

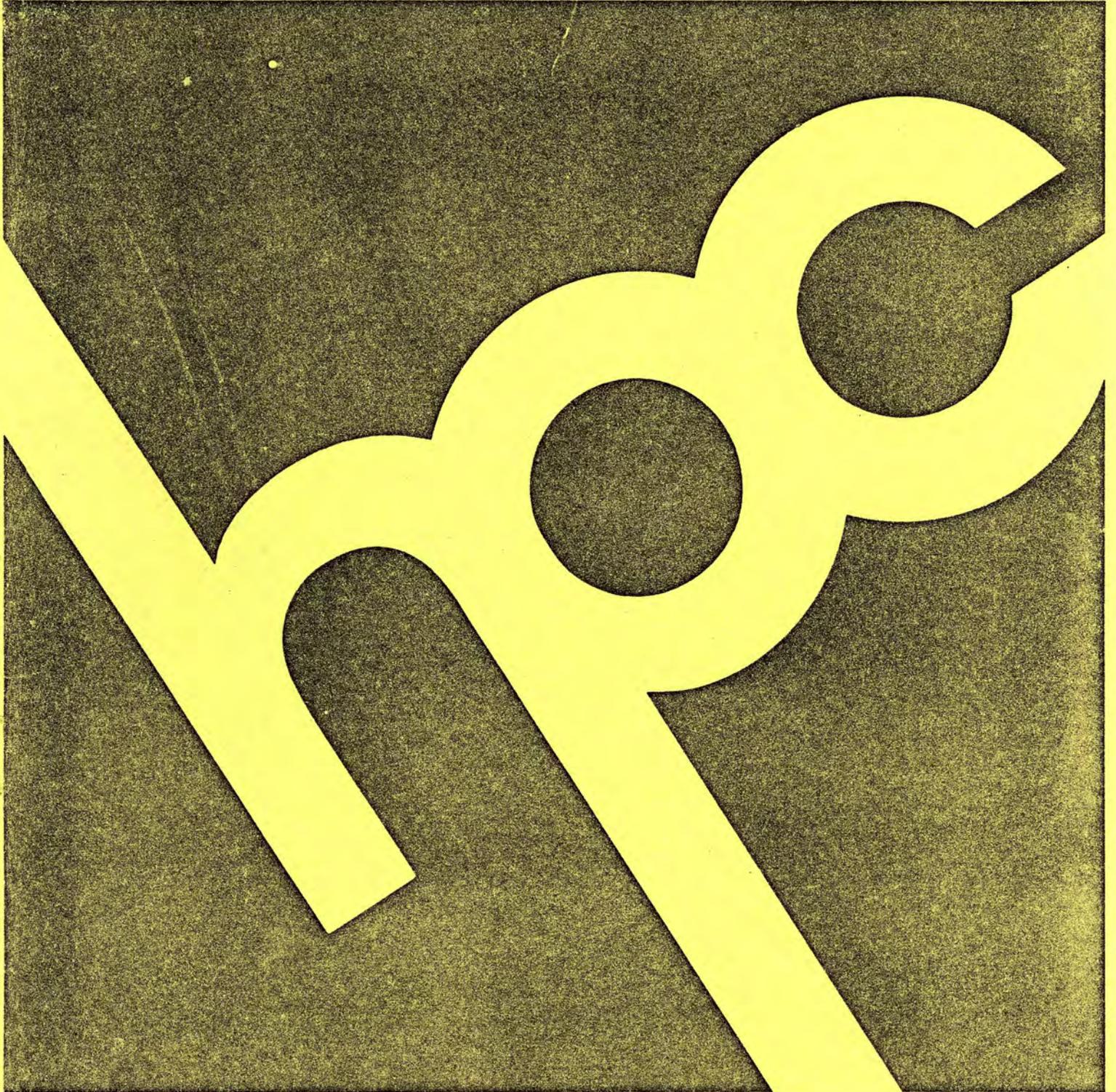


**Georgetown
University**

**Health Policy
Center**

**REVITALIZING OKLAHOMA'S
COMMITMENT TO THE MENTALLY ILL:**

**A Report to the Public and
Mental Health and Retardation Committee**



REVITALIZING OKLAHOMA'S COMMITMENT

TO THE MENTALLY ILL:

A Report to the Public and Mental Health and Retardation Committee

Standing Committee of the State Legislative Council

by

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Presented to the
Committees

April 25, 1978

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PREFACE

The Health Policy Center was funded by a three year grant to Georgetown University from the Robert Wood Johnson Foundation, Princeton, New Jersey, The purpose of the grant was to provide university-based policy assistance to state and local governments in the areas of health and mental health.

From its beginnings in 1975, the Health Policy Center concentrated most of its efforts on research and publication in a number of health areas of vital importance to state governments. Included in these publication were: Health Programs in the States: A Survey; A Legislators' Guide to Medical Malpractice; Paper Victories and Hard Realities: Implementation of the Legal and Constitutional Rights of the Mentally Disabled; Health Expenditures by State Governments; Death and Dying: An Examination of Legislative and Policy Issues; State Issues in Drug and Alcohol Abuse: A Sourcebook; Long-Term Care in the States: Medicaid Expenditures and Reimbursement Policies; and numerous other materials.

The Health Policy Center also maintained a 50 state network of correspondents providing the Center with up-to-date information on the latest developments in health policy in the nation's state capitols. In conjunction with this network, the Center published a newsletter highlighting innovative state policy developments entitled State Health News. In addition, the Center provided "technical assistance" requested by state and local governmental officials.

For the most part, the Health Policy Center's provision of technical assistance consisted of in-house research and response to inquiries. On a few occasions, however, the Center provided on-site assistance. This report on Oklahoma's mental health system represents the results of the most extensive assistance provided by the Center during its three-year funding period. Like other requests for assistance, it was pursued at the request of elected state officials and in accordance with the over-arching goals of the Center.

This report is based on the findings of Health Policy Center staff assigned to the project, and on the findings of consultants engaged by the Center in a private capacity. It is neither the official position nor the statement of Georgetown University, the Robert Wood Johnson Foundation, or the Human Services Research Institute. For all findings and conclusions contained herein, the Health Policy Center alone is responsible.

Gary J. Clarke
Study Director

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Gary J. Clarke
Study Director

SECTION I:

BACKGROUND TO THE REPORT

This report is the result of almost a year's negotiations and cooperative effort between the Health Policy Center of Georgetown University and the Oklahoma State Legislature. In early March of 1977, Representative Hannah Atkins, Chairwoman of the Mental Health and Retardation Committee approached the Health Policy Center to determine if the Center could provide assistance to the state legislature in its investigations of the state's mental hospitals. At that time, it was agreed that the Health Policy Center would consider providing some type of assistance if the request could be further specified. Both parties kept in regular contact thereafter, but no further action was taken.

In the summer of 1977, the Health Policy Center staff was requested to attend a meeting of the Joint Interim Public and Mental Health Committee. The purpose of the August 8 and 9 meetings was for the Center's staff to meet with members of the committee, visit some of Oklahoma's mental health facilities, discuss possible problems with executive and interest group representatives, and, in general, explore the possibility of providing assistance to the Joint Committee. Following these meetings, the Health Policy Center proposed a plan to provide the equivalent of 50 person days of staff time to visit Oklahoma, analyze findings, and write a report of its assessment of the overall status of Oklahoma's mental health system. The plan was proposed in a letter dated August 31, 1977, and accepted in a letter from Chairwoman Atkins dated September 8, 1977.

The Health Policy Center's study of the Oklahoma mental health system was to concentrate on four main areas:

- Organizational structure of the state's mental health system;
- Constraints impeding the development of mental health resources;
- Capacity to secure federal funds for the state's mentally disabled; and
- Implications of the state's new commitment law.

Gary Clarke, Senior Policy Analyst at the Center and editor of State Health News was appointed Study Director. Deborah Carr, Director of Program Services, was appointed Assistant Study Director. Human Services Research Institute, with whom the Health Policy Center had collaborated on several other mental health

ventures, was identified as the primary consultant to the Center.

The Health Policy Center perceived its role as one of providing broad review of the operations and facilities of the state's mental health system. In the short time available, Center staff could not investigate all the details of that system. Instead, the Center analyzed the major structural policies of the Department, and suggested changes where appropriate.

This report is intended as a rough road map showing where the state's mental health system is today and where it could be and should be in the coming years. It is intended to provide the Legislature, the Department, and ultimately the public, with an agenda for addressing critical problems in Oklahoma's present mental health system. It is intended to bring the problems of the state's mental health system in long range focus, thereby sharpening legislative and executive perspective on systematic concerns that need to be addressed. While specific issues involving the care currently provided to individual patients certainly merit investigation, it is our firm belief that those are symptoms of more general problems in the mental health system--including funding, treatment philosophies, and lack of community alternatives.

Funding and overall policy direction are surely as much the responsibility of the Board of Mental Health and the Legislature as it is the responsibility of the Department. Thus, in addressing our report to the Legislature, we believe we have properly emphasized those areas in which the Legislature has the greatest prerogatives and ability to act, i.e., areas of general policy direction and funding.

As noted above, Center staff did not have the time to collect primary data on the state's mental health system. While we have made some efforts to compare Oklahoma with national and regional norms on a variety of indicators compiled by the National Institute of Mental Health, our findings do not rest heavily on these facts. They are used primarily for illustrative purposes.

