

Oklahoma Needs Assessment and Resource Inventory Report



September 22, 2006

This report was prepared under the direction of John Hornik, Ph.D., Director of Research, Advocates for Human Potential (AHP), under contract to the ODMHSAS, by a project team of AHP and ODMHSAS Decision Support Services (DSS) staff. The report was written by Darby Penney, M.L.S. (AHP), Rebecca Moore, M.S. (DSS), Courtney Charish, M.A. (DSS), Steve Davis, Ph.D. (DSS), Tracy Leeper, M.A. (DSS), and John Hornik. Chapter 4 was based, in part, on a larger report on children's needs assessment written by Jim Rast, Ph.D. (Vroom Vandenberg). The report was word-processed and prepared for printing by Sean Couch. The Needs Assessment project team worked under the general supervision of Terry Smith, Assistant Director of the Oklahoma Innovation Center.

The Needs Assessment Project Team is appreciative of the efforts of many other individuals who have contributed to this report. This includes many Oklahomans who volunteered their time to participate in focus groups and representatives from many state agencies who provided information and discussed their own concerns about mental health and substance abuse services; staff of the Innovation Center directed by John Hudgens; and the members of the Needs Assessment Committee of the Governor's Transformation Advisory Board, who helped to shape this process through comments on the design of and feedback on an earlier draft of this report.

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An appendix listing all acronyms used in this document is included at the end of the report.

To our readers:

This document was prepared in support of the work of a broad and committed base of partners who support a transformation vision for our state. That vision is for *all Oklahomans to prosper and achieve their personal goals in the communities of their choice!*

This Needs Assessment and Resource Inventory was designed to be submitted to our federal partner, the Substance Abuse and Mental Health Services Administration (SAMHSA), in partial compliance with requirements under the Mental Health Transformation State Incentive Grant program. However, this report is much more than that. This report has the potential to provide Oklahoma a comprehensive view of our strengths, resources, and needs specifically related to the areas of mental health and substance abuse. It is intended to provide a framework for planning, decision making, evaluation, and eventual celebration of our achievements.

Appreciation is due to the over 1000 people who took time in recent weeks to share their experiences and their dreams. Persons with substance abuse and mental health service needs, along with their families and those who serve them, must have hope in order to begin their recovery. Their voices have guided this work.

The official version of this document was submitted to SAMHSA prior to a September 30, 2006 deadline. However, it remains a living document that can be updated to provide continuous information for all our partners in Oklahoma who are generously contributing their expertise, passion, and visions for great things to come for our state and our citizens whose health and recovery depend on a transformed approach to mental health and substance abuse services.

Specific comments and inquiries can be forwarded at any time to okinnovationcenter@odmhsas.org or Terry Smith, Assistant Director of The Innovation Center, 2401 NW 23rd Street, Suite 76-A, Oklahoma City, OK 73107

Thank you for your interest in, comments on, and use of this Report.

Sincerely,

A handwritten signature in black ink, appearing to read "John Hudgens", with a long horizontal flourish extending to the right.

John Hudgens
Director, Innovation Center

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Executive Summary

A. Overview

Oklahoma is one of seven states to receive a five-year Mental Health Transformation State Incentive Grant (TSIG) from the federal Center for Mental Health Services (CMHS), a center within the Substance Abuse and Mental Health Services Administration (SAMHSA). The purpose of the grants is to help transform state mental health service delivery systems from systems dictated by outmoded bureaucratic and financial incentives to systems driven by consumer and family needs, focusing on building resilience and facilitating recovery. The grants require state mental health authorities to work in collaboration with other systems that serve people diagnosed with mental illness, and to involve consumers and family members as active partners. All transformation planning and activities are to be guided by the recommendations of the President's New Freedom Commission on Mental Health; its 2003 final report called for a fundamental transformation of the nation's approach to mental health care. Noting that "[t]he time has long passed for yet another piecemeal approach to mental health reform," the Commission identified six principal goals of a reformed system of care. Oklahoma's transformation approaches reflect the state's commitment to be inclusive of substance abuse services as well as being a culturally competent and trauma-informed system. Consequently, the goals related to the New Freedom Commission report throughout this document have been restated as listed below:

- (1) Oklahomans understand that having mental health and being free from addictions is essential to overall health.
- (2) Care is consumer and family driven.
- (3) Disparities in substance abuse and mental health services are eliminated.
- (4) Early screening, assessment, and referral to services are common practice.
- (5) Excellent care is delivered and research is accelerated.
- (6) Technology is used to access care and information.

The Commission's goals and associated recommendations are organized around one key principle: that public mental health and substance abuse systems must fundamentally change "to make recovery the expected outcome from a transformed system of care."

Prior to receiving the Transformation grant, Oklahoma had built a strong foundation for systems change, through recent or ongoing collaborations with stakeholders and other state agencies to improve mental health, substance abuse and related services in the state. Oklahoma's grant - totaling \$2.73 million for the first year and up to \$3 million for each of the remaining four years - is being used to develop, implement and evaluate a Comprehensive Mental Health Plan that will guide transformation activities in years 2-5 of the grant project. While the grant is directed at transformation of mental health systems, ODMHSAS is also responsible for providing substance abuse services; therefore, a decision was made that transformation activities will include both the mental health and substance abuse service systems. The first year grant activities focused on:

- appointing and convening a Governor's Transformation Advisory Board,
- development of a Needs Assessment and Resource Inventory (this document), and
- preparation of the Comprehensive Plan.

A primary use of Transformation Grant funds has been the establishment of an Innovation Center as the locus of transformation activities hosted by ODMHSAS, to provide resources to all agencies and other groups involved in mental health and substance abuse services transformation. Staff of the center will be available to plan and implement changes on a variety of levels.

In December 2005, Governor Brad Henry issued an Executive Order establishing the Governor's Transformation Advisory Board (GTAB) to guide transformation activities; the Executive Order appears as Appendix A. The 28-member panel includes the heads of eleven state agencies; representatives from the State Senate and House of Representatives, the law enforcement community, the state's Indian Nations, the Indian Health Services; the chair of the Mental Health Planning and Advisory Council; eight representatives of consumer, youth and family advocacy organizations; and representatives from private industry and the philanthropic community. The complete list of GTAB membership appears as Appendix B.

B. Structure of the Needs Assessment/Resource Inventory Report

The Needs Assessment/Resource Inventory is made up of 17 chapters. The first three chapters provide 1) an overview and background information about the grant (summarized above); 2) a description of populations in need; and 3) a summary of current research and literature about the concept of "recovery," along with strengths and needs in this area. The next 13 chapters are organized around critical issues selected by ODMHSAS and approved by the Governor's Transformation Advisory Board. Each of these chapters is organized into sections that focus on existing resources and strengths, followed by sections on needs and barriers. The final chapter summarizes the existing resources and strengths, as well as the identified needs and barriers, organized according to the six goals of the President's New Freedom Commission Report (as adapted by the state to include substance abuse).

Populations in Need

An estimated 215,296 adults are in need of mental health and/or substance abuse services in one year. These adults represent 26.2% of all adults whose income is at less than 200 percent of the Federal Poverty Level. Of this number about one-third currently receive services that are provided or funded by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) and/or the Oklahoma Health Care Authority (OHCA). Persons with substance abuse disorders are less likely to receive treatment (21% treated) than persons with mental disorders (45% treated). Only 15% of persons with alcohol abuse and dependence receive services, the lowest rate of treatment.

An estimated 37,021 children and adolescents in Oklahoma, age 9 to 17, are in need of mental health and/or substance abuse treatment services in one year. These children represent 20.9% of all children in families whose income is less than 185 percent of the Federal Poverty Level. Of this number 89% receive treatment from the group of public child serving agencies. Few children with substance abuse disorders are likely to receive treatment (only five percent treated).

For both adults and children, there are very large disparities from county to county in terms of access to mental health and substance abuse services. These differences are shown in detailed maps presented in chapters 4-6.

A Consumer-directed, Recovery-focused, Trauma-informed Service System

Recovery in a mental health context is defined as "the idea that most people with

psychiatric diagnoses can, in fact, ‘get better;’ that they are capable of moving beyond their illness labels, out of the socially de-valued role of ‘mental patient,’ and can build their own lives as self-directed members of their communities. Recovery in the context of addiction and substance abuse is defined as “the process through which severe alcohol and other drug problems...are resolved in tandem with the development of physical, emotional, ontological (spirituality, life meaning), relational and occupational health.” Oklahoma’s existing resources and strengths in this area include the establishment of an Office of Consumer Affairs and the creation of new line staff positions, Recovery Support Specialist and Family Support Specialist. Nonetheless, much greater attention must be paid to involving consumers and family members in systems planning and evaluation, as well as in their own individual treatment planning.

Children’s Behavioral Health Services

ODMHSAS is the state authority for children’s mental health and substance abuse services, responsible for planning, coordinating, and partially funding services at the community level through its network of Community Mental Health Centers (CMHCs) and other contract agencies. However, ODMHSAS is not the sole provider or even the largest provider and funder of children’s mental health services. Seven other state agencies also fund, provide, or oversee behavioral health services for children and youth. These include OHCA (the largest funder), the Department of Human Services (DHS, serving the largest number of children with serious emotional disturbance), Office of Juvenile Affairs (OJA), Oklahoma State Department of Health (OSDH), the Oklahoma Commission on Children and Youth (OCCY), the Department of Rehabilitation Services (DRS), as well as the State Education Department and local school districts.

Among the strengths identified was the extensive work of an inter-agency collaboration, the Partnership for Children’s Behavioral Health, which has facilitated the coordination of behavioral health services and enhanced the system’s ability to approach services in a more integrated fashion. There has been an increased ability to identify children and youth in need of services, expansion of some critical services, and creation of new community-based services. Through the System of Care initiative, ODMHSAS now provides wraparound care coordination for 500 children and their families in more than 20 communities. Indian Health Care in Tulsa received a three-year Circles of Care federal planning grant with the goal of developing an Indian-friendly system of care for children and youth in Tulsa. Oklahoma has had significant involvement with the federally funded National Child Traumatic Stress Disorder Network (NCTSN), with the goal of improving the detection, assessment, and treatment of high-risk children with trauma-related behavioral health concerns.

Among the major needs identified is that state policies, rules, eligibility criteria, and insufficient funding still result in a lack of access to community-based services. Eligibility criteria favor children and youth in public custody, which has resulted in an increase in the number children in the custody of the Oklahoma Department of Human Services (OKDHS) or the Office of Juvenile Affairs (OJA). While there has been increased funding for children’s behavioral health services in the past three years, the number of children and youth eligible for behavioral health services has increased at a faster pace than has spending, creating a larger gap in unmet need. Limited access to a full continuum of community-based services has resulted in extensive, inappropriate use of out-of-community residential services. There are virtually no substance abuse treatment services. Among the greatest unmet needs is residential substance abuse treatment for adolescents.

Adult Substance Abuse Services

ODMHSAS funds or provides a continuum of substance abuse treatment services within the State. The agency contracts with private, non-profit, certified agencies to provide detoxification, residential, halfway house, outpatient, intensive outpatient, and early intervention services. Seven ODMHSAS-operated agencies provide residential and outpatient treatment services.

Among the strengths and existing resources identified was the development of strengths-based, person-centered case management training. ODMHSAS has initiated a statewide drug court program, with a total of 50 drug courts in operation and others in development. Collaboration with the Department of Human Services (DHS) has resulted in the availability of certified treatment agencies to provide screening, assessment, and outpatient services to clients receiving or making application for Temporary Assistance to Needy Families (TANF) and clients who have Child Welfare involvement.

Identified needs and barriers included a heavy paperwork burden that reduces the amount of staff time spent with consumers. Participants from all groups stated that the biggest barrier to service is the serious lack of capacity at all levels of the system. From county to county, there are significant gaps in the continuum. An individual may be able to gain access to a service at one level of care, but then be unable to access follow-up services at the next level of care. It was also noted that there is no organized way to access services, and that this fragmentation and lack of coordination makes it difficult to access the public services that do exist. Employment, housing, and transportation remain significant problems for people leaving residential treatment services.

Adult Mental Health Services

Oklahoma's adult mental health system is built around a network of 15 community mental health centers (CMHCs) with programs in 102 cities and towns, providing access to a comprehensive array of community-based services in all counties. ODMHSAS contracts with 13 organizations to provide additional community-based services, and with 30 other providers who operate residential care facilities. The Department operates two state hospitals for adults, as well as two specialized crisis centers.

Recently, ODMHSAS has introduced initiatives that promote a recovery-oriented system and improve service coordination, including the development of Recovery Support Specialist (RSS) positions, filled by people in recovery trained to provide peer support and advocacy services for consumers. Fourteen Programs of Assertive Community Treatment (PACT) have been started across the state; these multi-disciplinary teams provide treatment and supports to consumers with high levels of need.

Needs and barriers identified by focus group participants and personal interviews include a heavy paperwork burden that reduces the amount of staff time spent with consumers; systemic problems with quality medication management, lack of timely access to services, and a perception of poor quality services in some areas. Barriers to accessing government benefits, housing, employment, transportation and healthcare were also cited, as was the need for more consumer and family involvement at the state and local levels. Needs were also expressed for better-targeted, high-quality training and workforce development activities, enhanced financing, and reforms in audit and recoupment procedures. It was also noted that sufficient resources are not available to fully meet the needs of people who are dually diagnosed with developmental disabilities and mental health problems.

Co-occurring Disorders (Integrated Services Initiative)

In 2004, ODMHSAS received a five-year Co-Occurring State Incentive Grant (COSIG) from SAMHSA, with the goal of developing an Integrated Services Initiative (ISI) to improve the delivery of state-funded services for people with co-occurring mental health and substance abuse disorders. The project will contribute two interventions to promote systemic infrastructure change: 1) a standard protocol for the screening and assessment of mental health and substance abuse problems will be developed, evaluated, and field tested, and 2) a model of integrated treatment will be developed that is accessible, culturally competent, and grounded in evidence-based practices. Progress has been made in the first two years on developing a common screening instrument, building consensus on an integrative treatment model, creation of a training curriculum, and establishment of pilot programs.

Needs and barriers identified included a need for more internal policy integration between ODMHSAS's Mental Health and Substance Abuse Divisions; issues related to differences in the two fields in licensure, certification and program accreditation; differences in program philosophy; a continuing fragmentation of services; and the need for an integrated funding stream.

Criminal Justice System Issues

Adults come into contact with the criminal justice system first through the police, then with the jails, then with district attorneys and the courts, then, if found guilty and sentenced, with the prisons and jails, and finally, if court-ordered, with probation or parole. At each of these contacts, specific concerns related to the identification and treatment of mental illness and substance abuse exist.

Among the strengths and existing resources identified is Crisis Intervention Training (CIT). The training provides law enforcement officers with a context for understanding mental health issues, and practical strategies and techniques for intervening safely in a psychiatric emergency. Jail diversion programs, including mental health courts and drug courts, and local diversion programs such as day reporting, are also seen as strengths. ODMHSAS collaborates with the Oklahoma Department of Corrections (DOC) to provide several avenues of treatment for state prison inmates, and a number of community-based re-entry programs are available.

Needs and barriers identified included a lack of trained law enforcement officers, especially in rural areas. Participants from both the criminal justice and behavioral health systems stressed the need to make it a priority to re-direct as many people with mental health and substance abuse problems as possible into treatment rather than incarceration. Participants called for policy changes to ensure that all inmates with mental illness or substance abuse problems have access to sufficient, high-quality behavioral health services while they are incarcerated. People with criminal histories face serious barriers to housing and employment, and participants cited a need for more access to re-entry programs to support people with mental health and/or substance abuse problems who are leaving jail or prison. A need was also identified for more and better training on behavioral health issues for corrections, probation and parole staff.

Access to Physical Health Care

Among the strengths identified is the recent initiation of the O-EPIC Premium Assistance Program by the Oklahoma Health Care Authority, which pays part of the health plan premiums of people who cannot access private health coverage through their employer. Many people served by ODMHSAS will be eligible to participate in this program, which has the potential to

alleviate the healthcare disparities described in the needs section of the chapter. A variety of local free or sliding-scale healthcare and dental services operated by charities or universities are available for uninsured individuals in many parts of the state.

Extensive unmet needs for access to health, dental and vision services were identified by focus group participants. A large percentage of ODMHSAS clients have no health coverage. Single adults without children are not eligible for Medicaid in Oklahoma, and federal policies bar people with substance abuse disorders from receiving Medicare unless they have an additional disability. For people with psychiatric disabilities, it often takes two years or more to receive Medicare after application. Many mental health and substance clients who are employed work at low-wage jobs that do not offer health insurance. Clients in these categories currently rely on an inadequate patchwork of hospital charity care, free clinics, Community Health Centers, university clinics, and local charities for their health care needs.

Housing

Specialized housing options for mental health consumers are located in both urban and rural settings, and are funded through ODMHSAS, Housing and Urban Development (HUD), public housing authorities, and private sources. Housing models include transitional living programs, permanent housing (supervised, supported and independent), and several short-term subsidy programs that help people access and maintain permanent housing. In several communities, strong and effective housing development partnerships have been formed among local housing authorities, provider agencies, public health collaboratives, private developers, and other parties; these can serve as models for other communities.

Needs identified included an acute shortage of stable, affordable permanent housing for people with mental health diagnoses and a lack of sufficient sober living options for people recovering from substance abuse problems. All focus groups of people receiving mental health and/or substance abuse services, and most groups made up of service providers, named access to decent housing as one of the most critical needs of people in the system. There was broad agreement that people cannot make good use of other services if they do not have stable housing, yet it was clear that many people receiving services are homeless, precariously housed, or in undesirable living situations.

Employment

Existing employment resources for people with mental health diagnoses include pre-vocational activities within Psycho Social Rehabilitation (PSR) Programs, as well as Transitional Employment programs at the State's two certified clubhouse programs. Mental health consumers are eligible for services from the Department of Rehabilitation Services (DRS) and its contractors. DRS provides employment services that help individuals with disabilities find and keep employment in careers of their choice. A collaborative project between ODMHSAS and DRS to implement SAMHSA's Supported Employment evidence-based is in development, and model programs at seven CMHCs are projected to be implemented in October 2006.

Focus group participants identified a need for a comprehensive action plan to develop Supported Employment, Supported Education, and other opportunities for clients to succeed in the workplace. A need to develop additional types of employment approaches beyond those available through DRS was noted, including the suggestion to seek start-up funds from the private sector to encourage the growth of consumer-run businesses. Systemic barriers to employment were noted in focus groups from all parts of the state, including the fact that the

structure of public benefits programs creates disincentives to employment. Clients and service providers agreed that there is a lack of focus on employment within most mental health and substance abuse programs, and that few staff have expertise on this issue. A lack of new funding to develop additional capacity for employment programs was identified, and there was a call to re-direct some existing ODMHSAS funds into employment and education services.

Prevention

Existing prevention programs offer primary prevention activities to delay or avert the use of alcohol, tobacco, and other drugs among youth. ODMHSAS contracts with a network of 19 Area Prevention Resource Centers (APRCs), which use trained prevention staff to serve all 77 Oklahoma counties with information dissemination, education, community-based activities, and other prevention strategies. ODMHSAS has developed a number of collaborative prevention initiatives with other state agencies and with university programs. ODMHSAS is a leader within the Governor's Statewide Council on Substance Abuse Prevention Advisory Council (CAAC), funded by a federal CSAP grant. The Council has brought new focus on building a cross-agency strategic prevention framework using a public health approach.

Personal interviews and focus group participants expressed a desire for ODMHSAS to develop a clear definition of "prevention" that would apply to both the substance abuse and mental health service systems. Staff involved in prevention work called for a more integrated prevention effort made possible by development of an agency-wide strategic plan for prevention. Prevention providers said that low salaries, a requirement for enhanced credentials, and a lack of training opportunities combined to make it difficult to keep good staff. A barrier to the development of prevention activities on the mental health side is a lack of available funding; the federal Substance Abuse and Mental Health Services Administration (SAMHSA) offers prevention funding only on the substance abuse side.

Cultural Competence

Over the past two years, ODMHSAS has created a position of Cultural Competence Coordinator and has convened a Cultural Competency Advisory Team representing a range of cultural, racial, and ethnic groups, working for more community education and improving cultural competence within mental health and substance abuse services.

The State has been straightforward in recognizing that systemic barriers exist that continue to create disparities in access to health care, mental health, substance abuse, and other human services for different cultural, racial and ethnic minority groups. Among the root causes identified by participants are a lack of understanding that people from different backgrounds may not share majority views about the nature, causes and appropriate responses to emotional distress and substance use; prejudice against people from non-majority backgrounds; and a perception that cultural divides are so deep that they often make serious discussion of these issues difficult and frustrating for all parties. Focus group participants described a range of issues related to practices and services that interfere with providing culturally competent services to Latinos, African-Americans, Native Americans, and other ethnic and racial minorities, including language barriers and a lack of staff from diverse ethnic, racial and cultural backgrounds. It was noted that cultural competence issues also affect deaf people, as well as gay, lesbian, bisexual, and trans-gendered individuals seeking services. For many respondents, workforce development and training were seen as the primary mechanism for remedying many of the problems noted above. There was a consensus that cultural competence training should be required for all staff.

Workforce Development

In order to improve the quality of behavioral health treatment in Oklahoma, the state legislature has enacted licensure credentials for seven types of behavioral health professionals. Most professionals must achieve at least a Master's degree in their field, complete one to three years of supervised professional experience, and pass a state examination prior to becoming licensed. ODMHSAS sponsors continuing education opportunities through an increasing number of conferences and training sessions each year.

The comments of focus group participants and personal interviews focused on five major areas of concern: barriers to recruitment and retention of highly qualified staff; the need for in-service training and continuing education that prepares staff to work in a person-centered, recovery-oriented service system; the need to bring a focus on recovery and person-centered services to graduate programs in the mental health and substance abuse fields; licensing and certification issues; and training on substance abuse and mental health issues for staff of other systems and agencies.

Finance

There is a general belief among stakeholders that Oklahoma does not provide adequate funding to serve persons in need of mental health and substance abuse services, whether through ODMHSAS or through other state agencies. Oklahoma ranked 46th among all states in *per capita* mental health spending, according to a report by the National Association of State Mental Health Program Directors Research Institute. Providers said that reimbursement rates do not cover costs, and that the paperwork burden required to document services for funding purposes is excessive and interferes with their ability to provide services.

While there have been increases to the ODMHSAS budget in recent years, they have largely been dedicated to new program development. Rate adjustments to keep pace with the increasing cost of delivering services have been infrequent. Low staff salaries make it difficult to hire and maintain staff, leading to disruptions in consumer care.

Technology and Information Systems

Oklahoma has a history of strong commitment to data system development, and many state agencies have developed systems that meet or exceed national standards. All state agency transformation partners have developed performance monitoring systems that provide process and outcome indicators for program management, and most have them posted on their websites. Several projects have been developed that share data across and among agencies to improve services and reduce the data reporting burden for consumers and providers, thus making better use of limited financial and human resources.

The ODMHSAS Integrated Client Information System (ICIS) database has been developed with support from SAMHSA and is based on national mental health and substance abuse data standards. ODMHSAS has also developed specialized data collection systems for a number of treatment programs. In addition, several new data and technology projects are paving the way for expanded use of information resources to improve the delivery, management and effectiveness of behavioral health care.

There continue to be barriers to fully realizing the technology needs for system transformation in the areas of policies, technology practices, and consumer use of system information

Summary: President's New Freedom Commission Matrix

The final chapter summarizes the existing resources and strengths, as well as the identified needs and barriers, in a matrix organized according to the six goals of the President's New Freedom Commission Report.

Chapter 1: Introduction

Oklahoma is one of seven states to receive a five-year Mental Health Transformation State Incentive Grant (TSIG) from the federal Center for Mental Health Services (CMHS), a center within the Substance Abuse and Mental Health Services Administration (SAMHSA). The purpose of these grants is to help transform state mental health service delivery systems from “broken and fragmented” systems dictated by outmoded bureaucratic and financial incentives to systems driven by consumer and family needs that focus on building resilience and facilitating recovery (President’s New Freedom Commission on Mental Health, 2003). The grants require state mental health authorities to work in collaboration with other systems that serve people diagnosed with mental illness, and to involve consumers and family members as active partners in all transformation planning and activities.

Although the Mental Health TSIG focuses on mental health issues, Oklahoma believes that the management of mental health and substance abuse disorders share many common approaches and has made a commitment for both substance abuse and mental health to be included in its system transformation. Consequently, substance abuse services have been included in the statewide needs assessment and parts of this document address needs related to substance abuse.

Transformation activities are guided by the recommendations of the President’s New Freedom Commission on Mental Health. In its landmark final report, “Achieving the Promise,” (PNFC, 2003), the President’s New Freedom Commission called for a fundamental transformation of the nation’s approach to substance abuse and mental health care. Noting that “[t]he time has long passed for yet another piecemeal approach to mental health reform,” the Commission identified six principal goals of a reformed system of care and made specific recommendations to facilitate the implementation of these goals.

As mentioned earlier, Oklahoma’s transformation approaches reflect the state’s commitment to be inclusive of substance abuse services as well as being a culturally competent and trauma-informed system. Consequently, the goals related to the New Freedom Commission report throughout this document have been restated as listed below:

- (1) Oklahomans understand that having mental health and being free from addictions is essential to overall health.
- (2) Care is consumer and family driven.
- (3) Disparities in substance abuse and mental health services are eliminated.
- (4) Early screening, assessment, and referral to services are common practice.
- (5) Excellent care is delivered and research is accelerated.
- (6) Technology is used to access care and information.

All of the Commission’s goals and the recommendations associated with them are organized around one key principle: that mental health and substance abuse systems should be fundamentally transformed “to make recovery from mental illness the expected outcome from a transformed system of care.”

Oklahoma’s Foundation for Transformation Activities

Even before receiving the Transformation grant, the Oklahoma had built a strong foundation for systems change, through recent or ongoing collaborations with stakeholders and

other state agencies to improve mental health, substance abuse and related services in the state. These initiatives include:

- The Governor's and Attorney General's Blue Ribbon Task Force
- The Partnership for Children's Behavioral Health (including Systems of Care)
- The Integrated Services Initiative (for co-occurring substance abuse and mental health services)
- The Adult Recovery Collaborative

The Governor's and Attorney General's Blue Ribbon Task Force was convened in 2004 to study the impact of untreated or under-treated mental illness and/or substance abuse, and unserved domestic violence victims in the state. In its 2005 final report, the Blue Ribbon Task Force found that "Oklahoma is facing an escalating health and public policy crisis which, if not dealt with soon, will deepen in both intensity and gravity. It will continue to adversely and directly impact the state's economy and, most importantly, the lives of thousands of Oklahomans." The Blue Ribbon Task Force went on to make five over-arching recommendations for systems change, calling for:

- The availability of prevention, early intervention, treatment and recovery support services for all in need;
- The diversion of non-violent offenders with mental health or substance abuse problems from the correctional system to the service system;
- Mandated training standards for staff and establishment of a body responsible for oversight, coordination and evaluation;
- An increase in the number of professional and paraprofessional staff with the expertise to address current needs; and,
- Further study to evaluate the needs of people with mental health and/or substance abuse problems who are in criminal justice facilities or other custodial institutions.

The Blue Ribbon Task Force reported that "Despite the efforts of many dedicated people...we found that the present system is overwhelmed, less than fully efficient and not optimally organized to address growing demands. Without more focused and effective support from the Executive and Legislative branches of our state government, this crisis will progressively worsen. The results of failure to act are unacceptable."

The three ongoing initiatives, the Partnership for Children's Behavioral Health, the Integrated Services Initiative, and the Adult Recovery Collaborative, are cross-systems initiatives that reflect the model of change called for by the Transformation grants. These efforts have already made substantial progress in their respective areas.

The Partnership for Children's Behavioral Health grew out of the Children's Behavioral Health Policy Academy attended by key partners in December 2003. In early 2004, Governor Brad Henry created the Partnership for Children's Behavioral Health and charged the group with creating an integrated system of care. A Memorandum of Understanding solidifies the commitment from the major partners, which include the Office of the Governor (in the person of the Cabinet Secretary for Health), ODMHSAS, the Department of Health (OSDH), the Department of Human Services (OKDHS), the Office of Juvenile Affairs (OJA), the Oklahoma Health Care Authority (OHCA), the State Department of Education (SED), the Oklahoma Commission for Children and Youth (OCCY), the Department of Rehabilitation Services (DRS),

representatives from the State Senate and House of Representatives, and family member representatives appointed by the Governor. The Partnership created and has begun to implement an Action Plan, and has made substantial developments toward the coordination of behavioral health services provided by the various state agencies. This has enhanced the system's ability to approach services to children and their families in a more integrated fashion. The Partnership's work is examined in more detail in Chapter 4.

The Integrated Services Initiative (ISI) grew out of Oklahoma's participation in a December 2004 SAMHSA Policy Academy for Co-Occurring Disorders, enhanced by SAMHSA funding through a Co-Occurring State Incentive Grant (COSIG) and a Cross-Training Initiative Grant. ODMHSAS has used this grant funding and its participation in the Policy Academy to plan and initiate pilot programs at model sites designed to improve the delivery of state-funded services for people in Oklahoma with or at risk for co-occurring substance abuse and mental health disorders. The primary partners in this initiative are ODMHSAS, the Oklahoma Health Care Authority (Medicaid), provider agencies, and service recipients. A Consensus Document was developed for use among local providers at each model site; it spells the responsibility of each agency to the other agencies, describes a consensus plan of action that is consumer-driven and recovery-focused, and articulates the commitment of co-signers to specific activities and objectives. The work of the ISI is examined in more detail in Chapter 7.

The Adult Recovery Collaborative (ARC) is an initiative of ODMHSAS, OHCA, and OKDHS. This effort is considered both a program re-design and a Medicaid payment reform initiative. The associated workgroups are charged with the responsibility of developing a mental health and substance abuse treatment system for adults that incorporates the philosophies of a recovery model, uses evidence-based practices, and optimizes the use of state and federal resources. Additional partners focusing on vocational rehabilitation, housing, and other supports are expected to be engaged in the future.

Initial Transformation Grant Activities

Oklahoma's MH-TSIG grant - totaling \$2.73 million for the first year and up to \$3 million for each of the remaining four years – is being used to develop, implement and evaluate a Comprehensive Plan that will guide transformation activities in years 2-5 of the grant project. While the grant funding is directed at transformation of mental health systems, ODMHSAS is also responsible for serving people with substance abuse problems; therefore, a decision was made that Oklahoma's transformation activities would include both the mental health and substance abuse service systems. The first year grant activities focused on:

- appointing and convening a Governor's Transformation Advisory Board,
- development of a Needs Assessment and Resource Inventory (this document), and
- the preparation of the Comprehensive Plan.

Oklahoma's vision for a transformed system is one in which all citizens and their families prosper, contribute, and achieve their personal goals in the communities of their choice. As a result of the work funded by this grant, the State will build the infrastructure needed to guarantee a life in the community for everyone, where personal choice is respected; where people can build on their assets, strengths and competencies; and where they have an identity apart from their diagnoses.

A primary use of Transformation Grant funds has been the establishment of the Innovations Center hosted by ODMHSAS, to provide resources to all agencies and other groups

involved in mental health and substance abuse services transformation. Staff of the center will be available to plan and implement changes on a variety of levels. The Innovations Center will also be involved in efforts to enhance the current data infrastructure of all partners, as well as Oklahoma's capacity to utilize technology through training, electronic health records, teleconferencing, and telemedicine.

Inter-Agency Collaboration: The Governor's Transformation Advisory Board

Because people with substance abuse and mental health problems receive services from a number of state agencies, SAMHSA required applicant states to ensure the participation of all other state agencies that may impact upon this population. In December 2005, Governor Brad Henry issued an Executive Order establishing the Governor's Transformation Advisory Board (GTAB) to guide transformation activities; the Executive Order appears as Appendix A. The 28-member panel includes the heads of eleven state agencies; representatives from the State Senate and House of Representatives, the law enforcement community, the state's Indian Nations, the Indian Health Services; the chair of the Mental Health Planning and Advisory Council; eight representatives of consumer, youth and family advocacy organizations; and representatives from private industry and the philanthropic community. The complete list of GTAB membership appears as Appendix B. The state agencies represented on the Governor's Advisory Board are:

- The Oklahoma Department of Mental Health and Substance Abuse Services: the Department's Innovations Center is the locus for transformation activities;
- The State Department of Health
- The Department of Human Services
- The State Education Department
- The Oklahoma Health Care Authority
- The Commission on Children and Youth
- The Office of Juvenile Affairs
- The Oklahoma Housing Finance Agency
- The State Department of Corrections
- The Department of Rehabilitation Services
- The Oklahoma State Regents for Higher Education

Needs Assessment/Resource Inventory

The preparation of a Needs Assessment/Resource Inventory is a required activity under the Transformation Grant. Its purpose and goals are:

- To provide a justification of the need for change, in language that is accessible to all audiences;
- To present the findings in a way that emphasizes the overarching goals and values of the President's New Freedom Commission Report and the ODMHSAS Strategic Plan;
- To inform the direction of change;
- To recognize the strengths of current programs; and,
- To lay the foundation for the evaluation of change.

Process and Methodology

ODMHSAS contracted with Advocates for Human Potential, Inc. (AHP), to conduct the Needs Assessment /Resource Inventory, in partnership with ODMHSAS's Division of Decision Support Services (DSS). AHP is a small research and consulting firm specializing in mental

health and substance abuse issues. In years two through five, AHP and DSS will collaborate on the evaluation of transformation activities as set out in the Comprehensive Plan.

The preparation of the Needs Assessment/Resource Inventory included collection and analysis of qualitative data, as well as analysis of existing quantitative data. The process included the following steps:

1. Orientation meetings were held with ODMHSAS staff familiar with each of the issues selected for study, in order to clarify the scope of the topic, identify relevant existing documents, and identify key questions for which secondary analysis of existing data was needed to determine baseline needs.
2. Staff reviewed existing cross-agency data sources to determine the capacity to meet the information needs described above.
3. In order to assess stakeholder groups' perceptions of need in the selected topic areas, over 100 focus groups and personal interviews were conducted with consumers, family members, providers, advocates, local officials, community organizations and other constituency groups at 15 locations across the state. Over one thousand people participated. The complete list of communities, organizations and institutions visited appears as Appendix C. A standardized list of focus questions and prompts was used to structure the focus groups and personal interviews; this document appears as Appendix D.
4. Meetings were held with leadership and relevant staff from the state agencies represented on the GTAB, in order to gather information on their agencies' work related to the topic areas, and to identify additional information sources.
5. Content analyses were performed on the qualitative data collected in steps 2 and 3, to be used in preparation of the narrative sections of the Needs Assessment/Resource Inventory. The content analysis process was as follows:
 - a) Notes were reviewed, and thematic passages were coded according to the topics represented by Chapters 3-16.
 - b) The passages were further coded by the category of participant (i.e., mental health or substance abuse staff, mental health or substance abuse program managers, ODMHSAS staff, staff of other agencies, mental health consumers, substance abuse services clients, family members, and community group members).
 - c) Within each chapter topic area, passages were further categorized into thematic subgroups
 - d) Where available, direct quotes from participants that reflected the remarks of several (or many) participants were identified for inclusion in the chapter text.
6. Decision Support Services staff conducted secondary data analyses as identified in steps 1 and 2, above, with collaboration from other state agencies as needed.
7. Using materials derived from steps 1-6, a draft Needs Assessment/Resource Inventory report was prepared for internal ODMHSAS review and review by the GTAB members.

What Follows

The Needs Assessment/Resource Inventory is organized into chapters on topical issues selected by ODMHSAS and approved by the Governor's Transformation Advisory Board. For each topic area, the chapter is organized into sections that focus on existing resources and

strengths, which use data and narrative to present a picture of the current system. This is followed by a section on needs and barriers, which is further organized around some or all of the following list of elements provided by SAMHSA, as appropriate to the topic:

- Policies
- Practices and Services
- Workforce Development and Training
- Organization and Collaboration
- Data
- Financing
- Consumer and Family Involvement
- Cultural Competence

The final chapter summarizes the existing resources and strengths, as well as the identified needs and barriers, using the list of elements above, organized according to the six goals and related recommendations of the President's New Freedom Commission Report:

Goal 1: Oklahoman's understand that having mental health and being free from addictions is essential to overall health

Recommendations

- 1.1 Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.
- 1.2 Address mental health and substance abuse with the same urgency as physical health.

Goal 2: Care is consumer and family driven

Recommendations

- 2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
- 2.2 Involve consumers and families fully in orienting the mental health and substance abuse system toward recovery.
- 2.3 Align relevant Federal programs to improve access and accountability for mental health and substance abuse services.
- 2.4 Create a Comprehensive State Plan.
- 2.5 Protect and enhance the rights of people with mental illnesses.

Goal 3: Disparities in substance abuse and mental health services are eliminated.

Recommendations

- 3.1 Improve access to quality care that is culturally competent.
- 3.2 Improve access to quality care in rural and geographically remote areas.

Goal 4: Early screening, assessment, and referral to services are common practice.

Recommendations

- 4.1 Promote the mental health of young children.
- 4.2 Improve and expand school substance abuse and mental health programs.
- 4.3 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.
- 4.4 Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.

Goal 5: Excellent care is delivered and research is accelerated.

Recommendations

- 5.1 Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses.
- 5.2 Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.
- 5.3 Improve and expand the workforce providing evidence-based mental health and substance abuse services and supports.
- 5.4 Develop the knowledge base in four understudied areas: mental health and substance abuse disparities, long-term effect of medications, trauma, and acute care.

Goal 6: Technology is used to access care and information.

Recommendations

- 6.1 Use health technology and telehealth to improve access and coordination of mental health and substance abuse care, especially for Americans in remote areas or in underserved populations.
- 6.2 Develop and implement integrated electronic health record and personal health information systems.

Development of a Comprehensive Plan

The final step in the first year of transformation activities is the development of a comprehensive plan. The Plan will help guide development of a strong, sustainable infrastructure to promote lasting changes across all relevant state agencies, enabling people with mental health needs and/or substance abuse problems to access the individualized services and supports necessary to achieve and sustain recovery. The Governor's Transformation Advisory Board has appointed four committees to assist in this process:

- Child Mental Health and Substance Abuse Services
- Adult Mental Health and Substance Abuse Services
- Criminal Justice, Mental Health and Substance Abuse
- Workforce Development

These committees are meeting to develop plans that are responsive to the needs assessment findings, and many of the participants were also informants in the needs assessment. The final comprehensive plan will be submitted to the GTAB for review and approval.

Chapter 2: Populations in Need

The purpose of this chapter is to describe the estimated prevalence of mental illness and substance abuse and dependence in Oklahoma among the total population. In addition, estimates of the number of people with low income who needed but may not have received treatment are provided. Estimates may require additional explanations that will be discussed throughout the chapter. The chapter includes estimates for adults 18 years of age or older, and youth under 18 years of age.

A full account of Oklahomans receiving or in need of mental health and/or substance abuse services is not told only through data, but also through the personal stories of individuals facing these problems. Sections B and C, below, contain composite sketches of people dealing with mental health and/or substance abuse issues, drawn from the real-life stories gathered through focus groups and individual interviews as part of the needs assessment process.

A. Population

The U.S. Census estimated Oklahoma's total population as 3,523,546 as of July 1, 2004 (US Census, 2006). The population of the two largest urban areas was 684,500 (19.4%) in Oklahoma City and 572,100 (16.2%) in Tulsa. The 2004 population estimate showed a two percent increase since the 2000 Census. Of the total population, 1,740,252 (49.4%) were male and 1,783,294 (50.6%) female. The majority, 82.3 percent, were White (alone or in combination with another race), followed by 11.3 percent Native American or Alaskan Native, 8.5 percent Black and 1.9 percent Asian. An estimated 6.4 percent were of Hispanic or Latino origin. In 2004, approximately 243,125 (6.9%) were under five years of age, 859,745 (24.4%) were under the age of 18, and 465,108 (13.2%) were 65 years of age or older.

The Surgeon General's Report on Mental Health (DHHS, 1999) consolidated data from the Epidemiologic Catchment Area Survey (ECS), the National Comorbidity Survey (NCS), and the Methods for the Epidemiology of Child and Adolescent Mental Disorders (MECA). These sources were used to arrive at best estimates of the prevalence of mental disorders in the U.S. According to these estimates, about one in five Americans experiences a mental disorder in a given year. This represents about 44 million people in the U.S., and 704,709 in Oklahoma. The prevalence of mental disorders is similar among different age groups: 18.9% of youth (9-17 years), 21.0% of working-age adults (18-54 years) and 19.8% of adults who are 55 years and older.

B. Adults

Don, a single man in his mid-20s with a tenth grade education, had a 3-month psychiatric hospitalization about a year ago, his second in five years. As a result, he lost his job as a carpenter's helper, as well as his apartment and his car. With the help of his case manager, Don applied for Social Security Disability Insurance after leaving the hospital. While waiting for his application to be approved (which can take up to two years), Don has no income, so he sleeps on friends' and relatives' couches, dependent on them for meals and spending money, and he moves around a lot. He attends a Psychosocial Rehabilitation program at a Community Mental Health Center where he also gets psychiatric medication. His father helps him cover

the cost of a modest filling fee. However, as a single, childless adult, Don is not eligible for Medicaid, and he has no way to pay for badly needed health and dental care. Don was in recovery from alcoholism before his hospitalization and feels vulnerable to relapse because of the instability in his life. But he now feels unwelcome at his Alcoholics Anonymous meetings, because they frown upon his taking psychiatric medications.

Cindi grew up in an upper-middle class family, and had emotional problems since she was a child. As a teen, she received a mental health diagnosis, and for several years was in and out of treatment and on and off psychiatric medications. She left home and eventually started using street drugs when she was unable to afford her medication. At her lowest point, she found herself destitute, unable to get into drug treatment because of long waiting lists, and became homeless. Cindi says that during that period, the only place she found real help was through a consumer group and a counselor at a homeless shelter. They helped her get into residential substance abuse treatment, and then helped her get subsidized housing. When she was later arrested for a petty crime, her case was referred to mental health court, and she graduated from the program a year later. Now Cindi works as an advocate for other consumers who find themselves involved with the criminal justice system, and is pursuing a master's degree.

Prevalence among Adults

Prevalence data are derived using a broad definition of mental disorders which includes mental health and substance disorders for all adults, regardless of income, and for adults with reported incomes of less than 200 percent of the Federal Poverty Level (FPL) because most public agencies fund services for adults with low income (see Exhibit 2.1 and 2.2). Following the broad definition, prevalence of mental health disorders and substance disorders are evaluated separately for the general population and the population with low income (see Exhibits 2.3 and 2.4).

The National Comorbidity Survey Replication (NCS-R), a face-to-face survey administered to 9,282 English-speaking adults, was conducted between February 2001 and April 2003 in the coterminous United States (Kessler, 2006). Survey results indicated that 26.2 percent of adults in the U.S. have a 12-month prevalence of a mental health or substance disorder, as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (NIMH, 2006). Applying the national estimate to the 2004 Oklahoma adult population, there were an estimated 697,885 adults in Oklahoma with a mental or substance disorder in the past year (see Exhibit 2.1).

Exhibit 2.1. Estimates of Prevalence of Mental Health and/or Addictive Disorders in Past Year among Adults in Oklahoma 18 Years of Age or Older

Total Adult Population in Oklahoma (N=2,663,683)	Estimated Prevalence Percent from the NCS-R	Estimated Prevalence Count
Mental Health and/or Addictive Disorders in Past Year	26.20% ¹	697,885

¹ National estimated prevalence rate from the NCS-R.

To estimate the proportion of the population who would have met or nearly met the current ODMHSAS or OHCA financial criteria for publicly funded services, the prevalence rates among adults with a reported household income less than 200 percent of the Federal Poverty Level (FPL) were calculated.

Among the estimated 2,663,683 adults in Oklahoma in 2004, 821,742 (30.8%) have a reported household income of less than 200 percent of the FPL (US Census, 2000). As shown in Exhibit 2.2, using the NCS-R 12-month prevalence rate of 26.2¹ percent, an estimated 215,296 adults with low income had a mental or addictive disorder in the past year. This estimated prevalence rate has not been adjusted for poverty, a population that generally has a higher occurrence of behavioral health issues, and is therefore a conservative estimate.

Exhibit 2.2. Estimates of Prevalence of Mental Health and/or Addictive Disorders in Past Year and Untreated in the Public Sector among Adults in Oklahoma 18 Years of Age or Older with Report Income Less than 200% of the FPL

Adult Population With Income Less < 200% of the FPL (N=821,742)	Estimated Prevalence Percent from the NCS-R	Estimated Prevalence Count	Number Served in Public Sector	Estimated Number Untreated in the Public Sector	Estimated Percent Untreated in the Public Sector
Mental Health and/or Addictive Disorders in Past Year	26.20% ¹	215,296	71,684 ²	143,612 ³	66.70% ³

¹ National estimated prevalence rate from the NCS-R. Not adjusted for poverty and therefore a conservative estimate for people with low income.

² The number served was calculated using data from ODMHSAS and OHCA.

³ The estimated number and percent untreated in the public sector does not take into consideration those who received treatment provided through resources other than ODMHSAS and OHCA.

The federal Substance Abuse and Mental Health Services Administration's (SAMHSA) Office of Applied Studies (OAS) conducts an annual national survey that serves as the primary source of information on the prevalence and incidence of substance use in the civilian, non-institutionalized population, 12 years of age or older, in the U.S. Data in the National Survey on

Drug Use and Health (NSDUH) are collected through in-person interviews conducted with a sample of individuals at their residence. Approximately 70,000 individuals are surveyed each year across the 50 states and District of Columbia (OAS, 2003).

In addition to information about the prevalence and incidence of substance use, information about mental health is also collected. Serious Psychological Distress (SPD) is determined using the K6 scale. The K6 scale consists of six questions that ask respondents how frequently they experienced symptoms of psychological distress during the one month in the past year when they were at their worst emotionally (Wright & Sathe, 2006).

In addition to national estimates, survey results are reported for each state individually. Because of the relatively small number of interviews conducted in each state, estimates from the NSDUH are calculated using a running two-year average. As shown in Exhibit 2.3, the annual averages based on the 2003 and 2004 NSDUH indicated that 290,587 (10.9%) of adults in Oklahoma age 18 years or older had experienced Serious Psychological Distress in the past year. In addition, the NSDUH estimated that 200,354 (7.52%) had alcohol dependence or abuse in the past year, 72,111 (2.71%) had illicit drug dependence or abuse in the past year, and 243,817 (9.15%) had dependence on or abuse of any illicit drug or alcohol in the past year (Wright & Sathe, 2006).

Exhibit 2.3. Estimated Prevalence of Mental Illness or Substance Abuse or Dependence in Past Year among Adults in Oklahoma

Prevalence Category among Adults, 2004 (N= 2,663,683)	NSDUH Estimated Prevalence Percent	Estimated Prevalence Count
Serious Psychological Distress in Past Year	10.91%	290,587
Alcohol Dependence or Abuse in Past Year	7.52%	200,354
Any Illicit Drug Dependence or Abuse in Past Year	2.71%	72,111
Dependence on or Abuse of Any Illicit Drug or Alcohol in Past Year	9.15%	243,817

Using estimates from the NSDUH for adults in poverty in the U.S., multipliers of prevalence were calculated and applied to Oklahoma prevalence estimates for the general population to determine the estimated prevalence rates among adults with incomes less than 200 percent of the Federal Poverty Level (FPL). The results of these calculations are shown in Exhibit 2.4. Among adults in Oklahoma with a reported incomes of less than 200 percent of the FPL, an estimated 128,201 (15.60%) had serious psychological distress in the past year, 67,008 (8.15%) had alcohol dependence or abuse in the past year, 35,236 (4.41%) had illicit drug dependence or abuse in the past year, and 88,371 (10.75%) had dependence on or abuse of any illicit drug or alcohol in the past year.

Exhibit 2.4. Estimated Prevalence of Mental Illness or Substance Abuse or Dependence in Past Year and Number Untreated in the Public Sector among Adults in Oklahoma with Income Less Than 200 Percent of the Federal Poverty Level

Prevalence Category among Adults with Low Income in 2004 (N=821,742)	NSDUH Estimated Prevalence Percent ¹	Estimated Prevalence Count	Number Served in the Public Sector ²	Estimated Number Untreated in the Public Sector ³	Estimated Percent Untreated in the Public Sector ³
Serious Psychological Distress in Past Year	15.60%	128,201	58,225	69,976	54.58%
Alcohol Dependence or Abuse in Past Year	8.15%	67,008	9,937	57,071	85.17%
Any Illicit Drug Dependence or Abuse in Past Year	4.41%	36,236	13,368	22,868	63.11%
Dependence on or Abuse of Any Illicit Drug or Alcohol in Past Year	10.75%	88,371	18,253	70,118	79.35%

¹ Oklahoma estimates from the NSDUH adjusted for poverty.

² The estimated number of adults who received mental health and/or substance abuse services in Oklahoma through the public sector may not include all people who received publicly funded treatment. The number served was derived using data from ODMHSAS and OHCA.

³ The estimated number and percent untreated in the public sector does not include people who received treatment provided through resources other than ODMHSAS and OHCA.

Prevalence Among Specific Adult Populations

In response to requests from Needs Assessment Workgroup participants, prevalence among veterans, people who are hard of hearing or deaf, and people in jail or prison were also calculated.

Veterans. Data from SAMHSA's National Survey on Drug Use and Health (NSDUH) were used to compare substance use, dependence and treatment among veterans and non-veterans. Veterans were defined as persons who had formerly served in any of the U.S. Armed Forces. The non-veteran comparison group reflected the age, gender, and geographic distribution of veterans as indicated in the Veterans Health Administration's benefit eligibility data. SAMHSA's NSDUH found that in 2003, an estimated 56.6 percent of veterans used alcohol in the past month, compared with 50.8 percent of comparable non-veterans, and an estimated 13.2 percent of veterans reported driving while under the influence of alcohol or illicit drugs in the past year, compared with 12.2 percent of comparable non-veterans. In addition, SAMHSA's NSDUH found that an estimated 3.5 percent of veterans used marijuana in the past month, compared with 3.0 percent of their non-veteran counterparts. Past-month heavy use of alcohol was more prevalent among veterans (7.5%) than comparable non-veterans (6.5%). Estimated rates of dependence on alcohol and/or illicit drugs did not differ significantly between veterans and non-veterans, and rates of those dependent on alcohol and/or illicit drugs who did not receive treatment in the past year were also comparable. An estimated 0.8 percent of veterans received specialty treatment for a substance use disorder (alcohol or illicit drugs) in the past year compared with 0.5 percent of comparable non-veterans.

In the SAMHSA-sponsored National Alcohol and Drug Addiction Recovery Month Kit, September 2006, a chapter on military and veterans reported that during 2002, approximately 18 percent of military personnel were heavy drinkers of alcohol and 12.3 percent were dependent on alcohol. In addition, roughly 7 percent of military personnel reported using illegal drugs in the past 12 months. Even after their military service ends, veterans can be extremely susceptible to substance use disorders. Trends suggest that the prevalence of substance use disorders among veterans may be rising. This is due to several factors, including that drug use disorders are more common among people born after World War II. The total number of patients in the U.S. Department of Veterans Affairs (VA) health care system with a substance use disorder was 485,092 in fiscal year 2002. In federal fiscal year (FFY) 2001, there were 358,600 individuals who received VA inpatient care and 4.05 million who received VA outpatient care for substance abuse problems. (HSR&D, 2003).

The SAMHSA report also contained information about the mental health of veterans. In a survey of veterans from the first Gulf War, 32 percent met the criteria for a current or lifetime depressive disorder. Other studies have shown that veterans who have post-traumatic stress disorder (PTSD) experienced more severe substance use disorders and other co-occurring disorders.

The U.S. Census Bureau's 2004 American Community Survey (U.S. Census, 2004), reported 356,005 civilian veterans living in Oklahoma. Applying some of the national estimates to that number results in an estimated 43,789 (12.3%) civilian veterans in Oklahoma who were dependent on alcohol during 2002. Using the same method to estimate depressive disorders among Oklahoman veterans, 13,922 (32%) met the criteria for a current or lifetime depressive disorder.

Persons who are Hard of Hearing or Deaf. In a National Health Interview Survey in 2004, an estimated 7.7 percent of deaf people mentioned depression, anxiety or emotional problems that caused difficulty with activities (NHIS, 2004). The number of people in Oklahoma who are hard of hearing or deaf is unknown, but statistics from ODMHSAS indicate that, among the 21,818 clients who received ODMHSAS-funded mental health services, 53 (0.24%) indicated they were hard of hearing or deaf. Among the 14,521 who received ODMHSAS-funded substance abuse treatment, 16 (.11%) indicated being hard of hearing or deaf.

Persons in Prison and Jail. A study by the Bureau of Justice Statistics (BJS) released in September 2006 found that 56 percent of state prison inmates and 64 percent of inmates in local jails have mental health problems (BJS, 2006a). A mental health problem is defined as 1) mental health diagnosis or treatment within the 12 months prior to the inmate interview, or (2) symptoms of a mental health disorder as specified by the DSM-IV. This study also found that 66 percent of state prison inmates and 67 percent of inmates in local jails have substance dependence or abuse. On June 30, 2005, 9,585 inmates were in the custody of local jails in Oklahoma (BJS, 2006b). Applying the prevalence estimates from the 2006 BJS study results in an estimated 6,134 jail inmates with mental health problems and 6,422 with substance use disorders. On June 20, 2005, there were 21,518 inmates in Oklahoma state and contract prisons (DOC, 2005). Applying the prevalence estimates from the 2006 BJS study results in an estimated 12,050 inmates with mental health problems and 14,202 with substance use disorders.

In 1999, ODMHSAS conducted a survey of 870 prison inmates in Oklahoma, as part of the State Treatment Needs Assessment Project (STNAP) funded by the federal Center for Substance Abuse Treatment (ODMHSAS, STNAP Phase I, 1999). Evaluation of all survey respondents under Oklahoma Department of Correction (DOC) supervision indicated that an

estimated 25.6 percent of all inmates and 28.3 percent of probationers and parolees were in need of substance abuse treatment.

With funding from the federal National Institute of Justice and Center for Substance Abuse Treatment, the Oklahoma and Tulsa County Jails were sites for the Arrestee Drug Abuse Monitoring (ADAM) project. The ADAM project was designed to evaluate drug usage among new arrestees through the use of surveys and urinalysis. Data were collected once a quarter for 14 consecutive days, eight hours per day. A total of 4,313 arrestees were surveyed from the first quarter of 2002 through the third quarter of 2004 (ODMHSAS, STNAP Phase III, 2005). Results from the ADAM study indicate that 72 percent of all arrestees in Oklahoma and Tulsa counties used at least one drug prior to arrest, with females slightly higher than males (74.2% vs. 71.8%, respectively).

Untreated Adult Populations

To estimate the size of untreated populations (generally referred to as unmet need), the number who received treatment is subtracted from the number in need of treatment. Because the number of individuals who received treatment paid by private funds, private insurance, faith-based organizations or other resources is not known, the unmet need for treatment in the general population is unknown. To estimate the number of untreated individuals among the adult population eligible for publicly funded treatment, data ODMHSAS and the Oklahoma Health Care Authority (OHCA) (the State Medicaid Authority) were combined to determine the number of adults who received publicly funded substance abuse or mental health services in fiscal year 2005 (FY2005). The estimated number of people untreated in the public sector was calculated using the estimated prevalence count and number served.

As shown in Exhibit 2.2, an estimated 71,684 adults received mental health or substance abuse treatment funded by ODMHSAS and/or OHCA in FY2005. Subtracting the estimated number served from the estimated 215,296 adults with low income and a mental or substance use disorder, resulted in an estimated 143,612 (66.7%) adults with a mental or substance use disorder in the past year who did not receive publicly funded treatment in FY2005 (see Exhibit 2.2). As noted above, the estimated prevalence rate of 26.2 percent is for the general population and not adjusted for poverty.

Exhibit 2.4 contains estimated prevalence rates that have been adjusted for poverty and can therefore be applied to the adults with incomes of less than 200 percent of the FPL. In addition, Exhibit 2.4 contains a count of adults in the public sector who received services funded by ODMHSAS and/or OHCA.

The number of adults with Serious Psychological Distress (SPD) served in the public system in the past year was not available. Instead, diagnosis of a mental disorder was used as a proxy for SPD. Subtracting the 58,225 adults served in the public sector from the estimated 128,201 with serious psychological distress in the past year, it is estimated that 69,976 (54.58%) did not receive publicly funded mental health treatment in FY2005. As noted above, this does not include adults with low income who received treatment funded by sources other than ODMHSAS or OHCA.

Substance abuse estimates are in three categories: alcohol dependence or abuse in the past year; any illicit drug dependence or abuse in the past year; and any combination of the two in the past year (see Exhibit 2.4). The number of clients who received services in these categories funded by ODMHSAS and/or OHCA was determined by evaluating diagnosis and presenting problem variables in the two data systems. The estimated number untreated may be an

over-estimation, because some adults with low-income could have received treatment funded by sources other than ODMHSAS or OHCA.

As shown in Exhibit 2.4, an estimated 67,008 adults with reported incomes of less than 200 percent of the FPL were dependent on or abused alcohol in the past year. Subtracting the 9,937 adults who received publicly funded treatment for alcohol abuse or dependence from the estimated prevalence count found that an estimated 57,071 (85.17%) did not receive needed publicly funded alcohol treatment. The number of adults who received publicly funded substance abuse treatment for illicit drug dependence or abuse was 13,368. Subtracting the number treated from the estimated number of adults in Oklahoma who had illicit drug dependence or abuse in the past year (36,236), it is estimated that 22,868 (63.11%) did not receive needed treatment through the public system. When combining the two types of substance dependence or abuse (alcohol or illicit drug), the estimated number of adults with low income with dependence or abuse in the past year was 88,371. Analysis of the combined data from ODMHSAS and OHCA indicated that 18,253 adults received treatment for alcohol or illicit drug dependence or abuse in FY2005. Subtracting the number treated from the estimated prevalence, it is estimated that 70,118 (79.35%) did not receive needed treatment in the public sector in FY2005. According to a news release from the U.S. Department of Health and Human Services, September 5, 2003 “22 Million in U.S. Suffer from Substance Dependence or Abuse,” an estimated 94 percent of people in need of substance abuse treatment would not seek treatment (DHHS, 2003). Therefore, it should be noted that among the 70,118 with potentially unmet treatment need, approximately 65,900 would not choose to actively seek treatment.

Estimates of potentially unmet need among veterans in Oklahoma and people who are hard of hearing are not readily available. Combined data from the Veterans Administration, ODMHSAS and OHCA may provide an estimate of the number and percent of civilian veterans needing but not receiving treatment. There are no estimates of the number of people in Oklahoma who are hard of hearing or deaf, and the estimated number of people with a co-occurring hearing disability and mental health or substance use disorders in Oklahoma is unknown.

In 1999, ODMHSAS conducted a survey of 870 prison inmates in Oklahoma as part of the State Treatment Needs Assessment Project (STNAP), funded by the federal Center for Substance Abuse Treatment (ODMHSAS, STNAP Phase I, 1999). Using estimates from this and the number of inmates who participated in a DOC-approved substance abuse treatment program (4,572), an estimated 951 (17.2%) inmates had unmet substance abuse treatment needs. This is a conservative estimate because the estimate of need is dated and the results are based on self-report. The ADAM results show that 72 percent of arrestees are using drugs or alcohol at the time of arrest. Assuming that this rate (rather than 25.6%) should be used to estimate the need for addiction treatment, the number of inmates with unmet need would be 10,960. This is a high estimate; the actual unmet need probably lies somewhere between 951 and 10,960.

C. Children and Adolescents

Tim is a 9 year old boy with a history of trauma; as a 6-year old, he witnessed his father's death by gunshot. Afterwards, his behavior became increasingly hostile; he hit his younger siblings, threatened his mother, and killed the family's cat. Tim also expressed constant fear of being hurt or killed when he left the house. His mother Sarah asked school officials for help, but she felt that they did not acknowledge that he had a problem until months later, when he

began acting out at school, for which he was suspended. Sarah was advised to give up custody of Tim so he could receive institutional care. She was very reluctant to do this, but felt so overwhelmed that she seriously considered it. Before she could relinquish custody, someone in her church told her that there was a local Community Mental Health Center that offered services to children, and she sought services there. Now Tim regularly sees a counselor experienced in working with victims of childhood trauma. While Sarah is still not sure she will always be able to care for her son at home, Tim has developed a trusting bond with the counselor, and Sarah feels hopeful about his future for the first time in years. Sarah is also receiving counseling services to assist herself and her son.

Melinda is a 15 year old high school sophomore who has been using cocaine since she was 13. Her parents, Frank and Pamela, have tried to get her into a residential substance abuse treatment facility, but there are few available adolescent treatment beds. When Melinda finally asked for help, they tried to get her into the detox unit at a local hospital, but she was turned away because of her age. Frank and Pamela explained that as a working family whose daughter has a drug problem, they find themselves in a bind; their insurance doesn't cover substance abuse treatment and they don't make enough money to pay for Melinda to go to a private facility. They have considered taking a second mortgage on their house to pay for treatment, but are not sure they can afford the monthly payments. Frank and Pamela's search for outpatient treatment has been fruitless, and they feel that the local school is in denial that there is a drug problem among the students. Now Melinda has become resistant to their efforts to get her help, and her parents feel that they have nowhere to turn.

Prevalence among Children and Adolescents

The Surgeon General's Report on Mental Health (DHHS, 1999) reported that the Methods for the Epidemiology of Child and Adolescent Mental Disorders (MECA) study found that an estimated 20.9 percent of children ages 9 to 17 had a diagnosable mental or addictive disorder associated with at least minimum impairment (see Exhibit 2.5). Using this estimate, approximately 90,796 children in Oklahoma age 9 to 17 had a diagnosable mental or addictive disorder in the past six months.

When evaluating prevalence of mental illness among children (excluding addictive disorders), the commonly used term is Serious Emotional Disturbance (SED). SED is defined as a diagnosable serious disorder that meets criteria specified within the DSM-IV, with impairment in specific areas of functioning (ODMHSAS, 2006). Although there are no recent studies to determine the number of children with SED, the federal Center for Mental Health Services (CMHS) published a methodology for estimating SED in the U.S. (GPO, 1998). The methodology was based on the ranking of poverty rates among states in the nation and level of functioning. Using the CMHS methodology, Oklahoma had an estimated 56,476 (13%) youth age 9 to 17 with SED, as shown in Exhibit 2.5. Although the estimate of children with SED has been generally adjusted for poverty, a more refined method of adjustment to state-specific poverty and behavioral health prevalence is required to adequately estimate the number of children in Oklahoma with SED who would be served in the public sector. Researchers in Oklahoma are currently working on this methodology.

Exhibit 2.5 Estimated Prevalence of Mental or Addictive Disorders among Youth 9 – 17 in Oklahoma, FY2005		
Prevalence Category among Youth, 2004 (N=434,431)	Estimated Prevalence Percent	Estimated Prevalence Count
Any Mental or Addictive Disorder (MECA)	20.90%	90,796
Serious Emotional Disturbance (CMHS)	13.00%	56,476

In Oklahoma, the Medicaid program (administered by the OHCA) serves youth living in households with incomes less than 185 percent of the Federal Poverty Level (FPL), as well as other populations which meet other eligibility criteria. Hence, OHCA is the primary funder of medical services, including behavioral health services, for children in Oklahoma. ODMHSAS, OJA, and the Oklahoma Department of Human Services (OKDHS) do not have financial eligibility criteria for youth, but are frequently simultaneously involved in behavioral health services for children. ODMHSAS collects information that can be used as an indicator of poverty status. Data collected by OJA are useful to identify services not funded directly by Medicaid. OKDHS also is instrumental in arranging for services for children. However, data for most children's behavioral health services arranged by OKDHS are reflected in the OHCA data. To better estimate the number of youth in Oklahoma who need publicly funded treatment for addictive or mental disorders, the MECA prevalence rate was applied to the youth population age 9 to 17 with reported household incomes of less than 185 percent of the FPL. It is important to note that the MECA prevalence rate has not been adjusted for poverty and therefore may be a conservative rate to use with youth in poverty. As shown in Exhibit 2.6, applying the MECA prevalence rate to the number of children age 9 to 17 in households with incomes of less than 185 percent of the FPL resulted in an estimated 37,021 youth with any mental or addictive disorder.

Exhibit 2.6. Estimated Prevalence of Mental Illness or Addictive Disorders and Number Untreated in the Public Sector among Children in Oklahoma, Age 9 to 17, with Household Income at Less than 185 Percent of the Federal Poverty Level

Prevalence Category	Youth Population, Age 9 to 17 with Less than 185% of FPL, 2004	MECA Estimated Prevalence Percent ¹	Estimated Prevalence Count	Number Served in the Public Sector ²	Estimated Number Untreated in the Public Sector ³	Estimated Percent Untreated in the Public Sector ³
Any Mental or Addictive Disorder	177,133	20.90%	37,021	32,802	4,218	11.4%

¹ The MECA prevalence rate has not been adjusted for poverty.

² The estimated number of children age 9 to 17 who received mental health and/or substance abuse services in Oklahoma through the public sector may not include all children who received publicly funded treatment. The number served was derived using data from ODMHSAS (adjusted for poverty), OHCA and OJA.

³ The estimated number and percent untreated in the public sector does not include children who received treatment provided through resources other than ODMHSAS, OHCA and OJA.

Prevalence of substance abuse or dependence among youth age 12 to 17 was estimated using the same methods described above for adults. Results from the 2003-2004 NSDUH for

Oklahoma indicated that an estimated 20,118 (6.81%) of youth age 12 to 17 were dependent on or abused alcohol in the past year; 18,227 (6.17%) were dependent on or abused illicit drugs in the past year; and 31,640 (10.71%) were dependent on or abused any illicit drug or alcohol in the past year (see Exhibit 2.7). The estimates for substance abuse or dependence have not been adjusted for poverty because the majority of children and youth who received substance abuse services in the public sector were funded by ODMHSAS and were not required to meet financial eligibility criteria. Additional findings estimated that 99,000 (21.52%) individuals age 12 to 20 had past-month binge alcohol use (OAS, SAMHSA, 2003). While the estimated percent untreated appears promising, these calculators are not adjusted for poverty, nor do they address in any way the issue of undertreatment.

Exhibit 2.7. Estimated Prevalence of Substance Abuse or Dependence in Past Year and Number Untreated in the Public Sector among Youth Age 12 to 17 in Oklahoma

Prevalence Category among Youth, Age 12 – 17, 2004 (N=295,421)	Estimated Prevalence Percent	NSDUH Estimated Prevalence Count	Number Served by ODMHSAS ¹	Estimated Number Untreated In Public System ²	Estimated Percent Untreated in Public Sector ²
Alcohol Dependence or Abuse in Past Year	6.81%	20,118	Not Available	Not Available	Not Available
Any Illicit Drug Dependence or Abuse in Past Year	6.17%	18,227	Not Available	Not Available	Not Available
Dependence on or Abuse of Any Illicit Drug or Alcohol in Past Year	10.71%	31,640	1,711	29,929	94.59 %

¹ The estimated number of children age 12 to 17 who received substance abuse services in Oklahoma is not available for alcohol or illicit drugs separately. The estimated number who received services for dependence on or abuse of any illicit drug or alcohol in the past year through the public sector may not include all people who received publicly funded treatment. The number served was derived using data from ODMHSAS only.

² The estimated number and percent untreated in the public sector does not include children who received treatment provided through resources other than ODMHSAS.

Untreated Children and Adolescents

Estimated counts of untreated populations, generally referred to as unmet need, can not be calculated for the general population. Estimates of the untreated low income population have been calculated, but may not include all people treated in the public sector. Treatment data are not currently available for people who received treatment funded by individuals, private insurance, faith-based organizations, or other resources. To estimate the number of youth served with public funds, the data from the ODMHSAS, OHCA, and OJA were combined.

As shown in Exhibit 2.6, an estimated 32,802 children and adolescents age 9 to 17 with any mental or addictive disorder received mental health or substance abuse services from ODMHSAS, OHCA, and/or OJA in FY2005. Subtracting the number served from the estimated 37,021 children with a mental or addictive disorder living in families with a reported household income of less than 185 percent of the FPL, it is estimated that 4,218 (11.4%) children age 9 to

17, were untreated in the public sector. This estimate does not include children who received treatment provided through resources other than ODMHSAS, OHCA and OJA.

Exhibit 2.7 contains the estimates of youth age 12 to 17 who were dependent on or abused alcohol or any illicit drug in the past year and received services funded by ODMHSAS in FY2005. Subtracting the 1,711 who were served by ODMHSAS from the estimated number in need of treatment results in an estimated 29,929 (94.6%) untreated youth. This may be an overestimate of unmet need because of the lack of information about treatment funded by other sources.

