
Draft for Public Comment
08/20/2013

Combined Application Federal Fiscal Years 2014 & 2015

**Substance Abuse Prevention and Treatment (SAPT) Block Grant
&
Mental Health Services (MHS) Block Grant**

Sections II (Planning) & Section III (Intended Use of Funds)

II. Planning Section

Step One: Strengths and Needs of the Current Treatment and Prevention Systems

Overview of Oklahoma’s Treatment, Recovery Support and Prevention Systems. Services and supports are available statewide through a network of provider and community based programs. These include 14 community mental health centers (CMHCs), 68 substance abuse treatment facilities, 31 prevention organizations and 54 specialty providers, including housing, consumer and family operated programs. Licensure of most treatment and support service organizations is statutorily required and administered through the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) Provider Certification Division. The ODMHSAS also supervises mandated certifications for Behavioral Health Case Managers, Alcohol and Drug Substance Abuse Courses (organizations, and individual assessors and evaluators related to drivers’ licenses revocations), and Peer Recovery Support Specialists. The ODMHSAS Central Office in Oklahoma City provides planning, oversight, fiscal and accountability support for the entire system. Key Central Office functions include Decision Support Services, Information Technology Services, Consumer Advocacy & Wellness, the Inspector General, Human Resources Management and Development, Finance, Legal, Grants Management, and Provider Certification. All leadership and management structures are organized under the ODMHSAS Commissioner and her executive staff including the Chief Operating Officer, the Deputy Commissioner for Treatment and Recovery Services, and the Deputy Commissioner for Communication and Prevention. (Note: the Mental Health Division and Substance Abuse Services Divisions were recently consolidated under the Deputy Commissioner for Treatment and Recovery Services.)

During this planning and implementation period additional attention will be given to various emerging issue for the State of Oklahoma. Each is briefly discussed below.

- *Mental Health First Aid.* In 2013 the Oklahoma Commission on School Safety was formed to investigate school violence within the state. The Commission called for the establishment of a Mental Health First Aid (MHFA) training pilot program for school personnel, and the ODMHSAS received additional funding from the state legislature to train individuals throughout Oklahoma in MHFA, an evidence-based, public education program that helps the public identify, understand, and respond to signs of mental illnesses and substance use disorders.
- *Suicide Prevention.* For the first time in many years, the Oklahoma legislature provided state funding for the ODMHSAS to develop and implement suicide prevention initiatives. This funding will allow Oklahoma to expand its current suicide prevention efforts including support for active duty military and veterans.

- *Prescription Drug Abuse.* The ODMHSAS also received state funding for new prescription drug abuse prevention and treatment initiatives in 2013. The funding will aid in the implementation of the state's plan for reducing prescription drug abuse developed by the Oklahoma Prevention Leadership Collaborative in 2012. The new initiatives will address prescriber education, a pilot program for overdose counteractive medication, enhancements to Oklahoma's prescription monitoring program, and public education efforts.

Specific strategies and activities are under review to develop initiatives in each of these areas.

Regional and Local Entities Providing Services and Resources. As the Single State Agency for Substance Abuse and the State Mental Health Authority, the ODMHSAS fulfills state level responsibilities as regulator and purchaser of services. In some areas of the state, and with specific levels of care, the ODMHSAS also operates as a direct provider of services. Other state agencies collaborate with the ODMHSAS to fulfill similar roles within their authority. Regional and local responsibilities are typically carried out by specific organizations with which the ODMHSAS contracts.

Prevention Services. The 17 Regional Prevention Coordinators (RPCs) serving all 77 counties in Oklahoma are the backbone of Oklahoma's prevention service system. RPCs develop community-level prevention work plans in partnership with community coalitions. Community level prevention work is based on the Strategic Prevention Framework and aligned with state prevention priorities. Services focus on achieving sustainable, population-level outcomes. The ODMHSAS also administers 2Much2Lose (2M2L) as an overarching moniker of Oklahoma's underage drinking prevention initiative funded by the Office of Juvenile Justice and Delinquency Prevention's Enforcing Underage Drinking Laws Block Grant program. 2M2L initiatives include a youth leadership development program and underage drinking law enforcement activities. Other programs administered through the ODMHSAS prevention initiatives include the Oklahoma Partnership Initiative funded by the Administration on Children and Families; an underage/high-risk drinking law enforcement effort in college communities funded by a Justice Assistance Grant from the Oklahoma District Attorneys Council; an emerging statewide infrastructure for Screening, Brief Intervention, and Referral to Treatment (SBIRT) services; the Oklahoma Youth Suicide Prevention Initiative funded by the SAMHSA Center for Mental Health Services (CMHS); and the Mental Health First Aid training program through a statewide network of trainers.

Mental Health Services. The 14 CMHCs referenced earlier serve the state with programs established in approximately 70 cities and towns. Department employees operate four CMHCs in Lawton, McAlester, Norman and Woodward. The other 10 CMHCs are private, nonprofit organizations under contract with the Department. All CMHCs are also Medicaid providers and access funding from a variety of other sources. Community Based Structured Crisis Centers (CBSCCs) for adults operate in Oklahoma City, Tulsa, Clinton, Norman and Muskogee.

Through legislative funding in FY13, ODMHSAS added two additional CBSCCs, one in rural Oklahoma in Ardmore, and one in Tulsa. The new Ardmore site is in partnership between the local CMHC and local hospital. The CMHC provides staffing and the hospital provides the physical location. The new Tulsa site will be managed by a CMHC that is completing renovations to begin providing services at their center by late 2013. The ODMHSAS contracts with other organizations to provide community based mental health and recovery support services including statewide advocacy organizations, independent clubhouses, a peer drop-in center, and housing services and supports. Adult psychiatric inpatient services are provided at Griffin Memorial Hospital in Norman, the Oklahoma Forensic Center in Vinita and at smaller inpatient units located in McAlester, Ft. Supply, Tulsa and Lawton. In FY13, ODMHSAS piloted an Urgent Care service in Oklahoma City and provided funding for two more Urgent Care centers to be paired with the Ardmore and Tulsa CBSCCs. The Urgent Care Centers provide outpatient services to include medication management for person needing immediate care in order to prevent a psychiatric emergency. The Centers also provide 23-hour respite and observation in order to divert persons as indicated from inpatient or CBSCC placement.

Substance Abuse Services. The substance abuse treatment and recovery services funded through the ODMHSAS service system are provided at over 60 covering all 77 Oklahoma counties. All substance treatment organizations must be state licensed (certified). Facilities can be licensed as a basic Alcohol and Drug Treatment Program or as a Certified Comprehensive Addiction Recovery Center (CCARC). New administrative code was approved in 2012 authorizing the ODMHSAS to award this new category of certification that permits facilities that offer a comprehensive array of addiction treatment services to pursue official recognition of that through the state licensure process. That process is also administered through the ODMHSAS Provider Certification Division. Final decisions for licensures are approved by the ODMHSAS Board. All providers must be Medicaid compensable and many accept other types of third party payment. The ODMHSAS funded services are primarily purchased through contracts with private, for-profit and non-profit, certified agencies to provide detoxification, residential treatment, halfway house, outpatient, intensive outpatient, and early intervention services with substance abuse block grant funds and state appropriations. These agencies include substance abuse treatment facilities, community mental health centers, community action agencies, youth and family services agencies, and schools. Among the contracted facilities, the University of Oklahoma Health Sciences Center provides screening, assessment and treatment planning for children with Fetal Alcohol Spectrum. An essential component to the recovery system is the state's network of Oxford Houses. Currently, there are 64 Oxford Houses throughout the state with more in development. Most of the Oxford Houses have accessed loans from a revolving loan fund administered by the ODMHSAS. The ODMHSAS also directly operates three substance abuse residential treatment facilities staffed with state employees.

Services for Older Adults. Services to older Oklahomans are available at CMHCs through the general array of adult program services, but specific services targeting older adults and designated older adult staff are limited. Limited resources prevent expansion of current outreach and support efforts and impede the development of additional efforts. The Oklahoma Mental

Health and Aging Coalition provides a forum through which a variety of stakeholders advocate for increased, accessible and culturally appropriate services for older Oklahomans. Additionally, the Coalition provides statewide mental health, substance use, prevention and treatment education and advocacy, and partners with other networks that provide services to older adults to integrate and cross-train networks. ODMHSAS has a Coordinator of Aging Services who can provide consultation. Step 2 of this application covers some specific needs and reported gaps in services for older adults.

Problem Gambling Treatment Services. Over 100 casinos and four horse tracks/racinos currently operate in Oklahoma. Each year those numbers increase as does the need to expand services to treat people with problem gambling behaviors and related addictions. As many as 150,000 Oklahomans are estimated to need treatment to address problem gambling behaviors. The fastest growing populations among problem gamblers are older adults and adolescents. Gamblers are twenty percent more like to commit suicide out of the high risk populations and gamblers are more likely to be in recovery from other addiction issues but not be able to stop gambling. Some estimate as high as eighty percent likelihood for substance abuse recovery relapse for those who frequent casinos. Further, treatment providers observe coexistence of multiple addictions such as shopping, sexual addiction, and self-mutilation. It is noteworthy smoking is permitted in casinos – one the only public places smoking is acceptable and readily available in the state. Stigma remains a major barrier to people seeking treatment.

Resources to fund the treatment are limited but the 2005 Oklahoma Education Lottery Act and the Oklahoma Horse Racing State Tribal Gaming Act authorized the ODMHSAS to received \$750,000 per year to provide problem gambling education and treatment. \$250,000 per year comes from the Native American gaming and \$500,000 from the Oklahoma Lottery. The most recent legislative session approved the Oklahoma Lottery to increase that funding by \$250,000. In addition to funding authorized, state statute requires certification (licensure) for programs that provide problem gambling treatment services. The ODMHSAS Provider Certification administers this certification process, in accordance with OAC 450:65.

Currently, 10 certified gambling addiction treatment programs are available and eight of those programs are funded by the ODMHSAS utilizing the above described state resources. The funding provides advocacy, education, outreach, and outpatient treatment services to adults and adolescents with gambling related disorders/problems. Oklahoma residents can access services by calling Oklahoma's 24-hour toll-free Problem Gambling Helpline at 1-800-522-4700.

Services for Children and Their Families. Systems of Care are the preferred approach to coordinate services for children and their families. The Oklahoma Systems of Care Initiative (OSOCI) is strategically designed to eventually have local Systems of Care available to children, youth and their families in all 77 counties. Funding from SAMHSA and the Oklahoma Legislature has been leveraged to facilitate development of the OSOCI. Currently, 65 local Systems of Care sites serve 58 counties. CMHCs host most of the local Systems of Care sites, and work in equal partnership with local teams and community organizations to ensure that

children with Serious Emotional Disturbances (SED) and their families have access to the full array of services they need and want. Community Based Structured Crisis Centers in Oklahoma City and Tulsa address the emergent needs of children and their families. The ODMHSAS also operates the Children's Recovery Center in Norman to provide inpatient and residential services for children up to the age of 18 with mental health, substance use, or co-occurring disorders.

Oklahoma's Weaving Access for All (Wafa) initiative weaves the values and principles of the state's successful trauma-informed Oklahoma Systems of Care throughout the foster care system, creates a front-door diversion project for the juvenile justice system, and is the cornerstone of the planned health homes for children with serious emotional disturbance. The Wafa serves children from birth to 21 years of age with emotional, socio-emotional, behavioral, or mental disorders diagnosable under the DSM-IV or its ICD-9-CM equivalents. Children qualify if they are unable to function in the family, school, community, or a combination of these, or require interventions from multiple systems. The ODMHSAS and the Oklahoma Department of Human Services (OKDHS) have partnered to provide the Wraparound process for children in foster care who are in danger of going into group homes or other restrictive placements. The process will be available statewide with the goal of serving 300 children during the four years of this grant.

