

**1. FACE PAGE**

**Insert Standard Form 424 Here**

**“Application for Federal Assistance”**

*NOTE: When completing the form, applicants are to follow the instructions given in Appendix A of Part II, Form PHS-5161-1 (pages 13-16), rather than the instructions on the back of the form.*

## **2. ABSTRACT**

To improve the identification and treatment of individuals with co-occurring disorders throughout a diverse service delivery system, Alaska has committed to addressing SAMHSA goals of improved screening, assessment, treatment, and training, which will be accomplished through infrastructure development, focusing on staffing competency, credentialing, and licensure; financial planning and reimbursement; and information sharing and data collection. The work will be carried out in fulfillment of a State action plan for the integration of mental health and substance abuse services, developed in consultation with co-occurring disorders experts Dr. Kenneth Minkoff and Dr. Chris Cline. The conceptual model guiding the activities is based on eight clinical consensus best practice principles that promote an integrated clinical treatment philosophy applicable to the treatment of both mental health and substance disorders. The process will result in the development of an integrated planning and implementation structure; an organized strategic planning and quality improvement process; acceptance of a universal integrated screening process; implementation of a CQI program to monitor the provision of integrated treatment for individuals with co-occurring disorders; the elimination of barriers to integrated screening, assessment and treatment; establishment of an integrated management information system, Alaska Automated Information Management System (AKAIMS); and a system-wide training plan to ensure the achievement of dual diagnosis capable competencies across agencies and among all clinicians. Dr. Amy Salomon of Advocates for Human Potential will evaluate the program. When fully implemented, the system will use the Comprehensive, Continuous, Integrated System of CARE (CCISC) Outcome Fidelity and Implementation Tool (COFIT-100®) for measuring progress in CCISC implementation.

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## **5. PROJECT NARRATIVE AND SUPPORTING DOCUMENTATION**

### **A. DOCUMENTATION OF NEED/PROPOSED APPROACH**

#### **A.1 UNDERSTANDING THE PROBLEM**

People with co-occurring substance abuse and mental disorders live in all of our communities and at every economic strata. Separately, substance abuse and mental disorders are as treatable as other chronic illnesses. However, individuals who experience these disorders simultaneously are more ill, require more costly care, and are more difficult to treat than those with a mental illness or substance abuse disorder alone. Stigma, inadequate treatment, and uncoordinated systems of care hinder a successful response to co-occurring disorders. Fortunately, research and practice show that there are effective treatments for these chronic, complex, and interrelated problems. States and communities around the country have begun to develop innovative services and integrated systems of care to help people recover from co-occurring disorders.

##### **A.1.1 The Scope of the Problem**

In the United States, there are 7-10 million people with a mental disorder *and* a drug or alcohol disorder (SAMHSA, 2002). One disorder puts a person at risk for the other, and each can compound the other. As the U.S. Surgeon General reported in 1999 that, of those people who have either a mental or substance abuse disorder, about half have a co-occurring disorder (U.S. DHHS, 1999).

The 2001 National Household Survey on Drug Abuse found that of youth receiving mental health services, 43 percent had a co-occurring substance abuse disorder. Of the 14.8 million adults with serious mental illnesses, 20.3 percent had substance abuse or dependence (SAMHSA, 2002a); this is nearly triple the rate of those without a serious mental illness. In all, about 3 million adults had both serious mental illnesses—such as schizophrenia, bipolar disorder, borderline personality disorder, or major depression—and substance abuse or dependence in a single year. Individuals of all ages with co-occurring disorders represent the biggest challenge to the combined efforts of agencies providing mental health and substance abuse services.

##### **A.1.2 Treatment Barriers**

Substance abuse and mental disorders are complex problems with social, psychological, and biological elements. Screening and assessment can be problematic because of personal denial and because one disorder may mask, or masquerade as, the other. Treatment is complicated by the fact that individuals with co-occurring disorders may be rejected from a mental health program because of their substance abuse disorder and/or from a substance abuse program because of their mental disorder. Further, a “co-occurring disorder” is not a single disease. Co-occurring disorders are severe, chronic, symptomatic, or impairing to different degrees in different people, and individuals vary in their motivation and readiness to seek help and change. Similarly, substance abuse and mental health systems differ in their methods, staffing, outreach, capacity, and ideology. Funding methods and regulations do not encourage creative, cross-system responses to the need for screening, evaluation, and treatment. Systems of care are fragmented and rigid, which places the burden of coordinating care on individuals who may not be prepared for this task.

A growing evidence base supports the appropriateness of integrated treatment for people who have the most serious disorders. However, many people receive treatment for only their mental illness or their substance abuse disorder, if they receive treatment at all. Few receive treatment for both. One national study found that 29 percent of people with co-occurring disorders received no treatment and that only 19 percent were treated for both (Kessler, 2002).

### **A.1.3 Evidence-Based Treatments**

Limited resources and knowledge often produce a gap between what we know and what we do. Fortunately, in recent years more States and communities are developing and providing evidence-based and integrated services and treatments. Ideally, these approaches recognize that people with co-occurring disorders should be treated individually to address their specific needs (SAMHSA, 2002). Controlled studies have indicated positive results from integrated treatments in mental health settings for co-occurring disorders that involve serious mental illness (Drake et al., 1998 and 2001). These also appear to be cost-effective. At the same time, studies in substance abuse and mental health programs show integrated treatment can improve retention and reduce substance abuse and mental health symptoms (SAMHSA, 2002). The provision of integrated treatment ranges across a continuum from cross-referral and linkage; through cooperation, consultation, and collaboration; to integration in a single setting or treatment model (SAMHSA, 2002).

Regardless of the type or level of integration, specific interventions should respond to a person's stage of recovery and motivation, build a therapeutic alliance, and serve other needs such as housing and work (Drake, et al., 2001). These treatments can be tailored and modified for the level of each disorder and for the combined nature of the co-occurring disorders a person may have. Family-based treatment, for instance, is especially effective with adolescent clients.

### **A.1.4 System-level Changes**

Integrating mental health and substance abuse treatment is a complex task. As noted, mental health and substance abuse treatment programs have long had separate administrative structures, funding mechanisms, priority populations, treatment philosophies, clinician competencies, and eligibility criteria. Integration efforts also are hampered by inadequate resources for both mental health services and substance abuse treatment, and by a shortage of staff that are educated and trained in the treatment of co-occurring disorders.

Communities that are successful in creating system-level changes build consensus around the need for an integrated response to co-occurring disorders, develop aggregated financing mechanisms, cross-train their staff, and measure their achievement by improvements in client functioning and quality of life. Many make use of their Substance Abuse Prevention and Treatment (SAPT) and Community Mental Health Services (CMHS) Block Grant funds to do so, using the funds as authorized by law.

A conceptual framework for treating co-occurring disorders, developed with support from the Substance Abuse and Mental Health Services Administration (SAMHSA) by the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD), provides

a common language and establishes shared priorities between the mental health and substance abuse treatment systems for people who have co-occurring disorders (NASMHPD/NASADAD, 1999). This is an important tool for planning service coordination and affecting system change.

The Comprehensive Continuous Integrated System of Care (CCISC), recognized by SAMHSA as an exemplary practice, is an example of systems integration in action. The model unites the mental health and substance abuse systems in effectively treating people with co-occurring disorders (Minkoff, 2001). Two principles guide the CCISC: *integrated system planning* and *integrated treatment philosophy*. Integrated system planning acknowledges that people with co-occurring disorders are the expectation, not the exception, in treatment systems. Therefore, all service programs are designed to be “co-occurring capable,” meeting minimum standards of capacity. An integrated treatment philosophy recognizes that both disorders are primary and should be treated as such. Treatment must be individualized and success measured according to individual treatment goals. CCISC applies to any size system and is being implemented in at least 15 States. There is a toolkit to facilitate adoption and to evaluate program fidelity, capability, and competence (SAMHSA, 2002).

#### **A.1.5 The Report to Congress and COSIG**

Working with its National Advisory Councils and constituency groups, SAMHSA issued its report to Congress on co-occurring mental and substance abuse disorders in December 2002. The report points the way toward a life in the community for people with co-occurring disorders by making sure that any door is the right door for the services an individual needs. It describes how States and communities are initiating system-level changes and innovative programs, often using their Block Grant funds.

The new State Incentive Grants (COSIG) for Co-occurring Disorders, a centerpiece of SAMHSA’s 5-year Blueprint for Action, will help States continue and expand this work, in coordination with a new national co-occurring disorders prevention and treatment technical assistance and cross-training center. In addition, the COSIG program will address the capacity-building goals in the report to Congress, which call on States to develop their capacity to screen, assess, and treat individuals with co-occurring disorders; train their staff; and evaluate their results.

### **A.2. THE ALASKA STATE SYSTEM**

#### **A.2.1 Prevalence of Co-Occurring Disorders in Alaska**

Over the past 10 years, there has been a growing realization in Alaska that persons experiencing co-occurring substance related and mental disorders were both more numerous than previously believed and not receiving appropriate services. The reasons for the failure to provide appropriate services to these individuals were primarily related to the funding mechanisms and the structure and delivery of treatment services in Alaska. This has been exacerbated by the manner in which substance abuse and mental health professionals are recruited and trained.

Quantifying the number of individuals with co-occurring disorders in Alaska has been equally problematic for several reasons. First, the primary means of gathering prevalence data in Alaska has been connected to the treatment delivery systems. These systems have, until now, been structured to focus on either substance abuse clients (for substance abuse programs) or mental health clients (for mental health programs). While the

substance abuse treatment system has been relatively successful at producing unduplicated data, the mental health system has not. Currently, there is no mechanism for producing unduplicated data across the two systems. Second, there has been no common approach to diagnosing co-occurring disorders in Alaska. A survey of all substance abuse and mental health treatment providers conducted in 2000 found no consistent instruments in use for screening for co-occurring disorders (Alaska Division of Mental Health and Developmental Disabilities, 2001).

Given these limitations, the Alaska Mental Health Board indicates that approximately 40,000 individuals in Alaska (adults and children) suffer from a major mental illness or severe emotional disorder, based on prevalence data published by SAMHSA (SAMHSA, 1998). A survey of mental health service providers revealed that 67 percent of mental health service organizations believed that between 25 percent and 75 percent of all clients had co-occurring disorders (Alaska Department of Health and Social Services, 2001).

From the substance abuse perspective, a 1997 – 1998 study sponsored by SAMHSA's Center for Substance Abuse Treatment and the Alaska Division of Alcoholism and Drug Abuse estimated that 12.6 percent of the adult population (436,345 on 2000 census) need treatment for alcoholism, 1.2 percent of the adult population need treatment for both alcoholism and other drug disorders, while 0.5 percent need treatment for drug use disorders only (Division of Alcoholism and Drug Abuse, 1999). A survey of substance abuse service providers revealed that about 42 percent of the organizations believed that 25-75 percent of their clients had a co-occurring mental health diagnosis (Alaska Department of Health and Social Services, 2001). At the national level, a recent SAMHSA report indicated that, for organizations providing residential substance abuse services, about 47 percent of the clients had co-occurring substance abuse and mental health disorders (SAMHSA, 2003). These broad ranges of prevalence are indicative of the gaps in screening methodology and data collection/analysis capacity as well as the structural problems presented by the traditional treatment delivery systems in Alaska.

### **A.2.2 Alaska's Service Delivery System**

Alaska has a comprehensive behavioral healthcare system composed of diverse organizations that fulfill various roles. Understanding of the structure of this system, as well as the roles of the various agencies in the planning and delivery of services, is critical to the understanding of the history and the plans for the future. Delivery of behavioral health services in Alaska is accomplished primarily through the use of private, non-profit organizations, although there are municipal government agencies that deliver services in some communities. The management of service delivery, from a system perspective, has historically been accomplished by the Mental Health Section of the Division of Mental Health and Developmental Disabilities (DMHDD) and the Division of Alcoholism and Drug Abuse (ADA), both under the Department of Health and Social Services (DHSS). Planning for service delivery in Alaska is a more complex process, with other organizations assuming major roles.

Alaska currently has a combination of land and financial assets known as the Alaska Mental Health Trust intended to ensure delivery of services to a defined group of beneficiaries, including persons with mental illness and chronic alcoholics with psychosis. The trust is administered and managed by the Alaska Mental Health Trust Authority (AMHTA). The beneficiary groups represented by the AMHTA have associated boards that provide recommendations for service delivery as well as advocacy

and planning for their specific population. The two beneficiary boards of interest for behavioral health are the Alaska Mental Health Board (AMHB) and the Governor's Advisory Board on Alcoholism and Drug Abuse (ABADA). These boards work in concert with the AMHTA to advocate and plan for appropriate services. The mission and composition of these boards are defined in Alaska Statute and the boards, as well as the AMHTA, are administered as components of State government.

In 2001, the DHSS convened a task force to examine the issues related to integration of mental health and substance abuse services. This project brought together policymakers from service delivery systems as well as service providers and consumers from both systems. The project identified barriers to better integration and collaboration, including categorical funding issues, conflicting regulations, assessment and screening difficulties, philosophical differences, and structural issues (Alaska Department of Health and Social Services, 2001). Both groups came away from the project with a sense of urgency that major changes need to occur in order to provide appropriate services to persons with co-occurring disorders.

Until now, the responsibility for serving persons with co-occurring disorders in Alaska has rested simultaneously with two different service systems: the substance abuse treatment and the mental health service delivery systems. Further, the services for this population comprised only a part of each different system. The characteristics of service providers vary with the type of community in which they are located. In the large urban areas, such as Anchorage, providers are more likely to be highly specialized and focused on either mental health or substance abuse. In rural areas, providers are more likely to be integrated agencies providing both mental health and substance abuse services. In some communities, the services are integrated, while in others the services are separate even though they are provided by a single agency. Each system has separately undertaken changes and improvements, most recently in an attempt to better serve persons with co-occurring disorders. Efforts and initiatives designed to better serve this population are detailed in the sections that follow.

### **A.2.3 Action Taken/Accomplishments To-Date**

What is perhaps most compelling about Alaska's ability to advance the system of services to persons with co-occurring disorders is the State's remarkable record of achievement in this area combined with ongoing efforts. As a result of a DHSS task force on integration that concluded in 2001, an implementation group was formed to move the effort forward. This effort produced, and continues to produce, positive results in four focus areas.

#### **A.2.3.1 Infrastructure and Strategy**

A task list was produced that assigned specific responsibilities to various organizations and individuals intended to address the barriers identified in the original integration workgroup. These tasks were:

- develop a charter document to serve as a guidepost for initiatives and activities;
- capture data to identify, to the extent possible, the number of persons with co-occurring disorders being served;
- develop screening and assessment tools and associated support information and guidance;
- conduct a self-assessment related to dual-diagnosis capability;

- implement a train-the-trainers program designed to provide individuals with the skills and knowledge related to co-occurring disorders necessary to serve as change agents for their organizations;
- develop consolidated requests for grant proposals;
- identify ways to maximize the ability of Medicaid to address the issue of services to people with co-occurring mental health and substance abuse disorders; and
- develop structures to sustain the effort to improve services to persons with co-occurring disorders.

Some of these goals, such as the screening and assessment goals, have been achieved while others are still in process. The creation and expansion of infrastructure to continue this effort is the focus of this proposal.

The charter document developed as a part of this effort, although not formally adopted by Alaska's new administration, provides a framework for action. As a basis for action, there was tentative agreement to adopt the Comprehensive, Continuous, Integrated System of Care (CCISC) model for designing statewide systems change to improve access and outcomes for individuals with co-occurring disorders within the context of existing resources. This model is based on eight clinical consensus best practice principles identified by Dr. Kenneth Minkoff, which espouse an integrated clinical treatment philosophy that makes sense from the perspective of both the mental health system and the substance disorder treatment system. If ultimately implemented, the system would also employ the CCISC Outcome Fidelity and Implementation Tool (COFIT-100®) for measuring progress in CCISC implementation.