The following Chapters 4 – 6 address children’s behavioral health services, adult substance abuse services and adult mental health services in greater detail. In addition to data, the chapters focus on existing resources, strengths, needs and barriers for children and adults.

References:

BJS (2006a). *Bureau of Justice Statistics, Special Report, Mental Health Problems of Prison and Jail Inmates*. (September 2006, Publication No. NCJ 213600) Washington, D.C.: U.S. Department of Justice, Office of Justice Programs. Retrieved September 2006 from <http://www.ojp.usdoj.gov/bjs/pub/pdf/mhppji.pdf>.

BJS (2006b). Bureau of Justice Statistics, Bulletin, Prison and Jail Inmates at Midyear 2005. (May 2006, Publication No. NCJ 213133) Washington, D.C.: U.S. Department of Justice, Office of Justice Programs. Retrieved September, 2006 from <http://www.ojp.usdoj.gov/bjs/pub/pdf/pjim05.pdf>

DHHS (1999). *Mental Health: A Report of the Surgeon General—Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

DHHS (2003). *22 Million in U.S. Suffer from Substance Dependence or Abuse*. SAMHSA News Release, Friday, September 5, 2003. Retrieved June 2005 from <http://www.dhhs.gov/news/press/2003pres/20030905.html>.

DOC (2005). *Facts at a Glance*. Retrieved July, 2006 from <http://www.doc.state.ok.us/DOCS/Facts%20at%20a%20glance/0506faagweb.pdf>.

GPO (1998). *Children with Serious Emotional Disturbance; Estimation Methodology*. Federal Register: July 17, 1998 (Volume 63, Number 137) Published by the Office of the Federal Register, National Archives and Records Administration. Retrieved August 2006 from <http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi>.

HSR&D (2003) *Strategic Planning Guide, FY 2004-2008*. Retrieved September, 2006 from <http://www.chce.research.med.va.gov/pdf/CHCE%20Strategic%20Plan.pdf>.

Kessler, Ronald C. (2006). *National Comorbidity Survey: Replication (NCS-R), 2001-2003*. [Computer file]. Conducted by Harvard Medical School, Department of Health Care

Policy/University of Michigan, Survey Research Center. ICPSR04438-v1. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [producer and distributor], 2006-06-07. Retrieved August 2006 from <http://webapp.icpsr.umich.edu/cocoon/SAMHSA-STUDY/04438.xml>.

NHIS (2004). *National Health Interview Survey, 2004, Dataset 0004*. Retrieved August 2006 from <http://www.icpsr.umich.edu/cgi-bin/SDA/ICPSR/hsda3>.

NIMH (2006). *The Numbers Count: Mental Disorders in America*. Retrieved July 2006 from <http://www.nimh.nih.gov/publicat/numbers.cfm#>.

OAS, SAMHSA (2003). *National Survey on Drug Use and Health, The NSDUH Report, February 7, 2003*. Retrieved July 2006 from <http://www.oas.samhsa.gov/2k3/NSDUH/nsduh.htm>.

ODMHSAS (2006). Oklahoma City, OK: Oklahoma Department of Mental Health and Substance Abuse Services, Integrated Client Information System. Retrieved August 2006 from <http://www.odmhsas.org/eda/basicquear/basicquest.htm>.

ODMHSAS, STNAP Phase I (1999). *Oklahoma State Treatment Needs Assessment Studies, Alcohol and Other Drugs; Final Report on Study #1; Household Telephone Survey of the General Adult Population*. Oklahoma City, OK: Submitted to the SAMHSA, Center for Substance Abuse Treatment, Contract Number 270-94-0027 by the Oklahoma Department of Mental Health and Substance Abuse Services.

ODMHSAS, STNAP Phase I (1999) *Oklahoma State Treatment Needs Assessment Studies, Alcohol and Other Drugs; Final Report on Study #3; Survey of Inmates, Probationers and Parolees in the Oklahoma State Department of Corrections*. Oklahoma City, OK: Submitted to the SAMHSA, Center for Substance Abuse Treatment, Contract Number 270-94-0027 by the Oklahoma Department of Mental Health and Substance Abuse Services.

ODMHSAS, STNAP Phase III (2005). *Oklahoma State Treatment Needs Assessment Studies, Phase III; Final Report on Arrestee Drug Abuse Monitoring Program*. Oklahoma City, OK: Submitted to the SAMHSA, Center for Substance Abuse Treatment, Grant Number 1 UR1 TI13443-01 by the Oklahoma Department of Mental Health and Substance Abuse Services.

SAMHSA (2006). *Recovery Month Kit, Military and Veterans, Substance Use and Co-Occurring Disorders Among Military and Veterans*. Retrieved August 2006 from http://www.recoverymonth.gov/2006/kit/html/Targeted_Outreach/military.aspx.

US Census (2004). *American Fact Finder, Oklahoma S2101, Veteran Status*. Retrieved August 2006 from http://factfinder.census.gov/servlet/STTable?_bm=y&-geo_id=04000US40&-qr_name=ACS_2004_EST_G00_S2101&-ds_name=ACS_2004_EST_G00_-redoLog=false.

US Census (2006). *Oklahoma Population Estimates Program*. Retrieved August 2006 from http://factfinder.census.gov/servlet/DTable?_bm=y&-context=dt&-ds_name=PEP_2005_EST&-mt_name=PEP_2005_EST_G2005_T001&-CONTEXT=dt&

[tree_id=805&-all_geo_types=N&-geo_id=04000US40&-search_results=01000US&-format=&-lang=en.](#)

Chapter 3: A Consumer-Driven, Recovery-Focused, Trauma-Informed Service System

The purpose of this chapter is to illustrate the principles of consumer-directed, recovery-focused, trauma-informed service systems, based upon a synthesis of recent research and current thinking in the field. The concept of “recovery” particularly is one that has a different history and different meaning in the fields of mental health and substance abuse. Rather than attempting to merge the two, we have described each separately below.

A. Principles of Recovery-focused Service Systems

Recovery in the Context of Addiction and Substance Abuse

While the term “recovery” is of course widely used in the addictions field, the concept has a longer history and has traditionally been used in a somewhat different way than the term is currently used in the mental health field. The Alcoholics Anonymous (AA) 12-step self-help program, founded in the late 1930s, introduced the term “recovery” into the lexicon of the alcohol and drug addiction field, using it to refer to the process of attaining and maintaining sobriety. The World Health Organization (WHO) defines “recovery” as “Maintenance of abstinence from alcohol and/or other drug use by any means.” These definitions see recovery as primarily a matter of severing one’s relationship with a particular substance, whether through the support of one’s peers, as in AA, or through medical treatment, professional counseling, or other methods.

White and Kurtz (2005) more expansively define recovery as “the process through which severe alcohol and other drug problems...are resolved in tandem with the development of physical, emotional, ontological (spirituality, life meaning), relational and occupational health.” White and Kurtz are not merely describing the elimination of dependence, they point out that recovery also includes the process of inner healing and growth, and development of life skills that help one cope with life’s stresses without dependence on drugs or alcohol. As Daniel Laguitton (1993) puts it, “It is a recovery of personal integrity, the end of personal fragmentation and of denial. It is a movement towards conditions that are favorable to personal growth. Under this definition, abstinence from alcohol for an alcoholic can be called recovery only if it is accompanied by a resumption of personal growth.”

The definitions offered by White and Kurtz and by Laguitton are reflective of a more nuanced understanding of recovery from addiction, and seem to have a good deal in common with the recovery concepts of Deegan (1988, 2004), Ridgway (2004) and other people with psychiatric histories, discussed below. Like these ex-patient researchers, White and Kurtz state that recovery is not a straightforward linear process, but that there are multiple pathways and styles of recovery. If recovery is to be successful, each individual must find the approach or combination of approaches that works for him or her.

Recovery in the Context of Mental Health

In its final report, “Achieving the Promise: Transforming Mental Health Care in America,” the President’s New Freedom Commission (2003) called for a transformation of the nation’s mental health system that would “involve consumers and families fully in orienting the mental health system toward recovery.” The report noted that currently “consumers and families

do not control their care,” and went on to make recommendations for creating a recovery-oriented system that is driven by the self-defined needs of people who use mental health services.

Since the mid-1980s, much has been written about recovery and the environmental factors necessary to promote it, particularly by people with psychiatric histories (see, for instance, Campbell, 1989; Deegan, 1988; Zinman, et. al, 1987; Chamberlin, 1984, Penney, 1998). However, the idea has only recently begun to gain general acceptance in the public mental health field. In the last few years, there has been much discussion (and much confusion) about recovery within the field, but little in the way of concrete action to make the changes necessary to transform the system. This dearth of action may be due, in part, to a general lack of clarity among public mental health officials and clinicians about what is meant by recovery, and about what changes in policy, assumptions, attitudes, funding streams, and service delivery are required to create a system that will facilitate recovery.

What is “recovery?”

What is meant by the term “recovery” in the context of a diagnosis of serious mental illness? In general terms, “recovery” is short-hand for the idea that such a diagnosis need not preclude one from living a satisfying and productive life; that serious mental illness is not an inevitably deteriorating condition with a poor prognosis that results in life-long disability and dependency. It is the idea that most people with psychiatric diagnoses can, in fact, “get better;” that they are capable of moving beyond their illness labels, out of the socially de-valued role of “mental patient,” and can build their own lives as self-directed members of their communities.

The President’s New Freedom Commission (2003) defines recovery as “the process in which people are able to live, work, learn, and participate fully in their communities.” The National Association of State Mental Health Program Directors (NASMHPD/NTAC, 2004) calls recovery the “basic human right to feel better.” According to consumer/researcher Ruth Ralph, “Recovery can be defined as a process of learning to approach each day’s challenges, overcome our disabilities, learn skills, live independently and contribute to society. This process is supported by those who believe in us and give us hope.” Ralph, along with an eight-member Recovery Advisory Group of consumer/survivor leaders (1999), developed a complex model of the recovery process. This model is based on the assumption that recovery is a highly individualized, non-linear process that is strongly affected by internal and external influences (both positive and negative), in which a person moves from despair toward healing, well-being and wholeness. Shery Mead and Mary Ellen Copeland (NASMHPD/NTAC, 2004) refer to “life change and transformation—not returning to a former way of being, but going forward to create a new, exciting, and rewarding life.” Patricia Deegan (2004) writes of “the innate self-righting capacity, or resilience, of people with psychiatric disabilities.” Resilience, a central premise in the conceptualization of recovery, is defined by Priscilla Ridgway (2004) as “the capacity of people faced with adversity to adapt, cope, rebound, withstand, grow, survive and even thrive.”

Is recovery really possible?

Hundreds of personal accounts of madness and recovery have been published by ex-patients over the centuries, the earliest of these in the 14th century (Hornstein, (2002). The anthropologist Gregory Bateson (1974) uncovered and re-printed with commentary the amazingly detailed account of the self-directed recovery of John Perceval, a 19th century Briton who spent many years in asylums. In the U.S., a number of 19th century mental patients privately published their own stories, and in 1909, Clifford Beers, a recovered patient who

founded what became the National Mental Health Association, published his story, *A Mind That Found Itself*. The literature of the ex-patients' movement over the last 30 years is heavily focused on personal descriptions of recovery (see, for example, Campbell, 1989; Deegan, 1988 & 2004; Zinman, et. al, 1987; Fisher, 1994; Walsh, 1996, Penney, 2003) .

In addition to first-person accounts, there is significant empirical evidence from a number of longitudinal studies across the globe demonstrating that between one-half and two-thirds of people diagnosed with schizophrenia either significantly improve or completely recover over time. In the seven such longitudinal studies from the 20th century compared by Harding and Zahniser, (1994), the criteria for recovery were: “no significant signs or symptoms of any mental illness, no current medications, working, relating well to family and friends, integrated into the community, and behaving in such a way as to not be able to detect [their] having ever been hospitalized for any kind of psychiatric problems,” a standard much more rigorous than the definitions discussed above. Patricia Deegan points to even earlier studies demonstrating that recovery is not a modern phenomenon. She cites an 1881 study at Worcester State Hospital in Massachusetts that found that 51% of those discharged between 1833-1840 remained well as long as they lived; a follow-up study found that 58% of patients discharged between 1840 and 1893 remained completely recovered (NASMHPD/NTAC, 2004). The evidence shows that recovery rates have remained fairly constant for the last 170 years, despite many changes in treatment philosophy and the introduction of psychiatric medications in the 1950s. It appears that something other than treatment must be involved in recovery.

What impedes and what promotes recovery?

What is known about the factors that create an environment that encourages and supports recovery? There is widespread agreement among practitioners and authors who are actively involved in the recovery field that many common practices of the existing mental health system do not promote recovery, but in fact create impediments to the process. These practices include a lack of consumer choice in treatment, service provider, housing, and the use of medication; the lack of meaningful consumer and family involvement in decision-making, both at the system level and in their own service plans; focusing on people's perceived deficits rather than on their strengths; requiring consumers to fit into rigid program models that do not meet their individual needs; policies and service designs that ignore the fact that most psychiatric patients are trauma survivors; and the use of coercive measures such as restraint and seclusion, inpatient and outpatient commitment, forced medication, and the linkage of housing to treatment adherence (Onken, et. al, 2002; Ralph, 2000; Ralph & Recovery Advisory Group, 1999; Penney, 1997). Some of these problems are also endemic in the substance abuse field.

Patricia Deegan (NASMHPD/NTAC, 2004) finds that the biggest obstacle to recovery is “the creation of service models, and the organizing of services around models, as opposed to encouraging individualized supports with individual budgets for living in the community.” She notes that “services should be a means to an end—living a full and meaningful life in the community... Recovery is a person-centered phenomenon. You can't ‘do recovery’ to someone. You can't ‘do services’ that will force someone to recover. Recovery-based services will always be one small part or one small ingredient for a person with psychiatric disabilities to achieve a meaningful life in the community.”

Bill Anthony (2004) believes that “the vision of recovery is foreign to what has been masquerading as the mental health vision for the last century... If we are serious about the vision of recovery, then the mental health system of the last century—which for the most part was a

system characterized by low expectations, control, and no consumer-based vision—must disappear.” Anthony points out that these changes will not happen until leaders of mental health systems adopt the values that underlie a recovery orientation, and ensure that all of the decisions they make about policy, budgeting, human resources, and other matters are fully consistent with recovery values. He argues for a concept he calls “Values-based Practice,” which is grounded in people-first values such as choice, flexibility, consumer preferences and rights protection (Anthony, 2005). Anthony also emphasizes that consumers and family members must be integral to the planning process if a transition to a recovery-oriented system is to occur.

Among the values discussed in the literature as essential to a recovery-promoting environment are self-determination; hope; risk-taking and the freedom to fail; real choice among genuine alternatives; availability of self-help and peer support services; full and genuine partnership between consumers and providers; recognition that each person’s recovery journey is unique; putting people (not program needs) first; enhancing each person’s growth potential; dealing honestly with issues of power and control; and listening to consumers and understanding them in the context of their lives (Farkas, Gagne, Anthony, & Chamberlin, 2005; Deegan, 2004; NASMHPD/NTAC, 2004; Ridgway, 2004; Penney, 1997; Deegan, 1988).

Implementing these recovery values will mean re-thinking most of the current assumptions under which the mental health system operates. Anthony (2004) notes that one way to determine whether a system is moving toward a recovery orientation is to look at its mission and policy statements. “To assist people to improve their functioning so that they are successful and satisfied in the environment of choice” is a recovery-oriented mission statement, he says; “To provide continuous and comprehensive services to mentally ill clients” is not. Creating an environment in which recovery can flourish is primarily a matter of changing assumptions and attitudes, abandoning policies and program structures that create barriers to recovery, and creating a system that has the flexibility to respond effectively to individual wants and needs.

B. Existing Resources/Strengths

Office of Consumer Affairs

In recent years, ODMHSAS has introduced several initiatives designed to promote a recovery-oriented system. Most importantly, the Office of Consumer Affairs was established in 2003. Offices of Consumer Affairs (OCAs) exist in almost 40 state mental health authorities around the country; their purpose is to improve state mental health systems by working to support and expand the consumer/survivor voice within mental health policymaking, planning and practice. OCAs are headed by a self-identified consumer/survivor who serves as part of the senior management team and is a system change agent. Areas of responsibility for the OCA include policy and regulation development, program planning, evaluation and monitoring, training, and developing and promoting recovery-oriented, consumer-driven services.

OCA staff at ODMHSAS prepared a successful CMS Real Choice Systems Change grant, in collaboration with OHCA which TOfund the roll-out of two SAMHSA-identified Evidence-Based Practices: Family Psychoeducation and Illness Management and Recovery. The Real Choice grant also funds a Recovery Support Specialist Coordinator within the OCA, who, along with a grant-funded employee within the Oklahoma Health Care Authority (OHCA), will propose policy changes to establish Medicaid-reimbursable peer services in Oklahoma. The

OCA also includes a staff member specializing in co-occurring mental health and substance abuse disorders, funded by Oklahoma's federal Co-Occurring State Incentive Grant (COSIG).

Among the accomplishments of the Office of Consumer Affairs in its first two and a half years of operation was the development of Recovery Support Specialist positions within the mental health system.

Recovery Support Specialists

The introduction in 2004 of Recovery Support Specialists (RSSs) into the service system's staff mix is a promising step toward transforming the system into one that is consumer-centered and recovery-oriented. RSSs are people in recovery trained to provide peer support and advocacy services for consumers in emergency, outpatient or inpatient settings. The RSSs perform a wide range of tasks to assist consumers in regaining control of their lives and recovery processes, and all CMHCs are required to have at least one FTE (Full Time Equivalent) RSS on staff.

Consumers who had Recovery Support Specialists (RSS) in their programs were uniformly pleased with the performance of these staff; those who did not have access to RSSs expressed an interest in working with them. Most program staff and managers were equally supportive; one program manager said "Consumer reactions are positive. One RSS gets consumers involved in conferences and advocacy groups. These positions show consumers that recovery is possible, that they can recover, too." Several providers said that they would like to have more RSSs working in their programs.

Exemplary Programs

It was clear from site visits and focus groups with staff, managers and consumers that some CMHCs and other providers understand and are strongly committed to the values and practices of recovery-oriented services. In such agencies, the leadership modeled these principles, encouraged staff to learn and practice attitudes and skills that are consumer-centered, and valued the role of their Recovery Support Specialists, if they had them. These organizations fully involved consumers in the development of their treatment plans, and sought their input through other mechanisms: "We have a consumer advisory committee that meets every two weeks and takes up issues that require discussion and problem-solving, such as staff retention, consumer rights, member participation, investment of resources in new activities, and evaluating what we are doing to support recovery," one program manger said. "We run focus groups each year on our annual plan and budget, and we involve consumers on all our committees," said another. Consumers in these programs were decidedly more enthusiastic about the services they received than consumers in other programs. While these exemplary programs were not in the majority, their accomplishments can serve as models for other programs.

Role of Persons in Recovery Providing Substance Abuse Services

Unlike the mental health field, the addiction and substance abuse field has a long history of people in recovery working within the service system. While mental health has only started to appreciate the value of the experiential knowledge of people with psychiatric histories, recovering alcoholics' and addicts' lived experience has been recognized as a valuable asset in the delivery of substance abuse treatment services for at least the last thirty years. As ODMHSAS moves forward in developing a recovery-oriented service system, it will be important to maintain and enhance the utilization of the lived experience of people in recovery as

a key factor in the delivery of substance abuse treatment services.

C. Needs and Existing Barriers

Consumers, advocates, and some program managers and staff pointed out a number of barriers that interfere with efforts to move the system in a recovery-oriented direction. The most frequently identified obstruction was the wide-spread lack of understanding of the nature and extent of change needed to move the system in that direction. “People use the buzzwords, but really don’t know what they mean, or how different things would have to be if the system really adopted recovery values,” an advocate said. “We’re all so trapped in the current system, it’s hard to imagine what a good system would be,” a program manager said, “There are some who just don’t believe that recovery is possible.” Several program managers and staff noted that people in the field are eager to get more education about recovery values, in addition to specific skills training that would help re-orient local agencies toward a recovery model. Several consumers and advocates stated that “There is only one accepted view of ‘recovery’ in Oklahoma. If you are not on meds, you are judged as not being in recovery.” An RSS said, “I was told not to tell other consumers I don’t take medication, because people will then not believe that they should take their meds.”

Another frequently mentioned barrier was what many respondents saw as either indifference or outright hostility to change that would give consumers and families more control over their services. “Some [providers] see recovery as a threat to the system,” one consumer said. “They think us staying sick keeps the system well.” Another person noted, “There will always be someone else in line to fill the slot [at provider agencies], so why do they resist working toward recovery?” At several programs, staff were very clear that they did not support any changes that would lead to more consumer choice or involvement. Often this was just one or two staff members out of a larger focus group, but in several groups, the entire staff and management expressed these feelings.

Consumers and advocates also stated that consumer involvement in policy and planning at the state-level remains at a token level. People said that if they are invited to the table at all, it is in later stages, after the direction of an initiative had been set. It was also noted that the same handful of consumers and family members are the only ones asked to participate. Several RSSs and advocates stated that there is a need to mentor new consumer leaders at the local level, in order to increase the breadth and depth of consumer involvement in local agencies and at the state level.

References:

Bateson, G., ed.. (1974). *Perceval's Narrative: A Patient's Account of His Psychosis, 1830-1832*. New York: William Morrow and Company.

Campbell, J.(1989). *In pursuit of wellness: The well-being project*. Sacramento: California Network of Mental Health Clients.

Chamberlin, J. (1984). Speaking for ourselves: an overview of the ex-psychiatric inmates' movement. *Psychosocial Rehabilitation Journal*, 8(2), 56-64.

- Deegan, P. (2004). *I don't think it was my treatment plan that made me well: Self-directed recovery, peer support and the role of the mental health professional*. Unpublished manuscript. .
- Deegan, P. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*, 11(4), 11-19.
- Farkas, M, Gagne, C., Anthony, W.A., Chamberlin, J. (2005). Implementing recovery-oriented evidence- based programs: Identifying the critical dimensions. *Community Mental Health Journal*, 41(2), 141-158.
- Fisher, D. (1994). A new vision of healing as constructed by people with psychiatric disabilities working as mental health providers. *Psychiatric Rehabilitation Journal*, 17(3),67-81.
- Harding, C. & Zahniser, J. (1994). Empirical correction of seven myths about schizophrenia with implications for treatment. *Acta Psychiatr Scand*, suppl. 384, 140-146.
- Hornstein, G. (2002). Narratives of madness, as told from within," *The Chronicle of Higher Education*, January 25, 2002, B7.
- NASMHPD/NTAC (2004). *Implementing recovery-based care: Tangible guidance for SMHAs*. Alexandria, VA: National Association of State Mental Health Program Directors/ National Technical Assistance Center for State Mental Health Planning. Available at http://www.nasmhpd.org/spec_e-report_fall04intro.cfm#TOC
- Onken, S.; Dumont, J.; Ridgway, P.; Dornan, D.; Ralph, R. (2002). *Mental health recovery: What helps and what hinders?* Alexandria, VA: National Technical Assistance Center for State Mental Health Planning. Available at www.nasmhpd.org/publications.cfm#techreports
- Penney, D. (2003). Insist on your sanity: An interview with Kate Millett. *off our backs*, July/August, 2003.
- Penney, D., & Kalinowski, C. (1998) Empowerment and women's mental health services, in Levin, B., Blanch, A., & Jennings, A., eds. *Women's Mental Health*. Sage Publications.
- Penney, D. (1997). Redefining medical necessity: Toward a recovery-oriented mental health benefit, in Stout, C., ed., *The Complete Guide to Managed Behavioral Healthcare*. Hoboken, N.J.: John Wiley & Sons.
- President's New Freedom Commission on Mental Health. (2003) *Achieving the promise: Transforming mental health care in America. Final report*. DHHS Pub. No. SMA-03-3832. Rockville, MD: Department of Health and Human Services.
- Ralph, R. (2000) *Review of recovery literature: A synthesis of a sample of recovery literature*. Alexandria, VA: National Association of State Mental Health Program Directors and National Technical Assistance Center for State Mental Health Planning.

Ralph, R. & The Recovery Advisory Group.(1999).*The Recovery Advisory Group recovery model*. Paper presented at the National Conference on Mental Health Statistics. Available at www.nasmhpd.org/spec_e-report_fall04measures.cfm

Ridgway, P. (2004). *Resilience and recovery from psychiatric disability: Links in concepts and research*. Working paper. Lawrence, KS: University of Kansas School of Social Welfare.

Walsh, D. (1996). A journey toward recovery: From the inside out. *Psychiatric Rehabilitation Journal*, 20(2), 85-89.

White, W & Kurtz, E. (2005) . *The varieties of recovery experience*. Chicago: Great Lakes Addiction Technology Transfer Center.

World Health Organization. Lexicon of alcohol and drug terms published by the World Health Organization. http://www.who.int/substance_abuse/terminology/who_lexicon/en/ (accessed 24 August 2006).

Zinman, S., Harp, H., and Budd, S., eds.(1987). *Reaching across: Mental health clients helping each other*. California Network of Mental Health Clients, Sacramento, CA.

Chapter 4: Children’s Behavioral Health Services

The purpose of this chapter is to describe behavioral healthcare services for children, including existing resources, strengths of current programs, and needs. The chapter includes narrative information gathered through focus groups and personal interviews, as well as existing data from state agencies and other sources.

A. Existing Resources

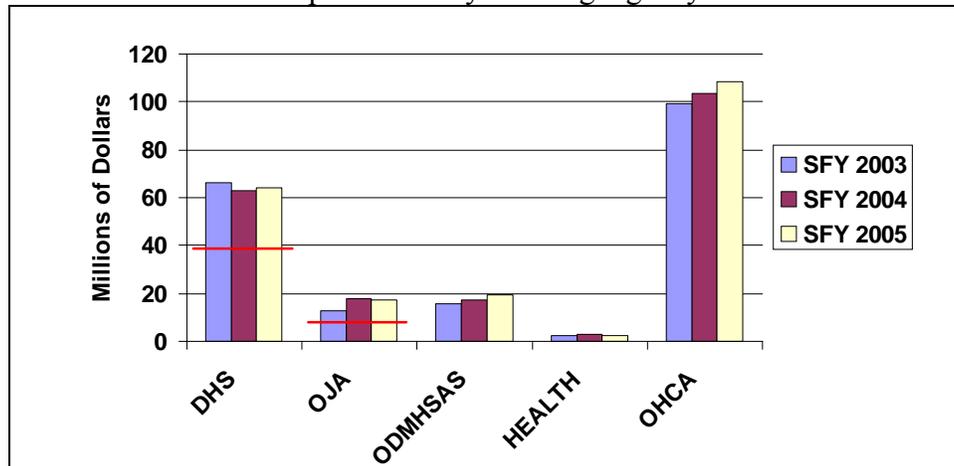
Responsibility for funding, regulation, service provision and advocacy related to children’s behavioral health has historically been spread across a number of state agencies. State agencies that fund children’s outpatient and inpatient behavioral health services, listed in order of total expenditures, are the Oklahoma Health Care Authority (OHCA), the Department of Human Services (OKDHS), the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), the State Department of Education (OKSDOE), the Oklahoma State Department of Health (OSDH), and the Office of Juvenile Affairs (OJA). In addition, the Oklahoma Commission on Children and Youth (OCCY) is responsible for the planning and coordination of services to children, and provides oversight of all state-operated juvenile facilities. As the state’s Medicaid agency, OHCA funds healthcare for eligible low-income children, including behavioral health services delivered through child-serving agencies. The Department of Human Services provides several services that impact children with behavioral healthcare needs, including Child Protective Services, Foster Care, and Family Preservation Services; OKDHS also runs two emergency shelters for children.

ODMHSAS is the state authority for children’s mental health and substance abuse services, responsible for planning, coordinating, and partially funding services at the community level through its network of Community Mental Health Centers (CMHCs) and other contract agencies. Medicaid coverage for children includes outpatient, inpatient, case management, TFC, psychologists, and psychiatrists services. The Department also operates the Oklahoma Youth Center, a 34-bed inpatient psychiatric hospital for children. In addition, ODMHSAS contracts with Oklahoma Federation of Families for Youth and Children’s Mental Health to provide statewide advocacy, education and technical assistance in support of children with serious emotional disturbances and their families.

The Department of Education funds or administers initiatives providing special education and certain behavioral health services through Oklahoma’s local school districts. The Department of Health provides a variety of services related to children’s behavioral health, including Child Guidance services, early identification and intervention for behavioral health concerns, programs on violence, child abuse, and suicide prevention. The Office of Juvenile Affairs promotes public safety and works to reduce juvenile delinquency through community-based resources, residential settings, probation and parole services, and secure facilities for juveniles. The Department of Rehabilitation Services offers employment services for youth with disabilities.

Funding for children’s behavioral health is included in five state agency budgets. The chart in Exhibit 4.1 shows the amount of spending for each agency for the past three years.

Exhibit 4.1.
Expenditures by Funding Agency



B. Strengths

Policy

In recent years, there have been substantial developments toward the coordination of behavioral health services provided by the state agencies, which have enhanced the system’s ability to approach services to children and their families in a more integrated fashion. The Commissioners and Directors of the eight state child-serving agencies voluntarily created the Partnership for Children’s Behavioral Health through a Memorandum of Agreement (MOA) in 2004. Governor Brad Henry has supported transformation of the behavioral health system by signing the MOA in support of the Partnership for Children’s Behavioral Health in 2004 and hosting a press conference to announce its creation; he charged the Partnership with creating an integrated system of care. The Legislature has supported this priority through expanded funding in each of the last five years.

The developing System of Care has adopted consistent values and principles for transforming the children’s behavioral health system, which have been the basis for state and local efforts related to the System of Care. These values were also adopted by the Partnership for Children’s Behavioral Health and the OCCY Board, each of which includes the Directors of all the State’s child-serving agencies.

Seven of the eight child serving agencies have devoted extensive staff time and resources to needs assessment and planning, and have begun to implement changes to transform the system. Policy changes in several agencies have led to more comprehensive assessments, resulting in better identification of need and more behavioral health services for children and youth. For example, a joint effort of OJA, OCCY, and the juvenile detention facilities resulted in screening for all youth in detention, resulting in identification of children in need and the provision of more needed services.

In Canadian County, local leaders were so concerned about the lack of access to appropriate children’s behavioral health services that they passed a dedicated sales tax to support

the development of the Judge Gary Miller Children's Justice Center. The local tax funds are employed to augment Federal and State funds in order to provide both a broader range of services and higher quality services than are generally available elsewhere. The Center, which is CARF-accredited, includes an alternative education program, residential treatment and aftercare programs, as well as a juvenile detention facility. The Center has over 100 staff and a \$3 million annual budget. It continues to identify unmet needs and develop plans to address them.

Indian Health Care in Tulsa received a three-year Circles of Care planning grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). The grant supports a behavioral health planning process called "Strengthening Our Children," with the goal of developing an Indian-friendly system of care for children and youth in Tulsa. The Muskogee (Creek) Nation received Circles of Care funding for a program with a rural focus to provide services for the Creek Community. The Circles of Care project will engage a wide range of community stakeholders to define the gaps between needed and available services, document barriers to care, and develop strategies to improve access to services for American Indian youth and families at risk of, or currently experiencing, a serious emotional or behavioral disorder.

Oklahoma has had significant involvement with the federally funded National Child Traumatic Stress Disorder Network (NCTSN) since its inception in 2001. Oklahoma City hosts the network's primary Terrorism and Disaster Center, as well as the Indian Country Child Trauma Center. The Oklahoma Child Traumatic Stress Treatment Collaborative also includes three additional sites in Norman and Tulsa. The goal of the Collaborative is to improve the detection, assessment, and treatment of high-risk children with trauma-related behavioral health concerns. This public/private collaboration provides intensive training in evidence-based and promising practices, as well as linkages to national expertise on specific types of traumatic events, population groups, and service systems.

The Behavioral Health Development Team piloted early screening processes in four local Systems of Care communities. These early screening efforts took place in child care settings, physician assistants' offices, and municipal courts. The OSDH has agreed to take the lead in implementing early screening efforts in local systems of care around the state. Families were open to having their children screened and able to find services appropriate to their needs.

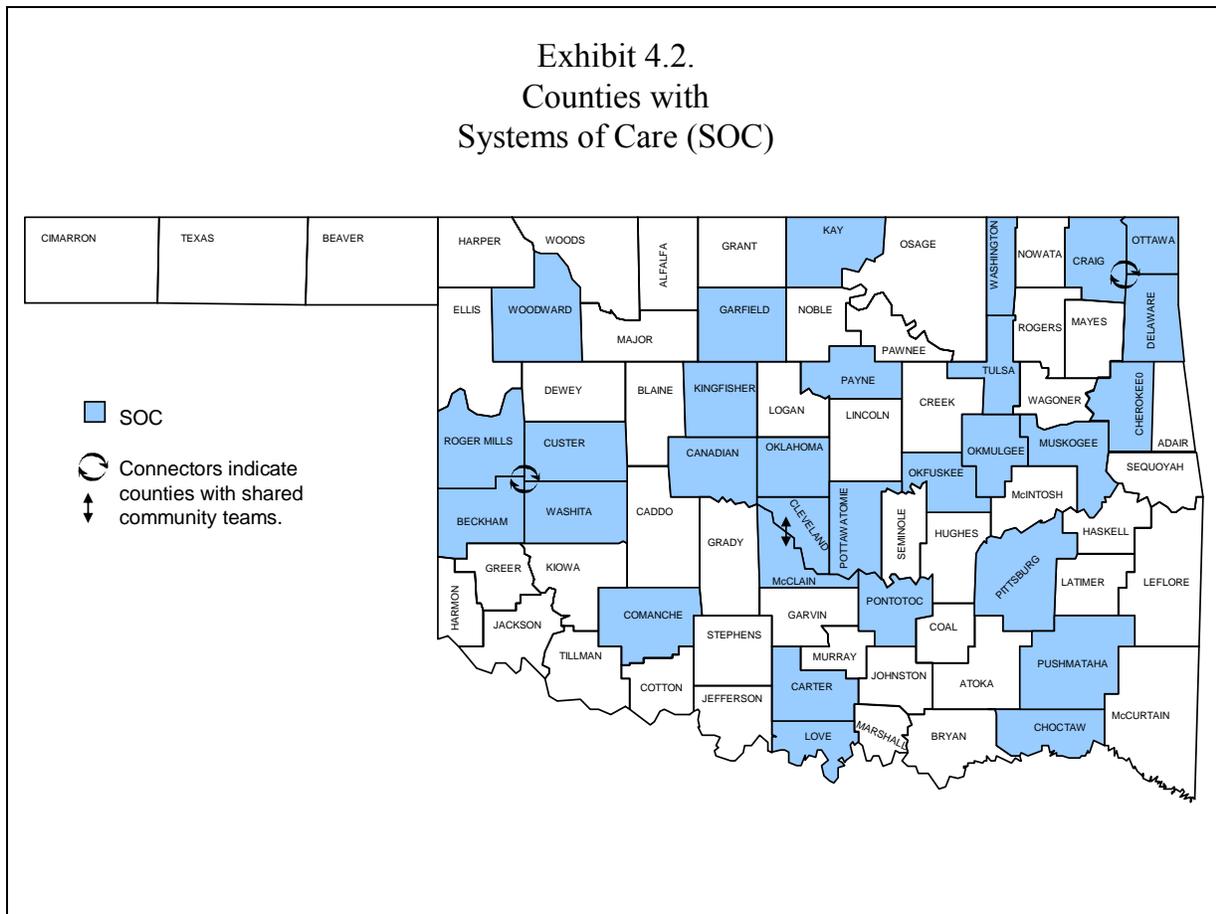
Practices and Services

The steadily improving collaboration among state agencies and stakeholders, along with increased funding, is beginning to show results. There has been an increase in the ability to identify children and youth in need of behavioral health services, expansion of some critical services, and creation of new community-based services.

State agencies involved in the Children's Partnership have recognized the need for earlier access to behavioral health services; early intervention services have been expanded by OKDHS, and OSDH is also focusing on early intervention and is working to expand the capability of Child Guidance Centers to provide these services. OHCA is partnering with pediatricians and other agencies to identify behavioral health needs through early screening, as well as, added more community based services to the benefit package. ODMHSAS is contracting with domestic violence shelters and CMHCs to provide early intervention services for children and youth exposed to trauma.

Efforts are underway to expand the continuum of services available for children, youth and their families. Through the System of Care initiative, ODMHSAS and its partner agencies have expanded wraparound care coordination, family support providers and behavioral health

aides. Wraparound coordination helps families find formal and natural supports, and related System of Care efforts are increasing the availability of surrogate natural supports. Exhibit 4.2 shows the counties with existing Systems of Care (SOC) programs.



The President’s New Freedom Commission report recommends individual plans and service coordination for all children and youth with serious emotional disturbance (SED) and their families (DHHS, 2003). Through the System of Care initiative, ODMHSAS has the capacity to provide wraparound care coordination for 500 children and their families in more than 20 communities. This process uses strengths, needs and culture discovery assessment process that identifies and prioritizes needs, engages families in the process, and results in individualized plans that are tailored for each child and family. In addition, OJA and OKDHS provide lower intensity care coordination for most children and youth in their custody through targeted case management.

ODMHSAS and its contractor from the University of Oklahoma have evaluated outcomes of the SOC Wraparound project, finding positive results. Of the 397 clients enrolled for at least six months, there was a 31 percent reduction in out-of-home placements; 64 percent reduction in school detentions; 65 percent reduction in self-harm attempts; and 54 percent reduction in arrests. In our own interviews, one child reported that “Last year I was sent to the principal’s office every day. System of Care changed my attitude. I have not been there once this year. I’m doing all my work and bringing up my grades.”

DMHSAS/OKDHS pilot programs are providing combined behavioral health services and supported employment for children and adolescents with more intense needs. Recent surveys and focus groups with Community Partnership Boards and System of Care Community Teams report a slight but consistent improvement in how well the behavioral health needs of children, youth and their families are met. Over the past three years, the amount of public funding for children's behavioral health has increased by over \$15 million. In addition, spending for children and youth not in the custody of the state has increased more than for those in custody, resulting in improved parity among the groups.

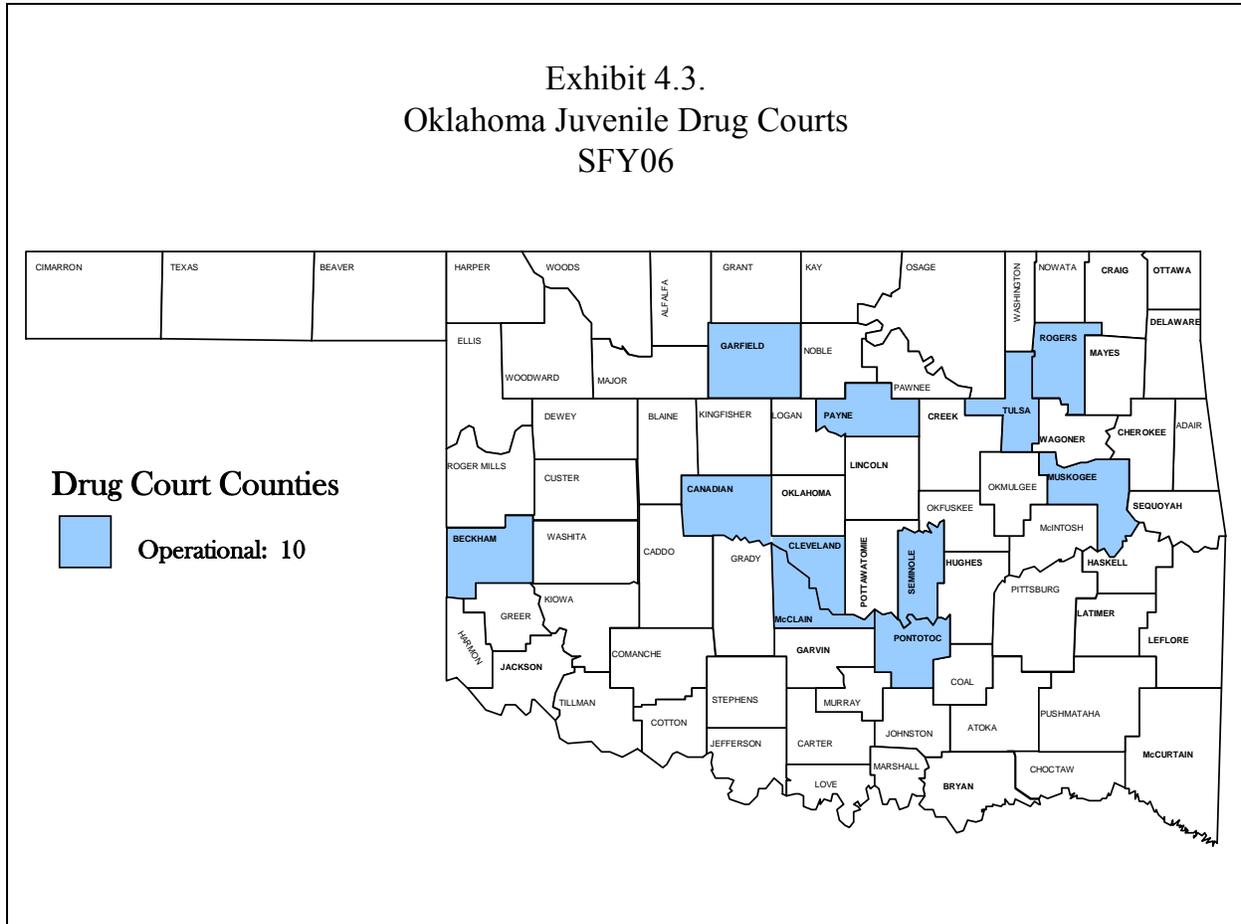
Assessment and case management services have increased in amount and quality, resulting in better identifying needs and connecting children, youth and their families to services. Within OJA, implementation of standardized assessment has resulted in increased identification of behavioral health needs, and targeted case management has led to better meeting these needs. OJA, in partnership with OCCY, has implemented behavioral health screening in the juvenile detention centers, which has resulted in identifying more youth with behavioral health needs and linking them to services.

School districts in many communities across the state have partnered with System of Care Community Teams, Community Partnership Boards, and other community stakeholders to provide positive behavior supports in schools, with the goal of creating school environments that support children's behavioral and emotional health, and providing early intervention services and supports within schools. System of Care Community Teams and Partnership Boards have collaborated with local stakeholders, such as youth court judges, county social services departments, and community service organizations, to initiate early intervention programs and services. System of Care teams have also begun or extended other collaborative efforts including co-location of staff, school-based programs, and joint programs across agencies. Through ODMHSAS, funding is available to provide staff and resources to support local System of Care infrastructure development.

Critical services have been expanded, including small group homes for children and youth in the OKDHS and OJA systems, crisis centers and mobile crisis teams through ODMHSAS, and multi-systemic therapy through OJA. ODMHSAS and OHCA have partnered to create and fund new community services, including care coordinators for wraparound services, family support providers, and behavioral health aides. DMHSAS and OKDHS have partnered with local mental health providers on pilot programs that combine behavioral health and vocational services to support adolescents to transition to the world of work. The OKDHS kinship adoption program has resulted in a greater number of adoptions of children by relatives each year. About half of all children in foster care are with kin and many of these placements lead to adoption. More than twenty years ago, OKDHS began a program of providing adoptive families with access to subsidies and ensuring that the children are enrolled in Medicaid. In Tulsa and Oklahoma City, there are Adoption Transition Units that focus on completing this process as efficiently as possible. Adoption is critical to creating stability in children's lives so that they are better able to address the effects of past trauma and develop hope for the future.

OHCA's provider recruitment efforts have resulted in a 95% increase in OPBH providers from FY'95- FY'2005. OHCA's Board has listed residential substance abuse treatment for adolescents as one of their top funding request priorities for the past two years.

To divert juveniles using illicit substances from juvenile facilities and to provide treatment, 10 juvenile drug courts have been established in Oklahoma. During FY2005, approximately 100 juveniles participated in those drug courts. Exhibit 4.3 shows the locations of the juvenile drug courts.



Workforce Development

The Children’s Partnership agencies have developed a common vision and values for behavioral health services and are beginning to provide cross-agency training to support stronger collaboration. Skills-based training and coaching have been developed and implemented to support work force development for care coordinators, family support providers and their supervisors. Skills-based training has been developed for behavioral aides. Training has been provided for juvenile justice staff in use of new assessment tools, and training on the Sanctuary model to provide a trauma-informed rehabilitative environment for children. The website is www.sanctuaryweb.com. Training across agencies and organizations about family-centered care has resulted in some improvement in this area. A Family Support Provider position has been created that allows experienced family members to support other families. Skills-based coaching and training is being provided for the Family Support Providers.

Collaboration

The Children's Partnership has started to bring a quality focus across agencies and organizations. Integrated quality improvement committees are working to streamline the documentation and quality assurance processes. OHCA Care Coordination staff are overseeing children who use higher levels of care, in an effort to move them back into the home and community with supportive services. OJA has reduced denied claims from almost 30% to none, through the use of a new information system and review process.

Local United Way assessments have identified the behavioral health needs of children and youth as "a quiet crisis" and are funding more programs to address it. The increasing collaborative efforts at the state and local levels are creating an environment that supports the ability to make positive changes in the system. Commitment from Governor Henry, legislators and the child-serving agencies is creating a stronger collaborative vision and working environment. The collaborative work of 24 System of Care Community Teams and Community Partnership Boards is creating similar collaborative efforts at the local level. The OCCY board has made improving the behavioral health system for children their top priority goal for the past two years, and OCCY has implemented multiple projects to initiate collaborative efforts at local levels to improve the system through its Community Partnership Boards.

Tulsa has developed a Children's Behavioral Health Community Transformation Team. The team initially met twice as a large group including inpatient and outpatient behavioral health providers (this included state-funded as well as private, not-for-profit and private for-profit agencies), OJA, OKDHS, Department of Health, Tulsa Public Schools, University of Oklahoma medical health clinic staff, advocacy organizations, parents and youth, and agencies that provide collaboration and support for local systems. The large group worked together to identify areas of need in the community and create small workgroups to focus on specific areas such as but not limited to Quality Customer Service and Access to services.

From the Children's Behavioral Health Team, Tulsa also developed a strategic planning committee which includes CEOs from local service providers, Tulsa Public Schools, advocacy organizations and family members. This group is facilitated by the Community Service Council and works to coordinate the Systems of Care community.

Consumer and Family Involvement

Consumer and family involvement encompasses two distinct concepts. The goal of the first concept is for parents, caregivers and youth to be partners in the planning and implementation of behavioral health services for themselves and their children. In the second, the goal is to have family representatives as partners in system level assessment, planning, implementation and evaluation.

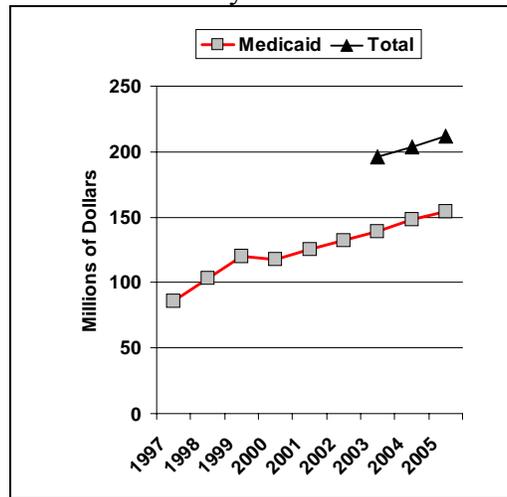
The Partnership Board was established with five family representatives (38.5% of the Board). The composition of the Partnership Board has served as a model for future system-level development. The state and community teams have been established with parent and youth members. Through multiple initiatives, especially System of Care development, Oklahoma has developed a vision and values that support family-centered practice. Family support groups have been started and sustained in many System of Care communities. A family leadership academy has been developed to engage and empower more family members in systems-level work. The OHCA Behavioral Health Advisory Council meets quarterly and includes consumers and family members.

Financing

Over the past five years, there has been a consistent focus and priority on meeting the behavioral health needs of children, youth and families, with increased funding to support these efforts. There is funding to support family and youth involvement in the assessment, planning and implementation processes. For FY07, the Legislature has provided more than \$6 million in additional funding for a range of community-based behavioral health services, including care coordination and family support, crisis centers and mobile units, transition initiatives, school programs, and small community-based group homes. As of July 1, 2006, Oklahoma's Medicaid program has extended the eligibility of children to a full 12 months. The children's collaborative is moving forward with plans to create an integrated and streamlined eligibility, authorization, payment, and data sharing system.

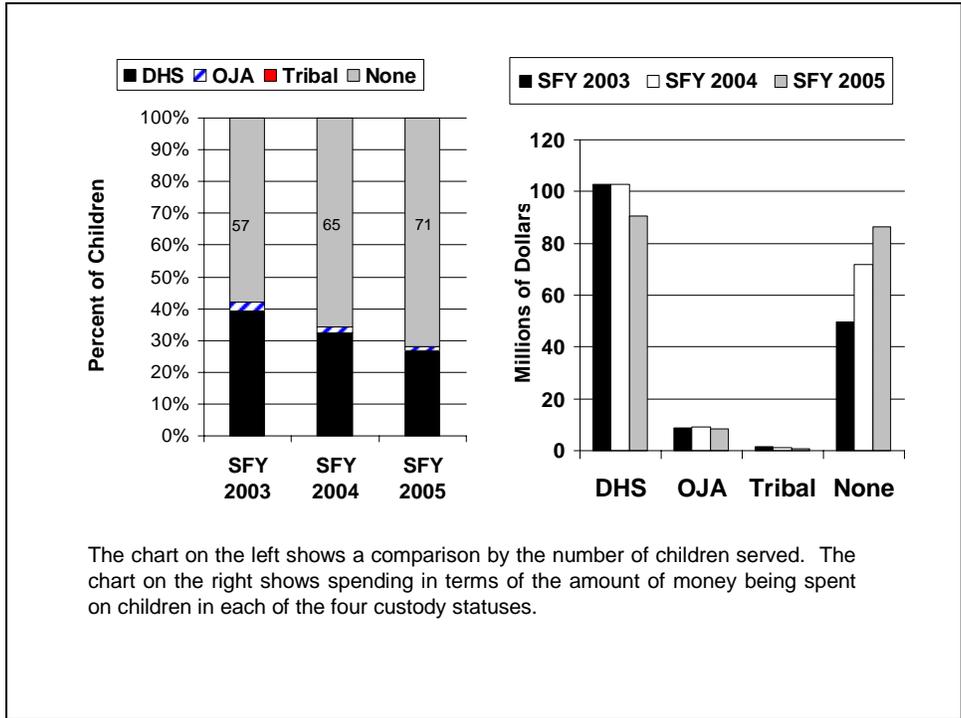
Over the past five years, state and federal funding for behavioral health services for children and families has increased. Exhibit 4.4 shows the total amount of state and federal spending (excluding OSDE).

Exhibit 4.4.
Amount of State and Federal Spending
by Year



There has been a shift toward a larger proportion of children not in custody receiving public behavioral health services. Exhibit 4.5 shows the spending for behavioral health services by custody status of the child for the past three state fiscal years. The amount of money being spent on non-custody children has increased during those three years, while the amount spent on children in custody has decreased.

Exhibit 4.5.
 Spending for Behavioral Health Services by Custody of Child
 FY2003 – FY2005



Data

OJA has implemented a new information system that supports integrated assessment and planning. This has resulted in almost all youth getting an initial assessment, access to more behavioral health services, and a better match between services and needs. This system has improved Medicaid billing for targeted case management. Another benefit has been fewer audit findings due to the system's validation filters related to documentation requirements for targeted case management services.

Through the System of Care program, ODMHSAS has implemented systems to monitor wraparound process fidelity and outcomes for children and family. Feedback from local staff and families are mixed about this system. Some sites have used the information to monitor process and progress and see benefit in gathering the data. These sites report that having the data available locally and having standardized reports has been very helpful.

At the state level, discussions are ongoing to develop an integrated preauthorization and payment system that will work across agencies and funding resources. A plan and concept to integrate this system has been submitted to CMS and approved, and workgroups are developing specific implementation plans.

C. Needs and Existing Barriers

Unmet Needs

The Surgeon General's Report on Mental Health (DHHS, 1999) reported that the Methods for the Epidemiology of Child and Adolescent Mental Disorders (MECA) study found that an estimated 20.9 percent of children ages 9 to 17 had a diagnosable mental or addictive disorder associated with at least minimum impairment (see Exhibit 4.6). Using this estimate, approximately 90,796 children in Oklahoma age 9 to 17 had a diagnosable mental or addictive disorder in the past six months.

When evaluating prevalence of mental illness among children (excluding addictive disorders), the commonly used term is Serious Emotional Disturbance (SED). SED is defined as a diagnosable serious disorder that meets criteria specified within the DSM-IV, with impairment in specific areas of functioning (ODMHSAS, 2006). Although there are no recent studies to determine the number of children with SED, the federal Center for Mental Health Services (CMHS) published a methodology for estimating SED in the U.S. (GPO, 1998). The methodology was based on the ranking of poverty rates among states in the nation and level of functioning. Using the CMHS methodology, Oklahoma had an estimated 56,476 (13%) youth age 9 to 17 with SED, as shown in Exhibit 4.6. Although the estimate of children with SED has been generally adjusted for poverty, a more refined method of adjustment to state-specific poverty and behavioral health prevalence is required to adequately estimate the number of children in Oklahoma with SED who would be served in the public sector. Researchers in Oklahoma are currently working on this methodology.

Exhibit 4.6. Estimated Prevalence of Mental or Addictive Disorders
Among Youth 9 – 17 in Oklahoma, FY2005

Prevalence Category among Youth, 2004 (N=434,431)	Estimated Prevalence Percent	Estimated Prevalence Count
Any Mental or Addictive Disorder (MECA)	20.90%	90,796
Serious Emotional Disturbance (CMHS)	13.00%	56,476

In Oklahoma, the Medicaid program (administered by the OHCA) serves youth living in households with incomes less than 185 percent of the Federal Poverty Level (FPL), as well as other populations which meet other eligibility criteria. OHCA is the primary funder of medical services, including behavioral health services, for children in Oklahoma. ODMHSAS, OJA, and the Oklahoma Department of Human Services (OKDHS) do not have financial eligibility criteria for youth, but are frequently simultaneously involved in behavioral health services for children. ODMHSAS collects information that can be used as an indicator of poverty status. Data collected by OJA are useful to identify services not funded directly by Medicaid. OKDHS also is instrumental in arranging for services for children. However, data for most children's behavioral health services arranged by OKDHS are reflected in the OHCA data. To better estimate the number of youth in Oklahoma who need publicly funded treatment for addictive or mental disorders, the MECA prevalence rate was applied to the youth population age 9 to 17 with reported household incomes of less than 185 percent of the FPL. It is important to note that the MECA prevalence rate has not been adjusted for poverty and therefore may be a conservative rate. As shown in Exhibit 4.7, applying the MECA prevalence rate to the number of children age

9 to 17 in households with incomes of less than 185 percent of the FPL (177,133) resulted in an estimated 37,021 youth with any mental or addictive disorder.

As shown in Exhibit 4.7, an estimated 32,802 children and adolescents age 9 to 17 with any mental or addictive disorder received mental health or substance abuse services from ODMHSAS, OHCA, and/or OJA in FY2005. Subtracting the number served from the estimated 37,021 children with a mental or addictive disorder living in families with a reported household income of less than 185 percent of the FPL, it is estimated that 4,218 (11.4%) children age 9 to 17 were untreated in the public sector. This estimate does not include children who received treatment provided through resources other than ODMHSAS, OHCA and OJA.

Exhibit 4.7. Estimated Prevalence of Mental Illness or Addictive Disorders and Number Untreated in the Public Sector among Children in Oklahoma, Age 9 to 17, with Household Income at Less than 185 Percent of the Federal Poverty Level

Prevalence Category	Youth Population, Age 9 to 17 with Less than 185% of FPL, 2004	MECA Estimated Prevalence Percent ¹	Estimated Prevalence Count	Number Served in the Public Sector ²	Estimated Number Untreated in the Public Sector ³	Estimated Percent Untreated in the Public Sector ³
Any Mental or Addictive Disorder	177,133	20.90%	37,021	32,802	4,218	11.4%

¹ The MECA prevalence rate has not been adjusted for poverty.

² The estimated number of children age 9 to 17 who received mental health and/or substance abuse services in Oklahoma through the public sector may not include all children who received publicly funded treatment. The number served was derived using data from ODMHSAS (adjusted for poverty), OHCA and OJA.

³ The estimated number and percent untreated in the public sector does not include children who received treatment provided through resources other than ODMHSAS, OHCA and OJA.

The federal Substance Abuse and Mental Health Services Administration's (SAMHSA) Office of Applied Studies (OAS) conducts an annual national survey, the National Survey on Drug Use and Health (NSDUH), that serves as the primary source of information on the prevalence and incidence of substance use in the civilian, non-institutionalized population, 12 years of age or older, in the U.S. In addition to national estimates, survey results are reported for each state individually. Chapter 2 contains the description of the methodology used in the national survey.

As shown in Exhibit 4.8, the annual averages based on the 2003 and 2004 NSDUH indicated that among the 295,421 children in Oklahoma, age 12 to 17, an estimated 20,118 (6.81%) of youth age 12 to 17 were dependent on or abused alcohol in the past year; 18,227 (6.17%) were dependent on or abused illicit drugs in the past year; and 31,640 (10.71%) were dependent on or abused any illicit drug or alcohol in the past year. The estimates for substance abuse or dependence have not been adjusted for poverty because the majority of children who received substance abuse services in the public sector were funded by ODMHSAS and were not required to meet financial eligibility criteria. Additional findings estimated that 99,000 (21.52%) individuals age 12 to 20 had past-month binge alcohol use (OAS, SAMHSA, 2003).

Because ODMHSAS was the primary public funding source for substance abuse services for children, the number of children served for dependence on or abuse of any illicit drug or alcohol was determined using only ODMHSAS data. Subtracting the 1,711 who were served by ODMHSAS from the estimated number in need of treatment (31,640) resulted in an estimated 29,929 (94.6%) untreated youth. This may be an overestimate of unmet need because of the lack of information about treatment funded by other sources (Exhibit 4.8).

Exhibit 4.8. Estimated Prevalence of Substance Abuse or Dependence in Past Year and Number Untreated in the Public Sector among Youth Age 12 to 17 in Oklahoma

Prevalence Category among Youth, Age 12 – 17, 2004 (N=295,421)	Estimated Prevalence Percent	NSDUH Estimated Prevalence Count	Number Served by ODMHSAS¹	Estimated Number Untreated In Public System²	Estimated Percent Untreated in Public Sector²
Alcohol Dependence or Abuse in Past Year	6.81%	20,118	Not Available	Not Available	Not Available
Any Illicit Drug Dependence or Abuse in Past Year	6.17%	18,227	Not Available	Not Available	Not Available
Dependence on or Abuse of Any Illicit Drug or Alcohol in Past Year	10.71%	31,640	1,711	29,929	94.59 %

¹ The estimated number of children age 12 to 17 who received substance abuse services in Oklahoma is not available for alcohol or illicit drugs separately. The estimated number who received services for dependence on or abuse of any illicit drug or alcohol in the past year through the public sector may not include all people who received publicly funded treatment. The number served was derived using data from ODMHSAS only.

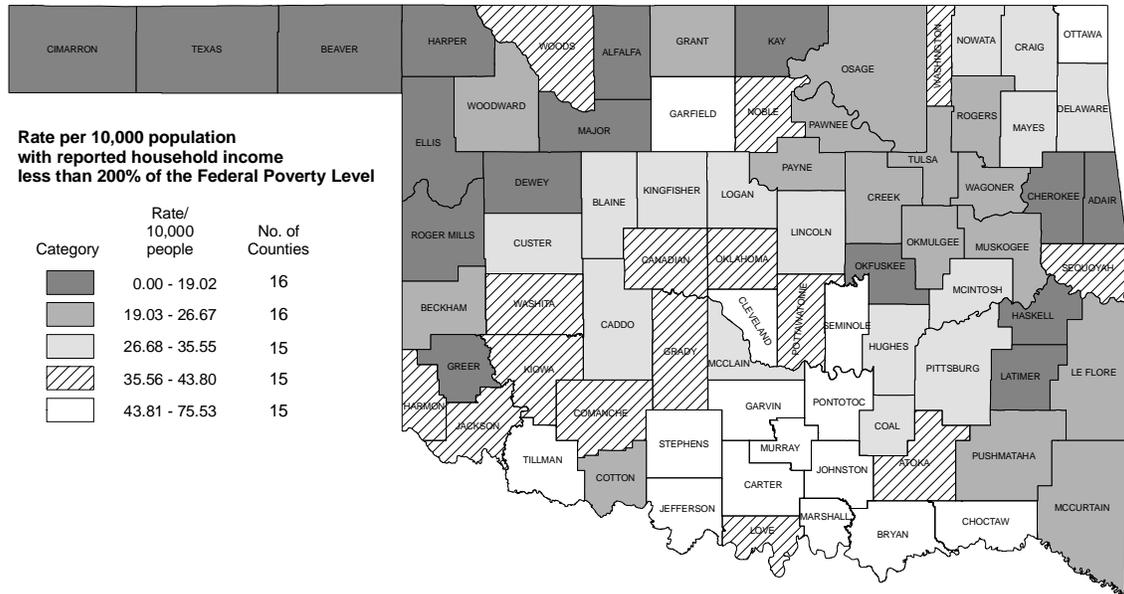
² The estimated number and percent untreated in the public sector does not include children who received treatment provided through resources other than ODMHSAS.

The above projections of how well the behavioral health needs of children and youth are being met in the public sector are based on service data and estimation of need technology. This is done by identifying the number of children eligible for public services, estimating the need for behavioral health services based on past assessment research and the presence of population-based risk factors, and comparing those numbers to the actual number of children and youth who receive behavioral health services.

The following exhibits show the rates of youth served by type of service (mental health or substance abuse) and level of care received in FY2005, per 10,000 youth in Oklahoma in families with a reported household income less than 200 percent of the Federal Poverty Level (FPL) by county of residence. The rates were calculated using the unduplicated count of clients who received services in a given level of care that were funded by ODMHSAS, OHCA and/or OJA, by county of residence, and divided by the number of youth in a county with a reported income less than 200 percent of the Federal Poverty Level. The counties shown in dark gray have the lowest rates while the counties in white have the highest rates.

Mental health services are shown in the next five exhibits with the following levels of care: acute inpatient, inpatient services in a residential treatment center, psychosocial rehabilitation services, outpatient and Systems of Care.

Exhibit 4.9. Youth Receiving Publicly Funded Mental Health Acute Inpatient Services Rates by County of Residence in Oklahoma During FY2005



Rate per 10,000 population with reported household income less than 200% of the Federal Poverty Level

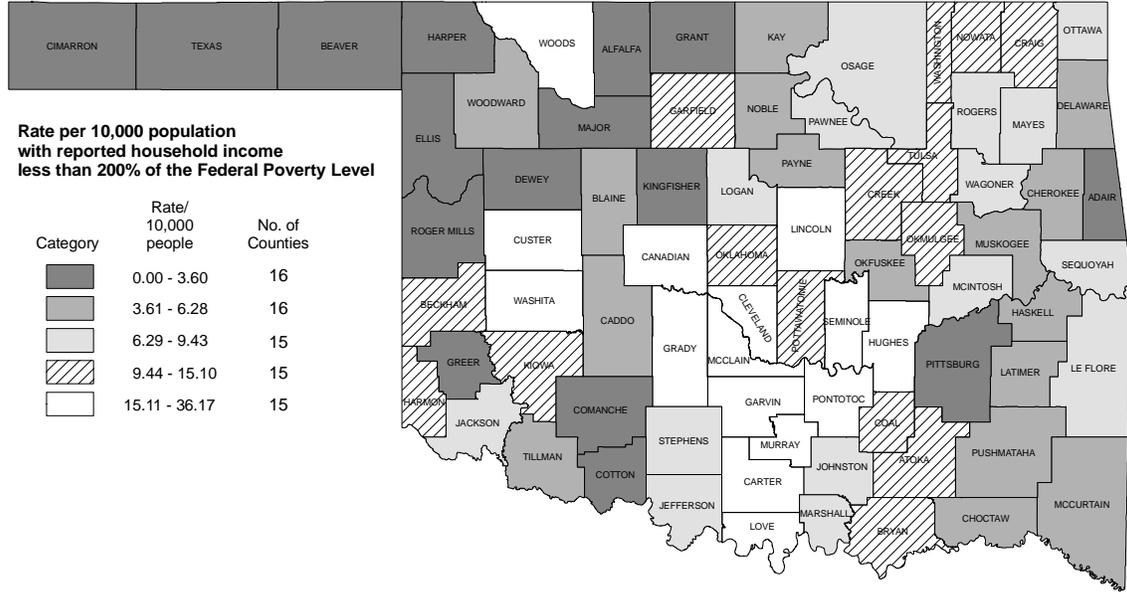
Category	Rate/10,000 people	No. of Counties
■	0.00 - 19.02	16
■	19.03 - 26.67	16
■	26.68 - 35.55	15
■	35.56 - 43.80	15
■	43.81 - 75.53	15

County Measure	Lowest	Rank 10	Median	Mean	Rank 68	Highest	OK County	Tulsa County
Rate/10,000 people	0.00	14.12	31.10	31.75	52.33	75.53	36.68	22.48

Exhibit 4.9 shows the rate distribution of youth who received publicly funded mental health acute inpatient services. The rate ranged from 0.00 in Beaver, Harper, Ellis and Roger Mills counties to 75.53 in Johnston County. The rates in Oklahoma and Tulsa Counties were 36.68 and 22.48, respectively. The median rate was 31.1 and the mean 31.75. To better evaluate the range of rates, the lowest nine ranked counties and highest nine ranked counties were excluded resulting in an inner range of rates from 14.12 to 52.33. Within the inner range, the upper range limit is over three times higher than the lower range limit, indicating a disparity in penetration rates among counties. Counties in the Northwest area had lower rates than the majority of the remaining counties while counties in the South central region had the higher rates.

Exhibit 4.10.

Youth Receiving Publicly Funded Mental Health Residential Treatment Center Inpatient Services Rates by County of Residence in Oklahoma During FY2005



Rate per 10,000 population with reported household income less than 200% of the Federal Poverty Level

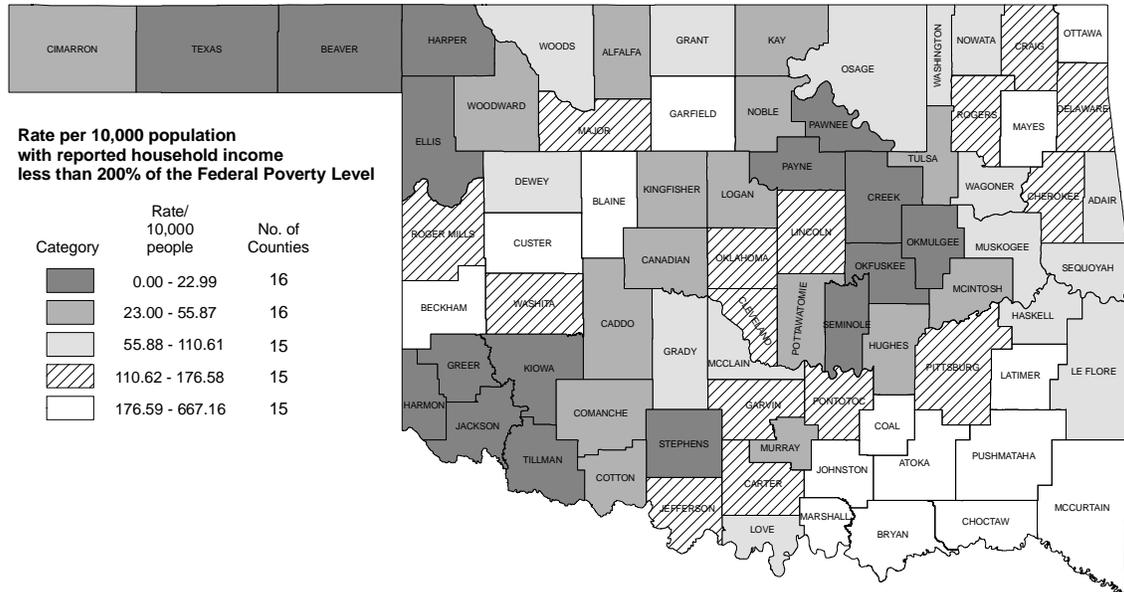
Category	Rate/10,000 people	No. of Counties
Category 1	0.00 - 3.60	16
Category 2	3.61 - 6.28	16
Category 3	6.29 - 9.43	15
Category 4	9.44 - 15.10	15
Category 5	15.11 - 36.17	15

County Measure	Lowest	Rank 10	Median	Mean	Rank 68	Highest	OK County	Tulsa County
Rate/10,000 people	0.00	0.00	7.65	9.16	17.56	36.17	13.26	11.75

The rates of youth per 10,000 population of youth under age 18 from families with low income who received publicly funded mental health inpatient services at a residential treatment center (RTC) are shown in Exhibit 4.10. Those rates ranged from 0.00 in 16 counties to 36.17 in Cleveland County. The median and mean rates were 7.65 and 9.16, respectively. The inner range had a lower rate of 0.00 and higher rate of 17.56, suggesting disparity of services among counties. The rates in Oklahoma and Tulsa counties were 13.26 and 11.75, respectively. As with rates for acute inpatient services, the majority of counties with little or no youth served were in the Northwest region of the state and the counties with the higher rates were in the South central region.

