

OK-COSIG
Quarterly Evaluation Report

Volume 4

Number 2

January 1, 2008 through March 31, 2008

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Acknowledgement

With the close of the 2nd Quarter of the fourth year of the OK-COSIG project, the major work on the project is drawing to a close. The fourth and fifth year are designed to be the follow-up and evaluation period. The cooperation from the OK-COSIG staff that started from day was excellent. The interactions and correspondence between the Evaluation team members and the OK-COSIG staff was frequent and time consuming for all. This level of cooperation, however, was needed to collect data that we will use to tell the story of the OK-COSIG project and document the outcome of these integrative system components, based on what was done, and how it was done.

Additionally, the OK-COSIG project evaluation has benefited and is made possible because of the cooperation and support of Department staff and administrators at all levels. The accomplishments of this 2nd Quarter are based on our work together, gathering documents, making observations and doing fidelity assessments. This continues to be the work of making integrated services for people with a co-occurring disorder a reality in Oklahoma.

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How this quarterly evaluation report is organized

This is the 2nd Quarterly Report for the 4th year of the OK-COSIG project. This report is in two parts. It contains the Co-Occurring State Incentive Grants Quarterly Progress Report: SAMHSA Format and a report on the quarterly activities that is similar to past reports. It chronicles interviews, documents, and meeting notes. The SAMHSA Quarterly Progress Report summarizes these data.

Following the SAMHSA Quarterly Progress Report, a brief overview of the work accomplished by the OK-COSIG staff and the OK-COSIG evaluation team in the last three months (January 1, 2008 through March 31, 2008). This will be followed by a list of the support activities that were carried out during the 2nd Quarter of this 4th year. Next, the work accomplished on the evaluation of the project will follow. Then the goals and objectives by timeline will be described in terms of their status and the resources that are

being employed to meet the objectives. Finally, additional emerging themes that were identified in the 2nd Quarter of this 4th year will be described.

Editorial note: The Quarterly Reports produced during the 4th year of this project will be data for the year-end reports. The year-end reports will be the data used in the previous four quarterly reports. These reports will also form the basis for the final report on the Process Evaluation. To maintain the highest level of accuracy, corrections will be made on quarterly reports as errors are identified or clarifications are needed. These changes will be issued as new pages that will replace the pages with errors. The new pages will retain the old text, but the old text will appear with a ~~strike through~~ to indicate that it was changed. The new added text will be underlined. All revision dates will appear at the bottom of the page.

Disclaimer:

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

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**Co-Occurring State Incentive Grants Quarterly Progress Report:
Formatted to comply with SAMHSA Reporting Requirements**

January 1, 2008 through March 31, 2008

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Year: 2008,

Title of Grant:

Quarter 2nd

**Oklahoma State Incentive Grant
for Treatment of Persons with Co-
occurring Mental Health and
Substance Related Disorders**

Grant Number:

State:

1 KD1 SM56568

OKLAHOMA

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I. Project Implementation

This is the 2nd Quarterly Report for year four of the Oklahoma-Co-occurring State Incentive Grant. This report is in the *Quarterly Progress Report Format* required by SAMHSA. The interviews, documents, and meeting notes on which this SAMHSA report is based can be found in the *OK-COSIG Quarterly Evaluation Report, Volume 4, Number 1* at http://faculty-staff.ou.edu/C/Andrew.L.Cherry-1.Jr/okcosig_project.htm.

The OK-COSIG project has two interrelated and overarching goals:

Goal 1. Develop, implement and evaluate a standard protocol for the screening and assessment of mental health and substance abuse treatment service recipients in all State funded programs.

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

These goals with their objectives, activities and timelines were designed to develop the capacity to identify and treat people who present with the co-occurring disorders of mental health, substance abuse, and trauma within Oklahoma's mental health and substance abuse treatment communities.

A major change in the personnel occurred during this quarter. One staff person transferred to another division and one person was added. Dr. Khepra Khem Co-Occurring Training Specialist has taken the position in Access Recovery as the Coordinator of Field Services. His last day with OK-COSIG was 2-16-08. Renea Butler-King, Coordinator of Field Services; and Amber Rentaria-Hulme, COD Field Representative will take on his training responsibilities. As well, a member of the evaluation team also resigned.

Kim Peterson, LADC, Director of Treatment Services, started working with the OK-COSIG team this quarter (FTE 25%). She has had an interest in the provision of treatment services for several years.

Dr. Lisa Byers, a member of the evaluation team resigned on 1-10-2008.

At the end of the 2nd Quarter of year four of the OK-COSIG project, many of the structural barriers that have existed over the years between mental health and substance abuse treatment have been bridged or weakened. Infrastructure changes such as the changes in the ODHMSAS State rules governing mental health treatment (Chapter 17) and substance abuse treatment (Chapter 18) continue to stand out as one of the major accomplishments. These rules set the standards for care. These rules now prominently include services to people with the co-occurring problems of mental health, substance misuse, and trauma. These rules will help make treatment for people with co-occurring disorders, the norm. An example of the text in these rules are:

Title 450

Chapter 15

450:15-3-14. Right to treatment

(f) Each consumer who has a co-occurring disorder shall receive services for those disorders. No program shall deny services to a consumer for any disorder solely because that consumer is displaying symptoms of, or receiving treatment for a co-occurring disorder of another type.

Title 450

Chapter 16

450:16-1-2. Definitions

(A) Currently or at any time during the past year have had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet criteria specified within DSM-IV with the exception of "V" codes, substance abuse disorders, and developmental disorders, unless they co-occur with another diagnosable serious mental illness; AND

Title 450

Chapter 17 and 18

"*Co-occurring disorder*" means any combination of mental health and substance abuse symptoms or diagnosis in a resident.

The word or terms related to "co-occurring" are used at least "62" times in these two documents. These ODMHSAS Administrative Rules can be viewed at <http://www.odmhsas.org/AdminRules.htm>

The trainings provided by the OK-COSIG staff over the last three years have been effective in alerting those in the substance abuse and mental health community to the treatment needs of those with a co-occurring disorder. There were three Core-Level Co-Occurring Trainings conducted this quarter. The first training was conducted at the Red Rock Treatment Center, in Oklahoma City on 1-8-2008, some 23 people attended. A second Core-Level Co-Occurring Training was conducted at Clinton, Oklahoma on 1-18-2008, 10 people attended. The third Core-Level Co-Occurring Training took place at the Red Rock Treatment Center, in Oklahoma City on the 2-5-2008, 33 people attended. Among those attending were six licensed clinicians and three Registered Nurses.

In addition to the Core-Level Co-Occurring Training curricula, the Intermediate-Level training manual has been compiled. Currently, the Advanced-Level training manual is nearing completion. The plan is to have the Advanced-Level training manual completed by summer.

At the State Department level, an Integrated Conference was held on January 23-25, 2008. This conference provided workshops and presentations on mental health issues, substance abuse issues and co-occurring issues.

Yet, making the changes necessary to provide services to all of the people with a co-occurring disorder continues to be a work in progress. Especially the provision of treatment that is “accessible, culturally competent, and grounded in evidence-based practices.” To accomplish the goal of ‘accessible’ an infrastructure for service coordination is slowly developing. The primary barrier to interagency cooperation and collaboration continues to be related to financial issues and contracting.

At the conclusion of the 2nd Quarter of this fourth year, the OK-COSIG project has met many of the objectives laid out in 2004 toward accomplishing the two goals of the initiative. The work toward developing statewide capability to identify, refer and/or treat people with a co-occurring disorder is evolving. The integration of treatment for people with a co-occurring disorder into the fabric of behavioral health across departments continues albeit at a slower pace. Changes in State law and contracting procedures support this capacity building effort.

The evaluation efforts over the next year and a half will focus on identifying and verifying the changes that have been made since 2004 using data from the Individual Client Information System (ICIS) for fiscal years 2005-2006 and 2006-2007. The evaluator also acquired access to the Government Performance and Results Act (GPRA). This data will be helpful in answering questions about individual outcomes that cannot be answered using the ICIS data files such as the number of previous hospitalizations.

The areas that have seen the least success has been in the areas of inclusion of consumers and advocates, Native Americans, African Americans, and Hispanics in this transformation process. The question can be asked, how would the transformation be different if the voice of the African American, Hispanic American, and Native American communities had been present?

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

Other than the modifications needed to collect the GPRA data no other major modification has been made. The GPRA data is being collected from the 3 pilot sites (Norman, Tulsa, Vinita/Tahlequah).

Goal 1. Develop, implement and evaluate a standard protocol for the screening and assessment of mental health and substance abuse treatment service recipients in all State funded programs.

Objective 1.1 – Develop consensus among providers, service recipients, consumer advocates and other interested parties on a standard screening and assessment protocol for use in mental health and substance abuse treatment settings

Meetings to look at the possibility of using assessment tools other than the ASI and CAR continue. The current rules require treatment agencies complete an ASI (a requirement for substance abuse treatment centers) or a CAR (a requirement for mental health centers).

Another activity that both supports the changes made and continues the process of developing program capability is the capability scale (it was called a fidelity scale) that has been developed and is being revised to define what program capability is and how it fits within ODMHSAS regulations.

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

For all intents and purposes, the work on Objective 1.2 has been completed. The vast majority of staff of the 15 pilot programs has been trained with the Core Level curriculum. Training continues, however, on the Intermediate Level curricula, which has begun and training on the Advanced-Level curriculum which will also begin this year.

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

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

Consensus building and maintaining the support of the agencies while the infrastructure changes are becoming a part of the Oklahoma treatment culture is important work that the OK-COSIG team has in front of it. Based on the number of agencies that are participating in the project, now at 28, this will require a great deal of work. The Team needs to continue to build consensus, and maintain and expand support of the organizational changes to provide program capable co-occurring services. The OK-COSIG team continues to be fully engaged in consensus building among the shareholders.

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

The staff continues to meet with a committee of representatives from the Board of Licensed Professional Counselors, the Social Work Licensure Board, and the Board that license Behavioral Health practitioners. The work to establish credentialing for a co-occurring specialist is still being discussed.

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

In year three, a great deal of time and energy was expended to change ODHMSAS State rules governing mental health treatment (Title 450:17, Chapter 17) and substance abuse treatment (Title 450:18, Chapter 18). These changes relate to treatment

for co-occurring disorders. The rules will make it much more likely that agencies will address the needs of people with a co-occurring disorder.

Objective 2.4 – Train all mental health and substance abuse treatment providers in the use of a comprehensive, integrated system of care model for persons with co-occurring disorders.

Much of the work has been completed on this Objective. The next phase is to provide Core-Level trainings to the additional 13 programs. The Intermediate-Level training has begun. The Advance-Level manual is near completion. The plan is to finish the Advance-Level manual by summer.

(2) Project timeline for project implementation

The collection of the GPRA data is underway. Three staff members were specifically hired to enter GRPA. One staff person is assigned at each of the three pilot sites to enter the GRPA data.

Over the last 40 months of the OK-COSIG project, most of the objectives and activities met their targeted timelines and have been completed. These activities are chronicled in the quarterly reports produced over the last three years. They are available online at http://faculty-staff.ou.edu/C/Andrew.L.Cherry-1.Jr/okcosig_project.htm. It is also available at <http://www.odmhsas.org/isi/>.

The work to train 80% of staff at all State funded mental health and substance abuse treatment facilities in the screening and assessment protocol within 60 months is ongoing.

The work of the ISI Advisory Group needs to evolve from “developing and implementing” to “monitoring fidelity and outcomes.”

(3) Approach and strategies proposed

In the 2nd Quarter of the fourth year the broad focus of the OK-COSIG staff was on: 1) incorporating, advocating, and sustaining the provision of co-occurring programming at the State policy level, 2) providing leadership to expand collaborative relationships among mental health and substance abuse treatment programs, 3) continue to orientate the new 13 model programs, 4) continuing to provide statewide and training of clinicians and staff, 4) continuing to work on developing credentialing standards for clinicians who treat people with a co-occurring disorder, and 5) supporting the OK Department of Corrections efforts to develop services for people with a co-occurring disorder. A request was submitted to COCE to assist with co-occurring disorder capability building for the Oklahoma Department of Corrections.

Status of Project

(1) Description of activities during this quarter regarding:

- screening and assessment,

The Screening & Assessment subcommittee did not meet during this quarter. The Screening & Assessment subcommittee completed their work on a database of screening and assessment tools.

- workforce development/curriculum development workgroup,

The Core-Level curriculum and the Intermediate Level curricula are available. The focus in the next quarter will be on the Advanced-Level curriculum. The plan is to complete it and evaluate it by summer.

- financing,

The Finance subcommittee did not meet during this quarter.

- the change agent regional committees,

The Tulsa Change Agents met three times this quarter. They meet the first Friday of each month. There are usually 8 or more attending these meetings. The activities needed to provide “best practices” include training and participation in infrastructure enhancements. The ODMHSAS and SAMHSA need to advocate for and make provisions for providing the support for training and infrastructure enhancement.