This grant has assisted the ODMHSAS and the Office of Juvenile Affairs (OJA), the juvenile bureaus and judges in Tulsa and Oklahoma City to develop a plan to divert youth with emotional disturbance from entering their systems. A standardized screening and linkage process identifies youth with potential mental health issues and, when needed, a full assessment is completed. The presiding judge can now more easily refer youth to appropriate community services, including Wraparound for those involved with multiple systems, rather than adjudicating the youth into the juvenile justice system. The goal is to divert 300 youth per year by the third year of the grant.

The ODMHSAS and the Oklahoma Health Care Authority (OHCA) are finalizing preparations for a State Plan Amendment request with the Center for Medicare and Medicaid Services (CMS) to formally establish specialty Health Homes for children with serious emotional disturbance. This will be included in the broader health home that includes adults and will be within community mental health centers. The plan includes use of the Systems of Care philosophy and values, and use of the Wraparound process for those involved with multiple systems. Health Homes will be open to children in the custody of the OKDHS and the OJA. The goal is to serve 2,500 children over the course of the first four years.

The Adolescent Recovery Collaborative (ARC) initiative is also SAMHSA funded and provides the ODMHSAS resources to implement the Adolescent Community Reinforcement Approach (A-CRA) and Assertive Continuing Care (ACC) in the Latino Community Development Agency (LCDA) and Specialized Outpatient Services (SOS), utilizing the GAIN assessment tools, serving adolescents ages 12-17 in Oklahoma County. As with many grant funded projects, Oklahoma will expand on the ARC and take to scale over time for statewide access and sustainability. The ARC will build a comprehensive community-based, trauma-informed

continuum of care for adolescents with substance use issues founded on the core principles of cultural and linguistic competence and person-centered planning

Disaster Responses Infrastructure and Services. The ODMHSAS Access Specialist is the designated coordinator for disaster response in partnership with local, state, and federal entities that mobilize following a disaster. The SAMHSA Disaster Technical Assistance Center (DTAC) and the Federal Emergency Management Agency (FEMA) provide additional resources.

- Immediately following tornadoes in Oklahoma in late May, 2013, 680 additional clinicians were trained in Psychological First Aid to assist as first responders in the communities most affected by the tornadoes, including Moore, Little Axe, Shawnee, and Carney. Also in response to the disaster, the ODMHSAS deployed 30 staff to “ground zero” within 48 hours of the disaster. Approximately 400 additional individuals provided volunteer services in the affected communities during the operation of the ODMHSAS temporary Disaster Field Office in Moore post-disaster.
- The ODMHSAS received a FEMA Immediate Services Crisis Counseling Program (CCP) grant to continue providing services to affected communities until July 19, 2013. That Immediate Services grant was approved for extension while the Regular Services grant (RSG) application is reviewed. It is anticipated the RSG application review will take approximately two months. Once approved, the RSG will allow the CCP to continue operation for another nine months.

Workforce Infrastructure. On a daily basis, approximately 2,040 behavioral health staff provide outpatient and other community based services to children, youth and adult consumers statewide. The majority of these are employed as case managers, counselors, social workers, psychologists, nurses and psychiatrists at the CMHCs. However, other providers are represented in this workforce including Recovery Support Specialists, Family Support Providers, and residential support staff. The ODMHSAS provides ongoing training and performance improvement opportunities to all providers throughout the system, including employees of the ODMHSAS and staff from partnering organizations. The ODMHSAS Human Resources Development training programs recorded combined audiences of over 41,448 participants from all areas of Oklahoma in state fiscal year 2012. E-learning and the telehealth infrastructure are now integral to the training of the behavioral health workforce.

Populations and Targeted Services. Descriptions of specific services, systems, and needs of target populations are listed below. These align with the framework historically mandated separately for both the MHSBG and SAPTBG. Each topic (items 1 through 11) also briefly highlights needs regarding access, capacity, disparity and other issues. Step Two addresses unmet needs and provides rationale for priorities stated in Step Three. Performance measures proposed in Step Four relate to each of the state’s priorities.

1. Comprehensive community-based system for children with serious emotional disturbances (SED) and their families. As referenced above, the CMHC network and the coordinated OSOCI sites provide statewide coverage for the comprehensive services available for children with SED and their families. All sites must be capable of screening and treating or referring children and youth with separate or co-occurring substance use disorders. Local affiliation agreements and memoranda of understandings with substance use treatment providers assure adequate access to a wider range of services needed by the children and their families. In FY2012, CMHCs, Systems of Care sites and substance abuse services organizations served 5,311 children under age 18 with a SED. Additional information is provided below to address specific MHSBG requirements.

- *Mental Health and Rehabilitation Services for Children with SED.* CMHCs and SOC (sometimes one and the same and sometimes collaborating partners) ensure that children with SED and their families have access to basic services, specifically crisis intervention, evaluation and treatment planning, medication and psychiatric services, and case management services. Additional services for children and their families are listed below.
 - Home-based services
 - Family counseling
 - Diagnosis-related education
 - Client advocacy
 - Outreach
 - Peer/family support
 - Family self-sufficiency (housing)
 - Socialization
 - School-based services
 - Respite care
 - Wraparound/flexible funds
- *Health/Medical, Vision and Dental Services.* Case managers assist parents and children in accessing treatment for health conditions ranging from vision and hearing problems to chronic illnesses. The Oklahoma Health Care Authority (OHCA) is designated to administer the Children's Health Initiative Program (CHIP). School based health services are organized by the OHCA through the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program. Many schools hire nurses to implement targeted health programs related to EPSDT to help parents access early and preventative care for their children. The program is statewide in most of Oklahoma's 77 counties. CMHCs and SOC sites are developing collaborations with Federally Qualified Health Centers (FQHCs), tribal health services, clinics, homeless clinics and county health departments. The ODMHSAS is currently developing plans with the OHCA to submit a proposal for a health home program within the state's plan. The health homes will be based at CMHCs and organize care for children and adults with serious mental health problems and other complex health needs.

- *Employment and Vocational Services.* Case managers assist children ages 14 and older with job search and job placement skills, social and interpersonal skills needed for job retention, and specific referrals to vocational-technical schools. The Department of Rehabilitation Services (DRS) offers transitional services within school districts. The DRS Transition School-to-Work program assists students with disabilities make smoother transitions from school to work through counseling, work adjustment training, on-the-job training and direct job placement. Other services are provided through a cooperative arrangement among the DRS, the Oklahoma State Department of Education and local school districts.
- *Housing Services.* Housing services and homeless outreach services for families with children are provided in the same manner by which they are provided to adults. This is summarized elsewhere in this application. In addition to accessing an array of supportive and subsidized housing options, providers are able to utilize the ODMHSAS flexible funds to address immediate and short-term needs to stabilize family housing situations.
- *Special Education.* Under the provision of the Individuals with Disabilities Education Act, children who are placed in a special education program because of a serious emotional disturbance must have an Individual Education Plan (IEP). Many CMHC staff and programs particularly affiliated with local Systems of Care are actively involved in supporting families and children for whom an IEP is needed.
- *Case Management.* Children and youth with an SED who want to access the full continuum of public behavioral services are assigned a case manager (care coordinator) to work closely with the youth and family to develop an integrated treatment and wraparound plan. Members of the wraparound team design a family and youth directed plan to address key needs on behalf of the children receiving services.
- *Substance Abuse Services and Services for Children with Co-Occurring Disorders.* CMHCs and local SOCs work closely with the ODMHSAS funded addiction treatment centers to provide specific substance abuse treatment and support services. All CMHCs are also certified substance abuse service providers and meet minimum requirements to be co-occurring capable service sites.
- *Other Activities Leading to Reduction of Hospitalization.* CMHCs and other community based providers offer screening and early intervention services to diminish the need for out-of-home placements, including inpatient treatment. Collaboration between providers also facilitates more integrated discharge planning as children and their families prepare for transition from out-of-home placements. This has resulted in lower hospitalization rates and shorter lengths of stay – particularly in Systems of Care communities.
- *System of Integrated Services and Systems of Care for Children and Their Families.* A rich array of state and local partners collaborate to assure a system exists to integrate

services appropriate for the multiple needs of children. The Systems of Care is the centerpiece of service integration on behalf of children with serious emotional disturbance and their families. Oklahoma began to implement local Systems of Care in 2000. Mental Health Block Grant funding provided a portion of the initial resources to support the first two Systems of Care sites. In 2002, Oklahoma received a six-year SAMHSA grant for Systems of Care development. Currently, there are 65 Systems of Care communities covering 58 counties. Other communities are in the formative stages of Systems of Care development. A second SAMHSA grant now supports statewide expansion of the Systems of Care and is funded through 2014. Oklahoma's state-level Systems of Care team oversees the overall operations of the Systems of Care communities. In addition, each local community has a team comprised of agency staff, community members, parent advocates and family members.

- *Transition Services.* The Oklahoma Healthy Transitions Initiative (OHTI) grant was funded by SAMHSA in FY2010 for five years at \$480,000 per year. The grant focuses on integrated services and supports for youth and young adults ages 16 through 25 with serious mental health conditions and their families. OHTI's developmentally-appropriate and effective youth-guided local Systems of Care are designed to improve outcomes in education, employment, housing, mental health and co-occurring disorders, and decrease contact with the juvenile and criminal justice systems. Grant activities in the first four years were based in two well-established local Systems of Care communities—Tulsa County and Cleveland County (Norman). Plans include expansion of services to Payne, Carter, and Pontotoc counties in the coming years. To date the OHTI has provided services to 192 young people.
- *Social Marketing.* Oklahoma Systems of Care utilizes social marketing to increase awareness of the behavioral health needs of children, youth, and young adults; reduce stigma associated with mental illness and substance abuse; promote mental health; and demonstrate that Wraparound is the premier intervention for children and youth with serious emotional disturbance and their families. Social marketing strategies and communications play a vital role in communicating these important messages to stakeholder groups throughout the state. Ultimately, social marketing efforts assist with the successful statewide implementation of Systems of Care as Oklahoma's comprehensive approach to children's behavioral health services. A recent and highly successful event has been the Children, Youth & Families Picnic Celebration at the State Capitol. Annual Children's Mental Health Awareness Day activities were expanded to this picnic format in 2012 and then repeated in 2013. The Picnic Celebration reached more than 1,200 children, youth, families, and service providers when the north lawn of the Capitol building was transformed into a school carnival-style event where service providers across the state host activity areas in 20' x 20' spaces. Parents and caregivers are able to comfortably meander among the 55-60 activity areas to learn about services and children participate in a variety of activities, arts, crafts and games. The Picnic Celebration receives huge support from Governor Mary Fallin. She has addressed the

crowd each year and voiced her support of behavioral health services for children and families.

- *Emergency Service Provider Training on Behalf of Children, Youth and Their Families.* The ODMHSAS provides numerous training opportunities for staff development each year. The Annual Children’s Behavioral Health Conference brings together approximately 1,000 participants. Many attendees work in first response settings, including emergency rooms, ambulance services and law enforcement. Local Systems of Care partners also engage law enforcement and other first responders in various trainings, planning and wraparound work on behalf of children and families. The ODMHSAS Prevention Division also provides training in various suicide intervention and crisis techniques to emergency room, health personnel, law enforcement staff and school districts.

2. Comprehensive community-based system for adults with serious mental illnesses (SMI).

The statewide network of CMHCs is primarily responsible for comprehensive services for adults with SMI. In recent years, this system has also intentionally expanded to proactively support diversion from the criminal justice system. Initiatives within this realm include 13 mental health courts that serve a total of 16 counties, a day reporting center in Oklahoma City, jail-based screenings in both Tulsa and Oklahoma City, statewide training in the Memphis Model Crisis Intervention Training (CIT) program, prison-based treatment for co-occurring mental health and substance use disorders, prison-based discharge planners, and community-based Re-entry Intensive Care Coordination Teams. In FY2012, the CMHCs and other network mental health providers served 68,657 people age 18 and over.

