

Region I Planning Council Report

July 1, 2007

I. Descriptive Features of the Regional Planning Council

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

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| Donny Youngblood Probation and Parole | Lori Strader Consumer Advocate | Gordon Williams Kelly Psychiatric Clinic (local provider) |
| Vickie Williams Area Agency on Aging | 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 |
| Renee Buckingham Department for Community Based Services | Sheina Murphy Consumer Advocate | Charlie Ross Purchase District Health Department |
| Roger Thompson Christian Counseling Center (local provider) | Rudelle Orazine, Board Chairperson-Four Rivers Behavioral Health | Jennifer Lewis Purchase NAMI |

The Regional 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 updates in July 2003 and 2005. The Council has primarily functioned as an advisory group during the past two years.

II. Regional Needs Assessment

The region has continued to focus on economic development issues in an effort to attract new business to the area. Other indicators regarding social service needs have remained high with an increase in demand for financial assistance. In particular, the demand for physical health care for individuals with limited resources has continued to grow in this region. The closure of small medical practices in more rural counties, as well as providers limiting or eliminating their acceptance of Medicaid and some insurance payers, has made care less accessible. There has continued to be difficulty finding physical health and dental health care providers willing to serve individuals with severe and persistent mental illness and developmental disabilities.

In the past two years there has also been an identified need for reducing the number of individuals being admitted to Western State Hospital from the four regions that are part of the catchment area. Region I admissions had remained steady over several years; however, there had been no impact on reducing the need for that level of care.

Substance use and the incarceration of non-violent offenders have also been on the rise. A change in law enforcement personnel and the enhancement of interagency drug enforcement has led to more arrests. The availability of jail diversion programs is limited and varies in access depending on the success of individual legal representation and availability of drug court options.

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 development of this project was begun in 2005 and is not yet finalized. There have been many setbacks due to the complicated funding structure and rigorous requirements for each involved entity. All requirements for application have been met several times; however, there continue to be procedural delays. The most difficult issue has been regarding tax credit funding, since there were legal concerns about equal opportunity housing laws when the project is for single gender residents.

The Direct Intervention: Vital Early Responsive Treatment System (DIVERTS) initiative represents a partnership between the Cabinet for Health and Family Services, the Kentucky National Alliance on Mental Illness and the four Regional Boards in Western Kentucky to address the needs of our most vulnerable citizens. In particular, this initiative has targeted the rising rate of adults being hospitalized in Western State Hospital by seeking to enhance the community based service array to include early intervention options to reduce the number of admissions and re-admissions. Over the past several years there have been two primary phenomena that have impacted the growing number of individuals seeking hospital care. The loss of locally available psychiatric inpatient services has increased the reliance on Western State Hospital as

a locus of care, and the growth in demand for more intensive community based services has outpaced the growth of human and financial resources available to community based service providers. The diversion of funding from the State Fiscal Year 2007 budget for Western State Hospital provided an opportunity for the hospital and community providers to build community capacity for the diversionary services that prevent hospitalization. The project has been based on both universal and regionally specific responses to the posed problem. The universal plan has been the establishment of a hospital and individual region-wide network to provide telementalhealth services. This advanced technology links the partners in this project both inter and intra regionally and has been the foundation upon which a “virtual treatment team” is being built. Each region reviewed data regarding the individuals they referred for hospital level of care and developed regionally specific plans to address the areas each thought would impact their admissions. For Region I the values and goals of this project’s first year were as follows:

Values:

- Individuals in crisis successfully treated in community settings tend to seek community options when future episodes occur.
- Some individuals will need hospital level of care; however, that must be the choice of last resort.
- Providing a single gate-keeping entity for hospitalization admissions that is ever-vigilant in this initiative’s mission should provide higher rates of diversion from that level of care.
- During periods of crisis, community professionals (i.e. law enforcement and Qualified Mental Health Professionals) will opt for the most expeditious solution to the situation at hand, necessitating the need to make a non-hospital option be “at hand”.
- Intensive outpatient services during periods of diversion are essential to the success of the diversion.
- Immediate access to psychiatric expertise and scripting in a community setting is crucial to hospital diversion.
- During periods of crisis, access to medications must be immediate.
- Stable community living/housing options can impact the need for hospital level of care and assist with shorter lengths of stay for those for whom community diversion is inappropriate.
- Limiting clinical practitioner duties that interfere with reliable, predictable, dependable, routine outpatient service delivery should ultimately lead to fewer consumer crises and therefore, a reduced need for hospitalization.

Goals:

- Establish a gate-keeping entity to review, illuminate community alternatives, and only when necessary approve Four Rivers Behavioral Health referrals to Western State Hospital.
- Establish the gate-keeping entity’s productivity standard clearly linked to the mission of this initiative.
- Establish an entity to assume the duties that frequently interfere with scheduled, routine, and predictable outpatient clinical services.
- Establish a centralized point for QMHP evaluation to occur that has a community placement option “at hand” so that this becomes the expeditious option.

- Establish an entity that can oversee and, when necessary, conduct intensive outpatient treatment during periods of assertive hospital diversion, especially during out-of-home community placements.
- Establish a telemental health connection between all service sites, the gate-keeping entity, Four Rivers Behavioral Health psychiatric services, and Western State Hospital to facilitate real-time communication, consultation, and when necessary and appropriate, medication management.
- Establish an interagency agreement between Four Rivers Behavioral Health and Western State Hospital to provide non-business hour psychiatric coverage for consultation and scripting via the telemental health system.
- Establish a method for immediate access to medications for consumers placed in the assertive hospital diversion program, when necessary.
- Establish a temporary “bridge fund” for medication purchase when other funding avenues are not immediately available.
- Establish a full-time housing coordinator to coordinate the development of permanent housing opportunities to address this need both pre and post hospitalization.

The first year has just ended and Region I statistics have been exceptional. The demand for all services has grown over the past two years in Region I, including the number of requests for involuntary admissions to a psychiatric hospital. However, by providing flexible funding for aggressive, regionally specific solutions to a problem rather than categorical funding with one size fits all programming, real differences can be made in the lives of individuals. In this project fewer persons lost their legal rights, and fewer persons were in the most restrictive level of care. One hundred per cent of the individuals who were admitted to the hospital needed to be there, as evidenced in the length of stay changing from an average of three to four days to fifteen to twenty days.

The following statistics outline the comparisons.

| Region I Counties | FY07 | | FY06 | |
|-------------------|------------|------------|------------|------------|
| | Petitions | Citations | Petitions | Citations |
| Ballard | 2 | 2 | 0 | 2 |
| Calloway | 24 | 25 | 39 | 11 |
| Carlisle | 1 | 3 | 0 | 4 |
| Fulton | 8 | 6 | 6 | 5 |
| Graves | 46 | 60 | 53 | 34 |
| Hickman | 15 | 2 | 9 | 1 |
| Livingston | 8 | 1 | 1 | 5 |
| Marshall | 27 | 25 | 9 | 4 |
| McCracken | 79 | 64 | 104 | 86 |
| Totals | 210 | 188 | 221 | 152 |

| | | |
|--------------------------------------|--------------|------------|
| Total Involuntary Evaluations | 398 | 373 |
| Certified* | 167 | 253 |
| Rate | 42% | 68% |
| 72 Hour Court Orders to WSH | 144 | |
| WSH Total Admissions** | 170 | 337 |
| WSH Admissions reduced by | 49.6% | |

***Includes involuntary admissions
to Lourdes Behavioral Health
inpatient unit**

****Includes 26 voluntary admissions**

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.

The region has four operating KY-ASAP organizations. The Calloway county initiative has been functional for about five 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.

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”.

III. Regional Response to Recent Events/Influences

The region continues to have 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 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 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 continued to be 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 continues to be 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. There are plans for three more courts to begin in Graves, Calloway and Marshall Counties during SFT 2008. 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. Work with Western Kentucky University will bring a graduate masters program in social work to Paducah this fall. The MSW program will offer non-traditional students financial aid and specialized program hours to accommodate working individuals. Four Rivers Behavioral Health has donated their training facility for the classes.

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 new integrated services through a grant from the Foundation for a Healthy Kentucky. 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 Regional Planning Council
Region II
Report to Legislature
July 2007**

I. Features of the Pennyroyal Regional Planning Council (PRPC):

A. List of PRPC Participants:

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
 Jeff Daugherty - Princeton Clinic Coordinator for the Pennyroyal Center
 Teresa Wurts - IMPACT Service Coordinator for the Princeton Clinic

Buffy Gaddis - Pennyroyal Center.
 Sue Gamblin - Pennyroyal Center Board Member
 Teresa Dixon, Southside Family Resource Center
 Tonya Cotton, Hanson Family Resource Center
 Debrina Duvall, Pride Family Resource Center
 Sarah Wortham, Big Brothers Big Sisters
 Teresia Perdue, Family Advocacy Center
 Scottie Alexander, Hopkins County Sheriff's Department
 David Brown, Madisonville Clinic Coordinator for the Pennyroyal Center
 Ed DeArmond, Mayor for the City of Greenville
 Rick Newman, Muhlenberg County Judge Executive
 Melissa DeCoursey, Office Manager for the Pennyroyal Center
 Candace Hubbard, United Way
 Kim Ford, DCBS
 Lynn Pryor, Commonwealth Attorney
 John Zartman, Volta Program
 Steve Wiggins, Western State Hospital (WSH)
 Barbara Ptaszek, Pennyroyal Hospice
 Delinda Yoakum, South Christian Family Resource Center
 Janice Boyd, Trigg County ASK Youth Services
 Della Edwards, Girl Scouts
 Beverly Thomsom, Adult Education
 Phillis Joiner, Department of Vocational Rehabilitation
 Steve Tribble, Christian County Fiscal Court
 Debra Aquino, Big Brothers Big Sisters
 Brooke Meacham, Christian County Family Court
 Connie Workman, Pennyroyal Center
 Sabrina Grubbs, Pennyroyal Center
 Cindy Starling, Pennyroyal Center
 John Walker, Pennyroyal Center.

B. Activities since last report

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 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 Pennyroyal Regional Planning

Council (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 and at levels necessary to meet client demand.

II. Describe changes in regional needs

A. Significant changes in 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. Changes in community indicators/prevalence rates

The continuing increase in the number of methamphetamine labs being discovered and arrests for methamphetamine production/distribution in the Pennyroyal area has been well documented, publicized and continues to expand. Through the efforts of the Muhlenberg County court system and its three-year commitment to establish and operate a drug court, FY2006 was the first year that it has been awarded funding and formal recognition of its drug court status. Coal severance money has been targeted to funding a very critical and intensely community-supported intervention mechanism. The prevalence of methamphetamine usage in Muhlenberg County combined with the determination of local residents to deal with the problem, has also lead to the award of a SPF SIG Prevention Grant on behalf of the county.

The deployment and return of thousands of soldiers from Ft. Campbell to Iraq and back home has created significant issues not only for the soldiers involved in the war in Iraq, but for the systems back home which are trying to deal with the results of their trauma. The federal government is scrambling for assistance in providing mental health supports for returning soldiers, which is a huge responsibility for an already under funded and under staffed mental health service system in this area. Additionally, those families of soldiers involved in combat in Iraq have demonstrated a greater need for mental health services, and all service providers in our area have been stretched in an attempt to meet the demand for services.

In addition to recovering from the local flooding which came as a byproduct of Hurricane Katrina, as well as the influx of immigrants from more southern states into our area, the Pennyroyal region was also devastated by two major tornadoes, the first which struck in the

Madisonville area in Hopkins County in November, 2005, and the second which struck just north of Hopkinsville in Christian County in April of 2006. Both of these tornadoes were extremely damaging and demanded a quick mobilization of the Center staff as well as ongoing services to people who were affected by these storms. The Center collaborated with a variety of other organizations, including KCCRB to provide needed assistance, both physical and emotional to persons in distress.

C. Changes in dollar resources

Dollar resources have essentially remained flat. A slight increase in community care dollars was awarded in FY2005, but it was not even able to replace the money which was cut from our budget previously through Governor Ernie Fletcher's earlier executive order. Medicaid rates continue to languish at FY2001 levels. One significant increase in funding availability has been the awarding of additional drug court dollars for fiscal year 2007. Additionally, this was the first fiscal year that the contracts from AOC for drug court services have featured a reasonable and realistic mechanism for paying for services. The SPF SIG award, beginning in FY2007, also provides a new funding stream for prevention dollars, but it is specific to Muhlenberg county. For part of FY2007, the Pennyroyal Center was awarded funding to implement the Direct Intervention: Vital Early Responsive Treatment System (DIVERTS) Program. This program is designed to provide for a strengthening of community based services to assist in diverting persons from unnecessary hospitalization at Western State Hospital. This a collaborative effort with three other regional boards in the Western Kentucky area and Western State Hospital. The program was actually initiated by the Pennyroyal Center in late October of 2006.

III. Updated Service System Description

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 three 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, but has been overwhelmed with the need to provide services to soldiers stationed at Ft. Campbell returning from Iraq. 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 the number of community-based psychiatric beds in nearby regions have also shrunk, and providers are struggling to manage the needs in their own communities, let alone serve persons from the Pennyroyal region.

This lack of resources has placed 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, has continued to expand. Our crisis stabilization services are also straining to meet client needs and

effectively deflect them from inpatient hospitalization, particularly through the DIVERTS Program. In its first half year of operation, the DIVERTS Program has been successful in bolstering community resources and even allowing the Pennyroyal Center to station a staff person at Western State Hospital to assist in deflecting admissions. Although admissions for the Center during this past fiscal year have been reduced by only approximately two percent, the DIVERTS program has dramatically reversed the increased trend in hospitalizations which had been going up by 10-15 percent per year. Although a variety of community alternatives are now available to hospitalization, community based psychiatric beds are still virtually non-existent.

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 has been 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. Presently, the Pennyroyal Center has one full-time and three part-time psychiatrists, while our staffing patterns call for four full-time psychiatrists and three full-time ARNP's. We now have two full-time and one part-time ARNP on staff. Waiting times for psychiatric appointments may be as long as two to three months. This is clearly unacceptable to the planning council and the Pennyroyal Center.

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, incarceration, and/or inpatient treatment services. It was determined over four years ago by the Pennyroyal Center Board 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 was rewarded with Governor Fletcher's announcement of his ARecovery Kentucky@ programs of which ten, five for men and five for women, are slated to be opened throughout the state. The Pennyroyal Center has been awarded one of these programs, for women, and anticipates opening the **Trilogy Center for Women** in April, 2008 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 continues to flow so that construction can remain ahead of schedule.

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 for 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 for all disability groups.

IV. Describe Regional Response to these Events or Influences

A. 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. The PRPC clearly and definitely supports the notion that services should be provided as close to the community in which a person resides as possible. Thus, 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. The DIVERTS program, both conceptually and in practice, is strongly supported by the Pennyroyal Regional Planning Council. The Council does believe that a longer-term implementation period must be allowed before any judgement is made on the success of the program.

B. Closure of psychiatric hospital beds

As I have noted previously, there are extremely few available 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, as well as difficulties in recruiting psychiatric staff.

Patients in ER's of Hospitals Without Psychiatric Units

In an unique approach to providing crisis services, the Pennyroyal Center continues to evaluate clients in the hospital emergency rooms of local general hospitals. The Pennyroyal Center responds to legally mandated screenings under the 202A Process and meets every aspect of our responsibility in line with the statute. Unfortunately, issues with local general hospital emergency room staffs often occur when the 202A Process has not been initiated, and Pennyroyal Center staff requests that a referred client be screened for alternate crisis stabilization services in the local community as opposed to hospitalization at Western State Hospital. At that point, the desire of the hospital staff for a quick determination and movement of the client under consideration to another facility often comes into conflict with the need of the Center staff to conduct a thorough evaluation of resources in the community

for potential diversion from hospitalization. Additionally, although the Pennyroyal Center has sought service contracts with local hospitals, the only one of our local hospitals has not negotiated a consultation contract with the Center. The remaining hospitals often demand that the Center staff act as consultants to the hospitals based on their interpretation of our charter by the Commonwealth of Kentucky. Center staff provide all mandated services at area hospitals and are willing to work cooperatively with local hospital staff as has been demonstrated on many occasions. However, the Center really can not afford the staff time or expense of providing consultation service to local hospitals without the establishment of some type of contract similar to the one which has been in place between the Muhlenberg Community Hospital and the Pennyroyal Center for many years. Contractual relationships between mental health centers and community hospitals continues to be discussed and has been addressed through statewide meetings among members of the Kentucky Hospital Association, the Kentucky Association of Regional Programs, the Department of Mental Health and Mental Retardation Services and representatives from the regional mental health boards. Further attention must be paid to this unwieldy and mutually frustrating situation. For our part, the Center continues to offer contractual services to area hospitals and to meet with hospital staff to provide training on the 202A Process or available community resources upon request.

D. Impact 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. Crisis Stabilization Services for Adults and Children

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, adult foster care, or contracted beds purchased from personal care homes, 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, including regular cost of doing business and capacity development increase. Originally, the crisis stabilization units had been rated at costing at approximately \$400,000.00 per year. However, when funding was awarded for these units, both the children's and adult crisis units of the Center were awarded far less than the \$400,000.00, which had been anticipated. For FY2007, this was corrected, and both programs were brought up to the level of funding at \$400,000.00 per year. Unfortunately,

these funds, although adequate for the moment, must be allowed to grow on a regular basis to cover the increasing cost of doing business as well as to ensure that capacity is maintained/maintained/increased according to community needs.

F. Implementation of Medicaid Pharmacy Benefits Administration

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.

G. Workforce Development

The Pennyroyal Center has not benefited from the additional availability of trained clinical workers, and continues to have difficulty in filling open positions for direct client services. State sponsored graduate programs are not universally providing a curriculum which prepares students for clinical work in a comprehensive care center. Salaries offered by the Pennyroyal Center have not kept up with local and statewide markets for competent clinical staff due to funding stagnation. The DMHMRS conducts two major training programs during the year, the Kentucky School for Substance Abuse and the Kentucky Conference, which 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 primarily in Frankfort or Lexington.

H. Integration of Mental Health & Physical Health Services/Mgmt

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 Intellectual and Developmental Disabilities (I/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. Issue of Children Aging Out of Youth Services

Unfortunately, because of the age designation of when childhood ends, services to youth who are either I/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 attends various state-sponsored events called RITT, the Kentucky Regional Interagency Transition Team, that focus on transition issues. Additionally, I/DD Case Managers maintain open communication with school systems and request to be invited to ARC meetings to help focus on transition challenges.

J. Impact of DIVERTS Program

All voluntary admissions to Western State Hospital (WSH) are assessed by DIVERTS staff, including those from other regions, unless the client was referred to the hospital from his/her local community mental health agency. This has decreased the number of clients that “just walk in” without any contact with the Pennyroyal Center or other community mental health center, and has allowed for least restrictive measures to be utilized prior to hospitalization. The Pennyroyal Center is approaching the issue of reducing hospitalization in two ways: 1) provide the necessary services and intervention to prevent hospitalization, and 2) for those who are hospitalized, to provide intense services after discharge to reduce the re-hospitalization rate. Each client has different treatment needs, and the Pennyroyal Center strives to have the program focus on meeting those.

The Center is creative in providing services instead of establishing one service with the hope it benefits every client. This for unlimited possibilities in service provision.

Through March of 2007, the Pennyroyal Center had only reduced hospitalizations at Western State Hospital by approximately five percent from the preceding fiscal year. During the months of April through June, the Pennyroyal Center had an inordinate increase in the volume of new clients and crisis service clients seeking services, often for the first time. The increase in new clients presenting for services, and especially crisis services, was reflected in an increase in the number of hospitalizations at Western State Hospital, basically our only resource for inpatient hospitalization within the Pennyroyal Region. Still, by the end of the fiscal year, with a little over a half year of implementation of DIVERTS, the number of hospitalizations was reduced by approximately two percent from the previous year. It must also be noted that following the trend in increasing hospitalizations we would have projected an approximate ten to twelve percent increase in hospitalizations during the past fiscal year if the DIVERTS Program had not been introduced.

When considering outcome measures, it is imperative that the number of clients served through the crisis program be included. If these clients had not been served in the crisis program, many would have been hospitalized. Since DIVERTS actually began in mid October 2006, staff have completed 177 assessments, which includes 35 completed for clients to step-down into crisis services after hospitalization. When reviewing the crisis services data, crisis case managers have been placed in a community crisis placement utilizing over 1,300 crisis bed days. The crisis case managers have provided over 10,000 case management services to clients this fiscal year. Had these services not been available and provided, one has to wonder what the rate of hospitalization would have been.

CIT Training in the Pennyroyal Region

The Pennyroyal Center had been working with NAMI of Kentucky of provide a training program for law enforcement officers for the past two years. At this time we are pleased to announce that a CIT Training has been scheduled for the week of December 3-7, 2007 and will be hosted in Hopkinsville with clinical training support being provided by the Pennyroyal Center. The Pennyroyal Center works very closely and collaboratively with NAMI and is excited about the potential of bringing the CIT Training to this region. The recognition of training credits by local law enforcement agencies had made this training much more viable in terms in the number of officers who might attend. Strong support has been voiced by many law enforcement agencies within the Pennyroyal region and, we look forward to an excellent, well-attended program.

Establishment of Recovery Centers, Drug Courts and Other Substance Abuse Initiatives

As noted previously, the Pennyroyal Center is developing a recovery center for women, the Trilogy Center for Women. At this point, construction is proceeding at a rapid

clip with the goal of opening the recovery center by April 1, 2008. The program will eventually house up to 100 women who are recovering from substance abuse, and will provide them with a safe living arrangement while working on maintaining their sobriety as well as developing work skills and obtaining employment.

At this time, drug courts have been established in all continues of the Pennyroyal region except for Todd County. It is our understanding that Todd County will be developing a drug court program within the next fiscal year, and that some money will be set aside by the Administrative Office of Courts to provide funding to the Pennyroyal Center in order to staff that drug court. Thankfully, this fiscal year has witnessed an increase in available funding treatment services for drug courts. It is certainly the hope of the Regional Planning Council of the Pennyroyal Center that dollars available to the Pennyroyal Center to provide treatment services for drug courts continue to expand at the same rate that drug courts and drug court utilization expands. This need must be addressed if the drug courts are to have the impact for which they were designed and which they have been demonstrating over the past several years.

The Pennyroyal Center is also working with Hopkins County fiscal court on developing an intensive outpatient program for adolescents. Additionally, the Pennyroyal Center has developed, in cooperation with the Hopkins County jail staff, a jail based program for the inmates entitled "Get A Life". This program is just slightly over a year old, but has already demonstrated a great deal of success.

V. Behavioral Health Goals

A. Top Goals Set by PRPC for 2001-2003 Time Period

1. Establishment of a crisis stabilization program for adults and adequate funding already existing for the children's crisis stabilization program
2. Establishment of supported transitional living/recovery-oriented centers for substance abusing women
3. Increased funding for community-based mental health services by trending and indexing all funds provided to community mental health centers retroactive to FY2001 in order to keep up with the cost of doing business as well as capacity building due to increased demand for services
4. Increase the level of community care dollars available in regions, but particularly these with lower per capita funding, such as Pennyroyal Center, 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 at the Pennyroyal Center and increase funding levels from AOC

B. Changes in Priority Goals Made in Past Two Years

Funding for an adult crisis stabilization program was obtained in FY2004 and the program has been completely implemented. Both the children's and adult crisis stabilization programs received funding increases for FY2007. Therefore, this goal has been changed from a goal of obtaining a crisis stabilization program and seeking adequate funding, to maintaining and developing this program, as incorporated in goal number three.

Additional emphasis has been placed on the goal of increasing community care dollars awarded to the Pennyroyal Center in order to provide adequate service availability.

As previously stated, the Pennyroyal Regional Planning Council is acutely aware of the lack of availability of psychiatric services at the Center. Therefore, recruitment, hiring and maintenance of psychiatric services by the Pennyroyal Center has been elevated to a priority goal. Additionally, the regional planning council believes strongly that the goals of increase funding from the Commonwealth of Kentucky is incredibly important, not only to the continuation and recruitment and hiring of competent psychiatric staff, but also for the recruitment and retention of competent clinical staff at all levels within the Pennyroyal Center. It is absurd to believe that the Center can continue to recruit and retain highly competent clinical staff members without the ability to regularly increase salaries and maintain the benefits which were used as a recruiting tool. Therefore, this goal is highly linked to the goals of increased funding on a regular and continuous basis by the Commonwealth of Kentucky.

C. Progress Toward 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 been awarded a ARecovery Kentucky@ site through the Kentucky Housing Corporation to be located on the grounds of Western State Hospital in Hopkinsville. The Trilogy Center for Women is currently under construction and is due to be completed and ready for occupancy by April 1, 2008. The process of obtaining funding and developing this project has been difficult and tedious at best, and hopefully points to the need for a more streamlined, less convoluted methodology in developing these programs in the future. However, the Pennyroyal Regional Mental Health-Mental Retardation Board, Inc. has preserved to establish this program despite the obstacles encountered for this program. The Board believes that because of the high ranking of this goal of establishing a recovery program for substance abusing women, the effort is worthwhile.

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, so that Kentucky will no longer place 46th nationally in per-capita funding for mental health services.

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. Recommendations Regarding Funding

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 \$25 should be established as a minimum for each of the community mental health centers throughout the state effective with fiscal year 2009. Without these additional dollars, the Pennyroyal Center is less able to recruit and retain qualified staff for current levels of service provision let alone 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. Rates must reflect the realities of cost, and artificial restrictions and regulations which do nothing to impact client care but consume staff time would be limited or eliminated. 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. Federal initiatives to reduce funding for programs such as targeted case management must be quashed.

B. Recommendations for Public Policy Changes

The PRPC is aware of efforts by the Cabinet for Health and Family Services to Amodernize@ 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 a

greater utilization of better supported community-based services as provided through the DIVERTS Program and other programs provided by “comprehensive” care centers.

C. Recommendations Regarding DIVERTS

The PRPC applauds the advent of DIVERTS in hopes that program will be funded on a continuing basis and that attention will be paid to allowing the program to unfold beyond its narrow focus on admission to the state hospital. The PRPC also recommends that some incentives be developed to encourage community based hospitals to designate beds for psychiatric use so that additional alternatives to hospitalization at state hospitals might be offered in areas which are currently bereft of community based psychiatric beds. Due to the foresight of our fore fathers, Kentucky has been blessed with a system of community based mental health services which at one time had been a model for the entire United States of America. The underlying system is still there, it simply needs serious attention in the form of targeted funding, particularly to the community care dollars to allow centers to compete in the market place for competent and well trained staff, maintain quality levels of current programming and expand capacity, and search out new alternatives for providing community based services to persons in need; thus, avoiding unnecessary hospitalization at state or community based hospitals. Although obvious to those of us offering the comprehensive care system, mandates such as the increases in the employer contribution for the Kentucky Retirement System must be funded by the Commonwealth, since there is no other way for these community based centers to increase revenue to pay for such increases.

Certainly, the comprehensive care system in the Commonwealth of Kentucky is a wonderful benefit for the citizens of this state. With proper, timely and continuing attention to the needs of this system, it can continue to be a model for the entire country.

Selected Quotes from Members of PRPC

Greenville Mayor DeArmond stated, “When a husband is on meth, he is intimidating and abusive, and I think that Trilogy Center for Women is a great idea and I really hope that we can house a thousand women if we need to. Treatment is the only thing that is going to solve this drug problem. Putting them in jail is not the answer. We do not need any more jails. We need substance abuse treatment. If you all ever have questions or concerns, please call my office. We really appreciate what you all do and this meeting has really helped me to understand more about what you do.”

Steve Tribble, Christian County Judge Executive stated that, “in addition to the recovery center, the success with the Drug Courts in the community is

widely acknowledged. The program has been really successful in this community and I think that there is a need for more.” Mr. Byars stated that the Center is struggling to keep up with the growth and demand for Drug Courts. Judge Tribble stated that the success for individuals who have completed the program at least here in this community is amazing. Mr. Wiggins stated that it is difficult to keep up with the ability to add resources to provide treatment to those folks. Judge Tribble stated that, “instead of putting money into prisons, we should shut one of them down and then we should put the money into the drug courts and keep people in the community.”

Lynn Pryor from the Commonwealth Attorney’s office stated that she believes that, “the Drug Court Program is the best treatment option that we have at this time.”

Mr. Byars requested information regarding data so far on the success of the DIVERTS program. Mr. Wiggins stated that in the first three quarters of this year, we have reduced admissions to the hospital as compared to last year by 12 percent. It is interesting to note that we were increasing admissions to the hospital from 10 to 15 percent every year since 2000. Therefore, the change in admission levels is even more dramatic.

Mr. Wiggins, stated that he believes that the Center’s 24 hour/day RESPOND Center is exceptional with regard to how it is set up and how responsive that whole unit is in responding to individuals in crisis situations.

Barbara Ptaszek, Chief Financial Officer for the Pennyroyal Hospice stated that she believes that the Employee Assistant Program has been beneficial to Pennyroyal Hospice. Of course, our staff are definitely under extreme anxiety and pressure and all kinds of problems and we certainly benefited from those services. The Pennyroyal Center worked in collaboration with the Pennyroyal Hospice and several other organizations on a Grief Workshop community-wide training, which is something that touches us all. We really appreciate the Center collaborating with us.”

