

**Ensuring a Uniform, Statewide System  
of Effective Community-Based Outpatient Mental Health Services  
for Adults who are Indigent**

**A Work in Progress**

**December 1, 2002**

Executive Summary

Oklahoma, like many other states, is experiencing a shortfall in revenue collections. Revenues in FY03 are already insufficient to support and maintain appropriation levels for state-funded services. This reality is projected to continue, at least through FY04. As a result, publicly-funded services of all types, and the persons they serve, are being affected accordingly.

The purpose of this document is to identify priorities for state-funded mental health services. It is based on input received over the course of numerous discussions with stakeholders over the past several months. Drafts have been widely reviewed to facilitate open discussion among mental health stakeholders across the state in order to guide the Oklahoma Department of Mental Health and Substance Abuse Services, and its partners, in steps to be taken over the coming months.

This plan was developed from a “zero base” approach, identifying the most compelling needs for state-funded services. Advocates and providers across our system have pulled together to make the most out of the resources that are available and will be working with the Legislature in the coming months to highlight the many unfunded needs that exist.

Change rarely comes easily. However, the reality of the revenue shortfall cannot be ignored; nor can the fact that incremental change will not satisfactorily address the issues at hand.

State and community partnerships are critical. Local providers, mental health advocates, and other stakeholders must collaboratively address the fact that, at the current time, mental health resources must be carefully directed to address the needs of those individuals, and their families and communities, who otherwise would be the most impacted by the absence of treatment for a serious mental illness. While it is understood that there may not be universal agreement on all features, the Department sought a plan that could be embraced by all interested parties and provide the very best foundation possible for growth and enhancement in the future as soon as state revenues recover.

This plan was developed based on certain key principles. It was also impacted by the realization that current services were already not uniformly or satisfactorily meeting the needs of many of our communities. As a result, the following features have been identified for implementation state-wide:

- Crisis intervention will be available to all in need. Longer-term services will be targeted to those most in need.
- A thorough face-to-face evaluation of the need for mental health services will be conducted for anyone meeting financial need criteria.
- Persons meeting defined diagnostic criteria will receive services on a timely basis, within uniformly defined time frames.
- Continuity of care between inpatient and outpatient providers will be emphasized.

The state cannot be all things to all people. The rationing of services has already become a reality in recent years due to historical funding limitations. Needs must be prioritized and resources must be carefully directed to ensure a standard of excellence for services that are delivered.

## The Challenge

Oklahoma's historical investment in its public mental health system has represented a very small percent of overall state expenditures. In the 1990's a downward trend in this support reached 2.6%. Other public functions, such as education and corrections, saw dramatic increases over this same period. A state legislator recently stated mental health has been "the most severely underfunded activity in state government." The Bazelon Center, a national research group, studied state funding in the 1990's and found that "public mental health services are Oklahoma's lowest public priority."

However, a number of positive forces have emerged related to mental health:

- Advocacy by consumers, family members, and others has grown in its numbers and effectiveness.
- A clear vision for the mental health of Oklahomans has been set forth in a long-range strategic plan.
- Nationally, evidence-based, "best" practices have emerged in mental health treatment and are being implemented in the state, providing tools that result in a recovery from mental illness for many individuals previously considered untreatable; as evidenced by stable living situations, employment, and reduced contact with the criminal justice system.

The Governor and state legislature have responded by providing increased funding for FY01 and FY02 and critical protection for FY03 during a period of an eroding overall state revenue base.

And yet we must cut services? Unfortunately, just as these positive developments are occurring, a longer-term period of significant revenue shortfall for the state is occurring. (See *Appendix for additional discussion of this issue.*) The result could be immediate and potentially damaging reductions to services across a system that is already inadequate.

We are challenged to stay the course.

Evidence-based interventions, as the new standard of care, must be the rule, not the exception. In addition, program capacity (both inpatient and outpatient) must be sufficient for those most in need.

## The Current State of Mental Health

The demand for public mental health services already greatly exceeds the capacity of the current treatment system. This has always been the case, but has been exacerbated in recent years due to three primary factors:

- Growing public awareness of mental illness and of the existence of effective treatment.
- The state's growing substance abuse problem, particularly the brain-damaging use of methamphetamine and resultant psychotic behavior.
- Level funding for basic services, combined with rising costs (e.g., pharmacy, insurance, utility, etc.), resulting in the rationing of care. In FY02 contracted mental health centers provided in excess of \$5 million in unreimbursed services to indigent clients. (In recent months providers have again taken steps to cut costs in order to maintain the financial viability of their organizations. Many of these actions have affected the availability of mental health services.)

