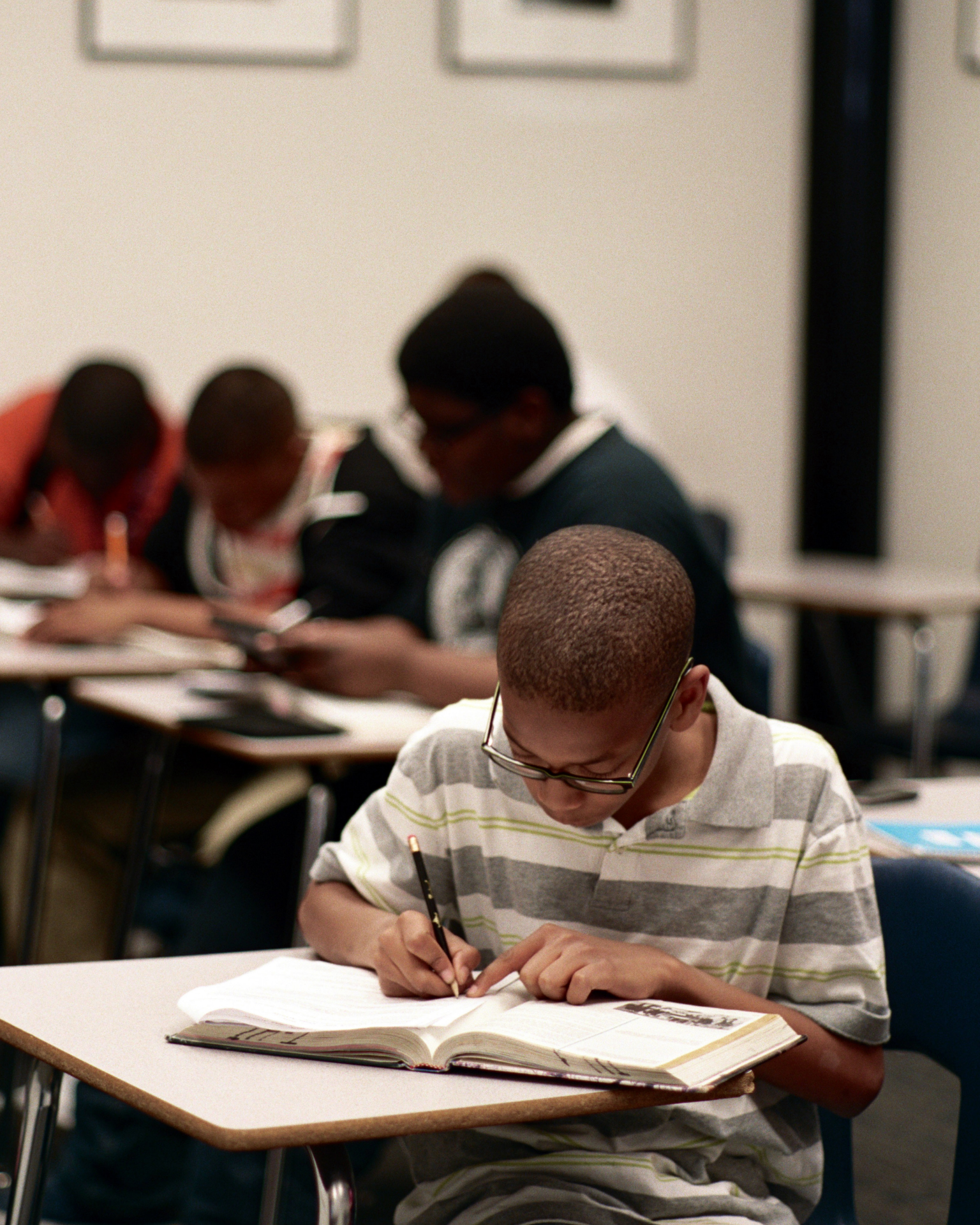




**A DECADE**  
*of* DIFFERENCE

BEHAVIORAL  
HEALTH



In 2005, the Health Care Foundation of Greater Kansas began making grants to Kansas City area organizations committed to eliminating the barriers to quality health for the uninsured and underserved.

The foundation was created two years earlier through the sale of Health Midwest hospitals to Hospital Corporation of America. Since 2005, HCF has awarded over \$200 million to hundreds of entities.

The past decade has been a difficult period for many individuals and organizations served by the foundation. Yet it has also been a time of unmatched opportunity. Most notably, the passage of the Patient Protection and Affordable Care Act in 2010 represented a landmark event in the evolution of health care reform.

As the foundation completes its first decade, we have looked back across the health care landscape to better understand the obstacles and accomplishments surrounding care to the uninsured and underserved in the Kansas City region. Our objective is to learn from, and reflect upon, past experience in order to better inform and assist the community's collective efforts going forward.

HCF contracted with researchers to conduct a series of interviews and focus groups with health care stakeholders in the behavioral health arena. The results of those conversations represent the heart of this report. More than 50 individuals participated in the process, and their reflections and insights about the past, present and future of behavioral health in the region were enormously beneficial.

But even though stakeholder perceptions form the bulk of this document, the final product inevitably has been filtered through the foundation's lens. The contents therefore ultimately are the responsibility of the foundation.

This document is not meant to be an evaluation of HCF or the behavioral health grants we've funded over the past 10 years. Nor is this an assessment of population level health needs or secondary data trends. Rather, the goal was to take advantage of our unique perspective in the health care community to examine system level challenges, changes and opportunities.

This assessment has allowed us to more clearly see the enormous strides that have been made in our region since 2005. Too often, those knee-deep in the day-to-day work of bringing about change are unable to pause to appreciate the role they have played in advancing the field. A spirit of cooperation, collaboration and commitment is reflected in these pages and in these efforts, and the HCF is proud to be a part of the progress our community has experienced.



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## IN TROUBLED TIMES, BEHAVIORAL HEALTH ORGANIZATIONS ATTEMPT TO DO MORE WITH LESS

The challenge of providing care and services to vulnerable populations has long been a struggle nationwide. In the best of times, the behavioral health system often lacks continuity, and resources inevitably fall short of need.

Today, in the uncertain aftermath of the Great Recession, that tension has never been greater. The unforgiving economic climate has dramatically altered the profile of those seeking mental health services and greatly increased demand. Unfortunately, this surge has come at a time when program funding at the state and local levels has continued to decline.

Compounding the predicament is an ongoing migration away from institutional care, as well as new mandates to privatize services. The end result is a fragile and fragmented mental health system that is increasingly dependent on already-hard-pressed institutions like shelters, hospitals and law enforcement agencies. The difficulties have been further aggravated by the departure of longtime caregivers from the field and growing burnout among those who remain.

As pervasive as these problems are, they have not stopped the progression of treatment methods and the growing adoption of evidence-based practices.

Nor have they undermined the determination of local organizations and individuals to strengthen behavioral health care in the Kansas City area. In fact, the opposite has occurred: Mental health advocates and providers understand that they must be more efficient and effective than ever to truly help those in need.

A new emphasis on collaboration has emerged, and this spirit of cooperation is producing a range of creative, pioneering solutions. The ultimate objective is the development of an integrated, community-based system of care that can respond quickly and appropriately to the full spectrum of mental health needs.

To that end, agencies and clinicians are implementing new programs to help first responders more effectively understand, address and defuse volatile situations. New courts have been created that substitute treatment for incarceration in non-violent cases where behavioral problems have contributed to criminal behavior. Technology is being harnessed to extend mental health care to underserved areas.



Since 2005, HCF has awarded

**289 GRANTS** totaling  
**\$49,302,498**  
**TO SUPPORT** behavioral health projects.

Agencies and care providers are working together to understand and address the underlying causes of behavioral health problems, including childhood and adult trauma.

Integrated approaches that link physical and behavioral care are becoming more widespread. And growing efforts are being made to improve the cultural competency of providers so they can provide high quality care to all populations.

At schools, a greater emphasis is being placed on programs designed to address adolescent mental health issues, and many of these have produced dramatic improvements.

Finally, education and outreach efforts are being developed to reduce misconceptions about mental illness and the discrimination that comes with them.

“These are, without a doubt, very challenging times in mental health, not just in the Kansas City area but nationwide,” said Mary Kettlewell, a program officer with the Health Care Foundation of Greater Kansas City (HCF). “But the good news is that entities that used to work independently are banding together to develop powerful solutions to long-standing problems. We have a long way to go, but I believe there is a growing sense that together, we will eventually get where we need to be.”

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**THE ULTIMATE OBJECTIVE IS**  
THE DEVELOPMENT OF AN INTEGRATED,  
COMMUNITY-BASED **SYSTEM**  
**OF CARE** THAT CAN **RESPOND**  
**QUICKLY** AND APPROPRIATELY  
**TO THE FULL SPECTRUM OF**  
MENTAL HEALTH NEEDS.