Exhibit 4.11.

Youth Receiving Publicly Funded Mental Health
Psychosocial Rehabilitation Services
Rates by County of Residence in Oklahoma
During FY2005



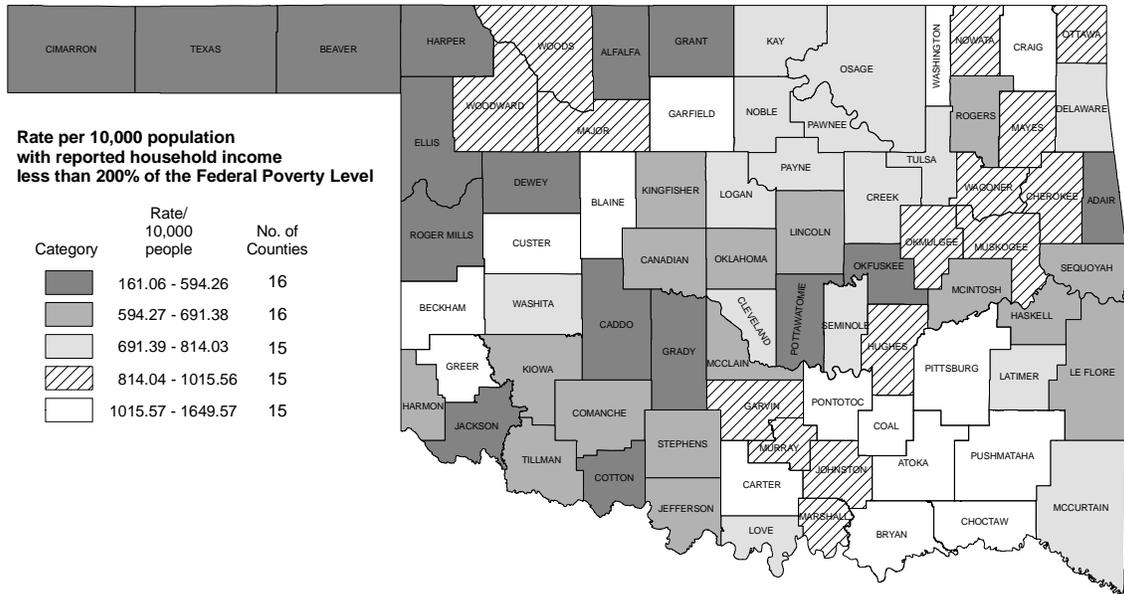
Rate per 10,000 population
with reported household income
less than 200% of the Federal Poverty Level

Category	Rate/ 10,000 people	No. of Counties
(Darkest Gray)	0.00 - 22.99	16
(Medium-Dark Gray)	23.00 - 55.87	16
(Medium-Light Gray)	55.88 - 110.61	15
(Hatched)	110.62 - 176.58	15
(White)	176.59 - 667.16	15

County Measure	Lowest	Rank 10	Median	Mean	Rank 68	Highest	OK County	Tulsa County
Rate/10,000 people	0.00	9.99	80.12	121.92	268.23	667.16	112.39	51.69

The rates of youth who received publicly funded psychosocial rehabilitation services ranged from 0.00 in Harper, Ellis and Harmon counties to 667.16 in Coal County, indicating a large disparity of utilization rates across the state. The median and mean rates were 80.12 and 121.92, respectively. The rate in Oklahoma County, 112.39, was much higher than the rate in Tulsa County, 51.69. As shown in Exhibit 4.11, the counties with the highest rates tended to be in the Southeastern region of the state and there were three clusters of counties with the lowest rates: Northwest, Southwest and the east central regions.

Exhibit 4.12. Youth Receiving Publicly Funded Mental Health Outpatient Services
Rates by County of Residence in Oklahoma
During FY2005



Rate per 10,000 population
with reported household income
less than 200% of the Federal Poverty Level

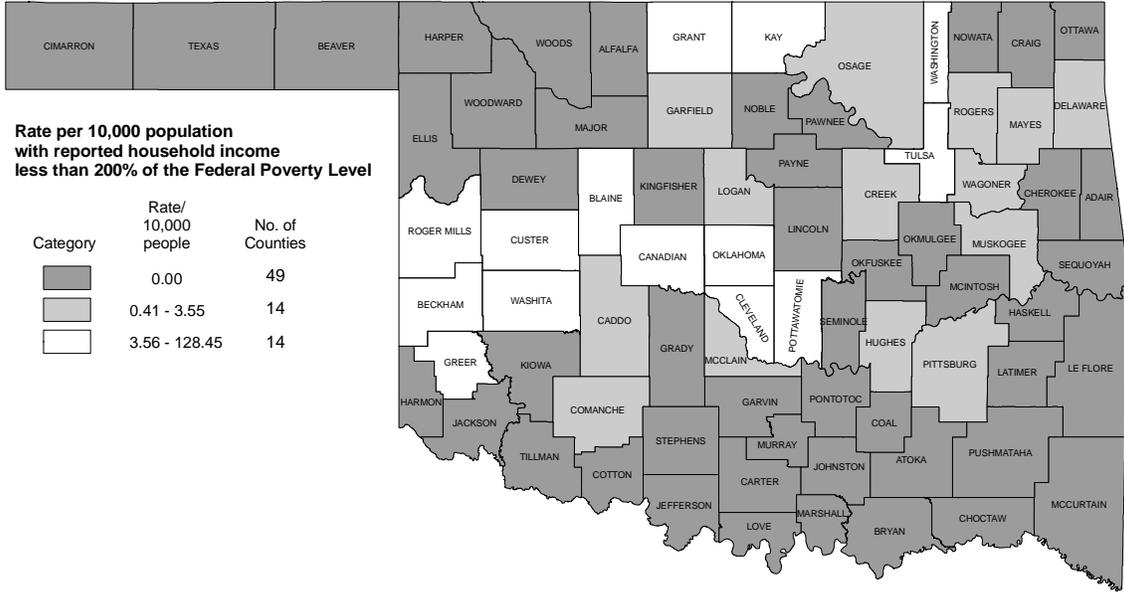
Category	Rate/ 10,000 people	No. of Counties
(Darkest Gray)	161.06 - 594.26	16
(Medium-Dark Gray)	594.27 - 691.38	16
(Medium-Light Gray)	691.39 - 814.03	15
(Diagonal Lines)	814.04 - 1015.56	15
(White)	1015.57 - 1649.57	15

County Measure	Lowest	Rank 10	Median	Mean	Rank 68	Highest	OK County	Tulsa County
Rate/10,000 people	161.06	509.70	714.14	770.02	1076.91	1649.57	686.33	715.98

The utilization rates of publicly funded mental health outpatient services received by youth in lower income families are shown in Exhibit 4.12. The rates ranged from 161.06 in Cimarron County to 1649.57 in Coal County. Evaluation of the counties that ranked 10th and 68th revealed rates ranging from 509.70 to 1076.91, with the higher rate twice the lower rate. This difference in the inner range indicated a small amount of disparity of utilization of outpatient services. The rates in Oklahoma and Tulsa counties were close, 686.33 and 715.98, respectively. A cluster of counties with the lowest rates were in the Northwest region and a cluster of counties with the highest rates appeared in the Southeast region.

Exhibit 4.13.

Youth Receiving Mental Health System of Care Services
Rates by County of Residence in Oklahoma
During FY2005

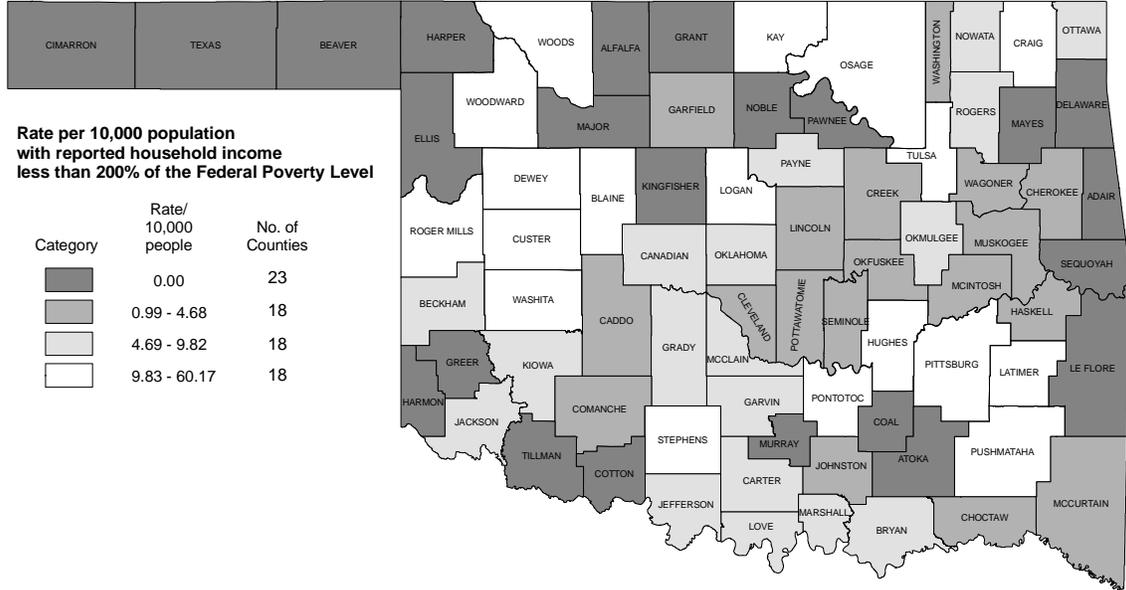


County Measure	Lowest	Rank 10	Median	Mean	Rank 68	Highest	OK County	Tulsa County
Rate/10,000 people	0.00	0.00	0.00	6.92	11.13	128.45	11.13	14.71

Data from ODMHSAS, OHCA and OJA indicate youth enrolled in the System of Care (SOC) programs reside in 28 counties, with rates of youth per 10,000 population ranging from 0.41 in Comanche County to 128.45 in Beckham County. Exhibit 4.13 shows the locations of the counties with youth enrolled in the SOC programs. The mean rate was 6.92 and the rates in Oklahoma and Tulsa counties were 11.13 and 14.71, respectively. The cluster of counties with SOC youth correlate with counties with SOC locations (see Exhibit 4.2 above).

Exhibit 4.14.

Youth Receiving Publicly Funded Substance Abuse Residential Treatment Services Rates by County of Residence in Oklahoma During FY2005



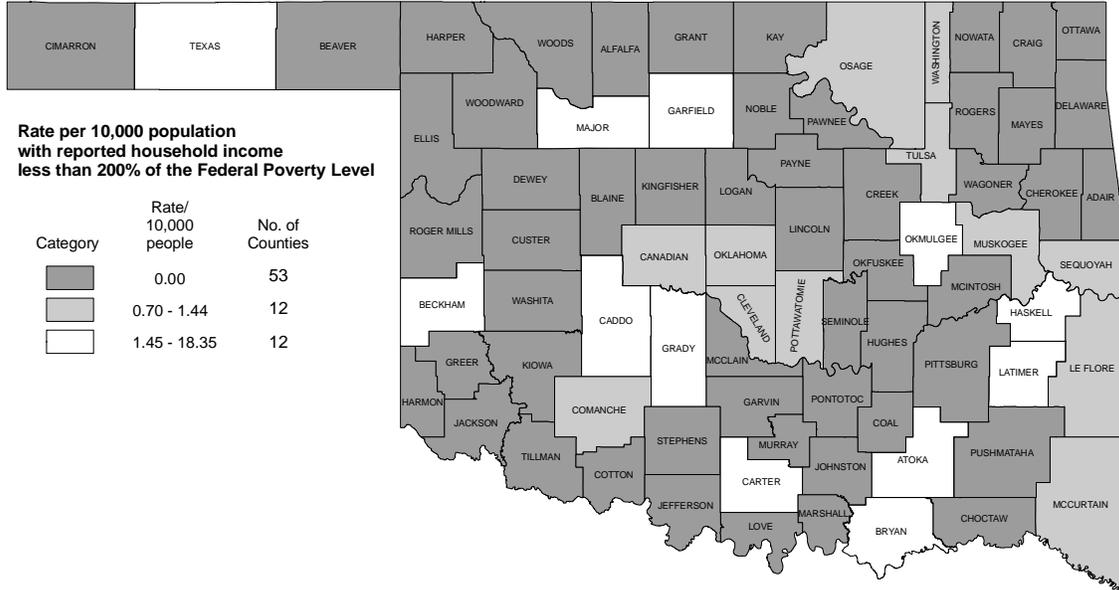
County Measure	Lowest	Rank 10	Median	Mean	Rank 68	Highest	OK County	Tulsa County
Rate/10,000 people	0.00	0.00	4.22	7.10	16.95	60.17	7.66	12.47

The rates of youth per 10,000 from families with low income who received substance abuse services in FY05 are shown in Exhibits 4.14 through 4.16. The levels of care include residential treatment, halfway house services, and outpatient services.

Exhibit 4.14 shows the rates distribution of youth who received publicly funded substance abuse residential treatment services. Among the 77 counties in Oklahoma, no youth received residential treatment services in 23 counties. Among the counties with youth served, the rates ranged from 0.99 in Wagoner County to 60.17 in Dewey County. The rates in Oklahoma and Tulsa Counties were 7.66 and 12.47, respectively. The median rate was 4.22 and the mean 7.10. Peripheral counties tend to have no youth receiving residential treatment services compared with the majority of the counties

Exhibit 4.15.

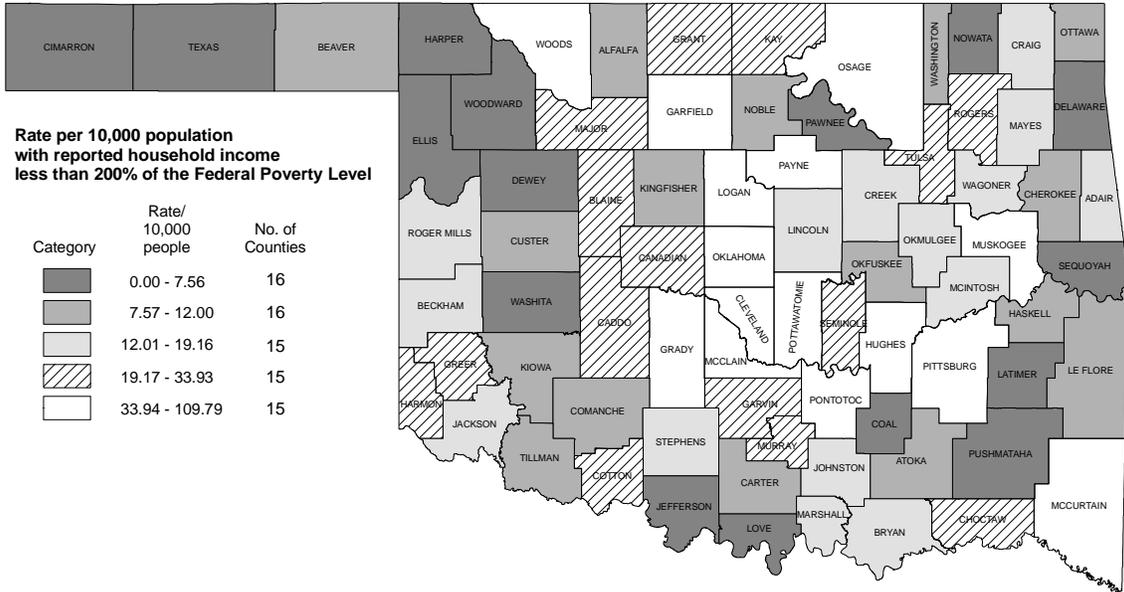
**Youth Receiving Publicly Funded Substance Abuse
Halfway House Services
Rates by County of Residence in Oklahoma
During FY2005**



County Measure	Lowest	Rank 10	Median	Mean	Rank 68	Highest	OK County	Tulsa County
Rate/10,000 people	0.00	0.00	0.00	0.95	2.40	18.35	0.71	1.44

Exhibit 4.15 shows the rates of youth who received publicly funded substance abuse halfway house services. The majority of counties (53) did not have any youth who received services, and among the 24 counties that did, the rates ranged from 0.70 in Muskogee County to 18.35 in Beckham County. The mean rate was 0.95 and the rates in Oklahoma and Tulsa counties were 0.71 and 1.44, respectively. There is no apparent geographic pattern of counties with rates greater than zero.

Exhibit 4.16. Youth Receiving Publicly Funded Substance Abuse Outpatient Services Rates by County of Residence in Oklahoma During FY2005



Rate per 10,000 population with reported household income less than 200% of the Federal Poverty Level

Category	Rate/10,000 people	No. of Counties
■	0.00 - 7.56	16
■	7.57 - 12.00	16
■	12.01 - 19.16	15
▨	19.17 - 33.93	15
□	33.94 - 109.79	15

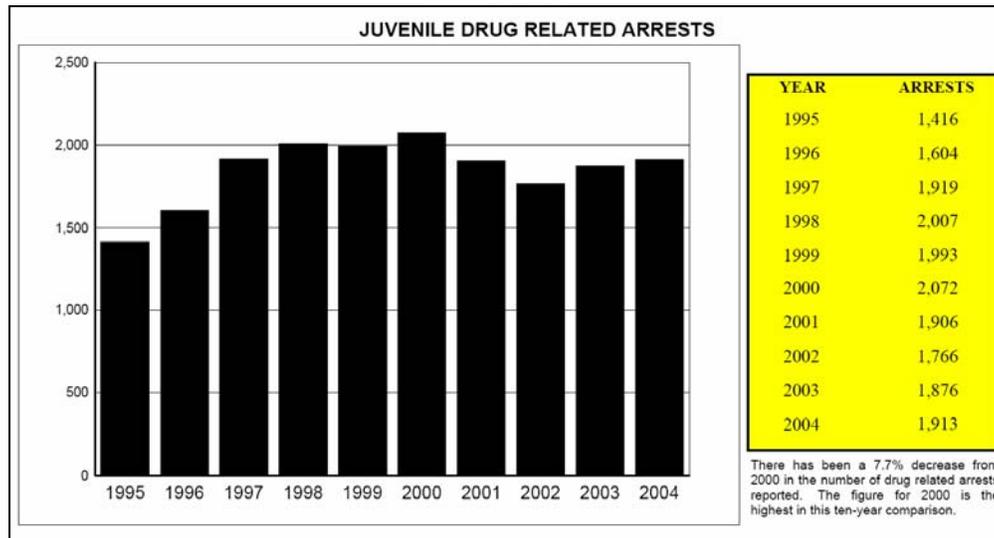
County Measure	Lowest	Rank 10	Median	Mean	Rank 68	Highest	OK County	Tulsa County
Rate/10,000 people	0.00	3.54	15.73	22.07	40.41	109.79	47.09	29.12

The rate of youth who received publicly funded substance abuse outpatient services ranged from 0.00 in eight counties to 109.79 in Woods County. As shown in Exhibit 4.16, there was a cluster of counties with high rates in the Central region and a cluster with low rates in the panhandle. The median rate was 15.73 and the mean rate was 22.07. The inner range contained a low rank of 3.54 and a high rank of 40.41, a multiple of more than 10, indicating disparity of youth served across the counties. Oklahoma and Tulsa counties had rates of youth who received substance abuse outpatient services of 47.09 and 29.12, respectively.

Alcohol-related arrests (driving under the influence, drunkenness, and other liquor law violations) accounted for 29.0 percent of all arrests in 2004. This percent represents the arrest of 45,920 adults and 1,773 juveniles.

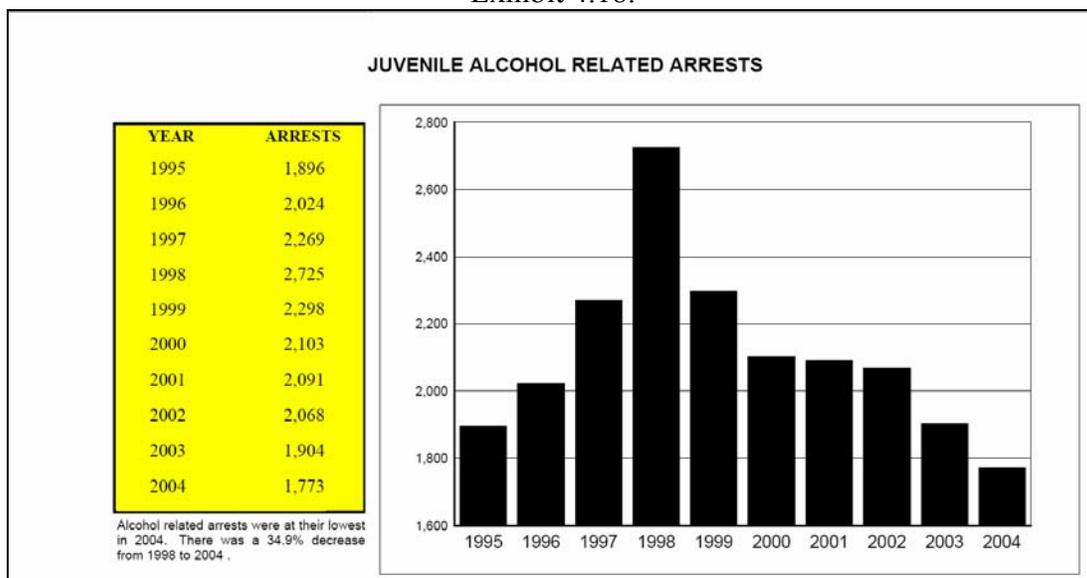
Exhibit 4.17 indicates the number of drug-related arrests among juveniles in Oklahoma from 1995 through 2004. The number of arrests peaked in 2000 with 2,072 but has been rising since 2002 from 1,766 in 2002 up to 1,913 in 2004 (OSBI, 2006).

Exhibit 4.17.



The number of juvenile alcohol-related arrests in Oklahoma has been on a steady decline since 1998, as shown in Exhibit 4.18, with 1,773 in 2004 (OSBI, 2006).

Exhibit 4.18.



In 2001, ODMHSAS conducted face-to-face surveys 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 percent. Every 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 seventy-one percent had used in the last month. Of the total weighted sample, 353 (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 percent.

When asked about their interest in participating in treatment, 42.9 percent of the youths found to be abusing substances reported that they would be interested, while 65.2 percent of the substance-dependent youths reported an interest (ODMHSAS, STNAP PHASE II, 2001).

In addition to substance abuse questions, a series of mental health questions were asked of the survey respondents. 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.

Policy

The lack of access to community-based services is the biggest challenge and is directly related to state policies and rules. Eligibility criteria favor children and youth in public custody. It is expected that children in custody will have a much higher need for behavioral health services, but even factoring in this higher need, a child in custody is more than three times more likely to receive needed services than a child who is not in custody. One outcome of access barriers is an increase in the number of children in OKDHS and OJA custody. One mother reported that she had been told by community providers that the only way to get her daughter the services she needed was to “abandon her” to child welfare custody. Another mother related that, “The day my daughter got arrested I knew it was an answer to a prayer because she would finally get the help she needed.”

Another challenge is the way that eligibility criteria are used in CMHCs to restrict access to public services. Eligibility criteria and interpretation of medical necessity in CMHCs results in services being reserved for children with the most severe problems. Failure to provide early services means that children and youth end up getting more restrictive and expensive services than they would otherwise have needed. A mother reported, “We knew something was wrong for several years but the CMHC said he did not meet eligibility criteria. He finally flipped out and now has been in and out of the hospital for two years.”

The triage approach to focusing on the children and youth with the most severe challenges is creating an over dependence on non-evidenced based, out-of-home and out-of-community residential services. While the overall amount of spending for children’s behavioral health services has increased over the course of the past few years, per capita spending for children eligible for public services has decreased, and the amount of community-based services per capita has significantly decreased.

Services are also limited by the type and amounts of services that are approved. The prior authorization processes for several of the public funding sources have set criteria for specific amounts of traditional (although not evidence-based) services such as outpatient therapy and family therapy with the identified child present, but make it much more difficult to justify rehabilitative services in the continuum. This results in cookie cutter services that are not

individualized. A local provider said, “The only service I can get approved is therapy in the office and only for a fixed number of sessions. It is not worth the hassle to ask for permission to do more. Sometimes I do one or two more for free because it takes less time than the paperwork.”

Another policy challenge to accessing the right service for children and families is that agency and program-specific funding stream rules often result in services that are based on the needs of the program funding the service, instead of based on the needs and preferences of the youth and family. One mother described the problems that this can cause for families. “I have three children in the system. The oldest just got out of OJA. He had a counselor he liked when he was in foster care (OKDHS) but when he came home he had to change because Medicaid did not pay for the one with the foster care (TFC). Then he got arrested and OJA made him get a new therapist. Now that he is coming home, he has to get a new one. It is crazy. Worse, his younger sisters are not in the system and they get their therapy from another agency, so I have to get them all over town and no one works together.”

The rates for services do not cover the cost of transportation, creating a significant barrier, especially for children in rural areas. Often the requirements of the different funding streams mean there is not enough work to maintain staff. A rural provider explained why they had dropped several services: “We have to drive out to the community and do not get paid for travel time. If the person does not show, we do not get paid at all. We may only have two youth at a time on the CARS contract, but another provider does CHBS, and the CMHC has their funding stream. We cannot afford to pay the staff a salary and cannot retain them on contract status.”

The complexity and amount of required paperwork to justify and document services significantly reduces the amount of services that can be provided. Estimates suggest that paperwork and documentation take 60 to 65% of staff time, compared to an optimal level of 12 to 15%, decreasing the time that providers are available to deliver services by 200%. These facts suggest that fixing this one barrier could double the amount of services available with current staff. An OHCA staff person explained to a group of providers, “We need to make sure there are no requirements to pay back the federal Medicaid agency (CMS) following audits by the regional office. We know that this requires a lot of documentation to protect providers from this payback and we expect staff to spend 65% of their time on paperwork.”

The differences and complexities of policies and procedures across agencies are a significant burden for providers. The majority reported that they find pre-authorization and quality monitoring adversarial to the point that some choose to limit services to those that can be easily justified or to eliminate services provided to children and families through the public system all together. This reduces individualization and effectiveness of services. An agency director said, “We hired two people just to do the paperwork because we could not train all our staff to do it right. They develop the plans and then the other staff provided the services.” The focus of policy and rules on documentation is frustrating for providers and families, and results in an organizational culture that values good paperwork instead of quality services or good outcomes.

Policy also impacts the ability and success of the state to draw down federal participation. For example, for OJA providers, it is easier to bill CARS than Medicaid, so they use 100% state money. A director of a provider agency explained, “We tried Medicaid billing but it took so much time and then they took our CARS funding away. Overall it cost us time and money. Why bother?” Providers find that current documentation required to support service claims result

in organizations spending valuable time ensuring compensable documentation making less time available to focus on quality services and good outcomes. The combination of the diffuse responsibility for behavioral health services across multiple state agencies, and the board structure that governs each of these agencies, makes it difficult to make coordinated change to improve the system.

Practices/Services

While there has been increased funding and expanded behavioral health services in the past three years, at the same time, the number of children and youth eligible for behavioral health services has increased at a faster pace than has spending, creating a larger gap in unmet need. Although there has been a focus on keeping children and youth in the community, spending on residential placements has increased, while spending on community-based services has remained largely unchanged, resulting in a larger disparity between values and spending on services.

The lack of early access options results in children having developing more serious needs and placing demands on higher levels of care. One mother explained, “___ started having problems when he was three but we were told we would have to wait until he was six. He got worse and we got play therapy when he was five. Our doctor (pediatrician) started him on Depakote when he was six, but he just got worse. Finally, when the school could not handle him in second grade, people started to believe us.”

Difficulty in accessing appropriate services is very hard for families. Although they may be accepted into the Systems of Care or other program, there is often a waiting period of several weeks when there is no one to help. The family may go back into crisis, lose hope and risk removal of children from the home.

Limited access to a full continuum of community-based services results in more use of out-of-community residential services. An OKDHS supervisor said, “We want to keep almost all of our kids in their home communities, but the first priority is safety. When there are not enough services or providers to keep the kid safe, we must place them.” Many of the children and youth with severe challenges have needs within multiple systems, and would benefit from cross-agency care coordination and family support, but the capacity of these services is limited.

Although the survey ratings for linguistic competency were higher than most other values, the interviews and focus groups told another story. There are a growing number of children and family members who speak English as a second language or do not communicate at all in English. There are few people who provide behavioral health services in other languages and the amount of unmet need in this area is increasing.

Transportation to services was listed as the number one barrier to access. A mental health provider explained, “We know that for many families it works a lot better to go to them for services, but we don’t have the time or funding for the transportation.” One mother said, “I have three kids who need services and they go different places and I don’t have a car. We miss and then they charge us.”

Surveys and focus groups consistently rated individualization as the System of Care value least often met, describing barriers in the authorization process, funding streams, lack of a full continuum of community-based services, and lack of staff that all result in cookie-cutter response to the unique needs of children and families. One community team member observed, “We reviewed 10 cases of children who had been placed in residential multiple times. There were simple things that could have been done early that might have kept half of them from starting the

revolving door. One seven year old girl needed a one-to-one aide at school. One foster family needed available crisis help and a couple of days of respite each month.”

Often families cannot choose their providers or are required to change providers because of funding policies. A mother complains, “We had a therapist who was good on our private insurance, but when the insurance ended she wouldn’t take Medicaid and we had to change. When ___ got arrested and was in OJA, they made us change therapists again. The new therapist told us ___ had some abandonment issues. Duh!”

Families often have multiple plans that are not coordinated and may even be contradictory. One family with three children asserted, “We have sixteen different staff for the five of us and they all have different plans. They say we are not well-organized and they wonder if we are committed to getting better because we miss some appointments.” Focus groups and interviews consistently supported that agency staff, providers and families are often not aware of available resources and how to access them.

While many families are ready and willing to work with the childcare system, not all families are prepared to do so. Prior experiences, either as adults or as children, make some parents very reluctant to respond to assistance that is offered. Child welfare staff and officials also estimate that 80 percent of cases of abuse and neglect involve families in which one or both parents have a major substance abuse problem, often involving methamphetamines. OKDHS provides \$3 million of TANF funds annually to support substance abuse services for these families. (These funds are transferred to ODMHSAS which contracts with its provider network.) However, the problems experienced are increasing.

Another major gap is the lack of services available to adolescents when they “age out” of the child serving system in turning eighteen. Although they are no longer eligible for adolescent residential services, they are often still in need of services and supports. One child welfare worker described dropping an 18-year-old girl off at a shelter on Easter Sunday after failing to find an appropriate placement for her. Others expressed concern about clients who would become homeless because the adult mental health system was not prepared to accept them.

Early Intervention with Children 0-5 Years Old

In order to be successful in school and later in the workforce, children must possess important social skills and emotional control, as well as cognitive skills with language and symbols. However, a significant number of children do not have those critical abilities due to delays caused by a number of conditions. Some of the most common conditions that appear to be on the increase in Oklahoma and nationwide are autistic disorders and problems associated with drug and alcohol exposure during pregnancy and after birth due to parental use. It is important that services be available that can support children’s developing brains and ameliorate some of the negative impact of these conditions. Evidence indicates that quality interventions and services for children with social/emotional and behavioral delays and difficulties are effective. Services at an earlier age can have a significant positive impact on a child’s self-perception, academically and socially. Yet in Oklahoma, we have few services available, and early screening for social/emotional and behavioral concerns is not the norm. Few training programs prepare mental health care professionals in the basics of screening, assessing or treating these children and their families. Professionals working in the primary health care system and the day care system are most likely to have ongoing contact with this population, but they are often not well-trained in this area. This results in most of the behavioral and social/emotional problems and concerns being picked up once the child starts school. All of the

shortcomings of the behavioral health care system for older children are most often more pronounced for our youngest citizens.

Workforce Development and Training

There is a general recognition that the lack of providers and staff who are willing and qualified to provide public behavioral health services is one of the largest barriers to meeting the needs of children and families, and this is especially true for rural areas. The biggest needs are for psychiatrists, mental health and substance abuse specialists, therapeutic foster care parents, and respite care providers.

System of Care pilots face high turnover and difficulty recruiting care coordinators and family support providers. A wraparound supervisor said, "It is hard to find staff and it takes six months before they are good at it. Then they leave. They love the work but hate all the stuff the state makes them do." Recruitment practices within communities are fragmented and competitive, resulting in duplication of effort and gaps in strategies and coverage.

High turnover rates are a general problem among childcare workers. OKDHS staff may face caseloads as high as 70 families for permanency planning and each family can have multiple children who may go to different placements. The constant pressure leads to burnout. When one staff member leaves her/his caseload is distributed among other staff, making the problem worse. It can take months until a new staff member is employed and trained and then additional months until they begin to gain the experience to do the work properly.

OKDHS staff observe the same problems of training and turnover at residential placements. As one person described it "even if you get the right match of the facility, the staff are young and not well-trained and get into conflicts with the kids rather than relating to them. Then they (the kids) are discharged to a shelter."

Research demonstrates the importance of professional supervision, showing when supervision is strengths-based, empathetic and focuses on the quality and outcomes of services, that services improve, staff are more satisfied, and turnover decreases. When supervision focuses on administrative issues rather than on clinical work, services suffer and staff are conflicted. In Oklahoma, estimates are that 75 to 90% of supervision focuses on administrative issues because of documentation requirement and funding concerns.

Organization/Collaboration

Most staff are funded through fee-for-service mechanisms that prioritize their time in some form of billable services and do not pay for collaboration. A supervisor of a community agency said, "Our board focuses on the bottom line so that we have enough money to operate. We can not bill for the time in team meetings so we tell our staff they can only go on their own time." For staff that are already spread thin, this further discourages them from collaboration. A provider said, "I like developing a plan with the other providers, but the facilitator (care coordinator) has to fill out a form for Systems of Care and another one for DMH, and I have to do one for my agency and then sometimes there is another one for OFMQ." (Oklahoma Foundation for Medical Quality; until July 1, 2006, OFMQ functioned as the Quality Improvement Organization (QIO) contracting with the Oklahoma Health Care Authority. They were responsible for post payment reviews of the CMHCs and preauthorization for private behavioral health providers. APS Healthcare, Inc. now serves in that capacity.)

Confidentiality requirements do not allow for easy sharing of information, which prevents need collaboration. In fact, rules about confidentiality and HIPAA restrictions on the ability to share information prevent agencies in most communities from working together.

Funding streams often prevent individualizing services and keep staff from different agencies from working together for a child and their family. A community provider explained, “When the family has multiple kids with multiple staff, it makes sense to do one plan, but the reality is that the funding streams decide what we do and who we can hire to do it.” Children and families with tribal status face additional barriers to individualized and quality services. A tribal member explains, “In addition to all the state stuff, we have three tribal funding sources that have different rules and who can figure it all out.”

Data

Each state agency has its own information system; efforts have been ongoing for several years to link these data systems on some critical functions (e.g., financial eligibility, Medicaid enrollment, custody status), but at the child and family level and for integrated systems planning, the separate data systems are a barrier. Each of the state agencies has their own quality standards and quality assurance processes. Many of the providers receive funding from multiple state agencies, which means they must meet different standards, rules and processes related to funding source.

Focus groups and interviews indicate the challenges providers face in regard to data and quality assurance activities. Providers believe that the current process of monitoring documentation does not consider the quality or outcomes of services. Providers felt it necessary to focus on quality of documentation as opposed to service provision. Additionally, they perceived this oversight as designed to catch them making mistakes and as missed educational opportunities. Consequently, they communicated a reluctance to pursue potential flexibilities and creative opportunities in the continuum of community based services.

Financing

While Medicaid offers the potential of increased federal funding, the process of authorization, documentation and auditing is perceived to be so complex and adversarial that some providers do not serve Medicaid-eligible children, and others choose to bill 100% state funding sources. Providers may also choose not to provide public services because of low reimbursement rates, creating further gaps in the continuum of services. Providers report that they would expand services except for problems with financing and threat of recoupment. An urban therapist said, “It might be o.k. to start with an agency that provides Medicaid services, but once you get established, it is easier and pays better to do private insurance and direct payment.”

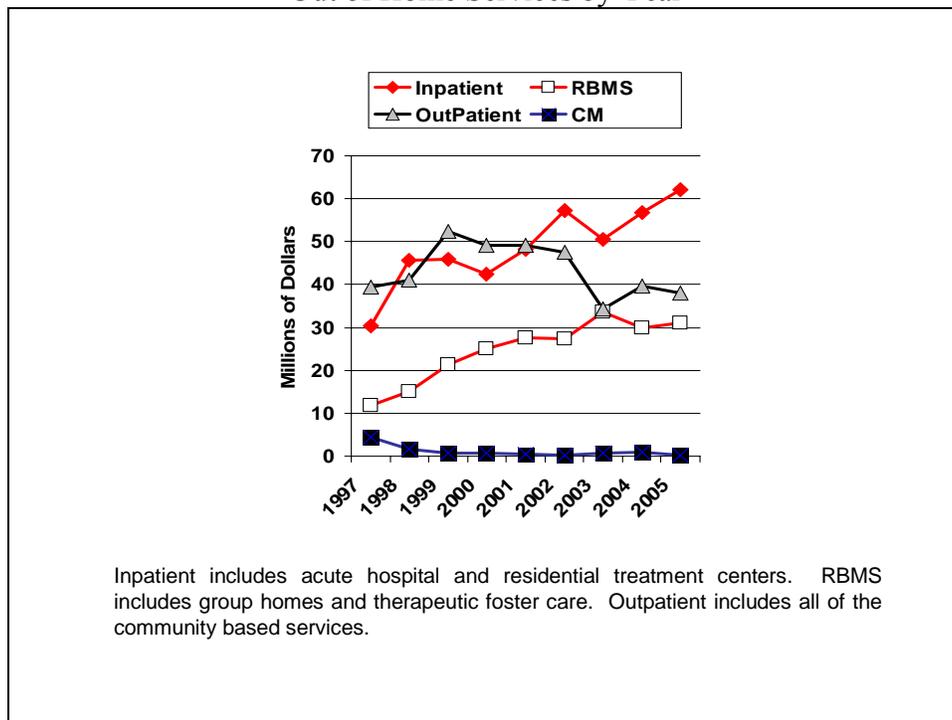
Paperwork requirements do not only affect providers. One youngster we interviewed reported that “I have to tell my story over and over again for medications, counseling, etc. When I went to (residential facility), fifty people asked why I was there... After discharge, it took three hours to check out with all the paperwork.”

A related difficulty is assuring that families maintain their Medicaid enrollment. Because low income families are more likely to move, they may miss letters informing them of the need to take steps to accomplish this. While OKDHS has attempted to increase staff outreach to avoid this problem, staffing reductions have undermined their capacity to do so. As a result, children may lose their Medicaid enrollment, further complicating their access to services.

Providers also consider audits inconsistent and adversarial and they communicated a reluctance to pursue potential flexibilities and creative opportunities in the continuum of community based services. Federal scrutiny of school-based programs has made schools wary of providing behavioral health services, citing inconsistency of funding and threat of recoupment as significant deterrents. OJA experience with federal IV-E funding from the Social Security Administration and recoupment have made them very cautious in using federal funding and creative services. The fee-for-service basis for paying for most behavioral health services does not support providers in rural areas because of transportation costs and time spent. Needed supervision is not covered in the rates for most services. Equally important, rates are not increased on a regular basis and do not reflect the costs of delivering quality services.

While the vision of system development is to maintain children in their homes and communities, funding is increasingly being spent on out-of-home and out-of-community services, as shown in Exhibit 4.19. Nationally, Oklahoma has been ranked from 7th to 9th in *per capita* out-of-home placements in the past few years.

Exhibit 4.19. Medicaid Expenditures for Out of Home Services by Year



References:

DHHS (1999). *Mental Health: A Report of the Surgeon General—Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

DHHS (2003). New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. DHHS Pub. No. SMA-03-3832. Rockville, MD.

GPO (1998). *Children with Serious Emotional Disturbance; Estimation Methodology*. Federal Register: July 17, 1998 (Volume 63, Number 137) Published by the Office of the Federal Register, National Archives and Records Administration. Retrieved August 2006 from <http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi>.

OAS, SAMHSA (2003). *National Survey on Drug Use and Health, The NSDUH Report, February 7, 2003*. Retrieved July 2006 from <http://www.oas.samhsa.gov/2k3/NSDUH/nsduh.htm>.

ODMHSAS, STNAP Phase II (2001). *Oklahoma State Treatment Needs Assessment Studies, Phase II; Final Report on Study #2; Face to Face Surveys of Criminal Justice Populations*. Oklahoma City, OK: Submitted to the SAMHSA, Center for Substance Abuse Treatment, Contract Number 270-98-7066 by the Oklahoma Department of Mental Health and Substance Abuse Services.

OSBI (2006). *Crime in Oklahoma, 2004 Uniform Crime Report, Oklahoma State Bureau of Investigation*. Retrieved September, 2006 from <http://www.osbi.state.ok.us/Publications/CrimeStats/ucr2004.pdf>

Chapter 5: Adult Substance Abuse Services

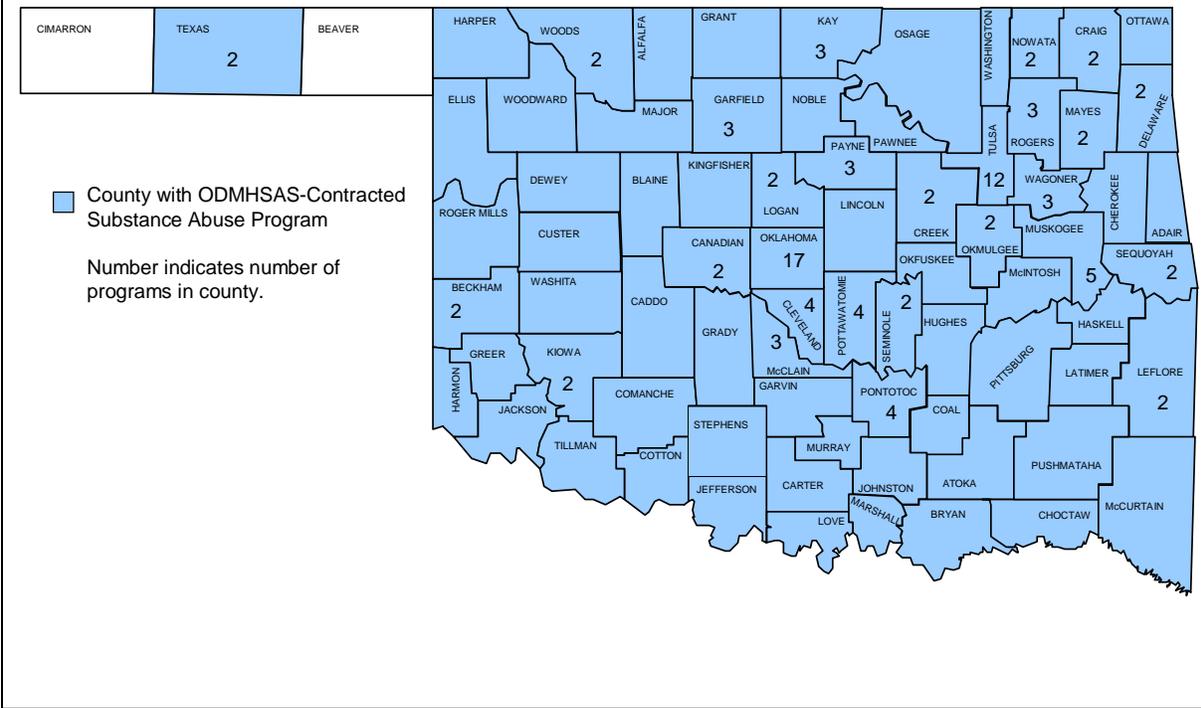
The purpose of this chapter is to describe substance abuse services for adults, including existing resources, particular strengths of current programs, and needs. The chapter includes narrative information gathered through focus groups and personal interviews, as well as existing data from ODMHSAS and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

A. Existing Resources

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

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

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



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

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

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

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

B. Strengths

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

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

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

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

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

Collaboration with the Department of Human Services (OKDHS) benefits both agencies' clients. OKDHS provides funding to ODMHSAS to subcontract with certified treatment agencies to provide screening, assessment, and outpatient substance abuse services to clients receiving or

making application for Temporary Assistance to Needy Families (TANF) and clients who have Child Welfare involvement.

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

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

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

C. Needs and Existing Barriers

Unmet Needs

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

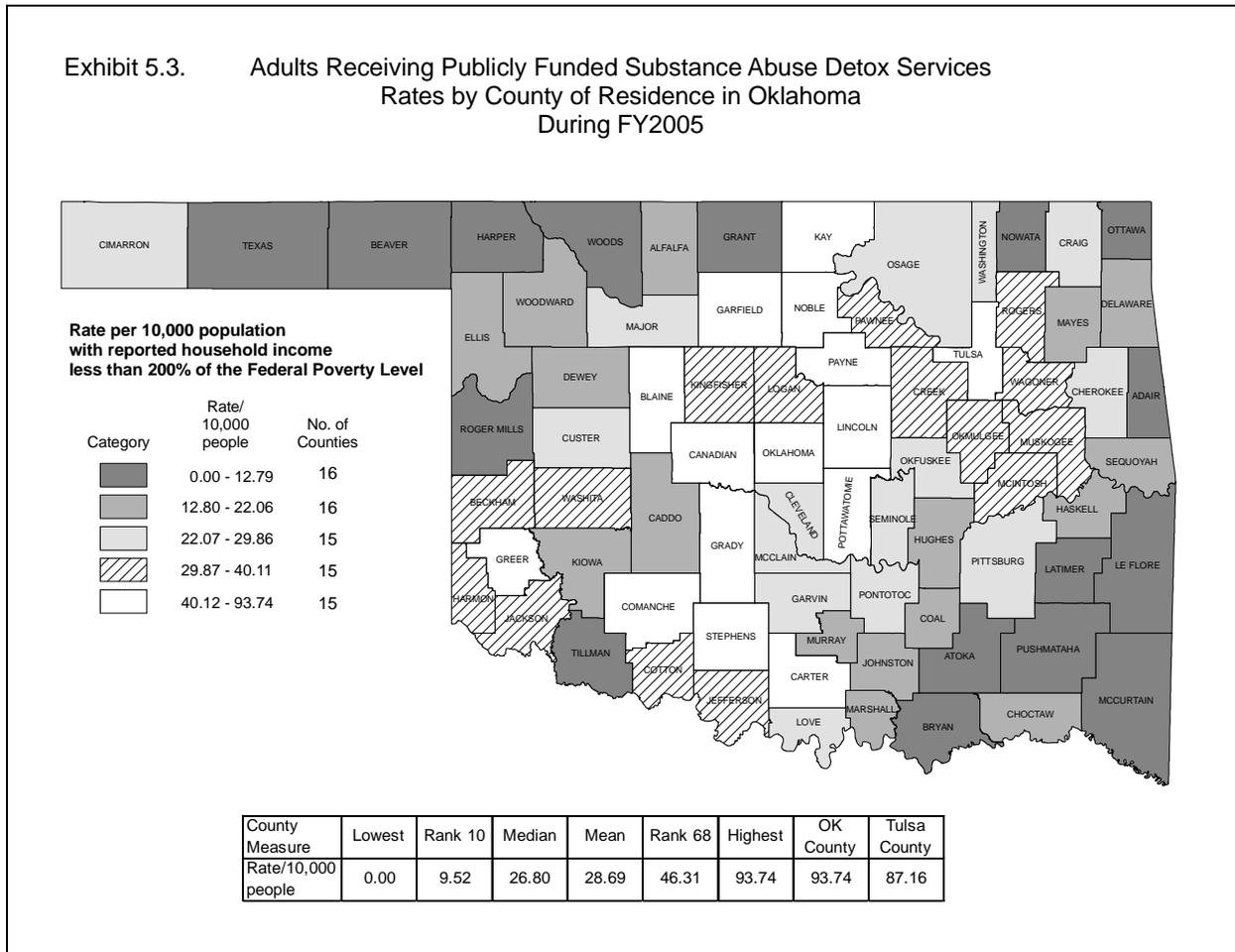
Exhibit 5.2. Drug of Choice for ODMHSAS Substance Abuse Clients Age 18 and older

Admission Year	Total Clients	Drug Type													
		Alcohol		Marijuana		Methamphetamine		Cocaine		Stimulants		Heroin		Other*	
		%	#	%	#	%	#	%	#	%	#	%	#	%	#
FY2001	11,666	69.0	8,045	46.1	5,383	28.4	3,308	19.9	2,317	8.4	980	5.5	644	4.4	518
FY2002	12,530	67.1	8,402	45.9	5,752	28.6	3,588	19.7	2,463	8.1	1,019	6.2	772	4.1	518
FY2003	12,715	64.4	8,194	43.6	5,544	28.4	3,605	20.0	2,538	8.5	1,076	6.2	783	4.4	557
FY2004	13,046	58.7	7,652	45.1	5,883	31.4	4,101	19.6	2,555	8.3	1,082	7.6	995	3.7	484
FY2005	13,703	57.3	7,857	44.2	6,052	31.2	4,280	22.2	3,041	8.8	1,200	8.9	1,222	3.5	479

*Other includes: Sedatives, LSD and Inhalants

The following exhibits show the rates, by level of care received in FY2005, per 10,000 adults in Oklahoma with a reported household income less than 200 percent of the Federal Poverty Level by county of residence. The rates were calculated using the unduplicated count of

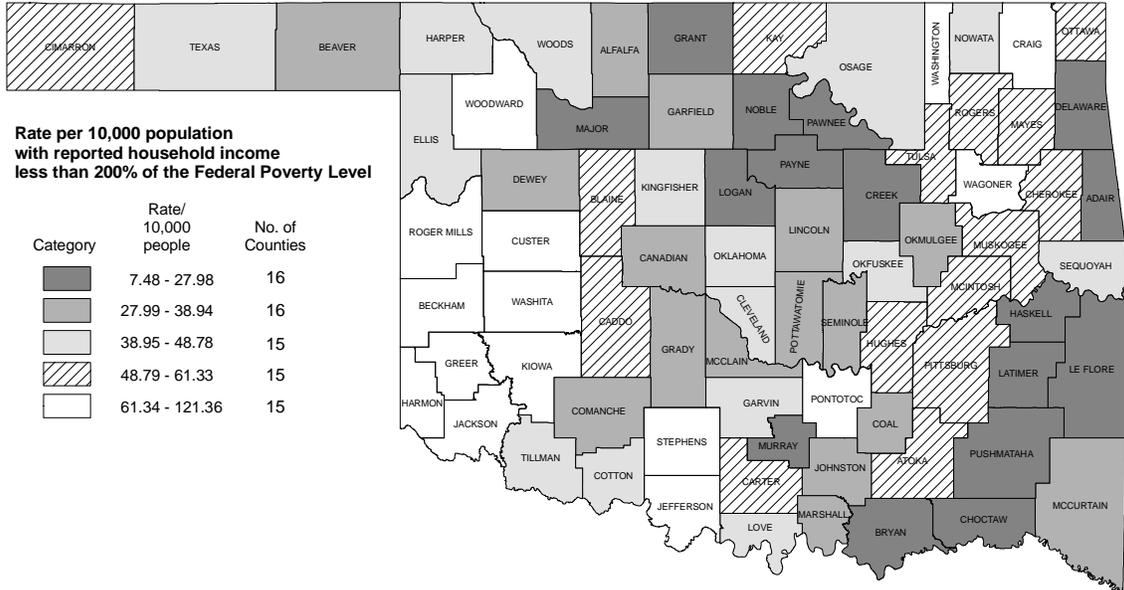
clients who received services in a given level of care and funded by ODMHSAS and/or OHCA, by county of residence, and divided by the number of adults in a county with a reported income less than 200 percent of the Federal Poverty Level. The counties shown in dark gray have the lowest rates while the counties in white have the highest rates.



As shown in Exhibit 5.3, the rate of clients who received publicly funded detox services by county ranged from 0.0 to 93.74 per 10,000 adults with low income. Harper County had the lowest rate and was the only county with no detox clients, while Oklahoma County had the highest rate, followed closely by Tulsa County with 87.16. The median and mean rates were 26.8 and 28.69, respectively. To better evaluate the range of rates, the lowest nine ranked counties and highest nine ranked counties were excluded, resulting in an inner range of rates from 9.52 to 46.31. Within the inner range, the upper range limit is five times higher than the lower range limit, indicating a disparity in penetration rates among counties. There appears to be a clustering of counties in the central region with the highest rates of clients who received detox services. The Northwest and Southeast regions have the majority of counties with the lowest rates

Exhibit 5.4.

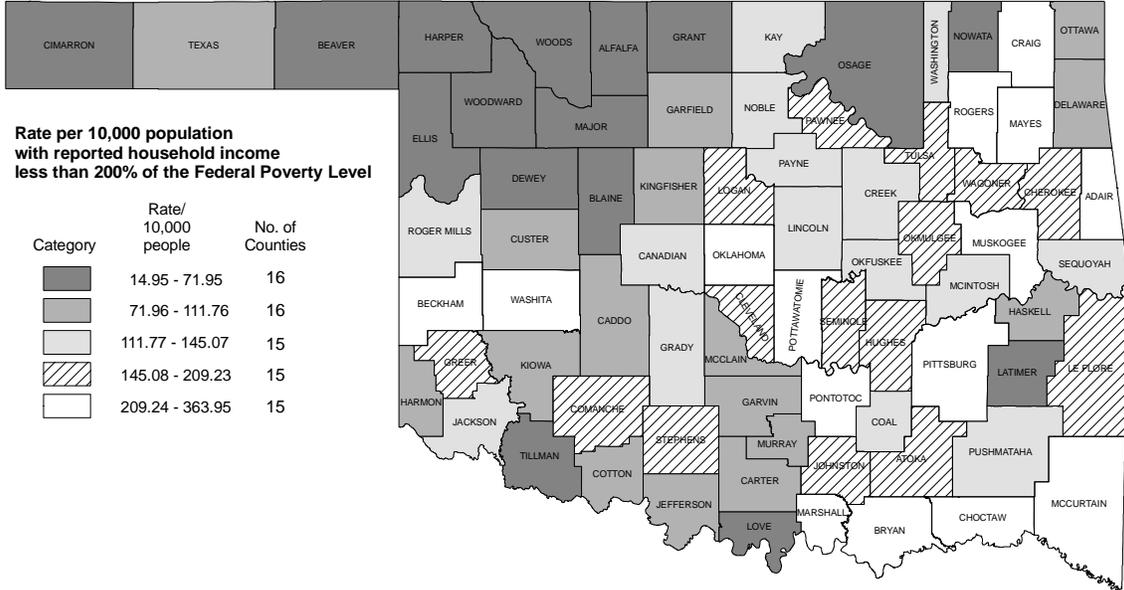
Adults Receiving Publicly Funded Substance Abuse Residential Treatment Services
Rates by County of Residence in Oklahoma
During FY2005



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

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

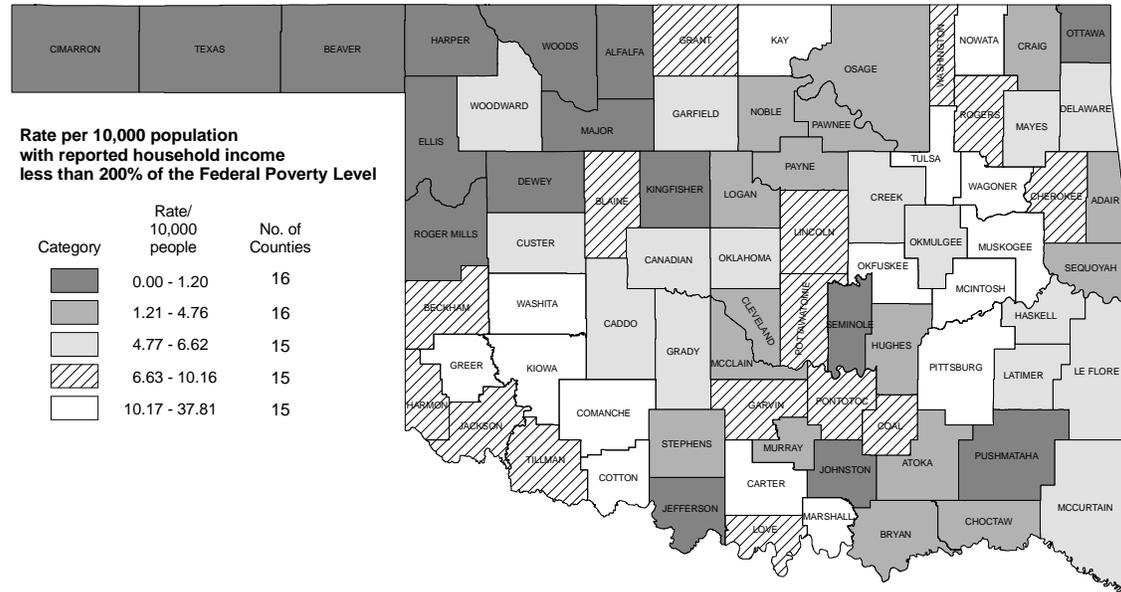
Exhibit 5.5. Adults Receiving Publicly Funded Substance Abuse Outpatient Services
Rates by County of Residence in Oklahoma
During FY2005



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

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

Exhibit 5.6. Adults Receiving Publicly Funded Substance Abuse Halfway House Services Rates by County of Residence in Oklahoma During FY2005



Rate per 10,000 population with reported household income less than 200% of the Federal Poverty Level

Category	Rate/10,000 people	No. of Counties
0.00 - 1.20	0.00 - 1.20	16
1.21 - 4.76	1.21 - 4.76	16
4.77 - 6.62	4.77 - 6.62	15
6.63 - 10.16	6.63 - 10.16	15
10.17 - 37.81	10.17 - 37.81	15

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

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

Policies

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

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

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

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

Practices/Services

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

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

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

Many clients interviewed believed that they are over-medicated with psychiatric drugs. One client said, “I am too out of it from the meds to really work my recovery program.” Clients in one program noted that the part-time psychiatrist available to them does not speak English well and is dismissive of their concerns about medication side-effects. Both staff and clients felt that there was a need for a full-time psychiatrist in residential treatment programs, as many clients either arrive dually-diagnosed, or staff believes they need a mental health assessment, which is currently hard to arrange. Staff and clients said that clients are only given two weeks’ worth of medication on discharge, which is often insufficient. Over the past year, OHCA has worked with the inpatient provider community to support adequate discharge planning and care

coordination. The group has agreed to provide discharged patients with a full 30 day prescription, along with the typical two week supply of medications. Another problem noted by both staff and clients is that programs such as AA encourage an abstinence approach to psychiatric medication, and discourage its use, which causes conflicts for people with co-occurring disorders.

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

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

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

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

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

As noted in the chapter on Housing, people with criminal and/or drug histories have an especially difficult time finding safe affordable housing, as most are banned from public housing for at least three years. According to one client, "Staff has no time to help look for housing." A staff person of this same center said that there are "no stable places for people to live, often we discharge to shelters." A staff member noted that, in long-term residential treatment, "You make big investment, and then there are no halfway houses or sober houses for them to go to." Some

staff noted that many clients will return home to families with multi-generational drug abuse problems. Another staff member stated, “Clients *will* relapse without a safe place to go.”

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

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

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

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

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

Exhibit 5.7. Number of Detox Admissions per ODMHSAS Client within 365 Days of First Admission in Fiscal Year

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

ODMHSAS collects information about how clients are referred to service. In FY2005 about half of all residential substance abuse treatment clients were referred to treatment by an individual, which can either be the client or a significant other (see Exhibit 5.8). Referrals from an individual have been steadily increasing since FY2001. Many clients enter substance abuse

treatment through the criminal justice system, either through Drug Court, Department of Corrections (see Chapter 8) or court order. Referrals from the criminal justice system comprise about 25 percent of referrals to residential substance abuse treatment each year. Since FY2001, a smaller percentage of referrals have come from ODMHSAS-funded agencies and other health care providers.

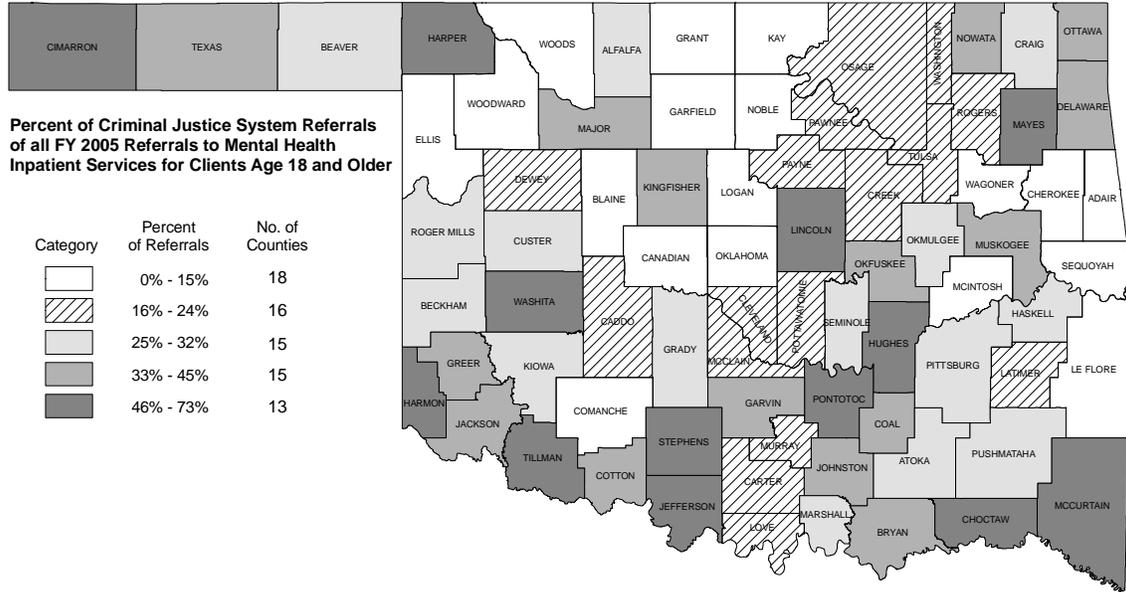
Exhibit 5.8. Referral Source for ODMHSAS Substance Abuse Residential Treatment Clients Age 18 and Older

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

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

Exhibit 5.9.

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



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

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

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

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

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

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

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

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

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

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

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

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

Workforce Development Issues

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

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

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

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

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

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

Organization/Collaboration

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

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

Data

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

Financing

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

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

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

Consumer and Family Involvement

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

Community mental health centers and other contractors provide specialized support services funded by ODMHSAS for adults (not all services are available in all areas), including: supported housing; transitional housing; permanent supported housing; Safe Haven programs for homeless individuals; vocational services; pre-vocational services; employment training; job retention support; residential care facilities; Outreach; community-based structured crisis care; drop-in centers; advocacy and peer support; Programs of Assertive Community Treatment (PACT); and mobile crisis teams.

ODMHSAS provides funds for adult consumer and family support through Oklahoma's National Alliance on Mental Illness (NAMI-Oklahoma, NAMI-Oklahoma City, and NAMI-Tulsa), the Oklahoma Mental Health Consumer Council, and the Depression and Bipolar Support Alliance of Oklahoma (DBSA). The Department contracts with the Oklahoma Mental Health Consumer Council (OMHCC) to deliver Wellness Recovery Action Plan (WRAP) training. OMHCC is also funded to conduct an annual consumer conference, which provides training and expanded opportunities for networking with peers across the state. ODMHSAS uses federal Mental Health Block Grant Funds to fund advocacy skill-building opportunities for consumers and family members, primarily by supporting attendance at conferences and seminars.

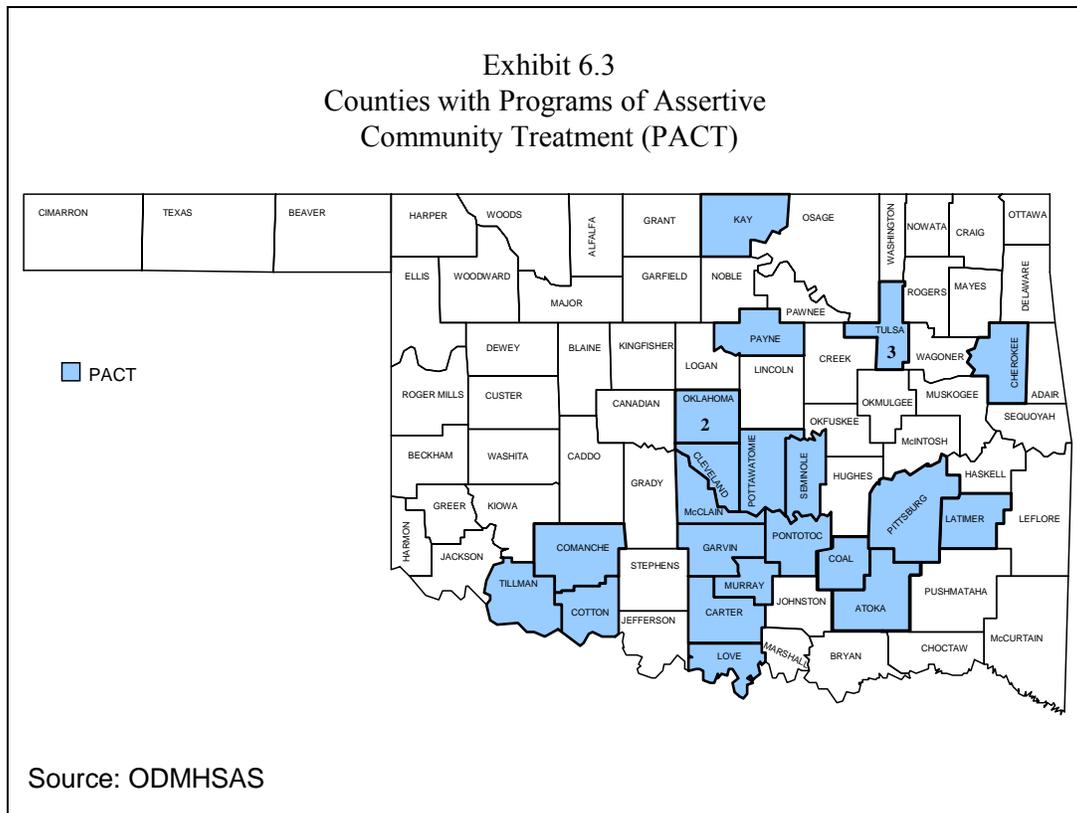
OHCA administers Medicaid funding for mental health services in Oklahoma. There are various eligibility criteria for Medicaid-funded services. The majority of adults who receive mental health services funded by OHCA have a mental health disability and a reported household income less than 185 percent of the Federal Poverty Level, or have a monthly income less than \$651 per month (OKDHS, n.d.). The disabled person must have a mental impairment that appears reasonably certain to continue at least 12 months without significant improvement and that substantially impairs their ability to perform labor or services or to engage in a useful occupation. The adult mental health services funded by OHCA include but are not limited to: Mental Health Assessment; Mental Health Service Plan Development; Individual Psychotherapy; Group Psychotherapy; Family Psychotherapy (with or without patient present); Hypnotherapy; Psychological Testing; Neuropsychological Testing; Psychosocial Rehabilitation; Crisis Intervention Services; Medication Training and Support; Program for Assertive Community Treatment (PACT); and Targeted Case Management.

