ROUND TWO –

Listening Session: State Level Engagement

Mental Health Courts and Drug Courts

What: Oklahoma has undertaken a variety of initiatives to promote a Smart on Crime approach to criminal justice challenges resulting from untreated mental health and substance use issues. These initiatives provide resources to courts and other criminal justice partners, local law enforcement, Oklahoma communities, families and individuals seeking help. Recovery courts are proven components of this effort, and provide eligible, non-violent, felony offenders the opportunity to participate in a highly structured, court supervised treatment programs in lieu of incarceration. They help guide participants out of the justice system and into lives of recovery and stability. Instead of viewing mental health challenges and addiction as moral failings, these courts recognize and address the disease that has contributed to criminal justice engagement.

Why: Because these programs work! Felony drug courts are now operating in 73 of 77 counties with over 10,000 graduates to date with an estimated savings of $193.6 million. Mental health courts have expanded statewide, with 22 currently operating and more in planning. These felony courts have also led to the development of effective options to assist courts in implementing misdemeanor diversion programs that are providing treatment to decrease future criminal justice involvement, veteran's initiatives, family drug courts, and partnership with the Office of Juvenile Affairs to initiate juvenile diversion opportunities. Oklahoma is a national leader in the implementation of these court-based programs. They are saving lives, tax dollars and reshaping the future of our state.

Criminal Justice Issues

What: Years of criminalizing and incarcerating people in Oklahoma who suffer with mental illness and substance abuse disorders has stretched the resources of Oklahoma's public safety system at both the local and state levels as well as proving to be an extraordinary financial burden. Over 80% of those who enter prisons in our state due to non-violent offenses have a need for mental health or substance treatment, and fewer than 1 in 3 leaving prison have received treatment, due in part to the enormous population of prisoners and too few providers in the criminal justice system. While passage of SQ780/781 in 2016 has reduced the number of felony charges for low-level non-violent crimes, the impact has proven to be uneven across Oklahoma's criminal justice jurisdictions. More importantly, perhaps, the expected cost-savings to our state's correctional system which was to financially benefit mental health and substance abuse prevention and treatment has proven to be disappointingly low. Though, in spite of few available dollars, new and expanded prevention and treatment programs as well as changes in law enforcement have shown promisingly positive outcomes.

Why: The Healthy Minds Policy Initiative (HMPI) based in Tulsa has estimated that each additional treatment facility reduces the social cost of crime in a county by $4.2 million. Expansion of programs such as crisis intervention teams in law enforcement, veteran's courts, drug courts, offender screenings, (mental health) crisis care centers, and other evidence-based programs save lives and reduce the financial expense of incarceration. HMPI data shows that the average cost to incarcerate an individual with mental health needs is $23,000 while the cost for someone to access the alternative mental health court is only $5,400. Further, the recidivism rate of those released from prison and who suffer mental illness is nearly 4 times higher. Investment in proven prevention and treatment services for mental illness and substance abuse as well as continuing to reform Oklahoma's criminal justice system pays off in multiple ways for all our state's citizens.

Transport

What:

Providing appropriate care for patients in acute psychiatric distress can be a challenge for care providers, state and local agencies, and loved ones of those in need. Patients experiencing mental health crises are often transported between multiple care providers in multiple settings before ultimately being admitted into a mental healthcare facility. Each care setting and each care provider leaves an important mark on the patient's experience and can ultimately contribute to the patient's health outcomes.

Why:

For patients experiencing a mental health crisis, it is not uncommon that their first interaction as they access the care they need will be with the police. Law enforcement are often the first to respond to a 911 call about individuals who are in distress. Law enforcement officers, however, are not medical providers, and they are not able to treat the underlying medical issues that have caused a patient's distress. The patient's best interests are served when the providers responding to the patient's needs are properly trained in how to respond to acute mental health crises, the patient is treated consistently throughout the entire transport process, and the transport is conducted in the least restrictive method necessary to ensure patient and caregiver safety.

