HEALTHY MINDS
POLICY INITIATIVE

The State of Oklahoma's Mental Health System for Children: Inpatient and Residential Services

Needs and treatment capabilities into a post-COIVD era

Already increasing before 2020, the number of children and youth struggling with poor mental health in Oklahoma has surged during the pandemic. Stressors unique to COVID-19– including deaths in the family, financial hardship, and social isolation because of the disease and virtual schooling – have weighed heavily on children and youth and have consequently intensified the youth mental health crisis. This increased need has exposed gaps in Oklahoma's mental health continuum of care, as more children and youth are placed in restrictive settings such as emergency rooms, inpatient, and residential placements.

Moving forward, the state needs a robust continuum of mental health services for its children and youth. For the small number of children and youth who cannot be safely supported in the community, this means having timely access to psychiatric inpatient care or residential interventions. In this report, we examine the current state of Oklahoma's inpatient and residential services for children and youth with complex and acute needs and offer considerations and opportunities for quality and capacity improvements. This is the fourth installment of our State of the Children's Mental Health System series. To read more, visit healthymindspolicy.org/children.

Key Findings

- **The state's limited beds are disproportionally concentrated in Oklahoma City.** The Oklahoma City metro has 60% of the state's 915 children's mental health beds but only 36% of the state's children. The Tulsa area has 12% of the beds but 26% of children, and non-metro areas have 27% of the beds for 37% of children.
- **Oklahoma overutilizes inpatient and residential beds, lacking appropriate alternatives.** Because the state has relatively few non-inpatient intensive services for children with complex needs, there are few options to divert these children from inpatient care or provide appropriate step-down care after an admission. This contributes to overwhelming demand on inpatient facilities, hospitals, and child protective services.
- **New beds like those proposed for state ARPA funds would provide immediate relief, but won't meet the need on their own**. Inpatient services are expensive and can be avoided in most cases. Filling gaps in other treatment areas is the first step toward ensuring inpatient resources are "right sized" for the children who truly need them.
- **Current inpatient services are often not community-linked, youth-guided, or family-focused.** Oklahoma children in inpatient or residential care can receive little discharge planning, connections to aftercare services beyond a referral, or family involvement.

Background

Healthy Minds Policy Initiative's fall 2021 update on the impact of COVID-19 on children's mental health in Oklahoma provides a broad overview of increasing suicidality, mental health crises, and emergency room utilization in 2020 and 2021. According to estimates based on the latest data, more than 54,600 children and youth ages 6 to 17 will experience a major depressive episode in any given year in Oklahoma. Almost 51,500 will struggle with a serious emotional disturbance, and more than 24,800 will attempt suicide (see Table 1 below).

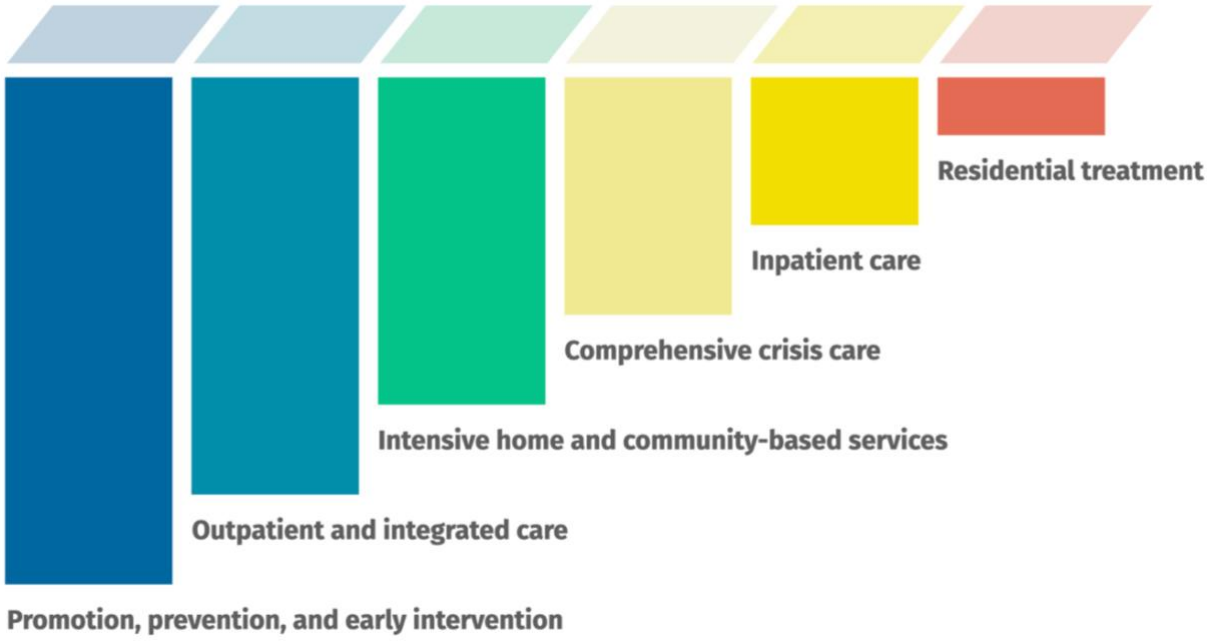
Data collected by schools early in the pandemic point to increasingly severe levels of crisis. Oklahoma Prevention Needs Assessment (OPNA) survey results for the 2019-2020 school year indicate that almost 60% of the students who responded to the survey struggled with high (approximately 30%) or moderate (28%) psychological distress.[1] Almost 78% of students indicated that they experienced high (8%) to moderate (approximately 70%) depressive symptoms. In addition, 17% indicated that they had seriously considered attempting suicide in the past 12 months, almost 15% said that they had planned to attempt suicide, and nearly 10% reported having "actually" made at least one suicide attempt. The number of students who were identified as experiencing psychological distress, as well as the number who reported experiencing depressive symptoms and thoughts of suicide, increased as compared to responses from the 2017-2018 school year.[2]

Table 1 – Oklahoma County, Tulsa County and Statewide Mental Health Prevalence Data