B. Strengths

Strengths: Innovative Initiatives

In recent years, ODMHSAS has introduced several initiatives that promote a recovery-oriented system, improve service coordination, or divert people with mental health problems from the criminal justice system. The introduction in 2004 of Recovery Support Specialists (RSSs) into the service system's staff mix is a promising step toward transforming the system into one that is consumer-centered and recovery-oriented. RSSs are people in recovery from mental health problems trained to provide peer support and advocacy services for consumers in emergency, outpatient or inpatient settings. The RSSs perform a wide range of tasks to assist consumers in regaining control of their lives and recovery processes, and all CMHCs are required to have at least one full time equivalent (FTE) RSS on staff. ODMHSAS received a Real Choice Systems Change grant from the federal Center for Medicare and Medicaid Services (CMS) which is being used to hire additional staff to implement two evidence-based practices identified by the federal Substance Abuse and Mental Health Services Administration (SAMHSA): Family Psychoeducation, and Illness Management and Recovery. ODMHSAS is

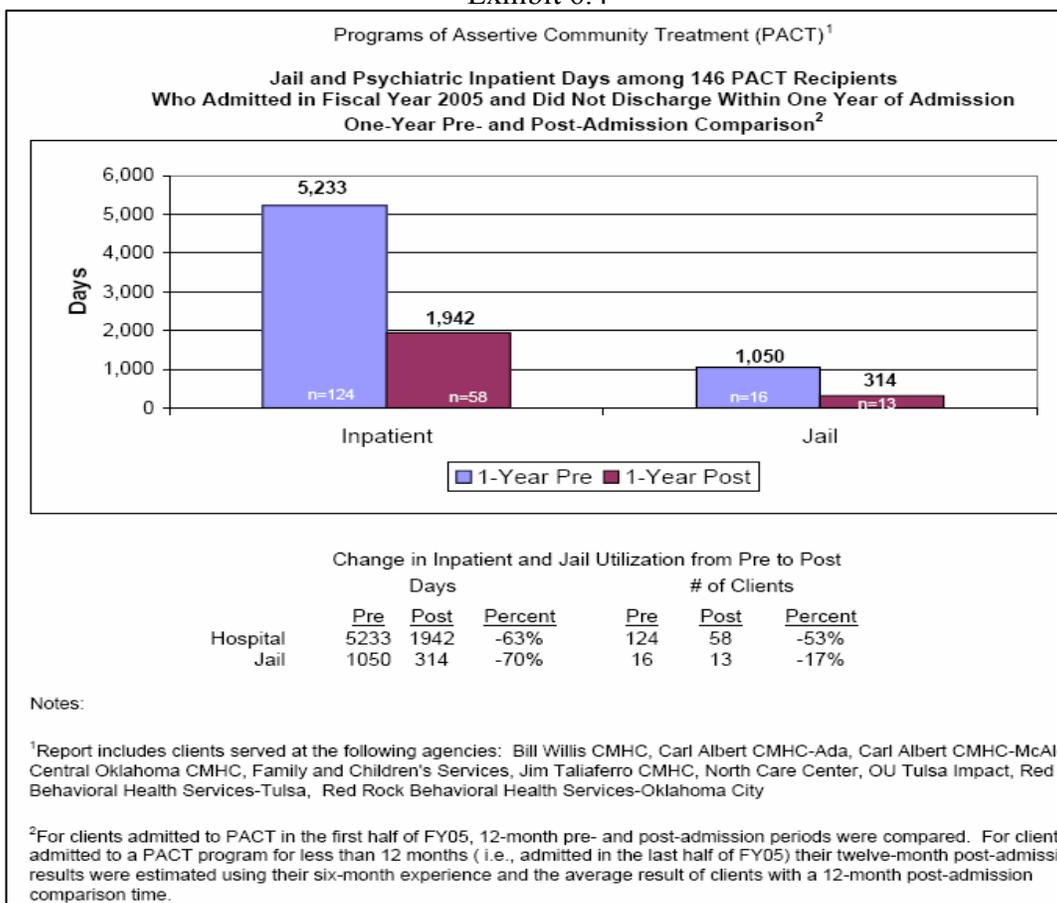
working with OHCA to propose policy changes to establish Medicaid-reimbursable peer services in Oklahoma.



Using state appropriations and Medicaid, Oklahoma has established 14 Programs of Assertive Community Treatment (PACT) across the state. These multi-disciplinary teams provide treatment and support services to consumers with high levels of need. Three PACT teams are targeted to homeless individuals, and three to consumers with co-occurring mental health and substance abuse disorders. Exhibit 6.3 shows the counties in Oklahoma with PACT teams. There are two teams in Oklahoma County and three in Tulsa County.

Annual reports to the Legislature on PACT’s effectiveness have documented decreases in hospital admissions and criminal justice involvement, as well as improved quality of life (ODMHSAS, 2006). To demonstrate the effectiveness of PACT programs in Oklahoma, Exhibit 6.4 was submitted by ODMHSAS to the state legislature during the state fiscal year 2006 session. Among the 146 PACT clients admitted into a PACT program in FY2005 who were not discharged within one year of admission, there was a decrease in inpatient days of 63 percent, and a 70 percent decrease in jail days.

Exhibit 6.4



OKDHS Developmental Disabilities Services Division (DDSD) has primary responsibility for persons who are developmentally disabled and have a co-occurring mental illness. One of the State-operated ICF-MR facilities, Robert Greer, is designed to serve dual diagnosed adults. Other persons, primarily but not exclusively adults, with dual diagnosis may be served in the community receiving individualized services financed through a Medicaid Waiver. DDSD has developed a small number of psychiatrists and psychologists who have special expertise in serving this population. They have also expanded use of the EPSDT program (Early and Periodic Screening, Diagnostic and Treatment) in order to improve access to services among children with developmental disabilities.

Strengths – Exemplary Programs

It was clear from site visits and focus groups with staff, managers and consumers that several CMHCs and other providers understand and are strongly committed to the values and practices of recovery-oriented services. In such agencies, the leadership modeled these principles, encouraged staff to learn and practice attitudes and skills that are consumer-centered, and valued the role of their Recovery Support Specialists. These organizations fully involved consumers in the development of their treatment plans, and sought their input through other mechanisms: “We have a consumer advisory committee that meets every two weeks and takes up issues that require discussion and problem solving, such as staff retention, client rights, member participation, investment of resources in new activities, and evaluating what we are doing to

support recovery,” one program manager said. “We run focus groups each year on our annual plan and budget, and we involve consumers on all our committees,” said another. Consumers in these programs were decidedly more enthusiastic about the services they received than consumers in other programs.

Other exemplary programs within the state’s public mental health system include the previously referenced Program of Assertive Community Treatment (PACT) as well as the Strengths-Based, Person-Centered Case Management certification process; recently re-designed day programs based on the Psychosocial Rehabilitation model; Intensive Care Coordination Teams; Mental Health Courts; training for law enforcement personnel; other jail diversion activities; a recovery homes initiative to provide wider options for persons in Residential Care Homes; and mobile crisis diversion/response teams. Of particular note is the Adult Recovery Collaborative; details of that program are discussed in Chapter 1 of this document. While these exemplary programs are building a foundation for a consumer-driven system, many are not available statewide. But the accomplishments of these initiatives are serving as models for other programs to take on transformation initiatives.

ODMHSAS contracts with the Oklahoma Mental Health Consumer Council to conduct onsite, point-of-service satisfaction surveys to reach a cross-section of adults who receive mental health services in non-hospital settings at ODMHSAS-funded facilities. Approximately 98 percent of the people who were presented with the opportunity to participate in the study chose to do so. The Exhibit 6.5 contains the results of the surveys collected in 2005. Over 90 percent of surveyed clients reported positively about access, quality and appropriateness of services, outcomes, participation in treatment planning and general satisfaction with services.

Exhibit 6.5. 2005 Adult Consumer Survey Results:	Number of Positive Responses	Responses	Percent Positive	Confidence Interval at 95% Level
Reporting Positively About Access.	2113	2211	96%	+/- 0.9%
Reporting Positively About Quality and Appropriateness	2039	2075	98%	+/- 1.2%
Reporting Positively About Outcomes.	1978	2171	91%	+/- 1.3%
Reporting on Participation In Treatment Planning.	2053	2104	98%	+/-1.1%
Positively about General Satisfaction with Services.	2103	2204	95%	+/- 0.9%

Collaborations in Oklahoma are present at both the state and local level. The Adult Recovery Collaborative and the Integrated Services Initiative are highlighted in other chapters within this document (see Chapters 1, 7 and 8).

C. Needs and Existing Barriers

Unmet Needs

Combined, ODMHSAS and OHCA funded mental health services for 58,225 adults in FY2005. The number of adults estimated to have experienced serious psychological distress in the past year was 128,201, leaving an estimated 69,976 adults with low income not receiving treatment in the public sector (see Chapter 2). The following exhibits show the rate, by level of care received in FY2005, per 10,000 adults in Oklahoma with a reported household income less than 200 percent of the Federal Poverty Level, by county of residence. The rates were calculated using the unduplicated count of clients who received services in a given level of care funded by ODMHSAS and/or OHCA, by county of residence, and divided by the number of adults in a

county with a reported income less than 200 percent of the Federal Poverty Level. The counties shown in dark grey have the lowest rates, while the counties in white have the highest rates.

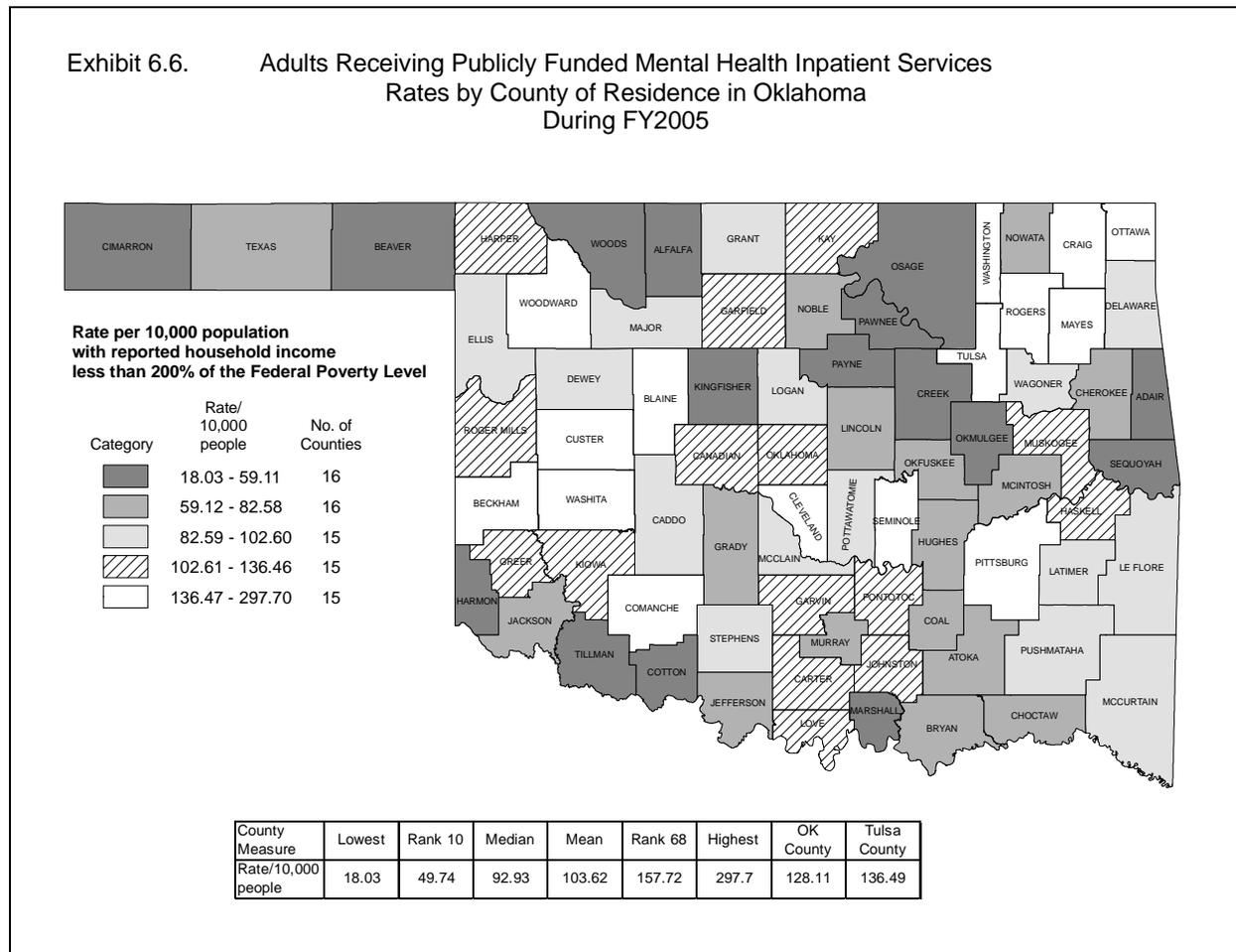
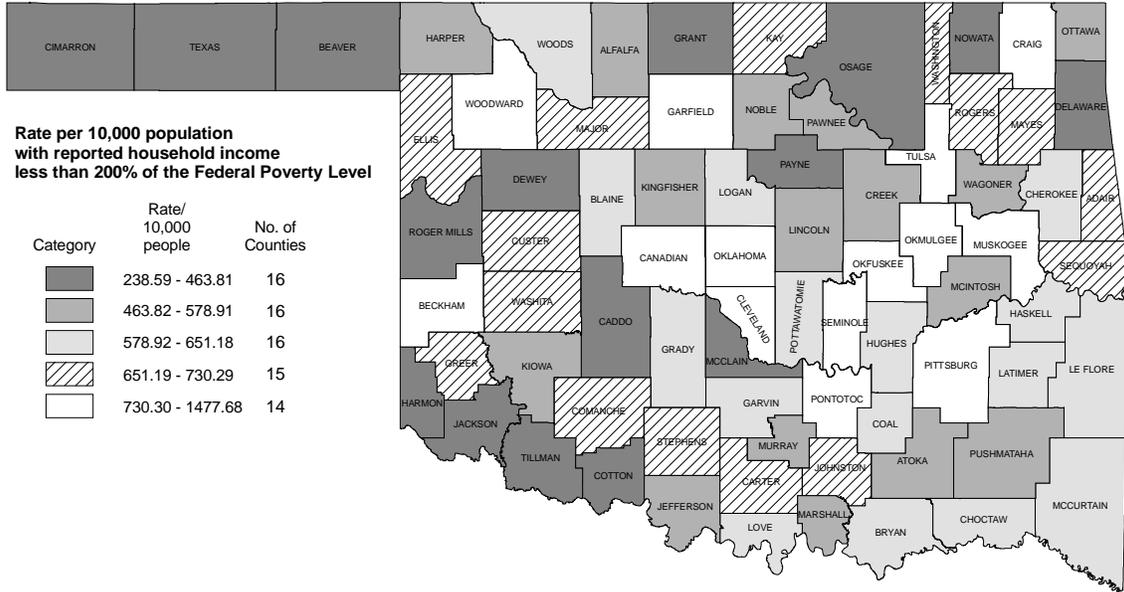


Exhibit 6.6 shows the rate distribution of adults who received publicly funded mental health inpatient services. The rate ranged from 18.03 in Okmulgee County to 297.70 in Craig County. The rates in Oklahoma and Tulsa Counties were 128.11 and 136.49, respectively. The median and mean rates were 92.93 and 103.62, respectively. To better evaluate the range of rates, the nine lowest ranked counties and nine highest ranked counties were excluded, resulting in an inner range of rates from 49.74 to 157.72. Within the inner range, the upper range limit is three times higher than the lower range limit, indicating a disparity in penetration rates among counties. Counties in the East Central area had lower rates than the majority of the remaining counties. Most counties with CMHCs had the higher rates (see Exhibit 6.1).

**Exhibit 6.7. Adults Receiving Publicly Funded Mental Health Outpatient Services
Rates by County of Residence in Oklahoma
During FY2005**

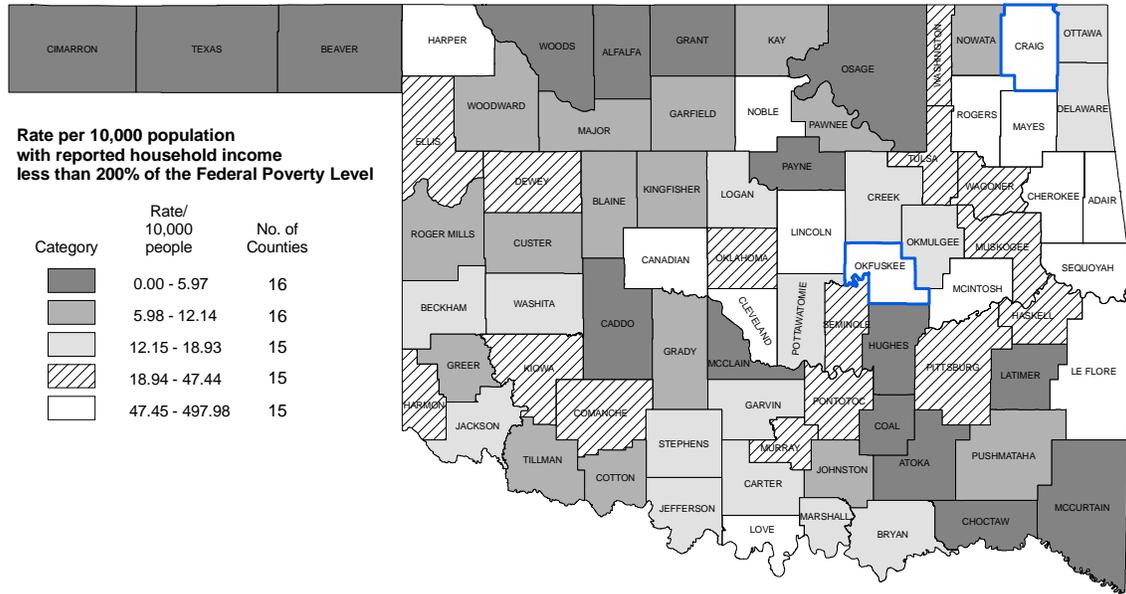


County Measure	Lowest	Rank 10	Median	Mean	Rank 68	Highest	OK County	Tulsa County
Rate/10,000 people	238.59	400.76	618.64	622.34	775.87	1477.68	795.13	838.53

Mental health outpatient services include hourly crisis services as well as individual and group counseling. The rate of adults who received publicly funded outpatient services ranged from 238.59 per 10,000 adults with low income in Roger Mills County to 1477.68 in Craig County. The median and mean rates were 618.64 and 622.34, respectively. The inner range had a low rate of 400.76 and high rate of 775.87, a difference of less than double, suggesting less disparity among counties than was found with inpatient treatment. As shown in Exhibit 6.7, there is little clustering of counties, although counties in the panhandle and southwest have lower rates, which may be due to accessibility. Craig County statistics reflect, in part, a concentration of residential care facilities historically located there due to their proximity to the former Eastern State Hospital (now the Oklahoma Forensic Center), which no longer serves non-forensic populations.

Exhibit 6.8.

Adults Receiving Publicly Funded Mental Health Housing,
Nursing Home and Residential Care Support Services
Rate by County of Residence in Oklahoma
During FY2005



County Measure	Lowest	Rank 10	Median	Mean	Rank 68	Highest	OK County	Tulsa County
Rate/10,000 people	0.00	4.23	14.53	39.04	84.10	497.98	47.44	33.85

Housing support services include supported and transitional housing and services provided to clients living in residential care settings and nursing homes, as shown in Exhibit 6.8. The rate of housing support services ranged from 0.0 to 497.98 per 10,000 adults with low income. Seven counties had no clients who received housing support services: Alfalfa, Atoka, Beaver, Cimarron, Grant, Latimer and Texas. The range was extreme due to two counties, Craig (497.98) and Okfuskee (445.24). Craig County has a permanent supported housing project and six residential care facilities, and Okfuskee County has three residential care facilities and one enhanced residential care facility. The median and mean rates were 14.53 and 39.04, respectively. The inner range went from 4.23 to 84.10, indicating a large disparity of housing services among counties in Oklahoma.

To evaluate mental health service retention, ODMHSAS collects the reason for clients being discharged from treatment. Exhibit 6.9 contains the number and percent of clients discharged from inpatient treatment by type and year of discharge. The majority of inpatient mental health clients were discharged as a result of completing treatment, and this trend has improved steadily since FY2001, increasing from 73.7% to 82.8%. Those clients who were discharged from inpatient services prior to treatment completion generally left the program “against counselor’s advice” (ACA), or they became AWOL or broke a program rule. Since FY2001, the number of clients who were discharged due to those reasons has declined; however, the five year trend is inconsistent. The third largest group of clients was discharged due to

“other” reasons. These reasons included the client moving, failing to begin treatment, treatment incompatibility and administrative discharges. Administrative discharges occur when a treatment facility fails to discharge a client after an extended period of time following their last date of service.

Exhibit 6.9. Discharge Type for ODMHSAS Mental Health Inpatient Clients Age 18 and older

Fiscal Year Discharged	Total Clients	Discharge Type											
		Completed Treatment		ACA/AWOL Broke Rules		Transferred		Incarcerated		Died		Other*	
2001	4,793	73.7%	3,534	13.5%	647	3.8%	181	1.9%	93	0.7%	33	6.4%	305
2002	5,901	74.2%	4,378	10.4%	611	5.1%	302	0.5%	28	0.7%	39	9.2%	543
2003	5,616	78.5%	4,406	11.1%	621	4.8%	272	0.4%	24	0.4%	25	4.8%	268
2004	5,257	81.1%	4,266	14.0%	734	1.5%	78	0.3%	17	0.3%	18	2.7%	144
2005	5,484	82.8%	4,543	10.9%	597	1.6%	86	0.6%	32	0.4%	22	3.7%	204

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

Another method of evaluating treatment effectiveness and community outreach is to analyze the readmission rates to inpatient treatment. Exhibit 6.10 contains the number of clients discharged from the ODMHSAS-operated state psychiatric hospital in FY2005 and the number who were readmitted within 30, 180 and 365 days.

Exhibit 6.10.

Profile of Non-Forensic (Voluntary and Civil-Involuntary) Patients Readmitted to the State Psychiatric Inpatient Hospital [Griffin] Within 30/180 Days of Discharge

Total number of	Number of Readmissions to State Psychiatric Hospital within			Percent Readmitted		
	30 days	180 days	365 days	30 days	180 days	365 days
3587	124	391	644	0.03	0.11	0.18

In FY2005, over half of all clients admitted to ODMHSAS-funded inpatient mental health treatment were referred to treatment by the criminal justice system (see Exhibit 6.11). Predominately, criminal justice referrals include people in crisis brought in by law enforcement for consideration for emergency detention and inpatient commitment. These data are based on the admission and the most recent discharge associated with each client during the fiscal year. The trend for criminal justice referrals shows that while the number of referrals appears to be stable, a smaller percentage of inpatient referrals come from this source each year. Referrals from an individual (usually the client or a significant other) comprise about 20 percent of referrals to inpatient treatment each year. The number of clients has remained stable at about 1,100. Since FY2001, the major increases in both the number and percentage of inpatient referrals have come from ODMHSAS-funded agencies and other health care providers.

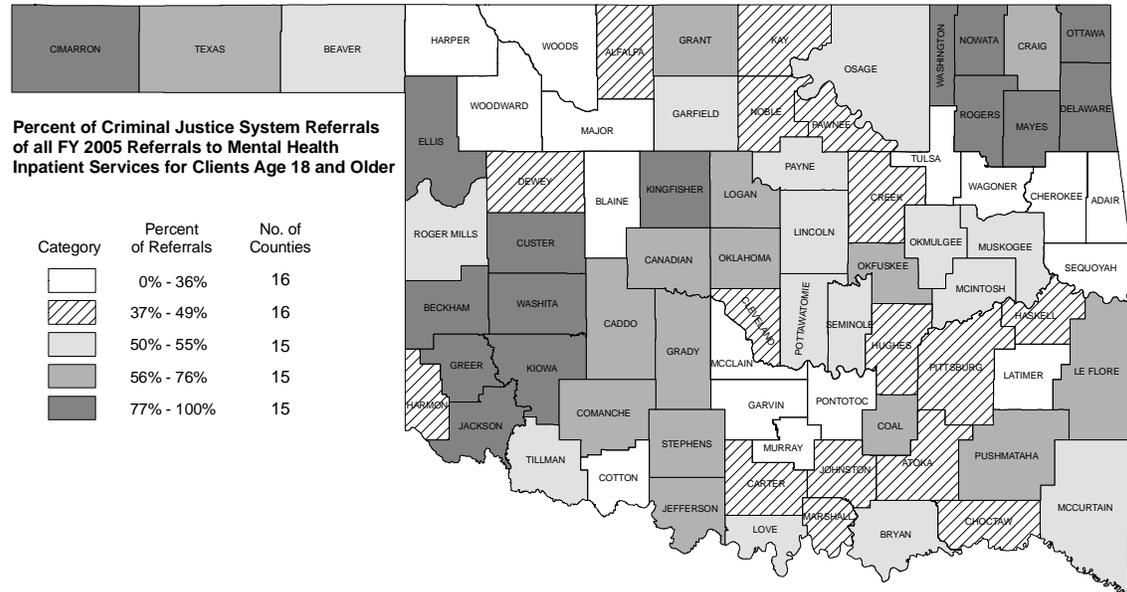
Exhibit 6.11. Referral Source for ODMHSAS Mental Health Inpatient Clients Age 18 or Older

Fiscal Year Discharged	Total Clients	Referral Source at Admission to Inpatient Services											
		Criminal Justice System		Individual		DMHSAS Funded Agency		Other Health Care Provider		Mental Health Care Provider		Other Community Referral*	
2001	4,793	60.1%	2,881	21.4%	1,026	6.9%	330	6.1%	294	4.9%	235	0.6%	27
2002	5,901	55.4%	3,267	19.8%	1,166	13.6%	800	4.0%	236	6.7%	394	0.6%	38
2003	5,616	57.5%	3,231	19.7%	1,107	11.5%	646	7.1%	397	3.8%	212	0.4%	23
2004	5,257	54.3%	2,853	21.2%	1,115	13.8%	723	7.6%	400	2.8%	145	0.4%	21
2005	5,484	51.7%	2,833	20.4%	1,116	17.0%	930	9.3%	509	1.4%	75	0.4%	21

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

Exhibit 6.12.

Criminal Justice System Referrals to ODMHSAS-Funded Adult Mental Health Inpatient Treatment



As shown in Exhibit 6.12, some regions of Oklahoma tend to refer from the criminal justice system to mental health inpatient treatment at a higher rate than other regions. For example, the Northeast and Southwest parts of the state have a higher percentage of criminal justice referrals among all referral types. The percent of referrals that were from criminal justice sources ranged from 0 percent to 100 percent.

Oklahoma is working to make services readily accessible, recovery-oriented, and consumer-driven. The discussion that follows addresses policies, services, access to services, and other topics. The information below includes anecdotal reports from many individuals expressed during numerous focus groups. They are included here to highlight possible areas for systemic improvements on behalf of adults who seek services and supports in Oklahoma.

Policies

The most frequently and fervently raised policy concern was what focus group participants viewed as excessive, redundant paperwork. Management, staff, consumers, advocates and family members all stated that it is extremely burdensome and interferes with the ability to provide quality services. Providers estimated that at least 60% of staff time is spent on paperwork, which was seen as unreasonable. It was noted that much of the paperwork required by ODMHSAS is redundant with that required by the Oklahoma Health Care Authority (OHCA), the state Medicaid agency. Staff and managers complained that the only way to keep up with

paperwork was to put in unpaid time on nights and weekends: “It takes us 60% of the time to do paperwork. We have to stay late and come in on weekends. I am here every Sunday doing paperwork; if I didn't do that, I would fall way behind. It takes all the fun out of the job. Paperwork is the main reason we can't get and keep good staff.” Consumers complained that staff are frequently unavailable to them: “I can't see my case manager when I need to, because she's in her office doing paperwork.”

Many participants noted that the problem is especially onerous for intakes; some stated that clients spend at least their first three visits on paperwork before receiving any services. Providers called for ODMHSAS and OHCA to collaborate on a single, streamlined documentation process that would free staff up to do more direct work with clients. “There are too many requirements layered on top of requirements,” one person said. “They need to start over and assess the real value of every question asked. There are too many forms with a lot of check boxes that don't really say anything; it's much harder than it needs to be.”

On a closely related topic, both providers and consumers said that assessment and intake forms were deficit-based, invasive of consumers' privacy, and were not client-centered. It was noted that it is hard for someone in acute distress to sit through a 2 hour assessment that highlights all their weaknesses, and that ODMHSAS needs to streamline the process of opening a chart so that people's needs can be met quickly. Consumers have to repeat their stories multiple times throughout the process, and this may discourage some people from returning for services. If a person moves from one program to another, or from inpatient to outpatient, the whole process must be re-started; this was seen as stressful for consumers and a waste of staff time.

Community Mental Health Center (CMHC) staff and management reported that it is hard to recruit and keep talented staff because of the paperwork burden and low salaries. Credentialing requirements were seen as an additional barrier. These focus group participants further noted that they felt that their views are not solicited before policy is made, and that this results in policies and practices that do not work at the local level: “Staff working with clients in the field should have more input into how policies and programs are designed.”

Advocates for older adults noted that younger people with mental health problems are increasingly being placed into long-term care and are not getting mental health services there. It was their perception that OHCA policies have precipitated the inappropriate placement of non-elderly mental health clients into nursing facilities. “There is nothing being done to prevent people going into nursing homes or hospitals who should actually be living in the community,” an advocate said. “We're locking people up in nursing homes because we have no outpatient services for them.”

Practices/Services

Medication

Problems with psychiatric medications were the most frequent service-related concern of consumers. Overwhelmingly, consumers said that they do not have sufficient time to talk with their prescribers about medication issues, that doctors do not take their concerns about side-effects seriously, and that they are given little if any information about their medications. Many consumers made comments such as “I never have a chance to talk to my doctor about side-effects – we are run through there like cattle” and “Doctors need to spend more time with people and get their meds right. They don't get to know you and don't even remember you from month to month.”

Many consumers noted that there are no psychiatrists at their programs, that their doctors don't have sufficient knowledge about psychiatric drugs, and that they have no access to doctors if they experience medication emergencies. Widely heard comments included issues such as "You can only see a doctor at med clinic every 6 weeks – if you have problems with meds or side-effects, you have to wait till your next scheduled appointment" and "The doctors at our med clinic are only part-time and are not psychiatrists; we need full-time, on-site psychiatrists here." Other consumers mentioned problems like "I went without sleep for almost six months because the doctor wouldn't change my meds" and "I would like them to reduce my meds. I'm very lethargic, I collapsed while walking, but I'm afraid to talk to the doctor." Consumers expressed concern about the unknown long-term effects of their medication and many felt that they were over-medicated and that this often interfered with their ability to function.

Another significant issue was the cost of drugs. Many consumers, particularly childless adults who are not eligible for Medicaid and may be waiting to be approved for Social Security benefits, have no private or public insurance and are unable to pay the high cost of multiple psychiatric drugs. While some programs offer free or low-cost medication, others do not, and consumers described experiencing rebound psychoses when they went off medications abruptly because they could no longer pay for them. Staff noted that Medicare Part D is creating a new set of problems with medication affordability, because few Medicare clients were able to find a benefit plan that covered all their medications, and many cannot afford the \$7 monthly premium.

There are particular medication issues that effect older adults, including those in nursing facilities. The federal Pre-Admission Screening and Resident Review (PASRR) program requires review for potential polypharmacy for persons receiving two or more antipsychotics, anti-depressants, or anti-anxiety drugs. In Oklahoma, a review is being conducted of the prescribing practices of physicians, but nursing facility physicians are exempt. An additional problem that affects older adults is the use in some nursing facilities of chemical restraint through the off-label use of anti-psychotics. It was noted that there is no vehicle through which to address what was described as "occasional egregious polypharmacy."

Research has shown that certain drugs or certain dosages are not appropriate for older adults. A widely used tool in geriatric medicine, The Beers criteria, lists medications that should generally be avoided in the elderly, doses that should generally not be exceeded, and medications that should be avoided in older persons known to have any of several common conditions. These are guidelines, and have no force of law, and are not universally followed by nursing homes, mental health programs, or private prescribers, unnecessarily putting older adults at risk.

Access to Services

Timely access to services was an issue for all constituency groups in all parts of the state, and this has been an ongoing issue. ODMHSAS implemented a core services plan in January 2003 to articulate expectations and access requirements with uniform standards and timeframes. That document was developed over a period of months through a consensus process including providers and advocacy groups prior to adoption. Those standards have been in place since 2003 and specifically require timely access to appropriate medication, with each CMHC being required to demonstrate capacity to immediately address emergent needs. All others are expected to receive a timely assessment and services within a two-week timeframe. Persons seeking aftercare following hospitalization are a priority.

Staff, family members and consumers continue to report that people often have to wait weeks to get a first appointment, and then do not receive any services for weeks, because the first

few visits are taken up with paperwork. Some consumers continue to report that “There is a 6-8 week wait to see a psychiatrist, and nowhere to turn in the meantime if you’re in crisis” and “It’s hard to get outpatient appointments when you return from the hospital – you are left without medication or counseling for weeks. What are we supposed to do?” Staff and management echoed these concerns, and stated that lack of funding was the cause of these problems. “There are just not enough services – there is no place for people to go,” was a typical staff comment. One consumer stated “I would like to see more therapy, there is no therapy offered to us. I’ve been in the system for three years and have yet to see a therapist.”

For older adults, particularly those residing in nursing facilities due to a physical health condition, access to mental health services is particularly challenging. The PASRR program requires screening of nursing facility (NF) applicants. Individuals with a primary mental health diagnoses are excluded; people with a history of mental health service use are only accepted if they have physical health needs that require NF-level care. Medicare does not cover mental health services in nursing facilities, and in 2004, OHCA eliminated Medicaid funding for behavioral health services for persons residing in nursing facilities. Services to residents are provided by outside agencies, but only to people who can pay out of pocket.

Advocates for older adults pointed out that there are many older people not in long-term care who still need mental health services, but that there are few services available for them. Even if they have private insurance or can pay out of pocket, there is nothing available except medications, according to advocates. “Older people with no insurance and no Medicaid eligibility have absolutely no way to pay,” an advocate said. “They have to choose between buying groceries and buying pills.”

It was also noted that older adults use mental health services at a lower rate than any other age group. Respondents believe that this is due in part to generational differences that attach shame to the receipt of services, and to fear of the system because of treatments used in the past, such as lobotomies. It was also suggested that programming in CMHCs is geared toward younger people and may not be responsive to the needs of older adults.

Persons with a dual diagnosis of developmental disabilities and mental illness also experience difficulty gaining access to mental health services. Although OKDHS through its Developmental Disabilities Services Division (DDSD) supports appropriate institutional and community programs, these are not sufficient to meet the need. DDSD officials indicate that there are significant waiting lists for its own programs. DDSD has begun developing alternative group home settings for persons who are dual diagnosed and identified as having unmanageable behaviors, many former residents of Vinita and DDSD facilities. ODMHSAS does not have the capacity to service this population. Furthermore, mental health providers do not generally see this as a part of their responsibility when clients with a dual diagnosis are referred to them. Persons with a diagnosis of Autism or Aspergers Syndrome particularly have great difficulty obtaining help.

As described in Chapter 2, military personnel returning from both Iraq and Afghanistan may suffer from post-traumatic stress. There is reason to be concerned about whether they are getting the treatment they need for their emotional and psychological problems. Not getting needed services can lead to escalating rates of divorce, domestic violence and DUI arrests, among other problems. Those in the United States Armed Forces are eligible for services through military insurance programs or the Department of Veterans Affairs. However, others are

part of the Oklahoma National Guard and do not have access to these programs, and the state does not have provisions to pay for the necessary services.

Quality of Services

The quality and variety of service types was also a key issue for both providers and consumers. Many providers acknowledged that because of staff shortages, large caseloads and the burden of paperwork, they are not able to provide enough good quality services to meet consumers' needs. One staff said that "There is no time – we never take lunch. I'm expected to do treatment plans for people I only met for five minutes" (implying that consumers in this agency are not involved in their treatment plans as required). Another provider said "People need a choice of the services they want – we could focus on recovery if we did not have to deal with survival every day."

Consumers in many programs were also dissatisfied with the range of service choices: "There are no alternatives to inpatient, like warmlines or respite houses – I've heard they have these in other states" and "This program doesn't offer anything for people like me who are ready to move on with their lives." Advocates echoed these comments, stating that most providers have not operationalized recovery principles, and many don't seem to understand the concept. Many PSR programs, they said, were still doing things to people and for people, rather than teaching consumers how to do things for themselves. People living in residential care facilities said that they were required to go to PSR or Day Treatment programs 4-5 days a week or risk losing their housing: "I would like to be able to go to services less than five days a week – I can't handle it. The rules here are confusing."

Inpatient treatment was an area that many people found problematic. "They used to have activities on inpatient units [at Griffin Memorial Hospital] – now all they have is drugs," one consumer said. There were additional concerns about how medication is used on inpatient wards: "People are very over-medicated there [at Griffin]; they over-use involuntary IMs [injections]," was a typical comment. "I had a bad reaction to the meds and wanted help – instead they did a take-down & shot me up with more meds," another consumer said. A number of people mentioned that they feared for their safety on the wards. Providers, family members and consumers also felt that a shortage of local inpatient beds was a problem. One program manager said, "There are no inpatient services available locally; people must go to Griffin or St. Anthony's in Oklahoma City, 2.5 hrs away."

Providers, family members and consumers saw the lack of crisis services in many areas as a major issue; this was particularly noted in rural areas. One provider said, "We used to have services that helped people stay in the community, but they were lost to budget cuts – now all we can do is send them to Griffin on emergency detention orders." Providers, family members, staff, advocacy groups and consumers all expressed a need for community-based crisis services and supports that would help divert people from hospitals and jails.

Access to Public Benefits

Across the state, all constituency groups expressed frustration with the complexity and long waiting periods involved in getting access to Social Security, Medicaid, and other public benefits. Consumers reported waiting up to two years or more to get benefits after application; one staff member said "It's so difficult to get onto SSI, people can wait 2-3 years and they have to suffer to convince people that they need the support; they are faced with an unsympathetic bureaucracy." A number of providers reported that they frequently wrote letters to legislators

asking for help in moving applications through the system. Consumers waiting for benefits said they were placed in impossible situations: “Some of us who’ve applied for SSI are doubled up with friends or relatives, sleeping on couches, but we have no spending money, no way to pay for food or medication.”

Providers noted that the lack of transportation made it hard for consumers to keep the appointments required by the application process; if they miss one appointment, they have to begin the process over again. For people who receive SSI benefits, both consumers and providers reported problems with Medicare Part D. “Some clients can’t even afford the \$7 monthly payment to enroll,” one program manager said. “Many clients are confused about the program. Some have been auto-enrolled but were not told about it, and the plans chosen for them do not cover all their meds.”

Housing

Housing was raised as a serious concern in all parts of the state. Many consumers reported having to sleep on friends’ or relatives’ couches; others said they had been on Section 8 or public housing waiting lists for up to two years. Some consumers living in transitional housing were frequently critical of these arrangements. Some said that the housing was in bad repair or in unsafe neighborhoods, while others felt that a single agency should not control both their housing and their mental health services: “You can get kicked out if you’re not on meds, don’t show up for an appointment, or act in a way that staff sees as inappropriate.” Staff in some programs did not seem knowledgeable about the housing options available to their clients, while others noted that local landlords don’t want to rent to mental health clients and keep informal blacklists. People living in residential care facilities often reported that these homes are far from public transportation or shopping areas, and that they have only \$25 month left of their disability checks after paying for room and board. This topic is covered in more depth in Chapter 10.

Transportation

In both rural and urban areas, providers and consumers agreed that insufficient public transportation in Oklahoma is a major barrier for people who want mental health services. The many consumers who don’t own cars rely on friends and neighbors, or hitchhiking, to get to appointments. In some areas, staff noted that there are rural van services for Medicaid beneficiaries, but that these require advance appointments, and sometimes don’t show up or don’t stick to a schedule. Some CMHCs provide transportation to and from their programs, but consumers in these programs reported that they have no transportation to shopping, non-mental health appointments, and other basic services. Staff in one program said “Transportation is a big issue. Consumers can’t get here and we can’t get to them. People miss appointments because of transportation problems and then go into crisis. It would be cost-effective to have a van and driver.” For many, transportation problems also keep them from the workforce. Consumers in a rural area suggested that ODMHSAS could address transportation problems and provide employment opportunities for consumers by funding consumer-run transportation services in rural areas. Older adults whose driving abilities are curtailed may also have particular transportation problems.

Stigma and Discrimination

Prejudice, discrimination, and a lack of public understanding of people with mental health problems was reported as a major problem, especially by consumers and family members.

A group of consumers in a rural area said that their community is very hostile to people with mental health problems, that they feel alone and that they are “treated like lepers.” They felt shunned and judged in their community, and even reported being treated badly at church. “Lots of people in this town would like to have us shackled to walls and kept in institutions for life,” one group member said. “They do not care about us.” A group of consumers in an urban area said that “The public is hostile to people with mental illness, and they make our daily lives even more difficult. They don’t want to wait on us in stores, don’t want to rent to us - there is fear and ignorance.”

Providers noted that, in addition to facing public discrimination, many consumers carry a burden of internalized stigma. “Even after 14 years in the field, I still see the internalized stigma. Before consumers tell me their names, they will tell me their diagnosis, like that defines them,” one staff member said. Other mental health professionals spoke of the pressure of public attitudes: “The public wants people locked up in hospitals – this is what they think needs to be done. We don’t want to violate people’s rights, and we don’t know how to reach the general public to change their attitudes.”

Workforce Development and Training

The most frequently mentioned workforce issues were clustered in three areas: factors that interfered with hiring and keeping qualified staff, ODMHSAS training opportunities, and a need to work more closely with graduate programs to prepare future staff to work in a recovery-oriented system.

CMHCs and other providers across the state frequently talked about the problems they have recruiting, hiring and keeping good staff. This was attributed to low salaries, confusing and rigid staff certification requirements, and the paperwork burden which, many staff reported forced them to put in too much unpaid overtime. A manager in one program noted that he and his staff were so over-worked due to staffing shortages that they couldn’t find time to train and orient new staff once they got them. Staffing problems are particularly acute in rural areas, where it is hard to attract professionals. One CMHC found it difficult to get an approved PACT Team off the ground because they were unable to attract any applications for the psychiatrist and nurses’ positions.

Staff and management in many focus groups felt that available in-service training and professional development conferences did not provide them with the kinds of information they consider essential to support them in their jobs. Also, some felt that time away from daily duties to attend training did not result in their receiving useful new information or skills. Participants indicated an interest in receiving training through video conferencing, web-based media, and other uses of newer technologies, when possible.

A number of managers and staff expressed concerns that graduate professional training programs are “still training in antique models,” as one participant put it. Providers and consumers alike expressed an interest in working with local colleges and universities to develop recovery – oriented training for the future mental health workforce.

Advocates for older adults called for mandatory mental health training for all nursing facility staff. “Nursing home staff need training on mental health issues,” one person said. “A lot of problems could be avoided if staff understood mental health issues and they had a mental health professional to consult with.”

Organization/Collaboration

A number of communities have grass-roots health coalitions that CMHCs and other mental health care providers participate in to varying degrees. Some of these coalitions are supported through the Department of Health's Turning Point initiative, which assists communities in organizing a coalition/partnership or adopting an existing one, and helps build organizational structure. A community assessment and resource evaluation is done, and then each community sets its own priorities for healthcare improvement works. While none of the Turning Points have selected adult mental health services as a priority area, some have chosen to focus on children's services, prevention, or substance abuse. ODMHSAS formerly had regional mental health advisory boards, but these were folded in to the Turning Point coalitions. Some providers, consumers and family members felt that this has not been a positive step, as mental health is given low priority in many Turning Point groups, and the opportunities for community input that regional boards provided are no longer available.

In one rural community, mental health providers, family members, health care and social service providers said that their area needs a comprehensive plan for mental health and substance abuse with collaboration among all health and human services agencies. They felt that the Turning Point should be the focus for regional mental health planning. It was noted that poverty and social problems like domestic violence and child abuse contribute to mental health and substance abuse problems, and that these issues need to be dealt with systemically, not in the current piecemeal manner. A number of staff and managers stated that it is very difficult for them to get involved in collaborative projects with other healthcare and social services organizations because of the restrictions that come with their funding streams.

Data

Some providers saw local data systems that are incompatible with state level data systems as a major problem. Others noted that the Department's mandate for all providers to switch to a new electronic medical record system will be very expensive, and that non-state programs will not be reimbursed for these costs, which they feel may bankrupt them.

As noted in the policy section of this chapter, virtually all providers, as well as many consumers and advocates, felt strongly that too much non-essential data is currently collected, and that a careful joint review of data collection instruments by ODMHSAS and OHCA was essential to ensure that all data elements are useful and not redundant.

Financing

There were strong feelings among providers that the system is seriously under-funded and that this interferes with the ability to provide quality services: "Until there is enough funding made available, nothing will change. The system is spread too thin and over-taxed at every level." Staff at one CMHC said, "We have to serve whoever comes through the door, but they don't give us the resources to do it."

In recent years, the Oklahoma Department of Mental Health and Substance Abuse Services has received additional state appropriations, and each CMHC received additional funding as a result of the new appropriations. These additions are most often dedicated to new programs (*e.g.*, PACT, SOC), and rate adjustments to existing programs have been very infrequent. All parties agree that current resources are insufficient to meet the needs. Many program managers stated that reimbursement rates are insufficient to cover their costs: "We are expected to deliver the same level of services without new money. Eligibility criteria were

relaxed by the state, so we have new demands for services, we're expected to serve a broader population." Another manager said, "Clients would be better served if we got paid more for having more clients. We are capped on reimbursement for ODMHSAS contracts, no matter how many people we see." A CMHC director stated that "We break even only by paying 1/3 less for staff salaries than the market rate."

Providers described audit, utilization review and recoupment procedures that they felt were punitive and risked undermining the financial stability of their programs. "Pre-authorization and UR [utilization review] is also a problem – the attitude is that the mental health providers are trying to rip off Medicaid," said one manager. CMHC management said that they are exposed to too much risk for the level of reimbursement received. Medicaid audits can extrapolate the findings from a small sample of cases and recoup very large amounts that undermine providers' already marginal financial stability. It was also noted that audits are inconsistent, with some auditors disallowing claims that other auditors allow, and there was a general feeling that Medicaid auditors were not well-versed in mental health policy and practices.

It was noted that only 2% of the mental health and substance abuse budget goes to older adults. Advocates said that this is not sufficient to meet the needs. "We need to be more active advocates for more funding," one advocate stated. "There used to be case management for elderly people, but it was cut. This is the cheapest way to serve people, but it is no longer funded, because some providers abused the system. Instead of targeting the specific providers who abused the system, they cut entire programs out."

Consumer & Family Involvement

Many providers and consumers felt that there is insufficient consumer involvement in policy-making, and that more such input is needed to develop a recovery-oriented, consumer-driven system. "The Department needs more active involvement of consumers in solving the problems of the system," an advocate said. "Participation of consumers at ODMHSAS is still spotty." Consumers and advocates noted that more consumers, and a broader range of consumers, should be involved in planning, policy direction, and systemic improvements at the state level.

At the local level, significant and meaningful involvement of consumers and family members in governance, program development, and quality assurance was the exception rather than the rule. "There are no opportunities here for involvement," a consumer said of one CMHC. "There is an advisory board, but consumers and families are not on it. No consumers or family members are on the governing body either." Staff at another CMHC said, "Consumers and families are not involved in governance. Each county in our area has an advisory board, but there's no requirement for consumers or families to be on these boards." A sizeable minority of staff and managers seemed unfamiliar with or even hostile to the idea of involving consumers and families in governance.

Responses about consumer involvement in treatment planning were mixed. All providers said that it is their policy to involve consumers in developing their treatment plans, but some indicated that rigid paperwork requirements made this difficult. "It's the client's treatment plan – they should call shots – but we have to fit them into cookie-cutter slots," said one manager. Another provider said "We try to involve consumers, but we are supposed to use specific kinds of language and wording in the treatment plan, and we are also supposed to use the client's own words. This is impossible!" Many consumers said they were involved in a meaningful way and that staff treated them as partners. Others felt that staff tried to involve them, but didn't have

enough time to do this right. Still others reported problems like being asked to sign a blank treatment plan form, or being handed a completed treatment plan that they had never seen and being told to sign it. “The meeting is over quickly and you have no real involvement in treatment planning,” one consumer said. “People sign the plan anyway, because if you don’t sign, they will get a court commitment against you.”

An older adult consumer stated that nothing was accomplished for mental health within the Legislature until consumers got involved, and said that “older consumers now need to organize. No one talks about recovery in the community. It’s supposed to be the goal for other people, so why not for older people?”

References:

ODMHSAS (2006). *Report on the Implementation of Programs of Assertive Community Treatment (PACT)*. 2006, April 1. Submitted to the President Pro Tempore of the Senate and Speaker of the House of Representative pursuant to House Bill 1084.

OKDHS, (n.d.). Retrieved August 2006 from <http://www.okdhs.org/medapp/medicaideligibility.htm#Blind%20and%20Disabled>.

Chapter 7: Co-occurring Mental Health and Substance Abuse Disorders

The purpose of this chapter is to describe services for adults diagnosed with co-occurring mental health and substance abuse diagnoses, including existing resources, particular strengths of current initiatives, and needs. The chapter includes narrative information gathered through focus groups and personal interviews, as well as existing data from ODMHSAS and other sources.

A. Existing Resources

Until quite recently, Oklahoma did not have a plan to assure that individuals with co-occurring mental health and substance abuse disorders had access to integrated mental health and substance abuse treatment. Although some community agencies understood this need and were prepared to respond appropriately, the system overall had little capacity to serve persons with a dual diagnosis. As described below, ODMHSAS has initiated a pilot program with 15 agencies in five counties to change this.

B. Strengths

In 2004, ODMHSAS received a five-year Co-Occurring State Incentive Grant (COSIG) from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). The overarching goal of the OK-COSIG project is to develop an Integrated Services Initiative (ISI) to improve the delivery of state-funded services for people in Oklahoma with or at risk for co-occurring mental health and substance abuse disorders. The project will contribute two interventions to promote systemic infrastructure change: 1) a standard protocol for the screening and assessment of mental health and substance abuse problems will be developed, evaluated, and field tested, and 2) a model of integrated treatment will be developed that is accessible, culturally competent, and grounded in evidence-based practices.

During the first year of activity, project participants and staff identified an integrative model and developed a consensus to support the implementation of this model to treat people with co-occurring disorders. The Change Agent concept was adopted; a Change Agent is a clinician or other front-line staff member with additional training in providing integrated services to people with co-occurring disorders who advocates and acts as a consultant to staff and professionals at his or her agency. The training needs, competencies, and curricula were identified and initial training provided, and a training manual developed. Planning was begun to develop three model sites to serve as pilot projects; the model sites came online in the fall of 2005, the beginning of the second grant year.

In December 2004, Oklahoma was invited to attend a Co-occurring Policy Academy sponsored by SAMHSA in Washington, D.C. A 12-member team comprised of staff from ODMHSAS, OHCA, University of Oklahoma Health Sciences Center and provider organizations attended and developed a state plan that supports and broadens the goals of the original COSIG Grant. The state plan highlights the importance of prevention, collaboration with other state agencies, advocacy organizations and the general health care community, as well as blended funding mechanisms and licensure and credentialing issues. This plan has helped expand the original scope of the COSIG Grant, supported systems integration inside ODMHSAS, and promoted greater integration among partnering agencies and organizations.

The OK-COD Integrative Treatment Screen instrument was developed and made available online as a part of the ODMHSAS Integrated Client Information System (ICIS). The instrument is being tested for reliability, validity, sensitivity and specificity. An ISI Advisory Group of stakeholders was formed, with subcommittees on Training and Workforce Development, Screening and Assessment, Outcome and Evaluation, Financial Issues, and Systems Integration.

A Consensus Document was developed for use among local providers at each model site; it spells out in detail the responsibility of each agency to the other agencies. The document was endorsed by the agencies at each of the model sites involved in the pilot projects, and is considered a major accomplishment. The document describes a consensus plan of action that is consumer-driven and recovery-focused; it also articulates the commitment of co-signers to specific activities and objectives, at all levels of the system.

A cross-training initiative for substance abuse service providers and mental health service providers was implemented in the first year of the project, and cross-training on creating a trauma-informed system was offered in the second year of grant activity. Also during the second year, consensus-building among stakeholders continued, workshops and core trainings were delivered, and agencies for the second cohort of pilot programs were identified. There are currently 15 community providers that have agreed to work toward becoming model dual-diagnosis capable programs. These programs are located in Oklahoma City, Norman, Tulsa, Vinita, and Tahlequah.

C. Needs and Existing Barriers

Unmet Needs

The SAMHSA annual National Survey on Drug Use and Health (NSDUH), 2004, estimated that 9.6 percent of all adults in the United States had serious psychological distress (SPD) in the past year (Wright & Sathe, 2006).

Oklahoma ranked ninth among all states, with an estimated 10.9 percent of the population, age 18 years or older, having serious psychological distress in the past year. In the 2002 NSDUH, an estimated 28.9 percent of adults aged 18 or older with SPD used an illicit drug in the past year. (Epstein J., Barker, P., Vorburger, M., & Murtha, C., 2004). Extrapolating these numbers to the estimated Oklahoma population with SPD results in an estimated 83,909 adults aged 18 or older with a co-occurring disorder in Oklahoma.

Among the 71,584 clients who received ODMHSAS-funded services in fiscal year 2005, an estimated 14,615 (27%) should have been served in an either integrated-capable programs (where providers can link people with the right treatment) or in enhanced programs (which provide integrated mental health and substance abuse services), based on diagnosis, presenting problem or assessment scores. While there is currently no ideal way to collect data on clients served in integrated programs, providers report the service focus for each client. During FY2005, 2,701 clients were served with ODMHSAS funds under one of three multi-service categories: mental health, substance abuse and domestic violence; mental health and substance abuse (where a program provides both services separately); or co-occurring (where integrated mental health and substance abuse services are provided). This results in 11,914 (82%) dually diagnosed clients with an unmet need for integrated substance abuse and mental health services.

This is an underestimate of unmet need for two reasons. First, the analysis does not include an additional 18,032 persons for whom mental health or substance abuse services were

reimbursed by OHCA, and who are therefore not included in the client information system. Extrapolating from the ODMHSAS data, there are an additional 4,868 persons estimated to need integrated services. Finally, this analysis is limited to persons who present for treatment. As described above, we estimate that almost 84,000 adults have co-occurring disorders. Based upon the services data, 77% of this group is not presenting for either mental health or substance abuse treatment.

Policies

Focus group participants said that there are several policy issues that need to be resolved if the Department's goal of providing integrated mental health and substance abuse treatment is to be implemented successfully statewide. It was noted that while plans call for coordination or integration of treatment at the provider level for people with dual diagnoses, the Mental Health and Substance Abuse Divisions within ODMHSAS maintain their separate "silos," and have policies that are not always compatible. For instance, the two divisions have different eligibility requirements, different staff licensures and certification requirements, and focus group participants said that the divisions have different approaches to monitoring and oversight. They even refer to the people they serve by different names: people using mental health services are called "consumers," and people receiving substance abuse services are called "clients." It was pointed out that while one of the Department's goals is that providers develop "Dual Diagnosis Capability," this concept has yet to be defined concretely.

Practices/Services

Staff and management in several programs pointed out that for clients with dual diagnoses, services are still fragmented: "About 85% of our clients have co-occurring disorders. We run a co-occurring outpatient group, but we're not allowed to do substance abuse treatment because we don't have a Certified Alcohol and Drug Counselor. Yet there's little in the way of outpatient substance abuse services locally." Consumers, family members and providers all described how difficult it is for dually-diagnosed individuals to find services that meet their needs. "We have no place to take mental health consumers who have acute drug and alcohol problems. There's no place to take them for detox," one CMHC manager said. A consumer said, "Mostly staff do not understand how to treat co-occurring mental health and substance abuse problems. If you're a mental health consumer, they don't want to hear about your drug issues." A CMHC staff member noted that "most drug and alcohol programs will not accept people with dual diagnoses - including our own! It's very frustrating to clinicians, even more so to clients."

In a residential substance abuse program that says it provides co-occurring mental health and substance abuse services, dually diagnosed clients indicated that the only mental health service they received was medication, and that in groups, they only dealt with substance abuse issues. "That's not co-occurring treatment to me," a client said. Clients also stated that almost everyone in the program was put on psychiatric medications, sometimes on multiple medications, even though fewer than half of them were dually diagnosed. Most people in the focus group said they felt seriously over-medicated: "I am too out of it from the meds to really work my recovery program."

It was noted that drug courts seem to be moving away from including persons with co-occurring mental health and substance abuse problems because they believe that they don't have capacity to serve them. Staff said that there is a need to ensure that every drug court has a

mental health provider on the team, and that every mental health court has a substance abuse provider involved.

Workforce Development and Training

Issues related to licensure, certification and program accreditation were raised by several providers. It was noted that the master's degree curriculum for Licensed Professional Counselors (LPCs), a licensing category common among mental health staff, does not include any required substance abuse courses. Most substance abuse treatment facilities use unlicensed Certified Alcohol and Drug Counselors (CADCs). As services are currently organized, most substance abuse agencies said they do not have staff members qualified to do mental health screening or provide mental health services, and many such providers' accreditation also limits the agency to providing substance abuse services only. Reciprocally, participants said that staff in most mental health programs are not trained to provide substance abuse services, so it is difficult for these agencies to envision how they will be able to provide integrated services. Staff and management suggested that there is a need for co-licensing of individual staff so that they can provide and bill for both types of services to an individual client.

Organization/Collaboration

Respondents pointed out that differences in the cultures of mental health and substance abuse services providers remains a barrier to systems integration and services integration for co-occurring disorders. The ISI Advisory Committee noted that "There is still a lot of work to do in the effort to make sure the substance abuse agencies are full partners in the integrated system of services."

Data

The ISI Outcomes/Evaluation Subcommittee found that there was a need for training for data entry personnel and providers related to the ability to enter more than one diagnosis into the information system. The subcommittee also called for assurances that the data system has the capacity to use the Integrative Treatment Screening instrument once it is ready for implementation.

Financing

The lack of a blended funding stream to serve people with co-occurring disorders was the most frequently mentioned barrier by focus group participants. "We should be able to co-mingle mental health and substance abuse funds," one mental health program manager said. "It's hard to do co-occurring treatment when the funding streams are segregated." Another provider asked "What about integrated funding? They say it is not an option. Providers are asked to integrate their thinking about serving this population, but at the state level, the separate funding silos exist." Yet another provider stated that "We have high rates of identifying consumers with co-occurring disorders, but there's no path to getting paid – neither mental health nor substance abuse wants to pay for it." In fact, mental health funding can be used to provide substance abuse services, but apparently, this fact is not clearly understood at the direct service level. Another participant warned that "there's a danger of creating a third silo, because both systems want to avoid treating people with co-occurring disorders. And for financial reasons, they each fear they will lose clients to the other system."

Some providers noted that reimbursement rates were lower for substance abuse services than for mental health: “The Department pays \$48 for a substance-abuse session but \$74 for a mental health session. There’s no reason for this disparity, and sometimes it drives agencies to game the system,” staff at one agency said. It was noted that, while many mental health consumers are Medicaid-eligible, many substance abuse clients are not, and that this issue needs to be addressed if integrated services are to be provided and funded. The ISI Financial Subcommittee recommended that an enhanced Medicaid rate specifically for co-occurring treatment services should be developed, reflecting the additional cost involved in assessment and treatment for both mental health and substance abuse.

Many substance abuse treatment facilities use unlicensed Certified Alcohol and Drug Counselors (CADC) to provide substance abuse treatment to dually diagnosed individuals, but the Oklahoma Health Care Authority does not reimburse for services provided by CADCs.

Leadership at agencies serving as model sites for the ISI noted that “under the grant, responsibilities are being cost-shifted to the providers.” A program manager said, “These initiatives are expensive for providers to participate in. We have to train 25% of our staff in co-occurring disorders –for us, that’s 100 people at \$65 per hour –the investment is huge.” It was also noted that agencies lose additional money by sending staff to training because that time is not billable.

Consumer & Family Involvement

While consumers and families were involved with planning at the project’s outset, it was pointed out that many consumers have dropped out since the project started. An advocate said, “The process must be made more welcoming to people with dual diagnoses.” It was also noted that a number of consumers who have been hired as Recovery Support Specialists would like to participate but are unable to get leave time from their jobs to attend meetings.

References:

Epstein J., Barker, P., Vorburger, M., & Murtha, C. (2004). *Serious mental illness and its co-occurrence with substance use disorders, 2002* (DHHS Publication No. SMA 04–3905, Analytic Series A-24). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

Wright, D., & Sathe, N. (2006). *State Estimates of Substance Use from the 2003–2004 National Surveys on Drug Use and Health* (DHHS Publication No. SMA 06-4142, NSDUH Series H-29). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

Chapter 8: Criminal Justice Issues

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

Adults come into contact with the criminal justice system first through the police, then with the jails, then with district attorneys and the courts, then, if found guilty and sentenced, with the prisons and jails, and finally, if court-ordered, with probation or parole. At each of these contacts, concerns related to the identification and treatment of mental illness and substance abuse may become important; thus, an analysis of the criminal justice system from this perspective requires attention to each stage of the process.

A. Existing Resources

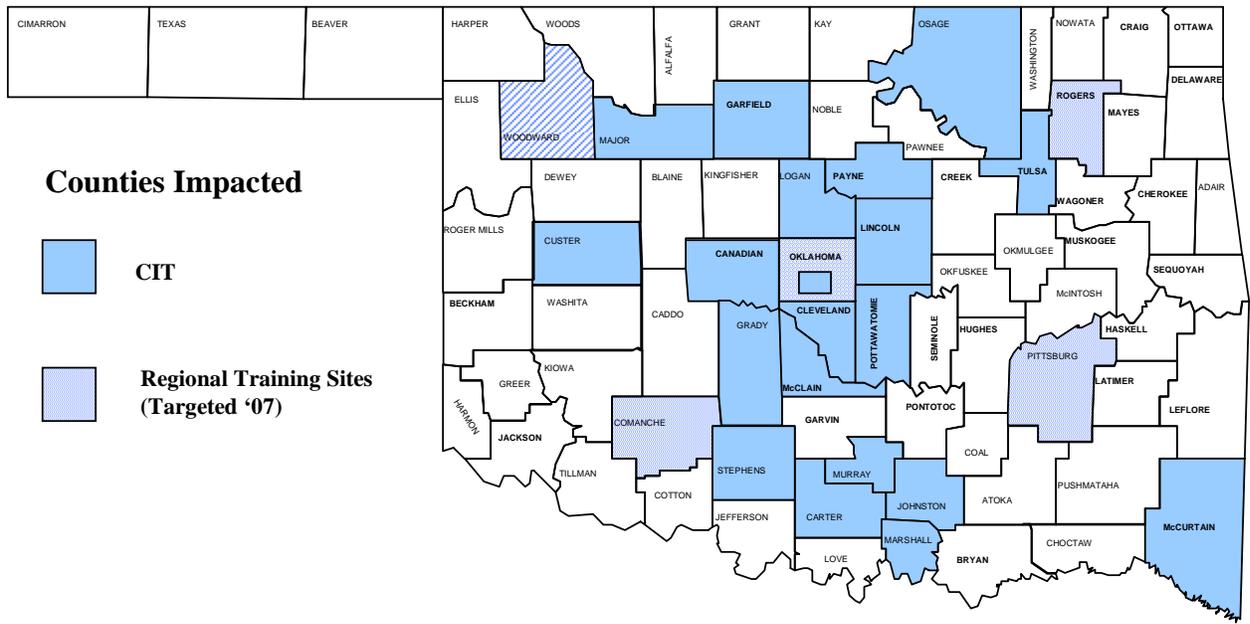
Police forces, jails, the courts, and the Corrections system have developed programs to address problems of mental health and substance abuse, both in collaboration with, and independently of, the Department of Mental Health and Substance Abuse Services. These are described in this section.

Law enforcement agencies are implementing specialized approaches to improve their responses to individuals in psychiatric crises. ODMHSAS, in partnership with the Oklahoma Police Chiefs Association, Oklahoma City Police Department, the Oklahoma Mental Health Consumer Council, consumers, and NAMI OK, provides training and technical assistance statewide for jurisdictions wanting to implement the Crisis Intervention Team (CIT) model, as developed by Memphis, TN. This gives officers a context for understanding mental health issues, and practical strategies and techniques for intervening safely in a psychiatric emergency.

The Tulsa Police Department adopted a strategy which includes a substantial commitment to training, a unique role for the police officer as the initial crisis responder and the added benefit of having access to a well established mobile crisis team comprised of mental health professionals who are available as secondary responders upon the officers' request.

Exhibit 8.1 highlights the counties in Oklahoma that have law enforcement officers trained in CIT or other formalized training in psychiatric emergency responses.

**Exhibit 8.1.
Crisis Intervention Training of Police Officers by County
FY2006**



Source: ODMHSAS

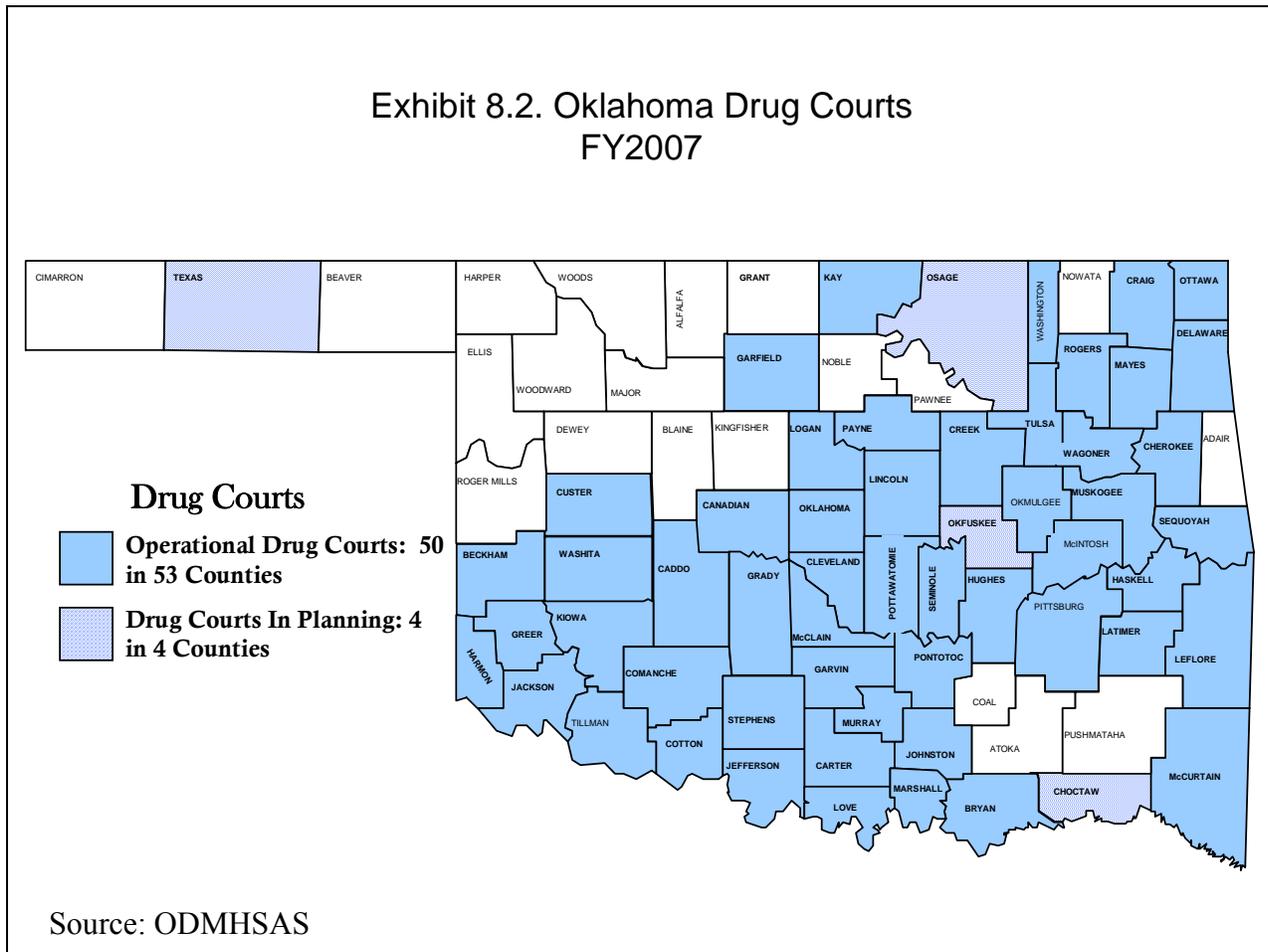
To assist DUI offenders with drug and alcohol assessments and treatment, the ODMHSAS Alcohol and Drug Substance Abuse Course (ADSAC) was established. The ADSAC is a statutorily authorized program to establish certification, assessment and curricula requirements for ADSAC instructors and assessors. The ODMHSAS ADSAC staff collaborates with the Oklahoma Department of Public Safety (DPS) in working with individuals who have had their driver's license revoked due to drug- or alcohol-related violations. In addition, ODMHSAS has collaborated with DPS to establish a data sharing protocol to provide ADSAC assessors with prior DUI conviction information.

