

**Region 1 Planning Council Report
July 1, 2003**

I. Descriptive Features of the RPC

Below is a listing of the current active members of the Region 1 Planning Council:

Mona Hoyle
Probation and Parole

Lue Feiler
Consumer Advocate

Jack Runyon
Psychological Associates
(local provider)

A representative from the
Area Agency on Aging

Jordan Litvack
Lourdes Behavioral
Health
local provider)

Jennifer Beck-Walker
Purchase Area
Development District

Chuck Sidleman
Department for Juvenile
Justice

Jane Frazier
Department for
Community
Based Services

A representative from
Family Support

Bill McMican
Department for
Community
Based Services

Lane Bridwell
(new member)

Charlie Ross
Purchase District Health
Department

Ron McGregor
Murray State University
Department of Education

Bill Albritten, Board Chair
Four Rivers Behavioral
Health

Rickie Dublin
Consumer Advocate

The council has met on an as needed basis over the past two years. However, meetings have been at least semi-annual. The council has continued to discuss the needs of the community and possible solutions to those identified in the initial report.

II. Regional Needs Assessment

There have been no significant changes to the region's demographics or community indicators since the initial report.

Our region has experienced increases in resources for adult and children crisis stabilization services. The region is building an adult unit and will be developing crisis services for children in FY04. The region also received monies for Jailer Training through the Department of Mental Health/Mental Retardation Services.

Due to the lack of increases in funding to keep pace with the expected rise in costs of doing business, funding levels have in true effect decreased. Additionally, the region has seen a reduction in funding from the Division of Substance Abuse of \$60,000.00

An emergency crisis response team has been formed in Region 1 as a collaborative effort of behavioral health providers, public and private, police, fire, hospitals, schools, and clergy. The Western KY Regional Crisis Response Team has been recognized by the Kentucky Community Crisis Response Board as an affiliated local team. Certification training has been provided in the region in both basic and advanced critical incident stress management and contacts are now being established with Disaster and Emergency Management coordinators in the counties served.

III. Service System Description

The initiative by the CMHC to establish an adult crisis stabilization unit along with combining all of the community support programs under the same administrator have been our primary attempts to raise awareness and address gaps in adult services. Gaps in the services to children and youth have continued to be minimal, with the exception of the absence of actual inpatient psychiatric hospital beds. We continue to see a gap in substance abuse services for transitional living facility for females as well as a medical detoxification unit.

We have also identified that there has been a lessening of the number and types of services available in the safety net. While historically there were many non-mandated services that we were able to offer, the lack of funds to keep pace with the growing needs within the mandated service areas has left us with no option other than to discontinue many non-mandatory free or nearly free services. Additionally, offices have been closed in Livingston, Ballard, and Fulton counties due to the lack of funding to keep up with needed services. Services are still being offered in those counties with no "official" site.

Unfortunately, during this review period several clinical practitioner positions due to the lack of adequate funding to support the positions. We were able to preserve most of the positions that are informally identified as "children's clinicians". On the positive side, very late in this review cycle we were able to fill many of the clinical practitioner positions that had been vacant due to a serious human resource shortage experienced earlier in the review cycle. Efforts continue to try to offer as many services to schools as possible including substance abuse services. We continue to identify a need for a substance abuse residential facility for adolescents but there continues to be no available funding for such.

The status of "revolving door referrals" with adult consumers has not changed for the most part. While any given month may have shown improvement through decreases in the relative indicators (e.g. repeat involuntary commitment evaluations, crisis line utilization by known consumers, emergency walk-in appointments by known consumers), other months will have shown an increase in these same factors. Moreover, despite the rather predictable pattern of seasonal fluctuation no significant impact has been achievable; however, we are most hopeful that when the crisis stabilization programs are in place we will see a reduction in some of the most severe aspects of this issue.

Services to the elderly are a developing focus for this area. We have been very active in the local aging initiatives and are urging our clinical practitioners to enhance their knowledge base and skill levels with this population. Unfortunately, funding limitations by nursing home facilities have prevented them from being able to purchase services; and our ability to use "community care dollars" to fund any such initiative does not exist, since the mandatory responsibilities for these funds more than exhaust the resource.

In actuality there has not been an appreciable change in interagency collaboration levels during this reporting cycle. However, it is important to note that our pre-existing level of interagency collaboration in this geographic region has been quite robust. Our Substance Abuse staff continue to work with KY-ASAP boards and KIDS Now agencies.

IV. Strategies to Increase Access to Community-Based Services

Access to community based services has decreased during this reporting cycle. Given cuts and defacto cuts through lack of increases, no longer have the resources to keep a full-time office open in three of the counties served. While every effort has been made to deliver services in those counties and to those consumers through alternative methods, we are aware that this does not replace the access we feel is appropriate. Our only hope is that eventually funding sources will rise to meet the need so we can someday return full-time services to those locations. More importantly, we truly hope that existing funding levels do not drop or continue to fail to keep pace with the need, leaving us with no option but to further restrict access to services.

There has been a drastic change in consumer access to medications during this reporting cycle. It is due to reduced access. We were faced with no choice, in both years, other than to discontinue the Community Support Medication Program shortly after the fiscal year mid-points. Concurrently, we have not had the resources (either human or fiscal) to provide as many medical practitioners as the need indicates. As of the end of this reporting cycle, we have had no choice but to limit medical service delivery to four of our twelve service sites.

Within the mental health arena, there have not been many changes in support group resources. In essence, the pre-existing resources continue to be utilized, but new initiatives have been met with limited interest.

Reduction in the literal and conceptual "criminalization of mental illness" has been one of the few areas of growth during this cycle. Initiatives with law enforcement include an annual update training event and ongoing contacts between the legal system and our Qualified Mental Health Professionals. We are pleased to continue to see low admission rates for involuntary commitments.

The jailer training has gone very well in our region. We have two Licensed Clinical Social Workers that provided the training in the past year and will continue to routinely provide it in the upcoming year. Unfortunately, we have had no choice but to require jails to fulfill their responsibility to fund the services to their inmates, given the absence of adequate funds on our part to continue to provide these services at drastically reduced or no cost.

There have been no significant changes in ADA accessibility status.

Cultural sensitivity has become an integral part of our new staff orientation. The individual who conducts this part of the orientation has been trained in the model endorsed by the Cabinet for Health Services.

We are in process of building an eight-bed adult Crisis Stabilization Unit at the geographic center of our region. This is due to open in the winter of 2003-2004. We are in the proposal process for a children's crisis stabilization program. In essence, this program will provide emergency placements in therapeutic home settings and intense crisis stabilization daytime programming.

V. Quality Assurance and Consumer Satisfaction

We continue to annually survey consumers regarding their perception of the services they receive and their satisfaction. We have not seen any areas needing significant change to increase the satisfaction with services that are currently received. Four Rivers Behavioral Health continues to evaluate the services provided at their

locations to ensure compliance with all applicable funding and regulatory requirements, as well as internal company policies.

VI. Behavioral Health Goals

The Region 1 Planning Council decided to use the behavioral health goals of the Healthy People 2010 project of the Surgeon General.

Progress has been made by the addition of funding for both adult and child crisis stabilization services.

VII. Implications

While there has been no appreciable change in the funding needs of this area; we do need to recognize that the pre-existing needs do still exist. Especially, we need to highlight that we continue to be unable to keep pace in terms of equitable salaries for the professionals we employ. It is quite troublesome for us that, if we do not have an appreciable increase in general operating funding levels, with each year that passes we will have to employ fewer and fewer professionals to stay within our resources. It is difficult to keep qualified staff when the Commonwealth can employ the same individual for \$5,000.00-\$15,000.00 more for a similar position.

One public policy recommendation is to evolve into a system that establishes local control and determination of priorities rather than state-level "priority population" mandates. These priority population mandates exhaust limited resources that could better serve the community as the region sees fit.

This region sees KY-ASAP and TAP funding as duplication of effort to services already provided in this region. It seems that these funds would achieve a more efficient purpose if funneled through the CMHC or other providers who already provide these services.

VIII. On-Going Process and Activities

Region 1 Planning Council will continue to seek new members as appropriate. All relevant parties and all local providers were sought during the initiation of the council. As potential and interested members become known, they will be contacted and invited to participate. No interested party will be turned away.

Beyond the legislated duties, the Region 1 Planning Council has agreed to serve as the community advisory body for the Adult Crisis Stabilization Unit, the Children's Crisis Stabilization Program, and new mental health federal block grant spending plans. As other advisory roles become apparent, it is anticipated that this council may be asked to serve in that capacity.

The Region 1 Planning Council has always responded expeditiously and appropriately to requests from the State Council and Work Groups. We anticipate that any time a request is made, a meeting will be called to act upon that request.

**House Bill 843
Biennial Update
Region III
July 1, 2003**

I. Descriptive Features of the RPC

A. Members of the Regional Planning Council for Region III

Mary L. Pate; Beaver Dam City Commission
Sandra Watts; Private Practitioner
Joe Van Roberts; Ohio County Board of Education
Mike Oliver; United Methodist Homes for Children
James Robinson; Ohio County Board of Education- Together We Care
Ken Roberts; Daviess County Public Schools
Bill Cooper; Green River Area Development District
Rev. James Brasher; West KY Family Enrichment Center
Mary Anne Long; Green River District Health Department
Brenda Brasher; West KY Family Enrichment Center
Dr. Don Cantley; Methodist Hospital
Eula Johnson; Bouleware Center Mission
Dianne Ford; Methodist Hospital- New Choice
Laura Freese; Department of Community Based Services
Tom Skiratko; Community Member
Libby Cambron; Parent
Lee Maglinger; Department of Corrections, Division of Mental Health
Dr. Oluwole Olusola; Owensboro Behavioral Care, PSC
Bonnie Kitchens; Henderson County Schools- Director of Special Education
Lexie Hicks- Private Practitioner
Fred Goodwin; Audubon Area Services- Community Services Director
Keith Cain; Daviess County Sheriff
Jim Toler; Department of Community Based Services- Regional Director

B. Activities of the Regional Planning Council since December 2000.

Since the initial study and report completed in December 2000, the RPC has met on 5 occasions with another meeting being planned for August 2003. The meetings continued to focus on the goals established in the initial study as well as provide training and information to members on other service systems to evaluate and review for possible implementation within the region. One member provided an excellent presentation on a system being used by the Department of Community Based Services to ensure that a more collaborative team approach is utilized when working with consumers of multiple services. In the last fiscal year, this member reported that over 400 cases have been managed in this fashion, including those being served through the Local Inter-Agency Service team.

The RPC determined that the best mechanism to achieve some positive outcomes was to divide into sub-committees that would then report back on a semi-annual basis to the RPC regarding progress or barriers the sub-committee may have encountered while trying to further develop and implement the goals and objectives of the RPC. A chairperson was established for each sub-committee from within the RPC. This individual would then recruit and incorporate other members from the community who are directly applicable to the project to ensure that all segments of the topic are incorporated. This, however, has not been as successful as the RPC would have desired. Without a central person within the Community Mental Health Center to coordinate the activities of the sub committees, the result was not positive. Therefore, in the past few months, the CEO of RiverValley Behavioral Health has decided to appoint a person from within the Community Mental Health Center to act as the administrative support for each sub committee. This person will then ensure that the communication within each subcommittee continues and can provide the Chairperson with the administrative resources that otherwise may not be available. Over the next six (6) months, the RPC hopes to see more movement towards implementation of the goals/objectives established.

II. Regional Needs Assessment

A. Region III continues to increase in respect to population. Between 1999 and the report of the United States Census Bureau of 2000, the region increased in population by 0.4% for a total of 207,377 individuals within the seven counties. This increase is only slightly lower than that of the State of Kentucky in general. Estimates provided by the census of 2000, predicted another increase of 0.4% by July 1, 2002. While the growth of the region may be interpreted as a positive pattern, it also would indicate a possible increase in the numbers of individuals with a mental illness or substance abuse disorder who would require treatment. Since the amount of dollars available within the region has remained relatively stable during this period (December 2000-June 2003), the resulting increase in population may require the same amount of dollars per person for treatment to be reduced. At this time, the lack of formal data requires the region to speculate given prevalence rates of mental illness/substance abuse within the population at large that these same rates of prevalence will occur within the population increases. Should the prevalence rates remain consistent within the population increase, and the financial resources remain stagnant, then certainly the services available to the current population and the increased population may require significant modification and/or reduction to ensure that all individuals have access to such services.

III. Service System Description.

A. Addressing gaps in services.

This remains a difficult area given the lack of increases within the financial resources during this reporting period. To compound this issue, the lack of qualified individuals to provide such services remains an issue. Certainly, the nation is experiencing a significant shortage within the nursing profession. Such shortages are only compounded by sub-specialties such as psychiatric/substance abuse services, rural settings such as Region III, and the inability to remain competitive within the employment market due to funding issues. As a result, agencies are exploring mechanisms to work together to provide services rather than having the resulting duplication of services that may currently exist in some areas. This however, reduces the element of competition and choice for consumers as providers within the region may work together to develop a single program. The need for step down services to address the "gaps" in services was discussed in the report of December 2000. Information on the specific programs developed or in development will be discussed below. Clearly all "gaps" in services have not been closed, however, significant progress as a result of inter-agency cooperation has been established.

B. Safety Net.

The Safety Net for region III remains the same as stated within the report of December 2000. As noted in that report, advocacy and education among consumers needed improvement. This area will be addressed within this report in section V.

C. Services for children and youth.

While the services for children and youth stated in the previous report remain, this area was also determined to be a "gap" in service. The need for step down programs was established by the RPC, and therefore additional services have been explored and developed. As a result of this need for step down services, a partial hospitalization program has been developed for children and adolescents. This program provides that additional treatment that is often necessary following an inpatient hospitalization, will allowing the child to return home each evening. Through a cooperative effort on the part of the Community Mental Health Center, the Daviess County School Corporation, transportation as well as academic instruction is provided by the school corporation while the psychiatric services, therapeutic services and location are provided by RiverValley Behavioral Health Hospital. Initially the program was only available to the middle school age child, however, due to the request of many referral sources and parents, the program has been expanded to include all school age children. Further, this program originally was intended to operate only during the school term, but based on the need and number of referrals, the program will be operational all 12 months per year.

Additionally, the need for a children's CSU was established during the initial assessment. Region III is in process of implementing this recommendation. See section IV-H.

D. Repeated referrals

In regards to repeated referrals for children and youth, the development of a partial hospitalization program is intended to reduce the number of repeat inpatient admissions. Previous to this program implementation, often children discharged from inpatient services to outpatient services could not make such a transition and change in support. The implementation of the partial hospitalization program is an attempt to provide that transition period with the additional support needed to reintegrate into the family, school and community systems. As the program has not been operational for a complete 12 month period, comparative data is not available at this time. Once such analysis is completed, the results can be reported to the RPC.

E. Services for the elderly

There has been no significant change within the region for services for the elderly. Currently, RiverValley Behavioral Health is exploring day programming services for elderly and the availability of other providers with which to collaborate to develop a program. Pro forma projections are in process so the implementation of this service cannot be guaranteed at this time.

F. Coordination and Collaboration between organizations

As previously mentioned, the development of new programs, such as the partial hospitalization program, has required the collaboration of multiple agencies and staff. This has proved to achieve a successful outcome. The programs implemented by the Department of Community Based Services to ensure collaboration among providers for a specific consumer definitely results in a better outcome for the consumer. Statistical measures regarding the effectiveness and possible cost reduction, due to the elimination of repeat or duplicate services, can hopefully be achieved over the next reporting period.

Further, RiverValley Behavioral Health and the Green River District Health Department have developed a cooperative arrangement whereby, RVBH provides a therapist to the Health Department for the purpose of assessment and services to expectant mothers who may also be at risk for substance abuse. This service has grown tremendously during the past 2 years, and the number of women receiving this service continues to increase.

In response to the growing National concerns of Bio-Terrorism, RiverValley Behavioral Health is working with the emergency services personnel of each county within the region. The purpose of this endeavor is to prepare to provide mental health support and services in the event of a biological attack. While currently in process, this working relationship has been a positive experience for the CMHC.

IV. Strategies to Increase Access to Community-Based Services

A. Changes in Access to community-based services

Currently there have not been any significant changes in access to community based services. Based on the December 2000 report, the only area determined to be of issue is that of substance abuse treatment for children and adolescents. This is an area that will be further explored and may be incorporated into the partial hospitalization treatment program or the development of an Intensive Outpatient Program within the school system as an after school program.

Additionally, the addition of a psychiatric Advanced Registered Nurse Practitioner for child/adolescents services in the Fall of 2002 has reduced the amount of time to get psychiatric medical services, and has increased the availability of appointments for consultation within a shorter period of time.

B. Access to Medications

Consumer access and the affordability of medications remains an issue within the region. Many consumers cannot afford medications, and while pharmaceutical companies have developed relationships with RiverValley Behavioral Health for sample medication distribution, all medications are not available. RiverValley will continue to work with pharmaceutical representatives to increase the amount of sample medications available.

C. Availability and Utilization of Support Groups

Families And Individual Teaching Hope (F.A.I.T.H.) is a support group that has started within the region. This support group is designed to provide education and support for parents and siblings of children with emotional/behavioral needs. Currently this parent led support group meets in 3 counties within the region on a monthly basis. In September of 2002, with the administrative support of RiverValley Behavioral Health, the support group obtained a grant from the Office of Family Leadership to offer a series of educational programs to increase the awareness of issues of children with emotional and behavioral needs as well as to increase the awareness within the community of the support group. This series was highly effective and has increased the attendance at support group meetings in some counties.

Additionally, the local Autism support group was in need of space in which to have their meetings. RiverValley Behavioral Health Hospital has provided this space at no charge, which allowed the support group to continue meeting.

Several consumers who attend the Therapeutic Rehabilitation Program participated in a training provided by the Bridges organization. This training gave consumers the skills needed to lead peer support groups for individuals with chronic mental illness. Now that the consumers have become certified, RiverValley Behavioral Health is working to obtain an independent location for the support group meetings.

D. Decriminalization of persons with Mental Health of Substance Abuse Disorders

One of the most critical issues regarding this area is the knowledge base within the law enforcement system. Training of law enforcement personnel is reported in Section E.

E. Relationship with Jails within Region III.

RiverValley Behavioral Health has continued to offer the services of a psychiatrist/therapist within the jail system. Since education is a key issue, RiverValley Behavioral Health offered training to jail personnel in all seven counties. The counties that responded had the opportunity to meet with RiverValley clinical staff and subsequent trainings were scheduled. To date, a total of 65 individuals within the jail system have been trained on the following topics:

- A review of mental health disorders
- Effective Communication
- Crisis Management
- Suicide Prevention
- Collaboration & Team Approach
- Clinical staff who provided the training, will continue to follow up with the jail personnel to offer more training and consultation upon request.

During this reporting period, RiverValley has executed contracts with the jails in all seven counties. These contracts provide the correctional system an avenue to secure mental health and substance abuse services from RiverValley Behavioral Health. Additionally, Dr. David Harmon, Medical Director, is working with the Daviess County jail to develop a comprehensive mental health program and service within the jail system. Once developed, this will provide consumers with a comprehensive treatment program while incarcerated.

F. Access to services for the elderly and individuals with disabilities

RiverValley continues to explore options for services to the elderly (see Section III-E). Additionally, RiverValley Behavioral Health obtained the services of a therapist who was proficient in American Sign Language. This individual was then able to provide comprehensive mental health services to individuals with a hearing impairment without the use of a third party interpreter. Unfortunately the therapist resigned from RiverValley Behavioral Health and the funding was discontinued at this CMHC and moved to another region.

Another service currently in review is the establishment of an inpatient unit within RiverValley Behavioral Health Hospital for children with a hearing impairment. Currently, services for inpatient consumers with hearing impairments are limited throughout the state. This would allow children to receive inpatient psychiatric services without the use of a third party, often non-medically trained, interpreter.

G. Cultural/Ethnic/Racial aspects of awareness, access and utilization

As part of an annual training that all employees at RiverValley Behavioral Health are required to complete, competencies in cultural diversity are required. Additionally, a full time child psychiatrist fluent in Spanish is now employed. This individual is able to provide services to individuals within the community where Spanish is the primary household language without the usage of a third party interpreter. This individual has been willing to assist with any case in which the need has arose. The ethnic diversity within the region remains relatively low, thus no other significant changes have occurred during this reporting period.

H. Funding for a CSU

RiverValley Behavioral Health has now been approved for a children's crisis stabilization unit. While the approval has been received, funding for this services will be in the budget for FYE 6/30/04.

V. Quality Assurance and Consumer Satisfaction

Quality Assurance is an area of great importance at RiverValley Behavioral Health. During this reporting period, RiverValley Behavioral Health Psychiatric Residential Treatment Facilities obtained accreditation by the Council on Accreditation for Rehabilitation Facilities (CARF). Currently RiverValley is preparing to obtain this accreditation for all other programs within the corporation.

Consumer satisfaction is a component of the health care delivery system that is often overlooked, especially in regards to Community Mental Health Centers. Often consumers of services at CMHC have limited options in respect to service availability and therefore are compelled to tolerate issues in service acquisition that may not be tolerated from other health care providers. Finding this unacceptable, RiverValley Behavioral Health in 2002 established a Consumer Affairs department within the agency. Employing a Licensed Clinical Social Worker, this department provides an avenue for consumers to voice concerns, complaints and make recommendations for improvements in services. As this individual reports directly to the CEO and maintains no administrative responsibility for any individual program within the agency, the consumer now has an independent "ombudsman" to look into their specific issue. Further, this employee is able to make recommendations, track trends in concerns, monitor consumer rights issues and provide such information to the executive management staff of the agency for improvement. This department will also become involved in the quality assurance measures within the agency to ensure that services are provided as required by regulations and in the best possible method to meet the needs of the consumer.

As a first step in providing some additional training, this office in conjunction with the RPC sponsored two training events on advocacy, the legislative process and current mental health/substance abuse legislation for staff, consumers, parents, community members and other agencies within the seven county region. Sheila Schuster, Ph.D, provided the educational offering in January 2003 which was attended by over 150 participants. Many consumers and parents of consumers attended this training, as well as employees of several social service agencies, universities and members of the faith community. Based on the response, additional training will be developed and offered by the RPC throughout the year.

VI. Behavioral Health Goals

A. Top Goals of the RPC for the initial period of 2001-2003. All established goals are long term goals, however, steps to address each goal taken to date are indicated below.

1. Improved Coordination of Services

As discussed throughout this report, members of the RPC have initiated this process. Most coordination of services to date have revolved around a specific issue, consumer or program. While successful on a micro level, the long term goal of organized, coordinated services among all providers remains an area needing attention. During the next reporting period, the RPC will continue to develop a specific method to ensure that all consumers receive coordination of services, have knowledge of services that are available, and have assistance in exercising their rights to a coordinated, integrated treatment approach among all providers.

2. Improved Recruitment and Retention

This is an area that remains an issue throughout the region, and among all providers. The difficulty in obtaining education at an advance level in some professions, the complete lack of program offerings within the region in some professions, the issues of a rural community and the inability to remain competitive with wages and benefits due to the lack of increased funding in proportion to inflation complicates this area. While the committee is aware of these issues, at this time the RPC has not developed a strategy for addressing this issue. A subcommittee has been developed specific to this area and it is anticipated that a formal plan will be developed.

Additionally, the CEO of RiverValley has been participating in the House Bill 843 Human Resource Workgroup. Initiated by the Department of Mental Health with Universities may lead to greater program offerings within the region, and thereby increasing the pool of available personnel. The RPC in Region III is interested in working with this workgroup to review and provide any recommendations as to the specific needs of Region III.

3. Improved Housing

The RPC explored the issues of housing during this reporting period, and there is agreement within the committee that this goal will require extensive work over a significant period of time. While the Housing and Urban Development program provides for some housing for consumers, further development and collaboration with the Kentucky Housing Authority and the establishment of available resources is needed. A subcommittee has been developed to address this goal.

4. Development of Step-Down facilities between Hospital, Jails and Communities

The lack of housing as previously mention, as well as the availability of medications for individuals stabilized within the hospital or jail setting, only add to the recidivism of individuals attempting to reintegrate within the community. Currently, individuals released from the state hospital can be assessed for admission into the Therapeutic Rehabilitation Program when appropriate. However, there remains a lack of residential facilities in which individuals can live while reintegrating into the community and building the supports necessary to maintain a health stable life. Because of the many issues involved with the development of such a program, this will continue to be a goal during the next reporting period.

5. Develop a Crisis Stabilization Program for Children

Refer to IV-H for information on progress.

6. Geriatric Day Health Program Development

Refer to IV- F. This goal will continue during the next reporting period. In addition, RiverValley Behavior Health has entered into discussions with the Green River Area Development District, Aging Services personnel on plans for an Inter-Generational day care. This model could provide the much needed support and socialization that many elderly individuals may lack in their current situations, while increasing the day care opportunities for young children within the region.

7. Increased Consumer Awareness

With the development of the Office of Consumer Affairs at RiverValley Behavioral Health, the consumer awareness training that was offered in January 2003 (see Section V) will be a beginning of further programs to promote awareness and advocacy among consumers, families and providers as well as the community at large.

VII. Implications

A. Funding Need Changes

No changes from the previous reporting period are noted. As indicated in the December 2000 report, continued flat resources in funding coupled with the lack of inflationary increases only complicate the ability to achieve many of the goals within the region. While the development of new programs to address the "gaps" in services is necessary, without additional funding current programs continue to have difficulty maintaining the services already in existence. The CMHC cannot direct funds, thus funding that is provided is dedicated to specific programs rather than to the consumer groups which may require more resources in a specific area.

B. Public Policy Changes

As stated in the report of December 2000, the state should consider offering a specialized prescription benefit for public behavioral health care. The inability to obtain necessary medication results in instability of the consumer, possible housing issues, recidivism rate increases, etc. This remains an area in which state wide assistance will be needed to make other recommendations possible.

The flexibility of funding is an area which requires additional research. Currently the public policy in place requires some services with low volume and high cost to be provided, while other high volume services are limited. The disproportionate level of funding in regards to the statewide allocation of mental health dollars adds to this situation. This result is rural areas, and regions which are primarily rural, do not have access to services available in higher funded areas. By funding regions on a per eligible consumer basis then services would be available to consumers regardless if the service is offered in their region. This access to programs currently outside the region would allow areas to develop as a "Center of Excellence" in one particular treatment area which would have the ability to provide the service to consumers throughout the state, thus increasing the volume of need, thereby reducing the overall cost of the service.

C. Further Recommendations

None at this time.

VIII. On-Going Process and Activities

A. Recruitment of New Members

Certainly, the recruitment of new members is critical to the on going functions of the RPC. Two distinct methods are planned during the reporting period. Each program within the CMHC is asked to provide a listing of individuals in other agencies who the programs routinely works with to resolve issues and remove barriers for consumers. This allows the RPC to add members who have knowledge of the service delivery system in place, and who are aware of the many barriers and issues that consumers may encounter. Education on House Bill 843 to all groups is also necessary. As the CMHC becomes aware of groups that meet regularly, the group is contacted and asked if a member of the CMHC or RPC could speak to the group and educate the group on this comprehensive legislation. This allows the RPC to come in contact with individuals who may not have traditional roles within the service delivery system, however are affected by or have an interest in these issues.

B. Activities over the next two years

During the next two years, the RPC will increase it's focus on the goals that have been established. As this was a new process, certainly lessons have been learned regarding the time, availability and resources needed for all committee members to actively participate and carry out the recommendations of the RPC. The addition of an administrative support person for each subcommittee as well as the RPC will ensure that the goals and objectives remain a focus for the committee and tangible results are achieved.

C. Reviewing recommendations of HB 843 workgroups

Given the distance between many members of the RPC, and the relatively short time-lines provided, this is an area of concern. Some methods to ensure that all members have an opportunity to receive, understand and comment on the recommendations of the work groups may include:

- Whenever possible increasing the time-lines for review/response

- Providing advanced notice of upcoming reports to alert the RPC that new recommendations are forthcoming to assist in planning.
- Provide as much information in an electronic format (email) to allow for the dissemination of the information more timely to RPC members from more distant locations from the main offices of the CMHC .

**REGION IV
REGIONAL PLANNING COUNCIL REPORT
JUNE 26, 2003
DESCRIPTIVE FEATURES OF THE RPC**

The Regional Planning Council is comprised of two or more representatives from each of the categories designated. Some members are new to the council. LifeSkills formed a consumer representation committee comprised of both consumers and family members representing mental health and substance abuse, adult and children's services. This committee has been asked to join the RPC. Please see the attached (Table A) for membership by designation. The * denotes new members.

There have been no significant changes in Region IV demographics since the initial report. The number of seriously mentally ill served by LifeSkills increased approximately 8% from FY 2000 to FY 2001 and increased 5.7% from FY 2001 to FY 2002. The number of persons receiving substance abuse services increased by 2% from FY 2001 to FY 2002. There have been few if any changes in prevalence rates and no significant events. State funding to the region increased from FY 2002 to FY 2003 with the addition of funds for specific projects in mental health and substance abuse such as Early Intervention, KIDS NOW, Outcomes, Champions, Peer to Peer and Jail Training. Funds for FY 2004 are basically flat which will likely result in less growth than in previous years.

SERVICE SYSTEM DESCRIPTION

The initial Regional Planning Council report identified gaps in services. Below is a description of measures that have been taken to address these gaps.

Adult Services

- LifeSkills has initiated training focused on co-occurring disorders (MH/SA) including assessment and treatment. Additionally, LifeSkills has been chosen as a pilot site for a SAMHSA grant. If awarded this would mean additional dollars focused on dual diagnosis treatment for MH/SA and MH/MR.
- Efforts have been made to collaborate with Western Kentucky University, located in Bowling Green, to identify needs and develop strategies for educating and training professional staff. Region IV will also benefit from the collaborative efforts of the Department for Mental Health and Mental Retardation Services, Kentucky Association of Regional Programs and other state universities as they strive to achieve the same.
- Supported Employment received additional monies in FY 2002 and 2003. These additional dollars have allowed some expansion of services into another county this year. The economy in general has been a barrier to placing and maintaining consumers in supported employment.
- Supported Housing summaries for FY 2001 and FY 2003 are attached. The Supported Housing program will soon be using the Kentucky Homeless Management Information System to track our Shelter Plus and HOME program clients. Supported Housing has increased the number of Yes You Can home ownership program recipients this year and will begin offering post-purchased home buyers seminars next fiscal year.

Children Services:

- There have been several changes in Impact Plus since the last report. Some changes have been beneficial, including the Crisis Unit receiving automatic 10-day authorizations when needed. However, the limit on Therapeutic Foster Care length of stay has been less beneficial and many children have had extensions filed on their behalf. LifeSkills has added

Therapeutic Child Support group services where we have trained providers. We are also providing more intensive community-based treatment.

- The new Early Intervention Grant has allowed a position to be devoted to treatment, training and consultation for children ages 0-5. Four staff, including the Early Intervention Mental Health Specialist, recently attended the Greenspan training for the treatment of pre-school age children.

Substance Abuse:

- Medicaid continues to limit their reimbursement for substance abuse services but now reimburses for substance abuse services provided to pregnant women. LifeSkills has started billing Medicaid for prevention services and substance abuse assessments. Delays in Medicaid establishing reimbursement have slowed our billing process for treatment services.
- LifeSkills makes every effort to recruit credentialed providers for all services to increase both quality and reimbursement sources. However with limited payor sources for substance abuse and less than adequate substance abuse curriculum in graduate programs, it is difficult but necessary to recruit credentialed staff to provide substance abuse services.
- Support groups such as AA are available or accessible in all Region IV counties. Narcotics Anonymous is available in about half the counties in this region. ALANON is less available. Double Trouble, a dual diagnosis self-help group, has been started several times but has lacked leadership to keep it going. LifeSkills' staff is currently identifying dually diagnosed persons who might be interested in starting this group again with agency encouragement.

Safety Net: LifeSkills remains the primary resource for persons with limited payor sources. For-profit providers continue to provide care where financial resources are available, including school and home-based services, through IMPACT Plus. LifeSkills continues to endure the burden of balancing increasing needs and decreased funding.

Current status of services for children and youth: There have been no changes in array of residential treatment services for children and youth. As for non-residential services the Student and Family Enrichment program, operated in conjunction with the schools, closed due to funding shortages. LifeSkills has expanded intensive community based treatment through the Therapeutic Child Support program and intensive home-based therapy is offered to children in the Therapeutic Foster Care program. The Warren County Day Treatment program, operated in collaboration with the Warren County Schools and Department of Juvenile Justice, will no longer be administered by LifeSkills. The Warren County School system will administer the program beginning with the 2003-2004 school year. LifeSkills may stay involved as a mental health provider if needed. Metcalfe County and Monroe County Day Treatment programs associated with their local school systems are growing.

Revolving door cases: As of May 2003, Region IV has seen an increase in re-hospitalizations at approximately 35% as compared to FY 2002. The region is now experimenting with flexible Olmstead funding in working with one consumer with high rates of re-hospitalization. If this proves useful, additional funding may be sought to provide non-traditional services to other complex cases. Attempts are also being made to identify individuals with two or more hospitalizations within a six-month period so that proactive crisis plans may be attempted with these consumers. Thus far, only a small number of consumers have agreed to participate in the process, but this effort will continue.

Elderly: Due to the continued low penetration rate in the 55 and older population, it remains economically impractical to offer specialized geriatric services. However, there is an active mental health and aging coalition. The coalition has set community education as a priority goal. In that vein, they have published and distributed a community resource guide containing information on area providers as well as helpful information on mental health topics. In addition, on May 20th the coalition hosted its first mental health and aging conference. This one-day event was targeted at professionals, caregivers and consumers with a special emphasis on Alzheimer's issues.

Coordination & Collaboration: Coordination and collaboration across systems and among agencies is always an issue with barriers such as schedules, confidentiality, etc. There has been an increase in the number of inter-agency groups, including six local agencies on Substance Abuse Policy, Targeted Assessment Program and a new program to Bowling Green called the ALIVE Center (a local information and volunteer exchange) designed in part to provide multi-agency resource information. Memorandums of agreement are increasingly used.

STRATEGIES TO INCREASE ACCESS TO COMMUNITY-BASED SERVICES

Access: In October 2000, LifeSkills changed its policy to discontinue face-to-face screenings for Medicaid recipients, most of who are disabled and exhibit the most severe disorders in order to expedite access to services. In March of 2001, LifeSkills increased access for everyone by discontinuing face-to-face screenings. Phone screenings are conducted in order to lessen financial hardship and allow for triage. Routine cases are given an appointment within 10 days, urgent appointments are scheduled within 3 days and emergent appointments are scheduled the same day.

As stated in our 2000 report, consumers who do not have medication benefits and meet both diagnostic and financial criteria are eligible for the Community Medication Support Program. This program continues to have barriers including income guidelines and a formulary that does not encompass all psychotropic medications. In addition to this we access numerous pharmaceutical company indigent programs but not all medications have a program. Indigent programs also have eligibility criteria and the paperwork can be cumbersome. Medicaid now requires prior authorization for Zyprexa, (an expensive atypical antipsychotic medication) for new patients with approval subject to a failed 30 day trial of other atypical antipsychotics within the past 3 months or medical contraindications, adverse side effects, or drug interactions with other atypical antipsychotics. Those already on Zyprexa were grandfathered in.

