Kentucky Revision Submission for ARPA Funds Award
July 2, 2021
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The American Rescue Act of 2021 (ARPA), signed by President Biden on March 11, 2021, directed SAMHSA to provide additional funds to support states through their respective Mental Health (MH) and Substance Abuse Prevention and Treatment (SAPT) Block Grants to improve and enhance community-based, mental health and substance use services and supports for designated populations. The designated populations include adults with serious mental illness (SMI), children with serious emotional disturbance (SED), adolescents and adults with substance use disorders (SUD) and those with co-occurring mental health and substance use disorders. There also are designated "set-asides" to address Primary Prevention of SUD, behavioral health crisis services and early interventions for first episode psychosis/early SMI. SAMHSA provided guidance requesting that states apply for the ARPA funds by including specific programming/considerations (i.e., Comprehensive Crisis Continuum, Increase access and low barrier services, technical assistance, including planning for Certified Community Behavioral Health Clinics, use of FDA–approved medications/digital therapeutics for SUD, SUD recovery supports, advanced telehealth access, expanded Assisted Outpatient Treatment services (AOT), school-based services, etc.). It also was requested that states use a specific format to make application (i.e., Identified Needs/Gaps, Plans to Address Needs/Gaps, Spending Plan/Budget, Collaborations with Other Departments/Agencies, etc.). In accordance with federal law that addresses block grant allocations, there are specific terms and conditions that must be adhered to and Kentucky complies with these laws.

ARPA allocated $1.5 billion each for MH and SAPT grants to states/territories and Kentucky's allocations are **$18,541,924.00 for MH** and **$16,496,159.00 for SAPT**, for a total of $35,038,083.00. Funds are to be utilized over a four year period.

Kentucky is pleased to receive these additional funds to further enhance its Systems of Care for its citizens with SMI and SED, Individuals with signs and symptoms with Early SMI/First Episode Psychosis and for Crisis Services to all populations. All required *Set-Aside* amounts will be met and no more than 5% will be used for Administration. Please find below Kentucky's *Identified Needs/Gaps* and *Plans to Address* them over the grant period of September 1, 2021 through September 30, 2025. A budget summary can be found at the end of this document.

Mental Health Block Grant Additional Funds: Identified Need/Gaps and Plans to Address Need/Gaps

Crisis Services (Required 5% MHBG Set Aside for KY = $927,096.)

Identified Need/Gaps in Crisis Services

Kentucky, along with all of the U.S., is experiencing a behavioral health crisis. Already increasing behavioral health needs have been exasperated by COVID-19, physical distancing, and social unrest, especially among youth. Nationally, the suicide rate has climbed 30% since 1999. Rates in the Commonwealth are up 21% in that time frame. While Kentucky is doing better than some areas of the U.S., Kentucky residents report they have, on average, five mentally unhealthy days every month, impacting their ability to thrive in school, work, family, and faith communities. Approximately one in five people above the age of 12 has a mental health condition in the U.S. During the past year, national and state surveys highlight the escalation of needs around mental health and lack of capacity to meet those needs. Thirty-five percent (35%) of students said they wanted mental health services but did not have access. At the same time 36% of their teachers wanted access to mental health services for themselves. Additionally, 21% of families said they would benefit from more mental health services and 74% of current college students report an increase of mental or emotional exhaustion over the past year.

Since 1995, the DBHDID has made a concerted effort to develop a statewide network of Crisis Stabilization Programs and include crisis stabilization units, mobile crisis teams, and emergency walk-in crisis intervention appointments. These programs, which primarily serve individuals with serious mental illness (SMI) are a major factor in Kentucky's effort at decreasing inpatient utilization. Department staff supports the ongoing development and enhancement of the network by facilitating quarterly meetings of Emergency Service and crisis stabilization program directors and training events. The Department supports a full range of crisis services, including: 24-hour emergency hotlines; Warm lines; Walk-in Crisis Services; Mobile Crisis Services; Suicide Hotlines; Residential Crisis Stabilization Units; Crisis Intervention Services; Overnight Crisis Beds; 23 Hour Observation Beds in Hospitals; and After Hours Face to Face Crisis Evaluations. Additional funds will be used to ensure providers have more adequate resources to maintain and enhance these services.

Plans to Address Identified Need/Gaps

KY plans to increase the capacity of its crisis response safety net to appropriately respond to behavioral health crises (mental health and/or substance use) of adults and of youth/young adults/their families, all across the state and improve the overall behavioral health and wellbeing of the Commonwealth's communities. This entails having supports that are non-acute to most acute (i.e., respite care to crisis and psychiatric beds). Funds will be used to assist CMHC crisis centers with updates to their technology for supporting web-based, *Call Documentation Centers, Automated Call Distribution*, text and chat to increase access to mental health and substance use services. CMHC crisis centers must have adequately staffed and responsive mobile teams to serve the needs of their entire region. Additional funds may be utilized to support technological improvements that will allow all CMHCs to implement web-based systems that offer text and chat options. Additionally, implementation strategies include securing technical assistance from national partners or other states to learn about innovative solutions to barriers to these goals.