The state's first mental health court was established in Oklahoma County in 2002. There are now five in the state, with more under development. Mental health courts work to divert people with mental health problems who are accused of non-violent crimes from jail by re-directing them into services. Participants must enter into a plea arrangement and sign a participant performance contract indicating their responsibilities and the consequences of not meeting those responsibilities. A multi-disciplinary team provides support, linkages and monitoring to participants.

ODMHSAS operates a statewide drug court program; there are currently 50 drug courts in operation, with additional courts in various stages of development. The 50 drug courts include

38 adult drug courts, 10 juvenile drug courts, and 2 family courts. Case management is included in the drug court program to help clients meet their educational or vocational needs, address family or financial issues, or other concerns that might cause relapse.

In FY 2005, 2,563 individuals were served through drug courts, out of an estimated 6,886 eligible adults. The following map indicates the counties with operational and planned adult drug courts. While the majority of counties have an adult drug court or are planning for one, there are none in the northwest region of the state.



Drug and mental health courts represent one form of jail diversion. Both Oklahoma City and Tulsa have other mental health jail diversion programs. NorthCare, a Community Mental Health Center (CMHC) in Oklahoma City, began a day reporting service in January 2005, in which people report daily for groups and counseling, call in three times a day, and are eligible to have charges dropped if they satisfactorily complete the program. A community-based advisory committee assists with the implementation and monitoring of outcomes. Family and Children Services (F&CS) operates a Tulsa-based jail diversion program, initially funded by a SAMHSA grant. This program works to identify people with mental illness early in their criminal justice involvement and either divert them to services or make sure they get the services they need in jail. Appropriations have been approved by the Oklahoma Legislature to continue that program.

If individuals are jailed, the availability of mental health and substance abuse services is very limited. For example, the Oklahoma County Jail, the largest in the State, has between 45-55,000 intakes per year. The average length of stay is 27 days, but stays have been up to three years. Jail staff estimates that the vast majority of persons have either substance abuse or mental health problems or both, although these are often not formally identified and even less commonly treated. When individuals enter the facility, there is a brief screening for mental health difficulties by a triage nurse. However, if the individual chooses not to self-identify, they will not be referred for assessment and possible treatment, unless they are later identified by jail staff who observe acting-out behavior. The county contracts for the services of a small mental health team including a psychiatrist. If individuals are assessed, they may receive psychotropic medications. Generally, these are older antipsychotic medications because of budget restrictions. Other interventions are limited to brief counseling in response to a crisis. Individuals may also be placed in a special observation unit if there is a high risk of suicide. Because of close monitoring, the jail has been able to reduce the suicide rate. With the exception of two Alcoholics Anonymous groups, there are no addiction services. There are no provisions for helping individuals access community services upon release. Staff recognize that the need is much greater than can be met by available resources. They recognize that persons with lower intelligence who also have mental health or substance abuse problems are particularly likely to fall through the cracks in the community system of care.

ODMHSAS collaborates with the Oklahoma Department of Corrections (DOC) to provide several avenues of substance abuse treatment for state prison inmates. The ODMHSAS contracts with established substance abuse programs to provide screening and assessment at the State's prison intake facility and to provide residential treatment services at several prisons. Treatment services are also provided at specific community correction centers and for individuals in the probation and parole system.

A national study by the Bureau of Justice Statistics (BJS) released in September 2006 found that 56 percent of state prison inmates and 64 percent of inmates in local jails have a mental health problem. A mental health problem is defined by either a mental health diagnosis or treatment occurring within 12 months prior to the inmate interview or symptoms of a mental health disorder as specified by the DSM-IV. This study also found that 66 percent of state prison inmates and 67 percent of inmates in local jails have substance dependence or abuse (BJS, 2006a).

On June 30, 2005, 9,585 inmates were in the custody of local jails in Oklahoma (BJS, 2006b). Applying the prevalence estimates from the 2006 BJS study results in an estimated 6,134 jail inmates with a mental health problem and 6,422 with a substance use disorder. On June 20, 2005, 21,518 inmates were in Oklahoma state prisons (both state and contract facilities; DOC, 2005a). Applying the prevalence estimates from the 2006 BJS study results in an estimated 12,050 inmates with a mental health problem and 14,202 with a substance use disorder.

During FY 2005, a total of 4,572 Oklahoma prison inmates received substance abuse treatment from a private prison (therapeutic community) or a residential substance abuse program at a state prison. The 4,572 number does not include offenders participating in AA or NA programs, which are considered voluntary faith-based services (personal communication with Bud Clark, July 20, 2006).

According to the Oklahoma Department of Corrections, approximately 36 percent of prison inmates have a history of, or are currently diagnosed with, mental illness. Seventy-two

percent female inmates, and 32 percent male inmates, fall in that category. Approximately 22 percent currently receive treatment, or need and refuse treatment, for a serious mental illness. These numbers/percentages have dramatically increased since 1998. As of June 2005, approximately 5,000 inmates take psychotropic medication as prescribed, and about 20 percent of inmates diagnosed with mental illness refuse to take recommended medication. Overall, 57 percent of prison inmates diagnosed with mental illness were incarcerated for non-violent offenses (68% of female inmates, and 54% of male inmates). The percentage of inmates who were first-time offenders was 47 percent (DOC, 2005b).

Specialty mental health units have been created at three state prisons, Joseph Harp and Oklahoma State Penitentiary for men, and Mabel Bassett for women. Joseph Harp and Oklahoma State Penitentiary's units are physically separate from the general population. Mabel Bassett's unit is located within a building that houses general population inmates. These units provide acute care and intensive mental health treatment for the most severely ill inmates in housing areas that are segregated from the general population, where inmates with mental illness often are vulnerable. All three units accept inmates from other prisons. Joseph Harp also has an intermediate care unit. At Joseph Harp and Mabel Bassett, inmates are seen daily by mental health staff, have access to medication, receive individual and group counseling and are assisted with pre-release planning. Inmates housed on the mental health unit at Oklahoma State Penitentiary receive similar services; however, the 23-hour-per-day lock-down status of the facility limits frequency of access to services.

The DOC, as noted in its Strategic Plan for 2006 – 2010, is addressing the need to improve offender re-entry services. Upon incarceration, a case plan is to be developed for each inmate to address their eventual re-entry into the community. Areas to be addressed include substance abuse, cognitive behavioral therapy, and education. Through effective case management, and positive outcomes of cognitive-behavioral therapy and psychoeducation, it is believed that the individual can be moved more quickly through the system. This will foster the successful transition from inmate to community member, and also reduce the costs incurred by continued incarceration or re-offense without proper treatment (DOC, n.d.a).

With newly appropriated funds by the state legislature, ODMHSAS and DOC are collaborating to strengthen discharge planning for inmates preparing to re-enter the community and linkage to needed mental health services and supports. Specialized treatment services for inmates with co-occurring mental health and substance abuse disorders are also being initiated.

B. Strengths

While the service needs of people who have mental health and/or substance abuse problems and criminal justice involvement cross a wide range of agencies and jurisdictions, there are a variety of existing resources and new, innovative initiatives that are beginning to make inroads to address these needs. There are also new and intensified efforts at cross-system collaborations that show promise in developing a continuum of approaches to meet the multi-faceted needs of this population at the state and local levels.

The police/mental health partnership discussed earlier is one of Oklahoma's strengths. As shown in Exhibit 8.1, above, law enforcement agencies in twenty-one counties have sought training and assistance. These agencies realized that they were not prepared to meet peoples' needs in the most humane and sensitive manner and wanted to improve their effectiveness. The adoption of this initiative was influenced by problems police encountered in situations involving

people with mental health problems, by the successes of similar programs in nearby jurisdictions, and by the active promotion by local consumers and family members.

In Tulsa, the Police Department adopted an approach that represents a significant expansion of the Memphis CIT model described above. Under the Tulsa Mental Health Response Officer (MHRO) model, all new officers receive most of the Memphis CIT model curriculum as a part of their initial training, and MHROs receive an additional 40 hours of training. Each class includes twenty police officers, as well as mental health professionals to facilitate cross-training; 100 officers have received the training-to-date. The goal is to have 150 officers - 25 percent of the police force-with MHRO training.

On a local level, collaborative relationships between law enforcement and mental health agencies have been developed, which greatly contributes to a better understanding of the problems faced by both systems. One example of this collaboration can be found in Tulsa with the Police Department and the COPEs (Community Outreach Psychiatric Emergency Services) team, which works with both the police and the Tulsa Jail Diversion program. Teams of two- a mental health therapist and a case manager - are generally on call 24 hours a day, seven days per week, to respond to psychiatric emergencies. COPEs responds to about 6,000 calls annually. They are often at the scene with police, who will allow the COPEs team to take control over the situation. Their goal is to engage the individuals' trust, to inform them about their choices, and to assist them in getting access to available services. Tulsa police cooperate regularly with both the COPEs team and the PACT teams to avoid unnecessary arrests.

Tulsa also has a courthouse-based jail diversion program, funded by a SAMHSA grant, which seeks to identify persons who have been arrested and jailed who require mental health services. The goal is to work with the judge presiding over the individual's case and to offer recommendations for pre-trial release or community sentencing, including ordering individuals to accept treatment. In addition, staff works to assure access to medications while in jail and to link individuals to community services upon release. The four-person staff does not have the resources to identify and assist all persons who enter the criminal justice system in Tulsa and are in need of mental health services.

Oklahoma County has a jail diversion program, the Day Reporting Program, limited to non-violent offenders. Individuals are identified at jail intake and recommendations are made to the presiding judges regarding appropriateness for screening and assessment at Northcare CMHC. Individuals admitted to the program are released from jail and live at home, reporting each weekday for up to 70 days. They receive treatment and rehabilitation services and report in by telephone on evenings and weekends. After disposition, they are offered additional services by Northcare. The program is considered successful, but is only able to serve 60 men and women at a time.

Outcomes of adult drug courts have been evaluated by staff in the ODMHSAS Decision Support Services Division. Between FY2002 and FY2005, the retention rate of active and graduate participants was 75.2 percent. To assess outcomes, comparisons were made between graduates' characteristics at entry and at graduation on a number of indicators. The findings were as follows:

- an 84.4 percent decrease in unemployment;
 - a 59.7 percent increase in income;
 - a 19.5 percent decrease in the percent of participants without a high school diploma;
 - a 20.5 percent increase in the number of participants who had children living with them;
- and

- graduates with methamphetamine as their drug of choice had better outcomes on unemployment, income, and child custody, than graduates with another drug of choice.
- Comparing the recidivism rate, measured by re-arrest, of drug court graduates to that of successful standard probation offenders or released prison inmates, indicates the following:
- drug court graduates were 63 percent less likely to be re-arrested than successful standard probation offenders; and
 - drug court graduates were more than two times (or 131%) less likely to be re-arrested than released prison inmates.

Oklahoma County has developed a Mental Health Court. Like the Day Reporting Program, briefly described above, it is only able to serve a limited population. To be eligible, individuals must enter a guilty plea and agree to a sentence if they fail to complete a performance contract. Once all parties (the client, the judge, the district attorney, and the public defender) have signed off on the agreement, the client is assigned to the Court case manager who links the person to mental health and substance abuse services. The program also has a probation officer assigned to all its clients. The program can serve up to 25 clients, generally for one year. Over the two and one-half year life of the program, there have been 22 graduates whose charges were dismissed. Eleven persons have had their probation revoked. Other counties have since begun mental health courts.

As described above, two prisons, Joseph Harp Correctional Center and Mabel Bassett Correctional Center, have developed extensive mental health services in designated, separated housing areas. At Joseph Harp, prisoners are assessed for level of acuity and assigned to one of three units which are separate from the general prison population. These include a Mental Health Unit for intake and acute care, in which individuals are largely confined to a cell; a transitional care unit, in which individuals receive individual and group treatment; and an intermediate care unit, in which individuals have the greatest freedom of movement. If they are successful in the latter unit, inmates are transferred to the general population at Joseph Harp or another prison. Individuals may remain on a mental health unit for their entire stay if they are considered too vulnerable to be placed in the general population. Treatment includes both medication and rehabilitation. There is also a separate Habilitation unit for individuals who are developmentally disabled, some of whom are also mentally ill. Clients with whom we met were very positive about the program and the staff, but commented on the lack of recreational opportunities and were concerned about what services and supports would be available to them upon release. While prison mental health staff were proud of what they have accomplished, they were concerned that they did not have the resources to reach more individuals and to provide a stronger program to individuals they work with.

Joseph Harp also has residential substance abuse programs that are valued by participating clients. The Lifeline program is quite structured; clients meet with staff four days a week. The focus is on understanding situations that trigger the craving for drugs or alcohol, as well as examining past behavior and belief systems and changing poor prior patterns. The program also works with individuals on reconnecting with family and planning for release, and AA and NA groups are offered. One concern raised by participants is that the program is too small to serve everyone in need. They also expressed concerns returning to their home communities, particularly in rural areas, where the police believe they are likely to re-offend and where follow-up substance abuse services are difficult to access. Both staff and clients commented on the differences between Joseph Harp and other prisons. A large part of the population is receiving some type of service. For example, an estimated 440 prisoners are on

psychiatric medications. A new geriatric unit is in the planning stages. The diversity of population promotes tolerance and respect for disabilities. Both inmates and correctional officers will identify persons who show signs of serious mental health problems to the staff. There are picnic tables in the yard and family events around them. As one person expressed it, “Here you can relax. You don’t have to worry about being cut for your tennis shoes.”

Similar services are provided to female inmates at Mabel Bassett. There is a separate mental health unit, as well as a large proportion of general population receiving mental health and substance abuse treatment services. Approximately half of the entire prison population at this facility is receiving psychiatric medications. In addition to individual and group treatment provided by mental health professionals, outside volunteers provide self-help, arts and crafts and current events groups. Some of these services have been provided through partnerships with the Oklahoma Mental Health Consumer Council and the Oklahoma Chapter of the National Alliance for the Mentally Ill. Mabel Bassett also has two residential substance abuse treatment programs. Clients were very positive about the Substance Abuse Treatment (SAT) program available to medium security inmates assessed as having a substance abuse treatment need. The SAT structure is similar to the Lifeline program at Joseph Harp. In addition, three program graduates stay on the unit to act as mentors, which is viewed as a very important, supportive feature of this program. Participants were concerned about limited access to this program. The federally funded residential substance abuse treatment program available to minimum security inmates was poorly regarded by participants. Participants’ primary dissatisfaction with this program involved the stipulation that inmates in this program are not permitted to have contact with inmates not in the program (a requirement of the grant) and participants’ perception that some inmates have roles that give them undue influence over others, which undermines the therapeutic value of the program.

In order to support community re-entry, mental health programs at Joseph Harp and Mabel Bassett have focused on establishing eligibility for Medicaid and Supplemental Security Income prior to release. Staff have received SSI eligibility training and working relationships have been established with the local Social Security offices to assure that applications receive priority attention. At Joseph Harp, most such applications have been approved the first time they are submitted, which contrasts with the typical outcome for SSI applications in Oklahoma. Recent staffing shortages at Joseph Harp have disrupted this program. With monies recently approved by the legislature and the support of the Oklahoma Department of Mental Health and Substance Abuse Services, facilities with mental health units are planning to expand their discharge planning efforts for persons with serious mental illness being discharged to the community.

The Department of Corrections, in collaboration with ODMHSAS and OHCA, are working with Mathematica Policy Research to develop new procedures to assure that persons who are seriously mentally leaving correctional institutions are enrolled in the Medicaid program. This should enable them to access mental health services more easily because providers can be assured that there is a source of payment for these services. Thus, they should be better able to obtain psychiatric medications and other follow-up treatment to assist in re-entering the community. This program is sponsored by the Substance Abuse and Mental Health Service Administration.

An innovative inter-disciplinary team of health and human services professionals provides re-entry services for high risk/high needs prison inmates under the age of 35, including those with mental health problems, who will be returning to Oklahoma County. Project Protect

is a collaboration among several county agencies, funded by a federal grant. The staff makes contact with inmates who are within six months of release, and offer a range of services to help people transition, including vocational training, assistance with applying for government benefits, lining up treatment providers, arranging for housing, and other services. They also maintain follow-up contact with people after they are released.

C. Needs and Existing Barriers

Unmet Needs

The unmet need for behavioral health treatment, particularly substance abuse, is demonstrated by the large number of addiction-related arrests, as well as prior drug and alcohol use among jail and prison detainees. There is also evidence of high rates of treatment for serious mental illness prior to incarceration in both jail and prison.

According to the Oklahoma Department of Corrections, Oklahoma ranked 12th among the states in total uniform crime rate per 100,000 population, with 4,743 violent and property crimes per 100,000 population (DOC, n.d.b). Among all states, Oklahoma had the highest rate of female imprisonment rates in 2004: 129 per 100,000 female residents were imprisoned in 2004, totaling 2,300 imprisoned females (Frost, Greene & Pranis, 2004).

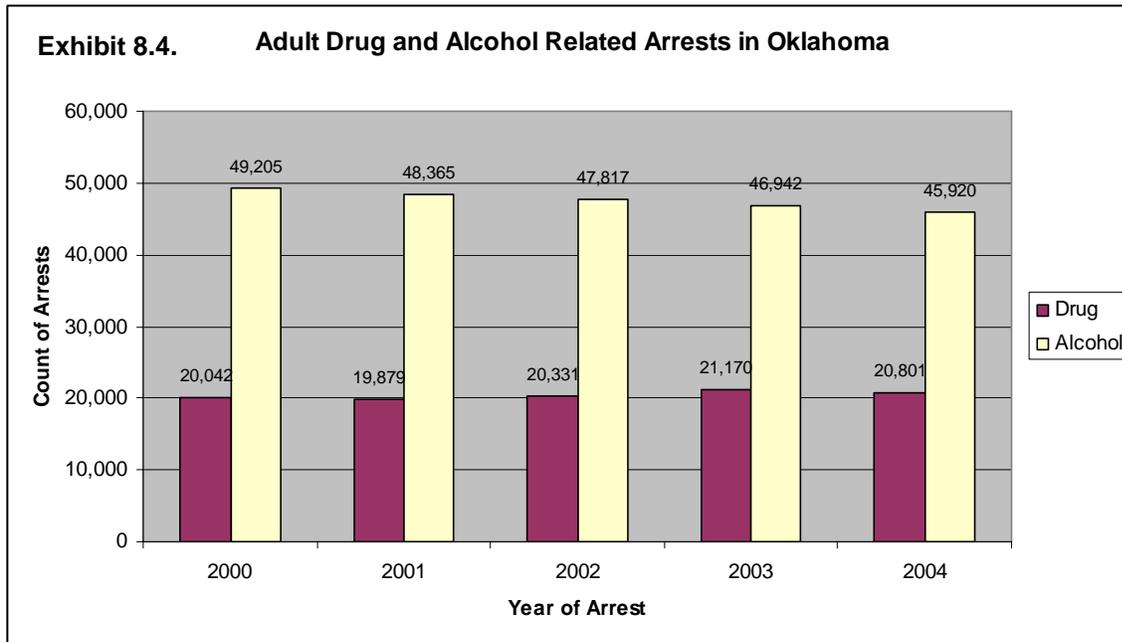
The State of Oklahoma, 2004 Uniform Crime Report (UCR), reported 22,714 arrests for drug abuse violations in Oklahoma in 2004. Possession of marijuana constituted 49.1% of the total drug abuse arrests, while sale of marijuana accounted for 4.9% of arrests. Possession of opium, cocaine and derivatives comprised 14.7% of the total drug abuse arrests; sale of opium, cocaine and derivatives equaled 2.9% of the total drug abuse arrests. Alcohol-related arrests (driving under the influence, drunkenness, and other liquor law violations) accounted for 29.0% of all arrests in 2004. This percentage represents the arrest of 45,920 adults and 1,773 juveniles (OSBI, 2006).

ODMHSAS routinely receives data from the Oklahoma Department of Public Safety (DPS) to provide data to the DUI Assessors licensed by ODMHSAS. Using those data, Exhibit 8.3 was developed to evaluate the number of DUI and drug convictions as a result of a motor vehicle or public place violation. These data do not include the number of convictions resulting from a violation of failing a blood alcohol limit test. The number of convictions related to motor vehicle or public place drug or alcohol violations increased during FY2003 to 26,108 from the 20,000 convictions that occurred in each of the other four years.

Exhibit 8.3. Oklahoma Department of Public Safety

Number of Drug or Alcohol Convictions by Year					
Motor Vehicle Violation Type	Fiscal Year				
	2000	2001	2002	2003	2004
DUI - Under 21	3,076	1,804	1,630	1,543	1,483
DUI	4,098	4,111	5,627	7,419	5,511
Felony Drug Possession	1,222	1,817	1,956	2,912	1,954
Misdemeanor Drug Possession	2,408	2,427	2,833	2,989	2,024
Drinking or Using Drugs in Public Place	2,663	2,892	2,527	4,223	3,878
Refused Test in Public Place	7,090	6,748	7,367	7,022	6,675
Total	20,557	19,799	21,940	26,108	21,525

Exhibit 8.4 illustrates that the number of drug-related arrests among adults in Oklahoma has been relatively consistent at 20,000 from 2000 through 2004. Alcohol-related arrests have been declining slightly since 2000, going from 49,205 in 2000 to 45,920 in 2005 (OSBI, 2001; OSBI, 2002; OSBI, 2003; OSBI, 2004; OSBI, 2006).



From 2000 through 2004, the number of drunk driving deaths increased from 229 to 278, respectively. In 2003, 38 percent of all traffic fatalities in Oklahoma were alcohol-related, compared to 40 percent nationally. Exhibit 8.5 shows the number of traffic fatalities for Oklahoma, alcohol-related fatalities, and fatalities in crashes where blood alcohol concentration (BAC) was 0.08 or above. The data in the table are related to fatalities that occur in crashes where at least one driver or non-occupant (pedestrian or pedalcyclist) involved in the crash had a positive BAC value.

Exhibit 8.5. Traffic Fatalities in Oklahoma

Year	Total	Alcohol-Related	Percent of Total	Highest BAC was 0.08+	Percent of Total
2000	650	229	35	194	30
2001	682	270	40	234	34
2002	739	251	34	215	29
2003	668	255	38	220	33
2004	774	278	36	245	32

Source: Alcohol Alert, Oklahoma Drunk Driving Statistics.
<http://www.alcoholalert.com/drun-driving-statistics-oklahoma.html>

With funding from the federal National Institute of Justice and Center for Substance Abuse Treatment, the Oklahoma and Tulsa County Jails were sites for the Arrestee Drug Abuse Monitoring (ADAM) projects. The ADAM project was designed to evaluate drug usage among new arrestees through the use of surveys and urinalysis. Data collection occurred one time each quarter for 14 consecutive days, eight hours per day. Exhibit 8.6 contains the percent of arrestees who tested positive for any drug (marijuana, cocaine, heroin, methamphetamine or pcp). A total of 4,313 arrestees were surveyed from the first quarter of 2002 through the third quarter of 2004 (ODMHSAS, STNAP Phase III, 2005).

Exhibit 8.6. Oklahoma ADAM Results

Percent Positive for Any Drug									
Year	Oklahoma County			Tulsa County			Statewide		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
2002	72.1%	72.1%	72.1%	73.4%	72.2%	77.2%	72.6%	72.2%	73.7%
2003	74.0%	72.5%	78.0%	71.8%	71.2%	73.2%	72.8%	71.8%	75.3%
2004	74.5%	78.4%	64.1%	70.3%	68.4%	75.9%	71.4%	70.9%	72.6%
Total	73.1%	73.0%	73.4%	71.8%	70.7%	75.0%	72.4%	71.8%	74.2%

The results from the ADAM studies indicate 72 percent of all arrestees in Oklahoma and Tulsa counties used at least one drug prior to arrest, with females slightly higher than males (74.2% vs. 71.8%, respectively). The rate of arrestees in Oklahoma County had a higher rate than the arrestees in Tulsa County (73.1% vs. 71.8%, respectively). Among arrestees surveyed at both county jails, 49 percent tested positive for marijuana, 24.7 percent for cocaine, 4.6 percent for heroin; 16.5 percent for methamphetamine, 3 percent for PCP and 31 percent tested positive for multiple drugs.

Of the 2,367 arrestees that completed the ADAM survey at the Tulsa County site, 28.5 percent reported having had inpatient or residential substance abuse treatment and 15.8 percent reported having had outpatient treatment at some prior time. When asked about prior mental health treatment, 13.5 percent reported having stayed at least overnight for mental health treatment at a psychiatric unit of a hospital or other facility.

Incarcerations

In 1999, ODMHSAS conducted a survey of 870 prison inmates in Oklahoma, as part of the State Treatment Needs Assessment Project (STNAP), funded by the federal Center for Substance Abuse Treatment (ODMHSAS, STNAP Phase I, 1999). Exhibit 8.7 indicates that an estimated 97.1 percent of inmates used alcohol and 41.9 percent reported using illicit drugs in their lifetime. When asked about past 30 day use, 12.4 percent reported using illicit drugs.

Exhibit 8.7. PREVALENCE OF USE AMONG PRISON INMATES IN OKLAHOMA, BY DRUG

Drug	Total Population	Population Estimates			Rate Estimates (%)		
		Lifetime	Last 18 Months	Last 30 Days	Lifetime	Last 18 Months	Last 30 Days
Alcohol	20,669	20,063	4,577	277	97.1	22.1	1.3
Illicit Drugs	20,669	18,438	8,661	2,567	89.2	41.9	12.4
Marijuana	20,669	18,183	6,909	2,285	88.0	33.4	11.1
Cocaine	20,669	12,644	1,631	78	61.2	7.9	0.4
Inhalants	20,669	3,876	277	66	18.8	1.3	0.3
Hallucinogens	20,669	10,653	286	0	51.5	1.4	0.0
Stimulants	20,669	10,449	1,920	337	50.6	9.3	1.6
Sedatives	20,669	8,749	1,337	17	42.3	6.5	0.1
Heroin	20,669	5,300	407	66	25.6	2.0	0.3

Exhibit 8.8 contains the estimated percent of prison inmates in need of substance abuse treatment by sex and time incarcerated. Among inmates incarcerated less than 18 months, an estimated 44.3 percent needed substance abuse treatment. Among inmates incarcerated 18 months or longer, more males were in need of treatment than females (19.4% vs. 6.9%, respectively).

Exhibit 8.8.
Inmate Need for Treatment

Gender	Months Incarcerated	Percent In Need of Treatment
Female	Less Than 18	53.1
Female	18 or more	6.9
Male	Less Than 18	41.7
Male	18 or more	19.4
Total	Less Than 18	44.3
Total	18 or more	19.6

In addition to conducting surveys with prison inmates, 382 probationers and parolees were surveyed to evaluate use of substances and the need for substance abuse treatment. The following table indicates an estimated 32.2 percent reported alcohol use in the past 30 days and 10.5 percent reported illicit drug.

Exhibit 8.9. PREVALENCE OF USE AMONG PROBATIONERS AND PAROLEES IN OKLAHOMA, BY DRUG

Drug	Total Population	Population Estimates			Rate Estimates (%)		
		Lifetime	Last 18 Months	Last 30 Days	Lifetime	Last 18 Months	Last 30 Days
Alcohol	31,471	30,493	22,462	10,125	96.9	71.4	32.2
Illicit Drugs	31,471	26,682	12,524	3,309	84.8	39.8	10.5
Marijuana	31,471	25,720	10,807	2,888	81.7	34.3	9.2
Cocaine	31,471	14,352	3,306	270	45.6	10.5	0.9
Inhalants	31,471	3,941	416	50	12.5	1.3	0.2
Hallucinogens	31,471	11,866	1,675	47	37.7	5.3	0.1
Stimulants	31,471	13,408	3,502	689	42.6	11.1	2.2
Sedatives	31,471	8,921	2,673	669	28.3	8.5	2.1
Heroin	31,471	3,312	223	124	10.5	0.7	0.4

Evaluation of all survey respondents under the Oklahoma Department of Corrections (DOC) supervision indicated an estimated 25.6 percent of all inmates and 28.3% of probationers and parolees were in need of substance abuse treatment. Using this estimate and number of inmates who participated in a DOC-approved substance abuse treatment program (4,572), an estimated 951 (17.2%) inmates have unmet substance abuse treatment need. This is a conservative estimate of unmet need because the estimate of need is dated and the results are based on self-report. The ADAM results show that 72% of arrestees are using drugs or alcohol at the time of arrest. If we assume that this rate (rather than 25.6%) should be used to estimate the need for addiction treatment, this would result in an unmet need of 10,960. This is a high estimate. The actual unmet need is probably between 951 and 10,960.

Policies

In October 2005, the Oklahoma Board of Corrections issued a resolution recognizing the needs of people with mental illness who “come into conflict with the law as a direct result of the challenge created by their mental illness”. The resolution acknowledges the need for increased funding in order to offer the necessary services, and urges government officials to develop and implement legislation and policies that support effective community-based health services, such as Programs of Assertive Community Treatment (PACT). It calls for further development of drug courts and jail diversion programs, and commits the Department of Correction to work with other agencies on better discharge and re-entry services, and to work collaboratively across agency and jurisdictional lines to improve mental health and substance abuse services available to people with criminal justice system involvement.

The seriousness and complexity of this constellation of problems was highlighted by the convening of an Emergency Summit on Mental Illness, Substance Abuse, and Criminal Justice in November 2005, hosted by NAMI-Oklahoma. One of the summit’s goals was to develop an action plan to be distributed to the Legislature and relevant agencies to serve as a vehicle for systems change.

In order to meet the multi-faceted needs of adults with mental health and/or substance abuse problems who are involved in the criminal justice system, respondents said that there are a number of policy issues across several agencies that need to be examined and aligned. The

criminal justice system involves multiple agencies and jurisdictions that may impact upon people served by ODMHSAS, including local law enforcement, criminal courts, family courts, jails, prisons, and probation and parole. Participants said that by focusing on policy coordination among the many organizations involved, outcomes for people with mental health and substance abuse problems can be improved, and problems within each of these systems that are exacerbated by lack of access to mental health and substance abuse services can be alleviated.

Focus group participants from the criminal justice, mental health, and substance abuse fields agreed on one major barrier; as one person put it, “There is a punitive environment in the state; the public wants people punished, not treated.” It was noted that Oklahoma has high rates of incarceration and that people are frequently incarcerated for low-level crimes that are dealt with through community service and fines in many other states. Both prison and jail officials said that they had many inmates with mental health problems “who shouldn’t be here.”

Respondents from the behavioral health field said that jails and prisons have very different approaches to dealing with people with mental illness and/or substance abuse problems than do community providers. People with substance abuse problems are not generally viewed by the corrections system as having health problems, they are simply seen as drug offenders. The official DOC website (<http://www.doc.state.ok.us/Programs/progwebpg.htm>) for Programs states: “All SAT’s utilize cognitive behavioral theory to address substance abuse not as a disease, but as a behavior that can be addressed.” It was noted that local jails may not have policies taking into account the mental health status of inmates who violate rules or act out, so many people are punished for experiencing symptoms and lose “good time” from their sentence. The DOC only recently enacted changes in disciplinary policies and procedures that required facility staff to consider the inmate’s mental status before considering disciplinary action.

Parole recommendations, which must be reviewed and approved by the Governor, are the responsibility of the Pardon and Parole Board. The Board is considered to be conservative in its parole recommendations, having a lower rate of parole recommendations than the national rate. In preparation for parole hearings, staff of the Board investigate each eligible individual and prepare reports about the crimes for which the person was sentenced and their record while in prison. If persons with serious mental illness have incidents of misconduct in their record, this will be reported to the Board. If these incidents are a consequence of their mental illness, that information is not in the record and cannot be taken into account by the Board. In general, investigators and the Board are not aware of an individual’s history of mental illness. By contrast, the Board is aware of addiction problems and will recommend substance abuse treatment as a condition of parole where it believes this is appropriate. Department of Corrections staff believe that virtually no one who receives treatment for mental illness while in prison is paroled. They typically serve their full sentence and then are released with no parole supervision. Since one important role for parole officers is to assist parolees in receiving necessary services, this increases the likelihood that the persons’ re-entry into the community will be without adequate services and supports. Even if they were under parole supervision, there are not parole officers available with specialized training in working with parolees with serious mental illness.

Participants from both the criminal justice and behavioral health systems stressed the need for policies that would make it a priority to re-direct as many people with mental health and substance abuse problems as possible into treatment rather than incarceration. Similarly, participants felt there was a need for policy changes within the Department of Corrections, the Oklahoma Health Care Authority and other agencies to ensure that all inmates with mental

illness or substance abuse problems have access to sufficient, high-quality behavioral health services while they are incarcerated.

Individuals with psychiatric disabilities enrolled in the Medicaid and Supplemental Security Income programs lose their enrollment when they go into prison. When they leave prison, it is difficult to re-establish enrollment in either or both programs. As a result, many are without the means to pay for medications and other mental health services, or to pay the costs of housing, food, and other necessities.

Staff in a re-entry program for people leaving state prison pointed out that policies within the criminal justice system create almost insurmountable barriers for inmates following their release. “The system is set up to have people fail,” a staff member said. “When they are released, they have obligations to the court, such as court-ordered fees, court costs, and fines. They even have to pay for their transportation to prison and for the public defender; they have to pay their room and board while imprisoned. The child-support meter doesn't stop either. They're behind the eight ball. They can work off their payments by sitting in jail for five dollars a day.”

Practices/Services

Consumers, family members and local behavioral health providers noted that, particularly in rural areas, many local police agencies have not received training on how to respond effectively to people in mental health or substance abuses crises, and that this results in unnecessary arrests and sometimes in mistreatment of people. Focus group participants said that there are not sufficient jail diversion programs across the state to re-direct people into services rather than incarceration, which they believed was both better for consumers and a more cost-effective use of tax dollars. They also said that there is a need for forensic PACT teams to help people with mental health and criminal justice involvement reintegrate into the community or to help them avoid further criminal justice involvement.

Consumers in the community who have had criminal justice system involvement reported that their needs were not understood or met, that some had suffered withdrawal symptoms because medications were abruptly stopped or changed, and that they were treated poorly and sometimes goaded by police or correctional staff because of their mental health status. Many also said they were released without enough medication to carry them over to their first mental health appointment in the community. There was a consensus among these respondents that being in jail or prison invariably made their mental health problems worse.

Concerns were raised about the small number of mental health courts across the state and the restrictive criteria that make many people ineligible to participate. It was also noted that in some mental health courts, the judge requires a guilty plea, leaving people with criminal records in order for them to get the services they need. Respondents noted that while many people seen in mental health court have substance abuse problems, and many people in drug court also have mental health issues, the two initiatives are not linked. It was pointed out that at least one drug court refuses to accept people who have co-occurring mental health diagnoses. Others noted that when people going through drug court are mandated to residential treatment, they received no help in gaining admission to a treatment facility, which often do not have the capacity to serve the number of people seeking treatment.

Respondents from all groups said that there are not nearly enough mental health and substance abuse services inside jails and prisons, and that many of the services that do exist in these facilities are inadequate both in the numbers of people they are able to serve and the types

and quality of services available. The Department of Corrections is only able to treat inmates with the most severe conditions, and others may get only medications or no treatment at all. In the past, when inmates with mental health issues are unable to follow rules or orders, their mental illness was not taken into account, and they are punished for violating codes of conduct, were often placed in solitary confinement, lose credit for good behavior, and often end up serving their full sentences.

Except in the specialty mental health prison units in three facilities, psychiatric medication is the primary treatment available for inmates with psychiatric problems, and primarily older drugs are used because of cost issues. In addition, respondents reported that even within the specialty units, funding is lacking and there are more people who could benefit from services than are able to be accommodated. In both Joseph Harp and Mabel Bassett Correctional Centers, there is very limited psychiatric time. Each facility has a single psychiatrist responsible for prescribing and monitoring the medications of hundreds of patients. In other prison facilities, there is less staffing, although there is extensive use of psychiatric medications. The same is true for substance abuse services, where Alcoholics Anonymous or Narcotics Anonymous may be the only services available, although not DOC-approved, and access to these is limited due to security restrictions. Inmates with mental health and substance abuse problems said that they needed more group sessions and more time for individual therapy. Within prison mental health units, staff reported that inmates are often afraid of doing too well, because they fear being sent back into the general population, where they feel vulnerable and unable to protect themselves.

Most inmates who participated in focus groups within correctional facilities were desperate for more time with their families. For example, women housed in the Mabel Bassett correctional facility said they cannot afford contact with their children, nor are there services to bring children to mothers. Many participants interviewed longed to share a picture with relatives; at one facility such a program existed, but was terminated. A serious problem for family reintegration after release is available housing for mothers and children.

People with mental health and substance abuse histories face a complex array of re-entry problems when they are released from jail or prison. As noted in Chapter X, housing is a particular problem. Depending on the nature of their convictions, these individuals are barred from public housing for at least three years after release; some are barred for life. Mental health and substance abuse service providers, clients, and professionals within the criminal justice system all raised this issue. Some criminal justice professionals stated that various sub-groups of people with criminal justice histories and mental health or substance abuse problems “have no options except to live under bridges.” A re-entry worker said that he was contacted by a prison asking for help placing an 80 year old inmate who was a sex offender. The man was not ambulatory, but no nursing home would take him, and the prison had no place to release him to.

Access to jobs is also a major barrier; many professions are closed to people with felony convictions, and employers generally are not eager to hire ex-convicts, let alone those with mental health and substance abuse histories. Since many people leave prison responsible for large fines, their difficulty in making a living leaves them vulnerable to being returned to prison. It was also noted that because it takes so long to receive Social Security Disability benefits, many inmates waiting for approval leave prison with no income. This leaves people with no way to pay for medication upon their release.

Workforce Development and Training

Focus group and personal interview participants stressed the need for expanded training on mental health and substance abuse issues for local law enforcement officers and correctional staff who interact with people with mental health and /or substance abuse problems on a daily basis. A lack of needed information on the part of these staff can jeopardize their safety and the safety of the person in custody, and can lead to counter-productive interventions for people with mental health and substance abuse problems. While many local law enforcement agencies have had staff participate in CIT training, others have not, and people with mental illness in those communities who participated in focus groups indicated that they felt at risk from the police. It was noted that most degree programs in criminal justice either do not address mental health issues at all, or that they erroneously teach that mental illness is a cause of crime. Both staff and inmates on specialty mental health units in prisons said there is a large unmet need among correctional staff for training on mental health issues; this echoed one of the findings of the Oklahoma Board of Corrections' resolution.

Mental health staff working with people in jails or prisons said there is an urgent need for additional staff. Some noted that between dealing with crises and spending inordinate amounts of time on paperwork, their capacity to respond to clients' mental health needs is stretched too thin. In one facility, the psychiatrist is only 20% time, and there is a need for a half-time psychiatrist just to fulfill basic requirements that inmates receive two hours with a psychiatrist over the course of a year.

Organization/Collaboration

While there is increasing cross-system collaboration on the state level and in some communities, there is still much more that remains to be done. Respondents pointed out that the success of local diversion programs including drug courts and mental health courts depends on the enthusiastic involvement of district attorneys and judges, not all of whom are sympathetic to these concerns. Participants noted that while initial discussions about collaborative efforts to systematically address the many issues involved in diversion and adequate treatment in jails and prisons were started at the November 2005 Emergency Summit, few concrete actions have resulted from those meetings.

Data

Both correctional staff and behavioral health staff emphasized the need for a common database to share information about the psychiatric histories of arrestees and inmates. Ideally, respondents said, there should be a database shared nationally in order to track cases and follow up to ensure people are receiving the appropriate care.

Evaluations of Medicaid reinstatement for released offenders have found that very little data are collected by DOC about mental health services in electronic format; therefore it is not possible to determine how many released inmates have mental health diagnoses or how many received mental health services in prison. Since July of 2003, however, DOC has collected electronic data concerning participation and completion of substance abuse treatment programs, as well as faith-based programs (AA/NA). There was a call for DOC to improve data collection in this area.

Financing

In its 2005 resolution concerning mental health and criminal justice issues, the Oklahoma Board of Corrections noted that there are “indications that the criminal justice system has become the primary service provider for offenders with mental illness, although it has not received sufficient funding to meet the needs of this population.” The lack of adequate funding to meet the needs of people with mental health problems in various parts of the criminal justice system was a major theme of respondents.

References:

BJS (2006a). *Bureau of Justice Statistics, Special Report, Mental Health Problems of Prison and Jail Inmates*. (September 2006, Publication No. NCJ 213600) Washington, D.C.: U.S. Department of Justice, Office of Justice Programs. Retrieved September, 2006 from <http://www.ojp.usdoj.gov/bjs/pub/pdf/mhppji.pdf>.

BJS (2006b). *Bureau of Justice Statistics, Bulletin, Prison and Jail Inmates at Midyear 2005*. (May 2006, Publication No. NCJ 213133) Washington, D.C.: U.S. Department of Justice, Office of Justice Programs. Retrieved September, 2006 from <http://www.ojp.usdoj.gov/bjs/pub/pdf/pjim05.pdf>

DOC (2005a). *Oklahoma Department of Corrections, Facts at a Glance, June 30, 2005*. Oklahoma City, OK: Oklahoma Department of Corrections, Public Information Office, Operations Support Division. Retrieved September, 2006 from <http://www.doc.state.ok.us/DOCS/Facts%20at%20a%20glance/0506faagweb.pdf>

DOC (2005b). *Oklahoma Department of Corrections, Mental Health Services, June 2005*. Retrieved September, 2006 from <http://www.doc.state.ok.us/MH/MH%20Fact%20Sheet.htm>

DOC (n.d.a). *Oklahoma Department of Corrections, Strategic Plan, FY 2006 – FY 2010*. Retrieved September, 2006 from <http://www.doc.state.ok.us/DOCS/FY%202006%20Strategic%20Plan%20-%20091504.pdf>

DOC (n.d.b). *2004 Crime Rate and Rank*. Oklahoma Department of Corrections. Retrieved September, 2006 from <http://www.doc.state.ok.us/MAPS/incrimUS.htm>

Frost, N., Greene J. & Pranis K. (2004). *HARD HIT: The Growth in the Imprisonment of Women, 1977-2004*. Retrieved September, 2006 from <http://www.wpaonline.org/institute/hardhit/HardHitReport4.pdf>

OSBI (2001). *Crime in Oklahoma, 2000 Uniform Crime Report, Oklahoma State Bureau of Investigation*. Oklahoma City, OK: Oklahoma State Bureau of Investigation, Information Services Division.

OSBI (2002). *Crime in Oklahoma, 2001 Uniform Crime Report, Oklahoma State Bureau of Investigation*. Oklahoma City, OK: Oklahoma State Bureau of Investigation, Information Services Division.

OSBI (2003). *Crime in Oklahoma, 2002 Uniform Crime Report, Oklahoma State Bureau of Investigation*. Retrieved September, 2006 from <http://www.osbi.state.ok.us/Publications/CrimeStats/ucr2002book.pdf>

OSBI (2004). *Crime in Oklahoma, 2003 Uniform Crime Report, Oklahoma State Bureau of Investigation*. Retrieved September, 2006 from <http://www.osbi.state.ok.us/Publications/CrimeStats/ucr2003.pdf>

OSBI (2006). *Crime in Oklahoma, 2004 Uniform Crime Report, Oklahoma State Bureau of Investigation*. Retrieved September, 2006 from <http://www.osbi.state.ok.us/Publications/CrimeStats/ucr2004.pdf>

ODMHSAS, STNAP Phase I (1999). *Oklahoma State Treatment Needs Assessment Studies, Alcohol and Other Drugs; Final Report on Study #3; Survey of Inmates, Probationers and Parolees in the Oklahoma State Department of Corrections*. Oklahoma City, OK: Submitted to the SAMHSA, Center for Substance Abuse Treatment, Contract Number 270-94-0027 by the Oklahoma Department of Mental Health and Substance Abuse Services.

ODMHSAS, STNAP Phase III (2005). *Oklahoma State Treatment Needs Assessment Studies, Phase III; Final Report on Arrestee Drug Abuse Monitoring Program*. Oklahoma City, OK: Submitted to the SAMHSA, Center for Substance Abuse Treatment, Grant Number 1 UR1 TI13443-01 by the Oklahoma Department of Mental Health and Substance Abuse Services.

Chapter 9: Access to Physical Healthcare

The purpose of this chapter is to describe access to physical healthcare for mental health consumers and substance abuse clients, including existing resources, strengths of current programs, and needs. The chapter includes narrative information gathered through focus groups and personal interviews, as well as existing data from state agencies and other sources.

A. Existing Resources and Strengths

The appointment of ODMHSAS Commissioner Terry Cline to the position of Cabinet Secretary for Health in 2004 has been a positive step for ODMHSAS, bringing more exposure and access on statewide issues related to mental health and substance abuse. Dr. Cline's dual appointment also creates a platform from which to heighten awareness and influence activities related to existing healthcare disparities.

In June 2006, the Oklahoma Health Care Authority initiated the O-EPIC Premium Assistance Program, which pays part of the health plan premiums of people who cannot access private health coverage through their employer. This plan extends coverage to uninsured self-employed individuals, workers whose employers do not provide health coverage, workers who are not eligible to participate in their employer's health plan, sole proprietors not eligible for small group health coverage, and the unemployed who are currently seeking work. Many people served by ODMHSAS will be eligible to participate in this program, which has the potential to alleviate the healthcare disparities described above by increasing access to health insurance for people with mental health and substance abuse problems.

Medicaid prescription and inpatient hospitalization benefits were increased in 2004, providing improved access to additional primary health services for service recipients covered. Case management services are used to link clients to medical, vision, and dental services. Other resources available for the non-Medicaid population include the OU Health Sciences Center in Oklahoma City and the OU Tulsa-College of Medicine, which provide indigent medical care. Many communities rely on local resources for health care, such as clinics, homeless clinics, county health departments, and *pro bono* health care providers. Tribal governments, the Indian Health Service, and urban Indian programs also provide health services. Dental services are provided in local communities through free dental clinics and *pro bono* providers, and in the state hospitals. Community mental health centers are encouraged to use flexible funds from ODMHSAS to purchase individual medical, vision and dental services for consumers. There are a growing number of federally qualified health centers in Oklahoma. While the total is still small, their presence should improve access to health care among low income consumers.

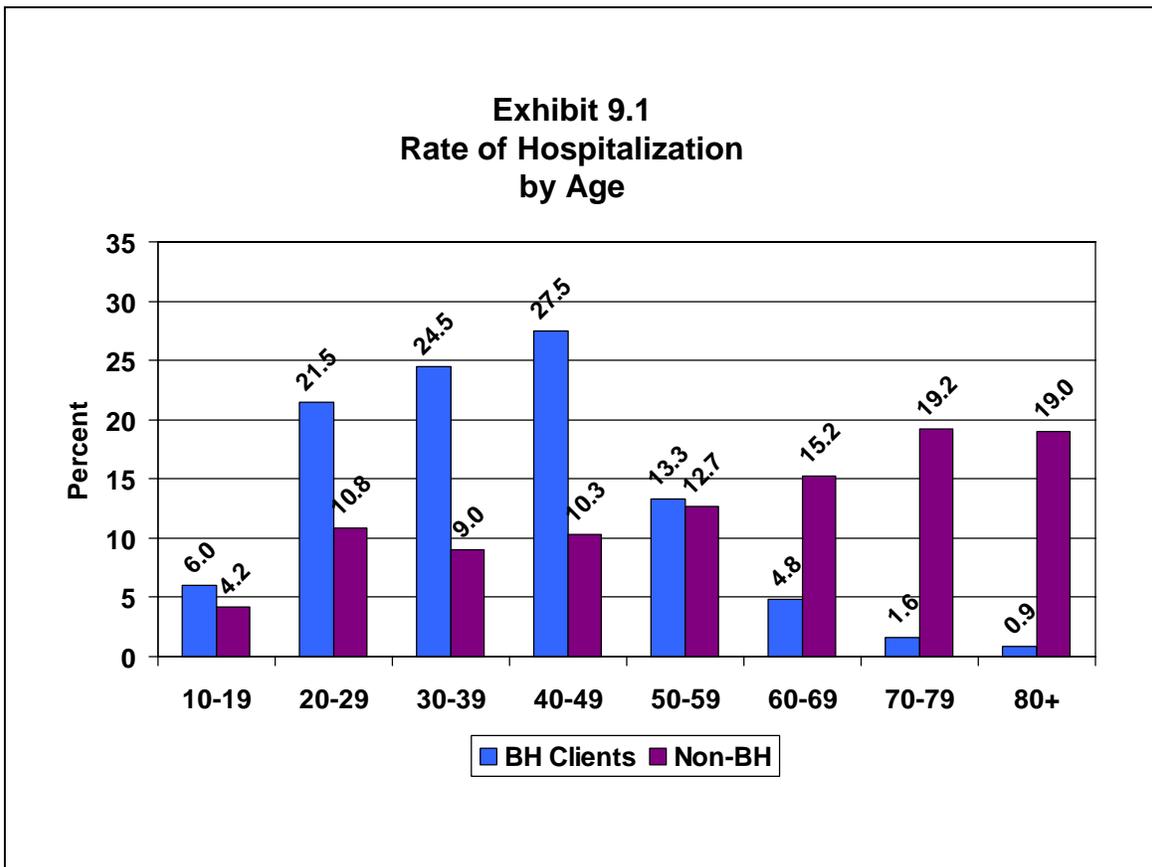
B. Needs and Existing Barriers

Unmet Needs

To determine why behavioral health clients are hospitalized for physical health problems in Oklahoma, ODMHSAS collaborated with the Oklahoma State Department of Health (OSDH) to study recipients of publicly funded behavioral health treatment and hospital-based physical health treatment (Moore and Leeper, 2006). Patient-identifying data from the 2002-2003 Oklahoma Hospital Inpatient Discharge Data (HIDD) System were linked to data from the ODMHSAS Integrated Client Information System (ICIS) using probabilistic matching. The

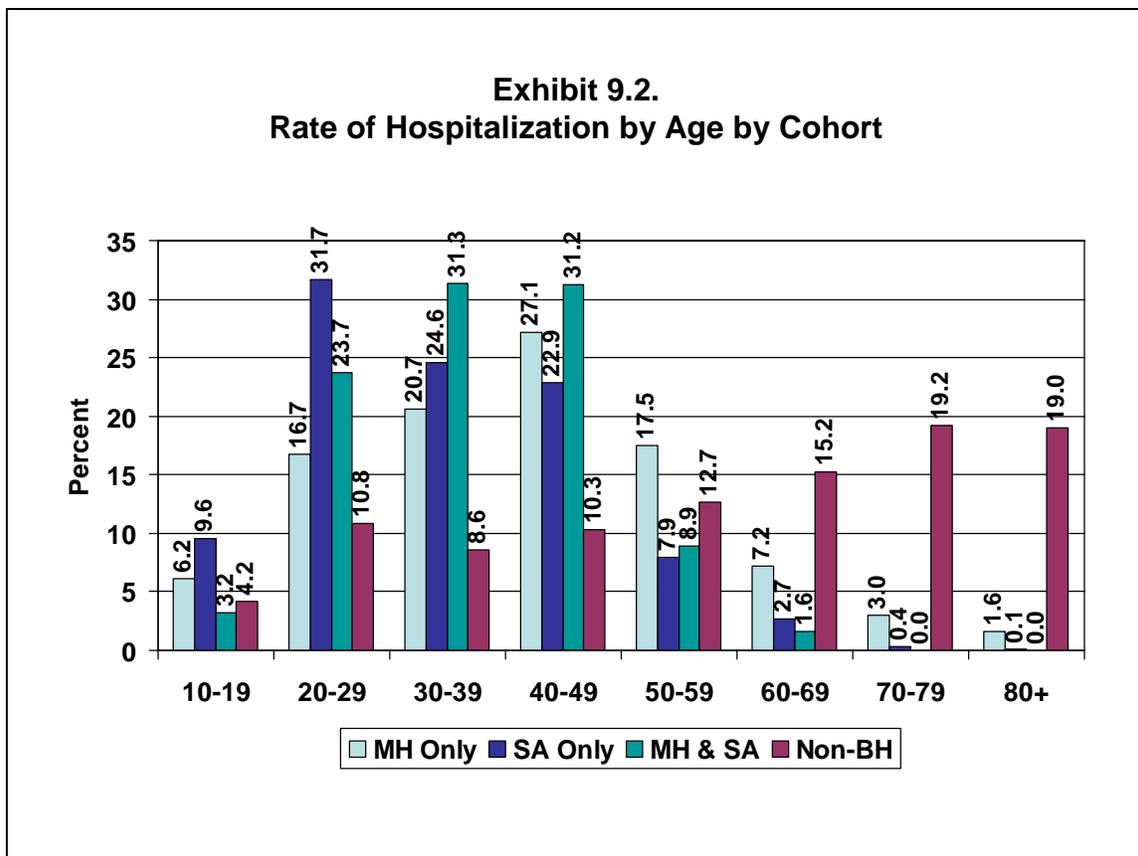
HIDD data included discharge records from hospitals providing physical care. Non-state psychiatric hospital data were excluded from the dataset for this analysis. The data from ICIS included records for clients admitted and served from 2000 through 2004 and were split into three cohorts: clients who received mental health treatment only (MH only), substance abuse treatment only (SA only), and mental health and substance abuse treatment (dual-treated). Of the 127,905 clients who received ODMHSAS-funded treatment from 2000-2004, 26,327 were found in the HIDD data. The rate of hospital discharges among behavioral health clients who received both mental health and substance abuse treatment was 31%, compared to 18% among the general population. The average number of discharges among behavioral health clients was 7.4, compared to 2.0 among people who did not receive behavioral health services.

Evaluation of the demographics of hospitalized ODMHSAS clients compared to non-ODMHSAS hospitalized people found no substantive difference in gender or race. There was a substantive difference in age. The percent of people who received ODMHSAS-funded services peaked at ages 40-49 and declined at older ages, while the rate of those who did not receive services from ODMHSAS steadily increased from younger age groups to the 70-79 and 80 or older age groups (see Exhibit 9.1). These findings indicate that persons age 20-29 who receive mental health and/or substance abuse services are more than twice as likely to be hospitalized for a medical condition as those who do not receive these services. This trend reverses at age 60. This may be due to the fact that individuals who have a mental health or addictive disorder do not live as long as others and that older people are less likely to receive mental health and substance abuse services.



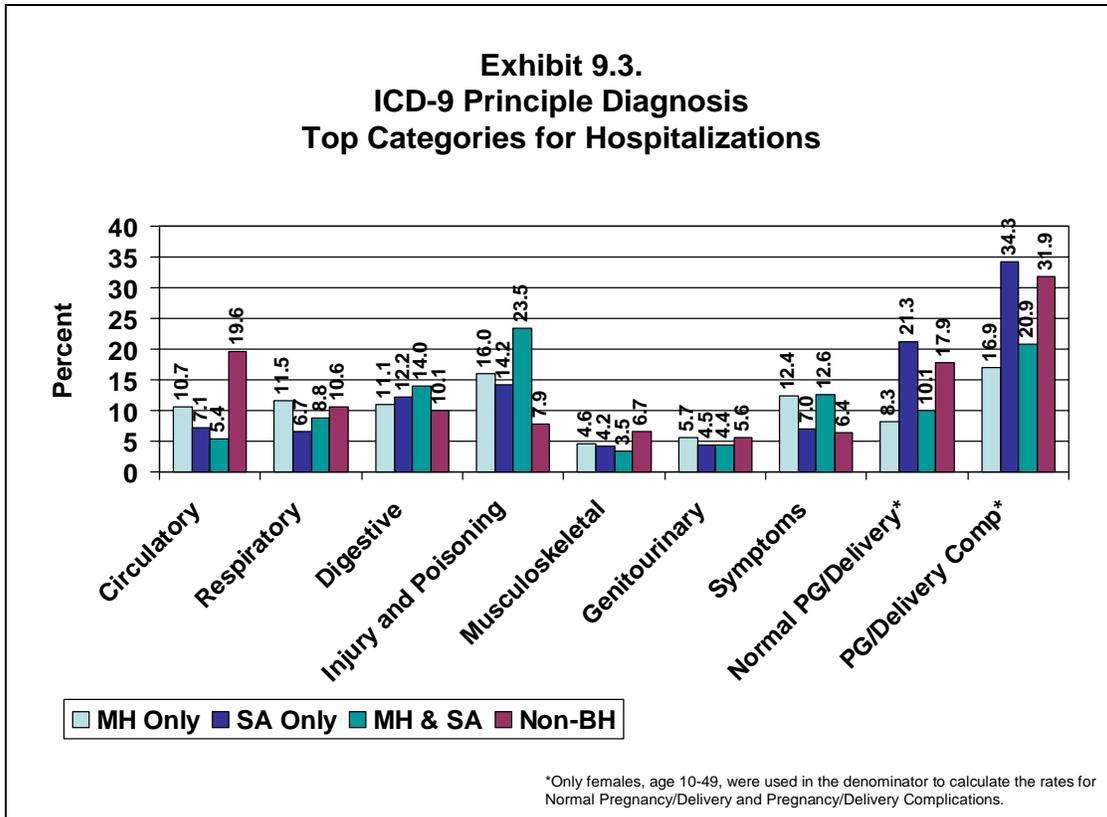
Analysis of age at time of hospital discharge among the cohorts indicated the rate of MH-only clients peaked at ages 40-9, SA-only clients peaked at ages 20-29, and dual-treated clients peaked at ages 30-49, as shown in Exhibit 9.2.

Additional analyses of these data included the principal diagnosis of ODMHSAS clients who were discharged from hospitals compared to non-ODMHSAS clients. As shown in Exhibit 9.3, when comparing ODMHSAS clients to non-ODMHSAS clients, there was a higher percent of clients hospitalized from digestive disorders, injury and poisoning, and symptoms, signs and ill-defined conditions. Digestive disorders include appendicitis, bile duct disorders, cancers, constipation, diagnosis and treatment, diarrhea, and dyspepsia. Injury and poisonings include fractures, sprains and strains, intracranial injuries, internal injuries, injury to blood vessels, and poisoning by drugs, medicinal and biological substances. Symptoms, signs and ill-defined conditions include abnormal results of laboratory or other investigative procedures, and ill-defined conditions for which no classifiable diagnosis elsewhere is recorded



In addition, as shown in Exhibit 9.3, ODMHSAS clients who received mental health services only had a higher rate of respiratory diagnosis than the other groups. Diseases and disorders of the respiratory system can affect any part of the respiratory tract and range from trivial to life-threatening. Examples include laryngitis, bronchitis, asthma, and tuberculosis. Among the people discharged from the hospital in 2002 or 2003, ODMHSAS clients had a higher rate of asthma than non-ODMHSAS clients (MH only, 20.2%; SA only, 18.8%, dual-treated, 27.6%; non-ODMHSAS, 7.8%).

Among the ODMHSAS female clients age 10-49 who received substance abuse treatment only, 21.3 percent were hospitalized for normal pregnancy or delivery, compared to 17.9 percent of females of the same age who did not receive ODMHSAS-funded services. In addition, 34.3 percent of the ODMHSAS female clients age 10-49 who received substance abuse treatment only were hospitalized for pregnancy or delivery complications, compared to 31.9 percent females of the same age who did not receive ODMHSAS-funded services. Additional analysis of these data revealed that the primary reason for the complications was an addictive disorder.



Policies

Many adults receiving services in the mental health and substance abuse systems have little or no access to physical healthcare or to vision, dental and hearing services. While there are some linkages in place, ODMHSAS lacks a comprehensive policy to assure that its clients get the medical care they need. Because research shows that people with mental health and substance problems have more physical health problems than the general public, and that many psychiatric drugs put patients at higher risk of obesity, diabetes, heart disease and other illnesses, this is a major policy concern.

As focus group participants pointed out, a large percentage of the Department's clients have no health coverage at all, due to a number of state and federal policies. Single adults without children are not eligible for Medicaid in Oklahoma, and federal policies bar people with substance abuse disorders from receiving Medicare unless they have an additional disability. For people with psychiatric disabilities, it often takes two years or more to receive Medicare after application. Many mental health and substance clients who are employed work at low-wage jobs

that do not offer health insurance. Clients in these categories currently rely on an inadequate patchwork of hospital charity care, free clinics, Community Health Centers, university clinics, and local charities for their health care needs.

Practices/Services

Family members, consumers and providers all reported that access to medical care was difficult if not impossible for many consumers. While this is clearly most acute for people with no private or public insurance, it was also cited as an issue for people on Medicaid, and in some communities, for people with Medicare. Some consumers with no insurance rely on federally funded Community Health Centers (CHCs), but many noted that access is not guaranteed: “There’s no public transportation [to the CHC], so many of us have a hard time getting there. You have to get there first thing in the morning or you don’t get in, and you may have to wait all day to be seen. They use a sliding scale payment system, and some people can’t even afford this.” In one focus group, more than 75% of the consumers reported that they had urgent needs for dental care, and that they relied on a university dental clinic that had a 6-8 month waiting list.

The Medicaid program in Oklahoma offers very limited vision and dental care, so even consumers with Medicaid must rely on the Lions and other local charities for vision care, and on widely scattered free dental clinics, most of which provide only extractions. Many people with Medicare reported no problems accessing physical health care, but in some communities, there are no providers willing to accept new Medicare patients.

Providers serving homeless people noted that medical hospitals often discharge people to shelters who have serious, even life-threatening illnesses, including people with amputations and those recovering from heart surgery; one shelter staff reported that a person with a tracheotomy was sent to the shelter from a hospital with no oxygen supply. Shelters are not equipped to serve people with such serious medical needs, and staff said that there are no facilities willing to serve these individuals.

A staff member noted that there is a system-wide need for better integration of physical health care and fitness with mental health services. Her colleagues in the focus group added that the mental health system does a poor job of ruling out physiological causes for behavioral symptoms, and may be treating people for psychiatric problems who really have a physical illness.

References:

Moore, B. and Leeper, T. (2006, May 31). *Linking Behavioral and Physical Health Records to Evaluate Co-morbid Conditions*. Presented at the 2006 Joint National Conference in Washington, D.C.

Chapter 10: Housing

The purpose of this chapter is to describe housing services for people with serious mental illness and/or substance abuse problems, including existing resources, particular strengths of current programs, and needs. The chapter includes narrative information gathered through focus groups and personal interviews, as well as existing data from ODMHSAS and other sources.

A. Existing Resources

As part of their current housing services, ODMHSAS offers Community Living Programs for mental health clients (see Exhibit 10.1). In FY 2005, 1,970 mental health clients were served by these programs, with the majority living in Residential Care facilities. Currently, Residential Care facilities operate as permanent housing for many clients.

Exhibit 10.1. Number of Adults who received
ODMHSAS-funded
Mental Health Housing Services during
FY2005

Service Type	Number of Clients
Residential Care	1,559
Transitional Supported Living	244
Permanent Supported Housing	167
Total	1,970

Specialized housing options for people with mental illness are located in both urban and rural settings, and are funded through ODMHSAS, Housing and Urban Development (HUD), public housing authorities, and private sources. Housing models include transitional living programs, permanent housing (supervised, supported and independent), and several short-term subsidy programs, as described above and below, that help people access and maintain permanent housing. Tribal housing authorities are another source of housing available to ODMHSAS clients who are tribal members.

The map in Exhibit 10.2 indicates specialized housing options are available throughout the Central and Eastern parts of the state but there is limited availability in the Western part.

To provide for and encourage the development of group homes for individuals in recovery from alcohol or illicit drug addiction, ODMHSAS participates in the operation of a revolving loan fund. Federal substance abuse block grant funds were used to establish and maintain \$100,000 in a revolving loan fund. Loan applicants must complete a one page document which establishes the loan amount and sets the amount of monthly payments. By signing the loan document, the applicants agree to repay the loan along with a 6 percent interest on the loan. Applicants must comply with the following requirements:

1. At least six people, all intending to be group home residents, must sign the loan contract;
2. The home must agree to operate as an Oxford House;
3. The home must be run on a democratic basis;
4. The home must be financially self-supporting and pay its bills on time; and,
5. The home must immediately expel any member who uses drugs or alcohol or fails to pay his or her fair share of expenses.

ODMHSAS Substance Abuse Services program staff monitor the Oxford Houses to ensure contract requirements are followed

B. Strengths

In some areas of the state, organizations and collaborations have developed innovative approaches to housing that can serve as models for other communities. In Tulsa, the Mental Health Association (MHA) has implemented a continuum of 13 specialty housing programs to meet the needs of people with mental illness for safe and affordable housing. These include two Safe Haven programs, with a “low-demand, high expectation,” *Housing First* model for chronically homeless, street-habituated adults (including those with a dual diagnosis), regardless of whether they have an income or are actively in treatment. The MHA also offers transitional group living, permanent supported housing, long-term independent living options, and the Metropolitan Apartment Program, which offers long-term supportive scattered-site apartments for formerly homeless individuals. They have a model program for home ownership with Habitat for Humanity Tulsa called the “Partnership for Open Doors,” providing mental health consumers the opportunities to achieve “the American dream” of home ownership. Using federal Housing and Urban Development (HUD) funds, State mental health block grant funds, and by completing a successful capital campaign, the MHA in Tulsa has been able to develop a range of housing properties which they own debt-free. These models are responsive to the needs of consumers at different points on their recovery journeys, while promoting stigma-free reintegration into the community with the necessary wrap-around services for a high quality of life.

The City of Norman Housing Authority was instrumental in putting together a public/private coalition (including mental health providers, other human service agencies, and private developers) that is successfully working to increase the range of transitional and permanent housing in their community. There are new housing options available through a growing Supported Housing program run by Thunderbird Clubhouse; Transition House in Norman is unique, because it not only provides transitional housing, but continues to offer support services to former residents after they locate permanent housing.

Members of the Governor’s Inter-Agency Council on Homelessness noted that cities and towns need to be given the resources to solve housing problems locally, and that, in most

communities, there have not been concerted efforts to address these complex problems. The success of communities such as Tulsa and Norman are models that other communities can learn from and build on.

In recent years, ODMHSAS has developed several new approaches to housing and the prevention of homelessness for the people it serves. Currently, each of these models is available in selected areas of the state. The HOPE Program supports Tenant Based Rental Assistance projects to assist very low income persons with mental illness in rural Oklahoma. This transitional assistance, which is available for up to 24 months, is provided through contracts with seven designated CMHCs, serving a total of 17 counties. The goal is to provide supportive services and to assist participants in accessing other community resources (e.g., Section 8, SSI, employment) to get and maintain housing.

Another pioneering model is the Family Self-Sufficiency Program, a time-limited housing program for families of children with serious emotional disturbances who are homeless, at risk of losing housing, or in crisis. The program helps families create a stable home environment, reduce out-of-home placement, increase school attendance, and reduce or mitigate contacts with law enforcement. The program incorporates elements of a system of care for families, including blended funding, wraparound services, collaboration with other service providers, and strengths-based, family-directed plans and services.

Discharge Planning Housing Subsidy Funds assist very low-income adults with mental illness or co-occurring mental illness and substance abuse disorders who are being discharged from psychiatric inpatient care, released from the Department of Corrections, or who are aging out of the foster care system. These tenant-based subsidy funds serve a bridging function so that people are not discharged to homelessness, giving people time to get jobs, and apply for public housing or other services that will help them maintain stable housing. The subsidies are available for 9-12 months and can be used for housing costs such as rent, utilities, rent deposits and utility deposits.

In several communities, strong and effective housing development partnerships have been formed among local housing authorities, provider agencies, public health collaboratives, private developers, and other parties. These partnerships have been able to leverage private and public funds to develop creative housing options for people served by ODMHSAS. In areas of the state where this has not happened, participants frequently expressed a need for assistance from ODMHSAS with the mechanics of creating and sustaining partnerships, identifying funding opportunities, and writing successful grants.

The Governor's Interagency Council on Homelessness (GICH) was created in 2004 and is chaired by an ODMHSAS staff member. The group consists of 25 members with representatives from the Governor's Office, Legislature, state agencies and individuals from the homeless community, and its mission is to promote collaborations among stakeholders and develop and implement strategies to improve access to services, mainstream resources, and develop affordable, permanent housing (Henry, 2004). Among the innovative projects initiated by the GICH is SOAR Training (SSI/SSDI Outreach, Access and Recovery), providing case managers and other staff with an in-depth, step-by-step explanation of the SSI/SSDI application and disability determination process, as well as strategies for working with homeless persons with serious mental illness and co-occurring disorders; only a fraction of this population currently receives the benefits to which they are entitled.

C. Needs and Existing Barriers Policies

An acute shortage of stable, affordable permanent housing for people with mental health diagnoses and a lack of sufficient sober living options for people recovering from substance abuse problems were perceived as major barriers to system transformation and to improved quality of life for clients. Focus group participants from a wide range of backgrounds across every area of the state noted that access to decent housing is a core issue that must be addressed if people are to have a foundation for recovery and community integration.

