Testimony to House Children and Seniors Committee

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Madame Chair and members of the Committee, my name is Mike Hammond, I am the Executive Director of the Association Community Mental Health Centers of Kansas, Inc. Thank you for the opportunity to be here today and to provide you with an overview of the Community Mental Health Center (CMHC) system in Kansas.

Snapshot of the CMHC System in Kansas

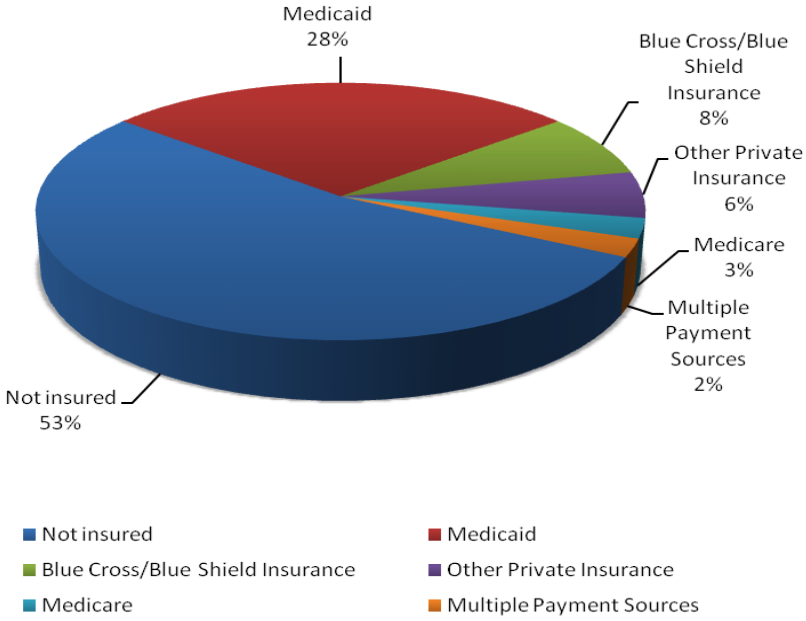
In Kansas, CMHCs are the local Mental Health Authorities coordinating the delivery of publicly funded community-based mental health services. The CMHC system is state and county funded and locally administered. In Kansas, you first must be designated by your County to serve as the CMHC to the county residents, then you must secure a license from the Kansas Department on Aging and Disability Services (KDADS), to become the publicly funded CMHC and recognized as such by the State of Kansas. Consequently, service delivery decisions are made at the community level, closest to the residents that require mental health treatment. Each CMHC has a defined and discrete geographical service area. Together, they employ over 4,500 professionals.

The CMHCs provide services to Kansans of all ages with a diverse range of presenting problems. Together, this system of 27 licensed CMHCs form an integral part of the total mental health system in Kansas. As part of licensing regulations, CMHCs are required to provide services to all Kansans needing them, regardless of their ability to pay. This makes the community mental health system the "safety net" for Kansans with mental health needs. Collectively, the CMHC system serves nearly 127,000 Kansans with mental illness. Some of the demographics of those we serve are listed below.

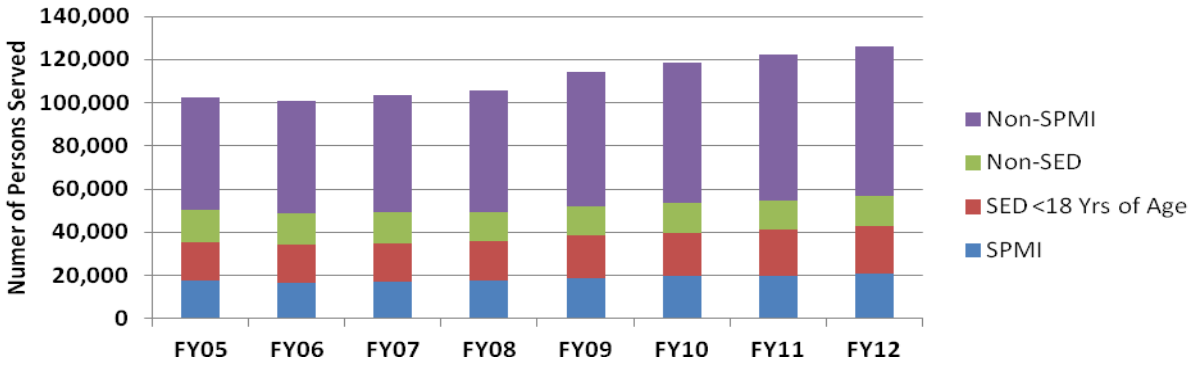
Characteristics		
SPMI	20,634	16%
SED	22,222	18%
Non-SPMI	69,738	55%
Non-SED	13,747	11%

Age		
0-17	36,790	29%
18-20	7,612	6%
21-64	77,385	61%
65+	5,074	4%

Gender		
Male	59,625	47%
Female	67,236	53%



The pie chart reflects a payor mix of those served by the CMHC system (the groupings do overlap). Once the particular benefits run out or we determine coverage limits, if that particular source of payment is exhausted and the need is still there, the Mental Health Reform grants would then pick up the cost of care. Sliding fee scales and the Mental Health Reform grants are what make our services affordable to those who either have no resources or their ability to pay prohibits them from paying 100 percent of the cost.



Since FY 2007, we have seen a steady increase in the overall number of individuals served by the CMHCs – a 24% increase. The majority of these individuals are uninsured.

The federally mandated target population consists of adults who have a severe and persistent mental illness (SPMI) and children/adolescents who have a serious emotional disturbance (SED). The non-target population is basically everyone else served by the CMHC. We also know that of those served by the CMHC system who are non-Medicaid, and reporting income information, 69% earn less than $20,000 a year.

We are a system that is not self contained, but rather one that crosses boundaries. For example, the correctional system is one that if you haven't broken the law, you don't get in their system. For community mental health, there aren't any boundaries. Literally every other human service system recognizes the need for mental health services. The CMHCs integrate and collaborate with systems such as education (regular education and special education), juvenile justice, developmental disabilities, corrections, aging, child welfare, general medicine, law enforcement, and many more.

