



PLANNING REPORT

Prevention, Treatment, and Recovery: Toward a 10-Year Plan for Improving Mental Health and Wellness in Tulsa

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Executive Summary

Tulsa residents living with mental illness and/or addiction die 27 years earlier than all Oklahoma residents. Their early deaths are most often caused by accidents, suicide, homicide, and overdoses. And their lives are often marked by poor physical health, poverty, and isolation. Mental illness takes a toll not only on these individuals, but also on their families, their communities, and the Tulsa region as a whole.

Yet residents with mental illness are not receiving the treatment they need.

In response, Tulsa is embarking on a 10-year plan to improve mental health and the mental health care system. The plan will have four overarching goals:

1. Close the gap in life expectancy between Tulsans living with mental illness and all Oklahomans.
2. Lower the rates of suicide attempts and overdoses, and deaths from both causes.
3. Lower the share of Tulsans who experience poor mental health.
4. Reduce criminal justice system, first responder, and hospital emergency room costs caused by untreated or poorly treated mental illness.

These goals reflect the improvement of mental health and well-being for all Tulsa residents, but the plan will prioritize children and youth, as well as Tulsans with serious mental illness and addiction.

This initial phase of the Tulsa Mental Health Plan initiative has been led by the University of Tulsa in collaboration with a 17-member steering committee made up of mental health care professionals, philanthropists, and community leaders. The initiative partnered with the Urban Institute to study the mental health care needs and resources in Tulsa, identify gaps and inefficiencies in the health care system, and recommend ways to move forward. Our findings and recommendations draw from best practices across the nation but are grounded in Tulsa's specific needs and context.

This report lays out the evidence base for Tulsa's mental health plan by previewing the committee's emerging goals and strategies and by reviewing the data and findings on which they are based. Preliminary recommendations for measuring the plan's success are also presented.

Tulsa's Challenges and Strengths

From September 2016 to February 2018, the Urban Institute worked with Tulsa research partners to examine the mental health and related strengths and challenges in Tulsa and the community's capacity to

improve mental health. The scope of this effort was broad, covering all residents younger than 65 across the Tulsa region (Tulsa, Rogers, Wagoner, Creek, Osage, Okmulgee, and Pawnee counties).

The following key findings emerged from this joint effort:

- **Mental illness is a major driver of poor health and low life expectancy across the region.** Tulsa residents living with mental illness have a life expectancy of under 50 years. This figure rivals low life expectancies in some of the least developed countries in the world. In greater Tulsa, roughly 140,000 residents have a mental illness and experience a wide variety of poor mental health, physical health, and social and economic outcomes.
- **Children and youth are at increasing risk of mental illness and lack a strong foundation for lifelong mental health.** According to Mental Health America, Oklahoma ranks 45th in the nation on a composite measure of youth mental illness and access to care, and 43rd on the share of youth with severe depression who do not receive some consistent treatment. Many of Oklahoma's youngest children are unwell; they experience the highest rates of adverse childhood experiences (ACEs) in the country. Given that half of all mental illnesses appear by age 14 and three-quarters by age 24, early and effective intervention can have profound lifelong benefits. With the right supports and resources, schools and programs that serve children and youth in Tulsa can do much more to protect the mental health and well-being of young people in their care.
- **Tulsa's system of care for mental health and substance use is fragmented, uncoordinated, and dominated by costly and ineffective responses.** Tulsa has some pieces of a well-designed mental health continuum of care, but there are many gaps, shortages, and inefficiencies. In many cases, the mental health and substance use treatment system is not delivering the right care at the right time to the right people. As a result, the criminal justice system has become the de facto setting for many residents with mental illness. Although Oklahoma ranks fifth in the nation on the number of mental health providers per 100,000 people, many Tulsans, including families with children and people with private health insurance, have difficulty finding consistent and high-quality behavioral health care (i.e., care for a mental health or substance use disorder).
- **Inadequate funding and support for mental health services constrains service provision and quality of care.** Oklahoma's current state budget crisis, past underinvestment in the behavioral health care safety net, and decision to forgo federal funds to expand health insurance coverage through Medicaid severely constrains Tulsa's ability to address unmet mental health needs. Without major changes in state policy, Tulsa has limited ability to improve health insurance coverage for mental health and substance use treatments and to deliver needed services.

- **Many mental health problems track closely to the geography of disadvantage, reflecting areas of concentrated poverty, economic underinvestment, and social exclusion.** Health and well-being are rooted in broader social, behavioral, and environmental conditions. Poverty, trauma, unemployment, food insecurity, and housing instability shape people’s lives, the conditions in which mental illness and other health problems develop, and the ability to seek and get help. The rate of mental illness among poor and near-poor residents of Tulsa (those living in households with incomes under 200 percent of the federal poverty level) is almost a third higher than that for the entire Tulsa population—19.4 percent compared with 14.2 percent. The connections between poverty and mental health have important consequences for Tulsans of color. Although Tulsa has made strides in desegregating its neighborhoods and schools, many residents of color continue to live in areas of concentrated poverty, with profound implications for their health and well-being. Native American and African American residents experience higher rates of mental illness than the Tulsa population as a whole, reflecting long-standing inequalities in the social determinants of health and mental health, and they are disproportionately represented in the publicly funded mental health service system.

Despite these challenges, Tulsa has considerable strengths, including cutting-edge treatment programs to address mental health and substance use disorders. Many existing public, private, and nonprofit collaborations can spark and support mental health innovations in the region, and higher education and health care institutions are well-positioned to contribute to this effort. Tulsa civic leaders and government officials are actively working to provide alternatives to incarceration for some people with serious mental illnesses. And the state department of mental health can be a powerful partner in supporting progress in Tulsa. A state opioid commission recently issued over 30 recommendations covering law enforcement, the medical community, prevention, treatment, and drug-endangered children.

The Evidence behind Tulsa’s Mental Health Plan Strategies

The Tulsa Mental Health Steering Committee used our research, as well as its own deep knowledge of local best practices and the Oklahoma mental health policy landscape, to develop preliminary strategies for the community to consider. Before finalizing the plan, the committee intends to use this report to gather another round of stakeholder input on its preliminary strategies.

The committee’s strategies are grouped into five distinct action areas and four crosscutting pillars that support all the action areas. This report includes a detailed discussion of data, some local context, and the evidence base underlying the committee’s proposed strategies. This work is summarized as follows.

Five Action Areas

1. **Prioritize children and youth**

About 19,000 children and youth in greater Tulsa—7.7 percent of the total—have a serious emotional disturbance (a common population measure of mental illness among people younger than 18). And the prevalence of mental illness among Oklahoma teens is alarming: nearly 13 percent report experiencing a major depressive episode, according to the National Survey on Drug Use and Health.

Childhood and adolescence are critical periods for lifelong mental health. Young children are highly susceptible to toxic stressors in their relationships and environments, and the first signs of mental illness often appear in adolescence and young adulthood.

Several stakeholders said that Tulsa has a shortage of pediatricians and mental health providers with training in child treatment strategies. This shortfall is compounded by the lack of bilingual providers for non-English-speaking families. Health insurance rates also drop off for youth around the time they turn age 18.

Schools should be one of the first lines of prevention and early intervention, but Tulsa-area schools are not adequately funded or staffed to address their students' mental health needs. Efforts within schools to promote trauma-informed approaches, social and emotional learning, and mental and behavioral health can be powerful and effective.

Based on these findings, the committee recommends developing more coordinated, systematic, and evidence-based ways for promoting mental health and well-being; preventing emerging mental illness and substance use in children and adolescents; and managing mental health challenges in effective and developmentally appropriate ways.

2. **Strengthen community-based services and supports**

Beyond medical care, people living with mental illness and/or addiction can benefit greatly from community-based services and supports such as assertive community treatment, patient education and illness self-management, family education, integrated treatment of co-occurring diseases, peer services, supportive housing, and supported education and employment.

Although Tulsa has community support programs like these, they are uneven, piecemeal, not widely known, and not sufficiently funded to meet the region's needs. Strengthening these services can reduce mental health and substance use-related crises, support recovery, improve lives, and reduce

costs. Community-based supports can also combat the stigma and discrimination faced by many people and families living with mental illness or addiction.

Based on these findings, the committee recommends scaling up and adding to existing community-based services.

3. Integrate mental health into the health care system

Mental health and physical health are intimately linked. Many people living with mental illness or addiction also experience physical health problems. Compared with the general population, people with mental illness are more likely to have chronic illnesses, such as heart disease and type 2 diabetes, and risk factors known to contribute to these illnesses, such as smoking and poor diet.

Better integrating mental health and addiction treatment into the general health care system would help professionals identify symptoms of mental illness and addiction, treat patients holistically, and, when needed, refer them to specialty care. Ideally, an integrated system would screen, identify, and support patients and their families as early as possible; prevent or mitigate mental illness and substance use; avert and manage crises when they occur; and support recovery and wellness.

In Tulsa, the lack of mental health integration is compounded by a shortage of public inpatient psychiatric beds and partial hospitalization programs. Police often must drive people experiencing psychiatric emergencies long distances across the state in search of a bed.

Based on these findings, the committee envisions creating a seamless system of prevention, early intervention, and care that better integrates mental, addiction, and physical health care and community-based supports and strengthens acute treatment options. Recent recommendations issued by the Oklahoma Commission on Opioid Abuse will also be important in supporting this system of care.

4. Work with criminal justice settings

One of the major consequences of an inadequate and fragmented system of care for people with mental illness is the large number of people who, in the absence of care, fall into inappropriate, traumatizing, and costly settings such as emergency rooms, homeless shelters, and, most tragically, the criminal justice system.

Of the 30,000 people who received medical care at Tulsa's David L. Moss Criminal Justice Center in 2016, a third received treatment for a mental illness. Given that the estimated annual cost of incarcerating a person with mental illness is \$23,000 and that the annual per person cost of

community-based treatment is \$2,000, this failure to help people before they become involved with the justice system is wasteful and shortsighted.

Tulsa already has several well-regarded diversion initiatives that offer alternatives to incarceration for some people with serious mental illness or addiction problems; these initiatives often connect them to community mental health centers. But few people with mental illness in the criminal justice system benefit from such programs. And residents with mental illnesses who are entering or leaving the criminal justice system need more support. Without access to effective reentry services in the community, many Tulsans with behavioral health needs will continue to cycle in and out of the justice system.

Based on these findings, the committee supports expanding diversion programs and the availability of mental health and addiction treatment services. It also recommends acting on guidance from the Vera Institute (on jail diversion strategies) and from the Oklahoma Commission on Opioid Abuse, chaired by Oklahoma attorney general Mike Hunter. Both initiatives, now well under way in Tulsa and across the state, will benefit from improvements in the mental health system.

5. **Collaborate with existing community-wide initiatives**

Urban and the committee identified several community programs whose activities intersect with the committee's interests and goals. Six multiagency coalitions are essential partners in this effort. These coalitions are working on early childhood health and education, public school performance, criminal justice, homelessness, hunger, and the social determinants of health.

Based on these findings, the committee seeks to bolster and accelerate partner efforts in the community, recognizing their important contributions to mental illness prevention, early intervention, treatment, and recovery.

Four Pillars of Success

To achieve success in these action areas, Tulsa needs to invest in four pillars of success. These pillars provide the workforce, policy, research, physical spaces, and funding necessary to reach the plan's goals.

1. **Human Capital:** Tulsa has more mental health providers than many communities do, but key informants and focus group participants described many barriers and said that providers were still too few and inaccessible. And lack of access to care is not only a problem for people who are uninsured or have low incomes; even insured people with higher incomes have trouble getting the care they need. Stakeholders also said that providers in the region need more and better training.

The committee seeks to increase Tulsa’s workforce of mental health professionals and invest in their skills through ongoing training and guidance. The committee also aims to cross-train people in other areas of work so that they can better identify and help people experiencing poor mental health or mental health crises.

2. **Physical Capital:** Many of the plan’s strategies require improvements to the physical spaces where mental health care is delivered. The committee has identified the need to upgrade and build new inpatient psychiatric and substance use treatment facilities, and it recommends a telereferral navigation process so that members of the community can access care when they need it.
3. **Intellectual Capital:** The success of any mental health improvement plan requires continuous learning about new research findings and best practices to influence better care, policy, and funding. The committee seeks to develop the expertise and capacity for translating mental health and addiction research into practice and to leverage data and technology to identify behavioral health problems and intervene before a crisis.
4. **Financial Capital:** Oklahoma ranks 46th in the nation in spending on mental health care. Inadequate financing is a major factor in the community’s poor mental health outcomes and a major barrier to improving care. The state budget crisis not only limits the addition of new services and programs but also threatens existing ones. The state’s many uninsured adults have limited access to public- and private-sector services. And the lack of funding and low reimbursement rates, particularly in rural areas, are barriers to recruiting and retaining mental health professionals. The committee seeks to garner new funding at many levels—Medicare; Medicaid; Insure Oklahoma; health insurers; federal agencies; private philanthropy; and state, county, and city government—to increase investment in mental health care.

Moving Ahead

Tulsa has a long road ahead in meeting the mental health needs of its citizens. But by adopting a staged and sequenced approach to its 10-year plan, ensuring it aligns with the community’s foremost needs, and building on existing strengths, Tulsa should be able to create a culture of real and continuous mental health improvement. This report and the preliminary strategies it identifies are the first stage in this effort.

Foreword

Dear Citizens of the Tulsa Region,

People living with mental illness in the Tulsa region die 27 years earlier than all Oklahomans. These citizens die most often from cardiovascular disease and cancer. Within Tulsa Public Schools, a suicide note is received from a student virtually every day. Tulsa County has just experienced a record year in homicides, but the suicide rate and drug overdose death rate (17 deaths per 100,000) is 50 percent higher than our homicide rate (12 deaths per 100,000). This places Tulsa at 15th in the nation in suicides. Behind each of these very sobering data points is the personal suffering of individuals, parents, and family members.

More than a year ago, a team of dedicated Tulsans set out to understand the impact of mental illness and substance abuse in our region and, more importantly, what we could do to improve quality of life, life expectancy, and the economic development potential for all in our region, including people with mental illnesses and addiction illnesses. The Anne and Henry Zarrow Foundation supported this report and research project. The Urban Institute drew on data from many sources, provided us with examples of best practices, and offered structure to our planning. Individuals with mental illnesses and addictions, family members, clinicians, business leaders, school personnel, and law enforcement and criminal justice leaders all provided personal stories to bring our research to life.

The following are some of our findings from interviews with individuals, family members, clinicians, and thought leaders and from database research:

1. **Brain disease and stigma.** We have made great progress in understanding the genetic and molecular dysfunctions that lead to diseases of the brain such as Parkinson's disease, multiple sclerosis, schizophrenia, bipolar affective disorder, major depressive disorder, autism, obsessive compulsive disorder, post-traumatic stress disorder, anorexia nervosa, alcoholism, and opioid addiction. The Laureate Institute for Brain Research in Tulsa is a world leader in the study of the biological roots of mental illness with a goal of curing mental illnesses. Despite this advanced research, the stigma of mental illness as a personal fault continues and is exemplified by the disinvestment in public, insurance carrier, and health system funding for mental illness and addiction treatment beginning with at-risk Oklahoma children.
2. **Shorter life expectancy.** The impact of this disinvestment has been deadly: Tulsans with mental illness die 27 years earlier than all Oklahomans. These Tulsans often die from advanced cardiovascular disease and late-detected cancers. Tulsa's suicide and drug overdose death rates from opioids and methamphetamine are 50 percent higher than the record-high murder rate. And

suicide affects children as well as adults: Tulsa Public Schools receive almost one suicide note every day.

3. **North Tulsa and the Tulsa County Jail.** North and downtown Tulsa bear the greatest burden of mental illness and addiction. Twenty percent of Tulsa Police Department bookings, 2,000 per year, are for drug possession. More than 40 percent of those in the Tulsa County Jail are prescribed psychotropic medications.
4. **An overwhelmed system of care.** Disinvestment has created a care system that cannot meet the needs of Oklahoma children and adults with mental illnesses and addictions. Prevention and early intervention programs for children are not sufficiently scaled. Outpatient care programs are at capacity with long waiting lists for a first appointment. Emergency rooms are flooded. Inpatient mental illness and addiction care facilities are at capacity. With the traditional system of care overwhelmed, patients are diverted in many directions. General medical and pediatric wards receive psychiatric patients, although they are poorly equipped to provide this care. And many people in the Tulsa County Jail and in Oklahoma prisons have mental illnesses and/or addictions. Even people with substantial financial resources struggle to obtain access to high-quality mental illness and addiction care.
5. **Seeds of innovation, excellence, and collaboration.** Many innovative programs in the Tulsa region would significantly improve quality of life and lower overall health care costs, if they were adequately funded and brought to full scale. And six public-private partnerships taking on complex social issues may also assist in the success of this initiative.

Improving Health across the Tulsa Region

In 2006, the Lewin study highlighted a 14-year difference in life expectancy between North and South Tulsa, but at that time, establishing the goal of shrinking the gap seemed a “bridge too far.” Instead, recommendations were put forward to hopefully stabilize North Tulsa’s health. Over the next decade, recommendations for new clinics and hospitals, health care coverage expansion, tailored clinical programs, and health professional training expansion were fully realized. A recalculation of 2015 life expectancy by zip codes showed, much to everyone’s surprise, a three-year improvement in North Tulsa’s life expectancy. The moral of the story was that when an entire community pulls together, stark health disparities can be improved and the bridge was actually not too far.

A Call to Action

Mental illnesses and addictions are complex diseases of the brain that require interventions far beyond psychopharmacology. Yet funding for prevention, early intervention, and direct mental health and addiction care services for children and adults does not come close to that for other medical conditions. Instead, Oklahoma's jails and prisons now house more individuals with mental illness and nonviolent drug offenders than Oklahoma's much less costly inpatient and outpatient care facilities. This paradox reflects a false belief that persists in 2018—that these individuals are personally at fault for their conditions. What follows is another false belief among some voters, decisionmakers, and people with influence over funding—that these citizens do not deserve financial support for prevention, early intervention, and direct care of their brain diseases. Our stark death rates are a direct result of the pernicious stigma associated with mental illness and addiction, and that is a wrong that must be made right. Tulsa has a history of being honest about things that are not right and of taking action to correct these wrongs. It is time to take action and correct this wrong. This report has provided us with the blueprint to get started.

Sincerely,

Gerard Clancy, MD, President, The University of Tulsa

Introduction

Like many communities across the country, Tulsa is grappling with high rates of mental illness and addiction. Life expectancy for people living with these disorders is under 50 years—rivaling that in some of the least developed countries in the world—and 27 years lower than that for all Oklahomans. These early deaths are commonly caused by accidents, suicides, homicides, and overdose from opioids and other drugs,¹ but they are preceded by years of poor physical health, social disconnection, and low economic productivity. Oklahoma ranks near the bottom on many of these measures, compared with other states (Woolf et al. 2016). The toll on families and the costs to the community of chronic illness, unemployment, homelessness, and incarceration are significant.²

Health and well-being are rooted in broader social, behavioral, and environmental conditions. Poverty, trauma, unemployment, food insecurity, and housing instability shape the life conditions in which many illnesses and other problems emerge and progress, as well as one's ability to seek and obtain needed care. These social determinants of health and mental health are weak in Tulsa, and they manifest in poor health and survival. A recent national study of health inequality ranked Tulsa among the five worst cities in the nation in life expectancy among lower-income Americans (Chetty et al. 2016).³

Even more alarming is the poor health and well-being of Tulsa's children and youth. For 2018, Mental Health America ranked Oklahoma 45th out of all states on a composite measure of youth mental illness and access to care. The state ranked 43rd on the share of youth with severe depression who receive some consistent treatment (MHA 2017). Even the very youngest Tulsans are not faring well. Children in Oklahoma have the highest rates of adverse childhood experiences (ACEs) in the nation (UHF 2016). ACEs are potentially traumatic events and experiences known to increase the likelihood of outcomes such as obesity, alcoholism, and depression later in life.⁴

In response to these challenges, Tulsa plans to launch a 10-year plan for improving mental health. The plan will have four overarching goals:

1. Close the gap in life expectancy between Tulsa residents living with mental illness and all Oklahoma residents.
2. Lower the rates of suicide attempts and overdoses, and deaths from both causes.

TULSA RESIDENTS
LIVING WITH MENTAL ILLNESS
AND/OR ADDICTION DIE

27
YEARS EARLIER
THAN ALL OKLAHOMA RESIDENTS.



3. Lower the share of Tulsans who experience poor mental health.
4. Reduce criminal justice system, first responder, and hospital emergency room costs caused by untreated or poorly treated mental illness.

These goals reflect the mental health and well-being of all Tulsans, but the plan will initially prioritize mental health–related prevention and intervention among children and youth, as well as treatment and recovery services for Tulsans living with serious mental illnesses and substance use disorders. These priorities will allow the community to focus limited resources on two important vulnerable populations, and they dovetail with several ongoing efforts within Tulsa and in the state, including recommendations recently made by the Vera Institute (for Tulsa’s criminal justice system) and the Oklahoma Commission on Opioid Abuse. These priorities also reflect state policy decisions that severely constrain the community’s ability to address unmet mental health needs—namely, Oklahoma’s state budget crisis, which dangerously diminishes care for these groups, and the state’s decision to forgo federal funds to expand Medicaid coverage for Oklahomans.

Medicaid is the single largest payer for mental health services in the country and is increasingly important in covering substance use disorder services. As of mid-2016, almost 781,000 Oklahomans were covered through the state Medicaid program, known as SoonerCare. If the state chose to expand Medicaid, 348,000 additional residents could be covered, and an additional \$8.6 billion would be available to the state over the next decade to fund much-needed services.⁵ Without major changes in state policy, Tulsa’s ability to expand access to effective mental health and substance use treatment will be very limited. Nonetheless, the community is committed to improving the mental health and wellness of children and people living with serious mental illness.

Background

This report paves the way for a 10-year plan for improving mental health in Tulsa by previewing emerging goals and strategies and by reviewing the data and findings on which they are based. In addition to reviewing existing data from a range of national sources, this study collected and analyzed new data (both quantitative and qualitative) covering Oklahoma and Tulsa.

The scope of this effort to inform Tulsa's mental health improvement plan was broad, covering all people younger than 65 across the seven counties that make up the Tulsa metropolitan statistical area (MSA): Tulsa, Rogers, Wagoner, Creek, Osage, Okmulgee, and Pawnee.

Different strategies will be needed in different neighborhoods and school districts, and at the city versus the county level. Different strategies are also needed for different subpopulations: people with diagnosable mental illness, people experiencing poor mental health because of social and economic challenges and stressors, and people at risk of poor mental health or mental illness.

Mental illnesses are disorders that interfere with a person's cognitive, emotional, or social abilities, and meet certain diagnostic criteria. Mental illnesses vary in severity and duration; those that cause severe functional impairment are commonly referred to as serious mental illnesses. Mental illnesses include mood disorders such as depression and bipolar disorder, anxiety disorders, and psychotic disorders such as schizophrenia. Although psychotic disorders are the least common, they are among the most disabling and costly mental illnesses. Nationally, about one in five US adults experienced a mental illness in the past 12 months, and 5 percent experienced a serious mental illness.

Like mental illnesses, mental health problems interfere with a person's cognitive, emotional, or social functioning, but they do not meet the criteria for diagnosable mental illnesses. They can result from stressful life events or conditions and usually are shorter and less severe than mental illnesses. If they persist or become severe, they can develop into mental illnesses.

Given the significant overlap between mental illness and substance use, many mental health providers must target substance use disorders, which span both addictive and nonaddictive dysfunctional use of substances including alcohol, opioids, cannabis, hallucinogens, inhalants, sedatives, and stimulants.

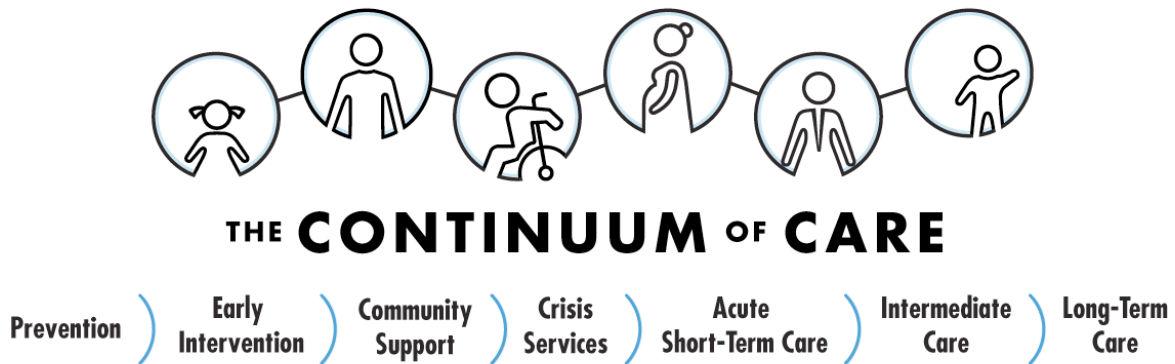
The Need for a Mental Health Continuum of Care

A well-designed prevention- and recovery-oriented mental health system can provide a range of services and supports to individuals and families in need. These include prevention and early intervention services,

community-based services and supports, crisis behavioral health services, and core treatment services from acute short-term care to long-term care (see figure 1). The types of treatments and services, providers of care, service settings, and funding streams can vary significantly along and within each component of this continuum of care.

