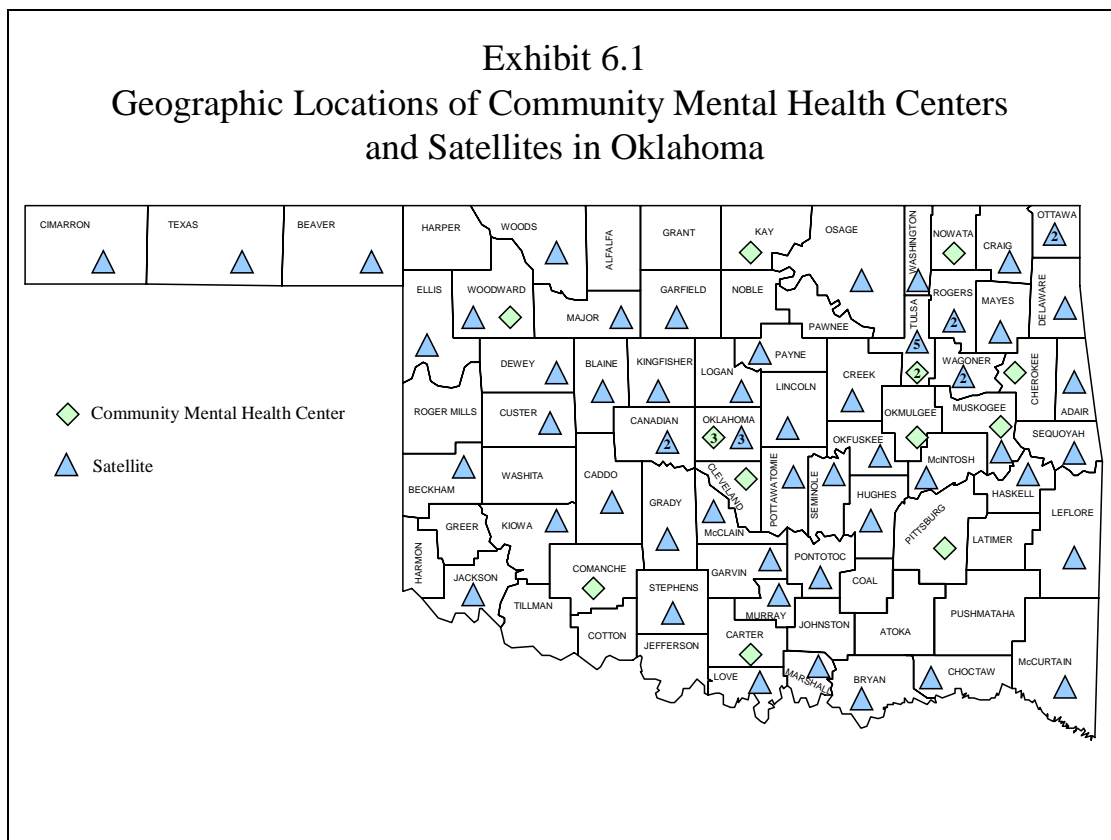


Chapter 6: Adult Mental Health Services

The purpose of this chapter is to describe mental health services for adults diagnosed with serious mental illness, including existing resources, strengths of current programs, and needs. The chapter includes both comments made on this issue in focus groups and available data from state agencies and other sources.

A. Existing Resources

Adult mental health services are funded primarily by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) and the Oklahoma Health Care Authority (OHCA) (excluding the Department of Corrections -see Chapter 8). ODMHSAS-funded services are available to any adult diagnosed with a mental disorder with a reported household income less than 200 percent of the Federal Poverty Level (FPL). There are no income restrictions for people in crisis. Due to funding limitations, clients diagnosed with a Serious Mental Illness (SMI) receive first priority for services.



The core of ODMHSAS’s adult mental health system is the network of 15 community mental health centers (CMHCs) with programs in 102 cities and towns. Exhibit 6.1 shows the counties with CMHCs and satellites; 13 counties have no facilities or clinics actually located within the county.