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## A FRACTURED LANDSCAPE

In the past decade, state and local governments facing budget shortfalls have significantly reduced funding available for traditional behavioral health services. Cuts have affected the full range of agencies and programs, from Medicaid to public health initiatives, emergency medical assistance and other funding mechanisms and grants.

Major cuts in the Missouri Medicaid program in 2005 produced substantial changes in eligibility for low-income families, disabled and elderly participants. Ultimately, 147,000 state residents lost coverage. This rollback brought rate cuts to hospitals, shortfalls at community health centers, decreases in public health initiatives, such as the State Children's Health Insurance Program, reductions in emergency medical assistance and cuts to mental health services.

"One of the groups that was hurt most by the Medicaid cuts was addicted mothers, since many of those women were no longer eligible if they earned more than \$290 a month," said Alan Flory, executive director of ReDiscover.

### MISSOURI DEPARTMENT OF MENTAL HEALTH

FUNDING FOR COMMUNITY-BASED SERVICES  
2009-2012



Substance abuse programs have been hard hit by the funding reductions. In the Kansas City area, the closure of long-time programs operated by MOSOS-Salvation Army, Renaissance West and Imani House over the past decade has diminished detoxification beds. Today, only the Heartland Center for Behavioral Change continues to operate detox beds on the Missouri side of the state line.

Predictably, gaining access to the few detoxification beds that remain has become increasingly difficult, due to constrained supply as well as restructured eligibility criteria and shifting admissions policies.

"The loss of beds has disrupted the whole treatment system," said Oneta Templeton of Children's Mercy Hospital. "Recovery is a journey and not a quick, linear process, but if the resources required to start that journey are not available, the individual frequently goes backward."

Funding cuts have affected not only accessibility but also the

way non-profits function.

"What it has meant for agencies is stagnant salaries, high turnover rates and high stress for the employees," said Marsha Morgan, chief operating officer at Truman Medical Center Behavioral Health. "In addition to the Medicaid cuts, there has been increased accountability for the service that we provide. So what you have is a safety net system that is very fragile and that struggles to serve those that need the services."

### SHRINKING CAPACITY, GROWING NEED

The budget reductions have come at a time when the demand for mental health services has never been greater. Job losses and other economic problems associated with the financial collapse of 2008, as well as the precarious recovery that has followed, produced many new and acute behavioral health needs. Increasing numbers of working poor, middle-class families with no insurance, and new immigrants have presented for care. Yet agencies have found it more difficult than ever to provide necessary services.

The situation has been complicated by a long-term shift in the way care is provided. In the 1990s, states began to transition mental health patients from longer-stay, state-owned institutions toward shorter-duration community settings. Much like the loss of detox beds, this development has reduced capacity and undermined the continuity of care.

The 2006 closing of the Western Missouri Mental Health Center marked a pivotal event in the Kansas City behavioral health community. Although the loss of the center's residential beds was mitigated somewhat when Truman Medical Center began providing inpatient mental health services through an agreement with the state, the impact nonetheless was significant. Truman's shift in focus from an intermediate level of care to shorter acute care resulted in reduced lengths of stay and — combined with other closures — further constricted the availability of comprehensive residential treatment options across the region.

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**INCREASING NUMBERS OF  
WORKING POOR, MIDDLE-CLASS  
FAMILIES, AND NEW IMMIGRANTS  
HAVE PRESENTED FOR CARE, YET  
AGENCIES HAVE FOUND IT  
MORE DIFFICULT THAN EVER  
TO PROVIDE NECESSARY SERVICES.**

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WESTERN MISSOURI Mental Health Center,  
Kansas City, Missouri.



RAINBOW Mental Health Center, Kansas City, Kansas.

Another major blow occurred in 2011, when the state of Kansas closed all but six beds at the Rainbow Mental Health Center, then a 50-bed psychiatric hospital. In 2014, the state partially reconstituted the facility by converting Rainbow into a 10-bed, crisis-stabilization resource. The facility today is designed to connect those with serious and persistent mental illness to community-based services and provides a place for short-term detox as an alternative to emergency room treatment or arrest.

Children and adults previously treated at inpatient facilities are now presenting at community-based mental health agencies, often with multiple complex diagnoses, including mental disorders, developmental diagnoses and serious medical conditions. Too often, agencies simply are not equipped to provide appropriate stabilization, follow-up, support and monitoring.

On the positive side, the reduction in acute and residential mental health capacity is seen by many professionals as an appropriate and necessary, if difficult, step in the journey toward community-based treatment.

Clinicians and program leaders interviewed by HCF through a series of focus groups recognize that increasingly scarce government dollars must be put to use as efficiently and effectively as possible throughout the care system.

The problem, they say, is that this shift is occurring without the corresponding policies, programming and funding necessary to fully support community-based mental health services. That means the early identification, assessment and intervention services essential to a community-based approach too often are not in place.

“Everybody would probably agree that residential treatment should be reserved for kids who are properly assessed to need that high level of care,” one program leader said. “But, there’s no policy that says, in addition to trying to move those kids that we can out of residential treatment, we’re also paying attention to what got them there in the first place.”

The overarching dilemma, then, is to develop a comprehensive and robust care continuum that can appropriately balance and accommodate both institutional and community-based care, and do so within today’s acute budget constraints.



QUESTIONS ABOUT PRIVATIZATION

Adding complexity to this situation is the fact that a reliance on private, for-profit agencies and managed care organizations has increased as the government’s role in delivering mental health services has diminished. Many observers remain wary about the shift toward privatization and believe much remains to be done to create an equitable and effective public-private approach to mental health care.

In Kansas, managed care organizations began overseeing and administering Medicaid mental health services with the launch of KanCare in 2013. Among other concerns, some question the overall efficacy and fairness of managed mental health care.

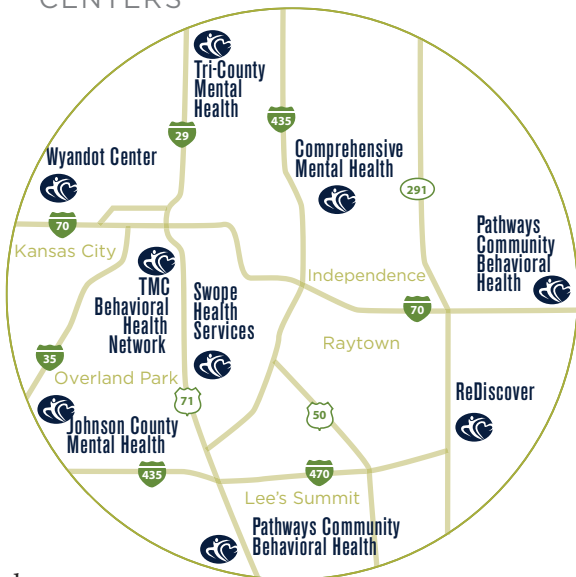
Other stakeholders argue that insurance companies are basing care not on the comprehensive clinical assessments necessary to help define a person’s behavioral health needs. Instead, they say, companies are pursuing systematic, one-size-fits-all approaches that are primarily concerned with cost reduction.

Despite these criticisms, most professionals agree that privatization does create significant potential for bringing innovation and energy to the mental health arena. The rise of privatization also has prompted increased collaboration among advocates, private agencies and government officials. The area’s mental health community recognizes the need for public-private partnerships to address the emerging gaps in services and to develop responsive and effective community-wide programs.

Ultimately, all public and private providers have a role to play in ensuring the safety, health and well-being of children, adults, families and communities. While the shift toward privatization has revealed significant shortcomings in the system, it also has opened up opportunities for community problem-solving, service innovation, and cross-system and interagency collaboration.

**THE AREA’S** MENTAL HEALTH COMMUNITY **RECOGNIZES THE NEED** FOR PUBLIC-PRIVATE PARTNERSHIPS TO ADDRESS **THE EMERGING GAPS** IN SERVICES AND TO DEVELOP RESPONSIVE AND EFFECTIVE **COMMUNITY-WIDE PROGRAMS.**

GREATER KANSAS CITY COMMUNITY MENTAL HEALTH CENTERS



### LEANING ON LAW ENFORCEMENT

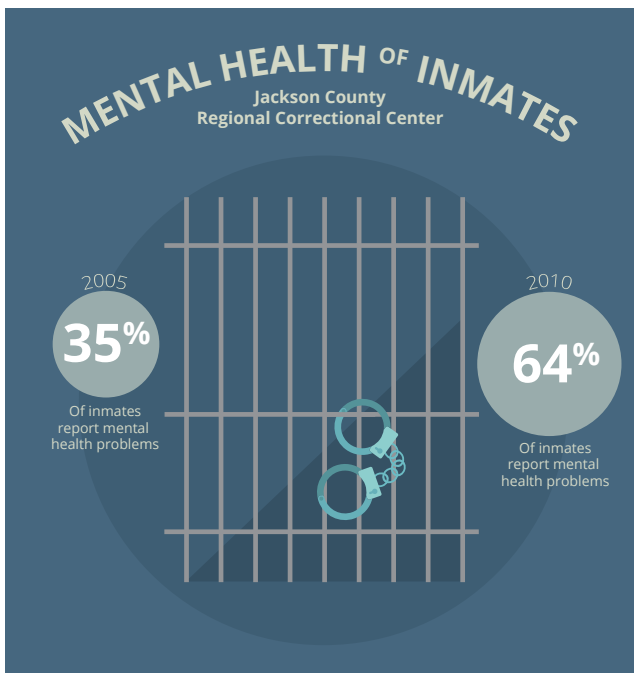
One of the most problematic consequences of today's shrinking spectrum of behavioral health options has been a growing reliance on public agencies and nonprofit institutions to help fill the void. These entities include hospital emergency rooms, homeless shelters, police departments and correctional institutions.