FIGURE 1

A Basic Mental Health Continuum of Care across Ages and Needs



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A wide array of nonclinical supports and services are also critical to helping people living with serious mental illness recover and thrive. The Substance Abuse and Mental Health Services Administration (SAMHSA) has identified four major dimensions of “recovery,” a process involving efforts to improve health and wellness, live a self-directed life, and achieve one’s fullest potential. The dimensions are as follows:

1. Health: overcoming or managing one’s disease or symptoms and making informed healthy choices to support physical and mental health
2. Home: having a stable and safe place to live
3. Purpose: having meaningful daily activities, such as a job, school, family caretaking responsibilities, or creative endeavors, and the independence, income, and resources to participate in society
4. Community: relationships and social networks that provide support, friendship, love, and hope

Recovery supports are distinct from clinical treatment and may be used before, during, or after clinical treatment, and even by people not in treatment. They are delivered through a variety of community- and faith-based groups, traditional or specialized service providers, and schools. They include outreach, engagement, and transportation to and from services; employment and educational supports; specialized living situations; peer-to-peer services, mentoring, and coaching; spiritual and faith-based support; parenting education, self-help, and support groups; and drop-in centers, clubhouses, respite/crisis services,

and warm lines (peer-run listening lines staffed by people in recovery). Recovery supports can also reinforce the success and effectiveness of clinical treatment.

People living with mental illness and their families are often de facto members of the mental health workforce. The self-care, family member care, peer support, and hands-on programming they provide can be among a system's most therapeutically productive and cost-effective resources. Empowering people and families affected by mental illness and substance use disorders is a core principle of trauma-informed approaches to care. Trauma-informed approaches can be used in any type of service setting or organization and apply to all aspects of the continuum of care shown in figure 1. Trauma-informed care involves understanding, recognizing, and responding to the effects of all types of trauma; it emphasizes physical, psychological, and emotional safety for both patients and providers, and helps survivors rebuild a sense of control and empowerment.

People living with mental illness and their families are often de facto members of the mental health workforce.

Some community members only need prevention or early intervention services, some have their first contact with this system after a crisis, and some need different types of services and supports at different times throughout their lives. The bottom line is that all these services and supports are needed and important in supporting mental health and well-being in the community. Although pieces of this continuum of care can be found across Tulsa, they do not form an effective and integrated system.

A well-functioning continuum of care should be broad, and even service providers and community program leaders may not know about the full range of services and supports or about availability at any given time. And people with mental illness and their families often are unaware of what help is available. As one person interviewed for this study explained, "even though Tulsa seems to have a lot of options, there's really no place to go to figure out where the options are, especially when you can't think right or you're needing to get high."

Practitioners and system leaders consistently describe care across the region as uncoordinated, especially in behavioral health care and primary care, which includes pediatric and obstetric care. Many important services and supports, including crisis beds, substance use treatment, and intermediate and long-term care, are not sufficient. Fragmentation and critical gaps extend beyond the health care system and into

schools, community supports, employment and housing, and the criminal justice system. Other populations that are not well served include children who struggle in regular schools, older youth transitioning into young adulthood, runaway and homeless youth, children whose parents have serious mental illnesses, LGBTQ youth and adults, people living in more rural parts of the greater Tulsa region, people who need bilingual services, Native Americans, and veterans and reservists.

UNTREATED MENTAL ILLNESS
COSTS TULSA AN ESTIMATED

\$387.8

MILLION ANNUALLY

IN DIRECT AND INDIRECT COSTS,
AND ANOTHER \$5.2 MILLION IN
CRIMINAL JUSTICE SYSTEM COSTS.



Services and supports should be balanced and work together. When the noncrisis portions of the continuum of care are not sufficiently developed, known, and available to everyone in the community, mental health and substance use crises—and demands on the crisis services portion of the continuum—intensify. It is a system out of balance, driving up costs and human suffering and depriving the community of services critical to health, equity, and well-being. The crisis portion of the continuum is where the system breakdown signals are often loudest and most visible, pushing people in crisis into the criminal justice system or other high-cost settings such as emergency rooms, but gaps in other parts of the system are also important. One member of the community explained, “Years ago, when I was in jail, I requested to see a psychiatrist. I finally saw one. Now, we have mental health court and homeless court,

so there is a greater chance of not going to jail/prison because there is better mental health care for you. You don’t have to go to prison to get mental health treatment. There was no place in the community to go to address mental health, so [I] had to address it in prison.”⁶

Addressing Mental Illness and Substance Use Disorders

Many of the mental health and substance use challenges in Tulsa mirror those in other communities across the state and the country, and they reflect fundamental inadequacies and weaknesses in the nation’s system of health care. Mental illnesses cause more disability than any other class of illness. They cost more too: the US spent an estimated \$201 billion on mental disorders in 2013—far more than on the second most costly group, heart conditions (\$147 billion), or on the third group, trauma and injuries (\$143 billion; Roehrig 2016). Although roughly half of Americans will experience mental illness at some point in their lives (Kessler et al. 2005), many communities do not have a system of care to support them. Years of inattention to this problem have left hospital emergency rooms, homeless shelters, criminal justice agencies, and individual families shouldering the burden of responding to people in crisis.⁷

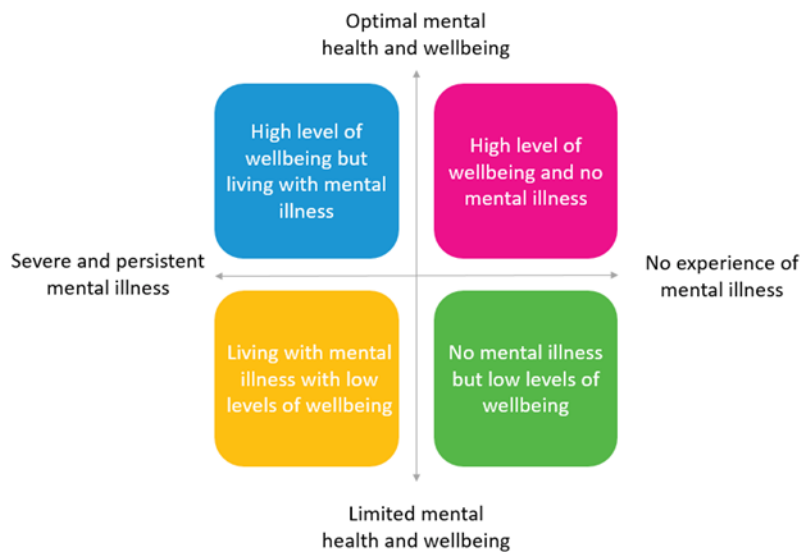
Stigma, ignorance, and misinformation still surrounds mental illness and substance use disorders, even among highly educated and well-intentioned professionals and paraprofessionals. Stigma alone is a major barrier to system improvement, and the education of providers, first responders, and others will be critical to changing the culture of fear, hopelessness, and disrespect that pervades many mental health systems and communities.

Mental illness is first and foremost an illness of youth and young adulthood.

With the right care and supports, people living with mental illness can enjoy good mental health and well-being. New insights and policies based on broader population health approaches to prevention and promotion are shedding light on two important and distinct aspects of health (see figure 2). Improving mental health means not only taking actions to reduce rates of mental illness and substance use disorders (and their consequences, including suicides and overdoses), but also providing early intervention services to groups or individuals who are at high risk or show early signs of poor mental health. It also means preventing risk before the onset of signs or symptoms.

FIGURE 2

Two Dimensions of Mental Health and Well-Being



Source: Adapted from NHS Health Scotland (2011).

Virtually every segment of the community can be involved in improving mental health. The health care sector can develop more evidence-based prevention and treatment interventions for mental illness and substance use disorders and better integrate them within primary care. The criminal justice system, which now holds many people with unattended mental illness, can connect them with treatment and supports. The education system can reach young Tulsans through early intervention and prevention programs.

Mental illness is first and foremost an illness of youth and young adulthood. Half of all mental illnesses first appear by age 14 and three-quarters by age 24 (Kessler et al. 2007). Intervening early and effectively can have profound lifelong benefits for young people, their families and friends, and entire communities.⁸ Employers and business leaders, community and economic developers, faith and civic leaders, and people in the tech, arts, and culture communities also have important roles to play.

Tulsa's Challenges and Strengths

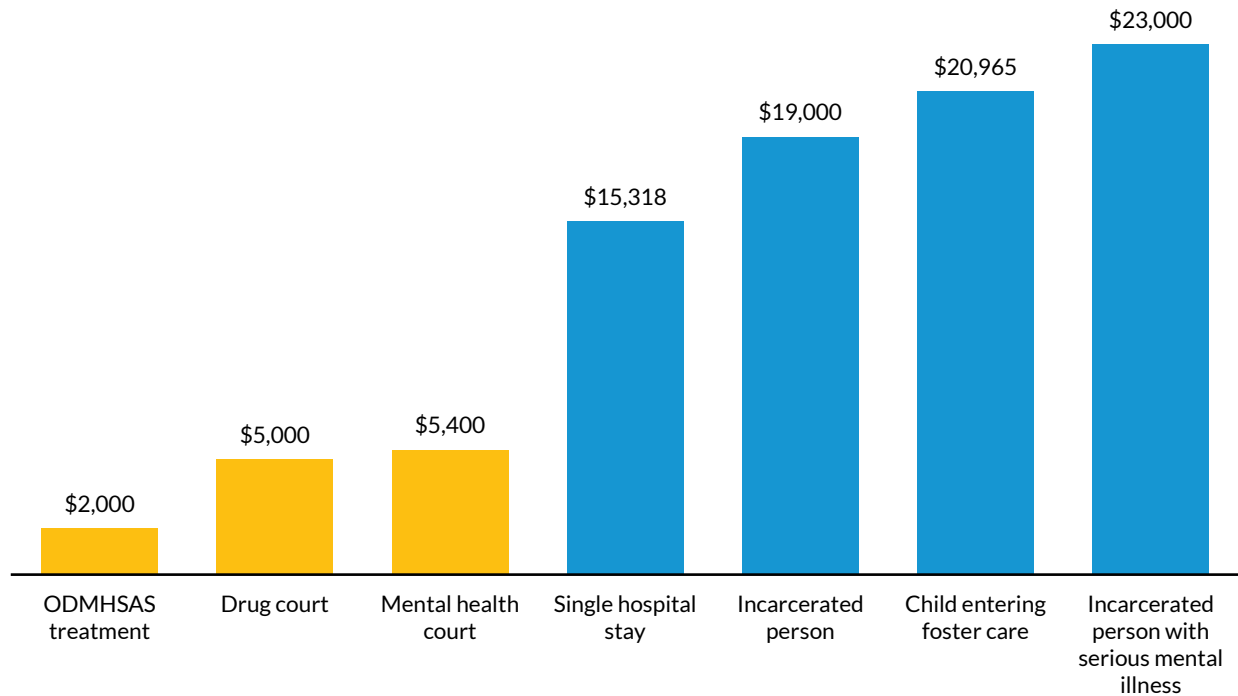
Tulsa's mental health care system is a paradox. Mental health problems and crises are widespread in the community, with significant social and financial costs. But Tulsa is also renowned for its work on brain science research, early childhood systems development, and housing programs for homeless people living with mental illness. A closer look at the data reveals a mixed picture of mental health and well-being in the community.

Compared with other states, Oklahoma ranks poorly on most measures of mental health and substance use, including frequent mental distress, suicide, and drug deaths. Rates of suicide and drug death have been worsening over time (UHF 2017). The health of women and children in Oklahoma is also among the lowest in the nation on several measures (UHF 2016). Rates of intimate partner violence among women and adverse childhood experiences among children are high, as are rates of teen suicide. Without strong and supportive environments including mental health, social and emotional learning, and trauma-informed care, children and youth in Tulsa will not be prepared to succeed in school, work, and life.

Tulsa's system of care and services is fragmented and dominated by costly and ineffective responses to mental health problems. Many Tulsa stakeholders, including law enforcement officials, lament that the criminal justice system has become the de facto setting for many community members. Of the 30,000 people who received medical care at the David L. Moss Criminal Justice Center, Tulsa's county jail, in 2016, one-third received treatment for a mental illness.⁹ Given that the estimated annual cost of incarcerating a person with mental illness is \$23,000 and that the annual per person cost of community-based treatment is \$2,000, this failure to help people before they become entangled in the criminal justice system (or the child welfare system) is both wasteful and shortsighted (see figure 3).

FIGURE 3

Comparing Annual Per Person Costs



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Source: Brian Veazey, “Prescription Drug Diversion Trends and the Opioid Crisis” (PowerPoint presentation, n.d.), <http://www.oag.ok.gov/Websites/oag/images/Second%20Opioid%20Meeting%20Presentations%20-%20Combined.pdf#page=119>.
Note: ODMHSAS = Oklahoma Department of Mental Health and Substance Abuse Services.

At the same time, Tulsa is nationally recognized as a “beta city” for pioneering innovation and problem-solving, including in areas that matter to mental health. The city hosts a prominent institute for brain science research, offers extraordinary models for early childhood programming and systems building, and is a leader in modeling housing solutions for homeless people living with mental illness.¹⁰

But in some areas, it is hard to distinguish strength from challenge. The state ranks fifth in the nation on the number of mental health providers per 100,000 people (including psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, providers who treat alcohol and other drug addictions, and advanced practice nurses specializing in mental health). Tulsa County has 421 mental health providers per 100,000 people—twice the national average (UHF 2017). But this figure should be understood in the context of long-standing nationwide shortages of psychiatrists and especially child psychiatrists; there are still too few clinical specialists in greater Tulsa. Many community members, including children and even people with private health insurance, have difficulty finding consistent, high-quality mental health care. Barriers to care in Tulsa include uneven geographic distribution of providers across the region (counties surrounding Tulsa have fewer providers per capita), poor training of providers,

and transportation challenges for patients and their families. A statewide behavioral health workforce study also found unmet mental health needs to be greatest in the northeastern quadrant of Oklahoma, which includes Tulsa (Hornik et al. 2011). A closer look at the data helps explain why, despite the community's strengths and assets, inadequate mental health care remains a major problem for the community.

Tulsa Challenges

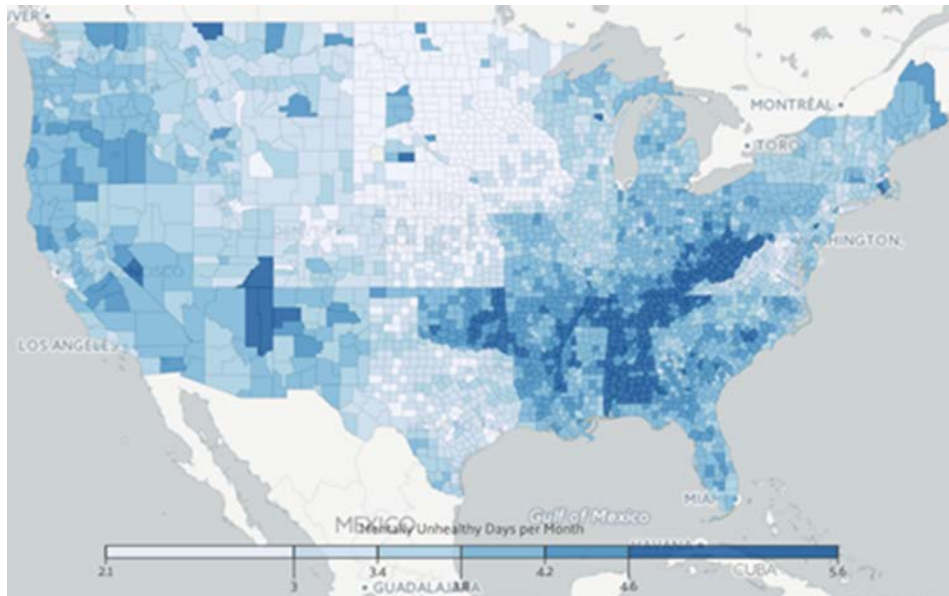
From September 2016 to February 2018, the Urban Institute team worked with Tulsa research partners to examine data on the mental health of Tulsans and the capacity of the community to meet Tulsa's mental health needs. Five major findings emerged from this joint effort:

- Mental illness is a major driver of poor health and low life expectancy across the region.
- Children and youth are unwell, lacking a strong foundation for lifelong mental health.
- The system of care for mental health and substance use has important gaps and is fragmented and uncoordinated.
- Inadequate funding for mental health services constrains service provision and quality of care.
- Many mental health problems track closely to the geography of disadvantage, reflecting areas of concentrated poverty, economic underinvestment, and social exclusion.

A national map of poor mental health days by county illustrates the first finding with striking clarity: poor mental health in Tulsa and across Oklahoma darkens the panhandle state relative to its neighbors (see figure 4).

FIGURE 4

Parts of Oklahoma and Tulsa Have Some of the Worst Mental Health in the Nation



Source: 2014 data from the CDC Behavioral Risk Factor Surveillance System.

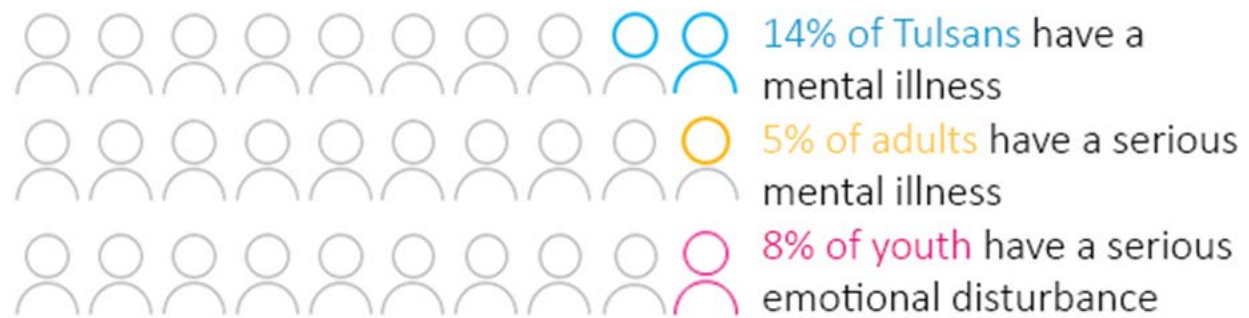
Note: The figure reflects county-by-county responses to the following question: “Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?”

As mentioned earlier, Tulsans with mental illness have a life expectancy of under 50 years. This alarming figure rivals the life expectancy in some of the least developed countries in the world and is 27 years lower than the life expectancy of all Oklahomans taken together. In Tulsa, the early deaths of people with mental illness are most often caused by accidents, suicide, homicide, and overdose from opioids and other drugs. But they are often preceded by years of poor health, social disconnection, and low economic productivity. All these factors have profound social and economic ripple effects on families, schools, employers, and communities.

What accounts for this dramatic mortality gap? Although rates of poor mental health can and do vary significantly from one community to another, epidemiological data on serious mental illness show that they do not vary considerably across time and place. A new analysis conducted for this study found that about 140,000 residents across greater Tulsa have a mental illness.¹¹ About 38,000 adults have a serious mental illness, and about 19,000 children and youth have a serious emotional disturbance (a common measure of mental illness among people younger than 18). The overall mental health profile across greater Tulsa is shown in figure 5. The large mortality gap reflects how poorly and inadequately mental health is treated and supported in Tulsa.

FIGURE 5

Mental Illness and Serious Mental Illness across Greater Tulsa



Source: Estimates developed by Charles E. Holzer III based on 2015 five-year American Community Survey data and prevalence rates from the National Institute of Mental Health Collaborative Psychiatric Epidemiology Surveys Combined Dataset.

One group disproportionately affected by poor mental health is Tulsa’s children and youth. In Oklahoma, one in six children experiences four or more adverse childhood experiences, such as witnessing domestic violence, substance misuse or mental illness within a household, an incarcerated family member, household separation or divorce, and various types of abuse and neglect, by the time they are 19.¹² The prevalence of some ACEs in Oklahoma has gone up substantially over the past two decades; for example, child maltreatment has risen by almost 30 percent since 1990. ACE rates among Oklahoma’s children are among the worst in the nation. And the consequences for children have also risen dramatically over the same period. Juvenile violent crime arrests have skyrocketed by almost 131 percent, and placements in out-of-home foster care have risen by just over 34 percent.¹³ Seventy percent of children in the juvenile justice system have a mental illness.

This dual burden on Tulsa’s children and youth and on people living with mental illness and addiction largely explains why mental health and well-being are so low in Tulsa. Schools and other child- and youth-serving programs are not adequately supported to deliver prevention and early intervention services. The mental health system is not delivering the right care at the right time to the right people. And this results in mental health crises and emergencies that are overwhelming the community’s emergency rooms, homeless shelters, and jails—all costly settings that were never designed or intended to handle behavioral health crises or support recovery.

Finally, the state of Oklahoma is neglecting to make adequate investments in the insurance and health care needs of its citizens, leading to worse outcomes for those affected and greater costs to the community from unnecessary chronic illness, homelessness, and incarceration. By one estimate, the annual costs of untreated mental illness in the seven-county greater Tulsa area total close to \$400 million—\$41.6 million in direct costs (associated with increased inpatient care, outpatient care, long-term care, and spending by local mental health agencies), \$346.2 million in indirect costs (including unrealized earnings because of disability

and early death, unemployment costs, and lost time and productivity while employed), and \$5.2 million in criminal justice system costs (from incarcerations because of untreated mental illness).¹⁴

Rates of adverse childhood experiences among Oklahoma’s children are among the worst in the nation.

Oklahoma has also had to contend with chronic underinvestment by the state legislature in the behavioral health care safety net, despite compelling evidence of the need for more care. This trend—along with periodic financial crises within the state Medicaid and mental health agency, the state’s unwillingness to expand Medicaid, limited inpatient beds (in both the public and private sectors), and the rising costs of providing evidence-based services—has undermined Tulsa’s capacity to meet the community’s significant behavioral health needs, especially among people who are uninsured or underinsured. As a result, many people with serious mental illness in Tulsa are sicker than they should be, and many are overwhelmed with poverty, hunger, homelessness, addiction, chronic illness, and a history of incarceration, unemployment, and social isolation.

Tulsa Strengths

In recent years, Tulsa has become nationally known for innovation and problem-solving. Thanks in large part to the efforts of generous local philanthropists, including the George Kaiser Family Foundation, the Anne and Henry Zarrow Foundation, the Maxine and Jack Zarrow Family Foundation, and the Charles and Lynn Schusterman Family Foundation, Tulsa is widely recognized as a place where evidence-based social programs are developed and tested for their potential to close disparities in health, education, employment, and other factors that shape one’s ability to lead a happy and productive life. Tulsa offers numerous public, private, and nonprofit collaborations, such as the Tulsa Mental Health Steering Committee, designed to spark and support innovation.

But Tulsa’s ability to drive improvements in mental health is diminished by the community’s difficult state funding context and a persistent legacy of racial segregation. Oklahoma’s structural budget deficit threatens a broad range of services and supports, including K–12 education, that most states provide to care for their citizens. And neighborhood-level data show that needs are especially great in North Tulsa, an

area of concentrated poverty and disadvantage. Nevertheless, Tulsa's strengths are considerable and deserve to be acknowledged for their potential contributions to the plan.

First, Tulsa offers some cutting-edge programs to address the acute and intermediate treatment needs of people living with mental health and/or substance use disorders. The Community Outreach Psychiatric Emergency Services (COPES) and Women in Recovery programs of Family & Children's Services offer real and immediate help to children and adults experiencing mental health problems. Likewise, the 12 & 12 treatment and recovery center serves Tulsans with co-occurring mental illness and substance use disorders. But demand for these services far exceeds their capacity.

Second, Tulsa offers innovative models in integrated primary care for people with mental health problems. One example is the federal Comprehensive Primary Care Initiative (CPCI) demonstration project of the federal Centers for Medicare & Medicaid Services (CMS) Innovation Center. This project seeks to strengthen primary care by working with public and private health care payers to offer bonus payments to providers who better coordinate care for their patients across areas such as mental health and addiction. Tulsa was one of seven regions in the nation selected for the CPCI test study, and it saw the largest reductions in Medicare expenditures and service use among all the regions. MyHealth Access Network, an extensive coalition of health care organizations throughout Oklahoma, convened the CPCI and may be a valuable partner in future efforts around data integration and management for Tulsa's mental health improvement plan.

Third, Tulsa provides field-leading models for supporting the development and good mental health of babies and children who are younger than 5 and live in vulnerable families. Thanks largely to federal and philanthropic funding, the city hosts three Educare schools, which are part of a highly regarded national network of comprehensive early care and education programs for low-income children; 13 Head Start and Early Head Start sites operated by CAP Tulsa, a community action agency; and a growing network of Early Head Start-Child Care Partnerships that bring higher quality and more comprehensive services to child care settings used by poor working families who may not qualify for subsidies available to lower-income families. Both CAP Tulsa and Educare incorporate evidence-based infant and early childhood mental health practices and programming to boost social and emotional learning among enrolled children. Family support and mental health specialists from Family & Children's Services are stationed at each CAP Tulsa site to help parents connect with community resources, assist in problem-solving, provide family counseling and children's mental health services, and offer support tailored to each family's specific needs. Under the auspices of the George Kaiser Family Foundation and Blue Meridian Partners (a national initiative to scale programs for national impact), Tulsa civic leaders and early childhood community stakeholders are currently mounting the Birth through Eight Strategy for Tulsa (BEST), a community-wide collaboration to provide a comprehensive continuum of evidence-based programs and other services to low-income children from

before conception to age 8, and to their families. The initiative's goal is to increase the rates of healthy births, children raised in safe and nurturing homes, children ready for kindergarten, and children succeeding in school by the third grade. Embedded in this goal is a determination to dramatically cut the number of children who experience ACEs.