As the local Mental Health Authorities for community-based mental health services in Kansas, CMHCs provide the primary linkages between and among service agencies as well as transitioning consumers from child to adult services. The CMHCs serve as the gatekeepers to state mental health hospital treatment by screening all referrals to state hospitals. Also, to ensure necessary linkages with community supports, mental health reform legislation mandates "that no patient shall be discharged from a state hospital if there is a participating CMHC serving the area where the patient intends to reside, without receiving recommendations from such participating mental health center." Each CMHC has one or more liaisons who go to the state hospitals to assist with discharge and aftercare plans, as well as coordinating with private psychiatric facilities and nursing facilities for mental health (NFMHs).

The primary goal of CMHCs is to provide quality care, treatment and rehabilitation to individuals through mental health programs in the least restrictive environment. The CMHCs strongly endorse treatment at the community level in order to allow individuals to keep functioning in their own homes and communities at a considerably reduced cost to them, third-party payers, and the taxpayer.

Highlights of Funding Reductions Sustained by the CMHC System

1. $15 million reduction in Mental Health Reform grants since FY 2008 – a 50 percent reduction.
2. $33.4 million all funds in Medicaid reductions (10% rate reduction in FY 2010; Medicaid spending reduction through a directive from SRS for FY 2011 and FY 2012).
3. $3.1 million in MediKan funding in FY 2010 – a 45 percent reduction.
4. $560,000 SGF in Community Support Medication Program funding during FY 2010 – a 53 percent reduction.

The CMHC system has seen a reduction of $31.2 million in SGF since FY 2007 ($52.2 million AF).

While the Governor's Budget Recommendations for 2014 cut the CMHC system by $9.75 million, his GBA #1, item 7, replaces that cut with $9.75 million from Children's Health Insurance performance bonus to create a Mental Health Initiative. As a result, the CMHC system is held harmless from any further budget cuts, collectively.

Governor's Mental Health Initiative

On January 10th, Governor Brownback announced his Mental Health Initiative, which sets aside $9.75 million, to increase our focus on mentally ill persons who are most at risk. This is not new money for the CMHC system. The Governor's budget reduces our mental health reform grants by $5 million and zeros out the Family Centered System of Care program (funded at $4.75 million from CIF dollars). He then creates a Mental Health Initiative with the same amount of money for individuals we serve who are most at-risk. The intent of the Mental Health Initiative is to put an increased focus on the following:

- Adults or youth with frequent psychiatric inpatient admissions
- Adults or youth with a mental illness released from prison or a youth detention facility
- Adults or youth with a mental illness who have frequent contact with law enforcement
- Adults or youth with co-occurring disorders
- Youth who are at risk of entering State custody

One-half of the $10 million will be allocated to all 27 CMHCs; the balance will be allocated to 5-7 CMHCs for the creation of Regional Recovery Support Centers (RRSCs). Funding allocated to these RRSCs will be available to all CMHCs within the region to allow for access to resources that they cannot always efficiently provide individually.

Services directed at these individuals who are most at-risk include:

- Intensive case management and care coordination
- Crisis stabilization
- Parent Support and Peer Support
- Employment and Housing supports
- Expanding evidence-based practices

We have appreciated the focus placed on the mental health system and the needs of those who rely on it for their care. We must do what we can to make community based mental health services affordable and accessible to all Kansans through the State's publicly funded mental health safety net system – our CMHCs. If we as a State fail to do so, the impact of mental illness will be devastating on the individual, our communities, and will cost our State more money in the long run. We must act because it is the right thing to do. Investing in community-based mental health treatment saves our State precious financial resources, particularly at a time when we are evaluating the best return on our tax dollars.

We look forward to working closely with the Governor's Mental Health Services Planning Council to examine our public mental health system and make recommendations for improvements and additional investments for the future.

What are the Needs?

In looking at the CMHC Needs Assessments; needs identified through the Hospital to Home Workgroup; and recommendations from Subcommittee Reports of the Governor's Mental Health Services Planning Council, our Association has asked KDADS to make the following needs a priority under the Mental Health Initiative:

1. Adults who are uninsured who utilize psychiatry inpatient resources and or hospital emergency rooms frequently
2. Adults who have complex dual disorders of mental illness and substance abuse, especially those who continue to use substances and do not want help but continue to access services either voluntarily or involuntarily
3. SPMI/SMI who are at early stages of episodic decompensation
4. Children with a SED who are at risk of out of home placement
5. Children with SED who are at risk of psychiatric hospitalization or residential placement

We also have identified key resources to focus on:

- Comprehensive array of crisis services, including local or regional crisis beds
- Respite resources
- Increased intensive community based services

- Jail diversion programs
- Integrated treatment approach for children and adults with a mental illness and substance abuse diagnosis
- ACT-like teams that focus on individuals at risk of admission to inpatient settings or entering the criminal justice system
- Creating foster care diversion programs that are focused on children at risk of entering state custody
- Promoting increased engagement of persons with a mental illness/families of children with a mental illness, to access the public mental health system early
- Mental Health First Aid
- Housing specialists
- Employment specialists
- Wraparound services for children and youth
- Parent Support and Peer Support
- Flexible funding
- Therapeutic services to preschools
- School violence prevention programs
- School based mental health services

The FCSC program is a statewide program designed to replicate two federally funded pilot programs. The program has been in place since 1999. Its target population is SED children and their families with a primary focus on those who are uninsured and those who have private insurance but whose insurance does not cover mental health rehabilitation services. Wraparound services are a critical evidence-based practice (EBP) that is being implemented in this program, in addition to Parent Support, which is a promising practice. It serves over 6,700 families per year. This program has been funded with Children's Initiative Funds ($5 million). Services provided include: psychosocial rehabilitation, case management, care coordination, psychiatry, medication management, in-home family therapy, school based therapy, independent living, crisis services, respite and attendant care. Since this program is being replaced by the Mental Health Initiative, it is going to be important that a portion of the repurposed funding be used to support these children and families with a similar array of services and supports.

Why Focus on and Fund Community-Based Mental Health Services?