- *Mental Health and Rehabilitation Services.* CMHCs, by regulation, must provide the following basic services:
 - Crisis intervention
 - Medication and psychiatric services
 - Case management
 - Evaluation and treatment planning
 - Counseling services
 - Psychosocial rehabilitation

Additional information is provided below to address specific MHSBG requirements regarding services to adults.

- *Employment Services.* CMHC case managers assist adults age 18 and older with job location and placement. These activities are funded by the ODMHSAS and specific service codes provide claims and reimbursement data for this. In addition, Supported Employment Programs are provided by HOPE Community Services and Green Country Behavioral Health. Transitional employment programs are provided by Thunderbird Clubhouse and Crossroads Clubhouse. Both clubhouses are accredited by the International Center for Clubhouse Development (ICCD). The ODMHSAS and the

Department of Rehabilitation Services (DRS) assist with funding various activities within this array of employment services and utilize a Memorandum of Understanding to coordinate and monitor related activities.

- *Housing Services.* Assuring satisfactory access to safe, sanitary, and affordable housing for adults with mental illness continues to be a challenge to the state. Specific housing services for people with mental illness are available in urban and rural settings and are funded through the ODMHSAS, the U.S. Department of Housing and Urban Development (HUD), public housing authorities and private sources. Housing models include transitional housing and permanent supported housing (both congregate and scattered site). Although some housing continues to be developed in settings specifically for persons with mental illness (i.e., HUD funded Section 811 and HUD SHP projects), the ODMHSAS has placed an emphasis on creating opportunities for more integrated housing, including permanent scattered site housing with available support services. Some stakeholders continue to encourage the development of transitional housing services to meet the needs of consumers whose current level of recovery would make it difficult to have success in a supported housing model.

Additional housing related services and supports embedded in the system for adults with SMI include flexible funds available to each CMHC that can be used to augment a variety of housing supports, including rental and utility deposits; a Discharge Planning Housing Subsidy specifically for adults discharging from psychiatric inpatient care, Department of Corrections, or aging out of the foster care system; a Transition Youth Housing Subsidy program to assist very low-income young adults ages 17 – 24; and Residential Care Facilities can receive a higher rate for services if they successfully meet criteria for designation as a Recovery Home.

- *Education Services for Adults with SMI.* Adult basic education, like GED classes, is offered on site at two clubhouse programs, and at general psychiatric rehabilitation programs at CMHCs. CMHCs and other providers also provide advocacy and support services to assist consumers with initial access/admission at community based educational institutions (i.e., technology centers, colleges, universities) and promote ongoing educational success.
- *Substance Abuse Services Within CMHCs including Services for Persons with Co-Occurring Disorders.* All CMHCs are also certified as substance abuse service providers and receive both mental health and substance abuse funding for persons with serious mental illness and co-occurring substance abuse disorders. Specialty substance abuse treatment providers also collaborate with CMHCs for mental health assessment and other CMHC services as needed. Individualized, gender and culturally specific substance abuse treatment is required of all providers.

- *Medical, Vision and Dental Services.* Case management services have historically been the major option by which adult consumers in the ODMHSAS system are assisted to access medical, vision, and dental services. Access has been more likely for Medicaid beneficiaries. More recently, the ODMHSAS and providers have focused on the primary health needs of adults with SMI. Three sites are currently funded by SAMHSA through the Primary Care Behavioral Health Initiative (PCBHI). Additionally, on-going planning is under way to more strategically align CMHC services with Federally Qualified Health Centers (FQHCs). The OHCA and the ODMHSAS are preparing an application to propose a health home initiative for adults with SMI as a waiver option in the Medicaid program. Collaborations continue with Federally Qualified Health Centers (FQHCs), tribal health and Indian Health services, homeless clinics, county health departments, and pro bono health care providers. Dental services are also provided in local communities through free dental clinics and pro bono providers.
- *Support Services and Psychiatric Rehabilitation.* All ODMHSAS certified CMHCs must provide a clubhouse or general psychiatric rehabilitation program. Clubhouse programs must also be certified by the International Center for Clubhouse Development (ICCD). CMHCs typically elect to provide a general psychiatric rehabilitation program which is reviewed under their state CMHC certification (licenses). In addition, two ICCD clubhouses currently operate independent of CMHCs -- Crossroads Clubhouse (Tulsa) and Thunderbird Clubhouse (Norman).
- *Case Management.* Case management is funded both by the ODMHSAS and the Medicaid program. Since the mid-1990s the ODMHSAS has promulgated the strengths based, person centered case management model to support case management activities in all community and facility settings. Case management services follow a plan approved by the service recipient and qualified staff. Billable activities include referral, linkage advocacy and support provided in partnership with the consumer to assist with self-sufficiency and successful integration into community life. All staff that provides publically funded behavioral case management services are statutorily required to be certified by the ODMHSAS. Applicants must complete a specified curriculum and examination to be eligible for Certification as a Behavioral Health Case Manager. As of July 1, 2012, over 450 individuals have satisfied basic requirements to be Certified Behavioral Health Case Managers Level I and II and 126 for Case Managers Level III. A dedicated website (<http://www.odmhsas.org/CaseMgmt>) provides access to the ODMHSAS certification information for case managers. Multiple entry points are available to attain certification. The ODMHSAS reorganized the training recently and provides options for on-line training of specific elements as well as the ability to test at numerous locations statewide to qualify as reimbursable case managers. The ODMHSAS also recognizes the value of potential workforce members who have case management life experience and subsequently opened up certification to applicants with 60 college credit hours or a high school diploma with 36 total months of experience

working with persons who have a mental illness, additional to those who have completed traditional degree-based programs.

- On July 1, 2013, ODMHSAS in collaboration with the OHCA, revised regulations and provider qualifications for certified behavioral health case managers (CM) and Behavioral Health Rehabilitation Specialists (BHRS). Certified Behavioral Health Case Manager II (CM II) means any person who is certified by ODMHSAS to offer behavioral health case management services and behavioral health rehabilitation services (BHR). Prior to July 1, 2013, the Behavioral Health Rehabilitation Specialist (BHRS) was considered and recognized as a billing designation and many providers of this service had minimal experience and/or training with no rules to govern their practice. The ODMHSAS has reorganized the training to include more extensive trainings (on-line and face-to-face). Also effective July 1, 2013, CM III's will no longer be required to be certified through the ODMHSAS. If they are a Licensed Behavioral Health Professional or are under supervision, or a Certified Alcohol and Drug Counselor, they are no longer required to submit an application, attend training, take the exam or renew their certification.
- *Other Activities Leading to Reduction of Hospitalization.* Oklahoma's service culture embraces a strengths based and person centered approach which begins with a thorough assessment of consumer interest, strengths and needs, and the formation of a plan to assist the consumers with successfully achieving their identified goals. The resources and supports necessary for community success are identified and facilitated through collaborative efforts among the consumers, their support systems, and the service provider. This level of focus helps to reduce the use of hospital or other institutional based resources. CMHCs are monitored to assure that services include cooperative discharge planning with inpatient programs and crisis units, early response and crisis intervention programs, and community partnerships with law enforcement. Community Based Structured Crisis Centers provide short term stays and stabilization in lieu of placement in inpatient facilities. Other modalities, such as Crisis Intervention Training (CIT) and Program of Assertive Community Treatment (PACT), provide intervention, coordinated care, and successful community integration. Recent enhancements of early intervention and transitional services for individuals who interface with the criminal justice system will also prevent the use of hospitalization as well as incarceration. Further, the Enhanced Tier Payment System (ETPS) discussed elsewhere in this application provides an enhanced payment based, in part, on meeting lower inpatient utilization targets.
- *Emergency Service Provider Training.* The ODMHSAS provides numerous training opportunities for staff development throughout the year to enhance skills needed when they encounter adults with SMI. The training announcements are distributed to individuals and organizations statewide, including emergency health workers. Many participants work in first response settings, including emergency rooms, ambulance

services and law enforcement. Law enforcement jurisdictions also collaborate with the ODMHSAS to cross train staff in diversionary and proactive responses with people who may be experiencing mental illness(es) or addiction(s) symptoms. The Memphis Model Crisis Intervention Training (CIT) is widely utilized. The ODMHSAS staff also provides training in various suicide intervention and crisis techniques to emergency room and other health personnel. The state has expanded training offerings of Practical Front Line Assistance and Support for Healing (PFLASH), Psychological First Aid (PFA), Question, Persuade and Refer (QPR), and other early intervention response techniques to non-mental health professionals, including first responders.

3. Comprehensive substance abuse services for children, youth, and adults. As described earlier, substance abuse services are provided through a statewide network of providers that work collaboratively to assure good access and quality care. Key functions performed by providers and ODMHSAS personnel include referral, reporting, monitoring and peer reviewing. Each of those functions is briefly described below to set the context within which specific SAPTBG targeted populations are served.

Substance Abuse Treatment Referrals. The ODMHSAS is committed to making accurate and appropriate referrals for all individuals into and outside of the substance abuse services arena. The ODMHSAS contractually requires substance abuse treatment providers to address both substance abuse and mental health needs of consumers. To aid providers in screening clients for co-occurring disorders, a tool has been developed by the ODMHSAS to screen for substance use and mental health issues regardless of the point of access. This tool can trigger a more comprehensive assessment process, to determine multiple issues, including co-occurring issues. Use of this tool is encouraged but treatment providers may use the co-occurring instruments of their choice. In addition, the Addiction Severity Index (ASI) and the latest version of the American Society of Addiction Medicine Patient Placement Criteria 2-Revised (ASAM PPC-2R) instruments continue to be the backbone of the substance abuse assessment. The ODMHSAS continues to provide monthly ASI and ASAM trainings.

Capacity Reporting. Residential and halfway house programs utilize an on-line capacity reporting system to provide the ODMHSAS with a daily accounting of priority and non-priority individuals waiting to be admitted into treatment. Outpatient treatment openings are typically more available and there are no waiting lists for those services. The ODMHSAS staff works with providers to help admit priority individuals into the first openings available. State staff also notes priority populations daily in the agency reports to ensure that priority individuals are moving into openings. In addition, staff work closely with providers to aid in the timely admission of individuals.

Service Monitoring. Oklahoma monitors substance abuse treatment providers by assigning Field Services Coordinators (FSCs) to specific state-operated and contracted programs for ongoing

compliance reviews. The FSCs are the primary contacts for assigned providers, visiting the agencies and conducting site reviews as well as reviewing provider staffing, services and performance reports. Plans of correction are developed as needed and technical assistance is provided by the FSC or other Department staff per the findings of the site review.

Peer Review. The ODMHSAS began a new system in SFY 2011 of requesting substance abuse block grant funded providers to coordinate peer reviews with other similarly funded providers throughout the state and forward a copy of the review to the ODMHSAS. That system is working well. Approximately 30% of the substance abuse block grant funded treatment providers received peer reviews in FY2013.

Partnerships. Collaborations are discussed in Section IV., N. of this application in which the range of partnerships all services within the ODMHSAS system are described. Specific to substance abuse services these viable partnerships have resulted in more services and improved access for Oklahomans in need of substance abuse treatment.

A range of recovery and support services are provided within the substance abuse treatment services network and specific services funded by the ODMHSAS are listed in other sections of this application. A strength of the system is the manner by which services are delivered to target populations mandated by SAPTBG requirements. Those are detailed below.

- *Persons who are Intravenous Drug Users (IDU).* Intravenous drug users are served by all ODMHSAS substance abuse treatment contract providers and state operated facilities. Interim services are required by contract for IDUs who providers are not able to admit upon requesting treatment. Contracts also require providers to meet the 14-120 day standard. In addition, residential and halfway house programs are contractually required to report their capacity and waiting list information to the ODMHSAS daily. Contract monitoring takes place annually.

