear view of how organizations and systems can be changed. It attempts to isolate significant phases in organization change and then identify tools that can be used to move an organization through the three stages of change, (1) unfreezing, (2) disequilibrium, and (3) reestablishing equilibrium.

Using this model to simulate organizational change, it is possible to identify what tools were used by the OK-COSIG team at each stage and how effectively the tools were used. It is also possible to determine what tools were used less successfully and why they were not as effective.

In the case of this project in Stage 1, broadly speaking (without regard to specific details or exceptions) the effort to raise awareness about the need to provide more effective treatment for people with a co-occurring disorder was enormously successful. In fact, resources could have been better distributed in stage one. Too much attention was given to tasks related to raising awareness. There was already a great deal of awareness among clinicians and agency administrators. Some of those resources would have been better expended to enhance shareholder involvement by African Americans, Native Americans, Hispanics, consumers, advocates, and other groups. Additionally, more resources committed earlier and focused on providing the knowledge and developing training on how agencies could go about changing would have reduced the fragmentation during stage 2, the implementation stage. Skill trainings have increased service effectiveness, networking, and support. Although, the OK-COSIG team is involved in “rolling out” the changes to the rest of the agencies in the state, resources need to be found to support the activities and the work of the Change Agents. They are in one of the most strategic positions to support and sustain the change at the agency level. As well, there is a need to develop concrete tools to monitor the changes that have been achieved.

Based on these analyses, there is still a great deal of work ahead for the OK-COSIG team. Even so, to this point, the OK-COSIG team has accomplished a great deal. In Oklahoma today, people with a co-occurring disorder have a much greater chance of being

identified and receiving treatment that is responsive to his or her co-occurring disorder. Without, the OK-COSIG project (an effort to move science to service) it is not unimaginable to believe that this level of service and treatment for people with a co-occurring disorder would not be available for years to come.

See the Appendix page 228 for the References used in the Analysis of the OK-COSIG Process Evaluation Data.

Postscript

With the close of year three, the majority of the work on the OK-COSIG Project has come to an end. The work remaining is primarily related to orienting and training staff in the 10 new agencies; support their change efforts, and “walking out” the agency changes to the remainder of agencies providing mental health and substance abuse treatment in the State. There are 14 previous quarterly and year-end reports that describe the work over the last three years. The work is delineated day by day, month by month, and year by year. These reports can be obtained from the website: http://faculty-staff.ou.edu/C/Andrew.L.Cherry-1.Jr/okcosig_project.htm

The major focus of the OK-COSIG Project over the next two years will be on evaluating the three year effort to change a large complex organization so that it can provide an integrated system of treatment that will better serve people with the co-occurring disorders of mental illness and substance abuse in Oklahoma.

Interestingly, in the focus group reviewing the events and themes that were important during year three, an observation that the focus group members agreed on was that the agencies have made more changes to institutionalize integrated treatment for people with a co-occurring disorder than the ODMHSAS. As one member reflected, “We tell our clients that changing means a change in life style. When is ODMHSAS going to change?”

The Following are Recommendations and Suggestion that have Emerged from the analysis of the Data Collected for this Evaluation

1. The cadre of Change Agents needs to receive continued support. This group can be effective in sustaining and moving the treatment of the co-occurring disorders

solidly into the mainstream of treatment. A great deal of money and Department staff and resources has been expended to develop the cadre of Change Agents. This could be one of the most effective and efficient groups developed to maintaining fidelity related to services provided people with the co-occurring disorders of mental health, trauma, and substance abuse. The Change Agent group could also be used as a conduit for moving best practices from the ODMHSAS to their contracting agencies. It would be a strategic investment if the ODMHSAS established a budget line at each agency to support the hourly work of the Change Agents. The ODMHSAS and SAMHSA need to advocate for and make provisions for providing the support for training and infrastructure enhancement.

2. Another strategic change that the ODMHSAS could make would be to establish a commissioner or vice-commissioner of Co-occurring Disorder services. A person in this administrative position could be an advocate within the ODMHSAS for promoting best practices for all people with a co-occurring disorder. The size of the population of people with co-occurring disorders related to mental health and substance abuse support such a position. Add to this group, people with a Traumatic Brain Injury (being reported in large numbers among the military) a vice-commissioner of Co-occurring Disorder services would be a strategic addition to the ODMHSAS administration structure.

3. Trainings have been effective raising awareness and providing skills training. Core-Level trainings have been provided for all of the staff at the model programs. The trainings using the Intermediate Training curriculum has begun. The staff is working on the advanced curriculum. Orientation and Core Level trainings are being delivered to the new model programs. The development of the three levels of training and the ability to provide it would be a good strategically sound change. These trainings are important in that they both educate and inform the public and those involved in the field of Behavioral Health.

4. Sustainability is a concern of the clinicians who participated in the OK-COSIG Project. Clinicians and staff that have been involved in the OK-COSIG project over the last three years are aware that the major work of the Project is coming to an end. They are concerned about sustainability of the changes that have been made. They have invested a great deal in making these changes. The discussion about sustainability needs to begin at the ODMHSAS leadership level.

5. Low shareholder participation was persistent over the three years. There was a low level of service recipients and consumer advocates. There was also a low level of other significant groups (e.g., African American, Hispanic American, and Native American Involvement). The lack of involvement from these shareholder groups beset projects of this type. It has been a serious problem since the efforts have been made to include shareholders in decision making about behavioral health planning. The OK-COSIG implementation team did no better or worse than others. SAMHSA needs to provide leadership in this area. SAMHA could take the lead in supporting the development of methodologies and programming that would increase shareholder participation from these vital groups.

6. A public education campaign is needed to raise awareness about the co-occurring disorders related to mental illness and substance use. The people of Oklahoma would benefit from information on co-occurring disorders and the treatment that is available.

7. Support the concept of Mentoring programs. These are the 28 programs that were model programs during the OK-COSIG Project. The idea is that these co-occurring capable programs will assist new agencies in their attempt to become co-occurring capable programs. If a mechanism to fund the Change Agent core-level training was developed, the Change Agents could also help mentor the new programs.

Then and Now

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

people who presented with the co-occurring disorders of mental health, substance abuse, and trauma.

That was then. A description of that same treatment environment at the end of September, 2007, is in a good way, surprisingly different. One example of the change that has taken place was elicited by a series of questions used in the focus groups that were designed to pinpoint any changes and the reasons for those changes. The following questions and answers are instructive. They tend to sum up the belief of the clinicians who participated in the OK-COSIG Project.

Question: What would you say was most responsible for the services that have been developed for people with a co-occurring disorder?

Answer: The answer was unanimous, “The OK-COSIG Project.”

Question: How long would it have taken to reach this same point without the OK-COSIG Project?

Answer: “Somewhere between 10 and 20 years.”

Appendix

References used in the Analysis of the OK-COSIG Process Evaluation Data

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