

**BOARD OF MENTAL HEALTH AND  
SUBSTANCE ABUSE SERVICES  
AUGUST 22, 2014  
SPECIAL MEETING  
DEPARTMENT OF MENTAL HEALTH  
AND SUBSTANCE ABUSE SERVICES  
OKLAHOMA CITY, OKLAHOMA**

Board members present:

J. Andy Sullivan, M.D., Chair  
Stewart Beasley, Ph.D.  
Brent Bell, D.O.  
Joel Carson  
Bruce Fisher  
Henry Haynes, Ed.D.  
Gail Henderson, M.Ed.  
Paul Pierce, M.D.  
Major Ed Pulido  
Ronna Vanderslice, Ed.D.

Others present:

Commissioner, Terri White, ODMHSAS  
Durand Crosby, ODMHSAS  
Carrie Slatton-Hodges, ODMHSAS  
Angie Patterson, ODMHSAS  
Steven Buck, ODMHSAS  
Jeff Dismukes, ODMHSAS  
Emily Summars, Journal Record Legislative Report  
Dewayne Moore, ODMHSAS

**WELCOME**

Dr. Sullivan called the meeting to order.

**STATE OF THE AGENCY (Highlight FY14)**

Commissioner White reviewed the performance measures highlighted below:

**Disaster Outreach**

**STARS Division – Tornado Outreach Services**

- June 26, 2013: Awarded Immediate Services Grant for total of \$275,502.
- November 4, 2013: Awarded Regular Services Grant for total of \$1,349,205.
- July 21, 2014: Awarded United Way grant for continued MH services to severe storm survivors for total of: \$362,467.
- Total funds awarded for storm survivor services: \$1,987,174.

Primary Service	Frequency	Percentage
Individual Crisis Counseling	3487	6.6%
Group Counseling/Public Education	16703	31.6%
Brief Educational/Supportive Contact	32740	61.9%

### **Prevention Division – OK Strong**

- Part of OK Strong campaign which is the statewide website set up and run by OMES and the Office of Civil Emergency Management in response to the May tornados.
  - A social marketing effort was initiated that included direct contact with other community organizations and their constituents in the area impacted by the May 2013 storms.
    - 425 community organizations contacted with requests for partnership
    - 146,958 direct contacts with individuals in the impacted areas
- Keeping Oklahoma Strong (publication) was created for children and schools. This was distributed prior to the end of the school year in partnership with the Oklahoman’s Newspapers in Education Program. This was a combined effort between ODMHSAS Communications and the Trauma program.
  - 14,550 workbooks delivered to a targeted 347 schools in the Central Oklahoma impacted area
  - Oklahoma Emergency Management teamed with the department to provide additional funding for statewide distribution.

### **Medicaid Changes**

About two years ago, bleak fiscal trends and outlook allowed the State of Oklahoma to transition the Medicaid behavioral health program to ODMHSAS, this not only included the funding but also the policy-setting responsibilities. Services to consumers improved as well as the financial bottom line. Some of those cost-savings are as follows:

- ODMHSAS stepping in to do authorization process - \$4 million
- Rehab restriction placed on children under 5 - \$9.5 million
- PA implementation - \$10 million estimated a year in over-billing averted
- Preventing inadvertent billing on nursing home clients - \$439,000 a year
- Privately contracted providers improperly billing for adults - \$139,000
- Limiting developmental screens to one year - \$314,000
- Identifying edit in MMIS allowing overpayment on PA lines - \$342,000
- Implementation of letters of collaboration/termination process, preventing providers from double billing - \$860,000 a year
- New eligibility rules on rehab - \$58 million a year
- 35 hours a week limit - \$8.5 million a year

Dr. Beasley asked if any of the cases of fraudulent billing were turned over to the Attorney General's office. Commissioner White stated that yes we are working with the AG's office, and several of these cases will probably come to light in the next year. Our duty is also to ensure that the public and policy-makers know that most of our providers are saving lives and doing amazing work.

### **Zero Suicide Initiative**

Last year in Oklahoma more people died by suicide than those who died in a car accident. Robin Williams' suicide has brought the issue to the front of the national consciousness. Our Department is the first state to take on the Zero Suicide Initiative. The goal is to have all mental health professionals, in our state, trained specifically in suicide prevention.

- Individuals with serious mental illness (SMI) have a 6-12 times greater risk for suicide than the general population.
- The suicide rate in the general population was 11.5 per 100,000 in 2007.
- Initial consultation with Mike Hogan, Ph.D.
- Workgroup planning meeting with David Jobes, Ph.D.
- Selection of Collaborative Assessment and Management of Suicidality (CAMS) as the treatment modality
- Selection of ERT to provide a customized self-administered online screening and protocol system
- 400 staff trained in basic CAMS, 153 therapists with role play training, with follow up weekly consultation calls
- Zero Suicide Summit is set for September 29 at UCO!
- Online screening system is set to be ready by September also!

### **Suicide Prevention**

The Zero Suicide Initiative is part of the STARS division because it is aimed at individuals with SMI who are contemplating suicide. The Suicide Prevention program in our Prevention division is aimed at those individuals who don't have a mental health history. It is truly a prevention initiative.

FY14 highlights for the Suicide Prevention program are as follows:

- Office of Suicide Prevention received the Oklahoma Public Health Association Health Educator of the Year award
- House Bill 1623, allowing school districts to implement suicide prevention programming under ODMHSAS guidance
- Partnership with Oklahoma EAP to launch Working Minds, workplace suicide prevention training for state agencies, non-profit, and private sector business
- T3: Time to Talk, a program partnership with the National Guard, launched in three OKC metro school districts
- Current federal youth suicide prevention funding supported:
  - Training of 10,802 people as suicide prevention gatekeepers with 53% of those trained reporting using their skills to identify a young person at risk

- 1,479 youth screenings in schools with 273 of those students screening positive for suicide risk. Almost 93% of those high-risk students were referred and received a mental health service.
- Postvention support to 10 school districts following sudden and traumatic death of a student

Major Pulido asked if private companies are receiving the Working Minds training. Commissioner White stated that this program is available to private companies as well as state agencies. We've been invited to speak to an association of HR professionals that consists of people from both the private and public sectors.

Mr. Fisher asked if we had data on the rate of suicides among state agency employees. Commissioner White stated that the Medical Examiner gathers information on suicides, and it is not cross-referenced against how many are state employees. She stated that we could try to get that information.

**Systems of Care**

This is the first year that Systems of Care has been implemented in all 77 counties in Oklahoma. Commissioner White reviewed the successful outcomes of the Systems of Care program.

