

Uniform Block Grant Application FFY 2016-2017: DRAFT

**Substance Abuse Prevention and Treatment Block Grant (SABG)
&
Mental Health Services Block Grant (MHBG)**

PLANNING STEPS

Step One: Assess the Strengths and Needs of the Service System to Address the Specific Population

Overview of Oklahoma 's Treatment, Recovery Support and Prevention Systems.

Services and supports are available statewide through a network of provider and community based programs. These include 14 community mental health centers (CMHCs), 96 substance use disorder treatment providers, 31 prevention organizations and 83 specialty providers, including housing, faith-based, and consumer and family operated programs. As of January 2015, through a request for proposal, 22 Health Homes (HH) for adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED) were established. Of these, 14 are CMHCs. These HHs are required to provide care coordination and care management to ensure integrated behavioral health and health care. Also, through request for proposal, the ODMHSAS is about to award agencies for substance use disorder services with the intent of increasing availability to a full continuum of outpatient services statewide.

Licensure of most treatment and support service organizations is statutorily required and administered through the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) Provider Certification Division. The ODMHSAS also supervises mandated certifications for Behavioral Health Case Managers and Peer Recovery Support Specialists, and the Alcohol and Drug Substance Abuse Course process (organizations, individual assessors and course facilitators, related to drivers' licenses administrative law reinstatement). The ODMHSAS Central Office in Oklahoma City provides planning, training, technical assistance, oversight, fiscal and accountability support for the entire system. Key Central Office functions include Support for Treatment and Recovery Services, Decision Support Services, Information Technology Services, Consumer Advocacy and Wellness, the Inspector General, Human Resources Management and Development, Finance, Legal, Grants Management, and Provider Certification. All leadership and management structures are organized under the ODMHSAS Commissioner and her executive staff including the Chief Operating Officer, the Deputy Commissioner for Treatment and Recovery Services, and the Deputy Commissioner for Communication and Prevention.

During this planning and implementation period additional attention will be given to various emerging initiatives for the State of Oklahoma. Each is briefly discussed below.

- To care for Oklahomans with acute health issues, the ODMHSAS partnered with the OHCA and developed a state plan amendment for health homes which was approved by CMS in December, 2014. As of January 2015, 22 health home providers have been awarded, serving over 100 locations statewide. The health homes provide coordinated primary and behavioral health integration to adults with SMI and youth with SED.

- The ODMHSAS is partnering with the Oklahoma Department of Veterans Affairs to share a full-time employee for prevention and promotion services reaching veterans and military families.
- To assist with meeting the healthcare needs of returning veterans and their families, the ODMHSAS is expanding its efforts to certify and recruit Veteran Peer Recovery Support Specialists. The shared experiences of military service and a commitment to overcoming the impact of mental health conditions and addictions create a bond like no other between Veteran peers. To ensure that quality Veteran peer support services are available to all, special curriculum is being developed for veterans.
- The ODMHSAS is partnering with Oklahoma State University to develop a support center for schools implementing the Good Behavioral Game. The project will provide the necessary, local infrastructure to assist schools in installing and evaluation the evidence-based programs.
- To more effectively reach young people the ODMHSAS is conducting a multi-media campaign, as a part of the Oklahoma Now is the Time initiative, for transitional youth in Oklahoma, Washington and Okmulgee counties. This campaign is utilizing evidence-based strategies, and approaches that are tailored to young adults in transition like text messaging, e-mail and social media. Messages are being crafted with consideration being given to reading comprehension level, youth culture, specific community culture, user friendliness and the capacity to engage the target audience. Messages are also being designed in relation to stage of readiness for change to ensure the most effective impact.
- To improve access to treatment for the LGBT population, the ODMHSAS has contracted with Be The Change in Oklahoma County, as a part of the Oklahoma *Now is the Time* Initiative, to conduct street outreach activities, specializing in outreach and support to youth and young adults who are LGBT.
- To better inform sentencing decisions, the ODMHSAS has increased use of Risk and Need Screens incorporating Risk-Need Responsivity models that are evidence based and match offender supervision and treatment with offender risk and needs. Matching treatment needs and supervision early in the legal process saves resources and makes reoffending less likely.
- The ODMHSAS is taking a multi-prong approach to combat the opioid issue in Oklahoma, including media campaigns, and training of law enforcement officers to carry and administer a life-saving opioid antagonist, naloxone. Although traditionally administered by emergency response personnel, naloxone can be administered by minimally trained laypeople, which makes it ideal for treating overdose in people who have been prescribed opioid pain medication and in people who use heroin and other opioids. Legislation was recently passed that

allow family members and friends to carry naloxone as well. Naloxone is now available without a prescription at 34 pharmacies across Oklahoma, including four Economy Pharmacy locations and several Walgreens across Oklahoma.

Regional and Local Entities Providing Services and Resources.

As the Single State Agency for Substance Abuse and the State Mental Health Authority, the ODMHSAS fulfills state level responsibilities as regulator and purchaser of services. In some areas of the state, and with specific levels of care, the ODMHSAS also operates as a direct provider of services. Other state agencies collaborate with the ODMHSAS to fulfill similar roles within their authority. Regional and local responsibilities are typically carried out by specific organizations with which the ODMHSAS contracts.

Prevention Services. The 17 Regional Prevention Coordinators (RPCs) serving all 77 counties in Oklahoma are the backbone of Oklahoma's prevention service system. RPCs develop community level prevention work plans in partnership with community coalitions. Community level prevention work is based on the Strategic Prevention Framework and aligned with state prevention priorities. Services focus on achieving sustainable, population level outcomes. The ODMHSAS also administers 2Much2Lose (2M2L) as an overarching moniker of Oklahoma's underage drinking prevention initiative funded by the Office of Juvenile Justice and Delinquency Prevention's Enforcing Underage Drinking Laws Block Grant program. 2M2L initiatives include a youth leadership development program, delivery of AlcoholEdu in Oklahoma schools and the enforcement of underage drinking laws. No SAPT Block Grant funds are used for enforcement, only training and technical assistance and support services to communities and law enforcement agencies. Other programs administered through the ODMHSAS prevention initiatives include the Oklahoma Partnership Initiative funded by the Administration on Children and Families; Screening, Brief Intervention, and Referral to Treatment (SBIRT) services funded by state and foundation sources; the Office of Suicide Prevention funded by the SAMHSA Center for Mental Health Services (CMHS) and state appropriated funds; Mental Health First Aid training program funded by state appropriated resources; the Strategic Prevention Framework Partnerships For Success program funded by SAMHSA Center for Substance Abuse Prevention and state appropriated funds; and Oklahoma's Take As Prescribed initiative supported by state appropriated funds. Two emerging prevention services include a partnership with the Oklahoma Department of Veterans Affairs to share a full-time employee for prevention and promotion services reaching veterans and military families; and the development of Good Behavior Game (GBG) Support Center for Oklahoma schools.

Mental Health Services. The 14 CMHCs referenced earlier serve the state with programs established in approximately 70 cities and towns. Department employees operate four CMHCs in Lawton, McAlester, Norman and Woodward. The other 10 CMHCs are private, nonprofit organizations under contract with the Department. All CMHCs are also Medicaid providers and access funding from a variety of other sources. Community Based Structured Crisis Centers (CBSCCs) for adults operate in Oklahoma City, Tulsa, Clinton, Norman and Muskogee. Through legislative funding in FY13,

ODMHSAS added two additional CBSCCs, one in rural Oklahoma in Ardmore, and one in Tulsa. The Ardmore site is in partnership between the local CMHC and local hospital. The CMHC provides staffing and the hospital provides the physical location. In Tulsa, Family & Children's Services (F&CS) acquired, equipped and now operates the CBSCC. They renovated a facility that houses both the Pavilion 23 hour Urgent Care Center and the CBSCC. The ODMHSAS contracts with other organizations to provide community based mental health and recovery support services including statewide advocacy organizations, independent clubhouses, a peer drop-in center, and housing services and supports. Adult psychiatric inpatient services are provided at Griffin Memorial Hospital in Norman, the Oklahoma Forensic Center in Vinita and at smaller inpatient units located in McAlester, Ft. Supply, Tulsa and Lawton. In FY13, ODMHSAS piloted an Urgent Care service in Oklahoma City and provided funding for two more Urgent Care centers to be paired with the Ardmore and Tulsa CBSCCs. The Urgent Care Centers provide outpatient services to include medication management for persons needing immediate care in order to prevent a psychiatric emergency. The Centers also provide 23-hour respite and observation in order to divert persons as indicated from inpatient or CBSCC placement. The ODMHSAS now funds four urgent care centers: Oklahoma City, Tulsa, Sapulpa and Ardmore.

Substance Use Disorder Services. The substance use disorder (SUD) treatment and recovery services funded through the ODMHSAS service system are provided at 96 facilities, covering all 77 Oklahoma counties. The intention is to offer a full recovery oriented system of care. All SUD treatment organizations must be state licensed (certified). Facilities can be licensed as a basic Alcohol and Drug Treatment Program providing a specific service set or as a Certified Comprehensive Addiction Recovery Center (CCARC) providing a full continuum of care. New administrative code was approved in 2011 authorizing the ODMHSAS to award the new CCARC category of certification permitting facilities that offer a comprehensive array of addiction treatment services to pursue official recognition of that through the state licensure process. The certification process is administered through the ODMHSAS Provider Certification Division. Final decisions for licensures are approved by the ODMHSAS Board. All providers must be Medicaid compensable and many accept other types of third party payment and self-payment. The ODMHSAS funded services are primarily purchased through contracts with private, for-profit and non-profit, certified agencies to provide withdrawal management, residential treatment, halfway house, outpatient, intensive outpatient, and early intervention services with substance abuse block grant funds and state appropriations. These agencies include SUD treatment facilities, community mental health centers, community action agencies, youth and family services agencies, and schools. Among the contracted facilities, the University of Oklahoma Health Sciences Center provides screening, assessment and treatment planning for children with Fetal Alcohol Spectrum Disorder. An essential component to the recovery system is the state's network of Oxford Houses. Currently, there are 80 Oxford Houses throughout the state with more in development. Most of the Oxford Houses have accessed loans from a revolving loan fund administered by the ODMHSAS. The ODMHSAS also directly operates three SUD residential treatment facilities staffed with state employees.

Services for Older Adults. Services to older Oklahomans are available at CMHCs through the general array of adult program services, but specific services targeting older adults and designated older adult staff are limited. Limited resources prevent expansion of current outreach and support efforts and impede the development of additional efforts. The ODMHSAS is currently working on curriculum to begin adding a peer support specialty for older adults to the current training process. Also, specific trainings for serving older adults with mental health issues have begun. The Oklahoma Mental Health and Aging Coalition provides a forum through which a variety of stakeholders advocate for increased, accessible and culturally appropriate services for older Oklahomans. Additionally, the Coalition provides statewide mental health, substance use, prevention and treatment education and advocacy, and partners with other networks that provide services to older adults to integrate and cross-train networks. The ODMHSAS has a Manager of Aging Services who can provide consultation. The manager also works closely with other state agencies who are serving older adults to provide education on the special needs of older adults with mental health problems and to identify appropriate services in the community and in long-term care. Planning Step 2 of this application covers some specific needs and reported gaps in services for older adults.

Problem Gambling Treatment Services. The Oklahoma Gaming industry is represented by over 120 casinos, four horse tracks/racinos, and the Oklahoma Lottery. No prevalence study exists in the State of Oklahoma on those individuals who might have a problem with gambling, however, prevalence studies estimate problem gambling to be on average at 2.59% in the U.S. As many as 101,000 Oklahomans are estimated to need treatment to address problem gambling behaviors. Many subgroups of the population have problem gambling prevalence above the adult average, including adolescents, African-Americans, individuals who are Hispanic, Asians, American Indians, lower socio-economic groups, men, those with substance use and mental health co-morbid conditions, military, college students and casino workers. The impact of problem gambling on the elderly is also an area of attention. Stigma continues to remain a major barrier to people seeking treatment.

Resources to fund treatment for problem gambling behaviors are limited, but the 2005 Oklahoma Education Lottery Act and the Oklahoma Horse Racing State Tribal Gaming Act authorized the ODMHSAS to receive \$750,000 per year to provide problem gambling education and treatment. \$250,000 per year comes from the Native American gaming and \$500,000 from the Oklahoma Lottery. In FY 2014, legislation was approved directing the Oklahoma Lottery to increase funding for program gambling services by \$250,000. In addition to funding authorized, state statute requires certification (licensure) for programs that provide problem gambling treatment services. The ODMHSAS Provider Certification administers this certification process, in accordance with OAC 450:65.

Currently there are eight certified and funded gambling treatment service providers in the State of Oklahoma. As of July 1, 2014, ODMHSAS certification rules were revised

for CMHCs, Alcohol and Drug Treatment Programs, and Comprehensive Community Addiction Recovery Centers to allow for outpatient gambling disorder treatment services as a part of services delivered. In FY 2016 it is projected that more of these programs will become providers of gambling disorder treatment services, resulting in greater geographical coverage for those who need treatment services. Another initiative targeted toward certified Mental Health and Substance Use Disorder treatment agencies was initiated on July 1, 2015 to encourage them to administer the Brief BioSocial Gambling Screen by offering reimbursement at \$5.00 per screen. The goal of this initiative is to increase screening among individuals seeking mental health and/or substance use disorder treatment, to better assess individual comprehensive needs and to allow for intervention on problem gambling issues along with other presenting issues.

In addition to gambling treatment services, the ODMHSAS funds the Oklahoma Association on Problem and Compulsive Gambling for advocacy, training, outreach and prevention services. Oklahoma residents can access services by calling Oklahoma's 24-hour toll-free Problem Gambling Helpline at 1-800-522-4700.

Services for Children and Their Families. Systems of Care are the preferred approach to coordinate services for children and their families. The Oklahoma Systems of Care Initiative (OKSOC) is strategically designed to eventually have local Systems of Care available to children, youth and their families in all 77 counties. Currently, Oklahoma has 80 local Systems of Care sites that cover 74 counties. Funding from SAMHSA and the Oklahoma Legislature has been leveraged to facilitate development of the OKSOC. CMHCs host most of the local Systems of Care sites, and work in equal partnership with local teams and community organizations to ensure that children with Serious Emotional Disturbances (SED) and their families have access to the full array of services they need and want. Community Based Structured Crisis Centers for children, in Oklahoma City and Tulsa, address the emergent needs of children and their families. The ODMHSAS also operates the Children's Recovery Center in Norman to provide inpatient and residential services for children up to the age of 18 with mental health, substance use, or co-occurring disorders.

Oklahoma's Weaving Access for All (WAFA) initiative weaves the values and principles of the state's successful trauma-informed Oklahoma Systems of Care throughout the foster care system, creates a front-door diversion project for the juvenile justice system, and is the cornerstone of the health homes for children with serious emotional disturbance. The WAFA serves children from birth to 21 years of age with emotional, socio-emotional, behavioral, or mental disorders diagnosable under the current version of the DSM or its ICD equivalents. Children qualify if they are unable to function in the family, school, community, or a combination of these, or require interventions from multiple systems. The ODMHSAS and the Oklahoma Department of Human Services (OKDHS) have partnered to provide the Wraparound process for children in foster care who are in danger of going into group homes or other restrictive placements. The original goal of the grant was to serve 300 children statewide during the four years of the grant. This goal has already been met and has been increased to serve 400 children by the grants fourth year.

This grant has assisted the ODMHSAS and the Office of Juvenile Affairs (OJA), the juvenile bureaus and judges in Tulsa and Oklahoma City to develop a plan to divert youth with emotional disturbance from entering their systems. A standardized screening and linkage process identifies youth with potential mental health issues and, when needed, a full assessment is completed. The presiding judge can now more easily refer youth to appropriate community services, including Wraparound for those involved with multiple systems, rather than adjudicating the youth into the juvenile justice system. To date, 265 juveniles have been identified for diversion and 195 have been diverted to community mental health providers.

The ODMHSAS and the Oklahoma Health Care Authority (OHCA) finalized a State Plan Amendment and received approval from the Center for Medicare and Medicaid Services (CMS) to formally establish specialty Health Homes for children with serious emotional disturbance in January 1, 2015. A Request for Proposal was released, and HH providers were identified and awarded in January 1, 2015. There are currently 22 Health Homes in Oklahoma, 21 of which are Health Homes for children. Children's Health Home programs use the Systems of Care philosophy and values, and use of the Wraparound process for those involved with multiple systems. Health Homes are open to children in the custody of the OKDHS and the OJA. The goal is to serve 2,500 children over the course of the first four years.

The Adolescent Recovery Collaborative (ARC) initiative is a SAMHSA funded initiative to serve adolescents ages 12-17 in Oklahoma with primary substance use issues. The ARC has provided the opportunity to bring adolescent substance use issues to the fore front and develop a platform to enhance existing substance use treatment modalities. The grant has allowed treatment providers to be trained and certified in the evidence based practice Adolescent Community Reinforcement Approach (A-CRA). The grant has afforded ODMHSAS the opportunity to create a call to action for the state to address the adolescent substance use issues in Oklahoma and how as a community the state can improve the outcomes of these young lives through evidenced based screening and treatment. The Global Appraisal of Individual Needs (GAIN) is being utilized at the two originating sites: Latino Community Development Agency (LCDA) and Specialized Outpatient Services (SOS). It is also being utilized at the Norman Addiction Information and Counseling Center (NAIC); a treatment provider for juvenile drug courts. The ARC began the process of a financial map and workforce development plan. The University of Oklahoma (OU) E-Team and ARC developed the online GAIN SS. It will be available to anyone in the state to utilize. The screener will give a score that will indicate whether there is a need to refer for further assessment. The ARC began and completed the process of changing the age range that could receive Peer Recovery Supports, lowering the age to 16 which is billable through Medicaid. The ARC has trained 47 therapists in A-CRA, four agencies have been trained in GAIN I, and over 100 individuals have been GAIN SS trained in regional face to face trainings.

Oklahoma has been increasing focus on the area of infant and early childhood mental health. In May 2014, the ODMHSAS hired a staff member to serve as the Early

Childhood Mental Health Consultant/Trainer to help support development in this area. The vision for Oklahoma's early childhood system of care has been defined as: the social and emotional well-being of Oklahoma's infants, toddlers and preschool age children, their families and caregivers is fostered through an early childhood mental health system of care that is collaborative, developmentally sensitive, relationship focused, trauma informed and spans the continuum of promotion, prevention and treatment. The vision is to be accomplished through four goals: 1) Promote awareness of the significance of infant and early childhood mental health; 2) Enhance the competency of the infant and early childhood workforce to effectively meet the needs of children birth to eight, their families and caregivers; 3) Develop, enhance and expand programs for Infant and Early Childhood Mental Health (IECMH) promotion, prevention, early intervention and treatment to support the well-being of children birth to eight, their families and caregivers; and 4) Establish infrastructure and develop policies to support the integrated Early Childhood System of Care.

Disaster Responses Infrastructure and Services. The ODMHSAS Access Specialist is the designated coordinator for disaster response in partnership with local, state, and federal entities that mobilize following a disaster. The SAMHSA Disaster Technical Assistance Center (DTAC) and the Federal Emergency Management Agency (FEMA) provide additional resources.

Immediately following tornadoes in Oklahoma in late May, 2013, 680 clinicians were trained in Psychological First Aid (PFA) to assist as first responders in the communities most affected by the tornadoes, including Moore, Little Axe, Shawnee, and Carney. Also in response to the disaster, the ODMHSAS deployed 30 staff to "ground zero" within 48 hours of the disaster. Approximately 400 additional individuals provided volunteer services in the affected communities during the operation of the ODMHSAS temporary Disaster Field Office in Moore post-disaster. The ODMHSAS received a FEMA Immediate Services Crisis Counseling Program (CCP) grant to continue providing services to affected communities until July 19, 2013. That Immediate Services grant was approved for extension while the Regular Services grant (RSG) application was reviewed. The RSG was approved, allowing the CCP to continue operation for another nine months. The field operations office only recently closed on June 30, 2015.

As in 2013, the spring of 2015 had extremely active weather. With a two-month long weather pattern of tornados and torrential rains, Oklahoma eventually had 45 of 77 counties declared for Individual Assistance. CMHCs across the state collaborated with the Red Cross and other volunteer agencies to provide crisis services to those affected, but the ODMHSAS did not apply for an ISP for this event. A RSP has been applied for, and the grant will likely be approved in September to carry services forward. In this case, the ODMHSAS will find it necessary to contract with eight community mental health centers across the state in order to provide coverage to such a wide area. Services will focus on outreach and psychoeducation with additional media outreach to assure those in outlying areas get the appropriate information.

Workforce Infrastructure. On a daily basis, approximately 2,040 behavioral health staff provide outpatient and other community based services to children, youth and adult consumers statewide. The majority of these are employed as case managers, counselors, social workers, psychologists, nurses and psychiatrists at the CMHCs. However, other providers are represented in this workforce including Recovery Support Specialists, Family Support Providers, and residential support staff. The ODMHSAS provides ongoing training and performance improvement opportunities to all providers throughout the system, including employees of the ODMHSAS and staff from partnering organizations. The ODMHSAS Human Resources Development training programs recorded combined audiences of over 25,868 participants from all areas of Oklahoma in state fiscal year 2015. E-learning and the telehealth infrastructure continue to be integral to the training of the behavioral health workforce.

Populations and Targeted Services. Descriptions of specific services, systems, and needs of target populations are listed below. These align with the framework historically mandated separately for both the MHSBG and SAPTBG. Each topic (items 1 through 11) also briefly highlights needs regarding access, capacity, disparity and other issues. Step Two addresses unmet needs and provides rationale for priorities stated in Step Three. Performance measures proposed in Planning Table 1 relate to each of the state's priorities.

1. Comprehensive community-based system for children with serious emotional disturbances (SED) and their families. As referenced above, the CMHC network and the coordinated OKSOC sites provide statewide coverage for the comprehensive services available for children with SED and their families. All sites must be capable of screening and treating or referring children and youth with separate or co-occurring substance use disorders. Local affiliation agreements and memoranda of understandings with substance use treatment providers assure adequate access to a wider range of services needed by the children and their families. In FY2015, a total of 12195 children under age 18 were served in the ODMHSAS system by both mental health and substance use disorder providers; 6929 children with SED. Additional information is provided below to address specific MHSBG requirements.

- *Mental Health and Rehabilitation Services for Children with SED.* CMHCs, Health Homes and SOC (sometimes one and the same and sometimes collaborating partners) ensure that children with SED and their families have access to basic services, specifically crisis intervention, evaluation and treatment planning, medication and psychiatric services, and case management services. Additional services for children and their families are listed below.

- Home-based services
 - Family therapy
 - Diagnosis-related education
 - Client advocacy
 - Outreach
 - Peer family support
 - Family self-sufficiency (housing)
 - Socialization
 - School-based services
 - Wraparound/flexible funds
- *Health/Medical, Vision and Dental Services.* Case managers assist parents and children in accessing treatment for health conditions ranging from vision and hearing problems to chronic illnesses. The Oklahoma Health Care Authority (OHCA) is designated to administer the Children’s Health Initiative Program (CHIP). School-based health services are organized by the OHCA through the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program. Many schools hire nurses to implement targeted health programs related to EPSDT to help parents access early and preventative care for their children. The program is in 74 of Oklahoma’s 77 counties. CMHCs and SOC sites are developing collaborations with Federally Qualified Health Centers (FQHCs), tribal health services, clinics, homeless clinics and county health departments. Oklahoma’s State Plan Amendment was approved by CMS and Health Homes (HHs) began in January 2015. Currently, 5,131 adults with SMI and 2019 children with SED are being served in HHs. Health Homes, for adults with SMI and children with SED, integrate behavioral health care and primary care services by: 1) directly providing primary care in-house performed by a qualified employee, or purchasing through a contract; or 2) establishing written agreements with external primary care providers and ensuring the coordination of care and treatment for identified physical care issues.
 - *Employment and Vocational Services.* Case managers assist children ages 14 and older with job search and job placement skills, social and interpersonal skills needed for job retention, and specific referrals to vocational-technical schools. The Oklahoma Department of Rehabilitation Services (OKDRS) offers transitional services within school districts. The DRS Transition School-to-Work program assists students with disabilities make smoother transitions from school to work through counseling, work adjustment training, on-the-job training and direct job placement. Other services are provided through a cooperative arrangement among the DRS, the Oklahoma State Department of Education and local school districts. Through the SAMHSA-funded Oklahoma Now is the Time (ONIT) initiative, the ODMHSAS has achieved a partnership with the OKDRS, for a pilot program which will allow ONIT providers in Oklahoma, Washington and Okmulgee counties to bill OKDRS for specialized career planning (employment) activities. Due to prohibitive payment methods, there has been almost no supportive employment rendered in Oklahoma for those with SMI. If the pilot goes well, the plan is that the OKDRS will switch to this payment method for all who provide the services to people with SMI.

- *Housing Services.* Housing services and homeless outreach services for families with children are provided in the same manner by which they are provided to adults. This is summarized elsewhere in this application. In addition to accessing an array of supportive and subsidized housing options, providers are able to utilize the ODMHSAS flexible funds to address immediate and short-term needs to stabilize family housing situations.
- *Special Education.* Under the provision of the Individuals with Disabilities Education Act, children who are placed in a special education program because of a SED must have an Individual Education Plan (IEP). Many CMHC staff and programs particularly affiliated with local Systems of Care are actively involved in supporting families and children for whom an IEP is needed.
- *Case Management.* Children and youth with an SED who want to access the full continuum of public behavioral services are assigned a case manager (care coordinator) to work closely with the youth and family to coordinate the development of an integrated treatment and wraparound plan. Members of the wraparound team design a family and youth directed plan to address key needs on behalf of the children receiving services.
- *Substance Abuse Services and Services for Children with Co-Occurring Disorders.* CMHCs, Health Homes, and local SOCs work closely with the ODMHSAS funded addiction treatment centers to provide specific substance abuse treatment and support services. All CMHCs are also certified substance abuse service providers and meet minimum requirements to be co-occurring capable service sites.
- *Other Activities Leading to Reduction of Hospitalization.* CMHCs and other community based providers offer screening and early intervention services to diminish the need for out-of-home placements, including inpatient treatment. Collaboration between providers also facilitates more integrated discharge planning as children and their families prepare for transition from out-of-home placements. This continues to result in lower hospitalization rates and shorter lengths of stay – particularly in Systems of Care communities. Health Homes are now responsible to ensure a smooth transition of care between any and all higher levels of care and HH services, including having formal agreements in place to facilitate this.
- *System of Integrated Services and Systems of Care for Children and Their*

Families. A rich array of state and local partners collaborate to assure a system exists to integrate services appropriate for the multiple needs of children. The Systems of Care is the centerpiece of service integration on behalf of children with SED and their families. Oklahoma began to implement local Systems of Care in 2000. Mental Health Block Grant funding provided a portion of the initial resources to support the first two Systems of Care sites. In 2002, Oklahoma received a six-year SAMHSA grant for Systems of Care development. Currently, there are 80 Systems of Care communities covering 74 counties. Other communities are in the formative stages of Systems of Care development. A second SAMHSA grant was funded through 2014. The Weaving Access for All (Wafa) state-level Systems of Care State Advisory Team oversees the overall operations of the Systems of Care communities. In addition, each local community has a team comprised of agency staff, community members, parent advocates and family members.

- *Transition Services.* The Oklahoma Healthy Transitions Initiative (OHTI) grant was funded by SAMHSA in FY2010 for five years at \$480,000 per year. The grant focused on integrated services and supports for youth and young adults ages 16 through 25 with serious mental health conditions and their families. OHTI's developmentally-appropriate and effective youth-guided local Systems of Care were designed to improve outcomes in education, employment, housing, mental health and co-occurring disorders, and decrease contact with the juvenile and criminal justice systems. Grant activities in the first four years were based in two well-established local Systems of Care communities - Tulsa County and Cleveland County (Norman). Activities were expanded to Pontotoc County. From state FY 2010 through state FY 2014, OHTI provided services to 680 young people.
- *Social Marketing.* Oklahoma Systems of Care utilizes social marketing to increase awareness of the behavioral health needs of children, youth, and young adults; reduce stigma associated with mental illness and substance abuse; promote mental health; and demonstrate that Wraparound is the premier intervention for children and youth with SED and their families. Social marketing strategies and communications play a vital role in communicating these important messages to stakeholder groups throughout the state. Ultimately, social marketing efforts assist with the successful statewide implementation of Systems of Care as Oklahoma's comprehensive approach to children's behavioral health services. Annual Children's Mental Health Awareness Day activities have been coordinated in various formats. In 2013 and 2014, it was coordinated in a picnic format. The Picnic Celebration reached more than 1,200 children, youth, families, and service providers when the north lawn of the Capitol building was transformed into a school carnival-style event where service providers across the state host activity areas in 20' x 20' spaces. Parents and caregivers were able to comfortably meander among the 55-60 activity areas to learn about services and children participate in a variety of activities, arts, crafts and games. The Picnic Celebration received huge support from Governor Mary Fallin; she addressed the

crowd both years and voiced her support of behavioral health services for children and families. In 2015, the day at the Capitol took the form of advocates contacting their legislators and setting lunch appointments on the same day. The coalition of advocates purchased sandwiches for all involved and many great discussions were held.

- *Emergency Service Provider Training on Behalf of Children, Youth and Their Families.* The ODMHSAS provides numerous training opportunities for staff development each year. The Annual Children’s Behavioral Health Conference brings together approximately 1,000 participants. Many attendees work in first response settings, including emergency rooms, ambulance services and law enforcement. Local Systems of Care partners also engage law enforcement and other first responders in various trainings, planning and wraparound work on behalf of children and families. The ODMHSAS Prevention Division also provides training in various suicide intervention and crisis techniques to emergency room, health personnel, law enforcement staff and school districts.

2. Comprehensive community-based system for adults with serious mental illnesses (SMI). The statewide network of CMHCs is primarily responsible for comprehensive services for adults with SMI. In recent years, this system has also intentionally expanded to proactively support diversion from the criminal justice system. Initiatives within this realm include 13 mental health courts that serve a total of 16 counties, a day reporting center in Oklahoma City, jail-based screenings in both Tulsa and Oklahoma City, statewide training in the Memphis Model Crisis Intervention Training (CIT) program, prison-based treatment for co-occurring mental health and substance use disorders, prison-based discharge planners, and community-based re-entry intensive care coordination teams. In FY2015, the CMHCs and other network mental health providers served 74,037 people age 18 and over.

- *Mental Health and Rehabilitation Services.* CMHCs, by regulation, must provide the following basic services:
 - Crisis Intervention
 - Medication and psychiatric services
 - Case Management
 - Evaluation and treatment planning
 - Therapy services
 - Psychosocial rehabilitation

Additional information is provided below to address specific MHSBG requirements regarding service to adults.

- *Employment Services.* CMHC case managers assist adults age 18 and older with job location and placement. These activities are funded by the ODMHSAS and specific service codes provide claims and reimbursement data for this. In addition, HOPE Community Services offers a supported employment program. Transitional employment programs are provided by Thunderbird Clubhouse and Crossroads Clubhouse. Both clubhouses are accredited by Clubhouse International (formerly the International Center for Clubhouse Development). The ODMHSAS and the Oklahoma Department of Rehabilitation Services (OKDRS) assist with funding various activities within this array of employment services and utilize a memorandum of understanding to coordinate and monitor related activities. The availability of supported employment services for adults with SMI have continued to be very limited, due to prohibitive payment methods through OKDRS. Through the SAMHSA-funded Oklahoma Now is the Time (ONIT) initiative, the ODMHSAS has achieved a partnership with the OKDRS, for a pilot program which will allow ONIT providers in Oklahoma, Washington and Okmulgee counties to bill OKDRS for specialized career planning (employment) activities in a way that is workable for providers. If the pilot goes well, the plan is that the OKDRS will switch to this payment method for all who provide the services to people with SMI.
- *Housing Services.* Assuring satisfactory access to safe, sanitary, and affordable housing for adults with mental illness continues to be a challenge to the state. Specific housing services for people with mental illness are available in urban and rural settings and are funded through the ODMHSAS, the U.S. Department of Housing and Urban Development (HUD), public housing authorities and private sources. Housing models include transitional housing and permanent supported housing (both congregate and scattered site). Although some housing continues to be developed in settings specifically for persons with mental illness (i.e., HUD funded Section 811 and HUD SHP projects), the ODMHSAS continues to place an emphasis on creating opportunities for more integrated housing, including permanent scattered site housing with available support services. Some stakeholders continue to encourage the development of transitional housing services to meet the needs of consumers whose current level of recovery would make it difficult to have success in a supported housing model.

Additional housing related service and supports embedded in the system for adults with SMI include flexible funds available to each CMHC that can be used to augment a variety of housing supports, including rental and utility deposits; a Discharge Planning Housing Subsidy specifically for adults discharging from psychiatric inpatient care, Department of Corrections, or aging out of the foster care system; a Transition Youth Housing Subsidy program to assist very low-income young adults ages 17 – 24; a smaller subsidy program for transition youth living in rural areas (added through grant funding in FY 2014); and Residential Care Facilities can receive a higher rate for services if they successfully meet criteria for designation as a Recovery Home.

- *Education Services for Adults with SMI.* Adult basic education, like GED classes, is offered on site at two clubhouse programs, and at some CMHCs. CMHCs and other providers also offer advocacy and support services to assist consumers with accessing GED classes within the community, as well as, other community based educational opportunities (i.e., technology centers, trade schools, colleges, universities) and promoting ongoing educational success.
- *Substance Use Disorder Services Within CMHCs including Services for Persons with Co-Occurring Disorders.* All CMHCs are also certified as substance use disorder service providers and receive both mental health and substance use disorder funding for persons with SMI and co-occurring substance use disorders. Specialty substance use disorder treatment providers also collaborate with CMHCs for mental health assessment and other CMHC services as needed. Individualized, gender and culturally specific substance use disorder treatment is required of all providers.
- *Medical, Vision and Dental Services.* Case management services have historically been the major option by which adult consumers in the ODMHSAS system are assisted to access medical, vision, and dental services. Access has been more likely for Medicaid beneficiaries. The ODMHSAS and providers have continued focus on the primary health needs of adults with SMI. Collaborations continue with Federally Qualified Health Centers (FQHCs), tribal health and Indian Health services, homeless clinics, county health departments, and pro bono health care providers. Dental services are also provided in local communities through free dental clinics and pro bono providers. Three sites continue with funding from SAMHSA through the Primary Care Behavioral Health Initiative (PCBHI). Oklahoma's State Plan Amendment was approved by CMS and Health Homes began in January 2015. Currently, 5,131 adults with SMI and 2,019 children with SED are being served in HHs. Health Homes, for adults with SMI and children with SED, integrate behavioral health care and primary care services by: 1) directly providing primary care in-house performed by a qualified employee, or purchasing through a contract; or 2) establishing written agreements with external primary care providers and ensuring the coordination of care and treatment for identified physical care issues.
- *Support Services and Psychiatric Rehabilitation.* All ODMHSAS certified CMHCs must provide a clubhouse or general psychiatric rehabilitation program, or individual and group rehabilitation services. Clubhouse programs must be certified by Clubhouse International (formerly the International Center for Clubhouse Development). CMHCs typically elect to provide either a general psychiatric rehabilitation program or individual and group rehabilitation services,

which are reviewed under their state CMHC certification (licensure). In addition, two clubhouses certified by Clubhouse International currently operate independent of CMHCs -- Crossroads Clubhouse (Tulsa) and Thunderbird Clubhouse (Norman).

