



# **COSII Screening Instrument**

## **Pilot Study Results**

Revised

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## Executive Summary

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In 2005, the State of Maine applied for and received a Co-Occurring State Incentive Grant intended to fund state efforts in developing a treatment delivery system for people and families affected by Co-occurring Disorders (COD). A goal identified in the grant was to determine a standard screening protocol for both mental health and substance abuse to be implemented in treatment agencies. Having such a protocol is considered a key aspect of an integrated agency as it allows for both disorders to be identified at the initiation of services.

In 2007, the COSII Initiative opted to implement a pilot study to test designated tools. The goal of this project was to provide the State with supporting information to make an informed decision about whether standardized instruments should be required of all mental health and substance abuse agencies. The information would be of two kinds: what proportion of people seeking treatment would screen positively for both disorders; and what would be the experience of agencies in using these tools. Three instruments were chosen to be tested in the COSII pilot sites: Mental Health Screening Form III for mental health; UNCOPE for adult substance abuse; CRAFFT for adolescent substance abuse.

Findings from this pilot were not groundbreaking in that the pilot data are similar to national findings. Rates of COD are high among the treatment population: slightly over 50 percent of clients screened positively for a COD. Moreover, agencies generally reported positive experiences with the screening instruments, but highlighted the frustration of using tools that didn't necessarily fit their agency or program. The report concluded with the recommendation that the State would benefit most from instituting screening guidelines requiring that agencies incorporate dual screening instruments into the intake process but not prescribing specific ones.

In 2008, the Directors of the Offices of Mental Health and Substance Abuse requested an additional screening pilot based on their interest in a particular instrument, the AC-OK. This is a single, integrated instrument that screens for mental health, substance abuse and trauma. Of note is that the instrument has been validated only for the adult, not the juvenile population. As with the previous pilot, the current cohort of agencies piloted the instrument on incoming clients for a ninety-day period. HZA (the evaluators) then interviewed agency representatives to gauge their experience with the instrument. Findings from the current pilot mirror those of the previous one, namely that a significant portion of clients entering treatment screen positively for a co-occurring disorder, 62.7 percent to be precise. Agency representatives again highlighted the benefits of a comprehensive screening process but emphasized that one screening tool should not be mandated of Maine's therapeutic agencies.

While the option to require comprehensive screening but not mandate a single instrument is still available, the state appears currently to be leaning towards the option of mandating the use of the AC-OK. If this option is pursued, the state should consider some of the specific concerns raised by the agencies as part of the interview process. Perhaps the most critical concern pertains to how to approach the juvenile population, since this instrument is not validated for this population.

In 2005, the State of Maine applied for and received a Co-Occurring State Incentive Grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). This grant is targeted to fund state efforts in developing a state treatment delivery system for people and families affected by co-occurring disorders (COD). The Maine effort is entitled Co-occurring State Integration Initiative (COSII) and is intended to function at two levels: developing state infrastructure to effectively monitor and serve people of all cultures who experience co-occurring disorders; and implementing capacity-building goals in a variety of settings throughout the state.

One goal identified in the grant was to determine a standard screening protocol to be implemented in Maine's behavioral health treatment delivery system. Having a standard screening protocol that encompasses both mental health and substance use is considered a key aspect of an integrated agency as it allows for both disorders to be identified at the initiation of services. The aim is to assure that all people entering an agency, regardless of its scope of practice or clientele, receive screening for both disorders so that an appropriate and informed assessment can be initiated. That is, a comprehensive screening process is the first step on the integrated treatment continuum. SAMHSA's 2002 report to Congress on the co-occurring population notes that, "effective treatment for co-occurring disorders begins with accurate screening and assessment. High prevalence for COD, the low treatment rates and under-diagnosis of substance use disorders highlight the need for better detection and screening strategies."

In 2007, the COSII Screening and Assessment Tools and Protocol Workgroup opted to implement a pilot that would utilize dual, standardized screening instruments on incoming clients at designated treatment agencies. The goal of the project was to provide the Directors of the Offices of Mental Health and Substance Abuse with supporting findings to make an informed decision about whether standardized screening instruments should be required of Maine's behavioral health treatment agencies and whether the piloted tools were the appropriate ones to require. The selected tools were the Mental Health Screening Form III (MHSF III) for mental health and the UNCOPE (for adults) or CRAFFT (for adolescents) for substance abuse.

