

Chapter 5: Adult Substance Abuse Services

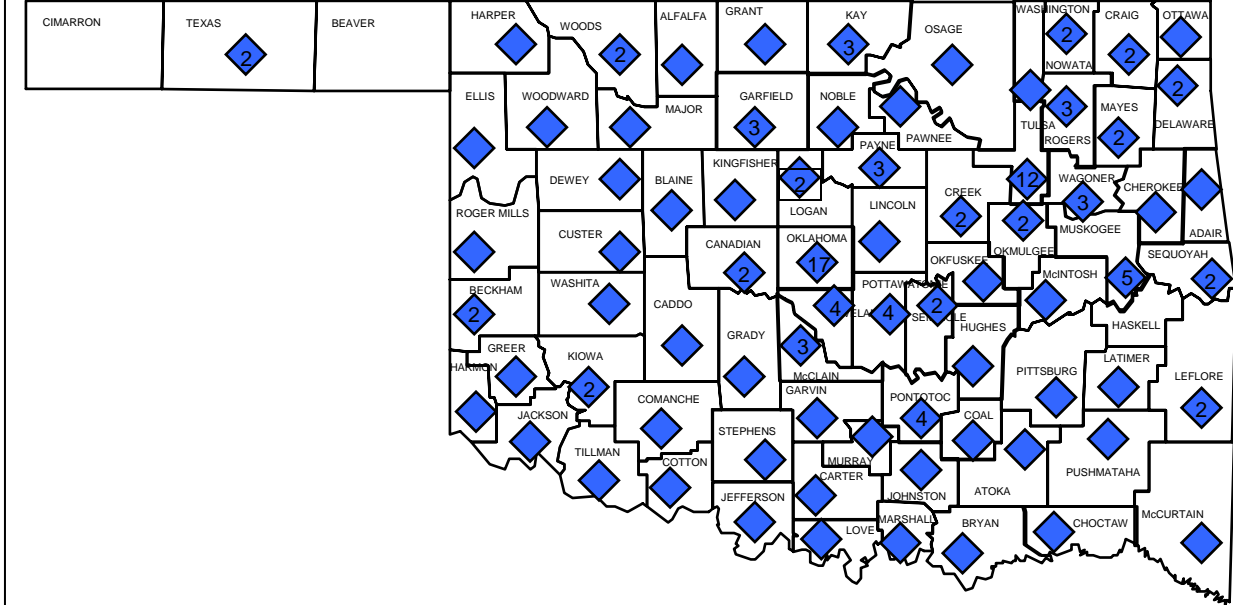
The purpose of this chapter is to describe substance abuse services for adults, including existing resources, particular strengths of current programs, and needs. The chapter includes narrative information gathered through focus groups and personal interviews, as well as existing data from ODMHSAS and other sources.

A. Existing Resources

ODMHSAS funds or provides a continuum of substance abuse treatment services within the State. The department contracts with approximately 60 private, non-profit, certified agencies to provide detoxification, residential, halfway house, outpatient, intensive outpatient, and early intervention services. These agencies include substance abuse treatment facilities, community mental health centers, youth and family services agencies, and Native American programs. Seven ODMHSAS-operated agencies provide residential and outpatient treatment services for adults in a range of facilities, including gender-specific programs, programs serving both men and women, and programs for women with children. The University of Oklahoma Health Sciences Center provides screening, assessment, and treatment planning for children with Fetal Alcohol Spectrum (FAS.) The Department also contracts with six agencies to provide early intervention services through public schools. Services include working with school personnel and parents to develop drug-free strategies with high-risk or substance-using students, educational programs, and group counseling. Exhibit 5.1 illustrates the locations of substance abuse treatment facilities in Oklahoma. The majority of counties have a substance abuse treatment provider that offers some level of substance abuse treatment funded by ODMHSAS.

The Oklahoma Health Care Authority (OHCA), the State Medicaid Agency, currently funds medical detoxification, outpatient psychotherapy, case management, and skills development services. OHCA recognizes that there is a gap in the continuum of care needed for adults with substance abuse problems and those with co-occurring substance abuse and mental health problems, and has proposed the addition of residential, partial hospitalization, and intensive outpatient services to the benefit package.

**Exhibit 5.1. Locations of ODMHSAS-Contracted
Substance Abuse Programs
FY2006**



ODMHSAS developed and operates a statewide drug court program, with a total of 50 drug courts serving 53 counties; others are in various stages of development. The Department has a series of specialty courts, including family court and juvenile drug court. ODMHSAS' collaboration with the Oklahoma Department of Corrections (ODOC) has established several avenues for treating inmates with substance abuse problems. The ODMHSAS contracts with established substance abuse programs to provide screening and assessment at the State's prison intake facility and to provide treatment services at several of the State's prisons; treatment services are also provided at specific community corrections centers and to individuals in the probation and parole system (see Chapter 8).

In 2005, after implementation of a state lottery in Oklahoma, legislation was signed by the Governor making ODMHSAS the statutory authority for gambling issues. New funds were made available to provide training for providers, additional treatment services, and prevention programs. The department began a training initiative for treatment professionals to become certified to provide gambling-specific services. Over 60 treatment professionals have completed the training. The department has a 24-hour problem and compulsive gambling help-line, answered by certified gambling treatment professionals.

The Department supports peer advocacy through contracts with the statewide organization Oklahoma Citizen Advocates for Recovery and Treatment Association (OCARTA). Among the services OCARTA provides is 30-day follow-up with people leaving residential substance abuse facilities, advocacy, and bringing Job Clubs and AA/NA into prisons.

The department works closely with the Oklahoma Substance Abuse Service Alliance (OSASA), the treatment provider organization. OSASA collaborates with the department on a variety of issues regarding substance abuse treatment services.

B. Strengths

ODMHSAS has collaborated with OHCA in an effort to make Medicaid funding available for substance abuse services. In 2005, Medicaid introduced new behavioral health rules specific to substance abuse, and ODMHSAS is providing training and technical assistance to treatment programs to enhance their understanding of the new rules and requirements. ODMHSAS treatment contracts require providers to become nationally accredited and treatment staff to become certified to be eligible for Medicaid certification.