Outreach services are contracted with two treatment providers in the largest metropolitan communities, Oklahoma City and Tulsa. These areas also represent the largest IDU populations. Utilizing a locally refined NIDA Indigenous Leader Outreach Model, outreach staff visits their local downtown and high-risk areas in which homeless and drug-using populations congregate. Information and education is discussed and distributed, HIV testing is provided with consent, and referrals and linkages to social services and treatment programs are made.

- *Adolescents with Substance Abuse Problems.* Oklahoma provides early intervention services for adolescents through four service providers that work closely with school systems in their areas, providing brief interventions for high risk students through individual and group sessions at schools. Students are referred for additional treatment if needed. Another early intervention program called “Together with Communities” targets the communities around three charter schools, with their choice of either the

Strengthening Families or Celebrating Families curricula made available by the schools to the communities each serves.

Adolescent treatment services include three adolescent substance abuse residential programs. One of the programs also provides co-occurring services for mental health issues onsite. Outpatient and intensive outpatient services are provided throughout the state by 13 providers. Family and juvenile drug court programs are also available for adolescents, with eight providers funded to provide the necessary services.

In addition to the services listed above, the CMHCs and other providers deliver outpatient treatment to youth with substance use and co-occurring mental health and substance use disorders.

- *Targeted Services for Underserved Individuals from Racial and Ethnic Minority Populations and LGBT Populations.* Oklahoma contracts with an agency in the more populous Oklahoma City area to provide LGBT services. Provider staff are trained in sexual orientation sensitivity and LGBT competency and utilize CSAT's "A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual and Transgender Individuals." Family education support groups are offered for family members as defined by the customer. Client Satisfaction Surveys are requested of customers to report their experiences related to service quality, access, and outcomes.

Substance abuse service providers also work with police, social workers, community outreach workers, substance abuse agencies, health care providers, religious leaders, and others to provide training and education on various aspects of substance abuse issues of the unique social and cultural needs of the LGBT community.

- *Women who are Pregnant and have a Substance Use Disorder.* Pregnant women have priority status in Oklahoma. The Addiction Severity Index (ASI) and the American Society of Addiction Medicine Patient Placement Criteria 2-Revised (ASAM PPC-2R) are utilized to assess the severity and placement needs of all clients. Pregnant women assessed as needing outpatient substance abuse services are able to admit into any outpatient program of their choice in the state. Pregnant women assessed at a higher level and needing a residential program are able to choose whether they prefer admittance to a pregnant women and women with children (WWC) facility or a female residential program. Upon entering a program, women receive individualized, culturally competent, gender-specific services that, along with treatment services, may include dietary information; parenting classes; case management services to help with housing, employment, education, food stamps or other basic needs; and integrating the customer back into the community. Additional needs identified by the ASI, such as mental health needs, are also included in treatment plans. Transportation to services is provided when needed.

- *Parents with Substance Use Disorders who have Dependent Children.* Oklahoma contracts with five residential programs to provide services for women with dependent children (WWC) and three WWC halfway house treatment programs. One halfway house for WWC also operates a residential treatment program. The Oklahoma City Housing Authority collaborates with the ODMHSAS to provide women a sober-living environment in which they can focus on their family, especially their dependent children, while continuing to work on recovery. Each resident must continue to attend self-help groups and work with the onsite case manager to address their educational, employment, mental health and other goals while easing back into the community. Another program administers behavioral and developmental assessments for children who may have been exposed to alcohol or other drugs prenatally. All WWC providers must give priority status to pregnant women, treat the family as a unit, provide child care, and provide health services for both the mother and children, including prenatal care and immunizations for the children. Transportation to services is also provided as needed.

In fiscal year 2007, the ODMHSAS was awarded a five-year Regional Partnership Grant through the Administration for Children and Families titled the Oklahoma Prevention Initiative (OPI). The purpose of OPI is to increase the well-being of, and to improve the permanency outcomes for, children affected by methamphetamine and other substance abuse. The project addresses the growing problem of children who are at high risk for substance abuse and other problem behaviors due to their parents' substance abuse. The goal of this project is to intervene effectively and early to prevent and reduce the risks for children associated with parental methamphetamine and/or other substance abuse. The Department actively collaborates with the Oklahoma Department of Human Services (OKDHS) and contracted agencies to advance the goals of this project.

The ODMHSAS collaborates with the OKDHS to provide appropriate outpatient substance use treatment services to applicants of Temporary Assistance for Needy Families (TANF), participants of TANF, or persons involved in the child welfare system. On November 1, 2012, legislation became effective requiring screening of all persons applying for TANF benefits to rule out substance use disorders and use of illegal substances; if the screening indicates the need for further assessment, contracted agencies provide the assessment. When TANF applicants require assessment, a drug test to rule out the use of illegal drugs in the past 30 days is conducted following the assessment. Due to TANF benefits being tied to the results of substance use screening and assessments, availability of services are needed in each of the 77 counties in Oklahoma. To provide such availability, the number of contracted providers serving TANF/CW referrals increased from 31 to 37 providers in FY13.

- *Services for Persons with or At Risk of Contracting Communicable Diseases: Individuals with Tuberculosis; Persons with or At Risk for HIV/AIDS.* The ODMHSAS substance abuse treatment providers are contractually required to make tuberculosis services available to individuals receiving substance abuse treatment and to provide interim

services for individuals waiting for admission. The required services include counseling, screening and treatment when needed. Tuberculosis services are provided through local Oklahoma State Department of Health (OSDH) facilities, or through other community health care programs. The ODMHSAS provider contracts require adherence to infection control procedures as established by the Centers for Disease Control and Prevention.

Oklahoma is not a designated state and, as such, does not provide early intervention programs for HIV/AIDS. However, Oklahoma Administrative Code (OAC 450) requires all ODMHSAS certified programs provide or arrange access to education, counseling and testing for HIV, AIDS and STDs for consumers and their partners as requested.

4. Military Personnel (Active, Guard, Reserve and Veteran) and their Families. Oklahoma was selected to attend the initial Veteran's Policy Academy sponsored by SAMHSA in 2008 and a return team in 2011. The Academy team developed a work plan that has served as a foundation for continued expansion of services for military personnel and their families. Oklahoma's Academy team members and others also convened recently to assess progress confer on the following emerging priorities and update other information.

- Support of a veterans docket as part of Oklahoma's Drug Court program in Tulsa County and comparable diversionary models for Oklahoma County.
- Free training offered to Licensed Mental Health Professions (LMHPs) on the Psychological Impact of War and training for Primary Care Physicians (in partnership with the Oklahoma Academy of Family Practitioners and Integris Behavioral Health) to education PCPs on how to identify and screen emerging behavioral health needs.
- Partnership with the Oklahoma Counseling Association in promotion of four Eye Movement Desensitization and Reprocessing (EMDR) trainings for military personnel effected by Post Traumatic Stress Disorder (PTSD).
- Coalitions in Oklahoma City and Tulsa continue to ~~to~~ build networks to address challenges faced by veterans in housing, transportation and access to services. Both communities offer training for professionals working with veterans and their families, and the Tulsa community has maintained the Coalition as an ongoing part of their community structure through the Community Service Council. Services include free counseling for veterans, information sharing, a Coffee Bunker for peer support and other social supports/connections.
- Dedicated programming for veterans/actives in multiple conferences, including the annual suicide prevention conference. The 2013 conference included guest lectures by General and Carol Graham.

- Telemedicine partnership for the ODMHSAS telemedicine equipment at remote locations (CMHC²s) to be available to veterans for participation in online support groups in partnership with the Veterans Administration.
- Annual cultural competency training for ODMHSAS personnel to learn more about the culture of military service.
- Data collection within Systems of Care families to determine extent of current veteran/active involvement in existing Systems of Care and explore program enhancements to serve this unique population.
- Continued work with Cabinet Secretary Rita Aragon and Oklahoma National Guard TAG Miles Deering on legislative advocacy to promote greater awareness of suicide risk and criminal justice involvement among veterans.
- A partnership with the ONG and multiple community stakeholders on T3 (Time to Talk). This program will work with Central Oklahoma High Schools on suicide awareness and resiliency efforts.
- Addition by statute (SB181) in statute (2013) to add two appointees to the Oklahoma Suicide Prevention Council directly representative of individuals who have served in the United States military.
- Designation of a “veterans point of entry” in each of the agency’s operated and contracted CMHCs.

Under the Oklahoma Youth Suicide Prevention and Early Intervention Initiative, two national guardsmen have been trained as trainers for Applied Suicide Intervention Skills Training (ASIST) and have completed three trainings for the military and those who work with veterans. The legislatively mandated State Suicide Prevention Council, which the ODMHSAS oversees, includes representatives from the Veterans Administration (VA). In addition, staff working on the ODMHSAS’ Garrett Lee Smith Suicide Prevention Grant has initiated a gun safety project using the VA’s national suicide prevention lifeline labels on gun locks provided by the Oklahoma City Police Department.

Governor Mary Fallin appointed Major (Retired) Edward Pulido to the ODMHSAS Governing Board. Major Pulido brings a variety of experience to Board including his advocacy work on behalf of military personnel and their families. The Major also formerly served on the State Planning and Advisory Council.

5. American Indians/Alaska Natives. Oklahoma is home to 38 federally recognized tribal nations headquartered in Oklahoma. Oklahoma is second, behind only California, with 482,760 Oklahomans identifying themselves with AI/AN status on the 2010 US Census. The proportion of Oklahoma's population identified as AI/AN people was 12.9%. In 2006, the ODMHSAS created a fulltime position for a Tribal Liaison. That position continues to facilitate collaboration among the state and tribal nations and addresses the unique aspects of tribal and state government relationships. In FY2013, 19,369 consumers identifying themselves as American Indian received services funded through the ODMHSAS and/or Medicaid (OHCA) behavioral health reimbursement system.

The Governors Transformation Advisory Board (GTAB) was formed in 2006 by Governor Brad Henry as his lead consultative body for Oklahoma's Transformation State Incentive Grant (TSIG) funded by SAMHSA. An early action of the GTAB, under the leadership of Chickasaw Nation Governor Bill Anoatubby, who served as GTAB chair, was to establish Oklahoma's Tribal State Relations Workgroup. Additional work of that group is described in more detail later in this application. However, the Workgroup has provided expertise and guidance for the ODMHSAS to continually assess better methods to engage with and provide culturally appropriate access to services and supports for Oklahomans with tribal affiliations.

The ODMHSAS participated in SAMHSA's "Policy Academy on Preventing Mental, Emotional and Behavioral Disorders" in September 2012. As a result, the Oklahoma delegation was able to create an Action Plan to address statewide prevention efforts related to preventing mental, emotional and behavioral disorders in the state. With the assistance of a representative from Chickasaw Nation, the State developed an Action Plan to the 38 federally recognized tribal nations in statewide prevention efforts. The Action Plan continues to be addressed.

In 2011, SAMHSA supported Oklahoma's participation in a National Policy Summit to Address Behavioral Health Disparities within Health Care Reform. The ODMHSAS utilized the resources and support for its Summit team to strategically address the unmet behavioral health needs of American Indian children and their families. An action plan was developed to assure that all Oklahoma children and youth who are self-identified by their family as American Indian have early and easy access to needed behavioral health services and supports. The team continues to meet, assess progress, and implement strategies to accomplish the goal. Changes that occur as a result of the plan will benefit all American Indians, regardless of age.

Tribal consultation activities are supported by the above referenced projects and are discussed in more detail in Section P. of this application

6. Targeted Services for Individuals Involved in the Criminal or Juvenile Justice Systems. The ODMHSAS collaborates with various partners within criminal justice and law enforcement to provide a variety of services. The Sequential Intercept Model is used in strategic planning

and aligning of resources for the greatest impact in terms of reducing involvement with criminal justice for adults and children with behavioral health treatment needs. Brief descriptions of related activities follow.