Findings from this pilot were presented in the original COSII Screening Instrument Pilot Report, dated November of 2007, and are incorporated into this current and revised version. In summary, the pilot found that a high number of clients entering a COSII pilot site screened positively for a potential COD, 52.7 percent to be precise. Findings from a series of follow-up interviews with pilot sites revealed that while agencies benefitted from the use of dual instruments in helping to identify co-occurring disorders and inform the assessment process, many agencies emphasized the difficulty in utilizing preselected instruments across the treatment spectrum. The report concluded with the recommendation that it is more important *that* the state mandate agencies use a standardized, dual screening process rather than *what* tools are utilized; guidance could be provided to agencies by the development of a short list of appropriate and acceptable tools.

In early 2008, the Directors of the Offices of Mental Health and Substance Abuse requested an additional screening pilot with the new cohort of COSII agencies based on their interest in a particular instrument; the AC-OK, developed by the evaluator for the Oklahoma COSIG project (Appendix A). The AC-OK represents a single, integrated instrument that screens for mental health, substance abuse and trauma, a domain previously unexplored. Like the tools utilized in the previous pilot, this instrument was chosen for its cost (none) and ease of use. Unlike the previous pilot, however, the AC-OK has only been validated for the adult, not the juvenile population. This pilot was in part implemented to identify whether the tool could be understood by juveniles but was not intended to validate the instrument among the population. Such a project would need to determine the ultimate diagnoses for individuals who completed the AC-OK and goes well beyond the scope of the pilot.

The AC-OK is a brief, fifteen question screen that can assist an agency in rapidly determining whether an incoming client would benefit from a comprehensive assessment. One of the advertising statements for the instrument is “What a difference five minutes can make.” A drawback of the instrument is that it identifies a high number of false-positives, or people who will screen positively for a COD but later be found through a formal assessment process not to have a co-occurring diagnosis. The AC-OK will “identify about twice as many people that will need a full assessment than will later be found to have a co-occurring disorder.” The author of the AC-OK notes that in the long-term it is far more costly to miss a person with COD than it is to assess additional people based on the significant costs that can be accrued if a person does not receive integrated and appropriate treatment.

As with the original screening pilot in 2007, the current pilot utilized two primary methods of data collection. All participating agencies administered the designated tool to incoming clients for a ninety-day period. After the implementation period was over, a representative from the COSII evaluation team contacted agency representatives to conduct a brief follow-up interview. The current pilot’s data collection was additionally augmented by dialogue that occurred at the COSII Pilot Site Meeting in October of 2008. The follow-up interviews were conducted individually with agencies; the pilot site meeting represented a conversation between agencies and COSII representatives.

## Data Collection and Analysis

Hornby Zeller Associates, Inc. (HZA), the evaluators for the COSII project, administered this project by providing agencies with formatted screening instruments, collecting and analyzing the screening instrument results, performing interviews with appropriate agency contacts and attending the COSII Pilot Site meeting.

HZA provided each agency with copies of the AC-OK as well as return supplies. Agencies were informed that the tool was to be administered to incoming clients for a ninety-day period; some of the larger agencies chose to implement the tool for a particular program instead of on an agency-wide basis. Agencies were given the freedom to decide who administered the tool as well as when the tool was administered.

Table 1 lists the number of screening forms received from each agency. One of the unique aspects of the current pilot was that the current cohort of agencies includes Maine Pretrial Services, a criminal justice agency that is different in nature when compared to the behavioral health focus of other participating agencies. Screening forms received from Maine Pretrial

**Table 1: Screening Forms Received by Agency**

Agency	Number of Screenings	Percent
Youth Alternatives / Ingraham	224	18.6%
Life by Design	91	7.6%
Maine Pretrial Services	478	39.7%
Day One	65	5.4%
Community Concepts	21	1.7%
Crossroads for Women	135	11.2%
Health Access Network	20	1.7%
Mid Coast Mental Health	110	9.1%
Community Counseling Centers	60	5.0%
<b>TOTAL</b>	<b>1204</b>	<b>100%</b>

Services represent a sizable portion of the screening sample, almost forty percent. Because the nature of this agency's clientele is different than the other agencies in the cohort, data from this agency is at times separated in this report.

