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LEGISLATIVE RESEARCH COMMISSION

State Capitol

700 Capital Avenue

Frankfort KY 40601

502/564-8100

Capitol FAX 502-223-5094

Annex FAX 502-564-6543

lrc.ky.gov

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Director

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September 30, 2005

The Honorable Ernie Fletcher, M.D.
Governor of the Commonwealth of Kentucky

Members of the Kentucky General Assembly

Dear Governor Fletcher and Members of the General Assembly;

We are pleased to present you with the 2005 annual report of the Kentucky Commission on Services and Supports for Individuals with Mental Illness, Alcohol and Other Drug Abuse Disorders, and Dual Diagnosis as required in KRS 210.504(8).

This report highlights the activities over the past year of the Commission, its 14 Regional Planning Councils and related workgroups. In particular, the report illustrates the Commission's commitment to the collaborative nature of its work and continued efforts to improve the quality, availability and delivery of services to citizens whose lives are affected by mental illness, substance abuse disorders or both.

Your commitment to individuals who are affected by mental illness and substance abuse has allowed our Commonwealth to take some steps forward in planning and implementation, despite times of financial hardship.

We are appreciative of the continued support and leadership we have received from you, Governor, and the members of the Kentucky General Assembly. We are also grateful for the leadership of the Regional Mental Health/Mental Retardation Boards and the participation of hundreds of committed consumers, family members, citizens, advocates, service providers and community leaders across Kentucky who are participating on the Regional Planning Councils.

On behalf of all Commission members and the citizens of the Commonwealth, we ask for your continued support of this important work. If you have questions or would like additional information about the Commission or any of the activities described in the report, please do not hesitate to contact us.

Sincerely,

Secretary James Holsinger
Co-Chair

Representative Mary Lou Marzian
Co-Chair

**HB 843 COMMISSION ON SERVICES AND SUPPORTS FOR INDIVIDUALS
WITH MENTAL ILLNESS, ALCOHOL AND OTHER DRUG ABUSE DISORDERS
AND DUAL DIAGNOSES
Annual Update
October 1, 2005**

The primary vehicle of the Commission’s work is its Plan, “Template for Change,” which is reviewed and updated annually using the reports of the Commission’s Regional Planning Councils and Workgroups. The annual update is sent to the Governor and Members of the General Assembly on October 1st.

Regional Planning Councils meet as needed, but are required to make recommendations to the Commission on July 1st of each odd-numbered year. Regional Planning Council Reports for 2005 are attached; these reports update activities and recommendations since 2003.

Meeting Date	Agenda	Actions
<p>December 9, 2004</p>	<p><u>Meeting</u></p> <p>Major Topic: Medicaid Modernization</p> <ul style="list-style-type: none"> • Division of Mental Health and Substance Abuse Reorganization and Vision • Review Hospital Merger Proposal • Office of Drug Control Policy • Jail Triage Update • Pre-filed Legislation regarding Behavioral Health and Substance Abuse 	<p>The Vision of the Division of MHSA will utilize Best Practices when administering services to provide the best possible outcomes. The Department is also focusing on improving the QA process to ensure overall quality for consumers by measuring the provided services they receive.</p> <p>The initial Concept paper merging Eastern State Hospital and Central State Hospital will not be adopted but dialogue between the Cabinet for Health Services and the HB 843 Commission will continue to evaluate recommendations until a suitable plan is developed.</p> <p>The Kentucky Jail Mental Health Crisis Network consists of four Program Components:</p> <ul style="list-style-type: none"> ➤ Standardized Screening Tools; ➤ Telephonic Triage by Qualified Mental Health Professionals; ➤ Follow up consultation by regional CMHC’s for those in acute distress and; ➤ Data Collection <p>The HB 843 Commission will continue to monitor the success of the Jail Triage Initiative.</p>

<p>June 22, 2005</p>	<p><u>Meeting</u></p> <p>Major Topic: Serving Transition Age Youth</p> <ul style="list-style-type: none"> • Designate a DCBS representative to serve as a member of the HB 843 Commission • SJR 94 – Expanding Community Based Services • Access to Medications and Medicare Part D • Kentucky Suicide Prevention Annual Report to Commission • Public Education Workgroup • Kentucky Suicide Prevention Planning Group 	<p>Secretary Holsinger named Commissioner Tom Emberton, Jr. to serve on the HB 843 Commission and represent the Department of Community Based Services.</p> <p>SJR 94 sponsored by Senator Borders urges the Cabinet for Health and Family Services to implement best practices and to enhance the availability and access to community-based services for individuals with mental illness and substance abuse disorders. The Kentucky Medicaid program is involved in Medicaid modernization and in conjunction with Mental Health and Mental Retardation Services has a joint interest in a service delivery system that supports consumer-driven health care and empowers participants to be informed in health care decisions.</p> <p>Regional Planning Councils make recommendations and prepare reports that are due to the Commission July 1, 2005.</p> <p>The Regional Planning Councils will present regional priorities and recommendations as illustrated in their reports to the HB 843 Commission at a future meeting.</p> <p>HB 843 Commission Public Education Workgroup distributed the Media Guide they developed.</p> <p>Kentucky Suicide Prevention Group submitted their Annual Report to the Commission.</p> <ul style="list-style-type: none"> ➤ The group has 150 active members; ➤ 80 QPR Gatekeeper Trainers; ➤ Four existing local suicide prevention groups and two under development; ➤ 4000 Information Packets have been distributed throughout the state;
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		<p>➤ A four day state-wide suicide prevention conference will be held in September.</p>
<p>September 28, 2005</p>	<p><u>Meeting</u></p> <p>Major Topic: Regional Planning Council Reports</p> <ul style="list-style-type: none"> • Jail Triage Update • Medicaid 1115 Waiver: Focus on MH/SA • Public Comments • Annual Report Approval • Two Year Plan Discussion 	<p>Wanda Bolze' reviewed the history and functioning of the Regional Planning Councils and summarized the major themes found in the updated reports which were distributed to Commission members. The Commission will discuss the primary needs identified in the reports at the January Meeting.</p> <p>Connie Milligan updated the Commission on the status of the Jail Mental Health Crisis Network. Currently, 64 jails are participating out of 83 total jails. Since the program began on 9-1-04 there have been a total of 5,244 mental health contacts through the triage service. There has been a reduction in suicides at the participating jails since the program began. The Community Mental Health Centers have been instrumental in the success of the program. Their staffs have been available to work in collaboration with jail personnel to ensure that the frontline personnel are trained to recognize mental health needs. However, they expect to see a shortfall in funding to the CMHC's for the services they are providing; this needs further discussion. Senator Dan Kelly suggested that the judges and prosecutors also be educated about the program and have access to the mental health screening assessment training.</p> <p>Shannon Turner gave an overview of the goals and concept associated with the Medicaid 1115 Waiver. Its purpose is not to correct the base funding problem but to control the overall growth of Medicaid as we go forward. Two central goals are to stretch the available resources and to encourage Medicaid members to take more responsibility of their</p>

own healthcare needs. The waiver would allow more flexibility in providing Substance Abuse services that are not currently covered by Medicaid when funding becomes available in the future. Also being considered is the potential for Medicaid to become a secondary payor if an individual has other health insurance coverage available. It may be more cost effective for Medicaid to pay those premiums. The waiver would also allow the 14 CMHC regions the chance to design the system to meet some of the specific needs of their region and cut costs allocated for a service that is not needed in the region. Medicaid will continue to administer the program internally.

Several audience members addressed the commission members with specific concerns on various topics and notified members of upcoming events.

Carl Boes (KARP) gave an update and report on the response to Hurricane Katrina by the CMHC's. To date, the CMHC's have provided 43 crisis counselors in this effort. The CMHC staff are also doing interventions with some of the crisis personnel who were deployed to the effected areas to provide help.

A meeting was proposed for December 2005 to discuss pre-filed legislation and to review funding and budgetary issues prior to the General Assembly. A January 2006 meeting was proposed as a forum to hear from the 14 Regional Planning Council's with priorities and concerns specific to each of their regions. This information will be included in the Commission's two year plan.

**HB 843 COMMISSION ON SERVICES AND SUPPORTS FOR INDIVIDUALS
WITH MENTAL ILLNESS, ALCOHOL AND OTHER DRUG ABUSE DISORDERS
AND DUAL DIAGNOSES
SUMMARY OF COMMISSION DUTIES**

The KY Commission on Services and Supports for Individuals with Mental Illness, Alcohol and other Drug Abuse Disorders and Dual Diagnoses shall **assess**:

- The needs of individuals with MI, SA and dual diagnoses statewide;
- The existing delivery system, gaps in services and adequacy of the safety net system;
- The coordination and collaboration between public and private entities, including the Council on Postsecondary Education on workforce issues, and roles of the DMHMRS and the regional community mental health centers, state hospitals, and other providers;

The commission shall **identify**:

- Funding needs, including Medicaid, limitations under government programs and private insurance, and adequacy of indigent care;

The commission shall **recommend**:

- Programs for providing MH/SA services and preventive education to children and youth;
- Ways to decrease repeated arrests, incarceration, and multiple hospitalizations of individuals with MI, SA and dual diagnoses;
- Quality assurance and consumer satisfaction monitoring programs that include persons with MI, SA and dual diagnoses, family members, providers, and advocates.

The comprehensive state plan developed by the commission shall:

- Provide a template for decision-making regarding program development, funding, and use of state resources for delivery of the most effective continuum of services in integrated statewide settings appropriate to the needs of the individual with mental illness, alcohol and other drug abuse disorders, and dual diagnoses.
- Include strategies for increasing public awareness and reducing stigma.
- Advise the Governor and the General Assembly concerning the needs and whether the recommendations should be by administrative regulations or by legislation.

**Four Rivers HB 843 Regional Planning Council
HB 843 Report – September, 2005**

I. Features of your Regional Planning Council (RPC)

The current members of the Region I Planning Council are as follows:

Donny Youngblood Probation and Parole	Lue Feiler Consumer Advocate	Jack Runyon Psychological Associates (local provider)
Vickie Williams Area Agency on Aging	Bill Stoner Lourdes Behavioral Health (local provider)	Jennifer Beck-Walker Purchase Area Development District
John Weyers Department for Juvenile Justice	Phyllis Youngblood Family Advocate	Betty Shaw Department for Community Based Services-Family Support
Bill McMican Department for Community Based Services	Lane Bridwell Consumer Advocate	Charlie Ross Purchase District Health Department
Roger Thompson Christian Counseling Center (local provider)	Scott Johnston, Board Chairperson-Four Rivers Behavioral Health	Rickie Dublin Consumer Advocate

Planning Council has met on an as needed basis over the past two years. The Council has continued to discuss the needs of the community and possible solutions to those identified in the initial report completed in December 2000 and the subsequent report update in July 2003.

II. Describe Changes in Regional Needs, if applicable

Two prevailing issues related to economic development have impacted regional needs. The first issue relates to sustainable large employers in this region. There have been a number of closings related to major industries, i.e. the downsizing and closing of the United States Energy Commission’s Uranium Enrichment Plant, and General Tire, and the resulting ripple effect on related supportive industry. Workforce redevelopment has been a continuing effort to address the loss of these jobs and the healthcare benefits.

With a shift to attracting smaller service centered companies, and workforce reeducation efforts, the concurrent loss of health care benefits has had a ripple effect on the physical and behavioral health care providers. Hospital emergency departments are seeing a surge in the number of individuals presenting for primary care services. The Department for Public Health does not provide primary care services, except for prenatal care, and the local Family Free Clinics only serve the working poor. The Department for Public Health has also reported a dramatic increase (30%) in the WIC Program and in the use of its Home Health Care Service. The latter has been impacted by the loss of private providers, due to the changes in the Home and Community Based Waiver Program. The Department reports that their program is seriously underfunded as the “public safety net” for these services and they have a waiting list, which has resulted in persons moving to a higher level of care.

There has been a growth in the percentage of individuals who are over 60 years of age, with eight (reflecting the Area Development District) of the nine counties covered in this plan reporting the highest percentage of individuals to the total population of the region being the highest in the state of Kentucky. The percentage of individuals 60+ years to the total population of Kentucky is 16.65%. The percentage of individuals 60+ years to the total population of the Purchase Area Development District is 20.96%. Of these individuals, 39% are age 75 or older, 56% are residents of a county considered to be rural, 11% are low income, 4% belong to a minority group, and 1% are persons both low income and minority.

The increase in the use of Methamphetamine substances has impacted correction facility overcrowding, and an increase in referrals for out of home placements due to neglect issues, directly linked to the distribution of the drugs. There has been a decrease in arrests for home manufacturing of Methamphetamine, since the change in the law regarding the purchase of ephedrine products; however, this has opened a market for outside “drug labs” to provide a higher quality, more potent product. There has also been a report of a major increase in adolescents coming into the care of Protection and Permanency due to being “out of parental control”. There are currently four children in out of state care from this region, due to a lack of instate availability of residential treatment services.

III. Update Your Service System Description

The region has applied for a Recovery Kentucky grant through the Kentucky Housing Corporation with Four Rivers Behavioral Health as the sponsor. The application is for a 100-bed facility for men to serve the First Congressional District. The initial request for Federal Home Loan construction funding was denied, but will be reapplied for on September 1st. The Kentucky Housing Corporation application has been approved, but at less than the requested amount. This allocation is being reviewed in detail; in order to make a determination whether there are enough resources to go forward with the project. Unfortunately, construction costs are rising quite rapidly in the current economy. This region determined in the original report that a transition facility for women was needed and it appears that this may become available through the Recovery Kentucky project developed by the Pennyroyal Mental Health-Mental Retardation Board, which will serve 100 women from the First Congressional District.

Crisis Stabilization Services for both Adults and Children have been fully implemented since the last report. The Adult Crisis Unit is a residential program that has no diagnostic exclusion criteria. The Children’s Crisis Program is a combination of day programming and overnight therapeutic foster care, if needed. The majority of children have been able to have their needs met in the day program, and could be maintained in their living situation.

The Western Kentucky Regional Crisis Response Team continues to meet and work in Region I as a collaborative effort of behavioral health providers, public and private, along with police, fire, hospitals, schools and clergy. Of particular note is the inclusion of this group in the HRSA Bioterrorism Response Plan for Region I. The inclusion of a plan for behavioral health services during and after an event has received much support with this team being the lead entity in writing this part of the plan. There have been two exercises conducted in the region and the team has played an integral part. The team is sponsored by Four Rivers Behavioral Health.

Gaps in service remain in the area of substance abuse. The need for a medical detoxification service available to this area of the state has been articulated from the

beginning of this process. There is also a lack of availability of adolescent residential treatment for substance abuse issues.

The continued underfunding of essential services has also resulted in the closing of treatment locations in five of the counties serviced in this region. Four main service hubs have been established to meet the needs of the nine counties and every effort has been made to deliver services to the five counties through alternative methods. However, there is awareness that this does not replace immediate local access to all service populations, since the focus has remained on DMHMRS established “priority populations.”

Unfortunately, during this review period, the region has begun to see a shortage of clinical practitioners, in both the public and private sectors. Through retirement and/or relocation, the overall availability of clinical practitioners does not meet the need in Region I. Recruiting is a continuing process for all providers.

Services to the elderly continue to be a developing focus for this area. There is a very active Purchase Area Mental Health and Aging coalition, which consists of over 30 organizations that serve the needs of seniors. Four Rivers Behavioral health has recently submitted a grant request to fund the designing of a protocol to integrate primary care and behavioral health services to individuals 60 years of age or older. The Purchase Area on Aging Agency was a supporter of this funding request.

As was mentioned earlier, there has been a lessening in the accessibility and availability of home health services, resulting in more admissions to higher levels of care. Private and public providers provide behavioral health services to local nursing homes on a limited contractual basis. These contracts are limited by the nursing homes feeling their current rate of payment does not cover the full cost of providing the services themselves or through contracts. Referrals to inpatient psychiatric care are being increasingly requested.

The region has four operating KY-ASAP organizations. The Calloway county initiative has been functional for about three years and has been awarded a Drug Free Community grant, which was obtained by using a portion of the original ASAP grant as matching money. Marshall County was awarded a start-up grant last year and is now working on the implementation of its strategic plan. Two other counties are in the development phase, with their local school systems being the lead agencies.

Service providers in this region have many opportunities for cooperation, communication. For true collaboration, an integral planning process would need to include specific goals to foster an upward progression of service integration throughout the region and the state. The Planning Council restates its original belief that “any possible reallocation of resources at the Federal and State level that could bring more dollars to the local platform for direct service delivery is well warranted”.

IV. Regional Response to Recent Events/Influences

The region has one private hospital unit providing inpatient psychiatric services to the area. As a result, Western State Hospital is the public provider of these services and is the only state psychiatric facility that is not managed by private contract. The admissions are growing at about 10% per year overall; however, Region I has maintained the same average number of admissions for the past two years. The need for an accessible, regionally-based specialty care psychiatric facility that is integrated with community-based care throughout the western part of the state is critical to meeting the needs of individuals with severe, complex, and specialized clinical presentations. The ideal should have a truly linked technology to enhance the communication link with community providers. The focus of the service should be part of a disease management approach,

which is seamless with the system of community-based providers in the geographic district being served. The hospital is in need of replacement and reorganization to focus on a state of the art therapeutic environment and best practice treatment initiatives. A long-term commitment by the Commonwealth to provide this essential service in a manner that supports positive outcomes is long overdue.

With the implementation of the Medicaid Pharmacy Benefits Administrator, there has been an increase in the timeframe for a consumer to receive their medication, due to long periods for approval of prescribed medication. Consumers, both child and adult, have been denied medications as prescribed, and only through very time consuming efforts have approvals been obtained. The current procedures have not contributed to quality care when clinical specialists are challenged by individuals with less experience and qualifications for dealing with specialty populations. Advocacy efforts have been strenuous, and disease management protocols fought for with limited results. There appears to be a lack of uniformity in process and protocols that contributes to the problem. Unfortunately, the individual consumer is the one who loses.

The implementation of the Jail Triage Program has been smooth in this region. As of August 2005 all jails in Region I are participating and have been trained in the model. Reduction in the literal and conceptual “criminalization of mental illness” has been an area of substantial success during this current reporting cycle. Initiatives with law enforcement include an annual update-training event and ongoing contacts between the legal system and the Qualified Mental Health Professionals who conduct the evaluations under this law. The net result is the lowest rate for involuntary commitments in this hospital district.

As previously reported the Adult and Child Crisis Stabilization services are fully operational and are further reducing this region’s referrals to inpatient services.

The establishment of the Governor’s Office of Drug Control Policy has shown little impact on the funding needs for substance abuse services in this region. The Administrative Office of the Courts has increased the funding for treatment services for individuals served through the Drug Courts, and this remains a viable treatment option supported as a best practice. The river counties of Ballard, Carlisle, Hickman and Fulton began the first area Drug Court in 1997, and since the last review, both Livingston and McCracken Counties have initiated these programs. The working relationship with the Administrative Office of the Courts, the local judges and the treatment providers has been very positive, with the ultimate outcome being the recovery of the individuals served, in a majority of cases. Funding has increased steadily, as this service has demonstrated its effectiveness.

Training opportunities for professional and paraprofessional staff has received support and resources from Four Rivers Behavioral Health in the development of an in-house staff development curriculum and an emphasis on bringing training opportunities to the community, in order to maximize resources and provide more staff with opportunities. The SKIPP initiative, sponsored by the Regional Interagency Council, has led the way in providing training in children’s issues. This model has been enhanced by the development of a full time position of Training Coordinator and the availability of a state of the art training facility. Travel and training expenses for professionals from this region can be prohibitive and with the development of curricula approved by various professional boards for continuing education, these costs can be contained and tuition/registration fees cover the costs of the training. This has been a growing focus, as resources become more limited for public and private providers.

The integration of physical and behavioral health care has been an initiative that is long overdue. The effort to integrate behavioral health services into primary care is

viewed within the overall model as a means to provide mental health/chemical dependency services to a broader spectrum of the general population. However, the goal is to achieve medical cost offsets and thus reduce overall medical costs by the appropriate diagnosis and treatment of co-morbid disorders. In particular, this region is actively investigating an opportunity to develop protocols with individuals over the age of 60, in order to impact the reportedly 70% of healthcare visits that are the result of psychosocial problems and not organically based physiological conditions. A 1995 study of high-utilizing Medicaid outpatients who received behavioral health treatment achieved a 21 percent reduction in medical costs after 18 months, while those who received no behavioral services had a 22 percent increase in medical service utilization. (Pallack, Cummings, Dorken, Hanke. *Mind Body Medicine* 1:7-12, 1995) The overutilization of psychotropic medications by primary care physicians is well documented and most would welcome the availability of behavioral health experts to assist in the treatment of their patients. A comprehensive approach is needed with evidence based practice protocols.

The issue of children “aging out” of youth services has been significant concern for community partners. When access to funding is removed due to age, every effort is made by the SED Service Coordinators to maximize the opportunities for the children. There is a regional interagency team being coordinated by the Western Kentucky Education Cooperative that is working on strategies to address this issue. The Regional Coordinator of Children’s Services and other treatment professionals are active participants in this initiative, with an emphasis on assisting schools in meeting the educational requirements needed for an effective transition.

V. Behavioral Health Goals

The Region I Planning Council has always used the behavioral health goals of the Healthy People 2010 project of the Surgeon General as a template for its planning. However, it was recommended that consideration be given to the mid-decade evaluation of this project, in order to establish new and/or revised goals. This is in progress.

The need for establishing a system of care based on critical mass to maximize available resources has been imperative in the current funding environment. By determining a geographic and program structure to meet identified needs, supported by new technologies, such as electronic medical records, the modernization of the system of care can be accomplished. This has been the goal of the consolidation of public behavioral health services in Region I.

VI. Recommendations

The sustainability of a system of care for individuals with behavioral health needs is the responsibility of federal, state and local authorities. These authorities share mutual accountability for resource stewardship and system effectiveness. The providers are responsible for providing the design and provision of an accessible, community-based service continuum. Kentucky has a long history of commitment to these principles with a network of organizations and advocates that promote services of unparalleled value.

It is important to review the current system of care to laud its strengths and take a critical look at the needs for improvement. The availability and accessibility of behavioral health services to all individuals, especially vulnerable populations, should be considered in terms of service array, facility location, public transportation, and timeliness of service. In the expenditure of public funds, behavioral health organizations, regardless of tax status, should be expected to provide accountability for the receipt and

expenditure of funds. Behavioral health services should be provided in the most cost-effective manner possible, and should avoid encouraging over-utilization or under-utilization of services based strictly on financial considerations.

All individuals who need behavioral health services should receive necessary treatment without prejudice as to the severity of their problems, and providers should be expected to reinvest the maximum amount of resources received from reimbursement and other sources in services to consumers and/or the community. However, reimbursement systems that provide incentives to providers to reduce the use of high cost services must not link financial rewards to a consumer's treatment decisions. Providers must try to help themselves function effectively by ensuring there is enough financial margin to support system maintenance and growth. It is important that behavioral healthcare providers have the capacity to retain and reinvest revenue in ways that support organizational and system improvement, and thereby direct care. It is also essential that providers be allowed to blend funding streams to provide integrated treatment for co-occurring disorders in order to maximize scarce resources.

The overarching principle of delivering proactive, innovative, locally-responsive services in community-based settings must be supported by public policy that shares this vision and secures adequate resources to create and sustain healthy and secure communities. This can only be achieved through a system that holds the needs of consumers' paramount.

Pennyroyal HB 843 Regional Planning Council HB 843 Report - September, 2005

I. Features of your Regional Planning Council (RPC)

A. List members of your Regional Planning Council and their area of representation

Laura Stewart - Family Member
Charlotte Cannon - Family Member/Staff
Jerry Bell - Family Member
Marcia Bell - Family Member
Cindy Randolph - Hospital Rep
Jacqueline Woodward - Child Rep
George Byars - Mental Health Rep/Board Member
Robin Jergens - Health Rep
Judge Jim Adams - Criminal Justice
Alisa Barton - Housing/Indigent Services
David Ptaszek - Mental Health Rep/Family Member
Andrea Biddle - Staff/Consumer
Janet Doyel - Child Rep
Bev Thomson - Adult Rep
Janice Boyd - Child Rep
Ken Roberts - Law Enforcement
Kecia Fulcher - Mental Health Rep/Family Member
Steve Marion - Family Member
Anna Marion - Consumer
Michael Munday - Family Member
Penny Angel - Family Member/Consumer
Betty Travis - Consumer
B. L. Travis - Family Member
Alice Gibbs - Facilitator/Family Member
Tom Mills - Family Member
Bobbie Mills - Family Member
Linda Francis - Family Member
Jim Dailey - NAMI KY/Family Member
Nancy Saavedra - Hospital/Board Member
Patsy Oliver - Schools/Board Member
Bob Winstead - Family Advocacy
Tricia Jordan - United Way
Sharon Watkins - Schools/Board Member

B. Describe activities of the RPC since your last updated report (July, 2003)

The Regional Planning Council structure of the Pennyroyal Center is somewhat different than those of other regions in that rather than having one council, the Pennyroyal Center actually has council meetings in each of its four service areas to allow for greater participation of persons from a variety of backgrounds in this process. While we have conveners in each of our four service areas, Mr. George Byars currently serves as the overall Chairperson of our 843 Planning Council. The planning councils meet two to three times per year to discuss the services of the Pennyroyal Center in relation to the needs of the local communities to help develop plans for addressing those needs.

Additionally, the planning councils review the annual plan and budget of the Center and review the goals which are developed by the Center for implementation each fiscal year. Planning councils also review and comment on legislation when it specifically applies to mental health, mental retardation and/or substance abuse services. The PRPC has taken a very strong stand on recommending to the legislature that funding for community-based mental health services be expanded to ensure that services in the Pennyroyal region may continue to develop and be provided in quantities necessary to meet client demand.

II. Describe Changes in Regional Needs, if applicable

A. Any significant changes in your region’s demographics

There have been no significant changes in the Pennyroyal region’s demographics during the past two years. The Pennyroyal region continues to experience a high unemployment rate particularly in Todd and Muhlenberg counties, and the Hispanic population in the region, especially in Christian County, remains quite high. The need for the Center to provide translation services has outstripped our capability, and we have not been successful in hiring the number of bilingual clinical staff necessary to serve this segment of our population. Costs for hiring translators are high, and there is no particular source of income to offset the additional costs which we are experiencing. The high unemployment rates, especially in two of our most rural counties, have contributed to other negative developments, particularly in relation to the manufacture and distribution of methamphetamine which will be detailed later.

B. Update changes in community indicators and prevalence rates; significant events

The continuing increase in the number of methamphetamine labs being discovered and arrests for methamphetamine production/distribution in the Pennyroyal area has been documented, publicized and continues to expand. Despite the efforts of the Muhlenberg County court system and its three-year commitment to establish and operate a drug court, this is the first year that it has been awarded funding and formal recognition of its drug court status. The coal severance money has for the first time been targeted to funding a very critical and intensely community-supported intervention mechanism.

C. Any significant changes in dollar resources

Dollar resources have essentially remained flat. A slight increase in community care dollars was awarded this fiscal year, but it has not even been able to replace the money which was cut from our budget previously through Governor Ernie Fletcher’s executive order. Medicaid rates continue to languish. One significant increase in funding availability has been the awarding of additional drug court dollars this current fiscal year. Additionally, this is the first year that the contracts from AOC for drug court services have featured a reasonable and realistic mechanism for paying for services.

III. Update Your Service System Description

Describe any significant changes in your region in access to community-based services:

Status of the “safety net” and addressing gaps in services

Services for specific populations (children, elderly, revolving door, deaf, homeless, dually-diagnosed, etc.)

Collaboration, cooperation and communication among service providers

Evidence-based practices and focus on Recovery

One of the major issues in maintaining the “safety net” in the Pennyroyal region is the clear lack of community-based psychiatric inpatient beds for adults within the region. The Regional Medical Center in Madisonville has closed its psychiatric unit which has not been available to the region for the past two years. Additionally, Methodist Hospital in Henderson had previously operated a psychiatric inpatient unit which was utilized heavily by the Pennyroyal region. This unit has also been closed. Cumberland Hall in Hopkinsville, an inpatient provider for psychiatric services for children/adolescents will accept adults on occasion when bed space allows. Otherwise, persons from the Pennyroyal region must seek community-based hospitalization quite a distance from their homes in other service regions or out-of-state. Complicating matters is the fact that community-based psychiatric beds in nearby regions have also shrunk and are struggling to manage the needs in their own communities, let alone serve persons from the Pennyroyal region. This lack of resources has in turn put more pressure on hospitalization utilization at Western State Hospital which is experiencing significant difficulties in handling its patient load. Demand for services on the other hand, especially services which are emergent in nature, have continued to expand. Our crisis stabilization services are also straining to meet client needs and effectively deflect them from inpatient hospitalization.

Psychiatric services are also in high demand. The Pennyroyal Center has had difficulty in recruiting and maintaining psychiatry staff in quantities which can adequately address demand. Additional psychiatric resources are one of the key features which are addressed through the 843 planning councils as an important service goal for the Center. However, we are in competition not only with the private sector, but Western State Hospital itself, for recruiting psychiatrists. Without a major university nearby to provide some type of affiliation, teaching or research program to assist in attracting psychiatric staff, our recruitment efforts continue to be an uphill challenge.

The 843 planning process has from the outset recognized the need in this area for addressing the revolving door for substance abusers between the community and jail incarceration or inpatient treatment services. It was determined at least three years ago by the Pennyroyal Center that the development of long-term transitional supported living programs supported by a recovery model would be a preferred means of addressing the needs of substance-abusing adults in this community, particularly women. In response, the Center has been working to address this need and has recently been rewarded with Governor Fletcher’s announcement of his “Recovery Kentucky” programs of which ten are slated to be opened throughout the state. The Center has applied for one of these programs for women and anticipates locating its recovery center on the grounds of Western State Hospital. This has certainly been a cooperative effort between the planning councils in the community, Western State Hospital staff, the Pennyroyal Center staff and board, the staff of the Department for Mental Health and Mental Retardation Services, the Kentucky Housing Corporation and the office of the Governor. It is our hope that funding for this facility can be finalized and ground can be broken within the next six to eight months.

The Center continues to focus on providing evidence-based practice. We are proponents of a recovery model in dealing with both the severely mentally ill as well as substance abusers and have embraced many of the principles of such a model. The Center has operated a therapeutic foster care program for children and a highly developed case management service for the mentally ill, as well as substance abusers, which is carried over into its crisis stabilization program. The Center is also currently launching into a major programmatic shift in providing supported employment services throughout our region.

IV. Describe Regional Response to These Events or Influences:

A. Concept of changes to state psychiatric hospital services

Western State Hospital is presently experiencing a higher utilization of its services than its staffing pattern calls for. The Pennyroyal Center is responding by attempting to limit hospitalizations through deflection to crisis services, but the lack of an adequate number of community-based psychiatric inpatient beds in our region, as noted previously, is a major factor in avoiding state hospital deflections at the rate and manner at which we would prefer. Although the discussions regarding the combination and relocation of Eastern and Central State Hospitals did not particularly affect the western Kentucky area which the Pennyroyal Center serves, we certainly do support the notion that services should be provided as close to the community in which persons reside as possible. The concept of reducing beds at the state hospital in Hopkinsville and encouraging the development of community-based psychiatric beds throughout the region through payment incentives is certainly encouraged by the Region 2 Planning Council.

B. Closure of psychiatric hospital beds in region, if applicable

As I have noted previously, there are actually no dedicated adult psychiatric beds in community-based facilities operating within the Pennyroyal region. Community-based psychiatric inpatient providers in nearby regions have also reduced beds and are having a difficult time in keeping up with the demand within their own regions, let alone serving people from the Pennyroyal service area. On a regular basis, we see clients in need of community-based inpatient services, but resources will not allow us to take advantage of such an opportunity. Limited reimbursement for inpatient psychiatric services in comparison to reimbursement rates for medical/surgical utilization of hospital beds is cited as a major factor in the closure of local community-based psychiatric inpatient beds.

C. Implementation of Medicaid Pharmacy Benefits Administrator (First Health) & impact on consumers' access to medications

The implementation of Medicaid Pharmacy Benefits Administrator (First Health) has been a nightmare. Although, thankfully, community providers have provided input, which has been utilized in tempering the approach of First Health in managing the pharmacy benefits, too often the information which has been provided to us has not been followed in practice. For many months, accessing authorization was an extremely tedious task which could take up to a week when we were seeing a client who was already in need at the time of the request. Persons who had been grandfathered in for medication utilization per the instructions we received did not have the grandfathering clause honored by First Health in providing authorizations. This took place despite our continued attempts at informing them and requesting their attention to the agreement with

the Commonwealth which had been provided to the community mental health centers. Clients suffered and several hospitalizations ensued which could and should have been avoided.

Many of the restrictions which were placed on the utilization of drugs, particularly multiple drugs and dosages, appeared to have no basis from our observation of their effectiveness with our clients. Reviews and withholding of authorizations seem to be perfunctory with little reflection on the understandings which had been provided to the community mental health centers. Although this process has improved somewhat, consumers' access to medication has certainly been significantly reduced, and many times in a totally unreasonable and non-justifiable manner. With our state hospital beds crowded and limited inpatient service access in our entire region, cutting costs on the utilization of medication on which clients have been stabilized, sometimes for many years, does not appear to be prudent or even cost-efficient on a long-term basis.

D. Implementation of Jail Triage program

This program has truly been a success and has brought the community mental health center staff and the staff of area jails much closer, particularly in regard to their understandings of the rules and responsibilities of each provider. Progress has been made in sharing an understanding that we have a community issue in terms of providing services to those mentally ill persons housed in our jails as opposed to a responsibility born by only one single provider. Center-sponsored trainings for jail personnel throughout our service area have gone extremely well with excellent participation, and the staff of the Center have responded by providing timely interventions in our area jails. With our jails generally welcoming this service, and with Center staff providing the needed interventions, the PRPC is extremely supportive of maintaining this service and urges the legislature to do all it can to prevent this service from being subject to reductions.

E. CSU services funded for both children and adults in each region

Crisis stabilization services in the Pennyroyal region are provided through a model of community outreach. We do not maintain crisis beds in the traditional sense, but use a variety of case management and temporary placements, such as in therapeutic foster care or adult foster care, to deal with crisis situations. The PRPC is extremely supportive of increasing the services offered through the crisis stabilization program offered by the Pennyroyal Center. They believe that it is absurd that the amount of money which was awarded for starting a children's crisis stabilization program back in 1998, \$275,000, is the same amount of money that is awarded on an annual basis in FY2006. When the state sponsors a service which produces desired outcomes and is welcomed by the persons and communities served, it makes no sense to allow such programs to languish without providing adequate financial sustenance to help the program meet not only known costs, but increases in demand.

Originally, the adult crisis stabilization unit, for which the Center had applied, was supposed to receive \$400,000 per year for operations. Through an unfortunate oversight, the Center was first awarded, \$320,000, which was increased to \$360,000 for the next year. This is now the continued funding level we receive and is still significantly lower than the anticipated \$400,000. When programs such as the crisis stabilization units are expected to meet ever growing

needs, the lack of targeted funding to maintain and enhance these services makes no sense programmatically, humanistically or financially.

F. Establishment of Governor’s Office of Drug Control Policy with focus on substance abuse disorders and increased funding for treatment and housing

This movement of the Governor was viewed as extremely positive by those of us observing the state of substance abuse services in Kentucky. However, confusion between the roles of ODCP and the Department of Mental Health and Substance Abuse quickly became evident as well as the apparent lack of a continuing role for the local KY-ASAP boards. While there is no question that the Governor’s stated commitment to the development of services for substance abusers is accepted as a major recognition for an issue which is affecting thousands of our local Kentucky citizens, confusion regarding the relative jurisdictions of groups providing a role in handling substance abuse services has caused difficulty in implementation of programming on a community level. A prime example of this was the transfer of substance abuse prevention services out of the oversight of the Department of Mental Health and Substance Abuse services to the Health Department. After nearly one year spent redefining the organization and administration of those services, Prevention has once again been shifted back to the Dept. of MH and SA. While we certainly support these services being provided under the administration of the Dept. of MH and SA, this confusing situation has often resulted in resources not being directed properly and timely. As noted previously, the Governor’s “Recovery Kentucky” program is timely, but must be supported by all elements of state government or it may also languish due to too many cooks stirring the broth with each reading a different a recipe.