There are also distinct differences in the state funding and other resources available to centers across the state. Over the years, local communities and providers have developed some wonderful programs to serve their communities, programs that rightfully carry a great deal of personal investment and ownership in their current design. Until now, the Department has established service priorities and issued general eligibility criteria (primarily based on income), but has given mental health providers as much flexibility as possible in the use of available resources to determine locally how best to meet the needs of the communities and the individuals they serve. This has meant that the diagnostic criteria employed and the quality and types of services available have varied somewhat across the state.

The needed changes will be easier for some providers, and for some consumers, than others.

Every attempt will be made to minimize the impact of this revenue failure at the consumer level. Providers will make a thorough assessment of a consumer's benefits to ensure all available resources are tapped. Nevertheless, some persons now receiving state-supported services will no longer be able to be served.

In addition, some services now available to persons who will continue to be served will no longer be available. A very careful evaluation and referral process will be carried out in a professional and humane manner to ensure the needs of persons transitioning out of the state system or out of certain services are addressed, including provision for wellness education.

Certain office-based services may need to be examined. As an example, over the last year, some centers have moved toward an "outrider" model, where crisis intervention and case management services in smaller communities are mobile and community sites such as churches or hospitals, rather than leased space, are utilized for scheduled medication services.

#### What Key Principles Are Being Followed?

The following have been identified as imperatives for the use of DMHSAS resources:

- Seriously ill persons who have no other resources by which to access treatment must be able to receive timely and appropriate services. As a result, priority populations must be more narrowly and uniformly defined (*see Appendix for details*) so that sufficient resources will be available to appropriately serve them.
- Timely access to medication is most often the number one priority in serving this population and the single most important step in preventing exacerbation of the illness and its symptoms.
- Personal and community safety must be protected.
- Core services must be uniformly accessible throughout the state.
- Access to existing best practice interventions must not erode.
- Inpatient and outpatient resources must be carefully balanced so as not to set off a downward spiral for the system from which recovery might not be possible without significant expenditures. Current demands for inpatient and outpatient services are equally compelling. A disproportionate reduction in the state's capacity for either one does not appear practical at this time. Instead we must ensure that those resources which are available are truly targeted and provided in measured quantities most appropriate to the individual's needs.
- Peer and family support services are economical and effective, evidence-based practices that must become a part of our service system. (*See Appendix for details.*)

- The financial viability of providers must be ensured. Payment rates for services purchased must adequately cover the cost of providing the service and centers cannot be expected to provide free services to the extent that the viability of the organization is threatened.
- Documentation requirements must be carefully determined in order to maximize clinical staff resources.

### What Exactly Can Consumers and Our Communities Expect?

A Core Service Plan, including minimum service thresholds, will be implemented throughout the state, no later than January 1, 2003.

Standardized features of the plan include:

- **Crisis intervention, with referral to critically needed services.**  
Each CMHC is responsible for assuring needed capacity for emergency examinations, as defined by statute. Such capacity should be collaboratively determined in discussions with local law enforcement and other local providers based on available resources.
- **A face-to-face clinical assessment** of new consumers not in crisis, and referral as indicated, within five days of initial referral or contact. (Telephone screening for non-diagnostic criteria is permitted.) Such assessment will include screening for substance abuse and violence in the home, with appropriate referral as indicated.
- **Timely access to appropriate medications** (typically newer generation) that will best facilitate treatment and recovery, **with the capability to address emergent needs within 24 hours** and all other needs within two weeks from initial contact. Centers must assure a capacity to provide medication services on various tracks.  
A drop-in opportunity must be offered (on a weekly basis at a minimum) for persons with non-emergent needs who have missed their regular appointment, with appropriate procedural safeguards to prevent abuse.
- **Involvement of family members** and other individually significant persons, as permitted by the consumer (*see Appendix for additional information*).
- **Ongoing, strengths-based case management** appropriate to a person's needs to facilitate integration and maintenance in the community.
- **Group psychiatric rehabilitation** (with specific program requirements as outlined by the Department).
- **Continuity of care** between inpatient and outpatient services. With appropriate releases from the consumer, inpatient staff will notify outpatient staff within 24 hours of a client's admission.  
Inpatient and outpatient staff will collaborate on medication therapy decisions and on appropriateness of outpatient referral options. Persons being discharged from crisis stabilization or inpatient treatment must have a two week supply of any needed medications (or assured of no gap in the provision of medication) as well as appointments scheduled for any needed aftercare.
- **Carefully facilitated aftercare** engagement within 24 hours whenever possible, but no later than 72 hours from discharge for persons who have required inpatient treatment and meet criteria for continuing ODMHSAS mental health services.
- When clinically indicated, a demonstrated attempt to contact a client within 24 hours of a missed appointment, including home visits when appropriate.

