

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.

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.

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.

Summary of Progress

The Kentucky General Assembly has passed important legislation in the past few years that has profoundly affected mental health, mental retardation, and substance abuse services. The Commission created by the legislation (HB 843) convened regular meetings throughout the Commonwealth since SFY 2001 and continued bringing together key stakeholders to monitor and upgrade plans for addressing service needs across the state.

House Bill 843 created the Kentucky Commission on Services and Supports for Individuals with Mental Illness, Alcohol and Other Drug Abuse Disorders, and Dual Diagnosis. This legislation also created fourteen regional councils organized by Regional MHMR Boards. Members include representatives of major state agencies (e.g. justice, social services) as well as consumers and other stakeholders. A planning process that began at the regional level, and was carried out during SFY 2001, culminated with a plan submitted to the Governor and the General Assembly on June 21, 2001. This plan (and annual updates) laid the groundwork for a budget request submitted for the SFY 2005 and 2006 biennium. The Commission charged eleven separate workgroups to provide in-depth study on various issues. Annual progress reports are submitted to the Governor on October 1 of each year.

Progress toward Achieving Each HK 2010 Objective

- 23.1. Increase the number of children with severe emotional disabilities (SED) who receive mental health services or coordinated interagency services from Regional MH/MR Boards or their subcontractors to 30 percent.**

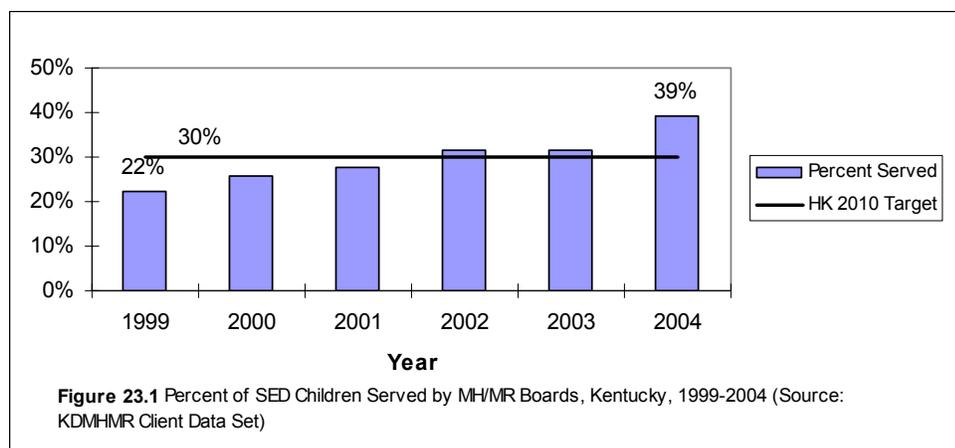
Data Source: KDMHMRS Client Data Set and Federal Prevalence Estimates

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

HK 2010 Target: 30 percent

Mid-Decade Status: 39 percent*

*NOTE: Percentages for all fiscal years changed due to the use of the 2000 US Census.



Strategies to Achieve Objective:

- 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.

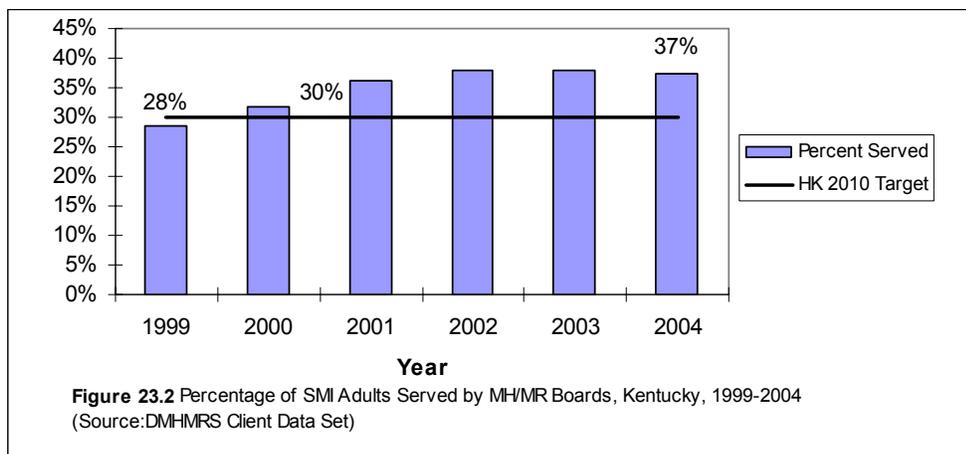
Data Source: DMHMRS client data set and federal prevalence estimates

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

HK 2010 Target: 30 percent

Mid-Decade Status: 37 percent*

*NOTE: Percentages for all fiscal years changed due to the use of the 2000 US Census.