Funding for Prevention and Treatment Services

What: Historically, funding for behavioral health services at a level to meet demand has been a challenge, both nationally and in Oklahoma. Multiple funding streams play a role in the availability and support for these services in a statewide system that provides both publicly supported and privately offered treatment options. Differing eligibility requirements, service restrictions and other challenges within a fragmented system can create significant challenges to linking persons in need to care. Consistency of care across multiple system platforms is also impacted. Public behavioral health systems are comprised of multiple and complex funding streams, including direct state appropriations, Medicaid, federal block grants, third party insurance, public benefits, housing, vocational rehabilitation and other funds. The differs from funding for general medical services particularly in that public sources play a larger role in financing behavioral health care than they do for overall health care services. State funding and Medicaid, including both state and federal shares, are the largest source of funding for behavioral health. Federal block grant funding and to a lesser extent, Medicare, also contribute. Private insurance coverage covers most Americans but finances only about a quarter of spending on behavioral health care; and, despite laws mandating parity, limits on services still exist. Prevention services are largely federally funded and tied to specific initiatives.

Why: Cost is a primary inhibitor for individuals accessing appropriate behavioral health care. Poor reimbursement and reimbursement rates additionally impact access by lessening the number of practitioners at various levels of services, reduce payer options and contribute to widening gaps in service availability. These and multiple other factors place an increasingly burdensome strain of the state system and state supported care. Given the array of payers with different funding objectives, reporting demands, and administrative mandates, it can be difficult to link consumers (sometimes with multiple eligibilities and conflicting payer requirements) with appropriate funding sources even when the clinical need is great. This hampers access to care and impedes the development of broad evidence-based clinical pathway, as programs are often developed to align primarily with payer specifications, which may not always align with evidence-based care or consumer needs and preferences. Prevention and early intervention are keys to lessening negative outcomes and complexity of treatment, however investment has been minimal from a behavioral health perspective.

Listening Session: Resource Management

Shortage of Mental Health Professionals

What: The Health Resources and Service Administration released a Health Workforce Analysis in 2018 showing an overall shortage of mental health professionals across the United States which is expected to continue to grow. There are differences noted between states/regions with some states/regions having a projected surplus; however, this is not the case for Oklahoma and its surrounding states. By 2030, Oklahoma has projected deficits in psychiatrists, psychiatric nurse practitioners, psychologists, and mental health counselors. For psychiatrists alone, the deficit is projected to be 340-370 FTEs (full time equivalents). The shortage of mental health professionals is further delineated along a rural/urban split. Within in the state, 72 of 77 counties are designated health professional shortage areas, with southeast Oklahoma being most affected. Only the counties surrounding Oklahoma City are not considered health professional shortage areas.

Why: Addressing the shortage of mental health professionals is critical to improving access to care which can be the greatest challenge for those seeking mental health treatment. Mental Health of America ranks Oklahoma as 41st in prevalence of mental illness and access to care. Not only do we need more mental health professionals, but we also need to strategically deploy them in order to reduce the number of health professional shortage areas. Having more mental health professionals locally available reduces the burden on the individual to obtain treatment. There is improved convenience with less time missed from work, greater ease of transportation, decreased childcare needs. In turn, this allows for the establishment of treatment that can increase the quality of life of Oklahomans.

Urban versus Rural resource deployment – Telemedicine / Tele-Health

What: Telemedicine/Tele-Health encompasses health care that is provided using technology independent of location and time. This can include audio/visual conferencing, telephone calls, text based messaging, emailing, patient portal access, remote monitoring, or store and forward uses, such as when a picture of a rash or a radiologic image is captured and send to a medical professional for interpretation. In Oklahoma, telemedicine/tele-health services can be provided in many different locations including within the hospital setting, in outpatient clinics, in care facilities and within a patient's home. Challenges that are faced in implementing telemedicine/tele-health in a rural setting include an inadequate data and technology infrastructure, minimal education related to use of telehealth among rural residents, and solidified partnerships between rural and urban health care entities, although the recent expansion of OSU's Telehealth Solution technology is helping to address this last concern.