With the assistance of the Robert Wood Johnson Foundation and the Network for the Improvement of Addiction Treatment, ODMHSAS has built a foundation for a statewide improvement initiative among substance abuse treatment providers. The goal of this initiative is to systematically identify problems, implement changes and measure results. The next step is to use the lessons learned and extend improvement in access and retention throughout the state's substance abuse treatment system. The Substance Abuse Services Division reviewed internal processes affecting services at the provider level and made significant changes to state-mandated requirements, which has dramatically reduced the amount of paperwork required from providers.

At the program level, ODMHSAS works directly with substance abuse treatment providers to improve services. Technical assistance is available to any contracted treatment provider on a variety of topics, including treatment planning, progress note writing, and proper use of assessment tools.

In collaboration with residential substance abuse treatment providers, ODMHSAS has developed a capacity list to assist those needing residential placement. This list is reflective of any empty residential bed at any time throughout the state, and is updated and distributed to all substance abuse treatment providers on a daily basis.

ODMHSAS has expanded the practice of case management within the substance abuse field by providing continuous training and technical assistance. Integrated, strengths-based, person-centered case management training was developed, using a generalist model which focuses on substance abuse, mental health, and trauma. Prior to the implementation of the substance abuse component and the generalist model, there were 28 certified case managers within the substance abuse programs. Currently there are approximately 50 certified case managers within substance abuse programs. A substance abuse case management coordinator works with all levels of care to implement an integrated case management component within provider programs. A four-day Behavioral Health Case Manager (BHCM) training is offered, with the goal of expanding the number of certified BHCMs within the substance abuse field, and increasing the number of certified case managers who can provide supervision to others going through the case management certification process. Technical Assistance is provided to facilities as ODMHSAS moves toward the implementation of the strength-based, person-centered model and documentation of the provision of case management. Providers are gaining a greater understanding of case management in the continuum of care and the positive outcomes it provides.

Collaboration with the Department of Human Services (OKDHS) benefits both agencies' clients. OKDHS provides funding to ODMHSAS to subcontract with certified treatment agencies to provide screening, assessment, and outpatient substance abuse services to clients receiving or making application for Temporary Assistance to Needy Families (TANF) and clients who have Child Welfare involvement.

Four women's substance abuse facilities and one substance abuse facility for adolescents are implementing the Sanctuary Model, a [trauma-informed method](#) for creating or changing an [organizational culture](#) to promote healing for trauma survivors. The Sanctuary Model aims to increase the perceived sense of community/cohesiveness, democratic decision-making and shared responsibility in problem-solving and to promote recovery, healing, and growth. A week-long training on the Sanctuary Model was attended by the directors and several staff from each of the five facilities.

ODMHSAS funds ten women's treatment programs located around the state in both urban and rural locations, with a total of 273 beds. The programs offer residential, halfway house and one intensive outpatient program. Two of the ten programs offer multiple levels of care (from detox to residential to halfway house to outpatient) and one is a long-term residential program with lengths of stay up to one year.

ODMHSAS collaborates with the Oklahoma City Housing Authority (OCHA) and Turning Point (Community Action Agency) on a 48-unit sober living apartment building. This housing is available to adults who have completed residential substance abuse treatment, with priority given to women with dependent children. The ODMHSAS-funded services include on-site case management and crisis intervention services, available 24 hours a day; on-site educational and support groups; and links to substance abuse treatment and aftercare.