In the past, planning for the two delivery systems has been independent and discipline-focused. If these efforts are to succeed, an overarching strategic and systemic approach must be adopted and executed. The first step in this process will be the merging of the mental health section of DMHDD and ADA into the Alaska Division of Behavioral Health (DBH), effective July 1, 2003. With common and committed leadership, the state is poised to organize these efforts, provide the necessary infrastructure, resolve conflicts, and implement policies and procedures that will bring high-quality, appropriate services to persons with co-occurring disorders.

#### **A.2.3.2 Training and Education**

Some of the difficulty associated with the delivery of services to persons with co-occurring disorders stems from the fact that services are delivered to consumers of the two systems by two separate groups of professionals. These professionals (some licensed, some subject to voluntary certification, and some not credentialed) receive training and education related to the discipline within which they serve. Cross-training, while sometimes pursued by individuals and agencies, has not been required of either profession in Alaska. This contributes to the insular nature of both disciplines in Alaska. Despite the efforts of policymakers, the lack of cross-training in both disciplines serves to maintain a narrow focus. .

#### **A.2.3.3 Financial Systems**

One of the major barriers to better collaboration and integration of services identified in the integration project was the fundamental differences in the financing structures of the two systems. Mental health services in Alaska are funded through a combination of grants, primarily targeted for emergency service provision and Medicaid, which

addresses ongoing services. Mental health service providers have implemented sophisticated systems that provide the ability to bill Medicaid effectively and efficiently. By contrast, the substance abuse system is primarily grant funded. There are provisions in place for billing Medicaid, however, programs report that a relatively small percentage of substance abuse clients are Medicaid eligible and many residential programs exceed the maximum bed capacity allowed for Medicaid reimbursement. Complicating this is the system of categorical funding that begins with the Federal government and requires that funds for the two treatment systems be tracked separately. While this does not pose a problem at the State agency level, since the two systems have been separated into two divisions, it causes substantial problems for the small, rural organization that must provide services to both populations and, more importantly, to those individuals with co-occurring disorders.

#### **A.2.3.4 Information Sharing**

Both the mental health and substance abuse service systems have sought to upgrade and improve their systems over the past 10 years. However, the latest efforts are unique in that they two systems are now working together to implement an integrated management information system. The Web Infrastructure for Treatment Services (WITS) system initially designed as a substance abuse web-based information system is being adapted and implemented by a contractor, Westat, Inc. The system will allow for web-based input of data for co-occurring mental health and substance abuse data collection at the provider level and will allow for integration of information. Implementation of this system is planned for fiscal year 2004.

### **A.3 THE PLAN**

In order to address the issues listed in the previous section and to improve identification and treatment of individuals with co-occurring disorders throughout a diverse service delivery system, Alaska has committed to seven major strategies. These strategies interact in the design of a comprehensive plan to address the SAMHSA goals of improvement in **screening, assessment, treatment, and training** and create an organized framework to address issues of **infrastructure development; staffing competency, credentialing, and licensure; financial planning and reimbursement; and information sharing and data collection**. A crucial element of this process in Alaska is that these activities are built upon years of development, as described in the previous section, and represent a broad recognition of the unique challenges in providing integrated care to a population that is the most geographically challenging, and arguably the most culturally diverse in the United States. The administration's commitment to this initiative and the creation of the new Behavioral Health Division represents an opportunity to create an organized infrastructure to build upon previous efforts. Strategies 1 and 2 below are systemic and set the framework to address all five of SAMHSA's capacity building goals and its five infrastructure areas.

**Strategy 1: Develop an integrated planning and implementation structure via merger of the mental health section of the Division of Mental Health and Developmental Disabilities with the Division of Alcoholism and Drug Abuse to form the Division of Behavioral Health (effective July 1, 2003)**

*Creation of the Division of Behavioral Health.* The creation of the Division of Behavioral Health carries a major planning and infrastructure development effort and has the potential to enhance collaboration and consolidation of services that is beyond anything implemented to-date. The merging of the divisions brings the following efforts and objectives into reach:

- effective development, deployment, and utilization of screening, assessment, and treatment tools specifically targeted to persons with co-occurring disorders;
- development and implementation of state policies that mandate appropriate care for persons with co-occurring disorders;
- development of financial systems that support appropriate delivery of services to persons with co-occurring disorders; and
- development of a professional development plan that will ensure appropriate skills for clinicians in both mental health and substance abuse fields.

The Project Implementation Team, under the direction of the Project Director, will oversee strategic planning, monitor implementation, and organize the quality improvement methodology for effecting system change and achieving system objectives. The Project Implementation Team will consist of a combination of dedicated staff, along with regular involvement of the ZiaLogic Consultation Team (which developed the CCISC model) and consultants, as-needed for Behavioral Health Division and Medicaid regulatory redesign, AKAIMS development (Westat), and project evaluation/data management (Advocates for Human Potential, Inc.).

***Division of Behavioral Health Integration Steering Committee.*** This committee, comprising top management and policymakers from both fields, will serve both as a resource and an oversight body for internal and external integration teams. The membership of this committee is detailed in Exhibit A.3.1

This body will identify the strategic goals and task the subordinate teams with identifying appropriate activities and approaches that serve to move the statewide service delivery system and supporting infrastructure toward those goals. They will also establish timelines and define appropriate boundaries for activities and approaches.

***Internal Integration Team.*** This group will coordinate and manage the substantial changes necessary to merge the two divisions. It will receive strategic direction and guidance from the steering committee. Note that the organizational affiliations shown reflect the current organizational structure. Once the merger is effective (July 1, 2003), the Divisions of Mental Health and Developmental Disabilities and Alcoholism and Drug Abuse will become the Division of Behavioral Health. See Exhibit A.3.1 for team membership.

The role of the Internal Integration Team is to determine and oversee the processes and activities required to integrate the mental health and substance abuse programs and operations into a new highly functional division.

***External Integration Team.*** This team will address the issues of integration as they apply to the statewide service delivery system, which transcends the State of Alaska organizational issues. Because this team will address a much wider range of issues, the membership of this group is expanded to include substantial stakeholder representation, and members will select their co-chairs. See Exhibit A.3.1 for team membership.

The charge of this team is to extend the strategic planning process to develop specific strategies that will ensure that the structural integration that occurs at the state level is matched with system changes and processes at the statewide service delivery level that are consistent with the Division of Behavioral Health policies and infrastructure and ensure the delivery of appropriate service to persons with co-occurring disorders.



**Strategy 2: Utilize this structure to create an organized strategic planning and quality improvement (QI) process that organizes the implementation of project objectives at each level of the service system and links these objectives to the creation of lasting changes in system infrastructure**

The Project Implementation Team will be responsible for implementing the specific details of this plan, utilizing the CCISC implementation toolkit, particularly the COFIT (system evaluation tool) to identify key objectives and measurable targets for change. The proposed project will build on this overarching QI framework as the prerequisite for accomplishing its goals. Anticipated outcomes include:

**System Level Outcomes:**

1. Identification of an empowered individual, team, or structure to oversee the change process;
2. Adoption/incorporation of a written, strategic plan that defines measurable objectives for a 6, 12, 18, and 24-month period at the system, program, clinical practice, and clinician level;
3. Identification and empowerment of individuals as “change agents” to work with programs and practitioners on implementing the change process through ongoing training and consultation;
4. Development of consensus at the system level on the goal of attaining universal dual diagnosis capability with regard to achieving project outcomes. The proposed project will utilize this QI structure to focus on four SAMHSA goals:
  - screen all individuals for the presence of co-occurring disorders;
  - assess all individuals who screen positive for both mental health and substance abuse for level of severity of co-occurring disorders;
  - treat both disorders in a comprehensive and coordinated manner; and
  - train all mental health and substance abuse providers in the screening and assessment of mental health and substance abuse disorders.

The remaining strategies outline specific approaches to achieve these goals, within this larger systemic QI framework.

**Strategy 3: Develop a clear description of a universal integrated screening process, recommended tools for providers to utilize in this process, and a quality improvement protocol to monitor the implementation and outcomes of screening and the degree to which positive screening results in a comprehensive integrated assessment**

There has been considerable progress in developing an integrated screening process, including development of an Alaska Screening Tool, along with a list of other recommended screening tools, from which providers can choose, based on their population and program design. The Project Implementation Team will work to finalize the “integrated screening process” and develop specific policies for implementation. This provider activity regarding screening and reporting the resulting data will be embedded as a priority in provider expectations to begin quality improvement processes at the program level (using the COMPASS as a self assessment tool to guide this process) to achieve dual diagnosis capability more generally, over time.

The proposed project will achieve the goal of universal screening and assessment for individuals with co-occurring disorders through infrastructure development activities to insure that programs are ready for a standardized approach; staff are adequately prepared and supported through training and ongoing expert consultation; quality improvement procedures are in-place and allow for continual feedback; and reports are regularly made on numbers of individuals screened, identified, and assessed.

In addition, credentialing, licensing, and financial barriers to the provision of integrated screening and assessment will be identified and addressed. This will involve specification of scopes of practice for both mental health and addiction clinicians to be able to perform integrated screening functions, capacity for billing integrated screening as a component of assessment in either setting, and eliminating Medicaid regulatory barriers to the provision of an assessment of the co-occurring disorder in a single grantee agency.

#### System Level Outcomes:

1. Screening instruments for MH and SA are selected.
2. Approach to assessment for MH-SA is selected/developed.
3. The system has created and implemented a training plan for screening and assessment with measurable objectives for achieving competency.
4. Routine quality improvement activities include monitoring whether providers are doing screening and assessment for co-occurring disorders, with progress in achieving goals fed back to systems, programs, and practitioners.
5. Scopes of practice to define capacity of single clinicians with regard to screening and assessment are identified and disseminated.
6. Medicaid regulations provide reimbursement for integrated assessment on site in single grantee settings.

#### Program Level Outcomes

1. Each program has identified an empowered structure to oversee its own change process to implement universal screening and assessment.
2. All relevant staff are trained in core competencies for screening and assessment.
3. An action plan is developed, with specific measurable strategies for attaining universal screening and assessment.
4. An audit procedure is identified and implemented for determining adherence to attaining these measures at six-month reviews.
5. Data on clients with co-occurring disorders and services are entered routinely into an integrated MIS.
6. Policies and procedures are in place for obtaining a formal integrated assessment triggered by findings on the screening.
7. An ongoing training plan is implemented, with participation by appropriate personnel indicating high levels of satisfaction from participants.
8. Staff of both SA and MH agencies screen all individuals coming in for treatment.
9. All persons who screen positive for both SA and MH receive full assessments.

#### Clinician Level Outcomes

Progress in achieving competency is demonstrated among clinicians in relation to screening and assessment, including:

- the ability to engage with individuals with co-occurring disorders in an empathic, accepting way;

- knowledge of the Alaska criteria for SPMI, and the diagnostic criteria for other mental illnesses, and the ability to identify their possible presence by history and by clinical presentation, using the tools embedded in the Alaska Screening Process; and
- knowledge of the diagnostic criteria for substance abuse and dependence and the ability to identify its possible presence by history and clinical presentation.

**Strategy 4: Develop specific criteria for defining integrated treatment and implement a quality improvement strategy to monitor provision of integrated treatment for individuals with co-occurring disorders**

The project will address the goal of treating both disorders in a comprehensive and coordinated manner by creating a state/provider/consumer task force for defining how integrated treatment will be measured and monitored and then addressing systemic barriers to integrated services that interfere with the delivery of integrated treatment in any setting. These include barriers specific to licensure and credentialing requirements, service coordination and network building, financing comprehensive and integrated services, and information collection and sharing. This aspect of the project will be a central activity of project leadership staff in collaboration with consultant teams and will involve the development of mechanisms for stakeholder input.

System Level Outcomes

1. Develop a QI structure with multi-stakeholder input to define the criteria by which integrated treatment will be monitored, to identify barriers to implementation and to assign and over see other activities to address these barriers, and
2. Develop and put into place a QI Process for defining, monitoring, and improving the percentage of clients who receive integrated treatment following screening and assessment.

Program Level Outcomes

1. Develop a program QI structure, with specific COMPASS item targets and IDDT fidelity scale item targets, to define integrated treatment in the context of that program, in accordance with CCISC principles.
2. Develop standard treatment plans and progress notes that are templates for illustrating integrated treatment activity.
3. Develop a training plan for developing competency in the provision and documentation of integrated treatment.
4. Provide best practice models appropriate for the population (IDDT toolkit; Seeking Safety Manual; Substance Abuse Management Module (for SPMI), et al).
5. Provide an oversight mechanism to ensure that the treatment provided incorporates culturally informed and appropriate interventions.

Clinician Level Outcomes

1. Develop specific competencies in integrated treatment, in accordance with individual licensure and scope of practice, the nature of the treatment program, and matching to the needs of the client.
2. Develop specific competencies in documentation of integrated treatment, in accordance with reimbursement regulations, program level and state level policies.

**Strategy 5: Conduct organized efforts, as part of the QI processes above, to identify barriers to the implementation of integrated screening, assessment, and treatment and develop specific infrastructure changes to address these barriers in the areas of clinician and program licensure, certification, and credentialing; service coordination and network building; and funding and reimbursement.**

*Licensing and Certification.* The activities associated with this component can be grouped into two distinct categories. The first, addressing individual professionals, deals with credentialing (licensure and certification) while the second, addressing organizations, deals with program standards for grantee status and standards for more general accreditation. Credentialing for all clinicians (including Traditional Counselors) to establish a baseline of dual diagnosis capability begins with developing a process that incorporates input from multiple stakeholder groups. This process will define core scopes of practice regarding individuals with co-occurring disorder for clinicians in each credentialing or licensure category and identify the attitudes, skills, and knowledge related to co-occurring disorders that fit that scope of practice for each profession.

One of the particular strengths of the current Alaska system is the wide availability of indigenous Native Alaskan counselors in remote rural areas who have developed integrated competencies and scopes of practice by necessity and can be identified as models around which the system can design criteria for other clinicians. In addition, the Project Implementation Team will have access to CCISC clinician self-assessment tools (CODECAT) and the comprehensive train-the-trainer initiative to help clinicians begin to move in the direction of exercising this scope of practice within the context of the larger system effort, and the expectation that each program will assist and encourage its clinicians in this direction. Simultaneously, the Behavioral Health Division will work collaboratively with each credentialing organization to first establish permission to exercise that scope of practice, and then, as more clinicians achieve competency, a requirement to exercise that scope of practice. A parallel strategy will be to encourage (and possibly create incentives) mental health professionals to seek certification as substance abuse counselors through ACCDPC and to similarly encourage substance abuse professionals that have the required educational background to seek appropriate mental health licensure.

A complementary challenge involves establishing basic dual diagnosis capability for all programs. This involves a core effort to enhance the general competency of all behavioral health organizations serving individuals with co-occurring disorders, in which the Division will pursue the requirement that all providers receiving state funds be accredited by an appropriate accreditation organization. In addition, the Project Implementation Team will organize stakeholder-driven processes to develop dual diagnosis capable standards for mental health, substance abuse, and consolidated grantees, as well as API and other types of programs. To assist in this process, the Team will have access to the CCISC program self-assessment tool for dual diagnosis capability (COMPASS) to help programs develop an understanding of what dual diagnosis capability involves and an awareness of their current baseline.

