

23. MENTAL HEALTH

Goal

Improve the mental health of all Kentuckians by ensuring appropriate, high-quality services informed by scientific research to those with mental health needs.

Terminology

Co-morbidity: The presence of two or more coexisting disorders. In this document, the term refers to the co-occurrence of mental illness and substance abuse disorders or physical illness.

Cultural competence: A set of knowledge, skills, and attitudes that allows individuals, organizations, and systems to work effectively with diverse racial, ethnic, religious, and social groups.

Disability-Adjusted Life Years: The sum of the number of years lost due to premature death and the years of life lived with a disability.

Homeless: An individual (whether a member of a family or not) who lacks housing, including an individual in transitional housing or whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations.

Juvenile justice facility: Such facilities include the following entities, as defined by the Office of Juvenile Justice and Delinquency Prevention: detention centers, shelters, reception or diagnostic centers, training schools, ranches, forestry camps or farms, halfway houses and group homes, and residential treatment centers.

Mental health services: Diagnostic, treatment, and preventive interventions designed to help improve the behavioral, physical, emotional, and social functioning of individuals with or at risk of mental illnesses.

Mental illness: Any one of an array of clinically significant behavioral or psychological syndromes, each of which ranges along a continuum of severity and manifests through specific, distinguishing, psychological or behavioral distress (and, frequently, concomitant impairment in functioning). They may arise without regard to age, gender, or ethnicity, as a product of genetic, biological, environmental, social, physical, or behavioral factors, acting alone or in combination.

Screening for mental health problems: A brief formal or informal process designed to identify individuals with or at risk of diagnosable mental health problems to determine whether further evaluation is needed and, if indicated, to link the individual to the most appropriate and available mental health services.

Serious emotional disturbances (SED): Persons from 0 to 18 years with a diagnosable mental disorder of such severity and duration as to result in functional impairment that substantially interferes with or limits functioning in family, school, community, or other major life activities.

Serious mental illness (SMI): Persons aged 18 or over with a diagnosable mental disorder of such severity and duration as to result in functional impairment that substantially interferes with or limits major life activities.

Overview

Mental illness is a term used for a group of disorders causing severe disturbances in thinking, feeling, and relating. Untreated, these disorders result in a substantially diminished capacity for coping with ordinary demands of everyday life. Mental illness can affect persons of all ages and can occur in any family.

An estimated 446,399 Kentuckians (1998 census data) (approximately 15 percent of the adult population) have some form of mental disorder. Although two-thirds of these individuals are in need of treatment, less than one-third actually seek mental health services. In Fiscal Year 1990, Kentucky community mental health centers served 73,000 adults and children with mental health problems of varying degrees. This number had grown to 95,040 in Fiscal Year 1999.

Treatment for mental illness has a serious impact on the use of health care. To assure that persons most in need have access to services, the Department for Mental Health and Mental Retardation Services (DMHMRS) has identified specific groups of people, who, because of type or degree of disability, concomitant functional level, and financial need, are considered the most vulnerable and most in need of services. These people are also the most unlikely to be served by the private sector. The DMHMRS has committed financial and staff resources in order to assure priority program and fiscal responsiveness of the service system for adults with severe mental illness and children and youth with severe emotional problems.

Historically, Kentucky spends less per capita on mental health services than almost any other state, and ranks 46th in expenditures for mental health services. Fortunately, the DMHMRS is noted for getting good value for its money. According to the most recent national report, Care of the Seriously Mentally Ill: A Rating of State Programs, Kentucky was ranked 16th in its services to persons with severe mental illness. The report noted that Kentucky “has a respectable system and a well-deserved reputation for innovation . . . and a real potential to develop one of the best service systems in the nation . . . but the limiting factor will be money!”

Goals in the provision of services include seeking to deliver services for adults and children in the least restrictive setting with the least disruption to the individual's life and to offer these services at a reasonable cost to the individual. Kentucky's system of mental health delivery is based on the concept of a comprehensive and coordinated spectrum of services which individualizes a person's needs, respects the rights and choices of the individual, and promotes living in normal, healthy ways.

The following vision statement was adopted as a response to the 99-660 planning grant. It has been reexamined several times, but remains unchanged.

That persons with severe and persistent mental illness, empowered by their personal and individual choices and capacities, will be able to live a life of dignity and hope in the community. Each person will have available options for housing, income, productive work, medical and social services, transportation, education, and personal support equivalent to that of all citizens in the Commonwealth and adequate to meet individuals wants and needs. The focus of all actions will be to protect and balance the rights and concerns of consumers, family members, and the larger community and to provide an environment that maximizes community integration and opportunities for acceptance.