- Reduced Days of Out-of-Home Placement 49%
- Reduced School Detentions 51%
- Reduced Number of Youths Self-Harming 42%
- Reduced Arrests 66%
- Reduced Contacts with Law Enforcement 51%
- Reduced Days Absent from School 46%
- Reduced Days Suspended from School 69%

**Offender Screening**

This program is about getting the right person in the right diversion program using the evidence-based principal of Risk-Need-Responsivity (RNR).

*About the program:* Felony offenders, after initial court appearance but prior to sentencing receive a criminogenic risk, mental health, and substance abuse screen to identify recommendations for prison diversion programs.

- Contracts are in effect with 18 counties
- Over 60 screeners training and approved by ODMHSAS
- Four screener trainers in the state (1 at ODMHSAS and 3 at treatment agencies) certified by the University of Cincinnati
- Over 3,000 felony offenders screened

*Outcomes:*

- Tulsa County saw an 87% decrease in jail days after arrest when compared with pre-program implementation (Savings of \$2.2 million)
- Pontotoc County saw a 72% decrease in time from arrest to drug court admission when compared with pre-program implementation

- Over 80% of offenders screened have been diverted from prison

### **Midwest City Diversion Program**

The Offender Screening Program referenced above is for individuals who have committed felonies. Our goal is to reach out to those individuals who have been arrested on misdemeanors at the municipal level before they commit felonies.

- Developed in partnerships with the ODMHSAS, Midwest City Police Department, and the Midwest City Municipal Court
- Midwest City has the largest municipal jail in the state
- Screening for treatment needs occur in the jail, with bonds and treatment in lieu of jail offered to eligible offenders
- Program goals
  - Reduce the number of offenders in the city jail
  - Reduce recidivism of municipal offenders
  - Get behavioral health treatment to those in need of it
- Activities
  - Program accepted its first participant in December 2013
  - Serving 19 individuals
  - Court supervision no longer than 6 months
  - Screening all incoming jail inmates for substance abuse and mental health treatment needs
  - Trained all jail staff on behavioral health treatment issues

### **Specialty Courts**

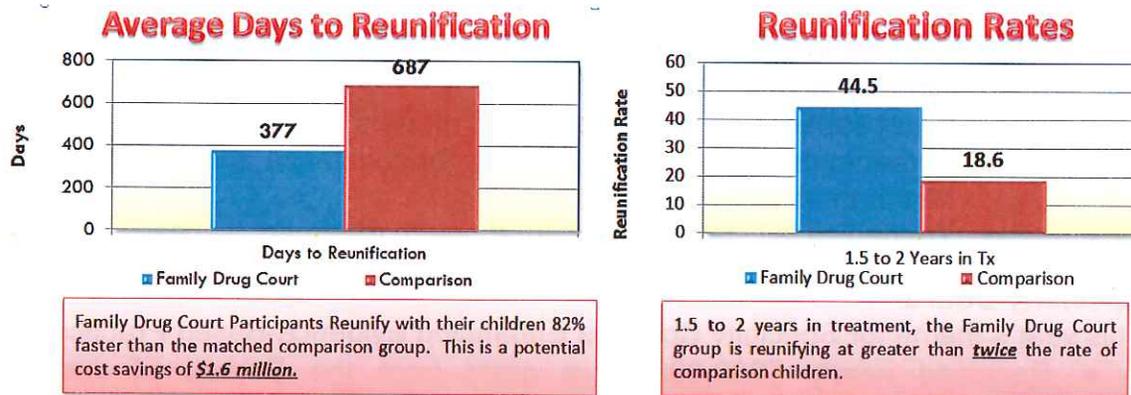
This year's theme for Specialty Courts is Enhancing Evidence-Based Practices.

- Received nearly \$200,000 in a grant from the Bureau of Justice Assistance which provided free training and treatment manuals to all specialty court contract providers in the evidence-based, Matrix Model
- Received over \$1,100,000 in a grant from the Bureau of Justice Assistance which began the Veteran Initiative Project (VIP). Enhancing access to and quality of services for veterans in specialty court programs
- Advanced the best practice of criminogenic risk assessments in specialty courts (one of the only states in the nation to have a state-wide implementation plan)
- Held over 50 days of quality training opportunities for Oklahoma's specialty courts, including the 2013 Oklahoma Specialty Court Conference which was attended by over 300 specialty court team members
- Among the first states in the nation to incorporate Drug Court Best Practice Standards (published in 2013) into state policies
- Began the integration of wellness into specialty courts by incorporating tobacco cessation focuses in specialty court functions
- Presented (for the second consecutive year) on mental health courts at the 2014 National Association of Drug Court Professionals Conference in Anaheim, CA

- Featured webcast presenter for the national technical assistance partner center for Court Innovation for their “Statewide Drug Court Training and Technical Assistance Series.” Topic: Data Driven Strategies

### Family Drug Courts

- The family drug court model is designed to assist child welfare-involved families who are struggling with substance abuse issues. Through collaboration among the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), county court systems, treatment providers, and the Department of Human Services (DHS), families receive holistic support to heal family systems with the goal of reunifying families.
- A grant-funded analysis was performed in which 142 Tulsa Family Drug Court participants and 236 matched non-participants (comparison) from the time period January 2011 through September 2012 were tracked on reunification.



93 active participants in Tulsa, Oklahoma, and Okmulgee Counties as of March 2013

Dr. Pierce asked how people are selected for Family Drug Court. Commissioner White stated that this program is voluntary, and those entering Drug Court must plead guilty before entering. Some people take their chances and go to trial. There is some self-selection when it comes to drug courts.

### Veterans

- Veterans Liaison connecting veterans and programs
- Veterans Court Docket
- Veterans Quarterly Newsletter

### Mental Health Re-Entry Program

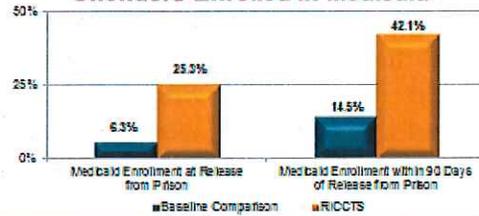
- The ODOC and the ODMHSAS have worked to improve the transition of incarcerated offenders with a serious mental illness (SMI) into community-based mental health services.
- Integrated Services Discharge Managers (ISDM), who are ODMHSAS employees, function at offices located in the mental health units of three prisons. The ISDM, as part of the ODOC treatment team, coordinate mental health services for discharge planning. Re-entry Intensive Care

Coordination Teams (RICCTS) provide treatment services in the community to persons discharged from prison.