Strategies to Achieve Objective:

- 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.

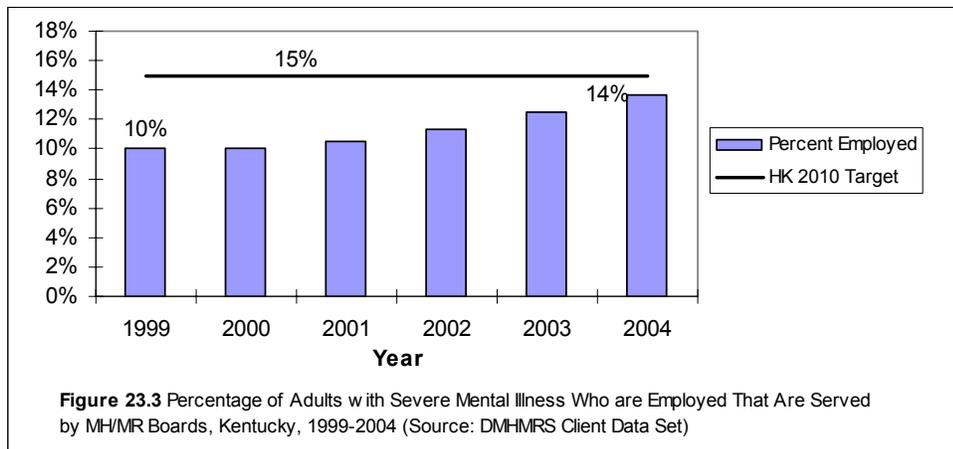
Data Source: DMHMRS client data set

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

HK 2010 Target: 15 percent

Mid-Decade Status: 14 percent*

*NOTE: Percentages for all fiscal years changed due to the use of the 2000 US Census.



Strategies to Achieve Objective:

- 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.

In the original baseline, the baseline was set higher than the actual. This was an error, and this objective now includes the new baseline.

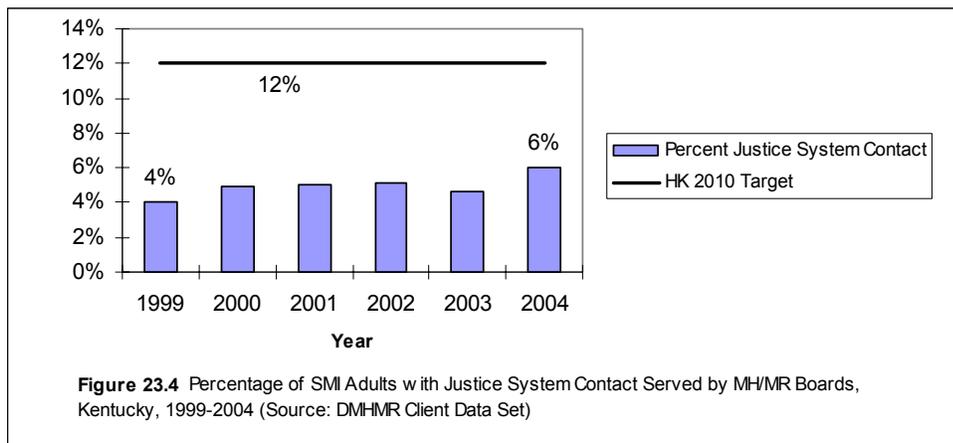
Data Source: DMHMRS client data set

Baseline: 797 referrals from the Justice System for adults with SMI in 1999 (4 percent*) (corrected)

HK 2010 Target: 12 percent

Mid-Decade Status: 6 percent*

*NOTE: Percentages for all fiscal years changed due to the use of the 2000 US Census.



Strategies to Achieve Objective:

- 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.

