

***OK-COSIG  
End of Year 4 Evaluation  
Report***

**Volume 4**

**Number 5**

**October 1, 2007 through September 30, 2008**

**Pages 221 – 263**

**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

Mary E. Dillon, Ed.D, MSW  
Adjunct Faculty,  
University of Oklahoma, School of Social Work, Tulsa Campus,  
OU OK-COSIG Associate Evaluator

Joseph F. Kavanagh, MIS, MPA, MSW Student,  
University of Oklahoma, School of Social Work, Tulsa Campus  
OU OK-COSIG Assistant Evaluator

**Year: 2008**

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

**Grant Number: 1 KD1 SM56568**

**State: OKLAHOMA**

## Table of Content

Acknowledgement .....	224
How this year-end evaluation report is organized .....	224
I. Project Implementation.....	226
II. Fourth Year Overview.....	227
A. Description of project changes or modifications [since reapplication] in: .....	228
1. Goals and Objectives .....	228
Goal 1.....	228
<i>Objective 1.1</i> .....	228
<i>Summary of Objective 1.1</i> – .....	229
<i>Objective 1.2</i> – .....	229
<i>Summary of Objective 1.2</i> – .....	229
Goal 2.....	230
<i>Objective 2.1</i> – .....	230
<i>Summary of Objective 2.1</i> – .....	230
<i>Objective 2.2</i> – .....	231
<i>Summary of Objective 2.2</i> – .....	231
<i>Objective 2.3</i> – .....	232
<i>Summary of Objective 2.3</i> – .....	232
<i>Objective 2.4</i> – .....	232
<i>Summary of Objective 2.4</i> – .....	233
2. GRPA Data Collection Project .....	233
IV. Project timeline for project implementation .....	233
V. Approach and Strategies Proposed .....	234
VI. Status of Project .....	234
1. <i>Description of activities during this last year regarding:</i> .....	234
2. <i>Accomplishments</i> .....	236
3. <i>Other significant project activities</i> .....	236

Regional Change Agent Committees.....	239
Accomplishments and work gathering GPRA data .....	239
OU Evaluation Team Report .....	246
The Evaluation Database .....	248
The MACRO Evaluation .....	248
The MEZZO Evaluation .....	249
Major Themes from the Key Informant Interviews in Year Four .....	249
A Beginning Analysis of FY 2006-2007 Data.....	252
Methodology .....	252
<i>Data Source</i> .....	252
<i>Procedure</i> .....	253
<i>Measures</i> .....	253
<i>Data Analysis</i> .....	254
A Beginning Comparison of the Model programs: FY 2005-2006 and FY 2006-2007 .....	259
Identifying People with a Co-occurring Disorder.....	259
<i>Treatment Completion</i> .....	260
<i>Days in Treatment</i> .....	261
<i>Plans for Continued Analysis</i> .....	262
Discussion.....	262
Postscript.....	263

## **Acknowledgement**

With the completion of the fourth year of the OK-COSIG project, the work on the project has come to the end. The fifth year is designed to be the follow-up and evaluation period. The cooperation from the Oklahoma Department of Mental Health and Substance Abuse Services, OK-COSIG staff that started from day one and has lasted for four years was superb. The interactions and correspondence between the Evaluation team members and the OK-COSIG staff resulted in 20 comprehensive quarterly and year-end reports. The data collected over the years tells the story of the OK-COSIG project and documents the outcome of these integrative system components, based on what was done, and how it was done.

Additionally, the OK-COSIG project evaluation has benefited and is made possible because of the cooperation and support of Department staff and administrators at all levels. The accomplishments of this 4<sup>th</sup> year are based on our work together, gathering documents, making observations, and analyzing both qualitative and quantitative data. The work over the four years has accomplished much in the way of laying the ground work necessary to provide services for all people with a co-occurring disorder in Oklahoma.

=====

### **How this year-end evaluation report is organized**

This is the 4<sup>th</sup> year-end evaluation Report for the Oklahoma Co-Occurring State Incentive Grant (OK-COSIG). This report is in two parts. It contains the Co-Occurring State Incentive Grants Year-end Progress Report: SAMHSA Format and a report on the quarterly activities that is similar to past reports. It chronicles interviews, documents, and meeting notes. The SAMHSA Year-end Progress Report summarizes these data.

Following the SAMHSA Year-end Progress Report, a brief overview of the work accomplished by the OK-COSIG staff and the OK-COSIG evaluation team in the last year (October 1, 2008 through September 30, 2008). Next, the work accomplished on the evaluation of the project will follow. Then the goals and objectives by timeline will be described in terms of their status and the resources that were being employed to meet the objectives. Finally, additional emerging themes that were identified in this 4<sup>th</sup> year will be described.

**Editorial note:**

The 4<sup>th</sup> year-end report was produced using the Quarterly Reports from the 4<sup>th</sup> year of this project. 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.