Why: Increasing use of telemedicine/tele-health offers both urban and rural areas increased access to care. However rural settings may have a greater potential benefit from increased use of telemedicine/tele-health services. In rural areas it also can offer access to specialty clinical expertise and treatment that they otherwise would have to leave their local community to obtain. For elderly and low-income populations, it can help to overcome the transportation challenges they may face if having to leave their community. Increased conferencing and data sharing opportunities allows specialists to share knowledge and help onsite clinicians develop more robust treatment plans. When combined with remote patient monitoring services, such as for diabetes or hypertension, this can help prevent adverse events for those with chronic health conditions, which are more prevalent in a rural population. Finally, telemedicine/tele-health services can help reduce the stigma around seeking help for certain medical conditions, particularly mental health illnesses. The ability to receive care from a clinician outside the local community can help increase their sense of privacy and confidentiality, which are often identified barriers for those seeking mental health care in rural communities.

Special Populations

What: As has been revealed in numerous studies over many decades, the intent and design of many programs fail to match the distribution and access benefit goals, whether it's financial, educational or health. That disconnect is most often prevalent among special and minority populations. Special populations are defined here as individuals with disabilities, from economically disadvantaged families, single parents, the homeless, the unemployed, and veterans. Minority populations would include, but limited to, African Americans, Native Americans, Hispanic/Latino Americans, and Asian Americans. More recently, the LGBTQ community has also been included in this definition. Despite advances in health equity, disparities in mental health persist. The Agency for Healthcare Research and Quality reports that "racial and ethnic minority groups in the US are less likely to have access to mental health services, less likely to use community mental health services, more likely to using emergency departments, and more likely to receive lower quality care." They also tend to have burdens of disability, depression tends to be "more persistent," and racial/ethnic minority youth with behavioral issues are more readily referred to the juvenile justice system than to specialty primary care.

Why: Every person's health is important. There should be no socio-economic, racial, or ethnic qualifiers to that statement. Therefore, improving educational awareness about and the development of "culturally and linguistically services is critical," according to the HHS Office Of Minority Health. Developing health policies and initiatives that reduce or eliminate health disparities among special and minority populations must play a larger role as our population continues to become more diverse. In addition to the quality-of-life reasons for improving health outcomes for these populations, there is a strong financial reason to do so too. US healthcare spending reached $3.8 trillion in 2019, or $11,582/person. That represents 17.7% of the US gross domestic product. Less than 3% of that was spent on prevention. According to the American Psychiatric Association, it is critical to identify and reduce key barriers affecting access to treatment by members of diverse ethnic/racial groups. Among the more critical: expanding insurance coverage (private and public), reducing the mental illness stigma, improving the diversity of mental health providers, and reducing language barriers.

Access to Appropriate Evidence-based Care

What: Utilization of evidence-based practices (EBP) in behavioral healthcare allows for the identification, implementation, and dissemination of interventions and treatments that have been demonstrative as effective, and replicable, in delivering desired outcomes. It is an approach allowing for adherence to the best evidence available, and promotes measurement and evaluation of results. Using evidence-based health care, mental and behavioral experts rely on strict facts from research alongside expectations from patients to make sure proper decisions take place in clinical settings. Challenges to consistent implementation of EBP statewide, and resulting access to care, include variation in the rate of practice adoption by providers and system partners, funding and policy inconsistencies.

Why: Focus on proven initiatives and treatments that are known to produce results allows for consistency in services across a statewide system, and helps to contain costs. Adherence to EBP allow providers to focus on specific interventions and treatments along with desired outcomes, enhancing quality of care. Recovery plans that revolve around clinical evidence and measured success rates. In relation to the state's behavioral health system, a strategic focus on the use of EBP has led to cost containment while still increasing numbers of Oklahoman's served. It is a strategy that has led to incredible advancement in Oklahoma's behavioral health system over the past decade. In short, practicing evidence-based behavioral health care promotes patient satisfaction and reduces guesswork in treatment.