Crisis Continuum – 988 Implementation

Identified Need/Gaps in Crisis Response

In 2020 alone, 754 people in Kentucky died by suicide, a 4% increase from 2019. Since 2000, more than 18,000 people have died by suicide in the Commonwealth. Suicide is the second leading cause of death among young people, and the tenth leading cause of death in the U.S. In Kentucky, it is the second leading cause of death for residents under the age of 35. Suicide deaths among youth, ages 10-24, in 2019 (latest data available) total 89, with 57% of those over the age of 19. Youth suicide deaths comprised 12% of all Kentucky suicide deaths. Suicide is a worst-case scenario for untreated mental health needs and substance use disorders. More Americans died from mental health and substance use disorder crises in 2018 alone than have died in combat in every war combined since World War II. For every person who dies by suicide annually, there are 316 people who seriously consider suicide but do not attempt suicide. Additionally, 135 people are impacted for every suicide death. In Kentucky alone, in 2020, more than 340,000 people – nearly 8% of the state's population - were impacted by suicide. A new national suicide prevention and mental health crisis hotline will be accessible to Americans in July 2022 by dialing a universal, easy-to-remember telephone number, 988. This new hotline and assistance system represents an opportunity to develop an infrastructure that focuses on immediately connecting individuals in suicidal, mental health and/or substance use crisis to supportive care. This easy-to-remember number is the first step in a fundamental shift in how people experiencing a behavioral health crisis will be engaged in our communities. 988 creates parity for mental health care access similar to that available for physical health through the 911 system and represents the next giant step in reducing stigma for those at risk of a behavioral health crisis. A landscape analysis conducted in March 2021 revealed that all of Kentucky's crisis centers are understaffed to respond to the anticipated volume of need once 988 is implemented, that they do not have the technological capacity to answer all calls, that mobile crisis services are insufficient to meet expected demand, and that a significant promotion effort will be needed to increase awareness of the services available through 988.

Plans to Address Identified Need/Gaps

KY is pleased that the ARPA application guidance letter specifically encouraged states to utilize funds to support a sustainable behavioral health crisis continuum of care, including the emerging 988 network- as was suggested in the federal legislation. Kentucky has received a 988 Implementation Planning Grant to support the initial planning process, with the state's initial plan due to SAMHSA by Dec. 31, 2021. That grant has funded the creation of a stakeholder coalition designed to provide insight into the implementation process. This proposed project takes that implementation plan to the next steps and ensures that crisis centers have the capacity needed to meet the projected volume requirements. Funds are needed to support increased staffing to meet the anticipated volume as projected by Vibrant.org, owners of the National Suicide Prevention Lifeline, through which the 988 number will be rolled out. Crisis center directors have indicated they do not currently have the capacity to ensure calls from all residents in their region will be responded to in a timely basis by a local provider and the coalition and others are strategizing solutions. Plans are underway for all 14 CMHC crisis centers will be accredited to answer 988 calls. Should a given CMHC not be able to become accredited, they will contract with an accredited call center to provide primary and backup coverage. The overarching goal is for all 988 accredited crisis centers to have the staffing capacity

to meet anticipated year one call, text, and chat volume as proposed by the National Suicide Prevention Lifeline. This is anticipated to be around 42,000 for KY in the coming year. For optimal success, these systems must have the capacity to coordinate crisis care in real-time, have full array of available crisis services (mobile, 23 and 24 hour crisis beds, psychiatric beds) and the ability to readily track such availability with interoperable IT systems. It also is imperative that appropriate and sustainable data collection systems be in place to ensure quality monitoring aimed at improving systems over time. These issues are challenging and additional funding and strategic planning for sustainable funding is underway. ARPA funds are greatly needed to meet immediate needs, particularly as KY is determining the actual costs associated with 988 implementation.

Adults with SMI

Evidence-Based Practices (SMI)

Identified Need/Gaps

Kentucky's statutory definitions for SMI is more stringent than the federal definition and thus the prevalence rates are lower than most used nationally. Based on an estimated prevalence rate of 2.6% of the adult population in KY, the 14 CMHCs served approximately 50% (43,410 of 86,216) of the estimated number of individuals with SMI and 6.90% (5,950) of those individuals receiving TCM services, in SFY 2020. DBHDID has created guidance documents for determining TCM eligibility, which includes SMI, SED and SUD designation https://dbhdid.ky.gov/dbh/documents/tcm/faq.pdf. A Recovery Oriented System of Care and Continuity of Care (between inpatient and outpatient) for individuals with SMI are top priorities for DBHDID, yet challenges remain, including:

- Increasing the utilization of crisis stabilization programs and other crisis services as alternatives to hospitalization;
- Inadequate reimbursement rates for specialty services such as crisis stabilization, peer support, and assertive community treatment;
- Limited availability of supervised housing in the community;
- Limited availability of safe, affordable housing for adults with SMI, especially in rural areas of Kentucky;
- Limited availability of housing assistance for adults with SMI, including housing vouchers, rental assistance, etc.; and
- Lack of consistency in beliefs about the reality of recovery for individuals with SMI, and subsequent lack of adoption of recovery mindset for all providers.

Plans to Address Need/Gaps

ARPA Funds will be used to further enhance and expand the availability of evidence-based practices for adults with SMI. This will include further supporting the delivery of services for which there is no other payor (Medicaid, Medicare, insurance) and for services for which the insurance/ Managed Care Organization rates are not adequate to cover the cost of providing the service. These include services like Individual Placement and Support (IPS) Supported Employment, Supportive Housing, Assertive Community Treatment, etc. Integrated Treatment and Housing Supports for adults with SMI are a very important part of the continuum of services and KY has several vendors with whom they contract to provide a full array of services and supports to ensure success among adults with SMI in integrated community settings. ARPA funds will be utilized to increase funding to allow for expansion of these services to a greater number of individuals in need. *(Note: Integrated Treatment includes those services for adults with co-occurring SMI and substance use disorders or co-occurring SMI and chronic physical health conditions.)*

Funds will be used to promote training, coaching and technical assistance for providers at all levels of the system and for partners in the community that may interact with adults with SMI, including first responders, landlords, family members and others. Funds will be used to support programming aimed at assisting adults with SMI, and their families, offered by statewide agencies. Such programming may include operation of warm lines, peer led support groups, training opportunities and other types of support activities. Funding may be used to create pilot projects and research initiatives to allow for future development of needed services like mental health courts, tobacco cessation (for adults with SMI) or practices like Cognitive Enhancement Therapy (CET), an intervention used to improve cognitive and social functioning in individuals with schizophrenia. DBHDID has solicited proposals from a large variety of current partner agencies, and possible new vendors, and will score these and determine how best to utilize ARPA and other funds that are available.