- *Case Management.* Case management is funded both by the ODMHSAS and the Medicaid program. Since the mid-1990s the ODMHSAS has promulgated the strengths based, person centered case management model to support case management activities in all community and facility settings. Case management services follow a plan approved by the service recipient and qualified staff. Billable activities include referral, linkage, advocacy and follow-up support provided in partnership with the consumer to assist with self-sufficiency and successful integration into community life. All staff that provides publically funded behavioral case management services are statutorily required to be certified by the ODMHSAS, or possess Oklahoma certification as an Alcohol and Drug Counselor (CADC), or possess Oklahoma licensure as a Behavioral Health Professional (or under state supervision). For ODMHSAS Certification as a Behavioral Health Case Manager, applicants must complete a specified curriculum and examination to be eligible. To date, over 2,358 individuals have satisfied basic requirements to be Certified Behavioral Health Case Managers Level I (310) and II (2048). A dedicated website (http://www.ok.gov/odmhsas/Mental_Health/Behavioral_Health_Case_Management/index.html) provides access to the ODMHSAS certification information for case managers. Multiple entry points are available to attain certification. The ODMHSAS provides options for on-line training of specific elements as well as the ability to test at numerous locations statewide to qualify as reimbursable case managers. The ODMHSAS also recognizes the value of potential workforce members who have case management life experience and maintains a certification option for applicants with 60 college credit hours or a high school diploma with 36 total months of experience working with persons who have a mental illness, additional to those who have completed traditional degree-based programs.
- *Other Activities Leading to Reduction of Hospitalization.* Oklahoma's service culture embraces a strengths-based and person-centered approach which begins with a thorough assessment of consumer interest, strengths and needs, and the formation of a plan to assist the consumer with successfully achieving their identified goals. The resources and supports necessary for community success are identified and facilitated through collaborative efforts among the consumer, their support systems, and the service provider. This level of focus helps to reduce the use of hospital or other institutional based resources. CMHCs are monitored to assure that services include cooperative discharge planning with inpatient programs and crisis units, early response and crisis intervention programs, and community partnerships with law enforcement. Community Based Structured Crisis Centers provide short term stays and stabilization in lieu of

placement in inpatient facilities. Urgent Care Centers in four locations, offer 23 hour 29 minute stabilization services. Other modalities, such as Crisis Intervention Training (CIT) and Program of Assertive Community Treatment (PACT), provide intervention, coordinated care, and successful community integration. Enhancements of early intervention and transitional services for individuals who interface with the criminal justice system also prevent the use of hospitalization as well as incarceration. Further, the Enhanced Tier Payment System (ETPS) discussed elsewhere in this application provides an enhanced payment based, in part, on meeting lower inpatient utilization targets.

- *Emergency Service Provider Training.* The ODMHSAS provides numerous training opportunities for staff member development throughout the year to enhance skills needed when they encounter adults with SMI. The training announcements are distributed to individuals and organizations statewide, including emergency health workers. Many participants work in first response settings, including emergency rooms, ambulance services and law enforcement. Law enforcement jurisdictions also collaborate with the ODMHSAS to cross train staff in diversionary and proactive responses with people who may be experiencing mental illness or addiction symptoms. The Memphis Model Crisis Intervention Training (CIT) is widely utilized. The ODMHSAS staff also provides training in various suicide intervention and crisis techniques to emergency room and other health personnel. The state has expanded training offerings of Practical Front Line Assistance and Support for Healing (PFLASH), Psychological First Aid (PFA), Question, Persuade and Refer (QPR), and other early intervention response techniques to non-mental health professionals, including first responders.

3. Comprehensive substance use disorder services for children, youth, and adults. As described earlier, substance use disorder (SUD) services are provided through a statewide network of providers that work collaboratively to assure good access and quality care. Key functions performed by providers and ODMHSAS personnel include referral, reporting, monitoring and technical assistance and peer review. Each of those functions is briefly described below to set the context within which specific SAPTBG targeted populations are served.

Substance Use Disorder Treatment Referrals. The ODMHSAS is committed to making accurate and appropriate referrals for all individuals into and outside of the SUD services arena. The ODMHSAS contractually requires SUD treatment providers to address both substance use and mental health needs of consumers. To aid providers in screening clients for co-occurring disorders, a tool was developed by the ODMHSAS to screen for substance use disorders and mental health issues regardless of the point of access. This tool can trigger a more comprehensive assessment process, to determine multiple issues, including co-occurring issues. Use of this tool is encouraged but treatment providers may use the co-occurring instruments of their choice. In addition,

the Addiction Severity Index (ASI) and the current version of the American Society of Addiction Medicine Patient Placement Criteria (ASAM) instruments continue to be the backbone of the SUD screening and assessment. The ODMHSAS continues to provide monthly ASI and ASAM trainings. The ODMHSAS has developed an instrument to determine the level of service needed based on the ASAM criteria. The Oklahoma Determination of ASAM Service Level identified level of need for each of the six ASAM Dimensions and matched the need to a particular level of care.

Capacity Reporting. Residential and halfway house programs utilize an on-line capacity reporting system to provide the ODMHSAS with a daily accounting of priority and non-priority individuals waiting to be admitted into treatment. A member of ODMHSAS administrative staff regularly reviews the time from placement on the residential SUD treatment list to treatment entry. This ensures all SAPTBG requirements are met and helps identify problems to be corrected. The ODMHSAS staff works with providers to help admit priority individuals into the first openings available. State staff also notes priority status populations daily in the agency reports to ensure that priority individuals are moving into openings within the required time frames. Outpatient treatment openings are typically more available and there are no waiting lists for those services.

Service Monitoring and Technical Assistance. Oklahoma monitors substance use disorder treatment providers by assigning Field Services Coordinators (FSCs) to specific state-operated and contracted programs for ongoing contract compliance reviews. The FSCs are the primary contacts for assigned providers, visiting the agencies and conducting on-site and/or desk reviews as well as reviewing provider staffing, services and performance reports. Plans of correction are developed as needed and technical assistance is provided by the FSC or other ODMHSAS staff per the findings of the on-site and/or desk review. The FSCs also provides other technical assistance as needed.

Peer Review. The ODMHSAS began a new system in SFY 2011 of requesting substance abuse block grant funded providers to coordinate peer reviews with other similarly funded providers throughout the state and forward a copy of the review to the ODMHSAS. That system continues to work well. Approximately 30% of the substance abuse block grant funded treatment providers received peer reviews in FY2015.

Partnerships. Collaborations are discussed in the Environmental Factors and Plan section of this application, #21, in which the range of partnerships all services within the ODMHSAS system are described. Specific to substance use disorder services these viable partnerships have resulted in more services and improved access for Oklahomans in need of substance use disorder treatment.

A range of recovery and support services are provided within the substance use disorder treatment services network and specific services funded by the ODMHSAS are listed in other sections of this application. A strength of the system continues to be the manner by which services are delivered to target populations mandated by SAPTBG requirements. Those are detailed below.

- *Persons who are Intravenous Drug Users (IDU).* Intravenous drug users are served by all ODMHSAS substance use disorder service providers and state operated facilities. Interim services are required by contract for IDUs who providers are not able to admit upon requesting treatment. Contracts also require providers to meet the 14-120 day standard. In addition, residential and halfway house programs are contractually required to report their capacity and waiting list information to the ODMHSAS daily. Contract monitoring takes place at least annually.

Outreach services are contracted with two treatment providers in the largest metropolitan communities, Oklahoma City and Tulsa. These areas also represent the largest IDU populations. The contract requires the use of an evidence-based outreach model such as, but not limited to, the National Institute on Drug Abuse (NIDA) Indigenous Leader Outreach Model, the NIDA Standard Intervention Model for Drug Users, or the health education model as described in Rhodes, F., et al., *AIDS Intervention Program for Injection Drug Users*. Outreach staff visits their local downtown and high-risk areas in which homeless and drug-using populations congregate. Information and education is discussed and distributed, HIV testing is provided with consent, and referrals and linkages to social services and treatment programs are made.

- *Adolescents with Substance Use Disorder Problems.* Oklahoma provides early intervention services for adolescents through adolescent specific contracted service providers that work closely with school systems in their areas, providing brief interventions for high risk students through individual and group sessions at schools. Students are referred for additional treatment if needed. Another early intervention program called “Together with Communities” targets the communities around the Santa Fe South charter school, which uses the Celebrating Families curricula made available by the school to the community served.

Adolescent treatment services include two adolescent substance use disorder and co-occurring residential programs. Tulsa Boys Home has 24 male beds and offers Equine Therapy to their residents. The Children’s Recovery Center is a state-run facility that has 55 beds and the capacity to serve kids with mental health, addiction and co-occurring needs. The units are divided into 12 co-ed crisis beds and 43 residential beds. The residential beds are then divided by dorm with girls and boys treated separately (26 female and 17 male). Each dorm has two sides. Youth with co-occurring needs are served on both sides of a girls or boys dorm, but youth with primary addiction issues are served on one side, and kids with primary mental illness are served on the other side. There are 13 female primary addiction/co-occurring beds and 9 male primary addiction/co-occurring beds. Outpatient and intensive outpatient adolescent specific services are provided throughout the state by 13 providers. Family and juvenile drug court programs are also available for adolescents. Currently there are four family drug court providers, and seven juvenile drug court providers.

Family drug court programs continue to collaborate with the TANF providers to serve the TANF population.

A designated juvenile drug court program is working to enhance treatment, using funding from a grant award from SAMHSA, by adapting the Celebrating Families Model to fit the needs of the youth and family in that program. Adolescent Community Reinforcement Approach (A-CRA) and Seeking Safety is also being provided to meet the needs of the program. Outcomes for this program are currently being monitored, to determine the effectiveness of these changes/additions. If successful, the plan is to expand to other juvenile drug court programs.

Peer Recovery Support Services is a new Medicaid compensable service for adolescents age 16 and 17. Peer support services have existed in the array of services available to adults for many years, and have proven to be a critical component of recovery-focused treatment. The availability of peer support services for adolescents will provide a more comprehensive continuum of services available to the adolescents served. The staff members who provide Peer Recovery Support Services must be Certified by the ODMHSAS as a Peer Recovery Support Specialist (PRSS). A specialized training component on adolescents and young adults will be incorporated in the current curriculum for PRSS Certification.

In addition to the services listed above, the CMHCs and other substance use providers deliver outpatient treatment to youth with substance use and co-occurring mental health and substance use disorders.

- *Targeted Services for Underserved Individuals from Racial and Ethnic Minority Populations and LGBT Populations.* Oklahoma contracts with an agency in the more populous Oklahoma City area to provide LGBT services. Provider staff members are trained in sexual orientation sensitivity and LGBT competency and utilize CSAT's *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual and Transgender Individuals*. Family education support groups are offered for family members as defined by the customer. Client Satisfaction Surveys are requested of customers to report their experiences related to service quality, access, and outcomes.

Substance use disorder service providers also work with police, social workers, community outreach workers, substance use disorder agencies, health care providers, religious leaders, and others to provide training and education on various aspects of substance use disorder issues of the unique social and cultural needs of the LGBT community. Other underserved minority populations are targeted with specific substance use disorder programs.

- *Women who are Pregnant and have a Substance Use Disorder.* Pregnant

women have priority status in Oklahoma. The Addiction Severity Index (ASI) and the current addition of the American Society of Addiction Medicine Patient Placement Criteria (ASAM) are utilized to assess the severity and placement needs of all clients, through use of the Oklahoma Determination of ASAM Service Level (ODASL). Pregnant women assessed as needing outpatient substance use disorder services are able to admit into any outpatient program of their choice in the state. Pregnant women assessed at a higher level and needing a residential program are able to choose whether they prefer admittance to a pregnant women and women with children (WWC) facility, a female residential program or a co-ed facility. Upon entering a program, women receive individualized, culturally competent, gender-specific services that, along with treatment services, may include dietary information; parenting classes; case management services to help with housing, employment, education, food stamps or other basic needs; and assistance with integrating back into the community. Additional needs identified by the ASI, such as mental health needs, are also included in the individualized plan for treatment. Transportation to services is provided when needed.

- *Parents with Substance Use Disorders who have Dependent Children.* Oklahoma contracts with five residential programs to provide services for women with dependent children (WWC) and two WWC halfway house treatment programs. One halfway house for WWC also operates a residential treatment program for women only. The Oklahoma City Housing Authority collaborates with the ODMHSAS to provide women a sober-living environment in which they can focus on their family, especially their dependent children, while continuing to work on recovery. Each resident must continue to attend self-help groups and work with the onsite case manager to address their educational, employment, mental health and other goals while easing back into the community. Additional options for transitional sober housing are in place and expanding currently. Another program administers behavioral and developmental assessments for children who may have been exposed to alcohol or other drugs prenatally. All WWC providers must give priority status to pregnant women, treat the family as a unit, provide a comprehensive range of services to women and their children either directly or through linkages with community-based organizations, including case management to assist in establishing eligibility for public assistance programs provided by federal, state, or local governments; employment and training programs; education and special education programs; drug-free housing for women and their children; Head Start; and other early childhood programs and promote and facilitate children's access to the fullest possible range of medical services available, such as health screening; well-child health care; screening in speech, language, hearing, and vision; and verify immunization records. All programs must document biopsychosocial assessments for the parent and for the children accompanying their parent into treatment. Case management services are offered to all parents and children. Transportation to ancillary services is also provided as needed. Oxford House has multiple houses for women with children, and two houses (one in Oklahoma City and one in

Tulsa) for men with dependent children.

In fiscal year 2012, the ODMHSAS was awarded a five-year Regional Partnership Grant through the Administration for Children and Families titled the Oklahoma Partnership Initiative Phase 2 (OPI-2). The OPI-2 proposed to increase the well-being and improve the permanency outcomes for children affected by substance use disorders. The OPI-2 implemented and continues to evaluate a multifaceted approach to address the presence of alcohol and other substance use disorders within the context of Oklahoma's child welfare (CW) system. The overall goal of the OPI-2 project is to build on Oklahoma's collaborative infrastructure to meet the needs of families involved with both substance use disorder treatment and the child welfare system. The ODMHSAS is the lead agency on this project and collaborates with the Oklahoma Department of Human Services (OKDHS) and substance use disorder service providers statewide to implement two evidence-based early intervention and prevention initiatives: Strengthening Families Program and Solution-Focused Brief Therapy.

The project will assure the full integration of the UNCOPE Drug Screening Tool and fully establish cross-system linkage. The project will impact families at distinct points in the life of their child welfare cases, and represent multiple types of service interventions.

The ODMHSAS contracts with the OKDHS to provide appropriate outpatient substance use treatment services to applicants for Temporary Assistance for Needy Families (TANF) benefits, participants of TANF, or persons involved in the child welfare system due to parental/caregiver's use of substances interfering with parenting and safety of children in the home. On November 1, 2012, legislation became effective requiring screening of all persons applying for TANF benefits to rule out substance use disorders and use of illegal substances; if the screening indicates the need for further assessment, contracted agencies provide the assessment. When TANF applicants require assessment, a drug test to rule out the use of illegal drugs in the past 30 days is conducted following the assessment. Due to TANF benefits being tied to the results of substance use screening and assessments, availability of services are needed in each of the 77 counties in Oklahoma. Oklahoma currently contracts with 33 TANF/CW substance use disorder treatment providers. OKDHS funds the ODMHSAS position of the Coordinator of TANF/CW and Women Specific Services. The Coordinator closely monitors the contracts to ensure providers meet timeframes for access to services in order for referrals to comply with federal timeframes regarding TANF applications and the Adoption and Safe Families Act timeline for CW involved families. Three contracted TANF/CW treatment providers offer the evidence-based Strengthening Families Program for TANF/CW referrals. One contracted agency provides Strengthening Families and Celebrating Families Programs for the TANF/CW population. Many TANF/CW contracted treatment providers offer gender specific and trauma specific services.

- *Services for Persons with or At Risk of Contracting Communicable Diseases: Individuals with Tuberculosis; Persons with or At Risk for HIV/AIDS.* The ODMHSAS substance use disorder service providers are contractually required to make tuberculosis services available to individuals receiving substance use disorder treatment and to provide interim services for individuals waiting for admission. The required services include counseling, screening and treatment when needed. Tuberculosis services are provided through local Oklahoma State Department of Health (OSDH) facilities, or through other community health care programs. The ODMHSAS provider contracts require adherence to infection control procedures as established by the Centers for Disease Control and Prevention.

Oklahoma is not a designated state and, as such, does not provide early intervention programs for HIV/AIDS. However, Oklahoma Administrative Code (OAC 450) requires all ODMHSAS certified programs provide or arrange access to education, counseling and testing for HIV, AIDS and STDs for consumers and their partners as requested.

4. Military Personnel (Active, Guard, Reserve and Veteran) and their Families.

Oklahoma was selected to attend the initial Veteran's Policy Academy sponsored by SAMHSA in 2008 and a return team in 2011. The Academy team developed a work plan that has served as a foundation for continued expansion of services for military personnel and their families. Oklahoma's Academy team members and others also re-convened a couple of years ago to assess progress, confer on emerging priorities and update other information. The ODMHSAS continues to collaborate with community partners in effort to better serve military personnel and their families. Current areas of focus include:

- Efforts toward an ODMHSAS certification for veterans to become Peer Recovery Support Specialists.
- Assisting CMHCs with TA and training, with bringing up their standards to match SAMHSA's Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics. The ODMHSAS has applied for a state planning grant to certify community behavioral health clinics. The SAMHSA established standards require an extensive array for service for veterans and it is anticipated this will greatly improve access to services, especially if Oklahoma is able to participate in the subsequent demonstration. If the planning grant is funded, CMHCs will also be assisted with financial resources.

- The ODMHSAS will hire and house a full-time employee, resources by the Oklahoma Department of Veterans Affairs, to develop strategic plans and partnerships for the provision of prevention and promotion services to veterans, active duty military and military families.
- Partnership with the Oklahoma Department of Veterans Affairs to work collaboratively on specific prevention initiative for Oklahoma Guard personnel.
- Facilitation of continued partnerships and linkages through specialty courts to facilitate intensive services to those who are service connected.
- Continued coalitions in Oklahoma City and Tulsa continue to build networks to address challenges faced by veterans in housing, transportation and access to services.
- Continued telemedicine partnership for the ODMHSAS telemedicine equipment at remote locations (CMHC's) to be available to veterans for participation in online support groups in partnership with the Veterans Administration.
- Continued data collection within Systems of Care families to determine extent of current veteran/active involvement in existing Systems of Care and explore program enhancements to serve this unique population. To date this has been done through informal polling of SOC communities, however, the evaluation partners (E-TEAM) have been asked to add this data piece to the Youth Information System (YIS).
- Under the Time to Talk (T3) partnership, will continue to work with Central Oklahoma High Schools on suicide awareness and resiliency efforts.
- Continued representation of two individuals who have served in the United States military on the Oklahoma Suicide Prevention Council.
- Continued representation of an individual who has served in the United States military on the ODMHSAS Governing Board.

5. American Indians/Alaska Natives (AI/AN). Oklahoma is home to 38 federally recognized tribal nation headquartered in Oklahoma. Oklahoma is second behind only California with 482,760 AI/AN population reported on the 2010 US Census. The proportion of Oklahoma's population identified as AI/AN people was 12.9%. In FY2015, 22,103 consumers identifying themselves as AI/AN received services funded through the ODMHSAS and/or Medicaid (OHCA) behavioral health reimbursement system.

The Governors Transformation Advisory Board (GTAB) was formed in 2006 by Governor Brad Henry as his lead consultative body for Oklahoma's Transformation State Incentive Grant (TSIG) funded by SAMHSA. An early action of the GTAB, under the leadership of Chickasaw Nation Governor Bill Anoatubby, who served as GTAB chair, was to establish Oklahoma's Tribal State Relations Workgroup. The Workgroup provided expertise and guidance for the ODMHSAS to continually assess better methods to engage with and provide culturally appropriate access to services and supports for Oklahomans with tribal affiliations.

In 2011, SAMHSA supported Oklahoma's participation in a National Policy Summit to Address Behavioral Health Disparities within Health Care Reform. The ODMHSAS utilized the resources and support for its Summit team to strategically address the unmet behavioral health needs of American Indian children and their families. An action plan was developed to assure that all Oklahoma children and youth who are self-identified by their family as American Indian have early and easy access to needed behavioral health services and supports. Changes that occurred as a result of the plan benefited all American Indians, regardless of age.

On September 22 – 24, 2012, ODMHSAS participated in SAMHSA's "Policy Academy on Preventing Mental, Emotional and Behavioral Disorders." As a result of this meeting, the Oklahoma delegation was able to create an Action Plan to address statewide prevention efforts related to preventing mental, emotional and behavioral disorders in the state. With the assistance of a representative from Chickasaw Nation, the State developed an Action Plan to the 38 federally recognized tribal nations in statewide prevention efforts.

In 2006, the ODMHSAS created a fulltime position for a Tribal Liaison. That position has continued to assist with facilitating collaboration among the state and tribal nations and to address the unique aspects of tribal and state government relationships. During the past year, the ODMHSAS established its first Tribal Consultation Policy. This is an important step in standardizing an approach with tribal nations that fits with the parameters of their sovereignty as nations and also fits within state policy. Also, in the pursuit of good communication and continued collaboration with tribal nations, the ODMHSAS facilitates a behavioral health tribal/state work group. This group meets regularly, identifies barriers to good communication and works on priorities established each year. For the past two years, they planned and held cultural learning events regionally. These events were well attended and received. The goal was to increase providers' understanding and awareness of tribal nations in their area and vice versa. The ODMHSAS Tribal Liaison is responsible to provide this group with the support necessary to fulfill their established priorities. This position became vacant recently and has been re-filled. The new liaison will be pulling the work group together very soon to refocus priorities.

6. Targeted Services for Individuals Involved in the Criminal or Juvenile Justice Systems. The ODMHSAS collaborates with various partners within criminal justice and law enforcement to provide a variety of services. The Sequential Intercept Model is used in strategic planning and aligning of resources for the greatest impact in terms of reducing involvement with criminal justice for adults and children with behavioral health treatment needs. Brief descriptions of related activities follow.

- *Prison-Based Substance Use Disorder and Community Aftercare Program.* The ODMHSAS works closely with the Oklahoma Department of Corrections (DOC) to provide substance use disorder treatment services to offenders in prison, to those offenders who have been released from prison through a probation/parole contract, and a Residential Substance Abuse Treatment (RSAT) aftercare program for those offenders that have completed their time and are not on probation. Twelve prison-based programs that range from four to nine months use cognitive behavioral therapy as the primary therapy modality. As offenders enter the prison system they are assessed by ODMHSAS contracted agencies at two assessment sites. Once identified as having a substance use problem, the offender is scheduled to enter more focused treatment nearer the end of the offender's prison time. The ODMHSAS contracts with 15 agencies to provide probation and parole services to assist with the re-entry process. The probation and parole officer refers the offender to one of the agencies and the agency coordinates needed services. An additional six agencies provide RSAT aftercare services as referenced above.
- *Substance Abuse and Mental Health Action/Recovery Teams (SMART) Project.* Oklahoma's SMART project provides discharge planning and community based services for adult offenders who need continued substance use disorder treatment and recovery supports in the community following incarceration with the Oklahoma Department of Corrections (DOC). This project is the result of ODMHSAS being awarded funding through the SAMHSA Offender Reentry Program (ORP) in October 2012. The project target population is offenders within the DOC with co-occurring substance use and mental health disorders discharging within four months from designated prison facilities. Program participants can be from all security levels and can include both male and female offenders. Offenders who meet the designated criteria and are planning to return or relocate to Oklahoma or Tulsa Counties are eligible for this program. Community based teams from behavioral health agencies with demonstrated ability and experience to work with this population provide assessment, treatment planning, intensive case management, recovery support specialist services, and treatment services provided by licensed behavioral health clinicians. This project builds on the successful ODMHSAS Prison Based, Reentry, Discharge Planning and Co-occurring Treatment Specialist program that provides a continuum of care for offenders discharging from DOC facilities and has shown promising outcomes and evidence of program effectiveness.

- *Drug Courts.* Oklahoma's Drug Courts offers court-supervised treatment (non-italic) to eligible, non-violent felony offenders in lieu of incarceration. These programs provide individualized treatment services while incorporating the accountability and structure of the judicial system. Individualized assessment and treatment planning, routine substance testing, supervision visits, and regular court appearances are all required throughout program participation. The ODMHSAS is statutorily responsible for funding and oversight to the 45 drug court programs in the state which serve 73 of the state's counties. The programs cost the taxpayers of Oklahoma \$5,000 per person per year instead of an annual average cost of incarceration of \$19,000. Drug courts also focus on reunification of families, employment and education of participants which, in turn, improves the quality of participants' lives and leads to further cost savings.
- *Mental Health Courts.* Thirteen mental health courts were in operation in FY2015. Two are in Oklahoma City and Tulsa and all others in rural communities. A total of 16 counties are served by these courts. Mental health courts have a significant percentage of program participants who are diagnosed with co-occurring mental health and substance use disorders.
- *Municipal Diversion Program.* In partnership with the City of Midwest City and the Midwest City Police Department, the ODMHSAS offers treatment diversion opportunities to the citizens of Midwest City charged with a municipal offense. Midwest City hosts the largest municipal jail in the state. The program was created in an effort to reduce the recidivism of municipal offenders by offering individualized behavioral health treatment in lieu of traditional case processing.
- *Offender Screening Program.* The Offender Screening program provides pre-sentence risk and need information to judges, district attorneys, and defense attorneys in order to recommend the best diversion options available for an offender. By using validated risk and need screens, approved and trained screeners provide the information necessary for the criminal justice system to utilize evidence-based sentencing practices in order to ensure the most efficient use of diversion resources and increase the likelihood of diversion success.
- *Jail Diversion.* The female jail diversion programs (Tulsa and Oklahoma City) and day reporting program (Oklahoma City) provide flexible community based wraparound services for persons at risk of entering or returning to these metropolitan jails.
- *CIT Training.* As of July 2015, over 1100 law enforcement personnel in Oklahoma had been trained in the Memphis Model Crisis Intervention Training (CIT) or a similar law enforcement-based diversion program. CIT training will continue to expand, in part, because of resources available through a Bureau of Justice Programs grant for Mental Health and Justice Collaboration.

- *Reentry Teams, Discharge Planners, and Co-Occurring Treatment Specialist.* The state funds four Reentry Intensive Care Coordination Teams (RICCTs). These contracts with community based teams include a specifically trained Intensive Case Manager and a Peer Recovery Support Specialist to provide success oriented and strengths-based reentry support following incarceration. The ODMHSAS provides three Discharge Planners to work in targeted correctional facilities. Discharge Planners work alongside prison treatment staff to identify and assist inmates preparing for reentry who are expected to have ongoing mental health and substance abuse treatment needs. Three co-occurring treatment specialists, also employed by the ODMHSAS, are assigned to two prisons and three community corrections facilities to provide co-occurring treatment to inmates who need integrated treatment for mental health and addiction issues.

The Discharge Planners, Co-occurring Treatment Specialists and the RICCT staff work under the supervision of the Manager of Correctional Criminal Justice and Reentry Services and under the direction of the ODMHSAS Director of Community Based Services with full support from the Department of Corrections.

- *Benefits Reinstatement for Returning Inmates.* In 2010, SAMHSA published a report summarizing the collaborative work between the DOC, the ODMHSAS, and other state and federal partners in conjunction with Mathematica Policy Research, Inc. (MPR). The report, “Establishing and Maintaining Medicaid Eligibility upon Release from Public Institutions” (DHHS, 2010) evaluated the methodologies in place in Oklahoma whereby people with SMI, upon discharge from prison, have immediate access to the Medicaid and disability benefits for which they are eligible. Due to a partnership with the local Social Security Administration office, and the Department of Disability Determination, a memorandum of understanding allows applications for public benefits for eligible offenders, including SSI, SSDI, and Medicaid, to begin at least four months prior to release from the DOC facility. This process is an integral part of the prison based discharge planning and reentry function. The findings suggested the model as one applicable to other states and other types of public institutions including state hospitals referred to in Social Security parlance as IMDs (Institutes for Mental Disease). The report is available at <http://store.samhsa.gov/shin/content/SMA10-4545/SMA10-4545.pdf>.

7. Targeted Services for Individuals who are Homeless. Some of the treatment and supports for adults and children who are homeless are described elsewhere in this application. Additional services targeted for individuals who are homeless are described below.

- *Outreach Initiatives and Projects in Assistance for Transition from Homelessness (PATH).* The PATH allocation for Oklahoma for grant year 09/01/2014 –

08/31/2015 is \$450,000. PATH programs are located in areas with the highest numbers of people who are homeless: Oklahoma City and Tulsa, and in the rural communities of Tahlequah (located in northeast Oklahoma) and McAlester (located in southeast Oklahoma). Services primarily focus on outreach and case management (including referrals for primary health services, job training, educational services and relevant housing services) but also include screening and diagnostic treatment services, community mental health services, habilitation and rehabilitation services, alcohol and drug treatment, staff training and housing services.

- *Substance Use Disorder Outreach.* The ODMHSAS also provides support to two urban-based substance use disorder treatment programs for outreach activities. Outreach activities target high-risk drug using individuals, many of whom are homeless and impacted by both mental illness and addiction problems. The outreach workers gain their trust, educate them about HIV/AIDS, communicable diseases, and the harm caused by IV drug use, provide tests for HIV if requested, and assist with linkages to treatment programs.
- *The Tulsa Day Center for the Homeless.* This urban program provides linkages with needed mental health and community services on behalf of adults and children who present at their site, including assistance with accessing housing. In addition, they provide supportive services to people who leave the shelter and become housed to help ensure transition success and reduce recidivism.
- *HUD Continuum of Care Projects.* These sites are operated by two CMHCs, Central Oklahoma Community Mental Health Center (McClain County) and Hope Community Services (Balance of State). Each facilitates a HUD Shelter Plus Care project that provides rental assistance to homeless persons with mental illness or co-occurring mental illness and substance use disorders. Other CMHCs also participate in local Continuums of Care.
- *Discharge Planning Bridge Subsidy Program.* The ODMHSAS provides targeted funds to assist very low-income individuals (age 18 and older) with mental illness or co-occurring mental illness and substance use disorders who are homeless or at risk of becoming homeless, as they discharge from psychiatric inpatient care, DOC, or age out of the foster care system. The primary focus is to access decent, safe, sanitary, and affordable housing. The funds assist with housing costs such as rent, utility costs, rent deposits and utility deposits. This assistance can be accessed statewide.
- *Safe Havens.* Safe havens emphasize a housing first approach and allow individuals to remain in that housing even if they do not want to seek treatment. Oklahoma will continue to utilize MHSBG funds for safe haven housing in state FY2016 and FY2017. Current safe haven programs are in Tulsa and are operated by the Mental Health Association of Oklahoma.

- *Home, Honor, and Health (H3OK)* – The project H3OK program follows the Pathways, Housing First key principles of consumer choice, recovery and harm reduction. People served in the H3OK program choose their own path to recovery. Participants are not required to be symptom free or sober to attain housing. They are encouraged through intensive case management to work on recovery at their own pace. Priority populations include homeless veterans and chronically homeless non-veterans. The model uses frequent staff contact to ensure safety and leverage opportunities for change and engagement in recovery. H3OK programs are located in Oklahoma City and Tulsa.
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8. Targeted Services for Individuals in Rural Areas. Individuals in rural areas generally have access to overall treatment and support systems described in earlier portions of the section. However, 59 of Oklahoma’s 77 counties are considered rural or frontier and the ODMHSAS continues to focus on improved access and providing services in more effective ways for adults and children in rural areas. Examples are discussed below.

- *Children and their Families in Rural Areas.* All rural CMHCs provide case management services to children. Most of the treatment is provided in the child’s home or a community based location. Transportation continues to be a problem in rural areas of the state. Of the state’s 74 Systems of Care counties, 71 are located within rural settings. These sites engage a broad stakeholder base to coordinate care, leverage resources, and improve services to children and their families in rural settings.
- *Adults Accessing Mental Health Services in Rural Areas.* Ten CMHCs serve the rural areas of the state. All offer the required mental health services and also purchase or provide local acute inpatient treatment or crisis services to stabilize individuals on emergency orders of detention. Case management services and flexible funds for case managers in rural areas provide in-home support for isolated individuals and assist in purchasing needed goods and services not otherwise available. Most ODMHSAS certified residential care facilities are located in rural counties in the far northeast corner of the state. CMHCs target additional services to these facilities including general psychosocial rehabilitation day programs, social skills training, case management, and medication clinics.
- *Substance Use Disorder Treatment and Supports in Rural Areas.* ODMHSAS Telehealth Services now include mental health treatment and follow ups for adults, children and families, substance use disorder services, telecourt, drug court and family drug court for all Oklahoman’s in need. Beginning in SFY 2011, Oklahoma’s telehealth initiative expanded to target specific rural based substance use disorder treatment facilities by adding units in seven facilities.

Today ODMHSAS Telehealth Service provides access in most substance use disorder treatment facilities.

- *Health Homes in Rural Areas.* As of January 2015, through a request for proposal, 22 Health Homes (HH) for adults with SMI and children with SED were established. Of these 22 HHs, 19 provide HH services to rural communities.
- *Technology Supports in Rural Areas.* The SAMHSA Transformation State Incentive Grant (TSIG) served as a major source for the ODMHSAS to establish a statewide telemedicine network. Initial units were placed in CMHCs and satellite locations serving rural settings. These units increase access to services and information including medication clinics conducted by psychiatrists, therapy sessions, court commitment hearings, and administrative meetings. Today the ODMHSAS is utilizing the latest in software based access (Cisco Jabber) to provide simple, cost effective, telehealth connectivity to the "most remote" areas of Oklahoma. In FY12 18,000 rural Oklahoman's received ODMHSAS services that would not have received services. For FY 15 this number was 84,000, and estimates are that this number for FY16 will be over 100,000. User fees and other sources, beyond TSIG, are now in place to sustain the ODMHSAS Telehealth Network.

9. Children and Youth who are At Risk for Mental, Emotional and Behavioral Disorders, including, but not limited to Addiction, Conduct Disorder and Depression. The ODMHSAS is building the infrastructure using the Strategic Prevention Framework to provide a foundation for the prevention of mental, emotional, and behavioral disorders. Many of these have the same risk and causal factors in common and could benefit from shared prevention interventions. Oklahoma supports a broadened focus on multi-sector prevention systems development to expand interventions using shared strategies to serve the same or similar populations. In FY 11, the ODMHSAS embarked on Step 1 (Assessment) of the Strategic Prevention Framework to assess the nature, extent and driving factors of mental illness in the state. Oklahoma now administers the Adverse Childhood Experience module in the Behavioral Risk Factor Surveillance Survey as a strategy to fill data gaps identified during the assessment phase. A rigorous application of the SPF has followed to develop a state strategic prevention plan that incorporates mental illness prevention and mental health promotion. As a result, the ODMHSAS has initiated a contract with Oklahoma State University to develop and sustain a statewide support center for the implementation of Good Behavior Game in schools. Additionally, the Office of Suicide Prevention has increased services for adults in community, emergency room, and behavioral health clinical settings.