Fourth, Tulsa offers models for effectively supporting the needs of people with mental illness in their homes, neighborhoods, and other communities. Mental Health Association Oklahoma (MHAOK) and A Way Home for Tulsa, a collaboration of housing and service provider partners, use the evidence-based "Housing First" approach to address the needs of people with mental illness who are homeless and of other populations such as veterans. Data suggest that most citizens with serious mental illness who have access to public services are now permanently housed. A small number of people with serious mental illness in Tulsa also benefit from evidence-based programs of assertive community treatment (PACT), which allow people living with persistent serious mental illness to receive care from a multidisciplinary psychiatric team wherever one can be found. The CO-PACT teams of Family & Children's Services (serving people affected by co-occurring mental illness and substance use disorders) and the OU IMPACT team of the University of Oklahoma School of Community Medicine serve about 200 people a year. Before PACT got involved, clients collectively spent 2,223 days in either a hospital or jail over the course of a year. A year after PACT, that went down to 423 days.¹⁵

Fifth, Tulsa civic leaders and government officials are actively working to correct the imbalance between crisis and prevention care that people with mental illness experience when they encounter the criminal justice system. These efforts focus limited local resources on diversion programs such as specialty courts and programs like Women in Recovery. These entities provide alternatives to incarceration for some people with serious mental illness, often connecting them to federally funded community mental health centers for mandatory follow-up care. Between January 2010 and September 2013, the Tulsa County Family Drug Court served 269 children who spent 227 fewer days per child in out-of-home care than justice system-involved children who did not receive family drug court services, resulting in \$5 million in savings/costs avoided (ODMHSAS 2015). Mental health courts in Oklahoma are estimated to save \$17,600 in costs per participant,¹⁶ but because of limited docket space and eligibility barriers, Tulsa and other localities serve only a fraction of those who could benefit from diversion. Many of these diversion efforts, as well as special training on mental health for law enforcement officers, are coordinated through the Tulsa County Criminal Justice Planning and Policy Council, which also pushed for construction of the two mental health pods at the Tulsa County Jail and is currently working to implement better mental health and drug screening procedures in law enforcement and corrections. A recent report by the Vera Institute suggested that "to reduce admissions to the jail," Tulsa must "address the drivers of municipal and misdemeanor admissions, *especially those related to substance use, mental health problems*, and court costs and fines. These are not individuals who necessarily need to enter the jail at all in order to be held accountable to the court or

to ensure public safety” (Fishman et al. 2017; emphasis added). The Oklahoma Commission on Opioid Abuse is also actively working to identify best practices and policies to protect residents across the state from the opioid epidemic sweeping the nation.

Sixth, Tulsa’s robust university and research community offers a wealth of basic and applied research, data, and evaluation support. For example, Oklahoma State University’s Tulsa Children’s Project offers Tulsa Educare schools an integrated set of interventions focused on improving children’s developmental outcomes. One such project is “Super Parents,” a group-based parenting program focused on mindfulness, positive parenting, and building executive function in children. A Tulsa Children’s Project team also provides reflective supervision/consultation services for Tulsa Educare’s mental health specialists and some administrators. The Tulsa-based Laureate Institute for Brain Research is a nationally recognized clinical neuroscience research institute committed to discovering the causes of and cures for disorders of mood, anxiety, eating, and memory. And the integrated data resources of MyHealth are likely to be a great asset to the entire community.

Despite these regional strengths, significant policy impediments—primarily at the state level—limit Tulsa’s ability to make significant progress. For example, although Tulsa has succeeded in housing some people who are homeless and have mental illness,¹⁷ affordability and eligibility barriers still prevent people with moderate mental illness and/or co-occurring disorders from accessing the housing supports they need to become stable and to enjoy full, productive lives. Likewise, some populations, such as people with felony convictions, are hard to house and employ because of public regulations and private practices, leaving these citizens and their communities in a precarious position. And the state’s ongoing budget crisis threatens to compound the human and financial costs of these poor policy choices; last year, all publicly funded outpatient mental health care was on the state budget chopping block until the 11th hour. Had the cuts gone through, programs like COPES would have been eliminated—and the approximately 5,600 people who received care from COPES in 2017 likely would have ended up in emergency rooms, homeless shelters, or jails.¹⁸ These are the stakes for Tulsa’s forthcoming mental health improvement plan.

Strategies

The Tulsa Mental Health Steering Committee drew from Urban Institute research support, initial interviews and meetings with a wide range of stakeholders, and their own deep knowledge of local best practices and the Oklahoma mental health policy landscape to develop preliminary ideas and strategies for improving the mental health of Tulsans. These ideas can serve as a starting point for wider community engagement and discussions as Tulsa’s 10-year plan takes fuller form.

Tracking success on the four overarching goals of the plan will also be important. Below are baselines and suggested targets to track improvements over the 10-year period on three of the four goals that can be measured with currently available data. These suggested targets are benchmarked against national, state, and peer county data.¹⁹ These targets are not meant to be definitive markers of success, but beacons for navigating a path of continuous improvement toward the plan’s goals. The final goal of reducing costs must be fleshed out more before a baseline and targets can be established. Many of these targets may not be achievable in the suggested time frames, especially in these uncertain policy and budgetary environments, but they are important measures around which the community can coalesce. Subsidiary measures (and targets) can also be adopted as different components of the plan are more fully developed and implemented.

TABLE 1

Overarching Goals and Suggested Targets for Currently Measurable Goals

	Measures to Track Plan Progress	Baseline	Year 5 Target	Year 10 Target
Goal 1	Life Expectancy Gap	27 years	24 years	14 years
Goal 2	Suicide Rate	19.1 per 100,000	16.0 per 100,000	12.6 per 100,000
	Drug Overdose Deaths	19.3 per 100,000	13.9 per 100,000	9.5 per 100,000
Goal 3	Poor Mental Health Days per Month	4.0 days	3.5 days	3.1 days
Goal 4	Criminal Justice System Costs	--	--	--
	First Responder Costs	--	--	--
	Hospital Emergency Room Costs	--	--	--

Sources: Life expectancy gap (2004–13): Oklahoma Department of Mental Health and Substance Abuse Services, based on data from state vital statistics and ODMHSAS clients. Suicide rate (2011–15): county-level data from National Vital Statistics System. Drug overdose deaths (2012–14): mortality data from CDC WONDER. Poor mental health days (2014): Behavioral Risk Factor Surveillance System data.

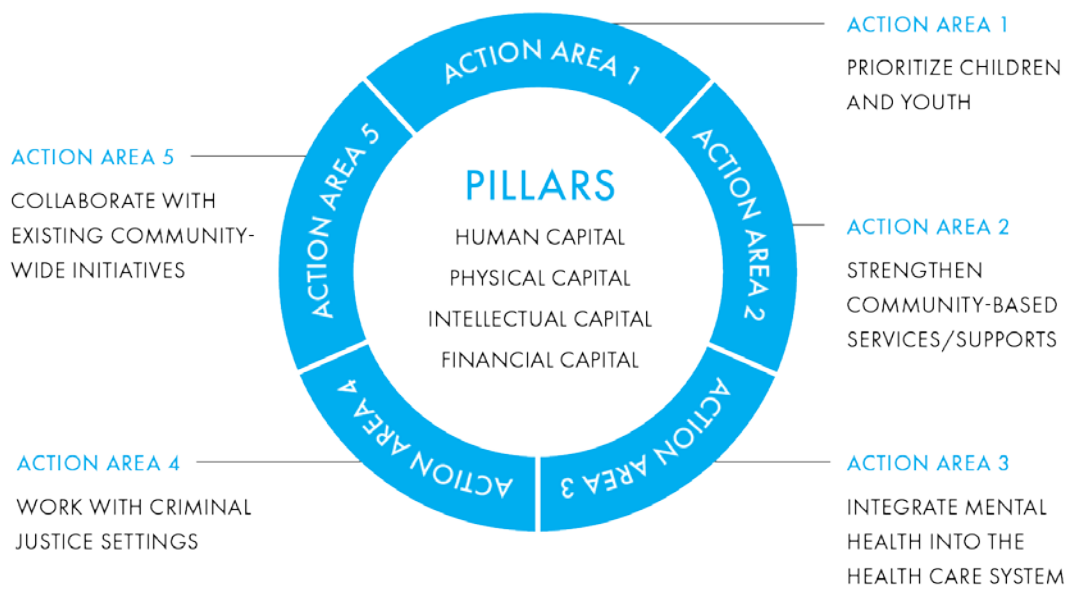
The life expectancy targets seek a small drop over the next 5 years and a 50 percent drop over the next 10 years in the gap between public mental health or substance use clients in Tulsa and the general population of Oklahoma. The suicide rate targets are set to get halfway to the national average in 5 years, and meet it in 10. Tulsa’s drug overdose rate is higher than the national average, so the 5-year goal is to meet the national average, and the 10-year goal is to reach the top quartile of similar counties. Tulsa may want to target the national average as a 5-year goal for mentally healthy days and work toward the top

quartile of peer cities in 10 years. Baseline data are not currently available to set cost-reduction targets for criminal justice, first responder services, and emergency room use. The community should gather financial data from local stakeholders once their activities are under way, and establish baseline figures and future targets using those data.

The Urban team has organized the strategies identified by the committee into five distinct “action areas” and four foundational “pillars,” as shown here:

FIGURE 6

Structure of the Plan: Five Action Areas Bolstered by Four Crosscutting Pillars



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The action areas are top-level groups of systems, settings, or people on which the mental health improvement strategies focus. The pillars are the types of capital needed to support the action areas. Each action area and pillar section below begins with a discussion of available data, local context, and evidence base underlying the proposed strategies. The strategies are then presented in tables that detail the committee’s initial ideas as areas of focus.

Action Area 1. Prioritize Children and Youth

Children and youth in Oklahoma are not faring as well as they should. In the 2017 KIDS COUNT report, children and youth in Oklahoma rank in the bottom half of states on health, family and community, economic well-being, and education, despite improvement on many measures within these domains (AECF 2017). In a 2016 America's Health Rankings report on women and children's health, Oklahoma ranked 46th out of all states (UHF 2016). These low rankings reflect many challenges for children and youth: one in four is food insecure, meaning they live in families with limited or uncertain access to adequate food.²⁰ One in six Oklahoma children experiences four or more adverse childhood experiences by the time they are 19.²¹ ACEs are stressful or traumatic events strongly related to the development and prevalence of a wide range of health problems throughout a person's life. ACEs can include witnessing domestic violence, substance misuse or mental illness within a household, an incarcerated family member, household separation or divorce, and various types of abuse and neglect. Oklahoma ranks 42nd out of all states on teen suicide (UHF 2016). Juvenile violent crime arrests have skyrocketed by almost 131 percent, and placements in out-of-home foster care have risen by just over 34 percent.²²

The cumulative effects of multiple ACEs are thought to be more important than the individual effects of any one ACE. A person's cumulative ACEs score has a strong, graded relationship to many physical, behavioral, and psychosocial problems throughout his or her life, including substance use disorders and mental illness.²³ New estimates developed for this plan show that about 19,000 children and youth in greater Tulsa (7.7 percent of the total) have a serious emotional disturbance—a diagnosable mental, behavioral, or emotional disorder that substantially interferes with a child's role or functioning in family, school, or community activities.²⁴ At the same time, Tulsa-area schools are inadequately funded and staffed to address behavioral health needs among their students.²⁵

Two periods of childhood are especially critical to lifelong mental health: early childhood and adolescence. Recent advances in brain science show that much of the foundation for learning and healthy social-emotional development is built during a person's earliest years through social and environmental interactions. Young children are highly susceptible to "toxic" stressors in their environments and relationships. Developmental trajectories can be improved permanently if healthy development is promoted, risks are identified, and appropriate supports and interventions reach those in need. Poverty and its correlates, such as high rates of maternal depression, can weaken the supports and protections parents would ideally provide to their children (Roehrig 2016). But in Tulsa, even families who are economically well off and have insurance coverage are often unable to find needed mental health care for their children.²⁶

The first signs of mental illness often appear in adolescence or young adulthood. National epidemiological studies have shown that half of all lifetime cases of mental illness begin by age 14 and three-quarters have begun by age 24.²⁷ The median delay for treatment of mental illnesses is nearly a decade, and the longest delays are 20 to 23 years. Delays and missed opportunities for diagnosing and treating mental health or substance use disorders often lead to crises that can throw families, schools, and entire communities into distress. Promotion of mental health protects children against an array of harmful consequences including isolation, substance misuse, suicidal thinking, dropping out of school, risky sexual behaviors, dating violence, gang involvement, and running away from home.

In Tulsa, even families who are economically well off and have insurance coverage are often unable to find needed mental health care for their children.

The rate of mental illness across Oklahoma ranks just under the national average, but the rate among Oklahoma teens is especially alarming. Data from the National Survey on Drug Use and Health reveal that nearly 13 percent of teens in Oklahoma report experiencing a major depressive episode, placing the state 39th in the nation on this measure.²⁸

TABLE 2

Oklahoma Adolescents and Young Adults Have Particularly High Rates of Poor Mental Health

Share of Oklahoma population with	Ages 12–17	Ages 18–25	Ages 26+
Serious mental illness	N/A	5.0%	4.2%
Any mental illness	N/A	20.6%	19.0%
Serious suicidal thought	N/A	7.7%	3.3%
Major depressive episode	12.6%	9.5%	6.4%
Oklahoma's rank among all US states in prevalence of	Ages 12–17	Ages 18–25	Ages 26+
Serious mental illness	N/A	21st	28th
Any mental illness	N/A	18th	35th
Serious suicidal thought	N/A	19th	17th
Major depressive episode	39th	15th	25th

Source: 2014–15 National Survey on Drug Use and Health data.

Many Tulsa-area key informants confirm that teens have high rates of untreated mental illness. One parent noted that when their teen was in crisis, they called for help and were told “to put away all the knives and medication because teens are impulsive—but it ends there if you don’t want to go inpatient. There is no

in-between.” Although rates of alcohol and drug use among Oklahoma teens are not higher than those in many other states, these behaviors may be responses to psychological distress brought on by trauma or chaotic school or home environments. One key informant observed, “There is a whole population of twentysomethings that are going from job to job, mostly in restaurants, dealing with mental health issues—depression, anxiety, panic disorder, bipolar, etc.—and [using] drugs and alcohol [to cope]. They are not quite ‘broken’ enough, or have not hit the bottom of the barrel, but are barely hanging on.”

Providers and key informants across the community report that school-age youth with mental illness often do not get the treatment they need while they are in school. Consequently, some teens disconnect from school and become entangled with the criminal justice system. One key informant explained, “Many of the kids coming through the juvenile bureau have a chronic mental illness that has never been addressed. Problem is that there is not the ability, due to lack of time and other resources, to really drill down and find the kids that need help. Demand for services vastly exceeds supply. Many times, it’s those that ‘rise to the top’ and somehow end up in the justice bureau that are identified as needing help.” Children in the juvenile justice system—70 percent of whom have a mental illness—lose their SoonerCare coverage when Medicaid conducts monthly “matching” and finds that children are in detention. Lack of coverage is a significant barrier to formerly incarcerated young people seeking much-needed community-based services and supports after release.

“There is a practice in Oklahoma of putting ‘difficult’ foster kids in inpatient care to ‘give foster parents a break,’ and this is a misuse of the system.”

Children in foster care are also poorly served. Until recently, they were not routinely screened for mental health issues, and according to several key informants, many never receive proper treatment for the psychological trauma that often goes hand in hand with their circumstances. And yet, one key informant noted, “there is a practice in Oklahoma of putting ‘difficult’ foster kids in inpatient care to ‘give foster parents a break,’ and this is a misuse of the system.”

Although Tulsa has several strong early childhood programs, critical gaps persist in pediatric mental health care for families. These gaps affect families of all incomes across the region. Several stakeholders expressed concern that Oklahoma policymakers often push for policies that penalize or withhold help from adults, failing to recognize that the well-being of Oklahoma’s children is inextricably bound to the well-being of their parents, particularly when it comes to mental health and well-being.

LESS THAN
50%

OF CHILDREN RECEIVE FOLLOW-UP CARE WITHIN ONE MONTH AFTER A PSYCHIATRIC HOSPITAL DISCHARGE.

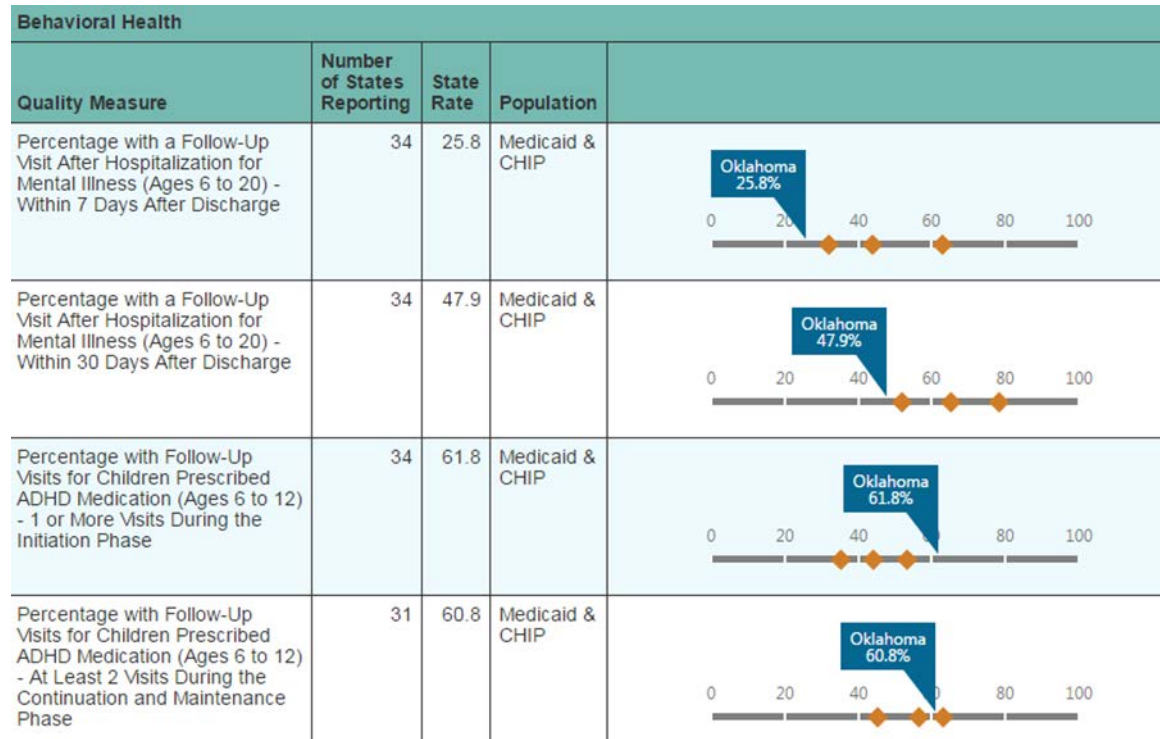


Several stakeholders said that the quality and amount of mental health care for Tulsa children is constrained by a shortage of pediatricians and other mental health providers with training in specialty areas such as infant mental health and child treatment strategies. This shortfall in pediatric psychiatrists and others capable of properly diagnosing and treating the mental health needs of very young and school-age children is further compounded by a lack of bilingual providers for non-English-speaking families. One local child psychiatrist expressed concern that Tulsa-area physicians pathologize child behaviors by misdiagnosing them as attention or mood disorders. This key informant and several other stakeholders also reported that children with behavioral challenges often receive medication such as stimulants and antipsychotics instead of receiving more appropriate cognitive therapy or learning strategies for self-management. Other key informants said that parents need more support and education from professionals on navigating services, managing their children’s medications, and extending care regimens to treatments such as exercise and art therapy.

The mental health system has limited capacity to meet the needs of school-age children. High rates of mental illness and suicide among Oklahoma teens are made even more alarming by the known inadequacies in mental health services. For example, Oklahoma falls in the bottom quartile of reporting states on two important measures of behavioral health quality within Medicaid (figure 7). Less than 30 percent of children receive follow-up care within seven days of being discharged from a hospital stay for mental illness, and less than 50 percent are seen within 30 days of discharge. Very few inpatient beds in Tulsa are available to children and teens who require hospitalization—even to those who can pay for them—and the few beds that are available may be in jeopardy because of provider management problems.²⁹

FIGURE 7

Oklahoma Falls Short on Medicaid Behavioral Health Posthospitalization Quality Measures for Children
Medicaid child quality of care, Oklahoma, FY 2014



Source: US Department of Health and Human Services, *2015 Annual Report on the Quality of Care for Children in Medicaid and CHIP* (Washington, DC: US Department of Health and Human Services, 2016), <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2015-child-sec-rept.pdf>.

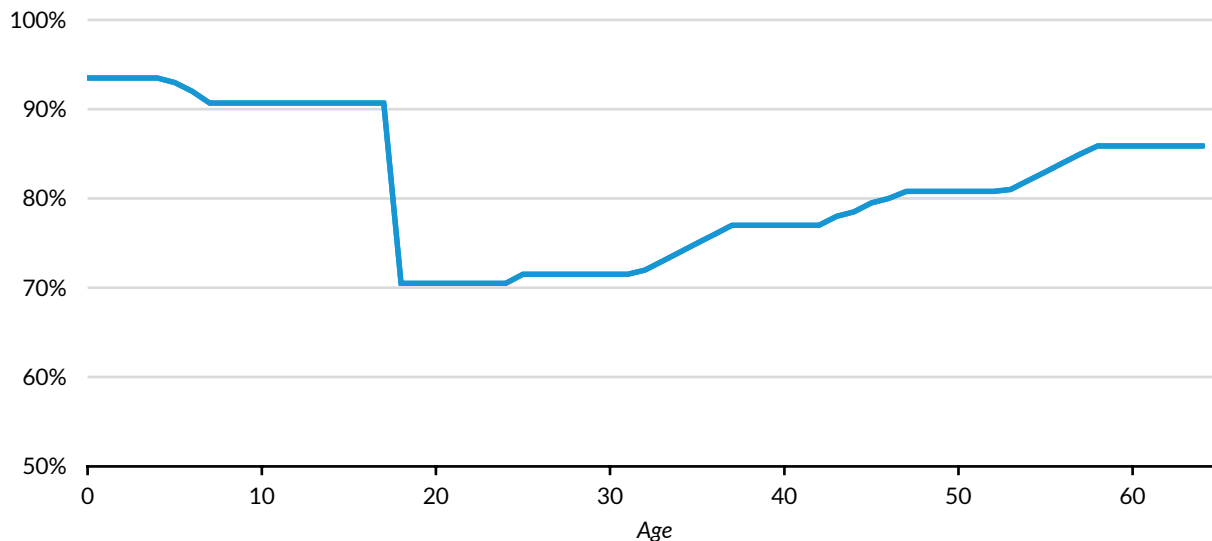
Note: From left to right, the diamonds on the scale represent the bottom, median, and top quartiles of reporting states.

Health insurance rates also drop off for youth at an age when many need behavioral health services for the first time. Vulnerable populations of children experience additional service inadequacies because of issues unique to the systems and funding streams serving them. Coverage drops off starting at age 18 for low-income teens, who may be at risk of carrying emerging mental illness into young adulthood; recall that about half of all mental illnesses first appear by age 14 and three-quarters by age 24.

FIGURE 8

Insurance Coverage among Tulsa Residents Is Lowest at Ages When Serious Mental Illness Is Most Likely to Emerge

Insured rates by age, Tulsa MSA



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Source: Urban Institute tabulation of 2011–15 American Communities Survey data for Tulsa MSA.

Supporting Prevention and Early Intervention for Children and Youth

Schools should be one of the first lines of prevention and early intervention for the mental health of school-age children. But many key informants said that Tulsa school staff of all levels—including principals, teachers, and school counselors—report being too overwhelmed and underresourced to perform this critical function. One key informant wanted schools to focus much more on preventive services, but said that bandwidth was a significant barrier: “Our schools are so busy putting out fires, there aren’t enough resources to address issues before they hit crisis levels, which is more reason to focus efforts on prevention.”

Tulsa Public Schools needs more support from the community to address the mental health and wellness of its students. The school system currently uses its Title I funding (supplemental funding that the US Department of Education provides to eligible local school districts) on counseling and coordination of mental health care for students. Several key informants agree that these arrangements are not well coordinated at the central office, and that the relationships between these providers and school staff are “tenuous at best.” Some schools and partner agencies have developed effective partnerships for on-site

treatment of students, but it is not systematic. In many cases, school counselors refer students to outside therapists with little connection or follow-up. The shortage of school-based mental health professionals is even deeper in rural school districts because these schools usually must use their Title I funding to supplement basic academic programs, leaving little to cover coordination and follow-up for student behavioral health needs.