QUALITY ASSURANCE AND CONSUMER SATISFACTION

For the second year LifeSkills analyzed data from consumer satisfaction surveys completed by nearly six hundred consumers. While overall satisfaction remains high, possible areas needing additional attention were identified. In addition to these paper-and-pencil survey formats, the Consumer Representation Committee, with membership comprised entirely of consumers and family members, conducted a series of focus groups to identify both strengths and weaknesses of the current delivery system. Following are some of the recommended service additions/innovations that consumers and family members endorsed:

- Expansion of supported employment and improved job support for those receiving the service
- Improving the professional level of Therapeutic Child Support providers
- Provision of mental health training to local law enforcement personnel
- Intervention, counseling and support systems for family members entering the mental health system for the first time; and
- Improved ability to provide respite for all ages, particularly for adults with severe mental illness.

A formal quality improvement plan was written and approved this fiscal year and a much greater effort has been made to continuously measure performance indicators. Some of the indicators which have been more consistently measured include contact timeliness for new clients, therapeutic rehabilitation outcome measures, state hospital readmission rates, consumer involvement in treatment planning, Kentucky Substance Abuse Treatment Outcome Study (KTOS) submission, timely aftercare for state hospital discharges and assessment of all severely emotionally disturbed /seriously mental illness consumers for case management needs.

BEHAVIORAL HEALTH GOALS

Coordination and System Integration –

Goal: Improve the coordination of services within the behavioral health delivery system.

- Western Kentucky University has written a grant and received funding for a program called the ALIVE Center. Part of the funding is to be used to develop a resource clearinghouse for professionals and consumers use.
- LifeSkills has made changes in our screening process that have improved access to services. A protocol is followed to determine the acuity of the situation and the client is either given a routine (10 days or less), urgent (3 days or less) or emergent (same day) appointment based on the therapist's assessment.
- LifeSkills has entered into a number of Memorandums of Agreement with entities such as primary care facilities (including health departments), jails, schools, Department for Community Bases Services (DCBS), etc.

Service Gaps –

Goal: Provide comprehensive behavioral healthcare services to persons experiencing mental health/substance abuse problems.

- Transportation issues remain a barrier to treatment. Legislation was filed this year that would require an escort to ride with some clients to Medicaid reimbursable appointments. Fortunately, an administrative action has clarified that this is the responsibility of transportation providers. Improving transportation remains a strong long-term goal.
- LifeSkills is assuring aftercare appointments within 14 days to person discharged from residential or inpatient programs. Our rate of compliance for aftercare from Western State Hospital (WSH) is 97% or 6.07 days. Weekly substance abuse aftercare is available at LifeSkills for persons discharged from residential substance abuse programs.
- Outpatient substance abuse treatment is available for varying lengths of time. Individualized treatment plans are developed for each client with outpatient treatment lasting between 90 days and 12 months. Multiple Driving Under the Influence (DUI) offender treatment programs are available for up to 12 months. Residential treatment programs extending up to 6 months are limited, there being no such programs in this region. The penal system has programs such as the Substance Abuse Programs (SAP), which are intensive programs for inmates close to parole. Many State and Federal prisoners are being housed in county jails, which does not allow them access to SAP programs.
- The Division of Substance Abuse has begun showing increased assertiveness in applying for grants (many only allow the government agent to apply). As stated above, LifeSkills may receive a SAMHSA grant to address dual diagnosis issues.
- The ALIVE center will become a centralized clearinghouse for information on human services in the Bowling Green/Warren County area.

Inappropriate Incarceration of the Mentally Ill –

Goal: Eliminate inappropriate incarceration of individuals with mental illness (as defined by KRS 202A) and minimize the amount of time spent by those incarcerated on inappropriate charges.

- Two staff from LifeSkills were identified to attend a train the trainers event sponsored by the Department for Mental Health and the Department of Corrections whereby a jail training module was presented. Each region was directed to offer the jail trainings and on-going consultation with jail staff. The curriculum covers mental illness with an emphasis on suicide prevention. LifeSkills' staff has provided training to jail staff in 6 of the 8 counties where jails exist. Logan County jail has chosen to conduct their own trainings. Monroe County jail has had scheduling problems but is interested in receiving the training. Post-training assessments have documented positive feedback.
- The program manager for the LifeSkills' Office of Consumer Advocacy advocates for clients in the judicial system. She has successfully advocated for pre-trial diversions and works with Adult Protective Services to secure housing for consumers when they are released from jail.
- LifeSkills Specialized Intensive Case Management services are targeted at decreasing hospitalization days and jail days for seriously mentally ill consumers who also have a history of violence.

- LifeSkills has developed a comprehensive back-up system for responding to both day and evening requests for evaluations. We are able to have an evaluator on site within one hour of the request when it is suspected that an incarcerated individual may be suffering from a mental illness.

Repeated Psychiatric Hospitalizations –

Goal: Reduce repeat hospitalizations by 30%

- Peer support services have increased the number of consumers served. Expansion of these services into additional counties is planned.
- As stated earlier in the report access to community medication support remains limited due to funding and eligibility criteria. However, efforts have been made to access pharmaceutical patient indigent programs, and samples at an estimated savings of \$850,000 in one year.
- Since the report in 2001, Westlake Hospital, frequently used for psychiatric hospitalizations, has closed the inpatient facility. Additionally, Medical Center has limited access to inpatient services making alternatives to WSH difficult to find. Medical Center continues to request payment for indigent people without Medicaid.
- LifeSkills Crisis Stabilization Unit has been designated as a homeless shelter allowing homeless persons to move to the top of the waiting list at the Housing Authority.
- LifeSkills has created a Continuity of Care Coordinator position whose main role is to serve as the liaison between WSH and Lifeskills. The COCC assists clients in transitioning from hospital back into their community and follows up on needed services. This position also works closely with the Salvation Army in identifying the mentally ill/substance abusing clients who are homeless and in need of services.

Funding and Policy

Goal: Design and implement an integrated, adequate, balanced array of local services.

- With financial resources decreasing, adequacy has not improved, integration has not occurred at the funding level, and balancing has not occurred.

ON-GOING PROCES AND ACTIVITIES

New members have been added to the Regional Planning Council as former members have been no longer able to serve. Additionally, LifeSkills Consumer Representation Committee has joined the RPC. A role of the RPC is to be involved in the strategic planning of mental health and substance abuse services. Periodic meetings will be needed to bring council members up to speed on statewide issues and to formulate strategies. In order to meet the requirements of HB 194, LifeSkills will disseminate the workgroups' recommendations once received then reconvene a meeting to discuss those recommendations in detail.

TABLE A	
Family Members: Marty Harrison (Adult) * Liz Whittaker (Adult) * Jim Williams (Child) * Linda Murphy (Substance Abuse)	Consumers: Danny Carroll Gloria Bluett * Kim Liddle (Phoenix House)
Gov't Officials & Business Leaders: Cathy Nunn Fred Keith (Chair)	IX. Health Department & Primary Care * Beth James (Health Department) * Dr. Priebe
Advocates & Community Organizations: Kaye Hope (Dept Voc Rehab) * Lee Alcott (BRASS)	Educators-School Personnel: Inga Wolff * Retta Poe (Western Kentucky Univ)

Regional Interagency Councils: * Tara Wilson (RIAC Chair) * John Sivley – (RIAC)	Law Enforcement-Court Personnel: * Bill Jenkins (Jailer) Doug Hawkins * Jackie Strode (Jailer) (BGPD)
Public-Private Facilities w/MH-SA: Kathleen Riley (Medical Center) Janice Richardson (Rivendell) Jim Croxton (Bellwood)	Individual Providers of MH/SA: Doug Bradley (Mental Health) * Karen Garrity (Substance Abuse)

**HB 843 Report
Region 5 Regional Planning Council**

June 6, 2003

I. Descriptive Features of the Regional Planning Council

- A. Member list of the RPC for Region 5 is attached.
- B. Activities since December 2000 have largely been involved with legislative advocacy. Since January 2003, there have been seven meetings. After the initial excitement related to “grass roots” input for state behavioral services, interest waned. The prospect of cuts in services and the looming threat to the “safety net” appeared to re-motivate the council.

II. Regional Needs Assessment

- A. There have been no significant changes in Region 5 demographics.
- B. It is believed the penetration rate for SED (Seriously Emotionally Disurbed) by Communicare has historically been low due to a coding issue of not marking a child as SED upon intake or thereafter. Communicare is implementing a review system to insure that all appropriate SED cases are “captured”. In addition, more children are being served through IMPACT (children’s case management) , the children’s CSU, and off-site therapy. Children’s case management caseloads have increased 14% since August 2002. Waiting lists have decreased, but recruitment continues to be an issue in the rural counties.
- C. There have been no significant changes in dollar resources.

III. Service System Description

- A. There have been several steps taken by Communicare to address service gaps. A women’s transitional housing program for recovering substance abuse females has opened within the past year. The Adult Crisis Stabilization Unit opened in November 2002.
- B. Communicare is charged with maintaining the “safety net” for the region. However, the viability of the safety net is highly vulnerable to any potential changes in Medicaid rates.
- C. Children’s Services has hired an Early Childhood Mental Health Specialist. The agency has also hired a full-time child psychiatrist and is in the process of having psychiatric services available for the Children’s Crisis Stabilization Unit.
- D. Because of the short duration since the opening of the Adult Crisis Stabilization Unit, no current data is available regarding decreased incidence of hospitalization.
- E. Communicare has no specific geriatric programs. However, we have collaborated with Caritas Peace and Jane Todd Hospital for referrals to their geriatric inpatient units. This results in more proper treatment for consumers and reduced inappropriate use of the 202A system.
- F. In the past two years, numerous formal and informal coordination and collaborative arrangements have been established. The formal arrangements include collaborating with Ten Broeck Hospital in the development of an adolescent IOP for substance abuse (evening program in Hardin County). Communicare provides the medical service for this program.

The agency and DCBS jointly created a Linkage Agreement to better serve the children and families involved with Protection & Permanency.

Communicare Children’s Services has continued to increase formal agreements with the area schools to provide school-based treatment. There have been three new schools requesting services and five schools have asked for an increase in services.

Children's Services also has linkage agreements with the Central Kentucky Head Start Program relating to site-based therapy services and the Children's Crisis Stabilization Unit.

In addition to providing standard inpatient psychiatric services, Communicare has forged a unique relationship with Hardin Memorial Hospital by hiring a Medical Director for the 15 bed inpatient unit. Communicare psychiatrists provide emergency room and house consults for the local hospital (Hardin Memorial Hospital). This has resulted in local treatment for the most "difficult cases". Utilization of Central State Hospital is now for times when HMH is full or long-term refractory cases.

IV. Strategies to Increase Access to Community-Based Services

- A. A centralized scheduling system is now being utilized for new appointments. This system is provided by Bluegrass CMHC.
- B. There have been significant increases in the amount of scholarships (free medications) with drug companies. This has resulted due to insurance not covering various medications or decrease in medication coverage in general. This change has significantly increased work for staff due to the required time and paperwork involved to obtain scholarships. These demands are likely to significantly increase, due to potential changes in Medicaid "eligibles".
- C. There have been changes in the availability and utilization of support groups. The significant change is in the completion and opening of a new 12-step clubhouse called the "Serenity Club" in Elizabethtown. They offer space to AA, NA, and Al-anon groups as well as a place for sober socializing. There is an Overeater's Anonymous group that meets on occasion, and new "in-house" women's sobriety groups at PASSAGES, Communicare's transitional housing program for recovering substance abuse females.
- D. In order to reduce criminalization of persons with mental illness, considerable changes have been implemented to treat 202A's locally.

Involuntary hospitalization evaluations now take, on average, 45 minutes to complete. There was a meeting on May 14, 2003, with all community stakeholders (judiciary, police departments, jails, CMHC, private providers, and state Department of Mental Retardation officials) to clarify the 202B process, the involuntary hospitalization process for those individuals with mental retardation. The goal is to substantially decrease any particular individual time spent in inappropriate settings. Communicare has drafted a protocol that will be piloted within our region and is intended to be a model for the entire state.

- E. Stronger relationships with jails in our region are being forged. We have an improved system to address the need for MIW evaluations for jail inmates. Additionally, we held the first Communicare-Regional Jailers meeting in May, with 5 of our 7 jailers attending. At the meeting, the jailers were able to voice needs regarding obtaining mental health services for inmates. The process was explained and they were encouraged to work with their local Communicare clinic managers. They also received names and phone numbers of individuals who could expedite the process if they ran into difficulties.

One of the jailers suggested that they work together to build a facility, or designate part of an existing facility in the region to house individuals with mental health needs so that services could be better coordinated.

The rationale for jail-mental health training was addressed. Jailers who have had the training in their facilities received positive comments on the training from their personnel. Dates have been set for Grayson County (July 7 and 10). Nelson and Larue counties are coordinating to send their staff to Hardin County for training. Thus far, all personnel from Marion County and approximately 2/3 of the personnel from Hardin County have been trained, for a total of 4 trainings held and 82 jail staff members trained. Dates for Meade County and Breckinridge County are still to be arranged.

The jailers expressed interest in continuing to meet on a regular basis to share information and help formulate a regional approach to mental health care in

the jails. They expressed an interest in having others attend the meetings; such as county judge-executives, judges, law enforcement personnel, etc. In order to facilitate working relationships between the jails and their local clinics, clinic managers will be invited to the next meeting scheduled for August 12th.

- F. There have been no changes in addressing access to services for the elderly or for individuals with disabilities (i.e. deafness, physical restrictions, etc.).
- G. In an effort to address cultural/ethnic/racial aspects of awareness, Communicare has begun cultural diversity training of trainers.
- H. Not applicable. CSU services are already in operation.

V. Quality Assurance and Consumer Satisfaction

In the past two years, Communicare has continued to survey the clinic populations via surveys. We have focused on refining the survey to one that will tap more subtle concerns/complaints. With the latest survey, we also allowed the differentiation by therapist along with a variety of statistics/crosstabs and pie graphs for each clinic and therapist for use by the clinic manager. We continue to refine the clinic survey questionnaire.

Also, the agency began to survey the Therapeutic Rehabilitation Program (TRP) consumers with a survey form with the results going to the Community Support Program Coordinator and TRP leaders. An effort to integrate a best practice model into an outcome based service system has become a priority goal for the next fiscal year.

In response to increasing stress on medical services, Communicare has created the position of Medical Services Director to provide increased planning and oversight.

VI. Behavioral Health Goals

- A. The original goals that were established by the Council have all been achieved. These goals included the opening of the Adult Crisis Stabilization Unit (ACSU). This facility opened in December 2002 and is located in the same building as Children's CSU on Gray Street. Another accomplishment is the partnership between the LifeSprings Psychiatric Unit at Hardin Memorial Hospital and Communicare. Communicare's psychiatrists now staff the unit. MIW patients are now admitted to this unit when there is a bed availability instead of being transported to Central State Hospital. Services for children and overall outpatient capacity have been increased at Communicare. The Intensive Outpatient Program (IOP) to serve adolescent substance abusers has begun and the Transitional Housing Project for recovering substance abusing women has opened.
- B. See item A above.
- C. The Regional Planning Council is currently in the process of being revitalized. Participation had declined considerably in 2002. There are numerous new members as of 2003. Issues regarding goals and objectives of the council, and reasonable expectations for participation are currently being discussed.

VII. Implications

- A. Communicare has tremendous need for increased funding due to the significant increase in demand for services.
- B. The council believes that there needs to be advocacy brought on behalf of Kentucky (and other states) regarding potential changes in the Federal Medicaid program. While "up front" dollars may appear attractive initially, the notion of shifting the entire burden of maintaining the "safety net" to the states would no doubt result in significant long-term damage to the "net".
- C. We recommend the following issues to be considered to further strengthen the "safety net":
 - 1. Remove the "one year experience" requirement for case managers (both SMI adult and SED children). This has been a significant barrier in recruiting much needed staff.

2. Require that IMPACT Plus rates be derived equitably and with the same methodology between the private-not-for-profit and private venues. We recommend that they also receive the same audit controls and oversight.
3. We believe that the RIAC system be re-evaluated. Although the notion of various stakeholder and perspectives being represented in a RIAC is a laudable goal, the reality is that very few cases are discharged as inappropriate. This suggests that most, if not all, cases are appropriate referrals. The RIAC process significantly delays access to this service. We suggest that the same oversight and scope of service utilized in adult case management be adopted for children.
4. We recommend that Medicaid strongly consider the reimbursement for substance abuse services. The current circumstance results in under-diagnosis, at times inappropriate treatment, with an overall underservicing of this population.
5. We recommend the removal of the Medicaid stricture that each treatment plan be reviewed and signed off by a physician. This clearly diminishes the credentials of non-medical clinical staff who are licensed to practice independently in Kentucky. It further adds a huge administrative burden on clinical teams where staffing and collaboration time is at a premium.

VIII. On-Going Process and Activities

- A. Efforts have been made to include as many representatives from other agencies that can be an asset to the Council. The Council is currently attempting to increase participation from consumers and their families.
- B. The Regional Planning Council plans to continue with the quarterly meetings, submit reports as required, participate in review of state budgetary goals and respond to the Commission guidelines with regards to work group issues.
- C. We will attempt to meet with as large a membership as possible to review workgroup recommendations for face-to-face discussion. We will mail out the recommendations and solicit feedback from the total membership.

Regional Planning Council Members

X. Agency/Community Representatives

1. Linda Funk, Chairperson
2. Lance Heffer, Communicare
3. Valerie Noffsinger, Communicare
4. Nancy Addington, Area Development District
5. Barbara Brown, Kids Care
6. Capt. Mary Hall, Sheriffs Department
7. Charlotte Jones, Hardin County Government
8. Reverend Richard Sullivan, Faith community
9. Chris Workman, DCBS
10. Ona Finlay, DJJ
11. Tonda Lockett, Bardstown Community Prevention Center

Consumers/Family Members

1. Marlene Elliott
2. Kim Baxter
3. Sue Tomes
4. Chet Millstead
5. Mona Johnson
6. Frieda Bartlett
7. B. Proffitt
8. Chris Goodrum
9. Danny Johnson
10. Victor McCallister

11. Susan Cowles
12. Bernice Yates
13. Doris West
14. Tami Sullivan
15. Judith Boulton
16. Clinton Smallwood
17. Karlos Brooks

**REGION 6 REGIONAL PLANNING COUNCIL
HB 843 REPORT UPDATE
JULY, 2003**

I. Descriptive Features of the Regional Planning Council

A. Members of the Region 6 Regional Planning Council:

Members of the Region 6 Regional Planning Council are listed in Attachment A. There have been a number of new members added to the Council since the first report was completed and submitted.

Regional Council members, both collectively and individually, have become vocal advocates around behavioral health issues. They were involved in the postcard campaign during the 2003 legislative session, urging no cuts in the human services budget and exploration of new revenue sources. The Council members also wrote Op Ed pieces and Letters to the Editors of local papers; references are listed in Attachment B.

B. Activities since the report filed in December, 2000:

Region 6's Regional Council members have continued to meet on a regular basis, both collectively and as part of local implementation teams and workgroups in an attempt to further, where they could, local actions on their 12 goals for the region. Of the 12 goals, six (6) were designated to have local implementation plans developed, as they did not require action at the state level.

In 2001 and 2002, implementation teams worked to develop strategies to further these six goals. From 2002 to the present, groups have begun trying to implement some of the strategies. Templates with current progress toward goals are available (Addendum B: Implementation Team membership and Implementation Team templates). Three (3) workgroups have been formed to address the three most-pressing issues: Housing, Access to Medications and School-Based Services; the Workgroup membership is available (Addendum C: Workgroup Membership).

II. Regional Needs Assessment

- there are no significant changes in demographics, community indicators, or prevalence rates since November, 2000
- merger of city/county government in Louisville/Jefferson County and reduction of that budget by \$18m
- DSH funding decreasing for indigent patients
- flat funding for community mental health centers, causing Seven Counties Services to reduce workforce and eliminate programs, close site in January 2003
- grant funding is increasingly hard to come by
- Medicaid reimbursement rate decreasing for psychiatric inpatient
- fewer Metro United Way dollars to be allocated in region
- fewer private sector dollars available
- more unemployment = fewer dollars and more uninsured people needing services
- increasing restrictions on access to medication
- HUD dollars decreasing in region by \$1m
- state revenues down
- growing Medicaid deficit
- Medicaid regulation of dual eligibles (Medicaid/Medicare) has decreased reimbursement rate
- fewer federal dollars coming back to state
- proposed federal changes in Medicaid funding

III. Service System Description

A. What steps have been taken in addressing gaps in services?

- Olmstead dollars have provided some wrap around services for long-term hospitalized persons
- community –based waiver increased slots for dual disorder
- Homeless Outreach services at Phoenix Center for adults with severe mental illness

- Increased and improved education: pre-jail diversion program and the Metro Louisville Police's Crisis Intervention Team
- beginning development of grassroots recovery advocacy movement to address, identify gaps in system for CD services
- Continuation funding for pregnant women with chemical dependency (Project Link)
- the regional collaboration that formed around the Medicaid transportation issues/problems in this region in 2002-2003
- community forums
- merged Metro Louisville government closer examination of gaps
- federal grant funding obtained for special programs through the Family Health Centers and Seven Counties Services
- Metro United Way fostering of collaboration and funding of dual diagnosis and criminal justice services
- More "one-stop shopping alternatives (Neighborhood Places)

B. What is the current status of the "safety net" in your region?

- less acceptance of indigent patients by primary care systems
- private insurance more stringent about chemical dependency treatment
- Seven Counties is less able or unable to take persons without an ability to pay
- the safety net is becoming even more frayed due to flat and decreased funding
- less access to meds for persons without any payer source
- increased demands on private non-profits and hospitals
- longer waiting lists
- more persons uninsured
- more demands for Metro United Way funding
- federal restrictions on funding has decreased flexibility
- fewer day care services for unemployed and TANF recipients
- federal reductions in Sect. 8 vouchers that makes finding affordable housing more difficult

C. What is the current status of services for children and youth?

- Less CD treatment for adolescents through Seven Counties due to Seven Counties reducing beds at the Lighthouse program.
- overall lack of residential CD beds for youth in region
- no housing for homeless families or domestic violence victims
- reductions in subsidies for childcare
- reductions in Youth/Family Service Centers in schools
- school counselors on overload
- long waiting lists for services
- Good news! Teen pregnancy is down
- no increase in the number of providers who work with youth
- underemployed parents cannot pay basic expenses
- child protective services system is overwhelmed
- little progress in training education profession re: identification of mental health/substance abuse issues and domestic violence
- reduction in Impact Plus funding resulting in increased use of institutional care
- services are needed on flexible basis, Saturdays, evenings
- teachers have increased responsibility for testing special needs but not trained
- less training dollars available for staff to attend outside training, and no time for staff to attend even free trainings
- nowhere to send mildly dual diagnosed indigent (without private insurance) for treatment
- education for teachers (both regular and special ed) to work with kids with emotional disorders
- respite funds cut and dried up for natural parents and caregivers
- in-home support dollars are gone

D. What is the current status of repeated referrals (revolving door cases)?

- Louisville Metro government has increased funding to continue jail diversion services
- The CIT (Crisis Intervention Team) training expanded with the former Louisville City Police, now Metro Louisville Police
- in the process of attempting to implement a pilot mental health court in Jefferson County
- discussion underway to implement drug court in Henry, Oldham and Spencer counties

E. What is the current status of services for the elderly?

- no psychiatric care in nursing homes for elderly with mental illness in our region. We have to 'ship' our residents to one of two outside our region, isolated from all known support systems
- closing of Seven Counties' geriatric program and closing of other agencies' geriatric programs
- reduction in community-based waiver providers
- no planning for the increasing numbers of seniors
- decreased value on senior citizens and those with disabilities
- moral/ethical decisions are made on cost criteria
- there have been trainings/continuing education specifically targeted for the elderly
- transportation remains a problem
- access to medication
- major reduction in services due to Medicaid cuts
- increase in elderly homelessness due to inadequate resources to maintain housing
- aging resources are decreasing
- lack of awareness of what is available

F. What changes, if any, have you seen in coordination and collaboration across systems and between organizations in your region?

- some increase in collaboration between Seven Counties and Family Health Centers.
- the HB 843 council has formed new relationships for networking and brainstorming and helped increase dialogue in region
- regional interagency council (RIAC) has committed to conduct trainings, which is an actual benchmark reported to state
- MH/SA providers have collaborated to develop common assessment tool for adolescents.
- Annie E. Casey Foundation promoting collaboration on several fronts
- increased collaboration has resulted from decreased resources, i.e. elder abuse
- newness of Metro government is promoting collaboration
- police crisis intervention training
- affiliation/subcontracting agreement between Seven Counties and Caritas (adolescent partial program) and the Morton Center (adolescent IOP services)

IV. Strategies to Increase Access to Community-Based Services

A. What changes, if any, have there been in access to community-based services?

- Bridgethoughton opened new dual diagnosis program
- Seven Counties Services has reduced hours and services at some rural offices
- Seven Counties Services eliminated its Adult Crisis Team program
- Central State Hospital eliminated its dual diagnosis special service
- Seven Counties has further tightened access criteria for SMI adults; access limited to highest priority only

B. Has consumers' access to medications changed? If so, how?

- Malpractice insurance crisis in state limits primary physician access to medication/care**
- primary care physicians excluded from providing mental health care
- The Passport formulary is restrictive for atypical antipsychotic meds (atypicals removed by Passport as of 1/1/03)
- Jefferson County is down to only 3 private psychiatrists who accept Medicaid

- Time requirements for indigent to get into system are lengthening, which causes delay in giving medication
- Medicaid removed one atypical
- rumors that splitting pills may be required by Medicaid, which will lead to non-compliance or dosing errors
- reduction in number of pharmacies participating in the Community Medication Support Program since CVS canceled contract in region.

C. What changes have occurred, if any, with regard to the availability and utilization of support groups?

- new NAMI support groups for parents of children under age 18 with mental illness began in 2003

D. How has your region attempted to reduce criminalization of persons with MH or SA disorders?

- the Crisis Intervention Team program (begun with the Louisville Police) continues to expand
- While CIT program is effective and has grown, it now is straining EPS (Emergency Psychiatric Services at U of L Hospital)
- jailers are pushing for judges and prosecutors to refer to mental health services. This in turn, requires fund transfer to mental health system.

E. Please describe the relationship of the CMHC with the jails in your region, including the status of jailer training.

- several Seven Counties' staff attended the initial 2-day state training
- in process of scheduling training in Shelby County
- training is in planning stages in other counties
- Jefferson County already has a training program.

F. Have there been changes in addressing access to services for the elderly and for individuals with disabilities such as deafness, physical restrictions, etc?

- Caritas opened a geriatrics unit
- Seven Counties closed its Geriatrics Program location. It continues to treat geriatric clients at its outpatient locations
- Seven Counties closed its Landmarks Program locations (dually diagnosed MR/SMI). It continues to treat clients with this diagnosis at its outpatient sites.

G. How has your region attempted to address cultural/ethnic/racial aspects of awareness, access and utilization of services?

- no major changes since 2000
- some local agencies report having more literature, forms, etc. translated into Spanish

H. If your region received funding for a CSU as a result of action during the 2002 General Assembly, describe your current activities and the status of implementing that service/facility.

Not applicable. The CSU in this region was one of the first to receive funding several years ago.

V. Quality Assurance and Consumer Satisfaction

What changes, if any, have been made to address quality assurance and consumer satisfaction in your region?

- the therapeutic rehabilitation programs are submitting info to the state outcome program
- otherwise, no change as region is waiting for HB843 state workgroup to complete its work.

VI. Behavioral Health Goals

A. Briefly describe the top goals set by your Regional Planning Council for the initial 2001-2003 time period.

Goal 1: Increase the number of supported housing units (including group, individual and independent housing arrangements) in the region for persons with mental illness and substance abuse problems by 50% by 2006. This housing must include supportive services to encourage and sustain independent living. An array of supportive services would include such things as job training and placement, transportation, interpreter/translation services, child care, training in daily living skills, case management, support groups, medication monitoring, nutrition, recreation and socialization activities. A part of this goal also is to increase by 25% by 2006 the availability of support services that facilitate the coordination of mental health and substance abuse treatment and care.

Goal 2: **Develop a seamless, coordinated continuum of care to successfully transition persons with mental illness and/or substance abuse problems from institutional care (i.e., hospitals, jails, prisons) to community care, helping to reduce inappropriate and unnecessary hospitalizations and repeat offenders in the criminal justice system each by 25% by 2005; 50% by 2010. By 2005, tie all of the region's providers (public and private) into a centralized regional network (available 24/7) to help coordinate referrals to appropriate services, improve continuity of care for shared clients, and provide interagency support.**

Goal 3: Increase the ability of physicians, school personnel, clergy, law enforcement personnel (officers, judges, probation and parole, corrections, etc.) and other professionals to effectively identify and screen for mental health and substance abuse problems, and then to access and/or refer individuals to the most appropriate services.

Goal 4: Attempt to improve quality of care for mental health and substance abuse by increasing access and choice for the public through expanding and diversifying provider participation in public sector programs by 2005.

Goal 5: Increasing diversion of defendants with mental illness and/or substance abuse related problems by 50% by 2010.

Goal 6: By 2005, require all providers statewide to participate in a standardized outcome measurement system that would allow information to be shared among providers and the general public.

Goal 7: By 2002, provide consumers/families statewide an easy method/process for asking questions, filing complaints, registering grievances, and filing appeals. This method also should meet payer/regulatory requirements and be mandatory and reasonable for providers to implement. This process should include a definition of grievable offenses (versus complaints), and how grievances and complaints will be handled.

Goal 8: By 2003, increase by 25% the current capacity of therapeutic schools/classrooms and before and after-school care for children and adolescents who have SED (serious emotional disturbance) or have other special behavioral health needs. Increase capacity 50% by 2006; 100% by 2010.

Goal 9: Reduce barriers to accessing mental health and substance abuse services, and increase the total number of persons served in the region by at least 5% annually over the next 10 years.

Goal 10: Establish five permanent and five mobile comprehensive healthcare service units in the region by 2010 to meet mental and physical health needs and to provide services to those consumers with access problems.

Goal 11: Make the most appropriate medications available to those who need them and expand medication monitoring.

Goal 12: By 2010, require licensure and /or accreditation of all appropriate agency/facility providers by appropriate licensure/accrediting bodies.

What progress has been made toward achieving these short-term goals?

Eight (8) of our goals were designated in 2001 as Implementation Goals, as they all lent themselves to work at the local level for implementation and were not fully dependent on actions at the state level. These eight goals addressed

Supported Housing (#1), Revolving Door (#2), Education & Early Intervention (#3), Criminal Justice Interface (#5), School Therapeutic Services (#8), Barriers to Access (#9), Increased Service Sites (#10) and Access to Medications (#11). The preliminary work around these eight goals is summarized in the second session of this report. As these eight goals were further studied, it became apparent that several were so closely linked that they could be put together for work by the implementation teams. Goals #2 and #5 were rolled into one implementation initiative, and Goals #10 and #11 were also put together. Three of the implementation workgroups have met a number of times to develop local strategies. These three initiatives are addressing: supported housing, access to medication and therapeutic classrooms. The work and updated recommendations of these three groups are also included in the second session of this report.

What longer-term goals were set by your Regional Planning Council?

The grids in Section Two of this report describe the long-term goals set by our Regional Planning Council.

What progress has been made toward achieving these longer-term goals?

Progress toward achieving these longer-term goals is also described in the second section of this update report.

VII. Implications

A. How have your funding needs changed?

- Safety net continues to unravel in all areas due to inadequate and flat funding
- Restrictions to outpatient access lead to increased, more costly inpatient utilization

B. What public policy changes are needed to further your objectives?

- Advance directive legislation passed
- the same changes council recommended in 2000 are needed to further objectives, particularly a commitment from the state to provide cost-of-living adjustments to maintain services at current levels
- Change Impact Plus policy on residential treatment

C. What further recommendations (or changes in past recommendations) need to be made at this time?

- strongly reemphasize the need by this (and all) regional councils for financial data from state for this region as requested in 2000. It is impossible to plan and make changes without knowing how much money from all pertinent state cabinets, divisions and departments currently is being spent in region.

VIII. On-Going Process and Activities

A. What process have you used or will you use to add new members to your HB 843 Regional Planning Council?

- using the membership guidelines HB 843 provided in 2000, this regional council replaced members no longer willing to serve in 2001. At its July 2003 meeting, it will embark on a similar process to refresh the membership and replace members who no longer can attend, and rejuvenate several of its workgroups.

B. What activities do you anticipate your Regional Planning Council will be involved in over the next two years?

- HB 843 membership will improve communication with stakeholders in region by visiting stakeholders and presenting updated plan. A particularly important focus will be the rural counties of the region. A goal is to ensure that stakeholders are using the plan as they carry out their internal activities and that they consider themselves part of the implementation solution. Several of our implementation teams have no current leadership and are not meeting, so they too, need to be reconstituted. We also may look at a SA/dual diagnosis sub-group.

C. How will your Regional Planning Council carry out the review of workgroup reports and recommendations expeditiously?

--As soon as the workgroup recommendations are made available, they will be sent out to regional council members for review. This council already has a meeting scheduled for July 22, 2003, and discussion of the recommendations is one of the two main agenda items for that meeting.

IX. The following is an additional question added: To your knowledge, in what ways has this region's HB 843 report been used in this region by other agencies, organizations, government entities, or individuals?

--The Homeless Coalition used the initial HB 843 Report as part of its strategic planning process

--Metro United Way has used the report and local council members as a resource in developing a RFP for available funds

--Some representatives of Louisville Metro government have been provided additional copies of the executive summary during community discussions about the Metro budget and planning priorities

--Several regional council members have served as reviewers of Seven Counties' plan and budget for adults (2002 & 2003) which has been submitted to the KY Dept. for Mental Health Mental Retardation Services.

Attachment A - Region 6 Regional Planning Council Members * New members (2001-02)

Joyce	Aldrich	Probation & Parole
* Elsie	Atherton	Metro United Way
Charlie	Baker	Jefferson County Schools - Safe & Drug Free Schools
Bernie	Block	Seven Counties Services Board & NAMI-Louisville
* Richard	Blondell, M.D.	U of L Family Community Medical Services
* Dennis	Boyd	U of L Department of Psychiatry
* Jim	Burch	Seven Counties Services, Inc.
* Cindy	Christensen	Presentation Academy
Molly	Clouse	
James	Dailey	NAMI-Louisville
* Mary Helen	Davis, M.D.	Integrated Psychiatry
Deborah	DeWeese	District Court Judge
Claude	Drouet	Mental Health Association - KY
Dan	Fox	Family & Children's Counseling Centers
Marlene	Gordon	Coalition for the Homeless
* Erlene	Grise-Owens, Ph.D.	Spalding University, School of Social Work
Vicki	Hines-Martin, Ph.D.	
Lynn	Howard	Metro Louisville Government
Ramona	Johnson	Bridgehaven
* Donald	Kmetz, M.D.	Jefferson Co. Health Department
JoAnne	Maamry	Caritas Peace Center
* Rita	Osborn	GuardiaCare
* Diane	Pedro	
* John	Rosati, Ed.D.	SCS Board Chair, Ohio Valley Educational Co-Op
* Trude	Scharff	
S. Abby	Shapiro, Ph.D.	KY Psychological Assoc.

Jackie	Simmons, M.D.	Passport Health Plan
Denise	Simpson	Jefferson Co. RIAC
Mike	Simpson	Oldham County Jail
* Donna J.	Smith, M.D.	Central State Hospital
* Eileen	Spahl	Baptist East Hospital
Michelle	Spurlock	Norton Healthcare, Inc.
Jackie	Stamps	Dept. for Community-Based Services
Joe	Stevenson	Volunteers of America
De De	Sullivan	Dept. for Community-Based Services
Greg	Taylor	KY Correctional Psychiatric Center
* Brian	Tinsley	Wicks Pharmacy
*Gary	Underwood	Pfizer, Inc.
* Bill	Wagner	Family Health Centers
* Bernadette	Walter, Ph.D.	U of L Psychological Services Center
* Wendy	Ward	getCare
Joanne	Weis	Jefferson Co. Dept. for Human Services
John	White	
Irene	Yeager	

Attachment B: Region 6 Media References

“A Promise Unfulfilled” by Howard F. Bracco and Bernard Block. *The Courier-Journal*; Sun. 19 November 2000. Op Ed.