C. Needs and Existing Barriers

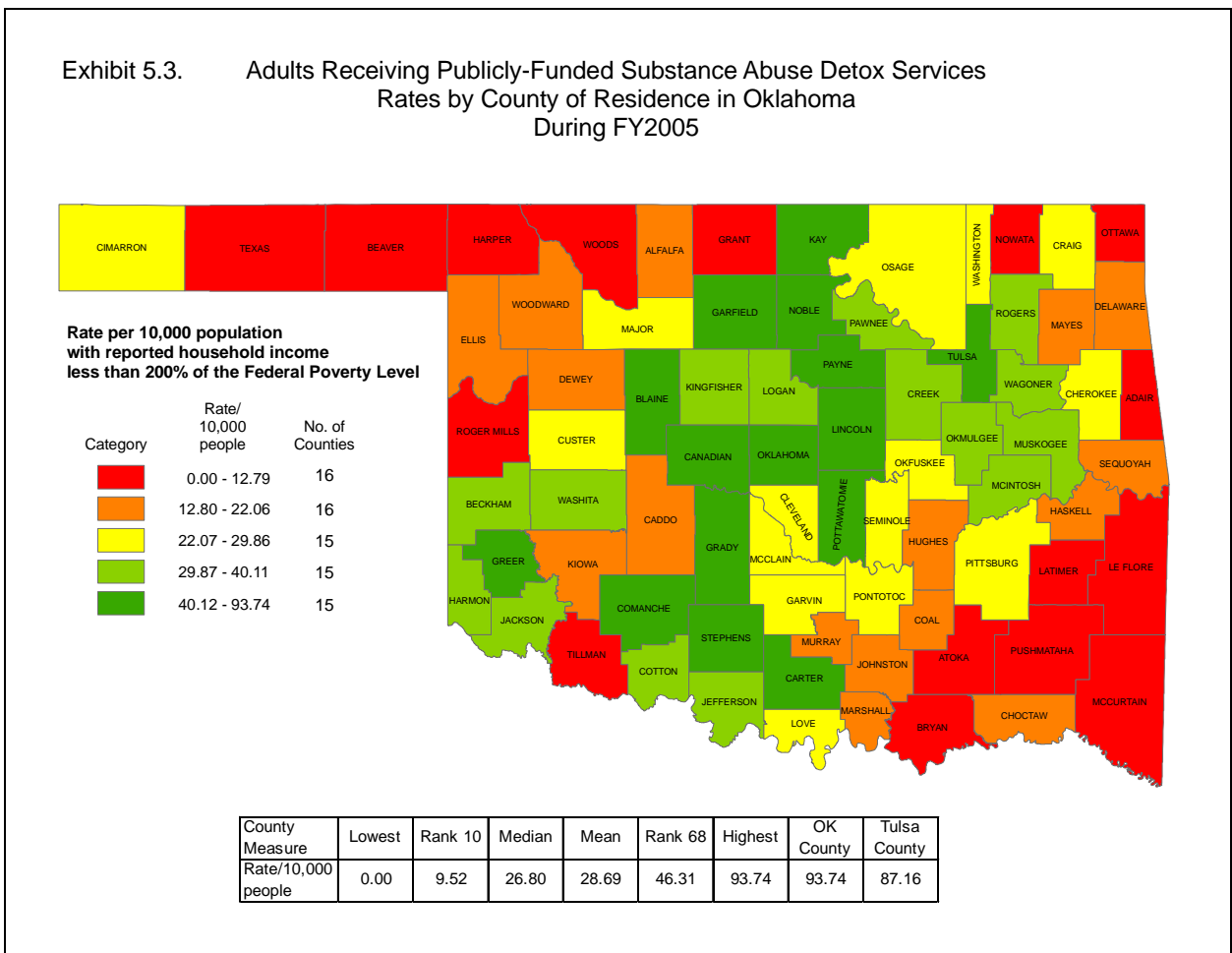
Unmet Needs

Combined, the ODMHSAS and OHCA funded substance abuse treatment services for 18,253 adults in FY2005. The estimated adult population in need of substance abuse services is 88,371 (see Chapter 2), leaving an estimated 70,118 adults with low income not receiving needed treatment. The majority of clients who received ODMHSAS-funded substance abuse treatment listed alcohol as one of their drugs of choice at admission; however, there has been a steady decrease in this percentage since FY2001 (see Exhibit 5.2). Marijuana is also a popular drug, used steadily over the years by about 45% of substance abuse treatment clients. The use of methamphetamines has increased slightly since FY2001, with a similar increase for cocaine and heroin use.

Admission Year	Total Clients	Drug Type													
		Alcohol		Marijuana		Methamphetamine		Cocaine		Stimulants		Heroin		Other*	
		%	#	%	#	%	#	%	#	%	#	%	#	%	#
FY2001	11,666	69.0	8,045	46.1	5,383	28.4	3,308	19.9	2,317	8.4	980	5.5	644	4.4	518
FY2002	12,530	67.1	8,402	45.9	5,752	28.6	3,588	19.7	2,463	8.1	1,019	6.2	772	4.1	518
FY2003	12,715	64.4	8,194	43.6	5,544	28.4	3,605	20.0	2,538	8.5	1,076	6.2	783	4.4	557
FY2004	13,046	58.7	7,652	45.1	5,883	31.4	4,101	19.6	2,555	8.3	1,082	7.6	995	3.7	484
FY2005	13,703	57.	7,85	44.	6,05	31.2	4,280	22.	3,04	8.	1,20	8.	1,22	3.	47

		3	7	2	2			2	1	8	0	9	2	5	9
*Other includes: Sedatives, LSD and Inhalants															

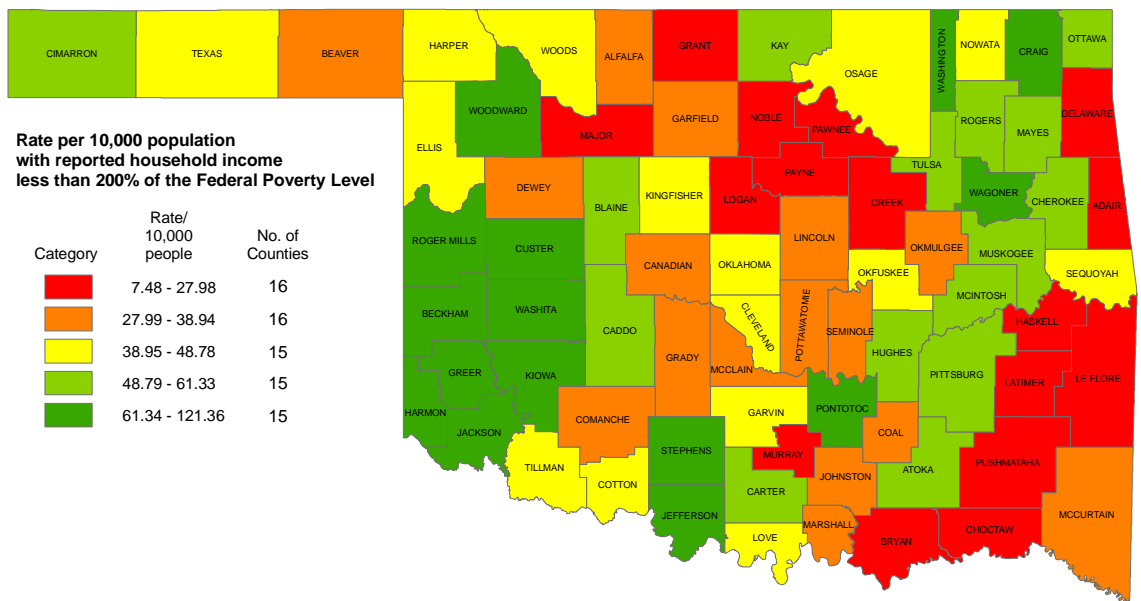
The following exhibits show the rates, by level of care received in FY2005, per 10,000 adults in Oklahoma with a reported household income less than 200 percent of the Federal Poverty Level by county of residence. The rates were calculated using the unduplicated count of clients who received services in a given level of care and funded by ODMHSAS and/or OHCA, by county of residence, and divided by the number of adults in a county with a reported income less than 200 percent of the Federal Poverty Level. The counties shown in red have the lowest rates while the counties in dark green have the highest rates.