A focus group with Teach for America teachers in Tulsa revealed similar themes:

- Teachers are not trained to deal with children who have mental health problems, but Teach for America teachers receive more training as part of their service requirements.
- School counselors don't counsel. They are not trained to do so or don't have the time to do so.
- Community resources for students and their families do not seem to be accessible to those in need.
- Income eligibility for SoonerCare excludes many families, and the cost of services without Medicaid is too high.
- Punishment is used too often to deal with mental health problems: "We should be looking to solve the root problems." "Kids with mental illness get labeled as bad kids."
- Class sizes are too big to effectively manage mental health crises.
- The stigma of mental illness keeps some teachers and administrators from addressing mental health problems appropriately.
- Students come to school traumatized from dysfunctional home environments that may include substance use, crime, parents with mental illness, abuse, and neglect. One teacher said, "Mondays are my worst days, after students come back from a weekend of trauma....Tantrums, fighting, biting, crying, and hitting are commonly seen after the weekend."

Parents and grandparents in the focus groups said that schools are the number-one problem they have in helping their children get and stay well. Interviewees cited untrained and uninformed teachers and counselors, inconsistent policies on issues such as behavior and attendance, and overcrowding in the classroom; these responses suggest that teachers and other school staff need more resources and training from the community to better support students. Family members lamented that school counselors are often unable to offer their children any direct help, but some parents praised school social workers for being helpful. Parents knew that schools have agreements with community mental health centers to provide direct care, but they said that this service is available only to children who qualify under Medicaid, which many families do not.³⁰

ONE IN THREE

OKLAHOMA CHILDREN

EXPERIENCES TWO OR MORE ADVERSE CHILDHOOD EXPERIENCES, SUCH AS ABUSE, NEGLECT, AND HOUSEHOLD DYSFUNCTION, BEFORE THE AGE OF 17.



Early intervention and prevention efforts can be used in many school, home, and community-based settings and by any child- or youth-serving agency or system, including pediatric care, arts and athletic programs, faith-based programs, summer youth employment programs, child protective services, and juvenile justice programs. A large and growing body of evidence points to the importance of multitiered systems of support within schools. Positive behavioral support refers to the application of behavioral analysis to achieve functional behavior changes, and positive behavioral interventions and supports (PBIS) are often based on functional behavioral assessments and involve long-term strategies designed to reduce inappropriate behavior, teach more appropriate behavior, and provide supports necessary for successful outcomes. When supported and implemented properly, PBIS set the

stage for schools to provide and connect students with other specific mental health services, such as structured psychotherapy for adolescents responding to chronic stress, mental health first aid, trauma-focused cognitive behavioral therapy, multisystemic therapy, and functional family therapy. Communities also need trained providers who are willing and able to deliver these services and strong partnerships between the school district, individual schools, and appropriate mental health providers.

PBIS started out as an alternative to traditional behavioral approaches for students with severe disabilities who engaged in extreme forms of self-injury and aggression. Now PBIS are used for all students in a school (known as tier 1 supports), for groups of students identified for more targeted prevention programs (tier 2), and for students identified for specific intervention (tier 3). These interventions can support children whose mental health needs are identified by pediatricians through increased screening. But they also require funding and staffing to allow school districts to partner with mental health providers in the community.

Some evidence-based programs in each of the three tiers are as follows:

- Tier 1, promotion/universal: Good Behavior Game, PATHS to PAX, Social and Emotional Foundations of Early Learning, Olweus Bullying Prevention
- Tier 2, prevention/selected: Coping Power, FRIENDS for Youth/Teens, The Incredible Years, Second Step, Social and Emotional Foundations of Early Learning, Devereux Center for Resilient Children resources, Strengthening Families Coping Resources workshops, PracticeWise
- Tier 3, intervention/indicated: cognitive behavioral intervention for trauma in schools, Coping Cat, trauma-focused cognitive behavioral therapy, interpersonal therapy for adolescents, PracticeWise

The research base for positive behavioral interventions and supports is still evolving, and Tulsa can learn from the experiences of other communities where efforts have been incomplete or short-lived. Key components for success include a formal implementation structure, the use of data and needs assessments to drive planning and activities, and strong connections between tiers of support. Many of the systems issues that affect children grow out of larger systems issues that affect Tulsans of all ages.

Efforts within schools to promote trauma-informed approaches (and mental health generally) can be a powerful lever for improving mental health. These efforts can also improve social competency, self-regulation, school attachment and attendance, and academic performance. Successful school-wide efforts can foster a positive school climate, prevent school violence, and lower dropout rates.

Bridging Research and Practice

Many elements of this report are drawn from national and state “what works” clearinghouses, reflecting careful reviews of rigorous studies of best, promising, or emerging practices. In some cases, cost-benefit analyses are also available to guide policy and program development. A listing of some of these useful resources is provided in the appendix.

ACTION AREA 1 STRATEGIES

The committee's recommendations for Action Area 1 are based on the potential of each strategy to increase and improve prevention and treatment services available to children and adolescents in their communities and schools. These preliminary strategies represent a first phase of effort in this important area of significant need. The committee suggests that, as the community learns more about what works and what doesn't for optimizing the mental health of Tulsa's children, these strategies be expanded to more directly cover the child welfare system (including foster care), runaway and homeless youth programs, before- and after-school programs, and youth development and summer programs. And because so many serious mental illnesses emerge during late adolescence and young adulthood, communities should add strategies to directly engage local colleges, universities, and career and technical education programs once school system strategies are finalized, under way, and bearing fruit.

1. Enhance community-based mental health supports for children, adolescents, and their families

Community-level prevention and treatment services for youth and their families are not sufficiently available and integrated throughout the Tulsa region. The community should investigate the successful Metropolitan Area Projects (MAPS) initiative in Oklahoma City for its potential to increase and improve community-based mental health facilities and services for families. See also the committee's recommendation to expand the CPC+ model in Action Area 3; this recommendation applies to integrating child and adolescent mental health and substance abuse consultants into pediatric practices.

2. Increase capacity at Tulsa-area substance use treatment facilities that serve children and adolescents

There is a serious shortage of substance use treatment services for children in the Tulsa region. The committee recommends that Tulsa stakeholders consider filling gaps in substance use disorder care for children and adolescents by increasing and enhancing services at Palmer Continuum of Care and Parkside Psychiatric Hospital & Clinic, which treat addiction issues and co-occurring mental illnesses.

3. Respond therapeutically to children who engage in juvenile crime

Children who are delinquent or commit crimes are often contending with trauma, abuse, or neglect and/or unattended mental illness. Much effort is needed to improve services for Tulsa's juvenile justice population and for special groups, such as girls who are sex-trafficked and children with traumatic brain injury. Often, parents also need therapeutic support. Tulsa stakeholders should respond with evidence-based strategies that are developmentally appropriate and can guide young offenders back into the

community or other recovery-oriented settings as soon as possible. The committee recommends that the Tulsa County Juvenile Justice Bureau be well supported to screen and treat all children under its care for mental health and addiction issues, and that the bureau have well-trained professionals on site to support children’s mental health needs and help reduce the rate of suicide attempts among children in custody.

4. Have at least one mental health specialist in each school district

Schools throughout the Tulsa region do not offer sufficient in-school prevention and treatment services, and care for students is poorly coordinated, especially at the district level. Each school district should have a mental health specialist responsible for overseeing the expansion and improvement of mental health services and supports for all students.

5. Adopt evidence-based and trauma-informed mental health programs for all students throughout schools in the Tulsa region

Most schools in the region do not have enough mental health supports for students. Tulsa-area stakeholders, especially school district superintendents, should focus on working with community-based and other partners to bring in evidence-based prevention models, such as the Good Behavior Game for younger students, positive behavioral interventions and supports for older students, and school-wide trauma-informed care for students of all ages.

6. Establish regular case consultation between school staff and multidisciplinary treatment teams through telehealth technology

Schools need more support for intervening with students who have behavioral health conditions. Extension for Community Healthcare Outcomes (ECHO) uses telehealth technology to provide health care to rural and underserved communities. Plan stakeholders should connect relevant staff at all public schools in the region to Project ECHO resources such as the interdisciplinary team at the Oklahoma State University Center for Health Sciences, which currently hosts ECHO sessions in psychiatry.

How to Measure Success

The community may want to consider these additional measures: teen suicide and overdose rates across the region and in specific settings, rate of pediatric behavioral health screenings, number of adolescents experiencing a major depressive episode, reductions in suspensions and use of seclusion/restraint in schools, and reductions in the number of juvenile offenders in custody over time.

Action Area 2. Strengthen Community-Based Services/Supports

The importance of primary care and behavioral health care for people living with mental health and/or substance use disorders cannot be understated. These services are critical to a healthy population and require explicit attention in policy and practice. The integration of primary and mental health care is the focus of Action Area 3, and building a well-trained behavioral health workforce is the focus of Pillar 1 in the overarching framework.

Less appreciated and understood is the critical importance of nonclinical behavioral health supports and services in the community. These are not only essential to good population health and mental health, but they are also often needed to support the effectiveness and success of core clinical services, including medications and counseling. Communities need a range of prevention and early intervention services, especially for children and youth (see Action Area 1), as well as supports for people in recovery. A person living with a mental illness or substance use disorder needs a home (a stable and safe place to live), a purpose (meaningful daily activities, such as school or a job, volunteering, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society), and a community (relationships and social networks that provide support, friendship, love, and hope).

Not everyone living with a mental illness or substance use disorder needs extra supports in one or more of these areas, but many do, at least at some point in their lives. In communities across the country, many types of support services have been developed, and many have been found essential to ensuring that individuals and families are stable, empowered, and socially and economically productive. Some programs and services that fall into this area of the continuum are assertive community treatment (ACT), patient education and illness self-management, family education, integrated treatment of co-occurring disorders, peer services and peer-run services, supported housing, and supported education and employment.

Although Tulsa has community support programs for people with mental illness, these programs are piecemeal, not widely known, and not adequately funded. Strengthening these services and supports (i.e., scaling and spreading strong programs and developing new ones as appropriate) can reduce behavioral health crises, support recovery, improve lives, and reduce costs. This requires not only that the services and supports be in place and available, but that people know about them (or know how to learn about them) and can access them when they need to.

Strengthening referral networks and providing trainings in mental health first aid and peer supports equips the community with basic knowledge about how to identify and respond to mental health warning

signs and crises. Mental health first aid is an eight-hour training program that builds a network of people willing and able to identify early warning signs and help when a crisis is imminent. Tenets of mental health first aid include monitoring risk of harm, actively listening, providing resources and reassurance, referring people to appropriate professionals, and providing self-help strategies (Kitchener and Jorm 2004). The evidence base is mixed and still evolving, but randomized control trials and other studies have demonstrated that mental health first aid training courses achieve some key outcomes, including increased knowledge about mental health, increased confidence providing help, and increased provision of help (Wong, Collins, and Cerully 2015). CREOKS and the Oklahoma State University Center for Health Sciences are among several Tulsa-area providers with staff who are trained to teach mental health first aid.

In addition to its small mental health first aid program, Tulsa has other component services to respond to crises and to direct people experiencing mental illness to appropriate sources of help. These services include crisis intervention team (CIT) training for police and other first responders, community support teams, and mobile crisis response teams such as COPEs, which is operated by Family & Children's Services. The community also has the CALM Center, which provides immediate support, assessment, and stabilization for youth ages 10 to 17. The university system provides support through pilot programs such as Community Assistance, Referral, and Education Services (CARES), a partnership between the Tulsa Fire Department, Mental Health Association Oklahoma, and the University of Oklahoma Anne and Henry Zarrow School of Social Work that embedded master's level social work practicum students within the Tulsa Fire Department to work on the front line with first responders to rapidly assess patient needs and initiate social supports. These and other community-based services are designed to address the needs of high utilizers of emergency services, freeing up emergency rooms and fire and EMS personnel to respond to other emergencies more appropriate for their services.

Peers and peer supports are essential to a strong community-based mental health system. Peers have several advantages over professionals in addressing mental health crises because they are often more approachable and have personal experience with recovery. A peer support network is considered vital to prevention, recovery, and ongoing wellness. Mental Health America is designing a standardized certification for National Certified Peer Specialists with the goal of making these specialists a regular part of mental health care and recovery services. Like mental health first aid, peers can reinforce and amplify the work of mental health professionals. They also help with advocacy, goal-setting, mentoring, modeling, relationship-building, group facilitation, and, in some situations, case management and crisis de-escalation. Mental Health Association Oklahoma's peer outreach services and Crossroads Clubhouse are two successful peer support networks in Tulsa.

Diversion programs such as Re-entry Intensive Care Coordination Teams help to place people living with mental illness who were previously incarcerated in a supportive environment upon reentry by linking

them to peer supports and supportive community services. Some day centers and temporary housing centers also seek to establish peer networks and permanent supportive housing for people living with mental illnesses or substance use disorders.

A small number of people with serious mental illness in Tulsa benefit from comprehensive, locally based treatment provided by the CO-PACT teams of Family & Children’s Services and the OU IMPACT Team sponsored by the University of Oklahoma School of Community Medicine. These assertive community treatment (ACT) models allow people living with persistent serious mental illness to receive care from a multidisciplinary psychiatric team wherever one may be found. Key components of the model are outreach, delivery of services in the community, holistic and integrated services, and continuity of care from an interdisciplinary team that spans psychiatry, social work, nursing, substance use, and vocational rehabilitation. ACT teams also increasingly focus on recovery, shared decisionmaking, outcome-based supervision, strengths-based treatment planning, and the use of generic community resources. Several studies have shown ACT to be effective in reducing hospital use and increasing time spent in the community; other positive outcomes include improvements in stable housing, symptom management, and quality of life (Bond and Drake 2015).

OVER
85%

OF PEOPLE WITH MENTAL
ILLNESS IN TULSA ARE NOT
WORKING.



Many people with serious mental illness can be permanently integrated into communities and neighborhoods using long-term supports in housing, education and training, and employment. Access to decent affordable housing and gainful employment are important goals for everyone, not just people with mental illness. Stable housing is a prerequisite for successful treatment and recovery. Supportive housing links decent, safe, affordable, community-based housing with flexible, voluntary support services designed to help the individual or family stay housed and live a more productive life in the community. Likewise, supported employment and supported education programs emphasize structured environments, skill-building, and as much autonomy and independence as a participant is capable of. These models often build in ongoing peer support. Like Housing First, the Individual Placement and Support (IPS) model for supported employment has a large well-established evidence base and should be available to Tulsans who want to work.

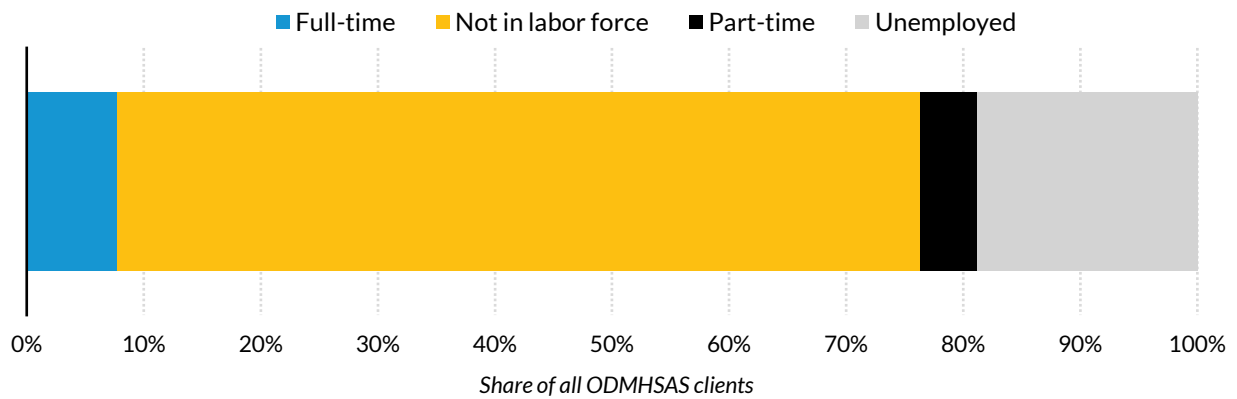
Tulsa can do much more to leverage the talent, skills, and productivity of its citizens living with mental illness. Almost 90 percent of Tulsans with serious mental illness are unemployed or not in the labor force (see figure 9), even though studies show that three in four people with serious mental illness desire paid employment (Drake et al. 1996) and that being a productively engaged and valued member of the larger

community is important for long-term stability and well-being. One interviewee with mental illness wanted the “chance to get education so that maybe I can get a job. I get tired of just sitting around all the time. I want to make money, to be a part of this world.”

FIGURE 9

Most People Receiving Public Mental Health Services Are Not in the Labor Force

Employment status of ODMHSAS clients, Tulsa MSA, 2015



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Source: Urban Institute analysis of 2015 ODMHSAS data.

Note: ODMHSAS = Oklahoma Department of Mental Health and Substance Abuse Services.

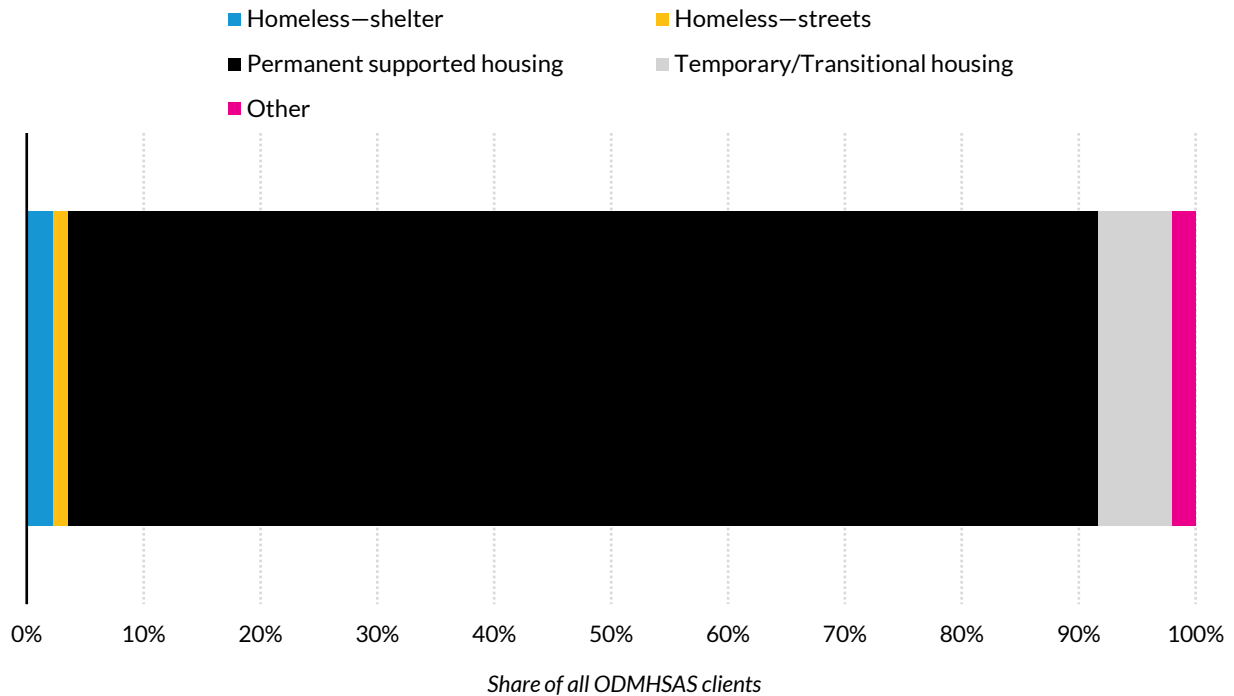
As shown in figure 10, most Tulsans with serious mental illness who are served by the public system are permanently housed. This is largely thanks to the efforts of Mental Health Association Oklahoma and A Way Home for Tulsa, a collaboration of housing and service provider partners, which uses a Housing First approach to address the needs of people with mental illness who are homeless, including special populations such as veterans.

But there are still significant gaps in housing for people with mental illness. Several stakeholders expressed concern that people with moderate mental illness and/or co-occurring disorders have little access to housing supports, much less to treatment and community-based supports. And people with felony convictions are hard to house because of regulatory barriers, leaving them and the surrounding community in a precarious position. Affordability and eligibility rules create barriers to early intervention; they often require a person’s situation to get far worse before more cost-effective, longer-term supports can be offered.

FIGURE 10

Most People Receiving Public Mental Health Services Are Permanently Housed

Housing status of ODMHSAS clients, Tulsa MSA, 2015



URBAN INSTITUTE

Source: Urban Institute analysis of 2015 ODMHSAS data.

Note: ODMHSAS = Oklahoma Department of Mental Health and Substance Abuse Services. “Other” includes nursing homes, residential care, and institutional settings.

Community-based services and supports can also educate, inspire, and empower community members around the issues of mental health and wellness. People living with a mental illness or substance use disorder continue to face misinformation, stigma, and discrimination, even from well-intentioned institutions and community members. One Tulsan said that the public seems to “look at mental illness as a choice I made.” Another said that he “doesn’t take the bus anymore because when I have an outburst from time to time, people stare at me and move away....On more than one occasion, the driver asked me to get off.” Stigma and ignorance are powerful barriers to recovery and can undermine the effectiveness of even the most well-designed and funded service and support systems. Tulsa must encourage stronger civic engagement, public education, and political will around mental and behavioral health. This work can be rewarding and inspiring. It can and should touch every sector of the community, including people from business, faith-based, education, science and technology, arts and culture, and local nonprofit groups.

ACTION AREA 2 STRATEGIES

The committee identified the following preliminary strategies for Action Area 2 based on their potential to maintain people with serious mental illness in their homes and neighborhoods and to improve their quality of life and cut public system costs. The strategies discussed under Action Area 2 concern supports in very accessible community-based locations, rather than in clinical settings such as doctor's offices, clinics, and hospitals. Strategies for clinical settings are discussed under Action Area 3, "Integrate Mental Health into the Health Care System."

1. Create a patient and provider navigation hub for behavioral health services

Many consumers of mental health services, including patients and the professionals who serve them, are unsure about where to go for help before or during crisis. Tulsa should work with the Route 66 Coalition, Sooner Health Access Network, the Oklahoma State University Health Access Network, and other coordinating entities to enhance the 211 phone line for behavioral health, employing mental health professionals to field calls from the public, schools, clinicians, and others who need help with mental health and substance abuse concerns in real time. This 24/7 triage, navigation, guidance, referral, and coordination hub for behavioral health services would direct callers to appropriate service providers and sites with current openings, work with existing crisis response systems (e.g., 911, COPES) to ensure that people receive postcrisis integrated care navigation, and connect people to psychopharmacology and substance use disorder treatment resources and other relevant physical health and social services. If necessary after the hub has been in operation for a while, a physical (or mobile) navigation and coordination hub with multiple services colocated and available on a walk-in basis could be considered, especially in parts of the community that are unable or unwilling to use existing programs and clinics.

2. Link peer navigators to patients receiving acute mental health care services

People who are in recovery from mental illness and have training in care navigation can be a source of information and compassion for patients and families in crisis. The community should work with entities such as MHAOK to ensure that these navigators can reach citizens receiving acute mental health care services, starting with people who come through the recommended navigation hub for help.

3. Support the emerging Tulsa County Assessment Center and create a community response team

The inefficient and inappropriate application of fire, EMS, and police services to mental health crises is a costly problem for both people experiencing mental health problems and Tulsa taxpayers. The Tulsa County Assessment Center is designed to help triage cases for first responders, diverting people who would otherwise go to jail or consume the time and resources of medical and paramedical personnel with nonemergency needs. With navigators on site, the center will provide priority-of-needs assessments and assistance as well as warm hand-offs to community-based resources including shelter, food, medical/mental health, and transportation (but not case management or beds). The committee recommends that stakeholders also form a community response team made up of fire, police, and COPES professionals who can meet and divert clients to more appropriate settings. The committee recommends that the Assessment Center and community response team be linked to the navigation hub, partnering to conduct data collection and analysis aimed at reducing service duplication and stabilizing frequent users of emergency services.

4. Expand overdose education and naloxone distribution

Tulsa can bring down its overdose death rate by expanding overdose education and naloxone distribution. Consistent with several recommendations made recently by the Oklahoma Commission on Opioid Abuse, the committee recommends that stakeholders explore how these interventions can be woven into the practices of community-based settings and providers who come into regular contact with people who have addiction disorders.

5. Expand Tulsa's programs of assertive community treatment to target certain populations

PACTs are an effective way to stabilize people with serious mental illness in their homes and neighborhoods. The committee recommends that stakeholders expand Tulsa's existing PACTs to provide care to more people from high-priority populations, such as young people who have recently experienced first-break psychosis and patients who experience co-occurring substance abuse.

6. Scale up existing high-quality community supports for behavioral health

The Tulsa region offers many strong behavioral health services, but not enough to meet the need. Stakeholders should work with the Route 66 Coalition to assess and close the gaps between supply and demand and to increase geographic coverage for the region's existing high-quality supports: Community Oriented Psychiatric Emergency Services (COPES), the Crisis Care Center at Family &

Children's Services, the CALM Center for Children at Counseling & Recovery Services, and the Mobile Integrated Health Team of MHAOK.

7. Scale up and add supported education and employment services

Tulsans who experience mental health problems need and want to be engaged in productive activities and gainful employment. The committee recommends that stakeholders scale up and build upon Tulsa's small supported-employment models, such as Crossroads Clubhouse. This strategy presents a powerful opportunity to engage local business, workforce development, and economic development leaders and to explore evidence-based models such as Individual Placement and Support (IPS).

How to Measure Success

The community may want to consider these additional measures: number of mental health-related emergency room visits, reduced hospitalizations, decreased use of crisis services by frequent users of emergency services, and readmission to inpatient care within 30 days of discharge.

