

**KDADS Regional Recovery and Support Centers
Regional Meetings
May 2013**

Vision

Kansans who have not achieved recovery through traditional means will live successful self-determined, meaningful lives in their home community.

Purpose

Education and buy-in
Begin regional needs assessment
Forming key community partnerships

KDADS Behavioral Health Regional Recovery Support – Region #1

***Hutchinson – May 17, 2013
14 participants in person and 1 on the phone***

What's unique about your region that would indicate some of these services are needed more than others?

- Distance
- Frontier area – A lot of the region
- Need for employment
- Crisis stabilization - if crisis passed would not need to be hospitalized
- Methamphetamine capital – high Methamphetamine user population
- Reno County – high crime rate increases the need to connect with behavioral health
- Poverty – see data from Regional Prevention Centers
- Evidence-based practice looks different in communities that have high percentage of methamphetamine users; rural; especially related to housing and homeless
- Demographics are changing – those new to communities from different cultures/counties have strong family connections and keep mental health issues “within” the family. As this population grows how will it impact the community?
- Difficult to find qualified staff
- Translation services not readily available
- Fewer resources available – Note: Cannot call four to five places/organizations, but just one organization in the community that provides services
- Lack of internet connection
- Lack of cell phone connection

- Transportation – transportation services don't run during the day / if you have transportation services
- Differences within the region (Garden City, Dodge City, Colby, Hays, Hutchinson and the frontier communities)
- Transportation to get to resources
- Providers take services further than “across town”
- Transient population → between border states (Oklahoma, Colorado and Nebraska)
- Safe and affordable housing is not available. (quality of housing)
- Lack of education/understanding by parents, siblings, etc. as to how they can be helpful
- Not as many 12-step, support groups → some in just 1-2 areas
- Some counties do not have a pharmacy

What are all the ways this region is already in contact or working with these individuals?

- Provide direct financial support for medicine or other needs
- SSI/SSDI, OUTREACH, ACCESS, AND RECOVERY (SOAR) program
- Assistance without seeing a specific doctor → this is a barrier in serving this population because of transportation to metropolitan areas for services
- Come into contact with consumers through jails and prisons
- Forced to recommend a lower level of care due to distance
- Meetings with local nonprofits, ministries, food bank, schools to discuss how to assist individuals with needs
- Substance use disorder (SUD) providers who work through Block grant → work with each other when no beds, waiting lists, using capacity as best possible
- Provide peer support in Hutchinson, Wichita; but not in other counties while waiting for bed
- Working with sheriff department/law enforcement center to work with inmates
- Planned meeting with foster care to help with stability of kids (both within and cross regions)

What could be done better to coordinate efforts to help these individuals?

- Prevention → get into schools for those who don't come to the mental health centers
- Agencies share resources (sometimes through legislation → example: mental health center with medications that can be purchased through co-op)
- Companies that sell medications recognize the high level of poverty (income eligibility) for people with behavioral health
- Red tape- different agencies guided by different guidelines, policies, etc.
- Getting information “out there” esp. to a group who may not be trusting of traditional services (Accessibility; education)
- Awareness/education of mental health issues to address stigma

- Flexibility in use of resources → mold and adapt to needs identified
- Transportation...how do we get people to the services they need?

Additional comments:

- Consider community needs assessments

Dodge City – May 14, 2013

20 participants in person and 6 participants on the phone

What's unique about your region that would indicate some of these services are needed more than others?

- Meeting medication needs both in prescribing & funding
- Transportation needs in this region
- Bilingual services are needed – significant population of Spanish and Southeast Asian-speaking people.
- Use of other evidence based practices i.e. Assertive Community Treatment
- Consumer Run Organizations in the region provide groups with speakers as a resource
- Distance/geography is an issue – resources and population are distributed across multiple frontier and rural counties.
- Working relationships with Larned State Hospital are a positive – Community Mental Health Centers have been working directly with Larned State Hospital since mental health reform.

What are all the ways this region is already in contact or working with these individuals?

- Lack of resources for medication at Juvenile Detention Centers – clients going to Juvenile Detention Centers to access medications
- Timely access to medication for “kids”
- Psychiatric Residential Treatment Facilities/hospitals/Juvenile Detention Centers
- More people showing up at emergency rooms
- Consumer run organization's members receiving help at Community Mental Health Centers– private
- Consumer run organization in Hays is open 6 days a week. On the day it is closed, members have a crisis
- Consumer run organization members want a safe place to go
- Substance Abuse mentoring – have been utilizing peer mentoring – is this helping?