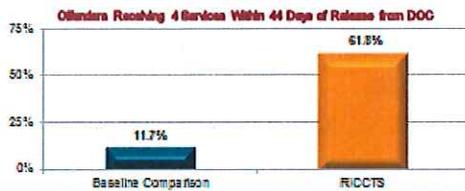
## PERFORMANCE AND OUTCOME MEASURES

RICCT offenders were over 3 times more likely to be enrolled in Medicaid at prison release than the baseline comparison group.

### Offenders Enrolled in Medicaid



### Rate of Engagement

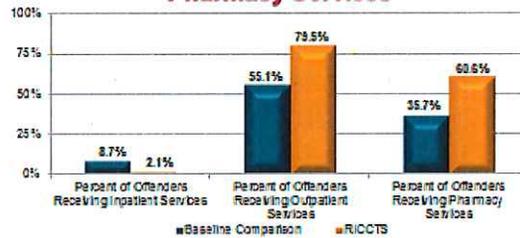


Service engagement rates for RICCTS offenders were over 5 times more than the baseline comparison group.

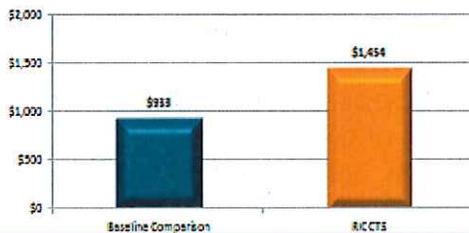
RICCTS offenders showed 76% less inpatient admissions than the baseline comparison group.

RICCT offenders received over 40% more outpatient services than the baseline comparison group.

### Inpatient, Outpatient & Pharmacy Services



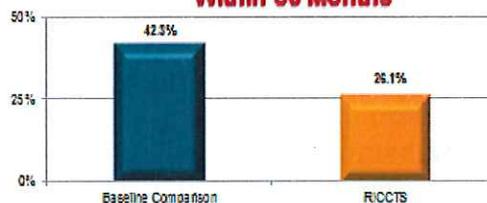
### Median Quarterly Wage 24 Months After Release from Prison



RICCTS offenders had a higher reported income 24 months after release, averaging over \$500 (or 56%) more than the baseline comparison group.

Returns to prison for RICCTS offenders were about 40% lower than the baseline comparison group.

### Offenders Returning to Prison Within 36 Months



### **OCCIC & Urgent Care**

Crisis centers were created to serve people who can be stabilized in a shorter time period and wouldn't have to go on to an inpatient facility. Some people still need to go on from a crisis center to an inpatient hospital, but if we can stabilize them in the Crisis Center, we can save a costly and often longer term admission to the psychiatric hospital. In addition to providing crisis services, we have recently implemented urgent care services. Urgent care is a 23 hour or less service for people who are on the verge of needing crisis care. If we can stabilize their needs within the 23 hours and get them linked to outpatient services the next day, we can often avoid a crisis center admission. This allows individuals to stay with their families and continue to work while reducing the demand on crisis beds.

- New building and new model
- Daily treatment team meetings, 7 days a week physician coverage, PRSS integration on the unit for wellness plans and running support groups, and community partners running support groups
- Providing crisis intervention services at a lower level of care, saving valuable treatment dollars
- Focus on Voluntary Services, increasing consumer engagement in treatment
- Increase number of people presenting for service (Avg. 486/month and climbing)
- Fewer admissions to crisis beds (A high of 218 in May of 2012 down to 67 in May of 2014)
- Fewer court commitments to Inpatient (2012 – 31.66/month, 2013 – 17.41/month, 2014 – 6.5/month)

### **Community Response Team and Liaisons**

- Increase communication and activity with Community Partners (CMHCs, PACT, Law Enforcement, Shelters, Private Hospitals)
- Shrinking the gap between crisis services and outpatient services (50% follow-up in 2011, now 80% follow-up in 2014)
- Recidivism rates improving (51% decrease in consumers returning to crisis or inpatient services within 7 days of discharge)
- Daily CMHC liaisons involvement in URC and OCCIC consumer treatment and follow-up
- Team of LMHP, PRSS, DM, and others to physically do into the community to assist with linkage to services

### **Comprehensive Community Addiction Recovery Centers**

- Certification for a new service array identified as the Comprehensive Community Addiction Recovery Center. The CCARC allows providers of Substance Use Disorder treatment services to come together in a coalition in order to offer a full range of available services to consumers.
  - Becomes a true “no wrong door” service

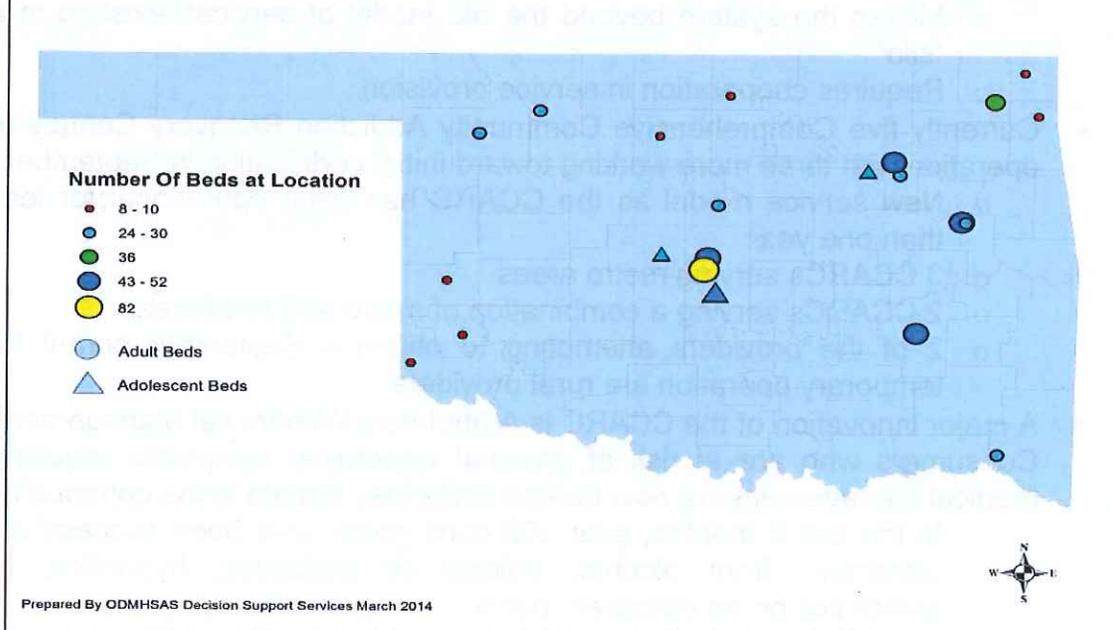
- Allows consumers to move through a recovery oriented system of care
- Moves the system beyond the old model of services existing in a “silo”
- Requires cooperation in service provision
- Currently five Comprehensive Community Addiction Recovery Centers in operation with three more working toward initial certification in September.
  - New service model as the CCARC has been operational for less than one year
  - 3 CCARCs serving metro areas
  - 2 CCARCs serving a combination of metro and rural areas
  - 2 of the providers attempting to obtain a September permit for temporary operation are rural providers
- A major innovation of the CCARC is Ambulatory Withdrawal Management. Consumers who are at risk of physical withdrawal symptoms requiring medical management are now treated while they remain in the community.
  - In the last 6 months, over 100 consumers have been successfully withdrawn from alcohol, opioids or sedatives, hypnotics, or anxiolytics on an outpatient basis.