Kentucky is a recognized leader in the delivery of services to children and youth with severe emotional disabilities. Kentucky has a statewide governing structure in place at the state, regional, and frequently local levels for collaborative decision-making for children with severe emotional disabilities. The ideal principles of care are as follows: the inherent value of the child must always be foremost; the rights of children and families should always be protected; and children and families should be involved as equal partners as much as possible in all planning, programming, and evaluation activities and decisions. Because the needs of children are multiple, varied, and change with time, a wide variety of services for children and families should be available, while particular treatment programs should stress the individuality of particular children and their families.

These services should strive to strengthen families and reinforce natural support networks such as family, friends, and community organizations. Interventions should promote normalized experiences, age-appropriate activities, and mentally healthy environments in the least restrictive setting as close to a child's home as possible. The Department strives to build a system of care that is capable of providing services that are accessible to each child in a timely manner at the appropriate level of intensity.

To best serve this population, the public service system for children must work closely together to plan, fund, implement, and evaluate services. Strong interagency partnerships must operate at all levels of the community, including local, regional, and state. The collaborative mechanisms must be designed to have broad-based applicability so that eventually all children can be served through them – from at-risk populations to those children and families most in need of intensive, long-term, and restrictive services.

These principles of care are embodied in the Mission Statement adopted by Kentucky IMPACT, the term used to describe the structure of the collaborative child-serving system: Building partnerships that support and strengthen children with severe emotional disabilities and their families in their own homes and communities.

Progress Toward Year 2000 Objectives

- 6.1. To increase to at least 76 percent (from 17,751 to 21,300 persons) the proportion of people ages 18 and older with severe, persistent mental disorders who use community-based support programs and to expand the array of community support programs available, such as housing, vocational, and crisis services. (Relates to National Objective 6.6)

Fiscal Year	Persons with Serious Mental Illness Served.	Percent Served
FY 1990 baseline:	17,751	63%
FY 1995:	20,137	72%
FY 1999:	20,449	73%

Implementation Strategy: DMHMRS will create a comprehensive funding base for a community-based system of care.

Significant progress has been made in the creation of a comprehensive funding base. Since Fiscal Year (FY)90, funding for community support services for adults with severe mental illness has increased. Medicaid funding for case management services, as well as increases in federal mental health block grant funding, has allowed DMH/MRS to increase the funding base for targeted services to adults with severe mental illness.

As increased funding has become available, targeted case management and related services, the community medication support program, decriminalization of mental illness, specialized personal care homes, regional housing developers, and regional crisis stabilization units have gradually expanded.

Implementation Strategy: The DMHMRS will establish quantitative targets for the number of persons with severe and persistent mental illness to be served, and for each of four areas (residential, vocational, interpersonal and global functioning) identify the outcomes of services provided to each patient.

The establishment of quantitative targets for the number of persons with severe and persistent mental illness to be served has been accomplished (primarily through the mental health block grant application process). From 1990 through 1997, the identification of outcomes for each consumer has been accomplished

through measures embedded in the statewide client data system (the Kentucky Minimum Data Set). This system measured changes in status in four areas (residential, vocational, interpersonal and global functioning). Beginning in state fiscal year 1998 (July 1, 1997), this system was replaced by the Kentucky Mental Health Outcomes Initiative System. This system measures changes in symptoms, functioning, medication usage and substance abuse patterns through the administration of clinician and consumer completed surveys. The system has been piloted in 1998 and 1999 with baselines to be established during SFY 2000 (July 1, 1999 – June 30, 2000).

Implementation Strategy: The DMHMRS will develop a cadre of trained staff in each regional Community Mental Health Center (CMHC), led by a psychiatrist-medical director, knowledgeable of state-of-the-art programming on behalf of persons with severe mental illness.

The development of a cadre of trained staff in each CMHC region has been partially accomplished. In the area of training, the Division of Mental Health (DMH) has provided the following low cost training opportunities:

- The annual Mental Health Institute
- Case management certification training (Level I and II)
- An annual case management and service coordination conference
- Specialized deaf and hard of hearing training
- Multi-cultural diversity training
- Training to providers of services to homeless individuals through the state psychiatric facilities
- Specialized housing training
- Training of peace officers in the decriminalization of mental illness
- Training in working with victims and perpetrators of sexual and domestic violence

Efforts to coordinate planning through the Human Resource Development (HRD) office have been minimally implemented. The establishment of collaborative agreements by HRD with universities to promote academic linkages, to offer student practicum opportunities, and to coordinate pre-service development also has been minimally implemented.

- 6.2. To strengthen the existing statewide and local self-help groups (representing both family members and primary consumer of mental health services) so that families and consumers in all 14 mental health regions will have access to an organized and active self help initiative. (Relates to National Objective 6.12)

Adults

1991 baseline: Self-help groups existed in seven mental health regions.

1995: Advocates Taking Action Against Mental Illness in Kentucky (ATAK-MI), and the Kentucky Alliance for the Mentally Ill (KAMI) affiliates now exist in six and nine regions respectively.