=====

## I. Project Implementation

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

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

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

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

These goals with their objectives, activities and timelines were designed to develop the capacity to identify and treat people who present with the co-occurring disorders of mental health, substance abuse, and trauma within Oklahoma's mental health and substance abuse treatment communities. Further, a major change in the personnel occurred at the end of this quarter. This was the last quarter of the fourth year and the end of the project. As such, all personnel hired and working on the project have been reassigned or moved on to other jobs with the exception of Kim Peterson – Director of Treatment Services (FTE 25%) and Krista Rhodes – Decision Support Services (DSS) Data Analyst.

## II. Fourth Year Overview

At the end of the 4<sup>th</sup> year of the OK-COSIG project, many of the structural barriers to treating people with a co-occurring disorder that have existed over the years between mental health and substance abuse treatment communities have been bridged or weakened. The Infrastructure changes such as the changes in the ODHMSAS State rules governing mental health treatment (Chapter 17) and substance abuse treatment (Chapter 18) continue to stand out as one of the major accomplishments. These rules set the standards for care. The word or terms related to “co-occurring” are used at least “62” times in these two documents. These ODMHSAS Administrative Rules can be viewed at <http://www.odmhsas.org/AdminRules.htm>.

Another major accomplishment was the integrated contracts that are being used for both mental health and substance abuse treatment facilities. The trainings provided by the OK-COSIG staff over the last four years have been effective in alerting those in the substance abuse and mental health community to the treatment needs of those with a co-occurring disorder and the concept of integrated treatment for people with a co-occurring disorder. The intermediate level curriculum has been successfully implemented through statewide agencies.

The evaluation efforts in year five will focus on identifying and verifying the changes that have been made since 2004 using data from the Individual Client Information System (ICIS) for fiscal years 2005-2006 and 2006-2007. The data and follow-up interviews related to the Government Performance and Results Act (GPRA) has also been completed. The GRPA website is reporting that the personnel collecting the GRPA data has a follow-up rate of 89.3 %. This was above the mandatory rate of follow-up, which was 80%. The hard work

of the people collecting the GRPA data is reflected in this rate. This level of follow-up will also be important in terms of the findings derived from the GRPA data. With this level of follow-up there is less concern about those who were not contacted being representative of a subgroup of participants.

The GRPA data will be helpful in answering questions about individual outcomes that cannot be answered using the ICIS data files such as the number of previous hospitalizations and how the people who received services were doing after being discharged.

**A. Description of project changes or modifications [since reapplication] in:**

**1. Goals and Objectives**

The project activities related to the grant ended at the end of year four on September 30, 2008. In year five, the work will focus on data collection and data analysis to determine the degree to which the goals and objectives were accomplished.

**Goal 1.**

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

***Objective 1.1 –***

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

***Summary of Objective 1.1 –***

The primary purpose was to obtain a consensus of the shareholders that changes needed to be made to better provide effective behavioral health services to people with a co-occurring disorder. For all intents and purposes Objective 1.1 has been accomplished. In year three, State rules governing mental health treatment (Title 450:17, Chapter 17) and substance abuse treatment (Title 450:18, Chapter 18) were changed to include the treatment of co-occurring disorders. These rules will make it much more likely that agencies will address the needs of people with a co-occurring disorder. Without a consensus among many of the shareholders, it is unlikely that these state regulations would have been changed.

***Objective 1.2 –***

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

***Summary of Objective 1.2 –***

For all intents and purposes Objective 1.2 has been accomplished. The vast majority of staff of the 28 model programs has been trained with the Core Level and Intermediate Level curriculum. The Change Agent Master Curriculum was received from Dr. Minkoff and Dr. Cline in the 4<sup>th</sup> quarter of 2008. It is a comprehensive curriculum with more than 200 pages of content. This will be used to orient and train new change agents that come on board.

The work to train staff at State funded mental health and substance abuse treatment facilities in the Core Level and Intermediate Co-Occurring curricula continued in year four

(FY 2007-2008). During the FY 2007-2008, ODMHSAS provided 13 Core-Level and Intermediate Co-Occurring trainings and 242 clinicians attended these trainings. These trainings were held at different sites across the state.

Date	People trained
1-08-08:	23
1-18-08:	10
2-05-08:	33
7-08-08:	11
7-15-08:	14
7-16-08:	23
7-18-08:	30
7-23-08:	6
7-24-08:	37
8-05-08:	11
8-28-08:	4
9-04-08:	27
9-09-08	13

## **Goal 2.**

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

### ***Objective 2.1 –***

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

### ***Summary of Objective 2.1 –***

This is an *Objective* that needs continued attention. During the 4<sup>th</sup> quarter, a Change Agent Lunch and Awards Ceremony was held on 9-12-2008 at the Reed Center in Midwest

City to recognize change agents who participated in the OK-COSIG project. At this point in the project, the number of model agencies is 28. The Change Agents, model programs and others were given certificates of appreciation for their work promoting and implementing integrating services throughout Oklahoma. After the awards ceremony, Kim Peterson conducted a meeting with the change agents called 'Integration Sustainability Dialogue.'