Janice Boyd, Trigg County ASK Youth Services, stated she “appreciates the continued services in the schools. We now have counselors or therapist in each of our schools in each county and that is so helpful to our counselors. Of course, we still have a waiting list in Trigg County.”

Phillis Joiner, Department of Vocational Rehabilitation, shared that across the state, “Vocational Rehabilitation and the mental health centers do not always work as well together. We are so unique here in Hopkinsville. I feel like I really have a good relationship with the Center. If there is a problem, I know whom to go to get it taken care of. We pay for therapy; they do not do that across the state.

They use the sliding scale to determine benefits. I hope that never changes for us. Again, we have an exceptional relationship with the Center.”

Teresa Dixon, Southside Family Resource Center stated that when she calls the clinics for parents, “everyone is very friendly and willing to work with the parent’s schedules and they have always been very cooperative. I have never had a negative experience.”

House Bill 843 Update
Regional Planning Council Report
Region III – River Valley
July 1, 2007

I. Members

Green River Area Development District – Nelda Barnett
Aging Services - Charlotte Whittaker
Green River District Health Department – Angela Woosley
Daviness County Jail – David Osbourne
DCBS – Jim Toler
Department of Juvenile Justice – Karen King Jones
Deaconess Health Systems – Jeannie Kirk
Owensboro Medical – Gary Lee
Brescia College – Nancy Keeton
Parent – Libby Cambron
Emergency Preparedness Coordinator – Rick Cox

The Committee has not met as a whole during this time period. It was decided that unless there was a need to physically meet, it would be more beneficial to develop sub-committees that would begin addressing some of the identified needs of the 843 assessment completed in 2005. The active committees of the past two years have been aging services/and the baby boomers; returning veterans and the need for both mental health and head injury services; emergency preparedness and the role of mental health in this process; and addressing the dwindling psychiatric resources in the area.

II . **Changes in Regional Needs**

Growth in the community continues to be stagnant, with the exception of an increase in the Hispanic population. The use of methamphetamines in the Green River district continues to lead the state. The number of psychiatrists in the area is at a critical level, and recruiting continues to be unsuccessful. The loss of the federal designation of being an underserved area three years ago has had a huge impact on the inability to recruit psychiatric professionals.

It is becoming increasingly apparent that a high demand for services is imminent, both from the aging population as the baby boomers turn 60, and as veterans return from Iraq, the demand for mental health services, and brain injury services will be astronomical as it is estimated that approximately 60% of returning veterans have sustained a head injury in this war. Data from the 24 hour helpline also shows an increase in gambling problems/addictions.

Unfortunately new funding has not been forthcoming to address the above mentioned needs. The only additional funding to date has been the money allocated for the Diverts program which allowed the region to purchase telehealth equipment to attempt to relieve some of the stress on the system for psychiatric consultations/appointments.

III Update on Service System Description

Gaps in Services:

The safety net remains virtually unchanged. With no additional funding, no additional resources have been added to address the methamphetamine problem.

Our clients continue to experience issues with public and medical transportation systems, such as the length of times the public transportation runs, lack of public transportation in rural counties, and availability of medical transportation.

Gaps continue with individuals diagnosed with a mental illness or dual diagnosis for people 18 to 23. This comes as a result of individuals who choose to no longer be eligible for children's services when they reach 18 years of age, and they do not appear or present themselves to the CMHC until ages 21 to 25 when they are in crisis or have been hospitalized. Many individuals with Mental Illness or Dual Diagnosis are residing in personal care homes in our area.

Services for Specific Populations

The Region determined that since the safety net could not accommodate any additional changes/services, perhaps the emphasis should be on dealing with the specialized populations, and that in turn it might remove some stress from the safety net services.

New programs were developed to deal with adolescents who are in the Juvenile Justice system. Two inpatient programs are currently operational for adolescents who are in the custody of DJJ and also have a behavioral health diagnosis. One deals specifically with sex offender treatment while the other focuses on children who are public offenders.

Two therapists have been certified in the treatment of problem gambling, and outpatient services are now available.

Case management services are available for individuals who have sustained a brain injury in order to insure a smooth transition back into the community.

Housing for adults with mental illness is being monitored for length of stay after receiving assistance with housing options. Successful housing placements are being monitored by the case managers for 90 to 180 days.

We are providing Intensive in Home Services for Families and Children using the Systematic Training for Effective Parenting (STEP) curriculum.

Collaboration, Cooperation and Communication

Collaboration is occurring with the Veterans Administration Behavioral Health Outpatient Clinic regarding Case Management Services, Therapeutic Rehabilitation Services, and Peer Support Groups.

A region-wide committee of aging services providers are regularly meeting to address the changing needs of this population as the baby boomers begin entering this system, acknowledging the need for mental health services, and it's role in the entire delivery system.

Evidenced based Practices

Typically, classification of mental illness has been diagnosis-based using various iterations of the DSM. Although very useful to the trained professional, the DSM-IV-TR is a tough read for the typical consumer and even for most direct service providers.

The clinical treatment of our target population is more often symptom driven, with the "episode severity" of these symptoms determining both the type of services and the intensity level within the services needed. We believed a classification system based more on similar symptoms and presenting problems/characteristics would better address our needs.

Utilizing various workgroups of trained professionals within the organization, we tasked ourselves to identify a set of clusters which would encompass all those individuals diagnosed with a mental illness. The initial work has resulted in 17 clusters such as mood/affect disturbance, anxiety/trauma issues, neglect/attachment issues, etc.

From these clusters, a set of goals and objectives specific to each group were derived. A set of therapeutic approaches was also described within each group. Each of these approaches then has specific goals and objectives associated with it, giving the typical consumer and caregiver an abundance of options to choose from when deciding on a treatment approach. Also within each cluster it is further broken down by age specific groupings (when appropriate). In addition, these modalities and approaches were further classified using a numbering system which allows us to easily identify what specific treatments each individual is receiving. From these various therapeutic approaches, a treatment plan can easily be created, adding in any associated educational or medical approaches utilized.

IV. Describe Regional Response to these events or influences

The closure and downsizing of hospital psychiatric beds have caused an increase in admission to WSH, as was identified in the 2005 report. Currently the region has a total of 8 inpatient psychiatric beds for adults.

The problem was exacerbated over the past two years when the number of psychiatrists in the RiverValley region dropped to two. The need for medication refills, and the long wait to see a physician, added an additional burden to the regions emergency rooms. Staff from both the hospital and the mental health center met regularly to attempt to address these problems cooperatively. RiverValley also began working with the University of Louisville to develop a partnership whereby the physicians at the University could provide services to the consumers at RiverValley. The University currently provides one day per week of outpatient services to RiverValley via telehealth, and sends a psychiatrist one day per month on site.

This region was fortunate to participate in the Diverts program this past year which made it possible to purchase and install the telehealth network throughout the region and is currently being used by both our psychiatrists and the psychiatrists at the University of Louisville.

In addition to the telehealth system, it was determined that in order to divert placements to Western State, the current CSU would need to be more secure. Renovations are being made in a portion of our regional office to move the CSU. This will allow access to all of our clinical staff including our physicians for at least 10 hours per day. Additional security measures have been incorporated into the design which will allow us to admit individuals with more challenging issues then what we can currently accommodate. In addition to these renovations, an Intensive Outpatient Program was added, not only for those individuals in the CSU, but other individuals who did not need 24 hour residential services, but did need a more intensive treatment program then the typical outpatient appointment.

We also found that much of the recidivism to WSH occurred with individuals within the criminal justice system. Often information about release from jail was not consistent and individuals were without medication as a result of their failing to call for an appointment. RVBH established a Case Management position which works exclusively with the criminal justice system and Western State hospital, in order to help the inmates when released to resources in the community.

One of the major issues which continue to impact admissions to Western is individuals residing in nursing homes. RiverValley routinely provided both psychiatric and therapy services to individuals living in these facilities throughout the region. When psychiatric coverage dropped, RVBH was unable to provide a

psychiatrist in these homes. Many nursing homes contracted with other community physicians, but also stopped our therapists from coming to see the individuals within the homes. Unfortunately the major impact of this decision was that no one was on-site to intervene when a situation began to escalate, thus resulting in a tremendous increase in admissions to Western.

Children's CSU services are provided through Therapeutic Foster Care. An RN has been hired to assist the foster families in regard to medication management, and physical health issues. As part of the Crisis Services, Intensive In-home services utilizing the Systematic Training for Effective Parenting (STEP) is offered to families whose children will be returning home.

There appears to be adequate access to medications for adults at this time. Initially there were problems with families accessing certain prescribed medications for their children due to a significant delay in the prior approval process. However, there have been no recent complaints received about this process.

Drug courts are available within all seven counties in the Green River Region. The Boulware Homeless shelter has started a new substance recovery program; Substance abuse services are also available at OASIS, the domestic violence program. River Valley continues to operate its intensive outpatient program, however with no new funding the need and the waiting list continues to grow.

A Recovery Center for women is expected to open in the Henderson area within the next few weeks. Owensboro is working to develop a Recovery Center for men.

Suicide Prevention training is provided annually upon request to all Detention Centers within the seven county area. To date, Daviess, Henderson, Webster, and Hancock county Detention Centers have taken advantage of the training. Additionally, CIT training will be scheduled this year.

Therapeutic Rehab Programs are utilizing not only the 'Club House' model, but recovery oriented programs as well such as medication training, goal setting and informal "warm lines". The Kentucky Youth First grant is providing training to the Community Mental Health Centers on assessment and treatment of adolescents with substance abuse problems. Training was provided to staff and clinicians at RiverValley Hospital.

Many young adults between the ages of 18 and 25 are now residing in Personal Care homes in the area. Staff from the Therapeutic Rehabilitation Programs, in addition to therapist providing services to some of the Personal Care Homes are making individuals aware of supports and services available through the CMHC. Outreach also includes introduction of Vocational Rehabilitation, Supported Employment, Case Management, and Therapeutic Rehabilitation Services.

V. Behavioral Health Goals

The goals identified for 2001-2003 were as follows:

1. Improved Coordination of Services – as has been discussed through out this report, community partners have come together to address a number of issues. In fact, the 843 Committee has become community coordination sub-committees.
2. Improved Recruitment and Retention - this continues to be a challenge. Two major problems are the cost of health insurance which is becoming prohibitive to fund, and because of the cost is not a good recruiting benefit; and the loss of the federal designation of being an underserved area.
3. Improved housing – in a community of this size housing will always be a priority to be addressed.
4. Development of Step-down facilities between Hospital, Jails and the Community – fortunately with the funding of the Diverts program, resources were expended to add the Case Manager for the hospital/jail system, and to add not only a more secure CSU, but an Intensive Outpatient program
5. Development of a Crisis Stabilization program for Children – completed
6. Geriatric Day Health Program – this issue has now taken on greater scope in the regions efforts of addressing the service delivery system for aging baby boomers
7. Increased Consumer Awareness – Consumers from the Therapeutic Rehabilitation Program attended the Consumer Conference in Louisville in the spring of 07. WRAP training has been completed at the Owensboro TRP. Staff from the TRP has been trained in the Recovery Model by IASPRS utilizing the SAMSA model for recovery, and six individuals with severe and persistent mental illness attended the Kentucky Peer Support Training in June.

Goals developed in 2005:

1. Increased Substance Abuse Treatment – unfortunately with no additional funding this goal has not been accomplished and the need for services continues to grow.
2. Gambling Addictions treatment – two therapists within RiverValley are now certified in the treatment of problem gambling.
3. Increased supported employment opportunities for individuals who have sustained a brain injury – the need for brain injury services has expanded with the return of Iraqi veterans. The region is now focusing on a more comprehensive array of services including case management, peer support, outpatient treatment, as well as supported employment.

Additional Priority Goals:

1. Increased services for juveniles in the Juvenile Justice System

VI. Recommendations

As can be seen through out this report, the major obstacle to increased service provision is the lack of additional funds. An individualized approach to service delivery is optimum, with emphasis on individuals having access to all forms of health care. Key to the success of a system which supports an individualized system of care is the advanced use of technology. With the limited amount of excess revenue to fund on-going projects, perhaps consideration should be given to the improvement of technological resources within each region, such as funding for electronic health records, etc.

Continued emphasis should be devoted to the recruitment and retention of professionals to the state, with particular attention being paid to the rural areas.

Creation of Centers of Excellence focusing on particular treatment areas serving multiple regions.

REGION IV - LIFESKILLS
HB 843 REGIONAL PLANNING COUNCIL REPORT
JULY 2007

FEATURES OF THE REGIONAL PLANNING COUNCIL

The Regional Planning Council is comprised of two or more representatives from each of the categories designated. Some members are new to the council. LifeSkills formed a consumer representation committee comprised of both consumers and family members representing mental health and substance abuse, adult and children's services. This committee has been asked to join the RPC. Please see the attached (Table A) for membership by designation. Since the last report the Regional Planning Council met to review FY'2007 Annual Plan and Budget and provide input in the Spring of 2006.

CHANGES IN REGION'S NEEDS

There have been no significant changes in Region IV demographics since the initial report. The number of seriously mentally ill served by LifeSkills increased approximately 18% from FY 2000 to FY 2006. The number of severely emotionally disturbed children increased approximately 24%. The number of clients receiving a mental health service increased approximately 10% from FY 2000 to FY 2006. Clients receiving substance abuse services decreased approximately 33%. There have been few if any changes in prevalence rates and no significant events.

LifeSkills is stretched to fulfill the demands of quality care to our existing clients. Additional funding has typically come with additional treatment and need for more providers. State funding to the region increased from FY 2005 to FY 2007 with the addition of funds for specific projects in mental health and substance abuse such as DIVERTS and Monroe Co. Inhalant Project. Some additional funds were also distributed in Community Care dollars and for the Adult and Child Crisis Stabilization Units. Substance Abuse funding has been cut since FY 2005 including unrestricted, DUI and Prevention. Other resources in the community have remained essentially the same.

SERVICE SYSTEM DESCRIPTION

Below is a description of measures that have been taken to address gaps identified in the original Regional Planning Council report.

Safety Net

There have been no significant changes since the 2005 report. LifeSkills remains the primary resource for persons with limited payor sources. For-profit providers continue to provide care where financial resources are available, including school and home-based services, through IMPACT Plus

and DUI services. LifeSkills continues to endure the burden of balancing increasing needs and decreased funding.

Services for specific populations:

Children and youth: LifeSkills therapeutic Foster Care Program has continued to expand and now has dedicated therapists and service coordinators. LifeSkills Therapeutic Foster Care program served 28 children in FY 2004 and has served 52 children so far in FY 2007. Community based services continue to thrive.

Metcalf County Schools chose to utilize alternative learning centers instead of the Day Treatment program resulting in its closing in May 2006. Monroe County Schools assumed management of the Day Treatment program in May of 2005. LifeSkills continues to provide school based services for both county school systems. Butler County Schools requested LifeSkills provide children's day services in their alternative learning program and this began during the 2005-2006 school year.

Revolving door cases: With the addition of DIVERTS funding, the region has seen a 17% reduction in overall admissions to the state hospital (748 vs. 620). A 15% decrease in 30 day readmissions to the hospital was also realized (82 vs. 70). For those individuals receiving intensive case management via the DIVERTS program, cumulative bed days at the state hospital fell from roughly 933 in the six months prior to implementation to 148 as of the date of this report. This represents an approximate 84% reduction in hospital stays for those individuals receiving intense follow-up.

Elderly: The mental health and aging coalition continues to host the annual training for providers and caregivers. In addition, a senior health fair was conducted in May of 2007 with emphasis on diet, nutrition, exercise and mental health. The local advisory council on elder abuse is working on proposing changes to the guardianship process in order to decrease the potential for abuse and neglect associated with guardianship.

Hearing Impaired: LifeSkills continues to treat a small population of hearing impaired individuals through substance abuse and mental health services. We do not employ any treatment providers who can sign so we continue to contract with approved interpreters and utilize video relay and TTY as needed.

Homeless: Additional Supported Housing funds have increased the numbers served through this program. Safe Havens-Safe Place funds have allowed us to serve 30 individuals. Additional funds recently awarded, including the Samaritan Project and Emergency Shelter Grant, will allow us to serve even more individuals. LifeSkills Crisis Stabilization Unit is designated as a homeless shelter allowing homeless persons to move to the top of the waiting list at the Housing Authority. Also, LifeSkills was recently awarded an Emergency Shelter Grant to serve approximately 20

homeless clients with housing, medical and transportation. A number of individual served through DIVERTS case management have identified housing needs.

Dually-Diagnosed: LifeSkills has continued to focus on integrated services for those with co-occurring disorders as much as payer systems will allow. Training, discussion and implementation is on-going. Staff consult when able and refer when needed. Warren County (LifeSkills' largest county) has consolidated outpatient mental health and substance abuse services in one location. This had already occurred in other counties in the region. Plans to consolidate more services in Warren County under one roof in the near future will continue to enhance treatment for co-occurring disorders including substance abuse, mental health and developmental services.

Coordination & Collaboration:

Coordination and collaboration across systems and among agencies remains an issue with barriers such as schedules, confidentiality, etc. LifeSkills is involved in a number of collaborative inter-agency groups, including Agency on Substance Abuse Policy, Targeted Assessment Program, Take A Stand for Kids, Monroe County Alliance for Inhalant Prevention, Regional Interagency Council, Growing Up Safe, Allen County-Scottsville Faith Coalition, VISION, Child Fatality Team, Anti-drug Coalitions, Champions, Barren River Area Suicide Prevention Council, Mental Health and Aging Coalition, Community Emergency Response Team, People Advocating for Recovery, Regional Interagency Transition Team, VISION, etc.

Evidence-based practices and focus on Recovery:

Lifeskills continues to increase the use of evidence-based practice as well as promising practices. Motivational Interviewing is a focus for substance abuse clinicians. Lifeskills holds a monthly motivational interviewing coaching group which is known to increase fidelity. Additionally Lifeskills is continuing to seek certification for the use of the 7-challenges along with the ability to have an in-house trainer for the 7-challenges. Lifeskills has planned a CYT training for staff this summer to improve the clinician competency of a short term evidence based curriculum.

DIVERTS has allowed us to provide outreach services to non-engaged consumers discharged from WSH. We have formed a committee to study Illness Management and Recovery but have put that on hold until SAMHSA makes the materials available again. LifeSkills has also formed a subcommittee through the Quality Improvement group to study issues affecting access.

Recovery remains a focus for substance abuse treatment. Whether a client enters treatment at the out-patient level or residential level, the focus is on improving the client's life and helping the clients define recovery for themselves. Staff members continue to emphasize long-term treatment and supports, which means encouraging a client to stay in treatment for the length of time required to develop stability. Also, clients are strongly encouraged to develop community support, such as involvement in the 12-step community, in order to establish a lifestyle that

supports recovery. When clients develop support systems for themselves they are assisted in maintaining long-term recovery.

The payors continue to follow a “medical model” which limits the ability for community mental health to practice more consumer driven, individualized care for its clients. Systems that continue to focus on symptoms, diagnoses and deficits make it difficult to focus on strengths, supports and individualized care.

REGIONAL RESPONSES TO THESE EVENTS OR INFLUENCES

- A. **Closure of psychiatric hospital beds in region-** There has been no change in the number of psychiatric beds since the last report. The Medical Center beds are frequently full and are for voluntary patients only. All involuntary patients are evaluated through the 202A process and sent to WSH if diversion is not possible.
- B. **Patients in ERs of hospitals without psychiatric units** – Most ER’s work well within the 202A guidelines and communicate well with the Adult Crisis Stabilization Unit for referrals to DIVERT when possible. There are some isolated issues with hospitals trying to subvert the 202A process.
- C. **Development of CSU services for both children and adults** – Both units have been in operation over 7 years. The DIVERTS program has increased the census as well as the level of acuity at the adult unit.
- D. **Impact of DIVERTS in Region IV** – DIVERTS has resulted in an 18% reduction of referrals to WSH and a 17% reduction in readmissions from Region IV. These reductions are accounted for due to an increased staffing pattern at the ACSU allowing for more acute cases to be treated there. In addition we have seen the number of evaluations drop 6%, we believe due to increased education to the law enforcement and other community resources regarding proper conditions and procedures for individuals in need of evaluation and to an increase in community awareness of the availability of Crisis Services in the community and how to access these services.
- E. **Preparation for CIT training in Region IV** – LifeSkills Crisis staff have been communicating with Bowling Green Police Department liaison Officer Jonathan Blick. LifeSkills will be ready to work with law enforcement on CIT training in the near future.
- F. **Medicaid: Consumers’ access to medications, Impact of KY HealthChoices** – Overall, consumers get most of what they need. There continue to be problems with the prior authorization process. Providers have to write the brand name with the generic in parentheses because those processing do not know the generic equivalents. Non-standard dosing (two different strengths) for stimulants presents challenges for the prior authorization process. It is nearly impossible to get a non-benzo sleep aide, specifically Rozerem, when an individual should not take benzodiazepines. This is inconsistent with efforts to control the

prescription of controlled substances and creates a detrimental “double standard”. Equal access to antipsychotics has helped significantly.

G. Establishment of Recover Centers, Drug Courts and other substance abuse initiatives - Collaborating and referring agencies are expressing a positive response to the establishment of drug courts in our region. The communities (courts, social services, churches, etc.) see the need for increased interventions and resources to individuals who find themselves addicted to alcohol or other drugs. Likewise there has been a positive response toward other substance abuse initiatives such as KIDS NOW and SPF SIG in various communities. With most social service systems over taxed, additional resources, especially those that are organized and are long term, are welcomed. The recovery centers in our COC area will be 1 – 2 hours away from our region. Many people in the community just want the “drug problem” taken care of and very much like the idea of sending an individual to a 6 – 18 month program. Although these programs are not a match for everyone, many in the community are positive about Recovery Centers being established.

H. Workforce recruitment, retention, training opportunities - LifeSkills has worked with Western Kentucky University to develop a substance abuse track that allows individuals to obtain required coursework for certification as a drug and alcohol counselor. Upon completion supervision is the only other requirement for certification. Lindsey Wilson is also providing this tract now. Lindsey Wilson’s Allen County-Scottsville Campus has a BA in Human Services and is scheduled to start a Master’s in counseling in January of 2008. LifeSkills has a program to assist some staff in attaining required courses for certification/licensure eligibility and may expand that to more employees in the future. A loan-forgiveness program would be welcome.

LifeSkills has expanded its internship program allowing us to utilize more students and give them exposure to and experience in the community mental health system which has enhanced recruiting. Allowing current employees internship opportunities has also helped retain employees. However, the licensing boards for Social Work, Professional Counseling and Marriage and Family do not allow for temporary licensing which present barriers to hiring. CMHCs are forced to hire these individuals, set up supervision, and wait up to a month before the board will approve them to begin practicing.

University officials have noted a decline in the number of individuals entering the human services field and LifeSkills has seen a decline in qualified applicants for professional positions. A broader approach may be needed to increase public awareness to mental health issues and make the field more enticing. Many individuals are opting for careers with more promising incomes. Additional funding will be needed to recruit and retain employees in the future.

- I. **Integration of mental health and physical health services and management** – LifeSkills formed a task group to address collaboration of physical and mental health. Their first objective was to increase awareness and enhance communication with local physicians. The initial target was pediatricians and family practice physicians. Educational information about LifeSkills services and referral forms were given to a number of physicians in the region. The group is also planning to provide some training with CEU's in the future to bring all parties to the same table.
- J. **Addressing issues of children “aging out” of youth services** – Therapeutic Foster Care program provides independent living skills class for kids age 16 and older. Children in the IMPACT program close to aging out have transition goals on their service plans based on individual needs.

BEHAVIORAL HEALTH GOALS

Coordination and System Integration –

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

- LifeSkills formed an access committee charged to “design or re-design processes that allow for maximum efficiency in use of clinical time available and to ensure that access to services is most available to those in greatest clinical need”. Short and long-term recommendations were made and some have been piloted and adopted.
- LifeSkills has a number of Memorandums of Agreement with and collaborates with entities such as primary care facilities/health departments, jails, schools, Department for Community Based Services (DCBS), hospitals, BRASS, Vocational Rehabilitation. This year LifeSkills identified two clinicians to take all TAP cases. This has eliminated many communication problems and between the two programs when so many different clinicians were involved. Additional efforts need to be made to identify specific contact persons to minimize miscommunication.

Service Gaps –

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

- Transportation issues remain a barrier to treatment. The DIVERTS grant has afforded Region IV the opportunity to purchase teleconferencing equipment allowing for at least emergency physician consultation to individuals at the adult crisis stabilization unit. We have also used some of the DIVERTS funding to provide transportation to the adult crisis unit.

- Access is still an issue with which we are struggling. New money is attached to “new” services such as DIVERTS, Jail Triage, KIDS Now, Early Childhood, Drug Courts, START, etc. The need for core services continues to grow slightly and the provider field appear to be shrinking. These challenges have had a negative impact on access. DIVERTS alone has increased the need for community based services that are more creative and individualized than ever before. The act of “DIVERTing” increases risk and liability. Improving access for those at highest risk delays access for others which in turn may lead to crisis. LifeSkills will need to make some difficult decisions in the near future regarding who we can serve and with what services.
- LifeSkills is assuring aftercare appointments within 14 days to person discharged from residential or inpatient programs. Our rate of compliance for aftercare from Western State Hospital (WSH) is 97% or 4 days. DIVERTS case management is specifically targeting individuals discharged from WSH. There has been weekly substance abuse aftercare available at LifeSkills for persons discharged from residential substance abuse programs.
- Outpatient substance abuse treatment is available for varying lengths of time. Individualized treatment plans are developed for each client with outpatient treatment lasting between 90 days and 12 months. Multiple Driving Under the Influence (DUI) offender treatment programs are available for up to 12 months. Residential treatment programs extending up to 6 months are limited, there being no such programs in this region. The penal system has programs such as the Substance Abuse Programs (SAP), which are intensive programs for inmates close to parole. Many State and Federal prisoners are being housed in county jails, which does not allow them access to SAP programs.

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.

- LifeSkills continues to provide jail training to those jails that request these services. FY’06- December of FY’07 160 jail staff had been trained. We have training agreements with all 8 jails in Region IV. The Jail Triage program began in 2005 and has been utilized by some jails more than others. LifeSkills has developed a comprehensive back-up system for responding to both day and evening jail triage requests. We are able to have an evaluator on site within the required time when it is suspected that an incarcerated individual may be suffering from a mental illness.
- 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.

Repeated Psychiatric Hospitalizations –

Goal: Reduce repeat hospitalizations by 30%

- DIVERTS has been an additional source of funding to target repeat hospitalizations. LifeSkills has used DIVERTS funds to hire 2 case managers targeting revolving door cases, high risk cases and those who have had little or no contact with community mental health. Funds have been used to purchase medications, transportation, and to secure stable housing and meet basic needs. Teleconferencing equipment has improved efficiency by allowing medical staff in other locations to consult and assess clients at the CSU to prevent hospitalization when possible and medical staff is on call weekends and holidays. LifeSkills is the gatekeeper for all WSH admission from Region IV. We have contracted with Pennyroyal to provide gatekeeping functions if individuals arrive voluntarily at WSH without a referral from LifeSkills. See Revolving Door Cases above for impact of DIVERTS on reducing repeat hospitalization.
- The Community Medication Support Program served approximately 300 consumers FY2007 to date and an additional 200 have accessed medications through pharmaceutical patient indigent programs. Approximately \$900,000 worth of samples are distributed throughout the year.

Funding and Policy

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

- With financial resources decreasing, adequacy has not improved, integration has not occurred at the funding level, and balancing has not occurred.
- LifeSkills proposed system of care submitted to the Department for Medicaid Services in April of 2006 focused on person-centered treatment planning which would allow LifeSkills to provide treatment and supports in a cost-efficient manner while also allowing for the ability to seamlessly step up or down intensity based on consumer need. The proposal included changes to service definitions including the definition of a unit of targeted case management (1 contact per unit instead of 4 contacts per unit). “Care Coordination” would be used to perform needs assessments, care planning, referral and linkage and monitoring to individuals who decline or do not qualify for targeted case management and decline individual therapy. Contacts could be face-to-face or via telephone. Therapeutic Rehabilitation would move away from site-based day programs to rehabilitation and recovery activities through community-based interventions that allow for the

development, acquisition, enhancement and maintenance of social, personal adjustment and daily living skills in the most appropriate setting (e.g. consumer's home). Provisions were proposed specific to children's services to include Therapeutic Child Support, Psycho-educational services and Therapeutic Foster Care. Co-occurring disorder (MH/SA) services allowing for a dual focus in therapy would promote seamless care.

| TABLE A | |
|---|--|
| Family Members: Marty Harrison (Adult) Liz Whittaker (Adult) Jim Williams (Child) | Consumers: Danny Carroll Gloria Bluett Josh Whittaker |
| Gov't Officials & Business Leaders: William Traugott – Fred Keith – | Health Department & Primary Care Tammy Drake Dr. Jennifer Gray |
| Advocates & Community Organizations: Kaye Hope Lee Alcott | Educators-School Personnel: Geovonda Stevenson Retta Poe |
| Regional Interagency Councils: Tara Wilson John Sivley – | Law Enforcement-Court Personnel: Officer Jonathan Blick 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) |

Region 5 - Communicare HB 843 Regional Planning Council Update

Fiscal Year 2007 has been a time of great transition for Communicare and for our Region's HB 843 Planning Council. In May of 2006, our CEO made the sudden decision to retire, which necessitated the appointment of an interim CEO. The interim CEO faced the immediate task of re-organizing personnel and services in order to continue quality programs for our consumers. Coming on the heels of this change in leadership at the agency, the chair of the Regional Planning Council resigned her position, leaving the Council without established leadership.