The two statewide self-help organizations, ATAK/MI and KAMI, will coordinate the development of local chapters and serve as a clearinghouse for information between the mental health system and the community.

1999: Kentucky Consumer Advocacy Network, Inc. (KY CAN, formerly ATAK/MI) has expanded its statewide membership to 125. Consumer support groups are located in regions 1, 4, 6, 10, 13, and 15. Peer advocacy and crisis response groups are located in regions 1, 4, 6, 10, 13, and 15. Peer advocacy and crisis response groups are thriving in region 4. Consumer and family support training and advocacy are available in all 14 CMHC regions. NAMI Kentucky (formerly KAMI) has resulted in the formation of support groups in 10 CMHC regions.

DMHMRS has continued to provide financial and administrative support to KAMI and ATAK/MI through the following initiatives:

- Establishment of the Office of Consumer Advocacy in FY 1994
- Establishment of the Commonground Training Center through a federal grant
- Establishment of the Mental Health Consumer Advocacy Council in FY 1994
- Participation of family members and consumers in on-site program reviews of CMHCs and state psychiatric facilities
- Maintenance of consumer and family initiatives as a priority in CMHS Block Grant planning and funding

The DMH now involves consumers and family members in program planning and policy development also. Examples include planning activities for all CMHS block grants; decriminalization of mental illness legislation and program development and training; and designing a statewide, behavioral health, managed care system for Medicaid recipients.

Parents of children with emotional/behavioral disorders came together to form the Statewide Partnership for Effective Support (SPOKES) which consisted of more than 75 support groups and more than 115 individual members. SPOKES acted as a clearinghouse of information and also provided Special Event grants to member groups and scholarships for parent training and conference events.

The State Peer to Peer Program is coordinated by the DMHMRS and involves family members and consumers in the review of Regional Mental Health/Mental Retardation (MH/MR) Board and state hospital programs.

Partnerships have been established with the Colleges of Medicine at the Universities of Kentucky and Louisville for the purpose of sharing research and learning experiences.

During State Fiscal Year 1999, the Office of Consumer Advocacy developed a new nonprofit corporation dedicated to consumer research - the Kentucky Center for Mental Health Studies. It is an independent research center which is collaborating with the Universities of Kentucky, Louisville, Pittsburgh and Chicago-Illinois. The Center is an outgrowth of the Commonground Training Center and is a consumer-governed research institute whose director is a consumer and researcher. There are five researchers at the Center (four of whom are consumers) as well as two interns from the University of Kentucky. The Center's efforts focus on evaluation, consulting, and education.

Local Consumer or Family Initiatives

The Department provides funding for four annual consumer conferences that are held in Lexington, Louisville, Hazard and Bowling Green. These conferences are sponsored by a number of consumer and provider organizations including Ky CAN, Living Independently in Kentucky/MI, the Bluegrass Regional MH/MR Board, Seven Counties Services, Inc., and Kentucky River Community Care.

Within the LifeSkills region, a very successful peer advocate/crisis response program has been operational since SFY 95. The program provides peer support to individuals who have been hospitalized involuntarily.

In the Northern Kentucky region, a consumer operated social support group offers "social club drop-in" services five days per week; another local group offers services twice a week in the Pathways region. In Paducah and Tompkinsville, clubhouses are also used as social club drop-in centers by consumers.

A consumer employment initiative has recently been funded by the Health Foundation. The consumer governed KCMHS is consulting with the group and doing an evaluation of the project.

A Community Support Program Volunteer Project in the Comprehend region recruits and trains volunteers (consumers and non-consumers) to work with adults with severe mental illness in therapeutic rehabilitation programs.

The Mental Health Association of Northern Kentucky operates a stigma-fighters campaign that airs public service announcements on television and through the recruitment and training of persons on mental health issues, coordinates live presentations about mental illness to area audiences to reduce the stigma associated with mental illness.

Children

Considerable support and collaboration with national initiatives have directed Kentucky's focus to the development of a family-sensitive system of care. Our family involvement effort has been an integral part of system of care development for children with SED and their families since 1985, when Kentucky was an early recipient of a state level Child and Adolescent Service System Program (CASSP) grant and a separate Children and Youth Service Branch (CYSB) was established within the state Division of Mental Health (DMH).

Kentucky then began the development of an integrated system of care and full array of needed service components -- with a focus on keeping pace with the national movement to promote parent empowerment, family involvement and cultural competence. Since 1985, Kentucky has made major strides in the development of a statewide system of care incorporating a family-focus and growing opportunities for pro-active family involvement. The CYSB developed the first state plan with children as a priority population and a comprehensive system of care agenda in 1986. Titled "Serving the Child with Emotional Problems: A Call for Action," this plan promoted ground-breaking statewide and regional training for system of care development, including improved parent-professional collaboration and the development of parent support/advocacy groups (13 organized in 1986) across Kentucky. Additional emphasis was placed on the development of support groups for parents of African American heritage through a demonstration project in Louisville and other regional projects focused on the needs of parents in rural communities, especially Appalachia. During these early years, Kentucky parents also participated in national Families as Allies training to promote parent-professional collaboration and sensitivity to family and cultural concerns and utilized technical assistance and training materials for parent support/advocacy group development provided by the CASSP funded, Research and Training Center on Family Support and Children's Mental Health at Portland State University.