- evaluation,

The focus this quarter has been on using the ICIS, FY 2005-2006 data to begin to develop a typology of the people with a co-occurring disorder who are admitted for treatment to the 15 model and 5 control programs. Using this data, the characteristics of people with a co-occurring disorder are compared to people admitted for treatment who do not have a co-occurring disorder. There are some significant differences that set this group of people apart. These differences are described in detail in the 2nd Quarter Report for Year 4 in the section titled: *A Beginning Typology of People with a Co-occurring Disorder Admitted for Treatment in Oklahoma*. This report can be found at http://faculty-staff.ou.edu/C/Andrew.L.Cherry-1.Jr/okcosig_project.htm.

The data file for the ICIS FY 2006-2007 was received. Data management will begin in the next quarter. The primary focus will be to compare data from FY 2005-2006 to data from FY 2006-2007. This data will in part show the impact of the OK-COSIG project on identifying and providing services to people in Oklahoma with a co-occurring disorder.

Additionally, Dr. Cherry of the evaluation team has acquired access to the GRPA data being collected by the model programs in Oklahoma. The analysis of this data will focus primarily on client outcomes and secondarily on approaches to evaluating outcomes.

(2) Accomplishments

Over the 44 months, the Goals and Objectives for the most part have been accomplished. The Project has expanded from the original 7 to 28 programs that are co-occurring capable or are in the process of becoming co-occurring capable. The major infrastructure changes were: 1) changes in the rules and contracts, 2) instituting screening

and assessment for people with co-occurring disorders, 3) raising awareness and support for changing to better provide for people with co-occurring disorders, and 4) developing curricula and training mental health and substance abuse staff.

(3) Other significant project activities

- The OK-COSIG staff are gathering GPRA data.
- The work on the *Access to Recovery Grant* award has begun. There is hope that this grant will provide the means to increase participation of service recipients and consumer advocate groups in the transformation process.
- The COSIG staff continues to provide technical assistance to the Oklahoma Department of Corrections Charter Group on co-occurring disorders.

c. Difficulties/Problems Encountered

(1) Barriers to accomplishment

- A plan is needed to guide a process to monitor the ongoing fidelity of co-occurring capable programs.
- The effort continued to involve Native American Tribes. There are 39 tribal nations in Oklahoma. The Choctaw Nation attended the COCE Policy Academy.
- The lack of African American and Hispanic involvement continues to be an area where work needs to be ongoing.

(2) Strategies to overcome barriers

- It is hoped that the *Access to Recovery Grant* will increase the participation of service recipients and advocates in the OK-COSIG project over the next two years.

2. Personnel

- a. List all current positions supported by the grant, including any vacancies, with percent of time on the project. The following OK-COSIG staff are working full-time on the project.

LD Barney – Co-Occurring Program Specialist
Renea Butler-King – Coordinator of Field Services
Amber Rentaria-Hulme – COD Field Representative
Suzan Esley – Co-Occurring Recovery Coordinator
Krista Rhodes – Decision Support Services (DSS) Data Analyst

- b. List staff changes, including contractors/consultants, within the reporting period.

A major change in the personnel occurred during this quarter. Dr. Khepra Khem Co-Occurring Training Specialist has taken the position in Access Recovery as the Coordinator of Field Services. His last day with OK-COSIG was 2-16-08.

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

The team continues to have staff to do the training and with the addition of Kim Peterson, L. D. Barney has some help in the effort to provide technical assistance and support for the 28 programs.

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OK-COSIG Quarterly Evaluation Report

Second Quarter of Year 4

(Note: The data for the SAMHSA report on the OK-COSIG Project has been developed from Interviews, Documents, Meeting Minutes, Committee Chair Reports, and Notes that are summarized in the following sections.)

This is the 2nd Quarterly report of Year 4 on the OK-COSIG project to improve treatment of persons with Co-Occurring Mental Health and Substance Abuse related disorders in Oklahoma. The overarching goal of the OK-COSIG project is to improve the delivery of state-funded services for people in Oklahoma with a co-occurring disorder. The project will contribute two interventions to promote systemic infrastructure change: 1) it will develop a standard protocol for screening and assessment of people with a mental health and substance abuse problem, and field test and evaluate a screen; 2) a model will be developed to provide integrated treatment that is accessible, culturally competent, and grounded in evidence-based practices. The following sections of the 2nd Quarterly Report of Year 4 will delineate the work **toward accomplishing these two objectives.**

Activities and Events

January 1, 2008 through March 31, 2008

This section lists the activities associated with the OK-COSIG project staff for the 2nd Quarter of the fourth year. The following is a week by week summary of the major activities of the OK-COSIG project staff from which data was collected and analyzed. The work behind the scenes, efforts involved in organizing and coordinating events is not fully reflected here. This list does not constitute the entire body of the OK-COSIG project staff work and activities during the 2nd Quarter of year four, but it is a good representation of the work that was accomplished.

January through March Activities

January 2 – 4.

L. D. Barney, Co-Occurring Program Specialist met with the accreditation group, headed by Debbie Spaeth for Health Care Groups. This group works on accrediting programs using independent resources for accrediting procedures rather than using the

department for this process. In the same week, he met with Todd Crawford and Leah Taylor to discuss a presentation on the new capabilities scale tool to be piloted next quarter. Later in the week, he was involved in a conference call with Dr. Minkoff. He met with Dr. Powitzky at the Department of Corrections to arrange technical assistance. He also met with the group of people who are collecting the GRPA data in relation to intake information taken from participating treatment facilities.

January 7 – 11.

L. D. Barney conducted a co-occurring team meeting and later had a meeting of the Behavioral Health Advisory Group. He met with Richard Bowden to discuss budget carryover. He also met with the licensing group to discuss and work on legislation before the house (HB2074). A Core Level Co-Occurring Training was conducted with Michael Hanes and Melinda Norton in Oklahoma City, Oklahoma, 23 attended.

January 14 – 18.

L. D. Barney had a conference call with A. J. Ernst to discuss technical assistance for the Department of Corrections. Then he participated in contract monitoring in Lawton. In the same week, he discussed technical assistance on co-occurring with the staff in Lawton. Later that week he was involved in a contract monitoring visit to the Jim Taliaferro Community Mental Health Services center in Altus Oklahoma. He also conducted a meeting with the Regional Change Agents in that area. In the same week he made a technical assistance visit to Bill Willis Community Mental Health and Substance Abuse Treatment Center in Tahlequah, Oklahoma. A Core Level Co-Occurring Training was conducted with Melinda Norton in Clinton, Oklahoma, 10 attended.

January 21 – 25.

L. D. Barney visited Dual Recovery, Inc. for contract monitoring. Most of the week was spent at the annual and now combined Mental Health and Substance Abuse conference in Tulsa.

January 28 – February 1.

L. D. Barney, Dr. Minkoff and Dr. Christy Cline of ZiaLogic met with the ODMHSAS leadership. Later that week he met with the OKC Executive Directors' Group, and the Executive Directors' Group in Lawton. He also visited Shekinah

Counseling Services, a facility in Duncan, Oklahoma for contract monitoring. The Shekinah facility is relatively new to the integrated services program.

February 4 – 8.

L. D. Barney arranged ASAM training for trainers with Dr. David Mee-Lee. He met with the provider certification group about going to Muskogee County Council of Youth Services (MCCOYS). He participated in contract monitoring at MCCOYS and Monarch in Muskogee, Oklahoma. He also worked on a research project with Dr. David Wright. A Core Level Co-Occurring Training was conducted with Michael Hanes and Melinda Norton in Oklahoma City, Oklahoma, 33 attended.

February 11 – 15.

A. J. Ernst visited the Department of Corrections to provide technical assistance; L. D. Barney was present for that visit. L. D. Barney finalized the contract with Dr. David Mee-Lee to lead a training for trainers workshop in September 2008. In the same week, he scheduled Ron Jackson to lead an ASI training in June 2008. L. D. Barney talked to Dr. Powitzky and met with NAIC in regards to the co-occurring program at the Lexington Prison. He also participated in meetings to finalize the budget.

February 18 – 22.

L. D. Barney visited Turning Point Treatment Center in Oklahoma City for contract monitoring. He worked with GPRA data collectors in regards to their progress. Later that week, he attended the Senate hearing on HB2074 to support the contents of that bill. He also finalized the contract with Ron Jackson to move forward with the ASI training.

February 25 – 29.

L. D. Barney spoke to field representatives on how to screen for co-occurring disorders. In the same week, he met with the OKC Change Agent Group at the new DRI facility. Later that week, he met with the detoxification committee. Then he spent three days discussing the budget carryover. He also worked with Kim Peterson on the training for trainers workshop and provided technical assistance.

March 3 – 7.

L. D. Barney gave a presentation at the gambling conference in Norman, Oklahoma regarding co-occurring. He met with the detoxification committee and

presented a case study from the Bill Willis Treatment Center. Later that week, he met with the community of mental health directors in Oklahoma City. Toward the end of the week he was involved in a focus group to help validate the typology of adult men and women with a co-occurring disorder that was developed from an analysis of the FY 2005-2006 ICIS data on the model agencies.

March 10 – 14.

L. D. Barney was in Ardmore and Durant for contract monitoring. He finalized contract monitoring in Durant at DADTC. He also visited with Janie Hogue from DADTC and discussed programs and what is needed as far as technical assistance at DADTC. Later that week, he participated in a conference call regarding Southeast Oklahoma regional meetings. He met with groups at OYC and NAC in Norman. He also met with the licensure group.

March 17 – 21.

L. D. Barney visited NADTC. He had a meeting on the OU/COSIG contract. He also went to Ardmore for contract monitoring.

March 24 – 31.

L. D. Barney spent time rewriting parts of the new Capability Scale tool (previously called a fidelity scale). He also did a presentation on the Capability Scale to the licensing board committee.

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Summary of the work of the ISI Advisory Group and Subcommittees

The Advisory Group did not meet this quarter. There is a meeting being planned for the next quarter.

There are six ISI Advisory Group subcommittees:

1. The Training-Workforce Development Subcommittee,
Curricula Development Workgroup
2. The Screening and Assessment Subcommittee (did not meet this quarter),
3. The Outcome and Evaluation Subcommittee,
4. The Finance Subcommittee (did not meet this quarter),
5. The Systems Integration Subcommittee (did not meet this quarter), and

6. The Regional Change Agent committees:

Regional Change Agents: Tulsa

Regional Change Agents: Norman Chair Report

Also included are reports from the:

Tulsa Executive Director Meeting

OU Evaluation Team

Training and Workforce Development Subcommittee

The majority of the training work continued to be carried out under the Curriculum Workgroup headed by Cindy Schultz.

Workgroup Chair Report:

There is no report this quarter.

Curriculum Committee: Chair Report

The intermediate curriculum is complete. The advanced curriculum is being developed.

Welcoming, Screening, and Assessment Subcommittee

The committee did not meet this quarter.

Subcommittee Chair Report

No report because the committee did not meet this quarter. .

Chair's Report Regional Change Agents: Tulsa

The Tulsa Regional Change Agents meets on the first Friday of each month. They met three times in the 2nd Quarter of this year. The purpose of these meetings was to help network with all of the model sites in Tulsa. Joe Yosten indicated that they typically have eight (8) or more agency representatives attending the meetings.

Joe Yosten reported that the Regional Change Agents have started inviting other service facilities to join the committee to continue to network and expand connections for a continuous integrated system of care within the Tulsa area.

Discussions included how they can resolve current and future barriers to ensure that all consumers can get services, or be able to refer them to the proper facility for help with their different needs. The members of this committee also help each other by

providing different educational information that they have come across in the area of co-occurring, alcohol and drug, or mental health.

Most of the individuals who attend these meetings are from the grass roots efforts; case managers, and clinical staff working at 12 X 12, Family and Children Services, Associate Centers for Therapy, Women and Children's Services, DVIS, John 3:16 Mission, and Tulsa Homeless Shelter. Recently, representatives from Resonance, Mental Health and Drug Court have been asked to join.

Joe Yosten also indicated that they have been able to get each of the facilities to commit to hosting a meeting at their facility. By hosting these meeting, each representative learns where each facility is and has the opportunity to learn about each program and what they offer. At each meeting, each representative is given information about the programs currently available at different locations.

Regional Change Agents: Norman Chair Report

This group is continuing to meet.

Tulsa Executive Director Meeting

The Tulsa Executive Directors did not meet this quarter.

Tulsa Executive Director Meeting Chair Report

The Tulsa Executive Directors' meeting is held every six (6) months. The last meeting was in November 2007. The next Executive Directors' meeting will be sometime in June 2008.