G. Workforce development – increased training opportunities for mental health professionals

The Pennyroyal Center has not benefitted from the additional availability of trained clinical workers, and continues to have difficulty in filling open positions for direct client services. The Dept. of MH and SA conducts two major training programs during the year, the Kentucky School for Substance Abuse and the Mental Health Institute, which attempt to provide not only an excellent level of training, but the ability for a clinician to receive all necessary CEU’s for license maintenance at one conference. The state is certainly to be applauded for these efforts. The Center has continued to work toward holding training sessions in western Kentucky to reduce the amount and cost of travel to trainings for staff from this area. The Center also continues to encourage the state to utilize technology such as interactive video to hold conferences in order to reduce the time staff must be away from the office as well as mileage and lodging costs when workshops, trainings and meetings are held only in Frankfort or Lexington.

H. Integration of mental health and physical health services and management

The Pennyroyal Center works very closely with area physicians and local general hospitals to ensure that all healthcare needs of our clients are managed appropriately. The Pennyroyal Center conducts health screenings on each new client and ensures that recommendations for physical care are made whenever indicators warrant.

One concern that has been raised by Center staff is that physicals which are provided for our clients who have developmental disabilities or mental retardation are often not as thorough or specific enough to meet the needs of this

population. Along with other professionals from the community mental health centers, we are working with the Cabinet for Health Services to develop more specific protocols for physicals for persons with MR/DD. We believe that it is imperative to increase the rates which Medicaid pays for these physicals to encourage local area physicians to accept this clientele and perform more thorough, though time-consuming, physicals and follow-up services.

I. Addressing issue of children “aging out” of youth services

Unfortunately, because of the age designation of when childhood ends, services to youth who are either MR/DD or severely emotionally disabled must be transitioned at designated points and times regardless of their functioning level. The Center is aware of the transition need and focuses its attention on this particular group. Specifically, the General Manager of Trace Industries, Donna Grant, has attended various state-sponsored events called RITT, the Kentucky Regional Interagency Transition Team, that focus on transitioning issues. Additionally, MR/DD Case Managers maintain open communication with school systems and ask to be invited to ARC meetings to help focus on transition challenges.

V. Behavioral Health Goals

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

1. Establishment of a crisis stabilization program for adults
2. Establishment of supported transitional living/recovery-oriented centers for women
3. Increased funding for community-based mental health services by trending and indexing all funds provided to community mental health centers in order to keep up with the cost of doing business as well as increased demand for services
4. Increase the level of community care dollars in regions with lower per capita funding to ensure that core services can be developed and maintained in line with demand
5. Increase penetration rate for youth served in the Pennyroyal region
6. Develop drug court options for adolescents/adults

B. Describe any changes in priority goals made in the past two years

Funding for an adult crisis stabilization program was obtained in FY2004 and the program has been implemented, though at a lower level of funding than had initially been offered. Therefore, this goal has been changed from a goal of obtaining a crisis stabilization program to seeking adequate funding to maintain and develop this program. Additional emphasis has been placed on the goal of increasing community care dollars awarded to the Pennyroyal Center to provide adequate service availability.

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

As noted above, a crisis stabilization program for adults has been established. The Center has been working feverishly for the past three years to establish transitional living facilities for substance-abusing women and has tentatively been awarded a “Recovery Kentucky” site through the Kentucky Housing Corporation to be located on the grounds of Western State Hospital in Hopkinsville. The Governor has announced in an address on Monday, August

15, that the Pennyroyal Center is a recipient of a grant for the program. This is welcome news, and we look forward to breaking ground in the next six to eight months.

Funding has not been adequately addressed by the legislature up to this point, and it is the belief of the PRPC as well as the NAMI groups within the Center’s service area that significantly increased funding must be addressed by the upcoming legislative session. This goal has been given one of the highest priorities by the PRPC, and it is expected that the legislature will deal with this issue in a substantial manner.

In order to improve the penetration with youth, the Pennyroyal Center has launched an ambitious school-based service program which, as of this school session, finds the Pennyroyal Center providing on-site services to children in school systems in six of our eight counties. In addition, the Center continues to grow its therapeutic foster care program in an attempt to provide critically important crisis services to youth in the communities in which they live. Drug courts have now been established for seven of the eight counties served by the Pennyroyal Center and contracts have been issued by the Administrative Office of the Courts.

VI. Recommendations

- A. Describe your recommendations regarding funding, particularly in light of the projected Medicaid shortfall and the impact on the Behavioral Health Safety Net

It is the stated position of the PRPC that the greatest impact on services in each region of the state, particularly the Pennyroyal region, can be made by increasing the community care dollars for each region and that a per capita rate of \$20 should be established as a minimum for each of the community mental health centers throughout the state effective with the coming fiscal year. Without these additional dollars, the Pennyroyal Center is unable to provide additional services. It was also noted by the PRPC that the investment of the commonwealth of Kentucky in the entire mental health system needs to be increased in line with the expectations of the 843 Commission. The PRPC was not satisfied to learn that a goal at one time had been set for Kentucky to be rated as 25th in the United States in terms of its per capita spending for mental health services, but did believe that any improvement in our record regarding funding for mental health services would be dollars well invested.

The PRPC also believes that Medicaid services within the state must be maintained at reasonable levels and that funding for these services must also keep pace with demand. The PRPC is supportive of constant review of utilization of services and ensuring that Medicaid payments are used wisely. However, artificially restricting care on the front end may only bring greater costs to the state when persons who are mentally ill must be served either in the prison system or in state hospitals.

- B. Describe recommendations for public policy changes, particularly in moving toward statewide “modernization” of the system of care

The PRPC is aware of efforts to “modernize” the system for providing community-based mental health care. The council supports the concept of moving away from the over-utilization of state hospitals that is currently taking place and a movement to more community-based services. However, until there can be some incentive developed to encourage community-based hospitals to

designate beds for psychiatric use, plus a much greater outlay to develop and strengthen the crisis stabilization programs throughout the state, this “modernization” will not materialize.

River Valley Regional Planning Council

HB 843 Report - September, 2005

I. Features of your Regional Planning Council (RPC)

A. List members of your Regional Planning Council and their area of representation

Mary L. Pate, Beaver Dam City Commission
Joe Van Roberts, Ohio County Board of Education
Mike Oliver, United Methodist Homes for Children
Ken Roberts, Daviess County Public Schools
Rev. James Brasher, Western KY Family Enrichment Center
Jiten Shah, Green River Area Development District
Angela Woosley, Green River District Health Department
Brenda Brasher, West KY Family Enrichment Program
Eula Johnson, Bouleware Center Mission
David Osbourne, Daviess County Jail
Laura McCarty, Administrative Office of the Courts
Dianne Ford, Methodist Hospital – New Choice
Laura Freese, Department of Community Based Services
Libby Cambron, Parent
Lee Maglinger, Department of Corrections, Div of MH
Lexie Hicks, Private Practitioner
Fred Goodwin, Audubon Area Services
Keith Cain, Daviess County Sheriff
Jim Toler, Department of Community Based Services – Regional Director

B. Describe activities of the RPC since your last updated report (July, 2003)

Due to time constraints, the members of the committee felt that they would prefer to be in contact through e-mails/phone unless specific activities indicated a need to physically meet. It was decided that in order to get an accurate picture of the opinions of the community, a questionnaire would be sent to a sample of people throughout the community, not just the members of the RPC, asking their opinions of the items needed for this report. Questionnaires were sent to approximately 150 individuals representing consumers, providers, and organizations directly affected by the mental health/substance abuse needs of the community. The results of these questionnaires and this report will be presented to the RPC within the next month.

II. Describe Changes in Regional Needs, if applicable

The region saw an increase in a number of areas. A marked increase in Hispanic and Asian populations has created language/communication barriers. The population is rapidly aging, with many young adults leaving the area. The number of people graduating from high school increased by 15.9%. There was a 13.4% increase in female head of households with 2,000 grandparents being responsible for 1,743 grandchildren in the region.

The community has not grown, and shows increased unemployment with no new industry entering the area, a decrease in coal mining jobs, a decrease in white collar jobs, and an increase in chicken/poultry farming. The increase in this area has also attributed to the increased presence of migrant workers. These factors have resulted in a large increase in the number of uninsured.

Overall, the largest and most significant change to the area has been the increase in methamphetamine use. The seven counties of Region 3 have one of the highest incidence of meth use in the state. Although substance abuse has been identified as an epidemic, and the state has committed to allocating future dollars for prevention/treatment, the current funding for substance abuse has remained static.

Many agencies stated they have seen a decrease in money allocated for social services in the area, and it was also noted that there is a lack of county and local funds to help support needed services. This problem is compounded by the increase in individuals who are uninsured but in need of services.

III. Update Your Service System Description

The overwhelming response to questions concerning the “safety net” was that it was stretched beyond it’s capabilities as more individuals present with increased trauma, and financial resources decline. The impact is further felt by the number of people having no benefits, and those individuals in need of interpreter services. Although the community is attempting to provide the necessary services/supports, there remains an increase in service needs with a subsequent decrease in services available due to funding.

RiverValley Behavioral Health has begun services to individuals who have sustained a head injury, providing case management, residential, and therapeutic rehab programs. There also is an increased awareness of the need to provide professional training as well as services for gambling addictions.

Unfortunately Day Cares and Senior Citizens programs have closed in the region due to funding issues, which has compounded the need for services to the elderly. Substance abuse, which was mentioned earlier, has become of almost epidemic proportions, and has in turn been responsible for an increase in the number of children needing foster care placement due to the substance abuse issues of the parents.

The closing of inpatient adult psychiatric beds has also had an impact on the community’s ability to handle these issues locally. Children’s services in the area continue to be comprehensive and of high quality. The major missing link in the children’s continuum of care is adolescent substance abuse treatment due to an absence of trained professionals.

Within the past year, more agencies are collaborating/communicating regarding the need for substance abuse treatment. Two groups, in both Daviess and Henderson counties, are possible candidates for the Recovery Kentucky initiatives.

It was also noted that there was an increase in the collaborative efforts between the jails and the community mental health center. Local Drug courts are expanding throughout the seven county areas, and a more collaborative relationship has resulted between the courts and the mental health center. More clinicians are teaching in local college systems, and more staff of the mental health center is becoming more active on local boards and committees.

Through Community/Regional disaster planning, hospitals, Fire and Rescue, the Health Department, and the mental health center have all begun to work closely together, pool resources, and share information. This area has been identified as one of the most significant positive changes in the behavioral health community.

RiverValley Behavioral Health is committed to providing services that are recovery oriented. The use of an annual self-assessment survey across populations to develop an individualized treatment plan, the hosting of consumer conferences, integration of services across populations, and the development of a cluster-specific treatment approach in it's children's psychiatric hospital, are but a few examples of this commitment. RiverValley was honored to win the Mental Health Corporation of America's Best Practice award for customer satisfaction in community mental health centers for 2003.

IV. Describe Regional Response to Events and Influences

The closing of many of the private psychiatric in-patient beds in the area, and the reduced length of stay at Western State hospital, has resulted in what many have referred to as a revolving door phenomenon. Due to the reduced length of stay, individuals are not stabilized in a hospital setting, return to the community, are not ready to be there, and are re-admitted. Although the Crisis Stabilization unit is used, certainly more frequently and for more acute levels of care than ever before, it is a social model, and not staffed to accommodate and keep safe individuals who are actually in need of inpatient hospitalization.

The implementation of the Medicaid Pharmacy Benefits Administrator and its impact on consumer's access to medications has been profound. It has become increasingly difficult for individuals to access newer medications, forcing the consumer to rely on pharmaceutical companies to receive their medications. Many times, consumers don't understand their benefits and often cannot afford medications they need. Many instances were reported of individuals having to choose which prescription they would have filled because they could not afford all of them. Sample medications and drug programs are becoming more difficult to access. Although it appears that many of the problems surrounding this program are being resolved, the impact has been immense.

All but two of the jails in the seven county areas have begun participating in the Jail Triage program, and all jails have been trained. The area has received nothing but positive responses to this program. As a result of collaborative cooperation between the court system, Detention Centers, and mental health services significant progress has been made in all jail treatment services.

As was stated earlier, two community groups have stepped forward to apply for the Recovery Ky initiative. In Owensboro, an application has been filed with the KY Housing Corporation, funding has been requested through the Federal Home Loan, and additional start-up funding has been received through the local Fiscal Court. The community of Henderson is also pursuing the potential for a women's facility in their area.

The region is beginning to look at the integration of mental health and physical health services. A more holistic approach to treatment of the individual is essential. Although at the very preliminary stages of development, it is certainly an area that will become more imperative within the next few years.

There continues to be a gap in children aging out of services. If the child is already enrolled in case management services through RiverValley, a referral is automatically made to adult case management of case management for adults with a developmental disability. This aids in the transition from one system to another. The problem is more severe with children who are not in the MH Center system during their school years, and may go without a smooth transition plan if they are not brought to the attention of the CMHC.

V. Behavioral Health Goals

The goals identified for 2001-2003 were as follows:

1. Improved Coordination of Services – as has been identified throughout this report, progress has been made in the collaboration/communication between community partners.
2. Improved Recruitment and Retention – this continues to be an issue, particularly for trained substance abuse professionals. Reciprocal agreements between states for licensing/credentialing of SA professionals still remains a priority need.
3. Improved Housing – This issue continues to be identified as a priority particularly in the need for development of transitional living for individuals discharged from Western State Hospital, but not ready for independent living.
4. Development of Step-down facilities between Hospital, Jails and Communities – this continues to be a long term goal due to the complexity of the issues
5. Develop a Crisis Stabilization program for Children – although not occupying a building, crisis stabilization services are provided in the child's home or if necessary, in foster homes where the families are trained to deal with a child in crisis.
6. Geriatric Day Health Program – as has been mentioned previously, due to funding cuts some of the current Senior Citizens programs have been closed. With the aging population, this continues to be a priority need.
7. Increased Consumer Awareness – RiverValley Behavioral Health opened an Office of Consumer Affairs which deals only with concerns/suggestions of consumers and their families participating in the service delivery system. Many changes have been made over the past two years, to accommodate these suggestions. A consumer conference focusing on employment issues was held.

Consumer conferences/informational sessions will be held this year to inform individuals about proposed legislation.

Additional Priority Goals for the Future

1. Increased Substance abuse treatment – due to the staggering abuse of methamphetamines, priority has to be given to increasing the funding and treatment of substance abuse, including aftercare. Services should include adults and adolescents.
2. Gambling Addictions treatment – the area currently provides outpatient gambling treatment with a certified therapist, a need exists for expanded treatment and inpatient/residential programs.
3. Increased supported employment opportunities for individuals who have sustained a brain injury.

VI. Recommendations

Funding:

With the continual decline in funding for behavioral health services, and the increase in need/usage, several problems become apparent. In rural areas it is not only difficult, but is also not cost effective to duplicate specialized services in each region throughout the state. As has been identified in Region 3's report since the inception of HB843, flexibility in funding is imperative. Individuals should be allowed to receive specialized services irrespective of whether it is in the individual's home region. Not all rural regions can recruit and retain specialists in substance abuse, brain injury services, etc. However, a specialized, state of the art program serving more than one region could accommodate the need for such services without the duplication and increased costs. Aside from this recommendation which has been presented in all of our reports, the following funding suggestions are taken from the responses to the surveys submitted:

1. Use lottery proceeds to fund gambling treatment
2. increase alcohol tax to fund Substance Abuse treatment
3. Continue to integrate services within agencies/service providers
4. City and County government should contribute a portion of their revenue to mental health
5. Assess the actual need for state inpatient hospital beds, and divert some of this money to community's to subsidize local inpatient care.
6. Increase funding to support best practices

Modernization of the system of care

As has been addressed in the previous section on funding, the creation of Centers of Excellence focusing on a particular treatment area is a major step in the modernization of the system. Funding should also be allocated to acknowledge that the provision of state of the art services is costly.

Added emphasis to a holistic treatment approach is rapidly becoming the only effective treatment methodology. Individuals must have access to all forms of health care and, in turn, treatment options should be chosen based on the results of all health and mental health needs. This approach must also encompass integrating treatment approaches for individuals with co-occurring disorders.

As individualization is the key to a modernized system of care, funding must become more flexible, and the reimbursement must increase to support these efforts. Key to the success of a system which supports a system of care for each individual is the advanced use of technology to insure a seamless delivery system.

LifeSkills HB 843 Regional Planning Council HB 843 Report – September, 2005

I. Features of your Regional Planning Council (RPC)

- A. List members of your Regional Planning Council and their area of representation
The Regional Planning Council is comprised of two or more representatives from each of the categories designated (see attached Table A). LifeSkills Consumer Representation Committee comprised of both consumers and family members representing mental health and substance abuse, adult and children's services also serves on the RPC.
- B. Describe activities of the RPC since your last updated report (July, 2003)
Since the last report the Regional Planning Council met to review Secretary Holsinger's proposal regarding the relocation and consolidation of Central State Hospital and Eastern State Hospital and to address how similar changes in our region might affect service delivery. The RPC made recommendations that were presented at the Louisville Public Forum on September 21, 2004.

II. Describe Changes in Regional Needs, if applicable

- A. Any significant changes in your region's demographics
There have been no significant changes in Region IV demographics since the initial report.
- B. Update changes in community indicators and prevalence rates; significant events
The penetration rates of seriously mentally ill served by LifeSkills remained mostly flat, as did our funding, from FY 2003 (58.6%) to FY 2004 (59%). However, the penetration rate for older adults with SMI nearly doubled from FY 2003 (15.4%) to FY 2004 (30%). Penetration rates for children with SED decreased from FY 2003 (54%) to FY 2004 (51%). Numbers of substance abuse clients served increased from FY 2003 to FY 2004 by 2%. The state hospital readmission rates rose from FY 2003 (11%) to FY 2004 (17%). There were no significant regional events.
- C. Any significant changes in dollar resources
The State required a 2.5% cut in FY'04 and FY'05 funding. LifeSkills lost funding to treat Probation & Parole clients in FY 2004 and DUI funding was cut for FY 06. We received additional funds for Early Childhood Mental Health in FY 04 but took a cut for FY'06. In 2004 LifeSkills received funds for Disaster and Emergency Preparedness and in FY'05 for Jail Triage. Early Intervention Prevention was given additional funding in FY'06. With funding being basically flat this will likely result in little to no growth in most areas.

III. Update Your Service System Description

- Describe any significant changes in your region in access to community-based services:
LifeSkills has improved access for routine, urgent and emergent cases through triage during the initial call. LifeSkills policy is to offer a routine appointments within 10 calendar days, urgent appointments within 3 days and emergent appointments same day. LifeSkills is tracking initial contact timeliness on a monthly basis. When possible consumers are diverted from involuntary forms of treatment to voluntary forms of treatment such as Crisis Stabilization Unit or other outpatient services. LifeSkills will begin tracking the percentage of these diversions in FY 2006. Case Management Admission and Discharge

criteria have been developed for adult SMI consumers beginning FY 2006. And LifeSkills is tracking single service episodes and conducting timely follow-up at first no-show following intake. WSH referrals continue to constitute a priority and the Continuity of Care Coordinator has increased her days on-site at the hospital to 3 days per week. As a result there has been no drop in fourteen-day aftercare appointment compliance. The Office of Inspector General recently licensed two additional facilities under a Non-Medical and Non-Hospital Based Alcohol and Other Drug Abuse Treatment Program allowing for greater access to substance abuse services for residents of Metcalfe Co. and children in Warren County. New Drug Courts established in Butler and Edmonson Co. will also provide resources for substance abuse treatment in those counties.

Consumers who do not have medication benefits and meet financial and diagnostic criteria are eligible for the Community Medication Support Program as mentioned in our 2003 report. Budget cuts specifically affecting this program place further restrictions on the income guidelines and the medications available on the formulary. We also access numerous pharmaceutical company indigent programs for both brand and generic medications. However, some medications are no longer available through any type of program and individual company eligibility guidelines have become stricter thus increasing the difficulty in obtaining assistance. Pharmaceutical drug discount cards have provided some relief for eligible consumers but most cards only offer a 20% discount on medication still keeping medication beyond the financial resources of most consumers. In addition, most discount drug card programs will be phased out by December of 2005.

Status of the “safety net” and addressing gaps in services

LifeSkills remains the primary resource for persons with limited payer sources. For-profit providers continue to provide care where financial resources are available, including school and home-based services, through IMPACT Plus however, Impact Plus regulations significantly reduced gap services such as TCS, Crisis Unit and Therapeutic Foster Care. So the services that private providers are getting reimbursed for are the same services that LifeSkills provides. LifeSkills continues to endure the burden of balancing increasing needs and decreased funding. Transportation continues to be a barrier in service provision particularly in the most rural counties in our region. Adult services gaps are in Intensive Case Management or ACT teams to treat the most complex cases (often revolving door cases) due to lack of funding. There continue to be no available medical detoxification beds in the region and regional psychiatric beds have decreased significantly.

As mentioned above, recent AODE licensure acquired in two additional sites and funding through the drug courts in two additional counties will allow for the provision of more substance abuse services. This in addition to training initiatives in substance abuse assessment, treatment and specifically group therapy provided during FY 2004 and FY 2005 will lessen substance abuse service gaps within the region. LifeSkills has also employed a substance abuse clinician to provide services specific to children and adolescents. LifeSkills has achieved a 98% rate of 14-day aftercare appointments for Western State Hospital discharges.

Services for specific populations (children, elderly, revolving door, deaf, homeless, dually-diagnosed, etc.)

Homeless

- Lifeskills operates a Supported Housing Program to provide rental subsidies to individuals and their families. In order to participate in the program, the qualifying individual must suffer from severe mental illness or a chronic substance use disorder. Since 2003 this project assisted more than 80 families in establishing and maintaining affordable safe housing. Many of these individuals do not qualify for other low income housing subsidies because of a history of legal charges or disruptive behavior which were results of their disorders. As they participate in this housing program, they maintain treatment services to stabilize the symptoms of their mental illness or substance use disorder.
- Lifeskills' Supported Housing Program also assists Lifeskills' clients who are not program participants. Since 2003 the Supported Housing Office has assisted 190 clients with needs associated with establishing and maintaining housing. This assistance has included purchasing kitchen necessities like pots and pans, used furniture, and paying past due electric bills, and rental deposits.

Deaf

- LifeSkills does not currently employ any direct service providers capable of communicating with the hearing impaired population through sign language. However, we do contract with certified interpreters in order to provide therapy case management and psychiatric services.

Children Services:

- Since 2003 there has been an increase in referrals and children accepted into the IMPACT program although there has been no increase in funding during this time. This has resulted in further gaps in services.
- IMPACT Plus has continued to restrict and limit the access to and availability of services for which it was originally created (i.e. services not otherwise provided through Medicaid). These denials result in additional time, energy, and money spent on appeals and Medicaid hearings to try and access services for children.
- The Early Childhood Mental Health Intervention services got up and running fully in January 2004, with our specialist in this area and began to offer services to families and daycares in this area. Since that time she has open 23 new cases of children ages 0-5, provided over 200 day care consultations, 16 daycare trainings, and 26 observations of children at Daycare centers. We have run into some difficulty with the restriction placed by the state on her ability to provide services to a wider range of clients, but with the training of additional clinicians in each county we are now able to provide services to families of children ages 0-5 in all 10 counties.

Dually Diagnosed:

- Lifeskills completed phase I of a region-wide substance abuse training during 2003 & 2004. Clinical staff that have been trained in and work in primarily the mental health field received a series of substance abuse focused trainings. The goal was to increase staff competency in assessing and treatment planning for clients with substance abuse issues.

- Lifeskills completed phase II of a region-wide training during Spring of 2005. Therapists and other direct service providers who usually work in the area of mental health received further training on the treatment of substance abuse and dependence.
- Dually Diagnosed individuals in residential treatment for chemical dependency are seen by a staff psychiatrist who is an Addictionologist. Dually Diagnosed individuals who receive treatment on an outpatient basis may received individual or group (in Warren County) sessions focused dual diagnosis related issues. Lifeskills was again chosen as a pilot site for a SAMHSA grant dealing with dual diagnosis treatment.
- Evidence based practices include the Seven Challenges, used with juvenile drug court participants, MET/CBT5
- Two additional centers (Metcalf Service Center and Warren County Child & Family) were licensed to provide substance abuse services.

Revolving door cases:

- As of June 2005, Region IV has seen an increase in re-hospitalizations at approximately 54% as compared to FY 2004 regardless of the efforts to create proactive crisis plans for these individuals. WSH has seen flat funding and increased referrals causing them to open overflow units and to shorten lengths of stay, which has in part perpetuated the revolving door crisis.
- The region continues to experiment with flexible Olmstead funding in working with consumers with high rates of re-hospitalization.

Elderly:

- As noted above, penetration rate for the elderly population has increased substantially since the prior reporting period. This is at least in part, due to active collaboration with area personal care homes and nursing facilities.
- In addition, the local mental health and aging coalition remains active in educating area providers and caregivers regarding mental health needs of the elderly.
- The Regional Medical Center of Bowling Green has recently opened a ten-bed geriatric unit to serve the population as well.

Collaboration, cooperation and communication among service providers

Coordination and collaboration across systems and among agencies is always an issue with barriers such as schedules, confidentiality, etc. Collaboration with other agencies continues to expand as programs are funded requiring multi-agency input. Examples of this have been Disaster Preparedness, which has brought together many physical and mental health agencies and emergency response systems, collaboration with school systems through Green River Educational Cooperative’s Emergency Response and Crisis Management Plan and collaboration with Corrections through Jail Training and Jail Triage.

Memorandums of agreement are increasingly used.

Evidence-based practices and focus on Recovery

The region is attempting to make a measured transition into the current call for evidence-based approaches and recovery-focused services. Recognizing the lack of consensus on what constitutes truly science-based practice and the current economic disincentives to implementing those approaches that are widely accepted, LifeSkills has focused its attention on three main objectives.

First, to instill a culture of data-driven decision making where none had existed. The managed care philosophy has taken much longer to infiltrate community mental health centers and, as a result, individual practitioners within the system have operated on what might be labeled a “quasi private practice” model in which individual accountability has been limited. The introduction of both performance and outcomes data will do more to push accountability down to the individual level.

The second objective, related to the first, is to begin demonstrating adherence to accepted standards of care by introducing a standardized outcome measure and treatment guidelines for the most pervasive mental health problem, depression.

The third objective attempts to move recovery principles into the mainstream of the current service array. LifeSkills has long been on the forefront of consumer-provided services through its peer support team concept. Unfortunately, fiscal restraints minimize the widespread availability of this service. A panel of frontline clinicians has been commissioned to examine the feasibility of implementing the SAMHSA-endorsed evidence-based practice of Illness Management & Recovery. It is hoped that a consensus approach, while slower to produce a deliverable service, will result in greater stakeholder buy-in and thus improved fidelity and outcomes upon implementation.

IV. Describe Regional Response to These Events or Influences:

A. Concept of changes to state psychiatric hospital services

Secretary Holsinger proposed a consolidation of Central and Eastern State Hospital the response to which was very negative—especially by consumers and families because of distance/access. Meanwhile, Medicaid Modernization has become the framework within which state and federal governments are looking to save money. The Feds are basically giving states more flexibility in exchange for a larger share of the cost. KARP (Kentucky Association of Regional Programs) is planning to submit a plan to the 843 Statewide Commission that would involve redistributing resources—money and facilities—closer to people’s homes. It will likely include newly defined levels of care related to efficient and effective numbers of resources such that there would be more acute beds in local communities and fewer but more specialized beds in differently centralized communities. For example there might be a few adult and child beds in Bowling Green, a couple of long-term “intermediate” care facilities in the Western State region, one or fewer geriatric or dual-disorder facility in the region and one state-wide facility for a more limited size but more intense subspecialty program.

Representative from a local hospital with psychiatric beds referenced a meeting with Western State Hospital and their willingness to work together.

B. Closure of psychiatric hospital beds in region, if applicable

Within the past 1 to 1-1/2 years the Medical Center at Bowling Green has reduced their psychiatric unit from 36 to 20 beds and changed their policies regarding accepting referrals of involuntary clients to the hospital. This resulted in virtually all 202A referrals being routed to Western State Hospital contributing to the increase in the number of referrals we sent to WSH in the past year. In April the Medical Center dedicated 8 of the remaining 18 beds to geriatric care leaving 12 acute care psychiatric beds with some flexibility to increase capacity

of the need is greater. The Medical Center has taken some clients who are on a 202A but are willing to sign themselves in if they have a relationship with an admitting psychiatrist. Rivendell children/adolescent hospital is nearly always at full capacity and cannot get additional specialty beds.

Committee member suggested Certificates of Need would be better if based on areas of need instead of community size. Another committee member reports there are times there is not an open bed anywhere in state for a child. Some hospitals in the state have CONs for large numbers of beds they have not used in many years. If funding were available local hospitals have said they would be willing to consider additional acute care beds to keep clients in region.

C. Implementation of Medicaid Pharmacy Benefits Administrator (First Health) & impact on consumers' access to medications

Medicaid guidelines have undergone significant changes. Although atypical anti-psychotics are exempt from the newly instituted 3 Brand Name Drug rule, now, all atypical antipsychotics and some antidepressant medications require prior authorization not only for initial administration but for dosage changes as well. Maximum dosage and pill counts have been set and use of two medications within the same drug class have been restricted.

One committee member reported these changes have left physicians with few alternatives and more paperwork.

D. Implementation of Jail Triage program

To address the issue of incarcerated inmates committing suicide, the Jail Triage program began in 2003 in Lexington and Frankfort. This program allowed the jails instant access via telephone with a "Qualified Mental Health Professional" for consultation regarding inmates who met certain "high risk" criteria. Shortly after this implementation, legislation was passed making this program statewide and funding it through higher court costs.

In December of 2004, LifeSkills went on line with the Jail Triage program with all 8 of the jails in our region at the same time. We were the first region to begin the program all at once rather than phasing it in county by county. The program has operated ever since with minimal problems. Every jail in our region participates in the program.

Since its inception we have dispatched QMHP's to perform face-to-face assessments for 54 inmates in our region (36 of these after regular business hours). Of the 8 jails in our region, all have utilized this service at least once since December.

Committee member expressed concern that a jail triage evaluation would take precedent over a 202A commitment when the jail should be a safer, more secure environment. He was assured that the 202A evaluation in custody of local law enforcement would be completed before staff went to a jail to do an evaluation on an inmate.

E. CSU services funded for both children and adults in each region

Regional IV has had a licensed Adult Crisis Stabilization Unit since 1995 and a Children's Crisis Stabilization Unit since 1998. Units that were opened after this time have been funded at a higher amount. We have had to add additional DMH dollars to the current level of funding for the past several years. CSU's were created to decrease hospitalizations. Though frequently full it is questionable whether this has actually had the intended impact or not.

Committee member representing a local hospital reported the adult CSU has been very valuable to the patients and staff and has shortened hospital lengths of stay. Representative from local group home expressed an interest in seeing the Children's CSU function more as an emergency shelter allowing for longer lengths of stay to provide more comprehensive assessment of children including full psychological and psychiatric evaluation in hopes of avoiding hospitalizations, multiple foster care placements etc.

F. Establishment of Governor's Office of Drug Control Policy with focus on substance abuse disorders and increased funding for treatment and housing

Governor Fletcher signed an Executive Order creating the Office of Drug Control Policy (ODCP) on September 8, 2004. The mission of the ODCP is to serve as a leader and a catalyst for improving the health and safety of all Kentuckians by promoting strategic approaches and collaboration to reduce drug use and related crime. During March of 2005, the ODCP assisted in the passing of new legislation that addressed methamphetamine issues in Kentucky. This legislation made it more difficult for criminals to obtain pseudoephedrine by requiring an ID and signature at purchase and by capping the amount purchased. Penalties were strengthened for methamphetamine involvement when children are placed in danger during situations such as manufacturing or use. Through ODCP funding, a new drug court in Ohio, Butler and Edmonson Counties was funded.

During the summer of 2004 Warren County established a juvenile drug court. They serve up to 20 juveniles at a time and Lifeskills provides treatment services for these adolescents. Our region received funding through the ODCP to provide services to the newly established drug court in Butler and Edmonson Counties.

Kentucky Housing Corporation is working in the state to address the housing needs for individuals with alcohol or drug dependence by initiative establishing large facilities to house them and by providing educational peer-to-peer recovery programming to them. Lifeskills hoped to participate in one of these projects, building at least one of these recovery facilities in Warren County. However the operational budgets being proposed and funded were inadequate.

Committee members acknowledged it would be a large commitment to fundraising that would have to take place to do the aforementioned housing project.

G. Workforce development – increased training opportunities for mental health professionals

There has been an identified shortage in clinicians especially those with skills specific to substance abuse treatment. LifeSkills has worked with Western Kentucky University to develop a substance abuse curriculum and propose a certificate program in Addictions Counseling and Health Education. Western will be submitting this proposal sometime in September. While training remains a challenge for all clinicians, KARP has continued to facilitate distance learning, especially in communities far from universities. They have also encouraged DMHMRS (Department of Mental Health and Mental Retardation) to get pre-service training, degree requirements and continuing education on videoconferencing, but with little capacity and success in western Kentucky. DMHMRS and KARP are pursuing e-learning in some centers.

Committee members acknowledged a lack of training in graduate programs and admitted a large part of training is on the job. They were pleased to hear of WKU’s initiatives to implement more substance abuse specific curriculum. A committee member pointed out the stringent requirements for CEU’s for CADC coupled with the minimum degree requirements has decreased the number of CADC’s across the state.

H. Integration of mental health and physical health services and management

There is a nationwide trend to take a closer look at integration of mental and physical health services or at a minimum increased collaboration. Locally, LifeSkills has focused more on collaboration through requesting all clients to sign releases to their primary care physicians at intake and referring them for a physical. There have been some barriers to this process since Medicaid will not pay for a “physical” causing many clients to be resistant to the suggestion. Many severely mentally ill clients have a higher rate of co-morbidity and we are requiring all clients with a schizophrenia spectrum diagnosis to complete a physical health questionnaire. This questionnaire is reviewed by staff psychiatrists and recommendations for primary care physician consultation may be made as a result of the information gathered. LifeSkills has not currently explored an integrated service model but through will be doing so through long-range strategic planning.

Committee member reported that some efforts of LifeSkills to have more open communication and collaboration between healthcare professionals has been beneficial. She also pointed out that patients often do not communicate well about their physical health needs. A family member on the committee addressed the issue of consumers with multiple medications (especially among the elderly) and the other healthcare representatives agreed they saw the same problems and discussed ways they have tried to address these problems through educating the patients and involving family etc.

I. Addressing issue of children “aging out” of youth services

Prior to an adolescent aging out of IMPACT services the treatment team meets to develop a plan for transition to adult services. Plans may include referrals to adult MH/MR services, centers for independent living, supported employment, job corps, and/or assistance in applying for vocational school or college.

Since 2003 there has been an increase in referrals and kids accepted into the IMPACT program although there has been no increase in funding during this time. This has resulted in further gaps in services.

IMPACT plus has continued to restrict and limit the access to and availability of services for which it was originally created (i.e. services not otherwise provided through Medicaid). These denials result in additional time, energy, and money spent on appeals and Medicaid hearings to try and access services for children.

Committee Representative from local group home reported they are funded in 2 ways to provide Independent Living Skills to adolescents but to get funding these children have to be involved with DCBS or DJJ and make a 1 year commitment to the program. Many of these children want “freedom” instead of making an additional commitment to follow rules. It was suggested that funding Independent Living Skills for SED kids or Impact Plus children would be

beneficial. He reports results for those who have voluntarily committed to the program have been positive. Other committee members agreed this is a pivotal point in adolescent's lives and the transition to adult services is less than adequate for many because the structure disappears. More transitional opportunities will be needed in the future according to one committee members who reported seeing the long-term effects in children of mother's crack use during pregnancy and expect to see the effects of methamphetamine in the future as well.