Conditions	Children and Youth (6–17) Estimates		
	OK County	Tulsa County	Oklahoma
Total Population (6–17)	**132,223**	**107,577**	**643,415**
Ages 6–11	68,397	54,815	322,382
Ages 12–17	63,826	52,762	321,033
Mental Health Conditions			
Major Depressive Episode (MDE) [3]	9,826	7,952	54,609
Bipolar[4]	1,468	1,214	7,384
Post-Traumatic Stress Disorder[4]	1,915	1,583	9,631
Co-Occurring MDE and Substance Use Disorder[5]	1,147	929	6,376
First Episode Psychosis (16–17)[6]	9	8	49
Serious Emotional Disturbance (6–17)[7]	10,578	8,606	51,473
Attempted Suicide[8]	4,864	4,030	24,833

The Children's Continuum of Care

The ideal behavioral health continuum of care for children comprises a seamless, comprehensive array of services and supports linking promotion and prevention services with physical health, mental health, and substance use disorder treatment. This continuum of care takes a population health-based perspective[9] and describes a comprehensive offering of services and interventions for all children, including those with emerging, low to moderate, or complex behavioral health needs. The continuum includes six components that range from promotion and prevention services to the most intensive interventions and provides an overview of recommended practices for each component.



The ideal continuum accounts for the fact that children, youth, and young adults may need different services at different times of their lives, and it connects individuals to the right level of care at the right time. The continuum recognizes that a mix of services from the various components may be necessary to meet complex needs and that different levels of care coordination (from service coordination to Wraparound) may be needed to help children, youth, and their families navigate services across the continuum. It also recognizes that children and youth with more involved needs are often served by multiple agencies (e.g., mental health, child welfare, juvenile justice, education).

The ideal system of care includes a continuum of crisis service components that range in intensity from comprehensive crisis care (Component 4) to inpatient care (Component 5) to residential treatment services (Component 6). The crisis care components include mobile response and stabilization services that can address urgent needs outside of care delivery. They include an array of crisis placements (such as in-home crisis respite, crisis stabilization, and acute inpatient

care) tailored to the needs of the community. More importantly, the components in the crisis continuum are anchored in, not a substitute for, a robust array of outpatient (Component 2) and intensive community-based services (Component 3). They also include time-limited follow-up care, coordination with emergency medical services, and inpatient care, with short-term residential treatment as the last option.

Overview of Inpatient and Residential Services

Children and youth whose acute behavioral health needs cannot be met safely in a less restrictive, more natural setting may benefit from inpatient care (Component 5). Inpatient care may include psychiatric consultation in emergency rooms and inpatient capacity to address health, mental health, and substance use needs. A smaller number of these children and youth may require additional support and time to be stabilized. They may benefit from residential treatment services (Component 6), which include short-term, community-based psychiatric residential treatment programs and therapeutic group homes.

Inpatient Care

Inpatient care is the most restrictive and intensive component of the continuum. It is needed to care for children and youth whose acute behavioral health needs cannot be safely addressed in the community. The primary goals of inpatient care are safety and symptom stabilization during a mental health crisis. Children and youth are more likely to be admitted to inpatient care if they are struggling with severe symptoms, present as a safety risk (especially related to suicide), were previously admitted to inpatient care, have a family history of mental illness, or have caregivers who are struggling with the child or youth's behaviors or their own mental health issues. Other factors that can also increase the likelihood that a child or youth is placed in care include lack of community-based services and supports and social circumstance (e.g., child welfare or juvenile justice involvement).[10] Inpatient treatment can reduce the symptoms of depression, anxiety, and suicidal ideations.[11]

Readmission

Readmission to inpatient care is a significant problem. National studies indicate that 30 to 60% of children and youth who are placed in acute care will be readmitted within three to 24 months.[12] Children and youth who exhibit suicidal behavior, have a history of being victimized, have problems with their peers, have a history of violence, or struggle with learning problems are more likely to be readmitted. Children and youth in foster care, younger children, and those living in rural areas are also more likely to return to inpatient care. However, children and youth who are connected to community-based services and supports after discharge are less likely to be readmitted.[12] Ultimately, a full continuum of high-quality community-based services and supports that is available before, during, and after an acute mental health crisis can effectively increase inpatient bed capacity by reducing the number of children and youth who need acute psychiatric inpatient care.[13]

Seclusion and Restraints

Seclusion and restraints are restrictive practices commonly used in acute psychiatric inpatient facilities and residential treatment centers when a child or youth is at imminent risk of harming themselves or someone else. A recent study on psychiatric inpatient centers across the United States found that seclusion or restraints were used with approximately 17-29% percent of children and youth admitted to psychiatric inpatient care.[14] These interventions, although intended to improve safety in extreme situations, are associated with negative outcomes including risk of injury (or death) to the child or staff, re-traumatization, distress, and negative emotions. However, certain organizational and clinical interventions have demonstrated success in reducing the use of seclusion and restraints without compromising patient or staff safety.[14] Organizational interventions to reduce seclusion and restraints promote shared goals, a framework, and a positive attitude toward change. Clinical interventions aim to improve the child or youth's communication skills and affect regulation, involve families and youth in their care, and promote the well-being of staff (Table 2).[14]

Table 2 – Interventions to Reduce the Use of Seclusion and Restraints in Inpatient Care[14]

Organizational Interventions	
Intervention	**Brief Description**
Six Core Strategies[15]	Developed by the National Association of State Mental Health Program Directors. The core strategies are (1) leadership toward organizational change, (2) use of data to inform practice, (3) workforce development, (4) use of seclusion and restraint prevention tools, (5) consumer roles in inpatient settings, and (6) debriefing techniques.
Trauma-Informed Care (TIC)	TIC embeds an understanding of trauma responses in all levels of an organization so that the organization is compassionate, nonviolent, and collaborative. Clients feel connected, valued, informed, and hopeful. Staff understand the connection between trauma and psychopathology and mindfully work with children, youth, and families in empowering ways.
Child- and Family-Centered Care (CFCC)	CFCC is a philosophy of care that recognizes that parents need emotional support. It is based on treating people with respect and dignity, sharing information with the child and family, and supporting them to build on their strengths. CFCC engages children and families in program and policy development.
Collaborative and Proactive Solutions (CPS)	CPS assumes that a child will do well if they can and that negative behaviors occur when expectations surpass abilities. CPS engages caregivers to identify problems and lagging skills and helps caregivers and youth solve these problems collaboratively and proactively.