Ironically, the difficulties many have in accessing comprehensive services mean that, in some cases, the only way to receive some level of mental health care is to experience a crisis that requires intervention by law enforcement. This dependence puts an added burden on agencies that were never designed to be sources of proactive care.

State and county jails, in particular, have seen a dramatic increase in prisoners with mental health issues. A survey of local jails performed by the Hale Center for Journalism revealed that 45 percent of inmates indicated they had mental health problems and 60 percent had problems with alcohol or drugs.

Similarly, a 2009 Health Management Associates Behavioral Health Needs Assessment for Metropolitan Kansas City found that 60 percent of incarcerated women had a mental illness problem, 80 percent had substance abuse issue, and 86 percent were homeless or had unstable, inadequate housing.

Beyond producing less-than-adequate care for many, reliance on the justice system also has put public safety officers in an increasingly untenable position. "It is extremely unfortunate that, as a community, we're asking police officers to do a lot more than they should have to," said one focus group participant. "We expect them to be clinicians in the field and they simply don't have the training or support systems for that. The result is that they end up taking people to jail and you really can't blame them, because most are not aware of other options that may exist."





## OVERBURDENED SHELTERS

Just as the law enforcement system has been strained by an influx of behavioral health patients, so too are domestic violence shelters becoming a default provider in today's mental health care system.

Most shelters are wrestling with the same fundamental challenges that other social service agencies face, including reduced funding and increased demand. But even though the number of shelter beds in the Kansas City region actually went up from 297 to 324 between 2009 and 2013, demand has far exceeded supply.

**More than 7,000 individuals were turned away from shelters because of full beds in 2013, up from 4,749 in 2009.**

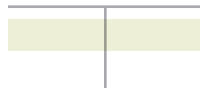
"When the economy goes down, domestic violence goes up," said MaryAnne Metheny of Hope House. "So we saw the demand for services soar during the recession."

A significant percentage of that increase, unfortunately, has been due to the fact that many had nowhere else to turn. The net result? Domestic violence agencies are faced with a growing number of clients experiencing severe mental illness in addition to their trauma-related issues. These cases present the agencies with complex problems and scenarios they've never dealt with before.

A focus group of domestic violence providers convened by HCF reported that over the past decade, virtually all caregivers have seen an enormous increase in the number of severely, persistently mentally ill individuals seeking assistance. Most agreed that there was direct correlation between the rising numbers of clients experiencing acute problems and the poor economy.

Shelters have likewise seen more clients with physical health and/or chronic medical conditions, as well as a growing number of older women presenting for services. Compounding the challenges has been the fact that many new clients have diverse linguistic needs.

Shelters are equipped to care for the needs of victims of domestic violence and provide counseling and other behavioral health services. But they are not the best entry point into the mental health system for people with intensive problems.



Since 2005,  
HCF has funded

# 81

**GRANTS**

totaling

# \$8.4 MILLION

to support  
domestic  
violence shelters  
across the HCF  
service area.

In Jackson  
County, Missouri,  
the annual cost  
burden of  
UNTREATED  
SERIOUS  
MENTAL  
ILLNESS  
is estimated to be

**\$283  
MILLION**



### IN SEARCH OF SOLUTIONS

As difficult as the funding environment is, there have been a few bright spots for agencies dealing with mental health and substance abuse issues, particularly in Jackson and Lafayette counties in Missouri. The Jackson County Mental Health Fund, which receives its funds from a tax levy, produces about \$11.5 million annually to fund grants focused on domestic violence, children and families, non-clinical consumer support and other behavioral health solutions.

Another Jackson County funding source, the Community Backed Anti-Drug Tax (COMBAT) tax, generates about \$19 million a year via a one-quarter-of-one-percent sales tax. The money helps fund drug treatment and prevention, drug courts, corrections and other drug and violent crime-related programs. The COMBAT tax has enjoyed widespread public support and was renewed by voters in 2009 by almost a two-to-one margin.

In Lafayette County, a one-eighth cent sales tax was passed in 2005 to create the Children's Services Fund, which supports counseling, family support and residential services for youth. The fund enabled the creation of the Brighter Futures Consortium by superintendents of the six public school districts in Lafayette County. The consortium has worked to identify mental health needs among their student populations and sought to increase promotion, prevention, detection and access to care.

As welcome as these funding sources have been, they represent the exception rather than the rule. Finding effective ways to overcome financial challenges consequently has required determination, resilience, creativity and most importantly, collaboration. The mental health community recognizes that public-private partnerships involving health centers, law enforcement, the courts and others are essential for developing responsive, effective programs that can help overcome reduced funding and widening gaps in service.

“ IN THE PAST **TWO** OR **THREE YEARS** I HAVE SEEN  
A SIGNIFICANT **INCREASE** IN **COLLABORATION**,  
AND THAT HAS REALLY **HELPED US OUT.** ”

TERESA PRESLEY, COMMUNITY SERVICES DIRECTOR,  
PATHWAYS COMMUNITY HEALTH

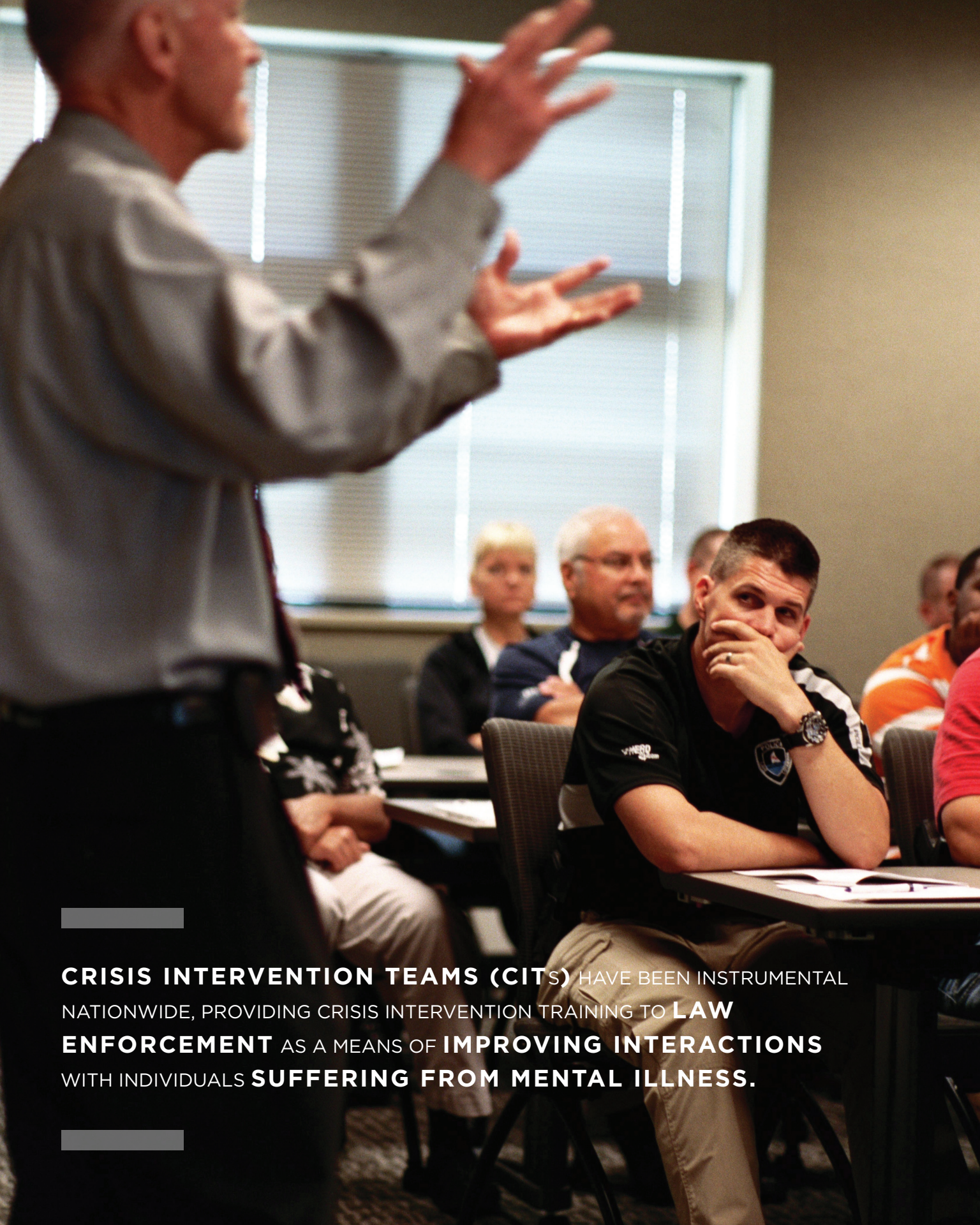
Nearly every focus group or interview identified some way in which enhanced collaborative capacities have improved the mental health service system in the region. The economic downturn significantly influenced the need for interagency collaboration, as noted by one focus group participant: “Maybe the silver lining in budget cuts is that it forced us to be more collaborative. It forced us to partner with each other. Social service agencies and state entities are now reaching out and saying, ‘We can’t afford to do this alone and it’s not the best kind of care.’”