Communicare's permanent CEO was not named until December of 2006, at which point the agency was finally able to sit down and re-examine the status of the HB 843 Regional Planning Council. The upheaval within both the agency and the Council resulted in a stagnant period for the Council, during which many of the existing members retired, moved out of the area, or became otherwise unavailable. We have been looking to find someone to fill that crucial leadership role on the Council, but have not been able to identify and appropriate candidate at this point. Faced with a depleted membership, who had not really had an issue to focus on, Communicare has made the commitment to re-energize the group.

Currently, we are in the process of contacting the existing members to determine whether they still want to serve on the Regional Planning Council. The possibility of funding from *DIVERTS*, coupled with the state's commitment to examine the impact of flat-funding on the Community Mental Health Centers, have given us issues to focus on. We plan on inviting these members to attend our legislative reception in August in the hopes of them becoming advocates for the mental health centers and for our consumers. We hope that the chance to meet with their legislators and the presentation from LRC staff will give them the information they need to feel comfortable serving as advocates for mental health issues.

During the course of examining the membership list, we did discover that a portion of our group is no longer in the area. This has tasked us with the responsibility of finding interested parties to fill those empty slots. With the assistance of organizations such as NAMI Kentucky, we are working to identify potential members and have already contacted them with information related to HB 843. The information that we give them will prove to be valuable should they accept our invitation to join the Regional Planning Council. It will allow them to come in with some prior experience, rather than being thrust into something which they have no knowledge of.

It is our hope that a renewed commitment on the part of the agency will serve to enhance the work of the Regional Planning Council. Our experience has been that the two entities must be closely entwined in order for the Council's efforts to succeed and we look forward to the upcoming challenges.

HB 843 Commission Report
July 2007
By
Region 6 (Seven Counties Services, Inc.)
Regional Planning Council

Our Mission:

The mission of the HB 843 Region 6 Planning Council is to promote greater access to comprehensive mental health and addiction services which are recovery-oriented, consumer-driven, seamless, coordinated, inclusive and sufficiently funded. We will do this by building strong collaboration to advocate together for those we serve and those who serve.

Our Vision:

The vision of the HB 843 Region 6 Planning Council is that all persons affected by mental illness and/or addictions have access to comprehensive, consumer-driven, recovery-oriented services enabling them to live, work, learn and participate fully as valued members of their communities.

I. Features of Your Regional Planning Council (RPC)

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

- *Robert Elliott, Council Chair, Board Member, Seven Counties Services, *Public and Private Service Providers*
- *JoAnne Maamry, Council Vice-Chair, CEO, Our Lady of Peace, *Public and Private Service Providers*
- Kim Allen, Director, Louisville Metro Public Protection, *Law Enforcement and Court Personnel*
- *Bernie Block, Past Chair, *Advocate and Community Organizations*
- *Dennis Boyd, U of L Department of Psychiatry, *Public and Private Service Providers*
- *Howard Bracco, President and CEO, Seven Counties Services, Inc.
- *Claudia Brewer, Oldham County Family Court Administrator, *Law Enforcement and Court Personnel*
- *Molly Clause, Executive Director, REACH, *Consumers of Mental Health and Substance Abuse Services*
- *Patricia Cummings, VP, Community Services, Seven Counties Services, Inc.
- *James Dailey, NAMI-Kentucky, *Advocates and Community Organizations*
- *Mary Helen Davis, M.D., Psychiatrist, *Individuals Providers*
- *Deborah DeWeese, District Judge, *Law Enforcement and Court Personnel*
- *Katharine Dobbins, Associate Director, Wellspring, *Public and Private Service Providers*
- *Elizabeth Ferguson, Family & Childrens First, *Public and Private Service Providers*
- Barbara Gordon, Director of Social Services, KIPDA, *County Officials and Business Leaders*
- *Marlene Gordon, Executive Director, Coalition for the Homeless, *Advocates and Community Organizations*
- *Earlene Grise-Owens, Spalding School of Social Work, *Educators and School Personnel*
- *Mary Ellen Harned, GuardiaCare, *Public and Private Service Providers*
- Julia Inman, VP of Community Impact, Metro United Way, *Advocates and Community Organizations*
- *Dean Johnson, Public Information Coordinator, Seven Counties Services, Inc.
- *Ramona Johnson, CEO, Bridgehaven, *Public and Private Service Providers*
- Bart Irwin, Family Health Centers, *Health Departments and Primary Care Physicians*
- Robert McFadden, NAMI-Louisville, *Advocates and Community Organizations*
- *Barbara Rutledge, Central State Hospital, *Public and Private Service Providers*
- Jackie Simmons, Director, PASSPORT Health Plan, *Public and Private Service Providers*
- *Bernadette Walter, Administrative Director, Psychological Services Center, U of L, *Educators and School Personnel*

*Linda Yeager, VP, Gateway Services, Seven Counties Services, Inc.

*Denotes individuals who have attended one or more meetings in the past twelve months.

B. Describe activities of the RPC since your last updated report (September, 2005)

The Region 6 Regional Planning Council continues to meet and engage in creating collaborative planning to address the behavioral health needs of our region. The council has held at least four formal meetings in that time frame. While participation, numerically, declined in recent years, the council remains active on many fronts, including:

- Lobbying the General Assembly in 2006 on our budget priorities, including funding for a new Crisis Stabilization Unit (CSU) and funding for cost of doing business adjustments in our state contract and additional staff and services to meet greater needs in our region.
- Working with our local congressional delegation and staff on issues of importance to our work.
- Working together to create a comprehensive DIVERTS plan for our region.
- Sharing information and strategies on federal and state legislative issues.
- Collecting service capacity and service provision data for our region.
- Adopting a Mission Statement and a Vision Statement to guide our work (see above).

II. Changes in Your Region's Needs, if applicable

A. Any significant changes in your region's demographics

The most significant change in demographics over the past two years is the increase in immigrant and refugee population in the Louisville metro area. In the metro area alone, 53,000 residents are foreign born and most likely this is undercounted due to the number of undocumented residents. Also, because of the large federal refugee resettlement programs, fifteen percent of Louisville's immigrants are refugees - twice the national average of seven percent. Between January 2005 and April 2007, 2,553 refugees came into the Louisville metro area.

The State Data Center expects that the Hispanic population will increase 25% from 2005 to 2010. Over 40,000 residents speak a language other than English at home and over 80 languages are spoken in the Jefferson County Public Schools. For the 2004-05 school year, 4,316 students were from a non-English language background. For the 2005-2006 school year, the number rose to 5,358.

The surge in immigrant and refugee population is creating challenges for behavioral health service delivery – in raw capacity, in cultural competence, in language barriers. The cost of interpreters, covered by Medicaid in some other states, remains a high, unreimbursed expense, in Kentucky and especially in this region due to the large numbers of immigrants and refugees. In addition, the prevalence of post-traumatic stress disorder (PTSD) in the refugee population is high.

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

No known significant changes in community indicators or prevalence rates. A number of service providers experienced a significant reduction in services to Medicaid recipients of at least 15 percent, beginning in FY 2006. We are searching for the causes or reasons behind this drop. It should be emphasized that the numbers served are not dropping but the number of individuals with no payor source is increasing. Many providers are experiencing significant increases in uncompensated care.

C. Any significant changes in dollar resources

Provider capacity continues to fall further behind each year as federal and state resources lag both cost of doing business inflation and increased service demand. Most rates have gone unchanged for a number of years. The Medicaid freestanding psychiatric hospital per diem rate has been frozen since 1999. The increase in KERS employer contributions, along with flat funding in Medicaid rates and DMHMR contracts and low insurance reimbursement has combined to create a significant negative impact on all providers. In the area of substance abuse, we have experienced a loss of approximately \$400,000 in state and federal support between FY 2005 and FY 2008. In the area of mental health, state and federal dollars have remained stagnant in all areas except crisis stabilization (CSU). Nearly \$600,000 in new funds have been committed to the region for both a new adult CSU and for more adequate support for child CSU operations.

Many providers have experienced losses in Medicare reimbursements due to tightening of medical necessity determinations.

We have seen a decrease in number of providers - mainly psychiatrists - but also other disciplines. More and more psychiatrists are moving to a fee-for-service business model.

We have also seen a decrease in school-based services and in addiction treatment slots for youth. A number of service providers have experienced a significant reduction in services to Medicaid recipients of at least 15 percent, beginning in FY 2006. We are searching for the causes or reasons behind this drop. It should be emphasized that the numbers served are not dropping. Many providers are experiencing significant increases in uncompensated care.

III. 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” is being largely relocated to the jails, the homeless shelters, the emergency rooms, hospitals, and the streets. Due to the continual decline in federal and state support, the ability of the community mental health center to provide uncompensated care in our region continues to diminish. In the past six years, the

uncompensated care capacity of the CMHC has eroded by nearly fifty percent. The demand has not lessened, but has shifted to other community providers, both public and private, who have seen significant increases in provision of uncompensated care, with no additional funding source.

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

With rare exceptions, services for specific populations have remained at pre-2005 levels or declined. The lack of any new or additional resources makes expansion of services for these populations nearly impossible. There has been some progress in addressing housing needs. Kentucky Housing Corporation now provides vouchers for housing enriched with services through the Safe Havens program. During the program's first six months, 45 vouchers for people with mental illness were provided to individuals in the region.

- Collaboration, cooperation and communication among service providers

The Seven Counties Services (SCS) region has a long mission-driven history of developing and implementing services in a collaborative effort involving providers, advocates, educators, and consumers of our region. In developing new programs or services, or revising existing efforts, we employ a systemic approach that draws on the knowledge, experience, and expertise of each partner in creating a total system of care.

The overall system of care encompasses the work of many organizations and entities throughout our region. Our regional effort integrates the work of 25 affiliated groups, all effectively creating and delivering expert services that address the many specialized behavioral health needs of our area's population.

The role of the HB 843 Council in maintaining a forum for open communication and locally driven planning is significant.

- Evidence-based practices and focus on Recovery

The region's goal, embodied in our mission and vision statements, is to promote the recovery, self-sufficiency and empowerment of individuals with severe and persistent mental illnesses and/or addictions. To this end, interventions are based on a belief that a comprehensive, coordinated, array of treatment opportunities has the greatest probability of meeting the needs of the individuals. This approach is based on a holistic approach to meeting peoples' needs, with a specific focus on helping people to maximize independent functioning through stable community living, socialization, employment, symptom management, self-advocacy and improved self-esteem. The employment of Peer Support Specialists throughout Seven Counties' Center for Supported Living (CSL) helps to promote the transformation to a recovery-based model and to facilitate the achievement of the division's mission.

The role of Peer Support Specialists and the employment of consumers to fill staff vacancies, when appropriate, are vital catalysts in our transition to a recovery model within the region. However, it is critical that Peer Support Specialists services become Medicaid billable. During 2007, each Center will hire at least one KY Peer Specialist to assist with

the move toward recovery and to provide direct services to other consumers, such as individual counseling, group counseling, socialization, support and recovery planning. As the budget permits, interested consumers will have an opportunity to receive training in clerical and other support position. Consumers will be encouraged to apply for positions within the CSL for which they are qualified.

In 2005, Bridgehaven received the Eli Lilly Reintegration Award for Social Support in recognition of the agency's evidence-based recovery and community integration services.

Several providers continue to implement evidence-based practices in rehabilitation and recovery, co-occurring disorders, supported housing, and specialized children's services. Additional provider trainer is needed for implementing and sustaining these practices.

IV. Regional Responses to These Events or Influences:

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

None

B. Patients in ERs of hospitals without psychiatric units

Our Lady of Peace provides mobile response at hospitals without psychiatric units throughout Jefferson County and at Jewish Hospital in Shelby County. Our Lady of Peace has experienced an increase of at least 20 percent in mobile assessments in the past year. They have seen an increase in requests for mobile psychiatric and CD requests in emergency rooms of hospitals without psychiatric units. They have placed two clinicians on-site for assessments at two such hospitals.

C. Development of CSU services for both children and adults

Wellspring will open the new David J. Block CSU for adults in July, 2007. The facility will provide the region with eight additional adult CSU beds, serving an additional 300 people per year. New funding of at least \$230,500 annually is needed to support current and new CSU operations.

D. Impact of DIVERTS in your region (if applicable); planning for DIVERTS II

The HB 843 Region 6 Council embraced the opportunity to work collaboratively in creating a comprehensive DIVERTS plan for our region. The process and content were topics of discussion at several council meetings. In addition, community affiliates, many of whom are also council members, were partners in the plan's formation.

The DIVERTS Phase II planning process provided our region with an opportunity to methodically inventory our current efforts in the four focus areas; identify gaps in services in those areas; and identify resources necessary to both maintain our current efforts and fill the gaps. Not surprisingly, we discovered that our current resource pool of finances, personnel, and services is insufficient to adequately address the needs of our region's population.

While we were able to quantify success in evidence-based practices and identify new and promising initiatives to further advance the goals of DIVERTS, we will need to acquire a minimum of nearly \$800,000 per year in new resources to continue our current efforts and an additional \$5.1 million per year to initiate new programs and services. This need is specific to those items addressed in the DIVERTS plan. These figures do not include the many other hospital, children's services, and provider efforts that require additional funding to maintain current service levels.

E. CIT training in your region; preparation for future training

SCS, NAMI, the U of L Department of Psychiatry, and others provide CIT training to the Louisville Metro Police Department on a quarterly basis. Both police rookies and seasoned officers participate in the weeklong, competency-based training. Some officers in Oldham County have received the training and others from the five other counties will be invited as slots become available. \$15,000 annually in additional resources are needed to fund continued service levels.

F. Medicaid: consumers' access to medications, impact of *KY HealthChoices*

Savings are being realized in the Community Medication Support Program, primarily as a result of greater physician initiatives and practices in securing samples and assisting patients in gaining eligibility for pharmaceutical companies' medication assistance programs. The greatest need in medication access is with the Medicare population, most of whom suffer multiple illnesses that require medications and who fall victim to the "doughnut" effect of the Part D benefit. We would like to see CMSP savings redirected to assist this population in maintaining consistent pharmaceutical treatment.

G. Establishment of Recovery Centers, Drug Courts and other substance abuse initiatives

Region 6 did not receive any additional state funding for Recovery Centers were not established in this region because the Healing Place – the model for the statewide program - already operated in the region prior to the statewide move to establish centers. We have seen a slight increase in funds from the Department of Community-Based Services to provide two FTE case managers from JADAC to partner with Social Workers from Permanency and Protection at Neighborhood Places to work with families when child abuse or neglect has been substantiated. Jefferson County Family Drug Court received funding to keep the program running for another year with expected funding to kick in for ongoing funding of the Family Drug Court.

There was a collaborative effort to secure a SAMSAH grant to create a system of services for homeless individuals with co-occurring disorders. The grant was not funded and this continues to be a major gap in the array of services available in this region.

For the past three years, the Louisville Area Network for Adolescent Substance Abuse Treatment (LANSAT) has operated an after school clubhouse for recovering teens.

Funding has been provided via a SAMSAH grant, which is expiring this summer. Additional resources of \$163,000 annually need to be secured to continue the operation of the clubhouse.

H. Workforce – recruitment, retention, training opportunities

None

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

Our Lady of Peace and the Physicians group at Jewish Hospital and St. Mary's HealthCare have continued to expand a behavioral health/primary care integration program over the past two years. They are now providing therapy and psychiatry services in five primary care sites.

Through the Mental Health and Aging workgroup, a small pilot project was funded in FY06 to support an integrated system of care for individuals age 60 and older. This project was a partnership with KIPDA and Seven Counties. Services included screening, community education on Best Practices for senior focal points, and development of a behavioral health consult model for primary care providers. Funding was one year only. As a result, services in FY 2007 were reduced to screenings and consultation using an ARNP with funding from Metro United Way and graduate students from U of L School of Nursing and a Kent School of Social Work student.

In partnership with the Family Health Care Centers, an ARNP is located at the Phoenix Homeless Health Care Center to provide behavioral health services for the homeless population using the Health Care Clinic.

With grant funding from the Louisville Department of Public Health and Wellness, Bridgehaven offers a fitness and wellness program to assist members in making healthy choices, improving nutritional status, reducing blood pressure and blood glucose levels, smoking cessation, and improving physical fitness. Services are integrated into the psychiatric rehabilitation program setting.

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

This region was one of two targeted to provide discharge planning for individuals leaving institutions and youth aging out of the foster care system. Family and Children First has provided this service through a contract with Adanta through the Department of Mental Health and Substance Abuse.

Brooklawn Child & Family Services recently opened a supervised group home for eight teenage boys in Louisville. In addition, a partnership of private care providers has received funding to develop additional housing unites for children aging out of foster care.

Seven Counties' service provision within the IMPACT program has evolved to better serve the needs of transitioning children, with greater emphasis on planning for job, housing, and transportation needs. Loss of medical care at adulthood remains a major challenge for this group. Increased collaboration with DCBS

and residential facilities through involvement in the KY Childcare Coalition has reduced the number of children falling through the cracks.

V. Behavioral Health Goals for Your Region

- A. Briefly describe the top goals set by your Regional Planning Council for the initial 2001-2003 time period and updated in September of 2005
- B. Describe any changes in priority goals for your region
- C. What progress has been made toward achieving these goals in the past two years?

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

A part of this goal also is to increase by 25% by 2006 the availability of support services that facilitate the coordination of mental health and substance abuse treatment and care. This is particularly crucial in counties outside of Jefferson County. All supportive services should be accessible to persons with disabilities, should be diverse, and should reflect the cultural and racial composition of the region. A part of this goal would be to increase flexible funding (i.e. state funding) for supportive/normalizing activities.

Progress – Most recent available data for many indices is 2005. According to the LRC Report (Dec. 2006), the number of consumers with “no fixed residence” in the Seven Counties region increased from 876 in 2001 to 976 in 2005, a change of 11.4 percent.

Kentucky Housing Corporation now provides vouchers for housing enriched with services through the Safe Havens program. During the program’s first six months, 45 vouchers for people with mental illness were provided to individuals in the region.

Wellspring added ten units of subsidized housing coupled with staff support.

State Budget allocations, specifically the DMH/MR contract, have remained stagnant through FY 2007. Since July 1, 1999, the state contract has increased an average of one-tenth of one percent annually. “Adjusted for inflation, the community care support funds [flexible funds] have declined nearly 7 percent since fiscal year 2001.” LRC Report (Dec. 2006)

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

Progress – Current regional efforts result in over 60% of persons presenting themselves for hospital admission diverted to other less restrictive and less expensive service alternatives. As a result, we have seen a reduction in bed utilization from 192 operating beds to approximately 123 currently at Central State Hospital. The private sector has not experienced a reduction in bed utilization.

In FY 2006, the Criminal Justice/Jail Diversion Program diverted 133 clients, avoiding an estimated 28,548 jail days at an estimated cost of \$999,180.

Jefferson County Jail statistics show that the monthly average intakes into the Mental Health Unit dropped slightly from FY 2006 to FY 2007 - from 113.8 to 110.0. Monthly suicide observations also fell from an average of 80.8 to 75.9 between the two years. The number of mental inquest warrants issued averaged 2.1 per month in FY 2006. Through the first eleven months of FY 2007, the monthly average was 1.8.

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

Progress – Some training is occurring in some sectors. Due to lack of funding, no significant progress has been made on this goal.

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

Progress – None.

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

Progress - In FY 2006, the Criminal Justice/Jail Diversion Program diverted 133 clients, avoiding an estimated 28,548 jail days at an estimated cost of \$999,180.

“NAMI KY reports that over 95 percent of persons with mental illness encountering officers who have completed the training are diverted to treatment rather than being taken to jail.” LRC Report (Dec. 2006)

Jefferson County Jail statistics show that the monthly average intakes into the Mental Health Unit dropped slightly from FY 2006 to FY 2007 - from 113.8 to 110.0. Monthly suicide observations also fell from an average of 80.8 to 75.9 between the two years. The number of mental inquest warrants issued averaged 2.1 per month in FY 2006. Through the first eleven months of FY 2007, the monthly average was 1.8.

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

Progress – The Region 6 HB 843 Council remains committed to the achievement of this goal. However, we are removing this as a regional goal under our plan as we have no authority to affect the outcome of this goal.

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

Progress – The Region 6 HB 843 Council remains committed to the achievement of this goal. However, we are removing this as a regional goal under our plan as we have no authority to affect the outcome of this goal.

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

Progress – We have seen a marked increase in demand for these services in our region. We have been unable to expand our efforts due to the lack of any new funding for these efforts.

According to the LRC Report, from 2001 to 2005, the mix of consumer age groups served by regional centers has remained relatively stable – “there have been small increases in the consumers younger than 18 years...”

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

Progress - Most recent available data for many indices is 2005. “From fiscal year 2001 through fiscal year 2005, the number of persons served by the centers increased by almost 17 percent and the number of services increased by almost 28 percent. Revenue increased less than 9 percent.” LRC Summary (Dec. 2006)

According to the LRC Report (Dec. 2006), Seven Counties’ regional population in FY 2005 was 888,196 or 21.6% of KY population. The consumer population for services in 2005 was 27,736 (16.5% of KY consumer population). This represented an increase of 31 percent over the 2001 consumer population of 21,214. Other providers in the region also report increased utilization of services.

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

Progress – None made due to the lack of any new funding for these efforts.

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

Progress - Savings are being realized in the Community Medication Support Program, primarily as a result of greater physician initiatives and practices in securing samples and assisting patients in gaining eligibility for pharmaceutical companies' medication assistance programs. The greatest need in medication access is with the Medicare population, most of whom suffer multiple illnesses that require medications and who fall victim to the "doughnut" effect of the Part D benefit. We would like to see CMSP savings redirected to assist this population in maintaining consistent pharmaceutical treatment.

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

Progress - The Region 6 HB 843 Council remains committed to the achievement of this goal. However, we are removing this as a regional goal under our plan as we have no authority to affect the outcome of this goal.

VI. Your Recommendations

A. Describe your funding recommendations, including a description of changes in the availability of services in your region without increases in funding

As noted throughout this report, current financial resources are not sufficient to maintain what this council considers to be acceptable levels of service to the population of our region. Public resources, through federal and state sources and publicly financed insurance plans, and private resources, through commercial insurance and private pay, do not constitute a sufficient fiscal effort to serve the many behavioral health care needs that exist today.

Over the past eight years, the contract between Seven Counties Services, Inc. and the Department of Mental Health and Mental Retardation Services has lagged inflation by nearly \$6 million, eroding service delivery capacity by 24 percent. This stagnation is felt throughout the provider community. The number one need in funding for our region is for contracts and fees to accurately reflect actual costs of doing business.

The recent collaborative effort to create a DIVERTS plan for our region provided an opportunity to methodically examine the effect of the insufficiency on our service delivery. The following items from that plan, comprising an annual need of approximately \$800,000, are required to simply continue services at the current level. In every instance, programs are currently running in deficit or with no specific funding source. Failure to secure identified resources will result in further diminishment of service capacity and greater undesirable consequences.

| | |
|--|-----------|
| Emergency Psychiatry Services/Adult Crisis Team | \$92,000 |
| Crisis and Information Center | \$109,541 |
| Crisis Stabilization Units – Adults | \$230,500 |
| Transitional Housing – Wellspring | \$183,600 |
| Psychiatric Rehabilitation Program – Bridgehaven | \$108,000 |
| Psychiatric Rehabilitation Programs – Seven Counties | \$60,000 |
| CIT Training | \$15,000 |

The following items, comprising an annual funding requirement of approximately \$5.1 million, represent regional strategies to address significant gaps in service and more thoroughly address barriers to recovery for priority populations. Greater detail on these initiatives can be found in the Region 6 DIVERTS Phase II plan, submitted to the Kentucky Department of Mental Health and Mental Retardation Services on June 15, 2007.

| | |
|---|-------------|
| Intensive Outreach for New Members – Bridgehaven | \$109,000 |
| Adult Crisis Team/Emergency Psychiatry Services Expansion | \$1,425,050 |
| Consumer Resource Center Operated by Consumers | \$75,000 |

| | |
|---|-------------|
| NAMI Connection Support Groups | \$7,500 |
| Dual Diagnosis Unit – JADAC | \$876,000 |
| Intensive Outpatient Program Expansion – Bridgehaven and Rural | \$300,000 |
| Staff Training in Evidence-Based Practices for Co-Occurring Disorders | \$50,000 |
| Jail Diversion Program Expansion | \$330,000 |
| Forensic Assertive Community Treatment | \$450,000 |
| Homeless Outreach Team Expansion | \$275,000 |
| Shelby Men’s Center Psychiatry On-Call | \$60,000 |
| Transitional Housing Options Expansion | |
| 40 additional community beds | \$1,112,000 |
| Crisis and Information Center Warm Line creation | \$17,000 |
| Suicide Survivor Support Groups creation | \$37,500 |

B. Describe recommendations for public policy changes to enhance the ability of the system of care to meet the behavioral health needs of consumers and families

The top four legislative priorities of the Region 6 HB 843 Council are as follows:

- Pass legislation to ensure that inflationary increases are made each year to continuing contracts.
 - *Community mental healthcare contracts with the Cabinet have not been adjusted for inflationary trending and indexing in over 12 years.*
 - *Local safety nets have been significantly frayed due to inflation.*
 - *Allow flexibility in funding at the local level, so allocations can be directed to identified regional needs and priorities.*
- **Assure that the state covers increases in the employers’ share of KERS for organizations mandated to participate.**

Mandated increases result in organizations redirecting dwindling resources to cover costs, resulting in decreased support for services and programs.
- Reduce administrative duplication and cost by granting “deemed status” to community health and affiliate agencies that are credentialed by a recognized external entity (JCAHO, CARF).
- Medicaid program improvements
 - Urge the Governor and General Assembly to invest sufficient general fund dollars into the program to maintain services and enhance quality.
 - Reinvest all “savings” realized through changes to improve quality and availability of Medicaid services.
 - Expand Medicaid coverage for diagnosis and treatment of substance abuse disorders for adolescents and adults, particularly to women of childbearing age.
 - Establish a Medicaid Buy-In Program to remove barriers to employment for persons with disabilities.
 - Expand Medicaid coverage to tobacco cessation treatment.
 - Expand Medicaid coverage for peer support services.
 - Establish a psychiatric treatment facility specialty population rate.

Other legislative initiatives supported by the council include:

HOUSING: Fund the Affordable Housing Trust Fund or other housing programs for persons with disabilities.

HEALTH INSURANCE: Ensure full parity of behavioral and physical health services in state employees' health insurance and other insurance plans; limit the frequency with which insurers can require prior authorizations for mental health and substance abuse treatment.

INCREASED REVENUE: Significantly increase the cigarette excise tax to reduce youth smoking and create new revenue, designated for Medicaid and mental health and substance abuse services.

GAMBLING ADDICTION: If gambling is expanded, a percentage of the income should be designated for gambling addictions, as well as treatment of substance abuse, domestic violence and child abuse.

JAIL DIVERSION TREATMENT: Ensure adequate funding through the Justice Cabinet and Corrections for community-based treatment programs.

**HB 843 Update Report
Northern Kentucky Regional Planning Council
July 2007**

I. Features of your Regional Planning Council (RPC)

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

| Name | Constituency | Name | Constituency |
|-------------------|---|----------------------|--|
| Vanessa Rose | MH-MR Regional Board member- RPC Chair | Edward Smith | Council on Aging |
| Michelle Barrett | St. Luke Hospitals | Mac McArthur | Transitions - Provider |
| Tim McDermott | St. Elizabeth Medical Center | Carol Fausz | Parish Nurse Program |
| Dennis Corrigan | DCBS -Agency | Mike Hodge | Provider |
| Elaine Chisholm | Recovery Network/Consumer | Barbara Sween | NKU – Provider/Planner |
| Janice Bogner | The Health Foundation of Greater Cincinnati - Planner | Paul Flaughter | Northkey Community Care - Planner |
| 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 |
| Marty Wilhoite | Consumer | Barry Johnson | DCBS - Agency |
| Mary Pat Behler | YSAT – Planner/Advocate | Mike Rinderle | DJJ- Agency |
| Larry Wells | Transitions - Provider | David Olds | Mental Health America 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 |
| Linda Young | Welcome House- Provider | Wayne Speigel | Kenton County Fiscal Court - Planner |
| Sue Davis | Northkey Community | Gary Goetz | Northkey Community |

| | | | |
|--|------------------------------------|--|------------------------------------|
| | Care – Provider/Planner | | Care – Provider/Planner |
|--|------------------------------------|--|------------------------------------|

E. Describe activities of the RPC since your last updated report (September 2005)

1. RPC continues mostly monthly meetings and communications with community members and legislators.
2. 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.
3. RPC continues to work on broadening membership in order to maintain and enhance regional perspective and community linkage.
4. RPC provided testimony at Northern Kentucky legislative Caucus meetings in 2005 and 2006.
5. RPC sponsored a five-year anniversary community forum, in September 2005 to review regional Mental Health and Substance Abuse service needs.
6. 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.
7. 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 provide additional regional resources to allow our region to be responsive to increased service demands created by strong and rapid population growth. The region's ability to respond to the growth has been worsened by the historical per capita under funding of our regional MH & SA services.
8. RPC work group reviewed existing crisis services for adults and youth and identified strengths and weaknesses and made recommendation to the Regional Board for enhancements as funds are available (priority enhancements recommended are emergency brief residential option, and improved crisis resources for adults and youth with an acute SA problem)

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 2006 is 422,062 (10.03% of the state population). Regional population continues to increase at a rapid rate and is projected to be 444,102 in 2010 (10.26% of state projected population).
 - B. Should the projections hold true, the region will add over 53,000 residents between 2000 and 2010.