Organizational Interventions	
Intervention	**Brief Description**
Modified Positive Behavioral Interventions and Supports (M-PBIS)	M-PBIS is a three-tiered approach that involves (1) universal interventions such as positively worded expectations and descriptions of how to meet those expectations, (2) targeted problem-solving conversations with select patients, and (3) functional behavioral assessments and individual behavior plans for a small number of patients.
Clinical Interventions	
Intervention	**Brief Description**
Sensory Rooms	Sensory or comfort rooms are designated spaces that contain fidget tools, weighted blankets, colored lights, or relaxing music, all of which are designed to stimulate the senses.
Mindfulness-Based Stress Reduction	MBSR combines mindfulness-based meditation and yoga and includes scanning, meditation, and gentle yoga positions.
Milieu Nurse	A milieu nurse is responsible for creating an environment that is structured, safe, consistent, and empathetic.
Autism Spectrum Disorder Care Pathway (ASD-CP)	ASD-CP includes autism-specific interventions that account for limited communication skills, intellectual abilities, and behavior problems.
Dialectical Behavioral Therapy (DBT)	DBT is an evidence-based treatment that addresses suicidal and self-injurious behaviors.

Research on behavior management programs, a widely used intervention in psychiatric inpatient and residential facilities, showed a decrease in use of seclusion and restraints when these programs were discontinued.[14]

Residential Interventions

A full continuum of behavioral health services for children and youth includes access to residential interventions when children and youth cannot be safely supported in less restrictive settings or through intensive community-based services. Residential interventions are second only to psychiatric inpatient and juvenile incarceration in their level of restrictiveness, intensive use of resources, and cost. For these reasons, they should be reserved for children and youth with very complex needs or unsafe behaviors (e.g., fire setting) who may not respond to less intensive interventions in the community.[16, 17]

Unfortunately, research on the full continuum of care has demonstrated that the population of children served in residential care is similar to the population receiving care in less restrictive settings.[17] Without a universally understood set of criteria, clinicians often use different standards for assessing the need for residential services, including the availability of placement options, risk of harm to self or others, the complexity of the child or youth's family situation, and

the severity of the child or youth's symptoms.[17] However, a lack or perceived lack of alternative treatment options is a common factor. When possible, less restrictive approaches should be considered first; when residential services are used, they should be brief, intensive, youth-guided, family-driven, as close to home as possible, and anchored in a full continuum of behavioral health services.[17]

Historically, residential treatment has been isolated at the far end of the children's behavioral health continuum of care, operating separately from community-based services, and seen as a long-term "placement of last resort" by service providers and payors. Children and youth placed in residential care are often described as having failed previous treatments.[18] The Association of Children's Residential Centers (ACRC) recommends shifting the residential treatment paradigm from a "placement of last resort" to a specialized opportunity offered earlier in a child or youth's care that can establish stability or restore a family's equilibrium.[19] ACRC's perspective on residential services is reflected in Building Bridges Initiative's (BBI) adoption of the term "residential intervention" as an alternative to "residential treatment." BBI defines residential interventions as a range of targeted, high-efficacy interventions for a child or youth and their family that have proven capacity for rapid stabilization, analysis, treatment, and discharge planning.[20, 21] Residential interventions include a range of practices delivered in the residential building, the family's home, and the community. They should not be considered places or destinations where a youth goes to live for an extended period.[20]

Improving Outcomes in Residential Treatment

The array and intensity of services vary greatly from one residential facility to another – some programs are more effective than others. This variability limits the ability to generalize or compare outcomes. Research suggests that the optimal window for the best outcomes in youth residential treatment is between one and six months, which supports the case for shorter residential stays.[22] However, treatment gains are frequently lost after the child or youth is discharged from residential treatment and returned to the community.[23] This implies that the apparent gains made in residential treatment do not easily translate to community living.

Four common factors have been identified in inpatient and residential treatment settings with the most successful treatment outcomes:[20, 23, 24, 25]

- **Family involvement** – The best programs partner meaningfully with families. They see themselves as a support to families that are struggling rather than as a substitute for families that have failed. A family-centered service philosophy emphasizes partnerships, focuses on the family as the decision-maker, and recognizes parents as the experts on their children. This requires residential treatment facilities to constantly forge and maintain strong relationships with families, support families to fully participate in the daily lives of youth, and share responsibility for outcomes through shared decision-

making and active partnerships between families and all care providers. Family-centered care includes interactions with families in the context of their everyday lives to offer support and guidance. When families are fully involved in treatment, inpatient and residential treatment stays are shorter and outcomes are improved.

- **Youth-Guided Practices** – Youth-guided practices engage and empower youth to be involved in all aspects of their treatment plan, including goal-setting and discharge planning, and support youth in advocating for themselves. Youth-guided practices engage youth in all levels of decision-making, preserve family relationships through regular contact between youth and their families, provide mentoring and peer-to-peer support, and collaborate with community providers to connect youth to home- and community-based services and supports.
- **Discharge Planning** – Research on youth post-discharge suggests that success relies on family involvement during treatment and returning to a stable, supportive environment.[23] In more effective programs, families, children/youth, and staff prioritize discharge planning from the time of admission. Specific practices employed in discharge planning include (1) ensuring stability in the child or youth's placement after discharge, (2) connecting to peer and youth advocates, (3) identifying funding to continue work with the child/youth and family post-discharge, (4) coordinating community-based and residential services to provide a seamless transition, and (5) supporting the child/youth in maintaining meaningful connections with their friends (with caregiver permission) while in care.
- **Community Involvement and Services** – Ideally, a residential treatment program should be as near to a child or youth's home as possible to anchor services in the community, cultures, and web of social relationships that surround a child/youth and their family. Effective residential treatment services for youth facilitate community engagement while in care, teaching them the skills they need to reintegrate once discharged. Characteristics shared by communities that have successfully linked residential services to their community include (1) a belief that residential care is not a destination where youth go to live for an extended period of time, (2) a capacity to rapidly triage, stabilize, analyze, treat and plan for discharge, (3) an emphasis on family involvement or the identification of natural supports when families are unavailable or unable to care for their child/youth, as well as an effort to continually work with families to support their ability to care for or engage with their children, and (4) the ability to ensure that services that begin in residential can be continued in the community.