Prevalence of Mental Illness

- 64% of inmates in local jails have a mental health problem (U.S. Department of Justice)
- 56% of inmates in State prison have a mental health problem (U.S. Department of Justice)
- Between 4-6% of U.S. adults experience a mental illness (National Institute of Mental Health)
- Of children ages 9 to 17, 21% have a diagnosable mental or addictive disorder that causes at least minimal impairment (U.S. Department of Health and Human Services)
- 20% of older adults have a diagnosable mental disorder
- Suicide is the third leading cause of death in youth ages 15-24. More teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza and chronic lung disease combined (U.S. Department of Health and Human Services)
- 60% of people who are chronically homeless have experienced lifetime mental health problems (Substance Abuse and Mental Health Services Administration)

The Impact of Untreated Mental Illness

According to the Health Care Foundation of Greater Kansas City, the annual cost burden of untreated mental illness to Kansas is estimated to be $1.17 billion. A high proportion, 87.5% of these costs are in the form of indirect costs to employers and individuals. Indirect costs include unrealized earnings due to higher unemployment rates, the cost of lost productive time at work due to untreated mental illness, time missed from work, and unrealized earnings due to permanent disability or premature death. About 10.5% of the overall costs are estimated to be direct costs, or medical expenses associated with lack of sustained treatment. Direct costs include increased inpatient care/hospitalizations, outpatient care, long term care/nursing homes, and money spent by mental health organizations. The remaining costs are due to criminal activity, Social Security disability, and social welfare administration costs.

In Kansas, untreated SMI is associated with an estimated 128 suicides, 21,000 incarcerations and 29,000 unemployed adults.

Untreated SMI in Kansas cost the private sector, including employers, nearly $429 million per year. Unrealized earnings for individuals due to unemployment, disability, institutionalization, or suicide amount to approximately $522 million annually. It costs State and local governments over $112 million per year and the federal government $111 million per year.

The CMHCs have played a critical role in accomplishing significant bed reductions in our state mental health hospitals, declining from 1,003 in FY90 to 340 today. While bed days have decreased, our inpatient system is nearing capacity due to reductions in SGF revenues for the uninsured/underinsured. 68% of admissions are non-Medicaid. The state must maintain its commitment to former clients of state hospitals who have moved from institutional care to community-based services.

Community-based services have proven effective in diverting thousands of individuals from state hospitalization. For children, intensive wraparound services allow them to stay at home and achieve higher performance in school. For adults, it means living independently and becoming competitively employed.

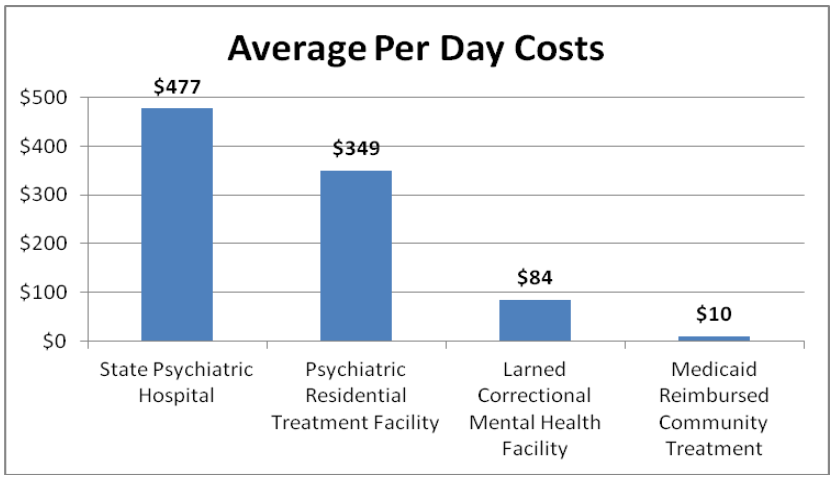
Without CMHC services, law enforcement, local emergency rooms, schools and families will be adversely affected. The failure to keep CMHC programs fully funded increases the census in state hospitals, impacts foster care and nursing homes, to say nothing of correctional facilities and juvenile detention facilities.

The cost-benefit ratios for early treatment and prevention programs range from 1:2 to 1:10, meaning that a $1 invested yields $2 to $10 savings. We also know that Intensive Case Management intervention is associated with significant reductions in inpatient, psychiatric 30-day readmission rates, and associated costs among adults who are at elevated risk of inpatient, psychiatric recidivism.

Overall, the economic models show that improving the treatment rate for mental illness is something our society cannot afford to ignore. Cost effective treatment options, such as community-based services, would lessen costs in the other areas of the state expenditures. We know that community-based mental health treatment provided by a CMHC is in fact the best value for the State of Kansas.

Community-Based Mental Health Interventions are Effective and Cost-Effective

- Research shows that reduction in disability occurs following pharmacological and psychosocial treatment, alone or in combination - between 70 and 90 percent reduction of symptoms and improved quality of life.
- The cost-benefit ratios for early treatment and prevention programs range from 1:2 to 1:10, meaning that a $1 invested yields $2 to $10 savings. We also know that Intensive Case Management intervention is associated with significant reductions in inpatient, psychiatric 30-day readmission rates, and associated costs among adults who are at elevated risk of inpatient, psychiatric recidivism.
- People who have untreated mental health issued use more general health services (20% more) than those who seek mental health care when they need it.
- Treatment success rates for such disorders as depressions (more than 80 percent), panic disorder (70-90 percent) and schizophrenia (60 percent), surpass those of other medical conditions.
- The failure to adequately fund community-based mental health programs increases the census in state hospitals, impacts foster care and nursing homes, to say nothing of correctional facilities and juvenile detention facilities. We know it costs on average, $477 per day for treatment at one of our State psychiatric hospitals; $349 per day on average at a Psychiatric Residential Treatment Facility; $84 per day on average to be incarcerated at Larned Correctional Mental Health Facility; $10 per day on average for Medicaid expenditures for community-based mental health treatment; and $22 per day on average for Medicaid expenditures for the most chronic mental health conditions.



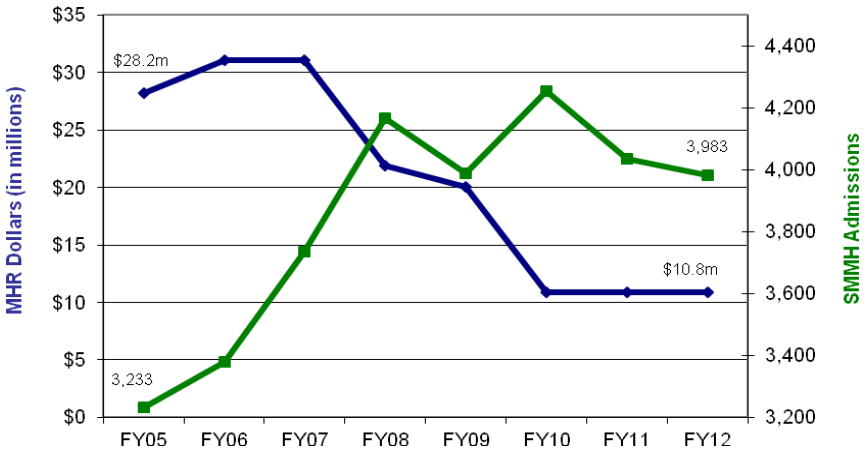
Policy makers must understand that paying for the costs of treating mental illness is unavoidable. Our only decision is how we as a State pay for it. The State can either invest in the public mental health system or pay a greater price through increased psychiatric hospitalization and primary care costs, greater reliance correctional facilities, homelessness, and other costs to society including lost productivity and suicide.