As shown in Exhibit 5.3, the rate of clients who received publicly funded detox services by county ranged from 0.0 to 93.74 per 10,000 adults with low income. Harper County had the lowest rate and was the only county with no detox clients, while Oklahoma County had the highest rate, followed closely by Tulsa County with 87.16. The median and mean rates were 26.8 and 28.69, respectively. To better evaluate the range of rates, the lowest nine ranked counties and highest nine ranked counties were

excluded, resulting in an inner range of rates from 9.52 to 46.31. Within the inner range, the upper range limit is five times higher than the lower range limit, indicating a disparity in penetration rates among counties. There appears to be a clustering of counties in the central region with the highest rates of clients who received detox services. The Northwest and Southeast regions have the majority of counties with the lowest rates

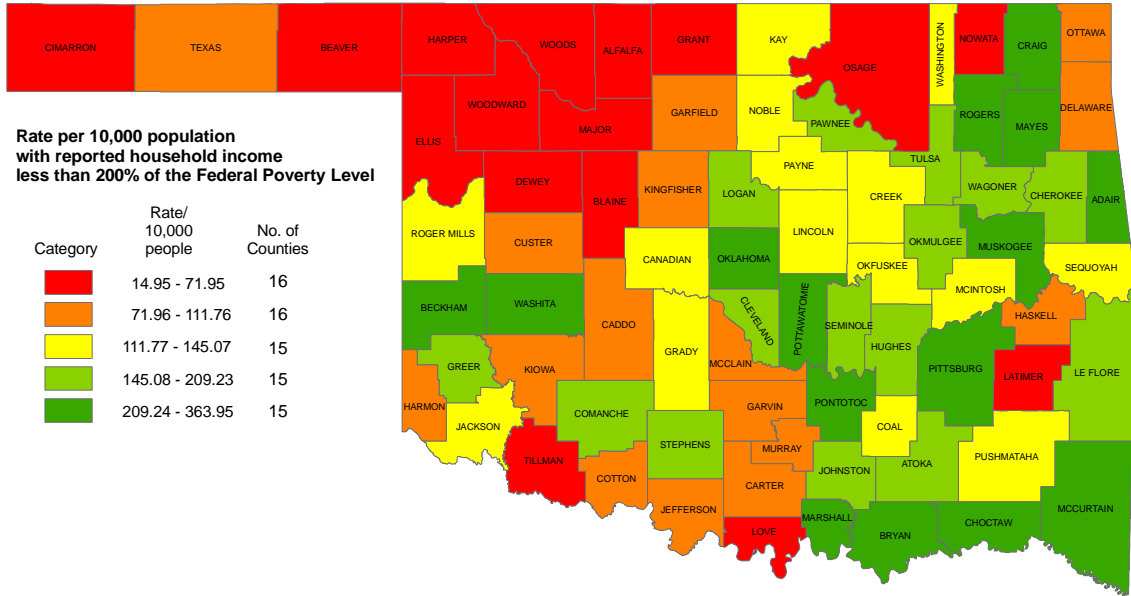
Exhibit 5.4. Adults Receiving Publicly-Funded Substance Abuse Residential Treatment Services Rates by County of Residence in Oklahoma During FY2005



County Measure	Lowest	Rank 10	Median	Mean	Rank 68	Highest	OK County	Tulsa County
Rate/10,000 people	7.48	23.97	42.25	47.15	81.44	121.36	40.94	55.48

The rates of clients who received publicly funded residential treatment in FY2005 ranged from 7.48 in Grant County to 121.36 in Greer County, indicating a large disparity across the state (see Exhibit 5.4). The median and mean rates were 42.25 and 47.15, respectively. The inner range of rates went from 23.97 to 81.44, indicating disparity in the penetration rates. As shown on the map, there is a cluster of counties in the Southwest region with the highest rates, possibly due to the low population and the location of a residential treatment facility in Greer County.

Exhibit 5.5. Adults Receiving Publicly-Funded Substance Abuse Outpatient Services
Rates by County of Residence in Oklahoma
During FY2005

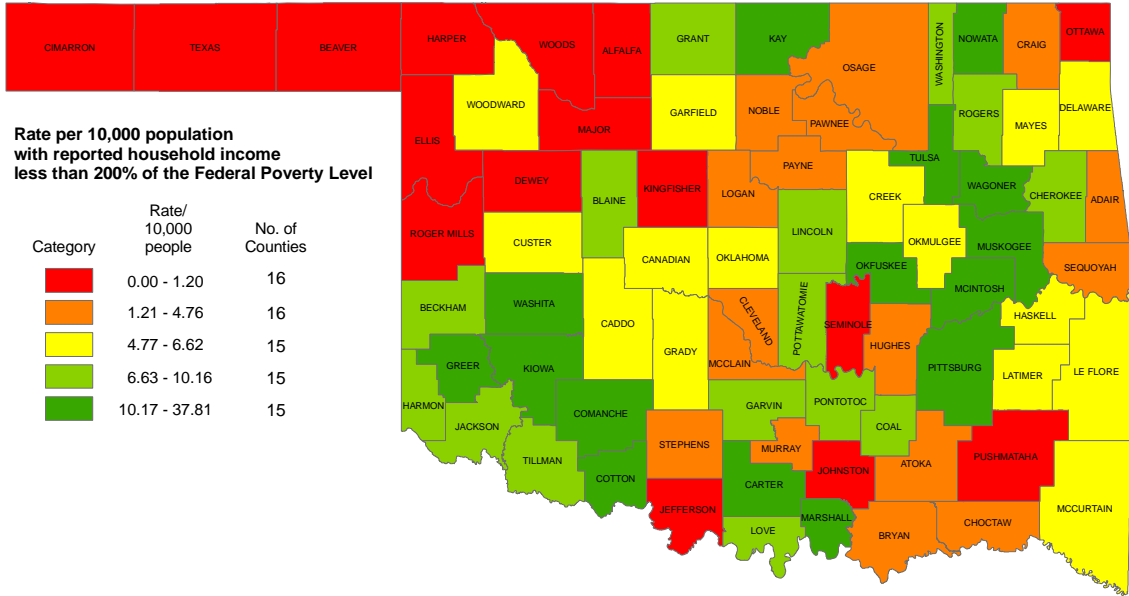


County Measure	Lowest	Rank 10	Median	Mean	Rank 68	Highest	OK County	Tulsa County
Rate/10,000 people	14.95	57.85	122.63	135.80	223.69	363.95	249.93	161.47

Substance abuse outpatient services include, but are not limited to, assessment, case management, and individual and group intensive outpatient services. The rate of clients who received publicly funded substance abuse outpatient treatment ranged from 14.95 in Grant County to 363.95 in Beckham County. The median and mean were 122.63 and 135.80, respectively. The rates in Oklahoma and Tulsa counties were 249.93 and 161.47, respectively. The upper limit of the inner range (223.69) was almost four times higher than the lower limit (57.85). As shown in Exhibit 5.5, the majority of counties with low rates of clients who received outpatient services are in the Northwest region of the state, indicating a lack of available services.