Table 3 provides an overview of three agency-wide frameworks or models that incorporate the four common factors reviewed above.

Table 3 – Agency-Wide Residential Frameworks and Models

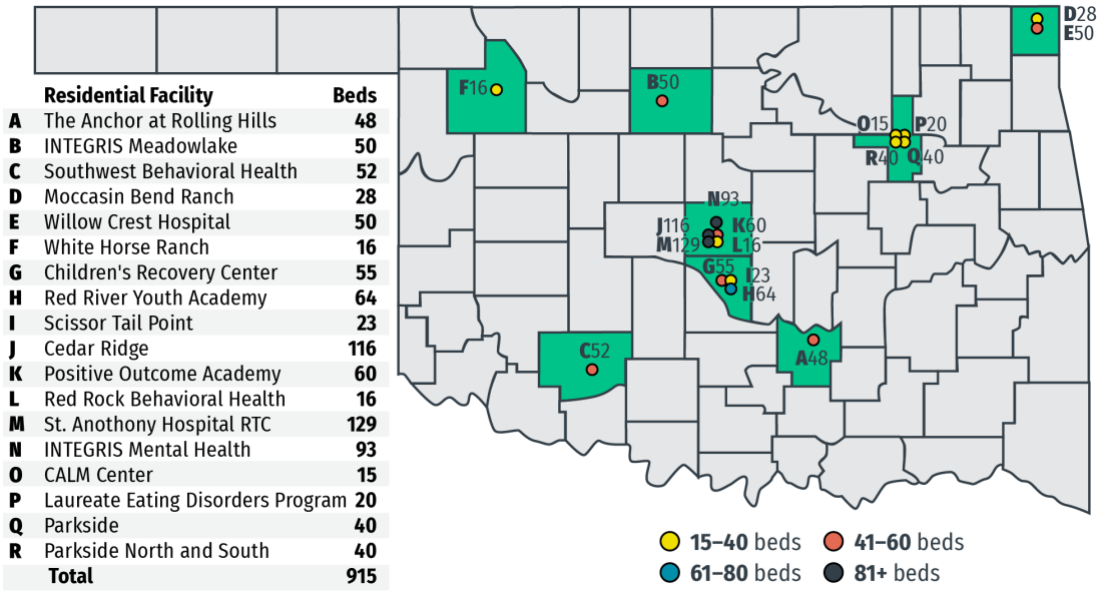
Building Bridges Initiative (BBI)[20, 26]	
Overview	**Principles, Values, and Characteristics**
BBI is a national effort to achieve positive outcomes for children, youth and families served in residential and community programs. It aims to promote a dialogue and provide a framework to address issues in residential care by advancing consistent and coordinated principles and practices across residential and community-based services. BBI identifies and promotes policies and practices to create strong partnerships between families, youth, communities, residential treatment programs, and service providers. The BBI framework comprises an extensive set of performance guidelines and indicators that carry out the BBI principles and values. They developed the *Performance Guidelines and Indicator Matrix* to help organizations assess how well they conform with BBI's principles and build on and foster linkages between residential and community services across a full continuum of care. The concept of child and family teams (CFT) is embedded throughout the matrix and is a fundamental element integral to successfully implementing BBI principles and practices.	When implemented, BBI principles are expected to improve outcomes for children, youth, and families. They are consistent with community-based System of Care approaches and serve to strengthen the partnership between residential and community-based care. The principles and values are: • Youth-guided • Family-driven • Culturally and linguistically competent • Comprehensive, integrated, and flexible • Individualized and strength-based • Collaborative and coordinated • Research-based • Evidence- and practice-informed • Sustained positive outcomes
Children and Residential Experiences (CARE): Creating Conditions for Change[27, 28]	
Overview	**Principles, Values, and Characteristics**
CARE is a relatively new model developed by the Residential Care Project at Cornell University. It targets childcare staff, clinical staff, and agency administrators who work with children, youth, and young adults ages 6 through 20 who live in a residential setting. CARE is a multi-level, principle-based program that uses an ecological approach to provide a framework based on research-informed principles and a valid theory for how children grow and develop. CARE is designed to enhance an organization's social dynamics by targeting staff development and staff interactions with clients, other staff, and community organizations. Expected outcomes of this care model include a decrease in behavioral incidents, an improvement in the quality of relationships between children and staff, a decrease in use of psychotropic medication, and a decrease in use of physical restraints.	The CARE framework provides consistency in approach to children and families and congruency throughout an organization. Six practice principles provide the foundation for organizational change. Childcare practices must be: • Developmentally focused • Family-involved • Relationship-based • Trauma-informed • Competence-centered • Ecologically oriented

The Sanctuary Model[29, 30]	
Overview	**Principles, Values, and Characteristics**
The Sanctuary Model is a trauma-informed, holistic approach designed to develop the organizational structures necessary to counteract the effects of trauma. It was originally developed in the mid-to-late 1980s as a way to provide treatment in short-term psychiatric settings for adults who have experienced trauma. It has been adapted for use in a variety of settings, including those that serve children, youth, and young adults. The Sanctuary Model is a theory-based, evidence-supported system change process that actively creates and maintains a nonviolent, democratic, and therapeutic community. Staff and clients are key decision makers in building this socially responsive, emotionally intelligent community that fosters growth and change. The model assumes a trauma-informed culture will result in less violence, improved staff morale, lower staff turnover, fewer staff injuries, a collaborative treatment environment, elimination of coercive forms of intervention, and better client outcomes.	The aim of the Sanctuary Model is to guide an organization in developing a culture that creates a sound treatment environment while counteracting the impact of chronic stress. This cultural change is grounded in seven dominant characteristics: • Nonviolence • Emotional intelligence • Social learning • Shared governance • Open communication • Social responsibility • Growth and change

The Oklahoma Landscape

Oklahoma has approximately 915 beds for children and youth licensed by the Oklahoma Department of Human Services (OKDHS). These beds are housed in five psychiatric residential treatment facilities (PRTF), five acute psychiatric and residential treatment centers, one specialty psychiatric hospital, and two crisis residential facilities. Approximately 60% of the beds (556) are in the Oklahoma City metro, where 36% of the state's population aged 6-17 lives. Another 12% of the beds (115) are located in Tulsa County, and 224 (27%) are in non-metro areas. **Although not the only cause of the regional disparity, 222 of Oklahoma City's beds are operated by private general acute care hospital systems.** For the rest of the state, a lack of general acute care hospital-based beds prevents seamless care transitions for children presenting in emergency rooms with mental health concerns and limits support for co-occurring physical and mental health conditions such as for children recovering from a suicide attempt.