There was a wide-spread perception among participants that housing is not a priority for the state, and that it lacks a comprehensive, coordinated action plan to ensure that resources are available to meet the housing needs of the people it serves. ODMHSAS participates in the Governor’s Inter-agency Council on Homelessness and the Oklahoma Olmstead Strategic Planning Committee¹. Some interviewees noted a need to develop a strategy to coordinate work across these two interagency workgroups to best meet the needs of its clients.

There are no current estimates of the number of homeless adults living in Oklahoma who have a mental illness or need substance abuse treatment. A survey conducted in Oklahoma City in 2005 found that approximately 1,500 (0.3%) of the city residents were homeless at that time. Of the adults surveyed, 31 percent reported having a mental illness and 29 percent reported having a substance abuse problem.¹

As clients enter, make their transition through, and exit programs funded by ODMHSAS, residential information is gathered. An evaluation of client discharge records from FY 2005 revealed that 12 percent of adult mental health clients were homeless during some part of their treatment episode, and 15 percent of adult substance abuse treatment clients were homeless (see Exhibit 10.3). On average, eight percent of both mental health clients and substance abuse treatment clients were chronically homeless, continuously homeless for a year or more, or had at least four episodes of homelessness in the past three years. The overall trend for homelessness among mental health clients has been fairly stable since FY 2001; however for substance abuse treatment clients there was a five percent increase from FY 2004 to FY 2005. It is not clear whether these changes are due to an increase in the homeless population, an increase in substance abuse among persons who are homeless, or improved outreach efforts.

Exhibit 10.3. Homeless Status for Clients, Age 18 or Older ,
who Received ODMHSAS-funded Services

Fiscal Year	Mental Health Treatment			Substance Abuse Treatment		
	Percent Homeless	Number Homeless	Total Served	Percent Homeless	Number Homeless	Total Served
2001	10%	1,779	18,610	9%	1,037	12,170
2002	11%	2,110	19,134	9%	1,162	12,967
2003	12%	2,078	17,252	9%	1,224	13,110
2004	11%	2,006	17,880	10%	1,363	13,593
2005	12%	2,313	18,510	15%	2,150	14,469

¹ The Oklahoma Olmstead Strategic Planning Committee is an inter-agency group charged by the Governor and the Legislature with the development and implementation of a plan to ensure that all Oklahomans with disabilities have access to the resources and supports to live successfully in the integrated community settings of their choice. This charge grows out of the Supreme Court’s decision in the case of *Olmstead vs. L.C.*, 527 U.S. 581 (1999), requiring states to prevent the unnecessary institutionalization of people with disabilities and to provide services in the most integrated settings.

Exhibit 10.4 presents movement in the type of residential situation from admission to outpatient programs to discharge for ODMHSAS adult mental health clients during Fiscal Year 2005. Most clients were living in a private residence at the time of admission and 97% of those remained in a private residence at discharge. Of the three percent whose residential situation changed, most moved to more restrictive settings (112 to residential care homes, 33 to nursing homes, and 102 to institutional settings) and 155 became homeless (100 to community shelter and 55 on the street). Movement to more restrictive settings should be avoided where possible. Movement to homelessness is clearly a major problem.

Of persons who were in more restrictive settings, the clear tendency was for them to remain in the same residential situation. The percentages showing no changes range from 84% (residential care) and 83% (nursing homes) to 55% (institutional setting). Movement from these facilities was primarily to private residences; however 21 individuals were discharged to a homeless situation. This lack of change in residential situation may be due to a failure of providers updating client records at discharge.

Among persons who were homeless upon admission, there was also a strong tendency for them to remain homeless, either in a community shelter, 66% or 310 persons, or on the street, 47% or 144 persons. Of those whose residential situation improved, most (227) went to private residences. Additional alternatives need to be available to ensure that more of these homeless people do not remain homeless

Exhibit 10.4. Change in Residential Situation Among Adults ,Age 18 and Older, who Received ODMHSAS-funded Mental Health Services and Discharged in FY 2005*

Residential Situation at Discharge															
Residential Situation at Admission	Total	Private Residence		Supported Living		Residential Care Home		Nursing Home		Institutional Setting		Community Shelter		On the Street	
		#	%	#	%	#	%	#	%	#	%	#	%	#	%
Private Residence	13,218	12,769	97%	47	0%	112	1%	33	0%	102	1%	100	1%	55	0%
Supported Living	283	72	25%	189	67%	4	1%	1	0%	5	2%	11	4%	1	0%
Residential Care Home	634	71	11%	4	1%	532	84%	13	2%	9	1%	4	1%	1	0%
Nursing Home	12	0	0%	0	0%	0	0%	10	83%	0	0%	1	8%	1	8%
Institutional Setting	99	35	35%	1	1%	7	7%	0	0%	54	55%	1	1%	1	1%
Community Shelter	472	113	24%	20	4%	10	2%	0	0%	4	1%	310	66%	15	3%
On the Street	306	114	37%	7	2%	9	3%	0	0%	6	2%	26	8%	144	47%
Total	15,024	13,174	88%	268	2%	674	4%	57	0%	180	1%	453	3%	218	1%

* Includes only OMDHSAS Mental Health Clients served at a CMHC with at least 30 days between their admission and discharge. Clients under the custody of DOC and those whose services were limited to inpatient and/or Community-Based Structured Crisis Care were removed.

Exhibit 10.5 presents similar residential information for adult ODMHSAS substance abuse treatment clients during Fiscal Year 2005. As with mental health clients, most substance

abuse treatment clients were living in a private residence at the time of admission and remained in a private residence at discharge. Of those whose residential situation changed, 39 became homeless. Also similar to mental health clients, substance abuse treatment clients living in more restricted settings remained in these settings at discharge. Only five of these clients became homeless. The tendency for homeless clients to remain homeless also continued, with 49% or 82 persons remaining in community shelters, and 53% or 157 persons remaining on the street.

Exhibit 10.5. Change in Residential Situation Among Adults ,Age 18 and Older, who Received ODMHSAS-funded Substance Abuse Services and Discharged in FY 2005*

Residential Situation at Admission	Total	Residential Situation at Discharge													
		Private Residence		Supported Living		Residential Care Home		Nursing Home		Institutional Setting		Community Shelter		On the Street	
		#	%	#	%	#	%	#	%	#	%	#	%	#	%
Private Residence	6,774	6,559	97%	42	1%	44	1%	1	0%	89	1%	13	0%	26	0%
Supported Living	44	17	39%	25	57%	1	2%	0	0%	0	0%	1	2%	0	0%
Residential Care Home	236	15	6%	1	0%	215	91%	0	0%	3	1%	1	0%	1	0%
Nursing Home	1	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Institutional Setting	110	36	33%	0	0%	3	3%	0	0%	69	63%	0	0%	2	2%
Community Shelter	168	52	31%	10	6%	16	10%	0	0%	2	1%	82	49%	6	4%
On the Street	298	91	31%	44	15%	0	0%	0	0%	2	1%	4	1%	157	53%
Total	7,631	6,771	89%	122	2%	279	4%	1	0%	165	2%	101	1%	192	3%

* Includes only ODMHSAS Substance Abuse Treatment clients with at least 30 days between their admission and discharge. Clients under the custody of DOC and those whose services were given at a detox-only facility are removed from the sample. Dependents of Substance Abuse Treatment clients were also removed.

The lack of a comprehensive approach to housing is not unique to ODMHSAS; the Olmstead Committee’s Housing Subcommittee Position Paper (Oklahoma Olmstead Strategic Planning Committee, 2005) identified this as a major cross-agency issue affecting all people with disabilities. The policy barriers identified in that position paper are strikingly similar to those raised by focus group participants and personal interviews, and point to the fact that there are also policy barriers at the federal level. Among the policy barriers identified by the Housing Subcommittee are the following:

- Individual choice and community integration is limited because of over-reliance on segregated congregate housing.
- The lack of safe, accessible, affordable, and integrated housing makes it difficult for people with disabilities to leave institutions and to maintain residency in their community of choice.
- The process of finding and securing subsidized housing is unnecessarily complex.

- The proposed decrease in federal appropriations for housing initiatives will severely limit the intent of the President’s “New Freedom Initiatives.”

Other state-level housing policy issues raised by focus group participants included the lack of a state housing trust fund that could be used to leverage other public and private development funds for low-income housing, and a wide-spread opinion that development of Supported Housing should be a major new policy initiative for ODMHSAS. Consumers across the state felt that the Department’s policy of funding housing through Community Mental Health Centers (CMHCs) should be changed, because it gives service providers too much control over individuals’ daily lives. This was summed up by consumers in one focus group: “The transitional housing is run by the CMHC; you get kicked out if you’re not on meds, don’t show up for an appointment, or act in a way they think is inappropriate.” People living in Residential Care facilities stated that they are required to attend daily programs at specific CMHCs in order to keep their housing. A provider put it this way: “We are still trying to figure out how to get the system to think about wellness instead of illness. It’s important that treatment compliance no longer be a barrier to accessing housing. . . People need to have choices without getting kicked out of housing.”

Some participants noted that Griffin Memorial Hospital often discharges people to shelters or the street, and said there should be an ODMHSAS policy forbidding this practice. However, consumer choice is certainly an important factor and it is understood that inpatient treatment settings are not intended to serve as housing once treatment objectives are achieved. Other groups noted that many mental health clients are inappropriately placed in nursing homes for lack of housing options, and that this policy runs counter to the mandates of *Olmstead*, which states that people must be served in the most integrated setting.

In addition to these over-arching policy barriers, respondents identified policies that effect specific sub-groups of people with mental health and/or substance abuse issues. It was reported that it is extremely difficult to find housing programs that will accept people who have both developmental and psychiatric disabilities, people with fetal alcohol syndrome, and people with traumatic brain injury, and that there are no policies in place at the state level to ensure access to housing for these individuals. It was also noted that people with mental illness who have trouble living in congregate settings have very limited housing options because of a shortage of independent housing with supports.

Another sub-group for which there are major policy barriers to housing is people with criminal justice system involvement, particularly those with felony convictions and drug convictions. Depending on the nature of their convictions, these individuals are barred from public housing, including HUD-funded housing, for at least three years after release; some are barred for life. Mental health and substance abuse service providers, clients, and professionals within the criminal justice system all raised this issue: “People with criminal backgrounds are barred from many types of housing, even some shelters. People can’t get what they need because of their legal status.” Some criminal justice professionals stated that various sub-groups of people with criminal justice histories and mental health or substance abuse problems “have no options except to live under bridges.” There are currently no policies within ODMHSAS or the various criminal justice agencies to ensure that people with mental health and/or substance abuse issues who are released from prison have a stable place to live.

Practices/Services

All focus groups of people receiving mental health and/or substance abuse services, and most groups made up of service providers, named access to decent housing as one of the most critical needs of people in the system. There was broad agreement that people cannot make good use of other services if they do not have stable housing, yet it was clear that many people receiving services are homeless, precariously housed, or in undesirable living situations.

The focus groups identified issues related to the following practices and services that interfere with people's ability to access housing:

- Serious shortages of safe, affordable housing in most areas of the state, both in the private real estate market and in publicly funded housing. In many areas of the state, consumers reported that private landlords do not want mental health or substance abuse clients as tenants, or do not accept federal or state housing vouchers.
- Cut-backs in federal housing funds in recent years resulted in the loss of over 1,000 existing Section 8 subsidy vouchers in the state, adding to already long waiting lists for subsidized housing programs. People also noted that the application process is complicated and that it is easy to lose subsidies if one has problems with paperwork or keeping appointments.
- Financial issues create major barriers to housing:
 - Many people have no income; it can take two years or longer to qualify for Social Security benefits. People in this situation say they sleep on friends' couches, move between family members, or have periods of homelessness in the interim.
 - Most clients have little savings, and cannot afford utility deposits, rent deposits, or the basics needed to set up a household.
- The scarcity of Supported Housing programs, public housing, and affordable private housing in the state, combined with the lack of public transportation in both urban and rural areas, has resulted in large numbers of people living in congregate care facilities from which they have no transportation other than to mental health programs. This keeps people virtually institutionalized and unable to participate in their communities. People in these facilities often pay all but \$25 of their SSI check for room and board, leaving them destitute, unable to purchase clothes, personal care products, and other necessities.
- In some areas, transitional housing programs are unable to accept new residents because there is no permanent housing to which current residents are able to move.

Workforce Development Issues

Clients, service providers and housing experts around the state felt that housing assistance should be a core service offered by all mental health and substance abuse service providers, but acknowledged that few programs have staff with the requisite skills and experience. Participants identified a need for training and mentoring on this topic to ensure that all clients have access to services that will help them secure and maintain decent housing.

Organization/Collaboration

As noted above under Strengths, there are a few communities in which partnerships have been formed among local housing authorities, provider agencies, public health collaboratives, private developers, and other parties. However, most areas of Oklahoma have yet to see these developments. These partnerships should provide a model for other communities. In addition, the Tennessee Department of Mental Health has created a very successful program that provides

regional housing specialists to assist communities in this process. Replication of this program in Oklahoma would pay for itself many times over if communities were able to leverage outside housing funds.

Data

Providers and staff of several state agencies noted that there is a lack of data on housing and homelessness in the state. For example, no one tracks who gets and loses housing subsidies, or how many homeless people there are in the state. Some state agencies do not attempt to count homelessness among the people they serve. It was also noted that multiple funding streams and redundant paperwork makes it difficult to collect accurate data, and that this keeps the state from being able to exploit certain funding opportunities.

Even programs that focus on homelessness have data problems. The Homelessness Management Information System (HMIS), a federal initiative, does not count everyone, and does not produce sufficient management reports. Participants pointed out that all state agencies use different data systems with different person identifiers, which means there is no easy way to aggregate data, and data that should be captured once has to be entered and re-entered. This issue has been discussed by the Governor's Inter-agency Council on Homelessness, which would like to be part of the state's interagency JOIN data project, to help address the need for full and accurate data about housing and homelessness.

References:

Henry, B. (2004). Executive Order 2004-10. Oklahoma City, OK. Retrieved August, 2006 from <http://www.sos.state.ok.us/documents/Executive/419.pdf>.

Oklahoma Olmstead Strategic Planning Committee, 2005 Subcommittee goals and action steps. Retrieved July, 2006 from <http://www.csctulsa.org/images/OLMSTEAD%20SUBCOMMITTEE%20ASSIGNMENTS%20FY05.doc>,

Chapter 11: Employment

The purpose of this chapter is to describe employment services for people with serious mental illness and/or substance abuse problems, including existing resources, particular strengths of current programs, and needs. The chapter includes narrative information gathered through focus groups and personal interviews, as well as available data from ODMHSAS and other sources.

A. Existing Resources

Existing employment resources for people with mental health diagnoses include pre-vocational activities within Psycho-Social Rehabilitation (PSR) Programs, as well as Transitional Employment programs at the State's two certified clubhouse programs. In FY2005, only 70 adults received employment services funded by ODMHSAS. This is among a total of 9,746 adults, 18 or older, who were unemployed or not in the labor force at admission to ODMHSAS-funded mental health outpatient services, with at least 30 days between admission and discharge. One CMHC, Green Country, has a contract with the Department of Rehabilitation Services to provide supported employment. Tribal employment programs are also available to ODMHSAS clients who are tribal members.

Mental health consumers are eligible for services directly from DRS and its contractors. Through its Division of Vocational Rehabilitation (VR), DRS provides employment services that help individuals with disabilities find and keep employment in careers of their choice. The primary vocational rehabilitation services are counseling and guidance with job placement. Other services may be provided as needed to compensate for, correct or prevent disability-based barriers to employment. These services can include, but are not limited to vocational, college or other training ; assistive technology evaluations, equipment and training; personal assistance services while receiving VR services; self-employment assistance; and transitional school-to-work services for youth with disabilities. DRS also contracts with community-based services providers to provide supported employment, transitional employment, and employment and retention services.

ODMHSAS serves adults with income less than 200 percent of the federal poverty level. As shown in Exhibit 11.1., adults who receive ODMHSAS-funded mental health services have low income and the majority have no more than a high school education. To evaluate the median income of clients who received ODMHSAS-funded mental health services, client records were matched with data from the Oklahoma Employment Security Commission. The following table indicates that the median income for clients has remained around \$7,000 from fiscal years 2001 to 2005.

Exhibit 11.1.
Median Income of Individuals, Age 18 – 64,
who received ODMHSAS-funded
Mental Health Services

Fiscal Year	Income
2001	\$7,044.84
2002	\$6,928.00
2003	\$7,375.71
2004	\$6,697.60
2005	\$7,004.84

As part of the intake process, ODMHSAS collects data on individuals' level of education. As shown in Exhibit 11.2., one-third of mental health clients have less than a high school education, and only 20 percent have had any education beyond high school.

Exhibit 11.2. Education Level of Adults
Admitted to OMDHSAS-funded Mental Health Services

Fiscal Year	Less than High School Diploma		High School Diploma or GED		Some College or College Graduate		Total
	#	%	#	%	#	%	
2001	5,776	33%	8,168	47%	3,586	20%	17,530
2002	7,400	33%	10,435	46%	4,787	21%	22,622
2003	6,502	31%	10,065	48%	4,291	21%	20,858
2004	4,888	31%	7,901	50%	2,967	19%	15,756
2005	6,190	33%	8,958	47%	3,726	20%	18,874

To evaluate employment among ODMHSAS mental health service recipients, discharge data from ODMHSAS were analyzed to determine the number of clients who were unemployed and not in the labor force. As shown in Exhibit 11.3., over two-thirds of adults receiving ODMHSAS-funded mental health services were either unemployed or not in the labor force at the time of discharge from a community mental health center (CMHC). The rate of adult clients age 18-64, not in the labor force appears to be declining slightly (from 45 percent in 2001 to 41 percent in 2005), but it does not appear that these clients are more likely to become employed, since the rate of full- or part-time employed is also declining over time. The largest change in employment status was a 5 percent increase in the percent unemployed from 2001 to 2005.

Exhibit 11.3. Employment Status at Discharge for Adults, age 18-64, who received OMDHSAS-funded Mental Health Services

Fiscal Year	Full-time Employment		Part-time Employment		Unemployed		Not in Labor Force		Total
	#	%	#	%	#	%	#	%	
2001	1,746	20%	785	9%	2,347	26%	4,028	45%	8,906
2002	2,376	17%	1,174	9%	3,801	28%	6,313	46%	13,664
2003	2,150	18%	1,036	8%	4,038	33%	5,010	41%	12,234
2004	971	13%	577	7%	2,785	36%	3,392	44%	7,725
2005	1,267	12%	755	7%	3,998	39%	4,168	41%	10,188

* The sample only includes Mental Health Clients served at a CMHC with at least 90 days between their admission and discharge. Clients under the custody of DOC and those whose services were limited to Residential Care are removed from the sample.

Additional evaluation of the 2,022 mental health service recipients employed either full- or part-time at discharge revealed that the majority (84%) were employed in a competitive setting, followed by 15 percent in supported employment settings, with the remainder either in volunteer, transitional employment, or sheltered workshop settings, as shown in Exhibit 11.4.

Exhibit 11.4. Employment Setting for People, age 18 to 64, who Received ODMHSAS-funded Mental Health Services and Discharged from a CMHC in FY 2005

Full- or Part Time Employment Setting	Count	Percent
Competitive	1,698	84.0
Supported	300	14.8
Volunteer	13	0.6
Transitional	9	0.4
Sheltered Workshop	2	0.1

Education and employment data for substance abuse clients is very similar to that for mental health service recipients. As shown in Exhibit 11.5. and 11.6., individual income for substance abuse clients has remained close to \$7,000 for the past five years, and one-third of the clients have less than a high school education.

Exhibit 11.5.
Median Income of Individuals, Age 18 – 64,
who received ODMHSAS-funded
Substance Abuse Treatment

Fiscal Year	Income
2001	\$7,174.89
2002	\$7,231.69
2003	\$6,716.58
2004	\$6,588.26
2005	\$7,441.33

Exhibit 11.6. Education Level of Adults
Admitted to OMDHSAS-funded Substance Abuse Treatment

Fiscal Year	Less than High School Diploma		High School Diploma or GED		Some College or College Graduate		Total
	#	%	#	%	#	%	
2001	4,077	33%	5,790	47%	2,370	19%	12,237
2002	4,612	33%	6,467	46%	2,837	20%	13,916
2003	4,374	33%	6,400	49%	2,374	18%	13,148
2004	4,511	34%	6,552	49%	2,372	18%	13,435
2005	4,755	32%	7,203	49%	2,731	19%	14,689

ODMHSAS discharge data for substance abuse treatment clients were analyzed to determine the number of clients who were unemployed or not in the labor force. In comparison to mental health clients, a much larger percentage of substance abuse treatment clients (39% in FY2005) were employed either full-time or part-time. As seen in Exhibit 11.7., from 2002-2005, the percent of clients with full-time employment at discharge decreased by 22 percent, while the percent of clients unemployed at discharge increased from 37 percent to 44 percent. The percent of clients with part-time employment or not in the labor force has remained relatively consistent over the five year period.

Exhibit 11.7. Employment Status at Discharge for Substance Abuse Treatment Clients age 18 - 64*

Fiscal Year	Full-time Employment		Part-time Employment		Unemployed		Not in Labor Force		Total
	#	%	#	%	#	%	#	%	
2001	2,489	40%	509	8%	2,346	37%	951	15%	6,295
2002	2,868	35%	718	9%	3,182	39%	1,449	18%	8,217
2003	2,370	33%	564	8%	3,216	44%	1,116	15%	7,266
2004	2,423	32%	630	8%	3,456	45%	1,159	15%	7,668
2005	2,544	31%	701	8%	3,614	44%	1,399	17%	8,258

* Includes substance abuse treatment clients with at least 30 days between admission and discharge. Does not include clients under the custody of DOC, clients who received only detox services and dependents of substance abuse treatment clients.

Among the 3,245 adults age 18 – 64 who received OMDHSAS-funded substance abuse treatment and were employed either full- or part-time in FY2005, 89 percent were employed in a competitive environment, followed by 10 percent in a supported environment. The remaining one percent were in a volunteer or transitional employment setting.

B. Strengths

Strengths – Innovative Initiatives

A collaborative project between ODMHSAS and the Department of Rehabilitation Services (DRS) to implement the Supported Employment evidence-based toolkit from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) is in development, and model programs at seven CMHCs are projected to be implemented in October 2006. DRS is working to arrange for start-up funds to help develop capacity before the new programs are ready to bill through the existing “milestone” reimbursement system. The

University of Oklahoma will develop training curricula for staff in these model programs. ODMHSAS and DRS leaders said that the two state agencies have built an exceptionally strong working relationship, which is credited for the success of this initiative to date. Their collaborative efforts have included working with peer agencies in five other states to hold a regional conference on Supported Employment in Albuquerque in 2005.

C. Needs and Existing Barriers

Policies

Focus group participants identified a need for a comprehensive ODMHSAS policy and action plan to develop Supported Employment, Supported Education, and other opportunities for clients to succeed in the workplace. Several groups stressed that employment is an essential part of recovery for many people, and that a strong policy stance promoting and funding a range of employment and educational services is needed if the department wants to build a recovery-oriented system. Many participants noted that consumers need strong support services to successfully re-integrate into the workplace..

A need to develop additional types of employment approaches beyond those available through the Department of Rehabilitation Services (DRS) was noted, including a suggestion to seek start-up funds from the private sector to encourage the growth of consumer-run businesses. Expanding the number of consumers employed within the mental health system and the types of jobs available to them were also identified as ways to expand employment opportunities and to provide role models for consumers to encourage them to pursue employment.

Systemic barriers to employment were noted in focus groups from all parts of the state. On both the state and federal levels, the structure of public benefits programs creates disincentives to employment. For instance, public housing and food stamps can be issues when clients return to work; their rent goes up and their food stamps go down. Because keeping stable housing is key to people's recovery, many worry about their ability to keep their housing if they try to transition to employment. The possible loss of Medicare and/or Medicaid is a particularly strong disincentive to employment, as most entry-level jobs do not provide health insurance, and people can find themselves unable to pay for their medications and other health care needs; this in turn can interfere with their ability to hold a job. People receiving Social Security benefits face a complex formula that requires them to monitor the number of hours worked every month so they don't lose all their benefits.

Other systemic barriers have to do with policy issues in other systems. The lack of public transportation in both urban and rural areas was cited as a major barrier to employment, along with a shortage of stable, permanent housing and the lack of access to vocational training and higher education.

Practices/Services

As noted earlier, employment is an essential part of recovery for many people. One important outcome of mental health treatment included in the federal National Outcome Measurement System is the change of employment status from admission to discharge. ODMHSAS collects employment information at admission to and discharge from a treatment episode. Exhibit 11.8. indicates that the majority of clients do not change their employment status from admission to discharge. The largest change is that 15 percent of clients who were employed part-time at admission are employed full-time at discharge. Small percentages of

clients who are not employed or not in the labor force at admission become employed either full- or part-time, while others go from employment at admission to being unemployed when they leave treatment.

Exhibit 11.8. Change in Employment among Adult Recipients, Age 18 – 64, of ODMHSAS-funded Mental Health Services, Discharged in FY 2005*

Employment Status at Admission	Total	Employment Status at Discharge							
		Employed Full-time		Employed Part-time		Unemployed		Not in Labor Force	
		#	%	#	%	#	%	#	%
Employed Full-time	1,106	854	77%	64	6%	116	10%	72	7%
Employed Part-time	815	120	15%	509	62%	91	11%	95	12%
Unemployed	4,547	210	5%	118	3%	3,266	72%	953	21%
Not in Labor Force	3,717	83	2%	64	2%	525	14%	3,045	82%
Total	10,185	1,267	12%	755	7%	3,998	39%	4,165	41%

* Includes clients who received ODMHSAS-funded mental health services at a CMHC with at least 90 days between admission and discharge. Clients under the custody of DOC and whose services were limited to residential care were removed.

Change in employment is also an outcome for substance abuse treatment. As shown in Exhibit 11.9., the majority of clients remained in the same employment status from admission to discharge. Among those unemployed at admission, 15 percent became employed either full-time or part-time, and among those not in the labor force, 6 percent became employed. Nineteen percent of those employed part-time at admission are employed full-time at discharge. These gains are not offset by the much smaller percentages becoming unemployed at discharge; thus, the direction of movement is more positive for substance abuse than mental health clients, although there are still significant problems with a lack of employment.

Exhibit 11.9. Change in Employment among Adult Recipients, Age 18 – 64, of ODMHSAS-funded Substance Abuse Treatment, Discharged in FY 2005*

Employment Status at Admission	Total	Employment Status at Discharge							
		Employed Full-time		Employed Part-time		Unemployed		Not in Labor Force	
		#	%	#	%	#	%	#	%
Employed Full-time	2,092	1,890	90%	52	2%	110	5%	40	2%
Employed Part-time	704	136	19%	469	67%	67	10%	32	5%
Unemployed	4,231	471	11%	160	4%	3,298	78%	302	7%
Not in Labor Force	1,231	47	4%	20	2%	139	11%	1,025	83%
Total	8,258	2,544	31%	701	8%	3,614	44%	1,399	17%

* Includes substance abuse treatment clients with at least 30 days between admission and discharge. Does not include clients under the custody of DOC, clients who received only detox services and dependents of substance abuse treatment clients.

Consistent with the data reported above, clients and service providers agreed that there is a lack of focus on employment within most mental health and substance abuse programs, and that few staff have expertise on this issue. While Psycho-Social Rehabilitation programs (PSRs) offer volunteer in-house work activities and some pre-vocational activities, many clients noted that there was little capacity within the program to help them move forward into the job market. Many mental health consumers expressed an interest in preparing for GED exams, but did not have access to GED classes or even the funds needed to take the exam. Staff and consumers also talked about the need for Supported Education programs as an important adjunct to Supported Employment, so that clients can prepare for careers, not just entry-level jobs. Most people who raised employment issues said that they were aware of few if any services available in their communities.

People from several areas of the state noted that employer prejudice against people with mental health diagnoses was a barrier to employment. One staff group said that if people presented well, their chances of finding a job were better than people who exhibited symptoms. Another group mentioned that people with developmental disabilities, whom they believed employers preferred over mental health clients, held most of the low-wage jobs in their area. Consumers from all areas stated that “employers do not want to hire us.”

Differences in the cultures of the mental health system and the DRS system, and a lack of understanding of each system’s role by staff of the other system, were mentioned frequently as barriers to successful employment outcomes for mental health consumers. These differences and misunderstandings were also made clear by staff comments. Local DRS staff often complained that mental health agencies and homeless shelters seemed to assume that DRS is an employment agency, rather than a rehabilitation services agency, and refer large numbers of clients who are not ready to work. They felt that the mental health system’s priorities were out of order – that people needed housing, food and treatment before they were ready for a job. “There is such a lack of mental health services that people who are referred to us are unable to get the help they need to become ready to work,” was a typical comment.

DRS staff said that they would not accept referrals of mental health consumers who were not on medication or were not treatment compliant, a stance that is not compatible with a recovery-oriented philosophy. Similarly, some DRS staff felt that they should be able to talk with a client’s mental health worker because “the therapist knows better than the client what’s best for them.” Many DRS staff stated that they did not understand how local mental health systems worked and did not know how to help their clients access mental health services. Similarly, staff in many local mental health agencies seemed only vaguely aware of the scope of DRS services, how to help their clients gain access to these services, or whether the services were successful. Others stated that the DRS process was tedious and time-consuming, and was not welcoming to people who may need to make several attempts before succeeding at a job. Statements made by both DRS staff and mental health staff indicated that many of them did not believe that people with psychiatric disabilities are capable of holding a steady job for any length of time or of building a career.

Workforce Development Issues

DRS staff and mental health consumers who use DRS services agreed that training is needed for consumers on how to successfully use services, and for DRS counselors to familiarize them with mental health issues, to ensure that staff understand how best to support people with mental health problems. DRS staff noted that some of the barriers they face in working with

people with psychiatric disabilities are that this issue was not addressed in their rehabilitation master's program and that caseloads are too large: a typical caseload is 150 -200 people. Counselors feel that they aren't able to give each client the time they deserve. Both mental health staff and DRS staff expressed a need for cross-training and co-training.

Organization/Collaboration

While there is a good collaborative working relationship between ODMHSAS and DRS on the state level, many focus group participants noted that this is not necessarily true on the local level, and that better organizational linkages need to be forged in communities to better serve people with psychiatric disabilities. DRS counselors felt that they should be paired with mental health staff, so they can work together as a team and learn to trust each other. Participants said that this team approach would give workers in each agency a better appreciation of what each other was responsible for, and allow them to use a more holistic approach to meet clients' needs. Local DRS staff also spoke of a need to work more closely with criminal justice agencies, but felt that such overtures had not been responded to.

Data

DRS staff stated that barriers to sharing assessment and treatment information between agencies interfere with their ability to serve clients efficiently and effectively.

Financing Issues

Inconsistent DRS funding levels from year to year results in variations in the number of people who can be served. DRS has three priority groups based on level of disability; sometimes they have funds only to serve the most disabled. Under the current funding system, known as "milestone" reimbursement, there are barriers to establishing new employment programs, since the largest payments to a program aren't made until the client has a six-month job retention. It was felt that this puts programs in a bind because they do not have a steady cash flow. A number of CMHCs stated that they had formerly operated on-site Supported Employment programs, but that the funding structure forced them to discontinue the programs.

A barrier identified on the mental health side is the lack of new funding to develop additional capacity for employment programs. There was a call to re-direct some existing ODMHSAS funds into employment and education services.

Chapter 12: Prevention

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

A. Existing Resources

ODMHSAS uses the public health approach for prevention services, using a theoretical framework of risk reduction and protection enhancement to guide the development of prevention services across the state. By studying the characteristics of individuals, their families, and their environment, ODMHSAS develops risk and protection factor assessments for communities, giving them the resources to create community specific prevention programs. Risk factors are characteristics of individuals, their family, school, and community environments that are associated with increases in alcohol and other drug use, delinquency, depression and anxiety, teen pregnancy, school dropout, and violence. Factors associated with reduced potential for drug use and other problem behaviors are called protective factors. Protective factors encompass family, social, psychological, and behavioral characteristics that can provide a buffer for the children and youth. These factors mitigate the effects of risk factors that are present in the child or youth's environment. ODMHSAS prevention services focus on decreasing risk factors, such as the availability of alcohol, drugs, and firearms, family conflict, and youth rebelliousness. Such risk factors may lead to problem behaviors within youth. By decreasing risk factors, it is possible to simultaneously promote the development of protective factors. Problem behaviors related to risk factors include substance abuse, delinquency, violence, teen pregnancy and school dropout. These assessments also enable communities to identify protective factors that need improvement in order to increase community youth's bond to a healthy society. Protective factors include opportunities for pro-social involvement, recognition for pro-social involvement, and attachment to family and peers with healthy beliefs and clear standards.

To study risk and protective factors, ODMHSAS sponsors the biennial Oklahoma Prevention Needs Assessment (PNA) Student Survey to measure risk and protection variables, as well as gather information on youth's perceived availability of substances, substance usage, and antisocial behaviors. Results from this survey can be compared to two national surveys to evaluate or assess how Oklahoma ranks in relation to risk and protective factors and negative behaviors. During the off years of the PNA survey, Oklahoma students participate in the national Youth Risk Behavior Surveillance System (YRBSS) survey. The YRBSS also collects data on substance use and negative behaviors. In combination, these two surveys allow ODMHSAS and local communities to develop area and problem specific prevention programs.

ODMHSAS contracts with a network of 18 Area Prevention Resource Centers (APRCs). APRCs use trained prevention staff to serve all 77 Oklahoma counties and to provide information dissemination, education, community-based activities, and other prevention strategies. Three specialty centers provide services for specific populations throughout the state: the American Indian Institute, the African American Institute, and the Latino Community Development Center. A fourth specialty center providing education about fetal alcohol spectrum is also funded, as is a mentoring program for high-risk children referred through the juvenile justice system. ODMHSAS supports a statewide resource center, the Oklahoma Prevention

Resource Center (OPRC), which serves as a clearinghouse for print materials and has a lending library of audio-visual resources.

ODMHSAS oversees the Governor's portion of Title IV: Part A funding for the Safe and Drug-Free Schools and Communities Act. These are discretionary funds to support substance abuse prevention and violence prevention in schools and communities. The Oklahoma State Department of Education oversees the Title IV SFDFS portion of the State Grant to local education agencies (school districts) to promote education in the same areas. The OSDE also offers technical assistance, monthly videoconferences and an annual Safe and Healthy Schools Training Conference for adults to promote research-based programs and strategies and offers regional training sessions. The purpose of these federal dollars provide prevention education and early intervention for alcohol, tobacco, other substances and violence prevention. (At this time, these dollars are in jeopardy for 2007-2008 due to Congressional cuts). The schools depend on these funds for classroom instruction materials, teacher training, school safety and security measures, background checks of personnel, parent education and curriculum purchases for Pre-Kindergarten through twelfth grade. Data collection on risk behaviors and on risk and protective factors is gathered through the OSDE's Annual Incident Report form, the ODMHSAS's Prevention Needs Assessment Survey and the OSDH's Youth Risk Behavior Survey. Planning at the state level is coordinated through these agencies.

Community-based strategies are an important prevention approach for the APRCs. Each APRC is required to collaborate with and provide support to at least five community coalitions in their service areas. Environmental approaches are also used, with an emphasis on social policy change related to youth access to tobacco and alcohol. Local coalitions, with guidance from the APRC, work with tobacco and alcohol outlets to educate them about youth access. Local coalitions and APRC also offer alternatives including drug-free dances, after-prom drug-free activities, leadership skill building, and programs promoting youth community volunteerism.

ODMHSAS is a leader within the Governor's Statewide Council on Substance Abuse Prevention Advisory Council (CAAC). The CAAC is funded by a federal CSAP grant and has brought new focus on building a cross-agency strategic prevention framework using a public health approach. Other agencies involved include the Department of Health and the Department of Human Services, the Oklahoma Commission on Children and Youth (OCCY), the Alcohol, Beverage and Law Enforcement (ABLE) Commission, the Office of Juvenile Justice, the University of Oklahoma, the Oklahoma office of the US Drug Enforcement Agency, the State department of Education, and the Center for the Application of Prevention Technologies (CAPT). Each agency has responsibility for areas related to each agency's mission; the subjects addressed include violence prevention, teen pregnancy prevention, suicide prevention, school dropouts, and depression and anxiety. The Governor's Council has developed a strategic plan focusing on substance abuse, and the next round of CSAP funding will be used to broaden the strategic plan beyond substance abuse to other problem behaviors associated with substance abuse.

ODMHSAS oversees the Governor's Safe and Drug Free Schools and Communities (SDFSC) program. The program is designed to support local education agencies, community-based organizations, and other entities working on substance use and violence prevention. This program complements the Oklahoma Department of Education's SDFSC Program by providing a comprehensive prevention planning process and on-going collection of prevention needs assessment survey data.

In September 2005, ODMHSAS was awarded \$1.2 million over 3 years from SAMHSA's Center for Mental Health Services, authorized by the Garrett Lee Smith Memorial Act, to develop and implement youth suicide prevention programs. Oklahoma proposed to utilize this grant funding to implement the portions of the state plan on youth suicide prevention, including: implementation of evidence-based suicide prevention programs in local communities, tribal organizations, and institutions of higher learning for youth ages 10-24; coordination of prevention efforts statewide; strengthening collaboration among key stakeholders; evaluation of effectiveness; and development of a sustainability plan.

In October 2005, Governor Henry selected a team of seven individuals to attend a national meeting to address the serious problem associated with underage drinking. As a result of this meeting, Governor Henry created a fifteen-member Task Force on Prevention of Underage Drinking by executive order. As outlined in the executive order, the Governor's Task Force is charged with conducting a comprehensive study on the effect of underage drinking in Oklahoma. The overall purpose for the study is to have in place reasonable and effective strategies, policies, practices, and programs to reduce and prevent underage drinking. The goal is to reverse the alarming current use of alcohol by almost half of youth (compared to the national average of 44.9%), and to reduce the number of teens who report consuming alcohol before their thirteenth birthday (one of every four youth). ODMHSAS provides staffing for the Task Force and serves as the chair over the Task Force.

Other Oklahoma agencies also serve as valuable resources in the area of prevention. The Oklahoma Highway Safety Office receives a grant from the US Department of Justice, Office of Juvenile Justice and Delinquency Prevention for the Oklahoma Enforcing Underage Drinking Laws Program, called Project Under 21. Project Under 21 provides training for law enforcement and community members on enforcing underage drinking laws and environmental strategies for underage drinking prevention. The mission of Project Under 21 is to eliminate under 21 drinking and stop any person, anywhere, anytime, anyplace from providing alcohol to anyone under 21.

The Oklahoma Department of Education, through funding from the US Department of Education, administers Safe and Drug-Free Schools and Communities (SDFSC) program in schools districts across the state. The SDFSC (Title IV, Part A of the Elementary and Secondary Education act of 1965) is a critical part of the national effort to ensure academic success for all students. The SDFSC program includes a variety of activities designed to prevent school violence and youth drug use, and to help schools and communities create safe, disciplined, and drug-free environments that support student academic achievement. The purpose of the SDFSC is to support programs that: (1) prevent violence in and around schools; (2) prevent the illegal use of alcohol, tobacco, and drugs; (3) involve parents and communities and (4) are coordinated with related Federal, State, school, and community efforts and resources to foster a safe and drug-free learning environment that promotes student academic achievement.

Healthy Families Oklahoma (HFO) is a collaborative effort of the Oklahoma State University Cooperative Extension Service, Oklahoma Committee to Prevent Child Abuse, Oklahoma State Department of Health (OSDH), Office of Child Abuse Prevention, and other organizations. There are serious social, economic and health problems that families in Oklahoma face every day (e.g., economic stresses including lack of affordable housing, inadequate child care, and limited access to social supports). Such problems can overwhelm some families. HFO works as a parent education/parent support program for first time overburdened parents. Its goals are to systematically identify overburdened parents in need of

support, enhance family functioning, promote positive parent-child relationships, and promote healthy childhood growth and development.

The Oklahoma State Department of Health (OSDH) administers a wide variety of prevention services, including tobacco, injury, teen pregnancy, violence, substance abuse, sexually transmitted diseases, child abuse, and lead poisoning. Through a national initiative of the W.K. Kellogg and Robert Wood Johnson Foundations, OSDH received funding to transform and strengthen public health infrastructures. The initiative, called Turning Point, is founded on the idea that diverse groups working together can better identify and influence the determinants of health. Turning Point exemplifies the Institute of Medicine's vision of public health by promoting what society can collectively do ". . . to assure the conditions for people to be healthy." Turning Point starts at the local level, building broad community support and participation in public health priority setting and action. Turning Point begins with what some would call "social capital," engaging and linking affected people at the local level. Turning Point is anchored in two convictions: communities have strength and everyone has a stake in public health. Oklahoma Turning Point and the efforts of many individuals are working to improve the health of Oklahomans through education, planning and action. Currently there are 52 Turning Point partnerships that serve 49 counties. Areas of prevention include identifying and implementing incentives to promote and support prevention, identify gaps, adopting the Centers for Disease Control and Prevention's school health model as the standard for Oklahoma schools, establishing an obesity prevention program, educating the community about efforts to enhance healthy lifestyle choices, and developing and implementing processes that identify community needs, assets, and barriers to good health.

The Children First Program, also funded by OSDH, has the mission to produce healthy family members and enhance a family's ability to care for itself. Oklahoma families are encouraged through Children First to seek early and continuous prenatal care, to grow and develop personally, and to encourage the involvement of fathers, grandparents, and other supporting persons in parenting. This program works to achieve its mission through promoting goals that lead to improved pregnancy outcomes, improved child health, improved child development, strengthened bond between child and parent, achievement of personal goals, and improved utilization of and collaboration with community resources

OSDH also promotes child guidance programs that are comprised of three professional components designed to provide a continuum of services to build healthy family relationships and enhance child development. These include Behavioral Health Services, Early Childhood Development and Parent Education Services, and Speech, Language and Audiology Services. The types of services available to families and community child care providers include consultation regarding children's development, learning and behavior, and family relationships; training for parents and professionals on techniques and skills to promote optimal child and youth development and strengthen family interactions; screening and early identification of children with developmental delays, hearing loss, or behavioral issues; and educational services for children and youth to promote the development of appropriate personal, social and interaction skills.

In addition, OSDH is responsible for several other services and programs that promote building strong families, children, and youth. Within OSDH, the Maternal and Child Health Service (MCH) provides state leadership, in partnership with key stakeholders, to improve the physical and mental health, safety, and well-being of the Oklahoma maternal and child health population. MCH's Adolescent Health Program implements teen pregnancy prevention strategies

through community-based teen pregnancy prevention projects; provides adolescent health clinic services in county health departments; develops programs that reduce risk-taking behaviors of adolescents (violence, suicide, unintentional injury, substance abuse); promotes the health of adolescents through education, technical assistance and training for parents, grandparents, teens, schools, communities, and health and youth service providers; and provides leadership for a legislatively mandated youth suicide prevention task force, providing technical assistance in assessment, policy development and assurance of services assists communities and organizations in promoting and building resilience in youth. OSDH is also responsible for the Oklahoma Abstinence Education Project and Bullying Prevention.

The Oklahoma Commission on Children and Youth (OCCY) was created by the Oklahoma State Legislature for the purposes of providing independent oversight of the children and youth service system. OCCY assists local communities in the development of partnership boards to improve and increase needed services for children and their families and provides leadership on children's issues by testing models and demonstration projects for effective services. The mission of the OCCY is to improve services to children by facilitating joint planning and coordination among public and private agencies,, monitoring of the children and youth service system for compliance with established responsibilities,, and entering into agreements to test models and demonstration programs for effective services. In 2005, 40 Community Partnership Boards, representing 46 counties, developed local plans to address the concerns of children and families in their communities. Community Partnership Boards (CPBs) include citizens, service providers, prevention specialists, faith community representatives, and business leaders. CPBs are making a difference in their communities through the development of collaborative projects by using shared resources and conducting community needs assessments to support the development of comprehensive community driven services.

B. Strengths

Oklahoma's prevention services use selective and universal prevention approaches and activities to delay or avert the use of alcohol, tobacco, and other drugs among communities, families and individuals. In order to fulfill federal block grant requirements, prevention services supported by ODMHSAS use Evidence-based Practices (EBPs). Evidence-based prevention practices have been developed, tested and found to be effective in preventing substance abuse and other problem behaviors. Some EBPs that ODMHSAS providers are currently using include: Community Mobilizing for Change on Alcohol (CMCA), Parenting Wisely, Guiding Good Choices, Al's Pals, Parents Who Care, Community Mobilization, Communities That Care, and Media Advocacy.

ODMHSAS has developed a number of collaborative initiatives. One such collaboration involves the University of Oklahoma Southwest Prevention Center, which is developing a pre-school program called Growing Up Strong (GUS). GUS is being tested in several schools across the State. Research results will be used to ensure the effectiveness of the program, with the goal of having GUS adopted as a model program by the federal Center for Substance Abuse Prevention (CSAP).

There is also a Statewide Epidemiological Outcomes Workgroup funded by CSAP that is headed by the Oklahoma State Epidemiologist. The goal of this workgroup is to systematically collect, analyze, and report substance use in the state Oklahoma. The report will include incidence and prevalence rates of substance abuse, national outcomes measures for the state of

Oklahoma, and other related data. This information will be used by Oklahoma agencies and communities for planning, monitoring, and evaluation of substance abuse prevention services. Project Under 21 is a collaborative effort with the Oklahoma Highway Safety Office that brings together teams of high school students and adults to learn about under-21 drinking, impaired driving crashes, and other alcohol-related issues. Teams spend a week together developing action plans to be implemented in their communities. ODMHSAS is also partnering with the Oklahoma Highway Safety Office on a media campaign for home University of Oklahoma and Oklahoma State University football games. The campaign includes underage drinking prevention messages broadcast during games and the distribution of prevention resources.

On July 1, 2006, the Oklahoma Prevention of Youth Access to Alcohol Law went into effect throughout the state. This law is designed to decrease the availability of alcohol to individuals under the age of 21. The Prevention of Youth Access to Alcohol Law created a local revolving fund for municipalities. Local municipalities can enact ordinances prescribing the maximum fines, and \$50 from each alcohol fine or deferral fee will go into a local municipality fund. This fund can then be used to defray costs for enforcement of laws related to juvenile access to alcohol, other laws related to intoxicating substances, and traffic-related offenses involving intoxicating substances. In addition, the law includes provisions for a revolving fund for underage drinking prevention to ODMHSAS for programs and campaigns to educate the public and law enforcement about the dangers and consequences of providing alcohol to minors.

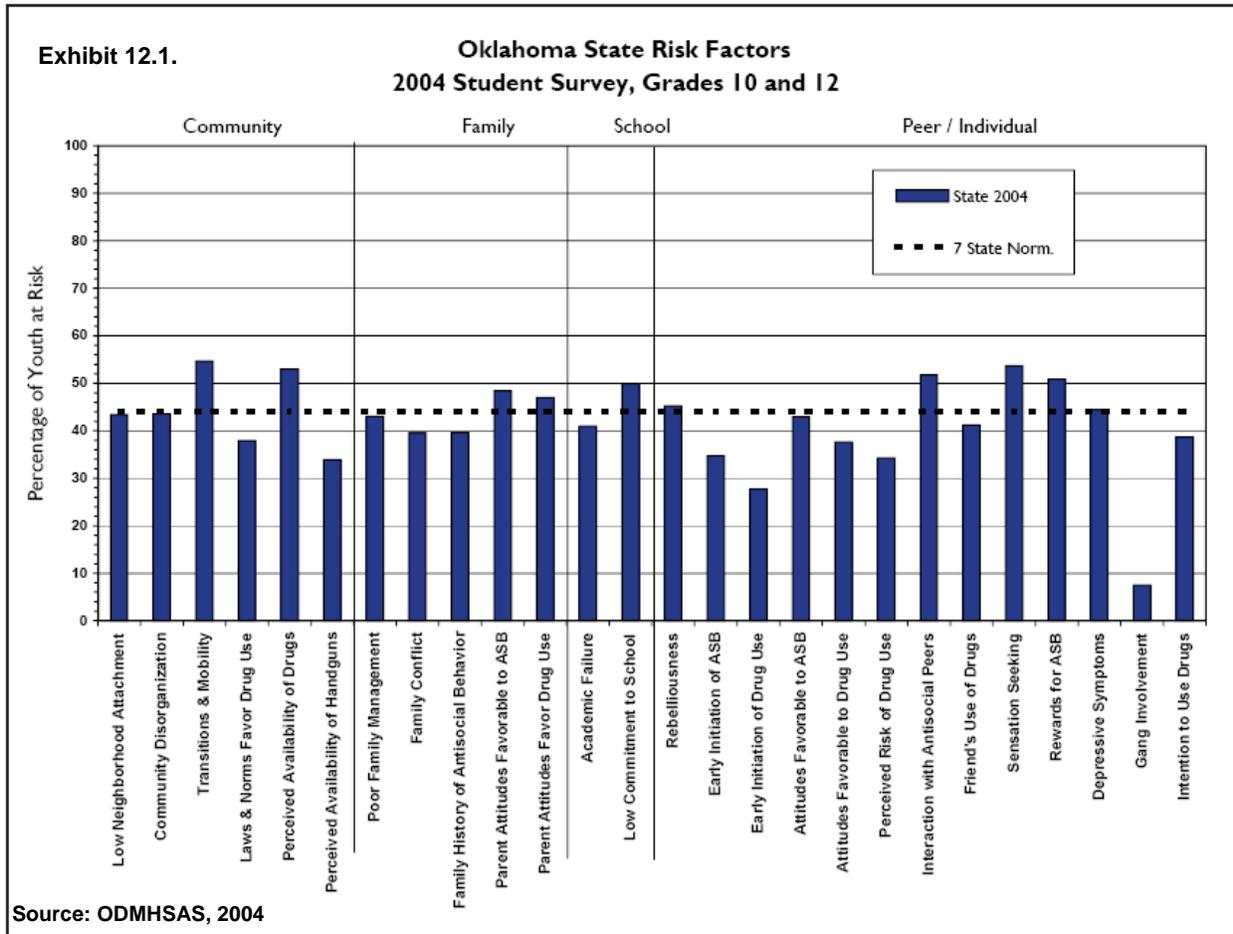
While it is noted in the section below on Needs/Existing Barriers that there is a general need for more collaboration between the substance abuse and mental health fields and among other state agencies, the suicide prevention program has been cited as an example of successful collaboration among substance abuse, mental health, and the Department of Health.

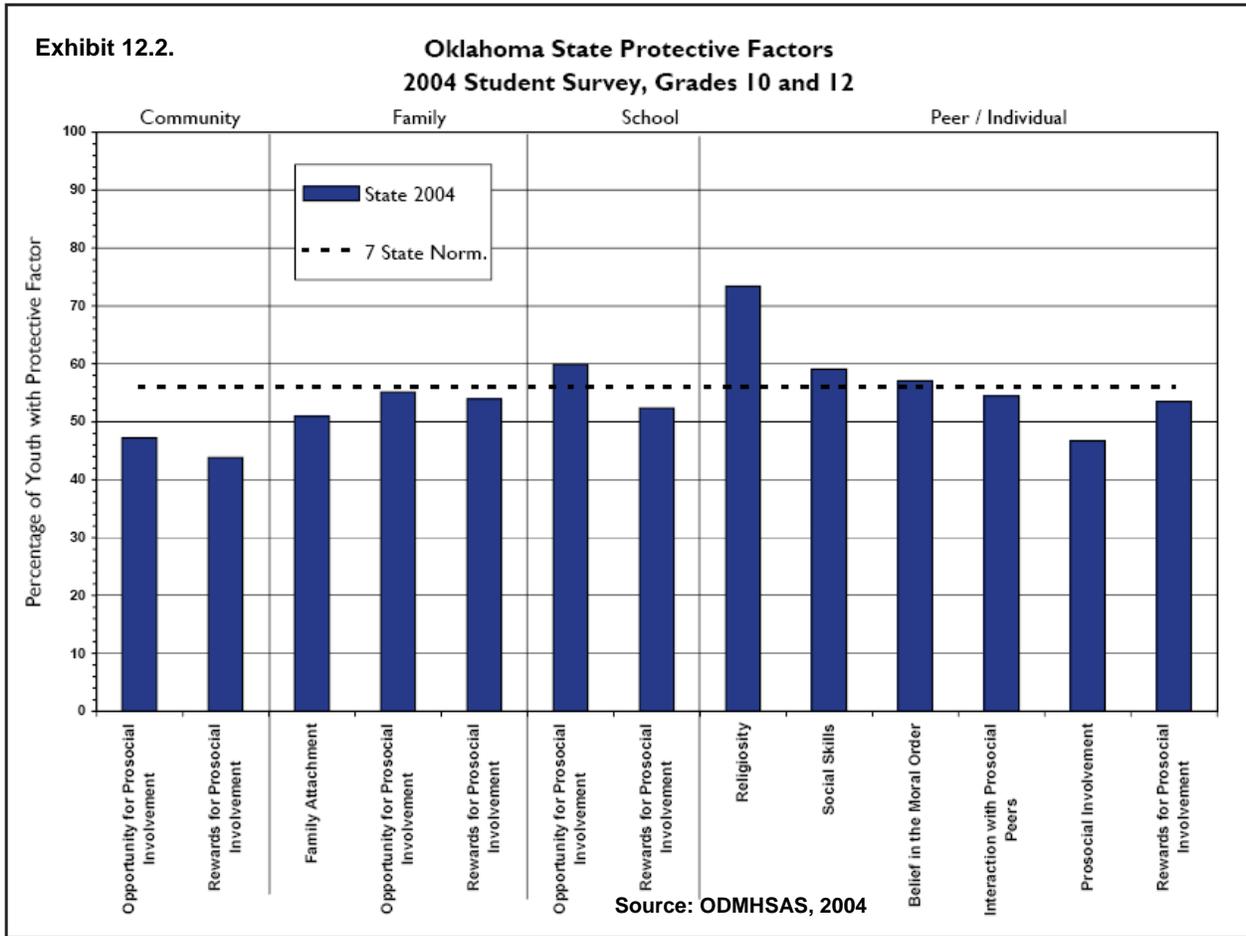
C. Needs and Existing Barriers

As previously discussed above, in order to design prevention programs around existing needs, communities need to know the incidence and prevalence of youth substance use, antisocial behaviors, as well as other risk and protective factors. During spring 2004, approximately 9 percent of students in grades 6, 8, 10, and 12 voluntarily completed the Oklahoma Prevention Needs Assessment (PNA) survey (n=16,752 students; ODMHSAS, 2004). With survey locations spread across the state, needs of specific locations and subpopulations can be estimated. Risk and protective factor comparisons can be made between youth in Oklahoma and youth from the seven other states (Colorado, Illinois, Kansas, Maine, Oregon, Utah, and Washington) who have taken the same survey. These comparisons reveal that Oklahoma students have similar levels of risk compared to students in other states (see Exhibit 12.1.). Oklahoma high school students were higher than the 7-state norm for 8 of the 26 scales. The risk factors that pose the greatest risk for Oklahoma youth were transitions and mobility, perceived availability of drugs, low commitment to school, sensation seeking, parental favoring attitudes towards ASB, drug use, and interaction with antisocial peers.

Oklahoma high school students also report a lower level of protective factors than students from the 7-states for 9 of the 13 protective factor scales (see Exhibit 12.2.). For students in Oklahoma, all the indicators for community and family protective factors were below the 7-state average. Only 31 percent of the protective factors exceeded the 7-state average. Indicators that are most alarming to Oklahoma include community rewards for pro-social involvement and peer/individual pro-social involvement having the lowest levels of protection compared with the

other states. The indicators with the highest protective factors for Oklahoma's youth are religiosity, school opportunities for pro-social involvement, and social skills.





On a state level, the results from the 2004 PNA survey revealed that 37.8 percent of students in grades 6, 8, 10 and 12 use some prohibited substance, including alcohol, tobacco, marijuana and other illicit drugs, either individually or in combination (see Exhibit 12.3.). Alcohol use presents the greatest problem among youth; 39.4 percent of surveyed 10th graders and 49.9 percent of surveyed 12th graders report using alcohol in the past 30 days, and 55.3 percent of students report using it at least once in their lifetime.

With regard to age, tobacco and inhalants appear to present the greatest problem, with the average age of first use of cigarettes at 12.6 years, and the 30-day inhalant usage peaking at grade 8 (5.4%) and declining to 1.2% by grade 12. The use of alcohol generally begins around 13.1 years of age, with the first sip, and regular use of alcohol begins at 14.8 years. First use of marijuana is reported at age 14.2 years, six months before students indicated that they had begun drinking regularly (ODMHSAS, 2004).

While some of these percentages may appear to be small, they represent a large number of adolescents. There are approximately 500,000 Oklahomans aged 11-19 years. An estimated 10.7 percent of this age group (Grades 6-12) reported using alcohol and at least one other drug within the past 30 days. This translates to almost 55,000 adolescents. Thus the problem of alcohol and drug use among youth in Oklahoma is very significant.

Exhibit 12.3. Percentage of Oklahoma Youth (Grades 6, 8, 10, and 12) Reporting Use of One or More Substances in the Past 30 Days

Percentage Using Multiple Substances in the Past 30 Days					
Drugs Used in Past 30 Days	School Grade				
	Grade 6	Grade 8	Grade 10	Grade 12	Total
Any Substance	19.3	35.1	48.8	58.0	37.8
Alcohol	9.3	24.6	39.4	49.9	28.0
Cigarettes	7.5	15.3	23.3	29.2	28.0
Smokeless Tobacco	1.9	4.3	8.0	9.2	5.3
Tobacco (cig. or smokeless)	8.4	17.4	26.8	32.7	19.7
Marijuana	1.8	8.8	15.1	16.8	9.6
Tobacco and Alcohol	3.1	10.5	19.8	26.9	13.4
Tobacco and Marijuana	1.3	5.7	10.4	11.6	6.5
Alcohol and Marijuana	1.0	6.6	12.8	14.6	7.8
Marijuana and Tobacco and Alcohol (all three)	0.8	4.6	9.2	10.5	5.6
Alcohol and Any Other Drug	2.9	9.8	16.1	18.2	10.7
Alcohol and Any 1 Other Drug	1.9	5.9	9.4	10.8	6.4
Alcohol and Any 2 Other Drugs	0.6	2.1	4.0	4.7	2.5
Tobacco and Any Other Drug	3.1	8.2	12.7	14.7	8.9
Tobacco and Any 1 Other Drug	2.1	4.7	7.0	8.3	5.1
Tobacco and Any 2 Other Drugs	0.6	1.8	3.2	4.0	2.2

Source: ODMHSAS, 2004

As an indicator of violent behavior, the PNA survey asked about physical attacks and handguns. The survey revealed that 21.3 percent of students have attacked someone with the idea of seriously hurting them at some point in the reporting student's lifetime, and 16.9 percent of students reported that they have attacked someone in the past 12 months. The survey also indicated that less than one percent of the students report taking a handgun to school in the past 12 months. Twelfth graders had the highest reports of taking a handgun to school at least once in the past month (1.2%) and the highest reports of carrying a handgun in their lifetime (6.3%).

Indicators for depression, suicidal ideation, and suicide attempts for Oklahoma youth come from the 2005 Youth Risk Behavior Survey (YRBS; CDC, 2004). The YRBS is administered to students nationwide in grades 9 through 12. The results indicate that 27.9 percent of Oklahoma students surveyed have stopped doing some usual activities within the past 12 months because of feelings of sadness or hopelessness that occurred almost every day for two weeks or more. Those students surveyed also indicated that during the past 12 months, 15.4 percent seriously considered attempting suicide, 12.4 percent made a plan to attempt suicide, and 7.9 percent actually attempted suicide.

Teenage sexual activity also requires prevention programs because of the risk for sexually transmitted diseases and teenage pregnancy. In addition, teenage sexual activity is associated with increased risk of school dropout, drug and alcohol use and incarceration. The YRBS results for Oklahoma youth revealed that 49.3 percent of students have had sexual intercourse, 17.8 percent of students have had intercourse with four or more people during their lifetime, and 6.5 had intercourse before age 13. Thirty-six percent of students indicated they had sexual intercourse with one or more persons during the past three months. Forced sexual intercourse is also a problem among youth, with 7.2 percent of students surveyed reporting being physically forced to have unwanted sex (CDC, 2004).

Prevention programs aimed at younger adults are also needed. The most recent mortality information for the state estimates alcohol related deaths at 294 per 100,000 for people age 18 – 24 years. The estimate declines for people age 25 – 44 years, with 169 alcohol related deaths per 100,000. The estimate increases with age, with 387 deaths per 100,000 for people 45 – 64 , and 1,136 deaths per 100,000 for people 65 and older (ODMHSAS, STNAP Phase III, 2005).

Young adults age 18 – 24 years have a higher rate of arrest for alcohol and drug related offenses compared to adults age 25 and older. In 2003, the rate of arrest for alcohol related offenses for people age 18 – 24 was 9,312 per 100,000, and the rate of arrests for drug related offenses was 5,823 per 100,000. The rate of arrest continues to decrease as people age, with a rate of 5,311 per 100,000 for alcohol, and 2,692 per 100,000 for drugs for people age 25 – 44. In contrast to these mortality and arrest data, young adults do not constitute the largest number of substance abuse clients served by ODMHSAS funded facilities. In 2004, people age 18 – 24 comprised 23 percent of ODMHSAS substance abuse treatment clients, while people age 25 – 44 comprised 61 percent, and age 45 and older, 16 percent (ODMHSAS, STNAP Phase III, 2005).

Policies

Personal interviews and focus group participants expressed a desire for ODMHSAS to develop a clear definition of “prevention” that would apply to both the substance abuse and mental health service systems. Staff involved in the development and implementation of prevention strategies would like to see a more integrated prevention effort made possible by development of an agency-wide strategic plan for prevention. Participants also suggested there is a need to develop prevention priorities within ODMHSAS.

It was noted that the term “prevention” tends to be used differently in the two fields. In substance abuse, primary prevention activities are used at the individual level and secondary prevention is done at the community, family, and school levels. Yet much of what is called “prevention” in the mental health field is actually early intervention. There are also differing views within the mental health field about whether mental illness is preventable, and, if so, what the appropriate prevention strategies (as opposed to early intervention approaches) might be.

Practices/Services

In 2005, ODMHSAS shifted priorities for prevention services based on federal requirements. All prevention services operate using the Strategic Prevention Framework (SPF), which allows communities to select evidence-based prevention programs, practices, policies and services based on the needs of the local community. The SPF allows APRCs to work with their communities in the following areas: assessment (assessing local needs), capacity (community mobilization and capacity building to address local needs), planning (developing a community action plan for prevention), implementation (implementing the prevention plan), and evaluation

(determining if what they are doing is working). Through the SPF process, communities are taught to infuse sustainability and cultural competency into each step. The shift to the SPF approach of strategically looking at community and individual needs and providing prevention based on documented needs has been difficult for some prevention providers who may find moving away from current practices undesirable. ODMHSAS has been working with APRC providers to provide them with the necessary training and technical assistance to overcome this.

Some providers with contracts to operate Area Prevention Resources Centers (APRCs) expressed a lack of satisfaction with the program. “We didn’t have input into the design,” one provider said. “The model doesn’t really work well in rural areas.” Another provider said, “The way these contracts are set out does not work for our community. APRCs used to provide services to kids during school hours, but now we can only work with schools before or after school hours. Schools and parents don’t understand why we can’t give them the services they ask for.”

ODMHSAS responds that the APRC contracts are not designed to provide direct services to youth, but rather to provide comprehensive prevention services to using a community-based approach. APRCs are designed to provide training and technical assistance in order to increase capacity for communities and schools to prevention substance use and other problem behaviors. Many APRC providers have found it difficult to shift from an individual approach of working one on one with youth to a community based approach. ODMHSAS has been working with APRC providers to provide them with the necessary training and technical assistance to overcome this.

Workforce Development Issues

Prevention providers said that low salaries, a requirement for enhanced credentials, and a lack of training opportunities combined to make it difficult to keep good staff. It was noted that the entry-level requirements for APRC staff are a BA degree plus certification as a prevention specialist, which requires 150 hours of CEUs and 120 hours of supervised work within 18 months of hire. “This is difficult because the department doesn’t offer enough opportunities for training, so we have to pay out of pocket to get trained elsewhere,” a provider said. “We have to use program funds for training, and staff have to pay some training costs out of pocket. It takes a lot to train people, and then they leave because the pay is so low.”

ODMHSAS has recently polled their prevention workforce in order to gauge the capacity and identify need within the Oklahoma prevention network. The assessment will be used to identify training gaps, build a training cadre, and focus ODMHSAS’s efforts in providing evidence based prevention training and technical assistance services.

Organization/Collaboration

ODMHSAS’s contracts with APRCs have recently been modified to require them to work with existing community coalitions in order to broaden the APRC impact. Some prevention providers questioned the value of this approach. “The need to work with existing coalitions only limits us in the number of kids we can reach. It’s hard, because these coalitions in the community are not always interested in prevention - they have other priorities. So we think this is not really very effective.”

ODMHSAS responds that community organizing is an EBP strategy and working within existing community based coalitions is an effective way to make prevention a community

priority. Community level change impacts entire populations whereas traditional individual level prevention methods, such as school based programs, are limited in their scope.

Financing

One barrier to the development of prevention activities on the mental health side is a lack of available funding. The prevention program is largely funded by the Center for Substance Abuse Prevention (CSAP) of the federal Substance Abuse and Mental Health Services Administration (SAMHSA). Currently, 20 percent of the SAPT Block Grant is earmarked for substance abuse prevention.

APRC providers said that a lack of funding hampered their ability to provide enough quality prevention services. “We need more funding to meet the demands placed on us,” one provider said. “There are things we'd like to do but can't afford to do. APRCs have not received any funding increases in five years; we are expected to do more work without any new dollars.” Another provider said, “It is too much work for too little money- we can't meet people's needs with the current funding.”

References:

CDC (2004). *YRBSS, Youth Online: Comprehensive Results*. Retrieved September, 2006 from <http://apps.nccd.cdc.gov/yrbss/SelHealthTopic.asp?Loc=OK>

ODMHSAS (2004). *Oklahoma Prevention Needs Assessment Student Survey, State Report, 2004*. Sponsored by: Oklahoma Department of Mental Health and Substance Abuse Services. Conducted by: Southwest Prevention Center, University of Oklahoma & Bach Harrison, LLC.

ODMHSAS, STNAP Phase III (2005). *Oklahoma State Treatment Needs Assessment Program, Phase III, Final Report on Social Indicator Study*. Oklahoma City, OK: Submitted to the SAMHSA, Center for Substance Abuse Treatment, Grant number 1 UR1 TI13443-01 by the Oklahoma Department of Mental Health and Substance Abuse Services.

Chapter 13: Cultural Competence

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

A. Existing Resources and Strengths

In 2005, ODMHSAS established a position for a Cultural Competence Coordinator to provide leadership around the provision of culturally competent care. The department also made more cultural competency training available. In 2006, a Cultural Competency Advisory Team was assembled, consisting of representatives of a range of cultural, racial and ethnic groups (not necessarily from the mental health or substance abuse fields), and including consumers and family members. The Team will respond to needs identified by the department, advise the department on promising practices for improving cultural competence, and will educate their own communities about substance abuse and mental health issues.

There are several ODMHSAS-certified programs throughout the state with a cultural emphasis. The Chickasaw Nation Alcohol and Drug Program is a 21-28 day residential treatment program for adult American Indian men and women. The Muscogee (Creek) Nation Behavioral Health and Substance Abuse Services (BHSAS) is an outpatient substance abuse program that believes “respect for culture and involvement in our Indian communities is essential to the success of our program.” Seventy percent of staff at this facility are American Indians with extensive educational backgrounds. The Latino Community Development Agency (LCDA) Adolescent Outpatient Substance Abuse Program provides individual and family counseling, group treatment, and crisis intervention and case management for individuals in the Latino community. Many other programs, both public and private, include a cultural emphasis. These programs include, but are not limited to: Citizen Pottawatomie Nation Health Complex, Community Adolescent Rehabilitation Effort (CARE) for Change, COPE, Inc., Inter Tribal Substance Abuse Prevention and Treatment Center, and Quapaw Tribal Family Services.

B. Needs and Existing Barriers

Multicultural Populations

As shown in Exhibit 13.1., Whites make up approximately 75 percent of the Oklahoma population, followed by Native Americans (7.4%), African-Americans (7.1%) and Hispanics (6.6%). People from multiple racial groups comprise 5.7 percent of the population, other racial groups 2.7 percent, Asian, 1.6 percent, and Pacific Islander .10 percent. When compared to the U.S. population, Oklahoma has a higher percentage of Native Americans and people from multiple racial groups (U.S. Census Bureau, 2006).