Dr. Beasley inquired about the process of Ambulatory Detox. Commissioner White explained how Ambulatory Detox works.

#### **Residential Treatment Electronic Waitlist**

- Nearly 161,000 Oklahomans over the age of 18 are in need of treatment for alcohol or drug addiction. However, only a fraction of those have access to behavioral health treatment services. Residential substance abuse treatment is one of the most scarce treatment resources in the state, with hundreds of Oklahomans on the waiting list. In order to improve access, efficiency, and fidelity to treatment best practices, the ODMHSAS is implementing a statewide residential treatment electronic waitlist.

## ODMHSAS Residential and Halfway Substance Abuse Programs



- Current residential treatment waitlist process
  1. Determination of residential treatment need by treatment provider (based on ASAM criteria).
  2. Outpatient treatment provider contacts multiple residential providers with client to be placed on individual waitlists.
  3. Each residential treatment provider uses established criteria for prioritizing order.
  4. Outpatient treatment provider continues interim services, a best practice, until a treatment bed becomes available or the client no longer requires residential services.
  5. Once available residential bed becomes available at one of the providers whom were initially contacted, the residential provider contacts the client and provider as needed.
- New residential treatment waitlist process
  1. Determination of residential treatment need by treatment provider (based on ASAM criteria).
  2. Outpatient treatment provider places client on statewide electronic residential treatment waitlist.
  3. Waitlist uses established criteria for prioritizing order.
  4. Outpatient treatment provider continues interim services, a best practice, until a treatment bed becomes available or the client no longer requires residential services.
  5. Once available residential bed becomes available at one of the providers whom were initially contacted, the residential provider contacts the client and provider as needed.

At this time, we are piloting the project. We will be live for all providers on January 1, 2015.

### **Non-Medical Use of Prescription Drugs**

The ODMHSAS has been a leader in the design and implementation of the Oklahoma State Plan to Reduce Prescription Drug Abuse. The ODMHSAS has implemented a series of state-level programs and policies as well as funded a network of local-level prevention project in 24 communities statewide.

FY14 Highlights:

Naloxone

- The ODMHSAS launched a first responder naloxone pilot in Tulsa County.
- Since April 2014
  - 367 law enforcement officers have been trained in the administration of naloxone.
  - 15 law enforcement agencies have joined the project.
  - 890 naloxone kits have been deployed.
  - 4 overdoses have been reversed.

Take as Prescribed

- The ODMHSAS launched the Take As Prescribed multi-media campaign, including a web presence at [TakeAsPrescribed.org](http://TakeAsPrescribed.org)

### **Mental Health First Aid (MHFA)**

Mental Health First Aid is a course that teaches how to help someone who is developing a mental health problem or experiencing a mental health crisis. The training helps you identify, understand, and respond to signs of mental illnesses and substance use disorders.

FY14 Highlights:

- Secured agreement with Norman Public Schools to train over half of their district staff over the next 4 years (1,000 personnel). The first 100 will be trained beginning in August 2014.

### **PACT 360**

PACT360 is a suite of research-based, multimedia community education presentations designed to mobilize communities and empower and educate parents and teens about the dangers of drugs and alcohol. PACT360 contains five key programs: Meth360, Parents360, Youth360, Latino360, and Padres360.

FY14 Highlights:

- Oklahoma was selected as one of two PACT360 pilot states by the Partnership at DrugFree.org
- 3,346 Oklahomans received PACT360 through a network of statewide, community-based trainers
- The ODMHSAS project also developed a recording of PACT360 for online access

- PACT360 was implemented as a module in the ODMHSAS New Employee Orientation

### **Responsible Beverage Sales and Service (RBSS) Training**

Responsible Beverage Sales and Service Training is an evident-based training for alcohol retail managers and employees that provides information about methods to prevent underage sales and over consumption of alcohol.

FY14 Highlights:

- 115 RBSS training events held in FY14
- 3,063 people trained in RBSS statewide
- Business/Organizations with RBSS policies in place and MOUs with RPC for regular RBSS training: Hard Rock Hotel and Casino, Cherokee Casinos, Creek Nation Casinos, Lucille's Restaurant, Fast Lane c-store chain, Eskimo Joe's, Buffalo Wild Wings (Tulsa), River Parks West Tulsa (OktoberFest, ScotFest, etc.), OU Concessions, Tulsa MayFest, Tulsa State Fair, and others.
- After attending RBSS training, the Tulsa State Fair was able to decrease youth access to alcohol by 100% from FY13 to FY14 and Tulsa MayFest by 80% as measured by alcohol compliance checks conducted by the 2M2L Law Enforcement Task Force.

### **GIDPAC**

The ODMHSAS Prevention Division was awarded three grants from the Oklahoma Highway Safety Office related to GIDPAC and the priority of impaired driving. The grants support:

- Statewide alcohol purchase survey
- Implementation of AlcoholEdu in Oklahoma high schools
- 2Much2Lose alcohol law enforcement task forces to enforce underage and high risk alcohol laws

### **National Prevention Network (NPN)**

The National Prevention Network (NPN) is an organization of State alcohol and other drug abuse prevention representatives and is a component of NASADAD. The NPN provides a national advocacy and communication system for prevention.

- Oklahoma was selected as the host site for the 26<sup>th</sup> Annual NPN Prevention Research Conference on August 27 – 29, 2013. There were over 700 attendees representing federal and state/territorial/tribal governments, prevention professionals, and community coalitions.
- Special guests included the White House Office of National Drug Control Policy, SAMHSA, and National Institute of Drug Abuse.