- C. Growth rate and projections indicate that population will continue to increase at a similar rapid rate.
- Continued growth in Spanish-speaking population
 - A. Northern Kentucky continues to have the 3rd largest primary Spanish-speaking population in the State, projected to be 9,825 in 2010.

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.
- Per the recently released 2004 poverty data, the region continues to be below the State average in percentage of population with income below the poverty level (averaging about 10.93% for the region). However, there has been an increase in both the percentage and number of people when compared with the 2000 census numbers. Using the 2004 estimates, there are approximately 44,868 individuals in the region with incomes below the poverty level, and of these approximately 15,452 youth under the age of 18 are living in poverty.
- Prevalence and service need (based on 2005 estimated population):
 - A. 7,819 Adults experiencing Severe & Persistent Mental Illness (2.5% SPMI)
 - B. 5,561 Youth experiencing Severe Emotional Disturbances (5% SED)
 - C. 54,702 Adults needing SA treatment (17.5%)
 - D. 1,591 Youth needing SA treatment (1.5%)

C. Any significant changes in dollar resources

- KEYS Grant funding continued in FY 2006 and FY 2007. The cost reimbursement expenses averaged around \$1,100,000 per year for the 2 years. The level of support will begin to shift away from federal grant support and more to local and state support over the next 3 years.
- FY 2006 - increase in State General Fund dollars (totaling around \$360,000) ... includes legislative increase for Community Care Support dollars and a small increase for population growth based upon the current funding formula.
- Funding from County MH tax dollars has remained essentially flat over the two year period with a total increase of \$15,000 from FY 2005 level.
- FY 2007 – in January 2007 United Way redirected \$120,000 of from supporting safety net outpatient services. NorthKey and Children’s Inc. received a United Way grant as part of a collaborative of providers for early childhood intervention/services beginning in FY 2007.
- FY 2007 - Increase in state contract crisis services dollars, by about \$450,000, to support additional expansion of adult and child crisis services.
- Beginning in 2005, NorthKey Community Care received approximately \$400,000 per year from a SAMHSA cost reimbursement grant for three years to support enhancement and

evaluation of adolescent IOPs in Boone, Campbell, Kenton and Pendleton counties.

- Start-up funding from The Health Foundation of Greater Cincinnati lapsed 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 providing necessary financial support for continuance.
- Start-up funding (approximately \$100,000 per year) from a regional collaborative, Youth Behavioral Health Initiatives, for FFT service to court-involved youth lapsed in April 2007. Sustaining funding was unable to be developed.
- KERS costs rose significantly in FY 2007 and have risen again in FY 2008 ... an increase of over \$500,000 per year when compared to the FY 2006 KERS expense (the year prior to the increases).

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 appropriate for the population growth. Some examples:

For the low-income population, the need for psychiatry appointments and medication management appointments continuously exceed available resources (90 day wait is typical). There is also periodic delay exceeding 30 days for availability of non-emergency outpatient appointments.

In the 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. This is an especially challenging issue for the KEYS grant in rural school locations.

Substance abuse services 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. A proposal is being developed by a collaborative led by the regional KY-ASAP board members, for the initiation adolescent SA residential services within the region.

Adequate screening/assessment for youth with substance abuse continues to need enhancement to be more readily available.

The CMHC provides over \$948,000 of outpatient treatment above the State allocated funding amount in the course of a year.

A positive regional safety net resource continues to develop with the MH mobile crisis stabilization services (adult and child). Both services continue to increase in coverage area and service utilization. Child crisis has an established day program and has 2 reserved PRN crisis

beds with local residential providers. Adult crisis services are planning for an expansion of service options. Planned is the start of a crisis response oriented day program.

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 one psychologist and one psychiatrist who are fluent in Spanish. The clinician proficient in sign language and targeted to the deaf population left for another job opportunity and that position is currently unfilled.

Regionally, resources for providing services to Spanish-speaking individuals and the deaf population remain challenging and require improvement and enhancement.

Collaboration, cooperation and communication among service providers

The Regional Board continues to value and foster increased collaboration and communication among service providers and other community constituents. There are several established community collaborative efforts and the ability to provide direct input into the budgeting and service prioritization process in these efforts is highly desired and helpful process within the region. These collaborative groups, like the RPC, have helped the region present a more unified voice regarding regional service needs. The KEYS grant is a System of Care based project and emphasizes a collaborative community-based and community-wide response to service need for youth with SED.

Evidence-based practices and focus on Recovery

NorthKey progressed from a readiness grant to an implementation grant from The Health Foundation of Greater Cincinnati for GAIN, Seven Challenges and CIT.

The adolescent IOPs in Kenton and Campbell counties and the KEYS project have embraced the concepts of the Seven Challenges Program. The KEYS staff has also been receiving training in the use of the GAIN.

Family Services of Northern KY has a grant to increase staff to provide the evidence-based practice of Parent-Child Interaction Therapy

A men's and women's recovery centers have received approval for the Northern Kentucky region and are in process of construction/development. One will be operated by Brighton Center and the other will be operated by Transitions, Inc.

IV. Describe Regional Response to These Events or Influences:

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

Psychiatry beds have remained unchanged 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 may be a need for increased numbers of inpatient beds. Despite the 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 does not currently support the availability of these PRTF beds for youth in our region.

B. Patients in ERs of hospitals without Psychiatric Units

All Kentucky hospitals in our regions have psychiatric units as part of their care options.

C. Development of CSU services for both children and adults

As stated above, our region continues to develop and expand crisis service availability in a planned manner. The current focus is to explore expanded hours for crisis day programming for youth, begin crisis day programming for adults, and increase availability of crisis response services for adults and children with identified SA problems.

D. Impact of DIVERTS in your region (if applicable); planning for DIVERTS II

NorthKey has submitted a plan for DIVERTS II. The plan's strategies include the following: regular presence of NorthKey outpatient staff at local hospitals in order to provide follow up planning and divert patients from the Eastern State Hospital; regular presence of clinical staff at local hospital emergency rooms; development of an intensive outpatient program; increased prescriber presence at the adult crisis stabilization program; and increased utilization of paraprofessionals to provide essential community supports.

E. CIT Training in region; preparation for future training

Trained over 150 emergency first-responders (police, EMTs, fire department, etc.) in level 1 awareness (6 hours) of mental health issues. Also had one 40 hour class of KLEC approved curriculum training for police officers - 22 attendees. Second 40 hour class scheduled for September 2007. Plan is to continue offering training to police and emergency responders in the region.

F. Medicaid: consumer access to medications, impact of *KY Health Choices*

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.

G. Establishment of Recovery Centers, Drug Courts and other substance abuse initiatives.

A 100 bed men's and 100 bed women's recovery center have been approved for this region. Construction has begun on both and the plan is for them both to open within the next 18 months. NorthKey has been actively collaborating with AOC to expand drug courts within the region. Currently there are adolescent IOPs connected to drug courts in Campbell, Kenton and Pendleton counties. Additionally, there is a Women's IOP active in Campbell County that accepts referrals from the court and an adult IOP connected with the court in Pendleton County. This region is also in the process of expanding SA services via the START initiative with DCBS and is one of the initial regions chosen to expand Medicaid-covered SA treatment services to families of high-risk youth.

H. Workforce – recruitment, retention, training opportunities

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.

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

NorthKey has a collaborative relationship with HealthPoint, the FQHC in our region, and shares a pediatrician/psychiatrist staff person. NorthKey also has a grant from a local funder to train local pediatricians to increase their awareness of MH issues. NorthKey staff participates in a planning group that is developing a free clinic for Spanish speaking people.

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

There continues to be 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 for the region

- 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 in the past two years?

- **Crisis Stabilization Services** – Continued expansion of service options continues in this area as described in earlier section. These expansions are paired with regional gaps and resource availability.
- **Adolescent IOP Services** – Have expanded with the receipt of additional funding from grants - 3 are operational and 1 is preparing to start. The region needs to develop sustaining funding for these services after the grant funding cycles.
- **Service expansion** – This has occurred to some degree for youth in collaboration with the KEYS federal system of care grant project. More services are available and delivered to school-aged youth in rural counties and the city of Covington. Sustainability support is now the priority for this grant.
- **Residential Treatment option for youth with SA treatment needs** – A community work group is evaluating and developing a plan for seeking funding for this treatment option within the region.
- **Adequate State General Fund dollar funding** – There exists a stop-gap improvement in State funding with the increased portion to the Northern Kentucky region of the recent community care dollars expansion. Continue working with Kentucky Association of Regional Programs (KARP) to develop a consistent funding formula that distributes state general funds in a manner that more adequately addresses high population growth regions.

VI. Recommendations

A. Describe your funding recommendations including a description of changes in the availability of services in the region without increases in funding

- The State must improve State General fund support for CMHC delivered and subcontracted safety net services in a manner that addresses inflationary and population growth issues for the next several budget cycles. The flat-lined State funding support of these

services in the face of continuing population growth for our region and sharply rising costs has severely stymied our regional ability to respond to increased service demand.

- The State system is founded upon, and has developed around, the concept of CMHCs being the central feature of the safety net service for MH and SA treatment. The chronic under funding of the CMHC treatment system, coupled with ever-increasing costs (i.e. retirement system expenses, healthcare costs and rising salary pressure as we compete with a large city salary structure) in Northern Kentucky is consistently eroding the CMHC's ability to respond to community service demands and provide expansion and enhancement of services in our region. Our region is under-resourced in terms of clinical staff to respond to the community demands for services.
- NorthKey has been highly involved with community coalitions aimed at preventing suicide. Additional funding is necessary in order for this region to provide additional suicide prevention trainings, as well as interventions with suicidal persons and postvention efforts with families, schools, and other community groups.
- Other regional service providers are available for some treatment issues, but they are not structured to offer the core comprehensive safety-net services. They can offer complementary service with an adequate payer source and rate.
- Our regional concern is that the community demand for services will remain high (and grow in our region), while less individuals may have Medicaid as a payment option, due to federal pressures to reduce and limit Medicaid expense growth. If Medicaid is narrowed in its scope, flexible State General Funds for community-based services must increase more rapidly to allow for adequate resources to response to this increased service demand. Disregarding this issue will once again increase costs for other Cabinets/community resources/sectors of the community (i.e. Education, Justice, Legal, Law Enforcement).
- 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. Evidence based practices are often more time intensive and costly than traditional outpatient services. These service models do not fit within the current traditional and historical funding, reimbursement and service designs.

B. Describe recommendations for public policy changes to enhance the ability of the system of care to meet the behavioral health needs of consumers and families.

- The State must have visionary leadership and a long-term plan including short-term targeted steps to achieve that plan.
- MH and SA treatment services must be recognized as valuable, essential and beneficial health services for the whole community and as broad State and community basic requirements for a healthy and desirable community.

- The mechanisms for evaluating appropriate funding and effectiveness of treatments must be flexible and broad enough to avoid the far too common error of merely focusing on narrowly defined cost management 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 continues to be the unplanned shifting of costs to the jail and prison systems. This is widely accepted as an outcome of short-term cost controls in the mental health and substance abuse expense arenas, which 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 may have been significantly more humane and cost effective than simply fostering the shifting cost and care to other ill-prepared systems.
- Future effectiveness of the MH and SA service delivery system will also require the development of more complete systems of care. At the State level this has been demonstrated to be 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 long term vision for effective and efficient care delivery. 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.
- Alliances and cooperative treatment efforts between primary care providers and community mental health centers must be enhanced. This will require changes in payment mechanisms to encourage mental health professionals to actively collaborate with primary care physicians including on site services and consultation in PCP offices.
- Cross-system coordinated treatment and intervention strategies to continue intervention and treatment are needed. Tracking effectiveness through overall community impact is a key component of honest intervention strategy analysis. We need to provide necessary treatment resources and evaluate true effectiveness to avoid repeating the ineffectual, and in some cases harmful, historical pattern (and continued temptation) of evaluating results from a narrow, silo-oriented and short-term viewpoint. In short, 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.

HB 843 Report
Region 8 - Comprehend
July 2007

1. Regional Planning Council Features

A. Members of the Region 8 RPC/areas of representation: David Bolt (Chair), Primary Care, Caroline Clarke-Ullery, ADD; Allan Levay, CMHC; Patty Rudd, CMHC; 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. Activities since last updated report. Activities have primarily focused on review of Comprehend (Region VIII MH-MR Center) Inc.'s SED and SMI service plans, as well as compilation of this document. In addition, David Bolt – Chairman of the Buffalo Trace local commission, was recently elected to serve on the statewide 843 Commission.

2. Changes in Regional Needs

A. Significant changes in the region's demographics. No significant change since the last (2005) report. The high percentage of area residents not covered by health insurance continues to be a concern in the region. Increased requests for services from individuals who reside out-of-region and out-of-state (Ohio) is also a concern.

B. Changes in community indicators and prevalence rates; significant events. Comprehend, Inc. reports serving 3,770 persons through the first 11 months of FY2007, as compared to 3,470 in FY2002 and 3,752 in FY2005 – an increase of 14.4% and 5.5%, respectively. The number of individuals receiving substance abuse services at the CMHC has increased by 46% in just two years – from 462 in FY2004 to 675 in FY2006; primarily as a result of an increased focus on intensive outpatient services. These services are now provided at three CMHC sites – one for adolescents and two for adults – as well as at the Mason County Detention Center.

C. Significant changes in dollar resources. The biggest problem facing the region is that there is no significant change in dollar resources. As was the case at the time of the last report, frozen Medicaid rates and flat funding for basic safety net services continue to challenge regional service providers. The local CMHC continues to receive Medicaid rates that are based on the FY2000 Cost Report – rates based on costs that are 8 years old at the time of this writing. The Kentucky Medical Assistance Program significantly reduced payments to persons with dual (Medicare and Medicaid) eligibility. The local CMHC has received funding from the ODCP for jail-based intensive outpatient SA services, from the Foundation for a Healthy Kentucky for an integrated care planning grant; and funding is forthcoming (FY2008) for funding from the Health Foundation of Greater Cincinnati for two small projects.

3. Update Service System Description

A. Safety net status; 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. There are no psychiatric beds in the region; nor are there any residential substance abuse programs. At the time of the 2005 report, it had been announced that Maysville was named as a site for a 100-bed Recovery Center; however, funding was ultimately NOT extended to Maysville. As a result, there has been increased emphasis on the provision of intensive outpatient services in the region, but funding has not kept pace with demand.

It was recently announced that Drug Courts will soon be implemented in Mason, Bracken and Fleming Counties. However, the treatment dollars associated with these three county drug courts fall woefully short of what will be necessary to provide even basic outpatient services. Approximately \$13,000 in total treatment funding will be available; which is probably less than one-fourth of what will be required.

B. Services for specific populations. The local mental health center continues to provide site-based crisis services to children via an 8-bed Children's Crisis Stabilization Unit, as well as mobile crisis services to adults through a modified Assertive Community Treatment model. Interpreters are hired when necessary to provide services to individuals who are deaf or hard of hearing. Clinicians are on-site during the school year in all but one public school facility in the region. The region is the site of a Children's Advocacy Center, specializing in the investigation of sexual assaults on children. The local Women's Crisis Center opened a new facility in 2005.

C. Collaboration, cooperation and communication among service providers. The local CMHC and the Lewis County primary Care Center continue to collaborate on integrated services. Comprehend, Inc., the local Women's Crisis Center and the Housing Authority of Maysville collaborate on a transitional housing project for persons who are recipients of service at all three organizations. In addition, the "Safe Havens" program, involving Comprehend, Inc. and the Kentucky Housing Corporation, continues to grow in the region.

D. Evidence-based practices and focus on recovery. The local CMHC has been selected as one of four new "Reclaiming Futures" sites in Kentucky. This program, spearheaded nationally by the Robert Wood Johnson Foundation, is designed to wrap services around adolescents who are involved with substances and who are also involved in the criminal justice system. Part and parcel of this project is the use of a nationally recognized assessment tool – the Global Assessment of Individual Needs (GAIN). Two staff at the CMHC are in the final stages of becoming certified as GAIN trainers, and the tool is being implemented not just with adolescent substance abusers, but as a standard assessment tool for all adolescents served by the Center.

In addition, the local CMHC is exploring the feasibility of implementing Illness Management Recovery through a planning grant from the Health Foundation of Greater Cincinnati.

Finally, the Adolescent Intensive Outpatient program operated by the local CMHC is based on the Bloomington model, which is a best practice model.

4. Regional Responses to:

A. Closure of psychiatric hospital beds in region, if applicable. There are no psychiatric beds in the Buffalo Trace region. While this has historically been identified as a shortcoming/service gap, it has forced local service providers to be extremely flexible and innovative with respect to serving individuals who are in crisis.

B. Patients in ERs of hospitals without psychiatric units. The local CMHC recently submitted a Diverts Phase II plan, which if funded will create 23-½ hour observation beds at the two local hospitals in the region. As stated above, the Buffalo Trace region has no hospitals with psychiatric beds.

C. Development of CSU services for both children and adults. The local CMHC continues to operate an 8-bed Children's Crisis Stabilization unit.

On the adult side, the local CMHC formed an Acute Care Team in 2004. Its role has expanded over the course of the past three years; and currently the Team coordinates and/or provides the following crisis stabilization services:

- 23-hour observation beds
- Response and Information Center (after-hours)
- Mobile Crisis Response
- Psychiatric Inpatient Liaison Services
- Oversight of emergency intervention funds
- Transitional Housing
- Community education, prevention and training services
- Jail triage/consultation
- Hospital/primary care consultations
- Assertive Community Treatment Demonstration project

D. Planning for DIVERTS II. The local CMHC recently submitted a DIVERTS Phase II plan. The primary goals are: reducing unnecessary hospitalizations in psychiatric facilities; diverting individuals from jail to treatment; reducing homelessness linked to mental illness and substance abuse; and reducing suicide of persons identified as having a serious mental illness. The following initiatives were included in the Phase II plan submitted by Comprehend, Inc: implementation of Illness Management Recovery into the current service array; offering crisis intervention team training to local law enforcement personnel; formulation of a regional suicide prevention group; recruiting, hiring, training and deploying a "jail interventionist" for the Mason County Detention Center; expanding telehealth services; and developing an agreement with at least one of the two local hospitals for a 23-hour observation service.

E. Regional CIT training. The local CMHC is proposing to offer CIT training to local law enforcement personnel as part of DIVERTS II. Comprehend is fortunate to have a staff psychologist who trained and served in the original Memphis CIT program who will serve as a local advocate and consultant for this project.

F. Access to Medications. The preauthorization process has not been successful in facilitating the original plan of increasing accessibility to services. On the contrary, it is reported that the process is actually been more cumbersome and labor-intensive than in the past.

G. Establishment of Recovery Centers, Drug Courts and other substance abuse initiatives. The Buffalo trace region was one of the initial sites approved for a Recovery Center, but that project did not materialize. There are Drug Courts in two of the five counties in the region; and it was recently announced that drug courts would be deployed in the other three counties. However, the treatment dollars attached to those three counties were recently announced at \$13,000. The local CMHC estimates that these dollars will only be sufficient to provide treatment services in those three counties (Bracken, Fleming and Mason) for no more than two to three months.

H. Workforce – recruitment, retention and training opportunities. As was the case at the time of the last report, training for behavioral healthcare professionals remains an issue in this rural region. The telecare network, which could be used to significantly alleviate this problem, is underutilized for training, educational and clinical purposes. At the last report, it was noted that Comprehend, Inc. had partnered with Lindsey Wilson College to offer an on-site Master’s program in Counseling. Several staff from the CMHC have now completed their degrees; and at least one person who was not a CMHC employee completed the program and recently was hired by the CMHC. There are still three persons enrolled in the program who are working on their degree.

Recruiting psychiatrists and psychologists to the region is still difficult. Several counties in the region are designated as National Health Service Corps sites, and as such offer incentives relative to repayment of student loans; but those opportunities are very limited.

The cost of for professional development is also a concern. Because of the distance to even Lexington, Cincinnati, or Louisville, the hard costs of travel are exacerbated; and the hidden costs of lost production are also magnified. We urge the increased use of teleconferencing at every opportunity.

I. Integration of mental health and physical health services and management. Efforts continue with Lewis County Primary Care to integrate mental health and primary care services. A planning grant was funded by the Foundation for a Healthy Kentucky and development of an implementation project is underway. During the planning phase several issues were identified that complicate the next steps. These issues include payment for services and exchange of clinically relevant information between the two entities. The exchange of clinical information is more of a perception than a real barrier. With appropriate patient consent clinical data can be moved between. Payment is problematic in that the local CMHC cannot be paid for a consultation, which is what would most generally be needed, for example with a patient suffering from depression brought on by a physical diagnosis of hypertension, diabetes or other chronic diseases. The fact that some anti-depressants can counter-act medication for treatment of hypertension is ample cause to push for a closer working relationship between the two agencies.

Other areas of integration include screening and treatment of prenatal patients. Lewis Co. Primary Care is the only OB provider in the region. OB offices are in Maysville where a new clinic is being built. Space for consulting services, including Comprehend is designed into the new building.

J. Children aging out of youth services. There have been no substantive changes since the last report. 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.

5. Behavioral Health Goals

A. Top goals for 2001-2003. 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 changes in priority goals. These primary goals have not significantly changed, as only minimal progress has been made; although it is noteworthy that school-based services are available in all but one public school in the region. As a result, this goal is no longer a priority in the Buffalo Trace region. Increased crisis services are now available as well; but the lack of residential services, particularly for individuals with substance abuse problems, keeps this issue on the table.

C. Progress toward achieving 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 seventh 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.

6. Recommendations

A. Recommendations regarding funding. 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 there is no evidence that this is happening. While there have been modest increases (early childhood mental health initiative, jail training, crisis services), they have been categorical in nature.

Additionally, while the addition of new drug courts is a positive step, there must be enough funding for treatment.

B. Recommendation for public policy changes. It is difficult to separate recommendations for funding from recommendations for policy change, 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; although this may soon be phased out in favor of national (as opposed to statewide) outcomes reporting. 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.

House Bill 843
STRATEGIC PLANNING FOR MENTAL HEALTH AND SUBSTANCE ABUSE

Region 10 Behavioral Healthcare Planning Council State Report 07-07

I. Features of your Regional Planning Council (RPC)

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

See Attachment A. Notices of meetings are mailed to the group; attendance varies from meeting to meeting.

B. Describe activities of the RPC since your last updated report (09-05)

10/05 – Members reviewed the Council's 08/05 report to the Statewide Commission, giving recommendations for additions and clarifications for the 01/06 report. Discussions included developing a community approach to hospital inpatient recidivism, smoking cessation, Opiate-addicted pregnant women, suicide prevention, Best Practices, and the Kentucky Treatment Outcome Study. The Council chairman was presented a plaque from the Kentucky Association of Regional Programs and DMH/MRS in appreciation of his service as chair of the group.

01/06 – The chair of the Council presented Region 10's recommendations at the Statewide Council meeting, highlighting trends, actions, area needs, and the paramount need for survival of safety net services in the region.

04/07 & 05/07 – The Council met to discuss the four focus goals of DIVERTS II and to develop the plan submitted 06/01/07 to reduce unnecessary hospitalizations in psychiatric facilities, divert individuals from jail to treatment, reduce homelessness linked to mental illness/substance abuse, and reduce suicides of persons identified as having a serious mental illness.

II. Describe changes in Regional Needs, if applicable

A. Any significant changes in your region's demographics

n/a

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

Information presented in the 01/06 report is still relevant.

- Providers are seeing more people paying out-of-pocket for behavioral health care services and being unable to pay even reduced fees. Likewise, some community participants report seeing fewer insurance payers in their client base.
- Hospitals and Addiction Services at Pathways report seeing more chemically dependent people, including increased Oxycontin and Methamphetamine users.
- Hospitals are reporting a higher percentage of indigent people.
- Older SMI clients are inundating the mental health system.

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- Young ladies with more severe problems are being referred to the Ramey Estep Home. There is a long waiting list. On the average, females' stays are longer than males' stays. Our Lady of Bellefonte Hospital (OLBH) mirrored the need for addressing adolescent chemical dependency use. Ramey Estep is interested in working to meet that need.

Additional trends and changes:

- Hospitals in the region are requesting increased Case Management services to ensure continuity of care, with the outcome being to reduce psychiatric hospital admissions. As this demand increases, funds are not available to provide services to Medicaid participants, and we are using more state dollars to provide services for this population.
- The Adult Crisis Stabilization Unit (CSU) is consistently running at a 90%+ occupancy rate. Fewer than 80% of clients have third party payors.
- Medicaid clients are aging out and transferring to Medicare, thus reducing reimbursement for services Pathways provides.
- OLBH is developing a geriatric psychiatric unit.
- Pathways has not had an increase in funding, which is stretching the capacity of safety net services.
- All schools in the region are increasing their demands for school-based services.
- Therapeutic Rehabilitation services are increasing in counties that have skilled nursing/personal care homes.
- The Recovery Kentucky urban model housing initiative is progressing in Region 10, with the Morehead Inspiration Center slated to open in 09/07.

C. Any significant changes in dollar resources
n/a

III. Update Your Service System Description

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

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

- The safety net is being stretched to its limit due to increased demand for services and static funding levels.
- Another difficulty is clients being seen in a timely manner. After the initial intake, it may be two weeks or longer before the person is scheduled for their next appointment.
- The FIVCO area does not have a Children's CSU, which was a need identified by the three hospitals with psychiatric units in the region.
- An Adult CSU is needed in the Gateway region. The distance from Gateway counties to the Adult CSU in Ashland causes problems for staff, families, and clients.
- As noted in the 01/06 report, KDMC was investigating whether an adolescent CON license can be recovered but, as of this date, there has been no progress on that activity.
- Clients' ability to get their prescription medications is still a significant problem in Region 10. Pathways provides \$24,000 worth of medications per month (\$288,000 per year) through the Community Medication Support Program and

utilizes samples provided by drug companies, which does not always meet the needs of our clients.

- Pathways has contracted with QoL to open a pharmacy program. The site is being developed, and QoL is seeking a pharmacist to staff the pharmacy.

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

There have not been any significant changes in services to the target populations.

C. Collaboration, cooperation and communication among service providers

HB 843 meetings include representatives from behavioral medicine, CMHC Board and staff, community organizations, Department for Community-Based Services, the medical community, advocates, and the legal and school systems. Pathways staff serve on the Board planning groups of local agencies region wide. DCBS and Pathways managers meet quarterly per the affiliation agreement.

D. Evidence-based practices and focus on Recovery

- Safety net service dollars are becoming scarcer, and Medicaid and Medicare funding are not adequately covering the cost of services. The goal will be shifting from maintaining clients in programs to developing more self sufficiency and independence so available funds can be used for the SMI and dually diagnosed populations.
- For outpatient services, Pathways will implement in August/September 2007 a common literature-based dictionary of problems, goals, objectives and interventions. The **Treatment Plan Library** that will be required to be used by clinicians is a series of treatment planners published by Wiley & Sons, authored by Arthur Jongsma and L. Mark Peterson. The implementation is scheduled for 08-09/07. The goal for this activity is to build consistency in Pathways' treatment planning process across the organization.
- Pathways' illness management and recovery program consists of a series of evidenced based sessions developed by the Center for Mental Health Services, started in FY '06-07 in the Therapeutic Rehabilitation programs.
- Examples of substance abuse recovery practices showing great promise are:
 - **Living in Balance: Moving from a Life of Addiction to a Life of Recovery** from the Hazelden group. This is a comprehensive and practical guide for conducting group and individual treatment sessions for people who have substance abuse problems involving alcohol or other drugs.
 - **The Matrix Model**, also from Hazelden, is a 16-week individualized program for intensive outpatient alcohol and drug treatment.
 - **The Seven Challenges** system challenges people to make wise decisions about alcohol and other drugs usage.
 - **Recovery Dynamics** is a method of counseling alcoholics in treatment. It is designed to make use of the text book, Alcoholics Anonymous, which is the core of the treatment program.

IV. Describe Regional Response to These Events or Influences:

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

- There have been no closures in Region 10.
- OLBH is developing a geriatric psychiatric unit.

B. Patients in ERs of hospitals without psychiatric units

Mary Chiles Hospital in Montgomery County does not have a psychiatric unit. Services are provided at Pathways outpatient office and by the Mobile Crisis Team which will respond to that site 24/7.

C. Development of CSU services for both children and adults

Additional crisis money for children and adults was provided to Region 10 for CSU services. See D, following.

D. Impact of DIVERTS in your region (if applicable); planning for DIVERTS II

- The DIVERTS II plan for FY '08 was submitted to include additional Case Management for the FIVCO region. This need was identified at the HB 843 meetings held in April and May 2007.
- For FY '09, the group identified the need for additional Case Managers, Case Manager Extenders, hospital liaisons, and an Adult CSU in the Gateway region. Future plans include a Children's CSU in the FIVCO region.