HZA used the rules established by the AC-OK to classify a client as having a positive screen. A positive response to one question in any of the three domains (mental health, trauma and substance use) constitutes a positive screen for that domain and identifies that further assessment is warranted. Seven questions pertain to mental health; two questions pertain to trauma related mental health issues; and six questions pertain to substance use for a total of fifteen yes/no questions. The instrument pertains to symptoms in the past year and also collects gender and date of birth. Rates for a potential COD were determined by the presence of a positive screen for mental health and/or trauma *and* substance use. As previously emphasized, not all clients who screen positively on this instrument will likewise be diagnosed.

To gauge agency perception of the screening pilot, a series of interview questions was developed by HZA (Appendix B). Interview questions were similar to those from the previous pilot but were modified

slightly to elicit conversation about the use of a single, comprehensive tool compared to the use of two separate tools, if this was the case in an agency. These interviews were intended to receive agency feedback on how the screening tools were administered as well as how the agencies' perceptions of the designated screening tool. Each agency's COSII representative was contacted by a representative of HZA. At that time, the representative was notified of the intent of the interview and given the option to include other agency staff in the interview process. Some agencies elected to include staff who either administered the instrument or oversaw the process. Interviews were conducted over a three-week timeframe in October, 2008, and were performed by the same HZA representative. Each interview took approximately 10 to 15 minutes. Interviews were conducted with seven of the nine agencies. Interviews were not conducted with Youth Alternatives / Ingraham and Life by Design due to an inability to schedule an interview. Representatives from these agencies were contacted multiple times.

Additionally, the HZA project manager attended the COSII pilot site meeting at which agency representatives were present. Data highlights from the pilot were presented to the group and resulted in discussion that focused on both the pilot project results *specifically* and the concept of a mandated instrument *generally*.

**Screening Results**

Many dimensions can be explored in the data collected for this pilot. The population that participated in this pilot comes from diverse agencies and represents a broad spectrum of clients who present to treatment. Likewise, the tool collects information on a domain (trauma) that previously has not been reported on. To highlight differences and similarities in the data, the findings are first presented generally and then described in more specific detail throughout this section of the report.

*General Screening Results*

A majority of the population screened positively for mental health, substance abuse, trauma and COD, as displayed in Table 2. Clients screened positively for mental health (85.1 percent) at a higher rate than they did for substance abuse (68.4 percent) or trauma (61.5 percent). Almost two-thirds (62.7 percent) of the entire population screened positively for COD. This rate is similar to, though slightly less, than the 70 percent identification rate estimated in the supporting literature for the AC-OK.

**Table 2: General Screening Results**

	All
Positive Screen for MH	85.1%
Positive Screen for Trauma	61.5%
Positive Screen for SA	68.4%
<b>Positive Screen for COD</b>	<b>62.7%</b>

*Demographic Characteristics*

Two demographic characteristics were collected on the instrument; gender and age. Additionally, information from the Maine Pretrial Services population was examined both in aggregate and separately based on the unique nature of the agency. The screening population was slightly more male (56.7 percent) than female (43.3 percent). The mean age was 32.9 years although the range was significant, from 10.9 to 78.3 years. Youth (under 20 years) constituted approximately 10 percent of the sample. Maine Pretrial clients were significantly more likely to be male (80.0 percent) and younger (31.3 years compared to 33.9 years).

Youth (under 20) screened at about the same rates as the adult population for all domains except trauma, where they screened significantly lower (Table 3). Maine Pretrial clients screened significantly lower in all domains except substance abuse (SA) (Table 3). However, they still have a relatively high rate of a positive COD screen (59 versus 65 percent). Clients who screened positively for SA and COD were significantly

**Table 3: Screening Results by Population**

	Adult <sup>1</sup>	Youth	Maine Pretrial
Positive Screen for MH	93.3%	84.1%	72.8%
Positive Screen for Trauma	71.8%	47.8%	50.6%
Positive Screen for SA	67.1%	69.4%	69.9%
<b>Positive Screen for COD</b>	<b>65.2%</b>	<b>61.8%</b>	<b>59.0%</b>

<sup>1</sup> Excludes clients from Maine Pretrial Services

younger (by about 2½ years and 1½ years, respectively); clients who screened positively for trauma were significantly older (by about 1½ years). Females screened positively for MH, trauma and COD at significantly higher rates than males, demonstrated in Table 4.