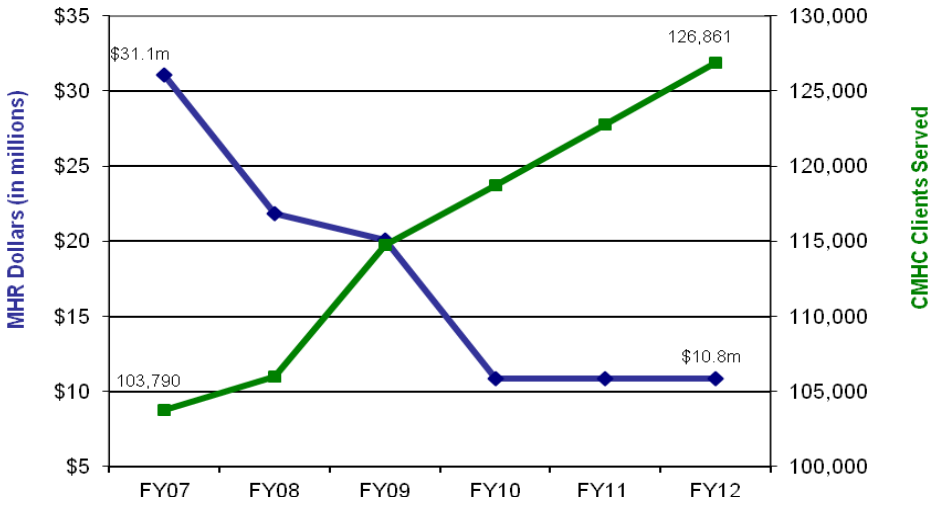
It is also important to note that investing in community-based mental health services directly lowers healthcare costs. Treatment for mental disorders is associated with a 20 percent reduction in the overall use of health care services. At a time when the State is struggling with containing the costs of health care, paying for the cost of community-based mental health treatment is part of the solution to our State's budget crisis.

Challenges Meeting the Needs of the Uninsured

Mental Health Reform grants allow CMHCs to serve the uninsured and underinsured who do not qualify for Medicaid and do not have resources to pay for their mental health treatment. It is this funding which essentially ensures every Kansan has universal access to mental health treatment. The CMHCs have a State mandate to serve everyone regardless of their ability to pay. If those living with mental illness do not receive timely treatment, they could easily end up being admitted into a State psychiatric hospital - the most costly level of care. It is the grant funding which has allowed Mental Health Reform to be a success.

As the pie chart illustrates on page 1 on my testimony, those served by the CMHCs who are not Medicaid eligible are the largest population segment served, yet the CMHCs have limited resources available to cover the cost of providing those services (90,000 individuals). Without treatment and care, many will end up in contact with law enforcement, jails, hospital emergency rooms or State psychiatric hospitals (see chart below). Individuals who are able to be treated in the community will have improved quality of life for themselves and their families, and ultimately be more productive citizens.

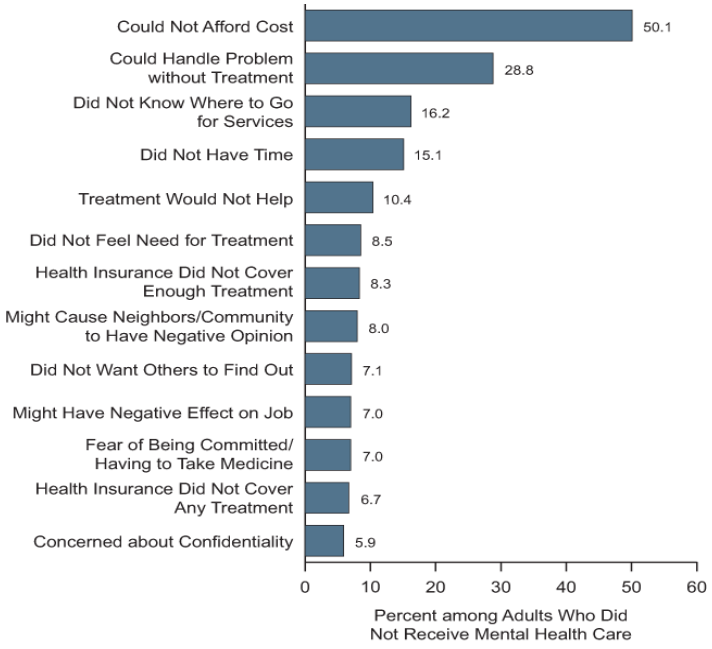




The impact of these reduced resources includes:

- Increased admissions to hospitals - local emergency rooms and psychiatric hospitals
- Increased suicide calls
- Increased demand for services
- Delayed access to services
- Raising monthly fee payment arrangements
- Elimination of programs
- Closing of satellite offices
- Reduced operating hours

According to the 2011 National Survey on Drug Use and Health (NSDUH), among the 4.9 million adults aged 18 or older who reported an unmet need for mental health care and did not receive mental health services in the past year, several barriers to care were reported, which are outlined in the bar chart below. **The top reason (50%) was they could not afford the cost of treatment.**



Mental Health Reform funding helped our system close state hospital beds and helps support services that are essential in keeping individuals out of inpatient settings. Reducing these funds puts at risk an already overstretched state hospital capacity. Without Mental Health Reform funding, there would be no universal system; no safety net; no 24 hour emergency care; increasing demands for mental health care in emergency rooms and in-patient setting; and a growing number of persons in our jails.