Rather, given the limited time and financial resources at our disposal, we purposely narrowed our inquiry. We concentrated our efforts on interviewing as many knowledgeable and influential individuals, both within the Department of Mental Health and without, as possible in a short period of time. In addition, we visited all three state mental hospitals, and four of the five presently operating community mental health centers. We also interviewed key executive personnel in both the Department of Health and the Department of

Institutions, Social and Rehabilitative Services, as well as a number of consumer representatives. Obviously, we could not talk to everyone with an interest in the subject. But our discussions with over 80 knowledgeable and influential individuals (including 45 in-depth interviews), our site visits, our review of the applicable statutes and regulations, and our review of the experiences of other states give us a more than sufficient background to feel comfortable with the recommendations made herein.

We believe the recommendations provide a good focus for the Legislature to use in its own evaluations of the performance of the Department of Mental Health and the entire mental health delivery system. More importantly, we believe that if our recommendations are acted upon, they will provide a springboard for a more comprehensive and diverse mental health system in Oklahoma, and a decrease in the current emphasis on institutionalization. The end result of such changes, we believe, will lead to the provision of better mental health care for all Oklahomans.

SECTION II:

NATIONAL TRENDS IN CARE FOR THE MENTALLY ILL

State care and treatment for the mentally disabled has undergone a rapid transformation in the last two decades. From little more than warehouses to incarcerate thousands of hopeless cases, state institutions changed into hospitals capable of providing a significant amount of rehabilitative care, enabling patients to return to their families and communities. This change has been brought about by at least three major forces.

The first significant breakthrough--and some still argue the most significant--was the development of the mind-affecting drugs in the mid 1950's. Though little is still understood about how these drugs act, they have permitted thousands of patients to control their emotions and reduce their anxieties and fears. The resultant change in behavior enabled hospitals to release great numbers of patients, and significantly reduced the purely custodial burdens on staff.

The second significant force affecting state hospitals has been the development of the concept of community-based care. While perhaps most easily symbolized by the passage of the federal Community Mental Health Centers Act in 1963, the concept has been significantly expanded to include a great variety of facilities not included in the original (and current) federal law. Satellites, clinics, room and board facilities, supervised apartments, halfway houses, and nursing homes are being used throughout the country to provide alternatives for persons once housed in large state hospitals.

The third, and most recent major force affecting the state hospitals has been the advent of significant legal challenges to both the commitment procedures used for involuntary hospitalization, and to the adequacy of treatment provided to the patient once he is hospitalized. These new legal challenges, perhaps most widely known from the cases of Wyatt v. Stickney in Alabama¹ and the Supreme Court's decision in O'Connor v. Donaldson,² have put state officials on notice not only that they may be required to expend huge sums of money to modernize their state hospitals, but also that they may become personally liable for deprivations of patient rights carried out in the name of treatment.

Though there are variations from state to state, in general, these three major factors have brought about a startling change throughout the country. Even in the face of an increasing population and an apparent increase

in social displacement, resident populations of state hospitals have dwindled to less than 190,000 patients from their all-time high of 550,000 in 1955.³

The impact of the new legal requirements on the mental health system has been mixed. On the one hand, a number of decisions have required a considerable tightening of the civil commitment procedure, making it more difficult to commit persons involuntarily, and required the development of "least restrictive alternatives" - community facilities - as an option to hospitalization. On the other hand, the effect of a number of court decisions has been to concentrate state tax dollars in state hospitals in an effort to upgrade patient care. In an era of limited resources, these investments may counteract the swelling tide of deinstitutionalization, limiting the amount of funds available to expand the number of community options.

Oklahoma has not been immune to these national trends. While no major litigation has yet been brought against Department officials, efforts to change the state's civil commitment statute and upgrade care in state hospitals are a reflection of the national reawakening to the needs and rights of the mentally disabled. Reductions in the state's resident hospital population, and increases in community facilities similarly mirror national trends. Thus, resident inpatient populations in Oklahoma have declined from approximately 8,000 patients in 1955 to present totals which hover around 2,200.⁴ In addition, five (soon to be six) federally funded community mental health centers, 26 state-run satellites and clinics, as well as a smaller number of private facilities, and more than 30 alcohol and drug abuse clinics (some operating jointly with other programs) are now in place throughout the state.

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SECTION III:

AN EVALUATION OF THE OKLAHOMA MENTAL HEALTH SYSTEM

The constellation of public and private programs that comprise Oklahoma's mental health system is unique in many ways. The system includes the most modern of community mental health facilities, as well as large, aging institutions. Both up-to-date and traditional treatment techniques are employed in the state, yet there is a surprising disregard for particular kinds of patient care philosophies and programs that have proven successful elsewhere. The system encompasses well-staffed, as well as understaffed facilities. The state provides significant amounts of funding for mental health care in a few public facilities, but almost no funding for care in equally good, but alternative private settings. It is a system that has made innovative uses of some types of federal funding, yet practically ignored other, perhaps more lucrative federal sources. In many ways, Oklahoma's experience is much like that of other states: it is struggling with traditional norms and attitudes with regard to mental health care, and with aging physical structures that impede its ability to respond and adapt to change. In the course of such struggles, however, it has developed an idiosyncratic character distinguishing itself from its sister states.

The Predominant Role of the State Hospitals

Perhaps the single most noteworthy feature of the Oklahoma mental health system is the pervasive presence of state government as the provider of most mental health services. For instance, a 1976 comparison of inpatient psychiatric beds in state mental hospitals revealed that Oklahoma's ratio of 97.5 beds per 100,000 population was at least 23 percent higher than ratios in Arkansas (42.5/100,000), Kansas (71.9/100,000), and Texas (79/100,000).¹

Yet ratios for total inpatient psychiatric beds (public and private combined) show that three of the four states are fairly similar. Oklahoma's total ratio of 127.8 beds per 100,000 population compares favorably with ratios of 129.9 per 100,000 in Texas, and 148.9/100,000 in Kansas.² Breaking those figures down still further, we find Oklahoma has 36 percent more state hospital beds per 100,000 population than Kansas. Kansas, on the other hand, has more than three and a half times as many private, non-profit psychiatric hospital beds per 100,000 population. The contrast with Texas, while similar, is not as stark.

It would be an oversimplification to draw conclusions directly from such figures.

Yet they present in bold relief the situation we found so unique in Oklahoma: the pervasive involvement of state government, the pre-dominance of the three state mental hospitals, and the virtual absence of private participation in mental health planning and decision making. With some notable exceptions, few groups outside of the Department and a handful of consumer groups have much stake in the present mental health delivery system.

Tax Implications of Large State Mental Hospitals

The distribution of public and private psychiatric hospital beds described above has significant cost implications. For instance, lengths of stay, while less costly on a per diem basis in a state institution, also tend to be longer than in private psychiatric facilities. In addition, third party reimbursement for inpatient hospitalization is frequently covered under private health insurance if the hospitalization is in a private, accredited facility. However, most private health insurance specifically excludes coverage for hospitalization in a state mental hospital, and most patients do not have the personal resources to entirely finance long stays in private hospitals. By implication then, *the larger the proportion of state psychiatric inpatient beds to private psychiatric inpatient beds, the greater the reliance on state tax dollars to finance inpatient care.*

Data compiled by the National Institute of Mental Health for 1975 tend to show that where there is a larger number of available beds in state mental hospitals, hospital admissions also tend to be higher. Oklahoma had the tenth highest admission rate per 100,000 civilian resident population among the 50 states--a rate of 253 admissions to state and county mental hospitals per 100,000 population.⁴ By contrast, admission rates for neighboring states with a fewer number of available beds were much lower. Arkansas had an admission rate of 119 patients per 100,000 population; Kansas had a rate of 186 admissions per 100,000 population; and Texas had a rate of 176 admissions per 100,000 population.

Again, we must emphasize that statistics cannot tell the whole story. Admission rates, by themselves, are not necessarily indicative of the mental health of the citizens of a state. But they do indicate that when available bed space is limited, the necessity for hospitalization appears to be reduced. Lower admission rates, in turn, mean reduced state costs--at least for hospitalization in state institutions, the most expensive form of state-supported mental

health care.

State Expenditures for Hospitalized Patients and Staff Ratios

The pervasive influence of the large, state-run mental hospitals in shaping the kind of care available in Oklahoma can be shown by still other information relating to two important indicators of patient care: expenditures per patient day and staff per resident patients. In 1974-75, Oklahoma ranked 39th out of the 50 states in its expenditure per patient day, with average expenses of \$30 per day per resident patient.⁵ *This is 20 percent less than average state expenditures nationwide.* Arkansas averaged expenses of about \$90 per day per resident patient, Kansas averaged \$50, and Texas \$27.

These extreme differences in expenditures on resident patients-- Arkansas spends 200 percent more per patient per day, Kansas spends 66 percent more--are more closely related to the number of hospital beds than tax expenditures. In fiscal 1975, Oklahoma made tax expenditures of approximately \$9.15 per capita (total civilian population) to care for residents of state hospitals.⁶ Yet per capita tax expenditures for resident care in Kansas were only 10 percent higher than Oklahoma (\$10.15), while Arkansas (\$6.34) and Texas (\$6.07) had significantly lower per capita tax expenditures for inpatient resident care in state mental hospitals.⁷ It seems that only the differences in the number of available state hospital beds--Arkansas has 51 percent fewer state beds, Kansas 44 percent fewer, and Texas 23 percent fewer--can explain the large variation in per patient expenditures when per capita tax expenditures are relatively the same or lower.

Given the difficulty in recruiting staff for state mental hospitals, the larger the number of patient beds the more difficult it is to provide sufficient patient/staff ratios. Oklahoma had a staff/patient ratio of 132 full-time equivalent staff for every 100 patients in 1975⁸--a performance which was slightly better than the nationwide average (109/100). Arkansas and Kansas, however, had staff ratios of 249 and 173 full-time equivalent staff per 100 patients respectively. Texas was lower than Oklahoma, with a ratio of 107 per 100.