In 1989, Kentucky received another significant boost to its system of care development, when it was awarded a major Robert Wood Johnson Foundation (RWJF) grant through their national Mental Health Services Program for Youth. This five-year demonstration project addressed interagency service system improvements in one large region of the state, and resulted in a statewide organizational mechanism, including new governance and financing strategies for a system of care in all regions. A major objective of the RWJ initiative was to establish a strong interagency, and family involved, infrastructure for Kentucky's System of Care -- enacted by legislation in 1990 and identified as IMPACT (Interagency Mobilization for Progress in Adolescent and Children's Treatment). IMPACT's 1991 mission statement called for: "Building partnerships that support and strengthen children with severe emotional disabilities and their families in their own homes and communities."

Central to Kentucky, IMPACT has been the development and refinement of state and regional interagency councils with governing authority to improve interagency coordination, ensure financing, and develop a full continuum of community- and family-based resources for children with SED and their families. With IMPACT, Kentucky established formal interagency agreements and created funding streams for expanded system of care service components, including intensive case management and service coordination. IMPACT is presently governed by a State Interagency Council (SIAC) and eighteen (18) Regional Interagency Councils (RIACs). Together, the SIAC and RIACs provide the overarching structure and support for Local Child-Specific Teams who plan, provide and/or broker services on behalf of identified children with Serious Emotional Disabilities (SED) and their families.

Another CASSP initiative, “Shaping Regional Systems of Care through Family Involvement,” from FY92-93 to FY94-95 further demonstrated a number of effective parent involvement activities central to Kentucky IMPACT on a regional basis (a Family Advocacy Network, a Family Council, and Family-Professional Training for Cultural Competence), and supported the statewide development and organization of Parent Leadership Training, Volunteer Family Advocates and a State Family Advisory Council. As a result of this initiative, increased family involvement and parent participation began to be strategically and structurally addressed in the redesign of key components of Kentucky’s System of Care through IMPACT.

With IMPACT, Kentucky also began a comprehensive program evaluation effort, incorporating both process and outcome data to assess the effectiveness and quality of Kentucky’s system of care for children with SED and their families. This evaluation included a focus on family-oriented outcomes with feedback from family members regarding family functioning, burden, ability to navigate the system, and family empowerment. Coordinated by Dr. Robert Illback, the evaluation after a five year period concluded in 1995: “Overall, Kentucky IMPACT has fulfilled its promise as a ‘system of care’ that works. While still an evolving program committed to on-going development and improvement, it can demonstrate that it provides effective and cost-efficient services to the most challenging children.” To date, Kentucky IMPACT has shown successful outcomes with substantial gains in the reduction of behavior problems, reduced utilization of psychiatric hospitals, increased placement stability, and increased family social support associated with the program.

Despite major advances in system of care development through IMPACT, the role of family members in Kentucky’s system of care development had not been clearly delineated or legitimated in any systematic manner. Continued re-design of IMPACT and related organizational structures in Kentucky has been undertaken to address the need for clear family involvement, including the roles and responsibilities of the family. Formal agreements among agencies and interagency representation and functioning were central to IMPACT. For

example, the originating 1990 legislation did not include a parent representative on the SIAC and RIACs. The addition of the parent representative was legislatively mandated by the General Assembly in 1992. Similarly, with a growing number of parent support groups and participating family members, there was no formal mechanism on the state level to promote and support the involvement and leadership of families. In 1992, with support from the latest CASSP initiative, Kentucky established the Office of Family Advocacy (later renamed the Office for Family Leadership (OFL) and employed a Director to formalize a state level commitment to a family-sensitive system of care.

The OFL was created with a mission “to ensure that parents of children with emotional disabilities will be included and heard in every aspect of decision making concerning children with emotional disabilities on local, regional and state levels.” With OFL oversight provided by the SIAC since 1996, family involvement activities were finally legitimated and supported across organizations at a high level of state government. OFL activities strive to appreciate and empower parents as true partners with professionals in addressing children’s mental health and related family needs. Activities include the provision of technical assistance, training, educational materials and scholarships to thousands of parents throughout the state. Training topics for both parents and professionals have included advocacy, communication, cultural competence, managed care, interagency collaboration and legal rights. The OFL also provides grant opportunities to the Kentucky Partnership for Families and Children (formerly SPOKES) and parent support groups to develop training opportunities in their own communities and co-sponsors several conferences, such as the Parent-Professional Conference, and the Mental Health Institute. The OFL has continued to provide considerable human and financial support for the full participation and leadership role of family members. The OFL Director provides staff support and has served as a liaison to the State Family Advisory Council and serves as the project director for the CMHS statewide family network grant for the Kentucky Partnership for Families and Children.