10. Targeted Services for Community Populations for Environmental Prevention Activities. Oklahoma's public health approach for substance abuse prevention services

utilizes the Strategic Prevention Framework and focuses on decreasing risk and casual factors, such as the availability of alcohol and drugs, community norms regarding the acceptability of high-risk behaviors, the promotion of alcohol products, reducing family conflict, and youth rebelliousness. The ODMHSAS contracts with local agencies to plan and implement a public health based prevention strategy in multiple targeted communities on data-driven alcohol and other drug priorities. The funded entities build local prevention infrastructures that can support the implementation of a broad array of practices in targeted communities identified through a needs assessment process. To achieve population-level outcomes, evidence-based prevention strategies are implemented and include policies or practices that create a community or cultural environment that supports healthy and safe behavior.

The ODMHSAS continues to broaden prevention activities across the behavioral health spectrum and within the broader view of overall health status. Prevention staff members work across other divisions within the ODMHSAS and train at the community level to ensure that prevention activities are based on the following elements:

- Valid estimate(s) of communities' prevention needs using epidemiological data
- Community prevention capacity building focus
- Strategic plan(s)
- Evidence-based policies, practices, and programs implemented with fidelity
- Evaluation of outcomes

Local prevention service agencies are the direct recipients of prevention block grant funds. Statements of work with these entities stipulate that prevention services must be implemented in partnership between these agencies, coalitions and communities. Contracted providers have two explicit roles at the community-level. First they must provide expertise and guidance through training and technical assistance to communities and community coalitions to build substance abuse prevention capacity. Secondly, they are required to strategically coordinate the implementation of prevention services at the local level in partnership with community stakeholders.

Environmental prevention strategies implemented in Oklahoma consist of local and state-level prevention policy development, law enforcement, media advocacy, and community organizing methods that limit access to substances and change social norms that are accepting and permissive of substance abuse. Specific evidence-based strategies include alcohol retail training and enforcement of youth access to alcohol, tobacco and other drugs.

11. Targeted Services in Community Settings for Indicated Prevention Interventions. Oklahoma will continue funding primary prevention services with the SAPTBG but the ODMHSAS will also continue to examine community needs and the impact of providing other prevention services, utilizing available resources. Many of the targeted services and system components described throughout this section include

public awareness and preventive supports within the contexts of providing those other direct services. Those often are targeted to specific community settings and groups closely affiliated with the recipients of targeted treatment and support services.

Conclusions for Step One: Service System Strengths and Needs

Items 1-11 above summarized information on systems, required services and access for target populations as required by the SAPT and MHS Block Grants. A review of these helped to identify critical access, capacity, disparity and other issues as listed below. Steps Two through Four of this planning document, and Planning Table 1, build upon this information to more clearly understand gaps and unmet needs, highlight priorities for the state, and then propose goals, strategies, and measures. This planning framework will be utilized by the ODMHSAS to continue focusing on its mission and to assure that recovery and improved health are realities for all our citizens.

Summary of Access, Capacity, and Other Issues

- Capacity and resource utilization requires further analysis to determine the best way to leverage limited funding and address disparities between communities and populations. However, this is being addressed through requests for proposals for health home contracts and AOD treatment contracts in FY2015 and 2016, respectively.
- Issues and needs of targeted populations should be more thoroughly analyzed, including the LGBT community and transitional age youth.
- A variety of activities currently address needs of adults and youth with criminal justice involvement. Expansion of these is needed to reduce future criminal justice involvement and to initially divert other adults and youth with behavioral health needs from these systems.
- More information is needed to raise awareness of and plan for an integrated service approach on behalf of military personnel and their families. Emphasis will be placed on this issue in the certified community behavioral health center criteria to be developed in FY2016.
- American Indians represent a significant population base within Oklahoma. Continued engagement with governmental representatives, additional study, and consultation are needed to more expediently and appropriately work with tribal governments in relationship to behavioral health treatment and prevention strategies for American Indians.

- Oklahoma continues to build state and local level capacity to implement a public health approach to preventing mental illness and substance abuse. Additional planning is needed to fully articulate a comprehensive state prevention plan that incorporates substance abuse prevention and mental illness prevention/mental health promotion.
- Continued review of epidemiological data is warranted to utilize population based data to further understand many factors that should guide the state to effectively plan, implement and evaluate prevention services. This is particularly true in effectively combating opioid misuse occurring at an alarmingly high rate in the State.
- Oklahoma is dedicated to implementing only evidence-based prevention services. Additional capacity will be required and is being developed at the state level to review and evaluate strategies that meet the state's criteria for evidence-based practices. This will be addressed through the certified community behavioral health center criteria to be developed in FY2016.

PLANNING STEPS - CONTINUED

Step Two: Identify the Unmet Service Needs and Critical Gaps within the Current System

Introduction. Step One in this Section summarized services and supports currently in place for behavioral health prevention, early intervention, treatment and support for Oklahomans. That review also identified a listing of access, disparity, capacity, and resource issues that are continually under review by the ODMHSAS. Step Two now addresses many of those in more detail and to more clearly articulate priorities for Oklahoma within the context of this combined SAPT and MHS Block Grant application for FFYs 2016-2017. Priorities are listed in Step Three of this Section.

A summary is included for each topic listed below to provide an overview of unmet service needs and critical gaps related to that systemic issue or target population. Data sources are cited to quantify, to the extent possible, that these are contemporary issues for Oklahoma and levers for actions the ODMHSAS will implement to address our mission and the goals of the block grant program.

Key data have been provided by the Oklahoma State Epidemiological Outcomes Workgroup (SEOW). The SEOW is a multidisciplinary workgroup whose members are connected to key decision-making and resource allocation bodies in Oklahoma. This workgroup, funded through a Federal grant from SAMHSA/CSAP, was established by the ODMHSAS in 2006 and is patterned after the National Institute on Drug Abuse (NIDA) community epidemiological workgroup. Oklahoma's SEOW is charged with improving prevention assessment, planning, implementation, and monitoring efforts through data collection and analysis that accurately assesses causes and consequences of the use of alcohol, tobacco, and other drugs and drives decisions concerning the effective and efficient use of prevention resources throughout the state. Other primary sources have included the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), and peer reviewed journal articles.

Overview of Oklahoma. According to the 2014 Census data, Oklahoma 20 has a population of 3,878,051 and ranks 20th in area among the 50 states, spanning nearly 70,000 square miles. Oklahoma is comprised of 77 counties with a population density of 54.7 persons per square mile. There are four metropolitan statistical areas and two combined statistical areas. Youth (under 18 years of age) are 24.6% of the population in Oklahoma. Females comprise 50.5% of the population. The census estimates 75.4% of the population is White; 7.7 percent is Black; 9% is American Indian/Alaska Native; 2% is Asian; 0.2% percent is Native Hawaiian and Other Pacific Islander; and 5.8% are of two or more races. Oklahoma also has a Hispanic/Latino population of 9.6%. Of note, is the American Indian/Alaska Native population. Oklahoma has the second largest Native American population after California and is home to 38 federally recognized tribes. The median household income for 2009-2013 is \$45,339 compared to the US median income of \$53,046. The percentage of persons below poverty level for 2009-2013 is 16.9% which is higher than the national percentage of 15.4% ¹.

Health Status for Behavioral Health Consumers with Complex Health Needs.

According to the America's Health Rankings® 2014, Oklahoma ranks 46th for overall health status². The state ranked 39th for diabetes, 44th for obesity, 45th on tobacco use, 45th on drug deaths and 44th on lack of insurance. The 2013 Commonwealth Fund State Scorecard on Health System Performance ranks Oklahoma 49th in overall health system performance, with the state in the bottom tenth percentile on dimensions of quality, avoidable hospital use and costs, and equity.³ Many factors contribute to this ranking and review of some of those is essential to highlight how those impact individuals with mental health or substance use disorders or those at risk of developing a behavioral health disorder. Data on general health status and information specific to tobacco use are included below.

Health Status

- Unhealthy lifestyles and behaviors contribute to most of today's leading causes of death. Health risk factors include smoking, physical inactivity and obesity.⁶
- More than 36,500 Oklahomans died in 2012. As a result, Oklahoma's mortality rate was 23% higher than the national rate⁴. While the US mortality rate dropped 20% over the last 20 years, Oklahoma's rate only decreased 5 percent.⁷
- Oklahoma had the third highest rate of death due to heart disease in the nation and was 30 percent above the U.S. rate. In 2012, more than 9,000 Oklahomans died from heart disease. From 1999 to 2010, heart disease death rates decreased by 26 percent in Oklahoma and by 33 percent in the US.⁸
- Stroke was the fifth leading cause of death in Oklahoma in 2007, resulting in more than 2,100 deaths. The stroke mortality rate decreased by 36 percent since 1990 in the U.S. but only decreased 24 percent in Oklahoma. ^{55, 43}
- Between 1999 and 2010, the cancer incidence rate increased by 2.5% in Oklahoma while it declined by 4.4% in the U.S.⁷. Approximately 20,000 new cases of cancer are diagnosed in Oklahoma each year. Risk factors for cancer are complex and include things such as behaviors, external or environmental factors, and genetics. Several cancers associated with alcohol and tobacco use could be prevented all together. ¹
- Oklahoma's death rate due to chronic lower respiratory disease was the highest in the nation in 2010.¹⁷ Chronic lower respiratory diseases, e.g., COPD, emphysema, chronic bronchitis, and asthma, are the third leading cause of death in Oklahoma. COPD is responsible for 98 percent of deaths from chronic lower respiratory diseases in Oklahoma.¹⁸ COPD is a major cause of disability.¹⁸ People with COPD over the age of 50 years are more likely to be considered disabled.¹⁸ Cigarette smoking is the leading cause of COPD, and secondhand smoke is associated with a 10-43 percent increase in risk of COPD in adults.¹⁸

- Diabetes is the seventh leading cause of death in Oklahoma.¹⁸ Oklahoma is ranked ninth in the nation for the prevalence of people living with diabetes and had the fourth highest diabetes death rate in the nation.²⁰ After adjusting for age and gender, people with diabetes have annual health care expenditures that are more than twice as high (\$13,741 vs. \$5,853) as people without diabetes.¹⁹ Approximately 313,800 Oklahomans age 18+ have been diagnosed with diabetes²⁰ and 1 in 5 Oklahomans aged 65 years and older have been diagnosed with diabetes.
- In Oklahoma 292,000 Oklahomans age 18+ reported in 2012 that they currently have asthma.²⁰ Adults who reported having asthma has increase from 7.1 percent to 10.2 percent over the last decade.²⁰ About 1 in 10 Oklahoma children aged 0-17 currently has asthma (123,100 children).²¹
- Oklahoma is the 6th most obese state in the nation.²⁰ The rate of obesity in Oklahoma has increased from 1 in 7 adults in 1995 to 1 in 3 adults in 2010. In 2013, 12% of Oklahoma youth were obese and 15% were overweight.²² Only 37% of high school students had a physical education class at least once per week, and only 31% had daily physical education.²³
- Persons with SMI die about 25 years earlier than other individuals. In Oklahoma, the years of potential life lost was found to be 26.1 years.²⁴
- The life expectancy of a drug addict is 15 to 20 years after they become addicts.²⁵

Tobacco Use

- Smoking is Oklahoma's leading cause of preventable death.⁴
- Smoking kills more Oklahomans than alcohol, auto accidents, AIDS, suicides, murders and illegal drugs combined.⁹
- Oklahomans spend approximately \$1.16 billion per year on smoking-related health costs.¹¹
- In 2012, approximately 1 in 4 Oklahoma adults smoked, compared to 1 in 5 nationally.¹²
- Each year, about 4,400 Oklahoma children become new daily smokers.¹³
- Oklahoma is one of only two states that prohibits communities from adopting any policy on tobacco that is stronger than state law.¹⁰

- In 2013 almost one in five (18.5%) mothers reported smoking while they were pregnant.¹⁴
- Persons with mental illnesses are twice as likely to smoke as other persons and comprise nearly 45% of the total tobacco market in the U.S.¹⁵
- Individuals who received treatment for a substance use disorder in the past year were about three times more likely to be current (past month) smokers than those who did not receive treatment (74.0 vs. 23.8 percent).¹⁶

Access and Disparities Impacting Specific Populations. Data on substance use and mental illness rates for adults and children are presented here to describe the prevalence of these disorders in Oklahoma and quantify gaps in terms of service penetration and unmet treatment needs.

Alcohol and Substance Abuse Prevalence

- According to the National Survey on Drug Use and Health (NSDUH) report, Oklahoma is above the national average among persons aged 12 and older reporting dependence or abuse of illicit drugs or alcohol in the past year. The percentage, based on 2011 and 2012 data, was 9.59 for Oklahoma and 8.27 for the nation.³¹
- The latest National Vital Statistics System (NVSS) data show that Oklahoma exceeds the Nation in number of deaths due to drug-related behavior. In 2013, the rate per 100,000 was 20.6 for Oklahoma and 13.8 for the US.⁷
- Oklahoma is ranked 6th in the nation for alcohol-related mortality. Long-term alcohol consumption is associated with chronic liver disease.³⁴ The relationship between alcohol use and suicide is also well documented.³⁵ Both chronic liver deaths and suicide deaths have been on the rise in Oklahoma since 2003.⁷
- Data from the Pregnancy Risk Assessment Monitoring Survey (PRAMS) show that alcohol use among pregnant women has increased in Oklahoma since 2003 when 2.5 percent of pregnant women had consumed alcohol during the last 3 months of their pregnancy. This percentage peaked in 2008 when 6.1 percent of pregnant women reported this behavior. In 2009, the percentage was 4.8.³⁷
- According to the Uniform Crime Report, the rate of crimes related to alcohol use has decreased in Oklahoma since 2005; however, Oklahoma has consistently higher rates than the United States. Crimes related to alcohol use include aggravated assaults, sexual assaults, and robberies. In 2014, the number of alcohol-related arrests (N=30,796) exceeded both index crimes, which include

murder, rape, robbery, aggravated assault, burglary, larceny, and motor vehicle theft (N=20,375) and drug-related crimes (N=16,846).³⁶

- The rate of drug-related crimes (larceny, burglary, motor vehicle theft) in Oklahoma also outstripped that of the nation; in 2011, Oklahoma reported 3,356.2 drug-related crimes per 100,000 population compared to the national rate of 2,908.7 per 100,000. ³⁸
- Fatality Analysis Reporting System (FARS) data for Oklahoma show that there has been an increase in the percentage of fatal crashes involving an alcohol-impaired driver. In the same period, the nation has seen a decrease. In 2007, Oklahoma's alcohol-impaired driver fatality rate was 31.3 percent, and in 2011, it was 35.7 percent. National percentages for those years were 37.6 percent and 35.6 percent, respectively.³⁸

Serious Mental Illness (Adults) Prevalence and Services Access

- Among those ages 18 and older, the rate of SMI across the nation averaged 4 percent. In Oklahoma, 5.24 percent of residents were found to have SMI, the second highest rate of SMI in the nation.³¹
- Nationally, 18.2 percent of the population is reported to suffer from some form of mental illness. Oklahoma has a rate 22 percent, again, the second highest in the US. ³¹

Serious Emotional Disturbance (Children and Youth) SED Prevalence/Penetration

- Oklahoma has an estimated 67,350 (13%) youth age 9 to 17 with SED.¹
- In state FY15, the total number of children 0-18 served was 12,195. Total number of children 0-18 with SED designation served in FY14 was 6,929.⁴⁵

American Indians

The U.S. Commission on Civil Rights, in its report, Broken Promises: Evaluating the Native American Health Care System, states that it has long been recognized that American Indians are dying of diabetes, alcoholism, tuberculosis, suicide, and other health conditions at shocking rates. Beyond disturbingly high mortality rates, American Indians also suffer a significantly lower health status and disproportionate rates of disease compared with all other Americans. The disparities in healthcare are especially significant for Oklahoma with the second highest percentage of American Indians as compared to all other states.

- In 2013, the American Indian and Alaska Native (AI/AN) population in Oklahoma was 349,023, comprising 9 percent of the state's total population and ranking Oklahoma second among all states for the number of AI/AN in its population.¹
- According to the CDC, AI/AN people have the highest prevalence of tobacco use of any population in the United States.⁴¹
- Deaths from injuries were higher among AI/AN people compared to non-Hispanic whites.
- Suicide rates were nearly 50 percent higher for AI/AN people compared to non-Hispanic whites, and more frequent among AI/AN males and persons younger than age 25.
- Death rates from motor vehicle crashes, poisoning, and falls were two times higher among AI/AN people than for non-Hispanic whites.
- According to data from the 2009 BRFSS, 14.2 percent of AI/AN adults reported binge drinking, and 4.0 percent reported heavy drinking; both percentages exceed those reported by any other race.²⁰
- Among AI/AN, 11.7 percent of deaths between 2001 and 2005 were alcohol-related, compared with 3.3 percent for the U.S. as a whole. The two leading causes of alcohol-related deaths among AIs were traffic accidents and alcoholic liver disease, each of which cause more than a quarter of the 1,514 alcohol-related deaths over the four-year period. Of these, 66 percent were people younger than 50 years old and 7 percent were less than 20 years old.
- Smoking among AI/ANs at 32.4 percent is the highest by far among any racial and ethnic group.⁴² In 2004, among youths, AI/ANs had the greatest cigarette smoking prevalence (23.1%), followed by non-Hispanic whites (14.9%), Hispanics (9.3%), non-Hispanic blacks (6.5%), and Asian Americans and Pacific Islanders (4.3%).⁴³ In 2005, AI/AN women had the highest rate of smoking during pregnancy (17.8%) compared to non-Hispanic white (13.9%) and non-Hispanic black (8.5%) women.⁴⁴

Adults with Criminal Justice Involvement

Many studies have shown that individuals with mental illness and addiction are overrepresented in jails and prisons in the United States. This is even more pronounced in Oklahoma, as the State incarceration rate is ranked 3rd nationally for males and 1st for females. In 2012, Oklahoma incarcerated over 25,000 people (excluding persons held in county jails due to bed shortages in the prisons) and 28% are charged with drug-related crimes.⁵²

- The Department of Corrections indicates that in 2012, approximately 13,000 or 50% of offenders have a history of, or are currently exhibiting some form of mental illness. Of the 2,650 female offenders, 69% have a mental health need (2,130), compared to 48% of the 23,000 male offenders.⁵¹
- Approximately 26% of the total prison population (52% female and 23% male) currently exhibit symptoms of a SMI, given the most conservative definition. Since 1989, the number of offenders receiving psychotropic medications has dramatically increased (300%), while the total inmate population has only increased by 19%.⁵¹
- Of inmates diagnosed with a mental illness, 50% of inmates (60% female, 42% male) were incarcerated for non-violent offenses.⁵¹
- The average recidivism three-year return rate for the general population is 15.8%; however, for females with SMI the return rate is 25.2% and for males with SMI the rate is 46%.⁵¹

Youth with Juvenile Justice Involvement

From one-quarter to one-third of incarcerated youth have anxiety or mood disorder diagnoses, nearly half of incarcerated girls meet criteria for post-traumatic stress disorder (PTSD), and up to 19 percent of incarcerated youth may be suicidal. In addition, up to two-thirds of children who have mental illnesses and are involved with the juvenile justice system have co-occurring substance abuse disorders, making their diagnosis and treatment needs more complex. Many programs are effective in treating youth who have behavioral health care needs in the juvenile justice system, reducing recidivism and deterring young people from future juvenile justice involvement. Generally, regardless of the type of program used or the youths' background, recidivism rates among those who received treatment are as much as 25 percent lower than the rates of those children and teens in untreated control groups.^{53, 54}

Data from 2013 and 2014 from the Oklahoma Office of Juvenile Affairs found that for youth in custody:⁵⁵

- 33% have a substance abuse issue
- 30% have a mental health issue

Youth on probation:

- 26% have a substance abuse issue
- 23% have a mental health issue

For those in "level E" OJA custody, the most secure level, it is estimated 79% have substance abuse problems.

Military Personnel and Families

The first of four goals of the White House Report: Strengthening Our Military Families, is to enhance the well-being and psychological health of the military family. The report recognizes with the increased exposure to combat stress due to longer and more frequent deployments, there has been a growing number of service members with behavioral health needs. Further, it recognizes that military families are not immune to the stresses of deployment and cites a growing body of research on the impact of prolonged deployment and trauma-related stress on military families, particularly spouses and children.

- As of September, 2014, there were 337,577 veterans in Oklahoma (Gulf War – 35%, Vietnam - 38%, Korean Conflict – 8%, and World War II – 4%).⁴⁶
- In Oklahoma 33,802 service members deployed between 9/01/2001 and 1/31/2015. Of these, 26,070 have deployed more than once.⁴⁷
- There are 35,007 dependents of service members deployed between 9/11/2001 and 1/31/2015 in Oklahoma. ⁴⁷
- Oklahoma veterans and active-duty military personnel are killing themselves at twice the rate of civilians.⁴⁸ In 2011, 141 of the state's 684 suicides were veterans.
- A Rand study found that 20% of returning service members met criteria for PTSD and 14% meet criteria for depression. It is estimated that 300,000 veterans who have returned from Iraq and Afghanistan are currently suffering from PTSD or major depression.⁴⁹

Prevention and Early Identification.

Suicide Prevention. According to the Centers for Disease Control and Prevention (CDC) in 2013 (the most recent year for which full data are available), 41,149 suicides were reported, making suicide the 10th leading cause of death for Americans.²⁷ In that year, someone in the country died by suicide every 12.8 minutes. For the same year, 494,169 people visited a hospital for injuries due to self-harm behavior, suggesting that approximately 12 people harm themselves (not necessarily intending to take their lives) for every reported death by suicide. Together, those harming themselves made an estimated total of more than 650,000 hospital visits related to injuries sustained in one or more separate incidents of self-harm behavior. Over 90% of men and women who deliberately harm themselves meet the criteria for a mental disorder diagnosis at the time of their self-harm.²⁸

- Suicide is the leading cause of intentional deaths in Oklahoma.⁴ Suicide deaths outnumber homicides by almost three to one. The suicide rate in Oklahoma

worsened by 25 percent from 1990 to 2010.

- The suicide rate in Oklahoma was 36 percent higher than the U.S. rate.⁴
- Central Oklahoma had the largest increase (42%) in the rate of death due to suicides between 2007 and 2012. ⁴
- One in five suicide victims had a history of suicide attempts and 32 percent had shared their intent/feelings with another person.²⁹
- Factors that are likely to increase a person's risk for suicide included mental illness, poor physical health and intimate partner problems²⁹
- For each suicide prevented, Oklahoma could save an average of \$1,097,763 in medical expenses (\$3,545) and lost productivity (\$1,094,218).³⁰

Early Screening and Referral. As stated in the President's New Freedom Report, for individuals of all ages, early detection, assessment, and linkage with treatment and supports can prevent behavioral health problems from compounding and poor life outcomes from accumulating. Early intervention can have a significant impact on the lives of children and adults who experience behavioral health problems. Emerging research indicates that intervening early can interrupt the negative course of some illnesses and may, in some cases, lessen long-term disability.

- The direct costs of untreated needs of people with mental illness and substance addictive disorders for Oklahoma businesses, governments and families is \$3.2 billion annually and the total cost on the Oklahoma economy due to untreated and undertreated mental illness and substance abuse is placed at more than \$8 billion annually.⁵⁰
- Oklahoma's criminal justice system spends 63 percent of its annual budget (over \$1 billion) to address the untreated needs of people with mental illness or addictive disorders.⁵⁰

Underage Drinking. The National Institute for Alcohol Abuse and Alcoholism published a News Alert which showed that many adolescents start to drink at very young ages. In 2003, the average age of first use of alcohol was about 14, compared to about 17.5 in 1965. People who reported starting to drink before the age of 15 were four times more likely to also report meeting the criteria for alcohol dependence at some point in their lives. In fact, new research shows that the serious drinking problems, typically associated with middle age, actually begin to appear much earlier, during young adulthood and even adolescence.

Other research shows that the younger children and adolescents are when they start to drink, the more likely they will be to engage in behaviors that harm themselves and others. For example, frequent binge drinkers (nearly 1 million high school students

nationwide) are more likely to engage in risky behaviors, including using other drugs such as marijuana and cocaine, having sex with six or more partners, and earning grades that are mostly Ds and Fs in school.

- NSDUH data from 2013 indicated 38.2 percent of 18 to 25-year-olds and 5.8 percent of 12 to 17-year-olds were binge drinkers.⁷ YRBS data also showed 23.3 percent of adolescents were binge drinkers at the time of the survey.³¹
- The 2013 YRBS showed 18.7 percent of Oklahoma students in grades 9–12 reported early initiation of alcohol and 68.3 percent of respondents reported they had consumed alcohol on at least one day of their life. ⁴⁰
- In 2013, Oklahoma’s percentage of adolescent drunk driving was 8.2 percent, compared to the national average of 8.6 percent. ⁴⁰

Misuse of Prescription Drugs. In the United States, prescription drugs are the second most commonly abused category of drugs, behind marijuana. There may be a perception, especially among younger people, that prescription drugs are safer than illegal street drugs. Most people do not lock up their prescription medications, nor do they discard them when they are no longer needed for their intended use, making them vulnerable to theft or misuse. According to SAMHSA, the number of teens and young adults (ages 12 to 25) who were new abusers of prescription painkillers grew from 400,000 in the mid-’80s to 2 million in 2000. New misusers of tranquilizers, which are normally used to treat anxiety or tension, increased nearly 50 percent between 1999 and 2000 alone. Like many other states, Oklahoma is experiencing a dramatic increase in the misuse of prescription drugs.

- Oklahoma led the nation in non-medical use of painkillers, with more than 8% of the population aged 12 and older abusing/misusing painkillers.³³ Oklahoma is also one of the leading states in prescription painkiller sales per capita.
- In fact, prescription drug abuse is Oklahoma’s fastest growing drug problem.³² There were nearly 3,900 unintentional poisoning deaths in Oklahoma from 2007-2012. Four out of five of these deaths involved at least one prescription drug. In 2012, Oklahoma had the fifth highest unintentional poisoning death rate in the nation (18.6 deaths per 100,000 population). Prescription painkillers were involved in 9 out of 10 prescription drug-related deaths, with 460 opioid-involved deaths in 2012 alone. The most common prescription drugs involved in overdose deaths are hydrocodone, oxycodone, and alprazolam. More overdose deaths involved hydrocodone than methamphetamines, heroin, and cocaine combined.
- According to data from the 2013 NSDUH, Oklahoma was higher than the national average for the nonmedical use of pain killers in the past year for all age categories. Oklahoma has been above the national average for the percentage of residents reporting nonmedical use of pain relievers since 2004.⁵

- The National Vital Statics System data show a 423% increase in opioid pain reliever-related deaths of all intents in Oklahoma since 1999. The latest data released in 2010 ranked Oklahoma 3rd in the nation for opioid pain reliever-related overdose deaths, exceeding the national average by 152 percent.

Older Oklahomans

The proportion of Oklahoma’s population that is over 60 is growing while the proportion that is under 60 is shrinking. The US Census Bureau estimates that more than 24 percent of Oklahoma’s population will be over age 60 by the year 2030, an increase of close to 25 percent from 2012.⁵⁷

- One in four persons aged 55 and over experiences behavioral health disorders that are not part of the normal aging process.⁵⁸
- Despite the availability of proven interventions for mental health and substance use problems, the majority of older adults with these behavioral health issues do not receive the treatments they need. Older adults are significantly less likely to receive any mental health treatment when compared to younger adults.⁵⁹
- An estimated one in five older adults may be affected by combined difficulties with alcohol and medication misuse.⁶⁰
- Up to 5% of older adults in the community have major depression and up to 15% have clinically significant depressive symptoms that impact their functioning, and the prevalence of depression is substantially higher in older adults with medical illnesses.⁶¹
- The incidence of suicide is particularly high among older, white males (30.3 suicides per 100,000). The rate of suicide in the oldest group of white males (ages 85+) is over four times higher than the nation’s overall rate of suicide. In 2007, the latest year in which comparable national data were available, 146 Oklahomans over age 55 committed suicide. The highest rate was the 75 and older age group at 25.3.⁶²

Good and Modern Services.

Use of Peer Recovery Support Specialists. It is evident in Oklahoma that persons in recovery from a mental illness and/or substance abuse disorder, who are trained to work with others on their individual roads to recovery, fulfill unique roles in the service system. Peer Recovery Support Specialists (PRSSs) offer the advantage of lived experience from serious mental illness and/or substance abuse. They know the journey to recovery is real and attainable, because they have traveled the path.

- Recovery Community Services Program has shown consistent, positive results. The most recent data collected by SAMHSA for individuals accessing services at

baseline and 6-month follow-up revealed:³¹

- 75% of clients reported no substance use, an increase of 16.8%
 - 95.9% of clients reported no arrests at six-month follow-up
 - 51% of clients reported being employed, an increase of 33.9%
 - 51% of clients reported being housed, an increase of 31.8%
 - Clients experiencing serious depression decreased 19.6%
 - Clients experiencing serious anxiety decreased 21.7%
 - Clients experiencing trouble understanding, concentrating, or remembering decreased 25.8%
 - Clients attempting suicide decreased 23.1%
 - 20% of clients were prescribed medication for psychological/emotional problem at six-month follow-up
- A meta analysis by Reif et al. showed studies demonstrated reduced relapse rates, increased treatment retention, improved relationships with treatment providers and social supports, and increased satisfaction with the overall treatment experience when recovery support services are delivered by an individual in recovery.³⁹

Impact of Trauma. Results from the Adverse Childhood Experiences (ACE) Study indicates that childhood abuse and household dysfunction lead to the development of the chronic diseases that are the most common causes of death and disability in this country. A strong relationship is shown between the number of adverse childhood experiences and reports of cigarette smoking, obesity, physical inactivity, alcoholism, drug abuse, depression, suicide attempts, sexual promiscuity, and sexually transmitted diseases. Traditionally viewed as public health or mental health problems, these behaviors appear to be coping mechanisms for people who have had adverse childhood experiences. Trauma-Informed Services can address the impact of trauma on people's lives and facilitate trauma recovery.

- As many as 80 percent of men and women in psychiatric hospitals have experienced physical or sexual abuse, most of them as children.³²
- The majority of adults diagnosed with Borderline Personality Disorder (81%) or Dissociative Identity Disorder (90%) were abused as children.³²
- As many as two-thirds of both men and women in substance abuse treatment report childhood abuse or neglect.³²
- Nearly 90 percent of alcoholic women were sexually abused as children or suffered severe violence at the hands of a parent.³²
- 82 percent of young people in inpatient and residential treatment programs have histories of trauma.³²
- Violence is a significant causal factor in 10-25 percent of all developmental

disabilities.³²

- For women in prison and jail, 80 percent have been victims of sexual and physical abuse.³²
- In one study, 92 percent of incarcerated girls reported sexual, physical or severe emotional abuse.³²
- Boys who experience or witness violence are 1,000 times more likely to commit violence than those who do not.³²
- A 2014 study looking at the prevalence of ACEs among children from birth through 17 reported Oklahoma as the only state that ranks in the highest quartile for each ACE domain.⁶³

Use of Technology. According to the 2014 Census estimate, 68% of the State's population lives in an urban area, with nearly one-third residing in a rural or frontier area. This leads to barriers to care for many Oklahomans who live in areas without the appropriate level of care and who do not have resources to get to the needed services. Telehealth is a primary strategy used by the ODMHSAS to increase access to mental health and substance abuse information and services to underserved areas. Through the Oklahoma TeleHealth Network, Oklahomans who were once unable to receive services due to geographical, economic and workforce barriers are now able to receive the care that they desire.

- In fiscal year 2015, over 10,585 Oklahomans were given behavioral health care services via Telehealth.⁴⁵
- For this same year, over 28,823 services were delivered via telehealth.⁴⁵

Step Two Summary. The data and discussion used in Step Two above do not represent what the State would consider complete in terms of a comprehensive gap analysis. Regardless, substantial data are available and have aided the State in this block grant planning process. In fact, use of those data has driven a process by which Oklahoma has identified priorities on which to focus this plan and application. Those priorities are listed in planning steps three and four and relate to the areas of health promotion, improved access, reduced disparities, service accountability, criminal justice concerns, prevention of substance use and mental health disorders, and public awareness.

