OK-COSIG
End of Year 2 Evaluation Report
OK-COSIG

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Produced by the members of the OU OK-COSIG Evaluation Team:

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

Lisa G. Byers, Ph.D.
Assistant Professor
University of Oklahoma, School of Social Work, Tulsa Campus,
OU OK-COSIG Associate Evaluator

Mary E. Dillon, MSW, ABD
Nova Southeastern University
OU OK-COSIG Associate Evaluator

Tiffany Adamson, BS. MSW Student,
University of Oklahoma, Tulsa Campus
OU OK-COSIG Assistant Evaluator

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Acknowledgement

This second year-end evaluation report related to the work on the Oklahoma Co-Occurring State Incentive Grant (OK-COSIG) will use both qualitative and quantitative data. This second year-end report will establish a baseline of program fidelity at the model programs against which future change can be assessed. The development of this baseline has involved both the Department of Mental Health and Substance Abuse and the model programs, and the administrators and staff at these agencies. Without their contributions and cooperation this evaluation would be impossible.

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

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

This report will identify work accomplished, including areas where continued efforts are needed to meet the deliverables promised in the proposal and needed to be able to deliver the best possible treatment services to people with co-occurring problems of mental health, substance abuse, and trauma..

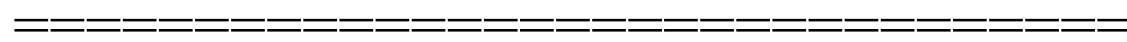
This was a particularly busy year for the evaluation team. In addition to attending numerous committee meetings, workshops, and presentations, the work involved program visits, individual interviews, focus groups, and the management of large databases. This work accomplished by our team of four exceeds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

and its subcommittees and their desire to promote, support, and to be involved in self-help groups contributed to the overall accomplishment of the OK COSIG project.

The following is the table that was compiled when the original grant was submitted. Notice the column "Dual Diag" which lists the number of co-occurring reported for each year by each agency listed. Although the people requesting treatment in Oklahoma have not changed dramatically, the number of people that are counted who are presenting with a co-occurring disorder has increased dramatically because clinicians are more sensitive to the high incidence of co-occurring disorders among people treated at mental health and substance abuse treatment programs.

Characteristics of Persons Served in the Proposed Pilot Sites

Year	Provider	Ave. Age	% Mental Health	% Subst. Abuse	**% Dual Diag**	% Female	% Rural	Total Clients
2002	12 & 12	34.3	2%	22%	**6%**	35%	77%	1397
	ACT	35.3	14%	9%	**11%**	57%	98%	1312
	TCBH	28	5%	5%	**6%**	39%	97%	438
	COCMHC	36.8	16%	7%	**10%**	55%	90%	1595
	Griffin	37.4	25%	21%	**25%**	41%	57%	2512
	NADTC	34.8	2%	11%	**4%**	31%	63%	709
	GLCMHC	37.5	37%	19%	**39%**	51%	34%	3587
	VADTC	32.4	0%	5%	**0%**	50%	29%	333
2003	12 & 12	34.8	2%	23%	**7%**	36%	77%	1328
	ACT	34.8	16%	11%	**15%**	56%	97%	1533
	TCBH	36	9%	7%	**8%**	41%	94%	899
	COCMHC	35.5	16%	7%	**10%**	55%	90%	1468
	Griffin	37.3	25%	21%	**25%**	42%	64%	2350
	NADTC	33.3	2%	12%	**4%**	32%	62%	674
	GLCMHC	39	30%	14%	**31%**	52%	26%	2772
	VADTC	32.1	0%	5%	**0%**	47%	34%	300



How this Year-End Report is Organized

This end of the year report for 'Year 2' is not meant to be a detailed report on the activities and events sponsored or participated in to further the goals of the OK-COSIG project. The activities and events are reported in a great deal of detail in each of the quarterly reports.

The primary purpose is to examine the goals and objectives of the OK-COSIG project. To that end, after a brief overview of Year 2, the accomplishments and challenges are listed and discussed. This report will review the two goals and five objectives to be satisfied by the OK-COSIG efforts and work, however, the bulk of this report will be on the information derived from the large ICIS database on the model programs, the Fidelity Evaluations, and the key individual interviews and focus groups to determine the relationship between organizational factors and implementation fidelity, and the changes that occur in implementation fidelity and outcomes from year two as compared to subsequent years of the OK-COSIG project.

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

Disclaimer:

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

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Executive Summary

The OK-COSIG project is a study in change management. Change management is the process and tools for managing the "people" side of change. In this case, these are the changes needed to introduce new and altered approaches to integrate mental health practices with knowledge of substance abuse practices. Changing approaches in two fields that have been in separate camps and at times oppositional for over half century, however is challenging, but not impossible.
To change an organization such as ODMHSAS, strategies must be developed that are based on sound organizational change principles that also help all shareholders understand, accept, and facilitate the changes. To this end, the first year was deemed a planning and development year. The second year of the OK-COSIG grant can be described as the year of implementation, integration, and evaluation. Implementation of core level trainings was achieved across the model sites through the hard work of Change Agents at their respective agencies. These trainings were evaluated by the participants with the results posted online at the ODMHSAS website. The ease of online access is another theme of the second year with a direct link on the ODMHSAS website to the COSIG project. The prominence of the COSIG link indicated the importance of this initiative to the mental health and substance abuse service structure in Oklahoma. Information related to newly developed policies, subcommittee meetings, upcoming trainings, and DTR group meetings was available. The presence of DTR information acknowledged the integral aspect of peer support to recovery. The COSIG webpage created a point of connection that had been requested at the beginning of the second year. The information sharing through online methods indicated another step toward integration of efforts among those working to implement the initiative. The year closed with a focus on the development of online training curriculum. These efforts will continue in the third year in order to widen the access to training.

Face to face education was another integrative characteristic of the year with seven conference presentations conducted across the state and nation related to the progress of the OK-COSIG. State level information sharing ensued with meetings among key personnel involved with other major state initiatives in mental health and substance abuse. The goal of these meetings was the integration of efforts to promote wellness of the consumer population.

Efforts to enfold previously under represented consumers were made during this year. Meetings with tribal leaders led to the conduction of a training for the Choctaw tribe. Discussions took place in regard to the inclusion of rural Oklahomans that live in census designated frontier areas. This work creates the potential for the diverse consumer voice to be heard.

The need for the presence of consumers to educate implementation efforts was expressed among a number of subcommittees with discussion regarding the ways to enhance involvement of the people served. The screening and assessment subcommittee was successful in gaining involvement of consumers in the writing of the welcoming policy. The approval of a welcoming and screening policy signified an institutional acceptance and implementation of the co-occurring initiative. This approval following a year of planning and development was a critical step. Efforts to evaluate detoxification policies, alterations to Chapter 18, and work related to financing were further indications of the structural changes that marked the second year of this project.

There are two websites related to the OK-COSIG project. They are the ODMHSAS OK-COSIG website and the OK-COSIG Evaluation Project website. The minutes of the ISI Advisory committee meetings and the minutes of the subcommittee meetings are posted on the ODMHSAS OK-COSIG website. The address is: http://www.odmhsas.org/cosig/. This Year-End Report for Years 1 and 2, and the eight quarterly reports by the evaluator and other links of interest can be accessed at the OK-COSIG Evaluation Project website. The address is: http://faculty-staff.ou.edu/C/Andrew.L.Cherry-1.Jr/okcosig_project.htm

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Second Year Overview

The planning that took place during the first year came to fruition in year two. Change agents transferred their knowledge and skills to their agencies. The OK-COSIG staff worked within the administrative, agency, community, and consumer levels to integrate the initiative across the state. The development and formal acceptance of policies was another critical characteristic of the second year that indicates an organizational shift to support real change in the service structure for people with mental health and substance abuse issues. The evaluation of

the project yielded data from multiple perspectives to fully capture the process of change and fidelity in relation to the vision, outcome, and goals that drove the initiative since its inception.

The ISI vision statement

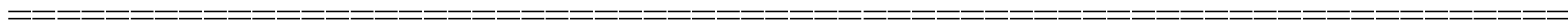
A Healthy Oklahoma: All people with or at risk for co-occurring disorders have access to a recovery-oriented, consumer-driven system of care.

The ISI statement of expected outcome:

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

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

The following sections of the Year-End Report for Year 2 will explicate the work toward accomplishing these two objectives in the year of the OK-COSIG project.



Progress on Project Goals and Objectives

Goal 1.

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

Objective 1.2-

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

Status:

- The first year closed with the completion of the screen and its formal approval by the ODMHSAS leadership. Plans for online access to the screen marked the transition from year one. The plan was realized in year two with a computerized version of the screen on the ICIS data system.

- The screen was piloted during the second quarter with 200 completed. At the beginning of the third quarter 600 screens had been completed. By the end of the 4th quarter, 3,071 screens were completed. A concern voiced within the first year end report was agency compliance with screen completion, which was a reality encountered by other states. The increase within this year is heartening. The formulation of a sub committee during this year that is focused on ICIS training for agencies and the inclusion of instrument completion in agency contracts will increase the completion of screens and other instruments (CAR, ASI, ASAM PPC-2R) necessary for evaluation.
- The plans for online ICIS training in addition to the availability of face to face trainings is intended to capitalize on different styles of learning with the provider population. The intent of the trainings is to increase consistency in data reporting across all staff.

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:

- The ISI Advisory committee was organized to facilitate consensus building among those that advocate for, receive, and provide services for co-occurring disorders. The OK-COSIG team continues to be fully engaged in consensus building among the shareholders.
- The staff attended several meetings with administrators of other state initiatives (Children's Behavioral Health, Cross Training Initiative 2, Recovery Collaboration, and Transformation State Incentive) to coordinate efforts within the realm of statewide service structure for individuals living with mental health, substance abuse, and trauma issues.

- The OK-COSIG staff interfaced at meetings and trainings with law enforcement representatives during this year in the Oklahoma City, Lawton, and Moore areas.
- Staff meetings with drug and mental health courts ensued to represent coordination among another entity that is involved in daily interactions with individuals experiencing co-occurring disorders.
- Expansion to Northwest Oklahoma or Frontier areas was a topic of the fourth quarter that was bolstered by COCE assistance.
- Presentations and trainings were conducted at the Inter-Tribal Substance Abuse Prevention and Treatment Center Northeast, Indian Health Service, and the Choctaw Nation.
- Ten new model sites were recruited in the final quarter of the year.
  1) NorthCare, a community mental health center,
  2) RedRock, a community mental health center,
  3) Mental Health Services of Southern Oklahoma,
  4) Northwest Center for Behavioral Health,
  5) Tulsa Women's and Children Center
  6) Specialized Outpatient Services, an outpatient substance abuse agency,
  7) Gateway to Prevention, an outpatient substance abuse program,
  8) Tri-City Substance Abuse Services
  9) Community Mental Health Center in Lawton,
  10) Carl Albert Community Mental Health Center

- Following a statewide Change Agent conference, Change Agents began to gather in regional meetings on a monthly basis within Tulsa and Norman to coordinate trainings and resources for co-occurring disorders.
- Members of the various committees have expressed a concern for the maintenance of consumer involvement and substance abuse providers. Members of the Screening and Assessment Subcommittee have been successful in maintaining consumer input in the work related to the drafting of policies. Outreach efforts took place to increase the presence of substance abuse providers. This indicated a commitment to the full

representation of those who provide and receive services related to co-occurring disorders.

Objective 2.2 –

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

Status:

Establishing joint licensure/certification has ostensibly been tabled over the last year but will be renewed in the next year.

Objective 2.3 –

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

Status:

- The Finance Subcommittee secured COCE technical assistance from John O'Brien, who is a national expert on funding opportunities for COD.
- There is a continuing discussion regarding the need to develop funding mechanisms for "enhanced COD services." The committee recommends ODMHSAS begin to discuss developing braided funding between MH and SA and possibly pilot those strategies in one or several model sites.

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.

Status

- Trainings from national level representatives continued with Dr. Cline, and Dr. Minkoff that emphasized the strengths-based assessment process. Dr. David Mee-Lee provided integrated treatment plan training.
- A modified training manual was presented in the third quarter. The modified manual was noted by meeting members to make it easier to follow. This manual was used by the lead Change Agents when they train their own agency personnel regarding the Welcoming Environment, Cultural Competency, CCISC Model, and the Person-centered, strengths-based approach.

- Dr. Walter Kristhardt provided consultation on the development of the Advanced Case Management Generalist Training in the fourth quarter. This training will qualify for 6.5 supervisory CEUs, a major motivator for providers.
- Progress has been made related to the provision of five e-learning modules. The modules are accessible through www.e-learningcenter. The purpose of this training was emphasized as knowledge enhancement versus certificate attainment. The modules will be tracked to provide data regarding access and which modules were tested.

15 Months

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

Status

- Core level trainings took place at all model sites during this year with additional trainings provided for the Choctaw Nation and for Residential Care Services.
- Evaluations for all the core level trainings are accessible through an Integrated Services link on the ODMHSAS website.

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:

- A total of 3,071 screens have been completed. Analysis found that the screen is catching 92% of the people it should in this sample for MH, and 88% of the people it should for SA.. Sixty-five total people were screened out that should not have been, which is barely over 2%.
- The screening policy has been approved.
- The development of a screening and assessment protocol was reported to be a focus for the first quarter of the next year.
- The Assessment Practice Guidelines have been approved.

- The opportunity for consumer panel comments regarding the Integrated Treatment Plan Practice led to a new draft that appears in the September minutes with the new title of Integrated Recovery Plan Practice Guidelines which was submitted by the Screening and Assessment Subcommittee and was approved by the Leadership Committee.

24 Months

- 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 measures have been used with all the pilot programs. A preliminary report will be produced for the year-end report. An assessment of clinical outcomes on a sample of persons with co-occurring disorders is in progress.

24 Months

- 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: ***In progress***

24 Months

- 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:

- Program Fidelity measures have been completed at all pilot programs. The results are presented in the Mezzo Evaluation section of this report.

- 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: ***In progress***

24 Months

- 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:

- The data for the MACRO evaluation for year one October 1, 2004 – September 30, 2005 or the baseline data has been received. The data management process continues. The results constitute a major element of this year end report that is presented in the Macro Evaluation section.
- *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:

- Key informant interviews and focus groups have been completed. The preliminary results appear in the Mezzo Evaluation section of this report.
- ***In progress- the interviews and focus groups required for the fourth and fifth funding year data.***

Evaluation Activities and Accomplishments

- A great deal of work and time was spent in the development of the OK-COD Integrated Treatment Screen during the first year. Year two accomplishments involved the piloting and preliminary analysis of the screen's use across the model programs. Some 3,071 screens were completed by the model programs before the end of 2006. The completion rate will allow for analysis regarding the screens ability to identify individuals that need to be assessed for either a mental health, substance abuse, trauma problem or any combination of the three. Preliminary results from the analysis of the screens appears in the fourth quarterly report for year two that appears on the OK-COSIG Evaluation website. Importantly, these preliminary results on the screen highlighted the need for ICIS training with a focus on COD. This spurred the creation of the Data Reporting Committee in the last quarter of Year two that is devoted to training in this area to enhance the integrity of the data within the ODMHSAS system. This is a major change that is a result of the co-occurring initiative.
- An evaluation of agency knowledge was assessed with a telephone call requesting information about self help groups for consumers experiencing co-occurring disorders. The results led to suggestions related to relevant information to communicate to consumers over the phone. A major achievement within this year was the development of a Double Trouble in Recovery (DTR) Directory that lists 21 DTR resources. The directory lists the name of the group, meeting location, date and time. A contact person's name, number, and email is also included. This list is available on the ODMHSAS website under Integrated Services Initiative. The information serves as a resource for providers that are involved with consumers. Susan Easley, a new DTR coordinator provided the directory that was distributed to ODMHSAS staff with a request to have the resource available to everyone that may come in contact with consumers.
- Immense time and effort went into the development of an evaluation that would assess the administrator, provider, and consumer experiences of the OK-COSIG implementation. Three separate Institutional Review Board applications utilizing qualitative and quantitative methods to asses the macro, mezzo, and micro level data were developed and submitted to the University of Oklahoma and the ODMHSAS. All proposals passed the University of

Oklahoma. ODMHSAS approved the macro and mezzo level proposals. The micro level evaluation that involved consumers has not been approved by the ODMHSAS. Therefore, the macro and mezzo level data was obtained this year.