Arrest and Incarceration Diversion (SMI)

Identified Need/Service Gaps

Nationally, an estimated 15 to 17 percent of people booked into jail have active symptoms of serious mental illness (SMI)[1], an estimate three times that of the general public.[2] The majority frequently have co-occurring substance use disorders[1] and chronic physical health problems[3], are often poor and/or homeless, and have a history of physical and sexual abuse.[1] Upon incarceration, individuals who have a serious mental illness are increasingly vulnerable to intimidation and assault. The jail environment can exacerbate symptoms leading to behaviors that prolong their incarceration. Rates of recidivism are also high, particularly among those with serious mental illness and co-occurring substance use.[4] Further, according to a study released by the Treatment Advocacy Center [5], the risk of being killed while being approached or stopped by law enforcement in the community is 16 times higher for individuals with untreated serious mental illness than for other civilians. And, most significantly, conservative estimates suggest that at least 1 in 4 fatal law enforcement encounters involves an individual with serious mental illness. The statistics are even more pronounced among black, indigenous, and people of color.[6] These numbers are stark and underscore the inhumanity that results from the criminalization of mental illness. Increased options for diversion of individuals suffering from severe behavioral health issues must be available to prevent them from being

improperly funneled into the criminal justice system. Implementation of jail diversion models has the potential to decrease costs to the criminal justice system, reduce incarceration rates and recidivism, and provide a more effective, trauma-informed, and racially equitable response to individuals with serious behavioral health needs who are in crisis.

Plan to Address Identified Need/Gaps

KY was awarded a Transformation Transfer Initiative (TTI) grant, Diversion Options: Voice and Empowerment (DOVE) Delegates, which is a research and development partnership that will design an alternative crisis response model that meets Louisville's unique needs, based substantially on input from the city's residents and those directly impacted. This initiative offers a unique opportunity to enhance the crisis behavioral health system of care in Louisville by initiating an alternative response model for individuals with serious behavioral health conditions. The timing and geographic location of this initiative has been optimal. As Kentucky's largest city, Louisville has been riddled by the opioid epidemic, the COVID pandemic, and racial tension. Protests across the city, exponential increases in calls to the local behavioral health crisis call/text lines, a rise in psychiatric crises, and a study of Kentucky's students and families indicate increased mental health distress all point to increased demand for behavioral health crisis response and linkages to treatment. This is a city in dire need of crisis system enhancements, including jail diversion options. The city has a history of fits and starts with similar initiatives and many community members and key stakeholders remain skeptical of innovations. Because of this history and current circumstances, there is need to balance urgency with pragmatism and take a purposeful, intentional approach to implementation driven by the principles of implementation science and practice. To that end, DBHDID has used TTI funds to implement a two-phased approach for addressing this issue. Phase I consisted of exploration by conducting a feasibility study of an alternative crisis response model for individuals with serious behavioral health conditions and Phase II will consist of the design and installation of a model which includes co-creation of the model, installation activities, and preparation for launch of a pilot in a police district.

Diversion Options: Voice and Empowerment (DOVE) Delegates builds upon existing jail diversion and other system transformation efforts in Louisville. Valuable partnerships have been forged between city leaders, local universities and the Department to learn about and determine feasible models to replicate. Resources for implementation and sustainability are outlined in the feasibility study and sources of funding and other needed resources are being identified and secured. KY proposes to utilize ARPA funds to offset some of the costs, particularly to conduct a pilot implementation program whereby replication and lessons learned could be shared statewide. Other funding sources are being sought at the local level.

References

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Children with SED

Evidence-based Practices (SED)

Identified Need/Gaps
Based on an estimated prevalence rate of 5% of the child (under age 18) population in KY, the 14 CMHCs served approximately 47% (24,094 of 51,169) of the estimated number of those individuals with SED in and 11% (5,722) received Targeted Case Management (TCM) services, in SFY 2020 (unduplicated counts).

Children under age six (6) with SED continue to be served at lower rates than older youth. Using the same prevalence rate (5%), only 6% of children ages birth through five (5) who had and SED were served in SFY2020 (1,022 of 16,948). Of those identified with SED, 17% (174) received TCM. This demonstrates the need for increased attention to workforce development and service delivery in the area of early childhood mental health (ECMH). While Kentucky has had a statewide ECMH program in place for nearly 20 years, it is solely supported with Tobacco Settlement Funds and Medicaid/insurance billing. Funding levels remain insufficient to meet the needs of young children and their families.

Rates for children with SED under age 18 (including those under age six) served have decreased annually for several years. Likewise, CMHCs report a decrease in the number of child-serving staff in several areas including Targeted Case Managers, Community Support Associates, and clinicians who are trained to and routinely serve children age birth-five. This may be attributable to workforce churn (i.e., staff turnover; schools hiring mental health clinicians rather than contracting with CMHCs for services; provider network expansion), and managed care organizations declining services.

