

# Improving Oklahoma's Mental Health Care System

a position paper developed by  
NAMI Oklahoma  
*The National Alliance on Mental Illness Oklahoma*  
1 December 2007

## Introduction

The **Executive Summary** is on page 8.

On December 1, 2007 the Board of Directors of **NAMI Oklahoma**, the National Alliance on Mental Illness Oklahoma, approved this position paper establishing 14 issues which currently have an important negative impact on mental health care in Oklahoma. We believe these 14 issues are in need of improvement to enhance the quality of life for mentally ill Oklahomans and their families.

**NAMI Oklahoma** is an advocate for change, assisting in positive outcomes for the treatment of mental illness. This position paper provides information from the point of view of families, guardians and caregivers of consumers in Oklahoma's mental health care system. In addition this paper is intended to assist the Oklahoma Department of Mental Health and Substance Abuse Services during the current effort to modernize and organizationally redesign the existing mental health care system.

The impetus for including an issue in this proposal is personal observations and experiences while working to obtain services for family and friends. It is recognized that some detrimental conditions are the product of laws and policies at higher levels of government or of inadequate funding levels. It is our opinion that as a part of the current *Transformation Initiative* these problems should be highlighted, specific change proposals formulated, and petitions for change presentations made to responsible entities. In addition, these petitions for change should be updated and accomplished annually until change has been completed.

## Needed Improvements

1. *Community Based Mental Health Centers*
2. *Housing*
3. *Clubhouses*
4. *Criminal Justice*
5. *Mental Health / Substance Abuse Parity*
6. *Schools*
7. *Facility Requirements for persons with Serious Mental Illness (SMI)*
8. *Privacy*
9. *Referrals*
10. *Assisted Outpatient Treatment (AOT)*
11. *Supplemental Security Income (SSI)*
12. *Staffing for Inpatient and Outpatient Care*
13. *Organizational Representative Payees*
14. *Licensing*

## Defining Needed Improvements

### *Community Based Mental Health Centers*

**Current Problem** – The private not-for-profit and state funded community mental health centers consistently report no growth funding for core services for several years.

### **Review for Improvement** –

1. Budget neutral funding for several years has resulted in inadequate staff compensation, high turnover and high *case loads* that do not allow for comprehensive community based services.
2. Oklahoma Medicaid behavioral health reimbursement rates remain inadequate for the cost of the service provided.
3. State funding levels and Medicaid behavioral health reimbursement rates do not provide sufficient funding to Community Mental Health Centers for reimbursement for individual psychotherapy for trauma victims and other psychiatric disorders.

4. Pharmacy and psychiatric medication funding levels have also been budget neutral for several years resulting in significant budget stress or shortfalls for the Community Mental Health Centers. While funding levels have remained virtually unchanged, it is estimated that the wholesale cost of psychiatric medications have increased by approximately seven percent annually for the past five years.
5. *Federal Mental Health Block Grant Funding* reductions will continue beyond 2006 in stark contrast to the *President's New Freedom Commission* recommendations regarding funding for community-based services.
6. Provide for dental care and shared office arrangements for general health care.
7. Assure quality and timeliness of service provided by contract services locations.

**Advantages** – By adequately funding core community based mental health services, more persons will be served and those served will have access to all the best practices in contemporary behavioral health and the most effective medications. Adequate funding will allow for improved engagement and retention in services for persons served and enhanced outreach services for individuals who experience difficulty in engaging in services. Increasing funding levels for community-based core services will result in improvement of more serious problems and suffering for persons served. Such improvement in funding will result in reducing the overall cost of providing services by preventing utilization of more expensive and higher levels of psychiatric care.

**Major Drivers for Implementation** – Funding Increase

*Note: Core services include: Crisis Intervention, Medication and Psychiatric Services, Case Management Services, Evaluation and Treatment Planning, Counseling Services and Psychosocial Rehabilitation Model Day Services.*

*Comprehensive Community based services include: employment, housing, education, and other medical, dental and other support enabling consumers to function in the community.*

### **Housing**

**Current Problem** – Shortage of available housing results in homelessness. Equal access to housing is not currently available for individual consumers. By any modern measure much of the available housing is substandard.