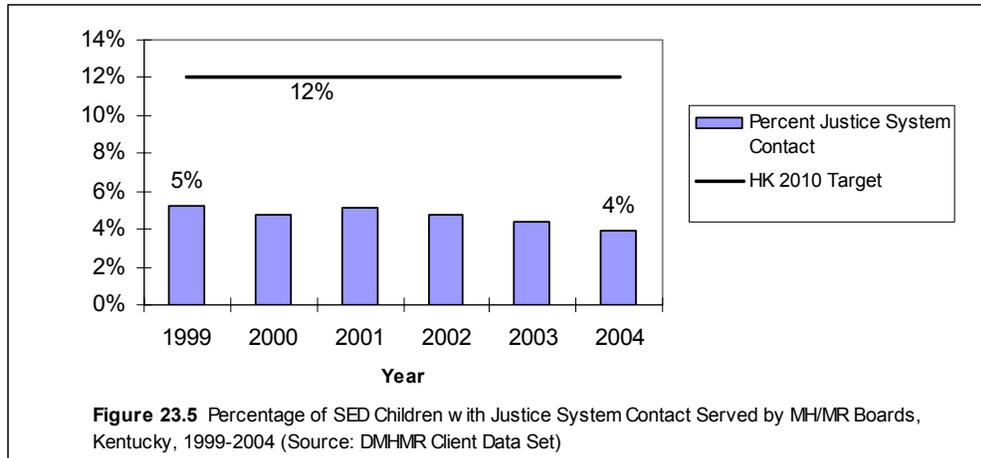
Data Source: DMHMRS client data set

Baseline: No baseline data available at the drafting of the original report in 1999. However, a new referral option now includes the Department of Juvenile Justice. 565 referrals from the Justice System for children with SED in 1999 (5 percent) (corrected)

HK 2010 Target: 12 percent

Mid-Decade Status: 4 percent*

*NOTE: Percentages for all fiscal years changed due to the use of the 2000 US Census.



Strategies to Achieve Objective:

- 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.**

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

Percent of Staff Who Have Received Cultural Competency Training			
Staff	Baseline 1999	HK 2010 Target	Mid-Decade Status 2004
Facility	60	90	75
Central Office	50	90	90
MH/MR Board	TBD (new data element)	TBD	TBD (new data element)

Data Needs: Data on the MH/MR Boards are needed. This fiscal year, the Joint Committee for Information Continuity has implemented a new field to track required trainings including Cultural Competency.

Strategies to Achieve Objective:

- 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 annual Mental Health Institute and Choices and Changes Conference
- As part of the new Cabinet for Health and Family Services (CHFS), the Equal Opportunity Compliance Branch has created the CHFS Cultural Diversity/Cultural Competency Training Committee which is coordinating the requirements of Executive Order 13166 and Section 601 of Title VI of the Civil Rights Act of 1964, 42 U.S.C.2000d, concerning services to people who have limited English proficiency (LEP) and cultural competency training. This included Train the Trainer Trainings for facilities and boards, as well as mandatory trainings for staff at the Central Office.

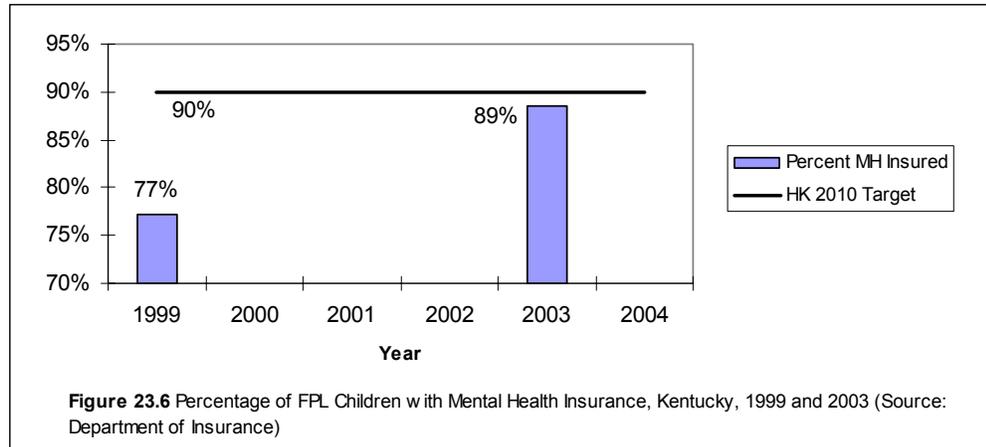
23.7. By 2010, of families who have incomes less than 200 percent of the Federal Poverty Level (FPL), increase to 90 percent the number of children who are covered by mental health insurance.