Currently, there is not a standardized process for the Department for Community Based Services/DCBS (Kentucky's child welfare agency) to screen and refer children and youth with SED to CMHCs for further assessment and treatment, except for those children and youth who enter out-of-home-care. With the support of a SAMHSA System of Care Expansion and Sustainability Grant, DCBS and DBHDID are creating the infrastructure to expand the screening, referral, assessment, and treatment process to children and youth who have DCBS involvement and are remaining in their homes. It is hoped that this will help identify the mental health needs of children, youth, and families early so that services and supports can be put in place and keep families together.

As families and children return to work and school after the pandemic, the need for mental health services and supports for Kentucky's children and families will likely increase. It is important that DBHDID engage in infrastructure development that supports a Kentucky's network of behavioral health safety net providers (i.e., CMHCs) in developing and maintaining a robust, well-trained workforce that can adequately address the needs of children with SED and their families.

Plans to Address Identified Need/Gaps

ARPA funds will be used to further enhance and expand the availability of a continuum of evidence-based/promising screening, referral, assessment, and intervention practices for children and youth with SED. This will include further supporting the delivery of services for which there is no other payor (Medicaid, Medicare, insurance) and services for which the insurance/ Managed Care Organization rates are not adequate to cover the cost of providing the service. These include services like High Fidelity Wraparound, early childhood mental health clinical and consultative services, multi-tiered school based services and supports, respite care and Individual Placement and Support (IPS) Supported Employment and Supported Education for older youth. KY has grown a network of youth and family (parent/caregiver) peer support specialists and hopes to further increase and enhance this important part of the continuum of services and supports. Kentucky's CMHCs have a large number of clinicians that serve the behavioral health needs of children/youth in the school setting and plans to utilize funds to allow for expansion of these services to a greater number of those in need.

Funds will also support CMHCs in creating streamlined screening, referral, and assessment processes for children and youth who are served by the DCBS. These efforts align with Kentucky's implementation of the Family First Prevention Services Act and currently-funded SAMHSA System of Care Expansion and Sustainability Grant, both focused on increasing availability and quality of mental health services and supports to children and youth with SED who are involved with the child welfare system in order to improve mental health outcomes and keep them safely in their homes.

ARPA funds will be utilized to promote training, coaching and technical assistance for providers at all levels of the system and for partners in the community that may interact with children and youth with SED, including first responders, teachers/coaches, family members and others. Funds will be used to support programming, offered by statewide agencies, aimed at assisting children, youth and

their families. Such programming may include operation of summer and afterschool programming, help lines, peer led support groups, virtual and in-person training opportunities and other types of support activities. Funding will be used to solicit proposals from CMHCs to provide expanded Wraparound programming.

Additional Youth and Family Peer Services

Identified Need/Gaps

In Kentucky, there are youth and family/caregiver peer support services available to some individuals through the network of behavioral health service providers that are able to bill Medicaid managed care organizations. However, there remains significant unaddressed need for these services for those who are not clients of the CMHCs or licensed Behavioral Health Services Organizations (BHSOs) or in areas where these providers do not have these services readily available. To meet this need, the Division of Behavioral Health has supported the creation of Peer Support Centers. These Centers have provided virtual services pairing certified Youth Peer Support Specialists with youth in need and certified Family Peer Support Specialists with parents in need. Kentucky has a certification process for Youth and Family Peer Specialists which is described in greater detail in their larger Block Grant application. There have been a variety of relationships developed that allow courts, schools, and parent support groups to refer youth and parents to the Peer Centers where they are able to access formal and informal services and supports, for no fee. There have been a variety of virtual support services (chat rooms, warm lines, on-line support groups) scheduled weekly and many virtual training opportunities scheduled over the course of the past 16 months.

ARPA funds will allow KY to open/operate additional Peer Support Centers in underserved geographic locations and afford the Centers to hire additional staff where needed. The KY Division of Behavioral Health partners contractually with the KY Partnership for Families and Children (KPFC), a statewide, private, not-for-profit organization that believes all families raising youth and children affected by behavioral health challenges deserve responsive systems providing services and resources that are Family-Driven and Youth-Driven. KPFC serves as the state chapter of the National Federation of Families for Children's Mental Health and Youth Move National. More information about KPFC can be found on their web site.

www.kypartnership.org

Transition Age Youth Services

Identified Need/Gaps

There is an urgent need to provide enhanced access to a variety of behavioral health service and support options for youth and young adults between 16 – 25 years old with or at risk of developing serious behavioral health disorders (mental health and/or substance use); hereafter referred to as transition age youth (TAY). The services and supports must be provided in a manner that is inviting to them. Many behavioral health services across Kentucky are provided in traditional outpatient settings that are not developmentally appropriate or culturally relevant to TAY, do not value the voice of TAY in their own treatment, are based on the medical model of care, and are not seamless when transitioning from child to adult services. The events of the past year and a half (social unrest, pandemic, weather related disasters in KY) have been particularly difficult for youth/young adults, increasing isolation and disconnection with their community and the supports available to them.