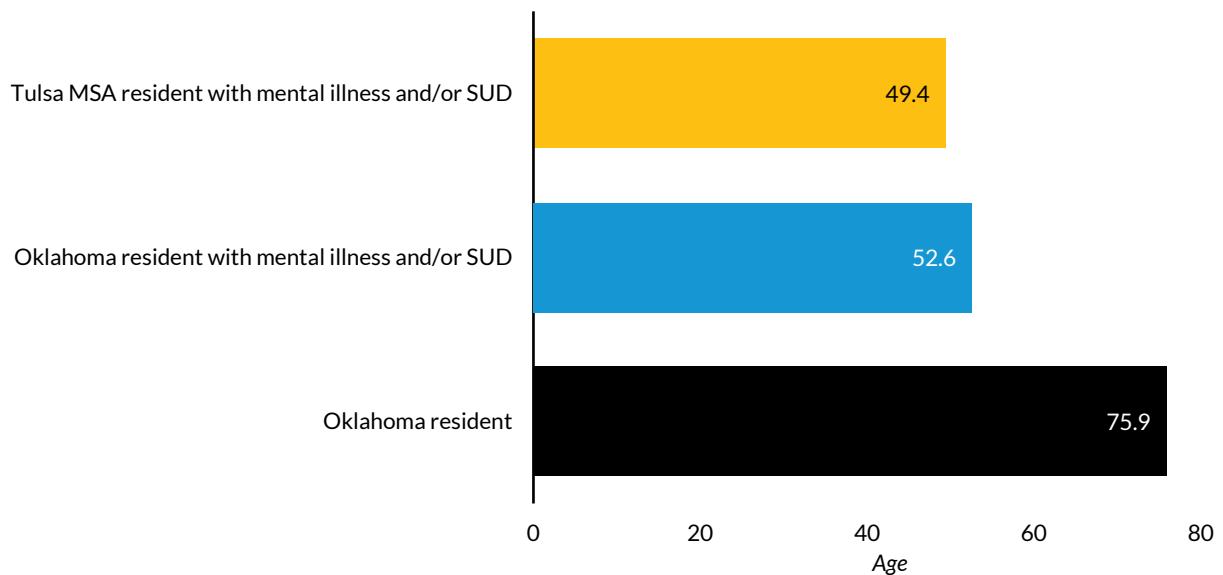
Action Area 3. Integrate Mental Health into the Health Care System

Life expectancy is a sentinel indicator of human health and well-being, and the low survival rates of Tulsans living with mental illness are shocking by any standard. The average life expectancy at birth in Oklahoma is 75.9 years, but clients of the state’s public mental health service system can expect to live an average of only 52.6 years (figure 11). In other words, Oklahomans with a mental illness and/or substance use disorder die an average of 23 years earlier than all Oklahomans. In greater Tulsa, this mortality gap is even larger: public mental health clients in Tulsa have a life expectancy of only 49.4 years, which makes for a 27-year gap with all Oklahomans.

FIGURE 11

Life Expectancy for Tulsans with a Mental Illness and/or Substance Use Disorder Is 27 Years Lower Than That for All Oklahomans

Average age at death, 2004–13



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Source: Oklahoma Department of Mental Health and Substance Abuse Services, based on data from state vital statistics and ODMHSAS clients between 2004 and 2013.

Notes: SUD = substance use disorder. Residents “with mental illness and/or SUD” are those who received at least one service funded by the Oklahoma Department of Mental Health and Substance Abuse Services between 2004 and 2013.

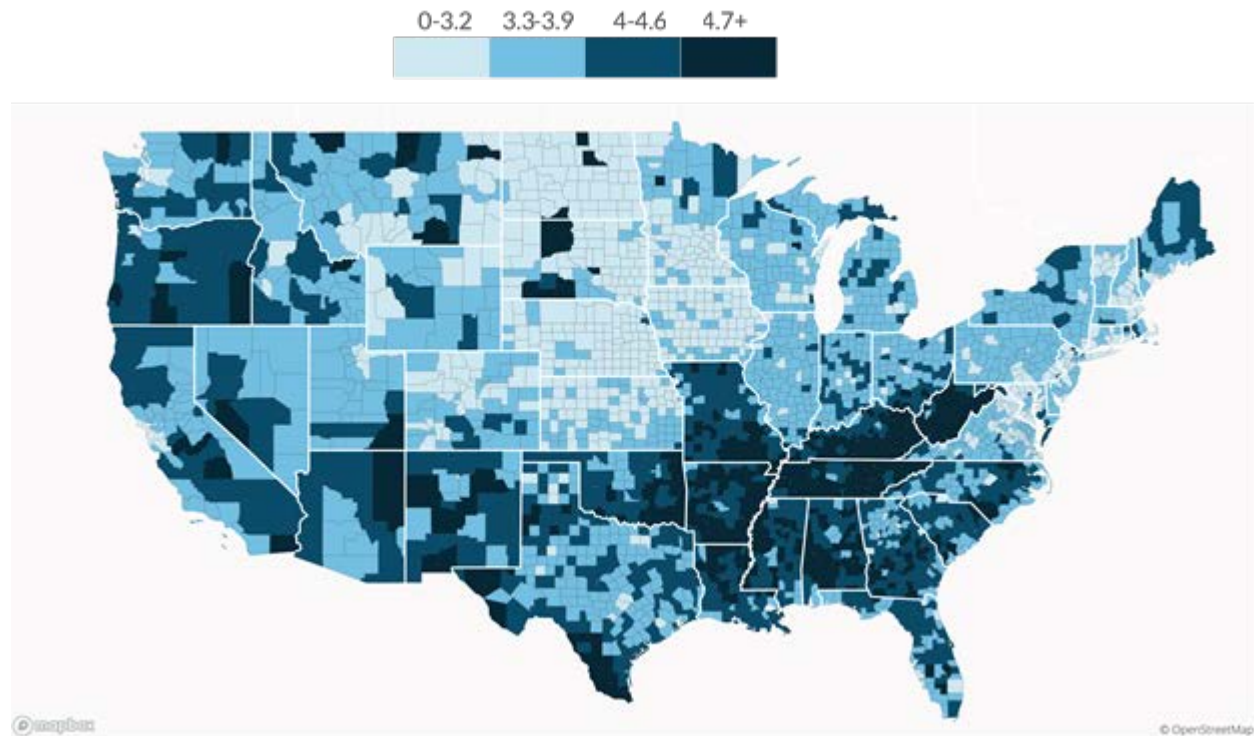
This “mortality gap” for people with a mental illness and/or substance use disorder is about the same as that observed almost two decades ago, suggesting that there has been no progress since then (Colton and Manderscheid 2006; Mauer 2006). Why do people with serious mental illness die so young?

Poor physical health is part of the answer; it is closely linked to mental health. Indicators of physical well-being show that in most parts of Oklahoma, including greater Tulsa, citizens are unwell. Figure 12 shows the average number of poor physical health days (in the past month) by county in the United States. In almost all (66 out of 77) of Oklahoma's counties, the average number of poor physical health days was greater than four.

FIGURE 12

Oklahoma Has High Rates of Poor Physical Health

Poor physical health days, 2015



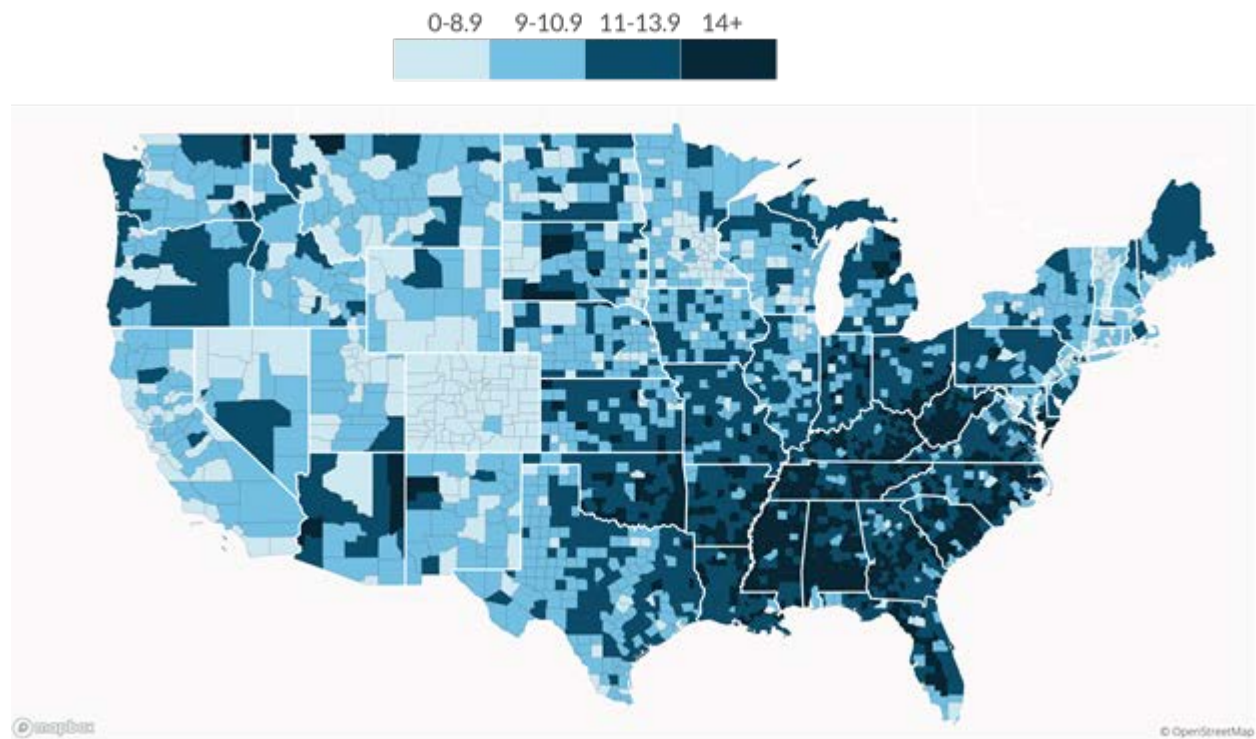
Source: 2015 data from Behavioral Risk Factor Surveillance System.

Poor health outcomes are seen in many other measures as well. Figure 13 shows that in 2015, all but five counties in Oklahoma had a diabetes prevalence rate above 11 percent. Similar patterns emerge in disease prevalence and mortality rates targeted by Healthy People 2020: Oklahoma's mortality rates per 100,000 for strokes (43.0 vs. 37.6), coronary heart disease (144.2 vs. 97.2), and chronic obstructive pulmonary disease (182.6 vs. 115.1) are higher than the national average.³¹ And on a broad set of health and health-related indicators, America's Health Rankings ranked Oklahoma 43rd out of all states; on health outcomes only, the state ranked 45th (UHF 2017).

FIGURE 13

Oklahoma Has High Rates of Diabetes

Diabetes prevalence, 2013



Source: CDC Diabetes Interactive Atlas.

Achieving and maintaining good physical health can be even more challenging for people living with mental illnesses or substance use disorders. Although low survival rates among this group are often thought to be because of suicide and violence, many other factors are involved (see box 1). Compared with the general population, people with mental illness are more likely to have chronic illnesses, such as heart disease and type 2 diabetes, and risk factors known to contribute to these illnesses (e.g., smoking, overweight and obesity, lack of moderate exercise, high alcohol consumption, and poor diet). Other risk factors include social determinants of health, such as poverty, food insecurity, homelessness, social isolation, and limited access to medical care, and the negative physical side effects associated with certain drugs, especially second-generation antipsychotics (Newcomer 2007).

BOX 1

Premature Death among People with Severe Mental Illness

On average, the life expectancy of patients with serious mental illness is 10 to 25 years lower than that of the general population. The gap in Tulsa is at the higher end of this range. The World Health Organization has identified several factors that contribute to premature death among people with severe mental disorders:

- The vast majority of these deaths are from chronic physical medical conditions such as cardiovascular, respiratory, and infectious diseases; diabetes; and hypertension. Suicide is another important cause of death.
- Depression is associated with a 1.8 times higher risk of death.
- People with severe mental illness do not receive the same quality of physical health care as the general population does.
- Most deaths of patients with severe mental illness from physical medical conditions could be prevented with more attentive checks for physical illness, side effects of medicines, and suicidal tendencies.
- Interventions can improve the mental and physical health of people with serious mental illness. Patients with severe mental disorders need better access to quality care and better diagnosis and treatment of coexisting physical conditions. The integration of mental and physical health care could facilitate this.

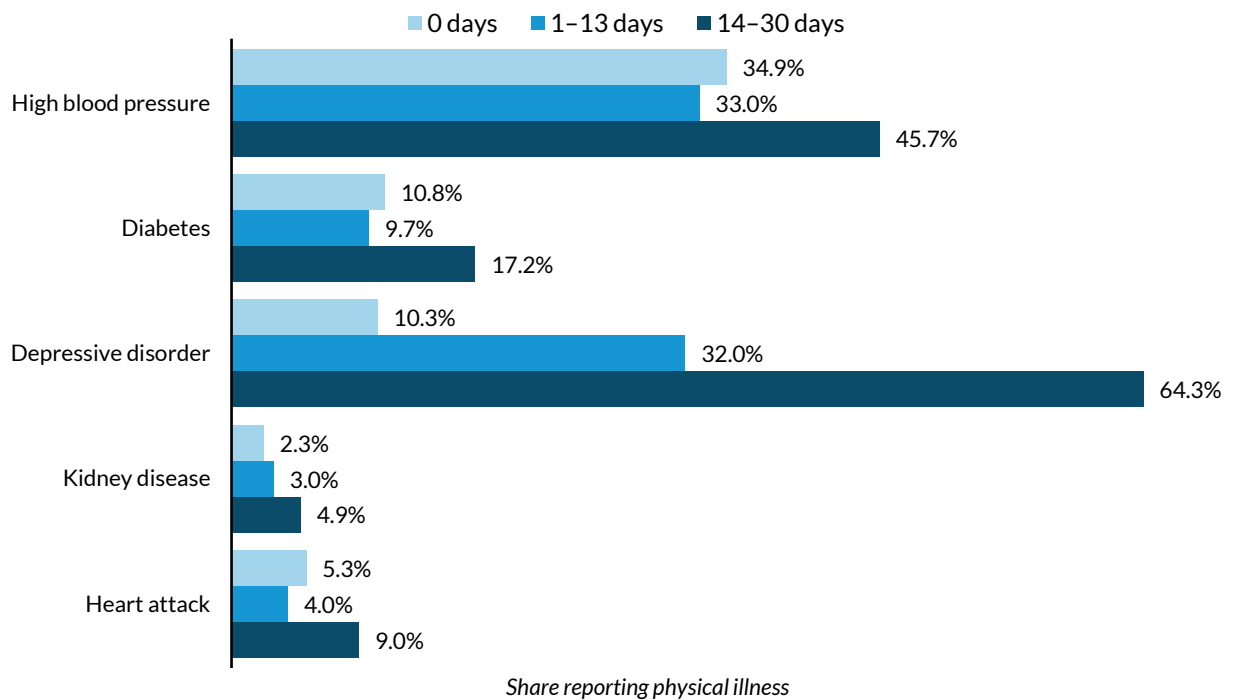
Source: Adapted from World Health Organization, "Premature Death among People with Severe Mental Disorders," http://www.who.int/mental_health/management/info_sheet.pdf.

Within Tulsa, people with mental illness are clearly more susceptible to many physical health conditions (figure 14). From 2011 to 2015, for example, Tulsans who reported 14 or more poor mental health days were 77 percent more likely to report having diabetes than those who reported 1 to 13 poor mental health days.

FIGURE 14

Poor Mental Health Is Correlated with Physical Illnesses

Prevalence of physical illnesses by number of poor mental health days, Tulsa County, 2011-15



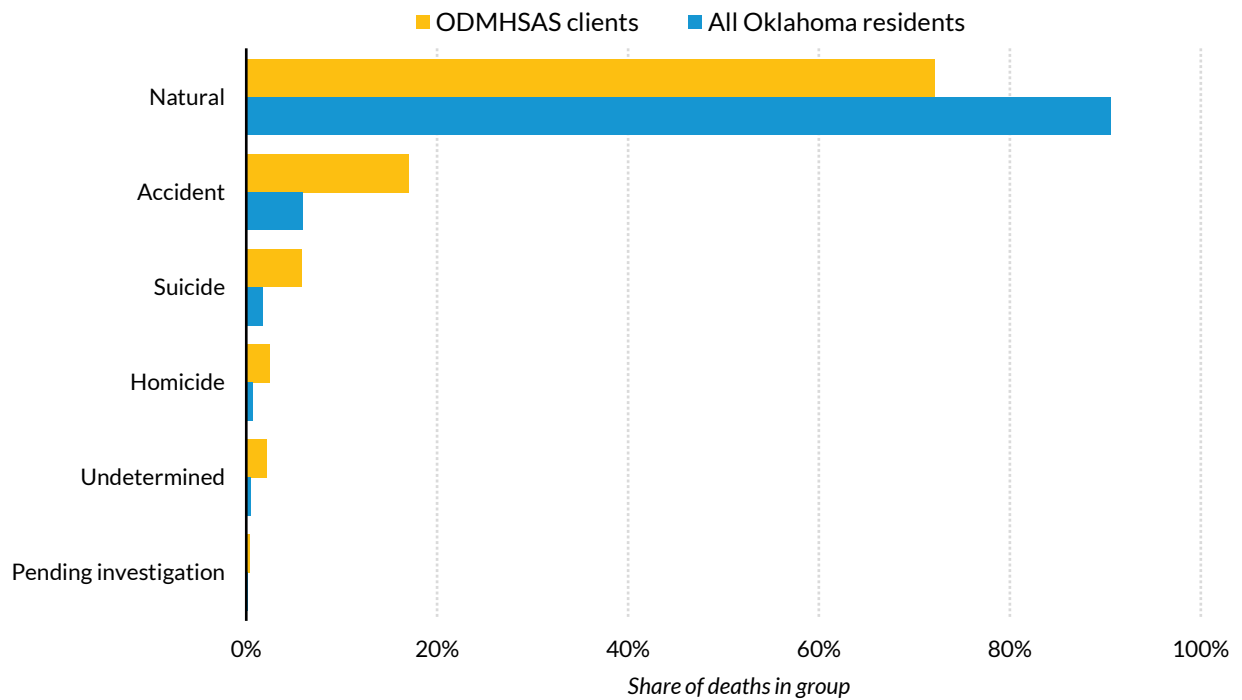
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Source: 2011-15 data from the Oklahoma State Department of Health OK2SHARE Service databases (<http://www.health.state.ok.us/stats/>).

Oklahomans living with a mental illness or substance use disorder are three times more likely than all Oklahomans to die from accidents, suicides, and homicides (see figures 15 and 16). Although most deaths among people with mental illnesses or substance use disorders are from natural causes, people with mental illnesses or substance use disorders are much more likely to die from other causes. As figure 15 shows, they are almost 3.0 times as likely to die from an accident, almost 3.5 times as likely to die by suicide, and more than 3.5 times as likely to die by homicide.

FIGURE 15

Oklahoma Public Mental Health Clients Are More Likely to Die from Accidents, Suicides, and Homicides



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Source: Analysis of 2017 vital statistics and public mental health client data from the Oklahoma Department of Mental Health and Substance Abuse Services.

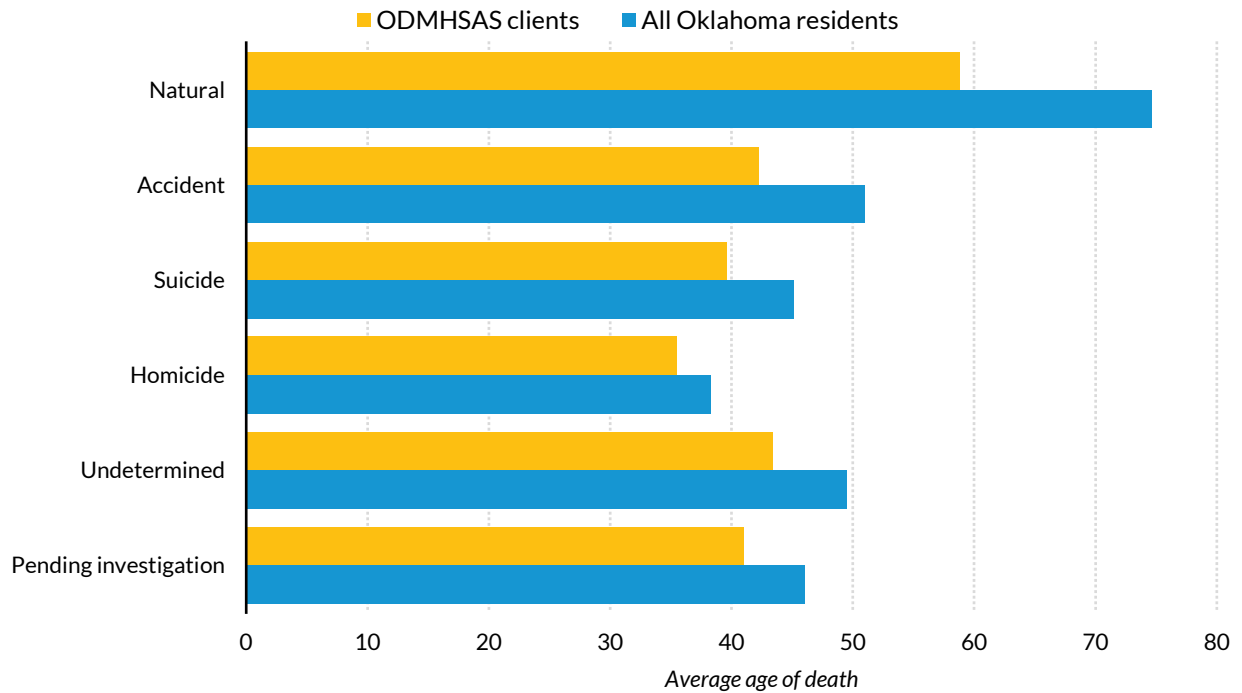
Note: ODMHSAS = Oklahoma Department of Mental Health and Substance Abuse Services.

These higher death rates are reflected in lower average ages at death (figure 16). Compared with all Oklahomans, people with mental illnesses or substance use disorders die much younger, on average, from every cause of death.

FIGURE 16

Oklahoma Public Mental Health Clients Are Dying Earlier across All Causes of Death

Average age of death by various causes, Oklahoma, 2016



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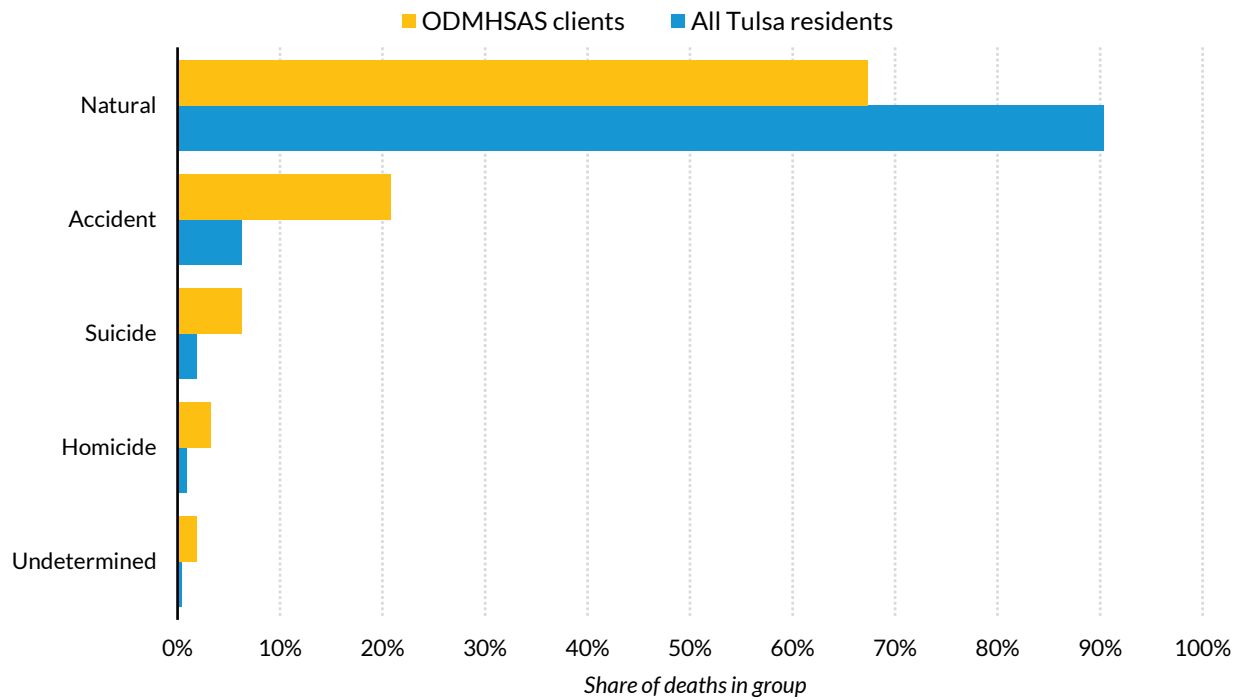
Source: Analysis of 2017 vital statistics and public mental health client data from the Oklahoma Department of Mental Health and Substance Abuse Services.

Note: ODMHSAS = Oklahoma Department of Mental Health and Substance Abuse Services.

Tulsa also has significant gaps in the rate of death by accident, suicide, and homicide. As figure 17 shows, public mental health clients in Tulsa are 23 percentage points less likely to die from natural causes than all Tulsans. Over 20 percent of all deaths among these clients are because of accidents, and over 6 percent because of suicides.