### **Certified Healthy Business (CHB)**

The Certified Healthy Oklahoma program began in 2003 as a collaborative initiative with four founding partners: Oklahoma Turning Point Council,

Oklahoma Academy for State Goals, the Oklahoma State Chamber, and the Oklahoma State Department of Health.

Recipients are recognized for promoting health and wellness in their workplaces.

Goal: Increase the number of facilities applying for and achieving CHB status in 2013.

2012 – 2 ODMHSAS facilities applied for and received CHB status

2013 – 10 ODMHSAS facilities applied for and received CHB status

### **State Employee Assistance Program**

- June, 2013, OMES requested ODMHSAS manage the statewide EAP program
- Added 24/7 availability – employees can reach an on-call counselor at any time after hours
- Added appointment availability in an employee's home area. Previously outside the metro area was telephone counseling only.
- Restored availability of female counselor. Male counselors only since May, 2010.
- 46.2% increase in clients served from FY13 to FY14.
- Increased utilization rate of counselor hours from 26.5% (FY13) to 52% (FY14).

### **Legislative Accomplishments**

- Amendment to the Anna McBride Act which now allows a Court to consider relapses and restarts in the program part of the recovery process.
- Ensure telemedicine bandwidth funding from the Oklahoma Universal Service Fund.

### **Facility Accomplishments**

- GMH
  - Sanctuary Accreditation
  - Mass grave memorial
- JTCMHC
  - Children's Treatment building

### **DISCUSSION AND POSSIBLE ACTION REGARDING EVALUATION OF COMMISSIONER PERFORMANCE**

Commissioner White reviewed the measures set for her by the Board for her evaluation.

### **Financial Efficiency**

- Administrative costs = 2.5%
- Utilization of budget
  - Carryover = \$247
  - Last year's carryover = \$46

## Treatment and Recovery

- Consumer outcomes

Statewide Consumer Satisfaction Survey			
	Satisfied	Dissatisfied	Neutral
General Satisfaction	86.2%	6.5%	7.3%
Access to Services	81.5%	8.9%	9.6%
Quality of Services	84.3%	5.6%	10.1%

## Prevention – Stigma Reduction

- Over 80 scheduled interviews
- More than 45 public presentations
- 15 specialty documents, position papers and reports
- Event Videos: Children’s Picnic, Press Conferences, Naloxone, EAC, Art Walk, OK Federation of Families, Server Training, and 2M2L
- Outreach Videos: Faith Partners, FATE, Rx Drug Abuse Prevention, Suicide Prevention, and OKStrong
- Social Media
  - Facebook: Over 1.4K page likes, up by over 400 likes from one year ago
  - Twitter: The Department has sent 474 tweets; the account has 525 followers, and is following 25 other accounts
  - YouTube: Approximately 2,100 video views; 137 views over the past 30 days

## Performance Improvement

- QTD (past 7 years)
  - 144 PI projects submitted
  - Received 104 awards
  - Representing over \$40M in savings!

Commissioner White showed several graphs that marked the improvement in several categories including Follow-up, Engagement, Peer Support, and CAR Scores.

Ms. Henderson asked if there was any area where the Commissioner has not accomplished what she wants. Commissioner White stated that she thinks continued focus on suicide prevention and prescription drug abuse issues are essential. Another area that the Department has been working on for years is people who end up in the criminal justice system, and we need to continue focusing on it and raising awareness.

Major Pulido asked what group should be targeted to raise awareness about mental health and substance abuse issues. Commissioner White stated that the business community would be a great source of untapped potential.

Dr. Beasley moved for the Board Members to go into executive session. Dr. Vanderslice seconded the motion.

ROLL CALL VOTE

Dr. Beasley	Yes	Ms. Henderson	Yes
Dr. Bell	Absent	Dr. Pierce	Yes
Mr. Carson	Yes	Major Pulido	Yes
Mr. Fisher	Yes	Dr. Sullivan	Yes
Dr. Haynes	Yes	Dr. Vanderslice	Yes

The Board Members took a short break before going into executive session.

The executive session started at 10:59 am.

The executive session ended at 12:12 pm.

Mr. Carson moved that the Board rate Commissioner White's performance in all categories presented as exceptional. Dr. Pierce seconded the motion.

ROLL CALL VOTE

Dr. Beasley	Yes	Ms. Henderson	Yes
Dr. Bell	Yes	Dr. Pierce	Yes
Mr. Carson	Yes	Major Pulido	Yes
Mr. Fisher	Yes	Dr. Sullivan	Yes
Dr. Haynes	Yes	Dr. Vanderslice	Yes

**NORMAN LAND PLAN**

Commissioner White suggested that the Board skip the Norman Land Plan agenda item due to being behind on time. She stated that they can do this presentation at a future Board meeting. The Board members agreed.

**DISCUSSION AND POSSIBLE ACTION REGARDING REVIEW OF CERTIFICATION PROCESS AND OVERSIGHT**

Commissioner White gave some background information about the Provider Certification division and a brief overview of the Provider Certification process. There has been an increase in applications for certification due to a change in the Medicaid rules that allows providers a choice between becoming nationally accredited or certified by ODMHSAS. Since the fee for ODMHSAS certification (\$300) is significantly lower than national accreditation, more providers are migrating towards us. We will probably need to add staff to the Provider Certification division to handle the increase in applications and certifications. As

a result, we will be discussing with Legislature and Governor about the potential to raise our certification fees to help cover the increase in expenses.

Commissioner White reviewed the current certification standards which are baseline standards for our providers. She stated that currently, all standards are treated the same. However, she said there are some standards that are more critical than others. For example, some standards are clinical in and are vital to the appropriate treatment and care of a consumer. Commissioner White recommended to the Board that they start the process of raising the standards so that if these critical standards are not being met, the provider should not be granted certification

Dr. Beasley asked why it takes some providers more than one visit to meet the standard. Commissioner White stated that it is rare for most providers to get 100% on the initial visit, although it occasionally happens. For the most part, the providers miss one or two items and have to fix those things which requires a second visit to verify that they are fixed.

Dr. Vanderslice stated that the Department does a much better job now of educating the providers on what is required to receive certification, so they are much better aware of the expectations. As such, it should not take more than three visits to become compliant, especially for critical standards.

Dr. Haynes noted that revoking a provider's certification would put them out of business, but stated that may be appropriate if they are not providing appropriate care. Dr. Bell pointed out that these site visits are announced in advance and the providers have plenty of time to get their paperwork together.