The 2017 Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) report to Congress indicated that in 2016, 5.9% of 18-25 year olds in the United States had a serious mental illness (SMI) and for children with severe emotional disabilities (SED) this prevalence varied between 6.8% - 11%. In Kentucky in 2017, the penetration rate for TAY with SED or SMI was 1.5% (KY Cabinet for Health and Family Services, 2018). The same ISMICC report indicated that the percentage of children with a mental disorder in the United States ranges between 13-20%. Within Kentucky's Community Mental Health Care (CMHC) system, the penetration rate for TAY with behavioral health issues served across Kentucky was 5.4%. In addition, the American Foundation for Suicide Prevention reports that in Kentucky, suicide is the second leading cause of death for young people between 15-34 years old. Among adults served in Kentucky's public mental health system in 2014, only 12.6% of those age 18–20 were employed (SAMHSA Behavioral Health Barometer, 2015; page 12). While all of the CMHCs provide the Individual Placement and Support (IPS) Model of Supported Employment, recent data from the Cabinet for Health and Family Services revealed that the average recipient receiving this service is 38 years old. Furthermore, data from the 2019 Kentucky Injury Prevention and Research Center survey shows that the overdose rate for the transition age population (15-24) is the fifth highest overdose rate in the state.

While there are pockets of specialized supports for TAY in various areas of the state, substantial service gaps still exist through the transition from child to adult service options. There also is need to improve statewide coordination of specialized TAY supports across all CMHCs. Young people are in-between existing service systems and present with multiple behavioral health issues including severe emotional disturbance (SED) and Early Serious Mental Illness (ESMI), including First Episode of Psychosis, with few receiving peer support services and even fewer receiving substance use services. In addition, prevention services could focus more on this population for early interventions in local communities. Targeting services to TAY while also being developmentally appropriate, culturally and linguistically competent builds protective factors specifically for this "invisible" population.

Plan to Address Identified Need/Gaps

The Division of Behavioral Health recently entered into a Memorandum of Understanding (MOU) between the Adult Mental Health and Recovery Services Branch, the Children's Behavioral Health and Recovery Services Branch, the Adult Substance Abuse Treatment

and Recovery Services Branch, and the Behavioral Health Prevention and Promotion Branch within the Division of Behavioral Health (DBH) under the Kentucky Department for Behavioral Health, Developmental and Intellectual and Developmental Disabilities (KDBHDID). Through this MOU, a Transition Age Youth (TAY) Cross Branch Implementation Team was initiated that includes key liaisons from each Branch. This state level TAY Cross Branch Team is charged with enhancing the seamless coordination of TAY behavioral health services across child and adult services, as well as substance use prevention, treatment and recovery. Kentucky proposes to mirror this state level work by increasing the seamless coordination of services within and across all fourteen CMHC regions, thus increasing the capacity of Kentucky to provide more engaging and youth-directed service and support options to TAY and their families through the behavioral health safety net.

This will be accomplished through systemic and programmatic enhancements aimed at shifting the paradigm in behavioral health services for TAY to a system of care that is more responsive, accessible and inviting to them. At the system level, there will be the establishment of a Transition Age Youth (TAY) Coordinator within each CMHC, responsible for collaborating across local programming to enhance supports that are developmentally appropriate and evidence informed for youth, youth adults, and their families who are affected by serious behavioral health issues (mental health and substance use). The TAY Coordinator will provide consultation, referral, education, training, technical assistance, coaching, outreach, and system development within the regional CMHC community in order to increase seamless and easily accessible supports for TAY.

KY will partner with NAMI Louisville to provide outreach and assist with ensuring youth and family voice as programming is further enhanced and implemented. NAMI Louisville has proven to be a valuable partner in effectively reaching and engaging the TAY population statewide.

At the programmatic level, building on the success of the present 2019 Healthy Transitions Grant, (TAYLRD 2.0), funding will be used to expand a drop-in center model of behavioral health care as well as TAY focused service enhancements. At least four (4) drop-in centers will be supported across the state which will include both formal and informal services such as peer support, employment, education, and career planning, medication management, age specific behavioral health treatment, coordination of care, life skills, and health care navigation. Referrals to specialty behavioral health services through local providers also will be available.

In various areas of the state, a drop-in center approach is not feasible. Kentucky also proposes to provide funding for an additional two (2) CMHC regions to enhance outpatient office environments and the service arrays within these offices to be more inviting for young people. KY's established Practice Guidelines will be used as a model for both drop-in center and TAY focused service enhancement (non drop-in centers). A Notice of Funding Opportunity Application process will be used to determine interest and readiness for both the drop in centers and TAY focused service enhancement. KY's established fidelity review process will be utilized to support implementation throughout the grant and sustainability of funding after the grant cycle is complete.

First Episode Psychosis (10% Required Set-Aside for KY = $1,854,192.40)

Identified Need/Service Gaps

Kentucky currently has eight (8) sites providing Coordinated Specialty Care (CSC) for young people experiencing First Episode Psychosis (FEP), operated by eight (8) Community Mental Health Centers (CMHCs). Kentucky named these sites iHOPE (Helping Others Pursue Excellence). Each of the iHOPE sites are unique, based on strengths and challenges of their respective communities and service areas. For example, four (4) of the iHOPE sites are located in very rural areas, in the far eastern and western areas of the state. Rural sites experience challenges such as transportation barriers, limited and changing workforce, low socioeconomic status, and geographic isolation. Four (4) of the iHOPE sites are located in areas considered more urban (i.e., Central/South Central). These areas generally have greater transportation options, participants are less geographically isolated and physical access is easier. However, each respective CMHC region include some counties that are considered rural.

The recent pandemic made access/obtaining needed services even more challenging for young people with FEP, and their families. The pandemic led to the loss of many in-person service settings, including schools, doctor's offices, community venues, actual CMHC offices, etc. The iHOPE staff had utilized all of these in-person settings to engage and provide services. Policies were quickly developed related to telehealth, social media and other virtual methods of contact. Some iHOPE participants preferred the virtual services, but for some, symptomology interfered with the ability to utilize virtual services.