Breaking down the staff/patient ratios a step further is even more revealing.

Oklahoma falls to the bottom third of the states when the ratio of full-time equivalent professional staff per 100 patients is examined. Oklahoma's ratio in this important category is 14.6 per 100, compared to 57.8 per 100 in Arkansas, 29.9 per 100 in Kansas, and 15.5 in Texas.⁹

The Predominant Role of the State in Community Care

With regard to outpatient psychiatric clinics, we note that Oklahoma has both one of the highest numbers of such clinics per million population, and one of the highest utilization rates of any state in the country.¹⁰ On the surface at least, this would indicate that Oklahoma is doing a good job of offering preventive mental health services. On closer statistical examination, however, this may not be the case. Over 63 percent of the outpatient clinics in Oklahoma have less than 300 additions per year.¹¹ This indicates that most of the clinics probably do little more than evaluation and reference, and cannot provide the aftercare, daycare, and vocational rehabilitation necessary to make preventive mental health care meaningful. In fact, our on site examination of the Oklahoma mental health system tends to support this conclusion.

In addition, it is interesting to note that only 15 percent of the free-standing clinics (29 clinics: 4 of 26 reporting clinics) in Oklahoma were run under private auspices.¹² Nationwide, almost half of all outpatient clinics are privately operated, and figures for Arkansas, Kansas and Texas were 88 percent, 32 percent, and 56 percent respectively.¹³ Of those states with ten or more free-standing outpatient psychiatric facilities, only five states had a smaller involvement of the private sector than Oklahoma.

In sum, an examination of national indicators tends to confirm many of our impressions and findings regarding the Oklahoma mental health system. The system is one which is dominated by state government, and the state department itself is dominated by the three state mental hospitals. As we have tried to intimate earlier, this emphasis dictates the type of programs provided for the mentally ill in Oklahoma, and the type of care patients receive.

Legislative Appropriation Shapes Department Emphasis on Hospitals

Over the past years, the Legislature's appropriation to the Department of Mental Health

has reinforced the hospital orientation of the Department. Even though there are many layers to the budget process, budgets are allocated almost solely on the recommendations of the Department, which in turn are largely based on the needs of each hospital. As a result, no special emphasis has been placed on community care, and no non-hospital based administrator has been given charge of a sufficiently large amount of resources to develop community oriented programs. Rather, each particular local program is largely an adjunct of one state hospital or another. Staff needs are defined in the hospital's budgets, and local programs must answer to superintendents whose first responsibility is running a large institution and keeping it accredited. For instance, even with all of the state's community mental health monies included in the Central State Hospital budget, over 75 percent of all 1977 expenditures under this item were still for inpatient services. Such an administrative structure, despite the best of intentions, stands the mental health system on its head. Rather than concentrating on programs to keep patients out of hospitals, top administrators have as their first concern the patients who are in the hospitals. Without minimizing the needs of hospitalized patients, a new system must be devised to ensure that the priorities of community based care get their proper place within the Department.

We also point out that the present budgetary scheme has had the effect of concealing information (in a non-perjorative sense) rather than helping with rational budget-making systems. Under the current scheme, considerable sharing of state line item positions can, and has taken place. Thus, administrators with control of both the hospitals and the clinics can move personnel between the two settings with relative freedom, depending on where the administrator's rather than the Legislature's priorities lie. In some cases at least, this has probably worked to the advantage of the clinics. But in the long run, it can only work to undermine the credibility and independence of the community facilities, and hide the real allocation of mental health resources in Oklahoma.

For instance, we note that each of the state-run community mental health centers is now administered out of Central State Hospital. This arrangement defies explanation in terms of building a rational, community oriented management structure, or in terms of developing regional treatment systems. To avoid obvious difficulties with management priorities and

oversight, this report recommends placing these facilities under a New Assistant Director responsible for all community mental health programs.

Care in State Hospitals Could be Improved

We also believe there are a number of problems with the care provided in the state's three mental hospitals. As noted earlier, despite their accreditation, these hospitals spend relatively little money and have relatively few professional staff persons per patient. With the exception of Western State Hospital, the hospitals are quite large, and all have aging physical plants.

In none of the hospitals we visited did we detect any widespread individualized treatment. Rather, we saw locked wards, a distinct lack of personal privacy, and few rehabilitative efforts aside from group participation in recreation activities and arts and crafts. *We were also made aware of various allegations of inadequate medical care.*

Our own site visits revealed that much of the medical staff were trained in non-English speaking countries, and that they apparently rendered mostly medical, as opposed to psychiatric care. Indeed, the lack of professional staff with formal, academic training in mental health care was particularly significant. With the exception of the Superintendents, not only were most of the physicians not trained in psychiatry, but there were also no psychiatric nurse practitioners and almost no psychologists.

It was also apparent from our site visits and discussions with staff that there were scarcely enough nurses to supervise an entire wing around the clock. Thus, the direct care staff most frequently in touch with the patients on a day-to-day basis are, at best, licensed practical nurses, or those with even less formal training.

Lack of Emphasis on Long Term Rehabilitation

The present treatment philosophy of the state-run mental health system is decidedly medically-oriented. That is, the Department has established a mental health system to treat mental illness in much the same manner as one would treat a medical disease. The system is based on providing primary care (clinics and satellites), linked to secondary care (community mental health centers), and tertiary care (the state hospitals). This model is excellent as far as it goes, but it ignores some of the

unique features of mental disability which distinguish it from standard medical care.

While the present system is well-designed to cope with acute episodes of mental illness, it makes almost no provision for the vocational and rehabilitative needs of many mentally disabled persons. The state has many places where its citizens can be diagnosed, evaluated, and counseled, and three hospitals where they can receive inpatient care. But there are virtually no facilities providing assistance for the more mundane but very real problems of securing alternative living arrangements, self-help skills training, and vocational and job placement services.

Under Oklahoma's present system of mental health care, if a person does not require inpatient hospitalization or medication, and is not undergoing a crisis situation, there is no place for him or her. *Unlike other states, which provide community-based living facilities for mental patients, including assistance with problems of day-to-day living and employment, the mental patient who leaves a state hospital in Oklahoma is virtually on his own.*

We cannot emphasize enough the need for such programs in Oklahoma. Breakdowns in day-to-day living patterns are the most frequent cause for institutionalization. And an inability to readjust to society after becoming accustomed to hospital routine is one of the more frequent causes for re-hospitalization. Yet nowhere in the current system is there a place to meet these needs.

The Absence of Community Living Facilities Attributable to State

Very few halfway houses or other supervised living arrangements are now operating in Oklahoma. None are operated by the state. Present licensing laws virtually prohibit the operation of such facilities without meeting all the structural and safety requirements necessary for non-ambulatory patients in a nursing care setting. Current levels of SSI supplementation are not sufficient to enable private individuals to provide both supervision and room and board to former mental patients and still break even. No state workers help prepare former mental patients for entry into the community by teaching them such simple tasks as how to make a bed, count change, or use a local bus system. No state workers identify suitable places for mental patients to live after they have been

released from an institution. No state workers identify foster families who might care for mentally disabled individuals, and no state monies are appropriated to reimburse foster families for care of the mentally disabled. *The Department of Mental Health has not even listed development of community living facilities as among its ten top priorities in 1977.*

Yet such programs are successfully operating in other states. They have made deinstitutionalization a realistic alternative. They have meant that former patients have an option beyond infrequent counseling or medication clinics, but less than full hospitalization. They have enabled the mentally ill to return to being fully productive members of society.

Scarcity of Private Facilities

The predominant presence of the Department of Mental Health as the major provider of mental health services in the state has meant that few private groups have had an impetus to get involved in the provision of mental health services. The lack of governmental programs to encourage the development of community alternatives has further contributed to the general citizen apathy about mental health. Yet those consumer groups that are active in mental health are presented with a unique dilemma: because the Department provides, and traditionally has been expected to provide, most mental health services, the Department has seen little need to encourage community participation. Because the Department will run the program anyway, there has been little pressure from within the community itself to become involved. As a result, many community groups have lacked significant political strength, and have been ignored or shunted aside to unimportant roles in shaping the state's policy.

Yet the mentally disabled in Oklahoma need both a strong public and private voice. The Department's distress at being the most vocal supporter of the mentally disabled would be considerably relieved if there was significant private support for its efforts. Yet by constantly excluding these groups in planning, and more importantly, by providing them with few, if any, opportunities to deliver care and treatment, the Department has created few friends and supporters in time of need. *Those few private groups that have been successful have done so without the Department's support, and sometimes in spite of its active opposition. Rather than building both a public and private coalition with mutually complimentary goals, the Department has, by commission and omission,*

created hostility and suspicion among many private mental health consumer groups who should be its strongest supporters.

New Commitment Law Needs Revision

The inability to build strong linkages between the Department and outside organizations is perhaps best illustrated by the recent attempts at implementation of the state's new commitment statute. Our review of this statute revealed that it has significant legal problems. As discussed further in Section IV, the statute does not require that proof of dangerousness be based on evidence of a recent overt act, lacks specificity on procedural and evidentiary requirements at examining hearings, does not make any meaningful provision for use of the "least restrictive alternative," contains no statutory time limits on the length of commitments, and does not require periodic review of commitments.

Irrespective of these deficiencies, the Department could have exercised sufficient leadership to inform local prosecutors, police officials, judges, and the private bar regarding the implications of the new law and the new procedures that are now mandatory. Instead the bill quietly became law and localities were faced with implementing a new statute with which they were unfamiliar. It is not surprising that local district attorneys voiced a number of problems with the statute less than six months after it became effective. As we understand their complaints, many had to do with simple administrative requirements that could have been uniformly explained throughout the State. The failure to seize the opportunity to be supportive and solicitous of local concerns led to a situation where antagonism and mistrust was engendered toward the Department and the Legislature as a result of the new statute.