The discussion covered a number of important issues related to sustainability. It was decided to continue the Advisory committee so that Change Agents from the different regions can continue to communicate with the Leadership in Oklahoma City and so that the Leadership can stay in contact with those facilities working to provide co-occurring services in the different regions of the State. Kim Peterson is investigating the possibility of providing incentives for this 5<sup>th</sup> year to help agencies and Change Agents help train other agencies that are trying to become co-occurring capable.

***Objective 2.2 –***

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

***Summary of Objective 2.2 –***

Objective 2.2 has been accomplished. The integrated contract establishes common standards for both mental health and substance abuse treatment facilities. As well, statutory changes that became effective this year will allow the Licensed Alcohol and Drug Counselors (LADC) to address co-occurring issues and to counsel people with a co-occurring disorder. The other professional license statutes have not changed; they are already able to address co-occurring issues in treatment.

***Objective 2.3 –***

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

***Summary of Objective 2.3 –***

For all intents and purposes Objective 2.3 has been accomplished. The new contract for both mental health and substance abuse has been implemented. In the past, this contract was used for mental health agencies. This infrastructure change will go a long way toward improving the quality of care for people with co-occurring disorders and people receiving services for substance misuse. This ‘universal contract’ will also set the standard of care across the state for both mental health and substance abuse treatment agencies.

In year three, State rules governing mental health treatment (Title 450:17, Chapter 17) and substance abuse treatment (Title 450:18, Chapter 18) were changed to include the treatment of co-occurring disorders. The rules will make it much more likely that agencies will address the needs of people with a co-occurring disorder.

***Objective 2.4 –***

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

### ***Summary of Objective 2.4 –***

Objective 2.4 has been accomplished. The Core-Level trainings and the Intermediate-Level trainings have been developed. The plan is for the Change Agents to conduct co-occurring trainings in the future.

## **2. GRPA Data Collection Project**

The Objective of this project was accomplished. The collection of the GPRA data came to an end on September 30, 2008. This was a data gathering requirement of SAMHSA as a result of the Government Progress Reporting Act passed by congress. In the case of the COSIG initiative, this Act required follow-up data to be gathered on people who received services for a co-occurring disorder under each COSIG grant. The staff members who were specifically hired to enter and gather the GPRA completed follow-up interviews on 89.3% of the people treated for a co-occurring disorder. One staff person was assigned at each of the three pilot sites to collect the GPRA data.

## **IV. Project timeline for project implementation**

Over the last 48 months of the OK-COSIG project, the majority of the objectives and activities met their targeted timelines and have been completed. These objectives and activities are chronicled in the quarterly reports produced over the last four years and three quarters. They are available online at [http://facultystaff.ou.edu/C/Andrew.L.Cherry-1.Jr/okcosig\\_project.htm](http://facultystaff.ou.edu/C/Andrew.L.Cherry-1.Jr/okcosig_project.htm). They are also available at <http://www.odmhsas.org/isi/>.

## **V. Approach and Strategies Proposed**

In the next quarter, the 1<sup>st</sup> Quarter of the 5<sup>th</sup> year, the focus will be on the Change Agents and the Advisory meeting scheduled locally and at the Department in Oklahoma City. One staff person (FTE 25%) will be retained as a data person so that the GPRA data is made accessible for the year five evaluation.

## **VI. Status of Project**

### *1. Description of activities during this last year regarding:*

- screening and assessment;

The Screening & Assessment Subcommittee completed their work on a database of screening and assessment tools.

- workforce development/curriculum development workgroup;

The Core-Level curriculum and the Intermediate Level curricula are available.

The Change Agent training curriculum has been received from Dr. Minkoff and Dr. Cline.

- financing;

The standardized contract that will be used for both Mental Health and Substance Abuse agencies will be useful in standardizing treatment and payment.

- the change agent regional committees;

The Tulsa Change Agents met three times this quarter. They meet the first Friday of each month. There are two other change agent groups but they were not active in the 4<sup>th</sup> quarter.

- evaluation;

The focus during the 4<sup>th</sup> quarter of 2008 has been on continuing to analyze the ICIS, FY 2005-2006 data to identify outcomes between the Model and Control programs. The analysis has shown that there are positive differences between people being treated at the Model Mental Health agencies and the Control Mental Health agencies. The data management of the FY 2006-2007 data has begun and is near completion. In the next quarter, the first phase of the data analysis should be completed. These findings from the analysis can be found at [http://faculty-staff.ou.edu/C/Andrew.L.Cherry-1.Jr/okcosig\\_project.htm](http://faculty-staff.ou.edu/C/Andrew.L.Cherry-1.Jr/okcosig_project.htm).

One of the overarching impressions, based on the data analysis completed in the 4<sup>th</sup> quarter using the ICIS FY 2005-2006 data, is that people with a co-occurring disorder who are in the Model Mental Health programs (programs that have improved their capacity to treat people with a co-occurring disorder) are spending less time in treatment and completing treatment far more often than people in the Control Mental Health programs providing typical treatment. Moreover, all clients in the Model Mental Health programs have statistically significant better outcomes than the clients in the Control Mental Health programs. However, the dramatic difference between the Model Substance Abuse Treatment programs and the Control Substance Abuse Treatment programs are not as evident.