Programs will receive technical assistance to develop quality improvement activities to move in the direction of dual diagnosis capability prior to the imposition of standards, in a strength-based approach. As the system develops more capacity, formal standards of care will be developed, with stakeholder input, and included in the Mental Health

Integrated Quality Assurance standards as well as the approval requirements for substance abuse programs. These standards will be broad based, but will prioritize the acquisition of program competency in screening, identification, data capture, assessment, and integrated treatment planning and delivery, per the project objectives.

#### System Level Outcomes

1. Individuals, teams or structures have been identified to oversee the statewide change process with respect to licensure and credentialing for dual diagnosis capable clinicians.
2. Complementary skills and competencies related to co-occurring disorders are identified for both practitioners and programs.
3. A set of standards defining dual diagnosis capability criteria, in accordance with national guidelines, are developed and required for all mental health and substance abuse programs.
4. Standards are adopted by credentialing entities so that certification/licensure requirements for substance abuse and mental health professionals include defined scope of practice for the provision of integrated treatment commensurate with their licensure.
5. Statewide training to support these standards is implemented and approved for continuing education credit.
6. A readiness tool for agency self-assessment as “dual diagnosis capable” is disseminated (COMPASS) and utilized; 80 percent of participating agencies make measurable progress in achieving dual diagnosis capability, based on annual monitoring of COMPASS scores, and QI monitoring is conducted by project staff.
7. An approach to assisting agencies to secure accreditation is developed and participating SA and MH agencies are identified.

***Service Coordination and Network Building.*** In a geographically and culturally diverse system, as well as a system with a history of divided mental health and substance abuse treatment cultures, developing the capacity to deliver integrated services from the perspective of an integrated behavioral health system is a significant challenge. The charter document produced by the integration implementation team, although not formally adopted by the state administration, provides an excellent framework for ongoing planning and action. The project intends to utilize the internal integration team to form an overarching structure in which intersystem and interdivisional issues can be addressed and transmitted to the field in the form of structured guidance for systemic inter-program collaboration and care coordination for Quadrants II, III, and IV. Similar activities will be required at the program level, in the form of developing collaborative relationships and mechanisms for proactive interagency care coordination (similar to the design of CASSP models in children’s services) regarding complex cases. These expectations will be connected to the development of specific program standards development and quality improvement as well as to the design of collaboration procedures, and associated competencies, for clinicians.

#### System Level Outcomes

1. Individuals, teams or structures overseeing the statewide change process, both internally at the new division (internal integration team) and externally (external advisory committee), identify, document and agree on their respective ongoing roles and responsibilities in the project.

2. The external advisory committee develops and implements strategies for monitoring progress at the program level in implementing Alaska's strategic plan for integrated services.
3. A feedback loop has been created that requires communication between the external and internal committees.
4. In each region, mental health and addiction providers develop structured mechanisms for interagency care coordination, including staff sharing, cross consultation, and regular interagency clinical case reviews.

***Funding and Reimbursement.*** The Project Implementation Team, working with the Integration Teams, will develop specific workgroups and hire consultants for the purpose of developing regulatory change. Addressing longstanding barriers to the provision of integrated assessment and treatment based on behavioral health and Medicaid regulations will involve the following specific objectives.

- Modify the Medicaid regulations and procedures to define the process by which mental health and substance abuse service providers can each bill Medicaid for provision of appropriately matched integrated services to their respective clientele.
- Develop a behavioral health request for proposal for "consolidated grants" that will combine funding streams from both mental health and substance abuse and will comply with all Federal and State regulations related to fund accounting.
- Review and modify all mental health and substance abuse grant regulations to remove or mitigate barriers to providing services to persons with co-occurring disorders and maximize the capacity to use either grant to provide integrated treatment.
- Review and modify all Medicaid regulations to remove or mitigate barriers to providing services to persons with co-occurring disorders, with a priority on providing access to co-located mental health and substance abuse assessment in each program.
- Establish procedures and policies that enhance the ability of Alaska Native health organizations to bill Medicaid for treatment services to Alaska Natives, using 100% federal funds.
- Provide specific instructions for billing procedures and the training of clinical staff, billing staff, and state auditors regarding the new procedures and regulations.

System Level Outcomes:

1. Individuals, teams, or structures have been identified to oversee the statewide change process with respect to financial barriers to integrated services.
2. A comprehensive review is completed of current and potential funding streams for services to persons with co-occurring disorders as well as developing a process for modifying program and funding regulations that currently preclude billing for these services.
3. A financial plan is completed to maximize revenue utilization and generation for services to this group, including strategies for increased revenues through Native Health Corporation and Medicaid.
4. New regulations are drafted to facilitate a billing and payment system that supports comprehensive services to dually diagnosed individuals.

5. New granting procedures and contracting requirements are in place.

**Strategy 6: Develop and deploy an integrated management information system, the Alaska Automated Information Management System (AKAIMS), which will, for the first time, allow gathering of reliable data regarding prevalence, screening, services, and treatment outcomes for individuals with co-occurring disorders, regardless of the type of service provider.**

Alaska's new integrated Information Management System, the Alaska Automated Information System (AKAIMS), based on CSAT's Web Infrastructure for Treatment Services (WITS) system, is a direct response to solving the current inability of these separate systems to adequately coordinate care and report data for individuals with co-occurring disorders. In addition, it provides a unique opportunity to create a national pilot for an integrated data set built upon a widely available existing system, originally designed for use in the substance abuse system (WITS). AKAIMS will be designed to incorporate not only contracted mental health and substance abuse grantees, but also Alaska Native Health System, Alaska Psychiatric Institute, and hospitals providing Designated Evaluation and Treatment. The AKAIMS data system is an essential component of this project, in that it not only is designed to generate the data that will be required by PPG, but also will provide the infrastructure development data that will be utilized in the ongoing quality improvement effort.

Further, AKAIMS can provide a flexible structure for implementing clinically appropriate screening, assessment, and treatment in a diverse system. A key feature of the WITS system is role-appropriate access to system capabilities. All qualified system users will have access to standard screeners. Mental health professionals will have access to assessment tools appropriate to their current credentials, as will substance abuse professionals. The AKAIMS system design specifically uses common core elements for identifying individuals, regardless of the type of facility (in Alaska this includes substance abuse only, mental health only, and consolidated facilities serving both populations). Once individuals have been screened into appropriate groups needing further assessments, instruments appropriate to the suspected diagnosis will be used. Most importantly, the system will allow the management of treatment from both areas in a common treatment plan, with problem and objective activities led by the professional with appropriate training. In consolidated facilities serving both populations, this is accomplished by allowing lead staff for each problem area.

Where treatment is across systems of care (i.e., split between SA and MH providers), the consent and referral features of AKAIMS allow sharing based on policies defined between each facility and consistent with privacy requirements for both 42 CFR Part 2 and HIPAA. In the case of treatment from two different provider organizations, collaborating professionals from the other system of care can have access to only the information cleared through informed consent.

System Level Outcomes:

1. The new integrated management information system (AKAIMS) gathers and reports performance related data on a regular basis, including:
  - Percentage of clients (adults and children/adolescents) in mental health and substance abuse programs with symptoms of the corresponding co-occurring problem.

- Percent of treatment programs that: screen for co-occurring disorders, assess for severity of disorders, and provide treatment through integrated models of care.
  - Percentage of clients who experience reduced impairment from their co-occurring disorders following treatment, as measured by improvement in GPRA-based core client outcome measures collected at discharge and follow-up.
2. Success of this deployment will be monitored by tracking the:
    - Percentage of providers of each type using the system appropriate to their data submission strategy (i.e., direct use versus electronic data interchange).
    - Percentage of total state clients/consumers whose data are successfully submitted through the AKAIMS system.
  3. AKAIMS is effectively linked to the Alaska Native Health System, Medicaid, and Vital Statistics.
  4. System users report satisfactions with the ease of using AKAIMS and the relevance of data reports

**Strategy 7: Develop a system-wide training plan (involving a train-the-trainer initiative) to implement the achievement of dual diagnosis capable competencies across all categories of clinicians, in all programs, in accordance with project goals**

As previously indicated, training all mental health and substance abuse providers will be incorporated into activities under Goals I and II. The State's proposed plan for training, however, goes beyond screening and assessment to include training related to other specific infrastructure development activities proposed in this grant (see complementary licensure, reimbursement, and information sharing). A train-the-trainer effort that involves broad representation from programs statewide has already been developed. Initial 1-week trainings in implementing this model have been provided in four regions across the state in May and June 2003. Using the previously developed training curriculum, individuals from organizations across Alaska will continue to be trained as trainers, with the training sessions conducted in regional centers across the state. In addition to being trainers for the screening, assessment, and treatment process, these individuals will be considered "change agents" for their respective organizations and communities. They will serve as catalysts for rigorously applying screening, data capture, assessment, and treatment procedures, as well as serving as resources for their communities and organizations on the subject of screening, assessment, treatment, and system development (including new billing methodologies) for persons with co-occurring disorders.

**System Level Outcomes:**

1. The system has created and implemented a training plan for both clinical and system change issues with measurable objectives for achieving competency in all relevant areas, tied to development of program and system standards.
2. The system has identified trainers and consultant to provide ongoing training and support to programs and practitioners.

**Program Level Outcomes:**

1. The program has identified trainers, supervisors, and/or clinical team leaders responsible for implementation of competency to screen, assess, meet licensure and credentialing requirements, and utilize the new integrated management information system.

2. Training is tied to formal competency expectations, including cultural sensitivity and is regularly monitored.
3. There is documentation of training delivered upon grant renewal.
4. Competencies are evaluated as part of annual staff performance reviews.

Clinician and Other Staff Level Outcomes:

Training participants demonstrate acquisition of competencies and consistently high levels of satisfaction with the trainings.

**A.4 SYSTEMS COORDINATION**

The imminent merger of the mental health section of DMHDD and ADA into the newly formed DBH will remove many of the existing barriers to delivery of services to persons with co-occurring disorders. The previously described structure of the integration planning and implementation workgroups associated with this merger will ensure that stakeholders, both governmental and private, will be heavily involved in the system delivery planning process. This fundamental change demonstrates a clear and focused commitment on the part of the administration in Alaska to removing barriers and to providing highly integrated services to persons with co-occurring disorders. The engagement of the AMHTA, AMHB, and ABADA further widens the reach of involvement into consumer groups, provider agencies, and the general public. Coordination of these components is assured through the interlocking structure of the various integration implementation groups, which include representatives from the various stakeholders.

## **B. ORGANIZATIONAL AND STAFFING PLAN**

### **B.1 PARTNERSHIPS**

The commitment for the development of integrated, efficient and high-quality services for individuals with co-occurring substance related and mental disorders starts with Governor Frank Murkowski. The Office of the Governor recognizes and is prepared to work on the issue of increasing the level of integrated service delivery and capacity building within the current system of care. One of his first acts as Governor was to draft an Executive Order integrating the two separate divisions that provide mental health and substance abuse services into one Division of Behavioral Health.

The Office of the Governor will partner with the newly formed Division of Behavioral Health, the Alaska Mental Health Trust Authority; the Alaska Mental Health Board and the Governor's Board on Alcoholism and Drug Abuse and other stakeholders to develop specific strategies for addressing the needs of Alaskans with co-occurring substance related and mental disorders. To do this effectively, the Office of the Governor has requested that Denny DeWitt, Office of the Governor Health and Social Services Staff, to actively participate in the Integration Steering Committee. The Steering Committee has been meeting over the last couple of months developing a MOA (Please see this MOA in Appendix 1) regarding the roles and responsibilities of each entity. The Steering Committee will hold its first official meeting since the signing of the MOA on June 17, 2003 and will begin to design and develop its protocols for ongoing communication and joint planning activities.

The active involvement of the Office of the Governor will be a catalyst for statewide changes and the development of meaningful partnerships at both the state and local community levels. Alaska has an existing and unique infrastructure for planning, supporting and implementing various initiatives for the beneficiaries we serve. The Alaska Mental Health Trust Authority (AMHTA) is responsible for monitoring and providing limited funding to the four state planning boards. These planning boards are expected to work together on behalf of the beneficiaries served through joint planning and funding efforts.

All of these entities understand the need to enhance the current system and make the changes required to allow for a more integrated system focusing on services for individuals experiencing co-occurring disorders. The Office of the Governor is committed to implementing the goals and objectives listed within the Alaska application.

The success of the COSIG project will depend on coordination of State activities that extend beyond the Division of Behavioral Health and even beyond the Department of Health and Social Services. Some of the major stakeholder groups internal to the State of Alaska are the Department of Corrections, Department of Public Safety, University of Alaska, Alaska Mental Health Trust Authority, Governor's Advisory Board on Alcoholism and Drug Abuse, and the Alaska Mental Health Board.

Collaboration and unity of direction will be enhanced through a number of initiatives, some currently in place and others that are currently in the planning stage. One of the strongest partnerships efforts is clearly evident in the relationship that exists between the Division of Behavioral Health (and other DHSS divisions), the Alaska Mental Health Trust Authority, the Advisory Board on Alcoholism and Drug Abuse, and the Alaska Mental Health Board. This partnership has functioned productively for the past 8 years

to enhance planning and advocacy, as well as providing some limited funding for innovative service delivery pilot projects. This partnership also includes other agencies, such as the Department of Corrections, as appropriate.

The initiative to merge the mental health section of DMHDD and ADA is another effort to ensure collaboration and unity of direction and vision. Effective July 1, 2003, the efforts to enhance and expand services to persons with co-occurring disorders will flow from a single, focused agency with planning and service delivery resources to address the traditional barriers that have impeded improvement efforts in the past. Beyond the reorganization, the administration has placed individuals with a high degree of commitment and competence in key positions in the new organization, further ensuring its long-term success. The formation of integration workgroups drawing on broad stakeholder representation is yet another factor that adds to the probability of success.

Finally, as the planning has proceeded for this project, stakeholders such as the University of Alaska have been brought in and engaged as key project partners (see the letters of support and commitment in Appendix 1). This diverse stakeholder participation, combined with focused project management and oversight, will ensure that all of the voices are heard while, at the same time, making sure that initiatives and effort are well-coordinated and planned.

#### **B.2.1 State of Alaska Staff**

The State of Alaska staffing is reflected in the organizational chart that follows as well as in the job descriptions contained in Section F of this proposal (see Exhibit B.2.1).

William Hogan is currently the Director of the Division of Mental Health and Developmental Disabilities. He has been tapped by the administration to direct the new Division of Behavioral Health. Mr. Hogan is particularly well qualified for this position, having served in a variety of senior management positions over the past 20 years, including Executive Director of LifeQuest, Inc., one of the largest mental health service providers in Alaska. He is a certified social worker and a licensed clinical social worker. Prior to assuming his duties at DMHDD, Mr. Hogan was the President of the Alaska Mental Health Board. Mr. Hogan holds a bachelor of sociology from the State University of New York and a masters of social work from West Virginia University. He has completed coursework toward a Ph.D. at Virginia Commonwealth University. He has served as chairman of the Alaska Mental Health Board, been a board member of the Alaska Community Mental Health Services Association, and Executive Director of the New York State chapter of the National Association of Social Workers. Mr. Hogan has been a strong advocate for enhanced services to persons with co-occurring disorders since arriving in Alaska in 1998.

#### **B.2.2 ZiaLogic Staff**

To support the efforts of State staff, the State will work with two firms that will provide staff who will offer essential strategic planning, infrastructure development, and program evaluation support to Alaska's COSIG activities. The first of these firms is ZiaLogic, Inc, a professional services corporation specializing in guiding State and regional clients through the complex process of developing and implementing major systems change for individuals with co-occurring disorders.