“It used to be that organizations would operate in isolation, but now we are working together at a much deeper level and truly collaborating to make sure that we’re able to provide effective services for our clients in a holistic manner,” said Julie Donelon, president/chief executive officer of the Metropolitan Organization to Counter Sexual Assault (MOCSA).

Cooperation is occurring at many levels throughout the community: Between similarly situated agencies, safety net mental health providers and other public and private organizations. As a result, barriers that long existed between organizations have been removed and strong partnerships are emerging in their place.

Although these relationships resulted in large part from the Great Recession, the sentiment among stakeholders was that this new, integrated approach is here to stay. This is because the benefits of conducting business in this manner go beyond simply doing more with less.





**CRISIS INTERVENTION TEAMS (CITS)** HAVE BEEN INSTRUMENTAL NATIONWIDE, PROVIDING CRISIS INTERVENTION TRAINING TO **LAW ENFORCEMENT** AS A MEANS OF **IMPROVING INTERACTIONS** WITH INDIVIDUALS **SUFFERING FROM MENTAL ILLNESS.**

## ENGAGING LAW ENFORCEMENT

The growing dependence on law enforcement to provide behavioral health interventions has spawned a range of solutions aimed at helping public safety personnel respond safely and effectively. New initiatives also have emerged to help keep those struggling with mental health problems out of jail.

In Johnson County, the Community Violence Action Council (CVAC) works to improve police responses to domestic disturbance situations. The Safe from the Start program provides officers with a card containing questions for children present at domestic violence scenes to help determine whether the child has also been victimized.

Both Jackson and Johnson counties have adopted Lethality Assessment Protocols (LAPs) to reduce the likelihood of intimate partner homicide. LAPs are partnerships between first responders and domestic violence organizations that are designed to immediately connect those in need with available resources and services.

Similarly effective is the Crisis Intervention Team (CIT) approach. CIT, first developed at the University of Memphis in 1987 after a mentally ill person was killed by a police officer, has expanded to more than 2,600 local and 300 regional programs nationally. CIT provides crisis intervention training to law enforcement as a means of improving interactions with individuals suffering from mental illness.

**CIT HAS EXPANDED TO MORE  
THAN 2,600 LOCAL AND  
300 REGIONAL PROGRAMS  
NATIONALLY.**



The program relies on enhanced partnerships between law enforcement and mental health care providers to produce better outcomes for individuals, family members and communities. Central to the approach is pre-arrest jail diversion to mental health services for those experiencing a mental health crisis.

CIT was initially rolled out in the metropolitan area in 2000 by the Lee's Summit Police Department and has now expanded to most of the municipalities in the metro area.

"Crisis Intervention Teams have been the biggest factor in success in the community over the last 10 years," said Guyla Stidmon, executive director of the National Alliance on Mental Illness. "It has diverted people from jail to treatment and has been highly successful in making the community a safer place to be."

### COMPASSIONATE COURTS

Community courts also have been effective in keeping those with behavioral health problems out of jail in non-violent cases. The courts, created through extensive collaboration between the judiciary, law enforcement and the mental health communities, offer treatments to help non-violent individuals deal with underlying issues that contribute to criminal behavior.

The programs focus on successful rehabilitation through early, continuous and intense supervised treatment, and in the case of drug abuse and addiction, periodic testing. Community courts were pioneered in Jackson County in 1993 and Lafayette County in 1996. Since then, they've become an increasingly accepted practice on both sides of the state line.



Since 2005, HCF has awarded

**12 GRANTS** totaling  
**\$1,700,000**

**TO SUPPORT** specialty courts across the HCF service area.

“Over the last decade, there has been a tremendous increase in specialty courts, including drug courts, mental health courts and veteran-to-treatment courts,” said Stephanie Boyer, deputy court administrator with the Kansas City, Missouri, Municipal Court.

“The impact has been huge. Individuals coming through the criminal justice system are able to access these services, frequently for the first time. It also can have a very positive impact on individuals’ families.”

**Ideally, programs should be in place that can provide at-risk individuals with positive intervention before a crime is committed.**

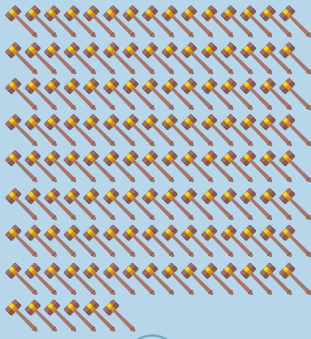
The courts depend on both public and private systems and require input and effort from a range of individuals, including judges, probation and parole officers and intervention providers. And while the partnerships have been shown to improve outcomes for offenders and victims of domestic violence by focusing on underlying causes of violence, the fact remains that they are not an ideal system entry point for someone requiring mental health services.



# SPECIALTY COURTS GAIN TRACTION



MISSOURI  126 COURTS



JACKSON COUNTY MISSOURI  16 COURTS



CASS COUNTY MISSOURI  17 COURTS



KANSAS  15 COURTS



## NUMBER OF SPECIALTY COURTS

\*AS OF 2013

WYANDOTTE COUNTY KANSAS 



**ADULT DRUG COURT**  
EST. 2008

JOHNSON COUNTY KANSAS 



**JUVENILE DRUG COURT**  
EST. 2001

JACKSON COUNTY MISSOURI 



**OLDEST METRO AREA  
DRUG COURT**  
EST. 1993



### CHANGING MODELS OF CARE

Just as the mechanisms for delivering behavioral care have evolved, so too have the nature and substance of the services provided. Like all health care providers, behavioral health agencies are migrating toward evidence-based care, or consensus best practices that offer clinically proven treatment protocols and pathways for a range of illnesses and conditions.

Evidence-based mental health care has become more embedded locally over the past 10 years in part due to encouragement from the funding community. The approach helps ensure optimal treatment by reducing care variance and by making best practices more accessible for small agencies.

For all the benefits, adopting evidence-based practices can be a complex process, and one that typically is done in stages. Identifying the appropriate practices or protocols and ensuring their adoption among all caregivers frequently requires a level of organizational efficiency that traditionally has not been required of community behavioral health agencies.

Most evidence-based practices involve proprietary instruments which require that agencies purchase the rights to deliver programming and work with an authorized trainer, coach or consultant during implementation. In many instances, it is expected that agencies will also implement the programs in the way they were designed. All of these stipulations require a financial commitment. Ongoing workforce challenges also have affected the sustainability of evidence-based care programs, given that high workforce turnover requires continual training of new workers.

“It’s probably taking us longer than we had expected, but I think we’ve tried to be thoughtful about it and make sure that it really takes hold,” said one caregiver. “There really is a commitment to this model and a desire to infuse it across our entire organization.”

**TRAUMA’S TOLL**

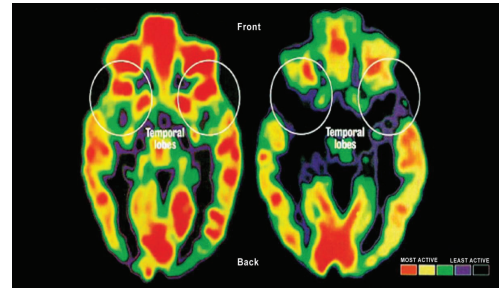
The shift toward evidence-based care is being complemented by new approaches in the understanding and treatment of mental illness. Among the most effective of these is trauma-informed or trauma-responsive care, an emerging field in which the Kansas City area has taken a leadership role nationwide.

Trauma-informed care is grounded in the knowledge that traumatic events or situations often produce lasting physical, emotional and behavioral effects. This understanding has led not only to new service priorities but also to cultural changes among community agencies.