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SECTION IV: RECOMMENDATIONS

The Health Policy Center staff and consultants have made numerous recommendations for changing the present structure of the Oklahoma mental health system. These recommendations are made in light of our findings in Oklahoma, as well as our experience with and knowledge of successful mental health programs in other states. While in the final analysis we alone bear the responsibility for these recommendations, it should be stressed that each was either suggested to us by Oklahomans or supported by Oklahomans who are knowledgeable about the present system.

We are aware that not all of these recommendations can be implemented overnight. We recognize that even those recommendations that are adopted may take quite a different form after they have been scrutinized by the legislative and executive branches. Our task however, as requested by the Committee, was to develop a wide-ranging blueprint to guide the Legislature and focus its inquiry into the mental health system of Oklahoma.

Our study focused on four main areas:

- Organizational structure of the state's mental health system;
- Constraints impeding the development of mental health resources;
- Capacity to secure federal funds for the state's mentally disabled; and
- Implication of the state's new commitment law.

We emphasize that our recommendations in no way imply a lack of overall competence or integrity on the part of the personnel of the Department of Mental Health. On the contrary, we were impressed by the dedication and devotion to the plight of the mentally ill shown by Department personnel. We were equally impressed, however, by the paucity of funding and by the strained relations between the Department and the Legislature, which have put the Department on the defensive. These two conditions seem to have led the Department to a greater concern for preserving existing mental health programs than with concern for modernizing the system in order to take advantage of some of the more innovative mental health

treatment and organizational concepts that have proven successful elsewhere. Our recommendations are intended to focus on the possibilities for modernization of the state's mental health system.

Some, but not all of these recommendations call for new state expenditures for the mentally ill. Others call for better use of existing revenues, including expanded use of federal funds. Other recommendations call for little if any new expenditures, but rather for better utilization of existing resources and an expansion of the state's regulatory powers, or for new ways of approaching current tasks. Many call for fixing responsibility for the care and treatment of each patient with clearly identified personnel within the Department of Mental Health. Almost all of these recommendations are separable, and could be implemented independently. Together, they encompass a sweeping agenda for change in the Oklahoma Department of Mental Health, and for change in the state mental health system at large.

RECOMMENDATION # 1

We recommend that the Legislature establish a Select Committee on Mental Health Care for the purpose of: (1) developing concrete legislation proposals to implement recommendations for recodification made in this report, and (2) overseeing departmental actions to implement studies and programs recommended in this report. The Select Committee should include members of both the Senate and the House.

Rationale: This report calls for extensive changes in Oklahoma statutes regarding the delivery of mental health care, especially in the areas of community mental health services and civil commitment. The report also calls for significant activities by both the Department of Mental Health and the Department of Institutions, Social and Rehabilitative Services. To ensure these activities are carried out, as well as to develop the particulars of extensive statutory changes, we believe the Legislature needs to establish a joint committee which can conduct extensive interim activities. Only continuing interim activities can maintain a high legislative profile in Oklahoma's changing mental health scene. Only such a committee can refine new legislative proposals in time for the next session.

RECOMMENDATION # 2

Establish a new state mental health advisory council in compliance with PL 94-63 comprised of consumers, including clients and their families; mental health providers; representatives of non-government agencies or organizations; and representatives of relevant state agencies. At least 60% of the council should have no affiliation with a direct or indirect provider of mental health services.

Rationale: The current five-member state mental health board is not sufficiently broad in its representation to meet the standards of federal legislation (PL 94-63) that mandates the creation of such a body. Unless Oklahoma develops a council that meets current requirements, it is in jeopardy of losing its federal mental health funds.

Federal law charges the new council with significant responsibilities for developing a state mental health plan. The council should also be required by state law to make yearly reports both the Legislature and the executive branch regarding the status of public mental health care in the State.

Appointments to the council should be made both by the Legislature and the Governor to ensure that the body is responsive to both parties. Members of the council should be appointed for revolving terms so that at least one-third of the membership is replaced yearly.

RECOMMENDATION # 3

Serious consideration, and further study should be undertaken, of the role of the state mental hospital in Oklahoma's mental health system. As community mental health facilities evolve, there should be a decreased need for the hospital. While this need will not disappear entirely, long term resident populations should decrease as new alternatives become available. The necessity for perpetuating the institutions as they now stand - particularly Western State Hospital - requires further study.

Rationale: Oklahoma's state hospitals are characterized by aging physical plants and a decreasing resident population. Significant state expenditures in these hospitals will be required simply to shore up old facilities, and provide, in essence, what are increasingly becoming facilities for the aged and infirm. The determination of exactly how and whether the State should make such expenditures should come as the result of an overall plan for the future of the State's mental hospitals, rather than as the result of short-term crisis requirements of particular institutions.

This is particularly true of Western State Hospital. Expenditures were required to shore up a boiler system that threatened to shut down entirely during last winter's (1977) severe cold. More repairs are still necessary. Foundations have cracked in several places, roofs need major repairs, etc. Deterioration is getting to the point that a major decision about the continuation of the facility in its present form seems advisable.

Thus, we note the following:

1. *According to Department of Mental Health officials, more than 100 patients at Western State Hospital have been transferred there from Central State Hospital in order to keep up the present census. In other words, patients were transferred because Western State Hospital would have been underutilized if the natural demands for service had dictated*

utilization rates.

2. Western State Hospital serves as the designated residential inpatient mental health facility for all of southwestern Oklahoma, although Central State Hospital is closer and has better highway access.

3. Most of the patients at Western State Hospital are geriatric patients, many with long residence there.

4. Of the 35-40 short term acute patients generally at the hospital at any one time, at least half could have been more conveniently served by the inpatient facilities of Jim Taliaferro Community Mental Health Center - a center where underutilization of inpatient capacity is particularly apparent.

We cannot help but wonder if Oklahoma citizens might not be better served by a number of mid-size nursing homes scattered throughout the State to care for the long term mentally ill, and by community mental health centers with both an inpatient and outpatient capacity. This is in contrast to reliance on a few large hospitals, with their attendant problems in administration, cost, quality of care, difficulties with meeting licensure and accreditation requirements, and problems with getting adequate reimbursement under federal health and welfare programs--especially Medicare and Medicaid.

We also note that closing or reducing the size of a state hospital does not, indeed should not, mean the automatic loss of jobs for state workers. Smaller facilities--including both nursing home type facilities and community mental health centers--will need to be established to take the place of the large institutions. Workers could be shifted to increase currently low staff/patient ratios in other hospitals. They could also be "out-stationed" in community-based programs such as halfway houses or partial hospitalization services.

State workers have proven their skills in supervising alternative community living arrangements. St. Louis State Hospital in Missouri, for instance, has been particularly successful in retraining hospital employees as community workers. As patients have returned to the communities, former hospital employees have been trained to help patients meet their needs in this new setting.¹

RECOMMENDATION # 4

Each of the state hospitals should immediately re-orient its personnel policies and methods of providing patient care. A "personnel" system promoting individual staff accountability for patient care should be implemented in the hospitals; a wage comparability study should be undertaken by the State Personnel Board; and a greater emphasis should be placed on the use of non-physician personnel.

Rationale: Oklahoma's state mental hospitals are plagued with a number of difficulties which are not atypical of problems in other states. Institutions are large, populated with a number of patients who have little chance of returning to the community, plagued by inadequate fiscal resources, ancient physical plants, high staff turnover, little staff training, and removed, rural locations for two of the three hospitals. Despite these problems, we were impressed with the dedication of a number of the staff, but believe more could be done to improve the provision of care in the institutions. Thus, we recommend a number of specific changes within the hospitals.

First, we recommend that the state hospitals adopt a system promoting individual staff accountability in providing care for patients. Under the present arrangements, aides and nurses have generalized responsibility for all patients on their ward. For instance, three persons on a shift have general responsibilities for all 40 or so patients on the ward. Instead of this practice, we recommend a system whereby an aide or nurse is specifically identified with a smaller number of patients. For instance, assuming three aides work the day shift, and three work the evening shift on a particular ward, each aide could be given personal responsibility for six or seven patients (i.e., $6 \div 40 = 6.67$).

Such a system has several merits. First, it permits the mental health administrator (including the charge nurse and the superintendent), and the patient to expect personal accountability for each patient's well-being. Each nurse or aide could be personally identified as the person for overseeing the general care and the treatment of the patient, reporting on his progress, making sure records are in order, etc.

Second, it permits the patient to have an individual within the system to whom he can turn and expect personal assistance and

cooperation. Third, and perhaps most importantly, implementation of such a personnel system permits rank and file employees to take a personal stake in their jobs and to have bona fide professional responsibilities. Such a system can not only fix responsibility, it can result in identifying a single individual who can function as an advocate for the patient.

Nothing in the personnel system as we propose it should be taken as undercutting the professional authority of medical staff at the state hospitals. Indeed, their cooperation and assistance are absolutely vital to make the concept work. Moreover, we highly encourage the use of team concepts to evaluate patient progress and undertake therapy. That being said, however, we think it is incumbent on the hospital administration to recognize their inherent limitations due to the small size of their medical staffs. We recommend that rather than focusing on legislative battles which are sure to be resolved less than satisfactorily, the present administration should try to take advantage of every ounce of existing staff's creative and therapeutic talents. We think a personnel system such as proposed, if implemented with proper training, would go a long way toward achieving this objective.