Kenneth Minkoff, M.D., a ZiaLogic Senior Systems Consultant and Trainer, is a board certified addiction psychiatrist who has provided teaching, training, program

development, clinical treatment, and system consultation in the area of co-occurring disorders since the mid-1980s, and in 1991 co-edited (with Robert Drake, M.D.) *Dual Diagnosis of Major Mental Illness and Substance Disorder*. He is an experienced mental health and addiction clinician and administrator, with experience in public and private sector settings, and in inpatient, residential, intensive outpatient, and outpatient treatment. Dr. Minkoff was chair of the SAMHSA CMHS Managed Care Initiative Panel on Co-occurring Disorders, authoring the 1998 Report entitled: *Co-occurring Disorders in Managed Care Systems: Standards of Care, Practice Guidelines, Workforce Competencies, and Training Curricula*.

Dr. Minkoff has become recognized as the premier consultant on developing comprehensive systems change, because of his equal familiarity and comfort with both administrative and clinical issues in addiction settings and in settings serving individuals with serious and persistent mental illness. In 2002, Dr. Minkoff (with Douglas Ziedonis, M.D.) co-authored the issues paper for co-occurring disorders for President Bush's New Freedom Commission. He has been a senior consultant to numerous States.

Christie A. Cline, MD, MBA, PC, is President of ZiaLogic and will serve this project as a Senior Systems Strategic Planner. Dr. Cline is a board certified psychiatrist and has served as the Medical Director of the Behavioral Health Services Division of the New Mexico Department of Health. She is largely responsible for the process of strategic planning and implementation of the New Mexico Co-occurring Disorders Services Enhancement Initiative. She also has a Masters in Business Administration with an emphasis in Strategic Planning. During the past 3 years, she and Dr. Minkoff have worked as a team in the process of statewide co-occurring disorder program enhancement, curriculum development, and staff and trainer training. Dr. Cline developed the New Mexico Train the Trainer Curriculum, and has been largely responsible for linking the content and process of the training to the overall process of strategic planning for systems change. This project has been described in a Technical Assistance Document commissioned by SAMHSA, and available on the SAMHSA website. In addition, she has been instrumental in designing and implementing system change toolkit materials for development of the CCISC model (CO-FIT 100™, a system fidelity outcome tool; COMPASS™, a program audit and self-survey for dual diagnosis capability; and CODECAT™, a clinician and supervisor competency assessment tool.) that are referenced in this proposal. During the past two years, Dr. Cline and Dr. Minkoff have begun to work together in systems outside of New Mexico to combine their expertise. These systems include: Florida, Maine, Vermont, Worcester and Montgomery Counties (MD), Grand Rapids (MI), Lynchburg (VA), San Diego (CA), Washington (DC), Manitoba, and British Columbia.

### **B.2.3 Advocates for Human Potential Staff (Key Personnel Only)**

Advocates for Human Potential, Inc. (AHP), will offer several senior staff that will play vital roles in the long-term implementation and evaluation of COSIG. Amy Salomon, Ph.D., Director of Evaluation Studies at AHP, will serve as a Senior Research/Evaluator. Dr. Salomon has more than 20 years of experience in applied research, human service delivery systems, program development, and public policy analysis. She will guide Alaska staff in the design of data collection instruments and procedures, assist in the development of screening instruments for individuals with co-occurring disorders, and ensure that all of SAMHSA's human subjects protection regulations are closely followed.

During Phase II of the project, Dr. Salomon will collect and evaluate data on the long-term effectiveness of Alaska's integrated service delivery system developed under COSIG.

James Winarski, M.S.W., is an AHP Senior Program Manager/Technical Assistance Specialist who will support this project. Mr. Winarski has 20 years of experience in the fields of counseling, psychiatric social work, program development, and technical assistance (TA). He currently serves as Project Director of a long-term AHP contract to provide technical assistance to grantees funded under the Projects for Assistance in Transition from Homelessness (PATH) initiative. Mr. Winarski was one of two AHP staff members who drafted several chapters of SAMHSA's landmark *Report to Congress on Co-occurring Disorders*, which was released on December 2, 2002. He also developed a training manual for SAMHSA on co-occurring disorders among the homeless and has provided on site training in over 15 States on working with homeless individuals with co-occurring disorders. He will be available to help State staff finalize the conceptualization of COSIG implementation plans and assist in the design and implementation of an infrastructure designed to ensure project success.



### **B.3 Facilities and Equipment**

#### Staff.

The Office of the Governor, the Commissioner of the Department of Health and Social Services [DHSS] and the Director of the Division of Behavioral Health are all located in the state's capital of Juneau. Staff hired to implement the COSIG will be located in either Juneau [Southeast Region] or Anchorage and its outlying communities [Anchorage or Southcentral Regions], allowing hiring latitude for the division. COSIG staff will be co-located within the existing Division of Behavioral Health's staff facilities in the Anchorage or Southeast Regions. All facilities housing Department of Health and Social Services staff are handicapped accessible complying with all ADA regulations.

Equipment associated with this grant is limited to office furniture and computers for four new staff positions associated with this project. The total estimated cost of furnishings and equipment is \$36,800.

### **B.4 Statement of Compliance**

The State of Alaska will comply with all reporting requirements associated with this grant. Additionally, the state will provide suitable representation at two technical assistance meetings annually for the life of the grant and will participate in technical assistance activities. The state will also cooperate and coordinate with SAMHSA's co-occurring cross training and technical assistance activity.

## **C. EVALUATION / METHODOLOGY**

### **C.1. PPG PERFORMANCE MEASURES**

#### **C.1.1 Current Capacity**

Both the Division of Alcoholism and Drug Abuse (ADA) and the Division of Mental Health and Developmental Disabilities (DMHDD) currently have data systems designed to capture information on client demographics, activity, services received, treatment outcomes and program performance. The ADA client MIS has been in operation since the early 1980s, and is based on a proprietary software application installed on grantee and Division computers. DMHDD installed the latest version of its MIS system, the Alaska Recipient Outcome Reporting Application (ARORA), in 1997, and it still experiences a number of operational problems. Moreover, the two systems are neither compatible nor coordinated, nor are they able to meet the SAMHSA PPG requirements.

Alaska is in the process of implementing a new integrated Management Information System (AKAIMS) that will become operational on January 1, 2004 for both mental health and substance abuse. The core of the system's design is based on CSAT's WITS (Web Infrastructure for Treatment Services) system, which Alaska has had a role in developing. As described further below, this system will be capable of meeting the CSAT Government and Performance Results Act (GPRA) requirements for CSAT grantees. It was also designed in collaboration with CMHS, anticipating its new GPRA requirements, and it goes well beyond the data standards described in the COSIG RFA.

#### **C.1.2. Baseline Performance Indicators**

The current data collection system is generally unable to report across both systems on the PPG indicators of interest to this application. Furthermore, a special survey initiated in the Fall 2002, has not yielded much additional information to this point. So we are unable to report baseline indicators in this application. However, the new, integrated

AKAIMS will correct this problem. When fully operational in January 04, AKAIMS will be able to:

- Track the percentage of clients (adults and children/adolescents) in mental health and substance abuse programs with symptoms of the corresponding problem, through the co-occurring screening information entered for all individuals evaluated for services;
- Provide the percentage of programs that screen/assess for co-occurring disorders, through methods for administering and recording screeners/assessments directly into the system;
- Track the percentage of programs that provide treatment to clients through integrated models of care, by capturing treatment activities in AKAIMS and being able to link services to organizations classified according to models of care; and,
- Provide the percentage of clients identified with co-occurring disorders who experience reduced impairment (and improved functioning) following treatment. As noted above, the AKAIMS items cover all of the mandated CSAT GPRA measures, including changes in use of drugs and alcohol, mental health symptoms, living status (*e.g.*, homelessness), education, employment, income, arrests, jail/prison, and physical health.

A full description of the client data elements that are included in AKAIMS, including those related to PPGs and GPRA, is shown in Appendix 3.

AKAIMS users constitute the major part of the Alaska behavioral health system. For other programs all data required for the PPG performance indicators will be collected for those contract facilities already using a commercial behavioral health system, which will submit these data via Electronic Data Interchange (EDI) connections from their systems to the State database in AKAIMS. The AKAIMS data will also cover all remaining (other than PPG) GPRA data elements, as well as the CSAT Treatment Episode Data Set (TEDS) items. AKAIMS will support data collection at screening, admission, discharge and follow-up, prompting the primary facility(ies) for data as appropriate. It will encourage and facilitate data entry by reducing the current multiple burden on the provider staff and enabling the collection of data for Federal reporting requirements one time as part of the treatment management process. The system is structured to meet all defined federal reporting requirements, as well as the basic MHSIP Decision Support 2000+ items for mental health. This strategy ensures that where there are common items between SA and MH, they will be collected on all persons evaluated and/or served with State support. Furthermore, unique information (*e.g.*, DSM IV diagnosis for MH) will be available as part of the same data system.

In completing the steps described above to implement new information systems by January 1, 2004, Alaska will become fully compliant with the PPG requirements of this grant.

### **C.1.3. Plans for Implementation of Future Performance Indicators**

*a. Consensus-Based Process and PPG Evaluation Study.* Alaska intends to participate fully in SAMHSA's consensus-based process to develop interim standards for collecting and reporting data on future PPG indicators. Following the development of these interim standards, the State will implement these appropriately during the period of the SAMHSA evaluation of the interim measures; it will also participate in the evaluation itself. The AKAIMS system is quite flexible, allowing the addition of new data elements

with much less difficulty than most client information systems. This will also allow implementation of the final PPG standards that are developed.

*b. PPG Targets.* The table below projects Alaska’s targets for the five PPG measures for each year of the COSIG grant years. Given the absence of baseline data, it is difficult to know, for example, exactly what the identified rates of co-occurring disorders are among the population in treatment in mental health and substance abuse programs. Therefore, we assume that the initial rates are likely to be low, and that with the implementation of the program that we have described above, we will see steady movement toward rates cited in the SAMHSA Report to Congress. Thus the targets described below are initial objectives that will be reconsidered once we have actual experience with this information and with a changing system.

Expected Performance Rates		Grant Years				
		1	2	3	4	5
Percentage of clients in mental health programs identified with symptoms of substance abuse	Percent of adults	15%	20%	25%	30%	35%
	Percent of children/adolescents	15%	20%	25%	30%	35%
Percentage of clients in substance abuse pro-grams identified with symptoms of mental illness	Percent of adults	15%	20%	25%	30%	35%
	Percent of children/adolescents	15%	20%	25%	30%	35%
Percent of treatment programs that:	Screen for co-occurring disorders;	20%	35%	50%	65%	80%
	Assess for co-occurring disorders;	10%	20%	30%	40%	50%
	Provide treatment to clients through appropriate models of care.	10%	20%	30%	40%	50%
Percentage of clients who experience reduced impairment from their co-occurring disorders following treatment.		30%	40%	50%	60%	70%

## C.2. Local Evaluation

**Evaluation Aims:** Alaska provides a unique opportunity to learn more about the dynamic evolution of the CCISC model in a large, diverse and complex state. Since CCISC activities have been underway in Alaska for the past two years, the state is an excellent laboratory for exploring the development of the model and the interrelationship between its parts. The study will use qualitative and quantitative methods to address the following research aims:

**AIM 1:** Determine the extent to which the project was implemented as intended and document the causes and consequences of deviations from the original plan (**fidelity assessment**)

**AIM 2:** Describe the process of project implementation, including CCISC readiness, planning, design, and implementation activities (**process evaluation**)

**AIM 3:** Determine the effectiveness of the project in meeting its proposed goals, targets and project outcomes (**outcome evaluation**)

**AIM 4:** Explore the relationship between CCISC components already in place in Alaska, especially its new overarching structure for integrated services (Division of Behavioral Health, integrated MIS system) and the achievement of project goals (**process and outcome**)

**AIM 5:** Monitor the capacity and impact of the state’s co-occurring services through collection and reporting of the PPG measures (**Co-occurring Performance Measures monitoring**)

### **C.2.1. Plans for using evaluation findings**

The major purpose of the local evaluation is to provide useful information on progress in reaching grant goals. Primary audiences are state and local level systems people. The purposes are to identify both achievements and problems, particularly those that may require changes to the plan in order to address unanticipated barriers (*e.g.*, licensing) or to provide additional effort (*e.g.*, training) in order to achieve project goals. Based upon the evaluation plans described below, as well as the collection of PPG indicators, the evaluation team will develop semi-annual reports summarizing available findings and making recommendations for revising implementation plans. These reports will synthesize project learning and provide an ongoing record of project development over the five-year period. An evaluation advisory group, composed of key statewide stakeholders, including project consumers, will be involved in interpretation of findings and will have opportunities to present them semi-annually to the state leadership committee. A final report will review the entire project, evaluating its success at meeting project goals and outcomes and the critical lessons learned about implementing CCISC statewide in Alaska.

### **C.2.2. Tracking progress toward implementation of the goals,**

The focus of the evaluation is determined by the combination of goals and systems changes to accomplish the goals that we have established. In Section A.3 above, we have described plans to meet the following goals:

- 1) Formation of the Division of Behavioral Health (effective July 1, 2003) which will provide leadership for system change;
- 2) Creation of organized, strategic planning and quality improvement processes at the state and local levels that guide implementation;
- 3) Development of universal screening and integrated assessment;
- 4) Development of integrated treatment;
- 5) Identification of barriers to implementation and development of structural changes to address these barriers;
- 6) Deployment of an integrated management information system (AKAIMS) to support gathering of common data across mental health and substance abuse programs; and,
- 7) Development and implementation of a system-wide training plan with relevant core competencies.

Goals 3, 4, 6 and 7 are consistent with the goals of the SAMHSA RFA, and are directly related to the expectations shown in the table in Section C.1.3 above. The specific targets for screening and assessment and integrated treatment represent reasonable increments in system change in a multi-year process. As described in section 2.3 below, we propose to use a combination of PPG performance indicators, interviews with key informants, and surveys of persons who participate in training to assess whether these goals have been met. The remaining goals are structural changes required to accomplish the others.

Goals for system change are less amenable to setting specific targets. As described in section 2.3 below, we propose to measure progress at systems, program, and practitioner levels, using interviews with key system informants and program managers. These will be based upon existing instruments for assessing development of dual diagnosis capable systems, programs, and practitioners.

### **C.2.3. Plans to assess implementation fidelity, process and outcome**

*Fidelity to the Implementation Plan.* The plan presented in Section A calls for achieving specific milestones related to the goals of systems change (See Evaluation Question below for examples of milestones related to the development and implementation of screening and assessment practices). For each goal, specific milestones will be abstracted from this application (see Section A.3 above) and augmented as necessary. A part of the evaluation will focus on whether, and when, milestones are actually achieved. If they are either delayed or not reached, we will seek to understand the barriers that have been encountered and possible paths to removing them. This analysis will occur for the statewide development of the CCISC model, as well as screening and assessment, and for the development of dual diagnosis capability at the local, program level. For this part of our evaluation we will focus on four, distinctly different geographic regions of Alaska. Each of these will constitute a separate case study.

*Annual Site Visits.* Site visits will be the primary mechanism for collecting data for the proposed evaluation. These visits will give researchers an opportunity to speak directly with system and program level staff, practitioners and consumers, conduct audits on program targets and outcomes, and review charts and other documentation on site. While the visits are evaluative in nature they will also provide a process and opportunity for technical assistance and program growth. Each visit will culminate in a project feedback session featuring a report-back on system/program level strengths, challenges and corrective feedback recommendations.