“Probably the most significant change over the last decade for our organization and for the community at large is the increased understanding around trauma,” said one care provider. “This knowledge continues to change the way we interact with children and families and how we think about the way we do our work. As a result, it has brought new directions and greater effectiveness to our service delivery models.”

The current focus on trauma is due in part to several key studies, including a 1998 report known the Adverse Childhood Experiences (ACEs) study. Authored by Dr. Vincent Felitti, the study was one of the largest ever to assess associations between childhood maltreatment and traumatic events and later-life health and well-being. The results were sobering: Adults who experienced traumatic events as children were at greater risk for illness and premature death, with higher reported incidences of obesity, addiction, depression and suicide attempts, ischemic heart disease, cancer and liver disease.

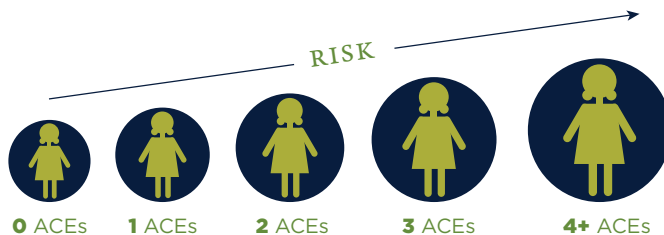
Other studies have confirmed the correlation between trauma and poor mental and physical health and defined a range of trauma triggers and responses. Today, the term “toxic stress” is used to describe the long-lasting and extreme changes that take place in the developing brain due to searing childhood experiences.



BRAIN SCANS (L) show healthy function and (R) affected by trauma.

# Impact of ACEs (Adverse Childhood Experiences)

AS THE NUMBER OF ACEs INCREASES, SO DOES THE RISK FOR NEGATIVE HEALTH OUTCOMES



**POSSIBLE RISK OUTCOMES**

**BEHAVIOR**

- LACK OF PHYSICAL ACTIVITY
- SMOKING
- ALCOHOLISM
- DRUG USE
- MISSED WORK

**PHYSICAL & MENTAL HEALTH**

- SEVERE OBESITY
- DIABETES
- DEPRESSION
- SUICIDE ATTEMPTS
- STDs
- HEART DISEASE
- CANCER
- STROKE
- COPD
- BROKEN BONES

## ACE QUESTIONNAIRE

*The ACE Study included only those 10 childhood traumas because those were mentioned as most common by a group of about 300 Kaiser members; those traumas were also well studied individually in the research literature.*

### Prior to your 18th birthday:

1. Did a parent or other adult in the household often or very often... Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?  
No \_\_\_ If Yes, enter 1 \_\_\_
2. Did a parent or other adult in the household often or very often... Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?  
No \_\_\_ If Yes, enter 1 \_\_\_
3. Did an adult or person at least 5 years older than you ever... Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?  
No \_\_\_ If Yes, enter 1 \_\_\_
4. Did you often or very often feel that ... No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?  
No \_\_\_ If Yes, enter 1 \_\_\_
5. Did you often or very often feel that ... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?  
No \_\_\_ If Yes, enter 1 \_\_\_
6. Were your parents ever separated or divorced?  
No \_\_\_ If Yes, enter 1 \_\_\_
7. Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? or sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?  
No \_\_\_ If Yes, enter 1 \_\_\_
8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?  
No \_\_\_ If Yes, enter 1 \_\_\_
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?  
No \_\_\_ If Yes, enter 1 \_\_\_
10. Did a household member go to prison?  
No \_\_\_ If Yes, enter 1 \_\_\_

Now add up your "Yes" answers: \_\_\_

**This is your ACE Score**

## TRAUMA COLLABORATION

Because the economic downturn spawned a rise in all types of trauma — from unemployment and housing disruptions to family violence — many area clients have experienced “trauma on top of trauma.” Repeated events that produce stress, anxiety or fear can result in complex clinical cases that may present as attachment disorders, substance abuse, bipolar conditions or post traumatic stress disorder.

As a result, expanding community awareness about the toll trauma takes has become a priority in the Kansas City mental health community. Trauma Matters KC, created by the Metropolitan Mental Health Stakeholders group, is a coalition of more than 30 social service agencies, behavioral health centers, philanthropies, institutions and individual providers from across the metropolitan area working to increase awareness about trauma-focused care.

Trauma Matters KC provides information on best practices related to trauma care and the causes and results of trauma. The organization promotes education, assistance and advocacy for trauma-related services, and engenders long-term improvement around practices and issue awareness.

Similarly, the Trauma-Informed Care Task Force (TICTF) of Johnson County was launched in 2012 with a grant from the HCF to create and support a more trauma-informed community. The Task Force's efforts include training educators, clinicians and other professionals. Local agencies designate staff to learn about trauma care, then bring that knowledge back to their offices to develop and implement in-house strategies, policies and procedures. These strategies both help clients cope as well as minimize additional trauma from the institutions serving clients.

The program is touching a broad group of agencies, including traditional behavioral health providers as well as police departments, the Johnson County District Attorney's office and Head Start of Shawnee.

## CHILDHOOD TRAUMA

Significant efforts also are being made to zero in on the problem of trauma at life's earliest stages. A pioneering local initiative known as Head Start Trauma Smart — created by Kansas City's Crittenton Children's Center and supported by HCF — focuses on childhood trauma intervention.

Trauma Smart serves as a practice model for preschool providers, parents and caregivers to help children calmly navigate serious emotional challenges. Through innovative coping strategies and hands-on tools, the program provides children with strategies for dealing with anger and stress so they can return to a more productive emotional state.

"The program provides knowledge about the sources and symptoms of trauma and gives adults the skills they need to therapeutically intervene with children when appropriate," said Janine Hron, executive director of Crittenton.

The program helps children who have experienced stressful events develop self-comforting skills and better executive function. These skills will be essential for relationships and later school success.

Since its inception, Hron said, Head Start Trauma Smart has shown that when families become more engaged in their child's school experience, there is a 50 percent decrease in the number of children who require therapy services. The initiative also is improving day-to-day relationships between adults and children in Head Start classrooms to better prepare students for learning once they move into kindergarten.

The innovative program has received considerable national recognition and acclaim and was awarded a \$1.4 million grant from the Robert Wood Johnson Foundation (RWJ) in 2013, with additional funding from HCF. Significantly, the money is helping expand interventions across Missouri and into Wyandotte County, Kansas. The program was taken as a national initiative by RWJ and started in additional communities.



### CARING FOR THE CAREGIVERS

Along with increasing understanding of behavioral problems in at-risk populations, the new focus on trauma also has led to a greater awareness of the “secondhand trauma” routinely experienced by caregivers and other professionals in the mental health field.

The impact of encountering the damage that trauma inflicts multiple times a day can have lasting consequences for caregivers, including diminished physical and mental health, chronic burnout and high stress. This, in turn, impacts the system by leading to lower morale and higher turnover.



The Secondary Trauma Resources Center was created to help alleviate this serious but frequently overlooked problem. The local nonprofit was created by women from various Kansas City-area service organizations who saw an opportunity to reinforce and sustain the mental health workforce. The resource center teaches strategies for reducing secondary trauma’s impact through educational presentations, tools and training for staff, workshops and retreats.

In addition, many local mental health care agencies are adopting the Sanctuary organization model. This trauma-informed, evidence-supported operating approach is specifically designed for human services organizations and emphasizes a non-hierarchical, highly participatory system of employment and service delivery. The objective is to help staff function in a healthy, humane, democratic and socially responsible manner in order to improve job satisfaction, reduce burnout and provide optimal care to clients.

**INTEGRATING CARE**

Growing knowledge about the relationship between the body and mind is driving a wider movement to more effectively integrate behavioral and physical health sciences. Increasingly, researchers and clinicians are pursuing comprehensive treatment solutions that transcend traditional barriers between mental and physical health.

Mounting evidence supports the shift. A 2010 report by the Milbank Memorial Fund found that up to 70 percent of primary care visits are related to psychosocial issues, even though patients often seek help for only their physical health concerns. The report further notes that it is frequently mental health or substance use issues that trigger the primary care visits in the first place. Yet primary care doctors typically have little or no training in mental health care.

Clinicians say an integrated approach can be particularly effective in the areas of pediatrics, substance abuse and for patients whose developmental disabilities are accompanied by physical or mental illness. Ultimately, however, all patients can benefit from a more holistic approach to health.

In the Kansas City area, the idea of integrating multidisciplinary services and practice continues to gain traction. Providers are working on mechanisms to jointly address individual well-being in one location. The concept is not without challenges and requires new kinds of thinking. But providers say the need is real.

“At Wyandot, Inc., we recognized that many of our consumers had many medical needs that were going unattended,” said Randy Calstrom of Wyandot, Inc., a community mental health center serving patients in Wyandotte County, Kansas. “As a result, a few years ago we opened a primary health care clinic inside the mental health center, and it’s turned out to be an extremely effective approach. We serve a population that doesn’t get medical treatment in any other way and generally has never sought out medical care. So, for the first time they are finally getting the treatment that they need.”