**Table 4: Screening Results by Gender**

	Male	Female
Positive Screen for MH	77.1%	95.5%
Positive Screen for Trauma	50.8%	75.5%
Positive Screen for SA	68.2%	69.1%
<b>Positive Screen for COD</b>	59.3%	67.7%

*Trauma*

While the trauma domain of the AC-OK is limited to two questions (pertaining to whether the client has experienced a traumatic event and whether the client has experienced repeated nightmares of the event), the inclusion of this domain is important. A significant portion of the co-occurring population has experienced a traumatic event,

**Table 5: Rates of Trauma by Treatment Population**

	Positive Screen for MH	Positive Screen for SA
Positive Screen for Trauma		
Male	60.9%	55.6%
Female	77.6%	80.3%
<b>Total</b>	<b>69.0%</b>	<b>66.2%</b>

especially among the female population, yet trauma is sometimes poorly addressed in the assessment and treatment process. Identification of a client’s trauma history can help to ensure that it is adequately addressed. Gender differences in the rates of trauma by treatment population are quite noticeable in the findings; among women who screened positively for SA, over three-quarters (80.3 percent) also screened positively for trauma (Table 5). In comparison, only about half of the men who screened positively for trauma likewise screened positively for SA. The gender discrepancy among the mental health population is not as large but still significant.

*Severity of Screening Responses*

Another dimension explored pertains to potential severity of mental health and substance abuse symptoms based on the number of positive responses for the respective domains. As the trauma domain includes only two questions, this domain was excluded from this portion of the analysis. As seen in Table 6, slightly under half of the population responded positively to four or more questions for both mental health

**Table 6: Positive Responses by Domain**

	Mental Health	Substance Abuse
None	14.9%	31.6%
One	11.5%	9.3%
Two or Three	29.4%	13.7%
Four or More	44.2%	45.3%

and substance abuse. Considering that the tool contains seven questions for mental health and six questions for substance abuse, almost half of the population responded positively to the majority of the questions on the instrument. While not all clients will go on to have multiple mental health and substance abuse diagnoses, these findings highlight that clients are reporting to treatment with multiple symptoms, some of which are quite serious: almost one in five (18.4 percent) reported a past suicide attempt; 15 percent reported hallucinations. Additionally, clients with multiple positive responses were also significantly more likely to screen positively for a COD. For example, 80.4 percent of clients who responded positively to *one* substance abuse question screened positively for a COD, while 98.3 percent of clients who responded positively to *all* substance abuse questions screened positively for a COD.

### *COD by Treatment Population*

A final dimension explored in the data analysis pertains to the rates of COD by either the mental health or substance abuse population, as displayed in Table

**Table 7: Rates of COD by Treatment Population**

	Positive Screen for MH / Trauma	Positive Screen for SA
Positive Screen for Both (COD)	71.4%	91.7%

7. In aggregate, almost two-thirds of the population screened positively for COD. Of note, though, is that the COD rates are much higher among those who screened positively for substance abuse in comparison to those who screened positively for mental health. That is, of those who screened positively for mental health, almost three-quarters also screened positively for substance abuse. However, of those who screened positively for substance abuse, over 90 percent screened positively for mental health. People with substance abuse are far more likely to have signs of mental illness than people with mental illness are to have signs of substance abuse.

### *Comparison to 2007 Pilot*

Screening rates from the two pilots are generally similar with a majority of the population from each time period screening positively for a COD, displayed in Table 8. This year, positive rates were lower for mental health but higher for substance abuse and COD. Because the prior instruments did not include a

**Table 8: Pilot Comparison**

	2007 Pilot	2008 Pilot
Positive Screen for MH	91.6%	85.1%
Positive Screen for SA	60.5%	68.4%
<b>Positive Screen for COD</b>	<b>52.7%</b>	<b>62.7%</b>

trauma component, no comparison can be made for this domain. Two points are important to consider when comparing the different pilots, however. First, the pilots utilized different tools and a different number of tools, two separate tools for the 2007 pilot and one comprehensive tool in 2008. Second, the separate pilots collected information from two different cohorts of COSII agencies. Thus, while both pilots support the finding that a sizeable portion of clients entering into treatment at a COSII site screen positively for mental health, substance abuse and a COD, the two studies cannot be considered comparable.