The State Family Advisory Council, established in 1992, is made up of the parent representatives and their alternates who serve on the RIACs for children with severe emotional disabilities across the state. Over 30 representatives gather on a quarterly basis to discuss and advise SIAC on issues that are important to parents and children in the IMPACT program and other initiatives. State Family Advisory Council members expand their role as a parent representative for their RIAC by bringing the regional perspective to a statewide forum.

SPOKES, established in 1994, combined with KFBSA in 1998 to become the KPFC. They are the statewide organization for the national Federation of Families for Children’s Mental Health. Uniting over 100 parent support groups today, KPFC has made considerable progress in carrying out its mission “to provide a united voice of individuals and groups dedicated to improving services for children with emotional disabilities and their families.” As a family-run

organization, KPFC has provided representation in key interagency efforts, including: 1) Integrated Resources in Schools Advisory Council (mental health prevention for children); 2) Joint Member Services Committee for Managed Care (with mental health and Medicaid); 3) Children in Placement Task Force (to foster more family- and community-based care); and 4) conference planning committees (e.g., Mental Health Institute, Parent/Professional Conference and Seasonal IMPACT Meetings.)

OFL and KPFC work together to develop and distribute the “Parent Directory: A parent-to-parent guide” to assist sharing of information and support among parents of children with similar emotional disabilities.

OFL has been instrumental in helping parents “manage” managed care during a fast-paced time of health care reform. In response to needs for improved understanding of managed care issues (identified by family and consumer organizations during focus groups conducted by the DMH in 1996), OFL developed a curriculum entitled: “Managed Care in Kentucky-Understanding the System: Training for consumers and family members.” Utilizing a train-the-trainers approach, this curriculum was completed in 1997 and 50 organizations received training to share with their constituents. Additionally, in working with the DMH and Medicaid on expanding family member choice of providers and service offerings through an effort known as IMPACT Plus, OFL has been helping frame the emerging managed care environment along family-driven guidelines. This significant initiative is now empowering family members to choose from a growing number of individuals and organizations approved to provide service coordination and other therapeutic supports for children with SED and their families (previously, only the state’s 14 Regional Mental Health Centers, and physicians, were approved for Medicaid reimbursement of community-based therapeutic services). Over the past year, planning by OFL has also resulted in new regulations regarding Medicaid-covered services through IMPACT Plus to include “parent-to-parent” activities identified in a child’s service plan--a most exciting advance on behalf of family involvement! Soon, parents will be approved by provider organizations to offer the following service activities: 1) therapeutic family support groups; 2) therapeutic independent living supports; 3) behavior management skills training; 4) in-home support (e.g., assessment, assistance with restructured living, therapeutic techniques training); 5) mentoring (by a parent of a child with an emotional disability); and 6) peer support education (training and information regarding family member participation in service planning).

OFL has identified and trained Volunteer Family Advocates for all 120 counties in Kentucky and aided the development of region-based Family Support Initiatives, of which there are currently nine (9) statewide, with more under development at this time. Family Advocates serve as peer-support persons for other parents of children with SED who have unmet service needs, problems accessing the system and other needs for support. They offer information about

the system of care, advise strategies for problem solving and also are available to accompany parents to important encounters with systems. Similar in function to OFL leadership on the state level, Family Support Initiatives are funded by the RIACs and staffed by a parent of a child with an emotional disability that advocates on behalf of, and provides support to, families of children with emotional disabilities. Training, education and peer-to-peer mentoring are offered through the initiatives.

Finally, with funding provided through the OFL, parent support groups are able to request funds and arrange local training events for family members on topics of interest to them. Some 108 local training sessions organized by KPFC members are planned for this year.

Overall, Kentucky has experienced positive outcomes regarding family involvement in system of care efforts on behalf of children with SED and their families. Our success to date is very much a testament to the growing number of family members involved at local, regional and state levels in planning, evaluation and advocacy for needed services and supports. With 13 parent support groups initially organized in 1986, Kentucky now benefits from the involvement of over 100 parent groups working on behalf of children with SED and their families statewide. Many of our results have been shared at a national level as we continue to learn from and with many others regarding system of care improvements and the growing impact of family members striving for “family leadership--full participation and collaboration.”

With a broad and growing leadership of involved family members who are invested in acquiring new leadership and management skills, Kentucky has established a strong foundation for continued system of care development and more effective family member collaboration with policy makers and service providers across the state. With support from this federal grant initiative, KPFC will gain the support and assistance necessary to firmly establish a statewide family network and sustain its important family leadership activities for many years to come.