A 2010 report found that up to

**70  
PERCENT**

of primary care visits are related to

**PSYCHO-  
SOCIAL  
ISSUES.**

**IN THE KANSAS CITY AREA, THE  
IDEA OF INTEGRATING MULTIDISCIPLINARY  
SERVICES AND PRACTICE **CONTINUES**  
TO GAIN **TRACTION.****





## WORKFORCE SHORTAGES

Essential to the success of a behavioral health system is a committed and competent base of professional caregivers. Yet beyond the inherent stress associated with the profession, numerous challenges are pressuring the Kansas City-area workforce. One chronic problem is a general shortage of psychiatrists, master's level clinicians and qualified substance abuse treatment professionals. Observers say the scarcity of professionals is due in part to aging demographics and increased retirements, which inevitably result in organizations losing their most experienced workers.

Also contributing to worker shortages is new competition from for-profit managed care organizations. These businesses typically are able to pay higher salaries than public mental health agencies, and this has been especially true in the wake of public budget cuts over the past decade. In Kansas, large numbers of staff at multiple agencies were lost when managed care organizations took over the state's Medicaid mental health services. Staff turnover puts a continual strain on the behavioral health system, as most positions have low salaries and high stress.

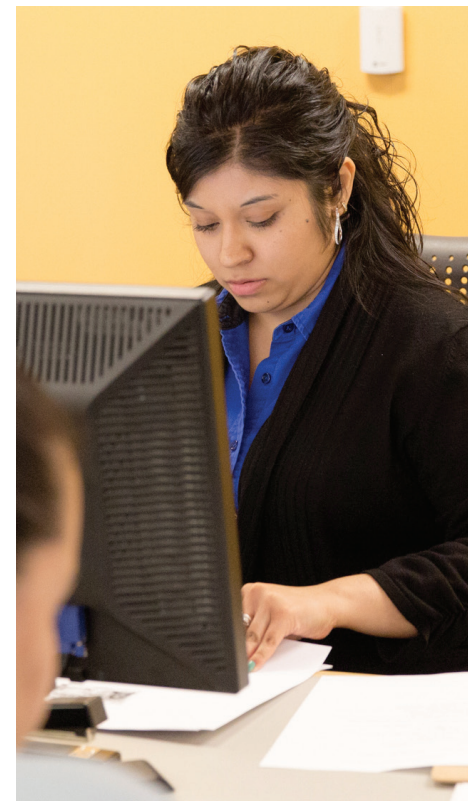


For all agencies, the issue of turnover is ongoing and requires continual attention and strategizing. One approach found to be effective is focusing on high-quality training and skilled supervision. And while evidence-based practices can be challenging to implement and sustain, these modalities can help strengthen the skills, confidence and ultimately, the job stability and satisfaction of frontline practitioners.

Agencies also are continuing to explore new ways to boost recruiting and attract more young people to the field. Part of this effort involves working to increase the diversity of the mental health workforce. As the general population has become more racially and ethnically diverse, mental health providers have struggled to bring in caregivers of color to care for these populations. More bilingual clinicians consequently are needed to serve clients who speak Spanish and other languages.

“We’ve seen an exponential increase in the number of Latina families in recent years, and finding licensed or properly credentialed staffers that are bilingual continues to be a significant challenge,” said one focus group participant.

Nor is it only Spanish that creates communication difficulties. The participant noted that 53 different primary languages are present among students attending one Kansas City, Kansas, school.





The Hispanic population in Missouri rose

**79**

PERCENT  
from 2000-2010.



In Kansas, the Hispanic population rose

**59**

PERCENT  
from 2000-2010.

### CREATING CULTURAL AWARENESS

Cultural competence is similarly viewed as a critical workplace issue that must become institutionalized and standardized throughout the behavioral health system. Changes in internal practices and policy guidelines that result from cultural competency training not only make providers more aware of the consumers their agencies serve, but also pave the way for consumers to have a more active voice in agency planning and service delivery.

A lack of culturally competent services to meet the increased needs of the Latino community is of particular concern in the Kansas City region. According to the U.S. Census, the Hispanic population in Missouri jumped by 79 percent between 2000 and 2010 and now accounts for about 3 percent of the state's total population. In Kansas, the Hispanic population increased by 59 percent between 2000 and 2010 and currently represents approximately 10 percent of the state's total population.

Budget constraints and cultural gaps in the Kansas City area have made providing necessary care for Latinos increasingly difficult. The problems have been especially pronounced in the areas of child welfare and children's mental health, where long wait lists for children, a lack of Spanish-speaking clinicians and high staff turnover are too often the norm.

Among the organizations tackling this problem is Rose Brooks, a domestic violence shelter. Rose Brooks created a Diversity Connections Committee and subsequently hired a training coordinator. The coordinator is responsible for creating and implementing an internal staff development program focused on cultural competency. Importantly, the organization makes some of its training available to other community organizations serving diverse populations. Rose Brooks made a commitment to increase not only the diversity of staff, but also their board of directors. Ongoing strategies will be used to emphasize the importance and visibility of the issue of diversity at the board level.

Mattie Rhodes, a Kansas City social services organization, likewise has made a point to include their board and community members in their diversity initiatives. The organization's cultural competence committee trains board members, and one board member, in turn, is assigned a seat on the committee. The approach helps ensure that cultural competency and diversity remain a priority.

## CULTURAL COMPETENCY INITIATIVE

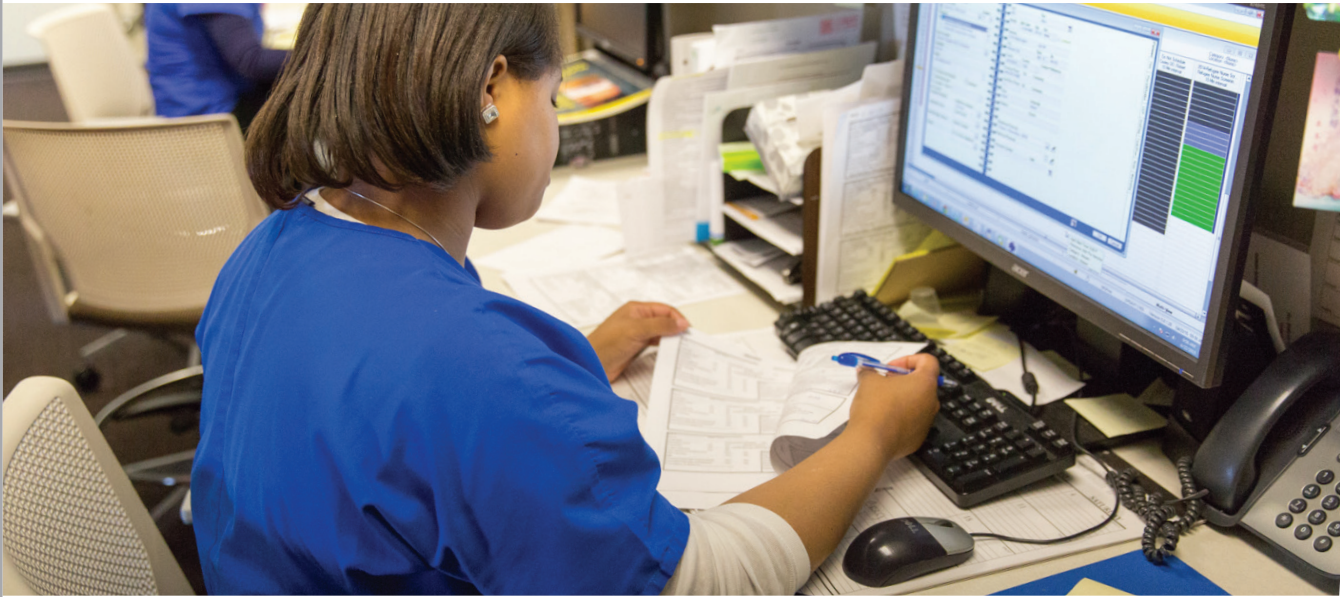
The Cultural Competency Initiative (CCI), created by the REACH Healthcare Foundation, has allowed more than 30 area health and social service providers to embrace a practice of cultural competency. The objective is to create systems, services and a workforce that are capable of delivering the highest-quality care to individuals, regardless of socioeconomic status, race, ethnicity, culture and language proficiency. Ultimately, the goal of the CCI is system-level change to reduce disparities in service.

SINCE 2009, HCF has provided  
**\$350,000**  
 TO SUPPORT the  
 Cultural Competency Initiative.



A LACK OF **CULTURALLY COMPETENT** SERVICES TO MEET THE **INCREASED NEEDS** OF THE LATINO COMMUNITY IS OF CONCERN IN THE KANSAS CITY AREA.