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PLANNING STEPS - CONTINUED

Step 3 and 4: Prioritize State Planning Activities and Develop Goals, Objectives, Performance Indicators and Strategies

Priority Area	Goals	Strategies	Performance Indicators
1. Overall Health Promotion	Further integrate behavioral health with primary care	Spread procedures and practices developed at Health Integration (PCBHI) sites to other community behavioral health settings	Number of formal agreements between behavioral health homes and primary care providers
		Health Homes will become well established and will increase persons served.	Number served in Behavioral Health Homes for adults with SMI and children with SED
	Improve the health status of behavioral health consumers with complex health needs	Outreach for intravenous drug users	Number of IV drug users and high risk substance abusers served through outreach contracts
	Reduce the use of tobacco	Promotion of OK Tobacco Quitline	Number of faxed referral sheets submitted from behavioral health providers to the OK Tobacco Quitline
2. Improved Access and Reduced Disparities	Expand services for American Indians (AIs)	Development of website to educate AIs about services available to them and how to access them	Number of American Indians receiving Medicaid-funded behavioral health services
		Outreach activities done through Behavioral Health Homes	Number of outreach activities conducted to AIs
	Improve access for military personnel and their families	Seek funding to make more specialty court slots available to veterans	Increase the number of specialty court slots for veterans
		Outreach to veterans and their families utilizing veteran peer recovery support specialists	Number of veteran peer recovery support specialists certified

Priority Area	Goals	Strategies	Performance Indicators
2. Improved Access and Reduced Disparities - Continued	Expand services for veterans	Pursue state planning grant to improve the public mental health system through certifying as certified community behavioral health centers with new standards around serving veterans	Increase the number of veterans served in HHs and CMHCs
	Expand services for children with SED	Local systems of care and Wraparound sites	Number of children with SED and co-occurring AOD disorders admitted to Systems of Care programs
	Improved services for older adults	Provide training to CMHC staff and others to improve skills and knowledge in serving older adults	Number of staff who receive training in serving older adults from ODMHSAS each year
	Utilize specific programs to address the needs of targeted populations	Strengthening Families and Celebrating Families – EBP family group counseling – for parents in substance abuse treatment programs and their children	Number of participants in Strengthening Families and Celebrating Families programs
	Improve access to treatment for pregnant and parenting women	Priority admission to substance use disorder treatment services for pregnant and parenting women	Average number of days pregnant women were on a waiting list before they were admitted to residential care
	Utilize evidence based practices to identify the warning signs of mental illness	Mental Health First Aid for educators and the general public	Number of individuals trained in Mental Health First Aid
Improve access to treatment to the LGBT population	Provide outreach and support to the LGBT population	Number of LGBT population served through LGBT outreach program	
3. Enhance Service Quality and Accountability	Expand use of recovery support services	Certification program for Peer Recovery Support Specialists (PRSS)	Number of PRSSs certified
		Expand use of PRSSs in substance abuse and mental health settings	Number of services provided by PRSSs

Priority Area	Goals	Strategies	Performance Indicators
3. Enhance Service Quality and Accountability - Continued	Utilize evidence based practices for individuals impacted by trauma	Require use of the Children and Adolescent Trauma Screening (CATS)	Number of youth receiving CATS screening and follow-up with trauma-specific services
	Increase options for self-directed care	Peer-run, drop-in centers as option for services and supports	Number of individuals receiving drop-in center services
	Leverage technology to improve access and quality of care	Telehealth services for both substance abuse treatment and mental health services	Number of services provided through telehealth
	Incentivize for more efficient use of resources and improved service outcomes	Use of the Enhanced Tiered Payment System (ETPS)	Percent of time agencies meet the benchmark for the incentive payment as a result of indicators of improved care
4. Reduced Criminal Justice Involvement	Utilize treatment and supports to divert individuals from incarceration	Specialty courts (drug courts, mental health courts, specialty courts dockets, etc.) and other criminal justice diversion programs	Number served through specialty courts
	Reduce recidivism for offenders	Co-occurring and substance abuse treatment in prison setting and Correctional Based Discharge Planners and Reentry Intensive Care Coordination Teams (RICCTS) for persons with SMI	Number of offenders served while incarcerated and following incarceration
			Reduced recidivism rate for individuals served through RICCTS
	Improve workforce capacity and skills in response to individuals with criminal justice/public safety involvement	Law enforcement training - Memphis Model Crisis Intervention Training (CIT)	Number of police officers trained in CIT
Increase use of Risk and Need Screenings to inform sentencing decisions	Promotion of Offender Screenings	Number of offenders screenings conducted	

Priority Area	Goals	Strategies	Performance Indicators
5. Prevention of Mental Illness and Substance Use Disorders	Reduce rates of suicide	Promotion of use of National Suicide Prevention Lifeline	Increase in utilization of Lifeline
	Reduce substance use	Community level strategies for substance abuse prevention	Number of evidenced-based prevention strategies reported
	Early identification and intervention of substance use problems	Screening, brief intervention and referral to treatment (SBIRT) services within primary care and other community health/hospital settings	Number of persons trained in SBIRT
		Mental Health First Aid training in schools, workplaces, and other settings.	Number trained in Mental Health First Aid
	Reduce underage drinking	Consistent and highly visible enforcement of state and local laws related to underage and high risk drinking	Prevalence of underage drinking
			Number trained in enforcement of youth access to alcohol laws
			Number trained in Responsible Beverage Sales and Service training
	Reduce misuse of prescription drugs	Increase state and community level prevention strategies to prevent non-medical use of prescription drugs	Number of individuals 18-25 reporting past year non-medical prescription pain reliever use
			Number of individuals 26 and older reporting past year non-medical prescription pain reliever use
		Increase opioid overdose prevention training and access to naloxone	Number trained in Naloxone administration
Number of Naloxone administrations			
6. Public Awareness	Utilize social media to provide awareness around behavioral health issues such as stigma and access to care	Social media efforts to promote recovery themes and topics	Number of Facebook posts, tweets, website hits
		Multi media campaign for transitional youth in Oklahoma, Washington and Okmulgee counties	Number of people contacted through multi-media campaign in three counties
	Provide public information for improved access to services	Provide information outreach	Number of materials disseminated

PLANNING STEPS - CONTINUED

Quality and Data Collection Readiness

In 2010, the ODMHSAS and the Oklahoma Health Care Authority (OHCA), the state Medicaid agency, merged the two agencies' management information systems into a consolidated claims system, establishing standardized processes, including eligibility determination, authorizations, claims filing and outcome reporting for all publically funded behavioral health care. At the same time, the combined payer system was designed to maximize federal Medicaid matching funds by ensuring that services for consumers eligible for Medicaid payments are paid from this funding source rather than State or block grant funds. The system uses a unique identifier that allows consumers to be linked across providers and over time. Because it is a relational database, pharmacy claims and encounter data, including inpatient and outpatient claims, can be linked back to the individual. Demographics, diagnosis, assessment scores and outcome data are also linked. The ODMHSAS was the first state to submit both the admission and the discharge set to the Treatment Episode Data Set (TEDS) program. Each facility, facility location and clinician has a unique identifier and can be linked back to the service and consumer. There are over 100 service codes and modifier combinations which provide detailed information about the types and duration of services each consumer is receiving. Rates are attached to all of the services, which allow cost reports to be calculated.

The ODMHSAS designed and manages the prior authorization system which interacts with the Medicaid Management Information System (MMIS). The prior authorization system, the Person-Centered Integrated Client Information System (PICIS) not only authorizes services and payment amounts but also collects data for outcome measures. These data include information about demographic characteristics, living arrangements, employment, income, legal and marital status, language proficiency, education, disabilities, diagnoses, level of functioning, drugs of choice (including tobacco), frequency of use, and client assessment results. Consumer information is collected and reported at admission, six-month update, and discharge. Comparisons can be made from admission to updates on items such employment status, housing status, frequency of alcohol/drug use, and level of functioning. PICIS data on age, race, ethnicity, gender, marital status, language, physical disabilities, drugs of choice, level of functioning scores, and other elements can be cross-tabulated with services, retention, and outcome information to determine where behavioral health disparities are occurring. This information is linked to claims and encounter data giving the ODMHSAS the ability to report data at the client, program, provider and state level.

The Medicaid Management Information System (MMIS), where all claims are submitted, collects data on behavioral health, physical health (including outpatient and inpatient), pharmacy, and dental care paid for by Medicaid and the ODMHSAS. The PICIS system is an integrated prior authorization and outcomes database that is specific to mental health and substance abuse treatment funded by Medicaid and the ODMHSAS. The systems are linked through unique identifiers.

The ODMHSAS has been reporting data at the client level since the late 1980s to the TEDS and reported client level data through the SAMHSA Client Level Data (CLD) reporting process for the 2011-13 block grant periods. In 2014 the client level data was submitted through the MH-TEDS process.

ENVIRONMENTAL FACTORS AND PLAN

1. The Health Care System and Integration

Oklahoma Health Care Coverage. The state of Oklahoma has opted for the federal government's state insurance exchange and chose not to expand Medicaid. The Cabinet Secretary for Health and Human Services, Dr. Terry Cline, is leading policy discussions to develop an Oklahoma solution for addressing the State's health needs. Oklahoma continues to apply for extensions for Insure Oklahoma, the state's premium assistance program that helps businesses and their modest and low-income employees afford health insurance coverage. The program, which has been in operation since November 2005, currently serves 17,923 Oklahomans with more than 3,700 businesses participating.

The ODMHSAS became responsible for the management of Medicaid behavioral health funds in 2012. Leadership of the ODMHSAS and the Oklahoma Health Care Authority (Medicaid) confer regularly to address access to behavioral health services, evaluate the appropriate use of Medicaid resources, and to jointly evaluate Medicaid related policies and practices.

Coordinated Care Initiatives. The Oklahoma Health Improvement Plan (OHIP) focuses efforts on making improvements in key strategic areas and creating a culture of health. Key areas of focus include: tobacco use, obesity, children's health, behavioral health, social determinants and health transformation. Mental health and substance abuse issues are among the most pressing concerns facing Oklahoma today. To address these behavioral health concerns the following goals have been created in the Oklahoma Health Improvement Plan; reduce the prevalence of untreated mental illness from an 86% treatment gap to 76% in 2020, reduce the prevalence of addiction disorders from 8.8% to 7.8% by 2020 and reduce suicide deaths from 22.8 per 100,000 in 2013 to 19.4 per 100,000 by 2020. Strategies in place to address these goals include: Health Homes, incorporate behavioral health into primary care, improved screenings (SBIRT), expansion of Drug Court, Family Drug Court and Mental Health Court, improved access to crisis and urgent care for mental health disorders and access to Systems of Care statewide. The ODMHSAS is partnering with the Oklahoma Department of Health and many other organizations to implement the OHIP and realize its goal.

Oklahoma Health Homes is a Medicaid State Plan option that provides an opportunity to build a person-centered system of care that achieves improved outcomes and better services and value for the Oklahoma SoonerCare Program. The ODMHSAS has partnered with the OHCA to expand upon the patient-centered medical home model and existing behavioral health case management and System of Care (SOC) infrastructure to provide coordinated primary and behavioral health integration. In accordance with the CMS, a Health Home must have the capacity to provide all of the following services, as appropriate, based on members' changing needs: comprehensive care management; care coordination; health promotion; comprehensive transitional care (including

appropriate follow-up from inpatient to other settings); individual and family support; and referral to community and social support services. The expectation is that behavioral health homes will result in improved quality of care and more cost efficiencies; improved experience with care on the part of members; and reductions in the use of hospitals, emergency departments, and other expensive facility-based care.

Systems of Care is a comprehensive spectrum of mental health and other support services that are organized into coordinated networks to meet the multiple and changing needs of children, adolescents and their families with a SED. It accomplishes this by providing community based, family driven, youth guided, and culturally competent services statewide.

Wraparound is a way to improve the lives of children with complex needs and their families by developing individualized plans of care. The key characteristics of the process are that the plan is developed by a family centered team, is individualized based on the strengths and culture of the child and his or her family, and is driven by needs rather than services. In addition to addressing the needs of the identified youth, Wraparound plans are designed to meet the needs of caregivers and siblings and to address a range of life areas. Through the team-based planning and implementation process, wraparound also aims to develop the problem-solving skills, coping skills, and self-efficacy of the young people and family members. Finally, there is an emphasis on integrating the youth into the community and building the family's social support network.

Certified Community Behavioral Health Centers (CCBHCs): Oklahoma has applied for SAMHSA's CCBHC Planning Grant. The State will capitalize on the high standards required for CCBHCs to build on the foundation laid the past several years with our pay for performance and Health Home initiatives to ensure: 1) better access to and availability of service; 2) integration of mental health, substance abuse and primary care to individualize holistic care for all individuals; 3) high quality of service through disseminating evidence based practices with an Oklahoma-proven method to ensure fidelity; 4) innovative financial solutions to ensure service regardless of ability to pay; 5) formal relationships with emergency departments and other crisis services; 6) ability to assist with transportation and/or deliver service through telemedicine; and 7) meaningful consumer involvement and voice at every level of the system. The ODMHSAS will build on the foundation laid over the past several years with the pay for performance, zero suicide, and health home initiatives.

The following advocacy agencies are powerful partners for the ODMHSAS and OHCA in our mission to continually improve the public behavioral health system. Each of them has promised participation in the State Planning Grant activities and in the Demonstration. Each of them consists of a unique set of consumers, persons in recovery, family members, and advocates. Collectively, they promise the breadth and depth of consumer and advocate involvement that is greatly needed to ensure success. They will advise the ODMHSAS based on the unique perspectives of their local, state and national connections. Advocacy organizations include: 1) the **Mental Health**

Association of Oklahoma (MHAO), which became one of the first mental health associations in the nation in 1955; 2) **NAMI OK**, the state's only organization affiliated with the National Alliance on Mental Illness (NAMI), the nation's largest grassroots organization; 3) The **Evolution Foundation**, a statewide, non-profit agency that supports Oklahoma families with children with behavioral health care needs; 4) OK Citizen Advocates for Recovery & Treatment (**OCARTA**), the first and only peer-run organization in the State; and 5) **The Depression and Bipolar Support Alliance (DBSA)**, the leading patient-directed national organization focusing on the most prevalent mental illnesses. All of these organizations will provide strong ongoing partnership and will actively assist in the planning and demonstration processes.

All of the Health Homes are utilizing **MyHealth Access Network**, a Health Information Exchange. MyHealth enables participating providers to access a portal that displays a community-wide snapshot of patients' previous treatments, medications, allergies, immunizations, procedures and lab results. Providers can then drill into patient data to access both structured data and clinical documents, such as care summaries.

Collaboration with the Primary Care Organizations. In preparation for health homes, the ODMHSAS and the Oklahoma Primary Care Association (OPCA) sponsored a joint meeting of Federally Qualified Health Centers (FQHCs) and CMHCs and brought in Joseph Parks, M.D., Chief Clinical Officer with the Missouri Department of Mental Health as the key note speaker. Dr. Parks was instrumental in bringing integrated care to Missouri through the health home model. Representatives from the OPCA participated in the Health Home State Plan Amendment work. Many of the Oklahoma health homes and FQHCs have agreements to co-locate staff for the health homes or are pursuing this option. In addition, four CMHCs have a Primary and Behavioral Health Care Integration Grant funded through SAMHSA, two of which are working with an FQHC.

Oklahoma State Department of Health (OSDH) is led by Oklahoma's Secretary of Health and Human Services, Commissioner Terry Cline, former Administrator of SAMHSA. Dr. Cline is a champion for integrated health care in Oklahoma and works closely with the ODMHSAS Commissioner and OHCA Director to guide all three agencies toward networks of providers that provide integrated care utilizing evidence-based practices. They are responsible for the Oklahoma Health Improvement Plan (OHIP), and work closely with the ODMHSAS on the behavioral health portion of this plan. They are committed to providing data helpful to state planning activities, providing guidance in line with the OHIP, and assisting with advising the Governor, if necessary, on additional resources that might be needed for sustaining advances made by CCBHCs. It is essential to have participation of FQHCs with the CMHCs as they transition to CCBHCs. Therefore the **Primary Care Association** is an important partner and has committed to participating in the planning process and providing guidance and updates to FQHCs. The **Oklahoma Hospital Association** will also be an important partner and will participate in planning and updating hospitals around the State.

Addressing Nicotine Dependence. For the past seven years, the ODMHSAS has collected tobacco usage information on every client at admission, update and discharge

to determine the prevalence of tobacco use within sub-populations and ascertain any changes in use over the course of treatment. Depending on the consumer's response to this question, the 5A's technique is implemented which promotes the use of a fax referral form to the Oklahoma Tobacco Helpline where consumers are connected with up to eight weeks of nicotine replacement therapy and five quit coach sessions.

Each contracted and state-operated facility must have a tobacco free policy in place and an enforcement plan for this policy for both staff members and consumers. Peer providers as well as other staff members can be trained as Tobacco Cessation Coaches and Wellness Coaches in order to help consumers address tobacco use

The ODMHSAS has created a tobacco free workplace taskforce to review the rate of tobacco use among consumers and staff at ODMHSAS-funded provider agencies. The taskforce provides recommendations on strategies to decrease tobacco use and improve lives. The three primary strategies used by the taskforce are the promotion of tobacco policy, building community support, and providing tobacco cessation options, including nicotine replacement products to individuals in inpatient, residential, and crisis center settings because these groups have difficulty accessing products provided through the Oklahoma Tobacco Helpline.

In addition to the taskforce, the ODMHSAS initiated a Tobacco Cessation Advisory Council made up of external partners in an effort to integrate nicotine dependence into other healthcare systems. The group recently expanded its effort to include physical activity and nutrition to stress the whole health needs of individuals with mental health and addictions issues and is now called the Behavioral Health and Wellness Systems Council.

Tobacco cessation focused services provided by physicians are paid for through the ODMHSAS and Medicaid in Oklahoma. The ODMHSAS also funds tobacco cessation focused wellness resource skills development services, which any level of staff can provide and is a required service for all of the consumers enrolled in the Health Home service delivery system.

Addressing Smoking with Clients. For the past seven years, the ODMHSAS has screened for tobacco usage information on every client at admission, update and discharge to determine the prevalence of tobacco use within sub-populations and ascertain any changes in use over the course of treatment. Depending on the consumer's response to this question, the 5A's technique is implemented which promotes the use of a fax referral form to the Oklahoma Tobacco Helpline where consumers are connected with up to eight weeks of nicotine replacement therapy and five quit coach sessions. For FY14, there were 2,508 individual consumers referred to the Oklahoma Tobacco Helpline and 502 (20%) of these individuals accepted the services offered. In FY15, 4,024 individual consumers were referred to the Helpline and 865 of these individuals accepted services (21.5%). The rates of referrals from more than 75 behavioral health providers represents approximately 50% of all fax referrals made to the Oklahoma Tobacco Helpline.

Tools and Strategies to Address Nicotine Cessation. The ODMHSAS meets regularly with the Oklahoma Tobacco Helpline representatives to discuss successes, barriers, and opportunities for growth. Approximately 50% of all the faxed referrals that come to the Helpline are delivered through the ODMHSAS's behavioral health provider network. Therefore, this consistent communication occurs because the ODMHSAS provider network is the Helpline's largest customer. For the most part, the Helpline and the ODMHSAS have a good working relationship and we are working together to make sure the services are accessible to all of the ODMHSAS consumer populations.

The PRSS core training curriculum was revamped this past year to include modules on tobacco cessation, self-care, and wellness planning. The PRSS workforce will be required to have their own wellness plan and are tested on how to help consumers develop these for themselves. The PRSS workforce is equipped to provide tobacco cessation support groups, are trained in the University of Colorado's evidenced-based Dimensions program, and most often are the main referral person to the Oklahoma Tobacco Helpline.

The Wellness Coach core training focuses on physical health and spends a considerable amount of time on tobacco cessation and how best to support consumers who are tobacco users. This workforce is also prepared to provide cessation groups and their knowledge is tested before they are issued a certificate of completion for the training course. The Wellness Coach workforce is mostly located within the Health Home service delivery system and is projected to become a primary referral source to the Oklahoma Tobacco Helpline over the next year.

Prevention and Wellness, Health Risk Screens and Recovery Supports. The ODMHSAS has established a training, the Well Body Wellness Coach, to prepare advocates, behavioral health staff and interdisciplinary providers who currently work with persons with behavioral health conditions. This initiative is a collaborative between the ODMHSAS, the Oklahoma State Department of Health and the Oklahoma Tobacco Settlement Endowment Trust. At the end of the three-day training participants will be able to: facilitate Well Body groups; provide the latest information about nutrition and weight management strategies; conduct motivational interventions, provide referrals to community nutrition, weight management, and wellness services; raise awareness of wellness initiatives through educational in-service and community training; elevate the importance of wellness initiatives in the organization; identify the historical aspect of tobacco control in Oklahoma; explain the USPHS-2008 Clinical Practice Guidelines and "5 As" and how it can be integrated into a standard clinical practice; explain the importance of follow-up for improvement in tobacco abstinence rates; identify pharmacologic agents used in the treatment of nicotine dependence, explain correct use and identify adverse reactions and complications associated with each; explain combination counseling and dosing of medications, use of higher dose medications and/or combining pharmacotherapy to enhance probability of abstinence; identify and

apply strategies for specific Motivational Interviewing techniques for treating consumers who are nicotine dependent; translate the concept of nicotine use as an addiction into the provision of treatment; and improve the skills to provide a comprehensive assessment for nicotine dependence.

The Certified Peer Recovery Support Specialist (PRSS) fulfills a unique role in the support and recovery from mental illness and substance abuse disorders. A PRSS is a person in recovery from a mental illness and/or substance abuse disorder, who has been trained to work with others on his/her individual road to recovery. This training incorporates the PRSS's recovery experience as a means of inspiring hope in those they serve, as well as providing a positive role model to others. A PRSS works in collaboration with the people we serve as well as clinical staff in the best interests of the individual's recovery process. There are many positive roles that a PRSS can fulfill in the organization based on their individual skills, experience, education, and desires. Peer Recovery Support Specialists offer the advantage of lived experience from serious mental illness and/or substance abuse.

2. Health Disparities

Tracking Access and Outcomes; Addressing and Tracking Language Needs. For each individual served through the ODMHSAS, client-level information is collected at the beginning of treatment. Demographical information, including race, ethnicity, age and gender are included. The clinician also asks if the person speaks English well, i.e., is she/he able to understand and convey information in English. If the response is no, the preferred language is required. If the response is American Indian, the specific tribal language is required. If the language is not of the eight listed languages, which includes Sign Language, the clinician is asked to specify the appropriate language. Because client-level information is tracked on all persons served, the ODMHSAS can view and analyze data in a variety of ways to determine which subpopulations are being served and which are not and the language needs of those served. Outcome measures can also be compiled for each subpopulation and compared to other groups. In addition, social demographic reports are produced for each provider agency to determine who is served or which groups it may need to outreach and additional supports to improve access.

Plans to Address and Reduce Disparities in Access, Service Use and Outcomes. To help ensure that services are more culturally competent the ODMHSAS supported access to CultureVision™ for a number of years; exposing providers to its utility. CultureVision™ is a comprehensive searchable database providing information on over 47 different cultural groups on such topics as communication, family patterns, nutrition, treatment protocols and ethno-pharmacological issues. Although the ODMHSAS no longer funds open subscription for Culture Vision™, there are providers within the ODMHSAS service system that continue its use.

The ODMHSAS utilizes CLAS standards as a work rule and require substance use disorder prevention contractors to address how they will adhere to the CLAS standards in their work plans. The ODMHSAS prevention staff members ensure contractors receive guidance and training on CLAS implementation strategies. Work plans and progress are reviewed during contract monitoring and site visits, providing an opportunity to discuss health equity success/challenges and linguistically appropriate services. In addition to the CLAS requirement, the ODMHSAS Prevention Services ensure that cultural competency is embedded in the five steps of the Strategic Prevention Framework both at the state and community levels. The low population density, high poverty rates, and multi-linguistic characteristic of Oklahoma reflect geographical and cultural barriers that can affect the implementation of services. Oklahoma's prevention efforts are tribe and community-specific. Project staff members, the Prevention Advisory Council and the State Epidemiological Outcomes Workgroup utilize an extensive network of cultural advisors and gatekeepers at the state and community levels to ensure the approach has optimal effectiveness. Project materials, products, and strategies, including evidence based practices, are produced and reviewed with the target population's cultural, language, and values in mind. Oklahoma's prevention system actively attempts to serve all populations equitably and in culturally relevant and responsive ways.

The ODMHSAS Human Resource Development (HRD) Division continues to offer cultural trainings throughout the year, both within the format of ODMHSAS conferences and in stand-alone trainings. These trainings are available to ODMHSAS staff, community based providers, and other community stakeholders. Training content varies from general cultural consciousness, to more specific population focus such as treatment considerations for American Indians.

During the past year, the ODMHSAS established its first Tribal Consultation Policy. This is an important step in standardizing an approach with tribal nations that fits with the parameters of their sovereignty as nations and also fits within state policy. Also, in the pursuit of good communication and collaboration with tribal nations, the ODMHSAS facilitates a behavioral health tribal/state work group. This group meets regularly, identifies barriers to good communication and works on priorities established each year. For the past two years, they planned and held cultural learning events regionally. These events were well attended and received. The goal was to increase providers' understanding and awareness of tribal nations in their area and vice versa. The ODMHSAS employs a full-time Tribal Liaison who is responsible to provide this group with the support necessary to fulfill their established priorities. This position became vacant recently and has been re-filled. The new liaison will be pulling the work group together very soon to refocus priorities.

The ODMHSAS system is in the midst of transformation and the intent is to vastly decrease the many types of disparities in our state, including but not limited to, racial and ethnic, geographic, age, gender and sexual orientation. Standards have increased with the implementation of Health Homes for adults with SMI and children with SED as of January 1, 2015. In addition, work has begun to assist CMHCs in building capacity toward certification as certified behavioral health clinics (CCBHC), and the ODMHSAS is hopeful of a state planning grant and a demonstration project. Goals within the planning grant application include: The ODMHSAS will produce a draft staffing plan for CCBHCs by September 1, 2015, along with its draft rules which must be approved by the OK Legislature in the SFY2016 Oklahoma CCBHC, oppSM-16-001, CFDA 93.829 Page 11 of 32 session (February 1 – May 30, 2016) and will go into effect July 1, 2016. The ODMHSAS will require CMHCs to complete a self-assessment of cultural and linguistic competency of staff as well as diversity of staff composition in the request for proposals process. The ODMHSAS will offer an ambitious schedule of training for CMHC staff during the planning year and will require participation through contract. These will be free of charge to the provider and will include consultation as well as training. To achieve certification, the CMHC will have to submit its own training calendar, as well as its own staffing chart that meets standards.

In Oklahoma, it is important to note that geography is a factor in disparity. The vastness of natural beauty of Oklahoma's geography is appreciated by many who enjoy our wide open spaces and diverse topography; however, this vastness also creates challenges. The 77 counties in Oklahoma cover 68,667 square miles, with 54.7 people per square mile, ranking our state 37th in population density. Oklahoma County is the largest with a population of 718,633 that has increased by 8.8 percent since 2000. The other more highly populated counties are Tulsa, with a population of 603,403; Cleveland, 255,755; Comanche, 124,098; and Canadian, 115,541 (U.S. Census 2010). Many of the remaining counties are very sparsely populated and are great distances from urban areas of Oklahoma where most service providers are located. The remoteness creates significant funding and logistical challenges for service systems and families. The stark reality is that many children, youth, and families are unable to access the care they need due to the distance from established service locations and economic conditions frequently associated with living in rural and remote areas.

The ODMHSAS successfully applied for a Child Mental Health Initiative (CMHI) grant in 2011 in which the goals were set for children, youth and families including addressing access issues for our most rural and remote areas of Oklahoma. In addition, the Weaving Access for All (WAFA) will lay out strategies to increase the Oklahoma System of Care (OKSOC) capacity to serve more children and youth in state custody of the Oklahoma Department of Human Services (OKDHS), Children and Family Services Division (CFSD). The percentage of referrals to the OKSOC sites statewide from the CFSD for the past year was 19%. As a result of this project, we expect that to increase. Funding is needed to adequately identify and address barriers that previously have

limited utilization of the OKSOC on behalf of children in state custody – many of whom have significant behavioral health treatment needs.

The Wafa budget reflects the expected cost to effectively address these challenges. Several objectives are identified to build capacity: (1) implement innovative service delivery strategies for sparsely populated yet large counties; (2) engage 983 OKDHS field staff as full partners in the OKSOC which will take a multi-faceted approach; (3) fully engage the 38 federally recognized tribal nations in Oklahoma which will also take a multi-faceted approach; (4) train in trauma-informed care as this is essential across all child-serving systems and community teams; (5) educate Oklahomans about the importance of social inclusion for children and youth with serious emotional disturbance through a multi-media approach; and (6) expand telehealth capabilities into the OKDHS foster care system and rural SOC's. Through seminars, conferences, and trainings, our state OKSOC sites are becoming more familiar with the advantages a culturally diverse staff has on a community accessing services. Oklahoma is planning a cultural linguistic competence web based training modules for mental health, child welfare and juvenile justice staff.

3. Use of Evidence of Purchasing Decisions

This section is not required.

4. Prevention of Serious Mental Illness

The presence of childhood mental health problems increases the likelihood of adults mental health disorders and ongoing need for costly services later in life. (Kessler, et al, 2005). Knowing that people with serious mental illness die younger than those without by as much as twenty-five years and are more vulnerable to homelessness, unemployment and alcohol abuse or addiction, the ODMHSAS has made it a priority to reach children at risk for, or with a serious emotional disturbance with effective services through local systems of care and the Health Home initiative.

With the priority of preventing serious mental illness, the ODMHSAS was happy to immediately make use of newly programmed SAMHSA dollars, beginning July 1, 2015, with the following initiative:

The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) prioritizes youth and young adults (YATS) with specialized services funded through the systems of care initiative, and through the Oklahoma *Now Is The Time* initiative. Utilizing state dollars, as well as SAMHSA funding through the Healthy Transitions Initiative, teams around the state perform outreach activities, screening, and referral to services and supports. The outreach is designed to identify and engage youth and young adults who may be experiencing symptoms of mental illness and/or substance use disorder as early as possible, putting them on a positive trajectory for

recovery and resilience. Oklahoma compiles data from this initiative through the E-TEAMS Youth Information System (YIS). The E-TEAM recently released an Oklahoma Health Transitions Initiative Study which we are always happy to share. Our providers continue to learn effective outreach and engagement techniques, and as a system we are learning more about what types of services and supports are most helpful and needed.

In our pursuit of continuing to improve our effectiveness, we are interested in technical assistance around the PIER screening tool.

5. Evidence – Based Practices for Early Intervention (5 Percent Set-Aside)

Oklahoma chose to use the NAVIGATE Model to treat young adults age 16-30 who are experiencing/have experienced their first episode of psychosis within the last two years. The ODMHSAS has partnered with Hope Community Services Inc. in Oklahoma City to fund a NAVIGATE Team, which consists of a Director/Family Clinician, Supported Education and Employment (SEE) Specialist, Individual Resiliency Training (IRT) Specialist, Prescriber, Case Manager, and Peer Recovery Support Specialist. All of these positions are funded at .5 FTE, with the exception of the prescriber, who is funded at a .1 FTE.

In addition to providing funding for the NAVIGATE Team, funds have been used to bring in the NAVIGATE Trainers (a team consisting of Susan Gingerich, Shirley Glynn, and Piper Kalos—along with Delbert Robinson, who have done webinars and consultation with the prescriber at Hope) to Oklahoma. In addition to offering a two-day training in February of 2015 (which was open not only to the NAVIGATE providers at Hope, but to all of the provider agencies who have been identified as lab sites through the OK Now is the Time (ONIT) Grant), these trainers have also been providing bi-weekly consultation calls to the providers at Hope to ensure that they are implementing the NAVIGATE Model with fidelity. All of the trainers will be brought back in September (with the exception of Dr. Robinson) to offer another round of training to providers from Hope and other interested agencies and afterwards they will continue to provide ongoing consultation and support.

The implementation of the original plan is going very well. Between January 1-July 1, 2015, Hope has served approximately 22 young adults using the NAVIGATE Model and they are currently looking at hiring an additional Case Manager and Peer Recovery Support Specialist to keep up with service demand.

The ODMHSAS has partnered with Be the Change, a non-profit agency out of Oklahoma City who is focused on outreach to young adults who are either homeless or at risk of homelessness, to help do street outreach to try to identify and engage young

people who are experiencing FEP in the Oklahoma County area. A partnership has also been formed with the Oklahoma County Crisis Intervention Center (OCCIC) in an attempt to identify young adults who are experiencing FEP as they are coming in to or transitioning out of the crisis intervention center.

Oklahoma was one of 17 states awarded with a Now is the Time (NITT) Grant through SAMHSA, which is focused on improving outcomes for young adults 16-25 who are experiencing mental health and/or substance abuse related needs. Hope is one of three ONITT “lab sites” in OK County. The other two ONITT lab site agencies in Oklahoma County, Red Rock and NorthCare, have been referring young adults who are experiencing FEP to Hope so that they can offer them services through the NAVIGATE program.

In an effort to help spread the word regarding NAVIGATE Services, staff from Hope’s NAVIGATE Team have been going out and presenting to various community organizations, such as local colleges and universities, the Oklahoma County Homeless Alliance, and inpatient providers. Promotion of community awareness about FEP and the services offered through Hope, as well as at other sites who are interested in receiving the NAVIGATE Training, will continue in the upcoming year.

Oklahoma plans to bring back the NAVIGATE trainers to train again in some of the components, and to consult on implementation. The ODMHSAS and providers are very pleased with the training and consultation received thusfar and believe it will be critical to success going forward. In addition, close monitoring will be done to ensure that intense outreach efforts are continuing and that ONITT sites are referring persons who qualify to the NAVIGATE treatment program at Hope. Additionally, the ODMHSAS is working with Hope to increase staff retention so that the model can become more and more effective over time. Objectives include 1) locating persons experiencing first break symptoms within recent history; 2) linking them with NAVIGATE program; 3) assisting them in receiving treatment, a stable place to live, employment, education, social, and family goals. Performance measures will include number who are employed; number of days worked pre and post treatment; number continuing education and number of days in school; living situation, looking to move toward independence in the community. The goal is to serve at least 15-20 people at a given point in time throughout the year.

Oklahoma intends to use MHBG set-aside funds to implement RAISE NAVIGATE and Transition to Independence (TIP) in five to six CMHCs in Oklahoma, Okmulgee, and Washington Counties by funding training, outreach activities and an employment/education coach. The total budget for NAVIGATE, TIP, and the funding for Be the Change equals the full set-aside amount.

USE OF MENTAL HEALTH BLOCK GRANT SET-ASIDE FUNDS:

Category	Program	Budget	Setting	Target Population	Level of Implementation	Use of MHBG Set-Aside Funds
CSC	RAISE NAVIGATE	\$53,350 for training, plus funding for services and supports	Urban	Transition-aged adults, ages 16-25. Adults over 25 will have access to specialized services.	Implement CSC model in CMHCs.	Training, employment/education coach and outreach activities as part of implementation of the RAISE model.
CSC	Transition to Independence (TIP)	\$15,365 for training, plus funds for services and supports	Urban	Transition-aged adults, ages 16-25. Adults over 25 will have access to specialized services.	Implement TIP in CMHCs.	Training and outreach activities as part of implementation of TIP.
	NAVIGATE through Hope CSI	\$140,000 for salaries and benefits for staff, flex funds, administrative fees, etc.	Urban	Transition aged adults age 16-30 newly identified with a serious mental health or co-occurring diagnosis.	Implement model in CMHCs.	Services and supports necessary to implement the NAVIGATE model in OK County through Hope Community Services, Inc.,
	Be the Change	\$40,000 for salaries and benefits to support a Youth Outreach Worker	Urban	Transition aged adults ages 16-25 who are homeless or who are at risk of homelessness and who are experiencing mental health or co-occurring issues.	Conduct outreach and engagement throughout OKC.	Services and supports intended to help screen young adults for mental health/co-occurring issues and then connecting them to appropriate services, including NAVIGATE and/or TIP Services through the NAVIGATE and ONIT Sites in OK County.

Data collection is currently underway regarding the implementation and effectiveness of the NAVIGATE Model through our state’s electronic Youth Information System (YIS) in partnership with our evaluators from the University of Oklahoma’s E-Team. The young adult and worker are asked to complete assessments related to problems, functioning, and hopefulness at baseline, 3 month data point, as well as at 6 month intervals until

the young adult successfully transitions out of services. In an effort to monitor the fidelity to the NAVIGATE Model, each of the NAVIGATE workers are asked to complete a NAVIGATE Event Reporting Form to document any substantial meeting that they have with a young adult and/or family member (including SEE Sessions, IRT Sessions, Family Clinician Sessions, Case Management and/or PRSS Sessions, etc.), throughout their time enrolled in services.

The ODMHSAS would like to receive some additional technical assistance around assessments and other tools to help monitor the effectiveness of the services. Although the problem and functioning scales from the OHIO Scale Assessments are both very strong assessment tools, they do not appear to do an adequate job of capturing information specifically related to psychosis.

6. Participant Directed Care

While the ODMHSAS does not have a formal voucher process, the treatment delivery system does incorporate several components and benefits of such a system. While provider agencies have service areas for which they must serve anyone in that area that meets criteria, consumers can choose to obtain services from any agency in the ODMHSAS network, regardless of whether they reside in the service area. At each new agency a consumer presents, an assessment is done and a prior authorization is given to determine the cap amount, array of services and length of authorization based on the clients' needs and severity at that time. If an agency is unable to provide all of the required services, there is a process in place where they can collaborate with another agency to ensure all of the needed services are obtained. The ODMHSAS requires an electronic document to be submitted designating which services are to be provided by which agency to ensure care coordination and non-duplication of services.