What could be done better to coordinate efforts to help these individuals?

- Unique challenge – undocumented individuals (Hispanic) – have fear of coming to the Mental Health Center
- Other agency support i.e. Housing Authority – ability to network – grant support
- Mental Health First Aid – many individuals take this course
- Outreach/engagement specialists – persons to help connect people with available services
- Potential partnership – providers and insurance companies
- Initially – case manager had time to go out and work with people
- Developing relationships that keeps one engaged
- Where are resources/funding going to come from to support this initiative?
- Engagement of unfunded target individuals – how to support the funded programs
- Taking family based perspective in solutions that we find

Who are we not hearing from today?

- Law Enforcement
- Medical providers
- Primary care safety net
- County Commissioners
- State Hospitals
- (limiting to (3) questions – need more input)

Additional Comments:

- Loss of funding of mental health reform – we have lost the resources
- Have had to close (3) programs due to loss of funding
- Programs that will be at risk – homeward bound
- Loss of funding – foster care diversion
- Crisis stabilization program will be at risk – High Plains
- In rural regions – not working for lack of intensive services
- Fear of loss – parent support

KDADS Behavioral Health Regional Recovery Support – Region #2

Wichita – May 17, 2013

38 participants

What's unique about your region that would indicate some of these services are needed more than others?

- Long history – strengths – based case management
 - Assertive Community Treatment
 - Supported Housing evidence-based practice
- Large crisis stabilization in regional areas
- Residential detox/sobering
- Choices critical
 - Crisis care/crisis stabilization
- Housing a big issue
 - Not enough of any level
 - Apartments scarce
- As urban & rural area, focus on supportive employment
 - Prevocational & connection to employers
- Clients without transportation seeking employment
- Need for respite services, children and families

What are all the ways this region is already in contact or working with these individuals?

- Hot lunch (Episcopal Social Services)
- Coming from jail, can't get them connected (to medication, for example)
- People (homeless) who come to shelter often most difficult to reach, serve
 - Were treatable earlier
- Emergency situations, emergency rooms
- Health system: safety net
 - Clinics
- Emergency Medical Services – getting people to emergency rooms for psychiatric reasons
- Crisis intervention team training for law enforcement
- Schools, interacting with kids
- Courts
 - Assessment program & mental health board at municipal level

What could be done better to coordinate efforts to help these individuals?

Question

- Community crisis center
 - Collaborate with hospitals, law enforcement, Comcare, Mental Health Centers & substance abuse
 - Can use \$ more effectively

- How access training?
- Opening to larger groups
 - Training & technology team at Wichita State University, for example
- Mental health 1st aid course for community, skill-building
- Who is eligible for which services? A number of folks have great need but don't quite qualify – unnecessary silos
- Need to fit in “boxes” for certain funding means people lose supports for which they previously qualified
- For persons with intellectual disabilities, may not progress in a way that maintains eligible status for funding
- Hours from a state hospital; few children's psychiatric beds
- When transitioning between systems, distance = more difficult
- Children on waiver when reaching adulthood do not qualify for disability
- Civil commitment
- More local, residential crisis stabilization options
- Separate authorization processes

Additional comments:

- Services are the issue, rather than engagement
 - Funding just enough to get people slightly engaged
 - Disconnect – nowhere to engage
- Where do people learn about their own illness
- Program that reduced recidivism no longer funded

KDADS Behavioral Health Regional Recovery Support – Region #3

Overland Park – May 13, 2013
42 participants

What's unique about your region that would indicate some of these services are needed more than others?

- No standard place for parents to get training or learn how to deal with schools, insurance companies service providers, Etc...
- No transparent standard of care in broken system – Parent education helpful
- Crisis stabilization – absent, central location needed
- Lots of providers willing to work – who currently cannot access funding codes
- Housing facilitation/supported housing
- Pilot program in Johnson County and Olathe – trained crisis intervention team, co-responder and Olathe police department
- Shawnee, Wyandotte and Douglas all juvenile detention alternative sites
- Highlight again Crisis stabilization
- Lack of in-patient resources
- Lack of transportation resources

- County-level initiative in Johnson County for crisis intervention team and any services should incorporate
- High proportion of clients are minorities
- Have strengths-based training

What are all the ways this region is already in contact or working with these individuals?