Exhibit 5.6.

Adults Receiving Publicly-Funded Substance Abuse
Halfway House Services
Rates by County of Residence in Oklahoma
During FY2005



County Measure	Lowest	Rank 10	Median	Mean	Rank 68	Highest	OK County	Tulsa County
Rate/10,000 people	0.00	0.00	5.33	7.00	15.63	37.81	5.77	19.55

Exhibit 5.6 shows the rates of clients who received publicly funded substance abuse halfway house services by county of residence. The rates range from 0.0 in 14 counties to 37.81 in Kiowa County. The mean was 7.0 and the median was 5.33. The rates for clients living in Oklahoma and Tulsa counties were 5.77 and 19.55, respectively. The inner range went from 0.0 to 15.63, indicating disparities of substance abuse halfway house services across the state. The majority of counties with no halfway house services are located in the Northwest region of the state.

Policies

Like their counterparts in adult mental health programs and children’s behavioral health programs, substance abuse services staff and management stated that the single biggest policy barrier they face is the burden of excessive paperwork. Across the state, staff said that paperwork takes more than 50% of their time, and keeps them from being able to provide the level of services that clients need. “This is not a client-driven system; it’s a form-driven system,” a program manager said. Clients also complained that staff are rarely available to talk to them outside of group, because they are in their offices doing paperwork. The Behavioral Health Development Team, led by OHCA staff, began a Documentation Workgroup with the goal of changing state agency policies to allow for

a decrease in documentation requirements. This workgroup will be proposing a number of policy changes to the state agencies in the Fall of 2006.

Program management and staff reported that their views are not solicited before ODMHSAS policy is made, and that this often results in policies and practices that do not work at the local level: “Staff working with clients in the field should have more input into how policies and programs are designed.” OHCA gathers stakeholder input on proposed policy changes from their Behavioral Health Advisory Council, Oklahoma Mental Health Planning Council, and all of their providers.

Focus group participants also pointed out that policies in the criminal justice system create almost insurmountable barriers to recovery for people leaving residential treatment. These people have frequently lost their jobs or can find only menial work, and most face huge fines that they have no way of paying. This often results in them being sent to jail, despite having met the requirements of court-ordered treatment in lieu of incarceration.

Practices/Services

Staff, management and clients stated that the biggest barrier to service is the severe lack of capacity at all levels of the system. One program manager said. “There are literally no places for people to go to get help. Everyone is frustrated -- clients and clinicians!” It was noted that there are serious shortages of detox facilities, residential treatment facilities, outpatient substance abuse services, half-way houses, and sober living facilities.

Focus group participants also pointed out that there is no organized way to access services; the burden falls on the individual to call detox or residential programs across the state every day to see if there is a vacancy. For people who are poor, in crisis, and/or homeless, making up to a dozen calls a day looking for services is a major barrier. If people find an opening in another part of the state, they are responsible for their own transportation. Clients noted that some residential treatment facilities require people to be sober and off drugs for 30 days before they can enter the program, while others only admit people who have just been through detox. The fragmentation and lack of coordination between various parts of the system make it difficult for people to access the few public services that exist. “We get 160 calls a month,” one staff said, “but we only have 23 beds.”

While most clients indicated that they felt fortunate to be in a treatment program, many had concerns about the quality of services they received. Some said that groups consisted of a staff member reading in a monotone from a sheet of paper. Clients felt they would benefit from one-on-one counseling, which is rarely available. Staff and clients reported that there is little trauma treatment available, which should be a high priority for this population. In general, there is very limited treatment available that addresses both substance abuse and mental health disorders (see Chapter 7).

Many clients interviewed believed that they are over-medicated with psychiatric drugs. One client said, “I am too out of it from the meds to really work my recovery program.” Clients in one program noted that the part-time psychiatrist available to them does not speak English well and is dismissive of their concerns about medication side-effects. Both staff and clients felt that there was a need for a full-time psychiatrist in residential treatment programs, as many clients either arrive dually-diagnosed, or staff

believes they need a mental health assessment, which is currently hard to arrange. Staff and clients said that clients are only given two weeks' worth of medication on discharge, which is often insufficient. Over the past year, OHCA has worked with the inpatient provider community to support adequate discharge planning and care coordination. The group has agreed to provide discharged patients with a full 30 day prescription, along with the typical two week supply of medications. Another problem noted by both staff and clients is that programs such as AA encourage an abstinence approach to psychiatric medication, and discourage its use, which causes conflicts for people with co-occurring disorders.

Most clients said that they were involved in developing their treatment plans. One client said, "I was listened to for the first time." However, in some programs, clients reported little involvement. "It totally depends on your counselor; some people are kept in the dark about treatment plans," said one client.

Clients in residential programs said that if they are injured or become ill while in the program, their healthcare is not covered. "There's no healthcare here - they take you to the ER and make you pay," a client said. Since most clients said they had no medical insurance and are not eligible for Medicaid, this becomes yet another financial obligation that clients have difficulty meeting upon discharge. Staff and management agreed with this assessment. "We need to be able to address emergency medical care onsite, but do not have the resources," staff at one program said. "Many people have major physical health problems but no insurance or transportation, so they don't get services. It's impossible to address peoples' problems in a holistic way when they have no access to physical health care." For adults receiving Medicaid, transportation to Medicaid-reimbursable medical services is a covered benefit. Staff also noted that there is little or no free dental care available, and that many clients have serious needs, becoming aware of chronic dental pain only after coming off drugs.

A concern of both staff and clients is the recent ban on smoking on the grounds of residential facilities. The majority felt that the ban is counter-productive. One staff person complained, "We are forced to become the anti-smoking police." Another said that this issue created a wedge between staff and clients that disrupted the formation of therapeutic alliances and interfered with treatment.