**Review for Improvement -**

1. Expansion of the *McKenzie Gardens Norman, Oklahoma* housing model to include graduated housing modules. For example there might be three modules. The first module requiring more extensive health care staff supervision than the third module. With the modular concept all consumers should have an appropriate level of housing service available. These levels of service vary from an inpatient residence to residences with relatively little staff supervision.

2. Define a level of recovery appropriate for access to each housing module. Health care staff should be able to determine if a consumer is stabilized to a sufficient degree to justify access to housing beyond inpatient care. This staff determination should override the current policy of withholding access because of consumer's legal and credit history.
3. Implement uniform and decent housing standards for all residential facilities.

**Advantages** – Fair and equal access for each consumer. Provide a model to work towards ending homelessness and substandard housing among consumers.

**Major Drivers for Implementation** – Funding Increase and Policy Change.

### **Clubhouses**

**Current Problem** – Lack of availability. Currently there are two, free-standing, certified clubhouses in Oklahoma. These are Crossroads in Tulsa and Thunderbird in Norman. These are licensed by Fountainhouse Clubhouse in New York City and certified by the International Center for Clubhouse Development. In addition some Community Mental Health Centers have imbedded clubhouse functions that are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).

**Review for Improvement –**

1. Involve communities in the establishment of certified clubhouses.
2. The Department of Mental Health and Substance Abuse Services should become proactive in helping communities, not presently served, to establish new clubhouses.
3. Work to establish new clubhouses using existing certified, free-standing clubhouses as a best practices model.
4. Establish Medicaid regulations for clubhouse billing.

**Advantages** – Provides consumers with necessary contact with other people and productive activities. Clubhouses greatly enhance the likelihood of recovery success. Clubhouses are an integral partner and enhance the success of the *Psychosocial Rehabilitation Programs* at the Community Mental Health Centers. Furthermore, Clubhouses are configured to enlist support and involvement from the surrounding community.

**Major Drivers for Implementation** – Funding increase and Policy Expansion.

### **Criminal Justice**

**Current Problem** – Many nonviolent mentally ill offenders are incarcerated in our jails and prisons. Many county jails use medications for behavior control. Often this mistreatment occurs for many months, until the inmate is transferred to the Department of Corrections. Although the Department of

Corrections is not adequately funded to do so, it does make an effort to provide mental health care.

**Review for improvement –**

1. The Department of Mental Health and Substance Abuse Services should be proactive in assisting local counties to establish *Mental Health Courts* and necessary support services, staffing and facilities in counties that do not have these judicial diversion tools.
2. The Department Of Mental Health and Substance Abuse Services should initiate and support changes to accommodate consumers who are offenders, non-violent and deemed appropriate for moving to a treatment environment rather than a jail or prison setting.
3. Fund the Department of Corrections for professional mental health care staff.
4. Fund access to all generations of pharmaceuticals.
5. Availability of Jail and Prison Diversion/Day Reporting Programs, forensic PACT teams, Crisis Intervention Team trained officers, safe housing and follow-up outpatient care after discharge.
6. Update Oklahoma’s Sexual Assault Laws to hold blameless consumers who are homeless, untreated and because of their illness are guilty of nothing more than relieving themselves in public places such as under bridges and parks. In these cases it is clear that there is no intent to violate decency laws, to offend others or to commit an act of sexual indecency.

**Advantages –** Divert consumers to treatment instead of incarceration. Lower the number of consumers in our jails and prisons. Enhance the possibility of treatment and recovery. Lower the rate of repeat offenders.

**Major Drivers for Implementation –** Funding Increase and Policy Change.

*Note: The Department of Corrections and the various Sheriff’s Department’s are not the subject of this paper. However, there are presently several thousand mentally ill offenders being held in Oklahoma’s prisons and jails. Oklahoma currently funds only the Department Of Mental Health And Substance Abuse Services pathway for mental health care. If the parallel Department of Corrections pathway were funded, incarcerated consumers would be given a chance for recovery and rehabilitation. We believe it is time for the Department of Corrections, the County Sheriffs and the Department Of Mental Health and Substance Abuse Services to come together and address these needs for Oklahoma.*

**Mental Health / Substance Abuse Parity**

**Current Problem –** Currently many individuals with mental health and addiction disorders do not have access to appropriate medical care. Almost no health insurance plans offer coverage for these diseases comparable to that provided for other medical conditions. In addition if coverage is offered there are usually severe financial and treatment limitations. This restricted access to insurance coverage results in a lack of

financial support needed to provide healthcare resources for treatment delivery.