Recent History of CMHC Funding in Kansas

State Aid – This State General Fund (SGF) expenditure ensures all Kansans have access to crisis and emergency services 24 hours a day, every day of the year. **Unchanged since FY 2002 at $10.3 million**

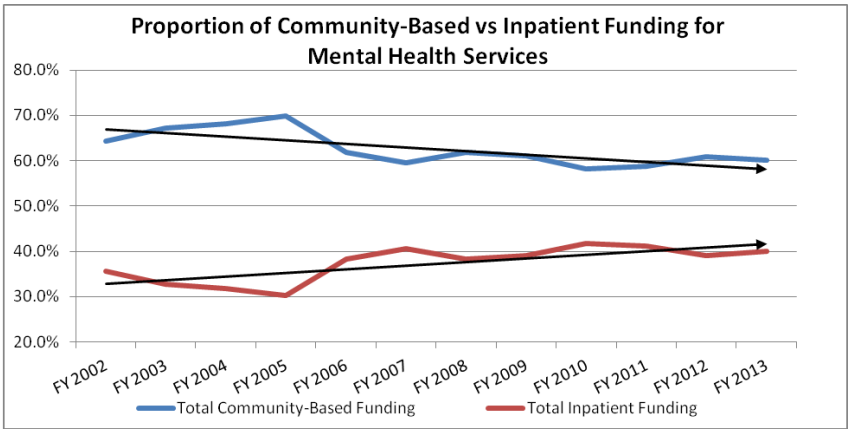
Mental Health Reform Grants – This SGF expenditure pays for uninsured/underinsured Kansans who have no other resources - over 90,000 Kansans. **Reached a high of $31 million in FY 2007 and has been reduced down to $15.8 million in FY 2013 (a 50% reduction)**

Total CMHC Funding – Of the $229 million All Funds that the CMHCs receive, only 11% is going to the uninsured and underinsured. **Yet it's for 53% of the people we serve**

- $15.8 million SGF from Mental Health Reform Grants
- $1.8 million SGF for Non-Medicaid Inpatient Screens (a statutory function)
- $2.9 million from the Federal Mental Health Block Grant
- $4.8 million for the Family Centered System of Care (CIF dollars)

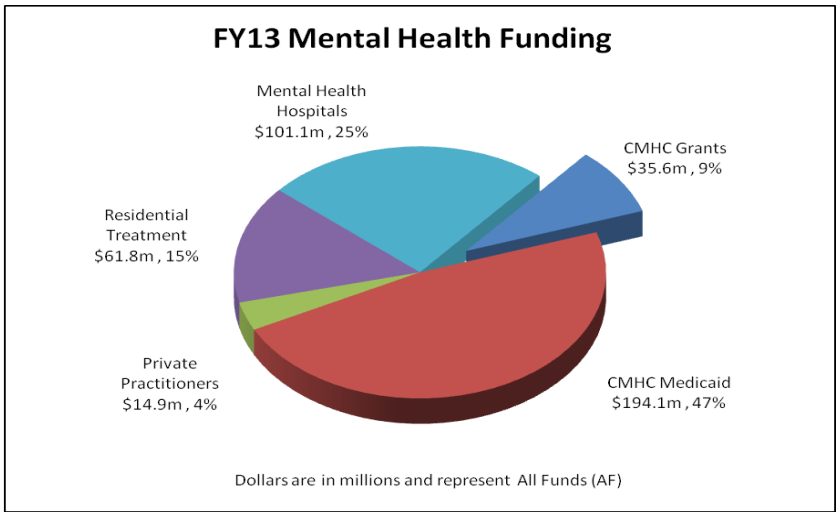
$25.3 million

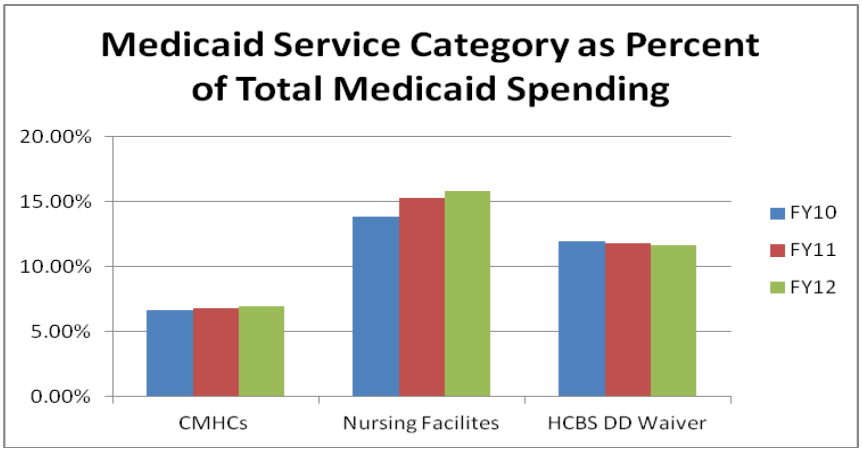
We are seeing a concerning trend when you look at expenditures for community-based services compared to inpatient expenditures.



Total Mental Health Services Funding – While total revenues (All Funds) for mental health services have doubled from $203m in FY 2002 to $407m in FY 2013, it is commensurate with the increased number of persons served. It's important to note that Medicaid consumers served nearly doubled in this time frame.

- $408m All Funds
  - $101.1 million for State Mental Health Hospitals
  - $61.8 million for Residential Treatment
  - $14.9 million for Private Providers
  - $229.8 million for Services Provided by CMHCs
    - $194.1 million Fee-for-service Medicaid
    - $35.6 million SGF/Other Non-Medicaid





It is important to note that mental health as a percent of total spending in Medicaid in Kansas has consistently been under 7% over the last three fiscal years

The Value of Early Intervention and Prevention

A combination of well-targeted treatment and prevention programs in the field of mental health, within overall public strategies, could avoid years lived with disability and deaths, reduce the stigma attached to mental illness, increase considerably the social capital, help reduce poverty and promote independence, and stem the tide of those becoming disabled and reliant upon State resources to pay for their care.

Studies provide examples of effective programs from prenatal and early infancy through adolescence to old age – and different situations, such as post-traumatic stress following accidents, marital stress, work-related stress, and depression or anxiety due to job loss.

For all individuals, mental, physical and social health are closely interwoven. Mental functioning is fundamentally interconnected with physical and social functioning and health outcomes. As our understanding of this interdependent relationship grows, it becomes ever more apparent that mental health is crucial to the overall well-being of individuals and societies.