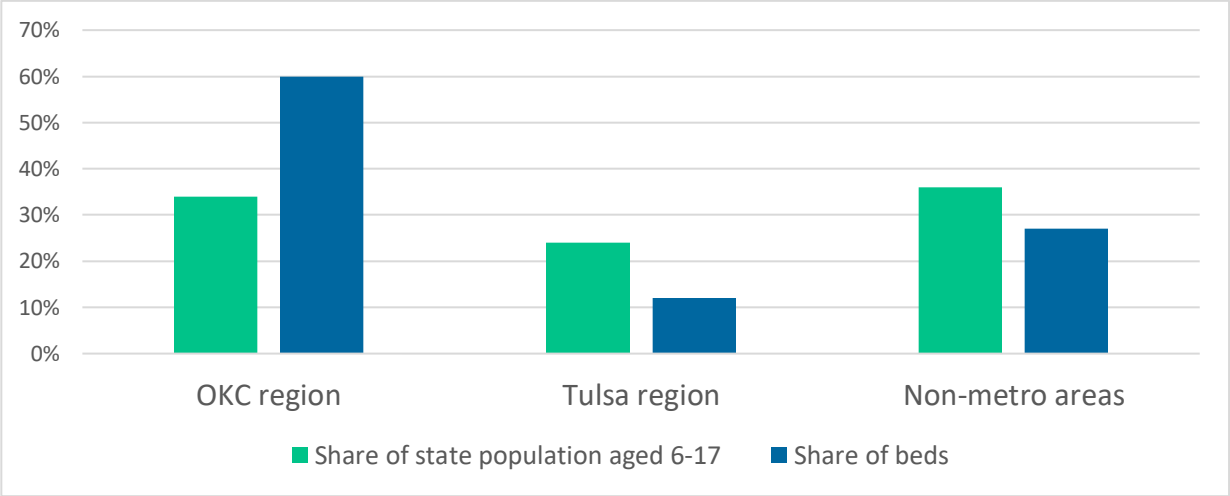
Map 1 – Location and Bed Count of Licensed Residential Facilities in Oklahoma



	Residential Facility	Beds
A	The Anchor at Rolling Hills	48
B	INTEGRIS Meadowlake	50
C	Southwest Behavioral Health	52
D	Moccasin Bend Ranch	28
E	Willow Crest Hospital	50
F	White Horse Ranch	16
G	Children's Recovery Center	55
H	Red River Youth Academy	64
I	Scissor Tail Point	23
J	Cedar Ridge	116
K	Positive Outcome Academy	60
L	Red Rock Behavioral Health	16
M	St. Anothony Hospital RTC	129
N	INTEGRIS Mental Health	93
O	CALM Center	15
P	Laureate Eating Disorders Program	20
Q	Parkside	40
R	Parkside North and South	40
	Total	915

The most significant and visible proposal to expand bed capacity for children in Oklahoma is in the Oklahoma City region, where the University of Oklahoma health system has proposed a $115.8 million facility that would add 72 children's inpatient beds. Project leaders have requested that a portion be funded by the state's share of federal COVID-19 relief funding via the American Rescue Plan Act (ARPA).[31] If the OU project is completed and the rest of the state's beds remain stable, the Oklahoma City region would house 68% of the state's children's inpatient beds. However, it is likely a significant portion of those beds would be used by children originating from outside the Oklahoma City region.

Figure 1 – Comparison of Licensed Beds to Population of Children and Youth



By comparison, the Tulsa metro area's share of state beds (12%) is less than half of its share of the state's children aged 6-17 (26%). **Mostly due to the 2019 closure of Shadow Mountain Hospital, Tulsa has lost 116 children's beds since 2018 – nearly half of its former children's inpatient capacity –** despite a recent expansion of children's beds at Parkside Psychiatric Hospital. The sudden and acute shortage has contributed to system bottlenecks, and Tulsa's hospital emergency rooms regularly report holding children for multiple days as staff search for available beds. Of the 947 children and youth from Tulsa County who were placed in an inpatient, residential, or crisis residential facility in fiscal year 2021, 27% were placed in a facility outside Tulsa, according to Medicaid claims data. Notably, Tulsa's lack of inpatient psychiatric beds housed inside general acute care hospitals is particularly unusual for a city of its size. According to a 2020 Healthy Minds survey of the 50 largest cities in the U.S., most mid-sized and large U.S. cities have at least one general acute care hospital with inpatient psychiatric beds for adults or children — including eight of the 10 cities nearest to Tulsa's population. Although the city does have a standalone psychiatric facility affiliated with a hospital system, Laureate Psychiatric Clinic and Hospital, that facility's 20 children's beds are limited to eating disorders.

It is important to note that a simple comparison of beds counts is not an adequate analysis of the need for inpatient and residential beds in a community, and a more complete examination of care systems would be required to draw a definitive conclusion. This simple comparison does not consider admission and discharge procedures that determine the ultimate effectiveness of the beds in a community, nor does it fully account for the types of beds needed (crisis residential beds, acute psychiatric beds, subacute psychiatric beds, long-term residential treatment beds, IDD beds, beds for children aged 5-12, and beds for adolescents aged 13-17). A full description of the services offerings of inpatient and residential facilities across the state follows.