For those who complete residential treatment, there is no organized process for linking them to outpatient substance abuse treatment, which is not widely available in any case. Once on the outside, if someone misses a court appointment, they can be sent back to residential programs, even if they are stable, as if treatment were some form of punishment. "We see a lot of the same people over and over again," said one staff member. Some management and staff said that judges often order people into residential treatment who do not meet the criteria for admission, but they must accept these clients anyway.

Employment, housing, and transportation remain significant barriers to success for people leaving residential treatment services. Clients and staff said that there are few if any employment services offered before discharge, which adds to the difficulty of finding and sustaining employment for individuals with a criminal and/or drug history. Most said that the only jobs available to these individuals are in fast food or other service industries where salaries are low. Some clients who enter 30-day treatment programs lose

their jobs, which may result in losing their apartments or cars, leaving them worse off financially than before they went to treatment.

As noted in the chapter on Housing, people with criminal and/or drug histories have an especially difficult time finding safe affordable housing, as most are banned from public housing for at least three years. According to one client, “Staff has no time to help look for housing.” A staff person of this same center said that there are “no stable places for people to live, often we discharge to shelters.” A staff member noted that, in long-term residential treatment, “You make big investment, and then there are no halfway houses or sober houses for them to go to.” Some staff noted that many clients will return home to families with multi-generational drug abuse problems. Another staff member stated, “Clients *will* relapse without a safe place to go.”

Transportation to outpatient treatment is a problem in both urban areas, where public transportation is spotty, but is especially problematic in rural areas. “Clients have to borrow money often for transportation. If they cannot get help, then they come less frequently,” observed one staff member. The financial stresses of unemployment and lack of housing threaten the recovery process, and limited access to outpatient services is yet another barrier.

Continuity of care is an essential part of recovery. To evaluate the need for follow-up from a detox setting, the referral from discharge was analyzed. In FY2004, 3,544 substance abuse treatment clients were discharged from ODMHSAS-supported detox services. Of these clients, 373 were referred to follow-up services within ODMHSAS-funded facilities. Other clients were referred as follows: 114 to a criminal justice agency, 109 to other health care provider, 99 to a non-ODMHSAS alcohol/drug abuse care provider, 82 to a non-ODMHSAS mental health provider, and the remaining 46 were referred to community services. Most clients (2,721) were referred to an individual (self or significant other).

For the purpose of this study, follow-up is defined as a lower level of care received within 14 days of discharge. After discharging from detox, 889 clients received follow-up services within an ODMHSAS funded facility: 548 entered residential treatment, 291 entered outpatient treatment, and 50 entered community living. Of the 373 clients referred to treatment within ODMHSAS, 175 (47%) received treatment, of which 98 percent was follow-up treatment.

Among the 3,544 clients discharged from detox in FY2004, 50 were re-admitted to detox within 30 days or less, 80 within 31-90 days, and 376 within 91-365 days; 86 percent of the clients had no re-admission to detox within one year. Clients discharged from detox services who received a lower level of care within an ODMHSAS facility had the same rate of re-admission within one year compared with those who did not receive a lower level of care.

Overall, the number of re-admissions to detox within one year of first admission is low. Since FY2000, about 78 percent of clients admitted to detox had no subsequent re-admission within 365 days of admission (see Exhibit 5.7). This rate has not significantly changed in the past five years. About 22 percent of clients had two or more admissions to detox within a one year period. The percent of clients with five or more admissions to detox within a one year period has decreased since FY2000, from 1.4% of detox clients to 0.7% in FY2004.

Exhibit 5.7. Number of Detox Admissions per ODMHSAS Client within 365 Days of First Admission in Fiscal Year											
Admission Year	Total Clients	Number of Admissions to Detox									
		1		2		3		4		5 or more	
		%	#	%	#	%	#	%	#	%	#
FY2000	3407	78.8%	2686	14.2%	485	3.9%	133	1.6%	56	1.4%	47
FY2001	3507	77.7%	2724	14.7%	517	4.2%	147	1.6%	57	1.8%	62
FY2002	3168	77.0%	2440	15.1%	477	4.8%	152	1.6%	52	1.5%	47
FY2003	3576	78.7%	2816	14.7%	524	4.3%	155	1.5%	53	0.8%	28
FY2004	3492	77.8%	2717	15.1%	529	4.5%	157	1.8%	64	0.7%	25

ODMHSAS collects information about how clients are referred to service. In FY2005 about half of all residential substance abuse treatment clients were referred to treatment by an individual, which can either be the client or a significant other (see Exhibit 5.8). Referrals from an individual have been steadily increasing since FY2001. Many clients enter substance abuse treatment through the criminal justice system, either through Drug Court, Department of Corrections (see Chapter 8) or court order. Referrals from the criminal justice system comprise about 25 percent of referrals to residential substance abuse treatment each year. Since FY2001, a smaller percentage of referrals have come from ODMHSAS-funded agencies and other health care providers.

Exhibit 5.8. Referral Source for ODMHSAS Substance Abuse Residential Treatment Clients Age 18 and Older