- *Prison-Based Substance Abuse and Community Aftercare Program.* The ODMHSAS works closely with the Oklahoma Department of Corrections (DOC) to provide substance abuse treatment services to offenders in prison, to those offenders who have been released from prison through a probation/parole contract, and a Residential Substance Abuse Treatment (RSAT) aftercare program for those offenders that have completed their time and are not on probation. Thirteen prison-based programs that range from four to nine months use cognitive behavioral therapy as the primary therapy modality. As offenders enter the prison system they are assessed by ODMHSAS contracted agencies at two assessment sites. Once identified as having a substance use problem, the offender is scheduled to enter more focused treatment nearer the end of the offender's prison time. The ODMHSAS contracts with 14 agencies to provide probation and parole services to assist with the re-entry process. The probation and parole officer refers the offender to one of the agencies and the agency coordinates needed services. An additional six agencies provide RSAT aftercare services as referenced above.
- *Substance Abuse & Mental Health Action/Recovery Teams (SMART) Project.* Oklahoma's SMART project, provides discharge planning and community based services for adult offenders who need continued substance abuse treatment and recovery supports in the community following incarceration with the Oklahoma Department of Corrections (DOC). This project is the result of ODMHSAS being awarded funding through the SAMHSA Offender Reentry Program (ORP) in October 2012. The project target population is offenders within the DOC with co-occurring substance abuse and mental health disorders discharging within four months from designated prison facilities. Program participants can be from all security levels and can include both male and female offenders. Offenders who meet the designated criteria and are planning to return or relocate to Oklahoma or Tulsa Counties are eligible for this program. Community Based teams from behavioral health agencies with demonstrated ability and experience to work with this population provides assessment, treatment planning, intensive case management, recovery support specialist services, and treatment services provided by licensed behavioral health clinicians. This project builds on the successful ODMHSAS Prison Based, Reentry, Discharge Planning and Co-occurring Treatment Specialist program that provides a continuum of care for offenders discharging from DOC facilities and has shown promising outcomes and evidence of program effectiveness.
- *Drug Courts.* Oklahoma's Drug Courts offers court-supervised treatment (non-italic) to eligible, non-violent felony offenders in lieu of incarceration. These programs provide individualized treatment services while incorporating the accountability and structure of the judicial system. Individualized assessment and treatment planning, routine substance testing, supervision visits, and regular court appearances are all required throughout

program participation. The ODMHSAS is statutorily responsible for funding and oversight to the 45 drug court programs in the state which serve 73 of the state's counties. Recent analyses report that the programs cost the taxpayers of Oklahoma \$5,000 per person per year instead of an annual average cost of incarceration of \$19,000. Drug courts also focus on reunification of families, employment and education of participants which, in turn, improves the quality of participants' lives and leads to further cost savings.

- *Mental Health Courts.* Thirteen mental health courts were in operation in FY2010. Two are in Oklahoma City and Tulsa and all others in rural communities. A total of 16 counties are served by these courts. Federal stimulus funding sub-granted through the District Attorneys' Council Justice Assistance Grant Board allowed the ODMHSAS to add additional courts. Some courts also focus on participants with co-occurring mental health and addiction disorders.
- *Jail Diversion.* The jail diversion program (Tulsa) and day reporting program (Oklahoma City) provide flexible community based wraparound services for persons at risk of entering or returning to these metropolitan jails.
- *CIT Training.* As of July 2013, over 950 law enforcement personnel in Oklahoma had been trained in the Memphis Model Crisis Intervention Training (CIT) or a similar law enforcement-based diversion program. CIT training will continue to expand, in part, because of resources available through a recently awarded Bureau of Justice Programs grant for Mental Health and Justice Collaboration.
- *Reentry Teams, Discharge Planners, and Co-Occurring Treatment Specialist.* The state funds four Reentry Intensive Care Coordination Teams (RICCTs). These contracts with community based teams include a specifically trained Intensive Case Manager and a Recovery (Peer) Support Specialist to provide success oriented and strengths based reentry support following incarceration. The ODMHSAS provides three Discharge Planners to work in targeted correctional facilities. Discharge Planners work alongside prison treatment staff to identify and assist inmates preparing for reentry who are expected to have ongoing mental health and substance abuse treatment needs. Three co-occurring treatment specialists, also employed by the ODMHSAS, are assigned to two prisons and three community corrections facilities to provide co-occurring treatment to inmates who need integrated treatment for mental health and addiction issues.
- The Discharge Planners, Co-occurring Treatment Specialists and the RICCT staff work under the supervision of the Manager of Correctional Criminal Justice and Reentry Services and under the direction of the ODMHSAS Director of Community Based Services with full support from the Department of Corrections.

Benefits Reinstatement for Returning Inmates. In 2010, SAMHSA published a report summarizing the collaborative work between the DOC, the ODMHSAS, and other state and

federal partners in conjunction with Mathematica Policy Research, Inc. (MPR). The report, “Establishing and Maintaining Medicaid Eligibility upon Release from Public Institutions” (DHHS, 2010) evaluated the methodologies in place in Oklahoma whereby people with SMI, upon discharge from prison, have immediate access to the Medicaid and disability benefits for which they are eligible. Due to a partnership with the local Social Security Administration office, and the Department of Disability Determination, a memorandum of understanding allows applications for public benefits for eligible offenders, including SSI, SSDI, and Medicaid, to begin at least four months prior to release from the DOC facility. This process is an integral part of the prison based discharge planning and reentry function. The findings suggested the model as one applicable to other states and other types of public institutions including state hospitals referred to in Social Security parlance as IMDs (Institutes for Mental Disease). The report is available at <http://download.ncadi.samhsa.gov/ken/pdf/SMA10-4545/SMA10-4545.pdf>.

7. Targeted Services for Individuals who are Homeless. Some of the treatment and supports for adults and children who are homeless are described elsewhere in this application. Additional services targeted for individuals who are homeless are described below.

- *Outreach Initiatives and Projects in Assistance for Transition from Homelessness (PATH).* The PATH allocation for Oklahoma for grant year 09/01/2013 – 08/31/2014 is \$420,000. PATH programs will be located in areas with the highest numbers of people who are homeless: Oklahoma City and Tulsa, and in the rural communities of Tahlequah, located in northeast Oklahoma, and McAlester (located in southeast Oklahoma). Services will primarily focus on outreach and case management (including referrals for primary health services, job training, educational services and relevant housing services) but will also include screening and diagnostic treatment services, community mental health services, habilitation and rehabilitation services, alcohol and drug treatment, staff training and housing services.
- *Substance Abuse Outreach.* The ODMHSAS also provides support to two urban-based substance abuse treatment programs for outreach activities. Outreach activities target high risk drug using individuals, many of whom are homeless and impacted by both mental illness and addiction problems. The outreach workers gain their trust, educate them about HIV/AIDS, communicable diseases, and the harm caused by IV drug use, provide tests for HIV if requested, and assist with linkages to treatment programs.
- *The Tulsa Day Center for the Homeless.* This urban program provides linkages with needed mental health and community services on behalf of adults and children who present at their site, including assistance with accessing housing. In addition, they provide supportive services to people who leave the shelter and become housed to help ensure transition success and reduce recidivism.

- *HUD Continuum of Care Projects.* These sites are operated by two CMHCs. Central Oklahoma Community Mental Health Center (McClain County) and Hope Community Services (remainder of the state). Each facilitates a HUD Shelter Plus Care project that provides rental assistance to homeless persons with mental illness or co-occurring mental illness and substance use disorders. Other CMHCs also participate in local Continuums of Care.

Discharge Planning Bridge Subsidy Program. The ODMHSAS provides targeted funds to assist very low-income individuals (age 18 and older) with mental illness or co-occurring mental illness and substance use disorders who are homeless or at risk of becoming homeless, as they discharge from psychiatric inpatient care, DOC, or age out of the foster care system. The primary focus is to access decent, safe, sanitary, and affordable housing. The funds assist with housing costs such as rent, utility costs, rent deposits and utility deposits. Individuals must be either homeless or at risk of becoming homeless if rental assistance is not received. This assistance can be accessed statewide.

Safe Havens. Safe havens emphasize a housing first approach and allow individuals to remain in that housing even if they do not want to seek treatment. Oklahoma will continue to utilize MHSBG funds for safe haven housing in state FY2014 and FY2015. Current safe haven programs are in Tulsa and are operated by the Mental Health Association of Tulsa.

8. Targeted Services for Individuals in Rural Areas. Individuals in rural areas generally have access to overall treatment and support systems described in earlier portions of the section. However, 59 of Oklahoma's 77 counties are considered rural or frontier and the ODMHSAS continues to focus on improved access and providing services in more effective ways for adults and children in rural areas. Examples are discussed below.

- *Children and their Families in Rural Areas.* All rural CMHCs provide case management services to children. Most of the treatment is provided in the child's home or a community based location. Transportation continues to be a problem in rural areas of the state. Of the state's 58 Systems of Care counties, 56 are located within rural settings. These sites engage a broad stakeholder base to coordinate care, leverage resources, and improve services to children and their families in rural settings.
- *Adults Accessing Mental Health Services in Rural Areas.* Ten CMHCs serve the rural areas of the state. All offer the required mental health services and also purchase or provide local acute inpatient treatment or crisis services to stabilize individuals on emergency orders of detention. Case management services and flexible funds for case managers in rural areas provide in-home support for isolated individuals and assist in purchasing needed goods and services not otherwise available. Most ODMHSAS certified residential care facilities are located in rural counties in the far northeast corner

of the state. CMHCs target additional services to these facilities including general psychosocial rehabilitation day programs, recreation and social skills training, case management, and medication clinics.

- *Substance Abuse Treatment and Supports in Rural Areas.* Many of Oklahoma's substance abuse treatment agencies are located in rural areas. Beginning in SFY 2011, Oklahoma's telemedicine initiative expanded to target specific rural based substance abuse treatment facilities by adding units in seven substance abuse agencies. Thirteen of the substance abuse facilities now have telemedicine capabilities. Other rural based substance abuse treatment providers can arrange telemedicine services at other sites within the ODMHSAS telemedicine network as described below.
- *Technology Supports in Rural Areas.* The SAMHSA Transformation State Incentive Grant (TSIG) served as a major source for ODMHSAS to establish a statewide telemedicine network. Initial units were placed in CMHCs and satellite locations serving rural settings. These units increase access to services and information including medication clinics conducted by psychiatrists, therapy sessions, court commitment hearings, and administrative meetings. In FY11, 162 separate telehealth sites were operational in the ODMHSAS system. User fees and other sources, beyond TSIG, are now in place to sustain this infrastructure.

9. Children and Youth who are At Risk for Mental, Emotional and Behavioral Disorders, including, but not limited to Addiction, Conduct Disorder and Depression. The ODMHSAS is building the infrastructure using the Strategic Prevention Framework to provide a foundation for the prevention of mental, emotional, and behavioral disorders. Many of these have the same risk and causal factors in common and could benefit from shared prevention interventions. Oklahoma supports a broadened focus on multi-sector prevention systems development to expand interventions using shared strategies to serve the same or similar populations. In FY 11, the ODMHSAS embarked on Step 1 (Assessment) of the Strategic Prevention Framework to assess the nature, extent and driving factors of mental illness in the state. A rigorous application of the SPF has followed to develop a state strategic prevention plan that incorporates mental illness prevention and mental health promotion.

10. Targeted Services for Community Populations for Environmental Prevention Activities. Oklahoma's public health approach for substance abuse prevention services utilizes the Strategic Prevention Framework and focuses on decreasing risk and casual factors, such as the availability of alcohol and drugs, community norms regarding the acceptability of high-risk behaviors, the promotion of alcohol products, reducing family conflict, and youth rebelliousness. The ODMHSAS contracts with local agencies to plan and implement a public health based prevention strategy in multiple targeted communities on data-driven alcohol and other drug

priorities. The funded entities build local prevention infrastructures that can support the implementation of a broad array of practices in targeted communities identified through a needs assessment process. To achieve population-level outcomes, evidence-based prevention strategies are implemented and include policies or practices that create a community or cultural environment that supports healthy and safe behavior.