The ODMHSAS statewide network of providers offers an extensive range of provider types and locations to address geographic, population, and service needs. There are three state operated hospitals, one adult, one youth and one forensic hospital; three community-based inpatient units; 10 private, non-profit community mental health centers (CMHCs) and four state-operated CMHCs, with approximately 70 locations for 77 counties; 96 substance abuse treatment providers, providing detoxification services, outpatient, community living and residential treatment; seven crisis stabilization centers, systems of care programs for children statewide; 14 Programs of Assertive Community Treatment (PACT) teams; criminal justice diversion and re-entry programs, including prison-based treatment; and 83 specialty providers, including housing, faith-based, and consumer and family operated programs. Further, agencies within the ODMHSAS

network are required to provide services to any qualifying consumer even if the agency has maximized their contract funding.

Through the ODMHSAS network a wide array of services are offered, including care coordination, motivational development, early/brief intervention, outpatient treatment, housing and employment support, family support services and peer resources.

Areas of technical assistance needed related to this section: Building a sustainable voucher system, while ensuring quality services from a broad range of providers for which ODMHSAS does not have oversight.

7. Program Integrity

Program Integrity Plans for Federal Block Grants. The ODMHSAS utilizes multiple programs and staff to assure compliance and appropriateness related to the SABG and MHBG programs. The following functions are included within the ODMHSAS approach to program integrity and compliance monitoring.

- The Director of Provider Compliance and Assistance reports directly to the Deputy Commissioner for Treatment and Recovery Services. This function monitors contract compliance and performance for provisions related to SABG and MHBG funded treatment services.
- The Director of Prevention Services reports directly to the Deputy Commissioner for Communications and Prevention. She and her staff monitor compliance and contract performance for provisions required in the SAPT prevention services activities.
- The Financial Division manages all budget preparations, expenditure monitoring, cash management, and cost accounting. Three staff members have major responsibilities related to management of federal funds, including federal block grants.
- The ODMHSAS Financial Auditor reports directly to the ODMHSAS Commissioner and monitors compliance with A-133 audit requirements and variances cited with sub grantees/contractors.
- The Office of Consumer Advocacy review consumer rights and complaints and related grievances. Frequently, individual advocates work directly with consumers to resolve related matters.
- The Office of Inspector General reviews reports of potential fraud, abuse, or related issues. Investigations are conducted and findings related to violation of Oklahoma Administrative Code are referred to the Director of Provider Certification for following up and corrective action plans. As indicated, findings are also referred to law enforcement or other regulatory entities.
- The ODMHSAS General Counsel provides assistance and represents the ODMHSAS in matters related to violations of code, employee misconduct, etc.

Monitoring the Appropriate Use of Funds. The ODMHSAS merged statewide data reporting systems in FY2010 with the Oklahoma Health Care Authority (OHCA), the state Medicaid agency, to create the Consolidated Claims Payment (CCP) System. The new structure that resulted provides for additional mechanisms related to claims adjudication, expenditure analysis, compliance, performance analysis and triggers for potential additional audit activities.

All state and federally funded services are billed through the OHCA Medicaid Management Information System (MMIS) which has a built-in rules engine, enforcing daily service limitations and determines that both the provider and client have eligibility at the time of service. Another benefit of the combined system was the addition of a prior authorization (PA) system. By using pre-programmed algorithms, the cap amount, array of services and length of authorization are determined based on the clients' needs and severity. The ODMHSAS prior authorization parameters mirror those of OHCA, except for additional recovery-type services or levels of care that the ODMHSAS funds and OHCA does not. The ODMHSAS algorithms are all computerized and do not require human intervention unless an exception request is being made for extenuating circumstances. The prior authorization system has established a high degree of standardization throughout the system, and requires providers to justify providing higher levels of care. In addition, a wealth of service utilization data is available to analyze and use for better care management and program integrity. These measures are used to examine all publically funded services but can be broken out by state, SABG, MHBG and other federal funding sources. Below are some examples of utilization measures that are in production.

- Percent of prior authorization (PA) dollar amounts that are used by provider and PA type
- Percent of PA caps that maxed out (and denied services showing the provider provided more services than the PA cap allowed)
- Percent of PA extension requests that remain at the same level (indicating the client has not improved)
- Frequency of high level PAs requested by agencies (do some provider agencies routinely ask for higher level PAs?)
- Variation in assessment scores by provider (is the provider using the same assessment score for every client to obtain a high level PA?)
- Changes in the assessment scores at 6-month follow up (are clients showing improvement?)
- Analysis of authorizations over time for various member sub-groups (who is being served and with what outcomes?)
- Expenditure report broken out by level of services, types of services and place of services (determine outliers that require further study)
- Number of services billed by provider (is there an unrealistic amount of services being provided by a clinician?)

Changes to the service delivery system are implemented based on results from various program integrity analyses. One example is the identification of overuse of rehabilitation services, without concurrent treatment services, and particularly with very young children. Restrictions were put in place to better ensure quality treatment. Another example is the use of long-term residential treatment for persons with addiction disorders. Long-term treatment seemed determined more by the provider agency and not client need, and could be contraindicative to recovery. Again, stricter requirements to justify lengthier stays were included to ensure clients were being integrated back into the community in an appropriate timeframe while allowing clients with more severe needs to remain longer.

In July 2012, ODMHSAS became responsible for administering the state portion of behavioral health Medicaid funds. Program integrity was expanded to include Medicaid-only providers. The same service utilization measures have been expanded to all publicly funded providers and have resulted in several thousands of dollars being recouped for inappropriate services and billing, and, in some cases, have resulted in contract termination.

Ensuring Payment Methodologies are Reasonable and Appropriate. The prior authorization system is based on client assessment scores and other information to determine the types and appropriate amount of services. Each authorization level has a pre-set time parameter, dollar limit and defined array of services. The time limit requires the provider to request an extension if needed at the end of the time frame and report current client assessment scores to determine whether the client needs to remain at the same level or move to a lower or more intensive level. The number of clients who do not move to lower levels is monitored. The dollar limit ensures that providers are not billing unnecessary services. The service array ensures clients get the appropriate types of services. Through service utilization and claims monitoring, the prior authorization parameters are adjusted as new issues are found, such as in the case of over utilization of rehabilitation services.

Appropriate Use of Block Grants Funds. The ODMHSAS stipulates in all contracts with partnering treatment provider organizations, that state funds or grant funds passed through the ODMHSAS must be used as the “payer of last resort.” Further, the ODMHSAS and the state Medicaid agency co-manage the Medicaid Management Information System, through which all state-funded and Medicaid claims are processed. In order to ensure that third party and other revenue is utilized to the fullest extent possible, the MMIS cross-references insurance databases to identify other sources of payment. If none are found, the service is funded through Medicaid for eligible enrollees. Only when no other coverage is found are state/grant funds utilized.

8. Tribes

Oklahoma is home to 38 federally recognized tribal nation headquartered in Oklahoma. Oklahoma is second behind only California with a 482,760 population with an AI/AN

status on the 2010 US Census. The proportion of Oklahoma's population identified as AI/AN people was 12.9%. In FY2015, 22,103 consumers identifying themselves as AI/AN received services funded through the ODMHSAS and/or Medicaid (OHCA) behavioral health reimbursement system.

The Governors Transformation Advisory Board (GTAB) was formed in 2006 by Governor Brad Henry as his lead consultative body for Oklahoma's Transformation State Incentive Grant (TSIG) funded by SAMHSA. An early action of the GTAB, under the leadership of Chickasaw Nation Governor Bill Anoatubby, who served as GTAB chair, was to establish Oklahoma's Tribal State Relations Workgroup. The Workgroup provided expertise and guidance for the ODMHSAS to continually assess better methods to engage with and provide culturally appropriate access to services and supports for Oklahomans with tribal affiliations.

In 2011, SAMHSA supported Oklahoma's participation in a National Policy Summit to Address Behavioral Health Disparities within Health Care Reform. The ODMHSAS utilized the resources and support for its Summit team to strategically address the unmet behavioral health needs of American Indian children and their families. An action plan was developed to assure that all Oklahoma children and youth who are self-identified by their family as American Indian have early and easy access to needed behavioral health services and supports. Changes that occurred as a result of the plan benefited all American Indians, regardless of age.

On September 22 – 24, 2012, ODMHSAS participated in SAMHSA's "Policy Academy on Preventing Mental, Emotional and Behavioral Disorders." As a result of this meeting, the Oklahoma delegation was able to create an Action Plan to address statewide prevention efforts related to preventing mental, emotional and behavioral disorders in the state. With the assistance of a representative from Chickasaw Nation, the State developed an Action Plan for the 38 federally recognized tribal nations in statewide prevention efforts.

In 2006, the ODMHSAS created a fulltime position for a Tribal Liaison. That position has continued to assist with facilitating collaboration among the state and tribal nations and to address the unique aspects of tribal and state government relationships. During the past year, the ODMHSAS established its first Tribal Consultation Policy. This is an important step in standardizing an approach with tribal nations that fits with the parameters of their sovereignty as nations and also fits within state policy. Also, in the pursuit of good communication and continued collaboration with tribal nations, the ODMHSAS facilitates a behavioral health tribal/state work group. This group meets regularly, identifies barriers to good communication and works on priorities established each year. For the past two years, it planned and held cultural learning events regionally. These events were well attended and received. The goal was to increase providers' understanding and awareness of tribal nations in their area and vice versa. The ODMHSAS Tribal Liaison is responsible to provide this group with the support

necessary to fulfill their established priorities. This position became vacant recently and has been re-filled. The new liaison will be pulling the workgroup together very soon to refocus priorities.

9. Primary Prevention for Substance Abuse

The ODMHSAS implements prevention services under the guidance of a state plan entitled the *Oklahoma Strategic Plan for the Prevention for Mental, Emotional, and Behavioral Disorders*. The state plan acts as the roadmap for Oklahoma's vision for building a strong prevention infrastructure for a broad array of prevention strategies. The plan reflects statewide input from community representatives and experts in substance abuse and related fields who participated in the planning process. The plan provides clear direction and common ground for future endeavors addressing the prevention of substance abuse, the prevention of mental illness, and mental health promotion. The mission of the plan is to implement and sustain comprehensive, statewide prevention efforts that are evidence-based and accountable to the state's citizens, encourage the collaboration of multiple agencies and organizations, and enhance the capacity of communities to provide an effective and comprehensive system of prevention services reflective of community needs and resources. State goals of the plan are:

1. Prevent the onset and prevent/reduce the problems associated with the use of alcohol, tobacco, and other drugs across the lifespan as identified and measured using epidemiological data.
2. Prevent the onset and prevent/reduce the problems associated with mental and emotional disorders as identified and measured using epidemiological data.
3. Use the Strategic Prevention Framework (SPF) process to create prevention-capable communities where individuals, families, schools, workplaces, communities, and the state have the capacity and infrastructure to prevent substance abuse and mental illness.
4. Develop systematic processes to collect and analyze data regularly to accurately assess the causes and consequences of alcohol and other drug use.
5. Develop data-driven decision methods to use prevention resources effectively.
6. Increase the use of prevention services that are evidence-based, implemented with fidelity, and evaluated for effectiveness.
7. Increase the capacity of prevention providers to meet the behavioral health prevention needs of diverse individuals and communities in a timely, culturally competent manner.
8. Actively seek opportunities to collaborate and coordinate prevention efforts and resources across sectors to achieve significant, population-level behavioral health outcomes.

The ODMHSAS utilizes the SPF model for prevention services, which employs a public health approach that focuses on achieving population outcomes. In instituting the SPF

process, Oklahoma transitioned from a focus on services to individuals or small groups of consumers to population-based approaches that view community wellbeing as the unit of outcome measurement, and from agency-centered services to coordinated, multisector systems approaches that use evidence-based practices to achieve and change. The ODMHSAS and its state and community-level partners are committed to implementing the five steps of the SPF process to enhance state and community prevention system accountability, capacity, and effectiveness.

SEOW

The Oklahoma State Epidemiological Outcomes Workgroup (SEOW) is a multidisciplinary workgroup whose members are connected to key decision-making and resource allocation bodies in the state. This workgroup, funded through a federal grant from SAMHSA/CSAP, was established by ODMHSAS in 2006 and is patterned after the National Institute on Drug Abuse (NIDA) community epidemiological workgroup. Oklahoma’s SEOW is charged with improving prevention assessment, planning, implementation, and monitoring efforts through data collection and analysis that accurately assesses the causes and consequences of the use of alcohol, tobacco, and other drugs and drives decisions concerning the effective and efficient use of prevention resources throughout the state. To study the nature and extent of the problem of alcohol, tobacco, and other drug use in Oklahoma, the state’s SEOW utilized the CSAP model of consumption and consequence constructs and indicators. Table 1 below provides a complete listing of alcohol, tobacco, and illicit and prescription drug consumption and consequence constructs. For each construct, one or more identifiable indicators (measures) were used to quantify consumption and substance-related consequences. Unlike the underlying constructs, these indicators are precisely defined and determined by specific data sources. Thus, while “alcohol-related mortality” is a relevant construct for monitoring trends of an important consequence of use, it does not provide a precise definition of how this construct can be measured. However, a number of indicators do provide specific measures of this construct (e.g., annual incidence rate of deaths attributable to alcohol related chronic liver disease, suicide, or crash fatalities). A comprehensive list of indicators and sources currently collected and monitored by the SEOW are housed in a dynamic data query system online for public access at: <http://indicators.bach-harrison.com/okdataquerysystem/>

Table 1. Alcohol, Tobacco, Illicit Drugs, and Prescription Drug Consumption and Consequence Constructs

	Alcohol	Tobacco	Illicit Drugs	Prescription Drugs
Consumption	<ul style="list-style-type: none"> • Current use • Current binge drinking • Heavy drinking • Age of initial use • Drinking and driving • Alcohol use during pregnancy • Apparent per capita alcohol 	<ul style="list-style-type: none"> • Current use • Age of initial use • Tobacco use during pregnancy • Total cigarette use consumption per capita 	<ul style="list-style-type: none"> • Current use • Lifetime use • Age of initial use 	<ul style="list-style-type: none"> • Current use
Consequence	<ul style="list-style-type: none"> • Alcohol-related mortality • Alcohol-related motor vehicle crashes • Alcohol-related Crime • Dependence or abuse 	<ul style="list-style-type: none"> • Tobacco-related mortality 	<ul style="list-style-type: none"> • Illicit drug-related mortality • Illicit drug-related crime • Dependence or abuse 	<ul style="list-style-type: none"> • Prescription opioid-related mortality

Needs Assessment

A focus on data collection, analysis, and use is built into each step of the SPF and continually informs the process. The formal assessment of contextual conditions, needs, resources, readiness, and capacity is used to identify priority issues in Step 1. In Step 2, data are shared to generate awareness, spur mobilization, and leverage resources. In Step 3, assessment data are used to drive the development of a strategic plan and guide the selection of evidence-based strategies. Data are used in Step 4 to inform (and, if necessary, revise) the implementation plan. And finally in Step 5, data are collected to monitor progress toward outcomes, and findings are used to make adjustments and develop sustainable prevention efforts. This process occurs at both the state and local levels.

The ODMHSAS utilizes needs assessment data, epidemiological and capacity indicators, to make decisions about the allocation of SABG primary prevention funds. The SEOW and the staff epidemiologist are tasked with analyzing the state epidemiological data to determine problem or emerging alcohol, tobacco, and other drug consumption and consequence patterns using CSAP data recommendations – national source, state level, validity, trend, consistency, and sensitivity. The SEOW determines a score for each substance with consequence indicators multiplied by two. Time trends are analyzed and regression analysis performed for each indicator. The constructs/indicators identified by this process are prioritized for SABG funding, and resources are allocated in 17 prevention service regions of Oklahoma serving all 77 counties. Oklahoma uses a hybrid equity planning model, with allocation across the state based on both per capita and need. The model allocates a baseline amount to each of the 17 regions for local needs and capacity assessment, prioritization, and plan development. Prevention subrecipients are required conduct local data collection and analysis to identify which of the state-issued priorities will be their focus and to identify populations of focus. In addition to epidemiological data, the ODMHSAS conducts state and community level needs assessments in the areas of coalition capacity, community readiness, workforce training and technical assistance needs, public health competencies, and infrastructure capacity.

Capacity

The ODMHSAS routinely conducts assessment of workforce needs. A comprehensive plan has been developed to address needs identified. The plan contains priorities in the areas of: data collection, analysis and reporting; coordination of services; training and technical assistance; and performance and evaluation. Areas of need related to training and technical assistance included:

1. The infrastructure to gather, assess, and disseminate available data on substance abuse and its contributing factors and impacts in communities
2. A common training and technical assistance (TTA) program
3. TTA related to culturally appropriate prevention programs

4. Linking and coordinating the Substance Abuse Prevention Strategic Plan with state and local prevention initiatives
5. Planning strategic prevention initiatives at the community level that are comprehensive, community specific, evidence-based, and data-driven
6. Ongoing technical assistance that promotes the collection of valid outcome data.

The ODMHSAS will continue to pursue strategies to build the capacity of its prevention system in several key ways, including formalizing prevention standards, standardizing the delivery and monitoring of prevention training and technical assistance, and providing increased training and consultation at the community level. To this end, the ODMHSAS has partnered with the Oklahoma State Department of Health and Oklahoma Tobacco Settlement Endowment Trust to develop the Public Health Academy of Oklahoma (PHAO). The PHAO project will (1) plan and deliver a regular Public Health Institute to improve public health core competencies among the prevention workforce; (2) offer an online Learning Management System (LMS) to conduct regular, distance learning opportunities for Oklahoma's diverse workforce; and (3) provide an Online Learning Community to increase linkages at the local-local and state-local levels among community-based prevention providers. The PHAO represents a significant step forward in building the capacity of Oklahoma's prevention workforce and leverages resources to unite public health systems in the state around shared workforce needs. Additionally, the ODMHSAS prevention system is integrated, meaning the SABG is intentionally aligned with the SPF and shares an infrastructure with Oklahoma's SPF PFS initiative. Oklahoma will continue to work collaboratively with the CAPT system on PHAO and additional training needs through regular capacity planning. Capacity planning and TTA development is conducted in partnership with the Cherokee Nation (a tribal PFS grantee) and made available to the full prevention workforce, including Drug Free Communities grantees.

Certification; TTA; Community Readiness

The Oklahoma Drug and Alcohol Professional Counselor Association (ODAPCA) is the certifying body in Oklahoma for Certified Prevention Specialist (CPS) and Associate Prevention Specialist (APS), which is recognized by the International Certification and Reciprocity Consortium. All individuals working under subrecipient contracts of the SABG for prevention in Oklahoma are required to be CPS or APS within 18 months of employment. The ODMHSAS provides prevention workforce training and technical assistance to the substance abuse prevention workforce, including Prevention Ethics, Substance Abuse Prevention Specialist Training, and a myriad of SPF and evidence-based strategy related training. Subrecipients are also required to conduct community readiness assessments within the first year and routinely thereafter. Prevention contractors report community readiness outcomes and progress toward improvement to the ODMHSAS.

Evidence Based Practices Workgroup

The Evidence Based Practices Workgroup was established in 2011 and actively supports subrecipients' implementation of the SPF for the SABG priorities. The Workgroup includes academic researchers, prevention professionals, tribal government representatives, prevention evaluators, and key state agency representatives. The EBP Workgroup conducts reviews of subrecipient workplans, develops evidence-based intervention matrices and guidance documents, and advises subrecipients in selection, adaptations, and fidelity issues. Plans to sustain the EBP Workgroup include a review of existing evidence-based matrices on prescription drug abuse prevention interventions, intervention cost/benefit evaluation, expanded application to other prevention fields, and ongoing membership evaluation and recruitment.

Prevention Service Types; Strategies

In 2009, the ODMHSAS began full application of the Strategic Prevention Framework, the public health approach, for prevention services. To prevent the onset and prevent/reduce the problems associated with the use of alcohol, tobacco, and other drugs across the lifespan, Oklahoma worked from a theory of change that was supported through research. Research has shown changing population behavior requires targeting resources to issues influencing that behavior (intervening variables, or risk or causal factors). Once these issues have been identified, a comprehensive set of state and community evidence-based strategies can be selected, employed and evaluated. In instituting the SPF process, Oklahoma transitioned from a focus on services to individuals or small groups of participants to population-based approaches that view community well-being as the unit of outcome measurement, and from agency-centered services to coordinated, multi-sector systems approaches that use evidence-based practices to achieve and change.

All strategies utilize primary prevention to prevent or delay the onset of alcohol, tobacco and other drug (ATOD). Collaboration with community coalitions empower 'local people to solve local problems'. Youth and families are the primary targets of the services provided; however, community leaders, businesses, local agencies, and individuals are targeted to develop and support local coalitions to plan and provide prevention interventions. In general, strategies promote healthy communities and work to change local norms from youth use/abuse of alcohol, tobacco and other drugs to social norms of no substance use and substance free activities by employing a compliment of policy, media, and community organizing strategies.

The ODMHSAS intends to fund evidence-based interventions as defined by Oklahoma's working definition of tiered evidence-based practices and guided by the state's Evidence Based Practices Workgroup. Prevention services are implemented by Oklahoma's system of 17 Regional Prevention Coordinators (RPCs), which are the backbone of Oklahoma's prevention system. RPCs are local non-profits, universities, and tribal governments that partners with community coalitions to plan, implement, and evaluate primary preventions services. RPC staff are certified prevention specialists and

monitored by the ODMHSAS. RPCs develop, in partnership with community coalitions, community-level prevention workplans based on the SPF and aligned with state prevention priorities. Services are focused on achieving sustainable, population-level outcomes. RPC staff are charged with implementing community-level workplans in collaboration with community coalitions and building local-level prevention capacity. Services provided and guided by the RPCs are evaluated at the local level. The University of Oklahoma's College of Public Health provides training and technical assistance on evaluation as well as overall Block Grant evaluation services. Funded prevention strategies include:

Information Dissemination – The ODMHSAS supports a state-level prevention resource center which serves as a clearinghouse for print and electronic materials. Making extensive use of private and public resources, the Oklahoma Prevention Resource Center provides materials to all 17 RPCs, to other prevention and treatment programs in the state, public and private schools, faith organizations, public and private agencies, state and local governmental officials, and private citizens within the State. The Prevention Resource Center fulfills requests for information via an online library and order fulfillment system, which was recognized through a Governor's Commendation in 2008 for saving staff time and other resources. The Prevention Resource Center also researches, plans, executes, and evaluates strategic community outreach efforts at large scale Oklahoma venues reaching defined populations related to the State's data-driven prevention priorities.

Education – The ODMHSAS and its prevention contractors are the single largest deliverer of substance abuse prevention education in the State. At the state level, the ODMHSAS offers training in public health competencies (SPF), prevention ethics, Substance Abuse Prevention Specialist Training, community and law enforcement youth access to alcohol training, youth leadership development, and numerous trainings on evidence-based prevention practices. At the local level, the RPCs conduct skill-based community and coalition training to build local capacity on topics such as public health principles, identifying signs and symptoms of behavioral health problems, coalition development, collection and use of risk and protective factor data, and evidence based prevention approaches. The RPCs conduct extensive training to business on Responsible Beverage Sales and Service training and responsible alcohol policy in partnership with the 2Much2Lose initiative, Oklahoma's underage drinking campaign. RPCs partner with two state law enforcement officers who serve as 2Much2Lose regional coordinators to train local law enforcement in youth access laws and deliver training to retailers. Additionally, the RPCs conduct opioid overdose prevention education and prescribing guidelines to communities and local organizations.

Alternatives – RPCs partners with youth leadership coalitions on the prevention of underage drinking and provide support to these groups for alcohol and drug-free youth activities and drug-free community events/venues. Funded RPCs and their partner coalitions work with local event organizers to establish written agreements to offer alcohol and drug-free activities within the communities they serve.

Problem Identification and Referral - Printed information about resources in local service areas and throughout the State are provided to Oklahomans who asked about referrals for alcohol, tobacco, or drug addiction. The ODMHSAS distributes referral information for statewide prevention agencies, substance abuse treatment programs, and mental health programs that were at least partially supported by the Department. The ODMHSAS offers training to prevention providers and their partners in Mental Health First Aid and Psychological First Aid for post disaster response to build local capacity to respond to emergent referral needs in the course of their primary prevention work. SABG prevention agencies provided no screening or intervention services.

Community-Based Processes – The ODMHSAS continues to focus the efforts of prevention services on coalition development and community mobilization. By spending time promoting and supporting coalitions, RPCs increased community engagement in the promotion and implementation of primary prevention ideas, norms, and evidence-based public health practices and activities. RPCs educated local community coalitions in prevention concepts such as community planning, utilizing the Strategic Prevention Framework model, evidence-based practices, and community mobilization. The RPCs support a network of 104 community coalitions throughout the state and develop written agreements with coalitions in data informed priority communities to develop and implement strategic prevention plans. Additionally, RPCs develop local alcohol enforcement plans to address underage and high-risk drinking in geographic hotspots within their service areas. RPCs are responsible for convening Regional Epidemiological Outcomes Workgroups to provide local data, recruit school participation and provide survey data from the Oklahoma Prevention Needs Assessment Survey (measuring risk and protective factors), and analyze other social indicator data. This information and other local data allow the coalitions to assess the prevention needs in their area and set priorities, as well as identify and implement programs to target those needs. Coalition development and community-based activities continue to be major components of Oklahoma’s prevention efforts.

Environmental Strategies – The ODMHSAS continues to invest in public health, community-level change interventions to impact and sustain population health outcomes. The RPCs, in partnership with community coalitions, plan, implement, and evaluate environmental prevention strategies required to incorporate a comprehensive compliment of policy, media advocacy/communication, and community organizing strategies. RPCs are required to develop and support the implementation of youth access and other high-risk alcohol prevention efforts in coordination with local and state law enforcement. No SABG funds will be used for actual enforcement. RPCs identify alcohol hotspots based on local data, provide responsible retailer training, obtain written agreements/policies with alcohol retailers, municipalities, and law enforcement, generate news media, and conduct alcohol risk assessments. The RPCs plan and implement similar environmental strategies on other data-driven priorities, such as non-medical use of prescription drugs, based on a guided planning process with the ODMHSAS, evaluators, and the community coalitions.

Use of Data; Monitoring; Evaluation

The ODMHSAS, in partnership with the SEOW, collects and analyzes epidemiological data to define state priority constructs for SABG funding. Subrecipient contractors of the SABG prevention set-aside are required to convene Regional Epidemiological Outcomes Workgroups (REOWs) to collect and analyze local level data to identify local-level priorities, from among the state defined constructs, based on consumption and consequence trends. Each funded subrecipient is required to partner with local coalitions to conduct a causal factor analysis, in partnership with the REOW, to determine the evidence-based intervening variables likely responsible for driving the problem locally.

The ODMHSAS administers the Oklahoma Prevention Needs Assessment (OPNA). The OPNA is a voluntary risk and protective factor survey for 6, 8, 10, and 12 graders and administered every other year in coordination with the Youth Risk Behavior Survey. The ODMHSAS also administers the Place of Last Drink Survey, which reports the location of last consumption for DUI offenders, and an alcohol purchase survey, which reports the rates of retailer violation for alcohol sales to youth under age 21. These three data sets are provided to the RPCs to guide the assessment of need in their service communities and to assist in strategy development and evaluation. In addition to the publish of an annual epidemiological profile, the ODMHSAS also houses relevant substance abuse prevention data in an online data query system that is available to the public, namely the RPCs and coalitions, to ensure data is current and easily accessible for prevention planning and evaluation. Contracted prevention providers utilize all available data to identify priorities, identify risk/protective/causal factors, and design needed primary prevention interventions.

The ODMHSAS staff monitor providers for compliance and review and approve local plans prior to implementation. Each ODMHSAS Field Representative is assigned provider agencies to monitor each fiscal year. Monitoring includes an annual site visit in addition to ongoing contacts with the agencies throughout the year to stay up-to-date on the agencies' needs, performance data, and to assess/deliver technical assistance. The annual site visit consists of a review of records, policies and procedures, staff credentials and training, billing, and other information gathering to insure all block grant requirements is adhered to as required. The ODMHSAS also reviews records and provides training to contractors on the appropriate use of SABG primary prevention funds.

The ODMHSAS require subrecipients to plan and conduct local evaluation activities. The University of Oklahoma College of Public Health contracts with the ODMHSAS to evaluate select prevention services funded by the SABG. Prevention subrecipients are required to report process and outcome data in a locally managed system called OKPROS (Oklahoma Prevention Reporting Outcomes System). Minimum requirements for local process and outcome data will include: numbers and demographics of people reached/served; evidence-based practices; service codes, population of focus, strategic partnerships and coalitions; community readiness; coalition capacity; media outputs;

consumption prevalence; consequences; causal factors/intervening variables; risk/protective factors. At the state level, the ODMHSAS will continue to monitor consumption and consequence data relevant to the identified SABG prevention priorities as noted in the table below. Additionally, the ODMHSAS will collect prevention workforce capacity strengths/weaknesses; training and technical assistance needs. The ODMHSAS will monitor these data to routinely evaluate the state's prevention system and inform needed changes.

10. Quality Improvement Plan

Quality Improvement Reporting. The ODMHSAS utilizes a variety of quality management practices to monitor services, assess effectiveness, and address needed improvement and expansions. The state has worked to further develop outcome and performance measurement systems in recent years. The analyses of information from those systems have proved useful to demonstrate effectiveness, clarify performance improvement areas, and advocate for added resources and policy changes.

The following information summarizes a culture of stakeholder involvement around quality improvement activities and the data infrastructure utilized to assure that the ODMHSAS is continually addressing important issues that comprise its total quality management report. Following that information, examples of specific quality improvement activities are described.

Consumer and Family Participation in Continuous Quality Improvement (CQI). An important value held by the ODMHSAS is the inclusion of consumer and family participation at all levels of operation and service delivery. One way this is accomplished is through the use of consumer surveys, in which individuals and caregivers participate in quality improvement activities by rating various aspects of their treatment experience. The ODMHSAS Decision Support Services has adopted and adapted a survey developed by consumers for use throughout the treatment system. The surveys capture information related to many of the fundamental components of recovery.

In FY2015, the ODMHSAS staff mailed 10,774 adult mental health survey packets to current and former clients who had been served in FY2015. To date, 1,143 surveys have been returned and analyzed. Results are distributed via 14 individual community mental health center (CMHC) reports and a statewide summary. This is available on line and data are provided to permit each CMHC to individualize reports to better address local community needs and CMHC-specific performance improvement issues.

To evaluate families' perception of care, a two-week time period was selected in which every caregiver of a child or youth receiving services during the time frame was asked to complete a caregiver survey. Results from the 759 completed surveys are distributed through an annual report to the CMHCs.

To obtain substance abuse treatment service recipients' assessment of care, staff prepared and mailed out 6,505 survey packets. The 3,189 returned surveys were scanned and analyzed, and results were distributed through 226 quarterly reports to 60 provider agencies.

A drug and mental health court participant survey is completed each year, looking at participants' perceptions of procedural fairness, legitimacy, treatment satisfaction, awareness of tobacco quit resources and other items. Individual reports are provided back to the specialty courts conveying the results and explaining how continued improvement in these areas can benefit the program's outcomes.

The Oklahoma Mental Health Planning and Advisory Council (OMHPAC) meets at least six times a year. The majority of those in this group are persons in recovery or family members. The remaining members are representatives of numerous state agencies and advocacy organizations. A standing agenda item includes reports from programs offering specific services. In that regard, the stakeholder group monitors and advises, on an on-going basis, the services and programs available to consumers and their families. As representative from the Decision Support Services, responsible for performance measures, also attends each meeting to answer any questions concerning performance improvement reporting.

Decision Support Services Systems for CQI. A major function of the Decision Support Services (DSS) Division is to measure and support ongoing efforts to improve services, processes and outcomes. Toward this end, the DSS primary responsibilities focus on evaluating programs, producing monitoring reports and educating others on a variety of topics to improve behavioral healthcare within the state and across the nation. Audiences include treatment providers, the ODMHSAS staff, legislators, the general public, and peers in other states and at the federal level. Selected DSS activities are discussed below. DSS staff members have been actively providing feedback concerning the development and operationalization of the National Behavioral Quality Framework (NBHQF) performance measures. One staff participated in the Integrated Behavioral Health Client–Level Data Reporting Strategy meeting with the Behavioral Health Statistics and Quality Center (CBHSQ) staff in February of 2012, dialogued with the CBHSQ staff on several occasions through participation in the National Association of State Alcohol and Drug Abuse Directors' (NASADAD) Performance Monitoring Workgroup, and submitted comments on proposed measures to SAMHSA as requested in April, 2015 as well as participating in a call with CBHSQ in June, 2015, initiated by NASADAD. The ODMHSAS appreciates SAMHSA's effort to establish validated performance measures and will work to align its data reporting system to be able to report the measures once they have been finalized.

DSS staff developed and maintains over 100 reports to monitor performance and continually increase the efficiency and effectiveness of various processes and procedures and improve outcomes. Each provider agency can access its specific reports through a secure website. Currently, there are four different report formats for each National Outcome Measure (NOM), ranging from an easily understood format for

non-technical groups to a highly detailed report that allows an agency to “drill down” to the client level for each measure. Also, a Provider Performance Management Report (PPMR) is produced that is a compilation of every measure calculated for a provider agency, and includes information on whether the agency is above or below the statewide trend, where the agency falls in relation to other similar agencies and how the agency is doing compared to the previous year.

An assortment of reports have been designed for different audiences’ needs, such as detailed staff productivity reports for local PACT program managers, a violations-to-sanctions ratio for drug courts and brief cost offset reports for legislators.

In addition to producing and publishing performance improvement reports, DSS routinely educate users to the uses of the reports available at the state, facility and individual clinician level for performance monitoring. In 2013, DSS provided more than 50 webinars to providers, and presented at 16 different conferences and numerous agency meetings.

DSS staff developed and maintains a user-friendly, web-based query tool, the Health Information Integrated Query System (HI IQs), which permits consumers, advocates, providers, legislative staff and the general public to submit requests for data summaries and receive the results immediately through a web-based application.

To ensure that ODMHSAS services positively impact people’s lives, DSS conducts evaluations of a variety of programs. These encompass promising, best and evidenced-based practices (EBPs). In 2013, these evaluations included:

- Freedom, Recovery, Empowerment (FRE) Project
- Crisis Intervention Team
- Systems of Care Weaving Access for All Grant
- Substance Abuse & Mental Health Action Recovery Team (SMART) project.
- Drug Court Assessment Project
- Oklahoma Partnership Initiative for Children of Methamphetamine-Involved Parents
- Oklahoma Youth Suicide Prevention and Early Intervention Initiative
- Correctional Discharge Planning (CDP)
- Children Affected by Methamphetamine Family Drug Court
- Drug Courts
- Mental Health Courts
- Juvenile and Family Courts
- Program of Assertive Community Treatment (PACT)
- Day Reporting Program
- Re-entry Intensive Care Coordination Teams (RICCTS)
- Intensive Care Coordination Teams (ICCTS)
- Co-occurring Treatment Team Specialist (COTTS)
- Tobacco Settlement Endowment Trust

- Justice and Mental Health Collaboration Program
- Homes, Honor, and Health for Oklahomans (H3OK)
- National Strategy for Suicide Prevention (NSSP)
- Zero Suicide
- Adolescent Recovery Collaborative (ARC)
- Veterans Drug Courts
- Prescription Drug Monitoring Program (PDMP)
- Medical Examiner Records
- Offender Screening
- Vital Records – Death Data

DSS staff participates in ongoing workgroups at the federal level to develop standardized performance measurements. These included the Department of Justice Advisory Board, the Washington Circle Group, NASADAD Performance Management Workgroup, the Centers for Mental Health Services Client-Level Data Project, the National Association of State Mental Health Program Directors Research Institute (NRI) Client Level Data Workgroup, the NRI Community Integration Pilot Project, the NRI Good and Modern System Measures Workgroup, and NASADAD-NASMHPD State Profile Project.