“Building ‘A Better System of Care’” by Jim Dailey. *The Courier-Journal*; Wed. 8 November 2000. Letter to the Editor.

“Suicide Prevention is responsibility of all” by Joanne Delorenzo Maamry. *Business First*; 10 August 2001. Comment article.

“Louisville police learn new approach for dealing with mentally ill” by Shannon Tangonan. *The Courier-Journal*; 18 August 2001. Article.

“A human response” by Erlene Grise-Owens. *The Courier-Journal*; 14 February 2003. Letter to the Editor.

“Don’t cut funding for mental health” by Bernie Block. *Shelby Sentinel*; 26 February 2003. Letter to the Editor.

“Protecting and caring for our most vulnerable citizens is a duty for all” by Bernie Block. *Trimble Banner*; 26 February 2003. Letter to the Editor.

“Bigger revenue pie” by Bernie Block. *Bullett Pioneer*; 5 March 2003. Letter to the Editor.

“Protect mental health and substance abuse programs” by Bernie Block. *Oldham Era*; 27 March 2003. Letter to the Editor.

GOAL 1

Goal 1 A: Fund development of 72 units of permanent housing across the regions 6 rural counties (1- 3 bedroom units) Fund development of 6 group homes (ea. 6 - 8 person capacity) Fund 30 clustered transitional beds (5 per rural county)

Goal 1 B: Jefferson County: Increase the number of transitional or time limited housing units by 25%, an increase of 85 units, cloistered and/or step down) Increase permanent housing units by 50% (46 units)

Identify the strategies and approaches to accomplish the goals and objectives.	Address the regional action that will need to take place to accomplish the stated goals and objectives.	What can be done; How to do it; Who needs to be involved to accomplish the action; the time frame to meet either the goal or objectives?	What are the financial considerations ; what is the expected cost to accomplish the goals or objectives; What are ways to meet the costs?	If necessary what State action will be required to meet the stated goal?	What are the outcomes they be
Lobby for funding - State Legislature	Approach legislatures sympathetic to affordable housing needs, such as Jim Wayne Aggressively pursue HUD Section 811 funding	Oversight entity; Region 6 Council; MH/SA Advocacy/Consumer groups 2 to 10 years	\$11 million over the determined build out period State funding, HUD, KHC, LITC, rental subsidies, bond issues, local seed dollars	Legislation will need to be passed allocating specific, binding dollars over an established period of time: Established legal set asides; KHC, LITC, AHTF	Increase support Region Establish for cons units, pe Ongoing support menu - of efficacy ratio.
Leverage dollars with KHC, HUD, HOME rental subsidy dollars Establish oversight entity to track progress and ensure flexibility of spending based on documented need.	Create an oversight entity comprised of Regional Council members and KHC staff and consumers to ensure fiscal due diligence, documented need and feasibility.				

XI. REGION 6 – GOAL 2A

Goal 2 A: Rural Counties: Fund fundamental supported services (6 Specialized Intensive Case/Housing Managers - 1 per rural county; Wrap Around Funds, 24-hour Group Home Staff Coverage; Per Diem Funding for Transitional Beds, Psych/Rehab Socialization Activities - 60% of residents)

Strategies	Regional Action	What? How? Who? Time?	Finances/Cost	State Action	Outcomes
Lobby for funding - State Legislature	Develop local definitions for “group homes”; Ensure that housing for special populations is included in Cornerstone 2020 guidelines; Educate Planning Councils on need;	Develop standards for ‘ideal’ array of supported services; Research models of service delivery, cost effectiveness, flexibility, staffing patterns; Time - on-going	\$3.5 million State allocations; (DMH/Medicaid); Aggressively pursue grant/ foundation funding to pilot ‘new’ models of care with focus on cost/benefit ratio;	Funding allocation from General Assembly; Possible changes in Medicaid allowable reimbursement stream - non-clinical services.	Access housing clients of success in vocational program Unduplicated served; Success of vocational

	Review/research other CMHC's supported housing development programs.				employ (s); Relapse rates.
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REGION 6 – GOAL 2B

Goal 2 B: Jefferson County: Fund 2 Specialized Case Managers, Wrap Around Funds, Psych Rehab Socialization Activities; Transitional units Supported Services - Per Diem

Strategies	Regional Action	What? How? Who? Time?	Finances/Cost	State Action	Outcomes
<p>Successfully transition persons with Mental Illness and/or Substance Abuse from institutional care to community care.</p> <p>Every hospital, jail, or prison will establish a care management or discharge planning team.</p> <p>Develop standardized screening tool for Mental Illness/Substance Abuse to be used at jail or prison at time of admission. (Screening presumed completed in psychiatric hospitals)</p>	<p>Establish standardized Mental Health/Substance Abuse screening tool that is to be completed within 48 hours of incarceration.</p> <p>Establish a regional network to develop a standardized discharge plan, including:</p> <p>Housing, Education needs, Employment needs, Physical medicine needs, Substance Abuse and Mental Health needs, Family/care giver resources, Functional assessment, Transportation needs</p> <p>Planning begins at the time of admission and becomes part of the service plan.</p> <p>Convene representatives of all correctional facilities in conjunction with the local Community Mental</p>	<p>For Forensic facilities:</p> <p>Sentencing authority, probation/parole attorney, family, prior service providers, inmate, and hospitals.</p> <p>Patient, family/guardian, treatment team, Out Patient provider, residential placement all need to be part of the discharge planning.</p> <p>City jails, county jails, detention centers, prisons, penitentiary, community corrections.</p> <p>May need to evaluate the need to have regional forensic facilities to accommodate and assess adults in counties that do not have sufficient resources to meet the requirements of Goal 2 recommendations.</p> <p>Crisis and Information Center's 1-800 number to be utilized for contact. Number to be made</p>	<p>Cost of assessment tool</p> <p>Cost of training</p> <p>Cost of professional staff for the evaluation/case management team.</p> <p>Cost for Crisis and Information Center for managing phone calls and training.</p> <p>Assess eligibility for public entitlements and other financial aid: Medicaid/Medicare, Impact/Impact Plus, SSI/SOI, self-pay.</p> <p>Shorten Institutional care to reduce costs.</p> <p>Grant writing to include cooperative efforts between the Department of Justice, Department of Mental Health and Substance Abuse, and Community Mental Health Centers.</p>	<p>Adequate funding to entitlement programs</p> <p>Medicaid and other entitlement programs need to review policies regarding application for services prior to release or reinstatement of services upon release.</p> <p>State contracts will require care management or discharge planning teams.</p> <p>Adequate funding to hire Mental Health Professionals.</p> <p>State mandates screening for all inmates in any correctional facility, and if Mental Health/Substance Abuse screen is triggered discharge planning is mandated.</p>	<p>For Forensic f</p> <p>Reduce recidi transition to co provides grea safety for clier community.</p> <p>For Hospitals</p> <p>Reduce recidi length of stay, compliance w treatment/med management.</p> <p>Measurement</p> <p>Decrease reci</p> <p>Decrease leng</p> <p>Decrease acu</p> <p>Employment</p>

	<p>Health Center to develop a standardized screening tool.</p> <p>Access assistance from Mental Health and care management providers.</p>	<p>available to judges, police, and jail personnel in the region.</p>			
<p>Decrease inappropriate and unnecessary hospital admissions and decrease repeat offenders in the criminal justice system.</p>	<p>Crisis Intervention and stabilization units to decrease acute psychiatric hospitalization.</p> <p>Adequate training of emergency personnel to deescalate situations, utilize community resources and identify Mental Health emergencies.¹</p> <p>Mental Illness and Substance Abuse screening allows treatment rather than re-arrest.</p> <p>Jail case management and discharge planning teams provide alternatives to arrest.</p> <p>Develop crisis response team to assist emergency personnel.</p>	<p>Cooperative effort among all inpatient hospitals and treatment facilities to support alternatives to admission</p> <p>Community task force to develop protocols for establishing crisis response team.</p>	<p>Tremendous savings of money in decreased admissions and decrease repeat offenders will increase available monies for treatment.</p> <p>Grant writing to include cooperative efforts between the Department of Justice, Department of Mental Health and Substance Abuse, and Community Mental Health Centers.</p>	<p>Mandated funding to Partial Hospitalization and Intensive Out-Patient programs.</p> <p>Mandate crisis response teams</p>	<p>Number of hospital admissions with mentally ill offenders treated rather than incarcerated.</p>
<p>Tie region's providers into centralized regional network.</p>	<p>Establish interagency council to determine regional needs of the community regarding recidivism:</p> <p>Access to information</p>	<p>All service providers</p> <p>Correctional facilities</p> <p>Emergency personnel</p> <p>Anyone coming in contact with identified</p>	<p>Hardware, Software, Maintenance</p> <p>Training, publicity</p> <p>In-kind services provided by participants</p>	<p>Clarify Privacy Laws pertaining to Mental Health/Substance Abuse/Legal</p> <p>Extension of Good Samaritan Laws for participating agencies to help reduce legal risk of</p>	<p>More appropriate and placement</p> <p>Fewer obstacles stakeholders in the continuum</p>

¹ We believe the importance of adequate training of emergency personnel to decrease recidivism, but feel this objective is detailed in Goal 3.

	Community resources Specialized services	populations Needs to be accomplished as quickly as possible.		participating providers in networking.	
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ADDITIONAL NOTES – below are listed ideas that were brought up in our sessions that we felt would impact the creation system, but felt that belong in the context of other goals within HB 843.

- 1) Establish court liaisons to expedite cases and community-based options.
- 2) Establish Mental Health Courts
- 3) Establish or expand Drug Courts for adults and juvenile
- 4) The mobile assessment team is addressed in Goal 10, but we feel that having access to an adult mobile assessment team would be decreasing recidivism.
- 5) To reduce barriers in accessing mental health and substance abuse services, we would advocate that all of the above recommendations be implemented in a fashion that is culturally sensitive to our diverse community.

REGION 6 – GOAL 3

Goal 3: Increase the ability of physicians, school personnel, clergy, law enforcement personnel (officers, judges, probation officers, etc.) and other professionals to effectively identify and screen for mental health and substance abuse problems, and then refer individuals to the most appropriate services.

Strategies	Regional Action	What? How? Who? Time?	Finances/Cost	State Action	Outcomes
Identify existing required training within professional groups and sub-groups	Complete a needs assessment by development of a survey of information needs and what is already available re Mental Health and Substance abuse issues.	Identify existing required training within professional groups and sub-groups. Completion of Needs Assessment: Summer of 2002	Ascertain current spending (time and materials) Consider training and advertising costs	State funding could be regionalized (may require line item in budget)	Expected
Determine key personnel or key groups within each professional group to target (tailor to group).	Determine best ways to increase awareness and reach greatest number of people in shortest time	Develop curriculum, which emphasizes accessing services, making it relevant. Completion date: Summer 2003	Organizations would donate services for training Consider possibility of state funding	State mandate for professional training Support of professional organizations for required training	1. Training provided to professionals
Determine group-appropriate curriculum	Review present process for distribution of information	Develop generic screening tool. Completion date: Summer 2003	Grant writing	Support of state agencies at policy level for required training	2. Training provided to professionals
Offer training to professionals through their professional organizations	Advertising and Marketing strategies	Provide education and training to identified professionals. Completion date: Summer 2004.	Possible costs: In-kind commitment for mandated training for staff; Salary; Design and duplication of materials (survey and curriculum); Distribution costs;		
Contact Human Services agencies about screening tools currently used		<u>Judicial system and law enforcement:</u> Eastern University, rural police forces,			

<p>Develop a generic screening tool</p> <p>Begin discussions with universities about post-secondary education in Social Sciences, Medicine and Education</p> <p><u>Accessing Services/Referral</u> Review Community Referral Network (determine accuracy; broaden if necessary)</p> <p>Provide Human Service organizations with best practices</p> <p>Assess difficulties in accessing services</p> <p>Provide education to address stigma against people as well as professionals' own stigma (fear) or lack of awareness of substance abuse and mental health issues</p>	<p>Create a screening tool</p> <p>Brief, simple Focus on function Focus on broad risk factors Able to cross language barriers</p> <p>Use contacts with HB843 as network to disseminate information</p> <p>Convene work groups in each Regional County to promote local ownership. Work through existing prevention coalitions.</p> <p>Jefferson County to break up into neighborhoods or work through "Communities within Communities"; work within Neighborhood Place structure.</p> <p>Negotiate agreements with professional and licensure organizations to comply</p> <p>Develop a survey to assess barriers to accessing services and making appropriate referrals</p>	<p>and county sheriffs' offices; Probation/Parole; Judges, Attorney groups (Bar Association, Kentucky Paralegal Association)</p> <p><u>Medical:</u> Kentucky Medical Association, Jefferson County Medical Society, Hospitals, nursing associations, nurse practitioner groups, Nursing home staff, health departments</p> <p><u>Staffs of residential facilities;</u> e.g. Housing Authority facilities, group homes, assisted living facilities</p> <p><u>Education</u> Jefferson County Public Schools and Rural public school districts</p> <p>H. Postsecondary Education University of Louisville (Nursing, Education, Counseling Psychology, Clinical Psychology, Social Work, Sociology, Justice Administration, Medical School)</p> <p>Spalding University (Social Work, Psy.D. program, Education, Nursing)</p> <p>Bellarmino (Nursing, Education)</p> <p>IUS (Education, Nursing, Counseling)</p> <p>Southern Baptist Seminary and Presbyterian Seminary (clinical pastoral education)</p> <p><u>Clergy:</u> major denominations, seminaries (pastoral training programs); Mental Health Association of Kentucky's clergy list; parish nurses' group, youth ministers, hospital and nursing home chaplains.</p>	<p>Data analysis</p> <p>Dissemination of information about CRN and its web page in a user-friendly way; i.e. Telephone stickers, magnets, stickers on computers</p>	<p>p cl e p (p c o p b e a r to a s m a a</p> <p>Meas</p> <p>Curric includ tests</p> <p>Scree shoul study cross profes being profes in ger</p> <p>Follow shoul all tra profes</p> <ul style="list-style-type: none"> • A in o • A s • F a a <p>Period shoul profes the in numb</p> <p>All pr</p>
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		<u>Social service organizations:</u> State/federal community based social services; other non-profit social service organizations <u>Homeless organizations</u> (Homeless Coalition and related organizations) <u>Mental health organizations and private practitioners</u> Determine other personnel who could benefit			be ab increa to acc A follo provid no-sh
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*NOTE: List of groups to be reached is not exhaustive. List should be prioritized before proceeding.

REGION 6 – GOAL 5

Goal 5: Increasing diversion of defendants with mental illness and/or substance abuse related problems by 50% by 2010.

Strategies	Regional Action	What? How? Who? Time?	Finances/Cost	State Action	Outcom
If there is a shortage of funds, direct client services should be the recipient of funds. For example, the amount of funding recommended for Mental Health Courts could fund 20 more halfway house beds that are very badly needed. Another example with drug court: We recommend looking for other ways to fund the court rooms, administrative services, so the funding is utilized for treatment/clinical services.	Meet with appropriate legislators (i.e., Mary Lou Marzian)	Region 6 HB 843 Council needs to set up the meetings		Budget approved through the General Assembly	Funding be prim client se
Top priority for this region is the development of an array of specialized housing including halfway houses, for persons with mental illness and/or alcoholism/drug addiction who are	1) Meet with appropriate legislators (i.e., Mary Lou Marzian) 2) Feedback given to Statewide Commission	1) The Region 6 HB 843 Council needs to set up the meetings 2) H.F. Bracco, Bernie Block, Sheila Schuster can give the feedback or decide who should	\$1.7 million Halfway houses should have no more than 20 residents/house. Residents could pay a portion of the cost. Majority of cost would be state and federal dollars.	Budget approved through the General Assembly	Funding have a designa houses justice o alcohol/ mental

<p>involved with the criminal justice system. In this region, we estimate a need for 90 additional halfway house beds as well as other housing, including sober living, group homes, etc., for the criminal justice population.</p>					
<p>If there is sufficient funding after the housing is funded, our second level priorities (not in any order of priority) are listed below:</p> <p>I. Case management services to assure pre-release planning from jails and prisons for all those who are severely mentally ill or alcoholic/addicted with linkages to community mental health centers. Require severely mentally ill released from county jail or prisons to have an appointment within 3-14 days (whenever the medication runs out)</p> <p>II. Develop specialized step-down treatment services (other than halfway houses) in the community to ease the transition from jail to the community</p> <p>III. Drug courts both in Jefferson and rural communities</p>	<p>Meet with appropriate legislators (i.e., Mary Lou Marzian)</p>	<p>Region 6 HB 843 Council needs to set up the meetings</p>	<p>Not calculated yet</p>	<p>Budget approved through the General Assembly</p>	<p>There w designa priorities</p>
<p>If there is sufficient funding left after funding the top and second level priorities,</p>	<p>Meet with appropriate legislators</p>	<p>Region 6 HB 843 Council needs to set up the meetings</p>	<p>Not calculated yet</p>	<p>Budget approved through the General Assembly</p>	<p>There w designa priorities</p>

<p>we recommend funding the next level of priorities listed below <u>not</u> in any order of priority.</p> <p>Alcohol/drug programs in jails and necessary aftercare in the community after leaving jail</p> <p>Assure that mental health and alcohol/drug evaluation and treatment is available in juvenile detention centers in all counties</p> <p>Assure training in all counties for law enforcement in dealing with the mentally ill</p> <p>Development of shared databases between community mental health, police, jails, to facilitate communication, but with appropriate safeguards to protect confidentiality.</p>					
<p>Development of local agreements between law enforcement agencies and community mental health centers as to appropriate disposition for individuals other than jail</p>	<p>Goal 5 Implementation Team will take the initiative to contact Jefferson County Police and State Police about receiving the Crisis Intervention Team (with Mentally Ill) training similar to the Memphis model. The goal is that Jefferson County and at least the State Police posts who serve SCS Rural counties will all receive the training (Louisville Police have already received the training). Then the small cities (i.e., Jeffersontown, St. Matthews, Shively, etc.)</p>	<p>Jim Dailey will make contact with Chief of Jefferson County Police. Cynthia Shain will make contact with Deputy Commissioner of State Police. Both of these team members will work together until training has been set up.</p>		<p>State Police will implement the Crisis Intervention Team training. The Department of Justice will implement a four hour training course on dealing with the mentally ill through the Department of Criminal Justice training.</p>	<p>Jeffersco and Sta posts w SCS Ru each ha Interve The sm Region with larg departm Jeffersco State P Crisis In Team s cities.</p>

	could contract with the larger police departments for the Crisis Intervention services.				
Develop a procedure where an individual who has a history of mental illness or substance abuse problems could be paroled one to two years prior to serve out and sent to a therapeutic halfway house. Engaging in treatment would be a condition of their parole.	The HB 843 Criminal Justice Implementation Team will review this issue to determine the action steps				

REGION 6 – GOAL 8

GOAL 8 Restated: To increase the capacity of schools/districts to deal with therapeutic needs of children.

Strategies	Regional Action	What? How? Who?	Finances/Cost	State Action	Outcom Measur
a. Stipends for teachers or free tuition if teaching is done in University classes b. Offer resources (i.e., Teacher’s Encyclopedia of Behavior) with workshops. c. Train personnel in Regional Service Centers in models like Second Step and Champs. d. Provide follow-up in classrooms with teachers who participate in workshops on behavioral strategies.	a. Provide trained personnel to work with school staff to accomplish strategies.	a. Work with local universities, school districts, ed co-ops, and Regional Service Centers to plan and deliver.	a. If within one region, 20 teachers per year could receive training/support/resources, the cost would probably approach \$10,000. b. It would depend upon in-kind contributions of trained staff to contain cost (service providers, university). c. Create Teacher Professional Growth Fund i. Content-area focused to increase skills in behavior management.	a. Funding b. Allowing credit to be applied to Rank I work – Professional Standards Board i. Offer more accessible, affordable ways to grow. c. Accepting University coursework for emergency certification requirements i. Must complete six hours in area during the teaching year. ii. Requirements could be more flexible to meet mental health issues d. Lowering the cost of tuition offering classes for teachers	Expecte Level of profess by provi More te prepare in class with stu issues. Measur Outcom
a. Raise public awareness i. Contact local and	a. All strategies listed can be implemented in all seven counties.	a. Notify newspapers of the HB 843 and all its	a. Approach Corporate Companies who	a. Coordination of resources and flexible spending	Expecte Increas parents

<p>regional newspapers, and run continuously at intervals throughout the year, specifically during season change. Tell them the need for educating the public on signs and symptoms of mental disorders.</p> <p>b. At the opening of schools, create an orientation program for parents, caregivers of children, and service providers of children – Teaching them the “red flags” and warning signs of children needing further assessment.</p> <p>i. Speak of the difference between usual and unusual behavior development.</p> <p>c. Begin a support group for those needing continued information.</p> <p>d. Announce classes/courses on “brain disorders” at grocery stores, malls, churches, health clinics, doctor’s offices.</p> <p>e. Avail information for teachers when they see “red flags” in a child.</p> <p>i. Have resources that are current.</p> <p>f. Participate in health fairs.</p> <p>g. Identify a space in Frankfort as a “storehouse” for all informational pamphlets, etc., for distribution to those interested in the EBD population.</p>		<p>goals- “It takes a village theory.” Write an editorial.</p> <p>b. Distribute literature on “Warning Signs, Usual and Unusual Behaviors, and Normal Development.”</p> <p>c. Implement thinking that- “It’s a biological disorder, not, just a behavior issue.”</p> <p>People needed to accomplish the Action:</p> <p>a. An empathetic and educated school board</p> <p>b. Educated press</p> <p>c. Willing caregivers, parents, and teachers</p>	<p>wish to support children’s health and well-being.</p> <p>b. Community collaboration</p> <p>c. Cost minimal</p>		<p>intervent ongoing</p> <p>Educati the key an incre assistan children</p> <p>Coordin educati include faction.</p> <p>Measur Outcom</p> <ul style="list-style-type: none"> ▪ Ono and prim reac edu ▪ Wh clas imp “wo clas with
<p>Focus on mental health agencies and school districts:</p> <p>a. Need to identify the schools that do not have a mental health professional.</p>	<p>a. Flexible spending and coordination of all community resources to maximize efficiency and non-duplication of services.</p> <p>i. Schools</p>		<p>a. In order for mental health professional to begin working in new schools, there must be enough clients for it to be</p>		<p>Expecte have ac mental professi schools</p> <p>Measur</p>

<p>b. Need to identify mental health agencies that are interested in having some of their clinicians work within the school systems.</p> <p>c. Must have district/agency cooperation.</p> <p>d. Need to identify within each district a “point” person for school district and local mental health professional.</p> <p>e. Need to identify a contact person within each (School Counselor, Family Resource Coordinator, Home/School Coordinator) that is responsible for advertising services, identifying clients, finding adequate space for therapy room within schools, establishing payment, e.g., help families that qualify for KCHIP access those services.</p>	<p>ii. Mental health organization</p> <p>iii. KCHIP/Medicaid</p> <p>iv. Prevention services</p> <p>v. Safe schools initiative</p> <p>vi. Community resources</p> <p>b. Increased access to KCHIP / Medicaid</p>		<p>financially sound. (e.g., There needs to be approximately 12-14 clients per school in order to offset the cost of the mental health professional.)</p> <p>These are the high-end need children whose needs cannot be met by less intensive services.</p>		<p>Outcom</p> <ul style="list-style-type: none"> ▪
<p>a. There needs to be a step-down ladder implemented. An example of such a letter would be:</p> <ul style="list-style-type: none"> -Inpatient Hospitalization -Day Treatment/Partial Hospitalization -Intensive Outpatient Services (3 x week) with Adjunctive Services in place at home and school <p>*When the child actually starts back to school, start only with half a day at first, instead of immediately putting back into school full time.</p> <ul style="list-style-type: none"> -Gradually taper Intensive Outpatient Services to 2-4 x month 	<p>a. Funding to:</p> <ul style="list-style-type: none"> i. Keep children in the hospital as long as they need to be there for their own safety and the safety of others, even if, the next level of care is not available. ii. Create more day treatment and partial hospitalization programs (an important step down from inpatient hospitalization). iii. Pay for the intensive services of Services Coordinators, Therapists, and Psychiatrists that necessary during the transition process. 		<p>a. See cost delineated under state and regional action.</p>		<p>Expecte develop entry pr hospital into the</p> <p>The mo toward systems effective We need more – of ment</p> <p>Measur Outcom</p> <ul style="list-style-type: none"> ▪ ▪

<p>b. There needs to be a Service Coordinator assigned to each child at the beginning of their inpatient hospitalization to coordinate all the clinicians, doctors, family, and school <u>and</u> to help ensure the step-down ladder is implemented.</p> <p>i. There needs to be at least a weekly Service Coordinator Meeting for the first month. This high frequency of meetings is necessary, in order to ensure coordination of services. Meetings can be gradually tapered as client progresses down the ladder.</p>					
<p>a. Identify the children 2-4 weeks after enrollment.</p> <p>b. Identify the children thru observation and interview in the classroom by teacher and mental health professional.</p> <p>c. Action plan is needed.</p> <p>i. Monthly meetings should consist of parents of identified child and pertinent team members.</p> <p>ii. Quarterly meetings should consist of mental health professional and staff.</p> <p>1. The focus of this meeting would be training.</p> <p>d. Conduct an exit interview.</p> <p>i. The exit interview should involve parents, staff, and administrative personnel.</p>		<p>a. Increased service delivery via collaboration with community resources and Community Mental Health Centers</p> <p>b. Early intervention for children with mental health issues</p> <p>c. The identification of children by the age of four</p> <p>Who needs to be involved:</p> <p>a. Mental Health Professional</p> <p>b. Community Coordinated Child Care (4-C's)</p> <p>c. Child Care Provider</p> <p>d. Community Services /Support, i.e., United Way, Crusade for Children, Corporate Involvement</p> <ul style="list-style-type: none"> ▪ Parents 	<p>a. Medicaid</p> <p>b. Sliding fee scale to be paid by parents and agencies</p> <p>c. Community Services/Support, i.e., United Way, Crusade for Children, Corporate Involvement</p>		<p>Early In</p> <p>To date pre-sch focused physical exclusio emotion I well-be extensiv with me young c schools wise to problem age pos</p> <p>Identifie Funding tied to p instead flexible. commu needs a -- This r more ov likely to "bang f commu able to</p>

					<p>needs in duplicat</p> <p>Expecte Promote interven increase identific maintain in the s Measur Outcom</p> <ul style="list-style-type: none"> ▪ Sho Nur iden <p>Long-Te children placeme</p>
<p>a. Lobby Council on KY Higher Education at University of Louisville, University of KY. Indiana University, etc.</p> <p>b. Lobby KY Department of Education for pay differential for ECE teachers.</p> <p>c. Scholarships for EBD teachers</p> <p>d. Local school districts need national recruitment for EBD teachers.</p> <p>e. Provide training in Behavior Management, Prevention Programs, and Identification of Mental Illness.</p>		<p>a. EBD Advisory Council for each school district ... KDE – ECE staff</p> <p>b. Encourage districts to look at research showing connections between therapeutic interventions and student achievement.</p> <p>c. Promote models for:</p> <ul style="list-style-type: none"> i. Funding ii. Collaborative relationships with agencies <p>d. Develop and require new curriculum at Teacher Trainings to:</p> <ul style="list-style-type: none"> i. Identify special needs/problems at all levels. ii. Increase curriculum involving behavior management concerns. <p>e. Provide special:</p> <ul style="list-style-type: none"> i. Resources to regular teachers ii. Classrooms within regular schools 	<p>a. Rank I Program include Behavior Management Training</p> <p>b. Increased funding</p> <p>c. Tuition Reimbursement Program for Behavior Programs</p>	<p>a. Change focus of teacher education.</p> <p>b. Change unit allocations and SEEK Formula.</p> <p>c. Create pay differential for ECE teachers.</p>	<p>Expecte</p> <p>Univers</p> <p>Training</p> <p>emphas</p> <p>prevent</p> <p>identific</p> <p>dealing</p> <p>disabilit</p> <p>Measur Outcom</p> <ul style="list-style-type: none"> ▪ ▪ ▪

REGION 6 – GOAL 9

Goal 9: Reduce barriers to accessing mental health and substance abuse services, and increase the total number of persons at least 5% annually over the next 10 years.

Strategies	Regional Action	What? How? Who?	Finances/Cost	State Action
<p>Improve Access to services that address human diversity.</p>	<p>Determine how people are accessing services now (baseline data).</p> <p>Assess resources available and population needs, align resources adequate to access needs.</p> <p>Establish a system of assessment and evaluation of access issues.</p>	<p>Develop improved resource directories in more languages, more widely distributed.</p> <p>Support one community resource directory in multiple languages and formats.</p> <p>Ensure broad, diverse representation on a multi-agency group to oversee access issues.</p> <p>Identify types of clients being served or not being served.</p> <p>Need to develop a mechanism for evaluating processes that aren't successful (no-show, drop out).</p> <p>Develop special training to enhance cultural competence of front-line staff.</p> <p>Develop outreach programs for diverse populations; include wellness & prevention activities.</p>	<p>Consolidate individual resource directories; find cost savings by reducing duplication and using existing resource—CRN is a region-wide resource database clearinghouse; could purchase software for translation of resource directories into different languages.</p> <p>Outreach activities will require manpower cost; (may be able to shift).</p> <p>Data systems to evaluate processes—some exist but may require improvement.</p> <p>Training &/or consultation will require \$\$ (may be able to charge for some).</p>	<p>Funds for outreach activities</p> <p>Endorse and share best practice guidelines for services to culturally and ethnically diverse groups (also Healthcare & Quality Research).</p> <p>Assist in grant acquisition to support outreach and prevention activities.</p>
<p>Improve availability of transportation.</p>	<p>Use resources such as KIPDA to determine transportation options currently available and constraints, restrictions for who can/can't use them.</p> <p>Inform potential clients of transportation</p>	<p>Need transportation vouchers for vulnerable, at risk population without Medicaid.</p> <p>Develop alternative sources of transportation.</p> <p>Co-ordinate insurance coverage for</p>	<p>\$\$ for vouchers.</p> <p>\$\$ for development of alternative sources of transportation. Cost of manpower, coordination of volunteer activity.</p> <p>Information about transportation can be incorporated into previously identified CRN</p>	<p>Investigate liability issues for drivers of vehicles. "Hold harmless" for volunteers? (school buses, church vans)</p> <p>Elicit resources & assistance of KIPDA.</p>

	options.	volunteer transporters. Get input from current transportation providers to identify gaps. Assess to what degree lack of transportation is a barrier to access.	resource directory. Funds will be needed to develop information about transportation that is easy to understand (ex., bus schedules/routes). Pay a lobbyist to advocate for transportation.	
Decrease stigma through increasing awareness and education.	<p>Coordinate multi-level organizational initiative to promote mental health, substance abuse education and awareness, year-round.</p> <p>Develop a Health Services consortium consisting of agencies, universities, consumer groups, providers, government, etc.</p>	<p>Identify common mission and goals across community healthcare providers.</p> <p>Collaborate with community systems, ex., schools, Police, Medical community, general public, & media to implement on-going public awareness campaign.</p> <p>Promote accurate portrayals of mental illness and substance abuse in media.</p> <p>Promote good mental health and prevention, ex., like cardiovascular health approach.</p> <p>Take issues identified from consumer focus groups to begin process of addressing stigma.</p> <p>Train, give information that is easily accessible to systems identified to promote better understanding of Substance Abuse and Mental Illness so interventions can be made as soon as possible.</p> <p>Promote mental health careers &</p>	<p>Need money for all out media campaign.</p> <p>Need money for education—curricula, packets, prevention and intervention projects.</p> <p>Collaborate with media, drug companies to find pro bono advertising and to reduce cost.</p> <p>Pool dollars, take 1 hour presentations on the road to community groups.</p> <p>Grant development—full time person to write grants for multiple areas; universities and community groups collaborate.</p>	<p>Increase knowledge and understanding of mental illness and substance abuse through use of education and awareness products; translate into something that can be measured (1 year).</p> <p>Increase use of products, ex., brochures, “dog and pony” that we develop (2 years)</p> <p>Measure satisfaction and ask “how did you find out about....”</p> <p>Track #s of brochures picked up</p> <p>Track # referrals to program</p> <p>Track # calls get for information</p> <p>Note if client identifies one our education/awareness efforts as reason for seeking treatment.</p> <p>Utilize Urban Studies questionnaire—include questions about beliefs, attitudes and bias re: SA& MI</p> <p>Continue Focus Groups for input</p> <p>Future decisions are made based on data obtained (3 years).</p> <p>Long term goal—acceptance</p>

		<p>professions and how they can really help people.</p> <p>Identify measures targeted to evaluation of educational and awareness efforts.</p> <p>View mental illness and substance abuse as physical health problems.</p> <p>Develop a “slick” easy to remember slogan that increases understanding of SA/MI</p>		<p>and empathy instead of distaste and fear.</p>
<p>Increase financial resources for provision of services to un- and under-insured individuals & families.</p>	<p>Systematically identify priority areas for financial support.</p> <p>Implement a plan based on multi organizational input that targets research and funding sources.</p>	<p>Establish short & long term cost of services.</p> <p>Push planned giving to support MH/SA service provision.</p> <p>Determine # of people who are un- or under-insured (see HB 843 report)</p> <p>Grant writer could increase available \$\$ for under and un-insured.</p> <p>Support strong, organized lobbying process (all SA/MH professionals pulled together).</p> <p>Proactively use and broaden appeal of annual DMHMR Mental Health conference to collaborate, identify problems and solutions to meet needs of under and un-insured.</p>	<p>Point people to connect with what exists and develop new connections.</p> <p>\$\$ to insure uninsured.</p> <p>Agencies pool resources to meet the needs of un-insured and reduce duplication.</p> <p>Partner with Universities to reduce cost of evaluation & access available funding streams.</p>	<p>State needs to determine accurate cost of provision of SA and MH services.</p> <p>Reduce bureaucracy, red-tape, and micromanagement that adds cost to service delivery.</p> <p>Encourage communication across Cabinets, provide incentives to collaborate across Departmental and Cabinet boundaries.</p> <p>Create mechanism to continue and evaluate process of 843; meet with local communities at least annually to share information.</p> <p>Use available state resources, provided in a user-friendly way.</p> <p>Negotiate matching fund agreement.</p> <p>Develop State recognition process for systems that are effective and cost efficient.</p>
<p>Improve collaboration, communication & linkage among and</p>	<p>Establish an organization of mental health service providers and related</p>	<p>Identify common mission and goals across community healthcare providers.</p>	<p>Cost of salary of 1 person for several months to facilitate development of the</p>	<p>Participation in quarterly meetings.</p> <p>Funding for initial set-up and</p>

<p>across systems.</p>	<p>agencies (multi-agency) whose purpose is to facilitate access across sites/agencies and levels of care.</p>	<p>Encourage buy-in by organizational members regarding participation, accountability, collaboration & evaluation.</p> <p>Establish a system of communication (e-mail, website) to various healthcare providers.</p> <p>Develop consistent community forums for the purpose of exploring collaboration and need for linkages among and across systems of service.</p> <p>Systematically elicit consumer feedback regarding services related to individual needs across the service delivery system.</p> <p>Establish an electronic referral (contact) system used to generate data and service feedback concerning client care, needs, and services.</p> <p>Assign a task force to research other communities that have established MH/SA consortia across systems, agencies & programs to see how they are organized, funded and operated.</p> <p>Use many strategies previously listed.</p> <p>Develop formal</p>	<p>consortium.</p> <p>Set-up costs related to data entry, mailings, development.</p> <p>Use strategies previously listed.</p>	<p>development of communication forums. Use previous strategies.</p> <p>To support effort for seamless service system, develop a system by which funding for services follows the client, not discrete categories of care.</p>
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		<p>agreement for multi-agency organization that identifies commitment to regional goals (developed through the HB 843 process).</p> <p>Establish committee structures and common mission that facilitate implementation of regional goals and timelines.</p> <p>Build services & public recognition of the multiagency group using the Homeless Coalition as a model.</p> <p>Identify facilitators and barriers to access related to funding and systems entry.</p>		
<p>Improve availability of services—locations, hours.</p>	<p>Identify gaps in services (focus groups of professionals and consumers).</p> <p>Use of all mechanisms for communicating and collaborating between agencies.</p> <p>Form a grant writing team.</p> <p>Determine what community needs are related to service availability.</p> <p>Use processes identified previously as they relate to service availability across multiple agencies.</p>	<p>An organized team of grant writers will be formed from various agencies. Applications submitted on a regular monthly basis, keep up-to-date and informed re: all grants sources, etc.</p> <p>Develop cost benefit summaries to agencies related to community needs and availability of services.</p> <p>Develop consumer questionnaire to determine service availability preferences.</p> <p>Survey community to determine service availability preferences.</p>	<p>Multiple agencies will share the cost of providing members for the grant team.</p> <p>Contract costs for community needs survey and report.</p>	<p>Facilitate channels of communication with the providers of and users of mental health and substance abuse services.</p> <p>Provide funding for community needs survey and report.</p> <p>Endorse cost benefit recommendations.</p> <p>Base state budget on feedback from multi-agency data sources.</p>

		Have different agencies make adjustments by promoting flexibility as a positive for people who are providing the services.		
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REGION 6 – GOAL 10

Goal 10: Establish five permanent and five mobile comprehensive healthcare service units in the region by 2010 to meet mental and physical health needs and to provide services to those consumers with access problems.