Part of the focus of the Executive Directors' committee meetings is to discuss better ways to communicate from top management down to the staff on the front lines of the operation in each facility. At their last meeting, the Executive Directors decided to take the integrated services systems information to a SIPS meeting.

OU Evaluation Team

The focus of the work by the evaluation team this quarter has been on using the ICIS, FY 2005-2006 data to begin to develop a typology of the people with a co-occurring disorder admitted for treatment to the 15 model and 5 control programs. Using this data, the characteristics of people with a co-occurring disorder are compared to people admitted for treatment who do not have a co-occurring disorder. There are some significant differences that set this group of people apart. These differences are described

in detail in the section below, *Outcome Evaluation for the 2nd Quarter — Year 4*. The title of the report on the analysis is: *Putting a face on people with a co-occurring disorder in Oklahoma*.

The data file for the ICIS FY 2006-2007 was received. Data management will begin in the next quarter. The primary focus will be to compare data from FY 2005-2006 to data from FY 2006-2007. This data will in part show the impact of the OK-COSIG project on identifying and providing services to people in Oklahoma with a co-occurring disorder.

Additionally, Dr. Cherry of the evaluation team has acquired access to the GRPA data being collected by the model programs in Oklahoma. The analysis of this data will focus primarily on client outcomes and secondarily on approaches to evaluating outcomes.

OU Evaluation Team Chair Report

The data base has grown over the years. With this quarterly report, we have completed 17 quarterly and year-end reports on the OK-COSIG Project. This is a qualitative and quantitative database that details the activities of the implementation team over three and one half years. The report tracks the proposed timeline for completing objectives and provides explanations for objectives and timelines that were not met.

In this quarter our focus has been divided between gathering ongoing data and working on the quantitative analysis of the ICIS data from FY 2005-2006. The results of this analysis will be used as the baseline or pre OK-COSIG intervention. Data collected in following years will be compared to FY 2005-2006 data to see if any changes occurred that can be attributed to the impact of the OK-COSIG Project.

The process data has grown over the years. The process data collected related to the OK-COSIG Project includes a detailed record of the activities of the implementation team. It also includes a compendium of documents generated as a result of the Project. Based on the process data, a beginning analysis of the qualitative data has been completed. It is presented in the End of Year 3 Evaluation Report, under the heading: *Analysis of the OK-COSIG Process Evaluation Data*. The End of Year Report will be published on online in February 2008.

Methodology

Data Source

Data used in this study was collected on 19,241 adults admitted for treatment to 20 agencies (15 model and 5 control agencies) providing mental health or substance abuse treatment in Oklahoma. The 15 model programs (10 mental health programs and 6 substance abuse treatment programs) used a variation of integrated treatment for people with the co-occurring disorders of mental illness and a substance use disorder, and the five (5) control programs (2 mental health programs and 3 substance abuse treatment programs) that provided standard treatment. The data was collected over a one year period (FY 2005-2006). This study sample represents approximately 42% of people admitted for treatment in a state funded or supported facility.

Study Sample

There were 9,863 (51.3%) males and 9,378 (49.3%) females in this sample. The total state population of women was 50.7% and 49.3% for men in the 2000 census. As a group they were approximately 36.5 years of age. Females with an indication of a co-occurring disorder were significantly younger (35 years of age). Men with an indication of a co-occurring disorder tended to be younger.

Procedure

The data came from the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) Individual Client Information System (ICIS). Agencies that contract with ODMHSAS are required to enter standardized data into the ICIS on clients that they treat. The data was provided through a data sharing agreement with the researchers approved by the University of Oklahoma IRB and the ODMHSAS IRB. The data was stripped of all information that could be used to identify individuals who had been in treatment.

This data reflects the results of the Oklahoma Co-occurring State Incentive Grant (OK-COSIG) project to develop and provide “best practice” treatment for people with co-occurring disorders. Clinicians, staff, and administrators in the model programs were

exposed to the latest concepts of treating people with the co-occurring disorders between October 2004 and September 2005. The data was collected on individuals treated in the year following the first year of reorientation, clinical training, and organizational modification. The data analyzed for this study was collected between October 1, 2005 and September 30, 2006.

Measures

To determine if a person had an indication of a co-occurring disorder scores of four (4) and above on the ASI subscale psychosis, and a score of 29 and above on the CAR subscale substance misuse were used to identify people with an indication of a co-occurring disorder. Among men admitted for treatment, 3,058 (43.7%) had an indication of a co-occurring disorder while 2,242 (39.1%) of women had an indication of a co-occurring disorder.

The data was collected by individual agencies and entered into the Oklahoma Department of Mental Health and Substance Services, Client Data Core. The data file constructed from the Client Data Core comprised 115 variables.

Data Analysis

The differences between people with an indication of a co-occurring disorder (Group 1) and people with *no* indication of a co-occurring disorder (Group 2) were examined using cross-tabulation, t-Tests, and multiple regression analyses. The chi-square tests were used to compare the two groups on nominal variables such as gender, race/ethnicity, admission status, presenting problem, diagnosis, program completion, etc. The t-test was used to identify the differences between the two groups on ordinal, interval, and ratio level data such as age, education, income, days in treatment, CAR, and ASI subscale scores, etc. Regression was used to identify the variables or characteristics that determined the number of days in treatment. In the regression analysis, important nominal variables such as group membership were converted to dummy variables.

Putting a face on people with a co-occurring disorder

In Oklahoma, when a clinician meets a person with the co-occurring disorders of mental illness and substance abuse at admission, people with a co-occurring disorder will probably have many of the following characteristics.

One of the overarching impressions, based on this data analysis, is that people with a co-occurring disorder have more in common with each other than they have differences. They are clearly an identifiable group of people and different from people who seek treatment with a mental health disorder or with a serious addiction.

Gender differences

There were more males (51.3%) than females (48.7%) admitted for treatment. Among this group of men admitted for treatment, 3,058 (43.7%) had an indication of a co-occurring disorder while 2,242 (39.1%) of women had an indication of a co-occurring disorder.

Age Differences

As a group people in this sample were approximately 36.5 years of age. Females with an indication of a co-occurring disorder were significantly younger (35 years of age). Men with an indication of a co-occurring disorder tended to be younger.

Differences by Race/Ethnicity

There were few racial/ethnic differences between people with a co-occurring disorder and people seeking treatment with no indication of a co-occurring disorder. Even so, there were three interesting differences.

People who identify as White – Statistically, white women and men are the typical client admitted to this sample of state funded treatment facilities (76%). This is similar to the state population of people who identify as White (75.6%).

People who identify as African Americans – Although conventional thinking is that instead of seeking treatment through state funded mental health or substance abuse facilities, African Americans tend to seek help through their church instead of what could be called “traditional” treatment avenues. Based on this data, however, only being African American would suggest a higher than expected number of men and women

admitted for treatment, approximately 13% of the sample as opposed to 6.9% of the state population.

In Oklahoma you can expect to see slightly more African American women and men diagnosed with a co-occurring disorder.

People who identify as Asians – The total number of Asians in this population was too small to have confidence in any statistical conclusions. The low percentage seeking treatment, however, could have resulted from a significant number of Asian clients who did not seek treatment for a MH/SA disorder because of the stigma that would befall on their family. Other possible reasons for the low numbers seeking treatment would include: 1) the Asian culture is more family oriented and tends to deal with major issues within the family structure; 2) alcoholism in the Asian culture could be a smaller portion of the population because alcohol is not easily tolerated physically by most Asians.

You can expect to see fewer Asian women and men diagnosed with a co-occurring disorder.

People who identify as Hispanics – The total number of Hispanics in this population was too small to have confidence in any statistical conclusions. Hispanics made up approximately 2.7% of people admitted for treatment in this sample. This is less than 50% of the percentage of Hispanics living in the state. Possible reasons for the low numbers seeking treatment would include: 1) the Hispanic culture is more family oriented and tend to deal with major issues within the family structure; 2) treatment settings are not staffed to treat people who speak Spanish, and 3) sanctions related to legal status creates a hostile environment for both legal and non-legal Hispanics residing in Oklahoma.

You can expect to see fewer Hispanic women and men in treatment or diagnosed with a co-occurring disorder.

Relationships

People with a co-occurring disorder were more likely to be involved or were involved in a relationship than people with no indication of a co-occurring disorder. Women were more likely to be involved or were involved in a relationship than men.

Statistically this resulted from people with an indication of a co-occurring disorder having less severe mental illnesses such as psychoses. People with a co-occurring disorder who did not have a serious mental disorder were about (m = 25%, w = 15%). Men were more likely to be divorced (20%) while women were more likely to be separated than people who had a co-occurring disorder and a serious mental illness. People with *no* serious mental illness and *no* co-occurring disorder were (m = 40%; w = 30%) more likely to be 'living as married.' People who had an indication of a co-occurring disorder reported more family problems on the CAR Family subscale and the ASI Family subscale. People with an indication of a co-occurring disorder were more involved in relationships and had more problems in their relationships.

You can expect to see more men and women diagnosed with a co-occurring disorder in relationships compared to people with a serious mental illness. However, they will have more problems with their relationships than people who are not identified as having a serious mental illness and having no indication of co-occurring disorder.

People with a serious mental illness had the fewest relationships.

People with no serious mental illness and no co-occurring disorder had the most relationships and they had the fewest problems in their relationships.

People with a co-occurring disorder had more relationships than people with an serious mental illness but fewer than people with no serious mental illness and no co-occurring disorder. Their relationships, however, were more turbulent than either of the other two groups.

Difference in Education

There was no significant difference in education among males; however, women with an indication of a co-occurring disorder had slightly less education than women without an indication of a co-occurring disorder.

Difference in Income

The average yearly reported income for all men (\$11,636) admitted to treatment was slightly higher than all women (\$10,648) admitted for treatment. The per capita income in Oklahoma in 2006 was \$32,391.

There was *no statistical difference* between men and women with an indication of a co-occurring disorder and men and women without an indication of a co-occurring disorder.

Differences in Homelessness

Both men and women with an indication of a co-occurring disorder were likely to be homeless.

Among the homeless individuals admitted for treatment, 1 in 2 had an indication of a co-occurring disorder. In this sample 52% of men and 45% of women who reported that they were homeless had an indication of a co-occurring disorder.

Differences in Admission Status

There were significantly *fewer* 'voluntary admissions' (about 15% less) among men and women with an indication of a co-occurring disorder. More women (about 30% more) and men (about 25% more) with an indication of a co-occurring disorder were admitted with 'emergency detention orders.' More women with an indication of a co-occurring disorder were admitted by 'court commitment' (about 80% more). More men with an indication of a co-occurring disorder were admitted by court commitment (about 15% more). More women with an indication of a co-occurring disorder were admitted by 'order of detention' (about 40% more). More women with an indication of a co-occurring disorder were admitted by 'court referral' (about 20% more). As well, more women with an indication of a co-occurring disorder were admitted by 'transferred-other legal entities' (about 50% more).

There were 4,928 women who were voluntarily admitted for treatment. Among these women, 27% (n = 1,316) had an indication of a co-occurring disorder. This is a ratio of about 1 to 4 or 1 woman with an indication of a co-occurring disorder for every 4 women who were voluntarily admitted.

There were 4,424 men who were voluntarily admitted for treatment. Among these men, 39% (n = 1,712) had an indication of a co-occurring disorder. This is a ratio of about 2 to 3 or 2 men with an indication of a co-occurring disorder for every 3 men who were voluntarily admitted for treatment.

You can expect both men and women to be admitted with some form of detention order; women, however, are more likely to come into treatment as a result of legal intervention.

Difference in Pregnancy

There was no difference among women in terms of pregnancy. There were 294 (3%) of the 9,378 women admitted for treatment who reported that they were pregnant when admitted for treatment. Some 66% (196 women) were in their first trimester. Only one was nine months pregnant.

Difference in Domestic Violence

There was no difference among women in terms of domestic violence. Over 44% (4,158 of 9,378 women) report having a history of domestic violence. Over 10% of the 9,378 women in this population reported being battered while pregnant. Among the women on which we have data (n=3,057), 7.4% (214 women) reported that they were the perpetrator of the domestic violence.

Difference in Arrest History

Among men and women with an indication of a co-occurring disorder who were arrested 30 days before admission, they had significantly more arrests than men and women with *no* indication of a co-occurring disorder.

Among men and women with an indication of a co-occurring disorder who were arrested six (6) months before admission, they had significantly more arrests than men and women with *no* indication of a co-occurring disorder.

You can expect that men and women with an indication of a co-occurring disorder will have had more arrests than their counter parts with no indication of a co-occurring disorder.

Difference in the Number People Identified with a Serious Mental Illness

At admission there were 5,731 (65.7%) of adult men and 5,824 (72.4%) of adult women identified as being seriously mentally ill.

At discharge, there were 5,029 (63.1%) of adult men and 4,716 (69%) of adult women identified as being seriously mentally ill.