FIGURE 17

Tulsa Public Mental Health Clients Are More Likely to Die from Accidents, Suicides, and Homicides



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Source: Analysis of 2017 vital statistics and public mental health client data from the Oklahoma Department of Mental Health and Substance Abuse Services.

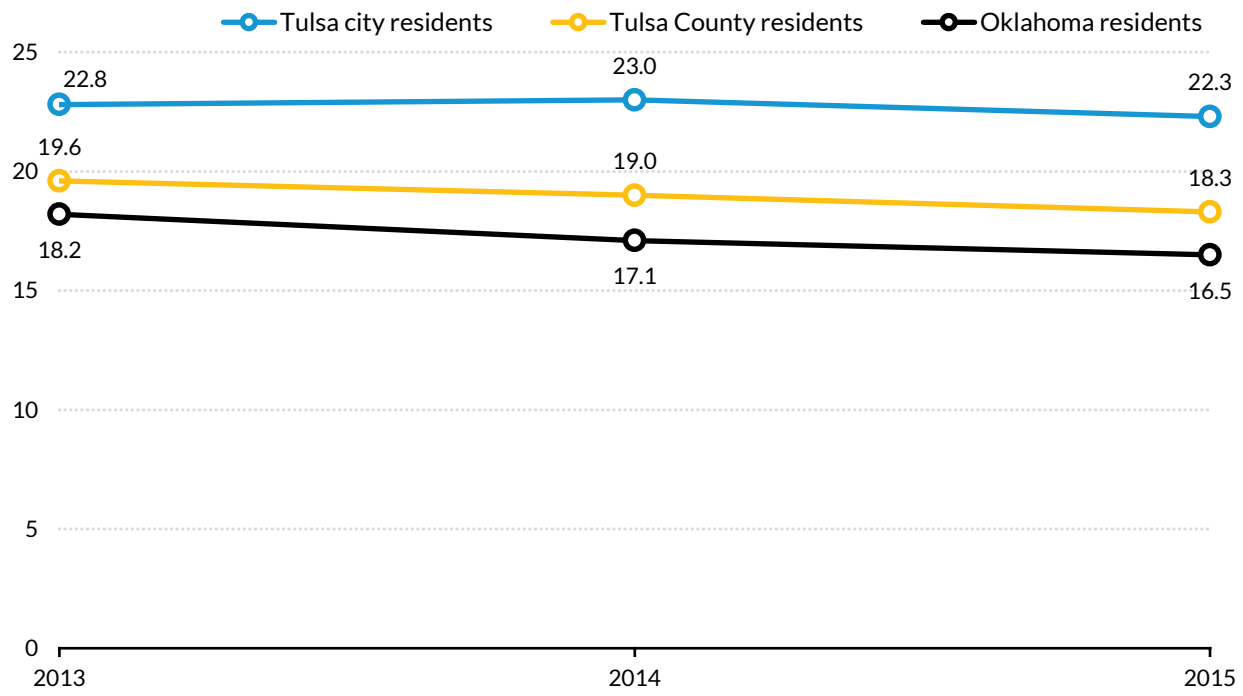
Note: ODMHSAS = Oklahoma Department of Mental Health and Substance Abuse Services.

Drug deaths, many of which are likely part of the nation’s larger opioid and drug epidemic, seem to be driving down life expectancy among people with mental illness. The numbers for the Tulsa region are particularly startling. As figure 18 shows, the rate of unintentional drug overdose deaths in the city and county of Tulsa are substantially higher per 100,000 than elsewhere in Oklahoma, and the state rate is high compared with the rest of the nation.

FIGURE 18

Unintentional Drug Overdoses Are Higher in Tulsa Than in the Rest of Oklahoma

Unintentional drug overdoses per 100,000 residents, 2016



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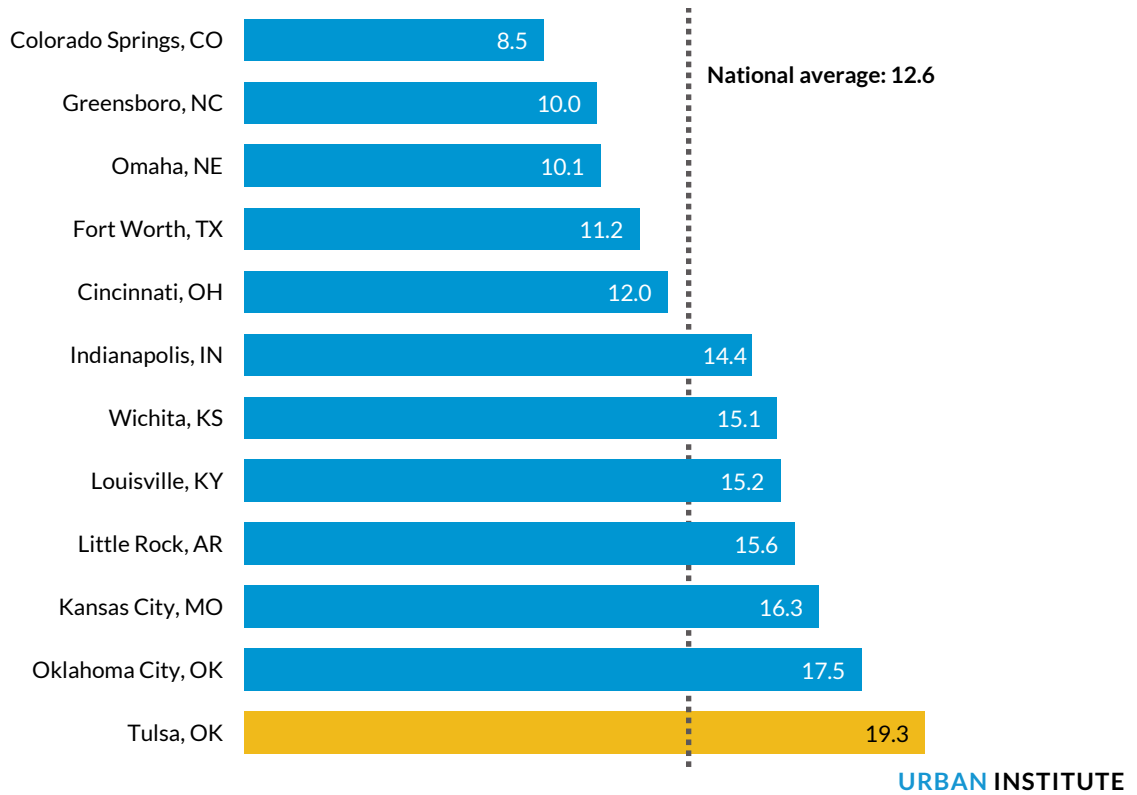
Source: Data from the Oklahoma State Department of Health Injury Prevention Service’s Fatal Unintentional Poisoning Surveillance System.

Suicide rates are also high in Tulsa, even though suicides from drug intoxication are underreported nationally (Rockett et al. 2018). In Tulsa, six more people die from suicide per 100,000 than the national average, and Tulsa County has the highest suicide rate among a group of comparable peer counties across the nation (figure 19).

FIGURE 19

Suicide Rates Are Higher in Tulsa Than in Peer Counties

Suicide rate per 100,000, 2010-15



Source: National Vital Statistics System data.

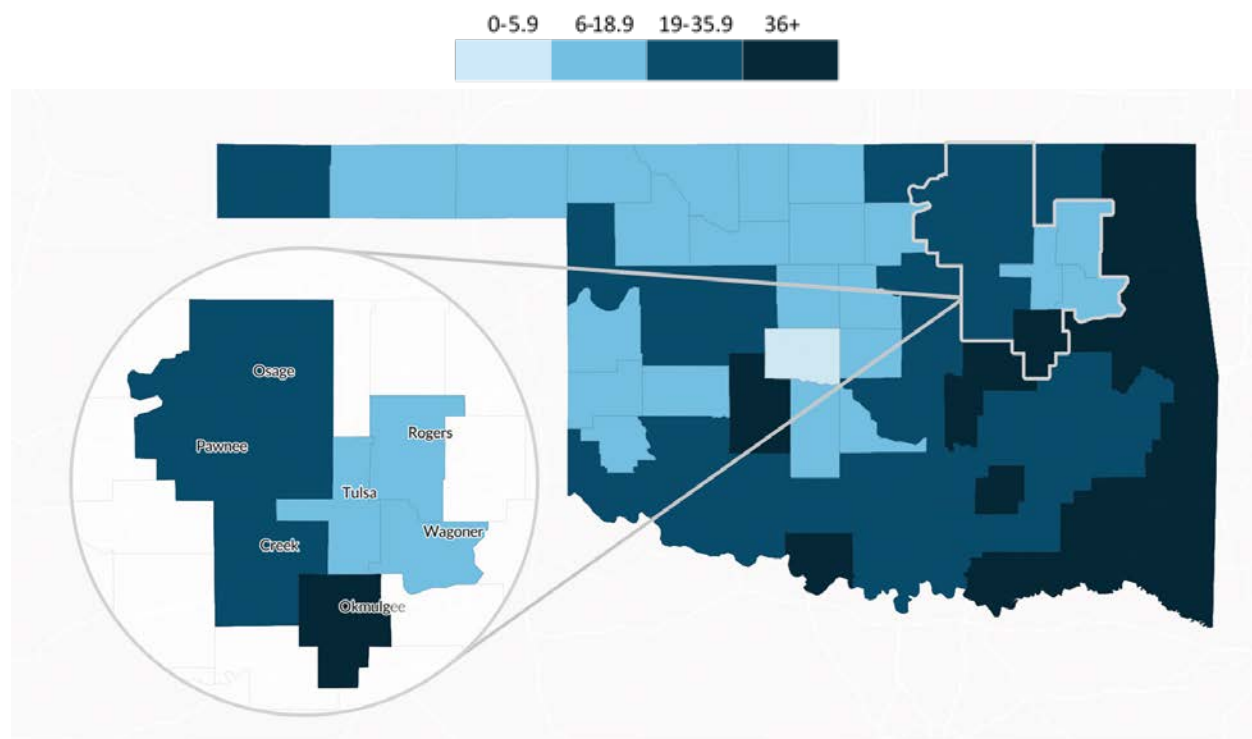
Note: Age-adjusted mortality rate from suicide per 100,000 residents.

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FIGURE 20

Most Counties in Greater Tulsa Have High Rates of Drug Overdose Deaths

Drug overdose deaths per 100,000, 2013–15



Source: CDC WONDER mortality data.

Mental health and physical health are intimately linked. Many people living with behavioral health problems are also contending with other physical health problems, including many chronic conditions. The Tulsa Health Department’s 2016 Community Health Needs Assessment found that 18 percent of adults rate their overall health as fair or poor. The need to better integrate behavioral health care into primary care, including obstetrical/gynecological and pediatric care practices and settings, is now widely accepted. Different approaches and models for delivering and sustaining this integration are being developed, implemented, and studied nationally.

Integrated behavioral health care is an emerging field within the wider practice of high-quality, coordinated health care. It is a critical access point for all patients, allowing for early identification of illness and entry into treatment, as needed. In the broadest use of the term, “integrated behavioral health care” can describe any situation in which behavioral health and medical providers work together. The term can also be applied more specifically to the care a patient receives from a team of primary care and behavioral health clinicians working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental illness and substance

use disorders, health behaviors (and their contribution to chronic illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care use.

For Tulsans of all ages, integration of primary and behavioral health care provides a clear early entry point for professionals to identify symptoms of mental illness and refer a client to the appropriate services. Many Tulsa system stakeholders view lack of integration between primary health care and behavioral health care as a leading driver of poor life expectancy and other negative health outcomes. This lack of integration often leads to missed opportunities to initiate mental health care and reflects costly gaps in expertise. One key informant said frankly, “We see a lot of mental illness in the hospital, but we don’t understand how to diagnose or treat it. We gravitate toward medical illnesses that we do understand, such as heart disease, and ignore mental health, or medicate it into silence using non-evidence-based treatments. However, many mental illnesses promote longer stays in the ICU and/or the hospital. It would behoove us to do a better job treating these illnesses.”

Though more work is needed, Tulsa has already made a promising start on integrated primary and behavioral health care. From 2012 to 2016, Tulsa was one of seven regions that participated in the Comprehensive Primary Care Initiative, a demonstration program sponsored by the federal CMS Innovation Center to foster collaboration between public and private health care payers to strengthen primary care. Nationwide, the CPCI model enlisted 37 payers (including commercial insurance plans and state Medicaid agencies), 441 practices, and 2.8 million patients.³² Participating medical practices were given enhanced resources to better coordinate primary care for their patients.³³ In the Tulsa region, approximately 100 primary care practices and three payers—Blue Cross Blue Shield of Oklahoma, Community Care, and the Oklahoma Health Care Authority—participated in the CPCI. Under the CPCI model, providers receive a “shared savings” payment if quality standards are met and overall care use is reduced; some teams have behavioral health specialists and mental health screenings in addition to care managers, and this can be expanded to more clinics in the region. Most Tulsa participants integrated a case manager and a behavioral health care provider directly into their practice as a result of the pilot.

Today, Oklahoma is a statewide participant in the newly begun successor initiative to the CPCI called Comprehensive Primary Care Plus (CPC+), a five-year CMS effort to shift payers and primary care doctors to a “value system” based on patient outcomes. CPC+ expands the practice areas included in the pilot CPCI program and improves the payment model used in the pilot sites. MyHealth Access Network, an extensive coalition of health care organizations throughout Oklahoma, is serving as the convener for CPC+ by supporting implementation and data management for the primary care practices selected to participate.

Another promising experiment in integrated care is the Oklahoma Behavioral Health Homes Initiative, which targets Medicaid patients—both adults with serious mental illness and children with serious emotional disturbances—and links care provided through community-based providers to a range of clinical

primary and behavioral health care services, as well as individual and family support and referral to community and social support services. Tulsa-area Health Home participants include Family & Children's Services, CREEKS, Dayspring, Counseling & Recovery Services, OU IMPACT, and Youth Care of Oklahoma.

Despite these bright spots, Tulsa still has many gaps that hinder the health and survival of people with mental illness. Even within the Tulsa health care system, behavioral health care is fragmented, poorly coordinated, and limited. This applies to basic screening and prevention services; crisis services such as triage, stabilization, and short-term alternatives to hospitalization; and acute, intermediate, and long-term mental health care.

Different members of the community will have different needs at different times, but ideally the system should screen, identify, and support individuals and families as early as possible; prevent the incidence or mitigate the effects of mental illness and substance use; avert crises whenever possible and attend to them effectively when they do occur; and support recovery. The efforts undertaken in the other action areas will contribute to these goals, but efforts squarely in the health care system are also needed to ensure that people receive the right care in the right settings at the right times.

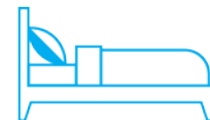
Behavioral health crisis services are a critical piece of the continuum of care. Every community needs them. Behavioral health crises can occur when someone with a mental illness or substance use disorder experiences severe problems with functioning, including sleeping, eating, or taking care of oneself; experiences confusing thoughts or delusions; and, in serious cases, becomes a danger to oneself (suicide) or others (homicide) or becomes severely disabled. This can happen when people experience a new mental health or substance use problem or when people in treatment stop taking their medications or otherwise drop out of treatment. In many communities, law enforcement agencies or emergency rooms end up managing behavioral health crises because there are few other options. But emergency rooms and jails are not designed to handle these crises, and the patients who cycle through these high-cost settings are rarely connected to the services and supports that will allow them to avert subsequent crises. Some communities are rethinking and redesigning their medical emergency room and community paramedicine services to better meet population health needs including behavioral health.

A more appropriate and better-designed set of crisis services provides safe, acute, time-limited crisis care (including respite and stabilization). The services are available 24/7, 365 days a year, and access is through a 24/7 call center, crisis mobile teams (for children and adults), specially trained emergency medical

ONLY
103

BEDS ARE AVAILABLE

TO PUBLIC MENTAL HEALTH CLIENTS.
THIS IS LESS THAN ONE-QUARTER
OF THE PUBLIC BEDS NEEDED IN
GREATER TULSA.



and law enforcement teams, and walk-ins. People in crisis are assessed and connected to settings including medical triage, sobering units, medical detox, or medical stabilization units (these units are supported by different medically appropriate teams of professionals and have different capacities and maximum stays). After discharge, individuals and families are given case management and navigation to acute and ongoing treatments and supports in the community.

There is no consensus in the field on how many public acute-care inpatient psychiatric beds communities need (and need also depends on other community support resources, such as ACT teams), but one common standard is 50 public beds per 100,000 residents (Aron et al. 2009). At 980,000 residents, greater Tulsa should have about 490 public psychiatric beds. As the table below shows, the vast majority of beds in Tulsa are private beds, and only 103 beds are available to public mental health clients (15 of these for children). This is less than one-quarter of the public beds needed in greater Tulsa.

TABLE 3
Psychiatric Inpatient Hospital Beds in Greater Tulsa Are Limited
Inpatient/Crisis mental health beds, Tulsa MSA

Facility name	Provider	City	Beds	Age	In ODMHSAS network?
Total beds			506		
Brookhaven Hospital	Brookhaven Hospital	Tulsa	64 ^a	Adult	No
CALM Center	Counseling & Recovery Services of Oklahoma	Tulsa	15 ^b	Child	Yes
Crisis Care Center	Family & Children's Services	Tulsa	16 ^b	Adult	Yes
Hillcrest Medical Center	Hillcrest Medical Center	Tulsa	14	Adult	No
Laureate Psychiatric Clinic and Hospital	St. Francis	Tulsa	75 15 ^c	Adult Child and adult	No
Parkside Psychiatric Hospital & Clinic	Parkside	Tulsa	15 36 20 ^d	Adult Child Child	No
Riverside Behavioral Health Center	Shadow Mountain	Tulsa	56 ^d	Child	No
Shadow Mountain Hospital	Shadow Mountain	Tulsa	24 36 48 ^d	Adult Child Child	No
Spring Creek Recovery Center	CREOKS Behavioral Health	Sapulpa	16 ^b	Adult	Yes
Tulsa Center for Behavioral Health	ODMHSAS	Tulsa	56 ^e	Adult	Yes

Source: Data compiled and verified by Dr. Gerard Clancy of the University of Tulsa, Parkside Psychiatric Hospital, and ODMHSAS.

Notes: ODMHSAS = Oklahoma Department of Mental Health and Substance Abuse Services.

^a Beds are split between psychiatric and neurological units.

^b Nonhospital crisis stabilization.

^c Swing beds for eating disorders.

^d Residential care.

^e Not a licensed hospital.

With psychiatric beds in such short supply, it is no wonder that Tulsa police are often forced to drive people long distances in search of a bed. In fiscal year 2016, for example, law enforcement officers in Tulsa County were called upon to make 1,960 transports of people experiencing a mental health crisis. Nearly 40 percent of these transports required leaving Tulsa County or the entire region.³⁴

Focus group participants frequently mentioned the lack of inpatient beds across greater Tulsa as an obstacle to moving from crisis to recovery. One individual living with a mental illness noted the difficulty of finding inpatient care: “On the [intake] assessment, if you are a[n IV drug] user or pregnant, then you get in immediately. If you are not one of those, you can game the system and shoot up once before the assessment or just lie and get help.” Parents of children and adolescents also expressed concern about how limited inpatient services are for children; others wanted services and supports that might allow them to help their children in crisis without the need for inpatient care. Focus group participants echoed the insights of professional stakeholders, noting that misguided state and local policies criminalize mental illness and that jails and prisons are, in effect, public psychiatric inpatient facilities.³⁵

FIGURE 21

Long Distances to Open Beds

Number of police transports out of Tulsa County, 2015



Source: ODMHSAS.

Note: According to ODMHSAS, the state reimbursed law enforcement agencies \$519,333 to account for mileage accrued on mental health transports in 2013.

Prehospital emergency medical care is also affected by behavioral health crises. Ambulance personnel, emergency medical technicians, and paramedics often must treat people having a behavioral health crisis with or without other acute medical emergencies. And emergency rooms are often where people in crisis go to get care. Tulsa emergency medical services and emergency rooms are used for many nonurgent medical reasons. These systems and settings are poorly designed to manage psychiatric and other behavioral health emergencies, but several communities across the country are experimenting and redesigning them to divert inappropriate emergency room admissions and to attend to behavioral health crises (Mauer 2006).

ACTION AREA 3 STRATEGIES

The committee identified the following preliminary strategies for Action Area 3 based on their potential to integrate mental health care and addiction treatment into primary health care and hospital settings and to improve patient outcomes and cut public system costs. The strategies discussed under Action Area 3 concern clinical settings such as doctor's offices, clinics, and hospitals. Strategies for integration of care within the community can be found in Action Area 2, "Strengthen Community-Based Services/Supports." The committee acknowledges that this distinction can sometimes be thin, especially for services like paramedicine.

1. Expand the CPC+ model

The CPC+ model of integrating mental health clinicians with substance abuse expertise into primary care practices should be expanded to cover more practices and to include expanded screening and treatment modalities. This recommendation also applies to integrating child and adolescent mental health and substance abuse consultants into pediatric practices.

2. Work with providers to implement evidence-based initiatives to address critical needs

Tulsa's high rates of suicide and substance abuse can only be addressed when all health care providers and mental health professionals take responsibility for recognizing and addressing these epidemics with effective interventions. Stakeholders should work to train mental health professionals, addiction specialists, and primary care providers in the Zero Suicide initiative and the Screening, Brief Intervention, and Referral to Treatment (SBIRT) protocol. These approaches should also be spread systemwide to other helping professionals, including social workers and counselors in social services agencies.

3. Expand telehealth initiatives to reach physicians who cannot integrate mental health and addiction specialists directly into their practices

Many primary care practices, particularly in rural areas, lack easy access to mental health and addiction professionals such as psychiatrists, clinical psychologists, clinical social workers, and psychiatric nurse practitioners. Stakeholders should work to expand Project ECHO to connect behavioral health professionals to all primary care settings as needed.

How to Measure Success

The community may want to consider these additional measures: number of mental health-related emergency room visits, percentage of population receiving mental health care services, reduced hospitalizations, decreased use of crisis services by frequent users of emergency services, percentage of mentally ill receiving primary care.

Action Area 4. Work with Criminal Justice Settings

In an inadequate and fragmented system of care, many people with mental illness end up in inappropriate, traumatizing, and costly settings such as emergency rooms, homeless shelters, and the criminal justice system. Few of these settings are equipped to deliver effective mental health care or promote recovery. In Tulsa, these conditions are the result of shortsighted and misguided federal, state, and local policies, at a huge cost to families, communities, and taxpayers. Redesigning systems and programs to undo the pathways driving people inappropriately into the criminal justice system—and to divert them when they do touch the system—is a major focus of policymaking across the country. Tulsa is no exception.

Reform is desperately needed. Many Tulsans living with mental illness are in correctional institutions, and many need both mental health and substance use services. In 2016, one-third of the 30,000 people treated by the medical unit at Tulsa’s David L. Moss Criminal Justice Center received treatment for a mental illness.³⁶ Criminal justice system stakeholders in the Tulsa area are already working to meet the needs of people with mental illness; many of these efforts are through the Tulsa County Criminal Justice Planning and Policy Council. The council supports several important initiatives to reduce the number of people with behavioral health disorders in jail by creating diversion strategies and training law enforcement officers and intake officers at county jails. More details on the work of community-wide planning entities like the council can be found in Action Area 5.

Tulsa already benefits from several highly regarded diversion programs. For example, specialty courts and the Women in Recovery program are designed to provide alternatives to incarceration for some people with serious mental illness or addiction problems, often connecting them to community mental health centers for mandatory follow-up care. Tulsa’s mental health court allows certain members of the community to receive mandatory mental health treatment under judicially supervised conditions as an alternative to incarceration. Eligibility for mental health court is limited to people diagnosed with a serious mental illness and those charged with nonviolent offenses. Between July 2014 and December 2016, 463 men and 246 women were screened to determine their eligibility to appear before the mental health court, constituting only a small fraction of people at the David L. Moss Criminal Justice Center who have a mental health diagnosis. Another 616 men and 174 women were screened for Tulsa’s separate drug court, which has a docket devoted to people with co-occurring mental health and substance use disorders.³⁷

Although Tulsa has some strong programs, much more work is needed to support people with mental illness as they enter or leave the justice system. For many people, especially youth, entry into the justice system is the first point of contact with the behavioral health care system. Because community-based

prevention and early intervention services are not yet sufficient to meet community needs (see Action Areas 1 and 2), mental illnesses intensify and place an undue and costly burden on the justice system. Even if a community has treatment services, it still needs appropriate, accessible reentry services, including assistance with medication and outpatient care; otherwise, many Tulsans with behavioral health needs will continue to cycle in and out of the justice system. One local respondent observed, “We went from [mental] institutionalization to putting people in prison, with nothing in between. We did not invest in community mental health treatment adequately. From my experience...I know that even with good reentry planning, too many people cannot thrive and end up back in the system. Often there are no wraparound services, and no family to assist. They end up homeless and eventually back in jail.”³⁸

ACTION AREA 4 STRATEGIES

The committee identified the following preliminary strategies for Action Area 4 based on their potential to reinforce and build upon Tulsa’s robust criminal justice reform efforts to benefit adults experiencing mental health and addiction issues.