- The macro level ODMHSAS data was received in the fourth quarter and analysis began. The data set contained over 21,879 cases with 115 variables. A number of days were spent reviewing the data set and transforming the data into SPSS. This will allow for in-depth analysis of the fifteen pilot sites. The selection and inclusion of five control agencies will allow for other forms of analysis that will offer enhanced knowledge of the OK-COSIG impact over time. An example of the preliminary analysis is in the Macro Evaluation section of this report. More in-depth analysis will occur in Year three.
- Telephone interviews of administrators and providers proceeded at the state and agency level to assess the implementation of OK-COSIG. The words of the individuals involved in service provision to consumers with co-occurring disorders yielded themes that were then re-submitted to a focus group of administrators and providers to rank them in terms of the areas that needed the least and most amount of work. This offers qualitative information that indicates areas of strength and areas for intensified efforts from the individuals most familiar with the funding and provision of COD services. These themes appear in the Mezzo Evaluation section.
- Fidelity interviews required extensive time and work related to scheduling of interviews and travel across the state to model sites to conduct face to face interviews with two agency representatives. In addition to the model sites, agencies that will function as controls were interviewed in the same format. The completed interviews which included a Likert type response assessed a number of areas related to fidelity. A model of the analysis that is possible with this data appears in the earlier Mezzo Evaluation section.
- The Evaluation Team produced Four Quarterly reports that document in a great deal of detail the activities and events that were meant to fulfill the intent and purpose of the first year of the OK-COSIG contract.

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The MACRO Evaluation

The MACRO evaluation is based on a subset of data from the ICIS database. This database is used by mental health and substance abuse agencies in Oklahoma that have contracts with ODMHSAS. The data analyzed for this report comes from the 15 OK-COSIG Model programs and 5 Control programs.

Note: The following is a **DRAFT** of the Site Specific Report that will be developed on each of the Model Programs during 2007. The structure may change but at this point this seems like the best design for what will be yearly reports.

The Evaluation Subset Databases

In this database there are 21,879 cases of people served by 20 programs on which data was collected on 115 variables that will be used in the MACRO analyses. Statewide 62,048 people were served by all ODMHSAS programs. The population in this study comprises a subset of 31.25% of all people served by ODMHSAS programs in FY 2005. This database was used to construct several other databases so as to better describe the population being served by the model programs and the control programs and to develop a baseline report on which to compare future data.

Limitations of the data

The data collected by ICIS has many advantages but also a number of limitations. The data collected is entered into the system by a cadre of data entry personnel at the different agencies around the state of Oklahoma. These data entry people have different skill levels and different levels of training. There is a fairly constant turnover of data entry personnel that require ongoing training and monitoring. The data entry people also depend on clinicians to give them the correct information on the cases that are receiving services. Clinicians also need to be trained on how to use the ICIS data Client Data Core. Some clinicians it is rumored also tend to assign critical scores to people on the ASI and CAR indicating a need for treatment when the need may be questionable. Scoring on the ASI and CAR is based on the judgment of the clinician. Finally the cases are data on people admitted. There is no ICIS data on people who were screened out of treatment. They are not necessarily unduplicated cases. Each time a person

entered treatment they were counted as an admission. Some people may have been admitted several times during FY 2005.

Working Databases

I. The Master file is a SPSS data file. This data is from the Model and Control programs for the fiscal year 2005 (October 1, 2005 to September 30, 2006). It is organized into one data file that was used to breakout the working data files on each agency and subpopulations of interest. There are 21,879 cases. Information was collected on a maximum of 115 variables (See Appendix A). Some variables have missing data and data was not collected on other variables because the information was not relevant to a particular client.

II. The COD SPSS data files created are:
   1) A database of Co-occurring Disorder programs (COD_DB),
   2) A database of Mental Health programs (MH_DB),
   3) A database of Substance abuse programs (SA_DB),
   4) A database of Adolescent programs (ADLOS_DB),
   5) 15 databases, one on each model program (NAME_program #)

People Receiving Services from the 15 Model Programs and 5 Control Programs

The following is a description of the 21,879 people who received services from the 20 Model and Control programs in fiscal year 2005 (October 1, 2005 to September 30, 2006). This is 36.6% of all people who received service and treatment in Oklahoma. The following description is an aggregate description which presents an overall view of the people served by the 15 model programs and the 5 control programs.

Based on available Statewide statistics for the "Health Information Integrated Query System (HI IQs)"(see the website at http://www.odmhsas.org/eda/statisticsother.htm) the ICIS data collected on the population served by the Model and Control can be compared to the state statistics. This comparison will help inform us on issues related to the representativeness of the sample.

Statewide in FY 2005, approximately 68% of people who were served by ODMHSAS were provided mental health services. The remaining 32% received treatment for substance abuse.

In 2005, **62,048** people received services from all ODMHSAS programs.

In 2005, **38,248** people received services from ODMHSAS mental health programs.

20,458 or 53.49% of the 42,717 people who received services in ODMHSAS mental health programs were FEMALE.

In 2005, **18,388** people received services from ODMHSAS substance abuse programs.

7,711or 40.90% of the 18,853 people who received services in ODMHSAS substance abuse programs were FEMALE.

In 2005, **56,636** people received services from ODMHSAS mental and substance abuse programs.

Population Served by Program and Program Type

The following is the list of Model programs and Control Programs used in this analysis. The Control Programs are **Bolded** (see the following table).

FY 2005: Model and Control Programs		
AGENCY **MH** Agency name by ODMHSAS #		
	Frequency	Percent
100 Griffin Memorial Hospital--MH	3053	21.01%
103 OK County Crisis Intervention Center--MH	2302	15.84%
500 Central OK CMHC--MH	702	4.83%
503 Bill Willis CMHC--MH	1080	7.43%
541 Family and Children's Services--MH	2332	16.05%
551 **Edwin Fair--MH**	935	6.43%
557 **Hope Community Services--MH**	2123	14.61%
559 Green Country Behavioral Health Services, Inc.--MH	645	4.44%
564 Associated Centers For Therapy, Inc--MH	1362	9.37%
Total	14534	100.00%
AGENCY **SA** Agency name by ODMHSAS #		
	Frequency	Percent
102 NAC –SA	663	18.80%
205 VADTC--SA	217	6.15%

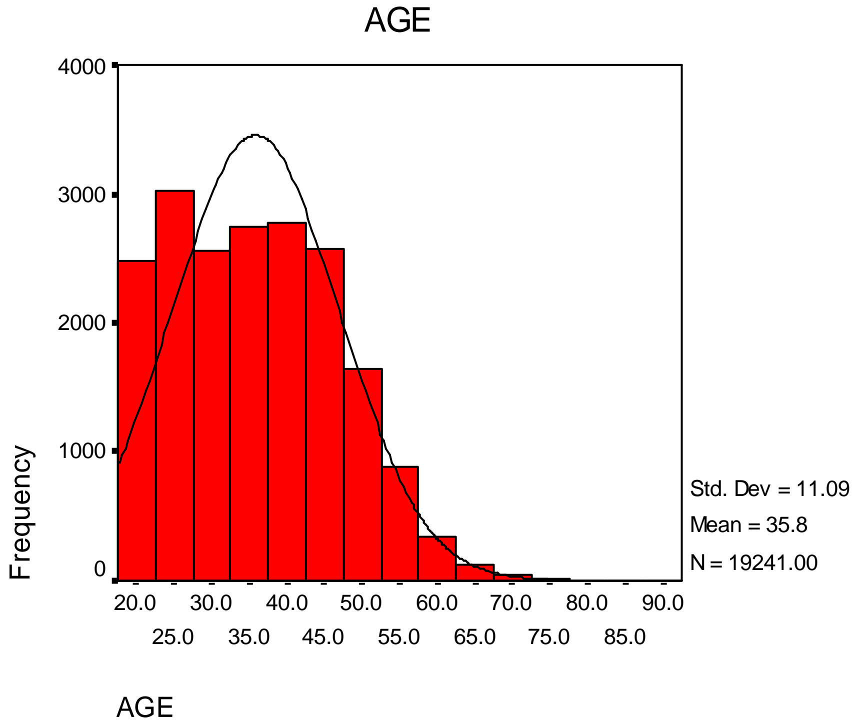
651 **Monarch, Inc.--SA**	302	8.56%
675 Domestic Violence Program, Tulsa--SA	1063	30.15%
906 Norman Alcohol Information Center--SA	476	13.50%
910 **Drug Recovery, Inc--SA**	333	9.44%
913 **Starting Point II--SA**	472	13.39%
Total	3526	100.00%
AGENCY **COD** Agency name by ODMHSAS #		
105 TCBH--COD	1902	57.57%
640 12 & 12--COD	1402	42.43%
Total	3304	100.00%
AGENCY **Adolescent** Agency name by ODMHSAS #		
110 Oklahoma Youth Center--MH	515	100.00%

Demographic Characteristics

In this section the basic demographic characteristics of the population served by the 20 Model and Control programs will be presented. The variables will be used to describe the populations.

Age

Of the 19,241 people on which age was reported, the average age for the people served by the model and control programs was 36 years of age. Almost 92% (17,671) of the people served were between 21 and 61 years of age. Typically, the most productive year's of one's life. There were 372 (1.9%) of those served who were 18 years of age or under, and 249 (1.3%) who were 62 years of age or older (see the following graph).



Gender

There was a slightly higher percentage of males (51.9%) who received treatment and services than females (48.1%). This was significantly different from the number produced by the Statewide percentages. In FY 2005, among those served statewide 47.54% were females and 52.46% were males (see the following table).

Gender of people in the Model and Control Programs

	Frequency	Percent	Cumulative Percent
1 Male	11,354	51.9	51.9
2 Female	10,525	48.1	100.0
	21,879	100.0	

Race/ethnicity

The vast majority of people who receive services in the Model and Control Programs were identified as White (15,281/72%). People identified as Black made-up 13.40% (2,834). Native Americans were the third major group to receive services (1,541/7.29%). Although there

were a small percentage of people who identified themselves as Hispanic (736/3.5%), for the most part, the individuals would have benefited from services provided in Spanish. Overall, these percentages are not significantly different from people served statewide (see the following table).

RACE among people in the Model and Control Programs

	Frequency	Percent	*tatewide*
1 White	15281	72.27	73%
2 Black	2834	13.40	14%
3 Native American	1541	7.29	10%
3. Hispanic	736	3.48	
4 Asian	103	0.49	
5 Multirace	622	2.94	
6 Hawaiian/Pacific Islander	26	0.12	
Total	21,879	100.0	

Education

Education is an important variable. The higher the education levels in a population the better the overall social economic status and health indicators. Among the people in these programs where education level was reported (n = 21,409), the average grade completed for people in the Model and Control Programs was 11th grade. Some 37% reported 11 years of school or less. Some 43.8% reported having 12 years of school. Of the 20% who reported 13 to 16 years of school only 4.3% reported 16 years of education. Overall, at least 56.2% of the people in this sub-sample had 12 years of school or more. In Oklahoma, in 2004, 80% of the people (3,547,884) reported having 12 years of school or more (a portion of this number may not have received a high school diploma).

Employment

A defining characteristic of people receiving services from the Model and Control Programs is their lack of employment. Almost 82% of those receiving services reported being unemployed or not in the labor force. Only 12% were employed full-time. The differences between the population in the Model and Control Programs are slightly different from the

statewide percentages. Statewide, among people receiving services from ODMHSAS, fewer people in this sub-sample are working full time and more people are not in the labor force (see the following 2 tables).

EMPLOYMENT reported at admission in the Model and Control Programs

	Frequency	Percent	*tatewide*
1 full time	2613	11.9	11.9
2 part-time	1330	6.1	18.0
3 unemployed	8988	41.1	59.1
4 Not in labor force	8948	40.9	100.0
Total	21879	100.0	

EMPLOYMENT reported at admission Statewide

	Frequency	Percent	Cumulative Percent
1 full time	3,790	9.4	9.4
2 part-time	2,712	6.7	16.1
3 unemployed	13,393	33.2	49.3
4 Not in labor force	20,461	50.7	100.0
Total	40,356	100.0	

Income

Among the 11, 812 people in the Model and Control Programs on which there is data on income the average income was $12,616. Some 25% earned under $6000. Those between the 25th and 50th percentile earned between $6,000 and $8,500. Those between the 50th and 75th percentile earned between $8,501 and $15,000. One of the most telling statistics is the median income. In this population, 50% of those receiving services from the Model and Control Programs reported an income of $8,485 or less. The per capita money income in Oklahoma in 1999 was $17,646. In this treatment population, almost everyone (92%) had an income below the state per capita individual income level. With all else equal, the rate for this population should be 50% not 92%. It was estimated that in 2003, 14.6% of the people of Oklahoma lived below the poverty level. The people served by ODMHSAS, for whatever reason is a sizable proportion of the group living below the poverty level here in Oklahoma.

Living Situation

The majority of people receiving services from the Model and Control programs lived in a private residence (84.3%). The rest, 14.3% lived in some type of supportive housing or reported having no home (1.5%) (see the following table).

RESDENCS Current Residence

	Frequency	Percent	Cumulative Percent
1 Private Residence	18449	84.3	84.3
2 Residential Care Home	1856	8.5	92.8
3 No Home	326	1.5	94.3
4 Community Shelter	199	.9	95.2
5 Supported Living	33	.2	95.4
6 Institutional Setting	755	3.5	98.8
7 Nursing Home	261	1.2	100.0
Total	21879	100.0	

Over 34% reported that at least one other person was dependent on the income of the person admitted to the Model or Control programs (see the following table).

NUMLIVHO numlivho: Number contributing to and/or dependent on income

	Frequency	Percent	Cumulative Percent
1	14,389	65.8	65.8
2	2,622	12.0	77.8
3	1,920	8.8	86.5
4	1,503	6.9	93.4
5	824	3.8	97.2
6 or more	621	2.8	100.0
Total	21,879	100.0	

Although, only 1.5% reported having "no Home," slightly over 6% were identified as being "chronic homeless." Those identified as chronically homeless are a group that requires specific skills in clinicians that work with this group and typically require more resources. The percentage of "chronic homeless" treatment may be a useful indicator of the general overall effectiveness of the OK-COSIG project (see the following table).

CRON_HOM Chronichomeless: Chronic homeless

	Frequency	Percent	Cumulative Percent
1 Yes	1341	6.1	6.1
2 No	20538	93.9	100.0
Total	21879	100.0	

Martial Status

Martial status is one of those demographic variables that is more often associated with better health outcomes. In the population served by the Model and Control programs only 11.4% were married or living as married (see the following table).

MS maritalname: Marital Status

	Frequency	Percent	Cumulative Percent
1 never married	10224	46.7	46.7
2 divorced	3289	15.0	61.8
3 separated	5385	24.6	86.4
4 widowed	480	2.2	88.6
5 living as married	709	3.2	91.8
6 married	1792	8.2	100.0
Total	21879	100.0	

Veteran Status

Although there are no numbers to compare, the number of veterans served by these Model and Control programs 554 (2.5%) does not seem disproportionate. Only 51 (0.2%) received veteran's benefits. Most veterans, one would assume, are treated by the VA hospital system (see the following 2 tables).

VETERAN Veteran

	Frequency	Percent	Cumulative Percent
1 Yes	554	2.5	2.5
2 No	21325	97.5	100.0
Total	21879	100.0	

VET_BENS Benmilva: Military veteran benefits

	Frequency	Percent	Valid Percent	Cumulative Percent
1 Yes	51	.2	.7	.7
2 No	7594	34.7	99.3	100.0
Total	7645	34.9	100.0	
Missing	14234	65.1		
Total	21879	100.0		

Disabled

There were 8.3% (1,819) people identified as disabled in this sub-population. In Oklahoma, the 2000 census reported that there were an estimated 19.3% (676,098) people who were disabled (see the following table).

DISABLED handicap1name: Disabled (Handicap blank 1)

	Frequency	Percent	Cumulative Percent
0 none	20060	91.7	91.7
1 chronic health problems	1532	7.0	98.7
2 severe sight disability	27	.1	98.8
3 hard of hearing	26	.1	98.9
4 deaf	17	.1	99.0
5 mental retardation/developmental disability	111	.5	99.5
6 semi-ambulatory	87	.4	99.9
7 non-ambulatory	6	.0	99.9
8 blind	9	.0	100.0
10 organic based communication disability	4	.0	100.0
Total	21879	100.0	

Legal Status

Over 72% of admissions were “voluntary admissions.” Even so, 21.3% were “emergency detention.” Another 5% were court commitments. The percentage of “emergency detention” may be a useful indicator of the general overall effectiveness of the OK-COSIG project (see the following table).

LEGAL legalstatname: Legal Status

	Frequency	Percent	Cumulative Percent
1 voluntary admission	15838	72.4	72.4
2 emergency detention	4671	21.3	93.7
3 court commitment	1107	5.1	98.8
4 order of detention	26	.1	98.9
5 court referred	176	.8	99.7
6 transfer-other legal entities	45	.2	99.9
7 juvenile court order	4	.0	99.9
8 protective custody	1	.0	99.9
9 community sentencing	5	.0	100.0
10 other	5	.0	100.0
11 criminal hold	1	.0	100.0
Total	21879	100.0	

Presenting Problem

The primary presenting problem area was related to a mental health issue (66.90%). A substance abuse issue was the second most common presenting problem 24.00%. People involved in the criminal justice system comprised 4.1%. Domestic abuse victims made up 2.6% of those admitted. Among the reported presenting problems related to mental health two need to be highlighted. Of those with a reported mental health issue 21.4% complained about depression. Moreover, 15.00% were suicidal. Ongoing training and education needs to focus on working with people who present with these related mental health issues. Given the effectiveness of the atypical anti-depressants and cognitive behavioral therapeutic interventions, the percentage of people presenting with depression and who are suicidal may be a useful indicator of the general overall effectiveness of the OK-COSIG project (see the following table).