To improve the quality of treatment data being reported, the ODMHSAS Data Integrity Review Team (DIRT) was formed in the fall of 2007. The team consists of senior staff members and other newer staff in the Decision Support Services (DSS) Division. Throughout the first year of implementation, DIRT members modified the review protocol to better meet the needs of treatment providers and ensure that minimal time is taken out of clinicians' schedules. Initially, the protocol consisted of reviewing 30 pre-selected client encounter records and comparing the information reported to the statewide data reporting system to that found in the client treatment record. Inconsistencies were highlighted and reviewed with clinical staff. However, many data reporting errors were common among agencies so, to minimize treatment provider time, DIRT members no longer conduct record reviews at each site but go over common reporting errors. The main objectives of the visits are to educate treatment staff about: (1) performance measures and how to properly report them; and (2) the use of various reports available at the facility and individual level to use the data to improve treatment performance.

In FY2015, DIRT members have conducted over 59 individualized agency, go-to-meeting trainings with community mental health centers and substance abuse treatment providers, as well as 15 webinar trainings for all providers. In addition to positive feedback from participants, the data demonstrate that reporting of NOMs outcomes has substantially improved during the period that the DIRT has been in place. To reduce the travel costs, webinars with individual agencies are now being conducted.

ODMHSAS CQI Projects. Examples of significant continuous quality improvement projects are briefly described below:

1. Pay-For-Performance. In 2009, the ODMHSAS implemented the Enhanced Tier Payment System (ETPS) as a pay-for-performance plan to proactively support provider level activities that improve consumer outcomes related to recovery from mental illness and substance abuse. Two primary objectives were to: (1) improve treatment and support outcomes; and (2) pay for outcomes with no additional costs to the state.

The ODMHSAS developed 12 measures that guide positive outcomes for consumer recovery. In addition, the ETPS was approved by the Center for Medicare and Medicaid Services (CMS), which then allowed Oklahoma to receive federally-matched funds for the project. For every state dollar contributed to the outcome measures, the federal government contributes \$1.93, a match rate of 65.9%. The funds are returned to communities to provide data-driven, research-based recovery outcomes to improve the lives of Oklahomans.

Benchmarks were established for 10 quality measures based on data from a previous six-month time period and knowledge of best practices. No additional access measures are determined through “secret shopper” phone calls made to the facilities. Funding is allocated based on number of clients served and agency performance on each measure. Facilities may earn zero dollars, 50% of their allotment, 100% of their allotment, or more than 100% of their allotment depending on where each lands in relation to the benchmark. The amount available to a facility is based on the percent of clients a facility serves. If Agency A serves 10% of the state’s mental health population, their ‘Amount Available’ would be 10% of the total. If a facility’s scores are above the benchmark on all scores, they would earn 100% of their funds. If any of their scores were below the benchmarks, there would be money ‘left on the table.’ Facilities scoring more than one standard deviation above the benchmark earn bonus money.

From the start of the new payment system in January 2009, all measures have shown improvement. After the initial round, all of the providers were so satisfied with the process, they agreed to voluntarily take money from their budgets to use as the matching funds. In SFY2013, \$39.3 million were paid to providers for meeting or exceeding the benchmarks. Through the ETPS, more attention has been paid to data quality and ongoing performance improvement processes have been put in place, resulting in higher quality care for citizens of Oklahoma.

Current Pay for Performance Indicators for mental health services are listed below. Resources to support a similar approach for substance abuse treatment services will be explored. Following are the current indicators tracked.

- Outpatient Crisis Service Follow-up within 8 Days
- Inpatient/Crisis Unit Follow-up within 7 Days
- Reduction in Drug Use
- Engagement: Four Services within 45 Days of Admission
- Medication Visit within 14 Days of Admission
- Access to Treatment - Adults
- Access to Treatment - Children
- Improvement in Client Assessment Record (CAR)Score: Interpersonal Domain

- Improvement in CAR Score: Medical/Physical Domain
- Improvement in CAR Score: Self Care/Basic Needs Domain
- Inpatient/Crisis Unit Community Tenure of 180 Days
- Peer Support: % of Clients Who Receive a Peer Support Service

2. Systems of Care CQI. A core principle for Systems of Care and Wraparound services in Oklahoma is “outcome based and cost responsible.” Related quality initiatives specifically benefit the children, youth, and families who access local Systems of Care and the partner agencies that participate. Data are collected from sites in 74 of the 77 counties. State level Systems of Care staff meet with lead evaluators from the University of Oklahoma’s Evaluation E-Team each month to review data and discuss ways to improve processes and outcomes based on the data, much of which are generated from the Youth Information System (YIS). The YIS is an electronic data reporting system developed by the E-Team for Oklahoma Systems of Care (OKSOC). Topics and recommendations are described below.

- Wraparound Fidelity Index (WFI) Study
 - Partnership between
 - ODMHSAS
 - Red Rock Behavioral Health
 - CROKS Behavioral Health Services
 - Grand Lakes Mental Health
 - E-TEAM, University of Oklahoma
 - National Wraparound Initiative
 - Study assesses correlations between fidelity of the wraparound implementation and individual youth outcomes as measured by the Ohio Scales.
- E-TEAM presentation at the National SOC conference—Georgetown Institutes—in Orlando, FL on *Using the Ohio Scales for Assessment and Outcome Measurement in a Statewide System of Care.*
 - The Ohio Scales have served OKSOC as measures of outcomes and of referral appropriateness since their adoption in 2004 as part of the state evaluation. The characteristics of the Ohio Scales have been an excellent match to the needs in rapidly expanding the wraparound program statewide. Extensive research-based recommendations were used in selecting the Ohio Scales to measure 'critical impairment' and 'clinically significant improvement.'
 - The Ohio Scales provides OKSOC with a measure of appropriateness for service—not only as a partial measure of overall referral appropriateness, but also to analyze differences in the appropriateness for service of youths arriving from diverse referral sources, i.e., juvenile justice, child welfare, the schools, etc. The Ohio Scales also allows for comparison -- using the definitions of 'critical impairment' laid down in the research—the

appropriateness of youths recruited by the referral networks of individual sites and of their sponsoring host agencies.

- Results from the Ohio Scales have been incorporated into OKSOC evaluation protocols as performance measures. In order to assess the overall effectiveness of the wraparound program – given that there are too many sites to allow frequent, in-depth reviews of caseloads and outcomes – OKSOC has identified several process and outcome elements of the evaluation dataset that it has adopted as performance measures. Two of these are related to scores on the Problems and Functioning scales.

- Multi-year analyses of evaluation data from the OKSOC wraparound program have also confirmed the value of the Ohio Scales as outcomes measures for those cases for which other types of outcomes measures are either scant or nonexistent. The ODMHSAS requires measures related to 'event count' types of phenomena such as out-of-home placements, encounters with law enforcement and negative school events. These measures are used routinely by OKSOC in outcomes reporting, but due to a percentage of the client youths having no meaningful record of these events in their lives, the Ohio Scales serves as a valuable outcomes measure that can approach 100% coverage of the client population.

In addition to discussing this information in the monthly Data Review Meetings, reports are provided at a bi-monthly local Project Directors meeting and at Quality Assurance meetings facilitated by our lead evaluators from the E-Team. Periodic summary presentations are provided to the State Team for Systems of Care.

3. Drug Court Pay for Performance. In July 2011, the ODMHSAS developed an outcome-based funding method to better manage and maximize drug court resources. By analyzing numbers of participants served as well as participant outcomes, programs which serve more eligible offenders and have the biggest positive impact on participants receive incentives for continued program growth. Drug court programs are compared against the state average to identify if they are higher performing than their counterparts across the state. By taking into consideration the following questions, ODMHSAS and drug court programs themselves are able to identify potential funding levels as well as areas that each individual drug court can focus to improve upon:

- Is the current number of active participants within the contract expectation?
 - *Purpose: Assess if the drug court program is currently serving the number of participants as directed by their current contract.*
- Is the average number of participants in the last six months within the contract expectation?
 - *Purpose: Assess if the drug court program has consistently met funded expectations.*
- What is the percentage of participants admitted without prior felony convictions?

- *Purpose: Determine if the drug court program is appropriately prioritizing program admission to prison-bound offenders.*
- What are the percentages of program graduates unemployed, without a diploma or GED, and without custody of their children?
 - *Purpose: Determine if the drug court program has successfully assisted program graduates with meeting identified goals during participation.*
- What are the percent changes in number of participants unemployed, without a diploma or GED, and without custody of their children from admission to graduation?
 - *Purpose: While some drug court programs may have abnormally high rates of unemployment, etc. at program admission, leading to higher than state average results at graduation, ODMHSAS recognizes significant changes in these outcomes categories from admission to graduation.*
- What is the completion rate of the program?
 - *Purpose: Determine how many individuals whom enter the program successfully graduate.*

Statewide data show a significant improvement in targeting of prison-bound offenders, the single best measure in enhancing cost savings. Additionally, while employment and education areas are often more difficult for individuals with felony criminal records, the drug courts have significantly improved these areas as well. A slight improvement was seen in program completion rates.

The competition between drug court programs for limited funds has led to a system in which:

- Performance improvement is a continued goal,
- Creativity is encouraged, and
- Partnerships among drug courts and community service providers have been enhanced in order to best meet participant needs.

3. CQI Related to Critical Incidents, Grievances and Complaints. Programs providing services within the ODMHSAS system are required by administrative code and specific policies to report critical incidents, records of grievances, and other related complaints. Reported incidents as well as overall trends are closely monitored. Corrective action plans are stipulated as indicated. Those plans are then monitored for completion. Summaries of reports are submitted to the ODMHSAS Board Corporate Accountability Committee. The Board Performance Improvement Committee and provided to all Board members. Problematic resolutions and other factors surrounding the incidents and complaints can result in sanctions, revocation of certification/licensure, and specific employee disciplinary actions, including termination. These processes are closely coordinated by the Chief Operating Officer with regular involvement of the ODMHSAS Advocate General, the ODMHSAS Inspector General, the ODMHSAS General Counsel and the Director of Provider Certification.

4. Oklahoma Quality Team Awards. Each year the Governor's Office and the Office

of Personnel Management (OPM) host Quality Oklahoma Team Day at the State Capitol to recognize projects demonstrating employee initiative, collaboration and accomplishment. All projects must be described using an acceptable total quality management approach, including reports on data and quantified results. The ODMHSAS participation has been a major emphasis shepherded by the Commissioner's Leadership Team. Prior to 2008, the ODMHSAS rarely submitted more than two projects in a single year. In 2008, the Department entered a total of seven projects, winning three Governor's Commendation Awards, including the Quality Crown Award - the premier award for Quality Oklahoma Team Day. The Quality Crown Award is the highest recognition included in the event and is awarded to the single project that best documents the use of the quality processes, continuous improvement and performance excellence.

The ODMHSAS participation in the Quality Team Awards has continued to grow through each subsequent year. In SFY2015, 13 of 32 (41%) ODMHSAS entries won a Governor's Commendation Award, ODMHSAS won 13 of the 22 (59%) Governor's Commendation Awards Given, ODMHSAS won 2 of the 5 (40%) specialty Awards, including the highest award, the Quality Crown Award; and ODMHSAS won 15 of 27 (56%) of all awards given.

5. ODMHSAS Board Quality Improvement Committee. The ODMHSAS Board Chair designates a committee to review and report on system wide performance improvement activities and initiatives. The ODMHSAS Leadership and other key staff attend each meeting. The Committee reviews activities and projects that have been performed by various state-operated facilities, contracted organizations, or administrative staff. Members of the committee provide feedback regarding the projects and results, as well as make suggestions to spread the improvements on a statewide scale. The Committee Chair reports to the full board at each meeting. On occasion, presentation on an exemplary performance improvement project is made at the full board meeting as well.

11. Trauma

Policies Directing Providers Related to Trauma Screening. Since 2008, agencies contracted with the ODMHSAS are required to screen for trauma. Staff members serving children have been using a state-wide standardized trauma-screen the UCLA-PTSD-RI since SFY13. In SFY15 this was changed to the CATS: Child and Adolescent Trauma Screen. While live trainings are provided to the CMHCs, a free online training is available so that staff may be trained immediately, and in order that the training is available to other non-CMHCs. Staff members serving adults are also required to screen for trauma and are given the option to utilize one of many trauma screeners in the public domain, such as Post Traumatic Stress Disorder Checklist – Civilian (PCLC-C). In FY2015, the Health Home providers, that are all of the CMHCs and other private providers, are contractually required to screen all adults entering their centers for trauma using the Post Traumatic Stress Disorder Checklist – 5 (PCL-5). The PCL-5 is the updated version of the PCLC to integrate the diagnostic criteria in the DSM-5.

Policies Related to Trauma-Focused Therapy. Persons who have a trauma history are referred to trauma specific services. A concerted effort is underway to train the behavioral health staff working with children and adults to provide trauma specific services in Oklahoma.

Policies for System Wide Trauma-Informed Care. All agencies are required through contract and through the Oklahoma Administrative Code (OAC 450) to provide trauma-informed, gender sensitive, age appropriate and culturally competent treatment for all consumers. Training for both the Sanctuary model and the Creating Cultures in Trauma Informed Care model (CCTIC) has been provided as funding allowed for several years. Oklahoma has two Sanctuary certified sites, Children's Recovery Center and Griffin Memorial Hospital. All providers are required to train all staff annually on trauma so that they have an understanding of trauma triggers that traditional service delivery may exacerbate. In FY2015 an on-line trauma-informed e-learning became available to all providers. The e-learning, "Trauma is Just the Beginning" is required for all Health Home staff, regardless of their role, to create a baseline trauma-informed foundation. All existing staff were required to complete it and all new staff before the end of orientation. The e-learning is also supplemented by available live trainings.

Evidence-Based Trauma-Specific Interventions. Oklahoma has been training the behavioral health workforce serving children in the Trauma Focused Cognitive Behavioral Therapy model (TF-CBT) for several years. Since 2006 The ODMHSAS has contracted with the University of Oklahoma for the training and related clinical consultation in TF-CBT. In FY2013 a policy change was implemented that required all child serving clinicians at each CMHC to complete the online TF-CBT training, and then for the CMHC to designate core staff to complete the live training and consultation process, meeting standards for the new TF-CBT certification, to improve capacity to provide TF-CBT for children. In FY2015 this requirement was expanded to all child serving Health Home providers. In addition, training in Seeking Safety for adolescents is provided and plans are underway to expand consultation statewide in this practice.

Two specific interventions are available for adults -- Seeking Safety and Trauma Recovery Empowerment Model for both men and women (TREM & M-TREM). In FY15 a policy change was implemented requiring all Health Home clinical staff that serve adults to complete the Cognitive Processing Therapy (CPT) online training, and new clinicians to complete by the end of their orientation.

Training Trauma-Specific Interventions. The ODMHSAS Training Institute resources support trauma specific trainings in multiple venues. In the past year Community Connections and the ODMHSAS partnered to train staff in TREM and M-TREM and in Creating Cultures in Trauma Informed Care (CCTIC). Treatment Innovations has also trained providers in the Seeking Safety model for adults and adolescents. An advanced training for those who are already facilitating a Seeking Safety group was offered in FY15. All CMHCs have the Seeking Safety curriculum to continually train staff. The ODMHSAS collaborated with Dr. Najavits the author of Seeking Safety to develop on-

line training available in FY14. In FY15, 450 staff were trained in the Seeking Safety model.

12. Criminal and Juvenile Justice

Note: Additional information is also included in Step 1 of this Combined Application under Targeted Services for Individuals Involved in the Criminal or Juvenile Justice Systems.

Medicaid Enrollment for Justice System Involved Individuals. Currently processes are in place that requires Medicaid eligibility to be reviewed on each specialty court participant. Medicaid is utilized as a priority funding source for those offenders receiving services whom qualify for coverage as defined by the current regulations. In some cases, indigent females with children qualify for Medicaid for a period of time. Families with children up to 185% of the poverty level are eligible to apply for Medicaid for their children up until age 17. Children that are in the custody of the juvenile justice system are automatically enrolled in Medicaid through the Oklahoma Office of Juvenile Affairs (OJA). Children presenting at service providers are routinely screened for Medicaid eligibility and families are assisted in applying for Medicaid if needed.

Offenders incarcerated at Department of Corrections (DOC) who meet disability criteria, whether based on mental health or physical health conditions, are assisted in applying for SSI/SSDI about four months prior to release. When SSI/SSDI is approved they are automatically approved for Medicaid coverage as well. Regretfully, some offenders who may have significant need for substance abuse and in some cases mental health care do not meet disability criteria and likewise, Medicaid is not available. (See information on *Benefits Reinstatement for Returning Inmates* in Step 1 including description of the project in SAMHSA partnered with the ODMHSAS to evaluate methodologies to enhance access to Medicaid for discharging inmates.)

Pre-Adjudication Screening and Services. Oklahoma Systems of Care in partnership with the Tulsa County Juvenile Bureau created a joint venture to divert youth with mental health and substance abuse issues to local SOC teams and community mental health providers. The Ohio Assessment scale is used as a component of the diversion process to screen youth entering the juvenile justice system for mental health and/or substance abuse issues and can be effective keeping youth from going deeper into the juvenile justice system. If positive, the youth is linked to a local mental health and/or substance use provider where a thorough mental health and substance abuse assessment is completed and treatment offered if indicated.

An offender screening program for adults was implemented in November 2012 and is now available to offenders in 27 of the state's 77 counties. Utilizing validated instruments, Ohio Risk Assessment System- Community Supervision Tool (ORAS), Texas Christian University Drug Screen (TCUDS), Mental Health Screen Form III (MHSF III) the screening package reviews risk to reoffend, mental health, and

substance use treatment needs. Screening results identify high/low levels of treatment need and risk to utilize the Risk-Need Responsivity (RNR) approach, an evidence based practice in referring offenders to appropriate diversion programs available in their community.

Coordination with Criminal and Juvenile Justice Systems. No formal coordinating agreement is in place between the mental health authority, Social Security Administration and juvenile justice to divert children in the juvenile justice system to community based services. However, Systems of Care programs are available in 74 of 77 counties in Oklahoma and juvenile justice staff are commonly part of the SOC teams in those counties. The SOC program welcomes referrals from the juvenile justice system and it is done on a case by case basis.

The ODMHSAS in collaboration with the OU ETeam will be launching the Global Appraisal of Individual Needs Short Screener (GAIN-SS) statewide through an online portal. Although no formal agreement, Oklahoma Juvenile Affairs will have access to screen all youth in their system for substance use and co-occurring disorders.

The Children's System Data Sharing Committee (CSDSC) seeks to identify better, more coordinated ways of serving shared clients and achieving better outcomes. The workgroup established a multi-agency data sharing agreement in December 2009 and are implementing data sharing projects through the organizational partners: the Office of Juvenile Affairs (OJA), the Department of Human Services (DHS), the Department of Corrections, and the Department of Mental Health and Substance Abuse Services (DMHSAS).

For adults the Social Security Administration (SSA) coordinates with the re-entry of persons back into the community from the Department of Corrections. SSA staff work with the inmates prior to discharge in an attempt for benefits to be in place when the person is ready to release. The program has been effective to help transition persons from prison to the community with benefits in place. The ODMHSAS funds and oversees operation of the state's adult drug, juvenile drug, mental health, and family courts with legislative funding. These diversion programs effectively assure that individuals with mental health or substance abuse issues gain access to treatment in these community programs rather than jail, prison or juvenile facilities.

Medicaid Enrollment and Care Coordination. For children and their families, referral to local Systems of Care programs can help address issues such as inadequate family support, school failure, negative peer associations and insufficient use of community based services. Care Coordination is a core value of SOC. The child and family build a team to support them with community members that may be more familiar with community resources, school system issues and better able to assist them throughout the juvenile justice process.

In the adult system there is significant effort around public benefit enrollment and care coordination to address specific issues faced by those involved with the criminal justice

system. There is an MOU in place with the SSA and Disability Determination Division (DDD) and Medicaid to get approval prior to release. There is a point of contact with the DDD, as well as a new information sharing agreement, to streamline the application process and avoid some of the delays and long turnaround times to apply which is especially helpful to persons who have been incarcerated since employment options will be scarce. The DDD examiners can now log into the DOC electronic medical and mental health records to review records to expedite applications.

Cross Training with Criminal and Juvenile Justice Personnel. The ODMHSAS provides training to the juvenile system including juvenile court personnel and juvenile judges at the annual Juvenile Justice conference. For the past three years the focus has been educating court personnel on trauma, on Oklahoma's efforts to build a trauma informed system, and the value of providing trauma survivors with trauma specific services. Dr. Vincent Felitti presented on the ACE study last year and ODMHSAS staff presented on introductory trauma and programs available to the justice system in Oklahoma. ODMHSAS staff will continue to educate the juvenile court system in the coming year.

In recent years, the specialty court system provided the following:

- *Specialty Court State Conference.* Two day conference providing information on evidence based practices in specialty courts. Topics include role specific sessions for judges, district attorneys, defense attorneys, and treatment providers, medication assisted treatment, ASAM, veteran and Native American-specific breakouts, and pharmacology.
- *Justice-Involved Veteran's Workshop.* Workshop presented by a nationally renowned veteran treatment expert educating judges, district attorneys, defense attorneys, treatment providers, coordinators and supervision/law enforcement on issues related to trauma, family, and cultural issues of military personnel. This training was supported by a grant from the Bureau of Justice Assistance (BJA).
- *Risk/Need Responsivity Workshops.* Three hour workshop presented throughout the state in four regional locations don the Risk Need Responsivity Model to enhance outcomes with offenders. For judges, district attorneys, defense attorneys, treatment providers, coordinators, and supervision/law enforcement.
- *Matrix Model Treatment Curriculum.* Five, two day workshops on utilization of the Matrix Model Treatment Curriculum were provided to all specialty court contracted treatment providers in order to enhance the utilization of evidence-based treatment practices. This training was supported by a grant from the Bureau of Justice Assistance (BJA).
- *Drug Court Coordinator Meetings and Mental Health Court Coordinator Meetings.* Held quarterly with a training component which has included presentations on Veteran Resources, Question Persuade and Respond (QPR), Experiential Mental Illness Simulations, Oxford House, etc.
- *Level of Service Case Management Inventory (LSCMI) Master Trainings and End User Trainings.* Training series offered in Oklahoma City, and coming up in Tulsa, to train trainers for the LSCMI, a validated risk assessment instrument in

working with offenders. This training was supported by a grant from the Bureau of Justice Assistance (BJA).

- *Ohio Risk Assessment System Community Supervision Tool (ORAS-CST)*. Two training series offered to train clinicians on the ORAS-CST, a validated risk assessment instrument in working with offenders. An ORAS-CST Master Training occurred in 2013, building the state's internal capacity to sustain trainings in the use of the instrument. .
- *Specialty Court Judges' Forum*. Annual workshop for specialty court judges focusing on ethics, constitutional issues, and evidence-based practices specific to the judges' role in the programs.
- *Gambling Disorders in Specialty Courts*. Full day workshop educating judges, district attorneys, defense attorneys, treatment providers, coordinators, and supervision/law enforcement on the recognition and treatment of gambling disorders in specialty court settings.
- *Sensitizing Providers to the Effects of Incarceration on Treatment and Risk Management Training (SPECTRM)*. Full day workshop on the nationally recognized training model which educates treatment providers and court systems on the cultural impact of incarceration when individuals with behavioral health treatment needs are released and enter back into community-based treatment settings. This training was supported through a grant from the Bureau of Justice Assistance (BJA).

The following training events were offered to OJA:

- Regional training on basic neuroscience, impact of drugs on adolescent brain, and Impact of substance use on the family.
- Introduction to and advanced Motivational Interviewing.
- Global Appraisal of Individual Needs Short Screener training was offered regionally. This tool screens for substance use and possible co-occurring disorders.
- Every year ODMHSAS' Children's division provides one to one matching scholarships to OJA to attend the Children's Behavioral Health Conference sponsored by ODMHSAS.
- The Adolescent Co-occurring Treatment in Oklahoma Now event educating and creating a call for action.

Motivation Interviewing Introductory and Advanced Courses cross training between the mental health and criminal justice systems involves two training models for which staff from each of the departments along with advocates and law enforcement is facilitators. Crisis Intervention Training (CIT) and Correctional Crisis Response Training (CCRT trainings) are regularly provided throughout Oklahoma. Crisis Intervention training (CIT) is a 40 hour mental health curriculum for law enforcement. Oklahoma currently has approximately 1100 officers trained in CIT.

CCRT (Correctional Crisis response training) was developed as a collaborative project between the ODMHSAS and the Department of Corrections (DOC). The training is

based on the CIT curriculum modified to fit the jail/prison setting. CCRT trainings have been provided to correctional officers in the Oklahoma State penitentiary, Mabel Basset, Joseph Harp, the Oklahoma County Jail, and the Midwest City jail.

SSI/SSD Outcome, Access, and Recovery (SOAR) training has been one of the largest contributors to inmates obtaining benefits prior to release. SOAR training was conducted for all of the prison staff working with inmates, mental health, and substance abuse staff at the CMHCs. SOAR is an in-depth, step-by-step explanation of the SSI/SSDI application and disability determination process. The training presents strategies for working with homeless persons with SMI and co-occurring disorders. The exercises and worksheets provide practical application tools to assist in the SSI/SSDI application process. This practical training has helped Oklahoma staff to assist persons in the justice system more expeditiously gain benefits and has resulted in more individuals gaining approval prior to release. The rate increased from 36% to 90% approval.

13. State Parity Efforts

The ODMHSAS has incorporated parity information into an overall messaging strategy. This includes focused press attention and also inclusion in multiple presentations.

Communication Plans to Educate and Raise Awareness about Parity. The ODMHSAS uses a variety of methods to communicate and educate on important issues. To inform providers, a broad approach is used such as emails, announcement at meetings, fax blasts, newsletter articles and provider trainings. To educate the general population, electronic messaging via the departmental web site and social media platforms such as Facebook and twitter are utilized; as well as public speaking opportunities, including talking points for agency officials and other state leaders; press briefings and press releases; public service announcements; and bill boards and radio advertisements. To reach targeted audiences, such as those needing behavioral health services, provider agencies and advocacy groups are utilized by providing training and education to the staff for outreach, and providing signage and other educational materials with additional resources to contact. Educating and training Peer Recovery Support Specialists has been successful to reaching persons directly impacted by related issues. State agency staff members also speak at various consumer organization meetings and trainings. An additional specific strategy includes the agency's provision of "Working Minds" to corporate partners across the state. This curriculum, primarily focused on suicide prevention, frequently engages stakeholders in enhanced discussions on what can be done to provide a quality benefit mix to support co-workers in need of treatment.

Coordinating across Public and Private Sector Entities. The ODMHSAS participates in a variety of interagency councils, advisory groups and workgroups. It is important to include these partners in any outreach and educational efforts made to ensure a broad and consistent message is conveyed since the populations served by the various

entities often overlap. In addition, persons in need of treatment but not receiving it may be seen by one of these entities and could be educated through their outreach efforts. A challenge is educating internal staff on the issue and the need to make it a priority with external partners. Having easy to understand educational materials is very helpful in educating staff, partner agencies and the general public. The ODMHSAS also has policy authority over behavioral health services that are delivered through the state's Medicaid program. This policy setting responsibility has led to heightened awareness of and access to quality behavioral health treatment services. Fortunately, there are many helpful resources available if states are aware of them. Some of these include: SAMHSA parity website, the Mental Health America's Parity Toolkit, the Parity Implementation Coalition's Frequently Asked Questions about MHPAEA, AHP Consulting Group's Special Report: MHPAEA Regulations, and CMS' Center for Consumer Information & Insurance Oversight's The Mental Health Parity and Addiction Equity Act Report.

Again, strategies identified above are used with both public and private sector entities. For example, parity is a topic that is frequently addressed when engaging in public speaking events targeting businesses. It is often a topic addressed when engaging groups interested in the topic of access.

Broad and Strategic Outreach. Because many people with behavioral health issues may be more isolated than the general population, outreach efforts need to be far reaching and deliberate to ensure the message reaches the appropriate audience. In many cases the clinical staff advocate on behalf of the individual. This will require comprehensive education to all provider staff to the extent they are knowledgeable about and comfortable with dealing with parity regulations. With the rate at which things are continually changing in the healthcare delivery system, it may be a challenge to stress the importance of this issue and raise it to the needed level of awareness. Another important advocacy group is the families of individuals with behavioral health needs. Since many of these people may never enter a treatment facility, particularly those of adult clients, outreach is needed within the general population to assure that previously unidentified families are provided essential information. The use of advocacy and support groups, social media and listservs will be utilized by the ODMHSAS as effective and efficient means of outreach.

14. Medication Assisted Treatment

Given the tremendous amount of research verifying the effectiveness of Medication Assisted Treatment (MAT) as well as the positive results noted by MAT providers, the ODMHSAS has committed to the development and implementation of MAT services throughout our system of care.

Currently, the ODMHSAS funds five Comprehensive Community Addiction Recovery Centers (CCARCs) to provide medication assisted ambulatory withdrawal management services for alcohol and sedative/hypnotic/anxiolytics utilizing chlordiazepoxide. Ambulatory withdrawal management services for severe opioid use disorders utilizing

buprenorphine is also funded by the ODMHSAS. Further, the Department currently contacts with two opioid treatment programs to provide maintenance and/or withdrawal management services utilizing methadone and buprenorphine. For years the ODMHSAS has funded medication assisted residential withdrawal management services with two main contracted providers operating today.

MAT is also being utilized to promote early recovery and as a preventative to relapse. Naltrexone, acamprosate, buprenorphine and methadone are utilized to enhance these treatment services.

Finally, the ODMHSAS promotes medication assisted tobacco cessation initiatives. Consumers at all levels of mental health and substance use disorder treatment are referred to services where medications used in nicotine cessation are provided at no charge. Currently, the ODMHSAS is supporting an Oklahoma Oxford House initiative with a targeted nicotine cessation program. Additionally, the ODMHSAS is assessing the possibility of providing medication assisted nicotine replacement therapy in residential care facilities.

The ODMHSAS has worked with a statewide task force to introduce and promote the use of Naloxone to address opioid overdose. This has involved numerous public speaking events, earned media, information on a dedicated website, the use of social media and a statewide media campaign to address abuse (TakeasPrescribed) of prescription painkillers.

The ODMHSAS has offered an anti-stigma MAT presentation statewide. Various versions have been offered to the public, the medical field, law enforcement, judges and prosecutors and clinicians working in mental health and substance use disorder treatment fields. Presentations on MAT are part of most major state conferences sponsored by the ODMHSAS. The ODMHSAS also has an annual training cycle offering monthly trainings at no charge to its contracted providers. This series is intended to raise the level of knowledge regarding SUD treatment services. One training is dedicated completely to MAT services. Other one and two day MAT trainings have been offered to clinicians working in both the general substance use disorder treatment field as well as opioid treatment and ambulatory withdrawal management programs. In addition, the Oklahoma Association for the Treatment of Opioid Dependency (OKATOD) has an annual one-day conference on MAT targeted to the SUD treatment field in general and specialty court staff in particular.

Utilizing MAT when appropriate is required for all contracted ODMHSAS providers at all levels of service provision. The ODMHSAS is also managing a MAT overdose prevention effort providing trained first responders with naloxone kits.

The ODMHSAS is currently in the process of reviewing and reallocating our SUD treatment resources. The reallocation will increase the number of MAT related services. Once in place, this new statewide system will be promoted to the general public and the courts, medical services and law enforcement.

A strategic plan is in development now by the State Opioid Treatment Authority with four new Opioid Treatment programs, two urban and two rural in active development.

All ODMHSAS contracted services are provided by ODMHSAS certified agencies. As part of the certification process, all agencies receive ongoing regulatory compliance reviews. These reviews ensure full and appropriate treatment protocols are followed.

The ODMHSAS State Opioid Treatment Authority works with all Opioid Treatment Programs providing technical assistance and oversight. This organization is also in charge of all other SUD MAT initiatives for the ODMHSAS.

The ODMHSAS has developed an instrument to determine level of SUD treatment service needed utilizing ASAM criteria. All available MAT services are included in the list of available referral options.

ODMHSAS has worked with the Oklahoma Bureau of Narcotics and Dangerous Drugs Control to develop protocol and regulation intended to reduce and eliminate diversion of drugs used in MAT services.

15. Crisis Services

The ODMHSAS offers an array of services, supports and prevention efforts that address crisis response. There are as follows:

Crisis Prevention and Early Intervention

In 2013 the Oklahoma Commission on School Safety was formed to investigate school violence within the state. The Commission called for the establishment of a Mental Health First Aid (MHFA) training pilot program for school personnel, and the ODMHSAS received additional funding from the state legislature to train individuals throughout Oklahoma in MHFA, an evidence-based, public education program that helps the public identify, understand, and respond to signs of mental illnesses and substance use disorders and link with resources to help with early intervention and crisis prevention. To date, approximately 1,062 individuals have been trained in Mental Health First Aid.

The ODMHSAS contracts with community organizations to provide community based mental health and recovery services and supports including CMHCs, substance use treatment providers, statewide advocacy organizations, independent clubhouses, peer drop-in center, and housing. These services and supports assist with overall recovery and crisis reduction. Service components can include crisis/safety planning, Wellness Recovery Action Plan (WRAP), Illness Management and Recovery (IMR), and other methods to facilitate consumer illness self-management and help avert crises. Education and assistance with completing Psychiatric Advanced Directives can also be provided.

For help in linking with services, the ODMHSAS offers a Reach-Out hotline at 800-522-9054 (V/TDD). This number is staffed around the clock to provide information and assistance.

Crisis Intervention/Stabilization

Within the Oklahoma outpatient behavioral health service system, crisis intervention services are provided for mental health and substance use disorder crises through community based service providers. Crisis services include 24-hour, 7 day per week triage, evaluation and stabilization and referral services. These crisis intervention services may also include mobile crisis services for both adults and youth and their families:

Mobile Crisis Response (MCR) Teams provide assistance for mental health and substance use disorder crises through telephone or face-to-face assessments. Teams provide outreach, assessments, evaluation, stabilization, referral, crisis/safety planning, access to therapy, access to inpatient treatment, short-term monitoring, referral services, and follow-up appointments for individuals experiencing a mental health or substance use emergency. MCR teams respond to crises in the community, at schools, hospitals, shelters, places of employment, and other community settings to stabilize the situation in the individual's natural environment. MCR services are designed to de-escalate the crisis situation, prevent possible inpatient hospitalization, detention, and homelessness, and restore the individual to a pre-crisis level of stabilization. Services are tailored to individual strengths, needs and preferences. The MRC teams are typically a two-person team including a licensed clinician or licensure candidate and a paraprofessional (i.e., case manager, peer recovery support specialist, family support provider, etc.)