Data Source: Department of Insurance, DMS and the Robert Wood Johnson Foundation's *Going Without: America's Uninsured Children* August 2005

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.

HK 2010 Target: 90 percent

Mid-Decade Status: 89 percent



Strategies to Achieve Objective:

- Work collaboratively with the Department for Medicaid Services (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 with 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.**

Data Source: DMHMRS, Division of Mental Health and Substance Abuse, Recovery Services (formerly the Office for Consumer Advocacy).

Baseline: No consumer consortium

HK 2010 Target: Develop consumer consortium

Mid-Decade Status: No consumer consortium

Strategies to Achieve Objective:

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

Meetings were held with the state consumer organizations to establish dialogue. After researching the issue, it was determined that incorporating the consortium as a 501(c)3 to obtain employee benefits was not feasible.

The administrative requirements for maintaining a 501(c)3 combined with complex health insurance regulations made this objective unobtainable. A number of these organizations offer individual/flexible employee benefit packages, however these packages are not consistent across agencies. A meeting will be held to revisit this issue. Also, these organizations participate on the Mental Health Consumer Advocacy Committee to discuss topics of mutual interest to consumers, family members and professionals.

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

Data Source: DMHMRS, Recovery Services (formerly the Office for Consumer Advocacy).

Baseline: No statewide consumer 5 year plan in 1999

HK 2010 Target: Develop a statewide consumer 5 year plan

Mid-Decade Status: No statewide consumer 5 year plan in 2005

Strategies to Achieve Objective:

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

Comprehensive statewide planning for services was initiated by the passage of the Kentucky Commission of Services and Supports for individuals with Mental Illness, Alcohol and Other Drug Abuse Disorders, and Dual Diagnoses (HB843) as well as through consumer participation on the Community Mental Health Services Performance Partnership Block Grant.

Through HB843, consumers participate on regional planning councils thus creating a mechanism for doing long-range, coordinated planning for mental health and substance abuse services encompassing both public and private sectors and including all the stakeholders in the process.

The Block Grant provides for the establishment of a recovery oriented, comprehensive, community-based system of mental health care for adults who have a severe mental illness, including case management, treatment, rehabilitation, employment, housing, educational, medical, dental, and other support services, which enables individuals to function in the community and reduces the rate of hospitalization.

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

Data Source: DMHMRS, Recovery Services (formerly the Office for Consumer Advocacy)

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

HK 2010 Target: 14 total programs including the program noted in the baseline

Mid-Decade Status: 0

Strategies to Achieve Objective:

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

Fully realizing this objective became problematic. Maintaining the prototype program in Bowling Green became cost prohibitive and the logistics of the Executive Director covering two fully functional offices was difficult. However, the Kentucky Consumer Advocacy Network (KY CAN) is in the process of developing a plan to establish affiliate chapters in each of the community mental health regions. It is envisioned that consumers will be identified in each region who can promote the advocacy and recovery work of KY CAN.

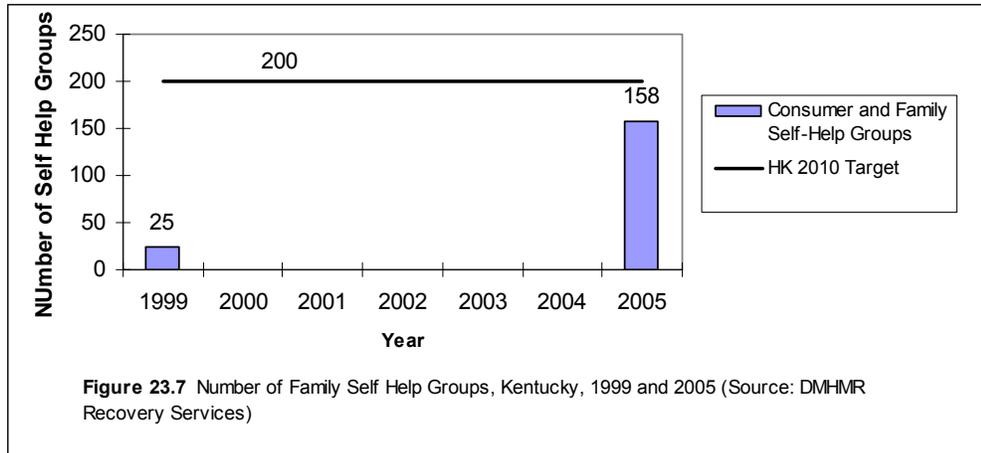
23.11. Increase the number of consumer and family self-help groups to 200 groups.