Thirty-six counties have ODMHSAS-contracted psychosocial rehabilitation programs (see Exhibit 6.2). Counties that lack PSR programs tend to cluster in the panhandle and the Southwest and Southeast corners of the state.

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.

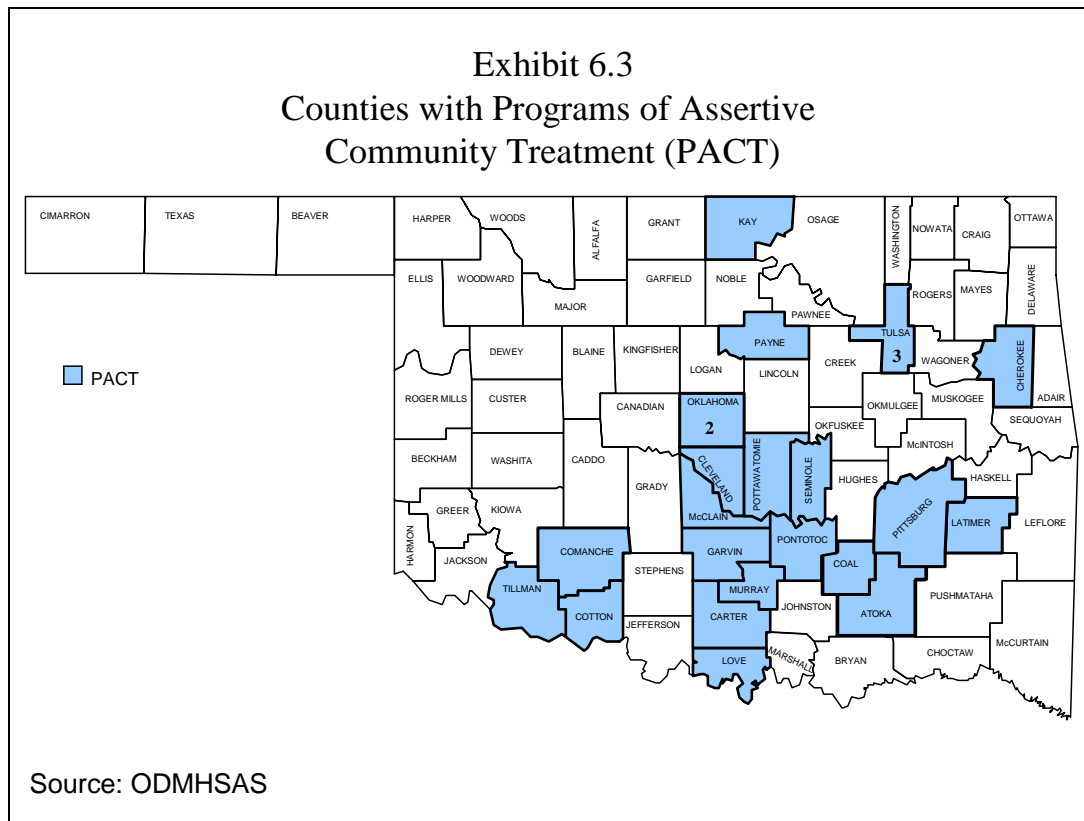
OHCA administers Medicaid funding for mental health services in Oklahoma. There are various eligibility criteria for Medicaid-funded services. The majority of adults who receive mental health services funded by OHCA have a mental health disability and a reported household income less than 185 percent 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.