The ODMHSAS continues to broaden prevention activities across the behavioral health spectrum and within the broader view of overall health status. Prevention staff work across other divisions within the ODMHSAS and train at the community level to ensure that prevention activities are based on the following elements:

- Valid estimate(s) of communities' prevention needs using epidemiological data
- Community prevention capacity building focus
- Strategic plan(s)
- Evidence-based policies, practices, and programs implemented with fidelity
- Evaluation of outcomes

Local prevention service agencies are the direct recipients of prevention block grant funds. Statements of work with these entities stipulate that prevention services must be implemented in partnership between these agencies, coalitions and communities. Contracted providers have two explicit roles at the community-level. First they must provide expertise and guidance through training and technical assistance to communities and community coalitions to build substance abuse prevention capacity. Secondly, they are required to strategically coordinate the implementation of prevention services at the local-level in partnership with community stakeholders.

Environmental prevention strategies implemented in Oklahoma consist of local and state-level prevention policy development, law enforcement, media advocacy, and community organizing methods that limit access to substances and change social norms that are accepting and permissive of substance abuse. Specific evidence-based strategies include alcohol retail training and enforcement of youth access to alcohol, tobacco and other drugs.

11. Targeted Services in Community Settings for Indicated Prevention Interventions.

Oklahoma will continue funding primary prevention services with the SAPTBG but the ODMHSAS will also examine community needs and the impact of providing other prevention services, utilizing available resources. Many of the targeted services and system components described throughout this section include public awareness and preventative supports within the contexts of providing those other direct services. Those often are targeted to specific community settings and groups closely affiliated with the recipients of targeted treatment and support services.

Conclusions for Step One: Service System Strengths and Needs

Items 1-11 above summarized information on systems, required services and access for target populations as required by the SAPT and MHS Block Grants. A review of these also brings to fore critical access, capacity, disparity and other issues as listed below. Steps Two through Four of this planning document build upon this information to more clearly understand gaps and unmet needs, highlight priorities for the state, and then propose goals, strategies, and measures. This planning framework will be utilized by the ODMHSAS to continue focusing on its mission and to assure that recovery and improved health are realities for all our citizens.

Summary of Access, Capacity, and Other Issues

- Continued expansion of most services is needed but within a “good and modern” framework.
- Capacity and resource utilization requires further analysis to determine the best way to leverage limited funding and address disparities between communities and populations.
- A variety of activities currently address needs of adults and youth with criminal justice involvement. Expansion of these is needed to reduce future criminal justice involvement and to initially divert other adults and youth with behavioral health needs from these systems.
- Issues and needs of targeted populations should be more thoroughly analyzed.
- More information is needed to raise awareness of and plan for an integrated service approach on behalf of military personnel and their families.
- American Indians represent a significant population base within Oklahoma. Continued engagement with governmental representatives, additional study, and consultation are needed to more expediently and appropriately work with tribal governments in relationship to behavioral health treatment and prevention strategies for American Indians.
- Oklahoma continues to build state and local level capacity to implement a public health approach to prevention for mental illness and substance abuse. Additional planning is needed to fully articulate a comprehensive state prevention plan that incorporates substance abuse prevention and mental illness prevention/mental health promotion.

- Continued review of epidemiological data is warranted to utilize population based data to further understand many factors that should guide the state to effectively plan, implement and evaluate prevention services.
- Oklahoma is dedicated to implementing only evidence-based prevention services. Additional capacity will be required and is being developed at the state level to review and evaluate strategies that meet the state’s criteria for evidence-based practices.
- The state has various accountability and system management processes in place. Further review of these will be beneficial to identify how these and other related methods can better leverage resources and address the mission of the ODMHSAS.

Step Two: Unmet Service Needs and Critical Gaps

Introduction. Step One in this Section summarized services and supports currently in place for behavioral health prevention, early intervention, treatment and support for Oklahomans. That review also identified a listing of access, disparity, capacity, and resource issues that are continually under review by the ODMHSAS. Step Two now addresses many of those in more detail and to more clearly articulate priorities for Oklahoma within the context of this combined SAPT and MHS Block Grant application for FFYs 2014-2015. Priorities are listed in Step Three of this Section.

A summary is included for each topic listed below to provide an overview of unmet service needs and critical gaps related to that systemic issue or target population. Data sources are cited to quantify, to the extent possible, that these are contemporary issues for Oklahoma and levers for actions the ODMHSAS will implement to address our mission and the goals of the block grant program.

Key data have been provided by the Oklahoma State Epidemiological Outcomes Workgroup (SEOW.) The SEOW is a multidisciplinary workgroup whose members are connected to key decision-making and resource allocation bodies in Oklahoma. This workgroup, funded through a Federal grant from SAMHSA/CSAP, was established by the ODMHSAS in 2006 and is patterned after the National Institute on Drug Abuse (NIDA) community epidemiological workgroup. Oklahoma’s SEOW is charged with improving prevention assessment, planning, implementation, and monitoring efforts through data collection and analysis that accurately assesses causes and consequences of the use of alcohol, tobacco, and other drugs and drives decisions concerning the effective and efficient use of prevention resources throughout the state.

Other primary sources have included the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), and published formulas that calculate prevalence of adults with serious mental illness (SMI) and children with serious emotional disturbances (SED).

Health Status for Behavioral Health Consumers with Complex Health Needs. According to the America's Health Rankings® 2012, Oklahoma ranks 43rd for overall health status.¹ The state ranked 43rd for diabetes, 45th for obesity and 47th on smoking. The 2009 Commonwealth Fund State Scorecard on Health System Performance ranks Oklahoma 50th in overall health system performance, with the state in the bottom tenth percentile on dimensions of access, quality, avoidable hospital use and costs, equity and healthy lives.² Many factors contribute to this ranking and review of some of those is essential to highlight how those impact individuals with mental health or substance use disorders or those at risk of developing a behavioral health disorder. Data on general health status and information specific to tobacco use are included below.

Health Status

- Unhealthy lifestyles and behaviors contribute to most of today's leading causes of death.⁵⁵
- In 2010, more than 36,050 Oklahomans died, resulting in a mortality rate that was 22 percent higher than the national rate. While the U.S. mortality rate dropped 22 percent over the last 20 years, Oklahoma's rate only decreased 4 percent.^{44,45}
- Oklahoma had the second highest rate of death due to heart disease in the nation and was 30 percent above the U.S. rate. In 2010, more than 9,400 Oklahomans died from heart disease. The rate of death due to heart disease dropped by 41 percent since 1990 in the U.S., but only 31 percent in Oklahoma.^{55, 43}
- Stroke was the fifth leading cause of death in Oklahoma in 2007, resulting in more than 2,100 deaths. The stroke mortality rate decreased by 36 percent since 1990 in the U.S. but only decreased 24 percent in Oklahoma.^{55, 43}
- In 2010, Oklahoma had the 15th highest rate of cancer deaths in the U.S.⁴³
- Chronic lower respiratory diseases, e.g., COPD, emphysema, chronic bronchitis, and asthma, are the third leading cause of death in Oklahoma. COPD is responsible for 98 percent of deaths from chronic lower respiratory diseases in Oklahoma. COPD is a major cause of disability. People with COPD over the age of 50 years are more likely to be considered disabled. Cigarette smoking is the leading cause of COPD, and secondhand smoke is associated with a 10-43 percent increase in risk of COPD in adults.^{43,42}

- Diabetes is the sixth leading cause of death in Oklahoma. Oklahoma had the fourth highest diabetes death rate in the nation.^{43, 48}
- Approximately 304,500 Oklahomans age 18+ have been diagnosed with diabetes. Oklahoma ranked seventh highest in the nation for the prevalence of people living with diabetes in 2009. Oklahoma has been consistently in the top ten for several years. Minority populations reported higher prevalence of diabetes than whites. Adults with older age, lower annual household incomes, or less education tended to report higher prevalence of diabetes. The prevalence of diabetes was higher among people living in the eastern part of the state. Adults who have ever been diagnosed with diabetes are more likely to report having cardiovascular diseases.⁵⁵
- One in five hospital admissions in Oklahoma includes a diagnosis of diabetes. Lack of physical activity is one of the major risk factors of diabetes. Oklahoma adults who participated in leisure-time physical activity reported significantly lower prevalence of diabetes.⁴⁵ Obesity (Body Mass Index, BMI \geq 30) and overweight (25 \leq BMI $<$ 30) are risk factors of diabetes. Diabetes is more common among persons with higher BMI.⁵⁵
- Health expenditures of diabetes in Oklahoma were estimated at \$3.28 billion.⁵⁵
- One in 10 Oklahoma children currently has asthma. 429,500 Oklahomans age 18+ (15.5 percent) reported having been diagnosed with asthma at some time during their lives by a health professional. Of Oklahomans aged 18+, 274,700 (9.9 percent) reported that they have asthma now. Women in Oklahoma had significantly higher prevalence of asthma than men. Non-Hispanic American Indians and blacks had a slightly higher rate of asthma than non-Hispanic whites. About 1 in 10 Oklahoma children aged 0-17 currently has asthma (~100,000 children). Asthma affects nearly one in 13 school-aged children and was the leading cause of school absenteeism due to chronic disease. In 2008, there were 4,367 hospital admissions with asthma as the principal diagnosis, and 66.3 percent of them were admitted from the emergency room. Most asthma hospital admissions came from Oklahoma City and Tulsa, however some counties in western Oklahoma had higher rates of hospitalization. Thirty-nine people died from asthma in 2007 in Oklahoma; five (12.5 percent) were less than age 25. Asthma mortality rates were much higher among people aged 65+. Blacks had twice the mortality rate compared to whites.⁵⁵
- Oklahoma's adult obesity rate has nearly quadrupled since 1988. Excess weight increases the risk of developing chronic disease, such as heart disease, stroke, diabetes, and some cancers. Oklahoma ranked 47th in the nation for obesity (or fifth most obese) and two thirds of Oklahoma adults had a Body Mass Index (BMI) of 25+ (overweight and obese). Fourteen percent of Oklahoma youth were obese and 16 percent were overweight.⁵⁵

- Oklahoma is ranked 47th in the nation for smoking, with 24.7% of the state population smoking compared to 18.4% nationwide. The prevalence is even higher among African American (30.4%) and American Indians (33.6%) in the State.⁵⁶
- Persons with serious mental illness die about 25 years earlier than other individuals. In Oklahoma, the years of potential life lost was found to be 26.1 years.³
- The life expectancy of a drug addict is 15 to 20 years after they start being a drug addict.⁴

Tobacco Use

- Smoking is Oklahoma's leading cause of preventable death.⁵⁷
- Smoking kills more Oklahomans than alcohol, auto accidents, AIDS, suicides, murders and illegal drugs combined.⁵⁷
- Smoking costs Oklahomans an estimated \$2.7 billion in medical expenses and lost productivity each year.⁵⁷
- Twenty-six percent of Oklahoma adults smoke, compared to about 18 percent nationally.⁵⁷
- Each year, about 5,400 Oklahoma children become new daily smokers.⁵⁷
- Each year, about \$213 million is spent by tobacco companies to promote their products to Oklahomans.⁵⁷
- Oklahoma is one of only two states that prohibits communities from adopting any policy on tobacco that's stronger than state law.⁵⁷
- Smoking among pregnant women is climbing in Oklahoma according to the Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS). In 2003, 16.2 percent of pregnant women reported they had smoked during the last three months of their pregnancy; in 2009, the most recent PRAMS for which data are currently available, the percentage of pregnant women who smoked during the last three months of pregnancy had risen to 18.5.⁵⁸
- Persons with mental illnesses are twice as likely to smoke as other persons and comprise nearly 45% of the total tobacco market in the U.S.⁹

- Individuals who received treatment for a substance use disorder in the past year were about three times more likely to be current (past month) smokers than those who did not receive treatment (74.0 vs. 23.8 percent).¹⁰

Access and Disparities Impacting Specific Populations. Data on substance use and mental illness rates for adults and children are presented here to describe the prevalence of these disorders in Oklahoma and quantify gaps in terms of service penetration and unmet treatment needs.