E. CIT training in your region; preparation for future training

At this time we have had no requests from the Kentucky Law Enforcement Council for staff or consumer representation for Crisis Intervention Team training. When KLEC wishes to provide CIT training in this region, we would like to be active in the development of the curriculum and presentation of the training.

F. Medicaid: consumers' access to medications, impact of *KY HealthChoices*

- Access to medication continues to be a problem. Pathways provides medications through our Community Medication Support Program, dispenses samples from pharmaceutical companies, and assist clients in completing applications for Patient Assistant Programs.
- It continues to be very difficult for clients to get established on *KY HealthChoices*. This year, the program raised monthly premium and consumers co-pays, which made it difficult for clients to purchase needed medications and food. There is consistent difficulty with Medicaid paying for medications prescribed by the physicians because Medicaid requires the individual to try two to three generic brands before it will approve a new medication that successfully controls symptoms.

G. Establishment of Recovery Centers, Drug Courts and other substance abuse Initiatives

- The **Recovery Kentucky** urban model housing initiative is progressing in Region 10. The facility is being developed by a private firm and the "Morehead Inspiration Center" is slated to open in 09/07 by Pathways via a contract with the City of Morehead.

- **Drug Courts** – Approximately a year ago, Pathways refused contracts with the AOC because we were losing money with open ended contracts. Funding at that time for clinical services was very short for meeting referral demands. We simply requested a ceiling be put on referrals commensurate with available funds. AOC denied that request. However, the Drug Courts still refer to us for clinical services, and services are still provided, but outside the Drug Court prescribed format. Other issues were also present which we will discuss with the LRC when they visit our region.
- **Other Initiatives** – see III, D.

H. Workforce – recruitment, retention, training opportunities

- Lindsey Wilson College offers a Master's program locally.
- Hospitals employ interns.
- 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.

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

Pathways, Our Lady of Bellefonte Hospital (OLBH), and St. Claire Medical Center (SCMC) are partnering in a *Foundation for a Healthy Kentucky* grant application to develop a physical and mental health integrated program. The goal is to establish mental health services at the hospitals' medical outreach clinics and to have nurse practitioners on-site at two Pathways outpatient sites. This will facilitate SMI clients to receive timely and needed assessments of their physical health needs, and will enable medical patients to receive mental health services as those needs are identified.

A goal that was accomplished from last year was the development of improved continuity of care between King's Daughters Medical Center (KDMC) and Pathways. The supervisor of Pathways' Adult CSU and the Mental Health Coordinator for Boyd County attend staffings at KDMC to facilitate communication. Plans are under way for similar collaboration with OLBH and SCMC.

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

At the HB 843 Council's 04/07 meeting, the issue of children aging out was again discussed. There has been no significant change from last year's report. This appears to be an unfunded mandate that taxes the capacity of the safety net to provide services in this region.

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 for psychiatric care 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.

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

- Develop Adult CSU in Gateway and Children's CSU in FIVCO
- Increase Case Management services

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

- Activities to increase the safety net funding are ongoing through the LRC and KARP.
- Pathways is working in collaboration with local psychiatric units to actively reduce the number of admissions to Eastern State Hospital through continuity of care activities, stepping-up people to the local hospitals, and stepping-down clients to the CSUs.
- Case Management activities are focusing on high-risk clients to provide services that will facilitate and actively promote recovering lifestyles.

VI. Recommendations

A. Describe your recommendations, including a description of changes in the availability of services in your region without increases in funding.

Approximately six years ago, the average caseload expectation for outpatient therapists was 75 to 80 consumers. Current caseloads run 110 or more. Generally speaking, this is not a good situation. There are also significant increases in service units. These things have occurred in spite of flat funding. We are about to complete our second year of operating in the red. I believe we are now trying to get blood from that proverbial turnip. We are now looking at staff reductions and curtailing some services. The following chart shows the dramatic increase in open cases since 2000. There may be some inaccuracies in reporting, but the obvious upward trend is absolutely real.

| Fiscal Year | Division Client Count | | | Grand Total |
|-------------|-----------------------|--------------|---------------|-------------|
| | Addiction | DDSS (MR/DD) | Mental Health | |
| FY 2000 | 1,819 | 550 | 3,688 | 6,057 |
| FY 2001 | 3,076 | 863 | 6,424 | 10,363 |
| FY 2002 | 3,983 | 886 | 8,299 | 13,168 |
| FY 2003 | 3,723 | 813 | 9,329 | 13,865 |
| FY 2004 | 3,303 | 290 | 8,006 | 11,669 |
| FY 2005 | 3,098 | 429 | 9,275 | 12,802 |
| FY 2006 | 2,738 | 251 | 11,104 | 14,184 |

Open clients by Fiscal Year

B. Describe recommendations for public policy changes, particularly in the system of care to meet the behavioral health needs of consumers and families.

- Increase in Medicaid reimbursement rate
- Increased safety net funding
- Public policy changes for Medicaid to reimburse for Case Management and Therapeutic Rehabilitation at a rate comparable to other services
- Medicaid reimbursement for Addiction Services

| 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 |
|--|---|---|---|
| MIKE HANEY 2 O L B H ST CHRISTOPHER DR ASHLAND KY 41101 | CLAY HALL, MD 2 THREE RIVERS MEDICAL CENTER P O BOX 769 LOUISA KY 41230 | TIM ROBERTSON 13 ED NECCO & ASSOC. 307 COUNTY RD 120 S SOUTH POINT OH 45680 | |
| CORAZON CHUA MD 2 THREE RIVERS MEDICAL CENTER P O BOX 769 LOUISA KY 41230 | 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 | |
| PATTI MCCLAIN 7 D C B S PO BOX 1036 MOREHEAD KY 40351 | PATRICIA STINNETT 2 THREE RIVERS MEDICAL CENTER P O BOX 769 LOUISA KY 41230 | CAROLYN STEVENS 2 OLBH BEHAVIORAL HEALTH ST CHRISTOPHER DR ASHLAND KY 41102 | |
| DR LAURA SALYERS 2 ST CLAIRE MEDICAL CENTER 222 MEDICAL CIRCLE MOREHEAD KY 40351 | DAVID MEADE 2 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 | TERRI FISHER 2 KDMC BEHAVIORAL HEALTH 2201 LEXINGTON AVE ASHLAND KY 41101 | |
| KATHY LITTERAL 6 EASTERN KENTUCKY CORRECTIONAL COMPLEX 200 ROAD TO JUSTICE WEST LIBERTY KY 41472 | JOEL CYRUS 2 KDMC BEHAVIORAL HEALTH 2201 LEXINGTON AVE ASHLAND KY 41101 | DR VAUGHN ESKEW 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 2223 RAIN TREE CT ASHLAND KY 41102 | JIMMY AND JUDY MEADOWS 1 410 DAVEY RUN GRAYSON KY 41143 | |
| SHAWN CRUMP 15 ASHLAND INDEP. SCHOOLS PO BOX 3000 ASHLAND KY 41101 | DONNA HILLMAN DMHMRS DMHMRS 100 FAIR OAKS 4E-A FRANKFORT KY 40621-0001 | KAREN FRASHER 2 THREE RIVERS MEDICAL CENTER P O BOX 769 LOUISA KY 41230 | |
| CAROLYN WELLS 2 ST CLAIRE MEDICAL CENTER 222 MEDICAL CIRCLE MOREHEAD KY 40351 | | HB 843 – MEMBERS-AREA OF REP 7-07 | |

| 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 | REGINA THOMPSON 2 ST CLAIRE MEDICAL CENTER 222 MEDICAL CIRCLE MOREHEAD KY 40351 | THE HONORABLE JOHN COX 6 DISTRICT COURT ROWAN COUNTY COURTHOUSE MOREHEAD KY 40351 |
| ANDY & DEBBIE PENNINGTON 1 4341 PINE ST ASHLAND KY 41102 | ANN PERKINS 5 SAFE HARBOR PO BOX 2163 ASHLAND KY 41105-2163 | MIKE RELIFORD 3 THE DAILY INDEPENDENT 224 17TH ST ASHLAND KY 41101 |
| ANGELA ESTEP 7 DCBS - #401 1539 GREENUP AVE ASHLAND KY 41101 | LESA DENNIS 7 DCBS - #401 1539 GREENUP AVE ASHLAND KY 41101 | DENNY LOCEY 5 RAMEY-ESTEP HOMES 2901 PIGEON ROOST RD RUSH KY 41168 |
| DR STEPHEN GREENBERG 2 KDMC BEHAVIORAL HEALTH 2201 LEXINGTON AVE ASHLAND KY 41101 | MICHAEL CAPUTO 3 KDMC BEHAVIORAL HEALTH 2201 LEXINGTON AVE ASHLAND KY 41101 | |
| <u>PATHWAYS STAFF & BOARD OF DIRECTORS PROGRAM PLANNING/ EVALUATION COMMITTEE</u> | | |
| DEBBIE STEPHENS 4-15 ELLIOTT CO BD OF EDUC PO BOX 767 SANDY HOOK KY 41171 | TOM DAUGHERTY 4-15 ROWAN COUNTY SCHOOLS 121 EA SECOND ST MOREHEAD KY 40351 | SHARON MCDONALD 4-2 OLBH ST CHRISTOPHER DR ASHLAND KY 4 1101 |
| KEVIN HARRISON 4-5 CHOICES AND CHANGES 1401 WINCHESTER AVE #532 ASHLAND KY 41101 | WB SANDY SAUNDERS 4-13 103 LYCAN ROAD ASHLAND KY 41101 | LARRY ALLEY 4-15 595 HWY 3 NO LOUISA KY 41230 |
| MARC KELLY 4 PATHWAYS INC 325 EA MAIN ST MOREHEAD KY 40351 | MISTY WALTER 4 PATHWAYS INC 57 DORA LANE GREENUP KY 41144 | DR SAM WELCH 4 PATHWAYS INC 300 FOXGLOVE DR MT STERLING KY 40353 |
| <u>PATHWAYS INTEROFFICE MAIL</u> 4 DICK STAI, EXECUTIVE DIRECTOR MARIANN MULLINS, DUAL DIAGNOSIS GLEN ROWE, QI DIRECTOR | TODD TRUMBORE, ADDICTION DIR. LORA REYNOLDS, MH DIR., RET. VICKI GREENE, CRISIS MANAGER TIFFANY E-HANEY, MH COORD. | WALT HOLBROOK, COO TOM LEACH, CFO DEBBI BAILEY, WOMEN'S SUPVR. BOBBI WYMER, ADM ASST |

HB 843 Report Outline
Mountain Regional Planning Council – Region XI
Due July 2, 2007

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

Dennis Dorton, Chairman of the Board of Directors, MCCC

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

Milton Harvey

Linda Lane

Consumers of mental health and substance abuse services

Walter Lane

Homer Jones

Jacinda Boudle

County officials and business leaders

Barry Davis, Asst. Floyd County Judge Executive

Andrew Dorton, business leader

Health departments and primary care physicians

Bertie Kaye Salyer, Director Magoffin County Health Department

Kathy Hembree, Registered Nurse, 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, 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

Susan Howard, Regional Supervisor, DCBS

Educators and school personnel

Sharon Moore, Director Special Education, Pike County School Board

Tonetta Nichols, Martin County Family Resource Center

Diane Rudd, Director of REACH, Magoffin County faith-based organization

Mark Walls, Minister, First United Methodist, Prestonsburg, Kentucky

Regional interagency councils established under KRS Chapter 200

Shauna Moore, Chair RIAC, Protection and Permanency

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

Law enforcement and court personnel

Steve Little, Prestonsburg City Police Detective

James Blue Marcum, Assistant 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

Bonnie Hale, IMPACT Coordinator

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 (September, 2005)* Meetings were held with the above members to discuss ongoing needs and issues related to our region. Our RPC Chair, Dennis Dorton, addressed the HB 843 Commission and provided a summarization of our Regional needs January 2006.

II. Changes in Your 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.* None at this time.
- C. *Any significant changes in dollar resources.*

An increase in MR/DD crisis response funding was provided to our Region's Community Mental Health Center (CMHC) to provide crisis supports for our area. Crisis Stabilization Units (CSU) was provided equal funding as others across the State. Otherwise, all funding remains the same (as our costs continue to climb).

III. 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. We remain without any additional funding to cover the continued rise in cost of living and inflation. Mandated increases in KERS will cause further funding woes for our Region. The continued cost of providing services without appropriate funding prevents our Agency from expanding upon any services. We continue to provide more and more services to indigent clients as the needs in our area, especially substance abuse services, continue to rise. These problems continue to fray the already fragile "safety net".

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

Mountain has been chosen as a pilot site (with no additional funding allocated) to participate in an infrastructure enhancement project targeted on better ways to meet the needs of youth and their families in which the youth have both mental

health and substance abuse disorders. This project is based on the Reclaiming Futures Model. Through this process, staff at Mountain has had the opportunity to participate and complete training in 7 Challenges and the GAIN Training.

Collaboration, cooperation and communication among service providers: Mountain continues to maintain an Agreement with DCBS regarding referrals and sharing of information. A significant change is that now MCCC staff have developed and are implementing a coordinated process by which staff will train all new DCBS staff regarding the Agreement and services that are available through the CMHC. The goal of this project is work more closely with community partners in order for mutual clients to receive all needed services.

We have proposed in conjunction with DCBS and University of Kentucky a START project for Martin County. This project provides screening intervention and treatment services for families who have had or at risk for out of home placement of their dependent children under three years old.

The Victim Service Program continues to collaborate 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- All substance abuse staff have been trained in the Seven Challenges Adolescent Treatment Curriculum. MCCC will be a fully-licensed provider of this model by July 27th, 2007. The Agency will have a trained trainer on staff in this model. Two Agency staff are trained trainers in the GAIN assessment model. Additionally, two other staff have been trained in the use of it.

IV. Regional Responses to These Events or Influences:

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

The closure of psychiatric units at Pikeville Medical Center and South Williamson ARH has added to the difficulties we often experience when making voluntary and involuntary referrals. There are frequently no beds available for these referrals. Last month, several clients waited in ER's for involuntary commitment admissions. One woman waited 6 days at a local hospital before being transferred to Hazard ARH. This was a SMI (severely mentally ill) client with a history of extreme agitation and aggression. Other hospitals in our area, were full as well and could not assist. The delay in attaining treatment, especially for individuals meeting involuntary commitment guidelines, is of great concern to the mental health community as well as the general hospitals. The client continues to decompensate, while staff and family members try desperately to find suitable placement. Our state hospital frequently has no beds, even for our involuntary referrals.

B. Patients in ERs of hospitals without psychiatric units.

The ERs of hospitals without psychiatric units are not suitable placements for clients experiencing mania, psychosis, etc. They do not have trained staff or psychiatrists available to manage these patients for days at a time. Unfortunately, this problem is becoming more and more frequent.

C. Development of CSU services for both children and adults

We continue to expand the array of services provided at our CSU's. We have improved accessibility at both units for individuals with co-occurring disorders. We developed an Acquired Brain Injury (ABI) Addendum to our psychosocial assessment. In addition, we trained all agency supervisory staff on available services for client's with ABI. We now provide psychological testing at the CSU's, when indicated, to speed the process of qualifying for MRDD services. We frequently admit clients to the CSU from our residential substance abuse program to assist in stabilizing psychiatric symptoms. These clients generally return to the SA Program and complete their treatment there. We also frequently treat clients in psychiatric crisis first and then refer for SA treatment. We are also working in collaboration with MRDD's Crisis Response programming, the Crisis line and our on-call crisis evaluators. We are exploring the addition of intensive case managers to work with the ACSU and CCSU. The ACSU added a full-time Crisis Consultant to provide daytime jail triage and hospital consults, as well as, group and individual psychotherapy to ACSU clients. We also added a full-time CSU Psychiatric Nurse to cover both units. Our CCSU has greatly expanded their array of services through family and collateral therapy; and collaboration with DPP and the Family Court System.

D. Impact of DIVERTS in your region (if applicable); planning for DIVERTS II

We submitted our DIVERTS proposal on June 1, 2007. In addition to the placement of the tele-mental health system in our CMHC sites, we asked that this service also be provided to our three (3) county jails. This would greatly enhance our ability to provide psychiatric assessment and medication management to jail inmates. Approximately 35% of MCCC referrals to Hazard ARH this past year were involuntary commitments from the 3 county jails in region 11. We proposed the addition of two (2) intensive case managers to work with clients with SMI diagnoses, a history of incarceration and psychiatric hospitalizations. We also requested a Community Liaison/Trainer to work with our community partners, such as, county jails, law enforcement, court system, personal care homes, etc. We believe promoting a productive partnership and providing trainings like Crisis De-escalation, Positive Behavior Management and QPR would benefit mutual clients and result in fewer hospitalizations. More than 60% of our admissions to Hazard ARH are from jails, nursing homes and personal care homes. We also propose a Bridge Medication Fund to help buy psychotropic medications for clients during the interim of their qualification for other assistance.

E. CIT Training in your region; preparation for future training

At this point, CIT training is a future goal. Most of our law enforcement agencies do not view working with mentally ill individuals as a part of their role. This is despite the increasing numbers of individuals with mental illness currently

incarcerated. We hope that a Community Liaison would be helpful in this area. Also, we are optimistic that the Crisis Intervention Team Initiative will have a positive impact and perhaps trickle down somewhat to our local law enforcement agencies.

F. Medicaid: consumers' access to medications, impact of KY HealthChoices
Physicians report frustration at times over the prior authorization process required to get the clients' medications approved. The electronic notification system in place does help somewhat in notifying the physicians timely of new changes in prior authorization status of medications. However, there is still a considerable amount of time that lapses from the time the prescription is written until the client can pick up the medication(s).

G. Establishment of Recovery Centers, Drug Courts and other Substance abuse initiatives.

We have proposed an establishment of Family Courts in Floyd and Magoffin Counties. We've expanded the service base for all of our Drug Courts within our Region.

H. Workforce-recruitment, retention, training opportunities

Increased training opportunities for mental health professionals – Mountain employs a Training Coordinator which provides or arranges to provide required training (s) within the Agency. 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. This has the potential for clients to not receive the most up to date treatment available d/t lack of training.

Recruitment of psychiatrists is an ongoing problem with no relief in sight. Flat funding and lack of inflationary funding increases over time has had an impact in the recruitment of credentialed, experienced clinical staff.

I. 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. Mountain staff respond to ERs 24/7 to be with the victim and their family/friends through

the process at the hospital. This would include explaining processes and procedures, roles, and provide community resource information.

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

With the IMPACT Program, services can continue past the usual 18 year 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 period and updated in September of 2005.

- 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 the 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.
- Increase collaborative efforts among community partners.

B. Describe any changes in priority goals for your region. No changes.

C. What progress has been made toward achieving these goals? School-based services continue to expand within our regional area. During the past year there has been an improved effort on the part of both ARH Psychiatric Hospital and the three CMHC's connected to the hospital to address the recidivism rate and to appropriately divert unnecessary hospitalizations. There are three committee/advisory meetings held quarterly to improve the overall quality of care to clients. The Continuity of Care meeting addresses specific cases that have high rates of re-hospitalizations and looks at factors contributing to recidivism and develops better interventions to reduce these rates. An Advisory Council addresses policy and practices that impact the quality of care and keeps partners advised on new practices and policies that impacts client care, and attempts to improve the overall relationship and communication between these entities. The third is a Continuity of Care meeting for prescribers. This meeting brings together physicians and ARNP's along with administrators to address best practices and improve the communications among prescribers. Mountain provides tuition reimbursement to staff to further their educational goals.

VI. Your Recommendations

A. Describe your funding recommendations, including a description of changes in the availability of services in your region without increases in funding

In light of the problems associated with the Hazard ARH Psychiatric Center, there is a need for developing inpatient care. This could possibly be achieved by

shifting a portion of the current funding from the Hospital to the CMHCs. Additionally, there could be a significant impact made on the numbers of psychiatric admissions if the CMHCs if we were truly the gatekeepers for all psychiatric admissions to the hospital. CMHCs could utilize this funding to expand CSU services, decrease hospitalizations and reduce the recidivism rate for ARH hospitalizations.

If Centers are to implement best practices, there must be adequate funding to provide the necessary training, staffing and resources at the community level. Additional funding will be necessary to implement a statewide compatible electronic medical records system. Kentucky ranks one of the lowest funded states in the nation relative to mental health funding and in spite of the lack of adequate funding, the CMHCs continue to be a vital part of the “safety net” for our most vulnerable citizens, keep current on all new regulations, requirements and performance incentives. Adequate funding CMHC contracts statewide should be a priority for mental health, substance abuse and mental retardation services. The expansion of services will not be possible without additional funding. Additionally, without adequate funding to help offset current costs, services may become difficult to access by increased wait times to see the therapists and psychiatrists.

C. Describe recommendations for public policy changes to enhance the ability of the system of care to meet the behavioral health needs of consumers and families. Kentucky’s community mental health system is one of our greatest assets. It is our “safety net” system of care that provides licensed, monitored and audited quality services to our most vulnerable citizens. As we have seen the near demise of such services in so many other states, we, as caring citizens of the Commonwealth, should attempt to keep this very worthy system in place. This system should be adequately funded to fulfill all obligations to our communities and to the necessary 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”.

HB 843 Update Report July 2007

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KENTUCKY RIVER REGIONAL PLANNING COUNCIL
HB 843 UPDATE REPORT - 2007

A. Regional Planning Council Members and Their Area of Representation

- *Jim McDannel, Public / Private Education*
- *Charles Phillips, County Government*
- *Chris Gooch, Civic Organization*
- *Hill Smith, Public / Private Education*
- *Martin Douthitt, Business Owner*
- *David Mathews, Provider / CMHC Staff*

B. Activities of the RPC Since Your Last Updated Report (September 2005)

The Kentucky River RPC continues to emphasize efficiency and efficacy by keeping meetings to a minimum and combining efforts with the KRCC Board of Directors. Funds for planning are scarce in the face of declining state supports for community-based care while state facility budgets swell.

A. Significant Changes In Your Region's Demographics

None.

B. Changes in Community Indicators and Prevalence Rates; Significant Events

Recent federal reports have placed the Kentucky River region among the highest need region nationally for mental health and substance abuse services. Please refer to the attached DIVERTS II plan.

C. Significant Changes in Dollar Resources

This region continues to be successful accessing competitive federal grants and foundation grants nationally in the face of declining state resources.

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

A. Status Of The "Safety Net" And Addressing Gaps In Services

While the safety net services are in place, capacity and expansion issues remain.

B. Services for Specific Populations (Children, Elderly, Revolving Door, Deaf, Homeless, Dually-Diagnosed, Etc.)

Services for special populations continue to be a focus of federal and

foundation funding.

C. Collaboration, Cooperation and Communication Among Service Providers

Because of recent Robert Wood Johnson Foundation grants, progress is being made through Reclaiming Futures and Advancing Recovery.

D. Evidence-Based Practices and Focus on Recovery

The Kentucky River Region continues to be a leader in implementing evidence based practices using special grants and time limited funding sources. Sustainable implementation of these practice improvements requires long term funding increases.

A. Closure of Psychiatric Hospital Beds in Region (If Applicable)

None. Hospital beds remain full.

B. Patients in ERs of Hospitals Without Psychiatric Units

Access to emergency mental health consultation remains an important issue with these hospitals. Telehealth promises to alleviate some of these concerns in modern ERs.

C. Development of CSU Services for Both Children and Adults

Adequate resources still do not exist for adult mental health crisis services.

D. Impact Of DIVERTS in Your Region (If Applicable); Planning for DIVERTS II

Please refer to the attached DIVERTS II plan.

E. CIT Training in Your Region; Preparation for Future Training

The Kentucky River Region needs additional CIT training. Using interactive video training resources and teleconferencing is the current preferred means of accessing some training and avoiding down time and expensive travel costs.

F. Medicaid: Consumers' Access to Medications; Impact of KY HealthChoices

No current known problems.

G. Establishment of Recovery Centers, Drug Courts, and Other Substance Abuse Initiatives

Recovery centers are not yet operating in this part of the Commonwealth; therefore, their impact is unknown. Drug Courts continue to be a prime referral source although their funds for treatment are inadequate.

H. Workforce Development – Recruitment, Retention, Training Opportunities

Please refer to the discussion in the attached DIVERTS II Plan.

I. Integration of Mental Health and Physical Health Services and Management

KRCC was a pioneer in this area. As has often been said, pioneers were scalped significantly more often than the settlers who came later. KRCC discovered that the physical health services providers in the area are adamantly opposed to integrated services and still operate harboring attitudes of stigma toward behavioral health providers and clients.

J. 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 MR/DD services are transitioned in the same way. MR/DD staff are asked to participate in service team meetings to assure a smooth transition.

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 for your region.

C. What progress has been made toward achieving these goals in the past two years?

INITIAL GOALS CHANGES AND PROGRESS

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. New substance abuse services & support have been made available through Reclaiming Futures. Staff training has been available to all eight counties. 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. Epidemic has increased exponentially. Drug Courts and Unite have increased resources using time limited federal funds. 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.

New initiatives:

- *Project ADVANCE (Despite repeated efforts, have been unable to access funding for expansion into northern counties.)*
- *Cabin Creek*
- *EXCELL*
- *Reclaiming Futures Service Coordination*

INITIAL GOALS CHANGES AND PROGRESS

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. Access to housing funding is limited. KRCC has successfully established a flourishing housing program using tax credits, loans and other funds. Without skilled people, all other efforts 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. The PRISYM project with Eastern 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. 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. 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).

Goal 1: *Of the 10% of population, who abuse or are addicted to drugs, increase the number of adults who are accessing treatment options by 30%. Thru the Paths to Recovery project, access has been improved. For example: 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.*

Goal 2: *Reduce access to & use of opiates and other addictive, controlled prescription drugs by 20%. Operation UNITE increased access to jails.*

Goal 4: *Expand women's substance abuse service array to include service options & sites in each of the eight counties of the Kentucky River Region. Despite repeated efforts, KRCC has been unable to access funding for expansion into northern counties.*

Goal 1: *Increase by 40% the identification & referral for treatment of youth who may be abusing substances or who have key risk factors.*

- *Reclaiming Futures*
- *Collaborative work with the Letcher County Drug Court*

INITIAL GOALS CHANGES AND PROGRESS

Goal 2: Increase the number of substance abuse treatment program options for youth within the region.

- Riverbend has 16 beds.
- Cabin Creek has eight beds.
- Sewell Center has two beds.
- Outpatient staff have been trained in providing evidenced based and promising practice treatment models (Seven Challenges, CYT, Motivational Interviewing, Assertive Continuing Care)
- A new peer support group has begun in two counties – Life Challenges – based on the Seven Challenges model.

Goal 3: Increase the number of youth accessing treatment options by 50%.

- Reclaiming Futures
- Riverbend

Goal 1: Increase the number of adults accessing treatment by 10%. Specific programs have been successful at increasing admissions. However, the effect on the agency as a whole has not yet been evaluated.

Goal 2: Reduce adult hospitalizations & recidivism by 20%. Implemented use of LOCUS for all crisis evaluations to ensure appropriate level of care is utilized.

Goal 2: Reduce the incidence of youth substance abuse by 15% via effective prevention efforts. 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.

Goal 3: Increase by 30% the identification of children exhibiting risk indicators of mental health disorders. 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.

A. Describe your recommendations, including a description of changes in the availability of services in your region without increases in funding.

Please refer to the attached DIVERTS II plan. As long as Kentucky continues to operate from a 1950's perspective toward mental health and other disabilities, Kentucky's citizens will suffer from this lack of leadership. 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 Kentucky River Region HB 843 – 2007 Report Page 7
Kentucky River Region HB 843 – 2007 Report Page 8
industries exempt from the state sales tax. Eliminating protection to many sacred cow industries would generate much additional revenue. 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 to enhance the ability of the system of care to meet the behavioral health needs of consumers and families.

- Please refer to the attached DIVERTS II plan.
- 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.*
- *Reduce costs related to redundancy in reporting.*
- *Overhead cost in maintaining massive medical records.*
- *Support for integration of physical health and behavioral health.*

DIVERTS II

June 15, 2007

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DIVERTS II PLAN

Kentucky River Community Care, Inc.

June 15, 2007

Kentucky River Community Care (KRCC) presents this DIVERTS II plan with the hope that this initiative marks the beginning of a mental health system transformation for Kentucky and the Kentucky River region. Using a review of the literature and knowledge of the people and practices associated with mental health treatment success, this DIVERTS II plan outlines needed changes in the services system to decrease hospitalizations, increase jail diversions, decrease suicides, and reduce homelessness.

This DIVERTS II Plan identifies areas for system reform using Kentucky data comparisons from the Center for Mental Health Services (CMHS) National Outcome Measures Uniform Reporting System (NOMS). Kentucky is a state diverging from national norms in several critical areas. Current statewide policy results in limited access to mental health services for adults and children with serious mental illness. Kentucky's difference from National norms does not simply derive from inadequate fiscal appropriations, but also from the way policies divide the available appropriations and limiting access and quality of community based services. The major NOMS areas of Kentucky divergence are:

- 1) more resources committed to state hospitals than community care;
- 2) fewer evidence based practices being utilized;
- 3) more services and local resources devoted to persons with less serious illnesses;
- 4) lower support for jail services; and
- 5) lower support for homeless services

The KRCC DIVERTS II plan discusses the four foci of the plan, hospital diversion, jail diversions, suicides and

homelessness in the Kentucky River Region and presents compelling needs data which identifies the seriousness of these problems in the Kentucky River Region. Overriding contextual issues such as culture, community collaboration, access to services and workforce development highlight the need for comprehensive system transformation strategies. Administration and infrastructure changes focus on the needed policy shifts that must come to support and sustain a recovery model rather than a hospital based model of care. KRCC has developed the capacity and participated in demonstration projects to show that system transformation is possible even in remote rural regions of the state. Also described is a list of the most effective clinical strategies for impacting upon the four foci.