### **Agency Experience**

The interview conducted for both of the pilots was similar; the 2008 interview differed in that it contained questions pertaining to the use of one, integrated instrument, whereas the 2007 interview focused on the dual instruments. The initial part of the interview focused on past agency practice. No agencies reported the use of a single, standardized screening instrument, or what the AC-OK represents. Two agencies, Health Access Network and Maine Pretrial Services, reported the use of a standardized screen for both mental health and substance abuse *prior* to the implementation of the AC-OK; other agencies had previously utilized either a single, standardized instrument for only one disorder or a “home-grown” instrument that varied as to whether it encompassed both domains. Of the 10 agencies who participated in the 2007 pilot, only one (Catholic Charities Maine Counseling) likewise utilized dual, standardized instruments prior to the screening pilot. Thus, while this year a higher percentage of

agencies had previously utilized standardized tools (two of seven compared to one of ten), the majority of agencies still had not used a comprehensive instrument prior to the project<sup>2</sup>.

Most of the agencies administered the AC-OK as part of the intake process that occurs during a clients' first visit at the agency. One agency, Community Counseling Centers, administered the AC-OK during a person's first phone contact with the agency. This agency was the only one where a client's screening results determined what clinician a person would be referred to for an assessment. That is, a client who screened positively for a COD was referred to one of two assessment clinicians, both of whom were more experienced with co-occurring assessments. Other agencies administered the screening tool at the same visit as the assessment; usually the screening instrument led into and informed the assessment process but did not necessarily determine its scope.

Two agencies, Crossroads for Women and Mid-Coast Mental Health, had clients self-administer the tool while other agencies had a staff / clinician administer it. A few agency representatives noted that the tool added a slight burden to the client's intake process, either by taking time from the assessment process or by the volume of paperwork already expected of clients, but no significant concerns were raised. Some of the agencies recognized that a couple of the questions, particularly those relating to substance abuse, were slightly intrusive and potentially intimidating (for the client) to begin a conversation with. Day One highlighted that the juvenile population may be more sensitive than adults to some of the questions, in particular those pertaining to trauma.

Generally, most agencies reported that the AC-OK worked well for their agency. The tool was recognized for its brevity, in part that it is one instrument, and ease of use. Many agencies felt that it helped to inform the assessment process, mainly by directing a clinician to presenting symptoms but also helping clinicians to validate information disclosed in the assessment process. For example, if a person denied substance related issues during the assessment but had answered positively to multiple substance related questions on the screen, the clinician was able to refer back to the instrument and help the client to recognize a potential problem. While most agencies felt that they had accurately identified COD clients prior to the use of the AC-OK, mainly through a comprehensive assessment process, agencies did recognize that the tool helped to further inform the assessment process.

At the same time, the tool was criticized for being too brief, vague and at times misdirected. For example, one agency found that the AC-OK simply wasn't as comprehensive as the tool they had previously used, especially in the mental health domain. Likewise, another agency noted that the instrument didn't allow them to "map-out" clients' past substance use, a trait from the previously used tool that they find beneficial.

Three of the agencies administered the instrument to juveniles, the population that the instrument has not been validated for and was in part an impetus for this pilot. Two of the agencies felt as though the

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<sup>2</sup> While nine agencies participated in the pilot project, interviews were conducted with seven agencies. Thus, the evaluators cannot speak to prior practice at the two agencies with which interviews were not conducted.

tool was understood by juveniles, while one agency noted that juveniles at times struggled with the instrument. This agency in particular noted that clinicians administering the instrument identified to the interview respondent that the instrument was not validated for the juvenile population.

As with the interview findings from last year, the majority of agencies voiced their concerns with the state mandating the use of a standardized screening instrument, in this case the AC-OK. This concern was echoed and reinforced by some of the agencies present at the Pilot Site meeting on October 22, 2008. Generally, agencies noted that one instrument does not consider agency scope, practice and individuality. As with the previous pilot, agencies mainly noted that they recognized the importance of comprehensive screening process but felt that the goal would be better met by the state providing guidance on either what tools to use or what information to include in a screen (if the instrument was “home-grown”). One agency questioned whether a comprehensive screening process is needed if all incoming clients receive a comprehensive assessment, regardless of their presenting symptoms.

At the same time, a few agencies felt the state would benefit from a standardized screening process and felt that the AC-OK was an acceptable tool. One agency specifically said that it would support a state mandated screening process *if* the AC-OK was the chosen instrument but would object if the instrument was one that was more burdensome or lengthy. Another agency felt that a standardized screening process would facilitate interagency communication in cases where clients transfer to another agency.