There were 5,217 women who were admitted for treatment who were seriously mentally ill. Among women identified as having a serious mental illness 29% (n = 1,534) also had an indication of a co-occurring disorder. This is a ratio of 1 to 3.4 or 1 woman with an indication of a co-occurring disorder for every 3.4 women identified as seriously mentally ill.

There were 4,908 men who were admitted for treatment who were seriously mentally ill. Among men identified as having a serious mental illness 41.4% (n = 2,030) also had an indication of a co-occurring disorder. This is a ratio of 1 to 2.4 or 1 man with an indication of a co-occurring disorder for every 2.4 men identified as seriously mentally ill.

Significantly fewer people with an indication of a co-occurring disorder will also be identified as seriously mentally ill.

Difference in GAF scores

Men and women with an indication of a co-occurring disorder were given significantly lower/worse GAF scores than men or women with *no* indication of a co-occurring disorder. **At discharge, there was no significant difference in the GAF score between people with** an indication of a co-occurring disorder and those with *no* indication of a co-occurring disorder

You can expect that people with an indication of a co-occurring disorder will have lower GAF scores on admission than people admitted with no indication of a co-occurring disorder.

Difference in DSM-IV Axis I Primary Diagnosis at Admission

- Among *men* with an Axis I diagnosis of a substance use spectrum disorder, 69.4% completed treatment; 12.5% left ACA.
- Among *women* with an Axis I diagnosis of a substance use spectrum disorder, 65.6% completed treatment; 14.5% left ACA.

- Among *men* with an Axis I diagnosis of a psychoses spectrum disorder, 68.3% completed treatment; 11.3% left ACA.
- Among *women* with an Axis I diagnosis of a psychoses spectrum disorder, 65.9% completed treatment; 12.3% left ACA.
- Among *men* with an Axis I diagnosis of a mood disorder spectrum disorder, 62.1% completed treatment; 15% left ACA.
- Among *women* with an Axis I diagnosis of a mood disorder spectrum disorder, 51.7% completed treatment; 20% left ACA.
- Among *men* with an Axis I diagnosis of anxiety spectrum disorder, 25.4% completed treatment; 34.1% left ACA; 15.1% were administratively discharged.
- Among *women* with an Axis I diagnosis of anxiety spectrum disorder, 20.9% completed treatment; 37.8% left ACA; 13.8% were administratively discharged.

Clearly, this data indicates that people who are diagnosed with an anxiety spectrum disorder are failing to complete treatment in large numbers. Only 20.9% of women and 25.4% of men are completing treatment.

Based on those with an Axis I diagnosis (men = 7,714; women = 7,023), men with a co-occurring disorder that included a psychoses spectrum disorder completed treatment almost twice as often (41.1%) than men without an indication of a co-occurring disorder (23%). Women with a co-occurring disorder that included a psychoses spectrum disorder completed treatment about a third more often (78%) than women without an indication of a co-occurring disorder (58%).

Men with a co-occurring disorder that included a mood disorder completed treatment more often (41%) than people without an indication of a co-occurring disorder (34%). Women with a co-occurring disorder that included a mood disorder completed treatment a third more often (64%) than women without an indication of a co-occurring disorder (42%).

Men with a co-occurring disorder that included an anxiety spectrum disorder completed treatment almost twice as often (32%) than men without an indication of a co-occurring disorder (17.4%). Women with a co-occurring disorder that included an

anxiety spectrum disorder completed treatment twice as often (33%) than men without an indication of a co-occurring disorder (15%).

Of every 3 men admitted (n = 1, 012) with an Axis I diagnosis of a substance abuse spectrum disorder 2 men (69.4%) were admitted with an indication of a co-occurring disorder and a substance abuse spectrum disorder. Men with a co-occurring disorder that included a substance abuse spectrum disorder completed treatment more than twice as often (72.4%) than men who had *no* indication of a co-occurring disorder (27.6%).

Of every 5 women admitted (n = 573) with an Axis I diagnosis of a substance abuse spectrum disorder 3 women (62.5%) were admitted with an indication of a co-occurring disorder and a substance abuse spectrum disorder. Women with a co-occurring disorder that included a substance abuse spectrum disorder completed treatment more than twice as often (69.6%) than women who had *no* indication of a co-occurring disorder (30.4%).

Both men and women with an indication of a co-occurring disorder that had a DSM-IV TR Axis I diagnoses completed treatment significantly more often than people with no indication of a co-occurring disorder.

Differences in the number of days in treatment

Men who presented with an indication of a co-occurring disorder, **spent half as many days in treatment (47.11 days)** than did those men who **did not** present with an indication of a co-occurring disorder (**93.39 days**) (t=15.76, df = 6,197, p<.000).

Women who presented with an indication of a co-occurring disorder, **spent half as many days in treatment (62.05 days)** than did those women who **did not** present with an indication of a co-occurring disorder (**117.61 days**) (t=15.30, df = 5,804, p<.000).

This finding related to the number of days in treatment added to the findings about the percentage completing the program suggests that both men and women with an indication of a co-occurring disorder spend half as many days in treatment and completed treatment twice as often as people with no indication of a co-occurring disorder.

Differences in CAR Subscale Scores

Some of the differences among people with an indication of a co-occurring disorder on the CAR subscale score helped recognize people with a possible co-occurring disorder.

There was *no difference between adults* with an indication of a co-occurring disorder and adults with *no* indication of a co-occurring disorder on the CAR subscale ‘*feeling and mood*’ at admission and discharge.

There was *no difference between males* with an indication of a co-occurring disorder and males with *no* indication of a co-occurring disorder on the CAR subscale ‘*thinking*’. There was *a slight difference between women*. Women with an indication of a co-occurring disorder had a worse score at admission on the CAR subscale ‘*thinking*’. However, there was no significant difference at discharge.

The CAR scores on the subscale ‘*family*’ were significantly *worse at admission and discharge* for adults with an indication of a co-occurring disorder.

There was no difference among adults with an indication of a co-occurring disorder and adults with no indication of a co-occurring disorder on the CAR subscale “*interpersonal relations*” at the time of admission or at discharge.

There was *no difference among men* with an indication of a co-occurring disorder and adults with no indication of a co-occurring disorder on the CAR subscale ‘*role performance*’ at the time of admission, but men with an indication of a co-occurring disorder *had worse scores at discharge*. Women with a CAR subscale ‘*role performance*’ had *worse scores at admission and discharge*.

There was *no difference* among adults with an indication of a co-occurring disorder and adults with *no* indication of a co-occurring disorder on the CAR subscale “*socio-legal*” at the time of admission or at discharge.

There was *no difference* among adults with an indication of a co-occurring disorder and adults with *no* indication of a co-occurring disorder on the CAR subscale “*self-care/basic needs*” at the time of admission or at discharge.

At admission, 3,226 (33%) of 9,863 men assessed using the CAR subscale – ‘*substance use*’ had an indication of a substance use disorder. At discharge, 2,440 (52.2%) of 4,667 had a score indicating a substance use disorder. *This suggests that as*

In this group of men, 3,058 (43.7%) were admitted with an indication of a co-occurring disorder; 3,934 (56.3%) did not have an indication of a co-occurring disorder.

Note: To determine whether or not a person had an indication of a co-occurring disorder, scores above 4 on the ASI subscale—'Psychiatric Status' and scores above 29 on the CAR subscale—'Substance use' were used to determine if the person had a co-occurring disorder.

Difference in Age

There was *no* statistically significant difference in Mean age for men with *no* indication of a co-occurring disorder (M = 36.22 years, SD = 11.45) compared to the Mean age of men with an indication of a co-occurring disorder (M = 34.93 years, SD = 11.14) ($t=-1.873$, $df = 6,990$, $p<.061$).

Difference in Race/ethnicity

White = 7,445 (75.5%) (Statewide 75.6% in 2000); **African American = 1,364 (13.8%) (Statewide 6.9%)**; Native American men 762 (7.7%) (Statewide 8%); Hispanic = 259 (2.6%) (Statewide 6.9%); Multiracial = 233 (2.4%) (Statewide 4.1%).

Asian men, although their numbers were small ($n=44$), were significantly less likely to have an indication of a COD (.4%) (Statewide 1.7% in 2000).

Looking at people with an indication of a co-occurring disorder by Race and Ethnicity, in this population, only being African American would suggest higher than expected numbers of men diagnosed with a co-occurring disorder. Being Asian would suggest lower numbers of men diagnosed with a co-occurring disorder.

Difference in Marital Status

4,654 (47.2%) – Never married

2,464 (25%) – Separated

1,467 (14.9%) – Divorced

799 (8.1%) – Married

324 (3.3%) – Living as married

155 (1.6%) – Widowed

- Slightly more men who were married (about 10% more) had an indication of a co-occurring disorder.
- Slightly more men who were separated (about 10% more) had an indication of a co-occurring disorder.
- There was *no* difference among those men who were 'never married,' 'living as married,' or 'widowed.'

- Approximately 50% more men with an indication of a co-occurring disorder than women with an indication of a co-occurring disorder were ‘never married.’
- Approximately 20% more women with an indication of a co-occurring disorder than men with an indication of a co-occurring disorder were ‘separated.’
- Approximately 20% more women with an indication of a co-occurring disorder than men with an indication of a co-occurring disorder were ‘divorced.’

Men with a co-occurring disorder were slightly more likely to be involved or were involved in a relationship than men with *no* indication of a co-occurring disorder. Statistically this resulted from people with an indication of a co-occurring disorder having less severe mental illnesses such as psychoses. Men with a co-occurring disorder who did not have a serious mental disorder were 25% more likely to be living as married and 20% more likely to be divorced than men who had a co-occurring disorder and a serious mental illness. Men with *no* serious mental illness and *no* co-occurring disorder were 40% more likely to be living as married. Men who had an indication of a co-occurring disorder reported more family problems on the CAR Family subscale and the ASI Family subscale. Men with an indication of a co-occurring disorder were more involved in relationships and had more problems in their relationships.

Difference in Education

There was *no* statistical difference between men with an indication of a co-occurring disorder (M = 11.58 years) and men without an indication of a co-occurring disorder (M = 11.66 years).

Difference in Income

Mean = \$11,636

Median = \$8,100

SD = \$14,063

There was *no* statistical difference between men with an indication of a co-occurring disorder (\$11,658) and men without an indication of a co-occurring disorder (\$11,214). The per capita income in Oklahoma in 2006 was \$32,391.

Difference in Homelessness

Men with an indication of a co-occurring disorder were more often homeless (n = 349, 11.4%). Of those men with *no* indication of a co-occurring disorder, 8.3% (n = 328) were homeless. Significantly more men with an indication of a co-occurring disorder were homeless ($\chi^2 = 18.61$, $df = 1$, $p < .000$). For every two men who entered treatment and reported being homeless, one of the two had an indication of a co-occurring disorder.

Disabled

Among adult men with a disability, 789 (8%) reported chronic health problems.

Differences in Admission Status

6,564 (66.6%) – Voluntary admission
2,524 (25.6%) – Emergency detention
584 (5.9%) – Court Commitment
137 (1.4%) – Court referred

There were significantly fewer voluntary admissions (about 15% less) among men who presented with an indication of a co-occurring disorder. More men (about 25% more) with an indication of a co-occurring disorder were admitted with emergency detention orders. More men with an indication of a co-occurring disorder were admitted by court commitment (about 15% more), ($X^2 = 140.25$, $df = 8$, $p < .000$).

Men with a co-occurring disorder were forced into treatment more often than men without a co-occurring disorder.

Difference in Discharge Type

Discharged/completed treatment = 5,457 (55.3%)
Discharged/left ACA/90 days = 1,454 (14.7%)
Discharged/administrative discharge = 656 (6.6%)
Discharged/trfd to another treatment facility = 509 (5.2%)
Discharged/failed to begin treatment = 380 (3.9%)
Discharged/broke rules = 246 (2.5%)
Discharged/moved = 166 (1.7%)
Discharged/AWOL = 47 (0.5%)
Discharged due to treatment incompatibility = 11 (0.1%)
Discharged/completed court commitment = 54 (0.5%).

Of those men who completed treatment, slightly more men who presented with an indication of a co-occurring disorder completed treatment (about 10% more). Men with a co-occurring disorder were transferred to another treatment facility less often (about 10% less often). Of those men who left treatment, fewer men with an indication of a co-occurring disorder left treatment ACA (about 30% fewer ACA). Of those men who were administratively discharged, fewer men with an indication of a co-occurring disorder were administratively discharged (about 15% fewer).

Number of days in treatment

Men who presented with an indication of a co-occurring disorder, spent half as many days in treatment (47.11 days) than did those men who did not present with an indication of a co-occurring disorder (93.39 days) ($t=15.76$, $df = 6,197$, $p < .000$).