Strategies	Regional Action	What? How? Who? Time?	Finances/Cost	State Action	Outcom Measur
1. Utilize the Mobile Unit that is a grant-funded program through Spalding University to trial the effectiveness of a Mobile unit with mental and physical health practitioners.	Program already in place. Would need approval and support of Spalding University to add Mental health component to project.	Could utilize Psych ARNP, Psychology students on the mobile unit. Would need to work with Spalding students preferably for this. Short time frame for turn around.	If students were used there would be no added cost. In the event this works well and we desired a more permanent position a grant could be applied for the other position. ARNP would be preferable.	No actions required.	Increase Psychia education currently mobile u current and var the com health s fit in we
2. Identify areas of the region that are the most in need of services and could benefit from Mobile unit as in #1..	Evaluate services that would be needed through interviewing MD's and other service providers in the area.	Once determined apply for a grant for additional Unit and for 2 permanent staff. Work with Nursing schools for staffing with students for additional support.	Grant funding	None	Increase care, in prevent approach Reach t most in
3. Identify what are the needs regarding transportation and service needs in each county in region 6. (Each area's needs are different. Stating a number of units needed was premature.)	Each county should be surveyed to identify transportation now available; also need to talk with area MD's to determine what services are needed most in the areas. Also find out how much has been paid for ambulance, cab transportation in region 6 per year.	Seven counties services can help with interviewing patients and physicians in the area regarding their transportation needs and service needs. This should be accomplished by the end of 2001 first quarter of 2002.	Need to look at the current amount of money paid for transportation to determine if money can be spent more strategically to provide mobile care. Unable to determine cost at this time. If Spalding mobile unit successful with expanded role additional unit could potentially be purchased through Grant funding.	State would need to reevaluate the Medicaid transportation benefit and change to support proposed alternative transportation system.	Develop transpo indicate for each areas m services and som want to coordin transpo their ser Perhaps services so need at one s
4. Explore potential use of TARC services	Approach TARC regarding services	Based on information gathered	Unknown at this time. Would need to	Support of use of public transportation	Potential discour

to transport patients to their therapists.	provided and opportunities for future routes, programs.	in #2 could help subsidize the TARC service at lesser cost than currently paying for cabs, ambulances.	look at potential funding through crusade or United Way to help with cost for transportation.	to address access needs.	transport with TA route program
5. Increase the collaboration of behavioral health care and physical health care by increasing sites at which both services are offered	Survey current system to see where such combinations now occur Explore models from other communities of combining health care in one location	Form work group to survey & explore models of comprehensive care.	Establish planning connection between behavioral health and physical health care to look at funding, grants, etc. Graduate students may be a staffing resource.	State might help keep community aware of funding/grant options	Increase persons evidence collabor physical health care new medication

REGION 6 – GOAL 11

Goal 11: Make the most appropriate medications available to those who need them and expand medication monitoring.

Ranked #1 Strategy

Goal	Barriers	Step to Accomplish	Finances/Cost	State Action	Expected
<p>Develop and maintain a behavioral health medication list. The list will include prices per retail pharmacies to assist consumers in comparison-shopping for those required to purchase at retail prices.</p> <p>Develop and maintain a Community Database of Indigent Care Programs and what products are available through manufacturer indigent care programs to be used by consumers and providers.</p>	List must be continually updated. Should be centrally located. Must be distributed to all affected parties.	<p>Identify resource group to develop lock list. Identify sources of support financial and in-kind (i.e. local and state government, local agencies or grants to develop and maintain the list. The users must agree upon initial layout of list. Develop a method of distribution agreed upon by users printed, web based or both.</p> <p>An "owner" of the list must be identified (i. e. CIC or JCMS, or State such as DMH/MR). Education of Community about the use of this resource.</p>	Support for printing and distribution of the list. Support for Web site development and update. Coordination with community resource network of Metro United Way. Local and state funding for project to include staff to monitor phone lines. Local community data base begins operation in 2002	Funding for distribution and maintenance of the list to be completed by 2002. Provide a location on the State web site (ie DMH/MR) for the list to be published – should be functional by 2002.	Public useable medication and in resource quarter Education of medication appropriate care of and providers. Consumer able to medication recommendation provided be like and data

Ranked #2 Strategy – Goal 11

Goal	Barriers	Step to Accomplish	Finances/Cost	State Action	Expected Outcome
Provide a limited pharmacy benefit for behavioral health medication to the medically indigent through existing DMS programs such as KCHIP with affordable copays	Enrollment of members. Development of inclusion criteria Cost of the benefit who will pay?	Form an advisory panel to explore how the benefit will be structured and develop an implementation timetable.	Must have funds to administer and pay for the benefit.	Expansion of state funding for the drug benefit through existing programs. Exploration of federal funding for the benefit	Individuals with behavioral health needs will have access to medication through limited copays.

Ranked #3 Strategy – Goal 11

Goal	Barriers	Step to Accomplish	Finances/Cost	State Action	Expected Outcome
Educate providers on the use and monitoring of effective behavioral health medications with emphasis on cost effectiveness issues.	Develop a training program for PCP and ED physicians on the use and monitoring of effective behavioral health medications	Identify interested providers to develop curriculum (i.e. Explore partnering with the University of Louisville Dept. of Psychiatry and Family Medicine) to develop and distribute materials and provide workshops. Provide CEU's on Behavioral Health issues for PCP and ED physicians. Make programs available on a web site for easy distribution to rural areas.	Support the development and maintenance of educational materials. State regulation changes. Partner with health plans, pharmaceutical companies and Medicaid to promote educational programs with CEUs or cost effective treatment and indigent are programs.	Funds for printing and distribution of the educational materials and providing education workshops and seminars. Space on the state web site for CE programs.	Providers will be better equipped to prescribe and monitor behavioral health medications, leading to improved patient outcomes and reduced costs.

Ranked #4 Strategy – Goal 11

Goal	Barriers	Step to Accomplish	Finances/Cost	State Action	Expected Outcome
Develop and maintain prescribing guidelines for Behavioral Health Drugs with particular emphasis the use of those products available through indigent care programs.	Guidelines must be continually updated and distributed to affected parties. Products available through indigent care programs must be continually updated.	Initial guidelines must be established and agreed to by provider groups. Method of distribution must e agreed upon. Inclusion of those agencies with knowledge of indigent care programs must be	Support of printing and distribution of the guidelines. Support for Web site development and update.	Funding for distribution and maintenance of the guidelines. Provide a home on the State web site for the list to be published.	Providers will have access to updated prescribing guidelines for behavioral health drugs, ensuring appropriate use and access for indigent patients.

<p>Pilot the Kentucky Medication Algorithmic Program (KY Map) for Region 6 which is a Best Practices for general physicians. Assure Best Practices for psychotherapy.</p>		<p>done. Education about Best Practices models and potential benefits to consumers. Methods for update revision of guidelines must be delineated.</p>		<p>DMH/MR in coordination with the pharmaceutical companies and grant funding agencies to provide approx. 1.2 million to pilot test the KyMap guidelines in Region 6.</p>	<p>region Evalu effecti guidel on me treatm</p>
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Ranked #5 Strategy – Goal 11

Goal	Barriers	Step to Accomplish	Finances/Cost	State Action	Expec
<p>Increase the number of adult/child forensic psychiatrists working in the public sector trained in best practices and familiar with indigent care programs.</p>	<p>Lack of medical students who are pursuing psychiatry <u>as a specialty</u>. Kentucky lacks adequate psychiatric coverage for the population especially in rural areas. Lack of adequate compensation for providers to work in public sector psychiatry.</p>	<p>UL Department of Psychiatry applies for expansion of Child fellowship program from 2 per year to 4 per year. Expand the current adult community psychiatry program from 3 residents per year to 6 residents per year. Establish program/scholarship to assist with debt payment from medical training including incentive programs to encourage returning to rural programs. Develop telemedicine programs for consultation to rural areas for primary care providers and psychiatrists.</p>	<p>UL Department of Psychiatry in collaboration with SCS, CSH, DMH/MR to develop appropriate rotation schedules in community psychiatry</p>	<p>State to provide funding for Child Psychiatry expansion at approx. cost of 240,000 per year. Increase funding for adult residents from current \$150,000 to \$300,000.</p>	<p>Increa of psy provid who a provid manag to insu uninsu popula Expos numbe possib sector includ homel</p>

Ranked #6 Strategy – Goal 11

Goal	Barriers	Step to Accomplish	Finances/Cost	State Action	Expec
<p>Increase funding for current indigent care programs such as SCS, CMSP, KY Physician Care</p>	<p>State and local budgets</p>	<p>Expand CMSP to include more diagnosis groups and maintain current indigent level of care guidelines</p>	<p>CMSP – State should double funding allocation by year 2003. Increase funding from other sources ie City and Co.</p>	<p>Change guidelines for CMSP program</p>	<p>Media provid indige</p>

Program, FHCC, and U of L Hospital/ACB			Gov.		
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Ranked #7 Strategy – Goal 11

Goal	Barriers	Step to Accomplish	Finances/Cost	State Action	Expected Outcome
Increase the number of Advanced Register Nurse Practitioners trained in Best Practices and familiar with indigent care programs.	Increase the number of scholarships and programs that offer tuition reimbursement for advanced training in the state	School of Nursing to explore state, foundation, grant programs to provide scholarships and to dev. Public sector providers to develop appropriate rotations and learning experiences	School of Nursing and public sector providers to develop appropriate rotations and learning experiences for ARNP.	Provide funding for a director of public sector training at the School of Nursing to oversee the supervision and rotations in public sector.	Increase ARNP both in adults and ARNP public psych

Ranked #8 Strategy – Goal 11

Goal	Barriers	Step to Accomplish	Finances/Cost	State Action	Expected Outcome
Communities in Charge Coalition develops an identification card and verification process for indigent person uninsured by 2003 in the Jefferson County area. Develop plan for those without pharmacy benefits who are underinsured i.e. Medicare populations est. 110,000	Underinsured persons are not the focus of CICC. Lack of funding for the program especially pharmacy services. Lack of behavioral health providers on all committees. Need to expand the Community In Charge Program to the other 6 counties for identification and verification process.	Enrollment of members into the program and development of sliding fee schedule for regional indigent drug program. Also development of regional network of indigent care pharmacy providers. Communities In Charge Coalition, SCS, CSH, FHC, Health Department, UL Hospital, other inpatient psychiatric providers local pharmacy providers develop a benefit for indigent care health plans	Cost for planning from grant for Communities In Charge Coalition. The development of other grants, county, state or current provider programs to fund the plan	To assist with funding and possible change of regulations which guide current indigent programs (ie CMSP, or KY Physicians Care) or pharmacy regulation to allow for dispensing of samples to recipients via pharmacies.	Person uninsured identified improved care decreased verification indigent provided current indigent medication

Ranked #9 Strategy – Goal 11

Goal	Barriers	Step to Accomplish	Finances/Cost	State Action	Expected Outcome
Assure the state formulary(s) – Medicaid and CMSP – provide coverage of all psychiatric medication.	Monitoring of problems with state formulary which reduce availability or access to medication, i.e. such as pre-	The development of central complaint tracking system for providers and recipients who are experiencing difficulty in attaining	Funding for operation of the hot line that may be coordinate with the medication database of indigent programs	State regulation changes to remove all preauthorizations process for mediation	Increase most medication delay unnecessary cost for

	authorization for amphetamine drugs which creates unnecessary bureaucratic oversight without cost benefit	appropriate medication. Create coalitions of KY Mental Health Asst., NAMI, KyCAN, and KPA to develop/operate hot line.		prescribed by psychiatrists or development of preauthorization process that can track medication protocol and automatically have overrides by pharmacists.	
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Ranked #10 Strategy – Goal 11

Goal	Barriers	Step to Accomplish	Finances/Cost	State Action	Expected
Support a Pharmacy Benefit for Medicare based on need which includes coverage for psychotropic medications – on a National Level.	Political Issues and Expectations. Lack of clear plan. Financial Considerations based on economic climate	Develop a grassroots lobbying group to work with the Legislative and Executive Branches of the Gov.	Decreased cost to local and state programs.	Support from the Gov., Legislature, Ky Cong. Delegation at the national level	Approximately 100,000 people with access to medication for many disabled people

REGION 6 – PHASE III IMPLEMENTATION TEAM

Access to Medications Group

The committee met monthly September 2002 through December 2002, to determine what resources exist within our region and how to best utilize those resources. Presentations were received on KYMAP, (an evidence-based pathway for disease state management of schizophrenia, major depression and bi-polar disorder), and local organizations attempting to meet the medication needs of medically indigent patients. Those organizations being: 1) GetCare, under a Robert Wood Johnson Foundation grant, 2) Health Kentucky's KPC program, 3) Kentucky Prescription Drug Assistance Program, and 4) Family Health Centers Social Services. All these programs utilize a variety of industry and local resources.

It was determined that each served a specific population; however, there were significant overlaps and differences among the programs. In addition various Community Ministries and other helping agencies were serving in various ways.

In order to develop a more complete understanding of the specific requirements and services of these entities a survey was developed and sent out to the ministries and helping agencies. We are awaiting the responses to this survey.

The Goal is to develop a comprehensive catalog/database of resources available to providers and consumers of behavioral health medications in Region 6. This database would include the Patient Assistance Programs, Medication Discount Cards and community resources.

Upon completion of the database/catalog, a web-based site will be needed to house the information and keep it current. The "iris" site on the Community Resource Network would be one possible location. When developed this resource needs to be publicized to physicians, nurses, discharge planners, social workers, medical office personnel, and consumers.

Because of the variety and complexity of the programs, coupled with the educational levels of many behavioral health consumers the state/county needs to provide a coordinator/facilitator to guide patients through the application process. A facilitator, who was thoroughly familiar with the availability of various medications and the process to obtain those medications, would more than offset the cost of their salary by the decreased utilization of other resources. Medication is a cornerstone for successful treatment of patients. The Kentucky Prescription Drug Assistance Program is similar to this and is being piloted in the health departments of Henry, Shelby, and Spencer counties.

Three crucial problems remain with this approach. Providing access to prescribers that are well trained in behavioral health medications. How do we provide the needed medications during the 2-4 week application process?

How do we track the patient as they are transferred from the hospital to the CMHC, or from the CMHC to the primary care doctor?

Recommendations:

- The continuation of the Medications Subcommittee as all the problems and barriers outlined in our previous report still exist or have intensified.
- A comprehensive database of available resources for obtaining free or discounted behavioral health medications for uninsured consumers be developed.
- Metro Government house a Medications for Indigent Patients database on its website.
- The state or county should provide a coordinator for obtaining free or discounted prescriptions for uninsured consumers.
- Metro Government sponsors a training program for physicians, medical office personnel and social workers on how to utilize patient assistance programs.

Non-existent or inadequate treatment of behavioral health problems has a direct and substantial impact on resource utilization within our communities.

REGION 6 – PHASE III IMPLEMENTATION TEAM
School/Therapeutic Classroom Group

Strategies	Regional Action	Tasks	Time Frame	Finances/Costs	State Action	Outcomes/Measures
Build web site to provide information to educators and parents on resources available in region.	1. Agency /staff to manage site and collect info from agencies. 2. Cooperation among agencies to share information.	1. Determine willingness of agencies to take on task. 2. Develop data collection forms. 3. Determine costs.	6 months from start to finish	Cost of web site and or staff to manage project. Hosting costs if web site is separate from existing web sites.	None	Increase availability of personnel on mental health services in region to decrease number of site referrals.
Development of a Directory of Professional Development Programs for school personnel.	Mental health agencies will share their abilities to provide schools with PD programs.	1. Identification of agencies and personnel available to provide training programs to schools. 2. Collection of information on trainings topics and presenters and collating the information into a directory. 3. Disseminating the Directory to school personnel in the region. 4. Communicate to schools in the region of the availability of the Directory.	6 months to 1 year.	Staff time from participating agencies to share information. Cost of developing and publishing the directory. Dissemination costs.	None	Schools will have available professional development for employees. The cost of the directory will be judged by the district schools available with personnel. Each school will be made if necessary.
Dissemination of Model for Assessment of Students identified with behavioral problems.	JCPS will share model with other school districts in the region.	Model to be shared.	3 months.	Duplication costs.	None	Districts will have resources implemented.

Addendum to the Region 6 HB 843 Regional Planning Council Report

Permanent Supported Housing Concept & Project

September 26, 2003

Purpose: To demonstrate on a pilot program basis in both urban and rural settings successful collaboration and sharing of resources in order to develop housing opportunities and supports for individuals with serious mental illness, alcohol and other drug abuse disorders or dual diagnoses who are at-risk for institutional placement.

Parameters of the Two-Year Permanent Supported Housing Project:

- ◆ Through collaboration and development of the funding pool, creation of 48 units of supported housing which would be scattered site and would be sober, clean living. Through state funding, creation of necessary services to place and support 48 individuals at risk of institutionalization in these 48 housing units.
- ◆ The hiring of a Housing Facilitator, whose job would be to organize the resources of funders around an allocation pool for the development of affordable housing and then oversee the effective allocation of resources toward achieving established housing development goals. This person would be an employee of Kentucky Housing Corporation and would have an office in Louisville. The Housing Facilitator would have housing development experience.
- ◆ That the entities named in Attachment A would be recruited for participation in and contribution to such a funding pool.
- ◆ There would be established a 7 to 9 person steering committee consisting of persons with the requisite skills and representations for efficiently allocating such housing funds who would review, rank and recommend housing proposals for funding. Persons serving on the steering committee would not themselves be requesting any such funding.

What is Permanent Supported Housing? HUD defines it as long-term, community-based housing and supportive services for persons with disabilities. The intent of this type of housing is to enable this special needs population to live as independently as possible in a permanent setting. The supportive services – with an emphasis on intensive case management – may be provided by the organization managing the housing or may be provided by other public or private service agencies.

This region has had some success since the 1980's in providing permanent supported housing for persons with mental illness, alcohol and other drug abuse disorders or dual diagnoses, reflecting local efforts among non-profit organizations. What has been lacking has been integration and collaboration among all possible funding sources, significant investment of dollars from the state, and the lack of intensive case management, the core service which provides support and coordination to maximize community resources. Developers of housing are reluctant to build these units without having a guarantee that the necessary support services will be available and maintained.

Focus Population: The focus of the Permanent Supported Housing Project will be on 48 individuals with serious mental illness, alcohol and other drug abuse disorders or dual diagnoses who meet the Olmstead definition, in that they are at risk of institutionalization based on repeated hospitalizations, or are homeless as a result of being de-institutionalized. The goal of the project

parallels the goal of the Olmstead decision by the U.S. Supreme Court: “[to ensure] that individuals with disabilities receive services in the most integrated setting appropriate to their needs.”

Seven Counties Services has identified at least 90 such individuals currently being served and in need of permanent supported housing. Phoenix Health Center has identified 20% of its clients who are mentally ill, have had repeated hospitalizations and who could function in an apartment with case management; for this past year, that number would be 53. Another 200 individuals have completed inpatient alcohol and other drug abuse treatment at JADAC and are in need of a sober living environment to avoid repeated inpatient treatment. In Jefferson County, there are currently 8,475 individuals identified by the Social Security Administration as being “disabled” by virtue of having a psychiatric disorder. In the surrounding six counties, the number of individuals identified by SSA is 1,331. These 9,800 individuals represents only those who have qualified for disability insurance benefits, a small percentage of those affected by mental illness or alcohol and other drug abuse disorders.

The Case for Supported Housing: The report of the *President’s New Freedom Commission On Mental Health* (released July 22, 2003) notes that “The lack of decent, safe, affordable, and integrated housing is one of the most significant barriers to full participation in community life for people with serious mental illnesses....The shortage of affordable housing and accompanying support services causes people with serious mental illnesses to cycle among jails, institutions, shelters, and the streets; to remain unnecessarily in institutions; or to live in seriously substandard housing. People with serious mental illnesses also represent a large percentage of those who are repeatedly homeless or who are homeless for long periods of time.” The Commission cites a University of Pennsylvania study which found that homeless people with mental illnesses who were placed in permanent supportive housing cost the public \$16,282 less per person per year compared to their previous costs for mental health, corrections, Medicaid, and public institutions and shelters. (1) Hopefully, the outcome of this Permanent Supported Housing Project will be to duplicate this cost saving.

Housing Supports: Supports and services need to be flexible and individualized with varying levels of intensity, based upon need and the preferences of the individual. In addition to clinical services and medication, housing supports include the following array of available services:

- Targeted case management
- Crisis services, including 24-hour staff availability
- Skill development specific to the environment and the individual
- Payee services
- Consumer/Peer support
- Natural/Informal supports
- Resource assessment, coordination and modification specific to the individual
- Resource development
- Advocacy (combating stigma & community resistance)
- Financial support, including rental assistance
- Development of competencies in establishing and retaining housing

Need Identification: Housing and housing supports were identified by the Region 6 HB 843 Regional Planning Council as the number one priority in its initial needs assessment and report

(December, 2000) to the HB 843 Statewide Commission. The Regional Planning Council has continued to identify supported housing for individuals with mental illness, alcohol and other drug abuse disorders or dual diagnoses as the top priority need to be addressed in this region.

Systems Coordination: The formation of the Region 6 Housing Task Group has brought together a wide range of housing providers, coordinators, funders and service delivery entities in the community to share resources and information and to engage in collaborative activities. Through their continued contact with each other, they have committed to work together to bring about a model of systems coordination, information and resource sharing and collaboration.

Leveraging Resources: In order to successfully collaborate on a housing initiative, there must be commitment to bring together resources – bricks and mortar funding, loans, rentals, subsidies, tax credits, along with the service dollars – to create a large “bucket” of leveraged resources. Attachment A lists the possible collaborators and resources which would be tapped to create the funding pool for developing the housing units envisioned in the project.

Outline of the Two-Year Demonstration Project:

- Project will establish a model of collaboration, breaking down silos and barriers.
- Project will leverage available resources in the region to develop the housing units. Project will have the resources to assure continued wrap-around services to clients.
- Project will target individuals with serious mental illness or dual diagnoses who meet the Olmstead definition of being at-risk for institutionalization.
- Project will demonstrate cost-savings, not just in dollars saved from more expensive (inpatient) levels of care. Just as significant – but more difficult to quantify – are the “savings” in quality of life and societal costs.
- Project will address supported housing needs in both urban and rural setting in this region.
- Project will be replicable in other regions of the state, both urban and rural.
- Project will provide regular updates to the Region 6 HB 843 Regional Planning Council, other HB 843 Regional Planning Councils, the HB 843 Housing Workgroup and the HB 843 Statewide Commission.
- Project will establish the need for support/service dollars to be developed along with the necessary housing dollars and provided as an incentive to the developers.
- Project will develop the necessary infrastructure by having staffing support in the community (possibly housed at the Metropolitan Housing Authority office); the staff/special projects person will report to the KY Housing Corporation (KHC)*, but will also be accountable to the Region 6 HB 843 Regional Planning Council and to the HB 843 Statewide Commission.

The Kentucky Housing Corporation (KHC) recently obtained a grant from The National Corporation for Supportive Housing. This will allow for the hiring of a person to coordinate the many efforts around the state that are focused on affordable, appropriate housing for homeless persons.

Urgency: Continued difficulty on the part of consumers with mental illness or dual diagnoses in finding and securing appropriate supported housing in the region. Recent developments include: (1) Louisville Metro has lost 16 units of transitional housing units in the past year due to inability to meet the required Federal cash match;

- (2) Available Home Funds have been exhausted;
- (3) Local Section 8 waiting list is 5-6 years;
- (4) In 2002, 10,887 people experienced homelessness in the Louisville Metro Area. They used mental health services 2,522 times and used alcohol and other drug abuse services 3,720 times. Approximately 20% of those individuals using shelters have mental illness or an alcohol or other drug abuse disorder.
- (5) A significant barrier to securing subsidized housing for consumers is that many are unable to meet federal guidelines for housing due to having a criminal record, a history of evictions, and/or owing back rent or utility payments. The mix of resources and wrap-around funds projected in this project may address some of these barriers.
- (6) The lack of a consistent, guaranteed stream of money dedicated to support services is seen as a significant barrier in attracting housing developers.

Resources Needed: In order to develop a successful plan for increasing housing options for those with mental illness and dual diagnoses, sufficient resources must be allocated. The HB 843 Statewide Commission, in its initial report (issued in July, 2001) recommended as priorities:

Establish an array of **suitable housing options and housing supports** for consumers with mental illness, alcohol and other drug abuse and dual diagnoses through collaborative efforts and increased funding.

Support **Regional Flexible Safety Net Funding** to assure services for those who do not have any payor source and to assure a seamless continuum of care in each region of the state.

Projected Cost of the Project:

Background: The 2002-04 budget allocations created an Olmstead Initiative for 24 Severely Mentally Ill individuals who had been previously institutionalized in state psychiatric hospitals for extended periods of time. The Wrap-Around Services include housing, medications, therapy and intensive case management. The budget allocation was \$1.1M the first year and \$800,000 the second year of the biennium; the cost estimate, then, is \$45,830/1st year per person and \$33,333/2nd year per person.

The Permanent Supported Housing Project will be designed to serve 48 individuals with serious mental illness, alcohol and other drug abuse disorders or dual diagnoses who are at risk for institutionalization. Their support needs are projected to be high, but not at the same level of intensity as the 24 individuals in the Olmstead initiative who had been institutionalized for long periods of time. Therefore, the projected cost per person will be less in the project. Under the proposed project, 48 individuals will be served at a cost of \$800,000 the first year and \$1.1M the second year of the project. In addition, the Housing Facilitator as described above will be a new staff position under the KY Housing Corporation, with an estimated annual salary of \$50,000 (plus 22% fringe). The total cost of the two-year project: \$861,000 in FY05; \$1.161M in FY06.

Collaborators: Bridgehaven, Center for Accessible Living, The Coalition for the Homeless, GuardiaCare, The Housing Partnership, KY Association of Regional MH/MR Programs, Metropolitan Department for Human Services, Metropolitan Housing Authority, Metropolitan Housing Coalition,

NAMI-Louisville, Office of Housing & Urban Development, Phoenix Health Center, Region 6 HB 843 Regional Planning Council, Seven Counties Services, Volunteers of America, Wellspring.

(1) Culhane, D.P., Metraux, S., & Hadley, T. (2002) Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing. Housing Policy Debate. Available: www.fanniemaefoundation.org/programs/hpd/pdf/hpd_1301_culhane.pdf

Attachment A

XII. To achieve a substantial and sustained increase in the number of decent, affordable housing units developed to meet the housing needs of persons with a severe and persistent mental illness, alcohol and other drug abuse disorder or dual diagnoses, it is proposed that a pool of housing development resources be organized and efficiently leveraged. The strategy behind this initiative has been borrowed from states that have made dramatic progress in developing such designated housing

The proposed Permanent Supported Housing Project Development Funding Pool would be funded through the combined efforts of the following funders and collaborators.

1. Local Government

- ◆ HOME Funds
- ◆ Community Development Block Grant funds
- ◆ General revenue funds
- ◆ Local Housing Authority

2. State Government

- ◆ General revenue funds as allocated through any venue
- ◆ Affordable Housing Trust Fund (administered by KHC)

3. Federal Government

- ◆ HUD 811 program
- ◆ Continuum of Care, Supported Housing Program
- ◆ Any other allocations venue
- ◆ Technical Assistance funding

4. Fannie Mae

5. Kentucky Housing Corporation

- ◆ LIHTC
- ◆ Open Door Funding

6. Regional Banks

- ◆ Federal Home Loan bank of Cincinnati

7. Area Banks (Possible pools of capital for loan or grant)

8. Local Foundations (Possible contributions to pools of capital for loan or grant)

9. The Housing Partnership

- ◆ LIHTC syndication
- ◆ Housing Development loan pool

**Northern Kentucky Regional Planning Council
Update Report**

Descriptive Features of the RPC

RPC Membership (40 as of June 2003)

Name	Representing	Name	Representing
Eric Ante *	Consumer	Mike Hodge *	Provider
Mary Pat Behler*	Planner/Provider	Jessie Hogg *	Planner
Kelly Bond	Planner/Provider	Barry Johnson	Advocate
Valerie Bowman	Family Consumer	Alan Kalos	Planner
Rita Brooks *	Consumer	Vicki Kohus	RIAC/Courts
Shawn Butler *	Law Enforcement	Mac McArthur	Provider
Elaine Chisholm *	Consumer	Tim McDermott *	Hospital Provider
Kathy Choi *	Provider/Planner	Don Brewer*	Provider
John Clark	Hospital Provider	Rosemary Metzger	Consumer
Jim Coleman	Consumer/Advocate	Kathy Miller-Cox	Provider
Dennis Corrigan	RIAC/Advocate	Arlene Mockapetris *	Business
Pat Dressman	County Official/Planner	Pat Moore	Consumer
Shirley Duane	Schools	David Olds	Advocate
Chris Ertel *	Courts	Cathy Pedro *	Schools
Carol Fausz	MH-MR Board	Mike Rinderle	Courts
Marlene Feagan	Faith Community	Ted Smith	Advocate
Rick Flesch *	Planner/Schools	Lou Ann Thompson*	Consumer
Gary Goetz	MH-MR Board	Shiloh Turner	Planner
Jean Griffin *	Consumer	Joyce Williams *	RIAC/Consumer
Rick Hamm *	Provider	Constance Wong*	Provider

** Members joined the RPC after the filing of the initial report in December 2000*

RPC Activities Since December 2000

RPC continues to meet on a monthly schedule (met 31 times in 33 months)

RPC has grown from 28 members to 40 members

Submitted update reports in 2001 and 2002

Held a "Legislator Forum" in January 2001

Held a focus group for law enforcement, jails and emergency responders in April 2001

Held a "Community Forum" in September 2001 - over 100 people attended

Met with local legislators and Department of Mental Health staff in January 2002 and August 2002

Provides update reports to regional legislators and MH-MR Regional Board after each RPC meeting

Members of RPC participate in regional needs assessment updates performed by the MH-MR Regional Board

II. Regional Needs Assessment

In the year and a half since the first report the events that have affected the world and the nation, have also affected the residents of Northern Kentucky. The most significant of these events has been the economic downturn and stagnation. Northern Kentucky has been fortunate to have the economic depth and reserves to be able to capitalize on low interest rates and continue with slower growth in the housing industry. The economic gap between poor urban and rural classes and wealthy suburban and middle classes continues to widen due to the ability of latter to utilize reserves and profit in times of slower economy.

Significant demographic changes

The 2000 US Census data is now available while the first RPC Report used 1999 population estimates. The population of the Northern Kentucky District is predominately white (95.4%). Kenton County has the most ethnic diversity with 4.7% of non-white population. The most surprising change has been a significant increase in the Hispanic population. While still only a small percentage of the general population (1.3%), Hispanic population is steadily growing in NKADD. At the time of the first report, Hispanic and Asian populations were still representing less than one percent of the population of any county. At this time, Carroll and Boone counties have the highest percentage (3.2% and 2.0%) of Hispanic population, with rest of the counties having close to one percent Hispanic population on average. The actual number of Hispanics in the region is likely greater than reflected in the census data due to language barriers interfering with the survey and the presence of some Hispanics without appropriate immigration registration. This has meant a difference in service delivery and the need to provide information in both written and verbal Spanish language.

Table 1. Population Density

Counties	Population ¹ 2000	% Change 1990 - 2000	Non-White	Hispanic	Sq. Miles ²	Population Density
Boone	85,991	49.3	3,284	1,702	246	350
Campbell	88,616	5.7	2,306	765	151	587
Kenton	151,464	6.6	7,135	1,669	162	935
Sub-Total	326,071	15.0	12,725	4,136	559	583
Counties	Population ² 2000	% Change 1990 - 2000	Non-White	Hispanic	Sq. Miles ³	Population Density
Carroll	10,155	9.3	386	330	130	78
Gallatin	7,870	45.9	176	82	98	80
Grant	22,384	42.2	258	232	259	86
Owen	10,547	16.7	223	105	352	30
Pendleton	14,390	19.6	167	97	280	51
Sub-Total	65,346	26.9	1,210	846	1,119	58
Total	391,417	16.8	13,935	4,982	1,678	233

The rural counties in NKADD have the highest percent of population living below Federal Poverty Level with Owen having the highest percent (15.3%) followed closely by Carroll and Pendleton (14.6% and 13.2%). However, the urban counties, especially Campbell and Kenton Counties, have the highest number of residents (26,365) below Federal Poverty Level. More than ¼ of people living below Federal Poverty Level live in the NKADD urban counties. In five rural counties, the total population with income below Federal Poverty Level accounts for just under a third (31.2%) of the total population in the District.

Table 2. Median Family Income

Counties	Median Family Income ⁴ \$	State Rank	% Below Federal Poverty Level	Number Below Federal Poverty Level	% Population > age 25 with no High School Diploma
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² Kentucky Data Center, University of Louisville (2000)

³ University of Kentucky, Kentucky Atlas (www.uky.edu/KentuckyAtlas)

⁴ Kentucky Data Center, University of Louisville (2000)

Boone	61,114	2	5.6	4,785	14.9
Campbell	51,481	10	9.1	8,093	19.2
Carroll	44,037	54	14.6	1,482	31.9
Gallatin	41,136	52	13.2	1,035	32.0
Grant	42,605	31	10.9	2,436	27.6
Kenton	52,953	7	8.9	13,487	17.9
Owen	38,844	47	15.3	1,609	32.1
Pendleton	42,589	25	11.3	1,627	27.2

The Northern Kentucky Area Development District median family income is \$52,880 and the percentage of people living in poverty is 8.9% (34,836)¹. The three urban counties (Boone, Campbell, Kenton) rank in top 10 in Kentucky and rural counties are all in top 45% of all counties in Kentucky for median family income (see Table 2).