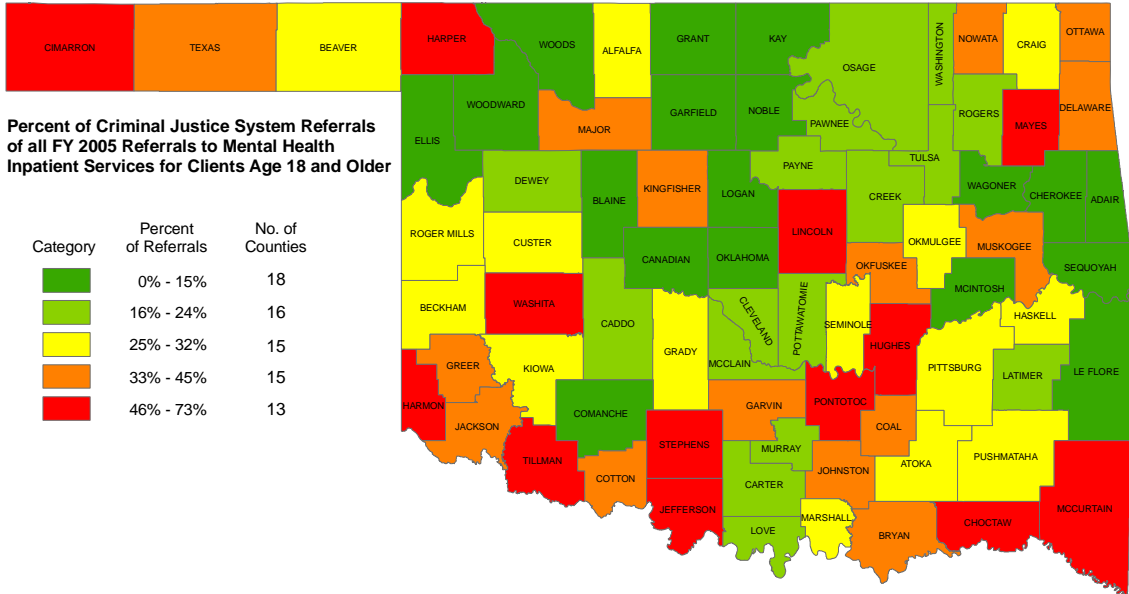
Fiscal Year Discharged	Total Clients	Referral Source at Admission to Residential Treatment									
		Individual		Criminal Justice System		DMHSAS Funded Agency		Other Community Referral*		Substance Abuse/Mental Health/Other Health Care Provider	
		%	#	%	#	%	#	%	#	%	#
2001	3,220	41.4%	1,333	25.0%	806	19.8%	637	7.2%	231	6.6%	213
2002	3,441	42.6%	1,467	23.7%	815	19.5%	671	8.4%	288	5.8%	200
2003	3,243	47.0%	1,525	22.7%	736	13.2%	428	12.2%	395	4.9%	159
2004	3,307	54.5%	1,801	20.8%	689	14.8%	491	6.3%	208	3.6%	118
2005	3,435	50.5%	1,735	24.9%	857	12.6%	434	8.4%	290	3.5%	119

*Other community referrals include: school, employer, OKDHS, shelters, clergy/church, and other community agencies.

Some counties within Oklahoma tend to make use of criminal justice referrals to residential substance abuse treatment more than others, with Pontotoc (73%), Tillman (67%), Jefferson (65%), and Cimarron (60%) having the highest percentage of criminal justice referrals as shown in Exhibit 5.9.

Exhibit 5.9.

Criminal Justice System Referrals to ODMHSAS-Funded Adult Residential Substance Abuse Treatment



In addition to evaluating how clients are referred to treatment, the reason for discharge is also collected and analyzed. The majority of ODMHSAS residential substance abuse treatment clients are discharged as a result of completing treatment; however, this trend has worsened steadily since FY2001 (see Exhibit 5.10). Those clients who are discharged from inpatient services prior to treatment completion generally leave treatment for incarceration. Since FY2001, the number of clients being discharged due to this reason has increased. Other clients leave treatment prior to completion “against counselor’s advice” (ACA), or they become AWOL or break a program rule. The number of clients being discharged for these reasons has also increased since FY2001, from 1.0 percent to 3.8 percent in FY2005.

Exhibit 5.10. Discharge Type for ODMHSAS Residential Substance Abuse Treatment Clients Age 18 and older

Fiscal Year Discharged	Total Clients	Discharge Type											
		Completed Treatment		Incarcerated		ACA/AWOL Broke Rules		Transferred		Died		Other*	
		%	#	%	#	%	#	%	#	%	#	%	#
2001	3,220	69.4%	2,236	25.7%	829	1.0%	31	0.6%	19	0.03%	1	3.2%	104
2002	3,442	66.1%	2,276	27.3%	941	2.4%	83	0.5%	17	0.03%	1	3.6%	124
2003	3,243	67.7%	2,195	26.0%	842	2.6%	84	0.2%	5	0.03%	1	3.6%	116
2004	3,307	65.7%	2,173	27.7%	916	2.4%	80	0.3%	10	0.03%	1	3.8%	127
2005	3,435	62.7%	2,155	28.7%	987	3.8%	129	0.5%	17	0.03%	1	4.3%	146

* Other discharges include: client moved, client failed to begin treatment, treatment incompatibility, and administrative.

As shown in Exhibit 5.11, many ODMHSAS outpatient substance abuse treatment clients were discharged from treatment into incarceration. While there has been a recent decline in the percentage being discharged into incarceration, the trend has not been consistent. There has been a steady improvement, however, in the number of outpatient substance abuse treatment clients being discharged because of treatment completion.

Exhibit 5.11. Discharge Type for ODMHSAS Outpatient Substance Abuse Treatment Clients, Age 18 and older

Fiscal Year Discharged	Total Clients	Discharge Type											
		Completed Treatment		Incarcerated		ACA/AWOL Broke Rules		Transferred		Died		Other*	
		%	#	%	#	%	#	%	#	%	#	%	#
2001	4,950	33.6%	1,662	47.4%	2,347	5.0%	246	2.0%	98	0.3%	16	11.7%	581
2002	6,822	27.7%	1,888	36.3%	2,478	7.9%	539	1.7%	115	0.3%	19	26.1%	1,783
2003	5,917	36.4%	2,154	41.5%	2,456	4.3%	254	1.8%	107	0.5%	30	15.5%	916
2004	6,201	37.5%	2,327	44.6%	2,768	3.4%	211	1.4%	84	0.3%	17	12.8%	794
2005	6,946	38.5%	2,674	36.7%	2,552	5.6%	391	2.0%	138	0.4%	26	16.8%	1,165

* Other discharges include: client moved, client failed to begin treatment, treatment incompatibility, and administrative.