The economic impacts of mental illness include its effects on personal income, the ability of the person with a mental disorder to work and make productive contributions to the State and local economy. Unemployed persons and those who fail to gain employment have more depressive symptoms than individuals who are employed. In the U.S., mental illness is considered responsible for an estimated 50 percent of the economic costs deriving from injury or illness-related loss of productivity. We know that employees with depression

are disabled at nearly twice the rate of persons without depression. Studies suggest that the average annual costs, including medical, pharmaceutical and disability costs, for employees with depression may be 4.2 times higher than those incurred by a typical beneficiary. However, it has also been found that the cost of treatment for depression is completely offset by a reduction in the number of days of absenteeism.

Studies have shown a significant relationship between the prevalence of common mental disorders and low education levels. Moreover, a low educational level prevents access to most professional jobs, increased vulnerability and insecurity. This contributes to a persistently low social capital, illiteracy and illness - therefore lock in poverty.

Without investment in mental health, the vicious circle of poverty and mental disorders are perpetuated, thereby preventing poverty alleviation and development.

Is It Possible to Promote Mental Health and Prevent Mental Disorders?

The simple answer is yes. Prevention and promotion programs have been shown to result in considerable economic savings to society. Psychosocial factors influence a number of health behaviors (proper diet, adequate exercise, avoiding cigarettes and drugs, and risky sexual practices). A growing body of cross-cultural evidence indicates that various psychological, social and behavioral factors can protect health and support positive mental health. Such protection facilitates resistance to disease, minimizes and delays the emergence of disabilities and promotes more rapid recovery from illness. Here is what we know from research:

During Pregnancy and After Child Birth

- Breast feeding improves bonding and attachment between infants and mothers, and significantly improves child development.
- Visits by nurses and community workers to mothers during pregnancy and after childbirth, in order to prevent poor child care, child abuse, psychological and behavioral problems in children and postnatal depression in mothers have proved to be extremely effective on a sustainable basis.
- Teaching mothers about early monitoring of growth and development in low birth weight babies, along with proper maternal advice, can prevent poor intellectual development.
- Early stimulation programs can enable mothers to prevent the slow development often seen in preterm infants, and improve the physical growth and behavior of such infants.
- Nutrient supplements to prevent neuropsychiatric impairment have also been found to be useful.

Childhood and Adolescence

- Promotive interventions in schools improve self-esteem, life skills, pro-social behavior, scholastic performance and the overall climate.
- Psychosocial interventions such as cognitive behavioral therapy and family-based group intervention for high risk children prevent the development of anxiety disorders and reduce depressive symptoms and conduct problems.
- Multisystemic Therapy and Functional Family Therapy are two of the top evidence-based family-focused programs.
- Depression in adolescents has a high risk of recurrence in adulthood and is also associated with the risk of development of personality problems or conduct disorders.
- It is possible to prevent the majority of suicides and suicide attempts among schoolchildren through a comprehensive school-based prevention programs that include teacher training, parent education, stress management and life skills curriculum, in addition to the introduction of a crisis team in each school.

Adults and the Elderly

- It is possible to reduce dysfunctional marital communication, sexual difficulties, divorce and child abuse among young couples through education and skills training.
- Programs to cope with widowhood and bereavement have been seen to help reduce depressive symptoms and facilitate better adjustment.
- Among various psychosocial factors linked to protection and promotion in adults are secure attachment; an optimistic outlook in life, with a sense of purpose and directions; effective strategies for coping with challenge; emotionally rewarding social relationships and social integration.

- Retrenched workers who received adequate counseling coped better, had fewer depressive symptoms and managed to find better jobs. Retrenchment and job loss can cause depression, anxiety, and many other problems such as alcoholism, marital stress, child abuse and even suicide.
- Exercise, such as aerobic classes provided both physical and psychological benefits in elder populations.
- Early geriatric screening and case management can result in a range of beneficial and cost-effective outcomes, including mental health benefits. In-home geriatric assessment, regular contact and a range of social services (home-making, personal care, emergency alert response) led to decreases in depression and increased mastery and life satisfaction. Significant decrease in institutionalized (15% reduction) was found for those who received intervention across the study.

According to the World Health Organization (WHO), there are evidenced-based social, environmental and economic determinants of mental health.

Risk Factors	Protective Factors
Access to drugs and alcohol	Empowerment
Displacement	Ethnic minorities integration
Isolation and alienation	Positive interpersonal interactions
Lack of education, transportation, housing	Social participation
Peer rejection	Social responsibility and tolerance
Poor social circumstances	Social services
Poor nutrition	Social support and community networks
Poverty	
Discrimination	
Social disadvantage	
Violence	
Work stress	
Unemployment	

Also noted by the WHO are main evidence-based factors that have been found to be related to the onset of mental disorders are outlined below.

Risk Factors	Protective Factors
Academic failure	Ability to cope with stress
Attention deficits	Adaptability
Caring for chronically ill patients	Autonomy
Child abuse/neglect	Early cognitive stimulation
Chronic insomnia	Exercise
Chronic pain	Feelings of security
Communication deviance	Good parenting
Early pregnancies	Literacy
Elder abuse	Positive attachment and early bonding
Emotional immaturity	Positive parent-child interaction
Excessive substance abuse	Problem-solving skills
Exposure to aggression and violence	Pro-social behavior
Family conflict	Self-esteem
Loneliness	Skills for life
Low birth weight	Social and conflict management skills
Low social class	Socioemotional growth
Medical illness	Stress management
Neuorochemical imbalance	Social support
Parental mental illness	
Personal loss	
Poor work skills	
Stressful live events	

The determinants of mental health and those risk factors identified as being related to the onset of mental disorders are things we as a state should invest in and focus on in the years to come.

Current Efforts in the Kansas Public Mental Health System

The following are examples of current early intervention/prevention efforts that are being implemented in the Kansas public mental health system:

1. Parenting classes. With a wide range of parenting topics and techniques, these programs are provided at no cost to families. The mission is to provide skills for parents, grandparents, foster parents, teachers, and child care providers to recognize normal developmental patterns, prevent misbehavior; use different forms of discipline, and take safety precautions and to manage stress and anger.

2. Mental health services targeted at children 0-5 years of age. Provide in-home family therapy, parent education, make referrals for treatment and provide education on social/emotional development to early childhood providers.

3. Preschool programs. It is an early intervention program aimed at increasing the social skills necessary to enter school and be successful. We are taking children who have been ejected from multiple daycare settings and who are on a trajectory for school failure due to their behaviors.