Clinical changes include mobile crisis outreach teams, improved and expanded case management; recovery focused community support system, integrated dual disorders treatment, crisis services embedded in day programs, jail diversion strategies through community intercepts, suicide prevention following the Kentucky Suicide Prevention Plan, and homelessness prevention through continuing KRCC model for housing expansion.

Financial considerations are outlined in a plan for parity in funding between hospital and community with gradual resources shifts or expansion over a several year span.

Major recommendations include:

1. Recognizing that 17 times as many people are served in the community for 36% of the total amount, adjust the division of funds between hospital and community to achieve parity through 50/50 funding.
2. Alternatives to incarceration and creating re-entry programs for the mentally ill can reduce crime, but increased jail based "in-reach" services come first to identify and connect inmates to treatment.
3. A suicide prevention program in the Kentucky River region with the goal of reducing suicides to the national average would save 15 lives each year.

4. Expanded affordable quality housing helps everyone.

During the past decade Kentucky River Community Care, Inc. has established itself as a leader and innovator in developing community based services for persons with serious mental illness and co-occurring disorders. Through its unique partnership with Mountain Comprehensive Care, Cumberland River Community Care, and Appalachian Regional Healthcare Hazard Psychiatric Center, a progressive model of a public private partnership for publicly contracted inpatient and community based services has been developed and tested. From the beginning the goal of this special partnership has been to avoid the unnecessary hospitalization of persons needing mental health services by contracting with a private hospital closer to the person's home and natural supports. Connecting the persons with community based agencies who can develop lasting relationships to support them in their own homes has the added benefit of providing linkages for crisis and aftercare services. Beginning in 1993, persons seeking hospital based mental health treatment were screened by the local community mental health center and placed at the 100 bed ARH-Hazard Psychiatric Center. The community mental health centers each had a cadre of qualified mental health professionals to determine if the person seeking care needed an inpatient level of care.

However, the availability of excellent psychiatric care in a brand spanking new community based inpatient psychiatric hospital fully staffed with psychiatrists, nurses, psychologists and social workers created a preference by the mental health consumer for hospital care, even when it may have not been warranted. Community screeners often have found it difficult to talk a community member out of going into the hospital since it costs them nothing, medicines were free, food was free. Sometimes the person knew the magic words to say about the entrance criteria involving suicidal or homicidal plans or threats. Consequently, hospital utilization has inched upward over the years. Monthly admission from the Kentucky River region often exceeds 120 persons with the average daily census being 60 persons or more from the KRCC region. The often quoted figure for the average public hospital mental health beds per 100,000 is 40 beds. In an area like Kentucky River where the entire adult population is less than 100,000 people exceeding the national average by 50% seems excessive. If the count of public psychiatric beds includes the Caney Creek rehabilitation Complex's 80 additional beds, most of which are occupied by persons from the Kentucky River Region, the case for over reliance on inpatient care becomes more distinct with the hospital utilization rate of 100

beds per 100,000 being approached. A business case for expanded community based care could be made since each hospital bed utilized costs between \$500 and \$1,500 per day per bed. The annual costs per bed becomes somewhere between \$180,000 and \$540,000. Community based care costs for even the most intensive services are a fraction of those figures. Reducing hospital utilization by the most modest amounts could save millions of dollars and provide much needed funding for the community if the dollars follow the person.

2.1 Purpose and Organization of the DIVERTS Plan

The DIVERTS II goal is to build community capacity in each region in order to appropriately and effectively meet the treatment needs of persons with mental illness and co-occurring disorders who are in acute distress. Some suggested ways of accomplishing this goal include: Gate Keeping Teams; Case Management; and Telehealth and e-contact technology; Crisis Stabilization programs. This Kentucky River DIVERTS II plan goes beyond just these four suggested means of accomplishing the DIVERTS goal. The Kentucky River plan looks at each focus identified by the DIVERTS creators and suggests ways to accomplish the goal based upon regional needs, available and expanded resources, and the best information from the scientific literature on the best practices in this area.

After examining the four foci in light of the Kentucky River Regional situation and needs, we examine the overriding contextual issues that impact all plans for all four focus areas. In addition, we examine aspects of system infrastructure which could be improved to address the focus areas. This means examining the use of technology and policy reform efforts which would aid in “Developing Administration and Infrastructure Changes as Strategies for Reducing Unnecessary Hospitalizations, Jail Placements, Homelessness and Suicides”. Included here are infrastructure issues such as Mental Health Court and Hospital Admission and Discharge policies. Based upon a review of the literature describing the types of clinical interventions which reduce hospitalization rates, we present a menu of services along with supporting documentation.

2.2 The Four Foci

2.2.1 Diversion from Inappropriate Hospital Admissions:

For Kentucky the numbers tell a clear story. Statewide the hospital admission rate exceeds the national average by 29%. In the Kentucky River Region the admission rate is the highest in Kentucky with 120 admissions per month or over 1,400 per year. The national average of 40 hospitals beds per 100,000 population is exceeded in Kentucky by

about 50% with over 600 licensed beds serving a state of 4 million people. Statewide about 7,800 persons are served per year in the state hospitals while over 130,000 are served in the community care system. Meanwhile 65% of mental health funding goes to the state hospitals with just 35% going to the community. Kentucky is one of the few remaining states where the majority of mental health funds go to the state psychiatric hospitals rather than the community support system where most people are served. This over reliance on expensive state hospital care limits the availability of community funds to provide supports which keep people out of the hospital. Twice the funding dollars go to inpatient care versus community care while nearly 17 times as many people are served in the community. The President's New Freedom Commission on Services and Supports for Persons with Serious Mental Illness makes community based care a national priority. The New Freedom Commission calls for a system transformation. Clearly a new emphasis on community based care for those persons with serious mental illness is needed in Kentucky.

2.2.1.1 Assessment of Regional Needs: The services to the people of the Commonwealth do exceed the national averages in some promising statistics. More people in every age group are served in the Kentucky mental health system than the national average. More people in each gender are served in Kentucky than the national average.

Overall the penetration rates in Kentucky exceed the national average by 70%. In the Kentucky River Region with a population of 125,000 people nearly 6,600 people per year are served by the mental health system or 52.8 per 1000 population, about three times the national average and nearly twice the Kentucky average. In the Kentucky River Region there is heavy community reliance on both the publicly contracted state psychiatric hospital and the community mental health center. The 100 bed ARH Psychiatric center in Hazard is usually filled to capacity with persons seeking treatment from the Cumberland River, Mountain and Kentucky River Regions. Usually about 50% of the beds are occupied by Kentucky River residents and 25% from each of the Mountain and Cumberland River Regions. The need for mental health services is so great in the economically distressed counties of southeast Kentucky that there is little current capacity for expansion in neither the hospital nor community systems.

Other data from state reports is even more revealing. The Commonwealth lags behind the nation in implementing evidence based practices such as supported housing, supported employment and

assertive community treatment. Nationally 5% receive housing supports, in Kentucky the figure is 1.6% or one third of the national figure. For supported employment the number is 2% nationally and 1.6% in the Commonwealth. Assertive Community Treatment, one of the most successful programs nationally for hospital diversion, often called the "Hospital Without Walls," shows the national rate for access is over six times the Kentucky rate (2% versus .3%). Following this discussion of the four foci is a presentation on the types of interventions which the scientific literature reveals as the most productive ways of diverting from inappropriate hospital care.

2.2.2 Diversion from the Criminal Justice System: The President's New Freedom Commission recommends widely adopting adult criminal justice and juvenile justice diversion and re-entry strategies to avoid unnecessary criminalization and extended incarceration of non-violent adult and juvenile offenders with mental illnesses. Further they have said: "Federal programs and State mental health authorities must capitalize on the many opportunities that already exist for financing core services for people with mental illnesses in contact with the criminal justice system." *Among these opportunities are:*

- Diversion programs to keep people with serious mental illnesses who do not need to be in the criminal justice system out of it."
- "Institutional services to provide constitutionally adequate services in correctional facilities..."
- "Reentry transition programs to link people... with illnesses to community-based services..."Without prioritized attention to individuals who cycle repeatedly through mental health, substance abuse and criminal justice systems true system transformation is impossible.

Across these three systems, professionals find themselves working with the same clients in a recurring cycle of contact. Markowitz (2006) in his major study "Psychiatric Hospital Capacity, Homelessness and Crime and Arrest Rates" found that hospital diversion negatively impacts crime and arrest rates. Furthermore jail diversion negatively impact hospital admission rates. Homelessness is increased by hospital diversion in most cities. The homeless are more often arrested than other persons. The KRCC plan for homelessness, hospital and jail diversion must consider the reciprocal impact on the other two factors.

2.2.2.1 Assessment of Regional Needs: For the past several years KRCC has provided assessment services at the regional jails and in one of them, Three Forks Regional Jail, KRCC operates a substance abuse treatment program. KRCC uses the APIC model when it assesses inmates' needs and develops treatment plans. Unfortunately too often KRCC does not have the staff nor is it called upon to

provide pre-release discharge planning. In an effort to improve jail-community coordination, KRCC formed a Criminal Justice Mental Health Planning Council in Perry County in 2006. That group meets monthly to plan improved services for those persons needing mental health treatment in the Kentucky River Regional Jail. Jail administrators estimate that 70-80% of jail inmates have substance abuse, mental health, or both problems. The APIC Model for serving persons re-entering communities from jails is a best practice approach. APIC stands for Assess, Plan, Identify and Coordinate. Described by Osher, Steadman & Barr (2002), they lament the fact that persons with mental illness frequently do not receive transition planning assistance prior to their discharge from incarceration. They believe the quality of the correctional-community behavioral health partnership is the key to effective transitional care. Good transition planning requires communication and role clarification among jails, jail based mental health and substance abuse programs, and community care givers. According to Osher et al., "Transition planning can only work if justice, mental health, and substance abuse systems have a capacity and a commitment to work together". The APIC model means that prior to release, there is: (1) An assessment of the clinical, social, and public safety needs and risks of the inmate; (2) Plans are made for treatment and services required to meet the inmate's needs; (3) Identifying required community and correctional programs responsible for post release services; and (4) Coordination of the Treatment plan to ensure implementation and avoid gaps in care.

The APIC Model

Assess Assess the inmate's clinical and social needs and public safety risks

Plan - Plan for the treatment and services required to address the inmate's treatment needs.

Identify - Identify required community and correctional programs responsible for postrelease services

Coordinate - Coordinate the transition plan to ensure implementation and avoid gaps in care with community based services.

The Kentucky Department of Correction publishes reports annually on the Inmate Profile and the Recidivism rates for releases from the correctional system. In the Recidivism Report for 1999-2000 statistics were presented that described the recidivism for male and female inmates.

Recidivism Rates Report for 1999-2000

Year Males Females Urban Females Non-Urban Females Drug Offenders

2000 28.1% 23.6% 24.0% 22.2% 28.7%

1999 30.6% 24.0% 26.8% 21.1% 31.6%

1989 31.9 20.2 20.4%

It is evident from these statistics that the recidivism rates for females are becoming more comparable to the male rates. While the urban versus non-urban rates remain different the rates for drug offenders and for younger females are quite high and trend toward higher rates. Interventions aimed at persons re-entering the community could change the direction of the statistics and reduce recidivism. The Perry County Criminal Justice Mental Health Planning Council has focused upon the intercept point in the criminal justice process, particularly prebooking intercepts. The model below comes from the GAIN Center.

The five jails in the Kentucky River Region are usually filled well beyond capacity. Only the new Leslie County Jail has capacity but that is because the entire facility is closed. Leslie County government does not have the funds to open it. Herein lies an opportunity for a forensic program if the funds were available to develop a special mental health services forensic facility. Area jail administrators report that 70 - 80% of inmates have a mental health, substance abuse or both illnesses. Current jail bed sizes, not counting excess beds, are: Knott – 18; Letcher - 80; Perry - 135; Leslie - 23; and Lee – 142 for a total of 398. Using the 80% estimate that means 320 inmates currently may need mental health or substance abuse treatment, or both. During a year's time the number could be expected to be over 1,000 persons who could be diverted if one assumes an average jail stay of 120 days. Below is a discussion of the KRCC plans for service expansion to the criminal justice system.

2.2.3 Reducing Homelessness: Beginning in the 1960's the United States experienced deinstitutionalization of the mentally ill. In 1960 there were 314 public psychiatric beds per 100,000 population compared with today's 40 beds per 100,000 population national average. In general there have been research studies to show that as public psychiatric hospitalization goes down, crime and homelessness go up. Cities with higher inpatient capacity have fewer homeless mentally ill on the streets. Homeless mentally ill persons are more likely to be arrested or to be victims of crime themselves. The Kentucky River Region plans to increase diversion of the mentally ill from the jails and the publicly contracted psychiatric hospital, but in doing so Homeless and Housing services becomes more critical to prevent increased crime and recidivism.

The President's New Freedom Commission report suggests that the goal of an individualized plan of care includes making housing supports widely available. The New Freedom Commission report states Research shows that consumers are much more responsive to accepting

treatment after they have housing in place. The commission recommends making affordable housing more accessible to people with serious mental illness.”

In 2003 the Kentucky Council on Homeless Policy (CHP), recognizing a lack of coordinated policy priorities to address homelessness, decided to focus on collaborative prevention efforts as a key to reducing the number of people who experience homelessness. Their resulting statewide homeless prevention plan identifies existing institutional barriers that can contribute to or exacerbate homelessness and makes recommendations on specific problems or barriers identified within existing programs.

They list goals and recommendations related to Coordination, Planning, Procedures, Training, and Funding. Among their recommendations are, “Increase resources and collaboration for staff assisting clients being discharged from state institutions.” During the past decade KRCC has focused efforts on the development of housing resources and increasing accessibility to person with mental health and other disabilities. Following are the results from housing needs assessments and housing development plan development activities. KRCC continues to make progress in the Housing Services area. KRCC has five emergency apartments available for homeless mentally ill persons.

KRCC has developed staffed residences for persons with developmental disabilities. In addition KRCC has developed apartment buildings in 6 of our 8 counties. Currently KRCC has 73 apartment units available with current expansion plans for an additional 34 units. This will bring the total to 112 KRCC units. Currently underway are plans to develop housing units in the remaining counties when property is located elsewhere in the region in 2008 and 2009.

2.2.3.1 Assessment of Regional Needs: Several years ago KRCC undertook an analysis of housing needs data that compared counties on numerous dimensions related to the cost, availability, condition, occupancy rates, age, type of structure and numerous other housing related factors. The following map depicts the results of the analysis of housing needs. In general the southeast part of Kentucky has the most serious need for improvements to the housing stock in the state.

2.2.4 Reducing Suicides Among Persons with Serious Mental Illness: Nationally the suicide rate hovers around 12 per 100,000 people. In Kentucky the rate is generally about 10% higher

than the national rate. In the Kentucky River region the suicide rate is **the highest in** the state and about 50% higher than the national rate (19.7/100,000 vs. 12/100,000).

Reports from the Kentucky Suicide Prevention Group and the Centers for Disease Control indicate suicide is a preventable public health problem. Knowledge of the risk and protective factors help develop a local plan for suicide prevention.

Risk Factors: The first step in preventing suicide is to identify and understand the risk factors. A risk factor is anything that increases the likelihood that persons will harm themselves. However, risk factors are not necessarily causes. Research has identified the following risk factors for suicide (DHHS 1999):

- Previous suicide attempt(s);
- History of mental disorders, particularly depression, history of alcohol and substance abuse;
- Family history of suicide;
- Family history of child maltreatment;
- Feelings of hopelessness;
- Impulsive or aggressive tendencies;
- Barriers to accessing mental health treatment;
- Loss (relational, social, work, or financial);
- Physical illness;
- Easy access to lethal methods;
- Unwillingness to seek help because of the stigma attached to mental health and substance abuse disorders or suicidal thoughts;
- Cultural and religious beliefs—for instance, the belief that suicide is a noble resolution of a personal dilemma;
- Local epidemics of suicide; and
- Isolation, a feeling of being cut off from other people.

Protective Factors: Protective factors buffer people from the risks associated with suicide. A number of protective factors have been identified (DHHS 1999):

- Effective clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support for help seeking
- Family and community support
- Support from ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation instincts

2.2.4.1 Assessment of Regional Needs: Following are tables and maps which highlight the difference between the KRCC region and the rest of Kentucky:

In rural southeast Kentucky there are several additional contextual issues which must be considered when examining the four foci that are a part of this plan. These are the type and availability of the local workforce, access to care in distressed counties, cultural issues in Appalachia, and community agency collaboration.

3.1 Workforce Development

Access to a well trained competent workforce in the Kentucky River Region is a particularly acute issue. While the state regulators continually impose more credentialing restraints and regulations, the supply of staff that are aware of the requirements and credentials is diminishing. KRCC Human Resources Department reports that at any given point in time there are 30-35 job vacancies at KRCC. Advertising a vacancy often produces no qualified applicants. This is not a problem unique to eastern Kentucky, although the problems are more acute here.

In a SAMHSA report (2007), the Action Plan for Behavioral Health Workforce Development states: "Across the nation there is a high degree of concern about the state of the behavioral health workforce and pessimism about its future. Workforce problems have an impact on almost every aspect of prevention and treatment across all sectors of the diverse behavioral health field. The issues encompass difficulties in recruiting and retaining staff, the absence of career ladders for employees, marginal wages and benefits, limited access to relevant and effective training, the erosion of supervision, a vacuum with respect to future leaders, and financing systems that place enormous burdens on the workforce to meet high levels of demand with inadequate resources.

"Most critically, there are significant concerns about the capacity of the workforce to provide quality care. The majority of the workforce is uninformed about and unengaged in health promotion and prevention activities. Too many in the workforce also lack familiarity with resilience- and recovery-oriented practices and are generally reluctant to engage children, youth, and adults, and their families, in collaborative relationships that involve shared decision-making about treatment options. It takes well over a decade for proven interventions to make their way into practice, since prevention and treatment services are driven more by tradition than science.

The workforce lacks the racial diversity of the populations it serves and is far too often insensitive to the needs of individuals, as they are

affected by ethnicity, culture, and language. In large sections of rural America, there simply is no mental health or addictions workforce." These workforce development issues must be addressed as part of any DIVERTS plan.

3.2 Access to Care in Distressed Counties

The mountains of eastern Kentucky pose their own barriers to accessing treatment. Many persons most acutely needing services live in remote areas isolated from easy access to any services including basic human needs such as decent housing, food, educational and vocational opportunities. Since severely mentally ill persons may have known only their remote mountain road and their family group, moving to another location is not appealing because of removing them from their natural support system.

Transportation is a factor since having an automobile is usually necessary or a family member willing to drive the person for treatment. There is no public transportation system except for those on Medicaid. Even then 72 hour advance appointments are required. Outreach is more difficult because many staff are not familiar with the remote areas of the region; finding the person where there are not house numbers or street signs can be a daunting task. Staff are frequently intimidated by traveling to a client's home and then transporting a hostile stranger in their own vehicle. Some poverty areas appear threatening by the abandoned vehicles and piercing stares. Penetrating these remote areas of the region is necessary for effective services such as assertive community treatment to occur. Case managers have to go out in pairs which cause greater costs. Traveling to a willing client's house and picking them up for an appointment and then returning them home can take most of the day for two people. These type issues must be considered in rural mountainous areas.

3.3 Cultural Sensitivity

The rich Appalachian culture of eastern Kentucky is a distinct cultural minority even though total population exceeds 22 million across all Appalachian states. Susan Keefe anthropologist of Appalachian State University calls Appalachians the "reluctant ethnic" because they are more likely to identify themselves as simply "Americans." The Appalachian language, music, religious practices, art, crafts, history, life style and family values are rooted in ethnic traditions going back centuries. Behavioral health providers have to be knowledgeable and open to the culture and treat the behavioral health client with dignity and respect. Because of the shortage of educated and trained professionals, particularly psychiatrists, the behavioral health clinician

often comes from outside the region or even the country, causing a cultural divide that is a barrier to effective treatment. For example the religiosity can be seen by someone outside the region as a symptom rather than a cultural tradition. Behavioral health professionals are best prepared for serving people from Appalachia when they are Appalachians themselves. So it becomes imperative that development of behavioral health professionals from the region is necessary for long term success with the clients. Short term infusion of funding or staff is often not enough to sustain the improvements gained on the short term.

3.4 Community-Agency Collaboration

Since the behavioral health problems are rooted in social, economic, political, educational, health and community differences, effective efforts to improve the lives of persons with mental illness can not occur without a collaborative effort. The social networks and social capital of Appalachia are strong in the family unit, but weak when it comes to strangers working together across historic boundaries. Still, collaboration between behavioral health, law enforcement, juvenile justice, courts, medical professionals, and other organization is critical to success of this plan. The standing joke is about the guy who comes to a meeting and says, "I am from the government and I am here to help you." Local folks remember the battles between federal tax agents and bootleggers, election investigators, the war on poverty missionaries, and others who often want values change or behavior change in organizations that are not interested in change. For diversion from jails and hospitals to happen consistently and on a long term basis, trusting relationships between partners have to be developed. Sometimes developing these partnerships and the level of trust necessary to institute and sustain change takes longer in appalachia than other regions where strangers collaborating with strangers are more commonplace.

4.1 Use of Technology

Kentucky River Community Care, Inc. plans to expand the use of technology in all aspects of the human endeavors involved with delivering the services discussed in this plan. The types of technology being discussed and referred to here include cell phones, e-mail, telephony such as auto reminder systems, e-therapy, telehealth, electronic records systems, websites, text messaging, video conferencing, and the use of computers in clinical assessments, analysis, and treatment planning.

4.1.1 Current Status: One goal identified for system transformation by the New Freedom Commission is that technology be used to access

mental healthcare and information. The New Freedom Commission recommends:

“Use technology and telehealth to improve access and coordination of mental health care, especially in remote areas or in underserved populations.” KRCC has been a leader in the development of telehealth technology and information technology in Kentucky. KRCC has invested heavily in the equipment and infrastructure within its region to be able to do telehealth and electronic medical records systems. There is more work that needs to be done. KRCC has a VoIP phone system that uses T1 lines connecting the eight county offices. This advanced Cisco IP phone system also is video capable and is routinely used for telehealth between medical staff. KRCC has also been testing MegaMeeting for use between providers and telephony system for follow-up. Most offices have computer networks for medical records and administrative purposes. Progress is underway to establish electronic medical records systems using the Avatar system from NetSmart.

4.1.2 Current Resources: KRCC has hundreds of computers, web cams, and a variety of software designed to make use of these technologies. The Information Technology Department at KRCC has 10 trained professionals who work to make the technology accessible, reliable, and easy to use. Technology becomes outdated as soon as it is purchased and installed. Although the use of technology improves behavioral health access and quality, it perpetually must be maintained and replaced. KRCC has an interagency technology planning group which meets bi-weekly to plan and implement technology solutions.

4.1.3 Timeframes: SFY '08, Biennium SFY '09 – '10

4.2 Recovery and Regional and State Policy Reform

In order for Kentucky to achieve a transformed mental health system as the President’s New Freedom Commission envisions, it will be necessary for major policy shifts to occur at the state, national and local levels. The following table shows that Kentucky has policies in place that prevent resources from being focused on persons with serious mental illness. State mental health authorities around the country focus resources and policies on those with mental disabilities rather than those persons better able to access care through other service systems. Kentucky’s rate is one half the state rate for adults and two thirds the national rate for children. Foremost among these policy changes is the statewide adoption of the recovery model for treatment of mental illness. The recovery model puts the client and family members in the forefront along with peer based services and personal responsibility. A medical based hospital model prevents communities and the state from adopting a recovery model.

4.2.1 Use of NIATX Model for Change: As long as the policy shift around hospital diversion, jail diversion, suicides and homeless does not occur at the state and local levels, taxpayers' funds will be spent disproportionately on those persons easier and less costly to treat in the community. Seriously ill persons will continue to be treated in hospitals, resulting in the most expensive and least effective mental health system possible. Since 2003 KRCC has been involved with the Robert Wood Johnson Foundation on several projects, most notably the NIATX program or the Network for the Improvement of Addiction Treatment. Process Improvement strategies are at the heart of the NIATX approach to systems change. KRCC is fortunate to have become a part of this national network and now knows how to change policies on the local and state level so those most effective changes are successfully implemented. Through a partnership known as the Partnership for Advancing Recovery in Kentucky or PARK, KRCC is working with ARH Hospital, Chrysalis House, and the Department of Mental Health to make policy changes that are a barrier to services. KRCC would use this strategy to implement DIVERTS II. This progressive system for policy reform and process improvement also can be transferred to other regions and at the state level. Too often policies exist which are barriers to quality care and prevent the implementation of evidence based practices.

4.2.2 Hospital Admissions and Discharge Policies: The theory and practice behind hospital admissions and discharges of clients varies. Theoretically, KRCC is the gatekeeper for hospital Admission to the publicly funded psychiatric unit at ARH-Hazard. Frequently high percentages, as much as 50% of the admissions occur without KRCC assessment for the appropriate level of care. Furthermore hospital discharge policies do not dictate release or KRCC involvement in discharge planning. Consequently about 50% of those persons discharged from the hospital do not receive follow-up after care services from KRCC.

4.2.2.1 Hospital Admissions Policies: Admission policies need to be changed to require KRCC assessment for the appropriate level of care on 100% of those persons receiving treatment there. Without certification by KRCC that the Inpatient level of care is required, the hospital should not be paid for the care by the state. Persons with less serious disorder who can be treated in the community should not receive their services in the hospital, the most expensive and least effective venue for these services.

4.2.2.2 Hospital Discharge Policies: By the same token persons receiving hospital services should be assigned a community case

manager the day of their admission to the hospital, who begins working as part of the treatment team to plan the discharge from the hospital to community based care. Without cooperative discharge planning for all hospital patients, progress on hospital diversion will not occur.

4.2.3 Mental Health Court: Jurisdictions around the United States have found that specialized mental health courts staffed by judges and attorneys who know community resources and understand the importance of hospital and jail diversion are more effective than overburdened criminal court judges. These specialized courts work closely with local officials to assure community safety and the health and well being of those persons coming before it. The court also makes it possible to follow and track persons using the power of the court to assure compliance with court orders. Prevention of community disasters such as what occurred recently at Virginia Tech are more likely using Mental Health Courts.

4.2.4 Involuntary Outpatient Commitment: While Kentucky's law concerning involuntary commitment for mental health treatment includes the possibility of outpatient commitment, this practice does not occur frequently because the current law requires agreement by the patient to the practice. A Mental Health Court should be able to better manage cases involving involuntary outpatient treatment.

4.2.5 De Novo Proceedings for Psychotropic Medications and KYMAP: While psychotropic medications aid in the recovery of persons with serious mental illness, courts are reluctant to use this mechanism. Another more valuable means of achieving medication adherence was demonstrated by the use of the evidence based practice of using medication algorithms. In Kentucky the national demonstration project was called KYMAP for the Kentucky Medication Algorithm project. When the prescribed medication helps the person recover with minimal side effects, medication adherence is increased and de novo proceedings are not necessary. Mental Health Court personnel can help determine causes of medication nonadherence and refer the persons for algorithm changes.

5.1 Mobile Crisis Outreach

Researchers have identified mobile crisis outreach as the most effective means for reducing inappropriate hospital admission. Researchers in Italy write that studies show that mobile crisis outreach reduces hospitalization by 50%.

5.1.1 Current Status: KRCC currently provides emergency crisis services at its outpatient facilities during the business day, and at the ARH Hospital in Hazard after hours and on weekends.

5.1.2 Current Service Data: No evaluations are being provided at the police stations, other hospitals, physicians' offices, sheriffs' departments, or at the homes of clients. Few evaluations are conducted at the jails.

5.1.3 Current Resources: On call staff provide access to emergency care after hours and on weekends at the limited locations mentioned earlier.

5.1.4 Community Need Estimate and Priority: In order for mobile crisis outreach to occur a team of clinical staff would need to be available to travel to the location where they are needed. Since the geographic region is so large two teams may need to be available. Potentially current emergency services personnel could be trained to provide the services as a part of the existing emergency health response system.

5.1.5 Plan for Development: There are no current plans for developing this type of expanded emergency response capacity. The benefits of having such a team available would also extend to suicide prevention, jail diversion, homelessness prevention as well as hospital diversion.

5.1.6 Goals: Develop a mobile crisis response team for the Kentucky River Region.

5.1.7 Objectives: Decrease suicides, inappropriate arrests, and inappropriate hospital admission by 50%.

5.1.8 Timeframes: Fiscal Year 2008 - Develop Plans. Fiscal Year 2009 - Receive Funding and Begin Operations. Fiscal Year 2010 - Decrease Admissions by 50%.