Some rural iHOPE sites have adopted the rural model of CSC programming, having several team members trained in CSC components who provide services that cover very remote counties. This model is designed to have a core iHOPE team, with a team leader who coordinates referrals, screenings, assessments and treatment among several outlying team members. Regular iHOPE team meetings are even more important with this model, being necessary to ensure communication and guidance for effective treatment of all participants. During the pandemic, many iHOPE team meetings were held virtually or via conference call. Workforce issues were pervasive during the height of the pandemic, and continue to be an issue, especially in recruitment and retention. Even though each iHOPE team remained viable, some teams look very different than they did before the pandemic, especially concerning workforce.

Prevalence Data

Kentucky Community Mental Health Centers - 2019 Estimated Population Chart - Per Year Estimated Incidence Rates for FEP

CMHC	Total Pop	National per year incidence estimate for FEP = .03%

Four Rivers	204,976	61
Pennyroyal	202,477	61
River Valley	215,967	65
Lifeskills	308,919	93
Communicare	278,433	84
Seven Counties	1,008,204	302
NorthKey	464,223	139
Comprehend	55,337	17
Pathways	216,362	65
Mountain	139,009	42
Kentucky River	103,599	31
Cumberland River	230,189	69
Adanta	209,369	63
New Vista	830,609	249
Kentucky	4,467,673	1,340

Number of First Episode Psychosis (FEP) Programs Needed -Kentucky 2019 Data

Estimated Kentucky Population (2019)	4,467,673
Estimated Incidence of FEP/Year	.03%
Number of FEP Instances/Year *(4,467,673 x .0003)*	1,340
Percentage of Individuals with FEP approached (this is high estimate of % of young people a program will reach)	50%
Number of Individuals experiencing FEP approached/Year *(1,340 x 50%)*	670
Percentage of Individuals likely to engage in FEP program	**75%**
Number of Individuals willing to engage in FEP program/Year (*670 x 75%)*	503
Number of Individuals served by 1 FEP program (CSC Model is low ratio of 30 – 40 participants)	35
Number of FEP programs needed statewide *(503 divided by 35)*	14

Coordinated Specialty Care (CSC) - Evidence Based Practice for First Episode Psychosis - Estimated Cost of CSC Team in Kentucky

Position	Full Time Equivalent (FTE)	Average Annual Salary per FTE in KY
Clinician/Team Leader	1.0 FTE	44,310
Targeted Case Manager	1.0 FTE	42,514
Peer Support Specialist	1.0 FTE	33,305
IPS Supported Employment/Education Specialist	.50 FTE	18,764
Prescriber (APRN)	.30 FTE	30,220
RN Nurse	.10 FTE	6,834
Clinician	.50 FTE	22,155
Total	3.90 FTE	198,102
36% Fringe + 15% indirect*		101,032
Total with Fringe		299,134

*This exceeds the allowable rate in KY

Data Sources

1. Kentucky State Data Center
2. Population and Housing Estimates | Kentucky State Data Center (louisville.edu)

3. Jennifer L. Humensky, Ph.D., Lisa B. Dixon, M.D., M.P.H., and Susan M. Essock, Ph.D., State Mental Health Policy: An Interactive Tool to Estimate Costs and Resources for a First-Episode Psychosis Initiative in New York State. Accessed online at http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201300186

4. First Episode Psychosis Programs: A Guide to State Expansion National Alliance on Mental Illness, February 2017

5. Kentucky Salary Estimates from https://salary.com

Plan for Addressing Need/Gaps

Kentucky Division of Behavioral Health has a core team for First Episode Psychosis. This team, which is comprised of program administrators across child, adult, and other programming, has developed plans for strengthening and supporting the iHOPE sites in Kentucky.

First, by utilizing available national tools, through OnTrack NY and NAMI National, Kentucky analyzed prevalence numbers regarding First Episode Psychosis as well as the actual cost for maintaining a CSC team in Kentucky. It was discovered that the cost of a team was significant and exceeded the financial support DBH had been providing teams.

Kentucky created a funding plan for funding existing iHOPE teams at full funding capacity, based on data analysis. In addition, contract deliverables were rewritten to further support and sustain CSC/iHOPE teams. All iHOPE teams must have some full time crucial positions on their teams, and must provide access to all needed CSC services. In addition, DBH will further support these teams with training and technical assistance, including ongoing coaching regarding CSC. Beginning in FFY 2023, Kentucky plans to fund one additional iHOPE team. Kentucky's core team is also working to develop additional funding sources for this important work, post pandemic. Kentucky has room for a few more iHOPE teams and hopes to fund new teams going forward.

In addition, Kentucky has always provided a small amount of funding to all CMHCs who do not have iHOPE teams. This funding was utilized to assist those CMHCs with identification of key contact staff in their region who could work on planning for identification and treatment of young people in their area with First Episode Psychosis. Statewide meetings have occurred twice a year for a while, where all CMHC identified staff attend to discuss First Episode Psychosis issues, as well as all CMHC identified staff have been trained in specialized screening and assessment tools and Cognitive Behavioral Therapy for Psychosis. In FFY 2023/2024/2025 planning with new funding, Kentucky is increasing the amounts given to these CMHCs without iHOPE teams and requiring they develop a written plan for how they will provide necessary services to this population, and take steps to have additional pertinent staff trained in screening, assessment and treatment processes that are evidence-based for this population.