Substance Abuse Prevalence

- According to NSDUH, Oklahoma has been consistently above the national average among persons aged 12 and older reporting the use of any illicit drug other than marijuana. The percentages were 4.6 in 2007 and 4.1 in 2011. The national percentages for those same years were 3.7 and 3.3, respectively.^{7,5}
- The latest NVSS data show that Oklahoma exceeds the Nation in number of deaths due to drug-related behavior. In 2010, the rate per 100,000 was 19.6 for Oklahoma and 12.4 for the United States as a whole.⁶¹
- Oklahoma is consistently above the national average in alcohol-related mortality. Long-term alcohol consumption is associated with chronic liver disease. The relationship between alcohol use and suicide is also well documented, according to CSAP. Both chronic liver deaths and suicide deaths have been on the rise in Oklahoma since 2003.^{12,13,14}
- According to the Uniform Crime Reports (UCR), Oklahoma has also been consistently above the national average in crimes related to alcohol use, which include aggravated assaults, sexual assaults, and robberies. Since 2003, there has been an 18.1 percent increase.¹⁵
- Fatality Analysis Reporting System (FARS) data for Oklahoma show that there has been an increase in the percentage of fatal crashes involving an alcohol-impaired driver. In the same period, the nation has seen a decrease. In 2007, Oklahoma's alcohol-impaired driver fatality rate was 31.3 percent, and in 2011, it was 35.7 percent. National percentages for those years were 37.6 percent and 35.6 percent, respectively.⁶¹
- The 2010-2012 NSDUH reported 339,137 Oklahomans were dependent or abused illicit drugs or alcohol in the past year⁶⁷ In 2012, 18,614 unique individuals received substance abuse treatment through ODMHSAS-funded treatment.⁵²

Serious Mental Illness (Adults) Prevalence and Services Access

- One study estimates that Oklahoma has the third highest rate of SMI in the nation. The rate of serious mental illness (SMI) in the past year for Oklahoma is 10.93, compared to the national rate of 8.76.¹⁷
- Utilizing methodology applied in previous block grant applications, Oklahoma's estimate of prevalence of adults with a serious mental illness (SMI) is based on federal guidelines from the Center for Mental Health Services, published March 28, 1997 (using 1990 census data). Data from two major national studies, the National Comorbidity Survey (NCS) and the Epidemiologic Catchment Area (ECA) Study, were used to estimate the prevalence of adults with serious mental illness. The estimated prevalence for adults with SMI is 183,366. In state FY08, the ODMHSAS served over 31,000 adults with serious mental illness or 16.5% of the estimated need. The gap between prevalence rates and those services decreased somewhat in FY12, when the ODMHSAS served 49,139 adults with serious mental illness or 26.8% of the estimated SMI population.⁵²

Serious Emotional Disturbance (Children and Youth) SED Prevalence/Penetration

- Using the CMHS methodology referenced above for estimating adults with SMI, Oklahoma has an estimated 56,476 (13%) youth age 9 to 17 with SED.¹⁸ In state FY10, the ODMHSAS served 4,987 children, ages 9-17, with SED or 11.32% of the estimated population in CMHCs and related mental health programs.⁵²

American Indians

The U.S. Commission on Civil Rights, in its report, *Broken Promises: Evaluating the Native American Health Care System*, states that it has long been recognized that American Indians are dying of diabetes, alcoholism, tuberculosis, suicide, and other health conditions at shocking rates. Beyond disturbingly high mortality rates, American Indians also suffer a significantly lower health status and disproportionate rates of disease compared with all other Americans. The disparities in healthcare are especially significant for Oklahoma with the second highest percentage of American Indians as compared to all other states.

- In 2012, the American Indian and Alaska Native (AI/AN) population in Oklahoma was 343,334, comprising 9 percent of the state's total population and ranking Oklahoma second among all states for the number of AI/AN in its population.¹⁹
- According to data from the 2009 BRFSS, 14.2 percent of AI/AN adults reported binge drinking, and 4.0 percent reported heavy drinking; both percentages exceed those reported by any other race.²⁰

- Smoking consumption was highest among this group according to the BRFSS. In 2009, 31.9 percent AI/ANs reported current smoking compared to all other races (25.0%).²⁰
- Data from the Oklahoma State Bureau of Investigation (OSBI) show Oklahoma's AI/AN population had substantially greater alcohol-related arrests (i.e., driving under the influence, liquor law violations and drunkenness) at 44 percent, compared to all races combined at 29 percent.²¹

Adults with Criminal Justice Involvement

Many studies have shown that individuals with mental illness and addiction are overrepresented in jails and prisons in the United States. This is even more pronounced in Oklahoma, as the State incarceration rate is ranked 3rd nationally for males and 1st for females. In 2012, Oklahoma incarcerated over 25,000 people (excluding persons held in county jails due to bed shortages in the prisons) and 28% are charged with drug-related crimes.⁴⁶

- The Department of Corrections indicates that in 2012, approximately 13,000 or 50% of offenders have a history of, or are currently exhibiting some form of mental illness. Of the 2,650 female offenders, 69% have a mental health need (2,130), compared to 48% of the 23,000 male offenders.²²
- Approximately 26% of the total population (52% female and 23% male) currently exhibit symptoms of a serious mental illness, given the most conservative definition. Since 1989, the number of offenders receiving psychotropic medications has dramatically increased (300%), while the total inmate population has only increased by 19%.²²
- Of inmates diagnosed with a mental illness, 50 % of inmates (60% female, 42% male) were incarcerated for non-violent offenses.²²
- The average recidivism three-year return rate for the general population is 15.8%; however, for females with serious mental illness the return rate is 25.2% and for males with serious mental illness the rate is 46%.²²

Youth with Juvenile Justice Involvement

From one-quarter to one-third of incarcerated youth have anxiety or mood disorder diagnoses, nearly half of incarcerated girls meet criteria for post-traumatic stress disorder (PTSD), and up to 19 percent of incarcerated youth may be suicidal. In addition, up to two-thirds of children who have mental illnesses and are involved with the juvenile justice system have co-occurring substance abuse disorders, making their diagnosis and treatment needs more complex. Many programs are effective in treating youth who have behavioral health care needs in the juvenile

justice system, reducing recidivism and deterring young people from future juvenile justice involvement. Generally, regardless of the type of program used or the youths background, recidivism rates among those who received treatment are as much as 25 percent lower than the rates of those children and teens in untreated control groups.^{39, 38}

- In a 2001 face-to-face survey with 274 juveniles in the custody of the Oklahoma Office of Juvenile Affairs (OJA), results indicated that over half of those surveyed had used alcohol in the past 30 days (57.5%). For lifetime use, youths had a rate of 93.5 percent, and for past year use, a rate of 82.9 %.⁶⁵
- All youth surveyed had used an illicit drug in his or her lifetime. Over eight out of ten youths (83.1%) had used an illicit drug in the last year and 71 percent had used in the last month.⁶⁵
- Of the total weighted sample, 46.6% were estimated to be in need of treatment for alcohol abuse and 548 (72.3%) were estimated to be in need of treatment for illicit drug use. This results in an overall estimated need of treatment for alcohol and/or drugs of 79%.⁶⁵
- Four percent reported that their overall emotional or mental health was poor, 41 percent reported that they had seen a health professional for emotional or psychological problems, 36 percent reported taking prescribed medication for psychological or mental health problems, and 20 percent said they had been hospitalized for their psychological or mental health problems.⁶⁵

Military Personnel and Families

The first of four goals of the White Report: Strengthening Our Military Families, is to enhance the well-being and psychological health of the military family. The report recognizes with the increased exposure to combat stress due to longer and more frequent deployments, there has been a growing number of service members with behavioral health needs. Further, it recognizes that military families are not immune to the stresses of deployment and cites a growing body of research on the impact of prolonged deployment and trauma-related stress on military families, particularly spouses and children.

- In Oklahoma, 12.5 percent (333,358) of our citizens are veterans, with 20.7 percent having served in the Gulf War.⁵⁹
- Over 47,000 individuals based in Oklahoma are active in military operations and 24,500 have been deployed since American troops entered Afghanistan.⁶⁰

- Oklahoma ranks third among states and territories for military recruits per capita.²⁷
- A 2008 Rand study found that 14% of returning service members met criteria for PTSD and 14% meet criteria for depression. It is estimated that 300,000 veterans who have returned from Iraq and Afghanistan are currently suffering from PTSD or major depression.²⁶
- According to the National Violent Death Reporting System, about 20% of suicides are committed yearly by veterans. There were in excess of 21% of suicides through 2007 among Operations Enduring Freedom and Operations Iraq Freedom.²⁹
- More than 60% of suicides among the Veterans Administration population are patients with a known diagnosis of a mental health condition. (Serious Mental Illness Treatment Research and Education Center).²⁸

Prevention and Early Identification.

Suicide Prevention. According to the American Society for Suicide Prevention, every 15 minutes someone dies by suicide. It remains the 11th leading cause of death in this country. Though suicide attempts are not reported, it is estimated that close to one million people make a suicide attempt each year. Research has shown that 90 percent of people who die by suicide have a diagnosable psychiatric disorder at the time of their death, most often unrecognized or untreated depression.

- Suicide deaths outnumber homicides by almost three-to-one.⁵⁵
- The suicide rate in Oklahoma was 33 percent higher than the U.S. rate.⁵⁵
- Suicide rates tended to be higher in the southeast area of Oklahoma.⁵⁵
- Men were four times more likely than women to kill themselves.⁴⁵
- Non-Hispanic whites and American Indians had higher rates of suicide than blacks or Hispanics.⁵⁵
- One in five suicide victims had a history of suicide attempts and 30 percent had shared their intent/feelings with another person.⁵⁵
- Issues that are most likely to increase a person's risk for suicide are mental illness, intimate partner problems, and physical health problems.⁵⁵

- Suicide is the most common manner of violent death in Oklahoma and the third leading cause of death to Oklahomans age 10-24.⁵⁵
- The first quarter of 2010 yielded an alarming increase in calls to Oklahoma's suicide prevention hotline; 53 percent greater than the same quarter in 2009.³⁵
- Oklahoma is ranked 13th highest among all states for the number of suicide deaths per capita.⁴¹
- Suicide was the most prevalent type of violent death in Oklahoma from 2004 to 2007, an average of 514 deaths per year. In 52 of the suicide deaths, the victim killed at least one other person before taking his/her own life, resulting in 65 homicide deaths.⁴¹

Early Screening and Referral. As stated in the President's New Freedom Report, for individuals of all ages, early detection, assessment, and linkage with treatment and supports can prevent behavioral health problems from compounding and poor life outcomes from accumulating. Early intervention can have a significant impact on the lives of children and adults who experience behavioral health problems. Emerging research indicates that intervening early can interrupt the negative course of some illnesses and may, in some cases, lessen long-term disability.

- The direct costs of untreated needs of people with mental illness and substance addictive disorders for Oklahoma businesses, governments and families is \$3.2 billion annually and the total cost on the Oklahoma economy due to untreated and undertreated mental illness and substance abuse is placed at more than \$8 billion annually.³⁷
- Oklahoma's criminal justice system spends 63 percent of its annual budget (over \$1 billion) to address the untreated needs of people with mental illness or addictive disorders.³⁷
- A needs assessment study found that 18,253 adults received publically funded substance abuse treatment in 2005, leaving an estimated 70,118 adults with low income not receiving needed treatment. For the same year, 58,225 adults received publicly funded mental health services leaving an estimated 69,976 adults with low income not receiving treatment.²⁴

Underage Drinking. The National Institute for Alcohol Abuse and Alcoholism published a News Alert which showed that many adolescents start to drink at very young ages. In 2003, the average age of first use of alcohol was about 14, compared to about 17 1/2 in 1965. People who reported starting to drink before the age of 15 were four times more likely to also report meeting the criteria for alcohol dependence at some point in their lives. In fact, new research shows that

the serious drinking problems, typically associated with middle age, actually begin to appear much earlier, during young adulthood and even adolescence.