- Already have a SSI/SSDI, Outreach, Access, and Recovery (SOAR) program
- Intensive case management
- Follow-up services are needed – Heartland RADAC provides intensive case management.
- Global crisis response team – Key partner is crisis intervention team officer
- Mental health centers prime resource to meet needs
- Get support group information to the public
- 211 is a good place to start to look for community resources
- Johnson County has a resource directory
- We need to be able to serve the individuals left behind because of reduced funding

What could be done better to coordinate efforts to help these individuals?

- Need a better network to help meet the needs
- Coordination with partners
- Mental health center – transport partnership
- Transportation is a huge issue
- Policies to address billing and driving
- Self-transportation options (bikes, etc.) busses
- Medical and mental health providers not working together (doctors prescribe conflicting medications)
- American Academy of Family Physicians
- Department for Children and Families (DCF) and Kansas Department for Aging and Disability Services (KDADS) needs to coordinate more
- Partners with local hospitals in services to crisis stabilization
- Draw on previous needs assessments for information
- Insurance/disability companies to reduce application time and communication needs
- Note - trade-off for medical access
- Navigation across all resources
- Note – Kids not considered at risk because hospitals won't take them
- Coordination of assessments across providers/managed care organizations/etc...
- Listen to be open
- Feed real world knowledge into medical schools

Who have we not talked to?

- Addiction and Prevention services

Additional comments:

- We are good at naming problems, but we need follow-up
- Community support – How to navigate system – What is available to learn how to enter the system
- People do not have access to what services are available
- Crisis service are very important but do not have a way to bill for it
- Outreach is very important
- It is hard to motivate providers when client is uninsured
- We are booked out – There are more clients than we can currently handle
- It is hard to get medications in a timely manner – it takes 6 weeks to get medications
- Currently so many clients are underserved
- Need more resources
- This is not new money – it is from one population to another one
- Consumer as providers graduates need to be hired
- Confidentiality is an issue when transitioning services between agencies

KDADS Behavioral Health Regional Recovery Support – Region #4

Manhattan – May 15, 2013

42 participants in person and 3 participants on the phone

What's unique about your region that would indicate some of these services are needed more than others?

- Need to go towards evidence based practices
- More integration of services - dual diagnoses
- Great amount of rural areas - Need to share resources
- Hard to get homeless screened to get medications
- Projects Assisting into Transition from Homelessness (PATH) services delivered differently in different areas
- Military - crisis stabilization within the military
- Too long of wait to get services
- Hard to get services for children under 5
- Need to start with parents to serve children
- At-risk homelessness - it is difficult to get services
- Transportation is needed/take services to the home
- Hard to get individual information for medication evaluation
- Problem to get service to the individual before they hit crisis
- Access to medications in a timely manner
- Hard for consumer to afford medications
- We have community support medication program - possible expansion

- Local task forces
- Need adequate housing
- Need to address serious ill individuals (not outpatient services)
- We have all (urban, rural & frontier) areas.
- Utilization of crises stabilization beyond Medicare
- Large veterans population
- Utilize peer support
- Absence of including faith based community

What are all the ways this region is already in contact or working with these individuals?

- Local community foundation grant to supplemental medications
- Partnerships with Salvation Army
- Veteran Administration issuing housing vouchers
- Through work with salvation army
- Early Head Start and Head Start see and assess the family before other organization
- Whole communities are recognizing the need for mental health along with physical health
- Jails need to be able to support inmates mental health needs
- Working with community reintegration (jail)
- Supported housing funds
- With reduced funds there is need to reach out to the community for support and services
- Rural areas do not have skills for delivering services
- Homeless shelters are working together. Not enough funding
- Crisis goes into the jails to work with consumers
- Reaching out to consumers - Going out with law enforcement and other community partners (support housing and partners)
- Churches - Shepard's Crossing help with medications
- Community health
- Connection/communications between Doctors
- Severe and persistent mental illness (SPMI) program
- Case managers use SSI/SSDI, Outreach, Access, and Recovery (SOAR) to help individuals receive disability services
- Apartments to severe and persistent mental illness (SPMI) I, but they are full
- Mental Health cuts - Management teams are working on getting individuals seen as soon as possible
- SSI/SSDI, Outreach, Access, and Recovery (SOAR) is important

What could be done better to coordinate efforts to help these individuals?