PRIM_PRB probprimname: Presenting Problem-primary

Problem Type	Frequency	Percent	Valid Percent	Cumulative Percent
332 Abuse Victim: Psychological - No Medical Treatment	104	.5	.5	1.4
342 Abuse Victim: Physical - No Medical Treatment	271	1.2	1.2	2.9
352 Abuse Victim: Family	206	.9	.9	4.5

Dependent of Abuse Victim-No Medical Tr				
410 Social Relations Disturbances with Family Member	219	1.0	1.0	5.7
500 Emotional Maladjustment/Disturbance	2571	11.8	11.8	17.8
501 Depression	4663	21.3	21.4	39.2
502 Anxiety/Panic	540	2.5	2.5	41.7
510 Perceptual Problems	514	2.3	2.4	44.1
520 Disorientation	57	.3	.3	44.4
530 Other Psychotic Symptoms	2690	12.3	12.3	56.7
610 Homicidal	145	.7	.7	57.4
620 Assaultive	194	.9	.9	58.3
621 Domestic Abuse Perpetrator	194	.9	.9	59.1
630 Other Behavioral Disturbance	322	1.5	1.5	60.6
631 Involvement with Criminal Justice System	16	.1	.1	60.7
650 Suicide/Self Abuse	3321	15.2	15.2	75.9
710 Alcohol Abuse	409	1.9	1.9	77.8
711 Alcohol Dependence	718	3.3	3.3	81.1
720 Drug/Other Abuse	623	2.8	2.9	84.0
721	1557	7.1	7.1	91.1
730 Poly/Both alcohol & drug	526	2.4	2.4	93.5
731 Poly Dependency/Both alcohol & drug	1384	6.3	6.4	99.9
Sub Total	21788	99.6	100.0	
Missing	91	.4		
Total	21879	100.0		

Drug Involvement

Statewide in FY 2005, alcohol was by far Oklahoma's number one drug of choice. Other drugs such as Marijuana and Methamphetamine continue to show a high percentage of use as well (see the following table).

Statewide Drug Use in FY 2005

Alcohol	56 percent
Marijuana	44 percent
Methamphetamine	31 percent
Cocaine	20 percent

Among the people served by the Model and Control programs, 52.8% reported using alcohol or other drugs. Of those who reported using alcohol or other drugs, 70.2% reported

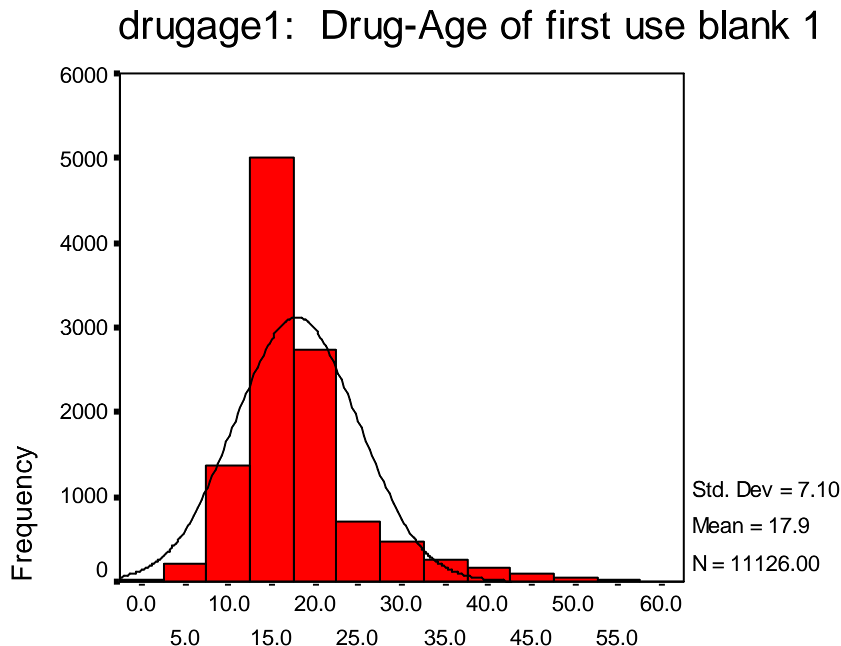
using alcohol. Marijuana was the choice of 9%, while methamphetamine was the choice of 8.4%, and cocaine was the choice of 5.9%. In the population served by the Model and Control programs, alcohol is significantly more preferred by people reporting alcohol and drug use than their counterpart statewide. As well, there are a significantly smaller percentage of people who prefer illegal drugs in this sub-population as compared to ODMHSAS clients as a group (see the following table).

DRUG_1ST drugch1name: Drug of choice blank 1

	Frequency	Percent	Valid Percent	Cumulative Percent
1 none	10344	47.3	47.3	47.3
2 alcohol	5024	23.0	23.0	70.2
3 heroin	66	.3	.3	70.5
4 non-rx methadone	19	.1	.1	70.6
5 other opiates & synthetics	349	1.6	1.6	72.2
6 barbiturates	15	.1	.1	72.3
7 other sedatives	36	.2	.2	72.5
8 amphetamines	286	1.3	1.3	73.8
9 cocaine	1290	5.9	5.9	79.7
10 marijuana/hashish	1978	9.0	9.0	88.7
11 other hallucinogens	16	.1	.1	88.8
12 inhalants	30	.1	.1	88.9
13 over-the-counter	12	.1	.1	89.0
14 tranquilizers	10	.0	.0	89.0
15 pcp	26	.1	.1	89.1
16 other	24	.1	.1	89.2
17 unknown	409	1.9	1.9	91.1
18 methamphetamine	1830	8.4	8.4	99.5
19 benzodiazepine	110	.5	.5	100.0
20 other stimulants	3	.0	.0	100.0
Sub Total	21877	100.0	100.0	
Missing	2	.0		
Total	21879	100.0		

The average age of first drug experience among this population was 17.88. The median age was 16. Over 78% of people admitted to the Model and Control programs for treatment, who reported "age of first drug use" said they had used drugs before the age of 21. Research has shown a correlation between age of first use and later problems with substance abuse and mental

health problems. In this population there is a very significant correlation between "age of first use" and the ASI Alcohol use subscale (r = 226, p < .0001), and the ASI drug use subscale (r = .094, p < .0001) (see the following graph).

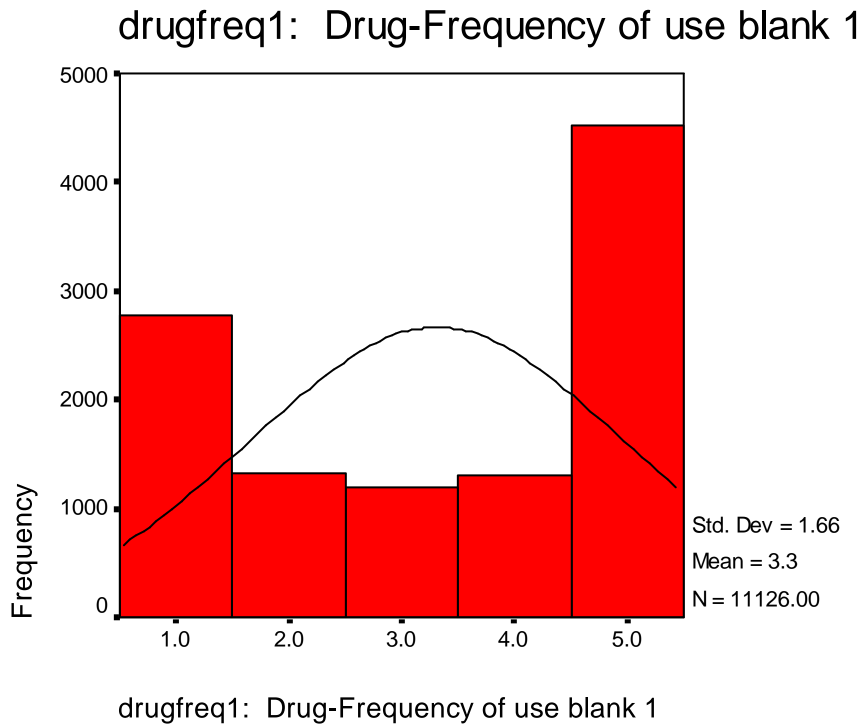


drugage1: Drug-Age of first use blank 1

Another important predictor of the poor health outcomes is drug frequency. In this group, those who reported "frequency of drug use" had an average score of 3.31 (where 3 = 1-2 times per week) with a median of 4.00 (where 4 =3-6 times per week). Around 41% report daily use before admission.

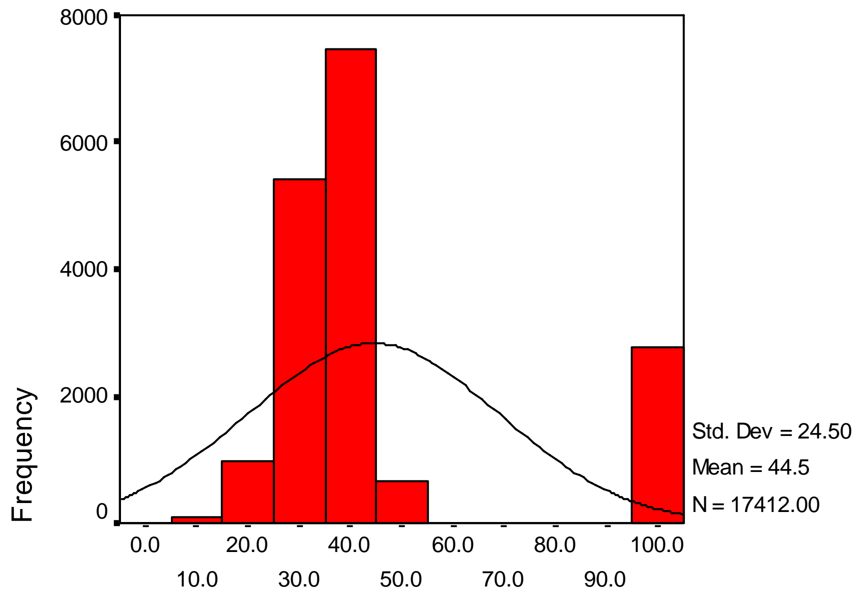
Typically, the frequency of use is a predictor of poor health outcomes. This was true for the population served by the Model and Control programs. A significant correlation was found between higher frequency of drug use and the poorer Global Assessment of Functioning (GAF) score (r = - .204, p < .0001). There was also a correlation between the frequency of drug use and the CAR mood subscale (r = .176, p < .0001), and the CAR thinking subscale (r = .126, p < .0001). There was an important correlation between frequency of drug use and people over 18 with a serious mental illness (r = .219, p < .0001). Given the improved effectiveness of

treatment for people with the co-occurring disorders of substance abuse and mental illness, the correlation between serious mental illness and frequency of drug use may be a useful indicator of the general overall effectiveness of the OK-COSIG project (see the following graph).

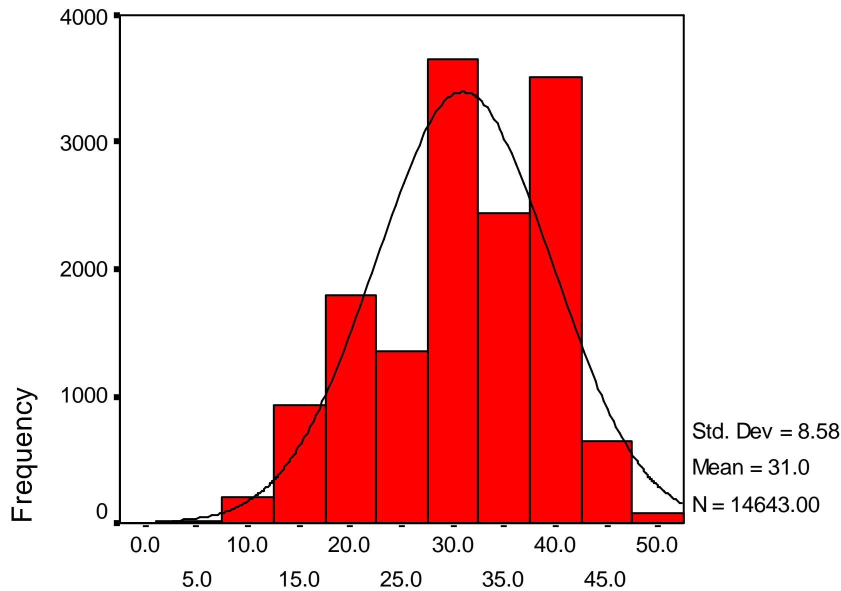


Assessment

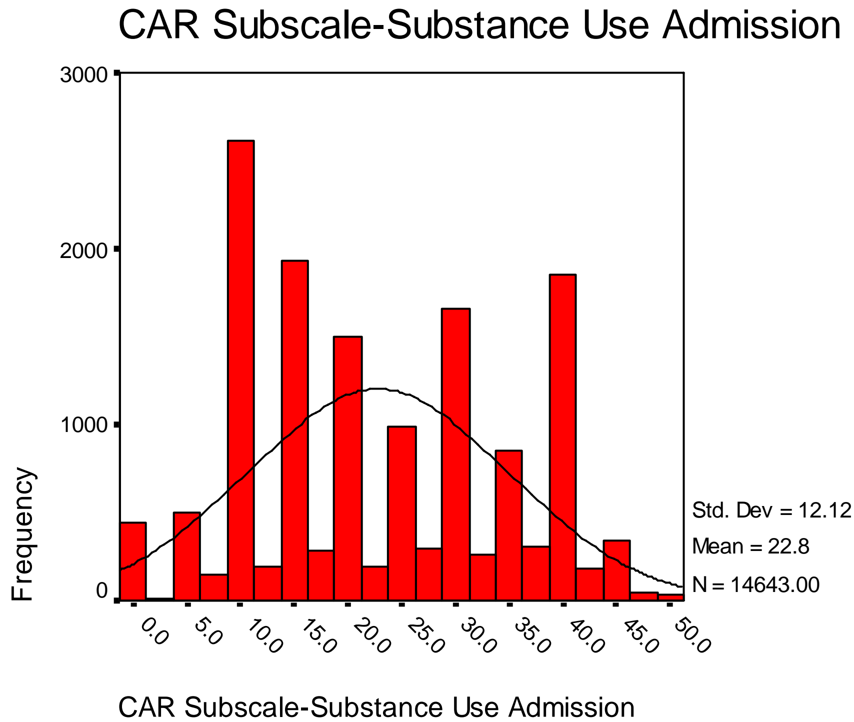
Mental Health: Those asking for mental health treatment from the Model and Control Programs that provided mental health treatment were assessed using the CAR. Among people who took the CAR in this population, the average CAR score on the **mood** subscale (n = 14,643) was 34.17 (standard deviation = 6.74). The median score was 35. Only 16% had a score of less than 30 which indicates there is no serious mood disturbance (see the following graph).



Among people who took the CAR in this population, the average CAR score on the **thinking** subscale (n = 14,643) was 30.96 (standard deviation = 8.58). The median score was 31. Some 34% had a score of less than 30 which indicates there is no serious thinking disturbance (see the following graph).



Among people who took the CAR in this population, the average CAR score on the **Substance Use** subscale (n = 14,643) was 22.77 (standard deviation = 12.12). The median score was 20. Some 36.1% had a score of 30 or more which indicates that the person has a serious Substance Use problem (see the following graph).