- 6.3 To increase to at least 15 percent the number of children with severe emotional problems who are receiving intensive community-based services planned and implemented on an interagency basis.

1990 Baseline: Zero percent. 47,705 Kentucky children (5 percent of population) are estimated to have a severe emotional disability. The IMPACT Program did not begin until the fall of 1990, so no children were being served on a formal interagency basis during FY 1990.

FY 1999: Approximately 5,440 children with severe emotional disabilities (11.4 percent) received intensive community-based services through the IMPACT Program. In addition, another 1400 children (3 percent) are estimated to have

received services through IMPACT Plus for a total of approximately 6,840 children (14.4 percent)

The DMHMRS, in collaboration with the Department for Social Services (*NOTE: now the Department for Community-Based Services*), the Department of Education and the Administrative Office of the Courts, will implement an interagency structure in response to legislation.

The SIAC for children with Severe Emotional Disabilities was formed in 1989, and is actively functioning. By statute, it meets monthly. This body oversees 18 RIACs which in turn oversee the Kentucky IMPACT Program in all areas of the state.

Ongoing program evaluation continues by tracking outcomes for individual children and through a rotating review of the 18 RIACs. A self-review process has also been implemented for the RIACs to establish and monitor their own goals.

Technical assistance is provided to regional programs upon request. Training initiatives include certification and advanced training for service coordinators; statewide seasonal meetings for program administrators, staff and parents, and a variety of statewide and regional training initiatives in selected areas of need.

DMHMRS, in collaboration with the Department for Community-Based Services, the Department for Medicaid Services (DMS), the Department of Education, and the Administrative Office of the Courts, will identify and direct resources to assist community mental health centers and other community agencies and institutions in developing new services in the community for children with severe emotional disabilities and their families. These services will expand the array of community-based services necessary to meet the varied and specialized needs of these multiple-agency involved children and families.

In ten years, IMPACT grew from an idea to a significant reality, serving 5,440 children with severe emotional disabilities and their families in FY '99. Significant state funding was added by the 1990, 1994, and 1998 legislative sessions. A special Medicaid funding stream called IMPACT Plus was implemented in January, 1998 for children with complex treatment needs who are at risk of institutional placement. IMPACT Plus supplemented services for many IMPACT children and provided interagency services for approximately 1400 additional children not previously served by IMPACT.

The overall array of mental health services for children varies considerably from region to region. Large increases in the availability of service coordination, wrap-around services, school-based services and in-home services can be observed statewide. More moderate increases can be observed in the availability of day

treatment, after-school programs, summer programs, crisis stabilization programs, and general outpatient services.

The growth of therapeutic foster homes and community-based treatment-oriented group homes called Psychiatric Residential Treatment Facilities has been disappointing given the continued urgent need for both services. Another frequently mentioned need is for more crisis stabilization services. State funding for crisis stabilization services began in FY 1999 for eight of fourteen regions. There are eleven crisis stabilization programs for children currently operating and three additional proposals were recently approved.

Significant changes in the array of services for children and youth can be expected in the near future if managed care is implemented.

2010 Objectives

23.1. Increase the number of children SED who receive mental health services or coordinated interagency services from Regional MH/MR Boards or their subcontractors to 30 percent.

Baseline: Fiscal Year 1999, there were 10,566 people with severe emotional disabilities served (22 percent)

Target Setting Method: Percent of children with SED served by Regional MH/MR Boards (or their subcontractors)

Data Source: KDMHMRS Client Data Set and Federal Prevalence Estimates

Implementation Strategy:

- Expand community-based services for children with SED through managed behavioral health care.
- Expand community-based services for children with SED through continued implementation of IMPACT Plus.
- Expand community-based services for children with SED through other state and federally funded start-up initiatives.
- Engage in collaborative efforts with other agencies that serve children.
- Train community mental health center staff (or their subcontractors) in accurately coding for severe emotional disability and severe mental illness.
- Expand full array of crisis stabilization services to all 14 mental health regions.
- Continue development of a community medication support program.

23.2. Increase the number of adults with severe mental illness (SMI) who receive mental health services from Regional MH/MR Boards or their subcontractors to 30 percent.

Baseline: In fiscal year 1999, there were 20,449 people with severe mental illness served (28 percent).

Target Setting Method: Percent of adults with SMI served by Regional MH/MR Boards (or their subcontractors)

Data Source: DMHMRS Client Data Set and Federal Prevalence Estimates

Implementation Strategy:

- Expand community-based services for adults with SMI through managed behavioral health care.
- Expand community-based services for adults with SMI through other state and federally funded start-up initiatives.
- Engage in collaborative efforts with other agencies that serve adults with SMI.
- Train community mental health center staff and their subcontractors in accurately coding for SED and SMI in the client data set and assuring inter-rater reliability.
- Prepare, submit, and follow-up on legislative budget requests for the expansion of core components of the community support service system including crisis stabilization units, housing supports, community medications support, wraparound funds, assertive community treatment and specialized homeless services.