### GREATER EMPHASIS ON TECHNOLOGY

Finding more effective ways to extend behavioral health services to underserved areas has long been a challenge. Fortunately, telehealth, or telemedicine, is emerging to help meet the needs of those who might otherwise do without care. Telemedicine uses Internet capabilities to connect clients and patients with health care providers. The capability has been essential for many who receive some care in the greater metropolitan area but live in rural parts of Kansas or Missouri.

The University of Kansas' Center for Telemedicine and Telehealth, developed in the early 1990s, today reaches more than 100 sites throughout the state of Kansas. The center was one of the first in the region to use telemedicine to provide mental health services. Increasingly, other providers and agencies are following KU's lead and creating telehealth options to bring new behavioral resources to outlying communities.

Electronic health records also have become more prevalent in behavioral health over the past decade, with many organizations adopting them in recent years. Given the regulatory incentives to expand the use of electronic health records, it is anticipated that an increasing number of mental health providers will follow suit over the course of the next decade.

Despite the automation benefits that electronic health records provide, not all mental health providers are embracing the technology. The transition to electronic documentation is costly, and training and implementation can be time-consuming. Issues of confidentiality and privacy, always a challenge in health care, are exacerbated in the behavioral health arena.

Funding likewise remains a significant challenge. The desire to capitalize on technological advancements is not always matched by available funding streams. Ultimately, the extent to which technology is adopted in the mental health community will depend to a great extent on funders and state legislators.

### EMERGING FROM THE SHADOWS

One positive and significant development in the local mental health community over the past decade has been a greater willingness by individuals, organizations and communities to discuss mental health issues. As long-standing taboos surrounding mental illness begin to fade, Kansas City has emerged as a leader in the collective search for answers through programs like Creating Community Solutions and a regional effort to promote mental health first aid.

In September 2013, the mayors of Kansas City, Missouri, Kansas City, Kansas, and approximately 360 others participated in a gathering designed to gain insight into mental health problems and solutions. The summit was set in motion by a federal initiative known as Creating Community Solutions, an effort developed by the Obama administration in response to much-publicized national incidents of violence involving persons with mental health issues. The program's objective was to stimulate community conversations about mental health issues in order to reduce misperceptions and promote community-based solutions to mental health needs.

Participants in the Kansas City Community Consensus included the general public, mental health providers, general practitioners, as well as people with mental illness and their families.

“Tragic events across the country have provided an opportunity to open up community dialogues regarding mental health,” said Theresa Reyes Cummings from the Jackson County Mental Health Levy. “More community-based service organizations, schools, the faith-based communities, government sectors and law enforcement are requesting information about the signs and symptoms of mental illness and emotional stress, and how to help those who may be experiencing a crisis. People want to be proactive, rather than being caught in a crisis situation without the appropriate knowledge or resources.”

“**TRAGIC EVENTS ACROSS THE COUNTRY HAVE PROVIDED AN OPPORTUNITY TO OPEN UP COMMUNITY DIALOGUES REGARDING MENTAL HEALTH.**”

THERESA REYES-CUMMINGS,  
JACKSON COUNTY MENTAL HEALTH LEVY





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*“THESE ARE, without a DOUBT, very challenging times IN MENTAL*

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HEALTH, *not* JUST IN THE *Kansas City* area but NATIONWIDE.”

DONNA BUSHUR  
HEALTH CARE FOUNDATION  
OF GREATER KANSAS CITY

Individuals attending the Kansas City event were polled to assess their understanding of mental illness, why they thought community involvement was important and what stake they had in the issue. Significantly, more than 80 percent of participants felt mental health services were not always available for those who needed treatment. Additionally, more than three-quarters felt society discriminates against people with mental illness.



**MORE THAN 75% OF  
PARTICIPANTS FELT SOCIETY  
DISCRIMINATES AGAINST  
PEOPLE WITH MENTAL ILLNESS.**

The meeting provided an opportunity to discuss and debate a wide range of problems and issues that surround mental health. These included the pain of stigma and isolation that comes with mental illness, the often-prohibitive cost of treatment, a fragmented system of care, a lack of awareness of trauma, the link between substance abuse and mental illness, a lack of mental health awareness within the criminal justice system, as well as the role that homelessness, poverty and social connectedness can play in one's mental health.

Solutions and strategies for improvement were identified. These ranged from increased focus and programming in schools to more extracurricular activities and more positive outlets for young people. Positive peer role models, life readiness and vocational training, family support, and law enforcement awareness likewise were suggested as ways to help young people avoid or overcome behavioral health issues.

The meeting was important, not only because of the range of individuals and institutions it brought together, but also because it helped to encourage open discussions about mental health problems and community solutions.

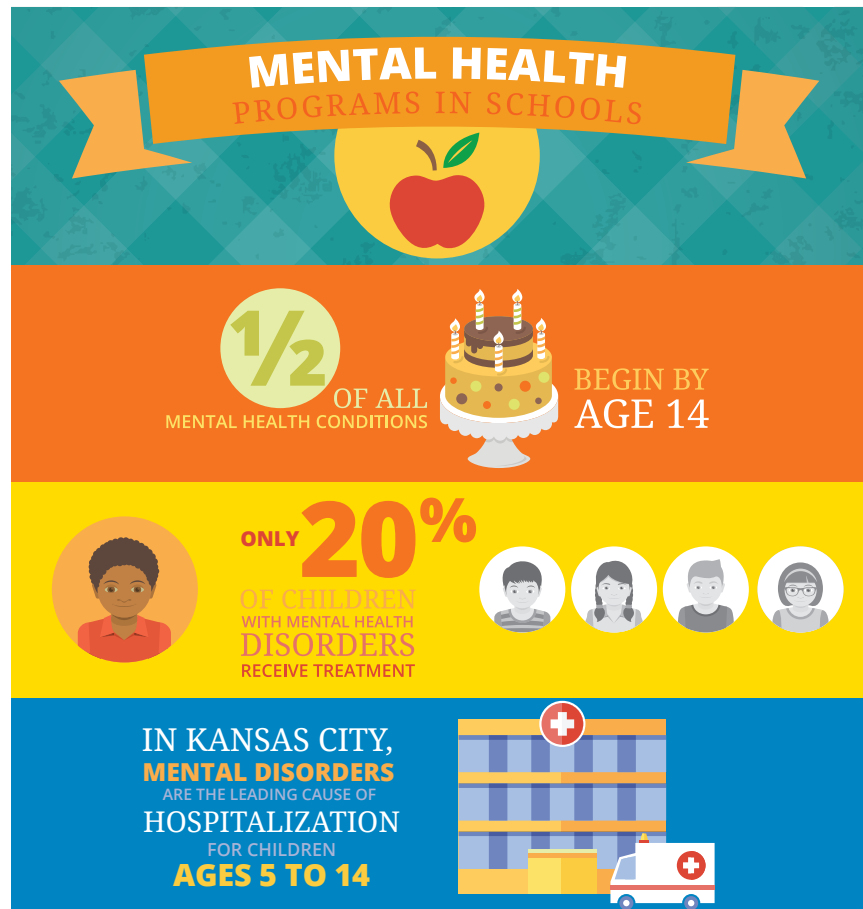


**SCHOOL-BASED BEHAVIORAL CARE**

Many mental health problems initially appear in late adolescence or early adulthood. According to the National Alliance on Mental Health, half of all mental health conditions begin by the age of 14. Yet only about 20 percent of children with mental health disorders receive some kind of treatment. The numbers are even worse among low-income children. Primary barriers to appropriate treatment include the absence of a diagnosis, limited resources, complicated payer regulations and a fragmented system of services.

School-based programs, consequently, represent a critical element in the care continuum. School programs frequently work well because they're offered in a place where children feel safe and comfortable. And because they are provided during the school day, a wider range of students can be reached, including those who may not have transportation to access external treatment options.

School programs additionally can involve teachers in the treatments and empower them to play a more effective role in student mental health. For these reasons, professionals and educators have placed a greater emphasis on school-based programs over the past decade, and many of these have shown dramatic results.



Since 2005,  
HCF has funded

**40**

**GRANTS**

totaling

**\$3.9**

**MILLION**

to support  
school-based  
mental health  
services across the  
HCF service area.

DeLaSalle Education Center is an alternative high school for students who have dropped out of traditional school or have had encounters with the legal system. Following implementation of a mental health program, 86 percent of students enrolled in the program either remained in school or graduated. That compares to a non-graduation/dropout graduation rate of 75 percent for students who did not take part in the initiative.

Genesis School, similarly, saw attendance improve by 20 percent among students who took part in an art therapy program. And at Gordon Parks Elementary School, visits to the CARE room (a location students are sent to following inappropriate behavior) dropped by 27 percent following implementation of a new therapy program.

For its part, the Belton School District saw a 50-percent decline in inpatient psychiatric placements of students versus previous years following the implementation of a broad-based mental health program.