These findings from the ICIS data FY 2005-2006 and FY 2006-2007 will be compared and contrasted with the GPRA data that was on the Model programs in Oklahoma. The analysis of this data will focus primarily on client outcomes and secondarily on approaches to evaluating outcomes.

## **2. *Accomplishments***

Over the 48 months, the Goals and Objectives for the most part have been accomplished. The Project expanded from the original 7 to 28 programs that are co-occurring capable or are in the process of becoming co-occurring capable. The major infrastructure changes were: 1) changes in the rules and contracts, 2) instituting screening and assessment for people with co-occurring disorders, 3) raising awareness and support for changing to better provide for people with co-occurring disorders, 4) developing curricula and training mental health and substance abuse staff, 5) developing a uniform contract for both mental health and substance abuse agencies, and 6) combining the mental health court and drug court into a specialty courts division. The combined courts will benefit those people with a co-occurring disorder that become involved in the legal system.

## **3. *Other significant project activities***

- The GPRA data has been collected.
- The Oklahoma Department of Mental Health and Substance Abuse Services have completed four years of successful work on the OK-COSIG project.
- The Change Agents can be the major resource (i.e., training, mentoring) for agencies and new Change Agents who are in the process of becoming co-occurring capable.

## **VII. Difficulties/Problems Encountered**

### **1. Barriers to accomplishment**

- A plan is needed to mentor agencies that are trying to become co-occurring capable programs.

2. Strategies to overcome barriers

- A plan is needed to continue to train staff at new and model agencies related to the agencies becoming and continuing to be sustained as co-occurring capable programs.

=====

### **OK-COSIG Yearly Evaluation Report - Year 4**

This is the report for Year 4 on the OK-COSIG project to improve treatment of persons with Co-Occurring Mental Health and Substance Abuse related disorders in Oklahoma. The overarching goal of the OK-COSIG project was to improve the delivery of state-funded services for people in Oklahoma with a co-occurring disorder. The project used two interventions to promote systemic infrastructure change:

- 1) it developed a standard protocol for screening and assessment of people with a mental health and substance abuse problem, and field test and evaluate a screen;
- 2) a model was developed to provide integrated treatment that is accessible, culturally competent, and grounded in evidence-based practices.

To this end and to recognize the efforts and work accomplished, A Change Agent Lunch and Awards Ceremony was held on 9-12-2008 at the Reed Center in Midwest City to recognize change agents who participated in the OK-COSIG project. The Change Agents,

model programs and others were given certificates of appreciation for their work promoting and implementing integrated services throughout Oklahoma. After the awards ceremony, Kim Peterson conducted a meeting with the change agents called 'Integration Sustainability Dialogue.' The discussion covered a number of important issues related to sustainability. The following highlight the issues discussed.

- It was decided to continue the Advisory Committee and to meet quarterly.
- It was suggested that two Change Agents or regional representatives from each region attend the Advisory Committee meetings.
- It was suggested that bimonthly regional Change Agent meetings might improve attendance.
- It was suggested that regional Change Agents meetings could help break down barriers between agencies so that clients can move between agencies.
- Change Agents meeting could assist agencies attempting to become co-occurring capable.
- Change Agents would be able to provide technical assistance to agencies attempting to become co-occurring capable.
- Regional meetings can be a place to discuss issues that come-up in the regions.
- Change Agents meeting would assist relationship building and networking.
- The Regional change agent meeting can help break down barriers between mental health and substance abuse treatment programs.
- The Advisory Committee can help different regions deal with similar issues.
- The Advisory Committee will facilitate the communication between the Change Agents and the ODMHSAS Leadership.

As well, Kim Peterson was to investigate the possibility of providing incentives for this 5<sup>th</sup> year to help agencies and Change Agents train other agencies that are trying to become co-occurring capable. She was also open to holding the Advisory Committee meetings in other parts of the State.

### **Regional Change Agent Committees**

During the 4<sup>th</sup> Quarter the North Eastern Regional Change Agent committee met three times. The other two Regional Change Agent committees did not meet during the 4<sup>th</sup> Quarter. The hope is that they will be meeting in year five.

### **Accomplishments and work gathering GPRA data**

The staff gathering Government Performance and Results Act (GPRA) data has, as of the end of the 4<sup>th</sup> year, completed their work. Their follow-up rate was 89.3%. The mandatory rate was 80%. This high rate of follow-up shows the dedication and hard work of the three people who did the GRPA follow-up work in Norman, Tulsa, and Vinita/Tahlequah. Collection of the GPRA data ended September 30, 2008.