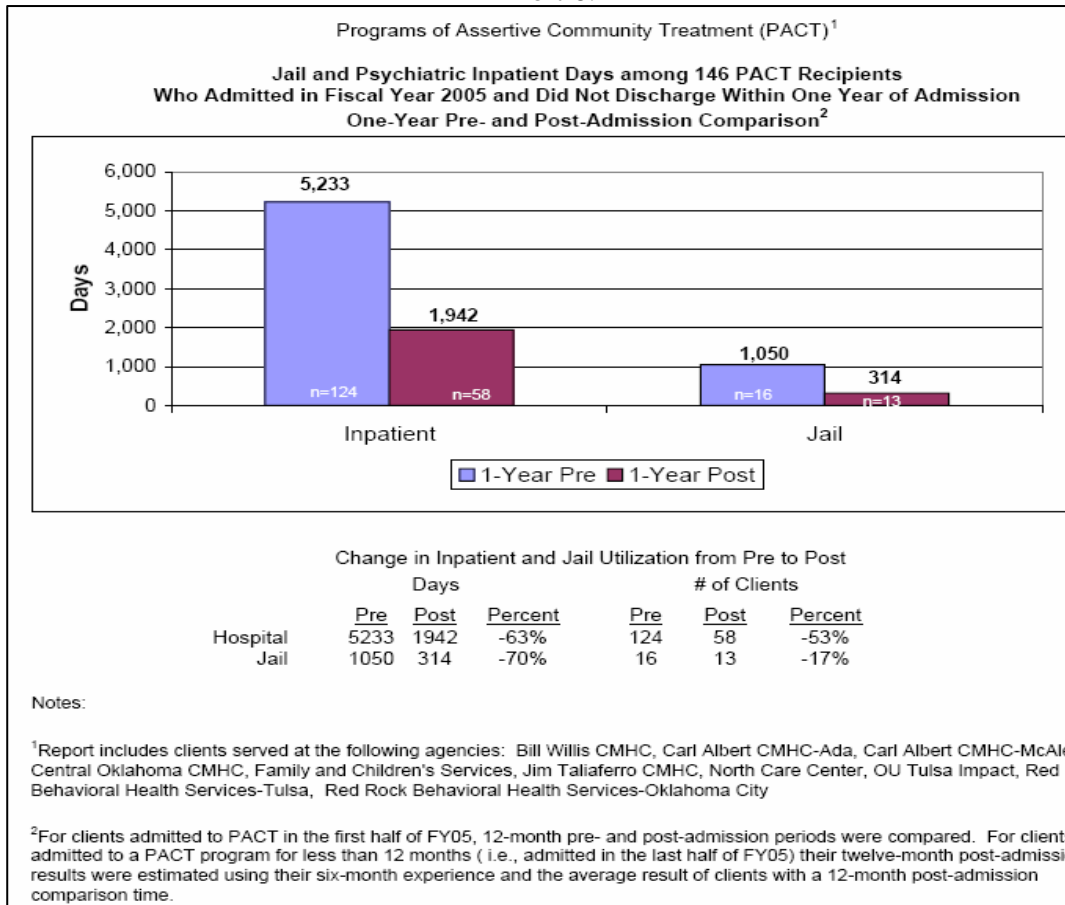


Using state appropriations and Medicaid, Oklahoma has established 14 Programs of Assertive Community Treatment (PACT) across the state. These multi-disciplinary teams provide treatment and support services to consumers with high levels of need. Three PACT teams are targeted to homeless individuals, and 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 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.

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 red have the lowest rates, while the counties in dark green have the highest rates.