For ODMHSAS outpatient substance abuse treatment clients who completed at least 30 days of treatment, only 36 percent had a decrease in the frequency of use of their primary drug of choice, as shown in Exhibit 5.12. Since FY2001, about 50 percent of these clients continued to use at the same frequency as at admission to outpatient treatment, and about 4 percent of clients increased their frequency of use. There has been a steady increase in the percentage of clients whose primary drug of choice changed from admission to discharge. In FY2005, 13 percent of clients fell into this category, and of these 193 clients, 32 percent changed their primary drug of choice from alcohol to marijuana. Another 11 percent changed their primary drug of choice from marijuana to alcohol, 7 percent changed from methamphetamine to alcohol, 6 percent changed from alcohol to stimulants, and 5 percent changed from methamphetamine to stimulants.

Exhibit 5.12. Frequency of Use by Primary Drug of Choice for ODMHSAS Outpatient Substance Abuse Treatment Clients, Aged 18 and older*

Fiscal Year Discharged	Total Clients	Frequency of Use							
		Decreased		Remained the Same		Increased		Drug of Choice Changed	
		%	#	%	#	%	#	%	#
2001	1,011	38.6%	390	51.5%	521	4.7%	48	5.1%	52
2002	1,063	35.8%	381	56.6%	602	2.1%	22	5.5%	58
2003	1,207	31.9%	385	56.6%	683	3.8%	46	7.7%	93
2004	1,345	32.0%	430	55.7%	749	3.2%	43	9.1%	123
2005	1,470	35.9%	527	47.5%	698	3.5%	52	13.1%	193

*Sample only includes non-DOC clients who successfully completed at least 30 days of treatment, and who had a frequency of at least 1-3 Times per Month listed for their primary drug of choice at admission.

Workforce Development Issues

Workforce development issues raised by focus group participants focused on three areas: ODMHSAS's changing licensing requirements for substance abuse services staff, the amount and quality of training available through the Department, and barriers to hiring and keeping good staff.

There were mixed feelings among staff about the Department's new licensing requirements. By 2010, substance abuse services staff will have to become Licensed Alcohol and Drug Counselors (LADCs), which requires a master's degree. Some see this as a positive development: "Substance abuse professionals should get the same recognition as other professionals," one staff member said. "The stigma is that they are just a bunch of old drunks. More people should embrace credentialing." Others said that the new requirements have already caused some staff to lose their jobs. "People who were on track to get a degree have had the rug pulled out from under them," a staff person said. "I'm glad they are increasing required credentials of staff, but they should have done this more gradually so people had time to meet requirements," another said. OHCA policy allows Certified Alcohol and Drug Counselors (CADCs), a position that does not require a master's degree, to provide substance abuse treatment.

Others viewed the licensing requirements as an unwelcome change in the philosophy of substance abuse treatment. "The department is professionalizing treatment to a dangerous degree. Counselors who are people with lived experiences are being phased out, and non-recovering professionals who don't know how to deal with addicts are being promoted," an advocate said. It was also noted that it is ironic that while the mental health system is promoting the inclusion of staff with lived experience through its development of Recovery Support Specialist and Family Support Specialists, the substance abuse side is working to eliminate peers from the workforce.

There was dissatisfaction with the training available. "We get lots of mandatory training that's irrelevant, but we don't get training to increase our skills and knowledge base for our jobs," a staff member said. "People start working on units with no training in de-escalation skills and are put at risk." Other staff and managers said that current training offerings are of poor quality and don't meet their needs. "We want new, cutting-edge training."

Managers and staff said that low pay scales are a serious barrier to hiring and keeping good staff. "We have high counselor vacancy rates due to low salary rates," one manager said. "We are not competitive with the private sector." Another manager noted that the new licensing requirements may exacerbate this problem: "Once people are licensed, they will be able to make 50% more in the private sector."

State-run programs reported long delays in approval to fill positions, which means that their programs are chronically short-staffed. "It takes at least three months to fill a vacancy," one manager said. "Central Office has to approve new hires and the process is too slow." Another said, "The State has to vastly improve the length of time it takes to hire new staff – we have vacancies sitting empty for months."

Organization/Collaboration

Some staff noted that different eligibility requirement, rules and organizational culture make it difficult for people with co-occurring substance abuse and mental health problems to find services that meet their needs.

A number of communities have grass-roots health coalitions in which substance abuse service providers participate to varying degrees. Some of these coalitions are supported through the Department of Health's Turning Point initiative, which assists communities in organizing a coalition/partnership or adopting an existing one, and helps build organizational structure. A community assessment and resource evaluation is done, and then each community sets its own priorities for healthcare improvement. A number of the Turning Points coalitions across the state have selected substance abuse as a priority area, which has increased cooperation across agencies in these communities, particularly around housing and healthcare needs.

Data

Many staff and managers said that the development of an electronic record would be helpful if it could help avoid redundancies in required paperwork. It was noted that clients have to keep telling their story over and over to every new professional they meet. One program manager noted that when clients move between levels of care within their program, staff is required to re-do the assessment and other paperwork, which was viewed as very inefficient – a shared electronic record would solve these kinds of problems.

Financing

Program managers noted that while they face increasing demands and more rigorous standards from ODMHSAS, they have not received the additional funding needed to meet these requirements. One manager noted that no additional resources are available for pay increases for staff who obtain master's degrees. "We need funding reform," one person stated. "We have not had a revision in payments to show costs of inflation for seven years. We are still providing the same services or increased services, but funding is flat. This negatively impacts treatment quality." Staff at another agency pointed out that "The department pays \$48 for a substance-abuse session but \$74 for a mental health session. There's no reason for this disparity."

Management at another agency noted that the department uses boilerplate language for all of their contracts that is based on residential care, and that many provisions are not applicable to outpatient treatment. "There should be different contracts for different types of programs," one person said.

Managers and staff also expressed concern about what they viewed as rigid auditing and recoupment practices carried out by staff with have no understanding of programmatic or clinical issues. "They actually demanded money back from us because our assessments were done by a nurse and not a CADC for a detox program," one person complained. Others believed that the rigor with which recoupment is pursued for minor technical violations threatened program viability. ODMHSAS officials maintain that these audits are carefully conducted and that recoupment occurs only rarely where there are clear violations of an agency contract.

Consumer and Family Involvement

Many programs reported that they used community meetings, surveys and suggestion boxes to gather consumer comments. Few reported involving consumers or family members in governance or on advisory boards. Many staff and managers felt that consumers had no role in program decision-making.