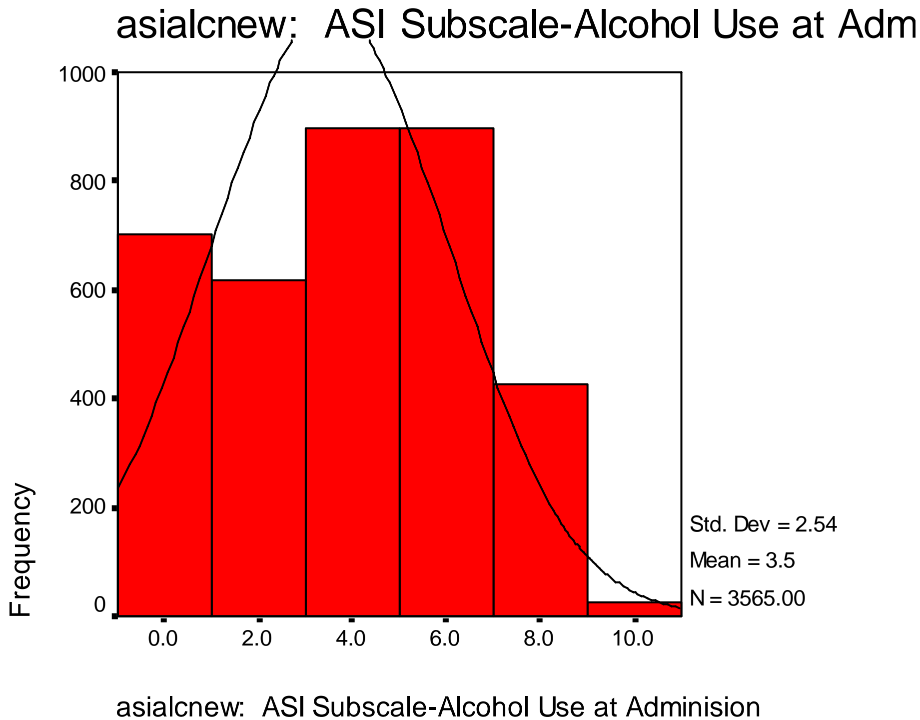


Substance Abuse: Those asking for substance abuse treatment among the Model and Control Programs were assessed using the ASI.

Among people who took the ASI in this population, the average ASI score on the **alcohol use** subscale (n = 3,565) was 3.52 (standard deviation = 4.00). The median score was 2.54. Some 37.8% had a score of more than 5 which indicates the person has a serious alcohol use problem (see the following table and graph).

ASIALCU1 asialcnew: ASI Subscale-Alcohol Use at Admission

	Frequency	Percent	Valid Percent	Cumulative Percent
0	703	3.2	19.7	19.7
1	373	1.7	10.5	30.2
2	244	1.1	6.8	37.0
3	278	1.3	7.8	44.8
4	619	2.8	17.4	62.2
5	345	1.6	9.7	71.9
6	552	2.5	15.5	87.3
7	289	1.3	8.1	95.5
8	137	.6	3.8	99.3
9	25	.1	.7	100.0
Sub Total	3565	16.3	100.0	
Missing	18314	83.7		
Total	21879	100.0		

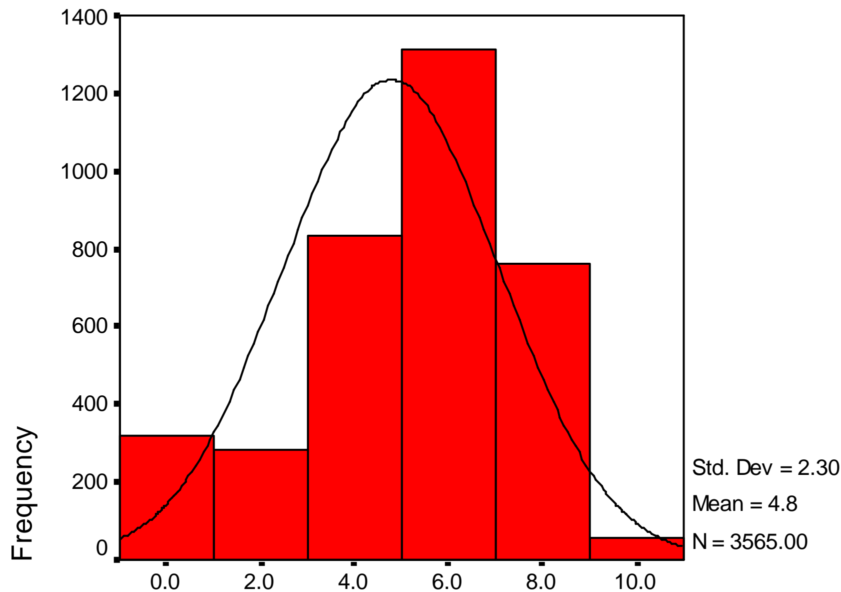


Among people who took the ASI in this population, the average ASI score on the **drug use** subscale (n = 3,565) was 4.77 (standard deviation = 2.30). The median score was 5. Some

59.8% had a score of more than 5 which indicates the person has a serious drug use problem (see the following table and graph).

ASIDG1 asidrugnew: ASI Subscale-Drug Use at Admission

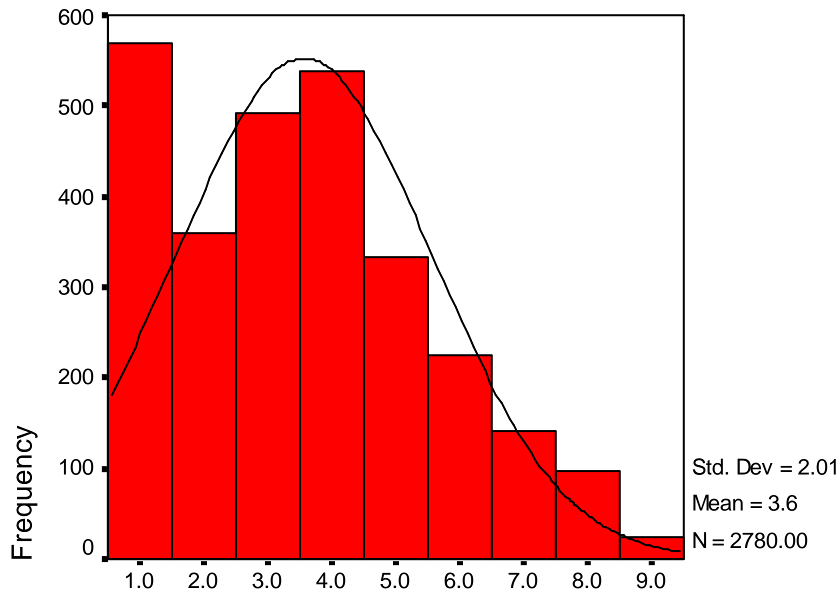
	Frequency	Percent	Valid Percent	Cumulative Percent
0	317	1.4	8.9	8.9
1	180	.8	5.0	13.9
2	101	.5	2.8	16.8
3	175	.8	4.9	21.7
4	661	3.0	18.5	40.2
5	480	2.2	13.5	53.7
6	831	3.8	23.3	77.0
7	533	2.4	15.0	91.9
8	230	1.1	6.5	98.4
9	57	.3	1.6	100.0
Sub Total	3565	16.3	100.0	
Missing	18314	83.7		
Total	21879	100.0		



Among people who took the ASI in this population, the average ASI score on the **psychiatric status** subscale (n = 2,780) was 3.57 (standard deviation = 2.01). The median score was 3. Some 29.5% had a score of more than 5 which indicates the person had a serious psychiatric disturbance (see the following table and graph).

ASI_PSY1 asipsychnew: ASI Subscale-Psychiatric Status Admission

	Frequency	Percent	Valid Percent	Cumulative Percent
1	569	2.6	20.5	20.5
2	359	1.6	12.9	33.4
3	493	2.3	17.7	51.1
4	538	2.5	19.4	70.5
5	334	1.5	12.0	82.5
6	225	1.0	8.1	90.6
7	142	.6	5.1	95.7
8	96	.4	3.5	99.1
9	24	.1	.9	100.0
Total	2780	12.7	100.0	
Missing 0	780	3.6		
Missing	18319	83.7		
Total	19099	87.3		
Total	21879	100.0		



Diagnoses

In this population of those admitted to the Model and Control programs approximately 79% have a diagnosis. Some of the diagnoses are presented below. In future analysis, the diagnoses will be grouped into logical clusters and the clusters will be used to support the estimated number of people with co-occurring disorders. The primary or secondary diagnosis of substance abuse combined with a primary or secondary diagnosis of a serious mental health problem will be another measure of the number of people serviced in the Model and Control programs who likely have a co-occurring problem (see the following 3 tables).

AXIS_1 disaxis1primname: DSM-IV Axis 1 Primary at discharge

	Frequency	Percent
.00 NOT diagnosed	3095	14.1
295.30 Schizophrenia Paranoid Type	905	4.1
295.70 Schizoaffective Disorder	1230	5.6
296.30 Major Depressive Disorder, Recurrent Unspecified	225	1.0
296.32 Major Depressive Disorder, Recurrent Moderate	600	2.7
296.33 Bipolar I Disorder,... Without Psychotic Features	1393	6.4

296.34 Bipolar I Disorder,...With Psychotic Features	983	4.5
296.44 Bipolar I Disorder,...Severe With Psychotic Features	316	1.4
296.53 Bipolar I Disorder, ...Severe Without Psychotic Features	209	1.0
296.54 Bipolar I Disorder,...Severe With Psychotic Features	252	1.2
296.64 Bipolar I Disorder, Mixed Severe With Psychotic Features	194	.9
296.80 Bipolar Disorder NOS	399	1.8
296.90 Mood Disorder NOS	1024	4.7
298.90 Psychotic Disorder NOS	998	4.6
303.90 Alcohol: Dependence	475	2.2
304.40 Amphetamine: Dependence	287	1.3
304.80 Polysubstance Dependence	714	3.3
309.40 Adjustment Disorders: W Mixed Disturb of Emotions/Conduct	208	1.0
309.81 Posttraumatic Stress Disorder	348	1.6
311.00 Dementia the Alzheimer's...Late Onset: Depres DisorNOS	1420	6.5
313.81 Oppositional Defiant Disorder	294	1.3
314.01 Attention-Deficit/Hyperactivity Disorder: Combined Type	259	1.2
998.00 diagnosis or condition DEFERRED on axis 1	1432	6.5
999.00 NO diagnosis or condition on axis 1	61	.3
Total	21850	99.9
Missing	29	.1
Total	21879	100.0

AXS1_SEC axis1secname: DSM-IV Axis 1 Secondary

	Frequency	Percent
.00 NOT diagnosed	9499	43.4
296.33 Bipolar I Disorder,...Severe Without Psychotic Features	256	1.2
296.34 Bipolar I Disorder, ...Severe With Psychotic Features	229	1.0
296.90 Mood Disorder NOS	374	1.7
298.90 Psychotic Disorder NOS	213	1.0
303.90 Alcohol: Dependence	585	2.7
304.30 Cannabis: Dependence	215	1.0
304.80 Polysubstance Dependence	866	4.0
305.20 Cannabis: Dependence	368	1.7
305.90 Caffeine: Intoxication	336	1.5
309.81 Posttraumatic Stress Disorder	436	2.0
311.00 Dementia the Alzheimer's...Late Onset: Depres DisorNOS	485	2.2
998.00 diagnosis or condition DEFERRED on axis 1	1750	8.0
999.00 NO diagnosis or condition on axis 1	1597	7.3
Total	21834	99.8
Missing	45	.2
Total	21879	100.0

AXIS_2 axis2primname: DSM-IV Axis 2 Primary

	Frequency	Percent
.00 none	13102	59.9
1.00 diagnosis deferred	3693	16.9
2.00 no diagnosis	3745	17.1
3.00 antisocial personality disorder	661	3.0
6.00 borderline personality disorder	327	1.5
Total	21772	99.5
Missing	107	.5
Total	21879	100.0

Services Information

People utilizing the services from the Model and Control programs most often used Community Crisis Care (51.2%). They also used Non-medical Detox (17.4%) and outpatient services (15.4) at a much lesser rate(see the following table).

TYP_CARE Sublevcarename: Sublevel of care

	Frequency	Percent	Cumulative Percent
1 Outpatient	3368	15.4	15.4
2 Community Crisis Care	11201	51.2	66.6
3 Acute Hospital	540	2.5	69.1
4 Non-medical Detox	3801	17.4	86.4
5 Community Living	1853	8.5	94.9
6 Intensive Resid.	1116	5.1	100.0
Total	21879	100.0	

Days in treatment

Of the 18,770 people who were discharged, the average days in treatment was 75 days (standard deviation = 103 days). Of those discharged, 25% were in treatment 5 days or less. Those between the 25th and 50th percentile were in treatment between 6 and 21 days. Those between the 50th and 75th percentile were in treatment between 22 and 115 days. The range was from 1 day to 626 days. Days in treatment will become more important when the programs are analyzed in their logical groups. Mental health and substance abuse treatment programs will be compared to other mental health or substance abuse programs. In this large database, Community Crisis Care, for example, which typically by design provides fewer “days in treatment” tends to eschew the average number of days in treatment to a lower average.

Discharge Status

This is an important measure of effectiveness. The effectiveness of the engagement model is manifested in the rate of people completing treatment. In this case, among the people being treated by the Model and Control programs in FY 2005, 47.3% “completed treatment.” The percentage of people who “completed treatment” may be a useful indicator of the general overall effectiveness of the OK-COSIG project. If the “No wrong door” and the “Welcoming” philosophy and policy are successful the number of people completing treatment should be significantly increased. It would also be expected that the number of people transferred to another treatment Facility will increase as more people as transferred to a facility more able to treat their presenting problem(see the following table).

DISCHAR1 Discharge Type: (distranstypename)

	Frequency	Percent	Valid Percent	Cumulative Percent
1 Discharge/Completed Treatment,	10243	46.8	52.4	52.4
2 Discharge/Transferred to another treatment Facility	1313	6.0	6.7	59.1
3 Discharge/Left ACA/90 Days,	3569	16.3	18.3	77.3
4 Discharge/Failed to begin treatment	863	3.9	4.4	81.8
5 Discharge/Due to Treatment Incompatibility,	96	.4	.5	82.3
6 Discharge/Broke rules	521	2.4	2.7	84.9
7 Discharge/Moved	532	2.4	2.7	87.6
8 Discharge/Administrative Discharge	1647	7.5	8.4	96.1
9 Discharge/Administrative Discharge	401	1.8	2.1	98.1
10 Discharge/Death	48	.2	.2	98.4
11 Discharge/AWOL	128	.6	.7	99.0
12 Discharge/Incarcerated	89	.4	.5	99.5
13 Discharge/Completed Court Commitment	105	.5	.5	100.0
Total	19555	89.4	100.0	
Missing 0	2324	10.6		
Total	21879	100.0		

Estimating the Number of People with a Co-occurring disorder based on the ASI and CAR Assessments

There were 14,643 CAR Substance Abuse subscales (CAR_sa) and the 2,776 ASI Psychiatric (ASI_psy) subscales administered to people in the Model and Control programs. Of

the 17,423 subscales administered, 1,879 were duplicates (people were administered both the CAR_sa subscale and the ASI_ psy subscale). Taking out the duplicates, there were 13,661 people tested for a co-occurring disorder with the CAR_sa subscale and ASI_ psy . Of this number, 4,865 or 35.61% of the individuals assessed had a positive score for a co-occurring disorder on the ASI_ psy subscale or the CAR_sa subscale. Based on this percentage (35.61%), out of the 21,879 people admitted for treatment to the Model and Control programs an estimated 4,865 were most likely people with a co-occurring disorder.

To determine the percentage of people with a co-occurring disorder using the CAR_sa or the ASI_psy, first the number of people who were administered both CAR_sa and the ASI_psy had to be determined. To identify duplicates the CAR_sa subscale and the ASI_psy were converted to nominal variables. The CAR_sa3 subscale values are 1 = Not COD and 2 = COD. The ASI_psy3 subscale values are 10 = Not COD and 20 = COD. Next, by adding the scores of the CAR_sa3 and the ASI_psy3 for each case will make a new variable COD_CN1. The COD_CN1 produces a combination of values that identify people who were administrated both the CAR_sa and the ASI_psy (See tables below).

CAR_AD3 Car Substance Scale: 1 -29 = 1: 30 -50 = 2

	Frequency	Percent	Valid Percent	Cumulative Percent
Score				
0 No CAR	7236	33.1	33.1	33.1
1 Below SA level	9353	42.7	42.7	75.8
2 COD	5290	24.2	24.2	100.0
Total	21879	100.0	100.0	

ASI_PSY3 1 to 4 = 1 = no problem; 5 t0 8 = 4 = problem

	Frequency	Percent	Valid Percent	Cumulative Percent
Score				
0 No ASI	19103	87.3	87.3	87.3
1 Below SA level	1956	8.9	8.9	96.3
2 COD	820	3.7	3.7	100.0
Total	21879	100.0	100.0	

COD_CN1

	Frequency	Percentage	Valid Percent	Cumulative Percent
Score				
.00	6339	29.0	29.0	29.0
1.00	8195	37.5	37.5	66.4
2.00	4569	20.9	20.9	87.3
10.00	628	2.9	2.9	90.2
11.00	811	3.7	3.7	93.9
12.00	517	2.4	2.4	96.3
20.00	269	1.2	1.2	97.5
21.00	347	1.6	1.6	99.1
22.00	204	.9	.9	100.0
Total	21879	100.0	100.0	

Estimates of percentage COD identified by (CAR and ASI Assessments)

To determine the percentage of people with a co-occurring disorder based on the ASI_ psy subscale and the CAR_sa subscale, the number of positive assessment is divided by the total number of assessments done in each domain:

⇒ In programs with a Mental Health focus, 3,457 CAR_sa scores were positive out of 9,701 or 36% of those being assessed with the CAR_sa.