Exhibit 13.1. Oklahoma Population by Race/Ethnicity, 2005 American Community Survey.

Race/Ethnicity	Population Estimate	OK Percent	U.S. Percent
White	2,589,660	75.40%	74.70%
Black or African American	243,094	7.10%	12.10%
American Indian and Alaska Native	253,783	7.40%	0.80%
Asian	54,270	1.60%	4.30%
Native Hawaiian/Pacific Islander	3,598	0.10%	0.10%
Some other race	93,669	2.70%	6.00%
Two or more races	195,422	5.70%	1.90%
Hispanic or Latino (of any race)	227,767	6.60%	14.50%

Policies

The State has been straightforward in recognizing that systemic barriers exist that continue to create disparities in access to health care, mental health, substance abuse, and other human services for different cultural, racial and ethnic minority groups and persons with disabilities. Focus group participants commented on a number of these barriers (some of which are discussed in following sections), including what was perceived as a lack of urgency on the part of state agencies in addressing the root causes of these disparities. Among the root causes mentioned were a lack of understanding that people from different backgrounds may not share majority views about the nature, causes and appropriate responses to emotional distress and substance use; prejudice against people from non-majority backgrounds, which was seen as exacerbating many mental health and substance abuse problems; and a perception that cultural divides are so deep that they often make serious discussion of these issues difficult and frustrating for all parties. It was also noted that the cultures of mental illness, addiction, and/or the culture of poverty often overlay individuals' core cultural identity, and that this can even cause breakdowns in communication between professionals and clients who are from the same cultural, racial or ethnic groups.

Participants said that state agencies lack rigorous policies around translation and interpretive services. Some respondents reported that very specific types of expertise are required for translation services related to healthcare, adding that many other states have special certification requirements that Oklahoma does not have. It was noted that grant reviews often are critical of state agencies for not adequately addressing cultural competency issues. Focus group members and personal interviews from some groups stated that their needs did not seem to be taken seriously. Participants called for an agency-wide strategic plan to systemically address the development of culturally competent services.

Practices/Services

Focus group participants described a range of issues related to practices and services that interfere with providing culturally competent services to Hispanics, African-Americans, Native Americans, and other ethnic and racial minorities.

In order to compare ODMHSAS consumer racial/ethnic composition to that of ODMHSAS staff, the racial and ethnic composition of ODMHSAS consumers is provided in Exhibit 13.2. Compared to the Oklahoma population, African-Americans and Native Americans appear at a higher rate among ODMHSAS clientele than would be expected by population statistics. This could be due to several factors, such as higher rates of poverty and an increased prevalence of mental health and/or substance abuse problems. The 2005 National Health Interview Study demonstrated a higher prevalence for serious psychological distress (SPD) during the past 30 days for African-Americans compared with Whites, 3.7 percent versus 2.8 percent respectively. While the initial report did not include data on Native Americans, it did report that 3.8 percent of Hispanics experienced a SPD in the past 30 days, higher than both Whites and African-Americans (CDC, 2006). This national finding, combined with ODMHSAS client data and Oklahoma population estimates for Hispanics, indicates a significantly lower than expected number of Hispanic consumers among those served.

Exhibit 13.2. ODMHSAS Mental Health and Substance Abuse Treatment Clients by Race/Ethnicity.

Year	Total Clients	White alone or with another race		African American alone or with another race		Native American alone or with another race		Asian alone or with another race		Hispanic alone or with another race	
		#	%	#	%	#	%	#	%	#	%
FY 2001	32,881	25,271	77%	3947	12%	3728	11%	177	1%	942	3%
FY 2002	34,648	26,376	76%	4269	12%	3850	11%	251	1%	1123	3%
FY 2003	32,835	24,594	75%	4341	13%	3672	11%	197	1%	1173	4%
FY 2004	33,589	25,327	75%	4476	13%	3497	10%	209	1%	1201	4%
FY 2005	35,508	27,667	78%	4892	14%	3838	11%	187	1%	1412	4%

For Hispanics, language barriers were seen as a key issue. It was mentioned that in some parts of the state, Hispanics make up as much as 45% of the population, but that there are very few bi-lingual professional staff available to serve them. “There are no bilingual residential treatment programs for substance abuse services,” one professional said. “The only bi-lingual services available are AA and NA. If people are arrested for DUI, they can be mandatorily referred to outpatient treatment, but there are none available that are bilingual or culturally competent.” It was also noted that the same is true for mental health services. A recent survey in Tulsa County about disparities in healthcare and human services was mentioned; the study found that language was a significant barrier to access.

In the 2005 American Community Survey, it was found that about 4 percent of Oklahomans speak English less than “very well,” with the majority of these individuals speaking Spanish in the home (U.S. Census Bureau, 2006). Similarly, ODMHSAS non-English speaking consumers overwhelmingly prefer Spanish over other languages (see Exhibit 13.3.) It should be noted that less than 1 percent of ODMHSAS clients are non-English speaking compared with 8 percent of the population (U.S. Census Bureau, 2006), which may indicate a perceived or actual lack of services for non-English speaking individuals, or racial/ethnic stigma.

Exhibit 13.3. Preferred Language for ODMHSAS Mental Health and Substance Abuse Treatment Clients.

FY 2005	Number of Clients	
English Speaking	35,295	
Non-English Speaking	213	
PREFERRED LANGUAGE	#	%
Spanish	160	75%
Native American	31	15%
Sign Language	8	4%

The bilingual status of ODMHSAS direct care staff is presented in Exhibit 13.4., by primary type of service (PTS) provided. This table shows that for those PTS displayed the percentage of staff bilingual in English and Spanish has increased since FY 2001. While this increase demonstrates improvement, it should be noted that the location of Spanish speaking service provides does not necessarily coincide with the location of Spanish speaking clients. This table also shows a need for more Native American speaking and Sign Language capable staff. Moreover, to become more culturally competent ODMHSAS staff and data system should take into consideration the numerous Native American languages spoken in Oklahoma to see if those languages most needed by consumers are those spoken by staff.

Exhibit 13.4. ODMHSAS Direct Care Staff by Bilingual Status for select Primary Types of Service.

Psychological or Counseling Services								
Year	Total Staff	Percent Bilingual	Language Spoken Other than English					
			Spanish		Native American		Sign Language	
			#	%	#	%	#	%
FY 2001	1,040	5%	23	2.2%	5	0.5%	3	0.3%
FY 2002	1,400	4%	30	2.1%	4	0.3%	4	0.3%
FY 2003	1,474	5%	36	2.4%	5	0.3%	6	0.4%
FY 2004	1,542	5%	36	2.3%	7	0.5%	5	0.3%
FY 2005	1,794	5%	51	2.8%	9	0.5%	5	0.3%

Exhibit 13.4. continued

Medical Services								
Year	Total Staff	Percent Bilingual	Language Spoken Other than English					
			Spanish		Native American		Sign Language	
			#	%	#	%	#	%
FY 2001	462	8%	7	1.5%	1	0.2%	3	0.6%
FY 2002	581	9%	11	1.9%	2	0.3%	3	0.5%
FY 2003	563	9%	11	2.0%	3	0.5%	4	0.7%
FY 2004	557	9%	11	2.0%	3	0.5%	4	0.7%
FY 2005	613	9%	15	2.4%	3	0.5%	5	0.8%
Case Management Services								
Year	Total Staff	Percent Bilingual	Language Spoken Other than English					
			Spanish		Native American		Sign Language	
			#	%	#	%	#	%
FY 2001	291	4%	8	2.7%	1	0.3%	0	0.0%
FY 2002	386	5%	15	3.9%	2	0.5%	1	0.3%
FY 2003	402	5%	15	3.7%	2	0.5%	0	0.0%
FY 2004	463	5%	15	3.2%	2	0.4%	1	0.2%
FY 2005	548	5%	22	4.0%	4	0.7%	2	0.4%
Administrative								
Year	Total Staff	Percent Bilingual	Language Spoken Other than English					
			Spanish		Native American		Sign Language	
			#	%	#	%	#	%
FY 2001	366	2%	2	0.5%	1	0.3%	1	0.3%
FY 2002	452	2%	2	0.4%	1	0.2%	1	0.2%
FY 2003	453	2%	3	0.7%	2	0.4%	2	0.4%
FY 2004	455	3%	6	1.3%	1	0.2%	1	0.2%
FY 2005	468	3%	6	1.3%	1	0.2%	1	0.2%

Beyond language, there are additional issues facing Hispanics who have mental health and substance abuse problems, including cultural values that tend to place a particular stigma on being labeled as “loco.” For undocumented residents, fear of deportation is often a barrier to seeking assistance; this was seen as true not only for Latinos, but for smaller populations of undocumented individuals from Africa and Asia.

A number of participants stated that “mental health” was a Western concept that is not a part of Asian, African, and Native American cultures. Interviewees commented that, for most non-European cultures, mental and emotional difficulties are traditionally handled within the family, the community, and the church, so that the idea of seeking help for these issues from a paid stranger seems peculiar to many people from other cultures. It was noted that this is as true for African-Americans as it is for people born abroad. Some providers noted that African-Americans are often very reluctant to be seen by Caucasian staff if they sense that the provider is not culturally attuned to them. “There is a huge lack of cultural competency; we need staff who can really relate to individuals from another culture,” one consumer said.

The racial/ethnic composition of ODMHSAS direct care staff is provided in Exhibit 13.5. While the race/ethnicity of service providers does not guarantee cultural competency, it does provide some reference when considering the reluctance of some clients to be seen by providers of a different race/ethnicity. In 2005, 14 percent of ODMHSAS consumers were African-American (see Exhibit 13.3.) compared to 12 percent of all direct care staff and 9 percent of psychological or counseling service staff. This disparity lends support to the focus group comments on African-American reluctance to seek treatment. Native American and Hispanic service providers are also slightly under represented when compared to client racial/ethnic composition.

Exhibit 13.5. ODMHSAS Direct Care Staff by Race/Ethnicity.

All ODMHSAS Direct Care Staff											
Year	Total Staff	White alone or with another race		African American alone or with another race		Native American alone or with another race		Asian alone or with another race		Hispanic alone or with another race	
		#	%	#	%	#	%	#	%	#	%
FY 2001	3,045	2,458	81%	311	10%	270	9%	56	2%	65	2%
FY 2002	4,038	3,210	79%	424	11%	378	9%	82	2%	90	2%
FY 2003	4,250	3,352	79%	464	11%	395	9%	83	2%	109	3%
FY 2004	4,621	3,610	78%	531	11%	418	9%	83	2%	121	3%
FY 2005	5,203	4,036	78%	614	12%	473	9%	92	2%	148	3%
ODMHSAS Psychological Or Counseling Services Staff											
Year	Total Staff	White alone or with another race		African American alone or with another race		Native American alone or with another race		Asian alone or with another race		Hispanic alone or with another race	
		#	%	#	%	#	%	#	%	#	%
FY 2001	1,040	879	85%	87	8%	81	8%	9	1%	27	3%
FY 2002	1,400	1,167	83%	124	9%	119	9%	11	1%	34	2%
FY 2003	1,474	1,211	82%	142	10%	124	8%	17	1%	39	3%
FY 2004	1,542	1,277	83%	141	9%	121	8%	14	1%	37	2%
FY 2005	1,794	1,476	82%	160	9%	155	9%	13	1%	50	3%

While Native Americans can receive mental health and substance services through the Indian Health Services, they are also eligible for ODMHSAS-funded services, although it was noted that cultural competence may be lacking in these programs. Others commented that some providers tend to refer Native American consumers back to their tribes for service, and that this may not be what the consumer wants. The tribes are small, close-knit communities, and individuals seeking help may not want people from their tribe to know about their problems. It was also noted that some tribes lack access to non-tribal services because of their rural location: “For example, the Osage tribe has no access to local outpatient services, or psychiatric services, which are 45 miles away.” The lack of good public transportation in the state and the fact that services are not often located in minority communities was seen as another barrier to access.

Respondents called attention to the fact that cultural competence is a factor not only for racial and ethnic minority groups, but for other cultural groups as well. For instance, language/communication barriers affect not only people who speak languages other than English, it is a major concern for people who are deaf. Community-based providers said that there is a lack of funding for sign-language interpreters, and that deaf consumers can only get inpatient care at Griffin Memorial Hospital, the only State facility where there are interpretation services.

According to the 2004 National Survey of Substance Abuse Treatment Services State Profile (N-SSATS), there were 59 facilities in Oklahoma capable of providing services in either sign language and/or a language other than English, including both public and private facilities. A total of 56 facilities offered services for the hearing impaired. Of those facilities with other language capabilities, 22 facilities had staff or on-call interpreters for Spanish speaking consumers, and 5 facilities had this coverage for Native American languages (SAMHSA, 2005).

Cultural competence is also an important issue for gay, lesbian and trans-gendered individual seeking services. "The gay and lesbian population in the state has been growing," one person noted. "This has led to a growing unmet need, as there are few services for them and a general lack of cultural sensitivity." Participants stated that hostility toward this population often leads to or exacerbates substance abuse problems and depression, and that gay youth may have trouble accessing services because they need parental consent but may be unwilling to come out to their parents.

Workforce Development and Training

For many respondents, workforce development and training were seen as the primary mechanism for remedying many of the problems noted above. There was a consensus that cultural competence training should be required for all staff. It was also suggested that one-time training on cultural competence issues was not sufficient to change agency cultures, and that leadership from the top and supervision are vital for the kind of environmental change needed within the system.

A significant shortage of mental health and substance abuse professionals from minority cultural groups was identified as a key barrier to the delivery of culturally competent services. Focus group members called for ODMHSAS to develop a targeted outreach and recruitment program aimed at people of color. A Latina professional said that large segments of the Hispanic population are not receiving services, primarily because there is not enough trained Hispanic or bilingual staff. She also noted that there is still little ethnic diversity among students in professional training programs, partly because successful students from cultural minority groups chose to go into higher-paying professions than human services. She suggested that scholarship programs to support master's level study for students from ethnic and cultural minority groups would be one way to increase the diversity of the system's staff.

References:

CDC (2006). *Early Release of Selected Estimates Based on Data From the 2005 National Health Interview Survey*. National Center for Health Statistics. Retrieved September, 2006 from <http://www.cdc.gov/nchs/about/major/nhis/released200606.htm>

U.S. Census Bureau (2006). *Fact Sheet, Oklahoma, 2005 American Community Survey*. Retrieved September, 2006 from http://factfinder.census.gov/servlet/ACSSAFFacts?_event=&geo_id=04000US40&_geoContext=01000US%7C04000US40&_street=&_county=&_cityTown=&_state=04000US40&_zip=&_lang=en&_sse=on&ActiveGeoDiv=&_useEV=&pctxt=fph&pgsl=040&_submenuId=factsheet_1&ds_name=null&ci_nb

SAMHSA (2005). *National Survey of Substance Abuse Treatment Services (N-SSATS): 2004, Data on Substance Abuse Treatment Facilities*. Retrieved September, 2006 from http://www.dasis.samhsa.gov/04nssats/nssats04_tbl6.14a.htm

Chapter 14: Workforce Development and Training

The purpose of this chapter is to describe workforce development and training, including existing resources, strengths of current programs, and needs. The chapter includes narrative information gathered through focus groups and personal interviews, as well as existing data from ODMHSAS and other sources.

A. Strengths/ Existing Resources

In order to improve the quality of behavioral health treatment in Oklahoma, the state legislature has enacted licensure credentials for seven types of behavioral health professionals, as listed in Exhibit 14.1. Most behavioral health professionals must achieve at least a Master's degree in their field, complete one to three years of supervised professional experience, and pass a state examination prior to becoming licensed.

<u>Exhibit 14.1. Licensure and Certification requirements for Select Behavioral Health Professionals</u>		
	Minimum requirements for State Licensure	Minimum requirements for State Certification
Social Worker	Bachelor's degree in Social Work plus two years post graduate experience and pass state examination, or a Master's degree in Social Work and pass state examination	N/A
Psychologist	Doctoral degree in Psychology plus two years supervised professional experience and pass state examination	Health Service Psychologist: licensed psychologist who also provides health services and has two years of supervised health service experience
Psychiatrist	Medical license.	Psychiatry is not separately licensed or certified by the State. However, most programs expect completion of a psychiatric residency and certification by the American Board of Psychiatry and Neurology.
Alcohol and Drug Counselors	Master's degree in behavioral science plus one year supervised work experience and pass state examination	Bachelor's degree in behavioral science plus two years supervised experience and pass state examination
Professional Counselors	Master's degree in a counseling field plus three years supervised professional experience and pass state examination	N/A
Marital and Family Therapist	Master's degree in marital and family therapy plus two years supervised professional experience and pass state examination	N/A
Behavioral Practitioner	Master's degree from a program in psychology plus three years supervised professional experience and pass state examination	N/A

As shown in Exhibit 14.2., the number of new behavioral health professionals licensed each year varies by type of licensure. Since FY 2001, the number of new Licensed Professional Counselors (LPC) has decreased by 65 percent, while the number of Licensed Social Workers has increased by 72 percent. Very few behavioral health professionals seek licensure as Marital/Family Therapists or as Behavioral Practitioners. The data for licensed Psychologists and Alcohol and Drug Counselors were not readily available. It should be noted that over the past six fiscal years, Oklahoma has a net loss of four psychiatrists with the non-renewal of licenses due to death, retirement, disciplinary action or moving out of state.

Exhibit 14.2. Number of New Behavior Health Licenses Awarded

Year	Type of Licensure					
	Licensed Professional Counselor (LPC)	Licensed Marital/Family Therapist (LMFT)	Licensed Behavioral Practitioner (LBP)	Licensed Social Worker: All	Licensed/Certified Alcohol and Drug Counselor	Certified Psychiatrist
FY 2001	411	11	310	92	not available	22
FY 2002	309	15	8	89	not available	19
FY 2003	220	22	3	118	not available	24
FY 2004	158	18	2	112	not available	24
FY 2005	142	17	6	159	not available	22
Total Current Licenses	2,681	502	243	1,384	874	454

Sources: All information provided by means of personal correspondence. LPC, LMFT, and LBP information provided by Nena West with the State Department of Health. Licensed Social Worker information provided by Kandi Hoehner with the Oklahoma State Board of Medical Licensure and Supervision. Licensed/Certified Alcohol and Drug Counselor information provided by Stori Johnson with the Oklahoma Board of Licensed Alcohol and Drug Counselors. Psychiatrist information provided by Chris Maloney with the Oklahoma State Board of Medical Licensure and Supervision.

Exhibit 14.3 shows information on the number of new social work licenses awarded between FYs 2001 and 2005. Social Work Licenses require a Master's degree, except in the case of Licensed Social Work Associate, which requires only a Bachelor's degree.

Exhibit 14.3. Number of New Social Work Licenses Awarded

Year	Type of Licensure				
	Licensed Clinical Social Worker (LCSW)	Licensed Social Worker (LSW)	Licensed Master's Social Worker (LMSW)	Licensed Social Worker-Administration (LSW-ADM)	Licensed Social Work Associate (LSWA)
FY 2001	64	4	2	0	10
FY 2002	62	4	6	1	9
FY 2003	69	10	11	1	12
FY 2004	106	2	39	1	0
FY 2005	130	2	32	0	0

Source: Personal correspondence with Kandi Hoehner with the Oklahoma State Board of Medical Licensure and Supervision.

As ODMHSAS-funded outpatient agencies hire new staff, educational and licensure information is collected. According to this information, there is currently 2,183 staff whose primary type of service provided is psychological or counseling services. Of these, only 39

percent have a behavioral health license. The educational level of these staff, however, demonstrates that 62 percent have achieved a Master’s degree, as noted in Exhibit 14.4. This exhibit also shows that 67 percent of all staff have achieved a Bachelor’s degree or higher. Staff in the medical services tend to have the highest level of education, with 33 percent achieving a Doctorial degree, and staff comprising the “other services” category have the least education, with 56 percent having less than an Associate’s degree.

Exhibit 14.4. Level of Education for ODMHSAS-funded Outpatient Service Staff

Level of Education	Primary Type of Service (PTS)											
	Psychological or Counseling Services		Other Services		Medical Services		Case Management Services		Administrative		Other Therapeutic Services	
	%	#	%	#	%	#	%	#	%	#	%	#
Less than High school	0.1%	2	3.9%	73	0.7%	5	0.0%	0	1.0%	5	1.7%	2
High school diploma/GED	1.3%	29	30.4%	569	12.3%	88	3.3%	22	19.3%	100	16.2%	19
College credits, no degree	2.5%	55	22.4%	420	11.7%	84	2.7%	18	23.4%	121	10.3%	12
Associate's Degree	1.6%	35	5.5%	103	20.9%	150	2.5%	17	7.3%	38	11.1%	13
Bachelor's Degree	29.0%	634	24.0%	449	13.2%	95	69.0%	463	21.4%	111	43.6%	51
Master's Degree	62.4%	1,362	12.5%	235	8.2%	59	21.6%	145	24.9%	129	15.4%	18
Doctorate	3.0%	66	1.3%	24	33.0%	237	0.9%	6	2.7%	14	1.7%	2
Total Staff in PTS	35.9%	2,183	30.8%	1,873	11.8%	718	11.0%	671	8.5%	518	1.9%	117

In order to provide continuing educational opportunities for behavioral health professionals, ODMHSAS sponsors an ever-increasing number of conferences and training sessions each year. As shown in Exhibit 14.5., the number of conferences and trainings sponsored by ODMHSAS has increased 169 percent beginning in FY2002. In FY 2006, the conferences with the highest attendance included: the 2006 Children’s Conference, the 2006 Substance Abuse Conference, the 2005 Consumer Conference, and the 2005 Best Practices Conference. The OHCA, ODMHSAS, and OFMQ provider training had one of the highest attendances for a training seminar in FY 2006.

Exhibit 14.5. ODMHSAS Sponsored Conferences and Trainings

Fiscal Year	Total conferences & trainings	Total hours	Total participants
FY02	85	514	7962
FY03	119	758	9392
FY04	119	903	9386
FY05	182	1413	10547
FY06	229	1629	11403

B. Needs and Existing Barriers

The comments of focus group participants and personal interviews focused on five major areas of concern: barriers to recruitment and retention of highly qualified staff; the need for in-service training and continuing education that prepares staff to work in a person-centered, recovery-oriented service system; the need to bring a focus on recovery and person-centered services to graduate programs in the mental health and substance abuse fields; licensing and

certification issues; and training on substance abuse and mental health issues for staff of other systems and agencies that interact with ODMHSAS clients.

Recruiting, Hiring and Keeping Staff

Providers across the state reported that they face a number of obstacles in recruiting, hiring and keeping good staff. Among the barriers identified are low salaries, the enormous paperwork burden which forces many staff to put in too much unpaid overtime, and, in the substance abuse area, a requirement for enhanced credentials without corresponding pay increases. “We have high counselor vacancy rates due to low salary rates,” one substance abuse program manager said. “We are not competitive with the private sector.” A supervisor in a System of Care agency said, “It is hard to find staff and it takes six months before they are good at it. Then they leave. They love the work but hate all the stuff the state makes them do.” A manager in a mental health program noted that he and his staff were so over-worked due to staffing shortages that they can’t find time to train and orient new staff once they get them.

Salaries for behavioral health professionals in Oklahoma are generally lower than those in surrounding states and compared to the nation as a whole, as demonstrated in Exhibit 14.6. In four of six professional specialties, Oklahoma ranks either at the bottom or close to the bottom within the region. One exception to this trend is the salaries for Licensed Marital/Family Therapists in Oklahoma, which rank higher than the nation and the surrounding states. However, this group has the smallest number of persons. Another exception to this trend is the salaries of psychiatrists, who are also in short supply in Oklahoma.

Exhibit 14.6. Median Wage for Select Behavioral Health Professionals, Oklahoma Comparison with Surrounding States and Nation, 2005

Location	Median Wage, May 2005	
	Hourly	Annual
Psychiatrists**		
Colorado	89.93	187,060
Kansas	83.66	174,010
OKLAHOMA	81.53	169,580
New Mexico	77.49	161,180
Missouri	73.28	152,420
NATION	70.26	146,150
Arkansas	68.64	142,780
Texas	63.06	131,170
Psychologist		
Texas	39.20	81,530
Kansas	38.43	79,940
Arkansas	37.78	78,580
NATION	35.70	74,260
Colorado	35.62	74,100
Missouri	33.94	70,590
OKLAHOMA	30.30	63,020
New Mexico	26.16	54,420

Location	Median Wage, May 2005	
	Hourly	Annual
LMFT		
OKLAHOMA	28.73	59,760
NATION	20.34	42,300
Texas	19.71	41,010
Colorado	19.40	40,350
Kansas	18.14*	37,731*
Arkansas	17.83	37,090
New Mexico	17.31	36,010
Missouri	16.41*	34,132*
Mental Health Counselors		
Missouri	19.54	40,650
Arkansas	19.35	40,240
New Mexico	19.25	40,040
Texas	17.90	37,230
Kansas	16.57	34,460
NATION	16.35	34,010
Colorado	15.42	32,070
OKLAHOMA	15.11	31,430
Substance Abuse and Behavioral Disorder Counselors		
New Mexico	16.83	35,010
NATION	15.66	32,580
Missouri	15.49	32,210
Kansas	14.42	30,000
Texas	13.67	28,440
Colorado	13.56	28,200
OKLAHOMA	13.08	27,220
Arkansas	11.60	24,130
Mental Health and Substance Abuse Social Workers		
NATION	16.54	34,410
Kansas	16.25	33,790
Arkansas	15.44	32,110
Texas	15.40	32,020
New Mexico	15.34	31,910
Colorado	15.31	31,840
Missouri	14.06	29,250
OKLAHOMA	13.13	27,310
*Data based on November 2004.		
**Data based on Mean Wages.		
Source: U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, May 2005. http://www.bls.gov/data/		

Staffing problems are particularly acute in rural areas, where it is hard to attract professionals. One CMHC reported difficulties in getting an approved PACT Team off the ground because they were unable to attract any applications for the psychiatrist and nurses' positions.

Prevention providers said that low salaries, a requirement for enhanced credentials, and a lack of training opportunities combined to make it difficult to keep good staff. “The Department wants people to have greater credentials, but it hasn’t raised the salary caps,” one provider said. “The department doesn’t offer enough opportunities for training, so we have to pay out of pocket to get trained elsewhere,” a provider said. “We have to use program funds for training, and staff have to pay some training costs out of pocket. It takes a lot to train people, and then they leave because the pay is so low.”

A significant shortage of mental health and substance abuse professionals from minority cultural groups was identified as a key barrier to the delivery of culturally competent services. Focus group members called for ODMHSAS to develop a targeted outreach and recruitment program aimed at people of color. A Latina professional said that large segments of the Hispanic population are not receiving services, primarily because there is not enough trained Hispanic or bilingual staff. She also noted that there is still little ethnic diversity among students in professional training programs, partly because successful students from cultural minority groups chose to go into higher-paying professions than human services. She suggested that scholarship programs to support master’s level study for students from ethnic and cultural minority groups would be one way to increase the diversity of the system’s staff.

For state-run programs, staff and managers indicate that ODMHSAS’ hiring freeze and associated procedures to fill vacant positions can result in delays and missed opportunities in hiring qualified staff.

One potential reason for staff shortages is the declining number of degrees awarded each year in fields such as psychology and social work. According to the Oklahoma State Regents of Higher Education, there has been a 20 percent reduction in the number of licensure level degrees awarded from 1999/2000 (727 degrees awarded) to 2003/2004 (576 degrees awarded; OSRHE, 2005). In order to increase the number of health service professionals nation wide, the National Health Service Corps Loan Repayment Program offers trained health care professionals, including behavioral health professionals, the chance to compete for repayment of their educational loans if they choose to serve in a community of need. The initial contract period must last two-years, and the loan repayment is \$25,000 each year. The contract may be extended until qualifying loans are repaid. Years of service after the initial two years provide \$35,000 repayment per year. In addition to the loan repayment, health care professionals also receive a competitive salary and some tax benefits (HHS, 2004).

There are very serious shortages of psychiatrists in Oklahoma. In most communities we visited, respondents repeatedly noted that it is difficult to get appointments for medication assessment or for ongoing medication monitoring. Focus group participants also said that programs often rely on non-psychiatrist physicians for prescribing. Child psychiatrists particularly are in very short supply. Because of the immediate demands on their time, one respondent reported that “child psychiatrists are on the edge of burnout as soon as they enter the system. They are too busy and stretched too far.” The state’s Physician Manpower Training Commission has programs to enhance medical care in rural and underserved areas of the state by administering residency, internship and scholarship incentive programs that encourage medical and nursing personnel to practice in rural and underserved areas. However, these programs do not extend to addressing the state’s deficits in medical specialty areas such as psychiatry.

Training and Continuing Education Opportunities

Focus group participants voiced the need for additional training on recovery-oriented services to increase their skills. There was also a call for staff to receive training that would allow them to help clients find housing, employment, government benefits, and other community-based services. Most staff and managers indicated an interest in learning more about recovery and the new skills and attitudes required to transform the system. Participants noted a pressing need for cultural competency training at all levels. There was a consensus that cultural competence training should be required for all staff. It was also suggested that one-time training on cultural competence issues was not sufficient to change agency cultures, and that leadership from the top and supervision are vital for the kind of environmental change needed within the system.

Managers also pointed out that some vital trainings, like orientation for PACT staff, are offered only twice a year, and that this makes it difficult for new staff to perform their jobs. One manager pointed out that nurses on her staff were required to attend a training that was only offered once, and that it was impossible to pull all nurses off their shifts to send them to training. Prevention staff noted that entry-level positions require certification as a prevention specialist, which requires 150 hours of CEUs and 120 hours of supervised work within 18 months of hire. “This is difficult because the department doesn't offer enough opportunities for training, so we have to pay out of pocket to get trained elsewhere,” a provider said. “We have to use program funds for training, and staff have to pay some training costs out of pocket. It takes a lot to train people, and then they leave because the pay is so low.”

There was broad agreement that requiring staff to travel to Oklahoma City for a 2-hour training was not a good use of time. Many called for the use of new technologies like computer-based distance learning and teleconferences to allow for more people to be trained at less cost. Consumers, family members and advocates also noted that being required to pay to attend trainings is a major disincentive to their involvement.

Professional Training Programs

Many respondents said that professional training programs in the state, including social work, nursing, psychiatry, and Licensed Professional Counselor (LPC) programs, have not incorporated educational material and skills training that is needed to work successfully in a consumer-driven mental health and substance abuse services system. Advocates, consumers, managers and staff expressed concerns that these graduate programs are “still training in antique models,” as one participant put it. Providers and consumers alike expressed an interest in working with local colleges and universities to develop recovery –oriented curricula for the future mental health workforce. “We need to be speaking to graduate classes and to medical students and interns on a regular basis,” a consumer advocate said. “That’s the only way recovery will be made real for them.”

Licensing Requirement for Substance Abuse Staff

There were mixed feelings among staff about ODMHSAS’ new licensing requirements. By 2010, substance abuse services staff will have to become Licensed Alcohol and Drug Counselors (LADCs), which requires a master’s degree. Some see this as a positive development: “Substance abuse professionals should get the same recognition as other professionals,” one staff member said. “The stigma is that they are just a bunch of old drunks. More people should embrace credentialing.” Others said that the new requirements have already

caused some staff to lose their jobs. “People who were on track to get a degree have had the rug pulled out from under them,” a staff person said. “I’m glad they are increasing required credentials of staff, but they should have done this more gradually so people had time to meet requirements,” another said.

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

Training for Staff in Other Systems

Focus group participants and personal interviews stressed the need for expanded training on mental health and substance abuse issues for local law enforcement officers and correctional staff who interact with people with mental health and /or substance abuse problems on a daily basis. A lack of needed information on the part of these staff can jeopardize their safety and the safety of people on the street or in custody, and can lead to counter-productive interventions for people with mental health and substance abuse problems. While many local law enforcement agencies have staff trained in Crisis Intervention Training (CIT) and similar training, others have not, and people with mental health problems in those communities who participated in focus groups indicated that they felt at risk from the police. It was noted that most degree programs in criminal justice either do not address mental health issues at all, or that they erroneously teach that mental illness is a cause of crime. Both staff and inmates on specialty mental health units in prisons said there is a large unmet need among correctional staff for training on mental health issues; this echoed one of the findings of a 2005 Oklahoma Board of Corrections’ resolution.

Counselors working for the Department of Rehabilitation Services (DRS) expressed a need for more information on mental health issues. DRS staff noted that one of the barriers they face working with people with psychiatric disabilities is that this issue was not addressed in their rehabilitation master's program. Both mental health staff whose clients are involved with DRS services and DRS staff working with people with psychiatric disabilities expressed a need for cross-training and co-training to better enable the two systems to work effectively on the clients’ behalf.

References:

HHS (2004). *National Health Service Corps, Loan Repayment Program*. U.S. Department of Health and Human Services, Health Resources and Services Administration, National Health Service Corps. Retrieved September, 2006 from http://nhsc.bhpr.hrsa.gov/join_us/lrp.cfm

OSRHE (2005). *Degrees Conferred in Oklahoma Higher Education*. Oklahoma State Regents for Higher Education. Retrieved September, 2006 from <http://www.okhighered.org/studies-reports/degrees-conferred/>

Chapter 15: Finance

The purpose of this chapter is to describe financing of services for adults and children diagnosed with mental health and substance abuses disorders, including existing resources, particular strengths of current initiatives, and needs. The chapter includes narrative information gathered through focus groups and personal interviews, as well as existing data from the Oklahoma Health Care Authority (OHCA), Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) and other sources.

A. Existing Resources

This section presents an overview of sources of funding for mental health and substance abuse services. We begin with funds appropriated by the State Legislature. There are a number of State agencies that have responsibility for serving persons with mental health and substance abuse problems; because of this, existing resources are best understood by looking at each agency. We then move on to a description of Federal sources of funding, concluding with brief descriptions of county and Tribal funding, third party private insurance, and other miscellaneous sources.

1) State Appropriations

State funds support mental health and substance abuse services principally through State Appropriations. Each agency receives an annual budget from the State Legislature. These funds are generally expended in one of the following ways: State agencies hire state employees to deliver services within state facilities (*e.g.*, Griffin Memorial Hospital). State agencies contract with vendors to deliver services (*e.g.*, private, non-profit community mental health centers). And finally, state funds are used to match Federal funds (*e.g.*, the State Medicaid program managed by the Oklahoma Health Care Authority).

Exhibit 15.1 contains the ODMHSAS FY2006 expenditures of state appropriated funds. The total expenditures were \$157,319,814 which included \$133,763,475 for mental health services, \$1,630,729 for services for a program designed to serve people with co-occurring disorders, and \$21,925,610 for substance abuse services.

Exhibit 15.1. Oklahoma Department of Mental Health and Substance Abuse Services FY2006 State Appropriation Expenditures

State Hospitals	\$40,514,639
Community Mental Health	\$88,811,262
Residential Care	\$4,437,574
Subtotal Mental Health	\$133,763,475
Co-occurring treatment unit with the Tulsa Center for Behavioral Health program	\$1,630,729
Substance Abuse Services	\$21,925,610
Total FY 2006 Expenditures	\$157,319,814

As shown in Exhibit 15.2, the Oklahoma Health Care Authority (OHCA) had total expenditures of \$197,598,258 for behavioral health in FY2005. These expenditures included \$143,467,687 for children and \$54,130,571 for adults.

Exhibit 15.2. OHCA FY2005 Behavioral Health Expenditures by Service Type by Child and Adult

Behavioral Health Services for Children	
Service Type	Expenditures
Inpatient (Acute)	\$5,095,022
Inpatient (Freestanding Hospital and RTCs)	\$61,823,614
Outpatient Behavioral Health (Private)	\$31,964,512
Outpatient Community Mental Health Services (Public/Contracted)	\$8,458,849
Psychologist	\$2,211,643
Psychiatrist	\$1,481,140
Other Outpatient Behavioral Health Services	\$125,913
Residential Behavior Management Services	\$32,172,073
Target Case Management (TCM)	\$134,921
Children Total	\$143,467,687
Behavioral Health Services for Adults	
Service Type	Expenditures
Inpatient (Acute)	\$8,743,465
Inpatient (Freestanding Hospital and RTCs)	\$743,149
Outpatient Behavioral Health (Private)	\$14,635,863
Outpatient Community Mental Health Services (Public/Contracted)	\$26,839,865
Psychologist	\$869,109
Psychiatrist	\$1,314,612
Other Outpatient Behavioral Health Services	\$325,318
Residential Behavior Management Services	---
Target Case Management (TCM)	\$659,190
Adult Total	\$54,130,571
Total All Behavioral Health Services	\$197,598,258

Department of Corrections: DOC reports spending of \$10,745,363 for prison mental health services during State Fiscal Year 2005. These included \$5,238,184 for professional services and \$2,514,700 for pharmacy services within publicly operated prisons. In addition, there were an estimated \$2,603,960 for these services in privately operated prisons. These costs were met entirely by State appropriations. These do not include the costs of housing/incarceration, nor do they include the percentage of time/costs incurred by staff under "medical services". They also do not include prison substance abuse expenditures and Community Corrections expenditures for mental health and substance abuse services.

Department of Rehabilitation Services: DRS reports mental health spending of \$2,985,482 in SFY 2004. This includes vocational rehabilitation expenditures for persons with psychiatric disability and other persons with a non-psychiatric disability who were receiving mental health services.

Department of Health: OSDH reported spending of \$19,075,996 on mental health services in SFY 2004 which this includes the Early Intervention program.

Office of Juvenile Affairs (OJA): OJA reported spending of \$2,380,000 and \$2,170,000 on mental health services in State fiscal years 2005 and 2006 respectively, and \$3,210,000 and \$3,070,000 on substance abuse services in State fiscal years 2005 and 2006 respectively.

2) Federal Funding Sources

Medicaid: Nationally, Medicaid is a jointly funded, federal-state health insurance program for low-income and people in need, administered by both the states and the federal Center for Medicare and Medicaid Services (CMS). In general, federal Medicaid covers children, aged, blind, and/or disabled individuals, and other people who are eligible to receive federally assisted income maintenance payments. Medicaid is an entitlement program, so anyone who meets the eligibility criteria and receives a medically necessary covered service from a Medicaid provider is entitled to have that service covered by Medicaid. Medicaid will not cover treatment in an Institution for Mental Disease (IMD) for persons 22 – 64 years of age. (An Institution for Mental Disease is a residential facility (*e.g.*, hospital, developmental center, nursing home) with 16 or more beds where more than fifty percent of the residents are persons with mental illness or mental retardation. Medicaid also does not generally cover costs of education, employment, or room and board except as part of a certified inpatient program. For example, the costs of room and board are allowable for residential treatment facilities for children and youth (RTF) and inpatient care in both general hospitals and state psychiatric hospitals.

Nationally, the federal government covers 50% to 83% of the costs of Medicaid services, depending on the state's *per capita* income, leaving the remainder of cost to the state. In Oklahoma, the federal government covers approximately 70% of Medicaid cost. The Oklahoma State Medicaid Plan is primarily administered as "Fee for Service" in which there are defined "covered services" and "covered populations" eligible for services. Oklahoma experimented with Medicaid Managed Care a number of years ago, but this had to be abandoned as managed care entities withdrew their plans. Medicaid-covered services are specified in two parts. One set of services is mandated by the federal government. There is also a set of optional services that a state Medicaid authority may choose to cover. Each state creates a State Medicaid Plan to specify the covered services and terms of Medicaid for their state.

Medicare: Medicare, also under the auspices of CMS, is a Federal insurance program for persons age 65 or older, and persons with disabilities. Medicare has two parts, Part A and Part B. Part A is Hospital Insurance, primarily covering inpatient services. This coverage is free to most eligible persons, and can be purchased by others. Medicare coverage of mental health inpatient services is capped at 190 days per patient per lifetime. This limitation applies only to psychiatric hospitals, not to psychiatric inpatient care in general hospitals. Part B is Medical

Insurance, with coverage including mental health outpatient services, and physical or occupational therapy. Part B must be purchased by eligible participants.

Federal Grants:

Mental Health Block Grant: The Center for Mental Health Services' Community Mental Health Services Block Grant awards formula grants to the States to provide mental health services to people with mental disorders. In FFY'06 the amount of Oklahoma's grant was \$4,493,977. Through the Community Mental Health Services Block Grant, CMHS supports existing public services and encourages the development of creative and cost-effective systems of community-based care for people with serious mental disorders. With the current changes in the health care delivery system, improving access to community-based systems is especially important. CMHS is the Federal agency that oversees Federally-mandated State Mental Health Plans and Implementation Reports.

Substance Abuse Prevention and Treatment Block Grant: The Substance Abuse and Mental Health Services Administration (SAMHSA) provides Substance Abuse Prevention and Treatment (SAPT) Block Grant formula awards to States. In FFY'06 the amount of Oklahoma's grant was \$17,660,794. Of the block grant award, approximately 75% is used for substance abuse treatment services for those in need who do not have the ability to pay for such services. Oklahoma funds state facilities and contracts with private, non-profit agencies to provide a continuum of care for substance abuse clients, including detoxification, residential, halfway, intensive outpatient and outpatient services. Approximately 20% of the block grant funding is set aside for primary prevention programs. Oklahoma funds a network of 19 prevention programs that serve all 77 counties.

PATH: The Projects for Assistance in Transition from Homelessness (PATH) is a Federal formula grant program providing funding to states to assist individuals with serious mental illness who are homeless or at risk of becoming homeless. In FFY'06 the amount of Oklahoma's grant was \$372,000. States use these funds to provide services such as outreach, mental health treatment, support services, and some housing services, generally through contracts with political subdivisions and/or county nonprofits.

Other Discretionary Federal Services Grants: Some federal grant funds are available to individual providers to support specific programs. One example is the National Child Traumatic Stress Network, which provided grants to a set of community treatment and service centers to implement and evaluate community-based treatments. Each year, the Substance Abuse and Mental Health Services Administration (parent agency of CMHS) releases several different grant programs for mental health and substance abuse services for which state and local governments and provider agencies may apply. These programs generally run for a minimum of one to a maximum of five years, after which federal funding ends. While these grants represent a fraction of the funds supporting the public mental health and substance abuse system in Oklahoma (about \$14 million), they can be very important sources of funding to the programs involved with them.

As shown in Exhibit 15.3, Oklahoma received an estimated \$36,336,685 in SAMHSA grant awards in FY 2005, or \$10.24 per capita. These monies include formula funding block grants and discretionary funding. Compared to surrounding states, Oklahoma ranked third highest with Colorado and New Mexico receiving more per capita.

Exhibit 15.3. SAMHSA Grant Awards
State Summaries FY 2005

STATE	Population	Grant Monies	Calculated
	2005		Per capita
United States	296,410,404	\$444,926,323	\$1.50
Kansas	2,744,687	\$17,580,738	\$6.41
Arkansas	2,779,154	\$23,794,667	\$8.56
Texas	22,859,968	\$222,667,529	\$9.74
Missouri	5,800,310	\$58,717,408	\$10.12
OKLAHOMA	3,547,884	\$36,336,685	\$10.24
Colorado	4,665,177	\$51,234,697	\$10.98
New Mexico	1,928,384	\$34,594,599	\$17.94

Social Security Administration:

SSI/SSDI: The Federal Social Security Administration maintains two income support programs for persons with disabilities. SSI (Supplemental Security Income) is a federal income program funded by general tax revenues. It is designed to help aged, blind, and disabled people, who have little or no income or work history. It provides cash to meet basic needs for food, clothing, and shelter. SSDI (Social Security Disability Income) is a federal income supplement program for qualifying workers who have become disabled and their families.

TANF: Temporary Assistance to Needy Families (TANF) provides income assistance to low-income families. These funds are provided by the federal government to families who meet income, eligibility, and work requirements. There is a lifetime limit of five years on eligibility for cash assistance. Some clients of the public mental health system are eligible for TANF. Oklahoma uses TANF funds to support substance abuse programs that serve the TANF population (\$3 million annually).

Housing and Urban Development (HUD)

Programs of the US Department of Housing and Urban Development (HUD) are open to States, to local government applicants, to providers, and to individuals.

Section 8: HUD Section 8 is a Federal program providing housing subsidy vouchers to elderly persons, persons with disabilities, and low-income families. Eligibility is determined based on total annual gross income and family size, and subsidy amounts are determined by annual income, reasonable rent, and actual rent.

Shelter Plus Care: Shelter Plus Care (S+C) is a HUD program providing long-term housing and supportive services for persons with disabilities who are homeless. This includes persons with serious mental illness, chronic drug and/or alcohol problems, and AIDS or related diseases and

their families who are living on the streets, in emergency shelters, or in other places not intended for human habitation (*e.g.*, abandoned buildings, cars). Program grants provide rental assistance payments through four components:

1. Tenant-based Rental Assistance (TRA);
2. Sponsor-based Rental Assistance (SRA);
3. Project-based Rental Assistance with (PRAW) or without rehabilitation (PRA); and
4. Section 8 Moderate Rehabilitation Program for Single Room Occupancy dwellings.

A number of private not-for-profit mental health providers in Oklahoma City and Tulsa have been successful in applying for HUD grants to support housing for persons who are seriously mentally ill.

3) County Funding

County government may also contribute to mental health and substance abuse services. For example, in Oklahoma County, the county pays for jail mental health services. In Canadian County, there is a dedicated sales tax to support mental health, substance abuse, and juvenile justice services for children and adolescents.

4) Tribal Funding

Some Oklahoma Tribes support mental health and substance abuse services for members, using revenues derived from Tribal businesses. In addition, the Bureau of Indian Affairs provides some support through the Indian Health Service.

5) Third Party Private Insurance

Commercial Insurance: A person may be covered by commercial insurance in three ways.

- 1) Direct purchase of coverage by the person, or on behalf of the person.
- 2) Purchase of coverage by an employer on behalf of an employee.
- 3) Coverage under the insurance policy of a family member such as a spouse or parent.

Mental health coverage varies from policy to policy, depending upon coverage. Most commercial insurers include only limited inpatient and outpatient services under their plans. They are not designed for adults with serious and persistent mental illness who may also need rehabilitative, residential and other support services or for children who are seriously emotionally disturbed.

6) Other Funding Sources

There are two other sources of funding, one of which is direct fees paid by clients, most often on a sliding fee scale for outpatient services. Many human services providers also raise funds through donations, gifts and other voluntary contributions from the communities they serve. This can also include donated time the value of which is not captured in the financial information.

B. Strengths

The Oklahoma Health Care Authority (OHCA) has established strong working relationships with the Oklahoma Department of Human Services (OKDHS), ODMHSAS, OSDH, and OJA. These agencies work collaboratively on the design of the state Medicaid program and on identifying and resolving difficulties as they arise. OHCA has added new programs and reimbursement rates on the recommendation of the other agencies (e.g., Systems of Care).

Agencies also cooperate through the transfer of funds from one to another. For example, ODMHSAS receives funds to contract for substance abuse services on behalf of TANF recipients from OKDHS, and to contract for residential substance abuse services for prisoners from the Department of Corrections (DOC).

OHCA officials state that the Medicaid benefit package has evolved over the years to the point where it is quite comprehensive, particularly for children. They view behavioral health services as just another necessary benefit with all other medical services. Through the development of provider credentialing requirements, they believe that the quality of services has improved over the past ten years.

OHCA has established a Behavioral Health Advisory Council that meets quarterly. The group includes broad representation among providers and consumers. A recent meeting had over seventy participants. The OHCA Director attends, as well as other senior management, and leadership sees this as an important opportunity to hear about what's not working. It is also an opportunity to update participants about Medicaid program changes that are under consideration by the State agencies and by the State Legislature. They also do annual focus groups; in the past year, attention was on the planning by the Adult Recovery Collaborative.

ODMHSAS has aggressively pursued federal grant funds. As shown in Exhibit 15.3 above, this has resulted in over \$36 million, a 23% addition to the agency's budget.

C. Needs and Existing Barriers

Policy

There is a general belief among providers that Oklahoma does not provide adequate funding to serve persons in need of mental health and substance abuse services, whether they are provided through the ODMHSAS or through other state agencies. This belief is supported—at least for mental health—by available national comparison data. In FY2003, Oklahoma reporting spending \$138,000,000 state appropriations only for mental health services. This is the most recent year for which comparison data from other states are available. This translated to \$39.43 per capita. The national average for *per capita* mental health spending in FY2003 was \$91.12, more than twice Oklahoma's rate of spending. Oklahoma ranked 46th among all states in *per capita* mental health spending. Exhibit 15.4, below, shows comparisons between Oklahoma and other states in the geographic region. In comparison to other states, the rate of spending for Oklahoma is much lower in every category except research, training and administration. Spending is very low in the category "other 24-hour services" which largely covers residential services. As discussed in Chapter VIII. Housing, this is an area where there are very significant unmet needs.

Exhibit 15.4. Per Capita Mental Health Expenditure Profile – FY 2003

SMHA Mental Health Per Capita Expenditures for State Mental Hospitals, Community-Based Programs, and State Mental Health Support Activities by Type of Services Setting and By State, FY2003												
STATE	Inpatient	%	Other 24-Hour Services	%	Less than 24-Hour Services	%	Other Services	%	Research, Training & admin.	%	SMHA Expenditure Total	Total Rank
Oklahoma	\$17.61	44.7%	\$0.40	1.0%	\$19.24	48.8%	\$0	0%	\$2.18	5.5%	\$39.43	46
Arkansas	\$9.42	31.9%	\$9.43	31.9%	\$9.03	30.5%	\$0	0%	\$1.69	5.7%	\$29.57	50
Colorado	\$17.61	26.6%	\$0.49	0.7%	\$0.00	0.0%	\$47.84	72.2%	\$0.36	0.5%	\$66.30	33
Kansas	\$21.58	28.7%	NA	NA	\$0.00	0.0%	\$53.64	71.3%	\$0.00	0.0%	\$75.22	26
Missouri	\$32.42	48.2%	\$5.75	8.6%	\$27.33	40.6%	\$0	0%	\$1.80	2.7%	\$123.41	11
New Mexico	\$11.85	41.1%	\$1.34	4.6%	\$15.62	54.2%	\$0	0%	\$0.00	0.0%	\$28.80	51
Texas	\$17.44	44.7%	NA	NA	\$20.31	52.1%	\$0	0%	\$1.26	3.2%	\$39.02	47
US Average	\$33.78	37.1%	\$10.07	11.0%	\$45.30	49.7%	\$4.29	4.7%	\$2.27	2.5%	\$91.12	
US Median	\$31.60	42.0%	\$8.30	11.0%	\$32.70	43.5%	\$0	0%	\$1.63	2.2%	\$75.22	

Source: State Mental Health Expenditure and Revenue Report published by that National Association of State Mental Health program Directors Research Institute.

In its 2005 resolution concerning mental health and criminal justice issues, the Oklahoma Board of Corrections noted that there are “indications that the criminal justice system has become the primary service provider for offenders with mental illness, although it has not received sufficient funding to meet the needs of this population.” The lack of adequate funding to meet the needs of people with mental health problems in various parts of the criminal justice system is discussed in Chapter 8.

Reimbursement Rates. The general funding problems are present in the rates of reimbursement of providers for services. There are a number of specific problems related to rates that apply not only to Medicaid, but also to contracted services from ODMHSAS, OKDHS, OJA, and other state agencies. Providers assert that rates do not reflect their rising costs. Rate adjustments are rare, in some cases more than ten years has lapsed since the last time that a program received a rate adjustment. For example, the reimbursement rate for psychosocial rehabilitation services has not changed in thirteen years. As a result, providers find themselves raising the productivity requirements of staff to produce more billable services and/or paying staff at rates that are so low they result in high turnover. Providers are also concerned about major disparities in rates. For example, rates for children’s mental health services are reported to be two-thirds of the rates for adult mental health services, although the costs of providing care are the same. Some necessary time is not billable; for example, time of clinical staff coordinating care with other agencies is not directly reimbursable and the rates for covered services are not high enough to include these added costs.

Many program managers stated that reimbursement rates are insufficient to cover their costs: “We are expected to deliver the same level of services without new money. Eligibility criteria were relaxed by the state, so we have new demands for services, we’re expected to serve a broader population, but we get no new money.” Another manager said, “Clients would be better served if we got paid more for having more clients. We are capped on reimbursement for ODMHSAS contracts, no matter how many people we see.” A CMHC director stated that “We break even only by paying 1/3 less for staff salaries than the market rate.”

The state agencies are aware of these problems. While some do review rates on a regular basis, others do not. Even when rates are reviewed, requests for funding to adjust rates from the Legislature are often not supported.

Reimbursement. Reimbursement for mental health services under Medicaid is available to agencies that contract with ODMHSAS (generally, CMHCs), and to other agencies that have no contractual relationship with ODMHSAS, but have contracts with OHCA.

Free Care. ODMHSAS includes funding in its contracts to allow providers to offer free care. However, under these contracts, CMHCs cannot turn people meeting certain criteria away. By the end of year, they report giving away services and medications that ODMHSAS does not reimburse, because they have exceeded the contract cap. As one manager described it, “the last few months are a fiscal nightmare; we have to raise private money to meet needs.” Staff at one CMHC said, “We have to serve whoever comes through the door, but they don’t give us the resources to do it. Staff have to pay personally for materials to hand out to clients- the agency should be able to pay for this. We are not even given copies of the DSM IV – we’re simply not provided with the materials that we need.”

Milestone Reimbursement. Providers who contract with the Department of Rehabilitation Services (DRS) report that the current funding system for supported employment services, known as “milestone” reimbursement, creates barriers to establishing new employment programs, since the largest payments to a program aren’t made until the client has a three-month job retention. It was felt that this puts programs in a bind because they do not have a steady cash flow since payments are based on outcomes. A number of CMHCs stated that they had formerly operated on-site Supported Employment programs, but that the funding structure forced them to discontinue the programs. Not only are payments based on outcomes (milestones) for the clients; but, no dedicated money for follow along had been specified by DMHSAS. There is also a need for new funding to support additional employment programs through DRS and/or ODMHSAS. DRS is currently restructuring the payment system for supported employment clients to better reimburse CMHC programs during the initial service phase.”

Program Models. Psychosocial Rehabilitation (PSR) programs include ICCD-certified clubhouses (only two in the state); these programs are currently not Medicaid-reimbursable. Other PSR programs are able to meet Medicaid requirements; however, a general concern was expressed regarding whether Medicaid rules are supportive of a recovery approach. Some Medicaid requirements violate clubhouse rules/philosophy. Some respondents indicated that there is a need to develop peer-run programs, but there is no current funding stream to support them.

Practices/Services

Documentation/Paperwork. In virtually all discussions with providers and some with consumers, the problems related to documentation of eligibility and development of treatment plan and notes were raised. Because documentation is integral to financing and requires such a significant proportion of resources, it is discussed here. Line staff at provider agencies estimated that 60-70% of their time was spent in documentation. State OHCA officials confirmed that this

was their expectation, as well. Management of provider agencies indicated that line staff must spend 70% of their time in face to face contact with clients in order for programs to be fiscally viable, given current reimbursement rates. This does not include the time for documentation. Staff also need time for supervision and training. The net result is that staff must continually put in unpaid overtime in order to keep up. This causes major problems of morale and consequent staff turnover.

The documentation requirements are also the first order of business in meeting with a new client. This leads to client dissatisfaction. As one staff member expressed it, “If we could do the first session just listening to clients, rather than doing paperwork, the retention rates would be greater. Wait until the second session to start paperwork”. A frustrated client who was expecting to receive medication said, “you mean after all this I am not going to get to see a doctor today?” She had just spent two hours responding to questions required to establish eligibility.

Medicaid eligibility. Clients reported that it is very difficult to establish Medicaid eligibility if you are an adult without children, unless you are already on SSI (another very difficult process). Removal from the program is a second problem. Medicaid eligibility must be periodically re-established. When clients fail to do that, they are removed from the program, which is a major problem for persons who are poor and disabled. Efforts are now made to contact persons requiring recertification, but they are not always successful. OHCA officials indicated that mental health agencies, which swipe the individual’s Medicaid card (Soonercard), have immediate access to information regarding end dates of enrollment, and that they might take a role in assisting clients in maintaining their eligibility. Children also lose their eligibility automatically when they become 18. Officials of OKDHS, which has the responsibility for determining and maintaining eligibility, report that they do not have enough staff to do the outreach necessary to ensure that persons who are eligible remain enrolled.

Seeking Medicaid Reimbursement. Some substance abuse providers, who recently became eligible to bill the State Medicaid program, are struggling to understand the rules and requirements of this process. ODMHSAS has developed a consulting program to assist substance abuse providers with this. However, until these issues are resolved, they do create barriers to treatment.

While Medicaid offers the potential of increased federal funding, the experience of providers is that the process of authorization, documentation and auditing is so complex and adversarial that they choose to serve Medicaid eligible children. Others choose to rely on 100% state funding sources until these contract funds have run out. Providers may also choose not to provide public services because of low reimbursement rates, creating further gaps in the continuum of services. Providers report that they would expand services except for problems with financing and threat of financial penalties. An urban therapist said, “It might be o.k. to start with an agency that provides Medicaid services, but once you get established, it is easier and pays better to do private insurance and direct payment.”

Prior authorization/Utilization Review. Prior authorization requirements have reportedly caused the reduction or elimination of two types of Medicaid mental health programs, case management and intensive children’s outpatient services. Programs simply could not comply with the complex procedures that were established to authorize services initially and to seek approval to

continue services. This is a problem for all programs. As one manager described it, “Pre-authorization and UR [utilization review] is also a problem – the attitude is that the mental health providers are trying to rip off Medicaid.” OHCA officials acknowledge that this has been a problem with the organization with which they contracted to undertake prior authorization and utilization review. They have recently (July 1, 2006) contracted with a new vendor and expect that the situation will change and that programs that were discontinued may be re-established.

Audit and Recoupment. Providers described audit and recoupment procedures that they felt were punitive and risked undermining the fiscal stability of their programs. CMHC management said that they are exposed to too much risk for the level of reimbursement received. Medicaid audits can extrapolate the findings from a small sample of cases and recoup very large amounts that undermine providers’ already marginal financial stability. It was also noted that audits are inconsistent, with some auditors disallowing claims that other auditors allow, and there was a general feeling that Medicaid auditors were not well-versed in mental health policy and practices.

Inconsistency and adversarial auditing and potential penalties have reduced flexibility and creativity in the continuum of community-based services. Past problems have made schools wary of providing behavioral health services because of the inconsistency in funding and threat of recoupment. OJA experience with IV-E funding and substantial recoupment have made them very cautious in using federal funding and creative services. The fee-for-service basis for paying for most behavioral health services does not support providers in rural areas because of transportation costs and time spent. Needed supervision is not covered in the rates for most services.

OHCA officials see their audit and recoupment policies as essential to maintaining quality of care. Poor record keeping—the primary basis for audit and recoupment—is indicative of poor quality care, in their view. They also note that the policies of the Center for Medicare and Medicaid (CMS), the Federal agency that supervises the Medicaid program, have recently introduced state comparisons of error rates that place greater pressure on state auditing. They also note that federal auditors are not always familiar with what are eligible services (*e.g.*, smoking cessation), and that Federal policies generally are running counter to efforts to streamline administration of the Medicaid at the state level. Because Medicaid is a joint federal-state program, the state must be careful to ensure that its programs and practices are consistent with CMS regulations and requirements.

Inconsistencies in funding. Some providers explained that there has been inconsistent funding levels for programs of the Department of Rehabilitation Services from year to year. This results in variations in the number of people who can be served. DRS has four priority groups based on level of disability; sometimes they have funds only to serve the most disabled.

Organization/Collaboration

Medicaid has significant contracts with providers who offer mental health services, but have no relationship with ODMHSAS. These providers operate under different standards than the community mental health centers which are under contract to ODMHSAS. This suggests that there are two publicly funded mental health systems, existing side by side - one managed by

ODMHSAS and jointly funded by ODMHSAS and OHCA, and another that is outside the authority of ODMHSAS.

The lack of a blended funding stream to serve people with co-occurring disorders was the most frequently mentioned barrier to providing integrated mental health and substance abuse services by focus group participants. “We should be able to co-mingle mental health and substance abuse funds,” one mental health program manager said. “It’s hard to do co-occurring treatment when the funding streams are segregated.” Another provider asked “What about integrated funding?. Providers are asked to integrate their thinking about serving this population, but at the state level, the separate funding silos are reinforced.”

Some providers noted that reimbursement rates were lower for substance abuse services than for mental health: “The Department pays \$48 for a substance-abuse session but \$74 for a mental health session. There's no reason for this disparity, and sometimes it drives agencies to game the system,” staff at one agency said. It was noted that, while many mental health consumers are Medicaid-eligible, many substance abuse clients are not, and that this issue needs to be addressed if integrated services are to be provided and funded. The Integrated Systems Initiative (ISI) Financial Subcommittee recommended that an enhanced Medicaid rate specifically for co-occurring treatment services should be developed, reflecting the additional cost involved in assessment and treatment for both mental health and substance abuse. (See Chapter VII for additional information about services for persons with co-occurring disorders.)

Data

In the initial section of this chapter, we presented an overview of existing resources. In many cases, we were able to identify the actual funding for mental health and substance abuse services. However, there are other circumstances where the information is either incomplete or missing. ODMHSAS needs mechanisms to allow it to identify all of the resources within Oklahoma that support mental health and substance abuse services and to track access and quality of services.

Chapter 16: Technology and Information Systems

The purpose of this chapter is to provide an overview of information and technology resources of the publicly funded behavioral health service agencies in Oklahoma, including an assessment of the strengths, resources, barriers and needs that have been identified to date.

A. Existing Resources

State Agency Data Systems. Oklahoma has a history of strong commitment to data system development. As described below, many of the state agencies have developed systems that meet or exceed national standards.

- The Oklahoma Department of Human Services (OKDHS) KIDS data system was the first DHHS-approved Statewide Automated Child Welfare Information System (SACWIS) in the nation. OKDHS also provides eligibility determination for Medicaid and a variety of other state services.
- The Department of Rehabilitation Services (DRS) data system meets national standards for compiling and reporting service recipient data to the federal Health Resources and Services Administration.
- The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) Integrated Client Information System (ICIS) database has been developed with support from SAMHSA and is based on national mental health (Mental Health Statistics Improvement Program, MHSIP) and substance abuse (Drug and Alcohol Services Information System, DASIS) data standards. In addition, ODMHSAS has developed specialized data collection systems for a number of treatment programs, e.g., Program of Assertive Community Treatment (PACT), children's Systems of Care, and Multi-Dimensional Family Therapy.
- The Oklahoma Health Care Authority (OHCA) Medicaid Management Information System (MMIS) is moving toward meeting Federal Medicaid Information Technology Architecture (MITA) standards. OHCA has developed specialized data systems for Breast and Cervical Cancer services and for O-EPIC, the Oklahoma Employer/Employee Partnership for Insurance Coverage, and a voluntary health insurance program for employees ineligible for other coverage or working for small companies without coverage.
- Oklahoma State Department of Health (OSDH) has developed PHOCIS, Public Health Oklahoma Client Information System, a web-based data system to inform providers and consumers about federal, state and best practice issues, e.g., Individualized Family Service Plans and related services of the Sooner Start early intervention program. In addition, OSDH collects vital statistics (birth and death records) and survey data from students (Youth Risk Behavior Survey) and adults (Behavior Risk Factor Surveillance System), the results of which are made available to other agencies and the public to inform a variety of state and local prevention activities.
- The Oklahoma Department of Corrections (DOC) has a centralized database that contains records for movements of all inmates. While these data include offense information and

levels of incarceration, there is no current data collected in a centralized data system regarding mental health needs or program participation. DOC does track program participation, which would include substance abuse treatment programs. Data on DOC program participation has been maintained since July 1, 2001, and contains offender identification, facility, program, starting date, termination date and type of termination. In addition, offenders' needs are entered into the Offender Management System and are used in a variety of ways to justify programs and program delivery.

- The Oklahoma Office of Juvenile Affairs (OJA) data systems main applications are the Juvenile On-Line Tracking System (JOLTS), Case Management System (CMS), HRIS (Human Resources Information System), Juvenile Electronic Management System (for institutions) and the On-line Training Enrollment System. OJA's primary focus is the integration of data within and outside OJA to streamline user data entry, while providing as much information possible to staff and contractors regarding the services and documentation on our clients.

All the state agency partners have developed performance monitoring systems that provide process and outcome indicators for program management and most have them posted on their websites.

Local Provider Data Systems. Many local provider organizations, particularly Community Mental Health Centers (CMHCs), have data systems that meet the Health Insurance Portability and Accountability Act (HIPAA) standards for electronic data collection and transmission, and some also include elements of an electronic health record (EHR). Many substance abuse treatment providers use personal computers or small networks with Internet access to state agency systems that permit on-line entry of treatment and billing data, as well as generation of reports for program monitoring and management. ODMHSAS has purchased modules of the Avatar data system from Netsmart Technologies, a software vendor that will be used by all Department-operated facilities, including hospitals, residential substance abuse programs and CMHCs. The Avatar modules provide a 'clinical workstation' (a computer workstation designed to support automated medical record keeping), and practice management (automated reminders of rules related to professional practice, reimbursement requirements, etc).

Telecommunications. ODMHSAS maintains a telecommunications network among its state-operated facilities, and is with the Oklahoma Corporation Commission to replace lines in the network to significantly increase their capacity to carry data thirty-fold. This will greatly increase the speed of communications and permit other activities, such as video conferencing (see local project, below). OKDHS also maintains a network (ONEnet) among all its state and county offices. In addition, CareerTech, the state's vocational and technical school system, has a network of studios equipped with telecommunications (including video conferencing capabilities). ODMHSAS DUI School management staff and others have begun to use this capacity to provide training and to conduct meetings, which helps to reduce travel and non-billable, out-of-office time for administrators and clinicians statewide.

B. Strengths

Interagency Projects. Several projects have been developed that share data to improve services and reduce the data reporting burden for consumers and providers, thus making better use of limited financial and human resources. The Joint Oklahoma Information Network (JOIN) is a multi-agency project which was initiated to coordinate data projects among the state's child-serving agencies; it expanded to address adult and child and employment issues when the Oklahoma Employment Security Commission (OESC) joined the project and contributed workforce development funds. JOIN project staff is located at the Oklahoma Commission on Children and Youth (OCCY). The actual data system is housed at the Office of State Finance (OSF) and supported by staff there. JOIN has three major goals:

1. to make referral and service availability information readily accessible to providers and consumers,
2. to support the electronic transmission of referral information from agency to agency to reduce the burden of paperwork for providers and consumers, and
3. to provide a resource for interagency data analysis to support cross-agency policy analysis and program evaluation.

To achieve the first goal, JOIN has purchased information and referral software and has established agreements with the developing '2-1-1' social services information networks around the state. '2-1-1' is an information and referral telephone system that will be accessible to human service providers and consumers throughout the State. Resource information is shared and updated among the networks and JOIN, and JOIN's central database provides a back-up for the 2-1-1 systems. The second goal has not yet been addressed, but a pilot project is underway to address the third goal. Data from four agencies (OKDHS, OJA, DRS and ODMHSAS) have been matched and merged using an algorithm developed at ODMHSAS to identify people served by multiple agencies. The combined dataset will be geo-coded to census tracts and mapped with a "social disorganization indicator" which is composed of community risk factors (e.g., crime rates) and will help identify areas of high need and common interest among participating agencies. Once the pilot has demonstrated the feasibility of the project, and data-sharing agreements have been better defined, the analysis will be expanded to include other agencies' data and more longitudinal data.

Another collaborative, interagency project is the Partnership for Children's Behavioral Health (PCBH). State agencies, local treatment providers, families and other stakeholders collaborate to plan, implement, evaluate and improve services to children with serious emotional and substance use problems and their families. Sharing data is an important element of this effort. Data are collected from a variety of sources and compiled by a project data analyst and university contractor to respond to requests for results from PCBH and the national evaluation of Systems of Care.

The Adult Recovery Collaborative (ARC) partners include OHCA, ODMHSAS and OKDHS (see Chapter 5). The aim of the project is to combine management of adult outpatient behavioral health services and funding (ODMHSAS and Medicaid) and improve the efficiency of provider billing and payment. There is a commitment on the part of both OHCA and ODMHSAS to retain the capacity to collect data on client characteristics and outcomes for all providers, consistent with the current ODMHSAS client data system. A key element of this transition will be the integration of data across the three agencies, particularly insuring that performance outcomes monitoring data collection reporting functions are maintained in the new

system. ODMHSAS is receiving technical assistance from Medstat, a health data research organization, with funding from the federal Center for Mental Health Services (CMHS). Medstat staff has worked with ODMHSAS and OHCA staff (as well as CMHS and Centers for Medicare and Medicaid Services (CMS)); to provide Oklahoma with guidance for the development of ‘advanced planning documents’ (APDs). APDs can be used to guide design, development and implementation activities, and justify a request for matching funds from CMS for those activities which are eligible under its guidelines for reimbursement of changes to automated systems that support the administration of the Medicaid program. Several workgroups, including a Systems Workgroup and an Outcomes Workgroup, have been meeting to prepare for this system change, to be implemented July 1, 2008.