- Look at community partners (Head Start)
- Work together → work smarter

- Better transition from youth to adult
- Coordination between agencies and nonprofits – National Alliance on Mental Illness (NAMI), Keys for Success
- Need 24 access for services
- Local conversations
- Better partnership for uninsured
- Substance use disorder issues need to be addressed
- social connection is vital
- Partnerships with faith based organizations to provide more information
- Develop communities that care
- Youth inclusion is important
- Better communication

Additional comments:

- Need program in state for affordable housing
- Private insurance does not cover crisis stabilization
- Need more Veteran Administration money for peer support
- Need more help to keep vets in community
- With high cost and number of medications local programs can provide little help
- Clients must go to hospital for screen before they receive mental health services
- 60% of adults with Severe and persistent mental illness (SPMI) do not get services

KDADS Behavioral Health Regional Recovery Support – Region #5

Independence – May 16, 2013

11 participants in person; 2 participants on the phone

What's unique about your region that would indicate some of these services are needed more than others?

- Inpatient provider in Oklahoma closed recently—have had to 'beef up' what we offer to keep folks in the community
 - Closest facility is now Stormont-Vail in Topeka (2 ½ hours away)
- We are sending folks out of state—Medicaid \$\$ go outside of Kansas and the rules and treatment standards are different/not consistent with Kansas
 - Adults go to Joplin MO
 - Children go to Nevada MO
- Dialectical Behavioral Therapy (DBT) is challenging in rural areas
 - People who need it are in various/different communities—not cost effective to transport for this intensive service

- Lack of Housing and Urban Development (HUD)/Housing dollars (lack of Continuum of Care funding)—these dollars not coming to SE Kansas
 - Impacts recovery
- SSI/SSDI, Outreach, Access, and Recovery (SOAR)—lacking case managers in this area of state/region
 - Need housing resources—both dollars and available housing
- Size of this region is large—how ‘region’ would meet needs of clients; distance
- No public transportation—20% (and more) don’t qualify for Medicaid transportation service (reimbursement)
- In Home Family Therapy—funded in way that doesn’t support the position/staff to provide it
 - Intensive service—valuable, however distance is issue; getting service to folks frequently enough
- Sustaining parent support services to 6 counties in light of loss of Family Centered Systems of Care (FCSC) money
- Family/Parent support in not only rural, but Frontier counties—not unusual for a worker to travel 200 miles in a day to visit a small number of families
 - Also true that many of the folks served in Frontier areas are some of the poorest/underserved/underinsured in our area
- Dual Diagnosis services
 - Don’t have reintegration/Step Down type services/programs here
- Family Centered Systems of Care—this model was created in this area/region and became the statewide model; was created through input and work with consumers
 - Want to protect these services for kids and families
 - Founders still work here; frightening this might go away
 - Went from serving approximately 60 kids to serving more than 300
 - Shows consistent and positive outcomes
- Strengths-based model—been doing this since 1985
- Patients are being discharged from Osawatomie State Hospital (OSH) while still experiencing symptoms because long-term care is no longer an option
 - Need long-term care options
- Peer support services could be strengthened in our area—there aren’t a lot of CRO’s/NAMI chapters here

What are all the ways this region is already in contact or working with these individuals?

- School/teacher referrals—Case managers assigned to schools
- Relationships with
 - Law enforcement

- Juvenile Justice Administration
- Emergency Rooms
- Faith-based organizations and institutions (churches)
- Extensive crisis departments who do significant outreach
- Partnership with Federal Qualified Health Centers (FQHC) (Pittsburg and other primary locations where uninsured and underinsured live)
 - FQHC is on CMHC campus—strong connection
- Parent to Parent; Peer to Peer connections and referrals—people who will call and ask for a specific individual they heard has similar experiences; more willing to talk with them about what’s going on and result in referrals
 - Family Centered Systems of Care (FCSC) money paid for these positions in some cases (concerned could lose this if these dollars are lost)
- A 2-bed crisis unit—case managers, on-call staff
 - Family Centered Systems of Care (FCSC) dollars pays for this—keeps folks in community (Four County area/Independence)
- Open Access model—persons receive an intake the same day as they present

Question 3: *What could be done better to coordinate efforts to help these individuals?*

- Community mental health center staff liaison between psychiatric residential treatment facilities, hospitals, etc. with community agencies like Juvenile Justice Administration (Michelle Van Winkle in Independence has this role)
- Been collaborating for years—just need funding so we can keep doing it (not lose staff)
- Have to stop waiting for folks to become ‘severe’—intervene sooner—not have funds restricted to the most severe
- Documentation and tracking that can connect to medical records more easily—flow of information
- TRANSPORTATION!!!!!! (and people to provide it)—currently no codes to bill for this
- Technology—use/develop more options like Telepsych/telemed, etc. where people can connect to service providers virtually