V. Behavioral Health Goals

- A. Briefly describe the top goals set by your Regional Planning Council for the initial 2001-2003 time period.
- B. Describe any changes in priority goals made in the past two years
- C. What progress has been made toward achieving these goals?

Coordination and System Integration –

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

- Western Kentucky University' ALIVE Center has developed a resource clearinghouse for human services for professionals' and consumers' use.
- While there will always be room for improvement regarding coordination and collaboration of service LifeSkills continues to enter into Memorandums of Agreement with entities such as primary care facilities (including health departments), jails, schools, Department for Community Bases Services (DCBS), emergency services departments, schools and regional educational cooperative, Drug Courts, etc.
- Integration of physical and mental health services remains a national issue and one that LifeSkills is currently addressing through a 5-year strategic planning process with the Board.

Service Gaps –

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

- Transportation issues remain a barrier to treatment. LifeSkills has increased community-based services to children in the region.
- 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 98%. Weekly substance abuse aftercare is available at LifeSkills for persons discharged from residential substance abuse programs.
- Outpatient substance abuse treatment will be more available FY 2006 as covered above under Service Gaps. Residential treatment programs extending up to 6 months are limited, there being no such programs in this region. Medical Detox beds still do not exist in this region. The Division of Mental Health and Substance Abuse has applied for grant funding for co-occurring disorders treatment though currently unsuccessful.
- The funding and creation of the Early Childhood Mental Health program has allowed for greater service capacity for children ages 0-5 years and

provided consultation to other service providers of children in this age group (e.g. daycares, Head Start).

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.

- To address the issue of incarcerated inmates committing suicide, the Jail Triage program began in 2003 in Lexington and Frankfort. This program allowed the jails instant access via telephone with a “Qualified Mental Health Professional” for consultation regarding inmates who met certain “high risk” criteria. Shortly after this implementation, legislation was passed making this program state- wide and funding it through higher court costs.
- In December of 2004, LifeSkills went on line with the Jail Triage program with all 8 of the jails in our region at the same time. We were the first region to begin the program all at once rather than phasing it in county by county. The program has operated ever since with minimal problems. Every jail in our region participates in the program.
- Since it’s inception we have dispatched Qualified Mental Health Professional’s to perform face- to-face assessments for 54 inmates in our region (36 of these after regular business hours). Of the 8 jails in our region, 7 have utilized this service at least once since December.
- The program manager for the LifeSkills’ Office of Consumer Advocacy continues to advocate 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. For typical 202A evaluations after hours response is within 1 hour. The Jail Triage system defines it’s own response times based on acuity.

Repeated Psychiatric Hospitalizations –

Goal: Reduce repeat hospitalizations by 30%

- 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.
- The Medical Center has closed a number of beds in the region and will serve only voluntary patients further limiting access to inpatient services. This has increased the utilization of WSH for involuntary commitments.
- LifeSkills Crisis Stabilization Unit continues to be used as a diversion to WSH when appropriate and as a step-down program for transition.

Lee Alcott	
Regional Interagency Councils: Tara Wilson John Sivley –	Law Enforcement-Court Personnel: Seargent James Hyde Jackie Strode
Public-Private Facilities w/MH-SA: Kathleen Riley Janice Richardson Jim Croxton	Individual Providers of MH/SA: Doug Bradley (Mental Health) Karen Garrity (Substance Abuse)

Communicare HB 843 Regional Planning Council HB 843 Report - September, 2005

I. Features of your Regional Planning Council (RPC)

A. List members of your Regional Planning Council and their area of representation
See attached list of Council Members

B. Describe activities of the RPC since your last updated report (July, 2003)

Activities

Participation in advocacy events has always been a priority (with community and consumer members alike). Similarly, the Council embarked on a public service campaign designed to reduce the stigma associated with mental illness and substance abuse. In-depth interviews with community partners and consumers of services were run over six local radio stations.

The Council has been active in budget review and preparation. It has responded to significant events such as the proposed merging of state in-patient facilities. It has provided in-put that included the maintaining of our local inpatient resource for local treatment of 202A consumers in addition to continued support for the Central State facility for our “longer-term” consumers, or those consumers that are not appropriate for short-term service or present with treatment needs beyond the capability of Hardin Memorial Hospital (HMH) 15 bed unit.

Of, late the Council’s thinking has been to focus on the number and kind of community collaborations it might promote. Given the shared understanding that resources are scarce “across the board” for human services, the Council now sees its role as a promoter of partnerships and/or collaborative efforts and has chosen to mark this as the measure of its activity and success.

II. Describe Changes in Regional Needs, if applicable

A. Any significant changes in your region’s demographics

There are no significant changes in the regional demographics in the past year except for the slight upward trending for total population.

B. Update changes in community indicators and prevalence rates; significant events

There have been no significant events within the region that have profoundly affected the over-all status of behavioral health with the exception of growing proliferation of “meth labs”.

C. Any significant changes in dollar resources

“Dollar resources” have remained relatively static.

D. Needs for medical detoxification beds remain a priority.

E. Moderate to long-term residential treatment for behaviorally disordered MR/DD consumers continue to be needed.

III. Update Your Service System Description

Describe any significant changes in your region in access to community-based services:
Status of the “safety net” and addressing gaps in services

The status of the “safety net” has remained relatively stable in the past two years. However, Communicare has embarked on a significant restructuring project that places particular emphasis upon accessibility, integration of services, accountability (driven by the concept of “medical necessity” and “best practices”), compliance and cost-effectiveness. Having engaged a nationally recognized consultant in behavioral health, in the past year the center has

generated a two-phase plan over the next four years that reflects significant changes with regards to finance/technology, standard documentation throughout the center, outcomes/ performance and clinical practice embracing rehabilitation and recovery models.

Services for specific populations (children, elderly, revolving door, deaf, homeless, dually-diagnosed, etc.)

Services for specific populations have shown significant increase in the past year across several key areas of special interest:

Population	Increase
Children w/SED	17%
Total SMI	9%
SMI/SA	7%
SMI/MR	26%
Deaf/Hard of Hearing	28%
Consumers w/DCBS	33%

These increases reflect Region 5’s commitment to providing access to services across all areas of disability. Of particular note is the access to acute, sub-acute and outpatient services for dually diagnosed MH/MR consumers. Significant strides have been made regionally in helping professionals to clarify the hitherto contentious problem of Axis I psychopathology and its expression in MR/DD consumers. Crisis dollars have assisted in allowing MR/DD staff to be intimately involved in “on-the-unit” participation during hospital and crisis unit admission for this population.

Collaboration, cooperation and communication among service providers
Evidence-based practices and focus on Recovery

Collaborations:

As mentioned before, the RPC has decided to focus on the number and kind of collaborations to promote and track over the next reporting period. They will include efforts to integrate behavioral health with regional physical health practitioners. Depression screenings and behavioral health information in general practitioners offices are seen as a priority.

The RPC has added the regional representative from the Office of Vocational Rehabilitation (OVR) to its membership. This is seen as a key component to the supported employment initiative within the region. Communicare will be meeting with OVR and Social Security representatives to insure that the problem of “benefits management” is fully addressed as it is the single most significant barrier to Supportive Employment participation.

Communicare continues to actively partner with the regional DCBS as evidenced by the 33% increase in consumers referred and served by that agency. Additionally, plans to provide region-wide parenting classes are being developed.

An interesting incipient project in collaboration with the Lincoln Trail Administrative District and public health is “in the works” and supported by the RPC. Discussions around the problem of aged adults with developmentally disabled caretakers are being addressed. Collaboration among these agencies will focus on skill-development, health practices and case management support for those disabled caretakers. The goal of the project is to increase probability of

them remaining in an independent or semi-independent status when their parents pass away.

IV. Describe Regional Response to These Events or Influences:

A. Concept of changes to state psychiatric hospital services

B. Closure of psychiatric hospital beds in region, if applicable

With respect to inpatient psychiatric services, the RPC steadfastly supports local treatment for our regional 202A consumers. While the unit cannot provide for all the exigent acute needs, it is seen as an important part of the service safety net within the region. The RPC is well-aware that estimates of Region V utilization at Central State Hospital (CSH) were oft-quoted at 20% of their capacity. Since the initiation of the Hardin Memorial Hospital (HMH) collaboration, referrals to CSH have been limited to those rare occasions when a consumer's presentation could not be accommodated at HMH or the unit is at capacity. Of deep concern to the RPC is the viability of the continued partnership between Communicare and HMH due to lack of funding to support this worthy project.

C. Implementation of Medicaid Pharmacy Benefits Administrator (First Health) & impact on consumers' access to medications

The implementation of the Medicaid Pharmacy Benefits Administration has been problematic. Pre-authorizations have been characterized by the necessity for repeated calls for authorization, the lack of "in-the-moment" collaboration resulting in those repeat calls, consumer complaints to the Regional Planning Board Ombudsperson regarding medication access and, at times, seemingly rigid adherence to protocols that do not serve the best interests of the consumer.

D. Implementation of Jail Triage program

Communicare initiated the Jail Triage Program in Region V on February 1, 2005. Memorandums of understanding were obtained from all seven detention centers in our eight county service area. Jail Triage is a 24 hour/7 day a week response service. During normal business hours (8:00 am -5:00 pm) the local outpatient mental health clinic provides on-site service to the local detention centers. To cover the entire region and to ensure a rapid response time for service when the outpatient mental health clinics are closed, the region has been divided into east and west with an on-call clinician in each area ready to respond to calls dispatched from the emergency services office.

As of June 30, 2005, Communicare responded to 65 calls for on-site service at local detention centers via the Jail Triage program. Upon responding to these 65 calls approximately 1/3 of the clinicians recommended either voluntary or involuntary in-patient hospitalization for psychiatric illnesses for consumers housed in the detention centers.

E. CSU services funded for both children and adults in each region

The Region V Adult and Child Crisis Stabilization Units have been fully operational during this reporting period. Of particular note within the region, is the commitment to fully integrating treatment of MR/DD consumers with Axis I diagnoses into the programs. The regional stance is that all consumers are eligible for all available services, regardless of disability.

The Adult Crisis Stabilization Unit (ACSU) is located in Elizabethtown and is an eight-bed, 24-hour alternative to inpatient hospitalization. The ACSU is a non-medical, voluntary unit and provides mental health services in the least restrictive manner possible. The treatment goal is to assist mental health

consumers through a time of crisis and help them return to a pre-crisis level of functioning. The ACSU utilizes a multi-disciplinary team to assist the consumer in returning to their home environment and linking them with community resources as quickly as possible and to avoid hospitalization. Of particular note is the acceptance for treatment of dually diagnosed MH/MRDD consumers.

The Children’s Crisis Stabilization Unit (CCSU) is located in Elizabethtown. It serves children ages 4 – 17. The CCSU provides an option to hospitalization for children who cannot be maintained in the home setting. Average length of stay is typically under a week. During their stay, children receive such services as individual, family and group therapy, nursing services and psychiatric evaluations with medication management follow up.

F. Establishment of Governor’s Office of Drug Control Policy with focus on substance abuse disorders and increased funding for treatment and housing

1. Local reaction to this office includes the observation that there has been a dramatic decrease in paperwork requirements for “Champions” project applications and this received much praise from our local Champions groups. The local KY-ASAP Board is undergoing significant changes due to the creation of the Governor’s Office of Drug Control Policy. What has been a focus on and membership of “prevention” oriented individuals, now includes a broadening of the scope of the Board.

This widening now includes active membership of law enforcement and treatment advocates. The four local boards have made it a priority to gather more information/data regarding law enforcement and treatment issues. The Heartland Board (Hardin, Grayson and Meade) recently made a recommendation to its state oversight to consider funding for the medical detoxification of indigent consumers.

2. Recovery KY programs promise to provide a much needed resource for parts of Kentucky. Particularly, they will fill a gap in areas where residential substance abuse services are not available, typically rural areas. By serving up to 100 substance dependent men or women over a long period of time, these projects will go a long way toward meeting needs of a population that has been overlooked in terms of residentially-based services.

Recovery KY programs aim to serve these individuals by providing a peer-led model based on two successful programs in Kentucky, the Hope Center in Lexington, and the Healing Place in Louisville. The Recovery KY model aims to serve these individuals with peer-led education and support. As such, these are not traditional “treatment” programs. Treatment, instead, involves professionally-led individual, group, couples, and family therapy combined with education and involvement in support groups. Therefore, Recovery KY programs should be viewed as a part of the “continuum of care,” as opposed to a replacement for residential treatment services.

A concern for this type of program is the lack of funds allocated to support the infrastructure and elicit the building of a ‘recovering community’ in areas especially more rural ones, where that support may be insufficient or missing. Funding should be established to allow Recovery KY programs and traditional treatment programs to partner in the provision of services to substance dependent individuals. Community mental health agencies are often at capacity based on their current funding levels. By supporting such a network financially, the treatment gaps may begin to close. To truly meet a gap in

services and to do so effectively within a variety of communities, seems to naturally equate to ensuring that the longer term community supports are in place and adequate to meet the demand.

One drawback to Recovery KY programs is their creation prior to the community supportive infrastructure being developed. In particular, with 100 individuals aiming to become, or return to productive citizens of the Commonwealth, job openings, leisure activities, support networks and transportation need to be in place for these individuals to have the chance for success they deserve. Careful examination of the locations of these programs to optimize outcomes should be undertaken.

With as many as 50% of the residents of these programs being referred from the criminal justice system, it is believed (based on national statistics) that as many as 40% of those residents will have co-occurring mental health and substance dependence problems. This means communities will have to have the capacity to provide initial and ongoing mental health services as well as jobs, etc. National best practice initiatives propose providing both substance abuse and mental health services simultaneously in an integrated care system. By not partnering with community mental health agencies to provide substance abuse treatment, any provision of mental health treatment will be fragmented care, at best.

Additionally, the capacity of small outpatient mental health clinics in our region is already stretched, let alone able to provide services for an influx of potentially high utilizers of services. As these consumers are not likely to have insurance coverage, it will fall to the State General Fund to provide the financial support for adequate treatment. While the Regional Planning Council certainly supports the concept of Recovery KY and notes that discussions in one of our more rural communities to build such a program, we do have concerns as noted above.

G. Workforce development – increased training opportunities for mental health professionals

Of note is the development of a fledging Mental Health Associate degree contained within Elizabethtown Community and Technical College. This degree is seen as “entry-level” preparation for direct care behavioral health providers. The hope was that the degree would provide “ground level” experience and spur people on to pursue bachelor and graduate degrees.

However, that has not seemed to be the outcome thus far.

Communicare has hired three graduates from Lindsey Wilson and one from Western Kentucky University, during the reporting period. Additionally four doctoral level clinicians serve as adjunct professors for both the universities.

H. Integration of mental health and physical health services and management

Communicare’s Early Childhood Specialist serves in a screening and consultation role with the Public Health program “Healthy Starts” across the region.

The RPC recognizes the need to collaborate more effectively with regional general practitioners. In collaboration with the Lincoln Trail Administrative District the council plans to provide behavioral health referral and resource information across the region.

The Council further recognizes the importance of physical health particularly with respect to SMI consumers and the known co-morbidity of serious health

issues. The RPC is planning to sponsor behavioral health educational opportunities (with Continuing Medical Education Units) for regional physicians. It is hoped that this will marry the physician's need to gain continuing education credits for licensure maintenance and the need to raise awareness and expertise in the management of behavioral health practices outside the MH/SA community.

I. Addressing issue of children “aging out” of youth services

Communicare's reorganization plan includes an attempt to integrate child and adult case management services to coordinate geographically as opposed to a supervision structure based on age. This will enhance the transition of youth to adult services (where appropriate) by increased communication among providers, more intimate knowledge of caseloads and a focus on service planning for older adolescents.

Communicare will be serving on the Regional Interagency Transition Team (RITT). It is a multi-disciplinary team with key “players” being education, juvenile justice and behavioral health.

V. Behavioral Health Goals

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

Initial goals for the 2001 – 2003 period included local treatment of 202A consumers, increased capacity of child outpatient services, adolescent IOP and adult transition housing for women's substance abuse. All four of these primary goals have been attained.

Communicare now has two full-time Board Certified Child Psychiatrists with the potential of adding another within the next six months. Communicare partnered with a private hospital (Ten Broeck) to provide an adolescent IOP for substance abuse. Communicare initially provided the space and medical component to the program. While the service continues to operate locally, it is come solely under the aegis of Ten Broeck.

B. Describe any changes in priority goals made in the past two years

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

As aforementioned, the RPC has found it difficult to maintain momentum. The recent Medicaid “crisis” seemingly has energized community partners' interest in maintaining behavioral health services within the region. The council has decided that the following goals serve as guideposts over the next biennium:

1. That a minimum of 50% of all general practioners within the region will have behavioral health resource and referral information in their offices.
2. The council will select a minimum of two collaboration projects per year to give its attention and monitoring.
3. To continue to support advocacy efforts at the state level in support of behavioral health issues in general and maintenance of the “safety-net” in particular.

Continue to collaborate in efforts to increase transportation to and from needed services.

VI. Recommendations

- A. Describe your recommendations regarding funding, particularly in light of the projected Medicaid shortfall and the impact on the Behavioral Health Safety Net
The Region V Planning Council supports the following agenda:

1. Support for the Communicare/Hardin Memorial partnership for local treatment of 202A consumers.
 2. Support for a potential pilot for “volunteer” transportation for consumers to include mileage and insurance coverage.
 3. Support for mental health treatment beyond current State General Fund funding levels.
- B. Describe recommendations for public policy changes, particularly in moving toward statewide “modernization” of the system of care

The Region V Planning Council supports the following agenda:

1. The promise of “moving Kentucky from 48th to 25th” in spending on behavioral health be given appropriate emphasis.
2. That behavioral health and human services be acknowledged as having well-documented hidden and often delayed consequences to it’s under-funding.
3. That institutions of higher learning (graduate programs in behavior health) place specific emphasis in their core curricula on the “medical necessity”/ best practices interaction and of co-occurring Axis I disorders in the treatment of MR/DD and SA consumers.

Seven Counties Services Regional Planning Council

HB 843 Report - September, 2005

I. Features of your Regional Planning Council (RPC)

A. List members of your Regional Planning Council and their area of representation
(Attachment 1)

B. Describe activities of the RPC since your last updated report (July, 2003)

Throughout its existence, the council has continued to keep current with the business of the statewide HB 843 Commission and the state legislature, with regular reports from commission member and Region 6 council chair Bernie Block, and legislative liaison Sheila Schuster. This council also participated in a review of the activities of statewide workgroups and provided comment to the commission. In addition, the council also continues to be a vehicle for the exchange of information in the region as council members share news from their organizations and geographic areas.

In 2003, the council determined the priorities it wanted support for by Metro Louisville government, and ways to work toward achieving that support.

Also in 2003, the council reconstituted its membership with the addition of several new members who replaced former council members who left the council due to professional or personal demands. The council provided an orientation for new council members. The council also named new chairs for several of its workgroups in an attempt to recharge inactive workgroups.

In 2004, the council hosted two community forums seeking regional input on the Hospital Concept paper presented by Dr. James Holsinger. In addition, it formed a Region 6 workgroup that included both council members and ad hoc members to measure the hospital paper against the council's principles of treatment and community services, and then develop a regional response to the concept paper. . Then the council presented its response both in writing and at the Louisville forum hosted by the Cabinet for Health and Human Services. Seven Counties also asked the council to review and support a separate response from Seven Counties, which it did.

Also in 2004, the council invited Dr. Vicki Hines-Martin, a council member and member of the U of L faculty, to present the results of her local research study on barriers to mental health services in the African-American community.

In addition, the council also has become an active advocate for the region and for mental health and substance abuse issues.

During the 2003 legislative session, the council sent letters to the editors of papers in the region that were published urging the legislature to find ways to increase revenue to help fund prevention, treatment and support services for mental health and chemical dependency.

In 2004, the council also responded to massive cuts in HUD funding for the Metro Louisville area by sending letters to Senators McConnell and Bunning, Rep.

Northrup, the governor, and the Metro Louisville mayor and chair of the Metro Louisville Council, urging them to help discern why the cuts were made and to help facilitate HUD reconsideration.

In December 2004, the planning council also sent a letter to the Commissioner of Mental Health/Mental Retardation Services drawing attention to the hospital bed crisis created when a local hospital closed psych beds. In the letter (Attachment 4) the council supported U of L Hospital and Seven Counties Services in a request for the state to open a 20-bed unit at Central State Hospital, which did occur.

II. Describe Changes in Regional Needs, if applicable

A. Any significant changes in your region’s demographics
 No

B. Update changes in community indicators and prevalence rates; significant events
 Prevalence data has been updated see attached spreadsheet. No significant changes noted just updated based on 2002 census data. (Attachment 2)

C. Any significant changes in dollar resources
 Louisville/Jefferson County lost \$ 4,858,901 from HUD for the Continuum of Care Plan. These dollars have been used to provide an array of housing and supportive services for both youth and adults many with mental illness and substance abuse problems.

III. Update Your Service System Description

Describe any significant changes in your region in access to community-based services:

Status of the “safety net” and addressing gaps in services
 Safety net continues to unravel, and gaps in services continue.

Services for specific populations (children, elderly, revolving door, deaf, homeless, dually-diagnosed, etc.)
 There have been increases in services for the deaf/hard-of-hearing as well as for non-English speaking populations, particularly Hispanic/Latino. The region’s comp care center, Seven Counties, also has made increasing dual diagnosis services for persons with MR/DD and mental health and/or substance abuse diagnosis a priority for the center.

Collaboration, cooperation and communication among service providers
 We have seen an increase in collaboration, cooperation and communication among service providers in joint planning and grant-writing. In addition, the local HB 843 housing work group has blended into a existing group that also is working on expanding housing services for the populations that HB 843 address. Seven Counties’ Homeless Outreach Team and the Family Health Centers work closely addressing the homeless population, as well as improving integration of behavioral and physical health, by co-locating staff.

Evidence-based practices and focus on recovery

The largest provider of MH/SA services in the region, Seven Counties Services, began moving to evidence based practices within about the last 24 months. Beginning this fiscal year, its contract with the state also links contract performance measures with evidence-based practices and recovery models. Central State Hospital and Seven Counties also are part of the evidenced-based state KYMAP drug algorithm project.

In addition, Bridgehaven, a subcontractor of Seven Counties under its DMHMR contract, uses an evidence-based rehab and recovery model in providing psych rehab services and an evidence-based model in providing integrated intervention for persons with co-occurring SMI and substance use/abuse disorders. The Seven Counties and the Bridgehaven staffs have been attending the teleconferences on evidence-based practices (specifically, supported employment) sponsored by DMHMR in an effort to determine ways to integrate supported employment services into their psych rehab and recovery programs.

IV. Describe Regional Response to These Events or Influences:

- A. Concept of changes to state psychiatric hospital services
(Attachment 3. The Region 6 HB 843 Hospital Concept Response paper)
- B. Closure of psychiatric hospital beds in region, if applicable
(Attachment 4. Letter from council chair Bernie Block on behalf of council requesting opening of 20 beds at CSH)
- C. Implementation of Medicaid Pharmacy Benefits Administrator (First Health) and impact on consumers' access to medications
The implementation of the Medicaid PBA has been very rough and created barriers for consumers to their medications. While representatives from this region have been involved in many discussions with the state on resolving the barriers and troubles with First Health start-up, problems continue and often create critical delays in consumers accessing medication.
- D. Implementation of Jail Triage
Contract is signed with two of the rural jails in the region, Shelby and Oldham, to use the Jail Triage program.

In the Louisville Metro area, we have worked closely with the staff to make major modifications to the statewide program as it is not needed with this corrections department. The Louisville Metro Corrections Department already has 24/7 coverage by qualified mental health professionals to screen all inmates. There is a need, however, to develop re-entry plans for those inmates with mental illness and substance abuse issues who are being released into the community. A committee has started working and will do a pilot project to address this complex problem that was identified in the original Region 6 HB 843 plan submitted to the state commission.

- E. CSU services funded for both children and adult in each region.
Yes, this was funded prior to the 843 legislation.

- F. Establishment of Governor’s Office of Drug Control Policy with focus on substance abuse disorders and increased funding for treatment and housing.

This region has yet to see little benefit from this new office. Because this region already had The Healing Place, dollars set aside for housing did not come to this region due to already having Healing Places in our region and in fact has had a negative impact in reducing dollars for other types of housing for the mentally ill which was a major goal and identified need especially in our rural counties. One of the benefits we have seen is an increased awareness of the need for substance abuse treatment and better coordination of effort.

- G. Workforce development—increased training opportunities for mental health professionals.

Nothing.

- H. Integration of mental health and physical health services and management

The Family Health Centers in Louisville have had a HERSA grant leading to Seven Counties providing psychiatric consultation to FHC’s primary care physicians. In addition, through a partnership with Park DuValle, a grant was submitted to provide a truly integrated model in Spencer County. However, the grant was not funded but received a high score, so it will be submitted again when HERSA reopens the window.

In addition, a pilot project has started with the Family Health Centers, the Jefferson County Public Schools, Seven Counties Services, Caritas, and the Housing Authority of LOUISVILLE to improve Key Health Indicators in the Hazelwood/Iroquois community. Part of the funding comes from the Community Foundation of Louisville as well as the key partners.

- I. Addressing issue of children “aging out” of youth services

The Coalition for the Homeless, with help from our HB 843 workgroup, worked on passing HB 376 legislation addressing individuals leaving state institutions. This includes corrections, foster care, and mental health facilities. Clients who would leave state institutions and go directly to a shelter would be engaged by the institutions prior to release and followed for six months into the community with consistent case management. Service plans would be developed to help individuals access needed services, thus reducing the likelihood that they will end up in the homeless shelter system or back in an institution. This two-year pilot project will be implemented in Region 6 and the Adanta region.

V. Behavioral Health Goals

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

They continue to be the same as in December 2000 (Attachment 5. Initial set of goals).

- B. Describe any changes in priority goals made in the past two years.

None really. Metro Louisville and Seven Counties Services will be convening a task group within this fiscal year that will include Region 6 HB 843 council membership to look at the interface between local criminal justice systems and the MH/SA/MR/DD systems.

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

The housing issue has had many ups and downs, but clearly there is an increased awareness of housing needs of the region.

Seven Counties Services, Metropolitan Housing Coalition, Volunteers of American, and the Kentucky Housing Corporation have all recognized the need to improve the housing array. Disappointments, however, have been KHC closing the TBRA funds, as well as placing so many of the dollars into the Recovery Homes, which did not help this region’s need for more housing for those with mentally illness and substance abusers.

There have been meetings with a private developer who is interested in building supportive housing in this region, and discussion continues to proceed with local government to explore the viability of expanding the housing stock based on data and identified need.

See above about initiation of services through the jail triage program.

Planned criminal justice task group for this fiscal year (see above).

VI. Recommendations

A. Describe your recommendations regarding funding, particularly in light of the projected Medicaid shortfall and the impact on the Behavioral Health Safety Net.

Our recommendations remain the same as they were in 2002; they are contained in the Attachment.

B. Describe recommendations for public policy changes, particularly in moving toward statewide “modernization” of the system of care.

The recommendations of this council continue are the same ones put forth in its initial December 2000 report; they are contained in the Attachment.

**NorthKey HB 843 Regional Planning Council
HB 843 Report – September, 2005**

I. Features of your Regional Planning Council (RPC)

A. List members of your Regional Planning Council and their area of representation

Name	Constituency	Name	Constituency
Carol Fausz	MH-MR Regional Board – RPC Chair	Edward Smith	Community Advocate
Michelle Barrett	St. Luke Hospitals	Mac McArthur	Transitions - Provider
Tim McDermott	St. Elizabeth Medical Center	Donald Brewer	Family Services - Provider
Dennis Corrigan	DCBS -Agency	Mike Hodge	Provider
Jim Coleman	Recovery Network/Consumer	Barbara Sween	NKU – Provider/Planner
Janice Bogner	The Health Foundation of Greater Cincinnati - Planner	Rick Flesch	Northkey Community Care - Provider
Alan Kalos	Health Department - Planner	Leisha Lyman	United Way
Joyce Williams	Family/Parent Support Coordinator	Charlotte Wethington	Family Member - Advocate
Kirk Kavanaugh	Boone County Human Services - Planner	Robin Rider- Osborne	Consumer
Navonda Patterson	Northkey Community Care - Provider	Michael Schroth	Campbell Lodge - Provider
Connie Wong	Holly Hill Children’s Home - Provider	Kyra McCormill	St. Luke IOP - Provider
Elaine Chisholm	Consumer	Barry Johnson	DCBS - Agency
Mary Pat Behler	YSAT – Planner/Advocate	Rita Brooks	Consumer
Larry Wells	Transitions - Provider	David Olds	Mental Health Association of NKY – Advocate/Provider
Kelly Bond	MH & Aging Coalition/NKADD - Planner	Pat Dressman	Campbell County Fiscal Court - Planner
Tammy Weidinger	Brighton Center – Provider/Planner	Stacy Alder	Boone County Human Services - Planner
Sue Davis	Northkey Community Care – Provider/Planner	Gary Goetz	Northkey Community Care – Provider/Planner

B. Describe activities of the RPC since your last updated report (July, 2003)

- ➔ RPC continues monthly meetings and communications with community members and legislators.
- ➔ RPC continues to collaborate with the MH-MR Regional Board, other agencies and other regional coalitions/planning groups to facilitate

- communication, advocacy and planning in support of on-going improvement in the mental health and substance abuse service delivery system.
- RPC continues to work on broadening membership in order to maintain and enhance regional perspective and community linkage.
 - RPC provided testimony at Northern Kentucky legislative Caucus meetings in 2004 and 2005.
 - RPC members met with legislators in Frankfort during 2004 legislative session to encourage their support for MH/SA services.
 - RPC sponsored a community forum, with over 100 attendees, in November 2003 to review regional Mental Health and Substance Abuse service needs.
 - RPC sponsored a Legislator Roundtable discussion in January 2005 to review regional MH and SA treatment needs and priorities.
 - RPC and its membership provided support (letters, information, some member assistance) for efforts to identify regional operators and facilitate submission of applications for Recovery Kentucky sites in the region.
 - RPC provided information to regional legislators and advocated for increased funding for mental health and substance abuse services statewide as well as regionally. RPC advocated for funding formula changes to allow the region to be responsive to increased service demands created by strong and rapid population growth and worsened by the historical per capita under funding of our regional services.
 - RPC member testified before the Joint Interim Committee on Health & Welfare in June 2005 regarding mental health and substance abuse funding needs (focused on both statewide and regional needs).

II. Describe Changes in Regional Needs, if applicable

- A. Any significant changes in your region's demographics
- Total Regional population continues to have sustained and rapid population growth
 - A. Total regional population estimate for 2005 is 411,952 (9.88% of the state population)
 - B. The region has added 20,535 residents in 5 years
 - C. Growth rate indicates that population will increase by over 30,000 people in the next 5 years
 - Continued growth in Spanish-speaking population
 - A. Northern Kentucky has the 3rd largest Spanish-speaking population in the State, estimated at 7,142 in 2005
- B. Update changes in community indicators and prevalence rates; significant events
- Recent county uninsured rate report from the census bureau (based on the 2000 census) estimates our region had 38,877 individuals without health insurance at that point in time.
 - The region continues to be below the State average in percentage of population below the poverty level (averaging about 8.5% for the region), which translates into approximately 34,921 individuals with incomes below the poverty level.
 - Prevalence and service need (based on 2005 estimated population):
 - A. 7,819 Adults experiencing Severe & Persistent Mental Illness (SPMI)
 - B. 5,561 Youth experiencing Severe Emotional Disturbances (SED)
 - C. 54,702 Adults needing SA treatment

D. 1,591 Youth needing SA treatment

C. Any significant changes in dollar resources

- FY 2004 – decrease of 2.5% (totaling over \$156,000)
- FY 2005 – decrease of 2.5% continued (totaling over \$156,000),
- FY 2005 – began KEYS grant implementation with DMH (received approximately \$170,000 in KEYS related expense reimbursement funding in FY 2005)
- FY 2006 - increase in State General Fund dollars (totaling over \$360,000) ... includes legislative increase for Community Care Support dollars and a small increase for population growth based upon the current funding formula.
- FY 2006 – Continued KEYS implementation (projected \$1,000,000 in expense reimbursement funding for FY 2006).
- Start-up grant funding lapsed/lapsing for Youth Substance Abuse Collaborative & Adolescent Intensive Outpatient Program (totaling approximately \$100,000 per year) ... KY ASAP Board provided some match and replacement support to date. Currently NorthKey is supporting continuance, for the immediate future.

III. Update Your Service System Description

Describe any significant changes in your region in access to community-based services:

Status of the “safety net” and addressing gaps in services

- In general, safety net services remain significantly challenged to meet regional demand. The region is unable to grow service resources at a rate comparable with population growth. Some examples:
 1. For the low-income population, the need for psychiatry appointments and medication management appointments continuously exceed available resources (90 day wait is typical).
 2. In CMHC, maintaining adequate clinical staffing remains challenging (especially in rural office locations), on-going staff turnover in general (related, in part, to non-competitive salary levels) continues to create inconsistency in availability of some services.
 3. Substance abuse service for adults and youth (especially residential and intensive outpatient services) for those outside the legal system or without adequate health insurance or sufficient private funds remains primarily non-existent.
 4. Adequate screening/assessment for youth with substance abuse needs to be enhanced and more readily available.
- A positive regional safety net resource has developed in the MH mobile crisis stabilization services (adult and child). Both services continue to increase in coverage area and service utilization. Child Crisis served 379 youth in the past year and adult crisis served 595 adults in the past year.
- Outpatient Intensive Partial Hospitalization services began for youth in 2004.
- Jail Triage and follow-up services began in Kenton and Grant County jails.

Services for specific populations (children, elderly, revolving door, deaf, homeless, dually-diagnosed, etc.)

- All outpatient SA services address co-occurring SA and MH problems (this includes adolescent Intensive Outpatient Treatment (IOP), Women’s IOP and regular outpatient treatment).

- NorthKey continues to employ a clinician who is fluent in sign language and also continue to employ one psychologist and one psychiatrist who are fluent in Spanish.
- Regionally, resources for providing services to Spanish-speaking individuals require significant improvement and enhancement.

Collaboration, cooperation and communication among service providers

The HB 843/RPC process continues to facilitate increased collaboration and communication among service providers and other community constituents. The ability to provide direct input into the budgeting and service prioritization process is a strong positive. It has helped the region present a unified voice regarding regional service needs. Additionally, a collaborative effort among several agencies to provide a more coordinated group of services to low-income individuals will soon begin in Covington (called “Community Solutions”)

Evidence-based practices and focus on Recovery

- NorthKey provides Functional Family Therapy with the justice system involved youth population (2nd year of 3 year grant)
- NorthKey, Transitions, Inc. and Family Services of Northern KY each have grants from The Health Foundation of Greater Cincinnati to evaluate readiness to implement evidence-based treatment for youth with co-occurring disorders (exploring both outpatient and inpatient options)
- The adolescent IOPs in Kenton and Campbell counties have been using concepts from the Seven Challenges Program.
- Family Services of Northern KY has a grant to increase staff to provide the evidence-based practice of Parent-Child Interaction Therapy

IV. Describe Regional Response to These Events or Influences:

A. Concept of changes to state psychiatric hospital services

In general region in support of modernized facility and resources. Our strong recommendation is that any savings from operating a more efficient and contemporary State facility/program must be used to strengthen the community-based service options. This would allow the treatment array to become more comprehensive at the community level to further minimize hospitalization need and duration and prevent relapse/revolving door scenarios.