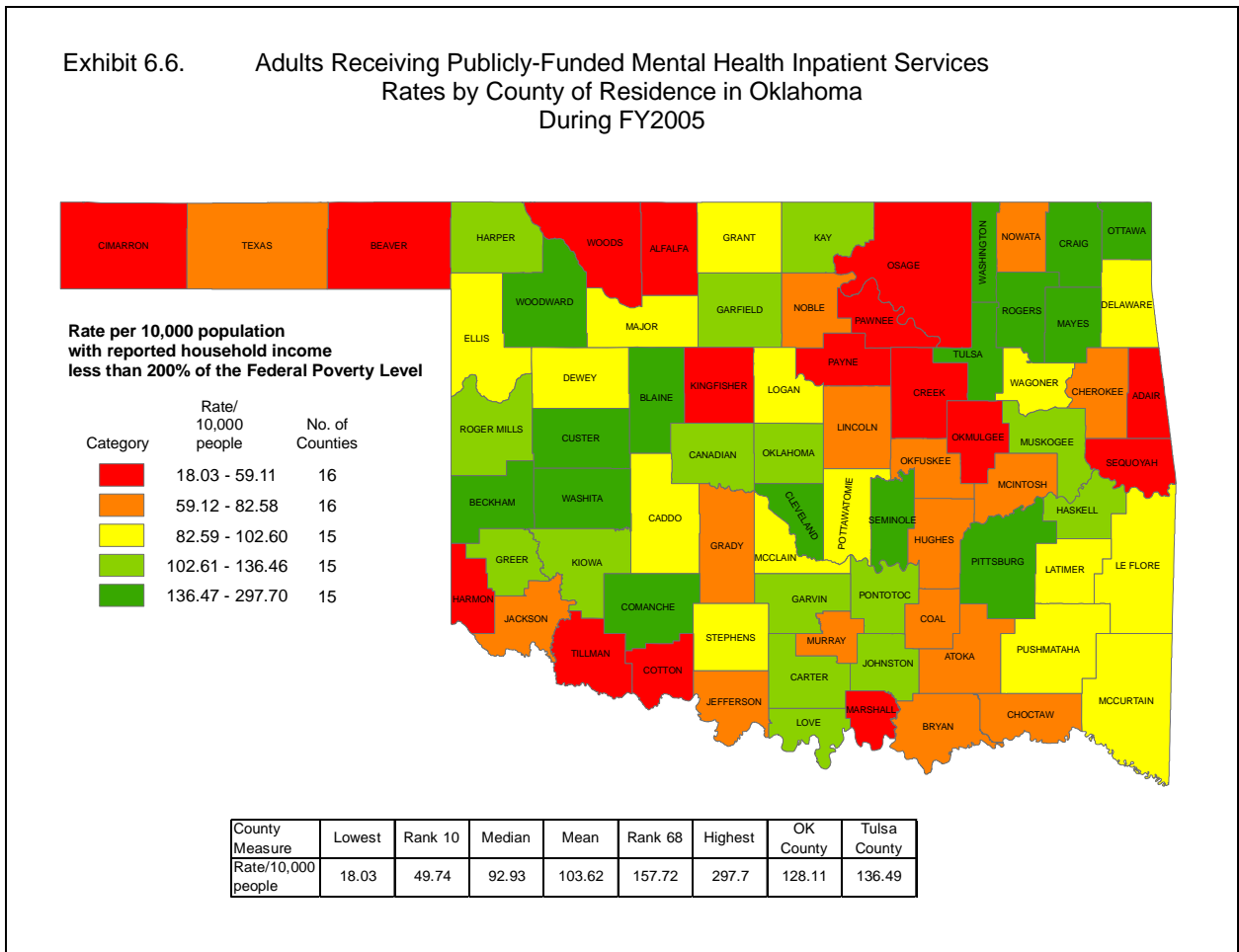
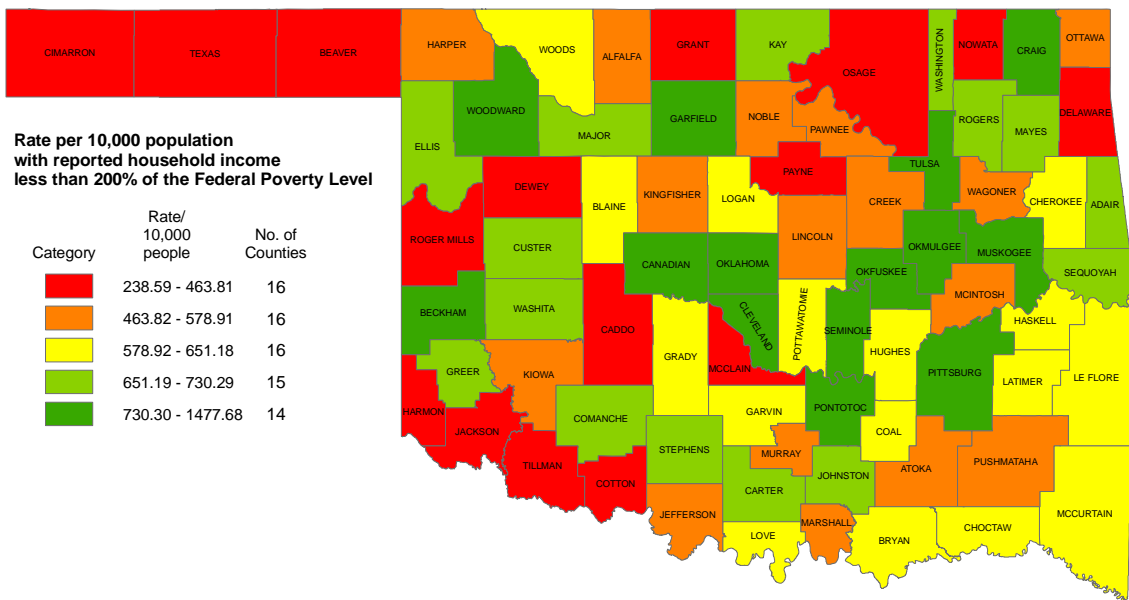