Facility Details

The facilities listed below are licensed as residential treatment facilities by the state. Some provide acute psychiatric care and residential treatment services. OKDHS defines a residential treatment facility as a program that provides 24-hour medical care for children with an emotional, psychological, or mental disorder.[32] Five of the facilities provide acute psychiatric inpatient services as well as PRTF care. The Centers for Medicare & Medicaid Services defines a PRTF as a psychiatric hospital, hospital with an inpatient psychiatric program, or a non-hospital psychiatric facility that is accredited by the Joint Commission or other accrediting body and has a provider agreement with a state Medicaid Agency to provide inpatient services under the direction of a physician to Medicaid-eligible individuals under age 21.[33, 34]

The descriptions below only address those the facility serves and the type of services provided, not the quality of the care delivered.

Psychiatric Hospitals and Residential Treatment Facilities

- **The Anchor at Rolling Hills Hospital**, Ada – Provides short-term stabilization services to youth between the ages of 12-18 who suffer from mental, behavioral, or emotional concerns.[35]
- **Cedar Ridge Behavioral Hospital**, Oklahoma City – Provides short-term, acute psychiatric inpatient services and residential treatment for children and youth ages 5-17 who are a danger to themselves or others. Cedar Ridge's primary goal is to provide crisis intervention and stabilization services in a secure setting with the aim of transitioning the child or youth to a lower level of care in the shortest amount of time possible.[36]
- **Children's Recovery Center**, Norman – This is the only state-operated inpatient crisis unit and residential facility; it has 55 beds for youth ages 13-17. The facility serves youth with mental health and substance use needs. Upon discharge, youth are connected to System of Care and Wraparound services provided through community mental health centers.[37]
- **Parkside Psychiatric Hospital**, Tulsa – Parkside provides inpatient treatment services to youth ages 13-17 who need crisis stabilization or inpatient psychiatric care. Residential care is available for children and youth ages 6-17 suffering from depression, mood disorders, psychiatric disorders, trauma, or behavioral problems and need ongoing and extensive support.[38]
- **Willow Crest Hospital** and **Willow Crest Hospital Moccasin Bend Ranch**, Miami – Willow Crest Hospital offers acute and sub-acute treatment for children and youth ages 5-17 requiring 24-hour care and experiencing emotional, behavioral, or substance-related needs.[39] Moccasin Bend Ranch is an extended residential program for older children and youth ages 11-17 with behavioral health challenges.[39]
- **INTEGRIS Meadowlake at Bass Baptist Medical Center**, Enid – Meadowlake at Bass Baptist is a 50-bed facility that provides acute inpatient and residential treatment services to children ages 5-12 and youth (including those with a dual diagnosis) ages 13-17.[40]
- **INTEGRIS Mental Health**, Spencer — INTEGRIS' Spencer facility provides services for acute and residential care for children between 5-12 years old and adolescents ages 12-17. The facility treats children diagnosed with anxiety disorders, panic disorders, post-traumatic stress disorder, mood disorders, attachment disorders, attention deficit disorder, oppositional defiance disorder, conduct disorders, at-risk youth, and co-occurring substance use disorders. It also has a program called STAR (Sexual Trauma and Abuse Recovery) for boys and girls ages 5-14 who exhibit sexual behavior problems.[41]
- **Red River Youth Academy**, Norman – Red River Youth Academy provides residential treatment services to boys ages 7-17 and girls ages 12-17 with serious emotional or behavioral disorders.[42]

- **Saint Anthony Hospital**, Oklahoma City – St. Anthony Hospital provides acute inpatient care to children and youth at their Midtown Campus.[43]
- **Southwestern Behavioral Health Center**, Lawton – Southwestern provides inpatient hospital care to children and youth ages 4-17 with severe behavioral health problems.[44]

Crisis Residential Facilities

- **CALM Center**, Tulsa – The CALM Center provides assessment, stabilization, and support for youth ages 10-17 experiencing a mental health or behavioral crisis.[46]
- **Red Rock Behavioral Health Services' Children's Crisis Unit**, Oklahoma City – Red Rock's Children's Crisis Unit is a community-based stabilization unit that fills a critical gap in the present continuum of care for children in Oklahoma. It serves children and youth ages 10-17 and provides services to assess a child in crisis, stabilize the crisis, and then refer to an appropriate level of care.[47]

Diagnosis- and Population-Specific

- **Laureate Psychiatric Clinic and Hospital**, Tulsa – Laureate Hospital provides intensive inpatient treatment for girls ages 11-17 struggling with an eating disorder.[48]
- **Scissor Tail Point**, Norman – Serves as a contracted group home for boys and girls with the Office of Juvenile Affairs (OJA) to treat juvenile delinquents or youthful offenders in OJA custody. The residential facility offers therapeutic treatment, education, medical care, recreation, independent living, and social skills.[49]
- **Positive Outcome Academy**, Oklahoma City – Positive Outcome Academy is a residential treatment program out of SSM Health Saint Anthony South for male juvenile sexual offenders ages 13-17.[50]
- **White Horse Foundation**, Mooreland – White Horse Ranch is a 16-bed residential treatment program for girls that uses equine therapy and personal treatment plans to teach delayed gratification and promote self-esteem and confidence.[51]

In addition to residential treatment beds, Oklahoma has more than 300 licensed emergency shelter beds for children and youth housed in 22 shelters, as well as 750 licensed residential beds housed in 48 residential childcare facilities across the state. OKDHS defines an emergency shelter as a non-secure public or private residential program that provides temporary care and supervision for children, and a residential childcare facility as a 24-hour residential program where children live with and are supervised by non-related adults.

Summary of Inpatient and Residential Interventions in Oklahoma

Several factors affect the number of available beds in Oklahoma, including the lack of lower levels of care, a fragmented crisis continuum, limited or no access to step-down services, and seasonality of demand. As a result, it is difficult to determine whether the number of available residential beds is adequate to meet the mental health needs of children and youth. Key informants indicated that there is limited availability of inpatient care in Oklahoma because a lack of intensive outpatient, home-based, and community-based services causes an overreliance on inpatient treatment. They stated that children and youth end up in emergency rooms (ER) and are boarded because appropriate placements cannot be located.