B. Closure of psychiatric hospital beds in region, if applicable

Psychiatry beds have remained the same since last report. Both adult bed hospitals operate at a high census level at this time. The child psychiatric bed service provider (NorthKey) has periods of bed unavailability due to high census, necessitating use of Children’s Hospital Medical Center in Ohio. As our region’s population continues to grow, there will likely be a need for increased numbers of inpatient beds. Despite the great need, our region continues to have no residential treatment beds for youth (PRTFs). The current reimbursement structure, combined with regulatory requirements preventing the cost effective development of beds do not support the availability of these beds for youth in our region.

C. Implementation of Medicaid Pharmacy Benefits Administrator (First Health) & impact on consumers’ access to medications.

Implementation has been challenging. Initial confusion about benefits, name brand medications approvals and prior authorization process resulted in several unacceptable scenarios resulting in medication doses being missed by clients.

The process for prior authorization has been especially cumbersome and inconsistent.

D. Implementation of Jail Triage program

Implementation has been in 2 jails to date (Kenton County and Grant County) with positive results in both locations. Kenton County has also contracted for additional MH services provided in the jail environment. This has been a positive addition in the jails that have initiated the screening process, NorthKey continues to discuss the option with other jails in our region.

E. CSU services funded for both children and adults in each region

Thus far there has been a very positive community impact from the services that have been developed. Services have become available to a group of youth that previously were not receiving intensive, focused treatment services. Residential components for adults and children are not developed – some community members continue to request the development of some level of overnight crisis stabilization capacity for both adults and youth.

F. Establishment of Governor’s Office of Drug Control Policy with focus on substance abuse disorders and increased funding for treatment and housing

1. Our understanding is that the ODCP does not provide funding for SA. Their charge is to better integrate prevention, treatment and law enforcement. They will partner with the Division of MH & SA (and support other agencies) in writing federal grants. Most of the emphasis appears to be on SA services for adults.
2. Our local KYASAP Board submitted a proposal to the ODCP requesting funding for outpatient SA prevention and treatment services – we are awaiting a response.

G. Workforce development – increased training opportunities for mental health professionals.

Some preliminary and beginning efforts with NKU and Gateway Community College have begun. Region produces degreed individuals (within the Greater Cincinnati area) but pay scales remain higher in Ohio than in Kentucky, thus the CMHC (and other community agency providers often experience a migration of clinicians to Ohio.

H. Integration of mental health and physical health services and management

An effective mechanism for encouraging and sustaining this seemingly natural collaboration has not been developed within the region. There are outreach efforts underway to build the bridge between primary care and behavioral health.

I. Addressing issue of children “aging out” of youth services

There is an issue of youth ‘aging out’ of SA services. If youth with Medicaid as payer (through EPSDT) do not receive the treatment they need, finding services as an adult becomes difficult to impossible. The same scenario occurs for youth with MH problems since Medicaid covers treatment for youth and then becomes very narrowly available as a payer for Adults.

V. Behavioral Health Goals

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

- ➔ Continue to educate local legislators about our regional service needs and statewide service needs. The goal is to acquire adequate statewide funding for MH/SA services.

- Continue to work with legislators and Cabinet of Health Services staff to seek changes to the funding mechanisms (and regulations when necessary) for mental health and substance abuse services so that our region has the appropriate funding support to meet the needs of our population, with an appropriate service array.
- Continue to enhance membership on RPC to involve more consumers and other community member representation.
- Work more closely with the northern Kentucky Chamber of Commerce to help our business leaders understand the importance of appropriate mental health and substance abuse service availability.
- Increase regional funding for mental health and substance abuse services.
- Increase flexible use of funding dollars to maximize our ability to meet local needs.
- Utilize 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 data collection regarding existing regional service resources and 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 SA services 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 who are 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 (Youth and Adults).
- Increase availability of appropriate psychiatric medications regardless of income level of the client/patient.

B. Describe any changes in priority goals made in the past two years

While we have achieved some improvements, the previously identified priorities remain for our region. The sustained tremendous growth of regional population continues to outpace the rate of service resource development.

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

- Our region (via NorthKey) has submitted a proposal for a 1.2 Million dollar SAMHSA grant to enhance/expand treatment resources for Northern Kentucky adolescent drug courts - we are awaiting a response.
- Two service providers in the region have submitted applications for 100 bed Recovery Kentucky projects (1 male and 1 female). Female project was recently approved for funding and male project is awaiting community approval of site.

VI. Recommendations

- A. Describe your recommendations regarding funding, particularly in light of the projected Medicaid shortfall and the impact on the Behavioral Health Safety Net
- A Medicaid shortfall that results in a global broad-based tightening of eligibility or services availability to Medicaid payer consumers will likely have a serious negative impact on service access. Presumably, this will require more service to receive support from State General Funds. The community demand for services will remain high (and grow in our region), while less people may have Medicaid as a payment option. Thus, if Medicaid is narrowed in its scope, flexible funding for community-based services must be increased more rapidly to allow for adequate response to this increased service demand. Additionally, if the State is committed to developing and prioritizing evidence-based and best practice services to achieve improved outcomes, with the goal of reducing overall long-term demand, then the payment mechanism and funding structure need to be modified to adequately support the development and sustainability of evidence-based treatments. They do not easily fit within traditional and historical funding and service designs.
- B. Describe recommendations for public policy changes, particularly in moving toward statewide “modernization” of the system of care

“Modernizing the system of care” seems to require visionary leadership and a long-term plan including short-term targeted steps to achieve that plan.

We define effective “modernization” as necessary services being delivered as effectively and efficiently as possible. This requires viewing appropriate MH and SA treatment services as valuable and beneficial to the whole community and as broad State and community basic requirements. The funding and evaluation mechanisms must be flexible and broad enough to avoid the far too common error of merely focusing on narrowly defined costs as an indication of success. This is short sighted and frequently results in shifting costs from one community system to another. A current example of this shifting of costs is the jail and prison systems where short-term cost controls in the mental health and substance abuse arenas led to the natural (and predictable) outcome of inadequately developed and supported community-based MH and SA treatment resources. Consequently there has been an overwhelming upswing in prison populations with increasingly complex and challenging mental illnesses and substance addictions. In retrospect, adequately funding community-based treatment resources would have been significantly more humane and cost effective than simply shifting cost and care to other ill-prepared systems.

Modernizing the system will also require the development of complete systems of care, which is most efficiently done from the financial perspective by leveraging dollars from other sources to minimize State cost. The availability of an adequate treatment array brings about effective outcomes and is a core requirement of any modernization effort. This perspective supports the use of Medicaid as payer for several services needed to fill gaps in the current care continuum. Medicaid leverages over two Federal dollars for each State dollar that is spent and thus is financially wise to fund service development. In particular, the addition of SA services into the State Medicaid plan for adults and youth would be an effective way to increase the service resources available to individuals with significant treatment needs while paying for a minor portion of the cost with State dollars.

In addition, to requiring flexible financial and resource investment to enable development and support of missing components of effective community-based treatment, true “modernization” also must promote cross-system processes to continue intervention and treatment where needed. It also must track effectiveness and be evaluated through overall community impact. The ability to provide necessary treatment resources and evaluate true effectiveness avoids repeating the ineffectual, and in some cases harmful, historical pattern (and continued temptation) of evaluating results with a narrow, silo viewpoint.

The view from the State must be broader than the individual Cabinet level, and the local view must be broader than the individual provider level, the individual city level and the individual county level.

Comprehend HB 843 Regional Planning Council HB 843 Report – September, 2005

I. Features of your Regional Planning Council (RPC)

- A. List members of your Regional Planning Council and their area of representation
David Bolt (Chair), Primary Care, Caroline Clarke-Ullery, ADD; Cheryl Love, Children's Advocacy Center; Sandra Pelphrey, Health Department; Rob Hall, Education; Tim Stump, Health Department; Donna Penrose, CMHC; Steve Lowder, CMHC; Goldie Williams, CMHC; Lorna Kay Sapp, CMHC; Kent Butcher, Criminal Justice; Todd Walton, Criminal Justice; Rickey Corns, consumer; Roberta Gilliam, parent of consumer; Shelly Minner, consumer; Myrtle Brown, consumer; Regina Jefferson, parent of consumer; Margaret Bothman, grandparent of consumer; Shari Stafford-Lang, Women's Crisis Center.
- B. Describe activities of the RPC since your last updated report (July, 2003)
Activities have primarily focused on review of Comprehend (Region VIII MH-MR Center) Inc.'s SED and SMI service plans, review of and response to the RPC Workgroup reports that were promulgated in 2003 and the current review.

II. Describe Changes in Regional Needs, if applicable

- A. Any significant changes in your region's demographics
There have been no significant changes. The region has experienced an estimated population growth rate of 0.7% during the last two years. An estimated 17.6% of area residents live in poverty, as compared to 14.8% statewide. A significant concern is that an estimated 27% of area residents are not covered by health insurance, which is nearly double the statewide figure.
- B. Update changes in community indicators and prevalence rates; significant events
Comprehend, Inc. reports serving 3,752 persons in FY2005, as compared to 3,470 in FY2002 – an increase of just over 8 percent. There has been an increased demand for school-based services in the region. A methamphetamine awareness conference sponsored by the local ASAP board conference was held recently, and while meth is not yet considered to be a critical problem in the region, there are increasing incidents involving meth in the counties bordering the region – particularly in southern Ohio. There was a significant increase in the number of admissions to Comprehend's children's crisis unit in 2005 as compared to the previous year.
- C. Any significant changes in dollar resources
Frozen Medicaid rates and flat funding for basic safety net services continue to challenge regional service providers. The addition of adult crisis service funding in FY2004 allowed Comprehend, Inc. to expand services to include an Acute Care Team, which is patterned after the Assertive Community Treatment model. Comprehend, Inc. notes that

virtually all new state funding for behavioral health services is categorical in nature, and that unrestricted general funds were actually cut last year. A recent grant from the Health Foundation of Greater Cincinnati established an adolescent intensive outpatient program in the region. Finally, Comprehend, Inc. recently received approval to fund an intensive outpatient program on-site at the Maysville regional detention center.

III. Update Your Service System Description

Describe any significant changes in your region in access to community-based services:

Status of the “safety net” and addressing gaps in services

With frozen rates and flat funding, adequately meeting the needs of the region’s uninsured and under-insured population is still problematic. We believe that recent increases in transportation costs have forced many area residents to neglect their behavioral healthcare needs. There are still no psychiatric beds in the region; nor are there any residential substance abuse programs. However, it was recently announced that Maysville was named as an approved site for a 100-bed Recovery Kentucky facility, which while not a treatment site per se, should address some of the area’s substance abuse issues. A locally identified problem is the shortage of foster care providers in the region – particularly in the area of therapeutic foster care. There are few such providers in the entire five-county area, and there has been recent communication that Kentucky Medicaid is planning to restrict payment for therapy services provided by community mental health centers to TFC children. The great majority of TFC providers are based outside of the region. When TFC children served residentially by these providers are referred to local treatment providers (i.e. the community mental health center), there is often little or no communication provided beforehand, which hampers the mental health center’s psychiatric staff.

Services for specific populations (children, elderly, revolving door, deaf, homeless, dually-diagnosed, etc.)

The addition of adult crisis funding has enabled Comprehend, Inc. to implement what they call an “Acute Care Team” program, which incorporates many Assertive Community Treatment principles. As mentioned above, the Health Foundation of Greater Cincinnati has provided funding for the implementation of an adolescent Intensive Outpatient Program; and a jail-based IOP will soon begin in Maysville. The adolescent funded by the Health Foundation program is now in place in Bracken County, with plans to expand to additional counties throughout the 3-year duration of the grant.

Collaboration, cooperation and communication among service providers Comprehend, Inc. has continued to develop strong collaborative ties with the Lewis County Primary Care Center, a Federally Qualified Health Center with clinics in three of the five counties in the service area. Communications between upper management regarding the delivery of

services in the region is routine and contact between clinicians occurs daily. Behavioral healthcare services provided in the clinic setting include depression screening, substance abuse screening and substance abuse prevention and counseling. Acute cases are referred to the community mental health center.

Evidence-based practices and focus on Recovery

The Council applauds Kentucky's movement towards best practices in behavioral healthcare. Kentucky's categorical funding streams for behavioral healthcare services have made best practices somewhat difficult to fully implement, but the state's recent MH-SA reorganization and the inclusion of monetary incentives for Community Mental Health Centers that implement best practices training for staff and board members are signs that policymakers are placing newfound emphasis in this area. Comprehend, Inc. has moved toward best practices on three fronts: Assertive Community Treatment (in a modified form; see 3B above), integrative MH/SA treatment for persons with co-occurring disorders, and supported employment. In addition, individualized plans of care that incorporate individual and family input and that emphasize recovery are becoming the standard. The Lewis County Primary Care Center's electronic medical record is a model that traditional medical as well as behavioral healthcare service providers would do well to emulate.

IV. Describe Regional Response to These Events or Influences:

A. Concept of changes to state psychiatric hospital services

Directors of the CMHCs that are located in the Bluegrass State Hospital catchment area have met to discuss modernization of the state psychiatric hospital system. Modernization discussions have largely focused on the implementation of best practices in the community, including integrated services for co-occurring disorders, recovery-oriented treatment services, the integration of physical and behavioral healthcare services, the expansion of residential alternatives such as crisis services, group homes, foster care, etc, enhanced approaches to family and community education, and additional services and supports to divert consumers from the criminal justice system. On the inpatient side, there have been discussions regarding the possible construction of a new psychiatric facility just outside of Lexington. Ongoing capital projects at the current facility are proving to be tremendously costly. A fully integrated electronic medical record system would greatly facilitate communication between facility and community.

B. Closure of psychiatric hospital beds in region, if applicable

The RPC advocates the reduction of state hospital beds in favor of increased residential services (described above). However, this is at the state facility level – there are no psychiatric hospital beds in the Buffalo Trace region.

C. Implementation of Medicaid Pharmacy Benefits Administrator (First Health) & impact on consumers' access to medications

The implementation of the new Medicaid PBM program has had “mixed reviews” in our area. For example, the local primary care center reports that while some patients report that they cannot meet the co-pay, they are not being denied medications as a result. However, the community mental health center has experienced much frustration with the prior authorization process, reporting many instances of denials for fairly routine medication orders from their psychiatrists. This has resulted in clients going without prescribed medication for extended periods of time, as the appeal process is time-consuming. This is especially problematic in two areas – dosages that exceed FDA guidelines; and medications that were started while clients were in inpatient treatment.

- D. Implementation of Jail Triage program
According to reports, this process has been going well. Mental health center staff and jail staff are pleased with the system.
- E. CSU services funded for both children and adults in each region.
As described elsewhere, Comprehend, Inc. has implemented an acute care team program, based on assertive community treatment principles, that focuses on “revolving-door” consumers. Additionally, services at the children’s crisis unit located in Maysville continue to increase.
- F. Establishment of Governor’s Office of Drug Control Policy with focus on substance abuse disorders and increased funding for treatment and housing
The newly-created ODCP conducted a regional public forum focusing on treatment, prevention and enforcement, which raised awareness on the part of the general public. As mentioned before, Maysville was recently named as a Recovery Kentucky site, which when completed will provide services to more than 100 persons per year. In addition, funding for Champions for a Drug-Free Kentucky nearly doubled for FY2006 in the region. To date, our RPC views the creation of the ODCP as a very positive development.
- G. Workforce development – increased training opportunities for mental health professionals
Training for behavioral healthcare professionals remains an issue in the region. The telecare network, which could be used to significantly alleviate this problem, is underutilized for training, educational and clinical purposes. A positive development since the last report in 2003 is the presence of Lindsey-Wilson College (on the campus of the Maysville Community and Technical College) in the area. Lindsey is providing a graduate program in Counseling. This program was implemented in large part because Comprehend, Inc., the local community mental health center, experiences tremendous difficulty in recruiting and retaining qualified psychologists, social workers and counselors. Many of the current program participants are persons with Bachelor’s degrees currently employed with Comprehend. Additionally, the recruitment of psychiatrists (and particularly child psychiatrists) is a process that literally takes years in some cases.
- H. Integration of mental health and physical health services and management

Clinical collaboration and integration of mental health and physical health services in the region currently involves the prenatal population in Lewis County and individual primary care patients with chronic diseases in Vanceburg and Tollesboro. Chronic conditions include diabetes and cardiovascular disease, as well as mental health diagnoses. Plans are in place to expand prenatal substance abuse services to Mason County and Fleming County. Finally, a grant proposal concerning the integration of mental health and primary care for seniors has recently been submitted to the Kentucky Department for MH-MR Services for review.

I. Addressing issue of children “aging out” of youth services

This remains an issue in our area. Severely emotionally disturbed children are eligible to receive extensive wraparound-type services, and there are mental health professionals working in every public school building in the region. However, the support services for these children once they reach the age of 18 are substantially narrower in scope. The RPC has noted that there is a tremendous need for funding a group home or similar residential program for young men with co-occurring MH/MR.

V. Behavioral Health Goals

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

The goals initially identified by the Buffalo Trace RPC were:

- flexible funding for local agencies;
- increased base support to cover the costs of employing staff;
- additional access to specialized services outside the region;
- increased school-based services;
- additional crisis services in the region; and
- initiate new policies to improve services and outcomes

B. Describe any changes in priority goals made in the past two years

These primary goals have not significantly changed, as only minimal progress has been made.

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

Funding has not been made more flexible except in a minimal fashion (some substance abuse dollars have been made more flexible). Typically, new funds are tied to very specific target populations and/or programs. As we reported in 2003, the increases recommended by the regional councils and the statewide Commission have not materialized. In fact, Medicaid rates to the regional Comprehensive Care Center are now frozen for the fifth straight year, and flexible general fund dollars are stagnant. Access to specialized services outside the region remains problematic, especially in light of increasing transportation costs. Crisis services in the region have increased – this is a goal for which significant improvement can be documented. The recent emphasis on best practices will have a positive effect on services and outcomes, but the process is in its infancy.

VI. Recommendations

A. Describe your recommendations regarding funding, particularly in light of the projected Medicaid shortfall and the impact on the Behavioral Health Safety Net

It is critical that flexible base funding to address locally identified needs and best practices be dramatically increased. Should the Kentucky Medicaid program reduce funding through rate reductions and/or eligibility changes, maintaining the safety net will be more difficult than ever. Significant general fund dollars could be leveraged if Medicaid included crisis services in its funding stream, but given the current projections, this is probably a pipe dream. The statewide Commission's goal of moving Kentucky from ranking 44th in per capita spending to 25th over a 10-year period is an admirable goal, but one that doesn't seem to be getting any traction. While there have been modest increases (early childhood mental health initiative, jail training, crisis services), they have been categorical in nature.

B. Describe recommendations for public policy changes, particularly in moving toward statewide “modernization” of the system of care

It is difficult to separate recommendations for policy change from recommendations for funding, as they most often go hand in hand. There are few policy changes that do not involve funding in some fashion. For example, extending Medicaid benefits to cover substance abuse services constitutes a significant policy change, but also has a fiscal impact. “Un-restricting” general fund dollars that currently flow to the mental health centers in response to locally identified needs could reduce the “hardening of the categories” syndrome that this Council has identified in its earlier deliberations. Increasing the scope of regionally-based residential treatment options, with less dependence on the state psychiatric hospital system, is an example of a policy change that would hopefully be revenue-neutral. Policymakers have begun taking steps to insist on the implementation of best practices and the gathering of outcome data. Substance abuse is farther along in this regard than is mental health in Kentucky with its Kentucky Treatment Outcomes Study. A similar initiative on the mental health side might go a long way in documenting the efficacy of community-based mental health treatment. Insisting on expanded use of the telehealth network for professional development and clinical applications is strongly recommended by this Council – surely the issues regarding communication of medical records, billing, etc. can be debated and settled. The implementation of a state-of-the-art electronic medical record system at the community mental health center is endorsed by this Council as a way to move toward system modernization; however, without assistance, the cost is probably prohibitive. The overarching concern of this Council remains the assurance of adequate funding for behavioral healthcare services in our region.

**Pathways HB 843 Regional Planning Council
HB 843 Report – September, 20005**

1. Features of your Regional Planning Council (RPC)

- A. List members of your Regional Planning Council and their area of representation.
See Attachment A. The Region 10 Planning Council's makeup has changed to a degree. However, there has been a core group that has participated in all of the Council's activities.

- B. Describe activities of the RPC since your last updated report (July 2003)

A representative of the Planning Council presented at the open forum relating to the closure and combining of Eastern State and Central State Hospitals. See Attachment B, the Council's 07/04 responses to ESH/CSH merger/relocation.

The Bluegrass NAMI brochure, *Our Shared Vision for State of the Art Psychiatric Treatment Services*, was shared as an alternative to the original reorganization plan for the hospitals. Bluegrass Regional Mental Health/Mental Retardation Board, Inc. is proposing a treatment center to be constructed in Lexington with industrial revenue bonds, asking for no state funds. There are no services for children included in the proposal, but the proposal is in response to replacement of an adult facility. The Planning Council would like to see more money coming into our area to support inpatient services.

Work on the Planning Council's goal for a Women's Treatment Center for mothers who have substance abuse problems was called to a halt due to being unable to find financial resources for operations. Pathways had already secured land and construction dollars for this project but will likely have to start over.

II. Describe Changes in Regional Needs, if applicable

- A. Any significant changes in your region's demographics
B. Update changes in community indicators and prevalence rates;
significant events
C. Any significant changes in dollar resources

Reports by various members of the Planning Council indicated that providers are seeing more people paying out of pocket for behavioral health care services being unable to pay even reduced fees. Likewise, some of the community participants report seeing fewer insurance payers in their client base. The hospital participants and the substance abuse program at Pathways report seeing more chemically dependent people, including increased Oxycontin and Meth users. The hospitals are also seeing a higher percentage of indigent people. Older SMI clients are inundating the mental health system. Young ladies with more severe problems are being referred to the Ramey Estep Home; there is a long waiting list; on the average the females' stays are longer than the males' stays. OLBH mirrored the need for addressing adolescent chemical dependency use. Ramey Estep is interested in working to meet that need.

The Recovery Kentucky housing initiative is an urban model of a 100-bed facility to be established in our rural areas.

III. Update Your Service System Description

- Describe any significant changes in your region in access to community-based services:
Status of the "safety net" and addressing gaps in services

Services for specific populations (children, elderly, revolving door, deaf, homeless, dually-diagnosed, etc.)
 Collaboration, cooperation and communication among service providers
 Evidence-based practices and focus on Recovery

Service gaps in Region 10 include younger children, especially in the psychiatric area, and programs for children who are extremely aggressive, for whom a Psychiatric Residential Treatment Facility [PRTF] is needed. The Ramey Estep Home’s goal is to establish a continuum of care in order to move a child from most to least restrictive placement. They have an intake/assessment center to determine where a child needs to go (which could be residential, step-down independent, independent, and foster care); and they hope to establish a PRTF to fill the gap. However, there is a Certificate of Need [CON] moratorium. Lifting of the CON moratorium in this instance would allow this provider to move forward on developing this much needed element in our local array of service.

In the meantime, King’s Daughters’ Medical Center will investigate whether the KDMC adolescent beds’ CON license can be recovered, perhaps in a collaborative effort of KDMC and Ramey Estep Home, though it was possibly transferred to adult beds.

Representatives from the court system commented that it is increasingly difficult to get Drug Court people into long-term treatment. Other regions are becoming less and less willing to take our people, unless they have the money to pay. The waiting list is six months plus. OLBH intensive outpatient [IOP] is full of Drug Court people [the capacity is 15]. Inpatient residential is a real gap. The demand for services will increase as Drug Courts grow in all of our counties.

School violence may go largely unreported because it is handled internally. There is a great need, especially in the middle schools, for increased outpatient services. Pathways’ clinicians are in nearly 80 schools.

There is a recognized medication gap in the system – people can’t be compliant so they return to the hospital, which costs more money. We, the system, set them up for failure because they can’t afford the medications and services. Pathways’ no-cost drug program provides \$240,000 worth of medications, in addition to a million dollars worth of free samples distributed.

River Cities Community Health Coalition lost its funding for the Med-Connex medication program, a program aimed a helping people who cannot afford their medication obtain it either at a reduced cost or free. This was a grant program and the grant has expired.

IV. Describe Regional Response to These Events or Influences:

A. Concept of changes to state psychiatric hospital services

While the Planning Council recognizes that it is not feasible to put a free standing psychiatric hospital in each region, proximity to our region is important. See Attachment C, the Council’s 07/04 report.

B. Closure of psychiatric hospital beds in region, if applicable

In this region, alternatives for people who need medication are jail, ESH, or KCPC. The revolving door cycle continues. We see a need for more, not fewer, beds.

C. Implementation of Medicaid Pharmacy Benefits Administrator (First Health) & impact on consumers’ access to medications

No comments were forthcoming.

D. Implementation of Jail Triage program

Jail triage has been implemented and is working well. All five jails in our region are cooperating in this crisis system aimed at preventing suicide in jail. This is not an ongoing treatment program but rather a crisis response management program. However, jail-based treatment remains a gap. There is a need for continued services after the crisis has resolved without which future crises could be seen.

E. CSU services funded for both children and adults in each region

Pathways missed out on full funding for the children's Crisis Stabilization Unit [CSU] in Morehead, with \$175M granted. The rest of funding is made up with fees and insurance. This region needs a CSU for adults in the Gateway area and a children's CSU in the FIVCO. This would round out Region 10's CSU services, allowing both adults and children to be served closer to their homes.

F. Establishment of Governor's Office of Drug Control Policy with focus on substance abuse disorders and increased funding for treatment and housing

The forums were held across the Commonwealth. The Region 10 Planning Council would like more information about how these activities interface with the work of the Planning Council. Furthermore, within the Justice Cabinet, there is a Department of Mental Health, which is being brought into collaboration with the Kentucky Department for Mental Health and Mental Retardation Services [DMH/MRS]. Access to Recovery insurance for substance abuse problems was not granted to Kentucky, and there has been no expansion funding for substance abuse services in years. As we improve our recognition of people with co-occurring disorders, funding for substance abuse services will increase in its importance.

G. Workforce development – increased training opportunities for mental health professionals

- Lindsay Wilson College now offers a Master's program locally
- Hospitals employ interns.
- The local universities have continuing education, Master's level, and PsyD opportunities.
- The CE Alliance is an organization of several mental health agencies in the tri-state that offers free monthly training for credentialing.

H. Integration of mental health and physical health services and management

- More collaboration is needed among agencies.
- KIDS NOW is a project to screen pregnant women for substance abuse difficulties, with Memoranda of Agreements with all health departments in the region.
- A therapist provides services with a pediatrician in Morehead.
- KDMC Behavioral Health is trying to establish direct admits to take pressure off the ER.
- Non-smoking efforts are developing between Pathways' ALERT Regional Prevention Center and the Boyd County Health Department.
- Pregnant drug abusers can be monitored more closely in the Drug Court program.
- There is a great need for residential services for pregnant women.
- Obesity among our youth is another problem that needs addressed; Boyd and Carter Health Departments are active with the schools to decrease children's obesity.

- The Ramey-Estep Home has a good program for their children, including 216 acres of land for a Ropes Course, which will also be opened to the community.

I. Addressing issue of children “aging out” of youth services

There is a transitioning program for seriously emotionally disturbed [SED] children in Boyd County. However, the other counties in Region 10 do not have similar services. The Office of Vocational Rehabilitation is available. SED youth transitioning out of their current services would be more successful if they had therapeutic support and case management services available to them.

The Ramey Estep Home has an 18-21 year-old independent living program through a Chafey grant, and will have an 18-month transition program in coordination with Boyd County Schools starting in August 2005.

V. Behavioral Health Goals

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

Children and Youth Service Priorities

Goal 1: Prevent 6 to 8 children from being placed out of the region when they need mid- to long-term care.

Goal 2: Increase wraparound services for 152 children in the next two years.

Goal 3: Within the next two years, serve 48 teenagers in an Intensive Outpatient Program.

Goal 4: Develop a Regional Resource Directory that will reduce the category of “lack of service information” as a barrier on future needs assessments.

Adult Service Priorities

Goal 1: Increase the funding for the behavioral health “Safety Net” Services and make the funding available to any qualified provider from the region who serves a person needing services without the ability to pay for them.

Goal 2: Reduce the number of people requiring multiple hospitalizations each year in Region 10 from 27 to 10.

Goal 3: Provide residential care for 6 to 8 mothers and their children relating to problems of substance abuse within the next two years.

- B. Describe any changes in priority goals made in the past two years

A significant change in Region 10’s priorities is to move the creation of a PRTF in our region from an alternate goal to an active goal. Likewise, the success of our local Drug Courts has led us to advocate for the development of Drug Courts in each of our counties.

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

Lack of local residential services for psychiatric care continues to lead us to out-of-area placements of children in need of psychiatric inpatient or residential care. The Planning council is unaware of any increase in funding for Wraparound services; therefore, we do not think our second goal for children has been met.

Pathways continues to have only one intensive outpatient service program. It is in Mount Sterling (Montgomery County), and the capacity today remains the same.

The Region 10 Planning Council decided to support the State’s efforts in having a statewide resource directory and has been working with the KY Cares web site.

In relation to our goals for adult services, Judge Mark Rosen announced \$180,000 funding from coal severance tax monies for a full Drug Court in Boyd County, thanks to the help of our legislators John Vincent, Charlie Borders, Rocky Adkins, and Robin Webb. He expressed appreciation for Pathways’ cooperation and assistance in the Drug Court.

The recidivism rate in our region is likely rising rather than lowering. We also see a need to develop goals regarding the geriatric population. There is a great need for services for caregivers of Alzheimer’s and elderly patients. With the aging of the seriously mentally ill [SMI] and MR/DD population, the need for specialty elderly service is increasing.

The safety net funding was dropped from the State’s budget due to financial constraints. Should this idea be funded, Kentucky has a tool to bring the private individual providers into the pool of safety net providers, thereby strengthening the safety net in Kentucky.

As mentioned earlier in this report, Region 10’s plans for a residential program for mothers with substance abuse problems came to an end when only construction funds could be found. Without funding for operations, the efforts have been suspended.

VI. Recommendations

- A. Describe your recommendations regarding funding, particularly in light of the projected Medicaid shortfall and the impact on the Behavioral Health Safety Net
- B. Describe recommendations for public policy changes, particularly in moving toward statewide “modernization” of the system of care
 - It is important that agencies collaborate to achieve some of these recommendations. Since the early 1990’s, State general fund increases to support the basic safety net services have been negligible. In light of the changes that seem to be coming in the Medicaid program, (payment for provided services only and an open marketplace), it is imperative that the Community Mental Health Centers receive additional State General Fund dollars in order to maintain the capability of providing the basic safety net services as required by law and agreed to in the State Contract.
 - Members recommended that the major goal for the meeting be to support obtaining a CON for a children’s PRTF in Ashland.
 - Members advocated for goals regarding the geriatric population:
 - liaison with nursing homes
 - service for caregivers to alleviate their stress, such as day cares
 - ECT [electroconvulsive therapy] for depression in the elderly
 - inpatient treatment programming
 - medication resources
 - tie-ins to senior citizens centers
 - outpatient services for treatment-resistant psychiatric elderly patients who are difficult to manage in a senior center setting
 - aging SMI and MR/DD individuals will be a chronic need



PO Box 790
Ashland KY 41105-0790

July 15, 2004

B

Region 10 House Bill 843 Planning Council

Responses to ESH / CSH Merger/Relocation

Secretary of the Cabinet for Health and Family Services, Dr. James Holsinger, recently released a draft plan for comment from various interest groups concerning possible consolidation, relocation and administrative operation (privatization) of Eastern State and Central State Hospitals. We at Pathways are appreciative of the Cabinet's interest in improving care for people with serious mental illness and in finding efficiencies in the use of our tax dollars, but have serious concerns regarding this approach to providing inpatient care. The Region 10 HB 843 Council consisting of representatives of our four hospitals, law enforcement, social services, Pathways, and consumer advocates, met 7/6/04 and voiced the following concerns:

1. **Distance.** Distance translates directly into accessibility and transportation problems. Even now, the distance to Lexington presents a problem for our Sheriff's departments as it puts a strain on manpower and adequate coverage while deputies are out of the region. Adding another hour to perhaps Shelbyville would only exacerbate the problem. The same strain is put on families who want to be or are part of the care process; and the continuity of care between hospital and local care providers becomes much more difficult. Consolidating and centralizing may be good for the bottom line in budgeting, but the literature dating back to World War II through the present suggests that treatment rendered in more familiar surroundings and utilizing the strengths of family and local community resources leads to a faster recovery and a more positive outcome for the consumer to find the supports needed to thrive in the local community.
2. **State Hospitals.** State hospitals are definitely needed to provide specialty care for the dually diagnosed (mental illness and addictions and/or mental retardation) as well as the few very difficult-to-handle patients that exist around the State. These facilities could be more centralized for cost containment reasons and should be longer care facilities. They should be located near medical schools where physical health care is readily available and should be available as training facilities for future professional specialties.

Nearly all other patients needing hospitalization (including 202A commitments) could be treated at local inpatient units with adequate State dollars following the indigent patient. Our region has psychiatric beds available, and some of our hospitals would entertain the possibility of contracts. Medicaid does pay for psychiatric hospitalization in hospitals that are not designated as Institutions for Mental Disease (IMDs). However, due to low rates and curtailed lengths of stay, as well as the increasing number of non-insured seeking services, the number of community hospital beds is shrinking across the state. In our area, we have a number of out-of-state residents seeking psychiatric inpatient care since the closure of the

Ironton general hospital and Portsmouth Receiving Center. Perhaps Interstate Compacts could furnish some relief for this situation.

Region 10 House Bill 843 Planning Council
Responses to ESH / CSH Merger/Relocation

At any rate, we could support the development of a new modernized campus in the Lexington area for specialized inpatient care for the eastern region and the safety net needs of their area. Furthermore, we have been very satisfied with the cooperative relationship with Eastern State Hospital since the Bluegrass Community Mental Health Center assumed operation of that facility. What we need is a strategy from the Kentucky Cabinet for Health and Family Services to sustain local inpatient care through local providers that ensures their continued participation in the safety net of psychiatric services, regardless of the patients' ability to pay. Secretary Holsinger suggests that Eastern State Hospital be sold and a trust fund established to support the development of needed services by local providers. We could certainly support this concept.

- 3. Privatization.** Whether by choice or by happenstance, the Community Mental Health Centers and the State Psychiatric Hospitals have been designated as the “Safety Net Providers” for the Commonwealth’s publicly funded mental health program. This basically means that we will serve all people in need regardless of their ability to pay. Kentucky has built a reputation as being one of the very best statewide-developed community- based services in the nation and has done so in spite of ranking 47th in per capita funding. Approximately 30% of our funds are from other than government sources. Although the Centers are private, non-profit, voluntary agencies, we are regarded as “quasi-public” due to the legislated mandates and controls under which we operate, including a well defined state contract. This is as it should be as it ensures that the Centers will maintain the “Safety Net” and carry out the goals and objectives of the Commonwealth.

The Centers need to play a key role in contracting out any parts of the safety net array of services. Privatization invites other agendas and jeopardizes the continuity of care between hospital and outpatient services. One only has to go as far as Hazard to sense that some services clearly belong in the public sector.

Respectfully yours,

Dick Stai

Richard T. Stai, LCSW
Executive Director

Region 10 HB 843 Planning Council

Responses to ESH / CSH Merger/Relocation

On July 6, 2004, the Region 10 Planning Council met to discuss the pros and cons of the proposal to close ESH and CSH and build a new combined facility between Lexington and Louisville.

Pros	Cons
There is a need for a specialty facility to serve complex and severe cases	Even though the proposed facility would have 300 beds, this would actually be a loss of bed capacity for the regions served.
There would be cost savings arising from the merger	Transportation is a problem now when a person needs to go to ESH. Moving the facility would exacerbate the problems for Region 10.
The “Trust Fund” could be used to increase residential services for dually diagnosed people.	Distance is an issue now for trying to provide continuity of care. Adding more time to the travel time of Case Managers would make it more difficult.
	Our local hospitals find themselves serving out of state people and wonder if the interstate compact would continue.
	Concern was expressed with the possible loss of ICF/MR bed capacity.
	Relocating the facility would make it even less likely that families could participate in the person’s care. Even the distance from our region to Lexington is prohibitive for families who want to be involved to do so.
	The privatization model used with the Hazard hospital has not worked well. One of our local hospitals receives numerous indigent people from that region, apparently, due to funding or other gate keeping issues.