The counties of Northern Kentucky Area Development District are very diverse with a complex mix of rich and poor, urban and rural, and industrial and residential. Additionally, NKADD also has the uneven distribution of population centers, wealth, and resources, due to its diversity. In order to make access to prevention, diagnosis and treatment of mental illness and substance abuse easy, one has to consider all of these descriptors and indicators.

Updates of Community Health Indicators, Rates and Events

Since the last report, the Northern Kentucky Community Health Committee completed the “Public Health System Improvement Plan 2003” strategic plan for Northern Kentucky. This plan emphasizes that mental health, depression and substance abuse have been identified as priority issues by several regional health assessments.

The Greater Cincinnati Community Health Status Survey⁵:

Greater Cincinnati Health Improvement Collaborative has published the results of the *Greater Cincinnati Community Health Survey 2002*. The results were not significantly different from the 1999 survey (contained in this region’s original report to the commission) in most areas but there has been a change in the number of persons reporting mental illness in the household. There was a decrease (6.9% to 3.9%) in the urban counties (Boone, Campbell, Grant, and Kenton) while the rural counties saw an increase (4.4% to 5.7%). While the rural counties show a higher rate of mental illness, the urban counties had more binge drinking at least once a month (8.8%) and seeking treatment for depression (15.8%). Urban counties residents also reported higher percentage of nervous problems or breakdowns (9.8%) in comparison to rural counties residents (7.8%). Higher percentage of individuals in rural Kentucky counties missed 11 or more days of work or school due to mental illness (2.2%), but more of them also received treatment (4.1%) and talked with mental health professional (3.3%). Almost half (47.7%) of the individuals in urban Kentucky counties have felt downhearted, depressed, overwhelmed, or blue in the past 12 months. Urban counties also had higher percentage of individuals seeking help for feeling downhearted, depressed, overwhelmed, or blue (15.8%). However, rural counties residents had higher percentage of missed regular activities due to having these feelings (6.7%). The rural Kentucky counties also had the highest percentage of individuals that did not get prescribed medications due to a lack of funds (14.7%). In case of reduced activity level due to emotional problems both rural and urban Kentucky counties were similar in response, 20.2% and 19.4%. Even though more individuals in urban setting had admitted to having problem with alcohol or drugs (5.0% vs. 4.1%), more participants sought treatment for alcohol or drug related problems in rural counties (3.3% vs. 1.8%).

⁵ Greater Cincinnati Health Improvement Collaborative: *Greater Cincinnati Community Health Survey 2002*

MH-MR Regional Board Needs Assessment Update (2002)⁶:

The Northern Kentucky MH-MR Regional Board funded an update to an assessment of mental health and substance abuse needs for the eight-county region in 2002. The process involved focus groups of consumers of mental health, substance abuse and mental retardation/developmental disability services and a written survey of providers. Both processes identified service gaps in the region and a ranking of service needs.

This update further supported the regional priority needs identified in the original survey completed in 2000. Below is a listing of the top priority needs from the consumer focus groups and the provider surveys from the 2002 update.

Consumer Focus Group High Priority Items

Consumers of Adult Mental Health Services

- ✓ Crisis Stabilization Unit
- ✓ Consumer Warm Line –Staffed by consumers
- ✓ Increased number of affordable Psychiatrists
- ✓ Community education to decrease the stigma associated with mental illness
- ✓ Transitional Living skill-building programs/support groups – help with finding/keeping a job
- ✓ Lower cost medications

Parents of Child/Youth Receiving Mental Health Services

- ✓ Local longer-term care and residential service programs
- ✓ Education about mental health and substance abuse for teachers, police, parents and youth
- ✓ Group homes and/or group treatment programs to teach the child living skills/social skills/job skills
- ✓ More psychiatrists skilled in working with emotionally disturbed youth

Adult Consumers of Substance Abuse Treatment Services

- ✓ Affordable residential treatment options
- ✓ Community-based transitional services (aftercare, support groups, assistance with housing and employment)
- ✓ Additional local de-tox beds
- ✓ Availability of treatment for individuals with co-existing disorders

Parents of Youth Receiving Substance Abuse Treatment

- ✓ Local inpatient and intensive outpatient treatment options
- ✓ Parent education and support groups
- ✓ Convenient aftercare programs following treatment

Provider Survey High Priority Items

- ✓ Financial assistance for medications
- ✓ Increased availability of psychiatrists
- ✓ Fewer days from initial contact to initial appointment
- ✓ Inpatient/residential treatment for substance abuse
- ✓ Intensive outpatient substance abuse treatment for adolescents
- ✓ Increased resources to cover cost of services
- ✓ Organized advocacy for additional regional funding

Changes in Dollar Resources

Region 7, and regions across the state, experienced some targeted area dollar increases for mental health and substance abuse service dollars in the most recent budget cycle. There was a small increase in Federal block grant dollars for mental health and substance abuse services in 2001, but no increase in 2002. The lack of an inflationary factor or periodic increases in the base level of funding continues to provide a significant challenge to sustaining programs and services that receive “seed” or “startup” funding.

⁶ Northern Kentucky MH-MR Regional Board: *Regional Needs Assessment Update 2002*

The primary issue for Region 7 continues to be the inability of general fund dollar increases to match the rate of our population increases. As a result, Region 7 is the lowest per-capita funded region in the state for mental health and substance abuse services. This is especially problematic since Medicaid rates have been frozen over the past two years. The cost-based reimbursement approach to payment for Medicaid services has historically allowed at least one source of payment to consider inflationary forces. At the moment, the rate freeze has taken this away. Thus, most dollars used for covering the costs of services for mental health and substance abuse are now reimbursing in a methodology that does not account for inflationary forces.

Northern Kentucky is located within the Greater Cincinnati regional job market. Thus, the region (Northern Kentucky, Southeastern Indiana and Southwestern Ohio) compete for the same pool of employees. The Greater Cincinnati area has approximately 3 million people within the 50-mile radius around Cincinnati. In order to attract and retain clinical staff, the salary scale within the Northern Kentucky region must be competitive with the opportunities available in this metropolitan setting. Over 80% of the residents in Northern Kentucky live within 30 minutes of downtown Cincinnati. A very low unemployment rate in the region (2.5 % to 3 % until a couple of years ago and now 4% to 4.4%) over the past 5 years has further pressured salary scales upward. These factors make the under funding of state general fund and the capping of Medicaid rates for 2 years even more troublesome. Our dollar resources are simply grossly under-matched with our service needs/demands and the prevailing wages of the local job market.

Positive and Potentially Positive Dollar Resource Changes

- ✓ Dollars allocated for expansion of youth crisis stabilization services and startup of adult crisis stabilization services
- ✓ Dollars allocated for training of jail staff in recognizing and responding to prisoners with mental health and substance abuse treatment needs
- ✓ The CMHC (NorthKey) is annually providing \$430,000 of free medication through the state medication program and between \$900,000 and \$1,000,000 of free medication through a sample medication distribution process supported by pharmaceutical companies.
- ✓ Time limited (1 to 3 years) startup funding from The Health Foundation for the adolescent substance abuse collaborative, adolescent substance abuse Intensive Outpatient Programs and a school-based services collaborative.

Harmful and Potentially Harmful Dollar Resource Changes

- ✓ Below cost Medicaid inpatient rate for children's intensive services unit results in a loss of approximately \$190,000 in revenue each year
- ✓ Below cost Medicaid rate (rates frozen) for outpatient services results in a loss of approximately \$130,000 of revenue each year
- ✓ Increased limitations on Medicaid eligibility, requires more use of state dollars and in some cases interruption of appropriate services
- ✓ Decreases in United Way Funding for many agencies throughout the region due to less than expected 2002 fund drive (related to slowed economy and job loss) have resulted in some service cuts.
- ✓ Unless the time limited startup funding from The Health Foundation for adolescent substance abuse collaborative and school-based services collaborative are replaced, these coordinated planning and service delivery approaches risk stoppage.

Service System Description

A. What steps have been taken in addressing gaps in services?

- ✓ The above mentioned increase in sample medications and state pharmacy program
- ✓ Expansion of Intensive Outpatient Programs for youth experiencing substance abuse problems (from 1 program site to 3 sites)
- ✓ Expansion of crisis stabilization services for youth and the beginning of crisis stabilization services for adults
- ✓ Pursuit of federal, national and local grants to expand services to justice system involved youth - receipt of one grant for a re-entry program for youth being discharged from prison

- ✓ CMHC (NorthKey) changing intake process to accommodate more referrals and decrease unutilized intake slots.
- ✓ Formation and community education activity of regional mental health and aging coalition
- ✓ CMHC (NorthKey) revised salary scale – salaries for clinical positions were increased to improve the ability to hire and retain staff for the delivery of services

B. What is the current status of the “safety net” in your region?

As previously mentioned, Region 7 receives the lowest per capita of state general fund dollars in the state.

Penetration rates (numbers/percentages of people served) into “estimated need population” are consistent with the level of under funding. Currently, gaps exist in emergency service availability and short and longer-term residential treatment availability in both mental health and substance abuse services for all ages. Full implementation of the developing crisis stabilization services for adults and youth will help reduce the gaps. But, it is unlikely that these services will completely remove the need(s) for residential services.

Services for homeless individuals who also have a serious mental illness or substance abuse problem are frequently unavailable and/or missed within the traditional community mental health system “safety net” in our region.

Organized services directed toward this population have been less than adequate in the recent past and other actions in the community underscore the ease at which this population is overlooked. For a full discussion see “*The Interface between Criminal Justice and Behavioral Health: Part II*” attached to this report. Some issues of concern highlighted in this report are:

- ✓ A “sweep” of the riverbank area was conducted about a year ago and many homeless individuals were chased from their place of temporary outdoor “housing.” No resources were offered to replace this “housing,”
- ✓ A local urban-setting community refused to alter zoning to allow a multi-service one-stop center geared toward providing supports to help homeless individuals rejoin the workforce.
- ✓ A local community also changed the laws surrounding use of park space to force homeless individuals out of park areas after dark.
- ✓ The same community mentioned above had funding from the federal government (Department of Housing and Urban Development) cut because their eligibility for this funding was reduced from \$750,000 to \$219,000 per year.
- ✓ Kentucky state legislature reduced the dollars for the Kentucky Housing Corporation (KHC). KHC provides the bulk of funding for affordable and low-income housing.

C. What is the current status of services for children and youth?

NorthKey has made significant investment of dollars in securing staff resources in the IMPACT program and school-based services for youth over the past three years. These investments have resulted in a fuller complement of staff and have provided increased access to services for youth and their families. And costs for delivering services have increased.

But, access to services for youth, especially substance abuse services, remains problematic and contributes to less than desired treatment alternatives and outcomes. The regional shortage of state general fund dollars, a very tight managed care market for insurance covered services and the frozen Medicaid rates significantly challenge and impede further expansion of services for children and youth.

D. What is the current status of repeated referrals (revolving door cases)?

Though the Northern Kentucky region has a variety of community-based social services agencies, all of these agencies have been hit with revenue problems due to the downturn in the economy and the lessened availability of all funding streams (United Way, County dollar support, State dollar support, grants, donations, payment from Medicaid and other third-party payers and available cash for self-pay). Thus, the strength of the supports to keep individuals with mental health and substance abuse problems stabilized in their home setting has lessened and become a bit more fragmented in the past year or two. The transitions between services also remain a point of increased “treatment drop out” or “falling through the cracks.” In some cases this is an outgrowth of inadequate hand-offs between providers and sometimes the isolated nature of funding streams for services increases the likelihood of an unsuccessful hand-off.

The region lost the only provider of Psychiatric Residential Treatment Facility (PRTF) services for youth approximately three years ago and currently has no such resource for youth who need longer-term residential treatment within Region 7. The state-set reimbursement rates for this service proved inadequate for the cost of such a service in this region (related to the aforementioned job market and salary issues). Since youth are now sent out of the region for this service, their reintegration into the community following treatment is more difficult and frequently less successful since the family is not able to participate as actively in the residential treatment process.

The full implementation of the adult and youth crisis stabilization services within our region will help this situation somewhat because of the more rapid access to intensive outpatient intervention, emergency medications and potentially short-term emergency residential resources. These enhancements all have potential to reduce “revolving door” experiences with clients.

Additionally, case managers from Region 7 routinely meet with staff of Eastern State Hospital to improve the transition from inpatient treatment to community-based care. Also, Northkey Community Care has implemented (in 2000) a pilot project with start-up funding from The Health Foundation of Greater Cincinnati to provide an intensive contact case management model which utilizes paraprofessionals to make frequent contact (several times per week) with adult clients with a severe mental illness diagnosis to help them maintain daily routines, appropriate medication utilization and attend scheduled appointments and meetings.

E. What is the current status of services for the elderly?

The Region 7 “Mental Health and Aging Coalition” formed in 2002 and meets monthly. Initial goals of this coalition, of roughly 14 service providers, are to increase the volume and organization of informational resources for older adults and those who serve them within the region. The coalition has purchased display materials and brochures related to mental health and substance abuse issues for use by regional agencies when attending a conference or health fair targeted to aging issues. Additionally, the coalition collaborated with publishers of regional resource guides to enhance and clarify existing resources for services targeted toward older adults with mental health and substance abuse problems.

The current task of the coalition is to increase awareness within the provider community, care giver community and general population of mental health and substance abuse service needs for the older adults in our region. Included in these efforts is raising awareness of signs and symptoms of possible treatment need and a greater awareness of treatment resources and/or how to locate such information.

There are limited targeted mental health and substance abuse services for older adults in Region 7. The community mental health center does not currently have a psychiatrist or nurse practitioner with certification or extensive specialized training for the older adult population. Many older adults are provided services within the context of the adult outpatient clinics. In 2002, NorthKey provided outpatient mental health and substance abuse services to 218 Adults over the age of 65. Home Health agencies deliver most of the support services to home-bound older adults (assessment, medication education, structuring daily routine, etc.) and refer to the CMHC if there are additional services needed after the initial stabilization.

One bright spot has been the opening of a geriatric psychiatry unit by St. Elizabeth Medical Center. This has resulted in the recruitment of two geriatric psychiatrist specialists and will provide the core of a specialized treatment staff. This is a much needed specialty service within the region.

F. What changes, if any, have you seen in coordination and collaboration across systems and between organizations in your region?

Beginning in 1999, with the infusion of grant dollars from The Health Foundation of Greater Cincinnati, there has been an increase in the collaborative planning, service development and service delivery efforts in the region. Currently, within the region there collaborative efforts are operating to:

- ✓ bolster school-based services
- ✓ expand adolescent substance abuse services

- ✓ increase services to justice involved youth
- ✓ increase services to homeless individuals who are struggling with mental health and/or substance abuse problems
- ✓ provide increased training to jail personnel focused on improving the identification of mental health and substance abuse treatment needs in the jail population
- ✓ increase general health (including mental health and substance abuse) services to inmates in county jails
- ✓ expand community-based consumer support services.

Additionally, the Department for Community Based Services (DCBS) has begun implementation of Comprehensive Family Services strategies, which pulls several agencies together for planning around a client and their family. UK's Targeted Assessment Program (TAP) collaborates with DCBS and NorthKey for planning around cases.

Participation in the RPC and other targeted collaborative planning efforts (such as KY-ASAP, Youth Substance Abuse Treatment Collaborative (YSATC), a Department of Juvenile Justice (DJJ) service and resource planning work group and School-based Services collaborative) continues to be positive, energetic and doing what can be done while being marginally funded.

While there are many efforts to collaborate within the region, there remain significant hurdles in the system(s) for funding service delivery in a truly collaborative manner. Until funding streams (at least a portion of them) from different cabinets have the ability to be blended into one pot that is managed in a blended fashion at the local level, collaborations will continue to suffer from "good ideas" that are *extremely* difficult and administratively awkward or impractical to implement. Perhaps an issue to resolve at the Commission level in the coming year is to develop a mechanism that accomplishes a true pooling of some dollar resources so that they arrive at the local level as a unified pot (from various "cabinets" or "divisions") with flexibility to support a collaborative approach to addressing the needs of members of communities. When this truer dollar blending occurs, there will be a real opportunity for system-wide modifications, savings and enhancements instead of the current real risk (and actuality) of inadvertently transferring the expense of serving a population from one cabinet to another cabinet.

IV. Strategies to Increase Access to Community-Based Services

A. What changes, if any, have there been in access to community-based services?

Forces Enhancing Access

- ✓ NorthKey's ACCESS (single point of entry) has continued development and is now available for both urban and rural office locations
- ✓ Crisis Stabilization Services for youth are expanding to rural counties
- ✓ Crisis Stabilization Services for adults will be developed in 2003/2004
- ✓ Case management services have increased for adults who have been recently treated intensively for a mental health problem, with the goal of maintaining stability in their recovery resulting in fewer re-hospitalizations

Forces Inhibiting Access

- ✓ Residential housing units for up to 9 adults were closed in 2003 with the dollars being moved into additional supports for community living
- ✓ Longer-term local residential service options within the region remain a stated need in the service array – there are none for adolescents
- ✓ Difficulty with staff retention, especially in the rural counties, significantly impacts access to services and continuity of care
- ✓ Medicaid is becoming a less desirable payer due to rate freezes, which limits accessibility for this population
- ✓ Psychiatrist availability remains less than needed
- ✓ Dual-diagnosis treatment for youth and adults remains a weakness in the region

B. Has consumers' access to medications changed? If so, how?

Within the past 18 months, St. Vincent DePaul has opened a pharmacy for low-income individuals to help them acquire needed medications. This adds another resource, with the stipulation that individuals must find transportation to the one site that exists.

State pharmacy medications dispersed through Northkey Community Care increased to \$430,000 in 2002 and almost \$500,000 in 2003. The sample medication program within the Community Mental Health Center (a collaboration with pharmaceutical companies) distributes between \$900,000 and \$1,000,000 per year in free sample medications for mental health problems. There are also many other hundreds of thousands of dollars worth of sample medications distributed by psychiatrists and family practice physicians outside of the Northkey Community Care service delivery system.

In spite of this high volume of free and discounted medications, there is still additional high demand for medications above the current distribution levels.

C. What changes have occurred, if any, with regard to the availability and utilization of support groups?

In 2002, Federal Block Grant dollars were increased to support Recovery Network of Northern Kentucky (RNNK). Federal Block Grant dollars were also allocated in a regional fund to support consumer attendance at statewide and national conferences and meetings. In 2003, the Kentucky Consumer Advocacy Network (KY-CAN) provided a 3-day workshop for adults with severe mental illness (SMI) in the past 12 months. RNNK, consumer members of the RPC, KY-CAN, the Mental Health Association of Northern Kentucky (MHANKY) and NorthKey are cooperating in the development of a Building Recovery of Individual Dreams and Goals through Education and Support (BRIDGES) program to encourage more collaborative participation (with the provider) in treatment by consumers within the region.

D. How has your region attempted to reduce criminalization of persons with MH or SA disorders?

The state work group is trying to solve the dilemma of those individuals who are picked up for disturbances or violence and are ruled mentally incompetent to stand trial, but on the other hand, do not qualify for admission to a mental hospital either.

At a lower level in the system, and a much more frequent problem for all concerned, is the issue of agencies and officials interfacing with people who are experiencing a psychotic episode or those who are chronically mentally ill. This is especially a problem for law enforcement personnel who frequently must balance the responsibility of apprehending people who are out of control with having no place to take the person except jail. Related to this is the feeling experienced by many officers of being unprepared in terms of training and skills to deal with an individual who is exhibiting mental illness or substance abuse symptoms.

Independence Police Chief Shawn Butler, Ted Smith, and Mac McArthur met as a local regional work group and discussed this issue and some practical applications, which could be started as an outgrowth of our local RPC initiative.

For practical, immediate steps towards progress, the local work group selected three areas the Regional Planning Council could address to improve service to mentally ill, substance abusing and developmentally disabled people the justice system faces daily. The three areas recommended for quick attention are:

1. First-contact with people with acute MH/SA problems who have broken no law, but who are "acting out" in public or homes and who need immediate help. They could be adults or children and include the homeless, the chronically mentally ill, or those with chronic Alcohol and Other Drug (AOD) addictions.
2. Treatment of those in jails and prisons who have MH/SA problems.
3. Training for social workers, parole officers, etc. who work with individuals who have MH/SA problems and also have to interface with police officers and jails in the course of their work. These individuals must become experts in both mental health/substance abuse treatment and the

court/law enforcement/jail systems. They provide the linkage and connection between systems necessary to effectively and efficiently resolve the transition treatment issues.

First-contact issues include:

In-service training of police officers to help improve their preparation for understanding and working with individuals who are displaying symptoms of mental illness and/or intoxication. Currently, new police recruits are required to take a 16-week basic training course. Annually, other police officers are required to take 40 hours of training a year. MH/SA crisis training should be added to the curriculum for both. (This needs to be coordinated with the Eastern State police academy curriculum). The Memphis and Louisville programs could provide models, but to be effective, this would need to be a regional effort between all police departments. Currently, only the Covington police force appears to have a large enough police force to do it alone.

Justice Cabinet Issues

1. Training of officers should be done with full cooperation between the Justice Cabinet and the Health Services Cabinet. Reports from officers suggest that previous training has been overly oriented to either the police perspective or to the social worker perspective. We need to encourage training that includes both perspectives together.
2. Evaluation of police agencies for certification/accreditation should include an evaluation of MH/SA training efforts and effectiveness.

Community Crisis Intervention Issues

The Northern Kentucky region needs an alternative to jails for those individuals who are acting out related to mental illness and/or relapse/intoxication. The services need to be targeted for detoxification and stabilization and for introduction to long-term care. Alternative treatment oriented options include hospitals or Residential MH/SA crisis stabilization units (CSU) where people can be kept overnight or longer. The hospitals are a must in order for the new system to work.

Treatment Of Those Incarcerated:

Integrated, long term MH/SA programs are an important tool for adequate management and treatment of prisoners who have mental illness and substance abuse symptoms. Ideally, these programs will properly assess, begin treatment and then link individuals with appropriate long term care programs so they can lead productive lives after they leave prison. Some issues within the jail setting are:

- ✓ **Medications:** The cost associated with medications is a growing problem for jail budgets. Medicaid coverage, for inmates who are eligible for Medicaid, seems logical, since Medicaid often covers their treatment before and after incarceration.
- ✓ **Necessary Treatment (while incarcerated):** Currently, Kenton County jail works closely with NorthKey to assess and provide necessary treatment. Maybe there is a pattern here other jails could follow.

Positives:

- ✓ **NorthKey provides regular trainings to Florence/Boone County Police**
- ✓ **NorthKey provides psychiatric services to rural jails within the region and has a contract to provide psychiatric assessment, triage and treatment in the Kenton county jail**
- ✓ **MHANKY provides regular training to some police departments and jails in the region**
- ✓ **Began training jail staff with a revised training process. This is done in collaborative manner by NorthKey and MHANKY**
- ✓ **A local collaborative of agencies (in partnership with a pharmaceutical company) develops and carries out a community wide marketing plan designed to increase awareness about mental**

health and substance abuse issues and reduce the stigma associated with these health conditions

Targeted Initiatives:

- ✓ Broaden training to additional police departments and emergency responders
- ✓ Enhance service availability and contracts with jails to provide more access to needed mental health and substance abuse services.
- ✓ Continue the roll-out of jail trainings per state developed curriculum

E. Please describe the relationship of the CMHC with the jails in your region, including the status of jailer training.

- ✓ NorthKey participates in a planning group for enhancing the health services (including mental health and substance abuse treatment needs) in the Kenton County Jail
- ✓ NorthKey delivers assessment and consultation services in jails in the rural counties
- ✓ NorthKey delivers psychiatric assessment and medication management through contract to the Kenton County Jail
- ✓ NorthKey provides assessment and consultation to the Campbell Juvenile Detention Center
- ✓ Training of jail personnel regarding the identification of mental health and/or substance abuse problems within the jail population have been completed in two counties. Two additional county jail staff trainings are scheduled for FY 2004
- ✓ There is a training from the National Institute of Corrections scheduled in the region for September 17 – 19 of this year

F. Have there been changes in addressing access to services for the elderly and for individuals with disabilities such as deafness, physical restrictions, etc?

Services to older adults were covered in section 3 E. (above). The primary change has been the opening of the inpatient unit at St. Elizabeth Medical Center, South. With the start-up of this unit, a couple of Psychiatrists who have expertise in geriatric psychiatry have been added to the treatment resources for the region.

NorthKey Community Care has recently hired (June 2003) a deaf therapist, who is fluent in sign language, to provide greater access to services for the deaf and hard of hearing individuals in our region. This therapist is also available for consultation with other clinicians within an outside of the region.

G. How has your region attempted to address cultural/ethnic/racial aspects of awareness, access and utilization of services?

The region held a diversity awareness and training conference in 2002, which focused on expanding sensitivity to cultural differences and diversity issues. Some agencies have taken some steps to educate staff related to the growth of the Hispanic-speaking population in our region. Northkey Community Care is in the process of translating important documents into Spanish, and employs three staff in the northern three counties who are fluent in Spanish.

Some local initiatives targeted to Hispanic population issues have been:

- ✓ A Citizen's Academy geared toward educating Hispanic population about important information
- ✓ Gallatin County offered conversational Spanish for it's police and service providers
- ✓ Grant County Adult Learning Center is focusing on inclusive activities planning with the Hispanic population
- ✓ Covington has developed a Hispanic Resource Center and a Spanish outreach ministry
- ✓ Centro de Amistad functions out of the Catholic Cathedral in Covington and is a resource for Hispanic Catholics

As mentioned above, NorthKey also recently hired a deaf therapist and will be increasing internal and external awareness and education activities related to accessibility of services to the deaf and hard of hearing population.

H. If your region received funding for a CSU as a result of action during the 2002 General Assembly, describe your current activities and the status of implementing that service/facility.

Region 7 received grant dollars for both adult and child crisis stabilization services as a result of the 2002 legislative session. The child crisis stabilization services had begun on a small scale due to a \$75,000 grant in 2001. The proposals for implementation from the 2002 session were approved in the fall of 2002, thus this current fiscal year reflects only initial activities from that time.

Adult Crisis Stabilization Services:

Finding a good candidate for the coordinator position took several months, with the final hiring occurring in late April 2003. The second clinical staff person was hired within a few weeks of the start of the coordinator and the program is now available to serve in a mobile crisis intervention capacity within the northern counties of the region. The initial startup plans also involve the use of a crisis psychiatric assessment and medication evaluation component, which allows for more rapid assessment by a psychiatrist and potentially a quick start on medication when needed.

Future expansion of the adult services will evolve based upon identified need and availability of payer support for services. It is expected that mobile services will be available for all counties in the region at some point in the expansion and strong consideration will be given to the incorporation of some capacity for brief overnight stays when necessary to deescalate a crisis situation.

Child Crisis Stabilization Services:

Child crisis stabilization services began with a mobile team on a very limited basis in the northern-most counties of the region. The additional dollars approved after the 2002 session allowed for expansion of the mobile crisis staff and allowed for therapist availability around the clock and greater capacity to respond to crises. The data reflect that 193 youth were seen by the crisis stabilization team in 11 months (July 2002 through May 2003). Of the 193 youth seen, 111 resulted in short-term intensive intervention, which maintained the youth in their current setting. Additionally, the remaining 82 resulted in a one contact assessment, with 11 requiring inpatient treatment.

There continues to be an on-going evaluation of the need for a residential component to the child crisis stabilization services. NorthKey is tracking the clinical need as it decides whether to contract for these services or explore the provision of short-term, crisis residential services. The second year expansion request was recently submitted to the Department of Mental Health with plans to expand mobile crisis team availability to all 8 counties, develop an intensive partial hospitalization service as another piece of the community-based continuum and develop contractual agreements for short-stay residential resources already existing in the community.

V. Quality Assurance and Consumer Satisfaction

A. What changes, if any, have been made to address quality assurance and consumer satisfaction in your region?

The MH-MR Regional Board (NorthKey) has revised its grievance procedure and made it more "user friendly" and the revised procedure also more clearly identifies the appeal process outside of the organization. Also, NorthKey's outpatient mental health programs and children's intensive inpatient services continue to gather monthly client satisfaction and quality improvement data on a monthly basis. This satisfaction data continues to be reviewed monthly by program and administrative staff with appropriate modifications being made when data indicates a problem process or situation.

VI. Behavioral Health Goals

- A. Briefly describe the top goals set by your Regional Planning Council for the initial 2001-2003 time period.
- ✓ Help assure that local legislators maintain an awareness of local mental health and substance abuse service needs

- ✓ Increase communication with legislators to assure awareness of local and state-level issues related to ability to provide adequate services for mental health and substance abuse services
- ✓ Continue to enhance membership in RPC
- ✓ Work more closely with the Northern Kentucky Chamber of Commerce to raise awareness of the importance of having appropriate availability of mental health and substance abuse services

B. What progress has been made toward achieving these short-term goals?

- ✓ Local legislators receive regular update reports from the RPC that highlight service needs and funding issues
- ✓ Membership has grown from the initial 28 members to 40 members
- ✓ The Chamber of Commerce has recommended a volunteer to participate in the RPC meetings and the RPC has on-going communications with Chamber Members and leadership

C. What longer-term goals were set by your Regional Planning Council?

- ✓ Increase funding, in general, for mental health and substance abuse services
- ✓ Increase flexibility in use of funding dollars to allow for local fit to local needs
- ✓ Use of continued Medicaid coverage to help ease the reintegration of an individual into the workforce
- ✓ Improve transportation issues to increase access to services, especially in rural communities
- ✓ Improve the data collection of existing regional service resources and regional gaps/service needs
- ✓ Increase service providers (psychiatrists and other clinicians) to improve access to timely services
- ✓ Increase access to substance abuse services by including coverage for them in the State Medicaid plan
- ✓ Expand school-based services
- ✓ Expand intensive outpatient treatment services for adolescents who have substance abuse problems
- ✓ Increase access to early assessment and treatment for youth with suspected mental illness or at high risk for experiencing mental illness and substance abuse
- ✓ Have crisis stabilization services available for youth and adults
- ✓ Have a local (in region) residential treatment option for mental health and substance abuse
- ✓ Increase availability of appropriate psychiatric medications regardless of income level of the client/patient

D. What progress has been made toward achieving these longer-term goals?

Progress Made

- ✓ Adolescent IOP services have expanded from 1 program to 3
- ✓ Crisis stabilization services are being developed for adults and youth as a result of 2002-2004 state budget dollars
- ✓ Some additional early assessment and intervention dollars were approved in the 2002-2004 state budget

Areas Requiring Continued High Priority Focus

- ✓ Receiving adequate state contract dollars and Medicaid reimbursement
- ✓ Medicaid coverage of substance abuse services
- ✓ Medicaid assistance during the transition period for individuals returning to work from a mental illness/substance abuse impairment
- ✓ Increasing availability of service providers (all types of clinicians)
- ✓ Increased availability of appropriate psychiatric medications at low cost
- ✓ Development of in region residential treatment options for substance abuse and mental health problems
- ✓ Fiscal and process support for consumer designed and led initiatives
- ✓ Transportation availability to help improve access to services

VII. Implications

A. How have your funding needs changed?

Positive Changes

- ✓ Crisis Stabilization Services for adults and youth now have a base level of sustaining funding in the State contract (assuming that expansion dollars for 2003/2004 are approved).
- ✓ Some grant dollars have become available in the region, through a private grant resource, for start up costs of new services (see related negative change below)
- ✓ State funding has been provided to partially support the employment of a therapist who is deaf and is fluent in sign language

Negative Changes

- ✓ Expansion in Adolescent IOPs has used remaining state contract substance abuse service dollars
- ✓ Rapid and widespread population increase in recent years, has increased demand above resources
- ✓ Grants from private and other resources provide only start up dollars and state contract dollars and/or Medicaid coverage needs to be expanded to help support the services after the grant money is fully utilized
- ✓ Capping of Medicaid rates for both Outpatient and Inpatient services results in a significant loss of revenue for NorthKey and hospital providers each year
- ✓ Loss of service support for youth and families struggling with autism and other developmental disorders due to Medicaid financial problems results in a significant stress for those individuals
- ✓ Region still needs a viable funding mechanism for substance abuse services

B. What public policy changes are needed to further your objectives?

In general, some mechanism to provide adequate statewide funds for the support of mental health and substance abuse services is needed. A funding stream that adjusts to service demand and is sensitive to program and service growth is preferred.

- ✓ Primarily, the entire state funding system for mental health and substance abuse services requires stronger financial support. Kentucky is mired in the bottom 10 to 20 % of national per capita spending for mental health and substance abuse services. This change would allow Northern Kentucky to receive additional dollars to support the population's service demands.
- ✓ Enhanced financial resources at the State level would also allow the formula for distribution of State general fund dollars to be adjusted so that an appropriate share of state funding comes to Northern Kentucky without harming other regions that are also not funded appropriately for their needs.
- ✓ Dollars from different Cabinets need to be pooled at the local level to maximize flexibility and impact.
- ✓ State General Fund dollars need to be increased statewide and Medicaid program needs additional funding to allow for appropriate eligibility thresholds, appropriate continuum of services for mental health and substance abuse treatment and appropriate reimbursement rates.
- ✓ The reimbursement rate for psychiatric residential treatment beds (PRTF) needs to increase to adequately cover cost of service in this region.

C. What further recommendations (or changes in past recommendations) need to be made at this time?

Since the dollars for crisis stabilization services for adults and youth have been approved and have begun to flow to the region, this service is not a high priority need as it was at the time of the last report.

In a related matter, the community has repeatedly expressed a need for some form of acute crisis residential services for both adults and youth to reduce the use of jails as temporary holding facilities. The development and expansion of the crisis services may reduce this need, but that is undetermined at this point.

The situation of the homeless population, who need mental health and substance abuse treatment, as detailed in Attachment A is a more pressing issue than at the time of the first report. Services for

this population have not developed as expected with the failure of the necessary support to allow for the proposed resource center to be developed in Covington.

State revenue shortfalls and Medicaid funding issues have combined to slow or stymie growth and weaken the service delivery network in the region. The single –most important issue for this region remains the need for adequate funding to come to the region so that the service capacity can more closely match the service demands.

VIII. On-Going Process and Activities

HB 194 (2003 GA) extends the HB 843 process at both the Statewide Commission and the local Regional Planning Council levels, with some specificity of functions having been added. For instance, the Regional Planning Council are now required to submit an updated report every two years, with the report being due on July 1st of the odd-numbered years.

A. What process have you used or will you use to add new members to your HB 843 Regional Planning Council?

Membership recruitment has been on-going since our RPC's inception. RPC members will continue to identify critical gaps in representation on the RPC and seek to identify representatives to fill these gaps.

B. What activities do you anticipate your Regional Planning Council will be involved in over the next two years?

- θ Continue to enhance and freshen RPC membership
- θ Continue to organize coordination and relationship between RPC and other entities (i.e. MH-MR Regional Board, KY-ASAP, United Way, existing community collaborative efforts
- θ Continue to foster collaboration to increase MH/SA services for older adults
- θ Improve listing and awareness of existing services resources for the region
- θ Continue to foster collaboration among regional service providers, consumers, and communities to encourage pursuit of funding to reduce service gaps
- θ Continue to provide educational information to legislators and the community regarding service gaps and needs
- θ Collaborate with the MH-MR Regional Board to develop necessary support and funding for meeting more of the community's service needs

C. Under HB 194, the Regional Planning Councils have a role in reviewing recommendations made by the Work Groups and giving feedback to the HB 843 Statewide Commission before those recommendations are acted on by the Commission. Given the short time-line for response, how will your Regional Planning Council carry out that function expeditiously?