Other research shows that the younger children and adolescents are when they start to drink, the more likely they will be to engage in behaviors that harm themselves and others. For example, frequent binge drinkers (nearly 1 million high school students nationwide) are more likely to engage in risky behaviors, including using other drugs such as marijuana and cocaine, having sex with six or more partners, and earning grades that are mostly Ds and Fs in school.

- According to Oklahoma's Youth Risk Behavior Survey (YRBS), in 2011, 38.3 percent of students in grades 9–12 reported current alcohol consumption. The National Survey on Drug Use and Health (NSDUH) for the population aged 12 and older, which showed 42.5 percent of respondents were current drinkers in 2011.^{20,5}
- NSDUH data from 2011 indicated 38.2 percent of 18- to 25-year-olds and 7.0 percent of 12- to 17-year-olds were binge drinkers.⁷ YRBS data also showed 23.3 percent of adolescents were binge drinkers at the time of the survey.⁵
- The 2011 YRBS showed 19.4 percent of Oklahoma students in grades 9–12 reported early initiation of alcohol and 71 percent of respondents reported they had consumed alcohol on at least one day of their life.²⁰
- In 2011, Oklahoma's percentage of adolescent drunk driving was 8.2 percent, compared to the national average of 7.2 percent.²⁰

Misuse of Prescription Drugs. In the United States, prescription drugs are the second most commonly abused category of drugs, behind marijuana. There may be a perception, especially among younger people, that prescription drugs are safer than illegal street drugs. Most people do not lock up their prescription medications, nor do they discard them when they are no longer needed for their intended use, making them vulnerable to theft or misuse. According to SAMHSA, the number of teens and young adults (ages 12 to 25) who were new abusers of prescription painkillers grew from 400,000 in the mid-'80s to 2 million in 2000. New misusers of tranquilizers, which are normally used to treat anxiety or tension, increased nearly 50 percent between 1999 and 2000 alone. Like many other states, Oklahoma is experiencing a dramatic increase in the misuse of prescription drugs.

- According to data from the 2010 NSDUH, Oklahoma ranked number one nationally for the nonmedical use of pain relievers in the past year for all age categories: 12 years and older, 12-17 years, 18-25 years and 26 and older. Oklahoma has been above the national average for the percentage of residents reporting nonmedical use of pain relievers since 2004.⁵

- Oklahoma hospital data associated with opiates have shown a 91% increase since 2003. Although this is a general category for opiates, for all practical purposes, heroin is the only illicit opiate taken into account.⁶¹
- The National Vital Statics System data show a 423% increase in opioid pain reliever-related deaths of all intents in Oklahoma since 1999. The latest data released in 2010 ranked Oklahoma 3rd in the nation for opioid pain reliever-related overdose deaths, exceeding the national average by 152 percent. The number of drug-related crimes (larceny, burglary, motor vehicle theft) in Oklahoma also outstrips that of the Nation; in 2011, Oklahoma reported 3,356.2 per 100,000 compared to the national rate of 2,908.7 per 100,000.^{67,15}

Older Oklahomans

The proportion of Oklahoma's population that is over 60 is growing while the proportion that is under 60 is shrinking. The US Census Bureau estimates that more than 24 percent of Oklahoma's population will be over age 60 by the year 2030, an increase of close to 25 percent from 2012.

- One in four persons aged 55 and over experiences behavioral health disorders that are not part of the normal aging process.⁴⁷
- Despite the availability of proven interventions for mental health and substance use problems, the majority of older adults with these behavioral health issues do not receive the treatments they need. Older adults are significantly less likely to receive any mental health treatment when compared to younger adults.⁴⁸
- An estimated one in five older adults may be affected by combined difficulties with alcohol and medication misuse.⁵⁰
- Up to 5% of older adults in the community have major depression and up to 15% have clinically significant depressive symptoms that impact their functioning, and the prevalence of depression is substantially higher in older adults with medical illnesses.⁵¹
- The incidence of suicide is particularly high among older, white males (30.3 suicides per 100,000). The rate of suicide in the oldest group of white males (ages 85+) is over four times higher than the nation's overall rate of suicide. In 2007, the latest year in which comparable national data were available, 146 Oklahomans over age 55 committed suicide. The highest rate was the 75 and older age group at 25.3.⁵²

Good and Modern Services.

Use of Peer Recovery Support Specialists. It is evident in Oklahoma that persons in recovery from a mental illness and/or substance abuse disorder, who are trained to work with others on their individual roads to recovery, fulfill unique roles in the service system. Peer Recovery Support Specialists (PRSSs) offer the advantage of lived experience from serious mental illness and/or substance abuse. They know the journey to recovery is real and attainable, because they have traveled the path.

- Recovery Community Services Program has shown consistent, positive results. The most recent data collected for individuals accessing services at baseline and 6-month follow-up revealed:³¹
 - 75% of clients reported no substance use, an increase of 16.8%
 - 95.9% of clients reported no arrests at six-month follow-up
 - 51% of clients reported being employed, an increase of 33.9%
 - 51% of clients reported being housed, an increase of 31.8%
 - Clients experiencing serious depression decreased 19.6%
 - Clients experiencing serious anxiety decreased 21.7%
 - Clients experiencing trouble understanding, concentrating, or remembering decreased 25.8%
 - Clients attempting suicide decreased 23.1%
 - 20% of clients were prescribed medication for psychological/emotional problem at six-month follow-up

Impact of Trauma. Results from the Adverse Childhood Experiences (ACE) Study indicates that childhood abuse and household dysfunction lead to the development of the chronic diseases that are the most common causes of death and disability in this country. A strong relationship is shown between the number of adverse childhood experiences and reports of cigarette smoking, obesity, physical inactivity, alcoholism, drug abuse, depression, suicide attempts, sexual promiscuity, and sexually transmitted diseases. Traditionally viewed as public health or mental health problems, these behaviors appear to be coping mechanisms for people who have had adverse childhood experiences. Trauma-Informed Services can address the impact of trauma on people's lives and facilitate trauma recovery.

- As many as 80 percent of men and women in psychiatric hospitals have experienced physical or sexual abuse, most of them as children.³²
- The majority of adults diagnosed with Borderline Personality Disorder (81%) or Dissociative Identity Disorder (90%) were abused as children.³²
- As many as two-thirds of both men and women in substance abuse treatment report childhood abuse or neglect.³²

- Nearly 90 percent of alcoholic women were sexually abused as children or suffered severe violence at the hands of a parent.³²
- 82 percent of young people in inpatient and residential treatment programs have histories of trauma.³²
- Violence is a significant causal factor in 10-25 percent of all developmental disabilities.³²
- 80 percent of women in prison and jail have been victims of sexual and physical abuse.³²
- In one study, 92 percent of incarcerated girls reported sexual, physical or severe emotional abuse.³²
- Boys who experience or witness violence are 1,000 times more likely to commit violence than those who do not.³²

Use of Technology. According to the 2000 Census, 68% of the State's population lives in an urban area, with nearly one-third residing in a rural or frontier area. This leads to barriers to care for many Oklahomans who live in areas without the appropriate level of care and who do not have resources to get to the needed services. Telehealth is a primary strategy used by the ODMHSAS to increase access to mental health and substance abuse information and services to underserved areas. Through the Oklahoma TeleHealth Network, Oklahomans who were once unable to receive services due to geographical, economic and workforce barriers are now able to receive the care that they desire.

- In fiscal year 2013, over 12,916 Oklahomans were given behavioral health care services via Telehealth.³⁷
- For this same year, over 41,683 services were delivered via telehealth.³⁷
- The average savings per quarter from the use of telehealth equipment is \$377,000.³⁷

Step Two Summary. The data and discussion used in Step Two above do not represent what the state would consider complete in terms of a comprehensive gap analysis. That was not possible during this application cycle due to time and resource constraints. Regardless, substantial data are available and have aided the state in this block grant planning process. In fact, use of those data has driven a process by which Oklahoma has identified priorities on which to focus this plan and application. Those priorities are listed in Step Three and relate to the areas of health promotion, improved access, reduced disparities, service accountability, criminal justice concerns, and prevention of substance abuse and mental health disorders.

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Step Three: State Priorities – 2014-2015

Step One described the Oklahoma public behavioral health system, highlighted strengths and unique characteristics of the system and set, in general, challenges that face the state. Step Two then further reviewed those challenges along general topics and reviewed data that quantify the extent to which gaps exist and point to significant issues for the state. A review of that information was used in a data driven process to identify the priorities the state will address in Federal Fiscal Years 2014 and 2015, in accordance with requirements for the combined Substance Abuse Prevention and Treatment (SAPT) and Mental Health Services (MHS) Block Grant programs. Those are listed below.

1. Overall Health Promotion
2. Improved Access and Reduced Disparities
3. Enhanced Service Quality and Accountability
4. Reduced Criminal Justice Involvement
5. Prevention of Mental Illness and Substance Use Disorders
6. Public Awareness of Behavioral Health, Prevention, and Recovery

Specific goals aligned with these priorities are detailed in Step Four. Strategies to accomplish those goals and performance indicators by which the accomplishments will be measured are also included.

Step Four: Goals, Strategies and Measures*

Step Three listed out state priorities for the FFY 2014 and 2015 block grant cycles. Those priorities appear below along with supporting goals.

Priority	Goals
Overall Health Promotion	<ul style="list-style-type: none"> • Further integrate behavioral health with primary care • Improve the health status of behavioral health consumers with complex health needs • Reduce use of tobacco
Improved Access and Reduced Disparities	<ul style="list-style-type: none"> • Expand services for American Indians • Target services to improve access for military personnel and their families • Expand services for children and youth with Serious Emotional Disturbances (SED) • Improved utilization of services for older adults • Utilize specific programs to address the needs of targeted populations
Enhanced Service Quality and Accountability	<ul style="list-style-type: none"> • Expand use recovery support services • Utilize evidence based practices for individuals impacted by trauma • Increase options for self-directed care • Utilization of management systems for more efficient use of resources and improved service outcomes
Reduced Criminal Justice Involvement	<ul style="list-style-type: none"> • Utilize treatment and supports to divert individuals from incarceration • Reduce recidivism for offenders • Improve workforce capacity and skills in response to individuals with criminal justice/public safety involvement
Prevention of Mental Illness and Substance Abuse Disorders	<ul style="list-style-type: none"> • Reduce rates of suicide • Expansion of Mental Health First Aid services • Reduce substance use • Early identification and intervention of substance use problems • Reduce underage drinking • Reduce misuse of prescription drugs
Public Awareness	<ul style="list-style-type: none"> • Address discrimination and stigmas related to behavioral health • Provide public information for improved access to services • Expand partnerships with media outlets

III. Intended use of Grant Funds

Projected Use for Federal Fiscal Year 2014			
Category	SAPT Block Grant	MHS Block Grant	Subtotals
Substance Abuse Treatment and Supports	13,023,806.00		13,023,806.00
Mental Health Treatment and Supports (Adults)		\$3,030,659.00	\$3,030,659.00
Mental Health Treatment and Supports (Children and Youth)		\$1,086,127.00	\$1,086,127.00
Advocacy Development		\$251,764.00	\$251,764.00
Primary Prevention	868,254.00		868,254.00
SAPTBG Administration	3,473,015.00		3,473,015.00
MHSBG Administration		229,924.00	229,924.00
Totals	17,365,075.00	4,598,474.00	21,963,549.00