**Review for Improvement –**

1. Exposing the myth that Parity is an unfunded mandate.
2. Group Health Insurance Plans for large organizations.
3. Group Health Insurance Plans for small organizations with 50 or less employees.
4. Insurance Plans for Individuals.
5. Premium increase exemption for employers.
6. Comparable Medicaid / Medicare reimbursement rates.
7. Discriminatory co-payments and deductibles for inpatient and outpatient care.
8. Complex prior authorization protocols prevent access to treatment.
9. Step protocols for medications.
10. Match insurance coverage to take advantage of current medical science.
11. Broad-based versus diagnosis specific. Using the American Psychiatric Associations Diagnostic and Statistical Manual of Mental Disorders (DSM), Evidence-based practice (EBP) and Emerging best practice.
12. Parity eliminates discrimination and stigma- a civil rights issue.
13. Additional inpatient beds.
14. Medicaid cap of 5 prescriptions.
15. Medicaid Dental Care beyond extractions.
16. Medicare 50 vs 80 percent reimbursement rates.
17. Medicare 190 day lifetime limit versus unlimited lifetime payment to general hospitals, Medicaid (ages 22-65) exclusion and private insurance reimbursement for inpatient treatment at *Institutions for Mental Disease*.

*Note: Medicare and Medicaid issues must be addressed at the Federal level. Small organizations with 50 or less employees provide 83% of Oklahoma jobs.*

**Advantages –** Biologically based brain disorders would be treated by insurance companies like any other physical illness. Parity would mean that health insurance plans must cover the same range of mental illness and addiction that Members of Congress and other federal employees receive under the Federal Employees Health Benefits Program. Expanded coverage lowers the societal cost of unemployment, divorce, domestic violence, suicide, violence to others, school dropouts, unwanted pregnancies and incarcerations. Employers will benefit with higher productivity, lower absentee rates, reduced claims for disability and lower workers’ compensation costs. In addition the costs of other medical problems will go down. This approach supports early detection and treatment limiting damage caused by the illness, allowing increased use of outpatient treatment which results in efficient use of resources and positive outcomes for consumers.

*Note: Of all people diagnosed with a mental disorder, 29 percent abuse either alcohol or drugs. These are clearly two*

problems which go hand in hand and need to be treated as such.

**Major Drivers for Implementation** – Policy Change.

### **Schools**

**Current Problem** – Today’s schools are attended by more people who suffer from mental illness than ever before. This is true at Primary, Secondary and at the Higher Education levels. This situation presents a unique set of challenges as well as opportunities. The challenges include classroom disruption, the lack of communication between parents, medical professionals and school personnel and overcoming problems that are unknown because of this lack of communication. The opportunity is created if communication is open and school personnel are trained to recognize the medical condition and trained to help these ill students.

**Review for Improvement** –

A. Primary Schools – Administrators, teachers, coaches, counselors, medical staff and security personnel should be trained to recognize, provide realistic classroom accommodation, assist with referrals to proper treatment and to work with parents students and personal physicians to aid the mentally ill student. Models used can include the following

1. NAMI Hope for Tomorrow preventive program
2. NAMI Visions for Tomorrow Course
3. NAMI Family to Family Course
4. Police CIT Crisis Intervention Training
5. DMHSAS - Oklahoma Systems of Care
6. Parental consent and student assent.
7. ODMHSAS Resource Call Center.
8. Parents and Teachers as Allies Program.

B. Secondary Schools – Administrators, teachers, coaches, counselors, medical staff and security personnel shall be trained to recognize, provide realistic classroom accommodation, assist in referrals to proper treatment and to work with parents, students and personal physician to aid the mentally ill student. In addition perform mental health screening and assessment. Models used can include the following

1. NAMI Hope for Tomorrow preventive program
2. NAMI Visions for Tomorrow Course
3. NAMI Family to Family Course
4. Police CIT Crisis Intervention Training
5. DMHSAS - Oklahoma Systems of Care
6. Establish Risk analysis by age
7. Implement the New Freedom Commission recommended TeenScreen Program
8. Parental consent and student assent
9. ODMHSAS Resource Call Center
10. Parents and Teachers as Allies Program.