⇒ In programs with a Substance Abuse focus, 380 ASI_ psy scores were positive out of 2,351 which is 16% of those being assessed with the ASI_ psy.

⇒ In programs with a Co-occurring focus, 367 CAR_sa and ASI_ psy scores were positive out of 3,120 which is 12% of those being assessed with the CAR_sa and ASI_ psy.

⇒ In the Adolescent mental health program, 137 CAR_sa scores were positive out of 363 which is 38% of those being assessed with the CAR_sa.

Interestingly, the ASI_ psy subscale in this population identifies a smaller percentage of people with a psychiatric disorder than would be expected. Typically in a substance abuse disorder treatment population, the percentage of people with a co-occurring disorder is within the 30% range. However, there is absolutely no correlation between the ASI_ psy at admission and the ASI_ psy at discharge ($r = -.10$; $p = .854$). This indicates that knowing the ASI_ psy score at admission cannot predict the score at discharge. This finding supports the belief that clinicians and people seeking admission to an SA program are biased against psychiatric issues. The admission CAR_sa score, on the other hand, is very predictive of the post CAR_sa score ($r = .919$; $< .0001$). In fact, all of the CAR admission subscale scores correlated very strongly with the CAR discharge scores. Even more puzzling, all of the ASI subscales are highly predictive of the discharge ASI subscale scores with the exception of the ASI_ psy subscale.

Defining Co-occurring disorders using DSM IV Diagnoses

The DSM IV diagnoses can also be used to identify people who have a co-occurring disorder. Although the numbers of people who have both a Primary and Secondary Axis I diagnosis 6,065 is much smaller than the number who received a diagnosis, it is still informative to know what percentage of people was given a co-occurring diagnosis. The definition of a co-occurring diagnosis is when the primary and secondary diagnosis has any combination of a mental health disorder and a substance abuse disorder.

Using the above definition, in this population admitted to the Model and Control programs, when the *Primary Axis I diagnosis* is a Substance Abuse disorder, 374 people have a *Secondary Axis I diagnosis* of a Mental Health Disorder.

When the *Secondary Axis I diagnosis* is a Substance Abuse disorder, 2,365 people have a *Primary Axis I diagnosis* of a Mental Health Disorder.

In this group, 41.5% had a co-occurring disorder. Some 9% (596) were given a substance abuse disorder on both the Axis I primary and Axis I secondary diagnosis.

A large number of people in this population were diagnosed with a Mood Disorder (48%). Interestingly, in this population, 23.4% of people with an Axis I primary diagnosis of Mood Disorder was given a substance abuse disorder as their secondary Axis I diagnosis. This finding may be useful in planning future clinical training.

Of the 16,664 people that had a *primary* Axis I diagnosis, 2,530 (15%) were diagnosed with a substance abuse disorder. Of the 8,488 people that had a *secondary* Axis I diagnosis, 4,121 (49%) people were diagnosed with a substance abuse disorder (see the table below).

AXSEC_CA Axis I Secondary Diagnosis in groups * AX1_CATS Axis I Primary Diagnosis in groups Crosstabulation

		AX1_CATS Axis I Primary Diagnosis in groups						Total
		1.00 Substance abuse DX	2.00 Psychotic DX	3.00 Mood Disorder DX	4.00 Anxiety DX	5.00 Childhood DX	6.00 Other DX	
AXSEC_CA Axis I Secdry DX in groups	1.00 Substance abuse DX	596	468	1547	194	156	277	3238
	2.00 Psychotic Dx	44	78	139	14	17	28	320
	3.00 Mood Disorder Dx	218	213	721	103	64	137	1456
	4.00 Anxiety DX	112	97	410	72	39	71	801
	5.00 Childhood DX	53	40	174	29	28	32	356
	6.00 Other DX	78	52	211	31	24	38	434
Total		1101	948	3202	443	328	583	6605

Determining the Best Percentage to Estimate Co-occurring Disorders

Based on the analysis of the data collected by the Model and Control programs and the analysis in this section, **the best percentage to use to estimate the number of people admitted for treatment with a co-occurring disorder in this population is 35%** (See the tables below). The reason for selecting this percentage (35%) to estimate the number of co-occurring individuals who are admitted for treatment as the Oklahoma Co-Occurring Estimator (OK-OCOE) was based on a number of observations. The ASI_psy is surely underestimating the occurrence of psychiatric issues. The diagnoses are probably over estimating the number because of selection bias. The more complicated cases tend to be referred for a diagnosis.

Typically Co-occurring cases are complicated. The CAR_sa is probably fairly close (as verified by the correlation between the admission and discharge CAR_sa, r = .919; < .0001) although it is surely a slight over estimation. Based on the data to this point, the OK-OCOE is probably the best percentage (35%) to use to approximate the number of people with co-occurring disorders admitted to ODMHSAS mental health and substance treatment programs. You may want to refer back to page 6 of this report to review the number of people reported to be admitted with a co-occurring disorder in FY02 and FY03.

CAR	
9353	Not
5290	COD
14643	
36.13%	

ASI	
1956	Not
820	COD
2776	
29.54%	

COD DX	
374	Prim DX SA. Sec DX MH.
2365	Prim DX MH. Sec DX SA.
2739	**Total COD DX**
6065	**Total Cases with Primary & Secondary DX**
3866	Not COD
41.5%	**DX COD**

CAR	
4569	Unique con-cn1=2 COD
12764	Unique CAR
35.76%	Car COD
CAR	
9353	Car = 1
5290	Car = 2
14643	Total CAR Dup
Unique CAR	
8195	CON-CN1 =1
4569	CON-CN1 =2 COD
12764	Unique CAR
CAR	
14643	Total CAR Dup
-12764	Unique CAR
1879	**Duplicate CAR**

ASI	
269	Unique CON-N1=20 COD
897	Unique ASI
29.99%	ASI COD
ASI	
1956	ASI = 10
820	ASI = 20
2776	Total ASI Dup
Unique ASI	
628	CON-N1=10
269	CON-N1=20 COD
897	Unique ASI
ASI	
2776	Total ASI Dup
-897	Unique ASI
1879	**Duplicate ASI**

Total COD
296
4569
<u>4865</u>
Total Tested
12764
897
13661
Percentage COD
35.61%

Comparing the Population of the Model Programs with the Control Programs

When testing a program intervention such as the OK-COSIG project is doing, one important condition is that the programs are similar. In a group comparison such as this, it is extremely important that the Model and Control programs (programs with a substance abuse focus) work with similar populations. In that way, if the population outcomes change it was not an artifact of work with different populations. Among these Model and Control programs, using an Independent Samples t-Test, only two significant differences were found when the programs were compared on the following characteristics:

RACE
SEX
AGE

EDUCATIO Highest grade completed, years of school
DAYS_TX Number of days in treatment (if 0 not discharged)
INCOME Income at admission
DRG1ONST drugage1: Drug-Age of first use blank 1
DRGFRQ_2 drugfreq2: Drug-Frequency of use blank 2
GAF_ADM lof: Level of functioning (GAF scale) Admission
CAR_MOD1 carmood: CAR Subscale-Feeling and Mood Admission
CAR_AD1 CAR Subscale-Substance Use Admission
ASI_PSY1 asipsychnew: ASI Subscale-Psychiatric Status Admission
ASIALCU1 asialcnew: ASI Subscale-Alcohol Use at Admission
ASIDG1 asidrugnew: ASI Subscale-Drug Use at Admission
ASIFSR1 asifamilynew: ASI Subscale-Family/Social Relations at Admission
ARST30_1 arrested30days: Number of arrests in the past 30 days, or since admission, if less than 30 days
ARST60_1 arrested6months: Number of arrests in the past 6 months, or since admission, if less than 6 months
CAR_AD3 Car Substance Scale: 1 -29 = 1: 30 -50 = 2
AXIS_1 axis1primname: DSM-IV Axis 1 Primary at discharge
AXS1_SEC axis1secname: DSM-IV Axis 1 Secondary

One difference was that Model programs had a longer average length of stay. This is probably an artifact caused by the DV program ($t = 7.757$; $df = 3318$; $p < .0001$). There are also a significantly higher number of positive scores on the ASI_psy from the Model programs (826) than from the Control programs (675) ($t = 7.944$; $df = 1499$; $p < .000$). There was also no significant difference between the Axis I primary diagnosis of people admitted to the Model and Control programs (Phi = .08; $p < .0001$). Nor was there any significant difference between the Axis I secondary diagnosis of people admitted to the Model and Control programs (Phi = .051; $p < .596$).

Given the lack of differences between the populations of Model and Control substance abuse focused program the group comparison approach using the ICIS data base will help identify changes that occur in the future because of the OK-COSIG project.

The Mezzo Evaluation

The Interviews and Focus Group

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. Sites for this assessment will be selected to provide equal coverage of all service areas within the State.

Key Information Interviews and Focus Group Data

The Mezzo level evaluation of the service coordination and networking within the state related to providing services to people with co-occurring disorders began with Stage 1. In Stage 1, 12 key informants were interviewed. The 12 randomly selected key informants were selected from a list of 30 people who were state level and agency level employees familiar with the OK-COSIG project. Once the interviews were completed important themes related to service coordination, networking, and barriers were identified and categorized. Using a slightly modified Delphi methodology to obtain a multi-level perspective, in Stage 2 a focus group of 10 model program and state level personnel met to review, discuss, revise, and confirm the validity of the themes. The focus group members were also asked to rank the themes in relationship to where the best work was done over the last year as a result of the OK-COSIG efforts.

Major Themes from the Key Informant Interviews

1. Barriers of entering into treatment center…
   a. Being short staffed, burnout or stressed out staff, better educated staff, lack of resources, and unavailability of full continuum of care, housing, and lack of transportation. Some staff members dismissed RSS's input because they felt they did not have the same level of education or training as they did.
   b. Facilities unwillingness to treat multiple issues and lack of qualified staff.
   c. At administrator level, access barrier for people of color and cultural issues
   d. The availability of space. There is a week to a month long waiting list. Strike while the iron is hot, get treatment when you ask for it, even the private payer has trouble- funding barriers for the agency.
   e. Availability of beds, due to limited space, to be matched from a cultural and financial perspective, and timing of services available.
2. How well are mental health providers or substance abuse providers dealing with the opposing problem?
   a. Poorly to barely adequate. Inadequate staffing, and the idea that unless you've been thru substance abuse TX it is impossible for you to understand.

b. Not really sure. The best that they can; lack psychiatric coverage. Both recognize that this is a problem, but clueless on how to deal with or treat. There is increased awareness.
c. Doing a pretty good job. That's what I hear from mental health administrators.
d. Not very well, problems ignored. Physicians are prescribing addictive meds to substance abusers.
e. They both are still pretty rigid, not treating both problems well at all. They're still leery of working with the opposite.

Why do you think this is the case?

a. Lack of funding is a sore spot for substance abuse agencies, and no training in dealing with mental health.
b. COSIG trainings have reduced some of the barriers.
c. Lack of cross training. No education. Some people still see substance abuse as a moral issue. Lack of desire in working together- substance abuse staff vs. mental health staff.

3. Discussion at state level with regards to DTR…
   a. Not been in on any discussion.
   b. Removed from that, have not heard any.
   c. Email this morning about training for those who'd be interested in leading DTR groups, a list of meetings, agency locations, and dates and times. Lots of conversations-Detailed and Descriptive. However, Dual Recovery Anonymous (DRA) is not really being used, and it may be a better choice.
   d. There is a lot of talk about Double Trouble in Recovery. It is a "huge" part.
4. Dual Diagnosis integrated treatment within ODMHSAS look like…
   a. A variety of different ways, with four quadrants, and agency advancement.
   b. Making an attempt to integrate the two. Mostly, its just theory. I am hoping that it becomes more practical, it's not concrete enough. The policies are too vague.
   c. It should be more seamless. We should be able to accommodate for this without there being a gap in services.
   d. Today, it is dependent upon the facility itself. Future, no wrong door for consumers. Co-occurring enhanced, one comprehensive place to treat both disorders and agencies that

are co-occurring competent that works collaboratively to treat the person with a co-occurring disorder.

e. Anyone who comes into any treatment center will not be turned away. "No wrong door." Provide treatment for both disorders.

What would you like for it to look like?

a. More mainstream, less stigma, more integrated, with a focus on the mind, body, and spirit.
b. Hoping that it becomes more practical.
c. Would like for everybody to be at the table, and for there to be room for everybody. Not every ethnic group is represented equally.
d. The future plan, more of co-occurring enhanced.

5. Co-occurring services being provided…

a. Too often the attitude prevails "You name it we do it; mental health, substance abuse services, all ages, residential, and integrated services" without trained clinicians.
b. Community based crisis services: SA, MH, or both. Only two state facilities are SA focused.
c. Several facilities are state operated. There is a division between the services. The client is bounced back and forth. Agencies under Department funding must perform a needs assessment/placement assessment to ensure that the consumer gets the services that they need. No one does a good job of including family in treatment.
d. Integrated model of case management and mental health medication education for substance abusers.

6. Policy for assessing for co-occurring disorders…

a. Not aware of a policy for assessing, but was aware of the OK-COD Screen.
b. In process of testing a new assessment tool for Dr. Cherry- testing validity and reliability. Not sure of actual policy.
c. ASI and Biopsychosocial being used.

7. Barriers to implementation:

a. Consensus, paperwork load, healthcare authority, and Medicaid protocol.
b. People's perspectives and establishing clear guidelines of what is expected.

c. All of the parties who have been working on the project seem to have a good sense about where this needs to go.

8. Satisfaction of Stakeholders…
   a. Some complaints. Trainings take staff away from agencies, not convenient, and there is redundant information in the trainings.
   b. They are very satisfied.
   c. Real good, discussed at the advisory board meeting last week. Lots of support and we are on the road to success. Impressed about the support and positive attitudes.
   d. Really excited about what should have been happening all along. Nothing negative.
9. Advice for COSIG staff…
   a. The trainers (Dr. Minkoff) really go out on site and listen to the consumer and clinicians. There is a need for desktop trainings with programs of practice.
   b. Get input from more than one person or side. Be clear when establishing components, communicating what you have designed to every party that will be impacted.
   c. Remain open to gain some sense of another's culture.
   d. Keep spreading the message. Continue the paradigm shift within the state.
   e. To communicate with everyone openly.

Based on these vital phrases and ideas, themes were developed and organized under 7 categories: Assessment, Training, Orientation, Self Help, Service Barriers, and Services Provided. These categories and themes were presented to the focus group. The members of the focus group deliberated for almost two hours. They added themes and came to a consensus on the rank order of the themes in each category. The ranking of the themes are presented in the following table.

OK-COSIG: Categories of Themes and their Elements
Revised by an ISI focus group 12-5-6
Note: Text inside the parentheses is comments added by the focus group.

ASSESSMENT	TRAINING	FUNDING	ORIENTATION	SELF HELP	SERVICE BARRIERS	SERVICES PROVIDED
3—Under assessment of trauma (Intermediate training/more conversation)	**1—**Cross Training (outreach training)	**4—** Transportation for consumers	**3**—Clinician stereotypes regarding MH/SA consumers	**1—** Promoted	**4a—**Availability-Wait List	Residential
1—Compliance	**3**—Training for Staff to assist Consumers with starting Self Help	**1—** Medications	**5—**Competitive, leery of working with other	**3**—Finding leaders	**3**—Substance Abuse treated second to Mental Health	**4—**Outpatient (agencies need more outpatient services for COD)
Qualifications	**2—**Training Consumers to Start Self Help	**2—**Differential funding for substance abuse	**2—**Unless been through substance abuse can't treat	**2—** Resource List	**4b—**Separate at all levels from leadership down	Family (need assistance for family education, another lack of funding)
2— (Not) Overwhelming to Consumers-2	**4—a** Legal System (DHS, DOC, APS, OJA, Drug Court, Mental Health Court)	Incentives to participate in COSIG	**1—**Reluctance MH providers to treat SA and vice versa-	**4—**Role for Advocates	Culturally Congruent (approaching awareness)	Vocational (more emphasis needs to be put on training)
Intrusive to Consumers	**4—b** Churches (Community and Civic organizations Local shelters)	**3**—Funding for assessment	**4—**Reluctance to working with peer trainers and advocates		Treat one and then monitor the other	**3**—Psychiatric Medication Management Only (educate Dr.'s at agencies)

Continued:

OK-COSIG: Categories of Themes and their Elements
Revised by an ISI focus group 12-5-6
Note: Text inside the parentheses is comments added by the focus group.