5.2 Housing & Homeless Services

5.2.1 Current Status: KRCC has developed apartment buildings in 6 of our 8 counties. Currently KRCC has 73 apartment units available with current expansion plans for an additional 34 units. This will bring the total to 112 KRCC units. Currently underway are plans to develop housing units in the remaining counties when property is located elsewhere in the region in 2008 and 2009.

5.2.2 Current Service Data: All apartments remain occupied nearly all of the time. Exceptions occur when tenants are waiting on a housing voucher or other tenant based rental assistance. While these situations may delay occupancy, the housing units stay above the 90% occupancy rates.

5.2.3 Current Resources: KRCC relies on a variety of housing supports and subsidies that are available through various Kentucky Housing Corporation programs. KRCC has been involved in tax credit housing develop, Safehaven, Section VIII, McKinney Act and PATH/Emergency Shelter grant housing programs. In short, if an opportunity exists to develop housing KRCC investigates it.

5.2.4 Community Need Estimate and Priority: The following

table presents an analysis and plan for housing development in the Kentucky River region. For each type of housing environment, current capacity and need are presented, along with an estimate of priority and cost for development.

Service Environments and Housing Service Development Plan

Kentucky River Community Care, Inc.

David Mathews, Ph.D. KRCC, Inc.

Plan for Development: KRCC has plans to develop additional units in 2008 and 2009 totaling approximately 72 units. The major barriers have to do with land that is suitable for construction and the availability of craftspeople who can construct quality dwellings.

Goals & Timeframes for FY '08, FY '09 – FY '10: Planning continues for forty (40) new apartment units in 2008 and 32 more, including single family homes, in 2009.

5.3 Integrated Substance Abuse & Mental Health Treatment

Comparing national statistics with Kentucky's rates for identifying and treating persons with co-occurring mental health and substance use disorders show that they are roughly equivalent, and both wrong. Epidemiological data from the National Survey of drug Use and Health and SAMHSA data show the rates of co-occurring mental health and substance use disorders if several times the rates being treated.

5.3.1 Community Current Status: In the Kentucky River Region there are the highest national rates of both substance abuse and emotional distress according to the National Survey on Drug Use and Health reports. Because of heroic efforts by local, state and national governmental authorities progress is being made addressing the drug problems of eastern Kentucky. Much of the attention has focused on interdiction and law enforcement of the illegal sale of prescription drugs. KRCC has received a federal grant from SAMHSA to provide substance abuse and mental health services to a group of the most severely ill persons. This SAMHSA TCE/METH grant is called Assertive Community Treatment for Appalachian Dually Diagnosed Adults (ACLADDA). Using assertive community treatment teams and integrated dual disorders treatment approximately 120 persons will be served annually. KRCC also received an evidence based practices grant from the Kentucky Department of Mental Health to provide staff training for both the community and hospital staff by David Mee Lee, MD, an international expert in treating these disorders.

5.3.2 Current Service Data: Currently there are 45 clients receiving ACLADDA services with 10 new cases being added each week.

5.3.3 Current Resources: The CSAT TCE/Meth grant is \$500,000 per year for three years ending in 2000.

5.3.4 Community Need Estimate and Priority: The number of persons being served by the ACLADDA is approximately 25% of those needing services. If there are currently 1,200 persons with serious mental illness receiving services from KRCC and 80% of them have co-occurring substance abuse and mental illness as the research literature suggests, the another 840 persons need to be a part of ACLADDA among those currently receiving services.

5.3.5 Plan for Development: Seven additional ACLADDA teams are needed to meet the existing level of need in the region.

5.3.6 Goals: Have available to every person with co-occurring disorder in the region special integrated dual disorders treatment services.

5.3.7 Objectives: Increase the number of ACLADDA teams by 2 each year for the next three years.

5.3.8 Timeframes: FY '08, FY '09 – FY '10:

5.4 Community Support Services

5.4.1 Current Status

- TR Facilities in 6 Counties, Serving all 8 Counties
- Case Managers Active in TR Centers
- Psychiatric Services in TR Centers
- Individual & Group Therapy Available in TR Centers
- Access to Community Resources Available
- TR Collaboration with Community Agencies to Provide Educational and Health Services for Consumers
- Consumer Internet Access at TR Centers

5.4.2 Current Service Data

- ☐ Providing Service to 76 Consumers

5.4.3 Current Resources

- In-House and Community Transportation
- DMH Funding for Indigent Consumers
- Caney Creations
- Internet Availability

5.4.4 Community Need Estimate and Priority

- Increased Funding for Supported Employment Services
- Community Awareness
- Social and Recreational Services

5.4.5 Plan for Development

- Train Peer Specialist
- NAMI

5.4.6 Goals

- Create Peer Support Specialist Position
- Increase Average Daily Attendance by 10%
- Obtain Funding for Social and Recreational Activities for Consumers

5.4.7 Objectives

5.4.8 Timeframes: FY08, FY09-FY10

- *FY '08:*
- Create Peer Support Specialist Position
- Train Peer Support Specialist
- Increase Average Daily Attendance 5%
- *FY '09 – '10:*
- Hire Peer Support Specialist
- Increase Average Daily Attendance 5%

5.5 Crisis Stabilization and Day Hospitals

5.5.1 Current Status

- Bailey Center
- 8 Bed, 24/7/365 for Adults in Crisis
- Clinical Coverage- 7 days per week
- Psychiatric Coverage- 5 days per week, with on-call services on the weekend

5.5.2 Current Service Data

- Between the Dates of 5/1/06-5/31/07, 294 Clients were served

5.5.3 Current Resources

- Psychiatric Services
- Clinical Coverage
- Nurse on Staff
- Local Hospital for Medical Coverage
- Outpatient Clinic on Campus
- TR on Campus

5.5.4 Community Need Estimate and Priority

- Transportation
- Step Down from Psychiatric Center

5.5.5 Plan for Development

- Psychiatric Coverage On-site 7 days per week
- Increase Average Daily Census
- Improve Training for Staff to Handle More Serious Crisis Situations
- Day Programs and Day Services
- Specialized Training for Developmental Disability Crisis
- Hire Outreach Worker

5.5.6 Goals

- Increase Availability of Transportation
- Decrease Hospitalization by Increasing Average Daily Census
- Provide Increased Crisis Training
- Clinical Coverage until Midnight
- 7 days per week Psychiatric Coverage On-site
- Day Programming

5.5.7 Objectives

- Decrease Psychiatric Hospitalization by 5%
- Increase Number of Clients Transitioning from Crisis Services to Outpatient Follow-up by 10%.

5.5.8 Timeframes: FY08, FY09-FY10

- FY '08:
 - Develop Day Program
 - Provide More Intensive Crisis Training
 - Provide Developmental Disability Specific Training
- FY '09 - 10:
 - Increase Average Daily Census
 - Implement Day Program

5.6 Jail Diversion, Treatment and Re-Entry Programs

5.6.1 Current Status: Programs related to or directly targeting jails are diverse and vary according to county and size. Our correctional system has both regional and local jails, each with their own level of sophistication regarding treatment of individuals with a Serious Mental Illness (SMI). Our primary tasks common to all the jails is diagnostic assessment and crisis management. We also contract for substance abuse services at one regional jail.

5.6.2 Current Service Data: KRCC continues to assist jail personnel to divert individuals from the jails to the appropriate level of care. One key obstacle is individual transportation. Individuals lack the necessary transportation to access the appropriate level of care. KRCC entered into agreements with each county's police force to transport individuals to central locations for appropriate mental health care evaluation and consultation.

The number of transports for Fiscal Year 2007 through May 2007 is approximately 182 with costs totaling \$28,662. Without this funding and combined community effort, these individuals would remain in the jails and not receive the appropriate level of care. The number of emergency evaluations through May 2007 is 1,886. Of these:

- 935 were seen after hours;
- 51 were seen at the jail;
- 182 were transported from the jail;
- 15 were diverted back to the jail; and
- 492 were referred to ARH.

KRCC also has a special arrangement with the Three Forks Regional Jail in Lee County, through which we have served 86 individuals through May 2007.

5.6.3 Current Resources: Current resources for jail diversion are influenced by our regional characteristics of a very limited number of police officers, geographical complexity, poor access to existing community based programming, and heavy reliance on arrest and jail as the first order of options. Community alternatives to detention are limited.

Another key expenditure for diverting individuals from the jails are on-call fees for evaluators. The cost estimated for Fiscal Year 2007 is \$69,762. KRCC has a 24 -hour toll-free Crisis Line for individuals to access for assistance in diverting from the jails. The estimated cost for the Crisis Line and staffing of this Crisis Line is \$82,642. Other direct costs relating to jail diversion include client transportation provided directly by KRCC staff at \$16,702 and Evaluation Salaries in excess of \$102,000.

5.6.4 Community Need Estimate and Priority: The actual number of individuals with SMI or co-occurring disorders housed within the jails is speculative, though what is becoming widely accepted is that jails are housing agencies for these populations. Therefore, the pressure of providing adequate health care and treatment is forcing the corrections system to seek more appropriate action and assistance from the larger community. One example for which numbers can be extrapolated, at least for the SMI population, is that of the approximately 540 monthly inmates at one regional jail, 150 individuals more or less would have a serious mental illness requiring more effective screening and diversion. A speculative annual number of individuals eligible for diversion would approximate 1,200.

5.6.5 Plan for Development: Developing an effective diversion plan for the region requires consensus among correctional, judicial, and behavioral health organizations. Collaborative planning must precede small system adjustments in order for those adjustments to be effective and sustainable.

5.6.6 Goals: The consequent development plan would have as a goal the development of systemic changes regarding the value of diversion and the benefits for the community health.

5.6.7 Objectives: The objectives include community-based alternatives to jail as well as training related to assessment and triage for decision makers and "front-line" professionals. The development of institutional supports through policy and procedural changes, with the assistance of the courts, would actively improve the chance of successful diversions.

5.6.8 Timeframes: FY '08, FY '09 – FY '10

5.7 Suicide Advocacy, Education, Marketing, & Community Mobilization

A basic recommendation of the New Freedom Commission was "Swift action is needed to prevent suicide." They recommend the National Suicide Prevention Strategy be implemented in every jurisdiction.

5.7.1 Current Status: KRCC has several trained suicide prevention professionals. These staff have been trained in a national model for suicide prevention known as QPR, or Question, Persuade, Refer. Staff and community members receive training from the KRCC certified

suicide prevention experts on how to use the QPR approach with clients, friends, and community. KRCC has a 24 hour crisis hotline with staff knowledgeable about suicide prevention techniques. On call staff are available to respond 24/7/365.

5.7.2 Current Service Data: KRCC staff conducts emergency evaluation 1368 times each year. Suicide prevention and risk assessment is a part of every admission and the psychosocial assessment process. 368 persons each year are admitted to the crisis stabilization unit.

5.7.3 Current Resources: No resources are currently earmarked for suicide prevention and education activities. Additional funds need to be allocated for full time suicide prevention staff to do training and education among healthcare providers, teachers, behavioral health providers, law enforcement, emergency services personnel, and the community at large.

5.7.4 Community Need Estimate and Priority: Presently 20 to 30 preventable deaths occur every year in the KRCC region because of suicide. To decrease the number of deaths due to suicide to the national average would mean saving 15 lives each year.

5.7.5 Plan for Development: The plan for KRCC is to have dedicated suicide prevention staff who would investigate the cause of every suicide in the region, and conduct training and education activities aimed at reducing the deaths due to the causes they identify.

5.7.6 Goals: Reduce the Kentucky River regions suicide rate to below the national average.

5.7.7 Objectives: Reduce the number of suicide death by 15 persons each year by conducting training and education, awareness, and prevention activities in all counties in the region.

5.7.8 Timeframes: FY '08, FY '09 – FY '10: Hire staff and begin prevention services in FY2008, reduce suicides by 5 in FY2009 and by 10 in FY2010.

5.8 Case Management

5.8.1 Current Status

- 13 Adult Case Managers- Outpatient
- Does not include Special Programs
- Billable to Medicaid or DMH only for CMI
- Wrap Around Funds from annual DMH allocation.
- Breathitt County/Case Management Assistant Wolfe County/Case Management Assistant

5.8.2 Current Service Data

- Providing Case Management Services for 628 Clients

5.8.3 Current Resources

- Wrap Around Funds, When Available
- Community Action
- Christian Appalachian Project

- Local food banks
- Methodist Mountain Mission
- Local charitable organizations
- LKLP
- MKRADC
- Daniel Boone Transit

5.8.4 Community Need Estimate and Priority

- Housing
- Transportation
- Additional Wrap Around Funds

5.8.5 Plan for Development

- One Vacancy in the North
- Development of Case Management at ARHPC
- Piloting Case Management Outreach Workers in Breathitt and Wolfe Counties

5.8.6 Goals

- Incorporate Use of Outreach Workers Region wide
- Increase Access to Safe Affordable Housing
- Improve Transition Between Levels of Service
- Decrease Hospitalization

5.8.7 Objectives

5.8.8 Timeframes: FY08, FY09-FY10

- FY '08: Pilot Case Management Assistants
- FY '09 – '10: Spread Case Management Assistant
- Access to Affordable Housing
- FY '08: North
- FY '09 – '10: South

6.1 Current Resources

The DIVERTS II initiative will be the foundation of which the community, the Community Mental Health Centers and the Psychiatric Hospital will transform the current system to meet the community based services need and to improve the quality of life for individuals by reducing hospitalizations, divert mentally ill persons from the jails, reduce suicides, and reduce homelessness.

It will be necessary to establish interventions, community collaboration networks and transportation systems to reduce the numbers of individuals needing the most restrictive level of care, hospitalization. The measurement strategy determining the success of the DIVERTS II initiative will be driven by having the total gate keeping responsibility within a single point of entry system that must be solely the responsibility of the Community Mental Health System. Without the full gate keeping responsibility, the measurement of the success of this program will not be obtainable.

Currently, the financial resources do not hinge upon the KRCC gate keeping actions and diversion activities. The community capacity and resources are not sufficient to meet the needs of a transformed system. Rerouting or additional dollars must become available. The following table compares Kentucky mental health system expenditures by level of care versus the national averages. Kentucky spends 35% on community care versus the national average 51%. As long as more money is available to the most restrictive levels of care the community capacity will not be able to match the need.

6.2 Additional Budgetary Requirements

In FY 2006 KRCC utilized \$13,013,316.00 for mental health services. It is anticipated that a bed at a Psychiatric Facility costs approximately fifteen hundred dollars (\$1500.00) per day. Therefore, a 100 bed facility cost a minimum of \$54,750,000.00. Approximately 50% of admissions are from the KRCC region. Therefore, fifty percent of \$54,750,000.00 totals \$27,375,000.00. To reduce admissions and achieve parity with a 50/50 level of funding between hospital and community, it will be necessary for the additional funding to be shared with the Community Mental Health System. KRCC contributed \$13,013,316 to mental health service in FY 2006. Therefore, reducing the cost of \$27,375,000 by \$13,013,316, the amount to be shared would total \$14,361,684. This amount includes Medicaid and all other funds. KRCC would hope that in FY 2008 35% would be made available to the Community Mental Health System totaling \$5,026,589.00, in FY 2009 40% totaling \$5,744,673.00 and in FY 2010 50% totaling \$7,180,842.00.

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CUMBERLAND RIVER REGION 13 REGIONAL PLANNING COUNCIL REPORT

OUTLINE

- I. Features of Region XIII Planning Council (RPC)
- II. Changes in Region's Needs, If Applicable
- III. Your Service System Description
- IV. Regional Response to These Events or Influences
- V. Behavioral Health Goals for Your Region
- VI. Your Recommendations

I. FEATURES OF REGION XIII PLANNING COUNCIL (RPC)

- A. Planning Council Members and Areas of Representation
- B. Describe activities of the RPC since your last updated report (September 2005)
Region XIII has moved forward in many areas the past two years. The second class of Certified Professional Counselor Associates graduated at the London and Harlan programs. Lindsey Wilson College is now offering a Bachelor's degree in Human Services at London. Union College began offering a Masters degree in Clinical, Counseling and School Psychology in the Fall of 2006. Union is also in the process of accreditation for their Social Work program. Union and Lindsey Wilson have developed a curriculum that meets the 270 clock hours of classroom instruction as part of the requirement toward CADC certification.

An eleven-unit apartment complex has been completed in Harlan. Chad's Hope Center, an 80 bed all male recovery center is under construction in Clay County and the Harlan Recovery Center, a 100 bed all female center has broken ground in Harlan. New Drug Courts were implemented. School-based services for children have expanded throughout the Region.

Project Unite continues to fund many services in the Region.

II. CHANGES IN YOUR REGION'S NEEDS, IF APPLICABLE

A comparison of the Region XIII (Cumberland Valley) demographics (including community indicators and prevalence rates) that existed two years ago with those that currently prevail indicates that there continues to be an increasing need 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 (CMHC) alone has experienced a 28% increase in its consumer census over the past five years, as well as an even greater increase (67%) in service volume.

Unfortunately, and with few exceptions, during the past two years there have still been no appreciable changes in funding availability for behavioral health services. As it was noted two years ago, the proponents of House Bill 843 had been an effective force in the funding of the CMHC's much needed crisis stabilization programs for children and adults. While the funding for those programs have shown some increases over the past few years they have not kept pace with the rising costs associated with the gradual increasing consumer utilization. The expenses for fiscal year 2007 are expected to exceed DMHMRS funding by approximately \$100,000, with 90% of those expenses occurring in the adult program. 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.

Recently, (for fiscal year 2007 and again for the upcoming 2008 fiscal year) a fairly significant funding increase occurred for the Cumberland River Comprehensive Care Center's (CRCCC) Rape Crisis program. An increase of approximately \$60,000 per year was allocated to meet the increasing service utilization needs for rape victims by more than doubling the number of qualified therapists available to provide these services and to provide 5% salary increases to aid in the retention of skilled clinicians and to upgrade the quality of their services by providing them with new computers. Currently, there is a rape victim counselor in every office in the CRCCC's service catchment area ready to meet these service needs.

The high unemployment, lack of public transportation and the rural area greatly influence the ability of consumers to find employment or meaningful activities that promote recovery to the person with a severe, persistent mental illness. With these contributing factors influencing the opportunities for our population in the recovery phase, the Cumberland River Comprehensive Care Center and the consumers find value in Therapeutic Rehabilitation Programming for persons who are diagnosed with a mental illness. The Center currently has approximately 450 consumers enrolled in TR programs in all of its eleven service sites within the region, which have average daily attendance that range from 10 to 40 consumers per day. These programs, along with the therapeutic effects of anti-psychotic drugs, have been a stabilizing force that has allowed these persons to function reasonably well in their home communities for many years now since the de-institutionalization movement occurred.

A demographic comparison of Region XIII with all other regions of the state reveals that this region continues to be 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 continues to be 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 continue to meet the challenges and service needs that lie ahead in behavioral health without adequate monetary support. Providers of these services in Region XIII continue to be 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.

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.

III. YOUR SERVICE SYSTEM DESCRIPTION

Adult behavioral health services are available in all eight counties served by Region XIII. Each site in the eight county area offers outpatient services, case management and therapeutic rehabilitation services, and children's services. Additional services are:

- 15 HUD apartments for adults with severe, persistent mental illness (11 apartments in Harlan County and four apartment in Whitley County).
- An eight bed Adult Crisis Stabilization Unit in Laurel County.
- A 14 bed Transitional Living Unit in Whitley County for adult with severe

mental illness who are unable to live currently independently.

- A ten bed Transitional Living Unit in Harlan County.
- An eight bed Children's Crisis Unit in Laurel County.

By having an outpatient office in each of the eight counties, most residents are within 25 miles of a point of service delivery. In a rural area, there are a number of factors that make inclusion of the Community Mental Health Center a crucial part of the safety net. A combination of isolated areas, limited public transportation, a lack of providers, both medical and psychiatric and high rates of poverty all impact the residents. Often the inclusion of a service such as case management has a profound effect on the overall access to resources and treatment. The growth of consumers and the increase in services within Region XIII has required the center to expand clinical services in all offices. Additional therapists have improved the access and availability for services in Adult Behavioral Health and Rape Victim Services. Additional funding in Rape Victim Services has expanded the number of persons serving victims from four clinicians to twelve clinicians for FY 08.

Often there have been gaps in services for specific populations but efforts to address these gaps are underway. In the past, some groups such as dually diagnosed have had limited treatment resources. Currently, in each of the outpatient offices, a senior clinician who is skilled in both mental health and substance abuse issues has been identified as the co-occurring clinician. Another treatment philosophy being employed is there is "no wrong door" to treatment. Individuals who enter our programs do not have to defer treatment on one area to access treatment in an equally important problem. Integrated treatment views the person as a whole and not a collection of unrelated diagnoses. There is less hand-off communication issues with this approach as one clinician is familiar with the client and his spectrum of needs. Clients feel more in tune with their treatment provider, as it doesn't require them telling their story over and over again.

Region XIII continues to collaborate and partner with our many community partners. Cumberland River Mental Health/Mental Retardation Board, Inc. believes that all children should have access to mental health services. Based on the past history of children's services in rural Southeastern Kentucky, children and families have had many obstacles and barriers to overcome for children to receive consistent mental health services. Even though each county in the region has an outpatient office for services, families have not always been able to get their children in for services due to lack of transportation, lack of finances (services are not a priority due to trying to meet, basic needs in home), or parents unable to miss work for scheduled appointment. 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.

This past fiscal year, we have provided school based services in 91 public schools in the region. Due to the connection with local universities, to provide advanced degrees locally, the number of mental health professionals for school-based services has improved. CRCCC has 62 CFI's (Child/Family Interventionist) serving schools with our eight county region.

Involvement with Department of Juvenile Justice Children's services continue to work on communication, collaboration and involvement with DJJ throughout the region. The Regional Interagency Council and the Local Interagency Councils in the region are represented by DJJ.

This past quarter Children Services has been asked by Kentucky Youth First (a division of the Dept. of MH/MR/SA) to participate in a pilot project with the National

program "Reclaiming Futures". . Each of the communities that accept the invitation will be asked to identify a juvenile court judge and seven other local leaders who represent the following agencies and areas: Department for Juvenile Justice: Court Designated Worker; Division of Protection and Permanency; Department of Education; the Community Mental Health Center's adolescent substance abuse and co-occurring treatment provider(s); and the community. At the end of this process our community will have a clear understanding of local needs of teens involved with the juvenile justice system with drug and alcohol problems and good knowledge of available treatment and community resources. Kentucky Youth First will work with CRCCC to begin the process of strategic planning. Later in 2007, we will also have an opportunity to apply - along any other interested community across the country - to join a planned new national effort called the Reclaiming Futures Learning Collaborative that will help spread the Reclaiming Futures model.

This project will give the region the opportunity to develop a Fellowship Change Team, which will focus on adolescents with substance abuse issues. The team has been formed and began meeting in May.

Children's Services staff has been trained in "Seven Challenges" a national evidence based practice. CRCCC have plans to look at developing an Intensive Outpatient Program for adolescents with substance abuse using this model. There have also, been discussions of turning two of the ten beds at the Crisis Stabilization Unit into substance abuse beds. We will continue to explore these areas due to the apparent need in our region.

IV. REGIONAL RESPONSES TO THESE EVENTS OR INFLUENCES

A Closure of psychiatric hospital beds in region.

There has not been any closure of psychiatric hospital beds in the region. The agency attempts to use the Adult Crisis Unit as an alternative to hospital care in most instances and is in the process of developing a Diverts II project. The difficulty with the Diverts project is that currently the ADA of Haven House is seven with an eight-bed capacity. It will be difficult to divert many more individuals in crisis to the unit if the bed utilization continues. If additional funding became available, the agency would like to create a four-bed unit in Harlan County. This would help serve an area that is a significant distance from the current unit.

B. Patients in ERs of hospitals without psychiatric units.

The agency does not have an accurate count of the number of clients in psychiatric crisis seen in the local ER without a psychiatric unit. Currently, the hospitals are referring individuals who are in a psychiatric crisis and needing hospitalization on a mental health inquest warrant. If the Diverts II project is approved, the agency would like to move the after-hours evaluation site to the Crisis Stabilization Unit. This would assist in diverting a person in crisis to the appropriate level of services based on identified need. As stated earlier, there is a significantly limited access to hospital beds in general and psychiatric beds are further limited. In the eight county area of Cumberland River, there are only eight hospitals and two have a psychiatric inpatient facility. The regional state psychiatric facility is located in Hazard, K.Y. From our closest office it is over forty miles to the Hazard facility. Obviously, with such a limited access to psychiatric beds, emergency rooms in medical hospitals often are "defacto" psych units. Relationships between the facility and the local mental health center are crucial. Despite the hospital's best efforts to make appropriate referrals, many clients leave the ER with instructions to go the CMHC but never show up.

C. Development of CSU services for both children and adults.

The adult and children's crisis stabilization units are utilized fully by the agency and other referral sources. Both programs are valued services the agency offers as it affords families and individuals to be treated near their home without leaving

the area.

D. Impact of Diverts.

The agency has developed a plan for Diverts II without any monies. If monies became available, significant changes would occur. (See Proposal) DIVERTS will be implemented in fiscal year 08. Modeled on successful programs in other parts of Kentucky will work to accurately assess and refer to the most appropriate level of treatment. One of the benefits to the state will be to reduce costs of inpatient psychiatric treatment by serving the client in a less intensive setting. Along with the jail triage system, individuals referred to our center have improved access to the most appropriate treatment setting.

E. Preparation for CIT training.

Currently, the agency would have to work with local law enforcement as to the number of sheriff s department who would be interested in this training. Many of the departments are short staffed and under funded. Laurel County has the highest number of individuals served with a mental health warrant. Several of the counties do not have sufficient staff to pick up a person on a petition in a timely fashion.

F. Medicaid.

Consumer's access to medication has gone through some adjustments but most of the consumers are able to access the appropriate medication to treat their mental illness. Information from Medicaid as to the approved formulary and restrictions has been useful.

G. Establishment of Recovery Centers, Drug Courts and other Substance Abuse Initiatives. New programs in development such as the 100 bed female Recovery Center in Harlan and Chad's Hope Center in Clay County, Seven Challenges, and Reclaiming Futures will address other service needs. The Seven Challenges program is a nationally recognized program utilizing evidence based treatment practices. Historically, we have a record of providing quality treatment services but with the Cumberland Hope Center, LLC, we will be able to address the long term recovery needs of the participants such as job training, education development and other life skill building activities. Vocational assistance will be a major feature to facilitate entry to the workforce and maintain gainful employment. Enhancement of educational status and participation will be a keynote feature. Currently, there are educational initiatives underway with Union College and Lindsey Wilson College. In particular, both colleges will be offering courses that will lead to Certified Alcohol and Drug Counselor (CADC) certification which will fill a chronic shortage of trained substance abuse treatment specialists. Continuing education programs with other agencies such as UNITE will be co-sponsored.

The Recovery Center is an excellent example of collaboration and co-operation between state and local government, community activist groups, and the CMHC. The local UNITE coalition identified a need for long term substance abuse treatment and began to work with the local fiscal court to secure a site and resources. Funds and support for the recovery program were already allocated by three state level programs. CMHC staff had been involved from the initial phases of planning for the program and was designated as the general operating partner. Staff training will be provided by agreements with other programs that currently offer long term recovery services. Individuals who have completed these programs will be placed in the recovery program to give continuity of care and troubleshoot any developmental problems encountered. On a day to day basis, there is a significant level of inter-agency collaboration. Clinicians in out patient and residential programs routinely involve other programs such as DCBS, Drug Court, transportation services such as RTEC, and other health providers including ARH and other medical programs in providing for client needs. Memorandums of understanding exist between CMHC and numerous other entities.

Accountability is a hallmark of our services and more evidence-based practices (EDB) are being delivered in treatment services. The substance abuse staff has participated in training to employ Motivational Interviewing techniques. Currently four program directors have been given initial training in Seven Challenges techniques. Nationally recognized for being an EDB, the program will be employed primarily with adolescents who are abusing substance. Besides the Recovery Center, the substance abuse program has some exciting initiatives for the next year. Currently and in the upcoming year, CRCCC's Substance Abuse and Children's Services are involved in a pilot program with Kentucky Youth First. The program is working with "Reclaiming Futures" on the national level in looking at community assessment and readiness for this best practice model. As a result of the work with Kentucky Youth First, staff have been trained in the "Seven Challenges" treatment modality and will be able to initiate the model into practice. By participating in the pilot project, the region will have the opportunity to increase substance abuse and mental health treatment. As we increase our access to services, we have looked at the possibility of developing two of our existing ten beds in the Children's Crisis Stabilization Program, "Turning Point" for adolescent substance abuse. Continued participation with the legal system will continue with programs for DUI offenders and Drug Court. DUI services are available in every center. Close coordination with the court and other providers maintain accountability and treatment effectiveness. Drug Court continues to be a stellar performer in the substance abuse program. Individuals are referred from the court system and given a second change. Courts are available for both adults and juveniles. In 2008, plans are to continue to operate eight adult courts and three juvenile court programs. Clients referred from out of region are accepted if appropriate for our services and many attend our residential substance programs.

H. Workforce-recruitment, retention, training opportunities.

The agency currently is understaffed in psychiatric services. Additional psychiatrists are needed and difficult to recruit to a rural area. A JI Visa is a long process and requires significant advance preparation. Area colleges offer advanced behavioral health degrees.