Difference in DSM-IV Axis I Primary Diagnosis at Admission

- Among men with an Axis I diagnosis of a substance use spectrum disorder, 69.4% completed treatment; 12.5% left ACA.
- Among men with an Axis I diagnosis of a psychoses spectrum disorder, 68.3% completed treatment; 11.3% left ACA.
- Among men with an Axis I diagnosis of a mood disorder spectrum disorder, 62.1% completed treatment; 15% left ACA.
- Among men with an Axis I diagnosis of anxiety spectrum disorder, 25.4% completed treatment; 34.1% left ACA; 15.1% were administratively discharged.

Based on those men with an Axis I diagnosis (n = 7,714), men with a co-occurring disorder that included a psychoses spectrum disorder completed treatment more often (41.1%) than men with an indication of a co-occurring disorder (23%). Men with a co-occurring disorder that included a mood disorder completed treatment more often (41%) than men with no indication of a co-occurring disorder (34%). As well, men with a co-occurring disorder that included an anxiety spectrum disorder completed treatment more often 32% than men with no co-occurring disorder (17.4%).

Of every 3 men admitted (n = 1, 012) with an Axis I diagnosis of a substance abuse spectrum disorder 2 men (69.4%) were admitted with an indication of a co-occurring disorder. Men with a co-occurring disorder that included a substance abuse spectrum disorder completed treatment almost two and a half times more often (72.4%) than men who had no indication of a co-occurring disorder (27.6%).

In this population, adult men with a co-occurring disorder completed treatment significantly more often.

Predicting days in treatment

The better the GAF score at admission, less frequent drug use, having no indication of a co-occurring disorder, having a better CAR Subscale-‘Feeling and Mood’ score at admission, a better CAR Subscale-‘Family’ at admission, and a better CAR Subscale-‘Self Care/Basic Needs’ at admission explained a moderate difference in the number of days in treatment (R² = .311, p<.000).

Although significantly more men with a co-occurring disorder completed treatment they spent only half as many days in treatment.

Residence

Among these adult men, their resident status upon admission was:

Private residence = 7,899 (80.1%)

Residential care home = 1,202 (12.2%)

Institutional setting = 409 (4.1%)

No home = 173 (1.8%)

Nursing home = 126 (1.3)

Among adult men, their resident status upon discharge was:

Private residence = 7,175 (72.7%)

Residential care home = 688 (7%)

Institutional setting = 571 (5.8%)

No home = 217 (2.2%)

Nursing home = 225 (2.3%)

Living situation for men:

Living alone = 3,329 (33.8%)

Living with family/relatives = 5,065 (51.4%)

Living w/non-related persons = 1,468 (14.9%).

Difference in Residence

Among men who came from a residential care home, about 35% more men with an indication of a co-occurring disorder came from residential care homes than men with *no* indication of a co-occurring disorder. Of those men who selected 'No home,' (n = 129) only 19 had an indication of a co-occurring disorder.

Difference in Arrests

Among men who were arrested 30 days before admission, men with an indication of a co-occurring disorder had significantly more arrests (M = .08) than men with *no* indication of a co-occurring disorder (M = .04) (t= -3.71, df = 6,945, p<.000).

Among men who were arrested six (6) months before admission with an indication of a co-occurring disorder had significantly more arrests (M = .19) than men with *no* indication of a co-occurring disorder (M = .13) (t= -3.42, df = 6,945, p<.001).

Difference in GAF scores

Men with an indication of a co-occurring disorder were admitted with significantly lower/worse GAF scores (M = 34.38) than men with *no* indication of a co-occurring disorder (M = 38.07) (t=12.39, df = 6945, p<.000). **At discharge, there was *no* significant difference in the GAF score (t = -.591, df = 6,202, p<.554).**

Difference in CAR scores

CAR subscale 'feeling and mood' score at admission and at discharge:

There was *no* difference among adult men with an indication of a co-occurring disorder or without a co-occurring disorder on the CAR subscale 'feeling and mood' at the time of admission or at discharge.

CAR subscale ‘thinking’ score at admission and at discharge:

There was *no* difference among adult men with an indication of a co-occurring disorder or without a co-occurring disorder on the CAR subscale ‘thinking’ at the time of admission or at discharge.

CAR subscale ‘substance use’ score at admission and at discharge:

At admission, 3,226 (33%) of 9,863 of men assessed using the CAR subscale – ‘substance use’ had an indication of a substance use disorder. At discharge, 2,440 (52.2%) of 4,667 had a score indicating a substance use disorder. This suggests that as many as 40% of those with a substance abuse problem were missed at admission using the CAR. This also suggests that more training is needed on how to identify substance use among clinicians who administer the CAR.

CAR subscale ‘family’ score at admission and at discharge:

CAR subscale ‘family’ scores were significantly higher/worse at admission for men who had an indication of a co-occurring disorder (M =29.47) than for men who did *not* have an indication of a co-occurring disorder (M = 27.48) (t = -9.13, df = 6,166, p<.000). As well, the CAR subscale family score was significantly higher/worse at discharge for men with a co-occurring disorder (M = 29.61) than it was for men with a co-occurring disorder (M = 28.46) (t= -4.51, df = 4,569, p<.000).

CAR subscale ‘interpersonal relations’ score at admission and at discharge:

There was *no* difference among adult men with an indication of a co-occurring disorder or without a co-occurring disorder on the CAR subscale interpersonal relations at the time of admission or at discharge.

CAR subscale ‘role performance’ at admission and at discharge:

There was *no* difference among adult men with an indication of a co-occurring disorder or without a co-occurring disorder on the CAR subscale ‘role performance’ at the time of admission, but men with an indication of a co-occurring disorder had higher/worse scores at discharge (M = 31.58) than men with *no* indication of a co-occurring disorder (M = 30.74) (t= -3.33, df = 4,569, p<.001).

CAR subscale ‘socio-legal’ score at admission and at discharge:

On the CAR subscale ‘socio-legal,’ men with an indication of a co-occurring disorder had significantly higher/worse scores at admission (M = 21.12) than men with *no* indication of a co-occurring disorder (M = 18.21) (t= -12.36, df = 6,167, p<.000). And, men with an indication of a co-occurring disorder had significantly higher/worse scores at discharge (M = 21.56) than men with *no* indication of a co-occurring disorder (M = 18.85) (t= -9.91, df = 4,569, p<.000).

CAR subscale ‘self-care/basic needs’ score at admission and at discharge:

There was *no* difference among adult men with an indication of a co-occurring disorder or without a co-occurring disorder on the CAR subscale “*self-care/basic needs*” at the time of admission or at discharge.

Clients 18 or over – serious mental illness score at admission and at discharge:

There were 5,731 (65.7%) adult men identified as being seriously mentally ill at admission. At discharge, there were 5,029 (63.1%) adult men identified as being seriously mentally ill.

Among men with an indication of a co-occurring disorder fewer were identified as having a serious mental illness ($\chi^2 = 63.48$, $df = 1$, $p < .000$). Among men identified as having a seriously mentally ill ($n = 4,908$), 41.4% ($n = 2,030$) also had an indication of a co-occurring disorder. This is a ratio of 1 to 2.4 or 1 man with an indication of a co-occurring disorder for every 2.4 men identified as seriously mentally ill.

Difference in ASI Scores

ASI subscale – ‘Alcohol use’ score at admission and at discharge:

Among the men assessed at admission using the ASI subscale – ‘alcohol use,’ 814 (42.2%) were identified as having a score that indicated a serious alcohol problem. At discharge, the number had dropped to 719 (38%).

Men with an indication of a co-occurring disorder had higher ASI subscale-‘alcohol use’ scores at admission ($M = 4.69$) than men with *no* indication of a co-occurring disorder ($M = 3.73$) ($t = -4.777$, $df = 633$, $p < .000$). And, men with an indication of a co-occurring disorder had higher ASI subscale-alcohol use scores at discharge ($M = 4.56$) than men with *no* indication of a co-occurring disorder ($M = 3.52$) ($t = -4.78$, $df = 633$, $p < .000$).

ASI subscale – ‘Drug use’ at admission and at discharge:

Among the men who were assessed at admission using the ASI subscale – ‘drug use’, 1,070 (54%) had a serious drug problem. At discharge 940 (50%) had a serious drug problem.

Although there was *no significant difference at admission* on drug use (co-occurring disorder $M = 4.85$; *no* co-occurring disorder $M = 4.48$) ($t = -1.906$, $df = 633$, $p < .057$), the men with *no* indication of a co-occurring disorder showed more improvement at discharge (co-occurring disorder $M = 4.73$; *no* co-occurring disorder $M = 4.12$) ($t = -2.96$, $df = 603$, $p < .003$).

ASI subscale – ‘Family/social relations’ score at admission and at discharge:

Although scores on the ASI subscale – ‘Family/social relations’ improved at discharge for both groups, the men with an indication of a co-occurring disorder had higher/worse scores at admission (M = 4.08) than men with *no* indication of a co-occurring disorder (M = 2.79) (t= -12.42, df = 1,471, p<.000) and at discharge men with an indication of a co-occurring disorder had higher/worse scores (M = 3.83) than men with *no* indication of a co-occurring disorder (M = 2.71) (t= -10.121, df = 1,306, p<.000).

ASI subscale – ‘Psychiatric status’ at admission and at discharge:

At admission, 634 (30%) of the 2,152 men assessed using the ASI subscale – ‘Psychiatric status’ had a psychiatric disorder. At discharge, 307 (27.3%) of the 1,124 men had a score indicating a psychiatric disorder.

Difference in DSM-IV Axis I Diagnosis at admission

Among the adult men in this group, 6,984 were given an Axis I primary diagnosis and 6,978 were given an Axis I secondary diagnosis. About 20% were deferred or null on the Axis I primary diagnosis and about 40% were deferred or null on the Axis I secondary diagnosis. Some 94% of these men were not given a secondary diagnosis.

Note: Only those diagnostic categories with 100 cases or more is presented here.

DSM-IV Axis I Primary Diagnosis at admission: Adult Men

Axis I Primary Diagnosis at Admission	# No COD Expected 56.2%	# No COD Actual	# COD Expected 43.8%	# COD Actual
295.30 Schizophrenia Paranoid Type	293	359/69%	227	161/31%
295.70 Schizoaffective Disorder	299	362/68%	232	170/32%
295.90 Schizophrenia Undifferentiated Type	63	79/67.9%	49	36/32%
296.32 Major Depressive Disorder, Recurrent Moderate	111	120/61%	87	78/39%
296.34 Bipolar I Disorder, Most RSevere With Psychotic Features	218	241/62%	170	147/37.9%
296.33 Bipolar I Disorder, Most RSevere Without Psychotic Features	284	308/61%	221	197/39%
296.80 Bipolar Disorder NOS	86	78/51%	67	74/67%
296.90 Mood Disorder NOS	209	171/46%	163	202/54%
303.90 Alcohol: Dependence	153	72/27%	119	200/74%
304.80 Polysubstance Dependence	124	81/37%	97	140/63%

309.81 Posttraumatic Stress Disorder	38	42/62%	30	26/38%
311.00 Depression Disorder NOS	296	241/46%	230	285/54%

Axis I Secondary Diagnosis at Admission	#No COD Expected 56.3%	# NO COD Actual	# COD Expected 43.7%	# COD Actual
295.30 Schizophrenia Paranoid Type	40	49/68.1%	32	23/31.9%
295.70 Schizoaffective Disorder	44	52/66.7%	34	26/33.3%
296.33 Bipolar I Disorder, Most RSevere Without Psychotic Features	55	63/64.9%	42	34/35.1%
296.34 Bipolar I Disorder, Most RSevere With Psychotic Features	52	59/63.4%	41	34/36.6%
296.90 Mood Disorder NOS	98	89/51.1%	76	85/48.9%
298.90 Psychotic Disorder NOS	54	50/52.1%	42	46/47.9%
303.90 Alcohol: Dependence	205	114/31.3%	159	250/68.7%
304.20 Cocaine: Dependence	47	29/35.8%	35	52/64.2%
304.30 Cannabis: Dependence	43	38/48.7%	34	40/51.3%
304.80 Polysubstance: Dependence	279	173/34.8%	217	324/65.2%
305.00 Alcohol: Abuse	167	100/33.6%	130	198/66.4%
305.20 Cannabis: Dependence	103	81/44.3%	80	102/55.7%
305.60 Cocaine: Abuse	50	30/33.7%	39	59/39%
305.70 Amphetamine: Abuse	48	27/31%	38	60/69%
305.90 Phencyclidine Abuse	65	38/32.5%	51	79/67.5%
309.81 Posttraumatic Stress Disorder	48	59/68.6%	38	27/31.4%
311.00 Depression Disorder NOS	103	71/38.8%	80	112/61.2%

Axis II – Primary Diagnosis at admission	# NO COD Expected 56.3%	# NO COD Actual	# COD Expected 43.7%	# COD Actual
301.70 Antisocial Personality disorder	55	45/45.9%	42	53/54.1%
301.90 Personality Disorder NOS	101	68/37.6%	79	113/62.4%
998.00 Diagnosis Deferred	826	673/45.8%	642	796/54.2%

999.00 No Diagnosis	674	628/52.4%	524	570/47.6%
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Axis I Diagnosis in Groups	# NO COD Expected 55.3%	# NO COD Actual	# COD Expected 44.7%	# COD Actual
Substance Abuse Diagnosis	559	310/30.6%	453	702/69.4%
Psychotic Diagnosis	675	840/68.7%	546	382/31.3%
Mood Disorder Diagnosis	2,016	1029/55.6%	1,632	1619/44.4%
Anxiety Diagnosis	98	136/79.4%	80	42/23.6%
Other Diagnosis	60	78/71.6%	49	31/28.4%

Difference in DRUG USE

History IV Drug Use

Slightly more men with an indication of a co-occurring disorder had a history of IV drug use ($\chi^2=62.86$, $df = 1$, $p<.000$). Of the 1,215 men with a history of IV drug use, 54% had an indication of a co-occurring disorder.