C. Colleges and Universities – Administrators, student advisors, campus residential managers, student health services, and campus police shall be trained to recognize, assist in referrals to proper treatment and to work with parents and students to aid the mentally ill student.

1. DMHSAS - PACT (Program of Assertive Community Treatment program
2. Police CIT Crisis Intervention Training
3. NAMI Family to Family Course
3. Student health service
4. DMHSAS - Oklahoma Systems of Care
5. DMHSAS Crisis Centers
6. DMHSAS Community Mental Health Centers
7. Student consent for parental notification
8. ODMHSAS Resource Call Center

**Advantages** –Early identification and referral to effective services avoids losing critical developmental years. Communication with families can help reduce the pain and suffering all too often experienced by students with undiagnosed and untreated mental and emotional disorders. In addition this will address the problem of suicide among 10 to 24 year olds and the high dropout rate among students with mental disorders. This program will lower the rate of incarceration and address security issues involving mentally ill students.

**Major Drivers for Implementation** – Funding increase and Policy Change.

*Note: To implement this mental health and wellness program the support of employee groups such as the OEA and Peace Officers Association must be enlisted. In addition this program should operate under a standardized state wide mandate with implementing regulations from the Oklahoma Department of Mental Health and Substance Abuse, the Department of Education and Oklahoma Regents for Higher Education.*

### **Facility Requirements for Persons with Serious Mental Illness**

**Current Problem** – The established inpatient admission criteria are not meeting the medical needs of consumers. These criteria deny many people medically appropriate admission and treatment. Untreated, their illness progresses until many severely ill consumers have problems with law enforcement officials. These admission criteria are a major contributing factor to the problems of homelessness and overcrowding of Oklahoma jails and prisons. Today mental health care has progressed so that many people are able to function without the need for continuous inpatient care. At the same time there remain large numbers who require periodic stabilization as an inpatient. As inpatient bed space has disappeared, it has become apparent that inpatient care continues to be a need of modern consumer treatment and recovery.

**Review for Improvement** –

1. Changes to the current admission criteria, a risk to self or others, to allow for early treatment of persons who are determined to be de-compensated or when in the judgment of the consumer’s physician it is needed.

2. Expand inpatient bed space and staffing to accommodate the need as demonstrated by current community demand for service.
3. Request changes or waivers to public law so that the *Institution for Mental Diseases* exclusion is eliminated.
4. Access to all generations of pharmaceuticals.
5. Assure quality and timeliness of service provided by contract services locations.

**Advantages** – Early intervention in the progression of mental disease means that consumers can be stabilized faster making more efficient use of the inpatient resources, reducing total cost per consumer. In addition to more effective use of resources, the probability of a good recovery dramatically increases. New cases can be more efficiently handled by earlier intervention with inpatient or stabilization services. This earlier treatment will result in less homelessness and crowding of our jails and prisons. We believe the best solution requires close scrutiny of inpatient bed capacity and increased access in those communities that lack adequate capacity.

**Major Drivers for Implementation** – Funding Increase and Policy Change.

### *Privacy*

**Current Problem** – Currently when consumers most need the support of family and friends they are separated by privacy laws. The consumer loses the advantage of help from his or her family when the consumer is least able to make rational decisions in his or her own best interest.

#### **Review for Improvement -**

1. Make Durable Powers of Attorney operative.
2. Make Mental Health Advance Directives operative.
3. Revocability.
4. Assist families with emergency/permanent guardianship requests.

**Advantages** – Consumers of mental health care should have the same advantages as patients of any other medical specialty. Durable Powers of Attorney and Mental Health Advance Directives executed when the consumer is in a good state of recovery should remain in force when the consumer becomes incapacitated by their mental disease. Consumers should not have the authority to revoke these documents while incapacitated. This gives the consumer and family confidence that the proper care is being administered. Since family and friends are usually the first to notice a worsening of the mental health condition, these improvements can aid in earlier intervention and treatment.

**Major Drivers for Implementation** – Policy Change.

*Note: Illinois, Maine, Pennsylvania, New Jersey, Missouri and Delaware have already addressed this issue.*

### *Referrals*

**Current Problem** – Continuity of care can be lost as the consumer moves between outpatient care, inpatient care, and other medical specialties or to a new primary care psychiatrist. Many times medical history is not readily available. Continuity of drug therapy is easily lost. Lack of familiarity with the consumer makes it hard to consult with other medical specialties that may be involved with the consumer. Finally all this confusion and change can cause a loss of confidence by the consumer.