Suggestions:

- Keep CSH as is.
- Build another facility in Lexington in order to keep services as close to the region as possible (a goal of HB 843)
- Sell the existing ESH and use proceeds to enhance services to the areas covered by ESH.
- When appropriate, use local resources.
- Use strategy of the funding following the patient so services may be delivered as close to home as possible.

1 – ADVOCATE 2 – BEHAVIORAL MEDICINE 3 – BUSINESS LEADER 4 – CMHC BOARD/STAFF 5 – COMMUNITY ORGANIZATION	6 – COURT / LAW ENFORCEMENT 7 – DCBS / RIAC 8 – FACILITY STAFF 9 – FAITH COMMUNITY 10 – MEDICAL COMMUNITY	11 – LAWYER 12 – LEGISLATOR 13 – PARENT ADVOCATE 14 – PROVIDER 15 – SCHOOL SYSTEM	A
JOHN STOCKBRIDGE 5 SHELTER OF HOPE 2944 WINCHESTER AVE ASHLAND KY 41101	ANN PERKINS 5 SAFE HARBOR PO BOX 2163 ASHLAND KY 41105-2163	LISA HUFF 10 KDMC 2201 LEXINGTON AVE ASHLAND KY 41101	
TOM DAUGHERTY 15 ROWAN COUNTY SCHOOLS 121 EA SECOND ST MOREHEAD KY 40351	THE HONORABLE MARC ROSEN 6 COURTHOUSE ANNEX PO BOX 417 CATLETTSBURG KY 41129-0417	VINCENT GEREMIA 7 D C B S - #401 1539 GREENUP AVE ASHLAND KY 41101	
ANN JOHNSON 7 D C B S PO BOX 1036 MOREHEAD KY 40351	PATRICIA STINNETT 10 THREE RIVERS MEDICAL CENTER P O BOX 769 LOUISA KY 41230	CAROLYN STEVENS 10 OLBH BEHAVIORAL HEALTH ST CHRISTOPHER DR ASHLAND KY 41102	
DR LAURA SALYERS 10 ST CLAIRE MEDICAL CENTER 222 MEDICAL CIRCLE MOREHEAD KY 40351	DAVID MEADE 10 KDMC BEHAVIORAL HEALTH 2201 LEXINGTON AVE ASHLAND KY 41101	STEVE KOUNS 7 DCBS #401 1539 GREENUP AVE ASHLAND KY 41101	
JIM MCDONALD 6 PROBATION & PAROLE PO BOX 350 MT STERLING KY 40353	HELEN ASHWORTH 1 608 PINE GROVE COURT ASHLAND KY 41101	SISTER SALLY NEALE 5 SARAH'S PLACE PO BOX 197 SANDY HOOK KY 41171	
KATHY LITTERAL 6 EASTERN KENTUCKY CORRECTIONAL COMPLEX 200 ROAD TO JUSTICE WEST LIBERTY KY 41472	ERNEST BEAN 1 209 DAVIS RD MT STERLING KY 40353	DR VAUGHN ESKEW DIRECTOR 10 FIVCO DISTRICT HEALTH DEPT PO BOX 4069 ASHLAND KY 41105-4069	
DAVID DANIELS 10 GATEWAY DISTR. HEALTH DEPT PO BOX 555 OWINGSVILLE KY 40360	DR DREMA HUNT 10 OLBH OUTREACH CLINIC 12470 US RT 60 ASHLAND KY 41102	JIMMY AND JUDY MEADOWS 13 410 DAVEY RUN GRAYSON KY 41143	
LISA HENSON 15 ASHLAND INDEP. SCHOOLS PO BOX 3000 ASHLAND KY 41101	LISA RICE DMH DMH/MRS 100 FAIR OAKS 4E-A FRANKFORT KY 40621-0001	TANYA NAPIER 10 THREE RIVERS MEDICAL CENTER P O BOX 769 LOUISA KY 41230	
		HB 843 – 8-05 MEETING ATT. A – MEMBERS AND REPRESENTATION	

1 – ADVOCATE 2 – BEHAVIORAL MEDICINE 3 – BUSINESS LEADER 4 – CMHC BOARD/STAFF 5 – COMMUNITY ORGANIZATION	6 – COURT / LAW ENFORCEMENT 7 – DCBS / RIAC 8 – FACILITY STAFF 9 – FAITH COMMUNITY 10 – MEDICAL COMMUNITY	11 – LAWYER 12 – LEGISLATOR 13 – PARENT ADVOCATE 14 – PROVIDER 15 – SCHOOL SYSTEM
HON. CHARLIE BORDERS 12 KDMC 2201 LEXINGTON AVE ASHLAND KY 41101	DR. STEPHEN GREENBERG 10 KDMC BEHAVIORAL HEALTH 2201 LEXINGTON A VE ASHLAND KY 41101	THE HONORABLE JOHN COX 6 DISTRICT COURT ROWAN COUNTY COURTHOUSE MOREHEAD KY 40351
ANDY & DEBBIE PENNINGTON 1 ASHLAND ALLIANCE FOR THE MENTALLY ILL 4341 PINE ST ASHLAND KY 41102	TOM PHIPPS 3 PUTNAM INSURANCE 1557 WINCHESTER AVE ASHLAND KY 41101	MIKE RELIFORD 3 THE DAILY INDEPENDENT 224 17TH ST ASHLAND KY 41101
		DR SAM WELCH 4 PATHWAYS INC 300 FOXGLOVE DR MT STERLING KY 40353
PATHWAYS BOARD -- PROGRAM PLANNING AND EVALUATION COMMITTEE:	LARRY ALLEY 4 595 HWY 3 NO LOUISA KY 41230	W B SANDY SAUNDERS 4 103 LYCAN ROAD 3 ASHLAND KY 41101
BECKY WALKER 15- 4 SCHOOL-BASED SERVICES PO BOX 965 GRAYSON KY 41143	JOHN GALLAHER 4 THE GALLAHER GROUP 3 PO BOX 910 ASHLAND KY 41105-0910	SHARON MCDONALD 4 OLBH 10 ST CHRISTOPHER DR 9 ASHLAND KY 4 1101
KEVIN HARRISON 4 CHOICES AND CHANGES 1 1401 WINCHESTER AVE #532 ASHLAND KY 41101		PASHIA R STATON 4 1788 FEARING RD 15 OWINGSVILLE KY 40360
INTEROFFICE MAIL.....>>>	DICK STAI 4 TODD TRUMBORE LORA REYNOLDS	TOM LEACH 4 DEBBI BAILEY NEVA MCGUIRE BOBBI WYMER

Mountain HB 843 Regional Planning Council
HB 843 Report – September, 2005

I. Features of your Regional Planning Council (RPC)

A. List members of your Regional Planning Council and their area of representation

MCCC Board of Directors representative and Chairman of the Council

Andrew Dorton

Family members of adults and children with mental illness, alcohol and other drug abuse disorders

Walter Lane

Milton Harvey

Consumers of mental health and substance abuse services

Homer Jones

Jacinda Boudle

County officials and business leaders

Paul Hunt Thompson, Floyd County Judge Executive

Denny Dorton, CEO, Citizens National Bank

Health departments and primary care physicians

Bertie Kaye Salyer, Director Magoffin County Health Department

Advocates and community organizations

Donna Frazier, Director of Big Sandy Area Agency on Aging

Jim Kelly, Chair of Big Sandy Aging Advisory Council, Big Sandy Social

Security Administrator, Veterans Advocate

Chris Conley, Chair of Big Sandy Human Services Coordinating Council,

Prestonsburg Community College Director of Community Lifelong Learning Center

Doug Lawson, Information Director, Big Sandy ADD

Educators and school personnel

Sharon Moore, Director Special Education, Pike County School Board

Regional interagency councils established under KRS Chapter 200

Debbie Price, Chair RIAC, Protection and Permanency

Pam Meyer, RIAC member, Director Clark Elementary Family Resource Center

Law enforcement and court personnel

Steve Friend, Pike County Sheriff's Office

Keith Bartley, Floyd County Attorney

Public and private facilities that provide services for mental health and substance abuse in the region representing inpatient services, outpatient services, residential services, and community-based supportive housing programs

Polly Johnson, Representative of Pikeville Methodist Hospital

Katrina Lewis, Director of Adult Crisis Stabilization Unit

Judy Music, MCCC Director of Housing

Individuals who provide mental health and substance abuse services in the region.

Steve Price, LCSW, Pikeville

Vicki Woodward, DUI Counselor

B. Describe activities of the RPC since your last updated report (July, 2003)

Meetings were held with the above members to discuss ongoing needs and issues related to our region.

II. Describe Changes in Regional Needs, if applicable

A. Any significant changes in your region's demographics

No.

B. Update changes in community indicators and prevalence rates; significant events

According to the most recent data from the Department for Public Health, Division of Epidemiology and Health Planning Surveillance and Health Data Branch report titled **Resident Deaths from Intentional Self-Harm (Suicide)**; during 2002 the Big Sandy Region had 26 Suicides. This is a rate of 16.3 per 100,000. The highest rate by age is for individuals 45-64 years. Ranking 2nd was a tie between ages 35-44 and the Under 20 year's category. Of our counties, Pike and Floyd had the highest suicides of 11 and 10 respectfully. However, Floyd had the highest rate of 23.7 due to population.

A report from the Kentucky Department for Public Health, Health Policy Development Branch issued a report Updated 10/22/04 titled Kentucky Suicide Attempts and Self Inflicted Injuries Resulting in Hospitalization, By Year and County. This report provides data about each county in the Commonwealth and provides totals from year 2000 to year 2003. Floyd County saw a dramatic increase of 18 attempts in 2000 to 34 attempts in 2003 with a rate of 80.1 per 100,000. In Johnson County, attempts were at 22 in 2002 and fell to 17 in 2003 for a rate of 72.5. Magoffin Counties increase from 9 in 2000 or 13 in 2003 indicates an alarming rate of 97.5. Likewise, suicide attempts also increased in Martin County. In 2000, there were 8 attempts, but by 2003, there were 11 attempts indicating a rate of 87.5. And lastly, Pike County has the largest attempt and rate in the entire region. In 2000 there were 43 suicide attempts, but by 2003, there was a substantial increase to 82 attempts with a rate of 119.3. In summary, within our region, in 2003, there were 157 individuals that attempted suicide that resulted in hospitalization.

C. Any significant changes in dollar resources

Early Childhood Mental Health Initiative funds were reduced for SFY 06, with the expectation that the same level of services would continue. Anytime there is flat funding, it equates to a reduction as costs rise without the benefit of an increase to cover inflation.

III. Update Your Service System Description

Describe any significant changes in your region in access to community-based services:

Status of the "safety net" and addressing gaps in services

One of the region's service systems, the Court Appointed Special Advocate (CASA) program closed recently due to the lack of funding. This service assisted the court in understanding issues from the child's perspective, while also gathering information from mental health, protection and permanency, and other entities associated with services for the child. An ongoing gap involves children that are in the custody of the Department of Juvenile Justice. When these children return to the community, the local community mental health center is not involved in planning or providing services to assist the child in being successful in their community.

Services for specific populations (children, elderly, revolving door, deaf, homeless,

dually-diagnosed, etc.)

The Community Mental Health Center and the Department for Community Based Services, specifically the Division for Protection and Permanency have partnered to form an Agreement specifies by which referrals can be made, priority appointments are given, and outlines efficient and effective communication between the two entities. Additionally, the Adult Crisis Stabilization Unit (ACSU) has revised its admission criteria, referral form and intake format to increase accessibility for individuals with co-occurring disorders. We are screening for acquired brain injury (ABI) and providing appropriate referrals for individuals with ABI. Substance abuse counseling is now available to those individuals that are dually diagnosed.

Collaboration, cooperation and communication among service providers.

The Victim Service Program collaborates with the Big Sandy Area Child Advocacy Center (CAC) to provide Mental Health Assessments at the CAC.

Additionally, children that have suffered child sexual abuse may also receive ongoing mental health treatment at the CAC, should the family want to receive services at that location. CMHC staff are involved in community groups as a collaborative effort with other service providers. Some of these groups include: Mental Health and Aging Coalition, Human Services Coordinating Council, Targeted Assessment Project Advisory Committee, etc.

Evidence-based practices and focus on Recovery

Wraparound Model for Children's Service Coordination, Individual Therapy, Collateral services, Psychiatric services, Testing Resources (Child Behavior Checklist, Connors, Child Depression Inventory, Trauma Symptom Checklist, Child Sexual Behavior Inventory), Therapeutic Games (Stop, Relax & Think, The Self Control Patrol, The Conflict Resolution Game, the Talking, Feeling & Doing Game). Boston Rehabilitation Model for SMI population, cognitive behavioral therapy, school-based therapy, person-centered therapy, etc.

IV. Describe Regional Response to These Events or Influences:

- A. Concept of changes to state psychiatric hospital services.
Please see response to VI. Recommendations.
- B. Closure of psychiatric hospital beds in region, if applicable.
Please see response to VI. Recommendations.
- C. Implementation of Medicaid Pharmacy Benefits Administrator (First Health) & impact on consumers' access to medications.
Minimal problems noted at this time.
- D. Implementation of Jail Triage program
Implementation of the Jail Triage program began in December 2004. We provide an increasing number of these services monthly, with 25 performed in July 2005. The system appears to be working very well for most. We have received positive feedback from both the Floyd County Jail and Pike County Jail. However, the Big Sandy Regional Detention Center in Paintsville has declined to continue participation with Bluegrass. They complain that the triage with Bluegrass takes too long. We have contacted Connie Milligan regarding their concerns.
- E. CSU services funded for both children and adults in each region.
Please see VI. Recommendations.
- F. Establishment of Governor's Office of Drug Control Policy with focus on substance abuse disorders and increased funding for treatment and housing

The Office of Drug Control Policy’s Mission was to integrate and support substance abuse treatment, intervention and prevention services across the State and internally with the Kentucky State Government. The impetus behind the establishment of this department was the “Drug Summits” held throughout the State of Kentucky.

G. Workforce development – increased training opportunities for mental health professionals

Mountain employs a Training Coordinator which provides or arranges to provide required training (s) within the Agency. The Coordinator also maintains the in-house Speakers Bureau. In addition to required training, staff has access to training opportunities both locally and across the state. Within the Agency, the Victim Services Program and the IMPACT Program collaborate to provide an annual training with topics centered on children’s issues. Agency staff also participate in the Mental Health and Aging Coalition’s effort to sponsor two trainings per year with topics including legal rights and services available. Staff also participate in various trainings as the trainer. Many staff within the Agency are experts in their discipline and are contacted to provide trainings both within and outside of the Agency. However, it should be noted that when there are no increases in funding, and staff continually are expected to do more with less funding streams, training is one area that suffers, which causes clients to not receive the most up to date treatment when their treatment provider is not up to date.

H. Integration of mental health and physical health services and management

Clients of Mountain are asked to obtain a physical exam once per year, and provide the results to their therapist. With the client’s permission, Mountain staff can collaborate with physical health providers to assure the needs of the client are met. Mountain has also been working with local Health Departments to discuss services of each entity and to clarify fees, access, and other issues. Through this collaborative effort, each entity can provide more efficient and appropriate referrals. The Victim Services Program works intensely with local hospitals, specifically the emergency room staff in providing medical advocacy for individuals who have experienced sexual assault or domestic violence.

Specialized Sexual Assault Nurse Examiners (SANE) are trained and certified to perform the forensic exams. Mountain staff respond to ERs 24/7 to be with the victim and their family/friends through the process at the hospital, explaining processes and procedures, roles, and provide community resource information. Mountain has contractual agreements with three of the hospitals in our region. We provide psychological consultation and referrals as appropriate within one hour of request. We provide involuntary evaluations on site at all hospitals in our region within one hour of request.

I. Addressing issue of children “aging out” of youth services

With the IMPACT Program, for instance, services can continue past the usual year 18 milestone. In other programs, transition services are available to assess what services are needed and link the youth to adult services. In some cases, the magic age of 18 does present some new issues for the client and their families.

The client can now choose their own services, sign for treatment independent of their parent/guardian, decide how much if any of their chart they would like to release to another source, etc. These issues, and many others, are discussed with the client so that they and their families understand the new boundaries.

V. Behavioral Health Goals

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

To provide a comprehensive array of quality services that will result in success and satisfaction of consumers, providers and the community. To improve the mental health of residents of Region XI by ensuring appropriate, high-quality services confirmed by scientific research to those with mental health needs.

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

The agency has assisted several staff in pursuit of masters’ degrees from the Lindsey Wilson Counseling Program and the University of Kentucky Social Work Program.

“Develop a case management transitional program for young adults ages 18-21”

Case management program has not been implemented however; IMPACT sponsors three youth councils and two summer day camps that address transitional issues with youth.

Increase by 10% the number of children who receive mental health services.”

The baseline in FY 2000 was 770 children who are severely emotionally disabled, who received a service. For FY 2005, XXX children with SED diagnosis received services.

“Increase by 20% collaborative efforts among community partners outside the regional hub of Floyd County”

MCCC staff has been included in several community initiatives in each of the five counties during the past five years.

- B. Describe any changes in priority goals made in the past two years.
No changes.
- C. What progress has been made toward achieving these goals?
Please see response to A.

VI. Recommendations

- A. Describe your recommendations regarding funding, particularly in light of the projected Medicaid shortfall and the impact on the Behavioral Health Safety Net

In view of the problems associated with the ARH Psychiatric Center, there is needed funding for developing inpatient care possibly by shifting funding from inpatient care if the Centers truly become the gatekeepers for psychiatric admissions to the Hospitals. To reduce the expended of inpatient care, funding for a tiered level of care between hospitalization and CSU would be necessary. Additionally, the funding levels of CSUs should be at the level of recently funded CSUs. If Centers are to implement best practices, there must be sufficient funding for training, staffing and resources at the community level and funding for the development of a statewide compatible electronic medical records system.

Kentucky currently rates among the five lowest funded states in the nation relative to mental health funding and in spite of the lack of adequate funding; the Community Mental Health Centers have continued to be a vital part of the safety net for our most vulnerable citizens, kept up with all new regulations, requirements and incentives without appropriate funding. The electronic medical records system and upgrading the capabilities will cost hundreds of thousands of dollars to implement and will require the necessary funding to bring about change. Funding CMHC contracts statewide should be a priority for mental health, substance abuse mental retardation services worthy of upgrading to at least

bring the Commonwealth to a minimum rating of 25th ranked funding in the nation.

B. Describe recommendations for public policy changes, particularly in moving toward statewide “modernization” of the system of care.

The community Mental Health system of Kentucky is one of Kentucky’s greatest assets as a licensed, monitored and audited system of care as a vital part of the Commonwealth’s safety net. As we have seen the near demise of such services in so many states we, as caring citizens of the Commonwealth, should attempt to keep a very worthy system in place to protect our most vulnerable citizens. This system should be funded adequately to fulfill all obligations to our communities and to all regulatory entities. We need not look any further than West Virginia, Tennessee, and many other states to see the devastation of attempting to “fix something that isn’t broken” when we rank the lowest five (5) states in the country in mental health funding.

Kentucky River Regional Planning Council HB 843 Report – September, 2005

I. Features of your Regional Planning Council (RPC)

A. List members of your Regional Planning Council and their area of representation

- | | |
|---|---|
| <ul style="list-style-type: none"> • Terri Sewell, Civic Organization • Jim McDannel, Public / Private Education • Charles Phillips, County Government • Karen Ditsch, General Public • Chris Gooch, Civic Organization • Hill Smith, Public / Private Education • Martin Douthitt, Business Owner • David Mathews, Provider / CMHC Staff • Donna Hawse, Provider / CMHC Staff • Nora L. Johnson, Provider / CMHC Staff | <ul style="list-style-type: none"> • Rosemary Brown, Provider / CMHC Staff • Agnes Fugate, Consumer • Mary Fugate, Consumer • Melissa Kay Ratliff, Consumer • Johnny Gross, Consumer • R.C. Taulbee, Consumer • David Turner, Consumer • Matt Triplett, Consumer • Kevin Ritchie, Consumer • Madro Neace, Consumer • Sally Terry, Consumer • Sheila Smith, Consumer |
|---|---|

B. Describe activities of the RPC since your last updated report (July, 2003)

- Stakeholder Review Panels
- Housing Needs Assessment
- Surveys
- Focus Groups

II. Describe Changes in Regional Needs, if applicable

- A. Any significant changes in your region’s demographics.
- B. Update changes in community indicators and prevalence rates; significant events.
- C. Any significant changes in dollar resources.

The Kentucky River Region, comprised of Breathitt, Knott, Lee, Leslie, Letcher, Owsley and Wolfe Counties continues to be one of the most distressed regions in the U.S. Appalachian counties and nationally, although small improvements are occurring. While there has been little in the way of significant changes in socio-economic indicators for the region since six of the fifty most impoverished U.S. counties are in the region, there is an improvement in the past decade compared with the demographics of the 1990 decennial census. Compared to other Kentucky Counties, four of the 10 most impoverished counties are in the Kentucky River region with Owsley the most impoverished in Kentucky with a

poverty rate of 45%. In terms of population change, 5 of the 8 counties have lost population and these counties are experiencing the highest rates of population loss in Kentucky. Declining home values exist in 6 of the counties which are among the 10 lowest home value counties in the state. Owsley County also now leads the state in death rate. The Kentucky River Region has Kentucky's highest unemployment and underemployment rates with 32% being unemployed or underemployed.

Since the HB843 report in 2000 to the statewide commission, the Kentucky River Community Care has focused upon improvements in health services, prescription drug abuse, workforce development, mental health services, housing, fund raising, and administrative operations. Because of efforts to raise awareness about the conditions in eastern Kentucky caused by the publicity around the prescription drug epidemic and the growing health care disparities, Kentucky River Community Care has been an active participant in the Kentucky Governors Drug Summit, the Appalachian Regional Commission focus on health disparities, Operation UNITE and the national program development efforts of the Robert Wood Johnson Foundation. The deaths and arrests associated with drug abuse have been just a part of the growing tide of troubling news about health and economic conditions in eastern Kentucky. Some counties such as Breathitt have documented a majority of the deaths associated with drug abuse. Other counties, such as Letcher have reported the highest smoking rates in the nation and the highest suicide rates in Kentucky. Meanwhile job and economic opportunities continue to elude most residents of the region. Because of a crack down by law enforcement efforts like Operation Unite the jails have become more overcrowded women, teenagers, and men and the state supported psychiatric hospital in Hazard stays full. The number of adults and children seeking substance abuse treatment has more than doubled since 1998 and the psychiatric hospital reports that most persons seeking admission have co-occurring mental healthy and substance abuse issues. The creation of Drug Courts in every county has further increased the demand for services.

III. Update Your Service System Description

- Describe any significant changes in your region in access to community-based services.
- Status of the “safety net” and addressing gaps in services.
- Services for specific populations (children, elderly, revolving door, deaf, homeless, dually-diagnosed, etc.).
- Collaboration, cooperation and communication among service providers.
- Evidence-based practices and focus on Recovery.

Kentucky River Community Care has vigorously pursued creation of new programs through obtaining additional resources to address the growing service needs of special populations. While KRCC has not significant seen increases in state funds, KRCC has been successful in attracting support from the Robert Wood Johnson Foundation, the Substance Abuse and Mental Health Services Administration, the Heath Resources and Services Administration and philanthropic foundation support. Services expansion has focused on juvenile substance abuse offenders through the Reclaiming Futures project. AHASP, the Appalachian Assertive Services Partnership brought special assertive community

treatment to homeless individuals with co-occurring disorders. The Paths to Recovery Project made KRCC part of a National Network for the Improvement of Addiction Treatment learning new process improvement techniques to increase access and engagement. The KYMAP project banded KRCC with Central State Hospital, UK, U o L, and Seven Counties Services in the implementation of the evidence based medication algorithms project. The regional Mental Health and Aging Coalition focused training on persons serving older adults and special; efforts at developing housing resulted in the opening of new apartment in Wolfe and Owsley Counties

Collaboration, cooperation and communication among regional service providers have expanded. KRCC has worked with the National Alliance for the Mentally Ill to begin the establishment of a NAMI group within the region. The Reclaiming Futures Program has expanded collaboration and communication between KRCC and the district and circuit courts who serve juvenile offenders. The AHASP homeless assertive community treatment project has increased cooperation between Hazard Perry County Community Ministries and KRCC. Operation Unite has increased cooperation and collaboration between KRCC and the Drug Courts and the Administrative Office of the Courts. The major healthcare initiative which integrates mental health and physical health has created a joint provider arrangement between Juniper Health and KRCC. Juniper is KRCC's federally qualified Healthcare partner agency. The creation and funding of Juniper Health as a physical health partner agency to a mental health agency is the most significant event in behavioral health in eastern Kentucky in the past decade.

KRCC is serving adolescents with substance abuse and co-occurring disorders through their eight (8) bed residential program called Cabin Creek. These youth are followed up in the outpatient setting to continue with their treatment and/or to receive support and continuing care. KRCC has been providing cross training to all clinicians that serve children and families to improve their ability to assess, diagnose and treat youth with co-occurring substance abuse problems. In addition there has been an emphasis on identifying youth involved with the juvenile justice system through a Robert Wood Johnson grant. KRCC has been working closely with our only juvenile drug court, located in Letcher County, to provide therapy, training and support to the program.

The Early Childhood Mental Health Specialist has provided services and trained five other staff to provide assessment, diagnosis and treatment for young children. This Specialist has been working closely with the Child Sexual Abuse Coordinator to learn new techniques most effective with young children who have experienced abuse. In addition, a service coordinator has been designated to serve the youngest children referred to IMPACT and supported in developing their expertise and resource knowledge with this population.

Reclaiming Futures, a Robert Wood Johnson grant, has underscored the strength of community and agency collaboration. Each of the four counties has a local advisory group comprised of citizens and agency representatives that helps to mold service development and delivery to best fit the needs of their community. In addition the county councils are responsible for identifying existing “natural supports and helpers” within their community and assisting with the development

of new resources that can serve as protective factors for their youth. Reclaiming Futures has also engaged the existing Regional Interagency Council (RIAC) as the regional advisory council.

KRCC has received a sub-contract with Community Ministries (Perry County) to serve families through a Community Collaborations for Children grant. A KRCC Family Team Meeting Facilitator is receiving region-wide referrals through the Department for Protection and Permanency and assisting with the development of family intervention plans. The Facilitator is using the wrap-around process learned through IMPACT and Bridges to provide a quality approach to these team meetings. Community Ministries' case managers are providing the follow up for these families.

Through its vigorous pursuit of federal and foundation grants, KRCC has been able to become a laboratory for testing the implementation of evidence based practices in a rural Appalachian community. Since most evidence based practices are developed and tested at larger academic institutions the challenges associated with implementation in a rural mental health center with limited resources provides a test for the evidence based practice and administrative adaptation to change. KRCC has been fortunate to implement and test five evidence based practices in the past five years. These include AHASP, KYMAP, LOCUS, SBORT, and Reclaiming Futures.

IV. Describe Regional Response to These Events or Influences:

- A. Concept of changes to state psychiatric hospital services.
- B. Closure of psychiatric hospital beds in region, if applicable

The Kentucky River region, the Mountain region and the Cumberland River region have collaborated on a tri-regional response to the need for improved management of the state funded hospital psychiatric beds at the Appalachian Regional Healthcare Psychiatric Center at Hazard.

Regions outside the KRCC area have limited access. Access could be improved if the beds were located in their regions too. The financing system needs revised so that the dollars follow the patient rather than going to the hospital.

- C. Implementation of Medicaid Pharmacy Benefits Administrator (First Health) impact on consumers' access to medications

Comments from the focus group included:

- Results may include increased emergency room visits due to consumers not being able or willing to pay the co-payments for medications.
- Due to multiple medications being prescribed, consumers may not be able to afford the co-payments.
- \$3.00 may be too expensive for some consumers.
- Prescribing medications based on affordability of co-payments could result in medications being prescribed that have more or worse side effects.

D. Implementation of Jail Triage program

Jails and staff trained in program but utilization by the jails has been slow. Lack of resources for purchasing suicide supplies. Training and retraining must occur. No incentives to use system.

E. CSU services funded for both children and adults in each region

The Kentucky River region crisis stabilization unites for adults and children continue to operate smoothly and serve youth and adults. However, the utilization is limited by “Open Door” policy for the state psychiatric hospitals admissions.

KRCC is providing residential crisis stabilization services for youth in two locations. One is located at the Sewell Center in Breathitt County and the other is provided at Cabin Creek in Knott County. The crisis stabilization services continue to provide a valued alternative to psychiatric hospitalization; provide a step down from a more restrictive setting; and an alternative to the juvenile detention center for those youth that need treatment rather than incarceration.

F. Establishment of Governor’s Office of Drug Control Policy with focus on substance abuse disorders and increased funding for treatment and housing

The Office of Drug Control Policy has supported grants written by KRCC staff for the region and the ODCP has supported and approved some funding for drug abuse prevention. There has not been a substantial increase in funding while some funding ended in 2001 has not been replaced. UNITE has funded the Administrative Office of the Courts Drug Court Program which has funded treatment we have provided. Recovery Kentucky has reduced access to housing funding for other special populations by diverting funds from severely mentally ill and planned projects were cancelled due to cuts in project based rental subsidies.

G. Workforce development – increased training opportunities for mental health professionals

- University Center of the Mountains
- Lindsey Wilson
- Reclaiming Futures training / CEU opportunities
- Grant monies enable staff to attend trainings and conferences.

I. Addressing issue of children “aging out” of youth services

The children that are “aging out” of youth services, particularly those with severe emotional disabilities, participate in individual case planning and, if needed, consultation with the RIAC. Youth who have been identified through IMPACT prior to age eighteen (18) may continue with service coordination and RIAC consult until they reach age twenty one (21). Young adults who need to continue case management will have their new adult services case manager attend IMPACT service team meetings prior to a formal transition. Youth who need to

be involved with MRDD services are transitioned in the same way. The MRDD staff are asked to participate in service team meetings to assure a smooth transition.

V. Behavioral Health Goals

- A. Briefly describe the top goals set by your Regional Planning Council for the initial 2001-2003 time period.
- B. Describe any changes in priority goals made in the past two years
- C. What progress has been made toward achieving these goals?

<i>Initial Goals</i>	<i>Changes and Progress</i>
<i>Children suffer from abuse, assault, addictions & poverty. Treating these problems produce long-term results. Model programs begun by the Kentucky River Region should be expanded & available to children & families region wide.</i>	<i>New substance abuse services & supports have been made available through Reclaiming Futures. Staff training has been available to all eight counties.</i>
<i>An epidemic of substance abuse problems is costing lives & breaking up families. Treatment programs must have all avenues available to combat this problem. The nationally recognized Kentucky River Appalachian Project treatment model must be expanded to all eight counties.</i>	<i>Epidemic has increased exponentially.</i>
<i>Most persons requiring treatment have multiple problems. Mental disability & substance abuse go hand in hand, so our programs will only be effective if they are dual treatment programs. New models of psychiatric treatment for individuals with dual diagnoses in this region are urgently needed. Using treatment models that include a broad array of mental health professionals, including psychiatrists, will improve effectiveness.</i>	<i>New initiatives:</i> <ul style="list-style-type: none"> • <i>Project ADVANCE (Despite repeated efforts, have been unable to access funding for expansion into northern counties.)</i> • <i>Cabin Creek</i> • <i>EXCELL</i> • <i>Reclaiming Futures Service Coordination</i>
<i>The beneficial results of visiting a clinic for mental health treatment usually evaporate if a consumer returns home to inadequate housing and family despair. Treatment programs must have the resources to shore up inadequate social support systems or to provide alternative ones. Residential & vocational services that equal the community needs must be a part of the solution.</i>	<i>Access to housing funding is limited.</i>
<i>Without skilled people, all other efforts</i>	<i>The PRISYM project with Eastern</i>

Initial Goals	Changes and Progress
<p><i>are wasted. There is a great need for education & training programs in the Kentucky River Region that produces trained mental health professionals. Funding is needed for training programs & incentives that help trained people make the decision to live & work in the mountains.</i></p>	<p><i>Kentucky University is placing bachelor social work, master psychology and occupational therapy students into the region to experience rural, multidisciplinary approaches to behavioral health. One goal is to attract more providers to the rural areas and encourage others to stay.</i></p>
<p><i>One of the greatest opportunities for improvement in the region’s mental health system lies in building strong community networks that respond to the needs of those with mental disabilities & substance abuse problems. Partnerships among community agencies, public officials, & the Commonwealth must be strengthened and expanded. Results will come from pulling together the resources to work in a coordinated, simultaneous way to address the major problems consumers have.</i></p>	<p><i>Reclaiming Futures, through much hard work of the agency partners, has begun data sharing and cross training efforts with D.J.J., Administrative Office of the Courts, Division of Mental Health, schools and KRCC. DJJ has adopted a common assessment tool and treatment program as KRCC’s Reclaiming Futures project (the GAIN and Seven Challenges).</i></p>
<p>Goal 1: <i>Of the 10% of population, who abuse or are addicted to drugs, increase the number of adults who are accessing treatment options by 30%.</i></p>	<p><i>Thru the Paths to Recovery project, access has been improved. For example:</i></p> <p><i>Wait time from 1st contact to 1st scheduled appointment has gone from 21 days to 24-hours in Perry County. Wait time from 1st contact to 1st scheduled appointment has gone from 22 days to 4.19 days in Breathitt County. No- Show rate has dropped from 65% to 35% in Breathitt County.</i></p>
<p>Goal 2: <i>Reduce access to & use of opiates and other addictive, controlled prescription drugs by 20%.</i></p>	<p><i>Project UNITE increased access to jails.</i></p>
<p>Goal 4: <i>Expand women’s substance abuse service array to include service options & sites in each of the eight counties of the Kentucky River Region.</i></p>	<p><i>Despite repeated efforts, KRCC has been unable to access funding for expansion into northern counties.</i></p>
<p>Goal 1: <i>Increase by 40% the identification & referral for treatment of youth who may be abusing substances or who have key risk factors.</i></p>	<ul style="list-style-type: none"> • <i>Reclaiming Futures</i> • <i>Collaborative work with the Letcher County Drug Court</i>
<p>Goal 2: <i>Increase the number of substance abuse treatment program</i></p>	<ul style="list-style-type: none"> • <i>Cabin Creek has eight beds</i> • <i>Sewell Center has two beds</i>

Initial Goals	Changes and Progress
<i>options for youth within the region.</i>	<ul style="list-style-type: none"> • <i>Outpatient staff have been trained in providing evidenced based and promising practice treatment models (Seven Challenges, CYT, Motivational Interviewing, Assertive Continuing Care)</i> • <i>A new peer support group has begun in two counties – Life Challenges – based on the Seven Challenges model.</i>
<p>Goal 3: <i>Increase the number of youth accessing treatment options by 50%.</i></p>	<p><i>Reclaiming Futures</i></p>
<p>Goal 1: <i>Increase the number of adults accessing treatment by 10%.</i></p>	<p><i>Specific programs have been successful at increasing admissions. However, the effect on the agency as a whole has not yet been evaluated.</i></p>
<p>Goal 2: <i>Reduce adult hospitalizations & recidivism by 20%.</i></p>	<p><i>Implemented use of LOCUS for all crisis evaluations to ensure appropriate level of care is utilized.</i></p> <p><i>Hospitalizations in:</i></p> <ul style="list-style-type: none"> • <i>May, 2005 – 124</i> • <i>June, 2005 – 105</i> • <i>July, 2005 - 94</i>
<p>Goal 2: <i>Reduce the incidence of youth substance abuse by 15% via effective prevention efforts.</i></p>	<p><i>Reclaiming Future’s community advisory councils and youth leadership groups are concentrating their efforts on awareness; early intervention; and community involvement in the lives of these vulnerable youth.</i></p>
<p>Goal 3: <i>Increase by 30% the identification of children exhibiting risk indicators of mental health disorders.</i></p>	<p><i>There is a significant increase in the number of young children being identified with emotional problems through the Early Childhood Intervention Specialist and community/provider awareness of how to identify these youngsters and make a referral.</i></p>

VI. Recommendations

- A. Describe your recommendations regarding funding, particularly in light of the projected Medicaid shortfall and the impact on the Behavioral Health Safety Net

Kentucky is last in the nation in many categories of health and education. The solution to this funding crisis is not to balance the budget of the poorest and sickest among us. There are over 60 industries exempt from the state sales tax. Eliminating protection to many sacred cow industries would generate much additional revenue. As we prepare this HB843 Update report the Governor and Cabinet for Health Services is preparing a new 1115b Medicaid Waiver application to the federal center for Medicaid Services. This 1115b Waiver would address the Medicaid shortfall through increasing the technology that supports Medicaid and improved Managed Care practices. While the state has a budget crisis when it comes to health care and Medicaid funding, the state continues to find ways to fund its other priorities. Kentucky must recognize that the health of its citizens is paramount and that other state priorities must be secondary to a healthy citizenry.