23.3. Increase by 5 percent the number of adults with severe mental illness (SMI) served by Regional MH/MR Boards (or their subcontractors) who are employed.

Baseline: In fiscal year 1999 there were 2,021 employed persons with mental illness (10 percent)

Target Setting Method: Percent of adults with SMI served by Regional MH/MR Boards or their subcontractors who are employed.

Data Source: Client data set

Implementation Strategy:

- In collaboration with the Kentucky Center for Mental Health Services, a consumer-directed mental health research organization, Department of Vocational Rehabilitation, and the Kentucky APSE chapter, submit an application for planning grant to the CMHS that would fund a planning initiative focused on replicating a supported employment best practice.
- In collaboration with Department of Vocational Rehabilitation, continue efforts with stakeholders in supported employment programs to identify and implement expansion opportunities.
- Prepare, submit, and follow-up on legislative request for expansion of supported employment.

23.4. Increase the number of referrals of adults with severe mental illness (SMI) from the Justice system to Regional MH/MR Boards or their subcontractors to 12 percent.

Baseline: 1,151 referrals from the Justice System for adults in 1999

Target Setting Method: Percent of justice system referrals of adults with SMI to Regional MH/MR Boards (or their subcontractors)

Data Source: Client Data Set

Implementation Strategy:

- Promote the establishment of diversion programs at the local level.
- Improve justice systems staff knowledge of mental health issues through the provision of training opportunities.
- Develop uniform referral form.
- In collaboration with the Department of Corrections, plan for the development of alternative methods of providing the Least Restrictive Environment for evaluation and treatment of persons with severe mental illness who are involved with the criminal justice system.

23.5. (Developmental) Increase the number of referrals of children with SED from the justice system to Regional MH/MR Boards or their subcontractors to 12 percent.

No baseline data available.

Target Setting Method: Percent of justice system referrals of children with SED to Regional MH/MR Boards (or their subcontractors)

Potential Data Source: Client Data Set

Implementation Strategy:

- Establish local program agreements between mental health and justice system.
- Improve justice systems staff knowledge of mental health issues through the provision of training opportunities.
- Develop uniform referral form.
- Add source of referral codes for Department for Juvenile Justice and Court Designated Workers in client data set.

23.6. (Developmental) Develop and implement a plan to improve the cultural competence of personnel within Kentucky’s mental health delivery system. Increase to 90 percent the number of facility and DMHMRS central office staff and to 75 percent the number of regional MH/MR Board staff, who have received cultural competency training.

Fiscal Year	Staff	% of Staff Who Have Received Cultural Competency Training
FY 1999 Baseline	Facility Staff	60
FY 1999 Baseline	Central Office Staff	50
FY 1999 Baseline	MH/MR Board Staff	NA (new data element)

Target Setting Method: Percent of facility, central office, and Regional MH/MR Board staff who have received cultural competency training.

Potential Data Source: Attendance rosters, training logs, and required reports.

Implementation Strategy:

- Require that cultural competency training be made a part of orientation training for all new facility and Regional MH/MR Board staff.
- Offer cultural competency training to central office staff on at least a semi-annual basis. Require that all new and current central office staff participate in this training at least annually.
- Obtain directives from the Commissioner of DMHMRS outlining these attendance requirements.
- Provide Training-of-Trainers opportunities, on an as needed basis, to facility and Regional MH/MR Board training representatives.
- Offer cultural training at statewide and regional meetings, including the Mental Health Institute and SIAC Seasonal meetings.

23.7. By 2010, of families who have incomes less than 200 percent of the Federal Poverty Level (FPL), increase to 90 percent the number of children who are covered by mental health insurance.

Baseline: In 1999, 423,813 (77 percent) of children through 18 with income under 200 percent of poverty had mental health insurance. Twenty-three percent (124,943 children) had no mental health insurance coverage.

Target Setting Method: Percent of children whose families have incomes less than 200 percent of the federal poverty level and who have mental health insurance.

Data Source: Department of Insurance and DMS.

Implementation Strategy:

- Work collaboratively with the DMS in implementation of Phases I, II, and III of the Kentucky Children's Health Insurance Program (KCHIP).
- Assist DMS with KCHIP outreach and enrollment efforts.
- Provide CMHC staff who primarily serve children information related to Medicaid and KCHIP eligibility.
- Continue collaboration with DMS in implementing managed behavioral health care.
- Support mental health insurance parity.

23.8. (Developmental) Form a consumer consortium of state consumer organizations for mutually beneficial activities.

Implementation Strategy:

- Conduct three general meetings to hold dialog.
- Incorporate consortium as a 501.c.3.
- Obtain mutual employee benefits through the consortium.

23.9. (Developmental) Develop a statewide consumer 5-year plan.