Data Source: DMHMRS, Recovery Services (formerly the Office for Consumer Advocacy) and Opportunities for Family Leadership (OFL)

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

HK 2010 Target: 200

Mid-Decade Status: 158



Strategies to Achieve Objective:

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

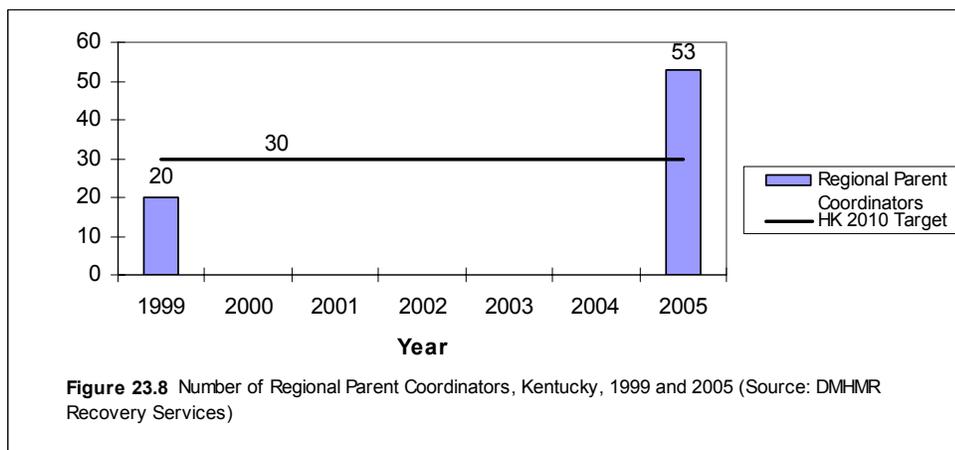
23.12. Increase by 50 percent the number of regional parent coordinators.

Data Source: Office of Family Leadership

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

HK 2010 Target: 30

Mid-Decade Status: 53



Strategies to Achieve Objective:

- 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. (See Revision)

23.13R. (REVISION) Increase by 10 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.

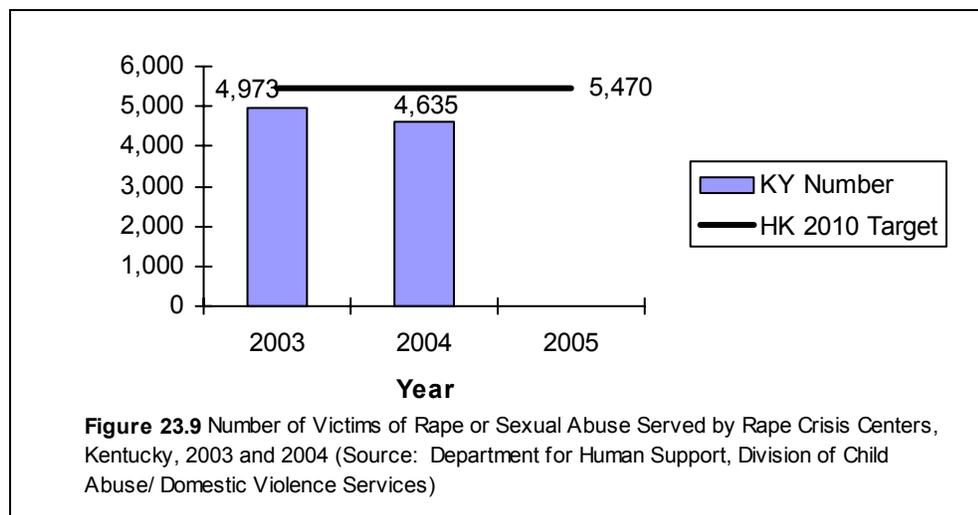
Reason for Revision: The data definitions used by the Rape Crisis Centers changed in 2003; therefore, the baseline and target were revised.

Data Source: Department for Human Support, Division of Child Abuse/Domestic Violence Services

Baseline: In fiscal year 2003, there were 4,973 victims of rape or sexual abuse that received services at Rape Crisis Centers.