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

The agency has recently hired a nurse practitioner that is performing physicals for all residential programs. This has increased the agency's ability to treat 10 individuals both for their mental health needs but also for their physical health needs. Many individuals do not seek out treatment for their physical health needs or they may seek out too many opinions for their health needs. This opportunity has afforded the agency to the ability to identify, treat and refer individuals when needed.

Additionally, the agency reviews with each client the current medications they are taking from any providers and any over the counter medications. This process assist the clinician, psychiatrist or the ARNP in identifying any current physical health issues that are being treated by the client's physician or those issues being self-treated. The integration of physical health needs with the mental health needs continue to be an issue and an ongoing performance improvement initiative. CRCCC 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 was 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, and etc. CRCCC served at the rural site in McKee, Kentucky in Jackson County at the Whitehouse Clinic. The clinic saw approximately 1,500 children last year by the pediatrician. They estimate that 10% of those children need mental health

services. Even though the grant has ended, we continue to work closely with the Whitehouse clinic in providing mental health services. Children are seen in our school-based program, home visits and in our out patient clinic. The supervisor of the area's school-based clinicians meets monthly with the pediatrician to follow up on services, issues or referrals. Continued focus on referrals and family involvement is a priority.

J. Addressing issue of children "aging out" of youth services.
CRCCC 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. We will continue to explore ways to expand this service.

V. BEHAVIORAL HEALTH GOALS FOR YOUR REGION

Briefly describe the top goals set by your Regional Planning Council for the initial 2001 - 2003 time period and updated in 2005.

- ◆ 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.

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- ◆ 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 80-bed treatment facility in Clay County will assist with some of the unmet residential treatment needs of substance abusers in our region. 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. The agency in partnership with Cumberland Hope Community LCC in Harlan County will be operating a 100-bed recovery center for women.

Chad's Hope Center and Cumberland Hope Community LCC are currently under construction.

New priorities include the Diverts II proposal, the CIT proposal, additional housing units, additional drug courts, increasing the number of psychiatrist practicing throughout the region and continued expansion of behavioral health graduate and undergraduate programs.

VI FUNDING RECOMMENDATIONS

A. There has not been an increase in State General funds or Medicaid for core services (psychiatry, outpatient counseling, group counseling and TRP) in many years. Increased costs continue to erode CMHC's ability to meet increased demand for services. It is essential that the State provide the funds needed to care for these individuals.

The Legislative Research Committee recently did an in-depth review of community mental health centers. They found a large growth in individuals served over the last five years with a net decrease in funding. Their conclusion is

that consumer needs cannot be met at current funding levels.

As cost rise (cost of living increases for employees, employer's portion of KY Retirement, health insurance, gasoline, utilities) our ability to provide services will decrease.

It is our recommendation that the State address the needs it has identified in its own study.

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B. Public policy needs to address mental health, mental retardation and substance abuse as it does physical health, education and employment. These are some of our most fragile individuals who cannot always speak for themselves.

C. Diverts II and the CIT funding proposals should be given high priority.

13 CUMBERLAND RIVER REGIONAL MH/MR BOARD, INC. DIVERTS II Plan

An emergency is defined by the American Psychiatric Association as "an acute disturbance of thought, mood, behavior or social relationship that requires an immediate intervention as defined by the patient, family or community. A psychiatric emergency is then defined as a set of circumstances in which 1) the behavior or condition of an individual is perceived by someone, often not the identified individual, as having the potential to rapidly eventuate in a catastrophic outcome, and 2) the resources available to understand and deal with the situation are not available at the time and place of the occurrence.

The Cumberland River Mental Health/Mental Retardation Board served 14,620 Individuals. These individuals received 386,836 services during the Fiscal Year 05/06. The agency welcomes an opportunity to address the needs of our consumers and members of the community in order to prevent unnecessary hospitalizations, suicides, and homelessness of those affected by co-occurring disorders and inappropriate use of the jails. During Fiscal Year 05-06, the agency evaluated a total of 701 clients for a total of 856 evaluations. Seventy five percent (75 %) of those evaluated were involuntarily hospitalized at Hazard Regional Hospital Unit, but only 34% of the total admissions (voluntary and involuntary) were active clients with the agency.

In order to serve the citizens of our community in a more effective manner, the Cumberland River Comprehensive Care Center would like to implement the attached strategies for reducing hospitalization, if there are additional funding streams.

Needs identified through HB 843

- Individuals in crisis often opt to seek out care in the local hospital emergency rooms. During this time of crisis, the person may be agreeable to community options and not under the provisions of KRS 202A statutes.
- Individuals who are being served in private Support for Community Living Programs are often involuntarily hospitalized when there is a disruption in their behavior or living situation.
- Resources are needed to assist other community agencies in dealing with persons who are in psychiatric crisis, but not meeting the criteria for a Mental Health Warrant

Values:

- Individuals and their families who are in crisis wiii tend io seek

community options if they are successfully treated in a community setting.

- Both timeliness and responsiveness to clients needs are important, especially when dealing with depression and potential suicides.
- In order to successfully intervene and provide treatment to a person in crisis, the crisis response team (clinicians) must help the client to identify reasons that functioning in the community has become too difficult, to recruit support and to address the challenges that precipitated the crisis.
- Rapid response by a Qualified Mental Health Professional is crucial.
- Individuals seen in crisis are to be evaluated as to treatment options locally available.
- Collaboration and jointly working with other providers or community agencies will reduce friction and, overall, improve the situations for the individuals (and their families) that are in a crisis.
- Communication will improve among all community providers.
- Families will be more receptive to the process and will view the treatment options in a favorable manner.

Goals:

- Establish a gate-keeping entity to review and determine if community alternatives are appropriate.
- Establish a decision tree to determine when a person is referred for inpatient care. The initial screening process determines the need for immediate intervention to protect the client or others recognizing that suicidal ideation does not necessarily result in involuntary hospitalization.
- Establish a centralized point for QMHP evaluations to occur that has a community placement options "at hand" so that this becomes the expeditious options
- Establish an entity that can oversee and when necessary, conduct intensive outpatient treatment during periods of assertive hospital diversion.
- Establish a protocol for all individuals to be screened for any cooccurring physical illnesses within 24 hours of admission to a community alternative.
- Establish a method for immediate access to medications for consumers placed in the Diverts Program (Crisis Unit), when necessary.
- Establish a fund for medication purchases when other funding avenues are not available.
- Establish a protocol for the housing coordinator to work with consumers on obtaining appropriate housing upon discharge.
- Establish a collaborative agreement with providers of Community Living Supports to assist in determining appropriate services for adults with developmental disabilities who are in crisis.

Objectives:

- Hire a Qualified Mental Health Professional to function as the Crisis (Diverts) Director. Target Date: July 1, 2007
- Hire a second Qualified Mental Health Professional to function as the Crisis (Diverts) Co-Director by Dec. 30, 2007.
- Revise the CRCCC Policies and Procedures regarding the 202A Evaluations to mandate that all 202A Evaluations will be conducted at the CCSP after hours and on weekends, unless the petition is initiated during a period of preexistent medical hospitalization or incarceration. Target Date: Oct. 31, 2007
- By Oct. 31, 2007, all qualified mental health professionals will be trained in the revisions of the after-hour/weekend evaluation site and the purpose of the Diverts Program.

- By July 1, 2007, hire an Advanced Nurse Practitioner to conduct physical exams at the Crisis Unit and prescribed medications.
- Notify all law enforcement entities in the CRCCC area of the revision of after-hours/weekend evaluation site. Target Date: Sept 30, 2007
- By Oct. 31, 2007, trainings will be conducted between all providers of crisis services on dealing with crisis situations and diverting individuals into community options.
- By Oct. 31, 2007, develop a program to track all individuals seen for crisis evaluations and the disposition of their crisis. The initial goal is to divert 10 % of those evaluated.

Future Goals if additional Funding were available:

The Cumberland River Comprehensive Care Center serves a large geographical area. Due to the area, many consumers who reside in the Harlan area have difficulty with transportation or accessing the current crisis stabilization unit without assistance in transportation. (The current means of transportation is provided by the Crisis Unit.) The addition of a 4 bed unit would assist in serving individuals who did not want to leave their current geographical area and increase the accessibility of care. To adequately fund this endeavor, the agency would need \$300,000 to start up an additional crisis unit in the Harlan area.

The attached budget is for staffing and cost related to increase in the transportation and staff time (both the agency's staff and the sheriff's staff) for FY 08 funding. Additional monies would have to be spent to move the current emergency line to the Crisis Unit. This cost would be approximately \$1,000.00 for the phone line.

DIVERTS PROGRAM

Cumberland River Regional MH/MR Board, Inc

July 1, 2007~June 30, 2008

Personnel

Licensed Clinical Social Worker @ 1.0 FTE 44,522.00

Advanced Nurse Practitioner @ 0.4 FTE 21,525.00

Certified Psychiatric Nurse @ 1.0 FTE 30,649.00

B.S. Degree Intake Worker @ 1.0 FTE 24,000.00

Three (3) Techs (part-time staff) 42,000.00

Total Salary Cost 162,696.00

Fringe Benefits @ 25% of Salary (FT staff) 30,174.00

Fringe Benefits @ 10% of Salary (PT staff) 4,200.00

Total Fringe Benefits 34,374.00

Total Personnel Costs (Salary plus Fringe) 197,070.00

Operating Expenses:

Staff Travel 2,500.00

Increased Payment to Law Enforcement 7,200.00

Increased Payment to Law Enforcement (for travel) 25,000.00

After Hours QMHP Travel for 202A Certifications 10,000.00

Equipment and Supplies 8,000.00

Telephone and Utilities 6,000.00

Miscellaneous 730.00

Total Operating Expenses 59,430.00

Administrative Cost @ 10% 28,500.00

Total Proposed Budget Amount \$ 285,000.00

HB 843 Regional Planning Council Report Outline Region 14 - Adanta

I. Features of Your Regional Planning Council (RPC)

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

Family Members

Marsha VanHook
Charlotte Stogsdill

Consumer

Kathleen Earls
Chestlene Popplewell
Greg Stogsdill

County Officials

Carrie Wiese, Attorney, City of Somerset

Health Department & Primary Care Physicians

Peggy Tiller
Claude Tiller

Advocates & Community Organizations

Karen Bristow
Kristi Kennedy
Brenda White
Beverly Hargis

Educators & School Personnel

Dr. Steve Mitchell, Somerset Community College
Kathy Hall

Regional Interagency Councils

Law Enforcement & Court Personnel

Tiffany Finley, County Judge Representative
Darwin Harris, Pulaski County Jail Staff
Tony Ball, McCreary Jailer

Facility Service Providers

Cathy Epperson, CEO, Adanta
Rod Thayer, Somerset Mental Health
Chris Deitzel, Lake Cumberland Regional Hospital
Rod Pyland, Lake Cumberland Regional Hospital

Individual Service Providers

Kim Reynolds
Nancy Thayer

Chair Designees/Coordinators for HB Effort

John Bolzé, Adanta Board of Directors Representative, Lake Cumberland
Regional Planning Council Chair

Cathy Settle, Clinical Director, Adanta

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

Susan Wilson, Child & Family Services Director/Asso. Clinical Director,
Adanta

Judy Wilson, Prevention Services Director

- E. Describe activities of the RPC since your last updated report (September, 2005)

The Lake Cumberland Regional HB 843 Planning Council has held the following meetings:

- June 13, 2006 - topics of discussion were:
 - NAMI Report Card
 - Legislative Update
 - Foundation for a Healthy Kentucky
 - State HB843 Nominations
- April 20, 2007 - topics of discussion were:
 - DIVERTS
 - Latest Statewide HB 843 Meeting/Updated Plan
 - 2007 Legislative Update
 - Crisis Intervention Team (CIT)
- May 30, 2007 – topics of discussion were:
 - DIVERTS
 - Progress Report to Statewide HB 843 Commission

II. Changes in Your Region's Needs, if applicable

A. Any significant changes in your region's demographics

No significant changes in the region's demographics.

B. Update changes in community indicators and prevalence rates; significant events. There are no changes in the community indicators and prevalence rates.

The Homeless Point in Time Study conducted within the region in February 2007 indicates there are over 300 homeless individual within the region.

F. Any significant changes in dollar resources

There are no significant changes in the dollar resources. However, the cost to provide services has continued to increase with no increase in state general fund dollars for 15+ years and flat Medicaid rates for 5+ years.

III. 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 organization has outpatient clinics in the ten county region which is the “safety net” for individuals in the region needing services. The Crisis Stabilization Units for adults and children also play a role in the “safety net”. There have been no significant changes in the service array. However, the status of the “safety net” is eroding due to flat funding in state general funds for 15+ years and no increase in Medicaid rates for 5+ years.

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

At this time the clients who meet the diagnostic criteria for severely mentally ill and are homeless have access to the PATH housing program. When appropriate for referral, this population can also be referred to the Safe Havens Program. The Safe Havens Program also serves those homeless clients who are victims of domestic violence and families with children. The CMHC is currently able to offer limited housing resources to clients who are homeless, who are severely mentally ill and in a jail or a psychiatric hospital through the Homeless Prevention Pilot Project. This program also serves youths who are aging out of foster care. Clients who are eligible can also be placed on a waiting list for the Tenant Based Rental Assistance Program (TBRA). This list is based on those meeting criteria for the highest need. The TBRA program currently has a long waiting list. During the last homeless point in time study conducted in February 2007, over 300 homeless individuals were identified within the region. All the programs identified have limited funding which limit the number of homeless clients that can be served.

- Collaboration, cooperation and communication among service providers

The organizations within the region collaborate on several levels regarding client care and services offered. The Community Mental Health Center (CMHC) collaborates with other providers on an individual client basis. At the regional level DCBS and the Community Mental Health Center meet monthly to ensure open lines of communication and to assist in the client referral process. There is also collaboration with other organizations for substance abuse prevention efforts and victims services programs. Currently NAMI has two active groups in the region. They assist in connecting the issues surrounding the severely mentally ill client with the community. They also provide support to families of individuals with severe mental illness. UNITE has established coalitions in three counties of our region that are in the UNITE congressional district. There is communication and collaboration between the various UNITE programs and the community mental health center regarding treatment of individuals with substance abuse problems. Adanta staff are active in these UNITE coalitions. Adanta Chief Executive Officer is Chair of the Medical Advisory Committee and Adanta

Substance Abuse Director is Co-Chair of the Treatment Committee of the Pulaski County UNITE Coalition.

- Evidence-based practices and focus on Recovery

Every CMHC staff employed has received training on evidenced-based practices. The Mental Health and Substance Abuse Therapists at the clinics within the ten counties are utilizing evidence-based practices in therapy services they provide. Evidence-based practices are shared with other service providers who may be involved in an individual's treatment. Other organizations are also made aware of the organization's commitment to the use of evidence-based practices. The CMHC also has a Peer Support staff who utilizes evidence-based practices in the support services she provides to clients.

IV. Regional Responses to These Events or Influences:

A. Closure of psychiatric hospital beds in region, if applicable:

Since the closure of the adolescent psychiatric unit which was located in Pulaski County, there had been no adolescent psychiatric beds in the region for several years. All adolescents requiring hospitalization are required to drive several counties away from their home to receive this level of treatment.

B. Patients in ERs of hospitals without psychiatric units

The patients being seen in the hospital ERs without psychiatric units frequently contact the local Community Mental Health Center offices for aid in making psychiatric referrals. The ERs also utilize the KRS 202A process to ensure the person is evaluated by a Qualified Mental Health Professional for mental status and referred for psychiatric inpatient treatment when indicated.

C. Development of CSU services for both children and adult:

The CSU services have allowed adults and children access to a 24-hour level of care without the need for a hospital setting. The clients being served at the CSUs receive psychiatric evaluation and individual therapy in a supervised residential setting, thus avoiding the need for hospitalization of those who are assessed to be at moderate risk to high risk.

D. Impact of DIVERTS in your region (if applicable); planning for DIVERTS II

A plan to implement DIVERTS II has been submitted to Mr. John Burt, Commissioner, Department for Mental Health/Mental Retardation Services, on May 30, 2007. However, this plan can only be implemented if appropriate funding is provided.

E. CIT training in your region; preparation for future training

Adanta and Jim Dailey with NAMI held a region-wide meeting in May 2007 to educate Somerset, Pulaski County area law enforcement on CIT. They are in the process of planning for implementation in the fall.

F. Medicaid: consumers' access to medications, impact of *KY HealthChoices*

There has been minimal impact from the KY Health Choices.

G. Establishment of Recovery Centers, Drug Courts and other substance abuse initiatives

The Recovery Center proposed to be opened within our region seems to still be in the planning phase. The Recovery Center has had little to no impact on the region at this time.

The Drug Court programs within the region have developed into a collaborative team approach to assist individuals who are in the recovery process. The Community Mental Health Center staff who are involved with these teams report the program has been a positive process for both the client and the therapist involved. The clients appear to be engaging in the recovery process and making improvements in their life choices. This is resulting in improvements in the quality of life these individuals lead. The clients are utilizing skills developed in the treatment and Drug Court settings, which has resulted in them becoming productive members of their communities. These persons may not have been able to make these changes in their lives without the support of the Drug Court team.

The UNITE programs are in three of the ten counties within the CMHC region and has engaged the communities in these counties to become involved in the areas of substance abuse prevention and treatment. UNITE also has a voucher program in which individuals meeting their assessment criteria can access residential treatment.

H. Workforce – recruitment, retention, training opportunities

Recruitment – The CMHC continues to try to recruit qualified mental health/substance abuse professionals to provide quality care. It is becoming harder to recruit qualified mental health/substance abuse professionals, due to lack of increase in funding to be able to offer competitive salaries.

Retention – Our turnover rate for the past several years has slowly increased to around 25% per year. It is our belief that members of our staff are lured away from the organization due to higher salaries being offered. It has also been difficult to hire staff with a competitive salary to replace staff leaving. CMHCs are limited on salary increases to our employees due to no cost of living increases in state general funds for 15+ years and Medicaid rate for 5+ years.

Training opportunities – Qualified providers are given opportunities to attend training to keep up their requirements for licenses. The CMHC does endeavor to

offer a variety of training through Essential Learning, a web-based training program.

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

There have been no changes in the integration of mental health and physical health services. The Community Mental Health Center continues to collaborate with physical health to enhance the continuum of care services for the individuals we serve. Regular meetings with Lake Cumberland Regional Hospital Adult Psychiatric Unit staff are held to better enhance communication and services.

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

Currently the CMHC has access to the Homeless Prevention Pilot Project. Part of this program provides assistance to youth, who are “aging out” of foster care in locating and obtaining housing. The program also provides limited case management services for these young people who do not have a place to live upon leaving foster care.

V. Behavioral Health Goals for Your Region

A. Briefly describe the top goals set by your Regional Planning Council for the initial 2001-2003 time period and updated in September of 2005

HB 843 Regional Planning Council Goals

- I. Increase access to services by increasing transportation opportunities.
- II. Increase the availability of mental health and substance abuse treatment professionals in our region.
- III. 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.
- IV. 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.
- V. Establish an Adult Crisis Stabilization Program.
- VI. 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
- VII. Increase access to supports and services that promote independent living.

B. Describe any changes in priority goals for your region

HB 843 Regional Planning Council Goals

June 2007

- I. Increase funding \$25 million, for the next 10 years, to move Kentucky from 42nd to 25th in funding among states for mental health and substance abuse services.
- II. Increase access to services by increasing transportation opportunities to vital services, i.e. medical, pharmacy, lab, grocery, laundry.
- III. Increase access to health insurance/medical services, i.e. physician, labs, pharmacy.
- IV. Increase the availability of mental health and substance abuse treatment professionals in our region.
- V. 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, by funding DIVERTS II Proposal.
- VI. 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.
- VII. Adequately fund Adult Crisis Stabilization Program.
- VIII. 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.
- IX. Increase access to supports and services that promote independent living, especially to subsidized housing facilities.
- X. Strengthen collaboration with the criminal justice system.

C. What progress has been made toward achieving these goals in the past two years?

VI. Your Recommendations

A. Describe your funding recommendations, including a description of changes in the availability of services in your region without increases in funding. Funding recommendations are based on the goals listed above. Without an increase in funding these services will not be implemented.

B. Describe recommendations for public policy changes to enhance the ability of the system of care to meet the behavioral health needs of consumers and families

Recommend changes in policy that would increase funds for existing programs and provide additional funds for the programs identified in the goals. There has been no increase in funding for existing programs in 15+ years. An increase in funding for the existing programs would aid in funding the cost of these programs which has increased over the years. Additional funds for programs would enhance the services currently being delivered, as well as provide clients with those services where there are gaps. Propose changes in Medicaid to increase existing rates to include a cost of living increase for the past 5+ years and to allow substance abuse treatment to be reimbursed by Medicaid.

Increased funding in state general funds for existing programs and increased Medicaid rates would allow the Community Mental Health Centers to:

- 1) maintain their existing service array
- 2) be competitive in salaries to retain and recruit qualified mental health/substance abuse professionals; and
- 3) assist in providing needed services to bridge service gaps.

Without these increases, Community Mental Health Centers will be forced to reduce services in their region, i.e. consolidation of programs such as outpatient clinics, therapeutic rehabilitation day programs, etc., thus resulting in more hospitalization cost.

Region 15 - Bluegrass Regional Planning Council Report 2007

I. Features of Your Regional Planning Council (RPC)

G. The following are members of the Bluegrass RPC:

| Name | Representation |
|----------------------|--|
| Dr. Phillip 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 |
| Ms. Cindy Ambrose | Consumer |
| Mr. John Gensheimer | Government Entity/Law Enforcement |
| Ms. Faye Morton | Family Member/NAMI Lexington/Advocacy |
| Mr. William Kendrick | Government Entity/Social Services/Juvenile |
| Dr. Melinda Rowe | Lexington-Fayette Health Department |
| Ms. Valerie Mudd | Consumer/Advocacy |
| Ms. Mary Wooley | Consumer/Advocacy |

H. Members of the RPC continue to work in close collaboration with the Bluegrass Regional MHMR Board and provide input on a continuing basis concerning needs, issues, and priorities. For example, RPC members of NAMI Lexington are involved in a work group determining program needs for innovative recovery-based services in Fayette County. The Bluegrass Regional MHMR Board and the Lexington-Fayette Health Department are currently collaborating on a grant establishing a model for integrated care. A number of RPC members are also members of the Board of Directors of the Bluegrass Regional MHMR Board. These and other ongoing relationships allow for input into establishing regional priorities through continuing dialogue, collaborative efforts, and joint projects.

II. Changes in Your Region's Needs, if applicable

- A. There have been few significant changes in the region's demographics since the last report. The region continues to have a number of the fastest growing counties in the Commonwealth. Of note are initial efforts towards increased region-wide municipal collaboration subsequent to the election of a new mayor in Lexington.
- B. Continued regional growth and stagnant governmental revenue streams place the obvious burdens on systems of care. It should be noted that the system of care continues to provide invaluable care resources to the community and an ability to respond immediately to its needs. This was exemplified in the immediate mobilization to respond to the Comair crash in Lexington.

- C. Static state general fund dollars and Medicaid reimbursement rates present significant challenges to the system of care in terms of maintaining and upgrading services especially in light of increased demand and need.

III. Your Service System Description

- The safety net in the region continues to function reasonably well especially in light of funding limitations. Programs and providers in the region continue to work collaboratively and to develop innovative approaches to care. Providers continue to seek grant and other funding options to fund innovative approaches to care. Grant funding however has significant limitations in terms of creating sustainable approaches to care. Expansions of governmental funding over the past few budget cycles have been limited to very specific targeted populations which are needed but do not address wider regional needs for community based mental health and substance abuse services.
- Services for children in their schools and homes continue to expand and are well-established throughout the region as a primary model for delivering services to children and youth. Services to the elderly and aging populations are limited and this is an area where there will need to be significant expansion as the baby boomer generation ages. The anticipated significant increase in the incidence of neuro-cognitive aging-related disorders will stretch the system beyond its current capacity in terms of trained practitioners and services. There continues to be a significant need to develop specialized approaches to services for the “revolving door” cohort of individuals with severe mental illness who revolve through mental health and social service, judicial, law enforcement, and correctional systems. This hard-to-serve cohort of individuals requires intensive service approaches with significant funding in order to address their needs.
- The Bluegrass Regional MHMR Board is a leader in the state in implementing evidence-based practices in its system of care. From integrated care for individuals with mental health and substance abuse disorders, to the Recovery Mall at Eastern State Hospital, to Recovery community-based services for individual with severe mental illness, to protocol-driven care in its outpatient services, BGMHMR has a continuing and now well-established effort in promoting and providing evidence-based services. Moving further into forefront, innovative services will also require increased flexibility in funding and relaxation of some of the rules governing state-funded services.

IV. Regional Responses to These Events or Influences:

- A. The impact of closure of psychiatric beds in the region continues to be experienced at Eastern State Hospital in surges of admissions.
- B. The issue of individuals in ERs of hospitals without psychiatric units is a significant one in the region. Many of these hospitals have closed psychiatric beds. Many of the individuals present with substance abuse and mental health issues and at times are in need of acute detoxification services.
- C. CSU services for children and adult continue to be provided by the Bluegrass Regional MHMR Board. The Therapeutic Foster Care Program at BGMHMR provides crisis residential services and is poised for a significant expansion.

The adult CSU in Harrodsburg is being moved to Lexington and expanded which will allow for increased region-wide accessibility and also increased capacity to admit higher intensity clients.

- D. Planning is currently under way to implement DIVERTS II in the region. A cornerstone of that effort will be the move of the CSU discussed in the above paragraph. Requests for additional funding to implement intensive approaches to services for the hard-to-serve cohort of individuals with severe mental illness have been made as part of DIVERTS II planning.
- E. Expansion of CIT training in the region is currently being planned and scheduled.
- F. The impact of Kentucky HealthChoices is difficult to gauge at this juncture.
- G. Several Recovery Centers are in the process of being built in the region and their impact remains to be seen. Concern remains about resources to treat the likely high incidence of individuals in Recovery Centers with dual diagnoses. Drug Courts have been expanding in the region although there continues to be concern about the proportion of dollars actually allocated to treatment services.
- H. While the recruitment of professional and others to work in the service system is somewhat less of an issue in this region than others, given its centrality and location of university training programs, there continues to be concern about the quality of professional training received in graduate programs. Graduates rarely are well-prepared to function affectively with the complex population seen in the public mental health and substance abuse service system.
- I. Through a grant received from the Foundation for a Healthy Kentucky, the Bluegrass Regional MHMR Board and the Lexington-Fayette County Health Department are implementing a pilot program to provide integrated care at the Health Department in Lexington. One of the goals of this pilot is to identify funding regulatory barriers to providing these services so that the model can be expanded on a sustainable basis.
- J. There continues to be considerable collaboration between agencies and programs to deal with the challenges of aging out youth. Critical to improving the system addressing the needs of these youth is early planning for transition and heightened collaboration between DCBS and service systems.

V. Behavioral Health Goals for Your Region

- B. The top goals of the RPC for the initial time period were:
 - Improve access to psychotropic medications
 - Increased services to children and youth
 - Enhanced access to transportation services
 - Develop uninterrupted substance abuse treatment delivery system
 - Increased substance abuse programs for children and youth
 - Improved access to housing for individuals with mental illness
 - Develop day treatment programs for youth

In 2005 the following goals were added:

- Improve and expand services for individuals with co-occurring substance abuse and mental health disorders
- Build a state-of-the-art facility to replace Eastern State Hospital

The 2005 report and presentation emphasized:

- a) Increased overall funding for mental health and substance abuse services,
- b) The replacement of Eastern State Hospital with a state-of-the-art campus of integrated services,
- c) Increased efforts to integrate physical health and mental health services,
- d) Increasing the availability of a full range of housing options for individuals with severe mental illness, and
- e) Improving transportation services especially in rural areas.

- C. This report affirms that goals emphasized in the 2005 report and presentation. Overall static funding is a threat to the viability of the service delivery system and the safety net. Funding must be put on a path towards sustainable funding for the public mental health and substance abuse service system. The replacement of Eastern State Hospital with a campus of integrated services continues to be a linchpin for improving the service delivery system. The integration of physical and mental health services is imperative but regulatory barriers to accessing reimbursement for those services must be eliminated. Providing safe and stable housing to individuals with severe mental illness is critical to assisting those individuals to achieve a more stable, functional, and satisfying life. Transportation to services is one of the main barriers to accessing services and improvements must be made to ensure that all individuals in need can obtain the services they need.
- D. The service delivery system has been successful in meeting the needs of the communities in the region. Innovation, efficient use of resources, management initiatives, and seeking alternative revenue streams are some of the strategies that have been utilized to maintain the viability of the system. However, with increased costs, demands, and administrative and regulatory requirements there is a tipping point in view on the horizon where the system will begin degrading without an infusion of funding adequate to maintain the gains achieved to date and meet the demand so the communities and citizens in the region.

VI. Your Recommendations

- A. The funding recommendation from the 2005 report remains critical. The Commonwealth must begin to address the need for an increased per capita funding of services to the citizens of the state in order to just maintain the current system. Improvements in the system will require that much more of a commitment of dollars above and beyond those required for maintenance.
- B. As in the prior report, a careful strengthening of the outpatient commitment laws would greatly assist in providing services to individuals with severe mental illness who are the most difficult to engage and retain in care.