We anticipate a ten-day visit in each of the first three project years for a team of two evaluators. Each visit will feature data collection at both the state system and local program level. Because the number of programs is so large and the geography vast, we will regionalize data collection and feature four representative areas for our visits, including: Anchorage (large programs, urban area); Juneau (small city, multiple outlying communities, state capital); Bethel, McGrath and Aniak (rural consolidated programs, Native Health system area); and Valdez (rural consolidated program, non-Native Health area). At least two full days of site visits will focus on system level activities with the remaining days dedicated to program sites. In years four and five we will substitute telephone interviews. The numbers and frequencies of these interviews are described below, along with additional detail on the interview content.

As described in Section A, each of the systems change goals has specific activities and milestones that are expected to occur. Monthly logs will be kept and analyzed for all activities at the statewide level. These will include a description of the purposes and outcomes of all events (e.g., discussion and consensus on screening instruments), as well as the names and roles of each participant. Events are not limited to meetings, but will also include training events.

#### System Change Goals: Moving toward Dual Diagnosis Capability.

A critical part of the state plan is the development of state and local structures that will support the implementation of dual diagnosis capable programs and systems. The American Society of Addiction Medicine (ASAM, 2001) has developed definitions of dual diagnosis capable programs. Drake and his colleagues (SAMHSA, 2003) have developed fidelity measures for dual diagnosis capable programs, the GOI and the IDDT. Minkoff and Cline (2002) have also developed an instrument to assess the fidelity of programs to a dual diagnosis capable model, the COMPASS™. In addition, they

developed instruments to assess the fidelity of a system to a dual diagnosis capable model, the COFIT™ (Minkoff & Cline, 2002), and to assess readiness of individual clinicians to practice in a dual diagnosis capable program, the CODECAT™.

All of these instruments are in their infancy. Drake and his colleagues are just in the process of implementing their fidelity measures in three states. The Minkoff and Cline instruments are currently being used in integrated systems development projects in over 20 US states, cities and counties, Canadian provinces, and managed care networks. The GOI and the IDDT have the advantage of including specific anchors for most of the fidelity dimensions on which programs are rated. However, they are limited to the program level. Minkoff and Cline's measures have much greater breadth, covering the system, program, and practitioner levels and include many items for each level.

We propose to take advantage of both of these existing measurement efforts. In order to assess progress in network building and system infrastructure, we will conduct interviews with key informants at the state level and in the 4 regions using an adaptation of the COFIT™. Specifically we will employ a smaller number of items than the existing 100, choosing those that are most relevant to the system changes that are goals of this application. We anticipate 50 interviews of persons who are participants in the change process annually, 10 for the State level and 10 in each of the 4 regions. This will include items that address infrastructure development, such as establishing an empowered team to oversee the change process, writing strategic plans, tracking measurable progress in achieving objectives, developing quality improvement processes, assuring outreach to other systems, and training on integrated treatment.

To assess progress in developing dual diagnosis capable programs, we will conduct interviews annually with a sample of 10 mental health and 10 substance abuse program managers in each of the 4 regions. These interviews will be based upon both the GOI and IDDT and the COMPASS™. Again, we will select items from the latter instrument that are not represented in the former and develop similar anchor points for these items. This will include items that address development of dual diagnosis capability such as assuring a welcoming approach and consumer satisfaction, access to screening, assessment, planning and treatment, development of necessary competencies among staff, coordination of care, and a supportive management structure. We will visit programs in each of the first three years to make these assessments, borrowing from the process evaluation approach developed by Drake and his colleagues to assess the implementation of evidence-based practices.

In the first year interviews will be conducted mostly in person. In subsequent years they will be conducted over the telephone. Although we could substitute mailed surveys for the interviews, we believe that interviews will be more successful in a number of ways: 1) Completion rates will be 90%, rather than less than 50%; 2) Questions about the meaning of items can be raised in the interviews; 3) Additional informal, narrative comments about systems and program changes can be gathered in order to better understand what is actually occurring.

To assess progress at the practitioner level, we will focus on individuals who participate in training for screening and assessment. Data collection will be based, in part, on the CODECAT™. Our goal will be to obtain a survey from each training participant at the time of training and to follow-up with a second, mailed survey three months after the

training. This will enable us to characterize the persons who participated in training and the effects of the training. Items will address encountering clients with dual diagnosis, skill and confidence in working with dual diagnosis clients, knowledge and use of appropriate clinical approaches, and ability to coordinate care.

System Change Goals: Screening, Assessment, and Related Training and Outcomes

A major focus of the Alaska plan is training practitioners in screening and assessment.

Looking at the success of this program suggests the following evaluation questions:

Evaluation Questions	Data Sources
<p>1. Are milestones necessary for plan implementation to be reached?</p> <p><i>Systems Level:</i></p> <ul style="list-style-type: none"> <li>• Identification and empowerment of individuals, teams, or structures to oversee the introduction of universal screening and assessment for persons who screen positive for both MH &amp; SA.</li> <li>• Completion of a written, strategic plan that defines measurable objectives for introducing universal screening at 6-month intervals at the system, program, clinical practice &amp; clinician level</li> <li>• Selection of appropriate screening instruments for MH &amp; SA.</li> <li>• Selection of appropriate assessment approaches for MH &amp; SA.</li> <li>• Creation and implementation of a training plan for clinical and system change issues with measurable objectives for achieving competency.</li> <li>• Participation in quality improvement activities including monitoring if providers are doing screening &amp; assessment for co-occurring disorders, if screening &amp; assessment data are entered into management information systems, and the quality of the process with progress in achieving goals routinely fed back to systems, programs &amp; practitioners.</li> </ul> <p><i>Program Level:</i></p> <ul style="list-style-type: none"> <li>• Identify an empowered structure to implement universal screening and assessment.</li> <li>• Train staff in core competencies for screening and assessment.</li> <li>• Develop an action plan, with specific measurable strategies for attaining universal screening and assessment.</li> <li>• Identify and implement an audit procedure for determining adherence to attaining these measures at 6-month reviews.</li> <li>• Routinely enter data on clients with co-occurring disorders &amp; services into integrated MIS</li> <li>• Develop policies and procedures for obtaining a formal integrated assessment triggered by findings on the screening.</li> </ul>	<p>Project records and interviews with key systems and program management staff, including ratings on selected items from CO-FIT™ as described above</p>
<p>2. Training: How many SA counselors receive training? How many MH therapists receive training? How effective is the training? [separately for screening &amp; assessment]</p>	<p>Participant evaluations of training &amp; self-assessment of competency, including ratings on items from CODECAT™ as described above</p>
<p>3. What proportion of SA programs are prepared to do MH screening? Assessment? Within SA programs, what proportion of staff has received training and is prepared to do MH screening? Assessment? [Vary by program type (e.g., residential, ER, outpatient)?]</p>	<p>Interviews with clinical directors of individual programs, including ratings on selected items from COMPASS™, as described above</p>
<p>4. What proportion of MH programs are prepared to do SA screening? Assessment? Within MH programs, what proportion of staff has received training and is prepared to do SA screening? Assessment? [Vary by program type (e.g., residential, ER, outpatient)?]</p>	
<p>5. What are the changes in rates in occurrence of MH screening in the SA system?</p>	<p>AKAIMS client-services management information system</p>
<p>6. What are the changes in rates in occurrence of SA screening in the MH system?</p>	
<p>7. What are the changes in rates in occurrence of MH assessment in the SA system for people who screen positive on MH?</p>	
<p>8. What are the changes in rates in occurrence of SA assessment in the MH system for people who screen positive on SA?</p>	
<p>9. What are the changes in rates of persons who are diagnosed as having both SA and MH disorders in receiving evidence-based, integrated treatment?</p>	

**C.2.4. Cultural appropriateness of the evaluation**

Evaluators will work closely with the evaluation planning advisory committee, composed of key statewide stakeholders including project consumers, to reflect on the feasibility of proposed methods, finalize design elements, and interpret study findings. It will be

especially important in Alaska to insure that research methods and content are culturally informed and appropriate. The advisory group will serve as a sounding board and resource to insure the cultural competence of the evaluation. All staff will participate in cultural competence training that is specific to issues in the screening, assessment and treatment of co-occurring disorders. This will include development of knowledge about the different cultural groups that reside in the State of Alaska with particular attention to the four regions. In addition, we will develop an inventory of possible problems that may occur if the systems and program changes are not implemented in a culturally competent manner. For example, we will look at the question of whether the screening instrument is appropriate for use with different cultural groups, including whether translations are available in languages other than English. We will also examine whether programs that are dual diagnosis capable are also culturally competent. We expect to employ the approach that will be included in the forthcoming SAMHSA Toolkit for Co-occurring Disorder Programs that is now in draft. A culturally competent evaluation must also systematically question whether there are differences in the PPG performance measures that are related to race, ethnicity, gender and age. It is possible, for examples, that persons of a particular racial or ethnic group have poor access to screening for both mental health and substance abuse disorders. This information then will help to identify particular problems that must be addressed within the systems change effort.



## **WILLIAM H. HOGAN – PROJECT DIRECTOR**

### **SUMMARY OF PROFESSIONAL EXPERIENCE**

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STATE OF ALASKA, DEPARTMENT OF HEALTH & SOCIAL SERVICES, DIVISION OF MENTAL HEALTH & DEVELOPMENTAL DISABILITIES, JUNEAU, AK, 2003-PRESENT

*Director* --Responsible for directing, planning, organizing and managing statewide programs for mental health and developmental disabilities. Formulates policy for community mental health services, state psychiatric center and community programs for the developmentally disabled. Monitors program performance, reviews and evaluates existing policies, procedures, statutes, regulations and recommends changes as appropriate. Oversees all Division administrative, financial, program and policy functions.

LIFE QUEST, WASILLA, AK, 1998-2003

*Chief Executive Officer*--Is responsible for designing, developing, implementing and managing all prevention, treatment and rehabilitation services in a private not for profit community mental health center. The organization serves over 1200 individuals annually in a geographic area comparable to the size of the state of West Virginia. The agency employs 150 staff with a budget of \$6.5 Million.

NATIONAL ASSOCIATION OF SOCIAL WORKERS, NEW YORK STATE CHAPTER, ALBANY, NY, 1997-1998

*Executive Director*--Serves as Chief Executive and is responsible for planning, organizing, directing, and implementing all chapter programs and activities. Has management responsibility for all administrative, financial, human resource, marketing, and educational functions. The New York State Chapter is the largest of all NASW Chapters with approximately 12,500 members.

SOUTHWEST MISSISSIPPI MENTAL HEALTH (SWMMH) COMPLEX, MCCOMB, MS, 1993-1997

*Executive Director*--Was responsible for directing, planning, coordinating, operating, and monitoring all mental health and developmental disabilities services and substance abuse programs within ten counties of Mississippi. Served as Chief Executive Officer of the SWMMH Commission and President of the SWMMH Foundation. Was administratively responsible for the supervision of 200 staff members and consultants, and a six million dollar annual budget.

COLONIAL COMMUNITY SERVICES BOARD, WILLIAMSBURG, VA, 1986-1993

*Coordinator*--Planned and coordinated mental health and substance abuse prevention, treatment, and rehabilitation services in York County and the City of Poquoson, Virginia. Supervised 12 staff members and consultants. Maintained a caseload of 50 clients.

SYSTEMETRICS, INC., WASHINGTON, DC, 1986-1993

*Consultant*--Reviewed patient care and case management records as a component of an Independent Quality-Assurance Monitoring Contract with the Office of Civilian and Military Personnel (Champus), Department of Defense.

CATHOLIC CHARITIES OF HAMPTON ROADS, VIRGINIA BEACH, VA, 1990-1993

*Private Practitioner*--Provided individual, couple, and family therapy.

VIRGINIA COMMONWEALTH UNIVERSITY, RICHMOND, VA, 1990-1993

*Adjunct Faculty Member*--Supervised graduate-level students.

ESSEX COUNTY COMMUNITY SERVICES BOARD, ELIZABETHTOWN, NY, 1984-1986

*Director*--Planned, coordinated, and served as Chief Executive Officer of mental health and substance abuse prevention, treatment, and rehabilitation programming in Essex County. Supervised 28 staff members and consultants.

DEVELOPMENT DISABILITIES PROGRAM, APPALACHIAN MENTAL HEALTH CENTER, ELKINS, WV, 1982-1984

*Director*--Developed, directed, and coordinated services for developmentally disabled children and adults in four counties. Supervised a staff of 26.

APPALACHIAN MENTAL HEALTH CENTER, BARBOUR COUNTY, PHILIPPI, WV, 1980-1981

*Director*--Coordinated and assured the delivery of mental health and substance abuse services to county residents. Maintained a caseload of 35 clients and supervised a staff of 12.

WEST VIRGINIA UNIVERSITY CENTER FOR EXTENSION AND CONTINUING EDUCATION, MORGANTOWN, WV, 1979

*Graduate Social Work Intern*--Facilitated the planning and implementation of the Cooperative Extension Leadership and Development Program, which included program-evaluation mechanisms, project planning, and grant writing.

SUMMIT CENTER FOR HUMAN DEVELOPMENT, CLARKSBURG, WV, 1979

*Graduate Intern and Staff Member*--Developed and implemented a primary prevention project in a small mining community. Involved grant writing, developing and conducting needs-assessment surveys, organizing community education programs, and revitalizing the Harrison County Mental Health Association.

OSWEGO COUNTY COMMUNITY MENTAL HEALTH CENTER, OSWEGO, NY, 1975-1978

*Social Work Assistant*--Developed community support programs for long-term psychiatric clients. Acted as the liaison to state hospitals and provided case-management services to 50 clients.

## EDUCATION

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- VIRGINIA COMMONWEALTH UNIVERSITY, RICHMOND, VA  
Post Doctoral Work, Sociological Theory, 1991
- WEST VIRGINIA UNIVERSITY, MORGANTOWN, WV  
M.S. in Social Work, 1980
- SYRACUSE UNIVERSITY, SYRACUSE, NY  
Additional Graduate Course Work, 1976-1979
- STATE UNIVERSITY OF NEW YORK AT BUFFALO, BUFFALO, NY  
B.A. in Sociology, 1971

## PUBLICATIONS AND PRESENTATIONS

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Hogan, W. Collaborative Services and Professional Roles for Non-Psychiatrists, Primary Care/Behavioral Healthcare Summit, The Leadership Forum on Integrating Behavioral Healthcare and the General Medical Section, 1997, Chicago, Illinois.

Hogan, W. Grief and Death Issues: Working Families Having Medically Fragile and Terminally Ill Children, Mississippi Department of Human Services Regional Conference, 1995, McComb, Mississippi.

Hogan, W. Successful Mental Health Program Development for Children in a Small Community, National Council of Community Mental Health Centers Annual Meeting, 1988, Boston, Massachusetts and Virginia State Social Work Conference, 1987, Williamsburg, Virginia.

Hogan, W. Protecting the At-Risk Disabled Adult in the Community, Behavioral Health Conference, 1983, West Virginia University, Morgantown, West Virginia.

Hogan, W. The Development of a Good-Neighbor Program: Using Local Resources as Federal Funds Disappear, Behavioral Health Conference, 1982, West Virginia University, Morgantown, West Virginia.

Hogan, W. Rural Psychiatric Rehabilitation: Effective Techniques in Selecting, Monitoring, and Evaluating the Progress of State Mental Health Clients in the Community, National Council of Community Mental Health Centers Annual Meeting, 1979, Washington, D.C.

Hogan, W. Development of a Rural Psychiatric Aftercare Group, Psychosocial Rehabilitation Journal, Volume 2, Number 1, 1978.

## **JOB DESCRIPTION: PROJECT DIRECTOR**

### **Required Education and Experience**

(see attached resume).