In FY13, ODMHSAS piloted an Urgent Care service in Oklahoma City and provided funding for two more Urgent Care Centers (URC) in Ardmore and Tulsa, to be paired with their Community Based Structured Crisis Centers (CBSCC). The Urgent Care Centers provide outpatient services to include medication management for person needing immediate care in order to prevent a psychiatric emergency. The Centers also provide 23-hour respite and observation in order to divert persons as indicated from inpatient or CBSCC placement. The URC provides follow-up services to individuals within seventy-two hours of discharge to help ensure that outpatient services are initiated. The ODMHSAS now funds four urgent care centers in: Oklahoma City, Tulsa, Sapulpa and Ardmore.

Community Based Structured Crisis Centers (CBSCCs) for adults operate in Oklahoma City, Tulsa, Clinton, Norman, Muskogee, Ardmore and Tulsa. The CBSCCs for children operate in Oklahoma City and Tulsa. The CBSCCs provide non-hospital emergency services for mental health and substance use disorder crisis stabilization as authorized by O.S. 43A 3-317, including but not limited to, observation, evaluation, emergency treatment, and referral for inpatient psychiatric or substance use disorder treatment service when necessary. These services are provided in a secure residential setting for

up to five days, if needed.

Adult psychiatric inpatient services are provided at Griffin Memorial Hospital in Norman, the Oklahoma Forensic Center in Vinita and at smaller inpatient units located in McAlester, Ft. Supply, Tulsa and Lawton. Psychiatric inpatient services for youth are provided at the Children's Recovery Center in Norman.

The ODMHSAS facilitates a Crisis Intervention Team (CIT) program which is a community effort partnering both police officers and the community together for common goals of safety, understanding, and service to individuals with mental illness and their families. As of July 2015, over 1100 law enforcement personnel in Oklahoma had been trained in the Memphis Model Crisis Intervention Training (CIT) or a similar law enforcement-based diversion program. These CIT officers work together with mobile crisis response teams, urgent care centers and inpatient psychiatric facilities to help better meet the crisis needs of the individuals served.

Post Crisis Intervention and Support

The ODMHSAS administrative rules for outpatient Behavioral Health Case Management (BHCM) outline requirements for individuals admitted to high levels of care, to include maintaining contact with existing consumers, and making contact with newly referred individuals when admitted in psychiatric inpatient care or in a CBSCC. The outpatient BHCM monitors consumer progress and assists with discharge/transition to outpatient services. A BHCM also provides follow-up to help ensure connection with outpatient services. When a consumer returns to outpatient care, current needs are assessed and treatment is modified as needed.

Both URCs, CBSCCs and psychiatric inpatient facilities work with the individual, their family or other natural supports if applicable, and community based service providers regarding discharge/transition planning to help ensure a successful connection with the services and supports necessary for integration back into the community.

16. Recovery

The ODMHSAS promotes a recovery-focused service system with focus on improving access to quality health and behavioral health treatment; incorporating peer, family and other community supports; emphasis on person-centered care that includes shared decision-making; and continued efforts to try to improve access to housing, employment, education and related supports.

The ODMHSAS defines recovery in the Oklahoma Administrative Code (OAC) 450:53.

“Recovery is a “...journey of healing and transformation enabling a person with a mental health or substance abuse diagnosis to live a meaningful life in the community of his or her choice while striving to achieve his or her full potential. The process of recovery leads individuals to the highest level of autonomy of which they are capable. Key

characteristics of recovery include:

- a) *Recovery is self-directed, personal and individualized;*
- b) *Recovery is holistic;*
- c) *Recovery moves beyond symptom reduction and relief;*
- d) *Recovery is a process of healing and discovery;*
- e) *Recovery encompasses the possibility of individuals to test, make mistakes and try again; and*
- f) *Recovery can occur within or outside the context of professionally directed treatment.”*

Access to Quality Health and Behavioral Health Treatment

The ODMHSAS has collaborated with OHCA on a Health Home initiative, resulting in the award of 22 HHs as of January 2015. Wellness Coach training has been offered to recovery support staff statewide, and will be offered to designated Wellness Coach positions with HH. Recovery support staff are available at most of the CMHCs and at many substance use disorder treatment agencies. Monetary incentives are available for CMHCs to provide recovery support services through a tiered system of payment developed to encourage positive outcomes. There are two peer run drop in centers in the state; located in Tulsa and Oklahoma City. Urgent Care Centers are available in Oklahoma, Tulsa, Sapulpa and Ardmore to assist consumers and avoid inpatient care if possible. The urgent care model incorporates the use of Peer Recovery Support Specialists (PRSS) as peer staff skilled in identifying and addressing holistic recovery needs of consumers. PRSS staff are also utilized in the adult HH model. Employment support services are available at all CMHCs, and there are seven supported employment programs (one for adults and 6 for youth). Consumer and family education is offered throughout the state on an ongoing basis by multiple advocacy organizations including the National Alliance on Mental Illness, the Mental Health Association of Oklahoma, the National Association of Black Veterans (NABVETS), the Oklahoma Citizen Advocates for Alcohol Recovery and Treatment Association (OCARTA), and the Evolution Foundation.

Oklahoma provides and supports training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services. The annual Recovery and Prevention conference provides a forum for presentations on recovery principles and practices and the role of peer providers. Staff in recovery and national leaders in recovery support services have presented at these annual conferences.

Following are examples of exemplary activities related to recovery support services.

- The ODMHSAS Enhanced Tier Payment System (ETPS) provides additional funding to providers who increase recovery support services to consumers. This system encourages providers to hire recovery support staff and to deliver recovery support services. Expansion of the peer support services to reach younger populations (transition age youth) is currently under development, and

further expansion of peer support services to reach veterans is currently being explored.

- Initiating Recovery Oriented Systems of Care (ROSC) trainings and extensive Oxford House availability incorporate important aspects of peer guided and provided recovery services.

Numerous structures continue to be in place to assure that the ODMHSAS operates with on-going guidance and advocacy from individuals in recovery, youth, and their families.

- The State Planning and Advisory Council for the ODMHSAS follow federal requirements to assure that consumers and family members comprise the majority of that body. The Council's functions and members are discussed further under Item 22.
- The Coalition of Advocates is composed of advocacy agency representatives who partner with the ODMHSAS legislative liaison staff to promote funding the behavioral health system adequately in Oklahoma. During legislative session the advocates host weekly "coffee chats" with legislators to discuss pending issues important to mental health and substance abuse funding.
- The State Advisory Team for the Oklahoma Systems of Care Initiative is composed of family members, agency staff, and advocacy agency representatives. Ongoing evaluation of the children's service system through evaluation presentations provides multiple opportunities for family input. The Children's State Advisory Workgroup (C-SAW) is composed of agency representation and family members and function as the workgroup for the SAT. Discussion of the system and how to continually improve the system is always on the agenda.
- The ODMHSAS Board, appointed by the Governor, includes one or more individuals who are self-identified consumers and speak to advocacy and consumer rights issues in many matters impacting governance of the agency.

The ODMHSAS works with all advocacy organizations to support meetings and conferences that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system.

The Annual Prevention and Recovery Conference and the Annual Children's Behavioral Health Conference incorporate widespread consumer and family involvement. Additional trainings throughout the year are provided by the ODMHSAS Training Institute, likewise utilize consumer involvement and provide avenues for important issues and gaps in knowledge to be addressed.

Peer, Family and Other Community Supports

The ODMHSAS hires people in recovery in leadership roles and throughout the system. The ODMHSAS Supporting Treatment and Recovery Services (STARS) Division has

staff that are self-identified consumers working in the division. Currently, the number of Peer Recovery Support Specialists (PRSS) working in state operated outpatient facilities is at around 5%.

The state’s plan for peer-delivered services is designed to meet the needs of specific populations. Peer Recovery Support Specialists (PRSS) are trained in diversity and cultural competency. PRSS certification training includes education on trauma and the need to provide trauma informed services to trauma survivors.

The State has a certification program and minimum standards for peer-run services. Peer recovery support specialist training is part of the certification process that is administered by ODMHSAS. The process includes application, initial training and 12 continuing education units required annually. There are a number of conference options offered throughout the year at which certification units specifically designed for peer staff and consumers are available.

The ODMHSAS contracts with family, peer run, and other support networks to provide ongoing training and education to Oklahomans. Recovery oriented services are provided throughout the system. The ODMHSAS provides family support providers and recovery support specialists throughout the system at CMHCs to work with families to support their ongoing recovery. The following list briefly details recovery organizations with which the ODMHSAS contracts and the funding sources used for those purposes.

Recovery/Peer-Operated Organization – Contracted for FY2016	Funding Source
Depression Bipolar Support Alliance (DBSA)	Mental Health Services Block Grant
Evolution Foundation	State Oklahoma Now is the Time (ONITT) Grant
Mental Health Association of Oklahoma	State Mental Health Services Block Grant
National Alliance on Mental Illness – Oklahoma (NAMI-OK)	Mental Health Services Block Grant Weaving Access For All (WAFA) Grant Oklahoma Now is the Time (ONITT) Grant
National Alliance on Mental Illness- Tulsa (NAMI-Tulsa)	Mental Health Services Block Grant State
National Association of Black Veterans (NABVETS)	Substance Abuse Prevention and Treatment Block Grant
Oklahoma Citizen Advocates for Recovery & Treatment Alliance (OCARTA)	Substance Abuse Prevention and Treatment Block Grant State
Oklahoma Family Network (OFN)	Weaving Access For All (WAFA) Grant

Person-Centered Care/ Shared Decision Making

The ODMHSAS encourages providers to use person-centered planning. The ODMHSAS offers a comprehensive training that assists service providers with understanding how to more fully implement person-centered planning in all aspects of the service process (from assessment, to plan development, to the provision of services, to on-going evaluation of progress). The training also addresses how this process translates to clinical documentation (in a way that is collaborative with the person served and conducive to self-direction). To further reinforce this process, the ODMHSAS and OHCA requirements for clinical progress notes allow for time spent by the service provider and the consumer completing a treatment progress note together to be compensable. Time spent by the service provider completing the progress note without the consumer is not compensable.

The Oklahoma Administrative Code (OAC 450:15) assures that each consumer is informed of their right to designate a family member or other concerned individual as their treatment advocate, to participate in consumer treatment planning and discharge planning to the extent consented to by the consumer.

Person centered and strengths based service planning are required in all state funded and certified programs. Training events referenced earlier, provide on-going staff development to further expand skills and awareness in this area. In addition, training opportunities with regard to strengths-based case management also help with continued development. The increased presence of Peer Recovery Support Specialists within ODMHSAS funded organizations assists with promoting and supporting shared-decision making. As previously mentioned, consumers are able to name a treatment advocate to help with making sure their wishes are known and addressed. In addition, consumers are afforded full access to the Office of Consumer Advocacy to assure that their voices and concerns are addressed on a timely and individualized basis.

Access to Housing, Employment, Education and Related Supports

ODMHSAS funds a variety of transitional and permanent supported housing options, along with housing subsidy assistance. One of the housing subsidy programs is specific to those individuals who are discharging from psychiatric inpatient, corrections, or aging out of foster care. The ODMHSAS maintains focus on expanding community based housing options for persons served, and participates in a variety of community collaborative efforts to address housing needs. Behavioral health case management services are offered at all the CMHCs and at many other provider agencies, and these services are used to assist persons served with accessing other housing assistance like Section 8, and to access housing through working with local landlords in the community.

For persons with substance abuse issues ODMHSAS funds Oxford House housing options as well as transitional and supportive housing and permanent housing.

Although there is still some congregate housing, the ODMHSAS maintains primary focus on the promotion of housing opportunities that are truly integrated into the

community. The ODMHSAS funds scattered site permanent housing opportunities, where individuals are assisted with finding apartments or houses in the community of their choice (usually owned by private landlords), and then receive on-going supports to help with long-term housing success. The supports include assisting the person served with developing and maintaining natural supports within their immediate community (ex: neighbors, landlords, etc.). The ODMHSAS will continue to utilize the block grant to fund, in part, supportive housing initiatives.

Though behavioral health case management, both youth (ages 14 and older) and adults can receive employment assistance with job search, and job placement and retention skills. Additionally, they can receive assistance with furthering their education through referrals to GED classes, vocational-technical schools, colleges and universities. Currently there are six supported employment programs for youth, and one supported employment program for adults with SMI. Programs have decreased over the years due to prohibitive reimbursement methods through the Oklahoma Department of Rehabilitation Services (OKDRS); the primary funder of supported employment in Oklahoma. Through the SAMHSA-funded Oklahoma Now is the Time (ONIT) initiative, the ODMHSAS has achieved a new partnership with the OKDRS, for a pilot program which will allow ONIT providers in Oklahoma, Washington and Okmulgee counties to bill OKDRS for specialized career planning (employment) activities. If the pilot goes well, the plan is that the OKDRS will switch to this payment method for all who provide the services to people with SMI.

17. Community Living and the Implementation of Olmstead

The Oklahoma Legislature created an Olmstead Strategic Planning Committee to assist the state in implementing the U.S. Supreme Court's decision in *Olmstead v. L.C.* (1999), which requires states to provide services that enable individual with disabilities to live in community setting rather than in institutions. This Committee was charged with drafting the Oklahoma Olmstead Strategic Plan to be submitted to the legislature and the Governor. The Plan outlined strategies to assure that persons with disabilities are provided with the services and supports necessary to move out of institutional settings, if they so desire. The Plan reflected cross-disability efforts, including efforts related to mental health, and was completed in 2006. This plan can be located at <http://www.csctulsa.org/files/file/Oklahoma%20Olmstead%20Plan%202006.pdf>.

The Oklahoma Legislature extended the work of the Committee to work with state agencies with regards to implementation of the Plan. The Committee completed a partial plan update in 2010, and then the Committee dissolved leaving further implementation of the plan to individual state agencies. The ODMHSAS actively participated on the Committee until it dissolved.

In order to continue Olmstead related efforts, in 2012, the ODMHSAS formed an Olmstead Planning and Implementation Committee specifically related to assisting individuals with mental health disabilities. This Committee was a breakout committee of

ODMHSAS State Planning and Advisory Council. The first priority task was to garner stakeholder input and update/revise mental health related strategies from the Oklahoma Olmstead Strategic Plan to develop a more comprehensive, up-to-date, mental health specific plan to guide future implementation efforts. Stakeholder planning groups were facilitated, and recommendations for the mental health system were collected, along with proposed areas of focus. Some of the proposed areas of focus included:

- Readiness: Consumer readiness education; review of data readiness indicators and outliers; development of a guidelines tool; integrate some trauma-informed concepts of safety, etc.
- Follow-Up Activities: Expand RICCTS/ICCTS models of care; garner information about community integration success through system data and surveys
- Expansion of the use of peer and natural supports.
- Explore the possibility of using mental health waivers to better meet integration needs.
- Communication: Phones and other ways to help people stay connected. Connection is critical to success.
- Some type of in-reach services provided within institutions with no timed discharge, like nursing homes and residential care facilities, to help people with natural anxieties about living in the community to work toward readiness.
- Increased access to wraparound services for both children and adults.
- Use of Building Bridges for Children to help with transition.
- Adequate funding for statewide implementation of evidence-based and emerging best practices from both Medicaid and state dollars.
- Expansion of services that support people in the areas of housing, employment, physical health and wellness (including health home model).
- Expansion of mental health courts and jail diversion services statewide to provide treatment and recovery based alternatives to incarceration.
- Expansion of core mental health services, including making services available to people in nursing homes.
- Expand community-based care options available to children and youth with SED placed in the custody of Oklahoma Department of Human Services, Division of Children and Family Services.

Although an updated plan has not been formalized, the recommendations and proposed areas of focus have been utilized by the ODMHSAS with moving forward on initiatives that support community integration.

In 2012, the ODMHSAS also participated in the SAMHSA project to pilot test a self-assessment tool for State Mental Health Agencies on their effort to promote community integration for adults with mental illnesses and children with SED.

Some of the areas in which progress has been made toward creating opportunities for successful community integration are increased peer supports, implementation of

Health Homes for adults with SMI and children with SED, and the creation of transition services to incentivize and assist with adults with transition from residential care facilities to community based permanent housing.

Assuring satisfactory access to safe, sanitary, and affordable housing for adults with mental illness continues to be a challenge to the state. Specific housing services for people with mental illness are available in urban and rural settings and are funded through the ODMHSAS, the U.S. Department of Housing and Urban Development (HUD), public housing authorities and private sources. Housing models include transitional housing and permanent supported housing (both congregate and scattered site). Although some housing continues to be developed in settings specifically for persons with mental illness (i.e., HUD funded Section 811 and HUD SHP projects), the ODMHSAS continues to place an emphasis on creating opportunities for more integrated housing, including permanent scattered site housing with available support services. Housing services for families with children are provided in the same manner by which they are provided to adults.

Additional housing related service and supports embedded in the system for adults with SMI and children with SED include flexible funds available to each CMHC that can be used to augment a variety of housing supports, including rental and utility deposits; a Discharge Planning Housing Subsidy specifically for adults discharging from psychiatric inpatient care, Department of Corrections, or aging out of the foster care system; a Transition Youth Housing Subsidy program to assist very low-income young adults ages 17 – 24; a smaller subsidy program for transition youth living in rural areas (added through grant funding in FY 2014); and Residential Care Transition Services to assist people with mental illness or co-occurring disorders who request assistance with transition from a residential care home into community based permanent housing.

CMHC case managers assist adults age 18 and older with job location and placement. These activities are funded by the ODMHSAS and specific service codes provide claims and reimbursement data for this. In addition, HOPE Community Services offers a supported employment program. Transitional employment programs are provided by Thunderbird Clubhouse and Crossroads Clubhouse. Both clubhouses are accredited by Clubhouse International (formerly the International Center for Clubhouse Development). The ODMHSAS and the Oklahoma Department of Rehabilitation Services (OKDRS) assist with funding various activities within this array of employment services and utilize a memorandum of understanding to coordinate and monitor related activities. The availability of supported employment services for adults SMI have continued to be very limited, due to prohibitive payment methods through OKDRS.

Case managers assist children ages 14 and older with job search and job placement skills, social and interpersonal skills needed for job retention, and specific referrals to vocational-technical schools. The Oklahoma Department of Rehabilitation Services (OKDRS) offers transitional services within school districts. The DRS Transition School-to-Work program assists students with disabilities make smoother transitions from school to work through counseling, work adjustment training, on-the-job training and

direct job placement. Other services are provided through a cooperative arrangement among the DRS, the Oklahoma State Department of Education and local school districts.

Through the SAMHSA-funded Oklahoma Now is the Time (ONIT) initiative, the ODMHSAS has achieved a partnership with the OKDRS, for a pilot program which will allow ONIT providers in Oklahoma, Washington and Okmulgee counties to bill OKDRS for specialized career planning (employment) activities. If the pilot goes well, the plan is the OKDRS will switch to this payment method for all who provide the services to people with SMI.

In February 2015, the ODMHSAS began participation in SAMHSA's State TA Olmstead Initiative. This participation will assist in future planning and promotion of community integrated efforts for persons with mental illness.

18. Children and Adolescents Behavioral Health Services

Systems of Care. Oklahoma is a Systems of Care (SOC) state. Prior to receiving targeted SOC funding from SAMHSA, the ODMHSAS partnered with other child serving agencies to develop wraparound services in the urban and rural communities of Tulsa and Ponca City in 1990 using integrated funding from partner agencies. These initial efforts were also funded in part by the Mental Health Block Grant. That practice continues today.

The ODMHSAS has pioneered the multi-system approach needed for children and families that are being served by multiple state agencies in Oklahoma. A State Advisory Team (SAT) was developed in the early 1990s and is composed of multiple state agencies, including child welfare, juvenile justice, rehabilitative services, private providers, community mental health providers, families and youth. The SAT provides oversight to all services to children and families, not just the wraparound services and monitors the SOC program based on evaluation reports that are delivered to the group at minimum annually. To be ever mindful of the SOC guidelines, the SAT meetings always begin with a review of one of the core principles and members are invited to share stories of how the principles are put into practice in the field.

The ODMHSAS Children, Youth, and Family Division provides technical assistance to contractors through liaisons or field service coordinators. The ODMHSAS has a Technical Assistance and Training Coordinator for SOC as well as a State Coach and Trainer for SOC. Finally, the ODMHSAS has contracted with four CMHCs for Regional Coaches who provide ongoing coaching and training over the various components of the Wraparound model to our SOC and Wraparound providers across the state to ensure fidelity to the model.

Individualized Care Planning. As referenced earlier, the SOC philosophy is embedded

into the system. The ODMHSAS certification process and contract language requires contractors to provide individualized assessment and service planning. Family voice and choice is the cornerstone of the treatment planning process. Families develop a wraparound team to help with needs throughout treatment. The philosophy of family centered services has been well grounded in Oklahoma for 20 years and is now firmly in place.

Collaboration with other Child Serving Agencies. The SAT (referenced above) is composed of multiple child and youth serving agencies. In addition to the monthly SAT meetings, agency representatives from child welfare, juvenile justice, rehabilitative services, prevention, education, Oklahoma Commission on Children and Youth, and family members meet in a smaller group called the Children's State Advisory Workgroup (C-SAW). The C-SAW is the workgroup that continually discuss challenges and barriers and work on ways to reform the system. The C-SAW has been instrumental in SOC receiving legislative funding every year to cover the state match. The ODMHSAS fosters and encourages these collaborations at the state level as well as at the local level.

- **Training in Evidence-Based Prevention, Treatment and Recovery Strategies.** The ODMHSAS provides evidence based trainings at several venues. The most prominent is the annual Children's conference normally held in the Spring and the other is the Treatment and Recovery conference held in the Fall. These two venues annually attract over 2,000 participants. Trainings at these conferences are required to be evidence based models. In addition to these trainings, the staff serving children and youth in Oklahoma receives ongoing training and consultation provided by the University of Oklahoma Health Science Center-Child Abuse and Neglect Division in trauma focused cognitive behavioral therapy (TF-CBT) as part of their contractual obligation to ODMHSAS. All CMHCs are required to have staff that can provide TF-CBT to children and youth. Here is a list below of the evidence-based trainings that ODMHSAS offers throughout the year.
 - **Celebrating Families** is an evidence-based cognitive behavioral, support group model written for families in which one or both parents have a serious problem with alcohol or other drugs and in which there is a high risk for domestic violence, child abuse, or neglect.
 - **Strengthening Families Program** is an evidence-based family skills training program found to significantly improve parenting skills and family relationships, reduce problem behaviors, delinquency and alcohol and drug abuse in children and to improve social competencies and school performance. Child maltreatment also decreases as parents strengthen bonds with their children and learn more effective parenting skills.
 - **Adolescent Community Reinforcement Approach (A-CRA)** is a developmentally-appropriate behavioral treatment for youth and young

adults 12 to 24 years old with substance use disorders. A-CRA seeks to increase the family, social, and educational/vocational reinforces to support recovery. A-CRA has been implemented in outpatient, intensive outpatient, and residential treatment settings. A-CRA includes guidelines for three types of sessions: individuals alone, parents/caregivers alone, and individuals and parents/caregivers together. A-CRA is a certification model.

- **Motivational Interviewing** is an evidence-based treatment that addresses ambivalence to change. It is a conversational approach designed to help people identify their readiness, willingness, and ability to change and to make use of their own change-talk.
- **Seeking Safety** is an evidence-based treatment for trauma and/or substance abuse (clients do not have to have both issues). *Seeking Safety* teaches present-focused coping skills to help clients attain safety in their lives.
- **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)** is an evidence-based treatment for children and adolescents impacted by trauma and their parents or caregivers. Research shows that TF-CBT successfully resolves a broad array of emotional and behavioral difficulties associated with single, multiple and complex trauma experiences. This is the official TF-CBT National Therapist Certification Program, in which clinicians can become certified in the TF-CBT treatment model.
- **Teen Addiction Severity Index (T-ASI)** is a relatively brief structured interview designed to provide important information about aspects of a youth's life which may contribute to his or her substance abuse and/or dependence syndrome. It is the first step in the development of a profile for subsequent use by research and clinical staff. Thus, it is particularly important that the youth and the parents or caretakers perceive the interview as a clinical first step in an attempt to help the youth (Kaminer et al., 1991; 1993).
- **Cognitive Processing Therapy (CPT)** is an adaptation of the evidence-based therapy known as cognitive behavioral therapy (CBT) used by clinicians to help clients explore recovery from posttraumatic stress disorder (PTSD) and related conditions. It is a manualized therapy that includes common elements from general cognitive-behavioral treatments. CPT typically consists of 12 sessions and has been shown to be effective in treating PTSD across a variety of populations, including combat veterans, sexual assault victims, and refugees. CPT can be provided in individual and group treatment formats. The theory behind CPT conceptualizes PTSD as a disorder of "non-recovery" in which erroneous beliefs about the causes and consequences of traumatic events produce

strong negative emotions and prevent accurate processing of the trauma memory and natural emotions emanating from the event.

- **The Collaborative Assessment and Management of Suicidality (CAMS)** is an evidence-based clinical intervention that has significantly evolved over 25 years of clinical research. CAMS is best understood as a therapeutic framework that emphasizes a unique collaborative assessment and treatment planning process between the suicidal individual and clinician.
- **Wraparound** is an intensive, holistic method of engaging with individuals with complex needs (most typically children, youth, and their families) so that they can live in their homes and communities and realize their hopes and dreams. The Wraparound *process* aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family. Wraparound also aims to develop the problem-solving skills, coping skills, and self-efficacy of the young people and family members. Finally, there is an emphasis on integrating the youth into the community and building the family's social support network. ODMHSAS also offers Wraparound 2 day trainings twice a month, Wraparound is known as a promising practice.

The ODMHSAS Children, Youth, and Family Division maintains an active training schedule that includes a menu of free trainings, usually with continuing education credits, available to the workforce. These trainings cover a wide range of topics (self-harm, substance abuse, sexually acting out, infant and early childhood mental health, etc) and are offered in different locations to lessen the burden on the workforce.

Monitoring Services, Costs, and Outcomes. The ODMHSAS contracts with the University of Oklahoma E-Team to provide ongoing evaluation of the SOC program. The E-Team collects data on service utilization and outcomes that is presented at minimum annually to the SAT. The ODMHSAS has contracts with other entities such as Kansas University and Chestnut Health Systems to track outcomes and costs as related to specific evidence based tools and practices as related to grants. The ODMHSAS has a juvenile drug court web based system that also tracks data as well as its main data system which collects client data core information.

19. Pregnant Women and Women with Dependent Children

Oklahoma ensures priority is given to pregnant females. The ODMHSAS has created and maintains an electronic wait list for consumers needing residential substance use disorder treatment services. The electronic wait list gives automatic priority to pregnant females. All admissions to residential substance use disorder treatment services, with

the exception of admissions based on medical necessity must come from the electronic wait list.

Currently, pregnant females and all other priority status populations receive the initial offer for residential substance use disorder treatment within 48 to 72 hours of determination of need. The consumer is free to accept the treatment service offer or choose to wait for the next offer.

Prior to entering residential treatment the pregnant female is immediately enrolled in interim services. The provider screening the consumer for residential service need also provides interim services. Screening and interim service delivery are required in contract and verified by tracking electronic billing records. With this system the ODMHSAS is able to track the progress of all priority status and general population consumers including pregnant consumers.

An ODMHSAS staff member is assigned to manage the electronic wait list as well as provide technical assistance on the process and monitor the wait list. As any issues are identified, actions are immediately taken to correct the problem in the most efficient manner possible. This staff member is supported by other ODMHSAS staff.

There are five residential substance use disorder treatment programs serving pregnant women and women with children. All residential substance use disorder treatment programs that admit women accept and provide all services for pregnant women. All outpatient treatment providers provide services including case management and referral to all pregnant consumers. This is required in contract.

- There are seven outpatient programs that offer medication assisted substance use disorder treatment for pregnant women. There are also two residential withdrawal management programs that also offer medication assisted treatment for pregnant women.
- Oklahoma is primarily a rural state. While residential substance use disorder treatment services are available statewide, most rural areas do not have adequate outpatient or medication assisted treatment services. Over the last six months the ODMHSAS has been evaluating the statewide service delivery system. This new service array provided for both outpatient and medication assisted treatment services statewide in both rural and urban areas.

There are five residential substance use disorder treatment programs serving women with children. The ODMHSAS is also developing transitional housing options for women with children leaving residential substance use disorder treatment. All outpatient treatment providers provide services including case management and referral to women with children. This is required in contract.

- There are seven outpatient programs that offer medication assisted substance use disorder treatment including women with children.

- Oklahoma is primarily a rural state. While residential substance use disorder treatment services are available statewide, most rural areas do not have adequate outpatient or medication assisted treatment services. Over the last six months the ODMHSAS has been evaluating the statewide service delivery system. This new service array provided for both outpatient and medication assisted treatment services statewide in both rural and urban areas.

The Department offers monthly trainings, available at no charge to contracted providers, addressing the basic areas of substance use disorder treatment services. ODMHSAS also provides program specific technical assistance to all contracted providers.

20. Suicide Prevention

The plan submitted in 2011 continues to remain the active plan. The plan can be located at <http://ok.gov/odmhsas/documents/SuicidePrevention.pdf>. The Oklahoma Suicide Prevention Council, a legislatively mandated committee, will finalize revisions to the current state plan no later than September 30, 2015. The Oklahoma Suicide Prevention Council revised and voted to adopt the new 2015-2020 Suicide Prevention Strategic Plan called, the Oklahoma Strategy for Suicide Prevention on February 26th, 2015. The revised plan is modeled after the National Strategy for Suicide Prevention ensuring that local efforts are aligned with national best practice. The plan covers the entire lifespan and includes goals that promote the understanding that recovery from mental and substance use disorders is possible for all (Goal 3, Objective 3). The plan also calls for the provision of training to community and clinical service providers on the prevention of suicide and related behaviors (Goal 7). Oklahoma's plan is comprehensive and addresses universal and high need populations, including those specifically prioritized by the MH/SABG.

21. Support of State Partners

The ODMHSAS continues to enjoy a rich experience with a variety of state and community partners. Copies of actual agreements or letters of support will not be attached to this application. Rather, the ODMHSAS will utilize this section of the plan to describe some examples of collaborations and partnerships – both formal and informal – that are essential to the delivery behavioral health and support services throughout Oklahoma.

One example is the 10 positions on the current Planning and Advisory Council for the ODMHSAS represent key state agencies and are directly appointed to the OMHPAC by each state agency director. That in itself is an indication of support and continued commitment to the work funded by the block grant programs and other initiatives managed by the ODMHSAS. Four additional members are appointed by state level

advocacy organizations to membership on the Council.

The Council anticipates it will transition to a broader scope (beyond mental health) in the near future to include additional stakeholders representing prevention, substance abuse treatment, and recovery support. The representatives from the current agencies and new partners from other state agencies will be key to this more inclusive Council composition.

Memoranda of Understandings. Specifically articulated partnerships and support provided to ODMHSAS from other agencies are formalized through a variety of memoranda of understandings or inter-agency agreements. Present agreements for partnerships with the ODMHSAS include but are not limited the following:

- Partnership for Children’s Behavioral Health
 - Oklahoma Department of Human Services
 - Office of Juvenile Affairs
 - Oklahoma Federation of Families
 - Department of Rehabilitation Services
 - Family members
 - Oklahoma State Department of Education
 - Oklahoma State Department of Health
 - Youth members
 - Oklahoma Health Care Authority
 - Oklahoma Commission on Children and Youth
- Department of Corrections (DOC) Data Sharing Agreement
- Oklahoma Department of Human Services (OKDHS) Data Sharing Agreement
- Governor’s Interagency Council on Homelessness
 - Faith-Based Community
 - Statewide/Local Continuum of Care
 - CareerTech
 - Legal Aid of Oklahoma
 - Disability Determination Division of the Department of Rehabilitation Services
 - Current of former homeless person
 - Oklahoma Legislature Member
 - Office of Juvenile Affairs
 - Veterans Administration
 - Oklahoma Employment Security Commission
 - State Department of Education
 - Governor's Office
 - Persons with experience or knowledge of the subject of homelessness
 - Head Start / Community Action Agencies
 - Department of Corrections

- Oklahoma Health Care Authority (Medicaid)
 - Oklahoma Department of Human Services
 - Homeless service provider
 - Oklahoma Department of Commerce
 - State Department of Health
 - Local Continuum of Care Representative
 - State Continuum of Care Representative
- Department of Rehabilitation Services (DRS) – Coordination of Employment Services
 - OKDHS Agreement for the ODMHSAS to provide assessment and treatment services for TANF & Child Welfare populations
 - The Oklahoma Health Care Authority Interagency Agreement
 - DOC Interagency Agreement to provide substance abuse assessment and treatment services to inmate population
 - Oklahoma Tobacco Settlement Endowment Trust cooperative agreement with the ODMHSAS for the statewide Cessation Systems Initiative and the Public Health Academy of Oklahoma
 - The Oklahoma State Department of Health Tobacco Use Prevention Service for contract monitoring related to statewide Cessation Systems Initiatives
 - The Oklahoma State Department of Health Turning Point and Center for the Advancement of Wellness for the Public Health Academy of Oklahoma
 - The Oklahoma Department of Veterans Affairs and the Oklahoma Department of Education for shared prevention staff
 - The Oklahoma Leadership Academy for Wellness and Smoking Cessation Summit in collaboration with The University of California at San Francisco Smoking Cessation Leadership Center for Tobacco Dependence Treatment for People with Behavioral Health Disorders
 - Chesapeake Energy Corporation
 - BlueCross and Blue Shield of Oklahoma
 - The Osage Nation, Oklahoma Tobacco Research Center
 - Red Rock Area Resource Prevention Center
 - The National Alliance on Mental Illness (NAMI-OK)
 - Central Oklahoma Integrated Network Systems
 - Oklahoma Veteran’s Administration Medical Center
 - Oklahoma Insurance Department
 - Oklahoma Primary Care Association
 - Oklahoma State University Center for Health Sciences

- NorthCare Center
- Crossings Community Church
- Latino Community Development Agency
- The Mental Health Association of Oklahoma
- Comprehensive Community Rehabilitation Services

Other Collaborations. Beyond the formal agreements listed above, ODMHSAS staff at various levels represents the ODMHSAS within many interagency initiatives. Examples of those are listed below.