Our second major recommendation concerning a re-orientation of state personnel and management policies is that the Legislature require the State Personnel Board to undertake a wage comparability study for all Department of Mental Health personnel, concentrating first on nurses, licensed practical nurses, psychiatric and nurses aides, psychiatric technicians, and other persons involved with day to day care for the mentally ill in the state's three hospitals.

We recommend that wage comparability studies be undertaken not only between these positions in state government and similar positions in private industry in Oklahoma, but also between these positions and similar positions in state hospitals in other states. In addition, we recommend that wage guidelines be developed for employees assuming new functions under the above proposed personnel system. Such studies would either affirm or deny long standing complaints within the Department of Mental Health concerning low wage scales.

If affirmed, we think they would clearly act to pressure the legislature to improve the compensation of mental health workers in the State.

Our third major recommendation, concerning a re-orienting of the state hospitals' personnel and management systems, involves the provision of medical and mental health care within the hospitals. Throughout our visits to Oklahoma we were struck by the numerous complaints voiced by patients, nurses, and other individuals about the scope and quality of medical care in the hospitals. In a similar vein, Departmental officials expressed concern about attracting qualified physicians given the present low wage scales. While we do think that physician wages in Oklahoma are probably at the low end of the scale compared to a number of other states, we think the problem lies deeper than that. We believe that, except for the dedicated few, medical practice in a rural mental hospital offers few personal, professional, or remunerative rewards for American-born and trained physicians. We also believe that a simple increase in salary will do little to alleviate the problem.

Rather than try costly and, in the end, probably unsuccessful campaigns to attract more American born and trained physicians to the state hospitals, we recommend that the Legislature and the Department recognize the inherent limits of the situation. As the head of the health care team, well qualified physicians need to be included in the state hospital system. But rather than trying to attract large numbers of physicians, we recommend that the Department be more selective. We recommend that it concentrate on getting only highly qualified physicians, and put the rest of its efforts into using non-physician primary care personnel - registered nurses, nurse practitioners and physicians' assistants - to carry out the bulk of the primary medical care at the state hospitals.

We believe that realistically speaking, the hospitals cannot hope to attain the high level of medical skill available in the community hospital. Pay levels are too low, facilities are often outmoded, and the patient load and variety is simply too low to insure maintenance of skill. There is no reason, however, why the state's hospitals cannot provide the same level of primary care as is available in the community. Study after study has conclusively shown that nurse practitioners and physicians' assistants, working under the

supervision of a physician, can provide quality of care equal to that of the physician.

What we are recommending is that the hospitals recognize their own inherent weaknesses. Rather than trying to be all things to all people, they should concentrate on what they can do well - provide mental health care and primary medical care. More difficult medical problems should be taken care of by contract with outside hospitals and medical centers. Within the institutions, emphasis should be placed on attracting more non-physician, American-born and trained primary care practitioners, rather than the latter practice of hiring a few M.D.s, regardless of the latter's qualifications or ability to communicate with the patient. For example, we note that a beginning salary of \$34,000 per year is not sufficient to attract a United States trained physician who has completed his or her internship and residency, but would be sufficient to attract two well trained nurse practitioners or physicians' assistants at \$17,000 each. While the net gain to the state would not be exactly two for the price of one, the productivity gains compared to a non-English speaking physician with little or no training in psychiatry would be significant. We think the hospitals and the state are limiting themselves, the patients, and their employees if they continue to be harnessed to a strict medical model role, requiring someone with an M.D. degree at all costs, in providing care at the state institutions.

In the same vein, we believe that the Department should place more emphasis on attracting qualified non-physician personnel with training in the mental health field to work in the state hospitals. We noted that there are a number of clinical psychologists shouldering considerable patient workloads in the community mental health centers. However, we met only one clinical psychologist in our visits to the three state hospitals. Similarly, hospital officials informed us that not a single psychiatric nurse is employed in the three state hospitals.

We believe the Department is missing a considerable opportunity to attract able and proven manpower into the state hospital system by not concentrating its efforts in attracting these two types of mental health personnel. Both psychiatric nurses and clinical psychologists have demonstrated their effectiveness in other state mental hospitals across the country. And there are numerous training programs for these types of personnel in other states. If the Department is unsuccessful in attracting candidates from these other states, it is not

inconceivable that the Department could help sponsor programs to train Oklahomans-- either undergraduates or current staff personnel-- in these specialized disciplines. Such sponsorship could take the form of assistance with out-of-state tuition in return for taking a position in the hospital, or cooperation with Oklahoma schools desiring to establish such programs. Whatever the case, the mental hospitals would be well-served by focusing their attention on attracting more clinical psychologists and psychiatric nurses.

As with other recommendations, we recommend the Department make quarterly reports on its progress in these areas to the Legislature's Select Committee on Mental Health Care.

RECOMMENDATION # 5

Require the Superintendents of all state hospitals to develop a pre-discharge plan for all patients released from the state hospitals. The plan must be developed in cooperation with community based mental health centers, clinics and satellites. At a minimum, the plan should state where the patient plans to reside (or where the Department recommends he should reside), the name of the mental health worker in the community who will act as the patient's case manager, goals for the patient in the community, any suggested drug or treatment regimen, and whatever treatment or rehabilitation services will be necessary to assist the patient in community adjustment. The pre-discharge plan should be developed in conjunction with the patient and/or his guardian, and a copy should be given to the patient and/or his guardian.

Rationale: Citizens throughout Oklahoma made numerous critical comments about the manner in which patients are released from the state hospitals, particularly Central State Hospital. Though we were not able to verify these reports, some patients are apparently given little more than a bus ticket home, while others are referred to room and board facilities that cannot meet even minimal expectations for providing sanitary and safe living conditions. In addition, community workers in at least some parts of the State do not appear to be notified when patients are released from the state hospital and return to their community.

This recommendation is designed, as are other recommendations in this report, to fix responsibility for the care and treatment of patients with clearly identified personnel within the Department of Mental Health. In addition, it is designed to get both the patient

and community personnel involved in helping to plan out the patient's future, notify him or her of opportunities in the community, and provide a linkage between the hospital, the patient, the community worker, and the services available in the community.

In keeping with this aim, accountability for the client at the local level should also be fixed with the development of a case management system at least at each community mental health center. Case managers should be responsible for working with institutional personnel in the development of pre-discharge plans and for ensuring that the aftercare services outlined in the plan are in fact secured. Further, community case managers should assist released patients to secure non-mental health services such as income maintenance, supervised housing and work training and job placement.²

RECOMMENDATION # 6

Establish an inter-agency task force to explore means of capturing a greater amount of federal funds set aside for the mentally disabled. Require the task force to report its findings and recommendations to the Legislature's Select Committee on Mental Health Care within six months

Rationale: We believe that none of the agencies involved in providing care to the mentally ill have fully explored the opportunities for obtaining federal funds for their client groups. For the state government to overlook the opportunities for capturing federal funds simply means that taxes raised from Oklahoma citizens and corporations are being used to fund projects in other states. We have previously alluded to opportunities in the Medicaid program which are not being taken advantage of. *In addition, the State has turned back a portion of its Title XX allotment to the federal government - money which will not be held in reserve for Oklahoma for the coming year, but which will be used by other states to fund their programs.* Yet one of Title XX's specific goals is to promote deinstitutionalization. Thus, this money could have been used for transportation, housing, homemaker services, resocialization services, and a host of other programs for the mentally disabled.

Similarly, there are federal funds available from the National Institute of Mental Health's Community Support Program, the Department of Housing and Urban Development, the Office of Developmental Disabilities of HEW, the Department of Labor (CETA) and the Rehabilitation Services Administration that

could be used to aid Oklahoma's mentally ill. We think many opportunities to capture these funds are being wasted, and urge the formation of a task force to identify all possible federal resources and develop a plan to obtain them. As we have stated earlier, Oklahoma's mental health system has some serious gaps, a number of which are attributable to a lack of fiscal resources. If Oklahoma is to fill these gaps, it should explore every opportunity to gather additional fiscal resources.

RECOMMENDATION # 7

Require the Department of Mental Health and DISRS to conduct a joint project to determine Medicaid eligibility for every resident patient of the state hospitals, and to determine whether or not that patient would be better cared for in a nursing home, or in some other non-hospital setting. Both Departments should make joint, quarterly reports on their progress to the Select Committee on Mental Health Care. Conditions to be considered in nursing home or other, less restrictive placement include:

- (1.) the severity of the medical problem;
- (2.) the severity of the mental problem;
- (3.) the capability of the patient to benefit from care in the nursing home or other facility;
- (4.) the capability of the patient to benefit from care through continuing residence in the state hospital;
- (5.) the potential for increased family involvement if the patient is placed in an nursing home or other facility close to his or her community;
- (6.) the capabilities of the nursing home or other facility to care for the patient;
- (7.) the availability of programs for care or rehabilitation available at the nursing home or other facility rather than the state hospital, or vice-versa; and such other criteria as may be appropriate.

Rationale: Throughout our site visits of the state hospitals, as well as in our discussions with state officials, we were told that there are a number of residents of the state hospitals who cannot benefit from further care and treatment, but who continue to reside at the hospital. *Many of these patients, while initially admitted for mental problems, have medical problems that have long since surpassed their mental problems.* Indeed, there are a number of persons in the hospitals who receive nothing more than medical and nursing care.