This cohort of agencies identified some specific concerns that have previously not been highlighted. First, one agency voiced concern over the ethical responsibility agencies are held to if a person screens positively for a domain that might be outside its traditional scope of practice. For example, this would be the case if a client entering treatment at a mental health agency also screened positively for substance use. The agency representative noted that if such a scenario occurred, the agency has the responsibility to address the issue but in some cases may not have the experience to do so.

Other agencies questioned the need to change their intake procedures from the use of an instrument/s they believed to be more appropriate for their practice or to be better tools overall. In some cases, these tools are integrated into an agency’s management information or reporting system. As such, representatives voiced additional concern over the potential burden that will be placed on them, and the resulting change to their systems, should the state require the use of an instrument other than what is currently implemented.

When screening tools are uniformly applied to people who come for treatment at mental health or substance abuse service providers, the results in Maine mirror that of other communities around the country. The rates of screening positively for both disorders is high; rates among those presenting to a criminal justice agency (compared to a behavioral health agency) are also high. Additionally, this pilot highlighted that many people entering treatment present with a history of trauma, especially females. Likewise, the interview results should not come as a surprise as they mirror the previous pilot's findings to a noticeable degree. There is obvious opposition among treatment agencies towards the idea of a state mandated screening instrument. Many of their positions and concerns have been represented to state officials at meetings during the period of this pilot.

Prior to both of the pilots, most agencies did not utilize a standardized, comprehensive screening process. It would not be presumptuous to assume that many non-COSII agencies throughout the state lack these practices as well. Clearly, a comprehensive screening process is an important first step in providing integrated treatment and should be universally implemented in some manner. With this recognition comes the question of how to accomplish such a goal. The recommendation from the previous pilot was that it would potentially benefit the state most to mandate that all licensed mental health and substance abuse treatment facilities utilize dual, standardized screening forms during the intake process and provide guidance for what tools are acceptable to use rather than mandate the use of one instrument. This recommendation is obviously still an option for the state and has certain advantageous characteristics, namely that it ensures comprehensive screening occurs while providing agencies with the freedom to decide what works best for their practice.

At the same time, it appears that the state is leaning in a different direction, namely that of requiring the use a standard tool, in this case the AC-OK. As such, this report does not contain a recommendation similar to that of the previous report, but instead highlights some issues that, if this option is pursued, the state should first consider. Perhaps of most immediate importance is how to approach the juvenile population. While some agencies felt that juveniles were able to understand the AC-OK, another agency felt the opposite. Regardless, the instrument has not been tested with this population and should not be implemented until it has been. To this author's knowledge, a single, comprehensive instrument validated for the juvenile population does not exist. Consequentially, the state would need to select two, separate instruments.

Almost of equal importance is whether and how agencies will be expected to report results from the tool. Certainly one of the more valuable aspects of a single, mandated tool is the benefit of collecting screening data on a statewide basis. The Administrative Services Organization currently in place with these agencies, APS, presents one option in the reporting schema, but others may be available as well.

An additional consideration is whether a comprehensive assessment could be utilized in lieu of a comprehensive screening instrument. It is a little surprising that the majority of agencies administered

the screening tool immediately prior to the assessment. While the use of the AC-OK helped to inform the assessment, such practice may not meet the intended purpose of “screening,” where the use of a tool helps to establish the need for an in-depth assessment. Only one agency assigned clients to a specific clinician, and therefore a more comprehensive assessment, based on the results of the tool. If the purpose of the tool is to ensure that clients who may have a COD receive a comprehensive assessment, is that purpose null if every incoming client at certain agencies is guaranteed a comprehensive assessment?

If the state were to mandate the use of a tool, it should contemplate whether to assist with modifications to the agencies’ information systems. Finally, training needs and the ability of all agencies in the state to address co-occurring issues must also be considered. The agency representative who highlighted the ethical responsibility of agencies provided an important point for many agencies that haven’t participated in the COSII process or other co-occurring training opportunities and may not be able to handle such a process. While co-occurring language has been incorporated into state contracts, some agencies may still need assistance in developing and ensuring that an adequate referral process is in place. The state should be available to provide technical assistance if needed.