Mr. Fisher asked what the process is for revocation. Durand Crosby stated that once we determine a provider should have its certification revoked due to failing to meet the standards approved by the Board, we file a petition and go before an Administrative Law Judge and present evidence proving the provider is deficient. The provider is also given the opportunity to present its side to show that it is meeting the necessary standards. If the Department prevails at the hearing, the provider has the ability to appeal to the ODMHSAS Board members at a Board meeting. If, after review of the evidence and transcript of the hearing, the Board members agree with the Administrative Law Judge, the provider can then appeal to the District Court and all the way up to the Oklahoma Supreme Court.

Mr. Carson moved to ask the Department to change the certification and revocation process. Dr. Sullivan suggested amending the motion to reflect that the Board is asking the Department to make recommendations for revisions that are then presented to the Board for approval. Mr. Carson accepted Dr. Sullivan's amendment. Ms. Henderson seconded the amended motion.

### ROLL CALL VOTE

Dr. Beasley	Yes	Ms. Henderson	Yes
Dr. Bell	Yes	Dr. Pierce	Yes
Mr. Carson	Yes	Major Pulido	Yes
Mr. Fisher	Yes	Dr. Sullivan	Yes
Dr. Haynes	Yes	Dr. Vanderslice	Yes

The Board Members took a short break for lunch.

### **PRESENTATION BY DURAND CROSBY**

Mr. Crosby gave a presentation to the Board members regarding their legal protections as State Board Members. He explained how the Governmental Tort Claims Act protects board members against claims of negligence for decisions they make within their capacity as board members. He further discussed various exemptions and exclusions under the Act. Mr. Crosby also stated that the State takes out a Directors and Officers Insurance Policy which provides additional coverage for Board members of up to \$5 million per claim, and \$35 million total aggregate for entire States. He discussed that the policy covers breaches of duty and neglect, and includes claims for: wrongful termination, sexual harassment, discrimination, retaliation, defamation, and plagiarism, and mentioned that certain actions are excluded from the policy, such as any criminal or fraudulent acts. Mr. Crosby noted that as recently discussed in the media regarding another state agency, one area we need to continue to be vigilant in surrounds the requirements under the Open Meetings Act. He stated that the purpose of the Act is to help inform the public of governmental processes and issues, and therefore, most of board discussions and all board actions must take place in open sessions. However, the Act does recognize certain situations for executive sessions such as discussing personnel matters, confidential communications with our attorneys to discuss pending litigation, or matters that are confidential by law. In these situations, we must follow a process outlined under the Act, and any action the Board wishes to take must not occur until we go back into open session.

There was discussion regarding how topics that might require executive session are listed on the meeting agenda.

### **DISCUSSION AND POSSIBLE ACTION REGARDING PENDING CLAIMS AND ACTIONS**

The Board indicated that they wished to discuss a pending claim that had recently been made against the Department. The Department's General Counsel, Dewayne Moore, advised that discussion of this claim, and in particular, discussion of the Department's defense strategy to this claim, would seriously impair the ability of the Department to process and defend itself against this claim. Gail Henderson stated that based on the advice of our General Counsel, she moved the Board members to go into executive session. Dr. Pierce seconded the motion.

ROLL CALL VOTE

Dr. Beasley	Yes	Ms. Henderson	Yes
Dr. Bell	Yes	Dr. Pierce	Yes
Mr. Carson	Yes	Dr. Sullivan	Yes
Mr. Fisher	Yes	Dr. Vanderslice	Yes
Dr. Haynes	Yes		

The executive session started at 1:25 p.m.

The executive session ended at 2:25 p.m.

Dr. Pierce made a motion to approve the Department vigorously fighting the false claims filed by Ms. Poff and Mr. DeLong, and further recommended that the Department immediately retain counsel to defend the Board, the Department, and the individuals named in the lawsuits. Dr. Beasley seconded the motion.

ROLL CALL VOTE

Dr. Beasley	Yes	Ms. Henderson	Yes
Dr. Bell	Yes	Dr. Pierce	Yes
Mr. Carson	Yes	Dr. Sullivan	Yes
Mr. Fisher	Yes	Dr. Vanderslice	Yes
Dr. Haynes	Yes		

**DISCUSSION AND POSSIBLE ACTION REGARDING MODERNIZATION OF MENTAL HEALTH SYSTEM**

Carrie Slatton-Hodges gave a presentation on “The Role of State Psychiatric Hospitals” including the history of psychiatric hospitals, their current status, and possibilities for the future of psychiatric hospitals.

History

- In colonial times, persons who were considered “demented” were placed in a local jail or almshouse if no relative or neighbor would care for them. With little oversight and funding, this way of care became environments of widespread abuse.
- Although initially based on principles of moral treatment, institutions became overstretched, non-therapeutic, isolated in location, and neglectful of patients.
- In the 1840s, Dorothea Dix led a movement to establish a national policy for caring for persons with mental illness and for federal lands to be set aside across the country dedicated to asylums outlined in the “12,225,000 Acre Bill.” The movement emphasized the need for humane care based on compassion and “moral treatment,” rather than ridding the person of demonic possession through corporal punishment.
- The legislation passed Congress in 1854, but it was vetoed by President Franklin Pierce who stated that responsibility for the care of the mentally ill should be placed on the states, not the federal government.

- States were left to rely on state tax dollars to fund these facilities. Despite the veto, Dix's advocacy led to the establishment of 32 psychiatric hospitals in 18 states. The implications of the veto and placement of the responsibility on states have had lasting and fiscal and philosophical effects to this day.
- Initially small facilities
  - Families and communities obtained care for people with mental illness through the state supported asylums.
- Became large public hospitals
  - Housed a mix of individuals
  - Some had mental illness. Others needed long-term care support but did not necessarily have a mental illness.
- Over the years, many state psychiatric hospital roles and missions changed to provide a variety of supports related to the most pressing issues and epidemics of the day.
  - Military hospitals during the Civil War
  - Quarantine and treat people with tuberculosis
  - Hospitals for WWI and WWII veterans suffering from PTSD
- The quality of care, once conceived as reform, deteriorated over time. Concepts of "curability" began to be replaced by concepts of "incurability" leading to long and even lifetime lengths of stay.
- Through the first half of the 20<sup>th</sup> century, the mental hospital system functioned to protect communities and families from dealing with distressed and often distressing patients.
- Economies of scale rationalized increasing size; the patients' quality of life was not part of the cost-benefit equation. Institutions operated on rigid schedules tailored to bureaucratic needs. Locked doors, loss of personal control, the regimentation of everyday life, separation from family and community, and unoccupied days of hopeless despair led to a social breakdown syndrome superimposed on the initial illnesses that led to admission.
- The longer the stay, the sicker the patient became. The symptoms generated by anomie were attributed to disease in the patient. The hospital contributed to the very chronicity that fed its growth.
- The number of in-patients in state and county mental hospitals continued to increase dramatically during the first half of the 20<sup>th</sup> century: from 188,000 in 1910 to 512,000 in 1950. At that rate of growth, the census was projected to exceed 700,000 within 20 years.
- Instead, it peaked at 550,000 persons in 1956, slowly receded in the next two decades (to 535,000 in 1960 and to 338,000 in 1970), and fell precipitously in the last 25 years to about 190,000 in 2000.
- By the 1950s and 1960s, a two class system:
  - U.S. Middle and Upper Class Patients
    - Had insurance or could afford services
    - Sought psychoanalytically oriented outpatient psychotherapy with private practitioners.