The process was based on three data gathering tasks. Once a person was diagnosed with a co-occurring disorder: 1) data was gathered from the initial intake, 2) data was collected at discharge, and 3) data was collected six months after discharge. During the intake and discharge phases, data concerning the services provided to the client was collected. Demographic data such as gender, race, age range, an extensive drug and alcohol history, and living situation and housing was collected. Data was also collected on case management activity, screenings, treatment and counseling. The data gathered for the GPRA database on each client was comprehensive. The unique thing about the GPRA data is the



513 SE Quapaw

Tuesday at 1pm

Contact Cindy@ (918) 342-9530

Ext. 2443 or 337-8080

**Boley**

Starting Point -

HWY 62E

Monday at 1:30pm

Contact Mike @ (405) 227-2339

**Claremore - Closed Meetings**

Grand Lake MHC

2000 W Blue Starr Drive

Friday at 2pm

Contact Cindy@ (918) 342-9530

Ext. 2443 or 337-8080

**Clinton – Closed Meetings**

Red Rock BHS

100 N. 31st

Tues, Wed, and Thurs at 1:00

Contact Ginger@ 580.323.6021 x2288

**Durant**

Mental Health Services of Southern Okla.

1001 W. Main St

Tuesday's

For more information call

(580) 924-7330

**Fairland - Closed Meetings**

Residential Care

Friday at 10am

Contact Cindy@ (918) 342-9530

**Grove - Closed Meetings**

House of Hope Inc

HWY 59

Friday at 12pm

Contact Cindy@ (918) 342-9530

Ext. 2443 or 337-8080

**Lawton**

Coming Soon

For more information

Contact Suzan @ (580) 591-1253

**Miami - Closed Meetings**

Grand Lake MHC

120 Treaty Road

Friday at 11pm

Contact Cindy@ (918) 342-9530

Ext. 2443 or 337-8080

**Norman**

Central Oklahoma CMHC

Moved to 700 Asp Street Suite 4

Contact Becky @ (405) 573-3987

**Norman - Closed Meetings**

Griffin Memorial Hospital

Hope Hall

Friday at 2pm

Contact Juan @ (405) 630-5100 ext 2875

**Norman – Open Meetings**

Norman Alcohol and Drug Treatment

Center

900 E. Main BLDG 54

Sunday @ 8pm

Contact Suzan @ (405) 522-1934

**Norman**

Transition House

700 Asp St Suite 4

Wednesday 5:30pm

Contact Becky @ (405) 573-3987

**OKC - Closed Meetings**

Crisis Center

1200 NE 12<sup>th</sup>

Saturday at 4:30pm

Contact Candy @ (405) 522-8129

**OKC**

Exodus Foundation

504 S. Dewey Ave

Tuesday at 1pm

Contact Alice @ (405) 208-4238

**OKC**

Hope CSI

4720 S. Shields Blvd

Wednesday at 1pm

Contact Wanessa @ (405) 634-4400

**OKC**

Jesus House

3134 W. Sheridan

Monday at 6:30 pm

Contact Penny @ (405) 232-7164

**OKC**

North Care

1140 N. Hudson

Thursday at 1pm

Contact John @ (405) 272-0660

Ext. 1132

**OKC**

Specialized Outpatient Services

5208 Classmen Circle

Wednesday at 1pm

Contact Gloria @ (405) 810-1776

Ext 229

**Pryor – Closed Meetings**

Grand Lake MHC

231 Graham

Thursday at 8:30

Contact Cindy @ (918) 342-9530

Ext 2443 or (918) 337-8080

**Sallisaw - Closed Meetings**

209 N Walnut Apt "B"

Daily at noon

Contact John @ (918) 774-9511

**Tulsa – Closed**

Family & Children Services

3604 N Cincinnati

Tuesday at 5:30 pm

Contact Kelli @ (918) 425-4200

**Tulsa – Closed Meetings**

Women & Children's Center

2442 Mohawk Blvd

Contact Dana @ (918) 430-0975

**Tulsa**

Associated Center for Therapy (ACT)

7010 S. Yale Ave. #251

Tuesday at 10:30am

Contact Donna @ (918) 492-2554

**Tulsa**

ACT Transition House

For more information contact

Donna @ (918) 492-2554

**Tulsa - Closed Meetings**

Center for Behavioral Health

2323 S. Harvard

Contact Pam @ (918) 293-2140

**Tulsa - Closed Meetings**

Domestic Violence Intervention

For more information contact

Remy @ (918) 584-7500

**Tulsa**

Mental Health Association

COMING SOON

For more information contact

Mark @ (918) 585-1263

**Vinita - Closed Meetings**

Grand Lake MHC

405 E. Excelsior

Thursday at noon

Contact Cindy @ (198) 342-9530

Ext 244 or (918) 337-8080

=====

**OU Evaluation Team Report**

The focus of the work by the evaluation team in the 4<sup>th</sup> Quarter of the fourth year has been on completing the analysis of the ICIS, FY 2005-2006 data. Using this data the

variables, the analytical approaches, and the types of analyses that are needed to answer the questions about outcome have for the most part been determined. The data is broken out into several subgroups to better identify changes and effects of the transformation efforts. Two important subgroups are male and female. A data file is developed for each group. Then the data on the mental health centers and the substance abuse treatment programs are also grouped into separate data files.