Implementation Strategy:

- Hold meeting with core planning group.
- Conduct survey around the state.
- Develop master plan.
- Implement master plan.

23.10. Establish 13 regional consumer advocacy programs based on the prototype in Bowling Green, Kentucky.

Baseline: There was one Regional Consumer Advocacy Program in 1999.

Target Setting Method: Number of newly formed regional consumer advocacy programs

Data Source: Office of Consumer Advocacy data

Implementation Strategy:

- Obtain funding.
- Provide two training sessions.
- Assist in organizing each office.
- Coordinate activities.

23.11. Increase the number of consumer and family self-help groups to 200 groups.

Baseline: In fiscal year 1999, there were 25 consumer and family self-help groups.

Target Setting Method: Number of consumer and family self-help groups

Data Source: Office of Consumer Advocacy data

Implementation Strategy:

- Develop target communities.
- Enlist facilitator.
- Form groups.
- Hold annual conference.

23.12. Increase by 50 percent the number of regional parent coordinators.

Baseline: In 1999, there were 20 regional parent coordinators.

Target Setting Method: Number of regional consumer advocacy staff and regional parent coordinators.

Data Source: Office of Family Leadership data

Implementation Strategy:

- Request funding in the biennium budget to fund half-time positions in each of the 14 mental health regions.
- Offer technical assistance to RIAC who do not yet have a regional parent coordinator.
- Ensure that family liaisons that can bill for therapeutic family support services under IMPACT Plus will continue to be able to bill under managed care.
- Offer statewide forum for development and implementation.

23.13 To increase by 24 percent the provision of annual services to victims of rape/sexual assault in order to promote an effective recovery and alleviate the emotional trauma associated with rape and sexual abuse.

Baseline: In fiscal year 1999, there were 8,135 victims of rape or sexual abuse.

Target Setting Method: Increase by 200 per year.

Data Source: Rape Crisis Centers Annual Statistics

Implementation Strategy:

- Expand counseling services to victims in rural and underserved areas.
- Expand medical advocacy services to victims in rural and underserved areas.
- Expand legal advocacy services to victims in rural and underserved areas.

23.14 To increase by 46 percent the provision of services to family members and friends of victims of rape and sexual abuse.

Baseline: In 1999, services were provided to 2,160 family members and friends of victims of rape or sexual abuse.

Target Setting Method: Increase by 100 per year.

Data Source: Rape Crisis Centers Annual Statistics

Implementation Strategy:

- Expand counseling services to family members and friends of victims in rural and underserved areas.
- Expand medical advocacy services to family members and friends of victims in rural and underserved areas.
- Expand legal advocacy services to family members and friends of victims in rural and underserved areas.

23.15 To increase by 3 percent the number of persons educated within the Commonwealth regarding the incidence and dynamics of sexual assault in order to increase their understanding of this social problem and to prevent its occurrence.

Baseline: In 1999, there were 72,765 participants of rape/sexual abuse education programs.

Target Setting Method: Increase of 200 per year

Data Source: Rape Crisis Centers Annual Statistics

Implementation Strategy:

- Establish relationships with community school personnel
- Implement education and prevention programs
- Educate local community members and professionals regarding rape and sexual abuse
- Improve relations with local community groups and local school systems to access citizens, professional, children and teens

23.16. (Developmental) Provide comprehensive and coordinated mental health services for victims of child sexual abuse and their families.

Potential Data Source: To be developed.

Implementation Strategy:

- The Department for Mental Health and mental Retardation's Sexual and Abuse Domestic violence program will provide biannual meetings for each MH/MR Board's designated child sexual abuse coordinator to provide an opportunity for networking and training.
- The Department for mental Health and Mental Retardation Services will coordinate with other state agencies in providing quality mental health training in the area of child sexual abuse.
- Each MH/MR board will prioritize cases of child sexual abuse for provision of mental health services.
- Each MH/MR Board's designated child sexual abuse coordinator will work with other community agencies to provide appropriate and comprehensive mental health treatment for victims of child sexual abuse and their family members.

23.17. (Developmental) Provide comprehensive and coordinated mental health services for victims of domestic violence and their children.

Potential Data Source: To be developed.

Implementation Strategy:

- The Department for Mental Health and Mental Retardation Services will coordinate with other state agencies in providing quality mental health training in the area of domestic violence.
- Each MH/MR Board will prioritize cases of domestic violence for provision of mental health services.
- Each MH/MR Board's mental health professionals will work to provide comprehensive mental health treatment for victims of domestic violence and their children.
- MH/MR Board mental health professionals will collaborate with other professional agencies including the local spouse abuse shelters, including

participation on local domestic violence councils, to address the multi – faceted needs of victims of domestic violence.

- The Department for Mental Health and Mental Retardation Services will certify mental health professionals to provide court-ordered domestic violence offender treatment to ensure the goal of victim safety.

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