HK 2010 Target: 5,470

Mid-Decade Status: 4,635 in 2004



Strategies to Achieve Objective:

- 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. (See Revision)

23.14R. (REVISION) To increase by 10 percent the provision of services to family members and friends of victims of rape and sexual abuse.

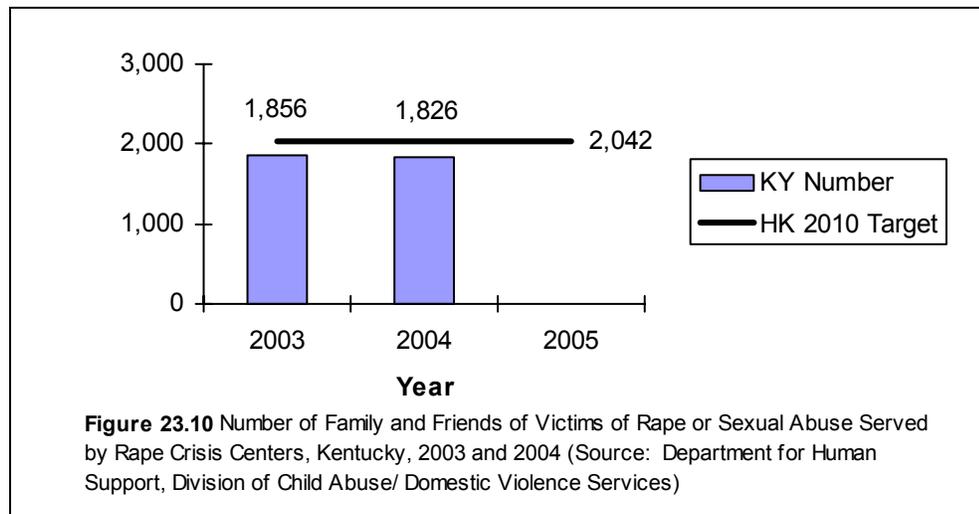
Reason for Revision: The data definitions used by the Rape Crisis Centers changed in 2003; therefore, the baseline and target needed to be revised.

Data Source: Department for Human Support, Division of Child Abuse/Domestic Violence Services

Baseline: In 2003, services were provided to 1,856 family members and friends of victims of rape or sexual abuse.

HK 2010 Target: 2,042

Mid-Decade Status: 1,826 in 2004



Strategies to Achieve Objective:

- 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. 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. (See Revision)

23.15R. (REVISION) Increase by 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.

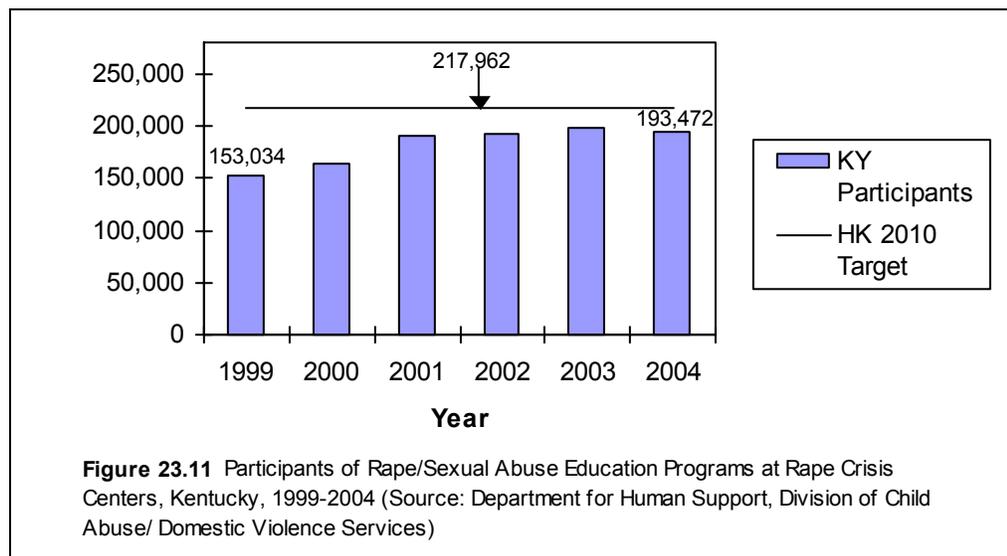
Reason for Revision: In the original baseline, the baseline was set lower than the actual. This was an error, and the objective 23.15 now includes the new baseline and target.