ASSESSMENT	TRAINING	FUNDING	ORIENTATION	SELF HELP	SERVICE BARRIERS	SERVICES PROVIDED
(The ASAM is not related to Mental Health)		**5—**Funding for self help groups-			**1—**Single Point of Entry-No Wrong Door-1 (Problem at discharge: lack of cont. services)	**6—**Crisis
4—(Billing problems for ongoing assessments)		**6—**(RSS's for SA (they have them for MH)-6			One Stop Shopping (for MH centers has the ability)	**5—**Case Management
		(Some programs do not know how to use RSS's)			**2—**Collaboration service Referral network -(State contract make it difficult)	**2—**Evidence Based (Group work)
		(How would clinicians best train RSS's?)			**5—**Cross Hires MH-SA (Some agencies have this as part of their "Action Plan." They are not there, yet.)	**1—**Referrals of: TX at other agency
		(AA needs more info on persons who are co-occurring.)				

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Model Program Site Specific Report: Program Description, Fidelity Report and Baseline Data Analysis

Organization Plan

A. Program description
B. Fidelity Levels
C. Program data variables:
   1. Demographic Vars.
   2. Outcome Vars:

Model Program Site Specific Program Description

The purpose of the Model Program Site Specific Report is to examine the relationship between organizational factors and implementation fidelity, and the changes that occur in implementation fidelity and outcomes from year two to year three. Both qualitative and quantitative data were collected. Analyses of the data from the Fidelity Evaluation and the program's ICIS data file will be reported in this section.

Note: 1) One program description is incomplete. It will be completed in the final report. 2) The Baseline FY 2005 Data file is complete in its final form; however, the analysis is in draft form. It may be changed as more variables and their feasibility are studied for use in this analysis.

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Norman Alcohol and Drug Treatment Center DRAFT

Program Description

Name of Agency	Norman Alcohol and Drug Treatment Center (102)
Physical Address	900 E. Main street, BLDG 54
	Norman, OK 73069
Mailing Address	P. O. Box 151
	Norman, OK 73070
Primary Phone	405-573-6624
Fax	405-573-8252
Website	N/A
Hours of Operation	Admissions: 8am-5pm(M-F) except for emergency
Director	Wynema Ra(Executive Director)
Lead Change Agent/Contact	Bo Cox
	405-573-6624 ext 2633
Intake/Admission Phone	405-573-6624 ext 2126
Admission Contact	Dave Mehta,Ken Wilson, Jo Williams, John McGraw
	405-573-6624
Admission Criteria	As per ASAM guidelines for level III.5 (Clinically
	Managed High intensity Residential Tx).
How to refer	Phone or Face to Face
Primary Focus	Residential and Co-Occurring treatment
Services Provided	Group and Individual Therapy, Relapse Prevention, Co-
	Occurring and Gender specific groups, Recreational
	therapy, Psychoeducational lectures, Tai Chi.
Type/Level of Care	Level III.5 as per ASAM PPC 2R
	Clinically Managed High intensity Residential Tx

Target Population	Pregnant, HIV, IV users, Homeless, Co-occurring
Special Programs/Groups	Manual Therapy, Chemical Dependency Education, Trauma Informed Therapy, Co-Occurring tx groups, CBT, Stages of Change, Intensive Case Management
Forms of Payment Accepted	Private insurance, Self pay
Payment Assistance	Sliding Scale determined on consumer's ability to pay
Special Language Services	Interpreters for hearing impaired and language line services.

Norman Alcohol and Drug Treatment Center, Program Fidelity Baseline FY05 Report

Fidelity refers to the degree of implementation of an evidence-based practice related to treatment and services for people with a co-occurring disorder. The Fidelity Scale used in the OK-COSIG evaluation project is based on the Comprehensive Continuous Integrated Systems of Care (CCISC) model (Minkoff, 2001). It also incorporates competency areas from the Integrated Dual Disorder Treatment (IDDT) model, and the General Organizational Index for Evidence-Based Practice (GOI) model (See attached scale)

The purpose of these Fidelity evaluations is to examine the relationship between organizational factors and implementation fidelity and changes in implementation fidelity from year two to year three.

During each on-sight visit, there were a number of program documents reviewed: written policies and procedures related to the provision of services and treatment of people with a co-occurring disorder, and 10 randomly selected case records of people with a co-occurring disorder currently in treatment. Two (2) agency staff members who were knowledgeable about the agencies co-occurring program answered the fidelity questions about the agency's co-occurring programming. One staff person was at the administrator/supervisor level and the second person was a senior level practitioner, who was knowledgeable about the agency's co-occurring program.

Each program is described under three headings: Program Description, Fidelity Baseline Levels, and Quantitative Baseline Data.

This measure was designed to determine program fidelity. The questions were grouped under areas believed to be good measures of the extent to which a program is providing the best levels of services covering 19 areas.

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1) Philosophy
2) Management Structure
3) Access
   Describe the eligibility criteria for your program.
4) Identification/Detection of Co-occurring Disorders
5) Assessment/Diagnosis
6) Treatment Planning
   How many members are on the interdisciplinary treatment team?
7) Treatment Content and Treatment Programming
8) Integrated Treatment Relationships
9) Treatment Program Policies
10) Psychopharmacology
11) Discharge Planning
12) Integrated External Care Management
13) Staff Competency/Training

Specific Competencies: The program demonstrates specific programming for the following:

14) Cultural
15) Gender
16) Age
17) Developmental Disability
18) Trauma
19) Family Competency

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NADTC Quantitative Baseline Data Report FY05

Demographics

Gender

Male	443 (65.8%)
Female	230 (34.2%)

Age

The average age is 34.5 with a standard deviation of 10 years.

AGE

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	18 to 25	136	20.2	24.3	24.3
	26 to 35	174	25.9	31.1	55.5
	36 to 45	160	23.8	28.6	84.1
	46 to 55	78	11.6	14.0	98.0
	56 to 65	10	1.5	1.8	99.8
	66 to 90	1	.1	.2	100.0
	Total	559	83.1	100.0	
Missing	17 & under	114	16.9		
Total		673	100.0		

Race/Ethnicity

Of the 673 discharged from treatment 23 (3.45) people identified themselves as Hispanic.

RACE

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	White	493	73.3	73.3	73.3
	Black	102	15.2	15.2	88.4
	Native American	59	8.8	8.8	97.2
	Asian	2	.3	.3	97.5
	Multi-race	15	2.2	2.2	99.7
	Hawaiian /Pacific Islander	2	.3	.3	100.0
	Total	673	100.0	100.0	

Marital Status

In this population only 10% were married or living as married. Over 50% reported that they had never been married. People who are married tend to have better health outcome than single people.

Marital Status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never married	344	51.1	51.1	51.1
	divorced	61	9.1	9.1	60.2
	separated	179	26.6	26.6	86.8
	widowed	9	1.3	1.3	88.1
	living as married	18	2.7	2.7	90.8
	married	62	9.2	9.2	100.0
	Total	673	100.0	100.0	

Education

The average years in school completed by these clients were 11.5 years with a (sd = 2). The median number of grades completed was 12.

Income

The average income for these clients was $15,000 (sd = $16,600). The median income was $10,000.

Number of persons he/she is contributing to and/or dependent on his/her income.

Among these clients, 237 (35.2%) supported one or more people on their income.

Chronic homeless

Among those admitted, 33 (4.9%) were identified as chronic homeless.

Disabled

There were 29 people identified as having a disability: chronic health problems 23 (3.4%), hearing impaired 3 (0.4%, and semi-ambulatory 3 (0.4%).

Legal Status

Among these clients, 671 (99.7%) were voluntary admissions and 2 were court committed.

Presenting Problem

Presenting Problem-primary

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Alcohol Abuse	1	.1	.1	.1
	Alcohol Dependence	98	14.6	14.6	14.7
	Drug/Other Abuse	14	2.1	2.1	16.8
	Drug/Other Dependency	293	43.5	43.5	60.3
	Poly/Both alcohol & drug	1	.1	.1	60.5
	Poly Dependency/ Both alcohol & drug	266	39.5	39.5	100.0
	Total	673	100.0	100.0	

The Number Admitted that were Co-occurring

Based on the ASI psychiatric subscale results, there were 79 people with a co-occurring disorder of Mental Illness and Substance Abuse admitted to NADTC in FY05. .

Discharge Type

Of those admitted and discharged, 60% completed the program, 24% against clinical advice (ACA), and 7% were discharged for breaking rules. Out of the 27 people with a co-occurring disorder, 14 (52%) completed the program, 8 (30%) left ACA, 2 (7.4%) did not begin treatment, 1 (3.7%) left AWOL, 1 was discharged for breaking rules, and 1 was transferred to another treatment facility. Among the people *without* a co-occurring disorder, 61.5% completed the program, 19% left ACA, 9.6% did not begin treatment, and 5.8% were discharged for breaking rules.

Discharge Type

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Discharge/ Completed Treatment	403	59.9	59.9	59.9
	Discharge/ Transferred to another treatment Facility	9	1.3	1.3	61.2
	Discharge/Left ACA/90 Days,	163	24.2	24.2	85.4

	Discharge/Failed to begin treatment	30	4.5	4.5	89.9
	Discharge/Due to Treatment Incompatibility,	2	.3	.3	90.2
	Discharge/ Broke rules	49	7.3	7.3	97.5
	Discharge/ Administrative Discharge	9	1.3	1.3	98.8
	Discharge/ AWOL	6	.9	.9	99.7
	Discharge/Incarcerated	1	.1	.1	99.9
	Discharge/Completed Court Commitment	1	.1	.1	100.0
	Total	673	100.0	100.0	

Number of days in treatment

Among those who were discharged, they were in treatment an average of 40 days (sd = 30). The median was 34 days in treatment. The range was between 1 and 139 days. Some 80% were discharged within 60 days.

The Bivariate and Multivariate Analyses

Behavioral health treatment success is dependent on any number of events and characteristics. The ICIS system collects a great deal of quantitative data so as to track treatment provided by its programs. This type of quantitative data is often useful in testing hypothesis about treatment. It can also be used to both monitor and determine if treatment for people with a co-occurring disorder improves as a result of the OK-COSIG project.

One characteristic of treatment success is associated with days in treatment. In this draft site-specific report, days in treatment will be examined using a multi variate approach.

In these analyses to identify the important and interesting significant correlations, the variables that were rank order and interval level measures were examined.

A number of variables correlated significantly with the number of days in treatment: Age ($r = .267$, $p < .0001$), Education ($r = -.190$, $p < .0001$), Income ($r = .145$, $p < .013$), and the number the person is contributing to and/or dependent on his/her income ($r = .146$, $p < .0001$). Among those discharged, the older the person the longer they stayed in treatment. The more education the person had, the less time he or she stayed in treatment. The more income the person had, the longer he or she stayed in treatment. As well, the more people dependent on the client's income, the longer he or she stayed in treatment.

Age and education was significantly correlated ($r = .169$, $p < .0001$). Education and income is one of the standard positive correlations that are seen in almost all studies. It is no different in this population.

As well, the number the person is contributing to and/or dependent on his/her income was significantly correlated with education ($r = -.288$, $p < .0001$) and income ($r = .263$, $p < .0001$). In this population, the higher the education the fewer people are dependent on the client's income. However, the higher the client's income the more people are dependent on the client's income.

Finally, using the 3 variables that were significantly related to days in treatment, (Age, Education, Income, and the number of people that the person is contributing to and/or dependent on his/her income), only Age explained any of the difference in days in treatment among these clients ($R^2 = .03$, $p < .015$) and this difference is miniscule. As the analysis moves forward other variables will be tested an models developed.

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Griffin Memorial Hospital **DRAFT**

Program Description

Name of Agency	Griffin Memorial Hospital (100)
Physical Address	900 E. Main
	Norman, OK 73070
Mailing Address	PO Box 151
	Norman, OK 73070
Primary Phone	405-321-4880
Fax	Executive Director's office 405-321-4514
Website	
Hours of Operation	24 hours a day
Director	Don Bowen
Lead Change Agent/Contact	Kathy Otis-Davis
Intake/Admission Phone	405-573-8239 or 405-321-4880 ask for admissions
Admission Contact	Roy Williams
Admission Criteria	Danger to self or others. In need of stabilization of
	acute psychiatric stabilization
How to refer	contact admissions
	most admissions are civil commitments
Primary Focus	Adult psychiatric (18 years and older)
Services Provided	acute psychiatric stabilization
Type/Level of Care	Inpatient acute care

Target Population	Adult psychiatric (18 years and older)
Special Programs/Groups	
Forms of Payment Accepted	indigent
Payment Assistance	indigent
Special Language Services	Some Spanish speaking staff, utilize Language
	Line and other translation services

Griffin Memorial Program Fidelity Baseline FY05 Report

Fidelity refers to the degree of implementation of an evidence-based practice related to treatment and services for people with a co-occurring disorder. The Fidelity Scale used in the OK-COSIG evaluation project is based on the Comprehensive Continuous Integrated Systems of Care (CCISC) model (Minkoff, 2001). It also incorporates competency areas from the Integrated Dual Disorder Treatment (IDDT) model and the General Organizational Index for Evidence-Based Practice (GOI) model (See attached scale)

The purpose of these Fidelity evaluations is to examine the relationship between organizational factors and implementation fidelity and changes in implementation fidelity from year two to year three.

During the each on-sight visit, there were a number of program documents reviewed: written policies and procedures related to the provision of services and treatment of people with a co-occurring disorder, and 10 randomly selected case records of people with a co-occurring disorder currently in treatment. Two (2) agency staff members who were knowledgeable about the agencies co-occurring program answered the fidelity questions about the agency's co-occurring programming. One staff person was at the administrator/supervisor level and the second person was a senior level practitioner, who was knowledgeable about the agency's co-occurring program.

Each program is described under three headings: Program Description, Fidelity Baseline Levels, and Quantitative Baseline Data.

This measure was designed to determine program fidelity. The questions were grouped under areas believed to be good measures of the extent to which a program is providing the best levels of services covering 19 areas.

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1) Philosophy
2) Management Structure
3) Access

Describe the eligibility criteria for your program.

4) Identification/Detection of Co-occurring Disorders
5) Assessment/Diagnosis
6) Treatment Planning
   How many members are on the interdisciplinary treatment team?
7) Treatment Content and Treatment Programming
8) Integrated Treatment Relationships
9) Treatment Program Policies
10) Psychopharmacology
11) Discharge Planning
12) Integrated External Care Management
13) Staff Competency/Training

Specific Competencies: The program demonstrates specific programming for the following:

14) Cultural
15) Gender
16) Age
17) Developmental Disability
18) Trauma
19) Family Competency

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Program Philosophy

Program philosophy covered the estimated degree of staff training related to: co-occurring disorders, welcoming, and the empathic approach to the treatment. Additionally, the degree to which displayed and distributed literature and other materials emphasize recovery of the individual from both the mental illness and the substance disorder was measured.

The score on the OU Fidelity Measure for Co-occurring Programs was 5.50 out of 10, which suggests a fair amount of, but plenty of room for improvement.

Management Structure

Management structure covered the management systems oversight of the needs of clients with co-occurring disorders and the quality improvement and outcome evaluation systems and their evaluation of outcomes of clients with co-occurring disorders?

The score on the OU Fidelity Measure for Co-occurring Programs was 4.50 out of 10, which suggests a fair amount of, but plenty of room for improvement.

Access

These questions covered the agency's use of a pre-admission screen, admission barriers, any arbitrary exclusion criteria being used (alcohol level, urine toxicology screen, psychiatric diagnosis),

The score on the OU Fidelity Measure for Co-occurring Programs was 3.50 out of 10, which suggests little has been done to eliminate barriers, but much more work is needed.

Identification/Detection of Co-occurring Disorders

These questions inquired about policy and procedure for using a screen to determine the need for an assessment and the documentation on the process in the case record.

The score on the OU Fidelity Measure for Co-occurring Programs was 10 out of 10, which suggests virtually everyone is screened for a co-occurring disorder.

Assessment/Diagnosis

These questions inquired about policy and procedure for doing the assessment for co-occurring disorders and documentation of a comorbid disorder in the case record.

The score on the OU Fidelity Measure for Co-occurring Programs was 7.75, out of 10, which suggest, which suggests virtually everyone is assessed for a co-occurring disorder when the screening process calls for it.

Treatment Planning

These questions covered documentation of the treatment plan, evidence of specific goals, objectives, and interventions identified for a co-occurring disorder.

The score on the OU Fidelity Measure for Co-occurring Programs was 7.75, out of 10, which suggest, substantial effort is made so that the treatment plans have evidence of specific goals, objectives, and interventions identified for a co-occurring disorder.

There are typically between 6 and 7 people on an interdisciplinary treatment team at Griffin Memorial.