Currently the FY 2005-2006 has been organized into eight separate data files. Using this data, the characteristics of people with a co-occurring disorder are compared to people admitted for treatment that do not have a co-occurring disorder at both the mental health and substance abuse treatment Model and Control programs. In the analysis, some significant differences have been identified that suggest that the Mental Health Model programs are having a major effect on the treatment outcome of people with a co-occurring disorder. These differences are described in detail in the 3<sup>rd</sup> Quarter Year 4 report and in this quarterly report. See the section below under the header, *A comparison between the Mental Health and Substance Abuse Model programs regarding people treated for a Co-occurring Disorder.*

Data management on the ICIS FY 2006-2007 data file, for the most part has been completed. There are still some questions about variables and responses that need to be resolved but the initial analysis has begun. See the section on page 260 under the header, *Beginning Comparison of the Model programs: FY 2005-2006 and FY 2006-2007*

The primary focus in the next Quarterly report will be to continue to analyze the FY 2006-2007 data. This analysis will provide FY 2006-2007 information on how people with a co-occurring disorder did in the Model agencies as compared to the Control agencies. Just as important, it will allow for the comparison of data from year two to year one data.



## **The MEZZO Evaluation**

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

At the end of year three the evaluation of the *Service Coordination and Networking* identified seven primary themes. In year three, the information collected from the 11 key informants was analyzed. Again in year three, using a slightly modified Delphi methodology to obtain a multi-level perspective, the seven focus group members (clinicians from participating agencies) were also asked to rank the themes identified from the key informant interviews. In the beginning of the fourth year this information was used to provide further training and support to the agencies and personnel providing treatment services to individuals with a co-occurring disorder.

As the fourth year began, many focus group members continued to express the belief that the COSIG Project was coming to an end. They acknowledged the work that had been accomplished but expressed concern about the work that was left undone. The seven themes and the perspective of the focus group members reflect this state of mind.

### **Major Themes from the Key Informant Interviews in Year Four**

#### 1) Assessment:

In the majority of agencies, although the staff continues to work on the assessment process, screening and assessment has improved. The process of integrating the screening and assessment for people with a co-occurring disorder with the standardized assessment

procedure required by an individual “accrediting body” is continuing. Trauma identification has improved, but staff still needs more training. Nevertheless, at some agencies, the assessment process has stayed pretty much the same as before the COSIG Project.

2) Training:

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

3) Services Provided:

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

The waiting list for outpatient treatment services is still very long. There may be as many as 70 people on a waiting list at any given time. Transportation to and from treatment is still a problem. This continues to be a problem in year four of the project.

4. Service Barriers:

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

5) Self-Help Groups:

Over 30 Double Trouble Recovery (DTR) groups have been started over the last four years. Some agencies had difficulties with the initial start-up of groups in year three but dramatic progress in developing these groups occurred in year four. The Recovery Support Specialist staff has been instrumental in starting and maintaining DTR groups in some agencies and in various communities.

6) Funding:

Agency administrators have expressed concern about the amount of staff time required for OK-COSIG training and program development, especially since no additional monies were allocated. This continues to be the case with the additional 13 Model programs that came on-line this past year. Additionally, the paperwork increases when the agencies become co-occurring capable providers.

7) Next Step:

There will be an on-going need at agencies for staff training related to people with a co-occurring disorder. For agencies to continue to comply with co-occurring capacity standards, the Department will need to find a way to provide for continued trainings.

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

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

=====

## **A Beginning Analysis of FY 2006-2007 Data**

This is the beginning analysis of data collected on adults who received treatment from both the Model and Control programs in FY 2006-2007. This analysis is intended to provide general background on the ICIS data elements. It is also a continuation of the data management process to ensure the veracity of the data and the variables. The data management work will continue into the 1<sup>st</sup> quarter of year five.

### **Methodology**

#### ***Data Source***

Data used in this study was collected on 30,645 adults admitted for treatment to 32 agencies (28 Model and 4 Control agencies) providing mental health or substance abuse treatment in Oklahoma. The 28 Model programs (18 mental health programs and 10 substance abuse treatment programs) used a variation of integrated treatment for people with the co-occurring disorders of mental illness and a substance use disorder, and the four (4) Control programs are two mental health and two substance abuse treatment programs that provided standard treatment. The data was collected over a one year period from October 1, 2006 through September 30, 2007 (FY 2006-2007). In this study sample 30,640 were in mental health programs and 4,385 were in substance abuse treatment programs. This represents a 37% increase over the number of people on which we had data in FY 2005-2006. In FY 2005-2006, there were 15 Model programs and five Control programs. One of the Control programs became a Model program in FY 2006- 2007.