Individual psychotherapy or rehabilitation may be made available by centers on a limited basis, as clinically indicated. ODMHSAS funding for counseling services will be capped. The Department encourages the establishment of an open, drop-in support or rehab group for consumers wishing to attend.

Existing community-based specialty programs for assertive community treatment, crisis stabilization, inpatient treatment, and consumer housing will continue.

#### What About Children's Services?

This document addresses services to adults. The state's current investment in meeting the needs of children with a serious emotional disturbance is so seriously low that further reductions would be crippling. Centers are expected to maintain current programming and services available to children. In addition, each center is expected to provide or ensure a local capacity is in place to perform emergency examinations as defined in state statute.

## Appendix

### The State's Revenue Shortfall

The impact of the state's revenue shortfall on the delivery of publicly funded services has been a highly visible topic of discussion in recent months. Oklahoma is now experiencing what is already well under way in most other states. Reductions to all state agencies, including the Department of Mental Health and Substance Abuse Services, have already commenced. The Office of State Finance recently issued a statement saying all four major revenue sources (income tax, sales tax, gross production tax on natural gas, and motor vehicle taxes) continue to be below projections and it is not yet known if we "have reached the bottom."

As a result, the Department earlier announced plans to anticipate a 7½ percent reduction in state funds, totaling more than \$10 million across the Department's three major program areas (mental health, substance abuse, and domestic violence). This reduction was first implemented in the Department's Central Office and state-operated facilities. Administrative positions have gone unfilled whenever possible. Travel costs, particularly out-of-state, are carefully monitored and restricted to essential business. Continuing education and training is being sacrificed in the short-term. Equipment purchases are being deferred as long as possible. Given the magnitude of the budget crisis, however, reductions in services funding to state-operated facilities and contract agencies have also been necessary.

### Defining the Target Population to be Served

**Diagnostic, income, and geographic criteria all determine an individual's eligibility for ongoing services.**

**Geographic criteria** Each mental health center has a defined geographic service area determined by the Department for accountability purposes. Persons meeting the defined diagnostic and income criteria and residing, working, or going to school within that area must be served. This includes persons who meet the diagnostic and income criteria, but who are temporarily being served in a ODMHSAS-funded facility for substance abuse treatment or domestic violence services outside their primary residential service. At the consumer's request, the CMHC of residence will assist the consumer in accessing services at a site meeting one of the alternative conditions. Persons not meeting one of these geographic conditions but desiring services from a particular center may be served if funds are available.

**Income criteria.** Persons eligible for state-funded services must also meet defined income eligibility criteria. This is currently set at 200 percent of the federal poverty level. Individual insurance coverage is also a factor in determining a specific person's eligibility. No income criteria apply to persons in crisis.

**Diagnostic criteria.** Services will be available to persons with serious mental illness who:

- 1) Are at danger to self or others as a result of mental illness;
- 2) Require long term treatment for serious mental illness;
- 3) Have psychotic or major mood disorders; or
- 4) Are completing stabilization or inpatient treatment of mental illness.

Priority will be given to persons as follows:

First Priority

Individuals with psychosis and who have a level 3 or 4 CAR score. This includes persons with Bipolar disorder with psychosis, Major Depression with psychotic features, Schizophrenia, and Schizoaffective disorders;

Those who pose a danger to self or others as a result of mental illness (“imminent” danger is not a requirement for outpatient services); or

Persons at risk of institutional placement (i.e., mental health, criminal justice, etc.) due to symptoms and behaviors resulting from a mental illness and who have a level 3 or 4 CAR score.

Second Priority

Individuals with the diagnostic disorders described above and who have a level 1 or 2 CAR score;

Individuals with major mood disorders and a level 3 or 4 CAR score; and

Individuals with anxiety disorders and a level 3 or 4 CAR score.

Third Priority

Individuals with major mood disorders and a level 1 or 2 CAR score; and

Individuals with anxiety disorders and a level 1 or 2 CAR score.

Fourth Priority

Individuals with other diagnoses who meet the ODMHSAS criteria for serious mental illness.

**Persons meeting the conditions of the First or Second Priority groups will be served.** CMHC's will utilize available funding to the maximum extent possible to serve consumers in the other priority groups described above, particularly those with major mood disorders. However, services to consumers in those lower priority groups may be restricted if funding levels are not sufficient to do so.

Due to resource limitations, except for medication and other critically needed services, it is recognized that DMHSAS clients may be eligible for a different set of complementary or supplemental services than persons covered by other payers.