We recommend that a joint project be undertaken to: (1.) identify those patients who only require medical and nursing care or who should be placed in less restrictive facilities; (2.) identify those patients requiring only medical and nursing care who are also eligible for Medicaid; (3.) identify those nursing

homes or other community facilities that could provide equivalent or better nursing, medical or psychiatric care to those patients so identified; (4.) place patients identified as benefitting from such placement in nursing homes or other facilities; (5.) require that DISRS pay the state's matching share of Medicaid monies for those patients placed in nursing homes; and (6.) require that the Department of Mental Health pay nursing homes any additional amounts required to provide specialized mental health care. Payments to facilities other than nursing homes should be made from those sources suggested in the previous recommendation.

Throughout our visits to Oklahoma, numbers of accusations concerning the question of nursing home placement were constantly bandied about. In truth, however, there seems to be no accurate data to identify which patients are both Medicaid eligible and medically eligible for nursing home placement. A joint project to determine their number would set apparently long standing resentments at rest.

More importantly, it would identify those individuals who can no longer benefit from care in a state hospital and place those who can receive equal or better care from a private nursing home or other facility, in such a facility. Such placement would relieve a substantial administrative burden on the state hospitals now dictated by the sheer force of numbers.

Unlike our previous recommendations concerning provision of the state Medicaid matching amounts from the Department of Mental Health, we believe the major portion of the state share of the cost of placing individuals in nursing homes should properly rest with DSHRS. Those persons who were or are mentally ill should not be discriminated against if medical problems are now the paramount concern in providing for their well-being. The mere fact of placement in a mental institution per se should not operate to deny Medicaid benefits to an otherwise eligible recipient.

We do believe, however, that if funds are needed to provide greater reimbursement to nursing homes to care for the mentally ill, the Department of Mental Health should be responsible for funding such supplementary payments. Such a joint funding program would operate to keep the Department of Mental Health vitally interested in the adequacy of care provided in these nursing homes. In addition, it might act as a spur to encourage the

Department to develop programs for reducing hospital populations, without relying on nursing homes, if the money was made available only on a per patient basis, and was encumbered in such a way as to permit expenditures either for upgrading a nursing homes, or for adult day care, home care, etc.

The Departments should be required to make quarterly reports on all activities in this area to the Legislature's Select Committee on Mental Health Care Reform. Only through such a mechanism can the Legislature oversee performance and help resolve inter-departmental dispute in accord with legislative intent.

RECOMMENDATION # 8

Amend the state's current Medicaid program to provide reimbursement for services provided by federally approved community mental health centers, including private centers, as well as qualified clinics and satellites; permit Medicaid reimbursement for services provided by non-physicians even when the physician is not on site, and require the Department of Mental Health to provide the state matching funds for the state share of Medicaid expenditures attributable to these recommendations.

Rationale:

Six community mental health centers started with grants from the federal government are now in operational or planning stages in Oklahoma. Three of the centers are run by the state and three are non-profit private ventures (one of which is not yet under construction). Because of federal funding requirements, all of these centers either will or do provide a comprehensive range of mental health services, and all have imposing and costly physical plants. Each of these centers, whether private or state-run, is vital to the provision of mental health services in Oklahoma. And each will be, or has been faced with the scheduled withdrawal of virtually all federal program funding. As a result, each will or has faced the necessity for finding replacement funding, cutting back on services, or going out of business. Given Oklahoma's large low-income population, and given the inadequate coverage for mental health services in most insurance policies now in force in the State, each of these centers will be financially pinched - a phenomenon that has already occurred at two centers.

In order to avoid the financial crisis and subsequent attempts to garner direct state subsidies that will surely result from withdrawal of federal funds, we recommend that the

State begin now to provide coverage for mental health services in its Medicaid program. A large number of persons, who are currently either receiving Medicaid or are Medicaid-eligible, now receive services from both the state and private community mental health centers. If the State provided coverage for these individuals under the Medicaid program, it would pay only 35 percent of the cost of delivering services (based on the state's current federal Medicaid Assistance Percentage). If such coverage is not provided, the State will eventually have to subsidize these services at 100 percent of cost, or have services dramatically reduced from their present levels. In the long run, however, even the latter alternative is unlikely to reduce overall state "savings." If individuals do not receive community care, they may wind up in the more expensive state hospitals, where the State is obligated to provide treatment. In addition, it should be noted that state hospitals will become even more expensive in the future as the result of mounting accreditation and legal pressures to upgrade present institutions.

For instance, we note that the state-administered Carl Albert Community Mental Health Center currently has an annual budget of over \$1 million, almost all of which is provided by the federal government. In four years, however, these funds will have diminished to almost nothing. At that time the State will be faced with either coming up with an extremely large subsidy or drastically cutting back on services, since 80 to 90 percent of all recipients at the Center have incomes below the poverty level, and thus are unable to pay for the care they receive.

We think a better approach would be to begin a program of Medicaid reimbursement for community based mental health services. The federal government permits such coverage in other states under either the "clinic services" or "other services" categories of optional state services for which federal Medicaid matching funds are available. Since federal officials are fairly lenient in permitting states to design their own programs under the "optional services" headings, the State could design a reimbursement program to meet its own peculiar needs. The program could start out fairly restrictively, and then grow over time as both the need to replace federal program funds became more serious and as the centers and the State became more expert in administering such a program.

Since the savings resultant from using such a reimbursement program would aid the budgetary requirements of the Department of Mental Health, we recommend that the Department be responsible for providing the state's Medicaid matching funds for these services. We also recommend that the new Assistant Director for Community Mental Health have the primary responsibility for designing the program and its restrictions, that DISRS provide only fiscal and initial eligibility services, and that quarterly reports on progress toward implementing this program be made to the Legislature's Select Committee on Mental Health Care.

RECOMMENDATION # 9

Permit the Department of Health to license and regulate room and board facilities and alternate living facilities (including half-way houses and adult day care centers); require the Department to make its regulations governing personal care facilities more flexible; and require the Department of Health to develop flexible standards for regulating each of these facilities based on the needs of the patients served by the facilities. This would include a modification of state fire standards where ambulatory patients are residing.

Rationale: Experience in both Oklahoma and other states demonstrates that in order for the State to have the authority to insure even minimal compliance with fire, safety, and sanitation codes, licensure of room and board facilities and other living facilities is required. Otherwise state and local officials are powerless, in all but the most extreme cases, to prevent abuse and exploitation of patients, to prevent maintenance of unsafe facilities, and to prevent preparation of unhealthful food. Under present Oklahoma law, it is difficult to inspect, much less close, an inadequate facility.

Mindful of the liabilities of excessive governmental regulation, we nonetheless believe that a system for licensure and regulation of these facilities must be put into place. We believe the Department of Health, with responsibility for a number of other licensing and facility inspection programs, should have the responsibility for this program.

We also believe that the regulatory system set in place by the Department must be a flexible one, and must include consultation with the Department of Mental Health, DISRS, and the state fire marshall. In order to keep duplication at a minimum however, only the Department of Health should be given the

licensure authority. We urge this Department to develop standards for regulation that are keyed to the needs of the residents in a facility, rather than arbitrary and inflexible standards designed to protect patients who are wholly chairfast or bedfast. A great opportunity will be lost if heavy structural building requirements are placed on operators of these facilities. Not only will the number of facilities be greatly diminished, but cost will necessarily increase.

Furthermore, we note that creation of this licensure authority would coincide with new federal regulations (effective October 1977) requiring that all states designate an authority to enforce standards in all facilities where a "substantial number" of SSI recipients reside. We believe the designated authority under the federal requirements should be the Department of Health because many of the facilities licensed under federal requirements will be the same as recommended for licensure in this report.

Since the programs we are recommending for payment for patients residing in these facilities would be state controlled, we see no compelling need to follow the most recent Life Safety Code. California, for instance, has developed a flexible program for regulating room and board and other types of facilities based on the size of the facility and the particular needs of the patients residing therein. A similar system could be adopted in Oklahoma.

We also highly recommend that the Department of Health amend its present licensing standards for "personal care facilities." These types of facilities are designed to care for patients who do not require the same high level of care as in a nursing home, yet still require a significant amount of supervision. These personal care facilities - somewhere between a nursing home and a room and board facility - are virtually nonexistent in Oklahoma. This seems almost certainly due to present restrictive licensing requirements, as well as the lack of a public reimbursement mechanism. Under present regulations, the structural requirements for a personal care facility are almost the same as for a licensed nursing home. As a result of the large capital investment required to meet such standards, it makes no sense to open a personal care facility when more lucrative reimbursement rates are available if the facility is a nursing home. If care in less

expensive personal care facilities is to become a viable alternative in Oklahoma, existing standards must be changed.

RECOMMENDATION # 10

Enact a new statute providing direct payments to recipients, and vendor payments to providers, to promote deinstitutionalization. The new program should make provision for: additional state supplementary income for mental patients who are SSI recipients, above and beyond that supplied by DISRS; subsidies to encourage home care and adult day care; special vendor payments for nursing homes, room and board facilities, and other living facilities which provide specialized care for the mentally ill; and provision for vocational rehabilitation for the mentally ill through Medicaid.

Rationale: The Health Policy Center staff believe that a reduction in the size of the resident populations of Oklahoma's state mental institutions is both a legal and programmatic imperative. An increasing number of federal court decisions have held it unconstitutional to place patients in institutions more restrictive than necessary. And certainly Oklahoma's mental institutions-where locked wards are the rule rather than the exception-fail to pass constitutional muster with regard to this rule.

Perhaps more important, however, are the social imperatives for reducing the state's institutionalized population. Numerous studies have revealed that former mental patients can be rehabilitated to become contributing members of society, and that many patients would never become dependent on state institutions if the proper mix of preventive services were available in their own community. From the patient's perspective, from the treatment perspective, and from society's perspective, reintegration into the community should be the goal of all mental health programs.