### ***Procedure***

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

This data reflects the results of the Oklahoma Co-occurring State Incentive Grant (OK-COSIG) project to develop and provide “best practice” treatment for people with co-occurring disorders. Clinicians, staff, and administrators in the Model programs were exposed to the latest concepts of treating people with the co-occurring disorders between October 2004 and September 2005. The data was collected on individuals treated in the year following the first year of reorientation, clinical training, and organizational modification. The data analyzed for this study was collected between October 1, 2006 and September 30, 2007.

### ***Measures***

To determine if a person had an indication of a co-occurring disorder scores of four (4) and above on the Addiction Severity Index (ASI) subscale psychosis, and a score of 29 and above on the Client Assessment Record (CAR) subscale substance misuse were used to identify people with an indication of a co-occurring disorder. Among men admitted for

treatment, 4,139 (35.6%) had an indication of a co-occurring disorder while 3,457 (25.7%) of women had an indication of a co-occurring disorder.

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

### ***Data Analysis***

The differences between people with an indication of a co-occurring disorder and people with *no* indication of a co-occurring disorder were examined using crosstabulation, t-Tests, and multiple regression analyses. The chi-square tests were used to compare the two groups on nominal variables such as gender, race/ethnicity, admission status, presenting problem, diagnosis, program completion, etc. The cross-tabulation and t-test were used to identify the differences between the two groups on ordinal, interval, and ratio level data.

### **Gender differences**

There were more females (51.9%) than males (48.1%) admitted for treatment. Among this group of men admitted for treatment, 4,139 (35.6%) had an indication of a co-occurring disorder while 3,457 (25.7%) of women had an indication of a co-occurring disorder.

### **Age Differences**

As a group, people in this sample were approximately 35.75 years of age. People with an indication of a co-occurring disorder were younger (35.45 years of age). People with *no*

indication of a co-occurring disorder tended to be older (36.08 years of age). This was a statistically significant difference ( $t = 3.89$ ,  $df = 23,498$ ,  $p < .000$ ).

### **Differences by Race/Ethnicity**

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

People who identify as White – Statistically, White women and men are the typical clients admitted to this sample of state funded treatment facilities (77.1%). This is similar to the state population of people who identify as White (75.6%).

People who identify as African Americans – Although conventional thinking is that instead of seeking treatment through state funded mental health or substance abuse facilities, African Americans tend to seek help through their church. Based on this data, however, only being African American would suggest a higher than expected number of men and women admitted for treatment, approximately 12.6% of the sample as opposed to 6.9% of the state population.

People who identify as Asians – The total number of Asians in this population (118) were too small to have confidence in any statistical conclusions. The low percentage seeking treatment, however, could have resulted from a significant number of Asian clients who did not seek treatment for a MH/SA disorder because of the stigma that would befall them and their family. Other possible reasons for the low numbers seeking treatment would include: 1) the Asian culture is more family oriented and tends to deal with major issues within the

family structure; 2) alcoholism in the Asian culture could be a smaller portion of the population because alcohol is not easily tolerated physically by most Asians.

People who identify as Hispanics – The total number of Hispanics in this population were too small to have confidence in any statistical conclusions. Hispanics made up approximately 3.1% (964) of people admitted for treatment in this sample. This is less than 50% of the Hispanics living in Oklahoma. Possible reasons for the low numbers seeking treatment would include: 1) the Hispanic culture is more family oriented and tend to deal with major issues within the family structure; 2) treatment settings are not staffed to treat people who speak Spanish, and 3) sanctions related to legal status creates a hostile environment for both legal and non-legal Hispanics residing in Oklahoma.

### **Relationships**

People with a co-occurring disorder (19.5%) were less likely to be involved in a relationship than people with no indication of a co-occurring disorder (23.6%). People with *no* serious mental illness and *no* co-occurring disorder were more likely to be married or living as married (26.3%). People with no indication of a co-occurring disorder, but identified as having a serious mental illness were less likely to be married or living as married (22.4%). People with an indication of a co-occurring disorder, and *no* serious mental illness were likely to be married or living as married (22.5%), while people with a co-occurring disorder *and* a serious mental illness were less likely to be married or living as married (17.6%). This suggests that those with a serious mental illness tend to have fewer relationships than those without a serious mental illness.

### **Difference in Education**

Among the adults admitted for treatment, the average grade in school completed was 11.68. Of this group, 68.8% completed 12 years of school or more. Among those with an indication of a co-occurring disorder, 67.6% completed 12 years of school or more. Those with no indication of a co-occurring disorder had a similar level of education, 68.5% completed 12 or more years of school.

### **Difference in Income**

The per capita income in Oklahoma in 2006 was \$32,391. People with no indication of a co-occurring disorder reported an average income of \$7,039 at admission, and people with an indication of a co-occurring disorder reported an average income of \$5,558 ( $t=5.650$ ,  $df = 25,074$ ,  $p<.000$ ) at admission.

### **Differences in Homelessness**

People with an indication of a co-occurring disorder (7.1%) were more likely to be homeless than were people with no indication of a co-occurring disorder (4.1%) ( $X^2=100.798$ ,  $df = 1$ ,  $p<.000$ ).