B. Describe recommendations for public policy changes, particularly in moving toward statewide “modernization” of the system of care

- Reduce micro-management thru regulation reform
- Divert from expensive hospitalization to community-based services
- Increase privatization of state hospital services.
- Reduction in overhead at state level.
- Costs related to redundancy in reporting.
- Overhead cost in maintaining massive medical records.
- Support integration of Physical Health and Behavioral Health

**Cumberland HB 843 Regional Planning Council
HB 843 Report - September, 2005**

I. Features of your Regional Planning Council (RPC)

A. List members of your Regional Planning Council and their area of representation

Carla Allen –Mental Health	Debra Anderson –Psychiatric Hospital
Nancy Bean –DCBS	Yvonne Bishop –Vocational Rehabilitation
Dr. C. William Briscoe –Private Practice	Dora Burchett –Consumer
Susan Burgan –Education	Betty Caldwell –DCBS
Dr. Michael Colegrove –Education/College	Amanda Colton –Children & Mental Health
Steven Combs –District Health Department	Martha Copeland –Legal
Doreen Comelious –Court System	Shirley Cummings –Transportation
Pam Doan –Consumer	Cheryl Franklin –DCBS
Dr. Bob Fields –Private Practice	Terry Gray –Education/College
Faye Hubbard –Retired Mental Health & Substance Abuse	Linda Ingle –Consumer
Chad Jackson –Mental Health	Paula Johnson –Probation & Parole
Danny Jones –Mental Health, Substance Abuse, & Children	Diane Kagin –Substance Abuse
Dennis Karr –Business Development	Duane Kauffman –Retired Mental Health & Children
Stacy Killon –Elderly	Ralph Lipps –Retired Mental Health, Substance Abuse & Children
Gerald Lockhart –Mental Health, Substance Abuse, & Children	Linda Moyers –Mental Health & Children
Roland Mullins –Retired Mental Health, Substance Abuse, & Children	Walt Neachman –Law Enforcement
Donna Pace –Transportation	Mike Patrick –Elected Official
Diane Secrist –Consumer	Mike Sewell –Substance Abuse
Joanne Sizemore –Children	Craig Sutton –Law Enforcement
Gail Temperio –Health Department	Bill Thompson –Mental Health & Substance Abuse

Dr. Steve Toadvine –Medical	Kathy Tremaine –Mental Health
Pat Wagoner –District Health Dept. & Education	Pam Wenger –Psychiatric Hospital
Jill West –Children	Mona Whitaker –Transportation
Loretta White –Psychiatric Hospital	Raven Whitt –Student! Graduate School
Tammy Williams –Aging	Helen Yonce –Retired Education

B. Describe activities of the RPC since your last updated report (July, 2003)

Region Xlii has moved forward in many areas the past two years. The first class of thirty-four Certified Professional Counselor Associates graduated in December 2004 and the first class of twenty-seven undergraduates in Human Services graduated in December 2003, thus helping to alleviate the critical shortage of Human Service Professionals.

Another undergraduate and graduate class will complete degree requirements in Harlan in December 2005 and another graduate class will complete degree requirements in London in December 2006.

New BSW programs are being offered by ECU in Corbin and Manchester. Union College is in the planning stage of developing a Masters in Clinical and School Psychology, hopefully to begin in the Fall of 2006.

Other colleges and universities are exploring and offering a variety of other graduate and undergraduate programs.

A new facility was purchased and renovated for the Children’s Crisis Stabilization Unit in Southern Laurel County. An eleven-unit apartment complex is under construction in Harlan County on land donated by the Harlan County Fiscal Court. A four-unit apartment complex has recently been completed in Corbin for adult mental health clients.

New Drug Courts were implemented in several counties.

School Based Services for Children has greatly expanded throughout the entire region.

Project Unite funded by Congressman Hal Rogers’s office to combat alcohol and drug problems throughout the Fifth Congressional District is providing additional funding for indigent substance abuse clients to receive residential, halfway house, and outpatient services through the Voucher Program.

II. Describe Changes in Regional Needs, if applicable

A comparison of the Region XIII (Cumberland Valley) demographics (including community indicators and prevalence rates) that existed almost five 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 (co-occurring) MH and SA 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 35% increase in its consumer census over the past five years, as well as an even far greater increase (79%) in service volume.

Unfortunately, and with few exceptions, there have been no appreciable

changes in funding availability for behavioral health services during the past two years, as well as the three years prior to that. While the proponents of House Bill 843 were indeed an effective force in the funding of the CMHC's much-needed crisis stabilization programs for children and adults, the total combined expenses for those programs have exceeded appropriate funding by 40% during the past three years. Funding for those programs increased by 48% from 2003 to 2004, but only increased by 2% from 2004 to 2005. 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 are much more cost-effective.

For the past two years, the only significant increase in DMHMRS funding to the CMHC recently came as a contract modification to add \$98,000 of Community Care funds for fiscal year 2006. However, with budget cuts in state general funds of \$115,000 per year for fiscal years 2004 and 2005, the Center's actual monetary experience is a \$132,000 loss in a time of increasing service demands.

Two years ago there were funding hopes for two new substance abuse programs for the CMHC, which over time could have provided more than a million dollars for the provision of specific substance abuse services. The Center's funding proposals for these SAMHSA-funded programs were rejected, presumably because there was a greater need for the service programs elsewhere. The intent of one of these programs was to improve consumer engagement and retention in treatment at two outpatient programs and two gender-specific residential facilities, while the other program would target for treatment those consumers who have co-occurring substance abuse and mental health disorders. In recognition of the service needs of persons with these dual disorders, and without the advantage of special funding, the Region XIII CMHC has arranged specialized training for ten clinical staff persons who are now working region-wide with persons who have co-occurring disorders.

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.

III. Update Your Service System Description

Region XIII now operates a Children's Crisis Stabilization Unit (Turning Point) which continues to be a very beneficial service throughout the region. All

children presented in a crisis situation receive a psychiatric crisis evaluation. All children's clinicians have been trained to do the crisis evaluations and the appropriate paperwork that must be completed.

Based on past history services to children and families in rural Southeastern Kentucky, many barriers and obstacles must be overcome. Even though each county has an outpatient office, many families have not always been able to get in for services due to lack of transportation, finances, or unable to miss work for scheduled appointments.

By providing school based services, children are able to receive consistent services while attending school. In addition, the majority of the children needing services have poor academic performance. Providing services within the school setting allows the child to receive services on a regular basis and continue with classes. School based services also provide the opportunity for teachers, school staff, parents, and community partners to participate in the wraparound process for treatment intervention.

Our goal this upcoming fiscal year will be to provide school based services in 90% of all public schools. Due to the connection with local universities to provide advanced degrees locally, the number of mental health professionals for school based services have improved. CRCCC has 52 CFI's (Child/Family Interventionist) serving schools within our eight county region.

Parent involvement continues to be a major focus for care in Children's Services. The region has grown and made significant progress toward building a region-wide family network.

The family support network "COPE" (Creating Opportunities for Parents Everywhere) has been very productive this year and through a grant was able to rent a facility for their network. The facility is a three-bedroom house located in the local housing project in Williamsburg, Kentucky.

Cumberland River Comprehensive Care Center now operates an eight bed Crisis Stabilization Unit for adults with severe mental illness. These individuals can have co-occurring issues/diagnoses of substance abuse and/or mental retardation. The Crisis Stabilization Unit has assisted individuals in having an alternative to hospitalization and the ability to remain in their home community with access to local behavioral health services. The unit is working collaboratively with the Hazard Regional Psychiatric Hospital on referring individuals with a high recidivism to the unit as a step down alternative.

Major gaps in services for mental health and substance abuse include the lack of residential treatment for adolescents with substance abuse disorders, a non-medical detoxification program, and the need for more intensive outpatient services for both adults and adolescents with substance abuse disorders.

Transportation is also a major issue in rural Southeastern Kentucky for many clients.

Region XIII has entered into a collaborative agreement with Operation Unite to provide residential substance abuse services to those indigent individuals meeting Unites criteria for admission. This criteria includes being a resident of the Fifth Congressional District, meeting income and substance abuse guidelines. The Voucher Program reimburses for these services.

A collaborative agreement also exists with the Administrative Office of the Courts to provide outpatient and residential services to drug court clients. These drug court programs are funded by Operation Unite.

The Children's Program has entered into many collaborative agreements, especially with the local school systems and various social service agencies.

The agency continues to concentrate and expand services to those suffering from co-occurring illnesses. Currently 10-15 staff are identifying and providing specific services to identified clients.

The agency is currently training staff on evidence based practices. A training was held July 21, 2005 on Supported Employment with a goal of training 100% of all program staff in the Therapeutic Rehabilitation Program on the concept of supported employment and recovery. The agency is presenting to the clinical staff the concept of evidence-based practices on Aug. 19, 2005. Currently, the agency has 32 Performance Based Outcomes in the area of mental health. The data collected is aggregated and analyzed to determine the effectiveness of the service delivery in the area of adult mental health.

Cumberland River Comprehensive Care Center is currently reviewing the Evidence Based Toolkits from SAMHSA for implementation over the next five years.

IV. Describe Regional Response to These Events or Influences:

A. Adult and Children Crisis Stabilization Units

The Children's Crisis stabilization Unit, "Turning Point" in Region XIII continues to be a very beneficial service throughout the region. CRCCC as an agency has adopted the policy that all children who present in a crisis situation will receive a psychiatric crisis evaluation. All children's clinicians have been trained in how to do the evaluation and the appropriate paper work that must be completed. These evaluations are done in outpatient offices, schools, and home-visits or on crisis calls by the mobile crisis team.

The region received funding and was able to obtain a new and larger facility. The facility is very homelike and provides additional space for offices for individual and family sessions. A group area is available and a separate area for recreation and the ability to work on social skills. The unit has the capability for ten beds.

The following are the fiscal year 2005-year end numbers for the Children's Crisis Stabilization Unit:

- Number of unduplicated persons served — 192
- Number of unduplicated SED served with any crisis stabilization service — 232
- Number of instances of overnight crisis care — 360
- Number of persons receiving overnight crisis care — 192

The availability of the Adult Crisis Stabilization Unit has assisted in placing individuals in a safe therapeutic environment when needing treatment and voluntary admission is not available with existing psychiatric facilities.

B. Implementation of Medicaid Pharmacy Benefits Administrator (First Health) & impact on consumers' access to medications

The replacement of name brand drugs with generic drugs or changing to other drugs has created major problems for several clients. Some clients who have been stable for several years have recently been hospitalized due to medication changes.

Some medications are not pre-authorized on a timely basis often leaving the client without medications for three to five days.

C. Implementation of Jail Triage program

The Jail Triage Program, in conjunction with Blue grass Comprehensive Care has been implemented in Region XIII. Blue Grass Staff conducted an organization/training meeting in April of this year. At that time, Harlan and Laurel were the only two counties represented from Region XIII. More trainings are scheduled to bring more counties into this system this fiscal year.

The influx of referrals for one jail has been overwhelming to the agency and is in the process of being reviewed as to the reasons for the number of referrals in comparison to the other community mental health centers. The issues may be related to the number of arrests in our area due to Meth Labs and drug issues. Further investigation is needed.

D. Establishment of Governor’s Office of Drug Control Policy with focus on substance abuse disorders and increased funding for treatment and housing

Cumberland River Comprehensive Care Center is working closely with the Office of Drug Control Policy in order to ascertain this offices priorities for substance abuse treatment and housing for the substance abusing clients in our region.

Training of substance abuse staff continues to be a high priority for the agency. Recently, selected staff has been involved in the Kentucky School of Alcohol and Other Drug Studies, training offered by the Kelly Foundation form Little Rock, Arkansas, and the Southeast School of Alcohol and Other Drug Studies, Athens, Georgia.

E. Workforce development – increased training opportunities for mental health professionals

The agency’s Substance Abuse Program is committed to continuing efforts to develop Best Practices for substance abuse services. In conjunction with this, plans to develop a substance abuse course of study need to be discussed with local colleges and universities. As the Certified Alcohol and Drug Abuse Counselors Certification Board requires 270 clock hours of classroom instruction as part of the requirements toward certification (one college hour equals 15 clock hours toward certification, thus a three-hour course yields 45 clock hours toward certification). Six three-hour classes would meet the classroom requirement of 270 hours. Also, these classes would form the basis for candidates to have a workable knowledge of providing services to substance abuse clients while meeting the additional requirements to be certified. These additional requirements include: 300 hours of supervision, 6000 hours of experience (three years experience as a full time employee counseling substance abusers), making a passing score on a written examination, plus pass an oral exam based on a case study.

The region has been very successful at developing additional employees through the local colleges and universities. Currently, the number of individuals with a Master’s Degree in Professional Counseling has significantly increased through the availability of the Master’s Program with Lindsey Wilson College in London, Harlan, and Somerset.

F. Integration of mental health and physical health services and management

Cumberland River Comprehensive Care Center was asked to participate in a grant funded by Healthy Foundations for a Fit Kentucky written by Dr. Thomas Young at the University of Kentucky. The grant is attempting to add mental health services in a physical health clinic for children. Many children are brought in for physical health services and in fact are in need of mental health services. Pediatricians/family doctors will often refer children to a mental health provider

but the child is never seen. The lack of follow through is thought to be related to stigma, fear, lack of trust, etc. The grant is located in a rural and urban site and provides a clinician and a service coordinator at each physical health clinic. The staff is on-site on a daily basis and interacts and collaborates with the staff.

Cumberland River Comprehensive Care Center serves at the rural site in McKee, Kentucky in Jackson County at the White House Clinic. The clinic saw approximately 1,500 children last year by the pediatrician. They estimate that 10% of those children need mental health services. Children's Services currently has one master's level clinician and one bachelor's level service coordinator who are serving at the clinic. Continued focus on referrals and family involvement is a priority in this project.

G. Addressing issue of children "aging out" of youth services

Cumberland River Comprehensive Care Center continues to be concerned about this specific population of children. Many youth in this age have had limited transition into adult services and are ill prepared for adulthood. During the current school year, a transitioning project will be piloted in a local alternative school. A Child/Family Interventionist, who is also an occupational therapist, will be collaborating with children who are transitioning into adulthood. The project will focus on developing social skills, job possibilities and how to obtain; wood working and gardening skills will be used to assist in the process. The local school district is very excited with this project and hopes the project can be expanded. Other community partners will also be invited to become involved in the project.

V. Behavioral Health Goals

The major goals of Region XIII during the 2001 —2003 time period are as follows:

- Increase the number of behavioral health professionals.
- Obtain funding for an adult and children's crisis stabilization unit.
- Provide more treatment and housing for adults with mental illness.
- Provide residential treatment for adolescents with substance abuse disorders.
- Provide intensive outpatient programs for adults and adolescents with substance abuse disorders.
- Support the development of more drug courts.
- Offer a non-medical detoxification program.
- Provide more substance abuse residential treatment for adults and adolescents.
- Expand school-based services for children.

Many of these goals have been met. The development of educational programs within the Cumberland River District is meeting many of our staffing needs. Funding of the crisis stabilization units has met many needs for children and adults. The establishment of drug courts continues throughout the region.

Funding for a new private seventy-five bed treatment facility in Clay County will assist with some of the unmet residential treatment needs of substance abusers in our region.

- A. The plans for developing a residential substance abuse program for adolescents with substance abuse disorders have yet to materialize. Specific funding of this type of program must emerge before plans for this program can become a reality. Requests are put in place to the

- Division of Substance Abuse via the Annual State Plan and Budget.
- B. Intensive outpatient programs for adults and adolescents continue to be unable to be initiated because of a lack of a funding source although intensive outpatient services are offered at Baptist Regional Medical Center.
 - C. The agency continues to support the drug courts throughout the region, as the drug courts continue to support our efforts to provide treatment. The agency is currently serving over 100 clients through drug court.
 - D. The agency is in the process of training residential program staff on issues related to non-medical detoxification. More effort is being made to accommodate individuals in the program, rather than sending them to medical facilities. This must be done with the utmost concern for the welfare and safety of the client. This is an ongoing learning process.
 - E. The agency, in partnership with the Cumberland Hope Community LCC in Harlan, has applied for a grant through the Governor's Office to operate a 100-bed facility for women. If accepted, this program will be located in Harlan County. The Governor's Office has allocated 3.2 million dollars to construct and operate this facility. The treatment to be provided in this facility must replicate two existing programs in the Commonwealth, Peace Place in Louisville and The Hope Center in Lexington. This model has been proven to be an extremely effective modality in assisting substance abusers on the road to recovery. On August 11, 2005, Governor Fletcher announced that Harlan has been accepted as one of the sights.
 - F. Adequate housing units continue to be a top priority for adult MH and SA clients.

VI. Recommendations

Community Mental Health Centers have been meeting by State Mental Health Hospital District to address the funding issues including the state Medicaid shortfall.

Cumberland River, Kentucky River, and Mountain Comprehensive Care Centers make up our district and Appalachian Regional Hospital contracts with the Department of Mental Health to provide our inpatient mental health services.

Our recommendations for modernization and funding of modernization are briefly described below:

- Adopt recovery models, evidence based practices, and best practices that can be adapted to region.
- Increase community supports, education, and prevention.
- Develop services targeting family unit.
- Increase use of algorithms for medication treatment.
- Assure diagnosis and level of care is appropriate by identifying and using consistent screening assessment tools.

Funding Issues:

- Kentucky is one of only six states that spend more on inpatient care than community based service

Recommendation: Reduce inpatient beds to fund community based supports and services.

- **Level of Care:** Best practices, algorithms, and assessment tools to assure dollars are used m effectively.

**Lake Cumberland HB 843 Regional Planning Council
HB 843 Report - September, 2005**

I. Features of your Regional Planning Council (RPC)

- A. List members of your Regional Planning Council and their area of representation
We currently are in the process of sending invitations to various community organizations to involve cross disciplines on this council.

House Bill 843 Regional Planning Council Members as of August 2005

FAMILY MEMBERS

Marsha Vanhook

CONSUMER

Kathleen Earls

Chestlene Popplewell

Marsha Vanhook

COUNTY OFFICIALS

Letter has been sent to Pulaski County Judge Executive asking for his participation

HEALTH DEPARTMENT & PRIMARY CARE PHYSICIANS

Emily Branscum, Lake Cumberland District Health Department

ADVOCATES & COMMUNITY ORGANIZATIONS

Judy Wilson, Kentucky Agency for Substance Abuse Policy

Wanda Bolzé, Somerset UNITE Coalition

Dr. Richard Held, Chair of the UNITE Coalition

EDUCATORS & SCHOOL PERSONNEL

Wanda Bolzé, Somerset Community College

Dr. Steve Mitchell, Somerset Community College

Warren Lambert, Somerset Community College

REGIONAL INTERAGENCY COUNCILS

Jill Quaid, Regional Interagency Council, Adanta

Karen Bristow, Regional Interagency Council, Department for Community Based Services

Kristi Kennedy, University of Kentucky Women's Program

Rebecca Roaden, University of Kentucky Women's Program

LAW ENFORCEMENT & COURT PERSONNEL

Letter has been sent to UNITE Commonwealth Attorney representative to ask for his participation to serve

FACILITY SERVICE PROVIDERS

Cathy Epperson, CEO, Adanta

INDIVIDUAL SERVICE PROVIDERS

Kim Reynolds, Mental Health

CHAIR DESIGNEES/COORDINATORS FOR HB EFFORT

Cathy Settle, Clinical Director, Adanta

Lisa Palmer, Substance Abuse Director/Associate Clinical Director, Adanta

CONCERNED CITIZENS

Nola Mills

Jean Ellis

Richard Whitis

Teresa Loveless

Monica King

B. Describe activities of the RPC since your last updated report (July, 2003)

Continued to meet quarterly

Continued to monitor needs in the service area

Continued to work with UNITE coalition and KY ASAP Pulaski Board to assist with elimination of duplication of efforts and services

Reported back to various state workgroups including: Evidenced Based Practices Sub-Group; Advanced Mental Health Directives; Aging; Children's; Housing; Professional Staffing; Public Education; Quality Assurance; Employment; Transportation; Criminal Justice. Also responded to Secretary Holsinger's proposal to consolidate and relocate Eastern State Hospital.

II. Describe Changes in Regional Needs, if applicable**A. Any significant changes in your region's demographics**

Increase in population in Spanish speaking individuals

Increase in Substance Abuse service needs

Increase in Co-Occurring Disorders

Increase in those accessing Mental Health Services

Increase in children aging out of foster care

B. Update changes in community indicators and prevalence rates; significant events

Operation UNITE

Increase in Recovery Efforts

Planning NAMI Affiliate in Somerset (1st organizational meeting held 07-23-05; another organizational meeting scheduled in conjunction with Suicide Prevention on 08-19-05)

NAMI, Jansen Pharmaceuticals, Adanta & Lake Cumberland Regional Hospital promoting video "OUT OF THE SHADOW" September 20th

Medicare Part D co-pays

Federal Medicare modernization plan – coordinated by NAMI and State

Recovery Rally in Frankfort – September 1st

Suicide Prevention Support Group

Multiple Schlerosis meeting/Medicaid Party 09-03-05

C. Any significant changes in dollar resources

Adult Crisis Stabilization Unit – reduced from original amount

Medicaid rate freeze – last four years for everyone

State and federal cuts continually decreases services and access to services

Women's Center – SAMSHA lost federal funds

Flat funding and State General Fund dollars

III. Update Your Service System Description

Describe any significant changes in your region in access to community-based services:

Status of the "safety net" and addressing gaps in services

Aging population

No residential treatment for substance abuse

Outpatient support after substance abuse treatment

No services for children aging out of foster care

Services for specific populations (children, elderly, revolving door, deaf, homeless, dually-diagnosed, etc.)

Services offered – see grid

Collaboration, cooperation and communication among service providers

Hospitals, private care doctors, drug courts, schools, Department for Community Based Services, Multi-disciplinary teams, Department of Juvenile Justice, Administrative Office of the Courts, local jails, UNITE, Somerset NAMI Support Group, Suicide Prevention, Interagency, Chamber of Commerce, Foothills Academy Residential Treatment Facility

Adanta/Taylor County Hospital Memorandum of Understanding for psychiatric consults – need more physical health collaboration; 40% psychotropic medications prescribed by general practitioners

Evidence-based practices and focus on Recovery

State training on Matrix Model for Substance Abusers

IV. Describe Regional Response to These Events or Influences:

- A. Concept of changes to state psychiatric hospital services
New hospital to replace Eastern State Hospital
- B. Closure of psychiatric hospital beds in region, if applicable
Jane Todd Crawford Hospital reduction in beds – only leaves Eastern State and Lake Cumberland Regional Hospital – does not save beds
- C. Implementation of Medicaid Pharmacy Benefits Administrator (First Health) & impact on consumers’ access to medications
Medicaid prior authorization has caused problems with consumers accessing medications – has improved but prior authorization taking several days and is time consuming for medical staff
- D. Implementation of Jail Triage program
Jail Triage Program has been implemented and Community Mental Health Center has a contract with every jail in Region 14.
- E. CSU services funded for both children and adults in each region
Children’s Crisis Stabilization Unit in Somerset
Adult Crisis Stabilization Unit in Jamestown
- F. Establishment of Governor’s Office of Drug Control Policy with focus on substance abuse disorders and increased funding for treatment and housing
Still waiting on clarification of UNITE and KY ASAP Board’s role
What is the role of the Governor’s Office of Drug Control Policy
- G. Workforce development – increased training opportunities for mental health professionals
More educational opportunity through universities and private colleges – more publicity
Human Service degree to include co-occurring educational classes to count toward Qualified Substance Abuse Professional status
- H. Integration of mental health and physical health services and management
Collaboration efforts being completed throughout regional
 - o Community Mental Health Center developing Memorandum of Understanding with Taylor Regional Hospital
- I. Addressing issue of children “aging out” of youth services
No funding for kids aging out
Participating in Homeless Prevention Pilot Project to serve persons aging out of the foster care program.

V. 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 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.

B. Describe any changes in priority goals made in the past two years

Goal #5 has been implemented - all other goals stay as priority.

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

Goal #5 has been implemented

VI. Recommendations

- A. Describe your recommendations regarding funding, particularly in light of the projected Medicaid shortfall and the impact on the Behavioral Health Safety Net
 - Increase in flexible funding to meet the needs of the community as established by the Regional Planning Council
- B. Describe recommendations for public policy changes, particularly in moving toward statewide “modernization” of the system of care
 - Prevention and maintenance of care; tracking system
 - Use lottery funds to help support mental health, substance abuse and mental retardation
 - Have a tracking system to maintain the existing system of care

I. Grid of Essential Services – MH, SA, MR/DD, Dual Diagnosis

Service Type	Populations Served	Locus	Demand
Long Term Care			
Skilled Nursing Care (Medical)	All	Regional	More
Hospital Beds	All	Regional	More
Crisis Management	All	Local	Equal
Therapeutic Rehab	SMI	Local	Less
Housing with as needed supports	All	Regional/Local	More
Acute Specialties			
Dual Diagnosis (All Combinations)	All	Local	More
Geropsych Services	All	Regional/Multiple	More
Children’s Services	All	Regional/ Local	Equal
Neuropsych Services	All	Regional/Local	More
Medical Detox	SA	Regional/Local	More
Social Detox/residential	SA	Regional	More
Foster Care (adult and child)	All	Local	More
Crisis Management	All	Local	More
Criminal/Juvenile Justice	All	Regional/Local	More
Intermittent			
Intensive Outpatient Programs	SA/MH	Local	Equal
Adult Day Health	Elderly	Local	Equal
Outpatient (traditional)	All	Local	More
Service Coordination	All	Local	More
Employment	All	Local	More
Community Integration	All	Local	More
Other Services			
Independent Living	MH	Local	More

Bluegrass Regional Planning Council HB 843 Report – September, 2005

I. Features of your Regional Planning Council (RPC)

A. List members of your Regional Planning Council and their area of representation

Bluegrass Regional Planning Council Members

Dr. Philip Berger	Family Member
Mr. Robert Hicks	Family Member
Ms. Joe Ann Dove	Family Member
Ms. Wanda Chandler	SED Parent
Ms. Janice James	Provider/Hope Center
Ms. Lisa Minton	Provider/Chrysalis House
Ms. Kelly Gunning	NAMI Lexington/Advocacy Group
Cindy Ambrose	Consumer
Mr. John Gensheimer	Government Entity/Law enforcement
Ms. Faye Morton	Family Member/Advocacy Group
Mr. William Kendrick	Government Entity/Social Services/Juvenile
Dr. Melinda Rowe	Health Department
Valerie Mudd	Family Member/Advocacy Group
Ms. Mary Wooley	Consumer/Advocate

B. Describe activities of the RPC since your last updated report (July, 2003)

During the past two years, the Bluegrass Regional Planning Council has met approximately twice per year. These meetings have been for the purpose of reviewing annual service plans developed by Bluegrass, reviewing proposed changes to inpatient and related services (as proposed by Secretary Holsinger), reviewing development of the Jail Triage system, and discussing local planning issues. This group has been active in developing plans to replace Eastern State Hospital with a state of the art campus designed to provide a wide array of inpatient, crisis stabilization, substance abuse, and related services. This will continue to be a significant issue in the coming year(s).

II. Describe Changes in Regional Needs, if applicable

A. Any significant changes in your region's demographics

There have been few changes in the region's demographics. The growth of the Hispanic population in the region has continued. This continues to place some strain on the system in attempting to deal with a sometimes significant language barrier. There also seems to be an increase in physical health needs among consumers of mental health and substance services in the region. For most consumers, there has been little improvement in access to these services, and thus, they present for mental health or substance abuse services with an array of physical health needs which have gone un-met and may complicate our treatment efforts. Otherwise, community demographics are consistent with those outlined in the original report.

B. Update changes in community indicators and prevalence rates; significant events

Most community indicators and prevalence rates remain consistent with the original report. As the economy has slowed, there have been several companies in the region which have downsized or closed. This is especially critical in some of our smaller communities such as Carlisle, where the only

manufacturing employer (Jockey Corp.) has ceased operations, eliminating the primary employer in the entire county. These kinds of developments have impacts ranging from loss of tax base to placing further strains on the social and economic safety net in the community. Meeting these increased demands in the face of no-growth (and thus, reduced) revenues, is a significant challenge throughout the system within this region.

C. Any significant changes in dollar resources

The most significant change in dollar resources in the region is that State revenues and most other reimbursement rates have remained constant. After repeated budget cycles in which revenues remain essentially constant while costs of providing services continue to climb, it is becoming more and more difficult to maintain adequate service levels in the region. Local governments have also continued to face significant budget problems. In addition to the effect this has had on services directly provided by the local governments, there have been significant reductions in the funding provided to a large number of social service agencies in our counties. Over the past two years, funding for social service agencies has been reduced. For many agencies in this area, this has been a significant loss, and has directly impacted the ability to meet demand for their services.

III. Update Your Service System Description

Describe any significant changes in your region in access to community-based services:

Status of the “safety net” and addressing gaps in services

The “safety net” in the region is functioning reasonably well, given the continuation of flat funding cycles and the increase in demand for services. Improved communication among providers and with consumers has helped make the system somewhat more efficient and responsive to community needs. In addition, the implementation of the Jail Triage program in the region has improved access to assessment and care for consumers who arrive at jail for a variety of offenses. There remain some significant gaps in the areas of housing and access to transportation services.

Services for specific populations (children, elderly, revolving door, deaf, homeless, dually-diagnosed, etc.)

Services for children continue to improve as the Bluegrass Board seeks to expand efforts with local school systems, expand therapeutic foster care capacity and to improve collaboration with other community resources. These efforts have been successful despite a lack of any new funding to encourage expansion.

Services for the dually diagnosed in the region have continued to be a focus area. The Bluegrass Board has continued to expand training opportunities for staff in this area and have increased awareness and treatment options in both the outpatient settings and in Eastern State Hospital. Planning for the continued enhancement of these services is prominent in the development of plans for a new campus for Eastern State Hospital.

Efforts to limit the “revolving door” continue in the region. Steps have been taken in this region to improve the process by which consumers move from inpatient to outpatient care. We are attempting to provide assistance in attending an outpatient appointment upon discharge from Eastern State Hospital and a more “consumer friendly” initial appointment as part of efforts to more quickly and effectively engage consumers in follow up care.

Services to the homeless population continue to improve in the region, especially with expanded collaboration among the HOPE Center, Chrysalis House, Health Department and the Bluegrass Board. Most recently, the HOPE Center for Women’s Recovery and the Chrysalis House have collaborated on a SAMSHA grant to expand their service array. Also, the SHOW (Supported Housing Opportunities for Women) is now in operation to help locate housing and to provide support services.

Collaboration, cooperation and communication among service providers

Collaboration among providers in the region has expanded and continues to expand. Discussions between the Bluegrass Board and the Fayette County Health Department are underway in an effort to improve access to primary health care for consumers of mental health and substance abuse services. The local NAMI chapter has been very active in working with providers to improve current services and to engage in long range planning for system wide reconfiguration. There is also close collaboration between the Bluegrass Board and affiliate agencies to strengthen and improve the range of substance abuse services in the region

Evidence-based practices and focus on Recovery

The Bluegrass Board continues to promote the expanded use of Evidence Based Practices in service provision. A Depression protocol has been developed and many staff have been trained. Services for SPMI consumers are being moved toward a Recovery based model. There is currently a pilot program in the TRP in Lincoln/Garrard counties where principles are being incorporated. Bluegrass will be bringing a trainer in for a major training event on this approach this fall. Also, at Eastern State Hospital, a “Treatment Mall concept is being implemented. Included is an enhanced schedule of treatment opportunities, many focusing on Recovery concepts. This will enhance consumer choice and participation in treatment. Expansion of Recovery based principles to other areas/programs is being discussed, to the extent that current funding requirements will permit.

IV. Describe Regional Response to These Events or Influences:

A. Concept of changes to state psychiatric hospital services

The Regional Planning Council is highly supportive of the Bluegrass proposal to replace Eastern State Hospital with a state of the art campus to provide inpatient care and a range of integrated services in a single site. Key to this support is the understanding that there will always be a need for public psychiatric beds with an integrated service system surrounding them, and that the private sector is cannot be counted on to provide those

B. Closure of psychiatric hospital beds in region, if applicable

There have continued to be private bed closures, dictated by reimbursement rates and profit margins. The constant fluctuation in the number of these beds makes planning all the more complicated. This has an enormous impact on admissions to Eastern State Hospital. The continuation of this trend has reinforced the commitment expressed in ‘A ‘above.

C. Implementation of Medicaid Pharmacy Benefits Administrator (First Health) & impact on consumers’ access to medications

Discussions concerning the implementation of the Medicaid Pharmacy Benefits Administrator have centered on several perceptions. Consumers seem to be getting denied necessary medications on numerous occasions. There are also

reports of refusals by pharmacies for consumers who cannot provide the co-pay. There have also been reports by providers that they have experienced problems getting paid. There have been numerous implementation problems reported, especially with child medications, which have had an initial negative impact on care. There do seem to be some recent efforts by First Health to work to correct some of the systemic problems.

D. Implementation of Jail Triage program

The implementation of the Jail Triage program has demonstrated that there is a significant demand in local jails for access to mental health services. In addition to the risk management and consultation features of this program, it has demonstrated the need for more significant funding for more comprehensive services to be provided in jails.

E. CSU services funded for both children and adults in each region

Crisis Stabilization services continue to be provided through the Bluegrass Board for adults and children in the region. The model in place for children's services relies on use of Therapeutic Foster Homes to provide a safe place to manage the crisis. This approach seems to work quite well. As the number of Foster Homes in the program grows, our crisis stabilization capacity grows as well. Through this model, service capacity can grow without being restricted by the costs and delays of capital project processes.

F. Establishment of Governor's Office of Drug Control Policy with focus on substance abuse disorders and increased funding for treatment and housing

Office of Drug Control Policy – There has been little impact thus far in this region.

G. Workforce development – increased training opportunities for mental health professionals

There has been little progress in the area of workforce development for mental health professional that we can determine. The quality and quantity of graduates from training programs has not improved. Graduates of these programs are rarely trained adequately to meet the demand of practice in the public sector. This continues to be a significant need in this area.

H. Integration of mental health and physical health services and management

The integration of physical health and mental health services is clearly an issue of concern. Consumers of mental health services continue to experience difficulty in accessing physical health care. A model for integrating care would be highly desirable in that it would assure that all aspects of a consumer's health care could be addressed in one system. The main concern in developing such a system is that the priority given to mental health services would be secondary or that the mental health system would get "swallowed up" in the physical health system. The importance of this issue is prompting discussions between Bluegrass and the Fayette County Health Department to investigate a system that assures both sets of needs are accommodated.