Data Source: Department for Human Support, Division of Child Abuse/Domestic Violence Services

Baseline: In 1999, there were 153,034 participants of rape/sexual abuse education programs. (corrected)

HK 2010 Target: 217,962 (corrected)

Mid-Decade Status: 193,472 in 2004



Strategies to Achieve Objective:

- 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

The baseline data for this objective of 72,765 persons educated in 1999 should have been 153,034. State general funds for Rape Crisis Centers have not increased since 2001 and federal funding has decreased each year since 2000. Additionally, prevention efforts at the regional Rape Crisis Centers are moving away from one time, 50 minute education sessions. Centers are beginning to implement evidence based programs that seek to impact changes in attitudes, knowledge, beliefs and behavior, not just counting the numbers of participants in programs. This fundamental change in the way prevention education services are delivered will certainly impact the number of participants in the next five years.

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

23.16R. (REVISION) Provide a 50 percent increase in comprehensive and coordinated mental health services for victims of child sexual abuse and their families.

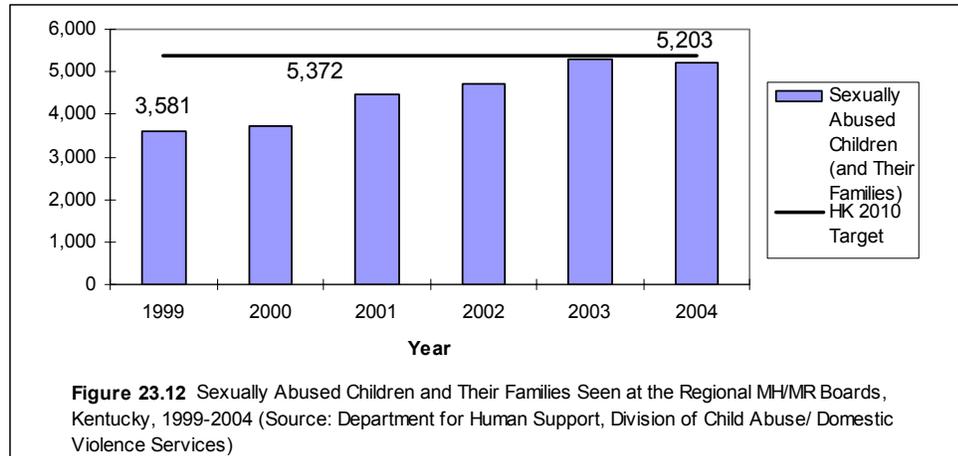
Reason for Revision: This objective was misclassified as developmental. Data to track this objective were available at time of initial draft. This was an error, and the revision for objective 23.16 includes the new data source, baseline and target. However, the name of the field was later clarified for SFY 2006 to include Sexual Abuse in addition to Victim of Rape/Sexual Assault.

Data Source: DMHMRS Client Data Set

Baseline: Fiscal Year 1999, there were 3,581 sexually abused children (and their families) seen at the Regional MH/MR Boards.

HK 2010 Target: 5,372

Mid-Decade Status: 5,203



Strategies to Achieve Objective:

- The Department for Mental Health and Mental Retardation’s Sexual Abuse and 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. (See Revision)

23.17R. (REVISION) Provide a 75 percent increase in comprehensive and coordinated mental health services for victims of domestic violence and their children.

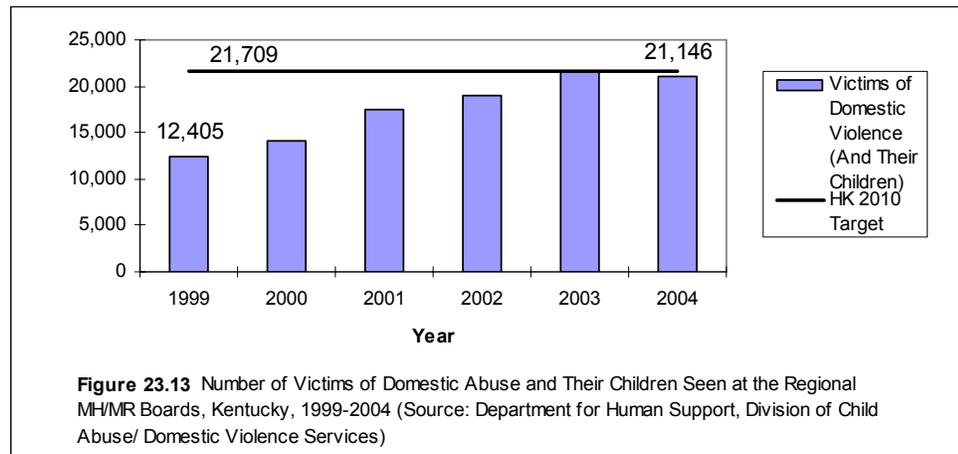
Reason for Revision: This objective was misclassified as developmental. Data to track this objective was available at time of initial draft. This was an error, and the revision for objective 23.17 includes the new data source, baseline and target. However, the name of the field was later clarified for SFY 2006 from Physical Abuse to Domestic Abuse.