#### **Review for Improvement –**

1. Coordination and follow up by the primary care psychiatrist.
2. Transferring the consumer to a new primary care psychiatrist.

**Advantages** - Just like any other medical specialty, the primary care psychiatrist should follow the patient through all services. Inpatient hospital physicians / support staff and outpatient clinic staff can support and or inform the primary care psychiatrist throughout the continuum of care. This would give consumers equal access to services, reduce confusion with consumer medical history, maintain ongoing consultations, expedite transference of medical / mental records and would be a boost to consumer confidence.

**Major Drivers for Implementation** – Policy Change.

### *Assisted Outpatient Treatment*

**Current Problem** – Certain consumers are not in treatment for three major reasons. They may not recognize that they are ill. If they have some awareness of their illness they think the problem can be solved without help and that it will get better if left alone. Less often they feel that treatment would cost too much, are unsure of where to go for help or may think that treatment would not do any good. Because of their perceptions, treatment history and present circumstances, these people are unlikely to survive safely in the community without supervision. Presently the mental healthcare system does not have adequate procedures in place to assist these high risk consumers before they become involved with the criminal justice system.

#### **Review for Improvement –**

ODMHSAS should improve educational outreach to make more effective use of current Oklahoma outpatient treatment standards. In addition using Kendra's Law from New York State as a model, establish and integrate court ordered *assisted outpatient treatment* procedures into:

1. The Mental Health Courts.
2. The Community Based Mental Health Centers.
3. The inpatient treatment hospitals.
4. Other healthcare settings including (but not limited to) private practice physicians and *Preventive Assertive Community Treatment* program (PACT)
5. Provide funding for community services to support implementation of the law.

**Advantages** – The adoption of *assisted outpatient treatment* drastically reduces hospitalization, homelessness and contact with the criminal justice system. Changes to the overall mental healthcare system leads to enhanced accountability and treatment. There is less violence in the community resulting in reduced stigma against mentally ill individuals. Finally, these changes can result in recovery and improved lives for these consumers.

**Major Drivers for Implementation** – Funding Increase and Policy Change.

*Note: Five years, 2000 thru 2005, of experience in New York State shows that 747 individuals per year were treated under Kendra's Law. That is approximately 39 per year per million people. In Oklahoma this rate of occurrence would result in about 140 per year. New York's success is due in large part to the increased community based appropriations that accompanied the legislation.*

*It must be recognized, at the time of implementation, that these procedures must adhere to all existing requirements for inpatient admissions.*

### **Supplemental Security Income**

**Current Problem** – When consumers are treated as an inpatient for 30 days or more their *Supplemental Security Income* benefit payments are suspended. Upon release from the hospital the consumer is without income until a reapplication can be made and approved. This leaves the consumer without means to apply for housing or money for other living expenses or medications.

**Review for improvement** –

1. The Department of Mental Health and Substance Abuse Services should become proactive in soliciting changes with the Social Security Administration to correct this injustice. The Department of Mental Health and Substance Abuse Services should provide a single contact point for consumers as well as guardians and families of consumers for recommended referrals to alternate relief agencies and or assistance in gaining reinstatement of *Supplemental Security Income* benefits.
2. The state legislature should appeal to the US Congress to ease the *Supplemental Security Income* rules.
3. Involve communities and agencies such as the United Way to establish a fund to provide temporary payments until *Supplemental Security Income* benefits can be restored.
4. Use the existing case management at the Community Mental Health Clinics as a best practices model.

**Advantages** – Provide consumers with the temporary resources to procure housing, medicines and other living expenses. Assure that consumers are discharged from the hospital with reinstated *Supplemental Security Income* benefits.

**Major Drivers for Implementation** – Policy Change.

### **Staffing for Inpatient and Outpatient Care**

**Current Problem** – Inability to recruit psychiatrists, professional nurses and inadequate professional and sub-professional staffing levels. Low professional and sub-professional staff morale and burnout exists

**Review for Improvement** -

1. Improve working conditions and competitive pay incentives and benefits.
2. Relationships among treatment providers and consumers as well as families, guardians and caregivers of consumers.
3. Training programs.
4. Systems to assure continuous improvements in consumer care as well as staff effectiveness.
5. Utilization of telemedicine.
6. Education debt relief for specialty providers who practice in Oklahoma State facilities after graduation.