### **Differences in Admission Status**

There were fewer 'voluntary admissions' (about 13% less) among people with an indication of a co-occurring disorder. This suggests that people with an indication of a co-occurring disorder were forced into treatment more often than people with no indication of a co-occurring disorder.

### **Difference in Arrest History**

Adults with an indication of a co-occurring disorder, who were arrested 30 days before admission, had significantly more arrests than adults with *no* indication of a co-occurring disorder. People with a co-occurring disorder had a higher arrest rate in the 30 days before admission to treatment. Those with an indication of a co-occurring disorder averaged .05 arrests while those with *no* co-occurring disorder averaged .03 arrests ( $t = -5.59$ ,  $df = 23,498$ ,  $p < .000$ ).

Adults with an indication of a co-occurring disorder, who were arrested six (6) months before admission, had significantly more arrests than adults with *no* indication of a co-occurring disorder. People with a co-occurring disorder had a higher arrest rate six (6) months before admission to treatment. Those with an indication of a co-occurring disorder averaged .14 arrests while those with no indication of a co-occurring disorder averaged .09 arrests ( $t = -7.81$ ,  $df = 23,498$ ,  $p < .000$ ).

### **Difference in the Number of People with a Serious Mental Illness**

At admission there were 15,990 (67%) adults identified as being seriously mentally ill, and at discharge, there were 13,002 (64.2%) adults identified as being seriously mentally ill. Among adults identified as having a serious mental illness 32.4% ( $n = 4,211$ ) also had an indication of a co-occurring disorder.

### **Difference in GAF scores**

At admission, adults with an indication of a co-occurring disorder were given significantly lower/worse (average = 41.34) GAF scores than adults with *no* indication of a co-occurring disorder (average = 46.69) ( $t = 32.28$ ,  $df = 25,074$ ,  $p < .000$ ). At discharge, there



### ***Treatment Completion***

In this table it appears that treatment completion has gone up for men and women with an indication of a co-occurring disorder and dropped for men and women with no indication of a co-occurring disorder.

Differences between Model programs by year on Treatment Completion

Model Programs	MEN No COD	MEN COD	Women No COD	Women COD
Models FY 2005-2006	54.5%	45.5%	66.3%	33.7%
Models FY 2006-2007	33.8%	50%	26%	41%

***Days in Treatment***

This table shows the days in treatment increasing for both men and women. Among other possible explanations, this may have resulted because the new model programs that are less effective than the more developed and mature programs identified as the original 15 model programs.

Differences between Model programs by year on Days in Treatment

Model Programs	MEN No COD	MEN COD	Women No COD	Women COD
Models FY 2005-2006	98	45	98	45
Models FY 2006-2007	143	91	164	120

*Plans for Continued Analysis*

In the last year of this project,

The ICIS data from the Fiscal Years 2005-2006, 2006-2007, and 2007-2008 will be compared as to the differences in the demographics, treatment, and outcome of treatment over the three year period. The original 15 Model programs will be compared to the group of 13 model programs that came on-line in 2006-2007 and the control programs. This will provide information to show if the original 15 Model programs maintained the level of service, treatment, and outcome identified in FY 2005-2006. Furthermore, to determine if the 13 new Model programs were able to produce similar outcomes as the original 15 Model programs, the 13 new Model programs will be compared to the 15 original Model programs on data collected in FY 2006-2007 and FY 2007-2008 .

=====

**Discussion**

Based on these analyses, there is still a great deal of statistical analysis work ahead for the OK-COSIG evaluation team. The sheer size of the data set precludes a cursory examination. Much useful information is available that will support or show a lack of support for the OK-COSIG project to made infrastructure changes to improve the treatment for people with co-occurring disorders. Even so, to this point, the OK-COSIG team has accomplished a great deal. In Oklahoma today, people with a co-occurring disorder have a much greater chance of being identified and receiving treatment that is responsive to his or her co-occurring disorder. Without, the OK-COSIG project (an effort to move science to service) it is not unimaginable to believe that this level of service and treatment for people with a co-occurring disorder would not be available for years to come.

## **Postscript**

The activities related to the OK-COSIG project are reported in great detail in the previously 16 quarterly reports produced through out each year. These can be found on the website: [http://faculty-staff.ou.edu/C/Andrew.L.Cherry-1.Jr/okcosig\\_project.htm](http://faculty-staff.ou.edu/C/Andrew.L.Cherry-1.Jr/okcosig_project.htm). The efforts of all involved in this project have been appreciated.

To sum up, the last four years have been a study in organizational change. At times it was been chaotic and even hectic. Nevertheless, much has changed for ODMHSAS, agency administrators, clinicians, and people who have a co-occurring disorder that seek treatment in Oklahoma. There is much to reflect back on and even more to be proud of. Not everything that was planned was completed nor accomplished. Then again, much more was accomplished than was planned for when the proposal was submitted to SAHMSA almost five years ago. The leadership and staff at ODMHSAS, and the administrators and staff at the model programs succeeded in changing the mental health and substance abuse treatment community in Oklahoma.