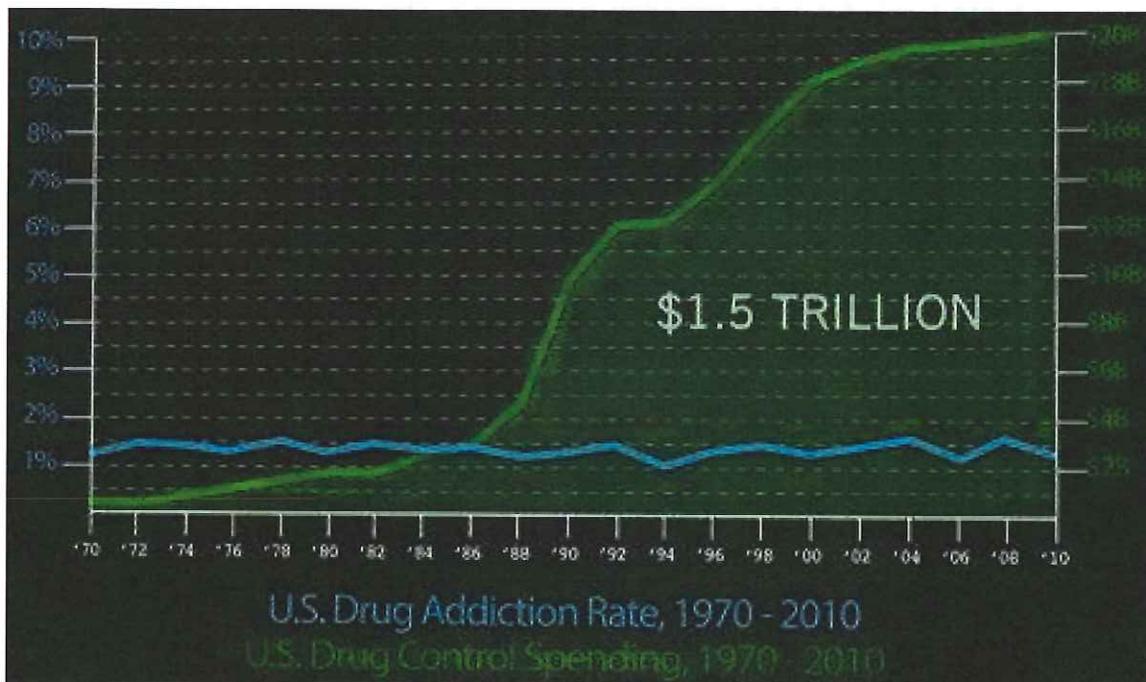
- U.S. Lower Working Class Patients
    - Cared for in grossly under-resourced state or county mental hospitals.
- In 1963, President John F. Kennedy introduced the Community Mental Health Centers Act. He believed that eventually all but a small portion of those residing in large mental institutions could be served in the community.
- In 1965, Medicare and Medicaid were signed into law. Federal funds offered fiscal relief to state budgets. Medicaid offered matching funds to the states from the federal government. Once patients were discharged, their housing, medical and general welfare costs were jointly shared between federal and state budgets. Specialty psychiatric hospitals were excluded from Medicaid coverage, but nursing homes were not. Thus, there were significant savings if states were able to transfer psychiatric inpatients to nursing homes. Medicaid along with Medicare became the largest supporters of the mentally ill in the U.S. without ever being labeled mental health programs.
- In 1966, establishment of national legislation for the long-term treatment and rehabilitation of narcotic addicts, and alcoholism, which was recognized as a major public health problem with the establishment of the National Center for Prevention and Control of Alcoholism (established as part of NIMH).
- In 1968, Congress passed the Alcoholic and Narcotic Addict Rehabilitation Amendments, which integrated services for the prevention and treatment of alcohol and drug addiction with the CMHC Act.
- In 1970, CMHC Amendments identified children as needing special mental health programs.
- From 1970 to 1973, there was resistance to spending money allocated to CMHCs. Only \$50.5 million was allocated out of the authorized \$340 million. Congressional support continued through expansion and renewing of the CMHC Act, even though Presidential support and funds were lacking.
- In 1975, the number of patients in mental hospitals had declined by 62%. Idealists believed that state and local resources would follow patients after their discharge from state institutions, as funds would be redirected from state hospitals to community-based care. This proved to be a false assumption. Federal funding was provided to the states for the initial establishment of community mental health centers, with the provision that those funds would be discontinued in favor of state funding. However, in legislature, the states failed to allocate adequate funding, leading to a mental health system bereft of resources.
- In 1980, deinstitutionalization was in full swing. President Carter's Mental Health Systems Act of 1980 provided federal funding for community mental health programs, focusing particularly on the chronically mentally ill, children and youth, the elderly, rural and minority populations. It was

- not passed, and that funding never came about. While many changes occurred between 1963 and 1980, no coherent national policy emerged.
- In 1981, President Reagan turned over to the states all responsibility for the provision of mental health services. It was at this time that the changeover from categorical to block grant funding transferred responsibility for community mental health to state governments, reversing one of the most fundamental principles of the CMHC Act. Surprisingly, the once-unwilling states, in the years following the creation of the Reagan block grants, expanded total state outlays for alcohol, drug abuse, and mental health programs from 3% to 24%. Despite this state willingness to serve its mentally ill, mental health policy in America continues to fail its neediest. Mental health policy since the 1980s has had little to do with legislation, and much more to do with insurance.
  - Is there a role for state hospitals anymore? The answer is yes.
  - State Psychiatric Hospitals' Role today
    - Vital part of the continuum of care
    - Should be recovery-oriented
    - Focused on service recipients returning to a community quickly when they no longer meet inpatient criteria
    - Not a person's home
    - Should be integrated with a robust set of community services
  - Misconceptions about people with mental disorders "released" into the community must be addressed.
    - Research: Despite perceptions by the public and media that people with mental disorders released into the community are more likely to be dangerous and violent, a large study indicated that those without substance abuse symptoms are no more likely to commit violence than others without substance abuse symptoms in their neighborhoods, which were usually economically deprived and high in substance abuse and crime. The study also reported that a higher proportion of the patients than of the others in the neighborhoods reported symptoms of substance abuse.
  - The top three offenses that are landing individuals in jail are as follows:
 