Treatment Content and Treatment Programming

Treatment content and treatment planning covered which treatment concepts and programs are available to the client during treatment. Medication education, access to dual recovery programs, access to peer leaders, availability of comprehensive curriculum, motivational and cognitive-behavioral techniques, the concept of recovery, and relapse prevention training were all addressed within this section of questions.

The score on the OU Fidelity Measure for Co-occurring Programs was 8.06, out of 10, which suggests that substantial effort is put toward treatment content and programming at Griffin Memorial.

There are typically 10 people in a treatment group. The treatment program typically lasts between 50-60 days.

Integrated Treatment Relationships

This section explores the accessibility to a primary, individual clinician, whether treatment compliance affects accessibility to that primary clinician, and if the treatment team shares responsibility for both disorders.

The score on the OU Fidelity Measure for Co-occurring programs was 8.67, out of 10, which suggests that clinicians are substantially accessible, staying with clients regardless of treatment compliance, and treatment teams are sharing responsibilities for both disorders.

Treatment Program Policies

This section of questions reviewed program policies and procedures, looking at whether the program had policies regarding co-occurring disorders and whether the policies and procedures incorporated client choice.

The score on the OU Fidelity Measure for Co-occurring programs was 4.5, out of 10, which suggests that there is room for improvement.

Psychopharmacology

This section of questions focused on psychopharmacology. The questions looked at client involvement, policy, and documentation within charts and case records.

The score on the OU Fidelity Measure for Co-occurring Programs was 7.1, out of 10, which suggests a substantial amount of effort from psychopharmacology providers.

Discharge Planning

These questions in this section covered the client's participation in discharge planning, resources, referrals, communication with family members and significant others, and vocational issues being addressed within the discharge plan.

The score on the OU Fidelity Measure for Co-occurring Programs was 7.67, out of 10, which suggests that substantial effort is being made so that discharge plans have evidence of specific goals, objectives, and interventions identified for a co-occurring disorder.

Cultural Competency

This section looks at cultural competency of staff and standards of care related to culture.

The score on the OU Fidelity Measure for Co-occurring Programs was 4.5, out of 10, which suggest a fair amount of, but plenty of room for improvement.

The staff to client ratio is 1 to 5.

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Oklahoma County Crisis Intervention Center Quantitative Baseline Data

Program Description

Name of Agency	Oklahoma County Crisis Intervention Center (103)
Physical Address	1200 N.E. 13th
	Oklahoma City, Oklahoma 73117
Mailing Address	P.O. Box 53277
	Oklahoma City, Oklahoma 73152
Primary Phone	(405) 522-8100 Crisis
	(405) 522-8108 Business
Fax	(405) 522-8113 or 522-8882
Website	
Hours of Operation	24/7
Director	Pete Reed
Lead Change Agent/Contact	Donna Hyde
	(405) 522-8127
Intake/Admission Phone	(405) 522-8100
Admission Contact	Reception and/or Triage
Admission Criteria	18 years of age and over, individuals experiencing a mental
	health or substance abuse related crisis in Oklahoma, Lincoln,
	Logan, Pott., Osage, Payne, Canadian, Kingfisher
	and Pawnee counties.
How to refer	call to refer or clients may walk in
Primary Focus	Mental Health and Substance Abuse

Services Provided	Evaluation stabilization and referral
Type/Level of Care	Community based structured emergency care
Target Population	18 years old and over experiencing a crisis in
	Oklahoma, Lincoln, Logan, Pott., Osage, Payne,
	Canadian, Kingfisher, and Pawnee counties
Special Programs/Groups	
Forms of Payment Accepted	Medicare, Medicaid, private insurance and self pay
Payment Assistance	N/A
Special Language Services	Spanish interpreter is on staff, other interpreters
	are called in as needed.
Other pertinent information	

Program Fidelity: Baseline FY05

Quantitative Baseline Data

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Tulsa Center for Behavioral Health (TCBH)

Program Description

Name of Agency	Tulsa Center for Behavioral Health Residential program (105)
Physical Address	2323 S. Harvard
	Tulsa, Ok 74114
Mailing Address	2323 S. Harvard
	Tulsa, Ok 74114
Primary Phone	(918) 293-2113
Fax	(918) 293-2116
Website	none
Hours of Operation	24hrs, seven days a week
Director	Joseph E. Yosten, LPC, LADC, CCS
Lead Change Agent/Contact	Joseph E. Yosten, LPC, LADC, CCS
Intake/Admission Phone	(918) 293-2113
Admission Contact	Jimmy Stone
Admission Criteria	Those in need of co-occurring care and meet ASAM
	placement criteria
How to refer	Contact Jimmy Stone at (918) 293-2113 and he will
	complete a screening with the individual at that point.
Primary Focus	Those with mental health, substance abuse and trauma
	issues that need a residential level of care.
Services Provided	Co-occurring Counseling, Recreational therapy,
	12 step meetings, Medication management, life
	skills training, family education, gender groups.
Type/Level of Care	

	Residential level of care.
Target Population	Indigent in need of co-occurring treatment that need
	residential level of care.
Special Programs/Groups	Enhanced Co-occurring program
Forms of Payment Accepted	State funded
Payment Assistance	State funded
Special Language Services	English

Program Fidelity: Baseline FY05

Quantitative Baseline Data

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Oklahoma Youth Center

Program Description

Name of Agency	Oklahoma Youth Center (110)
Physical Address	320 12th Ave NE
	Norman, OK 73071
Mailing Address	320 12th Ave NE
	Norman, OK 73071
Primary Phone	405-364-9004
Fax	405-573-3804
Website	www.odmhsas.org
Hours of Operation	24 hour servises
	Business Hours Monday-Friday, 8:00 am - 5:00 pm
Director	Robert Lee, Executive Director; Dr. Kearns M.D., Medical Director
Lead Change Agent/Contact	Clay Reaves 405-573-3822 (Lead)
	Jenny Bruner 405-573-3876
Intake/Admission Phone	Pager : 405-908-0909
Admission Contact	Gwen Downing and Christy Tobin
	Nursing Services after hours
Admission Criteria	A minor in need of treatment who has
	A demonstrable mental illness or is drug or alcohol
	dependent, AND as a result of that mental illness or
	dependency can be expected to within the near future
	inflict or attempt to inflict serious bodily harm to
	himself/herself or another person, and has engaged in
	one or more recent over acts or made significant recent
	threats which substantially support that expectation
	or shows a sufficient severity to cause substantial
	impairment or disability in major areas of functioning.
	** Minor must be medically stable
How to refer	Contact admissions by pager to initiate intake
	procedure or referral.
Primary Focus	Mental health services and when indicated will focus
	on trauma and substance abuse
Services Provided	Psychiatric evaluation, treatment, and medication
	management, individual, group, family, and
	recreational therapy, educational services and
	case management
Type/Level of Care	Inpatient Acute and RTC (short term)
Target Population	Ages 5-17

	Male and Female
Special Programs/Groups	Trauma focused-CBT, Sanctuary Philosphy
Forms of Payment Accepted	Medicaid, Private Insurance, Self Pay
Payment Assistance	Inquire upon admission
Special Language Services	State translating services for Spanish speaking and
	sign language. Phone Interpreter available for most
	other languages.
Other pertinent information	We accept patients with no insurance coverage
	JCAHO accredited

Program Fidelity: Baseline FY05

Quantitative Baseline Data

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Central Oklahoma Community Mental Health Center

Program Description

Name of Agency	Central Oklahoma Community Mental Health Center (500)
	- Adults
Physical Address	909 E. Alameda
	Norman, OK 73070
Mailing Address	PO Box400
	Norman, OK 73070
Primary Phone	405-360-5100
Fax	405-573-3958
Website	www.comhc.org
Hours of Operation	M, W, TH, F 8am to 5 pm.
	Tuesday 8am to 7pm
Director	Larry Gross
	405-573-3905
Lead Change Agent/Contact	Cindy D. Schultz
	405-573-3927
Intake/Admission Phone	405-573-3926
Admission Contact	Evaluation and Referral
Admission Criteria	Meeting diagnostic criteria for treaatment in mental
	health, trauma, and co-occurring as per ODMHSAS
	criteria
How to refer	Contact evaluation and referral for screening
Primary Focus	Mental Health and Co-occurring disorders
Services Provided	Outpatient counseling, psychosocial rehabilitation,
	case management, crisis assessment, and
	medication
Type/Level of Care	Outpatient services
Target Population	Adults ages 18 and over.

Special Programs/Groups	Enhanced Recovery Community, PACT, Psycho-social Rehabilitation, Intensive Care Coordination, Drug Court, Mental Health Court
Forms of Payment Accepted	Medicaid, Medicare, Private insurance, Self-pay, and a sliding scale as per ODMHSAS
Payment Assistance	Inquire upon admission
Special Language Services	All languages available including ASL
Other pertinent information	Current groups include: trauma, depression, bi-polar, CBT, WRAP, anger management, wellness and recovery, co-occurring, DTR

Program Fidelity: Baseline FY05

Quantitative Baseline Data

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Bill Willis CMHSAC

Program Description

Name of Agency	Bill Willis CMHSAC (503)	
Physical Address	1400 So. Hensley Dr.	
	Tahlequah, Oklahoma	74464
Mailing Address	PO Box 556	
	Tahlequah, Oklahoma	74465
Primary Phone	918-207-3000	
Fax	918-207-3064	
Website		
Hours of Operation	Outpatient: 8-5, Mon. through Friday	
	Crisis and Residential care: 24/7	
Director	Margaret Bradford	
Lead Change Agent/Contact	Lance Dickison, 918-207-3034	
Intake/Admission Phone	918-207-3000	
Admission Contact	N/A	
Admission Criteria	ODMHSAS eligibility criteria	
How to refer	918-207-3000	
Primary Focus	Outpatient Co-occurring, MH and SA services;	
	Residential SA and Co-occurring treatment;	
	Psychosocial day treatment;	
Types of services	Psychiatric care, Outpatient therapy, Rehabilitation	
	Psychosocial day treatment, Prevention,	
	Case Management, Residential SA treatment	

Type/Level of Care	Outpatient Co-occurring, MH and SA services;
	Residential SA and Co-occurring treatment;
	Psychosocial day treatment;
Target Population	SMI, SED, Mood disorders, Substance Abuse or any
	combination there in.
Special Programs/Groups	PSR/Psychosocial Rehabilitation,
	Residential Substance Abuse (male only)
	Women's corrections pre-release program
Forms of Payment Accepted	All types of insurance, ODMHSAS indigent care
	Medicaid/Medicare, Self pay
Payment Assistance	Yes
Special Language Services	Yes

Program Fidelity: Baseline FY05

Quantitative Baseline Data

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Family and Children's Services

Program Description

Name of Agency	Family & Children's Services (541)
	Mental Health Care
Physical Address - 3 sites	1. F&CS North- 3604 N Cincinnati, Tulsa 74106
	2. F&CS Harvard-2325 S Harvard #400 74114
	3. F&CS Salv. Army-102 N Denver
Mailing Address	same as above
	(Central admin office is 650 S Peoria, Tulsa)
Primary Phone	1. (918) 425-4200
	2. (918) 712-4301
Fax	North - (918) 425-4202
Website	www.fcsok.org
Hours of Operation	1. North - 8-5, open late for group services 3 nights
	2. Harvard - 8-5 M-F, late appointments available
	3. S.Army - 8-5 M-F
Director	Rebecca Wilson - Dir. Behavioral Health Services
	Jill Young & Krista Conder - Associate Directors
Lead Change Agent/Contact	Jennifer Freeman, Program Director - North
	(918) 425-4200 x.16
Intake/Admission Phone	Central Office - Intake
	(918) 587-9471
Admission Contact	Intake Department - Central Office- Claudia Arthrell
	Drug Court & Community Sentencing - Kelli Jacobsen
	Clinical supervisor @ North Office
Admission Criteria	adults w/serious mental illness and co-occurring
	disorders, 200% of poverty level; non-insured or
	under-insured
How to refer	contact intake department for assessment
	some programs court-referred
Primary Focus	services for chronic mental health and
	substance use disorders
	co-occurring capable services
Services Provided	Psychosocial Rehab (PSR), Crisis Intervention Team
	(C.O.P.E.S.) Assessment, Referral, Therapy,
	Case Management, Psychiatry, Pharmacy, Groups
Type/Level of Care	Outpatient mental health and substance abuse services

	for all stages of change; Ongoing assessment and relapse-
	prevention & wellness planning throughout recovery process
Target Population	adults w/serious and persistent mental illness
	and co-occurring disorders;
Special Programs/Groups	Drug Court, Community Sentencing
	Psychosocial Rehab (PSR), DTR peer-support on site
	Co-occurring capable services, Homeless outreach(S.Army site)
Forms of Payment Accepted	Medicaid
	non- insured (ODMHSAS)
Payment Assistance	n/a
Special Language Services	Spanish interpretor on staff; deaf & hearing-impaired
	assistance available
Other pertinent information	Family & Children's Services has several other locations
	throughout the Tulsa metro offering services for children & families
	including sexual abuse treatment, family counseling,
	children's mental health, play therapy, school-based

Program Fidelity: Baseline FY05

Quantitative Baseline Data

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Grand Lake Mental Health Center, Inc.

Program Description

Name of Agency	Grand Lake Mental Health Center, Inc (554)
Physical Address	Administrative Office
	114 W. Delaware
	Nowata, OK 74048
Mailing Address	114 W Delaware
	Nowata, OK 74048
Primary Phone	918-273-1841
Fax	918-273-1843
Website	www.glmhc.net
Hours of Operation	8-5 M-F other hours as needed
Director	Charles Danley
Lead Change Agent/Contact	Lissa James, Clinical Director
Intake/Admission Phone	918-273-1841
Admission Contact	Ask for Admission Staff and call directed to county
	and/or 24/7 access center
Admission Criteria	Same as DMH Standards
How to refer	Self, family member of under 18, other agency;
	police, court
Primary Focus	Mental Health Outpatient Services, 24/7 Crisis
	Stabilization Center & Inpatient Services by contract
	DTR Groups available
Services Provided	Mental Health Outpatient Services
Type/Level of Care	outpatient and 24/7 Crisis Stabilization

Target Population	Children & Adults
Special Programs/Groups	For all programs offered see our website at www.glmhc.net
Forms of Payment Accepted	DMH mental health services contract; T19; Medicare for medication clinic
Payment Assistance	DMH standards for criteria
Special Language Services	Available
Other pertinent information	Serving counties: Craig, Delaware, Mayes, Nowata, Ottawa, Rogers, Washington with clinics in all except Nowata

Program Fidelity: Baseline FY05

Quantitative Baseline Data

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Green County Behavioral Health Services Inc.