In order to meet these imperatives, Oklahoma needs to expand the range of community based services it now provides. With few exceptions, there are now no facilities between the state run hospitals and the acute care, crisis oriented centers, satellites, and clinics. Oklahoma needs to establish a program not only to support establishment of alternative living facilities, but to provide them with a viable source of long range fiscal support. We recommend that a financial program offering direct assistance to patients, and vendor payments to providers, be established to encourage

and ensure the long range availability of such programs.

First, the State needs to supplement the income of those SSI recipients released from the State's mental hospitals. A large number of these individuals, without a home or family, have been winding up in room and board facilities with no means of support except their SSI check. Yet the check, even with the current state supplement, is not sufficient to provide for more than food and shelter. If the State hopes to acclimate these individuals to society, it needs to give the patient a sufficient income to live in decent surroundings as he makes the readjustment.

Similarly, for patients who still need a small amount of supervision and care, there need to be financial incentives for organizations to provide such care. The present amount of SSI income is not sufficient to provide these incentives. What the State needs to provide is an additional supplement to that currently being provided that can be used to promote self-sufficiency, and that can be gradually withdrawn as this goal is attained.

For those patients who require more long term supervision, the State ought to make it possible for private facilities to provide such supervision without requiring them to be licensed as a nursing home. In many cases where supervision is required, a high-powered expensive health team is not necessary. Yet under current Oklahoma programs, state reimbursement is available only if the patient is in one of two costly settings: the state hospital or the nursing home.

It should also be noted that federal regulations forbid the placement of mental health patients in nursing homes unless the nursing home is equipped to adequately handle his or her emotional, as well as physical problems. For those patients in state institutions who can no longer benefit from the institution, and who have bona-fide medical problems, we recommend their placement in nursing homes. Where such placement is made however, the State should be able to require that special attention be provided, and should be able to reimburse the facility for providing such attention.

We also recommend that the State explore the use of its Medicaid program to provide vocational rehabilitation to mental patients returning to the community. The State of Connecticut has apparently funded many programs for the mentally retarded through this device,

and at a substantially reduced price from what wholly state funded programs would require.

Finally, we note that the possibilities for providing home care, adult day care, and community support services for the mentally ill seem to have gotten little attention in Oklahoma. A number of other states, however, are now beginning to experiment with these mechanisms as a method of reducing the high costs involved in institutionalization. New York, for instance, has recently enacted a new statute permitting payment for "nursing home care at home" for patients who otherwise would have been placed in nursing homes under the state's Medicaid program. New York and several other states are also now requiring that if private health insurance policies provide coverage for hospital care, they also must provide coverage for home care.

In California, the state has recently enacted an "Adult Day Health Care Program" as a part of its Medicaid program. Like the New York law, its goal is to reduce the high costs of institutionalization by providing a mechanism for reimbursing services provided to patients who reside at home.

Massachusetts, Rhode Island, and Arlington County, Virginia, are all starting programs to pay parents and other interested adults for the care, and especially treatment of the mentally ill and retarded in their own homes, rather than throwing that responsibility entirely on the state. Similar programs could certainly be designed in Oklahoma.

In essence, what we are calling for is the establishment of a varied arsenal of fiscal alternatives to meet multiple patient needs and to prevent, wherever possible, the necessity for costly hospitalization.

This programmatic focus has recently been reinforced by the National Institute of Mental Health through the creation of the new Community Support Programs (CSP). Funds for NIMH initiative come from two previous grant programs--Hospital Improvement Projects (HIP) and Hospital Staff Development (HSD). CSP grants are available to states and localities for the express purpose of mobilizing community support service networks for chronically mentally disabled persons.³

RECOMMENDATION # 11

Re-organize the top administrative structure of the Department of Mental Health by creating a new position of Assistant Director for Community Mental Health. The Assistant Director should report directly to the Director, and be accorded the staff, influence and authority over aftercare currently under the jurisdiction of the Superintendents of the Central State Hospital.

Rationale: Under the present administrative structure, responsibility for community development is not given the high level of recognition and influence necessary to shape the overall policy of the Department. Aside from the \$120,000 now appropriated for community mental health services, all departmental resources are oriented around the state hospitals, and indeed, flow through them. The natural result is that Oklahoma's current mental health system is predominantly state hospital oriented.

We believe the Oklahoma Mental Health Department should place an increased emphasis on community mental health facilities and services, and that its structure should be changed to reflect those priorities. Thus, the Assistant Director for Community Mental Health should have increased staff, increased resources, and be responsible for carrying out duties newly delegated to the Department through other recommendations. In addition, state supervision over the budgets and personnel of the community mental health centers, the clinics, and the satellites should all be organized and administered by the new Assistant Director and his or her staff.

RECOMMENDATIONS # 12-17

Undertake a comprehensive revision of the Community Mental Health Services Act (Oklahoma Revised Statutes 43A 601-609).

- Change the definition of facilities eligible for state assistance to include half-way homes and other living arrangements for the mentally ill. (Recommendation 12)
- Permit the state to sponsor and/or fund community mental health facilities wherever local mental health boards fail to devise a plan for care and treatment of the mentally ill in their own jurisdictions. (Recommendation 13)
- Increase the state-local matching ratio of 50/50 so that the state assumes a proportionately larger share. (Recommendation 14)

- Increase the present appropriation under this statute from \$120,000 to \$360,000, and evaluate the need for further increases in future years. (Recommendation 15)
- Establish legislative priorities in the statute to guide the Department in its development of community mental health facilities. (Recommendation 16)
- Place responsibility for administering this statute with the new Assistant Director for Community Mental Health. (Recommendation 17)

Rationale: The present statute permits state monies be used to establish and run three types of community mental health programs:

- a. Community mental health centers offering an expensive and extensive range of services;
- b. Outpatient facilities offering diagnostic and treatment services; and
- c. Day care facilities.

Nowhere does the statute permit funding for facilities that would provide supervised residential care for mentally or emotionally disturbed patients, as well as counseling, case management, and other services. There is a crying need for just such facilities in Oklahoma. Basically the State provides three types of services--hospitalization, outpatient acute care, and prescription medicine clinics. Yet many patients need a place to get away, a place to become gradually reintegrated into society, and a place that will provide a supportive atmosphere while the person actually lives in his or her community.

Although alternative living facilities have been a major success in different parts of the country, they are almost non-existent in Oklahoma. Discharge workers at state institutions must now send patients to either a nursing home, an unlicensed, unregulated room and board facility, or the patient's home. Placement in the nursing home is costly to the state, often inappropriate, and generally precluded by the patient's finances and Medicaid restrictions. Room and board facilities in many places can barely provide safe and healthful living conditions, much less care. And return to the family may reinvolve the patient in conditions that contributed to his or her problem in the first place.

We recommend that the State of Oklahoma build on the successful experiences in other states and begin to provide seed money to establish half-way homes and other living arrangements for the mentally ill. To do so, the definitions of eligible facilities for receipt of state assistance must be changed.

In addition, we recommend that the state have the power to sponsor and/or fund community mental health facilities wherever local mental health boards fail to devise acceptable local mental health plans. The objective of this recommendation is to provide an incentive for active local involvement in mental health planning, as well as to permit the state to act in those areas where local mental health boards fail to recognize the need for priority services. Inherent in this recommendation is that the Department, in conjunction with the State Health Planning Commission, develop standards for local mental health plans.

The present state-local matching ratio of 50/50 should also be increased. The fiscal resources of many private organizations and local units of government are limited, and they may be unable to supply the match necessary to secure state funds for priority services. In many communities where the need is greatest, financial constraints are the most pronounced. Experience in a number of other states has shown that by increasing the state portion of the matching ratio, development of community facilities is hastened. In California, for instance, the current state-local matching ratio is 90/10. We believe that the state government, with its larger tax base and greater ability to distribute funds to communities where the need is greatest, should assume a greater portion of the funding costs for community mental health services.

Budgetary priorities within the Department's appropriation need to be realigned. The present expenditure of \$120,000 to support the development of community mental health services needs to be increased. This amount has not changed for a number of years, resulting in a real decline in the actual resources devoted to community mental health services under this statute. While we do not know the optimum level of financing for this program, an immediate 200 percent increase seems necessary at the present time (i.e., an additional \$240,000). Thereafter, the Legislature should re-evaluate the appropriation in light of further increased needs for community mental health services, including both alternative living arrangements as well as a variety of other community support services.

We also recommend that the Legislature establish in the statute priorities to guide the Department in its development of community facilities. In order to ensure that the community development monies are used to support a variety of different types of projects, and to prevent use of the increased funding solely to support ongoing programs, the Legislature should spell out its own priorities. We highly recommend that these priorities emphasize the development of facilities such as half-way houses, supervised apartments, and other alternative living arrangements enabling the mentally ill to make the transition back into their communities. Community mental health monies should not, however, be used exclusively for these purposes. Other services, such as resocialization, transportation, job training, and case management should also be taken into account.

Finally, we recommend that the authority for implementing the new comprehensive Community Mental Health Centers Act be lodged with the new Assistant Director for Community Mental Health.

RECOMMENDATION # 18

Require that a regional, community based mechanism be established for examining and referring all patients.

Rationale: As noted earlier, the present Oklahoma mental health system is dominated by, and oriented toward, care in state hospitals. The emphasis on the state hospitals necessarily results in the costly and often inappropriate utilization of the state hospitals when less restrictive and more beneficial avenues for care and treatment are available.