**Advantages** – Adequate staffing levels have a direct positive impact on consumer care. Training programs can allow positive reinforcement of good practices. At the same time training can allow a break from the day-to-day routine of work. Better level of training with better morale means less staff turnover and better consumer care. Increasing the use of telemedicine will result in better rural coverage and utilization of available mental health care providers and expand the capacity of a facility to treat larger numbers of consumers.

**Major Drivers for Implementation** – Funding Increase.

### **Organizational Representative Payees**

**Current Problem** – This applies to consumers that are not provided this service by a Community Mental Health Center. Consumers commonly show poor judgment with money management. In addition predators often take advantage of the consumer's inability to care for themselves and their property.

**Review for improvement** –

1. The Department of Mental Health and Substance Abuse Services should become proactive in recruiting Organizational Representative Payees and should, working with Social Security assure the establishment of protective auditing measures. The Department Of Mental Health And Substance Abuse Services should provide a single contact point to consumers as well as guardians and families of consumers for recommended referrals of approved Representative Payees.
2. Involve communities and agencies such as the United Way to establish licensed *Organizational Representative Payees*. Work with institutions such as banks, clubhouses, savings and loans, Community Mental Health Clinics and hospitals in this effort.
3. Use the existing case management at the Community Mental Health Clinics as a best practices model.

**Advantages** – Provide consumers with the necessary trustworthy support structure to help with money management. Prevent victimization of consumers.

**Major Drivers for Implementation** – Policy Expansion.

**Licensing**

**Current Problem** –In some states individuals with mental health and addiction disorders do not always have equal access to licensing procedures. Reasonable accommodation is not always provided to give consumers equal access to professional licensing procedures.

**Review for Improvement** – Review professional licensing to assure discriminatory procedures do not exist in Oklahoma.

**Advantages** – Qualified consumers will be assured to have equal access to be licensed as a professional. Consumers making application for licensing will receive consideration equal to that provided for individuals with other medical

conditions and / or provided for under the Americans with Disabilities Act (ADA). This means consumers will be tested and judged, like any other applicant, on their ability, education and knowledge.

**Major Drivers for Implementation** – Policy Change.

*Note: In Oklahoma licensing procedures are in place for the following professions and occupations: Accountancy, Legal, Alcohol and Drug Counselor, Architect and Landscape Architect, Chiropractic, Medical for Allied Professions (Dieticians, Provisional Dietician, Occupational Therapist and assistants), Medical, Nurses, Perfusionist, Professional Engineers and Land Surveyors, Psychologist, Real Estate and Speech Pathology.*

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**Approval Procedure**

This Document was approved on 1 December 2007. Desired changes may be submitted to the Point of Contact for consideration by the Public Policy Committee. The Committee will submit requested changes along with Committee recommendations to the NAMI Oklahoma Board of Directors for approval.

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**Applications for this Document**

This paper will be posted on the NAMI OK and affiliate web sites and provided to the ODMHSAS / The Innovation Center / Mental Health Transformation Initiative. In addition this paper will be the source document to prepare:

1. Legislative Requests.
2. Standard briefings and presentations for public officials, community leaders and organizations.
3. Outreach to friends and neighbors.

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**Karina Forrest**  
**Executive Director**  
**[kForrest@nami.org](mailto:kForrest@nami.org)**  
**NAMI Oklahoma**  
**405-230-1900**

**500 North Broadway Suite 100 Okla City, OK 73012**  
**[http://www.nami.org/MSTemplate.cfm?Site=NAMI\\_Oklahoma](http://www.nami.org/MSTemplate.cfm?Site=NAMI_Oklahoma)**

**Ken Zorger**  
**NAMI Oklahoma Board Point of Contact**  
**[mycomputer@prodigy.net](mailto:mycomputer@prodigy.net)**

**Dr Ed Hill, MD**  
**NAMI Oklahoma Board Public Policy Committee Chair**

**Wayne Merritt**  
**NAMI Oklahoma Board President**

**1 December 2007**

## Executive Summary

Oklahoma's mental health care system received a grade of D in a 2006 nation wide study released by *The National Alliance on Mental Illness National, NAMI National*. On December 1, 2007 the Board of Directors of **NAMI Oklahoma**, approved this position paper establishing 14 issues which currently have an important negative impact on mental health care in Oklahoma. In addition, Oklahoma's mental Healthcare system has the capacity to treat 60,000 people. This leaves 500,000 untreated and another 11,000 who are in our jails and prisons.