Community mental health centers are expected to provide high quality services to persons served. In order to do so within the funding made available from the state, centers must carefully evaluate persons presenting for services. Centers are expected to be responsive to requests from their communities for assistance with persons who show symptoms of a mental illness. Prompt, face-to-face evaluations within the defined timeframe are expected of all persons requesting or referred for such.

Persons with an additional diagnosis related to substance abuse or mental retardation, or persons who are sex offenders, are not to be excluded from treatment as long as mental illness exists.

In some cases mental illness is not a factor. Following a face-to-face evaluation, referral to other treatments or services may be the most appropriate for the individual. Examples include persons with:

- 1) head injuries or organic brain disorders,
- 2) mental retardation,
- 3) substance abuse disorders,
- 4) substance induced psychosis, or

- 5) convictions for sex crimes.

In other cases, mental illness may be a factor, but as indicated above funding limitations may not permit the center to provide ongoing services. In such cases, referral options will be thoroughly explored with the person.

Community mental health centers are expected to make reasonable and extended efforts to keep priority clients engaged in services. It is understood that self-medication and missed appointments are often a reality in working with persons with severe mental illnesses. Sobriety can not be a condition for receipt of services. Persons who regularly miss appointments may be assigned to special time slots for services that will maximize the use of staff time. Centers may, at a later point, based on appropriate clinical indicators, suspend services to certain consumers in cases where the individual has:

- 1) repeatedly missed appointments,
- 2) chronically abused substances while in treatment, or
- 3) shown or threatened violence toward mental health center staff.

Persons in crisis, but who do not have a serious mental illness, are eligible for:

- Telephone crisis intervention
- Face-to-face crisis intervention
- Crisis stabilization, including inpatient treatment as needed
- For those persons who receive inpatient treatment, outpatient services, including medication, for a period of up to three months
- Referral as indicated, including the person's primary care physician when possible

Centers shall ensure an appropriate transition plan, including the provision of wellness education, for clients not eligible for ongoing services. Each mental health center should promote and nurture strong partnerships with other local providers and community organizations, such as:

- Churches
- Good Samaritan counseling
- Resource centers
- OSU county extension centers
- OMHCC for WRAP and peer support
- NAMI-OK for Family-to-Family support

#### Defining the Involvement of Family Members and other Individually Significant Persons

Family members and other persons significantly involved in the lives of mental health consumers are an important resource and most often have information that can be of great benefit in the evaluation and process of assuring continuity of care.

Confidentiality laws limit the exchange of information and can create barriers between providers and family members, compounding the frustration and pain experienced as family members grapple with their loved one's illness. However, the challenges of developing an effective continuum of care plan with persons with a serious mental illness require that we utilize every possible resource to enhance service delivery. Input from family members is, for the most part, an untapped resource.

It is the expectation of the Department that family members be embraced as valuable contributors and resources to consumers and treatment providers and that their need for information be recognized and approached with understanding and compassion. Too much about these illnesses is unknown. We must make every attempt to fill in gaps whenever possible.

Two primary strategies are expected for all persons served:

1. Adult consumers will be encouraged to involve family/support systems in their treatment by conversing with them and signing a release of information. Consumers will be educated related to their options regarding the scope of the release of information (from acknowledgement of presence at a facility to participation on treatment team) and the fact that they may discontinue the release of information at any time. If family/support system contact and/or a release of information is not initially signed, this information should be presented again in a caring and supportive manner at appropriate points during the course of treatment, stressing the importance of a knowledgeable support system. In the absence of a release, provider staff may not disclose knowledge or lack of knowledge of a consumer's participation in treatment. However, the provider staff may take contact information of the family/support system and inform the consumer of their concerns.
2. Though Title 43A, the state's Mental Health Law, does not allow for agencies to divulge the presence or absence of an individual who is being held on a crisis or inpatient unit, it does allow for family members to receive a copy of the notice of the date, time and place of the hearing to be held on a petition alleging a person to be mentally ill (43A, §5-412, D). Agencies who detain individuals prior to hearings on petitions alleging mental illness should be diligent in notifying family members or assisting the court in notifying family members of the hearing. This may be done through information gathered from the detainee if they choose to permit family contact through a release and/or by taking contact information from family/support system members who call inquiring about the individual. Once again, in the absence of a release, provider staff may not disclose knowledge or lack of knowledge of a consumer's presence at a facility.

#### Peer-to-Peer and Family-to-Family Support Services

Evidence-based practices related to peer and family education have been developed. Mental health programs are encouraged to utilize these models, either directly or in partnership with appropriate organizations. In addition to offering wellness education, peer specialists and family advocates can fill a valuable role in assisting consumers and family members related to access concerns as well as in promoting consumer engagement in services.