### **Duties and Responsibilities**

The Project Director, Bill Hogan, will provide the vision for and articulate the expectations of the project to all staff and consultants. Additionally, he will provide general direction and oversight for the project, including the hiring of the Project Coordinator and support of that person as he/she oversees the project on a day-to-day basis. He will ensure that administrative support is provided to the project as needed for financial and administrative management of the project and bring resources, as needed from within the Division and the Department, to this project to ensure success. He will be the direct liaison with the Governor's staff person assigned to oversee this project, to ensure the Governor's office is directly involved in the project and efforts are well coordinated both internally and externally to State Government

## **JOB DESCRIPTION: PROJECT COORDINATOR (1.0 FTE)**

### **Required Education and Experience**

A minimum of a masters-level graduate degree in a behavioral health related field, preference will be given to an individual with mental health and/or substance abuse training. A minimum of three years of relevant program experience and a minimum of 2 years supervisory or project management experience is required.

### **Required Skills**

Excellent verbal and writing skills are essential for this position. The person must also be able to multi-task and have good inter-personal skills.

### **Duties and Responsibilities**

- Responsible for day-to-day management of the project
- Provide direct supervision and direction to the state staff hired to carry out the work of this project
- Coordinate the efforts of the consultants and evaluators to ensure all aspects of the work are being carried out in a timely and quality manner
- Ensure all reports are submitted, that all partners are kept informed and that feedback is provided to all involved in the project in a systematic and timely manner
- Identify and coordinate the solutions to problems or issues surfaced by any of the individuals or groups involved in this project

## **JOB DESCRIPTION: RESEARCH ANALYST IV**

### **Required Education and Experience**

Graduation from an accredited college and four years of research and/or statistical work, one year of which was served as a Research Analyst III with the State of Alaska or the equivalent working in the behavioral health (mental health or substance abuse) field.

Substitution: Research or statistical analysis experience may substitute for the required education (3 semester or 4 quarter hours equals one month); graduate study may be substituted for the required experience (2 semester or 3 quarter hours equals one month).

### **Required Skills**

Requires the ability to assess and understand program information requirements and develop suitable data applications and analyses to provide the required information. Must have basic skills in database, spreadsheet, and statistical software applications. This position requires written reports appropriate for diverse audiences.

### **Duties and Responsibilities**

- Analysis of screening and assessment data produced by AKAIMS data system
  - Development of written reports based on AKAIMS data intended for diverse audiences including management, clinical staff, and administrative support staff
  - Recommendations for changes or enhancements in the AKAIMS data system based on program information needs
  - Participation in COSIG continuous quality improvement system, bringing expertise in data analysis
  - Work with information technology staff, clinical staff, and provider agencies to identify desired enhancements to the AKAIMS (related to COSIG)
  - Provide training and consultation to provider agency staff as necessary
- Participate in overall integration infrastructure development efforts as directed

**JOB DESCRIPTION: MENTAL HEALTH CLINICIAN III (1.0 FTE)**  
(Training and Licensing Specialist)

**Required Education and Experience**

A minimum of a masters-level graduate degree in the field of Psychology, Counseling Psychology, Counseling, Social Work or Psychiatric Nursing, from an appropriately accredited program. A minimum of three years of relevant experience and a minimum of 2 years supervisory or management level experience is required.

**Required Skills**

The verbal and presentation skills needed to train and provide technical assistance and the writing skills to assist in drafting documents for accreditation.

**Duties and Responsibilities.** This full time position will be the natural combination of two part time positions, responsible for training, technical assistance and licensure.

- Responsible for developing and implementing the core competencies for training that will lead to certification or licensure;
- Ensure that intensive technical assistance is available and accessible for staff as required;
- Train and provide technical assistance for staff to acquire and maintain licensure;
- Assist in the development and design of core competencies for dual diagnosis training; and,
- Remain available for on-going consultation.

## **JOB DESCRIPTION: PLANNER**

(Accreditation Specialist)

### **Required Education and Experience**

A minimum of a masters-level graduate degree in the field of Psychology, Counseling Psychology, Counseling, Social Work or Psychiatric Nursing, from an appropriately accredited program. A minimum of three years of relevant experience and a minimum of 2 years supervisory or management level experience is required.

### **Required Skills**

The verbal and presentation skills needed to train and provide technical assistance and the writing skills to assist in drafting documents for accreditation.

**Duties and Responsibilities.** This full time position will be responsible for assisting agencies statewide in understanding the accreditation process, assessing agency readiness and developing accreditation plans. The Accreditation Specialist will be familiar with the various accreditation requirements and entities and will:

- Will coordinate and participate in agency accreditation overview;
- Provide intensive training;
- Gather and disseminate information on standards and procedures for accreditation;
- Assist agencies in determining costs, as well as, administrative and program changes required for accreditation; and,

**Assists agencies in developing a plan and timetable for accreditation.**

## **KENNETH MINKOFF, M.D. -- SENIOR SYSTEMS CHANGE CONSULTANT**

### **SUMMARY OF PROFESSIONAL EXPERIENCE**

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#### **ZIALOGIC, ALBUQUERQUE, NM**

*Chief Consultant/Systems Change Expert, April 2001 - Present*

Dr. Minkoff, developer of the Comprehensive Continuous Integrated Systems of Care (CCISC) Model and its associated "Twelve Step Program of Implementation," is a nationally known systems change expert. He is currently a consultant to numerous statewide consensus-building initiatives designed to create integrated systems of care for dual diagnosis of SPMI and substance disorder. Dr. Minkoff was Chair of the SAMHSA Managed Care Initiative Panel on Co-occurring Disorders in the mid-nineties, and co-authored the co-occurring disorder issues paper for the President's New Freedom Commission in 2002.

#### **CHOATE HEALTH MANAGEMENT**

*Medical Director, 1996-2003*

Responsible for medical leadership of a wide range of contracted relationships to provide management and program development services for behavioral health entities in numerous states, including Massachusetts, Vermont, Maine, and Tennessee. These programs included inpatient, partial hospital, outpatient, and crisis stabilization programs, for both adults and children, and for both mental health and substance abuse services.

#### **ARBOUR-FULLER HOSPITAL, ARBOUR HEALTH SYSTEM**

*Medical Director, 1998 - 1999*

Responsible for the medical leadership of an 82-bed psychiatric hospital, with adult, dual diagnosis, developmental disability, and adolescent inpatient programs, plus partial hospitalization

#### **CHOATE INTEGRATED BEHAVIORAL CARE**

*Medical Director, 1996 - 1997*

Company-wide Medical Director of a national public/private psychiatric and addiction managed-care oriented provider system. Responsible for overall quality enhancement; standards; clinical policies and procedures; and the training, recruitment, and supervision of regional medical directors and programs.

#### **CHOATE HEALTH SYSTEMS, INC.**

*Chief of Psychiatric Services, 1990 - 1995*

Directed clinical services in a freestanding psychiatric hospital. Responsible for management and coordination of psychiatric and addiction inpatient unit, respite services, psychiatric day treatment, emergency services, addiction day treatment, and coordination with private and public providers.

#### **CHOATE-SYMMES HEALTH SERVICES, INC.**

*Chief of Psychiatry, 1984 - 1990*

Responsible for the management and coordination of a psychiatric and addiction inpatient unit, emergency services, addiction day treatment, consultation and liaison, and outpatient services.

#### **SOMERVILLE MENTAL HEALTH CLINIC**

*Clinic Director, 1978 - 1984*

Clinical and Administrative Director of a large community mental health clinic serving adults and children. Responsible for clinical leadership, program development, budgeting, grant writing, and staff supervision.

*Medical Director, Day Treatment Center, 1976-1978*

Responsible for administration, coordination, clinical supervision, and case management in a full-time day treatment center program with 40 clients and 11 staff.

## **SKILLS**

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Board certified addiction psychiatrist with more than 17 years of experience in teaching, training, program development, clinical treatment, and system consultation in the area of co-occurring disorders. Experienced mental health and addiction clinician and administrator in public and private sector settings and in inpatient, residential, intensive outpatient, and outpatient treatment programs. Has delivered more than 1,000 training sessions on his integrated model for the treatment of co-occurring disorders. Consultant to numerous States and several Canadian provinces. Expert in developing and implementing major systems change.

## **EDUCATION**

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### **UNIVERSITY OF PENNSYLVANIA SCHOOL OF MEDICINE**

*M.D., 1972*

### **HARVARD UNIVERSITY, CAMBRIDGE, MASSACHUSETTS**

*Pre-Med Studies 1969*

### **HARVARD COLLEGE, CAMBRIDGE, MASSACHUSETTS**

*A.B., 1968*

*Postdoctoral Training: Medical Internship -- University of Pennsylvania; Psychiatric Internship -- University of San Diego County, CA; Psychiatric Residency -- University of California, San Diego*

*Board Certifications: American Board of Psychiatry and Neurology, with Special Qualifications in Addiction Psychiatry*

## **ACADEMIC APPOINTMENTS**

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From 1976 to the present, Dr. Minkoff has held academic appointments at Harvard Medical School in the Cambridge Hospital Department of Psychiatry. Since 1993, he has been Clinical Assistant Professor of Psychiatry.

## **SELECTED PRESENTATIONS & PUBLICATIONS**

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Since 1988, Dr. Minkoff has given more than 2,000 presentations in 45 States, Puerto Rico, Canada, France, Holland, and New Zealand.

Dr. Minkoff has served as a senior consultant on the development of the CCISC as a best practice model for enhancing services for individuals with psychiatric and substance disorders. His clients have included state and regional systems in Alabama, Alaska, Arizona, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Idaho, Illinois, Iowa, Indiana, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Texas, Utah, Vermont, Virginia, and Washington.

Dr. Minkoff has written more than 40 journal articles, book chapters, and monographs on a broad range of topics in the area of co-occurring disorders for the *American Journal of Psychiatry*, *American Journal on Addictions*, *Comprehensive Psychiatry*, *Disease Management & Health Outcomes*, *Hospital and Community Psychiatry, Innovations & Research*, *Journal of Alcohol and Drug Abuse*, *Journal of Psychoactive Drugs*, *Journal of Psychosomatic Research*, *Psychiatric Annals*, *Rehabilitation Psychiatry*, and *Western Journal of Medicine*, among others.

## **JOB DESCRIPTION: SENIOR SYSTEMS CHANGE CONSULTANT**

### **Required Education and Experience**

Doctor of Medicine. 15-20 years of experience in a clinical psychiatric setting, including in-depth experience in program development and administration, clinical treatment of co-occurring disorders, and systems change . Certification in addiction therapy. Experience in the design, development, and implementation of dual diagnosis programs.

### **Required Skills**

Ability to conceptualize and communicate complex theories of systems change and to develop and identify measurable outcomes. Ability to train professional staff in the processes of strategic planning and implementation, program development, and program evaluation. Ability to provide technical assistance and training in a flexible, responsive manner that reflects the variety of settings in which integrated, comprehensive systems of care are required.

### **Duties and Responsibilities**

- Train client staff in the use of the Comprehensive Continuous Integrated Systems of Care (CCISC) Model and its associated Twelve Step Program of Implementation
- Review system structure and organization; identify and analyze the mechanisms for decision making regarding clinical practice implementation; and analyze current system strengths and limitations regarding co-occurring disorder services, utilizing system fidelity tool (CO-FIT)
- Identify opportunities to create strategic incentives to reward change and facilitate integrated systems planning
- Assist clients in the development and implementation of a Continuous Quality Improvement (CQI) process within the newly integrated system
- Develop recommendations to facilitate the removal of barriers to change and promote the implementation of an integrated system
- Design interactive, incremental, and measurable performance objectives
- Establish mechanisms to engage consumers and family advocates in the systems change process and to ensure that their input is sought during the evaluation stage
- Facilitate meetings with provider organizations/associations to explain and discuss the CCISC Model
- Train client staff in the utilization of the competency assessment tool (CODECAT) to design and monitor training activities
- Develop and implement systemic training plans, including train-the-trainer plans
- Supervise the work of Senior Program Manager/Technical Assistance (TA) Specialists

## CHRISTIE A. CLINE, MD, MBA, PC – SENIOR SYSTEMS STRATEGIC PLANNER

### **SUMMARY OF PROFESSIONAL EXPERIENCE**

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#### ZIALOGIC, ALBUQUERQUE, NM

*President, April 2001- Present*

President of ZiaLogic, a professional corporation that provides strategic planning and implementation consultation and support for behavioral health systems development, performs clinical and administrative trainings, provides technical assistance, and produces a variety of instruments and tools to support clinician development and system change. Dr. Cline partners with Kenneth Minkoff, M.D., a ZiaLogic Senior Systems Change Consultant, in the process of statewide co-occurring disorder program enhancement, curriculum development, and staff training. She has been instrumental in designing and implementing utilization of system change toolkit materials for development of the Comprehensive Continuous Integrated Systems of Care (CCISC) Model. Dr. Cline has joined Dr. Minkoff in collaborating on CCISC implementation projects in Vermont, Winnipeg; Grand Rapids, MI; San Diego; Lynchburg, VA; Washington, DC; Worcester County, MD; Tampa, FL; Manitoba; and British Columbia.

#### NEW MEXICO DEPARTMENT OF HEALTH

*Director, Office of Behavioral Health Policy, Research, and Technology Transfer, Behavioral Health Services Division; November 2001 – May 2003*

Responsible for planning, management, and coordination of all activities (both within BHSD and collaborative with other State agencies), regarding development and evaluation of behavioral health policy and strategic implementation of best practices.

#### NEW MEXICO DEPARTMENT OF HEALTH

*Project Director, Co-occurring Disorders Services Enhancement Initiative; July 2000 – May 2003*

Developed consensus on the need for prioritization of co-occurring disorders for best practice system development, created a strategic plan for structured implementation using quality improvement processes to incentivize change within the Regional Care Coordination system, and, with Dr. Minkoff, developed a toolkit and curriculum for implementation, and provided train-the-trainer initiative and program technical assistance statewide.

#### NEW MEXICO DEPARTMENT OF HEALTH

*Medical Director, Behavioral Health Services Division (State Behavioral Health Authority), July 1999 – May 2003*

Responsible for establishing medical oversight of quality improvement, standards of care, best practice development, and interagency collaboration throughout the entire behavioral health system of New Mexico

#### NEW MEXICO DEPARTMENT OF HEALTH

*Project Director, New Mexico Pharmacotherapy Initiative for the Treatment of Schizophrenia; January 1999 – May 2003*

Adapted TMAP to New Mexico, created implementation plan involving consumers, and developed structures for implementation statewide, involving ongoing support to physicians and nurses in all regions.

### **SKILLS**

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Areas of expertise include combination of masters in business administration with a specialization in complex systemic strategic planning and development, along with clinical and administrative

background in adult psychiatry (medical specialty) and public behavioral healthcare systems planning and development.

## **EDUCATION**

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### **MEDICAL COLLEGE OF VIRGINIA, VIRGINIA COMMONWEALTH UNIVERSITY**

*M.D., 1995*

### **GEORGETOWN UNIVERSITY, GRADUATE SCHOOL OF BUSINESS**

*M.B.A., 1989*

### **SOUTHWEST TEXAS STATE UNIVERSITY, SAN MARCOS, TEXAS**

*M.S., Biology., 1984*

### **SOUTHWEST TEXAS STATE UNIVERSITY, SAN MARCOS, TEXAS**

*B.S., Biology., 1981*

*Postdoctoral Training: University of New Mexico Hospitals – Chief Resident in Psychiatry (1998 - 1999); Resident in Psychiatry (1996 – 1998); Intern in Psychiatry (1995 – 1996)*

*Board Certifications: Diplomate --American Board of Psychiatry and Neurology, Inc., a member Board of the American Board of Medical Specialties*

## **ACADEMIC APPOINTMENTS/COMMITTEES**

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Assistant Professor, Research Faculty, Department of Psychiatry, University of New Mexico School of Medicine

Ex-Officio Member, New Mexico HIV Prevention Community Planning Group

Technical Advisor and New Mexico Department of Health Behavioral Health Representative, Medicaid Managed Care Development Committee, New Mexico Human Services Department/Medical Assistance Division

Member, New Mexico Hepatitis C Prevention Taskforce

## **SELECTED PRESENTATIONS**

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“Implementation of the Comprehensive Continuous Integrated Systems of Care Model in Multiple State Systems” Statewide System Integration Conference, Portland, OR, (May, 2003).