- State Epidemiological Outcomes Workgroup
 - OU School of Social Work
 - Cherokee Nation Behavioral Health Services
 - OU Health Sciences Center
 - Oklahoma State Department of Health
 - Oklahoma Association of Chiefs of Police
 - Office of Juvenile Affairs
 - Oklahoma Bureau of Narcotics and Dangerous Drugs
 - Oklahoma City Area Inter-Tribal Health Board
 - Oklahoma Highway Patrol
 - Department of Corrections
 - Veterans Administration Hospital
 - Department of Human Services
 - Oklahoma ABLE Commission
 - Oklahoma Commission on Children and Youth
 - Oklahoma Health Care Authority
 - Oklahoma Department of Education
- Policy Summit Delegation – Reducing Disparities Within Healthcare Reform
 - Indian Health Services
 - The Chickasaw Nation
 - Oklahoma City Indian Clinic
 - Oklahoma State Department of Health
 - The Oklahoma Federation of Families
 - The Oklahoma Health Care Authority (Medicaid)
- Veterans Policy Academy Partners
- Oklahoma Overdose Prevention Committee
- Oklahoma Health Improvement Plan Team
- Oklahoma Health Innovation Model Team
- Consolidated Claims Process (CCP) – Shared service eligibility and claims services (Oklahoma Department of Mental Health and Substance Abuse)

Services, Oklahoma Health Care Authority)

- Develop Interoperable Solution Components Using Shared Services (DISCUSS)
 - Oklahoma State Department of Health
 - Oklahoma Health Care Authority
 - Oklahoma Department of Human Services
 - Oklahoma Department of Rehabilitation Services

- DISCUSS Data Subcommittee
 - Oklahoma State Department of Health
 - Oklahoma Health Care Authority
 - Oklahoma Department of Human Services
 - Oklahoma Department of Rehabilitation Services

- Health Information Security and Privacy Council (HISPC)
 - University of Oklahoma Health Sciences Center
 - Oklahoma Health Care Authority [Medicaid]
 - Oklahoma State Department of Health [Public Health]
 - Oklahoma Foundation for Medical Quality
 - Oklahoma Department of Insurance
 - Oklahoma Primary Care Association
 - Oklahoma Department of Human Services
 - Oklahoma Osteopathic Association
 - Oklahoma State Medical Association
 - Oklahoma Hospital Association
 - Oklahoma State University Office of Rural Health
 - SMRTNet Health Information Organization

- Governor's Interagency Council on Homelessness
 - Faith-Based Community
 - Statewide/Local Continuum of Care
 - CareerTech
 - Legal Aid of Oklahoma
 - Disability Determination Division of the Department of Rehabilitation Services
 - Current or former homeless person
 - Oklahoma Legislature Member
 - Office of Juvenile Affairs
 - Veterans Administration
 - Oklahoma Employment Security Commission
 - State Department of Education
 - Governor's Office
 - Persons with experience or knowledge of the subject of homelessness
 - Head Start / Community Action Agencies
 - Department of Corrections
 - Oklahoma Health Care Authority (Medicaid)

- Oklahoma Department of Human Services
 - Homeless service provider
 - Oklahoma Department of Commerce
 - State Department of Health
 - Local Continuum of Care Representative
 - State Continuum of Care Representative
- District Attorneys Council
 - Oklahoma Suicide Prevention Council
 - Oklahoma Prevention Leadership Collaborative
 - Oklahoma Prescription Drug and Overdose Prevention Planning Workgroup
 - Oklahoma Evidence-Based Practices Workgroup
 - State Underage Drinking Prevention Committee
 - Oklahoma Public Health Collaborative
 - Rural Law Enforcement Meth Initiative
 - OSOH to provide tuberculosis data for SAPT Block Grant reporting
 - OSDH for HIV rapid testing kits for the outreach program
 - Oklahoma Violent Death Reporting System Advisory Committee

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

SAS Planning with the PAC. Oklahoma's Council, the State Planning and Advisory Council (PAC) to the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) fully functions as an integrated body that fulfills the Council's purposes across a broad spectrum of mental health, substance use, and prevention activities in the state. This is also indicative of the overall organization and scope of the ODMHSAS. Staffs who support the Council likewise reflect representation from mental health, substance use disorder treatment, and prevention. The same mechanisms utilized to plan and monitor mental health services are also used by the Council to provide guidance, support, and advocacy related to prevention and substance use disorder treatment.

SMHA Advisory Body Coordination. Because the Council is integrated, there is no

separate SMHA advisory body.

Council Involvement with State Plan. A committee of Council members, appointed by the Chair, worked with the ODMHSAS planning staff to provide suggestions and guidance in the preparation of the 2016-2017 Combined Application. Because this was presented as a Combined Application, the Council was involved in developing the Plan for substance use disorder treatment, mental health services, and prevention. The full Council reviewed the entire Application and plan on August 20, 2015 and approved support for the Plan.

Integration with MH, SA, and Prevention. The Council revised bylaws in 2012 to expand and rename the body to more thoroughly embrace a larger constituency reflective of integrated and holistic behavioral health services in Oklahoma. As a result the Council name changed to the State Planning and Advisory Council to the ODMHSAS. Additional membership positions were added. New members were appointed by Commissioner Terri White in January 2013 to include individuals with experience in substance use disorder recovery, treatment, and prevention services.

Representation on the Council. The Council Chair annually appoints a Membership Committee to (1) review anticipated vacancies that will occur as voluntarily resignations and for those who will “term out” and (2) evaluate Council needs to expand diversity and achieve broader based membership. In that regard, the Council continually works to assure the membership is representative of those served by the state. Membership recommendations are forwarded to the Council at large. Based on Council action, a slate of proposed new members is forwarded the ODMHSAS Commissioner.

Current members include individuals from the two large metropolitan areas (Oklahoma City and Tulsa) as well as numerous communities in less populated and remote areas of the state.

Council Duties, Activities, and Input from Stakeholders. The Oklahoma State Planning and Advisory Council’s purpose is to (1) Review plans, including the Federal Mental Health Services Block Grant and Substance Abuse Prevention and Treatment Block Grant Plan, provided to the Council, and to submit to the state any recommendations of the Council for modifications to the plans; (2) Serve as an advocate in promoting quality of life for all adults with serious mental illness and/or addictions, children with a severe emotional disturbance and their families, and other individuals with mental illness, emotional issues and/or addictions; (3) Serve as an advocate for promotion of prevention of these disorders; (4) Monitor, review and evaluate not less than once each year, the allocation and adequacy of mental health, substance use disorder and prevention services within the State; and (5) Exchange information and develop, evaluate and communicate ideas about mental health, substance use disorder and prevention planning and services.

The Council consists of 40 members. It includes representatives of (1) the principal State agencies involved in mental health, substance abuse and prevention and related

support services; (2) public and private entities concerned with the need, planning, operation, funding and use of mental health, substance abuse and prevention services and related support activities; (3) adults with serious mental illnesses and/or addictions who are receiving (or have received) services; (4) the families of such adults; and (5) families of children with emotional disturbances and/or addictions.

Directors of the following state agencies appoint one member each to the Council: Oklahoma Health Care Authority; Oklahoma Department of Rehabilitation Services; Oklahoma State Department of Education; Oklahoma Department of Corrections; Oklahoma Office of Juvenile Affairs; Oklahoma State Department of Health; Oklahoma Housing Finance Agency; and Oklahoma Department of Human Services. The ODMHSAS Commissioner appoints all other members, typically based on recommendations from the Council.

The Council typically conducts six meetings each year. The Executive Committee may call special meetings at the request of a majority of the members of the Council. All meetings of the Council are open to the public. The members and Executive Committee develop meeting agendas with staff liaisons. Often presentations at meetings are around topics for which one or more Council members has requested additional information. Reports from the ODMHSAS Deputy Commissioners are also standing agenda items. These reports apprise members of current and anticipated opportunities and challenges, including opportunities for public advocacy and action. Likewise, information from the Deputy Commissioners frequently elicits questions and requests from Council members for additional information including formal presentations at subsequent meetings.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1
Priority Area: Overall Health Promotion
Priority Type: SAT, MHS
Population(s): SMI, SED, IVDUs, Other (all service recipients)

Goal of the priority area:

This priority will have multiple goals supported by strategies and indicators.

Objective:

To accomplish identified goals.

Strategies to attain the objective:

This priority will have targeted strategies aligned with specific goals and indicators; further explained in the attachment under Planning Steps for Steps 3 and 4. Oklahoma included a matrix attachment in the Planning Steps section of the application that reflects the relationship between priority areas, goals, strategies and performance indicators (there was not an option to attach it here).

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Number of formal agreements between behavioral health homes and primary care providers
Baseline Measurement: 148
First-year target/outcome measurement: 160
Second-year target/outcome measurement: 175

Data Source:

Annual questionnaire from ODMHSAS Decision Support Services

Description of Data:

Response to questionnaire.

Data issues/caveats that affect outcome measures::

Indicator #: 2
Indicator: Number served in Behavioral Health Homes for adults with SMI and children with SED
Baseline Measurement: 8,222
First-year target/outcome measurement: 10,275
Second-year target/outcome measurement: 12,850

Data Source:

Medicaid Management Information System (MMIS)

Description of Data:

Number served will be pulled from the MMIS system based on the number of individuals who have had a HH service billed.

Data issues/caveats that affect outcome measures::

Indicator #: 3

Indicator: Number of IV drug users and high risk substance abusers served through outreach contacts

Baseline Measurement: 7,013

First-year target/outcome measurement: 7,100

Second-year target/outcome measurement: 7,200

Data Source:

Contractor invoices for services

Description of Data:

Contractor submits a monthly invoice with the number of individuals served that month. Invoices are audited for accuracy and congruence with clinical documentation.

Data issues/caveats that affect outcome measures::

Counts may be duplicated by month, i.e., the same individual may be seen in more than one month.

Indicator #: 4

Indicator: Number of faxed referral sheets submitted from behavioral health providers to the OK Tobacco Quitline

Baseline Measurement: 4,072

First-year target/outcome measurement: 4,100

Second-year target/outcome measurement: 4,200

Data Source:

Ok Tobacco Quitline database

Description of Data:

The OK Tobacco Helpline keeps a database of where each faxed referral comes from (by agency) and provides monthly reports.

Data issues/caveats that affect outcome measures::

Priority #: 2

Priority Area: Improved Access and Reduced Disparities

Priority Type: SAT, MHS

Population(s): SMI, SED, PWWDC, IVDUs, HIV EIS, Other (Underserved Racial and Ethnic Minorities)

Goal of the priority area:

This priority will have multiple goals supported by strategies and indicators.

Objective:

To accomplish identified goals.

Strategies to attain the objective:

This priority will have targeted strategies aligned with specific goals and indicators; further explained in the attachment under Planning Steps for Steps 3 and 4. Oklahoma included a matrix attachment in the Planning Steps section of the application that reflects the relationship between priority areas, goals, strategies and performance indicators (there was not an option to attach it here).

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Number of American Indians receiving Medicaid-funded behavioral health services
Baseline Measurement: 22,103
First-year target/outcome measurement: 23,500
Second-year target/outcome measurement: 24,500

Data Source:

Medicaid Management Information System (MMIS)

Description of Data:

Data are compiled through the claims database and matched to the eligibility file containing race.

Data issues/caveats that affect outcome measures::

Indicator #: 2
Indicator: Number of outreach activities conducted to AIs
Baseline Measurement: 737
First-year target/outcome measurement: 750
Second-year target/outcome measurement: 775

Data Source:

Medicaid Management Information System (MMIS)

Description of Data:

Data are compiled through the claims database for outreach services and matched to the eligibility file containing race.

Data issues/caveats that affect outcome measures::

Indicator #: 3
Indicator: Increase the number of specialty court slots for veterans
Baseline Measurement: 68
First-year target/outcome measurement: 75
Second-year target/outcome measurement: 85

Data Source:

Drug Court (DC) online data reporting system

Description of Data:

Drug court participants are recorded in the DC online system and veteran status is also indicated within the DC online system.

Data issues/caveats that affect outcome measures::

Indicator #: 4
Indicator: Number of veteran peer recovery support specialists certified
Baseline Measurement: 33

First-year target/outcome measurement: 40

Second-year target/outcome measurement: 50

Data Source:

ODMHSAS Peer Recovery Support Specialist (PRSS) Certification database

Description of Data:

The number of veterans who acquire their ODMHSAS certification as a PRSS will be pulled from the ODMHSAS PRSS Certification database.

Data issues/caveats that affect outcome measures::

Indicator #:

5

Indicator:

Increase the number of veterans served in HHs and CMHCs

Baseline Measurement:

1,490

First-year target/outcome measurement:

1,750

Second-year target/outcome measurement:

2,000

Data Source:

Medicaid Management Information System (MMIS)

Description of Data:

Data are compiled through the claims database for HH services provided, and services provided by CMHCs, and matched to the eligibility file containing military status information.

Data issues/caveats that affect outcome measures::

Indicator #:

6

Indicator:

Number of children with SED and co-occurring AOD disorders admitted to Systems of Care programs

Baseline Measurement:

2,707

First-year target/outcome measurement:

2,800

Second-year target/outcome measurement:

2,900

Data Source:

Statewide Behavioral Health Reporting System (PICIS)

Description of Data:

Data will be compiled through the Statewide Behavioral Health Reporting System (PICIS).

Data issues/caveats that affect outcome measures::

Indicator #:

7

Indicator:

Number of staff who receive training in serving older adults from ODMHSAS each year

Baseline Measurement:

40

First-year target/outcome measurement:

40

Second-year target/outcome measurement:

40

Data Source:

ODMHSAS Human Resource Development (HRD) database

Description of Data:

The ODMHSAS HRD division maintains a database of individuals who have received training.

Data issues/caveats that affect outcome measures::

Indicator #:

8

Indicator:

Number of participants in Strengthening Families and Celebrating Families programs

Baseline Measurement:

800

First-year target/outcome measurement:

1,000

Second-year target/outcome measurement:

1,200

Data Source:

Evaluation database contracted with the University of Kansas School of Social Work

Description of Data:

The University of Kansas conducts evaluations of specific grant programs that utilize these evidence-based practices and maintains a database of all participants.

Data issues/caveats that affect outcome measures::

Indicator #:

9

Indicator:

Average number of days pregnant women were on a waiting list before they were admitted to residential care

Baseline Measurement:

24

First-year target/outcome measurement:

20

Second-year target/outcome measurement:

15

Data Source:

Online waiting list maintained by ODMHSAS

Description of Data:

Providers are required to report into database those clients needing residential services, and indicate if they are pregnant.

Data issues/caveats that affect outcome measures::

Indicator #:

10

Indicator:

Number of individuals trained in Mental Health First Aid

Baseline Measurement:

1,062

First-year target/outcome measurement:

2,200

Second-year target/outcome measurement:

2,500

Data Source:

The ODMHSAS Human Resources Development (HRD) database

Description of Data:

The ODMHSAS HRD maintains a database of individuals who complete training.

Data issues/caveats that affect outcome measures::

Indicator #: 11
Indicator: Number of LGBT population served through LGBT outreach program
Baseline Measurement: 65
First-year target/outcome measurement: 65
Second-year target/outcome measurement: 65

Data Source:

Contractor invoices for services

Description of Data:

Contractor submits a monthly invoice with the number of individuals served that month. Invoices are audited for accuracy and congruence with clinical documentation

Data issues/caveats that affect outcome measures::

Priority #: 3
Priority Area: Enhance Service Quality and Accountability
Priority Type: SAT, MHS
Population(s): SMI, SED, PWWDC, IVDUs, HIV EIS, Other

Goal of the priority area:

This priority will have multiple goals supported by strategies and indicators.

Objective:

To accomplish identified goals.

Strategies to attain the objective:

This priority will have targeted strategies aligned with specific goals and indicators; further explained in the attachment under Planning Steps for Steps 3 and 4. Oklahoma included a matrix attachment in the Planning Steps section of the application that reflects the relationship between priority areas, goals, strategies and performance indicators (there was not an option to attach it here).

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Number of PRSSs certified
Baseline Measurement: 137
First-year target/outcome measurement: 150
Second-year target/outcome measurement: 165

Data Source:

PRSS Certification Database

Description of Data:

ODMHSAS maintains a database of all certified PRSSs.

Data issues/caveats that affect outcome measures::

Indicator #: 2
Indicator: Number of services provided by PRSSs
Baseline Measurement: 116,422
First-year target/outcome measurement: 127,470
Second-year target/outcome measurement: 140,217

Data Source:

Medicaid Management Information System (MMIS)

Description of Data:

Data are compiled through claims database and matched with staff IDs who are PRSSs.

Data issues/caveats that affect outcome measures::

Indicator #: 3
Indicator: Number of youth receiving CATS screening and follow-up with trauma-specific services
Baseline Measurement: 9,792
First-year target/outcome measurement: 9,792
Second-year target/outcome measurement: 9,792

Data Source:

ODMHSAS evaluation database

Description of Data:

The ODMHSAS conducts evaluation of the above practices. The outcome and utilization data will be used to report on this measure.

Data issues/caveats that affect outcome measures::

Indicator #: 4
Indicator: Number of individuals receiving drop-in center services
Baseline Measurement: 21,377
First-year target/outcome measurement: 21,377
Second-year target/outcome measurement: 21,377

Data Source:

Contractor invoices

Description of Data:

Contractors submit monthly invoices with the number of individuals served that month.

Data issues/caveats that affect outcome measures::

Indicator #: 5
Indicator: Number of services provided through telehealth
Baseline Measurement: 28,823

First-year target/outcome measurement: 30,000

Second-year target/outcome measurement: 32,000

Data Source:

Medicaid Management Information System (MMIS)

Description of Data:

Data are compiled through the claims database. Telehealth service are identified in the claims system with a unique code modifier.

Data issues/caveats that affect outcome measures::

Indicator #:

6

Indicator:

Percent of time agencies meet the benchmark for the incentive payment as a result of indicators of improved care

Baseline Measurement:

92.5%

First-year target/outcome measurement:

92.5%

Second-year target/outcome measurement:

92.5%

Data Source:

Medicaid Management Information System (MMIS) and other administrative databases

Description of Data:

Data are compiled through the MMIS database and the ODMHSAS PICIS database.

Data issues/caveats that affect outcome measures::

Priority #:

4

Priority Area:

Reduced Criminal Justice Involvement

Priority Type:

SAT, MHS

Population(s):

Other (Criminal/Juvenile Justice)

Goal of the priority area:

This priority will have multiple goals supported by strategies and indicators.

Objective:

To accomplish identified goals.

Strategies to attain the objective:

This priority will have targeted strategies aligned with specific goals and indicators; further explained in the attachment under Planning Steps for Steps 3 and 4. Oklahoma included a matrix attachment in the Planning Steps section of the application that reflects the relationship between priority areas, goals, strategies and performance indicators (there was not an option to attach it here).

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:

Number served through specialty courts

Baseline Measurement:

6,886

First-year target/outcome measurement:

6,950

Second-year target/outcome measurement:

7,100

Data Source:

Specialty court administrative database

Description of Data:

All specialty courts report through an online court database.

Data issues/caveats that affect outcome measures::

Indicator #:

2

Indicator:

Number of offenders served while incarcerated and following incarceration

Baseline Measurement:

717

First-year target/outcome measurement:

750

Second-year target/outcome measurement:

800

Data Source:

Medicaid Management Information System (MMIS) and other administrative databases

Description of Data:

Data are compiled through the claims database and funded is a special code to indicate what program is paying for the services, including those programs that fund services in the prison-based and community reentry programs. Service recipients identified through the claims are then unduplicated for data analysis and summaries.

Data issues/caveats that affect outcome measures::

Indicator #:

3

Indicator:

Reduced recidivism rate for individuals served through RICCTS

Baseline Measurement:

24.1%

First-year target/outcome measurement:

24.1%

Second-year target/outcome measurement:

24.1%

Data Source:

Medicaid Management Information System (MMIS) and other administrative databases

Description of Data:

Data are compiled through the MMIS database and the ODMHSAS PICIS database.

Data issues/caveats that affect outcome measures::

Indicator #:

4

Indicator:

Number of police officers trained in CIT

Baseline Measurement:

197

First-year target/outcome measurement:

197

Second-year target/outcome measurement:

197

Data Source:

Data maintained by ODMHSAS CIT trainer

Description of Data:

ODMHSAS staff maintain a roster of all individuals who complete the CIT course.

Data issues/caveats that affect outcome measures::

Indicator #: 5

Indicator: Number of offender screenings conducted

Baseline Measurement: 3,642

First-year target/outcome measurement: 3,800

Second-year target/outcome measurement: 4,000

Data Source:

ODMHSAS Offender Screening database

Description of Data:

Information regarding the offender screenings conducted are entered into a ODMHSAS managed Offender Screening database.

Data issues/caveats that affect outcome measures::

Priority #: 5

Priority Area: Prevention of Mental Illness and Substance Abuse Disorders

Priority Type: SAP, SAT, MHS

Population(s): SMI, SED, PWWDC, IVDUs, HIV EIS, Other (general populations)

Goal of the priority area:

This priority will have multiple goals supported by strategies and indicators.

Objective:

To accomplish identified goals.

Strategies to attain the objective:

This priority will have targeted strategies aligned with specific goals and indicators; further explained in the attachment under Planning Steps for Steps 3 and 4. Oklahoma included a matrix attachment in the Planning Steps section of the application that reflects the relationship between priority areas, goals, strategies and performance indicators (there was not an option to attach it here).

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase utilization of Lifeline

Baseline Measurement: 9,783

First-year target/outcome measurement: 10,000

Second-year target/outcome measurement: 12,000

Data Source:

Lifeline monthly reports

Description of Data:

Monthly and yearly reports are produced by Lifeline for the two Oklahoma-based hotlines.

Data issues/caveats that affect outcome measures::

Indicator #: 2
Indicator: Number of evidence-based prevention strategies reported
Baseline Measurement: 32
First-year target/outcome measurement: 32
Second-year target/outcome measurement: 32

Data Source:

Oklahoma Prevention reporting Outcomes System (OKPROS)

Description of Data:

The ODMHSAS Prevention division analyzes data reported on OKPROS and identifies the specific number of EBPs utilized in delivering community level strategies.

Data issues/caveats that affect outcome measures::

Indicator #: 3
Indicator: Number of persons trained in SBIRT
Baseline Measurement: 415
First-year target/outcome measurement: 450
Second-year target/outcome measurement: 500

Data Source:

SBIRT Registry

Description of Data:

The ODMHSAS SBIRT trainer maintains a database of individuals who complete the training. Numbers will be reflected as annual (not cumulative) counts.

Data issues/caveats that affect outcome measures::

Indicator #: 4
Indicator: Number trained in Mental Health First Aid
Baseline Measurement: 1,062
First-year target/outcome measurement: 1,800
Second-year target/outcome measurement: 2,500

Data Source:

ODMHSAS Human Resource Development (HRD) database

Description of Data:

The HRD maintains a database of individuals who have received training.

Data issues/caveats that affect outcome measures::

Indicator #: 5
Indicator: Prevalence of underage drinking

Baseline Measurement: Lifetime Use: 86.3%; Past 30 Day Use: 33.4%

First-year target/outcome measurement: Lifetime Use: 86.3%; Past 30 Day Use: 33.4%

Second-year target/outcome measurement: Lifetime Use: 86.3%; Past 30 Day Use: 33.4%

Data Source:

National Survey on Drug Use and Health (NSDUH)

Description of Data:

State level data are obtained through NSDUH.

Data issues/caveats that affect outcome measures::

NSDUH may run a few years behind on state-specific data, and data is often reflected as a rolling average.

Indicator #: 6

Indicator: Number trained in enforcement of youth access to alcohol laws

Baseline Measurement: 20

First-year target/outcome measurement: 20

Second-year target/outcome measurement: 20

Data Source:

Prevention division database

Description of Data:

Prevention division staff maintain a database of all who have received the training.

Data issues/caveats that affect outcome measures::

Indicator #: 7

Indicator: Number trained in Responsible Beverage Sales and Service training

Baseline Measurement: 1,448

First-year target/outcome measurement: 2,500

Second-year target/outcome measurement: 3,500

Data Source:

Prevention division database

Description of Data:

Prevention division staff maintain a database of all who have received the training.

Data issues/caveats that affect outcome measures::

Indicator #: 7

Indicator: Number trained in Responsible Beverage Sales and Service training

Baseline Measurement: 1,448

First-year target/outcome measurement: 2,500

Second-year target/outcome measurement: 3,500

Data Source:

Prevention division database

Description of Data:

Prevention division staff maintain a database of all who have received the training.

Data issues/caveats that affect outcome measures::

Indicator #:

8

Indicator:

Number of individuals 18-25 reporting past year non-medical prescription pain reliever use

Baseline Measurement:

50,000

First-year target/outcome measurement:

50,000

Second-year target/outcome measurement:

50,000

Data Source:

National Survey on Drug Use and Health (NSDUH)

Description of Data:

State level data are obtained through NSDUH.

Data issues/caveats that affect outcome measures::

The NSDUH may lag in annual reporting of state-specific data, and often reflect rolling averages. The results for current efforts will not be known for several years.

Indicator #:

9

Indicator:

Number of individuals 26 and older reporting past year non-medical prescription pain reliever use

Baseline Measurement:

101,000

First-year target/outcome measurement:

101,000

Second-year target/outcome measurement:

101,000

Data Source:

National Survey on Drug Use and Health (NSDUH)

Description of Data:

State level data are obtained through NSDUH.

Data issues/caveats that affect outcome measures::

The NSDUH may run a few years behind with state specific data, and may reflect rolling averages.

Indicator #:

10

Indicator:

Number trained in Naloxone administration

Baseline Measurement:

1,134

First-year target/outcome measurement:

1,250

Second-year target/outcome measurement:

1,500

Data Source:

Prevention division database

Description of Data:

Prevention division staff maintain a database reflecting individuals who have received the training.

Data issues/caveats that affect outcome measures::

Indicator #: 11

Indicator: Number of Naloxone administrations

Baseline Measurement: 25

First-year target/outcome measurement: 35

Second-year target/outcome measurement: 50

Data Source:

Prevention division database

Description of Data:

Prevention division staff track and maintain this information.

Data issues/caveats that affect outcome measures::

Priority #: 6

Priority Area: Public Awareness

Priority Type: SAP, MHS

Population(s): Other (general population)

Goal of the priority area:

This priority will have multiple goals supported by strategies and indicators.

Objective:

To accomplish identified goals.

Strategies to attain the objective:

This priority will have targeted strategies aligned with specific goals and indicators; further explained in the attachment under Planning Steps for Steps 3 and 4. Oklahoma included a matrix attachment in the Planning Steps section of the application that reflects the relationship between priority areas, goals, strategies and performance indicators (there was not an option to attach it here).

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of Facebook posts, tweets, website hits

Baseline Measurement: 835,271

First-year target/outcome measurement: 850,000

Second-year target/outcome measurement: 875,000

Data Source:

ODMHSAS Prevention and Communications division

Description of Data:

Counters are used to record the number of hits.

Data issues/caveats that affect outcome measures::

User preference and available social media platforms are difficult to predict.

Indicator #: 2
Indicator: Number of people contacted through multi-media campaign in three counties
Baseline Measurement: 0
First-year target/outcome measurement: 10,000
Second-year target/outcome measurement: 15,000

Data Source:

ODMHSAS will contract with an organization to assist with this initiative

Description of Data:

The contracted entity will assist ODMHSAS with tracking and maintaining this information.

Data issues/caveats that affect outcome measures::

Indicator #: 3
Indicator: Number of materials disseminated
Baseline Measurement: 33,698
First-year target/outcome measurement: 33,698
Second-year target/outcome measurement: 33,698

Data Source:

Prevention division database

Description of Data:

Prevention division staff manage and track the dissemination of materials.

Data issues/caveats that affect outcome measures::

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	\$24,970,394		\$8,243,494	\$8,469,741	\$64,421,914	\$0	\$0
a. Pregnant Women and Women with Dependent Children*	\$12,386,200		\$0	\$0	\$0	\$0	\$0
b. All Other	\$12,584,194		\$8,243,494	\$8,469,741	\$64,421,914	\$0	\$0
2. Substance Abuse Primary Prevention	\$6,658,772		\$0	\$6,986,327	\$9,670,074	\$0	\$0
3. Tuberculosis Services	\$0		\$0	\$0	\$0	\$0	\$0
4. HIV Early Intervention Services	\$0		\$0	\$0	\$0	\$0	\$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention**							
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)							
10. Administration (Excluding Program and Provider Level)	\$1,764,692		\$0	\$0	\$3,220,109	\$0	\$0
13. Total	\$33,393,858	\$0	\$8,243,494	\$15,456,068	\$77,312,097	\$0	\$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			\$0	\$0	\$0	\$0	\$0
6. Other 24 Hour Care		\$0	\$0	\$0	\$0	\$0	\$0
7. Ambulatory/Community Non-24 Hour Care		\$8,953,758	\$229,547,162	\$13,903,616	\$246,408,483	\$0	\$0
8. Mental Health Primary Prevention**		\$0	\$0	\$0	\$0	\$0	\$0
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)		\$497,430	\$0	\$0	\$0	\$0	\$0
10. Administration (Excluding Program and Provider Level)		\$497,430	\$0	\$0	\$4,139,234	\$0	\$0
13. Total	\$0	\$9,948,618	\$229,547,162	\$13,903,616	\$250,547,717	\$0	\$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	SABG Expenditures	MHBG Expenditures
Healthcare Home/Physical Health	\$	\$
General and specialized outpatient medical services;		
Acute Primary Care;		
General Health Screens, Tests and Immunizations;		
Comprehensive Care Management;		
Care coordination and Health Promotion;		
Comprehensive Transitional Care;		
Individual and Family Support;		
Referral to Community Services;		
Prevention Including Promotion	\$	\$

Screening, Brief Intervention and Referral to Treatment ;		
Brief Motivational Interviews;		
Screening and Brief Intervention for Tobacco Cessation;		
Parent Training;		
Facilitated Referrals;		
Relapse Prevention/Wellness Recovery Support;		
Warm Line;		
Substance Abuse Primary Prevention	\$	\$
Classroom and/or small group sessions (Education);		
Media campaigns (Information Dissemination);		
Systematic Planning/Coalition and Community Team Building(Community Based Process);		
Parenting and family management (Education);		
Education programs for youth groups (Education);		
Community Service Activities (Alternatives);		
Student Assistance Programs (Problem Identification and Referral);		

Employee Assistance programs (Problem Identification and Referral);		
Community Team Building (Community Based Process);		
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental);		
Engagement Services	\$	\$
Assessment;		
Specialized Evaluations (Psychological and Neurological);		
Service Planning (including crisis planning);		
Consumer/Family Education;		
Outreach;		
Outpatient Services	\$	\$
Individual evidenced based therapies;		
Group Therapy;		
Family Therapy ;		
Multi-family Therapy;		

Consultation to Caregivers;		
Medication Services	\$	\$
Medication Management;		
Pharmacotherapy (including MAT);		
Laboratory services;		
Community Support (Rehabilitative)	\$	\$
Parent/Caregiver Support;		
Skill Building (social, daily living, cognitive);		
Case Management;		
Behavior Management;		
Supported Employment;		
Permanent Supported Housing;		
Recovery Housing;		
Therapeutic Mentoring;		
Traditional Healing Services;		

Recovery Supports	\$	\$
Peer Support;		
Recovery Support Coaching;		
Recovery Support Center Services;		
Supports for Self-directed Care;		
Other Supports (Habilitative)	\$	\$
Personal Care;		
Homemaker;		
Respite;		
Supported Education;		
Transportation;		
Assisted Living Services;		
Recreational Services;		
Trained Behavioral Health Interpreters;		

Interactive Communication Technology Devices;		
Intensive Support Services	\$	\$
Substance Abuse Intensive Outpatient (IOP);		
Partial Hospital;		
Assertive Community Treatment;		
Intensive Home-based Services;		
Multi-systemic Therapy;		
Intensive Case Management ;		
Out-of-Home Residential Services	\$	\$
Crisis Residential/Stabilization;		
Clinically Managed 24 Hour Care (SA);		
Clinically Managed Medium Intensity Care (SA) ;		
Adult Mental Health Residential ;		
Youth Substance Abuse Residential Services;		
Children's Residential Mental Health Services ;		

Therapeutic Foster Care;		
Acute Intensive Services	\$	\$
Mobile Crisis;		
Peer-based Crisis Services;		
Urgent Care;		
23-hour Observation Bed;		
Medically Monitored Intensive Inpatient (SA);		
24/7 Crisis Hotline Services;		
Other	\$	\$
Total	\$0	\$0

Footnotes:

It is the state's understanding that this is a not a required form. Oklahoma does not have cost codes for these specific types of services.

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Expenditure Category	FY 2016 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	\$12,779,263
2 . Substance Abuse Primary Prevention	\$3,407,803
3 . Tuberculosis Services	
4 . HIV Early Intervention Services**	
5 . Administration (SSA Level Only)	\$851,951
6. Total	\$17,039,017

* Prevention other than primary prevention

** 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by CDC, National Center for HIV/AIDS, Hepatitis, STD and TB Prevention. The HIV Surveillance Report, Volume 24, will be used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective FY 2016 SABG allotments to establish one or more projects to provide early intervention services for HIV at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state does not meet the AIDS case rate threshold for the fiscal year involved. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend FY 2016 SABG funds for EIS/HIV if they chose to do so.

Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Strategy	IOM Target	FY 2016
		SA Block Grant Award
Information Dissemination	Universal	\$187,429
	Selective	
	Indicated	
	Unspecified	
	Total	\$187,429
Education	Universal	\$163,755
	Selective	\$6,635
	Indicated	
	Unspecified	
	Total	\$170,390
Alternatives	Universal	\$20,446
	Selective	
	Indicated	
	Unspecified	
	Total	\$20,446
Problem Identification and Referral	Universal	
	Selective	
	Indicated	\$2,726
	Unspecified	
	Total	\$2,726

Community-Based Process	Universal	\$1,358,709
	Selective	
	Indicated	
	Unspecified	
	Total	\$1,358,709
Environmental	Universal	\$1,631,337
	Selective	
	Indicated	
	Unspecified	
	Total	\$1,631,337
Section 1926 Tobacco	Universal	\$36,766
	Selective	
	Indicated	
	Unspecified	
	Total	\$36,766
Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
Total Prevention Expenditures		\$3,407,803
Total SABG Award*		\$17,039,017
Planned Primary Prevention Percentage		20.00 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award	
Universal Direct	\$1,401,857	
Universal Indirect	\$1,996,585	
Selective	\$6,635	
Indicated	\$2,726	
Column Total	\$3,407,803	
Total SABG Award*	\$17,039,017	
Planned Primary Prevention Percentage	20.00 %	

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: Planning Period End Date:

Targeted Substances	
Alcohol	b
Tobacco	b
Marijuana	b
Prescription Drugs	b
Cocaine	b
Heroin	b
Inhalants	b
Methamphetamine	b
Synthetic Drugs (i.e. Bath salts, Spice, K2)	b
Targeted Populations	
Students in College	b
Military Families	b
LGBT	b
American Indians/Alaska Natives	b
African American	b
Hispanic	b
Homeless	b
Native Hawaiian/Other Pacific Islanders	b
Asian	b
Rural	b
Underserved Racial and Ethnic Minorities	b

Footnotes:

Oklahoma provides a comprehensive primary prevention message including all substances, targeting populations in the state with special emphasis on prescription drug use, tobacco use and underage drinking.

Planning Tables

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award			
	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	\$0	\$0	\$0	\$0
2. Quality Assurance	\$0	\$0	\$0	\$0
3. Training (Post-Employment)	\$0	\$345,000	\$0	\$345,000
4. Education (Pre-Employment)	\$0	\$0	\$0	\$0
5. Program Development	\$0	\$0	\$0	\$0
6. Research and Evaluation	\$0	\$0	\$0	\$0
7. Information Systems	\$0	\$0	\$0	\$0
8. Total	\$0	\$345,000	\$0	\$345,000

Footnotes:

Planning Tables

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Block Grant
MHA Technical Assistance Activities	
MHA Planning Council Activities	
MHA Administration	\$229,924
MHA Data Collection/Reporting	\$100,000
MHA Activities Other Than Those Above	\$21,800
Total Non-Direct Services	\$351724
Comments on Data: <input data-bbox="100 911 1521 940" type="text"/>	
Footnotes:	