Betsy MacLaughlin of Brighter Futures in Lafayette County said the organization has focused on specific areas of need in the schools. For example, when counselors saw self-mutilation among students on a regular basis, they developed a training program. Brighter Futures also targets substance use and abuse education in the middle and high school populations, and periodically brings psychologists and psychiatrists into the schools.

Community-wide fairs provide an opportunity to educate families, as well as offer wraparound services for parents of children with autism.

UPON IMPLEMENTING A **MENTAL HEALTH PROGRAM** AT DELASALLE, **86%**  
**OF STUDENTS ENROLLED REMAINED IN SCHOOL OR GRADUATED.**

While the results of school-based programs have been predominantly — and often, dramatically — positive, implementing mental health programs at institutions designed for education is not a simple process. Recipients of HCF grants have identified some common challenges, including difficulty in garnering parent involvement, significant needs of students and an already-crowded school day schedule.

Finally, funding is consistently a challenge: Some schools have struggled to continue programs after initial grants expired. Others have tried to extend the small amounts of money they receive as far as possible, but generally must focus on high-risk students. Because the funds schools receive are competitive and finite, sustaining even highly successful programs can be problematic.





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## LESSONS LEARNED

The Kansas City area's behavioral health community has faced enormous hurdles in recent years, from budget shortfalls and a brutal economic downturn to rising caseloads and increased patient acuity. Despite these difficulties, organizations and individuals have pulled together and significant progress has been made.

While it's clear that much work remains, the community's success in developing collaborative solutions has generated new insight about the challenges ahead.

Perhaps the most important objective will be to develop an integrated, community-based continuum of care that can meet the full spectrum of mental health needs from childhood to old age. Given shrinking budgets, growing need and the increased privatization of care, envisioning and assembling this framework will not be simple.

The good news is that many of the pieces required, from evidence-based and trauma-informed care to technological platforms, already exist, albeit in isolation or in nascent form. The task, then, will be to support and expand the most effective of these programs and capabilities while integrating them into a coherent and responsive whole. As formidable as the job is, it will be made easier due to the many new relationships formed over the past decade.

Consensus about the larger objectives means that areas of unmet need — however critical they may be — increasingly are viewed not as insolvable problems but rather as opportunities for growth, and changes already under way are seen as springboards to further refinement and success. Working together against long odds, the Kansas City mental health community has not only prevailed but prospered. In so doing, progress toward an integrated, collaborative and ever-more efficient and effective system of care has continued, and with appropriate leadership, policy and funding, will hopefully only increase in the decade to come.

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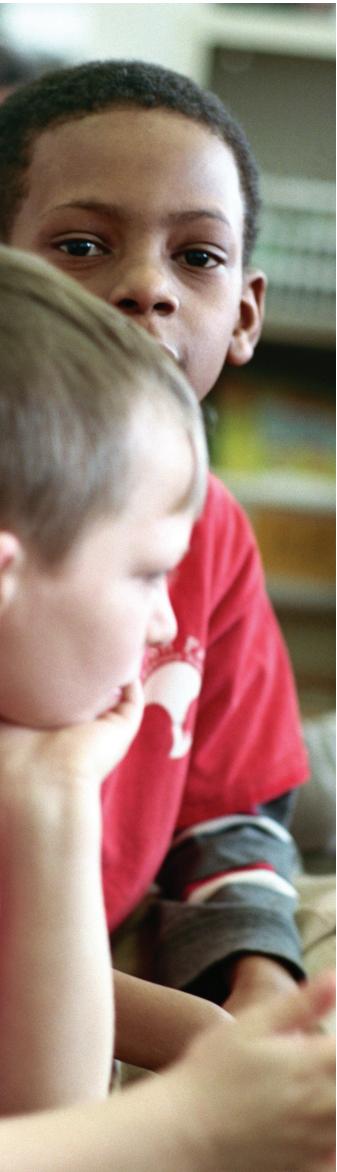
## LOOKING AHEAD

For all the successes achieved, the breadth of unmet mental health needs in the Kansas City area is undeniably immense, and establishing priorities for future efforts is therefore difficult. Nonetheless, a consensus has emerged among clinicians and professionals about areas that clearly are under-addressed.

Current knowledge in neuroscience and attachment theory suggests that early developmental years are critical and may set the stage for a person's entire life. The regional community needs to increase its expertise in this area and strengthen approaches for reaching young children.

Transition-aged youth are another population that will require growing attention in the coming decade. Research shows that the human brain is not fully developed until the mid-20s. This is far later than the late-teenage range at which society has traditionally deemed young adults to be self-reliant and mature.

The real-world implications of a longer developmental cycle are often seen by safety net providers, who've watched older teenagers become homeless young adults with untreated mental illness during the tenuous late-stage developmental period. At present, the community lacks sufficient services for homeless youth, adolescents aging-out of foster care and transition-aged youth (18-21) with mental illness. The future therefore provides an opportunity to build awareness about this critical phase and create necessary structures capable of providing assistance when needed.





## ADAPTING TO POPULATION SHIFTS

The region's demographics have changed dramatically in recent decades and are projected to continue to shift. The current need for bilingual, bicultural mental health providers therefore will remain a critical priority and will likely require continued workforce-related investments over the next decade.

The elderly population will increase substantially in the coming years. In 2011, approximately 12 percent of the metro region population was over the age of 65. The Metropolitan Research Center estimates this figure will double by 2040.

Many of these older people live in rural communities. In 2011, the metropolitan county with the highest percentage of people over age 65 was Allen County, Kansas. This creates a dual challenge of providing for the increased medical, psychological and social needs of older adults while overcoming the difficulties associated with providing care in rural areas.

Solutions will likely include the increased use of telemedicine, as well as possible incentives to bring more providers to rural areas and investments in non-professional resources, such as peer support programs.

### EVIDENCE-BASED EVOLUTIONS

The last decade saw the emergence of more evidence-based care in the Kansas City area mental health community. Groups are experiencing positive outcomes by embracing this approach. Yet agencies also have faced significant growing pains relating to evidence-based care and will continue to do so. Fully and effectively implementing evidence-based mental health care requires significant time, personnel and financial resources, all of which are in short supply for hard-pressed agencies.

Moreover, the commercial payer reimbursement environment remains, at least for now, almost exclusively fee-for-service. As a result, few payers recognize or reward the quality and potential cost-saving benefits associated with building and sustaining an evidence-based medicine infrastructure.

Some agencies that have pursued evidence-based practice approaches without sufficient funding streams in place, in fact, have been forced to suspend their efforts. Lessons can likely be learned from traditional medical care, where evidence-based medicine is finally approaching critical mass after years of implementation efforts. It is anticipated that social services will follow a similar path and, with adequate investment, see significant increase in evidence-based care over the next decade.

### TECHNOLOGY'S ROLE

Technological advancements of the last 30 years have affected virtually every aspect of our world, and in so doing, produced enormous benefits. The advent of telemedicine and electronic medical records, for example, offer enormous promise for health care providers. Yet technology's pervasiveness also presents new challenges for mental health agencies.

In the broadest sense, these include the strain on the economy resulting from deindustrialization and growing economic disparity triggered by the educational requirements associated with high-paying technology jobs. The resulting financial pressures inevitably will cause greater individual and family destabilization and concurrent behavioral health problems.

At a more personal level, a dependence on Internet communication can undermine those clients who require greater social activity and support. Yet the benefits of technology inevitably will outdistance the drawbacks. The Kansas City mental health service system will undoubtedly have multiple opportunities to continue making technological strides in the decade to come, providing they have the ability to take advantage through financial capabilities and access to expertise.





### BOOSTING TRAUMA CARE

Rapid gains in understanding trauma and how it can be treated represent a major advance in behavioral health. In the Kansas City area, ongoing efforts to create a trauma-informed mental health community have enormous potential for improving care.

Its influence should continue to expand across a variety of areas and programs.

Opportunities exist in adult and child mental health, the courts, substance abuse initiatives, domestic violence programs and hospitals. What's more, the nature of trauma-informed care easily lends itself to collaboration among agencies.

Gaining greater insight into trauma, including the realization that it can stem from a wide variety of events or situations, ranging from extreme poverty, an incarcerated family member or witnessing domestic violence or abuse, should enable organizations to better intervene in the future before the trauma occurs.

### THE ROLE OF REFORM

Broad, sweeping changes have been made in health insurance in recent years. Because of those changes, the full implications of the Affordable Care Act on behavioral health remains to be seen. This is predominantly because the feature of the ACA aimed at providing health care coverage to low-income individuals — Medicaid expansion — has not been enacted in either Missouri or Kansas. This reality puts a continued strain on social service agencies that treat lower-income clients.

Moving into the future, stakeholders are cautiously optimistic that the passage of the ACA represents an important step in the journey toward adequate and sustained improvements in mental health funding and care. Yet the cloudy, ever-shifting care landscape in Missouri and Kansas makes it difficult to clearly read the road ahead.





[HCFDecadeofDifference.org](http://HCFDecadeofDifference.org)