“Implementation of the Comprehensive Continuous Integrated Systems of Care Model for Individuals with Co-occurring Psychiatric and Substance Disorders, -- the New Mexico Co-occurring Disorders Services Enhancement Initiative,” Presented at “Changing the World: Strategies for Systems Change to Implement Services for Individuals with Co-occurring Psychiatric and Substance Disorders” conference, Santa Fe, NM (April 2002)

“Implementation of the Comprehensive Continuous Integrated Systems of Care Model for Individuals with Co-occurring Psychiatric and Substance Disorders”, Presented at the Annual Conference of the National Council of Community Behavioral Healthcare, Chicago, IL (March 2002)

“Bringing Best Practices and Systems Change to New Mexico Behavioral Healthcare,” New Mexico Health and Human Services Legislative Subcommittee, Albuquerque, NM (October 2001)

## **SELECTED MONOGRAPHS AND PUBLICATIONS**

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Substance Abuse and Mental Health Services Administration—A strength- based systems approach creating integrated services for individuals with co-occurring psychiatric and substance use disorders—A technical assistance document. NMDOH/BHSD. April 2003 .

Center for Substance Abuse Treatment--Treatment Improvement Protocol For Co-occurring Psychiatric and Substance Use Disorders – Number 9 Revised (Consensus Panel Member) Pending Publication.

## **JOB DESCRIPTION: SYSTEMS CHANGE CONSULTANT**

### **Required Education and Experience**

Doctor of Medicine. 5-7 years of experience in a clinical psychiatric setting, including experience in program development and administration, clinical treatment of co-occurring disorders, and systems change . Experience in the design, development, and implementation of dual diagnosis programs.

### **Required Skills**

Ability to conceptualize and communicate complex theories of systems change and to develop and identify measurable outcomes. Ability to train professional staff in the processes of strategic planning and implementation, program development, and program evaluation. Ability to provide technical assistance and training in a flexible, responsive manner that reflects the variety of settings in which integrated, comprehensive systems of care are required.

### **Duties and Responsibilities**

- Assist a Senior Systems Change Consultant in training client staff in the use of the Comprehensive Continuous Integrated Systems of Care (CCISC) Model and its associated Twelve Step Program of Implementation
- Use the system change toolkit materials to support the development of the CCISC Model (CO-FIT 100, a system fidelity outcome tool; COMPASS, a program audit and self-survey for dual diagnosis capability; and CODECAT, a clinician and supervisor competency assessment tool)
- Design, develop, and deliver training in a strategic planning process to enhance the development of an integrated co-occurring disorders treatment program
- Link the content and process of the training developed to the overall process of strategic planning for systems change
- Assist clients in the development and implementation of a Continuous Quality Improvement (CQI) process within the newly integrated system

- Develop recommendations to facilitate the removal of barriers to change and promote the implementation of an integrated system
- Design interactive, incremental, and measurable performance objectives that can be used to validate systemic improvements in behavioral health care systems
- Establish mechanisms to engage consumers and family advocates in the systems change process and to ensure that their input is sought during the evaluation stage
- Train client staff in the utilization of CODECAT to design and monitor training activities
- Develop and implement systemic training plans, including train-the-trainer plans

Supervise the work of Systems Change Consultants and Senior Program Manager/Technical Assistance (TA) Specialists

## **AMY SALOMON, PH.D. – SENIOR RESEARCHER/EVALUATOR**

### **SUMMARY OF PROFESSIONAL EXPERIENCE**

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ADVOCATES FOR HUMAN POTENTIAL, INC., SUDBURY, MA

*Director Evaluation Studies, 2002-Present*

Dr. Salomon is responsible for identifying, directing, and expanding AHP's program evaluation activities. Currently Dr. Salomon is consulting to Heath Choice Network, Inc., in Miami, Florida, on two multi-site process evaluations of care management programs in behavioral health and diabetes. She is also leading an evaluation technical assistance/training activities of the Project for Assistance in Transition from Homelessness (PATH Program), funded by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration., U.S. Department of Health and Human Services (HHS).

APPLIED RESEARCH AND CONSULTING, CAMBRIDGE, MA

*Principal, 2001-2002*

As founder and principal of this independent consulting firm working with non-profits, government, and philanthropic organizations, Dr. Salomon helped conceptualize research projects, advised on project implementation, led program development efforts, helped to integrate evaluation techniques into management planning and practices, and produced knowledge products from evaluation efforts. Her clients included The Better Homes Fund, Newton, MA; Educational Development Center Inc., Newton, MA; Florida Mental Health Institute, Tampa, Florida; The Kitchen Table Conversations Project, Cambridge, MA; St. Francis House, Boston, MA; and United Way of Massachusetts Bay, Boston, MA.

THE BETTER HOMES FUND, NEWTON, MA

*Executive Director, 1995-2001*

As Director of this national non-profit helping homeless families through research, model program development and support, and public policy analysis, Dr. Salomon was responsible for the day-to-day management of its operations as well as for directing key projects. Her major areas of research interest included family homelessness, public welfare, mental health, substance abuse, and interpersonal violence. She was Project Director for a study funded by the National Institute of Justice, U.S. Department of Justice, on the Impact of Partner Violence on Poor Women's Lives. Research findings were disseminated through peer-reviewed journal articles and, in an effort to bridge research to practice, findings were packaged for the Boston Police Department.

Dr. Salomon also led the Fund's efforts on the National Coordinating Center for the Women, Co-occurring Disorders, and Violence Study funded by HHS. She was responsible for implementing and overseeing this national studies, multi-site process evaluation.

**THE BETTER HOMES FUND, NEWTON, MA**

*Director, Programs and Evaluation, 1992-1995*

Dr. Salomon was responsible for all grant development activities, including designing and funding new model programs and managing evaluation activities for all Fund-supported programs. Her skills include evaluation design (both qualitative and quantitative), working with community-based programs, instrument selection and design, site visit protocol development and implementation, field operations, data management and analysis, and report writing.

**THE BETTER HOMES FUND, NEWTON, MA**

*Project Director, Homeless Families Research Project, 1991-1994*

Dr. Salomon supervised the collection of one of the most comprehensive national data sets on the course and consequence of homelessness for families and children, funded by the National Institute of Mental Health, National Institutes of Health, HHS. This longitudinal, case-control study followed more than 400 families and 600 children over a 5-year period. Dr. Salomon collaborated on efforts to transform findings into usable products for policy and practice.

**THE SPANGENBERG GROUP, NEWTON, MA**

*Senior Research Associate, 1987-1991*

Dr. Salomon directed policy oriented, multi-site studies on the civil legal needs of low-income people in New York, Maine, Ohio, and Wisconsin. The latter study evaluated Wisconsin's unique program of legal services to elders and included extensive work with Native American communities. She staffed community advisory boards, managed field teams and site visits, conducted focus groups, designed telephone surveys and program questionnaires, analyzed data, and wrote final reports.

**STATE HOUSE WATCH, MASSACHUSETTS HUMAN SERVICES COALITION, BOSTON, MA**

*Editor/Founder, 1981-1987*

Dr. Salomon founded this publication to provide coverage in all human services issue areas and help bring the voice of low-income people to State government.

**UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL, WORCESTER, MA**

*Associate of Family Medicine, 1993-Present*

**SKILLS**

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Dr. Salomon has 20 years of experience in applied research, human service program development and technical assistance, public policy analysis, and knowledge product development. Her work has focused on critical social policy issues, including homelessness, public welfare, mental health and substance abuse, and interpersonal violence.

**EDUCATION**

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**NEW SCHOOL FOR SOCIAL RESEARCH, NEW YORK CITY**

*Ph.D., Political Science*

**HOBART AND WILLIAM SMITH COLLEGES, GENEVA, NEW YORK**

*B.A., Political Science, Phi Beta Kappa*

## **SELECTED PUBLICATIONS AND PRESENTATIONS**

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Bassuk, EL., Weinreb, LF., Buckner, JC., Browne, A., Salomon, A., & Bassuk, S. (1996). Lives in peril: The characteristics and needs of sheltered homeless and low-income housed mothers. Journal of the American Medical Association, 276, 640-646.

Bassuk, S., Brooks, MG, Salomon, A. (1996). Patterns of welfare use among poor and homeless women. American Journal of Orthopsychiatry. 66(4), October, 510-525.

Salomon, A., Editor (1996). Welfare reform and the real lives of poor women: Introduction to special issue on welfare. American Journal of Orthopsychiatry. 66(4), October, 486-489.

Rosenheck, R., Bassuk, EL., Salomon, A (1999). Special Populations of Homeless Americans. The 1998 National Symposium on Homelessness Research—HUD

Bassuk, S., Browne A., Salomon A., (1999). The impact of recent partner violence on poor women's capacity to maintain work. Violence Against Women, 5(4), 393-426.

Bassuk, S., Huntington, N., Salomon, A., (2002). The relationship between intimate partner violence and the use of addictive substances in poor and homeless women. Violence Against Women, 8(7), 785-815.

## **JOB DESCRIPTION: Senior Researcher/Evaluator**

### **Required Education and Experience**

Advanced degree in field relevant to studies performed; 7-10 years of experience planning, designing, conducting, and reporting on complex, multi-site studies. Experience managing other Senior Researchers, Researchers, Research Associates, and support staff. Budget development experience.

### **Required Skills**

Must demonstrate the ability to develop, monitor and control costs. Must have the ability to monitor and evaluate project performance and take corrective actions, as appropriate. Requires the ability to direct, guide, and evaluate the performance of research staff. Requires the ability to develop project reports.

### **Duties and Responsibilities**

- Serve as Project Director or Task Order Leader on projects involving program design and/or evaluation, performance measurement, and data analysis
- Develop and monitor the implementation of approved research designs
- Develop study protocols and design data collection instruments
- Supervise staff in the collection, synthesis, and analysis of qualitative and quantitative research data
- Identify potential operational problems and recommend solutions
- Select, supervise, and evaluate research staff
- Develop draft and final research reports and present findings
- Communicate with client staff and corporate management to keep them apprised of AHP's progress
- Monitor and control project costs to avoid overruns
- Participate in new business development activities

## **JAMES T. WINARSKI, M.S.W. – SENIOR PROGRAM MANAGER/TA SPECIALIST**

### **SUMMARY OF PROFESSIONAL EXPERIENCE**

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ADVOCATES FOR HUMAN POTENTIAL, INC., SUDBURY, MA

*Director of Homeless Programs, October 1995 - present*

Directs the program that provides training and technical assistance to the federally funded Projects for Assistance in Transition from Homelessness (PATH), funded by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. Develops innovative strategies to assist programs serving homeless individuals with mental illnesses throughout the United States. Develops curricula and provides on-site technical assistance.

THE BETTER HOMES FUND, BOSTON, MA

*Director of Training, October 1993 - October 1995*

Provided training and technical assistance to systems and programs serving homeless people. Developed training curricula, technical assistance protocols, and program models and conducted workshops across the country. Provided technical assistance to grantees of the Center for Mental Health Services/Center for Substance Abuse Treatment Collaborative Demonstration Program for Homeless Individuals. Helped 16 national program sites develop manuals of state-of-the-art interventions for homeless people with co-occurring psychiatric and substance abuse disorders.

CENTER FOR PSYCHIATRIC REHABILITATION, BOSTON UNIVERSITY, BOSTON, MA.

*Senior Training Associate, July 1990 - October 1993*

Provided technical assistance in the area of psychiatric rehabilitation to mental health programs and systems. Assessed, developed, and implemented mental health programs and trained practitioners to provide psychiatric rehabilitation and case management services. Provided program development for McKinney Grant demonstration project for homeless people with psychiatric disabilities in New York City. Developed specialized treatment strategies for street dwellers and provided clinical training and supervision to the staff.

VETERANS ADMINISTRATION MEDICAL CENTER, BOSTON, MA

*Program Director/Social Work Supervisor, February 1987 - July 1990*

Provided program development and administration for Northeast Region Mental Health Initiative demonstration project for veterans with high risk for relapse. Implemented outreach, day treatment, residential, and intensive case management services. Coordinated training and provided clinical supervision to all social workers in the program.

VETERANS ADMINISTRATION MEDICAL CENTER, BOSTON, MA.

*Psychiatric Social Worker, June 1985 - February 1987*

Responsible for acute psychiatric ward and transition unit. Duties included family evaluation, discharge planning, psychosocial assessment and treatment, training of medical residents, coordination of aftercare services, and supervision of graduate students.

VETERANS ADMINISTRATION MEDICAL CENTER, BOSTON, MA.

*Rehabilitation Social Worker, October 1983 - June 1985*

Social worker for the Comprehensive Rehabilitation Program. Responsible for medical and neurological rehabilitation wards, chronic back pain program, and spinal cord injury patients. Duties included discharge planning, counseling regarding psychosocial adjustment to disability, leadership in patient and family support groups, liaison between medical center and community resources for the disabled, and supervision of graduate students. Member of patient advocate and patient education committee.

VETERANS ADMINISTRATION MEDICAL CENTER, BUFFALO, NY

*Rehabilitation Social Worker, September 1982 – October 1983*

Responsible for rehabilitation ward, respiratory care ward, and spinal cord injury patients on a hospital-wide basis. Duties included counseling regarding psychological adjustment to disability, discharge planning, and the organization of a stroke education group for patient and families. Received Veterans Administration Certificate of Appreciation for outstanding and dedicated service, September 1983.

ERIE COUNTY MEDICAL CENTER, BUFFALO, NY

*Dialysis Social worker, June 1980 – September 1982*

Responsible for dialysis units (including hemodialysis, CAPD, and transplants), cardiac and respiratory care wards (including associated intensive care units), medical clinics, and emergency room. Duties included counseling regarding adjustment to acute medical crisis and chronic terminal illness and discharge planning. Member of Western New York Dialysis Social Workers Association.

**SKILLS**

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Mr. Winarski has 20 years of experience in the fields of counseling, psychiatric social work, and technical assistance, with a special focus on serving handicapped veterans and individuals with co-occurring disorders. He is an experienced case manager, instructor, and technical assistance and training specialist.

**EDUCATION**

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**STATE UNIVERSITY OF NEW YORK AT BUFFALO**

*M.S.W., Social Work, 1980*

**STATE UNIVERSITY OF NEW YORK AT BUFFALO**

*B.A., Human Services/Social Gerontology, 1978*

**SELECTED PUBLICATIONS**

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Winarski, J.T., Cohen, M., et. al., Issues affecting clinical practice in an era of managed behavioral health care. Journal of the Washington Academy of Sciences. (Vol. 85) 1: 101-113. December 1998.

Winarski, J.T., Implementing Interventions for Homeless Individuals with Co-Occurring Mental Health and Substance Use Disorders: A PATH Technical Assistance Package, Sudbury, MA: Advocates for Human Potential, under contract with the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, March 1998. (Monograph SMA 98-3204: 92 pages).

Winarski, J.T. and Dubus, P. An Analysis of 16 Federally-Funded Programs for Homeless Individuals with Co-Occurring Mental Health and Substance Use Disorders, Newton, MA: The Better Homes Fund under contract with the Substance Abuse and Mental Health Services Administration, 1995. (Monograph 137 pages).