○ Drug Offenses	50.1%
○ Immigration	10.6%
○ Sex Offenses	6.1%
  - At the same time that mental hospitals were being deinstitutionalized, other factors came about that contributed to the rise in incarceration rates.
    - In 1971, President Richard Nixon declared a "War on Drugs."
    - In 1984, the Sentencing Reform Act was implemented which placed mandatory minimums and 85% rules in place.
  - Research
    - Findings on violence committed by those with mental disorders in the community have been inconsistent and related to numerous factors; a higher rate of more serious offences such as homicide have sometimes been found but, despite high-profile homicide

cases, the evidence suggests this has not been increased by deinstitutionalization. (Sirotych, 2008; Stuart, 2003; and Taylor & Gunn, 1999)

- Mental disorders are neither necessary nor sufficient causes of violence. Major determinants of violence continue to be socio-demographic and economic factors. Substance abuse is a major determinant of violence, and this is true whether it occurs in the context of a concurrent mental illness or not.
- Therefore, early identification and treatment of substance abuse problems, and greater attention to the diagnosis and management of concurrent substance abuse disorders among seriously mentally ill, may be potential violence prevention strategies. (Stuart, 2003)
- Drug Addiction Rate and Drug Control Spending 1970-2010



- Demand for Inpatient beds
  - The demand for the number of inpatient beds appears to be inversely correlated to the robustness of the community mental health system.
  - State psychiatric hospitals should not be a solution or default system for an underfunded or fragmented community system of care.
  - State psychiatric hospitals are not a solution to increases in homelessness and incarceration.
  - Further, poor access, fewer community services, and insufficient related supports such as housing, employment, and income do not justify an increase in community and state psychiatric hospital beds.

- The Role of State Psychiatric Hospitals Revisited: state psychiatric hospitals are a vital treatment component in the healthcare system to assess, evaluate, and treat the most complex mental health and substance use conditions and should include the expectation of discharge to a continuum of a robust set of community supports.

Dr. Sullivan asked what the percentage is of individuals who are being housed at our facilities. Deputy Slatton-Hodges stated that it is very low, and the reason most of them are staying longer than necessary is because there are not sufficient community resources and supports. Most of these individuals have very complex diagnoses that include developmental issues, and our society does not have adequate resources to take care of those individuals in the community.

Deputy Slatton-Hodges also explained the different housing options available to our consumers. She stressed that we consider group homes to be more like transitional housing and encourage consumers to move toward independent living in the community.

## **DISCUSSION AND POSSIBLE ACTION REGARDING FY15 BUDGET AND STRATEGIC INITIATIVES**

### **FY15 Strategic Initiatives**

- Suicide Prevention – Deputy Commissioner Slatton-Hodges explained some of the work that they are planning for the Zero Suicide Initiative. There was discussion about whether or not that is a reasonable goal.
- RFP for Substance Abuse Contracts – Historically, all contract funding went to existing contracts without much opportunity for new providers to contract with the ODMHSAS because there was never any extra money. We would like to be able to include new providers in our system and also evaluate current providers based on quality outcomes. The new RFP process will try to ensure that contracts are awarded based on need and population, and providers will compete based on quality outcomes. This makes our system more transparent.
- Independent Assessors – It is the Department’s goal to start reviewing the options for using Independent Assessors to complete the initial assessment of a consumer to determine the treatment needs of the consumer. The consumer would then go to another provider to receive those services.
- Wellness/Integration with Physical Health – The Department has focused on Tobacco Cessation to improve the physical health and wellness of our consumers. It is estimated that 44% of all smokers have a severe mental illness. ODMHSAS has made huge progress in decreasing tobacco use. The Tobacco Settlement Endowment Trust has awarded several grants to the Department because of the progress we have made. The next big focus is on the Big 4 - BMI, blood pressure, glucose, and cholesterol. Our staff will be talking about these factors with our consumers to help them with their overall health. ODMHSAS will also be working more on SBIRT.

The Department has received a \$1.5 million grant to focus on SBIRT and pushing this initiative out to primary care offices.

- Prescription Drug Initiative – There are many agencies who are involved in working on this initiative, but ODMHSAS is leading the way.
- Social Marketing – ODMHSAS Leadership has been discussing ways to improve the image of the Department. This is the year that the time is right to move forward. We would like to change the way people view mental illness which is usually negative because they're seeing the effects of untreated mental illness. We would like to show people what treatment can do, and how people who have received treatment are succeeding. This initiative will focus on multiple platforms and multiple vehicles to get the message out.
- Buildings and Infrastructure – The Department's buildings, especially Central Office, are falling apart. It is necessary to work on our buildings and infrastructure this year to ensure the safety of our consumers and employees.
- Budget – This next year the Budget will be a huge issue. It is estimated that some agencies will be facing budget cuts again this year.

**ADJOURNMENT**

Mr. Carson made a motion to adjourn the meeting. Dr. Pierce seconded the motion.

**ROLL CALL VOTE**

Dr. Beasley	Yes	Dr. Pierce	Yes
Dr. Bell	Yes	Dr. Sullivan	Yes
Mr. Carson	Yes	Dr. Vanderslice	Yes
Ms. Henderson	Yes		

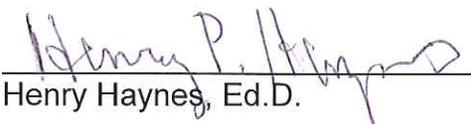
The meeting adjourned at 3:35 p.m.

  
 \_\_\_\_\_  
 Stewart Beasley, Ph.D.

  
 \_\_\_\_\_  
 Brent Bell, D.O.

  
 \_\_\_\_\_  
 Joel Carson

\_\_\_\_\_  
 Bruce Fisher

  
 \_\_\_\_\_  
 Henry Haynes, Ed.D.

  
 \_\_\_\_\_  
 Gail Henderson, M.Ed.

  
 \_\_\_\_\_  
 Paul Pierce, M.D.

  
 \_\_\_\_\_  
 Major Ed Pulido

  
 \_\_\_\_\_  
 J. Andy Sullivan, M.D., Chair

\_\_\_\_\_  
 Ronna Vanderslice, Ed.D.