4. Project Before. This is a family case management program funded by an Early Childhood Block Grant through the Kansas Children's Cabinet & Trust Fund. The program is offered at no cost to those families who qualify for the program. The Project Before program targets families who have one or more children in the home, ages birth to five. In addition, the parent/caregiver in the home must be perceived as having a mental health and/or substance abuse issue. Other at risk factors for families involved in the Project Before program may include, but are not limited to, family income below the poverty level, single parent home, parent without a high school education, teen parent, and other stress or risk factors.

5. Community Assessment Program for Seniors. This is an agreement with a local Department on Aging to provide early intervention services to seniors. This Community Assessment Program for Seniors (CAPS) reimburses for the first few contacts with a senior who may be experiencing a mental health problem. Referrals come through Aging and the CMHC sends a therapist to meet with the senior in their home, to determine if future services are needed and if so, to spend time engaging with the person so that they would be willing to consider coming to the Center for additional services. This program allows the CMHC to intervene sooner than if they wait for the individual to come to them for treatment, and to establish a relationship with them to improve the likelihood of their following through with other services.

These examples are not state-wide programs, but rather programs funded in a specific location. The CMHC system in Kansas also implemented in multiple locations a school violence prevention program and therapeutic services to preschools. Both programs were funded by the Children's Cabinet and the funding was eliminated because they were not State-wide programs and the Children's Cabinet was looking for ways to reduce expenditures. The following is brief summary of those two programs:

- **Therapeutic Services to Preschool Children.** The purpose of therapeutic services to preschool children funded by CIF funds was to identify young children experiencing SED early and to provide and/or connect the children and their families to the supports and services known to be successful in producing positive outcomes in children with special needs. These programs appeared in both urban and rural areas. They were implemented as collaborative endeavors among CMHCs and early childhood or preschool programs such as Head Start or local school district special education services. These programs incorporated the goals of maintaining at-risk children in the least restrictive, most natural residential and educational environmental possible, promoting attachment and effective family functioning, and enhancing social academic readiness to ensure success in school. Data shows that the majority of children served through therapeutic preschools were able to remain in their permanent family home and were also able to enter regular classroom settings with their peers. Parent evaluation data was also very positive.

- **School Violence Prevention.** These programs emphasized a collaborative approach to providing children with mental health support/services in a school setting, focusing on issues related to violence prevention. This collaborative approach involved CMHCs, schools, parents, youth, and coordinating councils. The target population was school-aged youth with SED and/or at risk for violent behavior. Program efforts focused on providing appropriate community level supports and services for

prevention of need for more restricted placement. Youth transitioning from a more restrictive placement such as treatment facilities, psychiatric hospitals and detention centers were a focus. These programs were critical to the Connect Kansas goals in that they impact the safety of the community and the school setting; help children feel safe in a school setting; help children succeed in school; and promote healthy behaviors.

Community-based mental health services are most definitely a good value. Paying for the cost of treatment is unavoidable. Our only decision is how and when we pay for it. Addressing early risk factors and determinants of mental illness help reduce and even prevent the onset of a costly and disabling mental illness. Providing community-based treatment is also far less expensive than providing treatment in institutions. Invest in a system of care and an array of services that work and prove to save State dollars!

Continuum of Care

Attached to my testimony (Attachment A) is a diagram depicting what the typical continuum of services looks like at a CMHC. That continuum includes: outreach, crisis services, outpatient services, rehabilitation services and prevention/education.

Service Array

Also attached to my testimony (Attachment B) is information about the service array for children and youth with an SED; adults with SPMI; and to the non-target population.

Evidence Based Practices

Evidence based practices are approaches to treatment and prevention that are based in theory and have undergone scientific evaluation. I thought it was important to highlight for you some of the examples of EBPs utilized in the CMHC system here in Kansas (Attachment C).

Outcomes

It is also important to highlight that Kansas receives high marks on the National Outcome Measures (NOMS) for its community-based public mental health system as well as other outcome measures tracked in our system.

Adult Consumer Survey Measures	**State Rate**	**U.S. Rate**
Access to Services	91.1%	85.2%
Quality/Appropriateness of Services	92.6%	88.4%
Outcome from Services	85.0%	70.5%
Participation in Treatment Planning	84.6%	80.4%
General Satisfaction with Care	92.7%	88.4%

Child/Family Consumer Survey Measures	**State Rate**	**U.S. Rate**
Access to Services	83.6%	83.8%
General Satisfaction with Care	87.5%	83.8%
Outcome from Services	81.7%	64.6%
Participation in Treatment Planning	92.5%	86.8%
Cultural Sensitivity of Providers	96.6%	92.5%

Change in Social Connectedness	**State Rate**	**U.S. Rate**
Adult Improved Social Connectedness	81.8%	70.0%
Child/Family Improved Social Connectedness	91.6%	85.3%

Source: 2011 SAMHSA Uniform Reporting System Output Tables

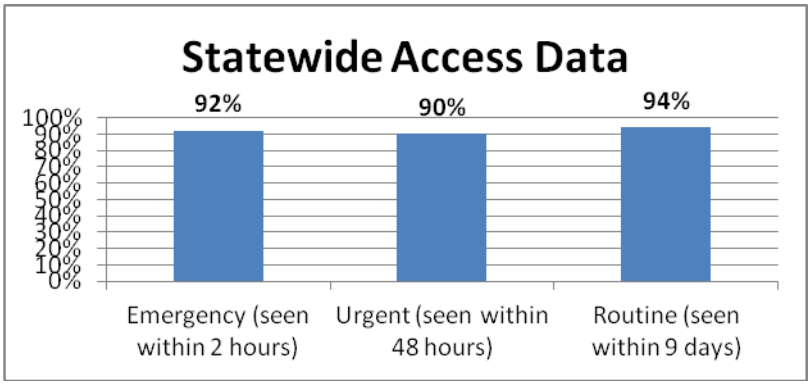
Additional Outcomes

The CMHCs have maintained or improved outcomes for children, adolescents and adults.

For SED Non-Waiver Youth	FY11
Living In a Permanent Home	80%
Receiving A, B, or C Grades	74%
Attending School Regularly	97%
Report No Law Enforcement Contact	95%

For SED Waiver Youth	FY11
Living In a Permanent Home	92%
Receiving A, B, or C Grades	75%
Attending School Regularly	98%
Report No Law Enforcement Contact	94%

For SPMI Adults receiving case management	FY11
Living Independently	81%
Competitively Employed	12%
Participating in Some Form of Education	11%



Services to Seniors

Many seniors in our communities have or will develop some mental illness during their golden years. As seniors face losses of health, family, friends, neighbors and even isolation as they age in place, they may develop depression or other mental health issues. Seniors deserve to maintain their mental health, and deserve to receive treatment so they can live well and age successfully.