## Appendix A: Screening Tool

### AC-OK Screen for Co-Occurring Disorders<sup>3</sup> (Mental Health, Trauma Related Mental Health Issues & Substance Abuse)

Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date of Screening: \_\_\_\_\_

#### During the past year:

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

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<sup>3</sup> A copy of the instrument with supporting information is available at:  
<http://faculty-staff.ou.edu/C/Andrew.L.Cherry-1.Jr/AC-OK%20COD%20Screen%20Packet%205-23-7.pdf>

## Appendix B: Interview Questionnaire

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**Agency:**

**Contact:**

**Date:**

1. Has your agency completed the 90-day time frame for the Screening Project?
  - a. Have all screening forms been submitted to HZA?
  - b. What program/s was the AC-OK administered at?
2. Was this the first time that your agency used a standardized screening tool for both Mental Health & Substance Abuse?
3. If you had previously used screening tools, what tools did you use?
4. If this tool is new to you, how do they compare to what you used before?
  - a. How do you feel that one tool (AC-OK) compared to using two, separate tools (if appropriate)?
5. Who administered this tool? When was it administered?
6. What was the impact of administering this tool? Did it create more administrative burden or was the process integrated into you standard intake protocol fairly easily?
7. In general, how did this particular tool work as a screening tool for your agency? Do you feel that this tool helped you to identify co-occurring disorders more effectively?
8. Did you find that your rates of identification of COD were higher or lower than normal / expected?
9. If you are a MH / SA provider, was it helpful to use a SA / MH screening tool?
10. What screening tool/s does your agency plan to use in the future? (*Pilot ones, ones previously used, new ones*); specify:
11. Do you feel that the state should adopt common screening and assessment tool/s?
12. Should this (AC-OK) be the tool that we use?
13. Any other comments about screening?

	All	Youth Alternatives / Ingraham	Life by Design	Maine Pretrial Services	Day One	Community Concepts	Crossroads for Women	Health Access Network	Mid-Coast Mental Health	Community Counseling Centers
<b>Positive screen for mental health (Q7-Q13)</b>										
Yes	85.1%	98.2%	84.6%	72.8%	90.8%	85.7%	98.5%	80.0%	90.0%	91.7%
No	14.9%	1.8%	15.4%	27.2%	9.2%	14.3%	1.5%	20.0%	10.0%	8.3%
<b>Severity of Dx (Q7-Q13)</b>										
None	14.9%	1.8%	15.4%	27.2%	9.2%	14.3%	1.5%	20.0%	10.0%	8.3%
One	11.5%	2.7%	15.4%	15.9%	21.5%	19.0%	3.0%	15.0%	8.2%	15.0%
Two to three	29.4%	22.3%	33.0%	29.1%	40.0%	52.4%	29.6%	30.0%	28.2%	35.0%
Four or more	44.2%	73.2%	36.3%	27.8%	29.2%	14.3%	65.9%	35.0%	53.6%	41.7%
<b>Positive for substance abuse (Q1-Q6)</b>										
Yes	68.4%	55.8%	45.1%	69.9%	87.7%	52.4%	98.5%	30.0%	83.6%	40.0%
No	31.6%	44.2%	54.9%	30.1%	12.3%	47.6%	1.5%	70.0%	16.4%	60.0%
<b>Severity of Dx (Q1-Q6)</b>										
None	31.6%	44.2%	54.9%	30.1%	12.3%	47.6%	1.5%	70.0%	16.4%	60.0%
One	9.3%	6.7%	13.2%	11.5%	7.7%	14.3%	3.0%	10.0%	7.3%	13.3%
Two to three	13.7%	13.8%	11.0%	17.8%	10.8%	19.0%	7.4%	5.0%	7.3%	16.7%
Four or more	45.3%	35.3%	20.9%	40.6%	69.2%	19.0%	88.1%	15.0%	69.1%	10.0%
<b>Positive for trauma (Q14-Q15)</b>										
Yes	61.5%	82.1%	63.7%	50.6%	36.9%	47.6%	81.5%	35.0%	61.8%	61.7%
No	38.5%	17.9%	36.3%	49.4%	63.1%	52.4%	18.5%	65.0%	38.2%	38.3%
<b>Co-occurring (mental health and/or trauma AND substance abuse)</b>										
Yes	62.7%	55.8%	40.7%	59.0%	84.6%	38.1%	97.8%	30.0%	78.2%	40.0%
No	37.3%	44.2%	59.3%	41.0%	15.4%	61.9%	2.2%	70.0%	21.8%	60.0%