**1. Community Based Mental Health Centers:** Low funding causes a lack of access to core and other services. *Core services* include Crisis Intervention, Medication and Psychiatric, Case Management, Evaluation and Treatment Planning, Counseling and Psychosocial Rehabilitation Model Day Services. *Other services* include other medical and dental.

**2. Housing:** Shortage of and equal access to decent modular housing. Health care staff should determine if a consumer is stabilized to a sufficient degree to access housing beyond inpatient care and this should override the current policy of withholding access because of consumer's legal and credit history. Implement uniform and decent housing standards.

**3. Clubhouses:** Expand the Clubhouse System beyond the two, current clubhouses in Oklahoma; Crossroads in Tulsa and Thunderbird in Norman. Licensing is provided by Fountainhouse Clubhouse in New York City and certification by the International Center for Clubhouses.

**4. Criminal Justice:** Expand incarceration diversion programs. There are presently several thousand mentally ill offenders being held in Oklahoma's prisons and jails. The parallel Department of Corrections mental healthcare pathway should be funded so incarcerated consumers have a chance for recovery and rehabilitation. We believe it is time for the Department of Corrections, the County Sheriffs and the Department Of Mental Health and Substance Abuse Services to address these needs.

**5. Mental Health / Substance Abuse Parity:** All health insurance providers should provide the same coverage for biologically base brain disorders and related substance abuse as for any other physical illness as defined by *Evidence based practice*. This includes private policies for individuals, group plans for small and large organizations, Medicare and Medicaid. Restricted access to insurance coverage results in a lack of healthcare resources required for treatment delivery.

**6. Schools:** Provide schools with the tools to open communication links with families and to provide early identification of untreated mental and emotional disorders so referral to effective services can avoid losing critical developmental years. Address the problem of suicide among 10

to 24 year olds, high dropout and incarceration rates and security issues for students with mental disorders.

**7. Facility Requirements for persons with Serious Mental Illness (SMI):** The established inpatient admission criteria deny many consumers medically appropriate admission and treatment. Untreated they become a major contributing factor to homelessness and overcrowding of Oklahoma's jails and prisons. While many consumers are able to function without the need for inpatient care there remain large numbers who require periodic stabilization as an inpatient.

**8. Privacy:** Durable Powers of Attorney and Mental Health Advance Directives executed when the consumer is in a good state of recovery should remain in force when the consumer becomes incapacitated by their mental disease. Consumers should be given the same advantage as anyone else and not have the authority to revoke these documents while incapacitated.

**9. Referrals:** Primary care psychiatrist, like other physicians, should follow the patient through all services. Inpatient hospital physicians / support staff and outpatient clinic staff can support the primary care psychiatrist. This would give consumers equal access to services, reduce confusion with medical history, maintain ongoing consultations and expedite transference of medical/mental records.

**10. Assisted Outpatient Treatment (AOT):** Certain consumers are not in treatment because they may not recognize that they are ill or that they need help. Less often they feel it would cost too much, don't know where to go or think it would not do any good. Because of their perceptions, treatment history and circumstances, they are unlikely to safely survive. Current procedures do not adequately assist these consumers before they become involved with the criminal justice system. Court ordered, New York's Kendra's Law is the model.

**11. Supplemental Security Income (SSI):** Treatment as an inpatient for 30 days results in the suspension of *Supplemental Security Income* benefits. Upon release, no income is available for living expenses, housing or medications until a reapplication is approved.

**12. Staffing for Inpatient and Outpatient Care:** Inability to recruit psychiatrists and nurses due to noncompetitive compensation and work environment as well as inadequate professional and sub-professional staffing levels. Utilize telemedicine to expand patient access.

**13. Organizational Representative Payees:** Provide a trustworthy support structure for money management to prevent victimization.

**14. Licensing:** Test and judge consumers like any other applicant for professional licensing, on their ability, education and knowledge.