To date we have successfully used a structure and process involving local work groups to review reports from statewide work groups. These work groups then report to the larger RPC membership and then following review/discussion the RPC membership responds with any suggested revisions. In some cases, the original work group material is included in the response in order to capture the input as accurately as possible. We plan to continue this process.

**REGION 8 HB 843 REGIONAL PLANNING COUNCIL
JULY 2003 REPORT**

I. Descriptive Features of the RPC

A. Sue Bane, CAP; David Bolt, Primary Care; Milton Brindley, Family Practice; Caroline Clarke, ADD; Linda Donovan, Education; Marlene Duffy, ADD; Bonnie Frodge, RIAC; Mendy High, Education; Rob Hall, Education; Bruce Hanna, Housing; Ann Johnson, DCBS; Duane Lambert, Education; John Lott, minister; Linda Ross, RIAC; Shari Stafford, Women's Crisis Center; Todd Walton, District Judge; Debbie Weber, counselor; Vicki Willman, Home Health; James Adams, CMHC; Paul Weaver, consumer advocate.

B. Primary activities have focused on adult and child subcommittee participation in annual plan and budget process for Comprehend, Inc. – Region 8 Community Mental Health Center – identifying service gaps/needs, resources, etc. In addition, the Regional Planning Council will greatly benefit from intensive needs assessments recently conducted under the auspices of planning grants funded through the Health Foundation of Greater Cincinnati and the Buffalo Trace Agency for Substance Abuse Policy. These planning grants will provide valuable regional information concerning mental illness and substance abuse.

II. Regional Needs Assessment

- A. There have been no significant changes in the demographics of the region, with the exception of economic changes.
- B. Two area factories have closed or announced that they will close within the last year. In total, the Buffalo Trace area has lost close to 1,500 jobs.
- C. The Community Mental Health Center will receive an additional \$400,000 in funding for adult crisis services in FY 2004. However, all other major areas of funding, including Medicaid and state general funds, have remained frozen. In addition, there have been significant reductions in private grants and donations that are directly related to the economy, and more specifically to poor return on investments.

III. Service System Description

- A. Comprehend, Inc. opened the Children's Crisis Center in April 2002, which has allowed for the provision of short term overnight crisis stabilization services to children in the region. Outpatient treatment services are provided on-site at each public school in the region. Services are now provided to individuals referred by the Lewis County Drug Court – a direct result of the participation of Judge Lewis Nicholls in the first RPC planning meeting. Also, Comprehend, Inc. has sponsored three major training events, with participation from a multitude of community agencies, companies and individuals.
- B. The safety net is essentially provided by the local mental health center, and is funded with general fund dollars. This funding has essentially remained the same for the past several years. The CFO of the mental health center currently serves on an ad-hoc group of the Kentucky Association of Regional Programs that is examining safety net funding.
- C. As previously mentioned, overnight crisis stabilization services for children are now being provided. Planning grants funded by the Health Foundation of Greater Cincinnati have focused on adolescent substance abuse services and school-based mental health services. The number of children receiving mental health services through the mental health center has steadily risen over the past several years.
- D. Comprehend, Inc. recently received funding through the Health Foundation of Greater Cincinnati to explore the provision of ACT (Assertive Community Treatment) services to "revolving door cases". It is hoped that this planning grant in conjunction with the new adult crisis funding for FY 2004 will result in improved services to this population.
- E. The local mental health center provides therapeutic rehabilitation programs in each of the region's five counties. In addition, the mental health center works closely with local senior citizen's centers and provides consultation on mental health issues, medication management topics, etc.

- F. There has historically been excellent cooperation between systems and organizations in Region 8. Many current employees of organizations such as school systems, Vocational Rehabilitation, DCBS, etc. are former employees of the local mental health center.

IV. Strategies to Increase Access to Community-Based Services

- A. One area of concern that has been reported is the increased waiting time for child psychiatry appointments at the local mental health center. Comprehend, Inc. has attempted to recruit additional child psychiatry services for several years. The recent implementation of an Early Childhood Mental Health specialist grant has increased referrals of young children to mental health services. Also, the CMHC recently implemented a regional scheduling system as well as a local area network in an effort to facilitate better communication among county offices. This was done with the ultimate goal of increasing access to mental health and substance abuse services in the region.
- B. There have been no reports of significant issues with respect to access to medication. The local community mental health center actively participates in sample and rebate programs with pharmacy companies.
- C. No major changes. Comprehend, Inc. is currently providing support services to victims of flooding and tornadoes in Lewis County through FEMA.
- D. The local mental health center has worked closely with local law enforcement officials and judges to ensure compliance with decriminalization. In addition, a local drug court provides referrals to the mental health center, with the cost of services subsidized by Kentucky ASAP funds. The Mason County Detention Center, a regional facility, has assisted in subsidizing the provision of an on-site Intensive Outpatient Treatment program (IOP). On a related topic, local needs assessments have indicated the need for supervised living settings (group homes, for example) for young adults with low functioning and behavior problems. These individuals are frequently in the care of DJJ or DCBS until the age of 18, but without appropriate residential options, often end up in the local courts and jails soon after reaching the age of majority.
- E. There are two local jails in the region. The CMHC has provided jail training to one of the jails, and training is scheduled for the second jails. Memorandums of agreement are in place between the CMHC and both jail facilities.
- F. Many of the participants in the CMHC's Therapeutic Rehabilitation program are elderly. All CMHC facilities are ADA compliant. The CMHC uses the services of an interpreter for services to individuals who are deaf or hard of hearing, and a TTY telephone is advertised and available for use by these individuals.
- G. Comprehend, Inc. provides DUI education services for Spanish-speaking individuals, and contracts with an interpreter for these as well as outpatient services. Staff have attended cultural competency training, and will train other CMHC staff.
- H. The region did not receive additional crisis funding in the 2003 session, but was approved for additional funds beginning in SFY 2004. The local CMHC is developing a comprehensive community-based crisis response system, which was identified as one of the region's most crucial needs by the Regional Planning Council.

V. Quality Assurance and Consumer Satisfaction

There have been no substantive changes in the area of quality assurance and consumer satisfaction.

VI. Behavioral Health Goals.

- A. The goals set by the Region 8 Planning Council are as follows: more flexible funding, increased funding to allow salaries of behavioral staff to be more competitive, increase access to specialized treatment services, and policy change.
- B. Flexible funding has not materialized. The vast majority of funding for behavioral health services is still targeted to specific programs and populations, and the safety net remains fragile in Region 8. The local CMHC has made a concerted effort to increase the salaries of behavioral health staff, and have recruited additional staff to provide school-based services and crisis services. Flexible scheduling for school-based staff (e.g. offering staff the option of working a "school schedule") has helped attract staff. As mentioned earlier, there have been several initiatives that have recently been implemented that have improved access to services, but child psychiatry continues to be a problem area with respect to access. A positive

development in terms of increasing access to early intervention services has been the creation of the Early Childhood Mental Health Specialist position within the CMHC.
C/D. Goals have not been differentiated as long-term or short-term.

VII. Implications

- A. The need for additional crisis funding has largely been met with the addition of adult crisis funding. However, two potential sources of additional funds for children's crisis services – Medicaid and DCBS/Juvenile Justice – are not currently reimbursing for these services. The fundamental problem of inflexible funding remains.
- B. Increased flexibility of general funds is necessary. Wraparound funds for services such as transportation and housing are critical. The current Medicaid moratorium on service expansion should be lifted in order to ensure reimbursement for new services such as crisis stabilization. Medicaid parity with respect to coverage of substance abuse services still has not been addressed. The Medicaid buy-in program, if implemented, would allow clients to continue receiving Medicaid coverage for services after they have entered the work force. All providers of MH/SA services should be held to consistent quality and access standards. We still believe that the standards for Medicaid targeted case management services should be changed (staff standards as well as billing standards).
- C. No change in recommendations at this time.

VIII. On-Going Process and Activities

- A. There have been no specific efforts to add members to the local planning council. Should the need arise, new members will be recruited through a committee of the current membership.
- B. Review of previous, current and potential MH/SA planning grants, attendance at meetings of other groups such as local KY-ASAP with similar interests, continued assistance with local CMHC planning and budgeting process.
- C. The local planning council will review Work Group reports within the timeframe specified.

HB 843 Report Outline – Due July 1, 2003
Region XI Regional Planning Council

RPC Report due on July 1st of each odd-numbered year

I. Descriptive Features of the RPC

- A. List members of the Regional Planning Council and the category of their representation, provided the members are willing to disclose that information; indicate which are new members since the report filed in December, 2000.

Chairman, Andrew Dorton, business leader
Milton Harvey, family member
Jimmy McCoy, consumer*
Brett Davis, elected official representative*
Denny Dorton, business leader
Bertie Kaye Salyer, health department*
Donna Frazier, advocate for elderly
Chris Conley, community college
Jim Kelly, advocate for elderly and veterans
Sharon Moore, educator
Debbie Price, Chair RIAC
Pam Meyer, RIAC
Steve Friend, law enforcement
Erdle Looney, private facility, in-patient substance abuse services*
Tony Bentley, public facility, adult crisis stabilization unit
Judy Music, community-based supportive housing program
(*denotes new members since the report was filed in December, 2000)

- B. Describe activities of the Regional Planning Council since your initial study and report (December, 2000)

II. Regional Needs Assessment

- A. Indicate any significant changes in your region's demographics
- Federal Prison built in Martin County.
 - Medical detox unit has opened at Pikeville Methodist Hospital in Pike County.
- B. Update community indicators, prevalence rates and significant events, if applicable
- No significant changes since the initial report.
- C. Indicate any significant changes in dollar resources
- Department for Mental Health funded Early Childhood Mental Health Initiative for 2003-2004.
 - Department for Mental Health funds Kentucky ASAP for 2003.

III. Service System Description

- A. What steps have been taken in addressing gaps in services?
- Several hospitals which accept referrals from CMHC have provided training for clinical staff regarding stream-lined admittance and discharge procedures.
 - CMHC has established a system to provide involuntary mental illness evaluations within 45 minutes of the referral 24/7.
 - Pikeville Methodist Hospital establishing medical detoxification services effective July 28, 2003
 - Drug Court Initiatives have been established in Floyd, Johnson, and Martin Counties with pilot project funding via KASAP.

- B. What is the current status of the “safety net” in your region?
 - Regional CMHC Flat funding threatens maintenance of services.
 - The waiting list for residential drug treatment services has grown to an eight week wait.

- C. What is the current status of services for children and youth?
 - No psychiatric beds in region for children
 - CMHC received funding for Early Childhood Specialist.

- D. What is the current status of repeated referrals?
 - No Significant changes.

- E. What is the current status of services for the elderly?
 - New senior citizens center opened at Blackberry in Pike County. CMHC provides elder abuse prevention workshops in all 15 senior centers.
 - New legislation regarding Adult Day Health Care will force many elderly to lose eligibility for Adult Day Health Care service.

- F. What changes, if any, have you seen in coordination and collaboration across systems and between organizations in your region?
 - Collaboration for the Protection and Permanency of Children Steering Committee has representation of child caring agencies from each county.
 - Magoffin County’s Teen Coalition addresses substance abuse and other issues relative to adolescents.
 - Big Sandy Area CASA incorporated and began training advocates.
 - Youth Transitioning Into Independent Adulthood Committee meets quarterly to explore issues of youth in Floyd County.
 - 3 K-ASAP committees allocated funds for various community projects to combat substance abuse.
 - The Prestonsburg Conference of the United Methodist Church has begun a ten year initiative to address drug addiction.
 - Pikeville MCCC staff member has been designated to represent the Agency in the Pike County interagency meetings at Community Action.

IV. Strategies to Increase Access to Community-Based Services

- A. What changes, if any, have there been in access to community-based services?
 - Transportation stipends have been provided to parents of children in IMPACT and Bridges services to attend family events.

- B. Has consumers’ access to medications changed? If so, how?
 - CMHC has revised the controlled substance medication policy which has provision to provide qualified physicians and nurse practitioners to provide medication services to individuals in order to enhance the quality of their lives by reducing the severity and intensity of symptoms. Physicians shall utilize medication, which are appropriate and beneficial in treating client symptoms in conjunctions with the client’s active participation in other therapeutic, psychosocial and /or other behavioral interventions. The availability of potentially addictive medications prescribed by MCCC physicians is addressed in this policy in order to assure that consumers receiving these medications are using them correctly. Physicians are required to obtain a KASPER report prior to prescribing controlled substances as well as continued use of the KASPER during treatment. It is the goal of MCCC to provide treatment for substance abuse and not be a contributor to problem of prescription drug abuse.

- C. What changes have occurred, if any, with regard to the availability and utilization of support groups?
 - National Alliance for Mental Illness has initiated support group for families in Prestonsburg.
 - IMPACT Family Liaison has support groups in each county.
 - The SMI Consumer Alliance continues to meet on a regular basis.

D. How has your region attempted to reduce criminalization of persons with MH or SA disorders?

- CMHC has established an evaluation system that allows an individual that is to be involuntarily evaluated for mental illness to be evaluated within 45 minutes from time requested. The system is open 24/7.
- CMHC has attempted meetings with criminal justice representatives within the region.
- Drug Court pilot programs are currently operating in Floyd, Johnson, and Martin Counties.

E. Please describe the relationship of the CMHC with the jails in your region, including the status of jailer training.

- The relationship with jail staff is positive, but none of the jails are willing to pay for services for their inmates. CMHC has provided training for two of the three jails in the region. The training was well received and had impact on workers about mental health issues.
- State prisoners are being housed in county jails and required to receive substance abuse treatment services, however there is no funding to pay for these services

F. Have there been changes in addressing access to services for the elderly and for individuals with disabilities such as deafness, physical restrictions, etc?

- CMHC participated in regional Aging Coalition.
- Aging Coalition promoted community education regarding Depression and the Elderly.
- Highlands Regional Hospital opened "Turning Point" Day Treatment Unit.

G. How has your region attempted to address cultural/ethnic/racial aspects of awareness, access and utilization of services?

- The MCCC training director has been trained as a trainer for cultural competency and will begin training for the Agency and other area providers this FY.

H. If your region received funding for a CSU as a result of action during the 2002 General Assembly, describe your current activities and the status of implementing that service/facility.

N/A

V. Quality Assurance and Consumer Satisfaction

What changes, if any, have been made to address quality assurance and consumer satisfaction in your region?

CMHC has developed a new Quality Improvement Plan which restructured the QI Process to include three working sub-committees, Peer Review, Technical Review and Risk Management. Reports are provided to supervisors with aggregate reports regarding compliance.

Client satisfaction is gauged through both informal and formal satisfaction process. The informal process includes comments cards available in the lobbies of each clinic. The formal process utilizes the Mental Health Improvement Project instrument for adults and youth. This instrument has measures of access, quality/appropriateness, treatment, participation and outcomes. Annual reports have been provided to management during the last two years.

Risk Management Sub-Committee has instituted an instant reporting and monitoring system.

VI. Behavioral Health Goals

- A. Briefly describe the top goals set by your Regional Planning Council for the initial 2001-2003 time period.

Combine the HB 843 Regional Council with the KY-ASAP Regional Councils to maximize local planning relative to mental health and substance abuse issues.

- C. What progress has been made toward achieving these short-term goals?

Combining the councils did not officially happen. KY-ASAP councils wanted to maintain their autonomy. The Regional Planning Council did not meet for a year, but was re-called in May 2003.

- D. What longer-term goals were set by your Regional Planning Council?

- Goal 1

Mental Health Goal is to provide a comprehensive array of quality services that will result in success and satisfaction of consumers, providers and the community.

- Goal 2

Substance Abuse Goal is to increase treatment options within the region for people who have problems associated with substance abuse.

- Goal 3

Substance Abuse Prevention Goal is to increase abstinence from substance while reducing experimentation, use and abuse, especially among youth.

- E. What progress has been made toward achieving these longer-term goals?

- **Goal 1**

Objective: Increase number of qualified staff to provide mental health and substance abuse treatment in Region XI.

Progress: CMHC advertises positions and application process via web site.

Mental Health related education programs now offered in the region include:

University of Kentucky offers MSW program in Prestonsburg, Kentucky

Lindsey Wilson College offers Master's in Professional Counseling in Prestonsburg

CMHC is a practicum placement site for Pikeville College, Lindsey Wilson College, University of Kentucky, University of Louisville, Eastern Kentucky University and Morehead University.

Objective: Increase collaborative efforts among community partners outside the regional hub of Floyd County.

Progress: Progress: Magoffin County community partners have made great strides in collaboration as demonstrated by the following projects:

KY-ASAP- Mission: (To develop a long term strategic plan that is designed to reduce the incidence of alcohol, tobacco and other drugs in the youth and adults in Magoffin County. *Vision:* (A healthy community free of alcohol, tobacco and other drugs and related consequences. Two major objectives of a strategic plan of the board has been to award \$8000 in mini-grants to other community providers to address problems and service gaps related to alcohol, tobacco and other drugs. Currently the board is focused on upon an activity called Mobilizing Action for Planning and Partnerships (MAPP). MAPP is the roadmap to Magoffin County improvement. It studies our county, recognizes its strengths, identifies active trends, establishes its needs and makes a plan for community involvement-inclusive of all the county's needs. This effort involves every facet of the community. There will be a county wide door-to-door survey to collect current data relative to this venture this year. We found existing data to be incorrect and unreliable in accurately accessing these areas.

Magoffin County Teen Coalition- Is made up of volunteers from various agencies and interested people in the community. He has it roots in the County Health Departments' (Abstinence Education Program). This group now is an incorporated board that has established and maintains a Teen Center (Teen Scene) and provides programming to children and adolescents as well as provides opportunities to other people in the community for enrichment and other special activities. Its Mission is: "To create an environment where the youth of Magoffin County can develop the skills and values to become responsible and productive citizens of the community".

Magoffin County Tobacco Coalition- Interested members in the community who have formed a coalition that promotes tobacco cessation programs and interventions. The Coalition is a participant of the KY-ASAP Board.

Connect with Kids- A group of community volunteers from a cross section of the community who taught a character development curriculum at the Herald Whitaker Middle School throughout the school year. The major benefit, aside from the curriculum, was an effort of the school administration to involve the community in school affairs, to collaborate with other communities entities, and remove barriers to community involvement in education.

Community Partnership for the Protection of Children is a district-wide collaborative effort initiated by Big Sandy DPP. A CMHC staff chairs the meetings which are held in Johnson County.

Multi-disciplinary Team meetings are held in each county.

Objective: Work with National Alliance for Mentally Ill and KyCAN to activate a national consumer group in Region XI.

Progress: The National Alliance for Mentally Ill provide 12 week training for family members of consumers at Prestonsburg Community College during spring of 2003. There is an active campaign to recruit membership.

Objective: Increase the number of opportunities to provide mental health education.

Progress: Spring and Fall Conferences last two years promoting "Caring for Every Child's Mental Health" with over 200 family member and professional attendance.

In April 2003, Kentucky State Police and the Community Partnership for the Protection of Children sponsored a full day training on Substance Abuse Prevention.

Objective: Increase the number of children who receive mental health services.

Progress: CMHC continues to provide school based services through the BRIDGES Project (SAMSHA grant) which ends June 2004. The CMHC is working on ways and means to sustain the level of services, but recognizes that the absence of \$500,000 grant will be a tremendous challenge.

Goal 2

- A medical detoxification program has been proposed by Pikeville Methodist Hospital.
- Drug Court Pilot programs have been established in Floyd Johnson, and Martin Counties.

Goal 3

- KY-ASAP regional councils initiated several projects in the five county area to work toward this goal.

VII. Implications

A. How have your funding needs changed?

- Funding needs are relatively unchanged through the past decade.

B. What public policy changes are needed to further your objectives?

- While recognizing the need for new mental health services is important, it is essential that policy makers recognize the need to maintain funding for basic mental health services for which community mental health centers were established.

C. What further recommendations (or changes in past recommendations) need to be made at this time?

- More funding and the need to move Kentucky from 47th in state funding for Behavioral Health services to a higher level of funding for appropriate and needed services.

VIII. On-Going Process and Activities

HB 194 (2003GA) extends the HB 843 process at both the Statewide Commission and the local Regional Planning Council levels, with some specificity of functions having been added. For instance, the Regional Planning Council are now required to

submit an updated report every two years, with the report being due on July 1st of the odd-numbered years.

C. What process have you used or will you use to add new members to your HB 843 Regional Planning Council?

- Telephone contact was made with original council members during May 2003. During the May 13th meeting attending members discussed recruiting and made suggestions of possible interested individuals.
- Council members are making contact with potential members.

D. What activities do you anticipate your Regional Planning Council will be involved in over the next two years?

- Regular quarterly meetings
- Meetings with legislators
- Representation at Statewide Committee meetings
- Review and evaluations of progress toward goals
- Review workgroup reports and provide feedback to the Commission

E. Under HB 194, the Regional Planning Councils have a role in reviewing recommendations made by the Work Groups and giving feedback to the HB 843 Statewide Commission before those recommendations are acted on by the commission. Given the short time-line (see attached), how will your Regional Planning Council carry out that function expeditiously?

- Mail reports to council members
- Meet to discuss recommendations
- Provide feedback to the Commission

**HB 843 Report Outline – Due July 1, 2003
Kentucky River Regional Planning Council**

RPC Report due on July 1st of each odd-numbered year

XIII.I. Descriptive Features of the RPC

F. List members of the Regional Planning Council and the category of their representation, provided the members are willing to disclose that information; indicate which are new members since the report filed in December 2000.

NAME	Type of Membership	AGENCY OR ORGANIZATION	NEW Member?
Kevin Ritchie	Consumer	Stepping Stone Center	No
Carol Riley	(1) Consumer; (2) Family Member – Child with SED		No
Doug Hudson	Consumer	Bridges	No
Mike Spare	Consumer	Private Practice Provider	No
Lynda Congelton	Family Member – Adult with SMI / Substance Abuse	(1) Kentucky River Community Care, Inc.; (2) Chair of the Regional Planning Council; (3) People Encouraging People Coalition	No
Bill Morton	Consumer		No
Jean Sullivan	Provider		No
Ruth Ann Woolum	Family Member – Adult with SMI		No
Cynthia Cole	Provider	Private Practice Provider	No
John Summers	Health Department	Ky. River District Health Department	No
Sarah Cox	Provider	Ky. River Community Care, Inc.	Yes
Ruth Ann Dome	Provider	Ky. River Community Care, Inc.	Yes
Mildred Lee Rogers	Local Government		Yes
Terry Sewell	Civic Organization		Yes

G. Describe activities of the Regional Planning Council since your initial study and report (December 2000).

- a. *Political Forums*
- b. *Council Meetings*

II. Regional Needs Assessment

A. Indicate any significant changes in your region’s demographics.

None

B. Update community indicators, prevalence rates and significant events, if applicable.

In 2000 – 2001, there were 2,600 drug-related deaths in Kentucky – of which, 1,300 occurred in Eastern Kentucky. Eastern Kentucky has less than 20% of the state’s population; however, Eastern Kentucky has 50% of the state’s drug-related deaths.

C. Indicate any significant changes in dollar resources.

- *Ending of federal grants.*
- *Reduction in SCL rates.*
- *Medicaid rates capped.*
- *Reduction in direct service dollars.*

III. Service System Description

A. What steps have been taken in addressing gaps in services?

Substance Abuse: *Kentucky River Community Care, Inc. (KRCC) and People Encouraging People, Inc. received a five-year grant from the Robert Wood Johnson Foundation Reclaiming Futures to plan and implement programming for youth with substance use problems who are at-risk of juvenile justice involvement. This project is designed to develop and implement new models for integrated systems of care that includes treatment, judicial, and social services.*

Public and Fiscal Policy:

- *KRCC was instrumental in forming the Coalition on Appalachian Substance Abuse Policy, a four-state coalition establishing a network to identify evaluation, policy, and data collection issues regarding substance abuse in Central Appalachia. The group hopes to create a more effective allocation of limited resources by:*
 - ⇒ *Identifying the scope and characteristics of substance abuse problems and substance abuse treatment in Appalachia.*
 - ⇒ *Increasing communication among Appalachian communities that are addressing substance abuse and health problems to identify common interests and concerns.*
 - ⇒ *Developing more information about and a better understanding of the effects of substance abuse on economic development and overall well-being.*
 - ⇒ *Developing and using data-collection strategies that are appropriate to Appalachia.*
 - ⇒ *Exploring national and statewide policies that can contribute to better identification of Appalachian-specific substance abuse problems.*
 - ⇒ *Identifying resources for addressing substance abuse problems.*
 - ⇒ *Proposing policies that create ways of solving those problems.*
- *The Kentucky River Regional Planning Council and KRCC's Board of Directors' sponsored a legislative forum to introduce local legislators to our region's substance abuse and behavioral health priorities.*

Professional Staffing - Increase Pool of Credentialed Professionals: *KRCC collaborated with Lindsey Wilson College to develop educational opportunities available in-region on a flexible schedule (evenings and weekends). Graduates of the master's program in Counseling and Human Development will qualify for QMHP status and state credentialing as a Certified Professional Counselor. A bachelor's program in Human Service was also designed. Classes began in the Fall 2002 semester.*

Housing: *KRCC, in collaboration with Kentucky Housing Corporation, completed one new housing complex for clients with special needs. Funding for a second complex has been secured. A third complex is in the development stages.*

Collaboration and Planning – Trauma Services for Women: *KRCC, area Health Departments, and the U.K. Women's Institute have established the Appalachian Violence Outreach Network (AVON): This project will establish a referral network and treatment services for women who have experienced physical and emotional trauma. AVON is designed to increase services for women who are trauma survivors by consolidating resources and focusing the efforts of agencies most likely to be in contact with trauma survivors.*

B. What is the current status of the “safety net” in your region?

Clients needing to be seen on a walk-in / emergency basis continue to outpace available services. All Shelter Plus Care allotments have been utilized with several clients being on a waiting list.

C. What is the current status of services for children and youth?

- *Impact Plus funding is being reduced and reorganized.*
- *The Bridges project, supported by a federal CMHS grant, is coming to a close. Bridges centered on the development of school-based mental health teams that are placed within twenty-one individually selected schools across the three mental health regions.*
- *The successful creation of a residential substance abuse treatment center remains dependent upon whether EPSDT funding will be adequate. The request for rates was initiated in March 2003.*

D. What is the current status of repeated referrals (revolving door cases)?

The revolving door cases remain steady at the hospital.

E. What is the current status of services for the elderly?

The Mental Health and Aging Coalition remains active with its second annual conference held in April 2003. KRCC and the Kentucky River Area Development District are jointly responsible for coordination of the Coalition. The Coalition also organizes and sets-up displays at local health fairs.

Linkages have been developed with nursing homes. Two KRCC staff are certified PASRR evaluators. Staff participate in trainings with tracks related to the needs of the elderly.

F. What changes, if any, have you seen in coordination and collaboration across systems and between organizations in your region?

Coordination and collaboration across systems and between organizations in our region have increased as a result of special private and federal projects such as the Robert Wood Johnson Foundation initiative Reclaiming Futures in the Mountains of Kentucky (RF); Kentucky River Appalachian Project (KyRAP), Appalachian Homeless Assertive Service Program (AHASP), Kentucky Agency for Substance Abuse Policy (KyASAP), and the Victims of Crime Act (VOCA)..

IV. Strategies to Increase Access to Community-Based Services

A. What changes, if any, have there been in access to community-based services?

The demand for community-based services continually increases. However, access to certain services has decreased due to grants coming to a close such as KyRAP, a project serving substance abusing adults, and Bridges, which provides school-based mental health services. With implementation of the Olmstead project, access to certain community-based services will increase for a very specific population.

B. Has consumers’ access to medications changed? If so, how?

The availability and quantity of samples from pharmaceutical companies has increased consumer’s access to medications. However, consumers’ access to the Community Medication Support Program has decreased because of a lack of pharmacies willing to participate in the program.

C. What changes have occurred, if any, with regard to the availability and utilization of support groups?

Since December 2000, the number of 12-step based supports groups for alcohol and other drugs has increased from three to 12.

- D. How has your region attempted to reduce criminalization of persons with MH or SA disorders?

The KRS 202A evaluation process is integrated into KRCC services in many ways to ensure rapid access and quality services are available 24 hours per day, 7 days per week. After-hours and on weekends, psychology interns, supervised by QMHPs, conduct evaluations (voluntary and involuntary) at the ARH Emergency Room in Hazard. During normal business hours, clients needing evaluations are routed to a local outpatient mental health clinic or to a local hospital emergency room where a QMHP will conduct the evaluation.

Youth involved with the KRS 645.120 evaluation process are seen at the nearest outpatient clinic during regular office hours. After hours, the crisis line is called and an on-call evaluator responds to perform the assessment. The youth and police are most often met at the nearest outpatient clinic to perform the evaluation. Assessments may also be conducted at the crisis stabilization unit if this is more appropriate for the youth. The crisis stabilization unit may offer an option for youth in need of crisis intervention, but not in need of immediate hospitalization.

- E. Please describe the relationship of the CMHC with the jails in your region, including the status of jailer training.

In relation to the KRS 202A evaluation process, KRCC has a contract with each sheriff's department in our eight county region. This contract states that the sheriff's department agrees to transport individuals to the appropriate KRCC office for evaluation and then to transport that individual on to the hospital or home, as needed. This agreement also states that the sheriff's department will transport individuals back home at the end of a 72 hour hospitalization. KRCC has an informal relationship with several local jails and responds to emergencies as available.

During the upcoming biennium, Kentucky River Community Care, Inc. will endeavor to contract with at least one jail for jail-based services, pending the jails development/availability of resources for this contract.

Training services were offered to all jails in the region. As of the date of this writing, trainings have occurred in 7 of the 8 counties in the Kentucky River Region with a total of 85 participants.

- F. Have there been changes in addressing access to services for the elderly and for individuals with disabilities such as deafness, physical restrictions, etc?

None.

- G. How has your region attempted to address cultural/ethnic/racial aspects of awareness, access and utilization of services?

The Kentucky River Region is in the heart of Appalachia culture. There is little cultural diversity other than the Appalachian people served here. Approximately 98.6% of the persons who reside in the region are Appalachians according to the U.S. Census Bureau. About .9% (1,250) are African American, .3% are Asian, and roughly .1% are Native American (116). Persons of Hispanic decent comprise less than .5% of the total population in the area or 659 persons out of 120,656. KRCC staff are proud of their heritage and encourage persons of other cultures to learn about theirs. If additional funds become available, KRCC will develop at least one new quality assurance mechanism for cultural competence and an "orientation" plan for staff that are new to the Appalachian region.

KRCC has also taken a leadership role in developing the Coalition on Appalachian Substance Abuse Policy (CASAP). The focus of CASAP is to develop culturally appropriate substance abuse policies and treatment models for Appalachia.

H. If your region received funding for a CSU as a result of action during the 2002 General Assembly, describe your current activities and the status of implementing that service/facility.

Does not apply, i.e., funding was received prior to the 2002 General Assembly.

V. Quality Assurance and Consumer Satisfaction

What changes, if any, have been made to address quality assurance and consumer satisfaction in your region?

KRCC uses the MHSIP as a client outpatient measure and the Multnomah Scale for day treatment as a part of the Mental Health Outcomes Project. KRCC also has a well developed, responsive client grievance process. .

VI. Behavioral Health Goals

A. Briefly describe the top goals set by your Regional Planning Council for the initial 2001-2003 time period.

- Kentucky takes a new policy direction that seeks to establish the Commonwealth as a national leader in community-based care for individuals with mental illness and addictions. This new direction shall become formally adopted by the legislature and executive branches as well as the regional mental health authorities.*
- The Cabinet for Health Services, Department of Mental Health and Mental Retardation Services, educational institutions, and the regional authorities develop a new public partnership with a treatment paradigm of community-based care. Current regulations, educational opportunities, training programs, and licensing requirements require modernization for the new millennium.*
- The Kentucky General Assembly takes the actions necessary to ratify the new policy direction and philosophy into law and passing legislation to increase the per capita state general fund spending by \$30 per person throughout the state.*

H. What progress has been made toward achieving these short-term goals?

None

I. What longer-term goals were set by your Regional Planning Council?

ADULT SUBSTANCE ABUSE PROGRAM

- GOAL 1:** *Of the % of population, who abuse or are addicted to drugs, increase the numbers of individuals who are accessing treatment options.*
- GOAL 2:** *Reduce access to and use of opiates and other addictive, controlled prescription drugs.*
- GOAL 3:** *Reduce hospitalization and recidivism rates for individuals with coexisting diagnoses.*
- GOAL 4:** *Develop a pool of trained and credentials substance abuse providers.*
- GOAL 5:** *Expand women's substance abuse service array to include service options and sites in each of the eight counties of the Kentucky River Region.*
- GOAL 6** *Increase the participation rate in treatment.*

CHILDREN'S SUBSTANCE ABUSE PROGRAM

- GOAL 1:** *Increase the identification and referral for treatment of youth who may be abusing substances or who have key risk factors.*
- GOAL 2:** *Increase the number of substance abuse treatment program options within the region.*

GOAL3: Increase the number of Division of Juvenile Justice youth accessing treatment options.

ADULT MENTAL HEALTH

GOAL 1: *Increase the number of adults accessing treatment.*

GOAL 2: Reduce adult hospitalizations and recidivism.

OLDER ADULT MENTAL HEALTH SERVICES

GOAL 1: *Define continuum of service needs for this older adult population*

CHILDREN'S MENTAL HEALTH

GOAL 1: *Reduce child and youth hospitalizations and out of home placements.*

TRAUMA SERVICES

GOAL 1: *Provide services to adults in the Kentucky River Region reporting trauma.*

GOAL 2: *Increase the number of individuals receiving treatment who have experienced interpersonal violence.*

GOAL 3: *Expand the capacity of the region to provide services for person who are experiencing psychological distress associated with interpersonal violence.*

GOAL 4: Provide services to children in the Kentucky River Region reporting trauma.

HOUSING SERVICES

GOAL 1: *Reduce hospital recidivism rates, by developing and maintaining community options for supported housing*

COMMUNITY AWARENESS AND PREVENTION SERVICES

GOAL 1: *Reduce the incidence of substance abuse via effective prevention efforts.*

GOAL 2: *Reduce the incidence of youth substance abuse via effective prevention efforts.*

GOAL 3: *Increase early intervention and prevention of mental health problems*

INFORMATION SERVICES

GOAL 1: *Reduce regional isolation and integrate community network of behavioral health practitioners, community organizations and community members.*

J. What progress has been made toward achieving these longer-term goals?

Refer to III. A. above.

VII. Implications

A. How have your funding needs changed?

A greater urgency for substance abuse treatment exists in response to the public health crisis in Appalachia. A lack of funding for residential treatment for youth is apparent. Funding is also needed to expand domestic violence programs.

B. What public policy changes are needed to further your objectives?

- *Develop data and information systems to better assess the economic impact of substance abuse on the region's economy.*
- *Residents of Appalachia represent a special population and as such, solutions to substance abuse must recognize that "one size fits all" treatment models are not effective in rural areas.*
- *Coordination between the criminal justice system and the substance abuse treatment systems is essential. Beyond this, a coordinated community response is needed to treat a growing problem*

C. What further recommendations (or changes in past recommendations) need to be made at this time?

None

VIII. On-Going Process and Activities

HB 194 (2003GA) extends the HB 843 process at both the Statewide Commission and the local Regional Planning Council levels, with some specificity of functions having been added. For instance, the Regional Planning Council are now required to submit an updated report every two years, with the report being due on July 1st of the odd-numbered years.