#1 Drug of Choice at admission	# NO COD Expected 56.3%	# NO COD Actual	# COD Expected 43.7%	# COD Actual
None	1,541	2120/77.4%	1,198	619/22.6%
Alcohol	1,258	905/40.5%	978	1,331/59.5%
Cocaine	245	173/39.7%	191	263/60.3%
Marijuana/hashish	374	351/52.9%	290	313/47.1%
Methamphetamine	259	181/39.3%	202	280/60.7%

Frequency of use of drug of choice

In this adult male group, 27% used drugs daily. Only 14.4% said they had *not* used drugs in the last month. There was a significant difference between the groups. Men with an indication of a co-occurring disorder used drugs more frequently ($t= -15.849$, $df = 4,208$, $p<.000$).

Difference in Age of first use of drug of choice

The Mean age for first drug use for this group of men was 17.26 years ($SD = 6.72$). The Mode was 15. Almost 75% used drugs by the age of 18 years. Almost 87% had used drugs by the age of 21 years. There was no significant difference between men with an indication of a co-occurring disorder and men with no indication of co-occurring disorder in terms of age of first drug use ($t= -1.409$, $df = 4,078$, $p<.159$).

Primary referral source at admission	# NO COD	# NO COD	# COD	# COD
	Expected	Actual	Expected	Actual
	56.3%		43.7%	
Self	1,278	1,333/58.7%	994	939/41.3%
Significant Other	173	193/63%	134	114/37%
Non-Psychiatric Hospital	434	355/46%	416	337/54%
Law Enforcement	738	620/47.3%	573	691/52.7%
Shelter for Homeless	52	70/76%	40	22/24%
Court	257	258/56.5%	200	199/43.5%
ODMHSAS Funded Facility	643	669/58.6%	499	473/41.4%

Primary referral source at discharge	# NO COD	# NO COD	# COD	# COD
	Expected	Actual	Expected	Actual
	56.5%		43.5%	
Self	890	934/59.3%	685	643/40.7%
Significant Other	51	71/78%	39	20/22%
Non-Psychiatric Hospital	123	89/41%	94	128/59%
Law Enforcement	68	61/51.7%	51	57/48.3%
Court	73	95/73%	57	35/27%
Private Physician	85	100/66.2%	66	51/33.8%
ODMHSAS Funded Facility	1,473	1,242/31.7%	1,135	1,366/52.4%
(28)	224	277/69.8%	173	120/39.2%
(41)	70	69/56%	54	54/43.9%
(45)	70	41/33.3%	54	82/66.7%

Presenting problem-primary at admission	# NO COD	# NO COD	# COD	# COD
	Expected	Actual	Expected	Actual
	56.2		43.8%	
Emotional Maladjustment/Disturbance	416	531/71.7%	324	210/28.3%
Depression	904	1,007/62.6%	704	601/37.4%
Anxiety/Panic	93	122/73.9%	72	43/26.1%
Perceptual Problems	153	195/71.7%	77	119/28.3%
Other Psychotic Symptoms	656	678/59.7%	513	493/42.1%
Suicidal/Self Abuse	813	627/43.4%	632	818/56.6%
Alcohol Abuse	79	58/41.4%	61	82/58.6%
Alcohol Dependence	143	90/35.3%	112	165/64.7%
Drug/Other Abuse	91	69/43%	71	92/57%
Drug/Other Dependency	131	114/49%	102	119/51%
Poly/Both Alcohol & Drug	88	67/43%	68	89/57%
Poly Dependency/Both Alcohol & Drug	168	149/50%	130	149/50%

Presenting problem-primary at discharge	# NO COD	# NO COD	# COD	# COD
	Expected	Actual	Expected	Actual
	56.2%		43.8%	
Emotional Maladjustment/Disturbance	451	519/64.7%	351	283/35.3%
Depression	992	961/54.5%	772	803/45.5%
Anxiety/Panic	68	82/67.8%	53	39/32.2%
Perceptual Problems	79	103/73%	62	38/27%
Other Psychotic Symptoms	479	484/57%	372	367/43%
Other Behavioral Disturbance	82	77/52.7%	64	69/47.3%
Suicide/Self Abuse	529	426/45.3%	411	514/54.7%
Alcohol Abuse	85	57/37.7%	66	94/62.3%
Alcohol Dependence	115	92/35.8%	113	165/64.2%
Drug/Other Abuse	105	76/40.9%	81	110/59.1%

treatment agencies. This was 48.7% of the population treated at these facilities. Statewide women make up 50.7% of the population.

In this group of women, 2,242 (39.1%) were admitted with an indication of a co-occurring disorder; 4,788 (68.1%) did not have an indication of a co-occurring disorder.

Note: To determine whether or not a person had an indication of a co-occurring disorder, scores above 4 on the ASI subscale—Psychiatric Status and scores above 29 on the CAR subscale—Substance use were used to determine if the person had a co-occurring disorder.

Difference in Age

There was a statistically significant difference in Mean age. Women with *no* indication of a co-occurring disorder were older (M = 36.68 years, SD = 11.68) compared to the Mean age of women with an indication of a co-occurring disorder (M = 35.26 years, SD = 10.54) ($t = 4.916$, $df = 7,028$, $p < .000$).

Difference in Race/ethnicity

White women = 7,275 (77.6%) (Statewide 75.6% in 2000); **African American** women = **1,167 (12.4%) (Statewide 6.9%)**; Native Americans women = 633 (6.7%) (Statewide 8%); Hispanic women = 267 (2.8%) (Statewide 6.9%); Multiracial women = 238 (2.5%) (Statewide 4.1%).

Asian women, although their numbers were small ($n=45$), were significantly less likely to have an indication of a COD (.5%) (Statewide 1.7% in 2000).

Looking at women with an indication of a co-occurring disorder by Race and Ethnicity, in this population, only being African American would suggest higher than expected numbers of women diagnosed with a co-occurring disorder. Being Asian would suggest lower numbers of women diagnosed with a co-occurring disorder.

Marital status

2,951 (31.5%) – Never married

2,921 (31.1%) – Separated

1,808 (19.3%) – Divorced

990 (10.6%) – Married

385 (4.1%) – Living as married

323 (3.4%) – Widowed

- Slightly fewer women with an indication of a co-occurring disorder were divorced (about 10% fewer).
- Slightly more women who were living as married (about 10% more) had an indication of a co-occurring disorder.

- There was no difference among those women who were ‘never married,’ ‘separated’ ‘widowed’ or ‘married.’
- Approximately 50% more men with an indication of a co-occurring disorder than women with an indication of a co-occurring disorder were ‘never married.’
- Approximately 20% more women with an indication of a co-occurring disorder than men with an indication of a co-occurring disorder were ‘separated.’
- Approximately 20% more women with an indication of a co-occurring disorder than men with an indication of a co-occurring disorder were ‘divorced.’

Women with a co-occurring disorder were slightly more likely to be involved or were involved in a relationship. Statistically this resulted from people with an indication of a co-occurring disorder having less severe mental illnesses such as psychoses. Women with a co-occurring disorder who did not have a serious mental disorder were 15% more likely to be living as married and 10% more likely to be separated than women who had a co-occurring disorder and a serious mental illness. Women with no serious mental illness and *no* co-occurring disorder were 30% more likely to be ‘living as married.’ Women who had an indication of a co-occurring disorder reported more family problems on the CAR Family subscale and the ASI Family subscale. Women with an indication of a co-occurring disorder were more involved in relationships and had more problems in their relationships.

Difference in Education

There was a statistical difference between women with an indication of a co-occurring disorder (M = 11.71 years) and women without an indication of a co-occurring disorder (M = 11.85 years) ($t = 2.81$, $df = 7,013$, $p < .005$).

Difference in Income

Mean = \$10,648

Median = \$7,356

SD = \$21,992

There was no statistical difference between women with an indication of a co-occurring disorder (\$9,671) and women without an indication of a co-occurring disorder (\$10,760). The per capita income in Oklahoma in 2006 was \$32,391.

Differences in Homelessness

Women with an indication of a co-occurring disorder were more often homeless, 7.4% (n = 167). Of those women with *no* indication of a co-occurring disorder, 4.4% (n = 212) were homeless. For every

2.3 women who entered treatment and reported being homeless, one of the 2.3 women had an indication of a co-occurring disorder. Significantly more women with an indication of a co-occurring disorder were homeless ($X^2 = 27.32$, $df = 1$, $p < .000$).

Difference in Pregnancy

There were 294 (3%) of the 9,378 women admitted for treatment who reported that they were pregnant when admitted for treatment. Some 66% (196 women) were in their first trimester. Only one was nine months pregnant.

Among the 9,378 women in this population, 10% reported being battered while pregnant.

Difference in Domestic Violence

Over 44% (4,158 of 9,378 women) report having a history of domestic violence. Among the group of women on which we have data (3,057 women), 7.4% (214 women) reported that they were the perpetrator of the domestic violence.

Disabled

Among adult women with a disability, 740 (7.9%) reported chronic health problems.

Differences in Admission Status

6,797 (72.5%) – Voluntary admission

2,000 (21.3%) – Emergency detention

516 (5.5%) – Court Commitment

35 (0.4%) – Court referred

There were significantly fewer 'voluntary admissions' (about 15% less) among women who presented with an indication of a co-occurring disorder. More women (about 30% more) with an indication of a co-occurring disorder were admitted with 'emergency detention orders.' More women with an indication of a co-occurring disorder were admitted by 'court commitment' (about 80% more). More women with an indication of a co-occurring disorder were admitted by 'order of detention' (about 40% more). More women with an indication of a co-occurring disorder were admitted by 'court referral' (about 20% more). As well, more women with an indication of a co-occurring disorder were admitted by 'transferred-other legal entities' (about 50% more). ($X^2 = 239.79$, $df = 9$, $p < .000$).

Women with a co-occurring disorder were forced into treatment more often than women without a co-occurring disorder.

Differences in Discharge type

Discharged/completed treatment = 3,956 (42.2%)
Discharged/left ACA/90 days = 1,695 (18.1%)
Discharged/administrative discharge = 917 (9.7%)
Discharged/trfd to another treatment facility = 495 (5.3%)
Discharged/failed to begin treatment = 393 (4.2%)
Discharged/broke rules = 237 (2.5%)
Discharged/moved = 239 (7.2%)
Discharged/AWOL = 63 (0.7%)
Discharged due to treatment incompatibility = 24 (0.3%)
Discharged/completed court commitment = 50 (0.5%).

Of those women who completed treatment, more women who presented with an indication of a co-occurring disorder completed treatment (about 30% more). Women with a co-occurring disorder were 'transferred to another treatment facility' less often (about 10% less often). Women with a co-occurring disorder 'left ACA' less often (about 30% less often). Women with a co-occurring disorder 'failed to start treatment' less often (about 25% less often).

Women with a co-occurring disorder were discharged 'due to treatment incompatibility' less often (about 30% less often). Women with a co-occurring disorder were discharged for 'broke rules' less often (about 15% less often). Women with a co-occurring disorder did not start treatment because they 'moved' (about 50% less often). Women with a co-occurring disorder were 'administratively discharged,' more often (about 25% more often).

Differences in the Number of Days in Treatment

Women who presented with an indication of a co-occurring disorder, spent half as many days in treatment (62.05 days) than did those women who did not present with an indication of a co-occurring disorder (117.61 days) (t=15.30, df = 5,804, p<.000).

DSM-IV Axis I Primary Diagnosis at Admission

- Among women with an Axis I diagnosis of a substance use spectrum disorder, 65.6% completed treatment; 14.5% left ACA.
- Among women with an Axis I diagnosis of a psychoses spectrum disorder, 65.9% completed treatment; 12.3% left ACA.
- Among women with an Axis I diagnosis of a mood disorder spectrum disorder, 51.7% completed treatment; 20% left ACA.
- Among women with an Axis I diagnosis of anxiety spectrum disorder, 20.9% completed treatment; 37.8% left ACA; 13.8% were administratively discharged.