One key informant noted that most children and youth seen in the ER for behavioral health reasons are admitted to inpatient care because providers often have limited knowledge of, or confidence in, community-based behavioral health resources. As a result, inpatient admission has become the default option for children and youth with behavioral health needs seen in the ER regardless of their level of need. **In short, gaps in the continuum of care manifest as increasing ER encounters that thereby increase inpatient bed utilization.**

Key informants also indicated that services and placements for youth with intellectual disabilities, autism, or a dual diagnosis are especially difficult to find. They noted that Medicaid does not cover upstream services such as Applied Behavior Analysis for youth with intellectual or developmental disabilities. In addition, key informants noted that when youth do enter inpatient facilities, there is limited family involvement, youth are not connected to aftercare services beyond a referral, and discharge planning is limited.

Key informants agreed that there is limited availability of intensive home- and community-based services in Oklahoma. Key informants described Health Home services (sunsetted in October 2021) for children and youth as a challenge to implement, a challenge to individualize, and a barrier to engaging families. They noted that the Certified Community Behavioral Health Clinic (CCBHC) model will be used to meet the needs of children and youth with moderate to intensive behavioral health needs but gave few examples of how this will be implemented across the state. Key informants also reported that time-limited intensive services – such as Multisystemic Therapy (MST), Functional Family Therapy (FFT) and Multidimensional Family Therapy (MDFT) – were nonexistent.

Considerations and Opportunities

Inpatient services and residential treatment are necessary components of the ideal continuum of behavioral health care services for children and youth whose behaviors make it difficult to keep them safe in a less restrictive setting. To be most effective, these inpatient and residential treatment services should be anchored in a full array of behavioral health services that includes intensive home- and community-based services and mobile response and stabilization services.

When these services are absent or limited, families are left to rely on inpatient and residential treatment options, which leads to over-utilization of the most disruptive, restrictive, and expensive levels of care in the continuum, without the guarantee of positive treatment outcomes.

Findings About Oklahoma's Inpatient System

1.) New beds like those proposed for state ARPA funds would provide immediate relief but won't meet the need on their own.

Although the state has clear geographic disparities in the location of beds, it is difficult to determine if the number of inpatient beds statewide is adequate to meet the behavioral health needs of children and youth in Oklahoma overall. Lack of inpatient treatment beds has resulted in ER boarding and admission to a physical health bed (where no behavioral health treatment occurs) while a child or youth waits to be transferred to an appropriate psychiatric inpatient bed. However, the consensus among leaders interviewed for this report is that this is the result of inefficiencies in the system, ER providers' limited knowledge of, and trust in, community-based care, gaps in crisis care and lack of crisis stabilization beds, limited capacity to serve youth with autism or developmental disabilities, and limited or no access to intensive home- and community-based services. **Consequently, although new beds would clearly have an immediate effect in improving access to care, the solution requires more than the addition of inpatient or residential beds.** It requires an assessment of need in combination with an expansion of the state's continuum of behavioral health services to include intensive community-based services before, during, and after a behavioral health crisis. Rightsizing Oklahoma's inpatient and residential interventions to fit the needs of its children and youth and anchoring it in a full continuum of behavioral health services will require cross-system collaboration between mental health, juvenile justice and child welfare.

2.) Inpatient and residential interventions in Oklahoma are often not community-based, youth-guided, or family-focused.

Key informants reported that for children and youth placed in inpatient or residential interventions, there is limited family involvement, connection to aftercare services beyond a referral, and discharge planning. There were few indications that inpatient and residential treatment providers had developed strong community partnerships that ensure continuity of treatment before, during, and after residential care. There was also no indication that aftercare was viewed as a critical component of residential treatment or that children, youth, and their families were engaged in community-based services while still in a residential program. Residential providers appear to recognize the importance of family and youth voice and of engaging them in developing individualized treatment plans. However, there were no reports of further efforts to engage and empower youth and families such as hiring peer-to-peer support providers as residential staff, promoting family contact (including regular visits home and daily

access to family members), or engaging community providers to connect youth to home and community supports while in care.

3.) The absence of home- and community-based care has produced an overreliance on inpatient and residential beds.

The absence of high-fidelity, intensive home- and community-based services increases the use of inpatient psychiatric hospital care, ERs, residential treatment centers, and child protective services. The transition from System of Care to Health Homes, and now to CCBHCs, has left a gap in the continuum of mental health services for children, youth, and families with the highest level of need. To ensure that children and youth with higher levels of need and more complex mental health challenges have access to services and supports that appropriately address their needs, Oklahoma should build and sustain an array of intensive home- and community-based services.

Opportunities

1.) Support strategic and well-vetted additions to children's inpatient capacity in areas of the state with severe shortages.

Growing Oklahoma's inpatient capacity is generally not the most sustainable long-term solution given the relative cost of inpatient services and the ability to treat most children effectively in lower levels of care. However, even with appropriate community-based capacity, some children will need to escalate to inpatient services. Moreover, it is worth noting that bed shortages in some areas of the state are an immediate and life-threatening crisis – particularly in Tulsa, a large community that has lost substantial bed capacity in recent years. If resources can be allocated to growing bed capacity in Oklahoma, it can be most effectively used in these areas. General acute care hospitals in Tulsa have a particular opportunity to grow capacity directly, given the unusual market hole in this space for a city Tulsa's size.

2.) Support ODMHSAS' expansion of crisis centers for children.

A national review of 10 years of emergency department data indicated that 39% of ER referrals for pediatric mental health concerns were non-acute and inappropriate.54 This means that an effective inpatient strategy must include diverting children in crisis from ERs to appropriate mental health emergency centers, where crises can be de-escalated and mental health professionals can recommend an inpatient bed only if appropriate. For this purpose, ODMHSAS is in the process of establishing across the state five urgent recovery centers for children, which will serve as emergency triage and assessment centers for children and families in crisis. Once established, the facilities can be expected to decrease the number of inappropriate referrals to emergency rooms across the state, potentially leading to a decrease in demand for inpatient hospitalizations.

3.) Capitalize on opportunities in mental health, child welfare, and juvenile justice systems to build a better-connected continuum of care for children. A special focus should be placed on increasing intensive home- and community-based services, mobile response and stabilization services, and integrating inpatient and residential interventions.