Program Description

Name of Agency	Green County Behavioral Health Services Inc. (559)
Physical Address	2719 E. Shawnee
	Muskogee, OK 74403
Mailing Address	
Primary Phone	918-682-8407
Fax	
Website	
Hours of Operation	
Director	
Lead Change Agent/Contact	
Intake/Admission Phone	
Admission Contact	
Admission Criteria	
How to refer	
Primary Focus	
Services Provided	
Type/Level of Care	
Target Population	
Special Programs/Groups	

Forms of Payment Accepted	
Payment Assistance	
Special Language Services	
Other pertinent information	

Program Fidelity: Baseline FY05

Quantitative Baseline Data

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Associated Centers for Therapy, ACT

Program Description

Name of Agency	Associated Centers for Therapy (564)	
Physical Address	7010 S. Yale Suite 215	
	Tulsa, OK 74136	
Mailing Address	7010 S. Yale Suite 215	
	Tulsa, OK 74136	
Primary Phone	918-492-2554	
Fax	918-494-9870	
Website	www.actcares.org	
Hours of Operation	8 - 5	M-W-F
	8 - 7	T - Th
Director	Larry Marks	
Lead Change Agent/Contact	Sheree Solitario or Kathryn Rawlings	
	918-492-2554	
Intake/Admission Phone	492-2554	
Admission Contact	Paula Vella	
Admission Criteria	Mental Health or Co-occurring diagnosis	
How to refer	Call main phone number and ask for intake.	
Primary Focus	Mental Health	
	Co-occurring	
Services Provided	Individual, group therapy, PSR, case management,	
	Adult, Adolescent, Children	

Type/Level of Care	Outpatient
Target Population	SMI
Special Programs/Groups	Co-occurring, gambling treatment, wraparound
	for children and adolescents, school based, PSR
Forms of Payment Accepted	DMH, Medicaid/Medicare, private insurance
Payment Assistance	for medication
Special Language Services	Spanish

Program Fidelity: Baseline FY05

Quantitative Baseline Data

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12 & 12

Program Description

Name of Agency	12&12 Inc. (640)
Physical Address	6333 E. Skelly Drive
	Tulsa OK 74135
Mailing Address	6333 E. Skelly Drive
	Tulsa OK 74135
Primary Phone	918-664-4224
Fax	918-663-0203
Website	WWW.12AND12.ORG

Hours of Operation	Business Hours 8-5 MON - FRI Treatment 24/7
Director	Executive Director - Walter Gerow Clinical Director -David Peters
Lead Change Agent/Contact	June Ross
Intake/Admission Phone	918-664-4224 XTN 1064
Admission Contact	Jonas Goins
Admission Criteria	ASAM Dependent
How to refer	Contact Admissions
Primary Focus	Substance Abuse and Mental Health TX
Services Provided	Medically Supervised Detox, Residential Treatment, Dual Diagnosis Residential TX, Halfway, Independent Living, Outpatient
Type/Level of Care	Medically Supervised Detox, Residential Treatment, Dual Diagnosis Residential TX, Halfway, Independent Living, Outpatient
Target Population	Adult Men and Women
Special Programs/Groups	Dual Diagnosis Treatment
Forms of Payment Accepted	Cash, Visa, MasterCard, Personal check Money Order, Insurance reimbursement Contracts with DMH, City of Tulsa, VA, Fed Probation, Community Sentencing
Payment Assistance	State contracted bed space
Special Language Services	Spanish speaking counselor

Program Fidelity: Baseline FY05

Quantitative Baseline Data

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DVIS/ Domestic Violence Intervention Services/Call Rape

Program Description

Name of Agency	Domestic Violence Intervention Services/Call Rape (675)
Physical Address	4300 South Harvard
	Tulsa, Ok. 74135-2608
Mailing Address	same
Primary Phone	918-585-3143
Fax	918-744-4432
Website	www.dvis.org
Hours of Operation	8:30-6:00 Mon.-Thurs.
	8:30-5:00 Fridays
	Shelter is available 24 hours a day
Director	Felicia Collins Correia
Lead Change Agent/Contact	Ivan Lopes
	918-585-3163
Intake/Admission Phone	918-585-3163
Admission Contact	Claudia Membrilla
Admission Criteria	Domestic violence abuser or survivor or survivor of
	sexual assault, children from domestic violent homes
How to refer	Call and set an appointment; in a crises situation,
	clients can be seen on an emergency walk-in basis
	or be referred to our Shelter facility
Primary Focus	Domestic violence intervention and recovery from
	sexual assault, intervention with children from
	violent homes
Services Provided	domestic violence assessment and evaluation, ASI
	assessment, individual and group treatment, case
	management, and advocacy. Legal services for
Type/Level of Care	victims of domestic violence or sexual assault

Target Population	Shelter for women and children fleeing domestic violence or women needing shelter following a sexual assault, transitional living for survivors of domestic violence and sexual assault and their children, outpatient services for abusers, and survivors
Special Programs/Groups	Combined groups treating both domestic violence and substance abuse for perpetrators of domestic survivors, their children, and sexual assault survivors both adult and adolescent
Forms of Payment Accepted	money order, cash.
Payment Assistance	sliding scale to no payment for survivors, reduction of fees to no fees for abusers meeting poverty guidelines
Special Language Services	Bilingual groups in Spanish for men and women in the domestic violence program

Program Fidelity: Baseline FY05

Quantitative Baseline Data

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NAIC - Norman Alcohol Information Center

Program Description

Name of Agency	NAIC - Norman Alcohol Information Center (906)
Physical Address	215 West Linn
	Norman OK 73069
Mailing Address	PO Box 824
	Norman OK 73070
Primary Phone	405/321-0022
Fax	405/360-4918
Website	www.naichelp.org
Hours of Operation	M - F 8-6
Director	H.N. "Sonny" Scott
	Executive Director
Lead Change Agent/Contact	John Bureman, ICADC
	Cindy Honeycutt, LPC, LADC
Intake/Admission Phone	405/321-0022
Admission Contact	John Bureman, ICADC
Admission Criteria	Based on ASAM
How to refer	Assessments provided on walk-in basis, M - F,
	except 3rd Fri of each month. Can call main #.
Primary Focus	Substance Abuse
Services Provided	OP, IOP, Adult/Juvenile Drug Ct, Probation/Parole, DUI
	Adolescent, TANF, Family, Assessments, Community
	Sentencing, Prevention, Education, Gambling
Type/Level of Care	OP/IOP

Target Population	All
Special Programs/Groups	See above.
Forms of Payment Accepted	Self-pay/sliding fee, private insurance, Medicaid
	No consumer is turned away for inability to pay.
Payment Assistance	Yes
Special Language Services	None. Will provide interpreter as needed.

Program Fidelity: Baseline FY05

Quantitative Baseline Data

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Postscript

The second year capitalized on the foundations laid during year one. The first year work related to organization, consensus building, curriculum development, screen development, and evaluation planning that paved the way for the numerous accomplishments of year 2: 1) the development and dissemination of a self help group directory for consumers, 2) consumers representation in the development of screening and assessment policies, 3) completion of core level trainings at the model programs, 4) the inclusion of the Choctaw Tribe in core level trainings, 5) the recruitment of ten additional model program sites, 6) training related to supervisory case management that was eligible for CEUs, 7) the building of new curriculum related to trauma, online learning, and ICIS data reporting, 8) the development of regional change agent groups to facilitate training efforts, 9) the integration of state wide initiatives to avoid duplication, 10) the launching of an initiative wide webpage to list all the policies, trainings,

evaluations, DTR resources, and committee meetings, 11) development and approval of policies related to regulations, 12) the designation of short term funding changes and longer term changes to be implemented in 2008, and 13) evaluation of administrators, providers, organization implementation, and trainings. These activities are reported in great detail in the four quarterly reports produced through out year two. They are found on the website: http://faculty-staff.ou.edu/C/Andrew.L.Cherry-1.Jr/okcosig_project.htm

The work of the OK-COSIG team to maintain the momentum and participation by shareholders that was carried over from year one was extremely important to the progress made in year two. The administrators, the clinicians, staff, and consumers at the model sites where the pilot is being conducted continued to be supportive and made major contributions. The organization of a cadre of *change agents* across programs added a great deal of needed support at the clinical level. The work of the OK-COSIG team will be to continue to build consensus among those involved and to assist and support the administrators and staff as they implement changes that will move these agencies and the State Department of Mental Health and Substance Abuse services closer to an integrated system of service for people in Oklahoma who present with a co-occurring disorder. The work over year three for the evaluation team will be to continue the analysis of the data, and to collect additional data. Interviews and focus groups will provide information on developments at the MEZZO level,

While ICIS files will be analyzed to develop a statistical picture of aggregate changes overtime, interviews and focus groups will provide information on developments at the MEZZO level. The MICRO level data collection is planned for this spring given ODMHSAS IRB approval. As well, in the second quarter, the analysis of the OK-COD screen data will hopefully be completed.

Year two has ended with much anticipation of the further implementation efforts related to training, contracts, and funding mechanisms. The in-depth analysis of the macro level data in year three will provide a state level and agency specific results of the providers' work under this unfolding initiative. These results will create a fuller picture of the experiences of individuals with co-occurring disorders within the state service system.

Appendix

Appendix A: Database: Variable list with Values

and the ODMHSAS variable name.

Database: Variable list with Values and the ODMHSAS variable name

ODMHSAS

Var Name	Description
id_num	Generic identification number
agencyname	Agency Name
age	Age at admission
multirace	Race
ethnicity	Ethnicity
sex	Sex
daysintx	Number of days in treatment (if null, not discharged)
transtypename	Transaction type
distranstypename	Transaction type at discharge (if null, not discharged)
batpreg	Battered while pregnant
disbatpreg	Battered while pregnant at discharge
histdvab	History of domestic violence
dishistdvab	History of domestic violence at discharge
histivdr	History of IV drug use
dishistivdr	History of IV drug use at discharge
dvperp	Domestic Violence Perpetrator
disdvperp	Domestic Violence Perpetrator at discharge
homeless	Homeless
dishomeless	Homeless at discharge
alertother	Other alert information
disalertother	Other alert information at discharge
alertdescr	Other alert information description
disalertdescr	Other alert information description at discharge
alertpreg	Client pregnant
disalertpreg	Client pregnant at discharge
custodydoc	Client in DOC custody
discustodydoc	Client in DOC custody at discharge
income	Income
disincome	Income at discharge
numlivho	Number contributing to and/or dependent on income

disnumlivho	Number contributing to and/or dependent on income at discharge
benssi	SSI benefits
disbenssi	SSI benefits at discharge
benfood	Food stamps
disbenfood	Food stamps at discharge
bentanf	TANF benefits
disbentanf	TANF benefits at discharge
benssdi	SSDI benefits
disbenssdi	SSDI benefits at discharge
benss	Social Security benefits
disbenss	Social Security benefits at discharge
benmilva	Military veteran benefits
disbenmilva	Military veteran benefits at discharge
privbhins	Private behavioral health insurance
disprivbhins	Private behavioral health insurance at discharge
medicare	Medicare
dismedicare	Medicare at discharge
medicaid	Medicaid
dismedicaid	Medicaid at discharge
speakengl	Speaks English well
disspeakengl	Speaks English well at discharge
langprefname	Name of preferred language
dislangprefname	Name of preferred language at discharge
langspec	Name of language specified under 'Other' or 'Native American'
dislangspec	Name of language specified under 'Other' or 'Native American' at discharge
veteran	Veteran
disveteran	Veteran at discharge
education	Highest grade completed, years of school
diseducation	Highest grade completed, years of school at discharge
sublevcarename	Sublevel of care
dissublevcarename	Sublevel of care at discharge
primrefname	Primary referral
disprimrefname	Primary referral at discharge
primrefagname	Primary referring agency when ODMHSAS agency was indicated
disprimrefagname	Primary referring agency when ODMHSAS agency was indicated at discharge

secrefname	Secondary referral
dissecrefname	Secondary referral at discharge at discharge
secrefagname	Secondary referral when ODMHSAS agency was indicated
dissecrefagname	Secondary referral when ODMHSAS agency was indicated at discharge
servfocusname	Service focus
disservfocusname	Service focus at discharge
residcurname	Current residence
disresidcurname	Current residence at discharge
livsitcurname	Current living situation
dislivsitcurname	Current living situation at discharge
employcurname	Current employment
disemploycurname	Current employment at discharge
emptypecurname	Reason if 'Not in Labor Force' was indicated
disemptypecurname	Reason if 'Not in Labor Force' was indicated at discharge
maritalname	Marital status
dismaritalname	Marital status at discharge
handicap1name	Handicap blank 1
dishandicap1name	Handicap blank 1 at discharge
handicap2name	Handicap blank 2
dishandicap2name	Handicap blank 2 at discharge
legalstatname	Legal status
dislegalstatname	Legal status at discharge
probprimname	Presenting problem-primary
disprobprimname	Presenting problem-primary at discharge
probsecname	Presenting problem-secondary
disprobsecname	Presenting problem-secondary at discharge
probtertname	Presenting problem-tertiary
disprobtertname	Presenting problem-tertiary at discharge
drugch1name	Drug of choice blank 1
disdrugch1name	Drug of choice blank 1 at discharge
drugrte1name	Drug-Usual route of administration blank 1
disdrugrte1name	Drug-Usual route of administration blank 1 at discharge
drugfreq1	Drug-Frequency of use blank 1
disdrugfreq1	Drug-Frequency of use blank 1 at discharge
drugage1	Drug-Age of first use blank 1

disdrugage1	Drug-Age of first use blank 1 at discharge
drugch2name	Drug of choice blank 2
disdrugch2name	Drug of choice blank 2 at discharge
drugrte2name	Drug-Usual route of administration blank 2
disdrugrte2name	Drug-Usual route of administration blank 2 at discharge
drugfreq2	Drug-Frequency of use blank 2
disdrugfreq2	Drug-Frequency of use blank 2 at discharge
drugage2	Drug-Age of first use blank 2
disdrugage2	Drug-Age of first use blank 2 at discharge
drugch3name	Drug of choice blank 3
disdrugch3name	Drug of choice blank 3 at discharge
drugrte3name	Drug-Usual route of administration blank 3
disdrugrte3name	Drug-Usual route of administration blank 3 at discharge
drugfreq3	Drug-Frequency of use blank 3
disdrugfreq3	Drug-Frequency of use blank 3 at discharge
drugage3	Drug-Age of first use blank 3
disdrugage3	Drug-Age of first use blank 3 at discharge
custodyoja	Clients under 18-Custody of OJA
discustodyoja	Clients under 18-Custody of OJA at discharge
custodydhs	Clients under 18-Custody of DHS
discustodydhs	Clients under 18-Custody of DHS at discharge
speceduc	Clients under 18-Child enrolled in special education
disspeceduc	Clients under 18-Child enrolled in special education at discharge
lof	Level of functioning (GAF scale)
dislof	Level of functioning (GAF scale) at discharge
carmood	CAR Subscale-Feeling and Mood
discarmood	CAR Subscale-Feeling and Mood at discharge
carthink	CAR Subscale-Thinking
discarthink	CAR Subscale-Thinking at discharge
axis1primname	DSM-IV Axis 1 Primary
disaxis1primname	DSM-IV Axis 1 Primary at discharge
axis1secname	DSM-IV Axis 1 Secondary
disaxis1secname	DSM-IV Axis 1 Secondary at discharge
axis1tertname	DSM-IV Axis 1 Tertiary
disaxis1tertname	DSM-IV Axis 1 Tertiary at discharge

axis2primname	DSM-IV Axis 2 Primary
disaxis2primname	DSM-IV Axis 2 Primary at discharge
prinaxis	Primary axis
disprinaxis	Primary axis at discharge
carsubuse	CAR Subscale-Substance Use
discarsubuse	CAR Subscale-Substance Use at discharge
carmed	CAR Subscale-Medical/Physical
discarmed	CAR Subscale-Medical/Physical at discharge
carfam	CAR Subscale-Family
discarfam	CAR Subscale-Family at discharge
carintper	CAR Subscale-Interpersonal
discarintper	CAR Subscale-Interpersonal at discharge
carrole	CAR Subscale-Role Performance
discarrole	CAR Subscale-Role Performance at discharge
carsocleg	CAR Subscale-Socio-Legal
discarsocleg	CAR Subscale-Socio-Legal at discharge
carself	CAR Subscale-Self Care/Basic Needs
discarself	CAR Subscale-Self Care/Basic Needs at discharge
smi	Clients 18 or over-Serious Mental Illness
dissmi	Clients 18 or over-Serious Mental Illness at discharge
sed	Clients under 18-Serious Emotional Disturbance
dissed	Clients under 18-Serious Emotional Disturbance at discharge
dhscase	Clients under 18-DHS case number
disdhscase	Clients under 18-DHS case number at discharge
asimednew	ASI Subscale-Medical
disasimednew	ASI Subscale-Medical at discharge
asiempnew	ASI Subscale-Employ/Support
disasiempnew	ASI Subscale-Employ/Support at discharge
asialcnew	ASI Subscale-Alcohol Use
disasialcnew	ASI Subscale-Alcohol Use at discharge
asidrugnew	ASI Subscale-Drug Use
disasidrugnew	ASI Subscale-Drug Use at discharge
asilegalnew	ASI Subscale-Legal Status
disasilegalnew	ASI Subscale-Legal Status at discharge
asifamilynew	ASI Subscale-Family/Social Relations

disasifamilynew	ASI Subscale-Family/Social Relations at discharge
asipsychnew	ASI Subscale-Psychiatric Status
disasipsychnew	ASI Subscale-Psychiatric Status at discharge
arrested30days	Number of arrests in the past 30 days, or since admission, if less than 30 days
disarrested30days	Number of arrests in the past 30 days, or since admission, if less than 30 days at discharge
arrested6months	Number of arrests in the past 6 months, or since admission, if less than 6 months
disarrested6months	Number of arrests in the past 6 months, or since admission, if less than 6 months at discharge
chronichomeless	Chronic homeless
dischronichomeless	Chronic homeless at discharge
inschool	In school
disinschool	In school at discharge
tasia	Clients under 18-TASI Subscale-Chemical
distasia	Clients under 18-TASI Subscale-Chemical at discharge
tasib	Clients under 18-TASI Subscale-School
distasib	Clients under 18-TASI Subscale-School at discharge
tasic	Clients under 18-TASI Subscale-Employment/Support
distasic	Clients under 18-TASI Subscale-Employment/Support at discharge
tasid	Clients under 18-TASI Subscale-Family
distasid	Clients under 18-TASI Subscale-Family at discharge
tasie	Clients under 18-TASI Subscale-Peer/Social
distasie	Clients under 18-TASI Subscale-Peer/Social at discharge
tasif	Clients under 18-TASI Subscale-Legal
distasif	Clients under 18-TASI Subscale-Legal at discharge
tasig	Clients under 18-TASI Subscale-Psychiatric
distasig	Clients under 18-TASI Subscale-Psychiatric at discharge
outofhomename	Clients under 18-Type of out of home placement
disoutofhomename	Clients under 18-Type of out of home placement at discharge