Exhibit 6.6 shows the rate distribution of adults who received publicly funded mental health inpatient services. The rate ranged from 18.03 in Okmulgee County to 297.70 in Craig County. The rates in Oklahoma and Tulsa Counties were 128.11 and 136.49, respectively. The median and mean rates were 92.93 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).

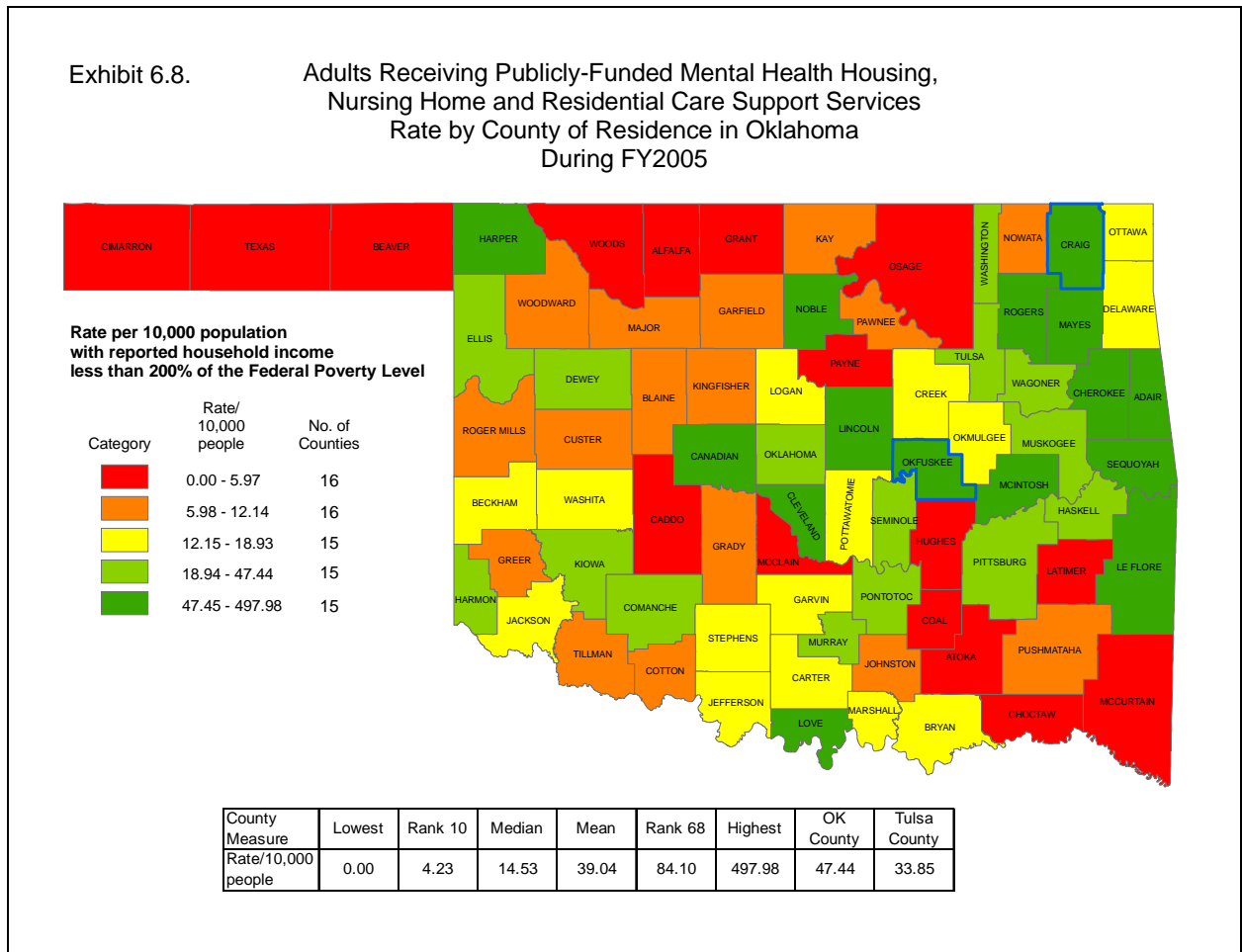
Exhibit 6.7. Adults Receiving Publicly-Funded Mental Health Outpatient Services Rates by County of Residence in Oklahoma During FY2005