Innovative Initiatives. Four data and technology projects are paving the way for expanded use of information resources to improve the delivery, management and effectiveness of behavioral health care. At the ODMHSAS Northwest Center for Behavioral Health (NCBH), distance is a barrier to service delivery. NCBH is responsible for public behavioral health services in an area that covers about one fourth of the state. Their administrative office is in Woodward, but they have satellites as far away as Guymon (112 miles), Enid (105 miles) and Ponca City (184 miles). In the past, a person scheduled for a court hearing might have to travel back and forth between one of these satellites and the Ft. Supply inpatient unit multiple times to appear before a judge. By collaborating with criminal justice system partners and installing video conferencing equipment, NCBH has established a ‘video court commitment program’ which has saved local law enforcement, the courts and NCBH thousands of dollars and many hours of staff time, as well as reducing the trauma of consumers who had been forced to travel many hours in handcuffs to hearings. The program won a Governor’s Commendation in 2005 and continues to expand.

In Cherokee County, a multi-agency group was awarded a grant from the federal Agency for Healthcare Research and Quality (AHRQ) to develop a regional health information organization (RHIO) that includes a state-operated behavioral health services center, an Indian Health Services hospital, a local health department and other healthcare providers. Its goal is to permit electronic data sharing among the partner agencies in order to improve the coordination of care for shared clients. It is the first project of its kind in the state; more importantly, it is one of the first projects in the nation to include behavioral healthcare providers and to address the specific data sharing concerns of people with mental and substance use disorders. The consent protocol they establish should inform the JOIN project’s referral information goal, as well as move the development of other RHIOs and data sharing projects forward. The Cherokee County RHIO is also developing an information and referral system that will be coordinated with similar JOIN and regional 2-1-1 activities.

As part of their continuing collaboration efforts, ODMHSAS and the Oklahoma Department of Corrections (DOC) identified a need to better identify the mental health and substance abuse treatment needs of offenders entering the prison system, in order to ensure access to appropriate care. ODMHSAS established a web-based query system that allows staff at DOC (with the consent of the inmate) to submit personal identifying information over a secure connection to an ODMHSAS database. Once the query is received at ODMHSAS, a response is sent back indicating whether the person has received Department-funded mental health or substance abuse services. This application has been used less than expected because medication information is not yet available through the link. Nonetheless, it provides a model that

ODMHSAS is proposing to use with jails around the state to help identify people who may be candidates for diversion programs, such as mental health court or drug court.

Cross-agency data linkage to better assess needs for and outcomes of care is another initiative at ODMHSAS that has reaped some benefits, but has the potential to have a much larger impact if appropriate data sharing agreements can be established. The Department's data matching efforts started with the children's services collaboration that preceded JOIN. With limited knowledge, but great interagency participation (pre-HIPAA), data from 18 programs across OSDH, OKDHS and ODMHSAS were matched and merged using a deterministic model that relies on an exact match of three individual variables (*e.g.*, gender) to show the overlap of clients across agencies, and to illustrate the geographic distribution of high-use service recipients. Since that time, the Department has used grant funding to support development of a more sophisticated probabilistic matching algorithm that accepts a wider array of identifying variables and accounts for possible coding errors and aliases. This method is the basis for the DOC query project, and is used to match data with several agencies (DOC, OSDH, OHCA, Oklahoma Tax Commission, Oklahoma State Bureau of Investigation, and Oklahoma Department of Public Safety) to collect long-term outcome information about ODMHSAS-funded service recipients. By using the algorithm to match with Medicaid data from OHCA, it also serves as an important tool to plan for, and evaluate the impact of, system changes planned by the Adult Recovery Collaborative and other interagency projects.

C. Needs and Existing Barriers

While Transformation Grant partner agencies have developed significant technological and human resources to meet the information needs of system transformation, there continue to be barriers to fully realizing the technology recommendations put forth in the report of the President's New Freedom Commission on Mental Health (PNFC) (DHHS, 2003), the Institute of Medicine report *Improving the Quality of Health Care for Mental and Substance-Use Conditions* (IOM, 2006), and other sources of guidance for developing information and technology resources that support recovery. The issues related to needs and barriers in Oklahoma's services systems can be summarized in three categories: policies, technology and stakeholders.

Technology Policies. In the vision of the PNFC report, "electronic records will enable essential medical and mental health information to be shared across the public and private sectors," [r]imbursements will become flexible enough to allow...e-health visits" and "policies will change to support these innovative approaches."

While OHCA has recently enacted provisions of the Uniform Electronic Transaction Act to permit service recipients and providers to use electronic signatures, such uses are not widespread and have not been adopted by other partner agencies.

The IOM report recommends that providers "should establish clinically effective linkages within their own organizations and between providers...with the patient's knowledge and consent." Further, it recommended that "Federal and state governments should revise laws, regulations, and administrative practices that create barriers to the communication of information between providers of health care for mental and substance-use conditions and between those providers and providers of general care." JOIN has established an interagency agreement among its participating agencies, but the default agreement is 'no sharing' without approvals for specific uses. The pilot project described above may help motivate agencies to broaden their

participation, but there has been no progress on sharing data for operational purposes, i.e., to facilitate referrals among agencies. The policies for data sharing developed by the Cherokee County RHIO project need to be closely studied and emulated, if appropriate, to advance informed consent. The IOM study further recommends implementing “policies and incentives to continually increase collaboration among these providers to achieve evidence-based screening and care of their patients.”

More progress is needed toward allowing and accepting recipient electronic signatures (as is done widely with commercial purchases); consent forms need to be developed to give consumers more options for selecting who sees their information; and data systems need to be revised to automatically accept, operate on and forward consumers’ choices, along with their data, as it is shared for treatment and operations.

Using information across multiple data sets by matching individual records is an important strategy for evaluating the performance of provider systems. However, privacy rules can be a barrier. The ODMHSAS data matching experience has led to the development of a protocol that has proved acceptable to privacy monitors in at least one instance—matching ODMHSAS recipient data and OSDH hospital discharge data—by having identifiers removed before any output is generated. More testing of the acceptability of this protocol with other datasets, *e.g.*, DRS and OKDHS child welfare data, needs to be pursued.

A recent SAMHSA-funded technical assistance report to Oklahoma recommended that the state “explore...the possibilities of expanding the range of services that can be provided and reimbursed through telemedicine.” Policies to support testing of reimbursement for e-health visits or tele-therapy need to be established. In a state where many people live in rural or frontier areas, access to quality services is a significant barrier that technology could help address. E-health visits or tele-therapy are visits where the consumer and practitioner are in different locations, but communicate through video-conferencing which allows them to see and hear each other simultaneously. The PNFC report encourages it, many providers in other areas are beginning to use technology successfully in this way and, with proper incentives and safeguards, many Oklahoma citizens could benefit.

Technology Practices. As noted above, technology needs to catch up with developments in policy and practice. A central aim of transformation is to give consumers more access to, and more choice about, services and the release of their treatment records. For example, in Oklahoma’s Transformation Grant application, it was proposed that ODMHSAS, OKDHS and OHCA “collaborate to test the utility of an ID card for authorizing transfer of referral information, scheduling of services, documentation of service delivery and other functions.” Mechanisms like a personal identification card and personal health record (PHR) need to be pursued as options for improving consumers’ access to care and information about their care. These mechanisms allow consumers to carry around a card which includes key information (or all information) from their medical record which can be read by an electronic system at an agency that provides medical and behavioral health services.

Another important goal of transformation is to give providers more time with consumers by reducing the burden of paperwork, while continuing to collect information needed for accurate assessment, quality improvement, and management of the service delivery system. Flexibility and security are key to meeting these goals successfully. For example, home-based services reduce the transportation burden on consumers and their families and permit accurate assessment of the home environment, among other objectives. Staff doing home visits must have

information resources at hand and the ability to record events as they occur, so access to portable equipment, such as laptop computers and personal digital assistants, is essential. However, technological solutions to maintain the security of information on these devices must be identified and monitored to ensure that consumers' trust in the system is justified. This requires continual updating of security software and staff training regarding security procedures.

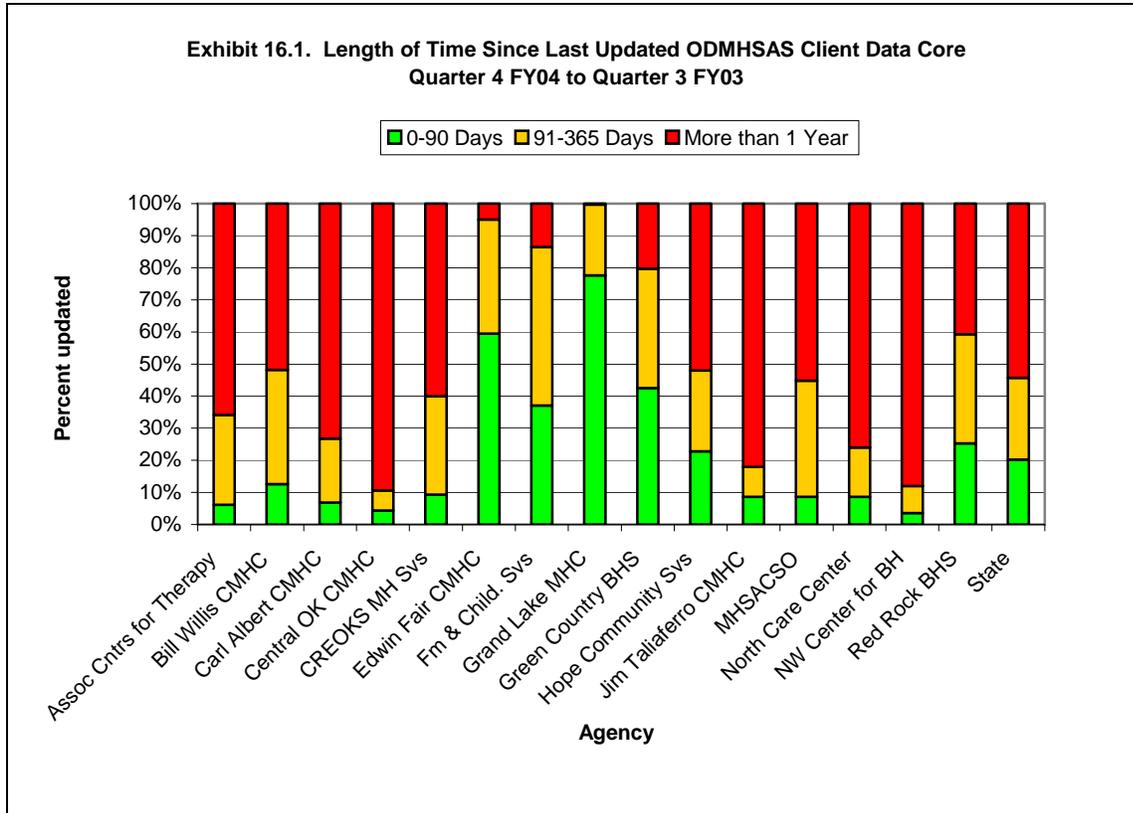
Child-serving agencies report frustration because health information is fragmented and not transportable among the multiple systems that serve children and their families. Recommendations from national reports regarding the need for policies and mechanisms to more easily share information have been noted; service providers, like consumers, need more access to technology and the information it can provide.

Many of the goals of transformation could be facilitated by the adoption of an electronic health record (EHR). The IOM study recommends "Federal and state governments, public-sector, and private-sector purchasers of [mental and substance-use] health care, and private foundations should encourage the widespread adoption of electronic health records, computer-based clinical decision-support systems, computerized provider order entry, and other forms of information technology." ODMHSAS contracts with community mental health centers establish a target date of July 1, 2008 for centers to have an electronic health information system operational. While ODMHSAS is implementing a data system for its state-operated providers that has elements of an electronic health record (the clinical workstation mentioned earlier), and CMS has announced plans to support the development of an EHR, there has been no system-wide adoption of EHR; indeed, national standards for behavioral health elements of an EHR have yet to be adopted. ODMHSAS is also implementing a pharmacy management system that will permit better monitoring of prescribing practices and patterns. Presently there is no state-wide pharmacy data system to ensure that physicians are prescribing properly, consumers are not 'shopping' for medications, and medication costs are being managed. A statewide solution to these issues needs to be identified.

Consumer Use of System Information. There are at least four stakeholder groups that have technology and information needs, and face a variety of barriers to meeting those needs: consumers, providers, state agencies, and others. Consumers need information about the location of services, the quality of services, and about their own service history. The information and referral functions being developed around the state, both on-line and phone-accessible are helping to address service location information needs. Agencies are also beginning to publish more quality indicator data, but the extent to which consumers use this information is unknown. More needs to be done to share such information and to provide toolkits or training on how to use the information to make choices among providers. Information about one's own service history, treatment scheduling, medications, etc., may be addressed by implementation of a statewide pharmacy system and PHR or 'smart card' carrying such information. However, consumers will still need training in the effective use of the information before access to the technology will make a difference in the way people manage their lives.

Data Quality. Despite having a data system built on national standards, and offering training and support for its use, the quality of some of the system's information is low. A recent ODMHSAS performance improvement report (see Exhibit 16.1) shows that data elements necessary for monitoring changes in consumers' functioning are not being updated in the existing data system. Statewide, only 20 percent of elements were updated within 90 days, and

more than 50 percent were not updated annually. There is a need for a different kind of training that focuses on how to use data for performance improvement and program management, rather than just defining data to be entered.



State agency staff. State agency staff needs more training in the effective use of technology and information for planning, monitoring implementation of changes, and evaluating the impact of system changes. At ODMHSAS, a new Systems Process Coordinator position may help identify opportunities for such interventions.

Other Stakeholders. A variety of reports and tools to generate reports have been developed by individual partner agencies to meet the demands of other stakeholders, including legislators, researchers and the general public. Little work has been done to share technology and methods of organizing and presenting data to meet these needs. Some planning under the Adult Recovery Collaborative and other initiatives has been done, but more collaboration and cooperation could conserve resources and provide more consistent information for these users. For example, the link with DOC to support staff queries and improve treatment for people in prison with mental and substance use disorders could be expanded to support the Medicaid eligibility project these two agencies and other partners are collaborating to implement. As noted earlier, DOC currently has little automated mental health information that would support Medicaid eligibility determination. The current link between the two agencies could be expanded to, not only allow queries, but also permit DOC staff to enter mental health-related assessment and treatment information that could facilitate their work with people while in prison and help the interagency

efforts to provide resources after their release that will support their successful transition back to the community and reduce recidivism. Other potential sources of collaboration include OSDH county profile data, Census data, ODMHSAS county data and similar data from OHCA, OKDHS, and other agencies.

References:

DHHS (2003). New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. DHHS Pub. No. SMA-03-3832. Rockville, MD.

IOM (2006). *Improving the Quality of Health Care for Mental and Substance-Use Conditions*. Institute of Medicine of the National Academies, The National Academies Press, Washington, D.C.

Chapter 17: Summary Matrix

This final chapter summarizes the existing resources and strengths, as well as the identified needs and barriers, from Chapters 3-16, organized according to the six goals and recommendations of the President’s New Freedom Commission Report. The following tables show the resources and needs arranged under the six goals, and further organized according to a list of elements provided by the federal Substance Abuse and Mental Health Administration (SAMHSA), as described in Chapter 1.

Goal 1: Oklahomans understand that having mental health and being free from addictions is essential to overall health.

1.1 Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention

1.2 Address mental health with the same urgency as physical health.

	Inventory of Resources	Needs/ Existing Barriers
1. Policies	ODMHSAS Commissioner named as Cabinet Secretary for Health, increasing statewide awareness of mental health and substance abuse issues (9)	Only about one-third of adults needing behavioral health services currently receive services provided or funded by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) or the Oklahoma Health Care Authority (OHCA). (2) Only about 36% of children in need of behavioral health services currently receive services provided or funded by the group of child serving agencies (2). The incidence of children identified as needing behavioral health services outpaces the number who are discharged from care (4). There is a lack of insurance parity between physical healthcare and behavioral health care. (4)
2. Practices/Services	NAMI “Hope for Tomorrow” education and prevention curriculum presented in some middle and high schools (11)	Many children and families, as well as adult consumers, experience prejudice and discrimination in housing, employment, and daily living in their communities (4) (5)(6)
3. Workforce/Training	n/a	n/a
4. Organization/Collaboration	n/a	n/a
5. Data	n/a	n/a
6. Financing	State legislature has provided increased funds for community-based services in recent years (15)	Resources for existing and new program development are quite limited. Oklahoma ranks 46 th among all states in per capital mental health expenditures (15).
7. Consumer/family involvement	Some degree of consumer & family involvement in some areas at statewide level and in some local agencies(5) (6)	Need to broaden, deepen consumer & family involvement at statewide and local levels (5) (6)

Goal 2 - Care Is Consumer and Family Driven

- 2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
- 2.2 Involve consumers and families fully in orienting the mental health and substance abuse system toward recovery.
- 2.3 Align relevant (State) programs to improve access and accountability for mental health and substance abuse services.
- 2.4 Create a Comprehensive State Plan.

	Inventory of Resources	Needs/ Existing Barriers
1. Policies	Establishment of Office of Consumer Affairs(3) (6) Establishment of Recovery Support Specialist and Family Support Specialist positions(3) (4) (6) Funding for consumer & family support organizations (3) (4) (5) (6)	Due to authorization processes, funding stream requirements, and other policy issues, children and families and adult consumers often receive “cookie-cutter” services rather than individualized service plans (4) (6) Financing and funding priorities limit the abilities of children and their families and adult consumers to have a genuine choice of providers and services (4) (6) Assessment and intake forms are deficit-based, invasive of consumers’ privacy, and not client-centered.(6)
2. Practices/Services	Consumers involved in treatment plan development to some extent at some agencies (5) OKDHS increasingly focuses adoption efforts on kinship adoptions (4) Consumers may name treatment advocates	To get access to residential mental healthcare for their children, parents often have to give up custody to OKDHS (4). Agency and program-specific funding streams mean that children and adult consumers often get services based not on their own needs, but on the needs of the program. (4) (6) Consumers express a need for sufficient time to talk with their prescribers about medication issues, concerns about side-effects, and information about their medications(6)
3. Workforce/Training	n/a	Need for workforce training on how to meaningfully involve consumers in treatment planning and in governance. (4) (5) (6) Need for better understanding of recovery, trauma, person-centered approach among all stakeholders (3) (4) (5) (6) Workforce training on recovery-oriented skills (3) (4) (5) (6) Add recovery, trauma, person-centered concepts to academic professional training (3) (6)
4. Organization/Collaboration	n/a	Need to establish & fund peer-run programs(3) (6)
5. Data	ODMHSAS contracts with advocacy groups to gather satisfaction data (6)	n/a
6. Financing	OHCA holds quarterly meetings to which consumers and families are invited to review pending changes in Medicaid financing and to receive comments (15).	More funding for consumer & family advocacy groups (6) Consumers not eligible for public benefits need a mechanism to pay for meds(6)
7. Consumer/family involvement	Consumer and family representation on the Governors Transformation Advisory Board (1). Some degree consumer & family involvement	Lack of understanding/consensus on what a “consumer-driven” system would look like (3) (5) (6)

	in some areas at statewide level and in some local agencies (5) (6)	Need to broaden/deepen consumer & family involvement at statewide and local levels (5) (6) Rights for children, youth and adult consumers are not clearly identified, are not consistent across agencies and organizations, and are not made a priority. (4) (5) (6)
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Goal 3: Disparities in Mental Health and Substance Abuse Services Are Eliminated

3.1 Improve access to quality care that is culturally competent.

3.2 Improve access to quality care in rural and geographically remote areas.

	Inventory of Resources	Needs/ Existing Barriers
<p>1. Policies</p>	<p>Oklahoma Board of Corrections issued a resolution recognizing the needs of people with mental illness who “come into conflict with the law as a direct result of the challenge created by their mental illness;” committed DOC to work collaboratively with other agencies to address issues. (8) Creation of ODMHSAS Cultural Competence Coordinator position and Cultural Competency Advisory Team (13)</p>	<p>Need for policies making it a priority to re-direct as many people with mental health and substance abuse problems as possible into treatment rather than incarceration (8) Need for more mental health court capacity and less restrictive criteria for participation (8)</p>
<p>2. Practices/Services</p>	<p>New approaches to housing and the prevention of homelessness available in some parts of state. (10) Crisis Intervention Training (CIT) for local law enforcement agencies and Tulsa’s Mental Health Response Officer (MHRO) program provide officers around the state with practical strategies and techniques for intervening safely in a psychiatric emergency (8) Mental health courts, drug courts, and other community jail diversion programs help steer clients into treatment instead of jail and prison (8) Tulsa’s COPES (Community Outreach Psychiatric Emergency Services) team, works with police and Jail Diversion program to avoid unnecessary arrests (8) Project Protect ,innovative inter-disciplinary team of health and human services professionals, provides re-entry services for high risk/high needs prison inmates returning to Oklahoma County. (8) The Department of Corrections (DOC) provides several avenues of treatment for state prison inmates, including specialty mental health units at three state prisons, Joseph Harp and Oklahoma State Penitentiary for men, and Mabel Bassett for women. (8) The revised plan adopted by CMHCs</p>	<p>There is a very wide range in the availability of and access to mental health and substance abuse services across all counties in Oklahoma (see particularly maps in chapters 4, 5, and 6). Timely access to services was an issue for all constituency groups in all parts of the state (4) (5) (6) Lack of transportation to services major barrier to access In rural areas, service rates do not cover transportation. (4) (5) (6) Eligibility criteria and interpretation of medical necessity result in services for children being limited to only those with the most severe symptoms. (4) No access to mental health services for nursing home residents.(6) Consumers in many programs are dissatisfied with the range of service choices (4) (6) Children, youth and adult consumers with tribal status face additional barriers in accessing services . (4) (6) For clients with dual diagnoses, services are still fragmented (7) Acute lack of culturally competent services and staff who can deliver services in languages other than English. (4) (5) (6) (13) Many adults receiving services in the mental health and substance abuse systems have little or no access to physical healthcare or to vision, dental and hearing services. (9) System- wide need for better integration of physical health care and fitness with mental health services (9) Acute shortage of stable, affordable permanent housing and a lack of sufficient sober living options. (10)</p>

		<p>Need for better balance between Supported Housing and congregate care (10)</p> <p>Systemic barriers to employment: public benefit structure, lack of transportation, prejudice (11)</p> <p>Punitive public attitudes a barrier to improving services for clients with criminal justice involvement . (8)</p> <p>Lack of jail/prison mental health treatment can be calamitous for people already in treatment/on meds before they enter (8)</p> <p>People with mental health and substance abuse histories face a complex array of re-entry problems when they are released from jail or prison. (8)</p>
3. Workforce/Training	Training on cultural competence offered by ODMHSAS (13)	<p>Need for cutting-edge, comprehensive training on cultural competency (13)</p> <p>Need for more bi-lingual professional staff (13)</p> <p>Acute staffing problems in rural areas -is hard to attract professionals. (4) (5) (6) (14)</p> <p>Serious shortage of psychiatrists, especially child psychiatrists, and especially in rural areas (14)</p> <p>Staff from DRS need training on mental health issues (11)</p> <p>Need for expanded training on mental health and substance abuse issues for local law enforcement officers and correctional staff who interact with people with mental health and /or substance abuse problems (8)</p>
4. Organization/Collaboration	<p>In some areas of the state, organizations and collaborations have developed innovative approaches to housing that can serve as models for other communities. (10)</p> <p>ODMHSAS chairs Governor's Inter-Agency Council on Homelessness. (10)</p> <p>DOH promotes regional planning of health and behavioral health needs through its support of community-based Turning Point collaboratives (12).</p>	n/a
5. Data	n/a	<p>No current estimates of number of homeless adults with mental health or substance abuse problems. (10)</p> <p>Multiple funding streams, redundant paperwork make it difficult to collect accurate data on homelessness and housing. (10)</p> <p>Need for a common database to share information about the psychiatric histories of arrestees and inmates (8)</p> <p>DOC does not collect data on mental health/substance abuse needs or treatment (8)</p>
6. Financing	State appropriations for mental health and	System is seriously under-funded - this

	<p>substance abuse services in budgets of six state agencies, increases in recent years (16)</p> <p>Oklahoma received an estimated \$36,336,685 in federal funds in FY 2005 and 2006, including \$14 million in discretionary grants (16)</p>	<p>interferes with the ability to provide quality services (4) (5) (6)</p> <p>Reimbursement rates are insufficient to cover costs (5) (6)</p> <p>Lack of blended funding stream for co-occurring services (7)</p> <p>Lack of adequate funding to meet the needs of people with mental health/substance abuse problems in all sectors of the criminal justice system. (8)</p>
<p>7. Consumer/family involvement</p>	<p>Some degree of consumer & family involvement in some areas at statewide level and in some local agencies (5) (6)</p>	<p>Need to broaden/deepen consumer & family involvement at statewide and local levels (5) (6)</p>

Goal 4: Early Mental Health and Substance Abuse Screening, Assessment, and Referral to Services Are Common Practice

- 4.1 Promote the mental health of young children.
- 4.2 Improve and expand school mental health and substance abuse programs.
- 4.3 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.
- 4.4 Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.

	Inventory of Resources	Needs/ Existing Barriers
1. Policies	5 year federal Co-Occurring State Incentive Grant (COSIG) to improve service delivery for people with co-occurring mental health and substance abuse disorders by developing screening tool and integrated services (7)	More internal collaboration between Mental Health and Substance Abuse Divisions needed within ODMHSAS (7)
2. Practices/Services	NAMI "Hope for Tomorrow" prevention curriculum in schools (12) Many school districts have partnered with System of Care and other stakeholders to provide positive behavior supports (PBS), to create school environments that support children's behavioral and emotional health and provide early intervention services within schools. (4) Uniform training for assessment adopted by CMHCs (4)	For clients with dual diagnoses, services are still fragmented (7) Lack of early access options results in children having developing more serious needs and placing demands on higher levels of care (4) Systems of Care are beginning to provide better integrated services for children and families, but have limited capacity in present communities and are not available in all communities. (4) There is a lack of consensus among providers about what services are appropriate for children age 0-5. (4) Daycare and early education are not equipped to handle children with significant behavioral concerns, and these children may be kicked out without a plan for follow-up services (4) There are a shortage of school-based services for children and youth. (4). Screening for developmental or behavioral disorders in young children are not routinely done in primary care settings. (4)
3. Workforce/Training	OHCA is partnering with pediatrician and other groups to promote early screening for behavioral health problems (4).	There are significant unmet needs for early screening and assessment of children; few professionals are trained to assess and serve children from 0-5 years of age. (4) There are significant unmet needs for screening of persons with mental health disorders in substance abuse services and persons with substance abuse disorders in mental health services (7).
4. Organization/Collaboration	Existing collaborative activities: Governor's and Attorney General's Blue Ribbon Task Force; Partnership for Children's Behavioral Health; Integrated Services Initiative (co-occurring disorders); Adult Recovery Collaborative	n/a

	(1)	
5. Data	n/a	n/a
6. Financing	n/a	OHCA procedures for prior and continuing authorization of school-based intensive outpatient services resulted in the closing of needed programs.(4) There is a lack of clarity and standards for compensation for serving the 0-5 population (4)
7. Consumer/family involvement	Some degree of consumer & family involvement in some areas at statewide level and in some local agencies (5) (6)	Need to broaden/deepen consumer & family involvement at statewide and local levels (5) (6)

Goal 5: Excellent Care Is Delivered and Research Is Accelerated

5.1 Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses.

5.2 Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.

5.3 Improve and expand the workforce providing evidence-based services and supports.

5.4 Develop the knowledge base in four understudied areas: mental health and substance abuse disparities, long-term effects of medications, trauma, and acute care.

	Inventory of Resources	Needs/ Existing Barriers
1. Policies	<p>Establishment of Office of Consumer Affairs(3) (6)</p> <p>Establishment of Recovery Support Specialist and Family Support Specialist positions(3) (6)</p>	<p>Excessive paperwork burden reduces amount and quality of available services (4) (5) (6)</p> <p>Eligibility criteria favor children and youth in public custody, causing lack of community-based services. (4)</p> <p>There is no clear guidance for the use of evidence-based practices or practice-based evidence in Oklahoma. (4)</p>
2. Practices/Services	<p>An array of outpatient mental health and substance abuse services for children and adults provided through network of 15 community mental health centers (CMHCs) with programs in 102 cities and towns, two adult hospitals, one children's hospital, and contract agencies (4) (5) (6)</p> <p>Increased ability to identify children and youth in need of behavioral health services, expansion of some critical services, and creation of new community-based services. (4)</p> <p>System of Care initiative: ODMHSAS and partner agencies have expanded wraparound care coordination, family support providers and behavioral aides. (4)</p> <p>ODMHSAS has developed 14 PACT programs (6).</p> <p>Several private not-for-profit mental health providers received federal HUD grants to support housing for consumers (10) (16)</p> <p>ODMHSAS contracts for independent evaluation of new, evidence-based program modes [System of Care (4); Integrated Systems Initiative (7)]</p>	<p>People in some housing types required to use specific mental health services as condition of residence(6)</p> <p>Concerns that consumers are over-medicated in inpatient and outpatient services(6)</p> <p>Consumers do not have sufficient time to talk with their prescribers about medication issues, doctors do not take their concerns about side-effects seriously, and they are given little information about their medications(6)</p> <p>Focus on children and youth with the most severe challenges creates over dependence on non-evidenced based, out-of-home and out-of-community residential services. (4)</p> <p>Prior authorization processes set criteria for specific amounts of traditional services, resulting in cookie cutter services for children that are not individualized. (4)</p> <p>There is a need for expanded respite care and therapeutic foster care for children (4).</p> <p>There is a need for expanded services for children and adults who have been victims of domestic violence. (4) (6)</p> <p>Program-specific funding stream rules often result in services that are based on the needs of the program, not the consumer (4) (5) (6)</p> <p>Times between discharge from inpatient and first outpatient appointment need to be drastically reduced (4) (5) (6)</p>
3. Workforce/Training	<p>Increasing amount of in-service training and continuing education offered by ODMHSAS (14)</p> <p>OK state legislature has enacted licensure credentials for seven types of behavioral health</p>	<p>Need for in-service training and continuing education targeted to recovery skills and values (6) (14)</p> <p>Widespread lack of satisfaction with training available through ODMHSAS (4) (5) (6) (14)</p>

	<p>professionals (14)</p> <p>Skills-based implemented for care coordinators, family support providers and supervisors. (4)</p> <p>Training for juvenile justice staff on new assessment tools and on the Sanctuary model to provide a trauma-informed rehabilitative environment for children. (4)</p>	<p>Hard to recruit and keep talented staff because of the paperwork burden and low salaries (4) (5) (6) (14)</p> <p>Need for training on substance abuse and mental health issues for staff of other systems and agencies that interact with ODMHSAS clients. (14)</p> <p>Need for more bi-lingual and culturally competent professional staff (13) (14)</p> <p>Serious shortage of psychiatrists, especially child psychiatrists (14)</p> <p>Need for recovery-oriented curricula in graduate training programs (3) (5) (14)</p> <p>Need to develop staff's knowledge about mental health disparities, long-term effects of medications, trauma, and acute care. (4).</p> <p>Professional training programs need to develop competencies of students in trauma, recovery-oriented services, and other needed areas for transformation. (4) (6)</p>
<p>4. Organization/Collaboration</p>	<p>ODMHSAS and DRS to implement Supported Employment evidence-based toolkit Fall '06 (11)</p> <p>Governor created of Partnership for Children's Behavioral Health in 2004; progress made toward creating an integrated system of care. (4)</p> <p>More than 20 System of Care Community Teams and Community Partnership Boards collaborating on system improvement for children (4)</p> <p>OHCA has established strong working relationships with OKDHS, ODMHSAS, OSDP, and OJA. These agencies work collaboratively on the design of the state Medicaid program and on problem-solving. OHCA has added new programs and reimbursement rates (15)</p> <p>State agencies cooperate through the transfer of funds from one to another, i.e., ODMHSAS contracts for substance abuse services on behalf of TANF recipients from OKDHS, and for residential substance abuse services for DOC inmates (11).</p>	<p>Need for training on substance abuse and mental health issues for staff of other systems and agencies that interact with ODMHSAS clients. (14)</p> <p>There is a need for better cross-agency collaboration and specialty services to keep children with the most complex needs from being placed out of state. (4)</p> <p>Most staff are funded through fee-for-service mechanisms that prioritize billable services and do not pay for collaboration (4)</p>
<p>5. Data</p>	<p>OJA has implemented a new information system that supports integrated assessment and planning for children (4)</p> <p>Ongoing discussions to develop an integrated preauthorization and payment system for children's services across agencies and funding resources (4)</p> <p>ODMHSAS maintains a public, web-based system of reports on the performance of both State-operated and State-contracted programs (15).</p>	<p>Some local data systems are incompatible with ODMHSAS Central Office data systems (6)</p>
<p>6. Financing</p>	<p>State appropriations for mental health and</p>	<p>Increase in percent of funding spent on</p>

	<p>substance abuse services in budgets of six state agencies, increases in recent years (15) Oklahoma received an estimated \$36,336,685 in federal funds in FY 2005 and 2006, including \$14 million in discretionary grants (15) OHCA has established strong working relationships with OKDHS, ODMHSAS, OSDP, and OJA. These agencies work collaboratively on the design of the state Medicaid program and on problem-solving. OHCA has added new programs and reimbursement rates. (15) State agencies cooperate through the transfer of funds from one to another, i.e., ODMHSAS contracts for substance abuse services on behalf of TANF recipients from OKDHS, and for residential substance abuse services for DOC inmates (11).</p>	<p>children in custody has reduced access to community services for children and families. (4) Funding is increasingly being spent on out-of-home and out-of-community services for children and youth (4) System is seriously under-funded - this interferes with the ability to provide quality services (4) (5) (6) Reimbursement rates are insufficient to cover costs (5) (6) Audit, utilization review and recoupment procedures are punitive and risk undermining the financial stability of their programs (4) (6)</p>
<p>7. Consumer/family involvement</p>	<p>Some degree of consumer & family involvement in some areas at statewide level and in some local agencies (5) (6)</p>	<p>Insufficient consumer involvement in policy-making at state level (5) (6) At the local level, insufficient involvement of consumers and family members in governance, program development, and quality assurance (5) (6)</p>

Goal 6: Technology Is Used to Access Care and Information

6.1 Use health technology and telehealth to improve access and coordination of care, especially for Americans in remote areas or in underserved populations.

6.2 Develop and implement integrated electronic health record and personal health information systems.

	Inventory of Resources	Needs/ Existing Barriers
1. Policies	Oklahoma has a history of strong commitment to data system development; many state agencies have developed systems that meet or exceed national standards. (16)	Excessive paperwork burden reduces amount and quality of available services; using integrated electronic health records could reduce this burden(4) (5) (6) (16)
2. Practices/Services	All state agency partners have developed performance monitoring systems that provide process and outcome indicators for program management, and most have them posted on their websites. (16) Many local providers, particularly CMHCs, have data systems that meet HIPAA standards for electronic data collection and transmission, and some also include elements of an electronic health record (EHR). (16)	A central aim of transformation is to give consumers more access to, and more choice about, services and the release of their records. Mechanisms like a personal identification card and personal health record (PHR) need to be pursued as options for improving consumers' access to services and information about their services. (16) ODMHSAS has developed a protocol that has proved acceptable to privacy monitors in at least one instance. More testing of the acceptability of this protocol with other datasets needs to be pursued. (16) Technological solutions to maintain the security of information on portable devices is needed to ensure that consumers' trust in the system is justified. (16) Better health technology and more tele-health is needed in rural areas (4)
3. Workforce/Training	n/a	Continual staff training regarding data security procedures is needed (16) Despite having a data system built on national standards, and offering training and support for its use, the quality of some of the system's information is low. There is a need for a different kind of training that focuses on how to use data for performance improvement and program management, rather than just defining data to be entered. (16) State agency staff need more training in the effective use of technology and information for planning, monitoring implementation of changes, and evaluating the impact of system changes. (16)
4. Organization/Collaboration	The state's vocational and technical school system has video conferencing capabilities; ODMHSAS has begun to use this capacity to provide training and to conduct meetings. (16) The Joint Oklahoma Information Network (JOIN) is a multi-agency project designed to	Health information is still fragmented and not transportable among the multiple systems that serve children and their families (4) (16) Confidentiality requirements have not been developed that allow for easy sharing of information, which impedes cross-agency

	<p>make referral and service availability information accessible to providers and consumers, to support the electronic transmission of referral information among agencies, and to support cross-agency policy analysis and program evaluation (16)</p> <p>The Adult Recovery Collaborative, a partnership among OHCA, ODMHSAS with the goal of moving management of adult outpatient behavioral health services and funding to ODMHSAS, is moving toward integration of data across the three agencies. (16)</p> <p>Northwest Center for Behavioral Health, in collaboration with criminal justice system partners, has established a 'video court commitment program.' (16)</p> <p>In Cherokee County, a multi-agency group received a grant from the federal Agency for Healthcare Research and Quality to develop a regional health information organization (RHIO). (16)</p> <p>A web-based query system allows DOC staff to determine whether inmates have received ODMHSAS -funded mental health or substance abuse services. (16)</p>	collaborat8ion. (4)
5. Data	n/a	n/a
6. Financing	n/a	n/a
7. Consumer/family involvement	n/a	n/a

Appendices

Appendix A: Governor's Executive Order: 2005-34



Brad Henry
Governor
EXECUTIVE DEPARTMENT
EXECUTIVE ORDER 2005-34

FILED

DEC 12 2005

OKLAHOMA SECRETARY
OF STATE

I, Brad Henry, Governor of the State of Oklahoma, by the authority vested in me pursuant to Sections 1 and 2 of Article VI of the Oklahoma Constitution, hereby establish the Governor's Transformation Advisory Board.

The purpose shall be to advise the state as it develops a Comprehensive Mental Health Plan. The Board shall be a catalyst to enable a process of meaningful and significant transformation to occur within the state to enhance services, minimize fragmentation and support a preventive and public health approach to mental health and substance abuse services in Oklahoma. This shall include a needs assessment, a thorough inventory of resources related to mental health and substance abuse services, and a comprehensive review of the proposed Comprehensive Mental Health Plan submitted to the Center for Mental Health Services in the Substance Abuse and Mental Health Services Administration.

The Board shall make recommendations addressing the financial commitments, monitoring and compliance plans, and the most appropriate and cost efficient services that can be achieved.

The Governor's Transformation Advisory Board shall consist of no more than twenty-eight (28) members as follows:

A. State officials of the following named offices, or their successors in office or function:

1. Commissioner of the Department of Mental Health and Substance Abuse Services
2. Commissioner of the State Department of Health
3. Director of the Department of Human Services
4. State Superintendent of Public Instruction
5. Chief Executive Officer of the Oklahoma Health Care Authority
6. Director of the Office of Juvenile Affairs
7. Director of the Commission on Children and Youth
8. Director of the Oklahoma Housing Finance Agency
9. Director of the State Department of Corrections
10. Director of the Department of Rehabilitation Services

Appendix A Continued

B. The following members shall be appointed by and serve at the pleasure of the Governor for a two-year term. However, of the following members appointed, half shall be appointed for an initial term of one (1) year.

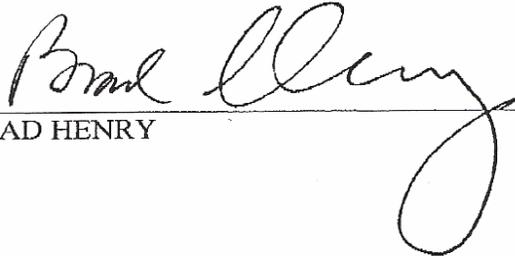
1. a member of the Oklahoma State Senate
2. a member of the Oklahoma House of Representatives
3. at least eight members representing consumer, youth and family mental health advocacy organizations
4. a member representing the law enforcement community
5. a member representing Indian Health Services
6. a member representing Indian nations in Oklahoma
7. the Chair of the Mental Health Planning Council
8. remaining members may be appointed from the general public

The Board shall meet at such times and places as it deems appropriate. Members shall serve without compensation. Board members employed by a state agency shall be reimbursed travel expenses related to their service on the Board as authorized by state law by their respective state agency. Remaining Board members shall also be reimbursed travel expenses related to their service on the Board as authorized by state law by the Oklahoma Department of Mental Health and Substance Abuse Services. Administrative support for the Board, including, but not limited to, personnel necessary to ensure the proper performance of the duties and responsibilities of the Board, shall be provided by the Oklahoma Department of Mental Health and Substance Abuse Services. The Board shall elect a chair and vice chair from its membership. The Board shall report to the Governor regarding its progress and status on May 31, 2006 and every six (6) months thereafter.

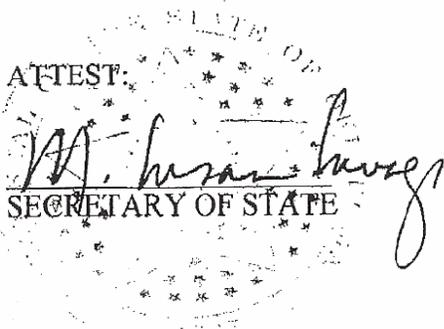
This Executive Order shall be distributed to the Oklahoma Department of Mental Health and Substance Abuse Services which shall cause the provisions of this Order to be implemented.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Oklahoma to be affixed at Oklahoma City, Oklahoma, this 12th day of December, 2005.

BY THE GOVERNOR OF THE STATE OF OKLAHOMA



BRAD HENRY

ATTEST:

M. Susan Harvey
SECRETARY OF STATE

Appendix B: The Governor's Transformation Advisory Board

Last Name	First Name	Title	Organization Name
Anoatubby	Bill	Governor	Chickasaw Nation
Archer	Carolyn	Consumer Representative	OMHCC
Barry	Sara	Chair	OMHPC
Been	Dave	Chief of Police	Tulsa Police Dept.
Boehrer	Susan	Exec Dir	Federation of Families
Bolin	Gary	Inter Exec Dir	OJA
Buck	Steve	Dir of St Policy	NAMI
Burger	Martha	Treasurer/ VP	Chesapeake Energy
Carter	Don	Director of BH	OK Indian Health Serve
Cline	Terry	Commissioner	ODMHSAS
Crutcher	Michael	Commissioner	OSDH
Fogarty	Michael	CEO	OHCA
Garrett	Sandy	Superintendent	OSDE
Glover	Linda	Citizen Representative	Jim Taliaferro CMHC
Hamilton	Misty	Youth Representative	SOC State Team
Hendrick	Howard	Director	OKDHS
Hendryx	Janice	Director	OCCY
Jones	Justin	Director	DOC
McMurry	Kermit	Vice Chancellor Student Affairs	OSRHE
Parker	Linda	Director	OK Dept of Rehab
Peden	Teresa	Exec Director	NAMI Ok
Richards	Gail	Family Advocate	Zarrow Foundation
Riley	Nancy	Senator	OK State Senate
Robinson	Pier	Family Advocate	
Rote	Kaye	Exec Director	OMHCC
Shockley	Dennis	ExecDirector	OHFA
Steele	Kris	Representative	OK House of Rep
Turner	Jack	Board Member	ODMHSAS

Appendix C. Needs Assessment Focus Groups and Personal Interviews

COMMUNITIES

Ardmore

Carter County Drug Court

Management

Staff

Mental Health Services of Southern Oklahoma

Consumers

Staff

Management

Family members of adult consumers

Mixed constituency focus group

Mental Health Services of Southern Oklahoma – Vantage Pointe

Residential substance abuse clients

Psychiatrist in private practice

Canadian County

Judge Gary Miller Children’s Justice Center

Judge Gary Miller

Claremore

Copp's Residential Care, Inc.

Residents

Edmond

Parents Helping Parents

Parents of people with substance abuse problems

El Reno

El Reno Residential Care Home

Residents

Ft. Supply

Northwest Center for Behavioral Health-Inpatient and Residential Programs

Consumers

Management and staff

Guthrie

Eagle Ridge Family Treatment Center

Residential substance abuse clients

Staff

Lexington

Joseph Harp Correctional Center

Mental health clients

Substance abuse clients

Mental health and substance abuse management and staff

Marietta

Love County Turning Point

Community members, health & human services staff, law enforcement

Appendix C Continued

McCloud

Mabel Bassett Correctional Center

Substance abuse clients

Mental Health Unit staff

Norman

Central Oklahoma Community Mental Health Center

PSR program consumers

PACT Program family members and consumers

Family members of children receiving services

Staff

Management

Norman Adolescent Center

Substance abuse services consumers

Norman Alcohol and Drug Treatment Center

Clients

Staff

Management

Norman Public Housing Authority

PHA staff and management, local housing providers & interested parties

Oklahoma Youth Center

Mental health consumers

Oklahoma City

A Chance to Change Foundation

Area Prevention Resource Center staff

Clinical staff and management

Center for Services to the Deaf and Hearing Impaired

Management

Hope Community Services

Management

Indian Health Care Resource Center

Staff

Management

Consumers

Latino Community Development Agency

Management

LIFE Senior Services

Management

Mental Health Association of Central Oklahoma

Management, Board members and members of the Housing Committee

North Care Center

PACT consumers

PACT management and staff

Appendix C Continued

PSR consumers
Management
Oklahoma City Jail
Correction officers & Day Reporting Program staff
Oklahoma County Mental Health Court
Consumers
Staff
Oklahoma City Police Department
Crisis Intervention Team
Oklahoma County Juvenile Justice
Judge Roger Stuart
Oklahoma County – Project Protect
Inter-agency project staff
Red Rock Behavioral Health Services
Management
Speck Homes, Inc.
Consumers (adolescent boys)
Staff
Management

Poteau

Mental Health Consumers
Substance Abuse Clients and Family Members
Law enforcement
Staff of private mental health center
Staff of public mental health center

Tahlequah

Bill Willis Community Mental Health Center
PSR program consumers
Clinical management team
Mental health staff
Substance abuse outpatient staff
Cherokee County Health Coalition
Regional Health Information Organization
System of Care Coalition

Tulsa

12 & 12, Inc.
Outpatient substance abuse clients
Management
Staff
Associated Centers for Therapy, Inc. - Psychosocial Rehabilitation Program

Appendix C Continued

Consumers
Management
Staff

David L. Moss Criminal Justice Center
Behavioral Health Nurse
Diversion Case Manager
Inmate

Family and Children's Services, Inc.
Management

Life Senior Services
Senior Services providers and interested parties
Management

Oklahoma Department of Rehabilitation Services
Local staff

University of Oklahoma Medical School
Gerard Clancy, M.D., Dean

Parkside Hospital
Management

Systems Improvement Planning Group
Membership

Tulsa Center for Behavioral Health
Inpatient/residential substance abuse clients
Management
Staff

Tulsa County Jail
Inmates

Tulsa Guidance Center
Staff

Tulsa Police Department
Chief David Been

Tulsa Public Schools
Taylor Young, Ph.D., Assistant Superintendent for Special Education, and staff

Tulsa Systems of Care Partners
Management and staff

Youth focus group – Systems of Care Conference

Woodward

Northwest Center for Behavioral Health
Outpatient mental health and substance abuse management and staff
Residential substance abuse clients, Lighthouse Substance Abuse Unit
Management and staff, Lighthouse Substance Abuse Unit

Woodward Turning Point
Community members, health & human services staff, law enforcement

Appendix C Continued

STATE AGENCIES

Oklahoma Commission for Children and Youth

Janice Hendryx, Executive Director

Lisa Smith, Assistant Director

Oklahoma Department of Corrections

Debbie Mahaffey, Deputy Director for Treatment and Rehabilitation

Robert Powitzky, Ph. D., Chief Mental Health Officer

Mary Smith, Substance Abuse Program Administrator

Bob Mann, Coordinator of Clinical Social Work

Laura Pittman, Clinical Coordinator for Mental Health

Bill Ellington, Clinical Coordinator, Oklahoma State Penitentiary

James Keithly, Mental Health Unit, Joseph Harp Correctional Center

Joe Taylor, DMHSAS, assigned to DOC for Project Protect

Community Corrections probation officers and staff

Oklahoma State Department of Health

Edd D. Rhoades, M.D., M.P.H.,

Deputy Commissioner for Family Health Services

Debra Andersen, M.A., CCC, Chief, Child Guidance Service

Oklahoma Department of Human Services

Farilyn Ballard, Chief Operating Officer

Kristi Blackburn, Director, Developmental Disabilities Services Division

Linda Smith, Director, Children and Family Services Division

Adult Protective Services Ombudsman supervisors

Oklahoma Department of Mental Health and Substance Abuse Services

Terry Cline, Ph.D., Commissioner

Dave Statton, Chief Operating Officer

Rand Baker, Deputy Commissioner, Mental Health Services

Ben Brown, Deputy Commissioner, Substance Abuse Services

Peggy Jewell, M.D., Medical Director

Melody Riefer, Director, Office of Consumer Affairs

Mental Health and Substance Abuse Services Staff

Oklahoma Department of Rehabilitation Services

Consumers, management and staff

Disability Determination Division staff

Oklahoma Health Care Authority

Mike Fogerty, Director

Debbie Spaeth, Director of Behavioral Health

Terrie Fritz, Director of Children's Services

Oklahoma Housing Finance Agency

Deborah Jenkins, Director, Rental Assistance Program

Rental Assistance staff

Appendix C Continued

Oklahoma Parole and Pardons Board

Terry Jenks, Director

J.D. Daniels, Deputy Director

STATE-WIDE ORGANIZATIONS

Depression/Bipolar Support Alliance

Staff and members

Federation of Families

Management

Mental Health Aging Coalition

Membership

NAMI Oklahoma

Management and staff

Oklahoma Citizen Advocates for Recovery and Treatment Association

Management and staff

Oklahoma Coalition Against Domestic Violence and Sexual Assault

Management, staff and volunteers

Oklahoma Mental Health Consumer Council

Management and staff

Appendix D: Focus Group Questions

Script and Prompts for Transformation Focus Groups

Thank you for coming. I am _____, and I'm part of an evaluation team from Advocates for Human Potential, a small research and consulting firm. We are working on a needs assessment for a federal grant received by the Oklahoma Department of Mental Health and Substance Abuse Services. This is _____, who will take notes during the focus group.

Oklahoma is one of seven states to receive a five-year Mental Health Transformation State Incentive Grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). The goal of these grants is to transform state mental health service systems from systems dictated by outmoded bureaucratic and financial incentives to systems driven by consumer and family needs that focus on building resilience and facilitating recovery. The grants require states to enlist consumers and family members as active partners in all transformation planning and activities.

The first year of Oklahoma's Transformation grant is devoted to needs assessment and planning, and Advocates for Human Potential (AHP) has been contracted to assist with this effort.

We'd like your help in identifying important issues that should be addressed in the transformation process. Your participation in the focus group is voluntary and confidential. You may decline to comment on any question that is asked. We will be taking notes during the session to record everyone's comments, but nothing you might say in this group will ever be reported in any way that would allow you to be identified. To protect everyone's privacy, we will use first names only in this room.

We want to hear what you think, as you are the experts. You will be doing most of the talking. Before we start, I want to mention a few more things.

There is no need to raise your hand during the discussion. Speak right up, but please respect others when they are talking. When today's discussion is over, please respect the privacy of your fellow group members. Please do not repeat anything they have said outside this meeting.

This discussion will last about an hour and a half. Is there anyone who can't stay for the whole period? Any questions? Now let's begin.

Appendix D Continued

QUESTIONS FOR MH CONSUMERS/FAMILY MEMBERS:

- 1) Please tell us about people's experiences with mental health services :
 - timely access to desired services
 - level of involvement in treatment planning
 - access to trauma services
 - PSR services
 - medication
 - access to Recovery Support Specialist and/or self-help groups
 - inpatient care
 - mental health court or other programs related to the criminal justice system

- 2) Can you tell us about people's experiences getting access to:
 - housing
 - public benefits including SSI/DI, Medicaid and Medicare
 - employment and/or vocational services
 - education
 - treatment for co-occurring substance abuse problems?
 - physical health care, dental care
 - crisis services

- 3) How are consumers and family members involved in decision-making at {program name}?

- 4) What are your greatest concerns about the mental health system?

- 5) What change to the current system do you think would have the most positive impact?

- 6) Is there anything else you think we should know that we haven't asked about?

Appendix D Continued

QUESTIONS FOR CMHC STAFF/ MGT:

- 1) What do you see as the greatest strengths of your program(s)?
- 2) What is the biggest challenge your program(s) face?
- 3) How do your MH clients access:
 - housing
 - public benefits including SSI/DI, Medicaid and Medicare
 - employment services
 - education
 - self-help groups
 - treatment for co-occurring substance abuse problems
 - physical health care, dental care
 - crisis services
 - trauma services
- 4) Please tell us about:
 - how consumers are involved in treatment planning
 - how consumers and family members are involved in program (Center) decision-making
 - your program's experience with Recovery Support Specialists
- 5) What are your greatest concerns about the mental health system?
- 6) What change to the current system would have the most positive benefit?
- 7) Is there anything else you think we should know that we haven't asked about?

ADDITIONS FOR MGT.

- 1) Please tell us about the impact of current financing mechanisms on your Center's (program's) delivery of services.
- 2) Please describe any collaborative relationships/initiatives that your Center (program) has with other local health and human services agencies.
- 3) From your perspective, what is the most pressing need for change on the state level?
- 4) Is there anything else you think we should know that we haven't asked about?

Appendix D Continued

QUESTIONS FOR SUBSTANCE ABUSE SERVICES PROVIDERS:

- 1) What do you see as the greatest strengths of your program(s)?
- 2) What is the biggest challenge your program(s) face?
- 3) Thinking about your clients who have both substance abuse and mental health problems, what challenges do they face getting services that address both issues?
- 4) How do your clients access:
 - housing
 - public benefits including SSI/DI, Medicaid and Medicare
 - employment services
 - education
 - self-help groups
 - physical health care, dental care
 - trauma services
- 5) Please tell us about:
 - how consumers are involved in treatment planning
 - how consumers are involved in program decision-making
- 6) What are your greatest concerns about the substance abuse services system?
- 7) Is there anything else you think we should know that we haven't asked about?

ADDITIONS FOR SA PROGRAM MGT.

- 1) Please tell us about the impact of current financing mechanisms on your program's delivery of services.
- 2) Please describe any collaborative relationships/initiatives that your program has with the CMHC and other local health and human services agencies.
- 3) From your perspective, what is the most pressing need for change on the state level?

Appendix D Continued

QUESTIONS FOR SUBSTANCE ABUSE CLIENTS/ FAMILY MEMBERS:

1) Please tell us about people's experiences with substance abuse services:

- timely access to desired services
- level of involvement in treatment planning
- access to self-help groups
- inpatient care
- trauma services
- drug court or other programs related to the criminal justice system

2) Some people have both substance abuse problems and mental health problems. Do you know what services are available locally for people with both diagnoses? If you know about these services, please tell us about any barriers or challenges people face in getting these services.

3) Do people have access to:

- housing
- 30 March 2006 public benefits including SSI/DI, Medicaid and Medicare
- employment services
- education
- self-help groups
- physical health care, dental care

4) In this program, please tell us about:

- how consumers are involved in treatment planning
- how consumers are involved in program decision-making

5) What are your greatest concerns about the substance abuse services system?

6) Is there anything else you think we should know that we haven't asked about?

Appendix D Continued

Focus Group Questions for non-MH/SA Groups

1. Please describe the nature and scope of the work your organization does.
2. Under what circumstances do you encounter/work with clients of the mental health and/or substance abuse service systems?
3. Please tell us about the experiences of mental health and/or substance abuse clients related to:
 - housing
 - public benefits including SSI/DI, Medicaid and Medicare
 - employment and/or vocational services
 - education
 - treatment for co-occurring mental health and substance abuse problems
 - physical health care and dental care
 - crisis services
4. Under what circumstances do you encounter/work with mental health and/or substance abuse agencies?
5. What do you think are the most crucial problems/challenges facing the mental health and substance abuse service systems?
6. What change to the current system would have the most positive impact?

Appendix E: Public Comment Summary

Analysis of Written Public Comments received on the *Oklahoma Needs Assessment and Resource Inventory Report*

The Oklahoma Needs Assessment and Resource Inventory Report was published online for public comment August 25, 2006. The deadline for submission of written public comments was September 15, 2006. Public comments could be sent to the Innovation Center via e-mail or through regular post. Six separate documents were received by e-mail; no public comment documents were received by post. Two of the six documents were from state employees representing two state agencies: The Oklahoma State Department of Health and the Oklahoma Department of Corrections. Three of the remaining four documents were from non-profit agency employees, representing an advocacy group, a health care center and a behavioral health center. The final document was from an individual behavioral health practitioner.

This section provides analysis related to the public comments received on the Needs Assessment. It should be noted that this analysis is qualitative rather than quantitative. Quantitative analysis generally includes objective mathematical procedures that may be replicated by other researchers. The procedures for qualitative analysis, however, tend to be intuitive and subjective. It is possible, therefore, that the same comments might produce a different set of results if analyzed by other researchers. All original documents have been saved so others may conduct their own analysis, if desired.

A multi-stage content analysis was performed. During the first stage, each comment within each document was classified by objective. The six documents contained 33 distinct comments. These comments were classified into five different objectives: 1) Congratulatory; 2) Correcting inaccurate information; 3) Advising the restatement of existing content to improve clarity; 4) Recommending new content; and 5) Proposing action plans. This final objective does not specifically relate to the Needs Assessment, therefore these four comments are removed from the analysis. The following table shows the number of comments per objective.

Objective	Number of Comments	Percent
Congratulatory	4	14%
Inaccurate information	2	7%
Restatements for clarity	4	14%
New Content	19	66%
Total Number of Comments	29	100%

Once classified into objectives, each comment was subsequently reviewed for content and similar comments were clustered into sub-categories that correspond to Needs Assessment chapters. Those comments classified as congratulatory did not require further sub-classification.

Appendix E Continued

The following information provides a synopsis of the public comments received. Comments have been paraphrased to provide an abbreviated, yet meaningful, summary. These paraphrased statements are clustered by chapter and will include a notation of the perceived objective.

General Congratulations

Congratulations on a well written document that expresses the mental health and substance abuse services needs in Oklahoma.

Consumer-directed, Recovery-focused, Trauma-informed

Information concerning Oklahoma's involuntary commitment law should be added, along with a discussion about its efficacy.

Children

Adolescents in OKDHS custody, or in other state supported treatment, have difficulties transitioning into the adult behavioral health system. A discussion of this problem should be added.

Adult MH

Information should be added concerning the shortage of beds for adult Medicaid patients with mental illness.

The CAR form needs to be revised or replaced, as discussed in the report, this form is time consuming, but what is not discussed is the forms apparent cultural bias and seemingly financial motivation.

Criminal Justice

In order to clarify the Department of Corrections stance on AA/NA programs, please be aware that AA/NA programs are not approved for offender achievement credits because these programs are considered voluntary faith-based services. It should be noted, however, that AA and NA programs are offered in nearly all of DOC facilities and all offenders are encouraged to participate in these programs if they choose.

It is inaccurate to state that the Department of Corrections does not collect electronic data in regards to services offered. This information has been gathered since July 1, 2003 on all approved programs, educational services and faith-based services.

Information should be included on the effect of parental incarceration on children, especially in relation to Oklahoma's high female incarceration rate.

A discussion on the cost effectiveness of shifting money from corrections to mental health and transferring mentally ill inmates into hospitals or other treatment settings should be included.

Add information on Native American (tribal) criminal justice programs.

Housing

Add information on Native American (tribal) housing authorities.

Appendix E Continued

Employment

Add information on Native American (tribal) employment programs.

Prevention

Information should be added concerning the need for the effective evaluation of early childhood prevention efforts.

Cultural Competence

More attention needs to be given to the Native American population in Oklahoma and to their specific mental health and substance abuse services needs.

The relationship between poverty and mental health and substance abuse problems should be clarified. Specifically, information should be added which explores the intersection of poverty, race/ethnicity and mental health and substance abuse problems.

Information should be included on the processes taken to ensure that screening tools and evidenced-based practices are culturally competent.

The census may not accurately count the number of minorities. This limitation of census data should be addressed.

Technology

Add information on the Indian Health Service data management system: Resource Patient Management System (RPMS).

Appendix

The NAMI listing within the acronyms appendix needs to be corrected.

Appendix F: Acronyms and Definitions

Acronyms and Definitions

Acronyms

AA – Alcoholics Anonymous
ABLE-Alcohol, Beverage and Law Enforcement
ACA – Against Counselor’s Advice
ADAM – Arrestee Drug Abuse Monitoring
AHP – Advocates for Human Potential
AHRQ – Agency for Healthcare Research and Quality
APD – Advanced Planning Document
APRC Area Prevention Resource Center
ARC – Adult Recovery Collaborative
AWOL – Absent without leave
BAC – Blood Alcohol Concentration
BHCM – Behavioral Health Case Manager
BHDT – Behavioral Health Development Team
BHSAS-Behavioral Health Substance Abuse Services
CADC – Certified Alcohol and Drug Counselor
CAPT-Center for the Application of Prevention Technologies
CARE-Community Adolescent Rehabilitation Effort
CARF – Council on Accreditation of Rehabilitation Facilities
CEU – Continuing Education Units
CHC-Community Health Centers
CIT – Crisis Intervention Team
CMCA-Community Mobilizing for Change on Alcohol
CMHC-Community Mental Health Center
CMHS – Center for Mental Health Services
CMS – Case Management Systems
CMS –Center for Medicare and Medicaid Services
COPEs-Community Outreach Psychiatric Emergency Services
COSIG – Co-occurring State Incentive Grant
CSAP- Center for Substance Abuse Prevention
DASIS – Drug and Alcohol Services Information System
DBSA – Depression and Bipolar Support Alliance
DDSD – Developmental Disabilities Services Division
DHHS-Department of Health & Human Services
DOC – Department of Corrections
DOH – Department of Health
DPS – Department of Public Safety
DRS – Department of Rehabilitation Services
DSDUH -National Survey on Drug Use and Health
DSM-IV – Diagnostic and Statistical Manual of Mental Disorders
DSS – Division of Decision Support Services
DUI – Driving Under the Influence

Appendix F Continued

EBP-Evidence-based Practice
ECS – Epidemiologic Catchment Area Survey
EHR – Electronic Health Record
F&CS – Family and Children’s Services
FAS – Fetal Alcohol Spectrum
FBI – Federal Bureau of Investigation
FFY- Federal Fiscal Year
FPL – Federal Poverty Level
FTE – Full Time Equivalent
FY- Fiscal Year
GED-General Educational Diploma
GICH – Governor’s Interagency Council on Homelessness
GTAB – Governor’s Transformation Advisory Board
GUS-Growing Up Strong
HIDD- Hospital Inpatient Discharge Data
HIPAA – Health Insurance Portability and Accountability Act
HMIS- The Homelessness Management Information System
HRIS – Human Resources Information System
HUD – Housing and Urban Development
ICCD – International Center for Clubhouse Development
ICIS – Integrated Client Information System
IMD – Institution for Mental Disease
IOM – Institute of Medicine
ISI – Integrated Services Initiative
JOIN – Joint Oklahoma Information Network
JOLTS – Juvenile On-line Tracking System
LADC – Licensed Alcohol and Drug Counselors
LCDA-Latino Community Development Agency
LEA- Local Education Agency
LPC – Licensed Professional Counselor
MECA – Methods for the Epidemiology of Child and Adolescent Mental Disorders
MHA – Mental Health Association
MHSIP – Mental Health Statistics Improvement Program
MH-TSIG – Mental Health Transformation State Incentive Grant
MITA – Medicaid Information Technology Architecture
MMIS – Medicaid Management Information System
NA-Narcotics Anonymous
NAMI – National Alliance on Mental Illness
NASMHPD/NTAC – National Association of State Mental Health Program Directors/
National Technical Assistance Center
NCBH – Northwest Center for Behavioral Health
NCS – National Co-morbidity Survey
NCS-R – National Co-morbidity Survey Replication
TSIG – Transformation State Incentive Grant

Appendix F Continued

NSDUH – National Survey on Drug Use and Health
N-SSATS-National Survey of Substance Abuse Treatment Services
OAS – Office of Applied Studies
OCA – Office of Consumer Affairs
OCARTA – Oklahoma Citizen Advocates for Recovery and Treatment Association
OCCY – Oklahoma Commission for Children and Youth
OCHA – Oklahoma City Housing Authority
ODOC – Oklahoma Department of Corrections
O-EPIC – Oklahoma Employer/Employee Partnership for Insurance Coverage
OESC – Oklahoma Employment Security Commission
OFMQ – Oklahoma Foundation for Medical Quality
OHCA – Oklahoma Health Care Authority
OHFA – Oklahoma Housing Finance Agency
OJA – Office of Juvenile Affairs
OKDHS – Oklahoma Department of Human Services
OKDMHSAS – Oklahoma Department of Mental Health and Substance Abuse Services
OMHCC – Oklahoma Mental Health Consumer Council
OPNA-Oklahoma Prevention Needs Assessment
OPRC-Oklahoma Prevention Resource Center
OSASA – Oklahoma Substance Abuse Services Alliance
OSDE – Oklahoma State Department of Education
OSDH – Oklahoma State Department of Health
OSF – Office of State Finance
OSU-Oklahoma State University
OU-University of Oklahoma
PACT – Program of Assertive Community Treatment
PASRR – Pre-Admission Screening and Resident Review
PATH – Projects for Assistance in Transition from Homelessness
PBS – Positive Behavior Supports
PCBH – Partnership for Children’s Behavioral Health
PCP - Phencyclidine
PHOCIS – Public Health Oklahoma Client Information System
PHR- Personal Health Record
PNA-Prevention Needs Assessment
PNFC – President’s New Freedom Commission
PRA- Project Based Rental Assistance
PRAW – Project Based Rental Assistance without Rehabilitation
PSR – Psychosocial Rehabilitation Program
RBMS – Residential Behavioral Management Services
RCF – Residential Care Facilities
RHIO – Regional Health Information Organization
RSS – Recovery Support Specialist
RTC – Residential Treatment Centers

Appendix F Continued

S+C – Shelter Plus Care
SACWIS – Statewide Automated Child Welfare Information System
SAMHSA-Substance Abuse and Mental Health Services Administration
SAPT – Substance Abuse Prevention and Treatment
SAT – Substance Abuse Treatment
SFY - State Fiscal Year
SMI – Serious Mental Illness
SOAR – SSI/SSDI Outreach, Access and Recovery
SOC – Systems of Care
SPD – Serious Psychological Distress
SPF-Strategic Prevention Framework
SRA – Sponsor-based Rental Assistance
SSDI – Social Security Disability Income
SSI – Supplemental Security Income
STNAP – State Treatment Needs Assessment Project
TANF – Temporary Assistance to Needy Families
TFC – Therapeutic Foster Care
TRA – Tenant-based Rental Assistance
UCR – Uniform Crime Report
US DHHS – United States Department of Health and Human Services
VR-Vocational Rehabilitation
WRAP – Wellness Recovery Action Plan
YRBSS-Youth Risk Behavior Surveillance System

Definitions

Federal Fiscal Year – Year beginning October 1 and ending September 30.

HIPAA- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) consists of two Titles. Title I protects health insurance coverage for workers and their families when they change or lose their jobs. Title II requires the Department of Health and Human Services (HHS) to establish national standards for electronic health care transactions and addresses the security and privacy of health information. The Privacy Rule is a federal regulation defining administrative steps, policies, and procedures to safeguard individuals' personal, private health information (protected health information or PHI). The Privacy Rule is designed to empower patients by guaranteeing them access to their medical records, giving them more control over how their PHI is used and disclosed, and providing a clear avenue of recourse if their medical privacy is compromised. The rule is designed to protect medical records and other personal health information maintained by certain health care providers, hospitals, health plans, health insurers and health care clearinghouses.

Mean rate – Mathematical average of rates.

Median rate – Middle rate when rates are ranked in order from lowest to high.

State Fiscal Year – Year beginning July 1 and ending June 30.

Substance Abuse – Regular, sporadic, or intensive use of higher doses of drugs, alcohol or tobacco leading to social, legal or interpersonal problems.

Appendix F Continued

Substance Dependence –Uncontrollable substance-seeking behavior involving compulsive use of high doses of one or more substances, resulting in substantial impairment of functioning and health. Tolerance and withdrawal are characteristics associated with dependence.