We recommend that no patient be admitted voluntarily or involuntarily to a state institution unless first screened by a community mental health center or designated, locally based screening unit. Those involved in screening should be able to assess the needs of the patient, and should be appraised of all available community placement options. We believe such a screening mechanism, which could be carried out simply by giving special training to personnel at existing centers, satellites, and clinics, would help counteract the present bias towards hospitalization. The new Assistant Director for Community Mental Health should be responsible for establishing and managing such a screening mechanism, and should make quarterly reports to the Select Committee on Mental Health Care Reform on the Department's progress in this area.

RECOMMENDATION # 19

The Department of Mental Health should expend greater efforts to involve community leaders in its planning and implementation of mental health programs.

Rationale: Throughout the period of our study in Oklahoma, we received numerous complaints about the lack of community involvement in development of the state's mental health programs. On more than one occasion, community representatives were not informed of critical Department meetings, or informed so late that attendance was impossible. Ideas for development of local mental health programs often have been assigned an extremely low priority, if not discarded entirely, in the face of Department counter-proposals. For instance, although a local group in Ardmore put together their talents and skills to develop a federally-funded community mental health center, their efforts were opposed by Department officials who wanted to develop their own center in the same town.

To our way of thinking, such efforts are counter-productive. Given the scarce resources available for mental health in Oklahoma, the Department and local organizations should not fight over the same turf. There is more than enough to be done by the Department in other areas where interest in mental health program initiatives is minimal. As noted earlier, one of the characteristics of the Oklahoma mental health system that distinguishes it from most other states is its high degree of reliance on state-run programs to deliver care. Such reliance not only drains state tax dollars, it may foreclose significant opportunities to expand and diversify the present system.

If the Department is going to develop the varied types of alternative living facilities recommended in this report, it is going to have to rely on community groups throughout the State for assistance. Such assistance will be forthcoming only if the state and community interests see themselves as partners striving to achieve a common goal-- better treatment for the mentally ill. One method for assuring ongoing interest and participation at the local level is the establishment of regional mental health advisory boards appointed by local government. Each regional body would be responsible for the development of yearly mental health plans for the area listing service priorities and needs.

Such plans could then form the basis for mental health grant allocations and resource development.

RECOMMENDATION # 20

Revise Oklahoma's commitment statute to bring it up to leading constitutional standards.

Rationale: A commitment statute occupies a key position in a state mental health system. It establishes under what circumstances individuals are involuntarily placed in state hospitals, and the nature of the judicial proceeding required to determine the necessity for such action. Commitment statutes have long been attacked on civil rights grounds because they act to deprive a person of his or her liberty despite the fact that the person usually has committed no crime, and because they have deprived persons of their liberty without the usual safeguards accorded even the most highly dangerous and wanton criminals.

The commitment statute serves as a main entrance point into the state hospitals. If strict procedures are not followed, and all alternative avenues are not explored, commitment hearings can result in unnecessary hospitalization. Such unnecessary hospitalization results in a significant personal loss to the individual, a significant drain on the fiscal resources of the state, and a significant drain on the manpower resources of the hospital. Thus, on both libertarian and fiscal and programmatic grounds, a civil commitment statute should be drawn as tightly as possible, permitting institutionalization only after a clear necessity has been shown, and only after all less restrictive alternatives have been ruled out.

The State Legislature's recent revision of Oklahoma's commitment procedures is a significant improvement over the previous statute. Nonetheless, review of the statute by Health Policy Center staff reveals several areas in need of change. These areas include the following:

1. The definition of persons who may be involuntarily committed leaves much to be desired. Almost all courts that have considered the issue have found there must be some actual proof of dangerousness, such as commission of a recent, overt, dangerous act, before a person can be committed as "dangerous." The present statute has

no such requirement. In addition, there is no indication of legislative intent concerning what is meant by "serious harm" which might befall a person unable to care for himself.

2. Since involuntary commitment under this statute involves as much (some say more) restriction of freedom as criminal imprisonment, the patient should be accorded the same procedural and evidentiary rights guaranteed to defendants in criminal proceedings. The statute lacks a number of safeguards and specificity about the commitment procedure itself, which would make the statute liable to constitutional attack. For instance, at least on its face, the statute makes no specific provision permitting the defendant's attorney to cross-examine members of the examining committee. In addition, it seems that the respondent (the person who may be committed) has no absolute right to be present at the preliminary inquiry of the examination commission, and, if he or she is present, there seems to be a simple presumption that the person will cooperate freely (i.e., no right to silence). Also, it should be noted that the petitioner (the person seeking the commitment of another) can testify at this preliminary inquiry, but cannot be cross-examined, and that no specific provision is made for payment of (in the case of an indigent respondent), or qualification for "expert" witnesses.
3. The new commitment statute makes mention of providing the "least restrictive alternative" for committed patients, but in fact there appears to be no statutory requirement that all avenues be explored. This is both a constitutional infirmity and a programmatic liability.

REFERENCES

1. See Appendix for article on this program
2. Case management is now a required service pursuant to recently adopted standards of the Joint Commission on the Accreditation of Hospitals for community mental health programs. See Appendix for a brief description of the new standards. Also see Appendix for an article on case management.
3. See Appendix for a brief description of the Community Support Program.

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in such treatment. In addition, there is no indication of legislative intent concerning what is meant by "serious harm" which might result in a person unable to care for him- self.

2. Since involuntary commitment under this statute involves such grave and potentially serious consequences, the patient's fundamental right to privacy should be accorded the same procedural and evidentiary rights guaranteed in proceedings in criminal proceedings. The statute lacks a number of safeguards and specifics about the commitment procedure itself, which would make the statute liable to constitutional attack. For instance, at least on the face, the statute makes no specific provision regarding the defendant's attorney to cross-examine members of the examining committee. In addition, it seems that the respondent (the person who may be committed) has no absolute right to be present at the preliminary inquiry of the examination committee, and, if he or she is present, there seems to be a simple presumption that the person will cooperate freely (i.e. no right to silence). Also, it should be noted that the petitioner (the person seeking the commitment of another) can testify at this preliminary inquiry, but cannot be cross-examined, and that no specific provision is made for payment of (in the case of an indigent respondent) or certification for "expert" witnesses.

3. The new commitment statute makes mention of providing a "least restrictive alternative" for committed patients, but in fact there seems to be no specific provision that all avenues be explored, this is both a constitutional fallacy and a programmatic liability.

APPENDIX

- A. Persons interviewed by project staff
- B. Brief introduction to new JCAH standards
- C. Article on Case Management
- D. Description of NIMH Community Support Program
- E. Article on St. Louis State Hospital project
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APPENDIX A:

List of Persons Who Participated in In-depth Interviews

1. David Cox
Office of the Governor
2. Hayden Donahue, M.D.
Department of Mental Health
3. John Holt
Department of Mental Health
4. Wesley Gibson
Department of Mental Health
5. Joseph Tyler, M.D.
Eastern State Hospital
6. William Blyth, M.D.
Western State Hospital
7. Edsel Ford
Department of Mental Health
8. Royce Means, M.D.
Jim Taliaferro Community Mental Health Center
9. Frederick Becker, M.D.
Carl Albert Community Mental Health Center
10. Ronald Smallwood, Ph.D.
Carl Albert Community Mental Health Center
11. Roger Turner
Carl Albert Community Mental Health Center
12. Sid Bridges
Carl Albert Community Mental Health Center
13. George Miller
Department of Institutions, Social &
Rehabilitative Services
14. Bertha Levey
Department of Institutions, Social &
Rehabilitative Services
15. Pauline Meyer
Department of Institutions, Social &
Rehabilitative Services
16. Michael Fogarty
Department of Institutions, Social &
Rehabilitative Services
17. Herbert Ham
Department of Institutions, Social &
Rehabilitative Services
18. Howard Miles
Health Department
19. Darrel Harwick
Health Department
20. Ronald McAfee
Health Department
21. Jack Boyd
Oklahoma Health Planning Commission
22. Jerry Knight
Department of Insurance
23. David Bickham
Oklahoma Medical Association
24. Lyle Kelsey
Oklahoma Medical Association
25. Cleveland Rogers
Oklahoma Hospital Association
26. James Cox
Tulsa Psychiatric Center
27. Linda Mullins
Oklahoma Mental Health Association
28. William Hancock
Oklahoma Mental Health Association
29. Elizabeth Holmes
Oklahoma City/County Mental Health Assoc.
30. Lois Fagin
Oklahoma County Mental Health Consortium

31. Jean Gumerson, Member of the Board
Oklahoma Health Systems Agency

44. Vivian Smith
Oklahoma Health Sciences Center

32. Robert Watkins, Ph.D.
Oklahoma Health Sciences Center

45. A Nurse Supervisor
Central State Hospital

33. Rod Huffman
Oklahoma City Health Department

34. Udell La Victoire

Thanks also to the physicians, nurses, and aides on the wards of the hospitals who took the time to answer our questions and show us the facilities, and also to the staff of the community mental health centers who were kind enough to extend their hospitality to us during our site visits. Their insights and suggestions were very valuable.

35. Shirley Barry
American Civil Liberties Union
Oklahoma City

Thanks also to the patients at the facilities we visited for their tolerance of our presence. For any invasions of privacy or descriptions of hospital routine which occurred during our site visits, we must apologize.

36. Juanita Nelson, Deputy Clerk
Oklahoma County Mental Health Court

37. Jane Ashley
National Association of Social Workers
Oklahoma Chapter

38. GeorgeAnna Snyder
Nursing Home Administrator

39. Donald Bertoch, Ph.D.
Clinical Psychologist in Private Practice

40. Ellen Oakes, Ph.D.
Oklahoma Psychological Association

41. Neal Towner
Oklahoma Blue Cross/Blue Shield

42. E.N. Earley
The Tulsa Tribune

43. Mike Boettcher
Oklahoma Monthly