A. What process have you used or will you use to add new members to your HB 843 Regional Planning Council?

- *Identify an "organizer/change agent" from each county.*
- *Utilize interactive video sites for meetings.*
- *Identify a core group of community members that are knowledgeable about the issues.*
- *Ask employers to assign a staff person to the Council as a part of their job.*
- *Approach local and regional newspapers about running human-interest stories.*

F. What activities do you anticipate your Regional Planning Council will be involved in over the next two years?

- *Community Forums*
- *Design of a communication plan.*
- *Activity increase in political arena.*

G. Under HB 194, the Regional Planning Councils have a role in reviewing recommendations made by the Work Groups and giving feedback to the HB 843 Statewide Commission before those recommendations are acted on by the commission. Given the short time-line (see attached), how will your Regional Planning Council carry out that function expeditiously?

Use of interactive video and other connecting communication systems allow timely meetings.

**Region XIII Regional Planning Council
Two-Year Update
July 1, 2003**

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I. Descriptive Features of the RPC

Several new projects have been initiated in Region XIII since the initial study and report, December 2001.

A new Graduate Program in Counseling is being offered by Lindsey Wilson College at the Community Colleges in London and Cumberland, KY. Enrollment is excellent as we enter the second year this fall. Eastern Kentucky University is offering a Masters in School and Mental Health Counseling at it's Corbin Campus. Lindsey Wilson College is also offering a B.A. in Human Services at the Cumberland, KY Campus with more than thirty students enrolled. The University of Kentucky, School of Social Work, will offer a social work class this fall and as more students enroll a decision to offer a cohort in the London/Corbin area will be evaluated.

Other B.A. and B.S. programs are being offered by a number of colleges and universities.

A Children's Crisis Stabilization Unit has opened in the Corbin area. The Cumberland River MH/MR Board constructed a ten-bed facility serving seven to eight children per day.

An Adult Crisis Stabilization Unit was funded during the 2002 Legislature. A facility was purchased and renovated in the London, KY area and is licensed to serve twelve adults.

All jail personnel within the Region have been presented the Behavioral Health Care Needs Training.

Additional funding has been secured to construct a four-unit apartment complex in Corbin and an eleven-unit complex in Harlan for adults with mental illness.

II. Regional Needs Assessment

A comparison of the Region XIII (Cumberland Valley) demographics (including community indicators and prevalence rates) that existed almost three years ago with those that currently prevail indicates that there is an even greater need now for behavioral health services for individuals with mental illness, alcohol and other drug abuse disorders, and dual diagnoses (co-occurring disorders).

Among all the region's service providers who are trying to meet those increasing service demands, the Community Mental Health Center alone has experienced a 28% increase in its consumer census over the past three years, as well as an even far greater increase (69%) in service volume.

Unfortunately, and with few exceptions, there have been no appreciable changes in funding availability for behavioral health services during the past three years. However, the proponents of House Bill 843 have, for certain, been an effective force in the funding of the CMHC's much-needed crisis stabilization program for adults and the expansion funding for the children's program. The adult program was funded with \$400k in FY 2003 and the FY 2004 DMHMRS contract provides for \$320k. The state funding for the children's program increased from \$100k in FY 2003 to \$433k in 2004. These programs, which provide a 24-7 safe and supportive environment for persons who are experiencing acute symptoms of mental illness, not only afford an alternative to hospitalization, but they too are much more cost-effective.

In addition to these mental health crisis care programs, there are now funding expectations for two new substance abuse programs for the CMHC for fiscal year 2004 (both expected to commence July 1, 2003). They include; 1) a program which is funded by a SAMHSA federal grant (\$200k and renewable for two additional years) that is expected to improve consumer engagement and retention in treatment at two outpatient programs and two gender-specific residential facilities, and 2) another SAMHSA-funded program that is intended to target for treatment those consumers who have co-occurring substance abuse and mental health disorders. The exact dollar amount of funding for this program is yet unknown, but Region XIII CMHC is expected to share \$500k to \$1,100k with one other Center for five consecutive years.

A demographic comparison of Region XIII with all other regions of the state reveals that this region is sixth in highest population, sixth in most land area, seventh in population density, fifth in the highest rate of unemployment (meaning ten other regions have higher employment rates), and, perhaps surprising to some, it is the lowest in per capita income

(having declined from fourth highest position in 1984). In addition, the per capita spending for behavioral health services is consistently less in Region XIII than it is in many other regions.

Given all this, and even without regard to certain service barriers that are unique to this region, the providers of behavioral health services in Region XIII can indeed be proud of what they are doing as they try, each day, to surmount this unique set of obstacles that can hamper their best efforts. But try as they may, even through all their misfortune, limitations have been reached, and they cannot meet the challenges and service needs that lie ahead in behavioral health without adequate monetary support. Providers of these services in Region XIII are in common agreement that the lack of sufficient funding for the vital work they do is the single greatest adversity that they face each day.

The “emergency” situation that was declared to exist three years ago, which prompted the passage of House Bill 843, does even now, and for the most part, remain unabated in the Cumberland Valley region of Kentucky.

III. Service System Description

Our agency has applied for two (2) Federal Grants to further enhance and address retention to substance abuse services in our region.

1. The first is a grant that has as its objectives to retain clients in the residential and outpatient substance abuse settings for longer periods of time. Research indicates that the longer clients stay in treatment, chances for recovery also improve.
2. The second grant relates to the division of Substance Abuse asking us to consider partnering with them to develop and enhance our treatment service system to increase the capacity to provide accessible, effective, compressive, coordinate/integrated, and evidenced-based treatment services to persons with co-occurring substance abuse and mental health disorders and their families.

Our agency has sought input from the Division of Substance Abuse regarding available funds for Intensive Outpatient Programs, Expansion of Residential Programs, and a Detoxification program.

Much work is needed in the areas of services to substance abusing parents referred by the Department of Community Based Services. Confidentiality continues to be a major obstacle in working with other agencies.

Drug Court Programs are now in Rockcastle, Laurel, Whitley, Knox and Bell Counties. All remaining counties in the region, (Clay, Jackson, and Harlan), do not currently offer services to clients through Drug Court. It is anticipated that these areas will offer Drug Court within the next one to two years; Cumberland River will actively participate with any and all efforts to begin Drug Court programs.

Cumberland River continues to actively seek information regarding the development of a residential substance abuse treatment program for Adolescents. Persons with the Division of Substance Abuse office in Frankfort have been supportive in our efforts to develop this service.

Staff have been employed to provide services to pregnant women substance abusers. Cumberland River currently has 1.5 full time equivalent case managers and 3.5 full time equivalent staff providing therapy to pregnant substance abusers. The University of Kentucky Medical Center has been extremely cooperative in providing detoxification for this extremely vulnerable population.

The “safety net” for substance abuse has been improved by the University of Kentucky Medical Center’s willingness to provide detoxification services to pregnant substance abusers in Region XIII.

The need to develop a viable medical detoxification program for our more indigent clients continues to be a critical need.

For Residential Substance Abuse Treatment, clients are restricted from consideration for re-admission to our programs for a period of six months. The Directors of the program may waive this requirement under special situations. Every effort is made to either locate another residential treatment program for these individuals, or develop an alternative treatment.

Cumberland River is currently developing an advertising campaign, emphasizing that throughout the Region services to the elderly substance abusers are provided.

Cumberland River Comprehensive Care Center continues to take the lead to coordinate and collaborate across systems and between organizations throughout the region within the legal parameters set forth in State and Federal regulations.

The gaps in providing mental health services in Region XIII have been reduced. The opening of the Adult Crisis Stabilization Program (Haven House) is reducing the gaps in services while increasing the safety net for adults with mental illness. Haven House offers a safe, supportive environment so that individuals can take the opportunity provided by the crisis to improve their level of functioning. The utilization of the Adult Crisis Stabilization is expected to impact on the recidivism rate of the individuals served at ARH Hazard. Those adults who have frequent hospitalizations in less than 30 days of discharge will be offered a step down program to Haven House. While at Haven House, the adult case manager will work with the client on accessing needed mental health and community services.

Additional Housing for adults with mental illness is in the foreseeable future. Grant funding had been awarded for apartments in the Corbin and Harlan area, a four unit in Corbin and an eleven unit in Harlan.

Services to the elderly have increased slightly during the current fiscal year. Efforts have been made to provide services either directly or indirectly to residents of nursing home facilities. Continued effort will be made to provide services to the elderly through the provision of education to primary care physician, senior citizen, organizations and/or nursing homes.

Communication has improved across the community with the involvement of committee members of HB 843. This communication has resulted in collaboration among service providers.

Partnership with Education: Collaboration between CRCCC and area schools continues to expand and be a very positive partnership throughout the region. Having the opportunity to be involved with the federal "Bridges Project" and in a system of care change has brought about many positive relationships.

Throughout children's services, we are striving to use the concepts of the "Wraparound Process" and "Positive Behavioral Supports" in connection with the many schools we are involved with. Utilizing programs that are already in place such as Kentucky IMPACT, School Based Services, Crisis Stabilization, in-home therapy, outpatient therapy, and after-school and summer programs, with the adoption of a new process, is proving to be very beneficial. However, it involves a great deal of education and training to staff and our community partners. Working with individuals on a change of philosophy, attitude, and taking on a different perspective is a slow but steady process.

Region XIII is working with the State Interagency Council on an education and training program to help foster system of care change throughout the state.

Many of our mental health professionals/school based therapists are back in school working on advance degrees as local universities have began offering classes locally.

Parent Involvement: Region XIII's parent involvement and movement continues to be very positive with the work of three family liaisons within the region. Support groups, work with community groups, consultation and collaboration with schools are ongoing. The Family Liaisons provided an overnight retreat for parents during the fall at Pine Mt. State Park. There were 15 parents in attendance with many plans developed for the future of the family movement. Children's Services administrative staff were invited to participate to improve communication and assist in providing information or resources as needed. The Retreat was a grand success with focus groups occurring throughout the winter and spring. An additional grant was submitted and approved by Kentucky's Office of Family Leadership to train interested parents how to become team-meeting facilitators for their own families and assist other families. This grant will continue to help parents throughout the region regarding empowerment. The family liaisons continue to participate in the presentation of workshops throughout the state and at national conferences in regard to the "Wraparound Process and Family Involvement". They serve as a great strength to our families and have been extremely beneficial in all areas of our services.

Involvement with Department of Juvenile Justice: Children's services continues to work on communication, collaboration and involvement with DJJ throughout the region. The Regional Interagency Council and the Local

interagency Councils in the region are represented by DJJ. However, this continues to be an area with opportunity for improvement.

IV. Strategies to Increase Access to Community Based Services

A new twelve-step meeting has been developed in Pineville, Kentucky. Efforts are on going to develop a meeting in Middlesboro, Kentucky. All other locations throughout the region continue to offer viable twelve-step meetings.

Federal grants are being sought that will assist with reducing criminalization of clients with MH and SA disorders. Through the Jail Education training currently going on in our region, these reductions in criminalization are improving our region.

Cumberland River continues its efforts to develop effective, professional relationships with the jails in the region as evidenced by the progress being made by personnel who are responsible for the jailer training currently being conducted. Through the first three quarters of the fiscal year, the Agency has provided the following services for each objective:

1. Twenty three (23) trainings held in Harlan, Bell, Knox, Whitley, Laurel, Clay, and Rockcastle
2. Jailer and Staff trained: 37
3. Consultation: 179
4. Contractual Agreements: 4

The agency continues to make every effort to offer services to these vulnerable individuals. The Substance Abuse Program is required as a result of being licensed by the State, to insure services are made available to those programs listed above.

In-service training is conducted on an on going basis regarding these issues.

With the development of a consultation and education program and a training division, the community's knowledge of behavioral health services has significantly increased. Educational services are offered at the jails, schools, community organizations and to other service providers.

These trainings and educational programs increase access to community based services.

The programs which have directly resulted in increasing access to Behavioral Health Services are:

1. Education/Collaboration with the local jails
2. Services to the deaf/hard of hearing population
3. School collaboration for children with severe emotional disturbance
4. Culture Sensitivity
5. Cross Training of clinical staff in the area of Mental Health and Substance Abuse

The one area, which is a potential issue, will be providing Behavioral Health Services to a Hispanic Population, if needed.

The agency did receive funding for an Adult Crisis Stabilization Unit. The unit is currently operational. A twelve-bed facility was purchased and renovated in Laurel County.

The pharmaceutical companies have been invaluable in assisting consumers access the newer medication. Consumers have access to samples, Indigent programs and coupons. Without their support and commitment to providing these medications, many of the consumers would not be able to afford a month's supply.

Two housing developments have been funded for Region XIII; a four-unit facility in Corbin and an eleven-unit facility in Harlan.

V. Quality Assurance and Consumer Satisfaction

Quality Assurance: As the enclosed matrix indicates (see Exhibit A), numerous mechanisms continue to exist to assure that quality services are delivered to consumers by many of the behavioral health providers in the Region XIII (Cumberland Valley) Catchment area. For example, the Community Mental Health Center, the Trillium Center (inpatient psychiatry), and the Appalachian Regional Hospital (inpatient psychiatry) are all currently Joint Commission accredited. The Trillium Center (in Corbin) was re-accredited in August, 2002, ARH psychiatric (in Harlan) was recently re-accredited in January, 2003, and the CMHC is currently conducting a self-evaluation in preparation for an accreditation survey that is expected to occur in early 2004. The CMHC has been JCAHO-accredited since 1979. And, of course, by being accredited, behavioral health care providers are held to rigid standards for quality consumer service through their adherence to ongoing programs of quality assurance and continuous performance enhancement. Such QA programs and CPE plans encompass a vast array of indicators and conditions that either directly or indirectly impact behavioral health care. Certainly too, accreditation entities like the Joint Commission do themselves show a responsiveness to quality service (their own QA programs, if you will) as they continue year after year, survey after survey, to improve their accreditation standards and adapt them to the ever-changing needs of those for whom they are intended. As such, it is primarily in this way (i.e., adherence to current standards of care) that behavioral health care providers address quality assurance issues.

Consumer Satisfaction: Consumer satisfaction with mental health and substance addiction services is a critical indicator of service quality and effectiveness. The implementation of consumer satisfaction surveys garners a perspective of care that can be invaluable to program planning and improvement. And too, while the primary objective of service delivery is to enhance the quality of each consumer's life, these such surveys elicit his/her input in helping to bring that about. In recognition of all this, Region XIII providers of behavioral health services have begun to rely more and more on consumer input for promoting quality programs that meet diverse consumer needs. These type surveys are now being conducted throughout the region on an ongoing basis, and their cause is even further advanced through their requirement by accreditors and the governing Boards of the service providers. Important too is the continuous effort to fashion their design in a manner that will address the changing needs of consumers. There has been some thought too, even among program planners in Frankfort, that a consumer survey instrument with uniform design, as well as a common protocol for implementation, could be utilized statewide for the purpose of promoting across-region and across-program comparisons of service delivery and service quality. With the variables that exist among service providers such an instrument may have some merit if the questionnaire issues were very general. A copy of the most recent (March, 2003) consumer satisfaction survey report by the CMHC is included herein as Exhibit B.

Organization	CMHC	Private Providers	DCBS	Trillium Center	ARH Harlan	Primary Care Physicians
JCAHO	■		■	■	■	
State Licensure	■	■		■	■	■
Medical Regulation	■			■	■	
Medicare Regulation	■			■	■	
Primary Source Verification	■			■	■	
Dept of MHR Standards	■		■	■	■	
Quality Assurance (Privileged/Credential of Professional Staff)	■			■	■	
Consumer Satisfaction Survey	■	■	■	■	■	■
Clinic Ombudsman	■					
State Ombudsman	■		■			
FIAC	■					
LAC	■					
Bridges Eval. Advisory Committee	■					
CMHS Initiative for Children	■					
SCL Certification	■		■	■	■	
Grievance Procedures	■					

 **Quality Assurance and Customer Satisfaction**

INTRODUCTION

This survey, which was conducted during the four weeks that ended December 10, 2002, targeted a sample of clients who were provided services during the past twelve months. The questionnaire respondents were selected per a set of criteria that was expected to maximize the reliability of the survey results. Of the 655 questionnaires that comprise the survey, the unduplicated number of respondents represents 5% of the FY '02 client census. While all service programs in the region were asked to participate in the survey, it should be noted that any city location or program that is not listed in the survey data did not submit any questionnaires, rather than having been inadvertently omitted from the survey data

Since the purpose of this survey was not only to determine program effectiveness from the clients own points of view, but also to identify what they believe are weaknesses and/or problem areas in their respective programs, the survey did in fact do just that. The negative responses and some of the general comments made by the respondents engendered an awareness of some quality care issues, though nothing really major was elicited. In turn, each of these issues will be addressed in a priority manner depending upon their urgency for action. For this purpose, the questionnaires have been passed along to the respective program directors so they can review them and implement appropriate courses of action to resolve the issues (see memorandum to Program Directors in Appendix). The survey results have been submitted to the chairpersons of the Continuous Performance Enhancement Committee where they will follow the review/action mechanism of that committee.

What follows this introduction to the survey are the aggregate results of the thirty-eight (38) service programs that participated in the survey. Included too are aggregate results for the Center, that are inclusive of all the service programs that submitted questionnaires. Since some of the questions were not responded to at all, the validity of the survey results required that the "Satisfaction Percentage" be arithmetically expressed as $S / (S+U) \times 100\%$, where S is the number of "Satisfied" responses and (S+U) is the total number of all responses ("Satisfied" plus "Unsatisfied"). It should be noted too that survey reliability depends in a large part upon the number of questionnaires submitted by each program. For the purpose of making comparisons among programs, a reliability factor of 1.0 was arbitrarily assigned to the aggregated results of ten questionnaires. By doing so, the satisfaction percentage for any program is meaningful to the extent that enough questionnaires were completed in order that the reliability index is equal to or greater than 1.0. In other words, a program whose survey was comprised of 10 questionnaires, and who showed a satisfaction percentage of 99%, may be less reliable, and consequently less impressive, than a program whose satisfaction percentage of 94% was derived from the results of 30 questionnaires.

Cumberland River MH/MR Board, Inc.

Client Satisfaction Questionnaire

Service Division (Check One): MH _____ MR _____ SA _____

Name of Program _____ City Location _____

Name of Proctor _____

How satisfied are you:	Highly Satisfied	Satisfied	Not Satisfied
1. That the staff in this program facility are well-informed, interested in your well-being, and eager to help you?	_____	_____	_____
2. With the services you have received:	_____	_____	_____
3. That the staff are attentive to your needs?	_____	_____	_____
4. That your rights to privacy and confidentiality are maintained by the staff in this facility?	_____	_____	_____
5. If you take medications from the Center, how satisfied are you that the	_____	_____	_____

instructions and possible side effects were sufficiently explained to you?

- 6. That the staff in this facility have been friendly, courteous and respectful toward you?
- 7. That you have been sufficiently involved in your own treatment plan?
- 8. That all your needs have been addressed on your treatment plan?
- 9. With how often you have been seen by your caseworker?
- 10. That the facility is always clean, neat, and pleasant?
- 11. That the heating and air-conditioning are always adequate to provide a comfortable facility?
- 12. That there is adequate space in the program facility?
- 13. That the location and accessibility of the facility are convenient?
- 14. That you have been given specific information about your progress?
- 15. That your caseworkers always make themselves clearly understood by the use of plain language?
- 16. That you would recommend this agency's services to others?

_____	_____	_____
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Signature (Optional) _____

Behavioral Health Goals

Immediate Goals

Increase the number of Behavioral Healthcare professionals through more graduate and undergraduate human service type degrees within the Cumberland Valley Region.

- Provide Adult and Children's Crisis Stabilization Services
- Offer Prevention Programs
- Expand School Based Services for Children
- Increase funding for Mental Health and Substance Abuse Services

Much progress has been made toward meeting the immediate goals with the addition of three graduate and two undergraduate human service degree programs, with a larger than expected enrollment. The Social Work Program has not become a reality; however, a meeting is scheduled for July 3, 2003 to discuss an M.S.W. Program with Dr. Hoffman at the University of Kentucky.

Lincoln Memorial University has updated the Graduate Counseling Program to meet Licensure Requirements and has received accreditation for the B.S.W. Program. Cumberland College is working on accreditation of their Social Work Program.

The Adult and Children's Crisis Stabilization Programs were funded and are operational.

Other goals have been met. Funding for the training of all jailers and jail personnel has been provided and has improved services and public relations.

Additional funding is needed for expansion of existing Mental Health and Substance Abuse Programs.

Long Term Goals

- Offer a Non-Medical Detoxification Program
- Provide more Substance Abuse Residential Treatment for Adults
- Provide Inpatient Services for Adolescents
- Provide more Residential Treatment and Housing for Adults with Mental Illness
- Offer Geriatric Day Care
- Provide Residential Treatment for Adolescents with Substance Abuse Disorders
- Provide Intensive Outpatient Programs for Adults and Adolescents with Substance Abuse Disorders
- Provide Mental Health Training to all Jail Personnel
- Secure more funding for Mental Health and Substance Abuse Services

Increase the number of Health Care Professionals through more graduate and undergraduate human service type degrees offered with the Cumberland Valley Region.

The first class of Master level graduate Mental Health Professionals is entering its second year of the program.

The first class of the B.A. in Human Services is entering its final year of the program. This will be a tremendous asset for the Mental Health and Substance Abuse Professional manpower shortage. House Bill 843 has been a tremendous tool to convince the various colleges and universities of the great need to provide an education at the local level.

More Residential Substance Abuse Residential Services may be possible as we enter the next two-year cycle.

Funding for two housing developments, a four-unit complex in Corbin and an eleven-unit complex in Harlan has been secured.

Hopefully more housing will be secured in the future.

Some success with detoxification has been secured through a contract with the University of Kentucky for Pregnant Substance Abusers. Additional services are needed.

Additional funding granted for the Children's Crisis Unit and the Adult Crisis Unit will meet a critical need throughout the region.

VII. Implications

Funding is needed to develop Intensive Outpatient Programs for adolescents and adults and residential substance abuse treatment programs for adolescents.

Funding continues to be an issue of providing a seamless continuum of care. Additional funding is needed in these areas.

1. Housing for Adults with Severe Mental Illness
2. Transportation to medical services
3. Indigent Care for those individuals without insurance, Medicaid, or Medicare

Efforts must continue to make the public aware of the needs of the substance abusing population, including decriminalization, the need for treatment, etc.

Treatment issues related to co-occurring illnesses need top priority. Training to develop skills in working with clients with co-occurring illness is a real need.

Refer to Regional Needs Assessment for additional comments.

On-Going Process and Activities

New members are added to the Regional Planning Council through news paper ads, local television adds, agency referrals, council member referrals, and individual referrals. Copy of Advertisement attached.

Increasing the number of Qualified Behavioral Health Care Professionals has been a top priority throughout Region XIII. Numerous Colleges and Universities have come together to offer a number of B.A./B.S. and Master level Human Service degrees within the Region. Approximately eighty students are currently enrolled and the completion of the first class will be in the summer of 2005. This will meet a very critical need.

A continuing top priority will be to increase the number of Graduate and Undergraduate Human Service Programs within the region and to increase the number of students in the current programs. House Bill 843 has given us the necessary research and information to convince Lindsey Wilson College, Lincoln Memorial University and Eastern Kentucky University to offer the necessary programs to meet our greatest need – Qualified Manpower. Hopefully, University of Kentucky or another University will bring other programs to the Cumberland Valley Region.

Advocating for increased Mental Health and Substance Abuse Funding will continue to be a major priority.

The improved working relationship with schools, child and family services, housing, health departments, hospitals and private providers has been very beneficial and will continue to be an important priority the next two years. The RPC has provided much needed cooperation and positive public relations.

The Planning Council assisted with the planning, review and recommendations with and to review the recommendations.

Public Service Announcement

Region XIII Regional Planning Council for Mental Health and Substance Abuse Services in the eight county Cumberland Valley District is seeking new members to serve on the council.

Interested agency personnel, consumers, private practitioners, or individuals should forward a letter of interest to:

Mr. Ralph Lipps
Cumberland River Comprehensive Care Center
PO Box 360
Pittsburg, KY 40755
Fax: 606-878-7794

**IX. CTA Manufacturing Explosion and Cumberland River's Emergency Evacuation and Response
Emergency Evacuation Summary**

Implemented on 2/20/03

Submitted by: Betty Jordan, PE,CADC, Team Leader

Upon discovering an explosion occurring at CTA Manufacturing located on American Greeting Road about 7:30 A.M. on Thursday, February 20, 2003 the following procedures were activated:

I contacted local area schools immediately and offered assistance for mental health services for any students who had parents or family working at CTA. This included Knox, Whitley, and Laurel Counties, as well as, City Schools in the Tri-County area. All schools declined at this time but agreed to contact CRCCC if any assistance was needed now or in the future.

I contacted Emergency Response in Laurel, Whitley, and Knox County. Dispatch was informed of services for families and emergency workers.

I contacted Laurel County Dispatch again later in the morning after the news broadcast related that families of employees of CTA could meet at the old American Greeting Card building also located on American Greeting Road to assess the status of family working at CTA. I informed dispatch that I could not contact CTA because of rescue efforts ongoing during the fire and downed phone lines and if they could relay the information that we would offer emergency assistance to families and CTA at the American Greeting Card building. (There was no evacuation notice at this time, only restriction into the area.)

Emergency evacuation plans were arranged for all out-patient clients. Since the road was blocked off at about 8:15 A.M., there were a minimal amount of out-patient clients in the building. Staff member George Young drove a client home because he had been dropped off and no one was allowed back into this immediate area. George Young was allowed back into CRCCC after showing his CRCCC identification. (There was no evacuation notice at this time, only restriction into the area.) There were no other out-patient clients coming into CRCCC after this time.

A discussion with Mr. Chad Jackson MR/DD Director was held on procedures for clients at Feltner Apartments. Arrangements and supervision of Feltner Apartments for any possible evacuation was conducted by Mr. Jackson.

I asked all staff in the Corbin Regional Office to check for their personal CRCCC identification in case evacuation was required or re-entry back on to American Greeting Road, due to traffic being re-routed around the immediate area, as well as, I-75. Out-patient staff volunteered to help transport Feltner clients if needed by means of their personal vehicles. (There was no evacuation notice at this time, only restriction into the area.)

A decision to place Feltner clients was arranged upon the “actual evacuation” to Peace Place in Williamsburg under direction of Mr. Jackson. Mr. Jackson left phone numbers of his staff with other administrators upon leaving the building.

Radio-broadcasts indicated that a 13 mile area of I-75 was blocked because of a smoke cloud covering the interstate. Attempts were made to make calls to emergency dispatch but phone lines were busy or down because of the CTA fire and explosion. Personal cell phones of staff were used and also had difficulty with over used lines.

Mr. Danny Jones, Executive Director of CRCCC preceded to our Crossroads Substance Abuse facility located near CTA after announcement on the radio indicated that evacuation of people in the area one half mile near CTA was implemented. (There was no official announcement from Emergency Services made to this facility at the time.)

I discussed with Mr. Pearl Ray Lefevers, Facility Administrator arrangements for staff to start leaving the area. Mr. Lefevers related that if a mandatory evacuation was given that the Emergency Response Team was to pull into the parking lot and sound a siren. All pregnant females were asked to voluntarily leave the area immediately and facial masks were given to three female employees due to smoke in the area. They were instructed not to turn on their heat or air-conditioners in their vehicles until well clear of the area. All three left the area. (There was no official announcement from Emergency Services made to this facility at the time and no sirens were ever sounded.)

Upon Mr. Jones returning to the CRCCC facility from Crossroads, a decision was made to evacuate the staff from the building and clear the area. Instructions were given to staff not to use their heat or air conditioners in their vehicles until well clear of the area and to wear their CRCCC identification. A check of the building was made by Mr. Lefevers and I to insure everyone was out of the building. The building was found clear other than the following:

I, Melanie Yeager, Administrator; Ina Gatliff, intake staff; and Mr. Jones remained to secure the emergency line roll-over system. The switch could not be made due to time restraints since rumors that Cyanide Gas had been released into the air from CTA, (this later proved to be a rumor reported by the local area newspaper and CNN television). Mr. Jones, Ina Gatliff, Melanie Yeager and I all left the building.

I met with Center Director, Kathy Tremaine, at the First Baptist Church and preceded to the Phoenix House Facility where Administrators, clients from the Crossroads, and CRCCC staff and assembled and set up operations.

Center Director, Kathy Tremaine contacted local area radio stations to give out the emergency line phone number of the London Office and Independence House to contact until normal operations could resume. Several of the staff's personal cell phones were once again volunteered since there is only a single line phone at the Phoenix House.

Kathy Tremaine and I went to Independence House and spoke with Mary Burnette Director who volunteered use of the empty mobile home for Crossroads clients accompanied by Crossroads staff if needed. Assessment of the facility indicated enough room for those clients who chose not to leave and return to their families on a pass. The mobile home did not have to be used and client's families were contacted and arrangements for clients to be picked up in London were made. Clients were transported by van to London by CRCCC staff person David Goodin.

Rape Crisis Line was informed that they may be receiving emergency calls for the on call 202A staff.

Review of the Emergency Protocol Manual which I took upon evacuation of the Corbin Regional Office was limited and of little value in this type of emergency. It was noted to Administration at the time of the evacuation. Certain things such as updated phone numbers and emergency shelters were no longer current. All staff did a superior job in teamwork and quick response. There were no injuries reported from any employee or out-patient client at the facility who was evacuated on 2/20/03.

FRIDAY: February 21, 2003

Return to normal work hours on this date. Clinical staff was assembled for a meeting and debriefing. Mental health services were discussed conducted by Center Director, Kathy Tremaine, and Team Leader, Betty Jordan. A plan to provide employee's of CTA with urgent care was developed. (See attachment)

CTA

CRISIS MANAGEMENT

2/21/03

Received call from Kim Benge representing CTA. Related she wanted us to provide services for hourly employees for crisis management and counseling. She related that employees were not to be billed for these services and that bills should be sent to CTA at P.O. Box 448, Corbin, KY.

Olive Bailey from CTA came by the office and left a list of names of the hourly employees who may be contacting the center for services.

Spoke with Danny Jones, Executive Director about request from CTA, and Jan Fox initiated service code and index numbers for billing.

The agreement was that employees would be seen as urgent care clients and could be seen in the closest available office of their choice. The offices included Corbin, Barbourville, Williamsburg, London, Manchester, McKee. The contact phone numbers were given to Kim from CTA.

CTA Contact:

Olive Bailey at 526-569

Kim Benge at 682-3623 (Human Resources)

The service code set aside for this is payor (12) Index (179).

2/25/03

Kim Benge called and related that CTA will be offering the same agreement to the families and spouses of CTA employees. She also advised that Vanderbilt Burn Center was providing some counseling for families of victims taken to their facility and then referring them out to CRCCC for follow-up. Also Kim related that a

support group was not being developed by CTA and that if CRCCC could do this she would announce it on the radio for the employees.

Debbie Davenport CTA representative in Lexington from CTA is involved in coordinating some of the referrals with Vanderbilt. Debbie related that if CRCCC is overwhelmed with employees she can be notified.

Debbie Davenport 1-800-465-6054.

2/26/03

Received call from Kentucky State Response coordinator Mr. Daron Rambo.

Daron Rambo at 1-888-522-7228

He relates he received a call from CTA Human Resource Director and had discussed making referrals to CRCCC. Mr. Rambo stated their agency had set up a facility at one of the local area churches on Saturday after the explosion but only 2 people attended. I reviewed with him our agreement and services available with CTA and he agreed that most referrals should be handled by this agency. He also related he would be providing debriefing for the medical and emergency service workers in the area and leave the employees to CRCCC since this could be a long-term need. Apparently there had been calls to his agency from Bowling Green that he was unable to clarify involving insurance. I related to him I was unaware of any insurance involvement and had not been notified by them or any representative of CTA pertaining to insurance. He offered assistance in the future if there was a need.

3/04/03

Met with Kim Bengé this date at CTA, also, psychologists from Nashville and local independent psychologist, Jeff Grand, on coordinating efforts to provide services. Kim was given information on what services we were providing and ongoing services that may be needed. Also it was discussed how to utilize community resources for employees. Explained that CRCCC is providing a support group meeting to help employees organize and provide them with educational information and referrals. I returned later this date with Jane Fox from billing and discussed billing and she reported that CTA will probably pay for services at this time rather than use their carrier. She asked about corporate discounts and after speaking to Mr. Jones, Executive Director, an agreement was made. Jane Fox was to notify Kim Bengé of the amount.

3/13/03

Spoke with Kim Benge this date to check on any services needed for employees and asked if we could assist in any way. She reports that employees have been given numbers of providers to choose from. I also offered a future EAP for CTA if they were interested. Discussed future support groups for employees as needed. Kim Benge now has a cell phone (606) 682-3623.