Did you know…

- ✓ Elderly population is projected to grow rapidly between 2010 and 2030, as the 76 million "baby boomers" reach 65 yrs of age.
- ✓ By 2030, older adults will account for 20% of the nation's people, up from 13% today. Simply by virtue of the growth of the older population, the need for geriatric mental health services will increase.

- ✓ The most common disorders, in order of prevalence, are: anxiety disorders, severe cognitive impairment (including Alzheimer's disease), and mood disorders (such as depression).
- ✓ Between 8-20% of older adults in the community, and up to 37% of those who receive primary care, experience symptoms of depression.
- ✓ Older Americans under-utilize mental health services. Barriers include: stigma surrounding mental illness, denial of problems, lack of collaboration and coordination among primary care and aging services providers.
- ✓ It is estimated that only 50% of older adults who acknowledge mental health problems receive treatment from any health care provider, and only a fraction of those receive specialty mental health services.
- ✓ Various studies indicate a high prevalence of mental illness in nursing homes. Dementia and depression appear to be the most common mental disorders in this setting. However, most residents with mental disorders do not receive adequate treatment. Approximately 66% of those in nursing homes suffer from mental disorders, including Alzheimer's and related dementias.
- ✓ Less than 3% of all Medicare reimbursement is for the psychiatric treatment of older patients.
- ✓ Older adults have the highest suicide rate of any age group, and persons over the age of 85 have a rate double that of any other group.

Of the 27 CMHCs, 7 have reported they have specialty or dedicated programs for older adults. However, all provide services to older adults and all work with the Area Agencies on Aging (AAAs) to identify seniors who may need mental health services and then provide treatment to those individuals. The following are a few examples of what specialty or dedicate programs look like for older adults:

Older Adult Services Overview at Prairie View (Newton, Kansas)

Prairie View employs psychologists, social workers, psychiatrists and APRNs who specialize in working with older adults in each of their six outpatient offices: Newton, McPherson, Hillsboro, Hutchinson, East Wichita-Legacy Park and West Wichita-Reflection Ridge.

Outpatient services include:

- Evaluations/Outpatient Assessment
- Psychological Testing
- Neuropsychological Testing (a comprehensive assessment of immediate and delayed memory, language, attention, concentration, visuospatial skills, mental processing speed and executive functioning)
- Driving Capacity Evaluations
- Individual Therapy
- Group Therapy
- Family Therapy
- Medication Evaluation and Management
- Caregiver Services
- Brief Assessment and counseling
- Monthly Support Group for Parkinson's Patients and Their Families in McPherson County.
- Monthly Support Group for families of people with Alzheimer's disease or a related dementia in McPherson.

In addition to outpatient services, Prairie View provides services to retirement communities in seven counties. Prairie View contracts with 36 long-term care facilities to provide gero-psych services.

Prairie View also provides Inpatient, Partial Hospital, Intensive Outpatient (IOP), a 2 day Comprehensive Outpatient Evaluation (COPE) and a Comprehensive Diagnostic and Treatment Center (CDTC) for older adults.

- **Inpatient Services.** The inpatient program provides intensive evaluation and treatment, including a psychiatric evaluation. Every older adult receives a complete physical exam and a thorough assessment of all medications and potential side effects. An older adult specialist – either a social worker or psychologist – provides individual and group therapy, and works with the older adult and the family. In addition to the traditional individual therapy, group therapy and psychiatric medication management, our inpatient setting offers art therapy, recreation therapy, pet therapy, pastoral counseling, sensory stimulation and more. To aid in follow-up after discharge, family members, the primary care physician and/or the long-term care facility in

which the patient resides (if applicable) receives a discharge summary and Practical Intervention Plan, which provides detailed information on "what works" with this particular person.

- **Partial Hospital.** Similar to the treatment received as an inpatient, partial hospital is a day program, meaning the client will go home in the evening and return in the morning.
- **Life Transitions Program.** This is an intensive outpatient program **(IOP)** designed for older adults who do not meet criteria for inpatient or partial hospitalization but need more intensive services than outpatient services. The program is scheduled Tuesday and Thursday at Prairie View's Newton campus from 9 a.m. to 12:30 p.m. The program is designed for those dealing with psychological problems and issues with growing older. Goals include relieving symptoms, developing coping skills, building social supports and maximizing quality of life.
- **Comprehensive Outpatient Evaluation for Older Adults (COPE).** This is a two day program that offers a comprehensive evaluation by a team of older adult specialists including a psychiatrist, family medicine specialist or internal medicine specialist, a psychologist, and a social worker. Following the evaluation, the patient and family receive recommendations for follow up treatment in their home community.
- **Comprehensive Diagnostic and Treatment Center for Older Adults (CDTC).** This program is an outpatient program but involves a stay of several days to several weeks on the inpatient unit. Both a comprehensive diagnostic workup and treatment are provided. The person must not meet criteria for inpatient hospitalization to be accepted into the CDTC program.

Other Prairie View services for the older adult population include:

- Training for staff in nursing homes which are starting Memory Care Units. Prairie View helped develop and direct the first Special Care Unit in Kansas in 1986.
- Free memory screenings for older adults in four counties, usually at local senior centers; each screening also includes a depression screen
- Aging conferences, which bring in nationally recognized speakers
- Psychology Internship Program with a rotation in older adult services
- Postdoctoral position in older adult services
- Testamentary Capacity Evaluations
- Consultations to families, funded by Area Agency on Aging grants

<u>Older Adult Services Overview at Four County Mental Health Center (Independence, KS)</u>

Senior Outreach Services provides specialized mental health and substance abuse services to persons in their four county area age 60 and older who are living at home or in senior housing, including assisted living.

Direct Services:

- Screenings and Outreach
- Counseling
- Case Management
- Group Therapy
- Community Support Groups
- Caregiver Support
- Collaboration with physicians, medical providers and other key resources

Madame Chair, this concludes my presentation. I thank you and the Committee for allowing me this opportunity to testify. I am happy to stand for any questions.