Based on those women with an Axis I diagnosis (n = 7,023), women with an indication of a co-occurring disorder that included a psychoses spectrum disorder completed treatment more often (78.1%) as compared to women with no indication of a co-occurring disorder (58.4%). Women with a co-occurring disorder that included a mood disorder completed treatment more often (64%) as compared to women with no indication of a co-occurring disorder (42%). Women with a co-occurring disorder that included an anxiety spectrum disorder completed treatment more often (33%) as compared to women with no indication of a co-occurring disorder (15%).

In this population, adult women with a co-occurring disorder completed treatment significantly more often.

Predicting days in treatment

The better the GAF score at admission, less frequent drug use at admission, having no indication of a co-occurring disorder, having a better CAR Subscale-‘Feeling and Mood’ score at admission, and having less education explained a moderate difference in the number of days in treatment ($R^2 = .316$, $p < .000$).

Although significantly more women with a co-occurring disorder completed treatment they spent only half as many days in treatment.

Residence

Among these adult women, their resident status upon admission was:

Private residence = 7,899 (85.4%)

Residential care home = 647 (6.9%)

Institutional setting = 324 (3.5%)

No home = 118 (1.3%)

Nursing home = 128 (1.4%)

Among adult women, their resident status upon discharge was:

Private residence = 6,950 (79.2%)

Residential care home = 688 (7.6%)

Institutional setting = 571 (6.3%)

No home = 217 (2.4%)

Nursing home = 225 (2.5%)

Living situation for women:

Living alone = 2,623 (28%)

Living with family/relatives = 5,127 (54.7%)

Living w/non-related persons = 1,439 (15.3%).

Living w/batterer = 189 (2%).

Difference in Residence

Many of the women in this group were in programs for battered women. Even so there were significant differences between women with an indication of a co-occurring disorder and women with *no* indication of a co-occurring disorder. There were over twice as many women with an indication of a co-occurring disorder who were in a 'community shelter.' Over 30% more women with an indication of a co-occurring disorder came from 'residential care homes.' There were 25% fewer women with an indication of a co-occurring disorder who reported 'no home.' And, 40% fewer women with an indication of a co-occurring disorder reported that they came from a 'supported living' situation. There was no difference in those reporting that they came from a 'private residence' or a 'nursing home.'

Difference in Arrests

Among women who were arrested 30 days before admission with an indication of a co-occurring disorder had significantly more arrests (M = .05) than women with no indication of a co-occurring disorder (M = .03) (t= -3.03, df = 6,890, p<.002).

Among women who were arrested six (6) months before admission with an indication of a co-occurring disorder had significantly more arrests (M = .12) than women with no indication of a co-occurring disorder (M = .07) (t= -4.56, df = 6,890, p<.000).

Difference in GAF scores

Women with an indication of a co-occurring disorder were admitted with significantly lower/worse GAF scores (M = 35.90) than women with no indication of a co-occurring disorder (M = 40.42) (t=14.37, df = 6,890, p<.000). At discharge, there was no significant difference in the GAF score (t = .314, df = 5,696, p < .753).

Difference in CAR scores

CAR subscale 'feeling and mood' score at admission and at discharge:

There was no difference among adult women with an indication of a co-occurring disorder or with *no* co-occurring disorder on the CAR subscale 'feeling and mood' at the time of admission. At discharge with women with no indication of a co-occurring disorder had a slightly higher score (M = 34.65) than women with an indication of a co-occurring disorder (M = 34.42) which was significant (t = 2.21, df = 4,470; p < 215).

CAR subscale ‘thinking’ score at admission and at discharge:

There was a difference on the CAR subscale ‘thinking’ at the time of admission. Women with an indication of a co-occurring disorder had a higher or worse score (M = 31.72) than women with *no* indication of a co-occurring disorder (M = 31.19) (t = -2.358, df = 6,331, p < .018). **However, there was no significant difference at discharge** (t = -.997, df = 4,470, p < .319).

CAR subscale ‘substance use’ score at admission and at discharge:

At admission, 2,242 (32%) of 7,030 of women assessed using the CAR subscale – ‘substance use’ had a score indicating a substance use disorder. At discharge, 1,457 (33%) of 4,472 had a score indicating a substance use disorder.

CAR subscale ‘family’ score at admission and at discharge:

CAR subscale ‘family’ scores were significantly higher/worse at admission for women who had an indication of a co-occurring disorder (M = 29.40) than for women who did *not* have an indication of a co-occurring disorder (M = 28.01) (t = -6.23, df = 6,233, p < .000). As well, the CAR subscale family score was significantly higher/worse at discharge for women with a co-occurring disorder (M = 29.86) than it was for women with *no* co-occurring disorder (M = 28.79) (t = -4.10, df = 4,470, p < .000).

CAR subscale ‘interpersonal relations’ score at admission and at discharge:

There was no difference among adult women with an indication of a co-occurring disorder or with *no* co-occurring disorder on the CAR subscale interpersonal relations at the time of admission or at discharge.

CAR subscale ‘role performance’ at admission and at discharge:

CAR subscale ‘role performance’ scores were significantly higher/worse at admission for women who had an indication of a co-occurring disorder (M = 30.05) than for women who did *not* have an indication of a co-occurring disorder (M = 29.06) (t = -4.63, df = 6,331, p < .000). As well, the CAR subscale ‘role performance’ score was significantly higher/worse at discharge for women with a co-occurring disorder (M = 30.69) than it was for women with *no* co-occurring disorder (M = 29.65) (t = -3.89, df = 4,470, p < .000).

CAR subscale ‘socio-legal’ score at admission and at discharge:

On the CAR subscale ‘socio-legal,’ women with an indication of a co-occurring disorder had significantly higher/worse score at admission (M = 20.46) than women with *no* indication of a co-occurring disorder (M = 16.06) (t = -18.96, df = 6,331, p < .000). And, women with an indication of a co-occurring disorder had significantly higher/worse score at discharge (M = 20.16) than women with *no* indication of a co-occurring disorder (M = 16.71) (t = -12.52, df = 4,470, p < .000).

CAR subscale ‘self-care/basic needs’ score at admission and at discharge:

There was no difference among adult women with an indication of a co-occurring disorder or without a co-occurring disorder on the CAR subscale ‘self-care/basic needs’ at the time of admission or at discharge.

Clients 18 or over – serious mental illness score at admission and at discharge

There were 5,824 (72.4%) adult women identified as being seriously mentally ill at admission. At discharge, there were 4,716 (69%) adult women identified as being seriously mentally ill.

Among women with an indication of a co-occurring disorder fewer were identified as having a serious mental illness ($X^2 = 37.54$, $df = 1$, $p < .000$). Among women identified as having a serious mental illness ($n = 5,217$), 29% ($n = 1534$) also had an indication of a co-occurring disorder. This is a ratio of 1 to 3.4 or 1 woman with an indication of a co-occurring disorder for every 3.4 women identified as seriously mentally ill.

Difference in ASI Scores

ASI subscale – ‘Alcohol use’ score at admission and at discharge:

Among the women assessed at admission using the ASI subscale – ‘alcohol use,’ 507 (27%) were identified as having a score that indicated a serious alcohol problem. At discharge, the number had increased to 650 (50%). This finding would suggest that more training is needed by clinicians that are administering the ASI subscale – ‘alcohol use’.

Women with an indication of a co-occurring disorder had higher ASI subscale-‘alcohol use’ scores at admission ($M = 4.33$) than women with *no* indication of a co-occurring disorder ($M = 3.07$) ($t = -5.669$, $df = 582$, $p < .000$). And, women with an indication of a co-occurring disorder had higher ASI subscale-alcohol use scores at discharge ($M = 4.11$) than women with *no* indication of a co-occurring disorder ($M = 2.99$) ($t = -5.08$, $df = 499$, $p < .000$).

ASI subscale –‘Drug use’ at admission and at discharge

Among the women who were assessed at admission using the ASI subscale – ‘drug use’, 848 (71%) had a serious drug problem. At discharge 804 (62%) had a serious drug problem.

Although there was small but significant difference at admission on ‘drug use’ at admission for women with a co-occurring disorder ($M = 5.61$) compared to women with *no* co-occurring disorder ($M = 5.22$) ($t = -2.05$, $df = 582$, $p < .041$); at discharge, the women with an indication of a co-occurring disorder showed less improvement at discharge ($M = 5.22$) compared to women with *no* co-occurring disorder ($M = 4.65$) ($t = -2.80$, $df = 499$, $p < .005$).

ASI subscale – ‘Family/social relations’ score at admission and at discharge

Scores on the ASI subscale – ‘Family/social relations’ for women with an indication of a co-occurring disorder were higher/worse at admission (M = 4.21) than women with *no* indication of a co-occurring disorder (M = 2.85) (t= -12.50, df = 1,418, p<.000) and at discharge women with an indication of a co-occurring disorder had higher/worse scores (M = 3.93) than women with *no* indication of a co-occurring disorder (M = 2.82) (t= -9.46, df = 1,253, p<.000).

ASI subscale – ‘Psychiatric status’ at admission and at discharge

At admission, 646 (31.2%) of 2,069 women assessed using the ASI subscale – ‘Psychiatric status’ had a psychiatric disorder. At discharge, 312 (30%) of 2,069 women had a score indicating a psychiatric disorder.

Difference in DSM-IV Axis I Diagnosis at Admission

Among the adult women in this group, 7,248 were given an Axis I primary diagnosis and 3,633 were given an Axis I secondary diagnosis. About 23% were deferred or null on the Axis I primary diagnosis and about 61% were deferred or null on the Axis I secondary diagnosis. Some 96.5% of these women were not given an Axis II diagnosis.

Note: Only those diagnostic categories with 100 cases or more is presented here.

DSM-IV Axis I Primary Diagnosis at admission: Adult Women

Axis I Primary Diagnosis at Admission	# No COD Expected 68.1%	# No COD Actual	# COD Expected 31.9%	# COD Actual
295.30 Schizophrenia Paranoid Type	158	183/79%	74	49/21%
295.70 Schizoaffective Disorder	331	368/75.7%	155	118/24.3%
296.32 Major Depressive Disorder, Recurrent Moderate	242	266/75%	113	89/25%
296.33 Major Depressive Disorder, Most RSevere Without Psychotic Features	516	563/74.4%	241	194/25.6%
296.34 Major Depressive Disorder, Manic Most RSevere With Psychotic Features	303	330/74.2%	142	115/25.8
296.44 Bipolar I Disorder, Manic Most	110	115/71%	52	47/29%

RSevere With Psychotic Features				
296.53 Bipolar I Disorder, Depressed Most RSevere Without Psychotic Features	92	95/70%	43	40/30%
296.54 Bipolar I Disorder, Depressed Most RSevere With Psychotic Features	89	97/75%	42	33/25.4%
296.64 Bipolar I Disorder, Mixed Severe With Psychotic Features	74	72/74%	34	36/33.3%
296.80 Bipolar Disorder NOS	133	132/68%	62	63/33.2%
296.90 Mood Disorder NOS	280	223/54.3%	131	188/45.7%
298.90 Psychotic Disorder NOS	194	174/61%	91	111/39%
304.80 Polysubstance Dependence	109	55/34.4%	51	105/66%
309.81 Posttraumatic Stress Disorder	125	152/83%	59	31/17%
311.00 Depression Disorder NOS	324	297/62.5%	152	178/35.7%
Axis 1 Secondary Diagnosis at Admission				
	#No COD Expected 68.1%	# NO COD Actual	# COD Expected 31.9%	# COD Actual
303.90 Alcohol: Dependence	100	43/29.3%	47	104/70.7%
304.80 Polysubstance: Dependence	187	101/37%	88	173/63%
305.00 Alcohol: Abuse	84	55/44.4%	40	69/55.6%
305.20 Cannabis: Dependence	70	50/49%	33	53/52%
305.90 Phencyclidine Abuse	76	41/37%	35	70/63%
309.81 Posttraumatic Stress Disorder	188	202/73%	88	75/27%
311.00 Depression Disorder NOS	113	105/63.3%	53	61/36.7%

Axis II – Primary Diagnosis at admission	# NO COD Expected 68.1%	# NO COD Actual	# COD Expected 31.9%	# COD Actual
301.83	153	136/60.4	72	
301.90 Personality Disorder NOS	129	100/53%	60	89/47%

998.00 Diagnosis Deferred	826	673/45.8%	642	796/54.2%
999.00 No Diagnosis	674	628/52.4%	524	570/47.6%

Axis I Diagnosis in Groups	# NO COD Expected 68.1%	# NO COD Actual	# COD Expected 31.9%	# COD Actual
	Substance Abuse Diagnosis	392	215/37.5%	181
Psychotic Diagnosis	547	613/76.7%	251	186/23.3%
Mood Disorder Diagnosis	3,020	3,056/69.3%	1,389	1,353/30.7%
Anxiety Diagnosis	175	207/81.2%	80	48/18.8%

Difference in DRUG USE

History IV Drug Use

More women with an indication of a co-occurring disorder had a history of IV drug use ($X^2=136.85$, $df = 1$, $p<.000$). Of the 1,124 women with a history of IV drug use, approximately 50% more women with an indication of a co-occurring disorder had a history of IV drug use.