I. Addressing issue of children "aging out" of youth services

The transition from "youth services" to adult status continues to be a challenge. As children "age out" of the broad array of youth services that exist, there is really no smooth transition into what is often not as comprehensive an array of services for adults. Factors ranging from provider/system problems to differing structures born out of funding differences all complicate this transition. The Regional Planning Council has discussed this issue on more than one occasion. We are currently investigating the possibility of adding a transitional

youth representative to the RPC in hopes of improving the insight we may obtain and focusing possible proposals/solutions to this problem.

V. Behavioral Health Goals

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

The top goals set by our Regional Planning Council initially included the following:

- To improve access to Psychotropic medications for consumers
- To increase services to children and youth
- To enhance consumer access to transportation services
- To develop an uninterrupted substance abuse delivery system
- To increase substance abuse programs for children and youth
- To improve access to housing for individuals with mental illness
- To develop day treatment programs for children and youth

B. Describe any changes in priority goals made in the past two years

During the past two years, we have discussed the following additional goals;

- To improve and expand services for individuals with co-occurring substance abuse and mental health disorders
- To build a state of the art facility housing inpatient and a range of related services to replace the aging Eastern State Hospital facility

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

As a result of continued flat (reduced) funding, there has been minimal progress on many of the goals. Some progress has been noted in the following areas:

- Access to medications continues to improve through increase utilization of patient assistance programs sponsored by pharmaceutical companies. This is only done at great expense with no support or reimbursement. As such, the extent to which this can be increased is minimal.
- Services to children and youth have increase modestly, largely in the area of school based services and collaboration. Again, without any additional funding, continuing this increase will be difficult.
- There has been virtually no progress in improving access to transportation services.
- Access to housing for individuals with mental illness has improved thanks to excellent leadership and support from Kentucky Housing Corporation and through collaborative efforts of local providers. The Bluegrass Board, HOPE Center, and Chrysalis House have all made progress in this area utilizing federal funding to improve capacity. While there has been significant progress, it is only seen as a beginning.
- Improving services to the dually diagnosed has begun with a major staff training effort by the Bluegrass Board. Specialized services are being developed and close consultation with staff at Eastern State Hospital is helping identify specific problems to be addressed.
- Plans for a new state of the art campus to replace Eastern State Hospital have focused on the necessary capacity and array of services and have involved consumers and a variety of providers. As a precursor to such an expanded service array, a “Treatment Mall” concept is being implemented at Eastern State Hospital. This will expand the range of treatments offered and improve

consumer choice. There is great excitement and anticipation surrounding this concept.

VI. Recommendations

- A. Describe your recommendations regarding funding, particularly in light of the projected Medicaid shortfall and the impact on the Behavioral Health Safety Net

It has long been a recommendation that a goal be set to increase funding for mental health and substance abuse services to a level that would move the state of Kentucky from 44th to 25th in state per capita funding. Notwithstanding the projected Medicaid shortfall, we would still make this a primary recommendation. While Medicaid has helped support community mental health services over the past several years, state funding levels have remained constant or declined. We would recommend that adequate state revenues be allocated to mental health services to begin to address some of the needs/gaps that have been mentioned.

We would recommend pursuing the proposed replacement of the Eastern State Hospital with a state of the art campus of integrated services and programs as soon as possible. This is a much needed and long overdue project which would greatly improve services, encourage innovation, and improve efficiencies. It is also an opportunity for the state of Kentucky to pioneer a new model for the provision of services to a very vulnerable population.

We recommend that transportation services receive special consideration and funding. Lack of adequate transportation continues to be a major barrier to those seeking mental health and substance abuse services. Until something is done to improve their transportation options (especially in rural areas), large numbers of citizens will be unable to access the services they need

We recommend that efforts to integrate physical health and mental health care be made so that mental health consumers can better access the physical health care so many of them need.

We also recommend that efforts be made to improve the number and types of housing options which are available to those with Serious Mental Illness. A full range of supported housing, transitional housing and independent living arrangements should be available.

- B. Describe recommendations for public policy changes, particularly in moving toward statewide “modernization” of the system of care

Policy changes could include the following:

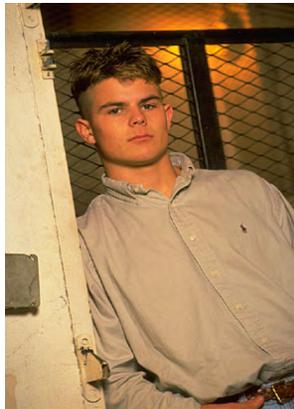
Outpatient Commitment Laws – Need to be able to compel follow through with outpatient treatment in certain conditions. This would help limit the “revolving door” problem for State Hospitals and conserve resources which are consumed with repeat inpatient admissions. In addition to the policy change, this would require an enhanced service system to meet the demand.

A significant barrier to housing and employment for some consumers is the fact that they may have a criminal record resulting from behaviors they exhibit when symptomatic. A change in policy which would allow, under certain circumstances, expunging their records of non-violent felony charges would help eliminate such barriers.

“... a life’s too much to lose...”



Preventing Suicide: Kentucky’s Plan



Prepared by the Kentucky Division of Mental Health and Substance Abuse in collaboration with the Kentucky Suicide Prevention Group (KSPG), a work group of the Kentucky Commission on Services and Support for Individuals with Mental Illness, Alcohol & Other Drug Abuse Disorders, and Dual Diagnosis (HB 843 Commission).



Kentucky
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ERNIE FLETCHER
GOVERNOR

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MENTAL HEALTH
AND MENTAL RETARDATION SERVICES
DIVISION OF MENTAL HEALTH
AND SUBSTANCE ABUSE
100 FAIR OAKS LANE 4E-D
FRANKFORT, KENTUCKY 40621-0001
(502) 564-4456
(502) 564-9010 FAX
[HTTP://MHMR.KY.GOV](http://MHMR.KY.GOV)

JAMES W. HOLSINGER, JR., M.D.
SECRETARY

Secretary James W. Holsinger, MD
Representative Mary Lou Marzian
Members of the Kentucky Commission on Services and Supports for Individuals with Mental Illness,
Alcohol, and Other Drug Abuse Disorders, and Dual Diagnosis (HB 843 Commission)
Citizens of the Commonwealth:

Dear Members and Citizens of the Commonwealth :

With Kentucky's suicide rate exceeding the national suicide rate and the need for a state plan to address this issue, we present you with "Preventing Suicide: Kentucky's Plan" as prepared by the Kentucky Suicide Prevention Group (KSPG), a workgroup of the Commission.

This plan highlights the activities of the KSPG since its inception in March 2002. In particular, the plan illustrates the commitment to the collaborative nature of its work and continued efforts to raise awareness about suicide and its prevention so that fewer Kentuckians experience the pain and grief resulting from the suicide death of a loved one.

We would like to take this opportunity to thank the many volunteers who have shared in the efforts of the KSPG ranging from those who have lost loved ones to suicide, community action groups, government employees, educators, mental health advocacy and support groups, and staff of the regional mental health centers.

Additionally, we are appreciative of the support provided by the administration, the Commission, and the General Assembly in addressing the issue of suicide. On behalf of the KY Suicide Prevention Group, the citizens of the Commonwealth, and especially those affected by the death of a loved one by suicide, we ask for your continued support of this important work.

For additional information about the KSPG or any activities described within this plan, please do not hesitate to contact us or the lead staff at DMHMRS for this initiative.

Sincerely,

Connie Milligan
Steering Committee Chair

Denis Walsh
Steering Committee Vice-Chair



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Introduction

“even one death by suicide is one death too many”

**Former HHS Secretary,
Tommy G. Thompson**

**Department of Health
& Human Services**

**An average of 502
Kentucky citizens die by
suicide each year.**

Kentucky loses twice as many
citizens to suicide as to homicide.

Kentucky’s suicide death rate is
the 19th highest in the nation.

Suicide is the 2nd leading cause of
death for Kentuckians 15 to 34
years old.

Suicide is the 4th leading cause of
death for 35 to 54 year olds.

73 percent of suicide deaths in
Kentucky were caused by firearms.

2920 self-inflicted injuries¹
resulted in an in-patient hospital
admission in Kentucky during
calendar year - 2003.

¹ Self-inflicted injuries from the ICD-9 coding range of 9--- to 9--- are included here. This is the code range identifying suicide attempts.

Suicide is permanent.

However, potential suicide victims usually exhibit warning signs before attempting to end their lives. Therefore, suicide, like other forms of violence, is preventable. It is a preventable public health problem.

With growing concern for the problem of suicide in Kentucky and the knowledge that such devastating acts of violence are preventable, in 2002 the Kentucky Department for Mental Health and Mental Retardation Services invited various community leaders to establish the Kentucky Suicide Prevention Group. In October 2004, a staff person was hired to focus upon suicide prevention efforts in the Commonwealth.

The group’s collaborative work continues to provide the framework for Kentucky’s response to the problem of suicide. This report provides an overview of the activities over the past fiscal year and incorporates the state suicide prevention plan for the future. The June 2004 Progress Report, which covers the history of the group’s efforts from its inception, is also available on-line at the following web-page:

<http://mhmr.ky.gov/mhsas/suicidepreventiongroup.asp>

The Impact of Suicide

Below are quotes from those who have been impacted by the suicide death of a loved one. The efforts of the Kentucky Suicide Prevention Group are dedicated to reducing the rate at which others experience their pain.



I am so tired of secrets. Being depressed is not something to be ashamed of. It's about brain chemistry, not some personal weakness. If I had known more about the risk factors, maybe there's something we could have done to help. I knew my son was sad but what I didn't know was that you can die from being too sad."

"My son was a basketball player who died by suicide. After an injury basically sidelined him, we all missed the signs of depression that followed. As his mother, I am convinced that if the coaching staff, his team members, his girlfriend, his family or even he had been able to recognize the symptoms of depression, and sought treatment, he would be alive today. That's why the work of the Kentucky Suicide Prevention Group is so important to me - to prevent other families from experiencing the grief and pain that we live with every day."



The Vision, Mission & History

Vision

The vision of the Kentucky Suicide Prevention Group is to lead the Commonwealth in providing and promoting opportunities for all Kentuckians to become active in the reduction of suicide deaths and attempts.

Mission

The mission of the Kentucky Suicide Prevention Group is to decrease suicide deaths and attempts in the Commonwealth through advocacy, education, training, and evaluation.

History

As the basis for a collaborative development of a state suicide prevention plan, Kentucky's Division of Mental Health recruited stakeholders from a number of interest areas and from all over the state. At the first meeting in March 2002, approximately 25 people were in attendance who subsequently formed the Kentucky Suicide Prevention Planning Group.

In July 2002, eight of the group members attended the national conference of Suicide Prevention and Advocacy Network (SPAN-USA)² in Washington, D.C. There they were given information and tools to assist them in writing a suicide prevention plan. Upon their return, they immediately began working intensively to prioritize goals and action steps. With leadership from this core group, the Kentucky Suicide Prevention Planning Group recommended that the outline proposed by Surgeon General Satcher (US Public Health Service, 1999) and the National Strategy for Suicide Prevention (US Department for Health & Human Services, 2001) be followed in Kentucky. This model recognizes suicide as a preventable public health problem.

In December 2003, several members, including state legislators Senator Tom Buford and Representative Mary Lou Marzian, attended a conference on suicide prevention planning sponsored by the national Suicide Prevention Resource Center (SPRC). At this time further development of efforts in Kentucky occurred through structured facilitation provided by SPRC staff.

In June 2004, a progress report of the efforts of this group and its initial goals was published and presented to the Kentucky Commission on Services and Support for Individuals with Mental Illness, Alcohol & Other Drug Abuse Disorders, and Dual Diagnosis (HB 843 Commission). Some additional highlights of progress from March 2002 through June 2004 included training over 35 trainers of QPR as well as teaching over 500 individuals the basic QPR gatekeeper skills, distributing over 2000 information packets at conferences and events, and utilizing the expertise of several experienced professionals in the field of suicidology and prevention planning.

² SPAN-USA is now the acronym for the Suicide Prevention Action Network.

In October 2004, a suicide prevention coordinator was hired to address the issue of suicide via collaborative funding from the Department for Public Health and the Department for Mental Health & Mental Retardation Services. In December 2004, the KY Suicide Prevention Planning Group held a strategic planning retreat. It was determined that the group had moved past the planning stage, thus that word – planning – was removed from its name. Thus the group has since been known as the KY Suicide Prevention Group (KSPG). The strategic planning process was continued in February 2005. As a result of these sessions, a state suicide prevention plan emerged. Additionally, the three main work groups of the planning period which focused upon Awareness, Education, and Evaluation/Research were closed and new task specific groups became the focal point of the efforts of the KSPG.

The group expresses three primary messages:

- * **A Life is Too Much to Lose**
- * **Suicide is a Preventable Public Health Problem**
- * **Suicide Prevention:
It's Everybody's Business**

Support and Collaboration

Since that first meeting in 2002 when a group of devoted and concerned people formed the Kentucky Suicide Prevention Group, over 150 individuals have joined the effort. These people represent much of the Commonwealth's diversity in many areas such as age, geographic location, professions, personal experience and agency affiliation. Some of the involved entities include:

Survivor Support Groups
Local School Boards
Private Psychiatric Hospitals
Community Mental Health Centers
Law Enforcement
Private Businesses
Citizen Advocacy Groups
KY School Boards Association
Local Public Health
Louisville Youth Group
Mental Health Association of KY
Suicide Prevention Training
Programs for KY

Stop Youth Suicide Campaign
Morehead State University
State Interagency Council
Protection and Advocacy
Kentucky Center for School Safety
Western Kentucky University
Hospice of the Bluegrass
University of Kentucky
Mental Health Association of
Northern KY
National Alliance of the Mentally Ill -
Kentucky

The Division of Mental Health and Substance Abuse sponsors the Kentucky Suicide Prevention Group, in partnership with the Department for Public Health. Each Department has several staff involved in these efforts which are coordinated by the state suicide prevention coordinator.

Strategy

The invested and active stakeholders propose a strategy to reduce the rate of suicide within the Commonwealth. The strategy is based upon the eleven goals and corresponding objectives from the National Strategy for Suicide Prevention (NSSP), published by the U.S. Department of Health and Human Services in May of 2001, with leadership from the Surgeon General.

NSSP is the result of advocates, clinicians, and researchers and survivors working together to respond to the Surgeon General's challenge. It lays out a framework for action to prevent suicide. It is designed as a catalyst for social change using the public health approach with focus upon the areas of *awareness, intervention, and methodology*.

Based upon the needs in Kentucky, the goals created were focused on the areas of advocacy, education, marketing/public relations, community mobilization, and securing funding which can be tied directly to the national goals of awareness, intervention, and methodology.

The Commonwealth of Kentucky's Suicide Prevention Plan focuses upon the importance of a plan which has a life-span approach. This is important because data shows that persons of all ages are affected by self-inflicted injuries and suicide deaths.

Goals & Objectives

Advocate: To advocate for suicide prevention efforts.

Objectives:

- Promote awareness that suicide is a public health problem that is preventable.
- Develop broad-based support for suicide prevention.
- Identify the need for increased access to and community linkages with mental health and substance abuse services.
- Pursue affiliation with the Suicide Prevention Action Network – USA.
- Prepare an informational packet for various audiences to distribute as needed.
- Make formal recommendations to the HB 843 Commission and the Commissioners of the Department for Mental Health & Mental Retardation Services and the Department for Public Health regarding suicide prevention efforts.
- Utilize survivors to tell their story to legislators, administrators, community leaders, and citizens of the Commonwealth.

Educate: To develop and implement educational strategies.

Objectives:

- Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention services.
- Identify and maximize existing anti-stigma events (walks, conference, etc.).
- Promote efforts to reduce access to lethal means and methods of self-harm.
- Implement training for recognition of at-risk behavior and delivery of effective treatment.
- Identify and promote effective clinical and professional practices.
- Promote and support research on suicide and suicide prevention.
- Develop, improve, and expand surveillance systems.
- Communicate the availability of gatekeeper training and screening tools.
- Educate public and medical practitioners about appropriate treatment options.

Marketing and Public Relations: To develop and implement marketing and public relations strategies.

Objectives:

- Market suicide prevention as a means to lower costs of mental and physical health care costs.
- Develop a public awareness media campaign.
- Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media.
- Enlist the support of media partners.

Mobilize Communities: To develop and expand community suicide prevention.

Objectives:

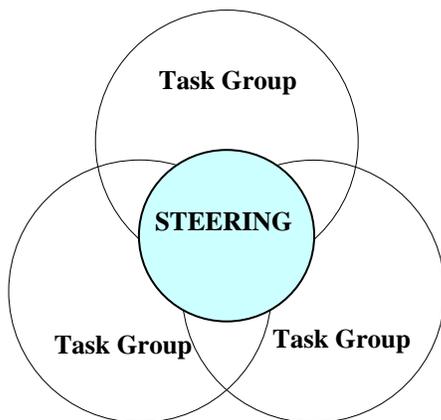
- Research, identify, and encourage implementation of community-based suicide prevention programs.
- Identify the need for increased access to and community linkages with mental health and substance abuse services.
- Mobilize geographic as well as organizational communities to expand suicide prevention efforts.
- Develop and train communities in the usage of a community suicide prevention toolkit.

Secure Funding: To secure funding for suicide prevention efforts.

Objectives:

- Identify grant funding options and grant preparation resources.
- Identify foundations and organizations to support the efforts of the KY Suicide Prevention Group (KSPG).
- Utilize public-private partnerships to secure funding and maintain leadership of the KSPG.

Structure



Task Groups are led by a volunteer from KSPG. Each task group may request technical assistance from the Steering Committee and the suicide prevention coordinator.

The Steering Committee consists of five individuals representing the full KSPG. They serve as the leadership component for the group and are responsible to report annually to the HB 843 Commission.

To accomplish the strategy set forth, there is a steering committee of five individuals which directs the efforts of the KY Suicide Prevention Group. Working task groups are formed to focus upon specific task areas as they arise. These are supported and coordinated through the suicide prevention coordinator.

Each fiscal year a 2-page document will be published to report updates and achievements.

Acknowledgements

Many thanks are due to the more than 150 Kentuckians who have joined the suicide prevention effort. Without each and every one of them, the group's work would not have progressed as it has.

The most heartfelt thanks go to the survivors of suicide. They are the essence of this movement. Without the spirit and dedication of those dramatically impacted by the suicide death of their loved ones, the reason for the efforts of this might would be lost. Thanks to their ability to communicate and advocate, we focus on practical and effective ways to prevent others from experiencing the grief they endure daily.

Special thanks are also given to the following individuals for their consistent support and encouragement, listed in alphabetical order.

Mark Birdwhistell	Undersecretary for Health, Cabinet for Health & Family Services
Tom Buford	Senator, Kentucky General Assembly
Steve Davis, MD	Deputy Commissioner, Department for Public Health
Sue Eastgard	Director, Youth Suicide Prevention Program - Washington State
Sarah Gilbert	EKU Facilitation Center, Training Assistant
William Hacker, MD	Commissioner, Department for Public Health
Linda Harney	Deputy Commissioner, Dept. for Mental Health and Mental Retardation Services
James Holsinger, MD	Secretary, Cabinet for Health & Family Services & Co-Chair, HB 843 Commission
Rice Leach	Former Commissioner, Department for Public Health
David Litts, OD	Suicide Prevention Resource Center, Air Force Suicide Prevention Plan
Mary Lou Marzian	Representative, Kentucky General Assembly & Co-Chair, HB 843 Commission
Margaret Pennington	Former Commissioner, Dept. for Mental Health and Mental Retardation Services
Lloyd Potter	Director, Suicide Prevention Resource Center
Paul Quinnett, PhD	President and CEO, QPR Institute
Bob Robey	Suicide Prevention Training Programs for KY
Karen Russell	EKU Facilitation Center, Facilitation Services Specialist
Bruce W. Scott	Former Director, Division of Mental Health
Steve Shannon	Director, Division of Mental Health and Substance Abuse
Pat Wear, II	Commissioner, Department for Mental Health and Mental Retardation Services
Sarah Wilding	Chief Nurse, Department for Public Health
Linda Whittle	Ohio Coalition for Suicide Prevention

Reference Web Sites

National Resources

American Association of Suicidology	http://www.suicidology.org/
American Foundation for Suicide Prevention	http://www.afsp.org/
Jason Foundation	http://www.jasonfoundation.com/
Jed Foundation	http://www.jedfoundation.org/
Kristin Brooks Hope Center / National Hopeline Network	http://www.hopeline.com/
National Center for Suicide Prevention Training	http://www.ncspt.org/courses/orientation/
National Strategy for Suicide Prevention	http://www.mentalhealth.org/suicideprevention/strategy.asp
National Suicide Prevention Lifeline	http://www.suicidepreventionlifeline.org
National Youth Violence Prevention Resource Center	http://www.safeyouth.org/scripts/index.asp
NMHA sponsored Depression Screening	http://www.depression-screening.org/
Organization for Attempters & Survivors of Suicide in Interfaith Services	http://www.oassis.org/
QPR Institute - Gatekeeper Prevention Training	http://www.qprinstitute.com/
Samaritans Suicide Prevention	http://www.samaritansnyc.org/
Stop a Suicide, Today!	http://www.stopasuicide.com/
Suicide Awareness/Voices of Education	http://www.save.org/
Suicide Prevention Action Network (SPAN USA)	http://www.spanusa.org/
Suicide Prevention Resource Center	http://www.sprc.org/
Suicide Reference Library: Suicide Awareness, Support & Education	http://www.suicidreferencelibrary.com/
Surgeon General's 1999 Call to Action	http://www.surgeongeneral.gov/library/calltoaction/default.htm
Web-based Injury Statistics Query and Reporting System	http://www.cdc.gov/ncipc/wisqars/default.htm
Yellow Ribbon Suicide Prevention Program	http://www.yellowribbon.org/

State and Local Resources

Hospice of the Bluegrass	http://www.hospicebg.com/
KY Department for Mental Health & Mental Retardation Services – Suicide Prevention Pages	http://mhmr.ky.gov/KDMHMRS/ http://mhmr.ky.gov/mhsas/suicidepreventiongroup.asp
KY Department for Public Health – Data Resources	http://chfs.ky.gov/dph/surv.htm
Mental Health Association of Northern Kentucky	http://www.mhanky.org/index.htm
SPAN Kentucky	http://www.span-ky.com/
Stop Youth Suicide Campaign	http://www.stopyouthsuicide.com/
Suicide Prevention Programs for Kentucky (QPR)	http://www.kysuicideprevention.com/index.html

Contact Information



Jason H. Padgett, MPA
MH/MR Program Administrator
Suicide Prevention Coordinator
Dept. for Mental Health & Mental Retardation Services
Division of Mental Health & Substance Abuse
Program Support Branch
100 Fair Oaks Lane, 4E-D
Frankfort, KY 40621
502-564-4456
jason.padgett@ky.gov

Kentucky Suicide Prevention Group – Steering Committee
Connie Milligan, Chair
Denis Walsh, Vice-Chair
Mary Bolin-Reece, Member
Linda Lancaster, Member
Jan Ulrich, Member

Hatim Omar, Former Chair
Richard Greer, Former Member
Bruce Hey, Former Member



Preventing Suicide: Kentucky's Plan
Kentucky Department for Mental Health & Mental Retardation Services
100 Fair Oaks Lane, 4E-D
Frankfort, KY 40621



Kentucky Suicide Death & Self-Injury Statistics

**Compiled by the
Cabinet for Health & Family Services
Office for Health Policy
Department for Public Health
and
Department for Mental Health &
Mental Retardation Services**



Printed September 2, 2005

Table 1
Suicide Attempts and Self Inflicted Injuries by Age Group 2000-2003
ICD 9 Kentucky Hospital Utilization Data

Age	2000		2001		2002		2003	
	Totals	Rate	Totals	Rate	Totals	Rate	Totals	Rate
0-4	*	*	*	*	*	*	*	*
5-9	*	*	*	*	*	*	*	*
10-14	56	20.0	41	14.7	64	22.9	51	18.2
15-19	238	82.4	277	95.8	259	89.62	326	112.8
20-24	287	101.4	346	122.2	388	137.1	371	131.1
25-34	619	109.0	710	125.0	801	141.0	748	131.7
35-44	623	96.9	754	117.3	778	121.1	795	123.7
45-54	292	52.4	361	64.8	404	72.5	434	77.9
55-64	98	26.3	122	32.7	138	37.0	127	34.1
65-74	36	13.1	34	12.4	43	15.7	52	19.0
75-84	17	9.8	25	14.5	11	6.4	22	12.7
85 +	8	13.7	9	15.4	8	13.7	5	8.6
State	2274	56.3	2681	66.3	2896	71.7	2933	72.6

Rates are per 100,000 people. 2000 Census data used in rates. * Indicates less than 5.

Cabinet for Health and Family Services

Kentucky Office for Health Policy

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Table 1A
Suicide Deaths 2000-2003
Kentucky Vital Statistics Data

Age	2000		2001		2002		2003	
	Totals	Rate	Totals	Rate	Totals	Rate	Totals	Rate
0-4	0	0	0	0	0	0	0	0
5-9	0	0	0	0	0	0	0	0
10-14	2	0.7	1	0.4	4	1.4	4	1.4
15-19	25	8.7	18	6.2	19	6.6	20	6.9
20-24	41	14.5	45	15.9	51	18.0	56	19.8
25-34	93	16.4	83	14.6	92	16.2	106	18.7
35-44	120	18.7	125	19.5	116	18.0	116	18.0
45-54	89	16.0	106	19.0	116	20.8	100	18.0
55-64	47	12.6	49	13.2	63	16.9	75	20.1
65-74	45	16.4	39	14.2	29	10.6	53	19.3
75-84	30	17.4	33	19.1	37	21.4	24	13.9
85 +	16	27.5	11	18.9	11	18.9	9	15.4
State	508	12.6	510	12.6	538	13.3	563	13.9

Rates are per 100,000 people. 2000 Census data used in rates.

2003 Death Data is preliminary. Cabinet for Health and Family Services

Kentucky Office for Health Policy

8/2/2005

Table 2

**Suicide Attempts and Self Inflicted Injuries by Gender 2000-2003
ICD 9 Kentucky Hospital Utilization Data**

	2000		2001		2002		2003	
Gender	Totals	Rate	Totals	Rate	Totals	Rate	Totals	Rate
Male	967	49.0	1099	55.6	1222	61.9	1230	62.3
Female	1307	63.3	1582	76.6	1674	81.0	1703	82.4
Total	2274	56.3	2681	66.3	2896	71.7	2933	72.6

Rates are per 100,000 people. 2000 Census data used in rates.

Cabinet for Health and Family Services

Kentucky Office for Health Policy

8/2/2005

Table 2A

**Suicide Death Data 2000-2003
Kentucky Vital Statistics Data**

	2000		2001		2002		2003	
Gender	Totals	Rate	Totals	Rate	Totals	Rate	Totals	Rate
Male	427	21.6	417	21.1	443	22.4	469	23.7
Female	81	3.9	93	4.5	95	4.6	94	4.5
Total	508	12.6	510	12.6	538	13.3	563	13.9

Rates are per 100,000 people. 2000 Census data used in rates.

2003 Death Data is preliminary. Cabinet for Health and Family Services

Kentucky Office for Health Policy

8/2/2005

Table 3

**Suicide Attempts and Self Inflicted Injuries by County 2000-2003
ICD 9 Kentucky Hospital Utilization Data**

County	2000	2001	2002	2003	2000-2003 (TOTAL)	AVG	AVG Rate	2000 pop
Adair	6	1	5	9	21	5.3	30.4	17244
Allen	9	15	7	8	39	9.8	54.8	17800
Anderson	13	7	4	9	33	8.3	43.2	19111
Ballard	2	1	6	4	13	3.3	39.2	8286
Barren	17	34	32	30	113	28.3	74.3	38033
Bath	3	4	6	7	20	5.0	45.1	11085
Bell	43	35	54	52	184	46.0	153.0	30060
Boone	48	85	83	97	313	78.3	91.0	85991
Bourbon	7	8	14	7	36	9.0	46.5	19360
Boyd	20	48	39	52	159	39.8	79.9	49752
Boyle	26	27	14	20	87	21.8	78.5	27697
Bracken	6	6	6	15	33	8.3	99.6	8279
Breathitt	6	10	20	16	52	13.0	80.7	16100
Breckinridge	5	2	5	15	27	6.8	36.2	18648
Bullitt	21	22	19	29	91	22.8	37.2	61236
Butler	3	10	6	8	27	6.8	51.9	13010
Caldwell	8	8	11	15	42	10.5	80.4	13060
Calloway	8	7	12	12	39	9.8	28.5	34177
Campbell	85	94	123	62	364	91.0	102.7	88616
Carlisle	4	3	4	6	17	4.3	79.4	5351
Carroll	6	3	9	9	27	6.8	66.5	10155
Carter	10	10	20	10	50	12.5	46.5	26889
Casey	2	16	13	17	48	12.0	77.7	15447
Christian	17	15	28	31	91	22.8	31.5	72265
Clark	10	10	8	20	48	12.0	36.2	33144
Clay	12	17	19	16	64	16.0	65.2	24556
Clinton	7	4	8	4	23	5.8	59.7	9634
Crittenden	6	9	11	12	38	9.5	101.2	9384
Cumberland	1	3	5	4	13	3.3	45.5	7147
Daviess	97	86	117	142	442	110.5	120.7	91545
Edmonson	6	3	4	8	21	5.3	45.1	11644
Elliott	0	2	2	4	8	2.0	29.6	6748
Estill	9	5	7	10	31	7.8	50.6	15307
Fayette	174	145	155	151	625	156.3	60.0	260512
Fleming	8	4	6	5	23	5.8	41.7	13792
Floyd	18	23	18	34	93	23.3	54.8	42441
Franklin	27	36	46	26	135	33.8	70.8	47687
Fulton	6	8	6	7	27	6.8	87.1	7752
Gallatin	10	13	8	11	42	10.5	133.4	7870
Garrard	14	9	9	10	42	10.5	71.0	14792
Grant	23	32	49	25	129	32.3	144.1	22384
Graves	30	28	49	36	143	35.8	96.5	37028
Grayson	11	5	11	12	39	9.8	40.5	24053
Green	2	7	2	12	23	5.8	49.9	11518
Greenup	19	26	29	28	102	25.5	69.1	36891
Hancock	9	4	9	9	31	7.8	92.3	8392

Suicide Attempts and Self Inflicted Injuries by County 2000-2003
ICD 9 Kentucky Hospital Utilization Data

County	2000	2001	2002	2003	2000-2003 (TOTAL)	AVG	AVG Rate	2000 pop
Hardin	49	64	51	81	245	61.3	65.0	94174
Harlan	21	37	29	37	124	31.0	93.4	33202
Harrison	4	11	7	6	28	7.0	38.9	17983
Hart	3	4	4	10	21	5.3	30.1	17445
Henderson	39	44	42	32	157	39.3	87.6	44829
Henry	6	4	9	3	22	5.5	36.5	15060
Hickman	1	2	0	1	4	1.0	19.0	5262
Hopkins	58	58	84	65	265	66.3	142.4	46519
Jackson	4	9	15	4	32	8.0	59.3	13495
Jefferson	318	345	362	409	1434	358.5	51.7	693604
Jessamine	17	26	29	29	101	25.3	64.7	39041
Johnson	22	19	24	17	82	20.5	87.4	23445
Kenton	87	173	159	120	539	134.8	89.0	151464
Knott	10	13	14	9	46	11.5	65.2	17649
Knox	5	17	13	13	48	12.0	37.7	31795
Larue	5	6	5	7	23	5.8	43.0	13373
Laurel	19	38	36	31	124	31.0	58.8	52715
Lawrence	19	9	22	11	61	15.3	98.0	15569
Lee	6	5	5	10	26	6.5	82.1	7916
Leslie	6	11	6	6	29	7.3	58.5	12401
Letcher	15	40	24	25	104	26.0	102.9	25277
Lewis	3	7	8	6	24	6.0	42.6	14092
Lincoln	16	24	15	24	79	19.8	84.5	23361
Livingston	2	9	10	5	26	6.5	66.3	9804
Logan	25	22	25	23	95	23.8	89.4	26573
Lyon	3	2	9	5	19	4.8	58.8	8080
Madison	14	11	25	21	71	17.8	25.0	70872
Magoffin	9	8	8	13	38	9.5	71.3	13332
Marion	8	7	13	13	41	10.3	56.3	18212
Marshall	14	21	22	22	79	19.8	65.6	30125
Martin	8	7	7	11	33	8.3	65.6	12578
Mason	4	11	14	9	38	9.5	56.5	16800
Mccracken	60	50	80	72	262	65.5	100.0	65514
McCreary	13	19	13	8	53	13.3	77.6	17080
Mclean	6	13	14	7	40	10.0	100.6	9938
Meade	10	7	11	12	40	10.0	38.0	26349
Menifee	2	3	1	2	8	2.0	30.5	6556
Mercer	9	16	11	11	47	11.8	56.4	20817
Metcalfe	11	6	5	9	31	7.8	77.2	10037
Monroe	4	8	8	11	31	7.8	65.9	11756
Montgomery	12	4	8	9	33	8.3	36.6	22554
Morgan	4	7	4	2	17	4.3	30.5	13948
Muhlenberg	25	15	19	26	85	21.3	66.7	31839
Nelson	12	22	24	33	91	22.8	60.7	37477
Nicholas	5	1	4	3	13	3.3	47.7	6813
Ohio	14	6	16	11	47	11.8	51.3	22916
Oldham	17	25	22	21	85	21.3	46.0	46178

**Suicide Attempts and Self Inflicted Injuries by County 2000-2003
ICD 9 Kentucky Hospital Utilization Data**

County	2000	2001	2002	2003	2000-2003 (TOTAL)	AVG	AVG Rate	2000 pop
Owen	3	2	2	4	11	2.8	26.1	10547
Owsley	4	8	8	5	25	6.3	128.7	4858
Pendleton	4	11	13	9	37	9.3	64.3	14390
Perry	38	56	42	36	172	43.0	146.3	29390
Pike	43	63	60	82	248	62.0	90.2	68736
Powell	4	12	10	3	29	7.3	54.8	13237
Pulaski	80	80	75	67	302	75.5	134.3	56217
Robertson	0	1	2	0	3	0.8	33.1	2266
Rockcastle	7	8	5	6	26	6.5	39.2	16582
Rowan	0	8	8	13	29	7.3	32.8	22094
Russell	10	17	13	14	54	13.5	82.7	16315
Scott	15	16	14	16	61	15.3	46.1	33061
Shelby	8	6	8	5	27	6.8	20.2	33337
Simpson	7	6	5	11	29	7.3	44.2	16405
Spencer	4	2	3	3	12	3.0	25.5	11766
Taylor	12	7	8	25	52	13.0	56.7	22927
Todd	6	4	1	4	15	3.8	31.3	11971
Trigg	4	2	1	6	13	3.3	25.8	12597
Trimble	2	1	2	3	8	2.0	24.6	8125
Union	8	13	19	9	49	12.3	78.3	15637
Warren	60	75	69	76	280	70.0	75.7	92522
Washington	3	3	2	5	13	3.3	29.8	10916
Wayne	5	6	4	9	24	6.0	30.1	19923
Webster	13	18	16	16	63	15.8	111.5	14120
Whitley	20	29	35	52	136	34.0	94.8	35865
Wolfe	3	4	7	5	19	4.8	67.2	7065
Woodford	13	7	10	8	38	9.5	40.9	23208
Kentucky	6274	2681	6900	6939	22794	5698.5	141.0	4041769

Rates are per 100,000 people. 2000 Census data used in rates.