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.



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

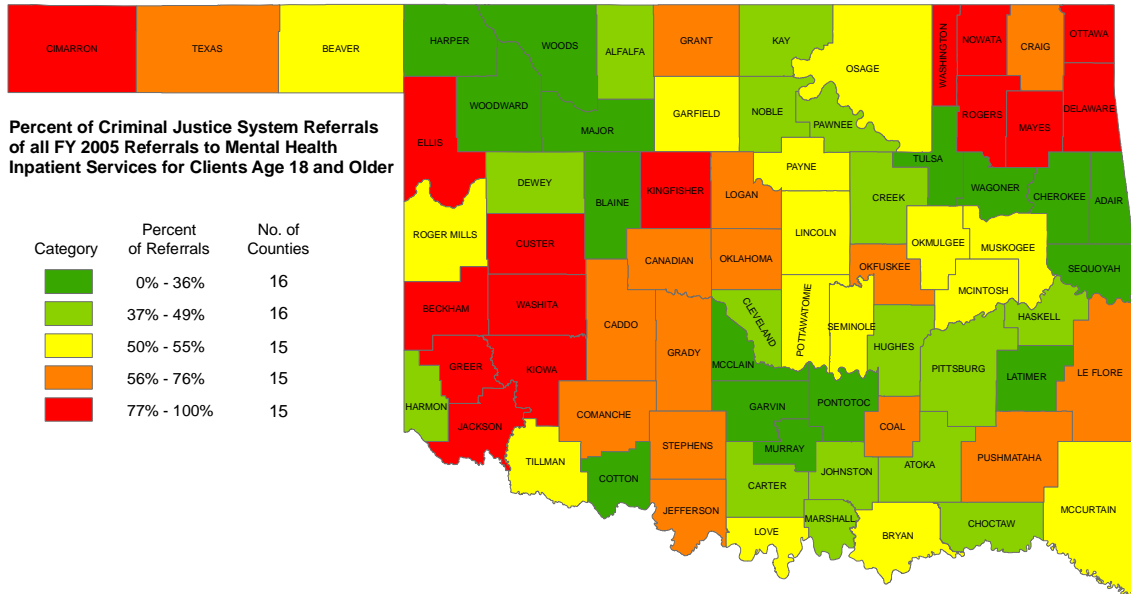
In FY2005, over half of all clients admitted to ODMHSAS-funded inpatient mental health treatment were referred to treatment by the criminal justice system (see Exhibit 6.11). Predominately, criminal justice referrals include people in crisis brought in by law enforcement for consideration for emergency 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 DDS 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?”

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