**HB 843 Report Outline – Due July 1, 2003
Lake Cumberland Regional Planning Council**

I. Descriptive Features of the Regional Planning Council

- A. List members of the Regional Planning Council and the category of their Representation, provided the members are willing to disclose that information; indicate which are new members since the report filed in December 2000.**

ORIGINAL MEMBERSHIP

REGIONAL PLANNING COMMITTEE

Chairperson: Wanda Bolze, Lake Cumberland Mental Health/Mental Retardation
Co-Chair: Consuella Maggard

EDUCATION & COMMUNITY SERVICES

Sharon Rogers
Dr. Steve Mitchell

PUBLIC & PRIVATE MENTAL HEALTH/SUBSTANCE ABUSE

Jim Hughes
Don Watson

FAITH COMMUNITY

Jan Fletcher
Rev. Dan Lincoln

LAW ENFORCEMENT

Sheila Nuszbaum
Jimmie Cox

PRIMARY CARE

Dr. Jennifer Friend

CONSUMER ADVOCATE

Janie Lee

HOUSING

Eddie Girdler
Mary Creekmore

REGIONAL INTERAGENCY COUNCIL

Karen Bristow

LOCAL RESOURCE COORDIATOR

Dana Sullivan

ADANTA

Cathy Settle

PARENT ADVOCATE

Katrina Murphy

PRIVATE PROVIDER

Kathe Carlton

COUNTY GOVERNMENT

Eddie Rogers
Jeffrey Schuhmann

PROBATION & PAROLE

Perry Parrish

LAKE CUMBERLAND DISTRICT HEALTH DEPARTMENT
Charlotte Phillips

House Bill 843 Regional Planning Council Members as of June 2002

FAMILY MEMBERS

Lois Baker – Green County
Betty Jo Moss – Pulaski County

CONSUMER

Kathleen Earls
Chestlene Popplewell

COUNTY OFFICIALS

Jeffrey Schuhmann, Team Taylor County

HEALTH DEPARTMENT & PRIMARY CARE PHYSICIANS

ADVOCATES & COMMUNITY ORGANIZATIONS

Mary Creekmore, Personal Care Home Administrator
Sherry Estes, Kentucky Agency for Substance Abuse Policy

EDUCATORS & SCHOOL PERSONNEL

Wanda Bolzé, Somerset Community College

REGIONAL INTERAGENCY COUCILS

Sandy Renfro, Regional Interagency Council, Adanta
Karen Bristow, Regional Interagency Council, Department for Community Based Services

LAW ENFORCEMENT & COURT PERSONNEL

Sheila Nuszbaum, Department for Juvenile Justice

FACILITY SERVICE PROVIDERS

Cathy Settle, Clinical Director, Adanta

INDIVIDUAL SERVICE PROVIDERS

Kim Reynolds, Mental Health

CHAIR DESIGNEES/COORDINATORS FOR HB EFFORT

Cathy Settle, Clinical Director, Adanta
Lynn Colvin, Associate Clinical Director, Adanta

B. Describe activities of the Regional Planning Council since your initial study and report (December, 2000).

- Quarterly meetings
 - a. Community education forums
 - b. Legislative receptions

II. Regional Needs Assessment

A. Indicate any significant changes in your region's demographics.

- Several new industries in the area since 2000 including:

Adair County – Williams Furniture second location, Adanta Clinical Services expansion, Harvey Ellis Motors, Inc. expansion, Columbia Auto Smart, Department of Justice Juvenile Detention Center, South-Central Drug and Alcohol Counseling, Lindsey Wilson College expansion

Casey County – America's Closet, B P Express, King's Express Tire, Emma's Café, Courtyard Billiards, Check for Check, Creative Memories, Bakers Lawnmower, Casey Medical Supply, The Lunchbox, M & M Grocery & Family, Hatter's Backhoe, Massey Animal Clinic, Campbell's Sanitation, Tidy Mighty Maids, Cundiff Chiropractic Center, China King

Cumberland County – Fred's; Grumpy's; Cumberland Valley Fitness Center; Checks For Cash; Lin's Garden; Riverside Loans; Helen's Closet; The Everything Place; 19th Hole

Green County – Main Street Merchants; Happy Endings; Vaughn's Variety; Jessica's Hair Unlimited; The Craft Shop; Taste Like Home; Tony's Discount; Houck's Gift Shop; Ratliff Motors; Quick Check-Check Cashing; Completely Charmed; Ginger's This and That; The Consignment Shop; Main Attractions; Skippers Restaurant; Butler Law Office; Sugar Plumb Cottage; BP Station; State Farm Insurance; China King coming soon

McCreary County –Carquest Auto, Federal Prison

Pulaski County – Adanta Child and Adolescent expansion, Somerset Community College expansion

Russell County – Yoga on Square, Sonic, Russell County Lube, Quantum Electric, Premier Designs, Michaels Total Fitness, Lake Cumberland Feed & Farm, Lake Cumberland Computers, GGF Herritage Manufacturer, Image FX Salem, Hometown Tire, Houseboat Services, Hitachi Cable Inc., Frank's Home Improvement, Franklin Motors, On Eagle's Wings Books & Gifts, Cliffside on Cumberland Art Gallery, Bluegrass Flooring, Bruce North America, Courtesy Tiles Joe Pike, Tantus Tobacco, Alligator Inn

Taylor County - Fleetwood Trailers; Murakami Manufacturing USA, Campbellsville Handmade Cherry Furniture; B & W metals 2nd location; Midsouth Metals Incorporation; Tim Horton Camp Kentachten for Children and Adolescents; Airguard; Tuliptree, Amazon.com, Seamweavers; Autozone; Lowes in process of building; Holiday Express in process of building, Krystals, Campbellsville University Expansion, Campbellsville Apparel

Wayne County – Wal-Mart Super Center, Department of Justice Juvenile Detention Center

B. Update community indicators, prevalence rates and significant events, if applicable.

- No changes since initial report

C. Indicate any significant changes in dollar resources.

2003

- Department for Mental Health funded Community Mental Health Center for Adult Crisis Stabilization Unit
- Department for Mental Health Path Grant funded to Community Mental Health Center
- Tobacco Settlement Dollars funded Kentucky Agency for Substance Abuse Policy Clinton County Local Board
- Department Mental Health funded Community Mental Health Center additional Community Medication Program

- Kentucky Agency for Substance Abuse Policy funded Community Mental Health Center (Taylor County) Mini-Grant
- Department for Mental Health Jailers Training funded to Community Mental Health Center
- Community Mental Health Center receives Kentucky Housing Corporation funding for Tenant Based Rental Assistance Program
- Community Mental Health Center receives Kentucky Housing Corporation funding for Tenant Based Rental Assistance Program
- Department for Mental Health funded Community Mental Health Center for Peer Support Program
- Department for Mental Health funded Community Mental Health Center Housing Program Director
- Center for Substance Abuse Treatment (Women's Center) funding to Community Mental Health Center

2002:

- Department for Mental Health Jailers Training funded to Community Mental Health Center
- Increase in Kids Now Initiative funding to Community Mental Health Center allowing case management wraparound money for pregnant women
- Tobacco Settlement Dollars funded South Central Kentucky Agency for Substance Abuse Policy (Green)
- Department for Mental Health funded Community Mental Health Center Early Childhood Specialist
- Community Mental Health Center receives Kentucky Housing Corporation funding for Tenant Based Rental Assistance Program
- Department Mental Health funded Community Mental Health Center additional Community Medication Program
- Department for Mental Health funded Community Mental Health Center for Peer Support Program
- Department for Mental Health funded Community Mental Health Center Housing Program Director
- Center for Substance Abuse Treatment (Women's Center) funding to Community Mental Health Center
- Campbellsville/Taylor County Anti-Drug Coalition received funding from the Office of Juvenile Justice Delinquency and Prevention (OJJDP)
- Citizens United for a Drug-Free Green County received funding from the Tobacco Prevention Enhancement Site/Division of Substance Abuse
- Community Mental Health received funding for Baby's Sake Program from "KIDS NOW" through the Division of Substance

2001:

- Department for Mental Health funded Community Mental Health Center for Peer Support Program
- Department for Mental Health funded Community Mental Health Center additional Community Medication Program dollars
- US Department of Justice Drug Court Funding - Wayne, Russell & Clinton Counties Judicial System
- US Department of Justice - Juvenile Drug Court in Pulaski County
- Kentucky Legislative Action funded Lake Cumberland Child Advocacy Center through Commonwealth Attorney's Office
- Department of Education funded Pulaski County School Systems Wilderness Trail Grant
- Tobacco Settlement Dollars funded Lake Cumberland Kentucky Agency for Substance Abuse Policy (Adair, Cumberland, Pulaski & Wayne)
- Tobacco Settlement Dollars funded Central Kentucky Agency for Substance Abuse Policy (Taylor)
- Tobacco Settlement Dollars funded Community Mental Health Center "Kids Now" Substance Abuse Pregnancy Initiative
- Kentucky Housing Corporation funded Community Mental Health Center transitional housing duplex in Taylor/Adair County
- Department for Mental Health funded Community Mental Health Center additional Community Medication Program
- Department for Mental Health funded Community Mental Health Center Housing Program Director

- Center for Substance Abuse Treatment (Women's Center) funding to Community Mental Health Center

2000:

- Department for Mental Health funded Community Mental Health Center Housing Program Director
- Center for Substance Abuse Treatment (Women's Center) funding to Community Mental Health Center
- Division of Substance Abuse funded Community Mental Health Center Early Intervention Program (EIP)
- US Department of Justice funded Pulaski Juvenile Drug Court
- Department for Mental Health funded Community Mental Health Center additional Community Medication Program

III. Service System Description

A. What steps have been taken in addressing gaps in services?

2003:

- Community Mental Health Center Adult Crisis Stabilization Unit
- Community Mental Health Center Jailers Training
- Community Mental Health Center Intensive Substance Abuse Services for Adults in Adair County
- Community Mental Health Center Intensive Substance Abuse Services for Children in Adair County
- Community Mental Health Center received Paths Housing Grant
- National Alliance for the Mentally Ill involvement in Pulaski, Adair, Russell and Wayne counties
- Community Mental Health Center Early Intervention Program & Zero Tolerance
- Community Mental Health Center Peer Support Activities including Wellness Recovery Action Plan, Building Recovery of Individual Dreams and Goals through Education and Support, volunteers, state council and boards
- Adolescent substance abuse consortium
- Substance abuse coalition
- Participation in Interagency Council in Wayne County
- National Alliance for the Mentally Ill involvement in Pulaski, Adair, Russell and Wayne counties
- Advocacy/Recovery group meeting
- Local Resource Coordinator meeting monthly with IMPACT Plus group
- Parent & Impact involvement in Wilderness Trail Special Education Institute
- Community Mental Health Center conducts quarterly meeting with Regional Department for Community Based Services leadership
- Outreach efforts by Early Childhood Mental Health Specialist
- Development and planned implementation of day care located within outpatient clinical site
- Renewal of contracts with schools to provide school based psychiatric and substance abuse services
- Dr. Mark Hyatt, Medical Director – Formulary Committee
- Rape Victims Services Public Awareness, health fairs, public announcement set-ups, sexual assault awareness, domestic violence awareness
- Rape Victim Services support groups at Lindsey Wilson College
- Friends of Kentucky Families
- Advocacy/Recovery group meeting
- South Central Drug and Alcohol Counseling, Adair County and Taylor County
- Central Kentucky Drug and Alcohol Testing

2002:

- Renewal of contracts with schools to provide school-based psychiatric and substance abuse services

- Community Mental Health Center Intensive Outpatient Substance Abuse Services for Adults in Wayne County
- Westlake Cumberland Hospital, Geriatric Intensive Outpatient Program in Adair & Casey Counties
- Community Mental Health Center Early Intervention Program & Zero Tolerance
- Community Mental Health Center Adolescent Intensive Outpatient Programs for substance abuse in Adair County
- National Alliance for the Mentally Ill involvement in Pulaski, Adair, Russell and Wayne counties
- Parent & Impact involvement in Wilderness Trail Special Education Institute
- Local Resource Coordinator meeting monthly with IMPACT Plus group
- Community Mental Health Center marketing with ads
- Community Mental Health Center Public forums
- Advocacy/Recovery group meeting
- Community Mental Health Center conducts quarterly meetings with Regional Department for Community Based Services leadership
- Teen Challenge in Adair County
- Dr. Mark Hyatt, Medical Director – Formulary Committee
- Rape Victims Services Public Awareness, health fairs, public announcement set-ups, sexual assault awareness, domestic violence awareness
- Rape Victim Services support groups at Lindsey Wilson College
- Friends of Kentucky Families
- South Central Drug and Alcohol Counseling Adair County and Taylor County
- Central Kentucky Drug and Alcohol Testing

2001:

- Community Mental Health Center marketing with ads
- Community Mental Health Center public forums
- Meetings with faith-based organizations – Jan Fletcher “Teen Challenge,” Matthew 25 Jubilee Center
- Advocacy/Recovery group meeting
- Community Mental Health Center conducts quarterly meeting with Regional Department for Community Based Services leadership
- Women’s Recovery Center in Taylor, Green & Adair Counties
- South Central Drug & Alcohol Counseling
- Central Kentucky Drug Testing
- Community Mental Health Center Early Intervention Program & Zero Tolerance
- Friends of Kentucky Families

2000:

- Cumberland County Hospital, Structured Out-patient
- Community Mental Health Center received funding for two transitional duplexes and Tenant Based Rental Assistance Program
- Domestic violence groups meet quarterly
- IMPACT/Education system Reciprocal Training
- Participation of Community Mental Health Center staff on Targeted Assessment Program advisory
- Community Mental Health Center Early Intervention Program & Zero Tolerance

B. What is the current status of the “safety net” in your region?

- **Regional CMHC Flat funding reduces services, “DO MORE WITH LESS!”**
- Medicaid funding not utilizing trended index for the last three years
- No cost of living increase

C. What is the current status of services for children and youth?

- No psychiatric beds in region for children
- Department for Community Based Services training for foster parents for prevention & early intervention
- Community Mental Health Center school based services able to provide no cost services to family where contracts are in place
- Enforcement of waiver restricting autistic children from medical coverage
- Department for Community Based Services increase funding for foster parents
- Community Mental Health Center conducts on-going meetings between children and adult case managers to focus on transitioning youth
- Community Mental Health Center Intensive Outpatient Program for children
- Zero Tolerance
- Community Mental Health Center received funding to employ Early Intervention Specialist
- Community Mental Health Center providing childcare at Taylor Women's Recovery Center for participants seeking substance abuse services

D. What is the current status of repeated referrals (revolving door cases)?

- **Eastern State Hospital continuum of care meeting with Community Mental Health Center staff**
- Community Mental Health Center established liaison with Jane Todd Crawford Hospital (20 psychiatric beds)

E. What is the current status of services for the elderly?

- Community Mental Health Center opened Adult Day Health Care programs:
 - Wayne opened August 26, 2002
 - Russell opened January 15, 2001
 - Cumberland opened August 6, 2000
 - McCreary opened February 1, 2000
 - Green opened January 28, 2000
- Recent legislation has changed eligibility standards for Adult Day Health Care, which will force many elderly, who no longer qualify for Adult Day Health Care, to not have adequate care

F. What changes, if any, have you seen in coordination and collaboration across systems and between organizations in your region?

- Community Mental Health Center provided Jailers Training
- Since Community Mental Health Care Jail training, McCreary County Jail contacted Community Mental Health Care for discussion of contract
- Community Mental Health Care is processing Memorandum of Agreement with Eastern State Hospital
- Taylor County Government, Center for Substance Abuse Treatment project
- Community Mental Health Center agreement with Jane Todd Memorial Hospital
- Community Mental Health Center meeting with leadership of local hospitals, Jane Todd Memorial Hospital and Lake Cumberland Hospital
- Kentucky Agency for Substance Abuse Policy
- National Alliance for the Mentally Ill – Community meetings with cross section of providers
- Peer Support Program – Kentucky Consumer Advocate Network, Protection and Advocacy for Individuals with Mental Illness Methodist Church
- Division of Substance Abuse Recovery Support Program
- Community Mental Health Center established collaboration with Jubilee ministries in Campbellsville, which is a faith-based ministry

- Substance Abuse Program Directors Taskforce meetings to address service delivery and referrals across systems
- Impact Plus sub-providers meetings
- Adolescent consortium meetings
- Wilderness Trail Grant funded to Community Mental Health Center
- Taylor County Government received funds from the American Bar Association Mini-Grant for Women's Substance Abuse Treatment
- Local Resource Coordinators monthly meetings with IMPACT Plus group
- Community Mental Health Center participating in Interagency Council meetings
- Parent & Impact involvement in Wilderness Trail Special Education Institute
- IMPACT/Education system Reciprocal Training
- Community Mental Health Center quarterly meeting with Regional Department for Community Based Services leadership
- Community Mental Health Center outreach efforts by Early Childhood Mental Health Specialist
- Community Mental Health Center developed and currently planning implementation of day care located within the Women's Recovery Center
- Community Mental Health Center renewal of contracts with schools to provide school-based psychiatric services
- Participation of Community Mental Health Center staff on Pulaski County Target Assessment Project advisory committee
- Community Mental Health Center meetings with district judges in Taylor and Adair County in planning a drug court in those counties
- Rape Victim Services contract with Child Advocacy Center for Mental Health Screening
- Rape Victim Services meeting with all regional hospitals for services to sexual assault victims

IV. Strategies to Increase Access to Community-Based Services

A. What changes, if any, have there been in access to community-based services?

- Community Mental Health Center diversion of children served by Department for Juvenile Justice in Adair County
- Community Mental Health Center provided Jail Trainings in recognizing mental health and substance problems and accessing treatment
- Pulaski County organizational meeting for establishing NAMI meetings
- Substance Abuse adolescent consortium meetings to coordinate and update resources available throughout the region
- Community Mental Health Center has regular meetings with Department for Community Based Services
- Support groups for Severely Mentally Ill consumers, facilitated by trained consumers
- National Alliance for the Mentally Ill information, education, and support groups for families
- IMPACT staff providing informational luncheons to school system staff across region
- Begin Substance Abuse Intensive Outpatient Programs in Adair & Wayne counties
- Community Mental Health Center has increased public awareness of services offered through public announcements, public forums, newspaper ads and community meetings
- "Kids Now" Initiative
- Community Mental Health Center Women's Recovery Center
- Child Advocacy Center
- Neighborhood Network provided by Pulaski County Housing Authority
- Tenant Based Rental Assistance

B. Has consumers' access to medications changed? If so, how?

- Medication Algorithm for Zyprexa
- Pre-authorizations of several medications now required
- Reduction in Medicaid eligibility
- Consumer voiced concern about new Medicaid co-pay

C. What changes have occurred, if any, with regard to the availability and utilization of support groups?

- Mental Health peer support groups
- Alcohol Anonymous and Narcotics Anonymous groups have increased throughout the region
- Foster Families Support Group
- Grandparents Support Group
- Family Survivors of Suicide
- Suicide Prevention and Survivor Support Group
- Russell County Singles Group
- Reduction in availability of Parent Advocate due to funding
- Grandparent Support Group in Pulaski
- Sexual Abuse Survivor's Group
- Couple's Support Group
- Pulaski County Singles Group

D. How has your region attempted to reduce criminalization of persons with MH or SA disorders?

- Community Mental Health Center Round Table meeting, June 20, 2003
- Community Mental Health Center Jail Training, Spring of 2003
- Community Mental Health Center has annual contract with three county jails for MH services
- Community Mental Health Center has ongoing local contact with criminal justice system (202A, 202B, 645, 504, court request for information, testimony)
- Drug courts
- Zero Tolerance

E. Please describe the relationship of the CMHC with the jails in your region, including the status of jailer training.

- Three contracts with the local jails (Adair, Casey and McCreary counties)
- Jailer Trainings were conducted in counties where jails are located in the region.
- Jailers Trainings were conducted:
February 13, 2003—Adair County
February 17, 2003—Casey County
February 20, 2003—Wayne County
March 6, 2003—Russell County
March 10, 2003—Clinton County
March 17, 2003—McCreary County
March 21, 2003—Pulaski County
Cumberland, Green and Taylor Counties were invited to the February 13 training
- Community Mental Health Center has ongoing contact with judicial system
- Drug Courts in Wayne, Clinton & Russell counties
- A drug court is being developed in Taylor & Adair counties

F. Have there been changes in addressing access to services for the elderly and for individuals with disabilities such as deafness, physical restrictions, etc?

- Community Mental Health Center has Deaf and Hard of Hearing Process in all ten counties
- Adult Day Health Care programs closing in region due to new eligibility requirements
- Community Mental Health Center has opened five Adult Day Health Care Programs and several others have opened within the region
- Community Mental Health Center conducted public forums to address needs for the elderly at the regional Aging Coalition meeting

- Community Mental Health Center Medical Director, Dr. Mark Hyatt, conducted Public Forum Overmedication of the Elderly

G. How has your region attempted to address cultural/ethnic/racial aspects of awareness, access and utilization of services?

- **Community Mental Health Center's Public Forums**
- Ongoing cultural/ethnic/racial trainings of Community Mental Health Center staff
- Community Mental Health Center Training of Trainers staff
- Community Mental Health Center submitted a performance improvement Substance Abuse Mental Health Services Administration grant and a Paths to Recovery Grant which would address some of these issues
- Community Mental Health Center developed a list of Spanish interpreters and deaf interpreters to utilize and be sensitive to the needs of this special population
- Community Mental Health Center increased marketing of services to all populations
- IMPACT staff focus on schools
- Fair Housing Training
- Educational substance abuse materials in Spanish
- Training provided for healthcare workers in Russell County

H. If your region received funding for a CSU as a result of action during the 2002 General Assembly, describe your current activities and the status of implementing that service/facility.

- I. The Community Mental Health Center has submitted the organization's Request For Proposal outlining the proposed Crisis Stabilization Unit

V. Quality Assurance and Consumer Satisfaction

What changes, if any, have been made to address quality assurance and consumer satisfaction in your region?

- Community Mental Health Center expanded Quality Improvement Office by hiring a full-time director
- Community Mental Health Center submitted Performance Improvement Grant to Substance Abuse Mental Health Services Administration
- Community Mental Health Center submitted Performance Improvement Grant to Robert Wood Johnson Foundation
- Regional Victim Services added consumer satisfaction survey
- Community Mental Health Center involvement of consumers in the Annual Plan and Budget Process for FY03 and FY04
- Regular feedback from Department for Community Based Services staff related to Community Mental Health Center residential services
- Participation of Community Mental Health Center residential staff in developing residential monitoring standards

VI. Behavioral Health Goals

A. Briefly describe the top goals set by your Regional Planning Council for the initial 2001-2003 time period.

- **Meet quarterly for updates and information sessions**
- **Review workgroup minutes and reports and provide input**
- **Monitor work of the Commission and workgroups to ensure continued bottom-up approach**

C. What progress has been made toward achieving these short-term goals?

- **Achievement of short-term goals**

D. What longer-term goals were set by your Regional Planning Council?

Goal 1: Increase access to services by increasing transportation opportunities.

- Goal 2:** Increase the availability of mental health and substance abuse treatment professionals in our region.
- Goal 3:** Decrease the number of individuals who are referred to other regions and other states for residential substance abuse treatment services, and increase the number of individuals who receive more appropriate levels of care locally.
- Goal 4:** Develop/increase the availability of transitional services and supports for adolescents, especially those turning 18 years of age, who will no longer be eligible for many services.
- Goal 5:** Establish an Adult Crisis Stabilization Program.
- Goal 6:** Increase public awareness of mental health and substance abuse needs and existing array of services in the community, and encourage proactive involvement to promote advocacy and support for consumers and their families, to reduce stigma, and to empower consumers and their families.
- Goal 7:** Increase access to supports and services that promote independent living.

E. What progress has been made toward achieving these longer-term goals?

Goal 1:

- Partially achieved through Legislative changes regarding transportation of minors and those who need an escort
- Community Mental Health Center received funding from Center for Substance Abuse Treatment to purchase a 15-passenger van for use at the Women's Recovery Center
- 72-Hour Medicaid transportation rule creates a barrier to access

Goal 2:

- Kentucky Association Regional Programs conducted a Statewide Survey regarding each mental health salary and benefits package
- TRAINING PROGRAMS
 - University of Kentucky offering MSW program in London, Kentucky
 - Somerset Community College and Lindsey Wilson College offering 2+2 Human Service degree
 - Lindsey Wilson College offering Master's in Human Services
 - Eastern Kentucky University offering Master's in Counseling
- Community Mental Health Center began a mentoring program for Substance Abuse therapists to become certified
- Community Mental Health Center is a practicum placement site for Campbellsville University, Lindsey Wilson College, Eastern Kentucky University, University of Kentucky, Spalding University, Western Kentucky University and University of Louisville.

Goal 3:

- Established a relationship with Jubilee Ministries, a faith-based organization with multiple resources
- Residential treatment program in region not established

- Community Mental Health Center has established a Substance Abuse Intensive Outpatient Service in Adair County for adults and adolescents
- Adult Crisis Stabilization

Goal 4:

- Community Mental Health Center established a youth day treatment program in Wayne county
- Community Mental Health Center working with Vocational Rehabilitation in career retraining, job placement and supportive employment
- Community Mental Health Center working with Kentucky Housing Authority in development of two transitional duplexes and 11 Tenant Based Rental Assistance slots
- Kentucky Children's Health Insurance Program
- Somerset Housing Authority Neighborhood Network
- Department for Community Based Services contracts yearly with an Independent Living Coordinator to provide Independent Living Skills Training to children age 16 to 18 in DCBS foster homes
- Department for Community Based Services contracts with Private Child Care Providers to provide independent living skills training to committed children in PCC placements
- Department for Community Based Services contracted with Kentucky Baptist Home for Children in the Lake Cumberland Region to provide independent living skills training and two transitional apartments through their independent living program
- Department for Community Based Services foster parents receive training from the Independent Living Coordinator to provide soft skills in independent living to children age 12 and above in DCBS foster homes
- House Bills 62 and 202 passed in 2001 and 2002 provide tuition waiver for foster or Department for Juvenile Justice kids currently in care, who were on their 18th birth date, or are in an independent living program. This applies only to public postsecondary educational institutions

Goal 5:

- Community Mental Health Center submitted Request For Proposal for Crisis Stabilization Unit

Goal 6:

- Community Mental Health Center, Women's Recovery Center staff have presented at local businesses and clubs about services
- Regional Prevention Center provides educational services for families and community organizations
- Community Mental Health Center participated in May Mental Health Month
- Community Mental Health Centers conducted the following public forums:
 - Somerset Community College – Overcoming Stigma Associated Mental Illness & Substance Abuse
 - Campbellsville City Hall - Overcoming Stigma Associated Mental Illness & Substance Abuse
 - Meece Middle School - Overcoming Stigma Associated Mental Illness & Substance Abuse
 - Adair County School - Overcoming Stigma Associated Mental Illness & Substance Abuse
 - Russell Springs Aging Coalition – Over-Medication of the Elderly
 - Lindsay Wilson College, Columbia – Over-Medication of the Elderly
- Ongoing newspaper ads, public announcements, health fairs, etc.
- Community Mental Health Center involved consumers in developing the annual plan and budget, received invitations to board meetings and to annual quality improvement conferences
- Mental Health parity was achieved
- Community Mental Health Center has increased marketing efforts to inform public of services offered
- Community Mental Health Center conducted training for law enforcement and jail staff in recognizing mental illness and substance abuse issues
- Community Mental Health Center was awarded funding from Kentucky Housing Corporation to develop two transitional housing duplexes to address housing needs of MH/SA clients

- Community Mental Health Center was awarded funding from Kentucky Housing Corporation for Tenant Based Rental Assistance
- Advocacy with consumers, council members and board members

Goal 7:

- Community Mental Health Center working with Vocational Rehabilitation
- Tenant Based Rental Assistance – 11 slots
- Community Mental Health Center received Projects for Assistance in Transition from Homeless grant to employ housing support specialist
- Community Mental Health Center Women's Recovery Center offers childcare for women in Substance Abuse treatment

Implications

A. How have your funding needs changed?

- Establish funding for Community Mental Health Center Women's Recovery Center
- **Increase in need for more indigent care funding because the ability to pay and third-party payers have decreased due to economic changes within the community and managed care**
- **Community Support dollars decreased**
- **Substance Abuse dollars decreased**
- **Consistent flat funding creates undue hardship on current and new programs, necessitating measures to offset lack of funding, such as:**
 - **Increase in Community Mental Health Center sliding fee scale and Substance Abuse treatment rates to offset shortfall in revenue**
 - Increase Adult Day Health Care self-pay rates to offset costs incurred to operate program and, hopefully, eliminate the possibility of closing much-needed programs for the elderly

B. What public policy changes are needed to further your objectives?

Goal 1: Increase access to services by increasing transportation opportunities.

Objective 1A: Develop a medical transportation system for psychiatric patients and reduce incidence of law enforcement transportation to and from state hospitals.

- Review KRS Chapter 202A to re-evaluate more appropriate transportation
- Allow substance-abusing clients to receive Medicaid vouchers to treatment

Objective 1B: Establish a hotline and emergency transportation system.

- Evaluate the Medicaid 72-hour rule to allow for emergency transportation

Objective 1C: Create client access to drivers education programs in order to increase the number of clients who have a valid Kentucky driver's license.

- Change billing policies where therapeutic rehabilitations programs could include driver's education as a billable service

Objective 1D: Establish a program to subsidize/assist needy individuals to lease/purchase a vehicle.

- Ask KARP to survey other states for public policy innovative programs

Objective 1E: Modify existing Medicaid transportation policies to allow for more flexibility in time allotments for notification of transportation needs.

- Review regulations related to Medicaid 72-hour required notification

Goal 2: Increase the availability of mental health and substance abuse treatment professionals in our region.

Objective 2A: Provide competitive salaries in order to recruit professionals to this region.

- Clearinghouse established at the state level to identify salary trends in the social services area

Objective 2B: Advocate for the development of incentive programs for behavioral health practitioners who choose to practice in a rural area. (Example: programs similar to those offered for medical professionals such as student loan debt forgiveness)

- Program already in place – Public Child Welfare Program (PCWCP) pays for tuition for students entering into social services within DCBS

Objective 2C: Increase the number of off-campus education/degree program opportunities, so that more local providers can complete their degrees while continuing to work.

- Local colleges and universities have made significant strides in addressing the needs by offering diverse education systems including:
 - University of Kentucky offering MSW program in London, Kentucky
 - Somerset Community College and Lindsey Wilson College offering 2+2 Human Service degree
 - Lindsey Wilson College offering Master's in Human Services
 - Eastern Kentucky University offering Master's in Counseling

Objective 2D: Advocate for and work with universities to develop resident/intern/practicum network for behavioral health students in our region.

- Practicum work to be counted as work experience

Goal 3: Decrease the number of individuals who are referred to other regions and other states for residential substance abuse treatment services, and increase the number of individuals who receive more appropriate levels of care locally.

Objective 3A: Work with the faith community to help individual's access the residential treatment services they have to offer.

- This issue does not need to be addressed through policy change

Objective 3B: Develop a residential treatment program for women that will allow them to keep their children with them while they are in treatment.

- Policy to subsidize treatment

Objective 3C: Develop residential treatment programs and non-medical detoxification program in our region, to serve adults (male and female) and adolescents (male and female) who have substance use disorders.

- Policy to subsidize treatment
- Provide access to Medicaid funded substance abuse treatment for adults

Goal 4: Develop/increase the availability of transitional services and supports for adolescents, especially those turning 18 years of age, who will no longer be eligible for many services.

Objective 4A: Increase the number of day-treatment programs in our region.

- Educational systems need continued education and information on how emotional/psychiatric disturbances impeded the learning environment and children. There continues to be lack of understanding on children's issues. Incentive for schools to develop true partnerships.
- Increase the number of day treatment programs in our region to serve adolescents who cannot maintain their behavior in a regular classroom setting.

Objective 4B: Increase career development/job placement opportunities.

- Youth Service Center does not always effectively work with the local mental health systems, again incentives for these collaborations
- This goal could possibly be achieved through collaboration with vocational rehabilitation and employment services agencies, could possibly require additional funding

Objective 4C: Establish independent/transitional living program.

- Funding

Objective 4D: Advocate for the "\$ to follow the child".

- This should be utilized for the most severe children in the same way Supportive Community Living slots are utilized

Objective 4E: Establish tuition assistance programs.

- Funding

Objective 4F: Provide funds/supports for them to obtain medical and dental services.

- Continuation of Kentucky Medicaid Assistance Program for foster children and those in poverty until age 25

Objective 4G: Provide transportation assistance as indicated in Goal 1.

- Donation of vehicles, i.e., state fleet cars to transitional youth. Insurance assistance, reinstatement of drivers education classes within schools, See 4F

Objective 4H: Develop a mentoring program to provide opportunities for youth that are doing well to help others.

- Funding. Americorps type activity

Goal 5: Establish an Adult Crisis Stabilization Program.

Objective 5A: Establish a program that operates 24 hours per day, seven days per week.

- This objective has been addressed through legislative action

Objective 5B: Develop the program to accommodate women and their children.

- Does not require a policy change

Objective 5C: Incorporate a peer support/peer follow-up program for consumers and family members.

- This objective would not require a policy change

Objective 5D: Provide education, crisis intervention-physical management-de-escalation training for law enforcement personnel.

- Legislative policy changes have enabled this to happen for jail personnel, should expand to include all of law enforcement

Goal 6: Increase public awareness of mental health and substance abuse needs and existing array of services in the community, and encourage proactive involvement to promote advocacy and support for consumers and their families, to reduce stigma, and to empower consumers and their families.

Objective 6A: Establish a region-wide clearinghouse on mental health and substance abuse supports and services.

- At the State level, significant efforts to improve access has been made, such as the Division of Substance Abuse now has a web site with current treatment facilities in the state that would include the Lake Cumberland Region.

Objective 6B: Encourage more involvement by the Faith community by sponsoring a conference where mental health professionals and pastors can network together more effectively.

- This objective does not require a policy change

Objective 6C: Develop a "How-to Booklet" for local education systems to implement school-based supportive and preventive mental health and substance abuse supportive programs.

- Partially achieved with KY-ASAP walkthrough of prevention services, Division of Substance Abuse working on a similar walkthrough for treatment of substance abuse, NAMI has also worked on this some for mental health issues

Objective 6D: Develop Peer support programs for consumers and their families.

- This objective does not require a policy change

Objective 6E: Provide community education via an annual conference for consumers, families, providers and community organizations, and other community support systems.

- This objective does not require a policy change

Objective 6F: Increase consumer and family-member participation in mental illness services planning at the local, state and federal level.

- No policy change required, currently individuals are involved within our region

Objective 6G: Promote equitable healthcare coverage-parity by advocating for public and private health insurance plans to provide treatment for the mentally ill and those with substance use disorders in a manner that is equal and commensurate with that provided for other major physical illnesses.

- Already addressed through passage of parity

Objective 6H: Increase access to community based treatment.

- Does not require a policy change

Objective 6I: Promote the development of and education about work incentives for persons with severe mental illnesses.

- Educate consumers and staff about Ticket To Work Program

Objective 6J: Promote reduction in the use of harmful actions-restraint measures.

- Education for staff, consumers and family members on Advance Mental Health Directives

Objective 6K: Provide specialized training for police and probation officers, promote the development of mental health courts, and establish medical transportation services for psychiatric hospitalization.

- No policy changes, already addressed in Objective 5D and Objectives 1A and 1B

Objective 6L: Promote the development of a housing assistance program to assist persons with severe mental illness and substance use disorders in accessing safe, decent, affordable housing.

- State funded housing policy changes in relation to felony charges (the type of crime)

Objective 6M: Advocate for the development of an adequately funded treatment system to meet the needs of children, youth and their families, including the prevention of custody relinquishment solely to access treatment.

- Does not require a policy change

Objective 6N: Advocate for changes that promote the right to Advance Directive, allowing individuals with mental illness freedom of choice to outline a plan of care during a time of wellness, that specifies the care they want to receive in the event hospitalization is necessary.

- Legislative policy has addressed this issue, implemented policy established by HB99

Goal 7: Increase access to supports and services that promote independent living.

Objective 7A: Increase funding to support the provision of affordable medication, medical care and dental care for those who cannot afford to pay.

- Re-evaluate Medicaid co-pay for medications

Objective 7B: Provide more pre-employment skills training so that those attempting to reenter the workplace post treatment have access to such training.

- This objective partially addressed through Ticket To Work and Vocational Rehabilitation efforts

Objective 7C: Increase the number of subsidized housing units and case managers.

- Evaluate current admission criteria for public housing (current felony charges)

Objective 7D: Develop transitional housing in each county for consumers who are recovering.

- Evaluate current admission criteria for public housing (current felony charges)

Objective 7E: Provide on-site childcare services for consumers in treatment.

- Advocate for funding subsidies for childcare services for consumers in treatment

C. What further recommendations (or changes in past recommendations) need to be made at this time?

- Review KRS 202A for consideration for possible revision in reference to individuals under the influence of a substance
- Community Mental Health Center recommends line item budget for Women's Recovery Center

On-Going Process and Activities

HB 194 (2003GA) extends the HB 843 process at both the Statewide Commission and the local Regional Planning Council levels, with some specificity of functions having been added. For instance, the Regional Planning Council are now required to submit an updated report every two years, with the report being due on July 1st of the odd-numbered years.

A. What process have you used or will you use to add new members to your HB 843 Regional Planning Council?

- Mailed letters on June 10, 2002 to charter members of the Lake Cumberland Regional Planning Council to determine continued interest in participating on the Council. Interested members in remaining a part of the council submitted their responses. Members who did not want to continue as part of the council were asked to nominate someone to represent their particular category.
- Council members recruiting others
- Public Announcements
- Letters
- Phone Calls

H. What activities do you anticipate your Regional Planning Council will be involved in over the next two years?

- Regular scheduled quarterly meetings
- Meetings with legislators
- Evaluate progress being made
- Representation at Statewide Committee meetings to bring information back to the Council
- Review and possibly revise goals
- Share Statewide meeting minutes with the Council

- Review workgroup reports and give feedback to the Commission
- Network with other Regional Planning Councils

I. Under HB 194, the Regional Planning Councils have a role in reviewing Recommendations made by the Work Groups and giving feedback to the HB843 Statewide Commission before those recommendations are acted on by the commission. Given the short time-line (see attached), how will your Regional Planning Council carry out that function expeditiously?

- Mailings to all members when the reports are received
- Meet to discuss recommendations
- Provide feedback to Statewide Commission