Winarski, J.T. Providing outreach outside the shelter. In Bassuk, E., Birk, A., and Liftik, J., (Eds.) Community Care for Homeless Clients with Mental Illness, Substance Abuse, and Dual Diagnosis, Newton, MA: The Better Homes Fund, 1994, 10-1, 10-18.

Shern, D.L., Tsemberis, S., Winarski, J., et al. The effectiveness of psychiatric rehabilitation of persons who are street dwelling with serious disability related to mental illness. In

Breakey, W.R. and Thompson, J.W., (Eds.) Mentally Ill and Homeless: Special Programs for Special Needs, Harwood Academic Publishers, The Netherlands, 1997, pg. 119-147.

**JOB DESCRIPTION: SENIOR PROGRAM MANAGER/TA SPECIALIST**

**Required Education and Experience**

Bachelor's degree in sociology, human services, counseling, management, or other related field. 7-10 years of experience planning, designing, conducting, and reporting on training and technical assistance (TA) projects. Experience developing curricula and other training materials. Experience providing onsite technical assistance in a variety of settings.

**Required Skills**

Requires the ability to develop, revise, and finalize TA/Training plans customized to client needs. Must have the ability to monitor and evaluate project performance and take corrective actions, as appropriate. Requires the ability to direct, guide, and evaluate the performance of TA/Training staff. Requires the ability to develop and monitor budgets and prepare and revise project reports.

**Duties and Responsibilities**

- Serve as senior staff on projects involving training and technical assistance, including on-site consultation, workshops, management information systems development, program development, and/or staff development
- Develop, modify, and revise TA plans and other training materials, utilizing technology as appropriate to expedite TA delivery and reduce costs
- Support infrastructure development by conducting policy and program assessments and designing and implementing strategic program plans
- Update existing systems and policies so that they can be effectively integrated into new, operational systems and policies
- Serve as “change agents” by assisting program staff in modifying and introducing new procedures
- Support stakeholder engagement and consensus building; facilitate meetings
  
- Identify potential operational problems and recommend solutions
- Select, supervise, and evaluate the performance of intermediate TA/Training staff
- Develop draft and final project reports and present findings
- Communicate with client staff and corporate management to keep them apprised of AHP's progress

## **G. SAMHSA PARTICIPANT PROTECTION**

### **G.1 Protect Clients and Staff from Potential Risks**

Participants will be persons who are identified as being key informants because of their participation in the systems change process (at both the State and the region level); substance abuse and mental health program managers from each of four regions; and direct care staff who participate in screening and assessment trainings. No clients will be involved in the evaluation, with the exception of clients who are participants in the systems change process and are, therefore, key informants. However, they would not be asked questions about their own past or present mental health or substance abuse problems or treatment.

Neither Alaska nor Advocates for Human Potential, Inc., believes that there are any significant physical, medical, social, legal, or other risks of adverse effects associated with participation in this project. Participants may refuse to answer individual questions and may end the interview or survey at any time.

A potential risk to project participants is confidentiality. The procedures to guard against risks to confidentiality are addressed in Section 5, Privacy and Confidentiality.

The participants will not be receiving treatment of any kind. Therefore, issues related to alternative treatments and procedures are not applicable.

### **G.2 Fair Selection of Participants**

As stated above, participants will be persons who are identified as being key informants (at both the State and the region level); substance abuse and mental health program managers from each of the four regions; and staff from each of the proposed regions who participate in screening and assessment trainings. At this point-in-time we have no information on the demographic characteristics of this population.

Regarding recruitment and selection, individuals selected for participation must:

- be identified as being key informants at the State level, mental health and substance abuse program managers within each of the four proposed regions,
- or be staff who have participated in related screening and assessment training, and
- must be individuals who voluntarily choose to participate.

Recruitment procedures for the evaluation will be implemented as follows: Evaluation staff will present evaluation information to each identified key informant/program manager/staff person. Key informants will be identified through their membership on key committees that are involved in the systems change process. Program managers will be randomly sampled from the roster of program managers for all mental health and substance abuse programs in the four regions. They will be presented with a verbal explanation of the evaluation interviews and a one-page consent/project description outlining the purpose of the project and participant rights. (Please see the first Consent Form in Appendix 2.)

Staff will be identified as they appear in trainings for screening and assessment. At the time of the training, they will be asked to complete an initial survey. Then they will be asked to complete a follow-up survey approximately 3 months after training. Before completing the initial survey, they will be presented with a verbal explanation of the

survey and a one-page consent/project description outlining the purpose of the project and participant rights. (Please see the second Consent Form in Appendix 2.)

### **G.3 Absence of Coercion**

Participation in the evaluation interviews will be entirely voluntary. Participants will not be compensated for their participation in this evaluation. The one-page consent/program descriptions specifically assure participants that their job status will not be affected by their completion of an interview or survey. As explained earlier, none of the participants will be receiving services as a part of this project.

### **G.4 Data Collection**

Data will be collected from key informants at the State level, mental health and substance abuse program managers within each of the four proposed regions, and staff who have participated in related screening and assessment training. The methods of data collection will include personal interviews (first year), telephone interviews (subsequent years), written and mailed surveys (immediately following training activities and at the 3-month follow-up period, respectively), and record review. The forms of specimens to be collected are interview and survey data and records. (Please see the Data Collection Instruments/Interview Protocols in Appendix 3.)

Aggregated client data tables will also be obtained from State mental health and substance abuse agency management information systems. The research team will not have direct access to any identified client data. The purpose of obtaining these data tables is to respond to SAMHSA PPG performance measures required as a condition of receiving this grant. Creation of these data tables falls within the ordinary, operations management functions of the State.

### **G.5 Privacy and Confidentiality**

Privacy and confidentiality will be assured in a number of ways, thereby limiting risks to evaluation participants:

- All individual names or other identifying information will be removed from the interview/survey and other records. A single identifying code will be substituted. A separate file linking this code, the individual name, and other identifying information will be maintained by the Director of the evaluation team. At the conclusion of the study, all copies of this file will be destroyed.
- Interview data will be transferred directly from the Interviewer to the Director of the evaluation team. The Interviewer will not retain copies, and s/he will sign a statement pledging not to disclose either the identities or identifying characteristics of individual interviewees or any information disclosed during the interview, except to the Director of the evaluation team. Any additional staff involved with the study evaluation and analysis will sign similar pledges.
- Data entry of all information described above will be conducted by staff that will not have access to individual identifying information.
- All physical records will be stored in a locked file with access restricted to the Director of the evaluation team.
- Once the records are in electronic form, they will be destroyed, unless there are parts that are not entered into an automated file. Physical and electronic copies of interview data will be destroyed upon completion of the study.

### **G.6 Adequate Consent Procedures**

A one-page consent/project description will be given to each participant prior to each interview/survey. (See Appendix 2.) The consent/project description developed by the evaluation team provides participants with an explanation regarding the voluntary nature of participation, the right to withdraw from the project at any time without any adverse effect, the

anticipated use of the data, the procedures for maintaining appropriate confidentiality of the data, the potential risks, and procedures that will be implemented to protect participants against these risks. Because the questions are related to respondents' knowledge of the mental health and systems and programs or their own competencies, we do not believe that it is necessary to obtain a signed consent form. No one will be asked to disclose any personal information about their own past or present mental health or substance abuse status.

#### **G.7 Risk/Benefit Discussion**

As stated earlier, a potential risk to project participants is confidentiality. The procedures to guard against risks to confidentiality are addressed above in Section G.5, Privacy and Confidentiality. The benefits of obtaining this information include the following:

- The project will have a multi-year record of both progress and barriers encountered in meeting program goals.
- Information about barriers and problems will be fed back into the project planning process in order to make necessary adjustments to plans.
- The information will be used to assure the efficient use of resources in the effort to achieve greater dual diagnosis capability among systems and programs serving persons with co-occurring disorders in the State of Alaska.

## **APPENDIX 1: LETTERS OF COMMITMENT/SUPPORT**

<b>A-1-1</b>	<b>The Trust</b>
<b>A-1-2</b>	<b>Advisory Board on Alcoholism and Drug Abuse</b>
<b>A-1-3</b>	<b>Alaska Division of Medical Assistance</b>
<b>A-1-4</b>	<b>University of Alaska</b>
<b>A-1-5</b>	<b>Denali Commission</b>
<b>A-1-6</b>	<b>Alaska Community Mental Health Services Association</b>
<b>A-1-7</b>	<b>Substance Abuse Directors Association of Alaska, Inc.</b>
<b>A-1-8</b>	<b>Association of Rural and Alaska Native Drug and Alcohol Programs</b>
<b>A-1-9</b>	<b>Southeast Alaska Regional Health Consortium</b>
<b>A-1-10</b>	<b>Alaska Native Tribal Health Consortium</b>
<b>A-1-11</b>	<b>Alaska Mental Health Board</b>
<b>A-1-12</b>	<b>Alaska Division of Alcoholism &amp; Drug Abuse and Division of Mental Health And Developmental Disabilities</b>
<b>A-1-13</b>	<b>Yukon-Kuskokwim Health Corporation</b>
<b>A-1-14</b>	<b>Fairbanks Native Association</b>
<b>A-1-15</b>	<b>Alaska Health &amp; Social Services Commissioner</b>
<b>A-1-16</b>	<b>Memorandum of Agreement – Integrated Behavioral Health Strategic Planning Project</b>

## APPENDIX 2

### State Incentive Grant (COSIG) for Treatment of Persons with Co-Occurring Substance Abuse and Mental Health Disorders

#### Consent to Participate in Systems Progress Interview for Program Managers and Other Key Informants

Title of Project: State Incentive Grant for Treatment of Persons with Co-Occurring Substance Related and Mental Disorders (COSIG)

Principal Investigator: INSERT

Purpose: The purpose of the COSIG project is to improve the quality of care and outcomes of persons who have co-occurring mental health and substance abuse disorders. One key project goal is to develop an infrastructure that will expand and support the State's 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 purpose of this particular interview is to assess the progress this system and its treatment programs are making and the barriers that are encountered in this effort to become Dual Diagnosis Capable.

You are being asked to participate in this interview because you are employed in a position that involves knowledge of our existing mental health and/or substance abuse service delivery system. Your honest feedback is integral to the success of this project.

This interview will last approximately 45 minutes. During this time you will be asked to rate a range of items concerning the implementation of a Dual Diagnosis Capable treatment system, as well as to comment on issues of particular concern to you. The areas to be covered in the interview include access to appropriate screening, assessment, and treatment; integration of mental health and substance abuse services; and the process of implementing system and program changes.

There are no known risks associated with participating in the interview. Your participation is voluntary and you may withdraw at any time without penalty if you no longer wish to participate, or you may refuse to answer any individual question. Your decision to participate or not will in no way affect your job status. You will not be paid for your participation in this interview.

Your interview responses will be kept confidential to the extent of the law. Authorized research personnel, audit staff of the Department of Health and Human Services, and members of the Institutional Review Board may inspect the records from this research project. The results of this study may be published, but all data obtained from you will be aggregated with data obtained from others. The published results will thus include only summarized information and will not include any information that would personally identify you in any way. All hard copies of data will be kept in locked filing cabinets in a locked office, and all electronic data will be stored on a password-protected computer.

If you have any questions about this project, contact XXX XXXX at XXX-XXX-XXXX. If you have questions about your rights as a person who is taking part in a research study, you may contact XXX XXXX at (XXX) XXX-XXXX.

**Principal Investigator / Project Director:**

NAME  
ADDRESS  
PHONE  
EMAIL

**Co-Principal Investigator:**

NAME  
ADDRESS  
PHONE  
EMAIL

**State Incentive Grant (COSIG) for Treatment of Persons  
with Co-Occurring Substance Related and Mental Disorders**

**Consent to Participate in Program Survey for Individual Staff**

Title of Project: State Incentive Grant for Treatment of Persons with Co-Occurring Substance Related and Mental Disorders (COSIG)

Principal Investigator: INSERT

Purpose: The purpose of the COSIG project is to improve the quality of care and outcomes of persons who have co-occurring mental health and substance abuse disorders. One key project goal is to train individual program staff to provide appropriate screening and assessment of both disorders among individuals who present for treatment. In this particular survey, we ask you to evaluate the training you recently received and to provide a self-evaluation of your competencies in treating those with co-occurring disorders.

You are being asked to complete this survey because you recently attended a training on screening and assessment for co-occurring substance abuse and mental health disorders. Your honest feedback is integral to the success of this project.

This survey will take approximately 15 minutes to complete. It lists a range of competencies to be rated according to your own assessment of your strengths in each area. The survey also asks you to evaluate the training you recently received.

There are no known risks associated with your completing this survey. Your participation is voluntary and you may withdraw at any time without penalty if you no longer wish to participate, or you may refuse to answer any individual question. Your decision to participate or not will in no way affect your job status. You will not be paid for your participation in this survey.

Your responses to this survey will be kept confidential to the extent of the law. Authorized research personnel, audit staff of the U.S. Department of Health and Human Services, and members of the Institutional Review Board may inspect the records from this research project. The results of this study may be published, but all data obtained from you will be aggregated with data obtained from others. The published results will thus include only summarized information and will not include any information that would personally identify you in any way. All hard copies of data will be kept in locked filing cabinets in a locked office, and all electronic data will be stored on a password-protected computer.

If you have any questions about this project, contact XXX XXXX at XXX-XXX-XXXX. If you have questions about your rights as a person who is taking part in a research study, you may contact XXX XXXX at (XXX) XXX-XXXX.

**Principal Investigator / Project Director:**

NAME  
ADDRESS  
PHONE  
EMAIL **Co-Principal Investigator:**

NAME  
ADDRESS  
PHONE  
EMAIL

### **APPENDIX 3: DATA COLLECTION INSTRUMENTS AND PROTOCOLS**

<b>A-3-1</b>	<b>General Organization Index (GOI)</b>
<b>A-3-2</b>	<b>Integrated Dual Disorders Treatment (IDDT) Fidelity Scale</b>
<b>A-3-3</b>	<b>COFIT</b>
<b>A-3-4</b>	<b>CODECAT</b>
<b>A-3-5</b>	<b>COMPASS</b>
<b>A-3-6</b>	<b>AKAIMS</b>
<b>A-3-7</b>	<b>CRAFFT – Alcohol and Other Drug Screening</b>
<b>A-3-8</b>	<b>Short Michigan Alcohol Screening Test (SMAST)</b>
<b>A-3-9</b>	<b>Drug Use Questionnaire (DAST – 10)</b>
<b>A-3-10</b>	<b>Alaska Screening Tool for Substance Abuse and Traumatic Brain Injury</b>
<b>A-3-11</b>	<b>Mental Health Screening Form III</b>
<b>A-3-14</b>	<b>Alaska Screening Tool for Mental Health and Traumatic Brain Injury</b>
<b>A-3-15</b>	<b>MAYSI-2 Questionnaire</b>
<b>A-3-16</b>	<b>Alaska Screening Tool for Dual-Diagnosis and Traumatic Brain Injury</b>
<b>A-3-17</b>	<b>Client Status Review of Life Domains (Adult Services)</b>
<b>A-3-18</b>	<b>Client Status Review of Life Domains (Child and Youth Services)</b>
<b>A-3-19</b>	<b>Mental Health Statistics Improvement Program Satisfaction Survey (Adult)</b>
<b>A-3-20</b>	<b>Mental Health Statistics Improvement Program Satisfaction Survey (Youth)</b>
<b>A-3-21</b>	<b>Mental Health Statistics Improvement Program Satisfaction Survey (Youth &amp; Family)</b>