1. Scale and expand district specialty courts and the Tulsa city municipal special services docket

The capacity of Tulsa’s mental health and other specialty courts is insufficient to restrain the increasing human and monetary costs of inappropriately placing people with mental health challenges in jails and prisons. The capacity of the city of Tulsa’s municipal special services docket—which connects people convicted of low-level offenses to treatment providers and relieves fines, fees, and charges after a successful six-month completion—is also insufficient to meet the needs of people with mental illness. Tulsa should set and meet targets for increasing the number of specialty court and municipal docket cases over the next few years, and educate the public about the cost and compassion benefits that will accrue when Tulsa shifts from being “tough on crime” to being “smart on crime.”

2. Screen more people for specialty court

More people should be screened for referral to specialty courts when they are booked into the David L. Moss Criminal Justice Center. The plan should actively support the Tulsa County Criminal Justice Planning and Policy Council (see Action Area 5 below) to see that this important priority is met.

3. Increase the number of case managers who help people move from jail back into the community

Poorly handled transitions from the Tulsa County Jail back into the community often result in crises such as homelessness or repeat cycles of incarceration, especially for people experiencing mental illness. The recent construction of two mental health pods and the creation of a mental health coordinator role at the David L. Moss Criminal Justice Center are important developments that expand care options for people with mental illness. Correctional facilities should employ more case managers to conduct warm hand-offs to treatment facilities and other supportive community-based settings.

How to Measure Success

The community may want to consider these additional measures: overall recidivism rate, recidivism rate among people who screen positive for mental health and addiction problems at time of booking into the David L. Moss Criminal Justice Center, and number of diversions from jail and prison to more appropriate mental health and substance abuse supports.

Action Area 5. Collaborate with Existing Community-Wide Initiatives

Tulsa stakeholders often convene and participate in community-wide planning and collaboration initiatives. The Tulsa Mental Health Plan Steering Committee is itself a community-wide planning initiative. Because the mental health care system is complex and highly fragmented, many existing community-wide initiatives can benefit from and contribute to the success of Tulsa's mental health improvement plan. Urban worked with the steering committee to inventory the activities of the most relevant initiatives and determine how they might mesh with the overarching goals of Tulsa's mental health plan. In addition, many members of the committee serve as members of these related initiatives and communicate frequently with their facilitators, so many of the strategies previewed in this report were influenced by these relationships.

The related initiatives are as follows:

- The **Birth through Eight Strategy for Tulsa (BEST)** is a comprehensive, continuous, and integrated approach that focuses on families to help break the cycle of intergenerational poverty. It aims to knit together programs and services to create a seamless continuum of support. Programs, services, community agencies, and philanthropies are partnering with Tulsa's families to build a cycle of opportunity. The initiative strives to raise performance on four measures: healthy births, children raised in safe and nurturing homes, children ready for kindergarten, and children achieving success by third grade.
- **ImpactTulsa** is a region-wide partnership of leaders who seek to improve education and prosperity for every child by improving rates of third-grade reading proficiency, high school graduation rates, and postsecondary education. The program targets six outcomes: kindergarten readiness, third-grade reading proficiency, eighth-grade mathematics proficiency, high school completion, postsecondary enrollment, and postsecondary completion.
- **A Way Home for Tulsa** is a Community Service Council collaboration funded by the US Department of Housing and Urban Development that coordinates housing and services funding for homeless families and individuals through a network of 23 public and private agencies with the aim of reducing homelessness in the region. When possible, the program uses a Housing First approach. The collaboration implements strategies that support a system of outreach, engagement, assessment, prevention, and evaluation for people experiencing homelessness or at risk of homelessness within the Tulsa County metropolitan area. It has helped house 211 chronically homeless people and 706 Tulsa veterans since 2015.³⁹

- **MyHealth Access Network** links more than 4,000 providers and their patients across Oklahoma in a secure, community-wide health information system designed to help providers monitor and improve care. MyHealth aims to reduce health care costs associated with redundant testing, hospital admissions, and emergency department visits; improve care coordination during transitions between health care settings; improve patients' experience and ability to take control of their own health; improve care quality for the state of Oklahoma and its nearly 4 million patients; and bring community leaders and organizations together to use health information in meaningful ways to improve community care. MyHealth began in the Tulsa region and is involved with many national health care planning and delivery initiatives, such as the Route 66 Coalition and CPC+ (see Action Area 3).
- **Route 66 Coalition** is creating an accountable health community for Oklahoma and the Tulsa region where social issues and needs—not just medical needs—are addressed to improve health. The coalition includes the Oklahoma City-County and Tulsa health departments and more than 200 other health care and social service organizations in Oklahoma. The accountable health communities model addresses a critical gap between clinical care and community services in the current health care delivery system by testing whether systematically identifying and addressing the health-related social needs of Medicare and Medicaid beneficiaries through screening, referral, and community navigation services will affect health care costs and reduce health care use.
- The **Tulsa County Criminal Justice Planning and Policy Council** was created by state statute to plan and oversee local sentencing and to support new partnerships and interagency collaboration. Currently, the council has three committees and five workgroups focusing on crosscutting needs: screening, assessment, and triage; data, outcomes, communication, and governance; public relations and education; curriculum, evidence-based programs, training, and culture; and discharge planning and case management. Although the council will continue to serve as a convener of local criminal justice initiatives, an independent criminal justice coordinating council (CJCC) will be formed to ensure coherence in the work currently led by different committees. The CJCC will have its own research capacity, report regularly on all criminal justice initiatives, and identify new areas of policy development. The following are some initiatives convened and/or supported by the Tulsa County Criminal Justice Planning and Policy Council that are relevant to Tulsa's mental health improvement plan:

 - » **Stepping Up** is a national initiative to reduce the number of people with mental illnesses in jails. Tulsa's Stepping Up team has used the sequential intercept model to map pathways, gaps, and opportunities to intervene. It has developed the following priorities for the community: (1) use information collected on risk, needs, and responsivity at booking to guide decisions at release

and use of community resources; (2) expand information exchange and data integration across systems; (3) use Housing First strategies to increase housing options to target high-need people, especially justice-involved people who are homeless and need the continuum of supports coordinated by A Way Home for Tulsa; (4) screen everyone at booking for mental health and substance use; and (5) increase funding for substance use treatment, including for low-risk offenders.

- » The **Outside Inside Collaboration for Justice** is a group of more than 61 Tulsa County agencies, including Tulsa's sheriff's office, police department, and Salvation Army chapter, which have come together to connect mental health patients apprehended by law enforcement officials with appropriate treatment instead of sending them to jail. The group focuses on community collaboration to help justice-involved people navigate resources and avoid incarceration. The group prioritizes system-level improvements, from initial contact by first responders through release, with the goal of decreasing jail admissions and improving reentry outcomes.
- » The **Vera Institute of Justice Implementation Committee** was established to work with Vera to examine the drivers of growth and overcrowding at the Tulsa County Jail. The committee includes community representatives and is supported by every major stakeholder within the criminal justice system, as well as the Tulsa County Board of County Commissioners, the Tulsa Regional Chamber of Commerce, the Oklahoma Department of Corrections, the Anne and Henry Zarrow Foundation, and the George Kaiser Family Foundation. In December 2017, Vera published a report containing its findings and proposed strategies consistent with the county's public safety goals to reverse growth in the jail population. The implementation committee will continue working to implement Vera's recommendations and to identify improved systemic practices.

ACTION AREA 5 STRATEGIES

The committee does not wish to duplicate or complicate the activities of the many other successful community improvement initiatives under way in Tulsa. Therefore, it recommends that the community bolster and accelerate related efforts by (1) adopting, as appropriate, similar measures of success; (2) strengthening behavioral health-related assets that these initiatives will need to succeed; (3) anticipating and planning for the consequences for the mental health and substance use treatment systems as these efforts mature and succeed (e.g., increased diversion from the criminal justice system); and (4) improving mental health and substance use services so that fewer people are inappropriately driven into hunger, homelessness, or the criminal justice system in the first place. Below are some ways that the plan can coordinate with other key initiatives, and vice versa. Some of these initiatives may be mentioned under other action areas or pillars, but they are compiled here to stress the importance and opportunities of inter-initiative coordination.

1. Birth through Eight Strategy for Tulsa (BEST)

Early support for and intervention in the health and development of families with very young children is one of the most effective ways to ensure that Tulsa's children grow into healthy, happy, and productive adults. The community should confer with BEST leaders to ensure that all care navigation and pediatric care integration strategies in this plan are aligned with their efforts, and to identify and build on joint efforts such as better screening and treatment for maternal depression.

2. ImpactTulsa

Schools in the Tulsa region, particularly at the district level, are not meeting the mental health needs of their students. Leaders of Tulsa's mental health plan should coordinate closely with the leaders of ImpactTulsa on the school-based strategies listed under Action Area 1. For example, together they could conduct a comprehensive mental health needs and services assessment throughout all districts in Tulsa MSA.

3. A Way Home for Tulsa

A continuum of care approach is needed to improve access to care for Tulsans who experience mental illness and to correct for the fragmentation of Tulsa's mental health system. Leaders of Tulsa's mental health plan should confer closely with leaders and participants in A Way Home for Tulsa to better understand and adopt the core components of building a continuum, such as supportive housing. Leaders should also partner in exploring the housing barriers for many Tulsans who have been inappropriately caught up in the criminal justice system because of mental illness.

4. Route 66 Coalition

As an accountable care organization designed to encompass services that address stress and health disorders caused by social conditions like poverty, the Route 66 Coalition is an ideal partner to mental health system stakeholders in addressing the social determinants of health. Stakeholders should work with the coalition to design the phone navigation hub, consider scaling up peer navigators to work with the hub, and build out more strategies to address Tulsa's epidemics of suicide and addiction.

5. Criminal justice collaborations

The activities of the Tulsa County Criminal Justice Planning and Policy Council are comprehensive and appropriately focused on diverting people with mental illness away from jail. Leaders of Tulsa's mental health plan should reach out to the Vera Institute of Justice Implementation Committee to confer on the preliminary strategies of this plan and to join forces on all areas of overlap.

How to Measure Success

The community may want to review indicators of success across these efforts and select a subset that most closely aligns with the goals and activities of the mental health improvement plan.

Our discussion now turns to the four crosscutting pillars of resources, or forms of capital, needed to support each action area. The four pillars are human capital, physical capital, intellectual capital, and financial capital. A deep dive into these essential pillars was beyond the scope of this first-stage effort for Tulsa, and the field's knowledge of best practices is uneven across the pillars and still evolving in all of them.

Pillar 1. Human Capital: Workforce/Education and Training

No aspect of this plan can be achieved without the support of a well-trained and adequately staffed workforce, including paraprofessional and peer supports. Nationally, there is a critical shortage of qualified mental health personnel, from psychiatrists and nurses to social workers and other direct service providers. The cost of these human resources makes up over 80 percent of all spending on people with mental health, addiction, and substance use problems.

A well-trained and adequately staffed mental health workforce must span a broad spectrum of disciplines, not only medical or psychological specialists such as psychiatrists, psychologists, clinical social workers, and other professional counselors. The findings in this plan point to the need for school teachers and other education professionals who are competent in recognizing the signs and symptoms of mental illness and addiction disorders in their students, appropriately managing these children in the classroom, and referring them to specialty services. In this plan, the workforce includes paraprofessionals who support people with mental illness, severe behavioral disorders, and/or addiction, such as peer support specialists and even family members.

The research findings show that Tulsa has more mental health providers than most communities do, but the type, distribution, and quality of these providers are inadequate. Improvements are needed in many areas including education, training, recruitment, retention, and diversity.

Strategies may target the continuing education of people who are already in the workforce or the training of students who have not yet fully entered the workforce. And as the clinical science of prevention and treatment evolves, training and resource dissemination must translate new evidence into clinical practice. Finally, in addition to a well-trained professional and paraprofessional workforce, communities need strategies to improve the distribution and accessibility of care for underserved populations.

Ensuring an adequate supply of qualified mental health personnel will require the cooperation and involvement of state and local policymakers and administrators in health care, education, and workforce investment. It will also require training many other types of professionals, educators, and first responders. Mental health first aid, positive behavioral interventions and supports, and crisis intervention training are all examples of community training that will help people identify and address mental illness more effectively.

And people living with mental illness and their families are de facto members of the mental health workforce, providing an enormous amount of self-care, peer support, and care for loved ones. They have a

unique capacity to educate formal members of the mental health workforce about the experience of illness, treatment, and recovery.

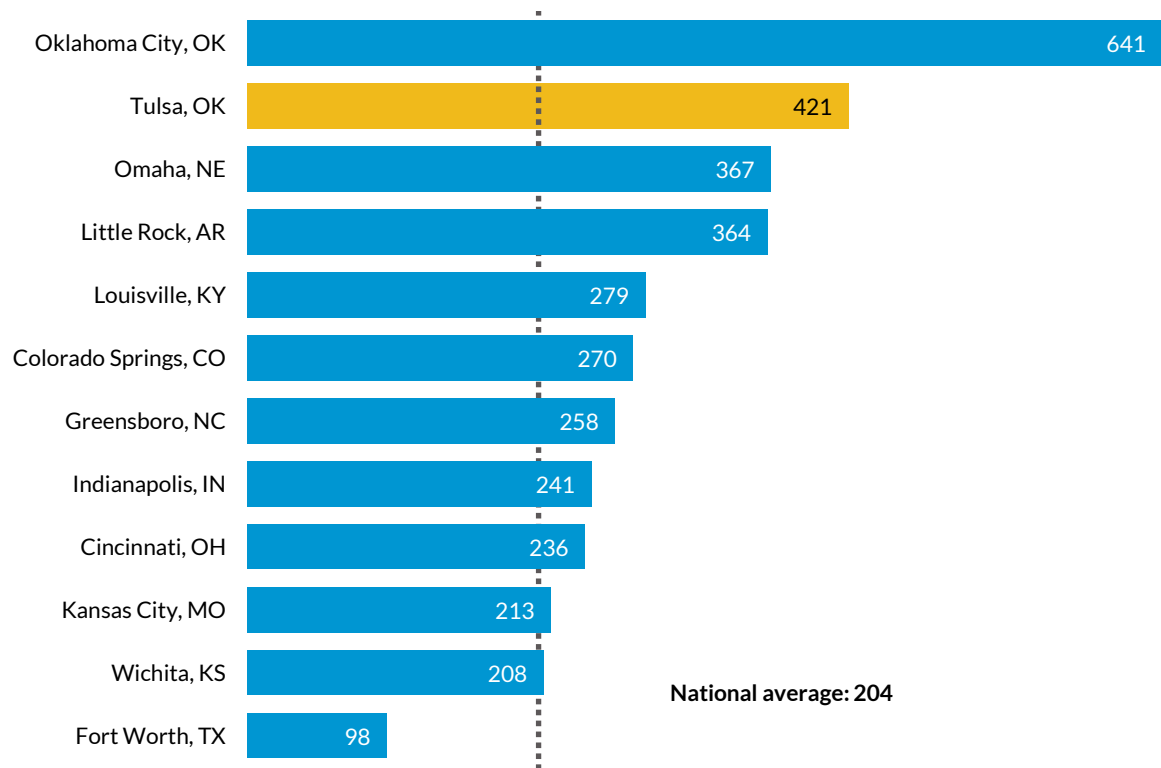
Two major areas of focus are developing peer supports, especially certified peer specialists, and using telehealth and tele-mental health options to support people with counseling and other related needs. The region is facing a shortage of well-trained mental health care professionals and paraprofessionals, and this, along with cost, hinders access to care for many. Key informants unanimously said that “we need more” providers of all types—more psychiatrists, psychologists, nurse practitioners and physician’s assistants with mental health training, psychiatric nurses, social workers, and peer support staff. Key informants described shortages in all kinds of settings, including hospitals. One hospital leader explained that they have one psychiatrist for a 700-bed facility and need more comprehensive behavioral health teams instead. Shortages of providers affect inpatient and outpatient settings, including community-based settings such as schools and homeless shelters. Legislative and regulatory barriers prohibit some types of providers from practicing at the top of their licenses and training. Focus group participants confirmed that the provider shortage is a barrier to access and makes for long wait times for appointments to adjust medications or change treatment strategies. People living with mental illness also described being “rushed in and out” when they do get an appointment. One participant said, echoing others’ sentiments, “I know what [medication] I’m taking, but don’t really know why and what side effects I might have.”

Although the number of mental health providers per 100,000 residents in Tulsa County (421) is twice the national average (figure 22), this estimate represents a wide mix of types of providers, not all of whom are able to diagnose and treat mental illness.

FIGURE 22

Tulsa Has More Mental Health Providers Than Peer Counties Do

Mental health providers per 100,000, 2010–15



URBAN INSTITUTE

Source: CMS National Provider Identification File.

Note: Mental health providers include psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, advanced practice nurses specializing in mental health care, marriage and family therapists, and mental health providers who treat alcohol and other drug abuse.

There is also a shortage of mental health providers nationwide, and some of Tulsa’s providers are likely engaged in research and education rather than direct care. Moreover, providers in Tulsa County serve the entire metropolitan area, and the northeastern region, which includes Tulsa, has been shown to have the greatest unmet mental health needs in the state (Hornik et al. 2011). Given how frequently transportation was cited as a barrier to care, the community should work on increasing access to providers and services (e.g., mobile clinics and telemental health) and increase the supply of practicing clinical specialists.

Stakeholders also said they need more and better training for providers, including primary care providers and pediatricians trained in behavioral health and providers trained in both mental health and substance abuse treatment. More training is also needed in evidence-based treatments, practices, and approaches such as medication-assisted treatment, harm reduction, trauma-informed approaches, and motivational interviewing.

Finally, although many people assume (and some thought leaders told us) that Tulsans with good insurance and higher incomes can access the mental health care they need, this is not what many community members reported. Some do get the care they need, but many are unable to. This is not unique to Tulsa, but it is a powerful sign of gaps and limitations within the overall mental health service system. It has system-level deficits and barriers that even well-off individuals cannot overcome. Interviews with family members who have adequate coverage reveal that they lack accurate early diagnosis and intervention from primary care providers; guidance on how to pull together a complete, continuous package of follow-up care; psychiatric and substance abuse treatment providers; and integrated substance abuse and mental health care services (for people with co-occurring disorders).

Focus group participants confirmed the widespread challenges faced by people living with mental illness and their caregivers—across income categories—in finding competent and consistent treatment services. In all groups, participants reported going from provider to provider in search of care and finding that each provider—particularly physicians and psychiatrists—had a different diagnosis and approach to treatment. One participant said that the process of locating treatment “has been ‘trial and error,’ and there is no good way to find out about the options for what I need.” Another person stated, “I would like to have the same people [provider] every time and not have to keep telling and retelling my story every time [I get a new provider].” Parents of children with mental illness also expressed challenges with multiple primary care providers and psychiatrists who are often not trained to address all the developmental needs of children and adolescents. One parent explained, “It’s a rollercoaster of diagnoses [and] medications and going from one doctor to another to get help. There are simply too few child psychiatrists.”

A 2011 study of the behavioral health workforce in Oklahoma offers useful insights. It found that (1) salaries among behavioral health providers are low and appear to be hindering recruitment and retention; (2) staff separation rates are high, reflecting and shaping the composition of the workforce—particularly among paraprofessionals, who had a turnover rate of 30 percent; (3) there is both a current and projected shortage of professional and nonprofessional staff (the shortfall is especially severe for psychiatrists and other prescribers), and higher education programs across the state are not producing enough new entrants to meet current needs; (4) a large share of the current workforce is people living with a mental illness or their family members; (5) providers are relatively well-prepared to offer cognitive behavioral therapy but less prepared to deliver other evidence-based practices; and (6) the most common unmet training needs relate to psychiatric medications and their side effects (Hornik et al. 2011).

PILLAR 1 STRATEGIES

The committee's workforce development strategies are designed to increase Tulsa's future workforce of mental health professionals and to ensure that all professionals are multiculturally aware and update their skills and knowledge with the most recent scientific evidence. The strategies also focus on cross-training professionals from other disciplines and on building the workforce of peer navigators, lay advocates such as family members, and everyday citizens who know how to identify and help neighbors who are in mental health crisis.

1. Build the capacity of medical providers to treat patients with mental health concerns

Trained mental health professionals, especially psychiatrists, are underrepresented in Tulsa's behavioral health care workforce, and Tulsa's primary health care workforce needs additional interdisciplinary training to meet the mental health needs of the patients they encounter in settings like clinics and emergency rooms (see Action Area 3). The community should develop resources and efforts to increase the numbers of community-oriented psychiatrists who graduate from Tulsa-area residency programs (generalists and specialists in fields such as addiction medicine, infant and child care, and forensic psychiatry); train and use more nonphysician medical providers such as advanced practice nurses and physician's assistants for psychiatric care and in primary care; expand education, knowledge, and use of American Society of Addiction Medicine criteria; and encourage medical and health professional development programs to embrace integrated care models by adopting interdisciplinary training experiences both in the classroom and in the students' clinical experiences. In keeping with the goals of Pillar 3 below, fellowships for professionals from various disciplines could also offer opportunities to test innovative evidence-based reforms to public policies, define their costs and savings, and develop strategies to accomplish such reforms. In addition, leaders should push for financial incentive programs to draw mental health professionals to work in geographic shortage areas and/or with populations in desperate need of services (e.g., children with traumatic brain injuries who commit violent offenses).

2. Build the capacity and retention of nonmedical community-based mental health professionals

Many people in related professions (e.g., policing, teaching) need interdisciplinary training to meet the mental health needs of the people they encounter every day (see Action Areas 1 and 2). Plan leaders should develop resources and efforts that develop the clinical skills and field experiences of a full range of multidisciplinary professionals such as licensed professional counselors, licensed marriage and family

therapists, licensed clinical social workers, licensed alcohol and drug counselors, behavioral health case managers, behavioral health rehabilitation specialists, and recovery support specialists. Plan leaders should also support and build in-service interdisciplinary training efforts for professionals who regularly come into contact with citizens experiencing mental health challenges (e.g., crisis intervention team training for police).

3. Improve the standard of pay and support for psychiatric technicians

Paraprofessionals such as psychiatric technicians are the backbone of Tulsa's system of care for the severely mentally ill. Turnover rates in these difficult jobs are unacceptably high. Stakeholders must improve the training and support that psychiatric paraprofessionals with bachelor's degrees receive, starting with large increases in their wages.

4. Train and support more peer navigators and personal advocates

People living with mental illness and their family members make up a large share of Tulsa's behavioral health workforce. The community should leverage the enormous capacity of this hidden workforce by developing efforts to expand the recruitment, training, support, and pay of paraprofessionals like peer navigators (see Action Area 2), and by providing more training and support networks for family members of people experiencing mental health challenges.

5. Work with businesses to train their employees in mental health first aid

Tulsa's high rates of suicide and substance abuse demand immediate neighbor-to-neighbor outreach and support so that people do not go without the help they need as mental health crises emerge. Plan leaders should reach out to businesses to train their employees to recognize and assist coworkers and customers in mental health crisis through innovative programs like mental health first aid.

How to Measure Success

The community may want to consider these additional measures: number of practice sites participating in Project ECHO or other initiatives to build and use an integrated workforce, presence of curricular innovations in health professions and other fields, number of psychiatrists and other mental health professionals practicing in underserved geographic areas or populations, and number of people receiving mental health services who also made contact with a peer recovery support specialist and/or were reached by a trained peer or lay advocate.

Pillar 2. Physical Capital: Facilities, Transportation, and IT

Many aspects of this plan will require thoughtful assessment of and upgrades to physical capital and infrastructure, including technology. A growing body of research links the built environment and mental health, not only in behavioral health settings, but also in schools, community centers, urban planning, transportation, and design more generally (Hunt and Sine 2017; Shepley and Pasha 2013). New insights, innovations, and standards are also emerging around the design, functionality, and safety of health care delivery (e.g., hospitals, clinics, mobile units) and social service settings (Verderber et al. 2014), which may be valuable for the mental health improvement activities in this plan. These features present opportunities for educating and engaging new sectors of the community, such as investors, developers, builders, planners, designers, students, and artists.

As the community inventories and evaluates existing physical capital, Tulsa should consider the following components:

- psychiatric hospitalization facilities for specific defined populations (e.g., adults, adults with children, children, youth)
- detox and treatment settings for adults, including those with children
- substance use disorder treatment for adolescents
- facilities for dual diagnosis treatment
- spaces for intermediate level of care
- drop-in centers
- substance misuse intensive outpatient programs
- opioid treatment programs
- office-based opioid agonist treatment programs

Supported housing (including residential care and group homes), supported work settings, and transportation issues must also be assessed. Transportation challenges were consistently identified by key informants as a major barrier to supports and care in the greater Tulsa area. In addition to looking at service location and transportation factors (McCay et al. 2017), Tulsa should explore the use of telehealth, tele-

mental health, and other tech-based options for improving behavioral health treatments and supports (Hilty et al. 2013; Nelson and Sharp 2016).

PILLAR 2 STRATEGIES

Many of the committee's recommended strategies must be accompanied by improvement or expansion of the physical spaces where mental health care takes place in the Tulsa region. Improving facility quality across the board should create a platform for improving inpatient and outpatient mental health care for adults, teens, and children. Making these investments in structures will require partnership with the major health systems in the Tulsa area to create more psychiatric units and inpatient beds.