Cabinet for Health and Family Services

Kentucky Office for Health Policy

8/8/2005

Table 3A

Suicide Death Data by County 2000-2003
Kentucky Vital Statistics Data

County	2000-2003				TOTAL	AVG	AVG Rate	2000 pop
	2000	2001	2002	2003				
Adair	1	4	3	2	10	2.5	14.5	17244
Allen	3	2	2	0	7	1.8	9.8	17800
Anderson	3	1	2	2	8	2.0	10.5	19111
Ballard	2	1	0	1	4	1.0	12.1	8286
Barren	3	3	7	4	17	4.3	11.2	38033
Bath	1	0	1	2	4	1.0	9.0	11085
Bell	4	4	2	5	15	3.8	12.5	30060
Boone	8	5	7	6	26	6.5	7.6	85991
Bourbon	2	3	2	3	10	2.5	12.9	19360
Boyd	7	5	4	9	25	6.3	12.6	49752
Boyle	4	3	1	6	14	3.5	12.6	27697
Bracken	1	1	3	1	6	1.5	18.1	8279
Breathitt	3	2	3	5	13	3.3	20.2	16100
Breckinridge	7	5	3	1	16	4.0	21.5	18648
Bullitt	6	9	2	10	27	6.8	11.0	61236
Butler	0	1	5	0	6	1.5	11.5	13010
Caldwell	3	0	3	2	8	2.0	15.3	13060
Calloway	4	10	4	2	20	5.0	14.6	34177
Campbell	7	11	8	15	41	10.3	11.6	88616
Carlisle	1	1	1	0	3	0.8	14.0	5351
Carroll	3	0	2	3	8	2.0	19.7	10155
Carter	4	4	2	6	16	4.0	14.9	26889
Casey	1	2	2	3	8	2.0	12.9	15447
Christian	5	10	6	6	27	6.8	9.3	72265
Clark	3	7	4	3	17	4.3	12.8	33144
Clay	4	3	3	4	14	3.5	14.3	24556
Clinton	1	1	2	1	5	1.3	13.0	9634
Crittenden	1	1	0	1	3	0.8	8.0	9384
Cumberland	2	1	1	2	6	1.5	21.0	7147
Daviess	3	12	19	14	48	12.0	13.1	91545
Edmonson	1	3	1	0	5	1.3	10.7	11644
Elliott	1	2	0	0	3	0.8	11.1	6748
Estill	4	3	2	0	9	2.3	14.7	15307
Fayette	25	28	23	30	106	26.5	10.2	260512
Fleming	4	3	1	1	9	2.3	16.3	13792
Floyd	8	3	10	7	28	7.0	16.5	42441
Franklin	4	4	12	12	32	8.0	16.8	47687
Fulton	3	3	2	2	10	2.5	32.2	7752
Gallatin	1	2	2	2	7	1.8	22.2	7870
Garrard	1	3	2	2	8	2.0	13.5	14792
Grant	2	2	2	4	10	2.5	11.2	22384
Graves	5	8	6	5	24	6.0	16.2	37028
Grayson	5	6	4	3	18	4.5	18.7	24053
Green	1	0	0	0	1	0.3	2.2	11518
Greenup	3	5	4	2	14	3.5	9.5	36891
Hancock	0	1	1	0	2	0.5	6.0	8392

Suicide Death Data by County 2000-2003
Kentucky Vital Statistics Data

County	2000-2003				TOTAL	AVG	AVG Rate	2000 pop
	2000	2001	2002	2003				
Hardin	9	11	11	5	36	9.0	9.6	94174
Harlan	6	4	3	3	16	4.0	12.0	33202
Harrison	3	1	4	0	8	2.0	11.1	17983
Hart	3	2	5	0	10	2.5	14.3	17445
Henderson	3	7	6	9	25	6.3	13.9	44829
Henry	3	0	0	1	4	1.0	6.6	15060
Hickman	1	1	0	1	3	0.8	14.3	5262
Hopkins	4	4	11	7	26	6.5	14.0	46519
Jackson	3	0	2	4	9	2.3	16.7	13495
Jefferson	93	74	91	100	358	89.5	12.9	693604
Jessamine	3	4	4	0	11	2.8	7.0	39041
Johnson	6	3	2	3	14	3.5	14.9	23445
Kenton	23	18	20	22	83	20.8	13.7	151464
Knott	1	1	2	2	6	1.5	8.5	17649
Knox	2	6	5	4	17	4.3	13.4	31795
Larue	1	3	1	0	5	1.3	9.3	13373
Laurel	12	5	8	12	37	9.3	17.5	52715
Lawrence	2	4	3	1	10	2.5	16.1	15569
Lee	2	3	4	2	11	2.8	34.7	7916
Leslie	1	3	4	0	8	2.0	16.1	12401
Letcher	6	5	6	6	23	5.8	22.7	25277
Lewis	3	2	4	1	10	2.5	17.7	14092
Lincoln	2	0	2	4	8	2.0	8.6	23361
Livingston	1	0	0	3	4	1.0	10.2	9804
Logan	3	3	2	6	14	3.5	13.2	26573
Lyon	1	0	0	0	1	0.3	3.1	8080
Madison	9	7	5	3	24	6.0	8.5	70872
Magoffin	1	1	1	5	8	2.0	15.0	13332
Marion	2	3	2	3	10	2.5	13.7	18212
Marshall	5	2	3	7	17	4.3	14.1	30125
Martin	0	1	2	1	4	1.0	8.0	12578
Mason	0	1	1	1	3	0.8	4.5	16800
Mccracken	14	10	17	10	51	12.8	19.5	65514
McCreary	5	1	6	2	14	3.5	20.5	17080
Mclean	1	0	1	1	3	0.8	7.5	9938
Meade	1	4	4	6	15	3.8	14.2	26349
Menifee	0	1	0	0	1	0.3	3.8	6556
Mercer	2	0	3	5	10	2.5	12.0	20817
Metcalfe	0	1	2	0	3	0.8	7.5	10037
Monroe	4	3	4	1	12	3.0	25.5	11756
Montgomery	4	4	2	6	16	4.0	17.7	22554
Morgan	2	1	1	1	5	1.3	9.0	13948
Muhlenberg	5	4	4	6	19	4.8	14.9	31839
Nelson	6	3	6	8	23	5.8	15.3	37477
Nicholas	1	1	0	1	3	0.8	11.0	6813
Ohio	2	4	3	5	14	3.5	15.3	22916
Oldham	6	4	5	3	18	4.5	9.7	46178

Suicide Death Data by County 2000-2003
Kentucky Vital Statistics Data

County	2000-2003				TOTAL	AVG	AVG Rate	2000 pop
	2000	2001	2002	2003				
Owen	2	0	2	2	6	1.5	14.2	10547
Owsley	2	1	3	1	7	1.8	36.0	4858
Pendleton	0	3	4	2	9	2.3	15.6	14390
Perry	5	7	3	3	18	4.5	15.3	29390
Pike	5	11	11	12	39	9.8	14.2	68736
Powell	0	4	1	0	5	1.3	9.4	13237
Pulaski	6	8	3	15	32	8.0	14.2	56217
Robertson	1	0	1	0	2	0.5	22.1	2266
Rockcastle	1	1	1	6	9	2.3	13.6	16582
Rowan	0	0	3	5	8	2.0	9.1	22094
Russell	6	3	4	1	14	3.5	21.5	16315
Scott	5	8	3	4	20	5.0	15.1	33061
Shelby	5	2	5	1	13	3.3	9.7	33337
Simpson	0	6	2	0	8	2.0	12.2	16405
Spencer	1	7	1	0	9	2.3	19.1	11766
Taylor	5	4	6	8	23	5.8	25.1	22927
Todd	3	1	1	1	6	1.5	12.5	11971
Trigg	4	0	1	2	7	1.8	13.9	12597
Trimble	2	0	0	3	5	1.3	15.4	8125
Union	1	2	3	3	9	2.3	14.4	15637
Warren	7	16	14	14	51	12.8	13.8	92522
Washington	1	1	1	0	3	0.8	6.9	10916
Wayne	2	4	3	3	12	3.0	15.1	19923
Webster	1	4	1	4	10	2.5	17.7	14120
Whitley	4	7	7	9	27	6.8	18.8	35865
Wolfe	4	0	3	2	9	2.3	31.8	7065
Woodford	3	2	3	2	10	2.5	10.8	23208
Kentucky	4508	4512	4542	4569	2119	529.8	13.1	4041769

Rates are per 100,000 people. 2000 Census data used in rates.

2003 Death Data is preliminary. Cabinet for Health and Family Services

Kentucky Office for Health Policy

8/8/2005

Table 4
Suicide Attempts and Self Inflicted Injuries by Area Development District 2000-2003
ICD 9 Kentucky Hospital Utilization Data

ADD	2000	2001	2002	2003	2000-2003 TOTAL	AVG	AVG Rate	2000 pop
Purchase 01	125	120	179	160	584	146.0	75.5	193495
Pennyrile 02	129	122	174	169	594	148.5	68.9	215519
Green River 03	186	184	233	226	829	207.3	99.9	207377
Barren River 04	145	183	165	194	687	171.8	67.3	255225
Lincoln Trail 05	103	116	122	178	519	129.8	53.4	243202
Kentuckiana 06	376	405	425	473	1679	419.8	48.3	869306
Northern Kentucky 07	266	413	446	337	1462	365.5	93.4	391417
Buffalo Trace 08	21	29	36	35	121	30.3	54.8	55229
Gateway 09	21	26	27	33	107	26.8	35.1	76237
FIVCO 10	68	95	112	105	380	95.0	69.9	135849
Big Sandy 11	100	120	117	157	494	123.5	76.9	160532
Kentucky River 12	88	147	126	112	473	118.3	98.0	120656
Cumberland Valley 13	131	190	206	211	738	184.5	77.4	238270
Lake Cumberland 14	138	160	146	169	613	153.3	79.2	193452
Bluegrass 15	377	371	382	374	1504	376.0	54.8	686003
Kentucky	2274	2681	2896	2933	10784	2696	66.7	4041769

Rates are per 100,000 people. 2000 Census data used in rates.

Cabinet for Health and Family Services

Kentucky Office for Health Policy

8/12/2005

Table 4A
Suicide Deaths by Area Development District 2000-2003
Kentucky Vital Statistics Data

ADD	2000	2001	2002	2003	2000-2003 TOTAL	AVG	AVG RATE	2000 pop
Purchase 01	35	36	33	28	132	33.0	17.1	193495
Pennyrile 02	27	20	26	28	101	25.3	11.7	215519
Green River 03	11	30	34	36	111	27.8	13.4	207377
Barren River 04	24	40	44	25	133	33.3	13.0	255225
Lincoln Trail 05	32	36	32	26	126	31.5	13.0	243202
Kentuckiana 06	116	96	104	118	434	108.5	12.5	869306
Northern Kentucky 07	46	41	47	56	190	47.5	12.1	391417
Buffalo Trace 08	9	7	10	4	30	7.5	13.6	55229
Gateway 09	7	6	7	14	34	8.5	11.1	76237
FIVCO 10	17	20	13	18	68	17.0	12.5	135849
Big Sandy 11	20	19	26	28	93	23.3	14.5	160532
Kentucky River 12	24	22	28	21	95	23.8	19.7	120656
Cumberland Valley 13	36	30	31	47	144	36.0	15.1	238270
Lake Cumberland 14	30	28	30	37	125	31.3	16.2	193452
Bluegrass 15	74	79	73	77	303	75.8	11.0	686003
Kentucky	508	510	538	563	2119	529.8	13.1	4041769

Rates are per 100,000 people. 2000 Census data used in rates.

2003 Death Data is preliminary. Cabinet for Health and Family Services

Kentucky Office for Health Policy

8/12/2005

Table 5	
KENTUCKY SELF INFLICTED INJURIES AND SUICIDE ATTEMPTS BY INJURY CODE 2003 HOSPITALIZATION DATA	
NON PSYCHOTROP AGENT	1209
PSYCHOTROP AGENT	1064
CUTTING	340
POISONING	116
OTHER/UNDEFINED	83
FIREARM	68
HANGING/SUFFOCATION	22
SUICIDE-BURNS/FIRE/SCALD	14
SUICIDE-JUMP	9
SUICIDE-MOTOR VEHICLE CRASH	7
SUICIDE-DROWNING	*
STATE TOTAL	2933

* Indicates less than 5.
Cabinet for Health and Family Services
Kentucky Office for Health Policy
8/16/2005

Table 5A
KENTUCKY SUICIDE DEATHS BY INJURY CODE
INTENTIONAL SELF-HARM

		2000	2001	2002	2003
X60	Intentional self-poisoning (suicide) by and exposure to nonopioid analgesics,	2	2	1	3
X61	Intentional self-poisoning (suicide) by and exposure to antiepileptic, sedative-hypnotic,	5	8	10	9
X62	Intentional self-poisoning (suicide) by and exposure to narcotics and psychodysleptics	2	7	6	2
X63	Intentional self-poisoning (suicide) by and exposure to other drugs acting on the	0	0	0	0
X64	Intentional self-poisoning (suicide) by and exposure to other and unspecified drugs,	24	31	42	31
X65	Intentional self-poisoning (suicide) by and exposure to alcohol	1	0	1	1
X66	Intentional self-poisoning (suicide) by and exposure to organic solvents and	1	0	1	2
X67	Intentional self-poisoning (suicide) by and exposure to other gases and vapors	15	14	14	15
X68	Intentional self-poisoning (suicide) by and exposure to pesticides	0	0	0	0
X69	Intentional self-poisoning (suicide) by and exposure to other and unspecified chemicals	1	0	0	1
X70	Intentional self harm (suicide) by hanging, strangulation, and suffocation	66	74	77	75
X71	Intentional self harm (suicide) by drowning and submersion	2	4	4	5
X72	Intentional self harm (suicide) by handgun discharge	43	44	35	43
X73	Intentional self harm (suicide) by rifle, shotgun, and larger firearm discharge	34	28	42	37
X74	Intentional self harm (suicide) by other and unspecified firearm discharge	297	281	289	321
X75	Intentional self harm (suicide) by explosive material	0	1	0	0
X76	Intentional self harm (suicide) by smoke, fire, and flames	3	3	2	2
X77	Intentional self harm (suicide) by steam, hot vapors, and hot objects	0	0	0	0
X78	Intentional self harm (suicide) by sharp object	3	6	3	6
X79	Intentional self harm (suicide) by blunt object	0	0	0	0
X80	Intentional self harm (suicide) by jumping from a high place	4	3	4	3
X81	Intentional self harm (suicide) by jumping or lying before moving object	1	1	1	2
X82	Intentional self harm (suicide) by crashing of motor vehicle	0	0	2	2
X83	Intentional self harm (suicide) by other specified means	0	1	1	1
X84	Intentional self harm (suicide) by unspecified means	3	2	2	2
Y870	Sequelae of Intention self-harm (x60-x84)	1	0	1	0

Cabinet for Health and Family Services
Department for Public Health, Kentucky Health Data and Surveillance
8/9/2005

Table 6

Suicide Death Data 2000-2003, Kentucky Vital Statistics Data

DISTRICTS AND COUNTIES	2000		2001		2002		2003	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate
PURCHASE								
BALLARD	2	24.1	1	12.1	0	0.0	1	12.1
CALLOWAY	4	11.7	10	29.3	4	11.6	2	5.9
CARLISLE	1	18.7	1	18.7	1	18.8	0	0.0
FULTON	3	38.7	3	38.7	2	26.5	2	25.8
GRAVES	5	13.5	8	21.6	6	16.1	5	13.5
HICKMAN	1	19.0	1	19.0	0	0.0	1	19.0
MCCRACKEN	14	21.4	10	15.3	17	26.4	10	15.3
MARSHALL	5	16.6	2	6.6	3	9.9	7	23.2
DISTRICT 01	35	18.1	36	18.6	33	17.1	28	14.5
PENNYRILE								
CALDWELL	3	23.0	0	0.0	3	23.2	2	15.3
CHRISTIAN	5	6.9	10	13.8	6	8.4	6	8.3
CRITTENDEN	1	10.7	1	10.7	0	0.0	1	10.7
HOPKINS	4	8.6	4	8.6	11	23.6	7	15.0
LIVINGSTON	1	10.2	0	0.0	0	0.0	3	30.6
LYON	1	12.4	0	0.0	0	0.0	0	0.0
MUHLENBERG	5	15.7	4	12.6	4	12.6	6	18.8
TODD	3	25.1	1	8.4	1	8.3	1	8.4
TRIGG	4	31.8	0	0.0	1	7.9	2	15.9
DISTRICT 02	27	12.5	20	9.3	26	12.1	28	13.0
GREEN RIVER								
DAVISS	3	3.3	12	13.1	19	20.7	14	15.3
HANCOCK	0	0.0	1	11.9	1	11.7	0	0.0
HENDERSON	3	6.7	7	15.6	6	13.3	9	20.1
MCLEAN	1	10.1	0	0.0	1	10.0	1	10.1
OHIO	2	8.7	4	17.5	3	12.9	5	21.8
UNION	1	6.4	2	12.8	3	19.3	3	19.2
WEBSTER	1	7.1	4	28.3	1	7.1	4	28.3
DISTRICT 03	11	5.3	30	14.5	34	16.3	36	17.4
BARREN RIVER								
ALLEN	3	16.9	2	11.2	2	11.0	0	0.0
BARREN	3	7.9	3	7.9	7	18.1	4	10.5
BUTLER	0	0.0	1	7.7	5	38.0	0	0.0
EDMONSON	1	8.6	3	25.8	1	8.4	0	0.0
HART	3	17.2	2	11.5	5	28.3	0	0.0
LOGAN	3	11.3	3	11.3	2	7.5	6	22.6
METCALFE	0	0.0	1	10.0	2	19.9	0	0.0
MONROE	4	34.0	3	25.5	4	33.9	1	8.5
SIMPSON	0	0.0	6	36.6	2	12.0	0	0.0
WARREN	7	7.6	16	17.3	14	14.8	14	15.1
DISTRICT 04	24	9.4	40	15.7	44	16.9	25	9.8

Suicide Death Data 2000-2003, Kentucky Vital Statistics Data

DISTRICTS AND COUNTIES	2000		2001		2002		2003	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate
LINCOLN TRAIL								
BRECKINRIDGE	7	37.5	5	26.8	3	15.8	1	5.4
GRAYSON	5	20.8	6	24.9	4	16.4	3	12.5
HARDIN	9	9.6	11	11.7	11	11.5	5	5.3
LARUE	1	7.5	3	22.4	1	7.5	0	0.0
MARION	2	11.0	3	16.5	2	10.9	3	16.5
MEADE	1	3.8	4	15.2	4	14.6	6	22.8
NELSON	6	16.0	3	8.0	6	15.5	8	21.3
WASHINGTON	1	9.2	1	9.2	1	9.0	0	0.0
DISTRICT 05	32	13.2	36	14.8	32	12.9	26	10.7
KENTCKIANA								
BULLITT	6	9.8	9	14.7	2	3.1	10	16.3
HENRY	3	19.9	0	0.0	0	0.0	1	6.6
JEFFERSON	93	13.4	74	10.7	91	13.0	100	14.4
OLDHAM	6	13.0	4	8.7	5	10.1	3	6.5
SHELBY	5	15.0	2	6.0	5	14.2	1	3.0
SPENCER	1	8.5	7	59.5	1	7.4	0	0.0
TRIMBLE	2	24.6	0	0.0	0	0.0	3	36.9
DISTRICT 06	116	13.3	96	11.0	104	11.8	118	13.6
NORTHERN KY								
BOONE	8	9.3	5	5.8	7	7.5	6	7.0
CAMPBELL	7	7.9	11	12.4	8	9.0	15	16.9
CARROLL	3	29.5	0	0.0	2	19.5	3	29.5
GALLATIN	1	12.7	2	25.4	2	25.5	2	25.4
GRANT	2	8.9	2	8.9	2	8.5	4	17.9
KENTON	23	15.2	18	11.9	20	13.1	22	14.5
OWEN	2	19.0	0	0.0	2	18.3	2	19.0
PENDLETON	0	0.0	3	20.8	4	27.0	2	13.9
DISTRICT 07	46	11.8	41	10.5	47	11.7	56	14.3
BUFFALO TRACE								
BRACKEN	1	12.1	1	12.1	3	35.4	1	12.1
FLEMING	4	29.0	3	21.8	1	7.1	1	7.3
LEWIS	3	21.3	2	14.2	4	28.7	1	7.1
MASON	0	0.0	1	6.0	1	5.9	1	6.0
ROBERTSON	1	44.1	0	0.0	1	42.3	0	0.0
DISTRICT 08	9	16.3	7	12.7	10	17.9	4	7.2
GATEWAY								
BATH	1	9.0	0	0.0	1	8.8	2	18.0
MENIFEE	0	0.0	1	15.3	0	0.0	0	0.0
MONTGOMERY	4	17.7	4	17.7	2	8.6	6	26.6
MORGAN	2	14.3	1	7.2	1	7.0	1	7.2
ROWAN	0	0.0	0	0.0	3	13.5	5	22.6
DISTRICT 09	7	9.2	6	7.9	7	9.0	14	18.4

Suicide Death Data 2000-2003, Kentucky Vital Statistics Data

DISTRICTS AND COUNTIES	2000		2001		2002		2003	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate
FIVCO								
BOYD	7	14.1	5	10.0	4	8.1	9	18.1
CARTER	4	14.9	4	14.9	2	7.4	6	22.3
ELLIOTT	1	14.8	2	29.6	0	0.0	0	0.0
GREENUP	3	8.1	5	13.6	4	10.9	2	5.4
LAWRENCE	2	12.8	4	25.7	3	19.0	1	6.4
DISTRICT 10	17	12.5	20	14.7	13	9.6	18	13.3
BIG SANDY								
FLOYD	8	18.8	3	7.1	10	23.7	7	16.5
JOHNSON	6	25.6	3	12.8	2	8.6	3	12.8
MAGOFFIN	1	7.5	1	7.5	1	7.5	5	37.5
MARTIN	0	0.0	1	8.0	2	16.0	1	8.0
PIKE	5	7.3	11	16.0	11	16.2	12	17.5
DISTRICT 11	20	12.5	19	11.8	26	16.3	28	17.4
KY RIVER								
BREATHITT	3	18.6	2	12.4	3	18.9	5	31.1
KNOTT	1	5.7	1	5.7	2	11.3	2	11.3
LEE	2	25.3	3	37.9	4	50.3	2	25.3
LESLIE	1	8.1	3	24.2	4	32.6	0	0.0
LETCHER	6	23.7	5	19.8	6	24.1	6	23.7
OWSLEY	2	41.2	1	20.6	3	63.0	1	20.6
PERRY	5	17.0	7	23.8	3	10.2	3	10.2
WOLFE	4	56.6	0	0.0	3	43.3	2	28.3
DISTRICT 12	24	19.9	22	18.2	28	23.4	21	17.4
CUMBERLAND VALLEY								
BELL	4	13.3	4	13.3	2	6.6	5	16.6
CLAY	4	16.3	3	12.2	3	12.4	4	16.3
HARLAN	6	18.1	4	12.0	3	9.2	3	9.0
JACKSON	3	22.2	0	0.0	2	14.5	4	29.6
KNOX	2	6.3	6	18.9	5	15.7	4	12.6
LAUREL	12	22.8	5	9.5	8	14.7	12	22.8
ROCKCASTLE	1	6.0	1	6.0	1	6.0	6	36.2
WHITLEY	4	11.2	7	19.5	7	19.1	9	25.1
DISTRICT 13	36	15.1	30	12.6	31	12.9	47	19.7
LAKE CUMBERLAND								
ADAIR	1	5.8	4	23.2	3	17.3	2	11.6
CASEY	1	6.5	2	12.9	2	12.7	3	19.4
CLINTON	1	10.4	1	10.4	2	20.7	1	10.4
CUMBERLAND	2	28.0	1	14.0	1	13.9	2	28.0
GREEN	1	8.7	0	0.0	0	0.0	0	0.0
MCCREARY	5	29.3	1	5.9	6	35.3	2	11.7
PULASKI	6	10.7	8	14.2	3	5.2	15	26.7
RUSSELL	6	36.8	3	18.4	4	24.0	1	6.1
TAYLOR	5	21.8	4	17.4	6	25.8	8	34.9
WAYNE	2	10.0	4	20.1	3	14.9	3	15.1
DISTRICT 14	30	15.5	28	14.5	30	15.3	37	19.1

Suicide Death Data 2000-2003, Kentucky Vital Statistics Data

DISTRICTS AND COUNTIES	2000		2001		2002		2003	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate
BLUEGRASS								
ANDERSON	3	15.7	1	5.2	2	10.2	2	10.5
BOURBON	2	10.3	3	15.5	2	10.2	3	15.5
BOYLE	4	14.4	3	10.8	1	3.6	6	21.7
CLARK	3	9.1	7	21.1	4	11.9	3	9.1
ESTILL	4	26.1	3	19.6	2	13.0	0	0.0
FAYETTE	25	9.6	28	10.7	23	8.7	30	11.5
FRANKLIN	4	8.4	4	8.4	12	24.9	12	25.2
GARRARD	1	6.8	3	20.3	2	12.8	2	13.5
HARRISON	3	16.7	1	5.6	4	22.1	0	0.0
JESSAMINE	3	7.7	4	10.2	4	9.8	0	0.0
LINCOLN	2	8.6	0	0.0	2	8.3	4	17.1
MADISON	9	12.7	7	9.9	5	6.8	3	4.2
MERCER		9.6	0	0.0	3	14.3	5	24.0
NICHOLAS	1	14.7	1	14.7	0	0.0	1	14.7
POWELL	0	0.0	4	30.2	1	7.6	0	0.0
SCOTT	5	15.1	8	24.2	3	8.5	4	12.1
WOODFORD	3	12.9	2	8.6	3	12.8	2	8.6
DISTRICT 15	74	10.8	79	11.5	73	10.4	77	11.2
KENTUCKY	508	12.6	510	12.6	538	13.1	563	13.9

Rates are per 100,000 people. 2000 Census data used in rates. 2003 data is preliminary.

Cabinet for Health and Family Services

Kentucky Health Data and Surveillance and Office for Health Policy

8/4/2005

Table 7

2002 Suicides by Method	10-14	15-19	20-24	25-34	35-44	45-54	55-64	65+	Total
By firearm discharge	2	11	34	50	70	82	51	66	366
By hanging, strangulation, and suffocation	2	6	11	20	16	15	3	4	77
By drugs, medicaments, and biological substances	0	2	1	13	23	11	6	4	60
By and exposure to gases, vapors, and other chemicals	0	0	1	2	4	5	3	0	15
By jumping from high place or before moving object	0	0	0	3	1	0	0	1	5
By drowning and submersion	0	0	1	1	1	1	0	0	4
By sharp object	0	0	2	1	0	0	0	0	3
By crashing of motor vehicle	0	0	0	0	0	2	0	0	2
By smoke, fire, and flames	0	0	1	0	1	0	0	0	2
By other means	0	0	0	2	0	0	0	2	4

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Source: KY death certificate file, resident deaths
 Compiled by Surveillance & Health Data Branch, CHFS/DPH
 9/2/2005

Table 7 A

2003 Suicides by Method	10-14	15-19	20-24	25-34	35-44	45-54	55-64	65+	Total
By firearm discharge	2	11	36	66	82	70	57	77	401
By hanging, strangulation, and suffocation	2	6	17	19	12	12	4	3	75
By drugs, medicaments, and biological substances	0	2	1	10	12	13	7	1	46
By and exposure to gases, vapors, and other chemicals	0	0	0	7	5	1	2	3	18
By sharp object	0	0	0	0	2	2	2	0	6
By jumping from high place or before moving object	0	1	0	0	1	1	0	2	5
By drowning and submersion	0	0	0	2	1	1	1	0	5
By crashing of motor vehicle	0	0	1	0	0	0	1	0	2
By smoke, fire, and flames	0	0	0	1	0	0	1	0	2
By other means	0	0	1	1	1	0	0	0	3

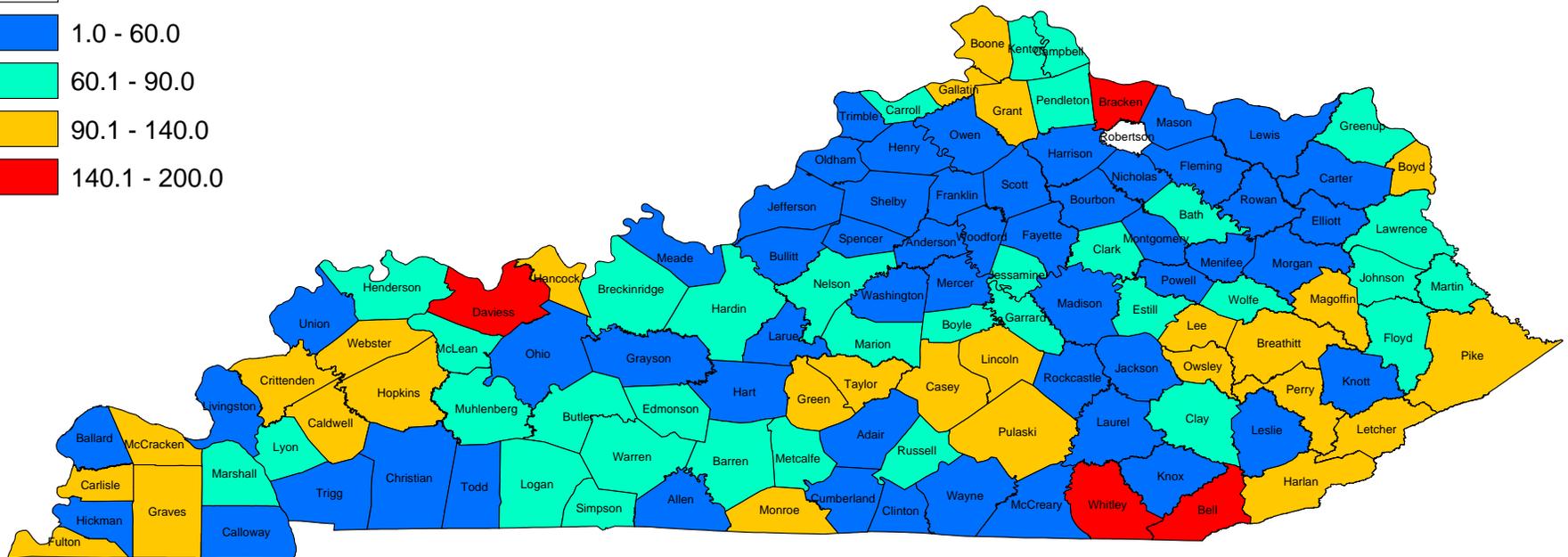
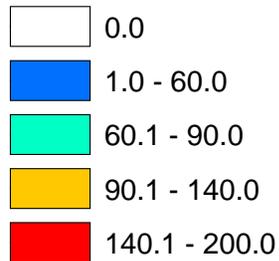
563

Source: KY death certificate file, resident deaths
 Compiled by Surveillance & Health Data Branch, CHFS/DPH
 9/2/2005

Suicide Attempts and Self-Inflicted Injuries by County, Kentucky, 2003 (Kentucky Inpatient Hospitalization Claims Data)

Legend

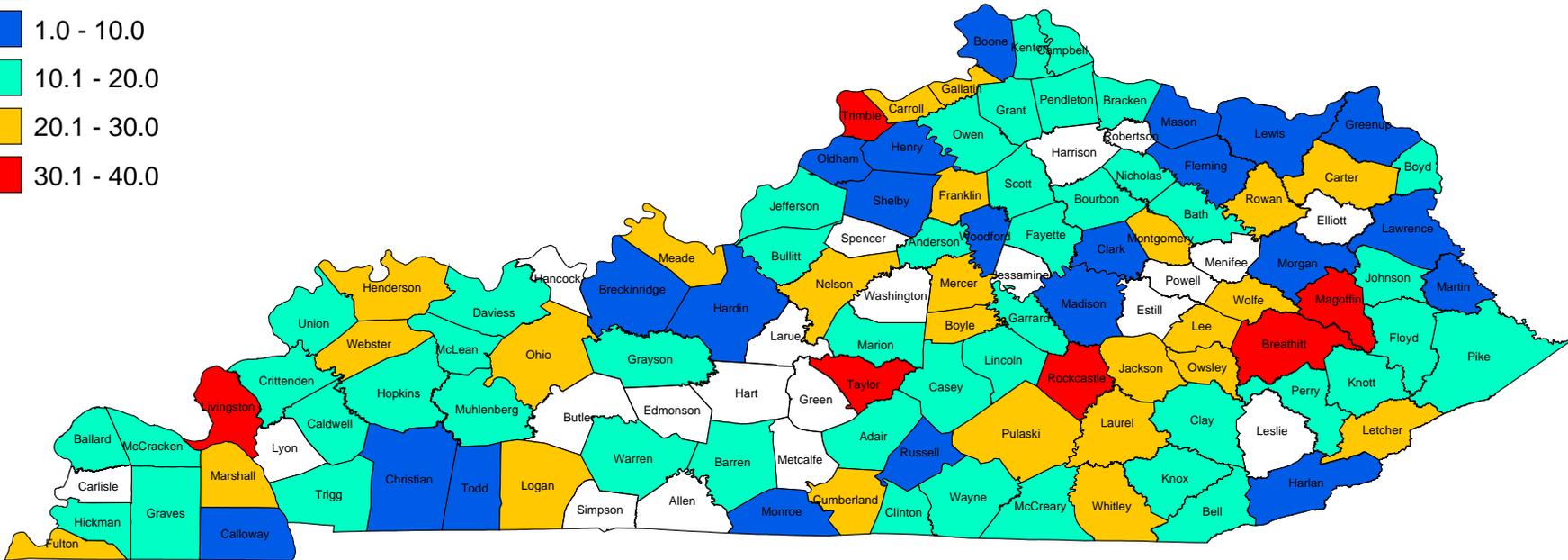
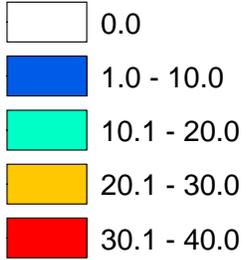
Suicide Attempt and Self-Inflicted Injury Rate per 100,000

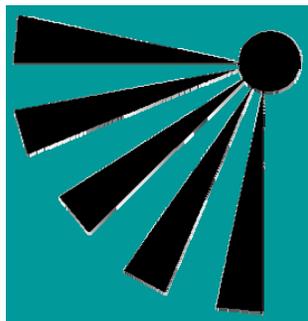


Suicide Deaths by County, Kentucky, 2003 (Kentucky Vital Statistics Data)

Legend

Suicide Death Rate per 100,000





REPORT TO 843 COMMISSION

**KY Jail Mental Health Network
September 29, 2005**

Connie Milligan

Bluegrass Regional MH-MR Board Inc.

KJMHN Program Summary

- 64 jails participating out of 83 – 77%
- Reductions in suicide rates – off the record
- Screening instruments are working
- Protocols provide consistency
- Triage process offers expertise to jail staff
- Follow-up provides in-house MH expertise
- Assessment information immediately available
- Diversion is more possible
- Collaboration possible with pretrial release services, courts, and forensic hospitals

Triage Data Summary

- Total Triages since 9-1-04 = 5,244
- Charges:
 - 64% Misdemeanors
 - 36% Felonies
 - .03% Capitol Offenses
- Charge a risk factor = 11%
- Hospitalization within the last yr. = 30% -
16% in last six months
- Suicide critical or high risk in 32%
- Any suicide risk – 65%

Triage Data Summary

- Substance Abuse risk = 38%
- Withdrawal risk present = 20%
- Mental Health Risk – 77% with symptoms
 - Depression 42%
 - Mania 20%
 - Psychosis 8%
 - Personality DO 40%
- Summary of Mental Health Risk Level
 - Critical = 2%
 - High = 34%
 - Moderate = 47%
 - Low = 17%

Triage Data Summary

➤ Follow Up Referral

- 27% of all Triages have follow up referrals
- 6% meet 202A criteria
- 1% meet competency evaluation criteria

➤ Response Time Compliancy

- Overall response 97%

Funding

- Projected funding of 2.7m is actually netting 2.18m = 520,000 shortfall
- Reimbursement formula based on 2.7m
- Need additional funding