Recently, in a webinar hosted by EPINET, it was announced that EPINET would host a third annual national conference on First Episode Psychosis in February of 2022. They encouraged all CSC teams in their states be able to participate in some way. The conference was reported to be a combination of virtual and in-person. Kentucky is planning to provide funds for iHOPE teams to be able to attend this national opportunity.

Lastly, Kentucky proposes to use some funding to assist with fidelity reviews for existing iHOPE sites. The pandemic interrupted the cycle and process for fidelity reviews for CSC. More work needs to be done to determine a viable method of review going forward, as well as a viable fidelity review team. DBH would like to collaborate with some partners in this effort. There are local universities that provide fidelity reviewers and coaches for various evidence-based practices. In addition, several advocacy groups in Kentucky bring

together individuals and family members with lived experience. Kentucky will be working with national experts and local partners to recreate a fidelity process and method that works best for this population and specific team practice.

Behavioral Health Workforce Development Initiative

Identified Need/Gaps

Current research about the impact of the COVID-19 pandemic and other natural disasters on individuals, families, and communities points to the inevitable truth that swift and appropriate intervention is needed. Many of Kentucky's citizens will experience short-term distress and a smaller, but measurable, portion of citizens will experience more long-term negative consequences. Specific plans to address the growing demand for behavioral health wellness and behavioral health treatment for individuals and their families can mitigate these consequences. As we move forward, behavioral health wellness interventions can be the best defense against long-term and more devastating outcomes for a larger percentage of the population. Prevention, early intervention, and research-informed treatment strategies should be provided by skilled preventionists, clinicians and paraprofessionals who meet the needs of Kentucky's continuum of care and are adequately compensated for their expertise.

Kentucky lacks an adequate number of behavioral health professionals needed to meet current demands for services along the continuum of care. Without long-term strategies to address these workforce shortages, including the implementation of prevention and promotion strategies, the situation will worsen. According to the U.S. Healthcare Resources and Services Administration (HRSA), Kentucky is designated as an underserved state for behavioral health services, meaning that there is not a sufficient number of various types of behavioral health providers (psychiatrists, prescribers, licensed clinicians, etc.) to meet the estimated need. Kentucky lacks a robust plan for attracting students into behavioral health and related careers and offers very few loan forgiveness or tuition reimbursement opportunities. The salaries for publicly funded providers are very low and the productivity standards are very high. Staff recruitment and retention is a constant struggle and clients often report staff turnover as a primary reason for discontinuing services. In order to adequately meet the behavioral health needs of Kentucky, workforce development issues must be elevated as a point of priority.

Plan to Address Identified Need/Gaps

DBHDID seeks to ensure that there is an adequate behavioral health workforce in Kentucky to meet the current demand for services across the continuum of care and the anticipated increase in the demand for the short- and long-range future. DBHDID also seeks to provide/support the provision of intensive training/coaching for the current workforce and all new hires of the publicly-funded, behavioral health providers in the 14 CMHCs, to meet the immediate- and short-range need to address the behavioral health demands initiated or exacerbated by the past couple of years. A multi-year strategic plan to address Kentucky's perpetual behavioral health workforce shortage is needed and will require a varied approach that is comprehensive and well executed. To ensure optimal outcomes, DBHDID proposes to utilize ARPA funds to employ a dedicated staff person to serve in a leadership role to address the short-term and training related workforce needs and

an additional dedicated staff person to serve in a leadership role to address the long-term workforce shortage of behavioral health professionals in Kentucky. Optimally, to be successful in a rather short timeframe (present to 2025), these proposed staff members must possess significant knowledge of the current publicly-funded healthcare network and the national entities with which Kentucky needs to partner, awareness of research-related strategies specific to workforce development, blueprints for initiation of career pipelines, skillsets to work with post-secondary institutions to address college curricula, and have the personal characteristics to engage a wide variety of persons and organizations to assist with meeting the objectives set out in this proposal and the organizational skills to oversee such an endeavor. To best achieve these goals, DBHDID plans to engage the assistance of multiple state agencies to rapidly advance the plans, including:

1) Department for Public Health in the Cabinet for Health and Family Services that is responsible for reporting to the National Surveillance entities the number of behavioral health professionals statewide;
2) Kentucky Council on Post-Secondary Education that collectively represents all public colleges and Universities who mission it is to provide needed workforce with appropriate knowledge and skills in a given profession;
3) Cabinet for Education and Workforce Development;
4) Department of Professional Licensing in the Public Protection Cabinet that oversee the certification and licensure of behavioral health professionals (Social Work, Marriage and Family Therapists, Art Therapists, Professional Counselors, Alcohol and Drug Counselors, etc.);
5) State Boards of Psychology, Nursing and Physicians (psychiatrists and pediatricians);
6) Kentucky Higher Education Assistance Authority (KHEAA) that improves access to college and technical training; and
7) Kentucky Certification Board of Prevention Professionals (KCBPP) that provides standards, examinations and certification for alcohol, tobacco and other drug (ATOD) prevention specialists (Certified Prevention Specialists, CPS).