Data Source: DMHMRS client data set

Baseline: Fiscal Year 1999, there were 12,405 victims of domestic violence (and their children) seen at the Regional MH/MR Boards.

HK 2010 Target: 21,709

Mid-Decade Status: 21,146



Strategies to Achieve Objective:

- DMHMRS 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 and local domestic violence councils, to address the multi-faceted needs of victims of domestic violence.
- DMHMRS will certify mental health professionals to provide court-ordered domestic violence offender treatment to ensure the goal of victim safety.

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, psychologic 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.

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23. Mental Health – Summary Tables

Summary of Objectives for Mental Health	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
23.1. Increase the number of children with severe emotional disabilities (SED) who receive mental health services or coordinated interagency services from Regional MH/MR Boards or their subcontractors to 30 percent.	22% (1999)	30%	39% (2004)	Target Achieved	DMHMRS Client Data Set
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.	28% (1999)	30%	37% (2004)	Target Achieved	DMHMRS Client Data Set
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.	10% (1999)	15%	14% (2004)	Yes	DMHMRS Client Data Set
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.	4% (1999)	12%	6% (2004)	Yes	DMHMRS Client Data Set
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.	5% (1999)	12%	4% (2004)	No	DMHMRS 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.	Facility: 60% (1999)	90%	75% (2004)	Yes	Training Logs
	Central Off: 50% (1999)	90%	90% (2004)	Target Achieved	
	Boards: Not available (1999)	75%	Not Available (2004)	TBD	
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.	77% (1999)	90%	89% (2003)	Yes	Dept. of Insurance
23.8. (Developmental) Form a consumer consortium of state consumer organizations for mutually beneficial activities.	No consumer consortium (1999)	Consumer consortium	No consumer consortium (2005)	No	DMHMRS Recovery Services
23.9. (Developmental) Develop a statewide consumer 5-year plan.	No 5-year plan (1999)	5-year plan	No 5-year plan (2005)	No	DMHMRS Recovery Services

Summary of Objectives for Mental Health	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
23.10. Establish 13 regional consumer advocacy programs based on the prototype in Bowling Green, Kentucky.	1 (1999)	14	0 (2005)	No	DMHMRS Recovery Services
23.11. Increase the number of consumer and family self-help groups to 200 groups.	25 (1999)	200	158 (2005)	Yes	DMHMRS Recovery Services
23.12. Increase by 50 percent the number of regional parent coordinators.	20 (1999)	30	53 (2005)	Target Achieved	Office of Family Leadership
23.13R. Increase by 10 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.	4,973 (2003)	5,470	4,635 (2004)	No	Div. of Child Abuse/ Domestic Violence Services
23.14R. Increase by 10 percent the provision of services to family members and friends of victims of rape and sexual abuse.	1,856 (2003)	2,042	1,826 (2004)	No	Div. of Child Abuse/ Domestic Violence Services
23.15R. Increase 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.	153,034 (1999)	217,962	193,472 (2004)	Yes	Div. of Child Abuse/ Domestic Violence Services
23.16R. Provide a 50 percent increase in comprehensive and coordinated mental health services for victims of child sexual abuse and their families.	3,581 (1999)	5,372	5,203 (2004)	Yes	DMHMRS Client Data Set
23.17R. Provide a 75 percent increase in comprehensive and coordinated mental health services for victims of domestic violence and their children.	12,405 (1999)	21,709	21,146 (2004)	Yes	DMHMRS Client Data Set

R = Revised objective

DMHMRS = Department for Mental Health and Mental Retardation Services

*NOTE: Percentages for all fiscal years changed due to the use of the 2000 US Census.