Collaboration between systems that handle high-need youth can transform access to care and offset the current high demand for inpatient beds. The state can use an existing multi-system collaborative group, such as the Children's State Advisory Workgroup (CSAW), to implement a plan that integrates the state's inpatient and residential interventions into a full continuum of care. This plan would aim to ensure children have seamless transitions between levels of care as their needs change. Inpatient and residential providers should be seamlessly connected with intensive home- and community-based services, as well as mobile response and stabilization services. A cross-system plan could incorporate and capitalize on the Certified Community Behavioral Health Clinic (CCBHC) model, the Family First Prevention Services Act (FFPSA), Oklahoma's Title IV-E Prevention Program Plan FFY 2022-2026, and efforts by the Oklahoma Office of Juvenile Affairs (OJA) to build the state's capacity to deliver Functional Family Therapy (FFT):

- ODMHSAS' statewide adoption of the **CCBHC model** has opened the door for strengthening the behavioral health service array available to children, youth, and families. ODMHSAS anticipates that the CCBHC model will fill the gap in intensive home- and community-based services left by the state's transition away from Health Homes. The CCBHC model requires providers that treat children and youth to offer developmentally appropriate, youth-guided, and family- or caregiver-driven evidence-based interventions and other psychiatric rehabilitation services. This includes mobile response and stabilization services, intensive care coordination using High-Fidelity Wraparound, and intensive in-home therapy services such as FFT and Multisystemic Therapy. The CCBHC model also allows for the development of strong partnerships between community-based and residential providers.
- **FFPSA** incorporates the latest knowledge and evidence to specify which residential interventions produce sustained positive outcomes. Included in those practices are family-driven and trauma-informed care, the provision of appropriate clinical services, shorter lengths of stay, focus on permanency, post-discharge services, and family-based aftercare.[26]
- The **OKDHS Title IV-E Prevention Program Plan** seeks federal approval for two evidence-based practices: SafeCare and Intercept. ODMHSAS, System of Care (ODMHAS), SafeCare and Intercept are included in the tertiary prevention component of the current Oklahoma Child Abuse Prevention Network. The state's prevention program plan indicates that OKDHS will continue to collaborate and coordinate with ODMHSAS and other state partners to transition the current service array to an integrated prevention continuum and child and family well-being network. The Oklahoma Service Array Matrix included in

the prevention program plan lists an array of additional evidence-based services that fall within the Title IV-E prevention program and could be included in the proposed continuum.[56]

- **OJA** is partnering with the Oklahoma State Department of Health to use medical marijuana excise tax revenue to build statewide infrastructure to implement FFT. There are currently no FFT providers in Oklahoma.[57, 58]

4.) Build on state-level efforts to adopt the BBI framework for transforming residential treatment programs statewide.

Oklahoma can improve its inpatient and residential outcomes by redefining residential care as an intervention; adopting the BBI values, principles, and framework; and strengthening partnerships with community-based providers. The BBI framework addresses issues in the delivery of residential interventions by promoting consistent and coordinated principles and practices across residential and community-based services. BBI also identifies and promotes policies and practices that create strong partnerships between families, youth, communities, residentially based treatment programs, and service providers.

State-level documentation and national reporting by BBI suggest that ODMHSAS and OKDHS have done some work to adopt the BBI values, principles, and framework. Those values and principles align with Oklahoma's statewide System of Care and support a coordinated partnership between ODMHSAS' community-based services, public and private providers of residential interventions, youth, and families.

Appendix A: OKDHS-Licensed Residential Treatment and Emergency Shelter Beds[59]

Psychiatric Hospital, Psychiatric Residential, Residential, and Crisis Residential Facilities	City	Number of Licensed Beds
The Anchor at Rolling Hills	Ada	48
INTEGRIS Meadowlake	Enid	50
Southwest Behavioral Health	Lawton	52
Moccasin Bend Ranch	Miami	28
Willow Crest Hospital	Miami	50
White Horse Ranch	Mooreland	16
Children's Recovery Center	Norman	55
Red River Youth Academy	Norman	64
Scissor Tail Point	Norman	23
Cedar Ridge Residential Treatment Facility	Oklahoma City	116
Positive Outcome Academy	Oklahoma City	60
Red Rock Behavioral Health	Oklahoma City	16
St. Anthony Hospital RTC	Oklahoma City	129
INTEGRIS Mental Health	Spencer	93
Calm Center	Tulsa	15
Laureate Eating Disorders Program	Tulsa	20
Parkside	Tulsa	40
Parkside North and South	Tulsa	40
	Total Beds	**915**

Emergency Shelters	City	Number of Licensed Beds
Unity Point Counseling & Resource Center	Ada	12
Community Children's Shelter	Ardmore	12
Washington County Youth Services	Bartlesville	8
Southwest Youth and Family Services	Chickasha	12
Cheyenne Arapaho	Concho	9
Youth Services of Bryan Co Inc.	Durant	20

Emergency Shelters	City	Number of Licensed Beds
Youth & Family Services of Canadian Co.	El Reno	16
Youth Service Center N Cent	Enid	14
Logan Community Services	Guthrie	8
Marie Detty	Lawton	16
Youth Emergency Shelter, Inc	McAlester	16
MID-DEL	Mid-West City	11
Cleveland County Youth and Family Services	Norman	12
PIVOT, Inc. "Family Junction Shelter"	Oklahoma City	18
Northern Oklahoma Youth Services	Ponca City	12
Leflore County Youth Services	Poteau	8
Creek County Youth Services	Sapulpa	12
Youth & Family Resource Center	Shawnee	16
Payne County Youth Services	Stillwater	17
Cherokee Nation Youth Services	Tahlequah	12
Youth Services of Tulsa	Tulsa	20
Western Plains Shelter	Woodward	23
	Total Beds	**304**

[1] Psychological distress was calculated using the K6 scale that was developed with support of the National Center for Health Statistics for use in the National Health Interview Survey. The tool screens for psychological distress by asking students how often they have felt nervous, hopeless, restless, depressed, worthless or like everything was an effort in the previous 30 days.

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