Proposed activities would include: 1) Establishing data sharing agreements in order to have access to the certified and licensed behavioral health providers statewide that address Kentucky's continuum of care needs. It might be necessary to hire or contract for a portion of an FTE to collect, organize and analyze data. The data will assist with understanding capacity in particular degree fields, including the number of graduates entering the workforce and those who attain and maintain licensure. This type of data collection will allow for data-driven decision-making; 2) Engaging behavioral health providers along the continuum of care in the strategic planning process inclusive of creating a multi-year plan to address the statewide behavioral health workforce shortages including region-specific goals and objectives; 3) Providing finances to incentivize/off-set costs associated with recruitment and retention of staff within the CMHCs including designating funding sources for this specific purposes; 4) Exploring, creating, and providing funding for tuition reimbursement and/or loan forgiveness programs across the network of CMHCs; 4) Expanding the role of students and their families in recovery;
5) Enhancing the means for promotional opportunities and the exploration of career ladders for behavioral health professionals of all types along the continuum of care, including fostering leadership skills; 6) Ensuring access to and provision of quality supervision strategies focused on attaining and maintaining competence; 7) Establishing pilots in different regions to test projects for successful

implementation of different approaches to addressing the issue of behavioral health professional shortages, including strategic experiential learning opportunities throughout coursework, developing scholarships for community partners to pursue further education and financially supporting the establishment of faculty position(s); and 8) Promoting oversight of infrastructure sustainability to support workforce development. All national resources would be used to accelerate and enhance these activities (e.g., Annapolis Coalition, MTTC Workforce Development materials, HRSA, BH Workforce Resource Center, etc.).

CCBHC Readiness Initiative

Identified Need/Gaps

In an effort to improve and sustain a strong behavioral health "safety net" provider system statewide that ensures optimal access to and improvement of quality, community behavioral health services, KY is anxious to adopt the Certified Community Behavioral Health Clinic (CCBHC) model. Kentucky is one of two states recently added to the CCBHC Demonstration Project. Currently, 4 of Kentucky's 14 CMHCs are CCBHC Demonstration candidate agencies. They, in partnership with KY Medicaid, DBHDID and other partners are working towards meeting the CCBHC certification criteria to demonstrate the effectiveness of this business model in KY. It is proposed that each of the four will receive $500,000 in ARPA funds from January 2022 through September 2025 to assist with readiness activities and expansion of needed infrastructure and service capacity. Specifically, this would include efforts to recruit, onboard and train required staffing, improve their IT capacity and improve their mobile services capability (including lab services) to ensure overall readiness for implementation of the CCBHC model.

Disaster Preparedness, Response and Resilience

Identified Need/Gaps

During February 6 - March 10, 2019, 60 of Kentucky's 120 counties experienced severe storms producing prolonged episodes of heavy rain, strong winds, and isolated tornadoes resulting in flooding, flash flooding, landslides, and mudslides. Declared a disaster on April 17, 2019, the event impacted federal, state, and local roads and bridges; state and local parks; and critical facilities such as utilities, schools, and drainage, water and sewer systems with estimated physical damages totaling $150 million (FEMA-4428-DR). There were subsequent events in 2020, including ice storms, flooding and landslides and FEMA was once again in the state to access and estimate damages.

While the majority of individuals who survive a disaster may not seek or require formal behavioral health services, most can benefit from short -term interventions that validate and normalize their reactive feelings or behaviors. Rates of psychological distress among survivors double after a disaster with nearly one-third of survivors reporting a post-disaster mental health disorder, one-fifth of which are Post Traumatic Stress Disorder (Gordon, et. al, 2011; North, et al, 2002). Post-disaster psychological responses fluctuate from emotional highs with community cohesion in the honeymoon stage immediately after the event to psychological lows and grief during

the disillusionment and reconstruction periods 6-24 months later ((Zunin & Myers as cited in Wolfe, 2000). Kōlves et al. (2013) purport that behavioral health impact should be monitored and appropriate interventions offered for several years after a disaster. The behavioral health impacts of the 2019 natural disasters in KY are further compounded by other public health crises, such as the opioid epidemic and the COVID-19 global pandemic, have been especially felt in some areas of the state. Given the high mortality rate for "diseases of despair" (e.g., overdoses, suicide), these individuals and communities were already suffering tremendous stress and strain. The confluence of the opioid crisis, suicide crisis, natural disasters, and the current COVID-19 pandemic place individuals in these communities at particularly high risk for serious psychological distress, especially those with pre-existing behavioral health conditions (SAMHSA, 2019). Thus, the need to support these communities with behavioral health resources to prepare, respond, and recover from disasters is paramount.

Plan to Address Identified Need/Gaps

Recent and on-going weather related disasters in KY, as well as the pandemic and have reminded us of the vulnerabilities of the SMI and SED populations when disasters occur. To this end, a small portion of ARPA funds will be used to secure a state level position to lead planning and implementation efforts around disaster preparedness, response and resilience for the individuals served in the publicly funded behavioral health network. Workgroups and strategic planning forums will be conducted to ensure that there are guidance documents created and implemented by the 14 CMHCs to assist the individuals, including those with SMI and SED, and their families.

A Proposed Budget for ARPA Mental Health Block Grant Funds is provided on the following page.

ARPA MH Block Grant Proposed Budget

Mental Health ARPA Funded Initiative	Set Aside* /Required Initiative	Total for Grant Period
Total		$18,541,924
Crisis Services ***$927,096.***	Yes 5%	$2,000.000.
Crisis Continuum - 988	Suggested	$2,750,000.
FEP ***$1,854,192.40***	Yes 10%	$2,575,000.
SMI - EBPs (ACT,IPS,SH, COSP) -Arrest/Jail Diversion	Required	$4,183,462.
SED -ECMH -School-based Srvs. -HFW -TAY	Required	$2,183,462.
Workforce Development	Suggested	$500,000.
CCBHC Readiness	Suggested	$4,000.000.
Disaster Preparedness, Response, Resilience (FEP, SMI, SED)		$350,000.