#1 Drug of Choice at admission	# NO COD Expected 68.1%	# NO COD Actual	# COD Expected 31.9%	# COD Actual
	None	2,686	3,299/83.7%	1,257
Alcohol	807	544/45.9%	378	641/54%
Cocaine	256	166/44%	120	210/56%
Marijuana/hashish	374	291/53%	175	258/47%
Methamphetamine	380	281/50.4%	178	277/49.6%

Frequency of use of drug of choice

In this adult female group, 18% used drugs daily. Only 13.4% said they had not used drugs in the last month. There was a significant difference between the groups. Women with an indication of a co-occurring disorder used drugs more frequently ($t= -12.33$, $df = 2,967$, $p<.000$).

Difference in Age of first use of drug of choice

The Mean age for first drug use for this group of women was 19.19 years (SD = 7.60). The Mode was 18. Almost 61.4% used drugs by the age of 18 years. Almost 75.9% had used drugs by the age of 21 years. There was no significant difference between women with an indication of a co-occurring disorder and women with no indication of a co-occurring disorder in terms of age of first drug use ($t = -.636$, $df = 2,967$, $p < .524$).

Primary referral source at admission	# NO COD	# NO COD	# COD	# COD
	Expected	Actual	Expected	Actual
	68.1%		31.9%	
Self	1,826	1,976/75.7%	855	705/26.3%
Significant Other	232	258/75.7%	109	83/24.3%
Non-Psychiatric Hospital	467	367/53.5%	219	319/46.5%
Dept of Corrections	65	22/23.2%	30	73/76.8%
Dept Human Services	86	104/80%	42	26/20%
Law Enforcement	614	680/61.5%	319	385/38.5%
Court	229	189/56.3%	107	147/43.8%
Private Physician	57	72/86.7%	27	11/13.3%
ODMHSAS Funded Facility	698	693/67.6%	327	332/32.4%
Non ODMHSAS Funded Psychiatric Hospital	95	106/75.5%	45	34/24.3%

Primary referral source at discharge	# NO COD	# NO COD	# COD	# COD
	Expected	Actual	Expected	Actual
	68.3%		31.7%	
Self	1,235	1,364/75.4%	574	445/24.6%
Significant Other	77	85/76%	36	27/24%
Non-Psychiatric Hospital	135	113/57%	63	85/43%
Dept of Corrections	64	21/22.6%	30	72/77.4%
Law Enforcement	58	51/60%	27	34/40%

Referral due to Unscheduled Discharge	339	397/80%	158	100/20%
Court	51	45/60%	23	30/30%
Private Physician	111	114/70%	52	49/30%
ODMHSAS Funded Facility	1,363	1,144/57.3%	634	853/42.7%
Non ODMHSAS Funded Psychiatric Hospital	68	67/67.7%	31	32/32.3%

Presenting problem-primary at admission	# NO COD Expected	# NO COD Actual	# COD Expected	# COD Actual
	68%		32%	
Emotional Maladjustment/Disturbance	622	737/80.7%	291	176/19.3%
Depression	1,665	1,865/76.3%	780	580/23.7%
Anxiety/Panic	210	244/79.2%	98	64/20.8%
Perceptual Problems	130	139/72.8%	61	52/27.2%
Other Psychotic Symptoms	577	561/66.2%	270	286/33.8%
Suicidal/Self Abuse	794	648/55.6%	372	518/44.4%
Drug/Other Abuse	100	63/43%	47	84/57%
Drug/Other Dependency	136	177/52.3%	83	124/47.7%
Poly/Both Alcohol & Drug	86	44/35%	40	82/65%
Poly Dependency/Both Alcohol & Drug	112	64/39%	52	100/52.3%

Presenting problem-primary at discharge	# NO COD Expected	# NO COD Actual	# COD Expected	# COD Actual
	68.1%		31.9%	
Emotional Maladjustment/Disturbance	575	655/77.5%	270	190/22.5%
Depression	1,503	1,547/70%	705	661/29.9%
Anxiety/Panic	157	177/76.6%	74	54/23.4%
Perceptual Problems	55	61/76.3%	26	19/23.8%

Other Psychotic Symptoms	394	378/65.3%	185	201/34.7%
Other Behavioral Disturbance	68	57/58.2%	31	41/41.8%
Suicide/Self Abuse	517	431/56.8%	242	328/43.2%
Drug/Other Abuse	90	57/43.29%	42	75/56.8%
Drugs/Other Dependency	164	129/53.5%	77	112/46.5%
Poly/Both Alcohol & Drug	93	43/31.6%	43	93/68.4%
Poly Dependence/Both Alcohol & Drug	108	66/41.5%	51	93/58.5%

Service Focus	# NO COD	# NO COD	# COD	# COD
At admission	Expected	Actual	Expected	Actual
	68.1%		31.9%	
Mental Health	4,101	4,259/70.7%	1,926	1,768/29.3%
Mental Health Court	208	120/39.2%	98	186/60.8%
Substance Abuse	276	256/63.2%	129	149/36.8%

Service Focus	# NO COD	# NO COD	# COD	# COD
At discharge	Expected	Actual	Expected	Actual
	68.1%		31.9%	
Mental Health	3,345	3345/68%	1,566	1,568/32%
Substance Abuse	266	239/61.3%	124	151/38.3%
14	94	94/68%	44	44/32%
15	190	111/39.8	89	168/60.2%

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Methodology Used to Develop the 2nd Quarter Report – Year 4

The methodology that was used to produce this quarterly report is both qualitative and quantitative. The qualitative data consists of interviews, collected materials, and observations by evaluation team members. Relevant documents were collected from committee meetings, trainings, and workshops. The minutes from ISI Advisory Group

subcommittee meetings were cataloged. These documents and data as a whole provide a description of events, activities, accomplishments, and tasks that have been completed, or are still being worked on. The quantitative data consists of the ICIS admission data on the 15 Model and 5 Control programs.

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Progress on Project Goals and Objectives

Goal 1.

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

Objective 1.2 –

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

Status:

For all intents and purposes, the work on Objective 1.2 has been completed. The vast majority of staff of the 15 pilot programs has been trained with the Core Level curriculum. Training continues on the intermediate curricula. The Advanced curriculum which will also begin this year.

Goal 2.

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

Objective 2.1 –

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

Status:

Consensus building and maintaining the support of 28 agencies will be a formidable task with a reduced OK-COSIG team. The Team needs to continue to maintain and expand support of the organizational changes to provide program capable co-occurring services. The OK-COSIG team continues to be fully engaged in consensus building among the shareholders.

Objective 2.2 –

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

Status:

The staff continues to meet regularly with a committee of representatives from the Board of Licensed Professional Counselors, the Social Work Licensure Board, and the Board that license Behavioral Health practitioners. The work continues.

Objective 2.3 –

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

Status:

For all intents and purposes, *Objective 2.3* has been accomplished.

- First, incentives were provided to model programs for reaching objectives such as training staff and clinicians related to co-occurring capable programming.
- Second, the changes in language in Chapters 17 (the Standards and Criteria for Community Mental Health Centers) and in Chapter 18 (the Standards and Criteria for Alcohol and Drug Treatment Programs) was a major strategic incentive for the agencies that provide client level services to become co-occurring capable programs.

Objective 2.4 –

Train all mental health and substance abuse treatment providers in the use of a comprehensive, integrated system of care model for persons with co-occurring disorders.

15 Months

- Fifteen months after the award date, the co-occurring disorders training specialist, under the guidance of the national consultants had trained all staff in the pilot sites in the integrated treatment model (Activity 2.4.2).

Status: Accomplished.

24 Months

- Within 24 months, the evaluator will produce a report assessing the implementation fidelity of the screening protocol at the pilot sites (Activity 1.2.4).

Status:

The data collected on the screen has been analyzed and a final revision has been produced. The statistical analysis of the AC-OK Co-occurring Screen has shown that this screen is highly reliable, valid, very **sensitive, and has high levels of specificity**. A report to the ODMHSAS leadership is available in the 3rd Quarterly, Year 3 Report, see Appendix A in that report.

- End of the second year after the award date, the evaluator will have conducted an assessment of treatment fidelity and clinical outcomes on a sample of persons with co-occurring disorders and will provide a report to the OK COSIG Advisory Group (Activities 2.4.3 to 2.4.5). The services pilot will be implemented in two urban settings in the second year, Tulsa (Service Areas 3 & 5) and Norman (Service Area 15).

Status:

Program Fidelity data has been collected from the 15 Model Programs and Program Fidelity data is being collected on the 13 additional model programs in year 3. A preliminary report was produced and is found in the Year-End Report, Year 2. A Program report based on the Fidelity and ICIS data is in the 2nd Quarterly, Year 3 Report.

- Implementation of the screening and assessment protocol will be assessed at the service pilot sites during years two and three and statewide in years four and five.

Status:

The data gathering continues. The first and second round of Fidelity data has been collected on the 15 pilot programs. The first round of Fidelity data for the 13 new model programs has been collected.

- A two person team under the direction of the Program Evaluator will visit each of the 15 pilot programs involved in the services pilot sites at the end of year two and three (The number of pilot programs has increased from 8 to 15).

Status:

This is ongoing. Program Fidelity data has been collected for two years on the original 15 programs. The first round of Fidelity data for the 13 new model programs has been collected.

- The Project Evaluator will produce a site specific report based on the three sources of information that will examine the relationship between organizational factors and implementation fidelity, and changes in implementation fidelity from year two to year three for the two urban sites and from year three to year four for the rural sites.

Status: Two years of Fidelity data has been collected on the original 15 programs. The first round of Fidelity data for the 13 new model programs has been collected. This data will be used to determine the changes in implementation fidelity from year two to year three for urban sites and rural sites.

- The Evaluator will work with Decision Support Services Division to extract this information for each of the service pilot sites on an annual basis for each year of funding. Data from the first planning year will provide a baseline against which data from the pilot sites at years two and three can be assessed.

Status:

A preliminary MACRO evaluation for FY2005 has been compiled and can be found in the Year-End Report, Year 2. A format for program reports based on the Fidelity and ICIS data has been developed. The current form is a revision of an

earlier version. The format was changed after feedback from clinicians and administrators. In this quarterly report, the ICIS data has been used to develop a typology of people with a co-occurring disorder who are admitted for treatment.

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

Status: A report on the analysis has been completed. It is presented in the End of Year 3 Evaluation Report, under the heading: *Analysis of the OK-COSIG Process Evaluation Data.*

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Emerging Themes

Based on the analysis of the ICIS data, there are several themes that stand out and have implication for clinical training and the treatment protocol.

1) Clinical Training

The finding that among the women assessed at admission using the ASI subscale – ‘alcohol use,’ only 507 (27%) were identified as having a score that indicated a serious alcohol problem. At discharge, however, the number increased to 650 (50%). This finding would suggest that more training is needed by clinicians that are administering the ASI subscale – ‘alcohol use’.

Additional training should also focus on treating people with the co-occurring disorder where the mental disorder is a ‘mood disorder.’ Among those individuals with an indication of a co-occurring disorder, who were given an Axis I diagnosis, over 80% of the men and 73% of the women identified as having an Axis I diagnosis. Among women the program completion rate is only 50%.

There is also a serious need for clinical training related to Anxiety spectrum disorders. Only 21% of men and 25% of women who were given an Anxiety spectrum, Axis I disorder completed treatment. People assigned other Axis I disorders complete treatment between 60% and 70% of the time.

2) Add Relationship Skills Building to the treatment protocol.

Given the scores on the ASI and CAR subscale related to family, more treatment time needs to be devoted to helping people with a co-occurring disorder learn the skills of developing and maintaining relationships.

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Postscript

At the end of this 2nd Quarter of year four, the majority of the work on the OK-COSIG Project is focused on helping the 13 new programs to become co-occurring capable and “walking out” the program to the remainder of agencies providing mental health and substance abuse treatment in the State. There is a major incentive for agencies to become co-occurring capable. The changes in ODMHSAS “rules” will require agencies to treat people with a co-occurring disorder. The work is delineated in the quarterly reports and year-end reports compiled over three and a half years. These reports can be obtained from the website: http://faculty-staff.ou.edu/C/Andrew.L.Cherry-1.Jr/okcosig_project.htm

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