1. Review existing facilities and their treatment options for low-income Tulsans

The community should conduct a comprehensive review of existing facilities and their capacity to increase access to health care, especially to mental health treatment, for low-income Tulsans. Facilities and beds to treat substance use disorders (e.g., 12 & 12) should be included in this review. Additionally, stakeholders should assess the current capacity of non-health-care-related facilities, such as homeless services and food centers, to provide additional access points for lower-income people to receive mental health care.

2. Expand the number of best-practice behavioral health care facilities for young people

There are significant gaps in the quality and number of mental health care and addiction treatment facilities for teens and children in Tulsa. The review of facilities recommended above should include a special focus on treatment settings for young people and their families. Knowledgeable stakeholder groups like Youth Services of Tulsa should be included in this assessment. If needed, a new Tulsa children's facility with flex beds, offering trauma-informed mental health services, services for co-occurring mental health and substance use disorders, and quality care for patients with autism spectrum disorders, should be designed with the help of recognized national experts like Boston Medical Center. In addition, K-12 and postsecondary schools, pediatric groups, and other child- and youth-serving organizations should be recognized as critical venues for identifying mental illnesses and intervening early. New facilities such as sober schools, which provide wraparound support for teens struggling with substance use disorders, and alternative or supported education models can be built out to help older teens and young adults complete their journey to graduation and work after the onset and treatment of mental illness and addiction. These efforts may start as pilots that build the evidence base and are then scaled up as performance metrics demonstrate their value.

3. Expand the number of charity or publicly funded psychiatric beds in hospitals

People with mental health issues who have lower incomes are less likely to have access to specialty mental health treatment (Cummings et al. 2017). In Tulsa, most inpatient mental health care beds are private, and there are no set-aside beds for “indigent care” at hospitals within the large health systems. Stakeholders inside and outside these systems should work together to expand no-charge medical psychiatric units in private settings. The community should also renovate the Tulsa Center for Behavioral Health and/or consider constructing a new state hospital to increase the number of high-quality public mental health care inpatient beds. Any new space should prioritize support for comprehensive family wraparound supportive services and facilitate warm hand-offs between inpatient care and community-based services.

How to Measure Success

The community may want to consider these additional measures: number of mental health/substance abuse inpatient beds for adults and children, number of subacute step-down beds, number of partial hospitalization beds, share of facilities that meet or exceed industry standards, and share of Tulsa-area hospitals that are opening up beds for public patients until agreed-upon policies and resources are in place.

Pillar 3. Intellectual Capital: Data, Research, Policy, and Practice

The success of this mental health improvement plan depends not only on collective effort and action, but on continuous learning, adoption of evidence-based policies and practices, and advocacy and accountability. A sound public policy environment is critical because it facilitates the adoption and spread of evidence-based clinical practice, supports proven systems of care, and provides the public funding necessary to deliver comprehensive mental health and addiction services. Thus, Tulsa's plan must ensure that thought leaders and influencers, policymakers, regulators, and the public understand that mental illness and addiction are diseases of the brain, that they are diseases that can be managed and treated effectively, and that state and local laws and regulations must be reformed to improve mental health and well-being in Tulsa.

Continuous learning and improvement should underlie every aspect of Tulsa's plan, with staged follow-on planning activities devoted to each action area and pillar. Launching and sustaining this major health system improvement plan will require a dedicated set of sustained activities and supports:

- data collection and integration for planning, monitoring, and real-time service delivery
- scanning and evaluating emerging, promising, and best practices in health care services, health care delivery, and support services, and in the use of civic tech, health information technology, and tele-behavioral health
- research and discovery around health-promoting programs (design and implementation) and policies (effectiveness and cost-benefit)

Oklahoma's policy environment is especially important because the state is among the few that opted not to expand Medicaid, one of the most important sources of funding for behavioral health services. But many other policy issues are critical in driving improvements in mental health and addiction services. In addition to the policy analysis and advocacy already taking place in the state, research on policy and practice is being done by national groups and organizations such as

- the College for Behavioral Health Leadership,
- the Bazelon Center for Mental Health Law,
- Mental Health America,
- the National Alliance on Mental Illness,

- the Treatment Advocacy Center,
- the AIMS Center for Advancing Integrated Mental Health Solutions,
- the Center for Mental Health and Addiction Policy Research at Johns Hopkins University, and
- the National Child Traumatic Stress Network.

The National Conference of State Legislatures and the National Governors Association also monitor and share information about best policies and practices in the areas of behavioral health. Finally, many states have policy institutes that focus on mental health and evaluations of behavioral health interventions. Two examples are the Meadows Mental Health Policy Institute in Texas and the Washington State Institute for Public Policy. Tulsa can learn from these studies and efforts in other states as it develops and strengthens its own mental health system. And these learning efforts can amplify and build on the considerable data and analytical capacities of the Oklahoma State Department of Mental Health and Substance Abuse Services; because of these capacities, Oklahoma is already among a small group of states participating in national studies sponsored by SAMHSA.

PILLAR 3 STRATEGIES

Tulsa’s mental health plan will require data-driven research and evidence-based policy improvement at the local, state, and federal levels and across all five action areas and four pillars. The Tulsa County Criminal Justice Planning and Policy Council is already working to build intellectual capital, as with the recently released *Report to Tulsa County Stakeholders on Jail Reduction Strategies* by the Vera Institute of Justice (see Action Area 5). Tulsa should increase expert capacity to develop evidence and conduct data work and set improvement targets more specific than those in this report. The committee also recommends that stakeholders establish strong public education and advocacy programs to ensure that Oklahoma takes full advantage of all federal dollars available to support mental health and addiction services, and that Tulsa get its fair share of those dollars, based on its documented needs and population.

1. Establish a regional research center to translate knowledge on mental health and addiction into policy and practice

A behavioral health policy and practice research center is needed to focus on local and state solutions to the opioid epidemic; new health care service design, delivery, and payment models; mental health parity laws and other legal protections for people with disabilities; adoption and translation of clinical, policy, and funding innovations into practice; and new funding models and innovations. The center should be charged with identifying innovations in clinical practice and policy reform, informing and training the workforce on these evolving methods, and educating the public and elected officials. A mental health policy research fellowship can attract and develop policy expertise specific to Tulsa and other parts of the state. The center should partner with agencies and academia to draw from their research talents, policy development skills, and data systems, but it should operate as a stand-alone entity that can be identified by lawmakers, regulators, and other decisionmakers as a single-topic nonpartisan resource for mental health policy and information in Tulsa and Oklahoma.

2. Ensure that all strategies and activities in support of this plan leverage data and IT resources

The committee recommends that stakeholders use performance measurement methodologies and metrics—such as those recommended by Urban in this report—that analyze data at the program and population levels. Stakeholders should (1) analyze population-level data (including “hot spots”) on mental illness, addiction, overdoses, suicides, physical health, and health-related social needs to refine strategies for high-priority populations (e.g., children, veterans, Native Americans, immigrants) and high-priority areas (e.g., North Tulsa in the city and Creek, Osage, Pawnee, and Okmulgee counties in the region); (2) examine use of apps, telehealth, and other IT-enabled models for therapy, crisis

intervention, and suicide prevention, especially for teens and young adults who may prefer these to more traditional approaches; (3) explore opportunities to work with MyHealth on a shared data architecture that integrates public and private pieces of the system and can highlight priorities for system improvement (an initial focus will be on high utilizers of emergency rooms); and (4) integrate dispersed population health and administrative data, and data integrators such as MyHealth, to gain better insights into priority groups, systems, and geographies.

3. Launch a public information program designed to increase public and policymaker understanding of mental illness

Multiple stakeholders identified stigma as a significant barrier to access for Tulsans with mental health problems and illness. Stakeholders should design a public information program to help the community understand that mental illness and addiction are diseases of the brain in much the same way that other chronic illnesses are diseases of body organs. Such a program would need champions among top leadership who see these issues as priorities; for example, Senators A. J. Griffin and Joe Newhouse, former House Speaker Kris Steele, and ACLU legal director Brady Henderson could become advocates for mental health and juvenile justice. Stakeholders could hold a quarterly round table for all local and state elected officials from the greater Tulsa area. Members of the public, especially those with mental health concerns, could be supported by local funders, health agencies, and advocates like MHAOK and NAMI Tulsa in hosting a mental health public policy education series at the Oklahoma legislature.

4. Establish a longer-term entity devoted to mental health policy

Some type of coordinating “backbone” will be needed to support the activities of Tulsa’s 10-year plan, but the mental health crisis is so deep that the community will also need a longer-term entity to solidify and sustain the work initiated by the plan. A mental health council or institute should be formed, with close connections to elected officials and agency leaders. The institute could be charged with building a culture of mental health, starting with city agencies and branching out to all partners and citizens. The Meadows Mental Health Policy Institute for Texas and the Hogg Foundation for Mental Health at the University of Texas at Austin are useful models for Tulsa to consider.

How to Measure Success

The community may want to consider these additional measures: increases in the state’s mental health budget to underwrite a comprehensive mental health service system, new mental health laws and regulations based on local research and national models of success, and percentage of mental health providers who share data with leaders of Tulsa’s mental health improvement plan.

Pillar 4. Financial Capital: Funding Sources and Models

It is difficult to overstate the importance of financing for mental health services. A workgroup of the American College of Mental Health Administration explained in a 2003 article: “The behavioral health field has learned much in the last 50 years about what it wants and needs, and how to get it by using financing mechanisms that provide the right incentives and avoid perverse ones. Above all, the field has learned that finances drive behavior. A statement of values, a strategic plan, research on evidence-based practices, and even regulatory efforts are critical, but they cannot overcome the reality that *what is paid for is what will be provided*. Frequently, what is paid for well or easily, or with a high reimbursement rate, will have more influence on which services are provided and in what manner they are provided than the professional standards or the nonfinancial actions of system leaders and stakeholders” (ACMHA 2003; emphasis added).

Financial resources are essential for building and sustaining a comprehensive, community-wide, prevention- and recovery-oriented mental health system. The financial costs of *not* treating mental illness are often greater. A full cost study was beyond the scope of this effort, but a cost calculator developed by the Health Care Foundation of Greater Kansas City estimates the annual costs of untreated mental illness in the seven-county greater Tulsa area at \$41.6 million in direct costs and \$346.2 million in indirect costs. Direct costs include those associated with increased inpatient care, outpatient care, long-term care, and spending by local mental health agencies; indirect costs include unrealized earnings because of disability and early death, unemployment costs, and lost time and productivity while employed.⁴⁰ These costs do not reflect the intangible costs associated with lower quality of life for people living with mental illness or their loved ones.

In Tulsa and across Oklahoma, inadequate financing is a major cause of the community’s poor mental health outcomes and a major barrier to improving care. A long-standing and deepening state budget crisis has undermined not only mental health and other health services, but also education, human services, and safety net programs, all of which matter to health and well-being.⁴¹ Oklahoma’s per capita expenditures on public mental health services are among the lowest in the nation: according to a Kaiser Family Foundation evaluation of state mental health agencies, Oklahoma spent \$203 million on mental health services, or \$53.01 per person, in fiscal year 2013. At this level of investment, Oklahoma ranked 45th out of 48 reporting states. These low levels of state mental health funding have been exacerbated by recent budget cuts. In fiscal years 2016 and 2017, the state legislature cut appropriations to ODMHSAS by \$23 million a year. This loss of state funding was especially damaging because it also resulted in the loss of matching federal funds.

The state budget environment not only limits the extent to which new services can be added and promising programs scaled up, but it also threatens existing services.⁴² In fiscal year 2016, 54 Tulsa County providers received rate cuts. Even before this latest round of funding cuts, Tulsa County providers only had enough public funding to serve about 20 percent of those in need, according to ODMHSAS.⁴³ Stakeholders interviewed for this study also noted that the limited pool of available funds from a small number of state and philanthropic sources discourages cooperation among providers. Multiple stakeholders reported this siloing effect of competition for resources, inhibiting collaboration across service systems.

Oklahoma's per capita expenditures on public mental health services are among the lowest in the nation.

Uninsured Tulsans have limited access to public- and private-sector services. In Tulsa MSA, about one in five people younger than 65 is uninsured, and across Oklahoma, almost one in three people ages 18 to 34 is uninsured.⁴⁴ The state's decision not to expand Medicaid is a major reason for these high uninsured rates. Expanding Medicaid would provide health insurance coverage to an additional 348,000 Oklahomans and bring in \$8.6 billion in additional funding over the next decade.⁴⁵ According to the Commonwealth Fund's new state health system scorecard, states that expanded Medicaid realized some of the biggest gains in both insurance coverage and access to care between 2013 and 2015. California, for example, saw improvements across all age groups and care settings and a substantial decrease in 30-day hospital readmissions for Medicare beneficiaries.⁴⁶

Cost was reported as a barrier to care in all the focus groups. Participants said that their ability to pay out of pocket or through a third party fluctuated over time depending upon eligibility changes, insurance coverage options, and income. One parent caregiver described having to quit work to deal with a child's illness; others said they made career adjustments that decreased their family income and productivity. Access to care is limited across Oklahoma. One 2015 analysis ranked the state dead last on an index measuring access to physicians generally (Merritt Hawkins 2015).

Stakeholders said that lack of funding and low reimbursement rates, particularly in rural areas, hinder recruitment and retention of mental health professionals. They also noted that Medicare and Medicare Advantage only reimburse for a limited set of mental health care services, limiting enrollees' access to services. Oklahoma has relatively low rates of Medicaid spending per full-benefit enrollee. It ranks 38th out of 50 states and the District of Columbia in overall spending on enrollees, and 34th in spending on people

with disabilities.⁴⁷ Eligibility is highest among children and pregnant women, but low among parents; childless adults are not covered at all.

In response to health care underfunding and poor health outcomes, Oklahoma and Tulsa-area insurers, health care providers, and others have been testing integrated health strategies to achieve the triple goal of better health care, better health outcomes, and lower costs. The discussion under Action Area 3 describes some of the most notable initiatives currently operating in the Tulsa region—CPCI, CPC+, accountable care organizations, and medical health homes—and their relationship to better coordinated care and health outcomes. To achieve lower cost outcomes, these initiatives typically rely on “shared savings” models to incentivize providers to focus on the value of care over the volume of care for payer reimbursement. So far, Tulsa’s cost reduction results stand out: it was the only CPCI region to see statistically significant savings over the first three years of the program, achieving a 3 percent reduction in Medicare expenditures.

Cost-shifting strategies are also growing in popularity because they loosely apply profit-making principles to public services. For example, mental health courts in Oklahoma are estimated to save \$17,600 in costs per participant—but because of limited docket space, they cannot serve all who are eligible for them.⁴⁸ A local Tulsa study showed that between January 2010 and September 2013, the Tulsa County Family Drug Court, which focuses on the needs of young people who enter the juvenile justice system, served 269 children who spent 227 fewer days per child in out-of-home care than justice system-involved children who did not receive family drug court services; this yielded \$5 million in savings. Policymakers who use a cost-shifting approach should look at the drug court’s high return on investment and consider increasing the court’s budget by some or all of these savings.

Pay for success (PFS) is another innovative form of financing. A PFS study is now under way in the Women in Recovery program at Family & Children’s Services. PFS uses methods such as performance-based contracting and results-based financing to improve delivery of social services to vulnerable populations. These projects shift the risk of implementing a public project from a traditional funder (usually a government) to a new private or nonprofit funder and scale evidence-based programs to improve outcomes for a vulnerable population. If an independent evaluation shows that the intervention achieved agreed-upon outcomes, then the traditional funder repays the new funder’s investment with interest. Other innovative funding sources that involve some form of cost-shifting include tobacco settlement funding and public revenue saved by the reclassification of drug and property crimes as misdemeanors via Oklahoma State Question 781, the Rehabilitative Programs Fund Initiative.

PILLAR 4 STRATEGIES

The committee selected the following strategies for Pillar 4 based on their potential to marry effective financing mechanisms with good mental health outcomes for all Tulsans. The committee advises that funds from all sources be used efficiently across the goals of the plan, and that old sources of funding be rebalanced with new sources and financing innovations, as well as with “lower-resource, higher-touch” options such as peer navigators, community health workers, and psychiatric technicians (CDC 2014).

1. Leverage the shared savings benefits of integrating primary and mental health care

Efforts such as the Tulsa region’s CPCI pilot and the CPC+ successor hold promise for producing both quality improvements and cost savings through more integrated care. Stakeholders should promote and expand these solutions, reminding insurers and policymakers that the triple aims of better health care, better health outcomes, and lower costs must be pursued in unison and are worth waiting for as these models mature.

2. Engage all sectors in improving Tulsans’ mental health

Tulsa’s mental health crisis affects everyone, from the average taxpayer to the customers and owners of local businesses. Stakeholders should call on all sectors to contribute their time and resources to improving the mental health of families and neighbors. They should engage the sectors with the most financial wherewithal—business, large hospital systems, politicians, and local philanthropies—in frank discussion about the ways their efforts can be combined and expanded to meet the desperate need.

3. Explore pay for success and other innovative payment models

Innovative financing strategies use cost-effective thinking and fair-minded resource reallocation strategies to aim for better outcomes for vulnerable populations such as people experiencing mental health and addiction problems. Plan leaders should work with public and private financing experts to explore how today’s most cutting-edge funding models, including PFS, can be leveraged to address Tulsa’s mental health crisis.

4. Expand Medicaid in Oklahoma

All the strategies listed above are under way and can be built up in one form or another, but state Medicaid expansion is not even close to becoming a reality. This is a catastrophe for all Oklahomans, especially the thousands who work but are not covered by an employer-based health plan. States that expanded Medicaid have far better insurance coverage rates and show signs of dramatic improvement

in health and wellness outcomes. Plan leaders must continue to communicate to state legislators and the advocacy community (see Pillar 3) the vital importance of expanding Medicaid for citizens' mental health.

How to Measure Success

The community may want to consider these additional measures: uninsured rate, new dollars fundraised or leveraged from public and private sources, and funding leveraged and appropriated by the state legislature. Any cuts in behavioral health funding should also be tracked in plan reports.

Conclusion

There are many reasons to be hopeful about the prospects for mental health improvement in Tulsa. The community's vision and commitment are reflected in this report and in the work that went into preparing it. Tulsa has a strong and engaged philanthropic and civic community, and many members of that community are supporting the existing initiatives that can and should dovetail with the 10-year mental health improvement plan. Strong local anchor institutions in higher education and the health care system, including the Laureate Institute for Brain Research, are well-positioned to unite as leaders in this effort, in partnership with community-based service providers and, most importantly, individuals and families affected by mental illness and substance use disorders.

Given its commitment to data-driven, evidence-based system improvement, the state mental health department can be a powerful ally in supporting progress in Tulsa. And two recent related efforts, the Vera Institute report on jail diversion strategies in Tulsa and the state commission on opioids, set the stage for future improvements in mental health across the region. By adopting a staged and sequenced approach to the upcoming 10-year plan, authentically engaging and partnering with members of the community, and ensuring the plan aligns with the community's topmost needs while building on its strengths, Tulsa should be able to create a culture of real, continuous improvement that will result in better mental health over time.

But the challenges are not insignificant. Poor mental health and substance use outcomes in Tulsa, Oklahoma, and the nation are in part the result of long-standing inattention to these aspects of health and well-being within the health care system and multiple shortfalls within policy, research, and practice. Like physical health, mental health and risk factors for mental illness are shaped by the environments in which community members live and grow. The social determinants of mental health—adverse early life experiences; poverty, food insecurity, and housing instability; poor neighborhoods and built environments; low educational attainment and under/unemployment; and social exclusion and isolation (Shim et al. 2014)—are driving many of the community's poor outcomes.

As Tulsa moves forward with its 10-year mental health improvement plan, it is important to remember that improving mental and behavioral health is a complex process and cannot be solved by any one entity or sector alone. The ongoing refinement and implementation of the 10-year plan will need to be supported and well managed, if the overall effort is to be sustained and successful. This means that partners must continue to meet regularly and work together; bring new partners to the table; develop trust, shared ownership and accountability, and commitment around a common agenda; share data and measurements; implement mutually reinforcing activities; communicate clearly, honestly, and regularly; and provide the whole endeavor with backbone support. For many, this work will be new and challenging. It may also require a fundamental change in mindset about who is involved, how they work together, and how progress happens.

Such a culture change has implications for practitioners, providers, funders, and policymakers. Most importantly, the community and people affected by mental illness and substance use disorders must be intimately involved in this effort.

Key organizations and institutions within Tulsa, including major hospital systems, insurers, health plans, universities, and other large businesses and employers, need to be at the table, contributing to solutions in service design, delivery, financing, and policy. This will require innovative and adaptive advocacy work, not just technical or transactional solutions, and it will require a significant commitment of financial, political (nonpartisan), and other resources within a framework of continuous improvement and mutual accountability.

Tulsa cannot do this alone. Progress will require the goodwill and cooperation of state agencies and policymakers, as well as changes in state and federal policy (or at least new ways of using existing federal policies, programs, and funding streams). This is especially important for Medicaid, which is jointly funded by the federal government and the state and is the most important source of funding for health services for lower-income people, including children, people with disabilities, and people with mental health and substance use disorders. Expanding Medicaid would cover an additional 348,000 Oklahomans and add \$8.6 billion in federal funds.⁴⁹ Other state and federal policies can help ensure better supports and treatment for people with mental health needs in mainstream settings such as primary care, community-based health clinics, schools, housing, and workplaces. There are many opportunities for improvement, and Tulsa should take full advantage of them.

Appendix

Every week, new scientific reports, evidence-based strategies, and cost-benefit studies emerge that can accelerate the adoption of best or promising practices in clinical and community-based settings. Many well-respected organizations and agencies are screening and assembling these resources for others to use and learn from. Below are some resources that we used in this report and that stakeholders can continue to draw from over the 10 years of the plan.

Advancing Integrated Mental Health Solutions (AIMS) Center

University of Washington center offering supports for implementation, education, and research for Collaborative Care, an evidence-based integrated care model.

<https://aims.uw.edu>

Agency for Healthcare Research and Quality

Clinical guidelines and recommendations, continuing education events, curriculum tools for education and training, hospital resources, prevention and chronic care management portfolios, quality and patient safety guidelines, up-to-date data and research, grant opportunities, and current news articles.

<https://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/index.html>

American Psychiatric Association

Resources including practice management guides, signature initiatives, a learning center, information on certification and licensure, an innovation zone, cultural competency tools, awards and leadership opportunities, state and federal advocacy information, calendars of meetings and events, and search directories and databases.

<https://www.psychiatry.org>

Annapolis Coalition on the Behavioral Health Workforce

Resources, news, technical assistance, and strategic planning on the behavioral health workforce.

<http://annapoliscoalition.org>

Behavioral Health Workforce Research Center

University of Michigan center disseminating research on the behavioral health workforce through webinars, newsletters, and other means.

<http://www.behavioralhealthworkforce.org>

Blueprints for Healthy Youth Development

Database of evidence-based programs promoting prosocial behavior, academic success, emotional well-being, physical health, and positive relationships among young people.

<http://www.blueprintsprograms.com>

Cochrane

Research, resources, handbooks, and trainings on both physical and behavioral health care.

<http://www.cochrane.org>

Human Services Research Institute

Resources for stakeholders interested in evidence-based practice and evaluations for behavioral health interventions.

<http://tecathsri.org/knowledge.asp>

Meadows Mental Health Policy Institute

Nonpartisan nonprofit working to change the condition of mental health in Texas with resources including policy updates and reports.

<http://texasstateofmind.org>

National Child Traumatic Stress Network

Information for frontline providers, researchers, and families on child traumatic experiences and evidence-based practices.

<http://www.nctsn.org/>

National Guideline Clearinghouse

A public resource for summaries of evidence-based clinical practice guidelines.

<https://guideline.gov>

National Resource Center for Mental Health Promotion and Youth Violence Prevention

Resources and technical assistance for states, tribes, territories, and local communities to promote the overall well-being of children, youth, and their families.

<https://healthysafechildren.org/>

Office of Juvenile Justice and Delinquency Prevention

Database and resources for practitioners and communities on evidence-based youth prevention, intervention, and reentry programs; delinquency prevention; child protection; and safety.

<https://www.ojjdp.gov/mpg>

OSEP Technical Assistance Center on Positive Behavioral Interventions and Supports

Support for schools, districts, and states to implement social, emotional, and behavioral supports to improve social, emotional, and academic outcomes for all students.

<https://www.pbis.org>

SAMHSA's National Registry of Evidence-Based Programs and Practices

A searchable online registry of more than 400 substance use and mental health interventions.

<https://nrepp.samhsa.gov/landing.aspx>

SAMHSA-HRSA Center for Integrated Health Solutions

Resources on integrated primary and behavioral health services including models, workforce, financing, clinical recommendations, and webinars.

<https://www.integration.samhsa.gov>

Texas Institute for Excellence in Mental Health

University of Texas at Austin group providing research, evaluation, implementation support, workforce development and training, and policy and strategic support within the field of mental health.

<https://sites.utexas.edu/mental-health-institute/>

Washington State Institute for Public Policy

Reports and cost-benefit analyses on topics including mental health and substance use.

<http://www.wsipp.wa.gov/Reports/PolicyArea/5>

Notes

1. Life expectancy estimates and causes of death are from the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) and based on data from state vital statistics and ODMHSAS clients between 2004 and 2013.
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11. Estimates developed by Charles E. Holzer III based on 2015 five-year American Community Survey data and prevalence rates from the National Institute of Mental Health Collaborative Psychiatric Epidemiology Surveys combined dataset. See Holzer's website, <http://www.charlesholzer.com/>, for more information.
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